Lessons Learnt from a Significant Event

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Issued By: Thameslink Programme, HSEA Team, James Forbes House, 27 Great Suffolk Street, London SE1 0NS

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Title: London Bridge Station Redevelopment, Broken Arm

For further information contact Sharon Fink, Health & Safety Manager, London Bridge, sharon.fink@networkrail.co.uk

Overview of Event:

On the 5th April 2013, during piling operations in the arches area below the main station, an operative sustained a broken arm when a section of unsecured auger dropped and struck the operative's arm.

The process involved connecting one auger to the other. Whilst the operative was clearing arisings to reveal the holes in the bottom auger to allow him to insert the bottom pin, the auger slipped from the piling rig head and dropped approximately 200mm. During this motion, the auger flight hit the operatives right arm near his wrist.

Underlying Causes:

The operating process was the main cause of this accident as the top pin was not inserted before the piling operator started to back screw to allow the augers to be attached.

There are a number of underlying factors that contributed to the accident: -

- The repetitive nature of the task meant that the spannerman (responsible for inserting the pin) mistakenly didn't insert the top pin to secure the auger in place
- The risk of entrapment was not captured in the risk assessment
- There had been a change in the method of piling which introduced new risks and controls which had not been included in the WPP or Task Brief

Photos:

Area showing the distance the auger dropped

Area showing where the auger caught the operatives arm

Key Messages:

- Competent persons should be employed for the tasks they are undertaking, and the safe system of work followed at all times
- Supervisors should satisfy themselves that the operatives are working in compliance with the task briefs and the defined practices for the equipment concerned
- When new risks and controls are introduced, the WPP and Task Brief should also be updated and briefed to the operatives to reflect this.