



The National Institute for Occupational Safety and Health (NIOSH)

Promoting productive workplaces
through safety and health research



Equipment Operator Struck and Killed by Skidder – South Carolina

FACE 9316

SUMMARY

A 28-year-old male equipment operator (the victim) died from injuries received after being struck by a skidder machine (a rubber-tired machine designed to pull or tow bolts, logs, or trees across the terrain). The victim was part of a four-man crew who were cutting trees, moving the logs from the cutting site to the landing area, and ultimately transporting them to either a paper mill or a sawmill. At the time of the incident, the victim had just used the skidder machine to pull a load of logs into the landing area and drop them off. As he was exiting the landing the skidder ran over two logs laying on the ground. Although the event was unwitnessed, the victim either fell or jumped from the skidder and was struck and run over by the rear tire. Another equipment operator in the area noticed the victim lying on the ground and ran to check his condition. The emergency medical service and coroner were called, and arrived approximately 30 minutes later. The coroner pronounced the victim dead at the scene. NIOSH investigators concluded that, to prevent similar occurrences, employers should:

- **ensure that seat belts are provided and used on mobile equipment**
- **develop, implement, and enforce a written safety program.**

INTRODUCTION

On April 8, 1993, a 28-year-old male equipment operator (the victim) was killed when he was struck and run over by the skidder machine he was operating. On April 22, 1993, officials of the South Carolina Occupational Safety and Health Administration (SCOSHA) notified the Division of Safety Research (DSR) of this fatality, and requested technical assistance. On May 12, 1993, a safety specialist from DSR investigated the incident and reviewed the circumstances with the SCOSHA compliance officer assigned to the case. Photographs of the incident site and equipment were obtained, and the county coroner's report was requested.

The employer in this incident was a small logging company that had been in operation for 12 years and employed 3 workers. The employer did not have a written safety program. The victim worked for the company for 4 months as a skidder operator, and had about 8 years of experience in this occupation. This was the first fatality the company had experienced.

INVESTIGATION

The employer had been contracted to clearcut a tract of mixed timber (e.g., oak, poplar, pine, maple, etc.), and transport the logs to either a paper mill or a sawmill. Work had been in progress for about 2 months, and approximately 2 weeks of work remained to be done at the site. The crew consisted of a tree feller, a skidder operator (the victim), a log-loader operator (the company owner), and a tractor-trailer driver. The tree feller would cut, limb, and buck the trees into logs, and the skidder operator would move the logs from the cutting site to the landing area (any area where processed wood is concentrated). At the landing area, the loader operator would load the logs onto the tractor-trailer for transport to either a paper mill or a sawmill.

On the day of the incident, the crew began work as usual about 8 a.m. The tree feller proceeded to his work area in the woods, while the log-loader operator and tractor-trailer driver prepared their vehicles for the day's activities. The victim drove the skidder (Figure) to a previous cutting site. He soon returned pulling a number of logs into the landing area, which had a slope of less than 5 percent. The victim unhooked the logs and drove away from the landing area around the idled log-loader. As the victim drove the skidder around the loader, it ran over two logs laying on the ground. One log was 6 inches in diameter, while the other log was about 14 inches in diameter. Although the incident was unwitnessed, it is assumed that when the skidder ran over the logs, the victim lost his balance, then fell or jumped from the skidder cab before being struck and run over by the left rear tire. The log-loader operator looked up while trying to start the loader, and saw the unmanned skidder in front of the two logs barely moving towards the woods. The loader operator ran to the skidder and shut off the machine, then went looking for the victim. He found the severely injured victim on the opposite side of the log-loader. He asked the tractor-trailer driver to call the emergency medical service (EMS). The EMS and county coroner arrived in approximately 30 minutes, and the coroner pronounced the victim dead at the scene.

CAUSE OF DEATH

The county coroner's report listed the cause of death as multiple trauma to the head and torso.

RECOMMENDATIONS/DISCUSSION

Recommendation #1: Employers should ensure that seat belts are provided and used on mobile equipment.

Discussion: Although the skidder machine—a 1979 Timberjack-Unit 7140—used to move logs from the cutting site to the landing area was equipped with a rollover protection system (ROPS), it was not equipped with a seat belt or other type of restraint system. OSHA standard 29 CFR 1910.266(c) (6)(viii) for pulpwood logging states that “Seat belts shall be provided on mobile equipment.” Employers should ensure that seat belts are installed and used on all appropriate mobile equipment.

Recommendation #2: Employers should develop, implement and enforce a written safety program.

Discussion: Employers should emphasize safety to their employees by developing, implementing, and enforcing a written safety program. The safety program should include, but not be limited to, safe work procedures for all tasks performed by workers. Also, worker training should be provided in the recognition of hazards and safe work procedures, the proper selection and use of personal protective equipment, and the proper operation of equipment/machinery. Particular emphasis on the importance of using seat belts or other operator restraint systems on mobile equipment should be included. For the safety program to be effective, it must be clearly communicated and fully understood by employees and supervisors.

REFERENCE

Office of the Federal Register: Code of Federal Regulations, Labor 29 Part 1910.266 p. 679. July 1, 1989.

FACE 93-16



Figure. Skidder Machine (not to scale).

[Return to In-house FACE reports](#)

Last Reviewed: November 18, 2015

Was this page helpful?

Yes

Partly

No