

Acton 24th June 2008 – A little bit of history





- Back in 2008 RAIB made a recommendation following the welding trolleys being struck at Acton.
- The Recommendation was to reinforce existing arrangements within Network Rail for COSS packs to be prepared and implemented by staff with adequate geographical knowledge of the locality.
- NR/OHS/L2/019 is a NR standard that defines how we access or work near the track and appropriate protection to keep us safe.

Why did we focus on 019 compliance?



- Whenever we access the track, we need to have a Safe Work Pack (SWP)
- This should drive a plan and discussion to decide how to deliver the work in a safe way.
- NR 019 standard sets out how we should plan our work on or about the line.
- It gives responsibility to the Responsible Manager to check the pack was relevant and had considered the risks.





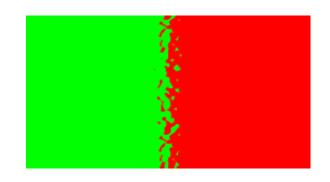


How did we investigate? Margam 019



- We had a copy of the SWP from the incident.
- There was an additional handwritten note that accompanied the SWP, which gave additional instruction of work to do.
- Quickly after the incident, the term 'parallel working' emerged.
- What was parallel working?
- How did this work with the hierarchy?
- We interviewed with a subject matter expert on 019.







Further investigation of 019

- We read the standard and reviewed what should have been in place for that location. The FFCCTV from the incident train and from site visits it was clear that the planned safe systems were not in place and that the work differed from what was planned.
- We realised, quite soon something wasn't quite right, and we needed to look wider.
- For the work being done we knew for that location and the type of work they would have needed a distant lookout, a sight/touch lookout



- We looked at packs from other depots and regions.
- The Surbiton investigation has also taken the approach and viewed a larger sample of packs. This gives a better picture of what is happening.

Investigating 019 Margam



- RAIB undertook a review of the packs NR had collected from Port Talbot Depot.
- NR then did an in-depth analysis of a small sample of those packs and found 50% to have significant issues of compliance.
- This included: planned use of lookouts, tip-ex, signing the pack before its verified, no involvement of PIC, different times......
- We also found gaps in local 019 assurance activities.



 When we checked - 019 v9 had not been briefed fully and a shorter version had been approved for use.



Conclusions



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Margam rail deaths: 'No safe system' when workers killed

- Pack was not compliant with 019
- Planning data inputter and the PIC wasn't involved
- Valueless and meaningless to those on site, who were reliant on their normalised ways of working
- 019 wasn't being applied or used correctly (It's just a piece of paper)

