Rail Accident Investigation Branch

# Near miss with a track worker near Leighton Buzzard, Bedfordshire, 16 June 2020

## Important safety messages

This incident demonstrates the importance of:

- staff following the requirements of the rule book related to personal track safety
- staff not becoming distracted by electronic devices while on or near the line
- Network Rail's contractors properly operating the industry's planning and delivery processes to ensure work has been risk assessed and the system of work is safe and appropriate for the task
- contractors wishing to access Network Rail's infrastructure ensuring that their staff do not go onto the railway without prior agreement.

## Summary of the incident

On Tuesday 16 June 2020, two track workers were undertaking a survey of the trackside vegetation on the west coast main line between Cheddington and Bletchley stations.

At 16:28 hrs the driver of a northbound train passing Leighton Buzzard station at 125 mph (200 km/h) observed a person standing next to the line in a place where the clearance was limited by the structure of an overbridge. The driver sounded the train's horn and observed the person move swiftly out of the way, but not to a defined position of safety, around one second before the train reached him.

## Background information

Between March 2019 and May 2020, Network Rail's London North Western business unit prepared tender documents for contractors to bid against, for vegetation management work along 10 miles (16 km) of the west coast main line between Cheddington and Bletchley.

One of the contractors involved in bidding for the work, MECX Group Ltd (MECX), wished to produce a business proposal incorporating up-to-date trackside photographs, which Network Rail had not been able to supply. Photographs could have helped MECX to review the lineside conditions, identify the correct equipment for the work and produce a more accurate costing for the work. Network Rail's project team considered that the line speeds and the nature of the locations meant that any work to survey the route safely would require a line blockage or possession. They decided that tendering contractors would not be allowed to undertake a track walk prior to the awarding of the contract.

Network Rail incorporated this restriction into the briefing it provided to tenderers for the work, and it is implicit in the letter of instruction which it also provided to tenderers. Although Network Rail has a system by which tenderers can request further information, MECX did not do so, because of a miscommunication within the company. MECX decided that it would still need to undertake a track walk / survey to photograph and record areas along the route that would require vegetation clearance work. The company made arrangements, including preparing a safe system of work pack (SSOW), for the work to be done between 16 and 19 June, the closing date for the tender proposal bids. MECX was not able to explain why the work had been approved without Network Rail's knowledge or sanction.

# The incident

To do the work, MECX engaged two track workers, who were both qualified as Controller of Site Safety (COSS) and Individual Working Alone (IWA), from two separate labour supply companies. On 15 June the SSOW pack was created by MECX's planner and reviewed by a person in charge (PIC) and responsible manager, both of whom had no knowledge of the restrictions that Network Rail had placed upon tenderers. The SSOW pack was emailed to the two COSS staff who reviewed the SSOW pack and returned it to the planner without comment.

On 16 June the track workers travelled from their respective home addresses in East London and Essex to the MECX depot in Flitwick, Bedfordshire, where they arrived at around 07:00 hrs. At around 10:30 hrs they were briefed about the nature of the work, which was to make a video and photographic record of the vegetation along both sides of the line, both working independently under IWA conditions and using personal video cameras. They had not had an opportunity to familiarise themselves with the location. Although accounts vary as to whether they stated to MECX that they were familiar with the site, the investigation identified that both track workers had little or no local knowledge or previous experience of working in the area. The opportunity for MECX to identify the track workers' lack of local knowledge was therefore missed.

Having received the briefing, the two workers travelled separately to Cheddington station, leaving one car at the station. They then travelled north together by car to an access point at Hospital Bridge (38 miles 77 chains – measured from a zero datum at London Euston), where they began work. One walked south in the down fast line cess while the other walked south in the up slow line cess, for about three miles (4.8 km) until they reached Cheddington station. They then drove back to the access point at Hospital Bridge, and from there they started to walk north towards Leighton Buzzard station, in the up and down cesses as before.

At around 16.20 hrs both workers were seen walking onto the platforms at Leighton Buzzard station (40 miles 14 chains) and then continuing northwards towards Linslade tunnel. When the worker who was walking in the down fast line cess reached the Soulbury Road overbridge (40 miles 30 chains), he became distracted, either by his video equipment or his mobile telephone, and stopped in an area where there was no position of safety, because of the restricted clearance created by the presence of the bridge abutment. The area of restricted clearance is marked by the sign highlighted in the picture below. The Rule Book (Handbook 1, section 10) says that this sign means that there is no position of safety on this side of the railway for the length of the structure it is attached to, and people must not enter or stand at that location when a train is approaching. The track worker had not made any arrangements for protection from moving trains to enable him to pass through this area safely.

At 16:28 hrs the driver of a northbound train, travelling at the permitted line speed of 125 mph (200 km/h), observed the track worker and sounded his horn. The worker was seen to react and move swiftly out of the way of the oncoming train, but not to a defined position of safety, which must be at least 2 metres from the nearest running rail. The train driver stopped his train and reported the near miss to the signaller, who then cautioned other trains in the area. Two Network Rail operations managers were asked to investigate, but they were initially unable to locate anyone in the area and at 17:45 hrs normal working was resumed.

**Images from the front (left) and rear (right) facing closed circuit television system of a northbound train taken at 16:28 hrs, showing the position of the track worker within an area of limited clearance, which is denoted by the sign in the yellow circle (images courtesy of Avanti West Coast).**

The two workers reached the south portal of Linslade tunnel at 16.37 hrs. They then turned round and walked the 1.75 miles (2.8 km) back to Hospital Bridge, from where they drove to an access point at 40 miles 75 chains, a short distance north of Linslade tunnel. After reaching the trackside and surveying the area between the access point and the tunnel portal, they then walked north towards Bletchley. Around 17:05 hrs, video evidence indicates that the worker who was walking in the up slow line cess decided to cross the four open lines without requesting a line blockage or having any form of protection, and a short time later he then crossed back again. In this area there is no position of safety between any of the four tracks, and the curvature of the line means that there is insufficient visual warning of approaching trains to enable all four tracks to be crossed safely.

Both workers then continued to walk north to the 42 milepost, and then turned and walked back south to their vehicle. When they reached it, around 17:45 hrs, one of the workers realised that he had lost part of his video equipment. They both returned to the railway and walked north next to the up slow line until they found the missing item, and then returned to the vehicle.

At around 18:15 hrs the two Network Rail managers, who had continued to search for the people involved in the near miss, were joined by a senior operations manager. All three observed the two workers walking along the up slow cess, and apparently about to walk across the four lines, towards the access point close to where their vehicle was located. The managers intercepted them and made arrangements for them to leave the railway safely.

## Previous similar occurrences

In 2017, workers carrying out a structural examination of Dutton Viaduct on the west coast main line found that it was difficult to gain access to the structure because the plan for the work had not taken into account the dense vegetation and a nearby fence. Consequently, the staff crossed the viaduct at track level and narrowly avoided being hit by a passenger train travelling at 125 mph (RAIB safety digest 18/2017). Improvements to the planning and safe delivery of work were also recommended in the reports on an incident at Roydon in 2012 (RAIB report 07/2013), and an accident near Bulwell in the same year (RAIB report 20/2013).

Since it became operational in 2005, RAIB has investigated 46 accidents and incidents in which track workers have been struck, or nearly struck, by moving trains. Two fatal accidents, at Margam, south Wales, on 3 July 2019 and at Roade, Northamptonshire, on 8 April 2020, are currently under investigation. RAIB has recently published a summary of the lessons from its investigations.