

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: Tanners Hill Enabling Works – Plain Lining Redundant Points

For further information contact Mike Netherton, Health & Safety Manager KO2 Signalling & Track – mike.netherton@networkrail.co.uk

Overview of Event:

- On 15th September an operative was carrying out a disc cutting operation on a 60 ft length of rail positioned in the 4 ft.
- When he was approximately $\frac{3}{4}$ of the way through the rail he leaned forward to confirm how much more of the rail required cutting when the cutting blade caught within the rail cut and sprung back towards the left hand side of the operatives face causing a deep laceration.
- First aid was given immediately and the operative taken to hospital where the wound was stitched and he remained overnight.

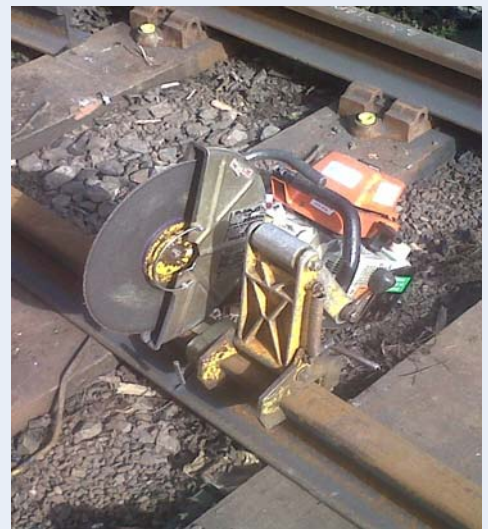
Underlying Causes:

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

- The way the rail was supported lead to the cut closing under the weight of the rail as it reached the last portion of the cut
- By digging out the ballast between the sleepers the portion of the blade that was revealed when the handle of the cutter was lowered towards the ground was increased
- The posture adopted by the operative during the cutting operation put him in a position of danger
- Although a risk assessment was in place it was not comprehensive in analysing all risks of the task
- The competence of the individual had expired which was not recognised by the agency supplying the operative



The photographs show the disc cutter that was being used and the injury sustained by the operative



Key Messages:

- Review and monitor risk assessments to make sure they address all aspects of a work activity
- When selecting agency staff check their competency is valid and suitable for the task they are carrying out and the equipment they are using
- Where possible select or encourage contractors to specify cutting tools which do not require operators to be in close proximity to the material being cut