NetworkRail

CLIC

Barnetby Maintenance Delivery Unit Project
Renewals & Minor Enhancements

Issue 142
25 June 2025

everyone home safe every day

SPEED PACE

Continuous Learning & Improvement Cascade

Eastern Routes Capital Programmes

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PROJECT ACE SPEED PACE

Continuous Learning & Improvement Cascade

Eastern Routes Capital Programmes

Collaborative Safety Session

In a powerful demonstration of industry collaboration and commitment to safety, representatives from Morgan Sindall, Palmers, Octavius, All Task, Taziker, and Network Rail recently came together for a dedicated safety session focused on scaffolding-related incidents.

The session served as an open and honest forum where participants shared real-life accidents and near misses from their respective projects. A particular focus was placed on recent incidents involving falling scaffold components at Liverpool Street and Waterloo Stations - events that underscored the critical importance of robust safety controls and proactive risk management.

Attendees did not shy away from discussing the pain points and challenges they've faced. Instead, they leaned into the opportunity to learn from one another, fostering a culture of transparency and continuous improvement. The group explored the root causes of incidents, shared the corrective actions taken, and highlighted controls that have since been implemented to prevent recurrence.

One of the key outcomes of the session was a collective agreement to review and potentially adopt some of the shared safety measures across other projects. All participants agreed that the session was a valuable and worthwhile exercise. It not only reinforced the importance of collaboration in driving safety improvements but also strengthened the relationships between organisations working toward a common goal: ensuring everyone goes home safe, every day.

The Collaboration Meeting

MORGAN SINDALL INFRASTRUCTURE · octavius · PALMERS® · ALLTASK® Serious about Service since 1992 · TAZIKER Infrastructure Access Engineering Industrial

Good Practices: Health First at Cambridge South

As part of Murphys continued focus on the health of their workforce, they have now installed emergency stations on the Cambridge South project to aid the treatment of Diabetes and Heat Exhaustion.

Diabetes Emergency

Diabetes is a hidden epidemic leading to increased absenteeism and risk of accidents. A staggering 7% of the population have diabetes. 80% have type 2 diabetes, 5% have type 1 diabetes. Some of those living with type 2 diabetes will be totally unaware they are living with the condition.

Murphys have chosen to help protect its workforce with provision of Hypo Kits located across site. These are available from The Diabetes Safety Organisation and will ensure immediate response capability in the workplace and empower the workforce, so they are ready to act when faced with a hypoglycaemic episode.

Diabetes Hypo kit

Heat Exhaustion & Heat Stroke

In keeping with the NHS guidelines for the recognition of Heat Injuries and treatment, Murphys have prepared and maintained a Heat Exhaustion & Heatstroke Emergency First Aid Kit
consisting of:

- Kool Pak Instant ice packs
- Dioralyte oral rehydration solution
- Bottles of water

Heat exhaustion does not usually need emergency medical help if you can cool down within 30 minutes. If it turns into heatstroke, it needs to be treated as an emergency. You can visit the NHS website for more information on signs & symptoms of Heat Exhaustion and Heat Stroke.

Kool Pak kit

Take 5

How prepared are your sites for medical emergencies such as a hypoglycaemic episode or heat exhaustion? What risk assessments do you have in place to manage any emergency health emergency?

Fast Facts

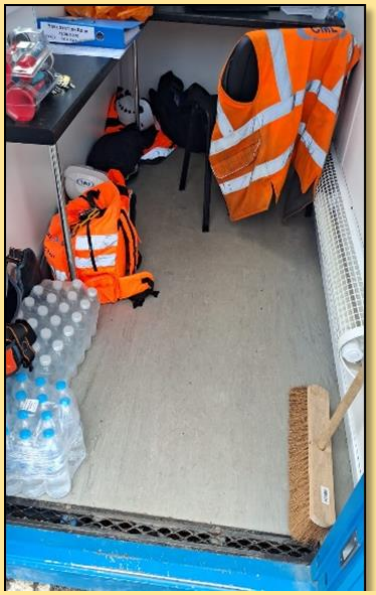
Note: This document contains information understood at time of incident and may change following investigation.

Supplier Organisation	**Construction Marine Ltd**	**Project**	**York Station Roof**
Date of Accident / Incident	16th June 2025	**Time of Accident / Incident**	0930 hours
Location of Accident / Incident	York Station Compound	**Type Accident / Incident**	Injury – Slip, Trip, Fall
Route Control Reference	TBC	**IRIS Reference**	43703

Outline of Accident Incident

When entering the site office, the IP caught their foot on the bag strap of an emergency kit bag that had been left on the floor along with several other items in the site office. As a result of this the IP fell forward striking their head on the shelf in the office. This resulted in a slightly swollen eye, with a small graze to their eyelid, caused by the prescription safety glasses they were wearing being forced against their face from the impact.

Photos



Welfare Unit

Injury to eye

Immediate Actions Taken

The IP notified the site manager, and it was agreed that they attend the Nearest A&E as a precautionary measure.

They returned to their normal duties with no ill effects apart from the minor graze and swelling their eye.

The site manager conducted a TBT on housekeeping the site was checked for obstructions to walkways with any items stowed away correctly covering the following:

What you must to do.

- **Always** Keep walkways clear of obstructions and maintain housekeeping not only on site but in the welfare and office areas.
- Safety equipment is provided to keep you and your workmates safe- **Don't leave it laid about on the floor where it could get damaged.**

Initial Known Facts / Causes Identified

It was noted that PPE such as helmets were left on the floor of the office, these should be stowed away safely so they are not damaged.

Next Steps

All action taken.

Fast Facts

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

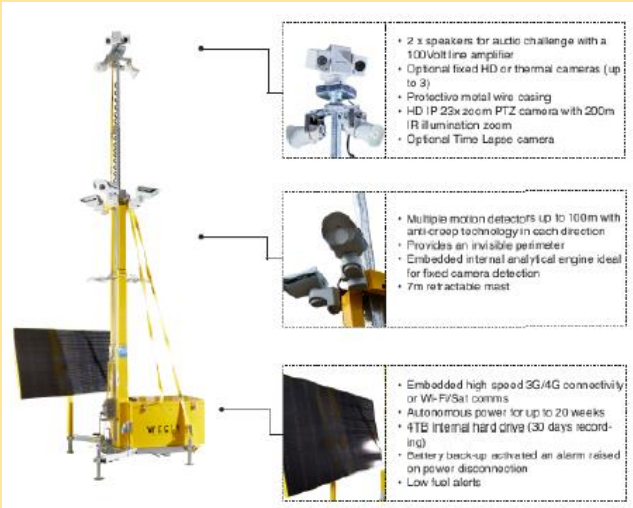
Supplier Organisation	**Aureos**	**Project**	**Thorpe Level Crossing AHB**
Date of Accident / Incident	16th June 2025	**Time of Accident / Incident**	1200 hours
Location of Accident / Incident	Thorpe Site Compound	**Type Accident / Incident**	Route Crime (Security)
Route Control Reference	3074625	**IRIS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

- 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 source.

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 the location to their local patrol route.

Fast Facts

Central Rail Systems Alliance
Improving Passenger Journeys

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

Supplier Organisation	**CRSA**	**Project**	**Domestic Track Renewals**
Date of Accident / Incident	21/06/2025	**Time of Accident / Incident**	06:30
Location of Accident / Incident	Grange Lane	**Type Accident / Incident**	Fire or Explosion
Route Control Reference	TBC	**IRIS Reference**	43732

Outline of Accident Incident

Sleepers that had been loaded onto the engineering train were smouldering due to the heat from hot works associated with rail cutting. Fire brigade was informed.

Photos

Source: South Yorkshire Fire & Rescues Facebook Page

Immediate Actions Taken

The fire crew arrived at site and dampened down the wagons.

The remaining sleepers were loaded, and the wagons were damped down via the bridge

Initial Known Facts / Causes Identified

Incident occurred due to the heat from hot works associated with rail cutting.

Next Steps

Level 1 investigation underway.

Fast Facts

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

Supplier Organisation	**SRSA**	**Project**	**Anglia Renewals**
Date of Accident / Incident	22/06/2025	**Time of Accident / Incident**	14:10
Location of Accident / Incident	Old Oak Common	**Type Accident / Incident**	Damage Event
Route Control Reference	TBC	**IRIS Reference**	43742

Outline of Accident Incident

A Road Rail Vehicle (dozer) blade has come into contact with an engineering train break handle whilst trimming the base stone. The engineering train was stationary at the point of contact. Prior to the engineering train departing, the Plant Operating Manager and SCO were informed and the necessary checks were completed to ensure safe travel.

Photos

Immediate Actions Taken

- A Stand-down of site for the investigation has taken place
- The Plant Operating Manager inspected the wagon and confirmed it is safe for train to depart.
- The train wagon was sent to to the maintainer to assess the damage.

Initial Known Facts / Causes Identified

N/A

Next Steps

Level 1 investigation is on-going.

Fast Facts

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

Supplier Organisation	**Story Contracting**	**Project**	**Goole Subway**
Date of Accident / Incident	22nd June 2025	**Time of Accident / Incident**	1000 hours
Location of Accident / Incident	Goole Station Compound adjacent to Goole Railway Station	**Type Accident / Incident**	Plant Damage
Route Control Reference	3077996	**IRIS Reference**	43735

Outline of Accident Incident

Whilst reinstating the dwarf wall on the North subway the dumper driver tried to pass the stationary telehandler through a tight gap and came into contact with the telehandler causing damage to the glass panel on the telehandler door. Glass remained intact within the door

Photos

Location of incident

Immediate Actions Taken

Incident reported to Route Control North & East and North East Incident Controller.

Onsite team arranged for replacement glass to be fitted in the telehandler door.

Initial Known Facts / Causes Identified

Driver from Onsite admitted rushing and accepted responsibility.

The driver misjudged the available space between the stationary telehandler and dumper he was driving.

The site has a small operational footprint.

Next Steps

Incident investigation to be undertaken with Onsite Contractor.

Shared Learning

Supplier Organisation	**CRSA**	**Project**	**Doncaster S&C, Domestic**
Date of Accident / Incident	12/10/2024	**Time of Accident / Incident**	05:27
Location of Accident / Incident	Sandbank Junction	**Type Accident / Incident**	Near Miss Incident

Overview of Accident / Incident

A Near Miss occurred between a member of staff vehicle and an Engineering train while attempting to cross Carr Lane Level Crossing. This incident happened within the possession limits of a planned track renewal and involved an Isolation team working on behalf of CRSA. The isolation plan was done in two phases and in line with the planned worksite. In phase 2 the Authorised Person (AP) attempted to cross Carr Lane Level Crossing to collect some belongings for his Earthing Assistant (EA) without contacting the signaller. The EA opened the Level Crossing gate whilst the AP drove over the crossing. On attempting to cross over, a Freightliner train traveling on the Down Lincoln Flyover line had to apply the emergency break and horn whilst the AP reversed back to clear the line.

Causes

- The Carr Lane level crossing procedure was not followed.
- The Authorised Person did not attempt to contact the signaller before crossing therefore not given permission by the signaller to pass over the level crossing.
- The AP did not utilise the allocated time at the start of the shift to familiarise the team with the area (the planned start time was 22:00 however the team started on site at 00:00)
- The AP along with other members of the OLE team did not sign into the CRSA site access and therefore did not receive the site access briefing.
- The Nominated Persons briefing of a complex isolation to the Authorised Persons took place in the car park rather than the cabins provided.
- The Authorised Person was confused on the location of the earthing location and had to contact the Nominated Person for clarification of earthing location.

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

- Improvements to infrastructure signage and warnings at Level Crossings within work areas implemented by site team
- Nominated Persons competence and training requirements reviewed as to conducting suitable site briefings that includes any access arrangements.
- All workforce rebriefed that they must receive a Site Access Brief before accessing the track. Nominated person or Person in Charge (PIC) to check all staff have received the site brief before deployment
- Increased assurance checks and site visits introduced to check work is being delivered in line with procedures.

General Key Messages / Learning for Others

- Review of access risks and arrangements in Task Briefs to be included in the Safe System of Work Pack if required.
- Whiteboard briefings are to include a reminder of crossing and access arrangements at all level crossings within the work area
- Level 3 On Call and Duty Management to be briefed on the management process and the wellbeing of staff post any accident or incident.

Photos: Carr Lane Level Crossing. Double gate access at each side of the crossing with clear crossing instructions on the front of the gate.

Key Message

Always ensure your teams understand their briefings and have the relevant site information including access & egress arrangements

Shared Learning

Supplier Organisation	**Morgan Sindall (PC)** **Palmers (Scaffolding)**	**Project**	**London Liverpool Street Roof Renewal Project**
Date of Accident / Incident	15/05/2025	**Time of Accident / Incident**	0230hrs
Location of Accident / Incident	Platform 3 London Liverpool St Station	**Type Accident / Incident**	Material Fell From Height

Overview of Accident / Incident

During installation of a tube and fitting hanger for the suspended scaffold, a supplementary coupler became loose and fell approximately 15m onto the station platform. The platform had an exclusion zone in place at the time of the incident and the coupler landed within it. There were no injuries or damage. The investigation concluded that the coupler had not been correctly tightened and vibrated loose when the scaffolder was working on an adjacent fitting.

Photos

Location coupler fell

The supplementary Couplers

The supplementary Coupler bolt not fully housed (red circle)

Causes

- The coupler was not fully housed in the fitting. Due to the number and types of coupler the scaffolder was working from touch / feel. Not being fully housed in the fitting the coupler became loose under vibration from the continuation of works on the scaffold installation.
- Encapsulation (netting) had not been installed as per the agreed methodology allowing the coupler to drop onto platform and not be contained at a high level .
- Communication to the night shift Supervisor did not adequately cover the controls required i.e. the encapsulation.
- The chain of documentation did not suitably pass risk controls from the Work Package Plan into the Task Briefing Sheet and therefore those undertaking the works were not adequately aware of the risk controls.

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

- All couplers already installed have been physically checked where there is a risk of them falling from height.
- Future couplers will use swivel type to allow visible fitment of bolt to housing.
- Encapsulation requirements now fully detailed in the Task Briefings and installed during hanger installation.
- Review of all WPPs and TBS to ensure controls are adequately captured.
- More emphasis of on-site review of TBSs during site engagements to ensure processes are being followed.
- A back shift implemented once per week to establish better two-way communication with the night shift team.

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 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.

Safety Advice

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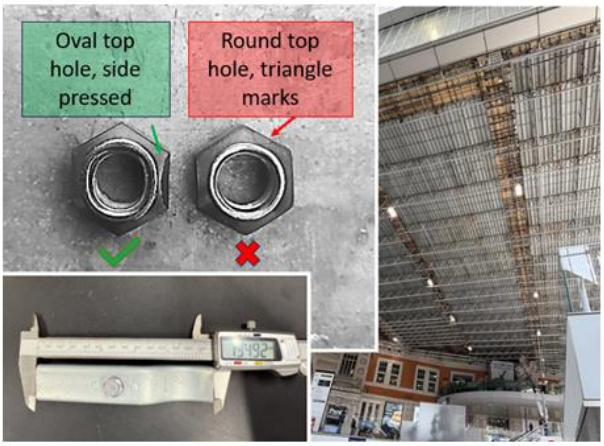
Scaffold equipment failure at Waterloo Station



Issued to: Network Rail line managers, safety professionals and accredited contractors

Date of issue: 25/06/2025

Ref: NRA25-05

Location: London Waterloo Station

Contact: Paolo Baroni, Health & Safety Manager - Southern Region.

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.

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.

Immediate action required

- **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.
- **Product Acceptance:** Check whether the scaffolding systems you intend to use on the operational railway have a Network Rail product acceptance certificate.
- Ensure your temporary works design has been thoroughly assessed for potential hazards and risks.

NetworkRail

- **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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