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# Aberdeen Western Peripheral Route: 11KV Overhead Cable Strike – HiPo L4

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## What happened?

This incident is a HiPo but may also become a Dangerous Occurrence. A HFACS Investigation is underway. Excavator working on water management works tracked through the GS6 boundary and under the live 11kV OHL. The arm of the excavator made contact with the overhead line. The OHL discharged on contact with the excavator arm.

## What were the details?

The excavator had initially tracked up the cut using the GS6 goal posts to cross under the line and had parked on the north east side of the goal posts. He then tracked along the demarcation boundary, running parallel to the line, before crossing the line at the extremities of the works / edge of cutting – in effect turning 90 degrees. The fence creating the OHL exclusion zone along its length in this location had been removed to carry out pumping works and hadn't been re-erected. Something had changed and their focus No injuries were sustained; SSE attended site and initially reported that there was no damage but subsequently it was confirmed that there was an outage.

## What can we learn?

The SEPA Emergency works are currently high priority for the project but the work must continue to be safely planned and executed in line with the Risk Management Process. Task Specific risk assessments and Task Specific briefings must be conducted for every operation – an area the investigation is currently focussing on. The South Section were all stood down immediately until they had been re-briefed and a further project wide briefing has been held to re-brief all operatives as part of their morning “putting to work” briefings. D&A testing was undertaken for the driver which returned negative. The driver has admitted that he was in the wrong and should not have crossed the boundary – he has been dismissed. A more robust ‘goal post / OH exclusion’ inspection regime has been introduced across all sections with daily records being collated centrally

5<sup>th</sup> July 2016



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# Major Projects, Highways:

## BBMMJV – HiPo L4

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23rd July 2016

### What happened?

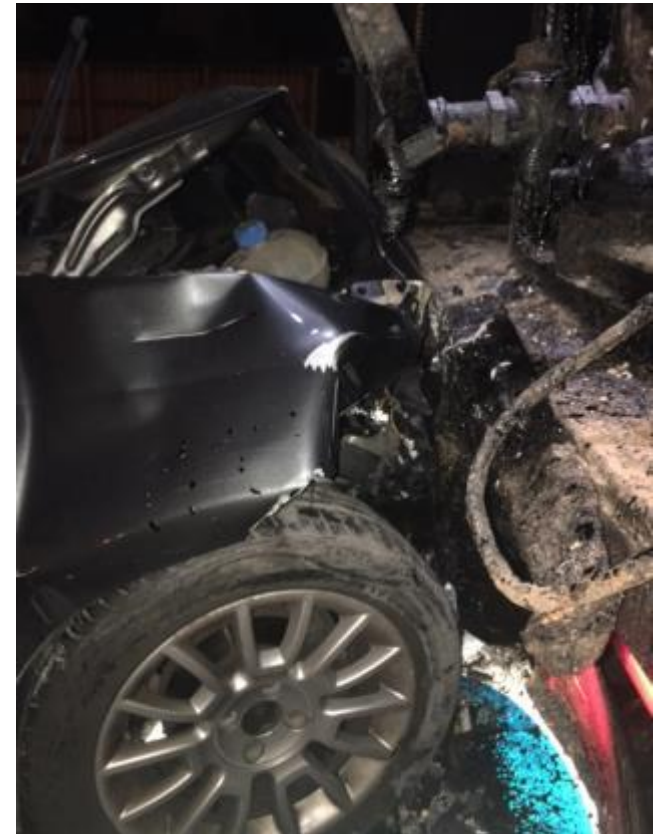
Errant vehicle entered total closure of slip road at speed colliding into the rear of a loop cutting vehicle. No physical injuries sustained. An operative suffered psychological injuries resulting in lost time.

### What were the details?

We were loop cutting at 02:43 on Saturday 23<sup>rd</sup> July working within an overnight closure on M60 junction 23 exit slip when a drunk driver ignored the signs, cones and T/M vehicle driving at speed struck the rear of the loop cutting vehicle. An operative was stood on the flatbed of the vehicle and was knocked over causing minor bruising. He was taken to hospital for further checks and later released. The incident was captured on CCTV and driver arrested at the scene and subsequently charged with drunk and dangerous driving.

### What can we learn?

We must assess if the T/M in place is adequate to prevent an errant vehicle incursion and wherever possible install additional physical barriers to protect the workforce from being harm. Our HiPo Investigation is on-going to identify further control measures and working closely with Highways England to raise public awareness for roadworker safety.



# Aberdeen Western Peripheral Route: Tree Felling Incident – HiPo Level 5

## What happened?

During the removal of 12x trees from the verge along the A96 to allow the construction of the hard standing, one of the trees fell onto Lane 1 of the live carriageway.

## What are the details?

As the tree fell onto the road a motorbike had to swerved around the tree and into the coned lane 2. Directly behind the motorbike was a silver VW golf carrying a child in the rear was unable to react, drove over the tree causing significant paint damage to the underside of the front valance. Initial findings indicate that the work was unplanned, the RAMS had not been reviewed in the last 6 months, no Task Briefing Sheet had been prepared for the works and the operatives had not attended a DAB before commencing works. Supervision on the day was also lacking for the amount of work being carried out.

## What can we learn?

Works must always be suitably planned and set to work by a competent supervisor ensuring the workforce are competent, inducted, briefed on their SSoW (inc Task Briefing Sheet specific to the works) and given a daily activity briefing at the start of the working shift. Also, tree felling must also always take place in a zone large enough to receive the tallest tree being felled with an adequate safety zone beyond to ensure under no circumstances can a tree breach the boundary of the works.

24<sup>th</sup> July 2016



The tree was felled in an area behind the yellow TM sign. At the time of the incident the TM was not as per this picture. When the incident occurred lane 1 was open, lane 2 was closed and a 30mph limit was in place.

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# Major Projects, Highways, M5:

## Vehicle struck by HGV – HiPo L4

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### What happened?

An employee left a works location, entered the live carriageway and came into close proximity with an HGV.

### What were the details?

An engineer was travelling through the works to the next location and found that his route was temporarily blocked. He took the decision to reverse back to the closest access point within the works and attempt to re-join the carriageway at this location.

The engineer looked in his mirror prior to pulling out and did not see the HGV until he was fully committed.

The HGV caught the vehicle in a glancing blow breaking off the wing mirror and continued on its journey.

### What can we learn?

Regardless of circumstances safety rules must be followed when entering and exiting works areas

Drivers must be fully alert and composed when attempting to enter/exit works areas

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27th July 2016



# UKCS North & Midlands, East DU:

## A1 CH2MC – Lost Time Incident

### What happened?

A Traffic Management (TM) Operative suffered a penetrating wound to his arm pit from the foot of an upside down sign as he exited the rear of a Traffic Management lorry.

### What were the details?

The TM Operative was preparing signs for the night, (loading / unloading from the lorry). The Operative was getting down from the vehicle, standing on the bar at the well, stepping / jumping forwards from the vehicle. As he moved forwards the foot of a sign that was stacked upside down against the vehicle (situation recreated in photo) went into his right armpit. The sign foot punctured the skin causing what appeared to be a deep wound.

The TM company Supervisor took the IP to hospital where he received stitches to the wound and was sent home. The Operative is currently believed to be returning to work on 8<sup>th</sup> August once his stitched are removed.

### What can we learn?

The correct method of dismounting the vehicle was not followed. The IP should have stepped down backwards using the rung below. The A1 CH2MC had built up an impressive record of no lost time accidents during the main phase of the works. Unfortunately, there has recently been a run of three lost time accidents. To address this a series of stand down briefings across all shifts is planned to take place on Monday 8<sup>th</sup> August.

01<sup>st</sup> August 2016

