WASHINGTON State FACE Program
Fatality Assessment & Control Evaluation

LANDSCAPING SERVICES

FATALITY NARRATIVE

FACE

Tree Trimmer Falls 50 Feet While Cutting Branches

INCIDENT FACTS

REPORT #: 71-269-2025s

REPORT DATE: August 4, 2025

INCIDENT DATE: December 1, 2023

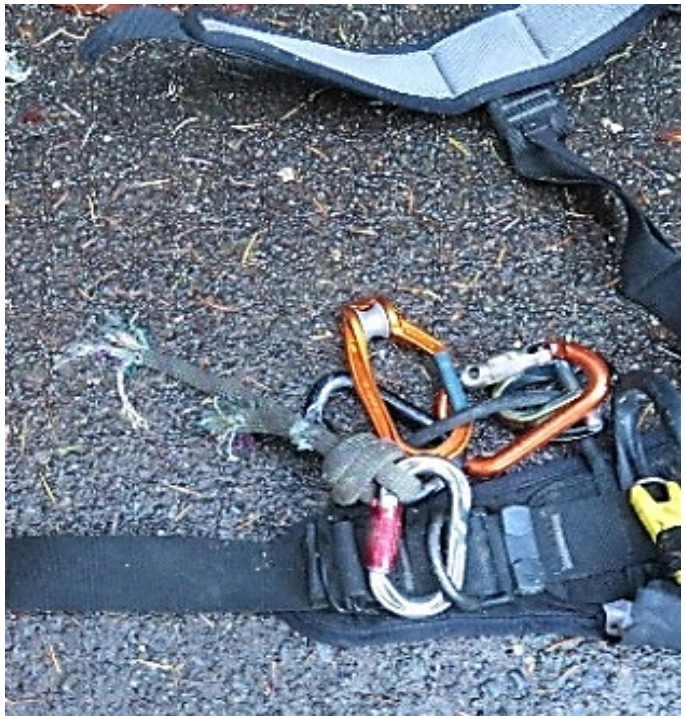
VICTIMS: 36 years old

INDUSTRY: Landscaping Services

OCCUPATION: Tree Trimmer

SCENE: Private residence

EVENT TYPE: Fall from elevation



SHARP Safety & Health Assessment & Research for Prevention

Washington State Department of Labor & Industries

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A 36-year-old experienced tree trimmer died when he fell 50 feet while cutting branches. He worked for his employer, a local tree care service, for just over a year.

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He was the climber on a five-member crew removing a 120-foot Fir tree. His personal protective equipment (PPE) and work gear included a helmet, safety glasses, gloves, climbing spikes, saddle (harness), a rope flip line (lanyard), a rappelling line (lifeline), and a rigging line. He had a handsaw and chainsaw to cut branches.

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He climbed about 50 feet up the tree, cutting branches along the way. Just after, he screamed and fell backwards to the pavement. He had cut his flip line with his chainsaw. His coworkers, who were clearing dropped branches on the ground, saw him fall and ran to his aid. They began CPR and called 911 and the employer. First responders came, began lifesaving efforts, and transported him to the hospital, where he was pronounced dead

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Following the incident, investigators found:

- The worker knew the hazards of not using a lifeline while working at heights but decided to use his rope flip line as his only point of attachment. He had a second rope or lifeline on his saddle but did not tie it off as required by ANSI Z133-2017-6.3 when using a chainsaw.
- The employer and crew supervisor allowed the trimmer to use a personally owned, lighter, soft-fiber rope as a flip line instead of requiring him to use a heavier, cut-resistant steel-core line that they provided to him. The supervisor told investigators they routinely allowed trimmers to use gear that was comfortable or easier to handle in order to maintain their climbing confidence.

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Following the incident, investigators found:

- The employer and supervisor did a site assessment and led two morning pre-job crew meetings.
- The employer had an outdated accident prevention program (APP) and did not conduct and document safety meetings, PPE hazard assessments and effective worker orientation and training.

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Photo 1. Cut flip line on saddle.

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Photo 2. Alternate view of cut flip line.

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Photo 3. Area where trimmer was cutting branches.

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Photo 4. Fall site.

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Photo 5. Close up view of fall site.

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Requirements

- Make sure arborists tie in and use a second means of being secured [e.g., lanyard (work positioning lanyard) or second climbing line] when operating a chainsaw in a tree. See ANSI Z133 2017 Chainsaws 6.3.6
- Provide your employees a workplace free from recognized hazards that are causing, or are likely to cause, serious injury or death. See WAC 296-800-11005
- Document hazard assessments and training for PPE and safety meetings. See WAC 296-800-16010, WAC 296-800-16035, WAC 296-800-13025(2)

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Recommendations

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

- Develop and enforce policies and standard operating procedures (SOP) in their APP that require tree trimmers:
  - To always use steel-core flip lines, except near power lines, and high-strand rope lifelines for a second point of attachment. Climbing gear should be top quality, reputable, and arborist-certified.
  - To have documented recurring training in arborist fall protection systems, including PPE and climbing gear identification and proper inspection, use, cleaning, maintenance, and storage.

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Resources

National Tree Climbing Guide

United States Forest Service

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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 the Washington State Fatality Assessment and Control Evaluation (WA FACE) Program 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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