

CLIC



Safety Events Digest



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Greener





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	31/01/2026	Time of Accident / Incident	20:35 hrs
Location of Accident / Incident	Sandy Station	Type Accident / Incident	Staff shot at with air rifle pellets
Route Control Reference	TBC	IRIS Reference	44821

Outline of Accident Incident

- Staff working near bridge 119 were shot at with air rifle from the lineside bushes.
- No-one has been injured.



Immediate Actions Taken

- reported to on call.
- Police were called.
- Armed police have attended to secure the area.

Initial Known Facts / Causes Identified

- Members of public were firing shots at staff while on site.

Next Steps

- Complete welfare checks on the staff involved.





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Supplier Organisation	Colas Rail	Project	Ingatestone
Date of Accident / Incident	6 th February 2026	Time of Accident / Incident	16:00
Location of Accident / Incident	A140 Long Stratton	Type Accident / Incident	Road Traffic Accident (No Injury)
Route Control Reference	N/A	IRIS Reference	44823

Outline of Accident Incident

MOS was decelerating steadily as they approached traffic, when they had almost come to a stop. Vehicle behind them failed to slow down and collided with the back of MOS' vehicle. Moderate damage to MOS van and major damage to 3rd party vehicle.



Immediate Actions Taken

- Emergency services were called, both ambulance and police arrived at the scene.

Initial Known Facts / Causes Identified

- 3rd party driver was arrested for being under the influence.
- No injuries sustained.

Next Steps

- Investigation is on-going, a full investigation report will be provided.
- Shared learning will be distributed once the investigation is complete.





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Supplier Organisation	CRSA	Project	Capital Delivery
Date of Accident / Incident	07/02/2026	Time of Accident / Incident	04:40 hrs
Location of Accident / Incident	Offord Level Crossing	Type Accident / Incident	RRV came into contact with overhead telecom cable
Route Control Reference	TBC	IRIS Reference	44836

Outline of Accident Incident

- While offloading attachments from a wagon at Offord level crossing
- RRV arm caught an overhead telecoms cable.
- There was very low visibility of the cable, and the cable was in the trees.



Immediate Actions Taken

- reported to on call.
- Statements taken.
- D&A post incident testing completed.

Initial Known Facts / Causes Identified

- Low visibility

Next Steps

- Level 1 Investigation to be complete.
- Delivery & Collection plans to be reviewed
- Contact service provider to plan repair.





Supplier Organisation	Taziker	Project	Darlington Station
Date of Accident / Incident	21/11/2025	Time of Accident / Incident	11:00hrs
Location of Accident / Incident	Darlington Station FB	Type Accident / Incident	LSR Work at Height breach

Outline of Accident Incident

Two operatives from Orchard Roofing self-reported that they accessed an area of the Darlington Station footbridge without adequate fall protection in place. This is a breach of the Life Saving Rule: Working at Height (Always use a safety harness when working at height, unless other protection is in place).

The two operatives had been instructed by Taziker management to retain the existing safety barrier in place and fit the end section of the Kee-Klump to the footbridge to create a work area free from leading edges. However, during the measuring phase of work, one operative briefly removed the Chapter 8 barrier separating them from the leading edge to take measurements up for the Kee-Klump stop-end.

The subcontractor had suitable and sufficient work at height protection equipment available to them, in the form of harnesses and fall restraint lanyards, however, these were not used. The SSoW in place was for the operatives to work behind the existing barrier to prevent leading-edge work from being required for this activity. The need to deviate from the agreed SSoW was not raised by the subcontractor to the Taziker management team present on site.

After realising their error, the two operatives replaced the temporary barrier, and returned to the site compound for their break. Here, they self-reported the Life Saving Rule breach to the Taziker site manager, who notified our Framework and Health & Safety Manager of the breach. To ensure the site was left in a safe condition, the Kee-Klump was fully installed using the correct fall restraint equipment.



Before



After

Causes

- Temporary Chapter 8 barrier was removed, exposing an open leading edge.
- Operatives accessed the area without using available fall protection.
- The safe system of work did not reflect the changed site conditions following staircase removal.

Actions taken to prevent recurrence

- Work was stopped and the temporary barrier reinstated.
- Task re-planned to include fall restraint and the team re-briefed.

Key Messages & Learning for Others

- Any change to site conditions must trigger a review of the safe system of work.
- Temporary controls must not be removed without suitable alternatives in place.
- Stop work if controls are missing or conditions differ from what was briefed



Shared Learning



Supplier Organisation	J Murphy & Sons	Project	Cambridge South Station
Date of Event	04 February 2026	Time of Event	06:30
Location of Event	Cambridge South	Type Event	Non-Work Related

Outline of Event

On the 4th February following completion of a night shift and whilst approaching personal vehicle to commute home, a member of agency staff experienced dizziness and began to feel unwell.

This was identified by the Murphy Supervisor on duty, who immediately approached the individual to undertake a welfare check. Upon initial assessment the Murphy Supervisor recognised some of the symptoms and linked them to an underlying health condition that the individual was faced with.

Without hesitation the Murphy Supervisor instructed the individual to leave his vehicle and took the individual to A&E.

Causes

The individual has experienced underlying health condition and was re-integrated into work following medical assessment.

Positive Actions taken

- Murphy Supervisor responded rapidly and effectively.
- Murphy Supervisor demonstrated strong team ethos and leadership skills.
- Murphy Supervisor embraced our core Value of “Never Harm” and demonstrated that his commitment does finish with completion of the shift.



Key Messages & Learning for Others

- Work as a team and have open conversations.
- Remain alert and ask questions if something doesn't look right.
- Treat each other with respect and keep your mates in mind.
- Wellbeing of our workforce does not end at the gates of a project.
- Remember the 3P's Preserve Life, Prevent Deterioration and Promote Recovery.

Remind your Project teams to Speak Up and Take-Action when required.

