DEPARTMENT OF MINERALS AND ENERGY
WESTERN AUSTRALIA

SIGNIFICANT INCIDENT REPORT NO. 55

CONVEYOR BELT - FATAL ACCIDENT

INCIDENT

A mobile crushing and screening plant operator died from severe crush injuries to the arm and chest when he became trapped between the belt and roller in the tensioning system on a screen feed conveyor.

At the time of the accident it appears that the deceased had been greasing the rollerbearings using a hand held grease gun while the conveyor was running. He was apparently able to pull the emergency stop lanyard, as when found, he was lying on the ground beside the unit and the conveyor was stopped.

There was no designed access to the belt tension take up area nor any provision for a maintenance work platform, and the roller grease nipples were located directly on the bearing housings.

CAUSAL FACTOR

The prime causal factor was that the deceased accessed the area of the belt tension take up mechanism while the belt was running.

PREVENTATIVE ACTION

1. Isolation and tag out procedures should be used whenever performing maintenance or other work on conveyors.

2. Lubrication systems should be designed so that the application point for the lubrication is located clear of the mechanism of the conveyor in an accessible and safe position with the lubricant being piped to the bearing. (Refer AS 1755-1986 Section 3.2.4 Lubrication of Bearings).

3. Where it is possible for a person to access a nip point inadvertently on a conveyor, provision should be made to prevent such access.

NOTE

A similar fatal accident resulted in the issuing of Significant Incident Report No. 2/89.

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25 May 1995

SAFETY AWARENESS SAVES LIVES