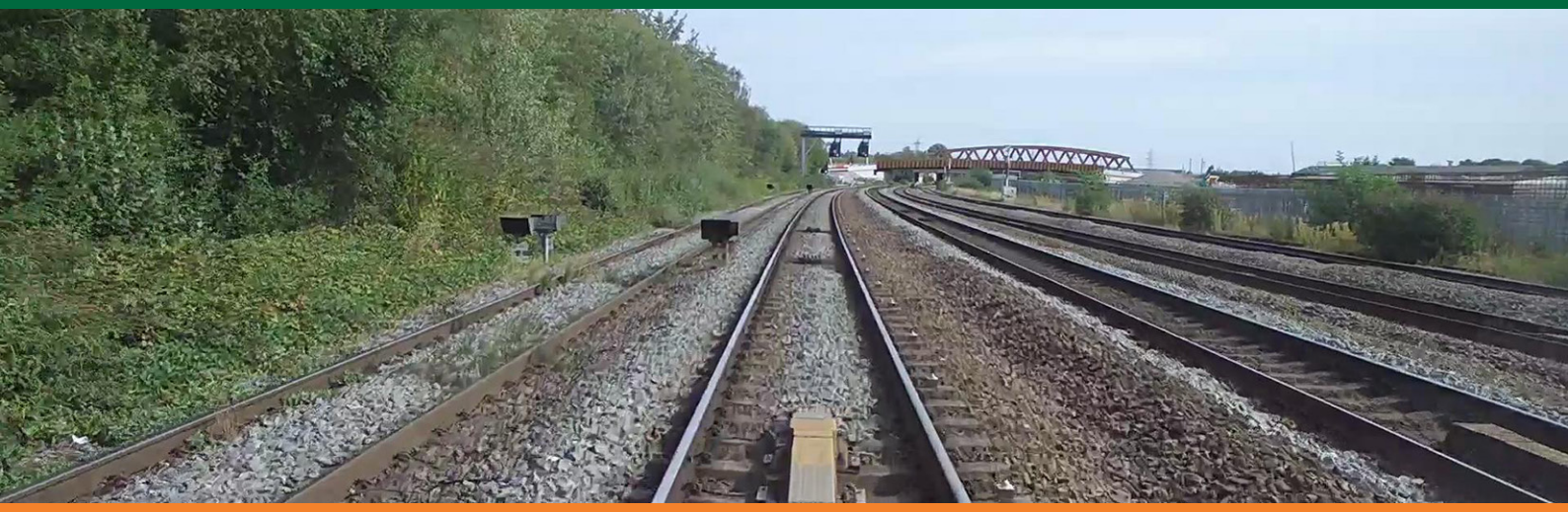
RAIB

Rail Accident Investigation Branch

Rail Accident Report



Near miss with a member of ground staff at Washwood Heath, Birmingham 18 September 2025

Report 13/2026
November 2026

This investigation was carried out in accordance with:

- the Railway Safety Directive 2004/49/EC
- the Railways and Transport Safety Act 2003
- the Railways (Accident Investigation and Reporting) Regulations 2005.

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This report is published by the Rail Accident Investigation Branch, Department for Transport.

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Preface

The purpose of a Rail Accident Investigation Branch (RAIB) investigation is to improve railway safety by preventing future railway accidents or by mitigating their consequences. It is not the purpose of such an investigation to establish blame or liability. Accordingly, it is inappropriate that RAIB reports should be used to assign fault or blame, or determine liability, since neither the investigation nor the reporting process has been undertaken for that purpose.

RAIB's findings are based on its own evaluation of the evidence that was available at the time of the investigation and are intended to explain what happened, and why, in a fair and unbiased manner.

Where RAIB has described a factor as being linked to cause and the term is unqualified, this means that RAIB has satisfied itself that the evidence supports both the presence of the factor and its direct relevance to the causation of the accident or incident that is being investigated. However, where RAIB is less confident about the existence of a factor, or its role in the causation of the accident or incident, RAIB will qualify its findings by use of words such as 'probable' or 'possible', as appropriate. Where there is more than one potential explanation RAIB may describe one factor as being 'more' or 'less' likely than the other.

In some cases factors are described as 'underlying'. Such factors are also relevant to the causation of the accident or incident but are associated with the underlying management arrangements or organisational issues (such as working culture). Where necessary, words such as 'probable' or 'possible' can also be used to qualify 'underlying factor'.

Use of the word 'probable' means that, although it is considered highly likely that the factor applied, some small element of uncertainty remains. Use of the word 'possible' means that, although there is some evidence that supports this factor, there remains a more significant degree of uncertainty.

An 'observation' is a safety issue discovered as part of the investigation that is not considered to be causal or underlying to the accident or incident being investigated, but does deserve scrutiny because of a perceived potential for safety learning.

The above terms are intended to assist readers' interpretation of the report, and to provide suitable explanations where uncertainty remains. The report should therefore be interpreted as the view of RAIB, expressed with the sole purpose of improving railway safety.

Any information about casualties is based on figures provided to RAIB from various sources. Considerations of personal privacy may mean that not all of the actual effects of the event are recorded in the report. RAIB recognises that sudden unexpected events can have both short- and long-term consequences for the physical and/or mental health of people who were involved, both directly and indirectly, in what happened.

RAIB's investigation (including its scope, methods, conclusions and recommendations) is independent of any inquest or fatal accident inquiry, and all other investigations, including those carried out by the safety authority, police or railway industry.

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Near miss with a member of ground staff at Washwood Heath, Birmingham, 18 September 2025

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Summary

At around 07:19 on 18 September 2025, the driver of a freight train reported a near miss with a ground staff operative (GSO) who was working adjacent to the Up Derby Slow line at Washwood Heath, Birmingham.

The GSO was undertaking a safety examination of a stationary train before its departure from the Up Washwood Heath Goods Loop. On approach the driver of the freight train, which was travelling at around 36 mph (58 km/h), saw that the GSO was between the stationary train and the line on which the driver's train was travelling and sounded the train's horn. The GSO acknowledged the warning and moved quickly towards the rear of the stationary train but only reached the rear wagon and a position of safety behind it, around 4 to 5 seconds before the freight train passed them.

There were no injuries or damage caused, but the driver of the freight train was shaken by the incident.

RAIB's investigation found that the GSO was in an unsafe place when the freight train approached. This was because the safety examination needed to be done outside the nearby freight terminal and the GSO had undertaken their duties on the side of the train next to an open line, without an appropriate safe system of work in place. An underlying factor to the incident was that Freightliner had not effectively managed the risk of undertaking this activity at this location. RAIB also observed that the process for testing for drugs and alcohol after the incident was not followed, as required by rail industry standards.

As a result of the investigation, RAIB has made one recommendation to Freightliner Limited, to improve its processes for undertaking train preparation activities outside terminals and depots. RAIB has also made two learning points, the first to highlight the importance of reporting potentially unsafe conditions, and the second to remind duty holders of the requirements to test staff involved in incidents for drugs and alcohol.

Introduction

Definitions

1 Metric units are used in this report, except when it is normal railway practice to give speeds and locations in imperial units. Where appropriate the equivalent metric value is also given.

2 The report contains abbreviations and acronyms, which are explained in appendix A. Sources of evidence used in the investigation are listed in appendix B.

The incident

Summary of the incident

3 At around 07:19 on 18 September 2025, the driver of train reporting number 6M90, the 05:06 freight service from Avonmouth Hanson Siding to Clitheroe Castle Cement works, reported a near miss with a ground staff operative (GSO). The GSO was working adjacent to the Up Derby Slow line at Washwood Heath, Birmingham (figure 1).

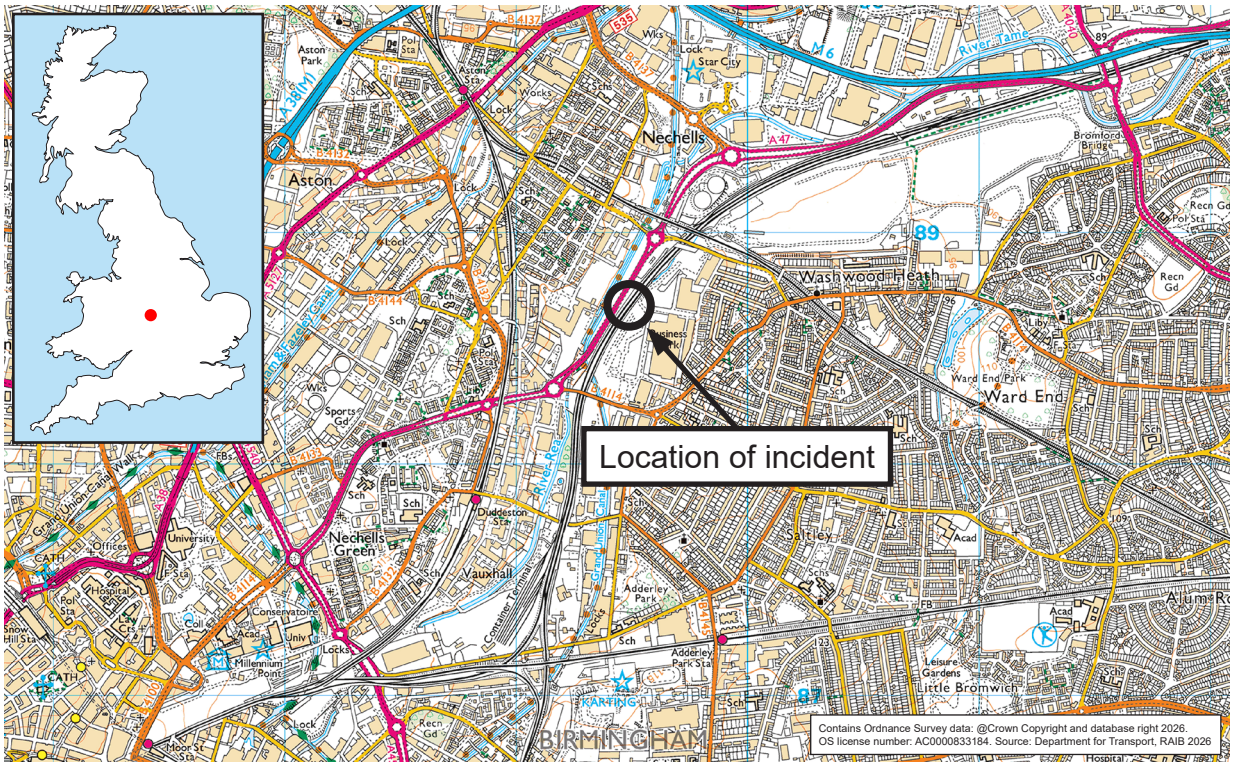


Figure 1: Extract from Ordnance Survey map showing the location of the incident at Washwood Heath.

4 The GSO was undertaking a brake examination of stationary freight train 4O15, as part of the train preparation tasks needed before its departure from the Up Washwood Heath Goods Loop (figure 2). The driver of train 6M90 saw that the GSO was between the stationary train and the line on which they were travelling and sounded the train's horn as a warning. Train 6M90 was travelling at around 36 mph (58 km/h) when the near miss occurred.

5 The GSO acknowledged the train's warning and moved quickly towards the rear of train 4O15. The driver of train 6M90 realised that the GSO was still not in a position of safety as the train got closer to them and made an emergency brake application. The GSO reached the rear wagon of the stationary train which allowed them to move to a position of safety behind it, around 4 to 5 seconds before train 6M90 passed them.

6 There were no injuries or damage caused, but the driver of train 6M90 was shaken by the incident.

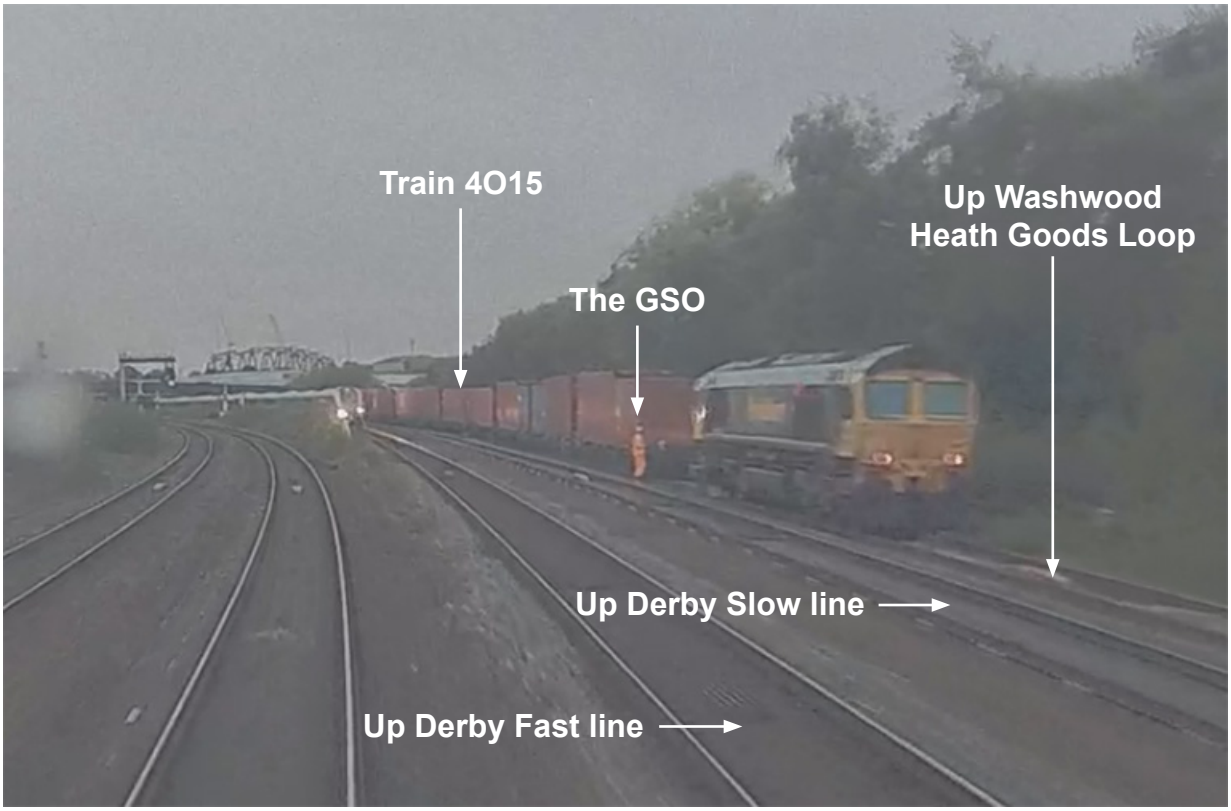


Figure 2: Forward-facing CCTV image from another train passing the site around 10 minutes before the incident (courtesy of CrossCountryTrains).

Context

Location

7 Train 4O15 was being prepared on the Up Washwood Heath Goods Loop before its departure via Landor Street Junction to Southampton. Train 6M90 was approaching from the south and travelled over Landor Street Junction to reach the Up Derby Slow line (figure 3). This line was separated from the goods loop by a distance of around 2 metres. Both lines are bidirectional and had a maximum permissible speed of 40 mph (64 km/h) in both directions.

8 The Washwood Heath Goods Loop gives access for trains arriving and departing from Freightliner's Lawley Street terminal. Container freight wagons are both received and prepared for onward departure at this terminal. The goods loop, and the other lines in this section of track, lead to and from Tamworth and Proof House Junction in Birmingham. All five lines at this location are non-electrified.

9 The signalling in the area is track circuit block (TCB) under the control of the West Midlands Signalling Centre (WMSC).

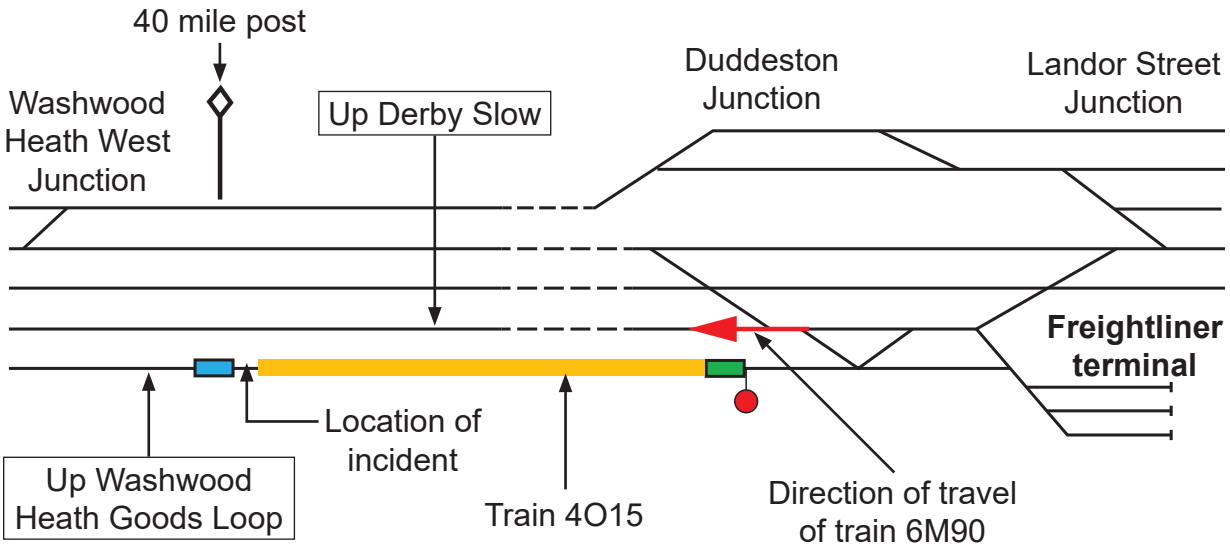


Figure 3: Location details of the incident.

Organisations involved

10 Network Rail owns and maintains the infrastructure at this location, including being responsible for the inspection and maintenance of lineside vegetation. Infrastructure maintenance is the responsibility of staff at Network Rail's Sandwell and Dudley delivery unit. This lies within its Central route, which is in turn part of its North West and Central region. Each Network Rail region acts as a devolved management organisation within the company.

11 At the time of the incident, Freightliner Group Limited was the employer of the GSO, as well as the driver and other staff involved in the preparation of train 4O15. It owned and operated Lawley Street terminal at the western end of the Up Washwood Heath Goods Loop from where the wagons forming the train were drawn out.

12 Since this incident and a change within the structure of the business, the terminal is now owned and operated by Freightliner Limited and the GSO is now employed by Heavy Haul Rail, a separate company.

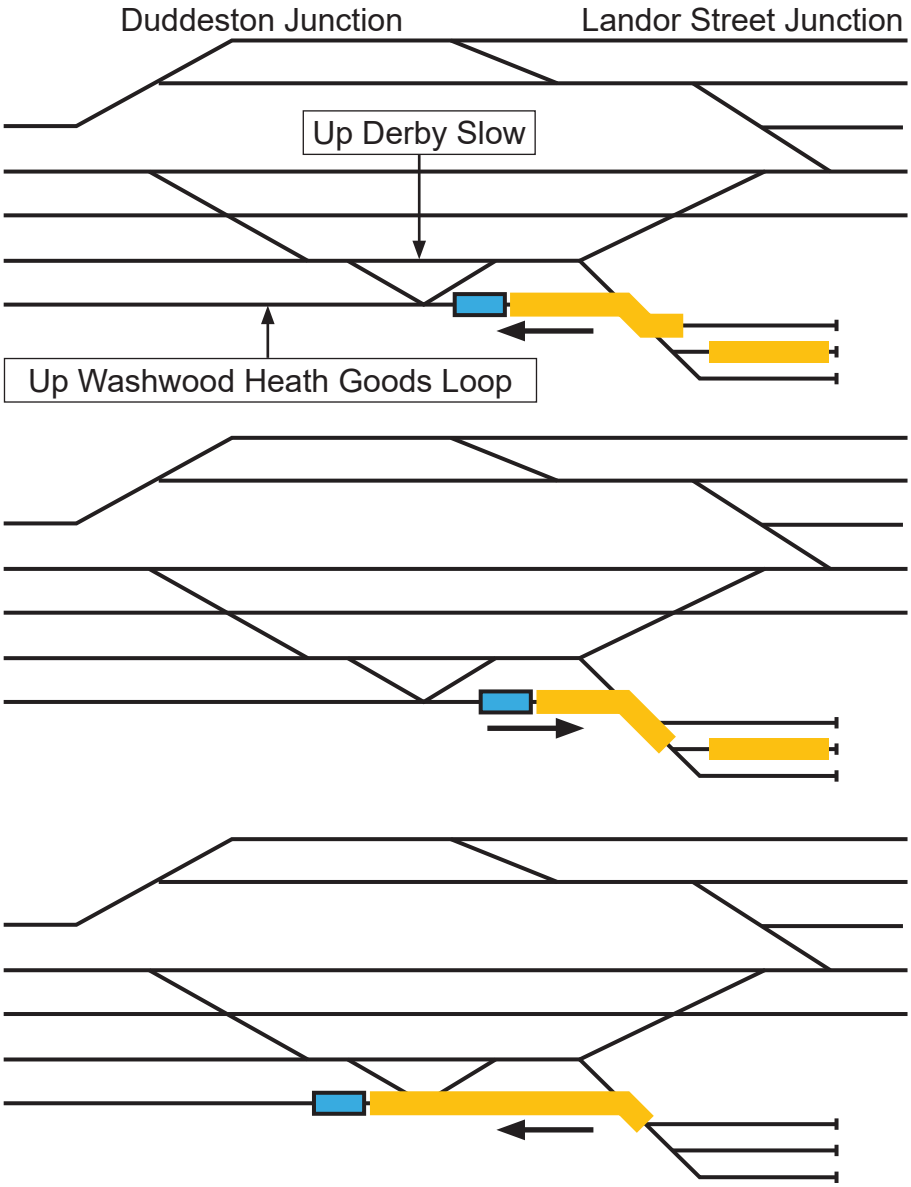
13 Train 6M90 was operated by GB Railfreight Limited (GBRf) which is also the employer of its driver.

14 All parties freely co-operated with the investigation.

Trains involved

15 Train 4O15 was formed of a class 66 diesel locomotive hauling 27 loaded single-unit FEA container wagons. It was approximately 580 metres long.

16 This train had been formed from two discrete sets of coupled wagons stabled within Lawley Street terminal on two separate tracks. The tracks within the terminal were long enough for each of the two sets, but too short to be able to form the whole train due to its length. The final forming of the train was therefore done by a locomotive drawing out one set of coupled wagons onto the Up Washwood Heath Goods Loop, and then reversing these back into the terminal to meet the other set to be coupled (figure 4).



a) Locomotive couples and draws out first set of connected wagons from the terminal

b) Locomotive reverses and the first set of wagons is coupled to second set

c) Locomotive draws out fully coupled wagons to the loop line

Figure 4: Coupling the locomotive and wagons and draw out from the terminal.

17 At the time of the incident, the train was undergoing final preparation on the goods loop. This included a brake continuity test which was assisted by the GSO at the end of the train furthest from the terminal.

18 Train 6M90 was the 05:06 freight train service from Avonmouth Hanson Siding to Clitheroe Castle Cement works. It was formed of a class 66 diesel locomotive hauling 23 loaded PCA and JPA wagons. At the time it passed over Landor Street Junction, it was running around 15 minutes early to the timetable.

Staff involved

19 The GSO had been a mobile ground staff operative with Freightliner UK since 2020. They had previously been a track worker, having started on the railway in 2014. During that time, they held the PTS (personal track safety) and lookout competencies.

20 At the time of the incident, the GSO held Freightliner's track safety certificate, having passed the safety knowledge and rules examination in April 2025. This satisfied Freightliner's track safety procedure for operational safety-critical roles in line with the competency requirements of section 7 of GERT8000 The Rule Book Module G1, 'General safety responsibilities and personal track safety for non-track workers', issue 10 dated September 2025.

21 Being a mobile operative meant that the GSO undertook train preparation duties at a variety of locations, both in depots and terminals, and out on open running lines. Freightliner informed RAIB that this was the GSO's fourth time undertaking this task at this location.

22 The driver of train 6M90 was based in Bristol and had been driving trains for over 10 years, having started on passenger trains before moving to freight trains.

External circumstances

23 The near miss happened during daylight and in dry conditions. External circumstances did not affect the incident.

Background information

Train 4O15 preparation process

24 Train 4O15 is a timetabled service with three train paths allocated per day between 02:00 and 07:00 on Tuesdays to Fridays. Not all these paths are used, and in the 7 weeks before the incident the train ran a total of seven times.

25 The train is timetabled as a 'run round' move (figure 5). This involves the locomotive which will form part of the service train drawing the wagons from the terminal and onto the Up Washwood Heath Goods Loop. It then uncouples from the wagons and travels back on its own along the Up Derby Slow line towards the terminal. Once there, it recouples to what will be the front wagon of the train, before departing via Landor Street Junction.

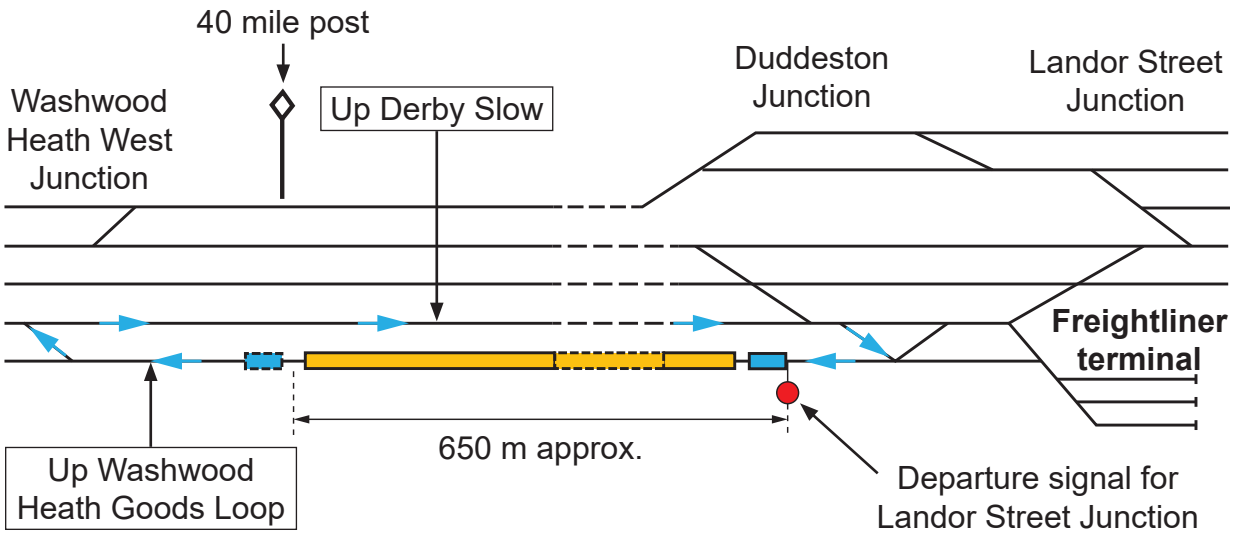


Figure 5: Single locomotive run round move.

26 On the day of the incident, however, this sequence of moves used two locomotives (figure 6). One locomotive drew the wagons from the terminal onto the Up Washwood Heath Goods Loop. A second locomotive was then coupled to the wagons at the terminal end forming the complete train, and the first locomotive uncoupled. This first locomotive then travelled back to the terminal via the Up Derby Slow line.

27 As part of this process, a brake continuity test is required before the train can be fully drawn out from the terminal. A second similar test is then undertaken following the uncoupling of the first locomotive and the coupling of the second locomotive. This safety check is to ensure that all wagons' brakes can be operated from a newly coupled locomotive.

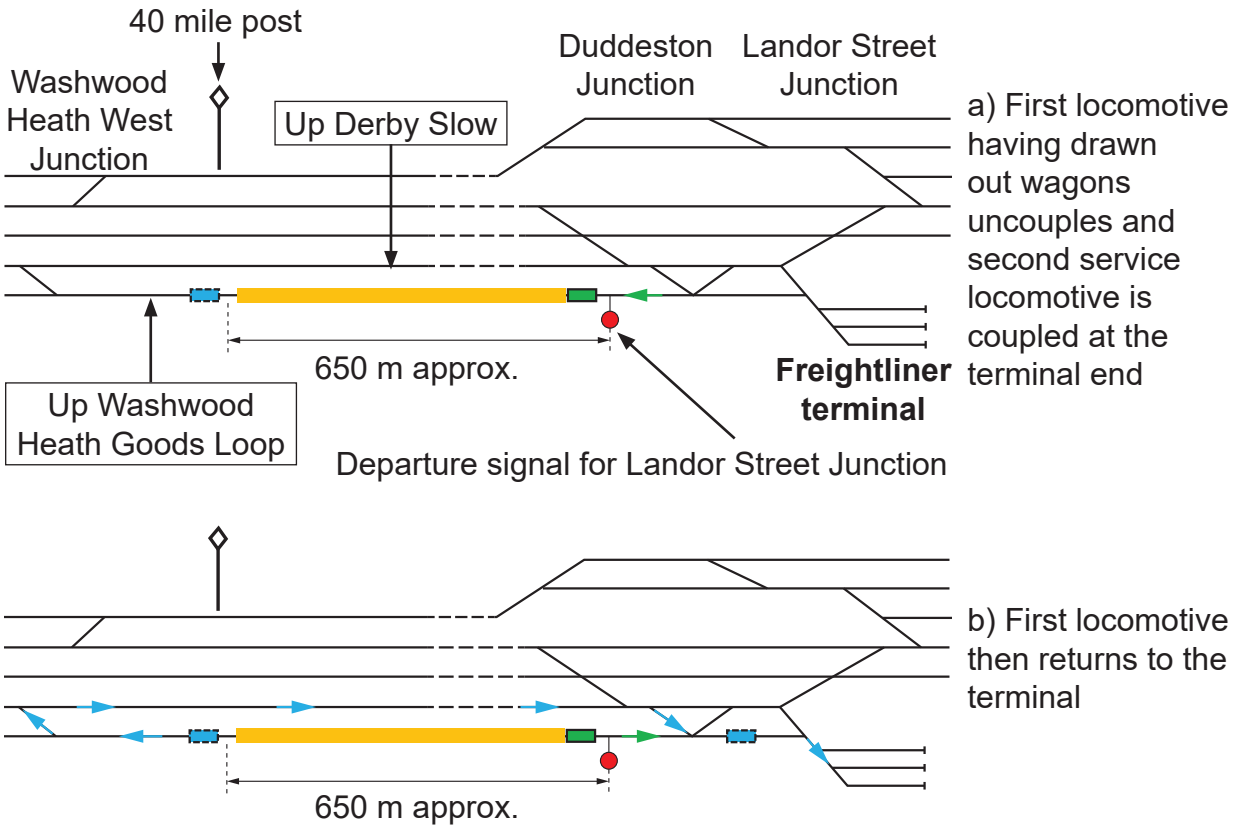


Figure 6: The move on the day of the incident using two locomotives.

28 An overview of the process for the forming of train 4O15 on that day is as follows:

a. The person in charge (PiC) of the move was in radio contact with the GSOs assisting in the train's preparation and the drivers of the locomotives (in this context, the PiC is the person acting in the role of the 'shunter' under GERT8000 The Rule Book Module SS2 'Shunting', issue 7 dated September 2024).

b. The first locomotive drew out the previously coupled wagons from one of the terminal lines onto the Up Washwood Heath Goods Loop once the PiC had obtained permission from the signaller to do so. The GSO rode in the cab of this locomotive and got out once it came to a stand on the goods loop.

c. The train then stopped and reversed so that the remaining coupled wagons on the other line within the terminal were connected to form the full train. This task was undertaken by a second GSO who was working within the terminal. A brake continuity check was then performed.

d. The train then moved forwards sufficiently far to allow another locomotive, the one which will be used for the service, to be added to what was then the rear of the train. An allowance of distance is made so that the driver of this locomotive, when coupled, has sight of the signal which controls the train's departure.

e. Before the second brake continuity test could begin, the GSO, upon instruction over the radio from the PiC, released the air from the wagons in the train before uncoupling the first locomotive which drew the wagons out of the terminal. This locomotive then moved a few metres forwards.

f. The train's brake pipe was then closed and charged with air provided by the newly coupled locomotive. All of this was co-ordinated by communication between the GSO, the train drivers and the PiC.

g. The final part of this test was for the GSO to check that the brake blocks have been released from the now rear wagons. This check involves inspecting that the brake blocks are clear of the wheel treads.

h. Once the driver of the second locomotive leading the fully formed train 4O15 has received the appropriate signal, it departs.

The sequence of events

Events preceding the incident

29 The GSO booked on at 05:25 on 18 September 2025 at Rugby and then drove to Lawley Street terminal where they signed in.

30 They received a briefing with details of the train preparation from the PiC and were given a radio. The GSO rode in the first locomotive with the driver of the train drawing out the wagons from the terminal. The formation of the train was recorded at 06:40 following the signaller's permission to occupy the Up Washwood Heath Goods Loop.

31 Once both coupled sections of wagons had been drawn fully onto the Goods Loop (paragraph 28), the GSO got out of the locomotive they had travelled on from the cess side (the cess is the area alongside the railway).

32 Being in radio contact with the PiC, the GSO waited until being informed that the second locomotive at the other end had been coupled. They then added a tail lamp to the wagon which was to be uncoupled from the first locomotive, uncoupled it, and released the air from the train (figure 3). The first locomotive was then given an instruction to move forwards a small distance away from the wagons.



Figure 7: The position of a GSO in the cess during their train preparation tasks.

Events during the incident

33 At around 07:15, the GSO received a radio message that the coupling of the second locomotive had been completed and that the train's brake-pipe air pressure was restored. The GSO then undertook the final part of their duties assisting with the preparation of the train, which was a check that the brakes on the rear wagons were released. They intended to do this by observing that the brake blocks on the wagons were clear of the treads of the wagons' wheels.

34 There was overgrown vegetation in the cess adjacent to the wagons (figure 8). The GSO viewed this to be a risk to them when carrying out the brake check as they would have to push their way through it. They considered that checking the brakes from the other side of the train, the six-foot side (the six-foot is the area between two adjacent lines), next to the adjacent Up Derby Slow line, to be less of a risk to themselves.



Figure 8: Image from the Automatic Intelligent Video Review system recorded on 8 September 2025 showing areas of overgrowth in the cess close to where the incident occurred.

35 A new procedure was introduced by Freightliner in March 2025 which stated that the final check on the condition of the brakes could be carried out by inspecting only the rear wagon. This replaced an earlier procedure which required the brakes to be checked on the rear three wagons. Although the GSO had been briefed and was aware of this new procedure, they nevertheless checked the brakes on the rear three wagons. Freightliner told RAIB that this practice has continued to be common for those who had been taught train preparation duties before the change in the procedure.

36 The GSO walked along the side of the train inspecting the wagon's brakes. They stated that, while doing so, they were looking up in both directions every 5 seconds for approaching trains.

37 Train 6M90 approached where the GSO was working on the adjacent Up Derby Slow line, having passed over Landor Street Junction, and was accelerating. The driver stated that they saw the GSO through the arch of a road overbridge. The on-train data recorder shows this was around 440 metres away and the train was travelling at around 37 mph (60 km/h).

38 The GSO stated that they had walked as far as the rear bogie of the third from rear wagon, a distance of around 45 metres, when they became aware of the approaching train (figure 9).

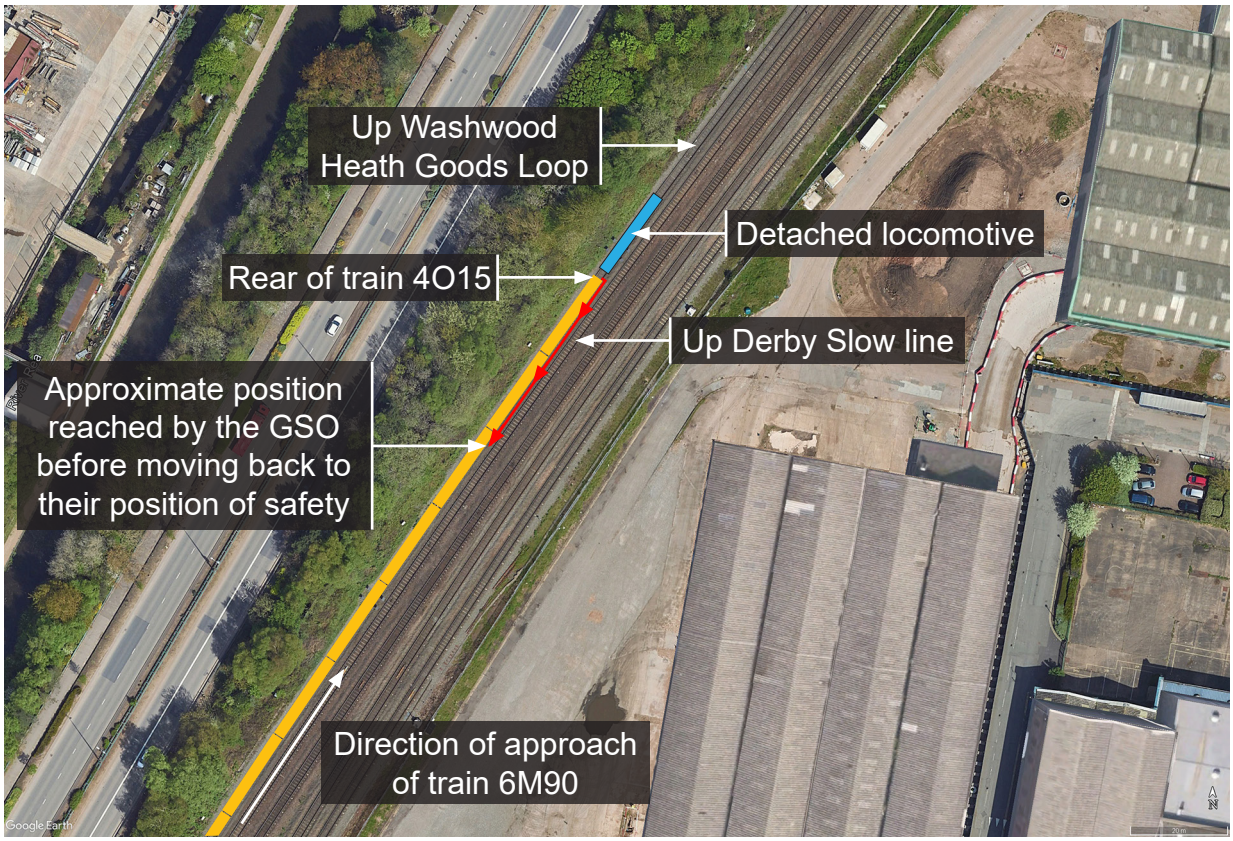


Figure 9: The approximate position reached by the GSO when they acknowledged the approach of train 6M90.

39 On seeing the GSO, the train driver sounded the train's horn as a warning. The GSO acknowledged this by raising one arm and began to move back towards their position of safety behind the rear wagon of the stationary train. After their train had passed under the bridge, the driver of train 6M90 had a better view of the GSO, and they removed power from the train, which was travelling at around 38 mph (61 km/h). Although the driver could see that the GSO was moving quickly towards the rear of the stationary train, they realised that the GSO was still in an unsafe position and operated the plunger to apply the emergency brake.

40 Based on RAIB's analysis, the GSO reached the rear of the stationary train and moved into a position of safety around 4 to 5 seconds before train 6M90 passed them.

Events following the incident

41 At around 07:16, train 6M90 came to a stop around 350 metres from where the emergency brake had been applied. The driver called the signaller and explained the reason why they had stopped the train.

42 By this time, the GSO had informed the PiC by radio that the brake test had been completed and had got back on to the uncoupled locomotive.

43 The incident log records that at 07:20 the Network Rail section signalling manager had been informed of the incident and a local mobile operations manager (MOM) had been asked to go to the terminal to obtain a statement from the GSO.

44 At 07:27, Freightliner control was contacted by Network Rail and told of the reported near miss. The incident log records that the plan was to allow train 4O15 to depart and for the uncoupled locomotive to return to the terminal for the MOM to take a statement from the staff involved.

45 Around 07:38, train 4O15 departed from Washwood Heath Goods Loop towards Southampton, 5 minutes later than scheduled.

46 During the time train 6M90 was at a stand, the GSO was contacted by Freightliner control and the report of the near miss was discussed. The GSO disputed that it had been a near miss.

47 The driver of train 6M90 had been shaken by the event. They resumed their journey around 25 minutes after train 6M90 had come to a stop, after they had spoken with their control and declaring themself fit to continue.

48 By around 07:43, the uncoupled locomotive had travelled on the Up Derby Slow line back to the terminal. The GSO was informed by terminal staff that the incident had been reported as a near miss and that the GSO should wait until being contacted.

49 Following this, there was a further conversation between the GSO and Freightliner control. The GSO was asked whether they were fit to continue. By 07:48, and with the agreement of Freightliner control, the GSO had left the terminal for their next job in Oxford. They left without being tested for drugs or alcohol, and without providing a report about the incident.

50 The MOM who had been sent to the terminal found that the GSO was not there, so Network Rail arranged for a different MOM, local to Oxford, to meet the GSO and take a report from them. This records that the GSO did not consider it a near miss as they were checking every 5 seconds, and in their view had plenty of time before the train passed them.

51 While in the area, the MOM who visited the Lawley Street terminal observed the conditions of the cess from an access point close to the far end of the goods loop and observed that it was “not really a walking route, just a cess”.

52 RAIB requested the forward-facing CCTV (FFCCTV) download from train 6M90 but was later told that it had been corrupted and could not be viewed.

Analysis

Identification of the immediate cause

53 The GSO was working in an unsafe place as the train approached.

54 The GSO was conducting a brake check from the six-foot between the stationary freight train and the adjacent open line. This is in an area which is defined as '*on or near the line*' in module G1 (paragraph 20) as it is within 3 metres of an open line.

55 Even though the GSO moved quickly to the rear of the stationary train, they were not in a position of safety for the required minimum of 10 seconds before the approaching train reached them.

Identification of causal factors

56 The incident occurred due to a combination of the following causal factors:

a. The planned brake continuity test needed to be undertaken outside the terminal (paragraph 57).

b. The GSO conducted the train preparation duties on the six-foot side of the train, adjacent to an open line, probably because the cess was overgrown, without an appropriate safe system of work in place (paragraph 62).

Each of these factors is now considered in turn.

The location of the planned brake test

57 The planned brake continuity test needed to be undertaken outside the terminal.

58 For a freight train of this length, it is necessary for it to be formed on the Up Washwood Heath Goods Loop. This is because the lines in the terminal are too short to accommodate all the wagons of such a train (paragraph 16).

59 The goods loop is adjacent to the Up Derby Slow line. Both are mainline bidirectional lines with maximum line speeds of 40 mph (64 km/h) in both directions. There is around 2 metres of separation between the two lines and there is no fence or other structure between them.

60 The signalling on the goods loop was upgraded in 2013 to allow for trains up to 640 metres in length to be formed on it. RAIB found no evidence that provision of an authorised walking route or safe cess which could be used during train preparation was considered during this upgrade.

61 There is an authorised walking route, approximately 400 metres long leading from the terminal boundary to the signals controlling train movements into the terminal, and those used to control departures via Landor Street Junction (figure 10). This allows drivers to access locomotives and for GSOs to undertake train preparation duties in this area. However, for other locations along the goods loop further from the terminal which personnel may be required to access or work, including the area where the near miss occurred, there are no authorised walking routes.

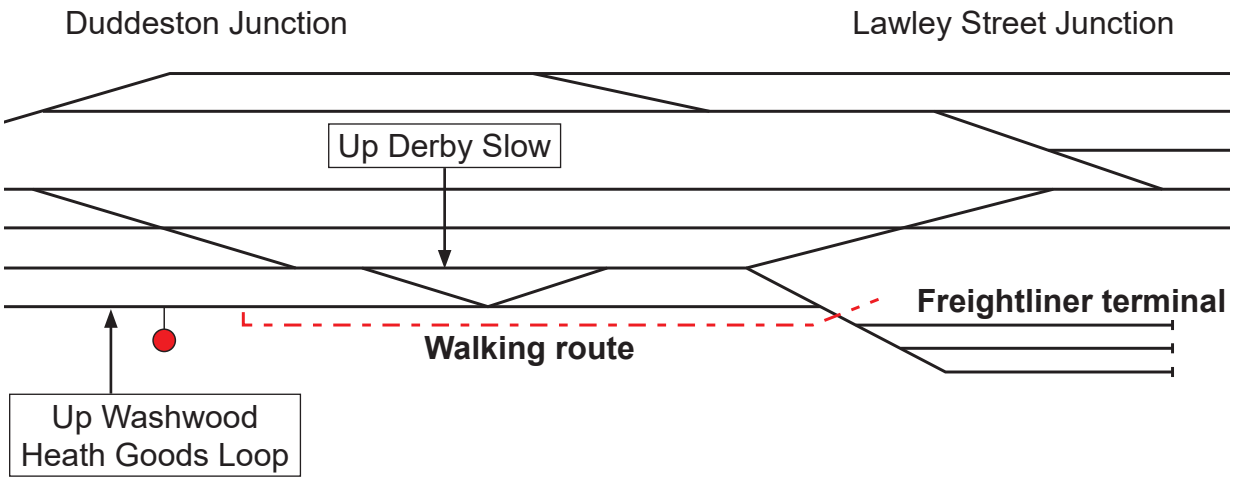


Figure 10: The walking route from the terminal to the departure signal.

The safe system of work and the decision of the GSO

62 **The GSO conducted the train preparation duties on the six-foot side of the train, adjacent to an open line, probably because the cess was overgrown, without an appropriate safe system of work in place.**

63 The cess in the area to which the GSO required access to undertake the brake check was overgrown in some places. Because of this, the GSO decided it was safer to undertake the task of checking the wagons' brakes from the six-foot side of the train.

The intended safe system of work

64 Safe access to the wagons with the adjacent Up Derby Slow line open to traffic relied upon the cess side of the goods loop being accessible. Using the cess to undertake this activity was the intended method of work for staff laid down by Freightliner in its local working instructions (see paragraph 78).

65 The accessibility of the cess was not being actively managed. Network Rail's local off-track vegetation team are responsible for the maintenance of lineside vegetation as detailed in standard NR/L2/OTK/5201, 'Lineside vegetation management manual', issue 7 dated 6 December 2025. This states that vegetation management controls the risks of obstructing refuges and positions of safety, blocking or restricting the safe use of authorised walking routes or access to facilities or pathways. It also covers proximity of vegetation to infrastructure, such as overhead lines, vegetation that affects the sighting of signals, and vegetation within 3 metres of a running line with the potential to come into contact with trains.

66 In common with other areas of the railway network, the lineside vegetation conditions in this area are inspected by reviewing the footage recorded by the AIVR (Automatic Intelligent Video Review) system. From this and supplementary cab rides, any work identified can be added to the work bank. Although not apparent from the FFCCTV from passing trains before the incident, images from Network Rail's AIVR system recorded on 8 September 2025 (10 days before the incident) show areas where the cess was overgrown in some places making access difficult (figure 8).

67 The cess in this area was assessed on 4 September 2025 and was given a priority that required it to be addressed with 6 months based on the general level of growth predicted over that period. The cess in the area in which this incident occurred is not defined as a refuge, position of safety nor an authorised walking route. As such, it was treated in the same way as any other standard lineside on the railway and not as a regular cyclical task for maintenance. Network Rail told RAIB that it would require a fault to be raised in response to a request by Freightliner for vegetation encroachment to be addressed.

68 There had been previous reports of overgrowth affecting staff accessing locomotives and trains in other areas close to the terminal. These had included areas closer to Landor Street Junction where trains stop to allow a change of drivers. A report of vegetation overgrowth by Freightliner was raised on 31 May 2025 and this was recorded as a fault on Network Rail's fault management system. This was rereported on 3 July, and the vegetation was cleared by the local Network Rail off-track team on 17 July. Another fault for the same location near Landor Street Junction was raised on 11 August with the comment that the vegetation had only been cut back by a few metres and that it had grown back quickly. Freightliner had offered a visit with the off-track team to show them the areas that needed additional clearing but there is no evidence that this was followed up.

69 A fault had also been raised on the fault management system regarding overgrown conditions on the walking route close to the departure signal on the Up Washwood Heath Goods Loop (paragraph 61) on 1 August 2025 (figure 10). This pathway was cleared on 4 August.

70 On 11 September, a Freightliner driver reported overgrown conditions in the cess of the goods loop, both to their management and union representatives. This was a result of them having to change ends of their locomotive close to the departing signal at the terminal end of the goods loop. This was slightly further from the terminal than the point at which the walking route met the track, so access to the cess was required. They had to push through vegetation while changing ends on the locomotive and provided a picture accompanying their report (figure 11).

71 This driver stated that this increased the risk of tripping on vegetation, scratches and skin irritation. They further stated that there was no safe place on the other side of the train as the Up Derby Slow was a running line. They suggested that a contingency measure was for drivers to request a line block on the Up Derby Slow line to reduce the risk. There is no evidence that action was taken to address this report before the near miss incident on 18 September.

72 Train 4O15 had run seven times over the previous 7 weeks before the incident and it was likely that the cess where GSOs worked, and where drivers may have changed ends on their locomotives before returning to the terminal, was in an overgrown condition. This includes the period in which the GSO involved in the incident had performed this task before, when they had also checked the condition of the wagons' brakes from the six-foot side. At that time, the GSO was concerned about twisting an ankle from having to push through the foliage. They also stated that on this previous occasion there were fewer trains passing on the other lines.



Figure 11: The condition of the cess on 11 September 2025 close to the signal at the terminal end of the Up Washwood Heath Goods Loop (courtesy of a Freightliner train driver).

73 Freightliner has an instruction within one of its instruction manuals for drivers and ground staff which states that they expect staff to '*report defective/unsafe walking routes'*. It gives briefings to its staff on its own work safe reporting system which allows them to report unsafe conditions confidentially.

74 Although there had been reports from drivers of overgrown conditions in other areas close to the terminal, there is no evidence that any reports had been made regarding the overgrown conditions of the cess in the area in which the incident occurred. This is the subject of a learning point (see paragraph 107).

Monitoring the safe system of work

75 Freightliner had procedures in place for its staff working within the terminal. These included its common safe system of work (CSSoW) and its local working instructions.

76 The CSSoW document contained information about shunting and loading activities within the terminal, methods of communication between personnel, and the role of the PiC in the preparation of trains.

77 The local working instructions contained the steps to be taken in the preparation of trains. This included shunting moves within the terminal, run round moves in the 'reception sidings' (which is a reference to the Up Washwood Heath Goods Loop, although this is classified as a goods line by Network Rail and not a siding) and propelling moves into the terminal.

78 One of the steps within the run round section of the local working instructions states:

> '*Remembering that all other lines are open to rail traffic running at up to line speed, the shunter must stand in a position of safety on the CESS side of the train, he/she may now instruct the locomotive driver to move onto the wagons. The shunter must instruct the locomotive driver to stop as soon as the buffers make contact.*'

This is the sole reference to the presence of open lines outside the terminal and there is no consideration of the steps to take if the cess is not accessible.

79 The train preparation being undertaken that day was a regular, planned move. However, there is no evidence that Freightliner was monitoring the condition of the cess or had considered an alternative safe way of working if it was not accessible. The industry's investigation report into this incident stated that Freightliner had not accompanied Network Rail on any safety tours of the area in the previous 2 years.

Actions of the GSO

80 Although working from the cess was the intended method of work for the task of checking the brakes (paragraph 61), working from the six-foot side and next to an open line placed the GSO at risk of being struck by trains. The GSO held the necessary competence to work on or near the line and had previously held a personal track safety competence (paragraph 19) and so should have been aware that being on the six-foot side of the wagon was unsafe.

81 In the absence of a clear, briefed procedure on what action to take in the event the cess was inaccessible, the GSO continued with the task relying on looking out for approaching trains. This was how the GSO had successfully undertaken the task on one occasion in the past.

82 For the GSO, the circumstances of the blocked cess resulted in a goal conflict in terms of undertaking the task and doing so safely, leading to a 'situational violation'. These are defined as '*necessary violations that arise from inadequate equipment or workplace environment that make it impossible to carry out the work and still comply with the procedures*'.[1] Such violations result from a lack of choice and can often be reduced through task design. The intention is to complete the job efficiently and not to cause a negative outcome.

83 RAIB assessed the GSO's roster for the previous 6 weeks and found no evidence that their working patterns led them to be fatigued. Witness evidence shows that they had fully rested the night before and did not feel tired during the task. They also did not feel under any time pressure to complete the check on the wagon brakes.

84 Although the GSO was not tested for the presence of drugs and alcohol in line with industry standards (see paragraph 95), there is no evidence that they were impaired by drugs or alcohol at the time of the incident.

[1] Reason J, 'Achieving a safe culture: theory and practice', Work & Stress: volume 12, number 3, pages 293 to 306 (1998).

85 While not listed in the local working instructions, there were other options available to the GSO to ensure that this task was done in a safe way:

- The GSO was aware of Freightliner's worksafe procedure for staff to report safety concerns. As such, the GSO could have contacted their own line manager or the manager of the terminal to seek advice.
- A request to stop trains on the adjacent line could have been made via the PiC at the terminal, as they were in contact with the signaller.
- The GSO could have requested one of the locomotive drivers to ask the signaller to stop train movements on the adjacent line. Rule Book module TW1, 'Preparation and Movement of Trains', allows for drivers to protect themselves and other staff when they have to '*walk alongside the train*'.

86 Freightliner's GSOs also receive training on taking line blockages within T3 possessions, allowing them to get safe access to trains within work sites. Freightliner told RAIB that staff have access to information electronically on lines, speeds and directions so that they can obtain local knowledge regarding the locations at which they work. This is a requirement of module G1 and forms part of Freightliner's GSO track safety training.

87 Since starting this role in 2020, the GSO had only requested one line blockage (which was not at this location) and stated that they did not feel sufficiently knowledgeable about the area near the goods loop to do so. This is probably because this was only the fourth time they had undertaken duties here. The GSO also stated that they believed that the line speed on the Up Derby Slow line was 10 mph (16 km/h) and not 40 mph (64 km/h), and that it was used just for run round purposes and trains stopping there. They considered that the line was "just a siding", whereas it is an open running line on the mainline network.

88 Freightliner told RAIB that the GSO had been observed by their team leader undertaking train preparation duties near open lines, although there is no evidence that they had been observed doing this task at the incident location. Freightliner told RAIB that they were satisfied that the GSO was aware of the lines, speeds and directions of rail traffic in the area.

Identification of underlying factor

Underlying factor

89 **Freightliner had not effectively managed the risk of undertaking train preparation at this location.**

90 The preparation of this train and others on the Up Washwood Heath Goods Loop is a regular, planned activity.

91 Accessing the cess at this location was the intended means by which staff could safely carry out the task, as detailed in local work instructions. However, RAIB found no evidence that the condition of the cess was being monitored to assure a safe system for working. Furthermore, there was no clear and briefed procedure in place for the actions to be taken if the intended safe system was not available.

92 Railway undertakings such as Freightliner are required by health and safety legislation and the Railways and Other Guided Transport Systems (Safety) Regulations 2006 (ROGS) to undertake a suitable and sufficient assessment of risks to safety, to implement control measures identified in their risk assessment, and carry out regular reviews to ensure they remain effective.

93 In addition to these legal requirements, Rail Industry Standard RIS-3781-TOM, 'Requirements for the operation of freight trains and the conveyance of dangerous goods by any train', issue 2 dated March 2025, requires freight operating companies such as Freightliner to '*have plans in place to consider the time and resources required to prepare trains to enter service*'. Freight operators are specifically required as part of generating such plans to assess the features of a location (such as whether they are in a terminal) and if a safe system of work exists for train preparation activities.

94 Freightliner stated to the industry investigation that the CSSoW (paragraph 75) had been developed '*on the back of a risk assessment of operational activities*'. However, RAIB found that Freightliner had not completed a specific risk assessment of train preparation activities being undertaken on the goods loop, as it was required to. As a result, Freightliner had not identified effective control measures intended to mitigate the risk of staff being struck by trains when undertaking such activities.

Observations

Managing the post-incident response

95 **The GSO was not tested for drugs and alcohol following the incident, as required by rail industry standards.**

96 Rail Industry Standard RIS-8070-TOM, 'Drugs and alcohol testing for safety-critical workers', issue 2 dated March 2022, states that 'for cause' testing should be carried out if there are reasonable grounds to suspect that a person who may have contributed to an accident or incident is under the influence of drugs and alcohol or is putting the safety of the operational railway at risk. Within this standard, there is a flowchart process of the decisions to be taken in the event of a reported incident or accident (appendix C). If followed, the GSO should have been tested for cause following the incident.

97 The GSO was not subject to for cause drugs and alcohol testing following this incident and left the terminal to prepare a train elsewhere (paragraph 49).

98 The internal railway incident log recorded that Freightliner control was informed of the near miss by Network Rail around 10 minutes after the incident (paragraph 44). This followed the immediate reporting of the incident by the driver to the signaller (paragraph 41). After discussing the incident with the GSO, who disputed that there had been a near miss, Freightliner control allowed the GSO to continue to their next job in Oxford. Freightliner stated to RAIB that for cause testing was not applied because of the challenge from the GSO, and a perception of delay in receiving the near miss report submitted to Network Rail by the driver of train 6M90. This meant Freightliner did not consider it appropriate to undertake the testing.

Summary of conclusions

Immediate cause

99 The GSO was working in an unsafe place as the train approached (paragraph 53).

Causal factors

100 The causal factors were:

a. The planned brake continuity test needed to be undertaken outside the terminal (paragraph 57).

b. The GSO conducted the train preparation duties on the six-foot side of the train, adjacent to an open line, probably because the cess was overgrown, without an effective safe system of work in place (paragraph 62), **Learning Point 1**.

Underlying factor

101 The underlying factor was:

a. Freightliner had not effectively managed the risk of undertaking train preparation at this location (paragraph 89), **Recommendation 1**.

Additional observation

102 The RAIB observes that:

a. The GSO was not tested for drugs and alcohol following the incident, as required by rail industry standards (paragraph 95), **Learning point 2**.

Actions reported as already taken or in progress relevant to this report

103 Since the incident, Freightliner has introduced a change to the local working instruction to implement the enhanced brake test procedure for the train 4O15 movement. This reduces the requirement for ground staff to undertake brake testing activities on the Up Washwood Heath Goods Loop by completing an enhanced brake test during train preparation within the terminal.

104 Since the incident, Heavy Haul Rail has:

a. Put together a reporting process and has added a new specific category on its Work Wallet reporting tool. This allows the tracking of vegetation issues that have been raised to ensure they have been reported and closed in a timely manner. This involved working with Network Rail to understand its process when issues have been raised.

b. Begun a review of its CSSoW on sites where its staff operate.

c. Developed a training and competence package for its ground staff members for line blockage protection.

Background to RAIB's recommendation

105 As noted at paragraph 12, Freightliner Group Limited employed the GSO and operated Lawley Street terminal at the time of the incident. However, the terminal is now operated by Freightliner Limited, and hence the recommendation made in this report is addressed to this new company. Heavy Haul Rail, which employs the GSO following this change, effectively acts as a subcontractor to Freightliner Limited.

Recommendation and learning points

Recommendation

106 The following recommendation is made:[2]

1 *The intent of this recommendation is for Freightliner to improve its processes for undertaking train preparation activities outside terminals and depots*.

Freightliner Limited should undertake a risk-based review of the arrangements it has put in place for train preparation immediately outside terminals and depots and other locations on the mainline railway where such activities are reasonably foreseeable. This review should consider whether the control measures provided by its current processes and operating rules are effective in controlling risk to staff.

The review should take account of Freightliner's competency frameworks, the requirements of Railway Group Standard GE/RT8000 The Rule Book, other relevant industry standards, and good practice. It should particularly consider the risks associated with staff working near open lines and the assurance processes used to verify that control measures remain effective.

Freightliner should develop a timebound plan for the implementation of any appropriate changes to competency frameworks, processes and operating rules identified by this review.

This recommendation may apply to other companies who undertake train preparation duties outside terminals and depots (paragraph 101a).

[2] Those identified in the recommendations have a general and ongoing obligation to comply with health and safety legislation, and need to take these recommendations into account in ensuring the safety of their employees and others.

Additionally, for the purposes of regulation 12(1) of the Railways (Accident Investigation and Reporting) Regulations 2005, these recommendations are addressed to the Office of Rail and Road to enable it to carry out its duties under regulation 12(2) to:

(a) ensure that recommendations are duly considered and where appropriate acted upon; and

(b) report back to RAIB details of any implementation measures, or the reasons why no implementation measures are being taken.

Copies of both the regulations and the accompanying guidance notes (paragraphs 200 to 203) can be found on RAIB's website www.gov.uk/raib.

Learning points

107 RAIB has identified the following important learning points:[3]

1 This incident highlights the importance of reporting potentially unsafe conditions, such as an obstructed or blocked cess, so that they can be rectified (paragraph 100b).

2 Duty holders are reminded of the requirements within RIS-8070-TOM, 'Drugs and alcohol testing for safety critical workers', issue 2 dated 5 March 2022, to initiate for cause testing of staff that have been involved in an accident or incident (paragraph 102a).

[3] 'Learning points' are intended to disseminate safety learning that is not covered by a recommendation. They are included in a report when RAIB wishes to reinforce the importance of compliance with existing safety arrangements (where RAIB has not identified management issues that justify a recommendation) and the consequences of failing to do so. They also record good practice and actions already taken by industry bodies that may have a wider application.

Appendices

Appendix A - Glossary of abbreviations and acronyms

Abbreviation / acronym	Full term
AIVR	Automatic Intelligent Video Review
CSSoW	Common safe system of work
FFCCTV	Forward-facing closed-circuit television
GSO	Ground staff operative
MOM	Mobile operations manager
ORR	Office of Rail and Road
PiC	Person in charge
PTS	Personal track safety
RAIB	Rail Accident Investigation Branch

Appendix B - Investigation details

RAIB used the following sources of evidence in this investigation:

- information provided by witnesses
- on-train data recorder information taken from train 6M90
- CCTV recordings taken from other trains passing the area
- train movement data recorded by the TMV system
- site photographs and measurements
- weather reports and observations at the site
- rail industry documents and records
- a review of previous RAIB investigations that had relevance to this incident.

Appendix C – Extract from RIS-8070-TOM

Uncontrolled when printed
Supersedes RIS-8070-TOM Iss 1 and GEGN8570 Iss 2 with effect from 05/03/2022

Drugs and alcohol testing for safety-critical workers

Rail Industry Standard
RIS-8070-TOM
Issue: Two
Date: March 2022

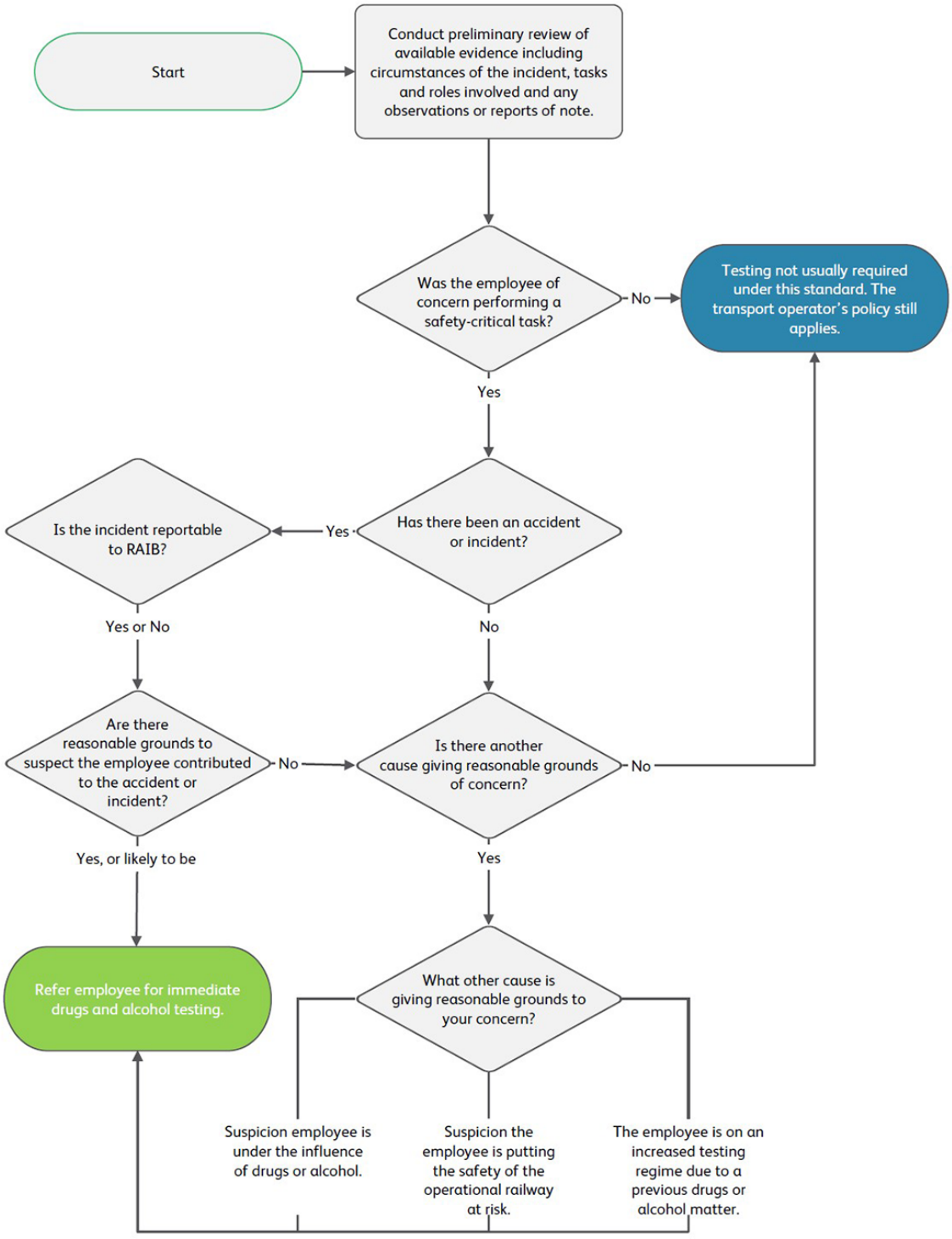


Figure 1: 'For cause' testing decision flow chart.

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Department for Transport.

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