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Safety Briefing

July 2025

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Monthly topics

Safety Guidance
- Driving Safe

Safety advice
- Tampering with braking systems

Shared Learning
- Scaffold incident at London Liverpool Street STN

Fast Facts
- Two MEWPS Collide during possession
- 1.5T Mini Excavator overturns onsite
- Shoulder injury onsite as worker trips over

Driving is the most common cause of death for rail workers.

For two decades, driving has been the single biggest cause of rail worker fatalities.

Safety central has an abundance of comms and literature to assist you to stay safer when on the roads.
Pre inspection checks, being aware of fatigue, keeping to speed limits

It is a breach of Sentinel scheme rules to break a lifesaving rule, and you can be investigated for speeding while travelling as part of your railway duties.

https://safety.networkrail.co.uk/safety/drive-safe/

Fatigue can kill you

- If you are fighting off sleep; blinking, yawning, bobbing your head forward ten you are already unfit to drive.

- STOP and rest.

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Safety Advice

everyone home safe every day

Tampering of braking systems on manually propelled trolley and grinding equipment

Issued to: All Network Rail line managers, safety professionals and accredited contractors

Ref: NRA25-08

Date of issue: 21/07/2025

Location: National

Contact: John Watt – Principal Engineer [Plant]

Overview

There has been several instances over the last two years where braking systems fitted to Manually Propelled Trolley (MPT) and Grinding Equipment have been tampered with thus making the braking systems ineffective. This activity increases the risk of runaway, possible injury to staff if struck by MPT and damage to equipment.

Operators of these equipment types are reminded that interfering with safety system such as brakes can lead to you or your colleagues being injured or killed; this is a breach of Network Rails Life Saving rules.

These practices also contravene NR/L2/RMVP/0200 P514 paragraph 3.3.2 "Do not adjust or interfere with the braking mechanism of a trolley" The practice of interfering with such systems should cease with immediate effect. If these systems are identified as faulty, then the equipment should be immediately removed and quarantined.

There will be increased surveillance activities around the use of these equipment types.

Discussion points

- Are competent staff operating the equipment as per their training and discharging their duties accordingly?
- Is the work planned correctly considering the distances and staff numbers that are required to push the equipment?
- When were staff last reminded of their responsibilities regarding interfering with designated safety systems such as brakes?
- What methods are in place to manage fatigue when operating MPT equipment?
- If there is an apparent issue with the safety system, how should it be resolved, is interfering with the system the right course of action?
- If the brake system fitted to the equipment is deemed faulty then it shall be labelled, quarantined, and not be issued for use before such time as new parts are fitted.
- Are the correct number of staff identified to allow the equipment to be operated safely.
- Ask yourself "how would I feel" if I or my colleagues were struck by runaway MPT where the brakes had been tampered with by you or someone else.
- Are L1 assurance activities being undertaken to check plant?

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Shared Learning

everyone home safe every day

Scaffold incident at London Liverpool Street Station

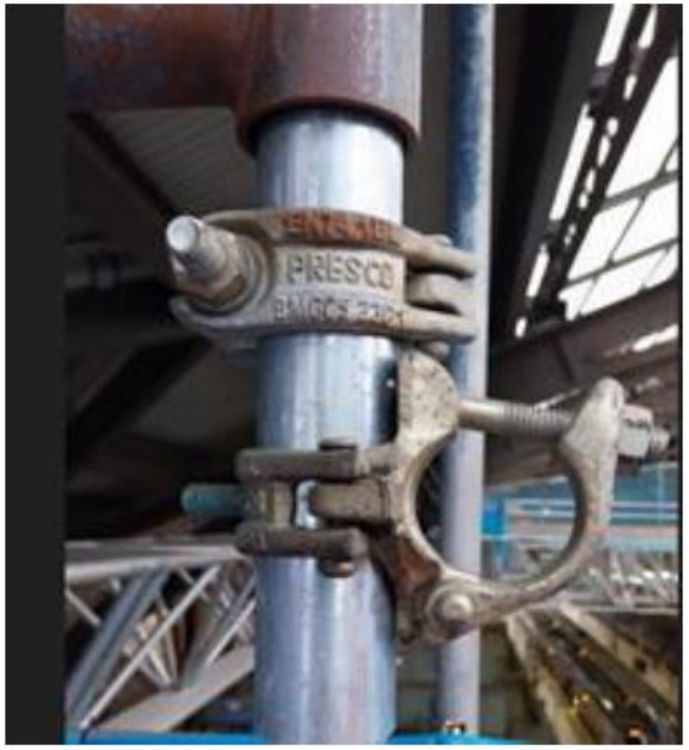
Issued to: **All Network Rail line managers, safety professionals and accredited contractors**

Ref: NRL25-03

Date of issue: 23/07/2025

Location: London Liverpool Street Station

Contact: Sharon Fink, Principal Safety Manager, Eastern Routes Capital Programmes



Overview

London Liverpool Street Station is currently undergoing roof refurbishment works, replacing the life expired Glass Reinforced Plastic (GRP) above platforms 1-10 as well as spot replacement of Georgian Wire Glass above the concourse area.

During the installation of a tube and fitting hanger for a suspended scaffold, a supplementary check coupler fell approximately 15 metres onto one of the station platforms.

The coupler landed within an exclusion zone that had been established on the station platform, resulting in no injuries or damage.

The investigation concluded that the coupler had not been correctly tightened and vibrated loose when the scaffolder was working on an adjacent fitting.

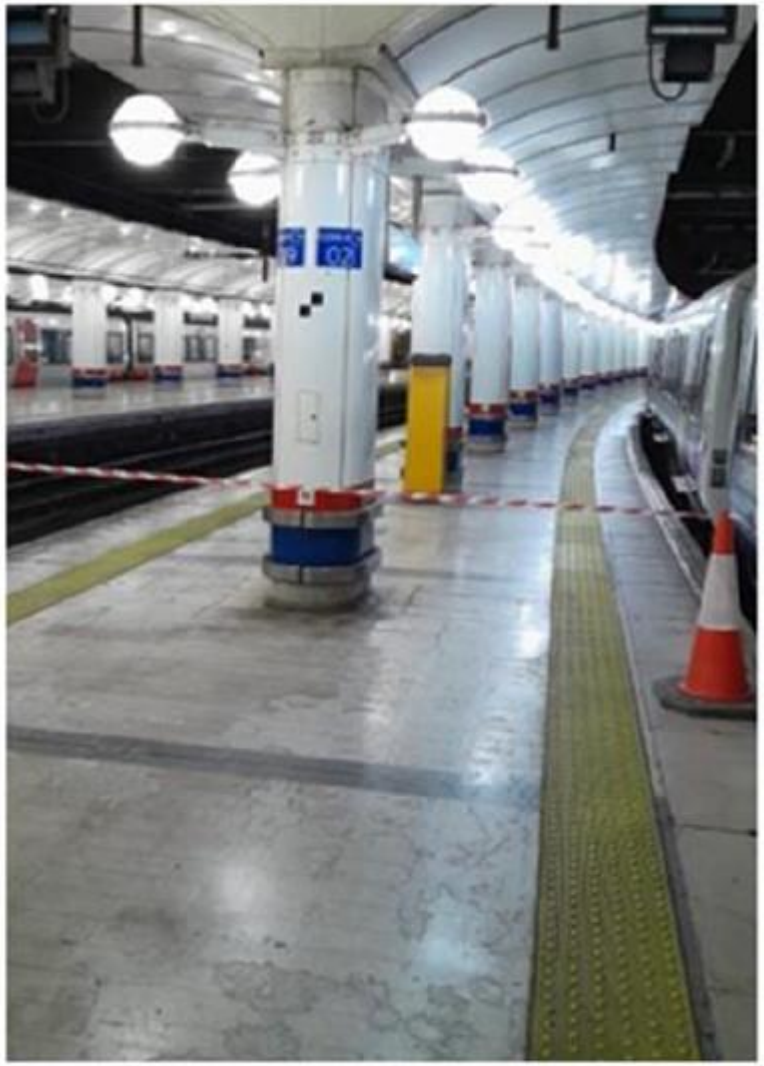
Underlying causes

- The check coupler fell because it was not correctly tightened. The orientation of the check coupler prevented the scaffolder having visibility of the bolt head whilst tightening the fixing. This led to the bolt being insecure, and vibrations from ongoing work caused the coupler to loosen and fall.
- The scaffold supervisor was working from a Task Briefing Sheet however the chain of documentation did not suitably pass risk controls from the Work Package Plan, therefore those undertaking the works were not adequately aware of the risk controls.
- The coupler was not contained at a high level because the encapsulation netting, which should have been installed, was not in place.
- The scaffold manager, who was aware of the planned methodology and specific controls, was not on site. The information had not been passed to the scaffold supervisor in charge of the night works. Consequently, the supervisor was unaware of the netting requirement. The scaffold design is complex, and netting can only be installed at certain points to address specific risks.

Bottom fitting was acting as supplementary coupler. Note: Not the actual fitting, this is a similar arrangement.

Fitting showing how the bolt head should have been seated in the clip body correctly to prevent fitting becoming loose and falling.

Revised detail with swivel coupler fittings permitting visual inspection of both fittings by erector. Note: Yellow Clikon caps to aid inspection.



Exclusion zone in place during the scaffold works.

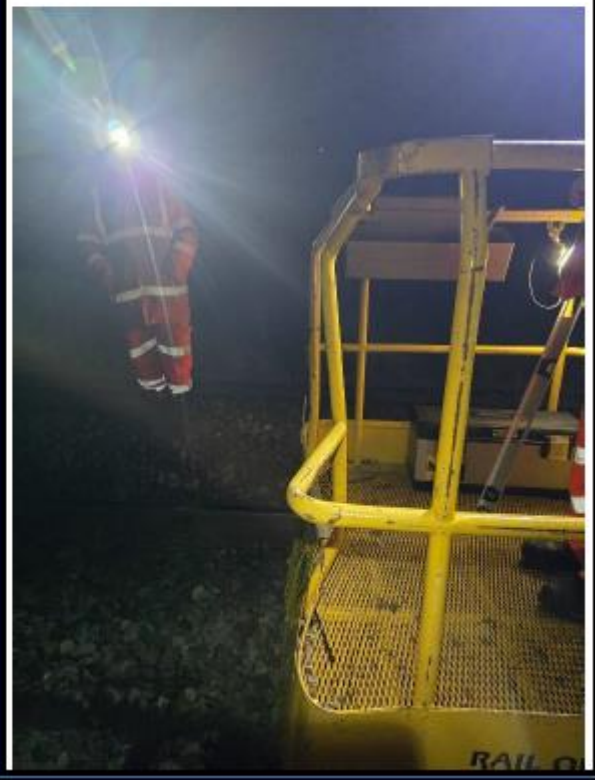
Key message

- The design of scaffold should take account of installation restrictions and make sure components are selected that suitable for safe installation by those undertaking the works.
- Supervisors in charge of works should be provided with and briefed on the Work Package Plan and Task Briefing contents and ideally involved in their development.
- Specific risk controls detailed in the Work Package Plan should be incorporated into the Task Briefing Sheet to make sure that the correct level of detail is delivered through briefing to those undertaking the works.
- Principal Contractors to review their assurance procedures and processes to assure that Contractors/Sub-Contractors are working in accordance with defined methodology and designs/specifications.

Part of our group of Safety Bulletins

Incident – Mewp Collision

To be completed and submitted to the AIW

Brief Overview of the Accident or Incident	Photos
On 02/06/2025 @23.40hrs, 2 X MEWPS were undertaking OLE SPS installation on the Rhymney Single line @ 19-mile 10ch. The Mewps were working basket to basket, Mewp No 7 was low mileage and Mewp No 8 was high. Mewp No 8 had his basket spun 360% to allow him to assist with the SPS installation. Once the works were completed Mewp No 8 went to travel back and the operator of Mewp No 8 went forward instead of back which caused the 2 baskets to collide causing damage to the basket of Mewp No 7. Incident reported to: • ES • CVL Level 3 Oncall • DCM - Incident log#: 3066540	

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Personnel Incident / Accident

To be completed and submitted to the AIW

Brief Overview of the Accident or Incident	Photos
Mini excavator(1.5t) fell over onto its side while working in the area between the back of the Downside elevated platform and the palisade boundary fence behind the DN platform.	

The 1.5t excavator was involved in breaking out old concrete light column foundations at the rear of the DN platform.

The excavator had just repositioned itself on the south side of the excavation after initially working on the northern side of the excavation. The excavator was sat on uneven ground /arisings from the excavation. During the excavation activity the excavator overturned in slow motion onto its right hand side.

The driver was wearing his seatbelt and was uninjured. Minor damage (slight denting to engine cover door and scratch) was caused to the excavator. The excavator has been assessed by a fitter and confirmed to be fit to use.

Within an hour of the incident occurring it was reported to the AGC PM and Operations Manager, the AGC SHEQ department and the AIW/TfW PM.

This incident is **not** reportable under RIDDOR due to; no-one being injured as a result of this incident and no harm could be caused to others as a result of this incident due to the exclusion zone in place.

Prior to recommencing this activity the type/suitability of plant and methodology will be re-assessed.

The operator and banksman have undertake for cause D&A testing. Both returning a negative result.

Location	
Ynyswen Station	
Contractor / Discipline	
Alun Griffiths	Civils
Date	**Time**
16-06-2025	15:40 approx.
Accident / Incident Category – (AIW Duty Manager issue)	
Initial Investigator & Contact No	
Pat Sheehan 07593216822	
Reported to AIW Duty Manager	
YES/~~NO~~	
Andrew Mason	AIW PM
Lost Time Injury (LTI)?	
No	
RIDDOR / Potential RIDDOR	
No	No

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EHS Fast Facts Alert

Subject: Shoulder injury following trip over concrete plinth (RIDDOR)

FF-006-2025

On 8th July 2025, a production operative from Chippenham Factory was on their way back from a tea break to the Electronics department.

Whilst walking past the Losev building, they tripped over the edge of an unused concrete plinth (1550[L] x 760mm[W] x 90[H]) and fell to the floor. This resulted in their left shoulder feeling stiff and uncomfortable, and they were correctly advised to go home to recover.

The injured party was unable to attend work the following day due to worsening pain, and on 10th July they attended hospital and were diagnosed with a fractured left shoulder (a RIDDOR Specified Injury).

A full investigation is underway, and further information will be shared as necessary.

Photos taken at time of accident showing the concrete plinth

Discussion Points

1. Did you know that slips, trips and falls continue to be one of the largest causes of accidents in our company and our industry?
2. Are there any potential slip or trip hazards in your workplace (or associated areas) where the risk of tripping could be eliminated or reduced?
3. How do you prevent becoming overconfident and familiar with every activities (such as walking to and from a place of work?
4. What are the potential distractions that could contribute to a slip, trip or fall?

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My Sentinel

https://mysentinel.me/Account/LogOn/?ReturnUrl=/

Do you know that you can view all of your own Sentinel Competencies in real time?

- See the competency expiry dates and assessment due,
- look at your medical and Drugs and Alcohol test records.
- Receive emails directly from Sentinel
- Search and email Sentinel sponsors directly
- Follow the link to my sentinel above and set up your own Sentinel profile

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Reminder to all Sentinel Card Holders & Checkers

Safety Central

Network Rail share updates of recent incidents, accidents and best practice advice online. Please get into the habit of checking this website for the latest news;
https://safety.networkrail.co.uk/tools-resources/safety-bulletins/

Southern Shield

Southern Shield is a collaborative safety forum that consists of Network Rail Southern Capital Delivery and its principal contractors. On their website they have useful articles and explain the rules of the Southern Shield charter, which are mandatory on some southern sites.
https://www.southernshield.co.uk/

Railway Rule book

Add this website address to your browser favourites to ensure that you always have access to the Network Rail Rulebook modules
https://www.rssb.co.uk/standards/types-of-standards-and-how-they-work/the-rule-book

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OFFICIAL

NetworkRail

1. Introduction

The purpose of this code

This section of the code tells you about getting access to the Network Rail standards and controls, which you will need to do before carrying out work on the rail infrastructure.

2. Network Rail standards and controls

Network Rail standards and controls are a set of documents we produce to define the way we work. They set out the information we share, the principles we have and the business requirements we work to.

Together, they give us a consistent, safe and coherent set of working practices across the whole company. By having a single external source for this information, we can be sure that contractors and suppliers have access to the most up-to-date standards and controls information. We publish Network Rail standards and controls quarterly. Publication dates are the first Saturday in March, June, September and December. We'll communicate any changes through the Network Rail Standards and Controls Change Summary Report.

All our principal contractors:

- Should show that they have systems in place to access our standards and controls and brief their own people on changes.
- Should brief their subcontractors on changes or, assure us that the subcontractors are competent to brief themselves.
- Must not distribute our standards and controls outside their organisation.

To aid your briefing process, you may give your subcontractors a copy of the Network Rail Standards and Controls Change Summary Report.

3. Who do I contact for more information?

Suppliers, principal contractors and subcontractors can access Network Rail standards and controls and the change summary report by registering for the Network Rail Standards Portal

To register, please complete and submit the webform. Please Click Here

To find out more, please contact the Network Rail Standards & Controls Management Team: STSupplierSupport@networkrail.co.uk

Changes to your shift times and increased fatigue risk

It is important that you notify your consultant as soon as possible if there is a change to you rostered work pattern while working on the Network Rail Infrastructure.

As part of our commitment to you and our obligations to monitor and manage your fatigue, we must always have an accurate understanding of where and when you are working.

In addition, you also have a legal obligation to ensure that you are safe to work,the Health and Safety at Work Act 1974. This states that “Workers have a duty to take care of their own health and safety and that of others who may be affected by their acts or omissions at work”

Do not start work until you are satisfied that the safety arrangements are appropriate to the activity

Never, ever drive while feeling tired

If you are starting to feel fatigued while you are onsite than instigate the work safe procedure.

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Work-safe Procedure

This is for anyone to use, it works as follows:

If you believe the Safety Arrangements to be inadequate:

- Stop Work and talk to the Team Leader or person in charge; they should:

- Review the arrangements
- Change them if necessary and re-brief

If you are still unhappy DO NOT RESTART; escalate to the next level by contacting one of the following:

- Your Line Manager, Your Safety Rep, Any member of the management team, The DU Safety Advisor, Network Rail Control, MT on-call 07786 265531
- Do not start work until you are satisfied that the safety arrangements are appropriate to the activity

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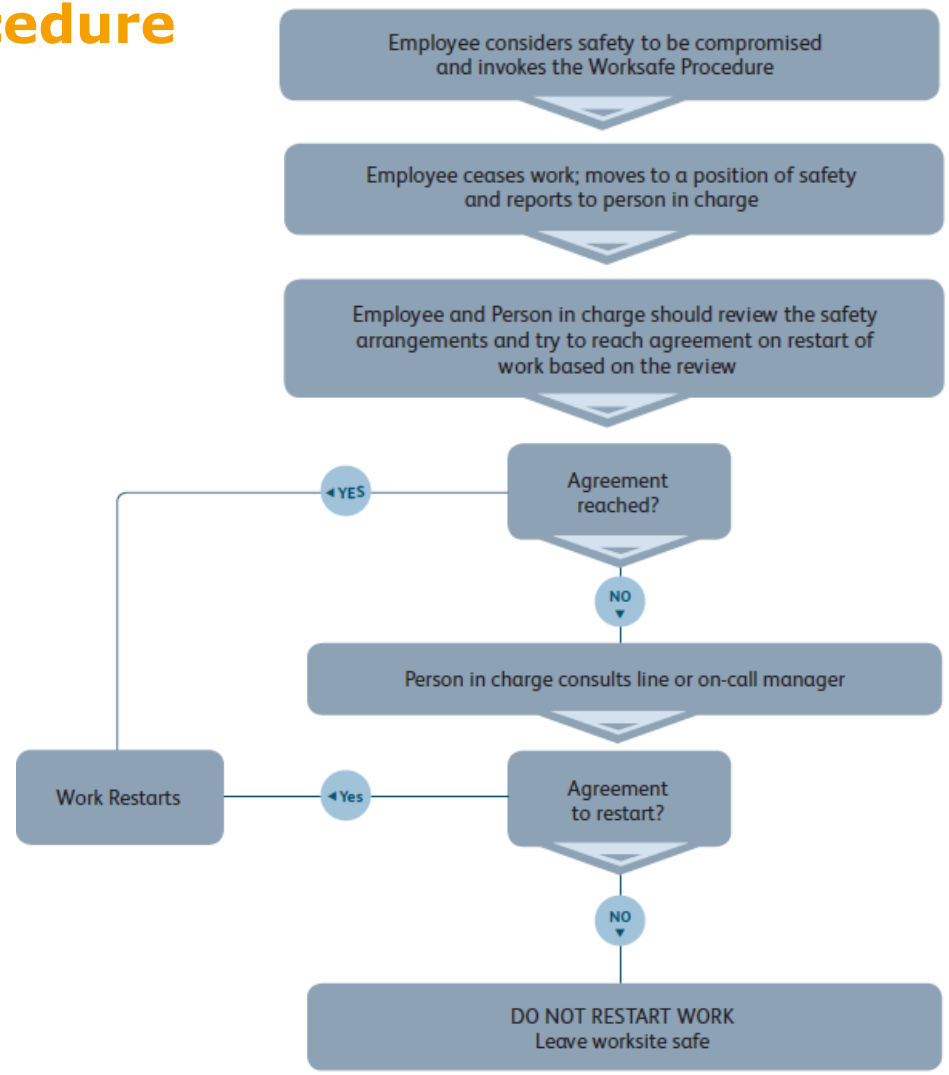
Work-safe Procedure



Contact the Rail team

24 hour on call - 07786 265531 Store this number in your phone in case of an emergency.

Use this on-call number if you need to contact someone from the company urgently, for example to report an accident / incident or if you are being pressured to do something that you are not comfortable with, such as being asked to exceed the working hours rules etc.

This number is not to be used to query timesheets or to enquire about vacancies, it is an emergency contact number.

If you would like to suggest a topic for future safety briefings, or need to talk to someone in confidence then email the Rail HSQE manager Joe Christopherson; jchristopherson@matchtech.com

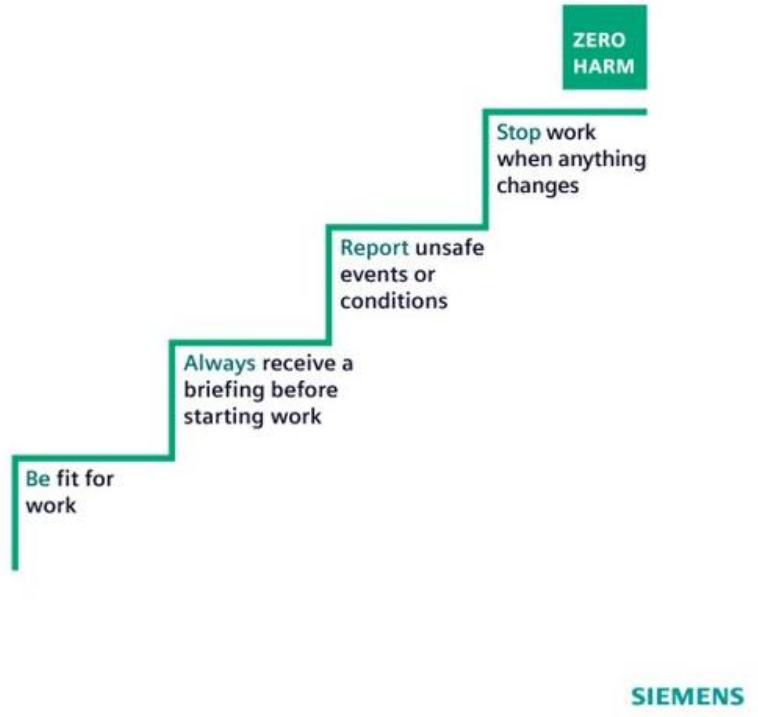
Your Feedback is always welcomed, email us at MT railonboarding@matchtech.com

Previous monthly rail briefings
https://www.matchtech.com/about-us/health-and-safety/safety-briefings

Safety sQuaRed

See it, Scan it, Share it

https://www.gattacaplc.com/report-near-misses



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Our Lifesaving Rules

- Always be sure the required plans and permits are in place, before you start a job or go on or near the line.
- Never use a hand-held or hands-free phone, or programme any other mobile device, while driving.
- Always use equipment that is fit for its intended purpose.
- Always test before applying earths or straps.
- Never undertake any job unless you have been trained and assessed as competent.
- Never assume equipment is isolated – always test before touch.
- Never work or drive while under the influence of drugs or alcohol.
- Always use a safety harness when working at height, unless other protection is in place.
- Always obey the speed limit and wear a seat belt.
- Never enter the agreed exclusion zone, unless directed to by the person in charge.

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CIRAS
CIRAS
Confidential Safety Hotline
If you have a safety concern,
make the right call and report it.
Tell your supervisor, or contact us in complete confidence.
Call 0800 4 101 101 or download our CIRAS reporting app.
Scan me
Google Play
App Store
We find safety in listening.

Scan me