Resourcing Solutions
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HSQE Briefing
February 2019

Think Safe, Act Safe and Be Safe

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!**

Resourcing Safely

Think Safe, Act Safe and Be Safe

In this edition:

- It has been a very busy month for Network Rail bulletins so please take the time to read and understand all of these briefings;

    - RIDDOR (Burned by hedge trimmer)
    - OTP exclusion zone lighting
    - Person struck by OLE
    - Near miss - Group of workers almost hit by a train
    - Long portable earths used in OLE Isolations
    - Control of mini diggers using digital comms

Action required:

After reading this briefing, you are required to respond, please click **"I have read and understood"** or email lmillard@resourcing-solutions.com with acknowledgement and any questions/suggestions

Shared Learning

Key learning following a serious incident

everyone home safe every day

RIDDOR Burn Injury – Use of hedge trimmer

Issued to:	**All Network Rail line managers, safety professionals and RISQS registered contractors**
Ref:	NRL19-01
Date of issue:	04/02/2019
Location:	Glendrissaig, Girvan
Contact:	Gillian Murphy, Senior Communications Manager gillian.murphy@networkrail.co.uk

Overview

On 23 August 2018, a five-person team, including two supervisors, were carrying out vegetation clearance tasks on a steep embankment utilising rope access.

A petrol driven hedge trimmer was being used to cut light brush. After 3-4 minutes the equipment was placed on the embankment where it ignited.

The flames spread to the operative's right leg causing a significant burn.

The investigation revealed that fuel leaked from the hedge trimmer whilst in use. There was no visible damage to the equipment but, the fuel cap was found 2-3 metres away.

All workers and supervisors on site were aware that the operative was not trained to use the equipment.

The injured person required hospital treatment for a duration of 5 days and 23 days recovery time in total.

Underlying causes

- The injured person had not been trained to operate the equipment
- The fuel cap was not attached / correctly attached to the hedge trimmer
- The IP had been permitted to use the hedge trimmer previously at site under supervision
- The lifesaving rule breach went unchallenged by both supervisors and workers on site

Key message

Consider the following on your sites:

How is visibility of workforce competence provided on sites to enable safe and appropriate allocation of resources?

What are the requirements for storage, checks and safe handling of equipment on site?

What are supervisors' safety responsibilities on site? How are these assessed?

To prevent recurrence:

Never undertake any job unless you have been trained and assessed as competent

Regardless of your role, be prepared to challenge Life Saving Rule breaches

All Safety Communications are available at Safety Central

Part of our group of Safety Bulletins

Shared Learning

Key learning following a serious incident

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OTP exclusion zone lighting systems

Issued to:	**All NR Functions and Principal Contractors**
Ref:	NRL19-02
Date of issue:	12/02/2019
Location:	National
Contact:	Ian Morgan, Principal Engineer, STE ian.morgan@networkrail.co.uk

Overview

Recently, there have been many articles relating to lighting systems fitted to On Track Plant. These lights are blue lamps projecting beam patterns to depict exclusion zones on the ground. These systems have not been reviewed through the Product Approval process, and therefore should not be used.

The fitment of blue lights for this purpose, particularly to OTP Excavator Cranes, has a high potential to be confused with the requirements of RIS-1530-PLT Issue 6 Clause 9.7.2.1 'there shall be a continuous blue light fitted externally to the machine, visible to site personnel under all foreseeable lighting conditions and illuminated when the RCI is in lifting mode'.

Extra blue lamps fitted to the exterior of a cab or superstructure could mask an event where the RCI was disengaged. This is quite pertinent as there have been several recent events where OTP has overturned due to the RCI being set in the wrong configuration.

(Note: RIS 1530 PLT Iss6 G5.15.1.9. Only lighting that is called up in this document is allowed to be displayed, so that there is one national agreed list of exactly what and why an external visible indication is given by any machine.)

Underlying causes

- Lack of understanding of Product Approval process.
- Lack of understanding of Engineering change process.
- Lack of understanding for the application of relevant standards relating to plant design.

Key message

As with other Proximity Warning systems these systems require Product Acceptance to permit the use on Network Rail Managed Infrastructure. Network Rail strongly support developing innovations such as this when managed correctly.

It is acknowledged that the development of these systems has been with the best intentions to attempt to address exclusion zone adherence. The Product Acceptance process would enable developers and innovators to demonstrate safety, compliance and engineering issues have been considered and relevant requirements met.

Part of our group of Safety Bulletins

Safety Bulletin

A serious incident has taken place

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Person struck by falling over head wire

Issued to:	**All Network Rail line managers, safety professionals and RISQS registered contractors**
Ref:	NRB19-03
Date of issue:	20/02/2019
Location:	Dollymans Bridge at S30/19 on the Up Southend
Contact:	Annette McStein, Safety Manager OCR annette.mcstein@networkrail.co.uk

Overview

During planned renewal of an OLE wire run, it was discovered that the planned methodology was unable to be applied. Following review by the site management the decision was made to revert to the contingency plan to manually de-wire.

A re-brief of the manual methodology and the associated hazards and controls was undertaken and the work re-commenced.

As the work progressed, some of the supporting temporary materials failed which resulted in the contact wire dropping to the ground uncontrollably, striking the injured person on the head and shoulders.

The injured person was wearing his hard hat, which took most of the impact, however he had pains to his back and forearm and was taken to the local hospital by ambulance for a check-up. The injured person was later released and is currently recovering at home.

Discussion Points

While the investigations into the accident are underway, please discuss the following points with your teams:

- What assurances do you have when making late changes to planned tasks that all risks have been assessed and controls are implemented, briefed and understood as required?
- Are the "Take 5" principles applied before, during and after your work?
- Are the methodologies and processes checked to ensure they are still applicable as the work progresses?
- Who can authorise late changes to a safe system of work / SWP?

All Safety Communications are available at Safety Central

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Safety Bulletin

A serious incident has taken place

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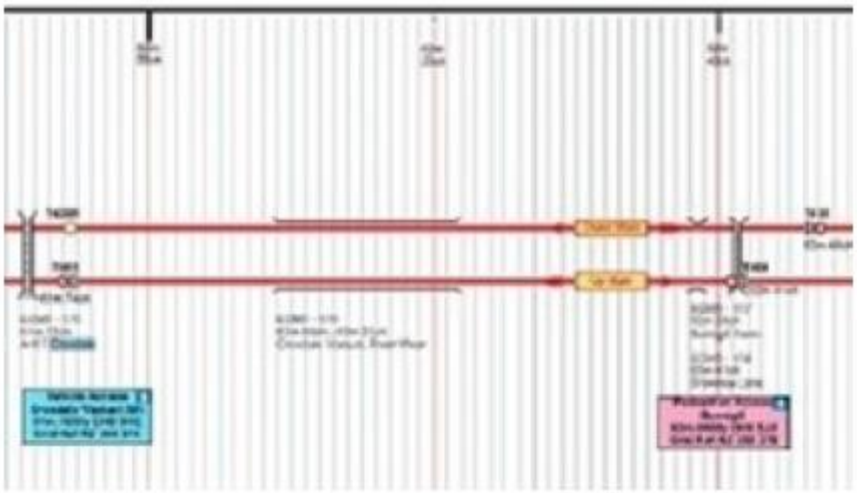
Near miss with a group of track workers - Croxdale Viaduct

Issued to:	**All Network Rail line managers, safety professionals and RISQS registered contractors**
Ref:	NRB 19/02
Date of issue:	07/02/2019
Location:	Croxdale Viaduct, LNE Route
Contact:	Emrys Warriner, Principal Health & Safety Manager, IP emrys.warriner@networkrail.co.uk



Overview

At 23:45 on the 20th January 2019, the driver of 5T83 made an emergency GSM-R call to report striking a worksite marker board on the Up Main at Croxdale Viaduct, and a subsequent near miss with two workers who had jumped clear of the train with just five seconds to spare.

The work group were monitoring the track associated with overhead line works and were working at the planned and agreed worksite location. But it was linked in error during planning to an unrelated possession at the same mileage on a different ELR some 90 miles away. This meant the worksite was on an open line, with a 90mph linespeed and no possession protection.

Discussion points

While we are investigating this incident, please discuss the following with your teams:

Work on the operational railway can be at similar mileages on different ELR's or lines of route (LoR).

- How do you identify when and where this will occur?
- What are the opportunities to identify these issues and discuss and agree solutions?
- Who needs to be involved in planning and communicating the arrangements?
- How do you familiarise yourself with the safe work pack?
- How are arrangements communicated on site?
- What controls should avoid confusion about location?

All Safety Communications are available at Safety Central

Safety Advice

Action required following a serious incident

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Long portable earths for 25kV OLE isolations

Issued to: **All Network Rail line managers, safety professionals and RISQS registered contractors**

Ref: NRA19-02
(reissue from NRA18-16)

Date of issue: 04/02/2019

Location: National

Contact: Rakesh Athukattu, Engineer - Contact Systems
rakesh.athukattu@networkrail.co.uk

Overview

Following an isolation audit, it has become apparent that the industry is continuing to use the non-interlocked variant of long portable earths for earthing overhead line equipment.

At Ranskill in1998 a member of the isolation team received a fatal electric shock when removing a non-interlocked long portable earth.

Investigation revealed the incident involved the failure to follow procedures detailed in Network Rail standard NR/L3/ELP/29987.

To increase safety, after the incident the interlocked long portable earth was introduced to eliminate the risk associated with the application and removal of non-interlock variants.

Immediate action required

- Long portable earths shall only be used to earth isolated overhead line equipment when justified in accordance with NR/L3/ELP/29987.
- Non-interlocked long portable earths must not be used for earthing overhead line equipment after 01/03/2019. Only Product Approved interlocked long portable earths with warning labels at the G Clamp end shall be used for this purpose.
- A video for guidance on the application of interlocked blue earths is available on the Safety Central website.
- Long portable earths shall be procured in accordance with the conditions on the Network Rail Product Acceptance certificate, PA05/00944.
- All Nominated and Authorised Persons shall be re-briefed on the process of applying and removing long portable earths. Long portable earths must be applied and removed in the following sequence:
    - a. When applying long portable earths, the earth connection shall be made before the line end is connected to the overhead line equipment
    - b. When removing long portable earths, the overhead line connection shall always be removed before the earth end is broken.

All Safety Communications are available at Safety Central

Safety Advice

Action required following a serious incident

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Control of Mini-diggers and use of Digital Radio communications

Issued to:	**All Network Rail line managers, safety professionals and RISQS registered contractors**
Ref:	NRA19-01
Date of issue:	01/02/2019
Location:	National
Contact:	James Adshead, Principal Health and Safety Manager, IP Track james.adshead@networkrail.co.uk

Never enter the agreed exclusion zone, unless directed to by the person in charge.

Overview

On 8th April 2018 a 1.6 Tonne mini-digger overturned at a site near Euston station. As it overturned it almost struck the banksman, who was standing next to the machine while it was setting up ready to dig.

The digger operator was in the process of extending the crawling tracks to increase stability by raising the machine using the rear blade and boom.

While in the raised position the operator accidentally moved the slew lever causing the machine to tip over.

The method of work used did not include the use of radio communications. As a result the banksman had to approach the machine to talk with the operator.

Network Rail Plant Manaul standard NR/L2/RMVP/0200/Module P300 makes it mandatory for digital duplex radio communications to be used.

"Where personnel are required to undertake controlling and operating activities involving OTMs, OTP and non-rail mounted plant (civils) on Network Rail construction sites (civils and rail), the Principal Contractor shall arrange for full digital duplex communication systems to be provided".

Immediate action required

Whenever On Track Plant (OTP), On Track Machines (OTM) or non-rail mounted plant is used on Network Rail construction sites (rail or civils) full digital duplex communications are to be provided (by the Principal Contractor) and used.

All construction staff are to be made aware of the importance of maintaining an exclusion zone around all plant and the relevant Life Saving Rule because of dangers of inadvertent plant movement.

Copies of Safety Bulletins are available on Safety Central

Part of our group of Safety Bulletins

Think Safe, Act Safe and Be Safe

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/

“Think Safe, Act Safe and Be Safe”

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