Crushed by wood pack—Insp # 1696239 C-Wood Lumber Co., Inc.

A **57 year old male** was crushed between a pack of wood and the discharge roller conveyor in the Green Chain area as a pack of wood was being moved down the conveyor by the operator.

The victim was the Supervisor over the Green Chain area and his main job duty was to keep the area running, make tickets and place the tickets on the finished packs of wood. The Green Chain area takes bundles of wood received at the site and de-stacks the wood and re-stacks the wood with "sticks" placed between each layer. The "sticks" are placed between the layers to allow the air to enter the wood while it is in the kiln to enable the drying process to work more efficiently. The victim was working with the Green Chain employees to install "sticks" between the boards. At the time of the incident, the area was running 1" x 6" boards that were 16 feet long. Each finished pack of wood contained 26 layers of boards with each layer made up of 11 boards. It was estimated that each pack of these boards weighed approximately 3500 pounds.

With a pack of wood built, the operator yells to make sure no one is around the discharge roller area and lowers the pack of wood onto the roller conveyor and starts the conveyor. This conveyor carries the pack about 20 feet where it stops. Stopping in this area allows the employee to count and make sure the correct number of boards are contained in a pack and place a 4" x 4" on top of the pack for stacking packs inside the kiln. Once counted, the victim would enter the office area and print a ticket off, leave the office area and place the ticket on each side of the pack. These tickets are to be placed on the packs when the wood has traveled to the end of the chain conveyor where the forklift removes it from the area. Interviews indicated that the victim was seen a couple of times a day on the roller conveyor or between the rollers of the conveyor normally using a hammer to drive boards back into the pack or maybe counting the boards contained in a pack.

Video footing from the day of the incident showed the victim on top of the roller conveyor prior to the pack entering the area where the incident occurred. After descending from the roller conveyor, the victim entered and exited the office area and appeared to climb back up onto the roller conveyor. As his head was shown rising, which is believed when the victim was climbing onto the roller conveyor, he disappeared again. Next the operator began to move the pack and it stopped moving on the roller conveyor. This is about 20-30 seconds after the victim disappeared from the view of the video camera. The operator noticed the pack was not moving, so he pressed the start button again, once again the pack did not move. An employee working on an adjacent platform asked the operator why the pack was not moving along the roller conveyor, to which the operator replied that a stick must have it caught. The second employee looked down the roller conveyor to look for the stick and saw the victim caught between the pack of wood and a roller on the conveyor.

There was no guarding in place to prevent employees from accessing the roller/chain conveyor portion of the Green Chain where packs of wood traveled along the roller conveyor.

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.

Citation 1 Item 1 **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 pinch points.

In that guarding was not provided to prevent employee access to the roller/ chain conveyor area of the Green Chain where employees are potentially exposed to hazards when packs of wood travel across the conveyors.

Citation 2 Item 1 **Type of Violation:** **Other-than-Serious** **$1000**

TDLWD Rule 0800-01-03-.05(1)(a)1:An oral report of an employment accident resulting in a fatality was not made within eight hours after the occurrence to the nearest Area Office of the Division of Occupational Safety and Health or to TOSHA toll free telephone number (1-800-249-8510).

In that the incident, occurring on September 6, 2023, at approximately 1:20pm resulting in the victim passing away at approximately 9:15pm the same day from injuries sustained during the incident, was not reported until 8:34am on September 7, 2023.

Citation 2 Item 2 **Type of Violation:** **Other-than-Serious** **$0**

TDLWD Rule 0800-01-09-.07: Employers did not provide employees with effective information and training on hazardous chemicals in their initial assignment, and whenever a new hazard is introduced into their workplace. Refresher training was not provided at least annually thereafter.

In that adequate annual refresher training and information was not provided to a maintenance employee for the chemicals he is exposed to such as, but not limited to: wood dust, BWT 14, RLT 45, BWT 3800, and BWT 6220.

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