



MINISTRY OF
CONSTRUCTION AND TRANSPORT
TRANSPORTATION SAFETY BUREAU

FINAL REPORT (EXTRACTION)



2022-1289-5
(HU-10336)

Railway accident / Derailment
Komárom-Rendező, 19th November 2022

Translation

This document is the translation of Points 1, 5 and 6 of Hungarian version of the Final Report. Although efforts have been made to translate the mentioned parts of the Final Report as accurately as possible, discrepancies may occur. In this case, the Hungarian Final Report is the authentic, official version.

Basic principles of the safety investigation

The purpose of the safety investigation fulfilled by Transportation Safety Bureau (TSB) as National Investigation Body of Hungary is to reveal the causes and circumstances of serious railway accidents, railway accidents and railway incidents and propose recommendations in order to prevent similar incidents. The safety investigation is not intended to examine and determine fault, blame or liability in any form.

The findings of the safety investigation are based on an assessment of the evidence available and obtained by TSB in the course of the investigation, taking into account the principles of a fair and impartial procedure. In the Final Report, the persons involved in the occurrence shall be referred to by the positions and duties they had at the time of the occurrence.

The Final Report shall not have binding force and no appeal proceedings may be initiated against it.

This safety investigation has been carried out by TSB pursuant to relevant provisions of

- Act CLXXXIV of 2005 on the safety investigation of aviation, railway and marine accidents and incidents;
- Commission Implementing Regulation (EU) 2020/572 of 24 April 2020 on the reporting structure to be followed for railway accident and incident investigation reports;
- in the absence of other related regulation of the Act CLXXXIV of 2005, the TSB conducts the investigation in accordance with Act CL of 2016 on General Public Administration Procedures.

Act CLXXXIV of 2005 is to serve compliance with Directive (EU) 2016/798 of the European Parliament and of the Council of 11 May 2016 on railway safety.

The competence of the TSB is based on Government Regulation № 230/2016. (VII.29.) on the assignment of a transportation safety body and on the dissolution of Transportation Safety Bureau with legal succession.

The safety investigation is independent of other investigations, administrative infringement or criminal proceedings, as well as proceedings initiated by employers in connection with the accident or incident.

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1. SUMMARY

On 19 November 2022, at 0:34 a.m., the rim slipped off from one of the wheels of the eleventh wagon of the freight train № 92759 departing from Hegyeshalom.

While the train was passing through Ács station, the traffic manager noticed that the wagon had an anomaly, which he could not identify, and therefore the train was stopped on the open line. When inspecting the train, the locomotive driver, did not notice any anomaly there until after the train had moved on, so the train was pulled over at Komárom-Rendező, but on entering the station the defective wagon derailed between switches 52-56 and then backed onto the track.

The exact location, time and cause of the rim separation could not be determined during the investigation which identified only brake failure as one of the usual causes.

However, it was noted that traffic control had detected the emergency and, even without relevant technical knowledge, had acted quickly and correctly for an inspection of the train, which helped to avoid more serious damage.

The TSB will not issue a safety recommendation as the cause of the failure has not been identified.

5. CONCLUSIONS

5.1 Summary

5.1.1 Direct causes

Acts, mistakes, events or conditions or a combination thereof the elimination or avoiding of which could probably have prevented the accident or incident:

- a) one of the rims of the wagon, which was the eleventh wagon on the train, came off the wheel.

5.1.2 Indirect causes

Acts, mistakes, events or conditions which influenced the occurrence by increasing its probability, accelerating the effects or the severity of the consequences, but the elimination of which would not have prevented the occurrence:

- a) the freight wagon's braking system got released more slowly than necessary.

5.1.3 Systemic factors

Causal or contributing factors of organisational, management, social or regulatory nature which are likely to have an effect on similar or related occurrences, particularly including regulatory framework conditions, the design and use of the safety management systems, the skills of the personnel, the procedures and maintenance: none was identified by the IC.

5.2 Actions taken

The railway company has carried out a routine inspection of all four-axle high-sided wagons concerned (in particular those with wheel rims) and filled in the missing markings. No safety deviations were found during the inspection, and minor defects were repaired and lubrications were made up for.

5.3 Additional notes

No risk-increasing factors, unrelated to the occurrence of the incident, have been identified by the IC.

5.4 Proven procedures, good practices

In order to reduce the consequences of the occurrence and avoid a more serious outcome,

- a) traffic management handled the emergency effectively and their actions helped to avoid more serious damage;
- b) the driver of the locomotive was monitoring his train, and on detecting the fault, he took the initiative to move the train out of the way.

5.5 Lessons learnt

The final report does not provide a causal finding and therefore a lesson on the wheel rim separation, but it is instructive in terms of emergency management that

the monitoring of trains and the actions taken on the basis of this monitoring can reduce the damage caused by vehicle failures that have already occurred.

6. SAFETY RECOMMENDATION

As the investigation did not identify the cause of the incident and the IC did not identify any significant safety critical issue related to it, the TSB does not consider it appropriate to issue a safety recommendation.