WASHINGTON State FACE Program
Fatality Assessment & Control Evaluation

TRUCKING & LOGGING
FATALITY NARRATIVE

Owner Crushed Loading Log Skidder on Lowboy Trailer

INCIDENT FACTS

REPORT #:
71-248-2023

REPORT DATE:
December 11, 2023

INCIDENT DATE:
February 14, 2023

WORKER:
52 years old

INDUSTRY:
Specialized Freight Trucking / Logging

OCCUPATION:
Company owner / operator

SCENE:
Heavy equipment loading yard

EVENT TYPE:
Crushed by heavy equipment

The owner was crushed under the skidder's tracked bogie wheels (X).

For a slideshow version, click here.

SUMMARY

A 52-year-old logging company owner was crushed while helping to load a log skidder onto a detachable lowboy trailer. He was a logger for much of his life and ran his own logging company for six years before his death.

The owner was at the yard of a heavy equipment dealer where the skidder was located. The owner of the skidder hired a commercial machinery transporter to haul it from the yard to a site where the logging company owner was working. The transporter had a lowboy semi-trailer to carry the skidder. The company owner was going to use his personal work truck as a pilot car for the transporter.

Semi-truck with skidder on lowboy trailer after incident.

An equipment operator who worked for the owner of the skidder drove the machine onto the trailer. The owner and the transporter were on opposite sides of the trailer acting as spotters for the operator. The owner was on the right side 10 to 20 feet away from the skidder. The skidder ended up with its bogie wheels uneven between the trailer's lowered flatbed deck and detached gooseneck. As the operator tried to adjust the wheels, he inadvertently turned on the maximum speed switch on the joystick. He then activated the travel trigger, which made the skidder lurch back 9.5 feet partly off the deck into the gooseneck. For an unknown reason, the owner walked behind the skidder when it moved. When the operator and transporter did not see the owner, they went around the trailer and found him crushed and gasping under the skidder's left tracked bogie wheels. First responders pronounced the owner dead at the scene.

Following the incident, investigators found:

- No evidence that the skidder malfunctioned or had any mechanical faults.
- The equipment operator had no previous experience using the model of skidder.
- Using the owner and transporter as spotters was not part of the plan.

REQUIREMENTS

- You must provide your employees a workplace free from recognized hazards that are causing, or are likely to cause, serious injury or death. See WAC 296-800-11005

RECOMMENDATIONS

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

- Never allow heavy equipment operators to load or unload any machine on a trailer unless they have been properly trained, evaluated, and certified to operate the machine.
- Train spotters how to identify and stay out of vehicle blind areas, remain visible to operators, approach vehicles, avoid distractions, and keep a safe distance between themselves and moving vehicles.
- Make sure operator and spotter pre-plan vehicle movements and agree on hand signals before loading or unloading equipment on trailer. Designate one spotter to communicate with operator to avoid confusion. If visual contact is lost with the spotter, the operator must stop immediately.
- Develop your accident prevention program (APP) to include a job hazard analysis (JHA) policy that requires supervisors and workers to identify hazards for each specific type of equipment and trailer loading operation. After hazards are identified, develop and implement protective measures. Revise the JHA when changes in work plans, equipment, tools or environmental conditions introduce new hazards.

RESOURCES

Lowboy Safety Training - Logger Safety Initiative (LSI), Washington State Department of Labor & Industries

SHARP Safety & Health Assessment & Research for Prevention

Washington State Department of Labor & Industries

This narrative was developed to alert employers and workers of a tragic incident and is based on preliminary data ONLY and does not represent final determinations regarding the nature of the incident or the cause of the injury. Developed by WA State Fatality Assessment and Control Evaluation (FACE) Program and the Division of Occupational Safety and Health (DOSH), WA State Dept. of Labor & Industries. The FACE Program is supported in part by a grant from the National Institute for Occupational Safety and Health (NIOSH grant# 5U60OH008487). For more information visit www.lni.wa.gov/safety-health/safety-research/ongoing-projects/work-related-fatalities-face.