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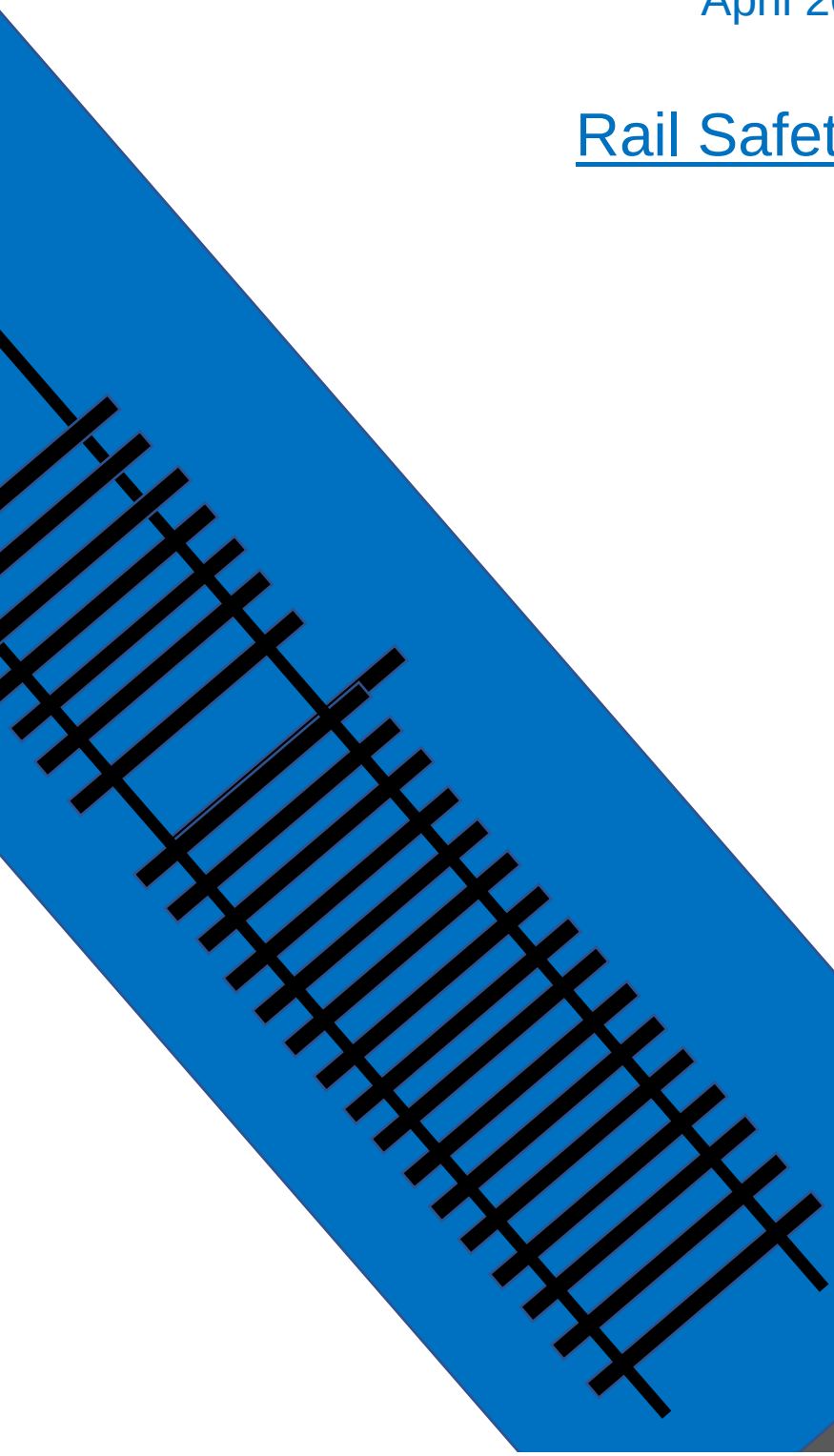
April 2022

Rail Safety Bulletin



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Contents

Network Rail fined £1.4m after ORR prosecution following life-changing injuries to employee

Network Rail has been fined £1.4 million for a health and safety breach after an investigation by the Office of Rail and Road.

ORR found failings that led to a worker being crushed between the conveyor of a 25 tonne 'Superboss' ballast distributor (see image) and Kubota people carrier.

The worker suffered catastrophic and life-changing injuries to his legs and spine. He lost 12cm of bone to his left leg and 4cm to his right leg. The tendons and nerves of his right leg were also irreparably damaged, causing permanent disability.

A second worker suffered minor injuries to his wrist and shoulder from the collision.

The incident happened on 19 September 2018 on a 19 mile stretch of track between Crewe and Chester. ORR's investigation led to it prosecuting Network Rail under the Health Safety at Work etc. Act 1974. Network Rail was fined after pleading guilty at Chester Magistrates Court yesterday (11 May 2022).

ORR found failings in Network Rail's management of the worksite, including poor planning, failure to provide adequate supervision of the works, poor communication at all levels and failure to provide adequate information, instructions and training to safety critical staff.

District Judge Sanders on sentencing Network Rail stated the subsequent accident was as a result of many layers of failure within Network Rail. Judge Sanders said there was a failure in the planning with a lack of clarity as to what was going on, failure in the supervision which was insufficiently robust, and there were operating failures by Network Rail.

ORR's HM Chief Inspector of Railways Ian Prosser CBE, said: "The injuries sustained to a Network Rail employee on 19 September 2018 were horrendous and have had a devastating impact on him and his family, to whom we offer our heartfelt sympathies.

"The incident was caused by totally inadequate supervision of the task at all levels.

"Nobody was making sure that those under their supervision had been following safe working practices, which led to this incident that could easily have been avoided."

Rail company fined after excavation worker buried

RAIL INFRASTRUCTURE company, VolkerRail Ltd has been fined £550,000 after pleading guilty to an offence under the Health and Safety at Work etc. Act 1974 after an investigation and prosecution by industry regulator the Office of Rail and Road (ORR).

VolkerRail Ltd was found to have failed to prevent danger to workers undertaking excavation work beside the railway.

The incident happened on 6 July 2014, when an employee was working in a trench as part of a project carrying out excavation work outside Stafford railway station. The wall of the trench collapsed, burying the worker.

The worker suffered serious injuries including a broken pelvis and several broken ribs. He underwent surgery on his pelvis, stomach and lungs and was placed in an induced coma.

By 2021 he was still in pain and no longer able to work full time.

At the time of the collapse the excavation was approximately two metres deep and had been constructed without any support to the sides.

In its investigation, ORR found the company did not use temporary works (such as trench supports) to shore up the excavation despite evidence of unstable ground conditions, and expert evidence shows that had they done so the collapse would not have occurred.

ORR also found VolkerRail Ltd. did not adequately brief its construction team on how to complete tasks and was not following its own methods. In addition, poor management meant failings were not corrected and complaints were not fully acted upon.

Sentence was passed by His Honour Judge Smith at Stoke-on-Trent Crown Court, following ORR's prosecution.

In his remarks, HH Judge Smith said trench supports had been delivered to the site but were not used, and proper consideration was never given to the use of temporary works. HH Judge Smith also said it was clear that some concerns were raised regarding the work, and whilst some steps were taken following these concerns, the methodology was not fully adapted.

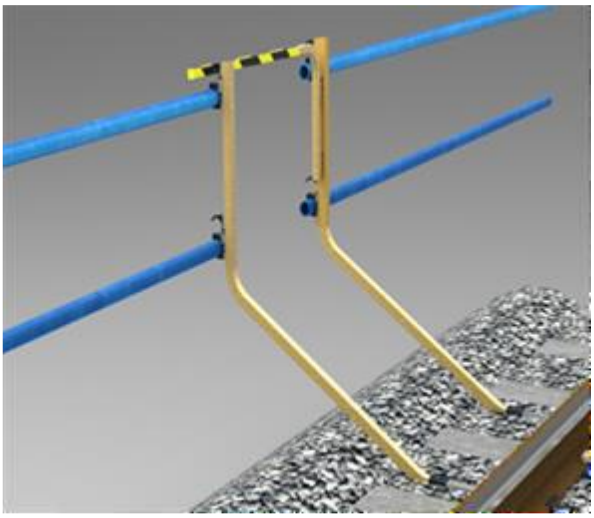
Ian Prosser CBE, HM chief inspector of Railways at ORR said, "VolkerRail Ltd. had opportunities to correct working practices and make the works safer, but these opportunities were missed. The result led to extremely serious injuries to one of its employees.

"Over many years we have worked with industry to ensure that there is a good level of understanding of the regulations when undertaking excavation work. It is important that companies working on the railways maintain a relentless focus on managing risks to protect their staff."

Rigid worksite fencing - NRA22-02

Investigation into the track worker fatality on 8 April 2020 found that the worksite safety barriers were not put up correctly.

Investigation found that the worksite safety barrier had gaps in it – more than required for safe refuges. This meant workers could get onto the open running lines too easily. The track worker was walking between two of those gaps when he was struck by a train.



Instructions on how to install the safety barrier correctly are found in the Manufacturer's Guidance Document and Product Acceptance Certificate.

Immediate action required

Review and check whether Rigid Safety Barriers are being used in line with the Product Acceptance Certificate PA05/01952: • The Rigid Safety Barrier System must be erected in accordance with the manufacturer's instructions. • A Safe Access Gate should be fitted. This is a one-way opening gate attached between fence supports to create a continuous fence but allowing safe access from the track every 40 metres.
• Rigid Barriers must be at least 1.25m from the nearest running rail. • Where barriers cause limited clearance, suitable Limited Clearance signs must be erected The previous Safety Alert regarding the incident can be found in Safety Central.

Part of our group of Safety Bulletins

Safety Alert | Safety Bulletin | Safety Advice | Shared Learning

Test before Touch on OLE - NRB22-03

The investigation into a worker's severe burns at Wolverton has revealed that there is uncertainty across the industry about what is required by the Test before Touch lifesaving rule on Overhead Line Equipment (OLE).

The accident occurred in the early hours of 14th May 2021 when track renewal contractors were working in a Network Rail managed engineering worksite at Wolverton. The work group were checking and adjusting the OLE to remove a temporary speed restriction.

The work group using a Mobile Elevating Work Platform (MEWP) unknowingly strayed outside the isolation. A linesperson touched the live OLE when they used a tool to take a measurement and received burns from an electric shock of up to 25kV.

The Test before Touch lifesaving rule must be followed when working on or near OLE. Every time before anyone works less than 600mm from the OLE a test must be conducted or witnessed using an approved voltage testing device.

A new test is required every time the work group moves past any in-line feature such as a section insulator or changes track. If in doubt, re-test. The test must show that the OLE is switched off before the work (re)starts.

Never rely only on the Reminder of Live Exposed (RoLE) equipment alone. It is used at the OLE permit (Form C) safe working limits but not always for residual electrical hazards. And it is only a reminder to check the OLE permit (Form C).

DISCUSSION POINTS	
When working on or near OLE, Test before Touch must be carried out. How Test before Touch is to be performed and who is responsible to carry out the test(s) must be identified during the planning process. The following must be considered: • Test before Touch must only be done once you have an OLE Permit to Work (Form C). • Test before Touch on OLE must be carried out by an Authorised or Nominated Person. C)? • How are the safe working limits on the OLE Permit (Form C) identified?	• An Authorised or Nominated Person must retest if the work group moves beyond an in-line OLE feature, onto a different track or a different conductor or if requested by a member of the work group. • If the work group does not have a competent person to carry out Test before Touch then the Nominated Person must plan for how this will be carried out throughout the work. • All staff should use Test before Touch in accordance with the guide to the Application of the Electrical Lifesaving Rules. • How do you reach a clear and common understanding regarding the safe working limits stated on the OLE Permit (Form

QUIZ TIME

Congratulations to James Coyle of Landsherriffs for correctly answering the question of Where Am I? The answer was the **Retford Station**

The £25 voucher is on its way to James

So, we have another opportunity to create a winner!

There is a £25 M&S Voucher up for grabs

To be a winner this month, just answer the simple question below;

Here is another ***Where Am I*** questions.

Opened in September 1850, I'm no longer operational but I am the oldest railway station in the UK.

Answers by email please to info@prb-consulting.co.uk to be in with a chance of winning the £25.00 M&S voucher

Closing Date: **25th June 2022**

RAIL SAFETY BULLETIN APRIL2022			
Briefed By:		Briefers Role:	
Briefing Date:		Briefers Signature:	
Sentinel Coordinator:		Sentinel Coordinator Signature:	

By signing below, I confirm that I have received and understood the briefing material contained within this bulletin.

NAME	SENTINEL NUMBER	SIGNATURE