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

[redacted]

2. Key risk and issues

Out of scope

[redacted]