

Rugby Model Engineering Society
Incident Investigation Report

Reference:	2026/01
Title:	Derailment of Myglyd, during public running 17/05/26
Date:	04/06/26
Version:	2

Time & Location:	1. Sun 17/5/26, 14:20, Rainsbrook Ground Level Station
Summary of incident:	<p>2. During arrival of Myglyd and 3 x passenger coaches into Platform 1 at Rainsbrook station, the locomotive became derailed as it passed over the mid-platform points between Platforms 1 & 2.</p> <p>3. The mid-platform points were operated in error under the train as it passed over.</p> <p>4. The driving truck and front bogie of the first carriage were derailed. The locomotive was damaged and removed from traffic.</p> <p>5. The train was carrying passengers at the time, with 3 x passengers on the leading carriage (310). There were no injuries.</p>
Root cause:	6. The mid-platform points were operated in error as the train passed over the points.
Contributory factors:	<p>7. Prior to the session commencing, the event organiser was advised that a wheelchair booking had been received. The event organiser decided to position the wheelchair coach at the station and attach it to a train once the customer arrived.</p> <p>8. When the customer arrived he was met by a member of staff who was spare on the roster and not working with the station team (Person A). Person A appeared flustered that the carriage wasn't ready and asked the Station Controller to arrange attachment promptly.</p> <p>9. The station controller stated on the radio that he wanted other members to help carry this task out.</p> <p>10. The wheelchair carriage was located on platform 2. It needed to be moved by hand across the mid-platform crossover to the back of a train on platform 1. Person A (who remained at the ground level station) agreed to do this.</p> <p>11. As there was no train waiting in the station at this time, the team needed to wait for the next arrival.</p> <p>12. The next train to approach Platform 1 was hauled by Myglyd. It had 3 x loaded carriages which needed to be stopped and unloaded before it could then be moved down to the far end of the platform to allow the wheelchair to be attached.</p>

	<p>13. As Myglyd approached the station, the driver was waved down to the far end of the platform, rather than stop at the normal mid-platform unloading position. This was done by another member of staff who was spare on the roster and was not part of the station team (Person B).</p> <p>14. The mid-platform points were under the control of a role known as the “pointsman”. This is a rostered turn as part of the station control team. The person undertaking this role was trained and competent.</p> <p>15. Due to a miscommunication between Person B and the Pointsman, the pointsman operated the mid-crossover points in error whilst Myglyd was still passing over them. The pointsman has accepted his error.</p> <p>16. The driving truck and front bogie of carriage 310 were derailed at low speed.</p> <p>17. Once the train came to a stop, the guard on Myglyd’s train was able to de-train the passengers and confirm no one was hurt.</p> <p>18. Myglyd’s driver stated there was damage to the locomotive and requested the locomotive be taken out of service.</p> <p>19. It is not known whether anyone carried out a track inspection or carriage inspection but both were placed back into use after re-railing.</p> <p>20. The Event Organiser attended the incident as he was in the area at the time.</p>
<p>Conclusion:</p>	<p>21. Myglyd was derailed because the mid-platform points were operated as the train passed over them.</p> <p>22. The pointsman did not check the location of the train when he operated the points.</p> <p>23. Too many people were involved in the shunting operation and there was no clear agreement between them on how the move was going to take place.</p> <p>24. The station controller did not control the move.</p>
<p>Recommendations:</p>	<p>25. Shunting within the station should be minimised during public running, for example for loco failures only etc.</p> <p>26. Any shunting within the station during public running must be controlled by the station controller.</p> <p>27. A clear understanding must be reached on how the shunt will be carried out, who will do it, and how train movement will be controlled safely.</p> <p>28. If use of the wheelchair carriage is needed during a public session it should be attached to a set before public running occurs and left attached through the session.</p>

	<p>29. Consideration should be given to the locking of the station entry points and mid platform points whilst a train is passing over – such a system is in place at the exit end of the station using treadles.</p> <p>30. The point control panels in the station could be improved using the same type of design used in the old station signalbox.</p>
Investigating officer signoff:	<p>David Penney RMES Safety Officer 05/06/26</p>