The Hinton train collision was a railway accident that occurred on February 8, 1986. Twenty-three people were killed in a collision between a Canadian National Railway freight train and a Via Rail passenger train. It was the deadliest Canadian rail disaster since the Dugald accident of 1947 which killed thirty-one people, and would not be surpassed until the Lac-Mégantic rail disaster in 2013 which killed forty-seven. It was surmised that the accident was a result of the crew of the freight train becoming incapacitated, and the resulting investigations revealed serious flaws in CN's employee practices.

Vicinity of the accident

The accident took place on a stretch of Canadian National Railway's transcontinental main line west of Edmonton, near the town of Hinton, Alberta. Nearby towns are Jasper to the west and Edson to the east. Passenger service on the line was provided by Via Rail Canada. Slightly over half of the 100-mile (160 km) stretch of track between Jasper and Edson was double-tracked, including 11.2 miles (18.0 km) of trackage from Hargwen control point west to Dalehurst control point. Traffic on this line was controlled with Centralized Traffic Control (CTC).

Prelude

On the morning of February 8, 1986, Via Rail's No. 4 train, the combined Super Continental and Skeena, was travelling from Jasper east to Edmonton on its transcontinental journey. It consisted of 14 units in the following order:

1. FP7 Diesel locomotive number 6566
2. F9 Diesel locomotive number 6633
3. Baggage car
4. Coach
5. Dome car number 513
6. Sleeping car
7. Sleeping car
8. FP9 Diesel locomotive number 6300 (inoperative)
9. Steam generator car
10. Baggage car
11. Coach
12. Lounge car
13. Sleeping car
14. Steam generator car

The unusual make up of the train was the result of two separate trains being coupled together in Jasper. The first 2 locomotives and 5 cars had originated in Vancouver, and the second section consisting of 1 locomotive and 5 cars had originated in Prince Rupert. The last car, a steam generator, was added in Jasper on its way to Edmonton for maintenance. One hundred and fifteen people were on board the train; 94 passengers, 14 stewards and seven crew.

Canadian National Railway's westbound train No. 413 consisted of three locomotives, EMD GP38-2W number 5586, and two EMD SD40 numbers 5062 and 5104, followed by a high-speed spreader, 35 cylindrical hoppers loaded with grain, seven bulkhead flat cars loaded with large pipes, 45 hoppers loaded with sulphur, 20 loaded tank cars, six more grain cars, and a caboose; a total consist of 3 locomotives 115 cars. It was 6,124 feet (1,867 m) long and weighed 12,804 short tons (11,432 long tons; 11,616 t). On the lead locomotive were engineer John Edward (Jack) Hudson,
aged 48, and brakeman Mark Edwards, aged 25. On the caboose, conductor Wayne "Smitty" Smith, aged 33. The freight train left Edson at 6:40 am, and took the siding at Medicine Lodge to allow two eastbound trains to pass. It departed Medicine Lodge at 8:02 am and reached Hargwen at 8:20 am, where a section of double track started. The train dispatcher at Edmonton had lined the dual control switch (DCS) so that the train was lined up onto the north track. At the same time, the Super Continental stopped at Hinton, and left five minutes late.

At 8:29 am, the dispatcher lined the DCS at Dalehurst, where the section of double track ended, to allow the Super Continental to take the south track. This turnout configuration at Dalehurst would have caused the absolute (home) signal at the control point to display a stop indication. The double-aspect approach signal 13,600 feet (4.1 km) east of Dalehurst showed an approach indication, yellow over red (meaning prepare to stop at the next signal while reducing speed to 30 miles per hour (48 km/h)). As the train approached this signal, the throttle was in the 8th notch with the train speed at 59 miles per hour (95 km/h), 9 miles per hour (14 km/h) faster than the 50 miles per hour (80 km/h) limit on this stretch of track. The engineer made no attempt to slow down after passing the approach signal.

Further west, there was an absolute three-aspect signal, 490 feet (150 m) east of the switch at Dalehurst that showed three solid-red lamps, indicating a stop. The freight still did not slow down, instead running through the DCS and entering the section of single track occupied by the Super Continental. Had the Super Continental been even a minute early, it would have been past the DCS at this point, but it was not. Seconds after the freight ran through the switch, at 8:40 am, the two trains collided.

Aftermath

After the derailment, diesel fuel spilled from the locomotives and ignited, and the locomotives, the baggage car, and the day coach were engulfed in flames. The two crew members in each of the locomotives were killed. Eighteen of the 36 occupants of the day coach were killed. The observation dome car behind the day coach suffered serious damage, and was also hit by a freight car, which was thrown into the air by the force of the collision. One of its occupants was killed. The others were able to escape either through a window in the dome that had been broken by passengers, or through the hole left by the freight car. The two sleepers following the dome car derailed and were thrown on their sides. There were no deaths in these cars, but there were several injuries. The three passenger cars at the rear of the train did not derail, but there were many injuries.

As the accident unfolded, the cars on the freight train piled up on each other, resulting in a large pile of rolling stock. The three freight locomotives and the first 76 cars of the train were either destroyed or severely damaged.

After the rear of the freight train came to a halt, Smith, the sole surviving member of the freight train's crew, attempted to contact the front of the train to no avail; he then contacted the emergency services after witnessing the growing fire.

Cause

Why the freight train failed to stop was unclear. A wrong-side signal problem was eliminated, leaving human error as the only possible cause. However, since the head-end crew of the freight train did not survive, it was not clear why they had erred. Enough of their remains were found that testing was able to rule out drugs or alcohol as the cause, though it was revealed that the engineer, Jack Hudson, was an alcoholic and heavy smoker suffering from pancreatitis and type 2 diabetes, thus placing him at risk for a heart attack or stroke.
A Commission of Inquiry investigated the crash. Justice René P. Foisy, Court of Queen’s Bench of Alberta, held 56 days of public hearings and received evidence from 150 parties. The inquiry report was published on January 22, 1987. Instead of condemning any one individual, it instead condemned what Foisy described as a "railroader culture" that prized loyalty and productivity at the expense of safety. As an example of this disregard of safety, it was noted that the crew of that train had boarded the locomotive at Edson "on the fly". While the locomotive was moving slowly through the yard, the new crew would jump on and the previous crew would jump off. While this method of changing crews saved time and fuel, it was a flagrant violation of safety regulations requiring a stationary brake test after a crew change. Management claimed to be unaware of this practice, even though it was quite common. In regards to engineer Hudson, the Foisy Commission concluded it was a possibility that Hudson had either fallen asleep at the controls or had suffered a heart attack or stroke in light of his extremely poor health, leading to the collision. The commission further criticized CN's ineffective monitoring of Hudson's health condition:

The serious nature of Hudson's medical condition...raises a strong possibility that it was a factor contributing to the collision of February 8...The Commission therefore concludes that Hudson's medical condition possibly contributed to his failure to control Train 413. The Commission also concludes that there are serious deficiencies in the manner in which CN monitored and reacted to that condition. The Commission finds that both the policies and procedures that permitted a man in Hudson's medical state to be responsible for the operation of a freight train on the CN main line to be unacceptable.\[5\]

Another frequently ignored safety regulation mentioned in the report was the "deadman's pedal", which a locomotive engineer had to keep depressed for the train to remain underway. Were he to fall asleep or pass out, his foot would slip from the pedal, triggering an alarm and engaging the train's brakes automatically a few seconds later. However, many engineers found this tiresome and bypassed the pedal by placing a heavy weight (often a worn out brake shoe) on it. It was uncertain whether the pedal had been bypassed in this case because the lead locomotive of the train had been destroyed. A more advanced safety device was available, the reset safety control (RSC), which required crew members to take an action such as pushing a button at regular intervals, or else automatic braking would occur, but neither lead locomotive was equipped with this safety feature. While the second locomotive in the freight train was equipped with RSC, it was not assigned as the lead locomotive because it lacked a "comfort cab". Management and union practice was to place more comfortable locomotives at the front of trains, even at the expense of safety.

The report also noted that although the front-end and rear-end crews should have been in regular communication, that did not appear to be the case in this accident. As the freight train reached Hargwen, Hudson radioed back to Smith that the signals were green, a communication that was heard by a following freight. As it ran towards Dalehurst there was no evidence of further communication. As the conductor is in charge of the train, had Smith felt that the train was out of control or there were serious problems, he should have pulled the brake cord in the caboose to stop the train. However, Smith, who appeared to be nervous while testifying, said that he did not feel that the freight was ever out of control, misjudging its speed. He also testified that he attempted to radio Hudson on two radios and several channels, but neither seemed to be working, despite the fact that immediately after the crash Smith was able to contact the dispatcher by radio. Despite Smith’s testimony, he apparently decided not to stop the train.

Dramatization[edit]

The story of the disaster was featured on the television program Crash Scene Investigation (2006) by National Geographic Channel in the 3-d episode, entitled "Train Collision".
Similar accidents[edit]

- **1987 Maryland train collision**, in which a freight also disregarded signals and collided head-on with an Amtrak passenger train at full speed; the crew of that freight was also found to have limited mental capacity due to marijuana use and had disabled safety features as well.
- **2008 Chatsworth train collision**, in which a Metrolink commuter train disregarded signals and collided head on with a Union Pacific freight train; the engineer of the commuter train was concluded to have been distracted by text messages.

See also[edit]

- [Alberta portal](#)
- [Trains portal](#)
- [Disasters portal](#)
- [List of rail accidents (1980–89)](#)

References[edit]

3. ^ Jump up to: "Head-On Collision" (Also "Train Collision" and "Impact on the Rails." [Mayday](http://arbitrations.netfirms.com/croa/20/CR1677.html) (Crash Scene Investigation)

External links[edit]