The National Institute for Occupational Safety and Health (NIOSH)

Promoting productive workplaces through safety and health research

Female Receiving Clerk Dies in Fall in Warehouse

FACE 8846

INTRODUCTION

The National Institute for Occupational Safety and Health (NIOSH), Division of Safety Research (DSR), performs Fatal Accident circumstances and Epidemiology (FACE) investigations when a participating state reports an occupational fatality and requests technical assistance. The goal of these evaluations is to prevent fatal work injuries in the future by studying: the working environment, the worker, the task the worker was performing, the tools the worker was using, the energy exchange resulting in fatal injury, and the role of management in controlling how these factors interact.

On September 3, 1988, a 33-year-old female receiving clerk died as the result of a fall sustained on September 2, 1988, while trying to locate misplaced merchandise on 7-foot-high steel shelving. The attending physician determined that the victim landed head first on the concrete floor.

CONTACTS/ACTIVITIES

State officials notified DSR of this fatality and requested technical assistance. On September 20, 1988, a research safety specialist met with company officials and the victim's immediate supervisor, photographed the incident site, and discussed the incident with the county coroner and the Occupational Safety and Health Administration (OSHA) compliance officer.

OVERVIEW OF EMPLOYER'S SAFETY PROGRAM

The victim was employed by a wholesale merchandise distributor that has been in operation for 55 years. The company employs 240 workers, including 3 receiving clerks. The company has no written safety program and all training for work-related tasks is conducted on the job.

SYNOPSIS OF EVENTS

On the day of the incident, the victim was assigned by her supervisor to locate misplaced merchandise that was previously stocked. The merchandise was on 7-foot-high by 3-foot-wide rows of steel shelving spaced 5 feet apart in a 25,200 square yard warehouse. The shelving was arranged so that four shelves existed for inventoried merchandise. The top of the shelving was used to store excess merchandise. The victim decided to check the storage area at the incident site even though a co-worker informed her that the storage area had already been searched. Co-workers noted that the victim apparently climbed the shelves to reach the top shelf instead of using an available 6-foot-high wheel-mounted ladder with handrails.

A fork-truck driver passing the scene offered the victim assistance in getting down, but she declined. A short time later workers in the area heard a scream and found the victim lying in the aisle between two rows of shelves. The emergency medical service arrived in 10 minutes and summoned a medical helicopter. The victim was flown to the local hospital where emergency neurosurgery was performed. However, the victim died the following morning as a result of injuries received in the fall.

CAUSE OF DEATH

The attending physician listed accidental closed-head injuries as the cause of death.

RECOMMENDATIONS/DISCUSSION

Recommendation #1: Employers should perform task hazard analysis for all tasks performed at their establishments, adopt safe work procedures for the performance of these tasks, and ensure that workers adhere to these procedures at all times.

Discussion: As previously stated, the employer had no written safety program or task procedures. Hazard analysis should be performed to identify any hazards that may be encountered by workers during the performance of their duties. Although a receiving clerk might not be identified as a dangerous occupation, there may be unanticipated hazards. One hazard encountered by receiving clerks is a fall hazard, especially while working at the level of the top of the shelving (i.e., 7 feet). The employer provides 6-foot-high, wheel-mounted ladders for working at this level or below, if necessary.

Written safety procedures should be developed that address the task of stocking shelves. These procedures should require the use of ladders. If a ladder had been used in this incident, the possibility of a fall would have been reduced once these procedures are developed, workers should be trained to perform their duties in the safest possible manner. Employers must ensure adherence to these safe job procedures in order to provide workers with the safest possible work environment.

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