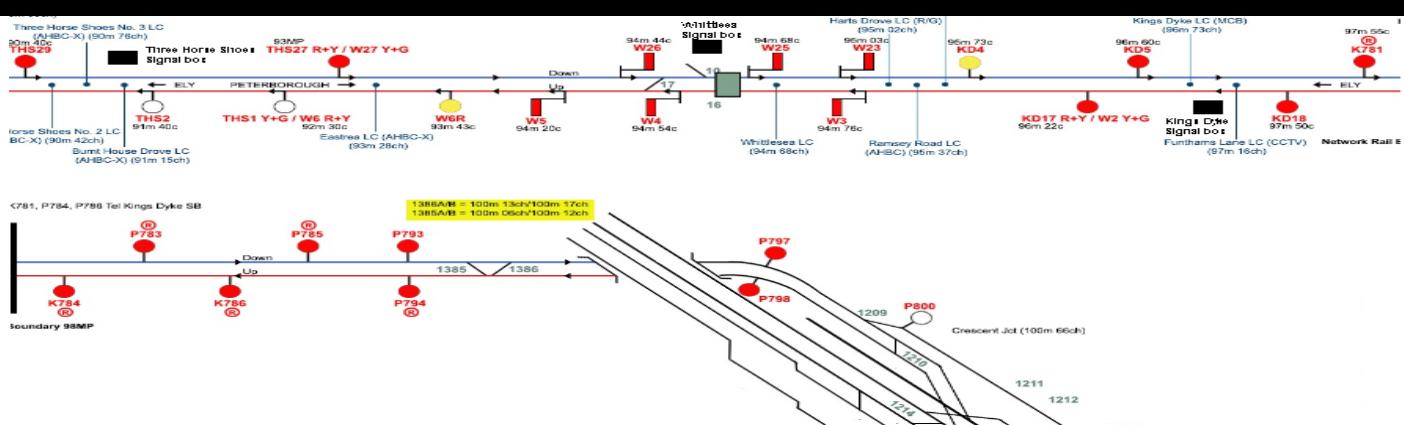


TRANSFERRABLE LESSONS FROM SERIOUS OPERATIONAL INCIDENTS / INVESTIGATIONS

| | | | | | |
|--------|---|------|------------|-------|--------------------------------|
| Issue: | 1 | Ref: | NR/OPS/104 | Date: | 01 st February 2021 |
|--------|---|------|------------|-------|--------------------------------|

Three Horseshoes to Peterborough Stop and Examine Irregularity

**Summary of Incident:**

On the 15th January 2021 the Three Horseshoes signaller reported to Whittlesea signaller that there was a “hell of a racket” coming from train 4E45 as it passed, and asked Whittlesea signaller to listen and see what they thought. 4E45 continued with proceed aspect signals past Whittlesea to Kings Dyke where the signaller reported “banging on the track” to Peterborough signaller.

4E45 travelled over 10 miles of track with a potential defect before RB TS1 Regulation 19 stop and examine train was implemented. All signal boxes involved had control signals that could be kept at, or returned, to danger.

Upon investigation there seemed to be an overall misunderstanding of the stop and examine train regulation. There was also a hesitance to replace a signal to danger for this reason with a train approaching, for fear of causing a SPAD. The safety critical communications highlighted a lack of urgency, there was also over familiarity with neither party taking the lead responsibility. Various discussions were had about whether they thought it was a wheel flat, but the actions required for a suspected wheel flat were not carried out and the issue was passed from box to box.

Learning Points:

- **Never** make assumptions or judgements about suspected faults or defects. TS1 regulation 19 is very clear and states that if you notice anything unusual then stop and examine should be implemented, and the train should be stopped immediately even if that means replacing a signal to danger.
- **Always** follow the correct safety critical communication protocols. Identify yourself clearly and state your message without superfluous chat. Over familiarity and the lack of the correct safety critical terminology could result in the receiver not identifying the nature or urgency of the call.
- **Never** assume that someone else will act or report an incident -take lead responsibility.
- If you suspect something is amiss, protect the line and/or train and **Take 5 for safety** to assess the situation before making a decision on what action you will take next.



OFFICIAL

Form: NR/L3/OPS/045/F3.27FA Issue 2 (Oct 2020)

TRANSFERRABLE LESSONS FROM SERIOUS OPERATIONAL INCIDENTS / INVESTIGATIONS

