

# CLIC



Hitchin Maintenance Delivery Unit Project  
Renewals and Minor Enhancements Portfolio

Issue 140  
11th June 2025



everyone  
home safe  
every day

SPEED ➤  
➤ PACE

Continuous Learning & Improvement Cascade  
Capital Delivery Eastern Region

# What's in this issue...



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Continuous Learning & Improvement Cascade  
Capital Delivery Eastern Region

# AmcoGiffen

## A Focus on People Performance



I joined AmcoGiffen as an Operations Director in the Eastern Region back in 2018 and have seen the business put significant focus into the development of its employees. Being involved in and supporting the growth of our people is one of the most important and enjoyable aspects of my role.

*Alan Sheffield, Operations Director, AmcoGiffen*

### Achieving improvement on performance

It goes without saying that our performance in delivery and the associated data and statistics that we measure our safety, health, environmental and quality performance against are fundamentally reliant on our people - from the front-line operatives, Supervisors and Safety Critical staff, including those of our supply chain, through to our project management and senior leadership team. To achieve what sometimes feels like elusive marginal gains, AmcoGiffen have invested significant time and effort in establishing excellent structured training and development programmes that have focus on where our historical trends have highlighted areas for improvement. These include:

**Front Line Leaders Academy** – Multiple modules completed by cohorts from around the business to learn and share in peer groups. Setting expectations around standards, accountability and developing often overlooked ‘soft skills.’

**COSS Academy** – An industry recognised and award-winning interactive course reinforcing the basics of undertaking a safety critical role with a focus on briefings, managing conflicting information and improving communication skills via role play.

**Behavioural Science** – Learning the principles of behavioural science has seen all roles across the AmcoGiffen business exposed to understanding what influences behaviour from a science-based perspective. Understanding that all behaviour is a product of the environment, including the people within it, has brought a new perspective to understanding why unwanted (At Risk) behaviours occur and how to get desired (Reduced Risk) behaviours consistently.

**Temporary Works Academy** – A recently launched development initiative aimed at Temporary Works Supervisors and Co-ordinators to establish a strong and consistent approach to identifying, planning and managing temporary works.

### Reflections:

Investing time and effort in people with strategic and focused development provides positive delivery outcomes, which are always strengthened by Senior Leadership engagement.



### Take Aways for Others

Health & Safety are not ‘bolt-ons’ or separate activities, and good SHEQ performance is just the natural outcome of developing an effective plan and following it through delivery.

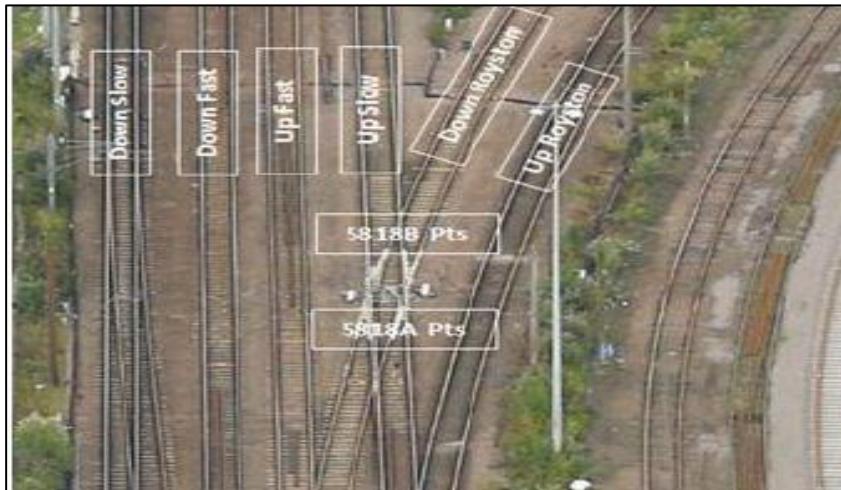
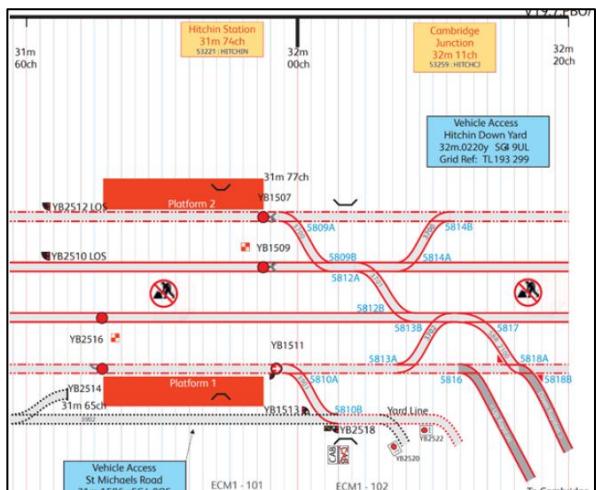
# Shared Learning: Engineering Train Derailment Incident



## Description of Incident

A train derailment took place on Saturday 25<sup>th</sup> January during track renewals work at Wymondley whilst crossing over from the Up Slow to the Up Fast within the worksite. During the move, both front axles derailed on 5818A points & the driver immediately brought the train to a stop.

5818A points are part of a switch diamond crossing that can only facilitate a move from the Up Fast to the Down Royston. It is not possible to make a move from the Up Slow to the Up Fast through this crossing. The team failed to recognise this both in the planning stage & on-site therefore making a move which caused the train to derail.



Photos: Location of 5818A on East Coast Delivery Manager Peterborough line diagram and aerial screenshot.

## Key Investigation Findings & Learning

- A knowledge gap was identified amongst the planning and delivery teams on how to identify different types of Switches and Crossing units.
- Line diagrams were updated to make it clear that 5818A and 5818B are part of a switch diamond assembly for future reference.
- Additional training was required for the planning and delivery teams on identifying and understanding different types of Switches and Crossing units.
- All planned train moves within a worksite over Switches and Crossing units to be reviewed by the Area Possessions Coordinator at the planning stage.
- Checks on engineering train movements within a worksite to be formalised with the local operations manager and added to the stage gate reviews.

## Considerations

- Could you recognise a Switch Diamond not fixed on site?
- Could you recognise a Switch Diamond on a Line Diagram during planning?

# Free Sustainability in Rail Learning Pathways Launched



Network Rail have worked with Supply Chain Sustainability School (SCSS) and others to launch the **Rail Infrastructure Learning Pathways**.

They have been designed to help upskill our supply chain in sustainability topics. This was to ensure all suppliers can use the same free resources to upskill their staff's capability.

There are 8 pathways that have been designed to align with Network Rail's new national **Greener Strategy** priority areas:

- **Supporting the delivery of net zero**
- **Contributing to a circular economy**
- **Adapting to a changing climate**
- **Protecting land, air, and water**
- **Supporting nature's recovery**
- **Creating an inclusive and accessible railway**
- **Supporting local economies**
- **Improving the wellbeing of communities**



Each pathway explores a specific theme and provides detailed insights on how these objectives can be achieved across the rail sector.



# Supervisors Culture Survey



## The Supervision & Culture SHELT Working Group

We have identified that supervisors play a fundamental role in setting a positive project culture which has a direct correlation to health, safety & wellbeing performance. This working group has been identified to create a consistent benchmarked approach through sharing & collaborating best practice across Network Rail suppliers to improve support for supervisors and recognise / improve the role of site supervision.



## What is the working group goal?

The working group aims to standardise best practices for supervision and culture across the railway supply chain by collecting and sharing key principles that drive effective supervision and a positive working culture. While promoting consistency across the industry, we respect each organisation's individuality, enabling companies to maintain their own values while raising safety standards industry-wide. Through collaboration and consultation, we will identify core principles that support success in supervision and culture..

## What do we need from you?

Supervisors - spend no longer than 15 minutes to support our working group by completing this anonymous survey.

Share the survey with anyone who is in a supervisory or equivalent role.

The survey closes on 25<sup>th</sup> June so please get involved now.

Scan the QR code on the right to access the survey or alternatively [click here](#) to access hyperlink for the survey

Supervision and Culture



# Shared Learning



## Derailment of freight train at Audenshaw

**Issued to:** Network Rail managers, safety professional and accredited contractors

**Ref:** NRL25-02

**Location:** Audenshaw, Manchester

**Date of issue:** 09/06/2025

**Contact:** Ellen Wintle, Chief Regional Engineer, NW&C or

Chris Bibby, Regional Engineer, P-Way, NW&C



### Overview

At around 11:25 on 6 September 2024, a freight train travelling between Peak Forest and Salford derailed as it passed over Sidmouth Street bridge in Audenshaw, Manchester. The train was made up of 2 class 66 locomotives and 24 wagons fully loaded with aggregate. The 2 locomotives and the leading 10 wagons passed safely over the bridge, but the following 9 wagons derailed, with the remaining wagons coming to a stand on the bridge itself. No injuries were caused as a result of the derailment but substantial damage was caused to railway infrastructure and some of the wagons.

The track over Sidmouth Street underbridge No. 3 is supported by a Longitudinal Timber Bearer System (LBS) and has a sub 800m radius curve.

Investigations to date suggest that the derailment was caused by gauge spread of the track which occurred when the baseplate chair screws sheared and broke.

### Underlying Causes

- The chair screws in the baseplates were the wrong type. For hardwood timbers they should have been high tensile screws (marked as HT) as per NR/L2/TRK/3038.
- The chair screws used were too short for the depth of packing between the baseplate and the timbers. Screws marked AS had been fitted which are 160mm long (6 5/16 inch). They should have been LSA screws as these are 206mm long (8 3/8 inch),
- There was no signed Longitudinal Bearer Management Plan in place – this should have been produced, approved and signed by both Track and Structures engineers as per TEF3279.
- Ellipse was not being used as required by NR/L3/MTC/MG0176. Specifically, Ellipse had not been populated to record previous incidents when screws had sheared and been replaced. Recording in Ellipse is vital so that similar or repeat incidents can be identified to allow any 'trends' to be identified and mitigated.
- Track geometry trace reviews had not been undertaken in accordance with NR/L2/TRK/001 mod 11.
- There had been several staffing changes in the maintenance team in the months prior to the derailment and the handover of high-risk assets between TMEs had not been sufficiently recorded.
- Assurance processes had not picked up the issues above.

## Key Message

SIN220 "Managing Lateral Forces on Sub 800m Longitudinal Bearer Systems" was issued on 06 December 2024 which requires the inspection of the type of chair screws and depth of packing to ensure any failed, ineffective or non-compliant screws are replaced.

In addition to actioning SIN220, review the implementation and associated assurance of the following controls:

- How effective is your management of longitudinal bearer systems between track and structures engineers including:
  - Do you have Longitudinal Bearer Management Plans (LBMP, TEF3279) for each longitudinal bearer structure that have been approved and signed by both the track and structures Engineers?
  - Where track geometry issues exist on longitudinal bearer systems, have they been discussed with the structures team in a timely manner?
  - When structural issues are identified on longitudinal bearer bridge systems how are they raised and discussed with track engineers in a timely manner?
- Are your inspection regimes at the correct frequency for the longitudinal bearer systems in accordance with NR/L2/TRK/001/mod02 Track inspection and NR/L2/TRK/3038 Longitudinal Bearer Systems – Inspection, Maintenance and Design?
- Are trace reviews being carried out effectively and to the required standard?
- Where inspection staff are regularly replacing components how are these being recorded and reported?
- Is all information recorded on the TEF forms being captured in Ellipse?
- Does your Level 1 Assurance include cradle to grave checks on work orders to ensure that all aspects from work order creation to delivery and close out are being captured fully and accurately.
- Are maintenance managers and engineers effectively reviewing the output of L1 assurance, not just completion rates and how are "not checked on this occasion" answers monitored in MSA?
- How robust are handovers between track maintenance engineers when people change roles?
- How are newly promoted staff supported by competent and experienced mentors through the transition period?

Part of our group  
of Safety Bulletins

**Safety  
Alert**

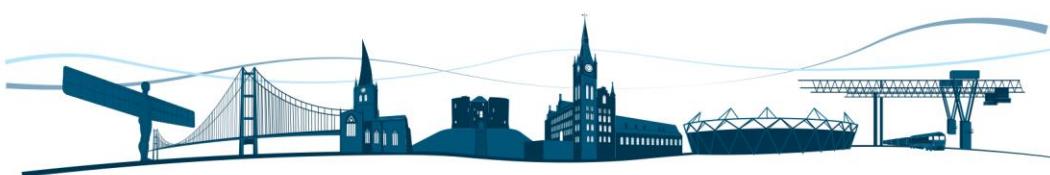
**Safety  
Bulletin**

**Safety  
Advice**

**Shared  
Learning**

# Recent Accidents and Incidents

Date of Incident	Portfolio	Project	Location	Type of Incident / Accident	Event Description
30/05/2025 (Late Reported 4 Days)	North & East S&T	174204 - Shildon & Heighington Renewals	Shildon Compound	Route Crime	Fencing to compound undone and window to welfare/office cabin forced open. Monitor and keyboard stolen. Nothing else disturbed or damaged.
08/06/2025	East Coast Track	A00129 – East Coast Balfour Beatty	British Steel - Redcar	Personal Injury	Whilst carrying a box of rollers, IP lost their footing and sustained a twisted knee. Immediate first aid was offered on site; however, the Injured Person (IP) declined treatment, deeming it unnecessary at the time. Following shift deemed fit for work.





- **Do you have something to share?**
- **Can others learn from your work?**
- **If you would like access to all our past issues, please use the below email to request access**



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

