

# SAFETY NOTES

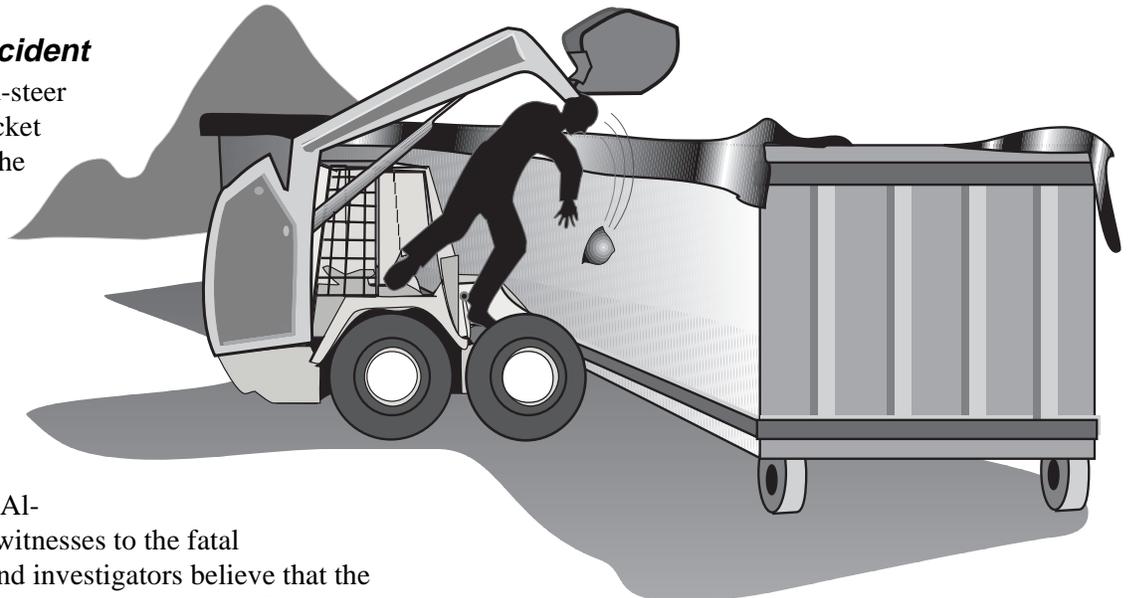
Department of Consumer & Business Services  
Oregon Occupational Safety & Health Division  
Salem, OR 97301-3882

## Fatality Report

Accident type ..... Crushed by vehicle  
Industry ..... Rendering/hauling  
Employee job title ..... Driver/skinner

### Description of accident

The driver of a skid-steer loader with a front bucket (843 Bobcat), was in the process of dumping layers of sawdust and grease residue into a large, outdoor sanitation-company bin. The sanitation company accepted the grease residue on the condition that it was layered with sawdust. Al-



though there were no witnesses to the fatal accident, employees and investigators believe that the driver was engaging in a common practice of loader drivers at the worksite: checking sawdust levels in the bin by leaning out of the loader, which was parked with its bucket raised against the sanitation-company bin, and peering into the bin.

Accident reconstruction indicated that the driver, whom another employee had seen exiting the cab of the loader earlier, had, at some point, turned off the engine with the boom and bucket raised overhead, placed the seat safety bar in the up position, stepped out, and leaned forward to look into the bin.

Investigators believe that the driver may have contacted the left-side foot control, bringing the bucket boom down and pinching his head between the bin and the underside of the pivot point for the boom. The driver was wearing a hardhat at the time of the accident; marks on the hat appeared to match the boom pivot supports.

The other employee working in the area happened to see the victim, who was partially obscured by a piece of plastic that lined and lapped over the bin's edges, apparently pinned against the bin by the loader boom. He rushed to the loader, calling the victim's name, and tried to get into the loader. The victim's leg was blocking his entrance onto the loader, so he went to the other side, climbed in, started the machine, and lifted the bucket off the victim. He checked for pulse and respiration and ran to the office to call 911. EMTs arrived shortly, but the victim was dead.

### Investigation findings

The practice of employees standing under the raised bucket of the loader had not been disallowed by management, although employees had been "warned" not to stand under the bucket. The vehicle involved in the employee death was being operated in an unsafe condition: neither the parking brake nor the manual safety interlock attached to the safety seat bar was working at the time of the accident, and the vehicle was not checked for mechanical safety at the beginning of each work shift. Operators of the loader had not received training and had not read or been shown the operator's manual for the loader.

### Applicable standards

- OAR 437-002-0223(3)(1)
- OAR 437-002-0223(3)(b)
- OAR 437-002-0223(3)(c)
- OAR 437-002-0223(16)(b)
- OAR 437-002-0223(19)(a)