Colorado FACE Investigation 92CO056

SUBJECT:

Warehouse worker dies from fall inside an elevator shaft in Colorado.

SUMMARY:

A warehouse worker at a distributor of styrofoam products was fatally injured when he exited an elevator that was in motion. In this incident the newly employed worker was starting work the morning of July 13, 1993. This would have been his second day on the job. A co-worker instructed him to go to the second level of the warehouse to cut forms out of styrofoam sheets. The co-worker assisted the new employee in starting a cable activated freight elevator to take him to the second level of the warehouse. The cable housing on the elevator was equipped with a manual switch that would automatically stop the elevator at the next level. The co-worker activated this switch and pulled on the cable which started the elevator in motion upwards. The original second floor of this building had been removed at sometime in the past and the elevator opening to the now non-existent second floor had been permanently blocked. It is thought that when the elevator passed this opening the deceased thinking he had missed his floor, panicked and exited the elevator while it was still in motion. He was able to get between the elevator and the wall of the elevator shaft. When the elevator passed above him he lost his grip and fell 3 stories to the concrete floor of the shaft. The co-worker on the first floor heard noises in the shaft and witnessed the deceased falling past the first floor. The elevator was still in motion at this time.

The Colorado Department of Health (CDH) investigator concluded that to prevent future similar occurrences, employers should:

- Ensure that all new employees are completely trained in the operation of equipment that they will be required to operate.

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

- Conduct a job-site survey on a regular basis to identify potential hazards, implement appropriate control measures, and provide subsequent training to employees that specifically addresses all identified hazards.

INVESTIGATIVE AUTHORITY:

The Colorado Department of Health (CDH) performs investigations of occupational fatalities under the authority of the Colorado Revised Statutes and Board of Health Regulations. CDH is required 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 of the incident from the local OSHA area office. The CDH investigator was on site seventy-two hours after the time of the incident. The investigation included interviews with coworkers's, the company owner, and the investigating OSHA compliance officer. The incident site was photographed and the autopsy report was obtained from the local coroner.

The company employs five permanent employees and at the time of the incident had hired 5 additional temporary personnel. The company does not conduct safety training and does not have a designated safety officer. The company did not have a safety program. The firm has been in business for thirty-five years and has been located at the present site for twenty years.

CAUSE OF DEATH:

The cause of death as determined by autopsy and listed on the death certificate as blunt force trauma to head with skull fractures, subarachnoid hemorrhage, cerebral and brain stem contusions, and multiple internal injuries.

RECOMMENDATIONS/DISCUSSION:

Recommendation #1: Ensure that all new employees are completely trained in the operation of equipment that they will be required to operate.

Discussion: When new employees are hired they should be given a orientation of the workplace and provided with detailed instruction on the proper operating procedures of all equipment they will be required to operate.

Recommendation #2: Develop, implement, and enforce a comprehensive written safety program.

Discussion: Employers should emphasize safety of their employees by designing, developing, implementing and enforcing a comprehensive safety program to prevent incidents such as this.

Recommendation #3: Conduct a job-site survey on a regular basis to identify potential hazards, implement appropriate control measures, and provide subsequent training to employees that specifically addresses all identified hazards.

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 addressed through engineering control measures or changes in work practices. Employers should instruct each employee in the recognition and avoidance of unsafe conditions, and to control or eliminate any hazards or other exposure to illness or injury. In this and similar situations the employer may need to provide additional training to ensure that employees understand the hazard and how properly use safety equipment to protect themselves.

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