Wessex Route

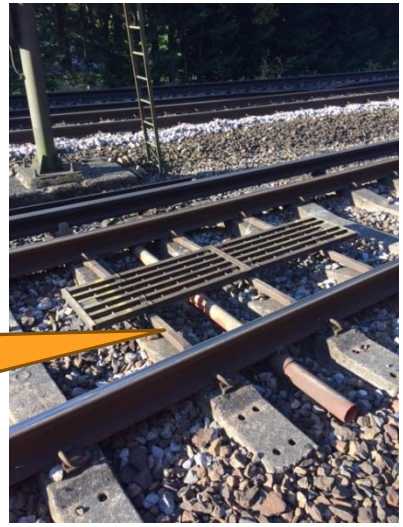
Welcome

Welcome to your Health, Safety and Environment Cascade for Period 8 2016. This contains all the documents and safety briefs you need to update your teams this period. Flick through this document and share with your team, print off the pages that you want to discuss and pin them up in mess rooms for staff to look at throughout the month.

In this cascade;

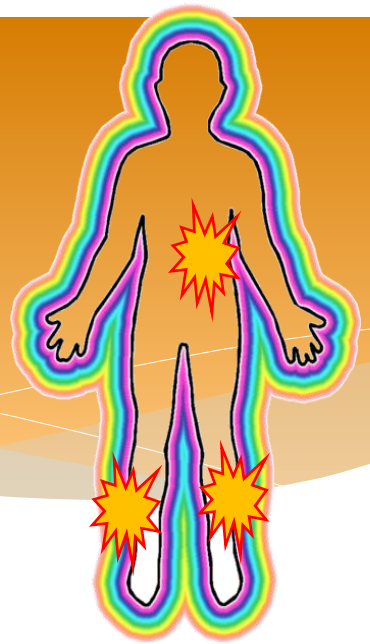
* Workforce Safety
* Safety Footwear
* Working on or Adjacent To the Conductor Rail
* Safety Hour
* Winter Driving
* Mobile Batteries
* Near Miss
* Close Calls
* Support Movember
* HAVS
* Investigations & Fair Culture Panel
* Safety Bulletins
* Safety Conversations

Tripping Hazard: Equipment, 3rd Rail and uneven ballast



Workforce Safety

3 Lost time: Slip Trip Fall Injuries.



INNER

* During hours of darkness: A technician was walking back to Strawberry Hill Station after completing strapping duties for T3 Possession, IP stepped over a running rail, placing his foot on to the ballast in the 4ft, the ballast gave way under his foot causing his right ankle to twist.

* During hours of darkness: A Supervisor whilst walking to site at Byfleet and New Haw to scope defects on the track, he was carrying a number of tools and walking on the down cess troughing route which was heavily covered in ballast. He slipped due to the uneven surface and was unable to break his fall because he was carrying tools. He suffered pain and bruising to his rib area.

OUTER

* During daylight in dry conditions working under lookout protection at Brockenhurst, the IP was called out to a position of safety. He picked up the Sperry Stick and moved to the safe cess , in doing so was required to step over a 3 x running rails and a conductor rail. When he placed his foot into the 4ft of the adjacent line, the ballast in the track bed was lower than normal and adjacent to infrastructure equipment. He lost his balance as he placed his right foot down adjacent to a TPWS Ariel grid (Spider), his foot then became trapped under the grid and he fell twisting his ankle in the process.

Focus on footwear next page

Workforce Safety

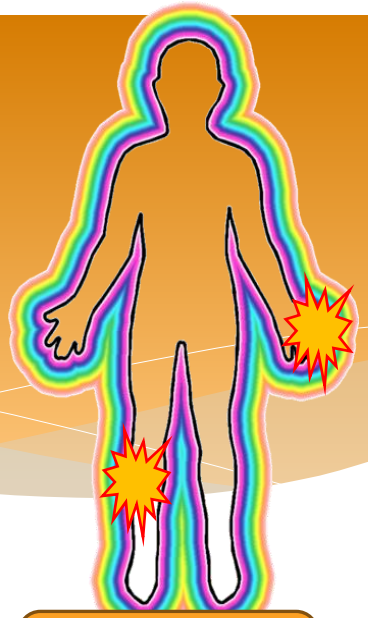
Focus on – Safety Footwear

- Check soles for wear – loss of grip.
- Change within 12 months if worn daily.
- If you have previously suffered an ankle injury the boots with a higher ankle support are preferable.
- Check they are laced and tied properly.
- Maximum support is provided by boots measured for right width and length.
- Higher risk of slip trip or fall when:
  - Manual handling *(check route first)*
  - Hours of darkness *(get/use lighting)*
  - Ballast on troughing *(remove when noticed and report CC and close it)*
  - Stepping over running and conductor rails. *(choose your route)*

Workforce Safety

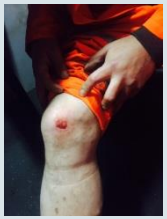
2 Other Lost Time injuries: Use of Plant and Equipment

INNER



* A technician was clearing scrap rail at Weybridge, the rail was placed on two iron men, however on one of these the rail was not level and stable. The Technician placed a rail clamp under the rail to support it and in doing this the clamp slipped and squashed his hand under the rail. This resulted in fractures to two fingers .

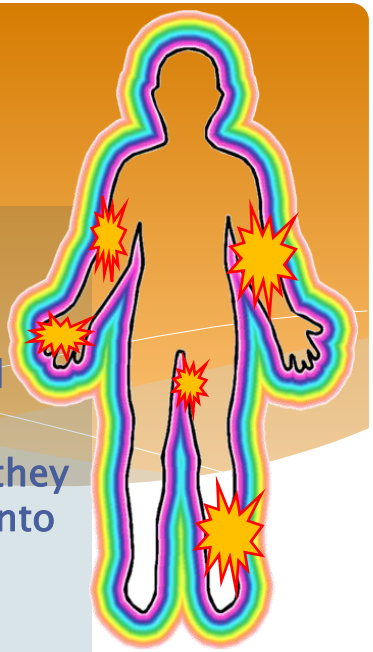
* At Sunningdale, a crane controller (CC)removing Strail panels from a level crossing using a Strail lifting attachment tool; (a Rhino Horn), that fits into a hole inside the panel. The panel was lifted out of the crossing, during the lift the Rhino horn slipped out of the panel locking system hole and swung toward the CC. The horn struck the CC in the leg who fell to the ground, sustaining cuts and bruising to his knee. CC attended hospital and thankfully had no broken bones. On examination it was discovered that the attachment tool was bent and had not been checked and certificated for use.



Check all equipment before use, is it certificated for use and in good condition….
and make sure you stand out of harms way.

Workforce Safety

5 No Lost Time Injuries



INNER

* New Malden Whilst removing a Cen 60 check rail at New Malden the injured person got his finger trapped between the check rail and the running rail.
* A Technician on his lunch break at Feltham got up from the chair in which they were seated , as they did so a colleague who was carrying hot food walked into him causing burning to his right arm.

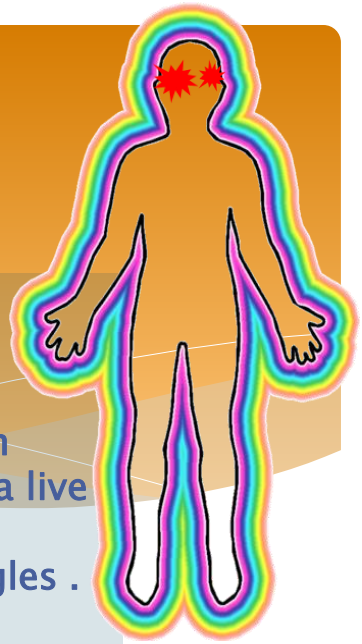
OUTER

* IP from Havant P-Way reported when using a disc cutter to change a rail at Petersfield, his foot slipped on a sleeper. When trying to correct this he pulled his groin causing a strain.
* IP from Eastleigh S&T was using a ratchet and socket to do up top union bolt on level crossing barrier. The socket slipped off the bolt causing his lower arm to come into contact with the edge of door aperture, causing a 2 inch cut to lower arm.

Works Delivery

* During daylight in sunny conditions, whilst carrying 20kg bag of cement mix over his shoulder on site at Honiton Tunnel, the IP stepped over a troughing route onto the cess area right foot first, the cess area was grassy, softer and lower in height than he had anticipated. This resulted in him loosing his balance and his right ankle twisted outwards causing injury.

Workforce Safety



2 No Lost Time Injuries: Electrical Flashover

OUTER

* An Apprentice from Eastleigh P/Way was taking measurements with a 300mm steel rule for side-wear movement on the Lymington branch line adjacent to a live conductor rail. The ruler came into contact with conductor rail. IP sustained redness to his face, but damage to his eyes was minimised by his safety goggles .

* The IP (an Apprentice from IP Track Renewals High Output) sustained temporary eye pain and blindness whilst completing measured shovel packing on the Down Brighton at 36m 32ch. He was distributing ballast into the 4 ft adjacent to a live conductor rail when it is suspected a metal object in the load came into contact with the live conductor rail causing an electrical flashover

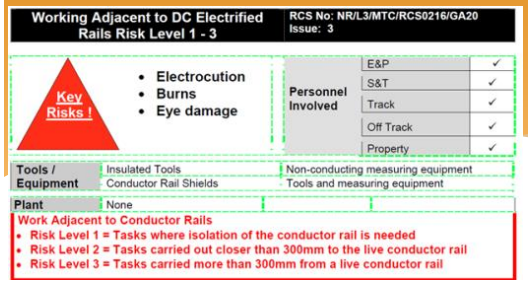
Discussion points;

Check understanding of the NR standard and Risk Control Sheets applicable to working on or adjacent to a conductor rail

Check understanding of the Management of Inexperienced Staff; Safety Passport Scheme.

1. *Have a Safety Passport*
2. *Have a Mentor*
3. *Get an on site Buddy*

Working on or Adjacent to the Conductor Rail



Working Adjacent to DC Electrified Rails Risk Level 1 - 3	RCS No: NR/L3/MTC/RCS0216/GA20 Issue: 3		
Key Risks ! • Electrocution • Burns • Eye damage	Personnel Involved	E&P	✓
		S&T	✓
		Track	✓
		Off Track	✓
		Property	✓
Tools / Equipment	Insulated Tools	Non-conducting measuring equipment	
	Conductor Rail Shields	Tools and measuring equipment	
Plant	None		

Work Adjacent to Conductor Rails
- Risk Level 1 = Tasks where isolation of the conductor rail is needed
- Risk Level 2 = Tasks carried out closer than 300mm to the live conductor rail
- Risk Level 3 = Tasks carried more than 300mm from a live conductor rail

NR/L3/MTC/EP0152 or NR/L3/MTC/RCS0206/GA20.

Both are really important

All Planners, Section Managers and Team Leaders must have a good working knowledge of this Task Risk Control Sheet.

3 Levels of Risks relative to the conductor rail:

- Risk 1. Mandatory Isolation
- Risk 2. Less than 300 mm
- Risk 3. More than 300mm

- Mandates the correct use of Insulated Tools
- Mandates the use of conductor rail shields
- Prohibits use of metal measuring tools.
- A copy of this RCS is attached to this Safety Cascade for briefing and discussion; please seize the opportunity to check your understanding.

Working on or Adjacent to the Conductor Rail

Ref:	NR/L3/MTC/EP0152
Issue:	5
Date:	03 December 2011
Compliance date:	01 March 2014

NR/L3/MTC/EP0152

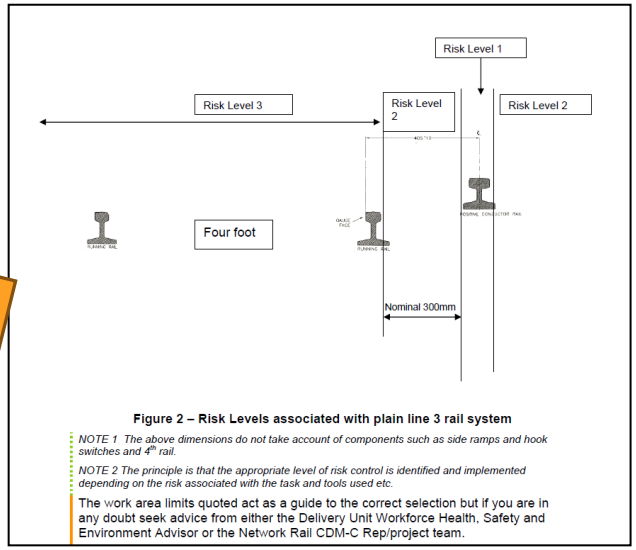


Figure 2 – Risk Levels associated with plain line 3 rail system

NOTE 1 The above dimensions do not take account of components such as side ramps and hook switches and 4th rail.

NOTE 2 The principle is that the appropriate level of risk control is identified and implemented depending on the risk associated with the task and tools used etc.

The work area limits quoted act as a guide to the correct selection but if you are in any doubt seek advice from either the Delivery Unit Workforce Health, Safety and Environment Advisor or the Network Rail CDM-C Rep/project team.

Risk Level	Description	Risk controls
Risk level 1	The risk of a person, any tool, plant or equipment making contact with the conductor rail(s) cannot be reduced to a tolerable level	Isolation and the issue of a conductor rail permit (unless a temporary isolation is secured) is mandatory
Risk level 2	Work that could impinge 300mm either side of the conductor rail(s) or any space above or below the conductor rail shall be considered as working live	Risk of accidental contact with the conductor rail(s) shall be managed by employing live working techniques
Risk level 3	Work not as close as 300mm of the conductor rail(s).	Risk of accidental contact with the conductor rail(s) shall be managed by implementing the controls specified in Table 3

Table 2 – Risk controls to be applied

Description	Risk controls
Work within 300mm either side of the conductor rail(s) or any space above or below the conductor rail should be considered as working live.	Fit sufficient conductor rail shields to prevent accidental contact with a live conductor rail. Yellow VORTOK shields shall be used for fitting and removing rail clamps. *NOTE the number of conductor rail shields used would normally be limited to the number which may safely be removed before the passage of a train; normally this number would not exceed more than one shield for each member of staff on site, excluding lookouts and site wardens.* Controls shall be implemented as specified in Risk Control Sheet GA20.
Work not as close as 300mm of the conductor rail(s).	If it is likely that any person, tool, or any equipment will encroach within 300mm of a live conductor rail, the conductor rail shall be protected with a conductor rail shield. *NOTE the number of conductor rail shields used would normally be limited to the number which may safely be removed before the passage of a train; normally this number would not exceed more than one shield for each member of staff on site, excluding lookouts and site wardens.* Controls shall be implemented as specified in Risk Control Sheet GA20.

Table 3 – Controls to be applied following a risk assessment

Workforce Safety

Key

Slips, Trips & Falls

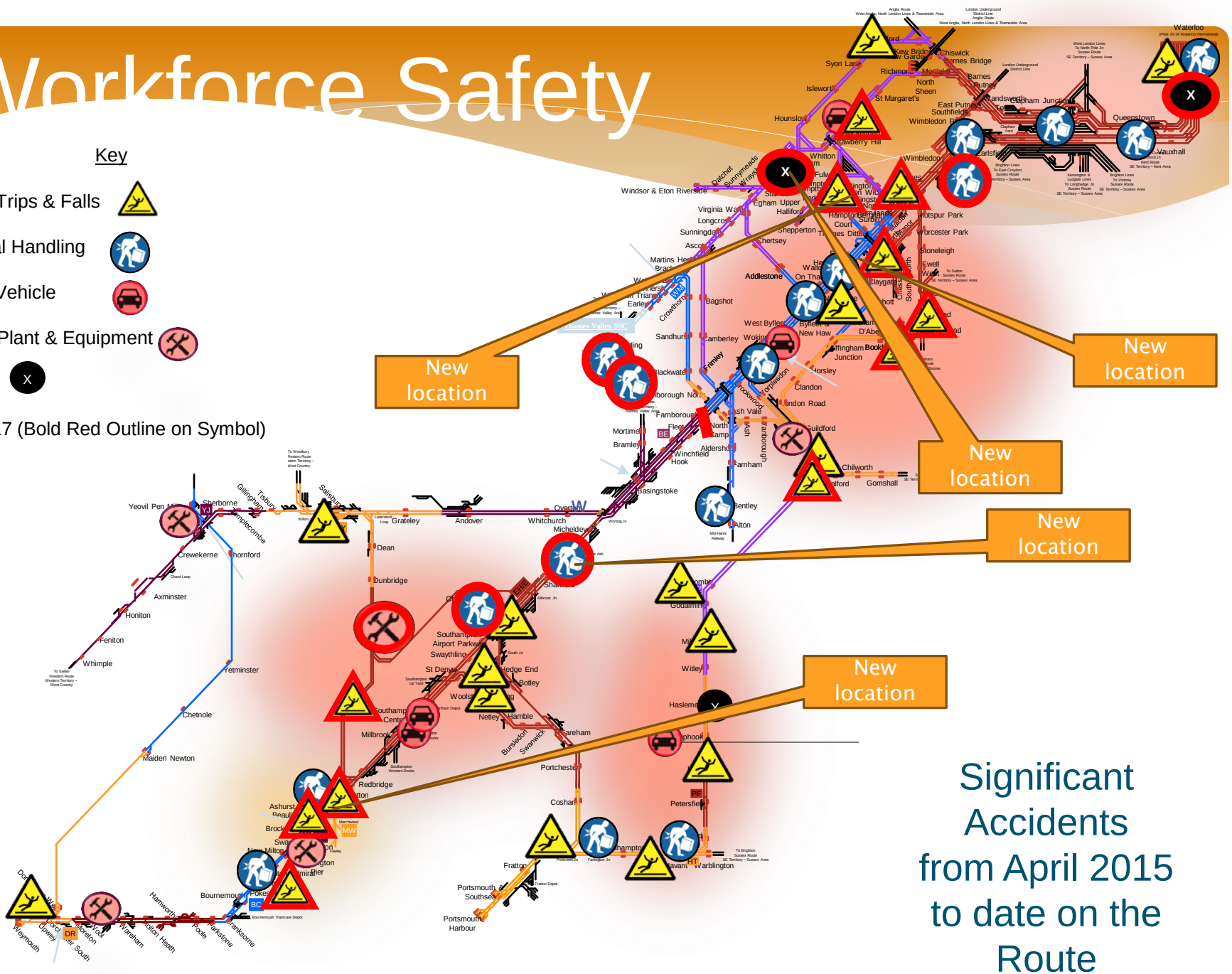
Manual Handling

Road Vehicle

Small Plant & Equipment

Other

2016/17 (Bold Red Outline on Symbol)



Significant Accidents from April 2015 to date on the Route

Safety Hour

Last month we discussed…

18th October– *Adam Stewardson* *Safety Blog updates and Healthy Apps* Safety Hour Attendance: **62%**	25th October– *Tracey Capstick and Grazia Elsehimy* *Symptoms of Heart Attack and Stroke* Safety Hour Attendance: 71%
1st November – *Amanda Ingram* *All you ever wanted to know about Level Crossings* Safety Hour Attendance: **60%**	8th November – *Tracey Capstick* *Honesty ,Boots and Home Safe Plan* Safety Hour Attendance: **55%**

Are you taking time out each week to discuss safety?

Make time for Safety Hour and record your attendance.

You can listen to the latest call **and** record your teams attendance using the Safety Hour **app** or **online** at http://safety.nrwessex.co.uk

Workforce Safety

Winter Driving Campaign

Safer driving and winter preparation guide

NetworkRail

SAFETY MEASURES

For driving in severe weather

- Before setting off, **clean** all your **windows** and **windscreen** and ensure all lights are working.
- To **improve visibility** in snow or rain, drive with dipped headlights.
- Only use **fog lights** where visibility is less than 100 metres.
- **Brake** before you go around corners.
- Drive in a **higher gear** than usual.

Safer driving and winter preparation guide

NetworkRail

BACK OFF!

Tips for keeping your distance.

- Where possible, **brake** in a straight line.
- Brake gently but earlier than usual so your **brake lights** warn drivers behind you.
- Don't underestimate stopping time in **slippery** conditions.
- Always leave **two car lengths** minimum between you and the driver in front.
- **Double** this gap in wet conditions, and **quadruple** it in snow and ice.

everyone home safe every day

Safer driving and winter preparation guide

NetworkRail

WINTER CHECKS.

Don't get caught out by the cold weather – give your vehicle a thorough check before Winter kicks in.

- Give your **electrics** a once-over: battery, ignition, lights.
- Check your **brakes**.
- Make sure your **wipers** work effectively and the blades are undamaged.
- Check all **fluid levels** in the vehicle and keep them topped up.
- Keep your **fuel tank** topped up, particularly on longer journeys.

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Safer driving and winter preparation guide

NetworkRail

HELP!

If the worst happens…

- Try and keep track of your **whereabouts**.
- If you must leave your vehicle, find a **safe place** to stand away from the traffic flow.
- On **motorways** it's always better to leave your vehicle with the wheels turned towards the verge and stand a short distance behind and to the side of it.

Ring the Road Fleet helpline on 0845 600 6767

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Safer driving and winter preparation guide

NetworkRail

TYRE SAFETY.

- Make sure your tyres are in **appropriate condition** for your journey
- Is the **tread depth** at least 2mm?
- Make sure they don't have any **major cuts** or damage
- Keep them **well inflated**
- **Check** them weekly or at each fuel top-up

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Workforce Safety

Mobile Phone Battery life

A fit battery could save your life:

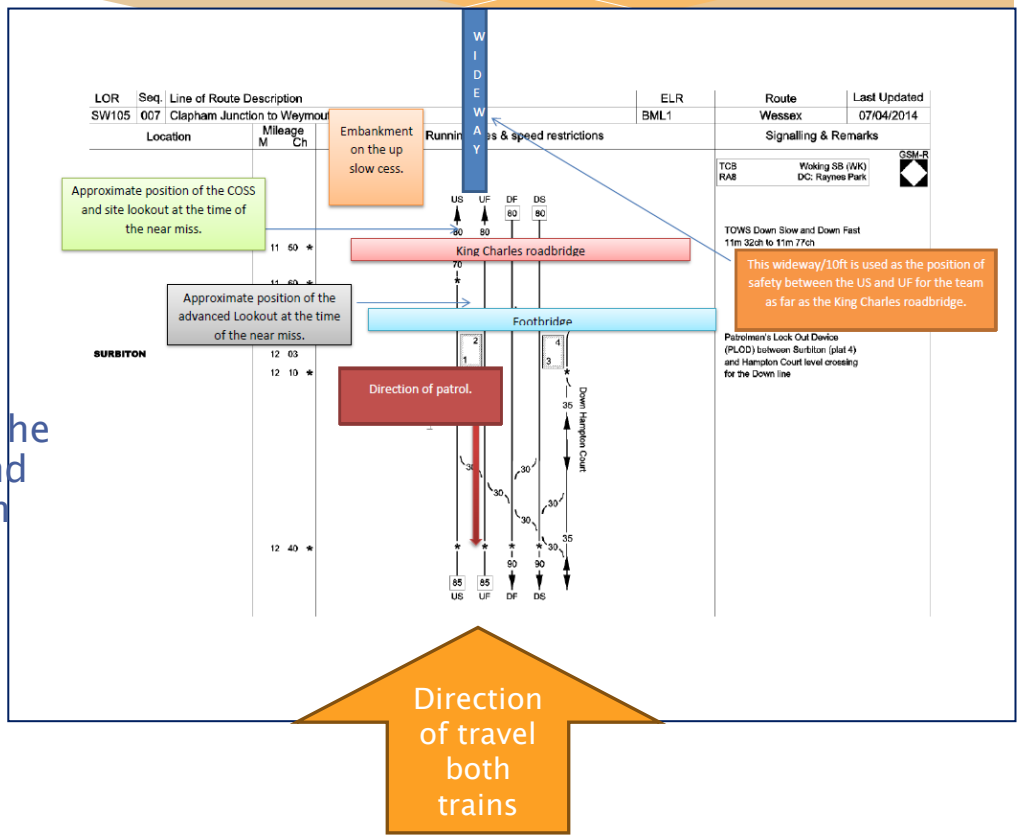
* Have a short screen saver turn off time.
* Turn off Bluetooth facility.
* Keep warm in an inside pocket.
* Turn off vibration facility,
* Turn down screen brightness.
* Deactivate Wi-Fi when not needed.
* Up-load and sync only on Wi-Fi.
* Shut down.
* Uninstall unnecessary apps.
* Use ‘fetch’ notifications if possible.
* Install a brightness toggle widget.

Workforce Safety
Near Miss

A Near Miss with a SWT train was reported in the 6ft between the Up Fast and Slow, London side of Surbiton Station on 2nd November.

1. Involved was an experienced Patrolman and COSS with two contract Lookouts.
2. Whilst walking from Berryland's toward Surbiton inspecting the Up Lines, the Distant Lookout was walking in front about 10 chain ahead in the wide-way between the Fast and Slow Up lines.
3. This position of safety diminished and became a 6ft.
4. As one train passed him on the Up Fast he moved toward the Up Slow line, a second train passed him almost immediately on the Up Slow line.
5. He did not have sufficient distance between him and either train.

The incident is still under investigation



Workforce Safety
Near Miss

TOP TIPS FOR
COSS's and Track Section Managers
to think about…

Section Managers

* **Are your Track Patrolling diagrams constructed with Patrollers safety in mind.**

COSSs –

* Be sure you know and brief the position of safety for your Distant Lookout every time; especially in a moving worksite
* Check ..Does everyone know their position of safety at all times.
* If you are in charge of a moving worksite – stop and check understanding regularly.

Close Calls

Call it in to prevent future accidents

Seen something that doesn't look or feel right? Call it in

By calling in an incident that has the potential to cause damage or injury, you can help prevent it occurring in the future

This period 222 **close calls** have been reported on the Route, 80 have already been closed, 152 remain open.

Can you make the situation safe?

Remember, **if it is safe to do so**, deal with the close call and then report it. For example:

Unclear Briefing by PICOP to Blockman	**Error on RT3181**
Not wearing head torch	**Phone Battery failed: not sufficiently charged**

Close Calls

Looking back at our close calls

Call it in to prevent future accidents

Risk of noise levels not included in SSoW briefing.

Walking across an authorised walking route without Hi-Viz

Worksite managed in a hazardous unorganised condition with tools and materials left for staff to trip over

Old boots with little tread

Driver not wearing a Seat Belt.

Support Movember

The issue

Dial in to Wessex Safety Hour on 22nd November 2016 at 12:30

For a special call on Cancer Awareness.

You don't want to miss this call!

The message

If you notice something, do something

You know your body better than anyone. If you notice something isn't feeling right, don't put it off and hope that it goes away, go to the doctor and get it checked out. Early detection is the most important factor in treating the big issues.

Hand Arm Vibration Syndrome (HAVS)

One IMDM was issued with an Improvement Notice by the ORR, these are the required actions……Grazia can help!

Grazia Elsehimy 077109 61628

Line Manager must;

- have sight of the vibration emission of their tools. Contact OHWM for bespoke list.
- have knowledge who in their team works vibrating tools
- have knowledge of everyone within the team who works with vibrating tools and whose health is at particular risk from exposure to vibration
- utilise the Route's Manual Vibration Monitoring system to record vibration exposure for each of their employees against Exposure Action Value (EAV) and/ or Exposure Limit Value (ELV).
- brief their employees on vibration risk. Contact the OHWM to assist.
- make sure that ALL at risk employees attend Health Surveillance
- make sure that vibration risk is reduced at source, if not possible, that it is reduced to as low as reasonably practicable.
- Implement any other equally effective means of achieving compliance with this Notice.

Published Investigations

Area	Date of incident	Level	Description	Lead Investigator	DCP	Published	Actions	Recs
Ops Outer	03/05/16	2	1J98 Close Call with Fareham GPL shunt through no coms (26 weeks)	Karl Grewar	Giles Baxter	07/11/16	6x Open	None
Works Delivery	30/06/16	2	A34 - Works Delivery LSR speeding breach 72mph in a 50mph limit (18 weeks)	Marc Minikin	David Smith	07/11/16	4x Open	None

Published Investigations

Area	Date of incident	Level	Description	Lead Investigator	DCP	Published	Actions	Recs
Ops Inner	22/04/16	2	6J61 signalled into T3 / Close Call with Possession Support Staff (20 weeks)	James Webb	Giles Baxter	21/09/16	1x Open 2x Closed	1x Open
Works Delivery	27/03/16	2	Lost Time Injury Waterloo – Broken ankle sustained (26 weeks)	Rob Graham	David Smith	23/09/16	3x Open 2x Closed	None
Ops Outer	09/03/16	3	Portsmouth and Southsea Cat A SPAD HT59 by 2N27 (28 weeks)	Paul Fleet	Giles Baxter	23/09/16	2x Open 3x Closed	None
Ops Inner	13/05/16	3	1A48 CAT A SPAD Wk 126 (19 weeks)	Philip Davies	Giles Baxter	04/10/16	7x Open 3x Closed	None
Maint Inner	10/03/16	3	Clapham Junction (Windsor Lines) Near miss with a Blue Hat Operative (34 weeks)	Steve Edwards	Andrew Malcolm	03/11/16	2x Open 6x Closed	1x Open

Fair Culture Panel Review

8.11.16

Event	Immediate Cause	Underlying Cause	L/Investigator outcome	FCP outcome	FCP comment
P06 1617 010816 Sig error	1P34 (8 coach length) signalled into a platform which was occupied by an 8 coach train.	The signaller had regulated according to the ACI information (which is the normal way of obtaining booked platform information (and generally reliable)) however, on this particular day 1P34 was altered on the ACWN to be platformed into Platform 15 but this had not been updated into the ACI system. This mislead the signaller.	Routine Error – different people	Contravention	Panel disagreed with the Lead Investigator as they were unable to understand what led the signaller into this error.
P06 1617 210816 New Kew Junction. Marker board irregularity	Marker boards placed in the incorrect position.	Person carrying out multiple duties (ES and Possession support), person got confused regarding the mileage on the NKE. Mileage on the line are not clearly displayed and 9m45ch does not exist on the up NKE.	Routine Error – different people	Not able to conclude	Panel not able to conclude the outcome based on the detail within the report; requires review and submitting again.
P06 1617 250816 Inner DU Near Miss Leatherhead	Failure to appoint touch lookout	Safe system of work was only tested whilst using hand tools and not with machinery (impact wrench) running. Coss was working under a heavy workload, performed Coss duties for patrol and then Coss for clamping ultrasonic defects.	Slip / Lapse	Contravention	The Panel disagreed with the Lead Investigator, as the safe system of work test should have included the equipment the team were working with.

Fair Culture Panel Review

8.11.16

Event	Immediate Cause	Underlying Cause	L/Investigator outcome	FCP outcome	FCP comment
P07 1617 280916 Barnes Line Blockage irregularity	Signaller set the route for 2H90 on the Up Richmond line, A Line Blockage was in place on the Up & Down Hounslow lines with W518 being the exit signal for the block, consequently 2H90 was signalled into the Line Blockage.	The signaller and COSS changed the LB limits to make them less restrictive, the signaller agreed that the COSS only required Barnes Hounslow CCTV Level Crossing to be protected and that the rest of the railway should not be affected. This was not reflected on the RT3180, the exit point of the LB on the Up Hounslow was agreed to be W518 but should have been c/o W2585 points.	Contravention	Contravention	The Panel agreed with the Lead Investigator.
P04 1617 300616 Works Delivery. LSR speeding 72mph in a 50 limit.	The Driver failed to observe the reduction in speed limit having left the motorway and onto a dual carriageway travelling at 72mph in a 50mph zone.	The Driver was not used to driving long distances and was unfamiliar with the route being taken resulting in a lack of concentration and fatigue. The Driver had not driven this type of vehicle (a van rather than a car) before and had therefore overlooked the speed that he was travelling.	Contravention	Contravention	The Panel agreed with the Lead Investigator. Upon the conclusion of this investigation, the Driver was placed on a Driver Awareness course and under mentorship for 3 months.

Workforce Safety

Safety Bulletin

Immediately Transferable Lessons from Possession irregularity At Portchester

Information for Signallers and Front Line Operational Staff

On Sunday 9th October 2016, at 00:10, the Signaller operating panel 2 at Eastleigh ASC granted signal protection for a planned possession from Eastleigh South to Portchester of all lines.

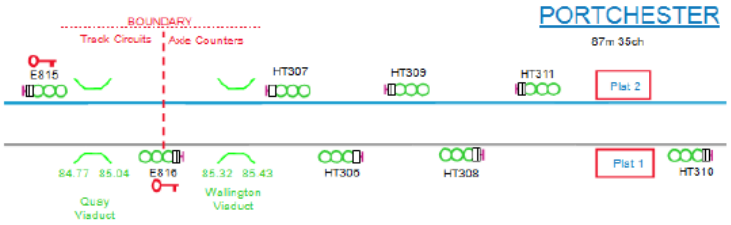
When discussing the limits of possession the Signaller and PICOP. The signaller didn't repeat back the detail of the possession limits.

The Signaller at Havant ASC wasn't aware of the possession and the Up line was effectively open to traffic.

At approximately 0603 the PICOP contacted the signaller at Eastleigh to advise that the possession was about to be given up. Shortly afterwards the signaller at Havant signalled 6J07 towards Portchester. The signaller at Eastleigh having been aware the possession was about being given up shortly contacted the Havant signaller to confirm that the possession was still in place. The signaller at Havant was unawre of the possession.

The driver of 6J07 stopped at the Possession limit board and contacted the signaller at Havant via GSMR

The incident was reported to WICC by both signal boxes and investigations commenced.



Reason Incident Occurred:

- PICOP did not contact the signaller at Havant ASC to make arrangements for the possession.
- The signaller at Eastleigh failed to confirm the arrangements with the signaller at Havant.

Points to Consider:

- Do you know what conditions must be satisfied before you can grant signal protection for a possession ?
- How do you confirm that the line is clear of trains for the whole area covered by a possession.
- Do you ensure that possession details are repeated back to the PICOP.
- Do you in each conversation ensure you reach a clear understanding as to who both parties are and confirm messages by repetition.

Date Produced:	10/10/16	**Date Posted:**	12/10/16
		Post For:	*12 Weeks*

Extract from Rule book T3 Issue 7 Part 2.3

If another signaller is involved with the possession arrangements, you must:

- tell them what the possession arrangements are
- get their assurance that they will keep to these arrangements.

1. PICOP did not contact the signaller at Havant ASC to make arrangements for the possession.
2. The Signaller at Eastleigh failed to confirm the arrangements with the Signaller at Havant.

Workforce Safety

Safety Bulletin

Safety Advice

Action required following a serious incident

everyone home safe every day

Electric shock from Bussmann CamMaster fuse carrier, CM32F, rated at 32A

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

Ref: NRA 16/11

Date of issue: 27/10/2016

Location: Oxford Parkway

Contact: Richard Stainton, Engineering Expert

TEST BEFORE TOUCH

Overview

A member of contractor staff supporting electrical testing of the signalling power distribution system received an electric shock from touching a Bussmann CamMaster fuse carrier in a lineside location case / Functional Supply Point (FSP).

Subsequent testing revealed that the fuse carrier had an elevated voltage of up to 300V on its surface.

Under normal operating conditions no voltage should be present. Insulation breakdown in the faulty fuse carrier caused the elevated voltage.

STE engineers are currently investigating but are unable to yet identify if this is a one-off component failure or a batch problem.

Fortunately in this instance, the contractor was not harmed by the electric shock.

Immediate action required

Touching one of these 32A fuse carriers (part reference CM32F) cannot be assumed to be safe when it is energised.

- Every member of staff must test the surface of a Bussmann CamMaster fuse before touching or removing the fuse carrier from the base.
- The special requirements in NR/SPS S002 (the Authority to Work Live process) must be used if touching or removing the fuse carrier when energised. Working live should be avoided wherever possible.

Copies of Safety Advice are available on Safety Central.

Part of our group of Safety Bulletins

Safety Alert | Safety Bulletin | Safety Advice | Shared Learning

Workforce Safety

Safety Bulletin

A serious incident has taken place

everyone home safe every day

Safety Bulletin

Team members injured during isolation irregularity

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

Ref: NRB 16/18

Date of issue: 19/10/2016

Location: Maxwell Bank, Orpington.

Contact: Rupert Lown, Head of Corporate Workforce Safety

Overview

During a possession, at 06:48 on Sunday 25 September members of Orpington Track team were injured when a pair of timber nips came into contact with the third rail within their worksite, which they believed to be isolated.

The incident happened in a two part possession that was planned to be shortened. The work was not planned within the usual timeframes, and due to this safety briefings were issued late.

The conductor rail within the Orpington track worksite was partly re-energised, and the team were not advised or aware of the change in isolation and the new hazard within the worksite

One staff member sustained a severe arc eye injury, another member sustained a bruised ankle and a fractured wrist whilst moving away from the flash over. A third team member's overalls caught fire but they did not sustain any physical injuries.

Discussion Points

Whilst the investigation is on-going please discuss the following with your team:

- When possession limits and worksite limits change, how do staff re-visit safety controls, for example re-test conductor rail or overhead lines.
- What do our Lifesaving Rules require?
- How do you minimise late changes, and what is your safe 'cut off' point for accepting any changes to a plan?
- Where changes do occur how are they briefed to all responsible staff such as the PICOP and ES?
- Are suitable risk controls being identified and implemented when making late changes to a work plan or possession?
- When making late changes how are SSoW Packs and other safety related information checked for accuracy and provided to staff giving them sufficient time to read and understand the documents?
- If you have worked in the same location before, and different safety controls are in place, how might you question and challenge the safe system of work with your peers?

Copies of Safety Bulletins are available on Safety Central

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Safety Alert | Safety Bulletin | Safety Advice | Shared Learning

Workforce Safety

Safety Bulletin

Immediately Transferable Lessons from CCTV Incident at Mortlake

Information for Signallers and Front Line Operational Staff

Details of the Incident;

On Monday 31st October 2016 a trainee signaller operating Mortlake CCTV Level Crossing set the route for the Up and Down protecting signals over the crossing for the passage of 2 approaching trains, and commenced the lowering sequence. The trainee observed the sequence until the road light indicator on the panel illuminated, at that point they stopped their observation and signalled a train on another part of the panel.

When the trainee had completed the route setting they returned their attention to Mortlake crossing, carried out a quick observation and pressed crossing clear.

When crossing clear was pressed both protecting signals stepped to proceed aspects with a member of public trapped within the crossing limits.

Reason Incident Occurred:

- The Signaller failed to observe the complete lowering sequence including final figure of 8 check.
- The Signaller pre-set the routes associated with the crossing prior to commencing the lowering sequence.

Points to Consider:

- Do you know what conditions must be satisfied before commence the lowering sequence for level crossings?
- Do you observe the complete lowering sequence for all monitored crossings in your area of control?
- Do you recognise the safety risks by becoming distracted during the lowering sequence?
- When supervising a trainee, do you observe all safety related tasks?

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		Post For:	*12 Weeks*

Immediately Transferable Lessons following 2 Trainee signaller incidents at Wimbledon ASC

Information for Signallers and Front Line Operational Staff

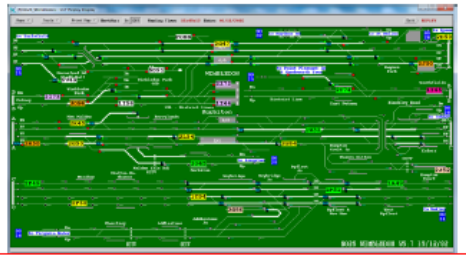
During a late turn on Panel 3 at Wimbledon ASC on Tuesday 01st November a trainee signaller was requested to run 2J50 on the Up Main Slow line non-stop from Wimbledon to London Waterloo. When the message was passed to the trainee signaller a breakdown in communication occurred, causing the trainee to give the Driver of 2J50 incorrect information regarding the stopping pattern. The trainee signaller should have instructed the Driver to run fast from Wimbledon but the trainee misinterpreted the message and asked the Driver to run fast from Raynes Park to London Waterloo.

The breakdown in communication has a transfer of risk of trains approaching red signals they wouldn't normally expect to be at red, and increased workload for signalling colleagues across Wimbledon and Woking ASC's. It also had a significant impact on train performance causing delays that totalled approximately 1800 minutes.

The mentor signaller was dealing with another incident on Panel 3 at the time the message was passed to the trainee.

On the 31st October 2016 a trainee signaller working Panel 5 at Wimbledon ASC trapped a member of public within Mortlake CCTV level crossing (please refer to Op's Alert dated 03/11/16).

Both Trainee signallers should have been observed by Mentor signallers at the time of the incidents.



Reason Incidents Occurred:

- The Mentor signallers were not in a position to assist the trainee's should anything go wrong.
- The Mentor signaller did not listen to the communication when it was passed to the trainee.
- The Mentor signaller became distracted dealing with another incident on the panel.

Points to Consider when Mentoring Trainee signallers:

- Do you put yourself in a position where you can react and support the trainee?
- Do you listen to messages given to trainees to ensure a clear understanding has been reached?
- Do you listen to conversations between the trainee and 3rd parties to ensure the correct information is passed on?
- Do you consider how much experience the trainee has before judging how closely supervision is undertaken?
- When multiple incidents occur on your panel and you are mentoring signallers should you;
  a) Relieve the trainee from the panel, deal with the incidents yourself asking the trainee to observe?
  b) Observe the trainee dealing with multiple incidents?

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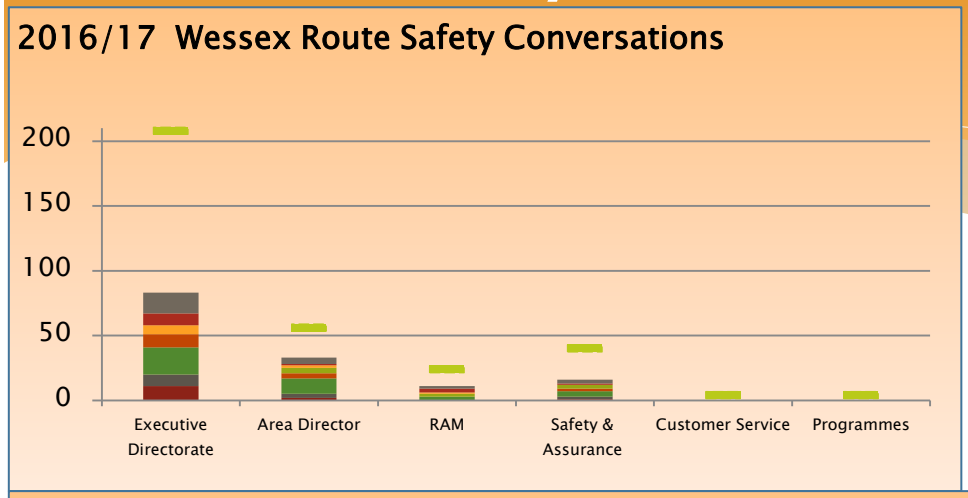
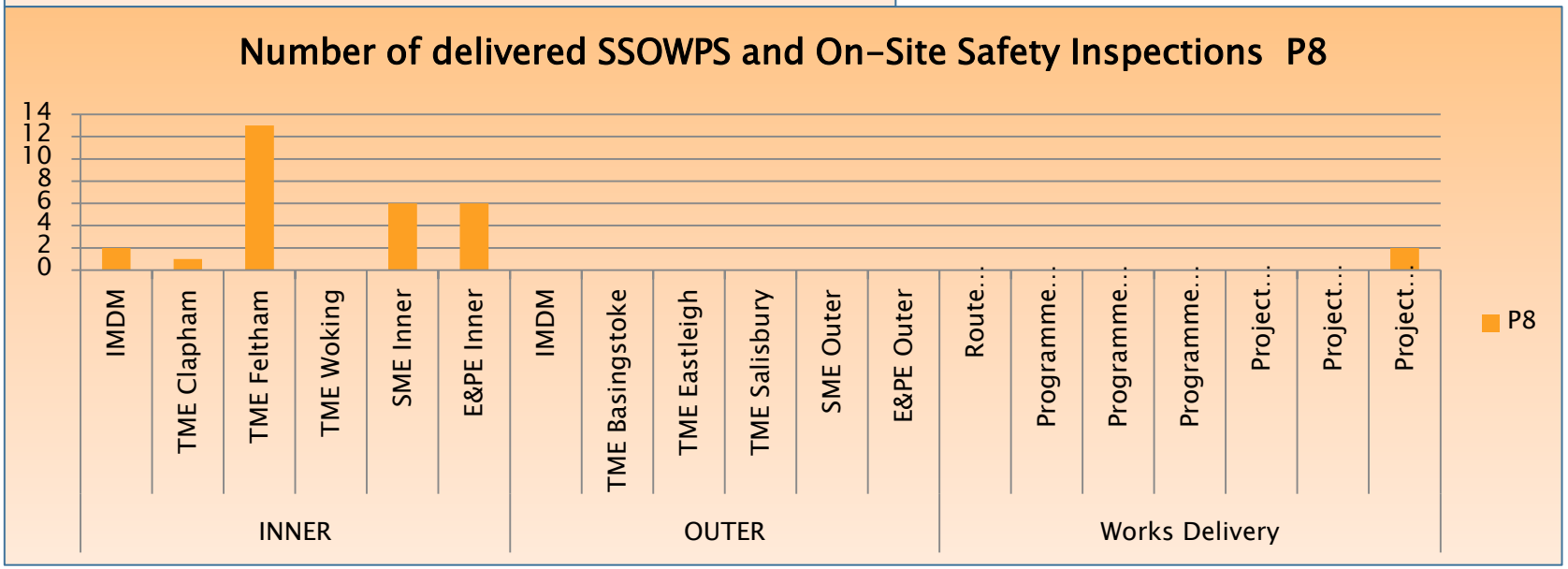
Safety Conversations and PGSIs





Appreciation Section

A thank you to:-

James De Mars Project Leader in the CMOs office who has worked hard to support many safety initiatives.

We all wish him well.

We would appreciate your feedback

Tell us how we could improve this cascade or if you would like to see an item next time round, please contact:

Your **Local WHSEA** or **Tracey Capstick** RWHSEA.

If you would like to take part in the Route Safety Hour session please contact your IMDM or equivalent.

Wessex Route

‘Happy worker, Happy customer’ by John Wright - *Entry to the Business Briefing photo competition:*