Struck By—Insp # 1667775 Walnut Creek Timber LLC

A 28 year old male employee was struck by 12" saw blades of a Pioneer Edger while cleaning out the sawdust bin beneath the blades with the saw was running.

The Pioneer Edger machine is used to trim the bark edges of the slats removed by the Head Saw from logs being cut down into railroad ties. The machine is equipped with dual 12 inch saw blades housed within the machine that adjusts side to side using a foot pedal control and a laser guide. The Edger is located immediately downstream of the Head Saw.

At the time of the accident, the 5 employees working in the lower mill were in the process of repairing the conveyor belt immediately downstream of the Head Saw. The conveyor belt carrying slats and rail ties had come off track when a smaller board became hung up underneath it. Power to the head saw and conveyor was turned off and locked out as the crew was working to realign the belt by removing the belt tensioner pulley. The victim had been helping with the task by handing hand tools to the other employees removing the tensioner pulley and assisted with pulling the belt back on track. The victim reportedly left the area; shortly thereafter, the other employees heard the Edger making a loud noise as if it had locked up.

One employee saw smoke coming from the edger drive belts so he quickly turned the machine off. As repairs to the belt were being made, the Edger had not been turned off; therefore, the sawblades were running. The victim went around to the back side of the Edger and unclasped a rope barrier to access the rear of the edger. A wooden box that had been installed several years ago to catch and feed saw dust into the dust collection system was installed on the back of the edger. The victim unhooked the simple hasp bolt and opened the 18 by 20-inch tall hinged wooden door to access the interior of the dust collection box. This is a task done reportedly four times a day as the dust builds up within the box and needs to be pushed into the hole in the floor of the box into the dust collection duct work. The Edger saws rotate at approximately 1500 RPM and are located approximately 11-inches from the opening to the dust collector box. As the victim cleaned the dust from the box by hand, pulling the dust downward toward the opening, he came into contact with the saw blades rotating upward and away from him. The victim was pulled into the blades and suffered the fatal injuries.

Citation(s) as Originally Issued

A complete inspection was conducted at the accident scene. Some of the items cited may not directly relate to the fatality.

Citation 1 Item 1 **Type of Violation: Serious** **$5400**

29 CFR 1910.147(c)(4)(i): Procedures were not developed, documented, and utilized for the control of hazardous energy when employees were engaged in activities such as servicing and/ or maintenance of equipment.

In that the employer failed to ensure that Lock Out Tag Out procedures were utilized to by employees when accessing the dust collection bin on the Pioneer Edger Machine.

Citation 1 Item 2 **Type of Violation: Serious** **$1600**

29 CFR 1910.147(c)(6)(i): The employer did not conduct a periodic inspection of the energy control procedure at least annually to ensure that the procedure and the requirement of this standard were being followed.

In that the employer failed to conduct annual inspections of the energy control procedures used by employees working in the lower mill to ensure that the procedures are being followed correctly.

Citation 1 Item 3 **Type of Violation: Serious** **$4000**

29 CFR 1910.147(c)(7)(i): The employer did not provide training to ensure that the purpose and function of the energy control program were understood by employees and that the knowledge and skills required for the safe application, usage, and removal of energy controls were acquired by employees.

In that the employer failed to effectively train employees on the energy control procedures for sawmill machinery used in the Lower Mill.

Citation 1 Item 4 **Type of Violation: Serious** **$1600**

29 CFR 1910.147(f)(3)(i): A procedure was not utilized to afford the employees a level of protection equivalent to that provided by the implementation of a personal lockout or tagout device when servicing and/or maintenance was performed by a crew, craft, department, or other group:
In that the employer failed to develop a procedure to ensure that employees were protected from the release of hazardous energy while working as a group to repair a conveyor from the Head Saw in the Lower Mill.

Citation 1 Item 5 **Type of Violation: Serious** **$1600**

29 CFR 1910.147(f)(3)(ii)(D): A personal lockout or tagout device(s) 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.
In that the employer failed to ensure that employees, authorized to work on equipment where there is a potential for the unsuspected release of hazardous energy, applied their personal lock to the disconnect powering the conveyor downstream of the Head Saw.

Citation 1 Item 6 **Type of Violation: Serious** **$1600**

29 CFR 1910.219(f)(3): Sprockets and chains which were seven feet or less above floors or platforms were not enclosed.

In that the chains and sprockets on the north end of the Green Chain conveyor were unguarded exposing employees to pinch points / nip points.

Citation 2 Item 1 **Type of Violation: Other-than-Serious** **$400**

TDLWD Rule 0800-01-03-.03(27)(a): The log of all work-related injuries and illnesses (OSHA Form 300), and/or the summary of work-related injuries and illnesses, (OSHA Form 300-A), and/or the injury and illness incident report (OSHA Form 301) or equivalent forms were not maintained by the establishment:(a) (IDENTIFY SPECIFICS AND/OR LOCATION)

In that the employer failed to maintain OSHA 300 logs or 300-A Summary form for the years 2020,2021 and 2022.

Citation 2 Item 2 **Type of Violation: Other-than-Serious** **$400**

TDLWD Rule 0800-01-03-.05(1)(a)2: Within twenty-four (24) hours after the in-patient hospitalization of one or more employees or an employee's amputation or an employee's loss of an eye, as a result of a work-related incident, the employer did not report the in-patient hospitalization, amputation, or loss of an eye to TOSHA.

In that an injury resulting in an amputation on 11-02-2020 was not reported to TOSHA.

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