

The importance of learning from incidents



everyone
home safe
every day

Dear all,

This week, I wanted to reflect and remember the tragic events at Eastleigh depot, 30 November 2020, where profound learnings around safety culture at Network Rail were revealed in the aftermath.

The incident, where Kevin Mauger, a rail loading operative, lost his life performing essential maintenance inside a welding machine, serves as a stark reminder of the critical importance of a robust safety culture.



Rob Cairns,
Regional Managing Director

Before we discuss Eastleigh I wanted to reflect on my last five messages, summarising each within a singular point below. They are all key ingredients of a culture where decency drives our leadership:

- **Safety Incidents' Ripple Effect:** incidents deeply impact everyone, not just those directly involved, with lasting emotional consequences.
- **Emotional Memory:** emotions, not just facts, drive safety culture. Traumatic experiences are deeply ingrained in memory.
- **Building Strong Safety:** leaders with incident experience are highly committed. We must foster this commitment in others through decency, diversity, and honest communication.
- **Diversity and Integrity:** be aware of unintended consequences in rebalancing representation. Uphold values and integrity. Foster decency and open communication to challenge unacceptable behaviour and build resilience.
- **Truth Blindness & Safety Culture:** promote honest communication and value diverse opinions. Be aware of personal biases. Lead by example and encourage open feedback. Create a safe environment for raising concerns.

The incident at Eastleigh depot occurred due to a lapse in safety procedures. Specifically, the machine's rail conveyors were not properly isolated, and the work was being conducted without the required permit. This meant that a maintenance operative, operating the machinery remotely, inadvertently activated the system in a manner that moved two rails simultaneously. The unexpected movement resulted in a rail entering the machine while the operative was still inside. The incident highlights a critical failure in adherence to established safety protocols and it emphasises the importance of thorough isolation procedures and the necessity of permits for potentially hazardous work.

The findings summarised that safety oversight at the Eastleigh depot was critically flawed. Despite numerous safety visits and risk assessments, those responsible lacked required competence. Hazards like inadequate machinery guarding were missed. Permit-to-work systems were untested and ineffective. The safety team, overwhelmed by senior leadership pressures, failed to identify these issues. The incident resulted from cleaning without proper isolation or permits, a task performed incompetently within an unguarded machine. Crucially, existing risk assessments failed to highlight these dangers, which were repeatedly overlooked despite prior warnings.

A systemic failure to address known risks led to the operator's injury.

The report also brought to the surface a culture of concern at the Eastleigh depot, where underlying behavioural and cultural issues were not adequately addressed. Competency gaps were observed across various levels of staff and management. While regular inspections occurred, opportunities to identify and rectify safety compliance issues were missed. The accessibility of the welding machine's control program presented a potential risk to weld quality. Elevated grievance levels highlighted deeper personnel challenges. Existing HR processes did not effectively identify or address these "people issues" and their potential impact on safety, indicating a need for improved oversight and support.

If we think about the themes I summarised above, we could see their relevance in the incident at Eastleigh. **The Safety Incidents' Ripple Effect** manifested in the aftermath, impacting morale and trust. **Emotional Memory** likely played a role, with staff becoming desensitised to risks over time. A lack of **Diversity and Integrity** was evident in recruitment and promotion processes, leading to unqualified staff and ignored safety concerns. **Truth Blindness & Safety Culture** prevailed, as management ignored warnings, and superficial safety visits masked critical issues. This culture silenced dissenting voices, as seen in the forced departure of a concerned operative.

The incident underscores the devastating consequences of ignoring safety, where complacency and incompetence fostered a dangerous environment, ultimately leading to a preventable fatality.

It is vital that we don't just mark days and incidents on a calendar, but we truly learn lessons and make changes in the aftermath. I want you to read about an incident like this and be stirred to make sure this could not happen on our region. A robust safety culture is all of our responsibilities and it is only achievable when we challenge our biases, incorrect practices and where we create an open space for all voices to be heard.

As always, please feel free to [reply directly](#) to me; your thoughts and experiences on this topic really matter to me.

Stay safe,
Rob

This update is provided by the Wales and Western Communications team. For any queries, please contact walesandwesterncomms@networkrail.co.uk