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Issue Number 0807

Tissue Mill – Perini Winder Fatality

On 8th November 2007, a Unite member, Chris Massey, was killed in an accident at Kimberly Clark tissue mill in Barrow.

After requests from Unite, Kimberly-Clark has issued the following statement:

“On Thursday 8th November, Chris Massey a Maintainer/Operator at Kimberly-Clark’s tissue mill in Barrow-in-Furness, was involved in a fatal accident while working on a Perini 900 series winder.

The accident is still under investigation by the Health and Safety Executive, and by Kimberly-Clark in order to identify the root cause of this tragic event.

It is good industry practise for all companies to ensure risk assessments of their winder operations take place after an accident like this and in particular, that you once again establish that:

- All parts of machines are properly guarded;
- Safe Systems of Work are in place;
- Any manual interventions are strictly governed by agreed Standard Operating Procedures;
- All personnel are competent

All companies should pay particular attention to the PABIAC guidance “Rewinding paper safely: Safe use of reeling and slitting machines”, available free on the HSE website at - www.hse.gov.uk/pubns/web07.pdf.”

Unite has investigated this accident further and believes that more information should be made available in the short term to encourage preventive action elsewhere, without attributing blame in any way in relation to this accident.

The circumstances of the accident are believed to be as follows. The machine involved takes tissue reels from pre-loaded carriages. This machine had been modified by the manufacturers to take two ply reels. Chris Massey was trapped by a cross bar connecting two guards, fitted as part of the modification, when the carriage was moving into position as part of a reel change.

Other companies should use this information and the statement from the company to ensure that any similar equipment is fully guarded and only operated under safe procedures.

Company Action

Companies should raise the attached information with their employers, and ensure that:

- a similar incident cannot occur;
- full account is taken of the PABIAC guidance on reelers and slitters
- safety reps and operatives are fully involved in investigations and risk assessments, etc.