No 93-114

Auckland-Wellington Passenger Service

Train No. 201

Cyclist Collided With Train

Levin Station

11 August 1993

ABSTRACT

This report relates to an accident involving a child cyclist who, while chasing a departing train along the station platform at Levin on 11 August 1993, lost control of his bicycle and became wedged between the train and the platform. The safety issues identified in the investigation were the supervision of station platforms as trains depart, the need for signs warning against cycling and similar activities on station platforms, and the promulgation of the statutory Railway Regulations.

TRANSPORT ACCIDENT INVESTIGATION COMMISSION

RAIL ACCIDENT REPORT NO. 93-114

Train Type and Number:	Auckland-Wellington Passenger Service No. 201
Locomotive:	DX5068
Date and Time:	11 August 1993, 1802 hours*
Location:	Levin Station 91.67 km NIMT
Type of Occurrence:	Cyclist collided with train
Persons on Board:	Crew: 3 Passengers: Not known
Injuries:	Crew: Nil Passengers: Nil Others: 1Fatal#
Nature of Damage:	Bicycle destroyed
Information Sources:	Transport Accident Investigation Commission field investigation
Investigator in Charge:	Mr W J D Guest

#Cyclist on platform

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

1. NARRATIVE

1.1 Train 201 was the "Overlander", New Zealand Rail Limited's daily express passenger service between Auckland and Wellington.

1.2 On the evening of 11 August 1993 the "Overlander" stopped at Levin Station at 1800 hours to allow one passenger to alight.

1.3 The Train Manager assisted the passenger from the train, and took up position in the doorway of the passenger carriage. The passenger had left the station platform, and the Train Manager did not see anyone else on the platform up to this time.

1.4 The Train Manager sent a radio telephone message to the Locomotive Engineer that the train could depart. As the train began to move, she noticed three young boys on bicycles riding along the platform. They were clear of the train, and she thought they were "trying to chase the train". She entered the train and closed the door as the train pulled away.

1.5 The Locomotive Engineer received the message from the Train Manager, and he looked to the rear along the station platform as the train began to move. He noticed three boys cycling along the platform about two or three metres clear of the train. He saw nothing which made him feel uneasy or alarmed by the situation, and turned to observe the track ahead of the train.

1.6 Two passengers who were standing in the passageway between the passenger compartments of two of the carriages also saw the three boys cycling along the platform, and gained the impression that "they were trying to race the train". They saw one of the boys "fall over the handlebars" of his bicycle, and the bicycle veer into the train.

1.7 The passengers realised that the bicycle and boy were trapped between the train and the platform, and ran into the passenger compartment to get the train stopped. The Train Manager who was in the carriage immediately activated the emergency stop switch, automatically applying the train brakes.

1.8 When the Locomotive Engineer noticed the application of the train brakes, he applied the locomotive brakes as well. The train came to a halt with the end of the last carriage approximately 45 m clear of the southern end of the platform.

1.9 The cyclist who veered into the train and fell was ten years old. His companions were of similar age.

1.10 The boy's two companions confirmed that they were racing the train along the platform. One of them noticed that he was "wobbling" just prior to the accident. He considered that the wobbles were not deliberate, and indicated a loss of control.

1.11 The damage caused by the accident to the bicycle made it impossible to determine whether the condition of the bicycle had any bearing on the loss of control. The passengers who observed the accident stated that they saw the boy "fall over" the handlebars, which could be explained either by loose handlebars or a loss of foothold on the pedals.

1.12 Immediately after the accident, the other two boys sought help. Levin Station was not manned by NZRL staff. The staff of a nearby service station called emergency services, and then went to assist the injured boy.

1.13 After first aid by ambulance officers, the critically injured boy was conveyed by helicopter to Palmerston North Hospital, where he died on 8 September 1993.

1.14 Although the Railways Regulations prohibit cycling on platforms there were no notices displayed to this effect or any other steps taken by New Zealand Rail Limited to draw this to the attention of the public.

2. FINDINGS

2.1 The train was being operated normally at the time of the accident.

2.2 The Train Manager and the Locomotive Engineer both observed the boys cycling on the platform as the train accelerated away from the platform.

2.3 At the time the Train Manager and the Locomotive Engineer observed the three cyclists, the boys were clear of the train and there was no indication that any of them was about to lose control of his bicycle.

2.4 Given that the boys were clear of the train, and were aware of its presence, it was reasonable for the train crew to proceed normally and to depart.

2.5 The passengers who observed the accident reacted promptly to bring the train to a halt.

2.6 The train crew reacted correctly to the passengers' advice of an emergency.

2.7 The victim's companions sought assistance without delay.

2.8 The cause of the accident was the loss of control of his bicycle by the accident victim when he was too close to the train to effect a recovery.

2.9 Contributory factors were the lack of any advice to the public that it was illegal to cycle on the platform, and the absence of any measures to control such activities.

3. SAFETY RECOMMENDATIONS

3.1 As a result of the inquiry into this accident, safety recommendations were made to New Zealand Rail Limited that:

They place prominent signs on rail platforms warning against cycling or similar activities (068/93), and

They take steps to promulgate the Railways Regulations (069/93).

3.2 New Zealand Rail Responded as follows:

"1. Given the circumstances of the Levin accident NZR supports the Commission's recommendation that signs be placed on platforms warning the public against cycling or similar activities.

2. A plan will be developed for progressive installation of signage on all stations served by passenger trains.

3. The rail safety educational awareness programme developed for schools includes a section on cycling and skate boarding activities near railway lines, level crossings, platforms and ramps.

The programme aims to focus on the dangers of cycling in these public places and informs the children not to engage in these activities on railway platforms and access ramps. It reinforces that access ways and platforms are provided for train passengers who are pedestrians either planning to board a train or have just arrived by train and are leaving."

4. OBSERVATIONS

4.1 This is the second instance in which a young person cycling on a station platform has been involved in an accident with a train since 1 April 1993 when the Transport Accident Investigation Commission was given responsibility for the investigation of rail accidents.

4.2 From the boys' perspective the train may not have held the same dangers as a road vehicle. A train follows a set path and cannot brake, swerve or turn unexpectedly as a truck or car might.

4.3 Any moving vehicle has the potential to inflict injury if people or other vehicles can come in contact with it. Operators of moving vehicles (of any type) must exercise reasonable care, and take reasonable precautions to prevent accidents.

4.4 However, operators are entitled to expect that the public, whether passengers, customers, or bystanders will also exercise reasonable care and judgement in the vicinity of moving vehicles.

4.5 Until the late 1980's Levin Station had a staff member on duty on the platform while any passenger train was present. With the decline in rail passenger numbers, and the closure of Levin to parcels and small freight traffic, the station is no longer staffed. The care and assistance of passengers, and the movement of the train, became the responsibility of the train crew.

4.6 Levin Station platform is open to public access at both ends and along a large part of its western side. There are no barriers to prevent the easy access of cyclists, skateboarders, or pedestrians. In this respect, Levin is similar to many other railway stations throughout the country.

4.7 The wide, flat, deserted platform at Levin provided an easy place to ride a bicycle, and probably looked much safer to the boys than most roads nearby. The train was apparently of interest to the boys who had deliberately gone to the station to see it, and it presented a tempting challenge for a race down the platform.

4.8 On the unmanned station, fences or barriers alone would have been unlikely to have prevented the accident that is the subject of this report. Access would still have been necessary for the public. It would have been difficult to have excluded the three boys and their bicycles, even though the Railway Regulations prohibited cycling on platforms.

4.9 An alert staff member on the platform could be expected to have ordered any cyclists from the platform before they created a problem.

4.10 A powerful aid to preventing accidents of this type is education of the public, and children in particular, to the potential dangers of railway operations.

4.11 The Commission has recommended to New Zealand Rail Limited and the School Trustees Association that they co-operate in a united effort on the development of a suitable module for teaching children about the potential dangers of railways (Report No. 93-105)

4.12 Following the accident at Levin, the Levin Police visited local schools and outlined the potential dangers of the railways to children. The Commission commends this effort by the Police to increase the awareness of Levin children to the hazards.

9 February 1994

M F Dunphy
Chief Commissioner