Lessons Learnt:
Local & Formal Investigations

Date:
Issued By: Infrastructure Projects Southern S&SD, Floor 2, Waterloo General Offices SE1 8SW

Issue Number: 002
Title: IP Southern: Fall from Scaffolding
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Overview of the Event

The works required the installation of a temporary access scaffolding to allow inspection, repair and painting of the bridge to commence.
The works were being undertaken within a 27 hour T3 possession and involved the erection of scaffolding to the soffit and wing walls of the bridge.
At about 1935 hours, a scaffolding operative working as part of a gang of five on the beam section to the underside of the bridge was individually tasked with cutting some over length scaffold tubes. This task was done away from the main group.
At some point the operative went for a drink of water; appears to have "blacked out" and fallen 5.5 metres on to the track below.
The emergency services were called and after stabilising the operative's condition he was taken to hospital where the operative was diagnosed with fractures to both his feet.

Immediate Cause

The operative fell from the scaffold because he was not restrained by his lanyard and safety harness because the lanyard and safety harness were not connected to the scaffolding at the time.

Underlying causes:

Fatigue caused by hunger (the operative had not eaten since breakfast – about 0730 hours that day), thirst (his last of water was about 1500 hours) and inadequate rest breaks (he had been working without a break since about 1440 hours).

Perceived pressure to complete works (the works were behind – but there was no immediate pressure to work on).

Distraction caused by a minor blow to the head while to operative was working under the bridge (the operative struck his head on a piece of metal that he did not see).

Failure to use the safety harness and lanyard provided at all times, including when accessing and exiting the scaffold

Other issues

Network Rail awarded the contract for the works several weeks behind programme.

The Operatives management of planned working/travelling hours in excess of 14 hour door to door recommended maximum. Investigation confirmed travel as a passenger was "work time" and should be included in calculations.

This work was outside the normal working pattern for the operative – he usually worked Monday – Friday but had to work both days at the week-end as well.

Key Message:

Always use a safety harness when working at height, unless other protection is in place. This includes access and egress from scaffolds