REPORTABLE INCIDENT REPORT

Delphi TVS Technologies Ltd, Oragadam

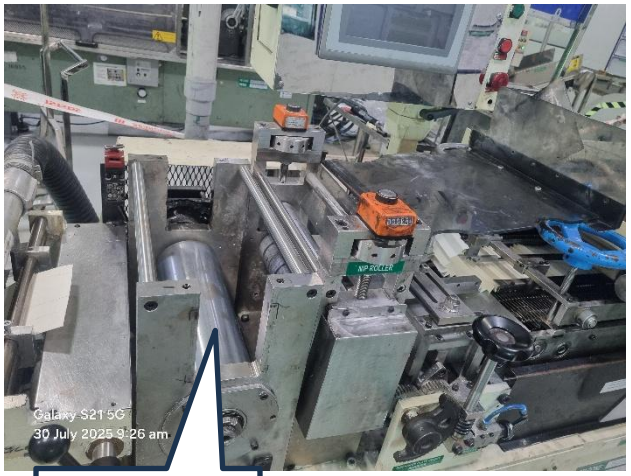
INCIDENT DETAILS

Department	**: Filter Cell**
Process / Activity	**: Pleating machine -1**
Injured person	**: T Monish**
CC.No	**: TIT 1504**
Date & Shift	**: 29.07.2025 & 2nd shift**
Incident Time	**: 10.35 PM**

INCIDENT DESCRIPTION

- The running Pleating paper roll emptied
- Trainee loaded new pleating paper roll at the loading point & started feeding to pleating machine
- He found paper struck up (Pop up) inside the roller & removed the paper manually
- Then stopped the pleating roller unit and opened the safety door which was in bye passed condition.
- Trainee tried to insert the paper roll at the pleating roller station manually by switching on the unit simultaneously.
- During the course of this activity, his left hand caught between the pleating rollers and got crush injury in his left index, middle and ring fingers.
- He pressed the emergency button immediately. Upon hearing his noise, the line supervisor and maintenance engineer rushed to the spot and removed the roller manually to free his hand .

Safety door



Pleating rollers

INCIDENT DESCRIPTION

Observations:

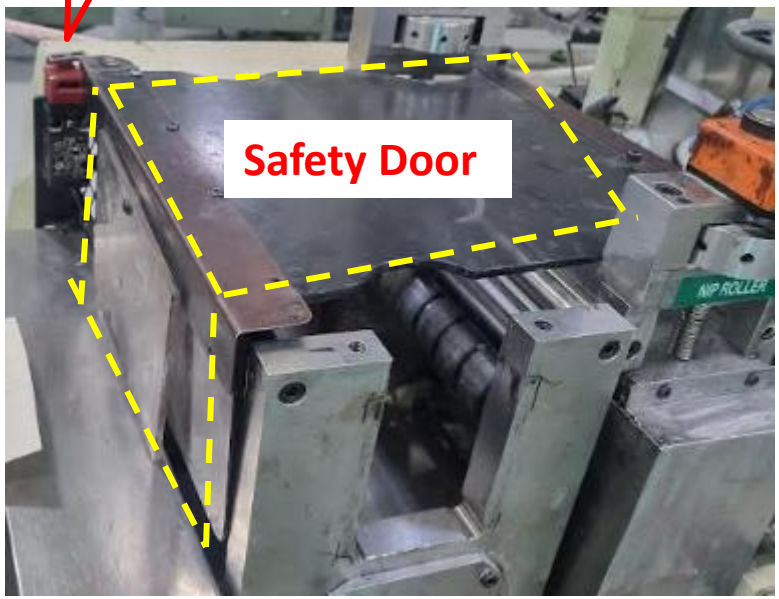
1) Pleating Roller safety door switch was found in bye passed condition

2) The machine was operated in an unsafe condition; production continued despite the known failure of the safety system by all responsible personnel

3) Manual insertion of paper while machine was energized

Safety door switch

Safety door switch is not connected with safety door



ROOT CAUSE ANALYSIS

Injury — Crush injury to the left hand index,middle and ring fingers

WHY 1 — The trainee's left hand got caught between the pleating rollers

WHY 2 — The operator opened the safety door and inserted his left hand into the running roller. The safety door switch was in a bypassed condition

WHY 3 — He attempted to feed the paper manually into the roller gap using his left hand while simultaneously switching on the roller unit with his right hand

WHY 4 — The new paper roll did not move properly inside the roller unit

WHY 5 — The edges of the running and new paper rolls were not properly joined

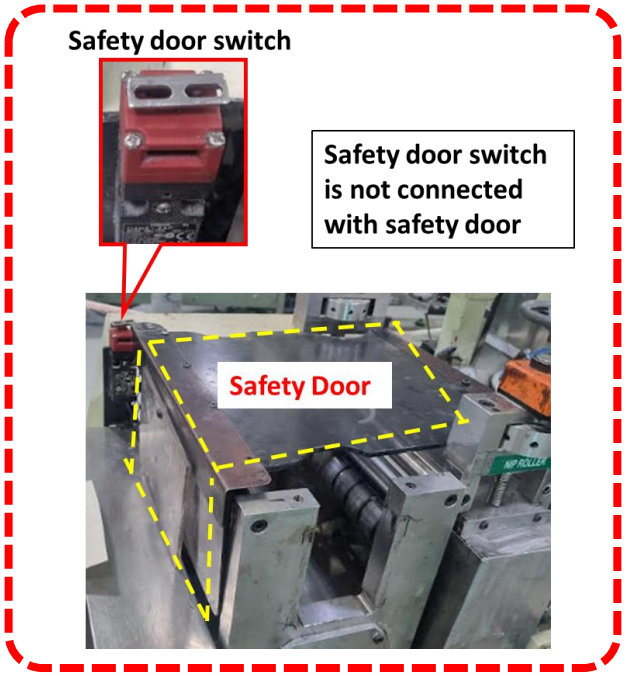
CORRECTIVE ACTION

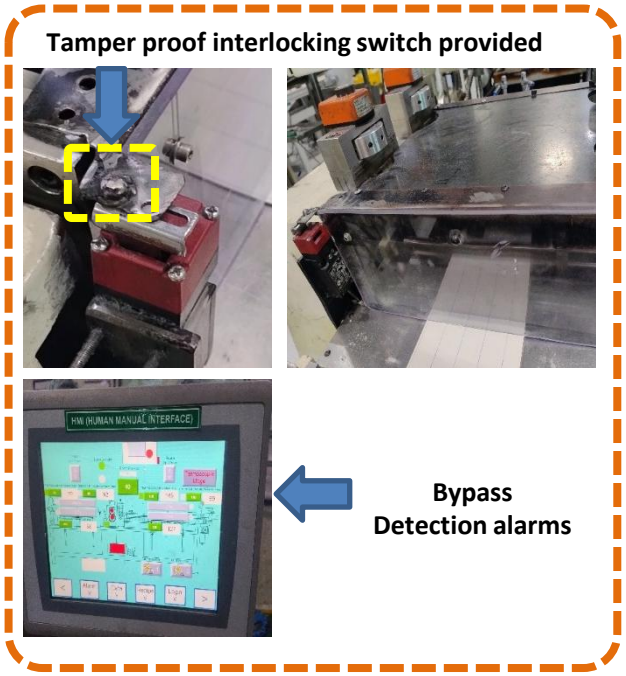
Sl.No	Cause of Accident	Corrective Action	Resp	Status
1	The safety door switch was in a bypassed condition	Install tamper-proof safety interlock switches with bypass detection alarms	Ravikumar	Completed
		Conduct On the Job training to all trainees/freshers and supervisors (with a focus on LOTO and interlocks)	Thiyagarajan	Completed
		Safety FLM gaps to be reviewed by the Supervisors and Managers	Thiyagarajan	Completed
		Review and audit all machines to identify any other bypassed safety systems	Thiyagarajan /Ravikumar	Completed
2	The edges of the running and new paper rolls were not properly joined	Develop and implement SOP for paper roll changeover, including safe methods for feeding	Thiyagarajan	Completed

Medical Treatment

- First Aid given at Jaya Hospital, Mathur
- After First Aid ,Injured person transferred to SIMS Hospital, Vadapalani & admitted under Dr.Karthikeyan-HOD, Plastic Surgeon
- Wound debridement & skin grafting is done in SIMS Hospital, Vadapalani

Cause of Accident	Corrective Action
Safety door switch was in a bypassed condition	Installed tamper proof safety interlock switches with bypass detection alarms





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Corrective Action

Conducted on the Job training to all trainees / fresher and supervisors (with a focus on LOTO and interlocks)

Cause of Accident	Corrective Action
Filter paper entry to roller: Safety door bottom having gap 20mm which having chance of finger may enter inside it	safety door design has been modified to reduce the gap to less than **8 mm**