Incident Description:
On the 9th February 2018 at 2010, during refuelling operations, the rear drum of a roller came into contact with a surfacing operative’s left foot resulting in a broken big toe.

Investigation Findings:
1. Improper decision making or lack of judgement - Roller driver moved before he was certain the IP was clear of the machine
2. Lighting Issues - Lighting to the area was good but once other plant had left the parking area, the section where the incident occurred was dark.
3. The safe system of work that manages the risk of the people plant interface was not adopted. The IP was stood in close proximity to plant which was prohibited under the SSOW.
4. Lack of spatial awareness - The IP believed he was in a position of safety due to the fact he was stood on a raised verge. His foot was hanging over the verge / half battered kerbstone allowing contact with rear drum of the roller.

Actions:
- Ensure that plant operators and site personnel are aware of ALL safe systems of work for their particular tasks
- When operating plant and equipment guards, ensure the safe system of work that has been identified and is implemented fully at the work site
- Ensure that the agreed controls are documented in the risk assessment for the activity and that these controls are implemented every time the activity is undertaken
- Ensure adequate supervision is present at site
- Ensure correct training has been given to the personnel who carry out the activity
- Ensure that safe system of work is included in pre - start site safety briefings and safety stand downs

If you have any enquiries please contact the National Health and Safety Team via NH&ST@highwaysengland.co.uk