

Recommendation(s) Status: Near miss between a train and a track worker at Shawford

This report is based on information provided to the RAIB by the relevant safety authority or public body.

The status of implementation of the recommendations, as reported to us, has been divided into eight categories:

Key to Recommendation Status

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| Open (replaces Progressing and Implementation On-going) | Actions to address the recommendation are ongoing. |
| Closed (replaces Implemented, Implemented by alternative means, and Non-implementation) | ORR consider the recommendation to have been taken into consideration by an end implementer and evidence provided to show action taken or justification for no action taken. |
| Insufficient response: | The end implementer has not provided sufficient evidence that the recommendation has been taken into consideration, or if it has, the action proposed does not address the recommendation, or there is insufficient evidence to support no action being taken. |
| Superseded: | The recommendation has been superseded either by a newer recommendation or actions have subsequently been taken by the end implementer that have superseded the recommendation. |
| Awaiting response: | Awaiting initial report from the relevant safety authority or public body on the status of the recommendation. |

RAIB concerns on actions taken by organisations in response to recommendations are reflected in this report and are indicated by one of the following:

Red – RAIB has concerns that no actions have been taken in response to a recommendation.

Blue – The blue triangle shows recommendations where the RAIB has concerns that the actions taken, or proposed, are inappropriate or insufficient to address the risk identified during the investigation.

White – The white triangle shows recommendations where the RAIB notes substantive actions have been reported, but the RAIB still has concerns.

Recommendation Status Report



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| Report Title | Near miss between a train and a track worker at Shawford |
| Report Number | 05/2017 |
| Date of Incident | 24/06/2016 |

| Rec No. | Status | RAIB Concern | Recommendation | RAIB Summary of current status |
|------------|------------|--------------|--|--|
| 05/2017/01 | Closed - I | None | <p>The intent of this recommendation is to increase awareness that lengthy travelling times before and after a work shift can cause staff to be fatigued, which in turn can reduce alertness and increase the risk of those staff making unsafe decisions while carrying out safety critical work.</p> <p>As part of its management of fatigue for staff undertaking safety critical work, Network Rail should continue its work to implement a process to require its managers who are directly responsible for staff working on or near the line to consider:</p> <p>he fatigue that regular long journeys, both before and after a shift, can cause, so that staff are not required to commute long distances to their place of work; and</p> <p>the actions that can be taken to reduce the amount of time staff spend travelling, where necessary, such as revised working times or providing lodging near to the work where appropriate (paragraph 95b).</p> | <p>ORR has reported that NR has reported that it has completed actions taken in response to this recommendation. ORR proposes to take no further action unless they become aware that the information provided becomes inaccurate.</p> |
| 05/2017/02 | Closed - I | None | <p>The intent of this recommendation is to improve the resilience of the rail testing and lubrication section within Eastleigh (now Wessex Outer) delivery unit to loss of resources and sudden increases in workload so that such situations do not compromise safety.</p> | <p>ORR has reported that Network Rail has reported that it has completed actions taken in response to this recommendation. ORR proposes to take no further action unless</p> |

Recommendation Status Report



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| | | | <p>Network Rail should:</p> <p>a. Carry out a review to identify improvements in how the Eastleigh (now Wessex Outer) rail testing and lubrication section manages rail defects so that it is more tolerant of changes to staff resourcing and peaks in workload. The review should include consideration of:</p> <p>the resourcing levels needed within the section to manage and deliver its work bank arising from planned inspections and likely volumes of work arising to support maintenance activities;</p> <p>the impact that planned runs by ultrasonic test trains can have on the management and delivery of the section’s workload when a large amount of time dependent work to verify suspect defects is generated by multiple runs taking place in short succession; and</p> <p>the impact that missed or partially completed runs by ultrasonic test trains can have on the management and delivery of the section’s workload.</p> <p>b. Take steps to implement any improvements from the findings of the review (paragraph 96).</p> <p>This recommendation may also apply to other rail testing and lubrication sections within Network Rail.</p> | <p>they become aware that the information provided becomes inaccurate.</p> |
| 05/2017/03 | Closed - I | None | <p>The intent of this recommendation is to reduce the risk to staff working on or near the line by improving compliance with the requirements for such working.</p> <p>Network Rail should:</p> | <p>ORR has reported that Network Rail has reported that it has completed actions taken in response to this recommendation. ORR proposes to take no further action unless they become aware that the</p> |

Recommendation Status Report



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| | | <p>a. Investigate why management arrangements within Wessex Route did not detect and/or rectify gross non-compliances within the rail testing and lubrication section at the former Eastleigh (now Wessex Outer) delivery unit with the processes for managing the safety of people working on or near the line. The investigation should include consideration of:</p> <p>why its audit and self-assurance processes did not identify the full extent of the non-compliances with planning and implementing safe systems of work found by the RAIB;</p> <p>why its monitoring and reporting processes did not trigger earlier action by senior management within the Wessex Route to resolve the way in which safe systems of work were being planned and delivered;</p> <p>how the availability of, and time pressures on, staff in roles within the work planning process affected the way in which safe systems of work packs were being produced, reviewed, signed off and used;</p> <p>whether there are other delivery units, with persistent non-compliances to processes that can affect the safety of its staff when on or near the line; and</p> <p>the effect that any other factors have had in contributing to the gross non-compliances with planning and implementing safe systems of work.</p> <p>b. Based on the findings of its investigation, take action to improve the management arrangements at Route level for monitoring the performance of the delivery units, with respect to planning and implementing safe systems of work (paragraph 98a).</p> <p>This recommendation may also apply to other Routes within Network Rail.</p> | <p>information provided becomes inaccurate.</p> |
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