TO: Director, Occupational Health Surveillance Program, Massachusetts Department of Public Health

FROM: Massachusetts Fatality Assessment and Control Evaluation Program (MA FACE) Investigator

SUBJECT: Massachusetts Trash Collection Company Operations Manager Dies When Crushed between Conveyor Truck and Dumpster MA 92-20-01

DATE: May 21, 1993

SUMMARY

On September 15, 1992, a 45 year-old male off-duty municipal firefighter was crushed to death while employed in a supplemental occupation as a trash collection operations manager. In the process of loading a trash dumpster onto a parked conveyor truck, the victim was pinned between the conveyor truck and the dumpster. He was transported to a regional medical center where he died of his injuries approximately two hours later.

The Massachusetts FACE Investigator concluded that to prevent similar occurrences in the future, employers should:

- establish a comprehensive safety program that includes safe work procedures that are pertinent to specific job tasks

- periodically evaluate job related processes to eliminate or minimize unnecessary and potentially hazardous measures

INTRODUCTION

On September 18, 1992, the Massachusetts FACE Investigator was notified by a municipal assistant city clerk of an occupational fatality on September 15, 1992. An investigation into the incident was initiated on September 28, 1992. On September 30, 1992, the MA FACE Investigator traveled to the incident site and interviewed the employer who was directly involved in the incident, and another employee of the company. The employer statement, employer articles of organization, multiple photographs and death certificate were obtained during the course of the investigation.

The employer was a regional trash collection/disposal company in business for 4 years and 5 months. Other than the victim who was operations manager, the company employed only one other employee, as a truck driver. At the time of the incident, the company did not employ a designated safety person nor did it have any written comprehensive safety rules or procedures in place. The

victim, whose primary occupation was as a municipal firefighter, also worked for the trash collection company for 6 years (1 1/2 years prior to company incorporation.)

INVESTIGATION

On the day of the incident, the employer and the victim were transporting dumpsters off the company storage lot for placement or disposal. The business was also being readied for final closure.

To ready the dumpster for transport, the victim backed the conveyor truck to within 15-20 feet of the dumpster, exited the truck and stood beside it. Believing the victim was beside his vehicle, the employer then operated a small front end loader from behind the dumpster to push it closer to the conveyor truck for loading. He lost sight of the victim during this process. He pushed the dumpster until it contacted the truck, exited his loader, and came around from behind the dumpster to help load in onto the conveyor truck. It was then that he discovered the victim pinned between the conveyor truck roller and the dumpster. The employer speculated that the victim may have backed the truck up a second time while the dumpster was being moved. Exactly how or why the victim came to be in the pinch point area remains unexplained.

The employer immediately released the vehicle parking brake permitting it to lurch forward, thus releasing the victim. He quickly summoned emergency medical services and tended to the victim until help arrived within 3-4 minutes.

The victim was transported to the regional medical center where he was pronounced dead approximately two hours later.

CAUSE OF DEATH

The medical examiner listed the cause of death as blunt trauma to the abdomen.

RECOMMENDATIONS/DISCUSSION

Recommendation #1:Employers should establish a comprehensive safety program that includes safe work procedures that are pertinent to specific job tasks.

Discussion: In this instance the victim was caught between the conveyor truck and the moving dumpster. Employers should systematically evaluate tasks performed by workers, identify potential hazards and develop, implement and enforce written safe work procedures addressing the identified hazards. The safety program should include training of all full time and part time workers in safety procedures pertinent to specific tasks and recognizing and avoiding job hazards. Had safety procedures required individuals to remain in the truck or in the line of vision, this incident may have been avoided.

Recommendation #2:Employers should periodically review job related processes to eliminate or minimize unnecessary and potentially hazardous measures.

Discussion: Apparently, previous placement of the dumpster necessitated repositioning by the front end loader to better situate it for loading onto the conveyor truck. Normally, dumpster loading is a single-person process in which the conveyor truck is simply backed up to the dumpster where a wire rope winch line is attached to hydraulically pull the dumpster onto the conveyor truck. Had original placement of the dumpster been more conveniently made it would not have been necessary to reposition it with the front end loader, which exposed the victim to the hazard.