

## **Acton: report and recommendations**

Rail Safety and Standards Board (RSSB) has issued its formal inquiry report into the circumstances that led to a track worker being struck and fatally injured by the 2345 hrs London Paddington to Oxford train near Acton Main Line Station on 11 June 2005.

The formal inquiry was convened under independent chairmanship and included representatives on the panel from the involved parties. As with all such inquiries the panel's task was to establish the immediate and underlying causes of the accident and make recommendations to prevent or reduce the risk of recurrence.

## **Sequence of events**

The work was the renewal of the Up Main line and was being carried out with possession being taken of the Up and Down Main lines.

The work required the first material train to go to the site of work. The train was standing on the site at the end furthest from the station on the Up Main. The Engineering Supervisor (ES) found that he could not make contact with the material train by radio and therefore contacted an Assistant Site Manager (ASM) and asked him to go to the train to instruct the driver to move into the site of work. The ASM boarded the locomotive and instructed the driver to move forwards.

After moving a short distance the train stopped short of a temporary lighting pole that was foul of the line. The ASM got down from the cab on the side adjacent to the Down Relief, which was open to traffic and the two drivers on the locomotive saw the lighting pole being moved.

At 2357 hrs, the 2345 hrs London Paddington – Oxford passenger train passed on the Down Relief, the track next to the material train and struck the ASM.

## **Conclusions**

### **Immediate cause**

The ASM was killed by being struck by the passenger train when he was in the gap between the Down Relief and Up Main.

### **Underlying causes**

He had left the locomotive by the door adjacent to the Down Relief and adjusted a lighting pole between the Down Relief and the Up Main.

Due to failure of radio communication between the ES and the driver, the ASM had been asked by the ES to escort the train on to the site of work.

The installation of the lighting had not been properly managed and there was no clearance standard available for the erection of the lighting.

The decreasing gap between Up Main and Down Relief lines had not been adequately recognised by the planning process and no suitable arrangements made to deal with the risks created.

## **Recommendations**

The report makes recommendations for improvements in a number of key areas and these are summarised as follows.

### **Lone Worker Issues**

Review lone worker incidents and incorporate any emerging conclusions into revised Rules and requirements-Network Rail

### **Processes**

Lead an industry-wide initiative to implement a national template for processes required for effective health and safety management during the planning and implementation of track renewals-Network Rail

### **Clearances for Lighting**

Lead an industry-wide initiative to implement standards for clearances for temporary lighting poles on track renewal sites-Network Rail

### **Radio Protocols**

Lead an industry-wide initiative to implement instructions for use of radios in possessions based on those in use for shunters-Network Rail

### **Method Statements**

Lead an industry-wide initiative to carry out a fundamental review of the creation, authorisation and use of method statements and implement new templates nationally for track renewal work-Network Rail

### **Safe Systems of Work in Possessions Booklet/Video**

Lead an industry-wide initiative to produce either a booklet or video to help planners and site managers to understand the existing track safety Rules as applied to possessions-Network Rail

### **Best Available Track Safety Systems**

Lead an industry-wide review of the use of site wardens on track renewal sites. Implement a policy to obtain the best available track safety protection methods, including investigation into the practicability of mandating fencing around main works, where Safeguarded Green Zone conditions are not possible-Network Rail

### **Resource Adequacy Following Contract Change**

Put in place a formal process to check and verify that the Principal Contractor has sufficient competent resources to deliver the work prior to award, prior to the start of construction work and at any point of significant change thereafter-Network Rail

RSSB has issued a full copy of the report to each member of the Railway Group and the other organisations involved in the accident. All recipients of the report need to review the findings and recommendations and take actions where appropriate to address identified deficiencies within their own systems. RSSB will track the industry's response to this report.