'Oh! Man!' the foreman cried, minutes after an Amtrak train killed two workers in Chester

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It was 7:51 a.m. last April 3, and an Amtrak train had just derailed in Chester, killing two workers on the tracks. The foreman on duty called a dispatcher, trying to grasp how a train could have been traveling on tracks he believed to be secure. They weren't, the dispatcher said. The tracks had been opened for train traffic less than a half-hour before.

“Oh my gosh!” the foreman is quoted as saying in transcripts from radio and phone communications after the impact. “You’ve got to be kidding me! Oh! Man!”

New documents released Thursday by the National Transportation Safety Board describe the shock and confusion of workers as a train slammed into a backhoe on tracks that should have been closed to traffic. The documents also show that the engineer and the two workers tested positive for drugs. The backhoe operator, Joe Carter, and a supervisor, Peter Adamovich, two veteran Amtrak employees, were killed.

The train of eight passenger cars, a cafe car, and a baggage car was heading from New York City to Savannah, Ga., carrying seven crew members and 337 passengers. The crash injured 41 on the train.

The NTSB docket includes hundreds of pages used in the ongoing investigation into the April accident. The agency is expected to release conclusions later this year.

The docket identifies problems at multiple levels, from Amtrak’s management down to track workers, that may have contributed to the crash. Among them:

• Miscommunication between two site foremen and between the foremen and dispatchers about what safety protections were active while workers were on the track.

• A lack of a briefing for on-site workers to explain the safety precautions in place.

• A failure to use shunts, devices that would alert dispatchers to workers on the tracks, despite Amtrak regulations requiring them.

• A lack of planning from Amtrak managers overseeing the maintenance operation.
Investigators documented conflicting stories between foremen who handed off responsibility for the work site between shifts, with each saying the other was responsible for confusion over whether the tracks were "fouled," or closed to train traffic. Foremen use "foul time," a safety designation that should prevent trains from being routed onto tracks where workers or equipment are present.

Documents indicate that management failures, along with mistakes on the part of workers, contributed to the derailment. The maintenance work in that area, NTSB said, was so extensive that Amtrak should have done extra planning. According to the NTSB reports: “Amtrak’s responses are simply a postaccident circling of the wagons to deny supervisory or management involvement in the review of a project gone bad.”

Amtrak argued that the day's work was routine maintenance. In comments Thursday, Amtrak CEO Charles W. "Wick" Moorman defended the company's protocols and said Amtrak conducts regular safety training.

Since the crash, Amtrak has more clearly defined the use of "foul time" and made shunting mandatory if equipment is on the rails for longer than five minutes. That has made a difference, said Jed Dodd, general chairman of the Pennsylvania Federation of the Brotherhood of Maintenance of Way division of the Teamsters.

The docket also revealed that the engineer on Amtrak Train 89, Alex Hunter, 47, tested positive for marijuana. He also tested positive for opioids, but that was the result of a morphine injection during his treatment after the crash. Amtrak reported Thursday that Hunter is no longer an employee with the railroad. The engineer acted attentive, responding to alerts and keeping his eyes forward in the minutes before the crash, according to the docket.

Drugs were also found in the systems of both men who died in the crash. Carter, 61, tested positive for cocaine, and Adamovich, 59, tested positive for codeine, oxycodone, and morphine. The document stated Adamovich did not report using medications or having chronic medical conditions.

Interviews, transcripts, and reports spun out the story of what occurred leading up to the crash:

The morning of the crash, just after 7 a.m., the night foreman, William Robinson, supervisor on the tracks for the work crew, ended his shift with tracks one, three, and four fouled, or out of service.

The day foreman, John Yaeger, came on. He said he would also need those tracks out of service for backhoe work later.

Just before 7:30, after Yaeger had begun his shift, Robinson called the dispatcher, Michael Franklin, and cleared his three tracks, giving permission for trains to operate on them again. That's usually done over radio, but because of interference, Robinson used his cellphone, meaning that Yaeger could not have heard on radio. Franklin said he anticipated that Yaeger would soon call to request foul time be reinstated for his shift.
That call never came. Robinson told investigators he had a conversation with Yaeger, making it clear that protections were being lifted and that securing the tracks was now his responsibility. But Yaeger said he was not aware that Robinson had removed the protections on the rails.

At 7:50, a radio transmission came through, though Franklin, the dispatcher, said he never heard it: “Emergency, emergency, emergency.”

Train 89 was traveling at 107 mph, below the 110 mph speed limit in the area of the crash. The operator had just 16 seconds between seeing the backhoe and the impact, video stills show. A transcript of video describes the engineer holding down the train horn while pulling the emergency brake before the crash. The engineer moved the throttle to idle, then activated the emergency brake as the train was going 106 m.p.h. One second before impact the train had slowed to 99 m.p.h.

Right before the impact, the engineer crouched in self-protection.

The horn continued to sound, and the train struck the backhoe.