

# Safety Bulletin

*A serious incident has taken place*



## Clapham Junction near miss

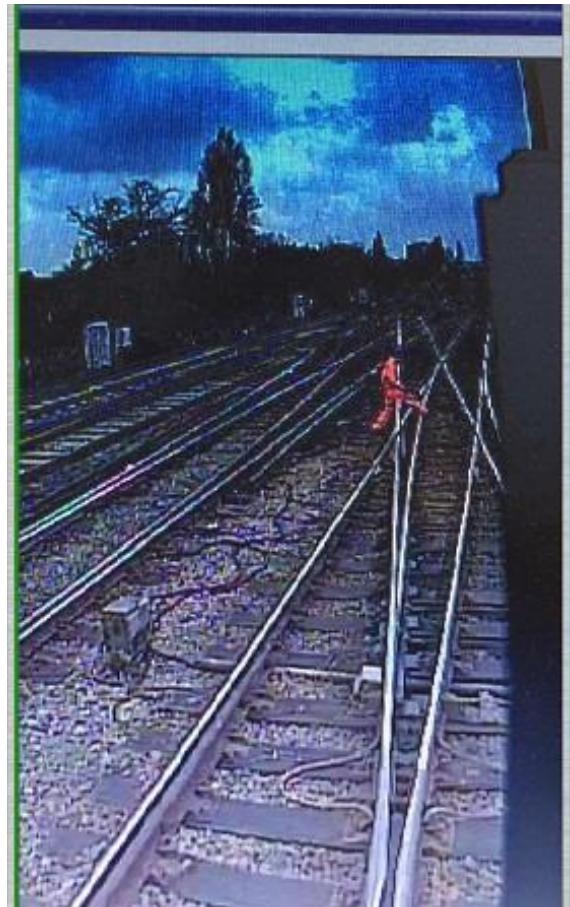
**Issued to:** Wessex Route

**Ref:** WXB 10/03

**Date of issue:** 16/03/2016

**Location:** Clapham Junction

**Contact:** Steven Edwards WHSEA  
Clapham D.U.



## Overview

On the 10th March 2016, a four man team were working within a line blockage at Clapham Junction, on the Down Windsor fast.

The COSS had placed his protection for the line blockage away from the group and had begun his track patrol from the commencement board.

The remaining members of the team were performing bridge inspections further up the line.

After retrieving the gauge the blue hat member of staff crossed four open lines to gain access back into the blocked line.

As he was doing this, an empty passenger train which was performing a shunt move across the Clapham ladder onto the Windsor lines approached the individual. The train was travelling at approximately 5 mph.

Blue hat member of staff then acknowledged the oncoming train before crossing in front of its path.

begun his track patrol from the commencement board.

The remaining members of the team were performing bridge inspections further up the line.

During the bridge inspection the gauge being used failed.

A blue hat member of the team was asked to retrieve a working gauge from the patrolling cabin over 200 yards away.

Clapham ladder onto the Windsor lines approached the individual. The train was travelling at approximately 5 mph.

Blue hat member of staff then acknowledged the oncoming train before crossing in front of its path.

The member of staff was said to be a matter of a few metres from the oncoming train as he crossed.

All staff involved were immediately stood down from duty for initial investigation.

### ***Discussion Points***

What are the dangers of separating yourself from the group?

Why do you believe that a blue hat member of staff was delegated the responsibility of retrieving the gauge?

Why do you think this was not challenged by anyone on site?

Who is responsible for your safety?

How are your access/egress points established?

Why might the member of staff have chosen to cross open lines to access the blocked line, rather than using the available access?

*Part of our group of Safety Bulletins*

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