Wessex Route

Plan & Deliver SAFE WORK

NetworkRail

Inner Delivery begin briefing and organising to go live on 9th December

Works Delivery with one or two exceptions go live on 23rd September

OUTER DU & Route Departments including PMG go live on 23rd September

Health, Safety and Environment
Period Cascade for P6. 2017/18

Welcome

Welcome to your Health, Safety and Environment Cascade for Period 6 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
- Take 5 for Personal Safety
- Staff Winter Preparedness
- 019/PDSW update
- Safety Bulletins
- Operational Alerts
- Close Calls & Safety Hour
- Investigations
- Appreciation

Wessex Safety Calendar

Wessex Safety Calendar

Aug/Sep

2017

Period 6

SUN	MON	TUE	WED	THU	FRI	SAT
20 Week 21	21	22 LTI	23	24 NLT	25	26
27 NLT	28 LTI	29 LTI	30	31	01	02
NLT 03 Week 23	04 LTI	05	06	07	LTI X 1 08 NLT x 1	09
10 Week 24	11	12	13 NLT	14 NLT	15 NLT	16

Key:

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

Workforce Safety

Advanced Lookout struck by train

See Safety Bulletin on slide 15 for further information

On 22nd August at 1205hrs an Advanced Lookout providing protection was struck by a SWR Train travelling on the Down Slow between Wimbledon West and Raynes Park at approximately 45mph. The Trackman who was walking in the Down Cess suffered an injury to his right elbow requiring 6 stitches.

Discussion points;

- Is it possible to plan more work in Protection (Green zone) and less in Warning (Red zone) systems?
- Are there alternative ways of doing some of our activities?
- Are there any areas you know that should be reviewed for suitability for walking or working?
- Contact your Line Manager or Safety Advisor to discuss.

Workforce Safety

4 Lost Time injuries to feet and ankles

- 28th August: an S&T Operative sustained sprain injury to his ankle when he tripped on vegetation on the infrastructure. *Slip Trip Fall (Inner)*
- 29th August: an S&T Technician sustained a fractured bone in his foot when, whilst clearing a pathway of vegetation his foot became trapped when he fell down a hole hidden by vegetation. *Slip Trip Fall (Outer)*
- 4th September: a P-way Tem leader sustained severe bruising to his left foot when whilst manually handling sleepers from the top of a stack, one sleeper situated underneath slipped from the stack and dropped onto the IPs foot. *Manual handling (Outer)*
- 8th September: A storeman sustained a fractured bone in his foot when, whilst using a bar to re-drum cable in the store the bar fell and struck his foot with some degree of force. *Use of tools and equipment. (Outer)*

Workforce Safety

No Lost Time injuries

* 24th August; IP sustained bruising to his stomach when he tripped and fell whilst walking in the Cess. *Slip Trip Fall (Inner)*
* 27th August: IP sustained minor injury graze when, whilst working at height under the arches at Waterloo a section of timber fell and struck his arm. *Contact with falling object (B&C)*
* 3rd September : IP was using a small angle grinder when the disc touched his knuckle and caused cut injury. *Use of Tools and Equipment (Inner)*
* 8th September : IP was stung several times by a wasp when the insect became trapped in his clothing. *(Inner)*
* 13th September: IP was the driver of a vehicle when another vehicle pulled out in front of him, His knee struck the dashboard of the NR vehicle upon impact. *Slow Speed Road Traffic Accident (Inner)*
* 14th September: IP sustained pain to his left ankle when he stepped awkwardly from a platform on to ballast. *Slip Trip Fall (Works Delivery)*

Take Five

For personal safety

Take 5 to:
Overgrown vegetation – clear &/or report badly overgrown locations

Take 5 to:
Plan the next move

Take 5 to:
Use Risk Based Commentary to warn others of hazards you notice

Take 5 to:
Close Call those particularly bad areas of underfoot conditions.

Take 5 to:
Give someone a hand.

Take 5 to:
Get the right PPE, tool or help.

Take 5 to:
Brief that little bit extra.

Take 5 to:
Report all accidents when they happen

Workforce Safety

Staff Winter Preparedness

Are you prepared – personal kit check.

1. Sufficient good condition PPE -Enough layers? Waterproof/Clean Hi-Viz external layer
2. Safety Boots - Good condition/no leaks/plenty of grip/ good laces
3. Personal Headlamp Lighting – new bulbs & batteries
4. Gloves – warm & waterproof, fit for purpose.
5. Task Related PPE – do you know what it is? see the TRCS and order to replace worn equipment.

The PPE catalogue is 'on line' and should be available in the depot.

Workforce Safety

Overview

019
Safety of people at work on or near the line

Go Live 23rd September:

Outer DU, Works Delivery, Possession Management Group, Route Based Teams & Contractors.

Go live means;

- There is a 'person in charge' with a Safe Work Pack.
- The person in charge has supported the planner in the creation of the SWP.
- The SWP has been verified and authorised at least a shift in advance of the work.
- The significant risks and controls have been thought about and planned for.

See Top Ten Tips Information guide

Overview

019
Safety of people at work on or near the line

Go Live 9th December:

Inner DU.

Next Steps;

- 019 L2 briefs to all COSS/IWA/Responsible Managers and Planners,
- SSOWPS 2.5 workshops for all SSOWPS Planners,
- Risk and control planning for access,
- Switching to 2.5 to create Safe Work Packs.

See Transition Plan

Safety Bulletins

Close call involving Conductor Rail short circuit

Overview

A close call was raised recently when a member of staff was applying a Vortok conductor rail shield sideways, the shield disturbed the ballast and in doing so forced a stray piece of otherwise hidden wire buried in the ballast into contact with the live conductor rail, resulting in some arcing.

The correct method to apply a conductor rail shield is to fit it from above. However the close call highlighted that staff have been fitting shields from the side. The horizontal application was included as an option in the PTS DCCR training material.

The PTS DCCR training is to be amended to make it clear that fitment of the shield is only from above as this removes the issue of potentially pushing stray metal onto the live rail.

Immediate action required

- Staff using conductor rail shields should only ever fit the yellow Vortok conductor rail shield from above the rail.
- All staff involved in training that includes the use of conductor rail shields, including PTS DCCR, should immediately amend the training course content to remove references to horizontal application.

Copies of Safety Advice are available on Safety Central.

Safety Bulletins

Manual Handling of a Frog Grinder

Overview

A five person team carried an MC3 'Frog' grinder through London Waterloo station on 9 August 2017 to get it onto the track. Three members of the team were left to lower the machine from the platform onto the track.

Two members of staff were positioned on the track, while the third member of the team remained on the platform, lowering the machine down to them. The machine dropped faster than expected and trapped one person's hand between the grinder handle and the platform.

The member of staff suffered a deep cut to his finger and realising that the injury was significant, went straight to St. Thomas's hospital so that his injuries could be cleaned, X-rayed and stitched.

An MC3 grinder weighs around 110kg and after a previous Prohibition Notice in Wales Route was the subject of an earlier Safety Advice (NRA 16/02 issued February 2016) which requires safer ways to move them and, if manual lifting was unavoidable, a minimum of four people.

This injury in Wessex is the second in just three months while handling an MC3 grinder with too few people. In May another worker was injured in LNE Route while unloading one from a vehicle.

Early investigation showed the workers at Waterloo had not prepared thoroughly for their task, including by swiping-in to Sentinel. One person had not swiped-in since April.

Discussion Points

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

- Did the earlier Safety Advice get briefed to all of your teams?
- Do you truly explore mechanical solutions, to prevent the need for manual handling?
- Lowering a load from a vehicle to the ground or from a platform to the track is higher risk. How can you reduce that risk?
- What line management checks do you undertake to know that teams comply with safety measures?
- Are we ALWAYS swiping in via Sentinel? It must be every time we go on track.

.Copies of Safety Bulletins are available on Safety Central

NRA 16/02 Issued February 2016 on next slide.

Safety Bulletin

NRA 16/02 Frog Grinder

Manual handling of turnout (frog) rail grinder

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

Ref: NRA 16/02

Date of issue: 04/02/2016

Location: Cardiff Delivery Unit

Contact: Ron Murray, Workforce Health Safety & Environment Advisor

Overview

ORR has issued a Prohibition Notice preventing the Geismar MC3 Turnout Grinder from being lifted and carried by two people.

The machine weighs 110 kg.

The prohibition does not prevent use of the machine or it being moved by two people in rail mounted mode.

A specific risk assessment is being carried out by a small team including expertise from Trade Unions and our Ergonomics team.

The results of this risk assessment will be communicated separately and any modifications required to the machine will be discussed with the manufacturer.

Immediate action required

- Manual handling of the MC3 Turnout Grinder is prohibited with immediate effect unless four or more staff are conducting the lift.
- Even with a bigger lift team, use of the grinder must be planned to consider the hierarchy in the Manual Handling Operations Regulations:

1. avoid manual handling operations so far as is reasonably practicable; use mechanical lifting aids such as a vehicle tail lift and avoid carrying long distances;
2. assess any manual handling operations that cannot be avoided; and
3. reduce the risk of injury so far as is reasonably practicable.

Where a four person manual lift is the only option it must be noted that at present the grinder is not specifically designed for four person lifting so good team lifting techniques will be required.

Consider how the principles set out above apply to other moveable plant such as generators, other grinders and fishplate wrenches that are all heavy items of plant. A useful list is found here.

Your local workforce safety advisor or safety specialist can help you plan this work safely.

Safety Bulletins

Lookout Struck by a Train

Overview

At approximately 12:05 on the 22 August, an advanced lookout was struck by a South Western Railways passenger train. The lookout sustained cuts and bruises to his elbow, which required stitches.

The advanced lookout was part of a three man track patrolling team and was providing advanced warning from the down cess to the patroller who was inspecting the up fast and up slow line, accompanied by his site lookout.

The advanced lookout was ahead of his colleagues, positioned in the down cess on a curve, in order to provide the required warning time to the team. He was standing on the raised ballast shoulder.

One train was passing on the down fast line when a second train approached the advanced lookout on the down slow line at approximately 45mph. That train struck the advanced lookout's right elbow. He was facing the other way as it approached.

When trains passed on either of the down lines, the lookout's view of any trains on the Up lines was compromised.

A lookout was fatally injured in similar circumstances at Leeds in 2009.

Discussion Points

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

- How do you maintain awareness of all trains, particularly when focusing on a specific task like looking out in one direction?
- How does the lookout make sure they are in a position of safety while performing their duties?
- How can site conditions such as vegetation impact upon or change the safe system of work in practice?
- How should planners, responsible managers and trackworkers assess whether an area is suitable for working under lookout protection?

.Copies of Safety Bulletins are available on Safety Central

Safety Bulletins

Collision within Possessions

Collisions within possessions

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

Ref: NRA 17/07

Date of issue: 01/09/2017

Location: Logan, East Ayrshire

Contact: Paul Ashton, Professional Head of Operations

Overview

There has been a number of high profile collisions in possessions in recent years. The RAIB issued an Urgent Safety Advice following the incident at Logan on 1 August 2015, which advised that Network Rail and industry partners should work together to reduce collision risk in possessions.

A cross industry group was formulated, which has already made a number of improvements in managing the risk. This Safety Advice is specific to one part of the overall package of changes.

Two recurring significant causes of these incidents has been sub-standard communications and inappropriate speed control of the train.

Sub-standard instructions contributed to drivers incorrectly assuming the line ahead was clear to a specific point and that up to 40mph was a safe speed to travel.

Rule Book Module T3 and Handbooks 9, 11, 12 and 15 are being updated in December 2017, when the maximum permitted speed in possessions is reduced from 40mph to 25mph.

A complete brief, including audio on these Rule Book and Hand Book changes has been added to Safety Central with the title Possession Speed Changes Brief.

A link on this safety advice notice takes you to a briefing film that must be received and recorded on Sentinel by 15th January 2017

Immediate action required

- All staff who are involved in planning and delivering work within possessions must receive this brief.
- All those with ES/SWL or PICOP competencies must record receiving this brief as a Competence Management Event in Sentinel. Instructions on how to do this are contained within the briefing materials.
- This briefing should be delivered by the most appropriate means, whether this is part of any annual Rule Book update brief, annual capability conversation, safety hour discussion, etc..
- Any ES/SWL or PICOP who has not had the briefing recorded in Sentinel by 15 January 2018 will have their ES/SWL and/or PICOP competence temporarily suspended, until such times the briefing is recorded.

Copies of Safety Advice are available on Safety Central.

Operations Notices

Immediately Transferable Lessons following an incident of Irregular Working when Passing a Signal at Danger

Information for Signallers and Front Line Operational Staff

On Thursday 24th August, a track circuit failure between Gillingham and Tisbury showed occupied when clear maintaining SE4672 signal at danger on the Up Exeter line at Gillingham Station, this also caused a block failure between Tisbury and Gillingham, Modified Block Working was introduced for the first train 1L09.

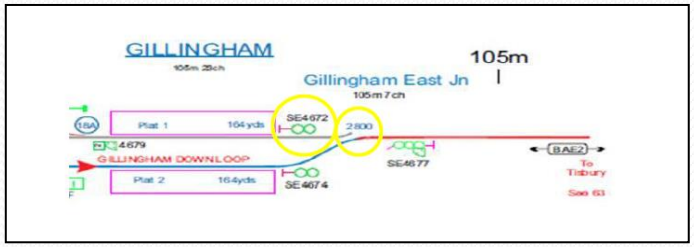
The signaller operating Salisbury panel examined the line in the Down direction with 1L09, the driver reported that the line was clear and safe for the passage of trains.

At approximately 08:27, the Basingstoke WoE signaller authorised the driver of 1L26 past SE4672 signal at danger, the Direction of Flow indication was set for movements in the Up direction. Shortly afterwards the signaller contacted the driver of 1L26 to report that the route had not been set correctly for the movement.

The signaller confirmed that the driver and train were fit to continue and authorised the driver to continue on to the single line, the driver reported to the signaller that they had felt a jolt and it was realised that SE2800 points had been run through.

The incident was immediately reported to Wessex Integrated Control Centre and the signaller removed from duty to allow a full investigation.

When interviewed the signaller confirmed that the associated route card had not been utilised to set the route from SE4672.



Reason Incident Occurred:

- The Signaller failed to use the Route Card provided to set the route, they assumed the route was set correctly without checking.
- The Signaller failed to have the route checked by other signallers on duty at Basingstoke ASC

Points to Consider:

- Do you know what conditions must be satisfied as per Rule Book module S5 before authorising a driver passed a signal at danger?
- Do you set the route as per the instructions on the associated Route Card?
- Where practical, do you get the route checked?
- Do you give yourself suitable time to plan and prioritise during late running or degraded working?
- Do you take 5 for Safety?

Date Produced:	**30/08/17**	**Date Posted:**	**31/08/17**

Operations Notices

Date issued: 22/08/2017 **Safety Alert: Kent Ops 08**

Safety Alert
Life Saving Rules – Test before Touch

Description of the event:

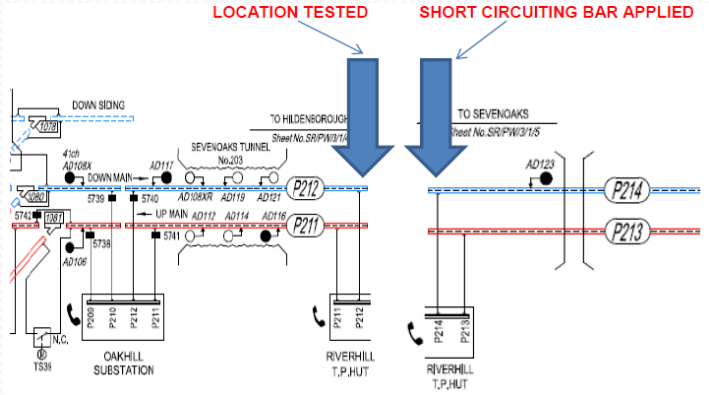
On the 16th August 2017 a MOM was asked to investigate an electrical tripping in Sevenoaks Tunnel. The MOM attended with ETM and a line blockage was taken on the up and down lines. The MOM entered the tunnel from the London end with 2 members of the ETM team, whilst a 3rd ETM team member drove the van to the country end of the tunnel.

Approximately halfway in the tunnel, the team found a speed board wedged between the running rail and the conductor rail. They continued through the tunnel looking for other potential causes of trippings, none were found.

After exiting the tunnel at the country end, the speed board was reported to control and the MOM requested a Temporary Isolation to facilitate its removal. A Safe System of Work was agreed between the MOM, ECRO, Signaller and KICC and the MOM acted as the PICTI. The agreed limits of the isolation were from Oakhill Sub Station to Riverhill TP Hut, electrical section P212.

The MOM did not have any equipment as the response van was at the London end of Sevenoaks Tunnel, but the ETM team had theirs' so it was agreed this would be used. The MOM tested the conductor rail with a Seward Live Line Tester to confirm the 3rd rail was dead but subsequently realised he didn't have a short circuiting bar so he returned to the van to get one. When he returned to site and applied the bar, the traction current was found to be live.

The MOM realised he had moved along the track and had placed the short circuiting bar in the adjacent electrical section, which was live. He had not returned to the location where he had tested. There was no ambient lighting at the location and the team were working by torch light.



Immediate Learning Points:

- The MOM believed he couldn't take an emergency isolation to remove the obstruction to make the line safe. Use of an emergency switch off to remove an object and make the line safe is acceptable.
- The team did not carry any equipment into the tunnel with them, such as St Crids, gauntlets, hook switch pole and GSM-R handheld radio.
- The MOM returned to the van to collect a short circuiting bar in between testing the conductor rail and applying the bar.
- The team on site were focused on the time, 03:00 hrs, the fact it would take 90 minutes to walk to the site of the obstruction and back, and that they may impact on start of service.

Actions to prevent similar incidents:

When taking a Temporary Isolation:

- Do you ALWAYS look for section gaps or breaks in the conductor rail?
- ALWAYS apply your short circuiting bar immediately after testing.
- When using multiple bars, ALWAYS test multiple times.
- NEVER allow yourself to become distracted, if a phone call, other task, environmental or other reason means you have become distracted or need to move location ALWAYS TEST AGAIN.

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

74 % of close calls have been closed within 90 days.

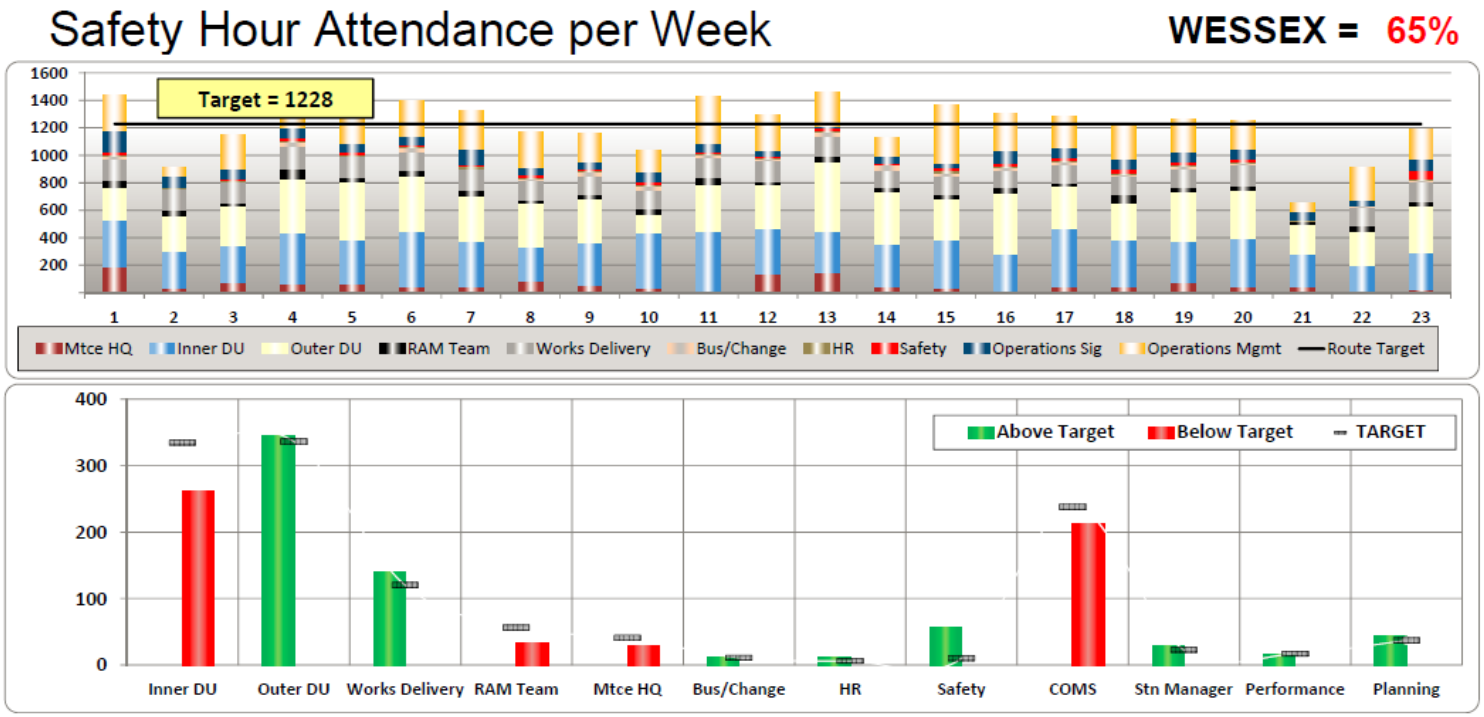
Can you make the situation safe?

Remember, **if it is safe to do so**, deal with the close call and then report it. For example:

No RRV exclusion zone	**Insufficient site lighting**
Missing catchpit lid	**Access Gate not padlocked**

Safety Hour

Don’t forget to record yours next week



Week	23

	Inner DU	Outer DU	Works Delivery	RAM Teams	Mtce HQ	Business Change	HR	Safety	COMS	Stn Manager	Performance	Planning
Actual	261	346	140	34	28	12	11	57	212	29	17	44
Target	334	336	120	56	41	11	6	10	238	22	17	37
Short Fall	73			22	13				26			
%	52%	69%	78%	40%	46%	75%	100%	100%	60%	88%	68%	80%

Published Investigations

During Period 06/ 2017/18

steve.cory@network rail.co.uk

Department	Date	Level	Description	Lead Investigator	DCP	Published	Actions	Recs
Mnt Inner	17/01/17	2	Epsom - Near Miss with IWA and 2D27 (33 weeks) SMIS: QSE/2017/JAN/565 -- Including Raynes Park Near Miss on 26/04/17	Steven Edwards	Andrew Malcolm	08/09/17	6x Closed 5x Open	None

Appreciation Section

- Adrian Breslin: All round top man, Inner DU.

  Whilst scoping other work at Clapham Junction, noticed a cracked rail (defect) on the Down Main Fast and arranged for a Emergency Speed Restriction.

- Mark Johnson: Signal Section Manager, Outer DU.

  For dogged determination, engagement and feedback on the subject of mapping VSWS.