



Specially trained firearms officers patrolling on board trains nationwide

Health, Safety and Environment
Period Cascade for P2. 2017/18

Welcome

Welcome to your Health, Safety and Environment Cascade for Period 2 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;

- Security Special
- Workforce Accidents
- Workforce Health
- Health and Wellbeing
- Close Calls
- Safety Hour
- Safety Bulletins
- Investigations & Fair Culture Panel
- SSOWP and On site Inspections
- Special thanks to....

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call 0300 456 4999, or at British
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Network Rail has also established a
Just Giving page. Money collected
will be passed to the Red Cross
appeal





Security Addition

Check out the App

Rail colleagues understand their environment better than anyone so will know if something is out of place or doesn't feel right.“ Suspicious activity is anything that seems out of place, unusual or just doesn't seem to fit in with day-to-day life.

The **WHAT** protocol is designed to help rail staff gather as much useful information as possible when receiving a report of suspicious behaviour.

- **W - What are they doing?**
- **H - How are they behaving?**
- **A - Alone or acting with others?**
- **T - Threat - What type of threat are they believed to pose?**

If suspicious behaviour has been reported by a member of public to a member of rail staff, it is important we find out:

- When the member of public saw the person displaying this behaviour;
- How long has it been between witnessing the behaviour and the reporting of it; and
- They should always obtain their contact details from the witness (ideally a mobile phone number) so police can speak to them directly.



Security Addition

Check out the App

Rail colleagues understand their environment better than anyone so will know if something is out of place or doesn't feel right.“ Suspicious activity is anything that seems out of place, unusual or just doesn't seem to fit in with day-to-day life.

Colleagues should apply the HOT protocol to any reports of unattended items.

- **H** - Has a deliberate attempt been made to HIDE the item?
- **O** - Does the item have OBVIOUS suspicious characteristics?
- **T** - Is the item TYPICAL of what you would expect to find in this type of location?



Security Addition

Fans of the famous Flying Scotsman are being urged to keep off the tracks and enjoy a safe day out when the locomotive tours the south and west this week.

Flying Scotsman will be journeying from Salisbury, through Hampshire and on to London Paddington on 3 June

Network Rail, the British Transport Police and other industry partners are warning those who are planning to view the train of the dangers of straying onto the tracks. Alongside the ever-present risk of being hit by a train, rail lines in the south west are powered by an electrified 'third rail' running parallel to the tracks. This is always switched on and carries enough electricity to kill a person.

BTP officers will be patrolling along the route and at stations to ensure everyone can enjoy the event without putting themselves or others in danger. So far on the Flying Scotsman tour there has been some disruption, with various incidents of trespass along the line.

Please report any incidents of trespass immediately.



Security Addition

Dear Wessex team

Following the tragic events in Manchester on Monday evening, the national UK terror threat level has been raised to 'critical' which means a terror attack may be imminent. At present there is no specific intelligence to suggest that there is an increased risk to either the rail network or infrastructure. We should remain alert; not alarmed.

In light of this, I thought it would be timely to remind you about the security protocol for visitors coming onto campus. Please take some time to make yourself familiar with the below process and share with any visitors you have coming onto campus. The below applies to visitors that arrive on foot or by car.

All visitors who do not have a Network Rail or SWT identification should:

- Produce their own ID at the security post
- Be held at the security post whilst the security guard phones their Network Rail nominated host (Always ensure you have advised reception of any visitors coming onto campus prior to their visit so they can inform security)
- Once the nominated host collects them from the security post, they will then be allowed on to site.

We are going to impose this process rigorously from now on, so please be patient if there is a delay at the campus entrance when there are lots of visitors arriving at a similar time.

I'd also like to take this opportunity to remind you to clearly display your security passes and lanyards at all times. If you see anybody not displaying their lanyards and passes within the ROC, please challenge them in a polite and professional way.

Safety and security on our network remains all of our responsibility.

Stay safe,
Becky-17



BTP contact details:
Call 0800-40-50-40
Text 61016
(or 999 in an emergency)

Safety Hour discussion pack
attached to this Cascade.

Wessex Safety Calendar

Wessex Safety Calendar

April/May

2017

Period 2

SUN	MON	TUE	WED	THU	FRI	SAT
30	01	NLT	03	04	NLT	06
		Week 5				
07	NLT	08	09	RTA	11	NLT
	Week 6			10	12	13
14	15	16	17	LTI	RTA	20
	Week 7			18	19	
NLT		RTA				
21	22	23	24	25	26	27
	Week 8	LTI				

Key:

NO Lost Time Injury
Lost Time Injury
NEAR MISS
RTA - No Injury



Workforce Safety

2 Lost Time Injuries

Two Lost Times injuries

INNER : Road Traffic Accident

23rd May at Fulwell: the IP sustained injuries consistent with whiplash following a low speed RTA when a vehicle driven by a member of the public pulled out in front of the NR vehicle colliding with the front passenger side of the vehicle.

Improve your road awareness - book on to the NR Driving course.

WORKS DELIVERY: Manual Handling/STF

18th May at Sherbourne (Lethay footbridge level Xing); the IP was one of four members of staff carrying a track trolley to load it on to a flatbed. One person slipped on the slippery underfoot conditions around the access, this unbalanced the load. The IP sustained head and face injuries when he was struck by the trolley as it fell.



Workforce Safety

Three No Lost Time injuries

INNER Ops

2nd May at Frimley; IP sustained a cut/gash to his right wrist whilst pushing a small tree back over the fence when his wrist came in contact with the barbed wire on top. Full PPE was being worn at the time.

INNER DU

8th May at Haselmere: IP picked up a substation log book, dust/dirt flicked up and went into his eye causing him to rub it. Later that day the eye felt sore. Eye drops administered and medical assistance sought.

OUTER DU

12th May at Guildford Depot: The IP was cleaning the boot of the team pool vehicle, whilst doing so he caught his hand on some broken glass left in the vehicle, thought to be a shard left following a change of rear windscreen.



Workforce Safety

3 more No Lost Time injuries

Work Delivery **Use of tools and equipment**

5th May at Cornton Steps Foot crossing: Whilst chain sawing though a Hawthorne bush the saw blade got caught on a piece of wood which caused that chainsaw to fire back a piece of wood towards his hand. A large thorn on the wood pierced through the IP's glove and finger. Attended A&E and was put on gas and air whilst they removed the thorn. Nasty hard wood is hawthorn.

Works Delivery **Slip trip fall**

13th May at Waterloo: The IP was working in the vicinity of a section of track that had the AS screws removed for the purpose of the work. One of the AS screws had been removed but left in the housing loosely. The IP whilst walking past and tripped over the loose screw twisting his ankle.

Works Delivery **Safe system of work/Manual Handling**

21st May at Milbrook: The IP sustained soft tissue damage to his shoulder and rib area whilst pulling cable. A 48core cable was being run out from Southampton using 30 men to pull it out at 20 metre intervals, the cable became tight on the drum causing the cable to snag which in turn caused the group to stop sharply with a jolt as the cable was on shoulders. The IP twisted sharply with pain in his shoulder and rib area.

Exposure Category	UV Index
LOW	0 - 2
MODERATE	3 - 5
HIGH	6 - 7
VERY HIGH	8 - 10
EXTREME	11 +



Workforce Health



WORKING TOGETHER TO BEAT OCCUPATIONAL CANCER

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[Supporters A to I](#)
[Supporters J to Z](#) ▾
[Gradient Consultants](#)
[Leo Lynch](#)
[Ask the experts](#)

Network Rail

Network Rail is supporting IOSH's No Time to Lose campaign as we are committed to the health and wellbeing of our people.

We recognise the benefits of taking a collaborative approach to engaging with our staff and supply chain to raise awareness levels, identify improvement opportunities and promote good practice.

Lisbeth Fromling
Chief Health and Safety Officer



Sun safety strategies:

- check regular updates on the UV index from weather forecasts. (*Visible on all websites/Apps*)
- minimise sun exposure in the middle of the day,
- wear long-sleeved, loose-fitting tops,
- tinted glasses preferred - encourage use,
- high-factor sunscreen is helpful but should not be relied on as the only barrier to the harmful rays.

Workforce Health

Observing Ramadan

The Muslim holy month will take place from Saturday 27 May.

- Muslim colleagues across Network Rail will be observing Ramadan from Saturday 27 May for a month. The Muslim holy month will coincide with the longest days of the year, meaning long days of fasting.
- Ramadan is determined by the lunar cycle and the timing shifts each year in relation to the Western calendar.
- "Fasting starts with a meal before dawn (Suhur) and breaks with a meal at sunset (Iftaar), with no food or drink consumed during the day. *It's important that we recognise the potential impacts on an individual, as well as providing available opportunities for support during the month of Ramadan.*"



Nasir Khan, contracts and procurement manager and chair of the multi-faith network, said:

"Ramadan represents one of the widest celebrated religious traditions in the world. As one of the 'five pillars' of Islam, Ramadan corresponds to the ninth month of the Islamic lunar calendar during which Muslims fast.

Health and Wellbeing

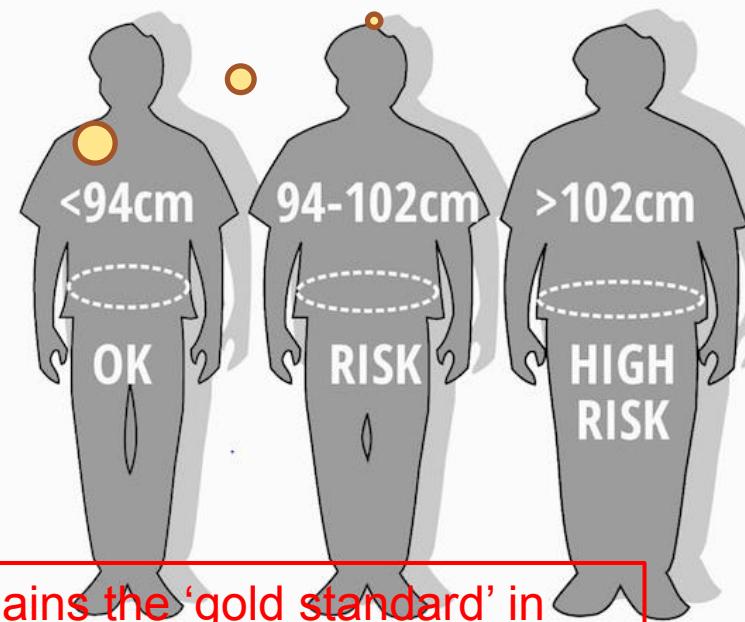
Men's Health Week: 12 – 18 June

It's all about the **Belly Fat**. Why? Because it is bad for your health and **men** are more likely to have it...who knew!

Regardless of your overall weight, a large amount of belly fat increases your risk of:

- Cardiovascular disease
- Insulin resistance and type 2 diabetes
- Colorectal cancer
- Sleep apnoea
- Premature death from any cause
- High blood pressure

A tape measure around the navel; should have thought of that earlier!



- Modifying what and how much you eat remains the 'gold standard' in any approach to reducing weight.
- Increase physical activity; to a point where you are slightly short of breath and have increased heart rate.
- Set realistic goals and work consistently towards them.





Carer-to-
carer
support



Carers – part of the 'Everyone Managing...' series

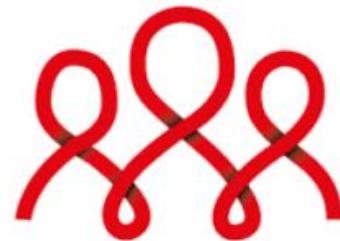
Everyone Managing... Carers

Version 2

Owner: Diversity and Inclusion
Approved by: Loraine Martins



Date issued 28-02-2017



A Brief Guide for Managers



Health and Wellbeing

It is estimated that **1 in 8** of the UK workforce is a CARER.

Due to a variety of different factors in our society it would **not be uncommon** for more and more people to have at least one period of **caring responsibility**, often whilst employed.

Many employees at Network Rail will find themselves in this situation and it is important to understand what help and support is available

KNOW about the support that are available to staff:

Myriad.

The Network Rail carer's staff network;

myriad@networkrail.co.uk

<http://oc.hiav.networkrail.co.uk/sites/myriad/Pages/Default.aspx>

An electronic copy of the below documents will also be circulated with this Period's cascade.

Please print this off and make it available to your staff.





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 160 **close calls** have been reported on the Route.

93% close calls have been closed within 90 days.

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:

Areas where the VTS appears to alert wrongly against the actual road speed.

Add your own....

Exposed or cut live cables

Reporting a mileage that should be Red Zone Prohibited in the Hazard Directory

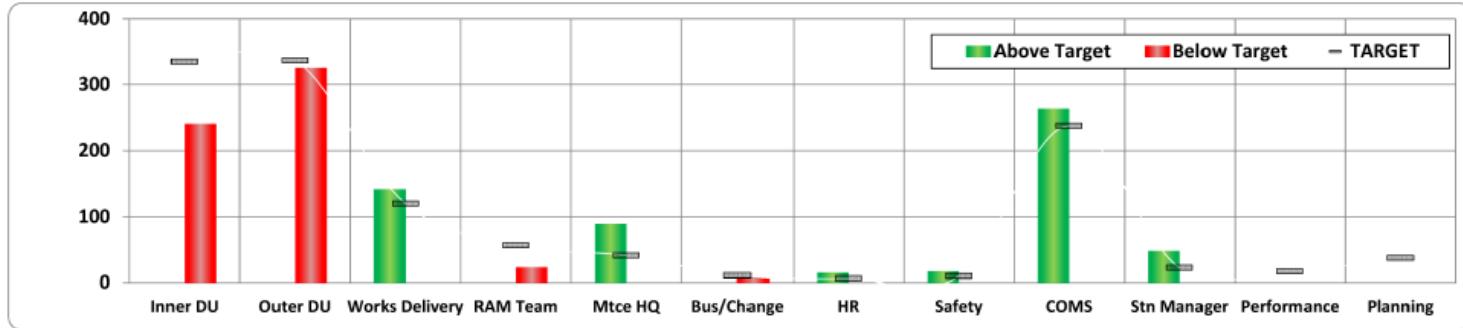
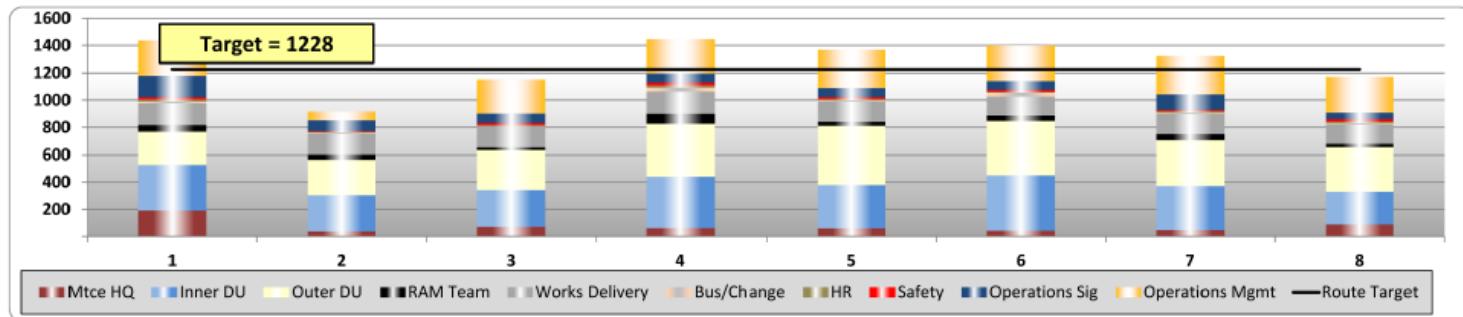
Safety Hour



Don't forget to record yours next week

Safety Hour Attendance per Week

WESSEX = **64%**



Week	8											
	Inner DU	Outer DU	Works Delivery	RAM Teams	Mtce HQ	Business Change	HR	Safety	COMS	Stn Manager	Performance	Planning
Actual	241	325	142	23	89	8	15	17	264	48		
Target	334	336	120	56	41	11	6	10	238	22	17	37
Short Fall	93	11		33		3					17	37
%	48%	65%	79%	27%	100%	50%	100%	100%	74%	100%		

Safety Bulletins

Safety Bulletin

A serious incident has taken place



Vehicle speed warning system data to be used in speeding investigations

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

Ref: NRB 17/10

Date of issue: 26/05/2017

Location: Nationwide

Contact: [Rupert Lown](#), Head of Corporate Workforce Safety

Overview

Between June 2013 and September 2015 eight colleagues died in driving accidents and have lost more since. Speed was a factor in a number of these incidents.

The number of speeding incidents recorded by speed cameras has declined since the safety stand down on driving. However recent data from the Vehicle Speed Warning System is recording up to four verified instances a day of colleagues driving at 20 mph or above the speed limit.

Many of the reported speeding incidents have happened on night shifts, particularly between the hours of 02:00 – 08:00.

As vehicle fitment of the system reaches 90% the data will be used in investigations, starting in some Routes from 30 May 2017.



We will continue to investigate every speeding incident in accordance with the lifesaving rules and fair culture principles and the Vehicle Speed Warning System will give us much better information about the reported speeding incident.

Speeding 20 mph or above the legal limit for the vehicle or road will continue to be considered gross misconduct except for very specific exceptional circumstances.

For Driver ID, licence check or password issues email VTSELadmin@networkrail.co.uk

To book vehicles in for fitment, or arrange a service call to rectify faults email VehicleTracking@networkrail.co.uk

Wessex Route VTS Fitment is running at 85% at the end of period 2.

It is anticipated that we will reach 90% on or about the 5th July.

After which the exemption for excessive speed at or over 20 mph will no longer exist.

If you have a vehicle that has not been fitted please arrange. If you have a complaint about the location of the unit please contact the fitters. Contact details sent out many times.

Safety Bulletins



No: NRS 343

Network Rail
The Quadrant, MK
Elder Gate
Milton Keynes
MK9 1EN

6 November 2014

Network Rail Safety Bulletin

Safe use of Ironmen

For the attention of: All staff involved in the planning, operation and maintenance of Ironmen

Background:

On 1 November 2014 a group of trackworkers were moving 2 x 52ft pieces of rail for approximately a mile and a quarter on the line between Pantyffynnon Jcn and Gwaun-cae-Gurwen in Wales using two pairs of Ironmen.



The Ironmen were being operated down a gradient which was up to 1 in 40, with the load for each pair being just short of 1 tonne. The rail head was contaminated with leaves and it was raining heavily at the time.

Both pairs of Ironmen experienced difficulties during braking; this resulted in them gaining speed to the point the operators could no longer control them. One of the operators of the first pair received a graze injury and another suffered from shock.

The first pair ran away for approximately 5 miles crossing 5 level crossings including narrowly avoiding a team working on the first. The second pair was brought to a halt at the first level crossing. Subsequent inspection of the brakes has shown them to be worn.

Immediate action re-iterated:

- Iron men shall not be used on gradients greater than 1 in 150 until further notice.
- Staff are reminded that a brake test is required at the start of every shift (rotational tests) and once mounted on the rail (prior to loading)
- The requirements for planning, operating and maintaining Ironmen including the number of staff required to control the equipment based on the load are contained within NR/PLANT/0200/modules P501, P514 and P702 Infrastructure Plant Manual.

Determine the manpower when planning to push a hand controlled trolley on a gradient.

Guidance for the recommended number of persons required is given in Table 1.

Load Gradient	Moving rail only	Moving any load				
	3000kg ⁽⁴⁾	2000kg	1500kg	1000kg	500kg	
Up to 1 in 250	5	3	3	2	1	
1 in 250 to 1 in 150	5	4 ⁽²⁾	3	2	1	
1 in 150 to 1 in 70	6	5 ⁽²⁾	4 ⁽²⁾	3	1	
1 in 70 to 1 in 50	7	6 ⁽²⁾	5 ⁽²⁾	4 ⁽²⁾	2	
1 in 50 to 1 in 30 ⁽¹⁾	10 ⁽³⁾	6 ⁽²⁾	5 ⁽²⁾	4 ⁽²⁾	2	

Table 1 Estimated persons required to move a trolley (except manually propelled rail handlers) on gradients

Safety Bulletin

A serious incident has taken place



Engineering work site given up whilst track remained obstructed

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

Ref: NRB 17/09

Date of issue: 19/05/2017

Location: Kirkham South Junction, LNW Route

Contact: [Darren Cobb](#), Head of Safety & Sustainable Development

Overview

At 05:25 on 15 May 2017 a tamper, travelling at 15 mph transiting to exit the possession safely stopped short of a 5 metre long pile which was obstructing the Down Main line.

The transit was not part of arrangements for verifying the line as clear. Other than the chance presence of the tamper, there were no further controls in place to prevent the first passenger service, at line speed encountering the pile.

Contractors installing piles had recently given up an engineering work site covering the area, declaring it safe for the passage of trains.

The pile, had been loaded into the Movax piling head and taken to the planned work location. On arrival the work group identified a pile "stored ready" on the lineside and set the pile they had been carrying down in the four foot of the opposite line a short distance from the place of work, and then proceeded to install the stored pile.

Due to installation complications the team realised that they would not be able to drive the pile to its complete depth in the time available before the work site was shortened back to allow the tamper to exit the possession.



So the work group installed the pile to a safe depth and travelled back to the access point approximately 20 minutes away. No-one on-site remembered to collect the pile which had been set down in the four foot.

An investigation is underway; however the following contributory factors have been established:

- The previous night's shift had been cancelled.
- The originally planned possession time had been shortened from 6 hours to 3 hours 20 minutes, to allow tamper access.
- Before setting down the pile at the final location the work group had taken it to two other locations where site conditions and missing supporting documentation had prevented installation.
- The engineering work site was approximately 17 miles long and one RRV associated with these works had travelled two hours within the work site to reach the first pile location.

Safety Bulletins

Discussion points:

- How do you know any planned work has sufficient time to deliver it?
- How do you make sure you have cleared any items left on the track by your work group or any previous shift?
- How long should an Engineering Worksite realistically be?

Operations Alert



South East Route

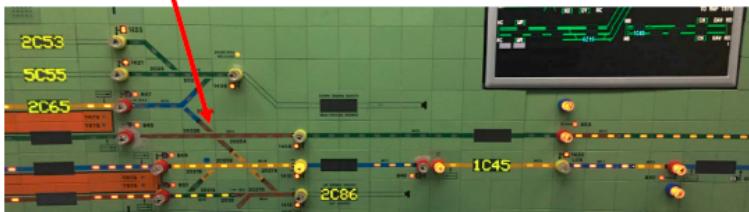
OPERATIONS MANUAL	
Form: 5-18A	Issue: 1
Page: 1 of 1	Date: 03 March 2012
TEMPLATE FOR BRIEFING OF SERIOUS OPERATIONAL INCIDENTS	

Immediately Transferable Lessons from Operational Incident

Information for Signallers and Front Line Operational Staff

During a series of Track Circuit Failures in the area which affected T845 signal at Horsham the duty signaller failed to use Route Cards appropriately to check the signalling route between T845 and T853. T2022 pts had been left in reverse from a previous move and subsequently 2J98 ran through T2022 pts in reverse.

Incident Date: 28/04/17 (approx. 06:20hrs)
T2022 Pts



Reason Incident Occurred:

The signaller did not use route cards and get the route checked by a competent person, for the movement of 2J98 from T845 Signal to T853 signal.

Transferable lessons where appropriate:

When authorising a train movement past a signal at danger with a route containing a set of points within the section ahead, a Signaller should set up the route correctly complying with Rule Book Module S5: Section 2.2 *Setting the route correctly on a panel or workstation*.

Specifically, Signallers should use Route Cards to check the points within the route and get the route set up, checked by a competent person, complying with S5: Section 2.2 *Setting the route correctly on a panel or workstation: Sub Section a) Operating individual point controls*

Date Produced:	08/05/2017	Date Posted:	09/05/2017
		Post For:	12 Weeks

Date issued: 11/05/2017

Safety Alert: Kent Ops 06

Safety Alert Line Blockages with Additional Protection

Description of the event:

At approximately 01:30 hrs driver of 3Z04 stopped at AD897 on a proceed aspect routed on to the Lydd Town branch due to a stop board and detonators placed at AD897 for protection for a line blockage. The blocking points were clear of AD1283A points to RY5 and RY25 covering the Rye single line for a PC.

The Signaller failed to confirm if the work affected the safety of the line when discussing the blocking points and granted the authority number to the PC prior to the detonator protection being put in place, which is an incorrect sequence of events. The PC then contacted the Signaller and confirmed detonator protection was in place at AD897 Signal instead of clear of AD1283A points as published.

Neither the Signaller nor the PC picked up on this.



Signallers:

- You must ensure that a clear understanding is reached with the COSS/PC
- Confirm if the work affects the safety of the line
- If you become aware of an irregularity with a line blockage you must instruct the COSS/PC to move all staff to a position of safety immediately.

COSS:

- You must be fully conversant with your area of work and the limits of your line blockage as contained in your Safe System of Work Pack.
- When you believe something is not right, move to a position of safety and call the controlling signaller immediately.
- You must ensure that a clear understanding is reached between you and the Signaller.

Operations Alert

Immediately Transferable Lessons from level crossing incident at Wymondham Crossing.

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: 11/05/2017



Location;
Wymondham Level Crossing.

ELR & Mileage;
GSM2 99m 67ch.

Controlling Signalbox;
Whissendine

Details of the Incident

- On Thursday 12th May 2017, the crossing keeper Wymondham requested the gates from Whissendine SB to allow a small van to traverse the crossing.
- The Signaller at Whissendine granted permission to the crossing keeper whom then opened the far side gate so that there was an exit then proceeded to open the down side gate and allowed the small van to cross.
- Approx. two minutes after the call, and the vehicle had traversed over the crossing, the crossing keeper then closed and secured the down side gate but failed to secure the up side gate (definitive reason unknown).
- The crossing keeper then rang the signaller Whissendine and confirmed the crossing closed to road traffic.
- On terminating this phone call, the crossing keeper then visually observed the up gate still open for road traffic; crossing keeper then checked the 'train in section' indicators (no trains in section) and immediately went and closed the gate.
- At the same time the signaller at Whissendine observed that the up side gate appeared to be open and immediately rang the crossing keeper.
- The signaller rang the crossing keeper who by this time had commenced securing the gate in the correct position.
- No trains had been signalled at the times of the incident.
- The signaller then contacted the Local Operations Manager and Operations Control.

Transferable Lessons:

- Crossing keepers always stop and double check the crossing is correctly closed to road traffic before confirming crossing clear.
- Signallers always to confirm with the crossing keeper the position of the level crossing gates prior to removal of reminder appliances.



Published Investigations

During Period 02 2017/18

steve.cory@network rail.co.uk

Area	Date of incident	Level	Description	Lead Investigator	DCP	Published	Actions	Recs
IP	13/02/17	2	W22 Approach control removed in error (11 weeks) SMIS: QSE/2017/FEB/9 73	David Slater (Colas rail)	Adam Parker	11/02/17	1x Closed 7x Open	2x Recs



Fair Culture Panel Review

Event	Immediate Cause	Underlying Cause	Lead Investigator outcome	FCP view	FCP comment
P09 1617 031216 Parkstone - Bas Dorset Coast Emergency Special Working irregularity (Level 2)	The Driver of 1Z08 passed BC178 signal on the authority of the incorrect Signaller.	<ul style="list-style-type: none">The GSM-R call from the Driver of 1Z08 was misrouted due to the failure.The Signaller did not identify the correct location of 1Z08.The Signaller had not acted on the verbal information that had been clearly given by the Driver.The focus and attention of the Signaller was distracted away when dealing with the incorrect GSM-R call.The Signaller's panel and route knowledge affected his decision making.The workload at Bournemouth Signalbox meant that the train digit / ID had not been inserted into the BC178 signal Train Describer berth.The overview screen at Bournemouth had an outstanding fault on it since March 2016, which prevented the Bournemouth Signaller from having a sufficient overview of their area of control.	Slip/Lapse	Slip/Lapse	The Panel agreed with the Lead Investigator.

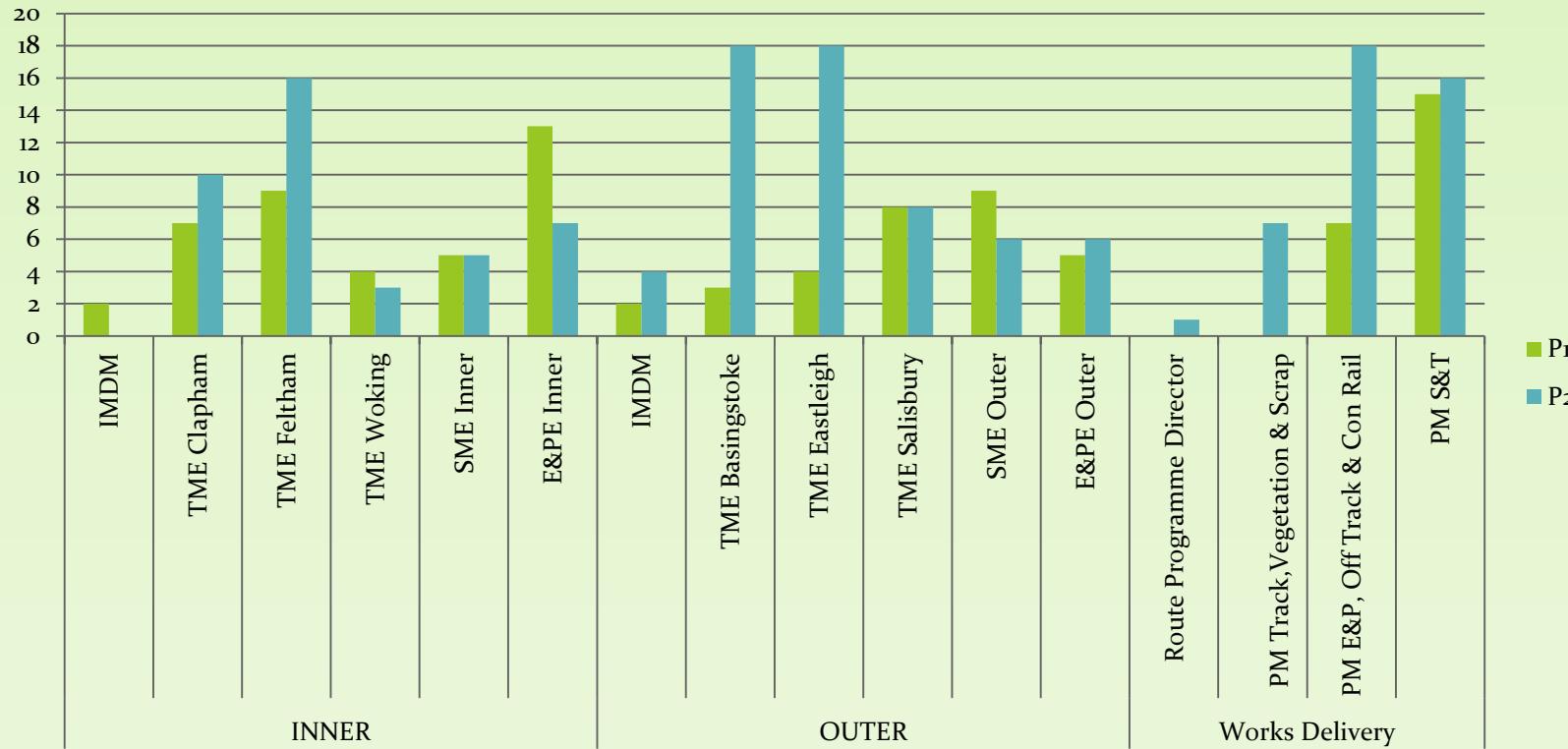


Fair Culture Panel Review

27/04/2017

Event	Immediate Cause	Underlying Cause	Lead Investigator outcome	FCP view	FCP comment
P01 1718 030417 Staines - LSR speeding 44mph vice 30 on the A30 (Level 1)	Network Rail member of staff was travelling at 44mph as they entered a 30mph zone	<ul style="list-style-type: none">The driver was travelling too quickly to slow down, prior to entering the 30mph zone.There is a 40mph sign followed by a 30mph sign which is approximately 120 yards further on and situated around a left hand curve.The 30mph signs are obscured by trees on approach around the curve however, on exiting the curve it is clearly visible.The vehicle has not yet been fitted with VTS(Vehicle Telematics System).	Contravention	Contravention	The Panel agreed with the Lead Investigator given the nature of the layout where the event took place and due to the signage being obscured by foliage.
P12 1617 140217 Woolston - CRE Sub- station process irregularity LSR (Level 1)	The Distribution level A' certificate of isolation to person in charge of working on track feed cable" was NOT issued.	<p>The planning arrangements between the office and the D&P technician was not satisfactory . Shortfall of staff with Level A competence and knowledge and experience within the Section</p> <p>ECR operator should have communicated the error to the staff on site and through the appropriate systems when identified.</p>	Slip / Lapse	Routine Error / Different People	<p>The Panel gained technical advice about the procedure and it was discovered that it was out of date.</p> <p>This therefore meant that others may do the same in similar circumstances.</p>

Planned SSOWPS and On site Safety Inspections: P1 & 2 2017/18



Appreciation Section

A big thank you to:-

Dean Moss IMDM OUTER – off to Brighton DU after years of service.

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.

