The National Institute for Occupational Safety and Health (NIOSH)

Promoting productive workplaces through safety and health research

# Farmer Dies in Indiana

FACE 8749

## Introduction:

The National Institute for Occupational Safety and Health (NIOSH), Division of Safety Research (DSR) is currently conducting the Fatal Accident Circumstances and Epidemiology (FACE) Project, which is focusing primarily upon selected electrical-related and confined space-related fatalities. The purpose of the FACE program is to identify and rank factors that influence the risk of fatal injuries for selected employees.

On May 26, 1987, a farmer suffocated when he was engulfed in shelled corn inside a grain storage bin. The storage bin had a capacity of 12,000 bushels.

## Contacts/Activities:

Officials of the Occupational Safety and Health Program for the State of Indiana notified DSR concerning this fatality and requested technical assistance. This case has been included in the FACE Project. On July 8, 1987, the DSR research team conducted a site visit, interviewed a surrogate for the victim, photographed the accident site, and discussed the incident with the coroner. Interviews with comparison workers were precluded in this case because the victim was the only employee of the farm.

## Overview of Employer's Safety Program:

The victim was the owner of a 100 acre grain farm. There was no written safety program or safety policy. The farmer was aware of the hazards associated with grain storage bins. He often instructed fellow farmers and family members never to enter a grain storage bin without a standby person present or without wearing a harness attached to a lifeline.

## Synopsis of Events:

The farmer had rented a grain storage bin with a 12,000 bushel capacity at a nearby farm. He had stored approximately 8,000 bushels of shelled corn in the storage bin. The temperature of the corn was beginning to rise and the farmer was afraid it was going to spoil. On the day of the incident he was going to load a portion of the grain onto a truck. He was planning to use a grain auger to load the corn onto a truck and to stir the corn remaining in the storage bin. He was doing this in an effort to lower the temperature of the corn. The farmer had diabetes and had recently suffered from "dizzy spells" associated with the disease. He was warned by his daughter as he left the house at noon not to enter the storage bin, and he said he would not.

The farmer drove to the bin and pulled the truck under the loading chute. He then started the auger, using the controls at the base of the storage bin. There were no witnesses to the accident, but it is assumed he climbed the ladder attached to the side of the bin (20 feet) and entered the door at the top. The farmer's son arrived at the storage bin at approximately 2:00 p.m. He noticed the auger running and only a small amount of corn coming out of the loading chute. Assuming that his father was visiting neighbors, the son opened the chute and loaded the truck. After the truck was loaded he closed the chute, but left the auger running and returned home.

At approximately 4:30 p.m., the son was notified by his wife that his father had not returned home. The son and a friend drove to the grain storage bin. The truck had not been moved and the auger was still running. In order to remove the shelled corn, the door on the side of the bin was opened. Cutting torches were used to cut holes at the base of the storage bin. The shelled corn was shoveled away from the storage bin by hand for approximately two hours before the farmer's body was found.

## Cause of Death:

The coroner listed "suffocation" as the cause of death.

## Recommendations/Discussion:

**Recommendation #1: When work is being performed in a confined space containing unstable material, a standby person should be utilized.**

Discussion: A standby person stationed outside of confined spaces containing unstable material (i.e. shelled corn) should maintain constant communication with the worker inside the area. If visual contact cannot be maintained, the standby person should at least maintain voice contact. The use of a standby person would have greatly reduced the amount of time before rescue procedures began and may have prevented this fatality.

**Recommendation #2: Confined spaces containing unstable material should be equipped with life lines and harnesses at their entrance point(s).**

Discussion: Life lines and harnesses should be present at the entrances) of confined spaces containing unstable materials and should be utilized by all persons entering the confined space. If these are not provided by the manufacturer they should be installed by the user prior to entry into the confined space. A life line and harness might have prevented this fatality.

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