



# HSQE Briefing November 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



**In this edition:**

- Winter Driving
- Near miss of track workers using L.O.W.S.
- RRV on tracked onto an open line
- Mobile scaffold tower comes into contact with live 3<sup>rd</sup> rail
- Failure of Tensorex OLE support bracket

**Action required:**

After reading this briefing, you are required to respond, please click **“I have read and understood”** or email [lmillard@resourcing-solutions.com](mailto:lmillard@resourcing-solutions.com) with acknowledgement and any questions/suggestions

Think Safe, Act Safe and Be Safe

# Winter is coming



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- Are you and your car ready for the winter weather?



# Prepare for the worst and hope for the best

Breaking down is never a pleasant experience – especially if you have to wait for recovery in the cold.

You'll also want your vehicle to be in the best condition to handle difficult driving conditions in severe weather.

This handy reminder for pre-journey checks is called the 'POWDERY' checklist:

- **P**etrol (or diesel) - don't run out of fuel
- **O**il - check levels once a month
- **W**ater - check radiator and screen wash once a month
- **D**amage - check wipers, lights etc for signs of wear and tear or damage
- **E**lectrics - check lights, indicators and controls are working properly
- **R**ubber - are your tyres well inflated, legal, with good tread and free from damage?
- **Y**ourself - are you fit to drive? - have you slept well? –  
are you taking any medication(s) that could make it unsafe for you to drive?

# Think Safe, Act Safe and Be Safe



## Be informed: Check the latest traffic and weather

### Before you set off

- In severe and wintry weather it's even more important to plan your journey. The Highways Agency for example provides the latest traffic situation for England's motorways and major A roads.

### Road and weather conditions may change, drive with care

- When you're on the road, pay attention to the changing road, traffic and weather conditions.
- Be ready to slow down and take more care if you need to, particularly on bends and exposed roads. Don't be lulled into a false sense of security - even if you drive every day on the same stretch of road.

### Updates on the move

- Keep listening to the radio for traffic and weather updates.
- On motorways, look out for overhead message signs where the Highways Agency will flash up important travel messages, including warning you of delays and advising of alternative routes.

# Think Safe, Act Safe and Be Safe



## Before You set off

- Allow extra time for winter journeys.
- Try to get up at least 10 minutes early, to give you time to de-ice the car.
- Check fuel levels – keep at least a quarter of a tank in case of unexpected delay.
- Don't drive off like a tank-commander, with a tiny hole cleared in the windscreen.
- Clear all windows using a scraper and de-icer.
- Use a cigarette lighter to warm a key for a frozen lock.
- Plan routes to favour major roads, which are more likely to be cleared and gritted.



# Think Safe, Act Safe and Be Safe



## Tips on being prepared for winter driving conditions

- Only travel if your journey is necessary
- Use dipped headlights and reduce your speed
- Ensure all your vehicle windows are free of frost and ice
- Check your radiator has the correct amount of water and anti-freeze
- Check your lights are clean and in working order
- Check your tyres – ensure they have plenty of tread and that air pressures are correct
- Check your vehicle battery is in a good condition and fully charged
- Keep a 'winter kit' of shovel, torch, wellington boots and warm clothing in your boot.
- Take food and a hot drink if going on a long journey.
- When roads are icy or covered in snow or slush use the highest gear possible to avoid wheel spin.
- When braking, to prevent locking your wheels, get into a low gear earlier than normal and allow your speed to fall and use the brake pedal gently.
- Tell children to take extra care when crossing the road in icy conditions because cars may not be able to stop as quickly.





# Think Safe, Act Safe and Be Safe

Please take the time to read these links for a better understanding

- RAC – Winter Driving check list
- <https://www.rac.co.uk/drive/advice/winter-driving/Winter-breakdown-kit-checklist/>
- AA – coping with Cold Snow and Ice
- <https://www.theaa.com/driving-advice/seasonal/winter>



# Think Safe, Act Safe and Be Safe

## Safety Bulletin

*A serious incident has taken place*



### **Near miss with staff involving Lookout Operated Warning System (LOWS)**

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

**Ref:** NRB 17/23

**Date of issue:** 02/11/2017

**Location:** Ecclefechan, Dumfries & Galloway

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



### **Overview**

On the morning of 29 September 2017 red zone working, by use of Lookout Operated Warning System (LOWS), was in place by to allow survey work for the High Output team to take place.

The work commenced at 0730 that morning and at 0830 advanced LOWS operators were positioned on the Up and Down lines. A site lookout was also in place for the group as per the planned safe system of work.

At 1010 the site lookout became aware of the approach of a train on the Up line due to hearing and feeling the vibration of a freight train on the rails.

The group had not been warned or alerted of this train by the LOWS system.

They were warned by the site lookout and moved clear and into a position of safety. One member of staff was walking on the Up line when the train approached and reached a position of safety 5 seconds before the train passed.

Immediately after the incident the COSS called the LOWS operator who had failed to warn of the oncoming train. The operator highlighted he had not seen this train passing his location, although they had not missed any prior to this event.

# Think Safe, Act Safe and Be Safe



## *Discussion Points*

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

- How can we manage the risk of fatigue in LOWS operators?
- What can you do to better protect the safe system of work from fatigue and concentration issues of staff carrying out LOWS duties?
- How do you provide increased sighting distance due to foliage obstruction?
- How do you take account of any changing conditions, for example new vegetation growth?

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

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of Safety Bulletins*

*Safety  
Alert*

*Safety  
Bulletin*

*Safety  
Advice*

*Shared  
Learning*

## Shared Learning

Key learning following a serious incident



### ***Kubota placed on line open to traffic***

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

**Ref:** NRL 17/04

**Date of issue:** 03/11/2017

**Location:** Rookery Bridge, Crewe

**Contact:** [Jane Cummings](#), LNW Accident & Assurance Investigator



### ***Overview***

At 00:02 on 3 January 2017 a Kubota road rail vehicle was placed on an open goods line during a T3 possession of the adjacent main lines at Rookery Bridge between Crewe and Sandbach.

In the Sectional Appendix the main lines are called the "Wilmslows" and the goods lines are the "Manchester Independents", while nearer to Crewe the main lines are called the "Manchesters".

The T3 possession is cyclical and usually includes both the main lines and the goods lines, however on this occasion only the main lines were blocked.

The Engineering Supervisor (ES) was unfamiliar with the location and referred to the main lines at this location as both the "Manchesters" and "main lines". The Controller of Site Safety (COSS) took this to mean the Manchester Independent goods lines.

The access point cited in the Safe System of Work Pack (SSOWP) was Rookery Bridge, however this is located on the goods lines side of the railway and therefore is not viable when the goods lines are not included in the possession.

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## *Underlying causes*

The ES was not familiar with the location and had not attended a site visit or the planning meetings.

The ES was sourced from a contingent labour provider and the team dynamics of them managing local in-house teams had not been recognised.

The ES conducted their briefing with one of the working parties over the telephone compromising clarity and restricting the chance to check understanding, including signed acceptance of the worksite details.

The SSOWP takes access point data from the National Hazard Directory (NHD) which allowed Rookery Bridge to be selected despite the goods lines not being included in the possession.

## *Key message*

The Person in Charge should be involved in the planning – a key factor is to make sure staff such as the ES, the PIC (and if different the COSS) have local knowledge.

Use location names as they are stated in the Sectional Appendix to avoid confusion.

Worksite briefings should be face-to-face to enable staff to sign their acceptance of the worksite details.

Attending site visits and planning meetings is of vital importance for safety critical staff.

The NHD is not 100% accurate and any discrepancy should be raised with the local Systems Support Manager.

Copies of Shared Learning documents are available on [Safety Central](#)

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## Shared Learning

**The Thameslink Programme** Issue Date: 26<sup>th</sup> October 2017 - For further info contact [mike.netherton@networkrail.co.uk](mailto:mike.netherton@networkrail.co.uk)

**Issue Number: TLP081 Title: Mobile Tower Pole Came In Contact with an Energised Conductor Rail**

### Overview of Event:

On 30<sup>th</sup> July 2017 at New Cross Station during a 2 Part Possession, a mobile tower was erected to inspect L221 Signal Gantry. The outriggers on one side were positioned between the conductor rail and running rail of No 3 Up Line. On the other side, both scaffold legs were positioned between the conductor rail and running rail of the Down Fast line.

As the possession moved into Part 2, operatives were dismantling the scaffolding, after carrying out a survey, when a scaffold pole was dropped and came to rest between the No 3 Up Line conductor rail and the Down Fast running rail, causing a flashover.

A COSS and team member were tested positive for drugs following incident.

### General Key Messages:

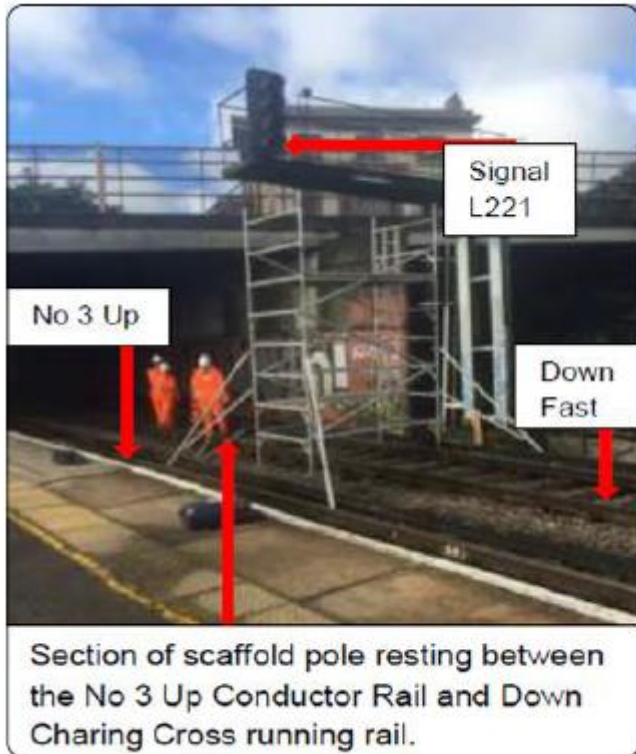
- Ensure that the complete work team is briefed and that they fully understand the track layout and isolation limits.
- When lines under possession change, during parts of multipart possessions, stand teams down and re-brief the new arrangements.

### Causes:

**Immediate** – Work party were unaware an isolation had been lifted on an adjacent line and a metallic scaffold pole came into contact with a conductor and running rail causing a flashover.

### Root and Underlying Causes

- Two COSS's failed to come to a clear understanding of the work site limits and isolated lines between Part 1 and Part 2 of the possession. Furthermore, although briefed, they both failed to confirm that they understood the detail of the Briefing.
- The COSS did not communicate to the Engineering Supervisor (ES) or Authorised Person (AP) that the work team would be erecting a mobile tower scaffold, nor was the use of a mobile scaffold tower mentioned in the 'white board briefing'.
- The senior COSS agreed to work even though he had to rearrange personnel commitments, which he left site to attend later in Part 2 of the possession. He had also broken his reading glasses and could not read the track diagrams clearly.
- The civils construction team had a number of personal on leave during the run up and the actual works, this resulted in disjointed planning and lack of robust communication of the detail of the working activities.
- The reproduced resolution of track diagrams contained in the Safe System of Work (SSOW) pack was poor.



## Actions Taken As a Result of the Investigations:

- COSS's used on Thameslink to have competency formally assessed.
- Introduction of compliance checks at site level, when scaffolding is used and to confirm understanding of possession arrangements.
- Increased frequency of random D&A testing to deter substance abuse.
- Site Supervision to undergo competence checks related to tasks they supervise.
- Contractor to ensure adequate site presence of supervisors.
- ES/AP's briefing for multi-part possessions are to be clearly communicated to all COSS's and confirmation received that they have a full understanding of the safe work limits for each part of the possession.
- COSS's to stand-down work teams and re-brief any changed arrangements when moving between parts of possessions.
- Introduce process to ensure version control and legibility of SSOW packs.

# Think Safe, Act Safe and Be Safe

## Safety Advice

Action required following a serious incident



### Failure of Tensorex C+ upper fitting bracket in OLE

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

**Ref:** NRA 17/10

**Date of issue:** 20/10/2017

**Location:** Structure MLN/46/424, Great Western Main Line

**Contact:** [David Campbell](#), Principal Engineer STE



### Overview

On the evening of 28 August 2017 the failure of a Tensorex Upper Fitting Bracket (Pfisterer part number 042216) was discovered in the Overhead Line Equipment (OLE).

Investigations indicate that the failure of the bracket was caused by poor quality welding of the stiffening plate during manufacture. This in turn caused a secondary failure of an M14 terminal fork.

The failed component is part of an assembly fitted to the specific assets listed:

PADS	OLE System	NR Allocation Ref Pfisterer Code	Compensation/ Load
0091/070159	SE1	000700687-104	1000/1680
0091/029025	Mk3b - SE2	000700679-102	1000/2250
0091/029030	UK1	000700680-102	1000/2085
0091/029023	Mk1(S)	000700678-102	1000/1985
0091/070132	SE1	000700687-1-104	1000/1680
0091/070157	SE1	000700673-1-104	750/1680
0091/070158	SE1	000701044-1-104	450/1680
0091/029038	GEFF/SSV	000700897-1B 101	1000/1345
0091/029039	GEFF/SSV	000701115-1B 101	750/1345
0091/029040	GEFF/SSV	000701116-1B 101	450/1345



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## ***Immediate action required***

IP electrification teams who are installing and any maintenance delivery unit which maintains the Tensorex devices listed above should:

1. identify all locations where they are installed;
2. inspect all installed brackets; and
3. check all brackets in stores for poor quality welding.

The inspection should focus on the quality of the welds, damage to the weld and insufficient welding of the stiffening plate.

Inspection can be from low level using a suitable camera device or at high level working from an access platform.

Any unit which has been fitted with the 042216 upper fitting bracket, and has subsequently failed the visual inspection should be retrofitted with a replacement part fully compliant to the design specification at the earliest possible opportunity.

All locations of failed units shall be reported to STE.

Alternatively, Route Asset Managers may wish to schedule replacement of the parts without survey.

To assist with future identification of any Tensorex C+ units which have passed the inspection criteria, or are retrofitted with a replacement upper fitting bracket, shall be clearly identified by way of yellow dots on the underside of the upper fitting, directly below both terminal fork positions.

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

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# “Think Safe, Act Safe and Be Safe”

## Compliance Team

Direct: +44(0)118 924 1639

Email: [compliance@resourcing-solutions.com](mailto:compliance@resourcing-solutions.com)

Find us on



[www.resourcing-solutions.com](http://www.resourcing-solutions.com)

