State FACE™ Fatality Narrative

Farm Equipment Operator Crushed by Cone Bottom Nurse Trailer

INCIDENT FACTS

REPORT #: 71-278-2026s REPORT

REPORT DATE: June 10, 2026

INCIDENT DATE: July 1, 2025

WORKER: 61 years old

INDUSTRY: Potato Farming

OCCUPATION: Equipment Operator

SCENE: Crop field

EVENT TYPE: Caught in or Between

Image 1. Trailer tipped on side at incident scene.

SUMMARY

- A 61-year-old equipment operator at a potato farm was crushed under a cone bottom nurse trailer when it flipped after he climbed a ladder attached to the back of it to close a latch on the tank lid.
- He had worked for his employer, a potato and onion grower and packer, for 20 years as an equipment operator and irrigation assistant.
- He was with a coworker in an irrigation field. They had dropped off the one-axle trailer at the pivot point of the irrigation system.
- The trailer's 525-gallon plastic cone bottom tank was full of gypsum powder, which was to be used for conditioning soil. The trailer and powder weighed an estimated 4,000 lbs.

SUMMARY

- When they were walking back to leave in separate work trucks, he noticed that a latch on the tank lid was not properly fastened. He decided to close it by climbing a metal ladder attached to the back of the trailer.
- As he climbed the ladder, the trailer began to tip back. He could not escape and was crushed. While pinned, he yelled out his coworker's name for help.
- The coworker ran and moved the trailer off him. The coworker then contacted their supervisor and began CPR.
- The supervisor called 911 and got to the scene a few minutes later to assist. They continued CPR until paramedics arrived. Shortly after, the worker was pronounced dead and taken away by the coroner.

CONTRIBUTING FACTORS

Following the incident, investigators found:

- The employer had attached a rear jack to the trailer to prevent it from tipping over due to its high center of gravity. The operator did not use the jack when he unhooked the trailer and climbed the ladder.
- The employer did not train the operator and his coworker in the company's step-by-step trailer parking procedure, which included how to set the rear jack before unhooking the trailer.
- The trailer was left parked on soft sandy ground against the manufacturer's safety instructions to place it on a level surface strong enough to support its total weight.

Image 2. Alternate view of trailer tipped over at incident scene.

Image 3. Rear view of trailer and tank resting on soft sandy ground. Arrow points to unused jack attached to rear of trailer frame.

Image 4. Close-up of unused rear parking jack on trailer.

Image 5. Undercarriage view of trailer at incident scene.

Image 6. Trailer in upright position after incident with ladder and rear parking jack set on hard, level surface.

REQUIREMENTS

Employers must:

- The employer must furnish and require employees to use any safety devices and safeguards that are needed to control recognized hazards. All agricultural methods, operations, and processes must be designed to promote the safety and health of employees. See WAC 296-880-20005(1)(a)
- The manufacturer's instruction manual, if published by the manufacturer and currently available, must be the source of information for the safe operation and maintenance of field equipment. See WAC 296-307-076(2)
- The employer must provide safety education and training programs. See WAC 296-307-018(7)

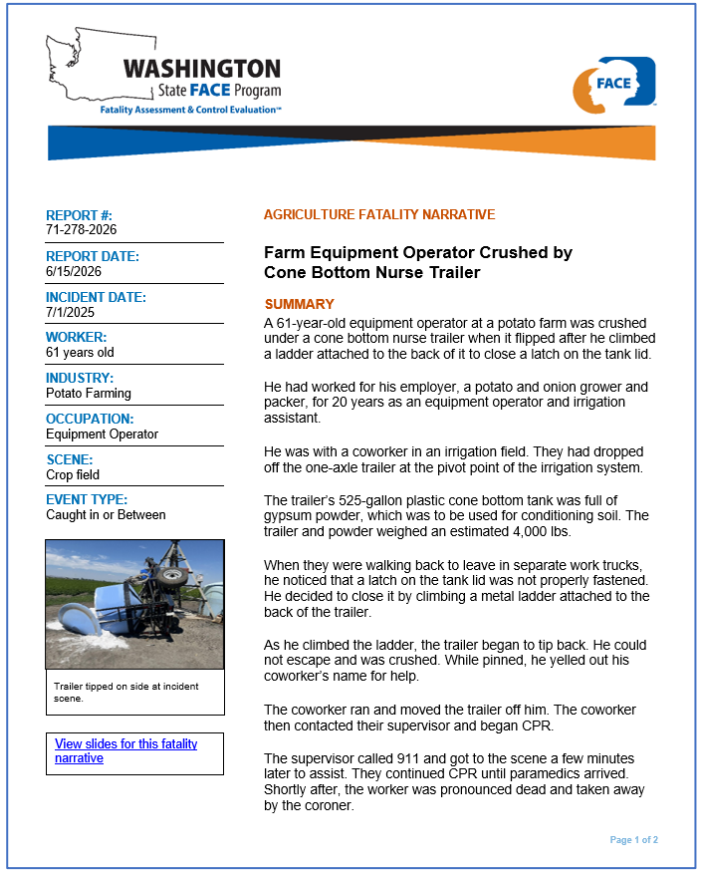
RECOMMENDATIONS

FACE investigators concluded, that to help prevent similar occurrences, employers should:

- **Develop trailer parking policies and procedures.** Include policies and step-by-step trailer parking procedures for workers to follow in your written accident prevention program (APP) developed according to the equipment manufacturer's safety instructions. Instruct supervisors how to implement the policies.
- **Perform a job hazard analysis (JHA).** Supervisors and equipment operators should jointly identify trailer hazards and develop solutions before putting equipment into use. JHAs should be documented and updated whenever equipment is modified or replaced. Ensure workers always have access to JHAs.
- **Provide trailer safety training.** Training should be hands-on, recurrent, documented, and tailored to each specific type of trailer. Do not allow workers to operate trailers until they demonstrate safe usage.

FATALITY NARRATIVE

Farm Equipment Operator Crushed by Cone Bottom Nurse Trailer



WASHINGTON State FACE Program
Fatality Assessment & Control Evaluation™

REPORT #: 71-278-2026
REPORT DATE: 6/15/2026
INCIDENT DATE: 7/1/2025
WORKER: 61 years old
INDUSTRY: Potato Farming
OCCUPATION: Equipment Operator
SCENE: Crop field
EVENT TYPE: Caught in or Between

Trailer tipped on side at incident scene.

View slides for this fatality narrative

AGRICULTURE FATALITY NARRATIVE

Farm Equipment Operator Crushed by Cone Bottom Nurse Trailer

SUMMARY

A 61-year-old equipment operator at a potato farm was crushed under a cone bottom nurse trailer when it flipped after he climbed a ladder attached to the back of it to close a latch on the tank lid.

He had worked for his employer, a potato and onion grower and packer, for 20 years as an equipment operator and irrigation assistant.

He was with a coworker in an irrigation field. They had dropped off the one-axle trailer at the pivot point of the irrigation system.

The trailer's 525-gallon plastic cone bottom tank was full of gypsum powder, which was to be used for conditioning soil. The trailer and powder weighed an estimated 4,000 lbs.

When they were walking back to leave in separate work trucks, he noticed that a latch on the tank lid was not properly fastened. He decided to close it by climbing a metal ladder attached to the back of the trailer.

As he climbed the ladder, the trailer began to tip back. He could not escape and was crushed. While pinned, he yelled out his coworker's name for help.

The coworker ran and moved the trailer off him. The coworker then contacted their supervisor and began CPR.

The supervisor called 911 and got to the scene a few minutes later to assist. They continued CPR until paramedics arrived. Shortly after, the worker was pronounced dead and taken away by the coroner.

Page 1 of 2

Download the fatality narrative:

https://lni.wa.gov/safety-health/safety-research//files/2026/71_278_2026_OperatorNurseTrailerCrush.pdf

RESOURCES

Large Farm Equipment Accident Prevention.

University of Arkansas, Division of Agriculture.

DISCLAIMERS

The WA FACE Program is supported by funding from NIOSH (grant #5U60OH008487).

These report slides are the product of NIOSH’s Cooperative State partner. The findings and conclusions in each report slides are those of the individual Cooperative State partner and do not necessarily reflect the views or policy of NIOSH.

This narrative was developed by the Washington State Fatality Assessment and Control Evaluation (WA FACE) Program and the Division of Occupational Safety and Health (DOSH), Washington State Dept. of Labor & Industries to alert employers and workers of a tragic incident in Washington State. It is based on preliminary data ONLY and does not represent final determinations regarding the nature of the incident or conclusions regarding the cause of the injury.

CONTACT US

Washington FACE
PO BOX 44330
Olympia, WA 98504-4330
1-888-66-SHARP (toll-free) or 360-902-5667

Washington State FACE: http://www.lni.wa.gov/safety-health/safety-research/ongoing-projects/work-related-fatalities-face

WASHINGTON
State FACE Program
Fatality Assessment & Control Evaluation™

FACE Fatality Assessment and Control Evaluation Program™