





Operator Electrocuted while Performing Maintenance on Center Pivot Irrigation System

INCIDENT FACTS

REPORT #: 71-204-2021s

REPORT DATE: February 2, 2021

INCIDENT DATE: August 15, 2020

VICTIM: 27 years old

INDUSTRY: Potato and corn farming

OCCUPATION: Irrigator operator

SCENE: Corn field

EVENT TYPE: Electrocuted











A 27-year-old irrigator operator was electrocuted after touching an energized pressure switch of a center pivot irrigation system.

His employer was a potato and corn grower. He had been employed as an operator for six days and was being trained on the job. He had two years' experience with a previous employer working on irrigation systems. This irrigation system was self-propelled by a motor around a center pivot point. It had drop sprinklers installed along horizontal pipes supported by steel towers that had wheels. The system had 480 volt, 30 amp, 3-phase power.









On the day of the incident, the operator was working with a coworker performing maintenance activities on the farm's center pivot irrigation systems.

At about 3:30 p.m., the operator and coworker were at the end, or gun, of the irrigation system circle. The coworker asked the operator to drive back to the pivot and turn on its power so that they could check the system's rotation.









The operator drove the company truck in reverse 1200 feet from the end of the circle to the pivot.

As he approached the pivot, the rear of the truck struck the system's above ground water main, breaking off its flow regulator and the water pump's energized pressure switch (though the pivot's power was off, the pump's power was on.) This caused water to be released from the main.

The operator called the coworker to let him know what had happened. The coworker told him they would make repairs in the morning.









The coworker went to another location and manually turned off the water. He called the operator, but received no response.

When he arrived at the pivot, he saw the operator unresponsive on the ground behind his truck near the water main still clutching the energized pressure switch. He then turned the power off at a nearby panel.

He called 911 and began CPR. Emergency services and the county coroner arrived. He was declared deceased at the scene. The cause of death was "electrocution."







FATALITY NARRATIVE [FACE]





Photo 1. Incident scene showing the operator's truck that he backed into the center pivot irrigation system's water main, breaking off its flow regulator and pressure switch. This caused water to be released. The operator was electrocuted when he picked up the electrified switch (indicated by arrow).







FATALITY NARRATIVE (FACE) THOUSEN'S THE STATE OF THE STAT





Photo 2. Pivot water main with broken water flow regulator and pressure switch (indicated by arrow).







FATALITY NARRATIVE (FACE) THOUSEHOUSE





Photo 3. Vegetation blocking operator's view of water main.









Requirements

Employers must establish a written energy control program consisting of:

- (1) An energy control procedure;
- (2) Employee training; and
- (3) Periodic inspections.

The purpose of the program is to ensure that before any employee services or maintains a machine or equipment where the unexpected energizing, start up, or release of stored energy could occur and cause injury, the machine or equipment is isolated from the energy source, and rendered inoperative.

See WAC 296-307-32007









Recommendations

- Always shut off and lock the master electrical control switch before servicing the machine.
- Train workers on the electrical hazards associated with an irrigation system, including:
 - The risk of electrocution from an electrical power source is increased when water is present.
 - Holding an electrified object can cause your muscles to contract, making it impossible to let go of the object as long there is electric current. This may cause serious injury or death.









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# 5U60OH008487). For more information visit work-related-fatalities-face.

Safety & Health Assessment & Research for Prevention



REPORT #: 71-204-2021s