Counselor Dies in Traffic Crash in Wyoming

SUMMARY

A 32 year old male group-home counselor died from injuries received in a two vehicle traffic crash on April 19, 1993. The victim was driving his personal car, a compact four-door sedan with four young passengers (ages 14 & 15) from the group-home residence to an in-town YMCA for an "adventure based training" program aimed at building self-esteem and confidence among group home residents. The vehicle was travelling in front of two accompanying vehicles of group home officials during the late morning, with snow falling and slush on the road. As the vehicle entered a left hand curve, the driver apparently lost control and the vehicle began a clockwise rotation into the opposite lane of travel, sliding sideways into a pickup that had entered the curve from the opposite direction. The impact was at the left front quarter panel of the victim's vehicle and the left front bumper of the pickup, killing the driver and two back seat passengers, and injuring two other passengers who were on the right side of the victim's car.

The incident occurred within visual distance of a health care center, and medical personnel were on the scene instantly. EMTs arrived within 7 minutes of the incident, and the highway patrol investigators arrived a minute later. The driver and the leftmost back seat passenger died instantly at the scene, and the back seat center passenger died within minutes of hospital arrival. Two additional passengers in the victim's vehicle were hospitalized.

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

- **Ascertain that drivers responsible for transport of clients are aware of area-unique driving hazards**
- **Limit vehicles used in transport to company vehicles when available**

INTRODUCTION

In the late morning of Monday, April 19, 1993, a counselor for young men residing in a court-referral group-home complex was in the process of transporting four residents from the home to an in-town YMCA facility for a confidence building training program. In caravan with other cars holding officials of the group home, the victim was driving his personal car in the lead. One of the four clients was seated in the front passenger seat, and the other three clients were in the back seat of the victim's car.

Snow was falling, and the blacktop roads were slush covered. The roadway was an adequately maintained state secondary highway, marked for two lanes of traffic with 8' shoulders on either side. There were no barriers to prevent vision, and visibility was such that drivers of approaching cars could

see each other at a distance from which they could react to a potential for collision. The car being driven by the victim was moving in a southeasterly direction at approximately 50 miles per hour, entering a curve that would bend to the drivers left.

Evidence at the scene suggests that the driver/victim drifted toward the right shoulder of the road approaching an intersection with a county road, and attempted to correct the vehicle by turning slightly to the left. This corrective action apparently caused the vehicle to go out of control and veer into the opposite lane in a clockwise spin that placed the driver's side of the vehicle in the path of oncoming traffic.

A pickup was approaching from the opposite direction, headed into the curve in a southwesterly direction. The driver of the pickup stated that he saw the victim's vehicle go out of control, braked, and moved to his right to avoid a collision. After having moved onto the right hand shoulder, the pickup driver then pulled back onto the roadway, apparently thinking either that the victim had regained control of his car or that the out-of-control car was moving to its left more quickly than it was.

INVESTIGATION

The WY-Wyoming FACE Program became aware of this incident from a radio news story on the afternoon of its occurrence. Newspaper articles and electronic media coverage the next day confirmed the early findings and verified that the incident was occupational. At that point, the Project Coordinator initiated requests for reports from hospital, ambulance, coroner, and law enforcement officials, and travelled to the location for an on-site investigation.

Evidence at the scene and reports from investigators show that the vehicles impacted with the front left bumper of the pickup protruding into the left front quarter panel of the victim's sedan. On impact, the rear of the victim's car rotated into the right front of the pickup and both vehicles came to rest in the southwest lane of travel.

The victim had been working for the employer for about six weeks as a counselor/teacher. He was transporting four youths from a youth home to a nearby gym for a planned exercise to build self-esteem and confidence among the participants. He was driving the lead car in a multi-vehicle caravan and was unfamiliar with driving conditions in the area, having recently moved from the mid-west.

CAUSE OF DEATH

The Medical Examiner listed the cause of death as multiple thoraco-abdominal trauma due to automobile accident.

RECOMMENDATIONS/DISCUSSION

This incident could have been prevented by limiting transport of agency clients to experienced drivers utilizing agency owned vans or buses. The driver in this instance was new to the area and to the facility,

having recently moved from the midwest. Winter driving conditions in Wyoming are unique. Absent severe blizzard conditions, the road in question would not have been especially hazardous to a driver with experience in Wyoming winter driving.

It should be noted that, due to snowfall, a change had been made in the expected procedure of the day's events. The staff had planned an event at the facility that would not require transport of the residents. A rather sudden change in plans took place, and the staff was making quick arrangements to adapt to the change. As a result, normal procedures were discarded to make the adjustments necessary in short order with minimal diversion for the residents. Quick decisions of this type often appear necessary to minimize the opportunity for events to get out of hand when dealing with young people from troubled backgrounds.

This incident points out the increased opportunity for error when changes are made abruptly. Such changes tend to place stress on the weakest part of the system (such as a helpful, willing, but inexperienced young counsellor) and the system deteriorates under pressure. Given time and thoughtful planning, the facility would have made arrangements for all of the residents to be transported by experienced drivers in company owned vehicles. Under the sense of urgency that accompanied the sudden change of plans, the driver was allowed to transport residents in his personal car.

While it might not have had an effect in this situation, as the facility's stated policy of not transporting their residents in private vehicles was not followed, it would be a sound practice to offer winter driving programs to company personnel who are involved in the transport of residents. Driver education and improvement classes are available throughout the state, including courses at local high schools and through law enforcement agencies or the Wyoming/Montana Safety Council.

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.