Ironmen Runaway Incident
‘Organisational Factors and Culture’

RAIB Seminar 13th November 2019

Steve Hutchinson
Senior Investigator - Network Rail
The runaway happened on a Saturday night early November 2014
……from the level 3 investigation report –

…..However, none raised the weather or resultant conditions as a risk at the time, even though they were expected to walk on slippery sleepers, negotiate trespass / cattle guards at each level crossing and manage over one tonne of equipment down a 1 in 40 gradient, in near pitch dark conditions with little – if any – means of communication. The expectation was that they would ‘just get on with it’.
Raven Crossing
10 Incident Factors

- Verbal Communication
- Fatigue, health and wellbeing
- Processes and procedure documents
- Written information on the day
- Competence management
- Infrastructure, vehicle, equipment and clothing
- The person’s environment
- Workload (real or perceived) and resourcing
- Teamworking and leadership
- Risk management
Processes and procedure documents

Competence management

Infrastructure, vehicle, equipment and clothing

Teamworking and leadership

Risk management
• There were also 13 ‘Safety Related Issues’ identified, relating to:
  ▪ Safety Leadership
  ▪ Planning
  ▪ Skills and equipment
  ▪ Design

• All fell into the ‘organisational’ category

• Four ‘local actions’ for Wales Route

• Fourteen ‘National’ recommendations - as far as I remember all were ‘accepted’

• Result - a step change in the way small plant are perceived, managed and operated. On Track Plant culture. Cinderella has made the ball!
“The weather was bad and it was windy. Didn’t worry about the weather conditions – would have been more cautious if it had been snowing.”

“Why am I here on a Saturday night!? It was all run of the mill and I’ve used the ironmen a lot. It was a normal shift and I was on auto pilot. Everybody knows what they are doing.”

“We took the apparatus for granted. We didn’t expect anything to go wrong. I had 100% confidence in it – may find it difficult to use in the future but would still do it.”

“As normal – some banter. We got everything ready. We knew what to do. We were confident it was safe.”
The report

- When it was time to man the ironmen there was no verbal instruction as to what the manning levels should be.

- two to the first, and three to the second, pair of ironmen had just ‘happened’ in an almost pre-conditioned autopilot manner.

- There were no red lights - front or rear - on the ironmen.

- He had his helmet and his head down – just got on with it and had become hardened to it over the years’.

- Those involved were ‘close knit’ and had worked well together for some time
• The kit provided was just part of the job
• A ‘learned helplessness’
• Not easily recognisable by management
Cultural, organisational and human factors issues; similarities with the Margam fatalities incident......?