Wessex Route

Health, Safety and Environment Period Cascade for P1. 2017/18

Welcome

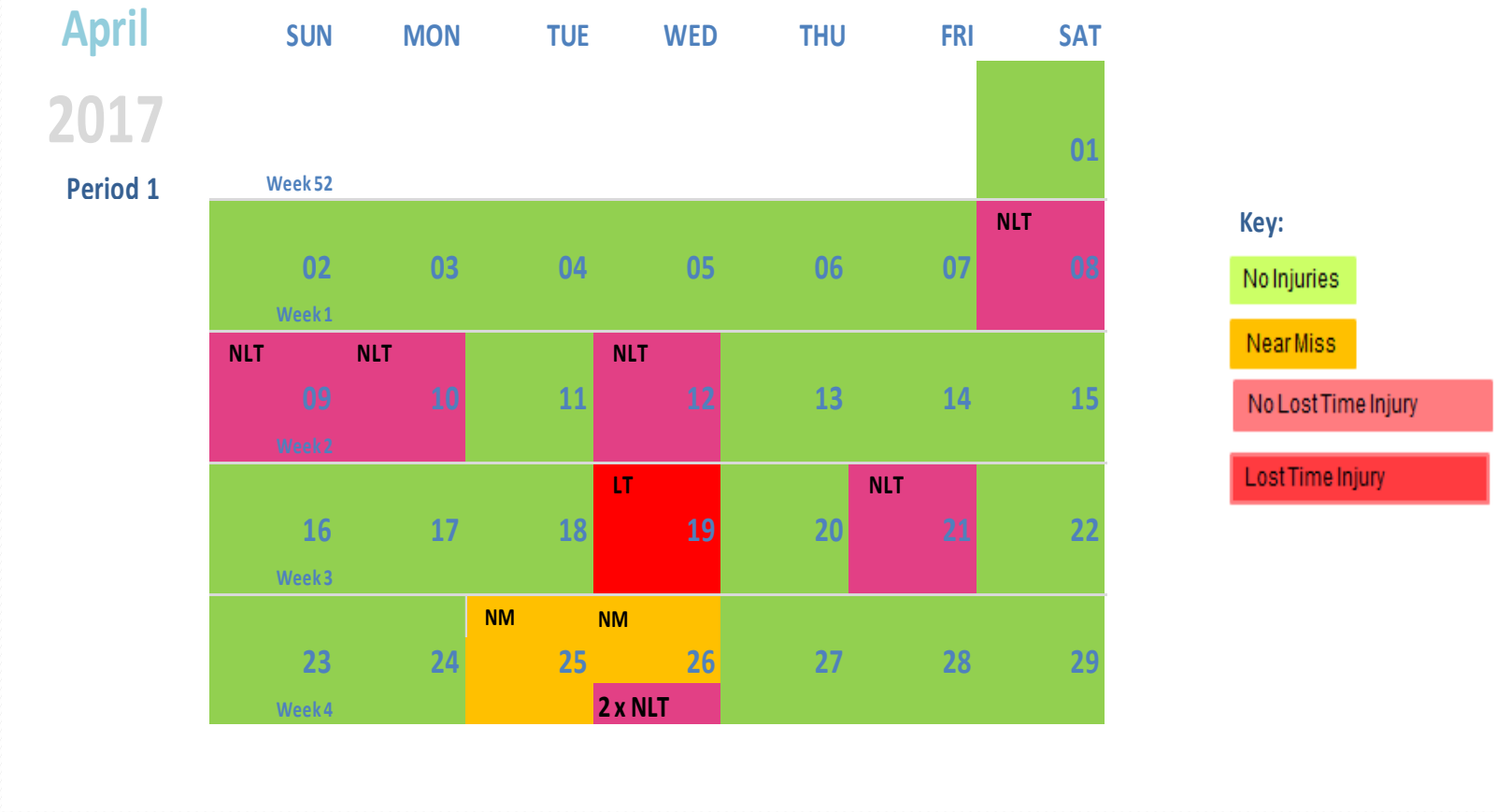
Welcome to your Health, Safety and Environment Cascade for Period 1 2017/18. This contains all the documents and safety briefs for you and your teams this period. Share as a team, print off the pages that you want to discuss and pin them up in mess rooms for staff to look at throughout the month.

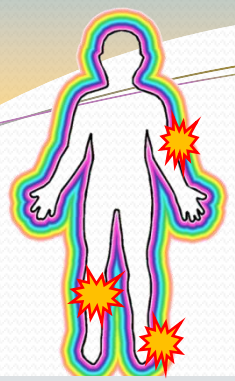
In this cascade;

- Safety Calendar
- Workforce Accidents
- Near Miss Special
- Sentinel Update
- VTR update
- Close Calls
- Safety Hour
- Health and Wellbeing
- Safety Bulletins/LLC
- Investigations & Fair Culture Panel
- SSOWP and On site Inspections
- Environmental
- SSOW and On-site PGSIs
- Special thanks to….

This is the underfoot conditions on a pavement that caused a lost time injury

Wessex Safety Calendar





Workforce Safety

3 Slip Trip Fall Injuries

One lost time

Asset Management

On 19th April whilst walking along the public highway to offices in Parish Gardens, London, the IP was so engrossed in his search for the office entrance he failed to notice the poor underfoot conditions to the pavement as a result of on going building works, he slipped twisting right foot/ankle sustaining bruising.

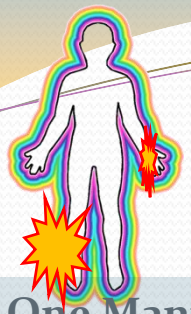
Two no lost time

INNER

On 26th April whilst moving from the 4 ft towards the cess in the vicinity of WK2137 and S&T Team Leader tripped on the point rodding which resulted in him falling into cess, bruising his elbow and knee as he struck the ground. IP was able to complete the shift.

OUTER

On 26th April IP was undertaking his duties as a distant lookout when he was signalled to come back towards the work group, when starting to walk back he tripped over a small tree stump which was overhanging the only safe walking route (Toughing). After falling the IP landed on his right side, sustained bruising and discomfort.



Workforce Safety

More No Lost Time injuries

One Manual handling (Inner)

On 12th April, A rail trolley was lifted from the track up onto a platform, it and was pushed 'end over end' and dropped on to the platform onto the injured person's finger, luckily sustained minor bruising.

Discussion point: Is there a better way?

One use of tool (Works Delivery)

On 9th April whilst following on from the welders, IP was installing pads under the rails, he went to tap in a wedge with a small welders hammer unfortunately missed the wedge and caught the thumb and knuckle of his left hand with the hammer.

Discussion point: Take 5.

One burn from a Weld (Works Delivery)

On 10th April whilst changing the welder's copper plate for the base plate, the IP inadvertently leant on the weld, his left wrist came into contact with the warm weld sustained a minor burn.

Discussion point: Longer gloves or leave to cool.

One contact with structure (Inner)

On 21st April Whilst walking along a platform and under a footbridge at Richmond station, the IP hit front of head against a concrete block forming part of the footbridge.

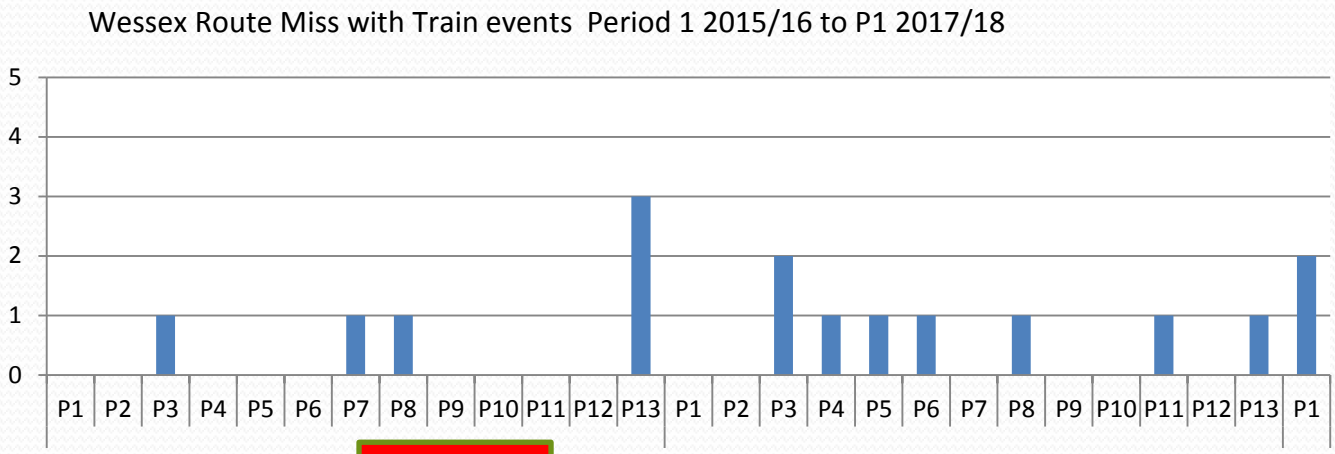
Discussion point: Look up/bend down.

Near Miss Special

- The purpose of the next few slides on this topic is to promote discussion on the biggest risk to workforce safety - the near miss with train.
- The trend continues to rise
- Do not assume it could not happen to you
- Feed back any preventative ideas to your Safety Reps, Safety Advisors or Line Managers

Near Miss Special

These photographs are from on train CCTV, they represent photographs from all near miss events.

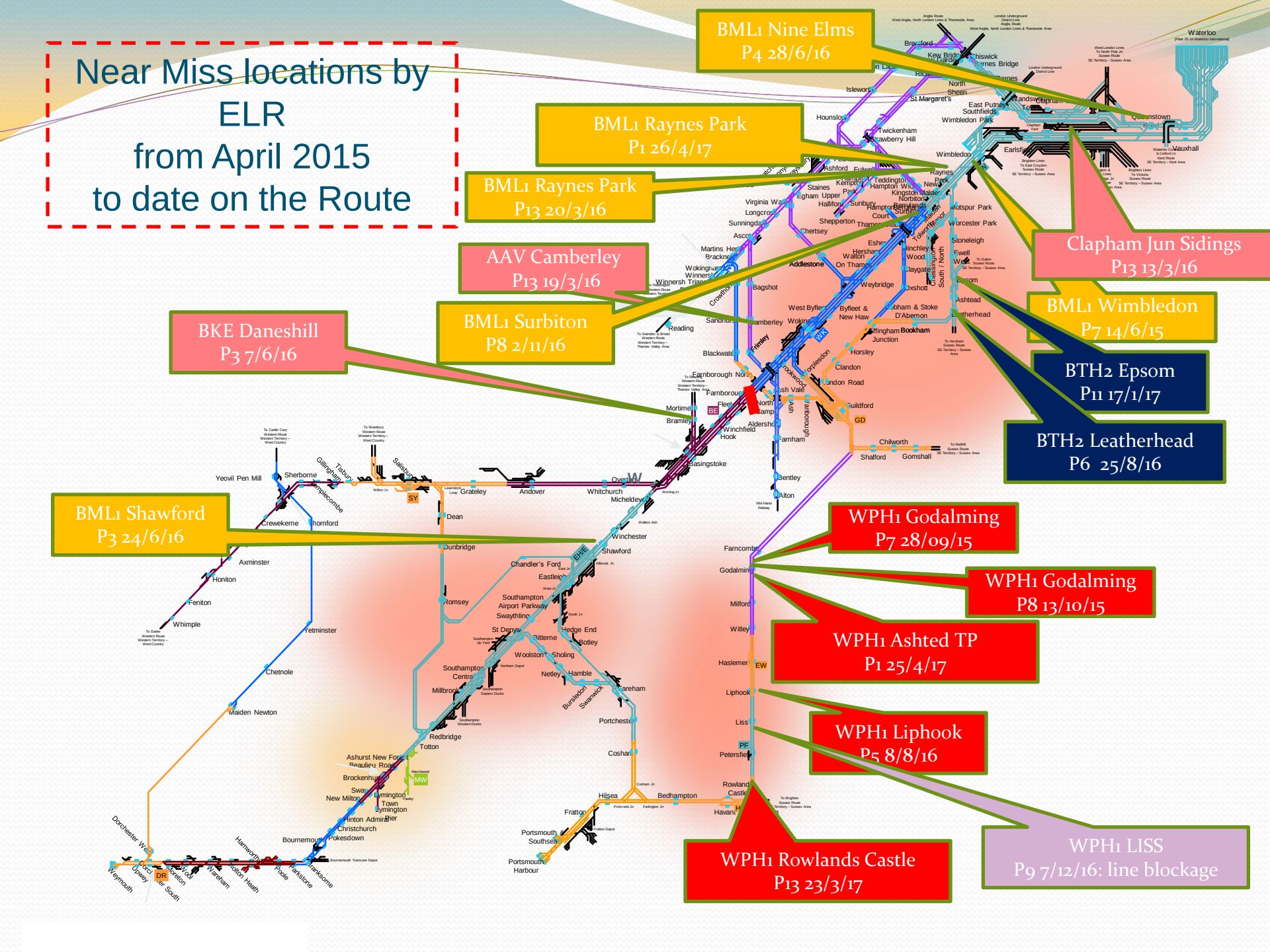


4 seconds to impact

3 seconds to impact

8 seconds to impact

Near Miss locations by ELR from April 2015 to date on the Route



Near Miss Special

Discuss

Most Common factors

- Red Zone Working
- All those involved did not think it would happen to them
- A last minute change to:
  - Group resources
  - The work activity
- The 'Just go and check something out' well intentioned decision
- SSOWP was not good enough

Who is more at risk?

- IWAs – engrossed in work activity?
- Small groups of two or three people all holding COSS & Lookout – take more chances because they are used to working together?
- Experienced – too confident?
- Inexperienced – too enthusiastic?
- Those who are not fussy about the SSOWPS?

Near Miss Special

Rowlands Castle

INCIDENT

- On 23rd March at 1106 hrs at a limited clearance structure sited on a 70mph curved section of track at 62m 27ch on the WPH1 Up Main at Rowland's Castle a Site Lookout was involved in a Near Miss of less than 3 seconds.
- He was part of a four man protection team of three Lookouts and a COSS supporting an Earthworks Examiner completing site inspections; they were walking between sites in the Up Cess.
- Two distant lookouts were ahead of the group further around a curve providing warning of trains approaching on the Up line. Upon reaching the limited clearance structure the COSS, site lookout and examiner stopped in a position of safety to assess the protection arrangements. The COSS asked the site lookout to signal to the intermediate lookout positioned ahead in the Down Cess to move further on to increase the warning time required to cross safely.
- Whilst the COSS was reading the SSOWP, due to a lapse in concentration and without warning the site lookout crossed the limited clearance structure. When he was in the middle of the structure the intermediate lookout warned a train was approaching; the site lookout had to run to the end of the structure before the train reached his location.

Near Miss Special

Rowlands Castle

Lessons Learnt: Take 5 to…

- When a COSS needs to review the SSOW then the team must be stood down and remain in a place of safety until the COSS instructs otherwise.
- It is important at all times whilst on track to reach a clear understanding; repeat back instructions to verify the message has been understood.
- To achieve our safety vision of Everyone Home Safe Every Day, we must care of each other. Throughout the day, take breaks and be aware of the concentration levels of our team mates.
- If you believe you have been involved in a Near Miss with a train, report immediately to ICC clearly stating a Near Miss with train has occurred.

Near Miss Special

Ashted TP Hut

At 14:13 hrs on 25th April the driver of 1P44 reported a near miss with two members of Balfour Beatty staff working for the E&P section Outer DU.

The two individuals were adjacent to the Ashted T-Hut Access Gate on the WPH1 Up line at 35m 15ch;

- The line speed here is 60mph,
- The site is in the middle of a reversible curve,
- Sighting distance availability is limited,
- There was no written SSOWP,
- There was no Lookout.

The driver advised on coming around the curve he was travelling rapidly toward two Trackmen in his path, one appeared to be bent over in the 4 foot.

The incident is subject to further investigation but immediate learning points are:

- Always have a safe system of warning or protection before going on or about the line,
- If you are responding to a fault; think about, arrange and record your SSOW.
- If you enter the infrastructure through an access gate and are uncomfortable with the sighting distance available; report it as either a Close Call or to the local Section Manager/Planner or Safety Advisor

Near Miss Special

Raynes Park

On 26th April at 1100 hrs, an Assistant Track Section Manager (ATSM) was conducting a track inspection as an IWA red zone working at Raynes Park , 8m 08ch on BML1.

As he was performing this task 2F26 approached from country end toward London on the Up Slow at line speed of 60mph.

As the train came through the station at line speed, the ATSM was observed in the 4 ft of the Up Slow by a train driver examiner who was on the right hand side of the cab, he told the driver who then issued a train horn warning; the train driver had not noticed the ATSM.

The ATSM reached a position of safety in the Up Cess approx 8 seconds before the train reached him.

The incident is subject to further investigation but the immediate actions taken by the Inner IMDM are-

- With immediate effect the implementation of a trial ban across the Wessex Inner Team for IWA (individual working alone) in a RED Zone environment for Supervisory Inspection Activities.
- Raynes Park Station Area is being updated in the hazard directory to show 'NO IWA/Red Zone Working to be permitted'.

Sentinel safer smarter simpler

Site Access is the latest upgrade;

- Records certain briefings (not site)
- Records competencies
- Reduces double shifting (primarily contractors)
- Initiates steps in NR fatigue management
  - Swipe in & out - checks 12 rest periods
  - Enables recording of who does the Fatigue Risk Assessment. (FRA)

Note: It does not give details of number of shifts to the general user.

Sentinel safer smarter simpler

How & What

- When a card holder is swiped in the App will show how many hours since the individual last worked.
- If this is < 12 hours as FRA must be conducted before the card holder can be allowed site access
- The App requires a FRA to be done by a duty manager or line manager, the name of that manager must be recorded along with a reference number before the card holder can work.
- There is no other potential exceedance information available

Sentinel safer smarter simpler

The Safety Role

It was agreed nationally with the Unions that only certain roles would have access to additional data, only after an incident or accident and when given permission by a Panel; initially only the HoRSHE, but since has been agreed other safety roles will be able to

- Live information of who, from Network Rail, is out on track working (Muster List)
- What competencies the above guys hold (Skills on Site).
- Swipe data for a particular date/person (Swipes)

Sentinel safer smarter simpler

Additional Information

- National Project Team agreed a ‘soft roll out’ within the Routes.
- Last Sentinel Update was March 2017
- The NR contract with the service provider is out for tender at the moment; it is not envisaged any major upgrades will take place in the foreseeable future.

VTS

- 73% Wessex Vehicles fitted
- All vehicles should have been fitted by 9th May; if not the book urgently, penalties will occur shortly.
- The National Project Manager Henry Whetstone is contacting vehicle owners weekly to make sure vehicles are booked in for VTS fitting.
- VTS Q&A documents are attached to this cascade.
- The link below will take you to the Safety Central area where further information can be found including fitment guides for all types of vehicles.

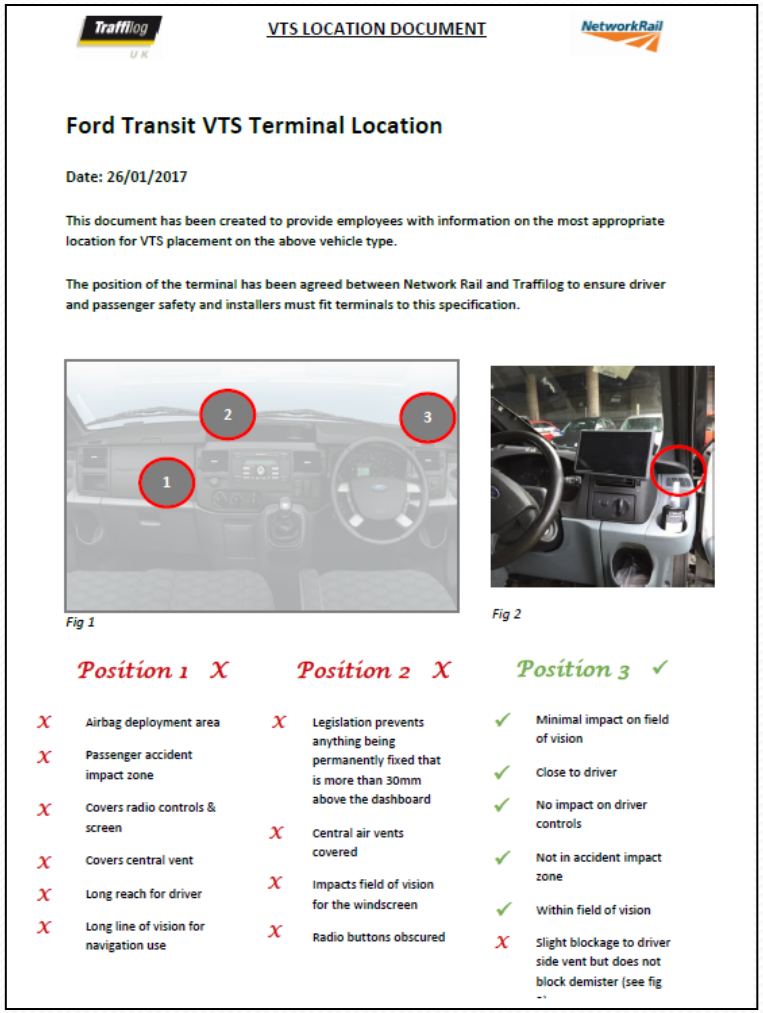
Safety Programme | Safety Central | Page 6

Speed Device Fitted

everyone home safe every day

VTS

All locations in vehicles have been tested and agreed with Ergonomics and Engineers. Where possible discussions with SMs have taken place on site.



VTS LOCATION DOCUMENT

Ford Transit VTS Terminal Location

Date: 26/01/2017

This document has been created to provide employees with information on the most appropriate location for VTS placement on the above vehicle type.

The position of the terminal has been agreed between Network Rail and Traffilog to ensure driver and passenger safety and installers must fit terminals to this specification.

Fig 1

Fig 2

Position 1 X	Position 2 X	Position 3 ✓
X Airbag deployment area	X Legislation prevents anything being permanently fixed that is more than 30mm above the dashboard	✓ Minimal impact on field of vision
X Passenger accident impact zone	X Central air vents covered	✓ Close to driver
X Covers radio controls & screen	X Impacts field of vision for the windscreen	✓ No impact on driver controls
X Covers central vent	X Radio buttons obscured	✓ Not in accident impact zone
X Long reach for driver		✓ Within field of vision
X Long line of vision for navigation use		X Slight blockage to driver side vent but does not block demister (see fig

VTS

- Letters to Wessex Drivers have been sent

If this has not occurred it may be because they are not registered through electronic licence checking and the individuals line manager must complete the VTS manual licence check form and send to

vehicletracking@network rail.co.uk

- The vehicle Helpline number is **0208 236 0545**
- Line Managers cannot track vehicles
- Stickers for vehicles as agreed with the unions, are available and are being ordered.

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 266 **close calls** have been reported on the Route, have 133 already been closed, 133 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:

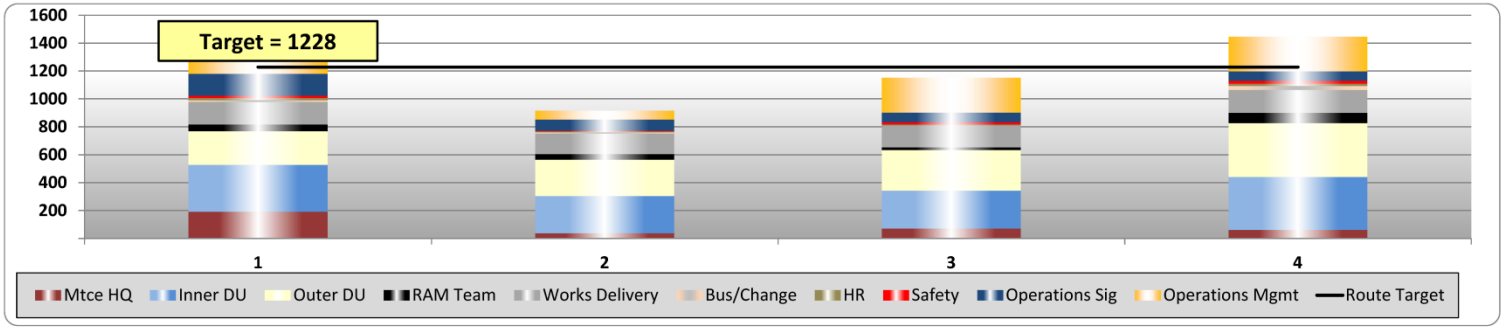
- **Not wearing seat belt**
- **Exceeding the speed limit**
- **Poor briefing**
- **Failing to reach a clear understanding.**

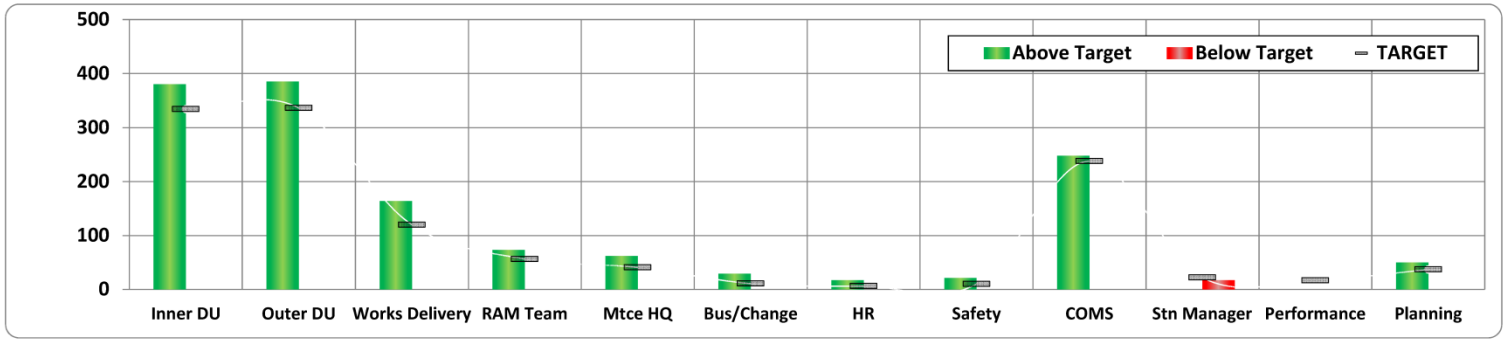
Safety Hour

Don’t forget to record yours next week

Safety Hour Attendance per Week

WESSEX = 79%





Week	4

	Inner DU	Outer DU	Works Delivery	RAM Teams	Mtce HQ	Business Change	HR	Safety	COMS	Stn Manager	Performance	Planning
Actual	380	385	164	73	62	29	17	21	248	17		50
Target	334	336	120	56	41	11	6	10	238	22	17	37
Short Fall										5	17	
%	76%	77%	92%	87%	100%	100%	100%	100%	70%	52%		91%

Is a legal requirement

Health and Wellbeing

HAVS Surveillance 2017/ 18

HAVS Tier 2: Online Electronic Questionnaire

- HRSS identifies employees that require this level of surveillance
- OH Assist will send a letter to employees in this programme's home addresses with the "logon" details to the online questionnaire they need to complete.
- Questionnaire takes a maximum of 5-10min to complete
- Line Manager's will receive a list of their employees that are on this programme with a paper version of the questionnaire for the employee to complete, if required.
- Line Manager's will need to provide access to a computer at work for employees on the programme to complete their online questionnaire.

HAVS Tier 3/ Hearing: Face-to-face appointment at an onsite clinic

- HRRS identifies employees that require this level of surveillance
- Wessex proposed a list of 11 onsite locations that will require auditing by OH Assist for suitability.
- Once these clinics have been signed off, the IMDM and Works Delivery Manager's will need to allocate a **nominated contact** to manage bookings for these locations.
- OH Assist will calculate how many clinics are required per location and provide a list of dates available to the nominated contact.
- Where possible, these dates will be over two months away to ensure adequate time for booking employees in.
- The nominated contact will confirm whether the date is accepted or not within five days of receipt of the dates from OH Assist.
- The nominated contact will liaise with line managers to book their employees into chosen clinic dates

An electronic FAQ will also be circulated with this Period's cascade.
Please print this off and make it available to your staff.

Health and Wellbeing

Dyslexia

What is Dyslexia?

Dyslexia is a permanent condition that affects how we learn to read, spell and/or write. Someone with dyslexia might also have difficulties processing information at speed, short-term memory, organising/arranging, sequencing, spoken language and hand-eye coordination

What can you do if you think you have Dyslexia?

- For employees who think that they might be dyslexic, or if you or a colleague thinks someone may have dyslexia, the first step is to arrange a diagnostic assessment with a chartered psychologist .
- Please print off the information booklet attached for more information on how to access help.

WHAT can ALL of us do?

1. Gain a better understanding of Dyslexia by reading the information booklet
2. Contact the diversity & inclusion team for more information and support.

Diversityandinclusion@networkrail.co.uk

Safety Bulletins

Safety Bulletin

A serious incident has taken place

everyone home safe every day

Test before touch while fault finding

Issued to:	**All Network Rail line managers, safety professionals and RISQS registered contractors**
Ref:	NRB 17/07
Date of issue:	07/04/2017
Location:	Barnham, Sussex
Contact:	Steve Kennedy, Senior Technology Engineer

Volt-Stick showing the location cabinet is live during "Test before touch"

Overview

Technicians were sent to site to investigate an Intelligent Infrastructure alarm.

The alarm was raised by a piece of equipment known as a Bender Earth Monitoring system which is typically found in signalling and plant equipment rooms and other trackside locations.

Staff used a volt-stick at the location to carry out the "Test before touch" lifesaving rule.

Following the "Test before touch" rule avoided the risk of electric shock as the signalling location cabinet was found during the test to be live at 200 volts.

Rubber gauntlets were used to access the location. A short circuit fault was observed in the 650 volt chamber located in the bottom of the signalling location cabinet which was then isolated and a repair carried out.

Discussion Points

Please discuss the following with your team.

- When would you test a signalling location cabinet?
- How would you test to check it was safe to touch?
- What would you do if you noticed smoke or sparks emanating from a cable route or enclosure?
- What precautions should be applied when investigating low insulation values of 650V feeder systems?

Copies of Safety Bulletins are available on Safety Central

Part of our group of Safety Bulletins

Safety Alert | Safety Bulletin | Safety Advice | Shared Learning

Published Investigations

During Period 01 2017/18

steve.cory@network rail.co.uk

Area	Date of incident	Level	Description	Lead Investigator	DCP	Published	Actions	Recs
Ops Outer	16/11/16	3	Fareham - CAT A SPAD E811 2E57 SMIS: QSE/2016/NOV/672	Paul Fleet	Giles Baxter	12/04/17	2x Closed 3x Open	None
Maint Inner	07/11/16	2	Wimbledon – Battery fire SMIS: SE/2016/NOV/266	Mike Terry	Andrew Malcolm	13/04/17	2x Closed 0x Open	None
Maint Outer	05/11/16	3	Canute 1Z91 derailment SMIS: QSE/2016/NOV/168	Nick Lewis	Dean Moss	18/04/17	5x Closed 7x Open	None
Ops Inner	27/08/16	3	1D43 Cat A SPAD W91 SMIS: QSE/2016/AUG/1372	Marc Ellix	Giles Baxter	24/04/17	3x Closed 2x Open	None

Fair Culture Panel Review

05/04/2017

Event	Immediate Cause	Underlying Cause	Lead Investigator outcome	FCP outcome	FCP comment
P13 1617 090317 Strawberry Hill CCTV Xing irregularity with 6J61	6J61 was authorised to exit the possession without the line being clear and safe for the movement to take place.	• The Signaller failed to fully apply the instructions contained within the route card for the movement from F96 to F94 signals as he was focusing his attention on the position of the points within the route. • The Shift Signaller Manager was asked to confirm the position of the points and had assumed that as the train had not yet been presented, that the Signaller would ask him to check the route again when 6J61 was presented and ready to depart the possession.	Contravention	Contravention	The Panel agreed with the Lead Investigator.

Fair Culture Panel Review

27/04/2017

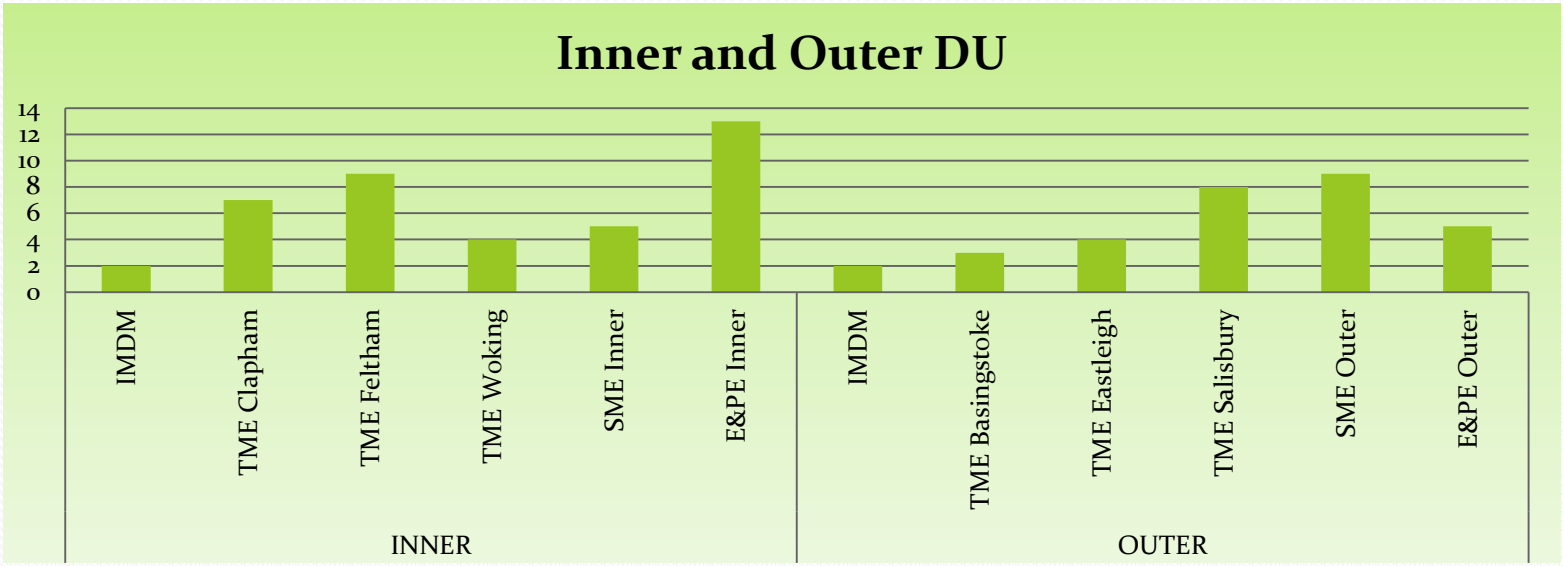
Event	Immediate Cause	Underlying Cause	Lead Investigator outcome	FCP outcome	FCP comment
P10 1617 131216 Driver 38mph in 30 zone B3145	Travelling at 38mph in a 30mph speed zone.	The Driver thought he had left the 30mph zone and was within a 60mph zone, potentially due to a lack of concentration.	Slip / Lapse	Slip / Lapse	The Panel agreed with the Lead Investigator
P10 1617 241116 Tisbury Wrong Direction Movement Irregularity	Wrong direction working agreed putting users at risk at Tysbury West AHB and Tysbury Quary red and green level crossings.	The Salisbury and Basingstoke West of England Signallers did not reach a clear understanding about the trains location or movement required. The Driver was not given the correct cautionary message , but had acted on what was required by his own experience and knowledge of the rule book requirement.	Contravention	Contravention	The Panel agreed with the Lead Investigator

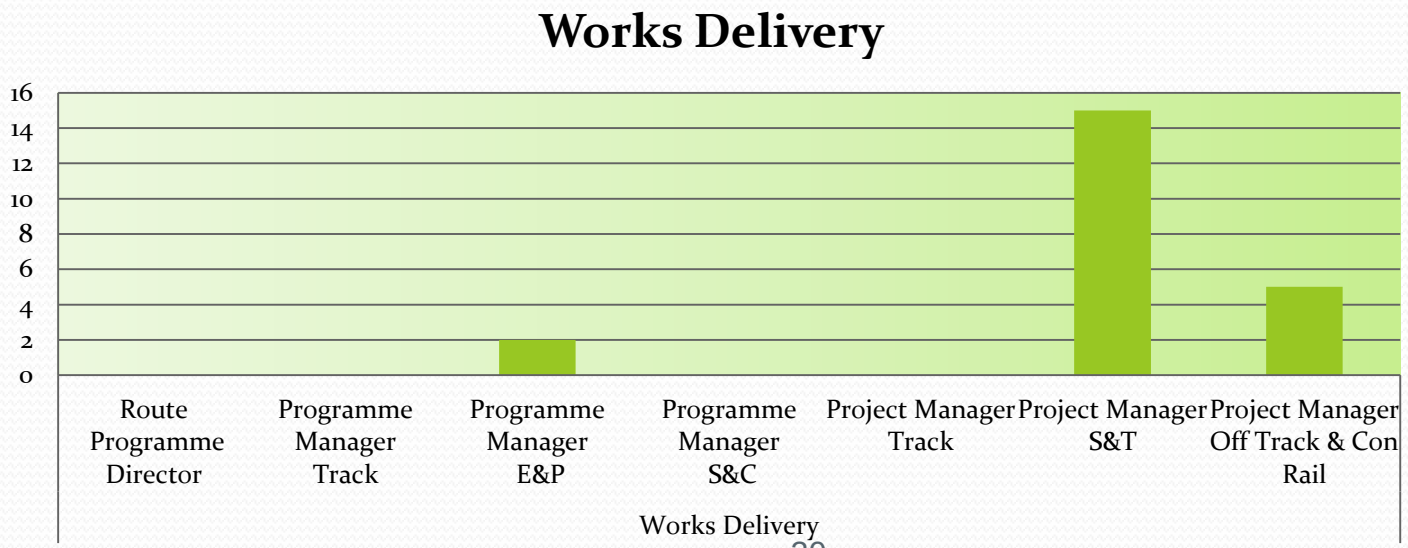
Fair Culture Panel Review

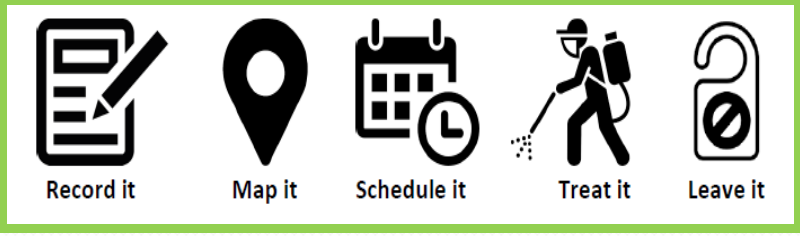
27/04/2017

Event	Immediate Cause	Underlying Cause	Lead Investigator outcome	FCP outcome	FCP comment
P11 1617 220117 Wimbledon T3 worksite irregularity	The COSS did not take in the information given to him by the ES.	A communication error occurred between the Engineering Supervisor and the Controller Of Site Safety not confirming which up line the engineering trolley should be placed on.	ES & COSS Contravention	ES & COSS Contravention	The Panel agreed with the Lead Investigator, but in association with not coming to a clear understanding with the ES.
P11 1617 230117 1N63 shunt risk Fareham junction	The Driver performed a shunt without permission.	The Driver and Signaller did not reach a clear understanding as to what was to occur and the communication was not fully repeated back, but had no control over the Drivers actions by him not following his own process requirements.	Slip / Lapse	Slip /Lapse	The Panel agreed with the Lead Investigator in this instance, as it was the Drivers unauthorised action that escalated this incident.

Planned SSOWPS and On site Safety Inspections:







Environmental Japanese Knotweed

Is an invasive non native plant. Is a nasty piece of work and is planning to illegally take over the world so:

- Record it
- Map it
- Schedule its destruction
- Treat it
- Leave it

Its rapid growth rate, up to 2m in 30 days, and ability to force its way through many substrates including tarmac and concrete mean it can pose safety and operational issues for the railway by blocking signals, sightlines and positions of safety. Moreover, Network Rail neighbours are increasingly having issues when attempting to sell property within a certain distance of knotweed on Network Rail land.

Appreciation Section

A big thank you to:-

Priti Patel and Ivan Kimble for hard work, dedication and unerring enthusiasm. Have a great time in your new jobs.

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.


EVERY ONE HOME SAFE EVERY DAY
ACCESS STEPS
OVERGROWN VEGETATION
YES PLEASE PHIL. What a fine thigh you have there!