

NATIONAL OPERATING PROCEDURES

TRANSFERRABLE LESSONS FROM SERIOUS OPERATIONAL INCIDENTS / INVESTIGATIONS

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Issue: 01

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Transferable Lessons from Serious Operational Incidents / Investigations



Issue No:	NR/OPS/038	Date Issued:	03/10/18
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Train signalled into occupied section Dumfries to Carlisle.



Summary of Incident:

At 14:25Hrs on Thursday 20th September 2018 the Signaller at Dumfries was contacted by the Driver of 1L76 to advise the Signaller his train was at a stand at DE3106 signal. The Signaller checked the train describer and noticed 1L76 description was in the TD berth. The Signaller asked the Driver if he could see any obstruction ahead, the Driver responded he didn't notice any obstruction and the Signaller then authorised the Driver of 1L76 to pass DE3106 signal and to proceed to Gretna Green station without first contacting the signaller at Carlisle.

The Signaller at Dumfries once the movement had been authorised, then contacted the Signaller at Carlisle PSB to advise them of the delay to 1L76, the Signaller at Carlisle PSB advised the Signaller at Dumfries that it was 2L07 (the previous train movement) that was at CE525 and not a track circuit failure. 2L07 has been sttod for an hour due to a points failure at Gretna Junction.

Learning points:

- Signaller at Dumfries should have checked with Signaller at Carlisle to ensure it was safe for 1L76 to proceed.
- Signaller at Carlisle PSB should have informed the Signaller at Dumfries that 2L07 was going to be at CE525 for some time due to a points failure.
- Signaller at Dumfries wrongly assumed the failure was a track circuit failure as this had happened the previous day.

Points to consider and further actions and precautions:

Poor communications and working practices between the Signallers at both locations contributed to this incident as one call from either signaller would have prevented the incident.

Signaller at Dumfries wrongly assumed the issue was a failed track circuit as this was the cause the previous day.

GSM-R communications from the Signaller to the Driver of 1L76 were identified as poor although this was not a contributing factor into the original incident, but could have led to a further incident.

Briefed out to:	Frontline Operational Teams and Managers
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