

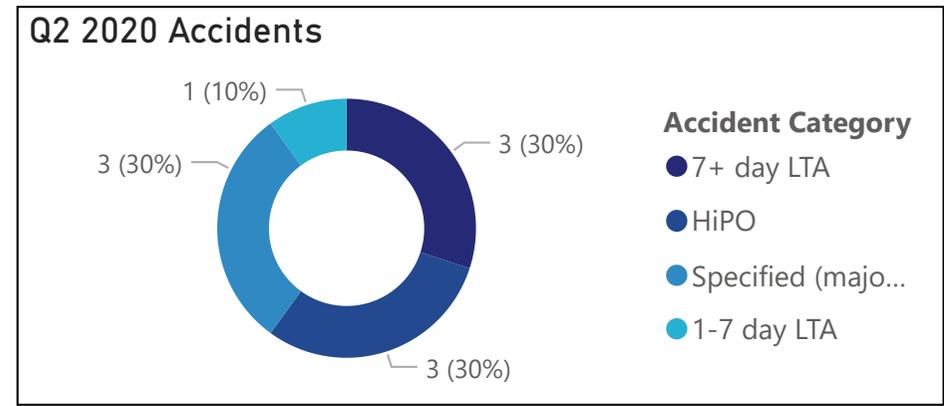
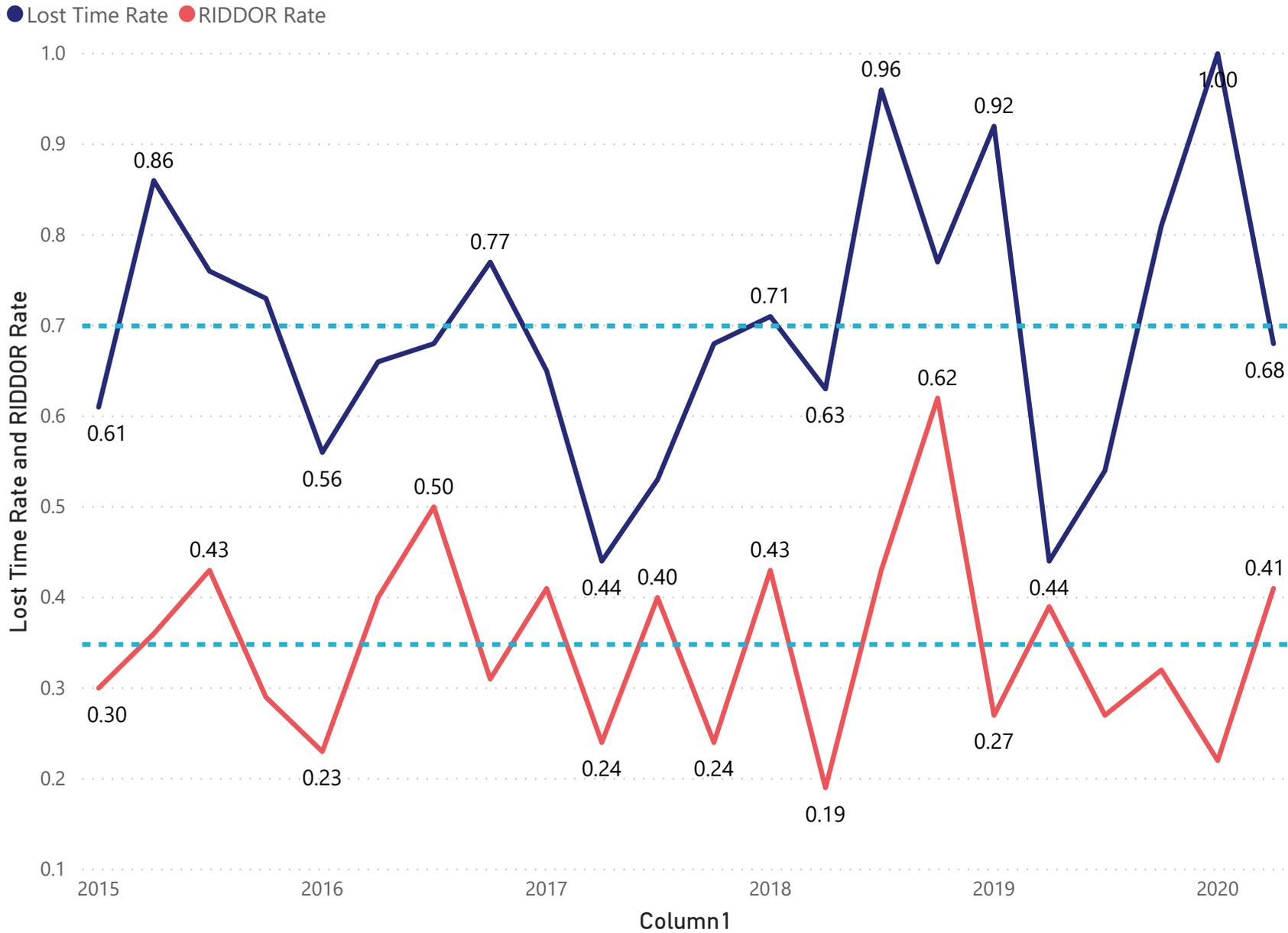
**FEDERATION
OF PILING
SPECIALISTS**

Quarter 2 2020

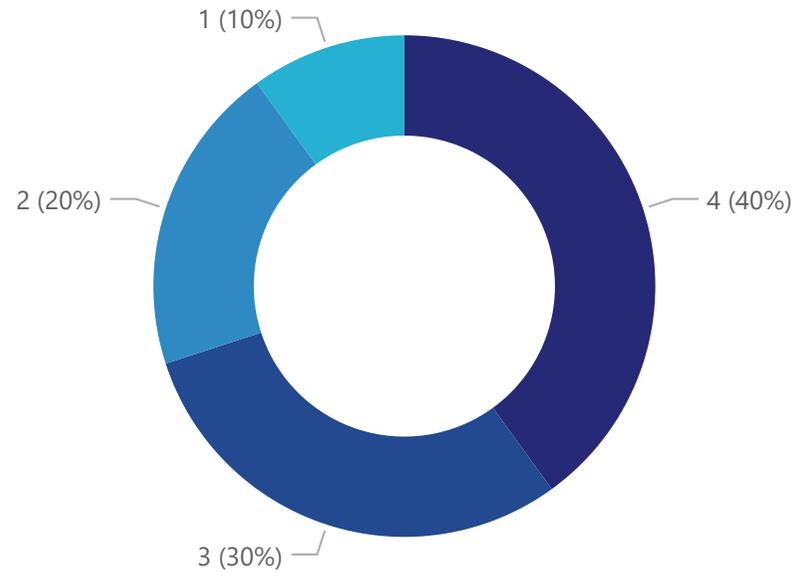
Accident/Incident Statistics

Frequency Rate: No Acc/Manhours x 100,000

Lost Time Accident Frequency Rate and RIDDOR Accident Frequency Rate

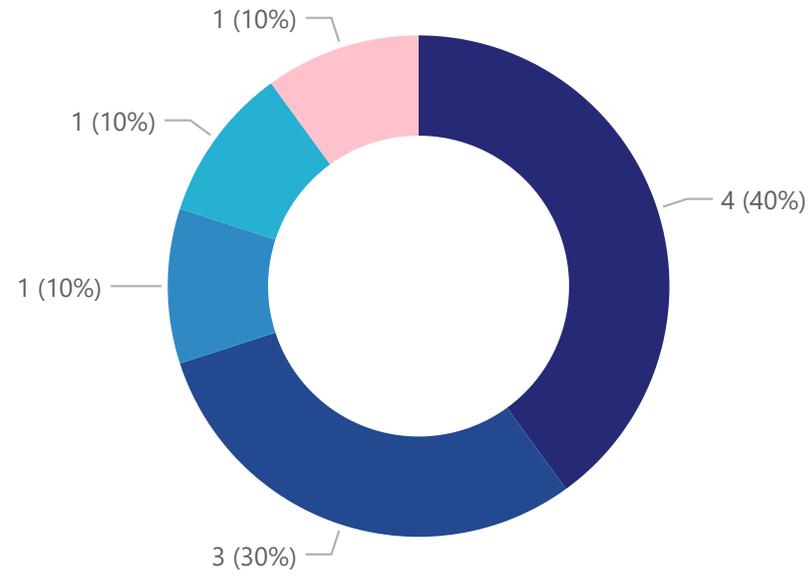


Type of Injury



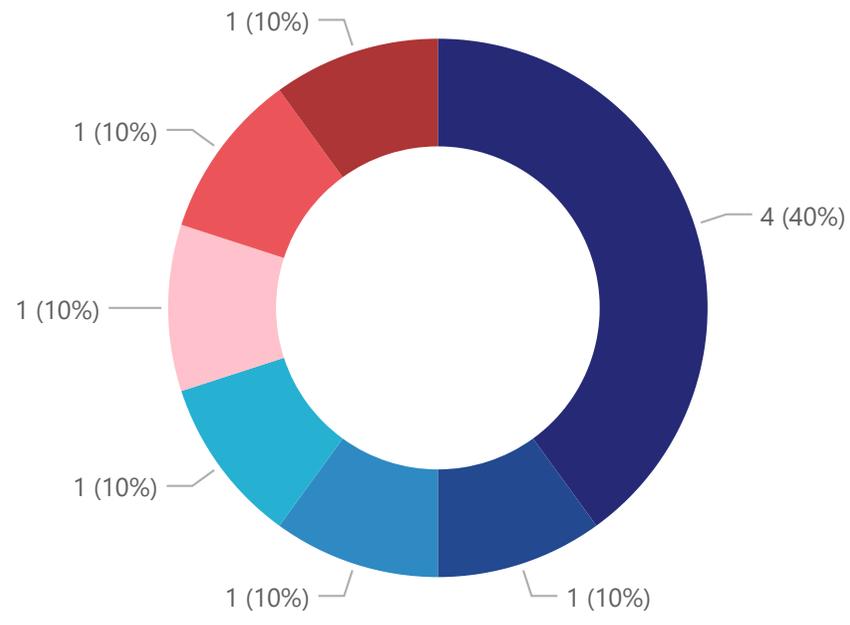
- Type of Injury**
- Fracture
 - Cuts / abrasions
 - Sprain / strain
 - No injury

Foundation Site Activity



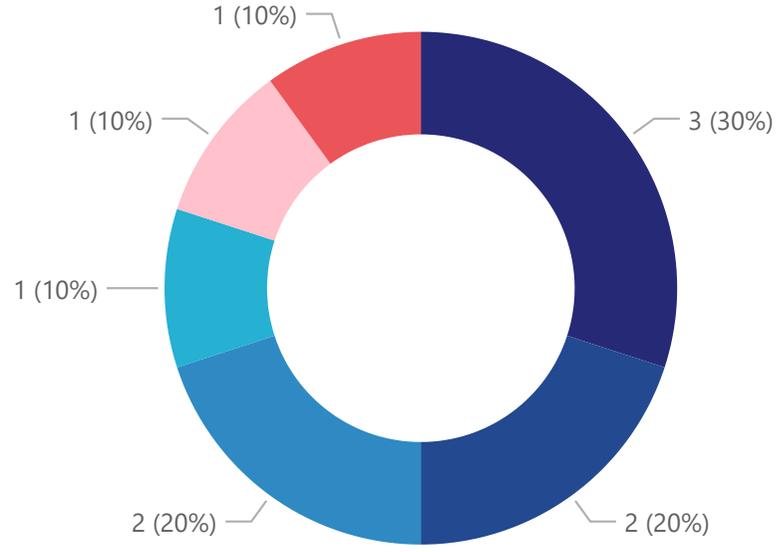
- Foundation Site Activity**
- Rotary site
 - Plant yard or Workshop
 - CFA/CSP site
 - Drilling/Minipile site
 - Factory Premises

Body part injured



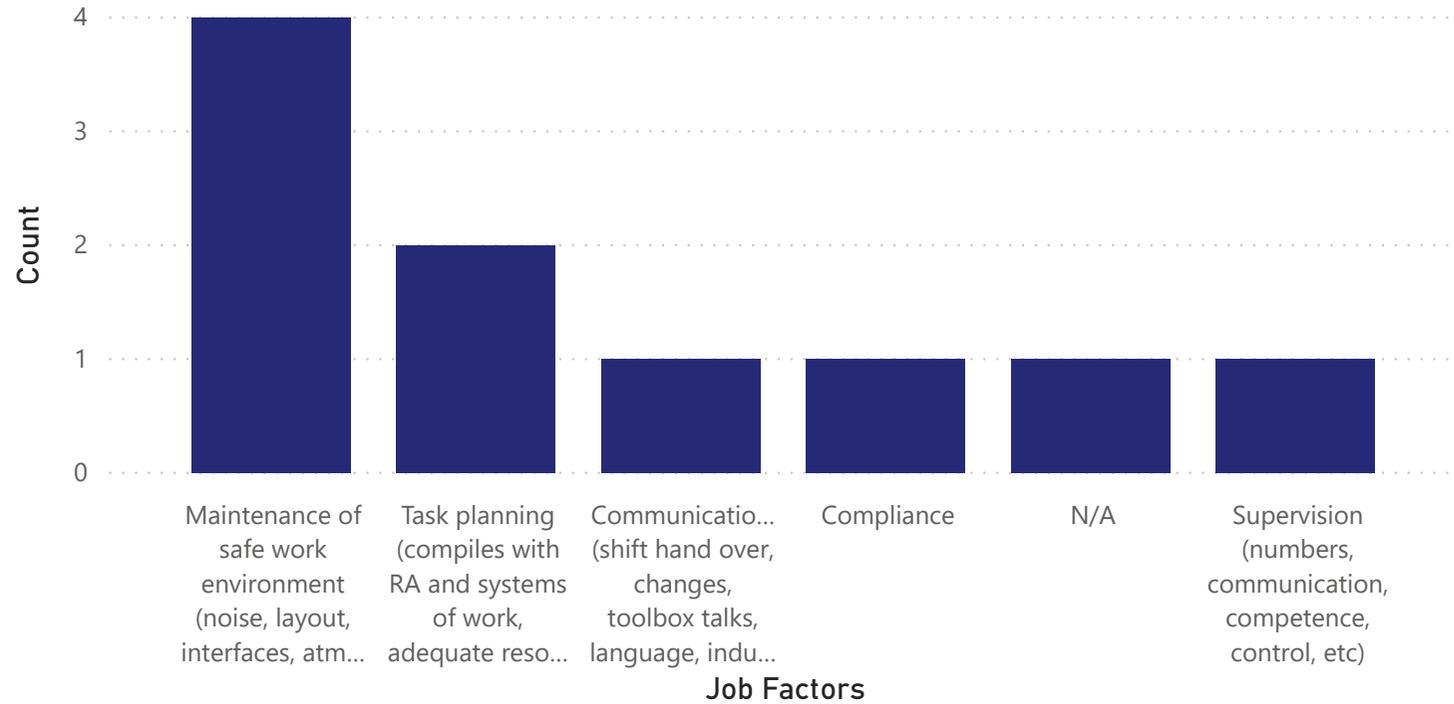
- Body part injured**
- Hand / Wrist
 - Back
 - Foot / Ankle
 - Head
 - Leg
 - No injuries
 - Torso

Role/Trade of injured person

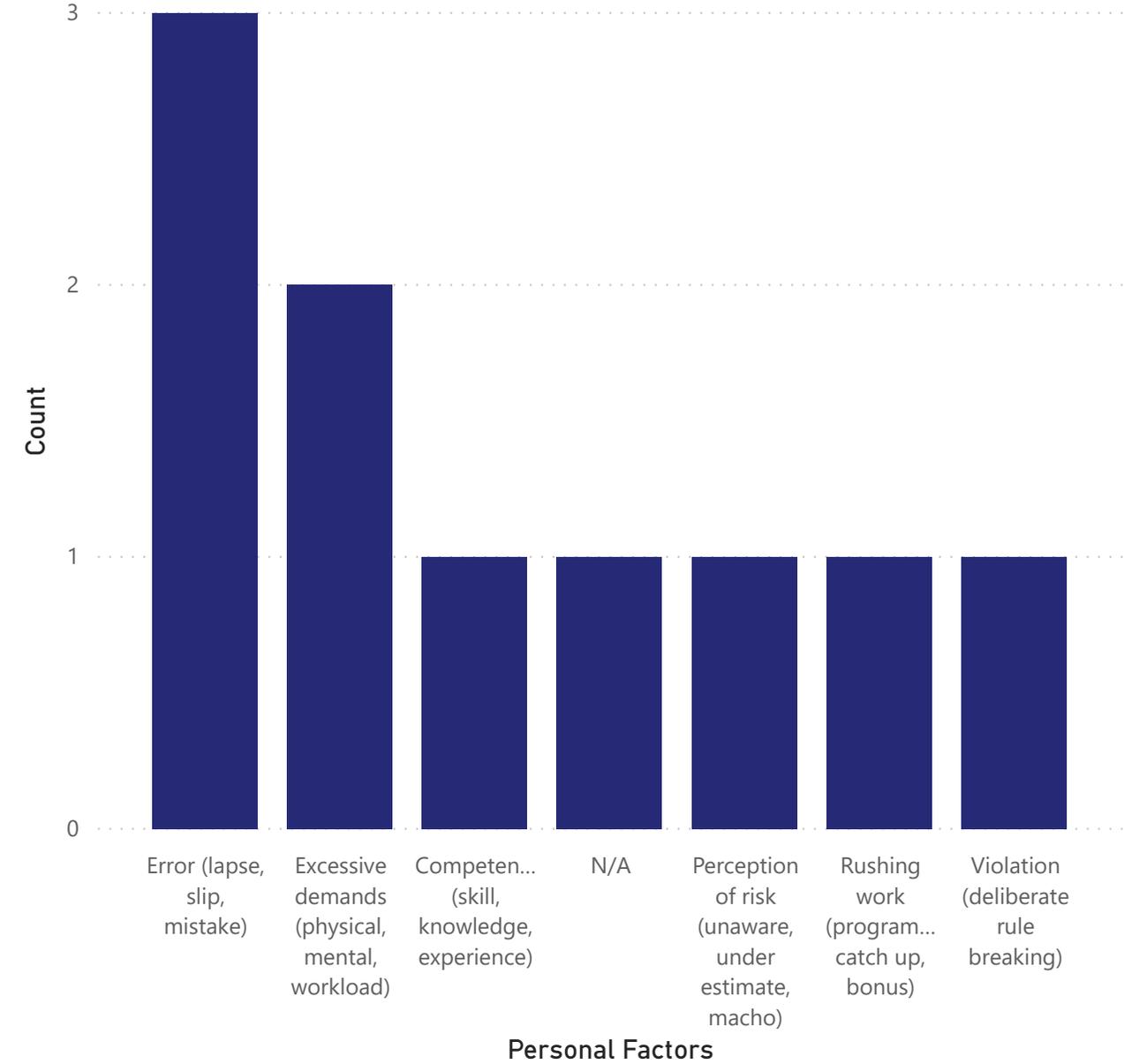


- Role/Trade of injured person**
- General Piling Operative
 - Fitter / Elec / Welder
 - Workshop /Factory Operative
 - Ancillary Plant Operator
 - Engineer
 - Manager/Supervisor

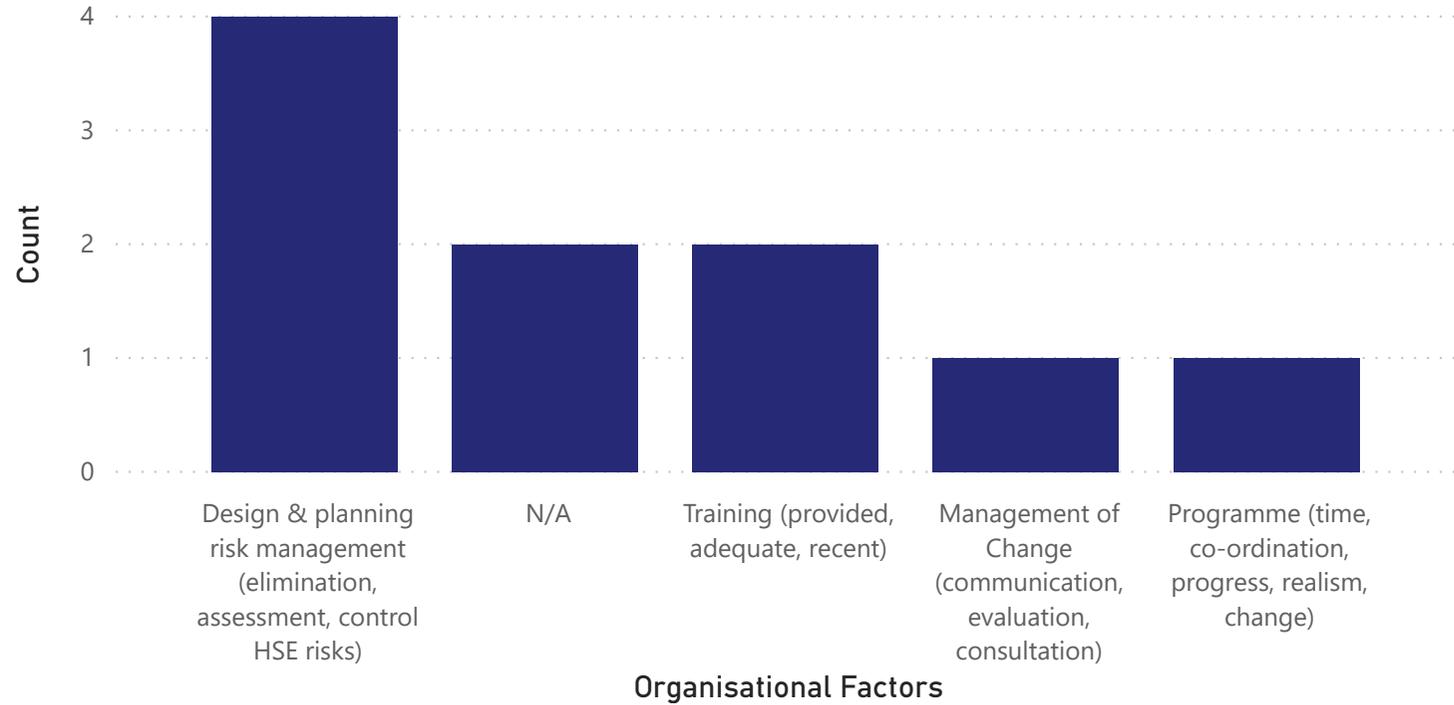
Job Factors



Personal Factors



Organisational Factors



Personal Factors

Outline/Description of Accident

Concrete pump operator decided to help out by helping to put bars in the rack - had never worked with this rig before. Hand caught between Bars as he was placing 1 in a rack

Cut to right thigh

IP was lifting 3 x 8m 250mm pre cast concrete piles, when he pressed the wrong travel button on the crane remote resulting in the load travelling in the wrong direction towards him
He put his hand out in attempt to control the load, but the load struck his hand.

Visited A&E the following day X-Ray revealed a fracture to one of the corpal bones on his left hand

IP was standing approximately 5 metres away from the pilling rig. it was reported by the IP As the rig was tracking into position an object was projected from the tracks striking the him on his left cheek.

It was reported, as the "IP" was manually handling cement bags to load into a 10/10 mixer they sprained their back.

The "IP" was in the process of rigging and LB24 rig and used a podium step (platform was 1m abgl) instead of a MEWP to access the hose bagging that was attached to the deflector on the mast which was in the horizontal position. The bagging was secured by 2 x ropes. As the second rope was cut the bagging dropped striking the podium the "IP" was standing in. The podium overturned and the "IP" sustained a minor concussion and 7 fractured ribs to their L/H/S rib cage.

The IP was assisting in the offloading of materials in the yard. Whilst the load was being supported by a lorry mounted crane close to the loads final resting place, the IP stood on a precast pile to gain an extra few inches of height/reach instead of using the correct equipment to move the load. The IP lost balance and fell to the ground resulting in fracture to the wrist

The IP was checking a reinforcement cage that was laying on the ground in the storage area. As she walked backwards with the tape measure her foot caught in a sling that was attached to the cage but hanging down on the floor. On falling she potentially fractured her hand.

The IP, a fitter was working on a rig prior to it leaving the yard. He had gone into the back of his van to work on a part. As he stepped out of the side door he went to grab the handle but missed. As he went to steady himself he put his leg out. His ankle was turned as he landed on the uneven ground.

When unloading a delivery vehicle using an attendant crane, in accordance with the site lift plan, a slinger/signaller was directing operations to remove a digging bucket from the bed of the vehicle.

As the lift was being carried out the Kelly box section,(collar) of the digging bucket, lifted and caught the end of the segmental casing (2m x 1000mm) causing it to roll off the side of the flatbed and land on the ground.

Remedial Action Taken

TBT done on selection of tools and work place - operative decided to cut material on the concrete floor rather than take it to a work bench safety stand down in yard discussing roles and personal responsibilities, and reminders of existing controls.

Review of RA. consideration by maintenance staff of where work is completed - move to workshop areas where possible.

One completion of the full investigation measures were agreed and put in place. No equipment is to be loaded inside other equipment. All site operatives were briefed to remind all slinger signallers and crane operators of the requirement to agree, deliver and only react to clear and positive signals, and the message reinforced to stop work and inform a Supervisor if anything looks incorrect or unsafe, and the duties on everyone who deal with loading and unloading.

The RAMS were reviewed, amended and rebriefed to include ensuring equipment is loaded, secured and unloaded correctly, and that exclusion zones must be enforced at all times in lay down areas.

Following the investigation into this incident a new procedure has been implemented onto all sites regarding equipment for fitters. Before a fitter starts any rigging and de-rigging they must complete an induction, start of shift briefing, have full access to a MEWP and Crane (if required), their site specific RA has been conducted and their line manager has verbally given them approval to start work.

Following changes to ergonomic layout of the area, improving the platform the operative is required to stand on and introducing an electric height adjustable / rotating turntable that will raise the bags to the correct height, the amount of manual handling has been significantly reduced to an acceptable level.

Discussion held with all site teams regarding training and competency's

crane direction arrows - switched over to better correspond to the crane remote control legend.

TBT carried out - re complacency / lapses / errors.

Briefing to all personnel on the findings of the incident and agree measure to prevent reoccurrence.

A collective insight held with the site team. They decided that all stops on large diameter cages would be attached back up to the cage using electrical insulation tape through the loop. This was briefed across the rest of the business. This only applies to the large diameter cages.

Outline/Description of Environmental Incident

Outline / Description

Black oily sludge noted from the manhole that looks to have flowed across the carpark to the surface water gully that runs alongside the office.

Discharge caused by burst hydraulic hoses on the vibrating hammer used for driving sheet piles. Bagging from hydraulic hoses caught on base of sheet pile during installation. This combined with the downward vibrating pressure caused pressure overload in the hydraulic pipes and they burst open

Following recent site visit by Energie Engineers regarding a scheduled PPM visit it was identified that the 1st floor AC system has lost its refrigerant charge due to a leak on the system. Following initial investigation, a leak on the BS control box flare joint above the director's office and a possible leak on fan coil joint above 1st floor kitchen. The volume of the leak is currently unknown.

Fuel line on agitator pump burst causing 10 litres of diesel to spill onto platform.

Hydraulic hose caught on gates of rig causing hydraulic hose to disconnect. The manifold had been tucked in due to close proximity of building and not returned to normal location.

Hydraulic hose leak on rig due to coupling not being fitted correctly. A very small amount of hydraulic oil spilt to the platform.

Low Loader burst hoses while leaving site. Minor spill onto stone platform.

Subcontractor operative disconnected our polymer return line without consulting or notifying any of supervisors. Started to send the polymer back to the mixing tanks which resulted in the spill. Approximately 500 litres of the inert polymer was released onto the concrete slab.

Undertaking drilling and grouting of shallow mineworkings for new housing estate. Water run off from our operations plus rain water was being collected in a bunded area to prevent it running off site. The groundworkers on site needed access to materials that were stored adjacent to the bund. To ease access, the excavator driver dug out the bund wall resulting in contaminated water exiting site and causing pollution of a watercourse. Even though all protections were down to the PC, and the actions of others caused the pollution, we received an official warning letter from the EA!

While concreting pile under fluid support, the polymer at Battersea made its way through an old anchor head in the retaining sheet piled wall into levels below in the adjacent site.

An old anchor head through which the polymer has entered into the adjacent site is located at a higher level than the toe of the steel tube casing used. Site had previously installed 2 no piles under support fluid in an exactly similar manner before this incident with no leaks/spills observed.

while constructing secant wall piles around the perimeter of the basement hydraulic oil from the SR90 rotary table splashed over a car parked in the road along side the hoarding, this was caused by a hose connection becoming loose over time. Once dried the marks had were noticeable on the car bonnet, It was later found that the car was owned by one of the operatives on site.

Whilst parking up the Klemm 702-2 after completing the days work a hydraulic leak occurred on the quick release coupler, depositing a small amount of hydraulic oil on the access road.

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Remedial Action Taken

Remedial Action Taken



Area along the back of the hoarding to where the piling operations were taking place were barriered off using cones for stop parking in this area and fitter called to attend site, this hose was tightened up on the following Wednesday when the rope was exchanged.

Minor spill onto stone platform addressed immediately by piling team under supervision using grab bag spill kit readily available on site. Materials bagged and disposed through site waste management.

Once spill was identified it was contained with spill kits and cleaned up. The polymer was then made inert by treatment and removed from site. Following this, actions were taken to install protection on the polymer line to prevent disconnection and damage.

Rebriefings on importance of PC fulfilling their contractual requirements, and for need to halt works if these requirements are not met.

Spill cleaned with on site spill kits and manifold returned to correct position. Site team briefed on incident and need to ensure the process was monitored.

Spill kit used to clean up excess oil and a fitter repaired the issue.

Spill kits on site used to clear spillage up and a fitter repaired the line.

Spill kits were used initially to control the spill. The polymer was then treated/broken down (made inert) and sucked out into a tanker for disposal off site. This work was carried out by our Principal Contractor.

The AC system flare joints were repaired and recharged

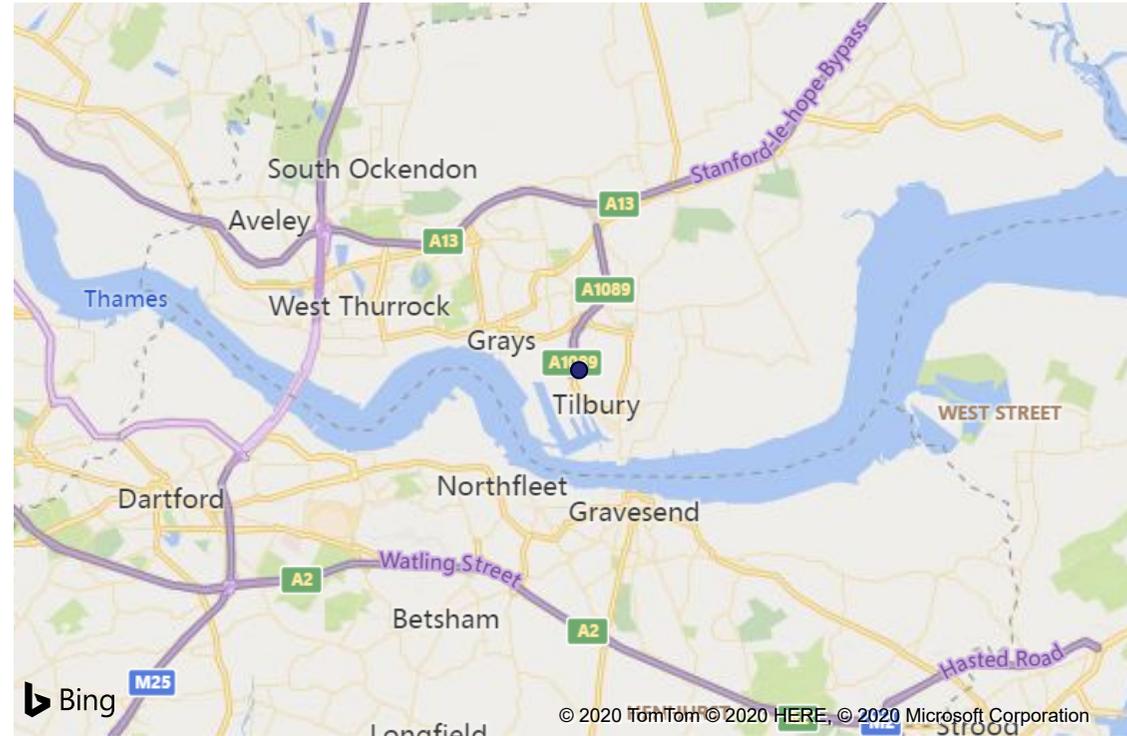
The Environment Agency was contacted reporting potential spill to surface water sewer caused by an external party. EA (Carole Brennan) called at 16:53 hrs to inform use that Thames will send out a team to assess the overflow to see if it is a blockage and clean up the material in the Carpark.

The hose was repaired and the spill cleaned up. Monitoring of the hoses was undertaken.

The spill was cleaned up and the coupler repaired.



Closest Town (Postcode)



Lessons Learnt / Remedial Action Taken

The principal contractor did not carry out sufficient survey and the permit was accepted in good faith but without full scrutiny of the information. Had the PC used CAT & Genny this may have identified the service as the main was relatively shallow. GE supervision could have questioned the extent of the work done leading to the permit issue and identified little explorative work had been carried out