

CLIC



Progress at Beaulieu Park Station
Major Projects & Enhancements

Issue 143
02 July 2025



everyone
home safe
every day

SPEED

PACE

Continuous Learning & Improvement Cascade
Eastern Routes Capital Programmes

What's in this issue...



Learning From History - Nuneaton



Dustite Implementation



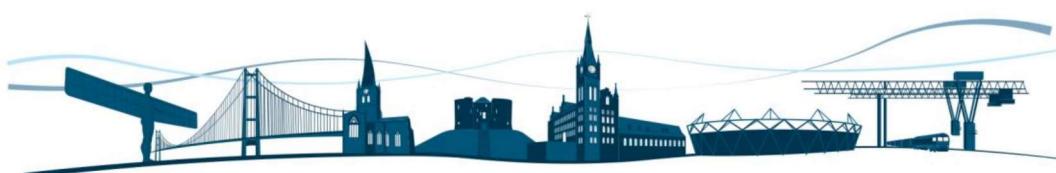
Leaving a Legacy – Transformational Project



Advice, Alerts & Bulletins



Fast Facts - Accidents & Incidents



Continuous Learning & Improvement Cascade

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Learning from History

Nuneaton (6th June 1975)



"I became aware of this incident following an article published on the BBC website. Further research on the accident led me to Danger Signals authored by Stanley Hall. The number of missed opportunities which would have prevented this incident really shocked me and there are still many lessons that we can learn 50 years on."

Scott McKavett, Principal Engineer (Track), Northern Powerhouse Rail, Network Rail.

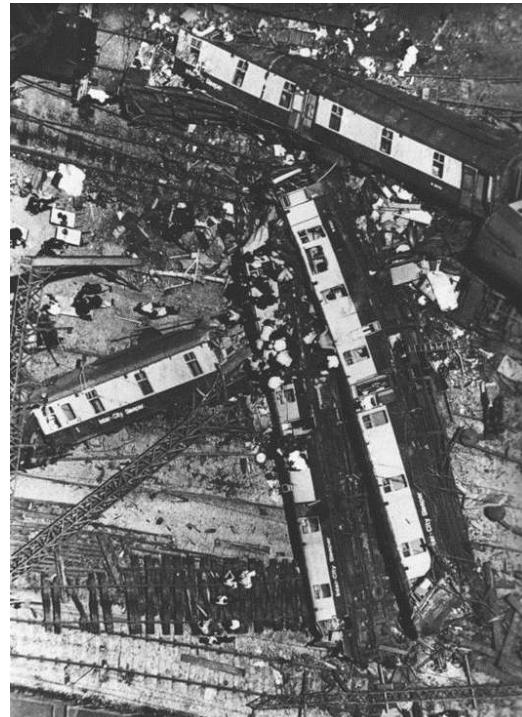
Incident Summary

In the early hours of 6th June 1975, a train derailed at Nuneaton resulting in the deaths of 6 people and multiple injuries.

A mile from Nuneaton station, the train passed a lineside board giving advance notice of a 20mph temporary speed restriction (TSR) in place through the station, however, the lights illuminating this board were not working. At the time, it was not practice to provide an AWS (Automatic Warning System) magnet with an advance warning board for a TSR.

The driver and second-man wrongly assumed that the 20mph TSR was no longer in place. Just before entering the station the driver saw an oil lit board marking the actual commencement of the TSR and made an immediate emergency brake application, however, this was too late, and the train derailed on a curve at 100mph:

- The curve was part of a temporary alignment in place during the remodelling of the station layout.
- The locomotive and all but the rear carriage derailed.



Public Enquiry & Aftermath:

- There was evidence that lights at advance warning boards and commencement boards used around the country were often out, vandalised or stolen,
- On the night of the derailment, several trains had passed the defective warning board.
- Many drivers admitted that they had not reported the defective board at the first convenient opportunity as required by the rules. 17 trains passed the defective board before the incident between 2230hrs and 01:40hrs.
- As a consequence of the accident, AWS magnets are now used at all temporary and emergency speed restrictions. This also addressed doubts that some drivers were missing or forgetting advanced notification of temporary speed restrictions in the operating notices.

Learning & Reflections:

- Always stop and report any unsafe situations and intervene to stop safe practices.
- How can we minimise the risk of human error?
- How can we mitigate against the risk of equipment or technology failures, theft or vandalism?
- Beware that in attempting to control one risk, we may introduce new risks.
- Will minimising the amount of temporary or phased works reduce risk overall?
- Minimising the reliance on TSR's will reduce the risk of over-speeding and the risks to those who must establish and remove any temporary restrictions.
- Keep corporate memory alive – Do not forget the tragedies and lessons learnt from the past!

Dustite Implementation



What is it?

Dustite is an inert PVA glue like substance designed to bind the fine-grained material to the surface of ballast and prevent it from becoming airborne.

Dustite was accepted for use on railway infrastructure in 2023 following application of full Common Safety Method Risk Assessment.



Application at Whitemoor depot, 2023

Benefits



Application to inbound new ballast supply will reduce airborne dust in depots



Remains effective for at least 7 days



Reduces ballast dust during conventional handling and delivery



Reduces operational impact and cost of applying water in depots

Trial Results

A trial tested ballast stockpiles handled 2 and 7 days after application of Dustite. One pile was treated, and the other was not treated. This was to look at the longevity of the product.

- After 2 days, total particulate matter was reduced by **82%**, and respirable dust by **52%**
- After 7 days, it was not possible to handle the dry untreated ballast (top image) due to dust levels but the Dustite treated ballast remained suppressed (bottom image).



7 day treatment of ballast (left)



7 day of untreated ballast (right)

Leaving a Legacy Transformational Project



What is the Stratton Roots Project?

This is a project being delivered in Long Stratton, Norfolk. With a strong focus on sustainability and education. Over the course of two weeks, the project will enhance outdoor environments at St Mary's Church of England Junior Academy and Manor Field Infant and Nursery School. This community-led initiative brings together the Octavius Eastern Routes Partnership Network Rail team and the Long Stratton Bypass project team, local contractors and the schools themselves, working in partnership to create a lasting and positive impact for local children and families.

Project Summary

Green spaces at two Long Stratton Schools will be enhanced to support co-curricular learning and environmental education. The project includes playground clean-up, minor repairs and the creation of new outdoor learning areas using donated materials and labour from the supply chain and local businesses. It builds on earlier sustainability and biodiversity workshops delivered by STEM and climate ambassadors from Octavius.

Register to Volunteer

You must register to volunteer for this event. A timetable of events is available upon request – CLIC@networkrail.co.uk

Scan the QR code below or visit:
<https://forms.office.com/e/gsDYiZiFiA>

The closing date is **25th July 2025**

Project Location

St Mary's Church of England Junior Academy,
Swan Lane, Long Stratton, NR15 2UY

2025 Leaving a Legacy Volunteer Details Form



St Mary's Church of England
Junior Academy



Long Stratton
Town Council



Norfolk
County Council



Fast Facts



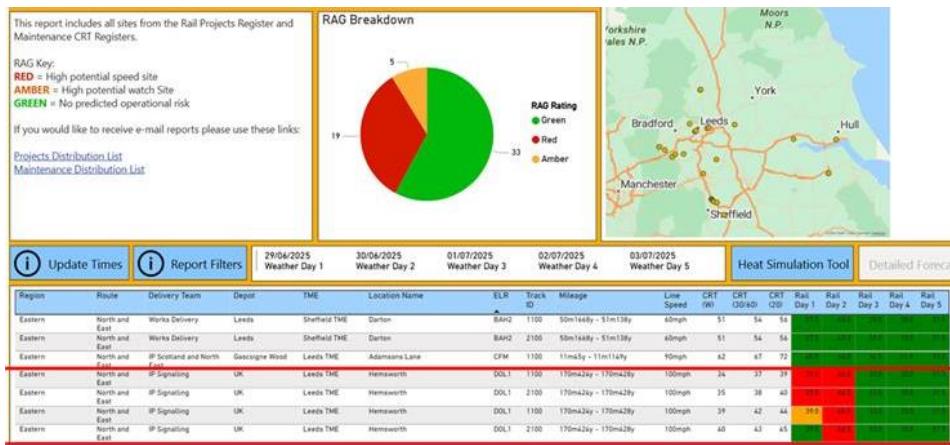
ALSTOM

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

Supplier Organisation	Alstom (ATUK)	Project	South Kirby
Date of Accident / Incident	28 June 2025	Time of Accident / Incident	07:00hrs
Location of Accident / Incident	Hemsworth (South Kirby)	Type Accident / Incident	Operational Close Call
Route Control Reference	TBC	IRIS Reference	43870

Outline of Incident

Works were undertaken to replace sleepers with hollow steel sleepers to facilitate the running of signalling cables and protect them from activities such as tamping. This is normal practice where the volumes of cables do not justify the installation of an Undertrack Crossing (UTX). This work involves digging out the ballast and as such disturbs the track bed which impacts on Critical Rail Temperatures (CRT), for a defined period until track consolidation is regained. This work was executed despite warnings of high temperatures and the reduction in CRT resulted in the need for track monitoring and a reduction in line speed via the implementation of Emergency Speed Restrictions (ESR). Trains were allowed to run at line speed over the site with site recorded rail temperatures, deeming a 20mph ESR should have been imposed on Sun 29th June 2025 when the CRT trigger temperature was reached. The CRT Register (extract below) was not updated until the morning on Monday 30th June.



Actions Taken

The Network Rail (NR) North and East Route team alerted our Renewals and Minor Enhancements (RenME) Management team to the situation on Monday morning. A call was held with Route team, RenME and Maintenance to discuss the urgency around implementing the required 20mph ESR on the afternoon of 30th June 2025. The ATUK Supplier Construction Manager contacted the Signaller and arrangements were put in-place for trains to proceed with caution between the limits: Down DOL – L625 Signal to L265 Signal and Up DOL – L620 Signal to L626 Signal on the afternoon and evening. A 20mph ESR was then designed and implemented on the Monday night shift (1st July).

Initial Known Facts / Causes Identified

- Subcontractor of ATUK installed hollow sleepers on the South Kirkby project at sites: SKR 170m 424y – 170m 428y DOL 1 Up & Dn roads and 170m and DOL 1 Down road, DOL1 & mileage 170m 424 – 170m 428y on Sat 28th June 25.
- Planned works were carried out despite warnings of predicted high temperatures and this was not questioned by the Principal Contractor's Responsible Engineers (CRE) or challenged on the Weekly Working Advice call (RenME)
- The CRT database was not updated at the time of executing the works.
- Mitigations were not implemented to react to live temperature data from site.
- Trains were allowed to run at line speed over the site with a site temperature of 45 degrees recorded.
- A 20mph ESR should have been imposed on Sun 29th June 2025 when the CRT trigger temperature was reached. CRT Trigger Temperatures at this site are: Watchman – 30degrees; 60mph ESR – 37 degrees; 20mph ESR – 40 degrees.
- Temperature readings on Monday 30th June 2025 (at 13:00hrs) also exceeded the 20mph ESR trigger temperature of 40 degrees.

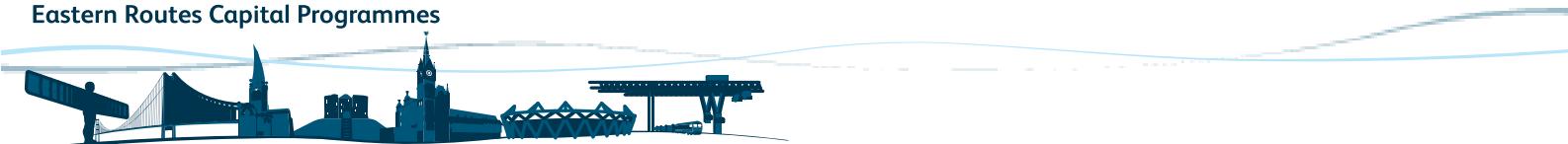
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Further actions

1. ATUK arranged for their supplier to provide a Track Supervisor to be on site to support with Hot Weather Patrolling / CRT Management activities and to act as the Site Rep & COSS. An external resource with the correct CRT competence was also deployed to site.
2. ATUK supplier provided a Safe Work Pack for the Hot Weather Patrolling / CRT Management activities. Initial thoughts were that line blockages would be required for the track staff to access the affected area, as they would need to travel from the Nostell Access Point through O/Br DOL1 44 which is an area of limited clearance.
3. ATUK supplier understood that the ESR could be lifted once the rail temperature reached 34 degrees (Down DOL) & 33 degrees (Up DOL). They would contact the signaller once these triggers had been met.
4. The ESR was removed at 02:53 on the morning of 2nd July 2025, following the required consolidation period detailed in the CRT standards.
5. RenME are to review the process for reviewing risks associated with CRT when in a dispositioned project structure (DPE with supplier) along with weekly working advise.
6. Level 2 Technical investigation commenced and led by Eastern Routes Capital Programmes Engineering team, supported by RenME Programme Engineering Manager and ATUK and suppliers.
7. ATUK have been paused from activities impacting on Track or CRT until the findings of the investigation are understood. There are no programme critical works at the present time.



Fast Facts



Amey

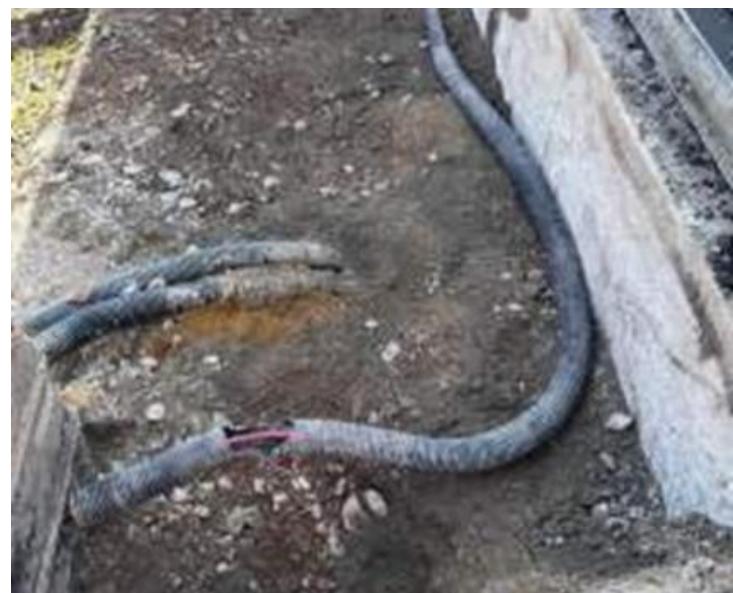
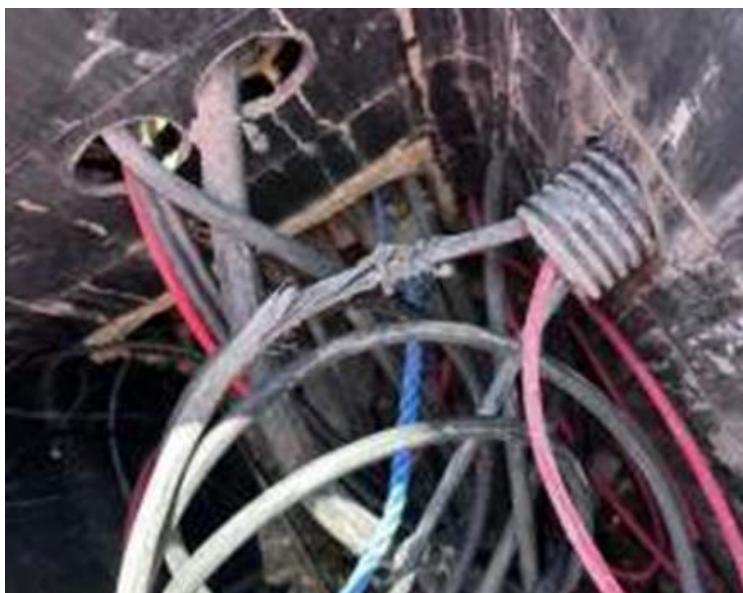
Note: This document contains information understood at time of incident and details may change following investigation.

Supplier Organisation	Amey	Project	Market Harborough
Date of Accident / Incident	28/06/2025	Time of Accident / Incident	12:00
Location of Accident / Incident	SPC3 83m 00ch	Type Accident / Incident	Infrastructure damage
Route Control Reference	Reference Number	IRIS Reference	43863

Outline of Accident Incident

During ACO drain removal on platform 1, the hearing aid loop cable duct was pulled upward as it was encased within the concrete below.

This pulling on the cable meant that it snagged on the chamber opening which has resulted in damage to one cable. Cable duct is being repaired to allow for future repair of cable.



Immediate Actions Taken

Ducting was fully exposed by hand to confirm route of cable and end connections.

Operatives re-briefed.

Initial Known Facts / Causes Identified

See above

Next Steps

- L1 investigation to be completed.
- Cable to be repaired.

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Fast Facts



Amey

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

Supplier Organisation	Amey	Project	Market Harborough
Date of Accident / Incident	29/06/2025	Time of Accident / Incident	07:00
Location of Accident / Incident	SPC3 83m 00ch	Type Accident / Incident	Infrastructure damage
Route Control Reference	Reference Number	IRIS Reference	43864

Outline of Accident Incident

A lighting column located within a non-operational area of the station was discovered to have been damaged. The area adjacent to the lighting column was being used to store aggregate material for the platform works, with excavator and dumper movements. It appears that the column was damaged during work once the stock-pile had reached a low level and the bulk timbers had been removed to allow the remaining aggregate to be removed. The cable within the column was not damaged.



Immediate Actions Taken

Plant operators were stood down and re-briefed.

Electricians were contacted to isolate and disconnect the column to allow the column to be lowered and protected.

Barriers were installed around each column to protect against further plant movements.

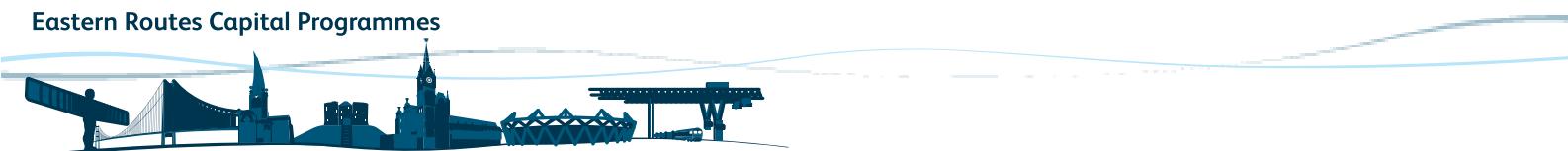
Initial Known Facts / Causes Identified

See above, causes currently unknown.

Next Steps

- Repair column and replace damaged parts.
- Level 1 investigation.

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- **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

