

FACE Investigation 90C0057

SUBJECT: Garbage Collector Dies After Falling From Back of
Moving Garbage Truck

SUMMARY:

A 33-year-old male garbage collector died after falling from the back of a moving garbage truck. The victim and the driver of the garbage truck were following a routine garbage collection route. The victim was standing on a smooth steel bar at the back of the vehicle. The driver entered an alley. The victim then signalled the driver to back up. As the driver was backing the truck, he checked the right mirror to determine clearance, and then looked into his left mirror to reestablish visual contact with the victim. The victim was not in sight. At that time he felt a slight bump. He stopped the truck, pulled forward, and then got out to investigate. The victim was lying face down behind the truck. The Colorado Department of Health (CDH) investigator concluded that, in order to prevent future similar occurrences, employers should:

- * provide a non-slip platform on which the employee could stand
- * require that steel-toed safety shoes with non-skid soles and protective head gear equipped with a chin strap be worn by employees at all times.
- * provide training and implement comprehensive safe work procedures that specifically address job site hazards

INTRODUCTION:

On November 7, 1990 a 33-year-old male garbage collector (victim) sustained fatal head injuries after falling from the rear of a moving garbage truck. On November 8, 1990 CDH was notified of the fatality by the Occupational Safety and Health Administration (OSHA) and an investigation was initiated. The CDH investigator obtained investigation reports from the local police department and the County Coroner. Site photographs were obtained from the police department. The employer was interviewed and the vehicle involved was inspected.

The employer in this incident is a privately-operated garbage collection service that employs 22 personnel and has been in business for 35 years. The company has a general written safety policy, but does not employ a full-time safety officer. Employee training is accomplished through classroom safety meetings and on-the-job supervision. All collection vehicles are equipped with 2-way radios through which personnel are to contact the company in the event of an emergency. There is no company requirement for personal protective equipment. The victim had been employed for 22 months as a helper on garbage collection trucks.

INVESTIGATION:

The employer assigned a garbage collection crew to a routine collection route in a residential area of the city. The crew consisted of a garbage truck driver and one garbage collector (victim).

The victim routinely rode on the back of the truck, standing on a smooth 4-inch steel bar that extends the width of the vehicle. A hand-hold is present on both sides of the compactor cavity. The bar is 22 inches above ground level.

At 9 a.m. the driver entered a residential alley and was signalled by the victim to back up. The driver began backing the vehicle, watching the victim in his left mirror. The driver checked his right mirror, and then could not locate the victim in the left mirror. At that time, the driver felt a slight bump. He then stopped, pulled forward, and stopped to investigate. The victim was lying face down behind the vehicle with his head directly behind the left dual wheels. The driver immediately radioed the company and ran to a nearby residence to obtain help.

The temperature was below freezing and a light snow had fallen that night. The victim's boots were a laced boot with smooth leather soles. All windows in the vehicle were clear and unobstructed and the mirrors were properly adjusted. The vehicle brakes were found to function properly and the vehicle was not equipped with a back up alarm.

CAUSE OF DEATH:

The cause of death was determined by autopsy and listed as skull fracture (egg shell), crushed chest with bilateral rib fractures and liver laceration.

RECOMMENDATIONS/DISCUSSION:

Recommendation #1: Install non-skid, self-cleaning platforms at the rear of the vehicle on each side.

Discussion: The employer should install platforms for the employee to stand on that are self-cleaning and have a non-skid surface. The steel bar that was presently in place did not offer any traction for the employee's boots and was subject to a build up of ice and snow.

Recommendation #2: Provide employees with steel-toed, non-skid safety boots and approved protective helmets.

Discussion: The employer should implement 29 CFR 1910.132 that requires personal protective equipment be provided, used, and maintained wherever it is necessary to prevent injury from existing hazards. In this incident, the presence of such equipment could have prevented the initial fall and possibly offered limited protection from the impact of the vehicle.

Recommendation #3: Employers should develop, implement, and enforce a comprehensive written safety program.

Discussion: Employers should emphasize the safety of their employees by developing, implementing and enforcing a comprehensive safety program. The safety program should include , but not be limited to, training workers in the recognition and avoidance of fall hazards.

Lyle E. McKenzie
Chief Investigator/Industrial Hygienist
Environmental Epidemiology Division
Occupational Epidemiology Program

Distribution:

Employer of Victim
COLORADO DEPARTMENT OF HEALTH (INTERNAL DISTRIBUTION)
NIOSH, DSR
CO. DIV. OF RISK MANAGEMENT
CSU (OSHA CONSULTATION)
COLORADO CORONER'S ASS'N
OSHA DENVER AREA OFFICE
OSHA ENGLEWOOD AREA OFFICE
OSHA REGION 8 OFFICE
NIOSH REGIONAL OFFICE
BUILDING AND CONSTRUCTION TRADES COUNCIL OF COLORADO
OPERATING ENGINEERS LOCAL NO 1
CONSUMER PRODUCT SAFETY COMMISSION
UNITED STEEL WORKERS OF AMERICA
COLORADO SAFETY ASSOCIATION
NATIONAL SAFETY COUNCIL
COLORADO AFL-CIO