Rail Safety Review

RAIL SAFETY AND STANDARDS BOARD

No. 107 – December 2025

Welcome

From station safety to health and safety

In Rail Safety Review No. 107, Siemens' Engineering Director Andy Stringer remembers the Clapham accident of 1988 and explains how he shares the important lessons our industry learnt with today's engineers. No other article could really join this important piece of work, so instead we give a shout out to Right Track 53, which is out now. It features another accident that should not be forgotten—the fatal derailment at Hatfield 25 years ago.

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We hope you find Rail Safety Review interesting and useful, but if you don't want to receive future issues, please email greg.morse@rssb.co.uk.

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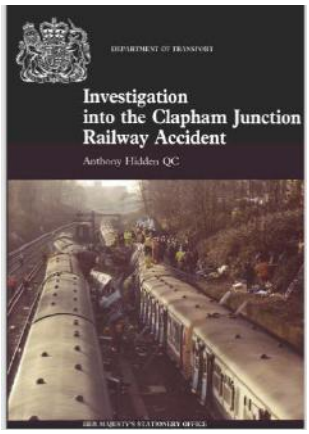
Corporate memory matters

Siemens' Engineering Director Andy Stringer remembers Clapham and shares the lessons with today's engineers



On 12 December 1988, a passenger train passed a green signal that should have been red and struck the rear of another. The impact led to another collision, with an empty stock formation that happened to be passing at the wrong moment. Thirty-five people were killed in what is still one of the worst train accidents this country has seen.

Clapham resulted from a technician leaving a bare wire dangling instead of cutting it back, tying and insulating it. A fortnight later—on 12 December 1988—further work jolted the wire. This caused it to touch a terminal, make a connection, and prevent a signal from turning to danger.

The accident led to a public inquiry, chaired by Sir Anthony Hidden QC. This revealed issues around fatigue, training, reorganisation, communication channels and a complacent attitude to safety. The error wasn't that of the technician, but of an industry that allowed such an error to be created and go undetected.

Much work was done to address the recommendations from the resulting report, and indeed from the investigation British Rail had led itself. Many standards and processes we follow today are as a result of the learning from Clapham, although it is not always apparent.

After all this time, what can we do to keep the learning alive? At Siemens, we made a copy of the wiring model that was demonstrated at the inquiry all those years ago. That was for the 30th anniversary.

For the 35th anniversary, we decided to replace our original with 10 new models. We built them locations right across the country, including one that was very special to me—Network Rail's Clapham maintenance depot. This one was a joint effort between Siemens and Network Rail's entry level talent. It had the distinction of being demonstrated to senior leaders from Network Rail, RSSB, and RAIB.

The original Siemens wiring model.
Photo: Greg Morse

The original model was made by British Rail to help Sir Anthony understand how one wire could have such catastrophic consequences. This allowed him to identify the many factors that allow an organisation to create an environment in which one error can be created and not detected. So much of what we take for granted in our processes have their roots in that still relevant accident report.

If you'd like to see and work one of our models, just ask anyone from Siemens. I'd like to think most of our staff will know about it, and if they don't, it's a great opportunity to find out more.

- To read the Hidden Report, click **here**.

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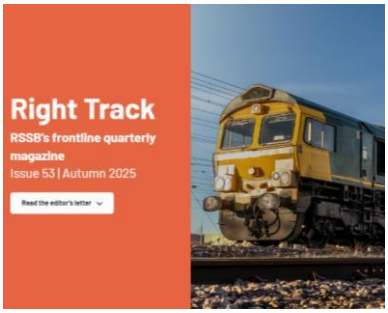
Right Track

Issue 53 of RSSB's frontline-facing safety magazine covers the Hatfield accident of 2000

On 17 October 2000, a passenger train derailed on the curve at Welham, near Hatfield. The high rail of the curve had broken into over 300 pieces. Beyond this, the rail was intact—but displaced—for about 44 metres, though there was a further fragmented length of 54 metres beyond that. Four people were killed and 70 were injured.



The investigations revealed the cause to have been 'gauge corner cracking'. But, as is so often the case with accidents like Hatfield, there were a number of errors, omissions, and policies that lined up to create the conditions for it.

- To find out more, read **Right Track 53**.

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