

Hinton train collision

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Jump to: [navigation](#), [search](#)

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 most lethal Canadian rail disaster since the [Dugald](#) accident of [1947](#).

Contents

[[hide](#)]

- [1 The vicinity of the accident](#)
- [2 Prelude to the accident](#)
- [3 The aftermath](#)
- [4 The cause](#)
- [5 The inquiry](#)
 - [5.1 Reading signals from the rear](#)
- [6 Similar accidents](#)
- [7 See also](#)
- [8 References](#)

The vicinity of the accident

[[edit](#)]

The accident took place on a stretch of [Canadian National Railway](#)'s transcontinental main line, near the town of [Hinton, Alberta](#), west of [Edmonton](#). 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 kilometre](#)) stretch of track between Jasper and Edson was double-tracked, including [11.2 miles](#) ([18 kilometres](#)) of trackage from [Hargwen](#) siding west to [Dalehurst](#) siding. Traffic on this line was controlled with [Centralized Traffic Control](#) (CTC).

Prelude to the accident

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On the morning of [February 8, 1986](#), [VIA Rail](#)'s No. 4 train, the *[Super Continental](#)*, was travelling from [Jasper](#) east to [Edmonton](#) on its transcontinental journey. It consisted of 14 units in the following order:

1. [Diesel locomotive](#)
2. Diesel locomotive
3. [Baggage car](#)
4. [Coach](#)
5. [Dome car](#)
6. [Sleeping car](#)
7. Sleeping car
8. Diesel locomotive (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 joined together in Jasper. The first seven units had originated in [Vancouver](#), and the next six units had originated in [Prince Rupert](#). The last unit, the steam generator car, was added in Jasper on its way to Edmonton for maintenance. One hundred fifteen people were on the train; 94 passengers, 14 stewards and seven crew.

[Canadian National Railway](#)'s westbound train No. 413 consisted of three locomotives, 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 of 118 units. It was 6,124 feet (1,866 metres) long and weighed 12,804 tons. In the front locomotive were [engineer](#) John Edward (Jack) Hudson, aged 48, and [brakeman](#) Mark Edwards, aged 25. In the caboose was [conductor](#) Wayne 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 remote dispatcher at Edmonton had set the switch so that the train was routed onto the north track. At the same time, the *Super Continental* stopped at Hinton. It left on time, five minutes later, at 8:25 am.

At 8:29 am, the dispatcher set the switch at Dalehurst, where the section of double track ended, to allow the *Super Continental* to take the south track. This switch setting would have caused the freight train to see signals indicating a stop. A two-light signal 13,600 feet (4.15 kilometres) east of Dalehurst showed yellow over red (meaning slow down and prepare to stop). As the train approached this signal, it was

already going full throttle at 59 miles per hour (96 kilometres per hour), faster than the 50 mile per hour limit on this stretch of track. It did not slow down after passing the signal.

Further west, there was a three-light signal, 490 feet (150 metres) east of the switch at Dalehurst that showed three red lamps, indicating a stop. The freight still did not slow down, instead jumping the switch 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 switch at this point, but unfortunately it was not. Seconds after the freight jumped the switch, at 8:40:52 am, the two trains collided, 1,270 feet (387 metres) west of the switch. As the freight train's momentum was greater than that of the passenger train, it ploughed through the first few cars of the passenger train.

The aftermath

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After the crash, 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 death toll might have been higher except that the contents of a grain car were propelled on top of the car, helping to smother the fire somewhat. Had the sulphur cars, for instance, been at the front of the train, the death toll might have been higher.

The observation dome car behind the day coach suffered serious damage, and was also hit by a freight car. One of its occupants was killed. The others were able to escape either through a broken window in the dome 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 some 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 damaged.

The cause

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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. However, enough of their remains were found that testing was able to rule out [drugs](#) or [alcohol](#) as the cause.

The inquiry

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A [Commission of Inquiry](#) investigated the crash. Mr. Justice René P. Foisy, Alberta Court of Queen's Bench, 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. Management claimed to be unaware of this practice, even though it was quite common.

Another frequently ignored safety regulation mentioned in the report was the "deadman's pedal" which a locomotive engineer had to keep depressed. 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 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), 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 were 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 velocity. 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. Even were Smith's testimony true, he apparently did not consider the problem sufficiently serious to stop the train, a second misjudgement.

Reading signals from the rear

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The general suspicion was that Smith had neglected his duties by sitting at the more comfortable desk seat instead of in the [cupola](#) of the caboose, where he should have been and where he would have a clear view of the track and the signals. However it should be noted that signals controlled by [track circuits](#) change to red as soon as the front of the train passes the signal, so that anyone in the caboose will mostly see red signals, all the more so with 2000m long trains. Tall wagons would also degrade visibility, even from the cupola of a caboose. It would be insanely expensive to modify the terrain to make signals at the

front visible from the rear. One might add that the lamps in the signals might use as little as 10W, and would not be easy to see in daylight at a distance.

Similar accidents

[[edit](#)]

- [Violet Town railway disaster](#)
- [Waterfall train disaster](#)

See also

[[edit](#)]

- [List of rail accidents](#)
- [Seconds from Disaster](#)

References

[[edit](#)]

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- [Main Page](#)
- [Community Portal](#)
- [Featured articles](#)

- [Current events](#)
- [Recent changes](#)
- [Random article](#)
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