

TO: Director, National Institute for Occupational Safety and Health

FROM: California Fatality Assessment and Control Evaluation (CA/FACE) Program

SUBJECT: A butcher died after getting his hand caught in a meat grinder.

SUMMARY
California FACE Report #03CA008

A 62-year-old Hispanic male butcher died the day after he caught his right hand in a meat grinder. The victim was cleaning the grinder when he stuck his hand into the revolving worm gear through the feed bowl. The power source to the meat grinder was not disconnected prior to the cleaning process. The victim was an independent contractor who rented space in a store and used the store's meat grinder. The owners of the store did not have any policy or program to ensure the safe use of the meat grinder. The CA/FACE investigator determined that, in order to prevent future occurrences, employers should:

- Ensure users of meat grinders disconnect or lockout and tagout the power source before starting the cleaning process.

INTRODUCTION

On November 3, 2003, at approximately 5:00 p.m., a 62-year-old butcher caught his right arm in a screw-type meat grinder. He underwent emergency surgery to amputate his right arm below the elbow and died the next day. The CA/FACE investigator learned of this incident on November 13, 2003, through the Division of Occupational Safety and Health (Cal/OSHA). On February 12, 2004, the CA/FACE investigator traveled to the market where the incident occurred and interviewed the owner and employees of the market. The meat grinder involved in this incident had been discarded by the owner before this investigation took place.

The market where the incident took place was a privately-owned small grocery and meat market. The market owner had owned the store for two years and had four employees. They were all at the market when the incident occurred. The victim was not an employee of the market. According to the store owner, the victim was self-employed; he rented space in the market and was allowed to use the meat grinder. The victim had been renting space for the past year. The victim was born in El Salvador. He had been in the United States for 23 years and spoke primarily Spanish with English as a second language. The victim communicated with the employees of the market in Spanish.

The owner of the market did not have a written safety program. There were no written instructions on safety for the store employees or other workers using the facility. Employees and the victim did not hold safety meetings, and the market did not have a training program.

INVESTIGATION

The site of the incident was a small grocery and meat market that was privately owned. The machine involved in the incident was a screw type meat grinder (**Exhibit #1**). The meat grinder was discarded before this investigation took place. It is not known if the meat grinder had an interlock safety switch that shut off the power when the feed pan was removed, or if the switch was faulty, or if it had been by-passed.

On the day of the incident, the victim was grinding meat for sausages using the market's meat grinder. According to a market employee, the victim had finished grinding the meat and was cleaning the grinder. The victim removed the food tray and put his hand inside the bowl of the meat grinder to remove a piece of meat that was stuck inside. Two employees of the market, who heard the victim scream, responded to his aid and tried to remove the victim's hand from the meat grinder but were unsuccessful. The paramedics were called and had to disassemble the meat grinder and take part of it with the victim as they transported him to the hospital. The victim went immediately into surgery, but died the next day.

CAUSE OF DEATH

The cause of death, according to the death certificate, was traumatic amputation of the forearm.

RECOMMENDATIONS / DISCUSSION

Recommendation #1: Ensure users of meat grinders disconnect or lockout and tagout the power source before starting the cleaning process.

Discussion: The cleaning of a meat grinder should always include the disconnection from its energy source to prevent any contact with moving parts. An energy control procedure would give specific safety instructions to those using the store's meat grinder on how to properly disconnect the power source before cleaning. This should be part of an employer's Injury and Illness Prevention Program (IIPP). Employers can ensure employees follow safe work practices through programs of training, supervision, rewards, and progressive disciplinary measures. Employers who allow others to use their equipment should develop a contractual agreement between the parties that includes an agreement that safety procedures are to be followed when using equipment, in this case safety procedures for using and cleaning a meat grinder.

References:

California Code of Regulations, Vol. 9, Title 8, Sections 3314, 4552
<http://www.cdc.gov/niosh/face/In-house/full2000105.html>

Hank Cierpich
FACE Investigator

Robert Harrison, MD, MPH
FACE Project Officer

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Laura Styles, MPH
Research Scientist

FATALITY ASSESSMENT AND CONTROL EVALUATION PROGRAM

The California Department of Health Services, in cooperation with the California Public Health Institute, and the National Institute for Occupational Safety and Health (NIOSH), conducts investigations on work-related fatalities. The goal of this program, known as the California Fatality Assessment and Control Evaluation (CA/FACE), is to prevent fatal work injuries in the future. CA/FACE aims to achieve this goal by studying the work environment, the worker, the task the worker was performing, the tools the worker was using, the energy exchange resulting in fatal injury, and the role of management in controlling how these factors interact. NIOSH funded, state-based FACE programs include: Alaska, California, Iowa, Kentucky, Massachusetts, Michigan, Minnesota, Nebraska, New Jersey, New York, Oklahoma, Oregon, Washington, West Virginia, and Wisconsin.

Additional information regarding the CA/FACE program is available from:

California FACE Program
California Department of Health Services
Occupational Health Branch
850 Marina Bay Parkway, Building P, Third Floor
Richmond, CA 94804

EXHIBITS:



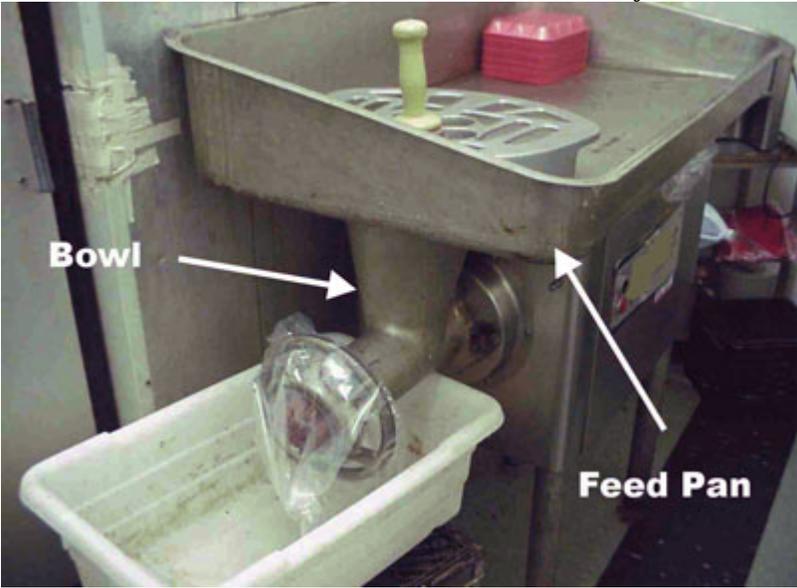
03CA008
Exhibit #1

A picture of what was left of the meat grinder after the incident. The grinding mechanism was removed by the paramedics and transported to the hospital with the victim.



03CA008
Exhibit #2

A picture of the meat grinder’s motor that was involved in the incident.



03CA008

Exhibit #3

A picture of a similar meat grinder that depicts the grinder's parts.