

Kentucky Injury Prevention and Research Center
Bona fide agent for Kentucky Department for Public Health
2365 Harrodsburg Rd., Ste. B340, Lexington, KY 40504 • 859 257-5839

INCIDENT HIGHLIGHTS



DATE:
January 17, 2025



TIME:
11:30 a.m.



VICTIM:
25-year-old white, non-Hispanic male



INDUSTRY/NAICS CODE:
238990



EMPLOYER:
Fencing & General Contractor



SAFETY & TRAINING:
No formal safety program



SCENE:
Residential fence installation site



LOCATION:
Kentucky



EVENT TYPE:
Struck against



REPORT#: 25KY009

REPORT DATE: December 17, 2025

Fencing Laborer Deceased after Skid Steer Attachment Fails

On January 17th, 2025, a 25-year-old white, non-Hispanic general laborer (victim) was assisting with the installation of fence posts at a residential job site. While doing so, the hydraulic post-driver being utilized failed. The post driver struck the victim from the rear. The victim succumbed to the injuries he sustained at the scene of the incident.

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CONTRIBUTING FACTORS

Key contributing factors identified in this investigation include:

- Distance to hazard,
- Distraction,
- Lack of job site spotter program,
- Equipment failure due to lack of maintenance, and
- Lack of safety and health program.

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RECOMMENDATIONS

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

- Establish a safe zone procedure to ensure workers maintain adequate distance from hazards presented by equipment operation,
- Implement and enforce a cell-phone-free work environment,
- Implement a job site spotter program,
- Implement a daily inspection procedure for all equipment, and
- Implement a formal health and safety program.

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[Kentucky FACE Program](#)



KENTUCKY

State **FACE** Program

Fatality Assessment & Control Evaluation

Kentucky Injury Prevention and Research Center
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Fatality Assessment and Control Evaluation (FACE) Program

This case report was developed to draw the attention of employers and employees to a serious safety hazard and is based on preliminary data only. This publication does not represent final determinations regarding the nature of the incident, cause of the injury, or fault of employer, employee, or any party involved.

This Case report was developed by the Kentucky Fatality Assessment and Control Evaluation (FACE) Program. Kentucky FACE is a NIOSH-funded occupational fatality surveillance program with the goal of preventing fatal work injuries by studying the worker, the work environment, and the role of management, engineering, and behavioral changes in preventing future injuries. The FACE program is located in the Kentucky Injury Prevention and Research Center (KIPRC). KIPRC is a bona fide agent for the Kentucky Department for Public Health.

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INTRODUCTION

On January 17th, 2025, a 25-year-old white, non-Hispanic male general laborer (victim) was assisting with the installation of fence post at a residential job site. The victim's primary job was to position the fence post vertically, hold the post, and assist the equipment operator with the positioning of the post-driver onto the fence post. Once the post-driver was positioned on the post, the victim would move to the next post to restart the process. After assisting with the positioning of the post-driver, the victim was moving to the next post while the operator was driving a post into the ground. While doing so, the post-driver failed which resulted in portions of the equipment striking the victim in the back/shoulder area. The victim succumbed to the injuries he sustained at the scene of the incident.

EMPLOYERS

The employer is a general contractor that focuses primarily on the installation of residential fences. However, they also build decks and complete exterior painting jobs. The company was established in 2019, employing 3 full-time employees and 3 part-time contract workers.

WRITTEN SAFETY PROGRAMS and TRAINING

The employer does not have a written safety program. The company owner informed investigators that the company utilizes a 3rd party consulting company to provide general construction safety training to employees at time of hire. Additionally, the employer requires a pre-employment drug screen and drug screens post-incident if an employee is injured on the job.

WORKER INFORMATION

The victim was a 25-year-old white, non-Hispanic male. The decedent was a high school graduate and had worked for the employer for the last seven months. According to the employer, the victim had primarily worked in the construction industry prior to onboarding with the involved company.

INCIDENT SCENE

The incident occurred on the lawn of an active residential farm in a rural area of Kentucky. The property, which sits off a two-lane Kentucky roadway, consists of 2 main structures, a barn and a single-family home. The grounds are covered in grass and have many trees throughout various locations on the property (Photo 1). The fence, which was being installed when the incident occurred, was intended to keep livestock on the property.

EQUIPMENT

The company involved was operating a skid steer mounted, single slide "Next Generation" model post-driver manufactured by [Extreme Post Drivers](#). (Photo 2). Once attached to the skid steer, the post driver utilizes a hydraulically controlled hammer to drive posts. Support arms on the driver's attachment (photo 2) help stabilize the driver during operation. The driver arm can be tilted to meet the needs of the post and terrain in which the post is being installed. The post driver specifications, according to the manufacturer's website, are as follows:

- Total weight: 3,000 lbs.
- Hammer weight: 750 lbs.
- Max post length: 14 feet

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- 26-degree front-to-back tilt
- 40-degree left-to-right tilt / 84-inch stroke



Photo 1. Google Earth photo showing overhead view of the residential location where the incident occurred. Red location marker identifies location on the property where the incident occurred.



Photo 2. Photo showing type of skid steer mounted post-driver utilized in the incident. The yellow circles show the driver support arms. Photo obtained via Google image search.

WEATHER

The weather on the day of the incident was approximately 36 degrees Fahrenheit, 70% humidity, with a 13-mph wind from the south. The weather is not believed to have been a factor in this incident.¹



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INVESTIGATION

On January 17th, 2025, a 25-year-old white, non-Hispanic male general laborer (victim) arrived on the job site, a private residence, at approximately 7:30 am. The victim typically worked Monday through Friday of each week, 7:30 am to 4:00 pm with occasional half workdays on Saturday, depending on the needs of the job. Having worked for the employer for the last seven months, the scope of the victim's job was to assist with the installation of residential fencing. Tasks include loading and unloading materials, using hand tools, setting posts, and other manual labor tasks.

The day the incident occurred was the first day on site of what was projected to be a two-day fence installation job. After arriving on scene, the victim was tasked with setting fence posts. The fence posts were constructed of wood, having a circumference of 5 inches and measuring 7 feet in height (Photo 3). To aid in the installation process, the company utilizes a hydraulically powered post-driver that attaches to a skid steer. The post-driver was purchased new in 2020 and had been used regularly.

Setting fence posts required the victim to lift each post and position it vertically while the skid steer operator positioned the hydraulic post-driver onto the top of the post. Once the post-driver was in position, the victim would move to the next post to restart his task while the operator drove the post into the ground.

Throughout the course of this repetitive task, at approximately 11:30 am, four hours after arriving at the job site, the post-driver suffered a catastrophic failure while driving a wooden post into the ground. For unknown reasons, the driver arm and head broke away from its mounting point while attempting to drive a wooden post (Photo 4 & 5). As a result, the hydraulic arm sheared off (Photo 6).

The broken arm and driver-head fell, striking the victim, who was approximately 10 feet from the equipment, in the back and upper left shoulder (Photo 7, 8, Diagram 1). The victim was reportedly on his cell phone with his back turned to the equipment, holding the next post to be installed, when he was struck. The strike knocked the victim forward and to the ground, bending him at the waist. The arm and driver-head remained on the victim after the strike, and in the bent position his head and torso were touching the front of his legs. The owner and two other crew members who witnessed the incident rushed to the victim, who was unconscious, to lift the arm and driver-head off the victim. Once removed, the owner contacted 911 while a crew member attempted to perform cardiopulmonary resuscitation (CPR).

The local police department arrived 11 minutes after the call was placed, at approximately 11:43 am. Paramedics arrived shortly after. The victim remained unresponsive; it was apparent to investigators that the victim was deceased upon their arrival. A local coroner verified the victim was deceased shortly after.

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Photo 3. Photo showing posts that were being installed when the incident occurred. Photo property of Kentucky FACE.

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Photo 4. Photo showing post-driver attachment point and point of break. Photo provided by involved company.



Photo 5. Photo showing post-driver attachment point and point of break. Photo provided by involved company.



Photo 6. Photo showing post-driver hydraulic arm that was sheared off. Photo provided by involved company.

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Photo 7. Photo showing failed post driver at the scene of the incident at final rest. Red location marker indicates location of the victim. Photo obtained via Kentucky open records request.

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Photo 8. Photo showing a similar post-driver. Yellow arrows depict points where machine broke from base. Red lines show the driver arm and head which fell towards the victim. Orange arrow indicates the point of contact with the victim's back/shoulder area. Photo obtained via Google search, modified to aid in investigation.

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Not to Scale

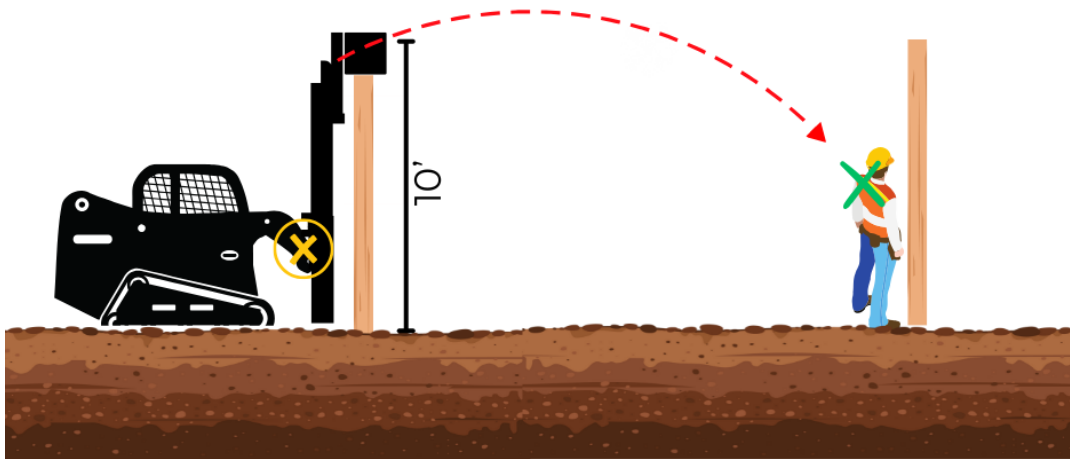


Diagram 1. Diagram depicting the incident. **YELLOW X** represents the approximate point where the post-driver arm and head failed and detached. The **RED DOTTED LINE** represents the approximate manner and path in which the arm and head fell. The **GREEN X** shows approximate point of contact where the driver head struck the victim. Diagram is a visual aid only and does not represent exact type of equipment utilized. Diagram property of Kentucky FACE.

CAUSE OF DEATH

According to the death certificate, the cause of death was blunt force trauma.

CONTRIBUTING FACTORS

Workplace injuries and fatalities are often the result of one or more contributing factors or key events in a larger sequence of events that ultimately result in injury or fatality. Kentucky investigators identified the following unrecognized hazards as key contributing factors in this incident:

- Distance to hazard,
- Distraction,
- Lack of job site spotter program,
- Equipment failure due to lack of maintenance, and
- Lack of safety and health program.

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RECOMMENDATIONS/DISCUSSION

Recommendation #1: Establish a safe zone procedure to ensure workers maintain adequate distance from hazards presented by equipment operation.

Discussion: Distance to hazard often refers to space between workers and machinery. Establishing a safe zone with adequate distances to protect workers from machinery may be an effective measure to prevent injuries on the job. In this incident, a machinery failure resulted in the post-driver arm and driver-head breaking away from the skid steer. The arm and driver-head fell, striking the victim in the back and upper shoulder, which ultimately led to his fatal injuries.

A safe zone procedure would account for maximum exposure distance from the hazard, in this case, the skid steer and hydraulically controlled post-driver. Once the maximum exposure distance is determined, a safe zone can be established. Once the safe zone is established, employees should be trained on the standard and prohibited from entering the safe zone until the machinery has been powered off and made safe (Diagram 2). In this incident, the victim's job required him to temporarily be in the proximity of the post-driver to properly position the driver head onto the post. However, once in place, equipment operation should cease until employees exit the exposure area and position themselves in the safe zone. Once in place, the hydraulic post-driver can operate and drive the post. Workers, although in the safe zone, should stay attentive and alert to work being performed. By doing so, the probability of a similar incident occurring decreases significantly.

To prevent a future occurrence, Kentucky FACE investigators recommend that companies performing similar tasks establish safe zones to protect workers from hazards associated with the operation of machinery.

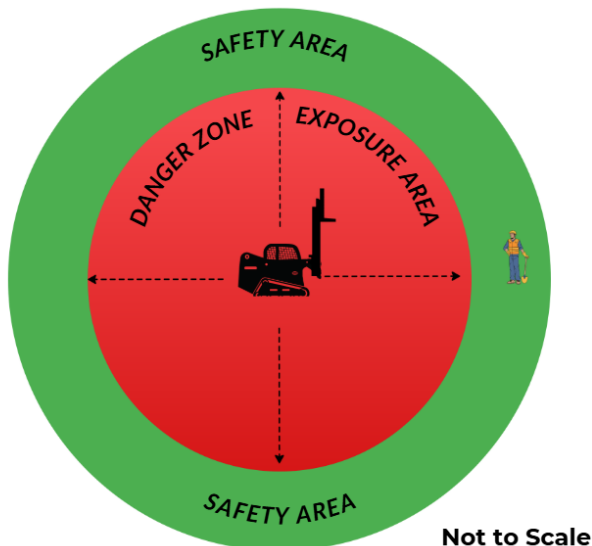


Diagram 2. Diagram depicting a safe zone. The **RED Circle** represents the approximate exposure area presented by the operation of the equipment. The **GREEN Circle** represents an established safe zone. Diagram property of Kentucky FACE.

Recommendation #2: Implement and enforce a cell-phone-free work environment.

Discussion: Struck-by injuries are produced by forcible contact or impact between the injured person and an object or piece of equipment. It is important to point out that in construction, contact hazards can also include caught-in or caught-between hazards. If the impact of the object alone causes injury, the event is considered a stuck-by event.²

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Struck by events in construction are all too common. Occupational struck-by incidents caused 150 deaths and 14,000 nonfatal construction sector injuries in 2020 alone. Falling objects pose an inherent risk for struck-by injuries on the job site. Tools, materials, and other objects can fall from roofs, cranes, and scaffolds, but even objects falling from lower levels such as a truck bed or dolly can lead to injuries. Several factors increase the risk of more severe injuries including the shape of the object and where on the body the person is struck. The height at which the object falls, and weight of the object are also extremely important, with injury severity increasing as the height and weight of the falling object increase.³

In this incident, a falling post-driver arm and driver-head failed, which resulted in the equipment falling away from its mounting points. The falling object struck the victim, who according to the involved company, was on a cell phone with his back turned to the equipment. Cell phone utilization on a job site may result in employee distraction. Distraction as it relates to cell phone usage is generally broken down into four primary categories:

1. Visual distraction: Taking your eyes off your surroundings to focus on your mobile device.
2. Manual distraction: Holding a cell phone, inhibiting your ability to react quickly.
3. Cognitive distraction: Loss of awareness due to focus on your phone.
4. Audible distraction: Sound produced by a cell phone that results in lack of attentiveness to your surroundings.

All four distraction types resulting from phone usage could inhibit an employee's ability to see, identify or react to hazards on the job site. Implementing and enforcing a phone-free work environment may help reduce job injuries and fatalities by eliminating employee distraction.

Some elements of an effective phone-free work environment policy could include requiring phones to be powered off while work is being performed, stored in vehicles, placed into airplane mode, or relinquished to site supervisors until scheduled breaks. A policy can be uniquely designed to fit the needs of each employer and reduce the risk associated with job site distraction.

Kentucky FACE investigators suggest employers implement and enforce a cell-phone-free work environment policy to prevent the recurrence of similar future events.

Recommendation #3: Implement a job site spotter program

Discussion: A spotter program is a helpful initiative to enhance job site safety in situations where an equipment operator has limited visibility or is working near other personnel. A spotter program typically consists of safety procedures, employee training, and clear communication guidelines for both employees who guide operators and operators. When utilized properly, the spotter and equipment operator effectively maintain two-way communication to warn of hazards that may not be visible to the operator and other workers in the area.

In this incident, a hydraulic post-driver was being utilized while employees were within the working area of the equipment. An equipment failure occurred, which resulted in an employee being struck in the back. As a result, the employee suffered fatal injuries.

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A spotter may have observed the victim's location, determined that he was not in a safe area, and communicated to the equipment operator to pause operation until the employee was relocated.

Other situations warranting a spotter include, but are not limited to:

- Backing up: Particularly when visibility is restricted.
- Working in tight or congested areas or around other workers.
- Overhead hazards: Low powerlines or structures.
- Tight maneuvers: Navigating narrow pathways or varied terrain.
- Operator request: If an equipment operator is uncomfortable with a maneuver, a spotter should be provided.

All employees designated as spotters must be formally trained and qualified for the role. Training should consist of the below key topics:

- Communication methods, radios, verbal commands, and , signaling techniques, including a standardized set of hand signals that the operator and spotter have agreed upon.
- Equipment-specific knowledge of blind spots and operating characteristics.
- Signaling techniques
- Recognition of hazards on the job site, including safe zones for employees.

Employers should reference OSHA part [1926.1428\(a\)](#) for further guidance on implementing an effective and compliant spotter program.

To aid in the prevention of on-the-job injuries and fatalities, Kentucky FACE investigators suggest that employers implement a job site spotter program

Recommendation #4: Implement a daily inspection procedure for all equipment.

Discussion: When working with heavy equipment or machinery, daily equipment inspections can help reduce or eliminate malfunctions that can lead to injury and/or costly downtime. According to the company involved, a thorough inspection of the hydraulically controlled post-driver occurs every six months by the manufacturer. In between 6-month interval inspections, adding daily inspections may help catch developing issues before they lead to injury and malfunction.

Daily inspections may vary based on the type of equipment in use. Manufacturers can often provide standard inspection procedures for equipment they produce, but not always. Below are general guidelines for inspecting equipment that may be helpful in preventing job injuries.

Prior to any work being performed, the following critical items should be visually inspected for defects:

- Examine attachment for cracks, visible signs of wear, damage or malfunction.
- Examine connection points to ensure connections are free of damage.
- Inspect hydraulic hoses and connections for leaks, cracks or other damage.
- Ensure hydraulic hoses are free of obstruction.

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- Inspect and ensure all fasteners, bolts, and nuts are tightened and properly secured.
- Visually inspect for missing fasteners, bolts and nuts.
- Visually inspect any safety features, such as locks, guarding, and warning labels.
- Verifying all moving parts are properly lubricated.
- Conduct a functionality test to ensure proper safe operation prior to beginning work.
- Any issues observed should be properly addressed prior to utilizing the machine.

To help reduce the likelihood of a similar event, Kentucky FACE investigators suggest equipment operators perform daily equipment inspections on all equipment prior to their operation.

Recommendation #5: Implement a formal health & safety program.

Discussion: The Occupational Safety and Health Administration (OSHA) requires employers to provide training to employees who face hazards in the workplace. According to the employer, the company had no formal training program in place for employees when the incident occurred but did utilize a third-party vendor to provide initial general construction safety training at time of hire. A formal health and safety program may be an effective way to help employers keep employees safe, mitigate risk, and meet regulatory requirements.

According to OSHA, the main goal of safety and health programs is to prevent workplace injuries, illnesses, and deaths, as well as the suffering and financial hardship these events can cause for workers, their families, and employers. OSHA offers a recommended practice guide for employers to use a proactive approach to managing workplace safety and health. Traditional approaches are often reactive, meaning problems are addressed only after a worker is injured or becomes sick, a new standard or regulation is published, or an outside inspection finds a problem that must be fixed. These recommended practices recognize that finding and fixing hazards before they cause injury or illness is a far more effective approach.

The idea is to begin with a basic program and simple goals and grow from there. If you focus on achieving goals, monitoring performance, and evaluating outcomes, your workplace can progress along the path to higher levels of safety and health achievement.

Employers will find that implementing these recommended practices also brings other benefits. Safety and health programs help businesses:

- Prevent workplace injuries and illnesses
- Improve compliance with laws and regulations
- Engage workers
- Enhance their social responsibility goals
- Increase productivity and enhance overall business operations.⁴



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The program should continue to develop with the addition of job-specific safety procedures and policies once the basic program is implemented, specifically, establishing safe work zones, hazard awareness training, equipment inspection procedures, cell phone policy and daily toolbox safety discussions.

To prevent similar incidents from occurring, Kentucky FACE investigators recommend employers implement a formal health & safety program.

DISCLAIMER

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INVESTIGATOR INFORMATION

This investigation was conducted by Beau Mosley, Fatality Investigator, Fatality Assessment and Control Evaluation, Kentucky Injury Prevention and Research Center, University of Kentucky, College of Public Health.

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