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HSQE Briefing
August 2019

Our Safety Vision:

Our vision of “preventing harm to all” is at the centre of our Safety Strategy and is synonymous with our commitment to resourcing and working safely.

We believe that our vision can be achieved if we all develop a safe mind-set, plan our tasks correctly and actively seek ways to prevent incidents. We also believe that behaving in a safe way will also lead to zero accidents. We have devised a set of rules that underpins our vision and are consistent with our mantra.

Think safe, act safe and be safe!

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This Months Safety Cascade

- World suicide awareness day

Shared Learning

- COSS potentially accessed an open line, believing that it was blocked at Stretham (Common) Station
- Worker walking along a bridge stepped though gap in removed walkway panels and fell 1.5m

Safety bulletins

- Brush Cutters– Metal blade strimmer's are BANNED
- Workers burnt touching Live conductor rail
- Near Miss, 3 x track workers almost hit by a train

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Mates in Mind

Mates in Mind is registered UK charity, aiming to raise awareness, address the stigma of poor mental health and promote positive mental wellbeing across workplaces.

We help to make sense of available options and support for employers to address mental health within the workplace.

Mates in Mind works across UK workforces, focusing on construction, as well as other sectors including transport, logistics manufacturing and others.

Together we can be the change needed to improve workplace mental health.

Be a mate. Be the change.

This year, World Suicide Prevention Day will be taking place Tuesday 10 September…

https://www.matesinmind.org/assets/uploads/WSPD_2019_resource_pack.pdf

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Shared Learning

Key learning following a serious incident

IP Signalling

Issue Date: 07/08/2019 contact: sam.purcell@networkrail.co.uk

Issue Number: IPSIG-SL010 Title: Operational Close Call – Streatham Common station

Overview of Event:.

The SWL/COSS arrived at Streatham Common station car park and contacted the Signaller to discuss the line block arrangements to access an area for FTN Node survey within a REB on the BTH1 line.

During the conversation between a Signaller and a COSS/SWL to arrange a line blockage it became apparent, due to the vigilance of the signaller, that the COSS was potentially going to access at the wrong location meaning the team would not have adequate protection in place.

The planned line block covered access from ***Streatham*** along the ***BTH1*** line between TVSC778 and TVSC788.

The COSS was potentially going to access from ***Streatham Common*** which is on the ***VTB1*** line, with the planned line blocks between TVSC778 and TVSC788 signals on the Up Portsmouth line. The operative stated that he was speaking from Streatham Common station (VTB1 line) and identified the location of the worksite. The Signaller challenged the COSS/SWL regarding the worksite location for access and cancelled the proposed line blockage.

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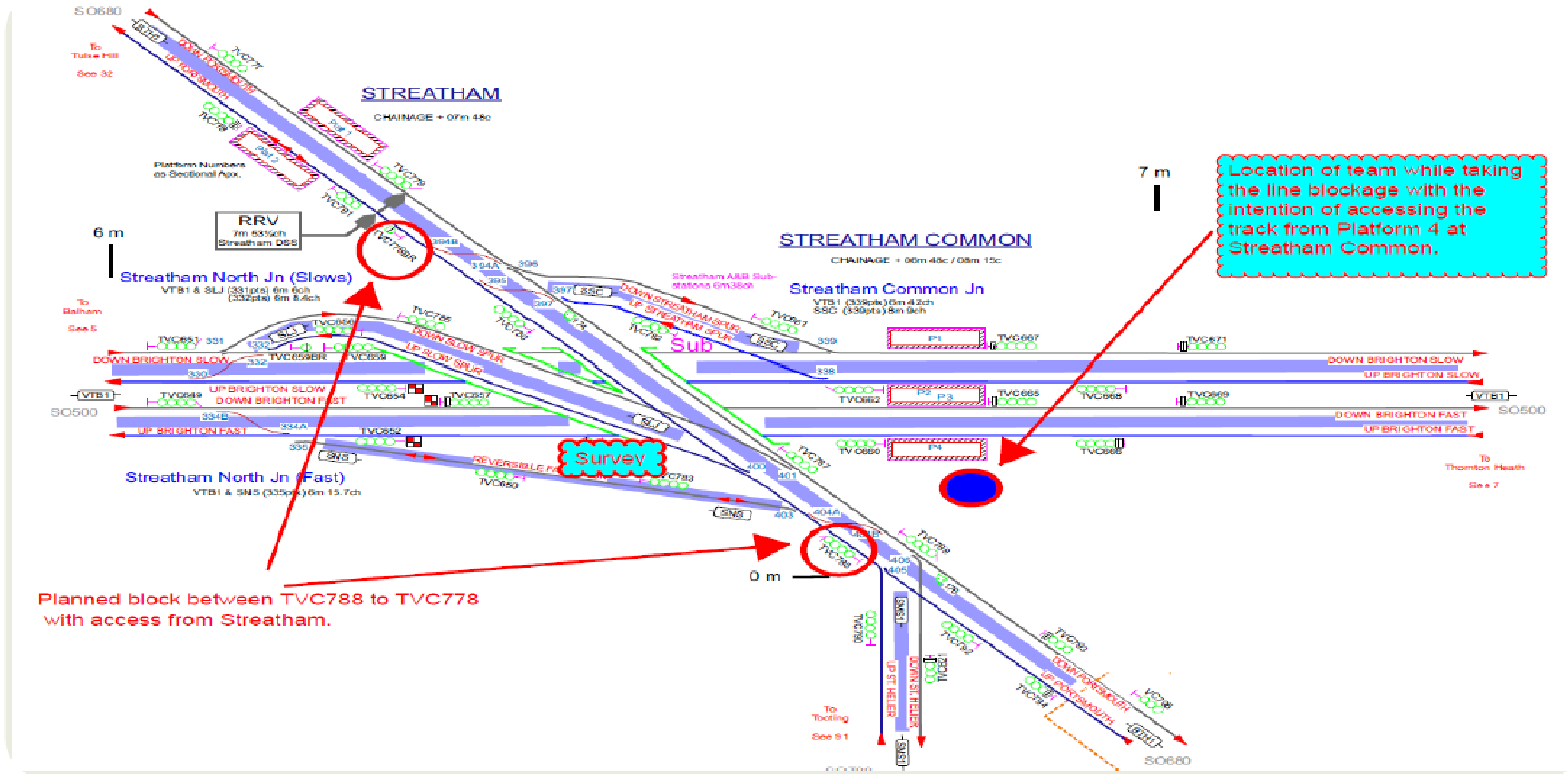

Discussion Points:

- Are Safe Work Packs comprehensively reviewed and authorised by the Responsible Manager before being issued?
- Are Safe Work Packs reviewed prepared and by the COSS/SWL prior to the start of work and on arrival at the access point?
- Do we allow ourselves to become complacent when working in familiar locations?
- Could we use technology to check our location?
- Do we regularly challenge and question current processes?

Fall from height - staff injury

Issued to:	**All Network Rail line managers, safety professionals and RISQS registered contractors**
Ref:	NRL19-11
Date of issue:	06/08/2019
Location:	UB304/004 Todholes, Scotland
Contact:	IP Scotland S&SD

Overview

Whilst walking at night along a mesh-grid walkway on the bridge at track level, the Injured Person (IP) fell forwards and through a void. The IP fell approximately 1.5 metres down onto the scaffold deck below and sustained bruising to the side of his body.

Walkway panels had been removed to allow workers to pass materials up from the scaffold deck below. However, the IP was unaware of this. The IP attended hospital and had to take time off work to recover from his injuries.

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Underlying causes

- A change in work activity occurred.
- The change was neither adequately planned nor risk assessed.
- The Task Briefing Sheet did not reflect the works or arrangements required.
- Suitable controls to address the hazard were not implemented or discussed before or after removing the walkway panels.
- Lighting at the site of works was inadequate.

Key message

- Works MUST be planned, and risk assessed to avoid late change in the first instance.
- Works MUST be re-assessed if late change is required to manage risk effectively.
- Who is responsible for controlling activity on site and ensuring effective communication of hazards and related risks?
- How do you ensure adequate resources are provided on site, particularly in remote locations?

Part of our group of Safety Bulletins

Safety Alert | Safety Bulletin | Safety Advice | Shared Learning

Safety Advice

Action required following a serious incident

Prohibiting use of brush cutters fitted with a 'Metal star blade' for brush cutting works

Issued to:	**All Network Rail line managers, safety professionals and RISQS registered contractors**
Ref:	NRA19-09
Date of issue:	02/08/2019
Location:	Newgate Street, Hertfordshire (LNE/EM)
Contact:	Malcolm Miles, Professional Head of Plant

Figure 1 - Stihl brush cutter with shredder blade and correct protective guard fitted.

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Overview

On 2 July 2016, an operative was using a metal star blade for brush cutting at the Newgate Street access point. This resulted in a piece of metal shard piercing the inner right thigh of the operator. A safety bulletin was subsequently issued (NRB 16/13), and a root cause investigation launched.

Since the Newgate Street incident, two additional events involving metal star blades have occurred.

Both incidents involved a metal object hidden in the undergrowth being struck and a shard of metal being ejected.

This Safety Advice supersedes the earlier version NRA 16/10 Update 1 dated 08/01/18. The significant change is to prohibit the use of metal star blades for brush cutting and replace these with an Original Equipment Manufacturer (OEM) approved shredder blade.

Immediate action required

Metal star blades must be replaced with OEM approved 'Shredder' blades for brush cutting operations. Metal star blades must never be used for brush cutting.

Nylon line or plastic blades are safer options than a metal star blade for strimming. If these cannot be used, metal star blades are permitted, but only for grass strimming.

- The tool and equipment supplier/maintainer must ensure that the brush cutter protective guard is undamaged/untampered and correctly fitted (See Figure 1). Brush cutters with defective blades must be quarantined until repaired.
- All operators carrying out de-vegetation works must possess the required level of training and competency.
- Use of brush cutters for de-vegetation must be considered during the task planning process as a "right handed" operation which offers the optimum protection to the operator.

- Operators should work their way down into the vegetation in layers enabling the operator to identify 'hidden' items inside the foliage that may not have been visible during the original site survey.
- Specialist PPE is required in addition to the standard PPE set out in the Task Risk Control Sheet (NR/L3/MTC/0003/SP021) to ensure adequate protection for all parts of the body. Specialist PPE made available in the Network Rail catalogue includes:

1. Item 500348, Hi vis Vulture ballistic trouser, orange.
2. Item 801070, Hi vis Breatheflex jacket, orange

- The exclusion zone for strimming and brush cutting operations is 15 metres.

- The team leader/supervisor shall be responsible for ensuring the exclusion zone is enforced both within and outside of the boundary.

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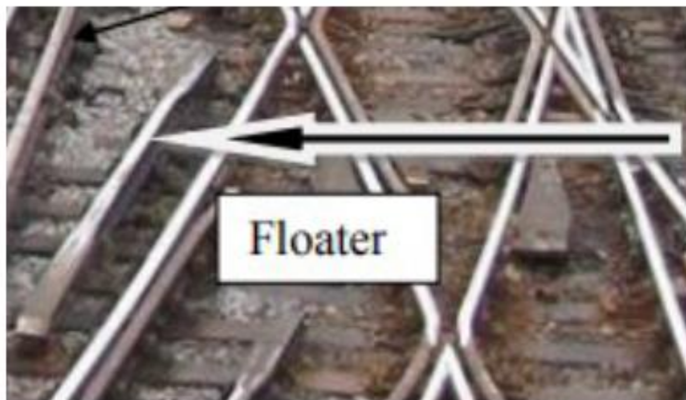
Serious Safety Incident

Issued to: All South East Route

Date of Issue: 07/0819



Overview

A serious safety incident occurred last night when a colleague setting up site lighting came in to contact with the live conductor rail. The live rail was a floater believed to have been isolated (example of a floater above)*.

The IP suffered severe burns to their hands. However, this could have been a lot worse but the IP was wearing flame retardant PPE and gloves at the time.

The investigation is currently ongoing but we'd like to issue a few immediate reminders.

Never assume equipment is isolated – always test before touch.

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Actions/Discussion Points

- Always assume that the third rail is live and test before touch
- Are you aware of live floaters in your worksites?
- Always wear the correct PPE for the task
- Are you indicating live floaters on site using devices such as self-testing con rail indicator devices?

Floaters are short lengths of conductor rail that can abut or infringe an isolation and can remain live because they are fed from an adjacent live conductor rail in a different electrical section.

Part of our group of Safety Bulletins

Safety Alert | Safety Bulletin | Safety Advice | Shared Learning

South East Route

Network Rail share updates of recent incident, accidents and best practice advice online.
Please get into the habit of checking this website for the latest news;

https://safety.networkrail.co.uk/tools-resources/safety-bulletins/

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Compliance Team
Direct: +44(0)118 924 1639
Email: compliance@resourcing-solutions.com

24 Hr On Call

07786 265531

Report hotline:
0800 4 101 101

Report textline:
07507 285 887

Freepost: CIRAS
www.ciras.org.uk