Rail Industry Safety Notice

19 October 2012

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FATAL ACCIDENT – NORTH YORKSHIRE MOORS RAILWAY
LESSONS LEARNED

Background

The Rail Safety Unit requests that rail transport operators in Tasmania read the attached investigation report released by the Rail Accident Investigation Branch in the United Kingdom into an accident on the North Yorkshire Moors Railway in which the train's guard was fatally injured during shunting operations.

The report can be found at the following internet link:
Rail Accident Report: Report 23/2012
(http://www.raib.gov.uk/cms_resources.cfm?file=/121018_R232012_Grosmont.pdf)

Action

The report is an excellent example of examinations carried out by investigators. It emphasises why rail operators must have robust, effective systems and the importance of maintaining records to demonstrate the system is being implemented. This particular case highlights:

- Training and assessment of competence of rail safety workers (see paragraphs 17-18 24, 47, 59-61 & 74)
- Document control (see paragraphs 26 – 27)
- Internal auditing and observation checks (see paragraphs 30, 62 & 73)
- Rolling stock standards (see paragraph 42)
- Rolling stock maintenance and inspection records (see paragraph 51)

The full RAIB report should be read and considered against your own Safety Management Systems to ensure similar risks are being adequately managed.

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