Health, Safety and Environment Period Cascade for P01 2019/20

Wessex Route

Content

Welcome to your Health, Safety and Environmental Cascade for Period 01 2019/20. Please discuss and share the items that are relevant to your teams and display any relevant Safety Bulletins or Lessons Learnt on your notice boards.

- Significant Workforce Events
- Near Miss at Woking Jn
- Near Miss at New Covent Garden Market
- The Importance of Supervision
- Near Miss at Sundon (LNE)
- Near Miss - Line Blockage (Western Works Delivery)
- Significant Lost Time Injury – Dislocated Knee
- Lost Time Injury – Ankle Tissue Damage
- Manual Handling
- Golden Hour Process
- Safety Bulletin – Needle Stick injury
- Plant Manual Update - Gradient Restrictions of Rail Trolleys and Rail Handlers
- Environmental Update
- Health and Wellbeing
- Diversity and Inclusion – Ramadan

Workforce Safety

Significant Events in the Period

Sun	Mon	Tue	Wed	Thu	Fri	Sat
Week 1	01	02	03	04	05	06
07 Week 2	08	09	10	11	12	13
14 Week 3	15	16	17	18	19	20
21 Week 4	22	23	24	25	26	27

	NR Staff	Contractor
Everyone Home Safe		
No Lost Time Injury	7	0
Lost Time Injury	2	1
Near Miss / Line Block	1	0
Road Traffic Accident	0	0

Slips, Trips and Falls x 4

04/04/2019 – Lookout stood on a catch pit lid which gave way. The IP fell over dislocating his knee. Unable to return to work to date LT
Discussion: How do you remain situationally aware of the hazards around you and your team?

Manual Handling x 2

11/04/2019 - The IP (LOSC Ganymede) was carrying a stressing ram down access steps at Vaggs Lane (New Milton). Reaching the last step the IP turned their ankle resulting in sprain and tissue damage LT
Discussion: Do you use the correct manual handling technique? Remember avoid, assess, review

Person interacting with tool/equipment

02/04/2019 – a strail lifter was dropped on IP's foot during a re-fitment of strail panels. This was not reported at the time as the IP was not aware of the severity of the injury LT

Near Miss

15/04/2019 – Near Miss occurred at C/E of Woking Jn. The COSS/PIC got out of the 4ft only 4 seconds before the train passed the location
Discussion: How do you remain situationally aware of the hazards around you and your team?

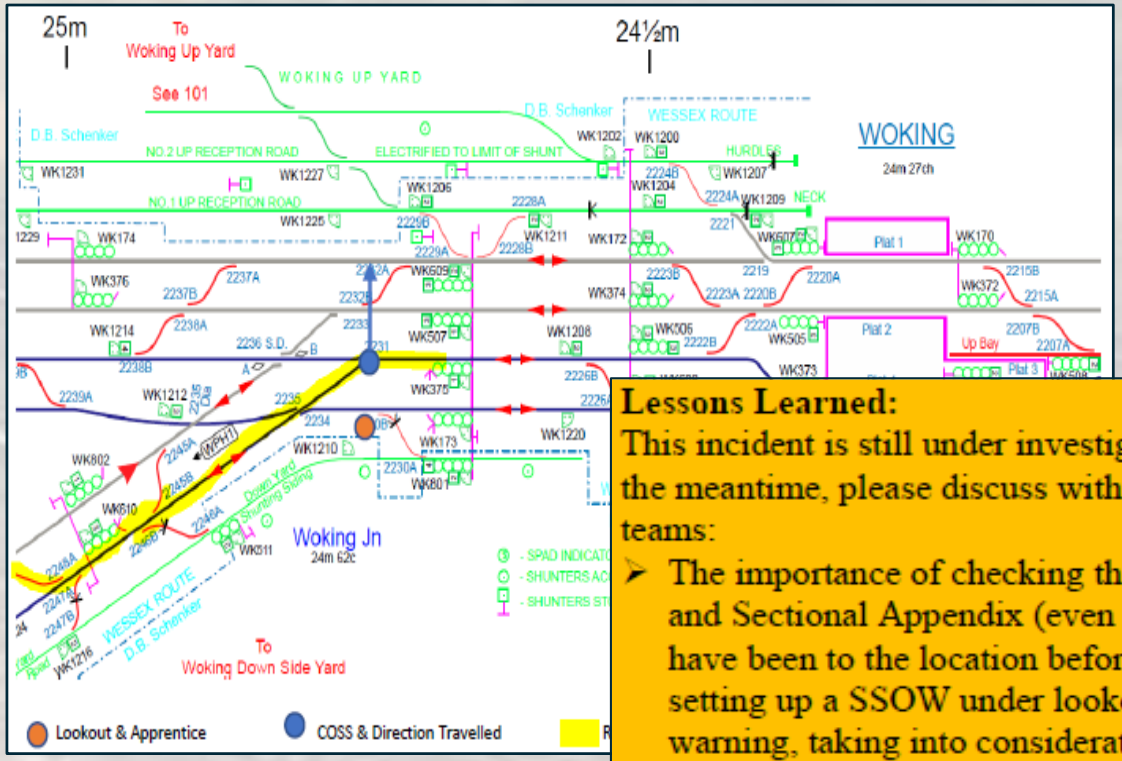
Operational Incident

Near Miss at Woking Jn

On 15th April 2019 at 11:27, during a Track Patrol of Woking Junction on the Down Fast of BLM1 at Country End of Woking Station, the Patroller /COSS was involved in **a Near Miss** with a SWR train 1P32.

This was a regular patrol and involved an experienced patroller. He had situated his lookout in a regularly used position of safety in the down cess, whilst he inspected 2231 pts. The site lookout was instructed to look out for trains moving toward the group on the Down Main and Slow. The 1P32 approached the group on the bi-directional Down Guilford line having crossed from the Up Guilford line (London bound).

The lookout noticed movement of the 1P32 toward the Patroller/COSS who made his way across the Down Main, Up Main and Up Slow to a position of safety. The 1P32 passed this location approx. 4 seconds later.



Lessons Learned:

This incident is still under investigation. In the meantime, please discuss with your teams:

- The importance of checking the SWP and Sectional Appendix (even if you have been to the location before) when setting up a SSOW under lookout warning, taking into consideration all lines where the movement of trains into the site of work can occur.
- The importance of Lookout/s having clear instruction regarding which lines and direction of travel they are looking out for.
- Tell the lookout where you want him to look and make sure sufficient sighting distance can be achieved in all directions.
- If you believe something is not safe, CHALLENGE!

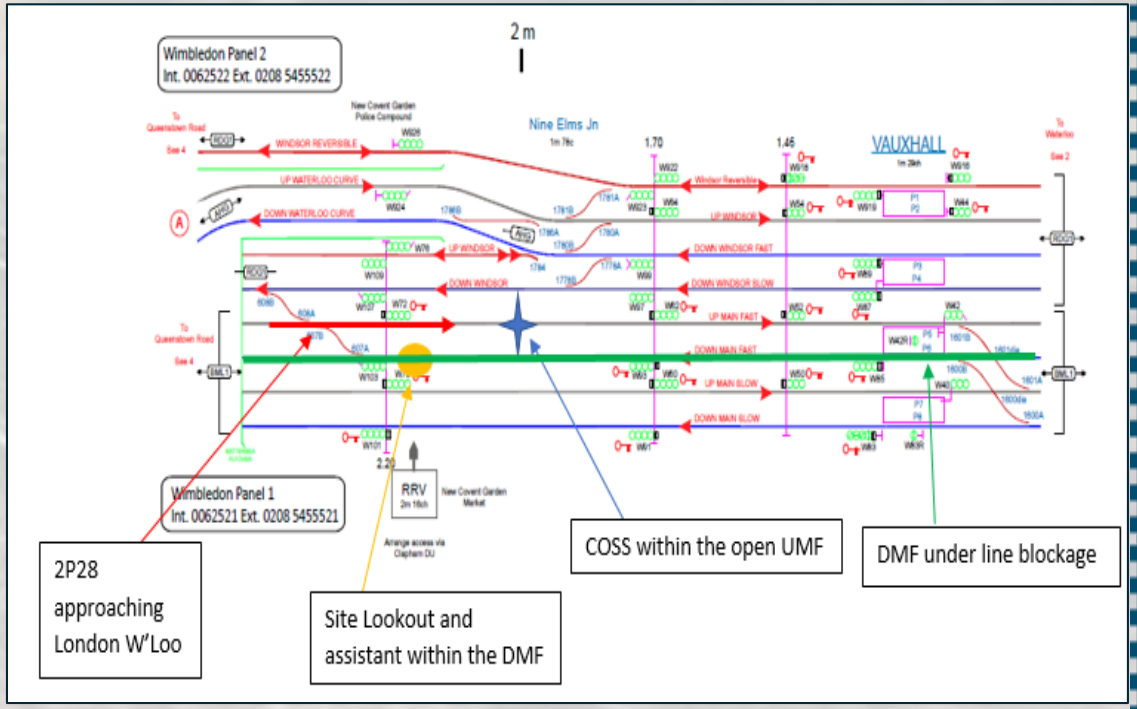
Operational Incident

Near Miss New Covent Garden Market – Period 02

On the 28th April 2019, a 3-man maintenance team based at Clapham Junction were undertaking a track inspection of the Down and Up Main Fast lines of the BML1's between 1m78ch and 2m50ch. The work was to be carried out within a Protection Controller's line blockage of the DMF.
The UMF was to be inspected under Lookout protection, using the blocked DMF as the position of safety.

The COSS/PIC instructed the Lookout and the assistant to remain at 2m14ch while he walked toward London to carry out the track inspection as far as 1m78ch.
After the COSS/PIC had completed this inspection he began to walk back toward his group on the DMF when he identified a number of dislodged Pandrol clips on the UMF.

The COSS/PIC crossed into the UMF to replace the clips and whilst undertaking this task 2P28 (Portsmouth to Waterloo) approached. The COSS did not hear the first warning from the driver. After the second warning the COSS acknowledged the driver and stepped into the POS in the blocked DMF.



Both the Near Misses are currently under investigation but the initial findings highlight the following:

- **Importance of the decisions we make every day**
- **Importance of raising concerns if something does not feel safe**
- **Importance of challenging each other to ensure we all go home safe to our loved ones every day**

The Importance of Supervision

Because when something goes wrong it is scrutinised

- The HaSAW Act requires the employer to provide ‘supervision’ for its staff including contractors ‘as far as is reasonably practicable’.
- The way we discharge this legal obligation is by Line Managers conducting either PGSIs or Senior Manager Safety Conversations.
- It is important Managers conduct PGSIs/Safety Conversations on their staff particularly when they are exposed to significant risks.
- These are the issues:
  - How do you know what your staff are doing unless you go out with them?
  - How do you prove you have done this if you do not document it? We have the PGSI App to enable us to record the visits.
  - What should you focus on, probably your departments high risk areas.
  - Some suggestions are
    - Implementation of operational risk controls
    - Manual Handling practises
    - Work where there is exposure to electrical risks
    - Exposure in a worksite to OTP and OTM

Would your ‘supervision’ regime stand up to scrutiny?

Operational Incident

Near Miss at Sundon, Bedfordshire (LNE)

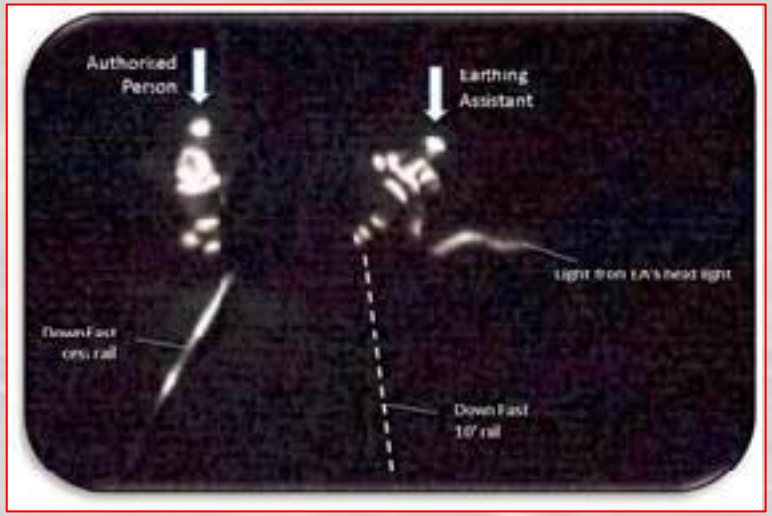
Overview

At approximately 23:50 hours on Wednesday 12th December 2018, the East Midlands Trains' 1D91 London St Pancras to Derby service approached two isolated staff who were walking back-to-traffic on the Down Fast line.

The train was travelling at 101mph, although the linespeed was 125mph. The driver of 1D91 sounded a warning horn and applied the emergency brake.

On realizing the imminent danger, one of the staff members pushed the other clear of the Down Fast and into the open Up Fast where he sustained minor injuries due to contact with the running rail.

The two staff did not get to a defined position of safety, but managed to get clear of the path of the train a fraction of a second before the train passed them.



Key message

Any person working as a COSS in an engineering worksite should ALWAYS receive a brief from the ES and sign the RT3199.

A COSS MUST NOT sign-out with an ES at the same time he/she signs in, unless the work is cancelled.

Every work group MUST have a SWP and Person in Charge.

Anyone going on or near the line should always be absolutely clear about the access, egress and protection/warning method.

Any COSS or PIC should ALWAYS have the Safe Work Pack to check and understand a minimum of a shift in advance.

Copies of Safety Advice are available on Safety Central

Underlying causes

The two workers accessed the open Down Fast line on the misunderstanding that it was the blocked Up Slow line. The pair had become disorientated, in part due to the safety brief they received being carried out at a different location on the opposite side of the railway to the point that they arrived at to access the track in their vehicles.

There were access points on opposite sides of the railway, linked by a footbridge which contributed to the misunderstanding. There were no access point information boards at either access point. Although experienced workers, the two staff had little experience on the section of line concerned.

The work group comprised of an Authorised Person (AP) and an Earthing Assistant. The AP was also fulfilling the duties of a Controller of Site Safety and Person in Charge (COSS/PIC). The AP was unclear about the role he was supposed to be carrying out.

The AP did not receive a brief on the arrangements from the Engineering Supervisor (ES). Instead the ES briefed the Nominated Person, and the Nominated Person onward briefed the information to the AP.

Consequently, the AP/COSS/PIC did not directly speak to the ES and did not sign in with him. In briefing the AP, the Nominated Person was not filling any official Rule Book role.

When the Nominated Person signed in with the ES, he also signed out to enable him to avoid going back to the ES's location once the work was finished. The shortcut had become custom and practice.

The AP/COSS's Safe Work Pack (SWP) did not detail the access point arrangements and was provided to him just 10 minutes before the planned start time.

Operational Incident

Near Miss - Line Blockage (Western Works Delivery)

On the 16th April 2019 a train passed a work group after the COSS took an approved line block with the Signaller.
The Driver did not sound the horn or report this as a Near Miss, as the 8 tonne excavator, which was being used to lift concrete blocks, was 8 meters away from the line and the 4 men team was in the cess side of the vortok fencing (separated). However this was an ALO work and the line was believed to be blocked, so the consequences could have been catastrophic.
The COSS is currently receiving counselling as he keeps replaying the incident and he has also been taken off of safety critical duties.
The voice communications were reviewed and the COSS made no Safety Critical Communication errors.


Actual location – the train above followed the train involved in the Near Miss

Please discuss with your teams:

- The importance of ensuring good Safety Critical Communications are followed at all times. Repeat back any signaller instructions and make sure a clear understanding is reached
- GERT800-HB8 Issue 7, IWA, COSS or PC blocking the line – Additional Protection should be used where possible

Trackworker Safety – Slips, Trips and Falls

Significant Lost Time Injury – dislocated knee

Incident

On the 4th April 2019 at approx. 12:02, an Off-Track team member based at Eastleigh, was working at Dunbridge (on the RTJ2) as part of the team clearing ballast from the tops of catch pits to enable future inspections.

After clearing ballast of the final catch pit, the team were ready to move over to the Up Road where the walking route was more suitable.

The IP, who was acting as a lookout, stepped onto the centre of a concrete catch pit lid which gave way underneath his right leg. This caused the IP's left knee to come down on the catch pit lid to the left of him and resulted in a knee dislocation. The IP has not been able to return to work to date.

Lessons Learnt

- Awareness of underfoot conditions
- Avoid stepping/standing on catch pit lids as they could be unstable
- Report any unsafe underfoot conditions via close call system and mark them up if possible to warn others

Please refer to the Lessons Learnt on the following link: Lessons Learnt Dislocated knee at Dunbridge 040419.pdf

Trackworker Safety – Manual Handling

Lost Time Injury - Tissue Damage

Incident

On Thursday the 11th March, in preparation for the work, a LOSC was carrying a stressing ram down a set of steps to the track at Vaggs Lane access point on the BML2.

On reaching the last step of the last tier the IP turned his ankle which resulted in a sprain and tissue damage.
The access point consists of 3 flights of stairs with landing points, which were lit by temporary lighting.
The IP had received a full site safety briefing at the start of the shift.

The individual was wearing a pair of "Rigger boots" and acknowledged he was aware this type of boots does not offer Metatarsal protection and ankle support.

The Network Rail PPE standard NR/L2/OHS/021 states: **Rigger boots do not meet the requirements for ankle protection and shall not be used.**

Boa style boots are now available on I-proc and can be ordered for your staff. These boots come with fitted metatarsal protection and some of the other benefits are:

- No laces to trip over
- Time saved putting on and taking off the boot
- Even tightening
- Quick release if the boot gets stuck

Supplier Item NR10/5

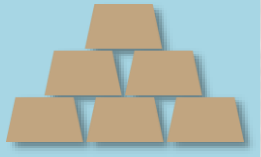
Please refer to the Lessons Learnt on the following link: **Lessons Learnt Ankle injury at Vaggs Lane 110419.pdf**

Workforce Safety – Manual Handling

Why do we have so many manual handling accidents?

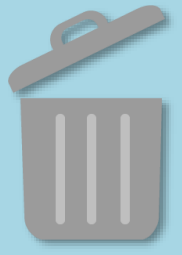
Trackside Hazards eg. vegetation

Incorrect manual handling techniques



Contents of the load

Attitudes and behaviours



Untidy worksites

Please watch the Manual Handling video that is part of the Think RISK campaign and discuss the content with your teams:
ThinkRISK_Plant_Sandiacre.mp4

Did you know that a specialised backpack has been developed (with the assistance from our route) to assist the strapping teams to carry all the necessary equipment to site safely. It is designed to carry 2 shorting cables, 2 worksite marker boards (lightweight version) and all the PPE, testing kit and paperwork for the task.

The backpack has a yoke to carry the shorting cables (preventing the need to carry them over the shoulder or roll them up in the bag). The bag is attached to the frame by magnets, so can be pre-loaded and stored away from the frame. Also, if the bag is snagged, it pulls off the frame to protect the user. The harness includes waist and chest straps to spread the load on the spine.

The backpack is available through iStore reference 0111/120776

WESSEX ROUTE - GOLDEN HOUR 2019

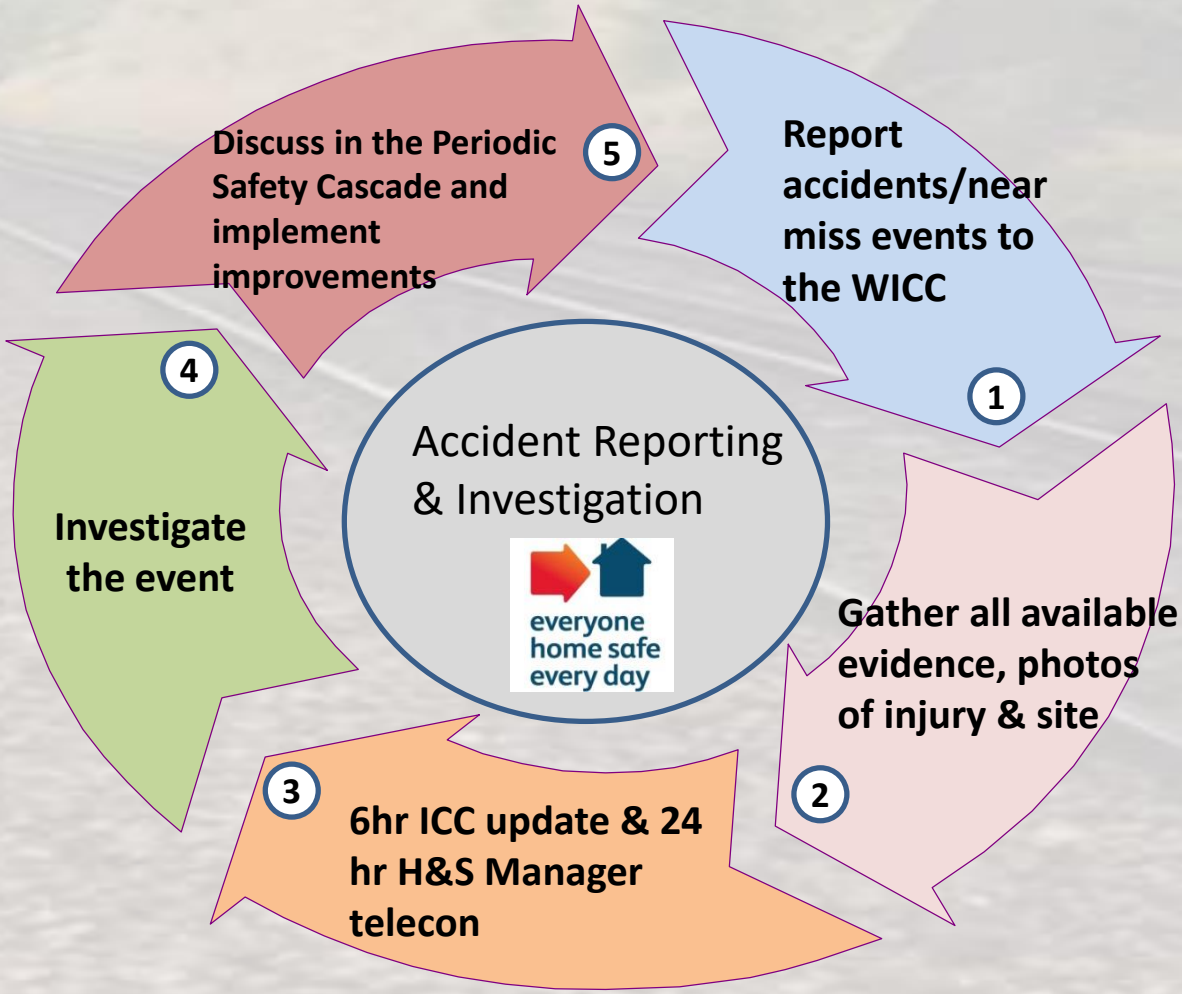
5

DCP to consolidate findings and ensure Lessons Learned document is completed; this will be submitted to the Safety Team for inclusion in the period safety cascade. Responsible manager to discuss with team at safety hour and implement any safety improvements recommended.

4

Lev1

Level 1 report to be completed and submitted to the DCP within 7 days. The DCP will appoint a Lead Investigator if a further investigation is necessary.



3

Responsible Manager to;

- Call ICC and provide a 6hr update
- Call into 24 hrs teleconference with the Health and Safety Manager..

1

All accidents/near miss events are reported **immediately** (or as soon as it is practicable and safe to do so) to the WICC and an initial accident form is completed by the ICC and the reporter.

2

It is vital **to gather all available evidence** as soon as it is practicable to do so. Take photos of the injury, the location where the accident occurred and of any tools/equipment that were used at the time and quarantine these so they can be examined during the investigation. Remember we are trying to understand what happened so we can prevent reoccurrence!

Key Point Card

1Hour

- Workforce accident or near miss reported to Wessex ICC
- On site Person in Charge (PiC) identified and any immediate action undertaken
- Responsible Manager appointed by Wessex ICC; liaises with PiC
- Responsible Manager will gather initial facts and secure all evidence from witnesses.
- Photographs of all injuries and site/plant involved will be taken.
- Wessex ICC issues alert to existing 'Accident Forms' distribution list

6 Hours

- Responsible Manager;
  - re-assesses of the injury severity
  - refines the care provided if necessary – consider both physical and mental wellbeing
  - provides updated event and injury details to Wessex ICC
- Wessex ICC issues control report form (NR2072R) at 6hrs

24 Hours

- Responsible Manager hands over duty of care & care plan to Line Manager who:
  - owns duty of care and confirms injury severity
  - undertakes medical referral / occupational support if necessary
  - completes Investigation Form (Level 1)
- Line Manager & WHSEA to attend Route Health and Safety Managers teleconference call to give full details and discuss progress in the 24hr update.

Safety Bulletin

Needlestick Injury (Western Route)

Needle Stick Injury

Issued to: **Western Route**

Ref: WNB1913
Date of issue: 16.04.19
Location: Trowbridge, Wiltshire
Contact: Emily Farthing- Chedzoy Workforce Health Safety and Environment Advisor

Overview

This morning (16.04.19) at 00:45 a Network Rail colleague whist attending site and unlocking an access gate padlock, came into contact with a needle stick and received a puncture wound to the palm of their hand.

It appears the needle sick has been deliberately stuck to the back of the padlock. Police have been made aware of the incident and will be provided with the object (if safe to do so). Our colleague was accompanied to hospital where they are being supported. Checks are being completed at other access points in the area and all colleagues are asked to share this alert and be vigilante on this new risk.

In the event of contact with a discarded needle, its advised the wound is allowed to gently bleed, ideally holding it under running water and seeking medical advice as soon as possible.

Always report the accident to Fault Control and arrange for removal of the needles by a competent person.

Discussion Points

While we are investigating this incident, please discuss the following with your teams:

Malicious incidents of this nature have unfortunately taken place before on our infrastructure.

- Are you and your colleagues aware of this type of risk and infection controls? (NR/GN/OHS/00150)
- Do you and your colleagues regularly check access areas and padlocks for sharps before opening?
- Are suitable gloves worn at all times to include when using padlocks?
- Any locations found to have padlock/s that have been tampered with in a similar way are to be reported immediately to Fault Control and the British Transport Police.
- Extra vigilance is required going forward as this can re-occur on any site at any time.

Infrastructure Plant Manual

Gradient Restrictions of Rail Trolleys and Rail Handlers

Runaway Incidents in CP5

NetworkRail

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

No: NRS 343

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 required:

- Before further use, all Ironmen shall have additional maintenance carried out by the maintainer. The maintenance shall follow the full maintenance requirements for brakes contained in the user guide or handbook.
- Ironmen 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 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*.

Issued by: Paul Conway, Professional Head [Plant and T&RS] paul.conway@networkrail.co.uk

Safety Bulletin

A serious incident has taken place

everyone home safe every day

Runaway of Permaquip 'B' type personnel trailer

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

Ref: NRB 17/11

Date of issue: 20/06/2017

Location: Hope, Derbyshire

Contact: Martyn Willis, Rail Plant Support Engineer LNW

Overview

During a Network Rail LNW North possession on the evening of Saturday 28 May an incident occurred involving a Permaquip Gator Road Rail Vehicle (RRV) and a 'B' type personnel trailer.

The driver had driven alone for 10 miles with the Gator and trailer from Grindleford to Cowburn tunnel. When at Cowburn tunnel he reported to the assistant section manager that the trailer brakes where sticking on and the machine was sluggish.

Subsequently, the section manager who was also the ES made a decision to send the machine and trailer to Bamford to facilitate off tracking the vehicle and trailer within the possession time. A strap was applied that disabled the trailer brakes.

During that seven mile journey, with the Gator propelling the trailer, the trailer became detached and ran away for some 1 ¼ miles within the possession before coming to a stop on a set of points. Other staff had been working at those points earlier in the shift.

Discussion Points

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

- How should the brakes on RRVs and trailers be tested during on-tracking and before uncoupling from an RRV?
- What action should you take if the brakes do not operate as expected?
- What should happen with the coupling pins and locking pins before a RRV and trailer are moved?
- When you take over the operation and control of an RRV and trailer how do you ensure the brakes are working correctly?
- If you became aware of any defective equipment being used in your work area, what would you do?

Copies of Safety Bulletins are available on Safety Central

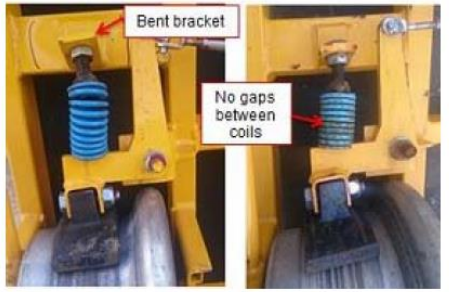
Part of our group of Safety Bulletins Safety Alert | Safety Bulletin | Safety Advice | Shared Learning

Safety Advice

Action required following a serious incident

everyone home safe every day

Safety critical failures of link trolley brakes - Issue 2



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

Ref: NRA 18/05

Date of issue: 23/05/2018

Location: Northampton

Contact: Malcolm Miles, Head of Plant

Overview

This Safety Advice is being re-issued following a review by the STE Head of Plant team to confirm the on-going actions that are required for the safe operation of this equipment.

Inspection of the link trolley fleet at Northampton Bridge Street Depot during 2015 found three out of eight units to have brake systems that had failed. Further investigation with Torrent Trackside identified evidence of other trolleys returned for maintenance with similar failures.

The right-angled bracket, which is welded to the frame and holds the brake spring in place, was bent away from the wheel. This reduces the brake force and increases the risk of runaway.

This Safety Advice was originally issued as NRA 15/06.

Gradient restrictions have been imposed on ironmen and link trolleys due to these incidents of a maximum gradient of 1 in 150.

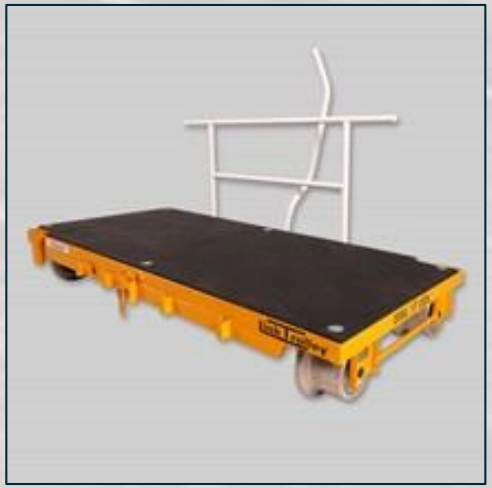
Gradient Restrictions of Rail Trolleys and Rail Handlers

Types of Rail Trolleys and Gradient Restrictions

Type A trolley is a single platform trolley that weighs 90kg and can carry a UDL of 1000kg. Can be used in gradients up to a maximum of 1 in 50 as per Handbook 10 GERT8000-HB10.

Type B trolley is in 2 parts and weighs 130kg. This has a larger loading platform than the type A trolley and can carry a UDL of 1000kg. This trolley can be used in gradients up to a maximum of 1 in 50 as per Handbook 10 GERT8000-HB10.

Link type trolley has a smaller loading area and weighs 47kg. Each link trolley can carry a UDL of 1000kg Three link trolleys can be joined together, which can carry a UDL of 2000kg. This trolley can be used in gradients up to a maximum of 1 in 150.



The gradient restriction of 1 in 150 applies to link type trolleys and manually propelled rails handlers (ironmen).

If you are planning to work in an area with a gradient greater than 1 in 100, then **control measures must be put in place to reduce the risk of runaways as per the standard NR/L2/OHS/019.**

If you require any more information, contact: Keith Penn, RPSE

mailto:keith.penn@networkrail.co.uk

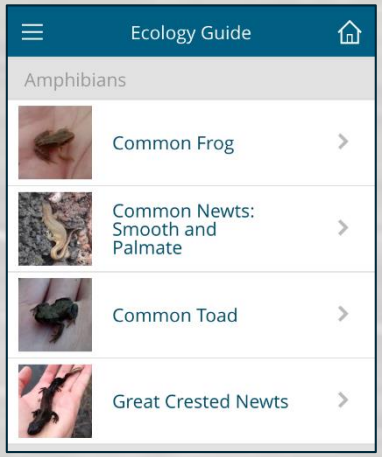
Safety Bulletins, Alerts, Advice

- Lessons Learnt Near Miss at Woking Jn 150419.pdf
- Shared-Learning-NRL19-06-Sundon-near-miss.pdf
- Lessons Learnt Dislocated knee at Dunbridge 040419.pdf
- Lessons Learnt Ankle injury at Vaggs Lane 110419.pdf
- Lessons Learnt Late Reported Foot Injury 020419.pdf
- Safety Bulletin Needle Stick Injury WNB1913.pdf
- Safety Alert Transferrable lessons ECRO error 220319.pdf
- Wessex Route Cable Theft Bulletin - Update 12APR19.pdf
- Safety-Alert-NRX19-02-Railway-security-and-safety.pdf
- NR-OPS-053 Ops Irregularity Henwick.pdf
- NR_L3_OPS_052_defective Signallers chair in TVSC.pdf
- CIRAS-Poster-2019.pdf

Species Identification Apps

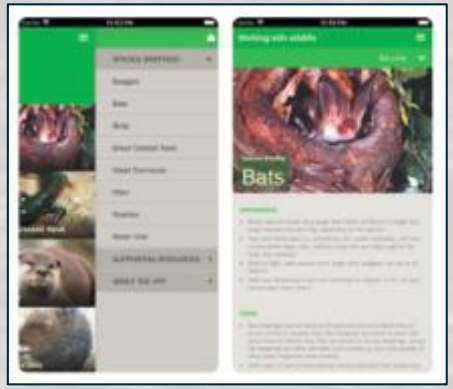
‘EcoReporter’ is a Network Rail App that contains a guide to assist the identification of key plants and animals on site.

The app can also be used to log sightings of animals and plants. This information can be used to inform future planning and management of works. Please also ensure you report any confirmed sightings to a WHSEA so that it can be added to the hazard directory and the invasive species treatment schedule when applicable.



The ‘Working With Wildlife App’ provides more in-depth practical advice on how to recognise common protected species out on site.

Further information includes why and how they are protected.



Health & Wellbeing

MENTAL HEALTH FIRST AIDER


Aaron Bever
Eastleigh DU


Alex Niblock
Salisbury Depot


Denise Hayward
Basingstoke ROC


Graham Hyde
Clapham Depot


Ivan Brown
Feltham Depot


John Williams
Bournemouth Depot


Kodjo Fosu-Mensah
Clapham DU


Meg Warren
Basingstoke ROC


Natalie Barritt
Basingstoke ROC


Peter Kinsella
Clapham DU


Riktesh Oochit
Waterloo

Course:	Date:	Time:	Room:	Location:	Booking Link:
Mental Health First Aid (Half Day Awareness)	03/05/19	09:00 – 13:00	Training Room 4 & 5	Basingstoke ROC	https://www.eventbrite.co.uk/e/mental-health-first-aid-awareness-tickets-59954811455
Mental Health First Aid (Half Day Awareness)	05/06/19	09:00 – 13:00	Training Room 4 & 5	Basingstoke ROC	https://www.eventbrite.co.uk/e/mental-health-first-aid-awareness-tickets-59955329003
Mental Health First Aid (Half Day Awareness)	10/09/19	09:00 – 13:00	Training Room 4 & 5	Basingstoke ROC	https://www.eventbrite.co.uk/e/mental-health-first-aid-awareness-tickets-59955414258

Health & Wellbeing

ACTION CALENDAR: MEANINGFUL MAY 2019

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
"We can change the world" ~ Nelson Mandela		1 Do something meaningful for someone you really care about	2 Share photos of 3 things you find meaningful or memorable today	3 Take interest in people who are older, younger or different to you	4 Get outside. Look at the sky & feel connected to the natural world	5 Choose one of your life goals and take a step towards it
6 What are your most important values? Use them today	7 Go on a kindness mission. Give your time to help others today	8 Tell someone about why your favourite music means a lot to you	9 Pay special attention today to the people you cherish most	10 Find out about the values and traditions of another culture	11 Do something to help a project or charity you care about	12 Visit a location that you find inspiring and meaningful
13 Find a way to craft your work activity to give it more meaning	14 Recall three things you've done that you are really proud of	15 Look for opportunities to be a good citizen of the world today	16 Share an inspiring quote with someone that matters to you	17 Gaze up at the stars and see that we are part of something bigger	18 Connect with people who matter to you (face-to-face if possible)	19 Today do something that makes your soul sing
20 Think about how your actions make a difference in the world	21 Ask a loved one or colleague what matters most to them in life	22 Support a cause that stands for something you believe in	23 Reflect on what makes you feel really valued and appreciated	24 Notice all the amazing wonders in the world around you today	25 Find out how to get involved in a group in your local community	26 Do something special today and revisit it in your memory tonight
27 Link today's choices and decisions to your purpose in life	28 Today do something to care for the planet	29 Tell someone about 3 events in your life that were really meaningful	30 What do you want to change in the world? Do something today	31 Take the AfH pledge: to create more happiness in the world		

ACTION FOR HAPPINESS

www.actionforhappiness.org

Find out more about the Ten Keys to Happier Living, including books, guides, posters and more here: www.actionforhappiness.org/10-keys

Diversity and Inclusion

Ramadan is expected to begin on the 5th May and end on 4th June– this is one of the five pillars of Islam and is a time of fasting for Muslims around the world.

During Ramadan most Muslims will eat a meal before dawn, and then again when daylight is over. No food or drink is consumed during the day and it is important we recognise the impact on an individual, as well as the opportunities available to them for support during the month of Ramadan. Some of the effects of fasting could include:

Dizziness or light-headedness
Headaches
Tiredness
Heat related issues e.g. heat stroke, heat exhaustion
Reduced concentration
Irritability

These will not be the same for everyone, and some people may show no effects. It is different from person to person. You can support fasting colleagues by talking about fasting in team meetings, acknowledge that it is coming up and make sure your other colleagues are aware of it. Encourage discussion so that a fasting colleague feels they can come to you if they need some support. The person who is fasting will know how it may effect them and will be the best person to tell you about this. Don't make assumptions.

We can play a major role in supporting those employees who observe fasting. This can in turn benefit our business. It should be appreciated that Muslims observing the fast have a longer day than usual.
If possible make allowances and provide access to relevant health and well-being guidance to employees.
Be sensitive to what fasting means and look out for each other when out on track

For more information, please contact your local D&I champion or email **diversityandinclusion@networkrail.co.uk**

Thank you and keep safe