



Safety First Briefing

February 2018

A note from Brian Madden, Head of Safety for ISS Labour

“One of the most important parts of our job is ensuring we communicate clearly and with accuracy at all times. The importance of Safety Briefings to notify and instruct our teams on any hazards or risks for the task ahead is paramount.

Therefore it’s important that we deliver, and receive, a high quality briefing before we undertake a task, and that you as the listener understand all of the points and information.

It is all our responsibility to pay attention, and ask questions, if there is anything in the briefing that we need clarified.

If there’s ever any questions, comments or feedback you want to raise, contact me at b.madden@isslabour.co.uk and let me know.

Below is a bulletin of what we should expect in a Safety Briefing.

Take care”



Safety: The Importance of Safety Briefing



The COSS (controller of site safety) will make sure that you have a safe system of work (SSOW) so you are not at risk from trains or electrified equipment. The COSS wears a blue badge with ‘COSS’ on it.

Without the correct safety briefing prior to a shift it is far more likely an incident, or worse, an accident will occur. Even if you already know the protocol, it remains imperative a briefing takes places prior to every shift.

A safety briefing will include the following:

- where you will work and what you will do
- how you will get to the work site
- what hazards there are
- what the site limits are
- the speed limit and direction of the lines and whether they are open or blocked
- how you will communicate in an emergency and who to contact.
- The safe system of work will also tell you how you will be protected from trains.

Fence – a fence will be put up between your worksite and the nearest open line.

Safeguard – all lines are blocked and no trains will come through the site.

Site warden – a site warden will make sure you stay in a safe area while you work. Never distract a site warden.

Equipment warning – a warning system, operated by a lookout, or automatically, or by the train, will give you enough warning to reach a safe position at least 10 seconds before a train arrives.

Lookout warning – a lookout will warn you in time to get to a position of safety at least 10 seconds before the train arrives. Never distract a lookout. You must be in a position of safety at least 10 seconds before a train arrives. Acknowledge the driver’s warning by raising one arm above your head. Do not leave your position of safety until the COSS tells you to do so.

If you do not understand any part of your safety brief, then it is important to raise this with your COSS so that they can provide clarification, or answer any questions you may have.

Accidents

During January there were three accidents & three incidents reported:

1. Accident Details: While taking measurements of overhead line equipment on 12/01/2018 at Newcastle South, operatives working in a MEWP basket above the IP dropped a ratchet pull-lift from the basket. This struck IP on the head (the safety helmet), causing a cut and bruising to the cheek, and leaving the IP dazed and in shock.

Investigation: Carried out by client (S&CNA) with ISS cooperation, closed.

Recommendations: The machine controllers to ensure non-essential personnel kept out of the exclusion zone. In this case the IP was authorised to be in the zone, as he was undertaking heights and staggers survey.

2. Accident Details – Car crash: While driving to work on the A470 on 17/01/2018 in very poor conditions, the rear of the vehicle aquaplaned and stepped-out on a bend. The driver attempted to correct, but lost control. The vehicle left the road, careered down banking, rolled-over and stopped on the roof. The driver and passenger suffered cuts and bruises.

Investigation: ISS Labour cooperated with client's investigation to ensure all factors leading to the accident were considered and taken into account.

Recommendations: Client (Babcock) issued traffic management plan showing directions and warnings on winter driving, and specifically aimed sections around the road of the incident. A safety alert was also issued.

3. Accident Details: While loading a trolley into a van on 24/01/2018 at Richmond Street worksite, the IP's middle finger on the left hand got trapped between two trolleys when setting down. This caused a cut to the tip of the finger.

Investigation: Supervision present however no instructions were given to assist with the task. Activity not planned sufficiently to avoid nipping and trapping of fingers. Task Brief identified risk and hazards of trapping and nipping whilst manual handling.

Recommendations: Review the activity of placing trolley on flat bed pickups to remove pinch and entrapment points by the use of wooden chocks.

Review of planning of task to consider use of tail lift.

Task specific cut level 5 gloves for manual handling task to protect from entrapment and pinches.

Incidents

1. Incident Details: On 12/01/2018 during a job to install a reinforcement steel cage and retaining bolts to take a signal base plate, and mix on site 150 bags of C40 ready-mix concrete, 150 empty bags of C40 were used. The empty bags were put inside of each other, 10 to 15 per bag, to remove from site at the end of the shift. The site was checked to ensure all materials were clear, and the team then headed towards the point of egress. The team were then informed some time later that bags of were found in the 4-foot around the area they were accessing and egressing.

Investigation: The COSS in question was found to be a very dedicated worker and takes the lead and ownership of the work at hand. He has agreed that this was an oversight on his part.

Recommendations: COSS in question re-briefed and reminded of his duty of care.

2. Incident Details: On 28/01/2018 a switch which was opened to instruction, livened up during the isolation process. An operative was asked to operate switch 4015/20 at Pangbourne. After operating it under ECO instruction he could not confirm that it was open. The ECO dropped the breakers back in and heard and saw an arc. The ECO was then asked to drop the breakers out so they could watch the switch close and open again while it was operated. The ECO dropped the breakers back in and there was no arc this time, so switch 4016/22 was operated.

Investigation: The investigation found this specific switch had a similar fault a few weeks earlier. The NWR (Maintainer) attended and repaired the equipment.

Recommendations: A new briefing note issued by client (HOBC) on operation of switches.

3. Incident Details: At 2:00 on 28.1.18 AP Webb Terrex RRV was set to task at 01:50, excavating the formation of Platform 6 in Liverpool Lime Street station. The RRV operator was instructed by his ISS Crane Controller to release the semi quick hitch and remove his ditching bucket placing it on platform. While undertaking this activity the knuckle of the boom struck the OLE contact wire at approximately 02:05 am. S&C duty manager alerted the crane controller and told the machine to stand down, as the machine moved back into gauge the wire was struck a second time. Staff removed from site "For Cause Testing". OHL staff inspected the OLE infrastructure and no damage has been caused.

Investigation: For cause D&A was undertaken and both Operative and Crane Controller passed

Recommendations: Machine Controller briefed on importance of positioning and communicating with the operator.

Close Call Reporting

We had 12 Close Calls reported by our workers since the last briefing:

Date Raised	Location	Details	Risk Level	Comments / Findings	Status
10/01/2018	NWEP 4 & 5	ISS staff member C Browitt presented in SACs cabin with no Cap lamp	Care	Provided at Second attempt	CLOSED
10/01/2018	Bradford Interchange - H2B	Welfare at Bradford interchange has ran out of water and fuel	Care	Emailed to Babcock and Siemens control	CLOSED
12/01/2018	NEXUS	ISS Staff member spotted a MEWP machine out with the Isolation limits, which could be very dangerous should the section be live and someone access the machine to move it.	Alert	Raised issue with client who investigated and await final report.	ONGOING
13/01/2018	NWEP 4 & 5	ISS staff member J Halliwell presented in SACs cabin with no Gloves or Glasses	Care	Provided at Second attempt	CLOSED
13/01/2018	NWEP 4 & 5	ISS staff member A Walker presented in SACs cabin with no Gloves or Glasses	Care	Provided at Second attempt	CLOSED
13/01/2018	NWEP 4 & 5	ISS staff member K Byrne presented in SACs cabin with no Gloves or Glasses	Care	Provided at Second attempt	CLOSED
13/01/2018	NWEP 4 & 5	ISS staff member J Chapman presented in SACs cabin with Gloves.	Care	Provided at Second attempt	CLOSED
13/01/2018	NWEP 4 & 5	ISS staff member Y Hail presented in SACs cabin with no Cap lamp	Care	Provided at Second attempt	CLOSED
14/01/2018	NWEP 4 & 5	ISS Staff member B Rowland on track wearing hoodie and no glasses. Yellow card issued by project.	Caution	Yellow card recorded - off site if happens again	CLOSED
16/01/2018	Bradford Interchange - H2B	Access gate found open at Wyke access point	Caution	Closed and secured on night	CLOSED
22/01/2018	Hillington	Access to SAMS cabin covered in ice - poor condition underfoot	Care	Bags of salt spread over the area after issue raised	CLOSED
29/01/2018	Watford	Tunnel Ventilation machine on track with no form C or Machine Controller. Advised not required but further checks requested.	Care	In future, all machines of this nature will be issued with Form C by Nominated person while onsite, and will have a MC or COSS	CLOSED

Vehicle Accidents

There were four reported vehicle accidents for January 2018:

MW16 NTG

Make/Model: Peugeot Boxer

Date of Incident: 08/01/2018

Time: 06:00

Location: Euston

Road condition: Average

Weather: Clear

Description: Vehicle ran-over rough ground that was raised and covered in ballast. This caught the underside of the vehicle.

Damage: Damage to the front underside.

Outcome: The driver is at fault. Designated roadways should always be used.



MJ16 TZD

Make/Model: Peugeot Partner

Date of Incident: 18/01/2018

Time: Between 12:30-13:00

Location: Valley Road, Crewe

Road condition: Average

Weather: Cloudy

Description: The van was parked outside of the home and was hit by a third-party. No insurance details were left.

Damage: Lower rear drivers-side of the van.

Outcome: An unfortunate incident that is non-traceable due to the lack of witnesses, and details left at the scene.

NL17 LVN

Make/Model: Peugeot Partner

Date of Incident: 25/01/2018

Time: 04:00

Location: Wythenshawe

Road condition: Average

Weather: Wet

Description: Third-party van did not check blind-spot and swerved into the wrong lane, this caused contact with the Peugeot Partner.

Damage: Damage to the passenger-side of the van.

Outcome: An unfortunate accident that appears to be the third party at fault, mainly due to a lack of awareness of other road-users.

DN15 2KV

Make/Model: Vauxhall Vivarro

Date of Incident: No date given (submitted in January)

Time: 23:00

Location: Poole

Road condition: Non-given

Weather: Non-given

Description: Van attempted a U-turn which resulted in contact with a lamppost.

Damage: Damage to tail-gate, rear windscreen and rear bumper.

Outcome: An avoidable slow-manoeuving incident. A person should be used to assist in the manoeuvre from outside of the van, and care and attention of the driver should be in place at all times.

Driver Reward Scheme

Over the coming months we will be rewarding the best drivers with vouchers on a monthly basis. This score is based on driver performance and is made up of the following:

- Harsh accelerating
- Harsh Braking
- Harsh cornering
- The maximum score possible is 100.

Congratulations to the drivers listed to the left for their fantastic performance in January, your prizes are on the way.

Driver/Vehicle	Score
Nick Elston	98.22
Alan Kelsall	97.98
Paul Garner	97.33
John Evans	97.1
Ashley Watkins	96.63

Client Feedback

We have received the following positive client feedback and would like to thank all of those workers concerned:

Volker Rail - I was really impressed with the engagement from ISS and particularly Dean the Coss from ISS. Dean was a pleasure to work /inspect with and showed the level of engagement we want whilst carrying out inspections/site tours. I would like to nominate Dean for a safety nomination. The VR site team had a good relationship with all the sub –contractors on site and although we identified a couple of minor issues the site overall was well managed and tidy. Please pass on our thanks to ISS for the staff who engaged with us.

Volker Rail - I was out today on shift 2, the lads were very engaging and happy to discuss potential issues.

Amey - I would like to thank ISS for the quality of Staff you have suppling over the past couple of weeks, especially the minibus drivers, points operators and Wes Hiles. It makes my life a lot easier when you have proactive staff out there.

This month, among the close calls we received, we had 2 items brought to the attention of the SQE team and our clients, which could have been very dangerous and posed a potential risk:

Steve Massey recognised that a MEWP was sitting outwith the Isolation limits on a job, which could have resulted in electrification of an operative if they were to access and try to move the machine under what could potentially have been a live OLE section.

Graham Carney, during a worksite inspection, noticed a tracked ventilation machine was ontrack with no Form C permit issued, and no machine controller. While this was deemed acceptable to the client at the time, we raised it with their SQE team and the supplier, who agreed that there was a potential risk to personal safety for the operator should that machine be on-track after the Isolation was handed back. We are pleased to note that this machine will now also require a Form C permit to be issued and that a COSS or Machine Controller will be used when onsite.

In recognition of their foresight and raising the issues, both will receive a small token of appreciation from the Company. If you see or are aware of any issues that could pose a danger to yourself or others, please raise it to your supervisor, raise a close call to the hotline 07870 842610, or email the SQE team. We can genuinely make a difference and look after each other, just by highlighting something.

Driving Safety

No mobile while mobile

Speaking on a hands-free phone whilst driving isn't illegal however it is distracting and increases the likelihood of an accident. Over 100 people are killed or seriously injured every week in crashes involving someone who has driving or riding for work.

High mileage & company car drivers are more likely than most to use a mobile phone whilst driving, and very often they are using the phone for work purposes. However a substantial body of research proves that using a hands-free mobile whilst driving is a significant distraction because the driver is concentrating on two thinking tasks at the same time & often taking their eyes off the road to look at the screen.

Drivers who use hands-free mobile phone:

- Are much less aware of what's happening on the road around them
- Often take their eyes off the road altogether to look at the screen
- Fail to see road signs
- Fail to maintain proper lane position & steady speed
- Are more likely to 'tailgate' the vehicle in front
- React more slowly & take longer to brake
- Are more likely to enter unsafe gaps in traffic
- Feel more stressed & frustrated

They are also four times more likely to crash, injuring or killing themselves and/or other people.



In line with the Network Rail Lifesaving Rules it is against our policy to make or receive phone calls, text or emails whilst driving – No mobile when mobile.

To keep yourself & others safe whilst driving ensure that you do the following:

- Plan journeys so they include rest stops when messages can be checked & calls returned
- To avoid temptation either turn off your phone, put it into 'driving mode' or allow a passenger to use your phone

If you need to make or answer a phone call, text or email please remember to pull over to a safe spot and turn off your engine before using your phone.



Industry Alerts

NetworkRail

Shared Learning

The Thameslink Programme Issue Date: 10th January 2018 - For further info contact mike.netherton@networkrail.co.uk

Issue Number: TLP083 Title: Cable Drum Spindle Fall into Public Area

Overview of Event:

On 19th November 2017 at 13:00hrs, a track team was lifting an empty cable drum from an 'A' Frame mounted on a track trailer. During the lift, the cable drum spindle bar snagged on the 'A' frame. On further attempting to lift, the drum jerked and tilted causing the spindle bar to slide from the centre of the drum. The spindle bar fell through a gap in the parapet wall approximately 8m to the ground below, into a public area.

The spindle bar weighs circa 50kg and is approximately 2m in length. The spindle bar did not come into contact with any persons or vehicles when it fell however, it had the potential to cause significant injury and/or damage.

General Key Messages:

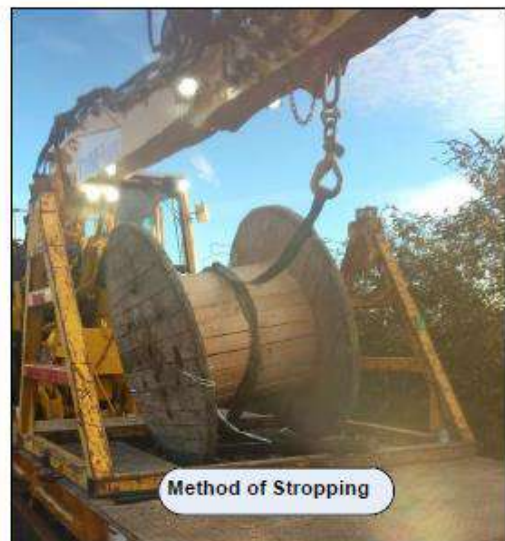
- Lifting arrangements need to be clear, documented in a Lift Plan and carried out by competent personnel.
- Any equipment used for lifting, requires individual identification and routine checks for condition.

Causes:

Immediate: Insecure spindle bar sliding from slung cable drum.

Root and Underlying Causes

- Inadequate assessment of the worksite and lack of detail in the Task Brief in relation to working around bridges/viaducts.
- Neither the Task Briefing nor Point of Work Risk Assessment (POWRA) considered or addressed the risk of lifting on under-bridges or viaducts.
- The Lift Plan was generic for lifting activities and lacked specific detail.
- Although the Lift Plan showed that whilst lifting on viaducts & under bridges was a hazard, it failed to identify any controls to mitigate the risk.
- The Crane Controller & Supervisor believed that the collars on the spindle were there to prevent the spindle coming out of or through the cable drum whilst lifting, rather than controlling drift and keeping the spindle on the 'A' frame.
- The drum was incorrectly slung with a single Strop allowing it to tilt.
- Lack of competence/experience of the team in lifting cable drums.
- Cable drums had been stored on their sides on the trailer.



Actions Taken As a Result of the Investigations:

- Communication issued to the project/supply chain that lifting must be carried out in accordance with the Principal Contractor 'Lifting operations: Our Expectations' process.
- Going forward, diagrams/instructions to be included in cable drum Lift Plans, including stopping arrangements.
- Safety Bulletin issued – 'Lifting of cable drums on bridges and the correct procedure for lifting, including the prohibition of lifting on viaducts /under bridges without a detailed Risk Assessment'.
- Project instructed to place all cable drums into the correct storage position on their rims.
- Mandate and train supervisors in the use of Lift Plan assessment sheets and POWRA (point of work risk assessment).
- Re-training and assessment of the Crane controller involved in the incident, followed by a period of mentoring.



Industry Alerts

ISSUED: 07 February 2018

SAFETY BULLETIN – 04-18 TITLE: Liebherr A900ZW - Suspended from BGCL Rail Projects



What Happened?

A Liebherr A900ZW was being utilized to transport box trailers containing spoil which had been removed from an excavation. The spoil was to be stockpiled at a laydown area within a site compound and the Liebherr would then return to collect more spoil.

It was discovered that a series of Clamp Lock Deflector boxes (see yellow box on the top right picture above) on various locations of points areas had been damaged on site, some were cracked and some were broken.

A Safe Work Leader undertook a review on site and it was suspected the above plant had potentially caused the damage, as the rubber wheels passed over the deflector boxes. 17 boxes were replaced on site.

Recommendations:

Because of this incident **ALL** Liebherr A900ZW have been suspended from any further use on Buckingham Group Rail Projects until further notice or unless authorization is given by a Buckingham Director. When using any low rider type machine, always ensure an adequate risk assessment has been completed and adequate controls put into place to mitigate any risk of the machine coming into contact with Clamp Lock Deflectors or other line lineside equipment. Network Rail have banned low riding OTP in the Southern region.

Work that is currently planned using these machines must be re-planned using alternative equipment

Industry Alerts



AWARENESS BULLETIN – AB01-18 TITLE: Drones – Unmanned Aircraft Systems ISSUED: 06 February 2018



As UAS / Drones become more affordable and popular it has been identified that some have been used on BGCL Projects for taking progress photographs and videos.

The use of Drones on BGCL sites is covered by our Group Procedure GP.1133 – Use of Unmanned Aircraft Systems (Drones). Copy attached with email. The summary points of GP.1133:

- Air Navigation Order (2016) drone flights having to demonstrate an equivalent level of compliance with CAA Procedures as manned flights.
- Anyone using drones on a BGCL Project must hold a valid CAA Permission for Commercial Operations and relevant indemnity insurance.
- All drone flights must comply with the Data Protection Act 1998 and Surveillance Camera Code of Practice.
- Insurance in compliance with EU Regulations EC785 / 2004.
- **APPROVED DRONE OPERATORS** - Anyone wishing to fly a drone on a BGCL Project **must** submit – CAA Permission, CAA Approved operation manual and drone operator's insurance certificate, to Head of Geomatics at least **2 Weeks** prior to any planned flight.
- If the above documents are approved, the drone operator will be added to BGCL's approved operators list.
- **NOTIFICATIONS OF FLIGHTS** – The Head of Geomatics must be notified at least **5 working days** in advance of the flight occurring.
- **Pre-site surveys, on-site survey and risk assessment, pre-flight briefings and post flight checks, are all identified in GP.1133.**

From the summary points above, it is clear the casual use of drones is **NOT allowed on any BGCL Projects** - therefore proper planning and controls **MUST** be followed.

As a company we have a Permission for Commercial Operations but this is strictly limited to our aircraft and pilots qualified and listed in our Operations Manual (which has CAA approval).

We do use third parties to fly our sites from time to time and these all have CAA Permissions. If you want to fly on our sites then the only way this could happen is for you to obtain a CAA Permission and then to tender for work as other preferred suppliers do.

If you have any questions or comments on the above, please contact Nick Smith – Head of Geomatics, or Steve Challis Group HSEQ Manager.

Industry Alerts

TAZIKER INDUSTRIAL

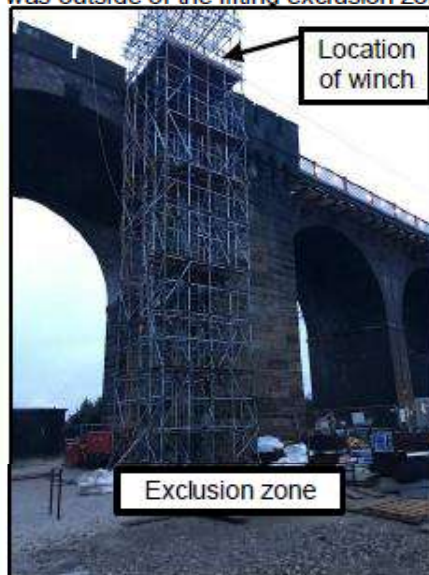
Cordek fall from height

Health & Safety Incident Bulletin

An incident has occurred this week on a Buckingham Group Rail Site where Taziker Industrial are a specialist contractor. Two operatives were lifting 50 sheets of Cordek up a loading bay using a electrical winch system.

The operatives folded the Cordek in half and slung the load with four slings using the cradle technique. After the load was slung, one operative went up to the top of the loading bay to operate the winch, whilst the second operative stayed below to monitor the lifting operation.

As the load reached the top of the loading bay a gust of wind caused it to become lodged on the scaffold, resulting in the Cordek slipping out of the cradle sling and into the exclusion zone below. No injury was sustained as the operative standing below was outside of the lifting exclusion zone.



What went wrong?

- The operatives were signed onto a task brief sheet however it did not cover the use of the hoist system.
- There was no lifting plan in place.
- There was no system in place to prevent unauthorised use of the hoist.
- The operatives did not hold any form of training for the winch system or for slinging, and therefore the incorrect sling technique was utilised.



DOUBLE BASKET SLING



BARREL SLING

What should you do?

Site operatives -

- If you are not trained and competent to undertake a task you must not do it, stop work and inform your Site Manager.
- If your task brief is not relevant to the works you are undertaking or does not cover all tasks, stop work and inform your Site Manager.

Site Managers -

- Check that operatives on your site hold the correct competencies to undertake the tasks they are expected to do.
- Ensure you have a suitable lift plan in place for lifting operations on your site.
- Implement lock out systems to prevent unauthorised use of plant and equipment that requires a specific competency.

TI-IB-080 (26/01/2018)

Industry Alerts

SAFETY BULLETIN -SB02-18



TITLE: Electric pallet truck incident - 10.01.18

Background information:

An electric pallet truck being utilised on the Liverpool Lime Street project fell from a platform when the forward/reverse button became stuck.



What Happened?

On Tuesday 10th January, an operative working on the Liverpool Lime Street Project avoided serious injury whilst he was utilising an electric pallet truck to move tubs of mortar on platform 6.

The platform is closed to passengers and staff to allow reconstruction, and the platform 6 track has been removed so works were taking place within a fenced green zone.

The operative in attempting to turn the pallet truck around on the platform realised the forward/reverse button on the electric pallet truck became stuck and could not prevent the pallet truck from moving, resulting in the pallet truck falling off the platform edge into the new riser wall footing below. The team member managed to jump off the platform and across the trench/concrete footing and onto former track level however, the pallet truck fell into the excavation.



The operative was uninjured though the pallet truck was damaged (as per the photos above) and leaked a cup full of battery acid. The leak was contained / bagged and placed in the COSHH store. The pallet truck was later removed and quarantined.

The incident has been reported to SCO 24/7 and a detailed Level 1 investigation has been completed following an in-depth event review.

Remedial actions:

- ALL BGCL team members involved with these works received familiarisation training on the use and inspection of the electric pallet trucks. Training last October had been delivered but not in a structured manner, formal training material was prepared with the assistance of the Hire Company and delivered to the users of these trucks.
- Only a select few will be defined as a designated competent operator and will be each issued with a designated competent operating card which will be required to be carried upon their persons when operating the plant.
- A pallet truck "safe operating procedure" has been put in place and briefed to ALL site team members who are involved with these types of works, which involves the use of electric pallet trucks to transport materials.
- Prior to usage the keys will need to be obtained from the Site Supervisor and a signature obtained from the operator upon receipt of the key.
- A Pre-Use Check Sheet has been prepared and will be undertaken on each electric pallet truck by the designated operator with records maintained. After usage at the end of each daily shift, a check sheet will be completed for the pallet trucks to search for any damage to the equipment with records maintained and the Site Supervisor informed, where required defective items of plant shall be quarantined.
- The pallet truck keys will be returned to the Site Supervisor at the end of each working shift and a signature to record the returning of the keys.
- GAP, the equipment provider, will be undertaking a thorough examination on each pallet truck on a weekly basis to ensure the plant is maintained.
- When the electric pallet trucks are being moved through the station concourse the plant operator will be escorted by means of a plant marshal. When the station concourse area is highly populated with members of the public the plant marshal and plant operator will wait until there is a more convenient time to transport the pallet truck through the station concourse.

Industry Alerts

HSEQ ALERT

Title of Alert	Mandatory Use of Metatarsal Foot Protection
Target Audience	All High Output
Date Issued	14 March 2017

Reason for this HSEQ Bulletin

There have been a number of safety events where employees on High Output sites have suffered injury to their foot as a result of rail dropping on their foot/feet.


The most recent event was reported on 9th March 2017, the injury sustained resulted in broken bones.


Action to be taken and learning to be applied

The use of metatarsal protectors is now mandated on all High Output worksites where rail is being handled manually or mechanically.


Exceptions will ONLY be made for employees wearing boots with demonstrable in-built metatarsal protection.

Loop the tongue of the metatarsal protector through the laces of your safety boots and then clip on to the front protective panel.





NR90/TARSAL
Metatarsal Protector



Why is metatarsal protection so important?

The metatarsal bones of the foot are very vulnerable to injury because the front of the foot sticks out beyond the body line, inviting a rolling or falling object to collide with this unprotected part of the body.

Conclusion / Final note

We acknowledge that the use of Personal Protective Equipment (PPE) is the final line of defence in the hierarchy of safety control. Therefore we will continue to look for alternative safeguarding

Issued by: D Deeley
Version 6 – Jul. 2016
Issue Date: 14/03/2017
Ref: NWR HO 16/17 076

measures to avoid the risk in the first place. In the meantime:

- Use of metatarsal protectors is mandatory and must be worn where rail is being handled
- Speak to your line manager if you have not been issued with a set of metatarsal protectors

Safety boots available through the iPROC catalogue now have in-built metatarsal protectors as standard. Please check your boots to see if they have in-built protection; if they don't you are required to wear the protectors as mandated.

If you have any ideas or suggestions; please speak to your Line Manager, your local HSEA Advisor or send an email to ho-admin@networkrail.co.uk

Delivering First Class Rail Solutions

www.isslabour.co.uk

Industry Alerts

Safety Bulletin

A serious incident has taken place



Staff walking in close proximity to live OLE contact wire

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

Ref: NRB 18/02

Date of issue: 22/01/2018

Location: Crewe

Contact: Mike Dobbs, Senior Asset Engineer



Overview

An overhead line incident occurred at the North end of Crewe station.

The overhead line contact wire parted as an electric train passed causing damage to the train's pantograph and resulting in the contact wire hanging down.

A Network Rail Mobile Operations Manager and British Transport Police officers were first on site.

When overhead line staff arrived they found that staff had been walking in close proximity to the live contact wire that was hanging down. An emergency switch off had not been requested.

The parted contact wire is believed to have been within 30cm of head height and staff had walked beneath it. In September 2014, less than 25 miles away, a train driver suffered extensive electrical burns in very similar circumstances when they left the cab after the overhead line had been damaged.

Discussion Points

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

- Who should you contact if you believe the overhead line equipment (OLE) may be damaged?
- What precautions must be in place before you can approach but not touch OLE?
- What precautions must be in place before you can touch OLE?
- What other circumstances might increase the risk of injury when attending OLE incidents?
- What are the additional risks during the hours of darkness (or in a tunnel)?

Copies of Safety Bulletins are available on [Safety Central](#)

Part of our group
of Safety Bulletins

Safety
Alert

Safety
Bulletin

Safety
Advice

Shared
Learning

Industry Alerts

QUICK HITCH SYSTEM ON 360 EXCAVATORS



Background

A quick hitch (QH) on an excavator is a latching device that enables attachments to be connected to the dipper arm of the plant and interchanged quickly. An excavator operator may change the bucket on his excavator up to 30 times a day to maximise the machines productivity.

A significant number of all accidents investigated on excavators are attributed to the bucket detaching from a QH and injuring a ground worker, most of which are fatal and major injuries. There have been four fatal incidents in the last 12 months involved semi-automatic quick hitches, but there have been other incidents involving both manual and automatic types in the past. However, there may be many more dangerous occurrences that occur that might not be reported when a bucket detaches unintentionally from the hitch, but without injury because no one is underneath at the time.

The QH systems on the market can be manual or non-manual. Non-manual systems are known as semi-automatic and automatic. A standard bucket is secured to the dipper arm with two pins. QHs may pick up a standard bucket using the original pins, or the QH may have a dedicated attachment system that only fits buckets with matching engagement lugs. The advantage of dedicated systems is that the original radius of bucket movement can be maintained by compensating for the thickness of the QH, thus keeping the same break out force as the manufacturer intended. The disadvantage is less flexibility because only dedicated buckets can be used. In addition, a significant investment in dedicated buckets and attachments is required. For this reason, most systems are 'pin' type rather than dedicated type.

The Vehicle or Plant Item

➤ Are they safe and suitable for the task / operation? Are they properly maintained? Do they need to be replaced with something newer or in a better condition?

What are the Project Teams or Operators doing?

- Do they have the correct competencies and accreditation for the vehicle or plant they are using? In addition to evidence of training in operating the excavator, have excavator operators been trained in the use of their QHs, and, where appropriate, in the use of the excavator as a crane? (NB: The CPCS excavator operator course has covered QH since January 2008. CPCS cards dated before this will not include testing/training on a QH and cannot be relied upon to demonstrate competence).
- Is there a checklist in the cab of daily and weekly inspection and maintenance carried out on the excavator, and does this checklist include a check of the QH and lubrication as appropriate? Is there a record of the inspection and
- Whether the safety pins are inserted where appropriate. (If the pin is missing, try looking behind the driver's seat!)
- Can the operator explain the type of QH system they have (do they know whether it needs a safety pin or not?) and is a manual or instruction card available in the cab?
- Does the operator know how to visually check that the QH is locked?
- Does the operator know that, for all types of QH, they should test the security of the bucket after changing it? (Some manufacturers advise "shake, rattle and roll", others suggest placing the bucket so that the bucket tries to disengage from the QH).

What are other People doing?

- Are other site workers or site visitors segregated and kept clear of vehicles / plant that are in operation?
- Is the 10metre exclusion Zone maintained as far as reasonably practicable?

Commencing Work

REMEMBER

- It is now a MANDATORY requirement that all 360 excavator operators being utilised on a Buckingham site have received "Quick Hitch" training and certification can be provided at induction stage
- For further guidance and technical information regarding OTP on Network Rail infrastructure please refer to NR L2 RMVP module P510 – Safe use of quick hitch systems and Infrastructure Plant module NR L2 RMVP L2 P510 Q200 infrastructure plant manual
- Please be aware that on Rail projects only OTP on the approved suppliers list can be used on Network Rail infrastructure
- "BEST PRACTICE" - Ensure the hire company of each 360 Excavator attends site and demonstrates the safe use of the "Quick Hitch" system and record the briefing/demonstration and keep on record for the duration of the Project
- It will always be a requirement to undertake a Risk Assessment in relation to the use of vehicles and plant that will be utilised in site operation activities, consideration should also be made to periodic or change situation to keep the risk assessment up to date as site development ensues
- Have you got the correct competence to carry out the task?
- Make sure you have been briefed on the safe system of work of all activities you will be undertaking
- Production of a people and plant management plan – site rules and drawings for the communication
- Don't be afraid to speak up if things don't look quite right
- Do not put yourself in a position of danger
- Ensure you have a safe zone to allow maintenance to be carried out on plant
- Demarcation of safe area/zones when working around plant to prevent unauthorised walkway

Industry Alerts

De-nailing of Timber



Content and Background

You would think that discussing nails is not a very important subject. However, the industry estimates that 20% of all minor injuries on a construction site is because of punctures, scrapes and cuts resulting from nails that were not properly removed from timber and other debris.

Timber which have not been de-nailed correctly, become a dangerous hazard when they become scrap placed within a skip or construction debris due to poor housekeeping on site.

Nails can cause a serious puncture wound. Ensure you have a robust housekeeping regime. Always de-nail timber; otherwise you may end up with puncture wounds, scrapes, cuts or potentially the loss of your eyesight.

De-nailing timber is often common sense, use it.

Planning

- Always ensure you are wearing the correct task Specific PPE
- Always de-nail timber before placing it in the designated skip
- Always pull or bend nails when stripping
- Use the right pulling device for the job
- If needed, use a block of wood as a fulcrum. It will make the job much easier
- Keep scrap materials in neat piles and out of walkways
- Place scrap timber in the designated skip provided
- Carefully discard used nails
- Implement a robust housekeeping regime
- Always ensure the de-nailing of timber has been risk assessed and details placed within the Task Briefing with suitable and sufficient controls

REMEMBER

It will always be a requirement to undertake a Risk Assessment in relation to the task you are undertaking, consideration should also be made to periodic or change in situations to keep the risk assessment up to date throughout the lifecycle of the project.

We have a duty of care not only to ourselves and employees but also the company who collects the skip to dispose of the timber.

Nails can become “snake fangs” if used incorrectly or left protruding in timber.

Do



Don't



Environmental

Bird Flu H5N6 within the UK



Highly pathogenic H5N6 bird flu has recently been detected in wild birds in Warwickshire with the potential of being spread to domestic and commercially bred fowl.

This is the second confirmed finding of the virus in the UK this winter, following the finding in Dorset earlier this month (January 2018). Tests have shown both cases are closely related to the H6N6 strain circulating in wild birds across Europe in recent months.

Public Health England have advised the risk to public health is very low. The Food Standards Agency have also offered reassurance that bird flu does not pose a food safety risk for UK consumers.

Whilst at this stage the restrictions apply to captive bird keepers Buckingham's are taking a pro-active approach and is reminding all site on the importance of biosecurity.

All high risks sites (close to farmland or access involve crossing farmers' fields) should follow the DEFRA Check Clean Dry principle.



Check all equipment and PPE (inc. boots) for living organisms.

Clean and wash all equipment, footwear and clothes thoroughly using a Government approved disinfectant at entrances and exits

Dry all equipment and clothing.

Action:

- minimise movement in and out of agricultural land.
- clean footwear before and after crossing farmland, using a Government approved disinfectant at entrances and exits
- clean and disinfect vehicles and equipment that have come into contact with poultry
- humanely control rats and mice
- keep a close watch on birds for any signs of disease:
 - swollen head
 - blue discolouration of neck and throat
 - respiratory distress such as gaping beak, coughing, sneezing, gurgling, rattling
- report any very sick birds or unexplained deaths to DEFRA swollen head

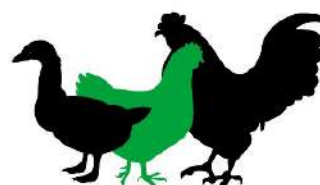
An assumption has been made that Bird Flu could possibly be anywhere in the UK. Therefore, a National Avian Influenza Prevention Zone (AIPZ) has been declared for the whole of England.

This means it is mandatory for all captive bird keepers in England to put enhanced biosecurity measures in place. Further information can be found on GOV.UK. This Zone will be in place until further notice and will be kept under regular review as part of DEFRA's work to monitor the threat of bird flu.

Members of the public should report
dead wild birds to the Defra helpline
on **03459 33 55 77**


Department
for Environment
Food & Rural Affairs

#birdflu



Feedback

We would like your feedback on any safety related issues that may help us improve the business and prevent further accidents and incidents.

We endeavour to minimise all foreseeable risks to you when you are at work. However you see what happens out there on a daily basis far more than we do, and will no doubt have some very valuable ideas or suggestions on how to make our industry a safer place for everyone. We would like to hear from you but appreciate you may want to remain anonymous. We value your opinion and thus confidentiality will be guaranteed when receiving your comments. You can send us feedback in any of the following ways:

- Send an email to the SQE Team directly sqeteam@isslabour.co.uk use the hashtag #Feedback in the subject heading and someone will contact you within 24 hours to acknowledge receipt of your message
- Complete the slip at the bottom of this page and take it into your nearest ISSL depot
- Call or text any of the “On Call” phone numbers listed on the rear of your Authority To Work Card
- Go to any ISSL Depot to talk to a senior member of the team, who will welcome feedback and consider confidentiality at all times
- Speak to any of the senior team when you meet them on-site for briefings or safety related visits.

Feedback Slip: **Monthly Brief**

Your name or contact number is optional. The detail is the most important section to complete 

Name:

Local Office:

Date:

Contact No:

Subject:

Details: