

TRUCKING HAZARD ALERT



Preventing Truck Mechanic Deaths from Rollaways

Two container chassis mechanics died in separate crushing incidents caused by rollaway trucks. Neither truck had parking brakes set or wheels chocked. A total of 472 bus and truck mechanics and diesel engine specialists died between 2003 and 2020, according to the US Bureau of Labor Statistics. Struck-by incidents, including rollaways, were among the most frequent causes of fatalities. Using parking brakes and wheel chocks can prevent fatalities and injuries.

MECHANIC CRUSHED AGAINST BUMPER JACK

Industry: General Automotive Repair Task: Welding rear of chassis

A 47-year-old mechanic was welding the rear of a container chassis when a rollaway semi-truck hit the chassis, crushing him against a bumper jack. A truck was parked in front of the chassis the mechanic was working on. Another driver arrived and parked his truck in the yard slightly uphill behind the first truck. He left his truck and walked to the office. The driver of the first truck was also in the office but soon went to move his truck, which left a nearly 300-foot space between the uphill truck and the chassis. Shortly after, the uphill truck rolled away and hit the chassis into the mechanic, fatally crushing him against the jack.



Site where mechanic was crushed by chassis.

What led to this incident?

- Practice: The rollaway truck was parked on a slope with its engine running, in neutral gear, and parking brake off. Site where mechanic was
- **Policy:** The employer allowed drivers to leave trucks unattended in the yard without shutting off engines and setting parking brakes.

MECHANIC CRUSHED BY CHASSIS WHEELS

Industry: General Freight Trucking Task: Repairing chassis suspension

A 62-year-old mechanic was repairing a chassis when it rolled away and crushed him as he waited for the air brake lines to be reconnected. He started the repair and disconnected the air lines to the brake chambers, which engaged the parking brakes. When he tried towing the chassis with a yard tractor, it would not move. He then told another mechanic to reconnect the chassis' air lines to release the parking brake. He kneeled between the chassis' wheels to wait for the mechanic to finish. With the air lines reconnected, the parking brakes released and the chassis rolled over and fatally crushed him.



Damage on rollaway truck from hitting chassis.

Area where mechanic was

crushed.

What led to this incident?

- **Practice:** The tractor was parked on a slope with the parking brake hand valve disengaged and wheels not chocked on the tractor and chassis.
- Policy: The employer's accident prevention plan (APP) lacked parking brake and wheel chocking policies.

TIPS TO LIVE BY

- Install electronic parking brake systems and driver warning alarms. Systems:
 - $\,\circ\,$ Set the parking brake automatically if the driver does not.
 - o Combine with fleet telematics systems to inform managers of rollaways or close calls.
 - o Alert drivers when the parking brake is not set.
- Create and enforce a standard operating procedure (SOP) policy for parking brake and wheel chock use. The SOP should be in the APP and require all vehicle operators, including truck drivers and mechanics, to:
 - o Set the parking brake whether or not they leave or stay in the cab.
 - Before exiting the cab, place their foot on the service brake, put the transmission in neutral, set the parking brake, shut off engine, lock the ignition, remove the key and place it in their pocket, and check their dashboard parking brake indicator if equipped with one.
 - o If parked on a slope, turn the truck's front wheels to the curb or side of the road and chock one or more rear wheels on both sides.
- Post high-visibility warning signs in maintenance shops, terminal yards, and at loading docks that remind vehicle operators to:
 - $\,\circ\,$ Shut off engine, set parking brake, and chock rear wheels before leaving the truck.
 - o Follow parking brake and wheel chock requirements during maintenance, loading, and unloading.
 - o Use truck and trailer restraints or dock locks if available.

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This alert is based on preliminary data and does not represent final determinations regarding the nature of the incidents or the cause of injuries. Developed by the WA Fatality Assessment and Control Evaluation (WA 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 (# 5U60OH008487). For more information: www.lni.wa.gov/Safety/Research/FACE.