KENTUCKY State FACE Program
Fatality Assessment & Control Evaluation

Kentucky Injury Prevention and Research Center
Bona fide agent for Kentucky Department for Public Health
2365 Harrodsburg Rd., Ste. B340, Lexington, KY 40504 • 859 257-5839

REPORT#: 24KY001 **REPORT DATE:** January 2, 2024

Employee Dies by Suicide

On January 3, 2024, a 66-year-old locksmith (victim) jumped from the roof of a 12-story building in an attempted suicide. The victim succumbed to his injuries at the scene of the incident.

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INCIDENT HIGHLIGHTS

DATE:
January 3, 2024

TIME:
10:09 a.m.

VICTIM:
66-year-old black, non-Hispanic male

INDUSTRY/NAICS CODE:
611310

EMPLOYER:
Educational Institution

SAFETY & TRAINING:
Formal safety program

SCENE:
Roof of building

LOCATION:
Kentucky

EVENT TYPE:
Suicide

CONTRIBUTING FACTORS

Key contributing factors identified in this investigation include:

- Unrestricted access to roof
- Lone work

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RECOMMENDATIONS

Kentucky investigators concluded that, to help prevent similar occurrences, employers should:

- Evaluate and consider means restriction methods to prevent suicide by jumping;
- Consider installing key card door entry system to roof access doors and implementing a roof access permitting system;
- Consider reducing or eliminating lone work situations; and
- Consider requiring suicide prevention and postvention training for all employees.

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Fatality Assessment and Control Evaluation (FACE) Program

This case report was developed to draw the attention of employers and employees to a serious safety hazard and is based on preliminary data only. This publication does not represent final determinations regarding the nature of the incident, cause of the injury, or fault of employer, employee, or any party involved.

This case report was developed by the Kentucky Fatality Assessment and Control Evaluation (FACE) Program. Kentucky FACE is a National Institute for Occupational Safety and Health-funded occupational fatality surveillance program with the goal of preventing fatal work injuries by studying the worker, the work environment, and the role of management, engineering, and behavioral changes in preventing future injuries. The FACE program is located in the Kentucky Injury Prevention and Research Center (KIPRC). KIPRC is a bona fide agent for the Kentucky Department for Public Health.

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INTRODUCTION

After arriving at work on January 3, 2024, a 66-year-old locksmith (victim) sent a text message to his supervisor from his company-issued phone. The text message informed the supervisor where the victim's company-issued equipment would be left. The victim ascended to the roof of a 12-story building and proceeded to jump off the east side in an attempted suicide. The victim succumbed to his injuries at the scene of the incident.

EMPLOYERS

The employer is a public educational institution.

WRITTEN SAFETY PROGRAMS and TRAINING

The employer has a well-established health and safety training program. All employees are required to complete an on-site orientation that covers general site safety precautions, location familiarity, policy and procedures, and general safety and health resources available to employees, including the institution's employee assistance program. Post-orientation training is job specific and varies based on position. The victim's department requires more advanced training: Some topics covered include blood borne pathogens, proper utilization of personal protective equipment, hazard communication training, driver safety training, ergonomics safety, asbestos awareness training, and other Occupational Safety and Health Administration and job function training. A broad range of annual voluntary training is available for employees as well, including suicide prevention training. The university periodically communicates occupational safety and health training opportunities and health services, including suicide prevention training, via email, social media, and campus events.

WORKER INFORMATION

The victim was a 66-year-old black, non-Hispanic male. The decedent was a high school graduate and had worked for the employer for 34 consecutive years as a locksmith.

INCIDENT SCENE

The incident occurred on the roof of a building located on the campus of the Kentucky-based institution. The 100,000-square-foot brick building was erected in 1977 and is utilized for housing both male and female students. The building consists of 12 total stories. The distance from the top of the parapet on the roof to the concrete surface below measures approximately 160 feet. The building is accessible by keycard only; access cards are issued to students living in the building and to applicable staff. Roof access is secured by a standard hand lock and deadbolt. The victim did have in his possession a company-issued access key. The roof of the building is coated in a rubberized coating and a masonry parapet that surrounds the circumference of the building measures 3.5 feet in height. The building involved in the incident is the highest building on the institution's premises, which is likely why the building was chosen by the victim.

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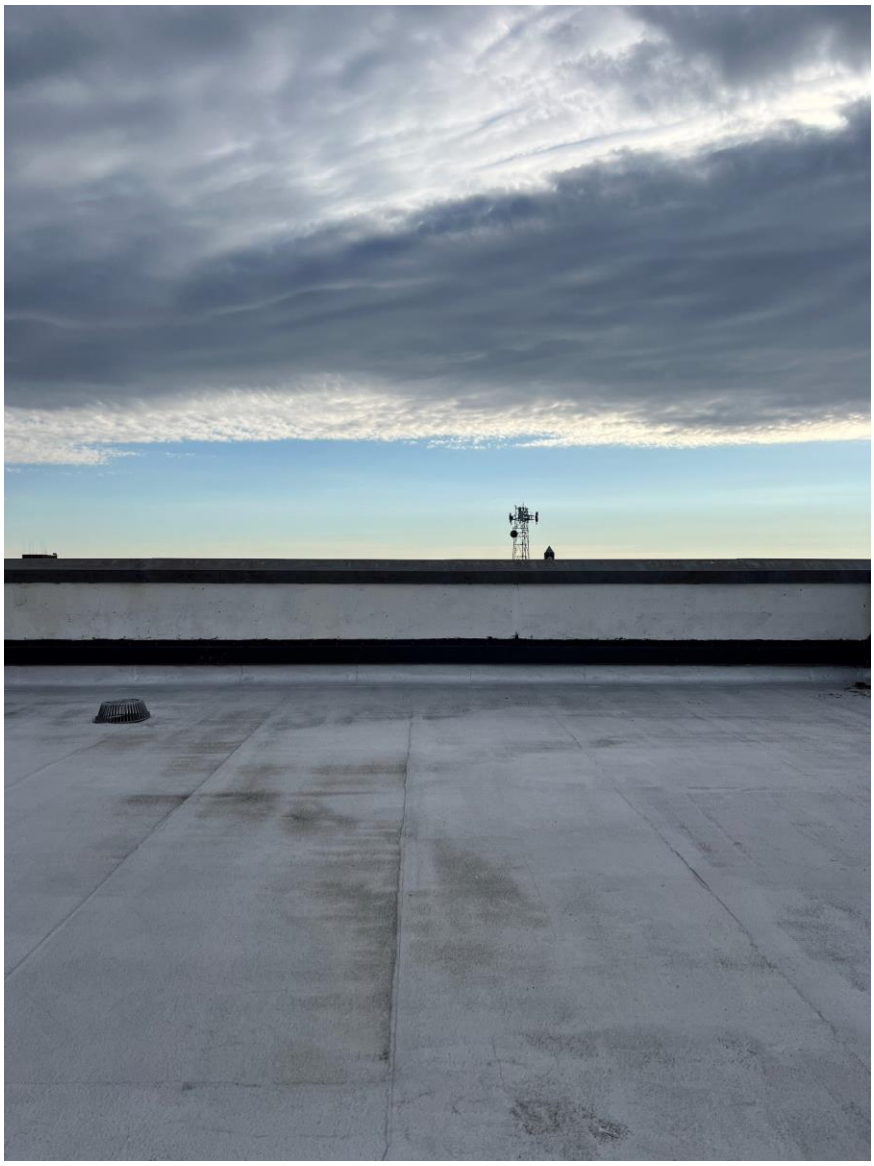

Photo 1. The roof where incident occurred. Photo property of Kentucky FACE.

WEATHER

The weather on the day of the incident was approximately 32 degrees Fahrenheit, with 82% humidity and little to no measurable wind speed. The weather is not believed to have been a factor in this incident.[1]

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INVESTIGATION

On January 3, 2024, a 66-year-old male locksmith (victim) arrived at work at 7:30 a.m. The victim was a tenured locksmith, having worked for the institution for 34 years. It is assumed by the employer that prior to the incident, the victim was going about his job tasks as usual. However, his activities at work that day prior to the incident are unknown because the victim was self-directed and was working alone. At approximately 10:07 a.m., the victim walked to a 12-story building located on the institution's campus, used his issued key card to access the building's front door, and proceeded to the elevator. After entering the elevator, the victim sent several text messages, including one to a family member and one to his supervisor. The text message to his supervisor was to indicate where his company-issued lock pick set, cell phone, and radio would be located. The text message was described as out of character for the employee and evoked concern. After arriving on the 12th floor, the victim utilized his keys to open the roof access door (photo 4). After opening the door, the victim proceeded to the southeast corner of the building, placed his equipment and a note on the building's roof, and jumped to his death at 10:09 a.m., just two minutes after entering the building. The family member and the supervisor simultaneously contacted emergency services to report the alarming text messages. While emergency services were responding, witnesses to the jump called campus emergency services to report the incident. The campus police department arrived on scene at 10:18 a.m. and located the victim on the sidewalk in front of the building. EMS arrived at 10:23 a.m. and pronounced the victim deceased. Upon further investigation, the victim's equipment and the note were found on the roof. Investigators determined the fatality to be the result of suicide by jumping from a height.

The employer had not received any notifications from other employees indicating the victim displayed changes in behavior, mood, or job performance prior to the incident. Post-incident, the employer conducted interviews with the individuals at the company who had interacted with the victim the day the incident occurred. Nothing abnormal or different with the victim's behavior was reported, nor had there been any changes in the decedent's work environment.

Notification of the loss was distributed to staff and students, along with an offer for assistance through the employer's employee assistance program for anyone who may be experiencing grief as a result of the incident.

CAUSE OF DEATH

According to the death certificate, the cause of death was blunt force trauma.

CONTRIBUTING FACTORS

Workplace 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. Kentucky investigators identified the following unrecognized hazards as key contributing factors in this incident:

- Unrestricted roof access
- Lone work

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RECOMMENDATIONS/DISCUSSION

Recommendation #1: Evaluate and consider means restriction methods to prevent suicide by jumping.

Discussion: Restriction of availability or access to lethal methods of suicide (means restriction) is an important universal approach to suicide prevention. Universal prevention strategies are targeted at the general public or entire population groups. These strategies are designed to influence everyone, regardless of suicide risk (Yip 2012). Means restriction is normally applied to the population as a whole to encompass individuals whose suicide risk may be undetected and who may not have sought mental health treatment. Suicides by jumping normally occur from man-made and natural points of elevation, such as high-rise buildings, bridges, cliffs, and terraces. Means restriction interventions enacted at these sites work by either providing a physical obstruction to prevent jumping (e.g., physical barriers, fences, guard rails) or by restricting access to these sites.[2]

FACE investigators suggest that employers consider the following methods of means restriction to prevent future similar occurrences:

Physical barriers on high rise buildings: Physical barriers can be an effective method of means prevention to combat suicide by jumping. Physical barriers on a building's roof prevent and/or increase the difficulty of jumping (photos 2 & 3). Physical barriers can be included in new building construction plans or retrofitted to existing structures.

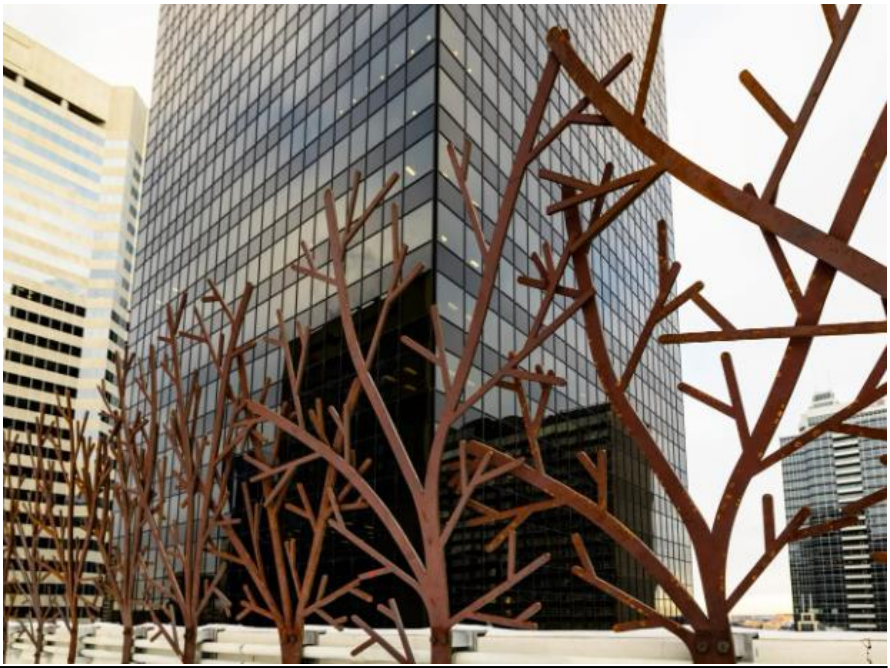

Photo 2. Photo showing physical barrier installed on top of a high rise building to combat suicide by jumping.[3]

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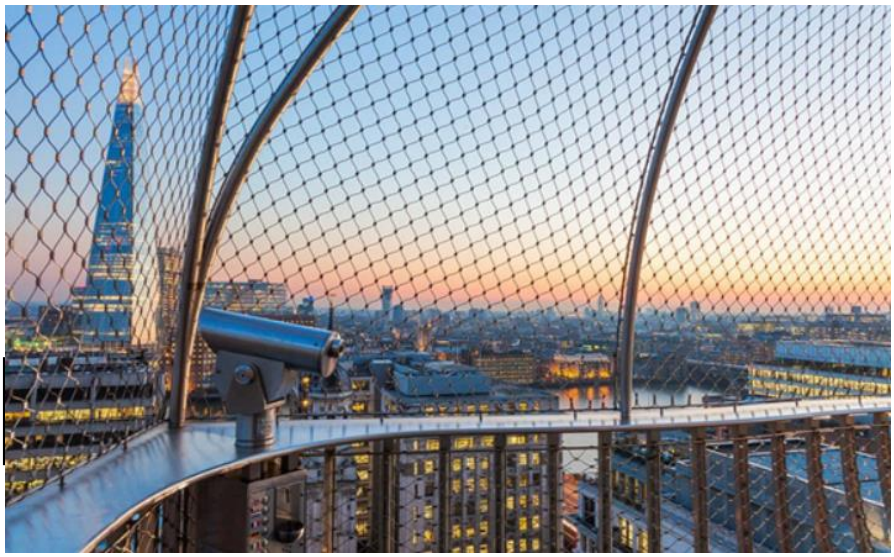

Photo 3. Photo showing physical barrier installed on top of a high rise building to combat suicide by jumping.

Recommendation #2: Consider installing key card door entry system to roof access doors and implementing a roof access permitting system.

Discussion: All exterior doors on the ground floor of the building where the incident occurred were secured by a key card door entry system. For an employee to enter the building, access to individual doors must be authorized and that authorization stored on a key card. The roof access door was secured by a keyed doorknob and deadbolt lock (photo 4). By installing a key card door entry system to the roof access door, access can be set to restricted for all employees as default. Using the key card door entry system in combination with a roof access permitting procedure could be an effective way to prevent suicide attempts by jumping. A roof access permitting procedure should require a formal request to be submitted prior to accessing a roof. Information on why access is needed, the task to be performed, the date that access is requested, and the duration of access should all be included on the request. The policy should also require that a minimum of two people access the roof.

Restricting access and having a formal roof access permitting process in place could help deter suicide by jumping. An example of a roof access permit can be found by clicking here. Additionally, employers may consider posting the Kentucky 988 Suicide and Crisis Lifeline phone number on roof access doors as an added safeguard.

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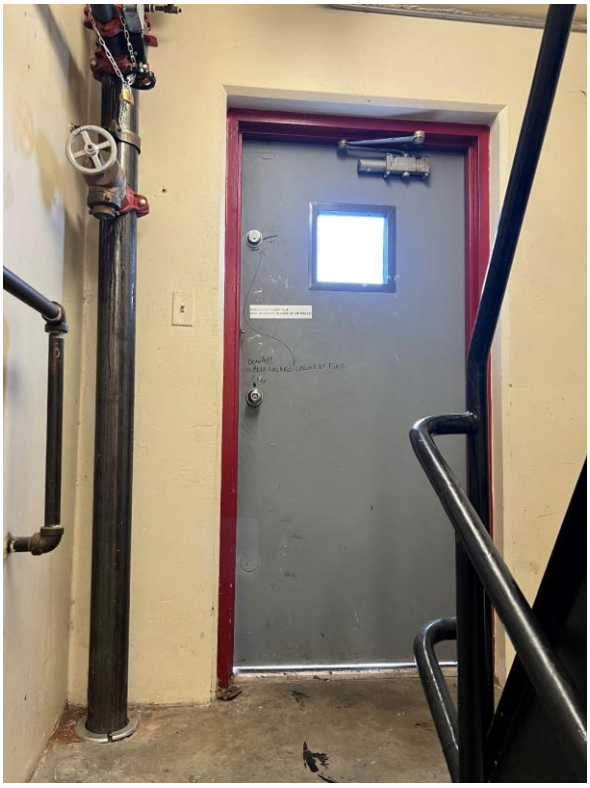

Photo 4. Roof access door at the location where the event occurred. Photo property of KY FACE.

Recommendation #3: Consider reducing or eliminating instances of lone work.

Discussion: According to the employer, the victim was a tenured employee who largely conducted self-led and self-paced activities. A lone worker is defined as an employee who performs an activity that is carried out in isolation from other workers without close or direct supervision. Working alone can have both advantages and disadvantages, according to Trade Safe, a safety products supplier. Advantages can include increased flexibility and enhanced productivity, personal development, and rapid response. Disadvantages to lone work include increased isolation and mental health issues and heightened safety risk.[5]

Research conducted by the British Occupational Health Research Foundation in 2010 found 64% of lone workers face psychological distress, a rate that is, according to Diverse Minds, significantly higher than workers who work alongside colleagues in a secure environment. Distress has a knock-on effect to both physical and mental health. If these negative feelings persist, depression and anxiety are more likely to take hold. This of course, affects performance, self-esteem, confidence, and suicidal thoughts, as well as the likelihood of acting upon suicidal thoughts.[6]

The Kentucky FACE Program suggests employers reduce or eliminate lone work when possible to help reduce the likelihood of suicide at work.

Recommendation #4: Consider requiring suicide prevention training and postvention suicide training for all employees.

Discussion: According to the U.S. Bureau of Labor Statistics, of the 5,190 total occupational fatalities that occurred in 2021, 236 were workplace suicides.[7] As workplace suicides become more common, employers should consider requiring employees to train on the common behaviors associated with potential self-harm. According to the American Foundation for Suicide Prevention (AFSP), suicide warning signs can be broken into three categories which include talk, behavior, and mood (see figure below).

Risk Factors

- Relationship stressors
- Relationship loss
- Death of a loved one
- Family history of suicide
- Legal issues
- Financial problems
- Chronic illness
- Prior suicide attempts
- Recent or upcoming crisis (within 2 weeks)

Warning Signs

Behavior

The following behaviors may signal risk:

- Increased use of alcohol or drugs
- Looking for a way to end their life, such as searching online methods
- Withdrawing from activities
- Isolating from family and friends
- Sleeping too much or too little
- Visiting or calling people to say goodbye
- Giving away possessions
- Aggression
- Fatigue

Talk

The following subjects can indicate that someone is at risk of attempting suicide:

- Killing themselves
- Feeling hopeless
- Having no reason to live
- Being a burden to others
- Feeling trapped
- Unbearable pain

Mood

People who are considering suicide often display one or more of the following moods:

- Depression
- Anxiety
- Loss of interest
- Irritability
- Humiliation
- Shame
- Agitation
- Anger
- Relief
- Sudden improvement

The AFSP states that there is no single cause for suicide, but it most often occurs when stressors and health issues converge to create an experience of hopelessness and despair (American Foundation for Suicide Prevention, 2021). Depression is the most common health condition associated with suicide, but other mental health disorders, substance misuse, chronic pain, and other health conditions can also be contributing factors.[8]

It's important to note that not all suicide victims exhibit signs or have a history of mental health issues or depression. According to the American Journal of Preventative Medicine, male victims are less likely to have known mental health conditions than females yet accounted for nearly 80% of all suicides in 2019.[9] Therefore, it's important for employers to have awareness and prevention techniques that don't rely solely on common warning signs and prevention techniques.

Employers can access a wealth of free training information from suicide prevention organizations such as AFSP or develop their own. Employer-provided training should include prevention, intervention, and postvention suicide training, an element of training that is critical and often overlooked. Postvention is psychological first aid, crisis intervention, and other support offered after a suicide to affected individuals or the workplace as a whole to alleviate possible negative effects of the event.[10] The Workplace Postvention Task Force of the American Association of Suicidology and the Workplace Task Force of the National Action Alliance for Suicide Prevention have developed a 10-step postvention action plan for employers that provides a detailed overview of what employers should do to effectively execute a postvention plan. A detailed overview of the 10-step plan, a decision-making flow chart, and more resources about postvention can be found by clicking here.

The involved employer offers awareness training; however, it's currently not required. Requiring training, including postvention training, may equip employees with the knowledge to recognize the signs, act, and prevent suicide in the workplace.

DISCLAIMER

Mention of any company or product does not constitute endorsement by Kentucky FACE and the National Institute for Occupational Safety and Health (NIOSH). In addition, citations to websites external to Kentucky FACE and NIOSH do not constitute NIOSH endorsement of the sponsoring organizations or their programs or products. Furthermore, Kentucky FACE and NIOSH are not responsible for the content of these websites. All web addresses referenced in this document were accessible as of the publication date.

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INVESTIGATOR INFORMATION

This investigation was conducted by Beau Mosley, Fatality Investigator, Fatality Assessment and Control Evaluation, Kentucky Injury Prevention and Research Center, College of Public Health, University of Kentucky.

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