"If you can, someone will" Winder injury







Kenneth D Fox Corp Manager Safety & Health



Introduction & Purpose





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Our group strategy

Through intentional evolution we will continue to grow Sappi into a profitable and cash-generative diversified woodfibre group — focused on dissolving wood pulp, paper and products in adjacent fields.



Sappi's International Footprint

GLOBAL REACH

PAPER CAPACITY: approx. 6.1 million short tons PAPER PULP CAPACITY: 1.7 million short tons SPECIALISED CELLULOSE CAPACITY: 2.1 million short tons

We employ over 13,700 people in 20 countries worldwide



Mills

Sales offices

Sappi North America Operations



Somerset Mill



Safety

Do You Know What's in Your Safety Circle?

Imagine a 10-foot circle around you.

What are the hazards in that area? Think ahead, what could potentially go wrong? Identify and understand the hazards before they do harm.



sappi

Somerset Mill Emergency Phone Number: x5222



Aesop's: Circle of Safety The Four Oxen and the Lion

A Lion used to prowl about a field in which Four Oxen used to dwell. Many a time he tried to attack them; but whenever he came near they turned their tails to one another, so that whichever way he approached them he was met by the horns of one of them. At last, however, they fell a-quarrelling among themselves, and each went off to pasture alone in a separate corner of the field. Then the Lion attacked them one by one and soon made a meal of all four.

Moral of Aesop's Fable: United we stand, divided we fail

If you really want to live in safety, keep close to your friends, retain your confidence in them and challenge your enemies. Sappi

Inspired by life

Overview of Incident

- On February 10th, 2011, an employee slipped/tripped while working at **Salvage Winder #1**.
- The winder was at thread speed when her right hand fell against the drive drums. While pulling that hand back, the employee's left arm went between the winder drums and the empty core.
- The core carriage was moving into the drum
- The employee pulled the emergency-stop cable located above the ingoing nip, but received a severe crushing injury to the left forearm.









Injury Investigation

Investigation Process

Team: Safety & Security Managers, F&S Operator, PM1 Winder Operator, F&S Shop Steward, USW Safety Council member, F&S Managers.

- Joint investigation team with **no-discipline guarantee.**
- The team was initially unable to interview the injured Employee, and the witnesses did not see the actual event occur.
- •The team built a root cause tree that compiled possible scenarios that could have resulted in the injury.
- The goal of the team was to correct **all possible scenarios**, not just the one that actually occurred.

Root Causes (possible)

- 1. Slip/trip hazards: uneven floor, gaps in floor, slippery surface, obstacles
- 2. Job required the operator to do tasks in a hazardous area: threading, re-positioning core, taking tape off of core, flattening sheet, etc
- 3. Machine was turning at thread speed (40 fpm) at time of injury: only run (not thread) logic included photo eye protection due to tasks requiring winder to be turning with operator in area
- 4. Station carriages could move with operator in the area: Line of fire, no safeguards incorporated into winder design
- 5. Exposed nip point: original machine design

Injury Investigation Q: Why did she get into the winder?

A: Because she could!

•The team tackled the injury investigation with a shared belief that if you put a hazard in a work area, then sooner or later someone will get into that hazard.

•The goal was to eliminate the hazard or minimize risk using an appropriate hierarchy of controls.

1. Addressed slip/trip hazards

2. Changed interlock so that winder goes to emergencystop mode anytime the light beam is crossed.

Sappi Inspired by life #1 Salvage Winder 10 Feb., 2011 Post Accident - Before Improvements

Privileged and Confidential Attorney Client Communications

Inspired by life

 Changed "carriage in" logic to ensure that the operator is physically positioned away from the hazard when the core moves towards the nip point.

4. Installed new threading air shower to blow paper off of bottom drum while threading prior to wrapping core; this allows threading without entering the hazard zone.

- 5. Installed new audible and visible alarms activated by the emergency stop circuit to alert other operators of an emergency.
- 6. Updated risk assessments, operator work instructions, and qualifications checklist for the winder.
 - Even though we did a risk assessment on this task, we did not identify the hazard that the employee was exposed to. We need to look at tasks with an unbiased eye and carefully observe the task being done to make sure we do not miss any hazards in the risk assessment.

Other Comments

Critical incident social counselor brought onsite (EAP).

OSHA Compliance Officer found the mill to be compliant with applicable regulations.

- •"Legal" does not equal "safe".
- •This equipment had been observed by OSHA during 2009 machine guarding audit.

What about the personal responsibility of the injured employee?

- •Safe conditions and safe behaviors are both required.
- •Difficult to find fault with the employee's behaviors in this incident.

Inspired by life

What did we do?

- VP of Manufacturing "No one gets caught in a nip again"
- Analyze all captured winder injuries and near misses.
- Two mill OLD managers
- Assembled a team GOYA Operations supervisors and manager
 - Experienced winder Engineers
 - o Safety
- Set the Stage & GLAS
- What did we find?

Intentional evolution

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Thank you

