

SOUTH CENTRAL RAILWAY

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SPECIAL BULLETIN - 1

Attention “**OPERATING & LOCO RUNNING STAFF**”

There was an incident of rolling down of a stabled load from a station in Moradabad Division of Northern Railway on 04.11.2015 **resulting in forced derailment**. The **cause of the incident is purely due to “human failure”** which could have been prevented had the field staff were vigilant and attentive.

Details of the case are;

DESCRIPTION OF THE SITE:

Harthala (HRH) is a Class ‘B’ station on double line with four running lines (UP Loop, UP Main, DN Loop & DN Main) and the signals & points are operated from a central panel. The system of working is Absolute Block System and the signals are MACLS.

DESCRIPTION OF THE INCIDENT:

- On 4th November 2015, at 15.05 hours, fresh crew took charge of UP LHM Goods at Ambala station and the load of the train was BOXNHL hauled by diesel loco.
- The train was on PF-3 and the LP while taking charge of the train noticed heavy leakage of lube oil from the engine and hence, asked for the Mechanics to attend and arrest the leakage.
- The Fitters tried to arrest the leakage but failed to arrest the leakage.
- LP informed ‘all-concerned’ and declared the failure of the loco.
- The train is without Guard.
- As the train was on Platform line, the LP was asked to take the train up to next station i.e., HRH where relief loco was assured by the Power Controller since the yard congestion was at Ambala.
- The train reached HRH station on UP Mainline at 16.25 hours and the LP declared the failure of the loco at 17.05 hours when enquired by SM/HRH at 16.50 hours.
- At 22.15 hours, the formation started rolling down towards Ambala station and the formation was derailed forcibly at Ambala station at 22.45 hours.

PREAMBLE

Negligence on the part of planning by the Control Organisation

The leakage of lube oil in the diesel loco of the train was known to the Power Controller. To avoid yard congestion at Ambala station, the Section Controller moved the formation to next station. The decision to receive the train on to the mainline of HRH station was given by the Section Controller. Gross negligence of Control Organisation is evident in not arranging relief loco and the formation was stabled on mainline. When they failed to arrange fresh loco, it should have been brought to the notice of the station staff and stabling precautions should have been ensured. Hence, the slackness on the part of SCOR and PCOR as a cause of the accident was not ruled out by the Accident Enquiry Committee.

Negligence of the crew

It is obvious from the available facts that LP & ALP did not follow the prescribed procedures of securing the loco and formation. The loco crew shut down the loco and left it unmanned without securing it properly. They left the papers of the formation on the panel of the SM and left the engine reverser in the loco and came back to their headquarters i.e., Ambala. Hence, the failure on the part of the crew is not ruled out by the Accident Enquiry Committee.

Negligence on the part of station staff

SM/HRH was conversant with all the happenings regarding failure of loco, delay in arranging relief loco, load is stabled on mainline with failed loco for more than 5 hours etc., He should have been more vigilant about all these circumstances in favour of Safety. He never tried to enquire whether the LP & ALP are planning to leave the engine unmanned or shutting down the engine. He failed to enquire from SCOR about the plan for clearing the stabled formation when the rake is stabled for more than 5 hours with dead loco on mainline which is not isolated. One of the crew came to SM Office to enquire about relief arrangement and handed over documents without intimation, but the SM did not bother to enquire about their plans about shutting down / leaving the loco unmanned / securing the load.

It was the responsibility of the SM/HRH to secure the load when the load is stabled on mainline, the loco is made dead and the formation is without Guard. Gross negligence on the part of SM/HRH which in turn led to the derailment of the train cannot be ruled out by the Accident Enquiry Committee.

Good work done by the SM/HRH

When the formation started rolling down towards Ambala station, SM/HRH acted with commendable sense and informed all (3 LC Gates) the Gatemen to close their gates and he also turned the block instrument commutator to TOL position as a result of which the LSS flown back to 'ON' which was taken 'OFF' to another UP Goods train at Ambala. The train was about to start at Ambala. Thus, SM/HRH contributed in averting a major accident and saved some lives as noted by the Accident Enquiry Committee.

Shortfalls and irregularities noticed

- LP & ALP failed to secure the loco as per SR 5.23 and left the loco unmanned without any authority from SM/HRH.
- LP failed to enter the details of the loco and securing precautions taken in the stabled load register.
- SM/HRH failed to ensure that the securing precautions of the formation as per SR 5.23 is taken and also failed to inform the SCOR under exchange of PN.
- Section Controller failed to confirm the stabling precautions by SM/HRH apart from keeping record of stabling the formation at stations.
- SCOR and SMs should as far as possible ensure that the formation is not stabled on non-isolated line like mainline.

Important Lessons to be learnt

- Loco Running Staff shall invariably ensure that the loco is secured by all means and an entry to that effect shall be made in the Stabled Load Register.
- When the formation is cancelled / stabled without Guard, Dy.SS shall ensure that all securing precautions are taken with the help of Pointsman and entry in Stabled Load Register is made to that effect.
- As far as possible, cancelling the load / stabling the formation on non-isolated line like Mainline shall be avoided.
- SCOR and Dy.SS shall exchange PNs whenever the load is stabled on running / non-running lines.

CHIEF SAFETY OFFICER
HEADQUARTERS SAFETY ORGANISATION