

Auto Technician Mistakes Handicapped-Accessible Accelerator Pedal for Brake Pedal and Fatally Pins Co-Worker

Incident Number: 14KY001



Photo courtesy of Kentucky OSHA

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**Kentucky Fatality Assessment and Control Evaluation (FACE) Program
Incident Number: 14KY001
Release Date: June 30, 2014
Subject: Auto Technician Mistakes Handicapped-Accessible Accelerator
Pedal for Brake Pedal and Fatally Pins Co-Worker**

Summary

Monday, January 6, 2014, a 50-year-old master technician and married father was sitting at his desk in the service bay area of a dealership, with his back to the service area, when an auto technician mistook a handicapped-accessible accelerator pedal for the brake pedal causing a Lincoln MKX to travel forward. The vehicle struck the desk chair the victim was sitting in and knocked him into the desk. The co-worker driving the MKX tried to steer to the right when he realized what was occurring, but was unable to avoid striking the victim. The co-worker quickly exited the vehicle and yelled for someone to call 911.

A third employee who had prior EMT experience arrived at the scene and assessed the situation, calming the victim and covering him to keep him from going into shock until the ambulance arrived. The victim died from blunt force injuries en route to the hospital.

Recommendation No. 1: Based on manufacture's recommendations service technicians should detach unfamiliar handicapped accessible equipment if untrained to use the special equipment before operating the vehicle.

Recommendation No. 2: All duties and other tasks not involving the driver of the vehicle, should be performed in an area away from, or barricaded from contact with vehicles being serviced.

Introduction

Monday, January 06, 2014, the Kentucky Fatality Assessment and Control Evaluation program was notified by a local news channel of a fatality at a dealership involving a vehicle and an employee. The local news reported that the employee was struck from behind while sitting at his desk in the bay area, with his back to the service area, where a technician attempted to idle a vehicle to proceed with an oil change. The technician accidentally mistook the handicapped accelerator pedal for the brake pedal and the vehicle traveled into the desk area where the victim was sitting. The technician desperately tried to veer to the right when he realized what was happening but was unable to avoid striking the chair where the victim was sitting and shoved the victim into the desk and wall.

Employer

The employer was an automobile dealership. The employer sold new and used automobiles and offered a full service department with 88 service bays as well as a collision repair department. The employer has been in business since 1969 and has 136 employees.

Written Safety Programs and Training

There was no specific written policy on removal of handicapped accessible equipment prior to operating a vehicle being serviced at the time of this incident. The employer did have OSHA required safety programs and training in place at the time of the incident.

Victim

The victim was a 50-year-old father and husband. He had been employed as the lead technician with the employer since September 7, 2011. He was a certified Master Technician. He was devoted to his wife and daughter. Friends described him as a prankster by nature who loved to make people smile. He chose attending church with his wife and daughter over golfing with his friends. He was an avid golfer who not only hit a hole-in-one on the local golf course once, but hit it twice in the same hole. He recently saw his daughter graduate from college. She remembers him by the saying of Dr. Seuss, "Don't cry because it's over, smile because it happened."

Incident Scene

The incident scene was a service bay area of an automobile dealership. The service bay area and the administrative area where serviced-related computer work was performed were all located together. The Administrative area was in front of the bays where vehicle servicing was performed, without any barriers and the employees sitting there had their backs toward the service area.

Weather

On the day of the fatal incident, Monday, January 6, 2014, the temperature was 19 degrees Fahrenheit with snow.

Investigation

Monday, January 6, 2014, a 50-year-old Master Technician and married father spoke to another technician about work that needed to be done to a 2009 Lincoln MKX that was accessible for a handicapped driver with a left-foot accelerator made for people who have lost the ability to use their right foot. The left foot gas pedal was purchased from Mobility Products & Design and was model number 3545. This model type is easily removable. To remove the left-foot accelerator you lift the key ring on the LFGP (left foot gas pedal) assembly and while lifting and holding the key ring up, slide the lockout base to the left. When the assembly begins to move, release the

key ring and continue to slide the assembly left until it can be lifted out of the base. The instructions are easy to follow and should be placed on the dash where other operators are aware of the installation of handicapped equipment. Mobility Products and Design includes a sticker with their products to be installed on the dash board for safety purposes. The sticker was not on the dash as per instructions of Mobility Products and Design.

After agreeing on the work that needed to be completed, the victim moved to his desk area in front of the bay area where the vehicle was going to be serviced. The Master Technician sat at his desk with his back towards the service area. The technician started the vehicle and while idling, he engaged what he thought was the brake. However, it was the handicapped equipped accelerator and it caused the vehicle to travel forward striking the chair of the victim and pinning him between the desk and the vehicle. As soon as the employee inside the vehicle realized what was happening, he desperately tried to veer to the right of the victim to avoid striking him, but it was too late. The employee immediately exited the vehicle and yelled for someone to call 911. The employee helped the victim to the ground. Another employee who had past EMT experience came over and assessed the situation, made the victim comfortable and covered him to prevent shock. Emergency crews were called at 11:53 am and dispatched by 11:54 am. The ambulance arrived on the scene at 11:59 am and found the victim conscious, lying on the floor, pale and diaphoretic and complaining of shortness of breath. The ambulance transported the victim at 12:12 pm to the local hospital. En route to the hospital the victim suffered cardiac arrest. The victim was given atropine and CPR was engaged. The victim was pronounced dead at 12:45 p.m.

Interviews with the employees discovered there was a prior handicapped vehicle that came in for service and the handicapped equipment was removed prior to the technician's operation of the vehicle. However, this time, the handicapped equipment was not removed even though the technician was not trained to operate handicapped equipment. It is unknown why the handicapped equipment was not removed and a warning sticker was not on the dash board of the vehicle.

Cause of Death

The cause of death was multiple blunt force injuries from being pinned between the car and the desk and wall.

Recommendations/Discussions

Recommendation No. 1: Based on manufacture's recommendations, service technicians should detach unfamiliar handicapped accessible equipment if untrained to use the special equipment before operating the vehicle.

Manufacturers' mobility products and design installation and the owner's manual specifically warns that the operation of a motor vehicle with a handicapped accessible adjustable accelerator and brake pedal may result in serious bodily injury, death and/or property damage. The owner's manual also states that the left foot gas pedal can be quickly attached and is to be used by TRAINED OPERATORS ONLY. The manual states that it can also be quickly detached. Also, since it's not uncommon for technicians to not take the time to read the manual, a warning

sticker should be posted on the dash where a new driver would see it telling them to remove the pedals or explaining the operation of the pedals. This particular manufacturer does include these stickers to be placed on the dash with each of their products sold as a warning to untrained drivers. The authorized installer of the equipment should mandate these stickers be placed in the vehicle for safety reason.

Another scenario, noted in the second photograph, the paper mat is covering the handicapped foot pedal. This could have played a factor into the incident, hiding the fact there was a handicapped pedal and surprising the technician. This is another reason why the warning sticker is necessary.

Recommendation No. 2: All duties and other tasks not involving the driver of the vehicle, should be performed in an area away from or barricaded from contact with vehicles being serviced.

While service technicians are also doing administrative work on their computers, it is highly recommended that for any task not involving the driver of the car the work area should be away from the area where the vehicles are being serviced or barriers/ guardrails should be installed to protect them from incidents of this nature in the future. If this is not possible, then an administrative procedure should be developed for the technician to clear the area in front of and behind the vehicle before moving the vehicle.

Keywords

Automobile technician
Car vs. pedestrian
Automotive repair
Handicapped accessible automobile equipment

References

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Desk area where victim was working

Photo courtesy of Kentucky OSHA



Inside the handicapped vehicle

Photo courtesy of Kentucky OSHA



Handicapped break and accelerator pedals

Photo courtesy of Kentucky OSHA

