

Laborer/Tender Dies In Fall From Scaffolding In Massachusetts

SUMMARY

On February 24, 1992, a 61 year old, male laborer/tender was fatally injured when he fell 20 to 25 feet from scaffolding on a Massachusetts construction site. The victim had finished his day's work aiding in the application of insulation and decorative plaster to the exterior facade of a building under renovation, when he began his descent down the tubular welded frame scaffolding (TWFS), and fell from the third or fourth level to the cluttered asphalt below. Never losing consciousness, the victim was soon transported to the local hospital where he died two weeks and three days later. The Massachusetts FACE Investigator concluded that in order to prevent similar future occurrences, employers should:

- **select and appoint a designated safety person to develop, implement, and enforce a comprehensive safety program that includes, but is not limited to, training in fall hazard recognition and the use of fall protection devices.**
- **ensure that scaffolding is properly erected, maintained, moved, dismantled and/or altered only under the supervision of a competent person**
- **ensure that scaffolding access ladder is provided**

INTRODUCTION

On May 22, 1992, the MA FACE Program Field Investigator was notified by the Massachusetts Department of Public Health Fatality Study Coordinator of a fatality that was briefly detailed in U.S. Department of Labor/OSHA data. On March 12, 1992, a 61 year old male construction site laborer/tender died from injuries received in a 20-25 foot fall from tubular welded frame scaffolding (TWFS) on February 24, 1992. An immediate investigation into the incident was initiated. On May 27, 1992, the MA FACE Field Investigator visited the incident site and interviewed the employer, and visited the regional U.S. Department of Labor area OSHA office which provided valuable information and guidance. Incident site photographs, the employer's first report of injury, the death certificate, and MA FACE Program data were obtained during the investigation.

The employer was a regional masonry/plastering contractor who employed six persons and was in business for three and one-half years. The company did not employ a designated safety officer, conduct regularly scheduled safety meetings, or have written safety rules or procedures. The victim was a 61 year old union employee who worked for the company on this project only two and one-half weeks.

INVESTIGATION

On February 24, 1992, the victim, who was a union laborer/tender, was one of several crew members applying a finishing layer of insulation and decorative plaster to the exterior facade of a newly renovated building which was 99% complete. He had been on this job for approximately two and one-half weeks.

At the outset of this project phase, the tubular welded frame scaffolding, which was to be used by the plastering subcontractor, was properly set-up by a professional scaffold supplier. Each scaffold section was 6 foot 4 inches high by 8 feet long and was constructed 8 levels high (approx. 50 feet).

According to statements taken and interviews conducted by the U.S. Department of Labor area OSHA office, the victim's employer instructed the crew on the day of the incident to reconfigure the scaffolding to accommodate a wheel well arrangement which would permit buckets of mortar to be elevated up the scaffolding to the immediate work area. A wheel well assembly is a vertical opening or shaft in the framework of the scaffolding in which a rather simple rope and pulley system is used to raise and lower material to the work area.

Having completed his workday without incident, the victim began his descent from the third or fourth level of the scaffolding by climbing down the wheel well area framework. Soon after, he apparently lost his footing or grip and fell between 20 and 25 feet to the cluttered ground below. Although he was working on the fourth level of scaffolding late in his workday, co-workers could not verify from which level the victim may have fallen. Never losing consciousness, the victim was soon transported the regional hospital where he died two and one-half weeks later.

CAUSE OF DEATH

The medical examiner listed the cause of death as anoxic encephalopathy with neck fracture.

RECOMMENDATIONS/DISCUSSION

Recommendation #1: Employers should select and appoint a designated safety person to develop, implement, and enforce a comprehensive 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 employees by developing, implementing, and enforcing a comprehensive safety program that includes, but is not limited to training workers in the recognition and avoidance of fall hazards, along with training in the proper selection and use of personal protective equipment. A selected and designated jobsite safety person versed in required fall protection requirements may have readily identified potential fall hazards and been instrumental in the prevention of this incident.

Recommendation #2: Employers should ensure that scaffolding is properly erected, maintained, moved, dismantled and/or altered only under the supervision of a competent person.

Discussion: The reconfiguration of the scaffolding shortly before this incident was not performed under the direction of a competent person trained in scaffold erection and maintenance. Consequently, the scaffolding reconstruction yielded poorly placed and unsecured planking, unsafe access/egress, and lack of appropriate guardrailing on all open sides and ends. U.S. Department of Labor OSHA Standards 29 CFR 1926.451 (a)(3) and 29 CFR 1926.451 (d)(10) require scaffold erection to be performed under direction of competent persons and appropriate guardrailing systems to be constructed on all scaffolding more than ten feet above ground or floor level.

Recommendation #3: Employers should ensure that scaffolding access ladder is provided for safe access and egress.

Discussion: Improper reconfiguration of the scaffolding just prior to this incident also resulted in poor access/egress for personnel. Since this scaffolding was not of the climbable variety, and easy access/egress was not ensured following reconfiguration, the victim scaled the scaffolding framework. U.S. Department of Labor OSHA Standard 29 CFR 1926.451 (a)(13) requires an access ladder or equivalent safe access be provided for personnel to access and egress scaffolding. Had such a provision been ensured, the victim may have opted for the safer method, thus preventing this incident.

REFERENCES

1. Office of the Federal Register: Code of Federal Regulations, Labor 29, July 01, 1991, Parts: 1926.451 (a)(3), 1926.451 (a)(13), 1926.451 (d)(10)

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