

NATIONAL OPERATING PROCEDURES

Form: F3.27A

TRANSFERRABLE LESSONS FROM SERIOUS OPERATIONAL INCIDENTS / INVESTIGATIONS

Issue: 01

Date: 03/12/2019

Issue:

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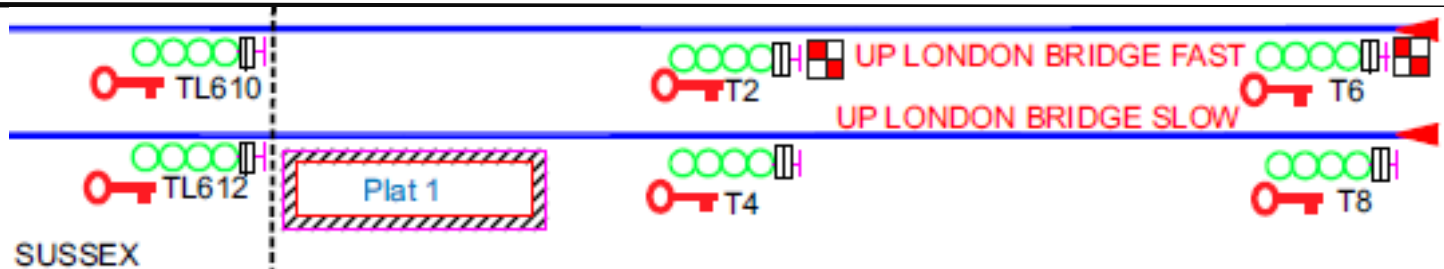
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Date:

16/01/2020

Line Blockage irregularity involving a Signal Post Replacement Switch



Summary:

On 30th October 2019, a line blockage was granted to a Protection Controller (PC) using TL610 and TL612 as protecting signals. These were placed to danger using a signal post replacement switch (SPRS).

The signaller informed the PC that a train was approaching and added, "I need you to give up your line blockage and then key back TL610 and TL612 please." The PC replied, "OK, I shall call you back shortly."

Shortly after, the PC called the signaller to explain that the train had gone by the signal into the line blockage area. The signaller challenged this as the line blockage had not yet been given up. The PC explained that he believed the signaller had asked him to key the signal back immediately.

Learning points & further points to consider:

- There was a breakdown in safety critical communication between the signaller and the PC regarding the operation of the SPRS.
 - The signaller gave a lot of information to the PC instead of breaking it down into concise, simple instructions.
 - Crucially, none of the safety critical information was repeated back which possibly led to the misunderstanding.
- ⇒ Always ensure any safety critical communication is repeated back. This will assist in a clear understanding being reached.
- ⇒ The signaller lead responsibility in this incident yet failed to prompt the PC to repeat back the instructions. The signaller always has lead responsibility except when talking to the ECO. (Electrical Control Operator.
- ⇒ Instead of giving a lot of information to the PC in one communication, the discussion could have been broken down into manageable steps which would have been easier to follow.

