

# INDUSTRY ALERT

## *Guillotine Lifting Bucket Fatality*

On the 15<sup>th</sup> March 2002 an employee was fatally injured after being struck by a guillotine lifting bucket.

Following a planned shut, unplanned maintenance work was being conducted on a Reel Splitter guillotine blade and lifting bucket.

Having rectified the guillotine blade problem it was decided to address a bolt shearing issue with the lifting bucket.

At this time the Back To Machine (BTM) Alley was full of reels to be split and returned to the machine for pulping.

The employee was called to the area to lift two isolations. This required crossing the BTM Alley area to reach the Winder Drive Annex room.

It is believed, from the evidence gathered, that the employee moved inside the mesh barrier and crossed between the bucket and a BTM reel. At the same instant a testing sequence began on the lifting bucket, sending it down from the raised position.

The employee was unable to move away from the bucket and was pinned against a reel by the downward movement of the lifting bucket.

Having been struck by the bucket, the electrician was found on the floor with serious injuries, which later proved to be fatal.

A team that comprised an independent chairperson; corporate representative; representatives from the three unions on site; the OHS&E Unit and other specialists as required completed a comprehensive incident investigation.

The root cause of this incident was deemed to be the ability of the employee to access the area between the reel and the bucket.

Following the determination of the root cause a series of recommendations were made, with a view to preventing a re-occurrence or similar incident.

## RECOMMENDATIONS

When taking into account all the factors identified in the investigation, the following controls were recommended.

1. That guarding on both sides of the guillotine be further extended from the leading bucket edge.
2. An interlock device should be fitted, such as a light curtain that detects when people, or an object, cross into the danger zone. This should shut down the bucket, conveyors and guillotine. Any devices installed should meet the requirements of the Australian Standard AS 4024.2 for Safeguarding of Machinery 'Optoelectronic Devices'.
3. The up/down controls for the bucket should be relocated (not replicated) to an area such that an operator has direct line of sight with the bucket before operating it.
4. That floor markings should indicate separate danger areas and safe access pathways.
5. The site should develop a Standard Operating Procedure or Work Instruction for the placement of reels in BTM Alley.

Given the number of machines fitted with lifting buckets utilised within the paper industry these recommendations should be considered for all existing and planned plant.

As a minimum legislative requirement all employers must undertake hazard identification and risk assessments on all plant prior to installation and commissioning; and after any significant changes to the plant.

For further information on this incident please contact:

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