**HU-6116**

**2019-0871-5 Hort-Csány (Railway incident)**

### Overview of the accident

On 09 August 2019, at Hort-Csány station, while the train № 566 was leaving the station following a subsidiary signal, it came in touch with the scheduled route of the train № 505 moving in the opposite direction, due to the incorrectly set switch № 3 (facing point) situated in its route.

Upon intervention by the locomotive driver, the train № 566 stopped, with service braking, on the switch № 3, with its locomotive in front of the entry signal of the station, in line with the pre-indication received. After standstill, the distance between the two trains was 204 metres.

The IC attributed the occurrence to human factors on the part of the traffic manager who had failed to apply the rules of use of the signalling system.

TSB issues no safety recommendation, but the IC discusses the lessons learnt from the occurrence in Section 3.6.

# CONCLUSIONS

## Direct causes

The factors which had direct effect on the occurrence were as follows:

1. the traffic manager inadvertently reversed the switch № 3 in front of the train leaving the station following a subsidiary signal;
2. the traffic manager failed to remove the standing fuses, and there were propped push-buttons on the safety installation.

## Indirect causes

Those findings relating to competences, procedures and maintenance which are related to the factors enumerated above:

1. the traffic manager chose an inappropriate solution to the conflict situation he had identified;
2. the signalling system failed to detect the malfunction of the insulation insert in the switch № 7 on several occasions.

## Root causes

Causes that are distant in time and space from one another but which are related to system operation within the regulatory environment and in the safety management system:

1. a wrong practice was not detected and rectified during the audits.

## Other risk factors

The IC identified no such factor.

## Proven procedures, good practices

It mitigated the consequences of the occurrence, i.e. helped avoid a more serious outcome that the locomotive driver, while moving at the required speed, detected the inappropriately set switch and, being aware of the relevant rules, stopped his train.

## Lessons learnt

The occurrence highlights that even those inappropriate processes and working methods which have been applied with no problem for a longer period may lead to an incident in the case of a coincidence of certain factors.

Another lesson to learn is that auditors/inspectors should not tolerate inappropriate practices but, via communication during the training or inspection of the personnel, they should prevent the formation of conflicts of goals, and demonstrate the hazards of the inappropriate activities (which are even against the rules sometimes) used.

# ACTIONS TAKEN

On 22 August 2019, MÁV Zrt. published a compilation on the circumstances of the danger situation the trains, and an out-of-turn training session was ordered for the traffic management personnel affected.