DATE: July 6, 1995

FROM: Minnesota Fatality Assessment and Control Evaluation (MN FACE) Program,
Minnesota Department of Health

SUBJECT: MN FACE Investigation 95MN01201
Laborer Dies After Being Caught Between Automatic Back Saw and a Guardrail.

SUMMARY

An 18-year-old male laborer (the victim) died of injuries at a pork processing facility when he was caught between an automatic back splitting saw and a guardrail. There were no witnesses to the incident and MN FACE investigators were denied permission to perform a site inspection. Due to the lack of adequate information sources, a detailed report of this incident and recommendations for the prevention of similar incidents could not be written. However, a brief summary of the incident using information obtained in a police report has been written.

INTRODUCTION

On May 2, 1995, MN FACE investigators were notified of a machine-related incident that occurred on April 29, 1995, and resulted in the death of the victim on May 1, 1995. MN FACE investigators contacted the local police department and obtained the initial complaint and accident reports. MN FACE investigators contacted the safety manager for the victim's employer but were denied permission to investigate the incident at the employer's premises. Information from the Minnesota Occupational Safety and Health Administration regional office was not available due to continuing litigation involved with the incident.

INVESTIGATION

The incident occurred at a pork processing facility during the night shift when operations were limited to routine cleaning and maintenance. The victim, a sanitation worker/laborer, had been assigned to clean an area around an automatic back splitting saw. The saw was suspended from the ceiling on a square-shaped rail. The rail transported the saw from its originating position to the location where it cut hog carcass on the production line and back to its home position. At the

time of the incident, the blades to the saw had been removed. A guard rail was in place around the saw's area of movement and saw controls were located outside of the guarded area.

A coworker was also assigned to clean in the area at the time of the incident. The police report stated the victim had activated the saw, causing it to move from its home position, in order to clean around it. The coworker left the split saw location to clean a separate area. When he returned a short time later, the coworker found the victim pinned between the split saw and the guard rail.

The victim's arm was pinned over his neck and his feet were hanging off the ground. The coworker immediately requested emergency assistance. The company nurse and another worker responded and were able to move the victim's arm and began rescue breathing and cardio-pulmonary resuscitation. The response workers did not restart the saw because of their unfamiliarity with the machine. While tending to the victim, other employees worked to pull the saw from the victim. The victim was extricated from the site and taken to a local hospital where he died two days later.

CAUSE OF DEATH

The cause of death stated on the death certificate was hypoxic encephalopathy.

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