

FACE INVESTIGATION

SUBJECT: Carpenter Dies Following a Fall From Ladder Scaffolding

SUMMARY:

A 67-year-old male carpenter (the victim) died of injuries received after falling from a ladder or improvised scaffolding. The victim was self-employed, and had been contracted to build and finish off partition walls in the storage area of an office building. On the day of the incident, he had been using improvised scaffolding as a worksurface while he placed and fastened sections of drywall. There were no witnesses to the incident, but it appears he fell from a ladder or scaffolding and landed on the concrete floor of the storeroom. An employee of one of the businesses in the building found the victim when he entered the storage room, and called for help. EMS responded and the victim was moved to a hospital where he was pronounced dead of massive head trauma. The Wisconsin FACE investigator concluded that, to prevent similar occurrences, employers should:

- ! provide and use equipment that is designed to safely meet the requirements of the job tasks**
- ! develop and implement a safety program that incorporates specific procedures that emphasize the importance of recognizing and avoiding hazards in the workplace. These procedures should include, but not be limited to, conducting hazard evaluations before initiating work at a job site and implementing appropriate controls**

INTRODUCTION

On January 13, 1994, a 67-year-old male carpenter died after falling from a ladder or improvised scaffolding. The Wisconsin FACE investigator was notified by the Wisconsin Department of Industry, Labor and Human Relations, Workers Compensation Division, on February 10, 1994. On April 25, 1994, the WI FACE field investigator conducted an investigation of the incident. The incident was reviewed with the owner of the building, and the victim's wife was interviewed. Copies of the coroner's report, police report and photographs, and death certificate were obtained.

The victim was a self-employed carpenter who had no employees. He had done residential and small business construction and remodeling for about 43 years and learned his trade through on-the-job training. He had no formal training or safety programs, and had not incurred any serious work-related injury prior to this incident.

INVESTIGATION

The victim had been contracted by the owner of a small office building to remodel part of the building's storage area. He had been working at the site for about six weeks, and was nearing completion of the project. On the morning of the incident, the victim began installing sections of drywall at about 8 AM. He measured and cut each piece of drywall on the floor of the storeroom prior carrying it up a ladder and then he stood on scaffolding to hang the drywall near the top of the 12-foot high wall he was finishing. He had erected a scaffolding using one wooden ladder of unknown length, one aluminum extension ladder comprised of two 10-foot sections, and a wooden plank of unknown dimensions. The plank had been supported on the two ladders in an unknown manner

at a height of approximately 6 feet above the concrete floor. The scaffolding was in place at the time the victim was found, but was disassembled immediately to provide access to EMS staff. No photographs were taken before it was disassembled and no other information about the scaffold assembly is available. The equipment was removed by family members soon after the incident, and was not available to be viewed at the time of the investigation. A seven-foot wooden stepladder was also in the vicinity of the scaffolding on the day of the incident.

Around 10 AM the victim left the worksite, picked up some tools and had a light meal at home. He returned to the worksite and was not seen again until an office worker went to the storeroom and found him lying on the floor in a pool of blood about 1:45 PM, near the ladder and scaffolding. No tools or work materials were found near the victim. It is unknown if he fell from the plank or from one of the ladders. The worker called 911 for emergency assistance, sheriff's rescue staff arrived within a few minutes and initiated CPR. Paramedics arrived and transported the victim to the hospital, where he was pronounced dead.

CAUSE OF DEATH

The medical examiner reported the cause of death as head trauma. Blood and urine samples were negative for drugs or alcohol.

RECOMMENDATIONS/DISCUSSION

Recommendation #1: Employers should provide and use equipment that is designed to safely meet the requirements of the job tasks.

Discussion: Equipment that is specifically designed for safe performance of job duties should be used by all workers, including those who are self-employed. In this instance, the use of scaffolding that met the OSHA standard of 29 CFR 1926.451 might have prevented the victim's fall. In addition, the use of a drywall lifting device would have eliminated the hazard of carrying pieces of drywall up a ladder.

Recommendation #2: Employers should develop and implement a safety program that incorporates specific procedures that emphasize the importance of recognizing and avoiding hazards in the workplace. These procedures should include, but not be limited to, conducting hazard evaluations before initiating work at a job site and implementing appropriate controls.

Discussion: Safety programs should be developed and training procedures incorporated which emphasize the importance of recognizing and avoiding hazards in the workplace and following established safe work procedures. The safety program should include, but not be limited to, safe working surfaces, proper selection and use of equipment, and the recognition of hazards and safe work procedures.

REFERENCE

Office of the Federal Register: Code of Federal Regulations, Labor 29 Part 1926.451, July 1, 1992.