KENTUCKY State FACE Program
Fatality Assessment & Control Evaluation™

REPORT#: 25KY028 REPORT DATE: 02/02/2026

DATE:
04/23/2025

TIME:
09:52 a.m.

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

INDUSTRY/NAICS CODE:
Poured Concrete Foundation and Structure Contractors/238110

EMPLOYER:
Concrete contractor

SAFETY & TRAINING:
No formal safety program

SCENE:
Residential (photo 1)

LOCATION:
Kentucky

EMPLOYER SIZE:
7 employees

EVENT TYPE:
Caught in or between

Concrete Finisher Crushed by Collapsing Dump Bed

SUMMARY

On April 23, 2025, a 27-year-old concrete finisher (victim) observed hydraulic fluid leaking from the raised dump bed of the company's Ford F-550 dump truck. While attempting to perform a repair, the hydraulic bed collapsed, crushing the victim between the truck's frame rail and dump bed. The victim succumbed to the injuries he sustained at the scene of the incident. **Read Full Report>:**

CONTRIBUTING FACTORS

Key contributing factors identified in this investigation include:

- Performing maintenance on dump bed in the raised position,
- Failure to utilize affixed bed support system,
- Employee performing work outside his scope of knowledge, and
- Insufficient training program. **Learn More>**

RECOMMENDATIONS

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

- Prohibit performing maintenance on dump beds while in the raised position. If bed cannot be lowered, require utilization of blocking and bracing devices,
- Implement a documented daily inspection procedure,
- Implement a formal scope of work (SOW) program and prohibit employees from performing duties outside their scope of work, and
- Implement a formal health and safety program.

Kentucky investigators concluded that, to help prevent similar occurrences, dump bed manufacturers should:

- Design and permanently affix positive means of support system capable of being locked at multiple heights and positions.

Learn More>

INTRODUCTION

On April 23, 2025, a 27-year-old concrete finisher (victim) arrived at the company's Kentucky-based shop at approximately 7:00 a.m. to prepare for the day's job, a residential patio installation. The victim's typical work schedule was 7:00 a.m. to 5:00 p.m., Monday through Friday. The victim held dual responsibility as both a concrete finisher and dump truck driver/operator, one of only two concrete finishers who held the additional responsibility of driving a dump truck.

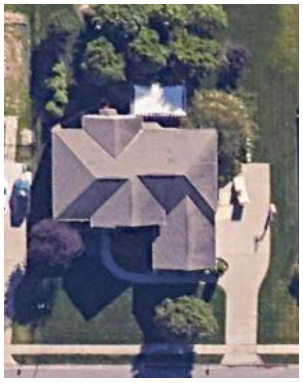

Photo 1: **Google Earth photo of the residence where the incident occurred.**

After arrival, the victim departed the shop at 7:30 a.m. to load the gravel required for the patio installation. The victim arrived at the local gravel yard at approximately 8:00 a.m. and proceeded to load 5,000 lbs. of gravel onto the Ford F-550 dump truck. After loading was completed, the victim departed the gravel yard for the residential job site.

The victim arrived at the residential job site (photo 1) at approximately 8:35 a.m., 20 minutes after departing the gravel yard. Upon arrival, the victim backed the Ford F-550 dump truck into the residential driveway and raised the hydraulically controlled dump bed 2 feet to assist with the gravel unloading process (photo 2). After raising the dump bed, the victim, job supervisor, and an additional concrete finisher began unloading the gravel with a Toro Dingo. After each scoop, which was approximately 400 lbs., the gravel was transported to the backyard of the residence for unloading and prep for a concrete pour scheduled for later that day.

After removing the fifth scoop, the victim noticed hydraulic fluid on the concrete driveway below the dump bed. Upon further evaluation, the victim discovered a leaking hose that controlled the raise/lower functions of the hydraulic dump bed. According to a representative from the company involved, the job supervisor instructed the victim to ignore the mechanical issue, stating he would call a mechanic to repair. The supervisor and additional concrete finisher proceeded to the backyard with the fifth load of gravel. At approximately 9:50 a.m., while unloading and spreading gravel, the supervisor noticed that the victim was not present or assisting them. After calling out to the victim and receiving no response, the supervisor walked from the backyard of the house to the driveway to check on him. He found the victim caught between the frame of the truck and the dump bed, which still contained approximately 3,000 lbs. of gravel (photo 3).

Finding the victim unresponsive, the supervisor contacted 911 at 9:52 a.m. EMS and fire arrived at 10:05 a.m. and worked to remove the victim by utilizing hydraulic tools and wooden wedges. The victim was extracted but was noted as "obviously deceased" according to investigators in the official police report. A coroner was later called to the scene and confirmed the victim's death; an autopsy later revealed traumatic asphyxia and blunt force trauma as the cause of death.

The investigation concluded that the victim positioned himself between the frame rail of the truck and the dump bed to tighten the leaking hydraulic hose fitting but in error loosened the fitting, which resulted in the hose disconnecting completely (photos 4 & 5). As a result, the hydraulic system lost pressure, which allowed the bed to collapse, crushing the victim between the frame rail and dump bed. The area of impact was to the victim's back and chest. A representative of the involved company stated that their policy does not allow employees to perform maintenance on equipment, which is why the supervisor instructed the victim to ignore the issue.

Photo 2: **Photo showing dump truck parked in the driveway of the residence on the day the incident occurred. Note: Dump bed is in the down position; this picture was taken post-incident. Photo obtained via Kentucky open records request.**

Photo 3: **Photo showing location victim was found (red X). The yellow circles show the victim's sunglasses and hat beneath the truck. Photo obtained via Kentucky open records request, edited by Kentucky FACE.**

Photo 4: **Photo showing hydraulic hose and hydraulic pump inlet (yellow circles). Red X indicates location of victim when the incident occurred. Photo provided by involved company.**

Photo 5: **Photo showing closer view of hydraulic hose disconnect point. Photo provided by involved company.**

EMPLOYER

- The employer is a privately held concrete contractor that specializes in the installation and repair of concrete driveways, patios, and parking lots. The company also installs epoxy floor coverings, sealant, and stains. The company was established in 2020, employing seven full-time employees: the owner, an office administrator, two concrete finishers who hold additional driving responsibilities, and three employees dedicated solely to concrete finishing.

WRITTEN SAFETY PROGRAMS and TRAINING

- The employer does not have a written safety program. The company informed investigators that new employees perform on-the-job training with the owner. Each job site and/or concrete project is unique, according to the company. Due to this variance, the average training period is one week. Once the owner feels comfortable with the new employee's progress and performance, the employee is authorized to join a crew, which typically consists of two to three employees. New employees responsible for driving must perform a road test, under the direction of the company owner, to ensure that the new employee operates the vehicle safely. If successfully completed, the employee can operate the dump truck solo.

WORKER INFORMATION

- The victim was a 27-year-old white, non-Hispanic male. The decedent was a high school graduate and had worked for the employer for the last 2.5 years as a concrete finisher. The victim also held the additional responsibility of driving the company's Ford F-550 dump truck. According to the employer, the victim had primarily worked in the construction industry prior to onboarding with the involved company.
- Wage (response options to be circled/checked)
  - ☐ Hourly
  - ☒ Salary

SUPPLEMENTAL DEMOGRAPHIC INFORMATION

- Preferred language
  - ☐ Interpretation services
- Race/ethnicity (response options to be circled/checked)
  - ☐ American Indian or Alaska Native

    For example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.
  - ☐ Black or African American

    For example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.
  - ☐ Hispanic or Latino

    For example, Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, etc.
  - ☐ Middle Eastern or North African

    For example, Lebanese, Iranian, Egyptian, Syrian, Iraqi, Israeli, etc.
  - ☐ Native Hawaiian or Pacific Islander

    For example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marshallese, etc.
  - ☒ White

    For example, English, German, Irish, Italian, Polish, Scottish, etc.
  - ☐ *Asian*

    For example, Chinese, Asian Indian, Filipino, Vietnamese, Korean, Japanese, etc.
  - ☐ Other

EQUIPMENT

- The company involved was operating a 2006 Ford F-550 pickup truck with a hydraulically operated dump bed (photo 6).
- The company involved was also utilizing a Toro Dingo to unload gravel (photo 7).

Photo 6: **Photo showing the 2006 Ford F-550 pickup truck involved in the incident. Photo provided by involved company.**

Photo 7: **Photo showing a Toro Dingo, similar to the type of equipment utilized by the involved company to unload the gravel. Stock photo obtained via Google image search.**

INCIDENT SCENE

The incident occurred on a residential driveway of a Kentucky single family home. The brick home, which is in a residential subdivision, is nearly 4,000 square feet and was constructed in 2008. The company involved was hired to construct a concrete patio in the backyard, which is lined with large mature trees.

WEATHER

The weather on the day of the incident was approximately 63 degrees Fahrenheit, 50% humidity, with a 3-mph wind from the northeast. The weather is not believed to have been a factor in this incident.[1]

CAUSE OF DEATH

According to the death certificate, the cause of death was traumatic asphyxia and 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:

- Performing maintenance on dump bed in the raised position,
- Failure to utilize affixed bed support system,
- Employee performing work outside his scope of knowledge, and
- Insufficient training program.

RECOMMENDATIONS / DISCUSSION

Recommendation #1: Employers should prohibit performing inspection or maintenance on dump beds while in the raised position. If bed cannot be lowered, employers should require utilization of blocking and bracing devices.

Discussion: According to the Occupational Safety and Health Administration (OSHA), performing maintenance work underneath the dump body of a dump truck presents extraordinary hazards to maintenance or servicing personnel.[2] Most dump beds are operated by hydraulic systems; if those systems fail, the consequences for workers can be deadly.

In this incident, an employee was attempting to tighten a leaking hydraulic line while the bed was in the raised position. In error, the employee turned the fitting in the wrong direction, disconnecting the line entirely. As a result, the dump bed collapsed, fatality injuring the employee.

There are two primary OSHA regulations that address this hazard, 1926.600(a)(3)(i) and 1926.601(b)(10). 1926.600(a)(3)(i): Heavy machinery, equipment, or parts thereof, which are suspended or held aloft by use of slings, hoists, or jacks shall be substantially blocked or cribbed to prevent falling or shifting before employees are permitted to work under or between them. Bulldozer and scraper blades, end-loader buckets, dump bodies, and similar equipment shall be either fully lowered or blocked when being repaired or when not in use. All controls shall be in a neutral position, with the motors stopped and brakes set, unless work being performed requires otherwise.[3]

1926.601(b)(10): Trucks with dump bodies shall be equipped with positive means of support, permanently attached, and capable of being locked in position to prevent accidental lowering of the body while maintenance or inspection work is being done.[4]

The dump truck involved was equipped with a permanently affixed safety bar; however, the bed was not raised high enough to engage the safety support bar. It is unknown whether the dump bed in this incident could have been raised higher to engage the safety bar prior to performing work. According to OSHA, height restrictions on factory-installed bracing devices are a common reason for lack of utilization. Most factory-installed bracing devices (photo 8) can be engaged only at one height. If the set height is too low or too high to grant employee access for repairs, it can lead to the device not being utilized at all.[2] Aftermarket bracing options are available (photo 9) and may be a solution for bracing when the factory bar cannot be used.

Kentucky FACE investigators recommend that employers prohibit employees from performing maintenance on dump beds while in the raised position. If bed cannot be lowered, employers should require utilization of

blocking and bracing devices.

Photo 8: **Stock photo showing an example of factory-installed safety support bar. Blue arrow points to the safety bar; yellow circle indicates notch where the safety bar rests on the dump bed frame. Image obtained via Google search, edited by Kentucky FACE.**

Photo 9: **Image showing aftermarket example of dump bed braces. Image obtained via Google search.**

Recommendation #2: Employers should implement a documented daily inspection procedure.

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, equipment inspections are supposed to occur daily. However, at the time the incident occurred, inspections were not required to be documented, so no verification of whether the dump truck involved was inspected prior to the incident is available. Implementing a formal documented daily inspection procedure may increase compliance with inspection requirements and aid employers in holding employees accountable to the procedure. Daily documented inspections can help catch developing issues before they lead to malfunction and injury. If issues are caught early, arrangements can be made to repair them properly and in the proper environment, not at the job site.

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 steps should be taken to identify 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,
- Inspect and ensure all fasteners, bolts, and nuts are tightened and properly secured,
- Inspect for missing fasteners, bolts, and nuts,
- Inspect any safety features, such as locks, guarding, and warning labels,
- Verify that all moving parts are properly lubricated and within recommended levels,
- Conduct a functionality test to ensure proper safe operation prior to beginning work,
- Properly address any observed issues prior to utilizing the machine.

To help reduce the likelihood of similar incidents occurring, Kentucky FACE investigators recommend that employers implement a documented daily inspection procedure.

Recommendation #3: Employers should implement a formal scope of work program and prohibit employees from performing duties outside their scope of work.

Discussion: An employee's scope of work (SOW) outlines the tasks and objectives an employee is responsible for completing. Often in document form, an SOW can be beneficial to employers and employees by increasing transparency on assigned tasks, understanding performance expectations and job restrictions, and ensuring that employees are appropriately trained to complete assigned tasks.

The victim involved in this incident was hired as a concrete finisher and dump truck driver; the scope of his job was to help with the prep work, pouring, and finishing of residential concrete jobs and to drive the company's Ford F-550 dump truck. According to the company involved, these were the only tasks the victim was authorized to do. However, the victim attempted to perform maintenance on the involved dump truck, which lead to an error that resulted in his death. The company did have a verbal "no maintenance" policy in place for all employees.

Performing tasks outside the scope of an employee's job presents risk to both the employee and others. Some tasks present more risk than others, as with this incident: Performing maintenance on a hydraulically operated dump bed subjected the victim to grave risk, as he did not have the proper training and knowledge to perform the job safely.

Kentucky FACE investigators recommend that employers establish formal SOW documents for each employee, review the SOW with each employee, and have the employee sign the document acknowledging his/her understanding of the expectations. Once completed, employers should prohibit employees from performing duties outside their scope of work. If new tasks are required of employees, employers should provide adequate training and supplies to employees and update the SOW accordingly.

Recommendation #4: Employers should implement a formal health and safety training program.

Discussion: 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. While not a formal program, the company does provide on-the-job training to new employees, typically via job shadowing and verbal instruction by the company owner or other trusted tenured employee.

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 with simple goals and grow from there. If a company focuses on achieving goals, monitoring performance, and evaluating outcomes, the 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**,**
- Reduce costs, including significant reductions in workers' compensation premiums**,**
- Engage workers**,**
- Enhance the business's social responsibility goals**,**
- Increase productivity and enhance overall business operations.[5]

Once the basic program is implemented, the program should continue to develop with the addition of job-specific safety procedures and policies, specifically, hazard awareness training, equipment inspection procedures, maintenance policies, blocking and bracing of dump bed procedures, and daily toolbox safety discussions.

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

Recommendation #5: Dump body manufacturers should design and permanently affix a positive means of support system capable of being locked at multiple heights and positions.

Discussion: As stated previously, the dump bed utilized in this incident was equipped with the required positive means of support system, more commonly referred to as a safety bar. Safety bars lock the bed in a fixed position and height, preventing the bed from collapsing while employees perform maintenance. OSHA suggests that factory-installed systems are often underutilized due to their lack of adjustability.[2] If the fixed height is too low or too high to perform the needed tasks, employees often don't use them at all, which can have deadly consequences.

Kentucky FACE investigators suggest that manufacturers design a permanently affixed, positive means of support system that allows the dump bed to be braced at multiple heights and positions. In doing so, utilization of the safety bar may increase, which should reduce the likelihood of on-the-job injury.

REFERENCES

[1]Weather Underground. https://www.wunderground.com/history

[2]OSHA. https://www.osha.gov/sites/default/files/publications/shib091806.pdf

[3]1926.600(a)(3)(i). https://www.osha.gov/laws-regs/regulations/standardnumber/1926/1926.600

[4]1926.601(b)(10). https://www.osha.gov/laws-regs/regulations/standardnumber/1926/1926.601

[5]OSHA Health and Safety Programs. https://www.osha.gov/safety-management

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.

ACKNOWLEDGMENT

The NIOSH FACE Program would like to acknowledge the company involved and sheriff's office for their assistance with the completion of this report.

DISCLAIMERS

CONTACT US

- Email kyfaceprogram@uky.edu
- Twitter https://x.com/kiprcnews
- Facebook https://m.facebook.com/kiprcnews/
- Website https://kiprc.uky.edu/programs/fatality-assessment-and-control-evaluation-face