Safety at the Crossroad
The Maritime Industry

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The MUA

- Approx. 11,129 Members in the following sectors
- Stevedoring
- Shipping
- Towage
- Port Authorities
- Diving
- Offshore oil industry

OHS Regulatory Frameworks

- Seafarers-SEACARE Workers Compensation and Maritime OHS Act
- Stevedoring-State Jurisdiction with compliance of National Codes/Standards
- Towage-State Jurisdictions
- Port Authority-State Jurisdictions
- Diving-State Jurisdictions with compliance to International and National Standards
- Offshore Oil Industry-NOPSA/State/National

Safety at the Crossroad

- Recent tragic fatal accidents during stevedoring activities in AUSTRALIAN PORTS

- Victoria 2005-one death

- South Australia 2006-one death

- Victoria 2007 two deaths

WORLD

- Every day in the world (on average) a seafarer or dock worker is killed on the job

Which “Safety Road” do we take?

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OCT 1973

THREE LOST AT SEA

3 Dead, 7 Survive

BLYTHE STAR LOSS

All five Seamen's Union mem-

Seamen's JOURNAL

VOL. 30, No. 1 JANUARY, 1975 Issued Gratis

JAN 1975

FIVE LOST IN BRIDGE TRAGEDY

Lake Illawarra loss — Hobart maritime tragedy

The tragic loss of *Lake Illawarra* in the Derwent River, Hobart, on Sunday, January 5, once again demonstrated the unexpected

26 ft. 9 in. (8.15 m). The ship's

Five workers gassed in Port of Geelong

Waterside workers narrowly escape death after suction fan below deck malfunctions

FIVE waterside workers had to be hospitalised last month after suffering overexposure to carbon monoxide. The men collapsed while working down the hatch of the Sky Trader, discharging frozen orange juice on the morning shift, June 28. Some were able to make it up the ladder before losing consciousness, others had to be carried out on trays by rope.

Ambulances were called to the scene and the men were sent to casualty for observation.

The Department of Transport inspector called to the scene reported a build up of carbon monoxide emitted from the fork-lift working in hatch 1 caused by malfunctioning extraction system in that hold.

Samples of air take from the hold detected carbon monoxide levels at between 400ppm to 600 ppm - 10 times the safe level.

The inspector also found the ventilation system in no 4 cargo hold to be of no effect. There was no air flow and work was restricted to no 1,2 and 3 [illegible] beneath the coaming before I turned it off. I didn't know at that stage what had caused the problem.

"I felt a bit funny. It was five below zero and I started to feel wheezy. Everything started to happen in slow motion. I climbed up out of the hatch then collapsed on the deck for a few minutes before picking myself up and moving away from the hatch. When I tried to walk again I felt drunk and couldn't control my movements.

"Another bloke collapsed in front of me. At first I thought he'd knocked it. That really upset me.

"I saw him move his hand and was starting to feel a bit better, when they brought up a guy stretched out on a tray. He really looked dead.

"The crane driver lifted them to shore and loaded them into an ambulance.

"I was high as a kite. There was only one ambulance at first so I asked my workmate to ring my wife but as I handed over my number I collapsed again.

"They carried me ashore and loaded [illegible] ambulance. In the ambu-

Chemical spill

[illegible] Chemical spill at Port Botany

THE Sydney Branch has called a meeting with Department of Industrial Relations inspectors and other interested parties, to discuss a spate of chemical accidents on the waterfront. In the three most recent incidents, workers at Port Botany narrowly escaped injury again, but recently when lethal chemicals escaped from drums.

Branch vigilance officer Ken Brinsden reports that the leak was first discovered by workers and seamen at the terminal. The spillage, containing organic phosphate ester, could have proved fatal if absorbed into the skin.

Man killed at Port Botany

MWJ June 1987

By John Coombs, federal organiser and WWF representative on the FAC

SYDNEY, May 30: A forklift ran over a foreman at ANL terminal on the day shift, crushing his chest and killing him instantly. The man was knocked down by the forklift that was carrying a container to the stacking area.

He was on the terminal on foot because the utility he was meant to be using had a flat tyre. The forklift had no reverse controls; visibility was impaired due to the container it was carrying.

At the time of the accident, 9.45 am, the operations underway at the terminal included rail receival, stacking of containers, and loading of containers onto a ro ro vessel.

An immediate inspection of the accident site revealed that the industry agreed recommendations for container handling equipment had either not been adhered to or were totally ignored. This led to the accident and loss of life.

Any industrial accident which results in the death of a worker invariably is followed by a call for increased safety standards. This is precisely what oc-

POLICE at Port Botany with union officials and witnesses after the accide forklift that ran over the man is in the background.

fatality in Port Melbourne. At that time a sub-committee of the Federal Advi-

bility of updating and review

followed by a call for increased safety standards. This is precisely what occured in July 1986 following the double

fatality in Port Melbourne. At that time a sub-committee of the Federal Advisory Committee was given the responsi-

MWJ June 1987

Tradesman killed in 70 foot fall

MELBOURNE: A man died after falling 70 feet from a crane he was repairing on a midnight shift at Seatainer terminal, Melbourne, last month.

Tradesman, Danny Briggs, 50, was instructed to check the cross travel cables on a No 2 OHT crane, with two other maintenance men at about 1 am on Saturday, May 2.

tenance men working cranes.

Branch secretary, Claude Cumberlidge, told the *Maritime Worker* that the tradesmen on the crane had been communicating with the driver by knocking on the metal rails.

"And this is 1987!" he said. "The only way the driver could know whether to stop or start the crane was by straining to hear the number of knocks. It was so primitive.

WORKER

Volume 72, No 5

June 1987

WWF bans Fiji cargo, p6

Two men killed on the job, p3

Why vote Labor?

On July 11 Australians will elect a full ticket of Senate and House of Representatives members.

This arises from the May 27 announcement of a double dissolution.

The election comes at a time when the so-called "New Right" (which represents extreme conservative forces) are on the attack. Notwithstanding that the Opposition is in some disarray due to the collapse of the coalition between the Liberals and the Nationals, the Right represents a real threat.

Pressure from the New Right has caused the Liberal Party to adopt more extreme conservative attitudes than in the past.

This has also had an effect on the Labor Party which seeks (as do all parties) to hold its base support, while winning a major slice of the centre ground — the "swinging votes".

In many respects the trade union movement has been disappointed with the performance of this Government.

It has to be stated, quite frankly, that some traditional Labor voters are saying 'What is the difference between the Liberals and Labor — Tweedledum, Tweedledee?"

This is a dangerous attitude for any sector of the labour movement to adopt.

The real choice facing Australians is whether to vote for a centre-right Labor Government or an extreme right Thatcher-type government.

Notwithstanding all the complexitities, faced with that choice, there can be no doubt that the union movement must support the Labor Party.

Cherrypicker ripe for fall

A new accident demonstrates danger of old machinery

SYDNEY, MARCH 6: Two workers narrowly escaped serious injury on the morning shift when the cable on a cherrypicker they were using as a work platform gave way.

The two men, Mario Borg, fitter's mate, and Howard Devenish, fitter, both of Patrick's Glebe Island terminal, were almost at ground level when the basket they were in sprang back. Borg was thrown out on to the ground, while Devenish fell on his side into the bottom of the basket.

"It just spewed me out," Borg told *e Maritime Worker*.

"As Mario was thrown out his foot ught me in the head," said Devenish. e were fortunate that it happened en we were on ground level and not 15 metres in the air. Otherwise e would have been a fatality for ."

Devenish and Borg: Lucky to be alive.

h and Borg said they were n repairing the transtainer

back down when the cable snapped.

"The first thing I knew I was on the ground," Borg said. "My back and knee were hurt — otherwise I was okay."

Both men said that the accident was to be expected considering the age and condition of the machine.

"The cable was covered with fibreglass, so we could not tell what condition it was in. But we commission the machine was in a bad way," said Devenish.

"It had been bought secondhand and on the cheap. But it passed an inspection by the Department of Industrial Relations, and we were told it was safe. Later when they removed the fibreglass covering the cable Devonish said the anchor had completely rusted through.

Last month's accident was not the first involving the cherrypicker. The controls on the machine had never been working well. Brian McGrath, fitters mate, who was driving the machine at the time of the accident said the it was

Devenish shows how the basket sprang back.

erected a steel frame to protect the glass.)

The tradesmen had originally been doing repair work from a back fixed to a forklift. But Patricks decided to buy the cherrypicker. The workers were not consulted over the purchase of the machine, which was already old when the company bought it.

The accident comes at a time when the condition of stevedoring machinery has been under focus. Employers submitted a paper to the Moore Commission (SIRC), accusing Federation members of fabricating safety disputes and refusing to drive machinery for political/industrial rather than practical reasons.

They complained about the high level of equipment downtime at ports — something also highlighted in last year's Webber Report (Industry Task Force on Shore Based Shipping Costs).

But this year when the Federation called a special federal council meeting to prepare for the Commission the truth came out — antiquated machinery, unserviced machinery, lack of consultation

TWO MELBOURNE DEATHS

By Acting General Secretary TAS BULL

ON May 18 a serious accident occurred in Melbourne, resulting in the death of two mem bers.

As Maritime Worker goes to press, the precise cause of the accident remains unclear.

There will need to be a Coroner's inquest.

However, it can be said with absolute certainty that a number of industry-agreed recommendations which should apply to operations involving the handling of containers and heavy mechanical equipment (especially where there is an interface between "pedestrian" workers and heavy mechanical equipment) were either ignored or breached at the job in question.

On May 20, with Branch Officers, the Melbourne Branch lawyer and various Departmental representatives, I inspected the site.

It was clear to all that the "arrangement" of the job fell far short of what was required to guarantee a safe operation.

Industry Recommendations

On May 26, 1980, the Federal Advisory Committee (representing employers, unions and the Department of Transport) issued recommendations to ensure safety in such operations.

These were developed by a Technical Committee of the Federal Advisory Committee, following fatalities in several ports and dealt with the design of fork trucks, minimum visibility standards, requirements for drivers and operational requirements.

Enforcing Safety

should be applied wherever practicable, was essential.

It is therefore recommended that:

a) Adequate clearances shall be provided for safe passing where aisles are used for the simultaneous passage of trucks, pedestrians and other traffic.

b) Aisles intended for the passage of powered trucks shall be defined or marked out and shall be arranged so as to facilitate safe manoeuvring of the trucks.

Color of Machines

No specific color is recommended for use in the industry, however, employers should

are painted in a color that is conspicuous in a working environment and hazard striped where necessary.

Particular emphasis should be placed on counterweights.

Flashing Lights

It is recommended that all container handling forklift trucks be fitted with automatic flashing lights.

Lights should be orange in color, this being considered most appropriate for the industry.

Audible Alarms

Due to variations in operational circumstances, no firm recommendation on the fitting of audible alarms is made. However, it is recommend

MARITIME WORKER

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Federal Council '86. Full report p 17

Worker killed, Port Fremantle, p 3

Safety Watch

DEATHS ON WHARVES

By Federal Organiser, J. COOMBS

An accident in Melbourne has resulted in the deaths of two waterside workers. This most recent tragedy follows closely on the death of a foreman stevedore at Burnie.

ANL Terminal — Burnie

During normal operations in clear weather, a foreman stevedore was knocked down and killed by a forklift.

The forklift was in the process of making a 180° turn prior to moving towards a truck to receive a container.

There was no obvious explanation of the accident.

The dead man had been wearing a safety vest.

Venture Star — Melbourne

Two watersiders working as lashers were removing twist-locks from the top of the first tier of containers stowed on the hatch lids.

They had been using a portable aluminium ladder which was still resting against a container apparently standing adjacent to the ladder when the container from the starboard side of the vessel, which was being discharged over the ladder, came into contact with it.

The ladder bowed and then sprung, catapulting he deceased to the deck below.

dbod — Melbourne

waterside worker was driving a prime r with a 40ft trailer carrying steel bars. e traversing the ramp, the turntab sing the driver to lose contro hicle subsequently ran

tor suffered

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ry",
ebration. Mr
also said that he
e Vietnamese protes-
re not para-military.
They were too young. They
didn't try to come in the win-
dows. They didn't seem all that
organised.
"Anyway there were no Viet-
namese protestors at our func-
tion.
"It was obvious the police
d spoken to them.
l only noticed one suspicious
n and he was one of the
white Australians who
ed on protestors at the
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ions know how to or-
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violence is fin-


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An example of a task of loading a “Heavy Lift” onto a vessel gone wrong

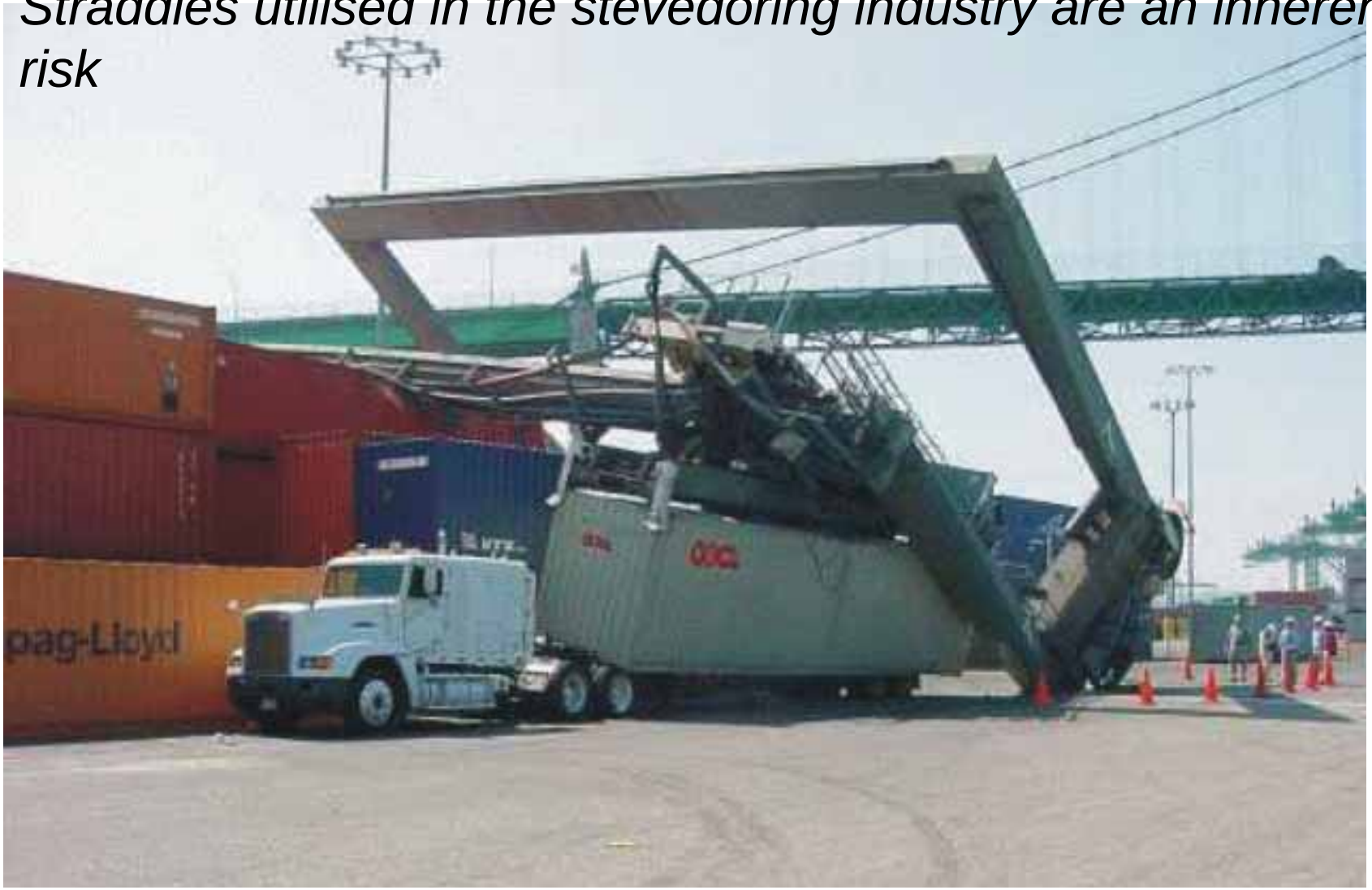
Appropriate type of vessel utilised

Correct procedures followed on shore with correct equipment

So what went wrong?

The “Root Cause” of this incident was traced back to vessel’s crew not been properly qualified and lacking the required experience

Straddles utilised in the stevedoring industry are an inherent risk



The driver escaped serious injury

The risks encountered by shore workers recovering cargo after a vessel has been through a Typhoon

This what's happens when a vessel is not maintained and is still sailing “after use by date”

Collapsed Quay Crane after berthing vessel “Clipped it”

Hazards at sea.

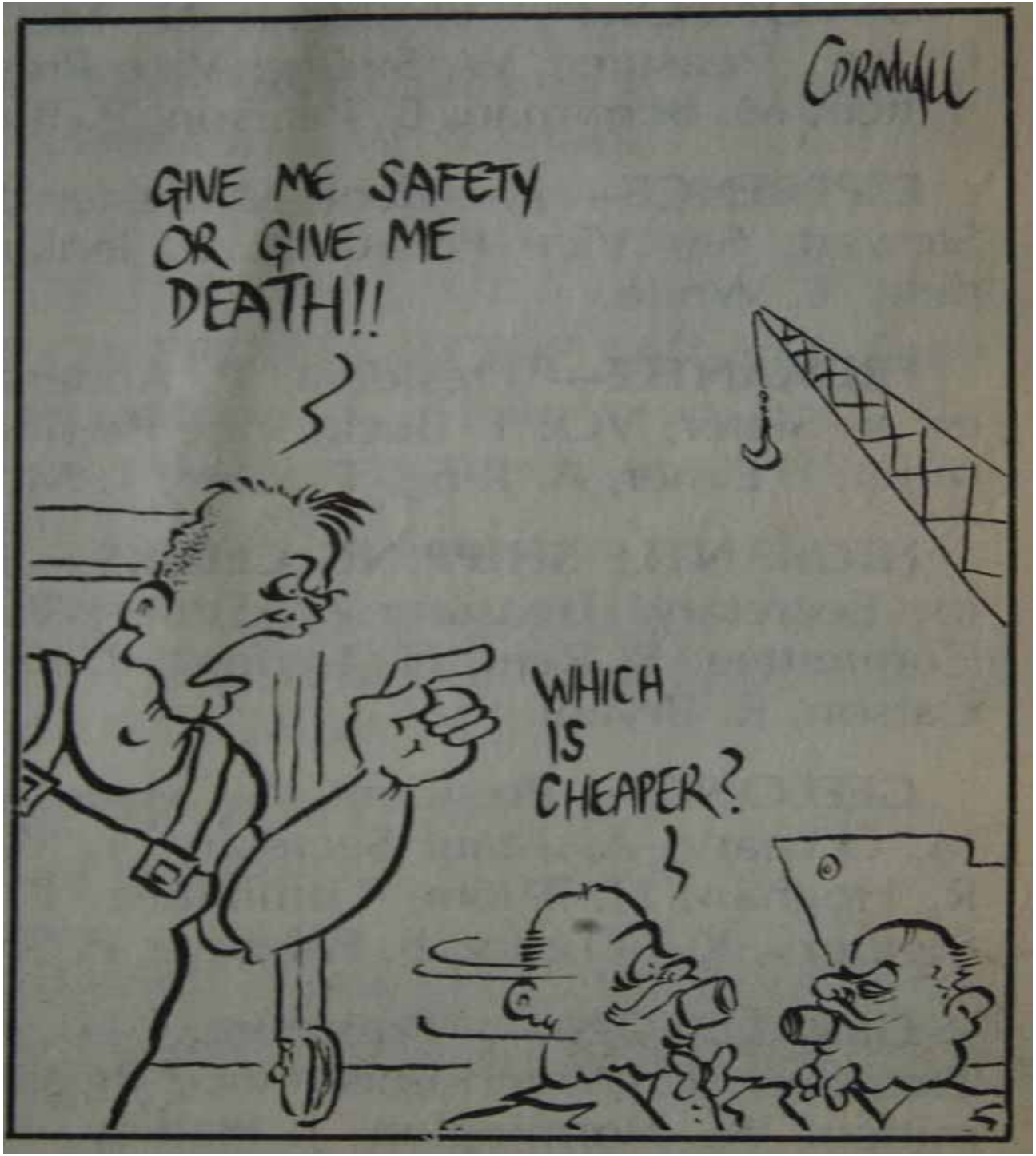
Forward deck of vessel in storm!!!

Australian Shipping Industry

- Seafarers-reduction in incidents/fatalities over last 5 years
- Why? Engagement of all stakeholders in the industry
- Recognition of need to train/induction in OHS
- Analysis of all incidents lead to review of procedures
- Ownership of OHS recognised as an important issue

Australian Stevedoring Industry

- De-regulation of industry in 1992
- Massive loss of experienced operators
- Led to introduction of “Casualisation”
- New employed Supervisory staff lacking experience in un/loading vessels (Same applies today)
- Lack of current national OHS Standards


CORNWALL
GIVE ME SAFETY OR GIVE ME DEATH!!
WHICH IS CHEAPER?

National Stevedoring Code of Practice

- Importance of moving quickly to establish a new national occupational safety standard for the Australian stevedoring industry to prevent further injury and deaths
- Occupational safety standard is usually implemented by way of regulation under relevant legislation and regulations and supported by a code of practice (COP)

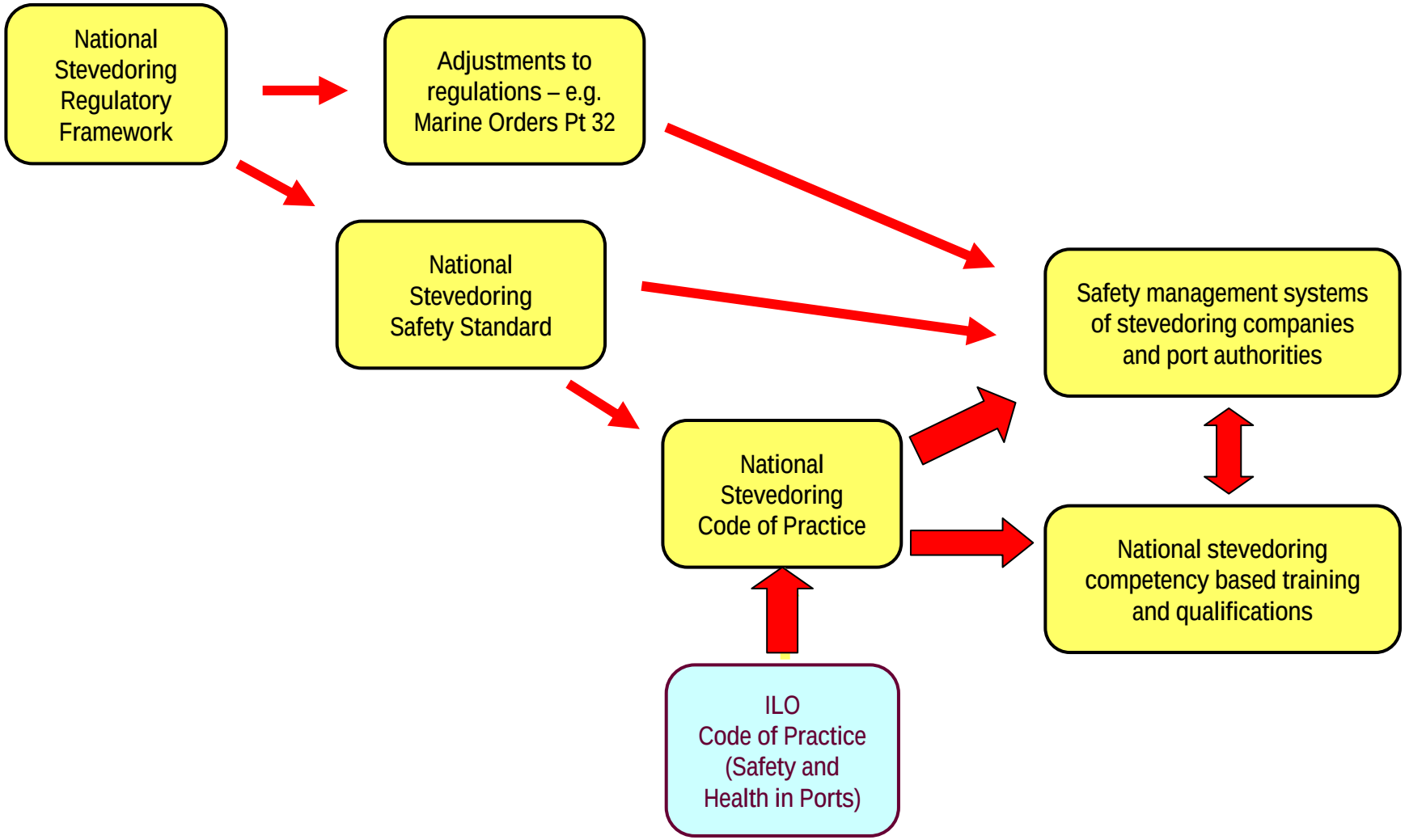
National Stevedoring Code of Practice

- Legislative requirements and the associated regulations and safety standard and COP are put into effect through…..
  - the safety management systems of companies and ports and
  - a national competency-based system of training, assessment and qualifications)

- Research undertaken by the MUA has indicated that the existing *ILO Code of Practice 'Safety and Health in Ports'* would provide a sound basis for an Australian Stevedoring COP

- The Stevedoring Sector Committee for the National Transport and Logistics Training Package has already identified safety management as a priority area for the further development of competency-based stevedoring training and qualifications

Proposed approach to safety management for stevedoring in Australian Ports



National Stevedoring Code of Practice

- Development process
  - Engagement with Stevedoring employers
  - Engagement with State Governments
  - Presentation to Australian Safety and Compensation Council (ASCC)

National Stevedoring Code of Practice

- Progress report
  - ASCC agrees to conduct “Gap Analysis” of Commonwealth and State OHS
  - Victorian Worksafe commences development of “Compliance Guidelines” via stakeholders forums
  - State Government ministers agree in principle to support development of NSCOP

Which "Safety Road" do we take

The "Road" to Safety → "HIGH" road

Based upon

- Consultation
  - Engagement of all stakeholder
  - Value input and views of workers
  - Fully inducted and trained personnel
  - Continual review of system
  - Collection of data and analysis
  - Performance and audits of system
  - Implementation of Code of Practice
  - Development of "over pinning" regulation