Colorado Fatality Assessment and Control Evaluation (FACE) Program

SUBJECT:

Colorado FACE Investigation 94CO031

A 35-year-old owner of a construction company died as a result of a fall from an unguarded floor opening.

SUMMARY:

On July 1, 1994, a 35-year-old construction company owner died as a result of a fall from a floor that had no protective barrier. The owner, who was not wearing fall protection, was involved in applying 4' X 8' sheets of subflooring material to the first floor level of a new home under construction. He had been kneeling to nail the sheets in place. When he stood, he was observed by coworkers to be slightly off-balance. He stepped from the unguarded edge of the floor and landed on a concrete basement floor that was 9 feet 3 inches below.

The Colorado Department of Public Health and Environment (CDPHE) investigator concluded that to prevent future similar occurrences, employers should:

- Implement 29 CFR 1926.500 (d)(1) (i) that requires the use of guard rails on all open-sided floors or platforms six feet or more above adjacent floors or ground level.

- Develop, implement, and enforce a comprehensive written safety program.

- Conduct a work-site survey to assess the potential safety hazards. Once an assessment has been completed, written safety rules and procedures should be developed, implemented, and enforced.

INVESTIGATIVE AUTHORITY:

The Colorado Department of Public Health and Environment (CDPHE) performs investigations of occupational fatalities under the authority of the Colorado Revised Statutes and Board of Health Regulations. CDPHE is authorized to establish and operate a program to monitor and investigate those conditions which affect public health and are preventable. The goal of the workplace investigation is to prevent work-related injuries in the future by study of the working environment, the worker, the task the worker was performing, the tools the worker was using, and the role of management in controlling how these factors interact.

This report is generated and distributed to fulfill the Department's duty to provide relevant education to the community on methods to prevent severe occupational injuries.

INVESTIGATION:

The investigation of this work-related fatality was prompted by a report from the local office of the Occupational Safety and Health Administration (OSHA). The investigation included interviews with coworkers present at the time if the incident. The incident site was photographed. Autopsy, emergency medical service, and police reports were obtained from local authorities.

This company employs three people in Colorado. The company did not have a designated safety officer or a comprehensive safety program. The company did not provide safety training for employees.

CAUSE OF DEATH:

The cause of death as determined by autopsy and listed on the death certificate was brain death and subdural hemorrhage.

RECOMMENDATIONS/DISCUSSION:

Recommendation #1: Implement OSHA's Regulation 29 CFR 1926.500 (d)(1)(i) which requires the use of guard rails on all open- sided floors or platforms six feet or more above the adjacent floors or ground level.

Discussion: In this incident, the use of guardrails would have reduced the risk of employee falls. The presence of a guard rail could have provided the necessary support needed when the deceased lost his balance.

Recommendation #2: Develop, implement, and enforce a comprehensive written safety program that includes, but is not limited to, training in fall hazard recognition and the use of fall protection devices.

Discussion: Employers should emphasize safety of their employees by designing, developing, implementing and enforcing a comprehensive safety program to prevent incidents such as this. Employers should also provide a training program for all employees that work from elevated platforms or floors so that they are able to recognize and deal with the associated hazards. Employees should also be trained in safety procedures, such as the use of appropriate fall protection, to be followed in order to prevent injury or death from falls.

Recommendation #3: The employer should conduct a work-site survey to assess the potential safety hazards. Once an assessment has been completed, written safety rules and procedures should be developed, implemented, and enforced.

Discussion: According to the General Duty Clause of the Occupational Safety and Health Act (Section 5 (a) 1), employers are required to provide a safe and healthy workplace for employees. To do so, employers must regularly survey the workplace to identify hazards. All identified hazards must be adequately abated through engineering control measures or changes in work-practices.

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