Case 175. 26-year-old machine operator was crushed between the carriage and frame of a bench draw machine while manually resetting a pipe grip on the carriage.

A 26-year-old male machine operator was crushed between the carriage and frame of a Vaughn 800Klb bench draw machine while manually resetting a pipe grip on the carriage. One of the decedent's coworkers (Coworker 1) was operating a nearby bench draw machine, but had run out of work for the machine. Coworker 1 walked over to the bench draw machine the decedent was operating to assist the decedent in resetting the pipe grip which had fallen to the floor. To reset the pipe grip, the plant supervisor indicated to the MIOSHA compliance officer that the bench draw operator was required to lock out the main control switch on the control panel located on the work platform, leave the platform and depress the carriage emergency stop button located on the path to the machine prior to entering the point of operation to pick up the pipe grip from the floor. The emergency stop for the carriage was installed after a near incident earlier in the year that identified this potential hazard. It is not known if the decedent, who had been operating the bench draw machine for approximately three weeks, locked out the control panel. It is also unknown if he depressed the carriage emergency stop button on his way to pick up the pipe grip. Coworker 1 came over to assist the decedent reset the grip by depressing the manual button to "jog" the carriage back into rest position. If the decedent had locked out the control panel, the coworker could have easily unlocked it by turning the main control switch. The buttons on the control panel were labeled, but many were poorly labeled to the point they were illegible or confusing due to the numerous times the control panel had been written on and due to normal wear over the years. Coworker 1 was unfamiliar with this bench draw machine. It appears that he depressed the wrong button on the control panel and instead of "jogging" the carriage back to position, he depressed the return button and the carriage returned to the rest position at full speed. The decedent's head was crushed by the returning carriage and the frame of the machine. The crane operator who supplied pipe to the bench draw machine heard the grip fall from the carriage and saw the decedent enter the point of operation to retrieve the grip. Upon hearing Coworker 1 scream, he looked to the bench draw machine and noted the decedent lying motionless on the floor. He sounded the crane horn in the manner used to indicate an emergency situation. The area supervisor, hearing the crane horn, arrived at the incident site, and per company procedure, called for security to contact 911. Emergency response arrived and the decedent was declared dead at the scene. The plant supervisor indicated that the emergency stop button was depressed, although it is unknown if it was depressed by the decedent prior to entering the point of operation or Coworker 1 after the incident. The day after the incident, the machine controls and emergency stop were tested and were determined to be functioning properly. A machine-specific written lockout program was not obtained by the MIOSHA compliance officer.

MIOSHA General Industry Safety and Health Division issued the following Serious and Other-than-Serious Citations:

SERIOUS:

THE CONTROL OF HAZARDOUS ENERGY SOURCES, PART 85, RULE 1910.0147(c)(4)(i) ADOPTED BY RULE 8502.

Develop, document and utilize procedures for the control of potentially hazardous energy when employees are engaged in service or maintenance of machines or equipment where

unexpected energization, start-up or release of stored energy could occur and cause injury.

Inadequate alternate lockout procedures, procedures implemented by the employer do not meet the requirement of the standard to protect workers from reactivation and un-intended movement, firm relies on an emergency stop to protect workers while in the point of operation, Vaughn 800Klb bench draw machine.

OTHER-THAN-SERIOUS:

GENERAL PROVISIONS, PART 1, RULE 33(3).
Each operating control device should be identified as to its function.

Inadequately labeled controls, controls labeled with black marker and difficult to see during evening hours.