Fatality **A**ssessment and **C**ontrol **E**valuation Project

Public Health

KY FACE #97KY022

24 May 1998

TO: Carl Spurlock, PhD, Director, Kentucky Injury Prevention and Research Center, and Epidemiologist, Kentucky Department for Public Health

FROM: Ellyn Moon, MA, KY FACE Project Investigator

SUBJECT: Migrant Worker Killed in 22-Foot Fall Inside Building

SUMMARY

A 35-year-old male (the victim) died when he fell 22.5 feet from the third floor of a warehouse to the concrete floor of the first level. The building was being renovated, and the victim had been cleaning on the third floor, which extended only about halfway across the building. The edge of the floor on which the victim had been working was unprotected. Although a rescue squad arrived at the scene within six minutes, the victim was pronounced dead in the operating room of a local medical center approximately two hours later.

In order to prevent similar incidents, the FACE investigator recommends that employers should:

- *instruct each employee in the recognition and avoidance of unsafe conditions and the regulations applicable to the work environment to control or eliminate any hazards or other exposures to injury or illness;*
- *protect workers on surfaces with an unprotected side or edge six feet or more above a lower level by the use of guardrail, safety net, or personal fall arrest systems; and,*
- *ensure that temporary or permanent stairways have landings and handrail or stairrail systems.*

INTRODUCTION

On March 15, 1997, KY FACE was notified of the death of a 35-year-old Hispanic migrant worker on March 13. An investigation was initiated through contact with the deputy coroner who handled the case. A site visit was not allowed in this case; however, the FACE investigator viewed the building from outside and interviewed the deputy coroner and the Occupational Safety and Health (OSH) personnel involved with the case, who shared their findings and photographs.

The victim was an undocumented Hispanic migrant worker. The case remained open in the OSH Legal Department for a number of months due to problems in determining who the actual employer was. The victim, as well as seven other undocumented workers who fled following his death, were paid in cash. The owners of the building and the contractor responsible for its renovation denied employing the victim. In all, five potential employers were cited by OSH for five "serious" violations. Two of those cited eventually agreed to pay the penalties, and charges were dropped against the other three.

INVESTIGATION

The victim had been working at the incident site for approximately six months. According to the testimony of a worker who had supervised the victim and seven other migrant laborers assigned to clean up the site, they "would pray prior to starting work because of the dangerous conditions" (OSH report). The workers were not provided with any type of personal protective equipment (PPE) and there was no rail or other protection from the open edge of the third floor, which only extended about halfway across the building. The supervisor testified that the workers were "afraid to complain about the working conditions because they needed their jobs" (OSH report).

On the day of the incident the victim was working alone cleaning the third floor of the warehouse. Three people were working on the ground floor. The victim had been throwing scrap wood over the unprotected edge of the third floor (see attached photographs). No one witnessed his fall, although two workers saw him when he hit the concrete floor. The incident occurred at approximately 4 p.m.; the fire department rescue squad arrived in six minutes. The victim was taken to a medical center, where he died in the operating room at about 6 p.m.

CAUSE OF DEATH

The cause of death, as stated on the death certificate, was "cerebral lacerations and intrathoracic hemorrhage; depressed skull fractures and multiple rib fractures with transection of descending aortic arch; blunt force (impact) injuries of the head and chest (intraoperative death)." An autopsy was performed.

RECOMMENDATIONS/DISCUSSION

Recommendation #1: *Employers should instruct each employee in the recognition and*

avoidance of unsafe conditions and the regulations applicable to the work environment to control or eliminate any hazards or other exposures to injury or illness.

Discussion: *In this case the employees had not received any instruction or training in recognition and avoidance of unsafe conditions. No safety meetings were ever held by the employer.*

Recommendation #2: *Employers should protect workers on surfaces with an unprotected side or edge six feet or more above a lower level by the use of guardrail, safety net, or personal fall arrest systems.*

Discussion: *There was no fall protection system for employees working on the third floor working surface, which was 22.5 feet above the lower level of the warehouse, and which extended only halfway across the building, leaving an unprotected edge. (See attached photographs.)*

Recommendation #3: *Employers should ensure that temporary or permanent stairways have landings and handrail or stairrail systems.*

Discussion: *There was no landing on the second floor for the temporary stairway located at the center of the warehouse. Also, there was no handrail, guardrail or stairrail system on either open side of the temporary stairway. Because there were no eyewitnesses to this fall, it is not certain whether the victim fell from the unprotected edge of the third floor or from the unprotected temporary stairway. (See attached photographs.)*

REFERENCES

Occupational Safety and Health Program, Kentucky Labor Cabinet, Inspection Number 301737672, CSHO Number SO126.

29CFR 1926.21(b)(2); 29CFR 1926.501(b)(1); 29CFR 1926.1052(a)(1);
29 CFR 1926.1052(c)(1); and 29 CFR 1926.1052(c)(12). Code of Federal Regulations. Washington DC: US Government Printing Office, Office of the Federal Register.