

Ranch Owner Run Over by Tractor in Wyoming

SUMMARY

An 87 year old male ranch owner died in the emergency room of an out of state hospital after having been run over by a tractor in an preventable early morning incident at a rural ranch near the border of the state. The victim had been riding to the loading site with a hired hand, and was opening and closing gates while the hired hand drove through them. The prescribed procedure was for the victim to remain in the pickup while the hired hand forked hay from the stack to the feeding area, and for a dog to keep the cattle away from the stack. At the time of the incident, the victim was behind the loader as it backed from the hay stack, and was trapped under the tires, crushing his upper torso and head. On realizing that an injury had occurred, the hired hand drove the pickup a mile down the road to where the victim's son was feeding, and the son stopped at a nearby phone to call 911 for the nearest ambulance location (estimated as an 8 - 10 minute drive). The ambulance service responded to the scene within 10 minutes of notification. The victim was transported to an out-of-state hospital 50 miles from the incident scene, arriving more than an hour after the incident had occurred, and was pronounced dead in the emergency room a half hour later.

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

- **Concern for good visibility and/or back-up warning devices on home-made machinery.**
- **Established emergency procedures for farm/ranch injuries.**
- **Reminders to elderly ranching family members of the increased hazards that accompany age.**

INTRODUCTION

At approximately 6:30 a.m., Monday, March 23, 1992, a ranch owner was working with his hired hand feeding livestock. The hired hand was operating a feeding tractor that had been constructed as a loader on a truck chassis. General operating procedure was for the hired hand to drive the tractor to the hay stack, use the loader to transfer hay from the loft to the feeding area, and return the tractor to its source destination. The owner rode with the hired hand, opening and closing gates for the tractor to pass through. While the hay was being transferred from the hay stack, the owner usually remained in a protected area away from the actual operation. A farm dog was present, and the victim was to send the dog after stray livestock when necessary.

INVESTIGATION

Through a notification agreement with the Colorado FACE Program, the WY-FACE Project was notified of the incident by copy of a Colorado Certificate of Death on April 21, 1992. Reports were requested from the investigating Law Enforcement agency, the hospital where the victim died, and the responding ambulance service. WY-FACE notified Wyoming OSHA of the event.

The victim was self-employed as part owner of a family corporation that had been in the ranching business for 35 years. The ranch was operated by the victim, his son and daughter-in-law and occasional part-time workers. The victim was semi-retired, in that he was no longer involved in major ranchwork but had, for the past five years, assisted by the duties he was performing when the incident occurred. He was an elderly worker, with limited hearing and sight and slowed reactions.

The victim had been assisting a ranchhand in a cattle feeding operation, and was on foot behind the loader at the time of the incident. The victim had diminished hearing and vision and other age-related impairments, such as slowed reaction time. Having opened gates for the ranchhand to drive through, the victim was expected to remain inside a pickup which was parked to the left of a hydraulic loader, while the ranchhand forked hay from a stack to a feeding area. A ranch dog was used for livestock control to keep cattle away from the open stack or from wandering outside of a corral. The corral area included an open haystack with a deer-fence around it. The loader was in front of the haystack and inside an opening in the deer fence. The pickup where the victim had been sitting was to the loader operator's left and adjacent to the loader. Cattle were roaming freely around the pickup, loader and haystack.

The vehicle is a 12 year old homemade hydraulic loader mounted on a pickup chassis. Vision from the operator's seat is partially blocked by the radiator. Both victim and operator appeared unaware of their proximity to each other. Operator ceased operation on discovery of contact with victim.

Emergency Medical Services was notified through 911, and was on the scene 10 minutes after notification. The victim arrived in the emergency room less than an hour after ambulance notification. CPR was begun enroute and continued in the emergency room. Blood was infused in the emergency room. The victim died from a loss of blood resulting from a massive head injury.

There is some question regarding the time span from the incident to ambulance notification. Witnesses and responders note time lengths from five to twenty-six minutes. The victim lay on the ground for a period of time while the loader operator attempted to get help for him. The operator drove a pickup approximately a mile away from the scene to alert another worker, who used a nearby phone to call for an ambulance. EMT's arriving on the scene, 10 minutes after notification, saw blood flowing from the victim and a large amount of blood was noted on the ground. At that time, he was not breathing, was pulseless and non-responsive, and his pupils were fixed and pinpoint. Oral airway was inserted and CPR started, and IV and defibrillation were performed enroute. The victim was brought to the hospital emergency room 56 minutes after ambulance notification and was pronounced dead 30 minutes later.

Other workers were involved in similar duties on other parts of the ranch, but not within visual or audio range of each other. Actions of the dog and the cattle are unknown immediately following the incident. Equipment was shut down to prevent further incidence.

CAUSE OF DEATH

The Medical Examiner listed the cause of death as Exsanguination from crushed chest and skull.

RECOMMENDATIONS/DISCUSSION

This incident could have been prevented if the victim had remained inside the pickup according to prescribed procedure. Concern must be given to a partial vision block from the tractor radiator. Even though the victim was expected to be out of harm's way, the driver might have better assured himself of safety while backing up.

Special care should be taken when elderly people with sight and hearing limitations and diminished reactive capabilities are involved in ranch or feeding operations. Apparent concern had been shown in that the victim routinely remained inside the pickup while the loading operation was being conducted.

There would be an advantage to developing and posting written safety rules for operation of farm equipment, along with a system for periodic review of safe equipment operation by farm workers.

There would be an advantage to written emergency procedures to be used in the event of a life-threatening incident, and review of the procedures on a periodic basis. They should list who to contact, and each worker should be aware of the location of other workers.

There would be an advantage for safety-oriented organizations to publish safety hints in newspapers or journals that are read by farm and ranch operators. Published reminders of this sort could be available to ranch owners, operators, and workers; and could be made available for posting on or near outbuildings and work areas.

FATAL ACCIDENT CIRCUMSTANCES AND EPIDEMIOLOGY (FACE) PROJECT

The National Institute for Occupational Safety and Health (NIOSH), Division of Safety Research (DSR), performs Fatal Accident Circumstances and Epidemiology (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: Georgia, Indiana, Kentucky, Maryland, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, Virginia, and West Virginia.

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

Additional information regarding this report is available from:

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Cheyenne, WY 82002
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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