Balfour Beatty

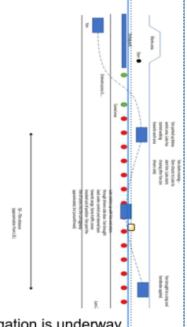
HiPo: Uncontrolled Vehicle Movement

What happened?

On the Highways M6 project, a parked van rolled forwards within the traffic management.

What were the details?

A vehicle belonging to a Drainage Subcontractor pulled into the works. The driver left the vehicle and walked to the nearby work area, but the unattended vehicle began to roll forwards, along an incline (see diagram) towards the live motorway. Upon noticing the van was rolling, the driver ran after the van and managed to catch up with it after it had travelled approximately 50m. He climbed into the van, stopped it and drove it back into a safe position. Several of the cones which demark lane one were pushed out of position. Investigations have identified that the event didn't lead to the public having to take evasive action and there were no injuries or damage as a result. The driver has stated the handbrake was only partially engaged when the van was initially parked, which led to it rolling away.



What can we learn?

Ensure hand brakes are fully applied and vehicle is left in engaged gear. A full investigation is underway.

HiPo: Uncontrolled Plant Movement

What happened?

Further to the initial details in last weeks' email, Highways M4 project had an incident where the boom of a lorry mounted crane entered a live lane.

What were the details?

A lorry mounted crane was being used to deliver vehicle restraint barrier units within a two-lane closure. Whilst in the travel position, the crane boom extended out above live lane 3 then dropped across the live lane, causing live lane traffic to stop. No collision occurred.



Initial Investigation findings indicated that the crane movements were due to the operator unintentionally operating the remote control.

What can we learn?

All plant and equipment must be fully isolated and shut down when not carrying out a work task. Remote controls must be isolated when not in use.

HiPo: Traffic cone entered live carriageway

What happened?

On the Highways M4 Project, a traffic cone was knocked into the live carriageway by an 8 wheel lorry from within the works.

What were the details?

Whilst a lorry was passing through the works it caught the base of a cone and knocked it into the live lane. Cars in the live lane stopped quickly resulting in a road traffic collision. Initial findings show that the cars were lightly damaged, and after exchanging details they continued their journey.

What can we learn?

All access and egress must be kept clear of equipment to ensure the maximum clearances are maintained. An investigation has commenced.





Highways - Initial Incident Notification

Site based HS&E support to complete form ASAP on the day of incident for <u>every significant incident as</u> <u>defined by IAN 128/15</u>. Distribution to include Sector Operations Director, Sector HS&E Manager, Divisional Highways HS&E Manager

Sector: North & Midlands/SMP/South	SMP
(Delete those not appropriate)	
Project Name:	M4 J3-12 SMART Motorway Scheme
Date of Incident:	07/01/20
Time of Incident:	05:15 (Approximately)
Date and Time Information Received:	07/01/20 0720hrs.
Airsweb Notification (Date)	07/01/20

Brief Description of Incident

Location: Between Junctions 13 and 12 Eastbound

Traffic Management pickup returning to Compound 3C at shift end was flagged down by an MOP vehicle and informed that a sign had fallen from their vehicle and caused damage to the MOP vehicle.

MOP was provided with the TM company's standard damage escalation insurance document.

Severity of Injuries / Harm / Damage (give indication of certainty regarding injuries/damage)

No injuries – alleged damage only (TBC) to MOP vehicle

Immediate Actions / Current Status

RCC contacted and 'Obstruction in Road' matrixes activated.

Deactivated once initial sweep by TSCO and attending HETO found no sign but confirmed all lanes were clear of any obstruction between 13 and 12.

Sign was subsequently found at 1230hrs.and removed (use of rolling block) from the central reservation some 3Km from where it was believed the incident had occurred. HIPO investigation launched.

Project Lead Name:	Peter Anusas
Project Lead Phone:	07716225290
Resident HS&E Manager / Advisor Name:	James McCrossan
Person uploading on to AIRSweb: (Name/Number/Airsweb No if completed)	Tier 1 TM Contractor H&S Manager No. 20678
Highways England Representative informed: (Yes/No/Person Informed – How & When)	Initially HETO attending at time of initial escalation
Have photographs been requested: (Include if available)	
Investigation Lead:	Mark Neville (BBV Snr TM CM)





Mandating dual view dumpers six ton and above

From 1 February 2020, all new orders for dumpers six ton and above must be for the Dual View Dumper model (pictured bottom right).

This is because these Dual View Dumpers set new standards in terms of operator and construction site safety, flexibility and economic efficiency. Their design ensures that the operator always has perfect vision in the direction of travel, during transportation, loading and unloading.

This is part of our continued programme of improving the safety of our plant and equipment for everyone on site.

All subcontractor-owned assets (not machines obtained through the rental market) working on Morgan Sindall Infrastructure projects will have a six month transition period (1 August 2020 deadline) to transition all six ton dumpers and above to Dual View models.

Further information will be issued in January 2020.





This advice should be used, where the above is applicable, and the information discussed with your team highlighting the following points:

- The Plant and Equipment Minimum Standards and poster will be updated beginning of January 2020 to reflect the mandatory changes.
- Any queries regarding content within this alert please contact Jonathan Hall (Magnor Plant) jonathan.c.hall@morgansindall.com / 01788 538700.





Gas Utility Strike



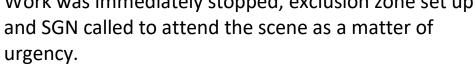
below ground level; it is believed that the Planer knocked the cap off.

Work was immediately stopped, exclusion zone set up and SGN called to attend the scene as a matter of

Planer at Welsh Road East clipped an uncharted 20mm

gas pipe pressure release valve (PRV), for a medium pressure gas main, located approximately 225mm

At approximately 11:30 on the 27th November, a







The service was completely unchartered and had been previously tarmacked over by an unknown party. The only services that were known about in the area were a BT cable at 750mm and Gas main at 800mm and these had exclusion zones set up to avoid them.

Extensive trial holes on Welsh Road East also gave no indication that the pressure valve was there. SGN inspector arrived within the hour and then the Gas team arrived another 30 minutes later to uncover the service fully and to repair the damage/make safe.

Initial findings show that all relevant processes and procedures were followed however, an investigation will be conducted to determine if our processes are robust enough and if we could have done more to prevent this.

There were no injuries as a result of this incident.



SAFETY ALERT

November 2019 Ref 080

North Yorkshire - RIDDOR Overturned Loading Shovel

Date: 12 November 2019

Time: 14:30hrs

Location: Salt Barn, Kirby Misperton Depot

Division: North Yorkshire

A serious incident occurred when a loading shovel working in Kirby Misperton depot turned over onto its side. At the time of the incident, the vehicle was working in the salt barn loading salt onto gritters in preparation for winter maintenance activities to take place later that same evening.

As the loading shovel reversed with the boom up, it appeared to mount the salt whilst undertaking a turning manoeuvre which caused it to turn over coming to rest on the driver's side. Fortunately, the highly experienced driver was wearing his seatbelt at the time of the incident, no injuries, but he was shaken.

The Division have instigated a full toolkit investigation to establish root causes and to identify corrective actions. They key findings of the incident investigation will be shared once complete.

Could this incident happen in your division?

Please carry out a review of this type of work or similar activities in your division. Looking at:-

- Personal factors (competency)
- Job Factors (equipment and location)
- Management Factors (has a risk assessment been carried out?)











David Campbell Health, Safety and Environment Director



SAFETY ALERT

November 2019 Ref 085

Ringway Worcestershire – Dangerous Occurrence

Date: 15 November 2019

Time: 09:00hrs

Location: Lydiate Ash Depot

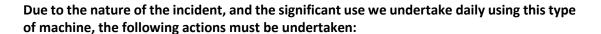
Division: Worcestershire Highways Term Maintenance

During the daily visual inspection of the JCB 535 Telescopic Handler machine (loadall), used for depot activities, the machine (plant) operator identified a significant crack within the extension boom of the machine.

Prior to the inspection of the machine, the defect was not known.

The assigned investigation team are currently in the process of conducting their investigation in line with company protocol and with full co-operation of the Plant Hire Company to determine the root causes and subsequent corrective actions going forward.

These findings will be shared once complete.



- 1. Identify any item of machine/ plant that uses telescopic extension booms.
- 2. Undertake a full visual check of the extension boom and with the boom in a fully extended state (this machine has a 9-metre reach).
- 3. Record the inspection on the machine Defect Report log sheet.
- 4. In the event of ANY defects being located on the extension boom contact your line manager immediately.
- 5. Ensure continued daily visual inspections are undertaken on this type of equipment BEFORE work commences and including a FULL visual check of the extended boom.
- 6. Check Plant Operators are appropriately certificated
- 7. The machines are used STRICTLY in accordance with the user manual

Picture Reference

Picture 1 – The JCB 535 Telescopic Handler (Loadall) Machine being used

Picture 2 – View of extended boom from the driver side

Picture 3 – Side View of the defect from the driver side



Picture 1



Picture 2



Picture 3



David Campbell Health, Safety and Environment Director Eurovia UK





SAFETY ALERT

December 2019 Ref 088

Ringway Gloucestershire- 1-Tonne High Lift Dumper Incident

Date: 2nd December 2019

Time: 11100hrs

Location: Orchard Way, Cheltenham

Division: Gloucestershire Term Maintenance

Works were being carried out at Orchard Way Cheltenham to remove the existing footway and to resurface with asphalt. A 1 tonne dumper was being used on site to transport the spoil being excavated by the mini excavator to the spoil heap.

The dumper was facing away from the spoil pile and therefore needed to turn around to be repositioned. The operative drove out of the site in order to turn around safely, avoiding a three-point turn and to re-enter the site facing the right direction.

The operative turned the dumper in a bell mouth of the road and at the end of his manoeuvre. This resulted in the immediate cause of the incident as he turned too sharply and at speed resulting int the dumper falling over onto its side.

The operative had his seatbelt on and followed his training held onto the steering wheel. This resulted in the operative suffered no injuries. The vehicle was righted, and a spill kit used almost immediately.

The operative was trained to use a dumper in October 2019 and was an inexperienced user. Although the operative was new to the site and was unfamiliar to the Supervisor and Chargehand.

Following the initial investigation, the following actions have been identified and will need to be replicated in other divisions where this item of plant is being used:

- Training and competence levels to be checked with all operatives when being inducted to site
- Buddy system to be in in place for inexperienced worker
- Ensure plant movements on site are planned thoroughly and where relevant, traffic management plans are in place







David CampbellHealth, Safety and Environment
Director
Eurovia UK













Safety Alert Excavator Injury

20 December 2019

The following pages of this safety alert were issued by Highways England's supply chain partner:

Carnell

Reference: SB- 110



Safety Bulletin

Excavator Injury

On the 17th of December an operative was injured whilst securing a 14t long reach excavator onto a drag trailer. The operative sustained cuts to the bridge of his nose and forehead both requiring stiches. This incident had the potential to cause serious life changing injuries.

Whist the investigation is still ongoing the factors below have been identified:

- Both the excavator operator and injured party knowingly worked within the swing radius of the long reach excavator.
- The excavator operators coat had hooked over the left control lever when he had accessed the cab. Once the 'dead mans' arm was lowered the excavator arm immediately slewed to the right contacting the injured party in the ribs and causing him fall and hit his head on the ground.
- The injured party is recovering well and is expected to be back at work soon.



REMEMBER -

- Never enter the exclusion zones around any item of plant unless they have been disabled and you have received the 'Thumb's up' (or similar approved acknowledgement) signal from the operator.
- Prior to starting any plant or equipment ensure that all controls are free from obstruction and not engaged in an operating position.

'Be SAFE' - 'Let's All Go Home Safely'

Danny Pitcher Senior SHEQ Advisor - December 2019

Follow safety procedures at all times







Safety Alert People Plant Interface

8 January 2020

The following pages of this safety alert were issued by Highways England's supply chain partner:

Huyton Asphalt

People Plant Interface



Accident Description:

At 0830 hrs on 9th December 2019, during a planned maintenance operation of sweeping and trimming bushes & shrubs on the verge, from the hard shoulder. This was protected by an impact protection vehicle (IPV) in accordance with Chapter 8 along with accredited personnel.

During this operation, the IPV slowly encroached within the work area and came into contact with a tree-clearing vehicle causing injury to two operatives. These work activities were being carried out to allow safe use of the hard shoulder for the travelling public for planned surfacing works on night shift.

Working on behalf of



Collaborating with



Immediate cause

Struck by a moving vehicle when the IPV encroached into the work area causing two injured personnel due to lapse of a concentration of the driver.

Contributing factors:

- i. The IPV had no motion sensors fitted.
- ii. There was no dash-cam fitted.
- iii. The communications between the two vehicles was insufficient.
- iv. There was a lack of awareness of the IPV location within the work force.
- v. Complacency (behaviour & culture).
- vi. LANTRA IPV training not adhered too.
- vii. Maintenance schedule on the strategic road network.
- viii. Had there be a full closure available, these traffic management arrangements would not have been necessary.

DO YOU KNOW YOUR SAFE ZONES?



Actions:

- A full investigation review was carried out at Director Level.
- A site wide safety stand down was undertaken to raise awareness and H&S behaviours.
- ➤ Induction & Permit reviewed to identify the method of communication and segregation during similar operations.
- Review Risk/No Risk zones and maintaining an exclusion area 75m +/- (25m) as per LANTRA guidance.
- Safe methodology to ensure no personnel works between the IPV and rear of any other vehicle (where possible).
- Traffic Management plans to identify high-risk areas and segregation distances as per LANTRA guidance.
- If unsure STOP works immediately and ask.

Lessons Learnt:

- 1. Immediate Terms (completed)
 - a. Review operations of this nature.
 - b. Ensure an adequate communication system in place between the IPV and the work force prior to moving any vehicles at any time.
- 2. Medium Term (implementation date 8 weeks)
 - a. Development of safety technology initiatives of proximity alarms and communications devices.
- 3. Long Term (on-going)
 - a. Further develop new safety technology for trial and implementations for IPV's, to be shared as best practice to the wider community.

