



HSQE Briefing February 2018



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!**



Think Safe, Act Safe and Be Safe



In this edition:

- PPE
- Mental Health contacts and tools
- Safety Bulletin
 - Leg injury
 - Electrical Fuse
 - O.L.E. damage and risk of electrocution
 - MPV struck branch resulting in brake failure and train runaway

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

Think Safe, Act Safe and Be Safe

Now is a good time to check your PPE

Do you have everything that you need?

- Safety Boots (sole protection)
- Hi vis Trousers
- Hi vis Vest / Coat (RSL on the back)
- Hard Hat (in date)
- Cut 5 gloves (suitable style and size)
- Eye protection (Clean, unscratched)



The list above are minimum requirements and must be worn / available at all times.

Ensure your Hi Vis are clean..!

If you are spotted onsite without gloves / eye protection then a close call will be raised and you will be reported to Network Rail

If you need any replacement PPE or have any questions about PPE then please [contact the Compliance Team](#)



Think Safe, Act Safe and Be Safe



Top tools for your mental wellbeing

Did you know that 1 in 4 people will experience some kind of mental health problem each year?

With a quarter of the population suffering at some point this year, we want to work towards ending the stigma that surrounds mental health and provide any support we can to our workforce, friends and families.

We have pulled together a list of the phone numbers, websites and apps that could be of benefit if you are struggling yourself or you know someone who is.

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Contacts for your mental wellbeing

Samaritans provide confidential, non-judgemental emotional support for anyone experiencing feelings of distress, including feelings that lead to suicidal thoughts. They are available to speak to over the phone, web, email and face-to-face.

Tel: 116 123 (24 hours a day, free to call)

Email: jo@samaritans.org - Web: www.samaritans.org

Mind Infoline provides confidential mental health information services, which enables people to make informed choices including where to get help, therapies and advocacy.

Tel: 0300 123 3393 (9am-6pm Monday – Friday)

Email: info@mind.org.uk - Web: www.mind.org.uk/help/advice_lines

PAPYRUS Prevention of Young Suicide provides confidential help and advice to young people under the age of 35 and anyone worried about a young person. Their service, Hopeline, is a confidential support and advice service, open 10am-10pm weekday, 2pm-10pm weekends and 2pm-5pm bank holidays.

Tel: 0800 068 41 41

Email: pat@papyrus-uk.org - Web: <https://www.papyrus-uk.org/>

Text: 07786209697

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Contacts for your mental wellbeing

Rethink Mental Illness Advice Line provides expert advice to people with mental health problems and those who care for them, including employers, health professionals and staff. They also run Rethink groups across England and Northern Ireland.

Tel: 0300 5000 927 (9:30am – 4pm Monday to Friday)

Email: info@rethink.org - Web: <http://www.rethink.org/about-us/our-mental-health-advice>

The Mix caters for young people aged between 13-25 providing judgement-free information and support on issues relating to mental health, with the option to receive peer-to-peer and counselling services.

Tel: 0808 808 4994

Email: (form fill) <http://www.themix.org.uk/get-support/speak-to-our-team/email-us>

Web: www.themix.org.uk/get-support



Download tools for your mental wellbeing

- **Headspace** (*free to install, in app purchases*) is a mindfulness and meditation app with bite sized meditations for busy schedules, SOS exercises in case of sudden issues and themed sessions from sleep to stress.
- **Silvercloud** (*free to use*) provides a wide range of supportive and interactive programmes, tools and tactics for mental and behavioural health issues.
- **Calm Harm** (*free to use*) provides tasks that help you to resist or manage the urge to self-harm. You can add your own tasks and it's completely private and password protected.
- **Stay Alive** (*free to use*) is a pocket suicide prevention resource, packed full of useful information to help you stay safe. You can use it if you are having thoughts of suicide or if you are concerned about someone else who may be considering suicide.
- **WellMind** (*free to use*) is your free NHS mental health and wellbeing app designed to help with stress, anxiety and depression.
- **SAM Self-help for Anxiety Management** (*free to use*) will help you to understand what causes your anxiety, monitor your anxious thoughts and behaviour over time and manage your anxiety through self-help exercises and private reflection.
- **Mood Tools** (*free to install, in-app purchases*) is designed to help you combat depression and alleviate your negative moods, including thought diary, activities, safety plan, information, tests and videos.
- **Relax Melodies** (*free to install, in-app purchases*) is a relaxation and sleep app that allows you to select sounds and melodies that you like and combine them to create a mix.
- **Rise Up** (*free to use*) is an app for people struggling with food, dieting, exercise and body image. The app is based upon self-monitoring homework, a cornerstone of cognitive behavioural therapy (CBT).

Keep up to date



Network Rail safety bulletins are updated regularly and available from here;

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

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Lessons from serious leg injury



An operative working for the supervisory controls project sustained a leg injury whilst surveying external cable routes at Penge sub-station. As he walked in an area covered in leaves, he stood on a cable chamber manhole cover which gave way beneath him. One of his legs plunged down the chamber to waist depth resulting in an injury to his right knee. He was taken to hospital where it was confirmed he had suffered serious ligament/tendon trauma, bruising and fluid accumulation to his knee.



The manhole cover was refitted, tested and found to be in good condition. It transpired that the manhole cover had not been fitted properly by previous users which resulted in the cover not being seated correctly in its frame. This caused it to tilt when weight was applied. This accident was recorded as an over seven day RIDDOR event.

A Close Call was also raised to remove a sharp, broken pipe from the cable chamber. Fortunately, the injured person had fallen on the opposite side to this pipe and did not come into contact with it. Had he done so, his injuries could have been even more serious.

Lessons Learnt from this incident

- Always ensure that you replace manhole covers correctly and test to check it is securely fitted in its frame.
- Always report (and Close Call) any missing, damaged or ill-fitting covers to the responsible owner/maintainer and make them safe or indicate there is a hazard before leaving site.
- Be aware that leaf fall and vegetation can hide hazards in the ground. In this particular case, the hazard of the incorrectly fitted cover was exacerbated by a covering layer of fallen leaves following recent high winds.





Safety Advice

Action required following a serious incident



Overheating on Bussman Cam Master fuse holders used to replace Red Spot fuse holders

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

Overview

Distortion caused by incorrect fitting of a Bussman fuse is likely to have caused the insulation on the holder to fail, creating both localised burning and a fault to its supporting metal plate. This fault could create a touch voltage above 60V on the supporting metal plate.

The technical investigation into the failure of the burnt out Bussman Cam Master fuse holder showed that at some time earlier it had been used to replace a Red Spot fuse holder.



The photograph above clearly shows that the spacing between the connecting studs is very different on these two types of fuse holder.

The Bussman fuse holder had been fitted to the metal plate which had been previously drilled to accept the Red Spot fuse holder and it can be seen that the Bussman fuse holder connecting studs were splayed-out to fit.



Immediate action required

- When accessing signalling power distribution equipment operating above 175V, members of staff and contractors must use procedure NR/SPS/S004 (see NR/L3/SIGELP/50002) to test for touch voltage on:
 1. metal covers on signalling power distribution equipment AND
 2. the metal plate on which Bussman fuse holders are mounted.
- The practice of direct replacement of Red Spot fuse holders for Cam Master fuse holders is prohibited without a mounting hole adjustment.
- Existing maintenance interventions and work instructions are being reviewed and amended to identify this potential defect.

Copies of Safety Advice are available on [Safety Central](#).

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of Safety Bulletins

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Safety Bulletin

A serious incident has taken place



Staff walking in close proximity to live OLE contact wire

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

Ref: NRB 18/02

Date of issue: 22/01/2018

Location: Crewe

Contact: Mike Dobbs, Senior Asset Engineer



Overview

An overhead line incident occurred at the North end of Crewe station.

The overhead line contact wire parted as an electric train passed causing damage to the train's pantograph and resulting in the contact wire hanging down.

A Network Rail Mobile Operations Manager and British Transport Police officers were first on site.

When overhead line staff arrived they found that staff had been walking in close proximity to the live contact wire that was hanging down. An emergency switch off had not been requested.

The parted contact wire is believed to have been within 30cm of head height and staff had walked beneath it. In September 2014, less than 25 miles away, a train driver suffered extensive electrical burns in very similar circumstances when they left the cab after the overhead line had been damaged.



Discussion Points

While we are investigating the incident please discuss the following with your team:

- Who should you contact if you believe the overhead line equipment (OLE) may be damaged?
- What precautions must be in place before you can approach but not touch OLE?
- What precautions must be in place before you can touch OLE?
- What other circumstances might increase the risk of injury when attending OLE incidents?
- What are the additional risks during the hours of darkness (or in a tunnel)?

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Safety Bulletin

A serious incident has taken place



MPV struck branch resulting in brake failure and train runaway

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

Ref: NRB 18/01 (Revised)

Date of issue: 04/01/2018

Location: Markinch, Fife, Scotland Route

Contact: [Simon Constable](#), Head of Route Safety, Health and Environment, Scotland Route



Think Safe, Act Safe and Be Safe



Overview

At approximately 04.00 on 17 October 2017 a Multi-Purpose Vehicle (MPV) was travelling between Ladybank and Markinch when it struck a branch which had blown from a third party tree during high winds.

At this stage the assumption is that the train's braking system became disabled due to the branch travelling sufficiently under the solebar of the MPV to cause damage to the air pipes and releasing the brake distributor cord on both the vehicles.

This allowed the MPV to start rolling backwards and at this point, as the train began picking up speed, the driver and operator both jumped from the machine with both sustaining injuries.

The driverless MPV ran for a distance of over 4 miles, in the wrong direction, back toward a point between Thornton North Junction and Thornton South Junction before stopping of its own accord at low point on the route.

The MPV was hauled from Thornton to Slateford where it was immediately quarantined.

The meteorological interpretation from our weather provider of the actual mean and gust speed at the time and location of this event confirmed that whilst the wind could be considered high it was not considered extreme and did not breach the extreme weather trigger thresholds.

Both the Rail Accident Investigation Branch (RAIB) and Network Rail are conducting investigations into the event.



Discussion Points

While we are investigating the incident please discuss the following with your team:

- What contingency arrangements apply following a report of high winds/severe weather events?
- What is your understanding of the operational procedures for managing risk post an adverse/extreme weather event and are they clearly understood and consistently applied?
- What immediate actions are to be taken on receipt of an emergency GSM-R Rail Emergency Call?
- How should a Signaller manage a train which is declared a runaway?
- How do you identify and report trees close to the railway boundary which concern you?

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