Safety Bulletin

A serious incident has taken place



Multiple trains in a signal section

Scope: All Network Rail line managers, safety professionals and accredited contractors Ref: NRB22-12 Date: 17/11/2022 Location: Wingfield, Alfreton, Derbyshire Contact: Adrian Moss, Principal Engineer (Signalling)



Overview/Underlying causes

On 26th October 2022, two following trains entered the same signal section due to an incorrect aspect sequence being displayed to the drivers of both trains. The irregularity resulted from a failure to carry out signal maintenance testing (SMTH).

Ballast cleaning works undertaken in the area required disconnection at DY586 signal and associated equipment. When the signalling system was reinstated following completion of the track works, the yellow and red aspects on DY586 signal were transposed. The incorrect aspect sequence resulted in the first train passing the signal at red when it should have been yellow, and a yellow aspect shown to the following train when there was a train in the forward section.

Testing to reinstate the signal after the works, was not carried out in accordance with the Signal Maintenance Testing Handbook (SMTH). Testing steps in the SMTH would have identified the transposition of the aspects had they been followed. The error was not self-revealing.

Discussion points

- Are SMTH testers aware of the importance of the words "check with the maintenance test plan for all items of equipment fed by the affected piece of equipment being changed and carry out the steps marked with an asterisk" in SMTH?
- Where any steps in a test plan have not been completed, are SMTH testers aware that the Line Manager must be informed and the equipment must not be signed back for operational use, until the testing can be completed?

Safety

Alert

- When conducting a wire count, are SMTH testers aware of the requirements to check cable core numbers against the wiring diagram?
- This irregularity is similar to the Clapham Rail Disaster, which killed 35 people and injured 484 resulting in the introduction of SMTH. More recently, the derailment at Dalwhinnie was a result of a failure to apply SMTH correctly. How can we prevent this happening again?

Part of our group of Safety Bulletins

Safety Bulletin Safety Advice Shared Learning