

Case 231. 33-year-old township laborer died from complications sustained from a fall from the cargo box of a Cub Cadet 4x4 utility vehicle.

A 33-year-old male township laborer died from complications sustained from a fall from the cargo box of a Cub Cadet 4x4 utility vehicle. The decedent was a member of a 3-person crew. The crew had been working on a piece of equipment in Building 1. The work crew walked to Building 2 and took a lunch break. Having finished lunch, they boarded a Cub Cadet 4x4 utility vehicle parked in the maintenance garage of Building 2. The Cub Cadet had a hydraulic tilt cargo box and an enclosed cab. The crew was using the Cub Cadet to transport them approximately 100 yards back to Building 1. One of the decedent's coworkers drove, one coworker sat in the passenger seat, and the decedent sat on the lowered tail gate of the cargo box. The cargo box was not enclosed and not equipped with a passenger seat belt. The tailgate height was 2 feet 9 inches above the ground. The vehicle was backed approximately 10-15 feet out of the garage onto a wet asphalt roadway/parking area. The driver then proceeded forward and to the left. The vehicle traveled approximately 10-20 yards, and then made a left turn onto the asphalt roadway that would take them back to Building 1. After driving a short distance, his coworkers noted that the decedent had fallen from the tailgate and onto the roadway. His coworkers stopped the vehicle and went back to the decedent. They found him unconscious. As they spoke to him, he began to respond and he indicated his head hurt. One of his coworkers called for emergency response and the decedent was transported to a local hospital. He died from complications of the head injury sustained approximately two weeks after the incident. The employer had placed the Cub Cadet into service several months prior to the incident. No training had been given to the operators on the hazards and safeguards of the equipment including the Operator Manual instruction: "Never carry more than one passenger – This vehicle is designed to carry the driver and one passenger only – NO riders are allowed in cargo box or anywhere else on vehicle."

MIOSHA General Industry Safety and Health division issued the following Serious and Other-than-Serious citations at the conclusion of its investigation:

SERIOUS: MICHIGAN OCCUPATIONAL SAFETY AND HEALTH ACT, ACT 154, P.A. 1974, AS AMENDED, SECTION 11(a):

The employer did not furnish to each employee, employment and a place of employment, which was free from recognized hazards that were causing or were likely to cause death or serious physical harm to the employee: Employees were permitted to ride on the lowered tailgate of the Cub Cadet 4x4 utility vehicle as it was driven from location to location on the site. An employee fell from the tailgate, striking his head on the paved drive, resulting in his death.

Among others, one feasible and acceptable method to correct this violation is to prohibit employees from riding in or on the vehicle, unless seated in a passenger seat properly

equipped with passenger restraint seat belts, as recommended by the vehicle manufacturer.

SERIOUS: GENERAL PROVISIONS, PART 1, RULE 11(a):

Training was not provided to each newly assigned employee regarding the operating procedures, hazards, and/or safeguards of the job.

No training on safeguards and hazards, power equipment.

OTHER-THAN-SERIOUS: RECORDING AND REPORTING OF OCCUPATIONAL INJURIES AND ILLNESSES, PART OSH 11, RULE 1139(1):

An oral report of a work-related incident resulting in a fatality or the inpatient hospitalization of three or more employees was not made within eight hours after the occurrence to the Michigan Department of Energy, Labor and Economic Growth, Michigan Occupational Safety and Health Administration, State Secondary Complex, 7150 Harris Drive, P.O. Box 30644, Lansing, Michigan 48909, phone 1-800-858-0397.