SUBJECT: Cattle Ranch Foreman was Fatally Injured While Unloading Portable Corral

FACE Investigation # 89CO027

Introduction:

The Colorado Department of Health in co-operation with The National Institute for Occupational Safety and Health (NIOSH),Division of Safety Research, performs Fatal Accident Circumstances and Epidemiology (FACE) investigations when a report of an occupational fatality is received. The goal of these evaluations is to prevent fatal work injuries in the future by 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.

On November 3,1989, a 42 year old cattle ranch foreman was fatally injured while attemping to unload several sections of a portable corral.

Contacts/Activities:

Under the terms of a cooperative agreement the Workmen's Compensation Division of the Colorado Department of Labor, notified the Colorado Department of Health of a work-related fatality. An investigation was initiated. A meeting was held with the employer. The accident site was photographed. Investigation reports were obtained from the employer and county sheriff. In addition, the coroner's report was obtained.

Overview of Employers Safety Program:

The employer has been in the cattle business for ten years. The company employs five individuals.

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

Synopsis of events:

The fatal accident occurred on a Friday afternoon at approximately 1430 hours. At 1400 hours the victim left the ranch headquarters unaccompanied in a pickup truck towing a gooseneck trailer loaded with 12 metal corral panels. His intention was to set up a portable corral at a leased pasture.

The twelve corral panels were wired to one side of the trailer, fastened as a group at each end.

When the victim had not returned to ranch headquarters by 1800 hours, two fellow employees were sent to assist him in completion of chores at a second site where the victim should have arrived. When discovering that the victim had not arrived at the site a search was initiated. Shortly after 1900 hours the victim was found at the leased pasture. The victim was inside the trailer pinned against the trailer wall by the portable corral panels. The panels were unwired on the end nearest the rear of the trailer. The victim was found at the point where the second wire had been fastened. It is assumed that when the victim loosened the second wire that the panels tipped towards him and pinned his chest to the opposite wall of the trailer.

Cause of Death:

The cause of death was determined by autopsy to be mechanical compression of the chest resulting in asphyxiation.

Recommendations/Discussions:

Recommendation #1: When portable corral panels are moved, the panels should be secured to the side of the transport vehicles in pairs.

Discussion: In this instance, the twelve panels had been secured as one unit. The combined weight of the panels was too great to allow the victim to stop their movement as they tipped towards him, or to push them upright.

Recommendation #2: Employers should develop and implement comprehensive written safety programs. As part of this safety program, the employer should conduct regular training for all employees.

Discussion: This employer did not have a written comprehensive safety program. Rules and procedures addressing the hazards associated with work of this nature should be developed, implemented, and enforced. A risk assesment should be conducted on each task so that possible hazards can be identified and included in the safety plan.

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Lyle E. McKenzie
Industrial Hygienist
Environmental Epidemiology Division
Colorado Department of Health