Height:	Weight:	Eyes:	Hair:	Home Phone:	Cell Phone:	OLN:	Lic. State:
					(540) 538-8638		

Address:

Involvement Type:
Misc. Associated Names

PROPERTY

	Quanity:	Property Class:	Property Status:	Color:
1	#Error			

Make: **Model:** **Description:**
(1) CD of scene photos

OFFICERS

Officer Name:	Involvement Type:	Involvement Date/Time:
Horn, Anthony a3720	Reporting	07/11/2022 06:24:00

NARRATIVE(S)

Title:

22-0707002 Chancellor Landfill: Workplace Fatality

FOIA REQUEST FOIA REQUEST

This is a supplemental report. I request that this case be closed; ADULT EXCEPTIONAL CLEARED.

I responded to 5917 Harrison Road for the Accidental Death of Brandon Michael Nutter, a county employee of the Chancellor Landfill. Upon my arrival, I met with Deputy J. Moore. Lt. Woodard and Major Skebo arrived at approximately the same time as I did. After being oriented by Deputy Moore, I took minimal photos from the top platform. This is the location where trash/ debris is deposited into the compactor as an employee, who is in the control booth, operates and controls the compressor which forces trash and debris into the trash storage container. Deputy Moore advised me that the power had been disengaged and lock-out tags had been placed by Fire/ Rescue in all locations that could possibly provide power to bin #5.

I then went to the lower level of the landfill. This is where the storage containers are backed into the platform. It is also the entrance point for any maintaince that needs to be conducted on the trash containers or compressor. Myself and Lt. Woodard were escorted into the area by Fire Chief Foster, who was one of the responding EMS personnel. He advised us that when he arrived, he and his personnel conducted a lock-out on all power leading to storage bin #5. A lock-out is a procedure used to secure all locations that have the potential to provide power to that specific piece of machinery. At that location the power is turned off, the location is locked with a keyed lock and the key is kept with the individual until completion of the reason for the lock-out. This prevents the machinery from being energized until it is safe to do so.

Chief Foster pointed out the power box located on the left side wall as well as the sawz-all (tool) that was being used at the time of the incident. Chief Foster advised that his personnel also unplugged that tool to ensure that it was safe.

As we inspected the area, I could see where it appeared that the victim had attempted to exit the machine area through the top, but was trapped at some point and could not free himself. This was approximately the time that Loren Kato made her presence known to me. She advised me that she was the county safety officer and stated that she needed to be with me through the investigation. This was unusual to me being that this was an active crime scene. However, because of her position, I allowed her to remain in the area for that time. As we inspected the area, Kato took photographs with a cell phone.

After getting an idea of what the situation was, I made contact with OSHA and the ME's Office and made arrangements for the proper people to respond. It is important to note that Kato wanted to be right next to me as I spoke with OSHA and the ME's Office. I then requested that Lt. Woodard have Detective R. Jacques respond to the scene for the purpose of conducting the forensics portion of the investigation.

Shortly after my initial call, I was contacted by OSHA representative Joseph DeJesus at 10:21. He advised me that he would be leaving Richmond shortly and that his expected arrival time was 11:30 – 12:00, depending on the traffic. I then attempted to locate personnel involved and begin interviews.

I first met with Christopher Randall who arrived on scene at approximately 06:00 this morning. He was the person who was with Brandon when the accident occurred. Christopher states that when he arrived, it was his job to check the bins and the surrounding area for cleanliness and functionality. When he checked bin #5 he could see that there was a piece of rebarb stuck in the machine. He states that Brandon had gotten the sawz-all to cut the piece out because it could cause the machine not to function. Christopher states that when Brandon removed the cover and got into the machine to cut the rebarb, the power had not been turned off/ de-energized and that no lock-out procedures had been followed. Christopher states that while Brandon was inside of the machine, he suddenly heard the machine kick on and immediately ran to the breaker box, which was located to the left of the machine, and turned off the main power. Christopher stated that he immediately yelled for someone to call 911.

I then spoke with Roosevelt Glover, who was in the booth when the machine kicked on and the accident happened. Glover states that when he arrived at work, he was advised that he would be working on bin #5. He states that he was on his third day at the facility, but that there was no one who was formally training him on the machine or his duties and responsibilities. When I asked what previous experience he had operating this type of machinery or at this type of facility, Grover alluded to the fact that this was his first time at a facility like this and that he had no previous experience. Glover stated that he went into the unlocked booth at approximately 07:30 – 07:40. He states that he attempted to start the machine, but it would not kick on. At that time, Glover notified the employee who was working at bin #8 and that person came over to assist. Glover could not remember the gentleman's name at the time. He states that they attempted to get the machine to start, but they were unable. At some point, operator #8 stated that he had to go back to his station because a line was forming, but he would come back to assist Glover. Glover states that when his line cleared, Operator #8 started over to assist him. As he stepped into the booth to assist, according to Glover, the machine kicked on. When I asked Glover to clarify, he stated that neither he nor Operator 8 were attempting to start the machine when it kicked on. Glover states that the next thing that happened was he heard some yelling to call 911 and stating that someone was in the machine. He later found out that it was Christopher yelling up about Brandon.

FOIA REQUEST FOIA REQUEST

It is my determination that when Glover initially attempted to start the machine and couldn't get it started, this was about the time that Christopher and Brandon were walking around checking for cleanliness and functionality of the bins and compactors. As Christopher and Brandon realized that there was rebarb in the machine and headed to get tools to cut it out, this was about the time that Operator 8 and Glover were attempting to start the machine, which means that the power was turned on then. As Christopher and Brandon were back at the bin on the lower level, it was about the same time that Operator 8 was reproaching the control booth.

It is assumed that since the crew on top had already energized the machine, the rebarb is possibly why the machine would not operate. Once Brandon was inside the machine, it is believed that the pressure/ hydraulics had already been put into motion and the release of the rebarb cause an automatic reaction from the energized machine.

It is also my determination that there were no safety protocols followed and it is unlikely that a 2-day operator and 2 week mechanic were properly trained on said protocols. There were no safety lock-outs used on either power location and no cones or safety flags placed on the lower level on the outside of bin #5, which would have visually indicated to personnel both up top and down below that there was maintaince being performed on the machine. It was also determined that bin #5 had been having mechanical issues as early as (1) week prior. I was informed that the manufacture had actually been out the week prior to perform maintaince on bin #5 because it was having issues where it would not turn on.

I then approached the County Safety Officer, Loren Kato, and asked for a copy of Facility SOP's indicating safety procedures, maintaince procedures as well as training records for the individuals involved. Her response was that she did not have any of that handy and that I could possibly get it the following week. Being that I have worked in OSHA directed positions before, I know that these documents should have been readily available not only in case of a work related accident, but also upon request and on hand if requested by any inspector. After speaking with a third employee, Apollo Williams, I was advised that there was absolutely no formal training program in place at the facility. Williams stated that he'd only been at the facility since early 2022 and that he had yet to receive training on the facility. The way he explained it was more of a learn as you go type of program.

Once Osha Arrived Investigators Joseph DeJesus and Kim Hewitt began their investigation at the upper deck of the facility, then moved down to where the victim was located. Loren Kato then came back to where we were located. She attempted to follow us and add her commentary. So much that the OSHA investigator had to advise her that this was now an OSHA scene, OSHA was in charge and asked her to stay back. By the time I left the facility, I still did not have the documentation that I requested. After making contact with OSHA on 7/13/2022, these documents still had not been provided for the either.

FOIA REQUEST FOIA REQUEST

At the conclusion of the scene investigation I was able to determine the following:

#1 - There are lock-out tags that are/ should have been used for the power sources to the compactor. There were (2) locations where the power should have been blocked/ cut off to the compactor; in the control shed, just above the compactor and on the wall at the lower deck approximately (1) foot from the compactor. Neither location was properly de-energized prior to maintaince being performed.

#2 - At the back of the compactor, where it is visible to personnel above, there should have been safety flags/ cones placed where they were visible indicating to everyone that maintaince was being performed on the equipment. These were not used.

#3 - When I asked the County Safety Officer, Loren Kato, for a copy of SOP's for safety and maintaince, she advised me that it would take a while to get it together and that I could possibly get it next week. This indicates that these documents which are required to be readily available were not.