

Investigation Report
Worker Fatally Crushed by Equipment
August 30, 2016

The contents of this report

This document reports Occupational Health and Safety's (OHS) investigation of a worker being fatally injured in August 2016. It begins with a short summary of what happened. The rest of the report covers this same information in greater detail.

Incident summary

On August 30, 2016, at approximately 3:00 p.m., a paid worker hauling oats to a farm near La Crete, Alberta (AB), was found trapped between the frame and the box of a grain truck the worker had been operating. The worker was working alone at the time of the incident and was in the process of transferring a load of oats from the box of the grain truck to the silo storage bins (bins). It was approximately 15 minutes from the time of last contact with the worker to when the worker was found by the employer. Emergency Medical Services (EMS) responded to the scene, along with the Royal Canadian Mounted Police (RCMP) from Fort Vermillion. The worker was pronounced deceased at the scene by EMS.

Background information

Owner/Employer – Herman Friesen O/A Northwest Mowing Inc.

The employer grew and harvested oats and other grains on his farm. The farm was located at LSD 36-102-18-15NE, approximately 15 kilometres (km) northeast of La Crete, AB. The employer also owned Northwest Mowing Inc., which mowed the roadside ditches, parks and businesses in and around the La Crete area. The employer hired the worker as both a farm hand and a foreman for Northwest Mowing Inc.

Worker

The worker was working as a farm hand at the time of the incident, hauling oats from a field to the employer's yard where the bins were located. The worker was to unload the oats into the bins from the grain truck box via a grain auger. The worker also worked for Northwest Mowing Inc. as a foreman, but at the time of the incident the worker was not working for North West Mowing Inc. The worker had been working for the employer doing both jobs for the past three years.

Equipment and materials

The 1976 Chevrolet C60 grain truck (grain truck) was a medium duty truck. The grain truck measured 2.4 metres (m) from the bumper to the back of the cab which allowed for the same cab to axle dimensions. The grain truck was a gasoline powered model with an 8 cylinder engine (V8), a gross vehicle weight rating of 8709 kilograms (kg), and a wheelbase of 4.8 m. The grain truck had a power transmission overdrive (PTO), dump box, and hydraulic system that controlled the lifting and lowering of the grain truck box.

Inside the cab of the grain truck was a 30 centimetre (cm) metal rod, with a T shaped handle, which was attached to the floor that could be used to engage the PTO from inside the truck. The grain truck box could also be manually operated with a lever at the hydraulic oil tank, located between the frame rails of the truck chassis. The grain truck had been parked in a field prior to August 30, 2016, and was borrowed from the employer's brother to haul oats during harvest time.



Figure 1. Driver's side of the grain truck the worker was operating at the time of the incident. Arrow A indicates the location of the worker when found.

Sequence of events

On August 30, 2016, at approximately 2:45 p.m., the worker and employer finished loading the grain truck with oats at a field near the employer's farm.

At approximately 3:00 p.m., the worker arrived at the employer's farmyard and backed the grain truck up to the grain auger, which was sitting in front of the bins at the northeast side of the farmyard. The worker then either lifted the grain box by using the hydraulic lift switch inside the cab of the truck or by using the secondary hydraulic lift switch, located on the passenger side frame by the hydraulic oil tank. The truck must have been running for either of the hydraulic lift switches to work. At some point the worker exited the grain truck.

At approximately 3:15 p.m., the employer drove into the farm yard and parked his vehicle. The employer stated he could hear the auger running but could not see the worker. The employer walked over to driver's side of the grain truck and saw the worker trapped between the frame of the grain truck and box. The employer could not recall if the grain truck was running when he arrived on the scene.

The employer got a tractor from the yard and with the bucket lifted the grain box up enough that the worker fell to the ground. The employer did not recall why he did not attempt to engage the hydraulic lift on the grain box. The employer checked the condition of the worker and administered first aid, but the worker was unresponsive. The employer then shut off the auger and tried to call 911 from his cell phone; he kept losing service so he went to the house and called 911. The employer then went back to the scene and continued to administer first aid to the worker until EMS and RCMP arrived on scene.

EMS and RCMP arrived on scene at 4:30 p.m., and the worker was pronounced deceased at the scene by EMS. OHS was advised of this incident by Fort Vermillion RCMP on August 30, 2016, at 5:00 p.m. OHS arrived at the incident scene on August 31, 2016, at approximately 2:30 p.m., and conducted an investigation which included taking photographs, measurements and interviews.

The employer asked if they could conduct a function test of the hydraulics on the grain truck during the course of the on-site investigation by OHS. After approval from OHS and a review of a hazard assessment for this task, the employer was able to lift the grain box, which still had a full load of oats, and maintain a hold without the box lowering.

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OHS advised the employer that they could transport the grain truck to High Level, AB for an inspection and repair of the hydraulic system if they wanted, but the employer refused this offer, electing to take the unit out of service and return it to the farmer's brother. RCMP evidence provided to OHS indicated that a small child was removed from the cab of the vehicle by the employer when he initially arrived on site.

Completion

A review for enforcement action was completed on November 14, 2017, and it was determined that prosecution or an administrative penalty were not appropriate based on the circumstances surrounding this incident.

This file was closed on November 17, 2017.

Final Report

Signatures

ORIGINAL REPORT SIGNED

March 8, 2018

Lead Investigator

Date

ORIGINAL REPORT SIGNED

March 8, 2018

Manager

Date

ORIGINAL REPORT SIGNED

March 5, 2018

Director

Date