

Operator Struck by Hay Press Guillotine Blade

INCIDENT FACTS

REPORT #: 71-174-2018s

REPORT DATE: August 13, 2018

INCIDENT DATE: February 9, 2018

VICTIM: 39 years old, 1 ½ years with employer

INDUSTRY: Farm supplies merchant wholesalers

OCCUPATION: Hay press operator

SCENE: Hay processing plant

EVENT TYPE: Struck by



A 39-year-old hay press operator died when he was struck by the machine's guillotine blade.

The victim had worked for 1 ½ years for his employer, a grower, processor, and a wholesale seller of hay forage. He worked in the hay processing plant where he operated a hay press that compressed field baled and loose hay into high density bales for shipping.

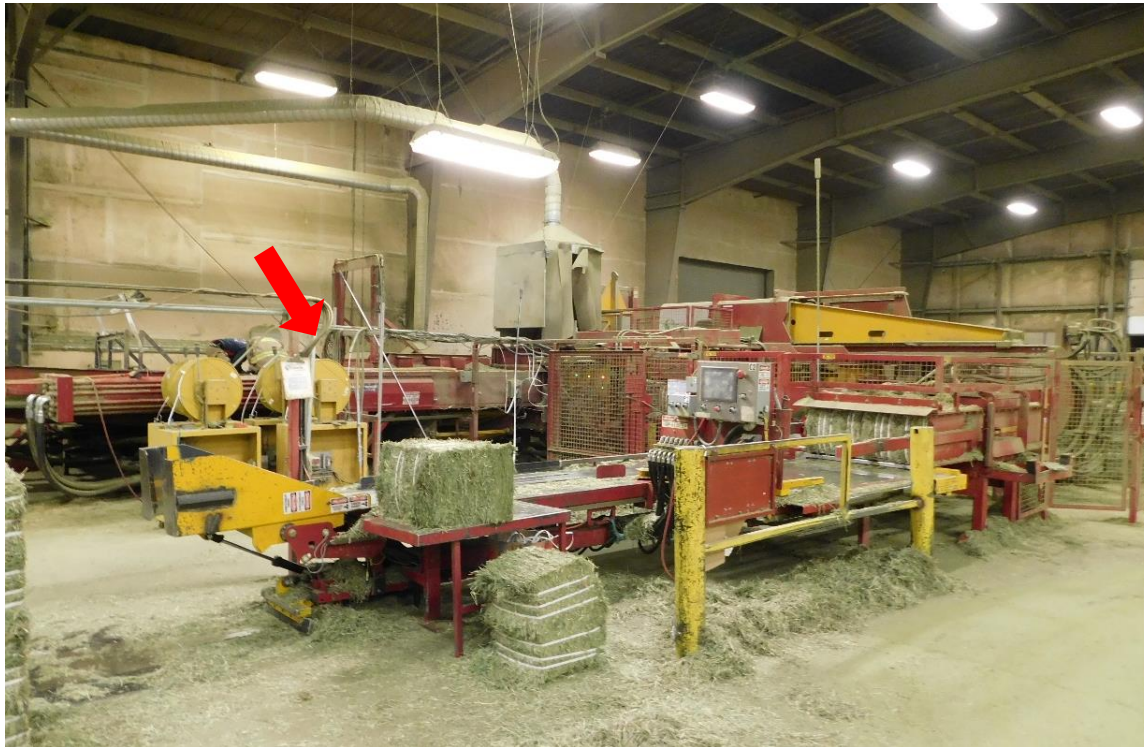
On the day of the incident, the victim had been operating the hay press as usual. Near the end of his shift, the plant supervisor asked the victim and two other employees to get the machine ready for maintenance.

They started cleaning up by manually placing a few bales onto the conveyor, which had been stopped, and pushing them along toward the scale. The victim was responsible for locking out the equipment, but he did not do this.

During normal operation, a conveyor moved hay into the covered area of the scale. When the hay reached the correct weight, a guillotine blade would slice off the section of hay before it was moved along by conveyor to be compressed.

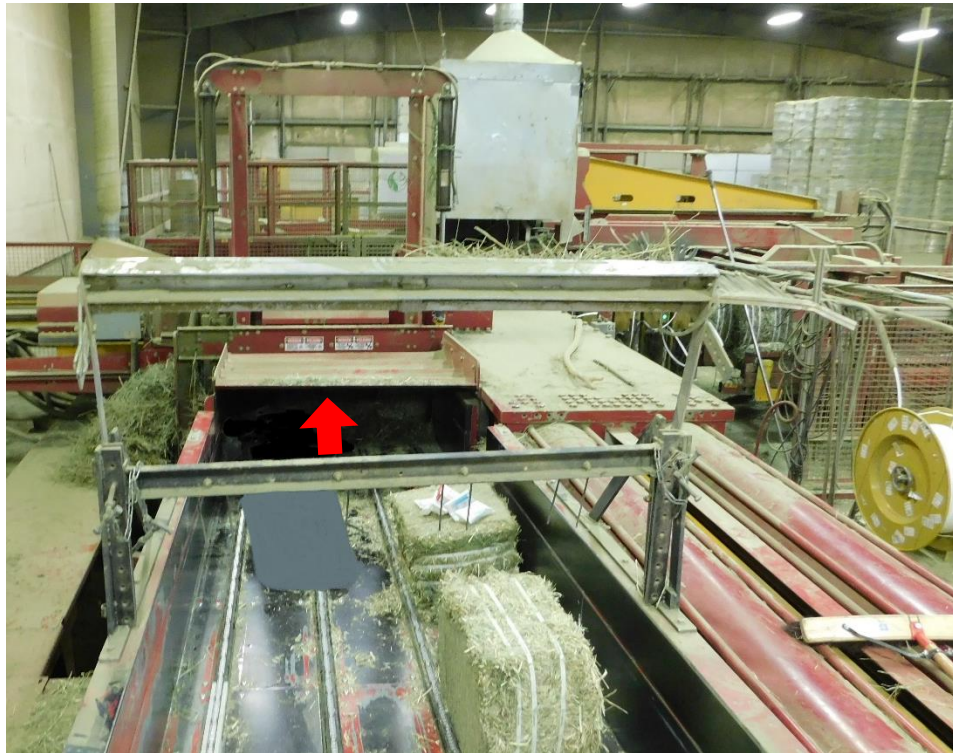
The victim crawled into the covered area where the scale was located and started to push a bale through to clear the area. His supervisor and coworkers did not notice him get into the machine. As he was lying on the scale, the steel guillotine blade activated and struck him, resulting in near decapitation.

Incident investigators found out through interviews with employees that the victim had on a number of occasions exposed himself and others to unsafe conditions by not following proper procedures for lock out/tag out of the hay press.



Incident scene showing the hay press. The arrow indicates the location where the victim was found.

FATALITY NARRATIVE



The hay press after the incident showing hay bales on the machine's conveyor. The arrow indicates the covered area that the victim crawled into to push hay bales through so that the crew could perform maintenance.



Incident scene showing where the victim entered the hay press.



The arrow indicates the victim's location on the scale when his weight activated the guillotine.



Hay being processed on the same make and model machine (not the incident machine). The photo shows the conveyor moving hay onto the scale where the guillotine then cuts the bales. (Photo from the manufacturer.)



Warning signs on incident hay processor.



A hay press guillotine blade of the same type that struck the victim.

Requirements

- Employers must use energy control procedures to protect employees servicing or maintaining machines and equipment from potentially hazardous energy. See [WAC 296-803-50005\(1\)](#)
- Retrain employees to reestablish proficiency when a periodic review shows the employee deviates from or has inadequate knowledge of the energy control procedures. See [WAC 296-803-60015\(2\)\(a\)](#)
- Provide and document employee training on the energy control program. See [WAC 296-803-60005](#)
- Provide and document periodic reviews to verify employees know and follow the energy control procedures. See [WAC 296-803-70005](#)

Recommendations

Always follow the machine manufacturer's operator and safety manual requirements regarding control of hazardous energy before performing cleaning, repairs, adjustments, or any other activity that could put employees at risk of safety hazards.

Resources

Lockout/Tagout. Washington State Dept. of Labor and Industries.
www.ini.wa.gov/Safety/Topics/AToZ/LOTO

This bulletin was developed to alert employers and employees of a tragic loss of life of a worker in Washington State and is based on preliminary data ONLY and does not represent final determinations regarding the nature of the incident or conclusions regarding the cause of the fatality.

Developed by Washington State Fatality Assessment and Control Evaluation (FACE) Program and the Division of Occupational Safety and Health (DOSH), Washington State Dept. of Labor & Industries. The FACE Program is supported in part by a grant from the National Institute for Occupational Safety and Health (NIOSH grant# 2U60OH008487). For more information visit www.lni.wa.gov/Safety/Research/FACE.