Shared Learning

COSTAIN

The Thameslink Programme Issue Date: 27th July 2016 - For further info contact sharon.fink@networkrail.co.uk

Issue Number: TLP061 Title: Glass Reinforced Panel Fell

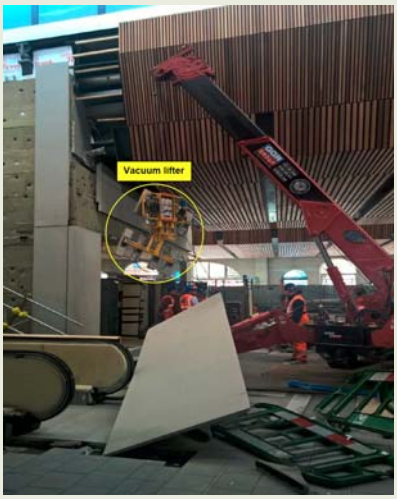
Overview of Event:

A Glass Reinforced Concrete (GRC) panel weighing 362kg became detached from a vacuum suction lifting device (GGR 1000) and fell to the ground hitting the Spider crane outriggers and the installed escalator. The Spider crane was being used for the lift. The panel was being lifted as part of the works to install cladding on the south elevation of a retail unit in the new station. There were no injuries but there was some damage caused to the GRC panel and the out rigger of the spider crane.

General Key Messages:

- **Planning / Documentation:** required documentation detailing the work should be in place prior to works commencing
- **Supervision:** supervision should be in place and effective for all works
- **Resources:** allocated resources should assigned for the works
- **Competencies:** persons undertaking the tasks should be competent to operate the equipment

Photo of Event :



Actions Taken As a Result of the Investigations:

- All documentation was reviewed, updated and briefed including Work Package Plans and Lift Plans
- Competencies of team reviewed to operate equipment
- Pre-use check regime implemented
- Additional safety inspections introduced
- Observation system introduced to oversee the activity
- Dedicated Appointed Person resource employed

Causes:

Immediate Cause – A collision between the GRC panel as it was being lifted and the [static] crane resulted in a loss of seal between the vacuum lifter suction pads and the surface of GRC panel; this caused the 362kg panel to fall.

Root and Underlying Causes

Procedure: The lifting operation was not adequately covered by a Lifting Plan and Lift Permit [e.g. insufficient detail and incorrect personnel].

Procedure: The WPP and TBS were inadequate.

Procedure: The lift was not adequately supervised. A Lift / Crane Supervisor was not in attendance.

Procedure*: There was no evidence that the vacuum lifter equipment was being inspected before use or on a periodic [weekly] basis i.e. as per PUWER. This demonstrates a lack of control and supervision of work equipment.

Training: The operatives did not have the necessary training to carry out the lifting operation [not slinger / signallers]; this resulted in loss of control of the activity; this resulted in loss of control of the activity.

Organisation: The Appointed Person [Lifting] was also acting as the Health and Safety Advisor. The lack of adequate resources did not allow him [AP] the opportunity to fully comply with his lift planning duties and resulted in a failure to produce competent lifting plans and therefore a loss of control of the lifting activity.

Organisation: The Supervisor failed to ensure that the works were carried out safely – he did not brief the work team in the safe system of work and controlling documents because he did not have them.

Organisation: The senior managers on site did not ensure that the works were carried out safely – principally, the work teams were not provided with safe systems of work and adequate supervision.

Organisation: The subcontractor contracted another contractor to execute the works; there is no evidence that sub-contractor was managing the contractor, that is, they left them to deliver the works without appropriate controls.

Organisation: The lack of direction and appropriate intervention by the sub-contractor resulted in a working culture that did not encourage safe behaviours and challenges of unsafe conditions.