Wessex Route

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DO NOT DWELL IN THE PAST; DO NOT DREAM OF THE FUTURE, CONCENTRATE THE MIND ON THE PRESENT MOMENT

Buddha

Health, Safety and Environment
Period Cascade for P3. 2017/18

Welcome

Welcome to your Health, Safety and Environment Cascade for Period 3 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;

- **Workforce Accidents**
- **019 update**
- **Parking Near Level crossings**
- **Vehicle Speed Warning System**
- **HAVs surveillance**
- **Close Calls**
- **Safety Hour**
- **Safety Bulletins**
- **Investigations & Fair Culture Panel**
- **SSOWP and On site Inspections**
- **Special thanks to....**

Gruesome little critter

Wessex Safety Calendar

Wessex Safety Calendar

May/June 2017

Period 3

SUN	MON	TUE	WED	THU	FRI	SAT
NLT 28 Week 9	NLT 29	NLT 30	31	01	NLT 02	03
NLT 04 Week 10	05	06	RTA 07	08	NLT 09	10
11 Week 11	12	13	14	15	16	17
18 Week 12	19	RTA 20	21	22	23	24

Key:

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

Workforce Safety

6 No Lost Time injuries

INNER DU

28th May. An S&T Team Leader was performing point maintenance work in the Surbiton area during the hours of darkness with only the use of hand-lamps/torches for lighting. As he turned around within the 4 ft. his foot caught between the concrete bearer and the tubular stretcher bar, he fell forwards sustaining a cut to his leg.

30th May. A Track Supervisor was changing trains at Surbiton, as he got on to a very crowded train another passenger adjacent to him, pushed into his bag twisting it around. This pushed his left shoulder into a hand rail. The IP had an existing rotator cuff injury, this has exacerbated pain associated with the injury.

2nd June. A Welding/grinding Team Leader was loading a hand grinding machine onto their vehicle, following the completion of works. As the Team Leader was folding down the hand grinders folding handle, he trapped his left hand between the hand grinder and a trolley. This resulted in a crushing injury and bruising to his finger.

4th May. A Machine Controller working for Feltham P-Way was walking down the track in the vicinity of Kew Bridge station to take control of an RRV, as he did so, he twisted his left knee after he stepped on some loose ballast, which then gave way underneath him.

OUTER DU

On 29th May . An S&T team member whilst performing points machine maintenance caught and squashed a finger between a tubular stretcher bar and sleeper causing a cut on his left hand index finger.

Workforce Safety

1 No Lost Time injuries

Works Delivery – Vegetation contractor.

The Injured Person was undertaking de-vegetation near Eastleigh ECR, he was wearing full PPE. When he got home he noticed 7 ticks on various parts of his body. He safely removed the ticks.

Ticks lurk in areas of deep vegetation and undergrowth,

They can carry the bacteria that cause Lyme's Disease.

<u>Protect yourself.</u>

* Wear protective clothing ; a long sleeved shirt and long trousers tucked into socks
* Consider using insect repellents, such as DEET-containing preparations

<u>Inspect yourself</u>

* Inspect skin frequently and remove any attached ticks. Ticks can be very small, something as tiny as a freckle, or a speck of dirt. They expand in size with the amount of blood they remove from their host.

See attached sheet for further into…..

Workforce Safety

Hot weather precautions

- Drink more water; do not wait until you are thirsty & continue drinking throughout your shift.
- Wear loose fitting light weight clothing, cover arms with long sleeved shirts.
- Use sun screen on exposed skin.
- Wear a safety helmet
- Keep out of the sun, take to shaded areas if available.

- We provide
  - Tinted Safety glasses
  - Sun screen
  - Water bottles.
- Ask your line manager .

019 update

The Technical briefings of standard NR/L2/OHS/019.

Safety of people working on or about the line

for the Outer DU, Works Delivery and other staff has three remaining sessions available to book places.

17/7/17	Basingstoke ROC	1000 - 1300
21/07/17	Basingstoke ROC	2130 - 0030
24/07/17	Basingstoke ROC	1000 - 1300

It is anticipated the 'Go-live' dates will be 23rd September for the Outer DU area and 8th December for the Inner DU area.

There are a number of activities to be progressed to support the Route including

SSOWPS Planner workshops,

Further Communications will follow to confirm more details as the Route Compliance Plan progresses.

Parking Near Level Crossings

WORKFORCE REMINDER

Vehicles Use Near Railway Lines NR Driver Handbook 2016

You should avoid parking in the immediate vicinity of a level crossing. Parking inappropriately at crossings can obscure signs and warning signals, create a distraction or obstruction for others – forcing them into the path of oncoming traffic or causing them to stop on the crossing. This could have tragic consequences.

When parking at level crossings: Use nearby car parks, lay-bys, side roads and rail compounds whenever possible. If dropping off heave and/or cumbersome equipment, consider all potential risks and keep dwell to an absolute minimum. In exceptional circumstances such as during level crossing failures or emergencies, use common sense and professional judgement.

Collision between a train and a lorry and trailer, Llanboidy Automatic Half Barrier Crossing, Wales, 19 December 2011. Causal factor - the contractors working on the line nearby had parked two of their vehicles close to the crossing partly obstructing the exit.

Why are we implementing Vehicle Speed Warning System

- **The Department for Transport reports:**
- Speeding as one of the biggest factors in fatal collisions
- Between 800 and 1000 people are killed annually in work-related road traffic accidents
- The risk of death is approximately four times higher for pedestrians hit at 40mph versus 30mph
- The Vehicle Speed Warning System is being introduced to:
  - Reduce the risks associated with driving
  - Provide a system that enables drivers to moderate their speed in real time
  - Improve the safety of our teams and members of the public whilst on the road

Take 5 for Safety

Why are we implementing the Vehicle Speed Warning System

Network Rail data reports:

- Driving is our highest workforce risk
- Between June 2013 and September 2015 at least eight colleagues have died in road accidents.
- Speed and/or seatbelt use were a factor in the majority of these.
- Since the Life Saving Rules were introduced in 2013, 306 Network Rail employees have been injured in 242 road traffic accidents

- Over 85% of the 242 RTAs occurred in 30, 40 and 50 mph zones
- The current VSMS data is showing us that we have between 2 and 5 over 20mph speeding events every day.
- The majority of these occur between 23.00hrs and 0530hrs.

Take 5 for Safety

What is the system

- *Traffilog UK Limited is a leading global provider of vehicle Telematics and associated services:*

*** Driver Data Terminal fitted to Dashboard**

*** Mapping System Inc. Speeding Visual**

Personal Driver Dashboard.

Provides information on your

- ***Speed***
- ***Braking***
- ***Cornering***

Take 5 for Safety

What is the system

- **The system:**
- Is a safety system to help us adhere to the speed limit
- It provides live data to the vehicle driver
- It will warn you both audibly and visually of your speed
- It enables you time to moderate your driving
- It provides data back to the line manager of any instances of speeding for more than 60 seconds

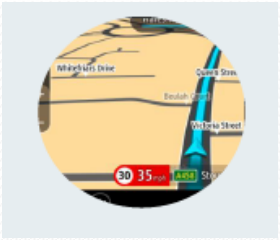
- It's about keeping you, your team and members of the public **safe.**

What happens if the speed limit is exceeded

- **The system will require the driver to speed for more than 60 seconds from the point where the vehicle first exceeded the speed limit before a report is generated and issued to your line manager.**
- To introduce the system and data use, we are phasing the speeding consequences:
- **Drivers are subject to the appropriate level of investigation as per the current Fair Culture process:**
- •An exceedance of more than 20mph over the speed limit results in a level 2 investigation
- •An exceedance of the speed limit but 20mph or less starts in a level 1 investigation

Week 1 to 4	Week 5 to 8	Week 9 > Business as Usual
>20 mph exceedance (>60 seconds)	>20 mph exceedance (>60 seconds) +10mph> to 20mph exceedance (>60 seconds)	>20 mph exceedance (>60 seconds) +10% exceedance (>60 seconds)

What are the benefits



- **Helps us to drive within the speed limit**
- Provides an audible and visual warning when the speed limit is exceeded. This gives the driver the opportunity to change their behaviour, slow down, and drive within the speed limit

- **Digital Vehicle Check**
- The digital vehicle check will replace the current paper forms. The vehicle check can be logged and sent through the portal and will log faults, as well as letting the driver know if it is still driveable

- **Sat Nav**
- Includes full TomTom navigation including map updates. The navigation has built in audible and visual speed limits

- **I.C.E Panic Button**
- When pressed, the 'In Case of Emergency' button will notify the 24/7 team in an emergency situation, allowing your location to be identified and someone to respond to the call.

HAVS Surveillance 2017/ 18

Attendance is a legal requirement

HAVS Tier 2:
Online Electronic Questionnaire

- Wessex is still in the process of verifying the list that we have received.
- Once complete, employees will receive a letter to their home address with bespoke user name and password to their questionnaire.
- This link is active for 28 days.
- Questionnaire takes a maximum of 5-10min to complete
- Line Manager's will need to provide access to a computer at work for employees to complete their online questionnaire.
- A small percentage of employees will be escalated to a Tier 3 face-to-face clinic in the same year.

SYMPTOMS OF VIBRATION WHITE FINGER

The affliction may not immediately become apparent. It can take months and sometimes years for symptoms to develop. Symptoms include:

Loss of Colour in Fingers
Decreased Sensitivity in Fingers
Tingling or Numbness in Fingers
Loss of Manual Dexterity

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

- Wessex have been working with OH Assist to ensure that the Tier 3 list is correct and up to date.
- Clinics will be held at 4x Route locations:
  Eastleigh DU; Basingstoke ROC; Woking Depot; Wimbledon Stable block
- Once employees have been booked onto a clinic, they will receive a letter in the mail informing them of their appointment.

An electronic FAQ 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 184 **close calls** have been reported on the Route.

91 % of 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:

Object falling from Roof

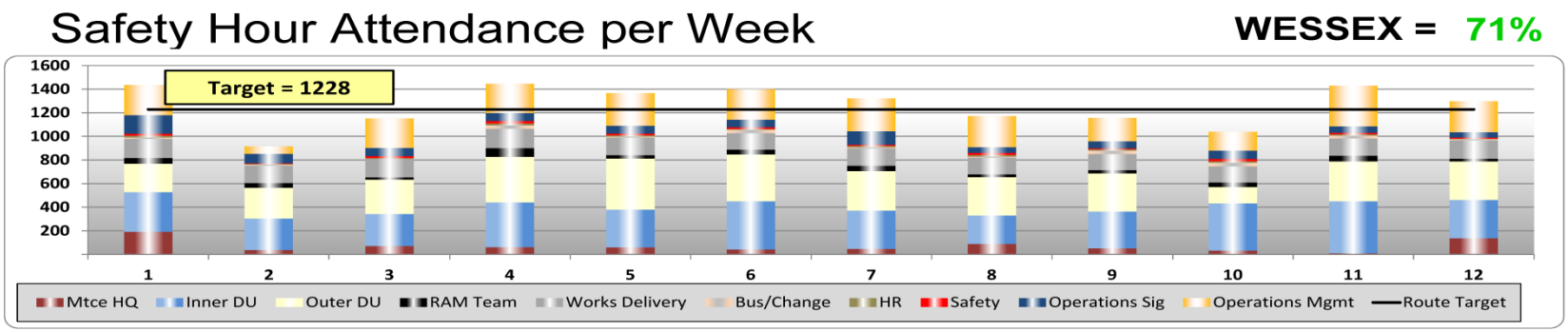
2 x 2ft rails left within the 4ft

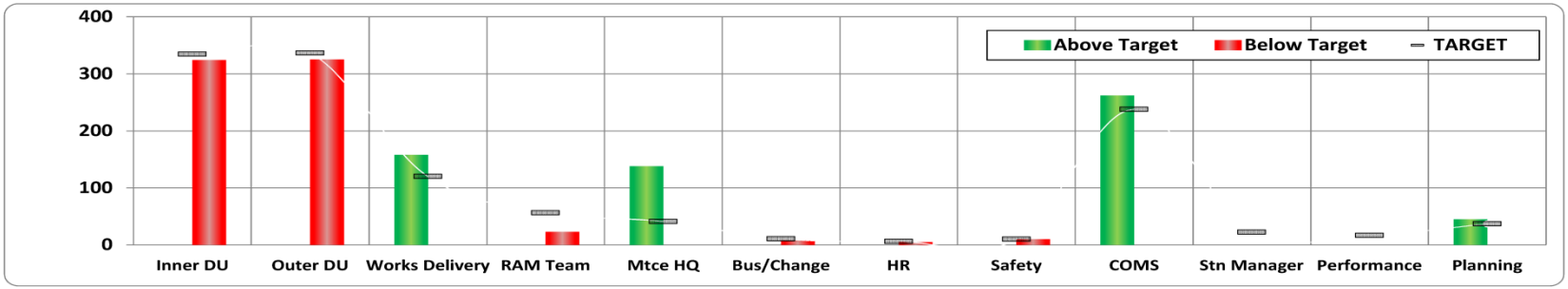
Steel shopping trolley in cess

S&T location box left unlocked and open

Safety Hour

Don’t forget to record yours next week





Week	12

	Inner DU	Outer DU	Works Delivery	RAM Teams	Mtce HQ	Business Change	HR	Safety	COMS	Stn Manager	Performance	Planning
Actual	324	325	158	23	138	8	5	10	262	0	0	45
Target	334	336	120	56	41	11	6	10	238	22	17	37
Short Fall	10	11		33		3	1	0		22	17	
%	65%	65%	88%	27%	100%	50%	56%	67%	74%	0%	0%	82%

Safety Bulletins

Safety Advice

Action required following a serious incident

everyone home safe every day

Defective hydraulic clamplock hoses

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

Ref: NRA 17/04

Date of issue: 16/06/2017

Location: Newton Abbot, Dawlish Warren and London Bridge

Contact: Colin Durrans, Principal Engineer STE S&C

Overview

The S&T teams from Newton Abbot have reported that recently installed Clamplock hoses have ballooned and burst, causing the sudden release of hydraulic fluid. The incident was reported by the Team Leader as a Close Call.

Similar failures have also been reported at Dawlish Warren and London Bridge.

Immediate action required

- All on-track teams to pay close attention to these hydraulic pipes and report any that exhibit 'ballooning' as seen on the defective ones as a precursor to total failure.
- Defective hoses should be replaced and quarantined pending return for investigation. LOT numbers, unique identifiers and install dates of each hose should be recorded with a photograph of the installed hose where possible.
- All staff must wear the correct PPE when working in and around hydraulics including eye protection.

Copies of Safety Advice are available on Safety Central.

Part of our group of Safety Bulletins

Safety Alert | Safety Bulletin | Safety Advice | Shared Learning

NR/PLANT/0200/P514 attached for full detail.

Safety Bulletins

Safety Bulletin

A serious incident has taken place

everyone home safe every day

Fatality at Trenos footpath crossing

Issued to:	**All Network Rail line managers, safety professionals and RISQS registered contractors**
Ref:	NRB 17/12
Date of issue:	23/06/2017
Location:	Trenos Footpath Level Crossing
Contact:	Amanda Mumford-Rudd, Head of Route Safety Health & Environment

Overview

On Thursday 1 June at approximately 15:50 an elderly lady was struck and fatally injured by a Cheltenham Spa to Maesteg service at Trenos Footpath crossing near Llanharran.

The driver of a preceding train saw a distressed lady on the crossing, stopped and advised her to leave the railway.

The train driver reported the incident to a signaller at the next station stop, but this was in a different GSM-R area, meaning communication was required between two signallers.

The location of the distressed lady was not clearly established resulting in subsequent trains not being warned.

The lady was struck by another train before a caution had been applied at Trenos crossing.

Discussion Points

While we are investigating the incident please discuss the following with your team.

- What steps can we take to report incidents on our infrastructure immediately?
- How can we improve the accuracy with which we identify the location of an incident?
- How can we improve communication and understanding between staff particularly when messages are relayed between a number of parties?
- What actions could we take to clarify the content of these messages?

Copies of Safety Bulletins are available on Safety Central

Part of our group of Safety Bulletins

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Safety Bulletin

Shared Learning

The Thameslink Programme

Issue Date: 15th March 2017 – For further info contact mike.netherton@networkrail.co.uk

Issue Number: TLP 072 **Title: Unclear Substation Isolation Arrangements**

Overview of Event:

On 15th December 2016 a team of electrical engineers undertaking works on low voltage (LV) equipment, during a planned HV Outage, at Lewisham Sub-Station. Whilst working they were alerted by Network Rail Maintenance that the transformer being worked on was still "live" as the residual energy had not been discharged when the supply was isolated. They were within 500mm of a Bus Bar holding the residual voltage.

Works were immediately stopped - Lewisham Electrical Control Room (ECR), Network Rail E&P Maintainer & Network Rail Project Staff were notified of the occurrence. An assessment of the potential risks from electrocution was made and works resumed, with only the Senior Electrician in a controlled environment undertaking the works, with direct supervision from Network Rail Maintainer holding Level A competence.

Underlying Causes:

- There was no HV (high voltage) assessment for the working environment
- There was a lack of pre-construction information provided for the works
- The NR Standard was not strictly followed and was vague around LV works in HV areas
- Isolation Forms gave no information about competent resources
- The WPP (Work Package Plan) was generic and not specific for the work, location and safety controls required
- Communication & briefing was poor by the contractor and NR Level A, particularly around working restrictions and the use of equipment
- Supervision and competency arrangements were not clearly documented/defined
- The Isolation process for the contractor's work was not clear
- Co-ordination overall was inadequate including the CDM arrangements

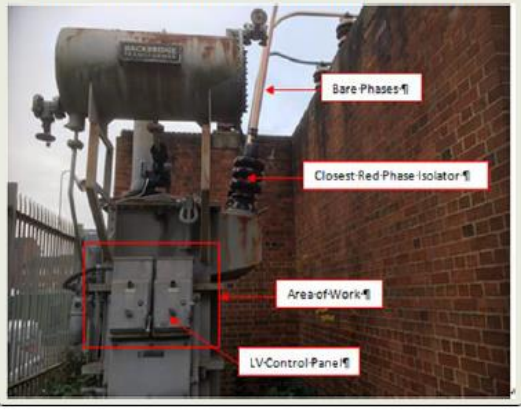
General Key Messages:

- The request process for HV shutdowns must be robust and communicated appropriately at all levels
- The limits of the HV permits must be communicated and understood by all personnel working within the area where a shut-down takes place
- The required level of competence to undertake specific roles must be appropriate to low or high voltage works including HV shutdowns
- Work Package Plans and Task Briefing sheets should be specifically detailed for work being carried out
- Principal Contractors processes should be robust and clear in coordination and planning of contractors work

Actions Taken As a Result of Investigation:

- NR Standard NR/L3/ELP/21067 to be expanded to cover instances where work is carried out on low voltage panels within high voltage compounds or raft sites
- The project management team to develop a written process for isolation planning
- Greater understanding of the need for HV assessments and parties responsible for provision
- Implement a detailed request form when utilising NR maintenance Level A/B/Competent person services
- More robust Principal Contractor involvement in planning contractors work
- Improvement in the project management support structures at contractor level to manage LV activities including the provision of work/site specific Work Package Plans and Task Briefing Sheets
- NR maintenance to challenge working parties have the correct level of competence
- NR Maintenance to review works undertaken by 3rd parties within substations and where possible assist with HV assesments

Work Area Within Lewisham Sub-Station



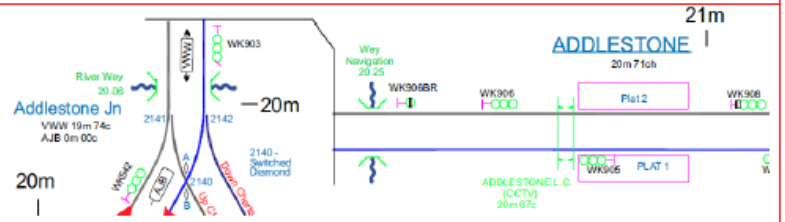
Operations Alert

Immediately Transferable Lessons from A Line Blockage Irregularity At Addlestone

Information for Signallers and Front Line Operational Staff

On the 24th May 2017 a line blockage had been booked GZAC number 5321705 on the up and down Chertsey lines between the limits; Down Chertsey WK905 signal to WK2142 points, Up Chertsey WK2141 points to WK908 signal. The signaller granted signal protection at 10:09 hours, at this time 2S26 was still within section on the Up Chertsey line approaching WK908 signal, the signaller thought that the train was clear of the section as he believed the exit signal to be WK906.

Incident Date: 24th May 2017



Reasons incidents occurred:

The signaller granted the line blockage without first making sure the section of line to be blocked was clear of trains.

The signaller believed the limits of the line blockage were up to WK906 signal when in fact the limits were to WK908 signal.

Transferable lessons where appropriate:

- Ensure that you are fully aware of the limits of the line/lines to be blocked.
- Ensure that you confirm the location of the work.
- What can you do to proactively control and prioritise your workload?

Produced: 6th June 2017	**Date posted: 13th June 2017**
Huw Margetts – Operations Manager Wessex Inner	*Display for 12 weeks from above date.*

Immediately Transferable Lessons from level crossing incidents

Information for Signallers and Front Line Operational Staff

On Friday 9th June, at approximately 09:58, the Signaller operating panel 5 at Wimbledon ASC initiated the lowering sequence at White Hart Lane CCTV level crossing for the passage of 2U22 which was approaching the crossing on the Up line. During the lowering sequence a member of the public entered the crossing limits and then stood by the pedestal for the up side facing boom, the Signaller then operated the crossing clear button with the member of the public within the crossing limits.

The Signaller immediately realised that the member of the public was within the crossing limits and made an urgent call to the driver of 2U22 who stopped his train before passing the protecting signal for the crossing. The protecting signal was replaced to danger and the barriers were raised following a timeout of the interlocking, to allow the member of the public to exit the crossing limits.

Reason Incident Occurred:

- The Signaller did not monitor the lowering sequence of the crossing and failed to observe the member of the public standing within the crossing limits.
- The Signaller operated the crossing clear button with a member of the public within the limits of the crossing.

Points to Consider:

- Do you have a "scanning strategy" for each CCTV level crossing on your area of control?
- Do you carry out a suitable "figure of eight" check that covers the whole of the crossing area?
- 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:	**12/06/17**	**Date Posted:**	**12/06/17**
		Post For:	*12 Weeks*

Published Investigations

During Period 03 2017/18

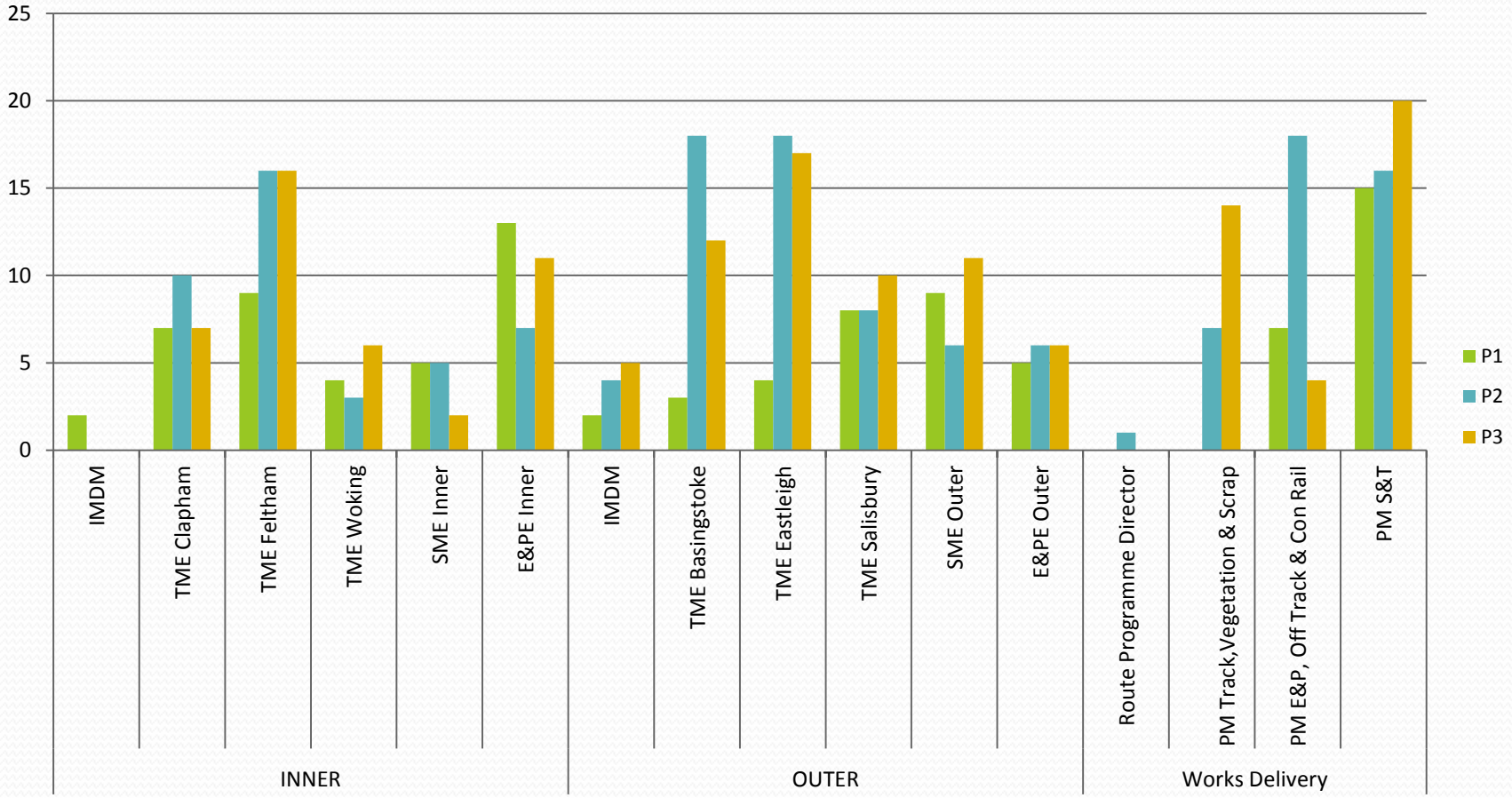
steve.cory@network rail.co.uk

Area	Date of incident	Level	Description	Lead Investigator	DCP	Published	Actions	Recs
Ops Inner	07/12/16	3	Liss - Line Blockage irregularity with a train in section (25 weeks) SMIS QSE/2016/DEC/269	Kerry Edmonds	Giles Baxter	06/06/17	3x Closed 4x Open	None
IP	07/04/17	2	Ascot – Near Miss with Osborne staff (10 weeks) SMIS: 26792	Chris Darlow (Osborne) / Keith Midwinter (Network Rail)	Stephen Webber	20/06/17	5x Closed 5x Open	4x Open

Fair Culture Panel Review

Event	Immediate Cause	Underlying Cause	Investigation outcome	FCP view	FCP comment
P09 1617 071216 Liss Line Blockage irregularity with train in section - Level 3	A signaller granted a line blockage with a train still within the line blockage limits causing a Near Miss.	The signaller ; • failed to contact the signal-box in advance to confirm the line to be blocked was clear of trains. • had a lapse in concentration and overlooked the presence of 2P19 within the line blockage limits; this was in part due to the train no longer indicated on the Hazelmere signalling panel. The Safety Comms between the Signaller and COSS did not reach a clear understanding - neither party clearly identified the line blockage limit arrangements. However; the COSS clearly stated to the Petersfield signaller that they were working at Liss station. Whilst working at Liss station, the staff could have been adequately protected entirely from Petersfield signal box using PF229 with a reliable replacement switch. This was not known about or considered . *The Rule Book (TS1 13.2.3 Blocking the Line) is not explicit on this issue: it implies that the signaller who controls the site of work should agree the arrangements for the line blockage. This is not reflected within the Rule Book HB 8 or Safe System of Work arrangements and therefore leads the COSS to call the signaller with the protecting signal.*	Slip / Lapse	Slip / Lapse	The Panel agreed with the Lead Investigator.

SSOWP and On site Inspections P1, 2 & 3



Appreciation Section