Resourcing Solutions
engaging people

Resourcing Solutions' HSQE Briefing:
February 2017

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:

- Fatal accident whilst working on the power network
- Near miss – Crossrail West
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- Serious road accident on the M5
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- Wiring anomaly – pasture street relay room
- What to do when an unintentional disconnection occurs in an operational railway environment
- Driving with diabetes – the facts
- Environmental – spill control
- Things to remember

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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Fatal Accident whilst working on the Network:

A fatal incident occurred on Monday 30th January 2017 involving an employee working for Western Power Distribution (WPD).

Tom Owen, 21, from Efail Isaf, was working in the Llanrumney area of Cardiff when it is believed he was electrocuted whilst undertaking work on the power network.

Although this incident did not occur on Network Rail Managed Infrastructure, it serves as a tragic and vital reminder of four of the Network Rail Lifesaving rules:

- Never undertake a job unless you have been trained and assessed as competent to do so
- Never assume that equipment is isolated – always test before touch
- Always use equipment that is fit for its intended purpose
- Always be sure that the required plans and permits are in place, before you start a job or go on or near the line.

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Near Miss – Crossrail West

A workgroup was involved in a near miss with a passenger train with high potential for serious injury or even death.

- Planned work was inside the possession limits, however the team became disorientated and inadvertently crossed the open Up and Down Main Lines.
- A passenger train travelling on the Down Main reported a near miss at approximately 2m 10ch.
- After the train had passed they realised their error, but then made the decision to cross back into the possession limits utilising lookout protection. This was a clear life saving rule breach as they did not have an adequate safe system of work in place.
- Visibility was limited at the location due to fog
- The team had limited familiarisation of the area and site demarcation was unclear.

Discussion Points:

- Suggest **three points** that you would do to prevent this problem occurring again?
- How do you obtain site familiarisation?

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Unauthorised RRV Movement – Crossrail West

- On 28/12/16 at 05:43 an RRV travelled through 8096A&B and 8097A&Bpts onto the OPEN Carriage Line. The Points Operator was given instruction from the ES to line 8096A&Bpts, after lining pts a Machine Controller gave the Points Operator instruction to line 8097A&Bpts which he did. This caused a SPAD (Signal Past at Danger) alarm, the Signaller notified the PICOP who notified the ES and the RRV was tracked back to down the Relief Lines.
- Crane Controller and Points Operator were Drugs & Alcohol tested with negative results.
- All possession support staff, Machine Controllers and COSS have been stood down across Crossrail West and have been briefed on this incident.

Discussion Points:

- Do you know who the lead communicator is when undertaking safety critical roles?
- Do you know the planned rail plant movements when you are undertaking the ES role?
- If you are an ES communicating RRV movement authorisation, how do you ensure that your message is fully understood?
- What would you do if your message was not understood?

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Serious Road Accident on the M5

- At 04:47 on 29 July 2016 a Ford 9-seater minibus left the north bound carriageway of the M5 between Junctions 19 and 20 near Bristol and came to rest on the motorway verge.
- All three operatives in the vehicle were taken to hospital but thankfully there were no serious injuries
- An investigation has concluded that the immediate cause of the accident was that the driver fell asleep at the wheel

Underlying Causes:

- The driver was fatigued from travelling between the work site and the team's home area near Cardiff
- The contractor had failed to confirm accommodation so the team had nowhere to sleep after their booked shift, (on 28 July) driving back to Cardiff and arriving at approximately 10:00
- The driver and his two colleagues had insufficient rest time (less than 12 hours) prior to starting the return journey to Cornwall for the following shift later on the same day (at 20:15)
- The Contractor failed to correctly assess the travelling time between Cardiff and the work site. The journey took approximately 3 hours 30 minutes, but the Contractor had not allowed for a suitable rest break during the journey.
- Only one of the group was able to drive the vehicle, so the driving task could not be shared

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Serious Road Accident on the M5 (continued)

Discussion Points:

- All staff should have a minimum of 12 hours rest between shifts. Travelling to work sites counts as work time.
- Accommodation must be confirmed prior to starting your shift.
- Contractors should allow for suitable rest breaks during journeys.
- Consider how many authorised drivers there are in your vehicle and report to the HSQE manager if provision is insufficient.

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Staff injured by OLE failure:

- On 1 January 2017 at approximately 06:30 a gang of Pway operatives were working on the Up Electric lines located towards the London end of Shenfield station platform 4.
- On the adjacent lines, an OLE team using three MEWPs were carrying out preparation for the de-wiring and removal of the existing OLE wiring systems.
- Whilst preparations were underway it appears that the existing OLE dropper suffered a failure causing the OLE to fall downward.
- The existing radius of the wiring allowed the cables to straighten and move across from the Down Electric to the Up Electric causing it to swing sharply hitting two operatives working as part of the permanent way gang on the Up Electric. One of the operatives was reportedly knocked to the ground.
- All activities immediately stopped and both men were taken to Queen's hospital, Romford for medical assessment where fortunately only minor injuries were confirmed.

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Staff injured by OLE failure (continued)

Discussion Points:

- When establishing exclusion zones around work, how do you ensure they are sufficient to protect all staff including those in other teams in the work vicinity?
- For OLE works how are radial forces considered when deciding the size of the exclusion zone?
- As a COSS, what action would you take as part of your assessment on the day, if the environment had changed?

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Wiring Anomaly – Pasture Street Relay Room

- Whilst removing redundant wiring from Pasture Street Relay Room an installation operative accidentally cut a live operational wire and did not report it to either the Signaller, Tester or Supervisor. Instead the installation team decided to undertake a twist repair and replace the cable back into the containment.
- As several wires were being cut at the time, the operatives unknowingly connected two incorrect ends together. The incident occurred on the 13th March, it was identified by a Network Rail fault team on the 15th March and the operatives involved came forward with information pertaining to their actions on the 21st March 2016.

Critical Factors

- The bespoke risk assessment was not briefed to the work group.
- The installation operatives were not aware of the planned control measures and as a consequence these measures were not implemented.
- The installation operatives did not follow the guidance laid out in the company's work instruction and cut several wires at once during the recoveries.
- The operatives failed to report the incident as per the project requirement (Siemens 4 steps and project induction) & standard signalling testing protocols.

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What to do when an unintentional disconnection occurs in an operational railway environment:

- Remember - Do not carry out any works that exceed your limits of authority or competency

1) Inform Signaller of the error.
2) Escalate issue in accordance with project incident reporting procedure (this should be described in your task brief).
3) Attempt to identify the impact to the Signaller caused by the error e.g. signal EN1458 will not clear.
4) Inform Signaller of the expected impact of error.
5) Do Not Reconnect wire until the following are in place:
    a) The wire has been positively identified (physically and within the site diagrams)
    b) Authorised to do so by the Maintainer.
    c) Authorised to do so by the site responsible manager. (TIC/Installation Manager).
    d) Authorised by the Signaller.
    e) Stop and Think. Do you feel confident that you fully understand what you are doing?
6) The wire re-termination must be completed to the standard stated in the installation handbook reference NR/L3/SIG/11303.
7) Test the circuit affected by the disconnected wire.

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Driving with Diabetes – the facts

Diabetes mellitus, commonly known as diabetes, is a chronic disease linked to high levels of glucose in the blood.

Statistics show that the number of people with diabetes is increasing every year.

The effects on living with diabetes day to day are well known, but what's not so well known is how diabetes can also affect your driving.

How does Diabetes affect your driving?

Millions of people with diabetes live full and busy lives. For many, being able to drive plays an important part in that. However, if you have diabetes, there is a risk of developing hypoglycaemia and 'severe hypoglycaemia' (a diabetic emergency that will affect your fitness to drive).

Hypoglycaemic episodes can be very sudden events, with symptoms ranging from feeling nauseous to a loss of concentration, and potentially loss of consciousness. An episode of 'severe hypoglycaemia' means you'll need assistance from another person. This is why it's so important that you keep your diabetes under control.

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Driving with Diabetes – the facts (continued)

Diabetes can be treated with insulin, tablets and/or diet control – it all depends on the individual. The treatment aims to control your blood glucose levels, and attempt to avoid the extremes of hyper and hypoglycaemia.

Do you need to tell the DVLA that you have Diabetes?

If you're keeping your diabetes under control with diet only, then you don't need to tell DVLA. However, if you're taking medication to control your diabetes, the following applies:

Treatment	Car or motorcycle licence holders (Group 1)	Bus or lorry licence holders (Group 2)
Tablets	Some tablets may cause Hypoglycaemia so you need to ask your GP about your medication	You must tell the DVLA
Insulin	You must tell the DVLA	You must tell the DVLA

It is a legal requirement to tell the DVLA if you have a medical condition that could affect your driving

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Environmental – Spill Control

Accidental releases of oils and chemicals from construction sites make up a large number of pollution incidents that occur each year.

Many spillages can be prevented. It is important that everyone on site knows how to control a spill to minimise its impact. Would you know what to do?

- **Minimise potential harm:** spills spread very quickly and lead to environmental harm
- **Avoid Prosecution:** Fines and clean up costs can be expensive
- **Public Relations:** Avoid negative publicity for the company and our clients and maintain our workload

Please see next slide for do's and don'ts in the event of a spillage

Environmental – Spill Control Do's and Don'ts

Do's	Don'ts
Stop work immediately	Don't ignore it – stop work and act immediately
If spillage is flammable, extinguish all possible ignitions	Don't hide the incident - ensure you report it and implement controls
Contain the spillage – on land use sand/earth to construct a bund to stop it spreading. Use booms to contain oil spills that have already entered a watercourse	Don't ever hose a spill into the drainage system. Always use absorbent materials
Contact your line manager	
Wear appropriate PPE for the task	
Protect sensitive areas (e.g watercourses or surface water drains)	
Clean up the spill. Use absorbent granules/pads to mop up spills. Large pools of oil or spills which cannot be absorbed should be removed by a gulper	
Dispose of all contaminated materials correctly – those containing substances such as oil, diesel or paint will be hazardous waste. Ensure any contaminated water is taken to an appropriately licensed disposal site	
Notify your line manager of actions taken	

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Things to remember:

Medication – A Resourcing Solutions worker recently had to leave site and was unable to complete his shift due to forgetting vital medication needed for a long term health issue. The worker was also unable to turn in for his shift the following day. ALWAYS take the required medication with you to your shift and ensure that the compliance team are aware any health issues or prescribed medication that you are required to take.

Signing in and out of site

- On arrival at your worksite always make yourself known to the SAC as soon as possible
- Always return any site equipment you have used during your shift
- Always remember to sign back out of the SAC when you finish your shift

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