WASHINGTON State FACE Program
Fatality Assessment & Control Evaluation

AGRICULTURE

FATALITY NARRATIVE

FACE

Experienced Operator Crushed in Tractor Rollover

INCIDENT FACTS

REPORT #: 71-267-2025s

REPORT DATE: June 1, 2025

INCIDENT DATE: June 14, 2024

WORKER: 55 years old

INDUSTRY: Farm Management Services

OCCUPATION: Tractor Operator

SCENE: Cherry orchard

EVENT TYPE: Crush - Caught in or between / Machine

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A 55-year-old tractor operator died when his tractor rolled over at a cherry orchard. He had worked for his employer, a farm management services company, for over 20 years as a tractor operator.

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The operator was driving the tractor to move cherry bins from orchard rows to a landing deck where they would be loaded onto trucks. The tractor had pallet forks attached to its 3-point hitch. The operator was traveling near the edge of a steep, 12-foot earthen embankment at the end of the rows. He appeared to take a left turn before attempting to back into a row to pick up bins. As he turned, the tractor slid in soft soil, rolled over the edge, and trapped the operator under the left rear tire.

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No one witnessed the incident, but soon after, a co-worker approaching the scene saw the pinned operator's legs sticking out from under the tire. He left to call 911 and guide first responders to the incident site, but the operator had already died from severe crushing injuries when they pulled him out.

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Investigators found:

- The tractor's rollover protective structure (ROPS) was in the down position, the seat belt was installed but was not being used, and the rear wheel split brakes were not engaged.
- The employer did not ensure the operator was using the ROPS and seat belt as required. The employer thought the tractor met a ROPS requirement exemption after mistakenly believing it was a low profile tractor and because the orchard had large trees where vertical clearance requirements would interfere with harvesting operations. Evaluation and measurements of the tractor determined it was not low-profile and not exempt from the requirement to have the ROPS up at all times. Not wearing a seatbelt with ROPS increases risk of serious or fatal crushing injuries if a rollover occurs.

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- The employer had a written accident prevention program (APP) that included tractor safety policies, training, and monthly safety meetings. The operator had up-to-date documented refresher training.
- The operator did not follow the employer's requirement to engage the tractor split brakes, which can improve vehicle maneuverability and control on difficult terrain.

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Photo 1. Tractor with ROPS folded down at rollover scene.

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Photo 2. Tractor at base of embankment.

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Photo 3. Side of embankment where tractor rolled over.

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Photo 4. Aerial view of embankment road at end of orchard rows.

Requirements

Employers must:

- Provide a ROPS for each employee-operated tractor that is covered by WAC 296-307-080. ROPS used on wheel-type tractors must meet the test and performance requirements of OSHA 1928.51 C.F.R. See WAC 296-307-08009
- Where ROPS are required by WAC 296-307-080, employers must provide safe seat belts and make sure workers use them according to the requirements of WAC 296-307-08012(1)(b).

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Recommendations

FACE investigators concluded, that to help prevent similar occurrences, employers should:

- Request assistance for ROPS and seat belt rules by calling their local L&I safety consultant.
- Develop clear policy requirements for ROPS and seat belt use and tractor operator safety training in their written APP. Review requirements with supervisors and operators at safety meetings.
- Provide documented, hands-on tractor operator training, including recurrent refresher training.
- Provide ample supervision of tractor operators and always enforce APP policy requirements.

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Resources

Tractor Safety: Overview, Requirements, and Training

Washington State Dept. of Labor & Industries

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This narrative was developed to alert employers and workers of a tragic incident in Washington State and is based on preliminary data ONLY and does not represent final determinations regarding the nature of the incident or conclusions regarding the cause of the fatality.

Developed by Washington State Fatality Assessment and Control Evaluation (WA FACE) and the Division of Occupational Safety and Health (DOSH), Washington State Dept. of Labor & Industries. WA FACE is supported in part by a grant from the National Institute for Occupational Safety and Health (NIOSH grant# 5U60OH008487). For more information visit www.lni.wa.gov/safety-health/safety-research/ongoing-projects/work-related-fatalities-face.

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