Fatal 1 – Fatal machinery crush incident on conveyor system – MP Connect Alert

WHAT HAPPENED

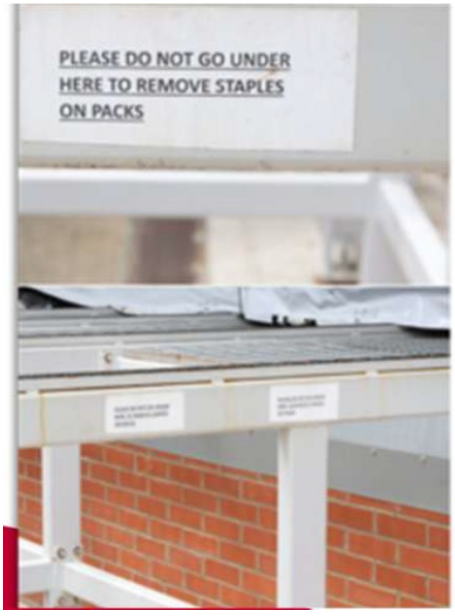
A 56-year-old was removing packaging from pallets at a sawmill before they were processed. To reach the wrapping, he climbed inside a conveyor system. An operator, unaware his colleague was inside the conveyor and unable to see him from the operating position, started the conveyor, causing a three-tonne pallet to strike him. When the pallet did not move as expected, the operator reversed and restarted the conveyor, causing a second collision. The injured person suffered fatal crush injuries.

KEY FINDINGS

Key findings from the HSE investigation:

- Access to a dangerous part of machinery was routinely occurring, despite the company being aware of the unsafe practice.
- The company relied on signage and instruction alone to prevent entry into the conveyor danger zone.
- CCTV evidence showed operative accessing the conveyor framework on at least 19 occasions in the weeks leading up to the incident.
- No close or distance guarding was in place to prevent access.
- The system of work required employees to access dangerous parts of the conveyor to remove packaging.
- This system was only changed after the fatality.
- The company was fined £2.2??million plus costs

The image below shows the signs that were on the conveyor system.



LEARNING POINTS / ACTIONS TAKEN

HOW COULD THIS HAVE BEEN AVOIDED?

• Undertaking suitable and sufficient work equipment risk assessments.

• Applying the hierarchy of control, prioritising engineering controls over instruction.

• Designing tasks to eliminate the need to enter danger zones.

• Implementing clear and effective safe systems of work for normal operation, cleaning, and maintenance.

• Using robust machinery isolation (LOTOTO).

• Providing effective training.

• Ensuring active supervision.

• Encouraging a positive reporting culture, enabling employees to raise concerns or near misses.

KEY REVIEW POINTS:

• Review PUWER risk assessments for all machinery, focusing on foreseeable non-routine tasks.

• Confirm the hierarchy of control is properly applied, with guarding and other physical controls in place.

• Audit guarding arrangements to ensure dangerous parts cannot be accessed.

• Verify LOTOTO procedures are robust, understood, and consistently applied.

• Check systems of work are clear, concise, and followed in practice.

• Strengthen supervision and routinely verify workforce understanding of risks and controls.

• Promote and act upon near-miss and hazard reporting.

For further details, refer to the HSE Press Release: Major builders merchant fined £2.2 million after worker killed in conveyor crush – HSE Media Centre

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LOCATION:	**OTHER**	**ALERT STATUS:**	**Normal**
ACTIVITY:	**GUARDING AND ISOLATION**	**DATE ISSUED:**	**27/04/2026 13:36:10**
SUB ACTIVITY:	**NO SUB ACTIVITY AVAILABLE**	**INCIDENT No:**	**04971**