

TRUCKING/AGRICULTURE FATALITY NARRATIVE



INCIDENT FACTS

REPORT #: 71-197-2020

REPORT DATE: July 6, 2020

INCIDENT DATE:

November 27, 2017

VICTIM: 61 years old

INDUSTRY: Specialized freight trucking/

Hay farming

OCCUPATION:

Truck driver

SCENE: Loading dock of hay barn

EVENT TYPE: Crushed by/struck by



The truck driver was cleaning the floor at the far end of the freight container when a forklift operator deposited hay bales, crushing her against the back wall.

For a slideshow version, click here.





Truck Driver Crushed by Hay Bales

SUMMARY

A 61-year-old truck driver working inside a semi-truck's freight container was crushed when a forklift operator loaded hay bales into the container.

The truck driver's employer was a hay farm that had two separate business entities, farming and hay hauling. She worked as a semi-truck driver hauling hay in intermodal freight containers to a port.

On the day of the incident, the driver brought the truck to the loading dock of her employer's hay barn to be loaded with hay bales. The employer required drivers to keep the containers clean, so she entered the container to remove debris. The workers had an informal practice of placing a



Screenshot from video of incident scene showing forklift entering the freight container.

cone or trashcan at the entrance of a container to indicate that an employee was inside. The driver did not do this, and she did not tell anyone that she was about to enter the container.

Shortly after she went into the 40-foot container, a forklift operator entered the container with a load of hay bales. The forklift's hay clamp attachment held four double-compressed alfalfa sleeve bales stacked two high, each weighing nearly 1,100 lbs. Due to the size and height of the bales, the forklift operator could not see over or around them. The driver was in the far end of the container, and was unable to alert the operator due to forklift noise. The bales were stacked so that there was no room for the driver to escape. The operator continued to load the container with bales until it was full.

When workers realized that the driver was missing, they reviewed video footage that indicated the driver was still in the container. They called EMS personnel and removed the bales from the container. The driver's body was found at the far end. She had been crushed against the container's front wall by hay bales.

Investigators found that the employer's accident prevention program covered only the farming part of their business operations and did not address loading dock safety or trucking hazards. After the incident, the employer required that drivers not be allowed on the loading dock; installed lighting on the dock that shines into the container; and instructed forklift drivers to no longer stack bales two high while in transit, allowing them to see in front of their load.

REQUIREMENTS

- Employers must ensure that their accident prevention program (APP) is tailored to the particular needs of their workplace and or operation and the types of hazards involved. See WAC 296-800-14005
- Employers must make sure that forklift operators do not drive up to anyone in front of a fixed object. See WAC 296-863-40005(6)
- Employers must make sure that forklift operators look in the direction they are going and keep a clear view of the path of travel. See WAC 296-863-40010(2)(d)

RECOMMENDATIONS

FACE investigators concluded that, to help prevent similar occurrences:

Employers should conduct a job hazard analysis with the participation of workers to assess the hazards to all workers associated with truck freight loading and unloading operations at loading docks. Based on this assessment, employers should establish and enforce safety policies, hazard control procedures, and training for truck drivers and loading dock workers.

This narrative is an alert about the tragic loss of life of a worker and is based on preliminary data ONLY and does not represent final determinations regarding the nature of the incident or the cause of the fatality. Developed by the 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#wa-face.