WASHINGTON State FACE Program
Fatality Assessment & Control Evaluation

AGRICULTURE
FATALITY NARRATIVE

FACE NIOSH National Institute for Occupational Safety and Health

INCIDENT FACTS

REPORT #:
71-189-2019

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

Wheel that ran over operator.

For a slideshow version, click here.

SHARP Safety & Health Assessment & Research for Prevention

Washington State Department of Labor & Industries

Operator Crushed by Irrigation System Wheel

SUMMARY

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

A wheel at the base of the irrigation system's tower ran over and crushed the operator.

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.

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 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.

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. 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.

RECOMMENDATIONS

FACE investigators concluded that, to help prevent similar occurrences:

- 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.
- 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