

## OPERATIONAL CLOSE CALL

No – 22.23

An Operational Close Call occurred recently on a Dyer & Butler site when a machine / crane controller gave permission for his operator to place the rail trailer unit on the track before the worksite had been granted by the authorising person.

On the 26<sup>th</sup> of May 2022 at 01:01 hours, an incident occurred on a Dyer & Butler rail site in the West Midlands. A rail trailer unit was allowed to be placed on the Down Wellington line prior to the work site being confirmed by the Person in Charge Of Possession (PICOP). This action of placing the trailer operated a track circuit which led to the signaller contacting the PICOP due to the Down Wellington line being shown as occupied within the area of possession.



As a result of the incident (and following a review with the client and infrastructure operator), a stoppage of works was imposed for a period of two weeks.

During the investigation it was identified that there was a breakdown in communication and procedure. In the lead up to the incident, the Engineering Supervisor (ES) for the works received a telephone call from the PICOP to grant him authority to place worksite limit marker boards. This conversation was observed by the site supervisor, and he enquired if they were good to proceed. The ES acknowledged "yes boards only". The site supervisor mistook the conversation between the ES and PICOP and believed that the worksite had been granted and as such he relayed this to the machine / crane controller. The machine / crane controller then took this as confirmation and placed the track trailer on the line rather than challenging the communication.

The PICOP had taken both the up and down lines from the signaller and train movements had been stopped at the time of the incident.

The investigation has also found that post incident protocols were not followed to the required standards. This resulted in the incident not being fully reported within the client's organisation. Immediately following the incident, drug and alcohol testing was carried out on all parties involved and the works were stood down pending Network Rail Mobile Operations Manager attendance.

After the works had been stood down, the track trailer was removed from the Down Wellington line, and the Engineering Supervisor, PICOP and Signaller discussed the incident with the intention of identifying the root cause of the incident.



**Remember:** Always follow official procedures and processes when accessing the track environment.

**Remember:** Authority to access the track can only proceed once the work site has been fully established and handed over to the Engineering Supervisor.

**Remember:** Only act on instructions given by the appropriate authorising person.

**Remember:** Where instruction is received from a non-authorised person, the instruction must be challenged and declined.

**Remember:** Where incidents occur involving rail plant, all parties involved must be subject to for-cause D&A testing.

**Remember:** Where arrangements do not meet the required standard, a close call should be raised.

**If you require any further information, please contact any member of the HSQE Team.**