NO. 94-103

AUCKLAND SUBURBAN SHUNTING SERVICE

TRAIN L8

NEW LYNN

9 FEBRUARY 1994

ABSTRACT

A suburban shunting train, L8, operated by New Zealand Rail Limited struck and killed a pedestrian who attempted to cross the tracks at the Totara Avenue level crossing in New Lynn while the train was approaching. The accident occurred on 9 February 1994. The crossing alarms were working and visibility was good. No specific safety issues were identified in this investigation.

TRANSPORT ACCIDENT INVESTIGATION COMMISSION

RAIL ACCIDENT REPORT NO. 94-103

Train Type and Number:	Auckland Suburban Shunting Service, L8
Date and Time:	9 February 1994, 1425 hours
Location:	New Lynn
	20.25 km, North Auckland Line
Type of Occurrence:	Collision with pedestrian
Persons on Board:	Crew: 2 Passengers: Nil
Injuries:	Crew: Nil Passengers: Nil Others[#]: 1
Nature of Damage:	Nil
Information Sources:	Transport Accident Investigation Commission field investigation
Investigator in Charge:	Mr WJD Guest

[#] Pedestrian

1. NARRATIVE

1.1 New Zealand Rail Limited's Train L8 was an Auckland suburban shunting service, taking wagons to and from private sidings between Westfield and Waitakere. Just before 1425 hours on 9 February 1994 the train was approaching New Lynn, heading eastwards on its return journey to Westfield.

1.2 The train was travelling at 55 km/h, and the headlights of the locomotive were illuminated in accordance with the standard practice of New Zealand Rail Limited.

1.3 As the train neared the Totara Avenue level crossing in New Lynn, the Locomotive Engineer observed that the crossing alarms were working and that the barriers had descended across the approaching road lanes. He sounded the locomotive horn.

1.4 When the train was a few metres from the crossing, the Locomotive Engineer saw a woman walk slowly on to the track. She had passed behind the barrier arm stand which had obscured her from the Locomotive Engineer's sight, and was continuing along the footpath over the crossing. The Locomotive Engineer noticed that her head was down and that she was not looking in either direction along the track.

1.5 The Locomotive Engineer sounded the horn and applied emergency brakes, but was unable to stop in the distance available. The pedestrian was struck and killed.

1.6 Eyewitnesses notified emergency services which attended promptly.

1.7 The 63 year old woman had been to the nearby shops and was returning home. She had passed within a metre of the barrier arm stand and the flashing light standard which had a bell on top of it, but had not reacted to their operation.

1.8 Visibility along the track from the crossing was unobstructed for approximately 200 m.

1.9 Road traffic was stopped for the train on both sides of the crossing.

2. FINDINGS

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

2.2 The train crew reacted correctly to the emergency.

2.3 The warning devices were operating normally.

2.4 The victim may have been pre-occupied, for she did not react to the warning given by the crossing barriers or flashing lights and bells, and did not appear to see or hear the approaching train.

3 May 1994

M F Dunphy
Chief Commissioner