

# Transportation Safety Board

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## News release

### Rail investigation highlights outstanding TSB Watchlist issue: the need for video and voice recorders on locomotives

**Gatineau, Quebec, 17 October 2012** – In its report released today about a 2011 rail near-miss near Meharry ([R11W0247](#)), the Transportation Safety Board of Canada (TSB) found once again that in-cab voice recording would have assisted in the identification of unsafe conditions or practices.

On 29 October 2011, a VIA Rail passenger train and a Canadian National (CN) freight train were within 1600 feet of a head-on collision near Meharry. The VIA Rail passenger train was proceeding eastward on a CN single main track en route to Winnipeg, Manitoba, when it failed to stop in the siding at Meharry as required by instructions issued by the CN rail traffic controller (RTC). Neither the trackside visual cues nor the RTC written instructions alerted the VIA train crew members that they were proceeding down the single main track rather than entering the siding. Upon seeing an approaching westbound CN freight train, the VIA Rail crew stopped the train. At the same time, the CN train also slowed to a stop, leaving the two trains stopped on the main line approximately 1500 feet apart. Subsequently, the VIA Rail passenger train reversed back into the siding at Meharry without proper clearance from the RTC.

In Occupancy Control System territory, train operations and train safety are maintained using administrative defences and written authorities that rely on train crews correctly interpreting and applying operating rules. Over time, shortcuts or "adaptations" to rules and operating procedures (such as not calling all station name signs, not performing required radio broadcasts, etc.) can occur and become part of the routine operating practice. By making these "adaptations", a routine task can normally be completed in less time and/or with reduced effort. During the course of this investigation, the TSB determined that when "adaptations" are made to railway operating rules and procedures, the redundancy and safeguards built into the rules are often compromised, which increases the risk of accidents.

This investigation also presented particular challenges because much of the information relied primarily on the recollection of the train crews. Understanding the sequence of events leading up to the incident, including the crew interaction, is a key component in many rail accident investigations. In this case, as in many others, the investigation would have been more expeditious and complete had the locomotive on VIA 692 been equipped with an on-board voice or video recorder.

In response to this occurrence, VIA Rail management met with all operating employees within the Winnipeg terminal and provided them with briefings and mentoring to reinforce the Canadian Rail Operating Rules associated with the Occupancy Control System.

On-board video and voice recorders are identified as an issue on the TSB's [Watchlist](#). When cab recordings are not available to an investigation, it may preclude the identification and communication of safety deficiencies that can advance transportation safety. The Watchlist is a list of issues the

TSB has determined to pose the most serious risk to Canada's transportation system.

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*The TSB is an independent agency that investigates marine, pipeline, railway and aviation transportation occurrences. Its sole aim is the advancement of transportation safety. It is not the function of the Board to assign fault or determine civil or criminal liability.*

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