





REPORT DATE: 12/20/19

Fatality Assessment & Control Evaluation

Michigan State University
Department of Medicine • Occupational and Environmental Medicine
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INCIDENT HIGHLIGHTS



DATE:

Winter 2018



TIME:

8:26 p.m.



VICTIM:

Tow truck driver in his 40s



INDUSTRY/NAICS CODE:

Transportation/48



EMPLOYER:

Tow truck Service



SAFETY & TRAINING:

Tow truck training



SCENE:

Intersection of road and freeway entrance ramp



LOCATION:

Michigan



EVENT TYPE:

Struck by motor vehicle



Tow Truck Driver Securing Vehicle to Tow Bed

SUMMARY

REPORT#: 18MI002

Struck by SUV Driver

In Winter 2018, a male tow truck driver, who was securing a pickup truck to the tow truck's flatbed, was struck by a driver, who was later charged with operating while intoxicated. The pickup truck had a flat tire. The pickup driver stopped near an expressway ramp intersection lit by overhead lights. The decedent arrived and activated the tow truck's flashing lights. When exiting the truck, he did not don his reflective vest. He was unsuccessful in lowering the spare tire from the under-the-truck mounting mechanism. He repositioned the tow truck to the front of the disabled pickup truck. He attached the front hooks to the vehicle and winched the pickup partway up the flatbed. He returned to the rear of the pickup truck and began to place the rear securement chains when a driver, returning home from a party did not stop...READ THE FULL REPORT> (p.3)

CONTRIBUTING FACTORS

Key contributing factors identified in this investigation include:

- Design and lack of maintenance of spare tire hoist system did not permit decedent to lower spare tire
- Driver operating while intoxicated
- LEARN MORE> (p.9)

RECOMMENDATIONS

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

 Vehicle dealerships/servicing centers servicing vehicles with spare tire safety retaining latch/hoist systems should inspect this system at least annually for functionality.

LEARN MORE> (p.10)

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Michigan Fatality Assessment and Control Evaluation (FACE) Program

MIFACE (Michigan Fatality Assessment and Control Evaluation), Michigan State University (MSU) Occupational & Environmental Medicine, 909 Fee Road, 117 West Fee Hall, East Lansing, Michigan 48824-1315; http://www.oem.msu.edu.

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SUMMARY

In Winter 2018, a male tow truck driver in his 40s died when he was struck by a vehicle as he was securing a pickup truck on his flatbed tow truck. After experiencing a flat tire on the expressway and a failed repair, the pickup driver exited the expressway and drove to nearby gas station to inflate the flat tire. The air compressor was not working, so the driver left the station and was driving in the right lane of the roadway to another nearby station when the tire bead came off the rear passenger wheel. The driver stopped the pickup truck near the expressway ramp intersection; there were two travel lanes and a turn lane for the entrance ramp. The driver stopped in the right travel lane and called for a tow truck. The intersection was lit by overhead lights. It was raining. The decedent arrived and parked his tow truck behind the disabled pickup truck. The tow truck's overhead yellow lights were activated as were the running lights and 4 LED lights that lit up the back of the tow truck. The decedent did not don his hi-vis vest when he exited the truck. The decedent worked 30+ minutes attempting to release and drop the pickup truck's spare tire. Unable to release the tire, the decedent offered to tow the vehicle. The decedent moved the tow truck to the front of the disabled pickup, loaded the pickup onto the flat bed of the tow truck, and partially raised the bed. After securing the front of the vehicle, he proceeded to the rear and was in the process of placing the hooks to secure the pickup to the bed when a vehicle driver, who had an elevated blood alcohol concentration (BAC) and marijuana level, struck the decedent, one of the pickup truck passengers, and the rear of the tow truck. The decedent was pinned between the rear of the flatbed and the front of the vehicle that struck him. The decedent struck the windshield on the driver's side and the pickup truck's hitch struck the windshield on the passenger side. Emergency response was called and the decedent was declared dead at the scene and the injured pickup truck passenger was transported to the hospital.

INTRODUCTION

In Winter 2018, a male tow truck driver in his 40s died when he was struck by and pinned against his tow truck by a vehicle driven by a driver with a BAC of 0.16. MIFACE learned of this incident upon receiving notification from MIOSHA. MIFACE personnel contacted the tow truck service owner who agreed to be interviewed. The tow truck service owner showed the MIFACE researcher the difficulty in removing a spare tire mounted in the same configuration and age as the vehicle the decedent was attempting to service. MIFACE reviewed the death certificate, police and medical examiner reports, documents provided by the employer, and the MIOSHA file during the writing of this report. Pictures used in the report are courtesy of the responding police department, pictures from the MIOSHA case file, and pictures taken by the MIFACE researcher with the permission of the employer.

EMPLOYERS

The current owner's father began the business in 1956 with a gas station and one tow truck. The current owner worked with his father and assumed business responsibilities in 1986. Since that time, the current owner closed the gas station and has operated the tow truck service which provided road service, vehicle transportation, heavy duty recovery, and impound services. The owner had three tow truck business locations and a repair shop. The business employed 42 individuals. The business owner and decedent were close friends.

WRITTEN SAFETY PROGRAMS and TRAINING

The employer provided safety equipment as required by the job (e.g. high visibility reflective clothing/vest, safety glasses/goggles, gloves for bloodborne pathogens as well as hand protection, hard hats with winter liners, safety harnesses and lanyards, personal flotation devices for work sites near the water, cold water rescue suits for entering cold/polluted water, fire resistant clothing as needed for specific job assignments and specific locations (as required by owners of the







property)). The firm had an employee handbook that included a section specifying that personal protective equipment must be utilized as required by the job/activity being performed but did not have a specific job analysis for personal protective equipment.

The employee handbook stated "Safety vest (reflective) will be worn over uniform by all drivers at all times. The type of clothing may vary due to severe weather conditions; however job-specific PPE shall be worn on every job as required by the site and circumstances!". Driver rules included the requirement "to wear appropriate PPE for the task at hand. Drivers must wear approved out garments at all times on duty out of a vehicle on any roadway. Task-specific PPE is required and dictated by the job and site requirement and must be worn." The employer was aware of Michigan Manual of Uniform Traffic Code Devices (MMUTCD) requirement "that all workers, including emergency responders within the right of way who are exposed either to traffic or to work vehicles and construction equipment within the TTC zone shall wear high visibility safety apparel."

The employer stated that he provided training to employees regarding the importance of wearing their high visibility vests. The owner indicated that he provided various sizes of safety vests (larger sizes to accommodate winter clothing) as well as high visibility vests/clothing based on the preference of the employee. For example, the decedent preferred safety orange, so the firm bought him orange shirts and jackets because of his preference for orange.

The employer required "ride-along" hands-on training of at least one week, depending upon the driver's previous experience. Additionally, for heavy duty towing, the firm utilized the Tow Safe program, a 3rd party training organization. Towing publication offering towing techniques were available to drivers. The firm required employees to perform daily checks on all tow trucks to ensure functionality. If an issue was found, the employee was instructed to take the truck to the garage for repair.

The employer had documentation of the most recent service/maintenance records and Michigan Department of Transportation (MDOT) annual inspection.

The employer indicated that he had a disciplinary policy; an employee received a verbal warning and then the loss of a paid day off if the employee was found in a repeat policy violation. If another employee tells management that one of his coworkers was not wearing adequate personal protective equipment, that reporting employee gained the day off lost by the reported employee. This policy was not documented in writing and not contained within the employee handbook. The owner indicated to the MIFACE researcher that the decedent had received a verbal warning in the past for not wearing his high visibility vest. The owner also mentioned to the MIFACE researcher that emergency responders report back to the owner regarding tow truck company employees not wearing their high visibility vests.

WORKER INFORMATION

The decedent had 10 years of experience driving tow trucks. He had his CDL Group A certification with a P endorsement (P stands for vehicles which are designed to carry 16 or more people (including the driver)). He had his required medical certification to drive this size vehicle. He had been previously employed by a landscape firm for 14 years driving trucks. All company drivers were assigned specific trucks. The decedent's truck was a 2007 International 4300 flatbed; he had always driven this truck and was very familiar with its operation. The decedent had received 3rd party training for specialized towing recovery. The decedent was described as a hard worker, and was the owner's "go to" person for training and







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mentoring new employees, and for assisting with technical towing services, such as overturned tanker trailers, recovering vehicles in water, etc.

Employees worked 14-hour shifts, within allowable DOT rules. The decedent began work that day at 7:48 a.m.

INCIDENT SCENE

The incident scene was near the intersection of an east-west roadway and entrance/exit ramps for an expressway. The intersection was illuminated by overhead street lights. The concrete roadway was wet from previous rainfall. Traffic lights directed traffic at the intersection. The posted speed limit on the incident roadway was 50mph.

The 2-axle, flatbed-style 2007 International 4000 tow truck had a gross vehicle weight of 10,001-26,000 pounds. It was positioned on the roadway facing northwest, staged in the right lane of roadway, between slow lane and the right turn lane providing access to the expressway. All required lighting was operational on the tow truck.

WEATHER

Weather Underground was utilized to check the weather conditions on the day of the incident. At time of crash there was light rain in the area and the temperature was 39 degrees. [Weather Underground]

Firm Remediation

The firm has instituted the following actions after the death:

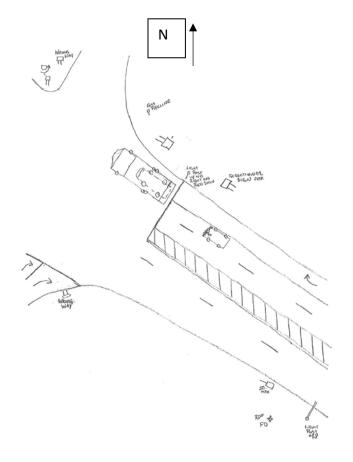


Figure 1. Police drawing of incident scene. Identifying notations removed by MIFACE.

- Performs random roadside onsite inspections for compliance with appropriate progressive discipline. Prior to the
 incident, the employer only noted what the employees were wearing when they clocked in for their shift. The
 employer indicated that the responding fire and/or police departments generally let the firm know if the
 employees were/were not wearing their personal protective equipment.
- Holds monthly safety meetings, which include near miss discussion
- Completed a firm-wide personal protective equipment assessment, including task specific personal protective equipment requirements
- Maintains training records

INVESTIGATION

There were three vehicles involved in this incident: a 2007 full-size pickup truck, the flatbed tow truck, and a SUV. The pickup truck had a flat tire on the expressway. A family member of one of the individuals in the pickup truck drove to their







location and put "fix a flat" into the tire. The "fix-a-flat" did not "fix" the tire and the tire became flat again. The pickup exited the expressway and drove to a nearby gas station to put air into the tire.

The gas station's air compressor was not working so the driver attempted to drive to another gas station when the tire bead came off the rim. The pickup truck had specialty rims; the driver did not want to damage the rim so he stopped the pickup truck on the roadway, set the 4-way hazard flashers, and parked the vehicle in the "slow" lane of the two-lane northwest-bound roadway. All three of the pickup truck occupants exited the pickup and stood on the side of the roadway. One of the occupants called for a tow truck.

During his work shift, the decedent had performed several tows, unlocked several vehicle doors, a tire change, and several jump-starts. The firm's dispatcher received the call for a tire change at 7:29 p.m. The decedent was dispatched at 7:36 p.m. The company owner indicated that tire changes are normally completed in 15-20 minutes.

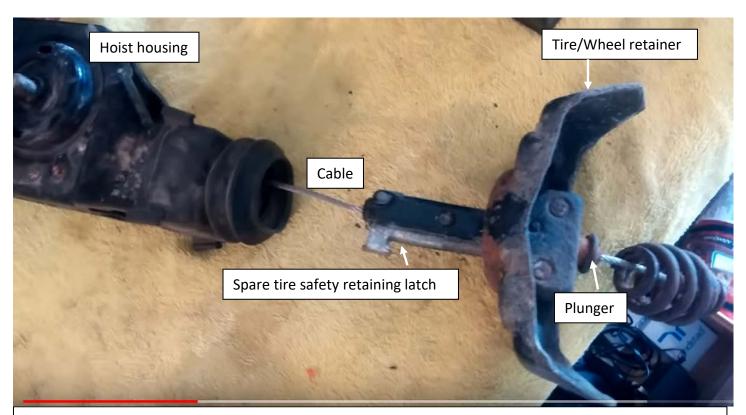


Photo 1. Photo from YouTube Video How To Remove Cheverolet Silverado Spare Tire That Is Stuck & Won't Come Down to illustrate spare tire hoist assembly components. https://www.youtube.com/watch?v=pV3DLNgGIn0

The decedent was wearing brown overall style pant and jacket with a pair of boots. The decedent arrived on scene at approximately 7:45 p.m. The decedent positioned the tow truck behind the disabled pickup and activated the tow truck lights (overhead lights, flashers, running lights on flatbed, four LED lights at the rear).

The pickup truck's spare tire was mounted to the undercarriage of the truck. A hoist system raised and lowered the spare tire. To ensure the tire would not fall during travel if the cable holding the tire unwound, the tire was supported by a







secondary safety latch (spare tire safety retaining latch). The spare tire safety latch must disengage from the hoist housing to lower the spare tire from the undercarriage. To lower the spare tire from the undercarriage, the decedent most likely first followed the manufacturer's instruction to lower the spare: a) assembled the extension tool and inserted it through the hole in the bumper, connecting the hoist end of the extension to the hoist shaft and b) turned the extension tool counterclockwise to lower the tire. It appeared from pictures taken by responding police that the cable did lower but the tire did not (Photo 2).

The truck's owner's manual states "if the spare tire does not lower to the ground, the secondary latch is engaged causing the tire not to lower." The decedent's employer hypothesized that the spare tire safety retaining latch did not disengage from the hoist housing due to rust/deterioration.

There are multiple steps in the pickup truck owner's manual the decedent may have tried to lower the spare. Due to the length of time the decedent was at the incident scene, the decedent most likely also tried other common methods to release the spare, such as using a flat-head screwdriver/and hammer or channel locks to loosen/pry free the spare tire retaining latch.

The decedent was ultimately unsuccessful in lowering the tire. The decedent offered to tow the vehicle and the client accepted the offer. He repositioned the tow truck to the front of the vehicle and again activated the tow truck lights (Photos 3 and 4). When he exited the tow truck he did not

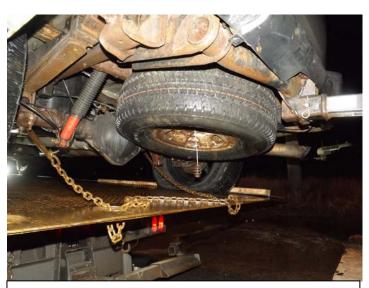


Photo 2. Picture of cable lowered but tire not released from safety retaining system while pickup truck on tow truck flatbed.

don his orange reflective high vis vest; the vest was left on the rear seat of the pickup truck. Using the controls at the panel near the tow truck cab, he lowered the flatbed, secured the front hooks and winched the pickup up onto the bed. To protect the truck's specialty wheel rims, he used a piece of wood to support the rim of the flat tire (Photo 3). With the rear part of the flatbed still partially lowered, the decedent returned to the rear of the truck. One of the truck passengers was also at the rear of the truck looking at the spare tire that was still attached to the truck. With the bed of the tow truck angled slightly downward and the pickup truck on the bed of the tow truck, the overhead hazard lights were substantially blocked from view for a driver approaching northwest in the slow lane; the rear lights of the tow truck would have been plainly visible (Photo 5). The decedent had placed the hooks onto the rear axle and had just placed the securement chains into the angle cuts (gotcha pockets) when the incident occurred.

An SUV driver was driving home from a company holiday party. The driver had consumed four drinks at the party (as stated to police; police found an alcoholic drink receipt from the venue of the party at the scene). The SUV was traveling northwest in the slow lane, approaching the tow truck from the rear. At approximately 8:26 p.m. (nearly 45 minutes after the decedent arrived to change the tire), the police report indicated that: a) the SUV driver saw the tow truck's overhead hazard lights, b) slammed on the brakes when the tow truck came into view, and c) the driver did not see the decedent at the rear of the vehicle. The resulting crash pinned the tow truck driver between the rear of the flatbed and the front of







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the SUV. The SUV also struck the pickup passenger positioned at the side/rear of the truck; the passenger struck his head on the flat bed, and lost consciousness.



Photo 3. Overhead and running lights on tow truck bed activated.



Photo 4. Pickup truck on tow truck flatbed, tow truck rear lights activated, wood under rim of flat tire.

The pickup passengers on the side of the road yelled at the SUV driver to back away from the tow truck. One of the passengers called for emergency response. A passerby stopped to block traffic. Emergency responders arrived and found the decedent on his back on the hood of the SUV. His head had struck and shattered the driver's side windshield. The upper passenger side windshield also had a strike mark from the pickup truck hitch.

At 8:47 p.m., at the incident scene, the SUV driver agreed to a police officer request for a preliminary breath test (PBT). The result was 0.16 BAC (at or above 0.08 percent is a crime and there is increased penalty for BAC of 0.17). At 9:12 p.m., a police officer spoke with judge on the telephone and drafted a search warrant for the SUV driver's blood but could not send it to the judge due to technical problems inside patrol vehicle. The officer transported the decedent to police department where the officer was able to send the affidavit to the judge. The judge sent back a signed copy of

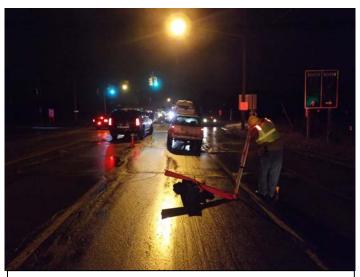


Photo 5. View for oncoming driver showing the overhead lights would be blocked by the pickup but the rear tow truck lights would be visible

search warrant and then the police officer drove the SUV driver to a nearby hospital emergency room to execute the







search warrant. Blood samples were drawn at 10:38 p.m. The results of the blood test found 0.136 BAC for alcohol and THC in the SUV driver's blood (THC 6 ng/ml and THC-COOH 36 ng/ml). (5 ng/ml or greater is considered driving under the influence in Colorado and Washington, there is no regulated blood level in Michigan).

Two days later, the SUV driver was charged with operating while intoxicated causing death.

MIOSHA Citations

MIOSHA General Industry Safety and Health Division issued the following Serious citation to the employer at the conclusion of its investigation.

SERIOUS: MICHIGAN OCCUPATIONAL SAFETY AND HEALTH ACT, ACT 154, 408.1011(a): The employer shall furnish to each employee, employment and a place of employment that is free from recognized hazards that are causing, or are likely to cause, death or serious physical harm to the employee.

The employer did not furnish employment and a place of employment free from recognized hazards that were causing or were likely to cause death or serious physical harm to employees, in that an employee was exposed to or struck by hazards from vehicular traffic while assisting motorists on roadways. On *Date* 2018, an employee was assisting a motorist on *Location* when he was struck by another vehicle, causing fatal injuries. The employee was not wearing a high visibility vest at time of accident. (MIFACE removed the incident date and location from the citation.)

Among other methods, one feasible and acceptable abatement method to correct this hazard is to ensure that employees are wearing proper high visibility/reflective garments when working in or near roadways. Ensure that employees are trained in the requirements of high visibility garments and the dangers of not wearing adequate personal protective equipment.

CAUSE OF DEATH

The death certificate listed the cause of death as multiple blunt force trauma. Post mortem toxicology found caffeine, cotinine, THC 1.5 ng/ml and THC-COOH at 11 ng/ml. These marijuana levels are below levels associated with an acute effect.

CONTRIBUTING FACTORS

Occupational 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 the injury or fatality. The following unrecognized hazards were identified as key contributing factors in this incident:

- Design and lack of maintenance of spare tire hoist system did not permit decedent to lower spare tire
- Driver operating a vehicle while intoxicated
- Visibility of operation (No hi-vis vest worn, pickup on truck bed obscured tow truck overhead lights, no portable emergency warning devices placed)
- Driver of pickup truck parked in active roadway rather than proceeding to nearby off-road parking







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RECOMMENDATIONS/DISCUSSION

Recommendation #1: Vehicle dealerships/servicing centers servicing vehicles with spare tire safety retaining latch/hoist systems should inspect this system at least annually for functionality.

Discussion: The underslung spare tire securement/hoist system in the pickup truck (Photo 6) has been redesigned to eliminate the use of the spare tire safety retaining latch system. There are still a substantial number of vehicles using this system still being driven. Although the 2007 pickup truck owner's manual stated under the heading At Least Once a Month: "Tire Inflation Check - Inspect your vehicle's tires and make sure they are inflated to the correct pressures. Do not forget to check the spare tire. See Inflation – Tire Pressure on page 123 (page number altered by MIFACE). Check to make sure the spare tire is stored securely. See Changing a Flat Tire on page ABC.", most owners do not crawl under their vehicle to check the spare tire pressure nor do they try to lower the spare. MIFACE recommends that vehicle manufacturers who have underbody/underslung tires with the spare tire safety retaining latch system require dealerships or other vehicle servicing centers to include an inspection of the system to insure functionality. If the system is nonfunctional, the entity performing service should inform the vehicle owner and identify/locate a manufacturer-approved aftermarket replacement system.



Photo 6. Spare tire hoist system from a similar make and model year of pickup truck involved in incident.

Recommendation #2: Workers working in active roadways should always wear appropriately selected protective equipment.

Discussion: The decedent did not wear his orange hi vis vest in violation of company policy (Photo 7). He had received a verbal warning in the past about the failure to wear the vest. It is unknown if the drunk driver would have seen him if he was wearing the vest, but with his brown clothing he would have virtually been invisible to any driver while standing behind the vehicle. To decrease the likelihood that tow operators will forget to don their vest before exiting the cab, employers should also consider a policy requiring that tow operators wear their vests at all times while operating a tow truck.



Photo 7. Hi-vis safety vest on back seat of tow truck







Recommendation #3: Towing companies should consider utilizing portable emergency warning devices.

Discussion: The warning devices the decedent used were the lights on the tow truck. The tow truck's overhead lights were obscured by the pickup truck while on the flatbed, but the flashing lights on the rear of the truck would have been visible (Photo 5). Portable warning devices such as cones, flashing triangles, and road flares warn approaching motorists of a stopped emergency vehicle ahead and provide time for drivers to slow down and move over. When setting the reflective cones, operators should carry the cone in front of them to increase visibility to passing drivers. Tow operators should never place, retrieve, or adjust cones with their back turned to the travel lane. Warning devices should be placed in accordance with Federal Motor Carrier Safety Regulations Part 392, Driving Of Commercial Motor Vehicles Subpart C, Stopped Commercial Motor Vehicles, Section §392.22(b), as follows:

- On a two-lane road with traffic in both directions, place the first device on the traffic side of the tow truck 10 feet (4 paces) from the front or rear, depending on the direction the truck is facing the adjacent traffic lane. Place another device 100 feet (40 paces) behind and ahead of the tow truck.
- On a one-way road or divided highway, place one device 10 feet, 100 feet, and 200 feet (80 paces) toward the approaching traffic.
- Within 500 feet of a hill, curve, or obstruction, place a device 100 to 500 feet from the tow truck in the direction of the hill, curve, or obstruction.

Recommendation #4: Tow truck operators should work in conjunction with law enforcement/emergency service providers to secure the work area prior to loading and securing a vehicle.

Discussion: Towing operators often must work in areas where the tow truck driver is lacking shoulder space to safely work on the traffic-facing side of the tow truck and/or with their backs turned to approaching traffic while securing loads. MIFACE recommends that tow operators request traffic-control assistance from law enforcement and/or other vehicles covered by the 2018 Move Over law (see list in Recommendation #8) when they need to perform towing duties in an area directly adjacent to/involving the following:

- multi-lane, high speed and/or high-volume vehicle traffic
- weather-related/site/environmental concerns.

The tow operator should not load and secure the vehicle until the traffic control assistance (e.g., police, fire, other tow trucks, DOT vehicles, etc.) is present. The drivers of traffic control assistance vehicles should remain in their vehicles for safety and ensure that the light bar is activated during the entire duration of the loading procedures.

Recommendation #5: Employers should implement/enforce their health and safety program policies and procedures.

Discussion: The decedent's employer had written safety and health procedures. The employer stated that safety training had been provided to employees but did not have written documentation of any safety/health training. The MIOSHA compliance officer was informed through interviews that approximately 20-25% of the crew did not always wear the required reflective personal protective equipment as required by the written program. The compliance officer was not provided evidence/documentation to show any discipline beyond a verbal warning per the employer or employees in interviews.







The employer's disciplinary policy stated: "In the event disciplinary action is necessary, the procedures listed below usually will be followed. There are some circumstances under which an immediate suspension, pending investigation and potential termination will be appropriate, but it is hoped these circumstances will be rare.

- 1. A verbal reprimand will be issued and written documentation of the verbal reprimand will be placed in the employee's file.
- 2. A written reprimand stating the behavior causing the problem, the solution to the problem and a warning that suspension will occur if the problem is not corrected will be issued.
- 3. If there are further problems, the employee may be suspended from duty pending investigation for a period from three to seven days.
- 4. Termination decisions will be based on each set of circumstances and the record. A Senior Manager must approve each termination."

The employer indicated to MIOSHA that the firm had a progressive disciplinary policy. The owner explained that their policy was a verbal warning and then the loss of a paid day off. If another employee shared that an employee wasn't wearing adequate personal protective equipment, they gain the day off lost by the employee. The owner was unable to provide to MIOSHA any documentation showing any form of discipline. The employer stated that he has given verbal warnings. One employee interviewed by MIOSHA indicated he had been given a verbal warning for not wearing his vest and that the decedent had also been given a warning in the past. Employees interviewed by MIOSHA had never heard of this policy and that no one had reported another employee and gained his/her day off.

Although the employer had a written program and stated training had been provided, the employer had not held their employees accountable for violations of policy and procedure. It is important that firms actually implement their programs and provide consistent enforcement of discipline to ensure employees understand and follow procedures to maintain a safe and healthy workplace.

MIFACE also recommends that the employer develop and implement, as part of their health and safety program, a standard operating procedure (SOP) regarding when and under what circumstances employees should request additional traffic control assistance (see Recommendation #4).

Recommendation #6: Tow truck operators should consider National Traffic Incident Management Responder Training, regardless of company size.

Discussion: Tow truck drivers should complete TIM training to be knowledgeable of roadside assistance best practices and to be aware of potential hazards that are inherent to the job. Training topics include:

- TIM fundamentals and Terminology
- Notification and Scene Size-up
- Safe Vehicle Positioning
- Scene Safety
- Command Responsibilities
- Traffic Management







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- Special Circumstances
- Clearance and Termination

More information on the National Traffic Incident Management Responder Training can be found by visiting the SHRP2 page on the FHWA website at:

https://www.fhwa.dot.gov/goshrp2/Solutions/Reliability/L12 L32A L32B/National Traffic Inc.

Michigan employers may contact the State SHRP2 representatives by accessing the following webpage: https://www.fhwa.dot.gov/goshrp2/Content/Documents/Factsheets/TIM%20Training%20State%20POC%20List.pdf

Recommendation #7: Employers should make every effort to moderate alcohol consumption at company-sponsored events through education and expectation that excess alcohol consumption and/or driving under the influence will not be tolerated.

Discussion: Holiday parties are way for employers to give back and to thank employees for a job well done. However, employers who permit the use of alcohol to be consumed can place themselves, their employees and the public at risk if the person driving home is driving under the influence. A quick search on the Internet found several website offering suggestions regarding employer liability at holiday parties and the steps employers can take to protect themselves (See <u>Additional Resources</u> section). MIFACE recommends any company holding company parties where alcohol is consumed institute prevention measures, such as arrange for alternate transportation, limit the time alcohol is served, instruct all party attendees to moderate their drinking and that excess alcohol consumption will not be tolerated, etc.

Recommendation #8: There should be increased public awareness of Michigan's "Move Over" Law.

Discussion: In 2018, Michigan's Move Over" law required Michigan drivers to slow down when passing police cars, ambulances and fire trucks that are stopped on the side of the road. Effective February 13, 2019, Michigan's "Move Over" law was expanded to include:

- Police
- Fire
- Rescue
- Ambulance
- Road Service: Road service vehicles include tow trucks and courtesy vehicles operated by the Michigan Department of Transportation (emphasis added)
- Road Maintenance
- Utility Service
- Solid Waste Hauler

Michigan's Emergency Vehicle Caution Law, more commonly known as the Move Over Law, requires motorists to slow down and move over for stationary emergency vehicles with their lights activated. When approaching a stationary emergency vehicle with its emergency lights activated, carefully slow down to at least 10 mph below the posted speed limit and fully move over into an open lane. If this is not possible due to traffic, weather, or road conditions, slow down to at least 10 mph below the posted speed limit and pass with caution allowing the emergency vehicle as much space as possible.







Both in-state and out-of-state drivers may not be aware of this law and the state should consider enhanced signage whether by billboards, electronic signs or roadway signs informing them of the law.

ADDITIONAL RESOURCES

- Baron, David. *How to Reduce Employer Liability at Holiday Parties*. https://www.thebalancecareers.com/how-to-reduce-employer-liability-at-holiday-parties-1918336
- Keller, John. Limit the Liability of your Company Holiday Party: 10 Ways to Protect Your Business. https://www.gulfshoreinsurance.com/limit-the-liability-of-your-company-holiday-party-10-ways-to-protect-your-business/
- Practical Law Company. (<u>Holiday Party Liability Prevention Checklist</u>)
 https://www.weil.com/~/media/Files/PDFs/Holiday%20Party%20Liability%20Prevention%20Checklist%2085039
 003.pdf
- Connected HR. *Company Holiday Parties Reminders and Waiver Form*. http://www.connected-hr.com/company-holiday-party-reminders-waiver-form/
- National Traffic Incident Management Responder Training Program". US Department of Transportation Federal Highway Administration.
 https://www.fhwa.dot.gov/goshrp2/Solutions/Reliability/L12 L32A L32B/National Traffic Inc
- Kentucky FACE Report 14KY033: Pedestrian Tow Truck Operator Struck and Killed by Drunk Driver While Rendering Assistance on Highway Roadside https://www.cdc.gov/niosh/face/stateface/ky/14ky033.html
- Kentucky FACE Report 16KY052: Tow Truck Driver Struck and Killed by Passenger Vehicle While Securing
 Disabled Vehicle onto Flatbed Tow Truck https://www.cdc.gov/niosh/face/stateface/ky/16KY052.html
- Michigan "Move Over" Law brochure.

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REFERENCES

Weather Underground [2014]. Weather history for nearby weather station. The Weather Channel Interactive, Inc.

Subchapter B. FEDERAL MOTOR CARRIER SAFETY REGULATIONS Part 392. DRIVING OF COMMERCIAL MOTOR VEHICLES Subpart C. Stopped Commercial Motor Vehicles Section 392.22. Emergency signals; stopped commercial motor vehicles. https://www.govinfo.gov/app/details/CFR-1999-title49-vol4/CFR-1999-title49-vol4-sec392-22

MICHIGAN VEHICLE CODE (EXCERPT), Act 300 of 1949, 257.653a Stationary emergency vehicle giving visual signal; duty of approaching vehicle to exhibit due care and caution; violation; penalty; exception on certain highways.







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http://www.legislature.mi.gov/(S(yamarudgcfpy3gxwmwjupqsr))/mileg.aspx?page=getObject&objectName=mcl-257-653a

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