# Crossrail Lesson Review

| | | | | | |
|---|---|---|---|---|---|
| **Date:** | 16/05/2015 | **Time:** | 09:45 | **RIVO Incident No:** | 4398533 |
| **Contract Number:** | C405 | **Location:** | Paddington Station, Departures Rd | | |
| **Contractor & Subcontractor:** | CSJV - Byrne Brothers | | | | |
| **Contact Name/Number:** | Sarah Roche H&S Manager CSJV | | | **Incident Type:** | LTI |
| **Key Words:** | Manual Handling/Lifting operations/Spill | | | **Crossrail Ref:** | |

## Engage:

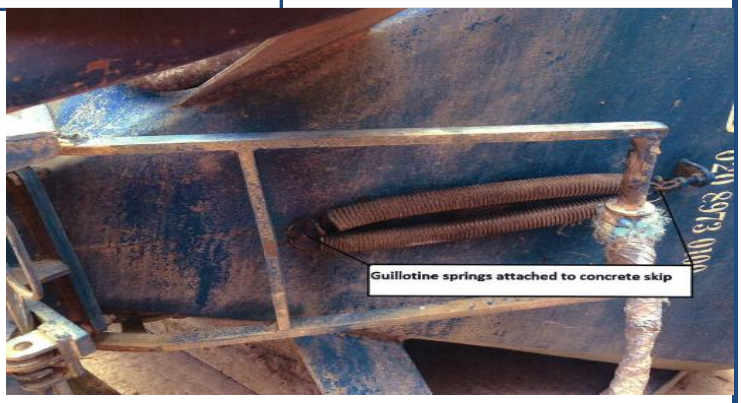
*Provide a brief description of the incident/practice allowing all to appreciate the work environment, tasks being performed, equipment usage. Provide pictorial examples to increase awareness of activities performed.*

A crane supervisor was injured whilst attempting to clear up a concrete spill on the main site haul road. The spill occurred due to the guillotine springs not being reattached to the skip after being washed out by the concrete gang. A traffic marshal and crane supervisor used a shovel to shift the concrete from the road back into the skip. As the crane supervisor lifted his first load of concrete he felt a sharp pain his lower back. I.P. visited hospital and was given painkillers and anti-inflammatory medication. I.P. returned to work on 19.05.15 having lost 1 working day due to the sustained injury.

The crane supervisor (injured party) had noticed the springs were missing when he first carried out his pre-lift inspections, but as the skip was empty at this stage, he felt it was safe to proceed with the lift. The I.P was distracted by other lifting duties and did not reattach the springs prior to the skip being load with concrete.

**Severity Index**

| | |
|---|---|
| 3 | 3 |
| 9 | |


## Educate:

*Identify the contributory factors that led to the incident / best practice * (Include specific notes on Do's and Don'ts to encourage correction of unsafe conditions or behaviors)*

### Immediate cause of event.

Manual handling using a shovel to lift spilled concrete from the road

### Contributory factors:

• *Procedure* - During the washing out process on the concrete skips the guillotine springs where detached and not connected to the skip prior to being used for the next concrete delivery.

***Error enforcing condition***

• *Rule-based mistake* - I.P. carried out a visual inspection of the skip and noticed the guillotine springs were missing, but as the skip was empty at this stage he felt it was okay to proceed with the lift and then attach the springs prior to the skip being loaded.

• *Skilled – based lapse-* After noticing the guillotine springs were missing he was distracted and forgot to attach the springs prior to the skip being loaded

• *Rule-based mistake* - After completing the washing out of the concrete skip the guillotine springs should have been reattached.

## Evolve:

*Identify learning opportunities, process improvements and opportunities for best practice, most importantly identify how this incident could have been prevented/how this practice prevents incidents.*

Project lifting team have been briefed on pre-lift visual checks of all lifting appliances and to ensure all is satisfactory prior to carrying any lifts.

The concrete gang has been briefed on the incident and told to ensure the guillotine springs are reattached after they have cleaned out the skips. The trade contractor will review their procedures to ensure this is made clear for future briefings.

## Leadership & Behaviour:

*What positive and/or negative consequences have there been in response to the incident*

• This incident should be reviewed by the lifting forum/ lifting working group for any additional improvement.

• Try to ensure distractions and interruptions are minimised, to ensure the slinger/signaller can safely and effectively manage ever load.



*Ensure maximum of 1 page per incident*

# Transport for London

## Health and Safety Bulletin – Surface Transport

# Cable Strike Incident

## Date of issue: May 2015

### Background

The Highbury Corner Bridge Structure is being refurbishment as part of the TfL Surface Transport Structures & Tunnels Portfolio. The works include demolition and upgrading of the Bridge. To carry out these works, traffic management arrangements have modified traffic movements at Highbury Corner reducing 2 lanes down to 1 in either direction.

The works required the installation of signage and posts to reduce 'rat-running' through narrow side streets in the area as a consequence of lane reductions. During the installation of the second sign-post an operative came across a service that was encased and struck a cable. He suffered burns following electrical discharge. He was using mechanical tools. The emergency services arrived and took the injured party to hospital.

Initial findings identified additional activities were scheduled outside of the normal planning/programming process. The operatives were instructed to carry out the intrusive work by their supervisor and were not wearing flame retardant PPE, as specified in the Risk Assessment & Method Statement. Had the appropriate PPE been worn the IP's injuries may have been lessened.

The stats drawings and GPR surveys previously undertaken did not cover the location of this sign post installation, Though the area was CAT scanned, it was done without using the associated 'Genny', resulting in the 'live' cable going undetected. Further investigation also highlighted further issues regarding the confidence of the operatives in using this equipment.

Injured party received burns to both forearms (the more extensive being the outer left forearm), burns to the inner upper thigh (left leg) and burns to the face and neck.

### Instruction

- Adequate enquiries must be made into the location of sub-surface utilities including the acquisition of suitable STATS drawings and appropriate surveys – eg. BSI PAS 128, confidence level surveys, A, B, C,D.
- Only competent persons must undertake scanning of the area, using suitable, calibrated equipment, prior to any intrusive works taking place, marking any findings with spray paint or similar. Scanning may need to be repeated throughout the excavation process.
- All equipment should be maintained, tested and used in accordance with the manufacturer's recommendations.
- Risk assessments and method statements, along with any other relevant information, must be provided and adequately communicated to the workforce by competent supervisors especially where English is a 2nd language, assuring that the information is understood. Adequate supervision is then a key factor in ensuring a safe working system is in place on site, including the use of appropriate PPE as identified in project specific risk assessments.
- Tasks additional to the main work/original scope, even when considered small tasks, do not automatically represent a lower level of risk and should therefore follow the same processes and procedures, employing the same safe system of work. Arrangements should be in place to communicate any changes to the design and scope of works with all relevant parties which includes obtaining advice from competent construction health & safety practitioners.

### Further Info

TfL ST SQA 0587 – Pre Works Utility Appraisal
BSI PAS 128 – Specification for Underground Utility Detection, Verification and Location
HSE HSG 47 – Avoiding danger from underground services.

**For construction health and safety information visit the Construction Safety Team Online or email CDM Team**