

# Slaughterhouse Worker Crushed in Cattle Chute Door

## INCIDENT FACTS

**REPORT #:** 71-262-2025s

**REPORT DATE:** January 20, 2025

**INCIDENT DATE:** December 1, 2022

**WORKER:** 36 years old

**INDUSTRY:** Animal (except Poultry) Slaughtering

**OCCUPATION:** Slaughterhouse Kill Floor Manager

**SCENE:** Beef slaughterhouse

**EVENT TYPE:** Crush - Caught in or between / Energized door



A 36-year-old slaughterhouse worker was crushed by a pneumatic sliding door while moving cattle through a chute. His employer was a family-run beef slaughterhouse that had been in business for seven months. He had extensive slaughterhouse experience and was working as a kill floor manager.

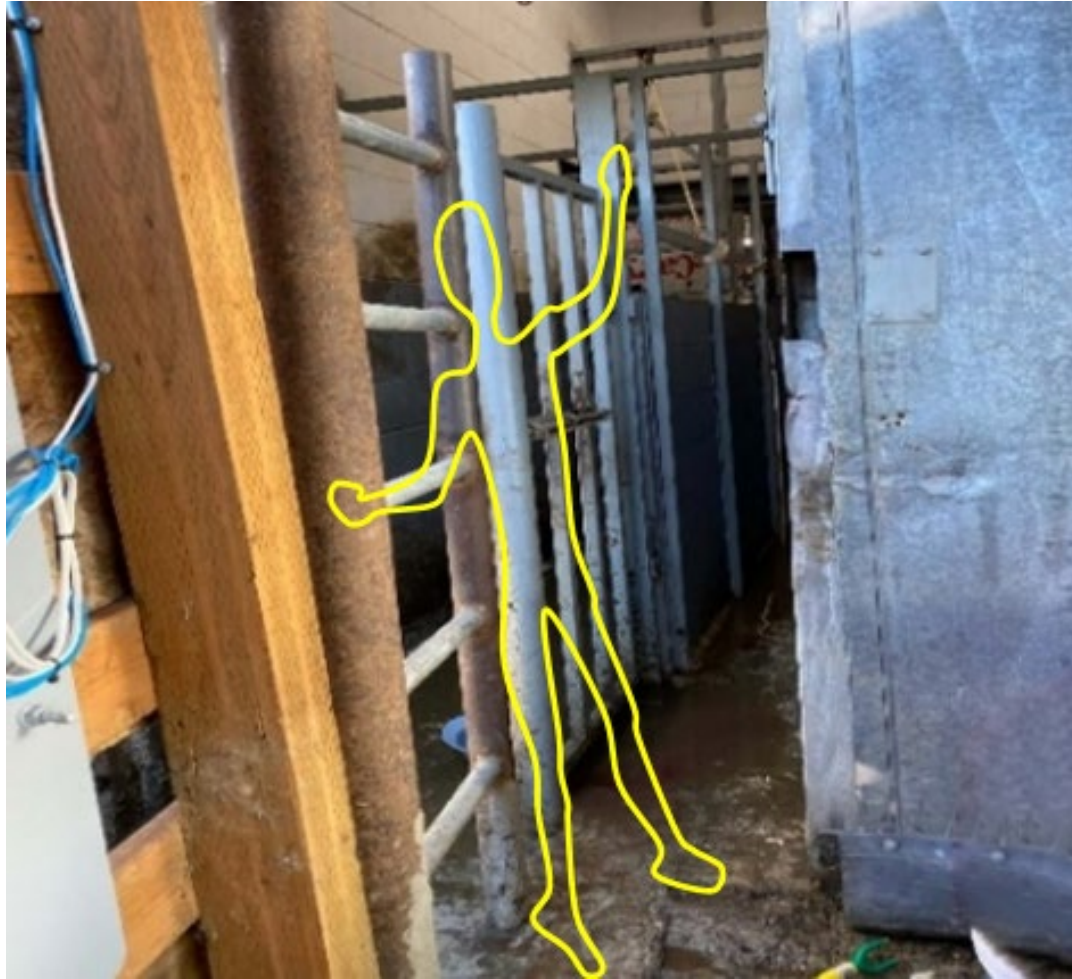
He was alone moving cattle from an outside corral to a kill floor access chute inside the slaughterhouse. He was using a handheld shock prod while operating a pneumatic metal sliding door to control the number of cattle entering the chute. The door opened and closed by sliding through a small gap in a steel barrier that separated the chute from a walkway. It was electronically activated by two switches; one outside nineteen feet from the door and one inside three feet away.

After waiting ten minutes and no cattle entered the kill floor from the chute, his coworker became concerned. She went to check on him and found him standing pinned and unconscious between the door and the barrier. She released the door pressure and he fell to the floor unresponsive. She called 911 and alerted coworkers who came to help do CPR until first responders arrived. He was emergency airlifted to a hospital where he died three days later from asphyxiation injuries.

Investigators found:

- The worker likely used the outside switch to close the door and started to go inside as the door was closing. As he entered the doorway, he tried to prod a remaining cow but was crushed between the closing door and barrier. He was unable to breathe for up to seven minutes.
- The door's pneumatic operating pressure was 65 to 70 psi, enough to compress the worker's chest and prevent him from breathing, yelling for help, or pushing the door open to get free.
- The employer did not have a written accident prevention program (APP), safety meetings, a safety committee, nor training on how to safely move cattle through the chute door.

# FATALITY NARRATIVE



**Photo 1.** Worker was crushed between door on right and barrier on left.





**Photo 2.** The door opened and closed by sliding through the gap in the barrier.

# FATALITY NARRATIVE



**Photo 3.** Walkway between barrier on left and door on right. Circle shows inside door activation switch.



# FATALITY NARRATIVE



**Photo 4.** Outside door activation switch.



**Photo 5.** Wall-mounted pneumatic cylinder that actuated door.

## Requirements

Employers must:

- Construct your workplace so it is safe. See [WAC 296-800-11020](#)
- Develop a formal, written APP. See [WAC 296-800-14005](#)
- Establish and conduct safety committees. See [WAC 296-800-13020](#)

## Recommendations

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

- Use sliding doors with pneumatic or electric sensing edges that stop and reverse the door when the leading edge contacts an obstruction. Inspect doors regularly to ensure proper functioning.

## Recommendations

- Develop and enforce policies in their written accident prevention program (APP) that:
  - o Prohibit lone work in corrals and instead require using a buddy system where workers team up so they can monitor each other and help quickly when someone is endangered.
  - o Require a formal job hazard analysis (JHA) be done jointly by supervisors and workers to identify hazards of corral systems, including pens, sorting alleys, chutes, gates, and doors.
  - o Implement less hazardous work practices and safety training to prevent fatalities and injuries.



## **Resources**

### [Cattle Handling Safety in Working Facilities](#)

Oklahoma State University Extension

*This narrative was developed to alert employers and workers of a tragic incident 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.*

Developed by Washington State Fatality Assessment and Control Evaluation (WA FACE) and the Division of Occupational Safety and Health (DOSH), Washington State Dept. of Labor & Industries. WA FACE 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](http://www.lni.wa.gov/safety-health/safety-research/ongoing-projects/work-related-fatalities-face).