Hoisting Safety Fatality File

Worker killed after being caught inside palletizer hoist area

A machine operator was killed while operating a palletizing machine at an ice cream manufacturing facility. The palletizer was designed to place and stack products from an assembly line onto pallets for shipping. The incident occurred after the victim had finished working a full second shift and was in the midst of four hours of volunteered overtime. The victim entered the machine's hoist area to position a pallet when the hoist unexpectedly began to rise. The machine was operating in automatic mode, which allowed the palletizer to continuously cycle. It was not locked out. A co-worker heard cries for help and ran to stop the machine. The victim was crushed between the empty pallet and the top portion of the hoist. When workers began to lower the hoist, the victim fell to the ground and was pulled away from the machine. A co-worker who also was an emergency medical technician tended to the victim until emergency medical services arrived. The victim was breathing but was unconscious and unresponsive. He was transported to a local hospital where he was pronounced dead later that day.

To prevent future occurrences:

Minimize the number of times palletizer cycles are interrupted because of failure to detect pallets in the hoist area. To reduce the number of times the palletizer automatically stops because of an undetected pallet, employers should inspect pallets regularly and repair or remove from service those that are damaged.

Employers should ensure all movable parts of machines are guarded at all times to minimize employee access. Three sides of the palletizer involved in this incident were guarded by a cage. The fourth was guarded by a light curtain presence-sensing device. However, the light curtain routinely deactivated between the time

a completed pallet exited and a new pallet was properly positioned.

Develop, implement and enforce a comprehensive hazardous energy control program, and routinely review the program and employee training. A hazardous energy control program that includes procedures for lockout/tagout is required by OSHA. All forms of energy must be considered – electrical, hydraulic, pneumatic and mechanical. The program should be enforced by performing random inspections to verify all employees are adhering to safe practices. Training should be conducted at least once a year or when safety concerns arise.