No 93-108

Y20 Shunt Service

Collision With Pedestrian

Caversham, Dunedin

8 July 1993

ABSTRACT

This report relates to a collision between a shunting locomotive and a pedestrian who was walking along the track. No specific safety issues have been identified from the circumstances of this accident.

TRANSPORT ACCIDENT INVESTIGATION COMMISSION

RAIL ACCIDENT REPORT NO 93-108

Train Type and Number:	Local Shunt, Y20 Shunt Service
Locomotive:	DSG 3018
Date and Time:	8 July 1993, 1550 hours *
Location:	Main South Line, 381.26 km, Caversham, Dunedin
Type of Occurrence:	Collision with pedestrian
Persons on Board:	Crew: 3 (1 Locomotive Engineer, 2 Shunters)
Injuries:	Crew: Nil Other: 1 fatal#
Information Sources:	Transport Accident Investigation Commission field investigation
Investigator in Charge:	Mr W J D Guest

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

Pedestrian on track

1. NARRATIVE

1.1 New Zealand Rail Limited's train Y20 was a loosely scheduled shunting service which was to collect wagons from stations south of Dunedin. As it ran south from Dunedin at approximately 1550 hours on Thursday 8 July 1993, it consisted only of the locomotive, DSG 3018.

1.2 On board the locomotive were the driver and two shunters. Under the operator's shunting procedures shunters were required, while riding in the locomotive cab, to assist the driver by keeping a lookout.

1.3 The locomotive climbed the grade from Dunedin Yard under light throttle as it was not hauling any wagons, reaching a speed of 65 to 70 km/h. As it travelled round a right hand curve both shunters observed a man walking along the track, between the rails, in the same direction as they were travelling.

1.4 The shunters immediately called to the driver, whose position on the left hand side of cab made it impossible for him to see the pedestrian initially. The driver applied full braking and sounded the horn, and as the locomotive travelled a short distance further round the curve, he sighted the pedestrian. The 25 year old man did not have time to jump clear before being struck by the locomotive and fatally injured.

1.5 The driver sent a radio message to the train control operator, who notified Police and Ambulance.

1.6 The pedestrian had chosen to walk along the track despite the existence of a well-formed if unofficial pathway 8 to 12 m from the track.

1.7 The main arterial road out of Dunedin, the southern motorway, was only 30 m away from the railway track and the noise of vehicles probably masked the sound of the approaching locomotive. Further, the DSG class locomotive had a reputation for being quiet. The heavy weight of rail and the good condition of the ballast through the area of the accident would have minimised track noise and vibration.

1.8 Although fencing alongside the railway in this area did not present a significant obstacle, access to the track required some physical effort, such as climbing banks or crossing drainage ditches. Safe and convenient accessways or footpaths were available for pedestrians, and recourse to walking on the railway track was not necessary.

1.9 When the locomotive was checked after the accident, no faults were detected in the brakes.

2. FINDINGS

2.1 The locomotive was being operated correctly.

2.2 The locomotive's brakes were serviceable.

2.3 The shunters kept a lookout as required.

2.4 The driver reacted promptly and correctly to the sighting of the pedestrian.

2.5 The driver was unable to stop the locomotive in the space available to avoid striking the pedestrian.

2.6 Adequate walkways clear of the track were available to the pedestrian.

23 September 1993

M F Dunphy
Chief Commissioner