

HEALTH, SAFETY & QUALITY REPORT

Topic: MANAGEMENT UPDATE TO THE BOARD

Board meeting: 13 June 2017

From: Stephen Bell

Paper type: Information

It is **recommended** that the Board:

- **Note** there were three safety incidents of note. These were investigated and follow up actions put in place.
- Out of scope
- **Note** The TRIFR moved from zero with an LTI and MTI this month. Out of scope

1. Status Update – progress on key objectives

Out of scope

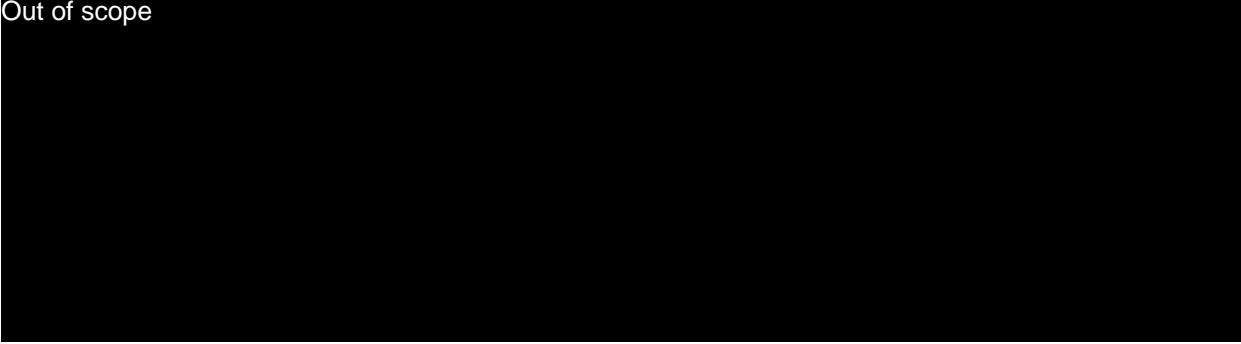
Out of scope

Incidents of note include the following:

- On the 19th of May an Abseiler was injured when a rock he had previously tried to move rolled 1 metre and fractured and dislocated his ankle, and then came to rest another metre below. The investigation identified:
 - The operator was inexperienced at scaling, but had experience on Rope work as an arborist
 - There should be better focused geotechnical daily planning of activities
 - The RA identified two key roles, Topside and on rope supervisors, only the rope supervisor was in place, there was no person topside of the abseiling activity.
 - Learnings included that the emergency plan was tested and proven. This plan was immediately activated and the injured person was recovered and delivered to the Kaikoura hospital within 25 minutes.
 - Further improvements to the emergency response plan have been identified internally in the debrief post incident.
- On the 19th of May an EWP was found stored in the mouth of Tunnel 21 by a high rail inspection vehicle during a pre-track livening inspection run. The tunnel critical works had been signed off as completed but the full disestablishment had not been undertaken. The key learnings and actions include:
 - That before each portion of track is handed back to rail the section will be walked by an RPO and NCTIR to ensure the track can take a vehicle.
 - Improved documentation for handback of works to KiwiRail has been put in place.
 - Tool Box talks have been given to further increase awareness of rail operational safety.

- The only service strike occurred at the “Village” when the safety rail on the cab of a machine encountered a cable tray. The findings of the investigation were:
 - The route chosen for the machine required the operator to drop the safety bar while travelling under the tray (poor job planning)
 - A D&A test for the operator was positive
- There were 706 recorded safety related events logged for the month nearly 400 of which were positive, and 203 hazards or near misses.

Out of scope



2. Key risk and issues

Out of scope

