

Wessex Route



TAKE 5 FOR SAFETY
Before, during and after a task

Welcome

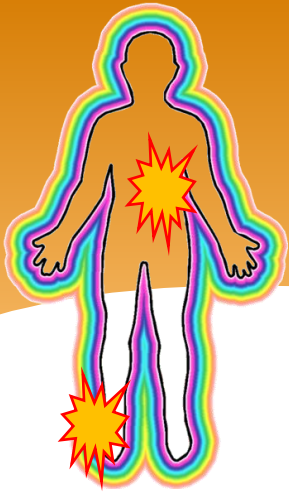


Welcome to your Health, Safety and Environment Cascade for Period 12 2016/17. This contains all the documents and safety briefs for you and your teams this period. Flick through this document and share as a team, print off the pages that you want to discuss and pin them up in mess rooms for staff to look at throughout the month.

In this cascade;

- * Workforce Safety
- * Our Safety Workshops
- * Close Call
- * Safety Hour
- * Health and wellbeing
- * Leptospirosis
- * Take 5
- * Safety and Operational Bulletins
- * Investigations & Fair Culture Panel
- * Safety Conversations & PGSIs
- * Special thanks to....





Workforce Safety

2 Lost Time injuries

INNER DU

The IP was in the depot manually handling a rail stressing power pack on to a pallet with others.

He was bent over lifting the equipment about 4 inches off the ground and suffered a shooting pain in his back, pulling a muscle.

Manual Handling:

Always follow the training: risk assess the load, sufficient people.

Work Delivery

A length of running rail was supported on rail jacks whilst changing wheel timbers. Once the timbers had been changed, a process was initiated whereby all jacks would be dropped in unison following clear commands, and after checking all personnel were clear. This happened as planned, unfortunately the IP had left the tip of a heel bar in the drop zone, once the rail was dropped it struck the bar, forced the bar out of his hand, the bar landed on his left foot behind the toe cap causing bruising his toes.

See next slide



Workforce Safety

Track Jacks

Task Risk Control Sheet



Use of jacks

RCS No: NR/L3/MTC/RCS0216/SP11
Issue: 2

Key Risks !

- Trapped Limbs
- Derailment
- Manual Handling

Personnel Involved

E&P	
S&T	
Track	✓
Off Track	
Property	

Tools / Equipment Pan Jack, Trip Jack, Slewing Jack, Toe Jack

Plant None

Key Risks	Controls	Implemented By
All Tasks	<ul style="list-style-type: none"> Planned preventative maintenance programme shall be implemented Pre use checks shall be undertaken including check of inspection date Always use correct Jack for task and safe system of work 	Line Manager All Staff
Trapped Limbs	<ul style="list-style-type: none"> Use correct Jack for task and safe system of work Do not overload the rating of the jack The jack shall have a level and stable base to stand on When using trip jacks check that all personnel are clear before tripping When using jacks check that all personnel are clear whilst lifting operation is underway Check clothing / limbs / other staff are clear when raising/lowering Use the correct handle and check that it is correctly seated in the socket 	Team Leader All Staff
Equipment Damage	<ul style="list-style-type: none"> Do not use inappropriate means to position jack 	All Staff
Derailment	<ul style="list-style-type: none"> If train passages are required, obstructionless jacks shall be used 	Team Leader
Manual Handling	<ul style="list-style-type: none"> Always lift jacks with the appropriate handle 	All Staff
Electrocution	<ul style="list-style-type: none"> See Risk Control sheets NR/L3/MTC/RCS0216/GA20 Working Adjacent to DC Electrified Rails Risk Level 	Team Leader / COSS
Slips, Trips & Falls	<ul style="list-style-type: none"> Remove handle when not in use Use the correct handle and it is correctly seated in the socket Do not stand on item being jacked When using check a firm footing is available Adopt the correct stance and position relative to operation to prevent falls if tension is released As far as is practicable remove all tripping hazards from around the work activity 	All Staff

Lessons Learnt






When lowering rails on jacks:

1. A clear line of communication must be established under one nominated person.
2. Prior to the drop, the nominated person gives clear instructions to 'clear',
3. All others remove tools and body parts in vicinity of drop zone and confirm back that tools and body parts are 'clear'
4. The Instruction is given to lower rail.

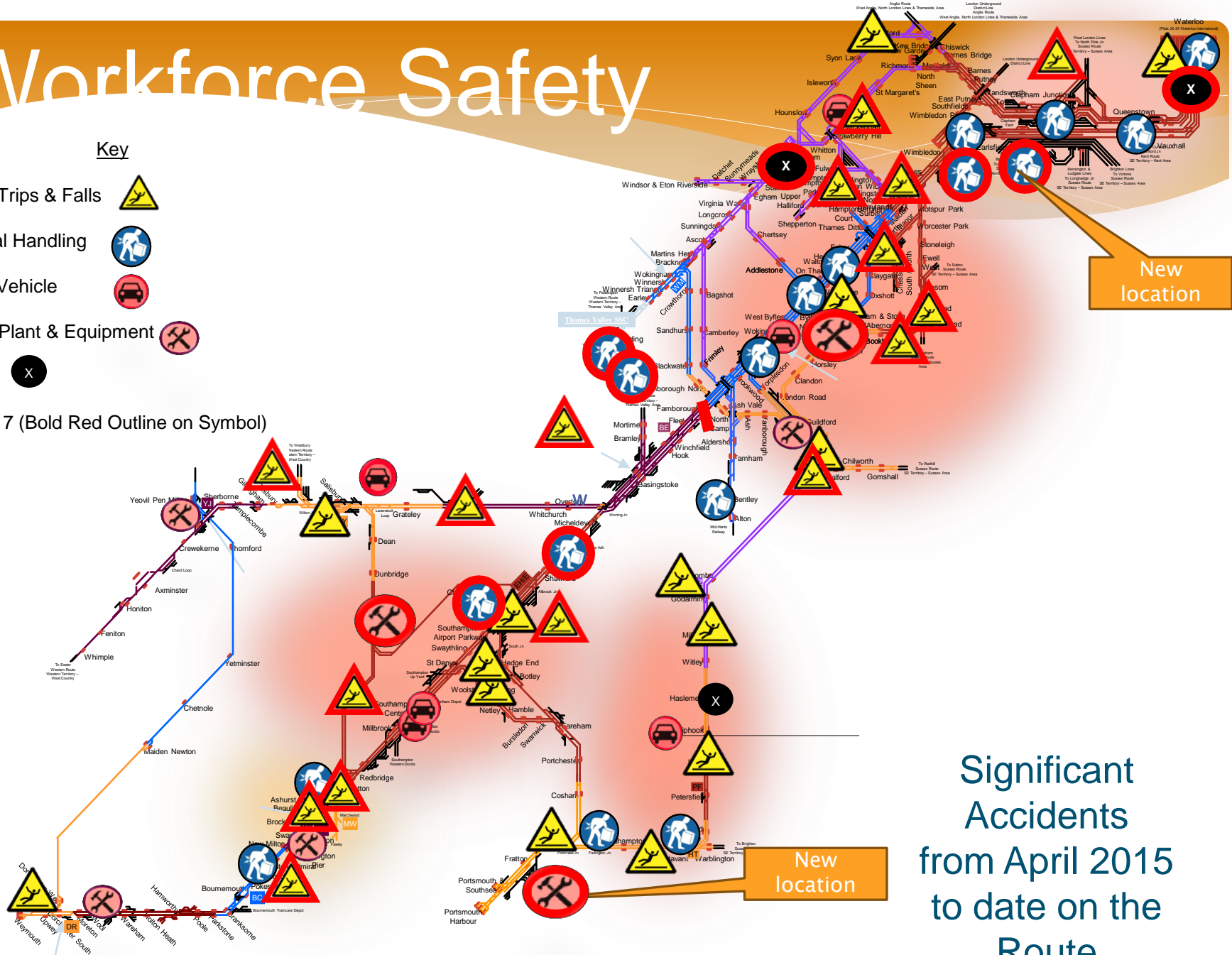
No parts of the body should ever be present under suspended loads.

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

3 No Lost Time Injuries



INNER

1. Waterloo/Westminster Bridge. IP tripped and fell over a cable, hitting knee and twisting ankle in process. He also sustained small cuts and bruises to his face as he struck the ground and safety glasses hit his nose.

Slip Trip Fall: site house keeping and hazard identification.

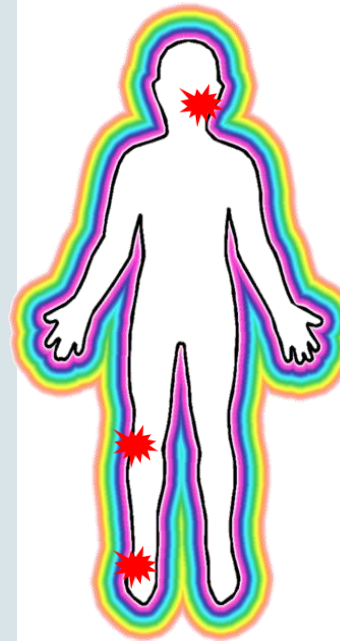
2. SWT Train; an off duty member of staff was assaulted when he intervened passengers using offensive behaviour. Suffered slight bruising to the side of his temple and lip.

Assault.

OUTER

1. Aldershot station area. IP was walking off platform ramp end going towards an access gate, whilst walking on the ballast some of the ballast gave way and IP twisted her ankle, she remained on her feet and did not fall over.

Slip Trip on ballast.





Workforce Safety

3 No Lost Time Injuries

WORKS DELIVERY

1. At Millbrook: IP sustained bruising to his right hand when a rail jack was dropped without formal warning, his hand became trapped adjacent to a Baseplate.

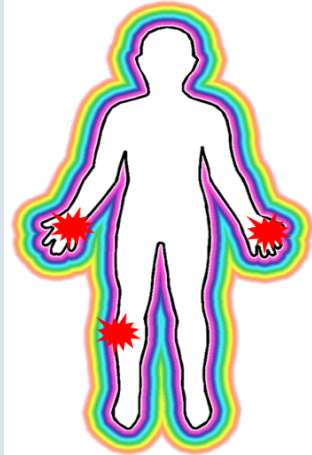
Contact/use of tools and equipment

2. At Brookwood: IP was tightening a bolt with a hand ratchet adjacent to a set of points, whilst doing this he momentarily lost purchase between the ratchet on the bolt. His right hand slipped sustaining a deep cut when it came into contact with the top of the points. Injury required butterfly stitches and glue to seal the wound.

Use of tools and equipment

3. Near River Avon: IP was walking off track when he tripped over a fishplate spanner left in the 4 foot. He fell over striking the ballast with his knee and the rail with his body, sustained a cut to his knee which was subsequently glued.

Slip Trip Fall/Housekeeping.





Our Safety Workshops

Get booked in now!

The South Western Railway

OUR SAFETY WORKSHOPS

SPRING
2017



Everyone home safe, every day

"Taking the lead"

This round of workshops will focus on taking responsibility and being a safety leader. The sessions will be interactive and will focus on improving our safety in the following areas:

Leadership

The revised Q19 standard and the effect it will have on us as a route.

Reporting

How we report and what we can report to avoid injuries to ourselves and others.

Innovations

Looking at the future of our railway and technologies to improve safety.

These workshops are a great way for everyone to have their say as well as to listen and learn about what we do and what we need to do to improve safety on our Route.

Everybody needs to attend these events where possible. Please encourage your teams and workmates to do the same.

*This is a great opportunity for all of us to help make sure that we get
Everyone Home Safe Every Day.*

FOR GENERAL ENQUIRIES ABOUT OUR SAFETY WORKSHOPS PLEASE
CONTACT [CAMILLA CURTIS \(07739 778 589\)](mailto:camilla.curtis@swr.co.uk)

Where and When?

15 March 2017 - Guildford

The Mandolay Hotel, 36-40 London Road, Guildford GU1 2AE

21 March 2017 - Bournemouth

Hallmark Hotel Bournemouth West
Cliff, 7 Durley Chine Road,
Bournemouth, BH2 5JS

28 March 2017 - Southampton

Novotel, 1 West Quay Road,
Southampton SO15 1RA

6 April 2017 - Woking

HG Wells, Church Street East,
Woking GU21 6HU

Workshop times are 0930 - 1400
and 2130 - 0200 at all locations

THERE WILL BE A MAXIMUM OF

200 ATTENDEES

AT EACH SESSION

**TO BOOK ON PLEASE CONTACT YOUR REP. YOU WILL NEED YOUR
BUSINESS FUNCTION AND COST CENTRE NUMBER TO BOOK ON. For all
infrastructure teams including MAINTENANCE, ASSET
MANAGEMENT, WORKS DELIVERY & IP:**

Inner - [Cecile Blackman](mailto:cecile.blackman@swr.co.uk) (02033 007431) / [Pauline Thomas](mailto:pauline.thomas@swr.co.uk) (02033 007438)

Outer - [Debbie Cataffo](mailto:debbie.cataffo@swr.co.uk) (03308 547225)

For all other teams including OPERATIONS, PLANNING, FINANCE,

PERFORMANCE & SAFETY:

[Mike da Silva](mailto:mike.da.silva@swr.co.uk) (07711 600 878)





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 545 close calls have been reported on the Route, have 430 already been closed, 115 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:

Scrap rail: removed

Tools discarded in a worksite.

RRV exceeding worksite speed

Rotten timbers on a bridge
structure walkway

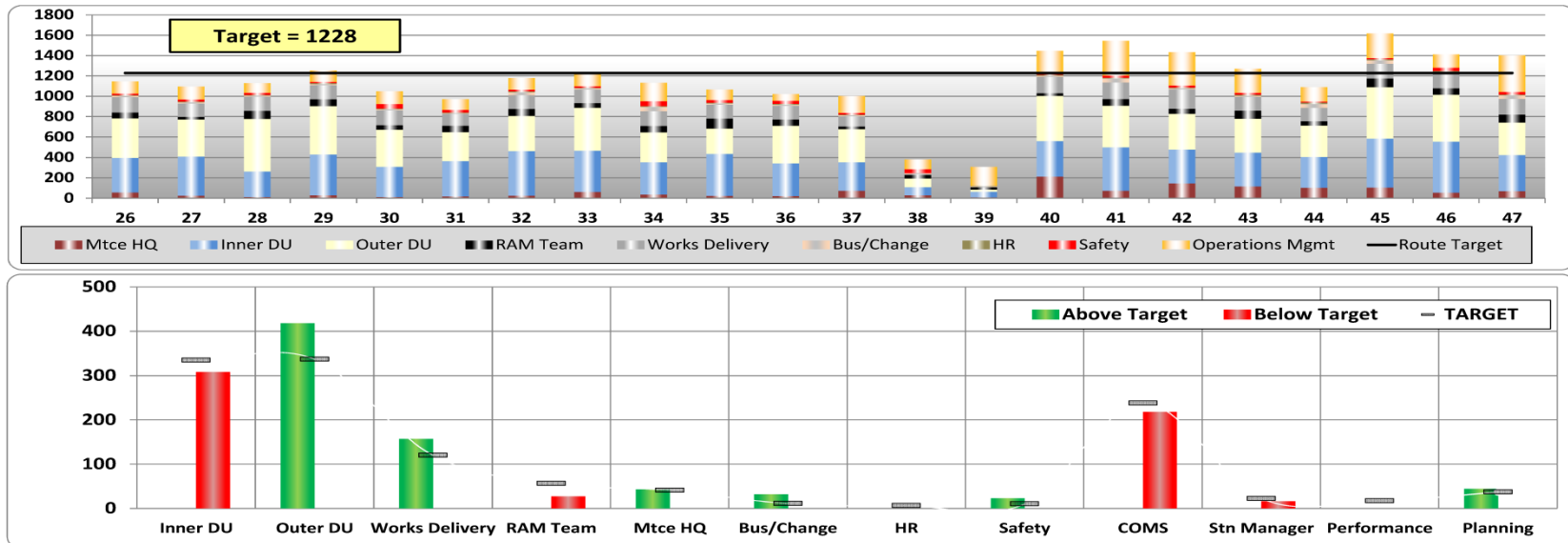


Safety Hour

Have you had one recently?

Safety Hour Attendance per Week

WESSEX = 70%



Week 48

	Inner DU	Outer DU	Works Delivery	RAM Teams	Mtce HQ	Business Change	HR	Safety	COMS	Stn Manager	Performance	Planning
Actual	308	418	157	27	43	32		23	218	16		44
Target	334	336	120	56	41	11	6	10	238	22	17	37
Short Fall	26			29			6		20	6	17	
%	62%	83%	88%	32%	70%	100%		100%	61%	48%		80%

Medical Standards

<https://safety.networkrail.co.uk/healthandwellbeing/network-rail-employee-area/medical-standards/>
Password: wellbeing

Health and Wellbeing

Medical Standard Update NR/L2/OHS/00124

Key changes:

1. Amendment of wording regarding general health issues; introduction of DVLA guidance for the management of general health issues. (refer to section 6.2 of standard)
2. Inclusion of speech impediments as part of general health review. (refer to section 6.4 of standard)
3. A review of the assessment of field of vision to be included. (refer to section 6.5 of standard)
4. The inclusion of advice on laser eye surgery. (refer to section 6.5 of standard)
5. The periodicity of medicals will be amended. (refer to section 8 of standard)
6. The OH Provider should provide individuals with additional H&W information at medical assessments. (refer to section 6.2 of standard)
7. The inclusion of the “supplier requirements standard” within this standard.



Health and Wellbeing

Respiratory Masks & E-Learning

- If your work activities require you to be in an area where dust and/or fumes are present,
- Or the Risk Control Sheet for the activity you are doing states you must wear RPE, you must wear an FFP3 mask which has been 'face fit tested' to you.
- FFP3: Is the only mask that meets NR standard of Assigned Protection Factor (APF: 20)
- Aura is the more comfortable of the two.
- **Need to be clean shaven for at least 8hrs before wearing mask to guarantee good fit.**

Two disposable masks in PPE Catalogue

3M

3M™ Aura™ 9332+ Flat-Fold Valved Dust/ Mist/Metal Fume Respirator

CONFORMS TO EN 149:2001 FFP3 NR D

- Unique 3-panel design, soft cover web - for comfort and excellent fit
- 3M™ Cool Flow™ valve
- Individually packed, flat fold
- Assigned Protection Factor = 20

Code: 292747

Box of 10



Economy Disposable Valved Respirator FFP3

- Protection against vinyl fire toxic Dusts, Fibre & Aqueous Mists protects against oil mists welding fumes (not nitrate gases) and microbiological hazards for use in Pharmaceutical iron & steel and construction industries
- Exhalation valve lessens heat build up and provides greater comfort
- Assigned Protection Factor = 10

Code: 290035

Box of 5



Respiratory e-Learning on Oracle: FF/OHS/1-3

The e-learning should be completed by ALL employees who are exposed to respiratory hazards as part of their job, or those who wish to become a face fit tester.

Module 1:

Awareness of Respiratory Hazard; for ALL employees identified as working with an exposure to a respiratory hazard;

Module 2:

Face fit requirements and fit check; for ALL employees who are required to wear tight-fitting respiratory protective equipment (RPE) as identified within the work activity risk assessment (WARA);

Modules 1 – 3:

Face fit testing; for employees wishing to become a RPE fit tester.

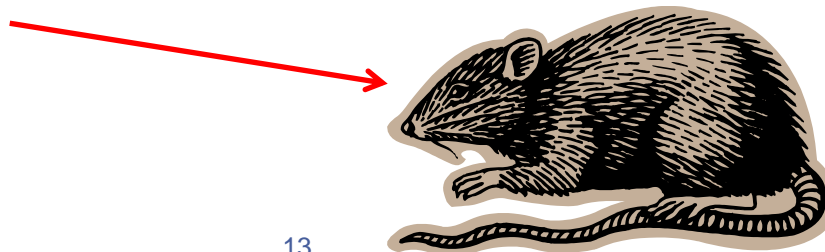




Workforce Safety

Leptospirosis – What is it?

- Weil's disease is a serious and sometimes fatal infection.
- Transmitted to humans through contact with the infected urine of both wild and domestic animals – most commonly though **rat urine**.
- The disease causes fever, headaches and flu-like symptoms. In severe cases, it can cause **jaundice**, **kidney failure** and even **heart failure**.
- A dirty rat...





Workforce Safety

How You Might Catch It...

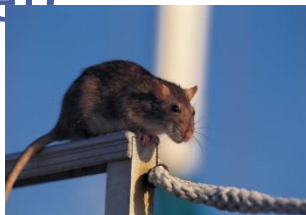
- The bacteria can get into your body;
 - through unprotected cuts and scratches
 - through the lining of your mouth, throat and eyes as a result of contact with infected urine or contaminated water
- Prevalent in sewers, ditches, ponds, cess walkways, tunnels etc

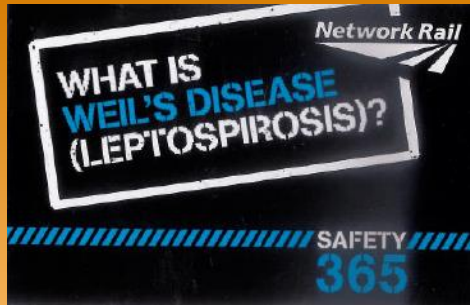
Who might catch it:

- Track/Signal/E&P/Off Track workers
- Drainage workers
- Asset Engineers
- Mobile Operations Managers

Anyone who has a need to go trackside

Anyone in contact with culverts, sewers, drains, ditches, tunnels, ponds, lakes rivers and the cess/vegetation.





Workforce Safety

How To Prevent Infection...

- Cover all broken skin with waterproof sticking plasters before and during work.
- Always wear PPE including Gloves.
- Avoid rubbing your nose, mouth or eyes with your hands during work.
- Wash all skin if it has been in contact with animals or contaminated water (**especially if you are unsure**) as soon as possible.
- **ALWAYS** wash your hands before eating, drinking or even smoking.
- If you go to a Doctor for with flu like symptoms, inform them you work in the rail industry and there is a risk of Leptospirosis. Arrangements can be made for appropriate investigations if necessary.

National Safety Campaign

Take 5



TAKE 5 FOR SAFETY

Before, during and after a task

Before:

- Think through the steps of what you will be doing
- Identify any risks within your work area and make sure they are controlled before starting

During:

- Ask yourself – do I feel safe doing this task?
- Are others around me working safely?

After:

- Observe the work area
- Reflect on the task – can any better every day improvements be made?



Connect/Take5

#Take5

TAKE 5

See Connect for
Posters and Video.

<http://connectdocs/NetworkRail/Documents/communities/Take5/Take5ForSafety.mp4>



Workforce Safety

Safety Bulletin

Safety Bulletin

A serious incident has taken place



Smouldering head torch

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

Ref: NRB 17/03

Date of issue: 23/02/2017

Location: IMDM Motherwell area, Scotland Route

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



Overview

On Monday 16 January 2017 a member of track staff put their Unilite head torch on charge following completion of their nightshift.

Later that afternoon the member of staff discovered the head torch smouldering whilst charging.

The member of staff switched off the power, removed the plug from the wall socket then removed the cable from the USB charging socket on the head torch.

The head torch and charging equipment were returned to the manufacturer for investigation.

This investigation flagged up that the head torch was being charged with a non-standard (not the manufacturer's) micro USB cable.

The cable shorted and started to smoulder but luckily the circuit protection on the head torch avoided the battery from overheating which is why only the outer casing showed signs of burning.

Safety Bulletin

A serious incident has taken place



Trespass causes severe electric shock to member of public

Issued to: All Network Rail line managers and Achilles registered contractors

Ref: NRB 17/04

Date of issue: 02/03/2017

Location: Whitelees Road, Lanark

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



Overview

On 8 December 2016 a member of the public came into contact with the live overhead line equipment after climbing over the parapet of overbridge 033/006 at Whitelees Road in Lanark.

It is apparent that the male came into contact with the OHLE after slipping from the ledge on the outside of the parapet girder, subsequently causing his leg to make contact.

This resulted in serious injury caused by the severe electric shock.

The circumstances as to why the young male was walking along the outside ledge of the parapet are unknown, however there is evidence of historic vandalism to the structure including graffiti on the external face of the parapet.

Additionally, there was an apparent suicide attempt at this structure in 2012. This was unknown to the structures team

Discussion Points

Please discuss the following with your team:

- If you find evidence of trespass and vandalism within the railway boundary how should you report this?
- What would you do if you saw a trespasser on the railway, or anti-social behaviour, near the boundary?
- When risk assessing lineside security, or when we receive reports of trespass, what do we do to understand the risks at the location?
- How could you help communicate the dangers of the railway to local communities?
- How can you propose improvements to prevent access at a structure?
- How do we consider potential weaknesses in security at bridges?
- What immediate action do you think could be taken to reduce the chances of access over the parapet and furthermore what long term mitigation should be considered (curved/sloped surfaces, spikes, etc)?

Discussion Points

Please discuss the following with your team:

- How do you check that you are using the manufacturer's equipment to charge your devices?
- What would you do if you did not have the correct equipment to charge your devices?
- How do you check your cables for defects prior to use?

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

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TAKE 5 FOR SAFETY

Before, during and after a task

OPERATIONS MANUAL

Form: 5-18A

Issue: 1

Page: 1 of 1

Date: 03 March 2012

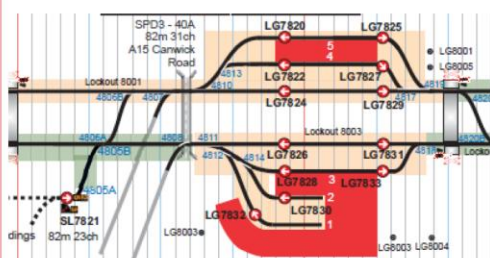
TEMPLATE FOR BRIEFING OF SERIOUS OPERATIONAL INCIDENTS

Immediately Transferable Lessons from Points Run-Through at Lincoln Central Station

Information for Signallers and Front Line Operational Staff

The circumstances surrounding the incident are described below. Please ensure that you ask your Manager for more information or advice if you consider it necessary.

Incident Date: 19/02/17



Location;
Lincoln Central Station

ELR & Mileage;
SPD3, 82m 576 yds

Controlling
Signalbox;
Lincoln SCC

Details of the Incident

- On Sunday 19/02/17, 4811 points were run through at Lincoln Central Station.
- A shunt move was required from platform 1 to platform 3.
- Essential engineering work had left some axle counters showing occupied which resulted in having to pass LG7832 signal at danger.
- The signaller utilised the route setting card but failed to get it checked by another signaller present in the signalling centre.
- The signaller had failed to set 4811 point in the required position.

Transferable lessons where appropriate:

- Are your route cards readily available?
- Ensure all points are detected in the correct position.
- Utilise reminder appliances.
- Always get the route verified by a competent person where available.

ALWAYS TAKE YOUR TIME & DOUBLE CHECK

Date Produced: 23/02/17

Date Posted: 23/02/17

Reference Number: AJ01

Post For: 12 Weeks

Operational Incidents

Safety Advice

Action required following a serious incident



Immediate quarantine of Manitou 160 ATJ Plus and 160 ATJ Plus RC based MEWPs

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

Ref: NRA 17/01

Date of issue: 03/03/2017

Location: Cowlares, Scotland

Contact: [Olufemi Okeya](#), Principle Engineer

Overview

At approximately 01:35 on 3 March 2017 a Rail Product ART 17 TH MEWP accessed at Cowlares Road Rail Access Point to carry out Overhead Line Equipment installations as part of the Edinburgh to Glasgow Improvement Programme (EGIP).

While the machine was in travelling mode the boom rotor assembly holding the basket failed resulting in the basket falling backwards onto the track. The basket was about 1 metre above rail head level at the time with one operator and light tools in the basket. The operator was not injured.

All other machines on site were off-tracked and quarantined. A prohibition has since been placed on the use of these machines by the companies involved. All known MEWPs based on the Manitou models (160 ATJ PLUS & 160 ATJ PLUS RC) have been placed on the Do Not Use list until Non-Destructive Test (NDT) inspection has been completed and machines confirmed to be fit for purpose.

Immediate action required

- All MEWPs based on the Manitou models 160 ATJ PLUS and 160 ATJ PLUS RC (both rail mounted and construction variety) are to be quarantined IMMEDIATELY.
- NDT inspection must be conducted and where confirmed as fit for purpose, evidence of inspection and confirmation shall be sent to the contact above before a machine can be removed from the Do Not Use list. This shall include as a minimum:
 - 12 digit number;
 - EAC number and expiry date;
 - Converter name and contact number;
 - Evidence of NDT inspection;
 - Confirmation of fitness for purpose.
- All other known conversions (where not specifically identified above) are to be reported IMMEDIATELY to the contact above so that they may also be placed on the Do Not Use list.
- An investigation is being carried out by the companies involved and further action may be necessary once the outcome of the initial investigation is known.

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



Those specifically identified are:

- Rail Products UK/Manitou ART17T
- Rail Products UK/Manitou ART17T(H)
- Neotec SkyRailer 400RR

While the exact cause of the failure is not yet known, it is believed to be a manufacturing related defect. This defect potentially affects all Manitou 160 ATJ PLUS models and Manitou 160 ATJ PLUS RC models (both rail mounted and construction variety).

The known converters for the Manitou base models (160 ATJ PLUS & 160 ATJ PLUS RC) have been informed and are arranging NDT inspections of their fleets produced for use on rail.



Published Investigations

During Period 12 2016/17

steve.cory@network rail.co.uk

Area	Date of incident	Level	Description	Lead Investigator	DCP	Published	Actions	Recs
Ops Inner	30/09/16	2	Ash Vale Cat A SPAD 2N56 WK408 (18 weeks) SMIS: QSE/2016/SEP/1474	Huw Margetts	Giles Baxter	06/02/17	1x Closed 0x Open	None
Ops Del	28/06/16	3	WON 13 Item 21 Vauxhall near miss with Possession Contract Staff (32 weeks)	Steve Cory	Andrew Patten	10/02/17	8x Closed 4x Open	None



Fair Culture Panel Review

22nd February 2017

Event	Immediate Cause	Underlying Cause	Lead Investigator outcome	FCP outcome	FCP comment
P09 1617 261116 2N33 Signalled into occupied Plat Ports Harbour.	Train signalled into an occupied platform with not enough space to accommodate it.	The Train Running Controller did not contact Havant Panel to inform the train would be an 8 vice 4 carriage.	Slip / Lapse	Slip / Lapse	The Panel agreed with the Lead Investigator.
P09 1617 301116 Eastleigh - MOM travelling 36mph in 30 zone LSR - Level 1.v1	The MOM allowed the vehicle they were driving to increase speed to 36mph in a 30mph zone.	Driver and his trainee were discussing the mornings workload including the meeting with the British Transport Police regarding the Fatality on the 28/11, this distracted the Driver from observing the speedometer during the decent down Twyford Road.	Slip / Lapse	Slip / Lapse	The Panel agreed with the Lead Investigator based upon the Driver having been distracted in conversation.
P09 1617 071216 Egham person trapped within crossing - Level 1.v1	Crossing clear button was operated with a member of the public inside the crossing limits	The member of the public positioned in such a way that he was virtually obscured from the signallers view by fencing within the crossing limits.	Contravention	Slip / Lapse	The Panel disagreed with the Lead Investigator due to the person not being visible and looking like a post.
P10 1617 040117 Waterloo 5 car on top of 8 Platform 13 - Level 1.v1	Signaller signalled train into occupied platform where the train could not be fully accommodated.	<ul style="list-style-type: none">• Mistake caused by belief of signaller he had his finger over button for Platform 11 exit, but had it over button for Platform 13• The Signaller had been routing a parallel movement.	Slip / Lapse	Slip / Lapse	The Panel agreed with the Lead Investigator.



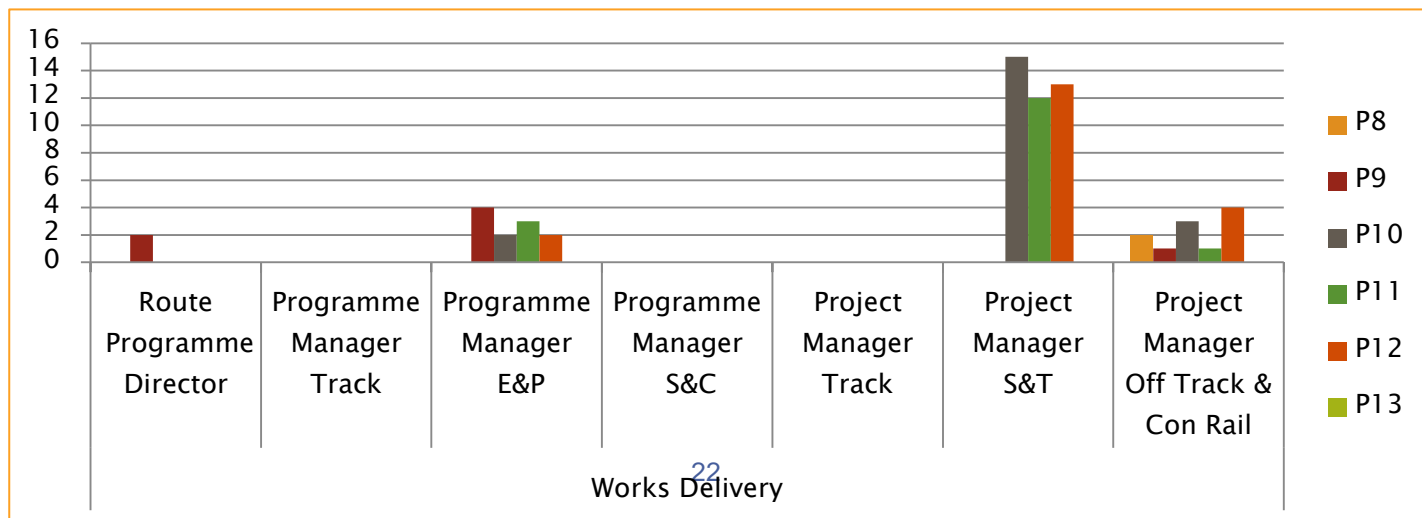
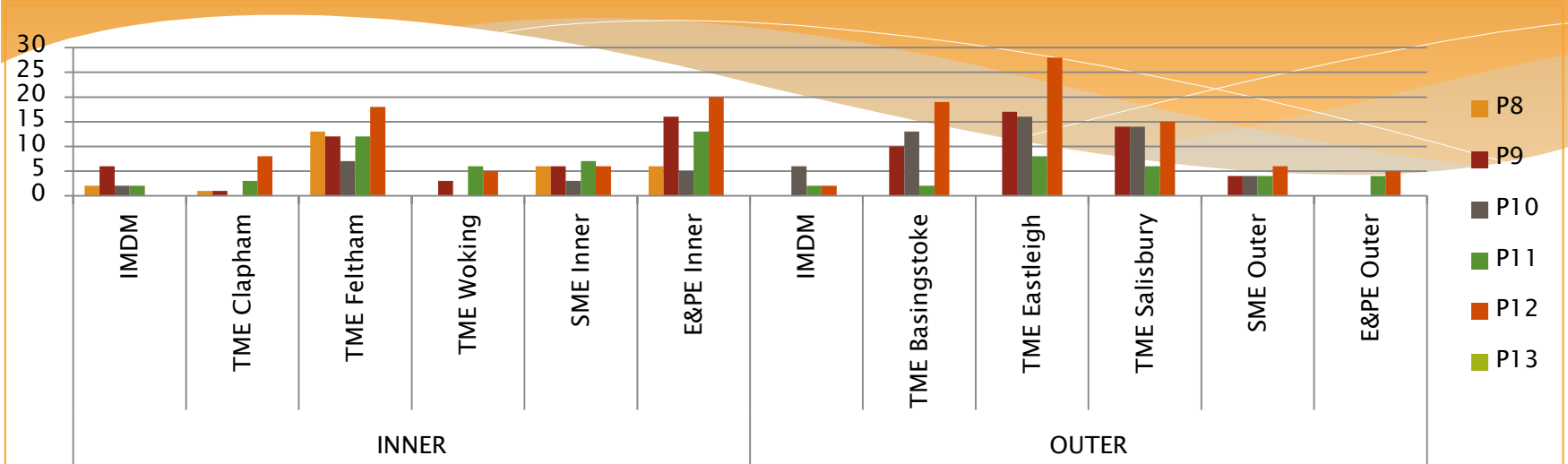
Fair Culture Panel Review

22nd February 2017

Event	Immediate Cause	Underlying Cause	Lead Investigator outcome	FCP outcome	FCP comment
P03 1617 240616 Shawford Ultrasonics Near Miss L2	The Team Leader had moved from the designated place of safety, the Down Cess and walked across three open lines of the operational railway, into the path of a SWT train.	<p>COSS There is no evidence to confirm a formal 'safe system of work' had been set up by the COSS when he and the Team leader, who had been nominated as site lookout for the shift, entered the infrastructure.</p> <hr/> <p>Team Leader The Team Leader (also a COSS) failed to follow the instructions of the COSS to remain in the Down Cess.</p>	<p>COSS Routine Error - Different People</p> <hr/> <p>Team Leader Reckless contravention</p>	<p>COSS Routine Error - Different People</p> <hr/> <p>Team Leader Reckless contravention</p>	<p>COSS The Panel agreed with the Lead Investigator; no <u>intention</u> on the part of the COSS to put safety at risk.</p> <hr/> <p>Team Leader The Panel agreed with the Lead Investigator.</p>



SSOW and Site Inspection PGSIs



Appreciation Section

A big thank you to:-

Des Keegan CRE Raynes Park.

Securing site safety and an isolation with ECR in relation to an incident of distressed drunken person on the infrastructure at Barnes.

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:*