Worker Hit by Truck in Off-road Incident in Wyoming

SUMMARY

A 29 year old female flag person died from injuries suffered when she was run over by the truck she had been using to service portable toilet facilities. The victim served generally as an oil field roustabout which included maintenance of toilet facilities in the area. While servicing these facilities, she drove a truck from facility to facility and left the truck parked while servicing the units. She reported her location by radio during mid-afternoon and was not heard from after than. During the late afternoon, an oil field employee noticed her truck which was apparently unattended and went to investigate. He found the driver's side door open, the motor running, and the radio playing. Tracing the truck tracks back up the hill, he discovered the deceased some two hours after her last radio contact.

On scene evidence suggests that the victim had left the truck parked with the motor running while she did her work, and that it rolled down the hill as she was either crossing in front of it or trying to reach the driver's door to stop the vehicle. She was caught under the wheels of the vehicle and apparently died within minutes of being run over.

Employers may be able to minimize the potential for occurrence of this type of incident through the following precautions:

- **Company vehicles that are available for employee use should be periodically inspected and maintained for safety.**
- **When employees who routinely report locations fail to report as expected, dispatchers should be alerted to contact them to ascertain that they are safe.**
- **Vehicles should not be left standing with their motors running while other work is being done.**

INTRODUCTION

On a Wednesday afternoon, September 1, 1993, a female oil field roustabout was servicing company portable toilet units. She had been hired as a truck driver and had worked for the company for four months. Her specific job at the time of the incident was to maintain portable toilets for the company by driving between units in a company owned, 4 year old, one ton truck that was equipped with two tanks for use in portable toilet maintenance. One of the tanks was used for rinsing the units and the other was used for vacuuming contents when necessary.The vehicle had been purchased by the company approximately two months prior to the incident.

The victim had been working since seven o'clock that morning. She travelled alone to various job sites and reported her location by radio. By mid afternoon, she reported by radio that she was at the location where the incident occurred. The last log book entry she made was to indicate the time and location of that stop.

INVESTIGATION

Through a reciprocal notification agreement with the Director of the Occupational Safety and Health Division of the Department of Employment, the WY- Wyoming FACE Project was notified on the afternoon of September 4, 1993. Reports were requested and received from local coroner and law enforcement offices and the Project Coordinator conducted an investigation.

The victim had worked for the company for only four months, and had been hired as a truck driver. Prior to the incident, she had conducted roustabout duties and was servicing portable toilets for the company at the time of the incident.

She had been driving a one-ton dual flatbed pickup truck that had two tanks on the flatbed. One of the tanks was used in rinsing the units and the other was to vacuum out the contents. The victim had been trained in the use of the tanks, but not on the operation of the truck, since she was hired as an experienced driver.

The truck was parked on a downslope in a high desert area that was covered by sagebrush. There were high winds from the west with gusts of 34 to 46 miles per hour. The truck was facing east with the driver's door open and the motor running. The truck radio was playing and the gear was placed in neutral. The emergency brake cable was not connected, leaving the brake inoperable, and there were no wheel blocks to prevent the truck from rolling.

It appears that the truck began rolling down hill with the wind behind the truck. The victim apparently saw the truck rolling and tried to get it under control. Evidence at the scene suggests that she grabbed the steering wheel, causing the truck to veer to its right, but that she fell and was run over by the back dual tires as the truck rolled on down the hill for approximately 275' more.

The victim was found by an employee of the oil field for which the victim's firm was working as a sub-contractor. A notation in the victim's logbook showed that the last entry was made nearly two and a half hours before her body was found, and it appears that she died instantly from the injuries resulting from being run over by the truck.

The employee who discovered the body used his truck radio to call for help and first responders arrived approximately 20 minutes after notification. Ambulance responders arrived within seconds of law enforcement officers and the victim was pronounced dead by the deputy coroner who also served as ambulance chief.

CAUSE OF DEATH

The Medical Examiner listed the cause of death as hemorrhagic shock due to rupture of spleen and mesenteric vessels, due to crush injury of chest and abdomen.

RECOMMENDATIONS/DISCUSSION

This incident could have been prevented by the victim herself by shutting off the motor of the truck and placing it in gear to prevent it from rolling. The fact that the truck's emergency brake was inoperable must also be seen as a contributor to the incident, although it is not known whether the brake had been set by the victim.

Evidence at the scene indicates that the victim attempted to gain control of the moving vehicle, and that her efforts prevented the truck from crashing into a power pole. Had she gained entry to the vehicle she might still have crashed into the pole and suffered injuries from that crash. Once the truck began rolling, her best safety action would have been to simply stay out of its way.

Her employer states that truck drivers are responsible for the maintenance of their vehicles and are to report major problems, such as the absence of an operable emergency brake, that require shop work. There is no documentation that any report was made on the truck that the victim was driving.

While it may not have helped in this instance, it would be good policy to have a dispatcher question long periods of non-communication where locations are routinely called in. There had been a radio location report when the victim arrived at the unit where the incident occurred, and she was not discovered for another two and a half hours. She appears to have died instantly from the injuries she received, but a periodic call-back might alert others in similar instances that a driver is unresponsive and a search for a less seriously injured driver may be life-saving.

FATAL ACCIDENT CIRCUMSTANCES AND EPIDEMIOLOGY (Wyoming FACE) PROJECT

The National Institute for Occupational Safety and Health (NIOSH), Division of Safety Research (DSR), performs Fatal Accident Circumstances and Epidemiology (Wyoming FACE) investigations when a participating state reports an occupational fatality and requests technical assistance. The goal of these evaluations is to prevent fatal work injuries in the future by studying the working 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.

States participating in this study include: Kentucky, Maryland, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, Virginia, and West Virginia.

NIOSH Funded/State-based Wyoming FACE Projects providing surveillance and intervention capabilities to show a measurable reduction in workplace fatalities include: Alaska, California, Colorado, Georgia, Indiana, Iowa, Massachusetts, New Jersey, Minnesota, Missouri, Wisconsin and Wyoming.

Additional information regarding this report is available from:

Wyoming Occupational Fatality Analysis Program
522 Hathaway Building - 2300 Capitol Avenue
Cheyenne, WY 82002
(307) 777-5439

Please use information listed on the Contact Sheet on the NIOSH FACE web site to contact In-house FACE program personnel regarding In-house FACE reports and to gain assistance when State-FACE program personnel cannot be reached.