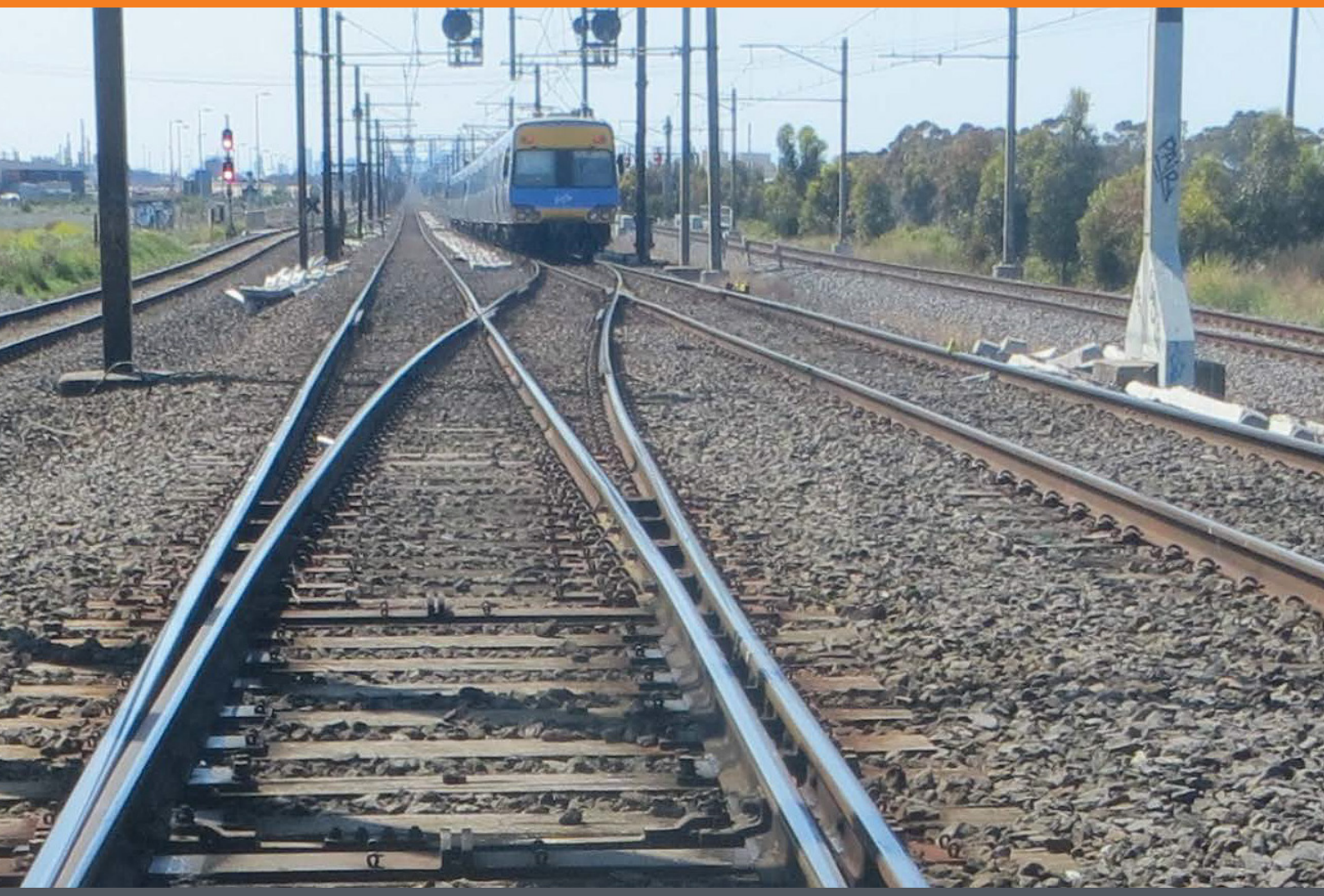
TRACK WORKER STRUCK BY A PASSENGER TRAIN: SHARED LEARNING

LAVERTON INCIDENT ENHANCING SAFE BEHAVIOUR MODEL

TOOLBOX 8



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OUR SAFETY PLEDGE

I WILL AIM TO DISPLAY POSTIVE SAFETY BEHAVIOURS AND ENSURE I'M AWARE OF MY ACTIONS AND THE POTENTIAL CONSEQUENCES THEY MAY LEAD TO

ZERO HARM

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INTRODUCTION

Actively and fairly managing safety behaviours promotes a culture where people feel comfortable to speak up without fear of blame.

This booklet provides clear information about importance of Safety Behaviours and how it relates to the Laverton incident.

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

RELATED STATISTICS

Careful consideration of human factors can reduce the number of incidents and accidents that occur.

It is estimated that up to **80%** of accidents may be attributed, at least in part, to the actions or omissions of people.

Many incidents are blamed on the individual. This is often short sighted.

Accepting that errors can and will happen provides the opportunity to consider how and why they may occur. We also need to consider the organisational system in which the individual works, to help us better understand what factors may have influenced the error to occur.

Only through truly understanding the cause of human errors will management or prevention of future errors be possible.

SOURCE: HSE UK PUBLICATION (1999), *REDUCING ERROR AND INFLUENCING BEHAVIOUR*, http://www.hse.gov.uk/pUbns/priced/hsg48.pdf

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LAVERTON INCIDENT SUMMARY

TRACK WORKER STRUCK BY A PASSENGER TRAIN

On the morning of Friday 2 October 2015, a workgroup was assembling track-side in Laverton, Victoria. They planned to undertake dog spike removal works in preparation for re-sleepering of a section of track on the Altona Loop Line.

At around 0910, the supervisor for the works commenced marking the track to identify those dog spikes to be removed. He was working in a track crossover about 400 meters on the Melbourne side of Laverton Railway Station. A lookout had been placed for his protection.

At about 0916, a Metro Trains Melbourne suburban commuter train arrived at Laverton station, bound for Flinders Street Station in central Melbourne. After its scheduled stop, the train departed Laverton and approached the worksite. The lookout observed the train, warned workers of its approach and signalled to the driver that the track was clear. However, as the train took the crossover, the supervisor was foul of the track, and was struck by the train that was travelling at about 59 km/h. The supervisor suffered serious injuries.

SHARED LEARNINGS – ENHANCING SAFE BEHAVIOUR

1

Different safety behaviours will have different consequences. For example, an honest genuine mistake should be treated differently to intentional rule-breaking.

2

Metro Trains Melbourne (MTM) encourages all staff to acknowledge their own limitations and the potential for error.

3

MTM encourages staff to raise workplace conditions that make errors more likely, such as issues with equipment, job design, work environment, procedures, training and team dynamics.

4

MTM encourages all staff to recognise positive safety behaviours.

5

In a 'Just Culture', staff are accountable for their behaviour. Acceptable and unacceptable behaviour is clearly defined and people are not blamed for human errors.

WHAT IS THE ENHANCING SAFE BEHAVIOUR MODEL?

This is a model MTM uses for the fair and consistent management of safety behaviours. It is a tool to help classify different types of behaviours and identify fair and appropriate actions to influence them. This model supports Metro's Fair, Open and Just Culture Policy.

WHEN SHOULD THE ENHANCING SAFE BEHAVIOUR MODEL BE USED?

It should be used after a thorough and impartial investigation has been conducted into an incident. It is important that behaviours are classified only after the full facts have been established by the investigation team.

WHY DO WE HAVE IT?

To actively and fairly manage safety behaviours that promote an organisational culture where people feel comfortable to speak up without fear of blame. Correct and consistent use of this model will encourage:

- **Fairness and transparency** by acknowledging that different types of consequences are required to address different types of safety behaviours.
- **Openness** where people feel comfortable to make suggestions and acknowledge their limitations and achievements.
- **Accountability** where people are more likely to understand the potential consequences of their actions.
- **Greater understanding** of different behaviour types and the many factors that can influence human behaviour.

WHO NEEDS TO APPLY THE ENHANCING SAFE BEHAVIOUR MODEL?

The model is mainly for use by Line Managers and Supervisors. Safety, Environment and Risk (SER) and People Business Partners can use this tool to support Line Managers/ Supervisors in classifying behaviours and identifying appropriate outcomes

APPLYING THE ESB MODEL TO THE LAVERTON INCIDENT

These are **examples only** of how the ESB model can be applied to individual behaviours based on information in the Australian Transport Safety Bureau (ATSB) Report of the Laverton Incident.

It important to apply the model to behaviours which have contributed to the incident. Sometimes there may be several behaviours to classify for one or more individuals involved in the incident. See some examples below.

	1 DESCRIBE THE BEHAVIOUR	2 CLASSIFY BEHAVIOUR	3 DETERMINE INDIVIDUAL OUTCOME
SUPERVISOR	Supervisor fouls the track at the cross over which results in being struck by the train.	**UNINTENTIONAL BEHAVIOUR – MISTAKE** Supervisor assumes train will continue along the West Line and is not aware that the train is running on a Saturday timetable, resulting in a cross over to the East Line.	**EDUCATE, TRAIN, COACH** Educate, train, coach in areas relevant to the behaviour.
SUPERVISOR	Supervisor goes on track without receiving the safety briefing from the TFPC, which results in being unaware of train running information and the designated Position of Safety.	**INTENTIONAL BEHAVIOUR** Supervisor knowingly decides to start work without receiving the safety briefing and train running information from the TFPC. Why did this behaviour occur? Did he want to get a head start on the work given the work pressure? – ***Organisational Gain?*** Did he believe he was highly experienced and didn't need the TFPC to tell him what to do? – ***Personal Gain?*** Or he didn't think or care about the consequences – ***Reckless?***	**REVIEW AND ADDRESS BEHAVIOUR** Coach supervisor on expected safety behaviours and speaking up if short-cuts are being encouraged in the work environment. Counselling or disciplinary action is appropriate if the behaviour is classified as either intentional – 'Personal Gain' or 'Reckless'. The most suitable classification needs to be based on a thorough and impartial investigation.
LOOKOUT	The Lookout gives the driver the 'All-right' hand signal as soon as seeing the supervisor move away from the track, even though the supervisor is not in the correct Position of Safety at this point.	**UNINTENTIONAL BEHAVIOUR – MISTAKE** The Lookout sees the supervisor begin to react and believes the track was or would be clear, so gives the 'All-right' hand signal to the driver. There is a failure in judgement, decision making or planning.	**EDUCATE, TRAIN, COACH** Coach the Lookout on identifying how this error can be prevented, detected and mitigated (e.g. reporting work conditions that make errors more likely).

CONSIDER YOUR OWN BEHAVIOURS

WHAT BEHAVIOURS DO YOU DISPLAY?
WHY DID YOU DISPLAY THESE BEHAVIOURS AT THE TIME?

- Leaving a tool behind?
- Forgetting to sign a document?
- Speeding to work?
- Rushing a job?
- Not following procedures?
- Not raising a safety issue or challenging an unsafe act because you felt uncomfortable to speak up?

Your behaviours affect your own safety and the safety of others.

Always speak up when time pressures or any other work conditions are encouraging short-cuts or work-arounds.

Always stop the job until it can be done safely.

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

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

INFORMATION SOURCES

– Australian Transport Safety Bureau (ATSB), Rail Occurrence Investigation, RO-2015-019, Final 24 August 2016
– HSE UK Publication (1999), Reducing error and influencing behaviour, http://www.hse.gov.uk/pUbns/priced/hsg48.pdf
– MTM ‘Safety Issue Resolution’ Procedure
– MTM ‘A Fair and Just Culture’ Policy
– MTM ‘Enhancing Safe Behaviour Model’ Guideline

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