August 16, 1995

Nebraska FACE Investigation 95NE034

SUBJECT:

Skid Steer Operator Crushed by Lift Arm

SUMMARY:

A 65-year-old male independent contractor, performing demolition work, was fatally injured in a skid-steer loader incident. It appeared the victim leaned out the right side of the machine and apparently activated the left foot pedal which caused the bucket to lower, crushing his head between the frame and the lift arm. The protective wire mesh had been removed from the cage of the loader.

The Nebraska Department of Labor (NDOL) investigator concluded that to prevent future similar occurrences, employers and employees should:

*Ensure that safety devices and physical safeguards on equipment are never bypassed or removed.

* Establish and enforce a through vehicle maintenance and inspection program.

PROGRAM OBJECTIVE:

The goal of the workplace investigation is to prevent work-related deaths or injuries in the future by a 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.

This report is generated and distributed **solely** for the purpose of providing current, relevant education to the community on methods to prevent occupational fatalities and injuries.

INTRODUCTION:

On June 26, 1995, at approximately 5:35 p.m., a 65-year-old independent contractor died as a result of injuries sustained when his head was crushed between the lift arm and frame of the skid-steer loader he was operating. The FACE investigator learned of this fatality from a death certificate received from the Bureau of Vital Statistics. Information for this report was obtained from the Sheriff's report and an interview with the victim's wife on July 12, 1995.

The victim was a master electrician and had been self employed in demolition work for the past 20 years. He employed no other personnel in the demolition business.

INVESTIGATION:

The victim had been working on this particular demolition project for about five months and this was his last day on the job. At the time of the incident there were two other individuals at the work site. The two others were a couple who were cleaning bricks from the demolished building. The victim told the couple he was going to load the skid-steer loader on the trailer to transport it off the property. They heard the engine on the skid-steer loader start and became concerned when they continued to hear it running. One of the them went to investigate and found the victim crushed between the skid-steer loader frame and the lift arm. She called 911 who responded. The victim probably died instantly from the massive head injuries. He was officially pronounced dead at 7:00 p.m..

Investigation of the skid-steer loader revealed some wire cable wrapped around the front right tire. There were no witnesses to the incident but from the physical evidence the following scenario is probable. The victim apparently raised the lift arm to get a better view of the problem (the cable wrapped around the right front tire). To view the wheel, he probably leaned out the right side of the loader and when he shifted his weight to the right, his left foot, which was on the pedal which controlled the up and down movement of the lift arm, activated the lift arm to lower. His head was caught between the lift arm and the loader frame. The loader did not have the protective wire mesh around the cab area, which allowed the victim to place his head in the danger area of the lift arm. He had purchased the skid-steer loader approximately two years ago according to his wife. She said she was not sure if the loader had the wire mesh on it at the time it was purchased or not. The loader is a 1975 model and according to the manufacturer was equipped with the protective mesh when it was manufactured. A protective wire mesh was installed on the incident loader by the victim's son prior to it being moved after the incident.

CAUSE OF DEATH: The cause of death according to the death certificate was brain laceration.

RECOMMENDATIONS/DISCUSSION:

Recommendation #1: **Ensure that safety devices and physical safeguards on equipment are never bypassed or removed.**

Discussion: Had this skid-steer loader still had the factory installed wire-mesh, or an acceptable replacement in place, this incident may have been prevented.

Recommendation #2: **Establish and enforce a thorough vehicle maintenance and inspection program.**

Discussion: Had the equipment been inspected prior to use, and not put into use until it was safe to operate, this incident may have been prevented.

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William E. Hetzler
Field Investigator
Department of Labor

Gary L. Hirsh
Principal Investigator
Department of Labor