CLIC

Safety Events Digest

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Continuous Learning & Improvement Cascade
Capital Programmes Eastern

Fast Facts

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

Supplier Organisation	Rail Electrification Alliance	**Project**	ECML PSU
Date of Incident	25/02/2026	**Time of Incident**	05:30
Location of Incident	Langley STATs, Stevenage	**Type Incident**	Crime & Security (Theft)
Route Control Reference		**IRIS Reference**	44874

Outline of Incident
A trespass and theft occurred at Langley SATS in the early hours of 25 February 2026. Unknown individuals gained access to the site, forced entry into containers, and removed a range of materials and tools. The incident resulted in both theft and damage to site infrastructure.

Stolen Items / Damage included:

- Copper tape
- Cembre crimp tool
- Drills
- Various fixings
- Damage to CT equipment
- Multiple containers broken into

Immediate Actions Taken
British Transport Police notified and crime reference obtained

TCS Security contacted for the overnight duty report, which has been issued

Network Rail / Vital trespass team attended the site

MOM applied a new XJK 859 padlock to secure the access gate at 05:15

Key Message
This incident highlights the ongoing risk of trespass and theft across operational sites. All teams must remain vigilant, ensure security measures are in place at the end of each shift, and report any suspicious activity immediately. A review of site security arrangements will follow to prevent recurrence.

Next Steps
- Security Review: All site managers to review current security arrangements, including container locks, lighting, CCTV coverage, and perimeter integrity.
- Incident Reporting: Any further information, suspicious activity, or similar incidents must be reported immediately to the local manager and security team.

Fast Facts

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Supplier Organisation	Story Contracting Ltd	**Project**	River Sheaf Bridge Renewal
Date of Accident / Incident	28/02/2026	**Time of Accident / Incident**	14:30hrs
Location of Accident / Incident	Dore and Totley Station	**Type Accident / Incident**	Unplanned Lift
Route Control Reference	N/A	**IRIS Reference**	44883

Outline of Accident Incident

- A new bridge deck was planned to arrive at the Story compound in the station car park during the day shift and remain on transport. The load was planned to be lifted from the transport into its proposed temporary location in the wideway during the following night shift.
- During the day shift, the new bridge deck was removed from the transport and lowered towards the ground in the car park. The load was held by the crane with timber packers placed underneath to prevent swaying. There was no temporary works design for landing the deck on the ground in the car park.
- During the night shift, the new bridge deck was lifted into its proposed temporary location in the wideway.

Immediate Actions Taken

- Car park surfacing checked to ensure no signs of damage from taking potential partial deck load

Initial Known Facts / Causes Identified

To be determined.

Next Steps

- Investigate decision making for removing the deck from transport
- Assess any risks imported by deviating from plan

Fast Facts

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Supplier Organisation	Story Contracting Ltd	**Project**	Crews Hill
Date of Accident / Incident	03/03/2026	**Time of Accident / Incident**	16:00
Location of Accident / Incident	Crews Hill-ES6-8	**Type Accident / Incident**	Property Damage
Route Control Reference	3220032	**IRIS Reference**	44880

Outline of Accident Incident

On Tuesday 03rd March 2026 at approximately 16:00, a 20-tonne excavator was transporting steel piles from the site compound to the working area. As part of the site setup, temporary double gates had been installed at both sides of the public footpath to maintain segregation between plant activities and members of the public.

During a routine movement of piles, the excavator travelled through the temporary gates under control of a designated banksman, with a gateman positioned at the footpath to monitor for any public access. Weather conditions included notable wind, which is believed to have caught the gate leaf. This caused the gate to swing shut unexpectedly toward the machine.

The gate became caught in the excavator tracks, resulting in damage to the gate.

The operator and the banksman were unaware the gate was caught until the damage had occurred.

Existing control measures were in place at the time of the incident:

- Dedicated communications (Det-Coms) between operator and banksman
- Exclusion zones around the working area were being adhered to
- Gateman observing the public footpath, which typically has fewer than 6 users per day

No injuries occurred, and no members of the public were exposed to risk.

Immediate Actions Taken

Inspection of all temporary gates on site to ensure they are adequately secured against wind loading and unintentional movement.

Review of gate-retention methods, including the potential installation of latches, drop bolts, or temporary restraints to prevent recurrence.

Briefing to all plant operators, banksmen, and gatemen to reinforce the need to visually confirm gate positions before plant passes through.

A Toolbox talk to be issued to the team & replacement of the damaged gate to reinstate full segregation as soon as possible.

Initial Known Facts / Causes Identified

High wind & no latches to secure gate from unexpected movements.

Next Steps

- Level 1 investigation commenced.

Fast Facts

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

Supplier Organisation	CRSA	**Project**	Capital Delivery
Date of Accident / Incident	07/03/2026	**Time of Accident / Incident**	07:00 hrs
Location of Accident / Incident	Cowton	**Type Accident / Incident**	RRV Oil Leak
Route Control Reference	TBC	**IRIS Reference**	44892

Outline of Accident Incident

- Liebherr 920 RRV Fleet No 7198-machine burst its main drive pipe.
- This resulted in a spray of approximately 5 litres of Hydraulic oil.
- A spill kit was deployed, and there was no contamination identified.

(Not actual RRV that had oil leak)

Immediate Actions Taken

- reported to on call.
- Spill kit was deployed.

Initial Known Facts / Causes Identified

- Hose Failure

Next Steps
Outline of what the next steps are in terms of investigation and actions that will be taken following the event:

- Confirm all hoses have been inspected for wear & tear before next deployment.

Fast Facts

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

Supplier Organisation	CRSA	**Project**	Capital Delivery
Date of Accident / Incident	08/03/2026	**Time of Accident / Incident**	09:30 hrs
Location of Accident / Incident	Cowton	**Type Accident / Incident**	Foot Injury
Route Control Reference	TBC	**IRIS Reference**	44891

Outline of Accident Incident

- MOS under instruction was moving an offcut of rail from the cess to a rail mounted trolley.
- The offcut of rail was circa 1 meter in length and was being carried by the IP and one other operative.
- The offcut of rail slipped from the IPs hand onto a sleeper end and then rolled onto the IPs right boot.

Immediate Actions Taken

- Reported to on call.
- IP attended A&E – Xray's taken, no broken bones only slight bruising was sustained.

Initial Known Facts / Causes Identified

- Correct PPE was being worn at the time of the accident.

Next Steps
Outline of what the next steps are in terms of investigation and actions that will be taken following the event:

- Level 1 investigation will be completed to establish the facts and any improvements that can be done in the future.
- MOS has confirmed they are fit to attend their next planned shift.

Fast Facts

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Supplier Organisation	Octavius Infrastructure Ltd	**Project**	Southend East Afa
Date of Accident / Incident	06 March 2026	**Time of Accident / Incident**	12:30hrs
Location of Accident / Incident	Riviera Drive – edge of site compound	**Type Accident / Incident**	Gas leak
Route Control Reference	No reference number received yet	**IRIS Reference**	44885

Outline of Accident Incident

Octavius are the principal contractor currently delivering an AfA scheme at Southend East Station on behalf of Network Rail.
Our site compound on platform 2 side of the station currently encompasses a section of the embankment at the rear of platform 2, as well as part of the public highway, Riviera Drive, where a lane closure has been in place for the past 5 months.
Our civils subcontractor, BPH Rail, have been undertaking a trial hole at the edge of the site compound (on Riviera Drive) to try and locate a manhole structure that is believed to have been covered over. A Permit to Break Ground was in place, with an extract drawing from the utilities CAD file attached. This had identified a gas main app 800mm from the trial hole and this had been marked on the ground by the Octavius Site Engineer.
Concrete was encountered immediately below the tarmac, which was broken out using a hand held breaker (TE1000) and found to be app 200mm thick. BPH then continued to excavate using hand tools only, and at a depth of app 700mm a smell of gas was observed.
Works were stopped and BPH reported this to Octavius Engineer at app 12:30.
Octavius Site Manager attended location and also observed the smell. It was unclear whether this was gas, or possibly methane from the manhole we were trying to locate. Passersby had also observed the smell so a decision was taken to backfill with the loose material to contain it. In the meantime, a member of the public notified Octavius Site Manager that they had reported it to the local council.
A member of the council streetworks team attended at app 13:20 and Cadent Gas attended shortly after, who used a meter to confirm that it was gas.
Cadent Gas then excavated the loose material and used a probe in the surrounding ground to locate the leak. They then carried out further excavation all the way across to the mains and discovered a domestic supply pipe that had become loose/disconnected at the joint with the mains, at a depth of app 1100mm. This domestic supply was not shown on the utilities CAD drawing and not picked up during CAT scanning as it is 25mm poly.
The supply pipe was cut and capped at app 15:30 however Cadent needed to access the property to test the supply so had to wait for the homeowner to return. The repair was then completed and tested by 18:45.

Site Compound

Immediate Actions Taken

Works stopped
Service Owner attended and is carrying out repair

Initial Known Facts / Causes Identified

TBC. It is not known at this stage if the trial works caused damage to the domestic supply pipe. BPH state that no services were encountered at any point during excavation works

Next Steps

- Excavation works on hold
- Investigation continuing Monday 09/03/26

Shared Learning

Supplier Organisation	BAM	**Project**	LESP ES5 - Leeds
Date of Incident	01 Dec 2025	**Time of Incident**	09:00
Location of Incident	Dark Arches – Leeds Station	**Incident Type**	Asbestos management incident

Outline of Incident

- BAM were instructed to carry out intrusive surveys in the Dark Arches of Leeds Station, information from Network Rail and previous surveys commissioned by BAM identified the presence of Asbestos across the footprint of the Station.
- In preparation for the works, an asbestos Refurbishment & Demolition (R&D) survey was commissioned with a specialist contractor on 19 November 2025 and undertaken on 26 November 2025.
- The site team were instructed that no intrusive works, where asbestos could be disturbed, were to take place until R&D survey results had been received.
- Between 1 and 3 December 2025, intrusive survey works took place in the basement room. The works involved breaking out concrete from steel beams to expose the steelwork beneath.
- On 10 December 2025, an additional room was entered and worked in to carry out core holes.
- The R&D survey results for the basement room were received by BAM on 11 December 2025. The survey confirmed the presence of asbestos in some areas of the rooms in question.
- Further testing confirmed that the areas where work took place did not contain asbestos and no members of staff were exposed.

Causes

- The requirement to complete and review targeted R&D asbestos surveys prior to intrusive works was recognised; however, this requirement was not fully embedded within project planning and sequencing controls.
- Asbestos hazards were identified within pre-construction information. However, these requirements were not clearly translated into verification controls within the Works Package Plan(WPP) and Task briefs
- Although asbestos related information was available to multiple project roles, responsibility for confirming R&D survey completion prior to intrusive works was not clearly defined.

Actions taken to prevent recurrence

- All works paused and full area being surveyed for presence of asbestos
- All site team staff undertaken asbestos awareness training
- Briefing given to whole project team on incident and lessons learnt
- Asbestos action tracker created
- Asbestos Hold points added to WPP/TB
- Designated person appointed to manage asbestos matters

Key Messages & Learning for Others

- Presume asbestos is present until proven otherwise
- Information sharing does not equal risk control
- Critical safety instructions must be documented, not verbal
- Identified risks must be converted into enforced hold points

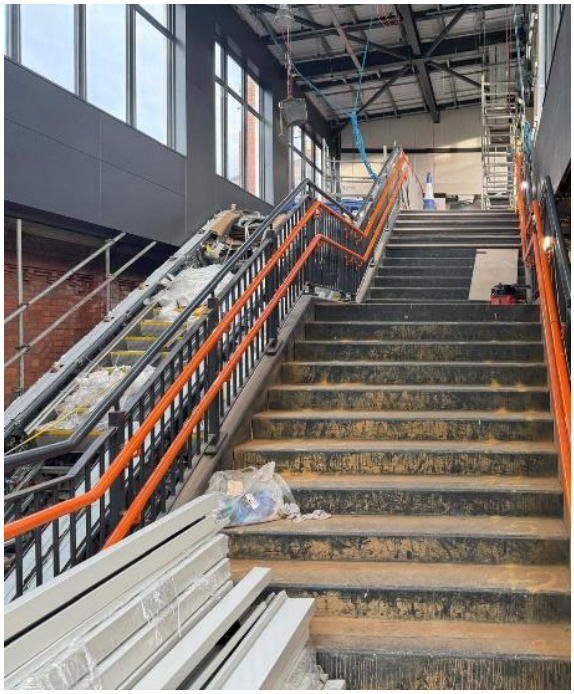
Shared Learning

Supplier Organisation	BAM	**Project**	Darlington Station
Date of Accident	07 Jan 2026	**Time of Accident**	20:36
Location of Accident	Existing station stairs	**Accident Type**	Trip – Non lost time

Outline of Accident

Ceiling installation above the escalator has been carried out within the existing station during back shift. Rope access was used to install the ceiling units. The ceiling units were passed to the rope access guys by a sub-contractor (SC) supervisor. The ceiling units were stored on one of the landings of the stair case. When the supervisor walked up the stairs in the existing station, they lost their footing where there is a tread difference (point where new treads have been laid over Christmas, resulting in difference in stair riser). They fell on their hand. This happened at 20:40 but they carried on working for the full shift – the BAM supervisor checked on them throughout the shift if they wanted to get it checked but they declined. They attended hospital for a check-up after the shift.

The difference in risers on the stairs had been highlighted as a risk but the identified actions to resolve had not been completed.



Causes

- Not all the new treads had been delivered but the site team decided to proceed with what they had, leaving a change in height between steps.
- No signage was put out to warn staff of the change in height
- No briefing to staff to warn of the difference in height

Actions taken to prevent recurrence

- Supervisors were briefed on the incident
- Area was cordoned off until completion
- Daily checks are carried out of all walkways prior to works allowed to start each day

Key Messages & Learning for Others

- Fully review arrangements when changes are made to the original plan – is it safe to proceed
- Before storage arrangements are made, review what impact this may have on others
- Ensure adequate information is given to workforce in the form of briefing and signage