

### **HS Broadcast 04 – Machinery and Blockages**

I recently read an article which brought back some very sad memories for me. My Grandfather was an Estate Manager and, as a result, I started working on the farm in my school holidays and weekends at a young age, and this continued up until I left University. In the article an employee fell into a baling machine and was killed when it automatically restarted. The problem was that the staff were habitually using bad practices to remove blockages without switching off the power. In my working days on the farm there was one particular machine that could be cleaned out and unblocked far more easily when the machine was running as opposed to when it was stopped. Human beings being what we are there is always a tendency to take the path of least resistance, and a good friend of mine, who was a similar age to me, was unfortunately killed due to poor safety procedures and ineffective supervision. I appreciate that I am going back a few years and health and safety then was not what it is now, thankfully!

**The overriding lesson is that if you use machinery you must have safety procedures for the full range of tasks which staff undertake.**

According to this article, in August 2012 Simon Brook (S), an employee of Gwynn Davies-McTiffin Ltd (G), was found lying seriously injured at the bottom of a baling machine. His legs were partially severed and he unfortunately died two days later. There were no witnesses to the incident but a steel pole was found alongside S. It was surmised that he fell while attempting to clear a blockage.

The conclusion drawn was that as he fell he must have pushed the obstruction out of the way triggering the machine to automatically restart. The machine in question was a 28-year-old horizontal baler. It had a hopper about one storey high which received loose cardboard from a long conveyor belt. A ram pressed the cardboard into bales.

At Court, the judge concluded that the machine was incredibly dangerous as it lacked the safety features which should have prevented it from being unblocked whilst still running. He also felt that the firm had been *“lulled into a habit of carelessness”* by allowing unsafe working habits to develop and continue unchecked. G pleaded guilty and the company was fined £80,000 and ordered to pay costs of £40,000.

These events were described by HSE investigators as *“entirely foreseeable”*. The machine was old and did not have up-to-date guarding. Blockages occurred on a daily basis and employees used various unsafe methods to clear them including:

- (1) Leaning over the side of the hopper and prodding the blockage with a stick;
- (2) Climbing over the side of the machine and standing on the conveyor belt at the top of the hopper to push the cardboard; or
- (3) Jumping on the material within the hopper.

G was entirely aware of the need to deal with the machinery safety issues as it had made improvements to a similar machine at another site. Inspectors concluded that had these been applied at the site in question the accident would have been prevented.

Many of the failures involved in this accident can be avoided by using general common sense. For example, supervising the work and taking action to stop staff from putting themselves at risk.

Therefore your risk assessments for all of your machinery should consider the hazards which arise from maintenance, cleaning and dealing with machine failure; not just the hazards from normal operations. If following a sequence of tasks is critical to staff safety, write it down, train staff in the findings and get them to sign to say they have understood. In almost all cases the first item on your unblocking procedure will be *“isolate and lock off power to the machine”*.

AT/DM