

FACE INVESTIGATION

SUBJECT: General laborer at a feed mill dies after presumed fall followed by vehicle run over

SUMMARY:

Twenty year old white male worker, 8 months on the job was found on the cement crushed by the wheels of a semi. The semi driver had his truck weighed then filled with corn. With the truck running, the driver got out and secured his tarp over the grain, then jumped into the cab and pulled off the scale. It is surmised that the worker had fallen while climbing on the truck to obtain a grain sample and then was run over by the semi and died immediately of injuries sustained. Other workers did not see the incident occur. The truck was wet as it was raining, the driver was not aware that any grain sample was being taken. The Wisconsin FACE investigator concluded that, in order to prevent similar occurrences, the employer should:

! Survey the work-site to identify hazards. All employees should then be informed of possible hazards.

! Consider and address worker safety in the planning phases of projects.

! Implement 29 CFR 1910.272 (e)(1)(ii), training in specific procedures and safety practices especially as it relates to signaling and lockout and tag/out.

INTRODUCTION:

On November 1, 1991 a 20 year old general laborer died of injuries sustained when he was run over by a semi as it pulled off the scale at a feed mill. The WI FACE investigator was notified by the Department of Labor and Human Relations, Safety and Buildings Division on November 5, 1991. The death certificate, worker's compensation claim, OSHA and sheriff's report and photographs were obtained. On March 3, 1992 a site visit was made, photographs were taken of the site and the employer and supervisor were interviewed.

The company has been in operation for 63 years and employs 18 people, 5 with occupations similar to the victim. The company owner serves as safety officer and is at the site full time. The only training provided is on the job training, there are no written safety rules and no meetings held regarding safety. It is surmised that the worker was taking a corn sample and that he fell and was then crushed under the wheels of the semi. Climbing up on trucks to obtain a sample is the company's current standard operating procedure.

INVESTIGATION:

It was raining heavily on the morning of November 1, 1991. The victim was working alone and the incident was not witnessed. Due to the rain the trailer would have been quite slippery. It is believed that the victim was attempting to get up to a platform or step on the front of the trailer to obtain a sample when he slipped

and fell under the wheels of the semi trailer. The police report indicates that a probe used to get samples of corn was found wedged in the frame of the semi tractor. The driver of the truck was not aware that a sample was being taken and noting that the weigh in was completed, pulled his truck forward over the victim. The county coroner and funeral home was called and death was pronounced on the scene by the coroner.

CAUSE OF DEATH: Massive head trauma

RECOMMENDATIONS/DISCUSSION:

Recommendation #1: Conduct a jobsite survey before starting any job to identify potential hazards. Implement appropriate control measures including training that specifically addresses all identified hazards. Workers require training and written safety procedures for taking corn samples.

Recommendation #2: Employers should address worker safety issues in the planning phase of all projects

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Recommendation #3: Implement 29 CFR 1910.272 (e)(1)(ii). Employees in this grain handling facility were not trained in the specific procedures and safety practices applicable to their job tasks including but not limited to cleaning procedures for grinding equipment, cleaning procedures for choked legs, housekeeping procedures, hot work practices, preventive maintenance procedures and lock-out tag/out procedures. At this feed mill there were no written signaling procedures and no specific signaling training had been documented. Had the victim and other workers been given training in signaling and had a written signaling procedure been in operation and had a mechanism been in place to prevent trucks from moving ahead until it was determined that all workers were clear, this incident may have been prevented.