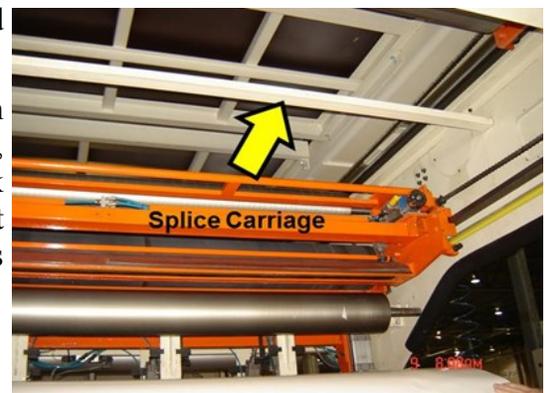


Fatal Incident Involving a Sheeter Machine at a Paper Converting Facility

A USW member was fatally injured when he was caught in-between the carriage and a cross-bar of #8 Sheeter's frame during rethreading operations. The sheeter had a "breakout" on the #1 unwind stand. The victim was assisting the operator in rethreading of an existing roll of paper into the sheeter. The operator turned the switch that actuates the carriage movement, attempting to partially move the carriage. Instead, the carriage ran all the way inward and then came backward towards the victim, pinning his chest between the carriage and a horizontal cross-bar of the machine's frame. #8 was a newer sheeter and was built by a different manufacturer than the other three sheeters in the facility. Although #8 is similar to the other sheeters, its splice carriages have a different type of operator control switches.

The splice carriages on #8 are not standardized with the constant pressure or "hold-to-run" type switches as provided on the other three sheeters to "jog" the carriages. The #8 sheeter splice carriages were instead provided with "spring-loaded" switches that require only a momentary contact or "trip" to move the carriage. These switches, once activated, would cause the carriage to automatically travel at full speed to one end of its track or the other. The only way to jog or move the carriage in increments is to rotate the switch in the desired direction of travel and then quickly turn it again in that same direction to make it stop. If the switch was turned in the opposite direction, as would seem logical to reverse the carriage or "stop" it, the carriage would merely continue to travel to the end of its track. The operator, having not worked on #8 before and unaware of this design flaw, tried (with heavy force on the switch) to 'reverse' the carriage or 'stop' it by turning the switch in the opposite direction. This broke the face of the switch completely off, but did nothing to stop the motion of the carriage, which continued to travel. It ultimately pinned the victim between the carriage and the cross-bar of the frame. Machine safeguarding was not provided in the immediate area where both employees were working and emergency stop button(s)/rope(s) were not accessible.

Each shift did rethreading differently. Some crews ran the carriage completely inboard to the end of its track, some ran it all the way to the outboard end of its track and some preferred to move or jog the carriage to a point along the length of its track. Safe Operating Procedures were not developed for rethreading operations.



Recommendations to Prevent Recurrence:

- Work with the machine manufacturer to relocate the cross-bar to eliminate the pinch point between the carriage and the cross-bar.
- The machine manufacturer must issue Product and Safety Notices with Mandatory Actions (#8 sheeter was made by GOHA – Model GS/B Number 101).
- Remove "trip" type switches and install constant pressure type or "hold-to-run" switches. This will allow the operator to control the 'jog' the carriage into a desired position.
- Develop and document procedures for: rethreading, Lockout/Tagout/Verify – all with input from the shift crews; update training accordingly.
- Improve labeling of operator control board(s) switches.
- Conduct a machine safeguarding assessment survey on all sheeters.
- Provide all workers with a Right-To-Act process (including, but not limited to; procedures to report hazards, refuse unsafe/unhealthy jobs/tasks and shut down any process without the fear of retaliation). All workers shall be trained/retrained annually on the process.



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This hazard alert is based on an actual incident, and reflects our best understanding of the incident at the time it was written. However, many incidents have multiple causes; this alert may not cover all of them. The purpose of the alert is to illustrate workplace hazards; it is not intended to be a comprehensive report on the incident.