21 Year-old Male Dies when Struck in the Head with a Track Hoe Bucket

Incident Number: 02KY106
Date of Incident: November 22, 2002
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Summary

On November 22, 2002, a 21-year-old male laborer died after being hit in the head with the bucket of a track hoe. He was wearing a safety helmet at the time of the incident. There were six to seven workers at the job site when the incident occurred. The work crew was pouring the footing for a retaining wall as part of a bridge for a private runway being built. The concrete form collapsed, trapping one worker and almost trapping two others. The decedent had left to retrieve a shovel to help free the trapped co-worker. As he retrieved the shovel, he walked into a blind spot of the track hoe operator at the same time another worker asked the track hoe operator if there was a chain in the cab of the track hoe. The operator looked down at the floor and as he did so, his hand slightly moved the hand control causing the bucket to move, thus striking the decedent. He was transported to a hospital where he was declared dead by the coroner from blunt force injuries to the head.

In order to prevent similar incidents from occurring, the Kentucky Fatality Assessment and Control Evaluation program recommends:

- A hazard assessment of the work area should be performed every time work conditions change. Workers should not be in a blind spot of heavy equipment operators without the operator's knowledge. When blind spots are identified, a spotter should be used.

During emergency situations employ safe work practices.

Recommendations with Discussions

Recommendation No. 1: A hazard assessment of the work area should be performed every time work conditions change. Workers should not be in a blind spot of heavy equipment operators without the operator's knowledge. When blind spots are identified, a spotter should be used.

A thorough hazard assessment of the job site should be performed whenever conditions change. This would have included taping off the area the track hoe was working in. When working around heavy equipment, an evaluation of potential blind spots should be included in this hazard assessment. Potential blind spots would have been identified and employees not allowed in that area. When workers find themselves in blind spots of equipment operators, there should be a spotter who is in communication with the

equipment operator to communicate with the operator while a worker is performing job functions in the operator's blind spot.

Recommendation No. 2: During emergency situations employ safe work practices.

The company had trained its work force in safety procedures. Emergency work procedures should be addressed and routinely reinforced along with normal work procedures.

Side Note:

KY FACE spoke with a track hoe manufacturer regarding installing voice activated lockout for the controls, or installing a video camera on the arm that could send a video image of the blind spots to the operator. The consensus of adding these devices was that there is too much noise in the cab for a voice-activated control to function properly. If a video camera were installed, the operator would be looking at the monitor and not at what the arm of the track hoe was doing. The manufacturer did not want any distractions for the operator. According to the manufacturer, the area of track hoe operations was to be taped off to limit access to the work area.