

ACCIDENT ALERT

Port worker crushed between bales of wood pulp

Introduction

A recent fatal accident highlighted the dangers of persons working in the proximity of forklifts, unsighted by the forklift drivers.

Setup before accident

The site was a busy port, multiple bales of wood pulp are stored in sheds. When a shipment was required it was placed into containers and loaded onto the ship. The task was normally carried out in one of the sheds adjacent to the ship. Sometimes, however, the ship was berthed at a different wharf and the job was carried out as close to the ship as possible.

The process normally involved two people and one forklift when the job was done inside, but on this occasion as it was being carried out in the open, four men using three forklifts were involved in the operation. Each palletised packet of bales was approximately 2 metres high weighing in excess of 4 tonnes. The bales were securely strapped to the pallet.

One worker was driving a forklift which had a lift capacity in excess of 10 tonne, he was transporting the bales from the shed to a layout pad at the wharf. He normally carried two palletted bales at once, due to the length of the forks.

Normally, he would place the first pallet down, then reverse and lower the second pallet approximately 0.5 metres from the first one, laying out the pallets in a line. This process was repeated until the pulp layout area was full or the required amount was laid out. On this occasion, however, as the job developed, he placed them anywhere he could find a gap.

A second forklift operator with a smaller forklift was transporting the relabelled bales to a tipping frame which tips the pallets over, so the pallet can be removed.

A third forklift operator was driving the smallest truck, he was picking up the individual bales and loading them into the containers ready for shipment.

The fourth person in the team (the paster) was walking around the bales in the layout area replacing old stock labels with new ones.

The accident

Nobody was sure what had happened. The fourth person (the paster) was working between two bales removing labels. The driver of the 10 tonne forklift had just returned with two more bales of pulp from No. 3 Shed and the second forklift driver picked up a pallet to take it to the tipper. Having not seen the paster for some time one of the drivers went looking for him. He found the paster crushed between two of the palletised bales.

The inspector investigating the accident established which forklift had pushed the bales together. There were skid marks immediately in front of the two bales where a pallet had been pushed along the ground. The noise of the working machines would have made it almost impossible for the forklift drivers to hear anyone cry out, before being crushed.

Working procedures had been left to individual staff to decide.

The deceased worker had been involved in a similar incident earlier in the year though it was not working with pulp. He was unsighted by the forklift driver.

Contributing factors

Staff were interviewed after the accident and the following points were noted:

- Supervisors said that all staff were experienced and were well aware of the dangers associated

with the job. If they weren't, they shouldn't be working there.

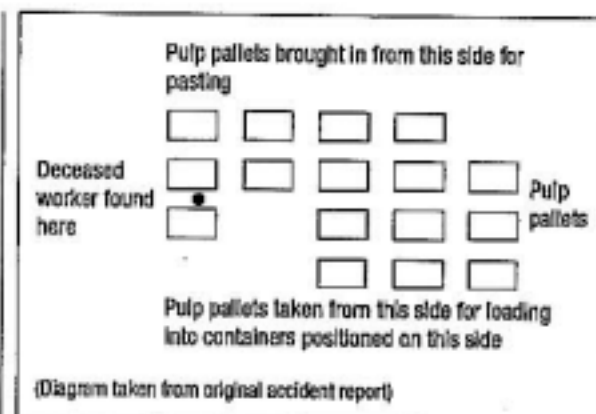
- The industrial safety clerk could not show the inspector anything in writing on:
 - Safety procedures,
 - Breakdown of how tasks should be carried out, or
 - Hazard identification procedures for the site.
- Hazards had not been identified.
- Cargo supervisors and drivers interviewed stated that they had not been trained on procedures for moving and loading wood pulp bales, procedures developed over the years.
- After speaking to the staff members, it was clear that they had many years experience at their jobs and believed they were doing their jobs safely as far as they were concerned.
- A number of operators were asked how they would lay out and relabel the pallets in this operation and it was found that the method differed between each person. Nobody raised the issue of sighting the pedestrian who was doing the labelling.
- Two staff members remarked on the earlier accident involving the deceased worker but when asked, said that to their knowledge, nothing had been done about what had happened.
- A check revealed that this earlier accident had occurred because the procedures were wrong in respect of situations where men and machines were working in close proximity.

Inspector's conclusions

The inspector concluded that had the company carried out a hazard identification and control programme the situation may not have arisen. The company should have set standards to work to, irrespective of the location, i.e. inside a shed or outside, or the varying numbers of staff and machines involved in the operation.

There were poor working procedures.

The deceased worker (the paster) was unsighted by forklift operators due to poor visual contact



because of size of bales and restricted sight through the mast.

The machines involved tend to have high noise levels which isolates the operator from the surrounding work environment increasing the need for good visual contact.

Prosecution action followed.

Court's conclusion

The judge commented that the company "did fail to take all practical steps to ensure the safety of an employee by failing to provide and maintain a safe working environment namely ... by failing to implement procedures which would have prevented ... death ...".

Evidence established that the bales were of such a height that a worker on foot was concealed from sight.

The driver of a manoeuvring forklift had no proper visibility once the vehicle was loaded with pallet bales of the type involved here.

The workers were experienced and were not unaware of the potential dangers. Shunting of pallets was discouraged.

The judge commented "I find as a fact that the worker's death occurred in direct consequence of a system of work in which workers walked between and worked upon substantial bales of wood pulp during an operation in which those were being moved by a forklift"....

The company was fined \$20,000, the bulk of which the Court directed be paid to dependants of the deceased worker.