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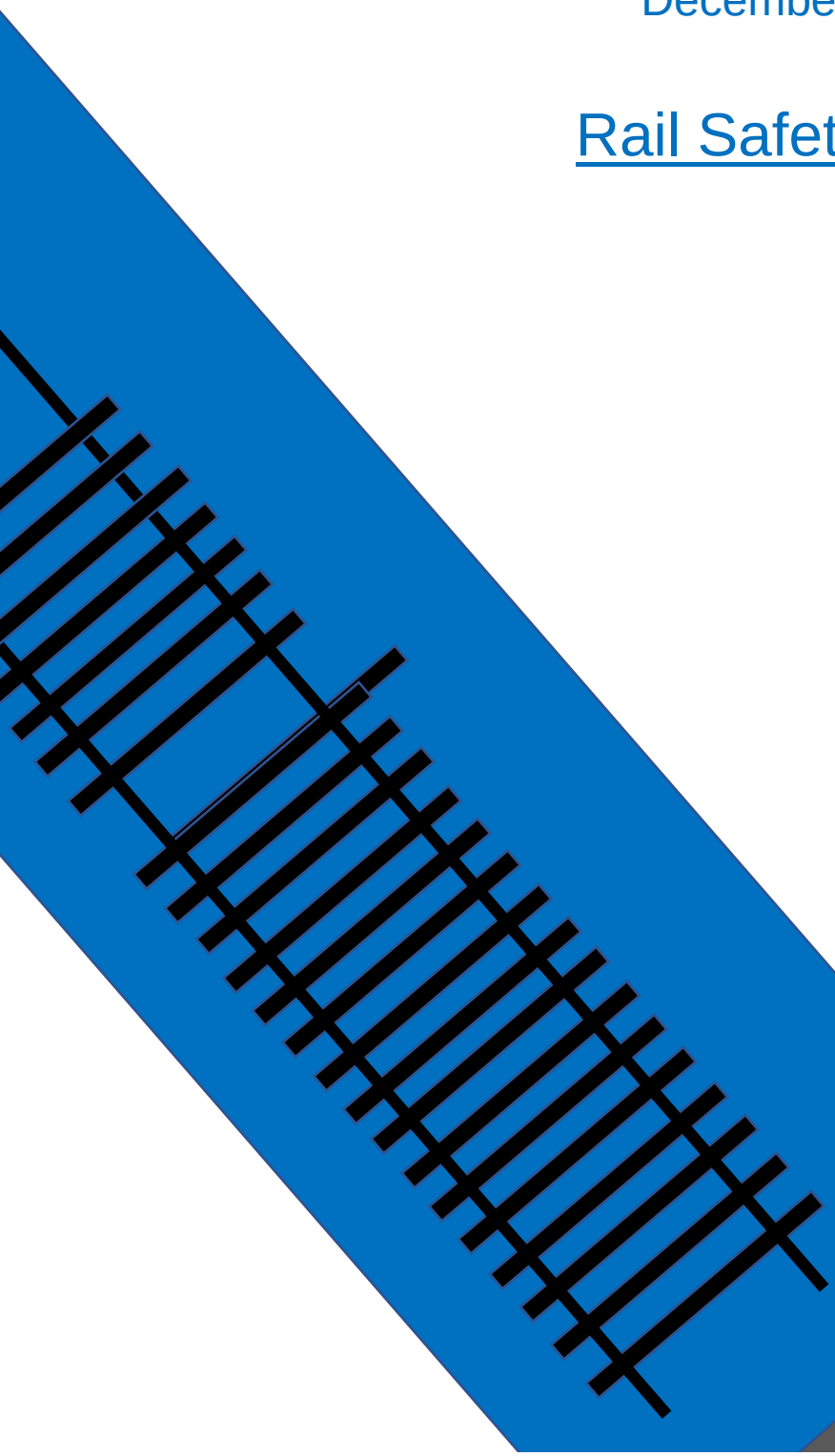
December 2022

Rail Safety Bulletin



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Contents

Single Approach to Isolations

Following the release of the new Network Rail Standard NR/L3/ELP/29987 it is a mandatory requirement that the following competency holders are to undergo a briefing on the new isolation process as defined in the new standard

THIS BRIEFING MUST BE UNDERTAKEN ON OR BEFORE 4TH JANUARY 2023 AND RECORDED ON SENTINEL

"FAILURE TO UNDERTAKE THE BRIEFING AND LOG THE EVENT ON SENTINEL BY THE 4TH of JANUARY MAY RESULT IN THE COMPETENCE BEING REMOVED"

AFFECTED COMPETENCES ARE:

- CONTROLLER OF SITE SAFETY (with OLP)
- NOMINATED PERSON
- AUTHORISED PERSON
- OLEC 3 (PARTS 2,3 & 4)

The links below will take you to the Safety Central Website. Here you can access the films that make up the briefings that need to be undertaken.

Film Title	COSS (OLP)	Nominated Person	Authorised Person	OLEC 3
Test-Before-Touch-Overview-with-MOC.	✓	✓	✓	✓
Full Film with Subtitles	✓	✓	✓	✓
Film – Method 1	✓	✓	✓	✓
Film – Method 2	✓	✓	✓	✓
Film – Method 3	✓	✓	✓	✓
Film – Method 4	✓	✓	✓	✓
Film – Principles	✓	✓	✓	✓

ALL APPLICABLE COMPETENCIES MUST:

- Watch each of the films listed above
- Be briefed on the detailed brief – copy available HERE
  OR
- Be briefed on the overview brief – copy available HERE

UPON COMPLETION OF THE BRIEIFNG THE SPONSOR MUST:

- Log attendance at the briefing on the sentinel website (events section)
- Maintain evidence of briefing attendance in accordance with their internal management system process

Fatality due to fall from Height NRX22-02

At approximately 1400 on the 3rd of November, a scaffolding inspector employed by a sub-contractor to a Principal Contractor, fell to his death through a Skylight on the roof of an industrial unit in Glasgow.

The industrial unit was being refurbished for use as a Network Rail Works Delivery location.

The inspection of the scaffold was not planned until the following day and there was no written record of the inspector's arrival on site.

On arrival the inspector accessed the scaffold and for reasons currently not known, he proceeded to access the roof of the building.

Approximately 10 metres toward the apex of the roof, the inspector fell through a skylight into the building below.

This tragic event is subject to internal and Health & Safety Executive investigation.

Discussion points
While Network Rail investigating the incident, please discuss the following with your team: Do you have areas of your workplace that are subject to stricter safety controls? What are they and how do you ensure they are communicated and followed? In your workplace, how do communicate areas that are safe / unsafe to access? In your workplace how robust are security and access control arrangements? Which of our life saving rules could prevent a repeat of this accident?

Multiple Trains in a Signal Section NRB22-12

On 26th October 2022, two following trains entered the same signal section due to an incorrect aspect sequence being displayed to the drivers of both trains. The irregularity resulted from a failure to carry out signal maintenance testing (SMTH).

Ballast cleaning works undertaken in the area required disconnection at DY586 signal and associated equipment. When the signalling system was reinstated following completion of the track works, the yellow and red aspects on DY586 signal were transposed.

Figure 1stock image

The incorrect aspect sequence resulted in the first train passing the signal at red when it should have been yellow, and a yellow aspect shown to the following train when there was a train in the forward section.

Testing to reinstate the signal after the works, was not carried out in accordance with the Signal Maintenance Testing Handbook (SMTH). Testing steps in the SMTH would have identified the transposition of the aspects had they been followed. The error was not self-revealing.

Discussion points
Are SMTH testers aware of the importance of the words “check with the maintenance test plan for all items of equipment fed by the affected piece of equipment being changed and carry out the steps marked with an asterisk” in SMTH? Where any steps in a test plan have not been completed, are SMTH testers aware that the Line Manager must be informed and the equipment must not be signed back for operational use, until the testing can be completed? When conducting a wire count, are SMTH testers aware of the requirements to check cable core numbers against the wiring diagram? This irregularity is similar to the Clapham Rail Disaster, which killed 35 people and injured 484 resulting in the introduction of SMTH. More recently, the derailment at Dalwhinnie was a result of a failure to apply SMTH correctly. How can we prevent this happening again?

Shared Learning Bulletin – Use of Trolleys on the Line NRL22-04

Overview and Underlying causes

Overview At 06:09 on 21 October 2021, a passenger train travelling at 123 mph struck a hand trolley on the track near Challow, Oxfordshire. The train was the first to pass through the area after completion of overnight maintenance work. This was the latest of several incidents involving trolleys being left on the line following engineering work.

A similar accident happened close to Twickenham station six weeks before Challow on 8 September 2021. On this occasion, an empty passenger train travelling from Staines to London Waterloo struck a hand trolley on the Up main line on the approach to Twickenham station.

The Rail Accident Investigation Branch have concluded an investigation into the incident at Challow and have made some recommendations aimed at preventing a reoccurrence. This Shared Learning is focused on three specific causal factors from the incidents that occurred.

Underlying Causes		
The trolleys had red lights fitted but they were not illuminated. The use of the lights (when illuminated) would have provided a visual indication that the trolley had been left on the line.	The Line Clear Verification (LCV) process was not used. Had this process been used correctly, it would have indicated to those responsible that a trolley had been left on the line by use of the relevant Vehicle Management Forms.	Assurance activities around LCV and the inspection of working red lights were not robust. Had assurance activities taken place, the incorrect use/lack of understanding of LCV and inoperable red lights on the trolleys would have been identified and corrected.

Key Message to all rail workers
All trolleys used on the line should be fitted with working red lights, these lights shall be maintained and used whenever a trolley or other similar equipment is used on the line. GERT8000 Handbook 10 is in the process on being amended to remove the option of using a red flag on trolleys. The Line Clear Verification process shall be used in axle counter areas and should be considered for use in areas with different methods of train detection.

Shared Learning- Depot Fire NRL22-06

Overview and Underlying Causes

On the evening of Tuesday 28th June 2022 a fire broke out at the Northampton Maintenance Delivery Unit Stores building. It quickly grew and destroyed the building. The building was not occupied and there were no injuries. The fire destroyed the building which has now been demolished.

It was initially reported that the cause of the fire was from the charging of Lithium Ion Batteries (LIBs) on unsuitable shelves. Following initial evidence gathered by the investigation team, the Ledlenser iFR8 lamp was temporarily quarantined.

During the investigation the exact source of the fire could not be identified with certainty. However, it was likely that the cause was from either the charging station sockets, the building wiring or the charging cable.

Discussion points
Network Rail commissioned an independent test of an iFR8 lamp, which to date has not been concluded. However local testing by Ledlenser and a review of the current processes in place at Ledlenser indicate that this product is safe to continue using. The iF8R lamp holds all current UKCA and other statuary certification. All plug and play devices, many of which contain LIB's, should be used, charged and stored in line with the manufacturer's instructions. The building maintenance Electrical instal condition report (EICR) could not be found and testing had not been completed for a number of years prior to the fire occurring. The investigation found numerous gaps in statutory testing, not isolated to Northampton Depot. This could not be ruled out as a contributory factor to the fire starting. Following the conclusions drawn from the investigation, the temporary restriction of the iFR8 lamp should be lifted with a cautionary note that all plug and play devices should only be used, stored and charged in accordance with the manufacturer's instructions. That charging facilities are fit for purpose. And that fire risk assessments are suitable and sufficient and the finding of which acted upon.

Underlying Causes
Do you know which of your devices contain Lithium-ion batteries? Are all of your plug-in devices suitably checked and inspected? Is your building up to date with EICR and statutory testing requirements? Do you have a person responsible for fire safety (PRFS) appointed and a suitable and sufficient fire risk assessment in place? Do you have suitable charging areas?

QUIZ TIME

There were no winners to the last quiz, so we are offering a double prize this month. That means there is a £50.00 M&S Voucher heading to the lucky winner – just have a go at the question below and email in your answer

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So, we have another opportunity to create a winner!

There is a £50 M&S Voucher up for grabs

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

The Question

Rearrange the letters to find the industry related word

Ara Wily	**Eelsrep**	**Arrowtinkle**	**Intune**
Axing Slob	**BulkOreo**	**intoast**	**Loftramp**

Answers by email please to info@prb-consulting.co.uk to be in with a chance of winning the £50.00 M&S voucher – Put QUIZ in the subject.

Closing Date: January 31st 2023

RAIL SAFETY BULLETIN DECEMBER 2022			
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