SLN-002

SAFETY LEARNING NOTE

LESSONS LEARNED: FATAL ACCIDENT AT LANGLEY GREEN

Following a fatal incident in late 2013 at the Langley Green project, we have reviewed the circumstances of this incident and the key findings and recommendations are as follows:

SUMMARY OF THE INCIDENT:

An operative was fatally injured after being struck on the head by a precast concrete unit whilst it was being lifted into position using a 360 degree (5t) excavator. The precast concrete unit was attached to the excavator arm using two legs of a four-leg set of lifting chains.

RELEVANT CONSIDERATIONS:

- The use of inappropriate lifting accessories; the chains used were too long for the task.
- The chains were not attached to the approved lifting eye on the excavator arm; they were wrapped around the dipper arm bucket attachment. This is likely to have led to them working free and destabilising the load.
- An exclusion zone was not established; the operative was located within the danger zone of the lifting operation and the operative was not a slinger signaller.

THESE PHOTOGRAPHS WERE TAKEN AS PART OF A REENACTMENT

ZERO HARM
MAKE SAFETY PERSONAL

Balfour Beatty

IMMEDIATE ACTIONS:

A number of steps were taken in the immediate aftermath of the incident:

- Regular CEO-led reviews throughout the investigation process.
- An immediate review of lifting operations and people and plant interface, resulting in the issuing of a number of safety stand-downs and CEO communications all staff throughout the UK business.
- A re-statement of the importance of compliance with "Bare Essentials" in a number of areas including lifting operations, people and plant interface, use of lifting plans, review of contractor risk assessments, adequacy and implementation of Safe Systems of Work and ensuring correct competencies for the required task.
- Production of a weekly check sheet to assist Project Leads in ensuring compliance with the "Bare Essentials".
- Enhancing the standard of HS&E training of staff across the business.

LEARNING POINTS FOR THE WIDER BUSINESS:

Those undertaking similar lifting activities are reminded to consider the following:

- Vigilant reviews of sub-contractors' competencies.
- Ensure Work Package Plans (Method Statements) are suitable and sufficient and can deliver a safe system of work for a specific task and location; not generic.
- Ensure that the Work Package Plans (Method Statements) have been briefed to the operatives completing works via Task Briefing Sheets.
- Ensure plant and associated equipment is fit for purpose and in good order.
- Ensure exclusion zones are in place and clearly demarcated.
- Ensure sub-contractors provide suitable and sufficient supervision for their works at all times.
- Regular and clear communication with sub-contractors from the commencement of the project and throughout the period of their work activity.
- Provision of a minimum level of Balfour Beatty management and supervision for our works at all times (min 1 x SMSTS at any time whilst works are being carried out)

Each of us has a responsibility to take heed of the lessons learned from this tragic incident and continue to follow the procedures outlined above to help to ensure there is no reoccurrence of a similar incident in the future.

Heather Bryant
HS&E Director
Balfour Beatty Construction Services UK

■ ACTION REQUIRED
☐ BMS WILL BE AMENDED
☐ FOR INFORMATION ONLY