

Forestry Bulletin

Skyline Cable Tensioning System Results in Logger's Death

While working on skyline tensioning, an employee suffered fatal injuries when struck by the hook being used in the process.

What happened

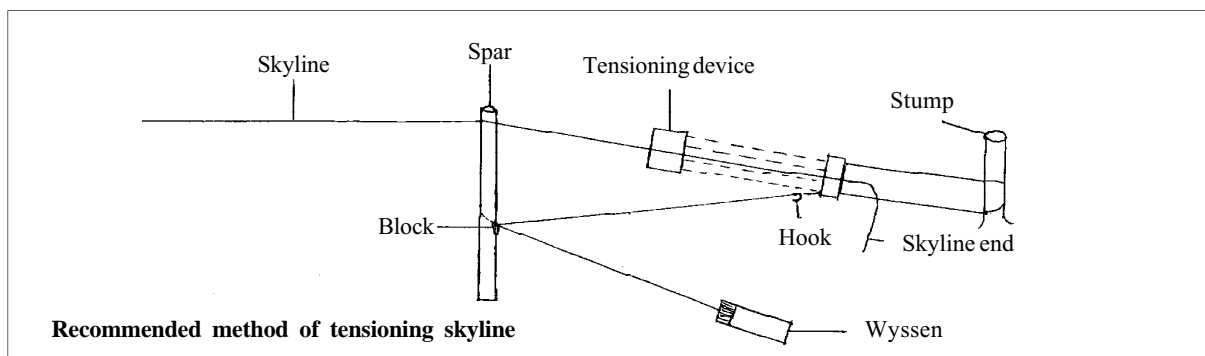
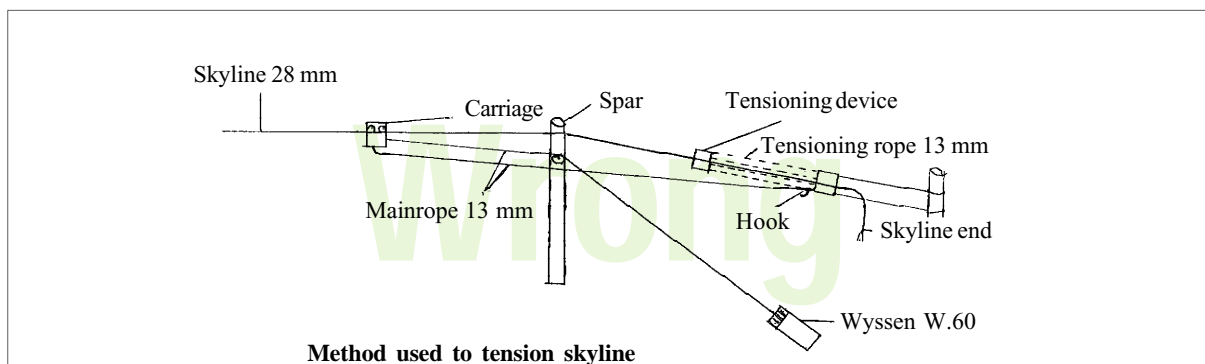
A crew in a Wysenn skyline operation was working on tensioning the cable before work started for the day. It was noticed that the cable was hooked under the arm of the hi-ab on the barge and the crew immediately began to de-tension the cable to release it from the hi-ab.

During this procedure, the carriage, which was being used in the tensioning, tilted, slipped along the

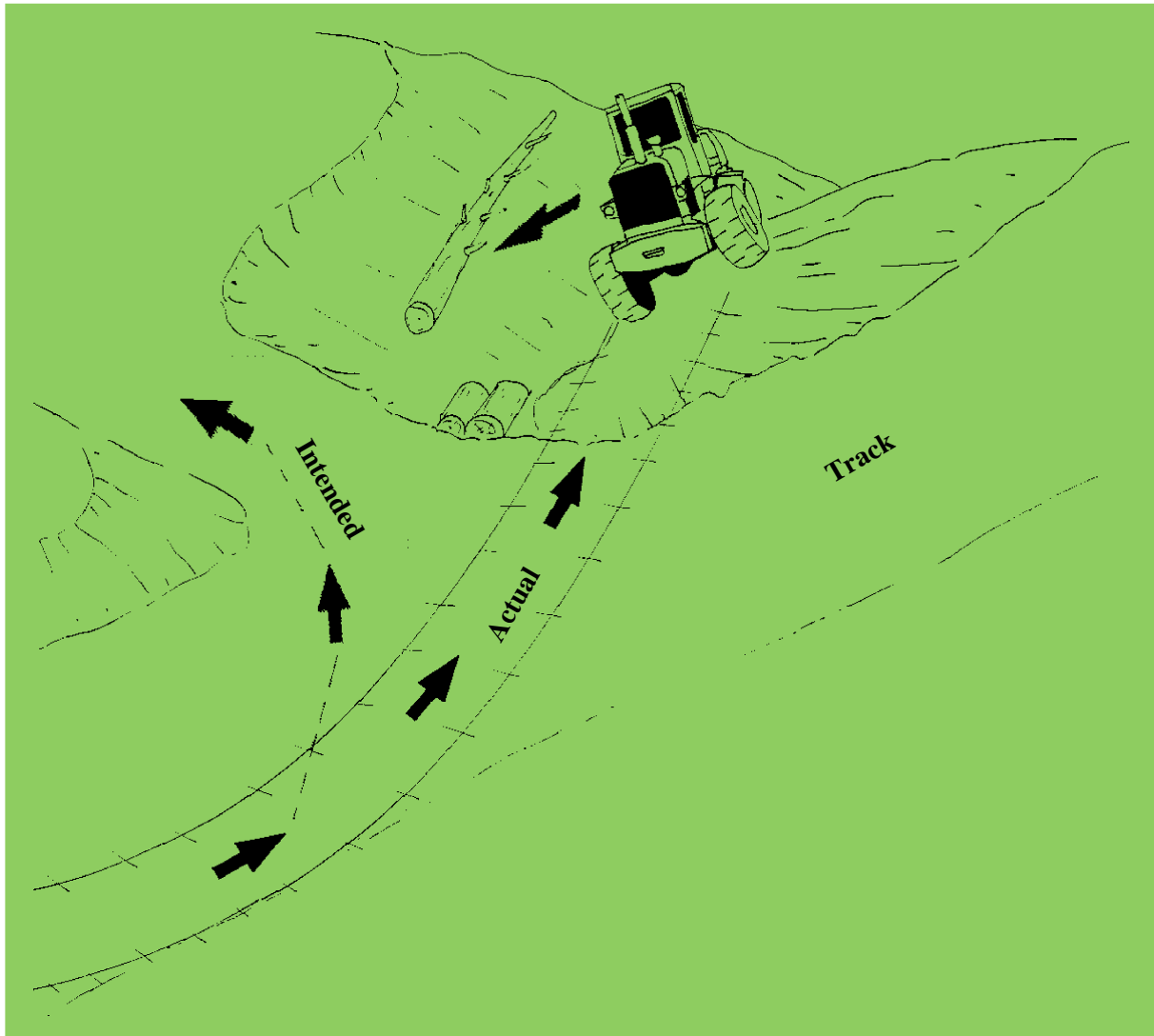
skyline and the hook became airborne and struck the worker.

General

The Havelock coroner, Colin Mcnab, listened to details of two systems of tensioning the skyline, one using the carriage and winch and the other the direct use of the winch only. He found that the method using the carriage had caused the accident which had resulted in loss of a life and asked that OSH circulate logging contractors with the appropriate method of tensioning the Wysenn skyline. This is illustrated in the bottom diagram.



Loader Driver Killed When Machine Tips



A truck driver suffered fatal injuries from being crushed when the front-end loader he was driving between skids went off the road and tipped.

What happened

A truck driver, working alone, had loaded his truck and was driving the front-end loader to the adjacent skid about 60 metres away. He failed to take a sharp left-hand turn from the road into the skid and drove into a steep-sided gully, passed over a log near the start of the gully and ended up 10 metres from the road. Evidence showed that the loader had tipped over on its left side damaging the ladder and left side. It gouged out earth along the gully side and then righted itself and came to rest on all four wheels. The driver was found under the loader with his right arm under the rear left-hand wheel. It appears he had been thrown out as the loader tipped and was crushed between it and the gully sides.

Cause

Examination of the loader after the accident showed that the front brake master cylinder was empty of fluid. This could have halved the braking efficiency of the machine.

The emergency braking system was fully operative and had not been activated during the accident. There were thoughts that the driver, although an experienced machine operator over 30 years, may not have been familiar with the model concerned.

The investigating OSH officers were unable to pinpoint the accident cause although partial brake failure and unfamiliarity and judgement error could have been contributing factors.

The accident probably would have resulted in minor injuries, not a fatality, if a seat belt had been fitted and worn.