Safety

EVENT LEARNING

Safety & Sustainable Development

No.020

Incident Date / Time:	***25th November 2014, 12:30 hours***
Location:	***Low Buckholmside, Galashiels***
Works Taking Place / Incident Type:	***Offloading sleepers from flatbed lorry /Accident Specified RIDDOR***
Issued By:	***Safety & Sustainable Development Team***
Project Name / Number:	***Borders Railway – Track / 129713***
For the attention of:	***All Scotland and North East***

DESCRIPTION OF INCIDENT

Concrete sleepers were unloaded from a flatbed lorry using a 4 sleeper spacer attachment which had been modified into a 5 sleeper grab. A member of site staff, acting as a slinger, was struck on the lower left leg by a sleeper when it fell from the grab resulting in a serious crush injury. The injured person subsequently had the lower part of his leg amputated.

CAUSES

Immediate cause

No physical exclusion zone had been set up on site and the IP was standing within 2 metres of the lifting activity.

Root cause

The root cause of this accident revolves around the management of change. Specifically, on this project, the logistics strategy for the delivery of sleepers to site changed.

One year before planned delivery, a decision was made to deliver sleepers to site in bundles of 5. This was the usual practice of the contractor working / delivering in Europe where bundles of 5 suit their sleeper spacers.

In the UK, sleepers are generally delivered in bundles of 4 or 7. Crucially, ’5 sleeper’ grabs are not readily available in UK.

The decision then, to change the logistic strategy, produced numerous failures in related processes and is at the root of this event.

Underlying causes

Plant and Equipment: Two 5 leg sleeper grabs, sourced from a subcontractor, were actually modified 4 sleeper spacers. These sleeper grabs were subject to uncontrolled modification and were not fit for purpose.

Procurement process: Processes to ensure that modifications complied with the required Regulations were not verified.

Planning: The Task Briefing Sheet did not reflect the changed work activity with different equipment.

Training: Formal training at various stages in the planning and delivery of the specified work was inadequate / absent.

Works Delivery: Significance of the changed work activity was not recognised at site level and the sleeper grab inadequacies were consequently worked around rather than being reported.

Infrastructure Projects

Scotland & North East

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In your role, consider the following aspects to mitigate risk and prevent recurrence:

- What changes have occurred (or are about to occur) on your projects? *Do you have a process for fully understanding the consequences?*
- When things change, how do you identify new risks?
- When a contractor gives you a picture of compliance, how will you test it at each stage of the delivery cycle? Are there *assumptions being made? How are these being validated?*
- How will you recognise potential hazards? *Do you recognise how identified hazards/risk could migrate to "normal practice"?*
- How can you assure yourself you have a positive and effective Close Call culture on your project?
- Are you sure that exclusion zones are implemented on your sites? *How will you know that the appropriate controls are observed?*
- What have you learned from the questions raised following this life changing accident? *What will you do differently to prevent a recurrence of this kind?*

Whether in the office or visiting site, what safety conversations will you have to procure, plan and deliver work safely?

How will we influence and enable Lifesaving Rules?

Always use the equipment that is fit for its intended purpose

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

Never enter the agreed exclusion zone, unless directed to by the person in charge.