Safety Bulletin May 2012

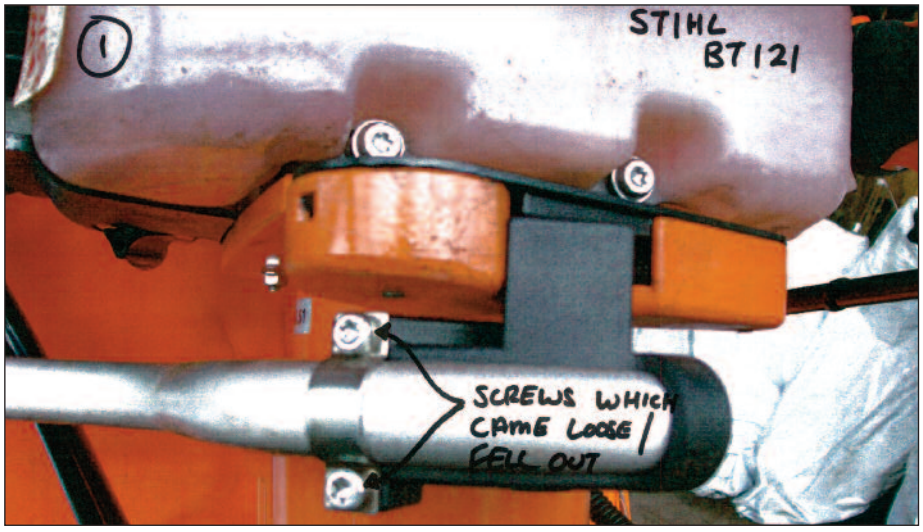
The Biofore Company UPM

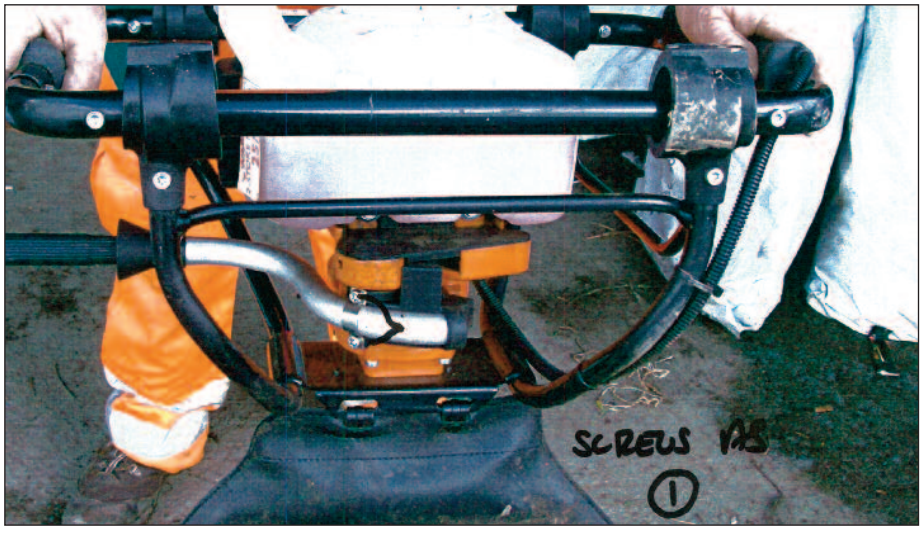
INSIST ON SAFETY

Hand Auger Kicks Back

An operator was injured using a hand auger as it kicked back when it became jammed. A fault on the brake meant that it didn't operate as it should have.

■ The investigation has shown that the machine was checked at the start of the shift and was found to be in good working order at that time. This check was relayed verbally by the operators instead of being officially documented. During the day a screw securing the brake worked loose and fell out. This caused the arm operating the brake system to fall out of its socket. This in turn prevented the brake from working, allowing the machine to spin round when the auger became jammed. During the investigation it is suggested that the screw had worked loose on previous occasions. If this had been noted on a plant check sheet it would have been easier to pick the fault up. The machine, a Stihl BT121, was a new unit that was on hire. All these units have been returned to the hire company, who are investigating the issue.





Learning Points:

1. Document plant and machinery checks, including faults that develop during use. It removes doubt about when plant was in full operational condition.
2. If plant and machines develop faults, stop using them, report the problems to your supervisor/ manager and write them on your check sheets.
3. If you are using Stihl BT121s check for similar problems and report any repeats to Chris Pike on 07785 511741.

Left: Images show the position of the relevant screws.

CONTENTS

Slip on rubbish

A subcontractor was injured while walking to a welfare unit on a major clients construction site.

■ The subcontractor was walking on an authorised walking route close to the welfare unit, adjacent to an area where waste skips are placed. The skips are small, uncovered skips. As he stepped down from a small concrete plinth he stood on a discarded sheet of polystyrene that, it is believed, had blown out of an adjacent skip. As he stood on the polystyrene, it slipped on the water beneath it causing the subcontractor to fall injuring ligaments in his knee. This injury will prevent him from working for many weeks. It is unclear exactly how and when the sheet had got to its final place, but the weather during the previous day had been extremely windy and remained windy on the day of the accident. There were other muddy footprints on the polystyrene, indicating that others had walked over it, but no-one had thought to put it in the adjacent skips.

Learning Points:
1. Consider weather conditions and their effect on your site. This may be windy conditions on construction sites or forestry sites, lightening risk to arborists or rain causing surface water issues.
2. Never walk by any hazard on site. Deal with it and prevent injuries to others. Never have the guilty feelings of "what if…?"
3. Housekeeping on site is an issue to be taken seriously. A tidy site is a safer site.

Below: One of the uncovered skips on the construction site.

One in the eye

A planting contractor got mud in his eye while planting trees in Scotland.

■ There was a source of clean water on site to rinse his eye out. He visited his GP, who also flushed his eye out, but some irritation of the eye ball occurred. He was unable to return to work for two days until his eye had sufficiently recovered. Fortunately, this is an unusual occurrence, but does highlight the need for eye wash on sites. Clean water is not always available. It is possible that the irritation was made worse by rubbing his eye before rinsing it out. This is a normal reaction, but can make the injury worse, especially if you have dirty hands or gloves.

Learning Points:
1. Always ensure sufficient, in-date, eye wash is contained in first aid kits.
2. If you feel a foreign body in your eye, wash it out rather than rub it. This can worsen the injury.

Control of Documents

Some confusion arose recently as districts, keen to improve safety, started making alterations to standard forms held on QPulse.

■ This very nearly resulted in a standard document proof with our printer being altered to suit one district. This would have meant that any other district ordering new forms from the reference number would have received a surprise when they opened the box from the printer.

We should not discourage people from trying to get on and make improvements in assurance documents. Indeed it is the inventiveness and 'can do' nature of our managers that is such a great strength of our company. We must however, remain in control of the approach we take to planning and executing work. This includes the forms we use.

If you think any standard document can be improved then raise a change request on QPulse or raise it with a member of the AMS team so we can keep a track of where trial forms are being used. This way we can share improvements across the rest of the business and continually improve our systems.

Speak Up!

A contractor took the brave step of reporting an unsafe act carried out by the UPM Tilhill Supervisor that issued him his work.

■ The incident took place when the Supervisor was conducting an AMS Inspection. The contractor had a new chainsaw. The Supervisor was interested in the machine and picked it up and started it without any chainsaw protective equipment. This was a gross breach of safety rules that resulted in the dismissal of the Supervisor.

The contractor should be commended for reporting this unsafe act. It would have been very easy for him to sweep it under the carpet, afraid that nothing would be done and it ruining his relationship with the Supervisor.

At the outset of Insist On Safety, we stated we must make sure that the problem is not with our managers. Three years on, we remain committed to that statement.

Learning Points:
1. Always speak up about unsafe acts and conditions.
2. If you are unsure who to speak to when the issue is with your manager or supervisor, then speak to Chris Pike, Head of Safety on 07785 511741.

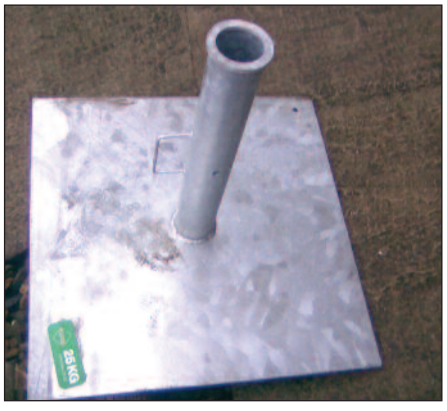
Changing the goalposts

There were two near miss reports during April involving goal posts that at the time were protecting overhead power lines from being struck by timber lorries.

■ The circumstances in both reports were quite different but the common factor was a sagging top rope running between the goal posts.

We recommend a rigid top bar, but this is often very difficult to erect, so blue polypropylene rope is used because, unlike bunting, it will not snap if caught by a vehicle. The visibility of this rope must be made more obvious by the use of tape or a drain pipe. Importantly it should also be taut so the correct height is maintained.

With the recent fatality in the industry, we are looking again at our guidance around goal posts. A set of extendable posts are being trialled within harvesting as a ready made short term solution. Early indications show they are likely to have some suitability, but perhaps cannot be considered as a one stop solution.



Above: Goalpost base

Above: Goalpost erected

Above: Goalpost telescopic pole

Above: Goalposts fit in a Skoda boot

Learning Points:
1. Always consult with the local electricity provider for the correct height goal posts should be set at.
2. A rigid cross bar should be used wherever practicable.
3. Our Electricity at Work Procedure states goal posts should be erected on access routes as well as the work site. This includes the designated access route on the forest road, not the public highway leading to site.

Ground control to Major Tom

A trend of reporting accidents on near miss cards, daily risk assessments and daily pre-start checks has been noticed recently.

■ This leads to quite a delay in the accident report reaching managers. This can cause problems in meeting reporting deadlines, but more importantly in conducting an effective investigation. If you suffer personal injury you must follow the correct protocol and phone the report through to your UPM Tilhill manager as soon as you can. This will give the best chance of an effective investigation and identification.

In The News

Estate trustee fined following tractor fatality

A worker was crushed to death when a tractor overturned during a poorly planned tree-felling operation.

■ Christopher Fox, 60, was part of a team responsible for maintaining trees at the Osberton estate in Blyth. He was employed by the GMT Foljambe 1996 Discretionary Trust, which manages the estate.

On 4 November 2009, Mr Fox and a colleague were cutting down a number of trees at Hodstock Forest Farm, which is located on the estate. The trees were leaning towards a farm building and the workers used a tractor to push them in the direction that they wanted them to fall.

Having successfully felled three trees, they began to cut a fourth when it span on its stump, and the resulting force caused the tractor to overturn. The vehicle landed on top of Mr Fox and he died at the scene from crush injuries.

An HSE investigation found that the men were only trained to cut trees that measured 200mm in diameter but the trees they were working on measured 390mm in diameter.

HSE inspector David Butter told SHP that the work had been authorised by George Michael Thornhagh Foljambe, the controlling trustee of the estate who manages all staff activities. He assessed the work before it started and instructed the team to fell the trees.

Inspector Butter explained that the work was not properly planned and the method of work was unsuitable, as there were no measures in place to control the direction in which the trees fell. He said Foljambe should either have hired a competent contractor to carry out the work or ensured his staff were adequately trained. He added that one method of safely felling the tree would have involved using ground anchors and winches.

"Felling trees is a high-risk activity and anyone engaged in such activities needs to have had sufficient training for the task being undertaken and be provided with appropriate tools to enable them to carry out the task safely," said the inspector.

"These employees had not been trained to carry out felling on this size of tree and were using inappropriate tools to assist them, which has unfortunately resulted in a death of a husband and father."

Foljambe appeared at Nottingham Crown Court on 16 April and pleaded guilty to breaching s2(1) of the HSWA 1974, and reg.9(1) of PUWER 1998. He was fined £10,000 in total, plus £20,327 in costs.

In mitigation, he said he had no previous convictions and entered a guilty plea at the earliest opportunity. He expressed his deep regret for the incident and has subsequently provided additional training, so workers can now cut trees up to 380mm in diameter.

Story and image courtesy of Safety and Health Practitioner magazine

May 2012 – Safety Bulletin briefing

I have been personally briefed in the contents of this Safety Bulletin.

Please add any questions relating to this briefing or any other health and safety matters you wish to raise:

Please add any suggestions on health and safety matters:

I have been briefed by: _____ My District is: _____

I understand that I am encouraged to submit comment and contribution from this bulletin.

Signed: _____ Name: _____ Date: _____

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ORIGINAL sheet to be held at District.

Send a **COPY** to: Head of Safety, UPM Tilhill, Birchden Farm, Broadwater Forest Lane, Groombridge, Kent, TN3 9NR. Fax: 01892 860441.