FACE Investigation 96C0080

In February 1996, a 54-year-old landscaper died of injuries incurred when he was catapulted from the operator's seat of a truck-mounted boom.

Introduction:

Fatalities occurring in Colorado workplaces are reported to the Colorado Department of Public Health and Environment (CDPHE) by , in co-operation with the National Institute for Occupational Safety and Health, Fatality Assessment Control Evaluation (FACE) investigations when a report of an occupational fatality is received. The goal of these investigations is to prevent future fatal work injuries by the study of: the working environment, the worker, the task the worker was performing, the tools the worker was using, and the role of management in controlling how these factors interact.

Contacts/Activities:

This incident was reported to CDPHE by the county coroner. An investigator from CDPHE conducted a site visit, photographed the site, interviewed the employer's son, and obtained the coroner's report.

Overview of Employers Safety Program:

The employer did not have a written safety program or hazard communication program. The operation being done was not a normal activity for the company or the victim.

Synopsis of events:

This landscaper normally worked in the logging industry. The equipment involved with this injury was a Barco model 8000 boom truck designed to lift logs to and from the truck bed, and was owned by the deceased. To supplement his income, he occasionally used the equipment to do landscaping work. On the day of the injury, he was using the truck and boom to lift a large rock from the truck bed to place it on the ground. To accomplish this task, he was seated in the operator's seat located at the rear of the truck bed, at the pivot point of the truck-mounted boom, approximately ten feet off the ground. The seat was not equipped

with a seat belt. As the boom swung free of the truck bed, the weight of the rock caused the right rear wheels of the truck to leave the ground. The operator released the rock, causing the truck wheels to drop to the ground. This action caused the operator to be catapulted from the seat. He landed on the ground, clear of the truck, suffering head and spinal cord injuries. He died 33 days later.

Cause of Death:

The cause of death was determined by autopsy to be adult respiratory distress syndrome due to a consequence of pulmonary emboli and bilateral pneumonia as the result of a fall.

<u>Recommendations/Discussions:</u>

Recommendation #1: Proper equipment should be utilized for any specific task.

<u>Discussion:</u> In this instance, the victim was using a boom truck designed to load logs onto a truckbed. When he attempted to use this piece of equipment to move a large landscaping rock, he exceeded the lifting capacity of the equipment.

Recommendation #2: Employers should develop and implement comprehensive written safety programs.

As part of this safety program, the employer should determine the rated capacity and design purpose for equipment to be utilized.

<u>Discussion:</u> This employer did not have a written comprehensive safety program. Even small companies should evaluate the tasks done by workers to identify all potential hazards. The employer should then develop and carry out a safety program addressing these hazards, provide worker training in safe work procedures and implement appropriate control measures.

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Distribution:

Family of Victim
NIOSH, DSR
CO. DIV. OF RISK MANAGEMENT
CSU (OSHA CONSULTATION)
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