

Tree Trimmer Dies After Being Run Over by Aerial Bucket Truck--Virginia

SUMMARY

A 47-year-old male tree-trimming groundman (the victim) died after being run over by an aerial bucket truck. Three tree-trimming crews and a supervisor had been dispatched to a powerline right-of-way to clear a tree that was about to fall over the powerlines. After the crews had felled the tree and cleared it away from the right-of-way, a truck driver instructed a groundman to secure a 12-foot-long push pole in the secure area underneath the truck bed at the rear of his truck. The groundman attempted to place the push pole in the travel position at the side of the truck-frame rail above the right tail light, but was obstructed by hydraulic lines. The victim assisted the groundman by kneeling in front of the truck's right rear wheels and pulling the hydraulic lines out of the path of the push pole. When he had moved the lines, he yelled to the groundman "All right, go ahead." The truck driver, thinking the order was directed at him, pulled forward, running over the victim. The groundman immediately yelled to the truck driver to stop. The victim was moved from underneath and checked for vital signs, but none could be detected. Due to the severity of the victim's injuries, cardiopulmonary resuscitation (CPR) was not attempted. The EMS arrived at the scene in approximately 20 minutes and pronounced the victim dead. NIOSH investigators concluded that, to prevent similar occurrences, employers should:

- *ensure that workers follow established safe work practices*
- *encourage workers to actively participate in workplace safety*
- *ensure that an established line of supervision is maintained at jobsites*
- *ensure that work implements are stored in such a manner so as not to endanger the safety of workers when they are placed in their storage areas.*

INTRODUCTION

On February 23, 1995, a 47-year-old tree-trimming groundman died after being run over by an aerial bucket truck. On May 19, 1995, officials from the Virginia Occupational Safety and Health Administration (VAOSHA) notified the Division of Safety Research (DSR) of this fatality, and requested technical assistance. On May 25, 1995, a DSR safety specialist conducted an investigation of this incident. The incident was reviewed with the company safety director and the VAOSHA compliance officer assigned to the case. Photographs of the site taken immediately after the incident were viewed during the investigation, and the police report was reviewed.

The employer in this incident was an interstate powerline tree-trimming company that employed 250 workers and had been in business under the present management for 3 years. The company had a full-time safety director, comprehensive written safety program and written safe-work procedures. Documented training was provided by the safety and health staff. Workers received written classroom and on-the-job training, and all workers were trained in first aid. Truck operators received training in safe truck operation from safety consultants. Each worker received

a personal copy of the company safety manual. Before workers could be promoted, they were required to demonstrate their proficiency in performing the new task, score in the 80th percentile range on a written examination, and receive a formal written certification from the company. Crew foremen conducted safety meetings once a week at the jobsite. The victim had worked for the company for 17 years. This was the first fatality experienced by the company.

INVESTIGATION

The company had been contracted by the local electrical cooperative to clear powerline right-of-ways. On the day of the incident, three tree trimming crews, consisting of two truck drivers, four groundmen (including the victim), and supervisor were dispatched to the site to fell and clear "a trouble tree" (a tree about to fall across powerlines). It took the crews approximately 1½ hours to fell the tree and complete the clean-up of the area.

As the crews were preparing to leave, one of the truck drivers (the victim's usual work partner) instructed a second groundman to secure the push pole underneath the truck bed. As the groundman tried to position the push pole at the side of the frame rail above the right rear tail light, the pole hit the hydraulic lines at the oil reserve unit of the articulating boom. The victim told the groundman he would help and climbed under the truck in front of the dual right-rear wheels. The victim then pulled the hydraulic lines away from the push pole and yelled "go ahead" to the groundman. The truck driver thought the command was directed at him and pulled the truck forward, running over the victim. The groundman immediately yelled to the truck driver to stop. The men moved the victim from under the truck while a worker ran to a nearby residence to summon the emergency medical service (EMS). The victim had no pulse, and due to the extent of the injuries, cardiopulmonary resuscitation (CPR) was not initiated. The EMS arrived at the scene in approximately 20 minutes and pronounced the victim dead.

CAUSE OF DEATH

The medical examiner listed the cause of death as crushing injuries to the head and chest.

RECOMMENDATIONS/DISCUSSION

Recommendation #1: Employers should ensure that workers follow established safe-work procedures.

Discussion: Workers were trained not to climb under equipment, or make adjustments or repairs to equipment while it was running. Had established procedures been followed in this instance, the fatality may have been prevented.

Recommendation #2: Employers should encourage workers to actively participate in workplace safety.

Discussion: Employers should encourage all workers to actively participate in workplace safety and should ensure that all workers understand the role they play in the prevention of occupational injury. In this instance, the victim climbed under the truck to assist the groundman while the truck was running. Workers and co-workers should look out for their personal safety and the safety of co-workers. When workers observe hazardous conditions or activities, they should, depending on the circumstances, notify management and/or remind co-workers of the proper way to perform their tasks and protect themselves. Employers must instruct workers of their responsibility to participate in making the workplace safer. Increased worker participation will aid in the prevention of occupational injury.

Recommendation #3: Employers should ensure that an established line of supervision is maintained at jobsites.

Discussion: In this instance, three different crews were working at the same jobsite. Confusion arose when commands were given by workers out of the line of sight of other workers. When several workers are present at a single site, especially with some workers out of the line of sight of others, a line of supervision should be established that would allow one person to direct all activities and eliminate the chance for confusion.

Recommendation #4: Employers should ensure that work implements are stored in such a manner so as not to endanger the safety of workers when they are placed in their storage areas

Discussion: In order to place the push pole in its storage area, one worker pushed on it from the rear of the truck while a second worker had to climb under the truck to pull hydraulic lines out of its path. Storage areas should be located in such a manner that worker safety would not be jeopardized while work implements are being stored. In this instance, the push pole could have been secured on either side of the truck bed, or under the bed in an area that would not have been obstructed by the hydraulic lines.