

# Initial Incident Notification

**Location:** Landulph Abham Langage Exeter

**Incident:** Broken Leg after falling down hole

**Incident Date/Time:** 16.08.17

**Category:** LTI

nationalgrid

**IMS Number:** 547135

**Senior Mgr. Informed** Emma Clark

## Incident Description

- The IP was working as part of a two man sub contract team undertaking the planned task of vegetation clearance works at scaffold location 4YF89 – 4YF90.
- At the time of the event the IP was working on uneven ground manually clearing the brushwood from the work area when he stepped into a hole that had been uncovered
- The IP was taken to the nearest A&E department for further assessment / treatment.
- As a result of this event the IP sustained a fractured Tibia just above the left ankle and a fracture to the Fibula just below the left knee.
- The IP spent five consecutive nights from the date of the event in Hospital where he underwent surgery to insert a plate pins into his left Tibia. The Fibula bone was realigned and correct alignment of the bone achieved.



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**Senior Mgr. Informed** *Emma Clark*

## Immediate Action Taken

- All works on site were stopped
- The emergency services were called to the scene
- All relevant parties were informed – Principal Contractor (Babcock), Client (National Grid) and Sub-Contractor (Ground Control)
- The IP was taken to the nearest A&E department for further assessment / treatment
- Full investigation commenced to identify the immediate and root causes of the event

## Follow Up Action required

- *Full investigation into the event was undertaken to establish immediate and route causes*
- *Event reported under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)*

## IMS Responsible Manager

- *Stuart Jones*

## Lessons Learnt

- *Controls for site hazards need to be clearly identified as part of the safe system of work in place*

## National Grid Contacts

- *Project Engineer – Robbie Griggs*
- *CIE details – John-Paul Heggie & Bryan Truscott*

# Incident Notification - Closure Report

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**Snr Mgr. Informed** Emma Clark

## Executive Summary of Investigation

### **Immediate causes**

- The IP lost where he was positioned in relation to the hole
- Inadequate risk assessment performed on site in advance of the works and no continued assessment as the works progressed

### **Root causes**

- Supporting documentation for the works did not give instructions on what to do if a hazard was uncovered
- The site specific method statement was produced in January 2017 and had not been reviewed in advance of the works taking place in August 2017.
- The IP had not signed onto the MS for the works so there is no evidence he had read and understood the contents.
- A lack of auditing and monitoring focusing on working practices, condition of PPE being worn; quality of the documentation completed is to the required standard.
- Lack of risk assessment training for the members of the site team

## Actions Identified

- Review and update all site specific method statements, Demarcate additional hazards and ensure all operatives are briefed
- Site team to undertake Risk Assessment training & brief all project staff on the importance of fully assessing the task in advance and continuously throughout the completion of it
- Improve the frequency of onsite monitoring focusing on working practices, condition of PPE being worn; quality of the documentation completed is to the required standard.

## Investigation Complete Date

- 13<sup>th</sup> September 2017
- 14<sup>th</sup> – Approved by Band B