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Frontline Matters

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Piper Alpha 30 years on

My supervisor said: "It'll be a quiet night, see you tomorrow". - I never saw him again.

> Survivor Steve Rae talks to CIRAS Pages 4-5

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Speaking up for health and safety

Editor's note

In this issue, we lead with an interview with Steve Rae, a survivor of the Piper Alpha accident 30 years ago.

He has some very poignant things to say about the way it has changed his outlook on safety, and indeed on life too.

His words are a reminder, if any were needed, that the effects and repercussions of an industrial accident are felt by individuals and communities decades after the event.

An organisation like CIRAS is there to act as an early warning system and help highlight safety issues long before they become an accident.

It is worth highlighting that there was no independent confidential reporting service in the oil and gas industry at the time of the Piper Alpha tragedy.

There was still no such system in place when there was a blowout at Deepwater Horizon in the Gulf of Mexico in 2010.

Good internal reporting systems are essential and a truly independent

service that is equipped to handle third-party reports provides an additional safety net.

Apart from the terrible human and ecological tragedies, the cost in the Gulf of Mexico, which runs into tens of billions of dollars, is still being counted.

For any organisation, investing in provision of an independent confidential reporting service could provide the intelligence needed to prevent a major accident.

At CIRAS, we always like to emphasise the inter-industry learning and intelligence that can be extracted from our reports.

Despite the unique differences between industries - such as rail, bus, road haulage, logistics, construction, and oil and gas - the challenges faced are often very similar.

One of those challenges is getting people to report health and safety issues in good time, so we can all learn from them.



Chris Langer Communications and Intelligence Manager

In our article on 'The art of spotting a hazard', we highlight why it's so important to pay extra attention to notice the hazards that we may otherwise be blind to.

Many of our reports bring attention to such hazards that have not been fully addressed.

In the reports section, you'll find examples of changes that started life as a CIRAS report – so please keep reporting where you notice something is amiss!

Please email editor@ciras.org.uk if you have any comments or feedback.

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A lack of sleep could be affecting your mental health

It may be doing more than making you grumpy in the mornings



You know how lack of sleep makes you feel. Anxious, irritable, grumpy. Hardly a joy to be around!

Most people will readily acknowledge that a lack of sleep impacts their emotions and also their ability to make sound decisions.

This is especially important in safety critical situations, where the decisions people make can prevent harm or injury.

But this isn't the only reason we need to monitor the duration and quality of the sleep we get.

Three things to keep in mind:

- 1. If we find ourselves on the slippery road to exhaustion when we are not sleeping properly, it can contribute to mental health difficulties.
- Disturbed sleep could in fact provide an early warning of mental health issues, such as depression or other conditions.
- 3. Even in severe cases, the remedy may be to get better quality sleep.

For example, researchers at Oxford University have found that delusional paranoia can be reduced by 50 per cent if sleep is stabilised using cognitive behavioural therapy.

Helping you get the sleep you need

- Get enough sleep. Aim for eight hours. Some individuals will need slightly less and some slightly more. Remember that just an hour less than your usual requirement can start to impact your health at the genetic level after only a week.
- 2. Go to bed and rise at the same time each day. Blood test research reveals that around 500 genes are switched on or off by changes in sleep patterns. A good night's sleep is enormously important and part of that is regulating your routine. You can't cheat your body and mind if you're sleep deprived.
- 3. Set up a bedroom routine. Bedrooms are for sleeping, or so you'd think – not so much in many households these days. Large screen TVs and an invasion of smartphones and tablets can make bedrooms anything but restful. These devices are also known for emitting blue light, which interferes with sleep. Enforce the discipline of a 'digital sunset' to restore a good night's sleep to the bedroom.
- 4. In addition, there's no harm in setting the alarm clock to remind you to start your bedroom winding down routine each night. Ensure you block out any light, using blackout blinds if necessary, to avoid interfering with the body's circadian rhythm. Take steps to block out any disturbing noise too.

A night to remember: Lessons from the Piper Alpha tragedy

Steve Rae had the luckiest of escapes, he explains here why inaction is never an option



© 1988 Press Association

It has been over 30 years since an explosion at the Piper Alpha oil rig killed 167 people.

Its legacy lives with us today – in the shape of significantly improved safety culture in the oil and gas sector, and through the shared memories of those who survived to tell the tale.

The industries represented by CIRAS are no strangers to major incidents which have changed or claimed many lives.

I ... I became acutely aware of the danger I faced, the need for self-preservation, and the need to remain in control.

Can we still learn from Piper Alpha, all these years on?

Steve Rae was working on Piper Alpha that fatal night and survived by leaping into the sea.

Today, it helps Steve to share his personal experience and what he

learned, in a bid to help prevent others going through what he did.

Tell us what happened to you that night

I arrived on Piper Alpha that day and went on shift in the evening.

I recall my brief handover with my supervisor – he simply said: "It'll be a quiet night, see you tomorrow". I never saw him again.

After the initial explosion I became acutely aware of the danger I faced, the need for self-preservation, and the need to remain in control.

Perhaps even make selfish choices that felt right for me.

I didn't follow my own work crew, who sought refuge in our accommodation block – a choice that saved my life.

Instead, I made my way as far down the rig as possible, before realising my only option was to jump into the sea, where I was quickly picked up by a rescue ship.



Steve Rae

Everyone who remained in the accommodation block perished.

What impact has Piper had on you?

My escape and survival left me intolerant of those who choose to display shoddy workmanship, and who have a poor work ethic.

I was a fairly driven individual before Piper, but this was heightened by my experience.

I take nothing for granted in life and feel a genuine concern and responsibility for those that I work with.

It also taught me important lessons about choice.

…while we are all free to choose, we are never free from the consequences of our choices.

Tell us what you've learned about 'choice'

I lost my father very young and as one of five siblings I had to grow up quickly, to support my mother and take personal responsibility for my life.

This taught me to think carefully about my choices from a very young age –

and also that poor choices often result in undesirable consequences.

This is something I've worked hard to pass on to my own five boys.

The night of Piper Alpha, I learned that, while we are all free to choose, we are never free from the consequences of our choices.

A powerful memory I have is the accommodation block door.

It should have been kept closed so the block could serve as a place of refuge in circumstances such as this.

However, it would often be left swinging open as closing it was awkward and took time.

I always closed the door but chose not to challenge others who did not.

We suffer from 'situational awareness fade' as we become accustomed to our surroundings.

I failed to recognise the consequences of my inaction, till that moment I stood at that very door, watching the fumes and smoke we were fleeing from pour in through the swinging door to the accommodation block.

I live with this thought most days.

What I learned was – by turning a blind-eye and walking away I made a poor choice; you should make choices as if the lives of all your loved ones depend on it.

I should have intervened, it's that simple.

Do you think people become 'blind' to hazards when they go unaddressed for a long time?

I do believe that people become desensitised to their regular environment.

We suffer from 'situational awareness fade' as we become accustomed to our surroundings.

With hindsight, I do believe that Piper Alpha had been a construction site for most of its life and that certain risky practices had become the norm.

Piper had been operating in this mode for years and prior incidents



and fatalities had been too quickly forgotten.

Finally, what advice do you have for those reading this

 Remember to question and challenge your personal choices frequently.

Practise reporting your own behaviours, work environment conditions and practices with a trusted colleague.

- If you share a work vehicle or are transferred to another work location, develop the habit of taking time to do a situational assessment - it can take as little as one to two minutes.
- Change the routes you take through the depot, station, car park - this guards against you becoming 'blind' to hazards.
- Make it your business to talk about the behaviours you want to reinforce. Share stories - ask your

colleagues for their opinions and share yours.

Expand the sharing amongst your colleagues and encourage them to do likewise.

- Encourage others to inspect your specific place of work and do the same in theirs.
- Practise reporting your own behaviours, work environment conditions and practices with a trusted colleague.
- Expand the sharing amongst your colleagues and encourage them to do likewise.
- Most importantly learn to be relentless in your approach to personal responsibility for your own safety.

If you'd like to ask Steve to share his experiences further, contact him at steverae1962@hotmail.com.

You can also donate to the charity "Pound for Piper" online: https://www. justgiving.com/poundforpiper

Fire doors repaired and reporting channels refreshed

Concerns raised about effectiveness of safety reporting



© NEMOL, fire door (left), repaired door hinge (right)

Concern

A reporter has raised a concern regarding the safety reporting culture within the customer service assistance team for North East Metro Operations Limited (NEMOL).

It is believed that employees are unaware of how to report health and safety issues internally.

Concern has been expressed that this could potentially lead to issues going unreported.

It is believed that employees are unaware of how to report health and safety issues internally.

It is also felt that once a concern has been raised, issues are not being adequately investigated and staff are not provided with any feedback.

An example of fire doors coming off their hinges and falling on employees and injuring them is given. This was apparently reported multiple times before any action was taken.

As a result of the above points raised, the reporter expresses concern that the reporting culture is creating an unpleasant and disengaging working environment, potentially impacting on employee wellbeing.

There is a concern that, if health and safety issues are not reported or addressed, operational safety could be affected.

Therefore, the reporter asks if NEMOL could ensure:

- All customer service employees are aware of where to report health and safety concerns?
- Employees receive feedback after reporting a concern?
- Concerns are fully investigated when reported through internal reporting channels?

NEMOL's response

NEMOL take Health and Safety very seriously and always strive to make our

staff comfortable and informed in the work environment.

Thank you for providing us with the opportunity to investigate the concerns raised and provide a detailed response.

...staff can attend and ask questions about any workrelated topic they like in a safe environment.

With regards to the fire doors, there were two separate instances of doors coming off hinges when opened.

These happened at different locations and were months apart.

As hinge failures could not be identified via visual checks, engineering support was sought which recommended a complete renewal of all hinge systems to these doors throughout all Metro Stations (over 100 doors).

The door repair plan was complete by mid-December 2018.





© NEMOL, 'Report My Abuse' email system (left), Service Quality app (right)

On each occasion, repairs were instigated, and information was communicated either via: Health and Safety representatives, notices to staff, face-to-face briefings, emails or all of the above.

Actions taken as a result of this report:

The various methods of communicating health and safety concerns will be reiterated to all staff. The Station Delivery Manager will also be reintroducing staff forums where staff can attend and ask questions about any work-related topic they like in a safe environment.

How staff can report their health and safety concerns

For infrastructure issues identified:

- Via Service Quality (SQ) app each member of Customer Service staff has access to on their hand-held mobile phones (safety related issues are then input into Compass/Maximo for work orders to be created via SQ team).
- Verbally with Customer Service Controller (safety related incidents are then input into Compass/Maximo).
- Verbally/electronically with Duty Customer Service Manager/Customer Service Supervisor (safety related incidents are then manually requested to be input into Compass/Maximo with CS controller).
- Verbally/electronically with union Health & Safety representatives.

For staff related incidents e.g. (assaults/accidents)

- Report My Abuse email system (for low level verbal abuse staff can use this reporting mechanism).
- Verbally with Customer Service Controller (controlled by staff member reporting i.e the staff need to report/request Police).
- Verbally/electronically with Duty Customer Service Manager/Customer Service Supervisor.
- Verbally/electronically with union Health & Safety representatives.

There is a Health and Safety Sectional Committee which takes place on a quarterly basis where any staff safety concerns can be raised.

Notes and outcomes of this meeting can then be shared by the union Health and Safety representatives to staff.

If staff feel that health and safety concerns raised at the Committee aren't being dealt with effectively, those matters can then be escalated further to the Safety Improvement Forum which is chaired by the Metro Services Director.

Recruitment and shift pattern review increases staff cover

Driver fatigue and distraction at Shields Depot highlighted



© John McIntyre, Shields Depot

Concern

A reporter has raised multiple safety concerns regarding Shields Depot in Glasgow:

Staffing levels

Following the implementation of multiple new units three years ago, drivers were experiencing an increase in workload, whilst staffing levels had not been increased.

This was felt to be having an impact on employee fatigue levels and general wellbeing...

Duties included depot driving, movement coordination and shunting.

This was felt to be having an impact on employee fatigue levels and general wellbeing and could possibly lead to operational incidents.

Working alone

Drivers could be rostered to work up to 12 hour shifts in the depot, alone.

Should a driver injure themselves, or be a victim of assault, there would be no available support.

Electronic radio devices

Drivers are required to have an electronic radio device on their person at all times.

However, drivers can receive up to fifty calls per shift, which is potentially a distraction which could result in an operational incident.

Lack of coordinator

In addition, the reporter stated that drivers do not have a designated movement coordinator to delegate responsibilities evenly and manage the team.

This resulted in confusion and potential tension within the work environment.

The reporter asked Abellio Scotrail if they could:

 Consider employing more drivers at Shields Depot, to manage the workload?

- Consider rostering at least two staff members on a shift, to ensure that staff are not working alone?
- Clarify if drivers should always have electronic radio devices on them and ensure that all staff are aware of the procedures?
- Consider hiring a person to act as a movement coordinator for drivers?

Abellio Scotrail's response

Abellio Scotrail would like to thank the reporter for raising their concerns.

Staffing levels

Firstly, it is recognised that Shields Depot has seen an increase in workload over the last few years due to a change in timetable and more recently in June with the introduction of 10x Class 365's.

On the back of this, a shunting review was carried out over all three shifts, day shift (D/S), back shift (B/S) and night shift (N/S) to fully understand how this had impacted on the daily duties and workload of a Depot Operator (DO).

Shields has DO's who can both drive and shunt.

Following the review, we initially recruited an additional full-time DO to take the team to eight.

We currently have seven full time DO's who, with the exception of Saturday and Sunday, provide 24/7 coverage with two DO's on shift.

The seven full-time DO's are supported by six relief DO's who work within the level 1-4 maintenance teams, and provide cover every six weeks on B/S but also cover for holidays and sickness as required.

One DO on shift will act as the movement coordinator for all depot movements.

Following the review, we initially recruited an additional full-time DO to take the team to eight.

However, we recently made the decision to increase the full-time team to 10 DO's and the additional posts have been advertised.

Working Alone

The longest shift a DO is rostered for is Saturday B/S, 1400 – 0030, which is a 10.5 hour shift.

There are no rostered shifts at 12 hours.

A certain part of the Saturday B/S, 1400 – 2100, and Sunday B/S 1600 -1900 is lone working.

At this time, the DO on duty should adhere to the 'Lone working' risk assessment ENG/RA/045.

We do have a security guard on depot through the weekend who patrols the yard on an hourly basis, this involves contacting the DO by radio before each hourly patrol.

This ensures we have support on depot should the DO injure themselves, become victim of assault or be involved in any other type of incident.

We are currently trialling a change to the level 1-4 maintenance team who work a Saturday night to assist the DO with workload.



This was previously carried out by the DO, and the feedback being received since this change is positive.

We also plan to review the DO roster to accommodate the 3x additional staff currently being recruited for, with a view to increasing the Saturday B/S cover during the busy period of arrivals 1900 – 0030, with two DO's on shift.

Electronic Radio Devices

During the review which was carried out, it was highlighted that the number of phone calls being received has increased with the increase in diagrams in and out of the depot.

We are currently trialling a change to the level 1-4 maintenance team who work a Saturday night...

This along with increased movements at certain times of the day, has highlighted the need for some form of yard coordinator to be on duty during the peak arrival times, as this is when most communications take place.

Lack of coordinator

We have recently advertised for a trial development opportunity for a DO yard coordinator/team leader.

This position will manage the daily workload, act as the main point of

contact for all depot moves during the busy peak times, and liaise with the different depot functions to understand maintenance requirements.

We have recently advertised for a trial development opportunity for a DO yard coordinator/ team leader."

This will enable future moves for the day to be planned for, and should eradicate any confusion and minimise any tension between departments.

Additional information:

Until the additional staff are recruited and trained over the next six months, wherever possible, we will commit to having a 3rd DO on duty through the peak arrival times on day shift of 0900 – 1100.

This will allow one DO on duty to act as the yard coordinator for all movements and communications during this busy period.

The lone working risk assessment ENG/ RA/045 is a generic risk assessment for all depots and out bases, and after review, has been amended to include Shields Shunting staff whereby they are to keep in contact with the Shift Manager or Team Leader every hour when they are working alone.

Comprehensive re-briefing process undertaken

Signaller training on obstacle detection system found 'lacking'



© Network Rail, Ferrybridge Signal Centre

Concern

A reporter has raised a concern regarding the new obstacle detection level crossings that have been introduced at Ferrybridge signal box.

According to the reporter, signallers have received no training on how to operate the crossings.

…there is a potential risk that a train could be signalled to proceed through a level crossing...

There are various action alarms that sound in the event of a level crossing failure or emergency, but signallers have not been briefed on what action to take should the alarms sound.

The concern is that signallers could fail to take the appropriate action following an alarm.

For example, there is a potential risk that a train could be signalled to proceed through a level crossing, when it shouldn't be allowed to. Also, the screens often freeze, meaning signallers have no visible indication of the level crossing, and have not been guided on what action to take following this.

It is felt that signallers are using trial and error to act upon receiving an action alarm.

This is not efficient and could potentially lead to operational incidents, should the wrong action be taken.

Therefore, the reporter asks Network Rail if they could:

- Produce a full guide on how to operate obstacle detection level crossings? Including actions to take following action alarms, and brief this to signallers at Ferrybridge signal box?
- Incorporate an instruction guide into the permanent instruction container within the signal box, detailing actions to take, at the mentioned level crossing, in the event of planned engineering works?

Network Rail's response

Network Rail would like to thank the reporter for raising their concern.

An industry learning day brief for Manually Controlled Barriers with Obstacle Detectors (MCB-OD) operations was produced in February 2017 and was designed to be used as a briefing tool for signallers.

The document was produced by the Signalling Design Group York and was issued to York Rail Operating Centre and other operating locations fitted with MCB-OD crossings.

The briefing document details the indications and controls and describes obstacle detector fault, failed, local Crossing Clear Unit and failed indications.

The document also describes the actions required when the obstacle detector at an MCB-OD has failed.

In addition, Rule Book Module TS9 Level Crossings-Signallers' Regulations Clause 7 outlines the actions required



in the event of: -

- normal operation
- obstacle detected
- failure of equipment
- passing a protecting signal at danger
- wrong direction movements
- appointing an attendant.

What is not described in any document is a definitive action to be taken in the event of the screen freezing.

…not described in any document is a definitive action to be taken in the event of the screen freezing

However, when the screen freezes the signaller is unable to operate the crossing and cannot determine if the road lights are working nor operate the lower/raise buttons.

Therefore, the signaller must arrange for an attendant to be appointed.

The document will now be updated to consider actions to be taken when the screens freeze, this was incorporated into local briefings by February 2019.

Details of investigation carried out:

Network Rail have interrogated the Fault Management System (FMS) to review failures of the obstacle detector screen (frozen screen).

FMS has recorded three reported incidents, 11/09/18, 18/09/18 and 16/10/18.

After the second failure (18/09/18) Volker Rail staff inserted a Smoothed Power Supply.

Network Rail have emailed the project team and Volker Rail (27/11/18) requesting: -

- What Network Rail are doing to fix the screens from freezing?
- What Network Rail are doing to identify the root cause of the issue?
- if we are planning to replace the screens or is the issue hoped to be rectified if so when/how?

The previous power supply was the root cause of the screen failures.

Since the supply change, we have been reviewing FMS and there has been no recurrence of the problem.

The existing screens will now remain in place. In addition an ergonomic review of the MCB-OD operation was undertaken on 11/01/19 to review the existing screens and for the new screen to be installed for Cridling Stubbs which was converted to MCB-OD.

Actions taken as a result of this report:

The industry learning day brief for MCB-OD operations has been re-issued to signallers.

We have issued an email instruction advising signallers that, in the event of the MCB-OD screen freezing and indications cannot be determined, then trains must not be authorised over the crossing until an attendant has taken duty (Rule Book Module TS9 applies).

We have been provided with more material for signaller briefing/training.

The following actions have taken place:

- Local briefings to signallers on the screen displays have been carried out and a revised booklet placed on the panels.
- 2. The MCB-OD briefing material has been added to the signal box training plan. A requirement that new signallers undertake a site visit to observe the crossing in operation in both normal and failure mode has also been added. Current signallers were also offered a visit - a handful have taken up on the offer.
- Local instruction is used as provided by the project. Signal box instructions are currently under review (following other changes required) and on completion the local instruction will be incorporated. The target date for review is 30/04/19.

Any lessons learnt that you would like to share with CIRAS and the relevant industry?

To ensure that a formal signed briefing pack is made available and completed by all end users when operational changes are made to signalling equipment, or new signalling equipment is introduced.

The art of spotting hazards to prevent another Piper Alpha

From motorcyclists to slip and trip hazards, why is it that we fail to notice the things that threaten our safety?



"I just didn't see him!" That's the phrase you often hear motorists use after they have collided with a motorbike or cyclist.

The brain takes longer to 'see' a bike than a car.

The truth, of course, is that they may not have seen their unfortunate victim in the seconds before impact.

In fact, it's been shown that we find it more difficult to see 'thinner' objects like bikes, because they take up far less space in our visual field than an object like a car.

The brain takes longer to 'see' a bike than a car.

But we're not just talking about driving here - in many safety critical environments, the art of spotting a hazard is important if we are to remain safe and unharmed.

So what can we do to train our brains to spot hazards we are less likely to see as quickly?

We can start by making a real effort to pay more attention to our environments in risky situations. On the road, for example, if we're turning out of a junction, we can give ourselves an extra second to scan the road for approaching hazards.

This form of visual scanning can save lives.

The unseen motorcyclist becomes a seen one.

The person in dangerous proximity of a digging machine on a construction site 'appears'.

We are then able to assess the risk they pose and take the necessary action.

In our working environments, we often encounter a target-rich environment of objects, stationary or otherwise.

Engineering works on the railway, an airport runway, or a busy construction site, can all present similar risks if we fail to notice the hazards.

Slowing down to visually scan our environments is just as important here too.

It's a skill that can be taught with a little practise.

In short, we need to train our minds to stop us becoming oblivious to the hazards around us. Sometimes you cannot see what is right in front of you, despite the fact you know it is there.

As an analogy, think about hanging a new picture or family photo on a wall at home.

You may even choose a prime, eyelevel location in the hallway for your child's first day at school.

But how long does it take for you to stop paying attention to it? A week? A month?

...comprehending the hazards in our working environments helps drive health and safety improvements.

Clearly no one is going to die if you forget the presence of a family photo – though your spouse or partner might get mildly irritated!

But supposing we're talking about that power cable trailing across the floor at work.

It's been left there for a little while, perhaps to provide temporary power to some equipment. It was never intended as a long-term fix, but can quickly become an unsafe, unnoticed part of the environment.

A bit like the family photo, except that this one could trip you up and cause serious injury.

A kind of perceptual blindness can prevail as hazards fade into the background and no longer 'pop out'.

Thankfully, we can overcome the brain's inbuilt bias to filter out what may be crucial for an injury-free existence.

It's surprising what a positive impact paying attention visually to our immediate working environment, can have on safety.

We just need to take the time to look out for those hidden risks, whether they're present in the physical environment, or relate to the way a job is being carried out.

Railway workers who fail to move to a position of safety when a train approaches may have become so distracted that they cannot see an approaching train, despite the fact it is life threatening.

Fully perceiving and comprehending the hazards in our working environments helps drive health and safety improvements.

One technique involves a quick, conscious scan of the immediate

environment to guard against a form of visual complacency.

For example, a mental checklist can guide our attention to walls, floors and working surfaces, all with the purpose of spotting potential hazards, or areas for improvement.

The HSE estimates that, on average, slips and trips cause 40 per cent of all reported major injuries in the workplace.

Slips, trips, falls and machine hazards are typical in many workplaces.

Paying attention to any perceived hazards upon arrival to a site, and then as people undertake their duties, could pay dividends.

The evidence suggests that such hazards often go unnoticed.

The Health and Safety Executive (HSE) estimates that, on average, slips and trips cause 40 per cent of all reported major injuries in the workplace.

At one manufacturing site, 60 per cent of recordable injuries were found to be due to a lack of hazard recognition.*

It is worth highlighting that hazard recognition is not quite the same as near-miss reporting.

A near-miss is normally construed as a largely unexpected event, one with the potential to cause harm or injury.

But we don't need to wait for an event of this nature. We can be far more proactive than that.

Call to action

This is where confidential reporting can play a strong role in facilitating responses to hazards and potential risks to the workforce. CIRAS often acts an early warning system.

Take the time to scan your workplace to look for hazards you may have become blinded to.

Take action or tell someone who can.

If you don't feel able to raise it internally, call CIRAS.

A report containing an unaddressed safety risk is often actioned effectively after being reported to CIRAS.

It may be prioritised once the risk is finally 'seen'.

Just like the family photo on the wall we've forgotten to notice over time, we all need reminding to pay attention to the risks around us.

*Inouye, J. (2018). A Second Look: Update on Visual Literacy. The Campbell Institute.



Spotlight: Railway Benefit Fund

How they provide bespoke care and advice to railway people



At the Railway Benefit Fund, no problem is too big or too small.

We are the only UK charity solely dedicated to supporting current and former railway people and their financial dependents in times of need.

We offer peace of mind and are here to support people like you...

We are an independent organisation and all enquiries to the charity are dealt with promptly and in complete confidence.

We offer peace of mind and are here to support people like you, whether you are a current or former railway employee.

Assistance is provided in many forms, on a short or long-term basis and is specifically tailored to an individual's situation. We do not operate on a 'one size fits all' system.

The charity offers financial assistance, practical help and wide-ranging advice, all in the strictest of confidence.

Help is only a phone call away.

We can help you through a variety of problems.

Specialist Money Advice

The RBF is the charity for all rail staff.

Our aim is to proactively support all rail staff that may be at risk of problem debt, through the provision of practical and accessible money advice services.

We understand that each person who seeks our support needs bespoke care and advice.

We have collaborated with Citizens Advice to provide free, confidential, general and specialist debt advice.

Financial Assistance

If you are currently experiencing financial difficulties, the RBF may be able to help you.

We help hundreds of current and former employees and their families each year.

Occasionally it may be that a situation requires specialist support

As a responsible charity, we assess all cases individually to ensure that the charity's funds go to those who need it most.

Examples of things we can help with include housing debts, family welfare, unforeseen emergencies, as well as other financial hurdles families face.

These are just a few examples of how we can help you - please get in touch today and talk to our team if you think there is a way we can help.

Advice

RBF has a team of experienced staff who can provide information and advice on a wide range of issues.

The charity offers financial assistance, practical help and wide-ranging advice, all in the strictest of confidence.

Occasionally it may be that a situation requires specialist support.

Should this occur, we will not turn you away - we pride ourselves on being the first step to fixing your worries.

This means that if you come to us with a problem, even if we are unable to assist you ourselves, we will signpost you to one of our specialist partner organisations.

New app

We are delighted to announce that you can now download our very own RBF advice app.

The app is home to an array of legal support and advice available to those within the rail industry.

Available for both Apple and Android phones. Search 'Railway Benefit Fund App'.

Contact us:

fundraising@railwaybenefitfund.org.uk or support@railwaybenefitfund.org.uk.

You can also call us on 0345 2412885.

Charity Number. 206312.

Work outside of rail? Other sectors also have benevolent funds which may be able to help you - search for them online.

Do you have any concerns about health, safety or wellbeing?

Have you tried internal reporting channels, or don't feel that you can?

Provide your contact details in the space below. Any information you provide will be treated as confidential.

We ask you to provide your name and contact details so we can get in touch to discuss your concerns. Once your report is processed, your report form will be destroyed.

Name:	
Job title:	
Employer:	
Phone:	
Mobile:	
Describe your concern:	
Convenient time to call:	
at happens next?	
We will contact you to discuss your health and safety concerns A report will be written on your behalf	
We remove any information that might identify you	

• Once we receive the response we will then provide you with a copy

CONFIDENTIAL

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Fold along the dotted line and seal edges

