



NO. 93-102
TRAIN 2671 PASSENGER SERVICE
COLLISION WITH PEDESTRIAN
NEAR PETONE
16 APRIL 1993

A B S T R A C T

This report describes an accident in which a pedestrian walking at night on the railway line near Petone was struck and killed by an electric multiple unit. The accident occurred in an area where a previously existing walkway had been removed as a result of road widening. A safety recommendation that the walkway be restored was made to the roading authority.

TRANSPORT ACCIDENT INVESTIGATION COMMISSION

RAIL ACCIDENT REPORT NO 93-102

Train Number and Type:	2671 Suburban Passenger
Unit Numbers:	EM 1085/ET 3085
Date and Time:	16 April 1993, 2040 hours *
Location:	Wairarapa Line, 9.10 km, near Petone
Type of Occurrence:	Pedestrian struck by train
Persons on Board:	Crew: 2 Passengers: not known
Injuries:	Crew: Nil Passengers: Nil Other: 1 Fatal
Nature of Damage:	Nil
Information Sources:	Transport Accident Investigation Commission field investigation
Investigator in Charge:	Mr A J Buckingham

* All times in this report are NZST (UTC + 12 hours)

1. NARRATIVE

1.1 Train 2671, the 8 pm Upper Hutt-Wellington service operated by one Ganz-Mávag electric multiple unit (EM 1085/ET 3085), had left Petone station at or about its scheduled time of 2035 hours, and was proceeding towards Wellington at normal speed on the “down” line.

1.2 Abeam the Horokiwi turnoff on the adjacent highway, the driver and guard sighted a male pedestrian, walking northward in the centre of the “down” line, at an estimated distance of 50 m ahead. The driver sounded the train’s air horn; the pedestrian stepped to one side of the track but did not move far enough out of the way.

1.3 The pedestrian was struck a glancing blow by the left front of the EM car and knocked over the seaward edge of the rail embankment onto the rocks below. He was fatally injured.

1.4 Under emergency braking, the train came to rest approximately 100 m from the point of collision. The train crew walked back along the line after having radioed for emergency services. No sign of anyone was found on the line, and it was not until the ambulance crew and Police arrived that the victim’s body was found on the rocks.

1.5 It appeared that the pedestrian had been making his way from the city area towards Petone, where he lived. The railway and State Highway 2 ran parallel and close together from Ngauranga to Petone with, for most of the distance, a fenced walkway between them. However, in recent years, the highway had been widened between the Petone overbridge and the Horokiwi turnoff, to provide a longer merging/acceleration lane for southbound traffic and to provide a right turning lane for southbound traffic turning into Horokiwi Road. The road and rail corridor between Ngauranga and Petone was laterally constrained by a steep escarpment on the western side, and Wellington Harbour to the east.

1.6 The road widening had been at the expense of the walkway, eliminating the pedestrian right-of-way between Horokiwi Road and the Petone bridge. Any pedestrian attempting to reach Petone from the south by following the walkway, was faced with a dilemma on reaching the Horokiwi area. Having come to the end of the walkway, he had the choice of lawfully walking along the

edge of the highway or unlawfully (in terms of the Railway Safety and Corridor Management Act 1992) along the railway formation.

1.7 This accident occurred on a Friday night; the highway was moderately busy, with traffic along this stretch of road travelling generally at 100 km/h. The highway verge was quite narrow in this area, with barely enough room for a vehicle to stop in an emergency. On the other hand, the adjacent railway line, not heavily trafficked at this time of night, would present an apparently safer alternative to the busy highway.

1.8 The victim may have opted for the railway line for this reason, and in walking along the centre of the “down” line, would have been facing oncoming rail traffic. However, during the on-site investigation, it was observed that the approach of a train was difficult to detect unless one was particularly vigilant. The normal train running noise was masked by the traffic noise on the highway, and the train lights could be confused with those of road traffic, particularly as there were numerous curves in the railway line in this area, precluding a head-on view of the train until it was only a short distance away. In addition, the victim was wearing “Jandals” (thongs) on his feet, which would have made for difficult progress on the rough gravel ballast of the rail line.

1.9 It appeared that the victim sighted the oncoming train, but as the train was probably travelling at or close to its limit of 70 km/h (for the curve immediately to the south of the point of impact), he may not have appreciated how quickly the train was approaching. His efforts to step aside may have been hindered by his footwear which was not suitable for the conditions underfoot.

1.10 The train headlight would not have directly illuminated the pedestrian until the train was established on the straight section of line where the accident occurred. Additionally, the headlight was set to “dim” in deference to traffic on State Highway 2. It would have been extremely difficult for the train crew to sight him any earlier.

1.11 Toxicological tests showed that the victim was not affected by alcohol at the time of the accident.

2. FINDINGS

2.1 The train was operating normally prior to the accident.

2.2 The pedestrian was unlawfully on the railway line.

2.3 The pedestrian stepped off the line, but not far enough to avoid being struck by the train.

2.4 The train could not have been stopped in the distance between where the pedestrian was sighted by the train crew, and where he was struck.

2.5 The lack of a pedestrian right-of-way and the intensity of traffic on the highway probably influenced the pedestrian's decision to walk along the railway line.

2.6 The pedestrian's footwear may have impeded his attempt to step clear of the line.

2.7 The pedestrian was not affected by alcohol.

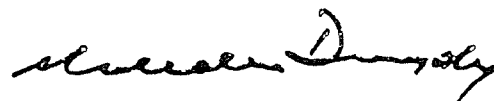
2.8 A previously existing walkway in the area had been lost to road widening.

3. SAFETY RECOMMENDATIONS

3.1 As a result of this accident, it was recommended to Transit New Zealand that:

In conjunction with the relevant local Councils and New Zealand Rail Limited, examine the feasibility of restoring the pedestrian right of way which previ-

ously existed adjacent to State Highway 2, between Horokiwi Road and Petone Bridge (049/93).



9 August 1993

M F Dunphy
Chief Commissioner