

**Service Technician Working Alone  
Dies after being Assaulted  
Incident Number: 09KY078**



Photograph of shop. Photograph courtesy of KY FACE.

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**Kentucky Fatality Assessment and Control Evaluation (FACE) Program**  
**Incident Number: 09KY078**  
**Release Date: September 30, 2010**  
**Subject: Service Technician Working Alone Dies after being Assaulted**

**Summary**

One late fall evening in 2009, a 53 year-old male technician was working alone at a repair shop. At approximately 9:45 PM, the technician returned to the shop with his dinner from a nearby fast-food establishment. He spread his dinner on the workbench and began eating when apparently he was attacked from behind. His attacker used a knife and cut the technician's carotid artery and jugular vein on the left side of his neck. The attacker fled, and the technician used a cell phone to call 911, emergency medical services (EMS). When EMS arrived, they found the technician dead at the scene.

To prevent future occurrences of similar incidents, the following recommendations have been made:

Recommendation No. 1: A workplace security analysis should be performed and personal safety practices implemented.

Recommendation No. 2: A building maintenance assessment should be performed on a regular basis and repairs made.

Recommendation No. 3: Neighboring businesses should partner and form a business neighborhood crime watch.

**Background**

The employer sold and leased arcade games such as pool tables, electronic games (not video games), pinball, and toy crane/ grabbers to bars, laundromats, and other retail businesses. Technical repair and maintenance were provided as a service. There were two repair shop locations approximately an hour apart. Employees from each location sometimes traveled and assisted at the other location. Service technicians received on-the-job training. At the location where the decedent was employed, there were three technicians and one manager. Technicians worked overlapping shifts. The decedent was a self-taught electrician and had on-the-job training to repair and install the arcade games.

The temperature on the day of the incident ranged from 42 – 36 degrees Fahrenheit and the area received .78 inches of rain. At the time of the incident, it was dark, windy, and raining.

**Investigation**

The Kentucky Fatality Assessment Control Evaluation program was notified via internet media of an occupational homicide involving an employee working alone. A site visit was made,

photographs were taken. Interviews were conducted with a homicide detective, and a relative of the deceased.

One afternoon in the late fall of 2009, at approximately 4:00 PM, a 53 year-old male technician arrived at work. He parked his personal vehicle in the employee/ visitor parking lot in front of the building and accessed the shop through the right front door. The building had two front doors side-by-side. Large picture windows flanked each door. On the north side of the building was a driveway that separated the shop from the next building. The driveway went to the back of the building next door, but did not access the alley behind the buildings. A chain-link fence with webbing separated the two properties on the north side. On the south side of the shop was another commercial building. There was a gated walkway between the two buildings.

The technician's work bench was located on the first floor, toward the rear of the building and near the back door. He worked third-shift and was scheduled to work that day until midnight, or later if the job required it. The manager and the second shift technician were at the shop when the third shift technician arrived.

The shop was the only occupant of a two story building located on a side street next to a major four lane highway in a neighborhood that was zoned residential and commercial. It was the third building north of the corner and on the east side of the street. On the southeast corner was a neighborhood bar and liquor store. Behind the business was a paved parking lot with company-restricted access where company-owned trucks were parked. The lot was enclosed, and secured by chain-link fence with privacy webbing. A gate surrounded the back lot of the shop, faced east, was secured with a chain and padlock, and opened into a curve in an alley that ran behind the shop. The alley behind the shop ran from a cross street to the north (left) of the lot, made a curve to the east, and ended at the next street (Diagram 1). To the north of the gate, another commercial building and private residences backed up to both sides of the alley; east of the gate, a fast-food establishment's parking lot had ingress/ egress to the alley. The corner bar did not have ingress/ egress to the alley.

Customers would typically call the shop and notify the technician(s) on duty that a game was inoperable. The technician would then exit the shop and travel to the customer, and make the repair on site, or transport the game back to the shop for repairs. Repaired games would be returned to the customer by a technician. Technicians never removed money from the games.

There were three service technicians and a manager employed at the shop. Technicians worked overlapping shifts. First shift worked 8:00 AM – 4:00 PM, second shift worked noon – 8:00 PM, third shift worked 4:00 PM – midnight. The manager worked from 10:00 AM – 6:00 PM. On the day of the incident, the manager and the second-shift technician were at the shop when the decedent arrived at work. The manager worked until 6:00 PM and the second-shift technician worked until 8:00 PM. After 8:00 PM, the third shift technician was alone.

At approximately 9:30 PM the service technician purchased take-out food then returned back to the shop. As he walked through the alley back to the shop, he spoke on the company cell phone to his girlfriend. According to the police officer, at this time, the weather was rainy, windy, and stormy. Once he was inside the shop, the landline rang and he terminated the cell phone call to

answer the landline. He spread the dinner on his work bench and was eating when he was apparently attacked from behind. His attacker used a knife to cut the technician's carotid artery and jugular vein on the left side of his neck. The attacker fled, and at 9:45 PM the technician used the company issued cell phone and called 911 to contact police and emergency medical services (EMS). While speaking with the 911 operator, it was implied that he was on the corner of the side street and the main street where the shop was located and that he was on foot. Police arrived two minutes later and could not locate the technician and contacted 911 back to say they did not see the technician. At 9:54 PM the police traced the cell phone number, determined the cell phone was issued to the business and was able to obtain the shop's address. They arrived at the front door of the shop and found it locked. The police officers and EMS personal went around to the back entrance, accessed the shop, and found the technician dead at the scene. At 10:10 PM, the police contacted the 911 operator and directed that homicide investigators and the local coroner be called to the scene. The coroner arrived, and at 10:15 PM, declared the technician dead. During this incident, nothing was stolen from the shop, nor was anything stolen from the decedent. There was no evidence of any vandalism.

An autopsy, including toxicology tests, was performed on the technician. Toxicology results were negative for drugs and alcohol. In addition to the incision of the carotid artery and jugular vein, there were two superficial incisions of head, left hand, face, and superficial abrasion of back and face. His 10th left rib was fractured.

Approximately two weeks prior to this incident, a jar of quarters had been on a counter in the front window of the shop. One night, the front door was broken into and the jar of quarters stolen. No suspects to the robbery had been apprehended at the time of this incident.

### **Cause of Death**

According to the death certificate, the cause of death was due to a single stab wound to the neck.

### **Recommendations and Discussions**

#### **Recommendation No. 1: A workplace security analysis should be performed and personal safety practices implemented.**

An assessment of the workplace should be performed to identify hazards that could expose employees to workplace violence. Engineering controls such as video surveillance, adequate indoor and outdoor lighting, motion door detectors, secure doors and locks, and controlling building access with a door buzzer system should be considered. Signage stating that employees do not have access to cash should be highly visible. If the workplace is under video surveillance, there should be signage stating that as well. Employees working alone should be equipped with personal safety alarms. Such devices can be worn on a belt, on the wrist, kept in a pocket and when activated, generates a piercing alarm to scare intruders away and alert others of danger. Employees working alone should lock doors when leaving the premises and re-lock the doors upon their return.

Companies should have a policy that includes procedures for employees to report that they feel unsafe at work due to: threats by panhandlers in the parking lot, people looking through windows, other employees, or domestic violence. Personal safety procedures should be reviewed with all employees, and, if appropriate, local law enforcement apprised of the situation.

**Recommendation No. 2: A building maintenance assessment should be performed on a regular basis and repairs made.**

An assessment to identify environmental safety issues should be conducted on a regular basis at each work location. Procedures should be in place to notify the maintenance department of needed repairs and, in turn, the maintenance department should document that repairs were completed. Repairs should be monitored for timely compliance.

There is speculation regarding the operation of the back door the technician used as access to the building. According to a person interviewed, the back door closed properly from the inside, but did not necessarily close properly from the outside. It is unknown if the door latched properly when the technician left to purchase his dinner from the restaurant, or if it latched properly when he returned to the shop. Access to the shop via the back door by the intruder could have been while the technician was at the restaurant, or after he returned. When emergency personnel and police tried to access the front door, it was closed and locked. Egress areas such as doors and windows should be maintained with hardware and devices to minimize illegal entry.

**Recommendation No. 3: Neighboring businesses should implement a Business Safety Watch.**

A Business Safety Watch (BSW) is a collaborative organization of local businesses that join together to assist each other in crime prevention. BSW organizations survey the local area, define their territory, set priorities, organize and implement business patrols, receive crime prevention training, and work closely with local law enforcement. Businesses working together can reduce violence in the workplace such as assaults on workers, robbery, illegal drug dealing, and vandalism. Guidance for organizing a BSW can be obtained from local law enforcement offices.

**Keywords**

Stab wound  
Technician  
Working alone  
Work place security analysis

**References**

1. Safety Central, <http://safetycentral.com/pesaa.html>
2. Peace at Work, <http://peaceatwork.org/>

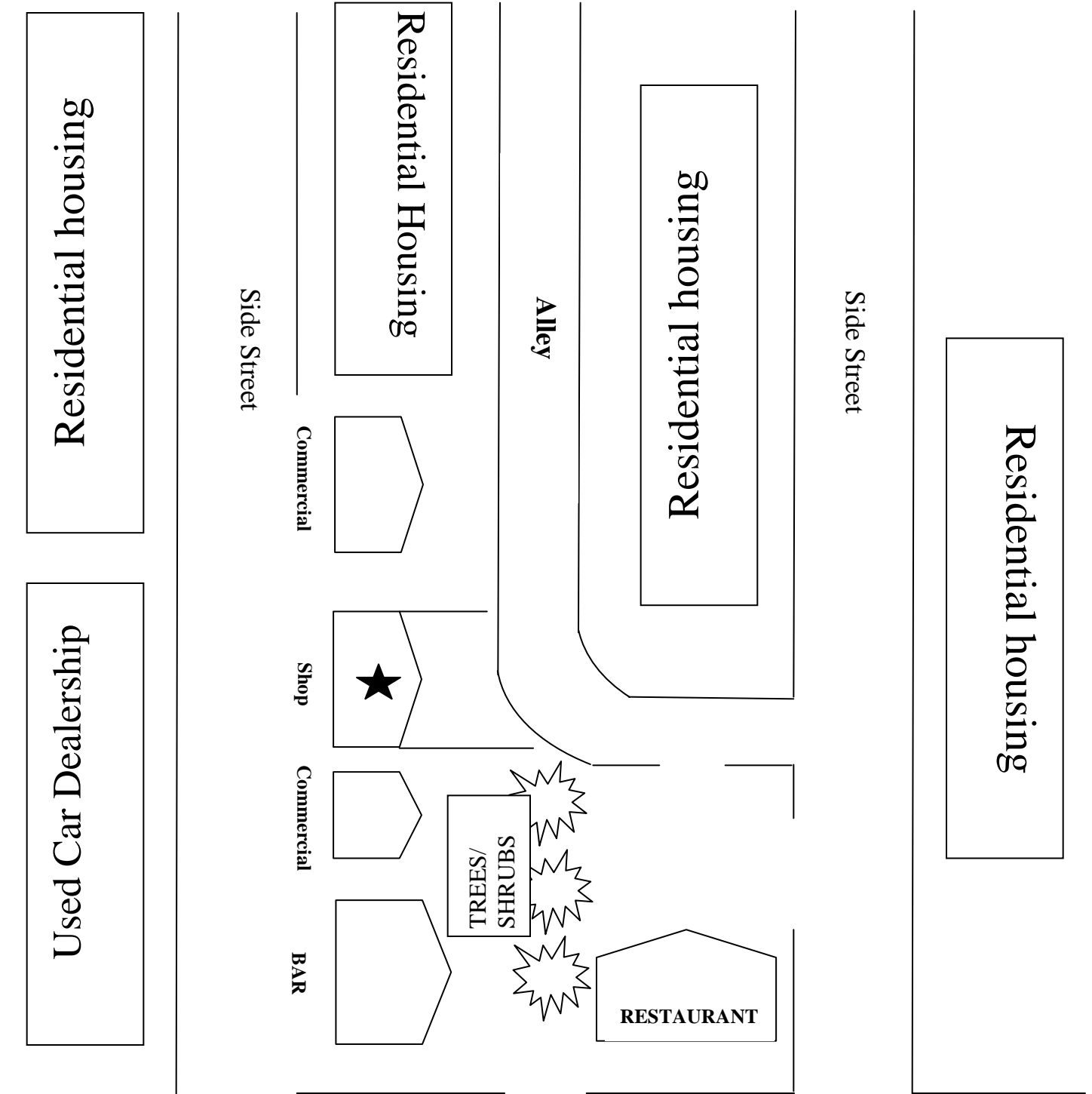
3. Business Safety Watch, <http://lexingtonky.gov/index.aspx?page=90>
4. National Crime Prevention Council, <http://www.ncpc.org/topics/home-and-neighborhood-safety/strategies/strategy-business-watch>
5. <http://www.osha.gov/SLTC/workplaceviolence/recognition.html>
6. <http://www.cdc.gov/niosh/docs/video/violence.html>
7. Keeping Your Workplace Safe, <http://www.osha.gov/Publications/98-40brochure.pdf>
8. Elements of a workplace violence prevention program, [http://www.osha.gov/workplace\\_violence/wrkplaceViolence.PartII.html](http://www.osha.gov/workplace_violence/wrkplaceViolence.PartII.html)
9. Working alone health and safety guidance on the risks of lone working, Health and Safety Executive, <http://www.hse.gov.uk/pubns/indg73.pdf>
10. *Working Alone* – Canadian Centre for Occupational Safety & Health <http://www.ccohs.ca/oshanswers/hsprograms/workingalone.html>
11. Centers for Disease Control and Prevention, Occupational Violence, National Institute for Occupational Safety and Health, <http://www.cdc.gov/niosh/topics/violence/>

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Diagram 1



North

Drawing not to scale

4 lane state highway