

Building safe and reliable railways

—Enhancing safety with the derailment accident on the Fukuchiyama Line as the starting point

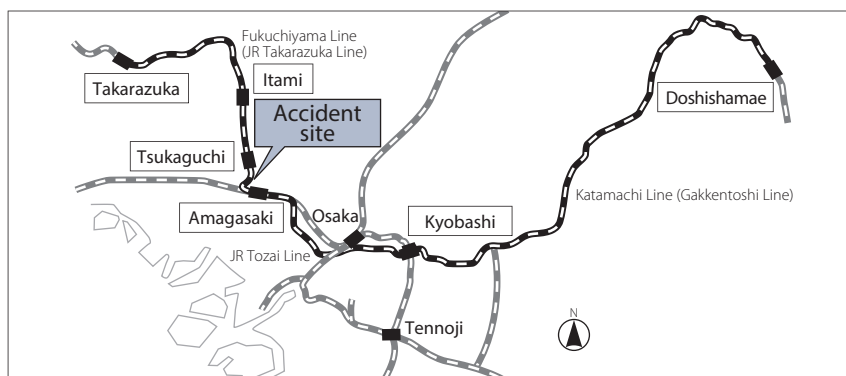
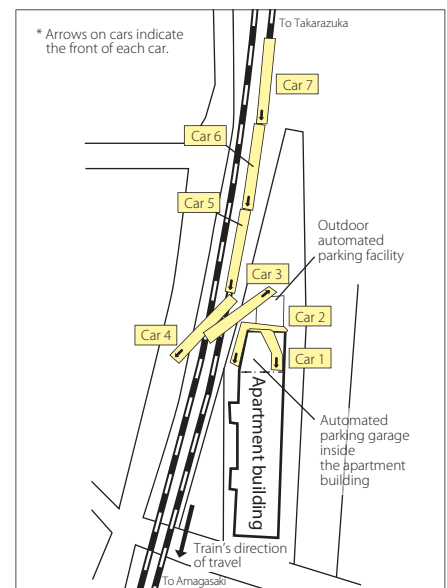
The derailment accident on the Fukuchiyama Line

On April 25, 2005, we at the West Japan Railway Company caused the Accident on the Fukuchiyama Line, an extremely serious accident resulting in 106 fatalities and more than 500 injured passengers. We pray for all the victims of the accident and would like to express our sincerest apologies to their bereaved families. We would also like to express our deepest sympathies and sincerest apologies to the injured passengers and their families.

For the immense anxiety that the accident caused, we offer the deepest apology possible to our customers and those in the local community.

Overview

Date/time	Monday, April 25, 2005, approx. 9:18 AM Weather conditions: sunny
Location	Between Tsukaguchi Sta. and Amagasaki Sta. on the Fukuchiyama Line Approx. 1,805 m before Amagasaki Sta. (Amagasaki city, Hyogo prefecture)
Trains involved	Rapid train from Takarazuka Sta. bound for Doshishamae Sta. Train No. 5418M (EMU 207 series, 7 cars)
Summary	Between Tsukaguchi station and Amagasaki station, train No. 5418M entered a rightward curve with a radius of 304 m at 116 km/h—greatly exceeding the speed limit of 70 km/h for the corner. As a result, the first through fifth train cars derailed, causing the first and second cars to collide with an apartment building on the left side of the direction of travel. On this derailment, 106 passengers and the train driver were killed. Furthermore, 562 passengers and 1 pedestrian walking near the scene were injured.



Cause of the accident

—From the Aircraft and Railway Accidents Investigation Commission's Railway Accident Investigation Report*
*The Aircraft and Railway Accidents Investigation Commission was reorganized as the Japan Transport Safety Board in October 2008

It is considered highly probable that the train driver's delay in applying the brake resulted in the entry of the train into a 304 m-radius rightward curved track at a speed of approximately 116 km/h, which was far higher than the specified speed limit of 70 km/h, and the running of the train along the curved track at the high speed caused the first car of the train to fall left and derail, which caused the second to fifth cars to derail.

It is considered probable that the train driver's delay in applying the brake is attributable to the diversion of his attention from driving the train to (1) listening to the dialogue between the conductor and the train dispatcher by radio communication which was caused by his belief that he had been hung up on by the conductor while he had been talking to the conductor on the intercom to ask him to make a false report and (2) making up an excuse to avoid being put on an "off-the-train" re-training course.

It is considered probable that the West Japan Railway Company's train driver management system in which drivers who caused an incident or a mistake are put on an "off-the-train" re-training course that can be considered as a penalty or are subjected to a disciplinary action and drivers who did not report an incident or a mistake they had caused or made a false report about such an incident or mistake are put on an even harder "off-the-train" re-training course or subjected to an even harder disciplinary action may have (1) caused the driver to make the call to the conductor on the intercom to ask him to make a false report and (2) caused the diversion of the driver's attention from driving the train.

We will continue to make concerted efforts for all persons affected by the accident, while striving to further enhance safety measures and reform our corporate culture.

This accident has left an indelible mark on our hearts and we will continue drawing upon all of our capabilities to be fully conscious of our responsibility for protecting the truly precious lives of our customers, and incessantly acting on the basis of safety first, while building a railway that assures our customers of its safety and reliability.

Taking to heart the lessons from the accident

Because JR-West had never predicted an accident of this great magnitude before, we did not have an ATS (Automatic Train Stop) system with speed check functions installed on the curve where the derailment occurred and we did not sufficiently take into account human factors in our employee training and similar programs.

After the accident, in looking back on the issues JR-West needs to rectify, and while implementing various safety initiatives, we came up with the following points of reflection as we reassess why we were unable to preempt the derailment accident on the Fukuchiyama Line.

Company-wide system for ensuring safety

Inadequacies in the system for identifying and addressing risks

As a company engaged in the railway business, we need to ensure safety by having each part of the organization earnestly fulfill its duties, while also mutually coordinating with its counterparts. These include management personnel, who handle overall supervision and determine the management policies and their requisite safety measures; technical/engineering personnel, who design and build the railway systems that put the above policies into action; and operational/functional personnel, who run the railways, stand on the front lines, and maintain railway system equipment. When implementing management policies in particular, the technical/engineering personnel work at the design stage to

first identify and evaluate risks accompanying those policies, then propose safety measures, while the management personnel execute decisions on management policies after confirming that the necessary safety measures have been taken. Then, the operational/functional personnel strive to notice any safety issues after the policies have been implemented (including during day-to-day work tasks), with the management and technical/engineering personnel responding to address any issues.

With regard to our framework for ensuring safety as a Company comprised of these three parts, we reflected on what should have been done before the accident and came up with the following improvement points for each stage of implementing management policies.

The planning stage for management policies	A system for preemptively identifying and addressing risks—in order to prevent severe accidents before they occur—was not established at the planning stage of management policies. For instance, at the planning stage for revising the timetable (which enabled large-scale formation changes to the train line and an accelerated operation schedule) when service began on the JR Tozai Line, policies did not include equipping the line with an ATS system on the curve where the accident occurred.
The decision-making stage for management policies	A system for deciding management policies after confirming that necessary safety measures have been taken was not established. As a result, the confirmation of safety measures and the decision-making process for management policies were undertaken separately, without mutual coordination, including in the case of management policies for changing the formation of the train line and revising the timetable, and safety measures such as equipping the line with an ATS system.
The post-implementation stage for management policies (including during day-to-day work tasks)	After the implementation of management policies such as changing the formation of the train line, revising the timetable, etc., there were insufficiencies in the system for acknowledging safety issues noticed by personnel during their day-to-day work tasks, as well as gathering information on risks that could lead to major accidents.

Inadequacies in systems such as employee training (greater attention to the “human factor”)

As stated in the Aircraft and Railway Accidents Investigation Commission’s Railway Accident Investigation Report, “It is considered probable that the train driver’s delay in applying the brake is attributable to the diversion of his attention from driving the train to (1) listening to the dialogue between the conductor and the train dispatcher by radio communication which was caused by his belief that he had been hung up on by the conductor while he had been talking to the conductor on the intercom to ask him to make a false report and (2) making up an

excuse to avoid being put on an “off-the-train” re-training course.” In the background to this were insufficiencies in our employee training program’s consideration of human factors, as well as a lack of resilience from minimal leeway built into the train timetable.

At that time, the Company thought that pursuing the individual’s responsibility for an error would prevent recurrence, so we were carrying out disciplinary action and a re-training program that could be perceived as a penalty against personnel. This led to personnel directing their attention toward covering up and making excuses for errors, which resulted in a situation that opened the door to accidents, as opposed to preventing human errors.

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Culture that makes safety the top priority

We believe that part of the background to not having these organization-wide systems for ensuring safety was not having a Company-wide culture that made safety the top priority, and that management personnel in particular had insufficiencies in their actions and awareness of the priority of safety.

Attenuated technical expertise and sensitivity to safety accompanying emphasis on operational efficiency

When the Company was initially founded, efforts were made to promote efficiency across all operations due to the challenging environment in which our operational foundations were being established. As a result, any surplus leeway in operations was reduced and we were not able to elevate safety initiatives as we only took care of maintaining daily tasks. Consequently, technical expertise lagged and we were not able to boost our sensitivity to safety issues.

Insufficient understanding of the “human factor”

As we built up safety measures grounded in experience-based engineering (which is a particularity of the railway business), our fundamental focus became a belief that we could assure safety, so long as we paid attention to laws, regulations, and other rules created from measures and knowledge gained from past accidents. As a result, there was a bias toward preventing recurrence of incidents in an approach that “treated symptoms” while not installing measures for predicting risks preemptively.

Additionally, a focus on ensuring safety by attending to laws, regulations, and other rules led to an inadequate understanding of human factors, such as “humans being prone to fallibility” and “human errors being effects, not causes.” This entailed insufficiencies in our multifaceted analysis of causes and our implementation of countermeasures.

Excessive top-down communications, insistence on punishment and rewards, and emphasis on liability

The particularities of the railway business mean that it is comprised of a variety of technical domains and organized with numerous specialized fields (transportation in general, rolling stocks in particular, facilities & equipment, electronics, etc.). This creates fertile ground for a culture prone to top-down communications, including hierarchy within each specialized field and a salient chain of command.

Drawing on lessons learned from when we were a nationalized company, we followed a workplace management approach in which instructions were comprehensively issued at each workplace and an emphasis on punishment and rewards was fundamental. When these were taken to extremes, the corporate culture became focused on pursuing individual liability and the general awareness of sectionalism was heightened. At the same time, top-down communication became excessive and frank discussion was difficult. Dialogue between management, technical, and operational personnel, as well as communication between superiors and subordinates, along with reciprocal coordination between specialized fields and separate workplaces, were all insufficient.

Overconfidence from a successful track record

As JR-West steadily established its management foundation, we weathered the Great Hanshin Awaji (Kobe) Earthquake disaster, then successfully emerged from full privatization and gradually built up a track record of continuously stable operations. We believe that experiencing these successes engendered an organization prone to over-confidence and a sense of contentment with current circumstances. A stance of humbly learning from external examples gradually diminished and discrepancies with society at large emerged.

Learning from the accident

JR-West Group has reflected deeply on the fact that we were unable to fulfill our responsibility as a company entrusted with the precious lives of passengers, and we have worked hard to build mechanisms in company-wide systems to ensure safety, while establishing a culture that makes safety the top priority.

Specifically, we formulated the “Safety Enhancement Plan,” “Fundamental Safety Plan” and “Railway Safety Think-and-Act Plan 2017.” As a result of developing various safety initiatives from both the tangible and intangible perspectives, we have reduced both railway operation accidents and transportation

disruptions due to internal factors.

Since fiscal 2019, the entire JR-West Group has been engaged in implementing the JR-West Group Railway Safety Think-and-Act Plan 2022, a specific plan for safety improvement that forms the core of the JR-West Group Medium-Term Management Plan 2022. This plan incorporates the lessons of the derailment accident on the Fukuchiyama Line and the initiatives we had developed up until that point, as well as the lessons of the critical incident on the Sanyo Shinkansen that occurred in December 2017.

JR-West Group Railway Safety Think-and-Act Plan 2022

The JR-West Group Railway Safety Think-and-Act Plan 2022 reaffirms our commitment to achieve “zero train accidents that result in casualties among our customers” and “zero railway labor accidents that result in fatalities among our employees,” as well as further reductions with regard to “train accidents involving people that result in casualties among our customers,” “accidents at level crossings,” and “transportation disruptions due to internal factors.”

Among these aims, we take very seriously incidents caused by us that result in the loss of our colleagues’ precious lives, such as labor accidents involving electrocution. By drawing up measures based on their causes, we are working hard to limit such incidents through initiatives including continually monitoring the status of measures implementation. To ensure that we steadily advance this Plan, we will further deepen our initiatives, including enhancing the tangible and intangible measures we have implemented hitherto, as well as initiatives whereby each individual considers

concrete risks and stops the train or their work without hesitation when they cannot confirm that the situation is safe. Furthermore, we are striving to develop an organizational culture whereby employees no longer take a passive approach to what has been simply decided or instructed. In other words, building organizations and employees who actively think, learn, introduce what they have learned and try putting it into practice by acting more independently to ensure safety, besides complying with rules and systems. In addition, we will review the safety initiatives implemented after the derailment accident on the Fukuchiyama Line in the light of the lessons learned, and as an organization, see that this is handed down. At the same time, we will implement effective training so that this is embodied in the thinking and actions of every individual. Concerning our response to the novel coronavirus pandemic, we will continue to make every effort to prevent the spread of the virus among our customers and employees.

● Safety enhancement with the derailment accident on the Fukuchiyama Line as the starting point

Building companywide frameworks for securing safety and establishing a corporate culture in which safety is the highest priority

- Highlighting and reviewing the lessons learned from the safety initiatives implemented after the derailment accident on Fukuchiyama Line, and advancing measures linked to the think-and-act initiatives of each individual.
- Establishing support tools, etc., for the realization of a corporate culture of “actively thinking, learning, introducing, and trying.”

Safety measures for crossings and platforms

- Trialing of systems that support detection of special signal light emitters¹ (figure 1)
- Developing safety devices for type 4 crossings²
- Enhancing safety confirmation methods used by train crew on platforms (L-space confirmation, etc.) (figure 2)

Railway labor accident countermeasures

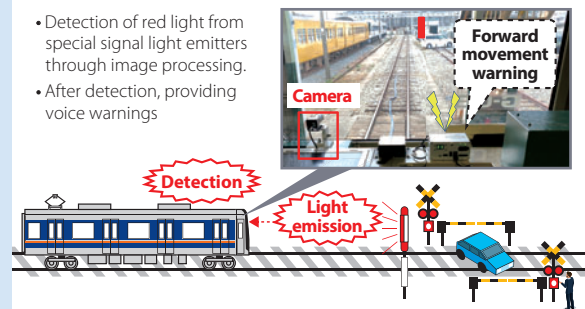
- Reducing on-track inspections through data measurement on rolling stock (3)

Natural disaster countermeasures (disaster prevention / damage reduction)

- Using radar to track amount of rainfall to address localized heavy rain
- Implementing measures that take into account flooding at rolling stock bases

Measures to prevent the spread of the novel coronavirus infection

- Anti-viral and anti-bacterial processing in stations and on trains
- Installing air cleaners on limited express railcars
- Providing real-time, detailed information to contribute to the avoidance of congestion



1. Special signal light emitter support system



2. Safety check of the area between the train and the line of tactile paving tiles (“L space”)



3. Flaw detection railcar

¹ Special signal light emitter: Equipment that displays a signal to indicate an emergency, for example when a car stalls on a level crossing

² Class 4 level crossing: A level crossing with a warning notice and level crossing sign, rather than a gate or warning signal

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Instilling an awareness of safety as the top priority

With 15 years having passed since the derailment accident on the Fukuchiyama Line, the majority of current JR-West employees joined the Company after the incident. In order to ensure that the accident is not forgotten, and to implement initiatives for improving safety, the entire JR-West Group is carrying out measures to hold in our hearts the lessons of that day.

We have designated the 25th day of every month “safety day.” In addition to continuing to hold study sessions and cross-departmental discussions on safety at each workplace, we hold “think-and-act” safety training at the Railway Safety

Education Center and Memorial Grove (Inori no Mori) at the accident site for the purpose of acknowledging the lessons and points of reflection from the accident, using those insights in safety improvement initiatives, and connecting this to the work tasks of each employee. We will enhance measures to ensure that everyone holds the derailment accident on the Fukuchiyama Line in their heart and deepens their understanding of safety-related policies (including the Safety Charter), in order to build a culture in which safety is the top priority and in which actions consistently put safety first.

Example initiative Kanazawa Branch

Initiative to pass on the experience of the accident

The Kanazawa Branch is conducting an initiative led by staff who worked in the Kansai Urban Area at the time of the accident.

We are deepening the relevance of the accident for each individual

Reiko Sato

General Affairs Section, Kanazawa Branch

At the time of the accident, I was working as a conductor in the Kyoto area, and when I was assigned to the Fukui area as a driver, I felt the difference between areas in their approach to the accident. Based on that experience, I devised an initiative to pass on the experience of the accident, with staff who had been working in the Kansai Urban Area as the instructors.

By hearing first-hand accounts of the circumstances of the accident from staff who themselves experienced it, the accident is engraved in the hearts of the participants and becomes something they can relate to on a personal level. As a result, our initiative serves to strengthen “safety first” in their thinking and actions.



We are keeping the experience of the accident alive

Shuichiro Umezawa

Chief Controller, Transportation Section, Kanazawa Branch

I was working at Amagasaki Station as a new employee immediately after the accident, and I experienced various things through the station's operations. It is my belief that we must never forget this experience and continue to talk about it, which is why I'm participating as an instructor. By practicing in our daily work our Corporate Philosophy and Safety Charter, which were established based on what we learned from the accident, this leads directly to customers use railway services with peace of mind when using our railways. This is what I always tell our participants.



We are also passing on the experience of the accident

Takuya Ukegawa

Truck & Structures Management Staff
Toyama Shinkansen Railway Maintenance Unit, Kanazawa Branch
(now Truck & Structures Controller, Shinkansen Truck & Structures Section, Kanazawa Branch)

Hideaki Yamagishi

(now RAILWAY TRACK AND STRUCTURES TECHNOLOGY CO., LTD.)

Hearing the instructors' memories of that time reminded us that we were working in a company that had caused an accident. This again brought home to us the importance of practicing the Corporate Philosophy and Safety Charter in our daily work, whether that be construction or planning. In a workplace such as ours, most of the employees joined the company after the accident, so we believe it is important to convey what we learned from this initiative within the workplace. As well as encouraging them to keep safety in mind in their day-to-day work, on “safety day” we share what we learned from this initiative to pass on the experience of the accident.

In addition, we are practicing specific thinking and actions such as initiatives that result in safe conduct, by objectively evaluating one's own behavioral characteristics, and using self-awareness to avoid making assumptions.

We will continue to implement such initiatives in future in order to instill a safety-first awareness and ensure safe operations on the Hokuriku Shinkansen.



Enhancement of organizational safety management

To improve the functions of railway systems for maintaining safety, we are working to establish organization-wide mechanisms to ensure safety, implemented at the managerial, technical and operational levels, based on an awareness of safety as the top priority. We also work to ensure that these mechanisms function effectively, without deterioration over time, and are continuously enhanced.

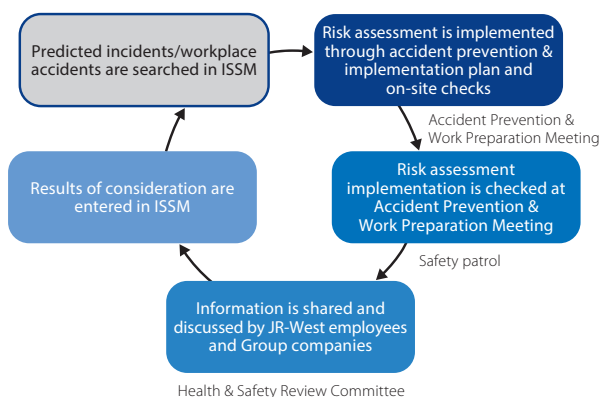
With regard to risk assessments, the head office, branches and work sites cooperate to identify and assess risk, and enact the appropriate measures for the priority risks. We also operate an Integrated System for Safety Management (ISSM),* a database for viewing and searching risk information, while also promoting Group-wide initiatives in which we learn from safety-related information at other sites.

Example initiative **Hiroshima Civil Engineering & Technology Center, Hiroshima Branch**

Creating opportunities for everyone to think about risk in concrete terms

At the Hiroshima Civil Engineering & Technology Center, we are using ISSM to build safety management systems with the goal that each person thinks in concrete terms about risk and becomes more sensitive to risk. When holding discussions prior to inspections and construction work, we use ISSM to search for past accidents with similar conditions and work processes to anticipate risk, thereby improving the quality of risk assessment. Also, we conduct safety patrols to check that the measures examined beforehand are being implemented. The results are shared with Group and partner companies at review meetings held every month, and following discussion, safety and risk-related information is registered in ISSM. Through this process, we are establishing a cycle in which risk information is disseminated throughout the company and risk assessments are constantly improved.

● Risk assessment flow using ISMM at the Hiroshima Civil Engineering & Technology Center



Using ISSM to identify work-related risk

Masato Bando

Assistant Manager

Hiroshima Civil Engineering & Technology Center, Hiroshima Branch

When carrying out a risk assessment, each individual's risk sensitivity and past experience has a significant influence. By searching for incidents in ISSM, we can learn about events that occurred at other locations and the measures that were considered, giving us new insights. Also, we identify risks associated with new work processes by verifying important points in similar work processes in the past.

Taking these identified risks as the starting point, we prevent misconceptions and misunderstandings by holding pre-work discussions at the work site, rather than indoors as was the case before, which makes it easier to identify risks that would have been difficult to spot in the office. Also, by allowing "confirmation time" in discussions at the work site, I feel there are now many more verbal contributions from Group and partner companies. I can really sense how the ISSM search results act as a primer for discussion and also stimulate more lively debate, creating a virtuous cycle of risk identification.



On-site Accident Prevention & Work Preparation Meeting

* Integrated System for Safety Management (ISSM): A database in which risk information can be viewed or searched

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Safety think-and-act by each individual

We aim to prevent serious accidents by each individual understanding the importance of reporting and sharing safety-related information, as well as anything they notice in connection with safety, while taking measures themselves to

reduce risk and manage their own actions. As well as working to create an environment that facilitates reporting, we are promoting the creation of workplaces in which safety-related information can be shared.

Example initiative Kamigori Station, Kobe Branch

Gathering safety-related information and measures to reduce errors at one’s own site

In the light of the car derailment that occurred during shunting work at Gobo Station on the Kisei Line in April 2019, at Kamigori Station on the Sanyo Line an examination was carried out to further improve safety in shunting work, premised above all on compliance with rules and proper implementation of basic

operations so as to prevent a similar incident here.

The use of different colors to categorize two patterns of shunting operation that are regularly carried out strengthens awareness of which operation is being performed, preventing errors during shunting work.

Note: Shunting work: Work carried out in the station yard, including moving rail cars around and positioning them on the platform.

Improving visibility using different colors



Example of use at the work site



Learning from experience to enhance empirical value

Mitsuji Okamoto
Transportation Management Staff,
Kamigori Station, Kobe Branch, Kansai Urban Area Regional Head Office

A single error in shunting work or other operations handling at the station could lead to a derailment or other major incident. I strongly feel that if an accident is narrowly avoided, that experience should be shared with other members and put to good use, rather than simply thinking it was fortunate that nothing happened.

We are making it a habit to think about what to do next and what measures to implement to avoid a similar mistake, based on that experience of a narrowly avoiding an accident, and when another location shares an incident, to consider what measures we would take if it had happened to us. We also get our colleagues involved in this process and tackle it with a sense of mission.

When thinking with my colleagues about what measures we should take in this particular instance, I felt that there might be a more “immediate” measure that triggers attention, rather than just taking a logical approach, and as a result we thought of using different colors for each work process.

Going forward, we will ensure that newly hired or transferred colleagues also understand the crucial points of shunting work, and also make sure that the measures we’ve put in place and their significance are properly passed on.



Enhancement of railway systems that maintain safety

To ensure railway safety at all times, we are improving the functions of railway systems for maintaining safety through a combination of tangible and intangible measures, while controlling risk to a tolerable range. Among the intangible measures, to enforce checks and communication we are working to ensure that individuals

communicate to mutually confirm an action or instruction that they believe to be mistaken or erroneous, regardless of the organization or position of the other party, based on the keywords “Just to confirm...” and “Thanks for confirming.” This is being addressed throughout the JR-West Group.

Example initiative **Nishinihon Electric System Co., Ltd.**

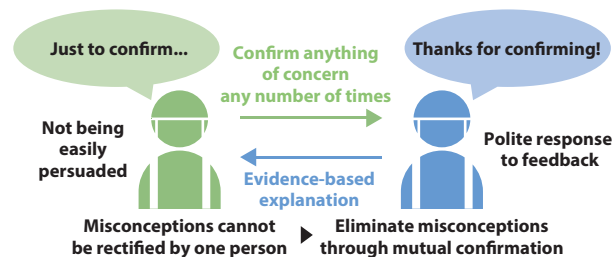
Eliminating misconceptions by creating a culture of mutual confirmation and checks

Group company Nishinihon Electric System Co., Ltd. (NESCO) allocates “confirmation time” in relation to any concerns or questions that arise about work. The aim is to eliminate misconceptions through mutual confirmation between the operation leaders and works personnel from external partners. As a result, asking questions with the phrase “Just to confirm...” is becoming a habitual part of collaboration between operation leaders and works personnel.

As well as thanking the questioner with the phrase “Thanks for confirming,” we are working to eliminate errors resulting from misconceptions from various perspectives, using mutual checking of documents and drawings used in work discussions, on-site equipment, etc.

By establishing mechanisms that allow anyone to speak up about something they are concerned about, without feeling uncomfortable, and making evidence-based checks a habit, the company is building an environment in which risk is tackled collaboratively.

● Communication between an operation leader (left) and work supervisor/worker (right) during “confirmation time”



Conversations for checking safety have improved both in quality and quantity

Kohei Tanigaki

Assistant Manager,
Kyoto Contact Line Construction Office, Nishinihon Electric System Co., Ltd.

We have always allowed time to confirm the degree of understanding in pre-work meetings, on points such as the work content and environment.

By allowing “confirmation time,” I have really noticed how confirmations not only by the work supervisors, but also by the workers themselves, have increased both in quality and quantity, and we are now able to consult openly about any doubts or concerns.

What I’m aiming for now is to inject variety into our “confirmation time” and think up new ways of communicating, as when the work conditions remain similar in the same work location, the points raised tend to be heard less critically.

Sensitivity to risk has improved through active exchange of opinions

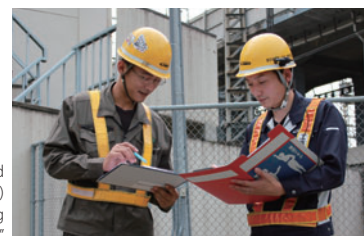
Daijiro Ogawa

Construction Section Manager,
Koyodensetsu Co., Ltd.

“Confirmation time” allows all the parties to have a common understanding of the finer points, so I think it’s very effective. Having conversation time separate from the time spent on explanations and the like creates an open and relaxed atmosphere, and our work personnel actively confirm issues during this time.

In cases such as work related to a major project, sometimes different work is going on at the same time in an adjacent location, so careful cooperation is essential to ensure the safety of our personnel as well as workers from other companies. By allocating “confirmation time,” the different viewpoints of those working on the front line are incorporated, and I can really sense how the team’s sensitivity to risks latent in the work content, environment and conditions increases.

Section Manager Ogawa (left) and Assistant Manager Tanigaki (right) exchange views during “confirmation time”



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Responding to victims

At present, our specially established Supporting Headquarters for the Victims of the Derailment Accident on the Fukuchiyama Line is responding to the needs of those who suffered from the accident. Going forward, we will earnestly listen to the thoughts and opinions

of each individual person and continue to make concerted efforts for all persons affected by the accident. Furthermore, we will continue to keep a contact office open in order to be able to consult with and listen to victims into the future.

Memorial ceremony

In September 2005, we held a Memorial Ceremony & Safety Event, which has been followed up with a Memorial Ceremony every year on April 25. In 2020, the Memorial Ceremony was canceled due to the spread of novel coronavirus.

Explanation meetings

We have been holding explanation meetings, with attendance by the Company President and relevant executives, as an opportunity to provide victims with information on Company issues and initiatives, while also receiving input from victims.



Offering flowers in memory of those who died in the accident

Memorial Grove (Inori no Mori) at the accident site

We incorporated input from victims and drew up a plan in order to construct a Memorial Grove (Inori no Mori) at the site of the Fukuchiyama Line accident in September 2018.

The Memorial Grove includes a cenotaph, a Memorial Corner (with letters to the deceased from their loved ones as well as various items donated in their memory), and an Accident Information Corner (with panels giving details about the accident, as well as newspaper clippings, publications, and other related media covering the accident). Anyone may freely visit the Memorial Grove.

The Memorial Grove serves as a place to remember and lay to rest the souls of those who perished, while also leaving a

record of the accident for those who come after. The site will keep the accident from being forgotten and will convey the preciousness of life to society and future generations. It will help JR-West reflect on the accident and will act as a physical pledge to on-going safety as the Company continues to carefully and responsibly preserve the site for all future generations.



Initiatives that take into account the accident and work to benefit local communities

As a company entrusted with the precious lives of passengers, we are committed to reflecting on the gravity of causing such a major accident and, as part of creating a society that affords safety and peace of mind, we established the JR-West Relief Foundation in April 2009.

The foundation has followed the spirit of its creation by engaging in physical and mental care for those affected by accidents and disasters, while also engaging in projects for building safer local communities.

Hosting events

The foundation holds Life Seminars given by guest speakers from various fields, which focus on life from multiple perspectives and strive to provide participants with the opportunity for personal reflection.

As an event marking its tenth anniversary, the organization held an essay and haiku contest for elementary and junior high school students, on the topic of "life," and this was so well received that it was repeated in fiscal 2020. We plan to continue holding this contest, through which students are able to reflect on the importance of life, and to continue sharing with the community the reflections contained in the best submissions.

Offering grants

Toward creating a society that affords safety and peace of mind, the foundation offers grants to groups and research projects supporting preparations and recovery care for accidents, natural disasters, and unforeseen tragedies. Furthermore, in order to help the promotion of emergency aid/life support training in local regions, the foundation subsidizes AED training devices and also supports a group whose achievements include providing Inochi no Denwa (a suicide prevention line servicing the six prefectures of the Kansai area).



Activity of a group that received a grant