

**SUPPLEMENTARY MATERIAL FROM CONSTRUCTION FORESTRY
MINING AND ENERGY UNION, FORESTRY & FURNISHING PRODUCTS
DIVISION**

Document tendered by	CFMEU - Rita Mallia
Received by	Chris Angus
Date:	28 / 03 / 14
NSW over a public place	Yes / No

The CFMEU FFPD Division also has a concern that WorkCover NSW over a public place of years has reduced its activity as a robust regulator of the OHS and WHS regime. Here are some examples of safety issues raised for which either further information was not forthcoming, or it is unknown whether WorkCover undertook a prosecution.

1. Correspondence Unanswered

Correspondence to WorkCover NSW dated 21 November 2008 and 14 July 2008 regarding various incidence. No response was ever forthcoming from WorkCover. Attachment 1.

2. Operator Fatality at Recycling Mill, Visy Paper

Despite three verbal discussions with Workcover investigators in the weeks following the incident the Union was unable to obtain further information that would allow the Union to produce an industry alert. At the time union representatives were informed that it would be "a few months" before the investigation was complete and in the interim the primary investigator was reassigned and a new inspector was given the job. There has been no further information provided to the Union since. Attachment 2 Safety Alert produced by the Pulp & Paper Industry Occupational Health, Safety & Environment Unit.

3. Forklift Fatality 22 July 2010 at Australian Paper Shoalhaven in July

On 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. Attached is the final joint Union/company safety alert / investigation outcomes for the fatality at Australian Paper Shoalhaven in July, 2010. We have not seen a report or prosecution for this event to date.

4. Other Safety Alerts

Produced by the Pulp & Paper Industry Occupational Health, Safety & Environment Unit, for which further information could not be obtained from WorkCover despite being sought by the FFPD Division of the CFMEU, it did make producing these very difficult.

21 November, 2008

Mr Tony Williams
 Manager - Manufacturing, Primary Production, Transport and Storage
 WorkCover NSW
 Locked Bag 2906
 LISAROW NSW 2252

Dear Mr Williams

Re: WorkCover Reference WCO1341/08

Thank you for your correspondence dated 10 September, 2008 regarding our request for information on the incidents that occurred at the VISY Industries Tumut site earlier this year.

The Steering Committee of the Pulp & Paper Industry OHS&E Unit recently met and considered your response to our request. Whilst we appreciate these incidents remain under investigation, I have been requested by the corporate representatives of the OHS&E Unit to seek additional information on these incidents.

Specifically, we are seeking additional information on the control measures introduced and any specific tasks, activities or issues that may have contributed to the incidents occurring. For example, procedures for clearing blockages on the lime bin vertical chute; type and size of screening mechanisms; redesign of inspection hatch door; controls that have been introduced into the Digester shut down and maintenance procedures.

Companies that participate in the Pulp & Paper Industry OHS&E Unit are extremely committed to continuous health and safety improvement and to raising the industry's state of knowledge regarding hazards and appropriate controls.

To that end, we are requesting that WorkCover NSW provide additional information to our OHS&E Unit on these control measures in order that we can improve safety for the whole pulp and paper industry. This information and any discussions around these issues should be directed to our National Coordinator, Denise Campbell-Burns on

Yours sincerely,

ALEX MILLAR

A/Chairperson – Pulp & Paper Industry OHS&E Unit
 Federal Secretary – CFMEU Pulp & Paper Workers Branch

c.c. Tony Robinson – A/General Manager – OH&S
 Steering Committee – OHS&E Unit

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14th July, 2008

Mr John Watson
General Manager
Occupational Health & Safety Division
WorkCover Authority New South Wales
92-100 Donnison Street
GOSFORD NSW 2250

Dear Mr Watson,

Re: Recent Incidents at Visy Pulp & Paper, Tumut NSW

We are writing to request your assistance with obtaining information about three (3) recent incidents that have taken place at the Visy Pulp & Paper mill in Tumut, NSW.

These incidents have occurred since early March. Two of these incidents involved serious chemical burns to operators (one a multiple operator incident) and one in the past 10 days that we understand involved an apprentice falling from a height.

The Pulp and Paper Industry OHS&E Unit was established in 1988, as a cooperative venture between prominent pulp and paper manufacturers and the CFMEU Pulp & Paper Workers Branch. The Steering Committee comprises the following organisations: **AMCOR Fibre Packaging; Huhtamaki Pty Ltd; Kimberly-Clark Australia; PaperlinX – Australian Paper; SCA Hygiene Australasia.**

The focus of the OHS&E Unit is continuous safety improvement across the industry, through key activities including the preparation and distribution of Safety Alerts when serious incidents occur in the pulp and paper industry.

Safety Alerts are distributed to inform the pulp and paper industry when serious incidents occur; any known circumstances leading to the incident and the immediate and long term learnings from the incident. The purpose of such Alerts is to share information, raise the state of knowledge for the whole industry and prevent similar incidents occurring where possible.

All Safety Alerts are non-identifying; respectful of 'commercial-in-confidence' issues, have company and/or regulatory approval prior to distribution and do not highlight the behaviour of individual operators or use names of individuals.

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Our attempts to obtain information, directly from Visy or the WorkCover office in Wagga Wagga, that can be utilised in an industry Safety Alert have been unsuccessful to date.

This is extremely disappointing as we regularly work closely with the WorkCover Authorities in other states for information sharing purposes and find this a very successful approach.

We are seeking generic information about these three (3) incidents, including factors leading to the event and post event changes introduced to prevent a reoccurrence, so that we may prepare Safety Alerts for the wider industry. These alerts could be provided to your nominated officer for approval prior to distribution to the pulp and paper industry.

The pulp and paper industry continues to improve our management of health and safety issues, primarily through cooperative work such as this and we would appreciate your intervention and assistance to support this path of continuous improvement and information sharing.

Yours sincerely,

Tim Woods
*Chairperson
Pulp & Paper Industry
Occupational Health, Safety
& Environment Unit*

Alex Millar
*Federal Secretary
CFMEU Forestry &
Furnishing Products Division
Pulp & Paper Workers Branch*

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SAFETY ALERT

Operator Fatality at Recycling Mill

19 December, 2012

Last week at a domestic recycling / paper mill an Operator received fatal injuries after being struck by a front end loader in the yard.

At this stage the incident is under investigation from WorkCover NSW and there is no preliminary information available on the circumstances leading to the incident.

However, we have established communications with WorkCover NSW and will endeavour to keep the industry up-to-date as information becomes available.

Should further details become available, they will be forwarded.

Further information:

Denise Campbell-Burns
National Coordinator
Pulp & Paper Industry
Occupational Health, Safety & Environment Unit
0419 591 181

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Occupational Health, Safety & Environment Unit

For more information on occupational health and safety in the pulp and paper industry, visit our website at www.pulpandpaper.org.au

Safety Alert Forklift Fatality

As previously notified, 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.
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.***

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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 end-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.

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.

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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.

Further information:

Denise Campbell-Burns
National Coordinator
Pulp & Paper Industry
Occupational Health, Safety & Environment Unit

0419 591 181
 d.campbellburns@ppwsafety.org

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INDUSTRY FLASH

2 Operators Injured

9 February, 2012

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On 8 February, 2012 two maintenance personnel suffered serious burns at a domestic paper mill.

The fitter and apprentice were working on a pump when they were sprayed with extremely hot pulp, causing severe burns to both employees. Both were transported to hospital by ambulance.

Investigations into the root cause of this incident are currently being conducted. Currently no further information is available.

Should further details become available, they will be forwarded.

Further information:

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INDUSTRY FLASH

Crane Sling Snapped

2 x 1.7 tonne Paper Reels Strike Forklift

27 August, 2010

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In the past week there have been two (2) incidents at domestic paper mills.

- A sling snapped during a felt change on a paper machine. The breast roll had been raised, was set in place and secured. The slings were relaxed to be removed from the breast roll. After a potential miscommunication the hook was raised, however the front side sling was caught while still secured to the roll. The resulting pressure caused the sling to snap.

A site investigation into this is currently underway.

- At a different mill an incident occurred when a forklift reversed into a stack of paper reels in a reel store whilst removing stock. The impact caused 2 x 1.7 tonne reels of paper to fall from the stack into the next aisle. Another forklift was operating in the direct vicinity and was struck on the cab roof by the paper reels. The forklift sustained damage.

Whilst fortunately neither of these incidents caused injury to operators, equipment damage was sustained in both occurrences. The potential for injury however was there and the results may have been extremely serious.

Please consider whether either of these situations could occur in your workplace and whether your controls are robust enough to address risks similar to these.

Further information:

Denise Campbell-Burns
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