

From: Stephen Bell

Sent: Thursday, 16 March 2017 1:19 PM

To: s 9(2)(a)

Subject: Month report

Statistics for February:

Number of Incidents reported 33, two minor injury and one machine damage (drone)

KPI's

TRIFR =0

Near Miss reporting 14/ 24952 man-hours giving a frequency rate of 561 or meeting stretch

Safety Conversations 3/ Approx 200 or 1.5% These have not been previously recorded and have only started. Pick up is not high but have seen many examples of unrecorded events.

Out of Scope

Stephen Bell

Health, Safety and Quality Manager

205 Annex Road, Middleton, Christchurch 8024

s 9(2)(a)

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From: Stephen Bell

Sent: Tuesday, 11 April 2017 8:58 PM

To: s 9(2)(a)

Subject: Report March

Progress to Date

- Reporting of safety activity increased greatly with over 4 events per day being reported
- 3 service strikes occurred during the month, the most significant being the striking of the vodaphone cable when drilling for foundation information around a rail tunnel. The investigation showed that no change management occurred when the driller was instructed to drill outside of permit
- The month operated with a staff of three with over 850 people inducted by the end of March. Four safety advisors will join in April which will hopefully allow a more structured approach to achieving the outcomes expected

Out of Scope

Stephen Bell

Health, Safety and Quality Manager

205 Annex Road, Middleton, Christchurch 8024

s 9(2)(a)

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HEALTH AND SAFETY (Steve Bell)

Out of Scope

Progress to Date

- 322 reports were logged for the month which is an average of 14 per day, 19 were incidents, only 5 of which required further investigation
- There was only one service strike in the month, the service was identified, marked and hit. Lack of a spotter, and working in the evening were root causes
- By the end of April over 1000 people had been inducted, and over 1300 to date
- Five Health and Safety Advisors are now in place after Easter. Three more are required to complete fulltime requirements
- First full, all worksite audit completed. There will be a minimum of one per site per month by non-site management

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HEALTH, SAFETY & QUALITY REPORT

Topic: MANAGEMENT UPDATE TO THE BOARD

Board meeting: 11 July 2017

From: Stephen Bell

Paper type: Information

It is recommended that the Board:

- **Note** There were two MTI's for the month, both involving stiches but this increases the TRFIR from 4.3 to 6.3.

Out of Scope

1. Status Update – progress on key objectives

Out of Scope

Incidents of note include the following:

- On the 10th of June a drill rig being flown to a slip face by a helicopter lost the load over the sea when the mechanical release control for the load hook failed discharging the load. The investigation has identified that the common mechanical release system can “fail to fail” unlike other release mechanisms. A hierarchy of controls has been developed and being implemented to ensure the safety of all people below.
- On the 16th and the 26th of June two MTI's occurred when a tunnel worker was hit in the lip with an alcatheine pipe recoil and the latter when a tunnel supervisor slipped on some spilled grout and cut his finger trying to prevent the fall. Both identified poor risk management and housekeeping as contributing issues.
- On the 23rd of June an operator returning to Kaikoura after a full working fortnight at Clarence was requested by the chopper pilot to change seats to gain better balance. He inadvertently walked around the no go rear area of the helicopter to reach the back seat opposite and singed his hair in the exhaust of the helicopter and just avoided the rotor. He stated his mind was elsewhere after a long stint and was thinking about the drive home form Kaikoura, and not about the immediate risk. While the injury could have been more serious the real issue is alertness and the pilots have been reminded to be clear even with their most regular passengers as how to safely move around a helicopter.

- 605 safety related reports received for the month. Of the 65 incidents reported, 35 were identified as requiring further investigation due to them being of moderate or higher risk. As shown by the MTI increase to date the increase in construction works this month has led to an increase in handling injuries. A series of Toolbox talks will be focus on these weekly.
- The extensions to the live rail operating corridor have been preceded by daily reminders, signage as to the risks of not following the rail protection processes. Compliance has been good this month and will remain a focus for the remainder of the project.

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HEALTH, SAFETY & QUALITY REPORT

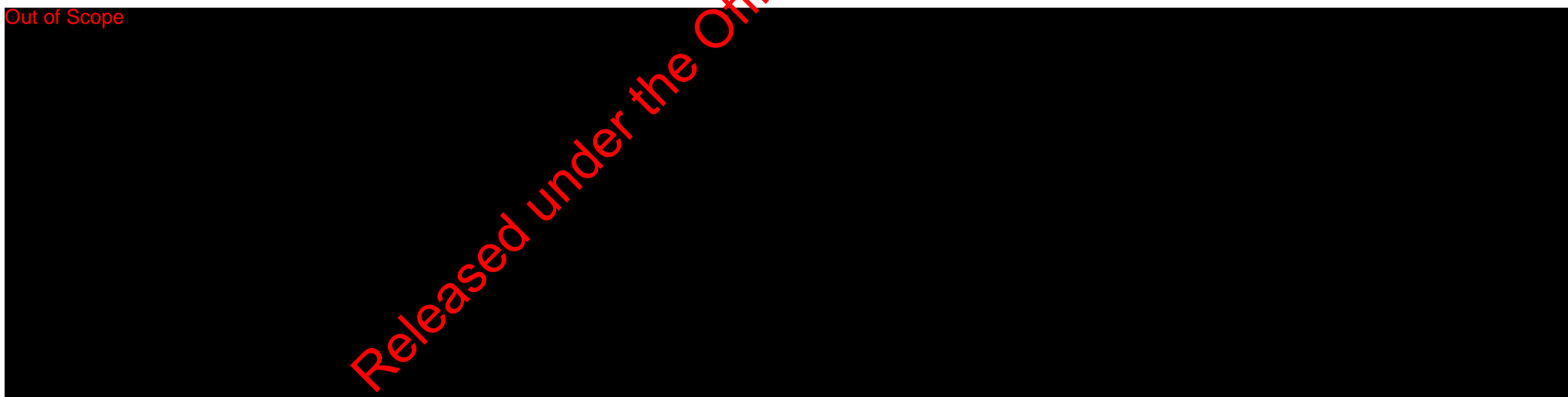
Topic: MANAGEMENT UPDATE TO THE BOARD	Board meeting: 8 August 2017
From: Stephen Bell	Paper type: Information
It is recommended that the Board:	
1. Note There was one MTI for the month involving a broken tooth from a fall. The LTI rate is 1.2, and the TRIFR is 5.8.	

Out of Scope



2. Status Update

Out of Scope



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Incidents of note include the following:

- On the 26th of July a helicopter landed on live rail north of Clarence. The lack of information getting to non-NCTIR participants over live rail has been identified as an initial matter that requires attention from this incident. As a consequence, the HSQ team has informed the helicopter firms directly, and a data base of all site contractors will be obtained from procurement so that they all can be informed directly of any key issues and safety information.
- On the 27th of July a worker sprained his ankle while stepping into a shallow trench, post incident D&A testing has resulted in this worker being removed from the site.
- On the 28th of July an abseiler twisted her ankle. This was not reported within the required timeframe and an incident investigation is underway to establish the cause.
- 544 safety related reports were received for the month. 44 of these reports were incidents, 14 of which were identified as requiring further investigation due to them being of moderate or higher risk. The increase in operating plant interaction incidents is noticeable. The challenges around overlapping activities in a small worksite is being discussed with the delivery teams to develop appropriate measures.
- The progression of the sections of rail corridor going live (i.e. the operating corridor) has been preceded by daily reminders (by way of an NCTIR email), signage as to the risks, and rail protection processes. A significant challenge for the team is to ensure distribution of the rail protection safety information to all project people. The full site contractor contact database is assisting with resolving this communication gap, as well as working in conjunction with the Stakeholder and Engagement Team on wider internal communications.

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HEALTH, QUALITY AND SAFETY REPORT

Topic: MANAGEMENT UPDATE TO THE BOARD

Board meeting: 5 September 2017

From: Stephen Bell

Paper type: Information

It is **recommended** that the Board:

1. **Note:** The programme LTIFR has increased from 2 to 2.9 and the TRIFR from 5.8 to 8.7 with one LTI and two MTI's for the month

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3. Status Update

Out of Scope

Incidents of Note Include:

- The one LTI was a back strain which occurred when the worker was changing into his gumboots for a concrete pour.
- The first MTI involved a worker dislocating his thumb when his glove became entangled in a small Hilti Drill while working in the tunnels.
- The second MTI involved a person's chin being cut when a large roll of alcatene was allowed to unravel catching him. This is the second incident of this nature.
- An incident of significance involved a worker going to help another guide a 5t concrete block into place while the normal person was away and he placed his hand in the wrong place and badly bruised it. It required treatment following the x-Ray showing no damage. The investigation showed that the worker had no training in the guiding process as it was not his assigned task.
- With the announcement of the construction access around Ohau Point a member of the public chose to drive around it in their 4WD. Efforts to stop it using a digger blocking the road failed and the person carried right through to the Clarence gates. The matter was handed to the police. In the South a school camp at Goose Bay chose to walk through one of the five rail tunnels much to the observer's surprise. The parent involved was spoken to.
- 494 safety activities were reported in August with 63 being incidents that caused damage or injury. 244 safety conversations were had but we expect this to rise when all the records around the life-saving rules are included.

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HEALTH, SAFETY AND QUALITY REPORT

Topic: MANAGEMENT UPDATE TO THE BOARD

Board meeting: 3 October 2017

From: Stephen Bell and Paul Stone

Paper type: Information

It is **recommended** that the Board:

5. **Note:** The programme LTIFR has increased from 2.9 to 3.6 and the TRIFR remains at 8.7 with one LTI and no MTI's for the month
6. **Note:** On the 26th of September a serious truck rollover occurred with the driver trapped for 2.5 hours. Thankfully injuries were minor.

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2. Status Update

Out of Scope

Incidents of Note Include:

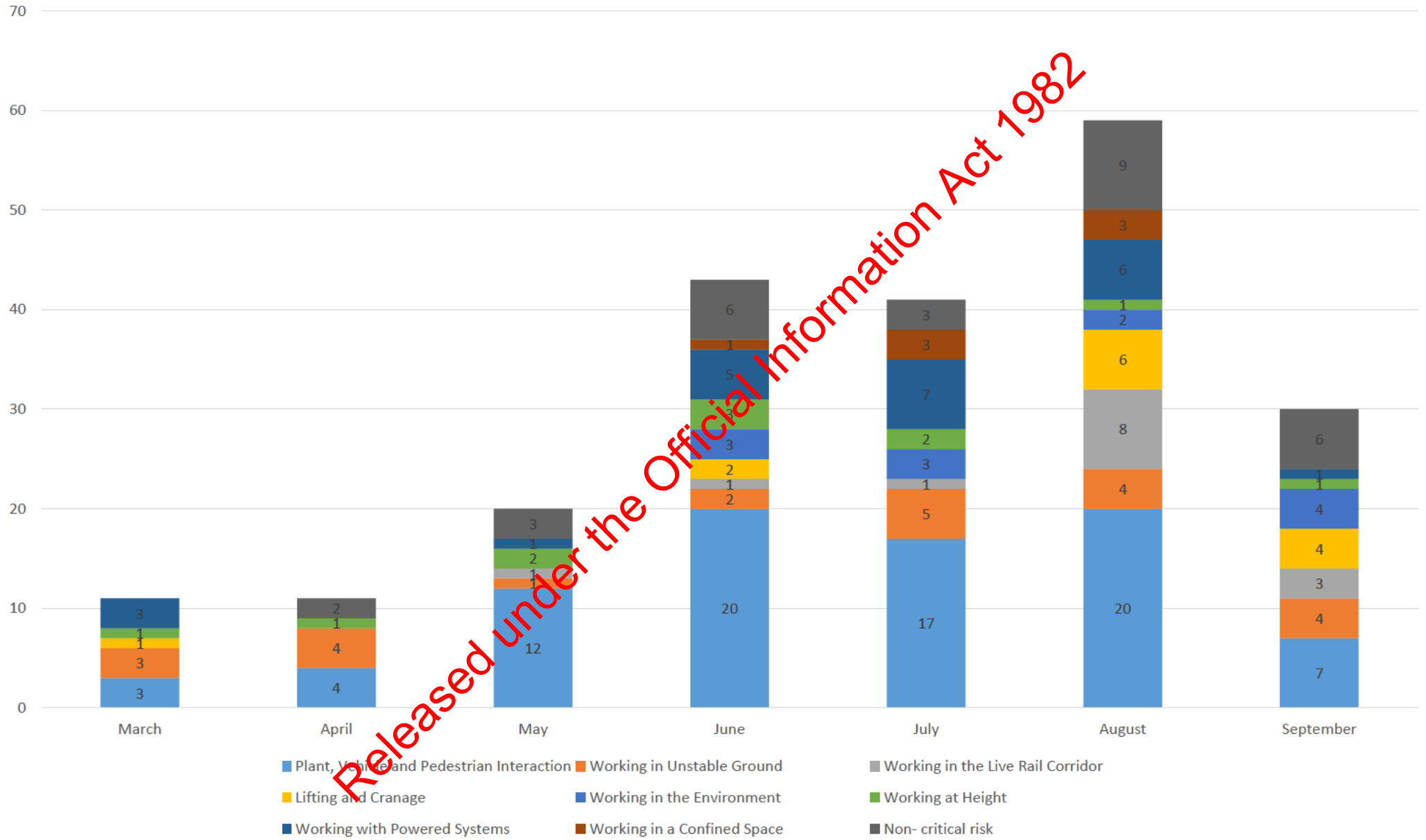
- The one LTI occurred on the 26th where a truck driver failed to negotiate a bend and rolled his truck into a ditch. As it occurred in Kaikoura emergency services were immediately involved however due to the cab damage it still took 2.5 hours to extract the driver. The investigation has so far identified that the competence of the driver and the truck maintenance are all in good order. Minor injuries occurred.
- Two newly contracted bus drivers were found walking through Tunnel 19 early on a Monday morning. They had been requested to go to tunnel 19 to await the operators from the “walking train”. They had been given a temporary induction until the full induction could be given on the Wednesday and therefore had not been strictly told not to enter tunnels. Signs have been erected.
- A slip detection device on a fence was disassembled to allow the material behind it to be removed. The NCTIR engineer spoke with a rail contact to check but had not followed the new protocol that had been established. The communication of the protocol and the implementation needs improvement
- During the early month rains Environment Canterbury contacted us with a warning that the natural dam upstream in the Hapuku River was near breaching. We ensured no one was working in the river bed, and the breach occurred at 4 30pm with an effect at the bridge at 5 30pm. The impact on river flow was quite short and dramatic, damaging the scaffolding that had been recently erected. It is still being recovered, carefully.
- A visiting design engineer encountered steel tiers working of the steel tray instead of scaffolding at Ohau Stream. The contractor has been removed from site and the site shutdown until the proper scaffolding is installed.

Out of Scope

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NCTIR Critical Risk Incidents



HEALTH and SAFETY REPORT

Topic: MANAGEMENT UPDATE TO THE BOARD

Board meeting: 31 October 2017

From: Stephen Bell

Paper type: Information

It is **recommended** that the Board:

7 **Note:** The programme LTIFR has increased from 3.6 to 5.5 and the TRIFR reduced from 8.1 to 7.7 with one LTI and no MTI's for the month

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Out of Scope

2. Status Update

Out of Scope

Incidents of note, and significant failures of the Critical Risk controls Include:

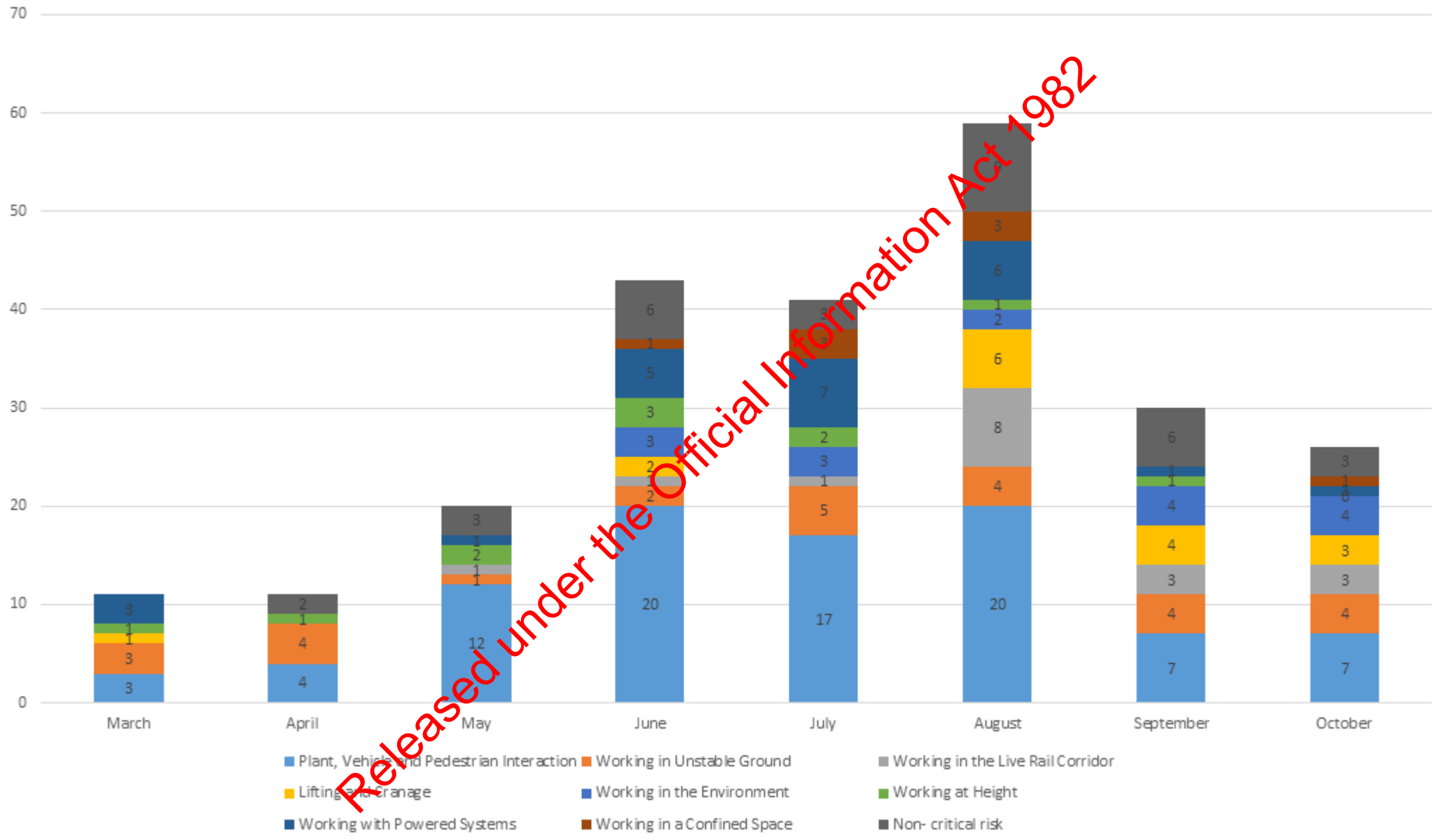
- The one LTI in September when the truck driver failed to negotiate a bend and rolled his truck into a ditch has been investigated by the police and the decision to prosecute is to be confirmed. Our own investigation shows that the roadway design and condition left little room for error and we have imposed speed and direction controls while a better geometry is designed. There has been a poor history with crashes at this intersection from both discussions with the NOC and the public. The age of the driver is also a possible factor and a study of the truck operators on site found that three more were over seventy, and their competence to drive will be more closely monitored. There are signs that another truck narrowly avoided the same fate before the signage was erected. The injured driver is recovering at home and in good spirits.

- There were two incidents of poor performance from our RPO's one where a rail line was called in as clear where there was material over the line, and another where the lock on device and records were found unattended. We are discussing with the NCTIR Rail retraining of the RPO's and roll out of these incident investigations.
- A failure to use the Contractor Authorisation form resulted in a confined space breach. Plumbers arrived at a worksite to remove a water tank and found it full of water and the bung was internal in the tank. One Plumber promptly submerged into the tank to release the bung and drop the water. Any discussion from site management about the task would have identified that their solution was unacceptable.
- An unplanned change to the Slip 7 traffic plan lead to an ADT (Moxy) being asked to undertake a three point turn involving reversing near to a TC cabin. On the third and last turn the Moxy hit the small TC Box just after the TC jumped clear. The investigation is to be completed but clearly the traffic change was poorly made as minimising reversing of large trucks is a priority, and the TC could have simply moved 5m down further which happened after the incident.
- Night Shift were requested to move a 12 m steel temporary culvert, if they had time. This they attempted at 5:30 am by attempting to lift the culvert first to empty it of the flow debris so that the culvert could be re-established. The steel culvert alone weighed 4 tonnes, which was in excess of the selected chains capacity, let alone it was full of mud and likely 15 tonnes was the overall weight. Once the digger tried to move the pipe (excavator lift) the chains broke starlight away and no injury occurred. This was two days before a "lifting with an excavator" course was organised to be run. We have many tools to prevent this type of incident SWMS, lift plans and tagged chains but none was used at the time.

Out of Scope

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NCTIR Critical Risk Incidents



HEALTH and SAFETY REPORT

Topic: MANAGEMENT UPDATE TO THE BOARD

Board meeting: 28 November 2017

From: Stephen Bell

Paper type: Information

It is **recommended** that the Board:

1. **Note:** The programme LTIFR has increased from 4.3 to 6.2 and the TRIFR increased from 6.2 to 7.25 with three LTI's and one MTI for the month
2. **Note:** The three LTI's are disappointing but all three would have been avoidable had the notification and post injury management been optioned better
3. **Note:** That Inductions continue at over 100 per week with Mondays now involving between 3 @ 5 inductions of over 24 people

1. PAB Overview

- Worksafe were involved two times since the last report.
 - A compliance notice under the HSNO Act was received demanding information be supplied concerning the activities of s 9(2)(a) in relation to shot firing. The notice seeks new information when the initial response for NCTIR supplied all that was requested and much more around investigated incidents. We are working to get the extra information and get the compliance notice lifted.

Out of Scope

- Three LTI's were acknowledged this month with confirmation sometimes difficult to ascertain as the person returns to their home organisation or is due leave anyway. All three were I believe manageable if good injury notification and management were followed, none were injuries of significance as noted below.
- The cramped worksites have again lead to rise in vehicle on vehicle incidents as the three main areas, Irongate, Ohau point and Kaikoura South are hives of activity. None of the LTI's related to incidents at these sites. Very slow operating speeds are enforced and complied with and where possible access by bus from light vehicle parks are being used.

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- The NCTIR critical risk incidents table records incidents in November to date. It does not capture the full month and therefore the downward trend shown may not transpire.

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Out of Scope

2. Status Update

2.1 Worksafe

Out of Scope

Upon identifying that formal notification was required for the excavation, Worksafe were notified and they allowed us to lodge a subsequent notice. Incidents of note, and significant failures of the Critical Risk controls Include:

- The First incident of note resulted in first aid treatment only but the graphic video recording of the incident shows the outcome could have quickly been far more serious. On a Sunday morning a supervisor reversed up a steep bank and collided with the site sign-in shed in which two men had just arrived. He checked to see what he had hit and then took off from the worksite likely to avoid the D&A test. Emergency services attended but ligament damage only was sustained. The police have charged the supervisor with failing to stop after he was tracked down in Christchurch. The media story of this incident was much worse than the actual outcome.
- The first LTI concerned a cleaning lady at the Clarence village where she swung a rubbish bag into the skip while holding the lid open with the other arm. The contra movement injured her back. In spite of a lot of signage about who to contact in the event of an injury she chose to take

herself to the Doctor, had a week off and sent the forms to the home organisation. We were unaware of anything until contacted on the Tuesday 5 days after the injury occurred. Light duties were available in the nearby gate control which we moved quickly to get her there but couldn't avoid the LTI.

- The second LTI involved the very windy second week in November when a TC lost her hard hat in a strong gust of wind and the second gust brought the sentry shed down on top of her. This is the third incident of this nature and messages around securing these have been sent out. The person was under concussion surveillance for half a day and then released, but the Doctor would not allow her to undertake very light duties.
- The third LTI was a very recent one where a workman in Blenheim picking up gas bottles wrenched his shoulder trying to do the job alone. While the Doctor allowed him back on light duties he was sent home by the site when apparently no one could be found. There was no communication from the site about options there or elsewhere or that the person had been sent home.
- The MTI was a cut finger sustained when a cutting tool was incorrectly used on a makeshift bench giving three stitches to the finger. First aid was given to a welder who had hot metal drop down his shirt front during the strong winds.
- A significant cable strike occurred when a tamper ripped the fibre optic cable out of ballast where it had been buried only 50 mm. This raises many questions about the level of control we have over its location on the rail line.
- A helicopter with the new hook fitting lost its small load only 3m into the air when a smaller than usual d shackle was used. Subsequent to this a notice that all undersized shackles are not to be used.

Out of Scope

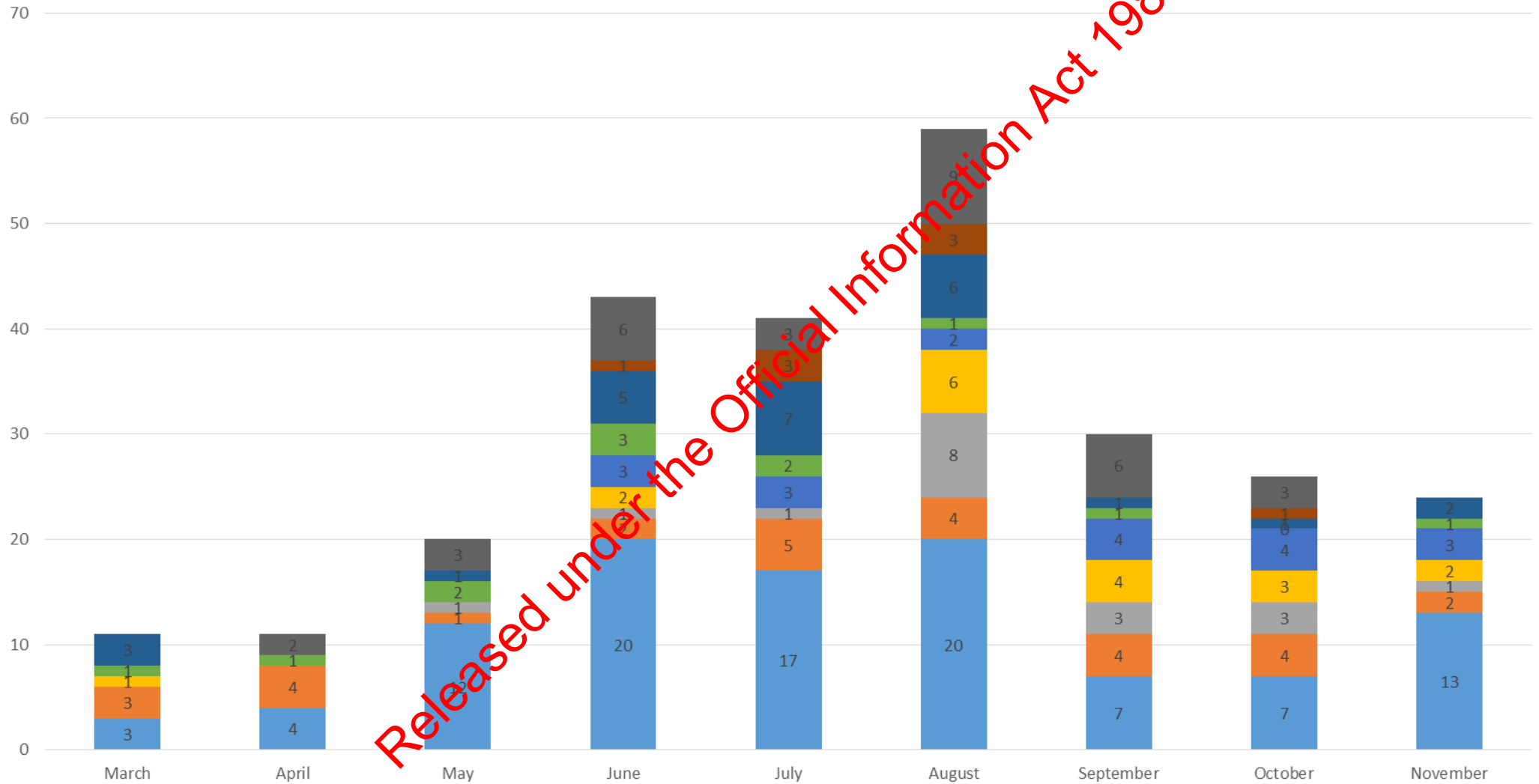
3. Key Risks and Issues

- The increase in LTI's is more a reflection of people not "owning" the injury and focusing on the person being able to undertake more work. A meeting with the local doctors will be held to look at how we can work together to ensure that peoples working life is continuous.
- 23 site audits were completed for the month and over 23 investigations completed. The uptake on the use of the critical risk verification audits has not been as high as would have liked but we will be using the MyVoice system to set targets here.

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NCTIR Critical Risk Incidents



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- Plant, Vehicle and Pedestrian Interaction
- Working in Unstable Ground
- Working in the Live Rail Corridor
- Lifting and Cranage
- Working in the Environment
- Working at Height
- Working with Powered Systems
- Working in a Confined Space
- Non-critical risk