Wessex Route

Welcome

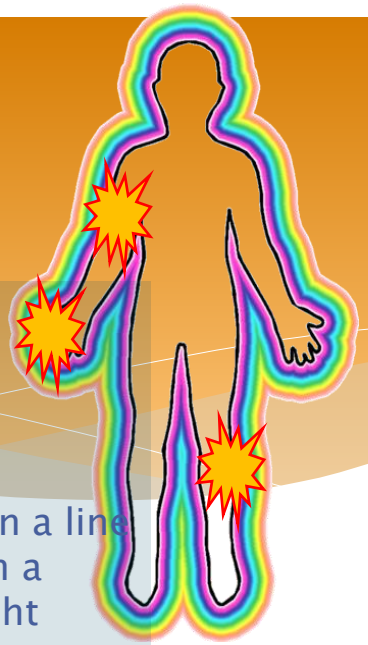
Welcome to your Health, Safety and Environment Cascade for Period 10 2016. This contains all the documents and safety briefs for you and your teams this period. Flick through this document and share as a team, print off the pages that you want to discuss and pin them up in mess rooms for staff to look at throughout the month.

In this cascade;

* Workforce Safety
* Lessons Learnt Circulars
* Lighting reminder
* IWA focus for discussion
* Close Calls
* Health and wellbeing
* Safety Bulletins
* Investigations & Fair Culture Panel
* Safety Conversations & PGSIs
* Special thanks to….

Get it down there !

Workforce Safety



3 Lost Time injuries: All slip, trip & Falls.

ONE REDUNDANT SCRAP RAIL

INNER

At London Waterloo, Down Windsor Slow line. Whilst walking in the 4ft within a line blockage whilst dealing with a fault, a member of the S&T caught his foot on a length of redundant rail and fell. He suffered a minor cut and bruising to right knee also graze on right shin and bruising to left knee.

TWO WHERE ICY UNDERFOOT CONDITIONS WHERE PREVALENT.

OUTER

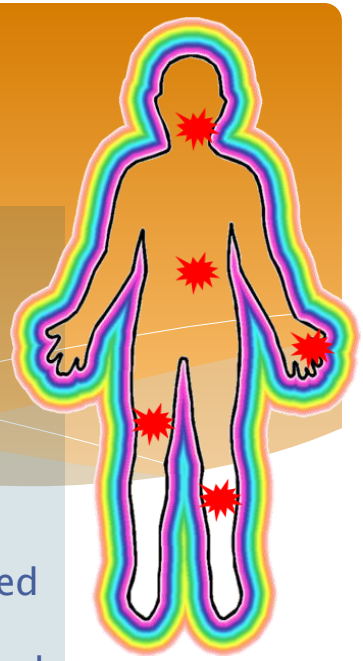
In the Andover area a member of staff from Salisbury S&T was attending an asset failure when he slipped in icy conditions. IP put his hand out to stop his fall, his hand got caught in a piece of equipment and he suffered a fracture to a finger.

Works Delivery

Whilst in Eastleigh DU yard, a member of WD staff was trying to clear the yard of ice. He walked across the yard to the plant store to locate salt to apply to a patch of ice, lost his footing on the edge of the icy patch, slipped over and landed on his arm/shoulder this caused a break in the upper arm, he was subsequently taken to hospital for treatment.

See Lessons Learnt Circulars on page:

Workforce Safety



3 No Lost Time injuries:

INNER

Whilst was walking to site past the site of an old substation that has been removed with just the floor remaining. The IP slipped on the painted floor which was covered in algae, this caused his knee to give way resulting in him slipping forward and jarring his back as well; sustained a sore knee and sore back

Discussion point: Unusual Slippery Underfoot conditions.

Operations

During the hours of darkness, a Signaller walking to the carpark tripped over a root, fell over grazing her right hand and chin in process.

Discussion point: Sufficient lighting on walkways

Whilst walking on the infrastructure a MOM has advised that he has suffered pain and discomfort at the top of his left leg.

Workforce Safety

Works Delivery

Title: Slip and Fall in icy conditions in Eastleigh Depot Yard: Broken Arm.

Incident.

On 3rd January at 0740 hours, a member of staff working for Works Delivery Signalling Section slipped and fell over in exceptionally icy underfoot conditions. He sustained a nasty break to a bone in his right arm. (Humerous)

At the time he had walked out of the building and noticed a large patch of ice which he had placed a red fence around to warn others, he had then walked across the yard to the plant store to get salt to apply to the ice patch (The white salted area in the photo).

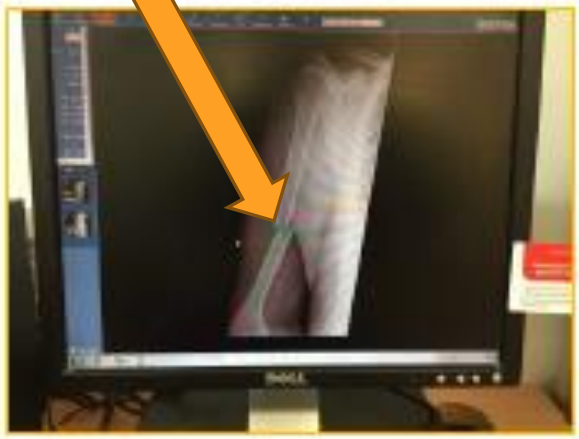
However before he could collect the rock salt to put on the ice, he walked back around the ice patch; it seems that he misjudged the slippery surface edge. He was wearing safety boots which were correctly fastened, but lost traction on the slippery surface; his feet went from underneath him. He put his hand and arm out to catch himself but as he came down he landed on his upper arm and shoulder, and he heard the crunch as his arm was damaged.

He was on the floor for approximately an hour, due to high level of demand on emergency vehicle response, subsequently treated with morphine on site before he could be moved to Hospital.

Additional Information

The front of the entrance of the Depot yard had been treated already but not the rest of the yard / compound where it had happened.

The area has been reported to Property Hotline as water is known to gather at this particular spot.



Lessons Learnt

1. During these very cold weather conditions all areas of Depot yards must be regularly treated with Rock salt or similar anti-ice treatments.
2. Areas known for gathering water should be closely monitored whilst waiting for action and if Property Action does not respond in a timely manner escalate the complaint.
3. During icy conditions make sure we have sufficient rock salt or similar anti-ice treatments available and use liberally;
   - At the depot
   - On or near the vehicles
   - Access Gates and steps
   - Taken to site.

Workforce Safety

IMDM OUTER

Slip Whilst Removing Fishplate Bolts: Neck Injury

Incident.

On 4th of December 2016 at 01.30 hrs on the BAE1 at 82m 35ch, at Salisbury Tunnel Junction, a P/Way Operative from Salisbury depot sustained a neck injury whilst undoing a Fishplate bolt. Weather conditions were extremely cold at the time.

The injured party (IP) was part of an 8 man team carrying out track maintenance and was tasked with removing a Fishplate. As he applied pressure the spanner slipped off the nut causing the IP to fall backwards.

IP was caught by a team member stopping him from falling to the ground.

The team were working with head lights on their helmets and K9 rechargeable lights.

The IP was wearing serviceable safety footwear and was using the correct tools for the task.

The IP has been referred to Network Rail 'Rehabworks' for physiotherapy type support by his Section Manager.

Lessons Learnt

1. Make sure when using handheld tools they are correctly and firmly fitted to the component being worked on.
2. When stood on ballast removing or replacing components where some pressure needs to be applied ensure that a firm footing is established and avoid standing on sleepers.
3. When working during inclement weather conditions;
    - take that little extra time to clear your work area of any potential slip hazards.
    - Keep warm to minimise risks of pulled muscles

Workforce Safety

Key

Slips, Trips & Falls

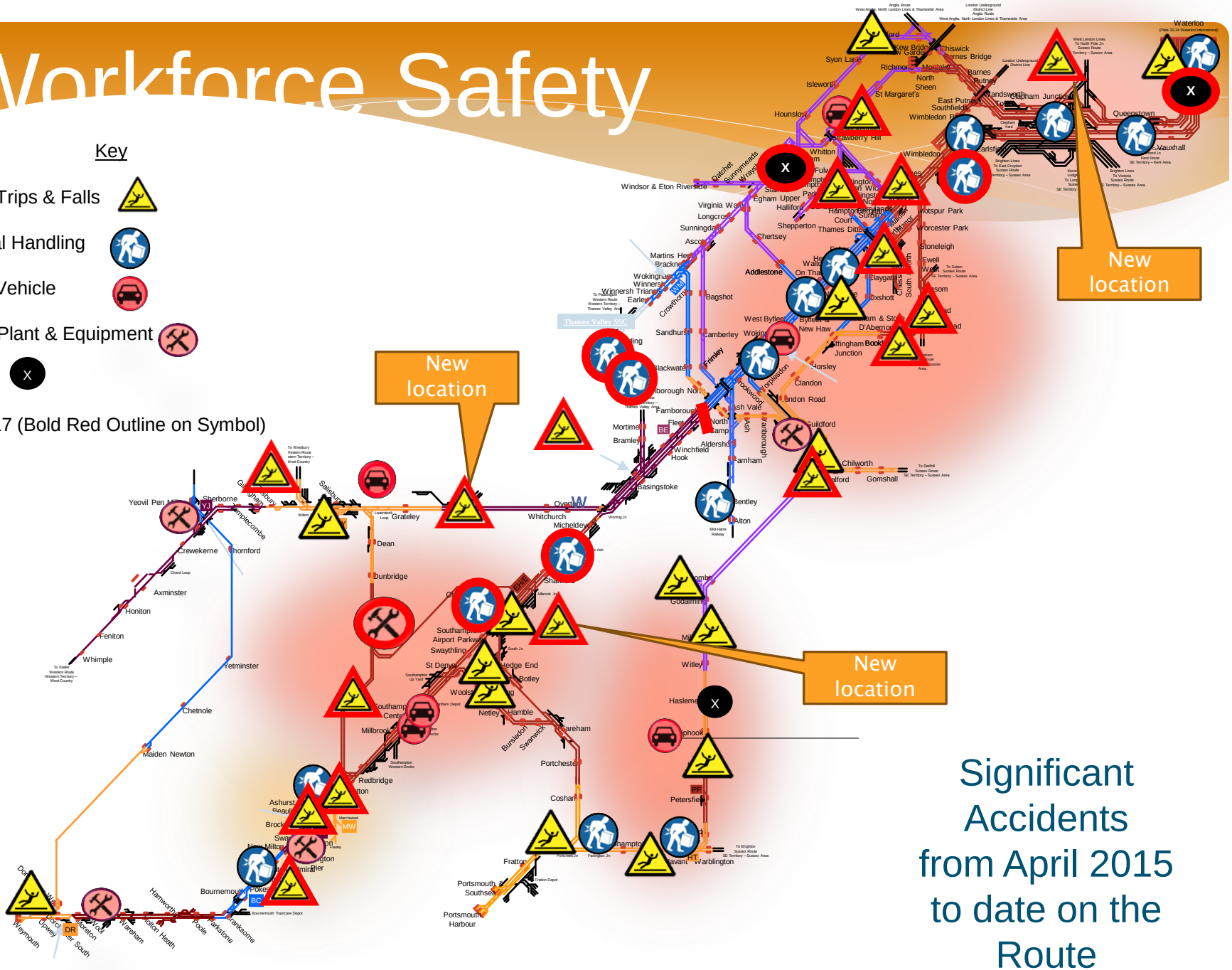
Manual Handling

Road Vehicle

Small Plant & Equipment

Other

2016/17 (Bold Red Outline on Symbol)



Significant Accidents from April 2015 to date on the Route

Workforce Safety

Let there be light!

Guidance on lighting levels

REQUIRED BY LAW

Good lighting whether natural or artificial, is essential to the health, safety and general comfort of our staff at all places of work.

The quicker and easier it is to see a hazard the higher the likelihood of avoiding it.

The types of dangers present at work therefore determines the lighting requirements for safe operation.

Providing the correct level of lighting is particularly important when working at night. Consider the diversity of the tasks that our staff perform in the hours of darkness.

Poor lighting can represent significant risks to our business – not only in the form of time off work as a result of accident and injury, but through reduced staff efficiency and productivity.

See attached Safety 365 leaflet for more details

Task lighting requirements

GENERAL GUIDANCE

…able below gives some guidance on the minimum level of lighting required, and how this can be achieved using the units we have available. This is by no means definitive, and the person responsible for organising any work must include as part of their risk assessment/method statement consideration for the requirement for temporary lighting to carry out the task safely and efficiently.

TYPE OF WORK	TYPES OF LIGHTING
Pedestrian access to/ from work site, access along or between sites	• Hand/head lamps • Fluorescent link lights
Site access points, loading/ distribution areas, and tracking machines on/off site	• Metal halide lighting towers • Single link tower • Trolley mountable Twin head halogen
Localised work using small plant e.g. single sleeper replacement, rail head repair weld	• Trolley mounted twin head halogen • Tripod type twin head halogen • Twin head halogen supported by ballast basket
Large worksite multiple task linkable lighting towers	• Fluorescent link lights • Metal halide lighting towers
S&T work location cabinets etc perception to detail required	• General background lighting • Supported by secondary lighting e.g. K9 Superlite, various portable lamps

Workforce Safety

Lone Working – read the attached documents.

Task Risk Control Sheet

Network Rail

Lone Working	RCS No: NR/L3/MTC/RCS0216/GA05 Issue: 3

Key Risks	Controls	Implemented By
Pre-Requisite for Lone Working	Prior to undertaking Lone Working the following shall be considered: • 'Lone working' is permitted where tasks can be carried out safely by one person, consistent with Rule Book and Network Rail standards requirements. Such tasks must be determined in line with the requirements below: a) nature, duration and complexity of work b) skills and competencies required to undertake task c) arrangements to protect employees from rail traffic d) method of working and associated risks e) environment in which task is to be undertaken and associated hazards • Where work is of an unplanned or reactive nature the team size for the task may need to be adjusted up to cater for factors that may not be apparent until a site specific risk assessment is made of the work to be undertaken. • For any task, planned, unplanned or reactive, where there is insufficient resource to carry out the task safely in accordance with established safe system of working and or the required technical standards, the work shall not be undertaken. • Only competent staff shall be permitted to undertake lone working For reactive work due cognisance needs to be given to the certainty or level of detail that can be ascertained for reactive work to be confident that the work could be undertaken safely and practicably by a lone worker.	Line Managers / All Staff

Handbook 6

General duties of an individual working alone (IWA)

2 Work you can do without the line being blocked

2.1 Working more than 2 metres (6 feet 6 inches) from an open line

If the work will not affect the safety of the line and you will not come within 2 metres (6 feet 6 inches) of the nearest running rail of an open line, you may carry out the work without blocking that line.

2.2 Patrolling, examining or inspecting

You can patrol, examine or inspect an open line if you are sure you will be able to look up often enough (at least every 5 seconds) to see any train approaching and:

- you will be able to reach a position of safety at least 10 seconds before any approaching train arrives, and
- you can reach that position of safety without crossing any open line other than the one you are on.

You must not rely on these arrangements during darkness, poor visibility or when in a tunnel.

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 148 **close calls** have been reported on the Route, 83 have already been closed, 65 of those reported in the period 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:

- **Icy steps and walkways**
- **Site management and tripping hazards**
- **Insufficient site lighting**
- **Permit to work systems**

Close Calls

Adopt a Close Call Principle

- *In order to support in closing down some of our most difficult and high risk Close Calls the Route Executive Team have decided to 'Adopt a Close Call'.*

- *Each Executive member will be:*
  - *Issued a Close Call from the system to adopt and support the responsible manager to close*
  - *The close calls issued are over 60 days old & ranked medium or high risk.*
  - *They will provide up-dates directly to the safety team each week*
  - *When closed they will then be issued with another*

- *Can you help with this new principle and support closure of our close calls? Could you adopt a Close Call?*

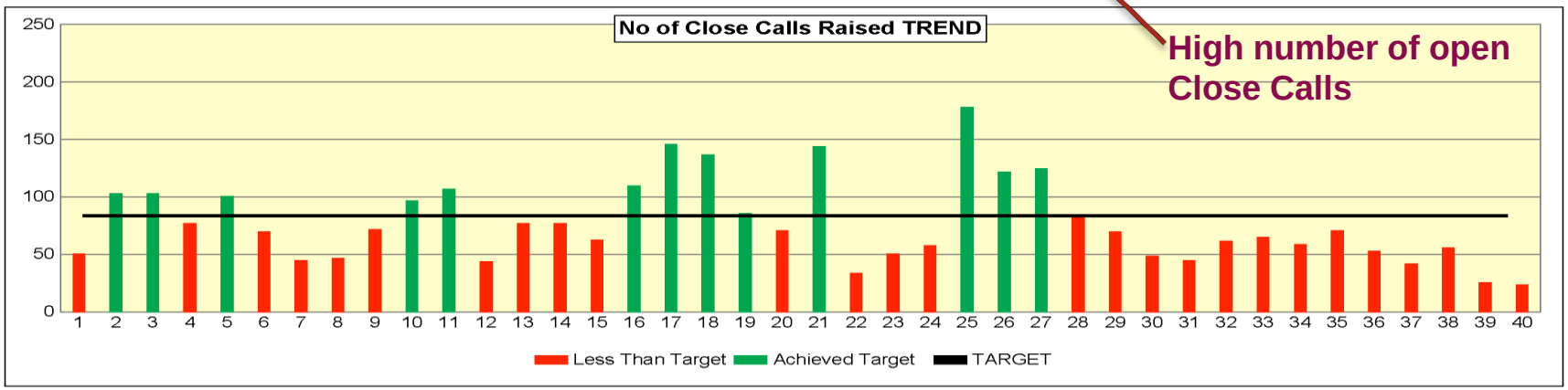
Close Calls

State of the nation Periods 1-10

Low number of Close Calls Raised

Wessex Department	No of Close Calls Raised for action			KPI - % Of Close Calls Closed in <90 days			All CC's	CC's Raised Since 1st April 2016		Not yet reached >28 days
	Last 7 Days	Last 28 Days	YTD	YTD Closed	YTD Closed <90 Days	%	CC Open >28 Days	CC Open >60 Days	CC Open >90 Days	CC OPEN
Alliance	4	8	130	127	92	0%	2	2	2	1
SWT	0	0	4	3	1	33%	3	1	1	0
Inner DU	4	45	937	632	498	70%	317	215	165	36
Outer DU	15	76	1572	1373	1075	87%	190	120	82	31
Infrastructure Mgmt	0	7	113	99	78	90%	10	7	5	4
Works Delivery	0	1	46	31	24	62%	27	13	10	1
Engineering (B&C)	0	3	82	57	41	64%	23	17	12	3
Engineering	0	1	51	15	7	17%	72	28	27	1
Operations	1	6	120	83	55	71%	36	23	15	5
Planning Team	0	0	7	7	6	86%	0	0	0	0
Safety Team	0	1	28	26	20	87%	1	0	0	1
Wessex	24	148	3090	2453	1897	79%	681	426	319	83
TARGETS	**85**	**340**	**3400**		**80%**		**286**	**0**	**0**	**-**

High number of open Close Calls



Health and Wellbeing

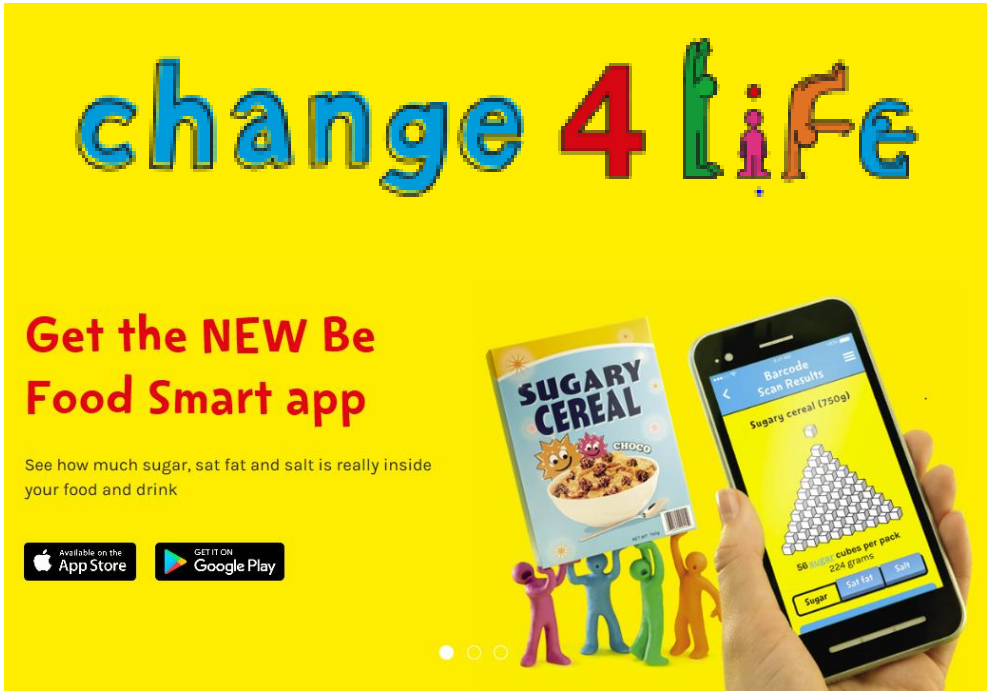
Be fitter, stronger and live longer.

Drink more water
Eat more fruit and veg
Drink less alcohol
Walk to work everyday
Cook from scratch
Join a gym

Do something good for january
9th - 15th 2017
www.jan-u-ary.co.uk

Health and Wellbeing

Get the App



- Making healthier food choices.
- Scan barcodes using the app to find out how much sugar, saturated fat and salt is in food and drink.
- If you don't have the bar code, you can use the handy chart below.

	Low	High
Sugar	<5g in 100g	>22.5g in 100g
Total Fat	<3g in 100g	>17.5g in 100g
Saturated Fat	<1.5g in 100g	>5g in 100g
Salt	0.3g of salt in 100g	>1.5g of salt in 100g

Workforce Safety

Safety Bulletin

Safety Bulletin

A serious incident has taken place

everyone home safe every day

Plant and equipment stored in tunnels

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

Ref: NRB 16/22

Date of issue: 14/12/2016

Location: Balcombe tunnel, SE Route and Stowe Hill tunnel, LNW Route

Contact: Allan Spence, Head of Corporate Passenger & Public Safety

Overview

On Thursday 1 December temporary lighting that was left lineside in Balcombe tunnel after track renewals four weeks earlier was caught by a train, damaging a track circuit cable and causing significant performance impact. The lighting was moved by vibration or turbulence from passing trains. Investigation found the equipment left in the tunnel included a full petrol can.

On Thursday 8 December one of four portable permanent way trolleys that were temporarily stacked in Stowe Hill tunnel after work the previous night was moved by vibration or turbulence and one was struck by a train. The train had a broken window and bodyside damage.

In each case, the contractors involved had not properly secured the equipment left in the tunnel and had not adequately considered and mitigated the risk of damage, fire or derailment.

In 2007 a London Underground train was derailed at Mile End after passing trains moved materials temporarily stored in a tunnel cross-passage.

The Infrastructure Plant Manual (NR/PLANT/0200/module P505) requires that all small items of plant or accessories are left securely after work.

Discussion Points

While the investigations are underway please discuss the following with your team:

- What risks are created by leaving equipment in tunnels?
- Would you recognise the additional risks in tunnels from wind effects?
- How should work teams plan plant and equipment storage after a worksite in a tunnel?
- What items would you regard as unacceptable to leave unsecured in a tunnel after a worksite is handed back?
- What controls and checks should be used to ensure worksites are left tidy and safe?

Copies of Safety Bulletins are available on Safety Central

Part of our group of Safety Bulletins

Safety Alert | Safety Bulletin | Safety Advice | Shared Learning

Driving Safety

Safety Bulletin

Shared Learning

Key learning following a serious incident

everyone home safe every day

Serious road accident on M5

Issued to: **All Network Rail line managers, safety professionals and Principal Contractors**

Ref: NRL 17/01

Date of issue: 04/01/2017

Location: M5, Clevedon

Contact: Gary Crosbie, Plymouth DU Workforce HSE Advisor

Overview

At 04:47 on 29 July 2016 a Ford 9-seater minibus left the north bound carriageway of the M5 between Junctions 20 and 19 near Bristol and came to rest on the motorway verge.

The vehicle was being driven by a sub-contractor working for Network Rail and had three occupants; all were labour-only sub-contract operatives.

All three operatives were taken to hospital. Fortunately, there was no serious injury to any of them and they were all released from hospital later that day.

The team were working for Plymouth Delivery Unit (Works Delivery) and were travelling back to South Wales after a shift near Liskeard, Cornwall. The vehicle belonged to the contractor.

An investigation has concluded that the immediate cause of the accident was that the driver fell asleep while driving.

Underlying causes

The driver was fatigued from travelling between the work site and the team's home area near Cardiff, leading to him falling asleep whilst driving.

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.

Key message

- All staff should have a minimum of 12 hours rest between shifts. Travelling to work sites counts as work time.
- Travelling time from base to worksite must be considered before allocating work. What can be done to ensure staff have sufficient rest between shifts?
- Door to door time must not be planned to exceed 14 hours. This needs to include picking up and dropping off team members.
- Planning must take account of fatigue management policies for every shift.
- Planning should identify and confirm designated driver(s) and, where necessary, hotel accommodation.
- Route and contractor assurance should test compliance with fatigue management policies and the Code of Conduct.

Copies of Shared Learning documents are available on Safety Central

Operational Safety

Safety Bulletin

OPERATIONS MANUAL

Form: 5-18A **Issue:** 1
Page: 1 of 1 **Date:** 03 March 2012
TEMPLATE FOR BRIEFING OF SERIOUS OPERATIONAL INCIDENTS

Immediately Transferable Lessons from level crossing incidents

Information for Signallers and Front Line Operational Staff

On Thursday 5th January, at approximately 12:25, the Signaller operating panel 4 at Feltham ASC initiated the lowering sequence at Chertsey CCTV level crossing for the passage of 2S25 which was approaching the crossing on Down line. The Signaller observed a member of the public (MOP) enter the crossing and stopped the lowering sequence, the MOP however did not exit the crossing and stood next to the down side facing boom pedestal. The Signaller attempted to raise the barriers but was unable to do so as he had already called a route from F301 signal which protects the level crossing on the Down line. It was not immediately clear to the signaller why the barriers would not raise, and whilst trying to raise the barriers he inadvertently operated the crossing clear button. F301 then cleared to a proceed aspect with the MOP inside the crossing, immediately after the crossing clear button was operated, the MOP then exited the crossing.

Reason Incident Occurred:

- The member of the public entered the crossing during the lowering sequence and failed to exit the crossing when the sequence was stopped.
- A route was set across the level crossing from F301 signal, the Signaller did not immediately recognise that this would prevent the barriers from raising when in manual.
- The Signaller inadvertently operated the crossing clear button with a member of the public within the limits of the crossing.

Points to Consider:

- Do you know that a route being set over a level crossing will then prevent the barriers from being raised manually?
- Are you aware that the protecting signal/s should only be cleared after you are sure the crossing is clear and the crossing clear button has been operated? *(National Operating Instructions, Unit 29, Section 6.2)*

Date Produced:	**06/01/17**	**Date Posted:**	**06/01/17**
		Post For:	*12 Weeks*

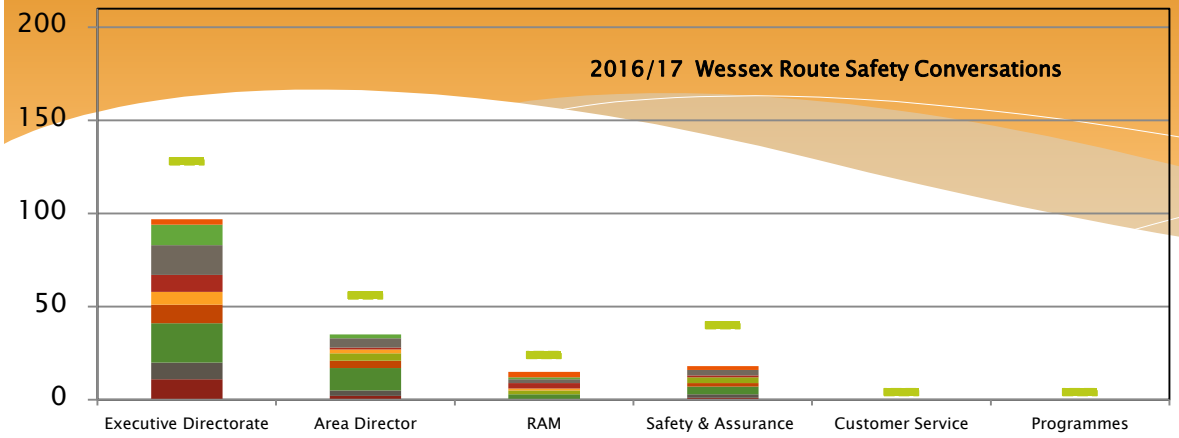
Published Investigations
During Period 10: 2016/17

Area	Date of incident	Level	Description	Lead Investigator	DCP	Published	Actions	Recs
Ops Inner	15/04/16	3	London Waterloo CAT A SPAD W4 by 2L26 (33 weeks)	Michael Barnes	Giles Baxter	07/12/16	4x Closed 1x Open	None
IM Inner	14/06/15	2	Wimbledon – Near miss with PWAY staff (77 weeks)	Steven Edwards	Andrew Malcolm	12/12/16	2x Closed 0x Open	None
IM Inner	07/02/15	2	Barnes - Possession irregularity. Protection placed on wrong lines still open (97 weeks)	Steven Edwards	Andrew Malcolm	21/12/16	5x Closed. 0x Open	None

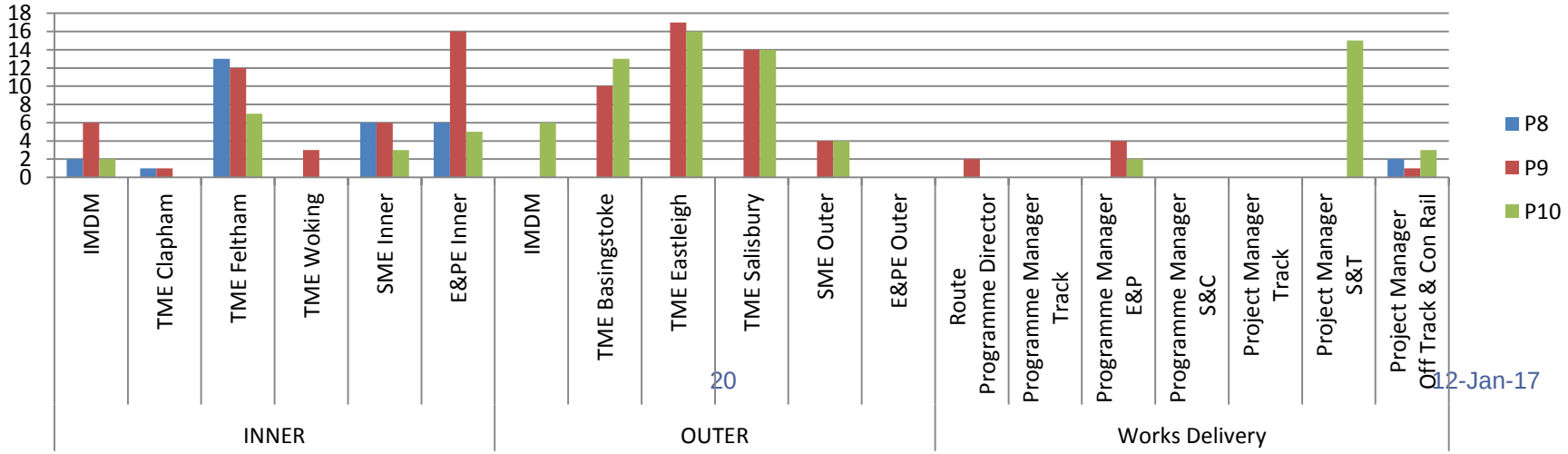
Fair Culture Panel Review
23rd December 2016

Event	Immediate Cause	Underlying Cause	L/Investigator outcome	FCP outcome	FCP comment
P10 1617 061216 Woking Seat Belt LSR	A member of staff was not wearing a seatbelt whilst carrying out a reversing manoeuvre within compound and station car park	The member of staff believed that the wearing of a seatbelt was not required, as per the highway code exceptions. The member of staff was not adhering to the Network Rails Driver's handbook rules for the wearing of seatbelts.	Routine Error – Different People	Routine Error – Different People	The Panel agreed that a LSR had been breached however; it had become confused with the High Way Code guidance and may not have been adequately briefed. The Panel agreed the same outcome as the Lead Investigator.

Safety Conversations and PGSIs



Number of Planned SSOWPS and On site Safety Inspections: 2016 - 17.



Don't forget the…

Welcome Back Brief

- Back to Work – Start Safe

The South Western Railway

Appreciation Section

A big thank you to:-

Mike Smith (WDM Signalling) for his outstanding management of and concern for his member of staff who suffered a broken arm this period.

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:*