Infrastructure Projects Southern

Home Safe

The Southern Region's Weekly Safety Update

14 December 2016

Fractured arm at Hackney

Operatives were undertaking piling works at Hackney Wick using a 13 tonne wheeled excavator. During the works, one of the piles entered the ground at an angle. The decision was made to add another short screw pile, which meant disconnecting the torque head from the machine.

Two operatives began removing the torque head, with one of the operatives using a hammer to knock out the bolts. The torque head came free and struck the other operative on his arm. He was given first aid on site before attending hospital, where it was confirmed that he had fractured his arm.

A reconstruction of the incident determined that a redesign of the equipment would ensure that similar incidents do not occur in the future. A full investigation is underway. This will focus on Safe by Design and planning, procurement, potential future engineering controls, competency management and supervision, behaviours and aftercare of the injured operative.

Operational Close Call

During proposed works at Barnhurst Station, a COSS phoned the signaller to take the planned line blockage with additional protection. However, when he was questioned about protecting signals, the COSS was not able to relay the correct information back to the signaller. The signaller refused the line blockage as he did not deem the COSS competent. The Route Mobile Operations Manager (MOM) attended and is investigating the event as an Operational Close Call.

There has been much debate as to when a Close Call becomes an Operational Close Call. In this event, the work group had not started work; but the intent to access the operational railway was there and had the signaller not intervened, this group would have gone onto the infrastructure.

Remember…
You do not have to be on the infrastructure to have an Operational Close Call – the intention to access it is sufficient.

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Is your site set for winter?

Upon arriving on site, operatives working on the Reading 10 car project discovered the water pipe that supplies the toilets was frozen.

The team were asked to fix lagging to the full length of the pipe to prevent future freezing.

Remember…
If welfare is not in place on site, works cannot commence.

A positive intervention

During a recent commissioning, it was brought to the Construction Manager's attention that there was a high risk of exposing operatives to excessive hours. The team were carrying out hot splicing which can take up to 10 hours to complete.

The Construction Manager spoke to the project manager to determine how delaying works would affect the programme. As a result, the jointing works were delayed to the following day so as to not exceed maximum working hours on site. This caused the commissioning to take slightly longer than planned, but is a great example of taking a positive intervention to manage fatigue.

Contact us: shield@networkrail.co.uk

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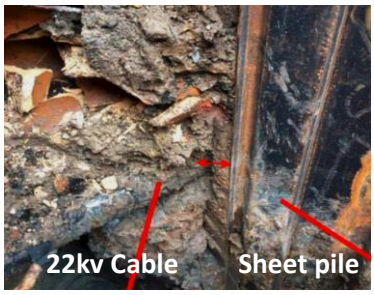
HV cable Close Call

Whilst carrying out drainage connection works for Thameslink, a 22kv cable was discovered close to where the sheet piles had been installed.



The sheet piles were over two metres below the ground level and the services drawing attached to the permit to dig showed a HV cable at a depth of 750mm; however, the team had not located this during their progressive scanning and sheet piling. They had uncovered another cable which was 11kv and thought this was the only HV cable.

In order to fit the pipe into the sewer, the operatives cleared the bottom of the trench. It was during this clearance that the team became aware of the 22kv cable. The cable was approximately 20mm from the edge of the trench sheets that had been installed. *You can find a copy of the full bulletin here.*

Lessons learnt…

Where services are indicated on service drawings but not found by those undertaking the works, safe digging practices must be followed until the presence of the services are confirmed.

Shared learning – fire alarm incidents

A sub-contractor was cutting through granite slabs when they struck cables associated with the fire alarm systems at London Bridge. The building controller witnessed a significant number of faults on the fire panel, but not recognising the fault status, the building controller incorrectly assigned the fault as a seven day action as opposed to the appropriate two hour action.

The weekly fire alarm test conducted five days later identified that the fire alarm zone affecting the Shard retail area was not working. It was subsequently identified that 75 fire detecting devices were not in operation during this period. *You can find the bulletin here.*

Lessons learnt…

All known service drawings must be available to those breaking ground. Roles and responsibilities must be clearly defined and understood by personnel undertaking specific roles.

On 5 September, failure to communicate to sub-contractors the updated alarm status of detectors resulted in the testing of a ‘live’ detector head. London Bridge station was evacuated. Two days later, the station was almost evacuated again after sub-contractors failed to update records with changes to detection zones. *You can find the bulletin here.*

Lessons learnt…

Information being used to plan and execute works on site must be up to date and accurate.

Spill at Queenstown Road

A tamper dropped approximately five litres of hydraulic oil from a burst hose at Queenstown Road. Most of the spill was caught with drip trays and nappy mats. Once contained, the spill was disposed of by the tamper crew.

Near Miss

Network Rail released a safety bulletin following a near miss in Surbiton whilst red zone working.

An advanced lookout was walking in the six foot, not in a position of safety. A passenger train approached on the Up Fast line and the advanced lookout moved his body toward the Up Slow line as it passed. He could not move into the Up Slow cess because he had observed another train approaching on the Up Slow line. The trains passed narrowly either side of the lookout, but fortunately not at exactly the same time.

This acts a reminder of the dangers of red zone working and reinforces why we do not carry out red zone working within IP Southern.

You can find a copy of the safety bulletin here.

If you would like a colleague to receive Home Safe, please contact daisy.read@networkrail.co.uk