WASHINGTON State FACE Program
Fatality Assessment & Control Evaluation

AGRICULTURE

FATALITY NARRATIVE

FACE

National Institute for Occupational Safety and Health NIOSH

Operator Crushed By Irrigation System Wheel

INCIDENT FACTS

REPORT #: 71-189-2019s

REPORT DATE: December 13, 2019

INCIDENT DATE: August 17, 2019

VICTIM: 30 years old

INDUSTRY: Crop farming

OCCUPATION: Irrigator operator

SCENE: Corn field

EVENT TYPE: Crushed

SHARP Safety & Health Assessment & Research for Prevention

Washington State Department of Labor & Industries

FATALITY NARRATIVE

A 30-year-old operator died when he was crushed under a wheel of a self-propelled irrigation system.

He was employed by a corn grower and maintained and repaired irrigation systems covering 1,500 acres of crops.

These irrigation systems are self-propelled by a motor around a center pivot point. They have drop sprinklers installed along horizontal pipes supported by steel towers that have wheels.

FATALITY NARRATIVE

Working alone for 12 to 13 hours per day, the operator drove to field locations to check on these systems. The fields were in isolated locations, often far from other employees.

If he needed help, he would call other irrigator operators working in their assigned fields for assistance.

His supervisor expected that operators would communicate with each other when necessary. There was no regular communication between operators and the supervisor.

FATALITY NARRATIVE

On the day of the incident, workers at the farm's maintenance shop last saw the operator near the end of his shift at about 6 p.m. when he left to work in the fields.

At 6:30 p.m., he called his wife to say that he would be home soon. At 10 p.m., when he had not returned home, his wife contacted the county sheriff's office and filed a missing person's report.

His brother went looking for him and found him early the next morning. He was deceased with his body pinned and crushed under the outer wheel of the center pivot's tower.

FATALITY NARRATIVE

Investigators concluded that the operator was most likely trying to jump across the two-and-a-half-foot deep rut made by the center pivot's wheels when he slipped and fell into the rut where one of the wheels ran over him, crushing his legs.

FATALITY NARRATIVE

Photo 1. Incident scene with self-propelled center pivot irrigation system. A wheel (indicated by the arrow) at the base of the system's tower ran over and crushed the operator.

FATALITY NARRATIVE

Photo 2. Wheel that ran over and crushed the operator.

Photo 3. The 38-inch diameter steel wheel at the base irrigation system’s tower that ran over and crushed the operator.

Photo 4. The incident scene showing the remote location of the corn field. The circle indicates the location where the operator was found.

Recommendations

Employers should have a lone worker safety plan that requires that:

- Lone workers inform their supervisor of where they will be working on a daily basis, and to check in with their supervisor periodically or if their work locations change.
- Supervisors check in with workers working alone in remote locations through both periodic visits and phone or radio.
- The supervisor or another employee verifies that lone workers have returned to an agreed upon place or home after completing their task.

Recommendations

- Conduct risk assessments to determine if work may be done safely by lone workers.
- Train workers not to walk in front of moving equipment.

Resources

Working Alone Safely

http://wisha-training.lni.wa.gov/training/presentations/WorkingAlone.pps

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This bulletin was developed to alert employers and employees of a tragic loss of life of a worker in Washington State and 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 fatality.

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