

CLIC



Stanningley Tunnel Project
Renewals & Minor Enhancements

Issue 141
18 June 2025



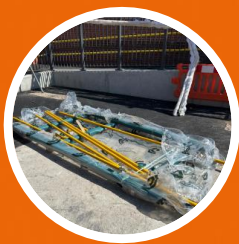
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What's in this issue...



Slips, Trips & Falls Alert



Rail Safety Week – Kids competition



Shared Learning – Open Line Walking



Advice, Alerts & Bulletins



Fast Facts - Accidents & Incidents



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Slips, trips & falls – RIDDOR Specified Injury

An AmcoGiffen Site Operative was removing a section of handrailing from a timber frame, prior to installation onto an access ramp. As they were carrying a section of handrail from the pallet, a gust of wind blew the shrink wrap (still attached to the pallet) around their foot; causing the IP to trip and fall to the ground injuring their right elbow.

The IP received first aid on site and visited A&E later that evening. Following an x-ray, the IP was found to have a potential fracture of their radius and referred to a specialist fracture clinic.



Slips, trips and falls are among the most common accidents at work in the UK, affecting every sector from construction to office environments.

According to the Health & Safety Executive (HSE), slips, trips and falls account for nearly 40% of all workplace injuries in the UK each year.

How can we help to prevent slips, trips and falls in the workplace?

Review your existing Risk Assessments:

- Evaluate the workplace for potential slipping and tripping hazards (including packaging materials).
- Can packaging be reduced, substituted or eliminated at source?

Implement Safe Unpacking:

- Establish clear guidelines for safely removing packaging materials, including the use of appropriate tools and techniques. Where materials are partially unpacked ensure that any loose wrapping is secured.
- Where possible, fully remove all packaging so as not to introduce any additional hazard to the workplace.

Keep walkways and work areas clear of obstructions:

- Ensure that all packaging materials are promptly removed and disposed of properly to keep the site and walkways clear.
- If you see a spillage, clean it up or arrange for it to be cleaned.
- Report any damaged floors or floor coverings to your supervisor / manager.
- Regularly inspect and maintain flooring, lighting and walkways.
- Prepare for adverse weather conditions such as gritting to prevent slips, trips and falls.

People and organisational factors:

- Play your part in keeping the workplace tidy: If you see items on the floor where someone could trip over them, remove them, or arrange for them to be removed or for the situation to be made safe.
- Consider how work is organised and managed, i.e. avoid rushing, overcrowding, placement of trailing cables etc...
- Promote a culture where employees report potential hazards or near-misses to prevent future incidents.

Rail Safety Week Kids Competition



What's Going On?

To celebrate Rail Safety Week 2025, the Rail Forum, in collaboration with the Rail Standards Safety Board (RSSB), have launched a competition to get kids involved with rail safety.

Whether it's colouring in a train, designing your own station, or creating a safety-themed masterpiece, we're encouraging children to get creative while learning about the importance of rail safety.

Colouring competitions for children aged 4–6 and 7–9

A 'Design Your Railway Station' competition for children aged 10–12

Final entries for these competitions is the 22nd August with winners for #RSW25 announced in September!

To download the competition artwork as well as view past submissions and prize details, visit the Safety Week [website](#).

If you are interested to see what else is going on or learn more about Rail Safety Week, then please visit the website [here](#).



WE'RE
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#RSW25

16th - 22nd June | 2025

Organised by: Rail Forum



railsafetyweek.org

Shared Learning



Supplier Organisation	Alstom	Project	Cambridge Re-signalling Project (C3R)
Date of Accident / Incident	01/05/2025	Time of Accident / Incident	1020 hrs
Location of Accident / Incident	BGK Line Down Goods Loop	Type Accident / Incident	Operational Close Call SSOW Breach

Overview of Accident / Incident

Two testers were observed walking on the operational Down Goods Loop (line speed 25 mph). They had been working in the Goods Loop REB conducting prep testing and needed to check a dis box. En route, they walked on the cess side of the vortex fencing and requested permission to pass the sub-contractor team installing troughing. The troughing works had created multiple holes, troughing and string lines which were obstructing the safe access route. After completing checks at the dis box, the testers discussed the safest return route. With alternative paths blocked by overgrown vegetation and the main route obstructed, they chose to walk on the Down Goods Loop. Although aware it was operational, they believed it was safe due to the line being clipped and scotched.

Causes

- The testers were working under a separated safe system of work, and they deviated from this without authority.
- There was reluctance for the incident to be reported due to the individual's fearing repercussions for their actions and by the team who witnessed it due to it being seen as revenge for a previous incident which was reported by the testers.
- The impact of the civils activities was not considered when planning the prep testing at the location of the incident and therefore there was insufficient arrangements to deconflict or integrate the works.
- There was a lack of a change management or point of work assessment procedure embedded within the project and if implemented this could have prompted the testers to consider their working environment and escalate the issue.
- The extent of the overgrown vegetation restricting the access routes was not known by the activity planners.
- The Person In Charge (PIC) had limited involvement in the planning of the work and there was no set forum to pass on feedback.
- There was confusion faced around the status of the Down Goods Loop.

Actions Taken As a Result of Investigation/ Key actions taken to prevent recurrence

- A point of work risk assessment developed and rolled out across all project teams.
- Alstom engaged with their Labour Supplier organisations the need for non-technical skills for their teams
- Checklist introduced to prompt discussion / assist in integrating activities of different disciplines at weekly reviews.
- A project stand down held on processes and importance of adhering to the SSOWs in place.
- Increased assurance checks and site visits introduced to check work is being delivered in line with procedures.

General Key Messages / Learning for Others

- Specific risk controls detailed in the WPP should be incorporated into the Task Briefing Sheet.
- Task briefing sheets including specific controls should be fully briefed to and understood by those undertaking the task.
- Point of Work Risk Assessments that require any deviation to the methodology should be assessed to take into account any specific environmental conditions and be approved before deviation.
- Project teams should review what methods they use to assure themselves that teams carrying out tasks are working in compliance with the methodology.

Photo taken showing the signalling testers walking on an open line.



Key Message

Although a mistake and the wrong decision was made by the testers, the testers were put into an unsafe situation that influenced their actions.

Safety Advice

Action required following part failure of HAKI suspended scaffold system.



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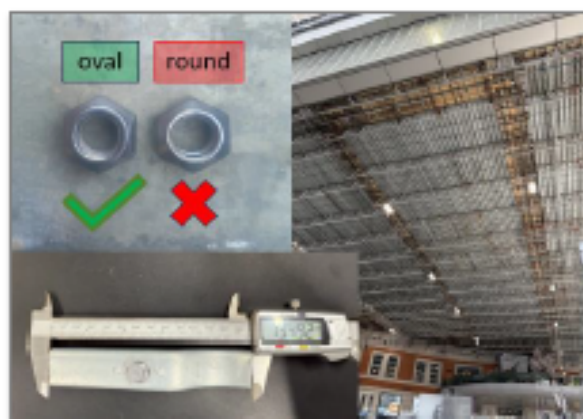
Scaffold equipment failure at Waterloo Station

Issued to: Network Rail and Contractors

Date of issue: 16 June 2025

Location: London Waterloo Station

Contact: Paolo Baroni



Overview

Glazing works above the main concourse at Waterloo Station are currently underway and are scheduled for completion in 2027. ([link](#)).

On Monday, 9 June, a passenger reported an object falling onto the concourse floor. The object was confirmed to be a locking clip from an aluminium plank used in the HAKI suspended scaffold system.

The clip measures approximately 13.5cm and had the potential to cause serious injury or a fatality. Fortunately, no harm occurred in this instance.

The affected component is assembled by HAKI using a locking nut intended to remain secure under normal conditions. The locking nut, supplied by another manufacturer, should have been crimped or pressed. However, in this instance it hadn't been.

It is believed that vibration and/or thermal expansion and contraction caused the assembly to loosen, resulting in the clip and its connecting bolt falling. The locking nut remained in place on the underside of the deck.

A properly compressed nut should feature an oval-shaped hole. The failed component (pictured) was found to have a round hole. HAKI has raised a non-conformance report regarding this issue.

All work was halted immediately. The scaffolding contractor is now conducting a full inspection of the nut-and-bolt assemblies on every plank before works resume.

No additional loose nuts have been identified during inspections following the incident.

Immediate action recommended.

- **Precautionary Checks:** HAKI advises that users inspect the tightness of the nut and bolt securing the locking device. This can be done using two wrenches to confirm the locking nut is fully functional. Any decking panel with a loose or damaged locking device must be removed from service, in line with the product manual.
- **Inspection Prior to Installation:** All scaffolding components — regardless of manufacturer — must be inspected thoroughly before installation, especially in applications above areas accessible to the public.

- **Ongoing Investigation:** HAKI is conducting a full investigation into this reported failure of a decking locking device. Based on current information, the root cause has not yet been established. This is the first reported incident of its kind since the product's introduction in 2017 and is currently believed to be an isolated case.
- **Structural Integrity:** It is important to note that the incident did not affect the load-bearing capacity of the plank.
- **Product Acceptance:** Check whether the scaffolding systems you intend to use on the operational railway have a Network Rail product acceptance certificate.

Part of our group
of Safety Bulletins

Safety
Alert

Safety
Bulletin

Safety
Advice

Shared
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Fast Facts



Note: This document contains information understood at time of incident and may change following investigation.

Supplier Organisation	Alstom	Project	Cambridge Resignalling
Date of Accident / Incident	9 th June 2025	Time of Accident / Incident	1510 hours
Location of Accident / Incident	Coldham Lane	Type Accident / Incident	Fire in Vehicle
Route Control Reference	3071958	IRIS Reference	43559

Outline of Accident Incident

RES operatives were travelling between Cambridge South and Coldham’s Road when they noticed a burning smell coming from the back of their work van. Upon arrival at Coldham’s road they opened the rear doors of the van and that a fire had started. The operatives attempted to extinguish the fire using an extinguisher they carry in their van. The operatives called emergency services who arrived at 1525 and fully extinguished the fire. Damage caused to the back door of the van, internal and external.

Photos



The van after fire extinguished

Immediate Actions Taken

The van was left at Coldham Road compound and was recovered back to RES Ilkeston depot on 10/06/2025. Investigation commenced.

Initial Known Facts / Causes Identified

The cause of the fire is currently under investigation. However, in the work van there were numerous electrical items, such as batteries as well as blow torches which will be part of the investigation remit. The operatives had completed works prior to travelling to another site so the equipment used by the operatives is being assessed to identify if this could have led to the fire.

Next Steps

Teams have been advised to check their work vans for emergency response equipment along with equipment / materials.
A review of equipment and materials stored in work vans is to be conducted and risk assessments are to be reviewed to ensure it covers the risk of a fire starting and additional hazards that may be present.

Investigation findings will be shared to the wider project teams / industry in the form of a shared learning.

Fast Facts



Note: This document contains information understood at time of incident and may change following investigation.

Supplier Organisation	Aureos	Project	Thorpe Level Crossing AHB
Date of Accident / Incident	16 th June 2025	Time of Accident / Incident	1200 hours
Location of Accident / Incident	Thorpe Site Compound	Type Accident / Incident	Route Crime (Security)
Route Control Reference	3074625	IRIS Reference	43658

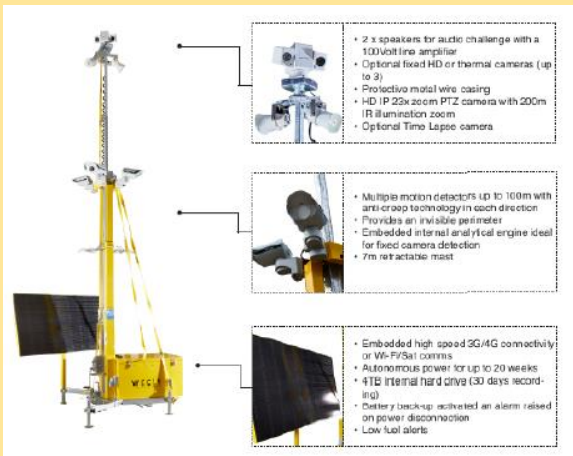
Outline of Accident Incident

Upon arrival at the site compound following the weekend, the team discovered that the padlock had been cut, allowing unauthorised access. Empty storage containers had been found to be open, indicating that individuals had entered the compound without permission.

Photos



Compound Unit



WCCTV Installation being deployed at the Site

Immediate Actions Taken

Incident reported to the British Transport Police (BTP) and the following undertaken:

- Security review: Assessment of planned security measures and storage strategy, adhering to a just-in-time approach due to the site's remote location.
- WCCTV installation: Completion of the WCCTV Rapid Deployment Tower installation, monitored 24/7 by an external security company. A designated responsible person has been identified to manage the system and power sour

Initial Known Facts / Causes Identified

The site is in a remote location.
The site is still in set up and therefore no materials or equipment where present.

Next Steps

BTP has now added to the location to their local patrol route.

Accidents and Incidents

Date of Incident	Portfolio	Project	Location	Type of Incident / Accident	Event Description
09/06/2025	S&T	157001 - Cambridge Interlocking Re-Sig	Coldham's Road Cambridge CB1 3EW	Fire or Explosion	Operatives were travelling between Cambridge station and Coldham's Road when they noticed a burning smell coming from the back of their work van. Operatives were unable to extinguish the Fire with a portable extinguisher. Emergency services called and fully extinguished the fire Damage caused to the back door of the van, internal and external.
15/06/2025	Track - CRSA	A00129 - East Coast Balfour Beatty	Darlington Station	Railway Operating Incidents - Asset Protection Irregularities	Worksite marker boards (WSMB) were placed in the wrong location, overlapping with an adjacent worksite to the north. The WSMBs in question were placed by a COSS on behalf of the ES at 51m 42ch V's planned 47m 41ch.
15/06/2025	S&T	167291 - Thorpe AHB - Compound Break In	Thorpe AHB - Doncaster	Route Crime	Break in at Thorpe compound over the weekend. Nothing taken, as only just had the units delivered on Friday. Reported it through Route Control. BTP crime number is: 170160625 and they're going to add the location onto their patrol.

Incidents raised by ERCP Supplier

15/06/2025	Civils	184839 - ILK1 Springs Tunnel	Springs Tunnel Portal	Railway Operating Incidents - Asset Protection Irregularities	Incident regarding a NWR maintenance team riding a track trolley on the ILK UP road towards CKR operatives working at Spring Tunnel Portal. This was not communicated to the CKR COSS when signing in with the ES to access track. This turned out to be Works Delivery and will be investigated by them.
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- Do you have something to share?
- Can others learn from your work?
- If you would like access to all out past issues, please use the below email to request access



SCAN ME

Whether it be linked Health, Safety, Environment or Social Value
Please get in touch and email: clic@networkrail.co.uk



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