July 2011

Health and Safety Briefing

Resourcing Solutions

Invensys OSHE Alert—Minor Head Injuries

Whilst working in Location Case 2/3 in Kentish Town the injured person caught their head on a piece of metal (earth stud) on the LOC door causing a minor abrasion to her head. At the time they have removed their hard hat to enable them to carry out a task in the LOC where the hat would have made the task difficult. The following precautions should be observed to minimize the risk of injuries caused by sharp projections:

- Before commencing work in a location case carry out an inspection/review to ascertain if there are any sharp projections which could cause an injury.
- Where possible remove or cover any projections that are found using sleeving, insulation tape or some other suitable material.
- Always wear a hard hat and where required a chin strap.
- If a task cannot be conducted whilst wearing a hard hat or it would be dangerous to do so the Supervisor shall conduct a risk assessment and state why a mandated item of PPE cannot be worn and implement the necessary mitigation to prevent head injuries. The risk assessment and mitigation shall be recorded on the Task Briefing Sheet.

In another incident an individual cut their head on a mini bus door. As the person exited the mini bus the door slid towards the closed position and caused a minor cut to their head. At the time the mini bus was not parked on level ground and the individual had not ensured the door was in the fully open position and retained from closing before exiting the vehicle. The following precautions should be observed to minimize the risk of injuries caused by closing vehicle doors.

- Ensure that the vehicle is stationary.
- Ensure that the vehicle (where possible) is parked on level ground.
- Before entering or exiting the vehicle ensure that sliding door is fully opened and retained in this position.
- Take care when entering and exiting vehicles, given your height, not to strike your head on any part of the vehicle.

Invensys OHSE Bulletin—Protection Irregularity

On the 8th June 2011, a work group consisting of a COSS and four operatives working on behalf of an IR sub-contractor were delivering materials (bags of dry cement) to the location of new signal gantry 11B base adjacent to a Down Goods Loop (DGL). To accommodate this material delivery, the COSS arranged a line blockage of the DGL with the signaller where they agreed protecting signals P7 and P29 (not shown on the diagram) and protection placed at 203 points. The COSS placed the last three detonators between the A and B ends of 203 points with the Stop Board nearest 203B and the last detonator just short of 203A.

Approximately 48 minutes into the activity the signaller noticed that a track circuit between signals P7 and P9 was showing occupied and telephoned the COSS to enquire whether he had the hand-trolley beyond signal P9. As the start of the conversation the COSS was unaware of signal P9 or that it was showing a red aspect; the signaller had to explain that it was a ground signal before the COSS realised where it was, but at that time he did advise the signaller that the hand-trolley was not beyond it.

Simultaneously, the TPWS on a freight train travelling towards Paisley was activated (because of the track circuit activation) which caused the train to come to an emergency stop approximately five or six wagon lengths beyond signal P6. The work group was never at risk from a train entering the DGL, however, the train coming to an emergency stop did have an unsteadying affect on the driver and of course had it been a passenger train could have led to more serious consequences. Whilst the investigation revealed that the activation of the track circuit was in all probability directly caused by the hand-trolley passing over a controlling IBJ, as is quite usual when investigating incidents a number of other factors both contributory and not were also discovered.

SSOW Planners

Ensure that you prepare a suitable SSOW—always consider the method of work & if plans change make sure the SSOW is amended/adapted accordingly.

Responsible Managers

Ensure that you check the SSOW thoroughly before authorising the pack—consider the method of work & reject the SSOW if it appears incorrect.

COSS's

Ensure that you check your SSOW Pack at least a shift in advance of the work—reject if it is incorrect—if in doubt speak to the SSOW Planner or Responsible Manager.
If you are the ganger/work group leader as well as the COSS, ensure that you heck your TBS thoroughly—if it is incorrect speak to the person who prepared it.
Ensure a Site Warden is formally appointed if the SSOW requires one & ensure that everyone in the group knows who the Site Warden is.
Do not allow a hand-trolley to pass a signal at danger without the signallers authority—remember this applies to all signals even those at ground level (Railway Rule Book Handbook 10 Section 2.2).
Always place line blockage protection clear of any points—not between the A and aB ends of a crossover (Railway Rule Book Handbook 8 Section 2.6).