Penn Central Company, Collision of Trains N-48 and N-49

Executive Summary

About 8:20 p.m. on August 20, 1969, Penn Central commuter trains N-48 and N-49 collided head-on just north of the Hoyt Street crossing on the New Canaan Branch near Darien, Connecticut. Train N-48, going from Stamford to New Canaan, had a three-man crew and about 60 to 80 passengers. The first car in train N-48 had been closed to revenue passengers before it left Stamford. Train N-49, a deadhead equipment train from New Canaan to Stamford, had a three-man crew and was carrying a car inspector and an electrician who had performed service at New Canaan and were returning to Stamford, still on duty.

Probable Cause

The Safety Board determines that the collision was caused by the operation of train N-48 beyond its meeting point, in violation of properly issued train orders. It could not be determined why the engineer of train N-48 failed to stop and enter the siding at Dale as required by train order. Among the several possibilities, the Board considers it most probable that the engineer misinterpreted the “high ball” signal given by the conductor at Stamford. He assumed that he had right-of-way over train N-49 and failed to read the order which was given him by the Stamford operator. If the conductor of N-48 had fully complied with the operating rules in obtaining a copy of the train order, in instructing the flagman in his duties concerning the meet with train N-49, and had monitored the operation of the train approaching the siding at Dale, the collision might have been prevented, despite the engineer's action.

Contributing to the cause of the serious injuries and fatalities of the employees and the one passenger were: the design and location of the engineer's control compartment, the inability of the leading cars to withstand the force of the impact, and the location of the victims at the time of the collision in the forward area of the cars. Factors contributing to a great extent to the passengers' injuries were: the lack of restraining devices to hold the passengers in their seats, and the failure and movement of the seat backs.
REVENUE PASSENGERS BEFORE IT LEFT STAMFORD. TRAIN N-49, A DEADHEAD EQUIPMENT TRAIN FROM NEW CANAAN TO STAMFORD, HAD A THREE-MAN CREW AND WAS CARRYING A CAR INSPECTOR AND AN ELECTRICIAN WHO HAD PERFORMED SERVICE AT NEW CANAAN AND WERE RETURNING TO STAMFORD, STILL ON DUTY. A PASSENGER, WHO WAS RIDING WITHOUT AUTHORIZATION IN THE HEAD CAR OF N-48, AND THE ENGINEER WERE KILLED. THE CONDUCTOR, FLAGMAN, AND ABOUT 40 PASSENGERS WERE INJURED. THE CONDUCTOR AND FLAGMAN ON TRAIN N-49 WERE KILLED AND THE ENGINEER WAS SERIOUSLY INJURED. THE HEAD CARS OF BOTH TRAINS WERE ALMOST COMPLETELY DESTROYED; OTHER CARS WERE LESS SEVERELY DAMAGED.

Recommendation: THE NTSB RECOMMENDS THAT THE PENN CENTRAL COMPANY: REVIEW ITS OPERATING RULES AND ITS INTERPRETATION OF SUCH RULES, AS THEY APPLIED TO THIS ACCIDENT, TO ASSURE THAT OPERATIONS OF THIS TYPE ARE ADEQUATELY PROTECTED. IT IS FURTHER RECOMMENDED THAT THE PENN CENTRAL COMPANY TAKE THE NECESSARY ACTION TO INSURE THAT ITS EMPLOYEES COMPLY WITH THE COMPANY’S OPERATING RULES.

Recommendation: THE NTSB RECOMMENDS THAT THE FEDERAL RAILROAD ADMINISTRATION: IF IT RECEIVES ADDITIONAL STATUTORY AUTHORITY UNDER LEGISLATION NOW IN PROGRESS, STUDY THE FEASIBILITY OF REQUIRING A FORM OF AUTOMATIC TRAIN CONTROL AT POINTS WHERE PASSENGER TRAINS ARE REQUIRED TO MEET OTHER TRAINS.


Recommendation: THE SAFETY BOARD REITERATES THE RECOMMENDATION MADE IN ITS REPORT COVERING THE DERAILMENT OF PENN CENTRAL TRAIN SECOND
115 at Glenn Dale, Maryland, on June 28, 1969, "...the Federal Railroad Administration initiate studies to determine the relationship between rail passenger car design and passenger injury and, where practical, take action for correction in the design of future high-speed and rapid transit passengers cars." These studies should include some form of occupant restraining device.