Case 266. 44-year-old male laborer died when he was crushed between stacker transfer and stacker frame while retrieving a piece of lumber that had fallen to the floor.

44-year-old male laborer died when he was crushed between stacker transfer and stacker frame while retrieving a piece of lumber that had fallen to the floor. Lumber from an upstream bin was placed on a roller transfer to be stacked and bundled on a pallet. The roller transfer started in the UP position and as lumber was delivered, stickers were placed on each row. The decedent was working with another employee placing four stickers (wood pieces with dimensions of 1/2-3/4" x 1½-2 inches wide and 4 feet long) to separate the layers of lumber before it entered the kiln for drying. Each employee placed two stickers on each row of lumber. The roller transfer lowered with each lumber piece to a predetermined height for the bundle of lumber. Once the predetermined height had been reached, the roller transfer dropped down slightly to match the height of the exit rollers. The rollers on the transfer activated and the bundle of lumber exited the stacking area past two photo eyes. After the lumber passed the photo eyes, the roller transfer automatically rose to the UP position and the process repeated. Sometimes there was a delay in the stacking operation to permit the upstream bins to be filled with the proper amount of lumber boards before the bins were emptied on the transfer to the stacker line. The stacked lumber remained on the transfer station until the upstream bins were filled. The delay allowed employees time to do other activities, such as cleaning up floor areas. The incident occurred during one of these delays. During the delay, the decedent's coworker left the workstation to use the rest room and apparently the decedent went to retrieve a 2x4x8 foot long piece of lumber from under the balcony where he and his coworker stood while the equipment was running. The incident area had standard barriers and a gate that had a sign at one time (DANGER-Lockout). The sign was missing. Similar gates in the area had the sign. After entering through the gate, as the decedent leaned over to pick up the lumber, the transfer roller activated. The stacked bundle moved through the photo eyes, and the roller transfer returned to the UP position. He was trapped between the roller transfer and the stationary frame. The operator of the feeding line to the stacker thought he heard something, turned around and observed the decedent trapped between the two fames. The operator lowered the roller transfer and the decedent fell out of the line and onto the floor. One of the employees ran to the foreman's office to notify the supervisor and to call 911. One of the supervisors ran to his aid to check for a pulse and start CPR until police and EMS arrived.

The MIOSHA General Industry Safety and Health Division issued the following Serious citations at the conclusion of its investigation.

SERIOUS: ACCIDENT PREVENTION SIGNS AND TAGS, PART 37, RULE 3706:

An employer shall provide, install and maintain signs and tags as prescribed by this part where an employee might be or would likely be injured if not alerted to the hazard.

Warning or caution sign on gate that employee entered was missing, Stacker.

SERIOUS: THE CONTROL OF HAZARDOUS ENERGY SOURCES, PART 85

- RULE 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 Part 85:

  No utilization of lock out procedures, Stacker.

- RULE 1910.147(c)(5)(i)

  Locks, tags, chains, wedges, key blocks, adapter pins, self-locking fasteners, or other hardware were not provided by the employer for isolating, securing, or blocking of machines or equipment from energy sources:

  a. No locks provided for authorized employees that are to perform lock out, Stacker
  b. No locks provided for authorized employees that are to perform lock out, Bins Area

- RULE 1910.147(c)(6)(i)
  The employer did not conduct an annual or more frequent inspection of the energy control procedure to ensure that the procedure and requirements of Part 85 were followed:

  No periodic inspections were performed, Stacker – Firm Wide.

- RULE 1910.147(c)(7)(iv)

  The certification of employee training by the employer did not contain each employee name and date of training:

  No certification of training, Stacker.

- RULE 1910.147(c)(7)(i)(A)

  Authorized employee(s) did not receive training in the recognition of applicable hazardous energy sources, the type and magnitude of the energy available in the workplace, and the methods and means necessary for energy isolation and control:

  No training for authorized employees in lock out procedures, Stacker.