NO. 93-127

TRAIN 573
COLLISION WITH PEDESTRIAN
NEAR MARTON STATION
21 DECEMBER 1993

ABSTRACT

This report relates to the collision between Train 573 and a pedestrian near Marton on 21 December 1993. The safety issue identified by this investigation was the lack of warning signs against trespassing over two rail bridges and along the track in the area of this accident.

TRANSPORT ACCIDENT INVESTIGATION COMMISSION

RAIL ACCIDENT REPORT NO. 93-127

Train Type and Number:	Freight, 573
Locomotives:	DX 5258 and DC 4876
Date and Time:	21 December 1993, 2310 hours NZDT
Type of Occurrence:	Collision with pedestrian
Location:	One km north of Marton Station, Marton New Plymouth line.
Persons on Board:	Crew: One Passengers: Nil
Injuries:	Crew: Nil Passengers: Nil Others#: One fatal
Nature of Damage:	Nil
Information Source:	Transport Accident Investigation Commission field investigation
Investigator in Charge:	R Chippindale

Pedestrian on track

1. NARRATIVE

1.1 Train 573 was a New Zealand Rail Limited freight service from New Plymouth to Wellington. As it approached Marton the train including the locomotives had a total weight of 1026.44 tonnes.

1.2 At 2310 hours on 21 December 1993 the train was nearing Marton from Wanganui on a straight approach to Marton Station travelling at a steady 30 to 35 km/h.

1.3 The weather was overcast with good night time visibility.

1.4 The locomotive engineer, the sole occupant of the cab, was seated in his normal position on the right hand side.

1.5 As the train approached a point some 1.6 km from Marton Station the engineer heard a noise which he assumed to be ballast hitting the train. Some 500 m past this point there was evidence of a collision with a pedestrian in the centre of the track. At no stage did the locomotive engineer see any person on the track.

1.6 The pedestrian's outer clothing was a silver grey overcoat and blue jeans.

1.7 The engineer subsequently stopped the lead locomotive some 50 m past the station to allow the shunter to cut off the two locomotives and four chip wagons which were destined for Marton. This uncoupling took some 65 seconds after which the engineer drove the locomotives and four wagons into the south backshunt.

1.8 As the engineer drove into the backshunt the shunter walked down the yard, turning on the yard's lights as he went. As he approached the backshunt he saw blood on the track and established that a person was lying under the locomotives.

1.9 The shunter advised the locomotive engineer who in turn notified Train Control of the accident. Train Control alerted the emergency services which attended the incident promptly. The pedestrian had been killed in the accident.

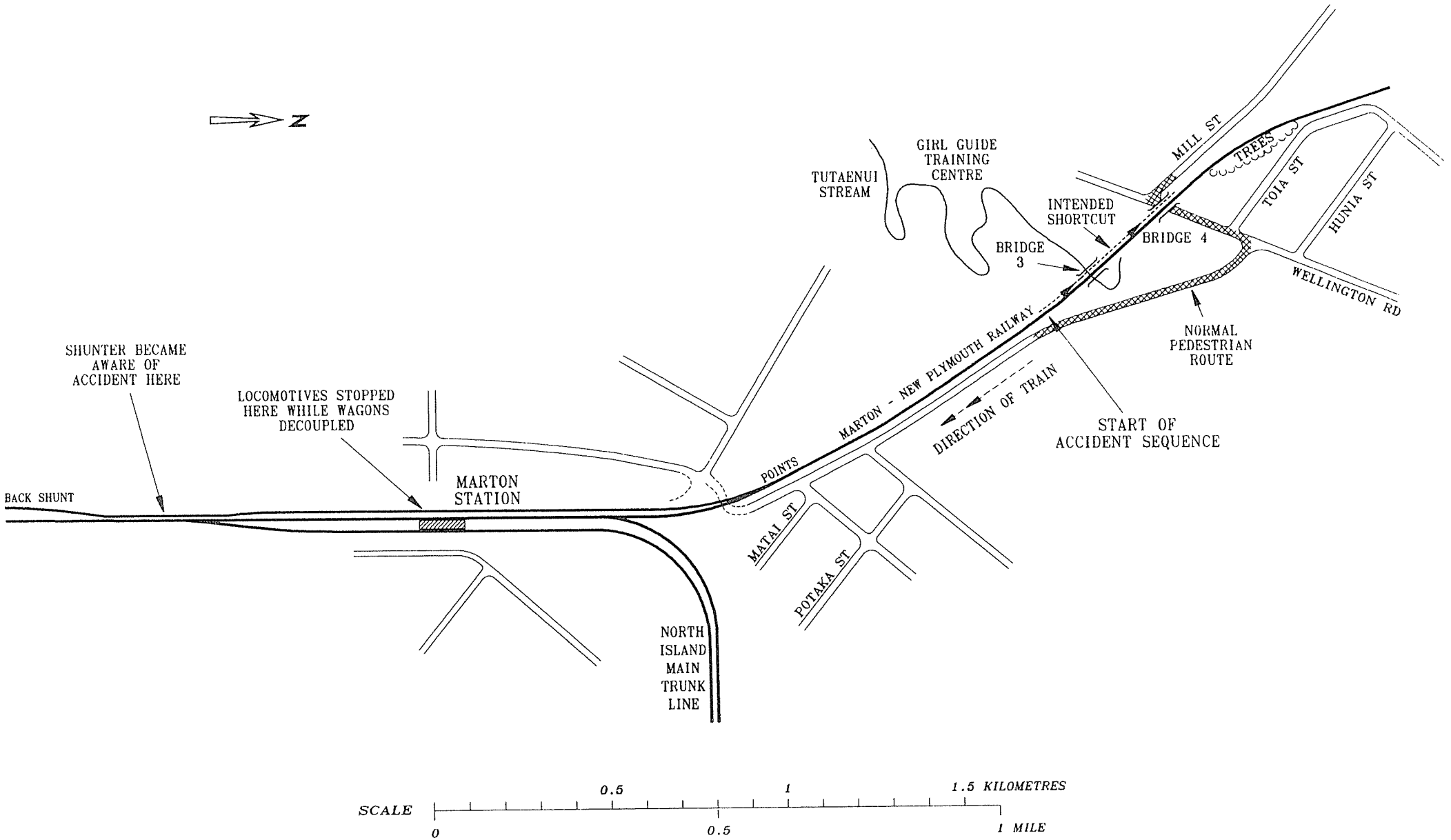
1.10 The incident occurred in the vicinity of two bridges, which carried the track across a large stream and then a main road, which stood between the residence at which the pedestrian had been attending a party and his home. The rail track provided a more direct access and a significant saving in time for his walk.

1.11 There was no refuge for the pedestrian on either of the bridges should he have been confronted by an approaching locomotive. The train approached the road bridge first and the approach to bridge and the bridge itself were screened from the driver's view by a tree lined left hand curve. Thus had the pedestrian been crossing the bridge over the road as the train approached the locomotive driver would have had no opportunity to stop the train before it collided with the pedestrian.

1.12 The point of the collision with the pedestrian was adjacent to a back gateway to Arahina a New Zealand Girl Guide Association training centre. The rail track was unfenced and was a frequently used short cut for local pedestrians.

1.13 The absence of any physical deterrent to free use of the railway property as a short cut was in keeping with the railway operator's practice in rural areas.

1.14 There were no warning signs in the area to advise persons using the rail bridges of the hazard of using them as a short cut.



MARTON RAILWAY LINES
ACCIDENT ENVIRONMENT

2. FINDINGS

2.1 The train was being operated normally prior to the accident.

2.2 The locomotive engineer was keeping an appropriate lookout but did not sight the trespassing pedestrian.

2.3 The pedestrian may not have sustained life threatening injury until the train reached the south backshunt some 2 km from the first evidence of his contact with the locomotive.

2.4 The train stopped for a period after the point of collision with the pedestrian but no audible or visual evidence of the pedestrian's plight was noticed at that time.

2.5 The track in the area of the occurrence had become a well used public walkway.

2.6 There were no signs or other advice to the public to warn them of the hazards of walking on or near the rail track.

3. SAFETY RECOMMENDATIONS

3.1 It was recommended to the Rangitikei District Council that:

3.1.1 They discuss the circumstances of this accident with the Managing Director, New Zealand Rail Limited Wellington, to determine the most effective way of warning local citizens and others of this particular hazard (003/94), and

3.1.2 They implement the appropriate measures to ensure the attention of the public is drawn to the particular hazard of trespass on the railway in this area. (004/94).

3.2 It was recommended to New Zealand Rail Limited that:

3.2.1 They discuss the circumstances of this accident with the Rangitikei District Council to determine the most effective way of warning local citizens and others of this particular hazard (005/94).

3.2.2 They implement the appropriate measures to ensure the attention of the public is drawn to the particular hazard of trespass on the railway in this area. (006/05).

4. OBSERVATION

4.1 The Commission has previously stressed the threat to pedestrians of quieter train running and higher speed trains. Since that warning there have been two further cases of pedestrians using railway tracks as a short cut and losing their lives as a result. In total, apart from those seeking to end their lives deliberately, six young men have lost their lives in such accidents since April 1993 when the Commission assumed the responsibility for investigating such occurrences.

4.2 It is evident that neither the operator nor local authorities are taking effective action to warn the public of the hazards of using railway tracks as short cuts.

4.3 The operator is backed by legislation in its claim that using railway property is an act of trespass. However it acknowledges the reality that people will risk prosecution to save time on a routine walk and has expressed a willingness to assist in the education of the public to the hazardous potential of such action.

4.4 Each investigation has shown that such tracks are used so frequently that local authorities must be aware of the practice and have the potential to use this local knowledge to save further loss of life. It behooves them therefore to take advantage of the operator's offer to ensure that their local pedestrians are given due warning of the danger of using local railway property as a short cut before their township borough or city becomes the venue for the next of these tragic accidents.

23 March 1994

M F Dunphy
Chief Commissioner