A 41 **year old female** was fatally injured when she was crushed between a pallet lift and the frame of the machine.

The victim was a temporary employee assigned to operate a machine called a pallet de-stacker. The overall process utilizes three stationary conveyor platforms and one conveyor platform fitted with a scissor-style lift (scissor-lift platform). The stationary platforms utilize an electronic "eye" recessed in the floor of the platform that senses the presence of a pallet, causing the chain conveyors to automatically start and stop. The scissor platform is similar; however, when the presence of a pallet is detected, the scissor lift operates, raising the platform at a speed of two feet per second. In addition to the platforms, a square magnetized "head" extends outward to pick a layer of cans to place them on a conveyor. The entire process is automatic as long as the operator sets the controls as such: there is also a manual function.

Assuming the controls are in automatic, the process begins when a forklift operator places a pallet of product (cans of beans) on the stationary platform furthest to the right of the scissor-lift platform (assuming the operator is facing the scissor-lift platform from the operator platform). The electronic eye triggers the conveyor to move the pallet to the left, and assuming the scissor-lift platform is in the down position and empty, that platform will move the pallet to the left and onto the scissor-lift platform. Once the electronic eye on the scissor-lift platform detects the pallet, the platform will raise at a speed of two feet per second. The magnetized head and scissor-lift platform work in tandem (with the use of sensor equipment) to systematically and automatically unload the entire pallet. Once the pallet is empty, the scissor-lift platform will lower to the down position and the conveyor will move the empty pallet to the left and onto the last stationary platform, where it will be removed from the machine.

Interviews indicated that the victim was observed cleaning around the machine with a broom and an air hose, first sweeping the platforms and then utilizing the air hose to blow out the recessed openings containing the electronic eyes. Apparently, the operator controls for the de-stacker were in the "automatic" position so when she unintentionally activated the electronic eye, the platform to lifted, catching her and pulling her into a pinch-point between the platform and machinery frame.

Citation(s) as Originally Issued

A complete inspection was conducted at the accident scene. Some of the items cited may not directly relate to the fatality.

<u>Citation 1 Item 1</u> Type of Violation: Serious \$4000

29 CFR 1910.147(c)(4)(i): Procedures were not developed, documented and utilized for the control of potentially hazardous energy when employees were engaged in activities covered by this section:

In that machine-specific lockout/tagout procedures were not utilized by the company for the pallet de-stacking machine in the bright stack area, which employees enter to perform cleaning activities.

<u>Citation 1 Item 2</u> Type of Violation: Serious \$4000

29 CFR 1910.212(a)(1): One or more methods of machine guarding was not provided to protect the operator and other employees in the machine area from hazards such as those created by point of operation, ingoing nip points, rotating parts, flying chips and sparks:

In that one employee operating a pallet de-stacking machine in the bright stack area was exposed to caught-in hazards and was not protected by machine guarding.

Citation 2 Item 1 Type of Violation: Other-than-Serious \$175

29 CFR 1910.l200(h)(1): The employer did not provide employees with effective information and training on hazardous chemicals in their work area at the time of their initial assignment and whenever a new chemical hazard the employees have not previously been trained about is introduced into their work area:

In that two employees working in the bright stack area were utilizing hazardous chemicals and had not received Hazard Communication training.

Photo shows the scissor-lift platform in the up position. The decedent was removed, and the machine was turned off and locked out in this position.



Photo shows the space into which the employee entered to clean. It is believed that she entered from the opposite side (note the air hose).

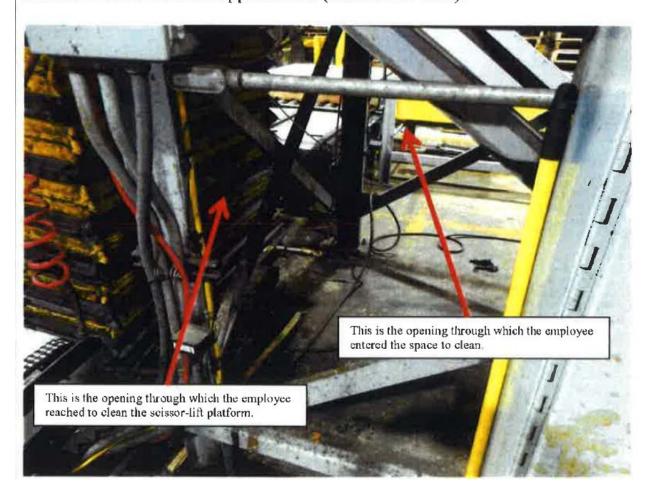


Photo shows the top of the scissor-lift platform that the decedent was cleaning at the time of the incident. The arrow denotes the location of the recessed electronic eye.

