Resourcing Solutions
engaging people

Welcome to Resourcing Solutions' Safety Briefing:

August 2016

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

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In this edition:

- Safety Rule of the month
- Network Rail Life Saving Rules reminder
- Sentinel Competence Update
- Serious Hand Injuries During Project Works
- Use of Brush Cutter Metal Blades
- Cable Drum Fell Into Four Foot
- Failure of Concrete Service Duct Slab
- Serious Leg Injury Whilst Lifting Precast Units
- Medication Declaration

Action required:

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

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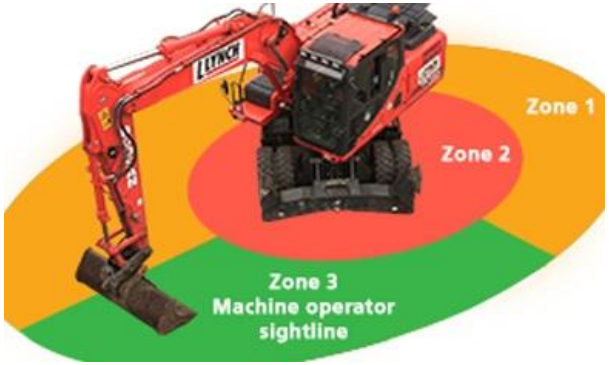
The rule that was focused on in August was:

- **Always practice good housekeeping and keep the workplace clean and tidy.** An untidy workplace can cause accidents and ill health. There are many things that will contribute to an unsafe workplace from poor lighting to inadequate ventilation. An unhygienic workplace can attract vermin that carry diseases. Simple actions (housekeeping) can help keep the workplace safe, this may include moving tripping hazards from walkways, cleaning windows, putting unsafe equipment in quarantine.

Safety Rules for September:

- **Never enter confined spaces, exclusion zones or excavations without authorisation.** High risk areas often require a permit to work and very specific precautions. These places are high risk because they can cause death. Work in these areas must be well planned and controlled.



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Life Saving Rule Reminder – Working with electricity :

- In July 2014, Network Rail revised their Life Saving Rules and as a result, reduced them from 11 to 10 in number.

Always use equipment that is fit for its intended purpose.

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

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Sentinel Competence Update:

Controller of Site Safety Conductor Rail Permit Live Line Tester - COSS CRP LLT (P)

- **Issue: Any full COSS who has attended the Conductor Rail Permit Live Line Tester training module to gain the new competence has been incorrectly awarded at probationary (P) level. This is due to the system being unable to recognise the difference between initial training following an initial COSS course, or a full COSS attending the bolt on module only**

- **Resolution: This will be fixed within Sentinel in September with the release of Site Access and we will let you know when the adjustments have been made.**

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Serious hand injuries during project works:

There have been a number of recent accidents resulting in serious hand injuries

- On the morning of Sunday 24 July a linesman employed by Network Rail OCR was installing a 2.8m long stove pipe through a wrap-around bracket on the Western Route. It is believed that the stove pipe moved as the linesman reached in to install a bolt, pulling their gloved right hand into the gap between the pipe and the bracket. The tip of the linesman's right index finger was torn off and surgeons were not able to reattach it.

A further two hand injuries have occurred on electrification project works over the preceding weeks:

1. A recent Safety Bulletin discussed an accident during June when an operatives hand became trapped between lifting chains and the load resulting in an amputation of part of a finger.
2. Last period an operative removing concrete cable troughing units from site trapped their finger during a two person lifting operation, requiring hospital treatment for a severed fingertip.

Discussion Points:

- **What can you do to ensure that your hands and those of your colleagues are kept clear of trapping points?**
- **Do you perform tasks that could be undertaken more safely with a tool rather than your hands?**

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Use of brush cutter metal blades:

- On 2 July 2016 an operative working for Works Delivery Off Track sustained a small impact wound to his inner right thigh whilst carrying out de-vegetation works at an access point.
- This happened whilst operating a petrol brush cutter fitted with a three-pronged (star type) metal blade. Upon investigation, it was observed the operator had struck a piece of steel re-bar hidden in the undergrowth, causing a shard to fire off and hit him.
- A similar incident had occurred during July 2015 where an operative sustained a serious injury after a 6 inch piece of metal wire was ejected during a de-vegetation operation using a brush cutter fitted with metal star type blades. In light of the recent event, the IP East Midland business area has imposed a temporary suspension on use of brush cutters fitted with metal blades.
- Early indications from these events suggest that in both cases the metal blades came into contact with hidden "non-vegetation" materials which resulted in a high velocity object being released causing injury to the operator.

Discussion Points:

- **How can you make you and your colleagues more aware of the controls required by the task risk assessment and make sure these are implemented each time?**
- **How can you make sure that all metallic off-cuts or other rubbish from our works are removed and disposed of appropriately?**

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Cable drum fell from trailer into Four Foot:

- An incident occurred during cable pulling operations on West Coast power supply upgrade.
- One cable drum was loaded on to the Drum Carrier by the Machine Operator with an additional three cable drums loaded onto the trailer using the cable drum yoke.
- Whilst traveling to the work site, one of the drums rolled off the front of the trailer into the four foot.
- The securing arrangements for the cable drum are yet to be established.
- The cable drum could not be recovered from the four foot due to the position of the trailer between the Drum Carrier and the fallen drum.
- The Supervisor instructed the Crane Controller to unhitch the trailer and take the machine back to the RRAP and cross over onto the next line so the drum could be retrieved.
- No personnel were in the vicinity and there were no injuries or damaged caused.

Discussion Points:

- **What are the risks and hazards associated with loading and unloading trailers?**
- **Who is responsible for ensuring loads are properly secured on a trailers?**
- **If you see an unsafe act or condition, who would you report it to?**

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Accident with cleaning machine – London Euston

- During the early hours of 8 June a contractor's cleaning machine operative drove a T7 cleaning machine along platform 2 at Euston station to clean the platform surface.
- The operative noticed a piece of rubbish between the tactile surface and the platform edge and decided to pick up the rubbish using a hand-held litter grab while still driving the cleaning machine.
- The operative approached the piece of rubbish and lent to the left of the machine to retrieve it using the litter grab; at the same time the front wheels of the cleaning machine ran onto the tactile surface.
- This resulted in the operative losing control of the cleaning machine which then made a sudden movement toward the platform edge and fell onto the track.
- The operative suffered a swollen ankle but fortunately didn't sustain any major injury.

Discussion Points:

- **What could the operative have done differently in order to retrieve the piece of rubbish safely?**
- **How do you assess the risks of undertaking the routine tasks that you undertake?**
- **If you witness an obstruction of a line that could be open to rail traffic what would your first action be?**
- **If you need to work on a platform how do you make sure you do not get within 1.25m of the edge?**

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Failure of a concrete service duct slab:

- On the evening of 5 June 2016 a 7m x 0.4m x 0.1m thick section of reinforced concrete slab fell from the underside of overbridge 268/004 on the Hyndland East Junction to Dalmuir (via Yoker) Line in Glasgow.
- The falling concrete damaged the OLE causing it to trip and the debris fouled both lines.
- The in-situ cast slab spanned between two precast concrete beams in the bridge deck and formed the base of a service duct under one of the footways. The service duct contained a 6" gas main and a 4" water main.
- Early indications are that the service duct slab was not constructed in accordance with the design and that the steel reinforcement in the slab did not extend into the nibs resting on the support beams.

- A review of the most recent bridge examination reports has found that there was evidence that the service duct slab had dropped slightly however it appears likely that those involved in examining the bridge and evaluating the subsequent reports did not realise that the element was a transverse spanning secondary slab and believed it was a longitudinally spanning main girder therefore the severity of the defect may not have been recognised.

Failure of a concrete service duct slab (continued):

Discussion Points:

- Where are transverse spanning in-situ concrete service ducts most likely to be found in overbridges (under footways and verges)?
- What signs do you look for to differentiate between transverse spanning in-situ concrete slabs and longitudinally spanning precast concrete beams (e.g. poorer quality concrete finish, less distinct chamfers/joints, change in concrete finish from adjacent beams)?
- What records could be obtained to confirm construction details (e.g.assessment reports, record drawings, technical queries)?

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Serious Leg Injury Whilst Lifting Precast Units – Maerdy Bridge Newport:

- On the morning of Monday 15 August, a slinger/signaller was working with a 48 tonne excavator to relocate L-shaped precast bridge parapet sections in a compound.
- As the slinger/signaller stood on a ladder and removed the upper lifting chains from a unit it toppled toward him.
- He escaped by climbing over the falling unit but his right leg was struck above the ankle causing multiple fractures.
- The slinger/signaller was assessed by paramedics and evacuated by air ambulance to Swansea where they had a number of operations on their leg.

Discussion Points:

- **What planning is required to handle such units including preparing the ground and lifting plans?**
- **What other controls e.g. ballasting or propping could be employed to prevent movement?**

Always declare changes in medical circumstances and any medication you are taking immediately to your primary sponsor:

- There have been a number of cases recently where Resourcing Solutions have called candidates to update their Fatigue Profile and found out during the course of the conversation that they are taking medication that we were unaware of.

- Prescribed drugs and over the counter medicine can affect your ability to work safely so a medication check must be performed to identify any additional control measures that may need to be put in place during the course of your medication

- Any change in your medical health must be logged with us so that we can increase medical surveillance where and offer additional support to the individual as required

- Failure to declare medication may result in a Positive D&A result

- Failure to declare medication or a change in your medical circumstances is a breach of the Sentinel Scheme Rules

Join us on Facebook

We have launched a dedicated Facebook group to allow our workers to come together and discuss health and safety matters.

We will be posting regular content such as briefings, policy reminders and important safety updates along with what we are up to.

We would appreciate your input and if you would like to join the group please click on the logo below.

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