Case 534. 64-year-old male supervisor at a recycling/alloy manufacturing facility was struck and run over by a front-end loader.

A 64-year-old male supervisor/furnace operator at a recycling/alloy manufacturing facility was struck and run over by a front-end loader. The decedent had gone into the yard for a "smoke break". He spoke with a forklift driver while in the yard, instructing him for his next duty. While in the yard, the driver of the John Deere front end loader looking to his left, noticed the decedent near a 24-foot wide overhead door opening when he was taking a full load of scrap in the 9-foot by 4-foot bucket to the furnace. After the front-end loader had passed him, the decedent entered the doorway and was bent over, presumably picking up debris in the doorway. After dropping off the load, and with the bucket estimated to be 12-18 inches above the concrete, the front-end loader driver had to turn the loader to exit through the door. As he was turning, due to the limited space, the driver was looking toward the wall and to where he had previously seen the decedent. As the front-end loader turned, the operator sounded the horn. The loader's bucket struck the decedent and knocked him to the ground. The loader's left wheels ran over and crushed him. The front-end loader proceeded to drive into the yard. The driver indicated that he felt a bump as he drove out the door but thought the loader had run over a pallet or debris. Contributing factors to the fatality include: (1) the front-end loader's Lexan windshield was dirty, mud-splattered, scuffed and opaque, which limited the visibility for the operator; (2) the decedent, wearing a high visibility garment, was bent over in the doorway; (3) the loader bucket was carried 12-18 inches above the ground, limiting forward visibility; (4) limited turning space for the heavy machinery to exit; (5) change in light levels from the inside of the plant (dark environment) to the outdoor-lit (bright) yard; and (6) the size of the bucket of the loader took up much of the width of the doorway especially when turning. The forklift driver saw the decedent on the ground and called on the radio for assistance. Production personnel administered CPR and called for emergency response. He was declared dead at the scene.

MIOSHA General Industry Safety and Health Division issued the following Serious citations at the conclusion of its investigation.

Serious: GI PART 22, TRACTORS

- 408.12243(1): A tractor shall be visually inspected prior to each shift to assure that there are no visible defects which would adversely affect the safe operation of the tractor and to assure that the prescribed safety devices are in place and functional.

  John Deere #13 front-end loaders windshield sections were not visually inspected to assure that there were no visible defects which would adversely affect the safe operation of the tractor and assure that the prescribed safety device was in place and functional. The front-end loader had a dirty and mud splattered Lexan windshield. The Lexan windshield was scuffed and limited the safe visibility of the operator, contributing to the fatality of an employee near the south bay door of the furnace room on *Date*, 2019. *(MIFACE removed the date of incident)*

- 408.12260(1): An operator shall do the following:

  (a) Operate a tractor according to the rules of this part and in accordance with local traffic rules when on a public road.

  (b) Look in the direction of and keep a clear view of the direction of travel.

(c) Travel with a load-engaging means elevated only sufficiently to clear obstacles on floor or roadway.

(d) Start, stop, and turn in a manner that will prevent a load from shifting or overturning the tractor.

(e) Drive at a slow speed over wet or slippery surfaces.

The following deficiencies were found onsite with employees that operated the John Deere #13 front-end loader:

(a) The operator of the front-end loader did not look in and keep a clear view of the direction of travel which contributed to running over and fatally injuring an employee near the south bay door of the furnace room on *Date*, 2019. *(MIFACE removed the date of incident)*

(b) The load engaging means was raised higher than necessary to clear obstacles during travel which partially obstructed the view of the operator and contributed to running over and fatally injuring an employee near the south door of the furnace room on *Date*, 2019. *(MIFACE removed the date of incident)*