CLIC

Issue 153 – *11th September 2025*

Simpler
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Continuous Learning & Improvement Cascade
Capital Programmes Eastern

Welcome to another issue of CLIC

This week's cover page features the Access for All (AfA) scheme at Menston Station.

At Menston the existing staircase-only footbridge has been demolished, making way for brand new lifts, stairs and footbridge, providing step free access to both platforms.

The project is a challenging one, in close proximity to local residents and with the local children's nursery actually housed inside the station building. Despite high winds, heavy snows, busy possessions and uncharted services, the Amco and Network Rail team have continued to deliver the project safely and on time, with the lifts expected to open to the public early next year.

Amco have done great work with the local community, presenting engagement sessions with the local high school, and especially with the nursery based in the station. Amco have maintained safe access for the staff and children, issued infant sized PPE, and even worked around designated nap times! The playground will be receiving some new outdoor play equipment and rail themed decoration courtesy of Amco's carpenters. If you have any questions on the great work we're doing at Menston, please do contact myself directly or my colleague Victoria Proudlock.

Building on the success of our recent scaffolding safety workshop, this lifting collaboration session brought teams together to tackle shared risks, spark innovation, and strengthen safety around lifting operations. Discover the key insights and what's coming next.

Suicide remains the leading cause of death among men under 45, and rates among young women continue to rise. Yesterday, on World Suicide Prevention Day, the Samaritans reminded us that suicidal thoughts can be interrupted—and that small moments of connection can save lives. Whether you're a friend, colleague, or stranger, showing you care can make all the difference. The campaign, shaped by people with lived experience, offers practical ways to spot the signs and support those in crisis. Let's carry this message forward because prevention doesn't stop with a single day.

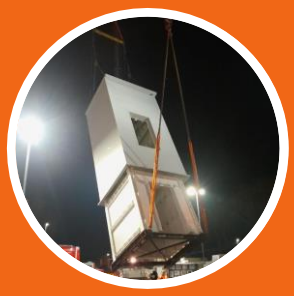
Finally, we bring you a roundup of fast facts and shared learning from recent incidents, demonstrating the continued importance of open learning and knowledge sharing across our programmes.

Matt Armstrong
Lead Portfolio Manager
Renewals & Minor Enhancements Team,
Eastern Region Capital Programmes

In this issue…

Lifting Collaboration Session

Strengthening Safety Through Shared Practice



Why We Held the Session

In response to a couple of recent incidents across our projects, a **People Interfacing with Lifting Collaboration Workshop** was held last week. While the incidents differed in nature, a closer review revealed shared contributing factors, particularly around communication technology and restricted working environments.

Recognising the opportunity for shared learning, the session brought together **Supply Chain Partners** and **Network Rail colleagues**, including representation from the **North-West & Central Region**, to explore these themes collaboratively. The aim was to identify practical improvements and strengthen our collective approach to lifting safety, particularly around people interface with lifting operations.

The session created space for open dialogue, where participants shared real-world experiences and discussed opportunities to strengthen lifting assurance regimes. The session focused on identifying common issues, reinforcing good practice, and generating ideas for additional controls that could be adopted across the supply chain.

Key Themes Discussed

- Communications during lifting and landing
- Competence and mentoring of those involved in lifting
- Management of exclusion zones and site-level control
- Good practice and innovations being implemented on projects
- Industry guidance “hands off, step away, safe space”
- Designer involvement, including transportation and installation

What’s Next?

The outcomes of this session will be shared at the ERCP Renewals Chain Meeting and the ERCP Health & Safety Managers Forum. These forums bring together suppliers to share learning and best practice, helping to drive continuous improvement across our infrastructure.

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World Suicide Prevention Day

Suicide is the single biggest killer of men under the age of 45 in the country, but suicides among teenage girls and young women have almost doubled in recent years

Yesterday was **World Suicide Prevention Day**, the Samaritans are sharing one important message: If you think someone might be suicidal, take action, interrupt their thoughts and show them you care.

Every 90 minutes, someone in the UK or Ireland dies by suicide* and 1 in 4 of us has had suicidal thoughts.**

Suicidal thoughts can be interrupted. The Samaritans surveyed people with lived experience of suicide, and the majority told us that their suicidal thoughts have been interrupted.***

- 60 % said their suicidal thoughts had been interrupted by someone close to them, like a friend or family member.
- 14 % said their suicidal thoughts had been interrupted by a stranger or someone they didn't know.

The **World Suicide Prevention Day 2025** campaign has been co-created with people who have lived experience of suicidal thoughts. These have been shared their experiences and insights to help you take action if you suspect someone may be suicidal. For more information, please scan or click the following webpages:

[How to interrupt someone's suicidal thoughts]

[Ideas for how to support yourself if you're struggling with suicidal thoughts]

*Office for National Statistics (2024). Suicides in England and Wales: 2023 registrations. National Records of Scotland (2024). Probable suicides 2023. Northern Ireland Statistics and Research Agency (2025). Northern Ireland Suicide Statistics, 2023. Central Statistics Office. (2024). Suicide death rates.

**NHS Digital. (2025). Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/24.

***Based on a survey with Samaritans' Lived Experience Panel, which had 65 responses, 92 % of which were from people with lived experience of suicidal thoughts

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Fast Facts

RESTRICTED

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

Supplier Organisation	Alstom Transport UK	**Project**	Ferrybridge to Goole Re-signalling
Date of Accident / Incident	04th September 2025	**Time of Accident / Incident**	01:30 hrs
Location of Accident / Incident	Thorne Moorends	**Type Accident / Incident**	Railway infrastructure fault
Route Control Reference	Reference Number 993221	**IRIS Reference**	Reference Number 44435

Outline of Accident Incident

A Civils Contractor attended Thorne Moorends level crossing to carry out scheduled material deliveries. Upon receiving authorisation from the Engineering Supervisor, the Controller of Site Safety (COSS) permitted the contractor team to proceed with loading materials onto a Track Trolley at the crossing.

Once the trolley was fully loaded, the team began to move it clear of the level crossing and associated trespass guards. At this point, the Controller of Site Safety called out to the trolley operator to confirm that all materials had been securely loaded. In response, the operator applied the trolley's brakes to conduct a check. During this action, a 20-litre water container dislodged from the trolley and struck a Track Circuit cable (ST38) located in the rail web, resulting in damage to both the cable and its connection.

The incident was not immediately reported by the Controller of Site Safety. It was only after the Civils team reached their delivery location that the Controller of Site Safety informed the Engineering Supervisor of the event.

Immediate Actions Taken

The incident was reported to the Engineering Supervisor, who then escalated to the Signaller and Fault Control ref CCIL 993221. The Fault team attended site during the Possession and made the necessary repairs allowing right time hand back of the line.

Initial Known Facts / Causes Identified

Although the incident was reported with sufficient time for the Fault team to rectify, the Controller Of Site Safety did not report the incident as it happened.
The materials were loaded on to the trolley without ensuring they were secure and couldn't fall.

Next Steps
Provide a detailed outline of what the next steps are in terms of investigation and actions that will be taken following the event in the form of a bulleted list.

- Next steps 1 Site teams stood down and briefed on reporting procedures.
- Next steps 2 Loads are to be assessed before travel
- Next steps 3 Investigation to be conducted

Fast Facts

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

Supplier Organisation	J Murphy & Sons	**Project**	Cambridge South
Date of Accident	07 September 2025	**Time of Accident**	0830
Location of Accident	Cambridge South	**Type Accident**	Slips, Trips, and Falls
Route Control Reference	3123667	**IRIS Reference**	44442

Outline of Accident Incident

During weekend works at Cambridge South station, a subcontractor member of staff (scaffolder) rolled his ankle on an exposed Steel Frame System when removing the platform screen and edge protection on the island platform.

Immediate Actions Taken

- Medical treatment was offered to the injured person, and they were encouraged to go to hospital for advice which were both declined.
- Statement was taken from the Injured person
- The event was immediately reported on Murphy internal system, however there was a delay in reporting to Route Control & the NR project/safety team

Initial Known Facts / Causes Identified

- Work area was present with uneven ground conditions
- IP signed onto Point of Works Risk Assessment (POWRA) which included "Take extra care while working and carrying materials"
- Injured Person rested at home as a precautionary measure and has now returned to work on full duties

Next Steps

- Level 1 investigation underway.
- Area sweep has been conducted by the site teams to eliminate potential trip hazards.

Fast Facts

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

Supplier Organisation	Kent PHK Ltd	**Project**	1060 - East Midlands PSP's Project
Date of Accident / Incident	04/09/2025	**Time of Accident / Incident**	14:30
Location of Accident / Incident	M1	**Type Accident / Incident**	RTA
Route Control Reference	N/A	**IRIS Reference**	44437

Outline of Accident Incident

At approximately 14:30 on Thursday 4th September 2025, whilst traveling back home from site at Market Harborough a Subcontractor vehicle carrying 4 members of staff was involved in a collision on the M1 Northbound. Shortly after joining the motorway there was a multiple vehicle collision that resulted in the subcontractor van running into the back of the vehicle in front. Thankfully no major injuries were sustained with minor injuries being reported.

Immediate Actions Taken

- Police attended scene
- Arrangements were made by Kent PHK to send another van to collect the Subcontract staff and transport back home safely
- Fatigue Index was assessed and all staff where within the risk limits
- Recovery of vehicle
- First Aid given to those requiring it
- Initial statements and photos gathered to produce Fast Facts
- Alternate vehicle to be arranged

Initial Known Facts / Causes Identified

- Multiple vehicle collision in front and unable to react
- Changing weather conditions – Wet Road surface / spray.

Next Steps

- Staff stood down from work the next day Friday 5th September 2025
- Staff expected to return to work on Monday 8th September 2025 once alternate vehicle is acquired
- Further information / facts gathering to determine any contributing factors
- Lessons learnt and re brief to staff
- Liaise with Network Rail to close down IRIS

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**	West of Netherton
Date of Accident / Incident	07.08.2025	**Time of Accident / Incident**	08:05hrs
Location of Accident / Incident	West of Netherton site Compound	**Type Accident / Incident**	Darlek CCTV Damage
Route Control Reference	N/A	**IRIS Reference**	44450

Outline of Accident Incident

On 07.08.2025. At the beginning of the shift, approximately 08:05 hours, at the site compound, the dumper driver walked from the rear of the vehicle to enter the vehicle cab. Upon entering the vehicle cab, the operative proceeded to drive forward and as he did, the dumper came in contact with a Darlek CCTV positioned close to the vehicle in the compound.

Immediate Actions Taken

- The site team was immediately stood down to address the incident.
- Reported Internally (CK Rail Incident Report system).
- A toolbox talk was conducted with the site team on safe vehicle movements and the awareness of the surroundings.

Initial Known Facts / Causes Identified

- The dumper driver did not undertake the pre-use walk around checks before moving the dumper.
- Consequently, the dumper driver failed to notice the Darlek CCTV, which was positioned close to the vehicles parked in the site compound.
- No Banksman was present at the time of the incident.

Next Steps

- Banksman was deployed for all the vehicle movements in the site, and the site teams are using the Three-way det comms for all Vehicle movements.
- Level 1 Investigation in progress.

Fast Facts

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

Supplier Organisation	Balfour Beatty Rail Ltd (CRSA)	**Project**	East IUT – Darlington
Date of Accident / Incident	07 September 2025	**Time of Accident / Incident**	C. 00:44hrs
Location of Accident / Incident	Darlington	**Type Accident / Incident**	Possession Irregularity

Outline of Accident Incident

At 00:24, the Person in Charge of Possession (PICOP) granted permission for the Engineering Supervisor (ES), who was working under mentorship, to place Marker Boards as part of the possession arrangements. At 00:35, the ES confirmed that all required boards were in position and the worksite was granted.

As part of routine checks, the PICOP believed Marker Boards had not been positioned on Platforms 2 and 3. The ES was then instructed to correct what was thought to be an omission. In response, the ES placed additional Marker Boards on those platforms and returned to signing staff into the worksite as required.

The PICOP subsequently asked the ES to stop signing staff in and reported what he considered to be an irregularity to Route Control. A Mobile Operations Manager (MOM) was dispatched to site, where they took statements and supervised for cause testing.

The ES was under mentorship, as recorded in the PICOP Pack. Both the ES and the ES mentor (Vital staff working for CRSA) were stood down from site and replaced, which allowed the planned works to continue safely.

Immediate Actions Taken

- Level 3 On Call made aware
- MOM attended site and took statements
- ES under mentorship and ES Mentor stood down and for cause tested – Vital On Call Manager made aware
- Worksite taken over by BAM Nuttall ES
- CRSA Fast Facts Issued

Initial Known Facts / Causes Identified

- Later review confirmed that no Marker Boards had been planned or required for Platforms 2 and 3, and their placement had not been agreed (or required) at the PICOP briefing, nor was it detailed in the PICOP pack (this was correct).
- All stabled trains were already appropriately secured with “Do Not Move” signs and derailers, which would have provided protection in the event of any unauthorised movement.
- The PICOP pack did not reference the use of “Do Not Move” boards or derailers, which may have contributed to the PICOP’s concern. However, both control measures were in place and clearly visible on site at the time of the incident.
- Both the ES under mentorship and the ES mentor had prior experience working at the Darlington site. The ES under mentorship, however, was relatively new to the ES role itself.
- At no stage, either at the beginning of the shift or shortly afterwards, did the PICOP indicate to the ES that he wished to amend the plan by placing Marker Boards on Platforms 2 and 3. The subsequent decision to place boards at these locations was contrary to the arrangements agreed during the PICOP meeting.

Next Steps

- Level 1 investigation by CRSA commenced
- Initial learning from the event will be shared with BAM, as the possession lead, during future weekend works.

Shared Learning

Supplier Organisation	J Murphy & Sons	**Project**	Cambridge South
Date of Accident / Incident	26- July 2025	**Time of Accident / Incident**	08:30 hrs
Location of Accident / Incident	Cambridge South	**Type Accident / Incident**	Lifesaving Rule Breach

Outline of Accident Incident

On the Cambridge South Enhancement project, two Electricians were identified working on the station roof without suitable edge protection or work restraint equipment in use. The planned activity consisted of cable re-routing for the irrigation system and the individuals had been briefed on the requirements to always wear work restraint equipment.

The investigation findings identified a series of deficiencies in managing the Work at Height activity including:

1. Inadequate review and approval process of methodology and risk assessment.
2. Inappropriate levels of supervision.
3. Failure to Speak Up and challenge unsafe acts.

1) The proposal for the works to be undertaken was accelerated and as such the Risk Assessment and Work Package Plan were presented late to the site manager for approval. This meant that all paperwork was not reviewed, and the author assumed that hearing nothing to the contrary, it was OK to proceed with the work.

2) The level of supervision provided for the undertaking of the task was deemed to be inappropriate and the lack of oversight for this activity enabled the workforce to commence works without adhering to the stipulated controls.

3) The team undertaking the works failed to act on their instincts of personal risk perception and challenge unsafe practices.

Actions taken to prevent recurrence

- Project team have undertaken a thorough review of nominated personnel as duty holders for Working at Height activities including:
  - Work at Height Coordinator.
  - Permit Issuer & Acceptor.
- Targeted safety standdown undertaken with the entire workforce with a key emphasis on the duty holders' responsibilities with individual letters of appointment issued for accountability and ownership.
- Implementation of area Supervisor allocation for the project clearly defined.
- Fair Culture model proceedings for individuals directly involved in the event.

Key Messages & Learning for Others

- Have competent duty holders been appointed to ensure Working at Height activities are correctly managed?
- Has your project been provided with suitable level of supervision and are they able to oversee the planned works?
- Have you considered eliminating the risk of working at height at design stages?
- **Remind your Project teams to Speak Up and Take 5 for Safety.**

Do you have something to share that others could learn from? Whether it's related to Health, Safety, Environment, or Social Value, we're always looking for stories, initiatives, and insights to feature in future issues. If you'd like to contribute—or if you'd like access to past editions of the CLIC—please get in touch by emailing: **clic@networkrail.co.uk**.