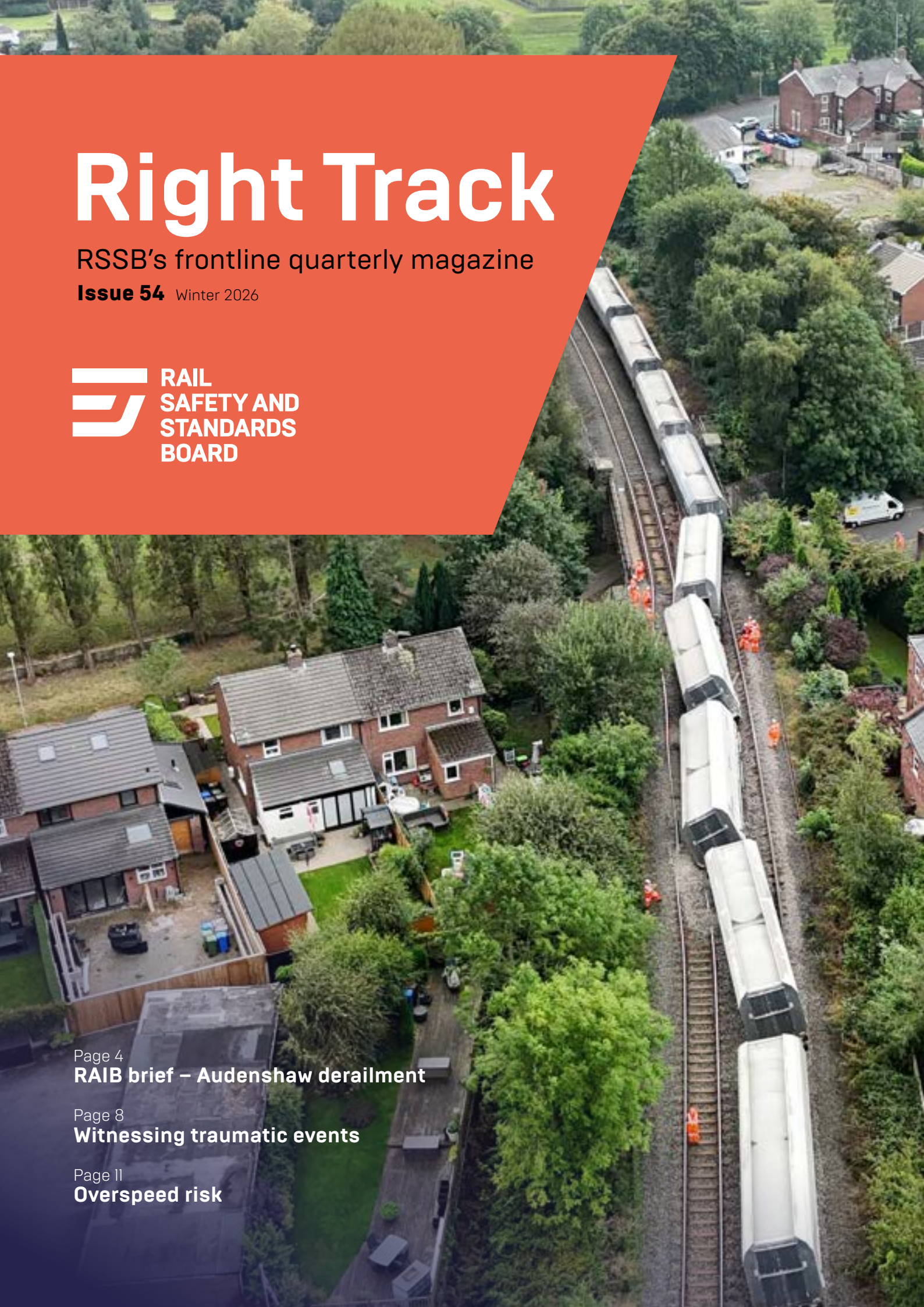
Right Track

RSSB's frontline quarterly magazine

Issue 54 Winter 2026

RAIL SAFETY AND STANDARDS BOARD



Letter from **the editor**

Believe in yourself

There's a case to be made that some of us have too much self-belief. Self-belief is the close relation of arrogance, and arrogance is best friends with lapses in judgement and errors. But while it's healthy for us to question ourselves from time to time, we also need to understand our capabilities and believe in the knowledge we've picked up and the training we've been given. Someone who encapsulates the best of these qualities is ScotRail driver Allanah Murphy—you can spend 10 minutes with her on page 8.

Allanah talks about her reaction to a platform-train interface incident. Such things can be very traumatic for drivers. With this in mind, South Western Railway's Mark Lawson discusses the guidance he's produced to help people through situations like this.

Elsewhere, we cover RAIB's report on the freight train derailment that occurred in Greater Manchester in September 2024. In that incident, the wagons were empty, but many of our freight trains carry dangerous goods.

Network Rail's Martin Bloomfield discusses the vital work of the Dangerous Goods Working Group.

The Llangennech derailment in 2020 showed how fires can erupt when these trains come off the rails. But fires can happen anywhere. In 1987, a fire broke out at King's Cross Tube station. RSSB's Tom Waghorn discusses the tragedy, outlines the lessons, and reminds us why they remain important.

Greg Morse
Editor

In **this issue**

Right Track is produced by Rail Safety and Standards Board (RSSB) through a cross-industry Editorial Board. It is designed for the people on the operational front line of the national mainline railway, yards, depots and sidings. Their companies are represented on various cross-industry groups, including the System Safety Risk Group, managed through RSSB.

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Cover image
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Freight derailment at Audenshaw

Credit: RAIB

At about 11:25 on 6 September 2024, a freight derailed as it crossed a bridge that takes the railway over a public footpath in Audenshaw, Greater Manchester. The derailment involved nine of the train's 24 fully loaded wagons and led to extensive damage to the track, the bridge and some of the wagons. Thankfully, there were no injuries, but the railway was closed for around eight weeks while repairs were made.

RAIB reported that the derailment occurred because of a loss of gauge between the rails. This caused the wagons' wheels on the right-hand side to drop from the rail into this widening space.

The spread of gauge was caused by the failure of a number of the screws securing the baseplates to the longitudinal wooden bearers on the track. Later examinations showed that these screws had sustained fatigue damage before the train passed by. Records of inspection and maintenance activities confirmed that there had been at least three previous failures, with one occasion known to have been before 2020, although many of the required records were not available.

RAIB also found that the failing screws had not been detected by Network Rail's inspection regime. This was because both the automated and manual inspection systems were not capable of detecting this type of failure reliably.

In addition, RAIB found that the track team in the maintenance unit responsible for the track over the bridge had neither recorded, nor reported, previous screw failures. Additionally, this oversight had not been identified nor corrected by Network Rail's assurance regime over a period of years.

As a result of the accident, Network Rail made changes to improve how inspection and maintenance work is recorded. It is also conducting modelling work to determine the best design for the baseplate assembly.

RAIB also recommended a number of measures, including a review of standards relating to the design of components of this type. Network Rail is also urged to research the effects of the condition of supporting structures on the behaviour of longitudinal bearer systems to better understand and pre-empt future degradation. It should also review the accuracy and completeness of its asset records, making any improvements where needed.

Read the full report

To read RAIB's full report on the Audenshaw derailment, search 'RAIB Audenshaw' on www.gov.uk/raib-reports

Simulators:
rethinking staff training

Simulators are no longer solely the preserve of driver training, says Network Rail's **Justin Willett**.

Most of us have had a go in a driving simulator—and they truly are brilliant. Even in times past, given the available technology, they were remarkable examples of innovation.

In the 1960s, a cab environment was used, featuring cine film played onto a 'windscreen' and hydraulics to provide a full ride experience. You could actually feel the acceleration and deceleration of your 'train'.

Now, while the motion element has gone, new technology enables all kinds of routes, scenarios, and conditions to be run, to test the driver against a range of circumstances. But these days, drivers aren't the only rail workers who use simulators to help with their training.

Alongside driving cabs, we have had signalling simulators—from lever frames, NX panels to VDU workstations—that have helped deliver initial and local training for signallers for more than 15 years.

As technology has improved, their capabilities have increased.

There is now a requirement for signallers training for Grade 6 and above locations to have 'Advanced Signaller Training', using simulators.

The top photo shows the absolute block simulator, complete with lever frame, which Network Rail uses at Newton Grange. The bottom photo shows the CCTV crossing simulator used on the Wessex Route. This is helping combat the decision-based errors we see in the control logs, where pedestrians become trapped between closed barriers or gates.

Those responding to incidents and events on our railway, such as mobile operations managers and station incident officers, can now benefit from simulators. Even some of our new controllers are using immersive screens to help them learn how to deal with a range of incident types.

There are now 21 immersive virtual systems across the country and three more being developed.

Simulators and simulation are becoming a particular feature of our ops Development days. No longer just about signallers, we are now rolling them out much further. They say forewarned is forearmed. Simulation helps with that in a safe, controlled environment.

Simulation in Basingstoke
Credit: Network Rail

Tackling trauma in the workplace

South Western Railway's **Mark Lawson** shares how his own experience inspired him to support fellow colleagues affected by traumatic events on the network.

In 2012, working as a driver manager, I was involved in a fatality and felt completely unprepared for what followed. Everything changed when a colleague handed me a book and I read an Underground driver's account of their own experience. While reading, I understood that my feelings were both valid and shared by others.

A traumatic incident is an event that falls outside your normal experience, is sufficiently serious or severe, and carries the potential to inflict physical, emotional, or psychological harm.

While some people may come through such an incident with little or no apparent impact, others may develop trauma. Trauma is a lasting emotional reaction that can manifest in many forms—sadness, anxiety, emotional detachment, or the intrusive re-experiencing of the event. There are numerous other valid responses, as shown in the two examples below.

Case 1: 'Affected in more ways than I could've imagined'

Coming up to a station, I had a sip of water and put my bottle back into its holder. There was a small group towards country end of platform and a guy dressed all in black walking towards the London end of platform. Then he turned 90 degrees and ran at the train.

It took a couple of seconds, but it felt like ages, to realise what had happened and smash the brake in. Once the train had stopped, I made an emergency call.

I managed to get the info out but wasn't great, and I wasn't very happy with the signaller's response. I was lucky that a guard's assessor was on board. He came to check on me as soon as we'd exchanged comms.

The paramedics arrived right on time as my adrenaline was starting to decrease and shock was starting to set in. They were brilliant and I can't thank them enough. I was then told that I hadn't yet contacted the fatality hotline, and I had to do it immediately. I found this quite unsettling and distressing, having to do this so soon after the event. I was still trying to process what had happened.

When the driver manager arrived, we had a quick chat and he was really comforting. He explained a few things and told me what was going to happen next. I filled in some paperwork, and he organised a taxi to take me home. I'm quite comfortable in my own skin, but I think if this had happened to a newly qualified driver or a younger driver it might have a bigger impact on their wellbeing.

The incident has affected me in more ways than I had ever imagined. I've developed anxieties that I had never experienced before, such as panic attacks, which are completely debilitating, and social anxiety. I still feel quite overwhelmed when in large

groups or open spaces where there are likely to be many people gathering.

I get easily frustrated and little things make my stress levels rise very quickly compared to before the incident. The biggest impact has been on my family. You don't really think of the impact something like this will have on everyone around you, but they face the daily rollercoaster of emotions with you.

What helped me cope was the ability to talk about my experience with family, friends, colleagues, and specialists. The outreach from colleagues was staggering, and I was able to speak to people about their experiences and what helped them. My local railway chaplain has been unbelievably supportive, and I urge anyone who is unfortunate enough to experience anything like this to reach out to theirs. I tried to keep my days filled with activity, as being alone can be extremely detrimental to your state of wellbeing. I went for coffee with friends, regular daily walks and kept some sort of structure and routine.

Case 2: 'The BTP were excellent on both occasions'

The first fatality I witnessed was after 34 years of driving. I remember reducing the speed from 90 mph to 70 mph. As I was almost at the platform, I noticed a man who looked like he was jogging on the spot. I saw him take a couple of steps towards the edge of the platform and realised what was about to happen, so I put the brake into emergency and saw him leap into my path. He hit the vestibule just below with a hell of a bang and vanished. I ended up getting relief and going back to the depot. Some time later I received a call to inform me the person was in fact a fellow driver. As you can imagine, it was quite a shock. This fatality affected me for a while; it took a long time to get my head round it. Eventually, I realised there was nothing I could do to prevent it from happening. It was his choice.

The second was seven months later. A youngster jumped off the platform while I was working a fast service. He ended up in the four-foot, and I went over the top of him. This one was probably a bit worse, as I had time to weigh up in my mind what was going on. The noise was worse, too. I hit the red button to get everything blocked and the power switched off. I know nothing about him.

I felt emotionally detached from this fatality. I gave my statement to the BTP and had some contact from them. But, as I said, I never found out anything about him.

The BTP were excellent on both occasions. They checked to make sure I was OK and checked on the guard. They also helped look after the passengers.

The driver/guard's managers who attended were also excellent and looked after us.

I did receive some counselling, and it helped. But I think nearly 40 years of railway work had prepared me for the day it happened.

The support of my colleagues and family and friends was also very helpful. I have found it pretty straightforward to put it all behind me and move on.

Reach out

It's important to remember that it's perfectly normal not to feel OK after a traumatic event. Everyone responds differently, and there's no single 'right' way to feel.

Talking openly about your experience can be a helpful step, as can accessing relevant resources. I'm keen to share a resource I've developed to support individuals and teams in navigating these challenging times.

Reach out to me at Mark.Lawson@swrailway.com

Ten minutes with
ScotRail driver **Allanna Murphy**

Q How long have you been on the railway?

A It's nearly 14 years now. I started when I was 19, working the barriers at Paisley. I then moved up to become a ticket examiner, which I also trained to new starters. I like people and had been happy doing that the most of my career, but I always wanted to be a driver.

About two years ago, I realised I'd picked up a number of useful skills, so I applied. It was quite an intense process. There was a lot of information to learn and different tasks to navigate before going out with my driving instructor. But then, all of a sudden, I was out there, getting on with it.

When I started on the practical side, I was quite nervous at first. I was overwhelmed by all the routes I'd be working, wondering if I'd ever learn it all. I had three different driving instructors, who all taught in different ways. I had to adapt my learning skills to and find a method that would work for us all. This was built on a lot of trust and doing extra revision outside work.

Being out myself and facing situations for the first time had its own challenges. But taking one task at a time and using all the knowledge I've learnt since starting helped me to get to grips with every situation.

Q What are the main differences between the gateline and the cab?

A Driving is a fast-paced job, and situations can change very quickly. It's my responsibility to step up and meet demands, while following rules and procedures. It's all about remaining situationally aware and being able to react, while keeping calm and professional.

I find that, at weekends, people like to try to hang on to the side of train. Obviously, drivers can't move the train when they do.

My station work has made me very aware of how you approach people to encourage them to move, so that everyone can move. I work closely with the on-board staff, so if something is happening in the coaches behind me, or there's something I need to be aware of, we can work together to resolve it. Again, it's about trust, and co-operation.

Q Who were your role models?

A I made sure I spoke to older, more experienced drivers. They all love the job, and they love passing on their experience and expertise. They would tell me about the different types of traction they worked on. So, I got a lot of information as well as the passion. Enthusiasm is infectious, and that's what I've picked up, too.

Q Have you had any safety incidents since getting into the cab?

A Yes. We run trains that don't stop at every station, and I can be running through many of them at 90 mph. Some people seem to think it's funny to stick their arm out like they're stopping a bus. It gives me the absolute fear when I see that. Obviously, I sound the horn and I'm ready to put the brakes on. But I know in my own mind that if I put a brake on a train at 90 mph and they're still standing there, I'm not going to be able to stop.

Most people stand back, but there was incident where a family was at a station. I was pulling in and one of the older children decided to walk right to the edge of the platform. His feet were actually over the edge. I was sounding the horn and the family was laughing.

Then the boy leaned forward, then jumped back. I realised I needed to do something to help raise awareness, so I suggested running a 'Behind the yellow line' campaign to make passengers aware that when the trains coming into the station or passing through the station that they've got to stand behind the yellow line on the platform. ScotRail took this up and started putting messages out on social media.

Q What's your best piece of advice for new starters?

A Keep going. I wanted to be a driver for 12 years, but I was always too scared to apply. What if they say no? But that's the worst thing that could happen. This is the most challenging yet rewarding thing I've ever done. I think more about safety, I think more positively about everything, and I've learnt many new skills. So don't give up and have faith in yourself.

Allanna's top safety tips

- **Think in alphabetical order when weighing up safety and time. 'S' comes before 't', safety comes before time, always. Even if my train is late, if it's not safe, I won't do it.**
- **Regularly read the Rule Book and any safety briefings. This helps me make sure I'm keeping up my competence and understanding.**
- **I use risk-triggered commentary and implement advice from the ScotRail safety campaigns, such as calling out my next station stop about a mile ahead. That way, you'll cut your chances of missing the stop. The same goes for caution aspects; calling it helps avoid a SPAD at the red.**
- **Talk to your colleagues as they always have a great story to tell and great advice to give. There's no such thing as a stupid question. If you need to know, ask.**

Behind the scenes:
the numbers that drive freight

GB Railfreight's **Bessie Matthews** sheds light on the numbers that keep Britain's freight trains on track.

Throughout 2025 I took note of almost everything I drove at work: loco numbers, tonnage, SLUs (standard length units – around 21ft), dangerous goods, mileage... the list goes on!

2025 was my first full year as a mainline freight driver, and it was a busy one. Over 234 shifts, in sunshine, fog, sideways rain, snow, and beautiful moonlight, I covered 28,061 miles, hauled 379,176 tonnes, and moved 32,294 SLUs around the network. I also safely delivered 185 loads of dangerous goods over the course of the year.

The distance I travelled is enough to go around the Earth and start heading back again. It sounds dramatic, but the reality is a thousand small, steady decisions made correctly, shift after shift.

The weight is just as eye-opening. In total, I hauled the equivalent of around 1.9 billion washing machines. Moving that weight safely by rail means thousands of lorry journeys that didn't need to happen. Fewer vehicles on the road, lower emissions, and a safer transport system overall are wins worth celebrating.

Freight is big, heavy, and always varied, and my first full year on the mainline has taught me more than any year before it. The mileage matters because it brings exposure to different routes, different loads, different conditions, and the unexpected bits in between. Each shift adds another layer of understanding, and over a full year that learning really compounds.

Spending that much time in the cab builds confidence in handling long, heavy trains, reading how they behave, and knowing when to be patient and when to be proactive. It's also where the wider railway starts to make more sense, like how planning decisions play out in real life, how signallers and controllers fit into the picture, and how much relies on clear communication and shared understanding. None of that can be rushed, it only comes with time and miles on the clock.

What really excites me is taking this mindset into 2026. Another year of learning, refining skills, sharing good practice, and continuing to build a strong safety culture within freight. The railway never stands still, and neither do we. Whether it's new routes, new challenges, or simply getting better at the job we already do.

The numbers are fun to look back on, but safety is what makes them meaningful. And as I head into 2026, I'm proud of what's been achieved, and I'm genuinely excited for what comes next.

Credit: Bessie Matthews

Overspeeding?

Not on our watch

RSSB's **Joe Wilson** and **Spence Hufton** give an update on the latest developments to mitigate overspeed risk.

While the risk of overspeeding is managed within the ORR's Railway Undertakings' Safety Management Systems, recent events continue to show that sustained focus is required to prevent what is in fact a precursor to a serious incident, like a derailment or collision. Despite ongoing engineering mitigation, the route to competence for drivers continues to evolve, and human performance needs consistent and sustained support.

Overspeeding may arise from many factors, including unclear or late communication of speed restrictions, momentary lapses in situational awareness, or skills fade following periods away from driving. Route knowledge remains a vital part of safe train operation. RAIB investigations, such as those covering the incidents at Spital Junction in Peterborough, repeatedly show that the erosion of route knowledge can have significant consequences. Whether caused by prolonged absence, unfamiliarity, or infrequent operation over specific lines, this decline can undermine a driver's ability to anticipate speed changes, recognise key route features, and correctly interpret route indications.

In several cases, drivers did not receive timely updates on temporary or emergency speed restrictions or misinterpreted route signage, contributing to derailments.

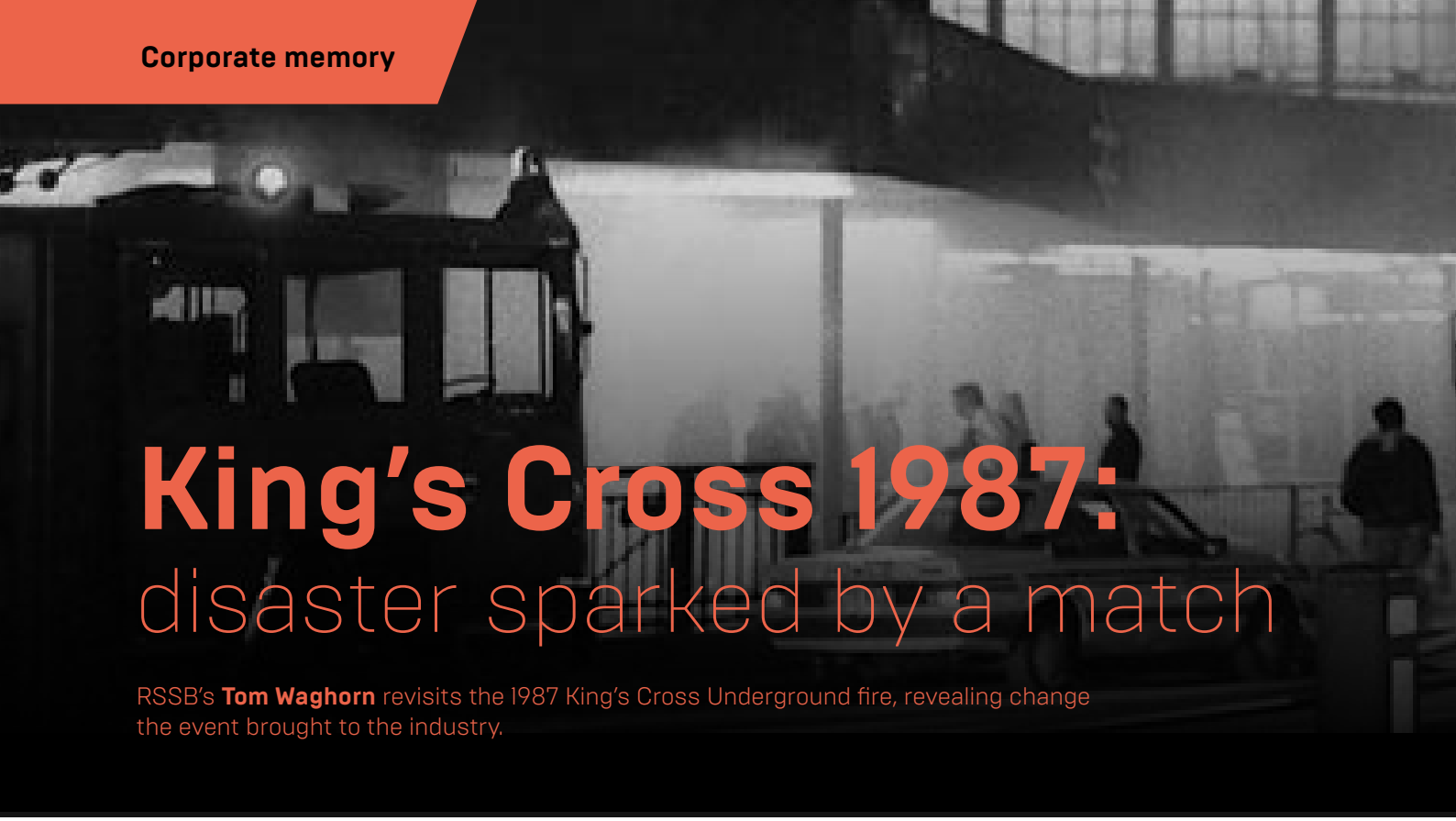
These patterns highlight that competence is not static; it must be actively maintained. Knowledge can degrade when exposure to specific routes, operational contexts, or unusual conditions becomes limited. Where structured reinforcement is lacking, the risks include procedural drift, erosion of confidence, slower recognition of hazards, and a potential increased in the likelihood of operational errors.

Corporate knowledge further reinforces these lessons. Greg Morse's reflections on railway incidents (page 14) show how inadequate route knowledge, weak safety critical communication processes, and misaligned resourcing can combine to create significant operational failures. These cases show that technology alone cannot eliminate the risk. Embedding clear communication, a proactive route to competence approach, appropriate resourcing, and effective safety leadership into everyday operations remains central to controlling risk.

Collectively, these insights underscore the continuing need for a holistic approach to overspeeding risk. This approach must integrate engineering measures with strong operational competence, high quality route learning, and sustained human engagement. Only through consistent reinforcement of knowledge and robust oversight can the industry ensure that overspeeding remains effectively controlled. Furthermore, a clear understanding of human performance characteristics, including both strengths and limitations, is crucial to mitigate iits role as a precursor to more serious events.

Every overspeed incident is now investigated not only for direct causes but also for wider systemic learning. The new standard (RIS 3772 TOM) published by RSSB strengthens this approach by setting out clear guidance on designing, identifying, implementing, and communicating speed restrictions. It also encourages the management of overspeed events through proactive detection, monitoring, and investigation.

Alongside this, the industry is investing in research such as the use of train describer data to automatically detect overspeeding and studies into the effectiveness of late notices for communicating speed restrictions. These developments reinforce that managing overspeeding risk relies on continuous improvement, combining robust systems, evolving engineering solutions, and sustained support for the human element at the heart of safe railway operations.



King's Cross 1987: disaster sparked by a match

RSSB's **Tom Waghorn** revisits the 1987 King's Cross Underground fire, revealing change the event brought to the industry.

18 November 1987, 73-yearold Alexander Fallon of Falkirk stepped into King's Cross Underground station ticket hall. Simultaneously, a commuter stepped off a Piccadilly Line train and took an escalator upwards. As the commuter neared the exit, they lit a cigarette, shook out the match, and flicked it away. They headed home, not knowing that they had just started a catastrophic chain of events. A traumatic incident is an event that falls outside your normal experience, is sufficiently serious or severe, and carries the potential to inflict physical, emotional, or psychological harm.

Then, as now, tens of thousands of passengers used King's Cross station each day. Then, as now, escalators took passengers to the concourse from the deep underground platforms. But, back then, those escalators made of wood.

On this particular day in 1987, several passengers coming up from the Piccadilly Line noticed the smell of smoke and a smouldering fire visible through the gaps between and beside the escalator treads. They told staff. It wasn't long before staff, and British Transport Police officers, began to respond. They shut down the escalator, called the fire brigade, and redirected passengers.

Fogging systems left idle

Many wooden escalators used on the Underground had been fitted with water fogging systems to reduce the risk of escalator fires. These systems could spray a haze of water droplets over the whole assembly, including the machinery underneath.

When installed, they had been used daily as a precaution against small smouldering fires. This drastically cut the risk of a fire spreading but also shortened the lifespan of almost every component of the escalators. After some time, the system fell out of daily use and was only to be used in emergencies.

The escalators at King's Cross had the fogging system fitted, but it had been so long since staff had used it that it didn't occur to them to do so. Many of the newer members of staff hadn't even been shown how to. So they tried to fight the fire with handheld carbon dioxide extinguishers but couldn't get near enough to quell the flames.

Despite the best efforts of police, staff, and firefighters, the fire slowly spread. But it seemed as though the situation would soon be under control. The ticket hall was emptying steadily and there was only a light haze of smoke in the air.

Moments later, everything changed. The small fire flashed over. A fireball shot up the escalator and exploded into the ticket hall. The fireman in charge ordered his personnel and the remaining members of the public in the ticket hall to run for their lives.

Those in the ticket hall, though blinded by smoke, did have immediate access to an exit, but there were also still staff, firefighters, and hundreds of passengers on the lower platforms. A fiercely blazing fire was now between them and open air.

'Body 115'

Just minutes before, drivers had been told not to stop at King's Cross. Now, however, drivers obeying this instruction were flagged down by their desperate colleagues on the northbound Victoria Line platform. Three trains, one after the other, stopped and took on passengers, evacuating nearly 200 who had no other way out of the burning station.

Credit: Christopher Newberry, CC BY-SA 3.0, via Wikimedia Commons

Ambulances queued outside the station to ferry more than 100 injured people to hospital, while more than 30 fire engines attended to contribute to the effort to control the flames.

Thirty-one people had been killed either by flames or by smoke inhalation. Thirty had been accounted for, but one could not be identified. They were simply known as 'Body 115'. It was only in 2004 that 'Body 115'—Alexander Fallon—was formally named, thanks to advancements in forensics.

Alexander had moved to London in 1974 after his wife passed away only to find himself amid a nightmare the evening he set foot into King's Cross.

Uncovering the causal chain

A scientific inquiry by the Health and Safety Executive examined the behaviour of the fire, seeking to understand why it had worsened so dramatically at the point of flashover. The investigation found a known phenomenon had been worsened by a previously undocumented effect known as the 'trench effect'.

Flammable gasses tend to adhere to surfaces. When this happens on an incline, the perfect conditions are created for the flame to race up the surface in a sudden jet when flashover takes place. This effect is worsened when the flammable gasses are effectively contained within a trench, as they were by the escalator in the case of King's Cross.

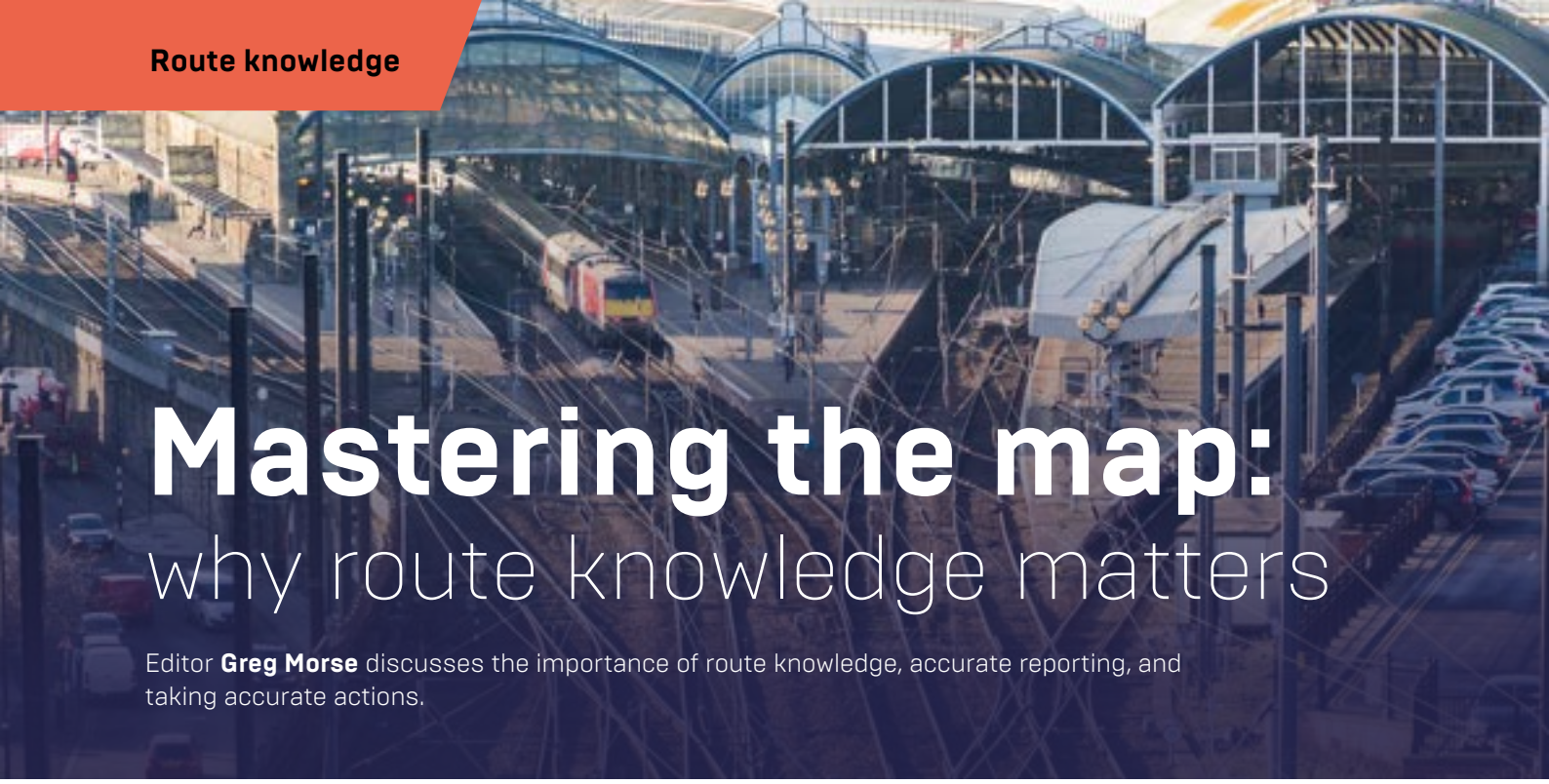
Meanwhile, government investigators considered the response to the fire and how the initial response might have been handled differently. Station staff, police, firefighters, and passengers were interviewed and a detailed timeline of the fire was assembled.

Small fires on the wooden escalators of the London Underground were a found to be a regular occurrence. Staff had been told to try and tackle small fires without alerting the fire brigade. In reports made by London Underground staff, it had become normal to refer to very small escalator fires as 'smouldering' to avoid using the word fire.

Meanwhile, training for dealing with fires was poor. Most staff had not used the water fogging system installed on the escalator or seen it used by their colleagues. There was no cohesive plan for evacuating the entire station, and many staff, including ticket sellers and cleaners, were not instructed on what to do in the event of an emergency.

Additionally, many wooden escalators across the network were poorly maintained. Grease and dirt were frequently allowed to build up in the machinery, creating the perfect fuel for a fire. When other wooden escalators were examined, multiple burn marks were found, indicating that fires had begun, smouldered, and burned themselves out repeatedly in the past.

In the years after the fire, the long-existent smoking ban was more readily enforced, clear signage was added to the Underground network, staff were retrained, and wooden escalators were slowly removed and replaced with more durable metal ones. Today, a rebuilt King's Cross is still a crucial transit hub and remains as busy as ever. In the ticket hall is a plaque that bears the names of those who died in the disaster and a memorial clock donated and maintained to this day by the staff of the London Underground.



Mastering the map: why route knowledge matters

Editor **Greg Morse** discusses the importance of route knowledge, accurate reporting, and taking accurate actions.

We've talked about the Ladbroke Grove accident of 1999 many times in Right Track. A key element of its causal chain was that the driver of the 'SPADding' train had, according to the public inquiry, received inadequate training, which focused more on traction handling than where that traction would be handled.

There are precedents in the past too where poor route knowledge has led to derailment. At Foxhall Junction in 1967, for example, an express came off as the signalling in place at the time made a green aspect with no route indication look like a straight run down the goods loop, when in fact it meant a switch across to the Down Main. This was taken at speed, with fatal consequences. In that case, the whole signal layout had combined with the way that layout had been briefed out.

A lot of the time, it's down to poor communication. Contributory to the fatal SPAD and collision at Colwich Junction in 1986, for example, was the way a change in the use of flashing yellow aspects ahead of junctions had been briefed, while the Potters Bar accident of 2002, in which 7 people died, is an almost textbook example of how comms can go wrong, with devastating effect.

The incident occurred on 10 May 2002. The train involved was 12:45 King's Cross–King's Lynn, which had left the capital on time and made its uneventful way north until it struck 2182A points just south of Potters Bar.

The points had moved under the unit, causing the rear bogie of the third coach and all wheels on the fourth to derail. The latter became detached and crossed to the adjacent line before flipping into the air, crashing into the station and striking the parapet of a bridge.

The points had been fully inspected on 1 May. A further visual inspection the day before the accident reported no problems. However, that evening, a station announcer heading home from Finsbury Park reported a 'rough ride' south of Potters Bar after travelling over the Down Fast.

Tapes of telephone calls recording and responding to this report showed that the relevant protocols between the different parties had not been followed. As a result, the initial message was misunderstood, which led in turn to a Permanent Way team being sent to the UP Fast in error. Unsurprisingly, they found nothing wrong.

There's a link here to the fatal tram derailment at Sandilands in November 2016. Evidence came to light that there had been a number of customer complaints about harsh, heavy or sudden braking before the day of the accident. These reports were not detailed enough and therefore could not be categorised to identify the risk of overspeeding on curves.

As a result, RAIB's investigation identified an underlying factor that potential safety learning from customer complaints had not been fully exploited. To help with this, RSSB undertook a project to collect, review and summarise good practice in this area. The report on that work includes information on accurate recording, routing the report to the appropriate responsible parties, taking action, and learning the lessons. There's a lesson there for all of us.

Tackling the dangers of dangerous goods

What is the Dangerous Goods Working Group? And why does it's work matter? asks Network Rail's **Martin Bloomfield**.

The Dangerous Goods Working Group (DGWG) supports a cross-industry approach of rail experts who meet on a quarterly basis facilitated by RSSB and chaired by Network Rail. Members include Dangerous Good Safety Advisers from Colas Rail, DB Cargo, Freightliner, GB Railfreight, the Office of Rail and Road, and Department for Transport (DfT).

DGWG promotes the sharing of good practice in the carriage of dangerous goods, especially where companies are working to exceed what is required by legislation and standards. It's the forum where companies can share, review and discuss their internal standards to promote mutual understanding and help the industry work more effectively together.

DGWG is supported by the Rail Freight Operations Group (RFOG) on the technical side of things and the Traffic Operation and Management Standards Committee (TOM SC) on everything to do with the Rule Book.

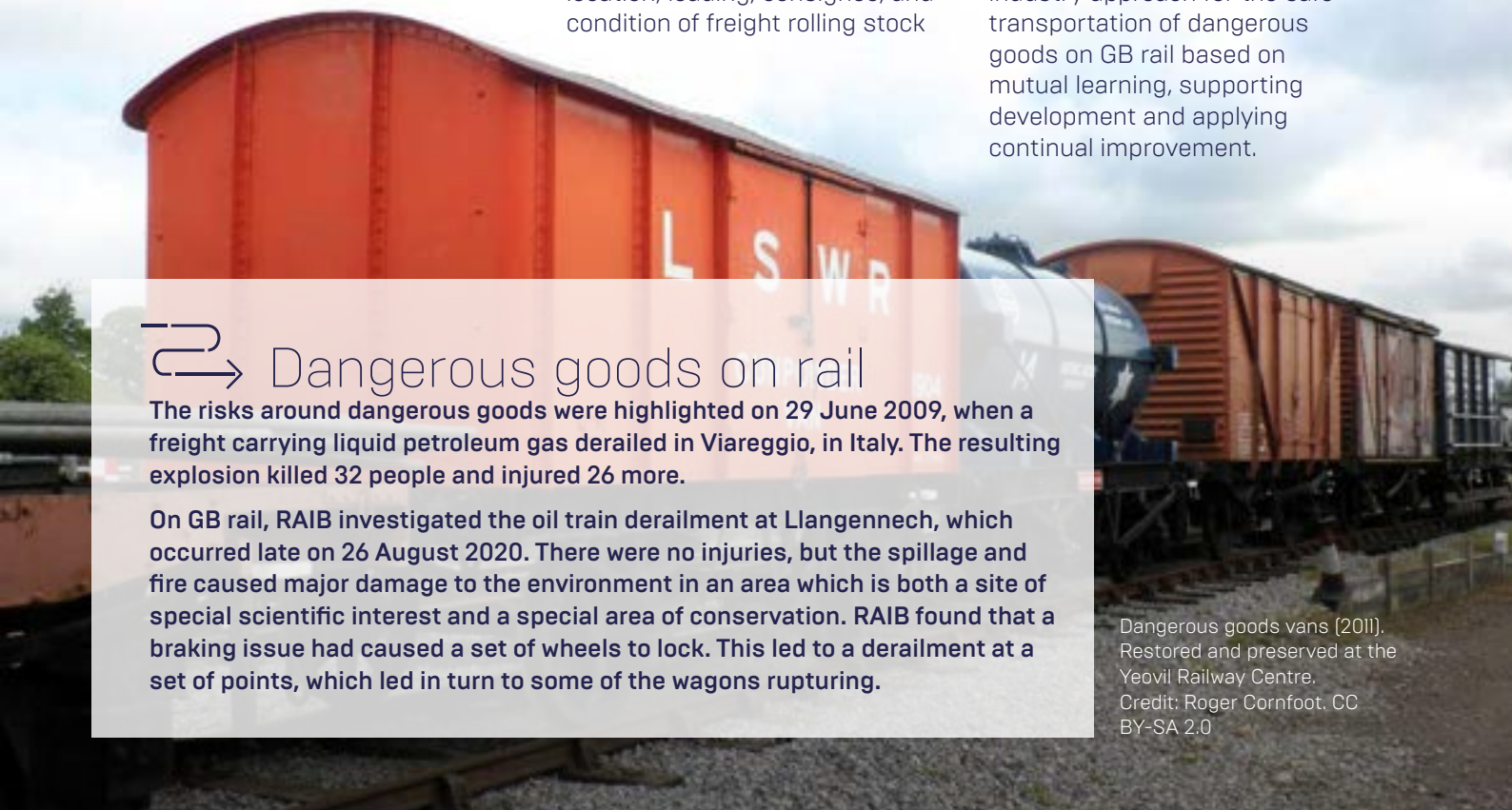
Part of the DGWG agenda includes reviewing events raised through the Rail Notices system. This is vital, as understanding the reason that an event has occurred and any opportunities for shared learning are the very basis of running a safe railway.

Regular updates to the Rule Book and standards are also reviewed and endorsed by DGWG.

In addition, it supports Network Rail with updates to the Total Operations Processing System. The was designed to provide real-time information on the location, loading, consignee, and condition of freight rolling stock on its introduction by British Rail in the 1970s. It was amended and expanded to handle locomotive activities and loco-hauled passenger operations via an extension module known as the Passenger Operations Information System.

Recent activities within DGWG have provided support with enhanced guidelines within GB Rail around the use of dangerous goods trains when route clearance activities are required following extreme weather events.

Current DGWG activities include a review of Module TW4, which mandates that when a Rail Notice Safety Event must be reported to operations control and raised within Rail Notices framework. DGWG plays a significant part within our industry approach for the safe transportation of dangerous goods on GB rail based on mutual learning, supporting development and applying continual improvement.



Dangerous goods vans (2011). Restored and preserved at the Yeovil Railway Centre. Credit: Roger Cornfoot. CC BY-SA 2.0

Dangerous goods on rail

The risks around dangerous goods were highlighted on 29 June 2009, when a freight carrying liquid petroleum gas derailed in Viareggio, in Italy. The resulting explosion killed 32 people and injured 26 more.

On GB rail, RAIB investigated the oil train derailment at Llangennech, which occurred late on 26 August 2020. There were no injuries, but the spillage and fire caused major damage to the environment in an area which is both a site of special scientific interest and a special area of conservation. RAIB found that a braking issue had caused a set of wheels to lock. This led to a derailment at a set of points, which led in turn to some of the wagons rupturing.

Newswire October–December 2025

13 October – Slovakia:

Two trains collide head on near Jablonov nad Turnou, 66 injured

Just after 10.00 (local time), two passenger trains collided where a double-track formation singles ahead of a tunnel near Jablonov nad Turnou. One locomotive and a carriage derailed. There were no fatalities, but at least 66 people were injured. An investigation has been launched.

18 October – Hong Kong:

Teen arrested for trying to prevent train door from closing at Wan Chai

A 16-year-old boy has been arrested on suspicion of criminal damage after he allegedly used his hand to prevent an MTR train door from closing at Wan Chai, according to local police. The teenager was arrested in Hung Hom after a review of CCTV footage.

19 October – USA:

Guard struck and killed in Columbus, Montana

At around 09.40 (localtime) on 19 October 2025, a BNSF guard was struck and killed by a passing train in Columbus, Montana. The chain of events is uncertain, but early reports suggest that the guard had been between two trains, one of which was moving, when the incident occurred.

20 October – Ethiopia:

Derailment and collision kill 15 in Shinile

A passenger train derailed before striking a stationary train on the adjacent line in Shinile, killing 15 people. The local district commissioner cited overloading as a major factor in the incident. The commissioner also noted that the derailed train had also been carrying goods, such as rice, pasta, and cooking oil.

30 October – Netherlands:

Lorry struck on Meteren crossing as it tries to move clear, 5 injured

A lorry was struck by a passenger train on a level crossing in Meteren. Five people were injured. Footage released by infrastructure manager ProRail showed 'how quickly things can go wrong at a railway crossing and is shocking to watch'.

2 November – USA:

Lorry struck on crossing in Shertz, Texas – no reported injuries

A lorry carrying cars was struck by a train at a level crossing in Schertz, Texas. The force of the impact pushed the cab of the lorry some 50 yards down the line. There were no reported injuries and no derailment. An investigation is under way.

4 November – India:

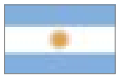
Passenger train strikes rear of freight near Bilaspur, 11 killed

A passenger train struck the rear of a freight near Bilaspur, some 116 kilometres from Raipur. At least 11 people were killed, including the passenger train driver. The passenger driver's assistant and 19 passengers were injured. Rescue teams worked until the following morning. An investigation has been launched.

9 November – Slovakia:

Rear-end collision in Pezinok injures 79

A passenger train ran into the rear of another near Pezinok, north of Bratislava. Of the 800 passengers involved, 79 were reported injured. Most of the injuries were minor, but 13 people were kept in hospital for treatment. Prime Minister Robert Fico said the collision was probably caused by human error.



11 November – Argentina:

Passenger train derails in Buenos Aires, injuring 20

A passenger train derailed 100 metres from a level crossing in Liniers, Buenos Aires. Around 20 passengers were reported injured. Early indications suggest the cause to be a problem with a set of points. However, the Federal Court has ordered that the driver take a breathalyser test.

20 November – Czech Republic:

Rear-end collision near České Budějovice injures 57

An express struck the rear of another passenger train near České Budějovice, injuring 57 people, four of them seriously. All passengers were safely evacuated from both trains. The driver of the express had to be freed from the cab by firefighters. Preliminary investigations suggest the express passed a red signal.

27 November – China:

Eleven killed as test train strikes staff in Kunming

Eleven were killed when a test train struck a group of trackworkers at Louyangzhen. Two more suffered major injuries, requiring hospital treatment. Rescue teams were soon on site, the local media reporting that the railway authorities had immediately launched its emergency response plan. An investigation has been launched.

2 December – USA:

Freight derails into Gunnison River, Colorado

A freight derailed near Whitewater, Colorado. Five coal wagons and both locomotives entered the Gunnison River. The two crew members were not injured. It was later confirmed that a rockslide had caused the incident. Site access was limited due to the remoteness of the area, which has no road access.

9 December – Thailand:

Collision at Kanchanaburi injures 33

A stationary passenger formation was struck a locomotive at Wang Yen station in Kanchanaburi. The locomotive had been backing towards the carriages in order to couple up and take the train forward. In all, 33 people were reported injured. Early reports suggest the locomotive suffered a brake failure.

19 December – USA:

Passenger trains collide, injuring 17, in Montclair

Just after 18.45 (local time), two passenger trains collided near Bay Street station in Montclair, New Jersey. One of the formations was derailed by the impact. A spokesperson for the operator said 17 people had suffered non-life-threatening injuries. The National Transportation Safety Board has launched an investigation.

28 December – Mexico:

Thirteen killed as passenger train derails on curve near Nizanda

A passenger train derailed in Asunción Ixtaltepec, killing 13 people and injuring 98 more. The incident occurred on a curve in the cliff side near the town of Nizanda. An investigation has been launched. Some reports note that passengers had been concerned about the speed of the train.

30 December – Peru:

Collision near Machu Picchu kills one and injures over 40 more

At 13.20 (local time), two passenger trains collided head on near Machu Picchu, in the Ollantaytambo District of Peru, killing one driver injuring 40 passengers. Staff quickly raised the alarm and rescue teams were soon on site. All services were suspended. An investigation has been launched.