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Preventing Workplace Injuries

Two recent WHS prosecutions in NSW were based on WHS failures that quite commonly result in serious injuries to workers. This article lists those failures and considers who could have prevented those injuries.

You may find it beneficial to compare the list of failures in this article with the systems of work in your workplace to see if any of these types of failures exist in your workplace.

The Forklift Incident

The incident occurred when a fork lift used in the warehouse collided with one of the workers who were supplied by a contractor to provide stock picking services. The judge concluded that the collision occurred because the PCBU:

- Did not develop and implement a traffic management plan and train all workers on its contents.
- Did not provide adequate information and training to workers concerning the risks of working in areas where forklifts were operating.
- Did not ensure that workers were appropriately supervised.
- Did not consult with the contractor in relation to training and supervision of its workers.
- Did not consult the significant amount of guidance material which was available on minimising the risk of injury from a forklift.
- Did have a safety system in place in relation to the movement of forklifts, but it was undocumented, and was not adequately conveyed to new workers in the factory.
- The injured worker began working at the premises only the day before the incident, and had clearly not been properly trained – she was a vulnerable new worker at the factory.

The Roller Mill Incident

This incident occurred when a worker was clearing the feed rollers on a roller mill that was used to grind wheat. The worker's hands were caught in the rollers. The judge concluded that the incident occurred because:

- There was no Safe Work Method Statement ('SWMS'), and no documented risk assessments or safe operating procedures for the task of cleaning the roller mill.

- The roller mill was not turned off while the clearing operation was being done.

- There were guarding mechanisms on the roller mill, but they were not permanently fixed or interlocked physical barriers. This meant that workers could remove the guarding with ease, whilst the roller mill was operating, thus allowing contact with the rollers.

- Adequate training, information and instruction had not been provided to the workers on how to isolate the power to the roller mill when it was being cleaned or maintained.

- There was no supervision of the workers whilst they were cleaning the roller mill.

Who Could Have Prevented These Injuries?

The PCBU could have prevented these injuries by authorising and ensuring that Managers, Supervisors and other workers used appropriate actions to ensure health and safety.

The PCBUs did not do that so the PCBUs were prosecuted. A PCBU has the primary duty of care which is why section 19 of the WHS Act appears frequently in prosecutions. In particular, sub section 19 (3) (f) occurs frequently and is the major deficiency that caused these 2 injuries. It says the PCBU;

"must ensure, so far as is reasonably practicable: the provision of any information, training, instruction or supervision that is necessary to protect all persons from risks to their health and safety arising from work carried out as part of the conduct of the business or undertaking,"

Before ticking off this requirement as being complied with for a particular task in your workplace you would first need to establish that effective risk controls were in place for that task.

Note

1. You can access the judgement in the forklift incident HERE
2. You can access the judgement in the roller mill incident HERE

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