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RISSB Contact details:

Head office:

Phone:	Email:	Web:
(07) 3724 0000	info@rissb.com.au	www.rissb.com.au

Standard Development Manager:

Name:	Phone:	Email:
Jodie Matheson	0447 454 501	jmatheson@rissb.com.au

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SDM name	Jodie Matheson
SDM phone	0447 454 501
SDM email	jmatheson@rissb.com.au

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Preface

This document was prepared by the Management of Proceed Authority Exceedance Events Development Group, overseen by the RISSB Operations Standing Committee.

Objective

The objective of this Standard is to ensure that these incident types are managed in a consistent manner that will reduce the likelihood of recurrence and minimize the potential consequences.

Compliance

There are four types of provisions contained within Australian Standards developed by RISSB:

(a) Requirements.

(b) Recommendations.

(c) Permissions.

(d) Constraints.

Requirements – it is mandatory to follow all requirements to claim full compliance with the Standard. Requirements are identified within the text by the term ‘shall’.

Recommendations – do not mention or exclude other possibilities but do offer the one that is preferred. Recommendations are identified within the text by the term ‘should’.

Recommendations recognize that there could be limitations to the universal application of the control, i.e. the identified control is not able to be applied or other controls are more appropriate or better.

Permissions – conveys consent by providing an allowable option. Permissions are identified within the text by the term ‘may’.

Constraints – provided by an external source such as legislation. Constraints are identified within the text by the term ‘must’.

For compliance purposes, where a recommended control is not applied as written in the standard it could be incumbent on the adopter of the standard to demonstrate their actual method of controlling the risk as part of their WHS or Rail Safety National Law obligations. Similarly, it could also be incumbent on an adopter of the standard to demonstrate their method of controlling the risk to contracting entities or interfacing organisations where the risk may be shared.

RISSB Standards address known hazards within the railway industry. Hazards, and clauses within this Standard that address those hazards, are listed in Appendix A.

Appendices in RISSB Standards may be designated either “normative” or “informative”. A "normative" appendix is an integral part of a Standard and compliance with it is a requirement, whereas an "informative" appendix is only for information and guidance.

Commentary

Commentary *C Preface*

This Standard includes a commentary on some of the clauses. The commentary directly follows the relevant clause, is designated by 'C' preceding the clause number and is printed in italics in a box. The commentary is for information and guidance and does not form part of the Standard.

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Tables

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Section 1 Scope and general

1.1 Scope

This document contains the minimum requirements for managing proceed authority exceedance (PAE) events as defined by the Office of the National Rail Safety Regulator's (ONRSR) guideline *Notifiable Occurrences Reporting Requirements*.

The term PAE is used throughout the document to ensure an approach which encompasses all PAE events and replacing the commonly used reference of signal passed at danger (SPAD).

The scope includes the management of the PAE event from the occurrence to the closure and communication of the investigation.

This document may be applied to light rail.

1.2 Normative references

The following documents are referred to in the text in such a way that *some* or all of their content constitutes requirements of this document:

- AS 7631, *Railway Infrastructure – Sighting*
- *NTC National Standard for Health Assessment of Rail Safety Workers* (2024)
- *ONRSR Guideline – Notifiable Occurrence Reporting Requirements* (2022)
- *ONRSR Guideline – Safety Management System* (2019)
- RISSB ANRP 6001 – *Overrun Limit of Authority*
- *RISSB Code of Practice – Rail Safety Investigations* (2025)
- *RISSB Guideline – Rail Traffic PAE Risk Management*
- *RISSB Guideline – Rail Emergency Management Planning*
- *RISSB SPAD Investigation Pro Forma*

NOTE:

Documents for informative purposes are listed in a Bibliography at the back of this document.

1.3 Defined terms and abbreviations

For the purposes of this document, the following terms and definitions apply:

1.3.1

legal professional privilege
common law right that protects confidential communications and documents between a lawyer and their client from being disclosed to third parties

1.3.2

limit of authority
sign or signal capable of displaying a stop indication or a specific kilometrage point on a line which defines the location to which rail traffic may travel under a proceed authority or the limits of a work on track authority

Note 1 to entry: For the purpose of this document, **limit of authority** includes:

(a) end of authority displayed on driver/machine interface;

(b) stop boards or indicators;

(c) platform stopping mark;

(d) limit of shunt boards or signs;

(e) position light and shunting signals where the normal aspect means 'stop' and (where applicable) the movement is in the direction for which the signal can be cleared;

(f) possession or occupation limit boards/signs;

(g) marker boards/signs at the entrance to or exit from a worksite within a possession; and

(h) stop indications given by authorized hand signallers or by a signaller.

1.3.3
multi-PAE
PAE events which have occurred at the same limit of authority location over a defined period

1.3.4
proceed authority exceedance
a rail vehicle exceeds the limit of authority or a train proceeds without a proceed authority or proceeds whilst a restraint authority is in place

Note 1 to entry: A proceed authority exceedance includes passing signals at stop and signals without indication without authority.
Note 2 to entry: A proceed authority exceedance excludes rail traffic passing their normal stopping location or stations if they have a valid proceed authority.

1.3.5
ONRSR
Office of the National Rail Safety Regulator

1.3.6
rail infrastructure manager (RIM)
As defined in Rail Safety National Law.

1.3.7
rail stock operator (RSO)
As defined in Rail Safety National Law.

1.3.8
rail safety worker (RSW)
As defined in Rail Safety National Law.

1.3.9
rail traffic crew (RTC)
competent worker responsible for the operation of rail traffic

1.3.10
rail transport operator (RTO)
As defined in Rail Safety National Law.

1.3.11
signal sighting committee (SSC)
specialist group managing a critical interface between wayside, other infrastructure, rail traffic crew and other external factors

Note 1 to entry: The signal sighting committee allows for input from rail traffic crew representatives regarding the positioning of signals and signs.

General rail industry terms and definitions are maintained in the RISSB Glossary. Refer to:
https://www.rissb.com.au/glossary/

Section 2 PAE categorization and communication

2.1 Principles

PAE events are classified as category A, B or C, as outlined in the *ONRSR Guideline – Notifiable Occurrence Reporting Requirements*.

Confirmed PAE occurrences must be reported by the RTO to ONRSR in accordance with *ONRSR Guideline – Notifiable Occurrence Reporting Requirements*.

All PAE occurrences should be investigated to establish contributing factors and the level of investigation required may be determined by the RTO in accordance with their safety management system (SMS).

RTOs shall have systems and documented processes to categorize and communicate as relevant to PAE events. Such systems and procedures shall include, but are not limited to:

(a) documented process provisions to report the event to ONRSR in accordance with *ONRSR Guideline – Notifiable Occurrence Reporting Requirement* for a category A, B, or C occurrences;

(b) systems for communicating between business units within the RTO at the relevant organizational levels to meet the requirements of this document;

(c) provision for the passing of information between RTOs and relevant stakeholders; and

(d) processes for identifying and providing competent persons to investigate PAEs based on the category and level of investigation deemed necessary by the RTO.

RTOs shall communicate recommended safety actions resulting from the investigation of PAE events to all other relevant and applicable stakeholders. Affected stakeholders shall implement the recommendations, or justify a decision not to, within their organization. Section 7 defines the additional requirements for communication post PAE investigation.

The communication and sharing of accurate and timely information between the RTOs to support investigations or share findings should be done at an appropriate organizational level and should factoring in any legal professional privilege or commercial in confidence requirements.

The RTO shall determine the requirements and responsibilities in respect of PAE reporting and documentation in its SMS.

Section 3 Initial responses to a PAE

3.1 The PAE management process

The PAE management process shall be included in the RTO's SMS. The PAE management process may include, but not be limited to:

(a) the initial categorization of the PAE;

(b) gathering and recording of substantive evidence;

(c) arranging tests, technical examinations or other investigative work on any rail vehicle, signalling and other equipment or system for which they are responsible;

(d) analysis of evidence for the identification of causative and contributory factors;

(e) assessing fitness of staff involved, including, but not limited to:

(i) drug and alcohol testing;

(ii) fatigue levels; and

(iii) currency of health assessment.

(f) rail traffic crew (RTC) training and competence which may factor:

(iv) training records;

(v) route knowledge; and/or

(vi) maintenance of competence.

3.2 Responsibility for managing PAEs

To ensure that any risk to system safety introduced by the PAE is eliminated or minimized in so far as is reasonably practicable, RTOs shall have documented processes in place to alert them of a PAE event and the initial steps required to safely manage the occurrence.

These processes shall include the care and safety of the rail safety worker/s (RSW/s) involved in the PAE occurrence.

RISSB Guideline – Rail Traffic PAE Risk Management provides further information which can help support organizations in establishing these processes.

PAE occurrences have the potential to be a precursor to an incident with varying level of severity. *RISSB Guideline – Rail Emergency Management Planning* provides information to support organizations in developing rail emergency management processes.

Organizations shall have an Emergency Management Plan (EMP) in place. *ONRSR Guideline – Safety Management System* provides detail on the development of EMPs.

RISSB ANRP 6001 – *Overrun Limit of Authority* provides detailed actions that RTOs shall follow in the event of a PAE occurrence

Section 4 Continuation and care of rail safety workers

4.1 Determining the continuation of rail safety work

RSW's who have directly or indirectly been involved in a PAE occurrence are at risk of psychological or psychosocial impacts caused by the event and/or the ongoing investigation process.

Organizations shall ensure that their SMS includes processes, procedures and support mechanisms that account for the welfare of individuals throughout the immediate occurrence and investigation process. In line with just culture principles, support shall be offered to employees, including contractors in the event of PAE occurrence.

RTOs shall have a process for determining whether a RSW (employee or contractor), who is carrying out rail safety work may be permitted to continue such work after a PAE occurrence in which that RSW was involved. Such an assessment shall factor the individual wellbeing of that RSW and their capacity to conduct ongoing rail safety work.

A RSW involved in the PAE shall be relieved of rail safety work immediately upon their request or if evidence or indicators are present that any of the following conditions are identified as being a factor:

(a) affected by drugs or alcohol;

(b) medically incapacitated;

(c) affected by the PAE to an extent which could impair the safety of work performance;

(d) RSW wellbeing;

(e) affected by fatigue; and/or

(f) where evidence which indicates a deliberate violation of rules or instructions by that RSW.

4.2 Medical assessments

Medical assessments of RSW involved in a PAE shall be conducted when:

(a) evidence indicates a person's medical fitness could have contributed to the PAE; or

(b) RTO's SMS deems it necessary.

Medical assessments shall be conducted in compliance with the *National Standard for Health Assessment of Rail Safety Workers*, applicable to the rail safety work being undertaken.

4.3 Drug and alcohol testing post event

Drug and alcohol testing shall be conducted after a PAE event. Under some circumstance an additional test can be required due to:

(a) non-negative result;

(b) initial result challenged by RSW;

(c) third party testing by police or regulatory body;

(d) faulty equipment; and/or

(e) discretionary requirement of the RTO.

For more information regarding drug and alcohol testing, refer to *ONRSR Guideline – Safety Management System.*

4.4 Rail safety worker return to work

Where a RSW has been relieved of duty following a PAE occurrence, the RTO shall have documented and effective processes or tools in place to manage the RSW's return to work.

The return to work process should assess:

(a) known outcomes and recommendations from the PAE investigation;

(b) physical and mental wellbeing of the RSW; and

(c) potential risks relating to future rail safety work.

Where a RSW has been relieved of duty due to being affected by fatigue, the RTO shall have in place processes or tools to assess the RSW fatigue before returning to rail safety work duties.

Section 5 Additional requirements for allowing rail traffic to continue

5.1 Rail traffic being moved by the PAE rail traffic crew

RTC involved with a PAE event may continue to an agreed location, provided the requirements of section 4.1 of this document are met and it is permitted by the RTO's documented PAE management process. RTOs should implement a system to support the ongoing welfare of RTC that have been allowed to continue.

RTC shall not immediately set back to contain or recover the limit of authority overrun.

Factors to be assessed in determining whether RTC can continue after a PAE, include, but are not limited to:

(a) risk to:

(i) the involved rail traffic;
(ii) other rail traffic;
(iii) rail infrastructure;
(iv) local track work or workers on track;
(v) signalling system integrity; and/or
(vi) level crossing operation or occupation.

(b) perishable evidence is gathered to support investigation;
(c) an assessment of any potential damage to rail traffic, equipment or infrastructure;
(d) remoteness, accessibility and distance from available RTC relief;
(e) passenger factors;
(f) customer factors;
(g) service delivery factors;
(h) rail network and rail traffic priorities:
(i) rail traffic recovery; and/or
(j) cargo type:
(vii) dangerous goods;
(viii) livestock; and/or
(ix) perishable goods.

Any damage identified shall be immediately reported to the NCO if a determination has been able to be made by the RTC.

Section 6 Investigating a PAE

6.1 General

Ensuring systemic investigations are conducted into PAE occurrences leads to understanding the contributory factors. This can result in actions which may be undertaken by RTOs to improve their SMS and prevent future occurrences.

Investigations should be conducted with an appropriate and restorative just culture approach and look beyond the immediate events and conditions surrounding the occurrence, and also at the contribution of organizational systems and processes.

RISSB Code of Practice – Rail Safety Investigations defines industry good practice and provides guidance on preparing for and conducting investigations of rail safety occurrences.

RISSB SPAD Investigation Pro Forma tool may be used as a standardized template for collecting and documenting relevant information during an investigation that relates to a SPAD specifically.

The following requirements and information relate specifically to PAE occurrences.

6.2 Initial classification and investigation level

The RTO shall initially assess the PAE as falling into one of the categories as defined by *ONRSR Guideline – Notifiable Occurrence Reporting Requirements.*

RISSB Code of Practice – Rail Safety Investigations may be used to determine the level of investigation required and provides clear categorization mapping based on severity and consequential outcomes. See Appendix B for detailed information.

6.3 Evidence gathering specifically for PAE investigations.

6.3.1 General

In addition to the evidence collection information detailed in the *RISSB Code of Practice – Rail Safety Investigations*, the below provides detail of evidence that should be gathered, where available, by the investigator when conducting PAE investigations.

6.3.2 Operational factors

Operational evidence that should be gathered, where available, and factors to assess may include, but are not limited to:

(a) level of competency and route knowledge of RSW involved in the occurrence;

(b) operational rail traffic management actions and decisions, including what led to stopping the rail traffic;

(c) reason for the limit of authority being in place (e.g. other rail traffic movements in the local area);

(d) train performance data from rail traffic's on-board datalogger to assess rail traffic handling in approaching limit of authority;

(e) rail traffic timetable and network performance;

(f) presence of any abnormal conditions such as de-graded working, track work or special working;

(g) on track activity or interference from RSWs or members of the public;

(h) communication data between RSWs involved in the occurrence, such as RTC, NCO;

(i) effectiveness of safety systems, such as infrastructure and on-board rail traffic systems; and

(j) known network vulnerabilities, such as multi-PAE location or signal.

6.3.3 Human factors

RISSB Guideline – Rail Traffic PAE Risk Management provides comprehensive information to support the understanding of human factors elements that can lead to a PAE occurrence.

RISSB Guideline – Rail Traffic PAE Risk Management should be read in conjunction with these requirements and recommendations by investigators who should seek to understand what error producing conditions might have contributed to RSW actions resulting in the PAE occurrence.

The assessment of these factors can be applicable to all individuals involved in the event which resulted in the PAE occurrence being investigated.

Evidence to support a human factors assessment may include, but not be limited to:

(a) any change to normal operations, including to driving route, routine or operational control tasks;

(b) consistency and design in signal aspect, speed or signage sequencing on approach to the PAE location;

(c) factors relating to the operation of signals or other proceed authority arrangements that might lead to habituation, expectation or misinterpretation;

(d) individuals state at the time of the incident (e.g. attention, situation awareness, fatigue, distraction, workload);

(e) awareness of and familiarity with the route and the designated limit of authority by the RTC;

(f) train management at the limit of authority;

(g) quality of safety critical communications preceding the PAE, including relating to any direction, instruction or verbal proceed authority;

(h) knowledge and understanding of the proceed authority process and/or its limits and conditions;

(i) ease of detection and conspicuity of the limit of authority, including with respect to visual clutter on approach and risks to perception; and

(j) presence of any other performance shaping factors that might have impacted the RSWs identification of and response to the limit of authority.

A human factors specialist may be requested to provide additional analysis of the human factors contribution to the PAE occurrence.

6.3.4 Multi occurrence locations

A targeted assessment shall be undertaken where there are repeat PAE occurrences at a single site, and the recommended mitigations from previous investigations are assessed as being ineffective in prevention.

The RIM shall determine and document the frequency which identifies a limit of authority as being classified as a multi-PAE location.

A multi-PAE assessment should be a multi-disciplinary review and incorporate input from engineering, RTC, NCO, infrastructure and human factors disciplines. This supports a systems-level approach to the identification of contributing factors and risk mitigations.

The assessment may include, but is not limited to:

(a) evaluation of the effectiveness of previous investigations in identifying the contributing factors to the PAEs, particularly with respect to design, operation and organization-level factors;

(b) assessment of how effectively identified actions and recommendations have addressed those contributing factors;

(c) assessment of the status and effectiveness of previously identified controls or corrective actions;

(d) assessment of any common themes across previous events that might identify causal factors not previously identified (e.g. such as time of day, rolling stock type, design elements, environmental conditions, training or procedure effectiveness);

(e) identification of any gaps in causes and controls that unintentionally introduce new recommendations for further assessment and implementation; and

(f) collation of any additional data or information specific to the area or the limit of authority, including relative to upgrades to the signal or surrounding area, signal sighting assessments or changes to the design or implementation of the limit of authority.

The RTO shall define and document the requirements and frequency of a multi-PAE assessment within their SMS.

Multi-PAE locations should be tracked and monitored as a defined category within PAE reporting data.

6.4 Post event inspection of infrastructure

Where evidence indicates it to be necessary, the RTO shall arrange for a post PAE inspection of the infrastructure and related factors. This may include signalling equipment, boards, signs and markers that were involved in the lead up to the PAE occurrence. The extent of inspection should be commensurate with the type of PAE and the potential consequences that might have arisen.

Inspections can include but not be limited to:

(a) rail conditions (including a rail head swab test if applicable);

(b) condition of assets or infrastructure designating the limit of authority;

(c) weather (including lighting and glare issues); and/or

(d) signal visibility and condition (where applicable), including:

  (i) structure;

  (ii) head alignment;

  (iii) location of signals attributing to signal read through or cross read;

  (iv) lens cleanliness;

  (v) red aspect condition;

  (vi) sun position; and

  (vii) general signal structure condition; vegetation encroachment.

When evidence indicates a signalling system irregularity has occurred, the RIM shall undertake a technical investigation of the signalling system.

6.5 Post event inspection of rolling stock

Where evidence indicates it to be necessary, the RSO shall arrange for an immediate post-PAE inspection of the rail traffic involved and related factors. The amount of inspection should be commensurate with the type of PAE and the potential consequences that might have arisen.

Inspections can include, but not be limited to:

(a) visibility through windscreen (such as cleanliness and cracks);

(b) in-cab environment (such as equipment, ergonomics, heating and ventilation);

(c) effects of sunlight on visibility from the driving cab;

(d) wheel and brake disc swabs (if applicable); and

(e) testing rolling stock sanding equipment operation, levels and flow rates; and

(f) testing wheel slip units if installed.

Where evidence indicates a brake or on-board system irregularity has occurred, the RSO shall undertake a technical investigation of the rail traffic braking system or on-board system.

6.6 Signal sighting committee utilization

If determined throughout the initial classification and investigation level assessment that a signal sighting committee (SSC) can assist in evidence gathering for a PAE investigation, then an SSC may be formed.

AS 7631 provides the requirements for the establishment and duties of SSCs.

When utilizing an SSC for the purpose of investigating a PAE occurrence specific to a SPAD, the SSC should factor in signal design and assess for:

(a) aspect sequencing;

(b) signal to track recognition;

(c) human factors (see 6.3.2), and

(d) signal context.

Section 7 Requirements following a PAE investigation

7.1 Reviewing reports and recommendations

RTOs shall have documented processes in place for systematically reviewing and responding to PAE investigation reports, actions and recommendations that are relevant to their operations.

Decisions and actions taken in response to PAE investigations shall be documented and the effects monitored.

RTOs shall have documented processes in place to:

(a) implement actions and recommendations applicable to its operation; or

(b) record the reasons for rejecting or modifying actions and recommendations of a PAE investigation.

7.2 Communication with stakeholders

7.2.1 Immediate communications

RTOs shall have documented processes in place to advise their employees and contractors of the circumstances of any PAE occurrence which is relevant to their work as soon as possible.

7.2.2 Ongoing communications

RTOs shall have processes in place to advise employees, contractors and other affected RTOs of the outcomes of PAE investigations. Any changes or improvements made through the integration of learnings from the investigation should be reflected in the RTO's SMS and subsequent procedures and training material where applicable.

Where signals have been involved in multiple PAEs or in operations and locations with an increased risk of PAE occurrence, RTOs should ensure that affected RSW are aware of the signal's location, and the causal and underlying contributory factors to previous PAEs. Updating route knowledge training material should be assessed after multi-PAE occurrences.

RTOs shall:

(a) brief RTC about signals on routes over which they operate which have been the subject of more than one PAE during the past five years; and

(b) amend impacted local instructions or other operational processes affecting the RTC, or other relevant stakeholders.

7.3 Network operational system irregularity reporting feedback

When RTC has reported an irregularity with the operational environment that might cause or be in relation to a PAE event, the RIM shall:

(a) ensure that the cause of the irregularity is rectified;

(b) notify the RSO responsible for the RTC in accordance with the RIM's documented processes; and

(c) inform the RSO of the status of the irregularity investigation and the date of the next response.

Section 8 Record management

8.1 Record keeping requirements

Records of PAE investigations and other supporting documents shall be managed in line with the requirements of the RTO's SMS.

This may include:

(a) maintenance, management and storage of documentation and evidence pertaining to investigations; and

(b) copies of and communicated changes to organizational SMS.

8.2 Event recording

The RTO shall:

(a) maintain a comprehensive record of PAE information, investigations and investigation outcomes;

(b) maintain an appropriate PAE database system (or similar) and monitor data input to ensure compliance with this document;

(c) retain records of PAE events;

(d) conduct verification activity to confirm that accepted corrective actions have been implemented and are effective in addressing the safety findings of the investigation;

(e) record verification of action implementation before recommendations are closed; and

(f) communicate lessons learnt where applicable.

Appendix A Hazard Register (Informative)

Hazard number	Hazard
2.1.2.1	The lack of understanding of the requirements of the Rail Safety Act (now rail safety national law)
2.1.4.1	Inadequate procedures being in place to ensure reviews are undertaken
2.1.9	The failure to follow appropriate risk management process
2.1.18	The failure to implement rail safety incident and accident reporting
2.1.19	The failure to monitor and review safety related trends
2.1.20	The failure to monitor and review safety related data
2.1.24	The failure to implement effective change management systems
5.7.1.3	Collision
5.7.1.26	SPAD causing collision
6.5.1.43	Personal stress
8.1.1.3	Operator Rules & Procedural Breaches (resulting in derailment)
8.2	Damage to rolling stock and or Infrastructure
8.3	Third party property damage
8.4	Injury or death of an employee
8.5	Injury or death of a third party

Appendix B Classification of Investigation Level (informative)

Table B-1 Classification of Investigation Level – extract from RISSB Code of Practice – Rail Safety Investigation

Severity level	Occurrence type description (see Note)	Minimal Level of investigation	Equivalent ONRSR CAT Level	Reporting requirements
1	A major occurrence which attracts intense public interest. Typically, a major accident involving extensive property damage or substantial numbers of fatalities or serious personal injuries.	Investigation led by an investigator independent of the organization involved.	CAT A	Detailed report of a systemic nature produced as specified in this CoP. See NOTE 3
2	A major occurrence not likely to generate intense public interest, but which involves significant property damage or some fatalities or serious personal injuries.	Investigation may be led by an investigator either independent of the organization involved or belonging to that organization.	CAT A	A detailed report as for Level 1 can be required at the upper level of severity in this category, otherwise a brief report as for Level 3.
3	An occurrence involving appreciable property damage but with only minor injuries, but notable by the fact that it had the potential to be much more serious, probably involving loss of life, had circumstances been only slightly different.	Investigation by the organization involved.	CAT A if injured party is rail safety worker CAT B if injury is a member of the public	Brief report produced, including analysis where appropriate.
4	An occurrence of minor consequence with either no damage or only superficial damage or injury where there is little evidence that a more serious occurrence has been narrowly averted.	Low level investigation required.	CAT C	Initial occurrence report prepared and retained for trend analysis.

Severity level	Occurrence type description (see Note)	Minimal Level of investigation	Equivalent ONRSR CAT Level	Reporting requirements
5	A safety violation identified during observations/inspections.	Low level investigation required.	CAT C	Initial occurrence report prepared and retained for trend analysis.

NOTE 1: Some jurisdictions can prescribe minimum levels of severity by means of numerical values of fatalities, personal injuries or property damage. These requirements should be incorporated into the relevant section of the RTO's Safety Management System.

NOTE 2: An occurrence can have significant public interest but might not be considered a major occurrence due to no fatalities or injuries. In this instance, a Level 1 investigation may be undertaken due to the weight of public interest or reputational risk.

NOTE 3: *RISSB Code of Practice – Rail Safety Investigation*

Bibliography (Informative)

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Recommended further informative reading

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