



Rethinking safety through  
**INCLUSION**  
+  
**WELLBEING**

# SAFETY INFORMATION

## SI 22/03

## HPC BYLOR FALL FROM HEIGHT INCIDENT

### INTRODUCTION

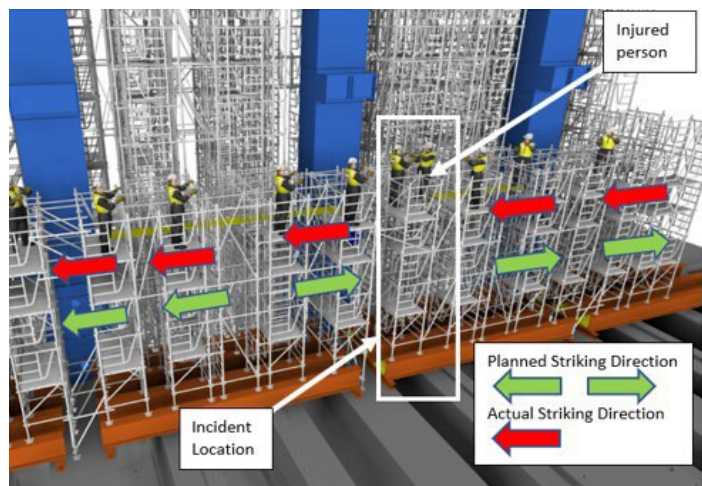
On the 4<sup>th</sup> March 2022 (nightshift), whilst striking falsework under the newly constructed Generator Table [in the Conventional Island Area of Hinkley Point C (Unit 1)] a worker fell 5.2m onto the raft level below. The person involved experienced minor injuries.

The incident happened when the IP stood, in a location not believed to require clipping on, on a floor pan that was unstable due to incorrect installation. The pan rotated creating a trap door void that the IP fell through.

### LOCATION AND DIGITAL IMAGES



View of the CI Unit 1 Falsework



Digital image of the activity before the incident



Image indicating the 'Pan' that rotated



Images showing the fall from height



This was a serious incident which Bylor are treating with the utmost importance. There has been a thorough investigation carried out by senior members of BYLOR and HPC NNB Leadership teams, and actions have been agreed to ensure there is no repeat.

The final investigation report has been shared openly with the Office of Nuclear Regulation ((ONR) i.e., the HSE for the HPC Nuclear Licenced Site). As a result of initial findings from the incident the ONR issued an Improvement Notice to both BYLOR JV parent companies to ensure that effective measures are taken to prevent a reoccurrence. The key lessons learnt are summarised in the below table:

<b>System Training for Falsework and Formwork</b>	<p>Not all construction personnel involved in the erection and dismantling of falsework systems [inc scaffolders] had received familiarisation training in the specific falsework system.</p> <p><b>BYLOR have refreshed training and competence systems and the training centre has increased falsework systems courses. A falsework academy is also being established.</b></p>
<b>Setting People to Work</b>	<p>Visual task sheets communicating the safe system of work were too generic and didn't include sufficient system specific risk information.</p> <p><b>Setting to work procedures have been updated, the quality of visual task sheets and POWRA documents have been improved and supervisor training on effective delivery, confirmation and monitoring has been increased.</b></p>
<b>Effective Reporting and Escalation</b>	<p>Observation reporting processes weren't effective in escalating the earlier issues experienced with the system to the right people/level.</p> <p><b>Everyone has been re-engaged in the importance of escalating H&amp;S issues on site, via any appropriate means but including workforce engagement sessions and via the new insight [app] reporting tool.</b></p>
<b>Supplier Information and design quality</b>	<p>Information supplied from the manufacturer did not sufficiently highlight the risks associated with the falsework system and the importance of the anti-tilt device and pan securing pins.</p> <p><b>The falsework supplier has updated their familiarisation training, the system manual and also the SHE risk boxes in their standard design drawings.</b></p>