Shared Learning

The Thameslink Programme Issue Date: 9th Sept 2015 - For further info contact sharon.fink@networkrail.co.uk

Issue Number: TLP037 Title: Working at Height – Recent Events

Overview of Event 1:

Whilst undertaking the installation of structural steel to the underside of a bridge, a steel erector climbed from the basket of a cherry picker onto the scaffolding adjacent to the site. The operative was restricted from completing the beam installation from the cherry picker and needed to access the scaffolding to complete the task.

Overview of Event 2:

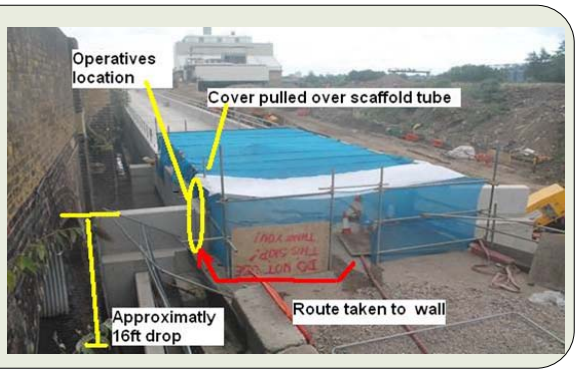
Works on site required blue netting to be placed with cable ties to a scaffold. These were all at shoulder height and behind scaffolding therefore the scaffolders were not required to wear their harnesses. The blue netting had run out and the team decided to use terram which is tougher and stronger and needed holes to be punched through to tie in to the scaffold. The operative took the action to go onto the wall on the outside area of the scaffold to do this. The scaffolder was not wearing a harness at the time. The fall from height would have been approximately 16ft.

Photo of Event 1:

Southwark Street, London Bridge

Photo of Event 2:

Bermondsey Dive Under



Causes:

Immediate - The site operatives in both events made conscious decisions to take shortcuts to progress the works which led to them putting their lives at risk.

Root and Underlying Causes

Event 1

- The operative identified an access issue which restricted the team from completing the task. The access issues were not foreseen during the planning and therefore did not form part of the WPP.
- The Fabricator did not communicate the required change of methodology to the other members of the Kilnbridge and Skanska team.

Event 2

- This netting element of the activity was not sufficiently planned. It was omitted from the WPP and TB.
- There was a change and the change procedure was not followed - the blue netting material had ran out and so the team decided to use the Terram as a covering.

Actions Taken As a Result of the Investigations:

- Both events were breaches of the Life Saving rules and subsequently both operatives went through the Fair Culture Matrix.
- On site behavioural checks are being undertaken as a result of both events.
- Teams have been re-briefed on safety working practices and how to manage change.
- Changes occurred in both events which were not followed as per the change control procedure therefore this has now been added as a documented requirement within the WPP and TB and briefed to the site team.

General Key Messages:

- Planning of works should consider materials / awkward working areas and the ability for operatives to reach all areas of work
- Worksafe procedures should be reinforced on site, so that teams are encouraged to stop work if it becomes unsafe
- Point of work risk assessments should be used to document any changes to planned working with appropriate controls documented
- Lifesaving rules should be continually reminded and reinforced to the workforce and management teams