



LOUISIANA

State **FACE** Program

Fatality Assessment & Control Evaluation™



REPORT#: LA202601 **REPORT DATE: March 2, 2026**

DATE:

January 15, 2024

TIME:

3:30 p.m.

VICTIM:

71-year-old Security Officer

INDUSTRY/NAICS CODE:

Security Guards and Patrol Services/561612

EMPLOYER:

Security Contractor

SAFETY & TRAINING:

Elements in place

SCENE:

Security gate at heliport

LOCATION:

Louisiana

EMPLOYER SIZE:

400

EVENT TYPE:

Pedestrian Struck-by/Crushed-by

Security Officer Crushed by Package Delivery Vehicle - Louisiana

SUMMARY

On January 15, 2024, a 71-year-old male security officer stumbled, fell to the ground, and was fatally run over by a delivery truck at a heliport facility. The victim performed the job for 11 years. This incident involved two workers – a security officer and delivery driver – who were employed by two different contractors: a security company and delivery vehicle company. Both contractors served a third company, a helicopter transportation company. Engineering controls were available and mandatory safety procedures were in place, but they were not utilized at the time of the incident. The security officer raised a barrier gate earlier than indicated by company procedure, and the driver, while distracted, drove over the security officer after the security officer tripped and fell in front of the vehicle. [Read Full Report>](#):

CONTRIBUTING FACTORS

Key contributing factors identified in this investigation include:

- Failure to use available engineering safety controls
- Distracted driving
- Failure to follow company procedures
- Normalization of deviance [Learn More>](#)

RECOMMENDATIONS

Louisiana FACE investigators concluded that, to prevent similar occurrences, employers should:

- Employers should ensure that engineering controls designed to prevent vehicle movement during pedestrian interactions are consistently used and actively monitored to reduce reliance on individual behavior
- Employers should reinforce a no-cell-phone policy/distracted-driver program
- Employers should design and oversee work systems that support consistent adherence to procedures by reducing dependence on worker attention, memory, and voluntary compliance alone.
- Employers should prevent complacency and normalization of deviance by modeling, reinforcing, and enforcing safety expectations during routine operations, particularly for repetitive tasks and experienced workers. [Learn More>](#)

INTRODUCTION

On January 15, 2024, a 71-year-old male security officer stumbled, fell to the ground, and was fatally run over by a delivery truck at a heliport facility. Paramedics were called to the scene, and he was pronounced deceased on site. There were two employees involved in this scenario, which involved three companies. Company A is a helicopter transportation company with a heliport facility where the incident occurred. The victim was employed by Company B, a contractor that provides security services at the heliport facility. Company C is another contractor that delivers goods to Company A at the heliport facility. The driver operating the delivery truck involved in the incident worked for Company C.

Documentation reviewed by Louisiana FACE investigators during the course of the investigation includes the OSHA summary report, the OSHA compliance safety and health officer's (CHSO) enforcement case file, the police report, the victim's death certificate, obituary, coworker interviews, and incident scene photos. Company B's third-party safety consultant was also interviewed.

EMPLOYER

- Company A, is a helicopter transportation company that provides service for the oil and gas industry, aeromedical services, pilot training, and aircraft maintenance. It has approximately 2,500 employees and has been in business for over 75 years.
- Company B, which employed the victim and was contracted to provide security services for Company A at the heliport facility, employs approximately 400 full-time workers and has been in business for about 60 years.
- Company C, the delivery service contracted by Company A, employs approximately four people and has been in business for 15 years.
- Figure 1 visualizes the employers and workers involved in this incident.

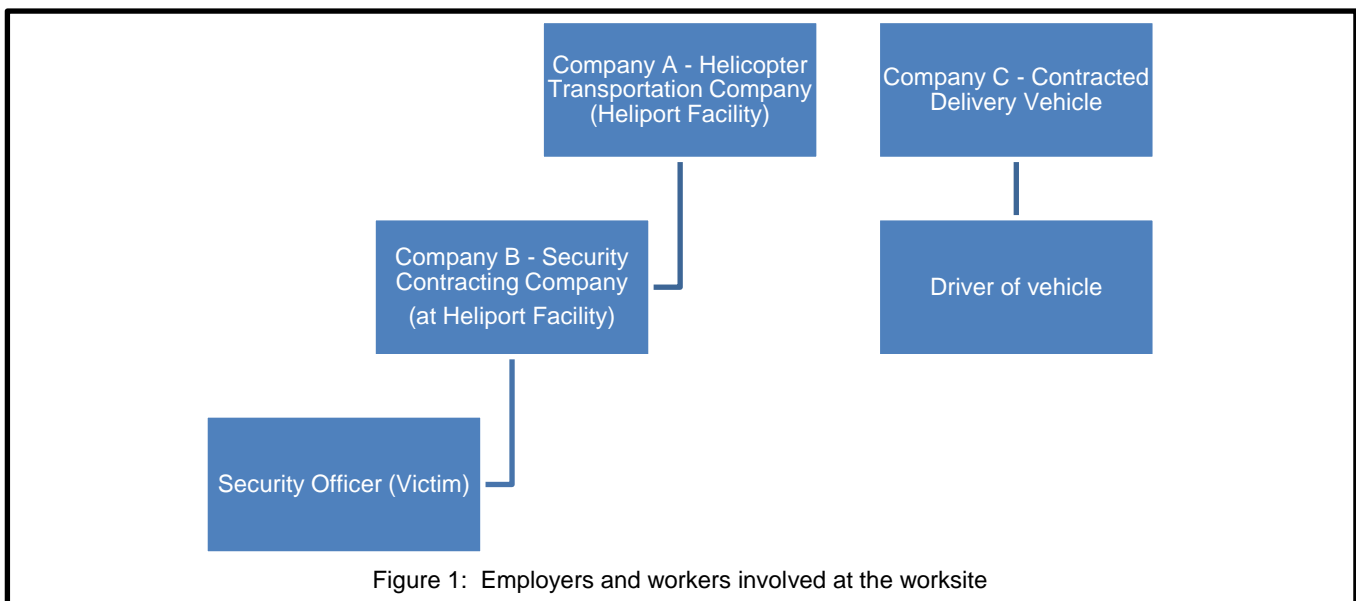


Figure 1: Employers and workers involved at the worksite

WRITTEN SAFETY PROGRAMS and TRAINING

- Company B, the victim's employer, provides safety training to its workers through a third-party safety consultant. There is a written safety and health program in place, and workers are provided training regarding company policies and procedures for checking delivery vehicles into the heliport facility. Company procedures require workers at the security gate to utilize the security gate as an engineering control. When a vehicle approaches the gate, the security officer should open a window at the security officer's building to obtain identifying information from the driver. The policy directs security officers to keep the barrier gate closed until an incoming vehicle is authorized to access the facility. Workers are trained to inform the driver, once the gate is opened, to pull through and past the gate about 5-10 feet then stop the vehicle until the gate has closed completely. According to policy, after the gate is completely closed, the security officer may then give the driver a verbal "all clear" to continue into the facility and proceed with the delivery. Company B also provides personal protective equipment (PPE), high visibility vests, to security officers. The employer instructs and trains workers to wear the high-visibility vests when working at the main gate at the site.
- The driver of the delivery vehicle received training on his employer's (Company C) distracted driver policy. Company C also monitors drivers using in-cab cameras.

WORKER INFORMATION

- The victim was a 71-year-old male security officer at the heliport facility of a helicopter transportation company. He had been in his position for 11 years. His primary job duties were checking delivery and visitor vehicles in and out of the facility of Company A.

EQUIPMENT

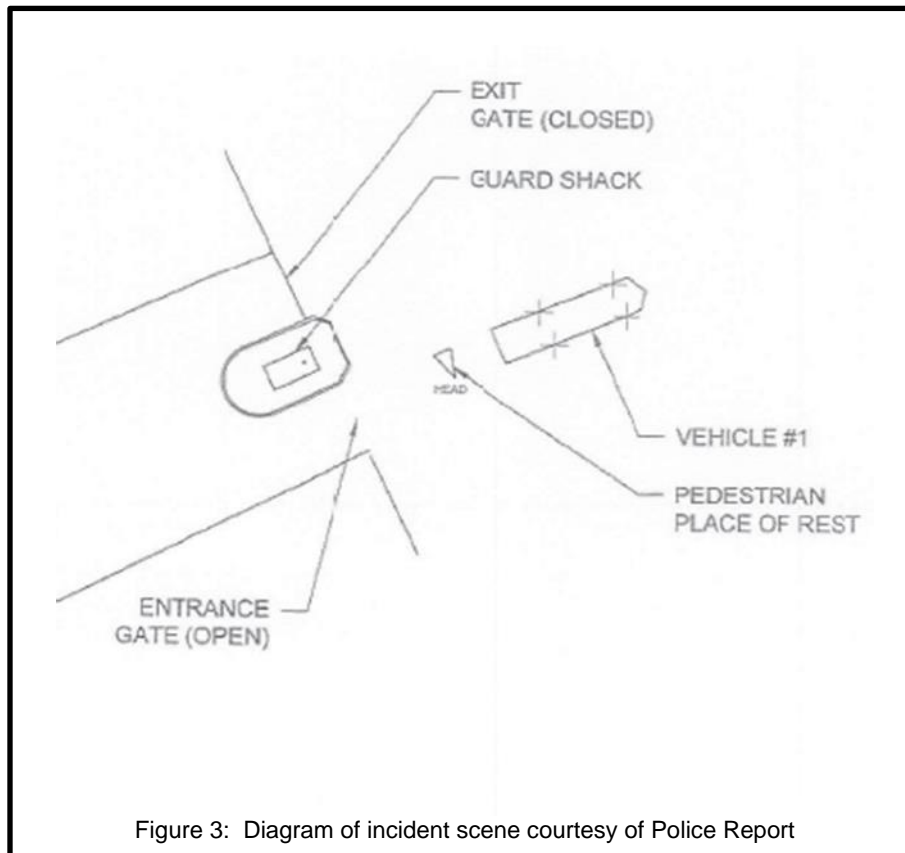
- The incident involved a 2017 Ford Truck, F-59 Commercial Stripped Chassis. This vehicle is a popular vehicle for delivery and parcel services.



Figure 2: Image of 2017 Ford Truck, F-59 Commercial Stripped Chassis. Image displayed is representative of vehicle involved in incident, not the actual vehicle involved.

INCIDENT SCENE

The incident occurred at a heliport facility in the Acadiana Region of Louisiana. The scene involved a security officer's house, a barrier gate, and a delivery truck. Under normal circumstances, the security officer remains in the officer's house until a vehicle approaches the entrance. A barrier gate is positioned at the officer's house for the security officer to raise, allowing approved vehicles entry.



INVESTIGATION

On the day of the incident, the victim worked as a security officer, guarding the gate and checking vehicles in and out of Company A's heliport facility. His job task included recording drivers' identification and license plates on a visitor log and conducting a walk around inspection of the visiting vehicle. According to protocol, the barrier gate is to remain closed until the security officer confirms that incoming delivery vehicles have authorized access to the facility. After logging the visitor, the security officer provides a visitor badge to incoming drivers. Once a delivery truck's authorization has been confirmed by the security officer, the barrier gate is then lifted, and the visiting vehicle is instructed to drive forward 5-10 feet. The security officer then lowers the barrier gate and gives the driver the all-clear, to allow passage of the truck into the facility. This procedure includes a combination of engineering and administrative controls. According to the OSHA inspection report and police report reviewed, the site's safety guidelines heavily depended on administrative controls.

On the date of this incident, multiple protocols were not followed. The security officer was not wearing his PPE, the high-visibility vest, as required by his employer (Company B). Also, Company B procedures for passage through the barrier gate were not followed. The barrier gate was not in the correct position, down, while Company C's vehicle was being checked in. The procedure of stopping at the gate, waiting for it to be raised before pulling through 5-10 feet, then waiting for an "all-clear" was not followed. The gate remained up the entire time the security officer checked in the delivery vehicle. While checking in Company C's delivery

vehicle (the F-59), the victim walked in front of the delivery vehicle, stumbled, and fell. The delivery driver, distracted by his cell phone, did not see this happen. He assumed the officer had finished checking his vehicle in and drove forward through the gate, fatally crushing the security officer.

CAUSE OF DEATH

The death certificate listed the cause of death as multiple crushing injuries from being rolled over by a truck.

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. OSHA did not issue any citations for this fatality. Louisiana FACE investigators identified the following hazards as key contributing factors in this incident:

- Failure to use available engineering controls
- Distracted driving
- Failure to follow company procedures
- Normalization of deviance

RECOMMENDATIONS / DISCUSSION

Recommendation #1: Employers should ensure that engineering controls designed to prevent vehicle movement during pedestrian interactions are consistently used and actively monitored to reduce reliance on individual behavior.

At Company A's worksite (the heliport facility), Company B operated a security officer station equipped with a barrier gate—an engineering control designed to prevent vehicles from moving forward while being checked in. Company policy requires the gate remain lowered during vehicle check-in and also requires the security officer wear the provided high-visibility vest. However, on the day of the incident, the barrier gate was not used as intended, and the security officer was not wearing his vest.

According to the CDC/NIOSH Hierarchy of Controls, the most effective hazard control strategies begin with elimination and substitution of the hazard, followed by engineering controls, administrative controls, and lastly, personal protective equipment (PPE) [NIOSH 2024]. Engineering controls are particularly valuable because they physically separate workers from hazards and reduce the opportunity for human error, making them more reliable than administrative controls or PPE alone. In this case, the use of PPE and administrative controls (such as requiring workers to wear a high-visibility vest and following check-in procedures) proved insufficient because those procedures were not followed. In contrast, had the engineering control—the barrier gate—been used as designed, it should have prevented the delivery vehicle from moving forward regardless of the driver's distraction. The non-use of the available engineering control, the barrier gate, in this scenario highlights the necessity of engineering controls not dependent on human compliance. The FACE team recommends that employers reinforce training, supervision, and accountability to ensure that engineering controls are used consistently whenever they are available, thereby reducing dependence on individual behavior and helping reduce similar incidents.

While the victim's failure to wear a high-visibility vest reduced his visibility to the driver, this form of protection is inherently less reliable, especially in dynamic, high-risk environments where overall visibility may be limited, and human behavior is unpredictable; however, if the barrier gate had been utilized, it should have prevented the driver from moving forward while distracted. Because the victim fell in front of the delivery vehicle and was no longer in the driver's field of vision, his failure to wear his high-visibility vest may ultimately have had little impact on the event, but if the driver had not been distracted by his cell phone, he may have seen the guard fall, thereby avoiding driving over him.

This incident highlights a critical breakdown in applying the Hierarchy of Controls. For future prevention, it is

essential to reinforce and monitor the consistent use of all hazard controls whenever they are available.

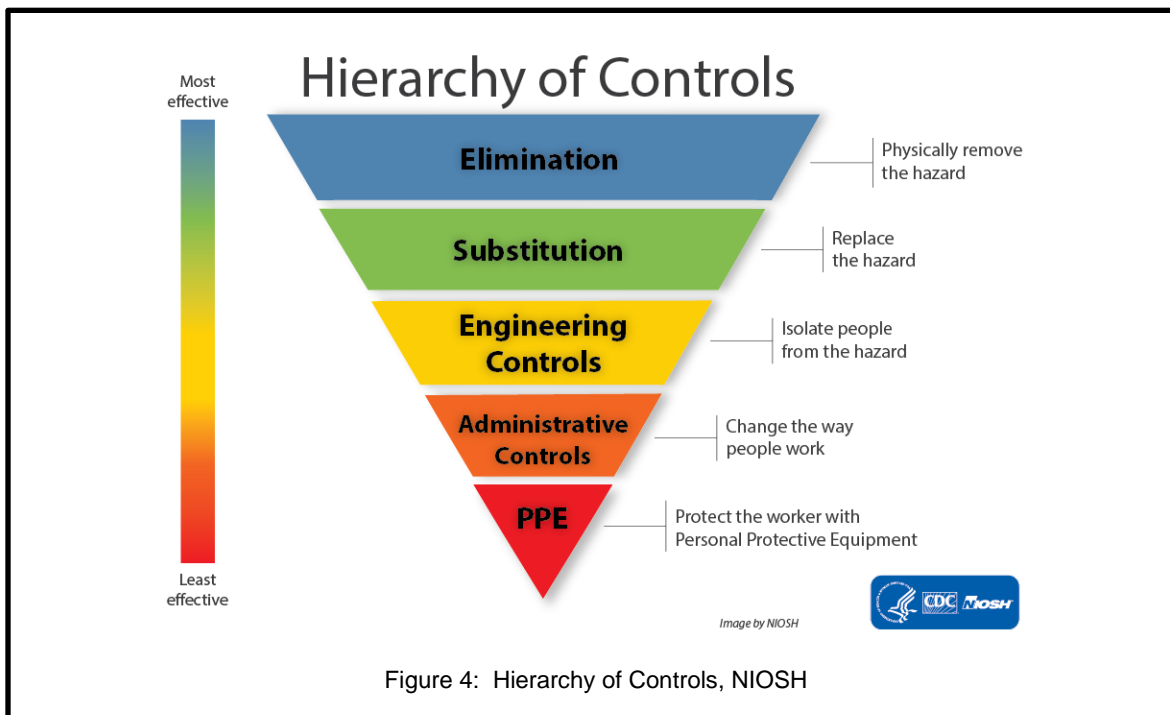


Figure 4: Hierarchy of Controls, NIOSH

Recommendation #2: Employers should reinforce no cell phone policy/distracted-driver program

Most states prohibit distracted driving with laws either banning handheld use of cellular phones or outright banning the use of cellphones while driving [GHSA 2025]. Effective August 1, 2025, in Louisiana, it became illegal to use a phone while driving unless it is hands-free or for navigation [Muller 2025]. The Louisiana law prohibits texting and emailing even while the phone is connected to another system through Bluetooth. It also prohibits driving while “accessing, reading, viewing, composing, browsing, transmitting, saving, or retrieving electronic data” from any application unless used for voice calls or navigation [Muller 2025]. While most states have laws, many employers also have policies against distracted driving. Employers are not federally required to have a distracted driver program in place, but it is considered a best practice. Company C had a distracted driver program in place, and the driver involved in the incident received documented distracted driving training. Drivers for freight delivery companies are generally monitored by GPS, video monitoring systems, or other technologies. Company C utilizes in-cab cameras that are monitored by staff. Freight delivery companies often are required to document delivery activities with a handheld device. Many companies (e.g., Company A), that contract out delivery services through third-party contractors (e.g., Company C), commonly referred to as owners/operators, have policies regarding qualifications that must be met before they are hired. Generally, owners/operators cannot have a criminal record citation (seven years from the date of clearance of a felony, five years from a DUI/DWI, and three years from a misdemeanor), or a conviction involving cellphone use or texting while driving, within one year prior to their application [FedEx Custom Critical 2025].

While the driver involved in the incident was not driving on a public roadway, he was distracted using his device while stopped at the security guard station. Distractions in driving can include a variety of actions that divert a driver’s eyes and focus from the road, including, but not limited to, eating or drinking, personal grooming, drifting into thought, and talking or texting on a handheld device. Distracted driving, oftentimes underreported, serves as a contributing factor in many crashes. Distracted driving accounted for 3,725 fatalities and 324,819 injuries among vehicular crashes in 2023 [NHTSA 2024]. Phone use while driving – particularly calling and texting – is one of the most common distractions.

Despite the security officer not using the barrier gate correctly and his required PPE, the driver's distraction was a contributing factor to this incident. Company C provided training on its distracted driver program to the driver. Companies should consider various approaches to delivering training to increase compliance. This incident demonstrates that policy and training alone are not sufficient to prevent distracted behavior during work-related driving tasks. Technologies such as real-time driver monitoring, instant in-cab alerts, and predictive safety analytics exist to support system-level controls that reduce reliance on individual compliance. AI-assisted technology can be used in driver-facing cameras to provide an instant in-cab alert to the driver if their gaze is diverted from forward for too long [Koniakowsky 2026]. One specific technology can be identified as Driver Monitoring System (DMS) with AI-based gaze tracking and head-pose estimation. This technology is increasingly standard in modern vehicles and is also part of safety ratings and regulations aiming to reduce distracted driving [Koniakowsky 2026]. This technology does come with additional costs financially, but it may potentially have helped prevent this distracted driving event from turning into a fatality. While Company C utilized in-cab cameras and provided distracted driving training, the driver was still engaged with a cell phone during the incident. The FACE team recommends that employers strengthen monitoring, enforcement, and engineering or technological controls to further remove room for human error. Ultimately, employers should be responsible for implementing and overseeing systems that actively prevent distracted driving during work activities.

Recommendation #3: Employers should design and oversee work systems that support consistent adherence to procedures by reducing dependence on worker attention, memory, and voluntary compliance alone.

Adherence to company policies and usage of PPE rely heavily on sustained human attention and behavior. Human attention and behavior are susceptible to error, distraction, and normalization of deviation over time. Unfortunately, this incident involved two workers not following their employers' policies and procedures. This incident included multiple individuals who fall under the responsibilities of multiple employers at the same worksite. Scenarios where multiple employers manage multiple workers at the same worksite are referred to as nonstandard work arrangements. Nonstandard work arrangements can present challenges in the workplace due to differences in how different workers are managed [Howard 2017]. Employers should ensure that workers receive effective training on required policies and procedures, which both the driver and the victim received. Company C trained the driver on the company's distracted driver policy. Despite Company C's policy prohibiting cell phone use while driving, the driver still violated the policy. Company B provided the security officer (the victim) with PPE in the form of a high-visibility vest that was to be worn while he was working. Company B also requires security officers to utilize the barrier gate, an engineering control, when checking in vehicles. Although the barrier gate is identified as an engineering control, its effectiveness is limited by the need for manual operation and discretionary use by the security officer. As referenced in Figure 3, engineering controls fall higher on the hierarchy of hazard controls compared with other controls (PPE and administrative controls), but are not as effective as elimination and substitution. The barrier gate, even though it requires a human element to be raised and lowered, is still more effective than PPE. PPE requires human compliance, thus increasing risk for human error. Controls are most effective when exposures can be controlled without significant human interaction [NIOSH 2024]. While it is not always practicable or possible to have all hazards eliminated or substituted, these controls are more desirable than controls involving human elements. Employers should design, implement, and oversee work systems in ways that support procedural compliance.

Recommendation #4: Employers should prevent complacency and normalization of deviance by modeling, enforcing, and reinforcing safety expectations during routine operations, particularly for repetitive tasks and experienced workers.

This fatality occurred after more than one deviation from compliance occurred. Organizational systems allowed deviations to persist. It is worth noting that routine noncompliance likely went unchallenged prior to this event. Workplace complacency often occurs among workers performing repetitive tasks. While many habits can be beneficial, repetitive actions can lead to complacency. When workers perform tasks frequently,

they can become complacent, viewing tasks as habits and losing concentration [Goren 2022]. Complacency is not solely an individual behavioral issue, but one that can become embedded in routine operations when procedural deviations are repeatedly performed without correction. Workplace complacency can present a significant safety hazard. Complacency can be challenging to address because it involves understanding how the brain forms and maintains habits [Lipinski 2021]. The prefrontal cortex (PFC) and the striatum, located at the top of the brain stem, are both involved with the brain's formation of habits. When an individual is creating a habit, the PFC is utilized. Once a habit is established, the PFC is no longer necessary to complete the habit [Lipinski 2021]. It has been suggested that engaging the PFC helps avoid complacency [Lipinski 2021]. Visible enforcement reinforces PFC engagement.

The security officer regularly performed routine tasks such as raising and lowering the barrier gate while checking in delivery vehicles, likely forming habits with these actions. The security officer and driver interacted multiple times per week [per conversation with Company B's third-party Safety Consultant and as documented in the police report]. The security officer opened the barrier gate prior to the driver coming to a complete stop at the check-in area, a violation of Company B's vehicle check-in procedure. Because the victim and driver were familiar with each other, perhaps this is why the security officer opened the barrier gate before the driver came to a full stop at the security gate. The OSHA casefile and police report suggest that early opening of the barrier gate may have become an accepted practice over time due to familiarity and repetition, which aligns with normalization of deviance. Company B requires the use of both the barrier gate and the high-visibility vest. Both of these hazard controls (engineering control and PPE) depend on human interaction for compliance. Hazard controls relying on human action, specifically operating the barrier gate and wearing PPE, require consistent supervisory oversight, visible leadership modeling, and active enforcement to remain effective. Training should be presented as an ongoing and reinforced activity, supported by refresher training, cross-training, task variation, safety observations, and timely feedback, particularly for experienced workers who may be at increased risk for complacency. The victim had been employed with Company B for 11 years. Experienced workers are at a greater risk of complacency than less experienced workers and could benefit from cross-training that engages the PFC. Research indicates that workplace complacency can be addressed by strategies incorporating more executive cognitive functions engaging the PFC [Lipinski 2021].

REFERENCES

- FedEx Custom Critical [2025]. [Qualifications for FedEx Custom Critical Owner Operators](#). Akron, OH: FedEx Custom Critical.
- Governors Highway Safety Association [2025]. [Distracted Driving](#).
- Goren, P. [2022, October]. [How to combat the dangers of workplace complacency](#). Occupational Health & Safety.
- Howard, J. [2017]. [Nonstandard work arrangements and worker health and safety](#). American Journal of Industrial Medicine, 60(1), 1-10.
- Koniakowsky, I., Forster, Y., Krems, J., Keinath, A. [2026]. [Driver monitoring systems mitigate visual distraction only when drivers are adequately instructed and driving in assisted mode](#). Transportation Research Part F: Traffic Psychology and Behaviour, Volume 116.
- Lipinski, S. [2021, October]. [Understanding the biological basis of complacency](#). Professional Safety, 66(10), 31-36.
- Muller, W. [2025, July 1]. [Louisiana bans most cell phone use while driving](#). Louisiana Illuminator.
- NHTSA's National Center for Statistics and Analysis. [2024]. [Driver electronic device use in 2022](#) (Traffic Safety Facts Research Note, Report No. DOT HS 813 531). National Highway Traffic Safety Administration.
- NIOSH [2024] [About Hierarchy of Controls](#)

INVESTIGATOR INFORMATION

This investigation was conducted by Marcia Oursler, MPH, CSP, Fatality Investigator, Louisiana Fatality Assessment and Control Evaluation Program (LA FACE); Anna Reilly, PhD, MPH, (LA FACE) Principal Investigator; and Sarah Owens, MSN, RN, Intern (LA FACE).

ACKNOWLEDGEMENT

The Louisiana FACE Program would like to acknowledge LA-OSHA for their assistance with the completion of this report.

IN MEMORIAM

This publication is respectfully dedicated to the memory of Jeff Funke, whose integrity, generosity, and passion for his work of public service enriched all who knew him. Jeff served as the Fatality Investigations Team Leader in the Division of Safety Research at NIOSH, specifically the Fatality Assessment and Control Evaluation Program (FACE) and the Fire Fighter Investigation and Prevention Program (FFFIPP), after a long career with OSHA. May his legacy continue to guide and inspire us, and may his life be remembered with gratitude and honor.

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