Shared Learning

Key learning following a serious incident

Saxilby - Three Years On

Issued to: **All Network Rail line managers, safety professionals and Achilles registered contractors**

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Location: Saxilby, near Lincoln

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Overview

It is three years since our colleague, Scott Dobson, died at Saxilby. The lessons learnt in an organisation following a serious accident can fade after time so we asking you to reflect again on the accident.

We would like you to challenge yourself, your team and your manager on how well you have learned from the underlying causes of Scott's death. A near miss report last year near Liverpool indicated the inadequate safe systems of work are sometimes still used.

Scott was the COSS for a workgroup 'snagging' at the site of newly installed track at an underbridge.

The workgroup drove to the access point at the underbridge, where Scott briefed them on the safe system of work (SSoW) for the first work activity.

The Track Quality Supervisor then identified remedial works that were required around the timber sleepers voiding on the Down Gainsborough line.

Working within a Line Blockage of the Down line, they initially worked on the cess rail before moving across to work with vibrating hammers and shovels on the six foot rail, with Scott acting as Site Warden. The SSoW did not protect this part of the work.

During the course of this work Scott was struck by a train on the adjacent Up line.

Underlying causes

A SSoW had not been implemented for the task that was being undertaken at the time of the accident and Scott was standing in an unsafe position as the train approached.

None of the staff challenged the absence of a SSoW or each other's actions of working within an unsafe area.

The supervisor did not challenge Scott on the lack of briefing prior to the second work item commencing and the absence of a SSoW.

There was a lack of possession strategy with no integrated line blockage plan between the various contractors working on the project.

Scott had been involved in two other incidents in the two months preceding the accident, but there had been no effective action taken by his Sentinel sponsor in response to this.

Scott's Sentinel sponsor had no effective performance review regime for managing the competence of people it hired for work on Network Rail infrastructure.

Key message

The investigation has led to a number of improved controls including new Sentinel and the supporting scheme rules and Safe Work Leader.

Please discuss how confident are you that the controls implemented for any work you are involved in address the underlying causes above.

In this accident work was undertaken on the six foot rail that was unplanned and not undertaken with both lines blocked. Are there circumstances where work you are involved in is similarly unprotected?

What could you do to check that work you are involved with is planned and undertaken safely? Are safety conversations and inspections planned and undertaken for your activities?

Where there are alleged breaches of the Sentinel Scheme Rules are you managing temporary take downs of competence or suspensions in accordance with the revised rules?

The RAIB investigation report into the accident is available on their website.