

Lessons Learnt: Local & Formal Investigations



Date: 1st May 2013

Issued By: IP S&SD Quadrant: MK, Elder Gate, Milton Keynes Central, MK9 1EN

Issue Number: 7:

Title: Staff Fatality. COSS/Site Warden Struck by 2P67 near Saxilby on 04/12/2012

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Photograph taken from Network Rail Guide Ref. JN:09079

Overview of Event

- Track monitoring was needed as a result of an installation of a transition ramp at Underbridge SPD3/68 down Gainsborough Line over Sykes Lane, Saxilby, Lincolnshire.
- The work group met at the access point for SPD3/68 and the COSS/Site Warden briefed the team on the safe system of work.
- The work group's first task on the cess rail was to rectify a twist fault and the installation of the low mileage lateral restraint plates.
- The Track Quality Supervisor observed trains passing the area and identified remedial works that were required around the timber sleepers voiding over the transition ramp on the Down Gainsborough line Lincoln side of SPD3/68.
- The COSS/Site Warden signed into the Protection Controller's line blockage at 13.45 and the work group commenced on these remedial works using vibrating hammers and shovels.
- During this operation a Track Worker moved over into the six foot to work on the sleeper end operating a vibrating hammer.
- The immediate cause of the event was that the COSS/Site Warden moved into the path of 2P67 on the adjacent open line. It is unclear where the COSS/Site Warden was standing prior to this event. Although given the six foot dimension and stepping distance, it is likely that the COSS/Site Warden was positioned in the six foot to the rear of the work group.
- At 13.54 the Driver of 2P67 reported that the train had struck the track worker.

Underlying Causes:

Planning and Preparation;

- There was a lack of possession strategy with no integrated line blockage plan between the various contractors within and outwith the Alliance;
- Late production of the Work Package Plans & Task Briefing Sheets and design technical approval;
- A lack of a resource plan across the Alliance.

Communication

- The following has not been embedded within the culture of the Alliance at site level;
 - Lifesaving Rules
 - Point of Work Risk Assessment (Carillion Plc).

Supervision

- It was unclear who was actually supervising these works. The deceased appears to be the unwritten team leader of the track workers and gave instructions around the tasks to be undertaken along with the Track Quality Supervisor.

Applications of Briefings;

- The SSOW Pack was only briefed once for both line blockages.
- The task briefing sheet was not briefed, however this did not adequately address the transient hazards on the site.

Roles and Responsibilities

- There is a clear understanding by the people involved of their own roles and responsibilities on the project

Key Message: All works irrespective of the task should be adequately planned and managed and people involved clearly understand their roles and responsibilities. If an operation can be undertaken at a different time when the level of protection is more suitable for the task then people should not progress and this must be supported by their manager.