Safety Advice

Action required following a serious incident

everyone home safe every day

Fatality in welding machine

Issued to:	**All Network Rail line managers, safety professionals and accredited contractors**
Ref:	NRA20-13
Date of issue:	09/12/2020
Location:	Eastleigh long-welded rail depot
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Overview

On Monday 30th November a rail loading operative employed at the Eastleigh long-welded rail depot died while maintaining a welding machine. He was part of a small team cleaning electrical contact plates. A 108m length of rail was inadvertently moved along the conveyor, trapping the worker. This conveyor which moves rail through the welding machine had not been isolated. No permit to work had been issued for the maintenance task.

The work activity risk assessment identified the trapping risk and described a mechanical isolation procedure. The lock-off procedure was flawed and not followed. There was a heavy reliance on personal protective equipment and procedures as controls identified in the risk assessment.

The depot is operated by Route Services but as other locations, the premises and plant are the responsibility of the local Route, in this case Wessex.

Immediate action required

1. Check all your risk assessments are current (within their review date). Have they been critically reviewed by people who do the work and a competent safety professional?

2. Ask yourself how effectively you and your team apply the principles of prevention: eliminating hazards; reducing risk; isolating danger; engineering controls; safe procedures and only as a last line of defence, personal protective equipment?

3. Asset owners in Routes must specifically check all sites and equipment operated by Route Services. Do you know how they are used in practice and can you show the right controls are in place?

4. Isolation and permit to work guidance can be found on the HSE website here.

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