

## Logger Dies After Being Struck By Falling Tree

**MO FACE Investigation # 98MO023**

**Date: September 2, 2005**

**Type: Logging**

### **SUMMARY**

On April 1, 1998, a 40-year-old male timber cutter (victim) died after being struck by a falling tree. The victim was part of a five-man crew working a selective-cut logging contract. He and another cutter had felled several trees and were waiting for the skidder to pull two logs out of the area. Without warning the logs being skidded out rolled and struck a standing tree, which sheared off at the base and began to fall. The skidder operator yelled a warning and the victim began running away from the skidder. He ran directly into the path of the falling tree and was struck on the head and shoulders. The co-workers came to the aid of the victim but he died within minutes at the scene.

The purpose of the FACE Program is to identify risk factors that contribute to worker injury and death, and to make recommendations to employers and individuals on how similar events can be avoided. From the information collected about this incident, the MO FACE investigator concluded that employers should:

- ensure that employees are trained in hazard awareness and proper escape procedures;
- develop, implement and enforce a written safety program which includes, but is not limited to, worker training in hazard identification and avoidance.

## **INTRODUCTION**

On April 1, 1998, the MO FACE investigator was notified of an occupational fatality involving a timber cutter being struck by a falling tree. The investigator contacted the company owners and arranged for a site visit on April 8, 1998. The investigator traveled to the site and interviewed the company owners. Also interviewed that day were the county coroner and the deputy sheriff who investigated the incident. The logging company normally has a crew of four to five, counting the owners. One owner usually loads the logs onto the log trailer and the other owner operates the skidder. One or two workers are usually the timber-cutters or fellers, and there is one worker who is the choke setter.

The company is a partnership between two brothers who have been in the logging business for approximately 25 years. The victim had approximately 20 years of logging experience but had been with this company only a short time. The company indicated they were very safety orientated and routinely talked about safety issues on the timber sites.

## **INVESTIGATION**

The incident took place on private land in a naturally occurring hardwood timber stand. The company was contracted by the property owner to selectively harvest hardwood trees for milling. The company had been on-site for approximately one week. The weather and ground conditions were clear.

The incident occurred on a skid trail approximately three hours into the work day. The skidder operator had two trees choked up and was pulling them up a 5 to 10 percent grade. Apparently one of the trees rolled sideways and downward. It struck a nearby standing tree. This tree looked alive and well from the outside but had heart rot. It sheared off at the base and began falling. The skidder operator yelled out to warn the other workers. The victim heard the warning and started running away from the skidder. It appears that the victim did not see the hazard before running away and ran directly into the path of the falling tree. He was struck directly on the head and shoulders pinning him to the ground.

The other workers immediately came to the victim's aid. They radioed out for

emergency services. The local fire and rescue, ambulance services, and sheriff's department responded to the scene. The coroner was notified and victim was pronounced dead at the scene.

## **CAUSE OF DEATH**

Cerebral Hemorrhage and fractured skull due to being hit and pinned by fallen tree.

## **RECOMMENDATIONS / DISCUSSIONS**

**Recommendation #1: Employers should ensure that employees are trained in hazard awareness and proper escape procedures.**

**Discussion:** Loggers are trained to establish an escape path and to evacuate their work area via this route immediately in the event of a hazard. In this incident the victim was not felling a tree at the time. Apparently when hearing the warning, the victim immediately started running away without first identifying the hazard. He ran directly into the path of the falling tree. When the situation and circumstances permit, workers should visually see what and where the hazard is before trying to escape it, especially when the most likely hazard is a falling tree.

**Recommendation #2: Employers should develop, implement and enforce a written safety program, which includes, but is not limited to, worker training in hazard identification and avoidance.**

**Discussion:** There are many hazards inherent to the logging industry. Employers should evaluate all tasks necessary in the operation of their businesses and the potential hazards associated with conducting those tasks. Likewise, they should

evaluate the individual tasks performed by workers; identify all potential hazards; and then develop, implement, and enforce written safe work procedures addressing these issues. The safety program should include at a minimum, worker training in hazard identification, and hazard avoidance.

Special consideration should be given to any and all tasks that could or do initiate the fall of a tree. Workers should be trained in the proper response to a falling tree or other hazards encountered in the work area.

The Missouri Department of Health, in co-operation with the National Institute for Occupational Safety and Health (NIOSH), is conducting a research project on work-related fatalities in Missouri. The goal of this project, known as the Missouri Occupational Fatality Assessment and Control Evaluation Program (MO FACE), is to show a measurable reduction in traumatic occupational fatalities in the state of Missouri. This goal is being met by identifying causal and risk factors that contribute to work-related fatalities. Identifying these factors will enable more effective intervention strategies to be developed and implemented by employers and employees. This project does not determine fault or legal liability associated with a fatal incident or with current regulations. All MO FACE data will be reported to NIOSH for trend analysis on a national basis. This will help NIOSH provide employers with effective recommendations for injury prevention. All personal and company identifiers are removed from all reports sent to NIOSH to protect the confidentiality of those who voluntarily participate with the program.

**SIGNATURES:**

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**Chief Investigator**

**Dr. Howard Pue**  
**Chief**  
**Office of Surveillance**

## MO FACE Dissemination List

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