A 47 year old male employee was fatally injured when the dump truck he was working on fell from the hydraulic jacks crushing him underneath. The trucking company hauls various aggregate materials. The incident occurred in the maintenance garage which the company leases from another trucking company. On the day of the incident the victim was removing a walking beam so that a bearing could be replaced on a dump truck. Another employee was working on the front passenger side steer axle simultaneously. The truck had been lifted and cribbed to allow for multiple repairs to take place at once. Although, once the driver side rear axles of the truck was lifted using 20 ton bottle jacks there was no cribbage used to prevent the truck from falling. It was determined that a plan was discussed to use jack stands and blocks to crib the rear of the truck once lifted but evidence reveled no cribbage at the rear of the truck. Three nuts had been removed and one broken stud was observed on the walking beam assembly. A hammer was observed under the two rear axles but it is unknown if the victim used the hammer during the disassembly process. The investigation concluded that as the victim began the disassembly of the walking beam, the truck shifted off the rear bottle jack causing the entire truck to shift and fall to the ground.

Citation(s) as Originally Issued

A complete inspection was conducted at the accident scene. Some of the items cited may not directly relate to the fatality.

Citation 1 Item 1

1910.244(a)(2)(iii)	Loads were not cribbed, blocked or otherwise secured immediately after being raised with a jack.
	In that the rear section of a Kenworth W900 that was elevated with hydraulic/air bottle jacks was not secured before the removal of the driver side walking beam began, leading to the vehicle falling and fatality injuring the employee conducting the repairs.

Citation 1 Item 2

1910.147(c)(1)	The employer did not establish a program consisting of an energy control procedure, employee training and periodic inspections to ensure that before any employee performed any servicing or maintenance on a machine or equipment where the unexpected energizing, startup or release of stored energy could occur and cause injury, the machine or equipment was not isolated from the energy source and rendered inoperative.
	In that there was not a Lock Out/Tag Out program established for when employees serviced or maintained the fleet of diesel powered dump trucks.

Citation 2 Item 1

1910.132(d)(2)	The employer did not verify through a written certification that the required workplace hazard assessment had been performed.
	In that there was not a written certification of the workplace hazard assessment having been conducted.

Citation 2 Item 2a

1910.1200(e)(1)	The employer did not develop, implement, and/or maintain at the workplace a written hazard communication program which describes how the criteria specified in 29 CFR 1910.l200(f), (g), and (h) will be met.
	In that there was not a written hazard communication program for the chemicals employees are exposed to during regular work operations such as transmission fluid, gasoline, motor oil and PB Blaster.

Citation 2 Item 2b

1910.1200(g)(1)	The employer did not have a material safety data sheet for each hazardous chemical in use.
	In that the employer did not have a SDS on site for transmission fluid, gasoline, diesel, motor oil, and PB Blaster that the employees were exposed to on a daily basis.

Citation 2 Item 2c

1910.1200(h)(1)	Employees were not provided effective information and training on hazardous chemicals in their work area at the time of their initial assignment and whenever a new hazard that the employees had not been previously trained about was introduced into their work area.
	In that employees did not receive training on the hazards associated with the chemicals that they are exposed to during their daily work assignments, such as transmission fluid, gasoline, diesel, motor oil and PB Blaster.

Citation 2 Item 3

TDLWD Rule 0800-01-0305(1)(a)1	Within eight (8) hours after the death of any employee as a result of a work related incident, the employer did not report the fatality to the TOSHA Division of the Tennessee Department of Labor and Workforce Development.
	In that the employer did not report the fatality that occurred on March 10th at approximately 10:30 a.m.



