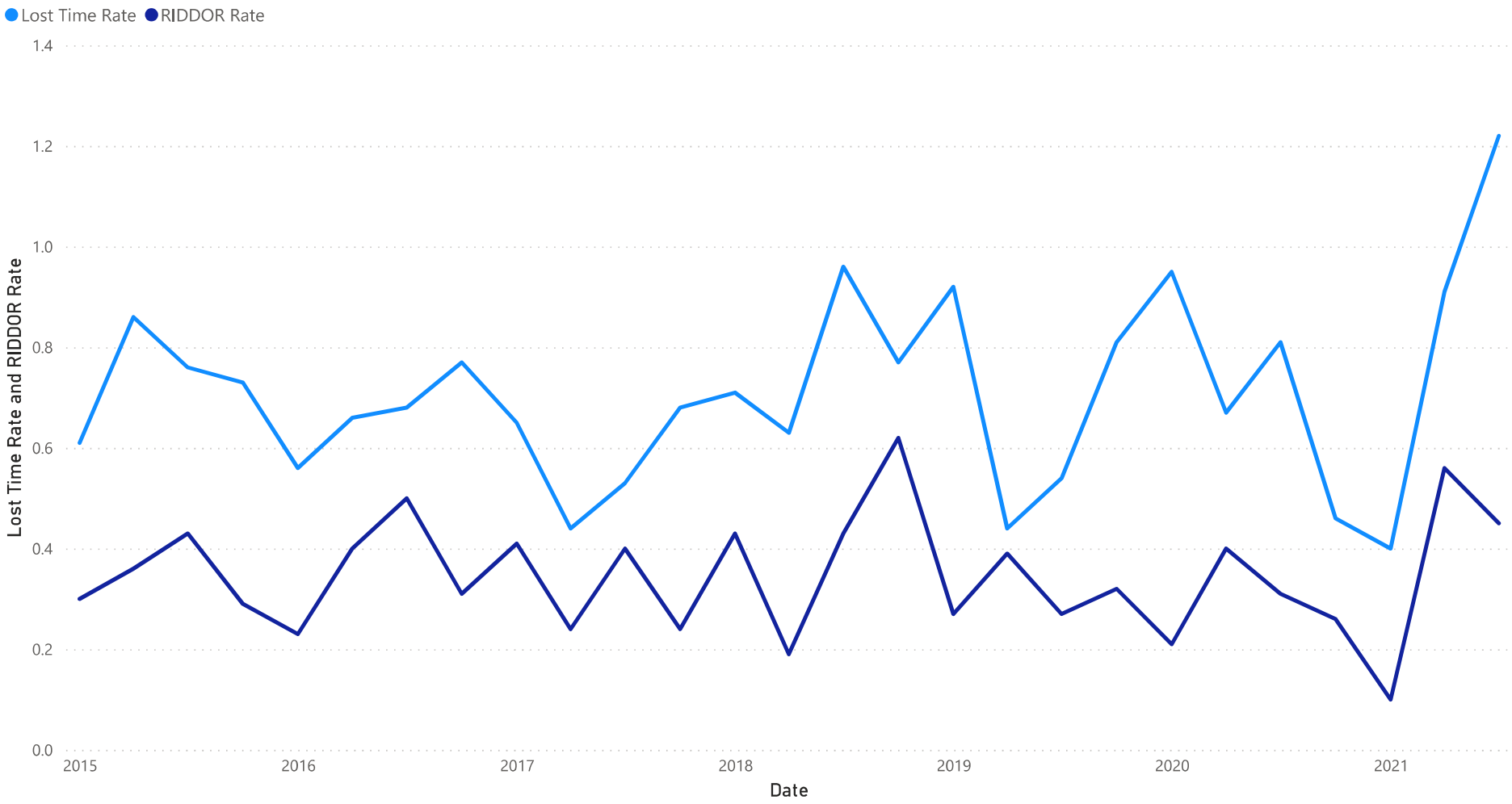
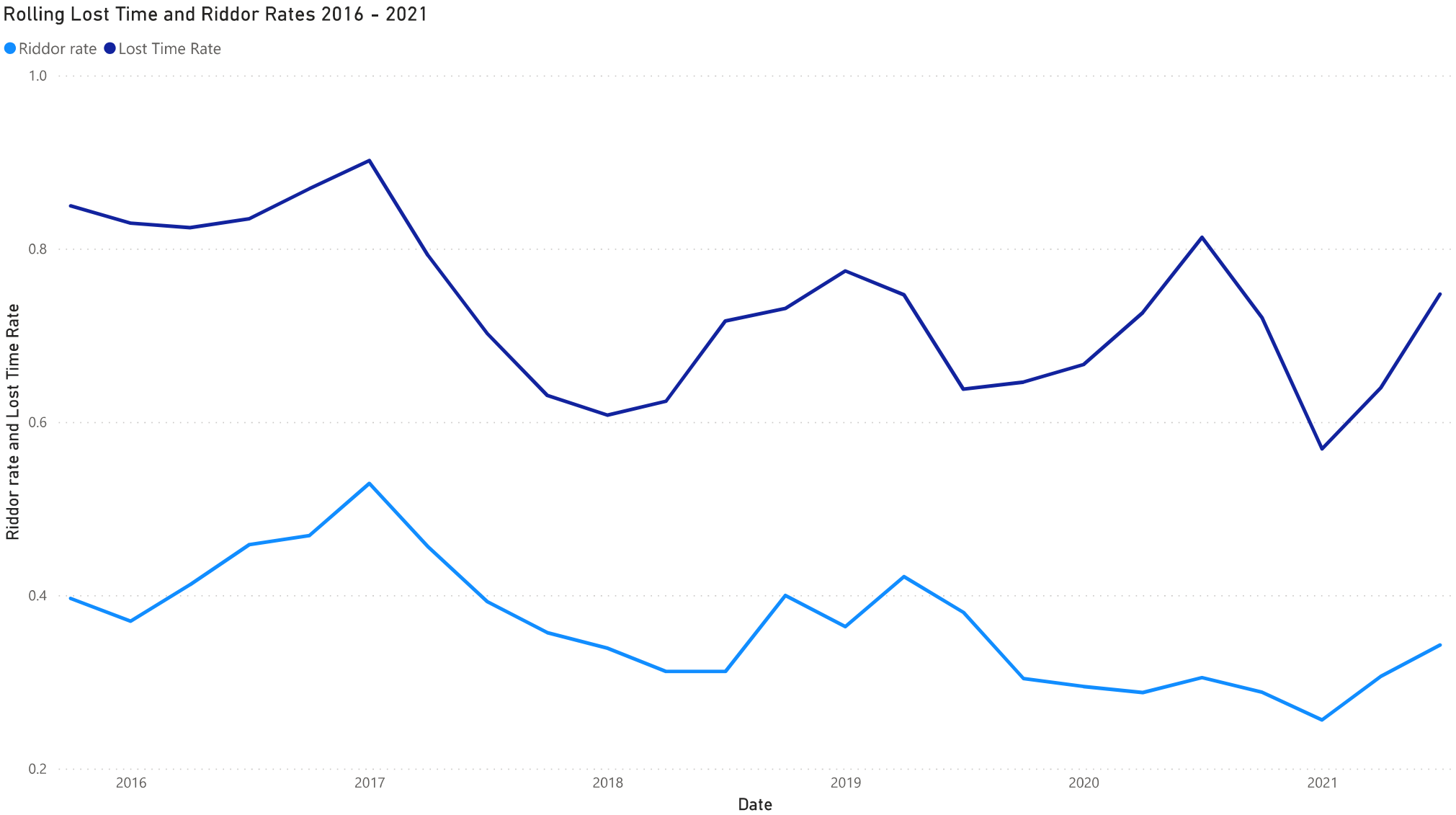
FEDERATION OF PILING SPECIALISTS

Quarter 3 2021 Accident Statistics

Quarterly Lost Time Rate and RIDDOR Rate 2015 - 2021




Rolling Lost Time and Riddor Rates 2016 - 2021
Riddor rate
Lost Time Rate
1.0
0.8
0.6
0.4
0.2
Riddor rate and Lost Time Rate
2016
2017
2018
2019
2020
2021
Date

Year, Quarter

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

Company Number	Man hours	Count Accidents	AFR
Company 16	22072	2	9.06
Company 1	45879	3	6.54
Company 10	129117	6	4.65
Company 17	101843	4	3.93
Company 15	25614	1	3.90
Company 14	45009	1	2.22
Company 12	361120	7	1.94
Company 5	194279	1	0.51
Company 9	197333	1	0.51
Company 13	254556	1	0.39
Company 11	25480		
Company 18	203333		
Company 2	55440		
Company 20	26400		
Company 21	11997		
Company 22	38531		
Company 3	75000		
Company 4	28673		
Company 6	19055		
Company 7	131025		
Company 8	225249		
Total	**2217005**	**27**	**1.22**

Year, Quarter

- 2020
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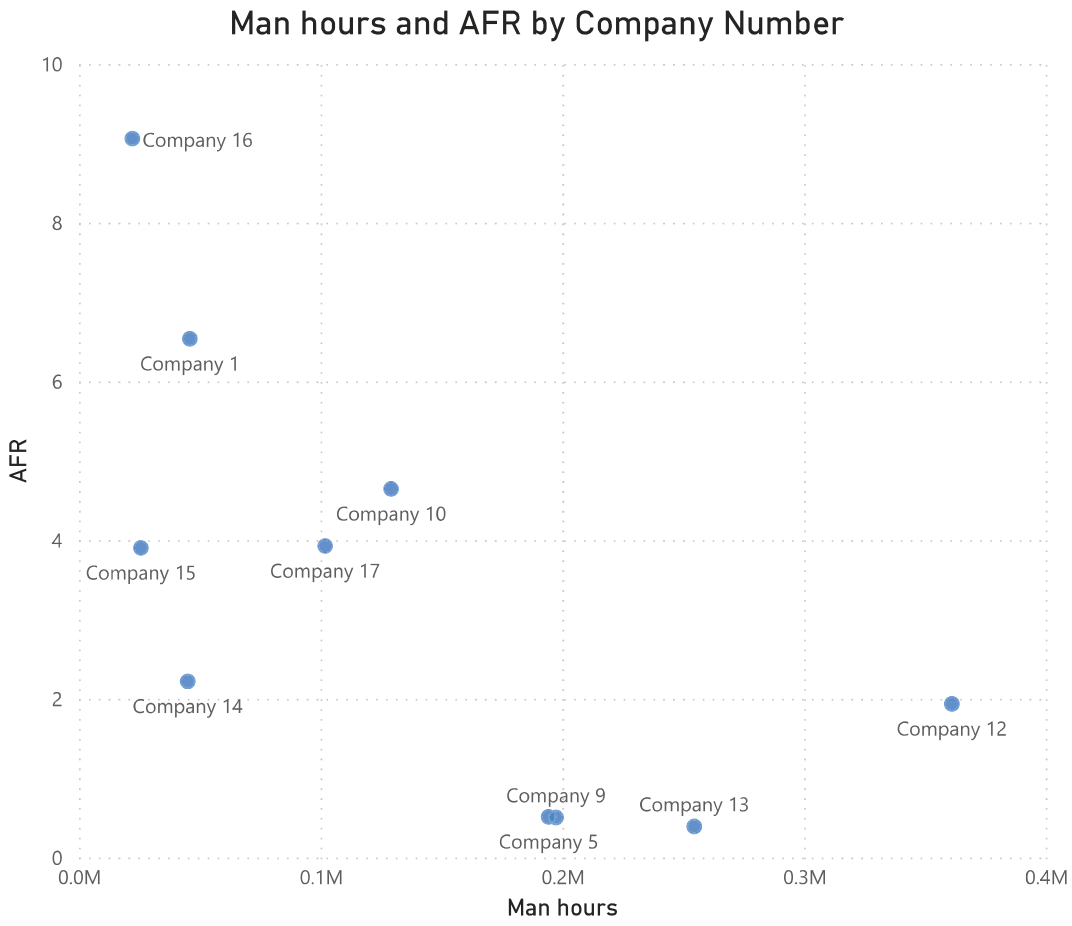
  - Qtr 4

RIDDOR

☐ RIDDOR



Year, Quarter

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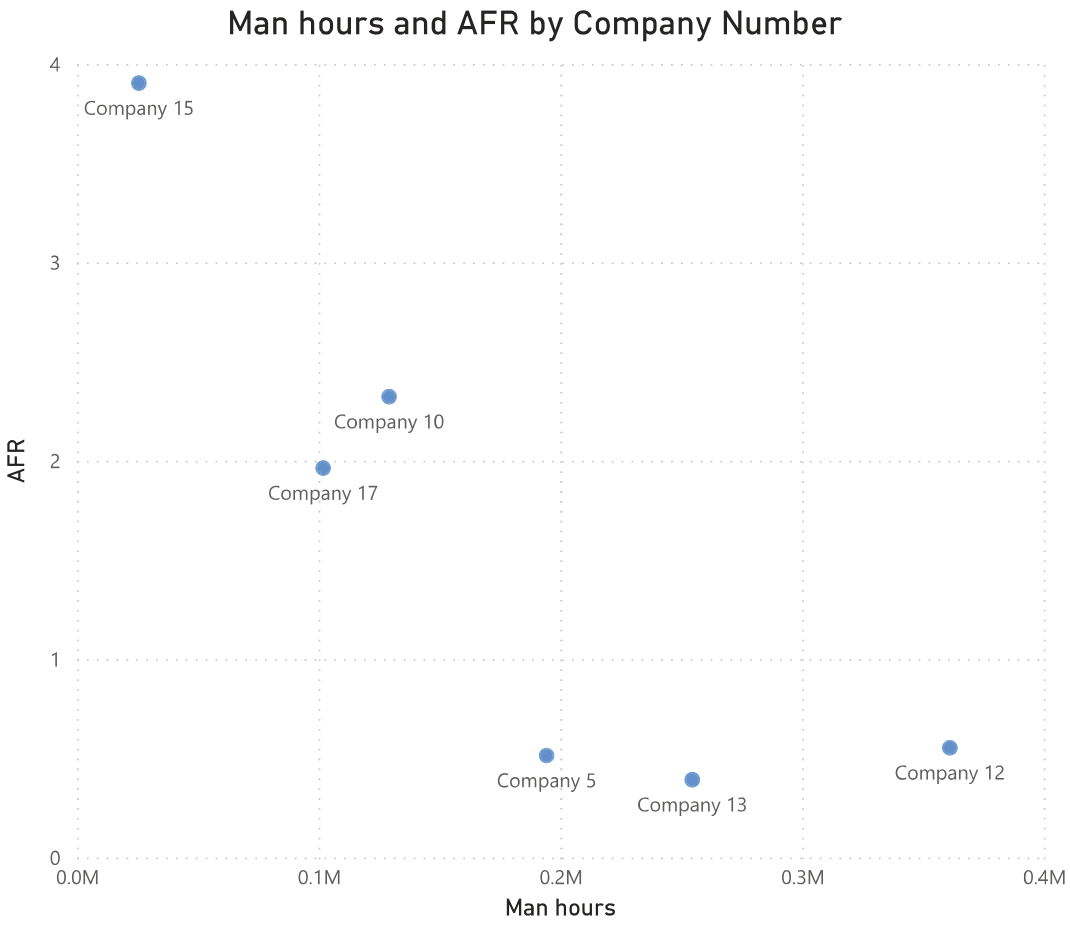
  - Qtr 3
  - Qtr 4

Company Number	Man hours	Count Accidents	AFR
Company 15	25614	1	3.90
Company 10	129117	3	2.32
Company 17	101843	2	1.96
Company 12	361120	2	0.55
Company 5	194279	1	0.51
Company 13	254556	1	0.39
Company 1	45879		
Company 11	25480		
Company 14	45009		
Company 16	22072		
Company 18	203333		
Company 2	55440		
Company 20	26400		
Company 21	11997		
Company 22	38531		
Company 3	75000		
Company 4	28673		
Company 6	19055		
Company 7	131025		
Company 8	225249		
Company 9	197333		
Total	**2217005**	**10**	**0.45**



Year, Quarter

- 2020
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RIDDOR

RIDDOR

Year, Quarter

- 2020
  - Qtr 1
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  - Qtr 4
- 2021
  - Qtr 1
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  - Qtr 3
  - Qtr 4

Company Number	1-7 day LTA	7+ day LTA	Dangerous Occurrence	HiPO	**Total**
Company 1	1			2	**3**
Company 10		3		3	**6**
Company 12	1	2		4	**7**
Company 13		1			**1**
Company 14	1				**1**
Company 15			1		**1**
Company 16				2	**2**
Company 17	2		2		**4**
Company 5		1			**1**
Company 9	1				**1**
Total	**6**	**7**	**3**	**11**	**27**

RIDDOR

- RIDDOR

Year, Quarter

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  - Qtr 4
- 2021
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  - Qtr 2
  - Qtr 3
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Company Number	7+ day LTA	Dangerous Occurrence	**Total**
Company 10	3		**3**
Company 12	2		**2**
Company 13	1		**1**
Company 15		1	**1**
Company 17		2	**2**
Company 5	1		**1**
Total	**7**	**3**	**10**

RIDDOR

RIDDOR

Accident Category	Count Accidents
1-7 day LTA	23
7+ day LTA	23
Dangerous Occurrence	6
Fatality	1
HiPO	26
Specified (major) injury	10
Total	**89**

Date Filter

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- 2021
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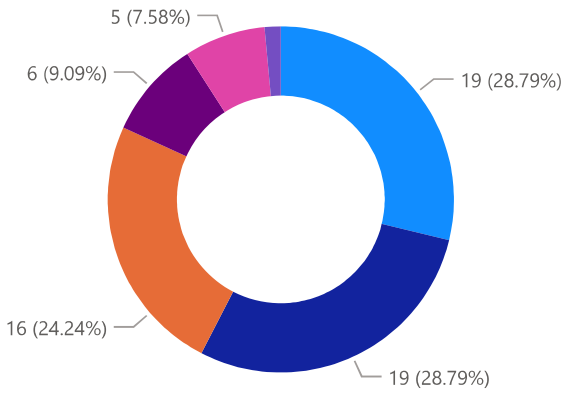
Accident Category

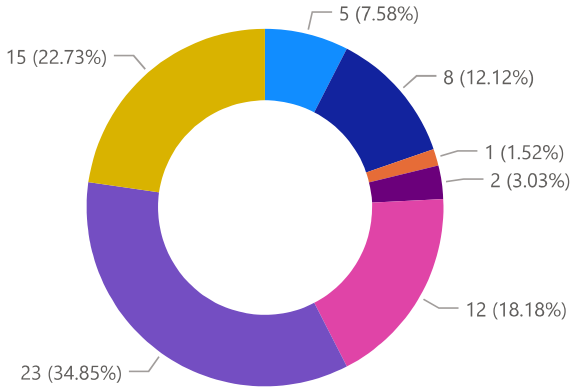


Accident Category
- 1-7 day LTA
- HiPO
- 7+ day LTA
- Specified (major) injury
- Dangerous Occurrence
- Fatality

66

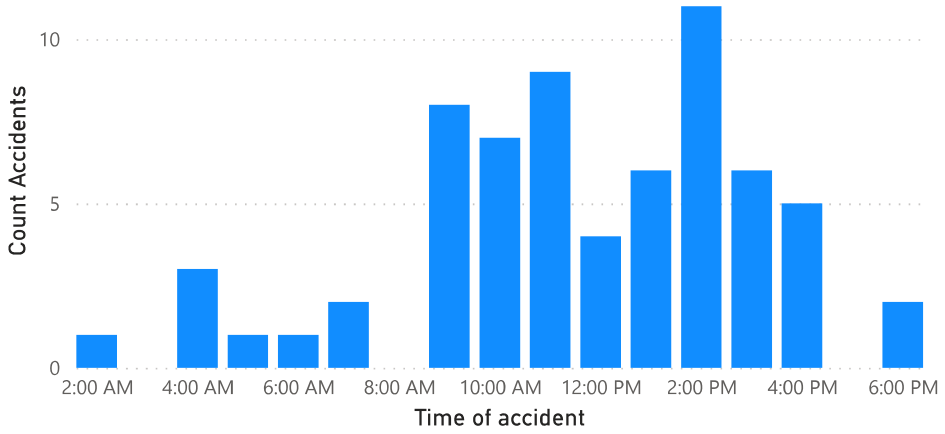
Count Accidents

Day of Accident



Day Name
- Friday
- Monday
- Saturday
- Sunday
- Thursday
- Tuesday
- Wednesday

Time of accident



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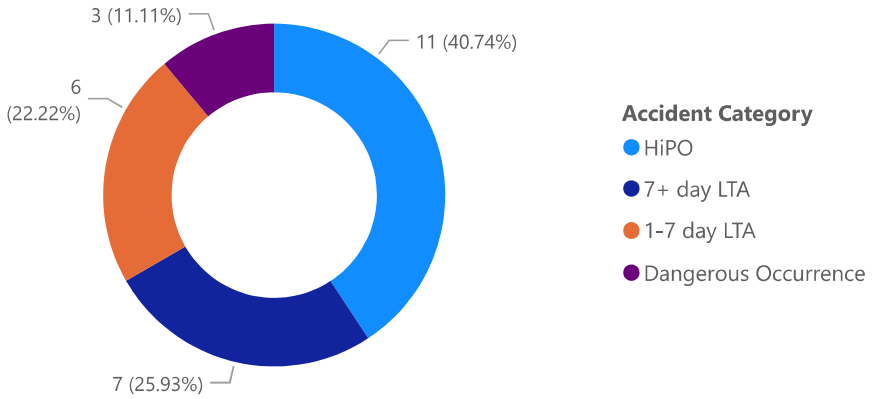
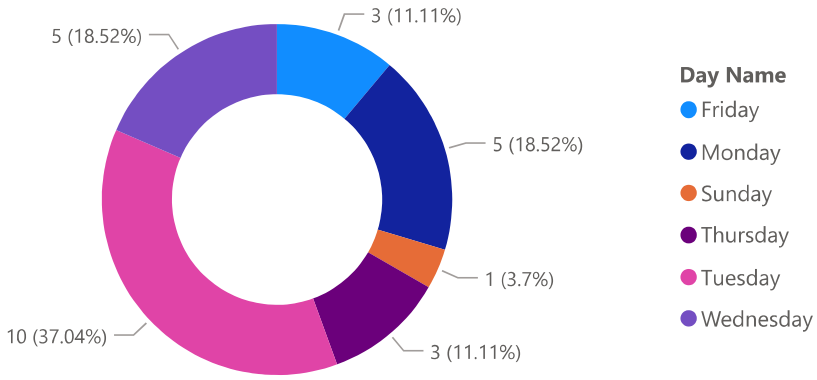
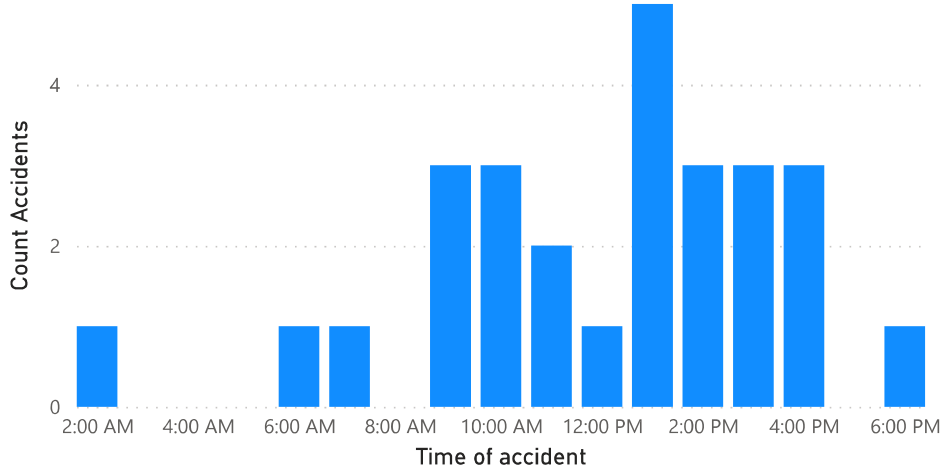
Accident Category



Accident Category



Count Accidents by Time of accident



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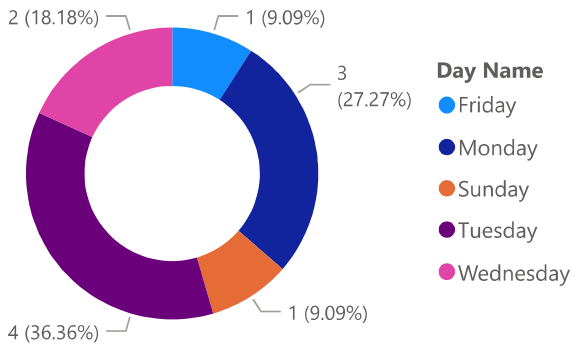
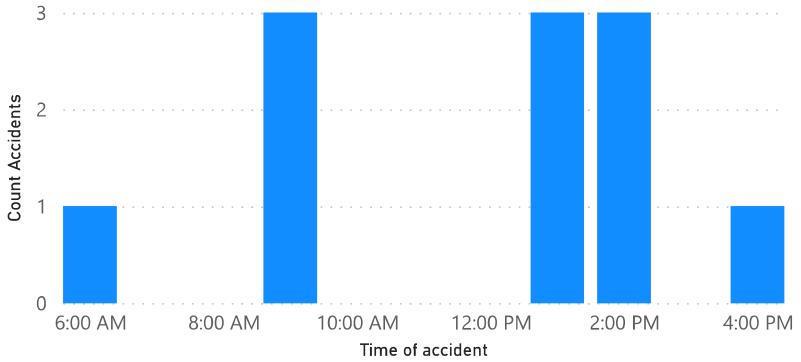
HiPo Day



Time of HiPo



Category Filter

Accident Category

- 1-7 day LTA
- 7+ day LTA
- Dangerous Occurrence
- HiPO

Outline/Description of Accident	Remedial Action Taken
a trailer loaded with reinforcement cages shed its load as it was moved around the yard. load was not secured or trailer posts fitted.	improved standard of trailers / posts and revisited load security.
An under desk fan heater over heated and caught fire. the fan heater melted and left scorch marks on carpet tiles.	Implementation of Facilities Management Plans that include other legal requirements. An electrician carried out an installation examination and provided a condition report for the facility. Emergency procedures were reviewed and content displayed on all facilities notice boards. Additional Fire Wardens were trained and appointed
At approx. 2pm a loud bang was heard from the back part of the rig. The banksman and operator both quickly realised that there was a fire behind the panels of the rig where the engine was located. The operator quickly stopped the rig and passed a fire extinguisher to the Banksman who then put out the fire. Both the operator and banksman then made the rig safe.	Fire damaged parts repaired, and hydraulic hoses inspected and replaced as required. All other rigs (similar models) inspected for fatigue of the hydraulic hoses. Confirmed that all daily checks and briefings had been completed on the day of the incident
Concrete hose burst sprayed concrete through the window of the ready mix delivery truck - no person injured. hired in hoses were in poor condition and should have been used.	puchased new hoses and instigated in house PPM shceme for these.
Grouting work was unable to start so the remaining work on the shift was completed and all of the plant and equipment returned to the RRAP at Lairg Station Sidings	Introduced a 'Check Out/Check In' process and a loading plan for the RRV trailer. Held a briefing/training session focussing

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Category Filter

Accident Category

- 1-7 day LTA
- 7+ day LTA
- Dangerous Occurrence
- HiPO

Outline/Description of Accident	Remedial Action Taken
Grouting work was unable to start so the remaining work on the shift was completed and all of the plant and equipment returned to the RRAP at Lairg Station Sidings. A passenger Train (06:26 LAIRG TO INVERNESS) reported striking one of between 8-10 grout bags in the cess between 64 3/4 and 66 1/2 mile posts which appear to have fallen from a trailer during RRV movements from the previous nights work. A cement bag that was sitting high was struck and no damage was reported to train.	Introduced a 'Check Out/Check In' process and a loading plan for the RRV trailer. Held a briefing/training session focussing on the preparation and handling of the site documentation. Provided a separate briefing session to ensure that all VER staff are complying with the contract folder structure and are maintaining their records as required. Conducted a safety conversation with the Crane Controller to ensure that he follows the rules
IP pulled the muscle in his arm removing hanging chains from a concreted pile	a Lifting beam was ordered to install cages and remove the hanging chains.
IP set the crane moving without first removing the fall arrest system from its anchorage point on the loadin gplatform. this caused the platform to be dragged into the pile storage area, damaging the platform and fall arrest system. Whilst IP was an experince operator he had not worked on this particular crane that often. this crane anchors the fall arrest to the platform whereas other crane attach to the crane.	A 'weak link' anchorage device was fitted such that this would break rather than drag the platform.
IP slipped walking on wet concrete floor which had a film of wet clay on it	Bags of grit are now available through out the site to spread on the concrete floor for grip
Reinforcement cage got caught on the bottom of another cage in the pile. as the ip pulled it clear it dropped onto his foot	The pile of reinforcement cages was organised and properly stacked so the cages could not snag on each other
The augers had just been changed from 600mm dia to 1050mm dia piles digging to a depth of 24.5m. Then at 1400hrs while concreting the 3rd pile the supervisor noticed that the rig was moving forwards. The rig attendant noted the same and went to the rig to report it. The site team stopped pumping and went to investigate. They noticed the piling mat had collapsed from the augers to front of the tracks. The augers were reversed out and the rig was tracked away from the area. Work was stopped and the supervisor reported the event to the contract manager. The hole was around 4m wide and 3m deep.	The rig was exchanged as the current rig did not have the torque to dig through the stiff material at depth. A new piling mat was designed and installed
Whilst attaching chains to the lifting eye on a quick hitch the hitch flicked and struck the IP on the shoulder. The IP had taken it upon himself to start lifting operations without the appropriate skill set.	The IP was reminded that he should only perform the tasks he is trained for and removed from site. The supervisor was reprimanded for not physically checking the competence cards in the induction.

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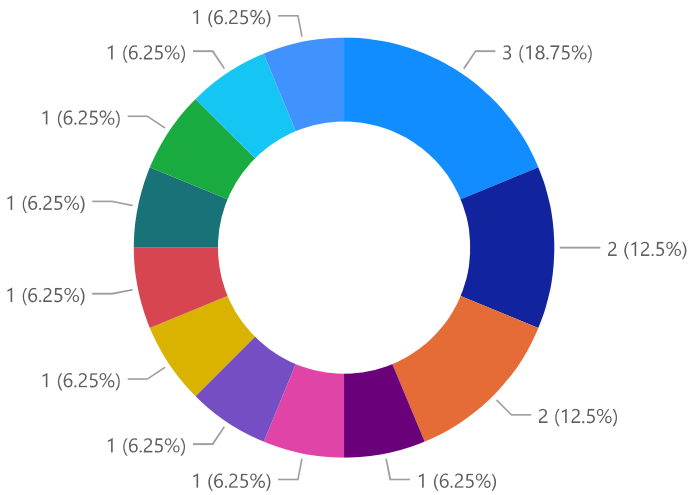
Accident Category

- 1-7 day LTA
- 7+ day LTA
- Dangerous Occurrence
- HiPO

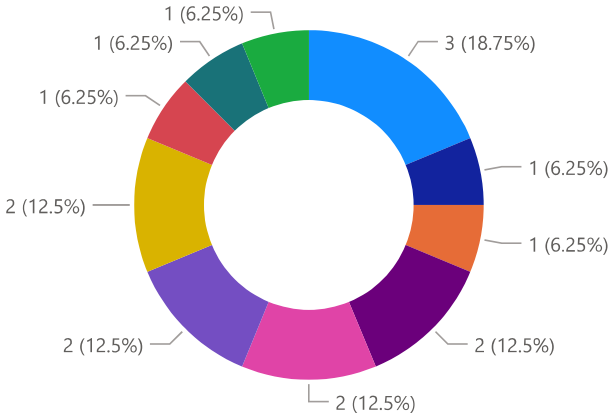
Activity of IP



Activity of Injured Person at time of accide..

- Manual handling
- Lifting operations
- Using handtools
- Auger string building
- Banking plant or vehicles
- Cutting a pile cage with a Stihl saw
- Getting on or off machine
- N/A (HiPo)
- Operating ancillary plant (jet wash, com...
- Operating concrete pump
- stock taking
- Stockpiling

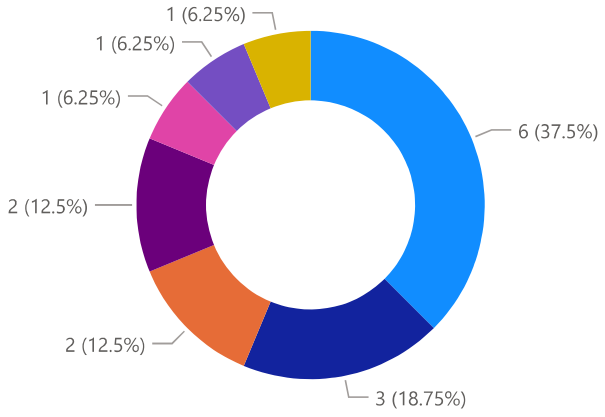
Body Part Injured



Body part injured

- Arm
- Back
- Eye
- Finger / Thumb
- Foot / Ankle
- Hand / Wrist
- Leg
- N/A (HiPo)
- Shoulder
- Tooth and Groin

Type of Injury



Type of Injury

- Bruising
- Fracture
- Cuts / abrasions
- Sprain / strain
- Dislocation
- N/A (HiPo)
- Oil entered IPs eye

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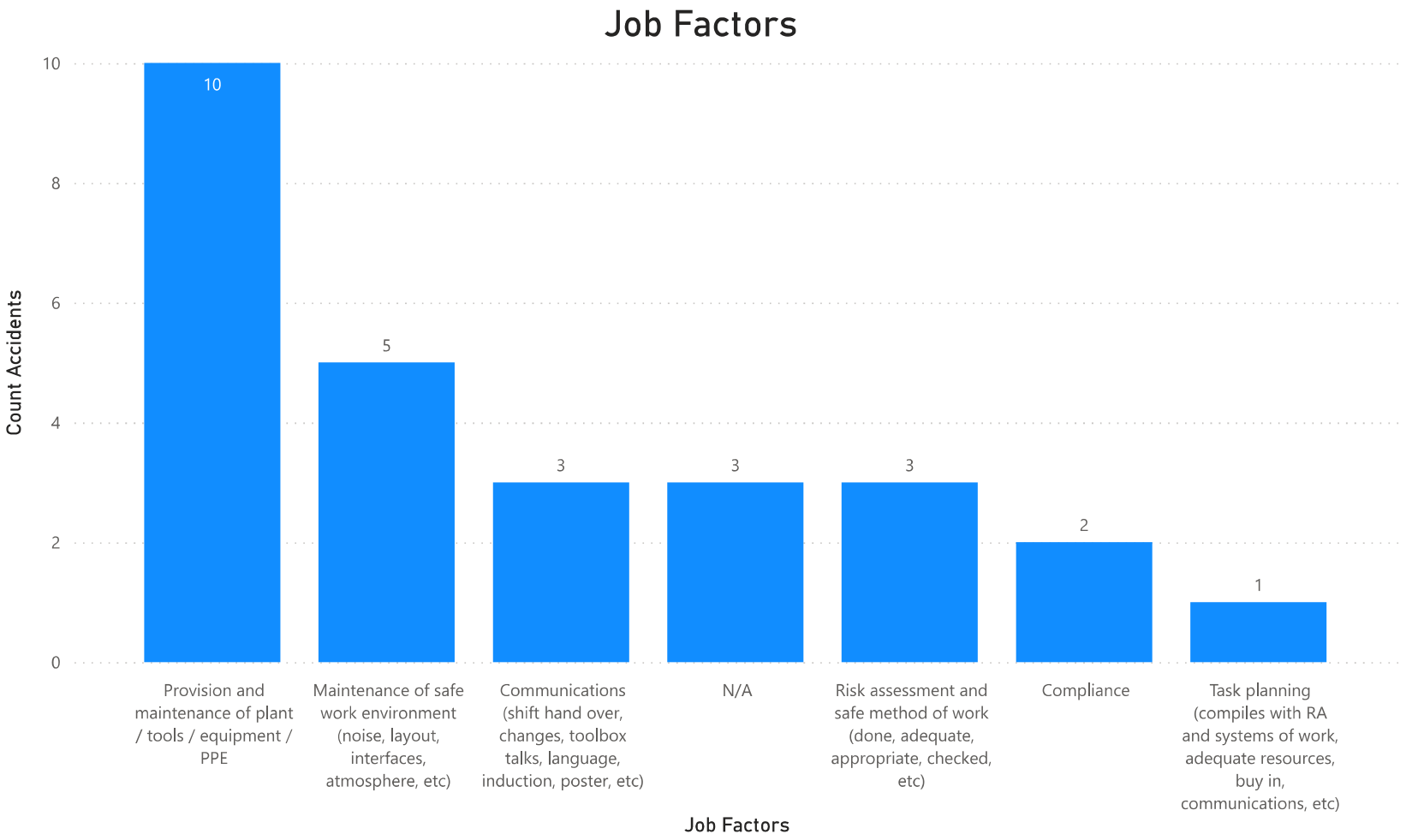

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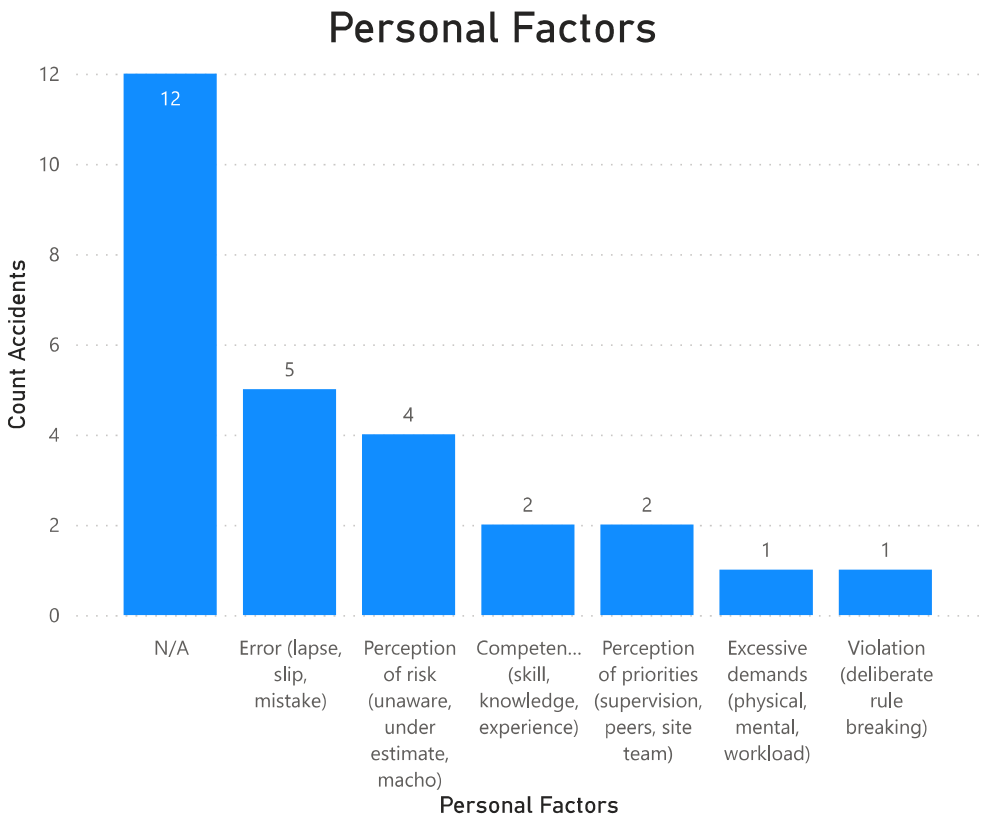

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Outline/Description of Accident	Remedial Action Taken
On the 18th August 2020 a Keltbray Piling fitter was dispatched to the Silvertown project to locate the origin of a hydraulic leak on a hired Bauer BG45 piling rig. The fitter was tasked to locate the source of the leak to expedite Bauer in replacing the parts required. Subsequent to locating the source of the leak the fitter began to egress the rig via an access step located to the front near side of the drivers gangway. Whist disembarking the gangway the fitter rolled an ankle on a rock resulting in him falling to ground. The fitter was taken to A&E where he was diagnosed with a sprained ankle and discharged that evening. The event resulted in a four day lost time injury A formal investigation was undertaken by Keltbray HSQE which identified a number of contributory factors.	- Introduce Point of work risk assessment - Deliver recorded 'Step-Up' Briefing to all KBP staff on the Riverlinx project - Revise and recirculate Group Visiting Risk Assessment. Update to identify hazards posed when accessing / egressing plant. - Draft and circulate HSQE Alert explaining details surrounding the event and lessons leant - Refer IP to KML to undertake a fit to work assessment.
Whilst opening the side shutters on the I section mould the hinged fixing plate slipped and trapped the injured persons finger against the side of the mould. Injured person sustained cut and swelling to his middle finger.	• Full review of risk assessments and methods statements • Handles have been installed along the fixing plates to prevent further incidents
A concrete hose burst during concreting of a CFA pile, the concrete was projected onto a KB operative around 2m from the house causing bruising to the groin area and a chipped front tooth to a Lendlease construction manager.	A concrete hose burst whilst pumping concrete to a CFA pile. The ejected concrete struck and injured two individuals. The first, a KB rig operator, was splattered and suffered minor bruising to his knees, hands and torso area. The second individual was a Lendlease Construction Manager, who was struck in the face and subsequently sustained a chipped tooth. Works were immediately suspended, the site made safe and first aid was administered. The two injured persons (IPs) were positioned circa 2m and 6m from the hose when it ruptured. Both IPs returned to work and normal duties the following shift. No lost time was incurred. The investigation concluded the hose failure would have been resultant of one of, or a combination of a number of factors, specifically: a blockage, wear and tear or damage to the hose resultant of being tracked over by vehicles or items of plant The investigator has concluded that considering the age of the hose and the recent pressure test, it's believed the rupture is most likely resultant of internal damage and/or wear and tear. It had been recorded on site that hoses were being tracked over by construction plant, what couldn't be determined is when this occurred or how many times the hose was driven over.

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Outline/Description of Accident	Remedial Action Taken
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IP pulled the muscle in his arm removing hanging chains from a concreted pile	a Lifting beam was ordered to install cages and remove the hanging chains.
IP set the crane moving without first	A 'weak link' anchorage device was fitted such that this would break rather than drag the platform.

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Outline/Description of Accident	Remedial Action Taken
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IP set the crane moving without first removing the fall arrest system from its anchorage point on the loadin gplatform. this caused the platform to be dragged into the pile storage area, damaging the platform and fall arrest system. Whilst IP was an experince operator he had not worked on this particular crane that often. this crane anchors the fall arrest to the platform whereas other crane attach to the crane.	A 'weak link' anchorage device was fitted such that this would break rather than drag the platform.
Whilst traversing to a pile position the track of the piling rig started to slip. The operator attempted to backtrack and back mast to stabilise the rig but was unable to. The rig dipped to the front right hand side and overturned coming to rest on its side. The operator jumped clear. The incident was reported to the HSE	Area barriered off and investigation started
IP slipped walking on wet concrete floor which had a film of wet clay on it	Bags of grit are now available through out the site to spread on the concrete floor for grip
The operative was filling up the petrol saw outside the exclusion zone, when the attendant excavator which was 6m away tipped rebar into the pile cropping stockpile area. The rebar in the stockpile then bounced/protruded up and over the exclusion zone 'A' frame barriers and caught the Operative on the arm whilst he was refueling the petrol saw. First aid was given and the Operative taken to Hospital for the wound to be cleaned. The Operative has returned to work today.	Exclusion zones going forward will be more robust and will be demarcated a sufficient distance from personnel not involved in the works and to ensure any accidental movement of stockpiled bar remains within the confines of the exclusion zone by use of correct barriers
At approx. 2pm a loud bang was heard from the back part of the rig. The banksman and operator both quickly realised that there was a fire behind the panels of the rig where the engine was located. The operator quickly stopped the rig and passed a fire extinguisher to the Banksman who then put out the fire. Both the operator and banksman then made the rig safe.	Fire damaged parts repaired, and hydraulic hoses inspected and replaced as required. All other rigs (similar models) inspected for fatigue of the hydraulic hoses. Confirmed that all daily checks and briefings had been completed on the day of the incident
It was reported, whilst pulling the starting toggle on a diesel pressure washer to start the engine, the flywheel jammed causing the toggle to stop suddenly. This resulted in the "IP" spraining their lower right forearm and a 3 day LTA.	Following this event an inspection of the equipment found the fuse to make the circuit for the electric start had dislodged preventing the electric start to function. This was re-inserted and the electric start worked. A more thorough pre-start check would have found this fault and prevent the event occurring.
On Tuesday the 21st of September 2021 at around 16:00pm, a Piling Rig	Immediate Action Taken - We reminded all staff on site that any incident on site should

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Outline/Description of Accident	Remedial Action Taken
On Tuesday the 21st of September 2021 at around 16:00pm, a Piling Rig Banksman was completing their normal duties within a restricted access area under the Piling rig auger when they were struck on the lower left hand side of the back by an unknown size piece of clay which had fallen from the auger. The Banksman returned to work 5 days later on the 27th of September 2021.	Immediate Action Taken - We reminded all staff on site that any incident on site should be reported to the supervision team immediately when it happens.The importance of cleaning the auger was reiterated in the morning briefings. Physical exclusion zone to be in place around the auger. Exclusion zone to be controlled by the rig banksman. Suitable auger cleaner to be in place and checked as part of the weekly plant maintenance sheets. Attendant excavator to assist in cleaning the auger where required. When working tight up against site boundary with public interface site specific risk assessment is required.
An under desk fan heater over heated and caught fire. the fan heater melted and left scorch marks on carpet tiles.	Implementation of Facilities Management Plans that include other legal requirements. An electrician carried out an installation examination and provided a condition report for the facility. Emergency procedures were reviewed and content displayed on all facilities notice boards. Additional Fire Wardens were trained and appointed
a trailer loaded with reinforcement cages shed its load as it was moved around the yard. load was not secured or trailer posts fitted.	improved standard of trailers / posts and revisited load security.
Grouting work was unable to start so the remaining work on the shift was completed and all of the plant and equipment returned to the RRAP at Lairg Station Sidings. A passenger Train (06:26 LAIRG TO INVERNESS) reported striking one of between 8-10 grout bags in the cess between 64 3/4 and 66 1/2 mile posts which appear to have fallen from a trailer during RRV movements from the previous nights work. A cement bag that was sitting high was struck and no damage was reported to train.	Introduced a 'Check Out/Check In' process and a loading plan for the RRV trailer. Held a briefing/training session focussing on the preparation and handling of the site documentation. Provided a separate briefing session to ensure that all VER staff are complying with the contract folder structure and are maintaining their records as required. Conducted a safety conversation with the Crane Controller to ensure that he follows the rules
During a auger flight change, IP struck his left hand with a club hammer while hitting out an auger pin with a punch.	Pin punches now have hand guards fitted.
Concrete hose burst sprayed concrete through the window of the ready mix delivery truck - no person injured. hired in hoses were in poor condition and should have been used.	puchased new hoses and instigated in house PPM shceme for these.
IP had damaged the hose connection when he put the grout connection elbow down onto the ground. The drilling crew were limping on with a burst hose on the rig (not using that control lever) when the driller inadvertantly operated the lever causing oil to spray into IPs eyes. He was not wearin glasses at the time.	raised awareness of consequence of decisions when reacting to change circumstances. limping on when the correct action was to stop.
At the time of the incident the IP was washing down the concrete	Reviewed the method statement and risk assessment to ensure that there is sufficient

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Outline/Description of Accident	Remedial Action Taken
At the time of the incident the IP was washing down the concrete storage drum (agitator). Water was not coming out of the pipe washing the inside of the agitator drum as it would ordinarily do. The IP got a hammer in order to tap the end of the pipe as he believed there was a build up of concrete on the end. The drum was still rotating while the IP was striking the hammer against the water feed pipe and because the drum was turning the internal blade of the agitator, the pipe and club hammer pinched together simultaneously and trapped the right thumb causing a laceration, loss of thumb nail and fracture of the bone.	Reviewed the method statement and risk assessment to ensure that there is sufficient detail on the cleaning and maintenance of the concrete storage drums. Refresher training given to all concreting operatives that included the isolation, cleaning and maintenance of the concrete storage drums. The concrete pumping procedure and work instruction was reviewed to ensure that the process is captured and detailed and isolation of the equipment is clear for specified tasks. The concrete equipment cleaning process identified on the works procedure required review to include storage drums.
The IP was cutting a pile reinforcement cage that was projecting from the concrete of a completed pile. The cage was slung/chained to the excavator but sling hooks attached too low. When the stihl saw cutting of the 7th and final bar of the cage, the cage flipped over hitting the IP on the back and knocking him to the floor.	Safety briefing to foreman for failing to follow instruction. One to One Just Culture meeting with divisional director. Company reinforced the Golden Rules
At the request of the PC the site team were requested to relocate a concrete pump and equipment from its existing position to a new location ready to be set up again ready for use. The IP was part of the team involved in this operation. As the pump was lifted the IP stepped back to move away from pump. As the pump was lifted the foot of the pump caught the concrete hose which was still connected to the agitator and the hose fell from the static hose bagging holder which is situated beside the concrete agitation tank and used to support the hose. The concrete bagging fell off the concrete holder and struck the IP on the right knee.	Site safety stand down which included a discussion of incident, a toolbox talk and a review and rebrief of RAMs.
IP was stocking in the maintenance stores container. Whilst stood checking stock he inadvertantly caught a roller with his knee and caused this to roll off the shelf landing on his foot. off work in excess of 7 days.	Stores stock was re stacked applying improved risk management principals. ligthing improved, although this was adequate at the time.
Whilst attaching chains to the lifting eye on a quick hitch the hitch flicked and struck the IP on the shoulder. The IP had taken it upon himself to start lifting operations without the appropriate skill set.	The IP was reminded that he should only perform the tasks he is trained for and removed from site. The supervisor was reprimanded for not physically checking the competence cards in the induction.

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Outline/Description of Accident	Remedial Action Taken
Reinforcement cage got caught on the bottom of another cage in the pile. as the ip pulled it clear it dropped onto his foot	The pile of reinforcement cages was organised and properly stacked so the cages could not snag on each other
The IP had just taken a bucket of concrete for sampling when he tripped over the concrete pump wash out tray and fell cutting his arm and bruising his ribs	The pump wash out tray was too large to fit between the legs of the pump correctly. a smaller tray was deployed
The augers had just been changed from 600mm dia to 1050mm dia piles digging to a depth of 24.5m. Then at 1400hrs while concreting the 3rd pile the supervisor noticed that the rig was moving forwards. The rig attendant noted the same and went to the rig to report it. The site team stopped pumping and went to investigate. They noticed the piling mat had collapsed from the augers to front of the tracks. The augers were reversed out and the rig was tracked away from the area. Work was stopped and the supervisor reported the event to the contract manager. The hole was around 4m wide and 3m deep.	The rig was exchanged as the current rig did not have the torque to dig through the stiff material at depth. A new piling mat was designed and installed
The lead auger had been placed within the gates by a 360 excavator and the team were completing the assembly of 750dia C.F.A. Augers. The rig operator closed the gates from a button/leaver within the cab while the IP still had hands on the auger. The IP's right hand was trapped between the auger and the gates causing laceration and contusion to fore finger	The risk assessment and method statement detailing controls for building augers was improved. The rig operator shared his learning with the wider team. HR and the Divisional Director took disciplinary action. Lift plans were reviewed across all Van Elle sites and Appointed Persons ensuring that all detail is being completed correctly and checked by a second qualified person. The process for assessing the competency of agency labour following their arrival on site was improved and included a formal management sign off . A Safety Stand Down was carried out by each division and completed. A Van-Elle First Aider must be on site for all activities and the level of cover must be communicated with the PC at pre-start and ongoing weekly meetings. Communicated the requirement to labour/resource managers. A proposal for mechanical modifications to prevent closure of the auger gates during auger assembly of similar was designed and implemented to the Llamada rig and other rigs with hydraulically operated gates.
IP was operating the overhead crane and slipped as he walked down a set of steps in the casting shed. His arm got caught momentarily behind the handrail as he fell causing the dislocation as reported. The steps were slippy but IP was not focused on walking down them and was not holding the handrail, as noted on cctv.	tightened controls in SSOW and rebriefed all personnel, focus on walking and not crane travel when ascending / descending steps and hold on to handrails at all times.

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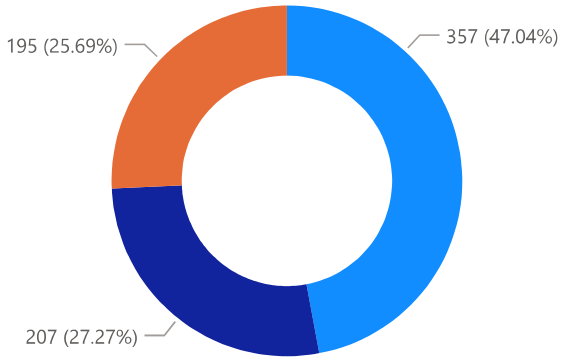
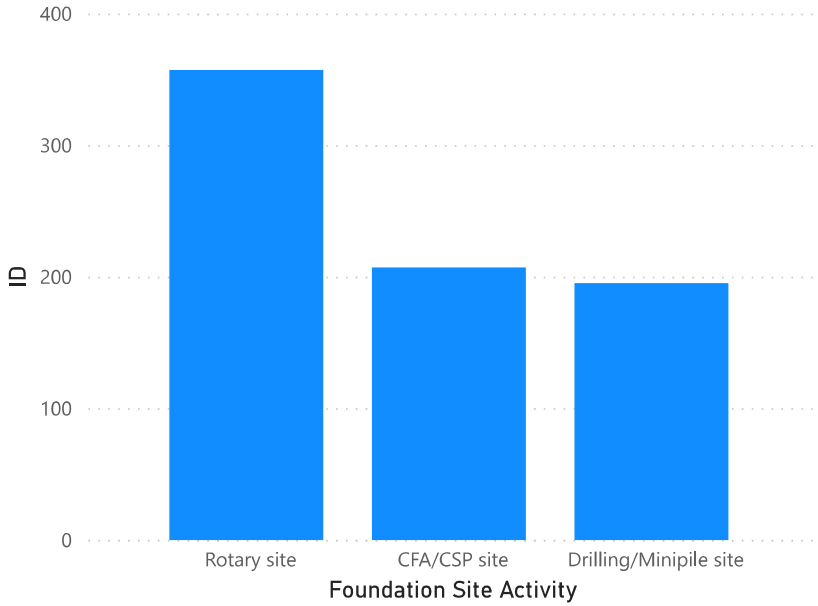
Foundation Site Activity

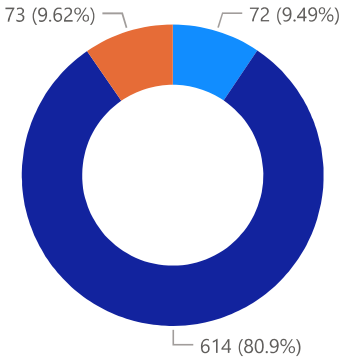


Foundation Site Activity
- Rotary site
- CFA/CSP site
- Drilling/Minipile site

Foundation Site Activity

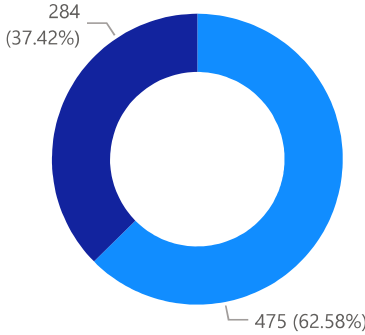


Type of Activity



Type of incident
- Ecology
- Spill
- Waste

Incident Severity / Category



Incident Severity / ...
- Minor
- Intermediate

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Outline / Description	Remedial Action Taken
he polymer line used to run along the pavement that runs along the north side of the road. As piling activities have moved from the area, the polymer line was being moved away. To manage the line the hose is split into sections. There must have been some residue of polymer in the hose that trickled out while the hose was split. This then ran across the road and reached a drain.	The spill was cleared as shown in the spill procedure, using absorbent granules., A gully sucker from RWR has been used to clear the drain.
When adding the next 2m of casing and rods in the drill mast, the drill head became difficult to move up or down. During this process an oil hose began to leak inside the main hydraulic valve block within a steel box fitted to the mast.	The rig was stopped, the oil was cleaned up and the hydraulic seals replaced on some of the hydraulic control valves.
While cleaning the sediment build up from the polymer tanks, they jetwash the base of the tanks and pump the water out. This was pumped into an insufficient unlined bund on site. This was not agreed with RLC before hand	The bund was cleared away. The sediment and wash off has been tested to show it is not a contaminate. A suitable check sheet to be developed for future bunds to ensure that RLC are okay with the construction of bunds going forward
A diesel pump (27219) was due to be replaced as it was missing a valve, so kept flooding. While lifting to manoeuvre the pump diesel spilled out and into the Bund in place. This was caused as the cap for the diesel tank was not on properly.	Spill kits utilised initially to pick up the bulk, followed by road sweeper to take away a percentage more.
Leaking main ram on concrete pump	Pump swapped
Hose Burst on mast	new hose fitted
Hoses damaged by concrete hose rubbing on them	Hoses replaced and a guard fitted around them
Leaking internal hose on mast	Fitter tightened joint on hose
A concrete wagon was seen by Riverlinx, washing his shoot out into an earth bund on site. Spilling concrete contaminated water into the piling mat/ ground	Capital have been asked to brief their drivers on the matter In the DABS the following day I briefed the team to make sure they all knew this is not allowed on site.
Whilst working close to the edge of a dock wall, a hydraulic hose burst on the drill head resulting in a small loss of oil onto a scaffold platform and surrounding areas. Some oil had penetrated the vis queen liner and dripped into river Mersey below. (Less than half a litre)	Absorbent granules have been put down as well as spill booms. A full clean up was undertaken of the area and our spill response company, Adler and Allen have been called for advice. No further action taken as the reaction and the controls undertaken by the site team were satisfactory.
During the drilling of anchor on B1-1 the rotation of the drill head seized and hydraulic oil started to leak from the box housing the hoses and spool values.	A drip tray was placed under the flow of hydraulic oil and the area of the spillage was covered in granules, absorbent pads and then cleaned up. The mast was removed from the area and a fitter was called to fix the leak.

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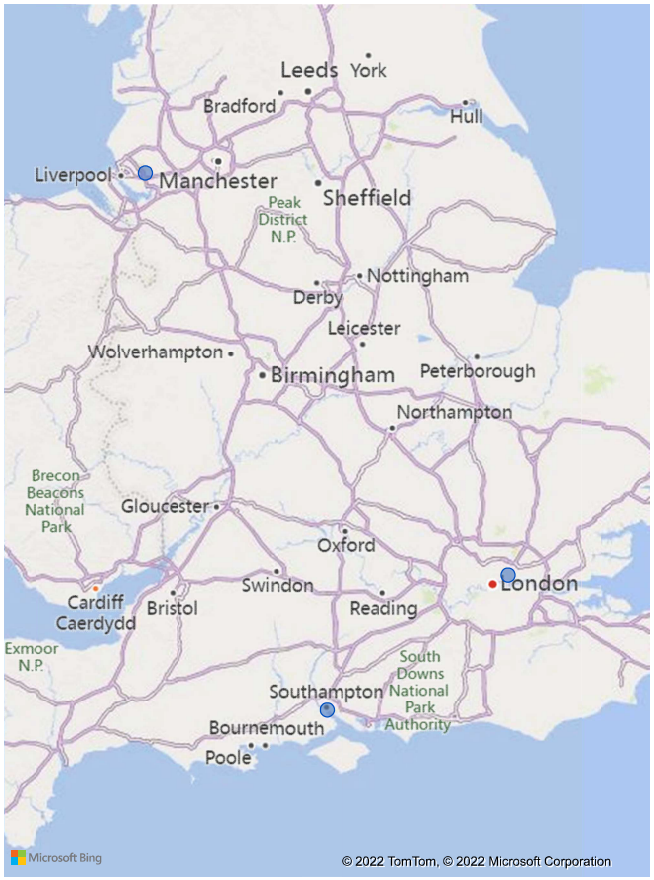
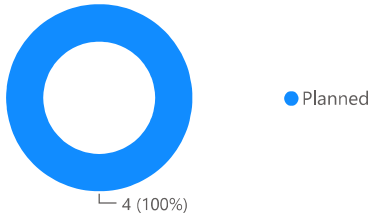
Closest Town (Postcode)



Severity of Strike

Nature of Works



Was the asset known to be present?