Health, Safety and Wellbeing Update

February 2023

Wellington Water

Our water, our future.

Contents

Welcome to a newer version of the Health Safety and Wellbeing Monthly Focus.

Each month we will cover off a topic as we have done in the past but we will share some other Health, Safety and Wellbeing info with you as well.

If there's anything you want to see from us in 2023 please let us know!

Noteworthy Incidents & Injuries

- A worker received second-degree burns when using a crack bandaging machine. The machine had run low of rubberized bitumen and needed topping up. The worker removed his gloves to unpack a new block. While inserting the cold block into the machine, the bitumen (200 °C) splashed up onto his left hand scolding the top of his 4 fingers.
- The worker ran his hand under cold water for 45 minutes before going to A&E.
- The worker has made a full recovery and the process has been updated with chemical and heat resistant gloves.

Band sealing machine

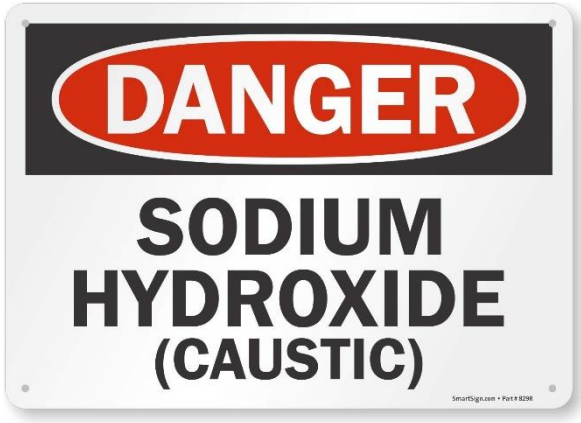
Left hand immediately following incident

Left hand two months after incident

Updated hot work gloves for the task

Something Goods

- There was a shortfall of sodium hydroxide at the Greytown Water Treatment Plant. The only way to get supply was to decant, transport, and top up with the supply from another plant. This would have posed multiple health and safety risks due to chemical handling, manual handling, and dangerous goods transport. All on a Friday afternoon!
  - It was agreed that these risks were too great, and the small increases of PH on the system for the weekend was tolerable.
  - This was a great example where the team made the right decision to assess the risk and decide not to handle the chemical in an unsafe way. Coupled with the external pressure from the public this was a good example of putting safety first.



- Contractors were excavating for a new sewer lateral connection. There was no cables on the service plans, and nothing pick up by ground penetrating radar. The workers noticed a change in the ground conditions so swapped to hand digging and found unmarked Vodafone cables.
  - This was a great example of recognising a change in conditions and changing the work method

Safety Alerts

Lock Out/Tag Out Failure – Wastewater in Excavation

In November 2022 wastewater began discharging into an open excavation after a lockout was removed from a nearby wastewater pump.

No crew or plant were in the excavation at the time, but there were nearby workers that were able to notify the WWL COG utilities team by phone call and subsequently shut the pump down. The wastewater was caught within the excavation.

What went wrong?

- The isolation was carried out by the contractor under instruction from Wellington Water.
- The pump was isolated with a *zip tie* – **No Lock** and **No Tag** was used.
  - This was in case the pump needed to be operated by Wellington Water during an emergency .
- The shutdown plan did not reference the Wellington Water Lock Out/ Tag Out Procedure.
- Key stakeholders (e.g., COG Utilities Team) were only involved with the shut down after the plan was approved and there was poor clarity around trial shutdowns vs. actual shutdowns.

Solution:

1. Always refer to the Wellington Water Lock Out/ Tag Out Procedure when isolating Wellington Water assets
2. Ensure everyone impacted by the lockout is aware of the isolation plan
3. Always Tag Out isolated equipment, Lock Out where possible

Safety Alerts

High Pressure Hoses – Controlling the Risk

From 01 April 2023 the following requirements apply at all Wellington Water sites (including all contractors and sub-contractors):

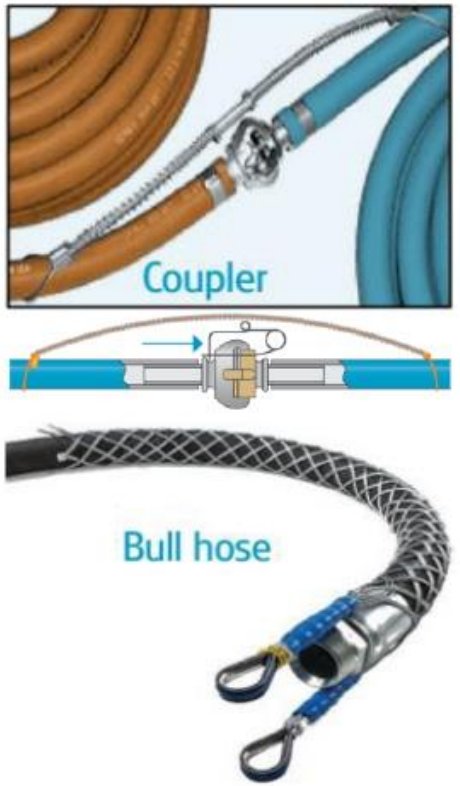
- All pressurised hoses used on Wellington Water sites must be fitted with appropriate hose restraints to prevent the hose/ pipe from flailing if it uncouples. This applies to:
  - High Pressure Jetting Operations (Defined as Class A and B in AS/NZS 4233.2:2013)
  - Compressed Air Hoses

Risk:

- In 2022 a Wellington Water contractor had a serious incident when they were struck on the head twice by a flailing jet flusher hose.
- In 2016, at the yard of a Fulton Hogan joint venture in Fiji, a worker was killed when a high-pressure water hose failed at a connector and whipped around striking the operator on the head.
- In 2012, A Downer worker engaged to break up rocks following a significant rock fall on Milford Road received fatal head injuries when an air compressor hose suddenly detached. The flailing hose whipped around and struck him on the head. He was wearing a hard hat at the time

Solution:

- Always fit the appropriate hose restraints before starting:
  - "Bull hoses" or hoses greater than 50 mm require purpose fitted and engineered whip socks.
  - Hoses with "twist and connect" style couplers typically have an internal measurement of 24mm +/- and these require the use of whip checks and locking pins
- When you need whip checks or whip socks, make sure these are installed at every connection point: where the hose connects to the compressor outlet, at every hose-to-hose connection, and at every hose to tool connection.
- If you are unsure on the appropriate solution for your equipment speak to a member of the Wellington Water Health and Safety Team



Topic of the month

Change Management

When something (or someone) changes during works, which has led to a change of process, this potentially creates new hazards that may need new controls.

Topic of the month - Change Management

Operator was operating a digger adjacent to an overhead power supply. The operator has lifted the boom and connected with a 240v cable. The post the cable was hanging from broke, leaving the cable hanging on the boom of the digger. The team has failed to identify the cable, reassess the risks and hazards associated with their works in this newly available area made possible by the demolition of a shed.

The root cause of this incident was a lack of planning including hazard identification following changes to the work area.

Topic of the month - Change Management

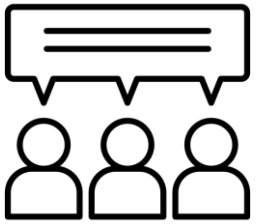
Something changes

- Materials used or handled
- Weather
- New tools or plant are introduced
- Works extend or veer from the plan
- Time has lapsed and the site or area has slowly changed over time
- Wear and tear

Someone changes

- Someone changes within the team
- Someone new arrives on site
- Shift change over or handover of a job

Topic of the month - Change Management



Discussion point:
Chat amongst your team about any situations when you've had to stop work and reassess due to change

What should we do when something changes?

Stop work and reassess

- Ensure that all hazards are identified and implement extra controls
- Update your RCP and re-induct everyone on site
- Check to see if you need other permits, more mark outs, different machinery, WorkSafe notifications etc

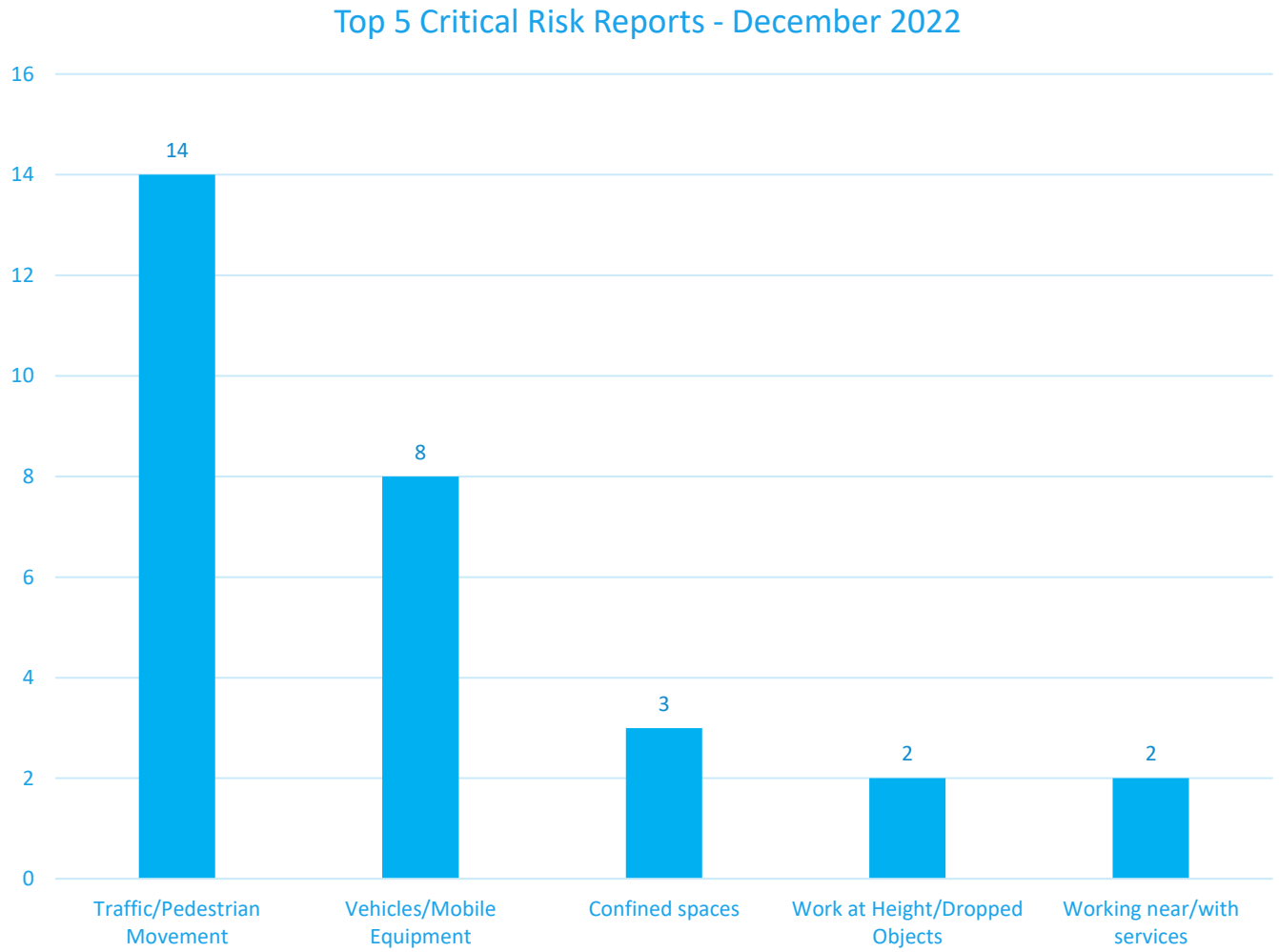
Induct any new people on site as soon as they arrive, including handovers, new shifts, contractors, consultants, utility providers etc

- Give thorough handovers, including all hazards, controls, service locations, markouts etc

If you are unsure STOP and ask – protect yourself and the people around you

Critical Risk Stats - December

- In December there were 42 reported critical incidents, this is a decrease from November (59)
- Traffic/Pedestrian Movement was our highest reported critical risk this month with 14 reports, followed by Vehicles/Mobile Equipment at 8



WorkSafe Updates

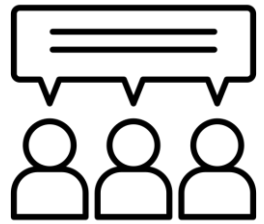
WORKSAFE NEW ZEALAND | MAHI HAUMARU AOTEAROA

Death a reminder to keep an eye on field staff

- WorkSafe New Zealand has found inadequate training and supervision contributed to the death of a forestry technician in northern Hawke's Bay.
- The man was repairing a mechanical attachment, known as a harvester head, when the device was activated by being manually spun. The 48-year-old was fatally crushed.
- The technician had been inadequately trained about the risks and controls involved in the job and weren't properly monitored to correct any unsafe practices.

Worker's hand injury prompts renewed safety focus

- While working on a steel bending and pressing machine, a worker became unbalanced, and his left hand slipped into the pressing mechanism as it was operating.
- The incident resulted in partial amputation of a finger, and the victim was off work for two months recovering.
- "This machine was not fitted with any observable safety devices whatsoever. It was possible to have physical guards and safety sensors installed on the machine, which would have protected the workers using it," says WorkSafe's area investigation manager, Danielle Henry.



Discussion point:
Are we all supported with adequate training?
Do our supervisors and managers check up on us and show us support?
Are our tools and equipment appropriately guarded?