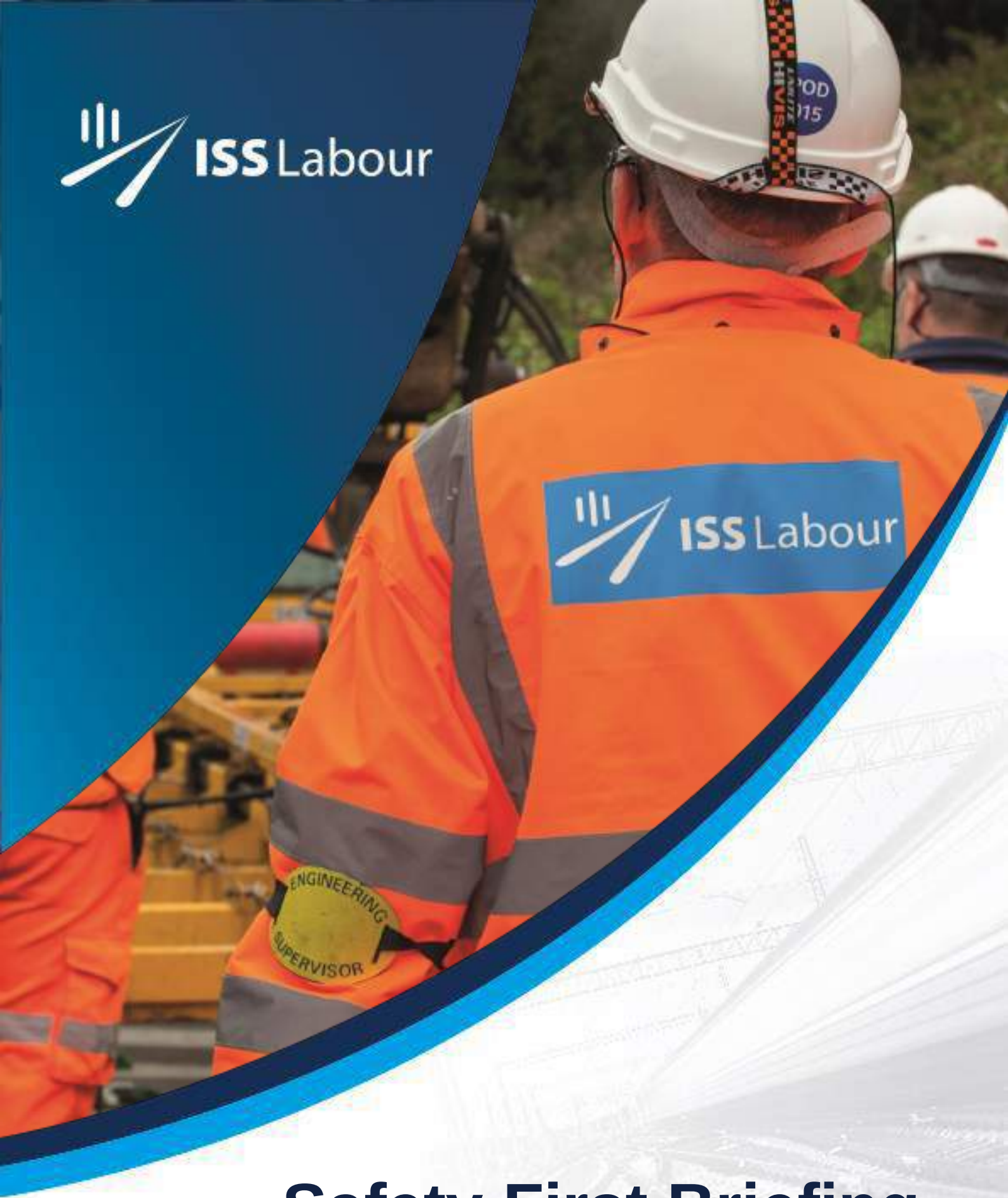
ISS Labour



Safety First Briefing

November 2017

Accidents and Incidents

During October there were 3 accidents and 4 incidents reported:

1. Accident Details

On 13th October the injured person was removing DEP earths for section proving works on EGIP project. Initial report was his shoulder popped out when pulling on poles. Helped from site and taken to hospital where damaged ligaments were confirmed before he was taken home.

Investigation

The IP had an old injury and this seems to have been a contributing factor. The activity and task was found to be following normal procedure and was as per the training and instruction given.

Recommendations

The IP was put on restricted duties, had an Occupational Health Fitness for work examination, and returned to normal duties after the appointment. The old injury was not notified on the personnel file, but not necessarily the case this would have restricted activities as same task had been undertaken previously with no known issue.

2. Accident Details

On 18/10/17 injured Person acting as Crane Controller, attempted to move a heavy box to enable chains to be attached to move item to new location. During this, he felt sharp pain to upper right arm.

Investigation

Found to have partially detached bicep, due to the weight of the load and the lifting motion. He should have assessed the load as being too heavy to move, and used alternative means to do so.

Recommendations

Manual Handling techniques to be re-briefed and updated on file.All staff to remember to ask for help or use correct lifting equipment for task, and only if suitable trained and competent to do so.

3. Accident Details

On 21/10/17 Injured party was walking to machine along drivers walkway when he slipped and fell, twisting ankle. He returned to SAC and reported the accident, and then go for medical check.

Investigation

Poor maintenance and weather contributed to the cause of the event. IP checked at hospital and discharged. Not a specific task, rather IP was walking to RRV to undertake works.

Recommendations

Staff to be aware of the hazards associated with the standard of walkways and the weather conditions when moving around worksite, and the increased possibility of slips, trips and falls. Any issues with the conditions should be raised as a close call.

Accidents and Incidents

1. Incident details

On 21/10/17, ISS Crane Controller on Babcock site was instructed to Off-track his machine. Take to first set of points and await a Points Op. Machine set off and proceeded to go through the points, which had not been set for the movement.

Investigation

It seems there was a break down in communication between the CC and the Operator, and the comms unit appeared not to work after the machine had set off. The CC did not get in position in front of the machine and had to follow in a man carrier. The Operator approached the points but did not notice the "Till Dawn" lamp in the 4 foot.

Recommendation

The CC and Operator suspended from respective duties for investigation period, until recommendations supplied. Potential retraining or mentor shifts to be confirmed. Incident not closed.

2. Incident Details

On 01/10/17 an ISS AP was working on a Carillion Isolation in the South. The AP was working to remove the earths to allow the isolation to be handed back. During the course of this, he didn't recover all the earths, and the breakers tripped when ECO attempted to re-energise to OLE.

Investigation

The main contributing factors the weather (high winds), a Deadspan DEP location, and numerous telephone calls to the AP, which lead to the AP feeling under pressure to hurry and cancel the Isolation. The AP became aware he had not retrieved all the earths, but had contacted the NP to hand back the Isolation prior to this, so couldn't get in contact in time to prevent the NP cancelling with the ECO.

Recommendations

AP was re-briefed and re-assessed by ISS Training Manager to confirm awareness of procedures and processes involved in the duties of the AP. APs to count and verify they have the correct number of earths prior to contacting the NP.

3. Incident Details

On 01/10/17 at Liverpool Lime St, the breakers tripped at a live open line adjacent to where an Isolation was held. Reports were there had been a flash over. Concern was if an RRV had entered an area where there were live cross feeds.

Investigation

ISS Isolation Planner was onsite, so investigated and found the exclusion zone was managed well, and a dead pigeon found at a bridge arm, which was the cause of the trip.

Recommendations

No recommendations, site notified and incident recorded with ECO.

Accidents and Incidents

4. Incident Details

On 04/10/17 an ISS CC was working at Liverpool Lime Street. He was taking his machine to another work area, and requested some cables were moved by S & T team onsite as they were blocking progress. After they had been moved, CC progressed to work location, but some cables not secured properly and snagged on machine tracks. 1 cable damaged and 1 snapped/cut.

Investigation

Cables not secured correctly and caught by machine. CC was in a position of safety but due to the platform could not see the cables were not in correct location. After incident, S & T staff rectified the issue.

Recommendation

CC was in correct position due to the location of the platform. cables could have been secured better, in future CC/MC to confirm with S & T staff all ok prior to progressing with machine.

Close Call Reporting

We had 22 Close Calls reported by our workers since the last briefing:

Date Raised	Location	Details	Risk Level	Comments / Findings	Status
01.10.17	Lime Street	EA sent to site without ICI competence	Caution	Individual had been sent to external company for training. However no notification of failure. Change made to process of rostering & checking ICI competence on Sentinel	CLOSED
01.10.17	Carlisle Station	Permit to work refused to COSS who had no Sentinel Card and unable to confirm COSS competency held. Sponsor flagged on Sentinel, picture of poor quality. Individual had wrong PPE and poor attitude. Galiford Try replaced COSS and permit issued.	Care	Closed out with agreement of client on site	CLOSED
02.10.17	Parcel Force RRAP	Mobile tower light broken	Care	Lights replaced	CLOSED
04.10.17	Liverpool Lime Street	ISS Minibus driver started to move off after dropping off an on site team when he felt a bump from behind. Slight damage to minibus & a car with possible injury to third party	Care	Under investigation	OPEN
05.10.17	Derby Warehouse	Individual raised up by forklift forks to retrieve an item that had fallen behind a panel	Alert	Individual briefed on safe working practices	CLOSED
07.10.17	Liverpool Lime Street	Impact wrench not on a drip tray	Care	Moved to a drip tray	CLOSED
07.10.17	Liverpool Lime Street	Cable overhanging onto ballast	Care	Moved into troughing	CLOSED
07.10.17	Cambuslang Cutting Drain	Skip in the compound overflowing	Care	Reported to PC	CLOSED
07.10.17	Cambuslang Cutting Drain	No fresh drinking water available in SAMS cabin	Care	Water on site for next core works	CLOSED
07.10.17	Cambuslang Cutting Drain	No lighting at machine access – potential trip hazard due to underfoot conditions	Caution	Reported to PC	OPEN
07.10.17	Cambuslang Cutting Drain	Spigot came free when applying earth at isolation DEP, requiring use of long blue earth instead	Caution	Long blue used at the same location the following week	OPEN
07.10.17	Cambuslang Cutting Drain	EA on site but not signed into Macrail	Care	EA spoken to regarding the importance of signing in	CLOSED
07.10.17	Severn Tunnel	Dust from excavation – very limited visibility & obvious hazard to health	Alert	Air fed masks issued & used, and exclusion zones set up	CLOSED
07.10.17	Severn Tunnel	No relief planned for CC working in the tunnel to allow for a break to eat, drink or get fresh air	Alert	Reported to PC – awaiting feedback or remedial actions	OPEN

Close Call Reporting

Close Calls continued……..

Date Raised	Location	Details	Risk Level	Comments / Findings	Status
12.10.17	Liverpool Lime Street	Needles thrown over bridge at mileage 192m 62ch	Alert	Site supervisor informed and item marked for removal	CLOSED
15.10.17	Cambuslang Cutting Station	2 x PC workers & 2 x other agency workers not in full orange PPE	Care	Raised to PC	OPEN
15.10.17	Cambuslang Cutting Station	Skip in compound overflowing	Care	Raised to PC – not their skip but raised issue that there is nowhere to put waste	OPEN
15.10.17	Cambuslang Cutting Station	No lighting at machine access – potential trip hazard due to underfoot conditions	Caution	Raised to PC – awaiting feedback or remedial actions	OPEN
22.10.17	Ordsall Chord	Breakers tripped several times during section proving works. NWR had left earths in place during previous isolation when superseding in same area	Caution	Earths removed and works commenced with no issues	CLOSED
23.10.17	Cambuslang Cutting Station	EA on site but not signed in with Macrail	Care	Individual rebriefed on importance of signing in	CLOSED
29.10.17	Leamington Spa	ISS Staff member not prepared to park vehicle in hotel car park due to security issues	Caution	Possibility of fatigue	OPEN
29.10.17	Cambuslang Cutting Station	No lighting at machine access – potential trip hazard due to underfoot conditions	Caution	Raised to PC – awaiting feedback or remedial actions	OPEN

Good Practice

15/10/17 at Cambuslang Cutting Station the vegetation was cleared back at site access after previous close calls were raised to the principal contractor

Safety Related Reminders & Client Feedback

PPE

We are still receiving close calls in regards to individuals attempting to sign in at site access without the mandatory required PPE. Please can we remind you that you must only present yourself to sign in once you are fully compliant and wearing ALL of the Network Rail mandatory PPE including cut-level 5 gloves, safety glasses, hard hat, safety boots & full orange.

Signing in & out requirements

We have received close calls in regards to individuals leaving site without signing out with SACS. It is imperative that you sign both in & out with site access to ensure correct fatigue monitoring can be completed and to account for all individuals working on site in the event of an emergency.

Client Feedback

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

Senior Supervisor – Babcock

"The whole team in the tunnel on the night shifts were spot on laying and lining sleepers, installing rails cutting and plating joints. Made life easy for the Babcock staff on site to manage the work with very little issues."

Senior Supervisor - Babcock

"Can you please pass on my thanks to all involved in working on that last shift as again without them we couldnt do our jobs, especially Ivor Protheroe, Kevin Winterburn and the massive efforts of Leon Fraser."

OHL Manager – Babcock

"Once again your guys have stood up to the plate we had 2 very demanding sites this week end and everyone performed to what they were asked to do. Please pass on my thanks to everyone involved."

Vehicle Accidents

NV17 NSZ – 07/10/17
Driver arrived at Tallington access road point, when reversing into the parking bay in between two vehicles. The vehicle struck the steps of the cabin due to poor lighting and that the steps were painted black. Minor damage was caused to the vehicle.

DN15 BHW – 29/10/17
Whilst travelling to work along the A438 driver indicated to overtake a vehicle and trailer in front. When in the outside lane performing the overtake a third party vehicle struck the back of our van causing damage to the rear and OS.

Driver Reward Scheme

Score	Driver/Vehicle
97.8	Liam Sheehan
97.7	Andrew Harland
97.6	Alan Kelsall
97.5	Paul Garner
96.7	Jonathan Evans

Score	Driver/Vehicle
20.6	NU66UXX
25.5	NV16XGM
37.8	MJ16TZK
38.8	NU15RUC
39.3	MW16OCS

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 in green for their fantastic performance in September, your prizes are on the way.

Driving Safety

Road Safety Week

Road Safety Week 2017 (20-26 November) will focus on the topic of speed. Speeding is a big problem in the UK and is a contributory factor in nearly a quarter of fatal road crashes. Driving is unpredictable, and if something unexpected happens on the road ahead – such as a child stepping out from between parked cars – it is a driver's speed that will determine whether they can stop in time and, if they can't stop, how hard they will hit. We all live busy lives and there is a temptation to speed up in the hope of saving time, where in fact we could be costing lives. That is why we are encouraging everyone to SpeedDown Save Lives for Road Safety Week 2017.
During Road Safety Week we will be holding workshops and providing interactive tools to focus the way we think about speed and road safety. Keep an eye out for the posters and leaflets that will be in our offices or why not take the time to visit http://www.brake.org.uk/ to find out more.

<u>During the road safety week the best performing driver will receive a £100 voucher prize.</u>

Industry Alerts

NetworkRail

Shared Learning

IP Central

Worksite Irregularity – Walsall to Rugeley Project

The Walsall to Rugeley Project had a blockade in place between 12th August 2017 – 29th August 2017. Part of the planning for the blockade by Network Rail included the provision for a freight train to enter Brook Sidings within the blockade, with agreement that a path would be provided on each mid-week day throughout the blockade duration. All train details were entered onto a train plan.

A Weekly Operating Notice London North Western Route published for Week 20, contained a remark stating that the path for the train into Brook Sidings was between 09.35 Sunday until 23.59 Friday – there was no reference to the train plan which had been produced.

On 14th August Network Rail's Operations Delivery Manager (ODM) established that the train which was planned to enter Brook Sidings that day had been cancelled. Later in the day the ODM became aware that an unplanned train was en route towards Brook Sidings.

The ODM notified both the Person in Charge of Possession (PICOP) and the Engineering Supervisor (ES) who agreed a plan to shorten back the worksite and possession. The ES failed to make contact with the Controller of Site Safety (COSS) to advise of this which resulted in the unplanned train passing through the worksite with the COSS being aware of the train movement. No injuries were sustained, and the event was reported as an Operational Close call.

Shared Learning:

- Are clear lines of communication in place between Network Rail and Suppliers who are undertaking works in a blockade?
- Does the published WON contain the information provide within the train plan?
- Has the ES been included in the planning stages of the works?
- Are all the relevant parties included on any distribution lists to ensure that they are kept up to date and informed of key messages?
- Does the planning for the project consider the effects of cancelled trains or the consequences of late arrangements for unplanned movements?
- Does the ES have sufficient geographical knowledge of the worksite that they have been deployed to manage?
- Network Rail Route Control must liaise with the Signaller and PICOP to ensure that any train which will require a possession to be lifted during its journey can be accommodated, before the train sets off from its origin.
- During 'T minus' reviews, has the WON been reviewed?

Industry Alerts

Shared Learning

Key learning following a serious incident

everyone home safe every day

Kubota placed on line open to traffic

Issued to:	**All Network Rail line managers, safety professionals and RISQS registered contractors**
Ref:	NRL 17/04
Date of issue:	03/11/2017
Location:	Rookery Bridge, Crewe
Contact:	Jane Cummings, LNW Accident & Assurance Investigator

Overview

At 00.02 on 3 January 2017 a Kubota road rail vehicle was placed on an open goods line during a T3 possession of the adjacent main lines at Rookery Bridge between Crewe and Sandbach.

In the Sectional Appendix the main lines are called the "Wilmslows" and the goods lines are the "Manchester Independents", while nearer to Crewe the main lines are called the "Manchesters".

The T3 possession is cyclical and usually includes both the main lines and the goods lines, however on this occasion only the main lines were blocked.

The Engineering Supervisor (ES) was unfamiliar with the location and referred to the main lines at this location as both the "Manchesters" and "main lines". The Controller of Site Safety (COSS) took this to mean the Manchester independent goods lines.

The access point cited in the Safe System of Work Pack (SSOWP) was Rookery Bridge, however this is located on the goods lines side of the railway and therefore is not viable when the goods lines are not included in the possession.

Underlying causes

The ES was not familiar with the location and had not attended a site visit or the planning meetings.

The ES was sourced from a contingent labour provider and the team dynamics of them managing local in-house teams had not been recognised.

The ES conducted their briefing with one of the working parties over the telephone compromising clarity and restricting the chance to check understanding, including signed acceptance of the worksite details.

The SSOWP takes access point data from the National Hazard Directory (NHD) which allowed Rookery Bridge to be selected despite the goods lines not being included in the possession.

Key message

The Person in Charge should be involved in the planning – a key factor is to make sure staff such as the ES, the PIC (and if different the COSS) have local knowledge.

Use location names as they are stated in the Sectional Appendix to avoid confusion.

Worksite briefings should be face-to-face to enable staff to sign their acceptance of the worksite details.

Attending site visits and planning meetings is of vital importance for safety critical staff.

The NHD is not 100% accurate and any discrepancy should be raised with the local Systems Support Manager.

Copies of Shared Learning documents are available on Safety Central

Industry Alerts

Safety Advice

Action required following a serious incident

everyone home safe every day

Failure of Tensorex C+ upper fitting bracket in OLE

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

Ref: NRA 17/10

Date of issue: 20/10/2017

Location: Structure MLN/46/424, Great Western Main Line

Contact: David Campbell, Principal Engineer STE

Overview

On the evening of 28 August 2017 the failure of a Tensorex Upper Fitting Bracket (Pfisterer part number 042216) was discovered in the Overhead Line Equipment (OLE).

Investigations indicate that the failure of the bracket was caused by poor quality welding of the stiffening plate during manufacture. This in turn caused a secondary failure of an M14 terminal fork.

The failed component is part of an assembly fitted to the specific assets listed:

PADS	OLE System	NR Allocation Ref Pfisterer Code	Compensated Load
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]

Immediate action required

IP electrification teams who are installing and any maintenance delivery unit which maintains the Tensorex devices listed above should:

1. identify all locations where they are installed;
2. inspect all installed brackets; and
3. check all brackets in stores for poor quality welding.

The inspection should focus on the quality of the welds, damage to the weld and insufficient welding of the stiffening plate.

Inspection can be from low level using a suitable camera device or at high level working from an access platform.

Any unit which has been fitted with the 042216 upper fitting bracket, and has subsequently failed the visual inspection should be retrofitted with a replacement part fully compliant to the design specification at the earliest possible opportunity.

All locations of failed units shall be reported to STE.

Alternatively, Route Asset Managers may wish to schedule replacement of the parts without survey.

To assist with future identification of any Tensorex C+ units which have passed the inspection criteria, or are retrofitted with a replacement upper fitting bracket, shall be clearly identified by way of yellow dots on the underside of the upper fitting, directly below both terminal fork positions.

Copies of Safety Advice are available on Safety Central.

Industry Alerts

Safety Bulletin

A serious incident has taken place

everyone home safe every day

Contact with moving machinery

Issued to:	**All Network Rail line managers, safety professionals and RISQS registered contractors**
Ref:	NRB 17/22
Date of issue:	04/10/2017
Location:	High Wycombe Station
Contact:	Chris Carey, Head of S&SD IP Central

Overview

On the 30 August 2017 at High Wycombe Station, an operative was seriously injured when he, sustained crush injuries from a JCB tele-handler.

The operative was working with the machine operator to lay "bog-mats" in preparation for heavy vehicle access.

Whilst positioning a section of "bog-mat", the operative became trapped at the front of the machine sustaining multiple injuries including fractures to their leg, and is currently in hospital recovering from these.

Discussion Points

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

- How do we make sure that exclusion zones are adequate for the tasks being undertaking?
- How do we know who is responsible for maintaining the exclusion zone?
- How do we make sure that the driver understands the task they are to perform?
- How are ground and weather conditions considered before operating plant?
- How do we set up clear communication channels between the driver of the vehicle and operative on the ground?
- How would you check that the machine has been correctly maintained?
- How do you know the operator is authorised to drive the machine?

Copies of Safety Bulletins are available on Safety Central

Industry Alerts

Safety Bulletin

A serious incident has taken place

everyone home safe every day

Near miss with staff involving Lookout Operated Warning System (LOWS)

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

Ref: NRB 17/23

Date of issue: 02/11/2017

Location: Ecclefechan, Dumfries & Galloway

Contact: Simon Constable, Head of Route Safety, Health and Environment, Scotland Route

Overview

On the morning of 29 September 2017 red zone working, by use of Lookout Operated Warning System (LOWS), was in place by to allow survey work for the High Output team to take place.

The work commenced at 0730 that morning and at 0830 advanced LOWS operators were positioned on the Up and Down lines. A site lookout was also in place for the group as per the planned safe system of work.

At 1010 the site lookout became aware of the approach of a train on the Up line due to hearing and feeling the vibration of a freight train on the rails.

The group had not been warned or alerted of this train by the LOWS system.

They were warned by the site lookout and moved clear and into a position of safety. One member of staff was walking on the Up line when the train approached and reached a position of safety 5 seconds before the train passed.

Immediately after the incident the COSS called the LOWS operator who had failed to warn of the oncoming train. The operator highlighted he had not seen this train passing his location, although they had not missed any prior to this event.

Discussion Points

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

- How can we manage the risk of fatigue in LOWS operators?
- What can you do to better protect the safe system of work from fatigue and concentration issues of staff carrying out LOWS duties?
- How do you provide increased sighting distance due to foliage obstruction?
- How do you take account of any changing conditions, for example new vegetation growth?

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

COLAS RAIL

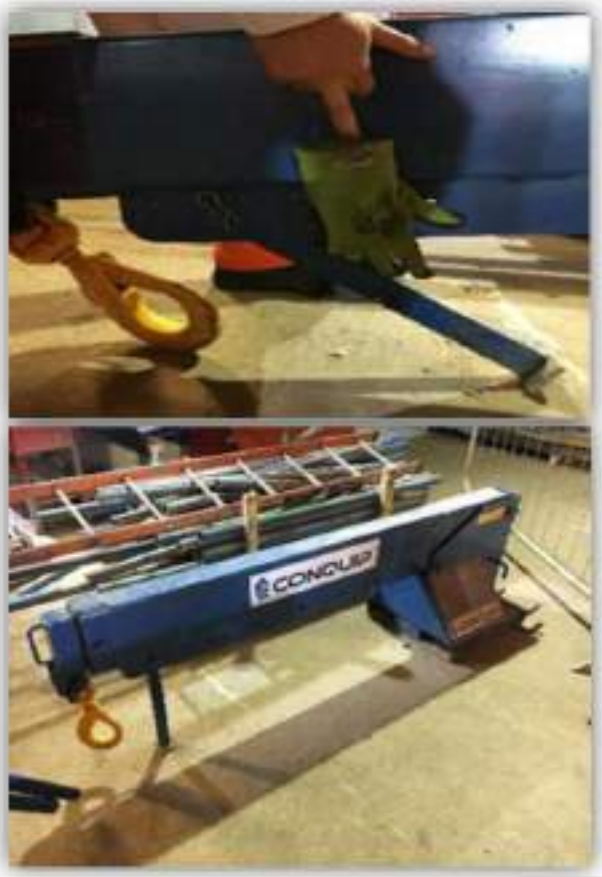
S&S Information No.250

Accident in Waterloo

This Alert is for the attention of: All staff and sub-contractors

Background

On the 31st October at Waterloo two operatives (Skanska staff) were asked by the sub-contractor to move some materials including a forklift attachment. Whilst manually moving the 260 Kg forklift attachment, the injured person's little finger, left hand became trapped between the leg-support and the beam of the forklift attachment. The Injured person received first aid treatment and was taken to hospital for further medical treatment where their finger was partially amputated. They are expected to return to hospital for further medical care.



Actions

- Do not move or transport any plant that does not belong to you or know how it operates.
- Manual handling activities should consider mechanical means before manual handling.
- All plant should be stored in a safe position and easily accessible with a safe system in place to manoeuvre.

Industry Alerts

COLAS RAIL S&C South Alliance

Colas Rail Infrastructure Safety Alert No.38

Un-Authorised Staff Operating RRV's

This bulletin is for the attention of:
All staff and sub-contractors

Overview:

During works at Three Bridges to Balcombe Plane Line renewal it was reported that a member of track staff climbed in and operated an RRV during shift change over.

This is a breach of the Lifesaving rules

Never undertake any job unless you have been trained and assessed as competent.

This was not reported at the time of the event and came to light 48 hours after.

The individual has been stood down pending investigation into the events

Actions Required:

- Verification that only trained and authorised staff operate tools and plant through the use of the Sentinel APP.
- All Colas Rail and Alliance Staff to follow the RED procedure when reporting events.
- All visitors to be briefed on the escalation process for reporting events on Colas Rail PC worksites

Industry Alerts

Shared Learning – Brent Cross Cricklewood

carillion

TEST BEFORE TOUCH

Recently on a Carillion site, an isolation of the OLE was required. The NWR Nominated Person (NOM) received permission from the ECO to take the isolation. The NOM instructed the Carillion appointed person (AP) to place the required earth bonds on the OLE

Before placing the bonds the AP carried out an electrical test to ensure the system was not live, in line with the earthing procedure. The result indicted that the system was still live. The AP informed the NOM who contacted the ECO. After a short period the ECO requested a second test and the OLE was proved not to be live.

In this instance the life saving rules were adhered to. The AP performed his duties to the book, preventing a potential life threatening incident

This highlights the importance of the Network Rail life saving rules and why we should always follow them.

ALWAYS TEST BEFORE APPLYING EARTHS

NEVER ASSUME EQUIPMENT IS ISOLATED – ALWAYS TEST BEFORE TOUCH

NEVER UNDERTAKE ANY JOB UNLESS YOU HAVE BEEN TRAINED AND ASSESSED AS COMPETENT

Health & Wellbeing

Cholesterol

Cholesterol is a thick waxy substance naturally produced by your liver. The amount of cholesterol in your blood stream is largely determined by the amount you produce, however dietary cholesterol can also be found in some foods including egg yolks and seafood.
Cholesterol is essential for your health and is used by every cell in your body, but if you produce too much of it, it can contribute towards you developing cardiovascular disease such as a stroke or heart attack.

Around six out of ten people in the UK have raised cholesterol and there are rarely any warning signs if you have high cholesterol. In some cases the first sign is a heart attack or stroke itself, but early warning signs could be angina (short lasting central chest pain), pain on walking or fatty deposits on the eyelids. The only real way to check is to have a blood test with your GP or other healthcare professional.
In most cases high cholesterol doesn't have any symptoms – like high blood pressure you'll only be aware you have a problem if you have a test – in this case a blood test.

Risk Factors

Like other factors relating to cardiovascular disease, there are a number of uncontrollable risk factors such as having a close family relative, or family history of high cholesterol. However some of the factors you can take control of include:

- Not being active enough
- A high saturated fat or sugar diet
- A diet high in cholesterol
- Smoking
- Consuming too much alcohol

Reduce your risk

If you've been diagnosed with raised cholesterol, or looking to prevent high cholesterol, the good news is that you can do lots to help by making small changes to your lifestyle by:

- Eating less saturated fats (foods containing saturated fats including pies, fried foods, processed ready meals, chips, butter, hard cheeses, cakes & biscuits)
- Eat more healthy fats (foods such as oily fish, avocado, nuts, seeds & olive oil)
- Eat more fibre (foods such as oats, barley, peas, beans, lentils, fruits & vegetables)
- Give up smoking
- Doing more exercise

In some cases your GP may also feel that you need to take medication alongside making lifestyle changes.

Safety

Worksafe

We do not expect any employee to work in an unsafe manner to achieve results. If you think something is unsafe, then it is imperative that you stop working. If you have concerns about safety, the worksafe procedure exists to ensure that you have the right to stop work and have the situation assessed in a fair way.

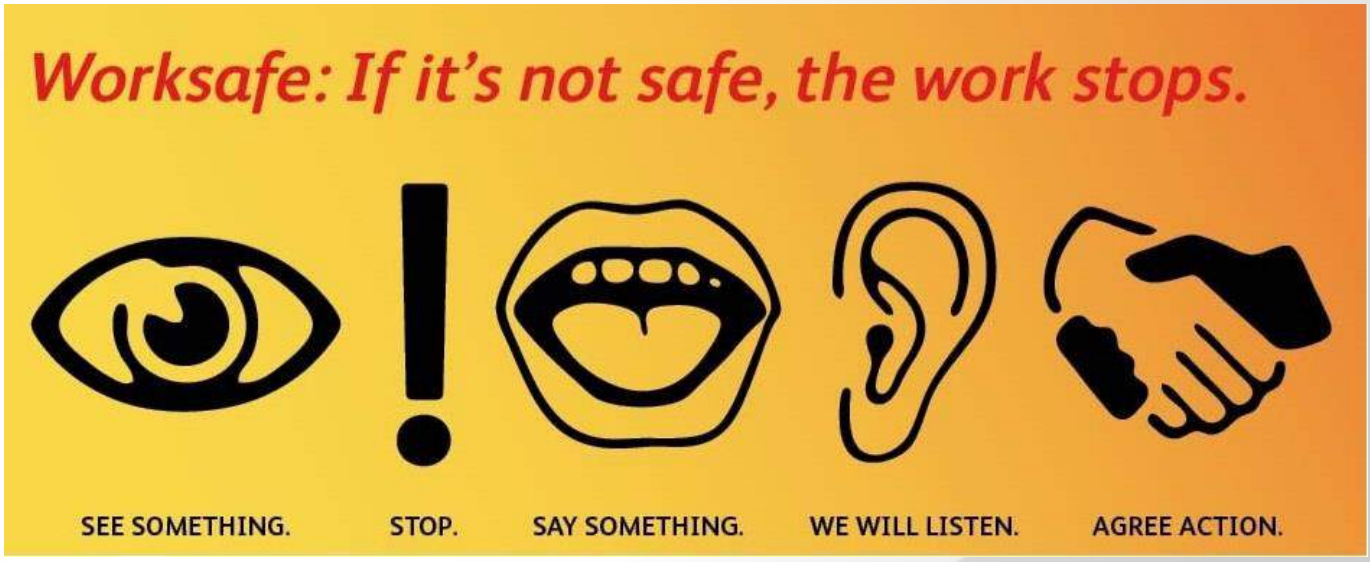
If you are asked to undertake a task without the required training, the correct equipment, adequate PPE or without a safe system of work then it is your right to invoke the worksafe procedure and prevent a potential accident or incident.

How work safe operates:

1) Stop work & move to a position of safety, and immediately contact the person in charge explaining that you have invoked the work safe procedure & explain why you have stopped the work
2) The person in charge shall, in discussion with the employee make an assessment of the situation & determine the course of action required
3) An agreement should be reached that there has been a suitable & sufficient risk assessment of the task, the system of work is safe and that the work can be restarted

If not agreement can be reached, the work will not be restarted and you must contact the on-call manager. The on-call manager alongside the person in charge will agree when the work can be made safe, when staff can return to work and whether to possibly assign them to other works in the meantime.

It is important to note that until the work has been made safe, you are not obligated to carry out the task and that you will receive full support from your manager.



Environmental

Carbon Footprint

A carbon footprint is the total greenhouse gas emissions caused directly & indirectly by an individual, organisation, event or product and is expressed as a carbon dioxide equivalent. As an organisation we are actively working to try and reduce our carbon footprint and offset our CO2 emissions in a practical way to reduce our contribution to climate change.

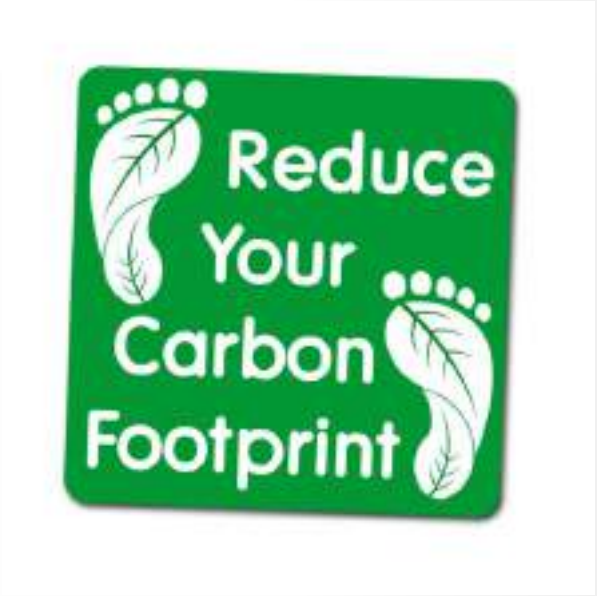
There are numerous ways that as an individual you are able to offset your carbon footprint whilst at work:

Driving

1) Car share for journeys if possible and utilise each seat in the vehicle
2) Avoid speeding and unnecessary acceleration which waste fuel & money
3) Properly inflate tyres to improve your fuel mileage
4) Avoid traffic where possible as being stuck wastes fuel and unnecessarily creates co2 – use traffic apps or websites
5) Remove excess weight from your vehicle & if possible utilise cruise control
6) Do not leave your vehicle engine idling when not in use

Other ways

1) Trim paper usage by only printing & using what is required
2) Ensure to recycle any recyclable items in the correct bins provided
3) Control the air conditioning and make sure it is switched off when not in use
4) Turn off lights or equipment when not in use



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:

ISS Labour