30. Struck by chipper guard

An **18-year-old** sawmill employee was killed when he was struck in the head by the guard on a chipper machine. The victim was hired to come in each day after school and clean up after all the machines were shut down for the day. He worked about two hours a day, five days a week. On the day of the incident, a co-worker shut all the equipment down and was standing by the chipper machine when the victim came into the area to begin cleaning up. The chipper is used to grind log slabs, which are the bark portion of the logs, into a finer mulch material that can be sold to wood-pulp mills. The procedure each day was for the co-worker to turn off the shaker conveyor and the chipper when production stopped for the day. Once the chipper was turned off at the control panel, the inner wheel keeps turning for 18-20 minutes before it stops. Each day after the wheel stopped rotating, the co-worker removed the hood guard from the chipper so the chipper knives could be changed. On this day, the co-worker removed the nut and bolt holding the guard on the chipper in place and was waiting for the wheel to stop rotating. After he removed the nut and bolt, he turned around to place his wrench onto a shelf behind the chipper. He heard a loud noise and turned back around to see the victim falling rapidly backwards. The co-worker ran to the victim and observed a large cut across the victim's forehead and could find no pulse. The victim normally helped the co-worker remove the hood guard since the guard weighed approximately 100 pounds. Apparently the victim attempted to remove the hood guard before the wheel stopped rotating and as he did so the guard came into contact with the chipper causing the guard to strike the victim in the head. The victim died from his injury.

Citations as Originally Issued

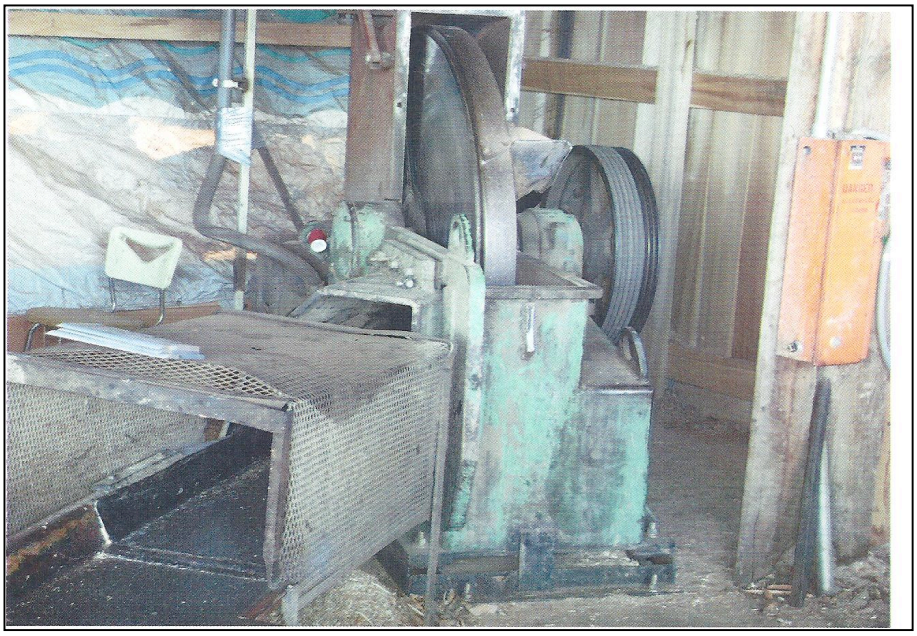
A complete inspection was conducted of the worksite. Thus, some of the items cited may not directly relate to the fatality

Citation 1

Item 1 1910.147(c)(7)(i)(A)	Each authorized employee did not receive training in the recognition of applicable hazardous energy sources, the type and magnitude of the energy available in the workplace, and the methods and means necessary for energy isolation and control.
Item 2 1910.147(d)(4)(i)	Lockout or tagout devices were not affixed to each energy isolating device by authorized employees.
Item 3 1910.147(f)(3)(ii)(D)	A personal lockout or tagout device was not affixed to the group lockout device, group lockbox or comparable mechanism when he or she began work (and to be removed when work stops) on the machine or equipment serviced and/or maintained.
Item 4 1910.151(b)	In the absence of an infirmary, clinic, or hospital in near proximity to the workplace which is used for the treatment of all injured employees, a person or persons were not adequately trained to render first aid. Adequate first-aid supplies were not readily available.
Item 5 1910.212(a)(1)	Machine guarding was not provided to protect operators and other employees from hazards created by moving parts.
Item 6 1910.305(b)(1)(ii)	Unused openings in cabinets, boxes and fittings were not effectively closed.
Item 7 1910.305(b)(2)(i)	Each outlet box in completed installations did not have a cover, faceplate, or fixture canopy.

Citation 2

TDLWD Rule 0800-1-9-.07	Employees were not provided annual refresher training and information on hazardous chemicals in their work area.



Chipper

Chipper guard