FATAL ALERT

April 23, 2007

Two companies a General Contractor with numerous years of excavation experience and a sub-contractor with numerous years of sewer and water pipe repair and installation experience were finishing their efforts to complete a pipe burst water line installation project in a public park. The owner of the sub-contracted company and one of his employees, who had only worked for the company for a month, positioned themselves between a front end loader's bucket and its front left tire in an effort to use the equipment as a wind block while they tried to melt a piece of plastic water pipe with a hand held propane torch.

Just after the owner of the sub-contracted company walked away from the front end loader, leaving his employee crotched between the bucket and the tire of the front end loader to continue his work efforts, the operator of the front end loader, an employee of the General Contractor, entered the cab of the loader and began to move it as part of his work efforts to gather equipment needed for the water line project. As the loader moved forward, the employee crotched between the bucket and the front left tire was struck by both the front and rear left tires before the operator could stop the front end loader. The injured employee suffered chest and head injuries as a result of the accident and died several days later in the hospital.

Neither worker informed the front end loader operator of their intension to use the front end loader as a wind block. The employer had not provided the employee with training relating to the hazards or method to be used to avoid hazards while working around heavy equipment.

Significant Factors:

- The employee had only worked for the company for a month prior to the accident.
- The only training provided to the employee was in the form of on-the-job training.
- The employer had no knowledge of the employees work experience, education or training.
- The employer did not understand or recognize the hazards of working near heavy equipment.
- The Company had no written Heath and Safety program.
- The employee put himself in a hazardous situation by using the front end loader as a wind block and the employer allowed an employee put himself in a hazardous situation.
- No one informed the loader operator of their intension to use the loader as a wind block.
- The loader operator entered the equipment by walking around the rear of the loader from the right middle area of the loader.
- The front end loader operator failed to adequately inspect the equipment prior to moving it.
- The operator did not see the worker move to the crotch position between the bucket and the tire.
- The view observed from the operator's seated position in the cab of the loader provided no view of the area where the crotched employee was working.
- The equipment was most likely running when the operator entered the equipment, and the crotched worker did not have time to respond to the movement of the loader.

Recommendations:

- Brief all employees on the facts and circumstances of this fatal mishap.
- Enforce the Wyoming OSHA rules relating to this type of work.
- Ensure employees are trained to recognize and avoid hazards associated with working around heavy equipment.
- Use the heavy equipment owner's manuals as guides for training worker to work safely around heavy equipment.