

# RAIB Bulletin 01/2008

## Shunter struck by train in August 2007

### Description of the accident and the findings of the RAIB

1. In August 2007 a shunter was struck by a train moving within a yard, sadly losing both his lower legs as a result.
2. At the time of the accident the train was being propelled by a locomotive, under the control of the shunter.
3. The shunter had driven in his own car from the cabin where he was based, located at one end of the yard, to the site where the train was to be staged at the other end. This was his normal practice; there was no safe route to walk between the two ends of the yard except by walking in the track in front of the train that the shunter was to control.

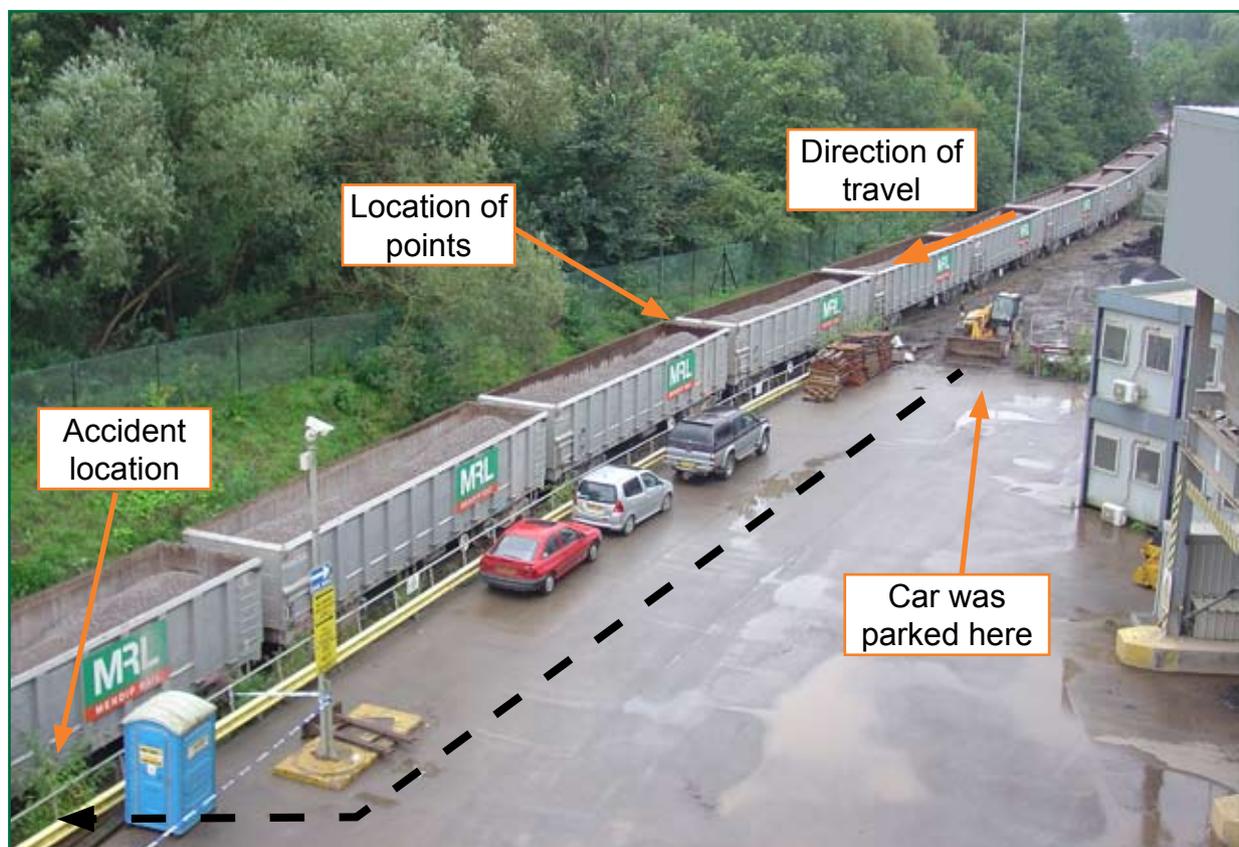


Figure 1: site of accident

4. The shunter controlled the train movement by back to back radios. He gave the train permission to start whilst still in his car, and was in the process of leaving the car and donning his personal protective equipment when he received a phone call from another company's shunter. Both companies' trains operated in the yard, and the two shunters communicated regularly by mobile phone.
5. For a period of 27 seconds the shunter was using his mobile phone and the train was moving. Whilst it is difficult to see how the shunter could have maintained constant verbal contact with the driver, as required by the rule book, during this period, the train continued to propel towards the siding.
6. Study of the times of the phone call and the movement of the train indicates that the shunter only had a period of some 34 seconds to move the distance of 68 metres from his car to cross in front of the approaching train so that he was in a position to carry out his next duties. This movement included climbing over a barrier, and descending a low embankment.
7. To cover 68 metres in 34 seconds requires at least a fast walk, and allowing for climbing the barrier and descending the bank, the movement must have been made in some haste.
8. It is probable that the shunter tripped as he hurried to cross the track, fell with his legs across the rails as the train approached, and did not have time to get clear.
9. The train driver heard a scream over the radio, stopped his train and found the injured shunter: he then called the emergency services.
10. The condition of the locomotive, and the communications systems, did not contribute to the accident, but the speed of the train of 5 mph (8 km/h) was greater than the 3 mph (5 km/h) permitted for this movement.
11. The lack of a clear, safe, and well lit walking route from the cabin to the sidings may have influenced the shunter in his decision to drive between the locations. Managerial and supervisory checks did not identify the conditions in the yard, or the fact that an unauthorised procedure was taking place.
12. There was no documented method of how staff should move around the yard, allowing the development of the unauthorised procedure.

#### Learning Points

13. Following a review of the evidence, the RAIB has decided not to conduct a full investigation as it does not believe that a full investigation would lead to the identification of any further significant lessons that would improve the safety of railways or prevent railway accidents and incidents. However, the RAIB does believe that there are some valuable learning points to be disseminated to other operators.

14. These learning points are:

- the necessity of allowing adequate time when carrying out safety critical duties;
- the necessity of never leaving, or planning to leave, a place of safety in front of an approaching train;
- the necessity of not dealing with mobile phone calls when carrying out safety critical duties;
- the necessity of stopping a train if verbal contact between shunter and driver is lost; and
- the necessity of adequate managerial or supervisory checks at remote locations, which should cover the method of working employed and the physical conditions at the site.

15. The RAIB has written to the operator of the yard informing them of its decision and conclusions.

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