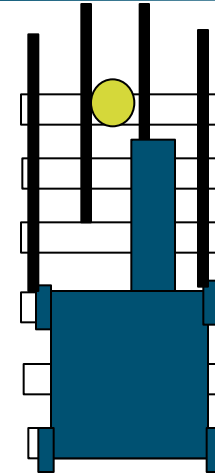


SAFETY ALERT



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On the 12th January at 03:00 hours a Machine Operator suffered an injury to his right ankle, when a 709ft rail slewed and struck the Machine Operator on his right ankle. This was a Track Renewals site at Pangbourne, Western Route and the, McGinley's Machine Operator was tasked to re-position rail in the 4ft of the down relief line. The Injured Person attached a drag clamp to a 709ft piece of rail. Due to ice on the rail, it slipped when then machine operative attempted to move the rail. The accident occurred when the Machine Controller requested a spanner from the Machine Operator in order to tighten the locking pins on the clamp. The Machine Operator leaned forward in his cab to pass the spanner and in doing so accidentally moved the jib lever causing the rail to move. The rail struck the crane controller on the right ankle. Due to another piece of rail in the 4ft and the fixed track the ankle may have been crushed as well as struck.



The Injured Person was taken to the Royal Berkshire Hospital where an x-ray fortunately found no fracture. The Machine Operator was in shock and was stood down. The machine controller returned to site and assisted with statements but avoided walking on track and elevated his leg to reduce swelling. Immediately after the accident the clamp was secured, with the machine stopped, before restarting the activity. The Injured Person is a highly experienced machine controller who works regularly on ACJV sites and the Machine Operator is a very experienced machine operative with at least seven years experience in the role.

Underlying Causes:

Failure to recognise the risk that movement of the machine jib presented to the machine controller stood in the 4ft.

This lead to the operative not taking the action to stop the machine and make sure it could not move before attempting to reach around in the cab to find tools. It also lead to the machine controller not moving to a safe position.

Not considering the risk of the clamp slipping at the start of setting up the clamp and securing the lock nut at the time of preparing for the lift. The use of a panel grab as apposed to a thimble to support the CWR is also being reviewed.

This accident is subject to an investigation, using the Life Saving Rules, fair culture matrix.

