NetworkRail

CLIC

Sharnbrook Viaduct
Renewals and Minor Enhancements
Credit: Paul Tomblin

Issue 145
16th July 2025

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SPEED
PACE

Continuous Learning & Improvement Cascade

Eastern Routes Capital Programmes

What's in this issue…

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PROJECT ACE SPEED PACE

Continuous Learning & Improvement Cascade

Eastern Routes Capital Programmes

HSE KPI Changes

Changes to Periodic Waste Reporting from Period 5

The Technical Authority have made amendments to the HSE KPI tool in relation to waste metrics.
<u>These changes will come into force from Period 5 Week Commencing 21st July 2025.</u>

What Has Changed?

The HSE KPI (Health Safety and Environment) (Key Performance Indicator) tool has been updated. This is to better enable Network Rail to track our performance against our sustainability goals more effectively.

<u>Three new waste KPI's have been added relating to material reuse</u>. This is to distinguish between proactive resource efficiency and reactive waste management. Waste reuse happens after a material has been classified as a waste, whilst material reuse involves keeping materials in use before they become a waste – avoiding waste generation.

Please note this does not impact the other KPI's within the tool e.g., fuel use, hours worked, etc.

What You Need To Do

- Review the guidance note via the QR code below
- Start collecting data for the new and amended KPI's from Period 5.

Why has this changed?

- **Standardise data** entry and improve reporting quality.
- **Help identify cost-saving opportunities** such as materials reuse or process changes
- **Ensure we are compliant** and avoids legal risks through accurate waste and material reporting

A full summary of the changes can be found by scanning the QR code.

If you need help please contact a member of the Network Rail S&SD team.

Further Guidance:

SRSA at Wixams:
Giving Back to the Community & Safety Standdown

Volunteering at Sue Ryder Hospice

Last month, the South Rail Systems Alliance (SRSA) dedicated a day of volunteering to Sue Ryder's St John's Hospice. From raking lawns to moving donated railway sleepers, the team covered a lot of ground!

Teamwork in Action

Groups were assigned tasks across the grounds and heard from Hospice staff about their vital work. A showcase highlighted past charity initiatives completed to assist with sustaining the funding the Hospice needs to keep it operating.

"It's just great to have the extra support with us today as we usually only have a few retired volunteers to cut the lawn areas. The team being with us today really helps, and it's for the patients and their families that enjoy the peacefulness and the time to reflect." ***Hospice Staff Member***

Over £1,500 worth of Social Value was recorded as part of the day on the Rail Social Value Tool

Safety Standdown Day at the Wixams Compound

As part of Rail Safety Week, SRSA undertook a safety stand down event at Wixams, in collaboration with one of their plant suppliers. This focused on exclusion zones. Working with one of its plant suppliers, the day was broken into two sessions commencing with a site walk-out followed by the team having the opportunity to have a go using a plant simulator to appreciate the risk associated with operating a machine and maintaining exclusion zones..

What Happened

- A site walkout started the day, with teams discussed what exclusion zones look like on the ground and gauging blind spots
- Operators used plant simulators to experience the challenge of maintaining safe zones

Key Takeaways

- **Site walk-out**: A useful conversation on gauging a minimum of 10 metres and demonstrating driver visibility and blind spots on the ground
- **Use of plant simulation:** Provided a real sense of the challenges the operators face for both Road Rail Vehicle's and high street plant.

WIXAMS STATION

Road Safety Week 2025

Safer Driving In The Rail Industry

What is it?

This week (14th – 18th July) is Road Safety Week, an annual event coordinated by the Rail Standards And Safety Board (RSSB), Network Rail and Driving for Better Business (DfBB) . It aims to raise awareness of safer driving on our roads in the rail industry.

The theme of this year's week is 'Safe Driver', to highlight the responsibilities of every driver – and the organisation that they work for – to manage their safety and consider the safety of other road users.

Why Safe Driving Matters In The Rail Industry:

Rail relies heavily on road transport for several activities. Those include logistics, maintenance, and employee travel. But unsafe driving can lead to delays, financial losses, and serious accidents.

By prioritising safe driving practices, businesses can improve their efficiency, lower their costs, and protect their workforce. Rail industry leaders can also take proactive steps to promote safe driving.

Resources available:

DfBB's Fitness to Drive Toolkit which covers drink and drug driving, eyesight and medical conditions, driver fatigue, mental health and wellbeing and physical health.

DfBB's Driver Roadworthiness Guide – Practical strategies to help drivers self-assess and maintain their fitness to drive.

RSSB Webinar – Thursday 17th July – 10:30-11:30 this will provide insights on human factors in bridge strikes, managing driver health and wellbeing and ergonomic vehicle setup.

RAIL SAFETY AND STANDARDS BOARD

NetworkRail

Driving for Better Business

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Shared Learning

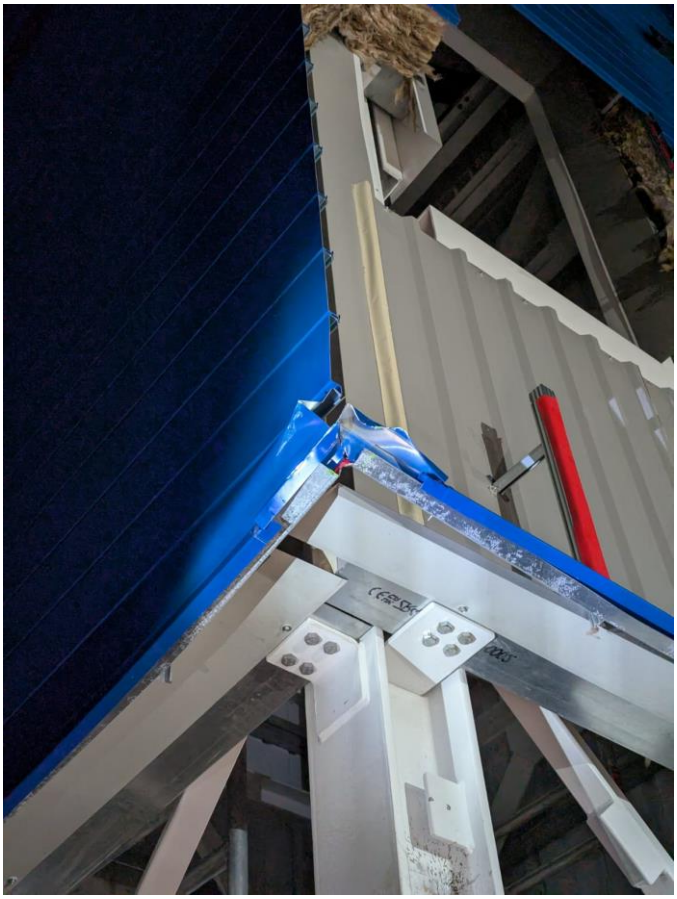
Supplier Organisation	Story Contracting	**Project**	Biggleswade AFA
Date of Accident / Incident	04/05/25	**Time of Accident / Incident**	03:45am
Location of Accident / Incident	Biggleswade Platform 1&2	**Type Accident / Incident**	Damage to Property

Outline of Accident Incident

A MEWP was on site and positioned (basket facing south) between the lift shaft and the trestle foundation – it was on site to facilitate the undoing of the lifting points on the top of the lift shaft once the lift shaft had been lowered into position. The MEWP was moved from its parked configuration by a sub-contractor whilst the lift shaft was being positioned on to the holding down bolts.

Once the lift shaft was over the install area, tag lines were used to lower the shaft in position. Due to the restricted access inside the hoarding the contractor couldn't get the pull on the tag line to turn the lift haft whilst being lowered. A Carver operative decided to get into the MEWP to help turn the lift shaft to assist his colleagues line up the shaft with the bolts on the ground. The tag lines were not able to pull the shaft into the correct position– whilst lowering the load the corner sill of the shaft caught the edge of the MEWP basket causing minor damage during installation.

The lift supervisor and crane operator were using 2-way radios as is their standard practice. The Lift supervisor was controlling the lift movements and was in direct communication with the crane operator via two-way radio.



Causes

- A sub-contracted operative used a MEWP for an activity that was not described in the RAMS – Tag lines only should have been used
- The Story site manager should have stopped the works when they deviated from the contractor RAMS
- The Story site manager should have reported to route control and completed internal Story reporting procedures
- Pre-clad lift shaft was used to minimise work on site

Actions taken to prevent recurrence

- Re-fresher to all Story Site Managers and Supervisors on the requirement to report via Eco-online and how to report – lunch & learn
- Direct management of sub-contractors

Key Messages & Learning for Others

- Greater supervision of sub-contractors
- Greater Story training of sub-contractors
- Training in the use of at point of work risk assessment. POWRA to be used when operational circumstances change and work cannot be carried out in accordance with planned methodology.

Shared Learning

Supplier Organisation	SPL Powerlines	**Project**	OLE 125 Compatibility and Enhancements Project
Date of Accident / Incident	24TH February 2025	**Time of Accident / Incident**	02:15hrs
Location of Accident / Incident	Leagrave	**Type Accident / Incident**	Electrical Tripping Event

Outline of Accident Incident

On the 24th February 2025 following the cancellation of the Leagrave OLE Form B at 02:11 electrical sections 624 DEF tripped whilst the ECO attempted to re-energise the system.

Derby ECR called the Nominated Person @ 02:15 to state electrical section 624 DEF Down Slow had tripped between Long Meadow Farm and switch 624/4 @ structure F50/07 when they had attempted to re-energise.

Initially the tripping was thought to be caused by an earth left in situ at F51/17. The Isolation Team walked the site, but no earth was found. The ECO attempted to re-energise the system again and this time the attempt was successful.

Causes

- Two Nose Droppers had been incorrectly installed by SPL's sub-contractor Pod-Trak
- The Nose Droppers were installed on the wrong side of the insulation on both the Down Slow and Up Slow at structure F50/15.

Actions taken to prevent recurrence

- The Contractor's Responsible Engineer (CRE) will now operate as an independent entity and will ensure all works are reviewed and approved in real time prior to hand-back.
- The Supervisor and Engineer will jointly review the work to ensure conformity with the approved design. Any deviations will be assessed, escalated through the CRE for acceptance and documented via the Field Change Request (FCR) process.
- The FCR process to be re-briefed.
- SPL will supply a dedicated OLE engineer on site who will review each location to confirm the construction works align to the AFC drawings and the infrastructure is fit for service

Key Messages & Learning for Others

- Always check that construction works comply with the design and AFC drawing prior to handing back asset.

Fast Facts

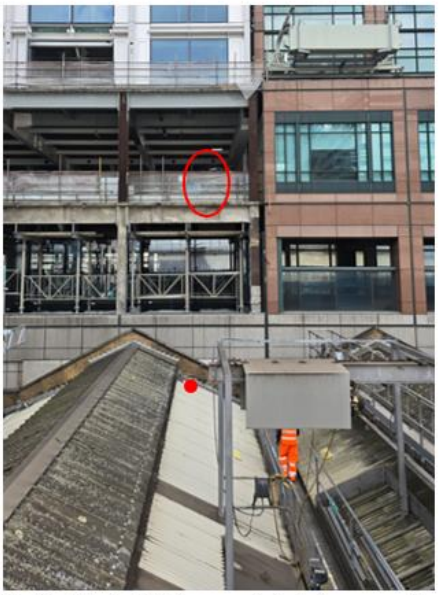
MORGAN SINDALL INFRASTRUCTURE

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

Supplier Organisation	Morgan Sindall	**Project**	Liverpool Street Station
Date of Accident / Incident	15 July 2024	**Time of Accident / Incident**	19:30hrs
Location of Accident / Incident	Liverpool Street Station	**Type Accident / Incident**	Scaffold Tube Fell from Height
Route Control Reference	ASPRO Incident	**IRIS Reference**	ASPRO Incident

Outline of Accident Incident

A scaffold tube fell from an adjacent construction site (a third-party developer works), penetrating the aluminium roof at London Liverpool Station and landed in the Morgan Sindall Principal Contractor area during their non-working hours. Damage was caused to both the roof and the Morgan Sindall crash deck.



Scaffold tube fell from red circled area and penetrated roof at red dot

Roof penetration point

Penetration point (top circle) and scaffold tube landing point on crash deck (bottom circle)

Immediate Actions Taken

- The Third Party's Contractor undertaking the works contacted a member of the Network Rail Station team via email on the morning of 16th July to inform them of the incident. The Network Rail Station team then advised Morgan Sindall who in turn informed the Network Rail Project Delivery team responsible for the station roof project.
- Third Party Contractor, Morgan Sindall and Network Rail personnel attended site on the morning of 16th July to further understand the incident.
- Morgan Sindall's safety team have liaised with the Third-Party Contractor on site and gained assurances that there are no other works taking place that could import risk to the Liverpool Street Roof project works.
- The Network Rail Senior Programme Manager has contacted the Management Consultant responsible for the Third Party works to seek assurance on preventative measures being put in place and to obtain further facts on why the works were taking place and not notified to Morgan Sindall.

Fast Facts

Initial Known Facts / Causes Identified

- The adjacent construction site where the tube fell from is not a Network Rail project. The project is for a third-party developer and is overseen by the Anglia Route, Network Rail Asset Protection team (ASPRO). The ASPRO team provides expert railway safety and support for those planning activities on or near the railway.
- The Third-Party Contractor undertaking the works and Morgan Sindall have regular stakeholder meetings discussing and agreeing works as part of their Principal Contractor duties to co-ordinated an communicate.
- It had been previously agreed that the Third-Party Contractor scaffolding works in this specific area where an exclusion zone was required could take place between the hours of 1700 hours and 2200 hours over a 4-day period and these works were successfully completed and confirmed on 11th June 2025. No further agreements have been made since this date.

Next Steps

- The Network Rail Route team via ASPRO will be requested to instruct the Third-Party Developer formally for the need to an investigation into the incident.
- Roof repairs works will be discussed between the Network Rail Senior Programme Manager and the Network Rail Route Team.

Fast Facts

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

Supplier Organisation	Story Contracting	**Project**	Biggleswade AFA
Date of Accident / Incident	07/07/2025	**Time of Accident / Incident**	16:30 hrs
Location of Accident / Incident	Public Road outside Train Station	**Type Accident / Incident**	Environmental Spill
Route Control Reference		**IRIS Reference**	44085

Outline of Accident Incident

On the 07/07/2025 at approximately 17:00 as the site was shutting down for the day site operative noted that a contractor vehicle which previously been on site was now parked on the public road and had sustained a small oil leak after leaving site.

Site operatives stopped to help the driver of the vehicle and prevent any environmental issues by putting sand down whilst the driver was awaiting recovery from his company.

There was no threat to ground or surface waters

Immediate Actions Taken

Operatives on site immediately assisted the driver, putting down absorbent material to prevent the oil reaching any surface or ground waters.

Recovery /Fitter called to attend the vehicle.

Initial Known Facts / Causes Identified

Small oil leak occurred after leaving site.

Probably due to a burst hose or failed coupling in the hydraulic system.

Note: The event was initially incorrectly identified / reported as a Hazard Spotter (Close Call) which resulted in late reporting of the event.

Next Steps

- In conjunction with the sub-contractor / delivery organisation establish probable cause of the oil leak.
- Ensure environmental spillages are correctly reported immediately in line with the event reporting process and not as Hazard Spotters (Close Calls).

Fast Facts

RESTRICTED

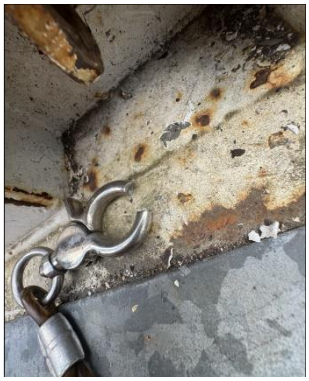
Note: *This document contains information understood at time of incident and details may change following investigation.*

Supplier Organisation	Alstom	**Project**	Cambridge (C3R)
Date of Accident / Incident	11/07/2025	**Time of Accident / Incident**	13:15 (Time of discovery)
Location of Accident / Incident	Shepreth Compound	**Type Accident / Incident**	Theft
Route Control Reference	3091634	**IRIS Reference**	44068

Outline of Accident Incident

On 11/07/2025 at around 13:15, one of the engineers working on the C3R project attended Shepreth compound to meet Aggreko to top up the fuel bowser for Shepreth DNO. While on site, the engineer discovered that there had been a break in and approximately a 1/4 of a tank of fuel has been stolen.

This comes after a close call was raised on 09/07/2025 highlighting that the access gate was not secure upon arrival and the padlock missing at Shepreth compound.



Photos taken at the time of discovery.

Photo of the action taken to secure the fuel bowser.

Immediate Actions Taken

The engineer secured the bowser using a small abus lock
BTP were contacted and informed of the fuel theft – crime reference 2500083284.
Fuel deliveries to the location have been paused until additional measures have been implemented to secure the area.

Initial Known Facts / Causes Identified

The theft is still under investigation however a possible timeline to identify when the theft could have occurred is being conducted.

Next Steps

- Alstom are to assist and provide information as part of British Transport Police's investigation.
- The civils team on the project have been contacted to install additional heras fencing along with a cover to act as another preventative measure.
- Alstom's security team and security provider have been informed and other compound areas of the project are being reviewed.
- Additional site visits are to be conducted at the compound areas to detect for early signs of criminal activity.

Fast Facts

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

Supplier Organisation	CK Rail Solutions Ltd	**Project**	Springs Tunnel
Date of Accident / Incident	04.07.2025	**Time of Accident / Incident**	01:32hrs
Location of Accident / Incident	Springs Tunnel Compound, Mileners, Yeadon, Leeds LS19 7JE	**Type Accident / Incident**	Attempted Theft
Route Control Reference	N/A (Police incident no-0119)	**IRIS Reference**	44022

Outline of Accident Incident

On 04.07.2025. Approximately 01:32hrs, Intruders were reported on the Springs Tunnel site compound. They entered through the main access gate by partially lifting it and crawling underneath (see photo below). The security alarm was raised automatically when it detected the movements of people, and police were called. Approx. At 02:00, police were on site along with the security service response officer, suspecting that intruders could still be on the premises. The police advised the mobile guard to remain outside for safety reasons while they conducted a thorough search and confirmed no individuals were present.

No theft and damage recorded.

Immediate Actions Taken

- Police and security service team attended on-site approximately. 30 minutes after the intruder alarm was activated.
- Communicated with the project team.

Initial Known Facts / Causes Identified

- The security alarm activated as intended, which may have caused the intruders to leave prior to the police attending the site.

Next Steps

- The project team reviewed the security arrangements on site to ensure that the compound security arrangements were suitable and sufficient.
- Operatives were briefed on the safe storage of tools and equipment in the site compound before leaving the shift.
- Discussed with the police to increase their patrolling on the site location.
- Undertook a company-wide briefing on the site security and safety.

Safety Bulletin

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Train derailment at Denbigh Hall South Junction

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

Ref: NRB25-02

Date of issue: 14/07/2025

Location: Denbigh Hall South Junction, West Coast South, NW&C

On Thursday 26 June 2025 1Y26 was declared a failure at Bletchley Station on Platform 4 (Up Slow). Due to the nature of the failure the train could no longer be driven from the front (up direction) cab. It was decided to send the train to King's Heath Depot in Northampton as 5Y26.

There is a signalled route available to make this move from Bletchley Station Platform 4, however this was unavailable due to an unconnected points run through within a possession earlier that day. It was decided to make a wrong direction move towards Denbigh Hall South Junction where it was intended to cross 5Y26 from the Up Slow to the Down Slow. A wrong direction move when a train can no longer be driven from the front cab is permitted in RSSB GERT-TW7 section 1.1.

Denbigh Hall South Junction is a flat junction where the Down and Up Bletchley Lines join the West Coast Main Line Down and Up Slow Lines. The Down Bletchley joins the Down Slow using TK262 which is the designation for combined trailing points (TK262A) on the Down Slow and a Switch Diamond (TK262A/B) on the Up Slow. Switch Diamonds are not intended to allow trains to cross from one line to the other.

It was decided to reverse TK262 A / B / C to cross 5Y26 from the Up Slow to the Down Slow. The route was checked by a second signaller and verified by the Shift Signaller Manager (SSM) in Rugby SCC. **Neither the controlling signaller, or the signaller who checked the route and the SSM, realised that the move could not be made using a switch diamond.**

The controlling signaller gave instructions to the driver of 5Y26 to make the wrong direction move. At 12:29 the driver of 5Y26 made a GSM-R REC call to advise the signaller that the train had derailed.

This incident is currently under investigation by the Rail Investigation Branch, ORR and Network Rail. Whilst the investigation takes place it is important to remember the requirements for the management of Operational competence.

Safety Alert | Safety Bulletin | Safety Advice | Shared Learning

Safety Bulletin

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Discussion Points

- How do you assure that staff have the capabilities to manage all aspects of degraded situations, such as Wrong - Direction movements, passing signals at danger or operating level crossings during failures?
- How do you make sure that all your staff are aware of the capabilities of the infrastructure in their area of control?
- Before authorising any train movements, how do you use your situational awareness and 'Take 5' moment to assure yourself that the route is valid, the infrastructure can support the move, and that you've considered all available information, especially when the movement deviates from the norm?
- How do you manage the risk of skills fade and how robust are your training plans?
- How can the learning from incidents be shared across the industry?
- How do you ensure there is the correct decision-making authority at your location?
- How do you ensure that your staff have the correct decision-making tools and can interpret them appropriately?

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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