

# WISE NEWS



## Workplace Industrial Safety and Environment Newsletter

Since June this year there have been a significant number of serious incidents at domestic paper manufacturing sites. These have, for the most part, involved Winders and Mobile Plant. As many people are aware, one of these forklift incidents resulted in the death of a contract maintenance operator.

Whilst there is a comprehensive summary of the investigation process and outcomes contained within this edition of WISE News I would like to take the opportunity to address some key issues concerning this incident and investigation.

There has been a lot of grapevine traffic around the circumstances that led to this incident. My involvement with the investigation team has provided the opportunity for some insights into this terrible incident. I am taking this opportunity to share some of these.

- There were no witnesses to the incident – only the pedestrian and forklift driver were in the area at the time.
- Whilst the pedestrian's mobile telephone was found on the ground in the immediate vicinity – the investigation team was not able to identify any evidence that he was using the telephone at the time.
- No one has come forward saying they were communicating with the pedestrian via telephone at the time he was struck by the forklift.

As part of the investigation team, I acknowledge that we will never be able to ascertain all the factors that led to the incident. In the absence of factual evidence, we are able to draw conclusions based solely on supposition.

Having made these comments, I am also aware that some organisations are in the process of developing policies and procedures for mobile communication use in the workplace. While the Unit would, and the industry should, always support initiatives that improve health and safety, we should work to ensure that the introduction of any initiative is:

- a. Not a knee-jerk reaction;
- b. Not going to create other hazards for individuals at work;
- c. Workable and enforceable;
- d. Undertaken utilising the appropriate consultative mechanisms, in accordance with OHS legislative requirements.

Further information on these incidents is available in this edition of WISE News and also on our website [www.ppwsafety.org](http://www.ppwsafety.org).

Please stay safe.

## A minute with ...

### Robert Burns Tumut Sub Branch Secretary



**Nickname ...** Burnsie, Rob, Bob and a few others you wouldn't repeat.

**I barrack for ...** We're a happy team at Hawthorn!

**My best trait is ...** Caring, helpful, persistent and honest.

**My worst trait is ...** Argumentative. If I know I'm right I'll argue all day!

**I am passionate about ...** Family and cars.

**Health & Wellbeing means ...** Being able to spend time with the ones we love doing the things we enjoy.



Pulp & Paper Industry  
Occupational Health, Safety  
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# FORKLIFT FATALITY—INVESTIGATION

On 22 July, 2010 a contractor was fatally injured after being struck by a forklift, while walking in a northerly direction on an internal roadway at a domestic paper mill. The forklift was also travelling in a northerly direction on the same roadway, transporting a pack of eight (8) pulp bales, presumably from a pulp storage shed. This shed is approximately 350 metres from where the incident occurred.

The forklift was travelling in forward motion at the time of the incident, which was the accepted practice at the site over this distance. There are no designated walkways or pedestrian exclusion zones on the internal roadway.

A joint investigation team was formed by the company and the CFMEU Pulp & Paper Workers District to independently investigate the incident and develop recommendations to prevent recurrence. The investigation team comprised an independent chairperson; representatives from the Company and Union as well as the Pulp & Paper Industry OHS&E Unit. The team completed a comprehensive incident investigation. In accordance with its intended purposes, the investigation team operated independently to reach its findings.

## Probable Causes or Contributors

The investigation team's analysis identified three (3) areas that were probable causes or contributors to this incident.

1. This internal roadway is a common thoroughfare for mobile equipment and pedestrians.
2. There are genuine 'visibility' concerns driving in a forward direction, and there are ergonomic issues associated with driving in reverse over anything more than a small distance.



Source: Linde

3. There are some gaps in the Standard Operating Procedures that relate to the work done by the Yard Gang in moving substances in and around the site.

## Identified Root Cause

The investigation team determined there were two (2) root causes of this incident. They were:

- ***Inadequate control of risks associated with pedestrian / forklift interaction.***
- ***Over reliance on individuals to manage these risks.***

## Investigation Recommendations

Following the determination of the root causes a series of recommendations were made, with a view to preventing a recurrence or similar incident.

## Making the Site Safe—Reducing Pedestrian / Forklift Interactions

1. Examine the opportunities to re-engineer the movements or "workflows" of bales and broke aimed at reducing collision risks. Key issues to consider include reducing pack sizes, moving bale storage locations closer to en-use (eliminating double handling), and establishing alternate broke holding locations.
2. Develop and implement a comprehensive traffic management plan for the internal roadway and immediate vicinity. The traffic management plan should ensure that the risk associated with pedestrian / forklift interaction is reduced. This may include: pedestrian exclusion zones; designated walkways and crossings; physical barriers to separate pedestrians and forklifts; designated safe zones for truck drivers and altered traffic zones.
3. Review and update the mill-wide traffic management plan to ensure it addresses and reduces the risks associated with traffic movement across the site. This plan should identify high risk areas and ensure they are prioritised for implementation.

**Visited the OHS & E website yet?**

# OUTCOMES AND RECOMMENDATIONS



Source: Linde

## Making the Task Safe—Improved Yard Gang Practices & Procedures

4. Conduct a review of all forklift related tasks to ensure equipment is task appropriate and incorporates all relevant safety features. These may include dual controls; swivelling, adjustable suspension seat with lumbar support and seatbelt; mirrors; flat screen colour camera and monitor; speed governing device and audio/visual warning system. It is critical to involve forklift operators in the review and selection of any modifications.
5. Update Production Services Standard Operating Procedures (SOPs) with the Yard Gang to identify and document the key steps and controls associated with the core or common tasks. The priority focus should be on the 'hot spots' that are associated with forklift / pedestrian interactions. When completed, the SOPs should be in a simple "user-friendly" format and freely accessible in the field.
6. Promote and monitor the use of Job Safety Analysis (JSAs) by Yard Gang members. This is an established procedure for non-routine tasks and one which will benefit the Yard Gang as they can perform a range of different tasks. These JSAs may, if appropriate, form the basis for any future SOPs.

## Making People Safe—Greater Safety Awareness & Visibility

7. High visibility clothing suitable for both day and night operations should be mandatory across the entire site.

8. Conduct a review of the training system to ensure that it includes applied knowledge and skills consistent with the job requirements. The review should address the over-reliance on the skills transfer (buddy) system and supplement it with detailed, documented training modules and assessments. The training and assessment system should be consistent with the Pulp & Paper Industry training package.
9. Publish and promote incident and near hit learnings across the site at all levels. Focus on increasing awareness of hazards, educating about the importance of reporting and discussing near hits / incidents (not the individuals), and sharing outcomes and preventative actions.



## Other—Enhanced Management Systems

10. Hazard management processes must comply with the documented standards / procedures. This will involve a stronger focus on addressing the gaps to ensure that all hazards are identified, assessed, controlled, and monitored.
11. Update the Emergency Response Plan to address: splitting the role of Incident Controller and First Aider; provision of a medical emergency crew; establishment of a Mill-wide alert system for medical emergencies; review and debrief whenever the Emergency Response Plan is activated.

A number of these recommendations may be valid across the wider pulp and paper industry. As a minimum requirement all employers have a legislative obligation to provide a workplace that is safe and without risks to health—hazard identification, control and monitoring are a key component to achieving this.



# SAFETY ALERTS

## Fall from Heights

A plumber fell through a laser light panel at a domestic paper manufacturing site in June 2010.

The worker had been walking across a roof when he stepped on to the laser light. It gave way under his weight and he fell through, hitting a spray booth before landing on the ground.

The worker received a broken femur, superficial head injuries and other minor injuries.

Preliminary investigations show that although robust hazard management processes exist for this type of work, they were not utilised for the task. As a result there were no suitable risk controls implemented.

Investigations are now underway to determine the root cause of the incident and introduce appropriate measures to prevent a reoccurrence.

The injured worker was airlifted to the closest capital city for specialist attention and it is anticipated he will be off work for an extended period of time with his injuries.

## Near Miss—Paper Machine Primary Arm Clamp Failure

On the 10th of February a partially built reel of paper fell from a paper machine to the floor while the machine was producing paper. The reel weighed approximately one (1) tonne and could have caused significant harm to people and equipment had the circumstances been different.

### Background

This incident occurred during an automated reel change sequence. Reel changes occur on this paper machine approximately every 30 minutes. In the lead up to the incident approximately 35 reel changes had taken place with no indication of any problems.

18 hours prior to the incident the paper machine had undergone a planned maintenance shut. A large number of tasks were undertaken around where the incident occurred during this shut. However a review of the work undertaken does not indicate a connection between any of this work and the near miss.

Upon start up, the primary arm clamp on the back side was sticking and slower to operate than the front one. Oil was added to the lubricator on the air system feeding the primary arm cylinder on the back side, and the back side primary arm clamp was also lubricated. The clamp performed as expected after this work and this too is not considered to have been a direct contributor to the incident.

## Operator Injured by Rider Roll

On the 20 June, 2010 an operator had his lower legs pinned between a Rider Roll and the Winder drums, causing soft tissue crush injuries.

### Description of Incident

Investigations to date have identified the following sequence of events leading to this incident.

1. As part of preparation for running up a new work set on the Winder the Operator taped the cores, reset the safety system, activated the Rider Roll and began to raise the Winder table.
2. The Operator had previously been informed of an air leak in the slitter roller knives (not involved in the current set-up). After activating the Rider Roll 'lower' function, the Operator climbed onto the Winder drums to check the air leak. (He was concerned that the air leak would impact operation of the other slitter knives located behind the Winder unit).
3. Whilst the Operator was on the Winder drums the Rider Roll continued its downward movement and pinned his lower legs between the Rider Roll and Winder Drums. Whilst the Rider Roll initially stopped when it detected resistance, it then continued a slow downward movement.
4. Operator called for help and was released by a co-worker.

***For the full text of the above Safety Alerts please go to our website ([www.ppwsafety.org](http://www.ppwsafety.org)) and click on Safety Alerts.***

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