

WELCOME

TRACK WORKER STRUCK BY A PASSENGER TRAIN: SHARED LEARNING

OVERVIEW OF THE LAVERTON INCIDENT

TOOLBOX 1



MetroSafe



OBJECTIVE

To welcome and clarify the goal of the session.

As we talk about the Laverton Incident today, together we will discuss learnings and practices which will contribute to our goal of Zero Harm.

WELCOME

Today's session is the first in a suite of ten Toolbox Talks (TBT's).

Today's session commences the series by providing an overview of what occurred at the Laverton Incident and the key findings.

The subsequent 9 TBT's unpacks the key learnings that were identified as contributing factors in the Laverton Incident.

Housekeeping rules – Phones off, duration of session (approximately 15 minutes).

WHY WE ARE HERE

Emphasise – Safety Starts With Us. We are all responsible for ensuring we remain vigilant in managing our risks and preventing incidents of this nature from ever occurring again.

OUR SAFETY PLEDGE

OVERVIEW OF THE LAVERTON INCIDENT

OUR SAFETY PLEDGE

I WILL ALWAYS ENSURE MY
SAFETY AND THE SAFETY OF
OTHERS WHEN WORKING IN
THE RAIL CORRIDOR

ZERO HARM

OBJECTIVE

To clarify and emphasise our Safety Pledge and ensure participant understanding.

READ

I will always ensure my safety and the safety of others when working in the rail corridor.

DISCUSS

Pose question to group... What does this mean for us as a work group?

Draw out thoughts from participants – for example:

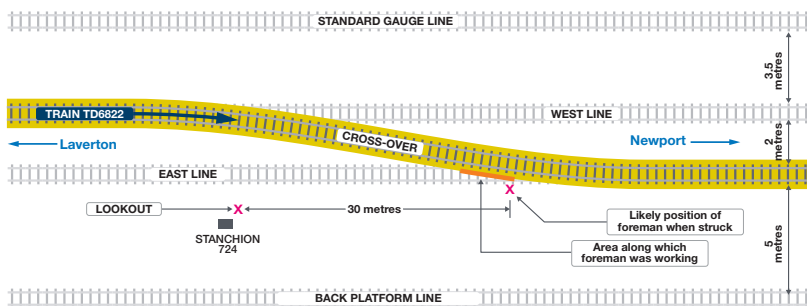
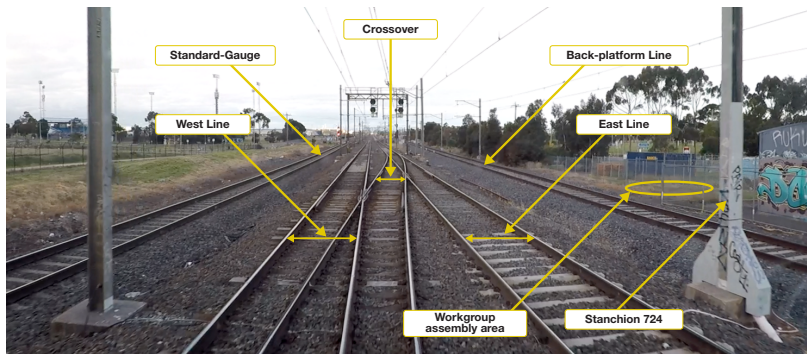
- Speak up if you see something unsafe
- Everyone should feel like their work mates are looking out for them
- I won't take short cuts

INTRODUCTION

This booklet provides clear information about the risks and controls associated with the Laverton incident.

This is the first of ten toolbox talks created to share learnings with industry.

The following toolbox talks will focus on specific shared learnings associated with this incident.



OBJECTIVE

Reiterate the purpose of the suite of the TBT series.

READ

This booklet provides clear information about the risks and controls associated with the Laverton incident.

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OVERVIEW OF THE LAVERTON INCIDENT

CASE STUDY LAVERTON INCIDENT

TRACK WORKER STRUCK BY A PASSENGER TRAIN

On the morning of Friday 2 October 2015, an infrastructure workgroup was dispatched to Laverton to remove dogspikes from sleepers on the Altona Loop Line. The dogspike removal was in preparation for re-sleepering works scheduled for the following Sunday night. Weather conditions were fine and visibility was good.

The dogspike removal works were to be conducted with trains continuing to run. The Friday had been declared a public holiday, resulting in train services operating to the Saturday timetable.

At about 0830 that morning, the Track Force Protection Coordinator (TFPC) for these works arrived at the site. Soon after his arrival, the Rail Safety Worksite Hazard Assessment Pre-Work Brief was made available for workers to sign. This form was normally signed after the Pre-Work Briefing, but some workers signed it on arrival, prior to the briefing.

At about 0832, the TFPC called Metro Trains Melbourne (MTM) Track Access Desk and advised them of the works to be undertaken on track. The TFPC informed Track Access that he had completed the RSWHA and had conducted the Rail Safety Pre-Work Briefing (safety briefing) to all staff, although this in fact, had not yet been conducted. Track Access then confirmed that the TFPC intended to apply full track protection, after which approval to access the track was granted.

While members of the workgroup were assembling, two trains travelled through this section in the Up direction (towards Newport via Altona) and two in the Down direction (via Altona towards Werribee).

The last of these trains passed at about 0904.

Soon after, the Infrastructure Work Group Supervisor (the supervisor) arrived onsite. He walked onto the tracks, followed by the TFPC and other track workers. After a short discussion, the supervisor commenced marking the sleepers from which dogspikes were to be removed. The TFPC then returned to an assembly area to commence the safety

OBJECTIVE

Provide overview of what took place at the Laverton Incident.

Ensure participants have a clear understanding of the incident, as it will be used as a basis for the following 9 TBT's.

CASE STUDY

1. The information contained in this case study has been drawn from the Australian Transport Safety Bureau (ATSB) investigation into a track worker being struck by a passenger train near Laverton Station, Victoria, 2nd October 2015.
2. Read case study.
3. Check for engagement and understanding whilst reading.

DISCUSS

- Ask someone to paraphrase the case study
- Key learnings and takeaways with participants
- How it relates to current works and possible risks

CASE STUDY

briefing and on his way back called for lookout protection for the supervisor. A suitably qualified track worker responded to the call and positioned himself at stanchion 724, about 30 meters from the supervisor. Other track workers remained in the area between the East Line and Back Platform Line.

The suburban passenger train TD6822 had departed Werribee at about 0905 bound for Flinders Street. At about 0916 the train stopped at Laverton station Platform NQ 1. The lookout stated that, when he saw the train at the station he alerted the supervisor. He said the supervisor looked at the train, acknowledged the alert and continued marking the sleepers.

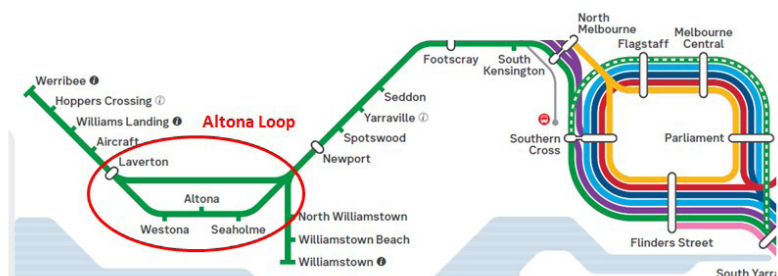
At about 0917, the train driver sounded the train horn and departed the station, travelling on the West Line. The lookout heard the horn and reported that he again informed the supervisor that the train was approaching. Two other track workers confirmed they heard the lookout's warning. The lookout stated

that he saw the supervisor move away from the tracks and then he turned to observe the approaching train.

Shortly after departing Laverton station, the train driver noticed track workers between the East and Back Platform Lines. He sounded the horn again and shut-off power, letting the train coast. At that point, the lookout gave the train driver the 'All-Right' hand signal. The train had entered the cross-over by this time and the driver sounded the horn again. The lookout continued to observe the train.

The train driver was looking at the lookout as he passed. He then looked ahead and saw a track worker (the supervisor) crouched over and foul of the track. The train driver immediately sounded the horn and then made an emergency brake application; however, the train struck the supervisor. The train speed at that time was 59 km/h.

The supervisor suffered serious injuries. He was treated at the site by paramedics then taken to hospital for further treatment.



OVERVIEW OF THE LAVERTON INCIDENT

CASE STUDY
LAVERTON
INCIDENT

SHARED
LEARNINGS

These Shared Learnings have been identified as the key factors that contributed to the Laverton incident.

Each of these will be explored in depth through further toolbox talks.

1

Overview of the **Laverton Incident**.

2

In preparation of **planning worksite protection**, a **Rail Safety Worksite Hazard Assessment** (RSWHA) is a requirement before works commence to determine the appropriate level of protection and ensure all personnel are not exposed to hazards.

3

All Rail Safety Workers (RSW's) must clearly understand, attend and sign on to the relevant **Pre-Work Brief** prior to entering the rail corridor to commence works.

OBJECTIVE

Introduce the 9 key learnings derived from the Laverton Incident.

Explain that each of these key learnings make up the next 9 TBT topics.

READ & DISCUSS

- 1. Read shared learning 1.
- 2. Brief discussion – “why is this important?” “how does this improve safety?”, “why must we do this?”.
- 3. Repeat for each of the 9 Shared Learnings.
- 4. Seek consensus of the importance of the shared learnings.

SHARED LEARNINGS

4

The hierarchy of **accountability** was not adhered to; the TFPC has a primary duty and responsibility to keep RSW's and the worksite safe from rail traffic; whereas the **WGS** is to maintain effective communication with the **TFPC** in accordance all safeworking and rail traffic movements.

5

Incorrect information provided to the **Track Access Desk (TAD)** when seeking approval for Rail Corridor and Danger Zone access.

6

Safe Systems of Work were not implemented sufficiently to identify the risks.

7

Successful implementation of safety compliance requires a **"just culture"** where people are encouraged to provide essential safety related information.

8

Safe Behaviour at work is critical as this turns systems and procedures into reality.

9

Protocols and procedures were not followed which increased the risk associated with the workgroup activities.

10

Insufficient communications and **interface with other stakeholders** (Lookout, Track Access) led to a lack of awareness regarding altered routing and service disruptions.

GLOSSARY

All Right Hand Signal:

The All Right hand signal is one arm held in the horizontal position. By night a white light held steady.

Australian Transport Safety Bureau (ATSB):

The ATSB is Australia's national transport safety investigator.

Danger Zone:

Is all space within 3 metres horizontally from the nearest rail and any distance above or below this zone including being on the line, unless a Position of Safety exists or can be created.

Flagman/Handsignaller:

Is a rail safety worker who displays hand signals to the operators of rail traffic movements. A Handsignaller is also referred to as a Flagman.

Metro Trains Melbourne (MTM):

Metro Trains Melbourne, known colloquially as simply Metro, is the franchised operator of the suburban railway network in Melbourne, Australia. Metro Trains Melbourne is a joint venture between MTR Corporation, John Holland Group and UGL Rail.

Office of the National Rail Safety Regulator (ONRSR):

An independent body corporate established under the Rail Safety National Law (South Australia) Act 2012. The primary objectives of the ONRSR are to encourage and enforce safe railway operations and to promote and improve national rail safety.

Protection Officer (PO):

The qualified worker responsible for rail protection (NSW, SA, QLD, WA).

Position of Safety (POS):

Is a place where people or equipment cannot be struck by rail traffic.

Rail Safety Pre-Work Briefing:

Is a formal briefing on the worksite protection arrangements provided by the Track Force Protection Coordinator to all rail safety workers associated with the worksite protection and the Work Group Supervisor.

Rail Safety Worksite Hazard Assessment (RSWHA):

Is an assessment of the rail safety hazards to determine the method/level of protection requirement for a worksite.

Rail Safety Worker (RSW):

Is a person who has carried out, is carrying out or is about to carry out, rail safety work, and includes:

- a) a person who is employed or engaged by a rail operator to carry out rail safety work
- b) a person engaged by a person (other than by a rail operator) to carry out rail safety work
- c) a trainee
- d) a volunteer.

Track Access Desk (TAD):

Provides a single approval point for access by internal and external stakeholders requiring track access within the Rail Corridor and Danger Zone.

Track Force Protection Coordinator (TFPC):

Is the person appointed to assess and implement worksite protection arrangements on site.

Track Force Protection:

Track force protection is a method of protecting work on track between rail traffic movements.

Work Group Supervisor (WGS):

Is the individual ultimately responsible for the supervision of the programmed activities within a Work Site.

Work Group Supervisor Pre-Work Briefing:

Is a formal briefing on the task related activities provided by the Work Group Supervisor to the work group and Track Force Protection Coordinator.

FURTHER INFORMATION AND SAFETY PLEDGE



FURTHER INFORMATION

If you require any further information, please discuss with your supervisor.

INFORMATION SOURCES

- Australian Transport Safety Bureau (2017), Safe work on track across Australia, Analysis of incident data, 2009 - 2014
- Australian Transport Safety Bureau (ATSB), Rail Occurrence Investigation, RO-2015-019, Final 24 August 2016

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OBJECTIVE

Commitment to the pledge from all participants.

Advise participants that further information about the incident is available.

READ

Restate the Pledge – I will always ensure my safety and the safety of others when working in the rail corridor.

DISCUSS

Leader commits to the pledge by providing an example of how they will enact it.

Ask each person for an example of what they can do in the workplace that demonstrates their commitment to the pledge and contribute to an environment of Zero Harm.

Highlight where further info can be obtained.