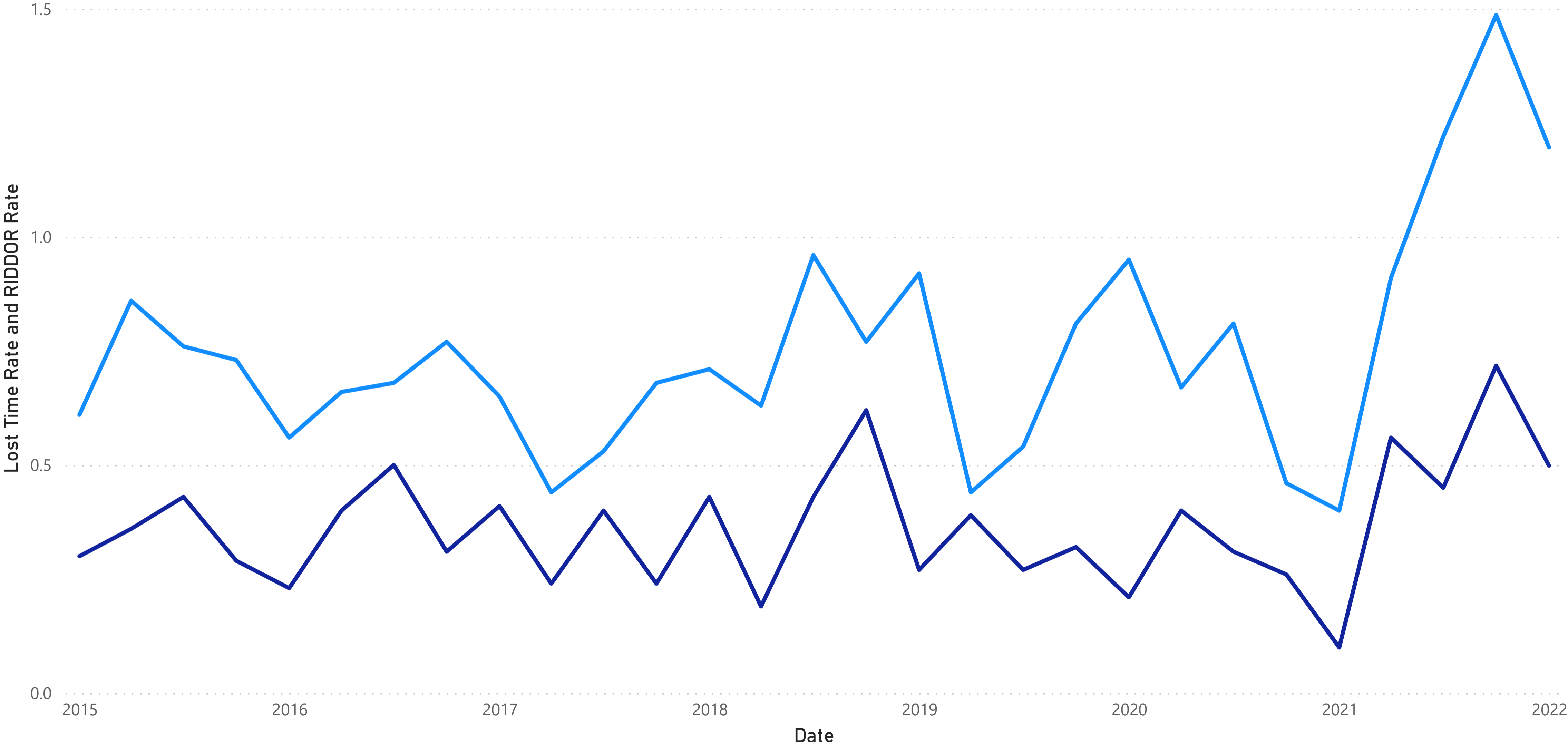


**FEDERATION
OF PILING
SPECIALISTS**

Quarter 1 2022
Accident Statistics

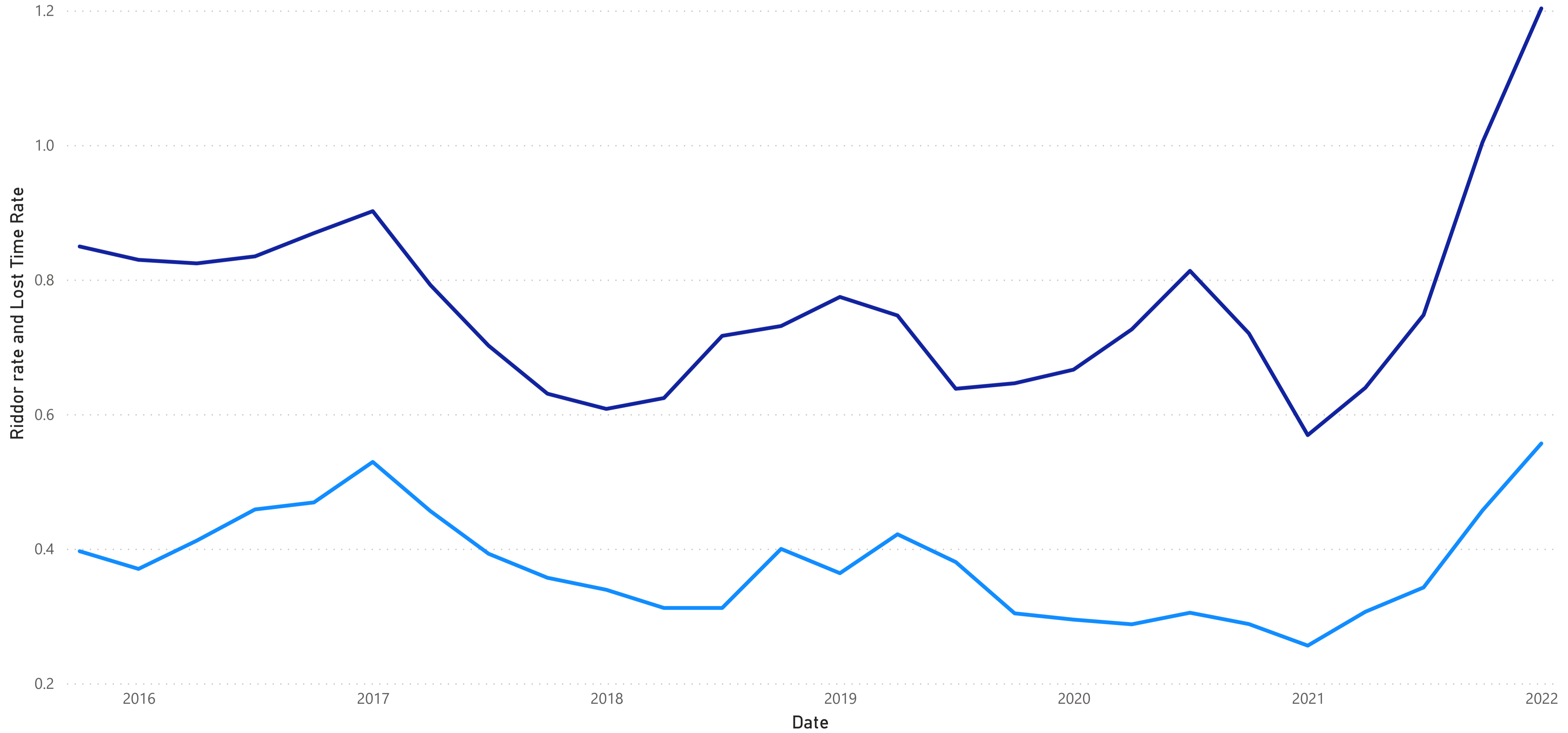
Quarterly Lost Time Rate and RIDDOR Rate 2015 - 2022

● Lost Time Rate ● RIDDOR Rate



Rolling Lost Time and Riddor Rates 2016 - 2022

● Riddor rate ● Lost Time Rate

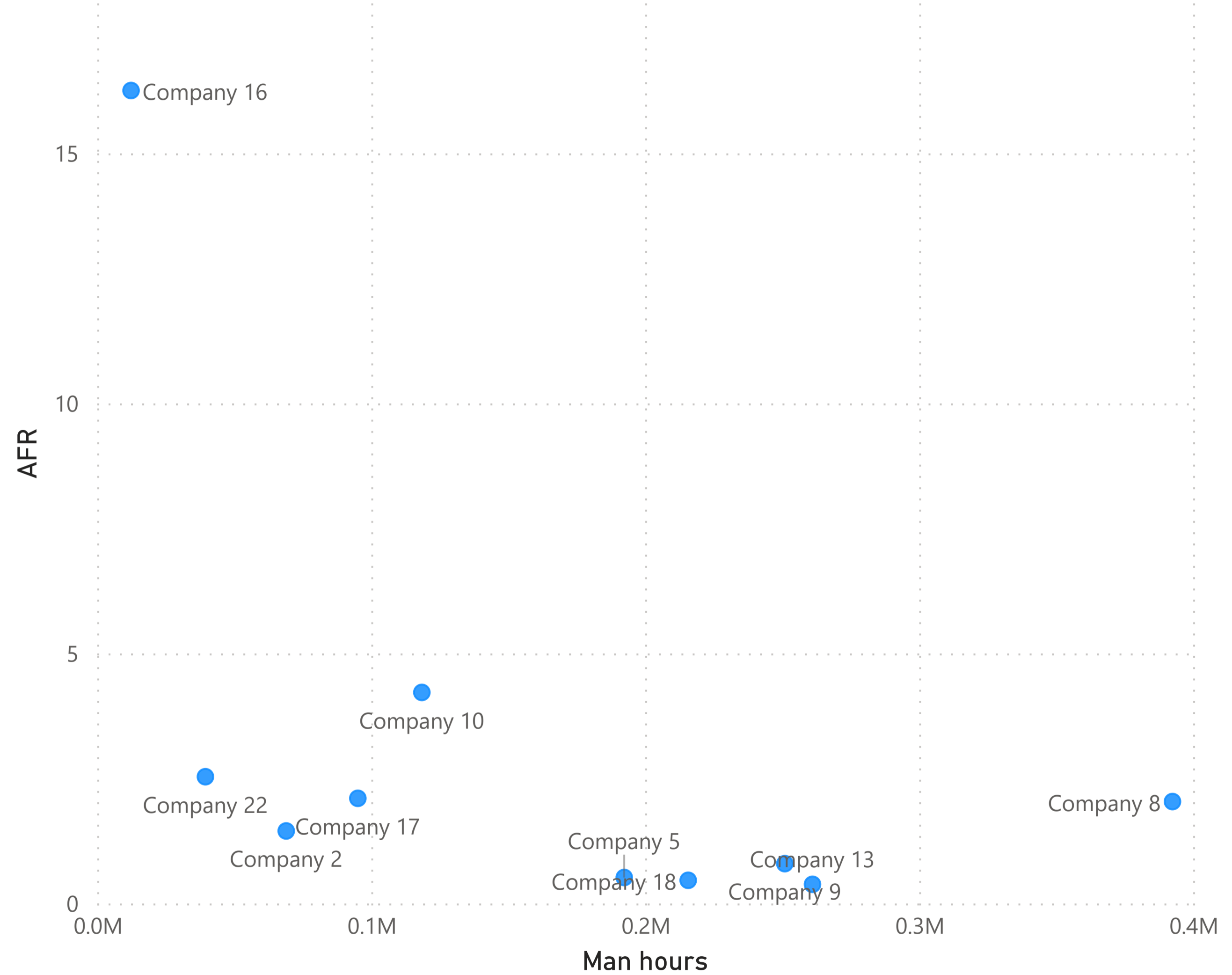


Year, Quarter

- ∨ 2020
- ∧ 2021
 - Qtr 1
 - Qtr 2
 - Qtr 3
 - Qtr 4
- ∧ 2022
 - Qtr 1
 - Qtr 2
 - Qtr 3
 - Qtr 4

Company Number	Man hours	Count Accidents	AFR
Company 16	12302	2	16.3
Company 10	118453	5	4.2
Company 22	39445	1	2.5
Company 17	95086	2	2.1
Company 8	392443	8	2.0
Company 2	68940	1	1.5
Company 9	250940	2	0.8
Company 5	192328	1	0.5
Company 18	215667	1	0.5
Company 13	261040	1	0.4
Company 1	32958		
Company 11	18944		
Company 14	44538		
Company 15	18309		
Company 20	24230		
Company 21	53255		
Company 23	40336		
Company 3	62790		
Company 4	43908		
Company 6	20521		
Total	2006433	24	1.2

Man hours and AFR by Company Number



RIDDOR

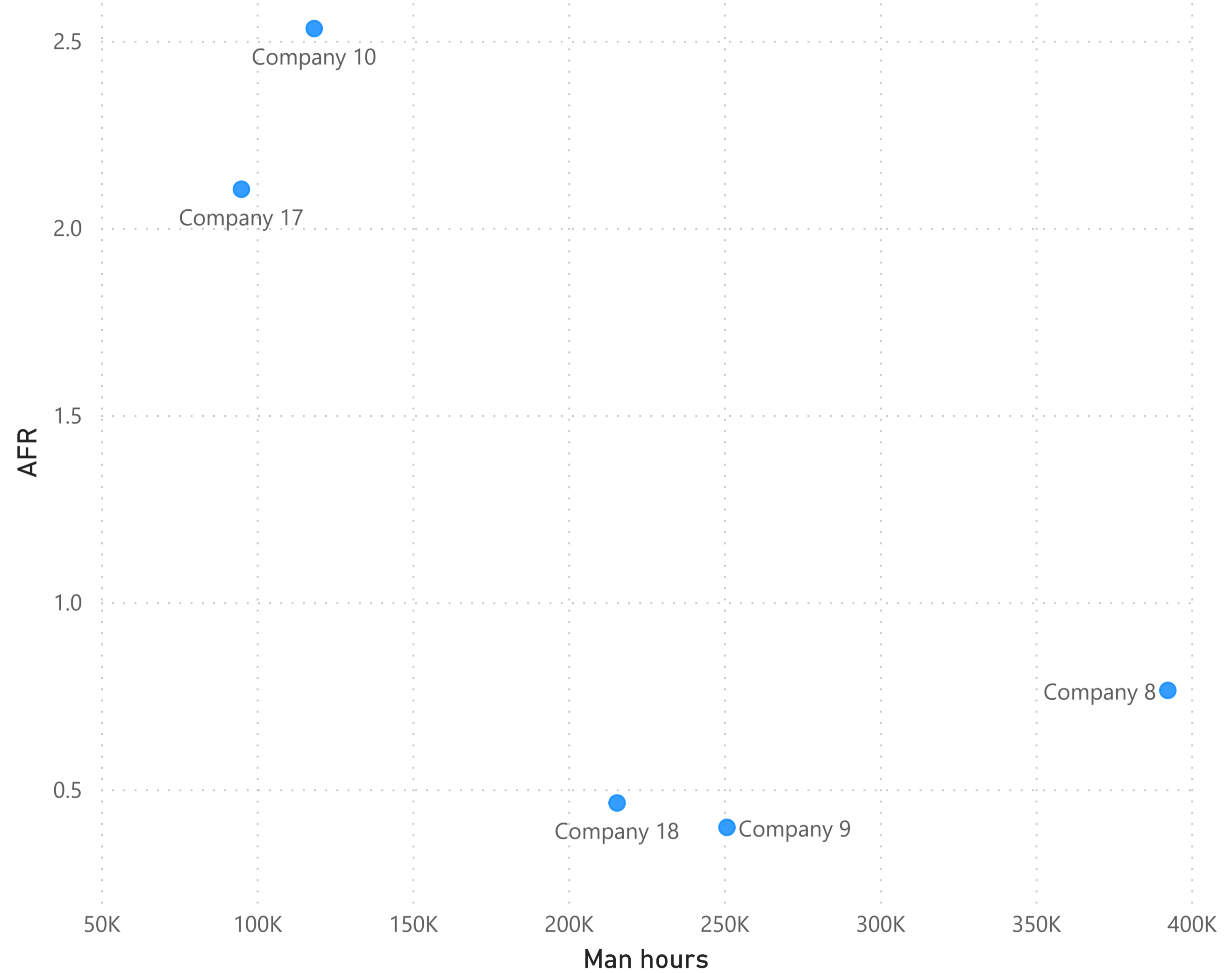


Year, Quarter

- 2020
- 2021
- Qtr 1
- Qtr 2
- Qtr 3
- Qtr 4
- 2022
- Qtr 1
- Qtr 2
- Qtr 3
- Qtr 4

Company Number	Man hours	Count Accidents	AFR
Company 10	118453	3	2.5
Company 17	95086	2	2.1
Company 8	392443	3	0.8
Company 18	215667	1	0.5
Company 9	250940	1	0.4
Company 1	32958		
Company 11	18944		
Company 13	261040		
Company 14	44538		
Company 15	18309		
Company 16	12302		
Company 2	68940		
Company 20	24230		
Company 21	53255		
Company 22	39445		
Company 23	40336		
Company 3	62790		
Company 4	43908		
Company 5	192328		
Company 6	20521		
Total	2006433	10	0.5

Man hours and AFR by Company Number



Year, Quarter

- 2020
- 2021
- Qtr 1
- Qtr 2
- Qtr 3
- Qtr 4
- 2022
- Qtr 1
- Qtr 2
- Qtr 3

RIDDOR



Company Number 1-7 day LTA 7+ day LTA Dangerous Occurrence HiPO Specified (major) injury **Total**

Company Number	1-7 day LTA	7+ day LTA	Dangerous Occurrence	HiPO	Specified (major) injury	Total
Company 10	2	2		1		5
Company 13	1					1
Company 16				2		2
Company 17			2			2
Company 18		1				1
Company 2				1		1
Company 22	1					1
Company 5	1					1
Company 8		3		5		8
Company 9	1				1	2
Total	6	6	3	8	1	24

- Year, Quarter
- ^ 2020
 - Qtr 1
 - Qtr 2
 - Qtr 3
 - Qtr 4
 - ^ 2021
 - Qtr 1
 - Qtr 2
 - Qtr 3
 - Qtr 4
 - ^ 2022
 - Qtr 1
 - Qtr 2

RIDDOR
 RIDDOR

- Year, Quarter
- ^ 2020
 - Qtr 1
 - Qtr 2
 - Qtr 3
 - Qtr 4
 - ^ 2021
 - Qtr 1
 - Qtr 2
 - Qtr 3
 - Qtr 4
 - ^ 2022
 - Qtr 1
 - Qtr 2

Company Number	7+ day LTA	Dangerous Occurrence	Specified (major) injury	Total
Company 10	2	1		3
Company 17		2		2
Company 18	1			1
Company 8	3			3
Company 9			1	1
Total	6	3	1	10

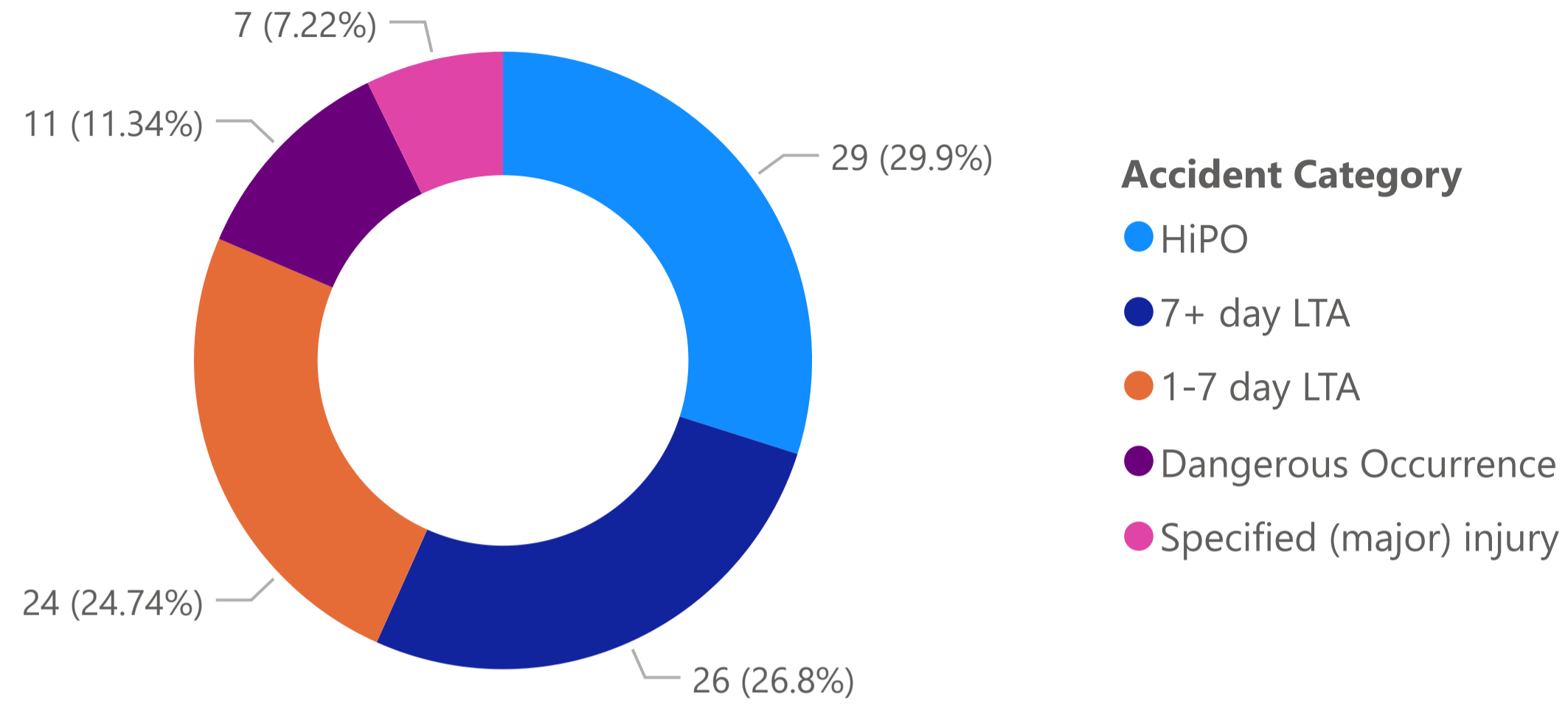
Accident Category	Count Accidents
1-7 day LTA	37
7+ day LTA	36
Dangerous Occurrence	13
Fatality	1
HiPO	41
Specified (major) injury	13
Total	141

Date Filter

- Year, Quarter
- 2020
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 - Qtr 1
 - Qtr 2



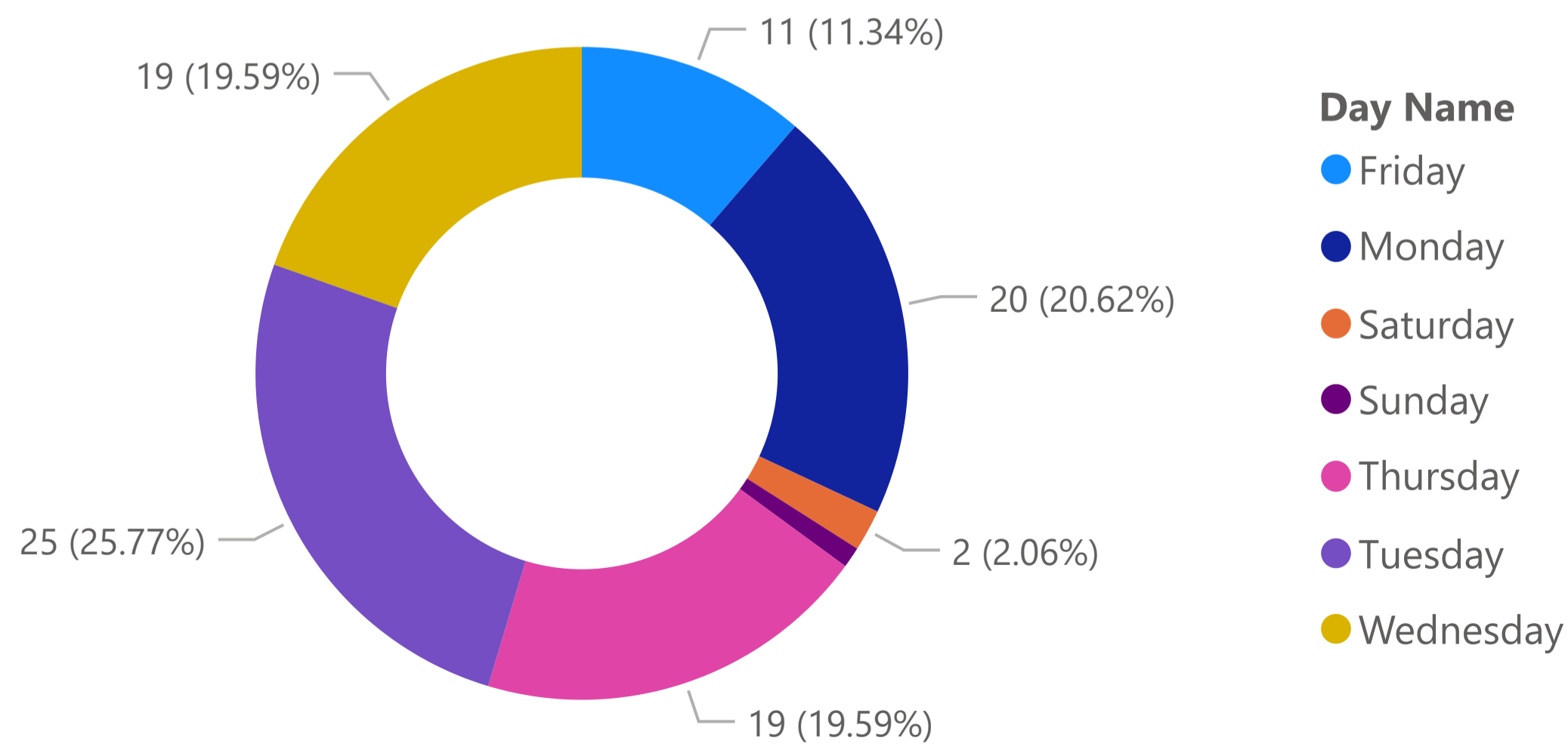
Accident Category



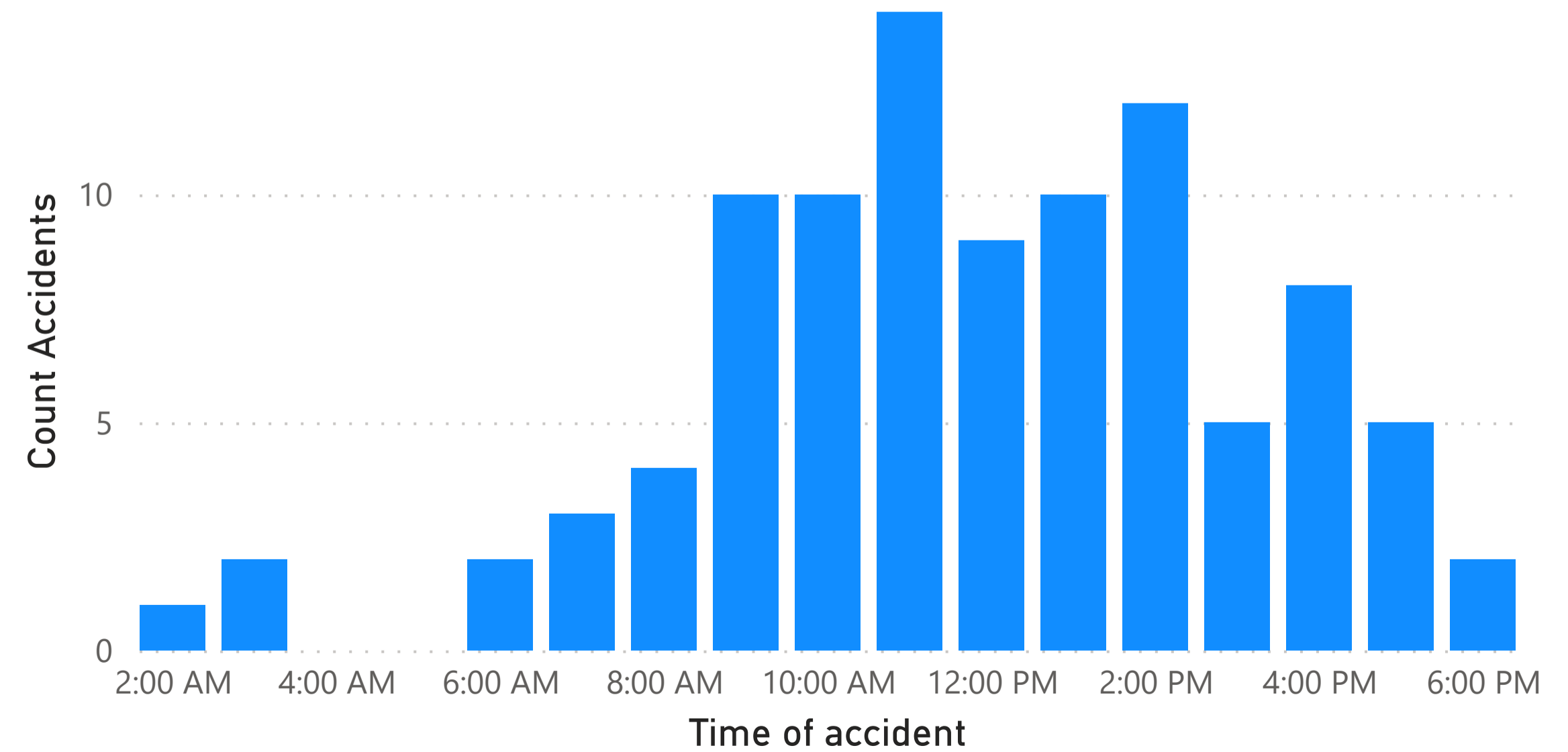
97

Count Accidents

Day of Accident



Time of accident



Date Filter

Year, Quarter

2020

2021

2022

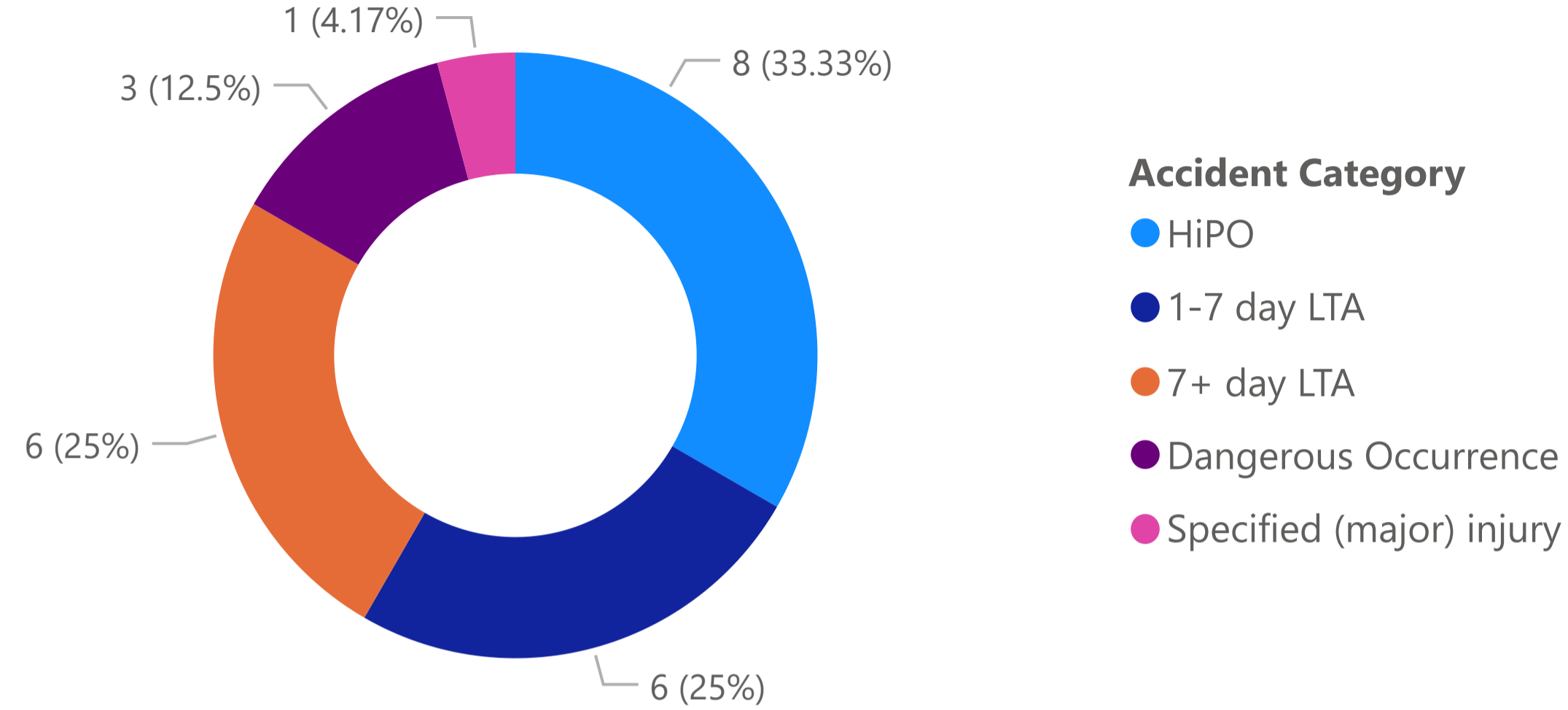
Qtr 1

Qtr 2

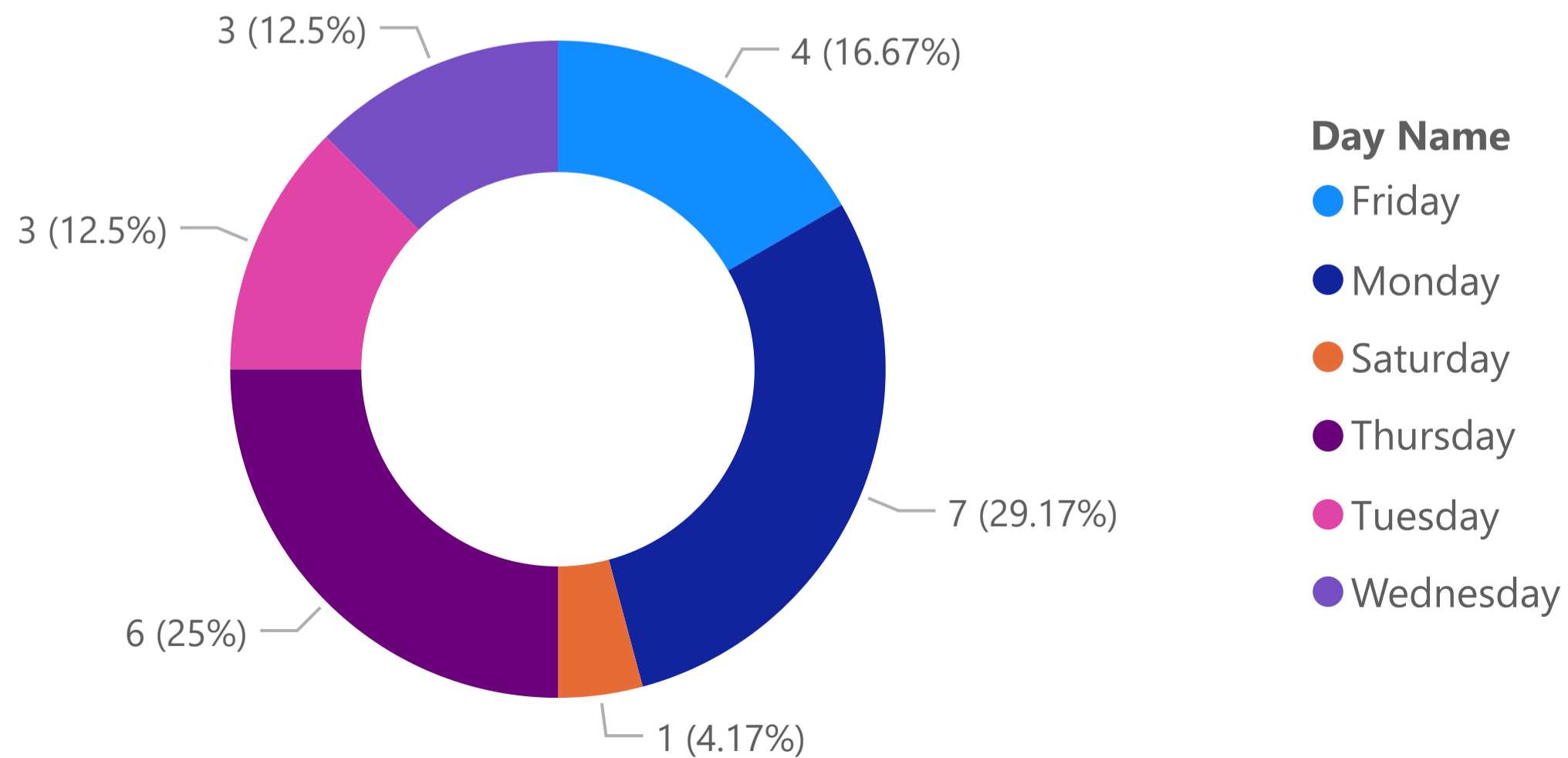
Qtr 3

Qtr 4

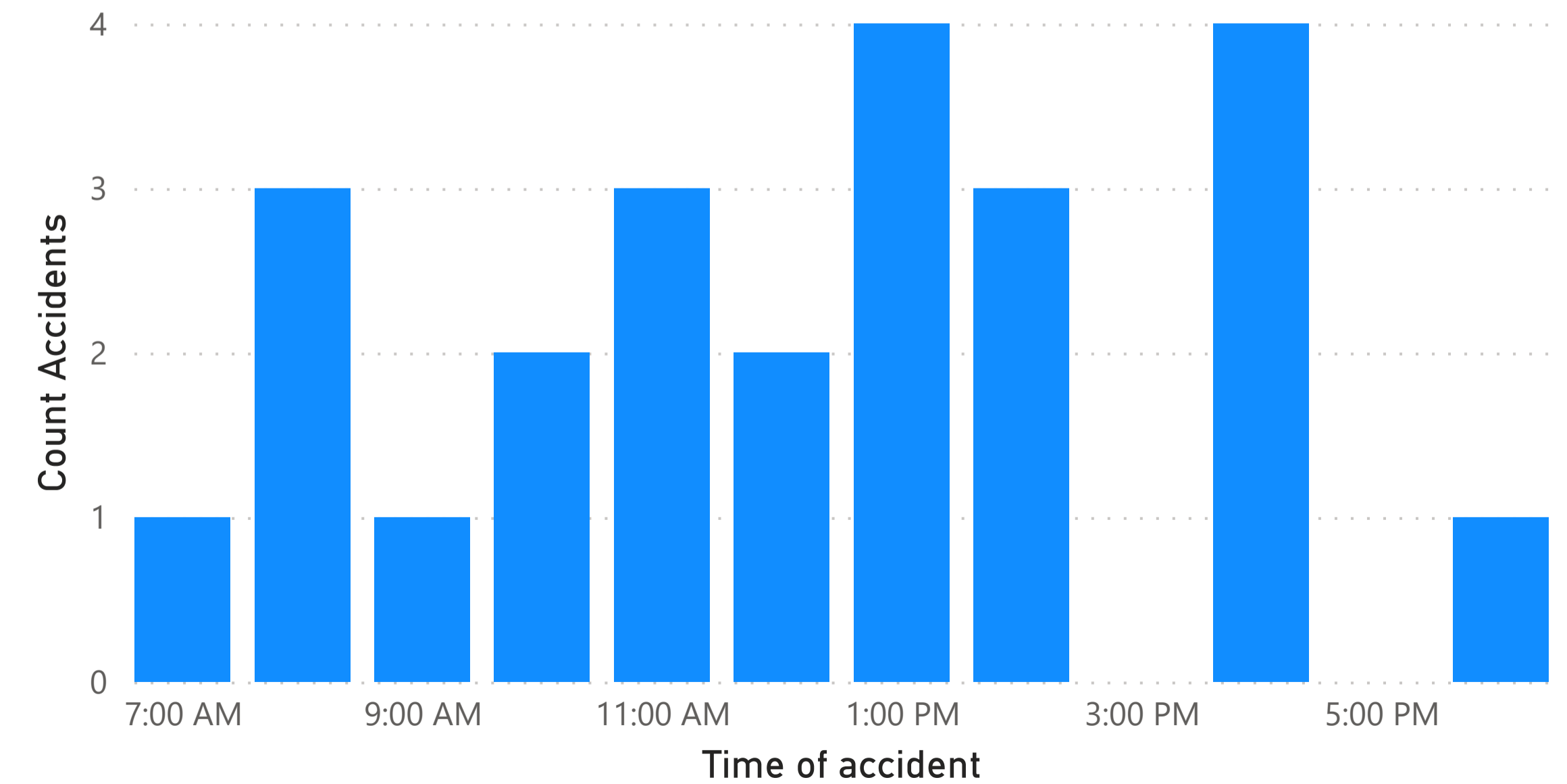
Accident Category



Accident Category



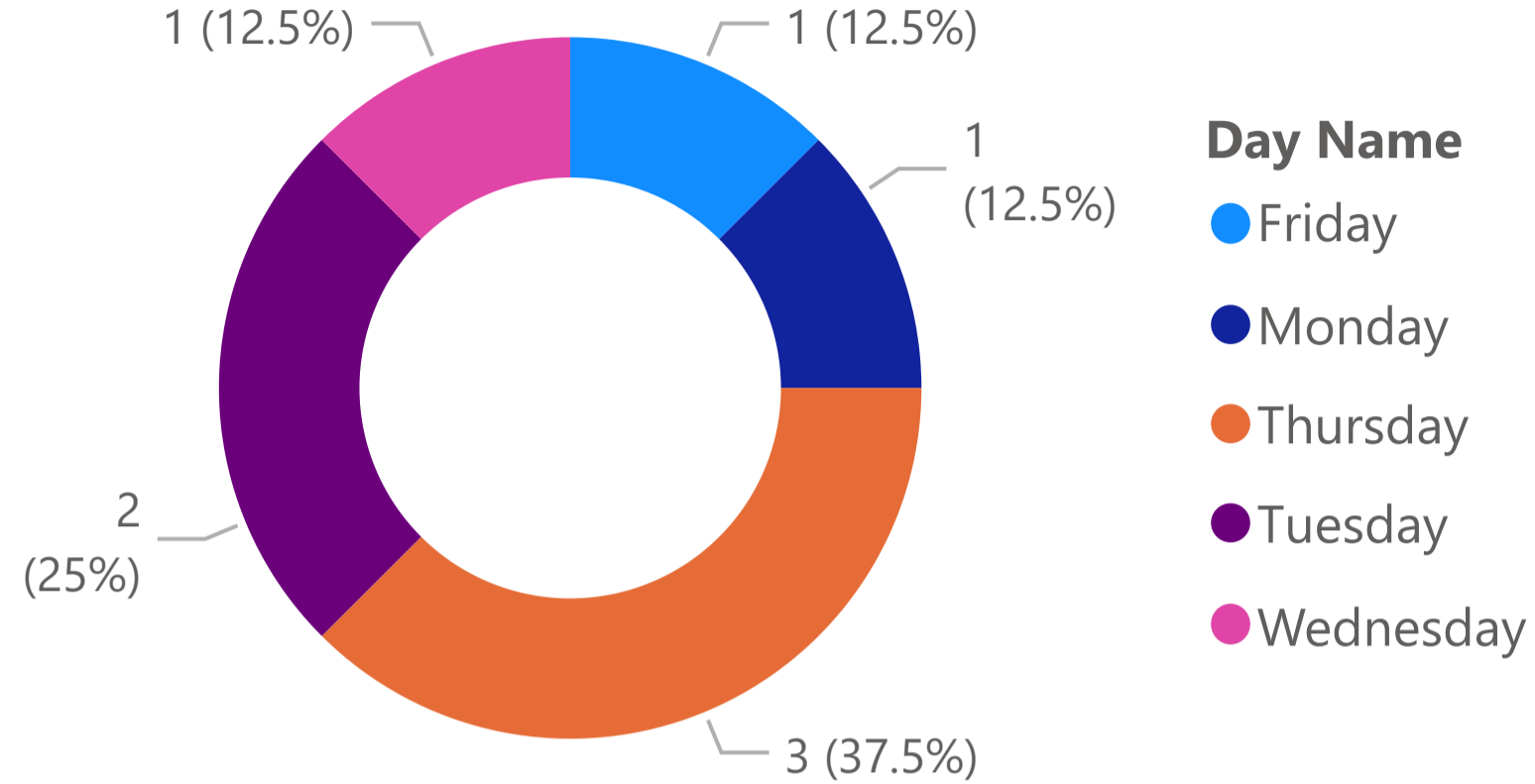
Count Accidents by Time of accident



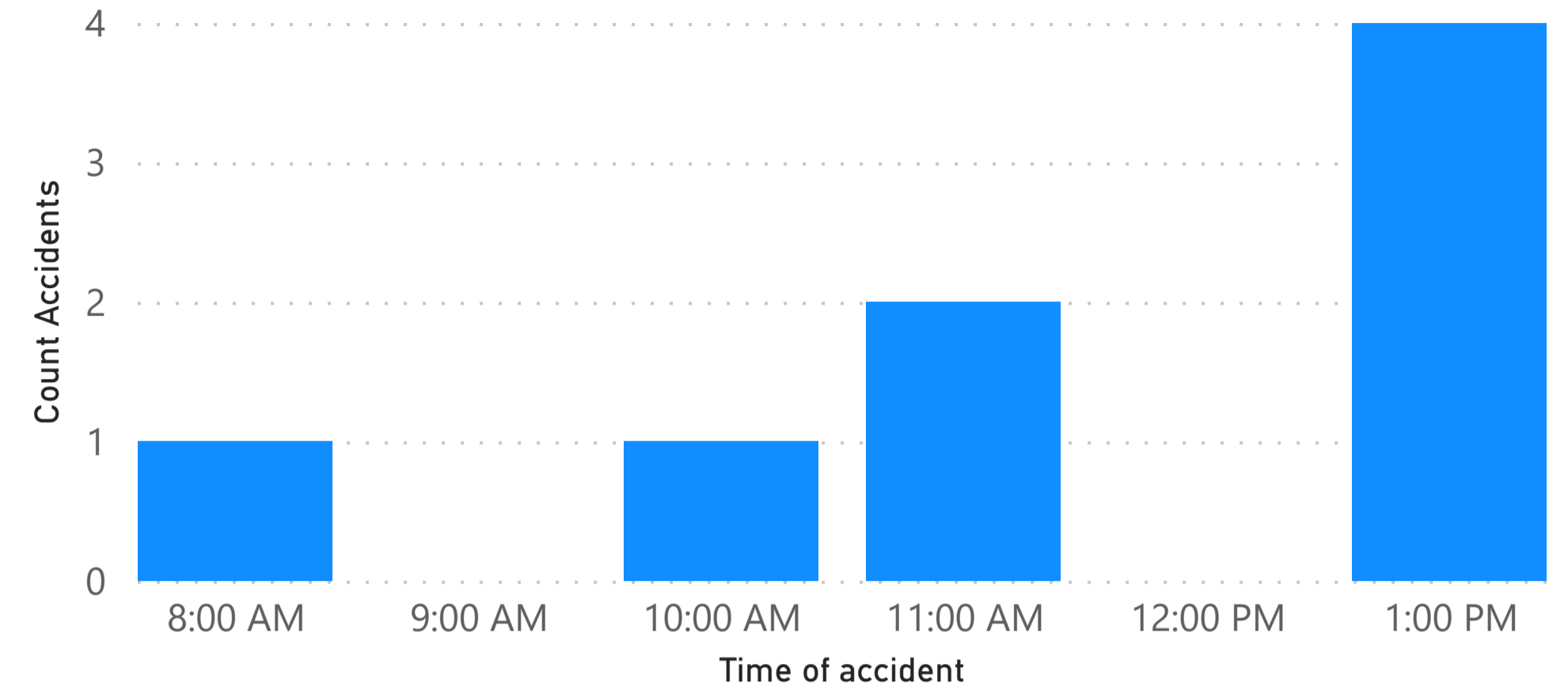
Date Filter

- Year, Quarter
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 - Qtr 3
 - Qtr 4

HiPo Day



Time of HiPo



Category Filter

- Accident Category
- 1-7 day LTA
 - 7+ day LTA
 - Dangerous Occurrence
 - HiPO
 - Specified (major) injury

Outline/Description of Accident

Whilst pumping concrete, a T-Piece Cap located at the front of the concrete pump has failed and broken free from the fitting. In doing so it struck the concrete truck and landed a few meters away from the pump. No one was injured in the incident. The pump operator and concrete truck driver were standing on the opposite side to where the cap landed.

Remedial Action Taken

All works on site were stopped and made safe pending further investigation. The other site pumping concrete was informed immediately and checks were carried out. A different type of pump and fitting was being used so works at this site we allowed to continue safely. The pump is relatively new and the manufacturer has been contacted. The investigation is still ongoing.

During the lifting operation for installing a rebar cage into a panel the inclinometer bar fitted to the cage became detached from the cage falling into the TFL depot on the northern site boundary. The bar came to rest at the side of an operational rail line but did not cause any damage to the line

Cage design was modified to alter the position of the strengthening bar to allow free movement of the inclinometer bar and prevent fouling

A 400mm deep trench was excavated across a site haul road, in front of the polymer plant to place a 4" vitraulic steel polymer transfer pipe underground. Magee Supervisor observed the works and challenged the plant operators, noting there was no permit to work was in place to cover the excavation works. Works were stopped and the incident was reported to the PC and HSEQ Team

Excavation was backfilled and rolled. Stand down was held

A delivery of precast piles had arrived on site and the site team were unloading them with a Junttan piling rig. Unloading/lifting a 13 metre 275 sq. precast concrete pile section from

Procedures were amended to provide clarity and lift plans, RAs and task briefings were all changed to suit. Disciplinary action

Date Filter

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2020

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Qtr 1

Qtr 2

Qtr 3

Qtr 4

Category Filter

Accident Category

1-7 day LTA

7+ day LTA

Dangerous Occurrence

HiPO

Specified (major) injury

Outline/Description of Accident

A delivery of precast piles had arrived on site and the site team were unloading them with a Junttan piling rig. Unloading/lifting a 13 metre 275 sq. precast concrete pile section from the second layer of the pile delivery vehicle was taking place and the slinger signaller had instructed the piling rig operator to hoist and take the weight of the load. As the slings went tight and the weight was being applied to the piling rig the pile began to move as the hook and cat head had not been coorectly positioned over the centre of gravity of the load. The caused the load to move forward away from its original position towards the edge protection at the far side of the vehicle. The slinger signaller was standing between the pile and the edge protection and the rig operator attempted to lower the pile/load to re-centralize the lift. At this point the load landed on the pile stacking timbers (which separate each layer of piles on the delivery vehicle) causing the stacking timbers to tip off the edge of the bottom pile layer and slide the pile/load into the walkway and into the area the vehicle delivery driver and slinger signaller had positioned themselves. The slinger signaller was pushed by the pile into the fabric straps that formed the edge protection. The give in the edge protection prevented the slinger signaller from being injured by the moving pile. The slinger signaller was instructed by the supervisor to move out of the way and the pile was lowered back on to the stack on the vehicle

When lifting the top cage for the pile as it was approaching vertical position a steel bar fell down the inside of the cage this bar was 25mm diameter by 730mm long. No one was injured as all personnel were outside the area of the lift exclusion zone in a position of safety

Finger trapped between spanner and drive head

The piling team had completed the installation of one pile to a depth of 8.5mtres which was drilled and concreted. The team then proceeded to drill the second pile, reaching a depth of 4 metres, when the rig operator suddenly heard a loud crashing sound and looked to observe the swan neck, concrete pressure sensor and concrete hose all lying on the ground having detached from their rig mounting positions and fallen approximately 22metres from height into the exclusion zone around the front of the rig. It should be noted that this was anew rig completing its second pile on its first contract.

working on digging bucket when the weight of the bucket shifted closing the bottom on the IP's thumb fracturing the tip.

Remedial Action Taken

Procedures were amended to provide clarity and lift plans, RAs and task briefings were all changed to suit. Disciplinary action took place against the supervisor. An animation of the correct practice was created and shared with all the team and a briefing on reporting culture was delivered to all employees

Reported the cage incident to the manufacture along with history of other cage related incidents. Arranged for audit of the manufacturer

TBT given on protecting hands and feet

The manufacturer is planning to replace all of the reaction rods on this type of machine in the UK for a stiffened unit having an increased wall thickness. Although they do not believe it was the primary cause of the incident, they have stated that it would be desirable to reduce movement of the swan neck anyway so feel this is worth doing in order to avoid any future questions over the rod.

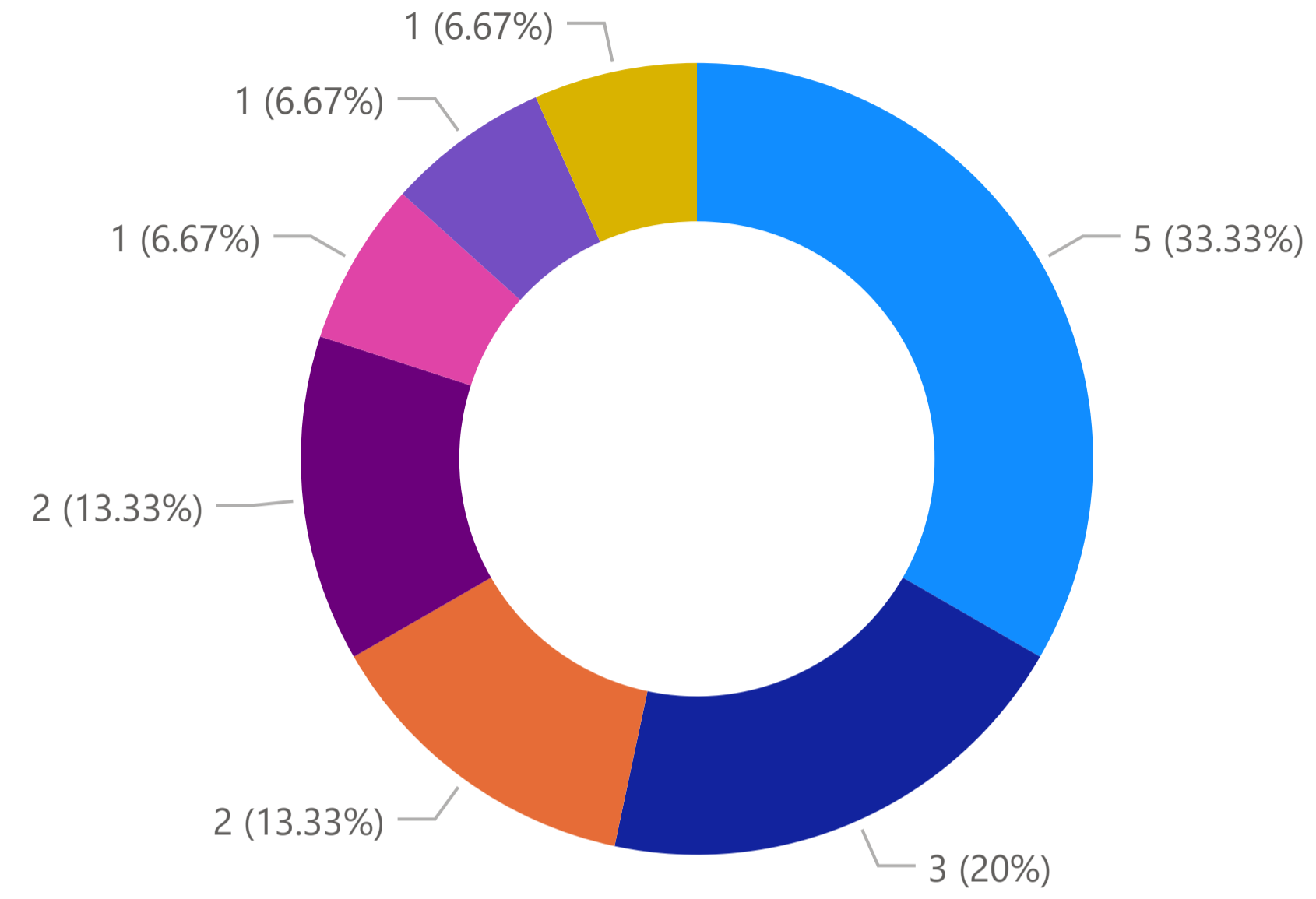
Works stopped and all staff briefed on the need for working safely at the correct vantage point.

Date Filter

- Year, Quarter
- ✓ 2020
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- Accident Category
- 1-7 day LTA
 - 7+ day LTA
 - Dangerous Occurrence
 - HiPO
 - Specified (major) injury

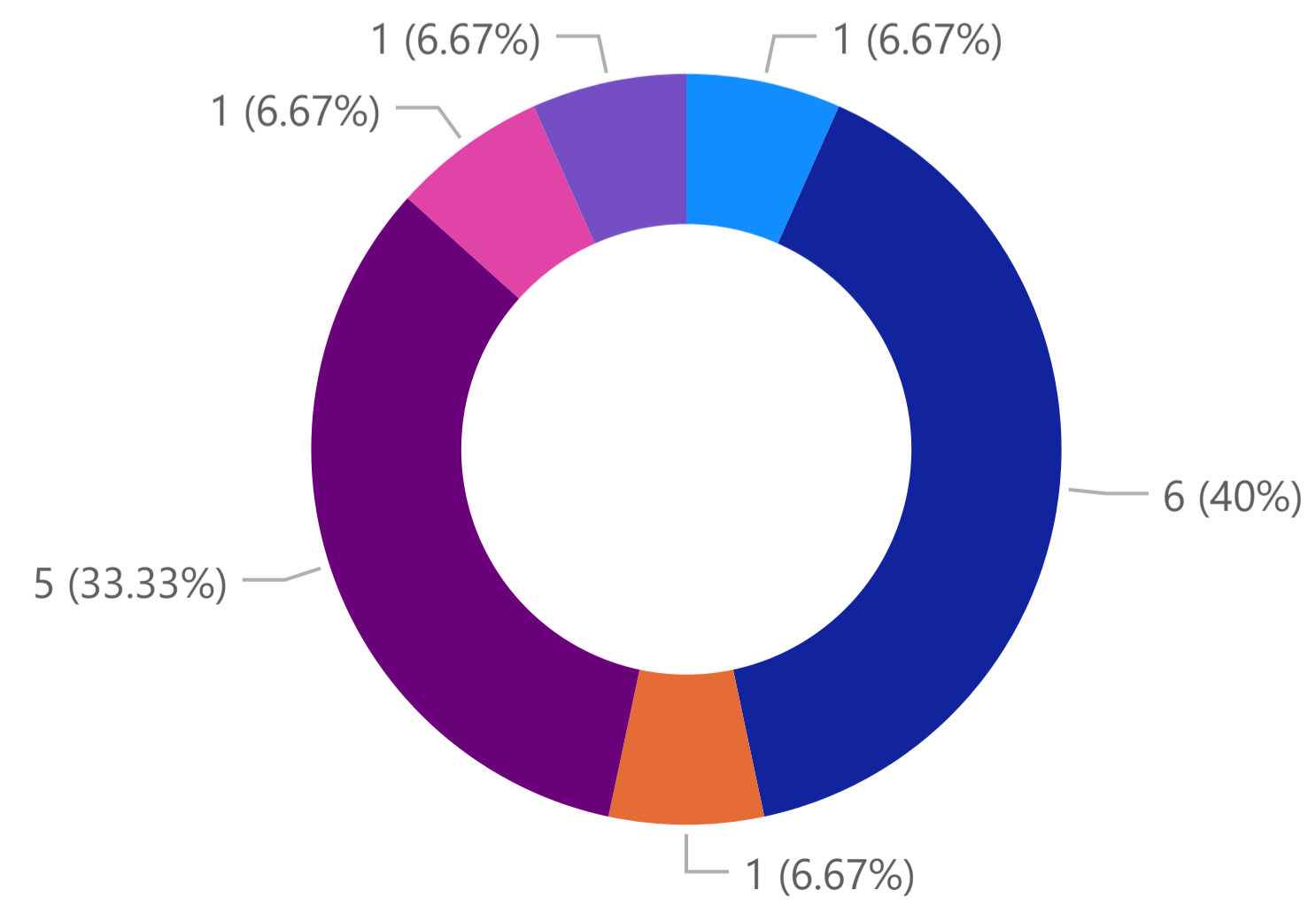
Activity of IP



Activity of Injured Person at time of accident

- Manual handling
- Maintenance
- Lifting operations
- Walking
- Getting on or off machine
- N/A (HiPo)
- Refuelling

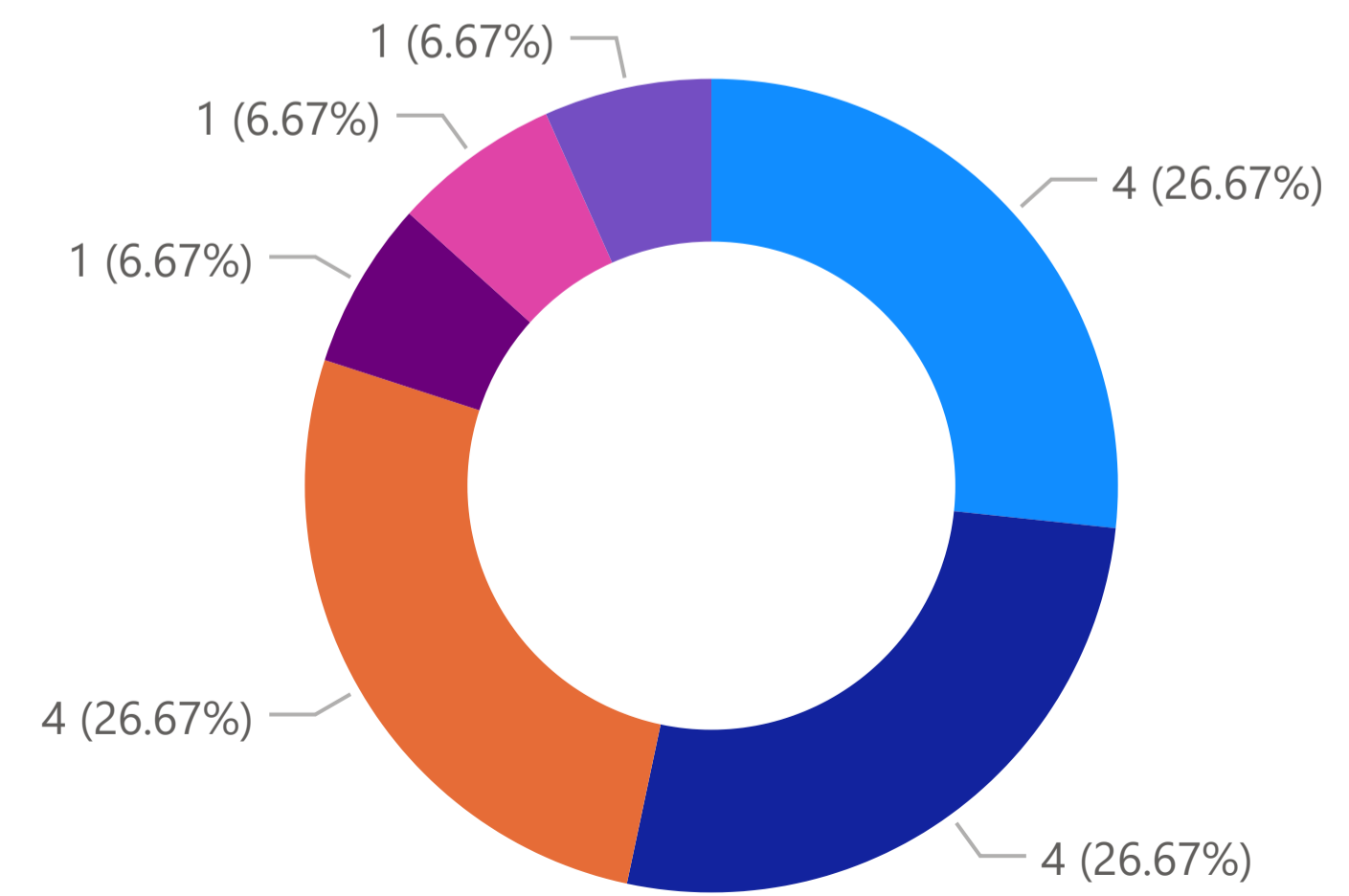
Body Part Injured



Body part injured

- Back
- Finger / Thumb
- Foot / Ankle
- Leg
- N/A (HiPo)
- Torso

Type of Injury



Type of Injury

- Bruising
- Cuts / abrasions
- Sprain / strain
- Dislocation
- Fracture
- N/A (HiPo)

Date Filter

Year, Quarter

∨ 2020

∨ 2021

∧ 2022

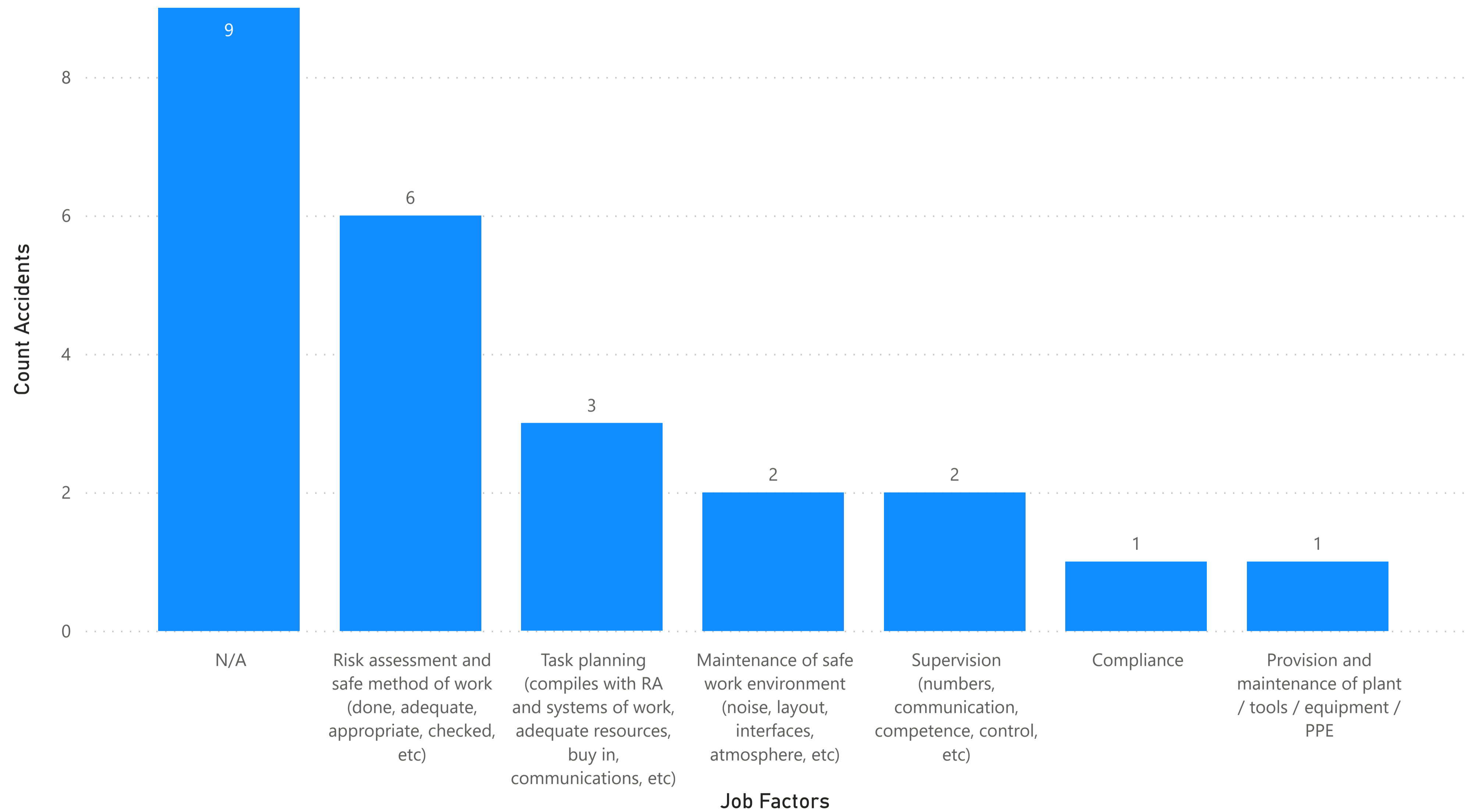
■ Qtr 1

□ Qtr 2

□ Qtr 3

□ Qtr 4

Job Factors

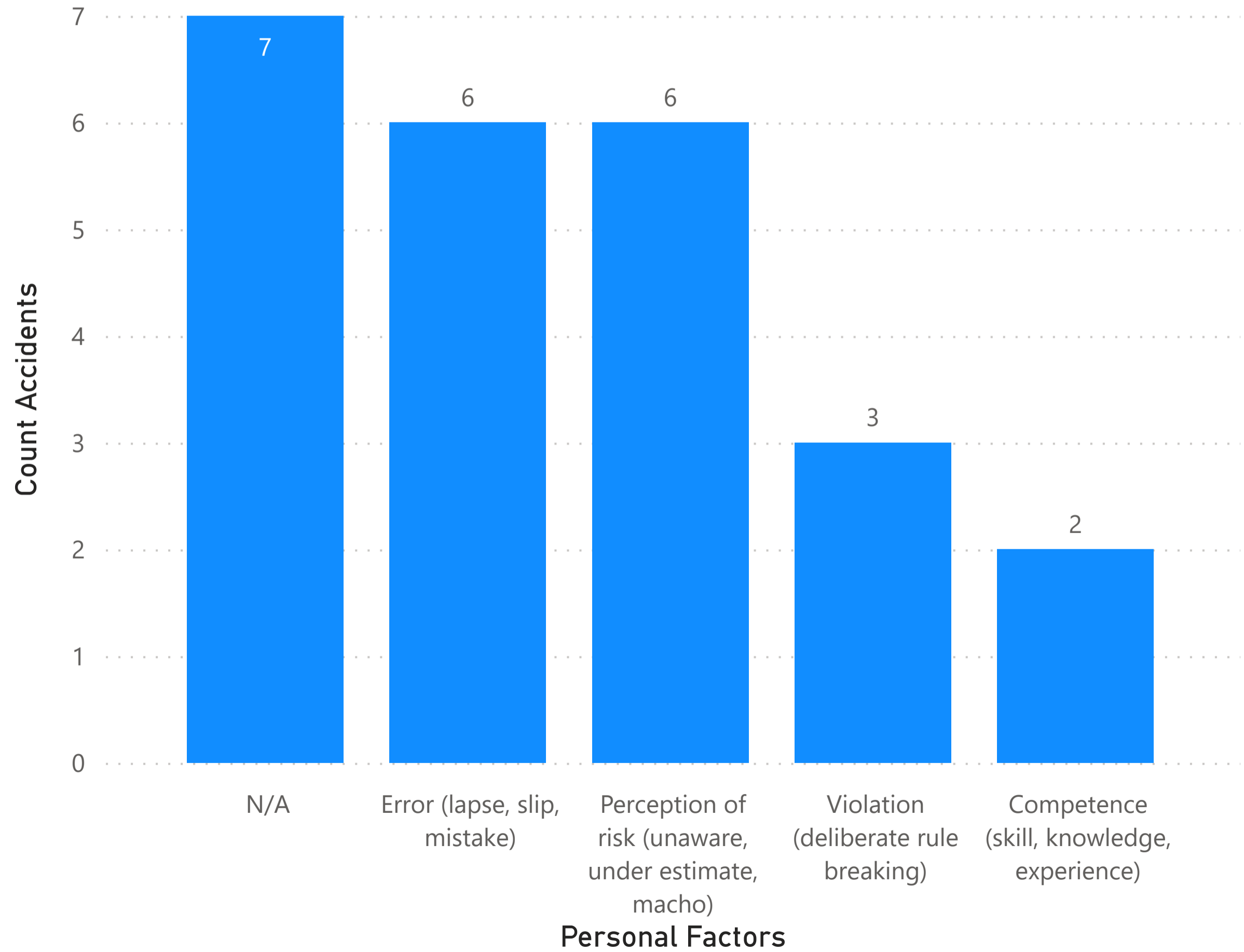


Date Filter

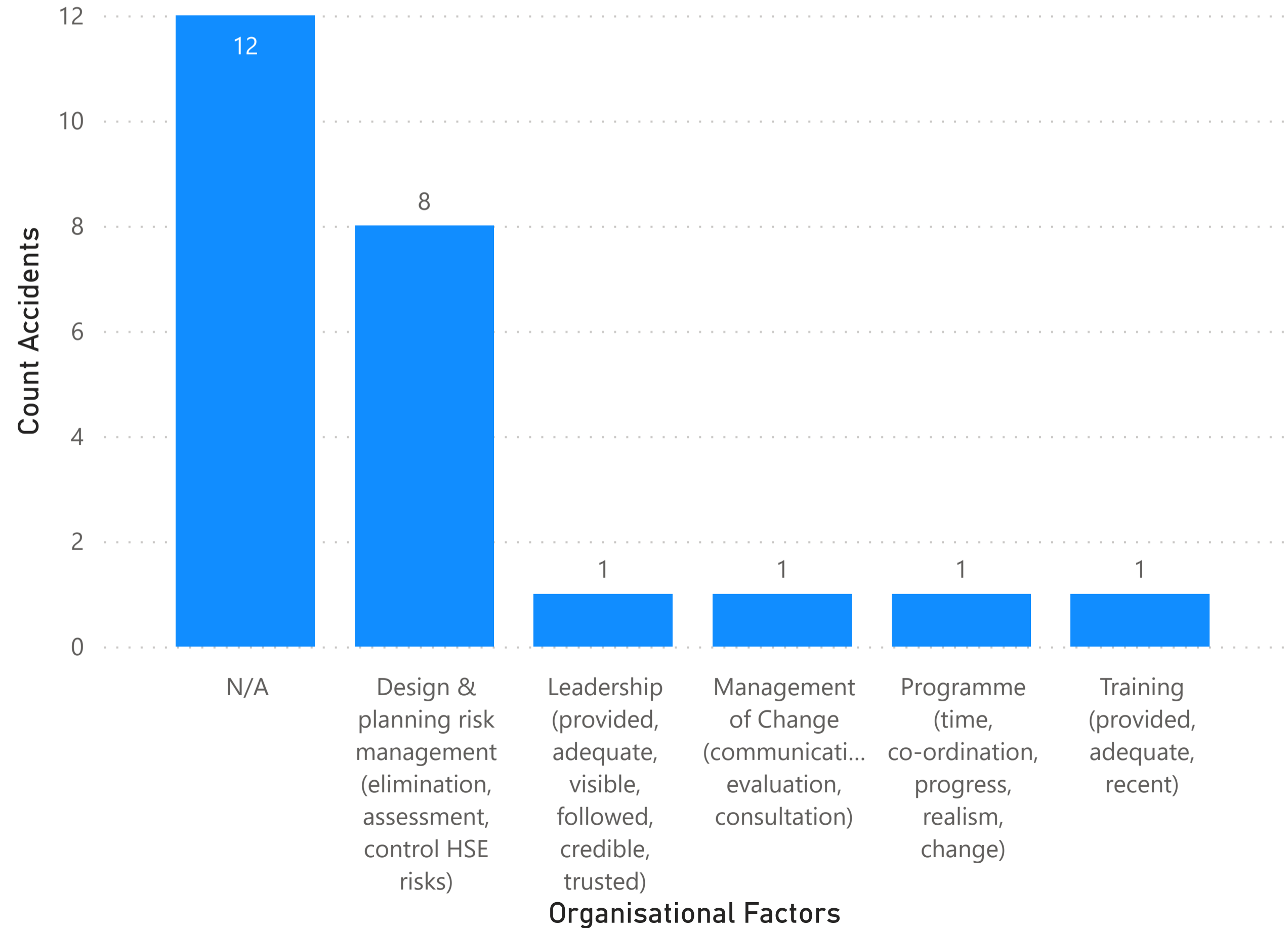
Year, Quarter

- ∨ 2020
- ∨ 2021
- ∧ 2022
- Qtr 1
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Personal Factors



Organisational Factors



Year, Quarter

2020

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2022

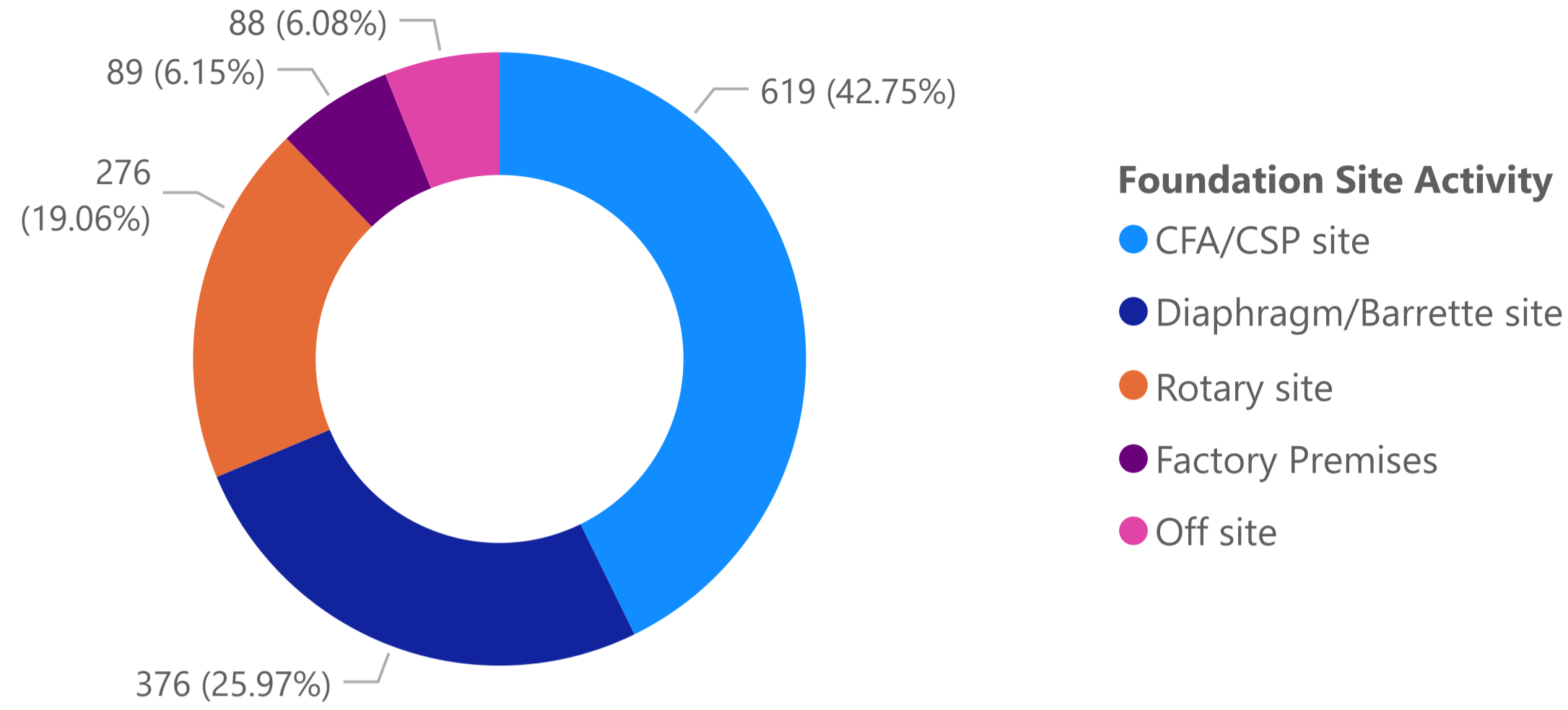
Qtr 1

Qtr 2

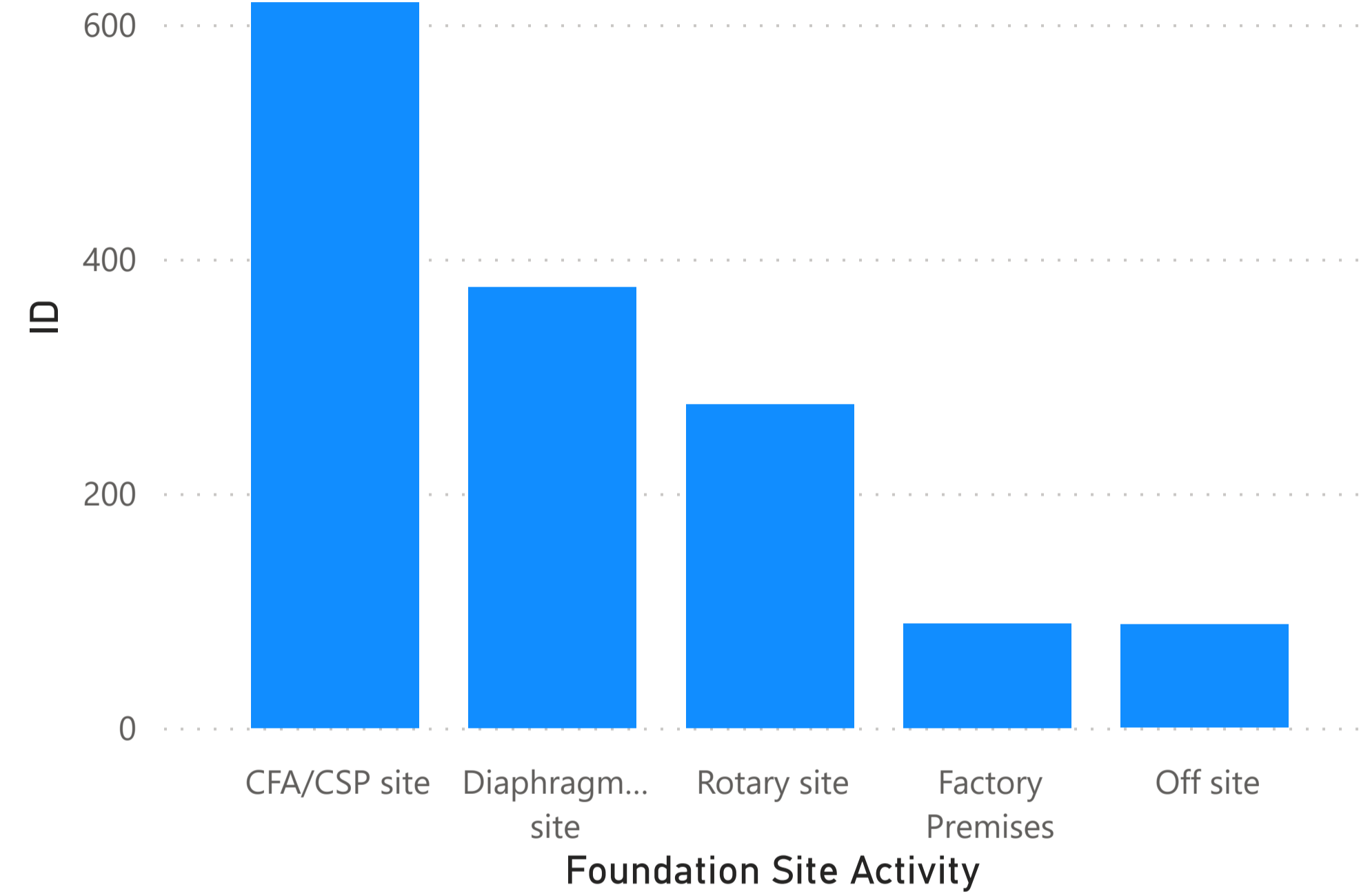
Qtr 3

Qtr 4

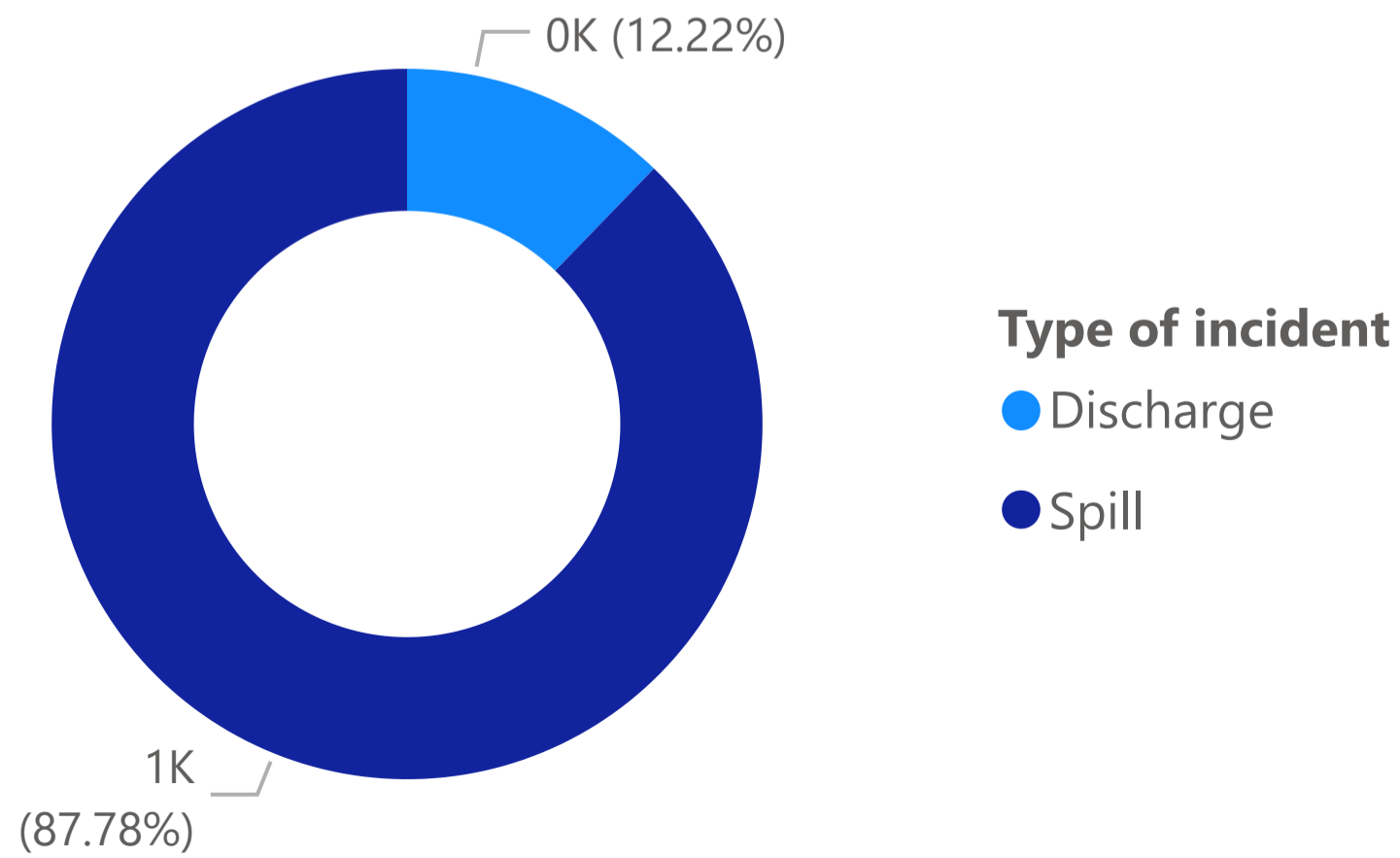
Foundation Site Activity



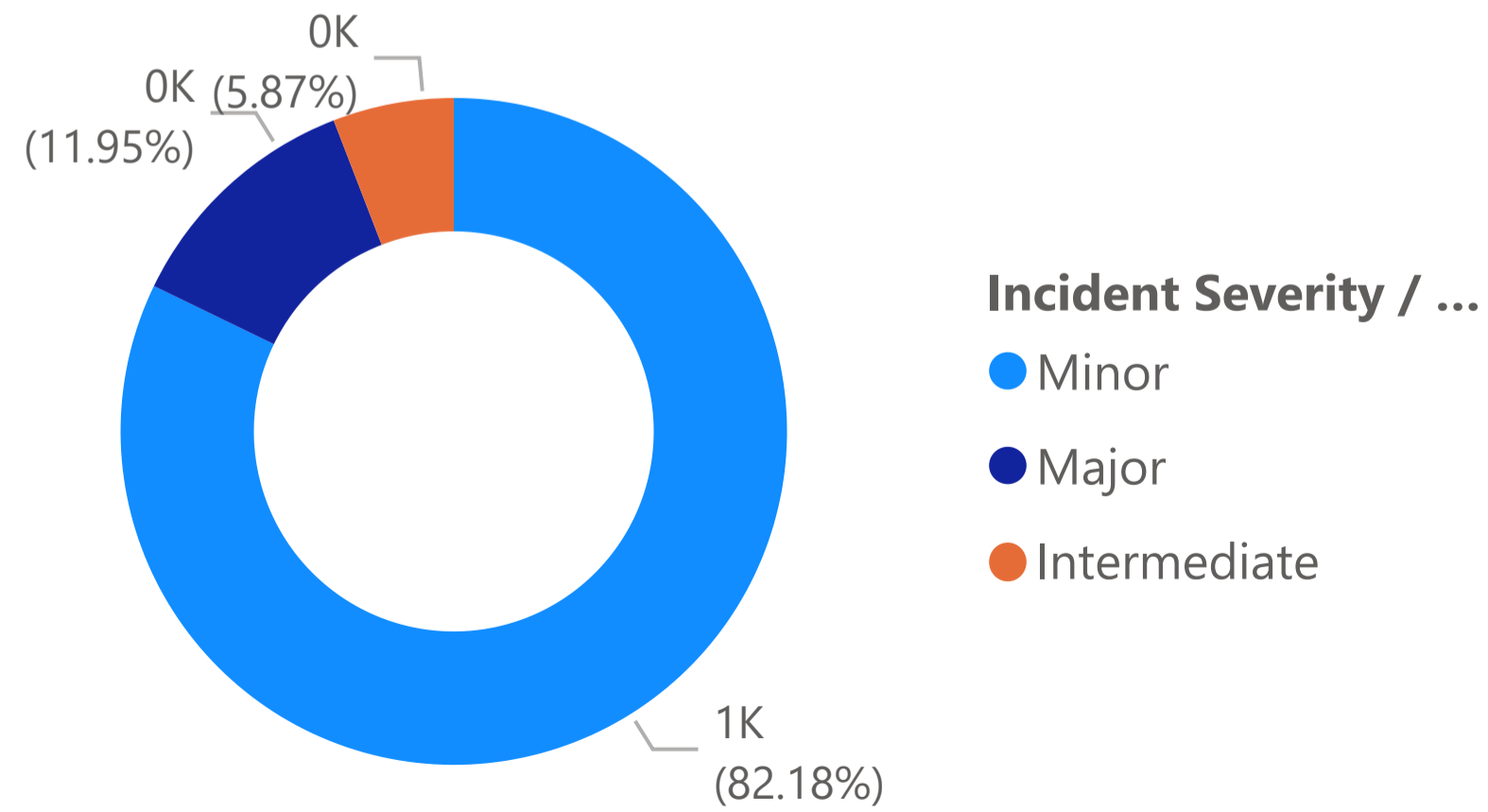
Foundation Site Activity



Type of Activity



Incident Severity / Category



Date Filter

Year, Quarter

2020

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Qtr 1

Qtr 2

Qtr 3

Outline / Description	Remedial Action Taken
The pump moving Bentonite from the plant to the Hydrofraise failed causing approx. 20-40 litres of Bentonite to be released into the contained ditch in which the pipes are run, along the side of the works. None was lost to drain, None lost from the ditch.	Cleaned up the spill and repaired the pump
Leaking fitting - unaccessable without corret tooling	Fitter attended site to repair
Broken Fitting on valave block	New hose
O ring blew	New O ring
Doughty seal worn	New seal
B175 Hydraulic Hoses were damaged whilst drilling leading to Hydraulic Oil leaking from hoses. During clearing of blockage in concrete hose swan neck, hydraulic hoses caught on gates as the gates were not fully open when the auger/rotary table was brought down to gain safe access. 20-30l lost in total. EA informed - no further action required	Repair to the hydraulic hoses complete and clean up took place
A hydraulic hose burst causing a small amount of hydraulic oil to land on the ground.	The area was cleaned up and the hose repaired
Overnight the sight glass on a bentonite tank had perished depositing a significant amount of bentonite on the ground.	The area was cleaned up and the sight glasses on all tanks were replaced. These are now included as part of the tanks planned maintenance.
A coolant pipe on the office AC unit split causing a small discharge of refrigerant into the atmosphere.	The coolant pipe was repaired and the system was recharged. No further issues reported.
As a hired diesel bowser was moved to fill up a rig a leak occurred below the bowser spilling about 3l of furl on the floor.	The hirer was contacted regarding the leak and bowser was replaced pending repair
A failure of the seal of the SYKES pump has caused a bentonite discharge. The discharge happened within the concrete bund and was contained by the bund. The discharge was discovered when operatives went to check the pumps were working ok following a previous incident on the same type of pump, this type of pump is not suitable for pumping bentonite and the manufacturer has been notified.	The pump was isolated and the discharge stopped, a spill kit was deployed and the area was cleaned up immediately. The spilt bentonite contained within the bund was pumped out and dry material deployed to clear up any remaining bentonite around the pipes. The pump was removed and replaced with a Selwood pump.
A hydraulic hose burst as the rig was tracking across site and sprayed nearby plant and equipment with hydraulic oil	The rig was isolated, the area cleaned up and the rig was repaired.
A catastrophic failure of a hydraulic hose on a power pack resulted in approximately 800L of hydraulic oil being deposited on the working platform.	The spill was contained and the power pack was repaired.
An articulated Aggregate Industries delivery vehicle was attempting to make a delivery to the concrete batching plant on site at OOC. The trailer used was an ejector trailer rather than a tilting trailer. Ejector trailers use a series of rams to push the load of bulk materials held within the confines of the trailer bed out of the rear doors of the trailer. During this operation one of two hydraulic hoses has ruptured allowing for the pressurised release of approximately 25 litres of hydraulic oil on to the vehicle and floor of the concrete batching plant slab	The spillage was identified by the batching plant management who proceeded to cover the oil with sand to prevent it from spreading and contaminating the water storage sump which holds recycled / recovered water used in the

Date Filter

Year, Quarter

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Qtr 1

Qtr 2

Qtr 3

Outline / Description

Remedial Action Taken

A catastrophic failure of a hydraulic hose on a power pack resulted in approximately 800L of hydraulic oil being deposited on the working platform.

The spill was contained and the power pack was repaired.

An articulated Aggregate Industries delivery vehicle was attempting to make a delivery to the concrete batching plant on site at OOC. The trailer used was an ejector trailer rather than a tilting trailer. Ejector trailers use a series of rams to push the load of bulk materials held within the confines of the trailer bed out of the rear doors of the trailer. During this operation one of two hydraulic hoses has ruptured allowing for the pressurised release of approximately 25 litres of hydraulic oil on to the vehicle and floor of the concrete batching plant slab

The spillage was identified by the batching plant management who proceeded to cover the oil with sand to prevent it from spreading and contaminating the water storage sump which holds recycled / recovered water used in the production of the concrete. The contaminated materials was disposed of as hazardous waste using an approved waste disposal contractor

Noticed T750 had a small leak on power pack on return from site.

Tightened up loose fittings

Cement release from tanker that was unloading in to silo.

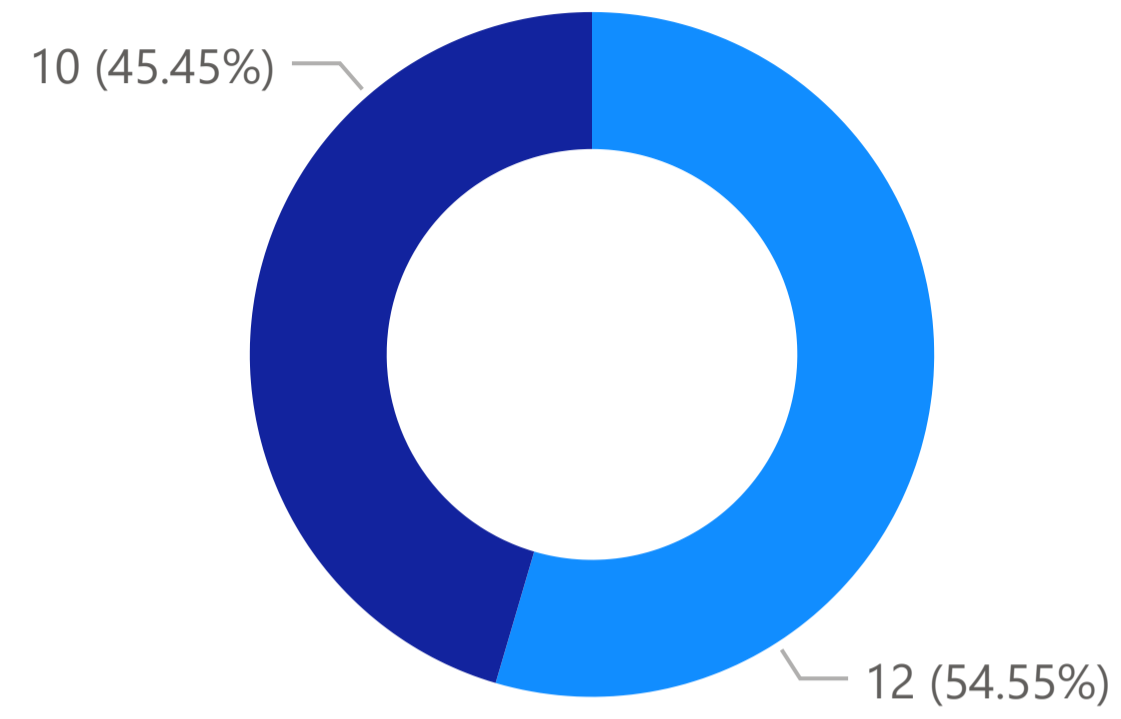
Unloading process stopped and load rejected. Factory evacuated and doors opened to allow "fog" to disperse.

Year, Quarter

∨ □ 2020

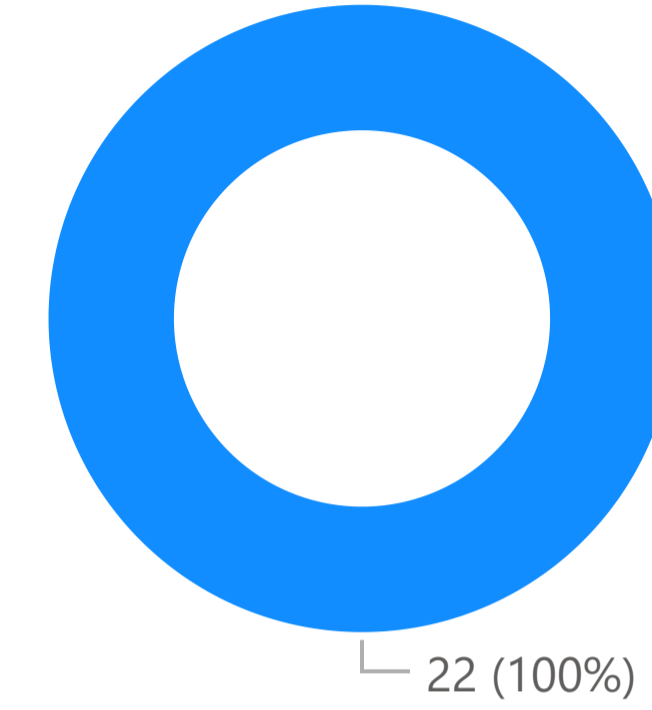
∨ □ 2021

Severity of Strike



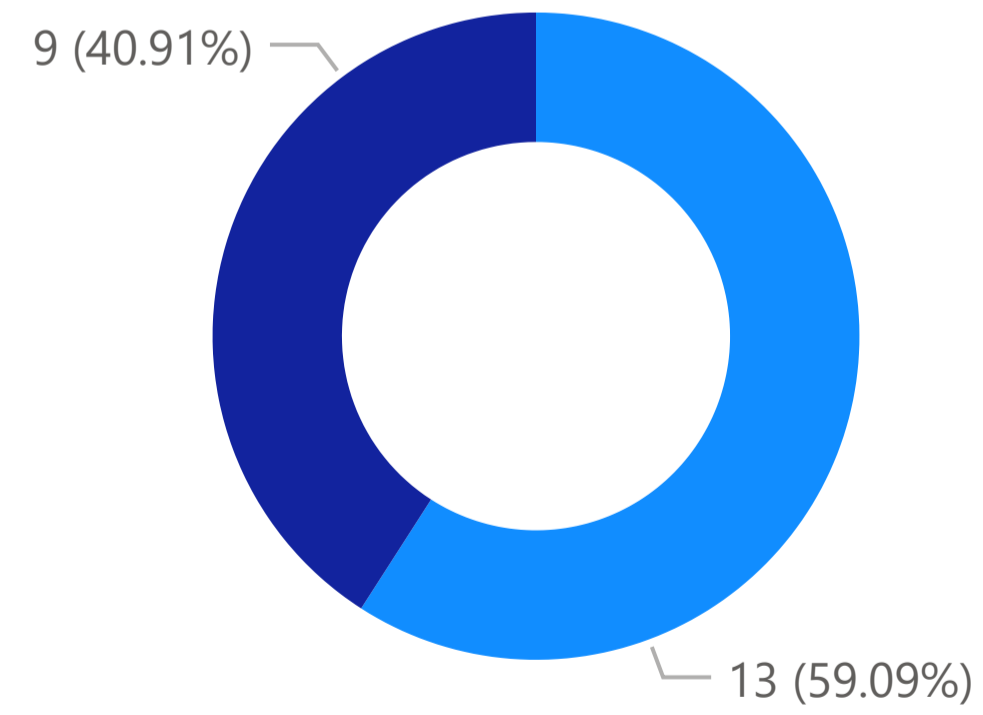
● Low
● Moderate

Nature of Works



● Planned

Was the asset known to be present?



● Yes
● No