FACE Investigation 91CO002

SUBJECT: Mason Dies after Falling 18 Feet from Scaffolding

SUMMARY:

A 52-year-old brick mason (victim) fell 18 feet to his death while working from a tubular welded frame scaffold. The victim was laying brick on the exterior of a new residence. At the time of the incident, the victim was attempting to move the plank platform to a higher level. The plank on which the victim was standing was not secured and apparently slipped from the scaffold frame work. The victim fell onto a concrete driveway after hitting a concrete retaining wall. The Colorado Department of Health (CDH) investigator concluded that, in order to prevent future similar occurrences, employers should:

* secure platforms to the scaffold or overlap platform ends a minimum of 12 inches

* develop, implement, and enforce a comprehensive safety program that includes , but is not limited to, training in fall hazard recognition and usage of scaffolding.

* provide appropriate fall protection equipment to all workers who may be exposed to a fall hazard

INTRODUCTION:

On January 10, 1991 52-year-old owner of a masonry firm died from injuries sustained in an 18-foot fall the previous day.

On January 11, 1991 the Colorado Department of Health (CDH) was notified by the Occupational Safety and Health Administration (OSHA) and an investigation was initiated. The CDH investigator interviewed other workers at the site and photographed the site. The autopsy report was obtained from the county coroner.

The victim was self-employed as the owner/operator of a masonry construction company and employed 2 other personnel. The firm did not have a safety officer or a written safety plan.

INVESTIGATION:

On the day of the incident, the victim had been laying brick on the external chimney of a new residence under construction. When last seen, the victim was starting to move planks to a higher level on the scaffold. The planks were not secured to the scaffold frame-work. Apparently the end of the plank on which the victim was standing slipped from the frame, causing the victim to lose his balance. The victim fell 18 feet, struck a concrete retaining wall, and landed on an adjoining concrete driveway. When other workers discovered the injured victim at the site, an ambulance was summoned. The victim was taken to a local hospital where he died the next day.

CAUSE OF DEATH:

The cause of death was determined by autopsy and listed as head injuries secondary to fall.

RECOMMENDATIONS/DISCUSSION:

Recommendation #1: Overlap all planking of platforms a minimum of 12 inches or secure from movement.

Discussion: The employer should implement 29 CFR 1926.451 (a)(11) which requires that "all planking of platforms shall be overlapped (minimum 12 inches), or secured from movement." The movement of the platform planks allowed the plank to slip off the scaffold frame.

Recommendation #2: Provide appropriate fall protection equipment for all workers who may be exposed to a fall hazard.

Discussion: Employers should provide appropriate fall protection equipment for all workers exposed to fall hazards, and should provide worker training in the proper use of this equipment. Once this training is provided, employers should institute measures to ensure the use of this fall protection equipment. A safety belt and lanyard would be appropriate fall protection equipment for use on scaffolding.

Recommendation #3: Employers should develop, implement, and enforce a comprehensive safety program that includes, but is not limited to, training workers in the proper methods of erecting and working from scaffolding.

Discussion: Employers should emphasize the safety of their employees by developing, implementing and enforcing a comprehensive safety program. The safety program should include , but not be limited to, training workers in the proper use scaffolds, along with the recognition an avoidance of fall hazards.

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