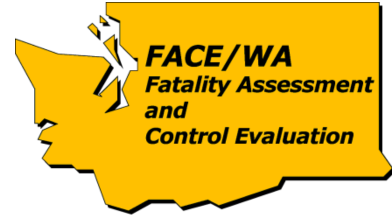
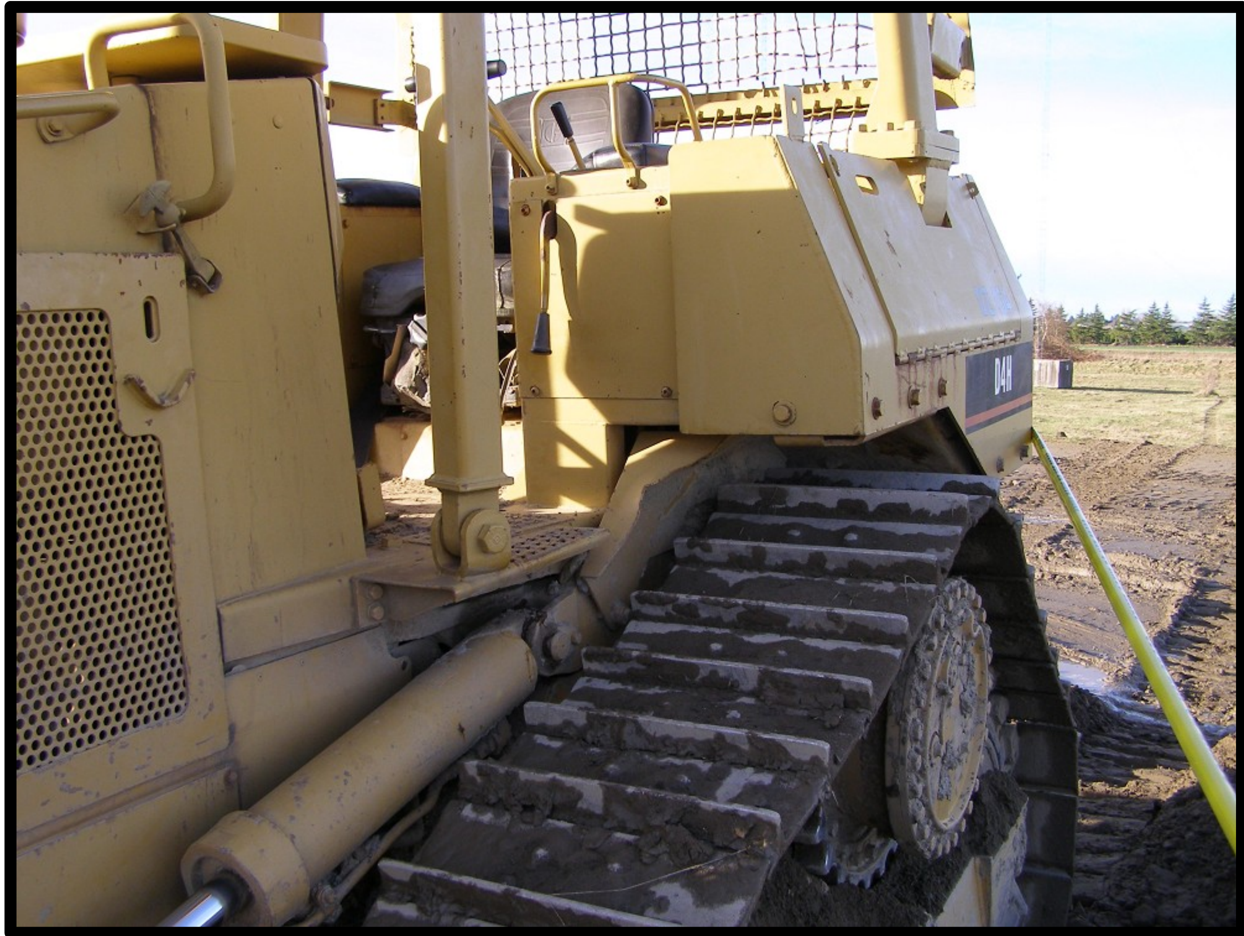
# Operator Dies after Being Caught between Bulldozer's Track and Fender

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Washington State Department of
Labor & Industries

SHARP
Safety & Health Assessment &
Research for Prevention

The WA Fatality Assessment and Control Evaluation (FACE) Program has published a new Fatality Investigation report. These reports describe work-related fatal incidents and provide specific recommendations that may have prevented the incident from occurring. We hope that they are disseminated and used for formal or informal educational opportunities to help prevent similar incidents.

**SUMMARY**

In February of 2010, a 68-year-old male construction crew supervisor and heavy equipment operator died of injuries he received after being crushed between the track and fender of his bulldozer. The operator was employed by a site development contractor. He had 48 years of experience operating bulldozers and other heavy construction equipment.

The operator was supervising a crew working at a job site zoned for commercial development. Structural fill was being brought in and dumped and then leveled and compacted. As dump trucks hauled fill onto the site, the operator was using a Caterpillar D4H Series II bulldozer to level the fill and was also directing the drivers as to where they should deposit their loads.

The operator exited the bulldozer on its right side to speak with a truck driver about where the driver should deposit his load of fill. When he did this, he left the bulldozer running and did not set the parking brake. After giving instructions to the truck driver, he walked to the bulldozer's left side and then walked up its track to return to the operator's seat. As he was standing on top of the track his elbow hit the transmission lever, shifting the dozer out of neutral into reverse. When the bulldozer began moving backward, his left foot became caught between the moving track and the underside of the fender. As the bulldozer continued moving backward his left leg was pulled in and crushed. The operator was carried several yards before being ejected onto the ground.

To prevent similar occurrences in the future, the Washington State Fatality Assessment and Control Evaluation (FACE) investigation team recommends that:

- **Before leaving a bulldozer unattended, operators should follow manufacturer recommended operating procedures to ensure that the equipment is secured from movement.**
- **Employers should develop, implement, and enforce a written safety program that includes, but is not limited to, procedures for operators entering, exiting, and securing bulldozers against unintended movement.**
- **Employers should consider buying mobile construction equipment installed with an interlock safety system or operator presence sensing system which will prevent inadvertent movement of equipment.**

Additionally:

- **Bulldozer manufacturers should consider design features of bulldozers so as to minimize or prevent injuries and fatalities of operators.**

To access the full version of this investigation report along with the detailed recommendations and discussions section, go to www.lni.wa.gov and enter **52-26-2012** into the search box.