

Report 14/2019: Fatal accident involving a train passenger at Twerton

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Summary

At about 22:04 hrs on Saturday 1 December 2018 a passenger was leaning out of the window of a moving train when her head came into contact with a lineside tree branch near Twerton, a suburb of Bath. The passenger suffered fatal injuries. The train, a Great Western Railway service from London Paddington to Exeter St David's, was travelling at approximately 75 mph (120 km/h) at the time.

On the type of coach making up the train, opening windows are provided to allow passengers to reach through and operate the external door handles when the train is in a station. This is the only means by which passengers can open the train doors. However, other than warning signs, there is nothing to prevent passengers from opening and leaning out of such windows when trains are away from stations and moving. The accident occurred because the passenger did this when branches from a lineside tree were in close proximity to the train.

A possible underlying factor was that Great Western Railway's risk assessment process had not historically identified the risk of passengers or staff being injured as a result of putting their heads out of windows on moving trains. Consequently, Great Western Railway had not provided adequate mitigation measures to protect against the risk.

Recommendations

The RAIB has made four recommendations and identified two learning points.

One recommendation is addressed to operators of mainline passenger trains, including charter operators, and seeks to minimise the likelihood of passengers leaning out of droplight windows when a train is away from stations. A second recommendation, is addressed to operators of heritage railways and seeks to improve their management of the risks associated with passengers leaning out vehicles.

The third recommendation is addressed to Great Western Railway and seeks to reduce the potential for hazards associated with its operations being overlooked.

The fourth recommendation is addressed to RSSB and seeks to ensure that its advice on emergency and safety signs reflects the level of risk associated with the hazard being mitigated.

The learning points reinforce the importance of undertaking regular tree inspections and the value of train operators having well briefed procedures for dealing with medical emergencies on board trains.

Notes to editors

1. The sole purpose of RAIB investigations is to prevent future accidents and incidents and improve railway safety. RAIB does not establish blame, liability or carry out prosecutions.
2. RAIB operates, as far as possible, in an open and transparent manner. While our investigations are completely independent of the railway industry, we do maintain close liaison with railway companies and if we discover matters that may affect the safety of the railway, we make sure that information about them is circulated to the right people as soon as possible, and certainly long before publication of our final report.
3. For media enquiries, please call 01932 440015.

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