

Tree Care Ground Worker Struck by Falling Branch

INCIDENT FACTS

REPORT #: 71-271-2025s

REPORT DATE: October 13, 2025

INCIDENT DATE: July 1, 2024

VICTIMS: 57 years old

INDUSTRY: Landscaping Services

OCCUPATION: Tree Trimmer

SCENE: Private residence

EVENT TYPE: Struck by falling object



A 57-year-old tree care worker died when a branch fell and struck his head. It was his first day on the job for a local tree care company.

He was on a three-member crew removing a fir tree at a private home. He and a coworker were gathering branches that had been cut and dropped to the ground by the company owner. The owner climbed down to start a wood chipper to process the cut branches. The worker was standing 37 feet behind the owner and his co-worker. When they turned around, they found the worker lying on the ground under a large, dry branch that struck him. The branch fell from another tree 11 feet from the one being removed.

The worker was badly hurt and barely conscious. The owner called 911, but neither he nor the co-worker were able to give first aid as they waited for the ambulance. First responders arrived 15 minutes later and brought the worker to the hospital where he died.

Following the incident, investigators found:

- The employer did not conduct a site assessment to identify overhead hazards before starting the job.
- The employer did not have a written [accident prevention program](#) (APP), and did not conduct and document [safety meetings](#), [job hazard analyses](#) (JHA), and new worker orientation and [training](#).
- The employer did not have [first aid](#) trained workers onsite.

FATALITY NARRATIVE



Photo 1. Area where worker was struck.

FATALITY NARRATIVE



Photo 2. Close up of incident site. Red X marks where worker was struck. Yellow X marks where owner and co-worker were located.

FATALITY NARRATIVE



Photo 3. Aerial view of incident site.

FATALITY NARRATIVE



Photo 4. Tree removal job site.

Requirements

- Before performing any tree removal work, conduct a site assessment according to the American National Standard Institute's (ANSI) Arboricultural Operations Safety Requirements. See [ANSI Z133.1 2017, Section C. Manual Tree Felling Procedure](#)
- Establish a safety committee and/or conduct and document safety meetings. See [WAC 296-800-130](#)

Requirements

- Develop a formal, written APP and develop, supervise, implement, and enforce safety and health training programs that are effective in practice. See [WAC 296-800-14005](#), [WAC 296-800-14020](#)
- Adequately train a person or persons to render first aid for the treatment of all injured employees in the absence of an infirmary, clinic, or hospital in near proximity to the workplace. See [WAC 296-800-15005](#)

Recommendations

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

- **Create a drop zone perimeter.** It should be twice the height of the tree being removed. Mark the zone with traffic cones, barrier tape, and signs. Plan two clear escape paths to safe areas.
- **Conduct a job site hazard assessment.** Look for loose branches, hangers, broken tops, chunks, lodged trees, leaning trees, snags, and other hazards in and around the zone. Use a bucket truck, binoculars or, where permitted, an aerial drone to enhance visual detection of overhead hazards.

Recommendations

- **Keep the drop zone clear.** Workers and equipment not involved in rigging should not enter until operations have stopped and a supervisor who is authorized and qualified signals it is safe to enter.
- **Maintain situational awareness.** Continuously, monitor and use clear communication in and around the zone. Look up, down and all around before, during, and after tree removal. As trees are being removed, use a spotter and pause often to check for hanging or lodged branches before continuing.

Resources

[Safety Lessons and Tips for Tree Trimmers](#)

TCIA Magazine of the Tree Care Industry Association

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 the Washington State Fatality Assessment and Control Evaluation (WA FACE) Program 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.