

# INDUSTRY ALERT

## FATALITY

### *Hog mill worker dies from entanglement in conveyor belt*

#### **What happened?**

A worker with more than 20 years experience at a sawmill was working alone in the hog mill, which receives waste material and reduces it in size for re-use as fuel. As the sawmill was shutting down for the day, a co-worker went into the hog mill and discovered the worker entangled in the roller and infeed belt in a restricted area under the conveyor. A wheelbarrow was lying on its side near the dead worker's feet, which were suspended approximately 45 centimetres (18 inches) off the floor.

#### **Why did it happen?**

A subsequent investigation concluded that the worker's right arm was the first part of his body to be drawn into the infeed equipment. Although there were no witnesses to the incident, an examination of the scene shortly afterward showed that the safety chains inside the conveyor belt were not in their proper position. It's believed that the worker removed the safety chains in order to enter the restricted area to clean up or try to remove something that may have become caught in the conveyor. (The worker's duties included clearing jams and cleaning up sawdust.) The conveyor was neither stopped nor locked out when the fatal incident occurred.

#### **How can it be prevented?**

The hog area of the sawmill where the fatality occurred was posted with lockout warnings and the chains were tagged with caution signs. Posted warnings, caution signs, lockout training and written lockout procedures are all good intentions, but they cannot prevent a single injury or death to workers unless their message is monitored, enforced and practised every time without fail, every shift of every day.

Because the worker was alone in the hog mill at the time of his death, only his judgement of the risk involved in what he was doing could have saved him. The repetitive nature of work with machines can result in a kind of blindness to the hazards of any deviation from lockout procedures. Getting away with a lockout "shortcut" even once intensifies that blindness. That's why vigilant monitoring and enforcement of lockout procedures by all workers, supervisors and managers are so important. The lockout rule is very simple: Machinery must be stopped, shut down and in a zero-energy state before any worker approaches it for any reason.

In the aftermath of this traumatic incident, the company reinforced a vigorous lockout campaign on a more frequent basis, including signed and maintained training reports. The only way to end the wave of lockout-related fatalities that continue to plague Ontario's forest industry is for all companies to conduct similar vigorous campaigns to monitor and enforce lockout procedures, and for all workers to abide by those procedures without exception.

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Although the description of circumstances arises from an actual situation, this Industry Alert does not reflect the final analysis of the situation, nor is it meant to assign blame on the part of any person or member firm. For further information, contact OFSWA at (705) 474-7233. For details on Ministry of Labour prosecutions regarding recent health and safety incidents in Ontario workplaces, visit [www.labour.gov.on.ca](http://www.labour.gov.on.ca) and click on "News Releases".