Lessons Learnt from a Formal Investigation

Date: 23 June 2014
Issued By: Corporate Investigation Manager, Milton Keynes, MK9 1EN

Document ref: NRRP13

Title: Lookout struck and fatally injured by train at Newark Northgate on 22 January 2014

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Overview of Event

- On Wednesday 22 January 2014 a workgroup comprising a COSS, rail tester and lookout were required to undertake ultrasonic rail testing at a number of sites on the East Coast Main Line between Grantham and Doncaster.
- After completing their testing at Claypole they drove five miles north to their next location, ultrasonic bolt hole testing through the points just south of Newark Northgate station.
- They arrived in the yard adjacent to the site of work at around 11.28 and the COSS gave a rudimentary Safe System of Work brief whilst still in the van. The SSOW for the location required Red Zone working with warning to be given by the site lookout.
- The workgroup accessed the up fast line and began their testing, but the COSS left them to go back the short distance to the van to check the paperwork regarding the nature of the next test.
- A short time later the 10.08 London Kings Cross to Newark Northgate passenger service was signalled across from the down fast onto the up fast and into the passenger loop. The driver saw the lookout and rail tester and sounded his horn. They both acknowledged the warning and moved immediately to the position of safety.
- At 11.35, just as the train entered the crossover from the down to up fast, the lookout, who was standing behind the rail tester, turned around and started to walk back towards where he had previously been stood acting as lookout.
- His path took him directly across the passage of the train and although the driver sounded a further warning, which the lookout acknowledged, he continued to walk directly in front of the train, seemingly oblivious to its proximity.

Underlying Causes:

Vigilance

- The lookout may have lost situational awareness of where the train was heading due to a reduced level of attention and his focus on the direction of traffic which presented the highest risk.

Familiarity

- The workgroup were all familiar with the area, task and SSOW. This may have impacted on the attention to detail required, with a minimal SSOW brief, the COSS leaving the group and the lookout leaving the position of safety.

Capabilities

- Lookout duties require some very specific capabilities, particularly in regard to attention management and conscientiousness. The lookout may have had limited capability in these areas and had not received the appropriate support and development needed.

Planning

- There was no challenge to the continued requirement for routine, planned work of this nature to be undertaken on the East Coast Main Line using warning with unassisted lookouts.
- There is some confusion regarding how to set up a safe system of work where different line speeds and facing point junctions are involved.

Key Message: We have a duty of care regarding the people we employ to work on the railway. It is a dangerous environment and we need to make sure that they are fully equipped with the skills, knowledge and capabilities to maintain vigilance and focus and that the plans we produce to keep them safe are accurate and fully understood by all concerned.