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Worker Dies After Falling Off Of Loading Dock Ramp

MN FACE Investigation 98MN04501

DATE: August 24, 1998

SUMMARY

A 63-year-old worker (victim) died of injuries he sustained after falling from a loading dock ramp. The victim worked as a part-time repair technician. On the day of the incident, workers were having a going away party for a coworker. Immediately prior to falling, the victim was walking up the dock ramp to join another coworker who was eating in the dock. The victim had a plate of food in his right hand and used his left hand to hold onto the dock door frame to pull himself up onto the dock from the top of the ramp. As he was pulling himself up, his hand slipped off the door frame and he fell backwards and hit his head. A coworker who was trained as a first responder was sitting nearby and immediately came to help. Another coworker placed a 911 call and emergency personnel arrived shortly after being called and transported the victim to a local hospital where he died six days later.

MN FACE investigators concluded that, in order to reduce the likelihood of similar occurrences, the following guidelines should be followed:

- employers should equip dock doors with barriers that prevent workers from using the dock as a walkway when the metal door is open; and
- employers should design, develop, and implement a comprehensive safety program.

INTRODUCTION

On June 31, 1998, MN FACE investigators were notified of a work-related fatal incident that occurred on June 30, 1998. The victim was a repair technician for a health care equipment manufacturing company. A site investigation and employer interview was conducted on August 4, 1998. During MN FACE investigations, incident information is obtained from a variety of sources such as law enforcement agencies, county coroners and medical examiners, employers, coworkers and family members.

INVESTIGATION

The employer is a health care equipment manufacturing company that employs approximately 80,000 workers. The incident occurred at one of the manufacturing plants where 21 permanent employees and 2 contracted workers work. The victim was one of the contracted workers. He was employed by a temporary agency and had been contracted to work 20 hours per week by the health care equipment manufacturing company. This was the first work-related fatality that

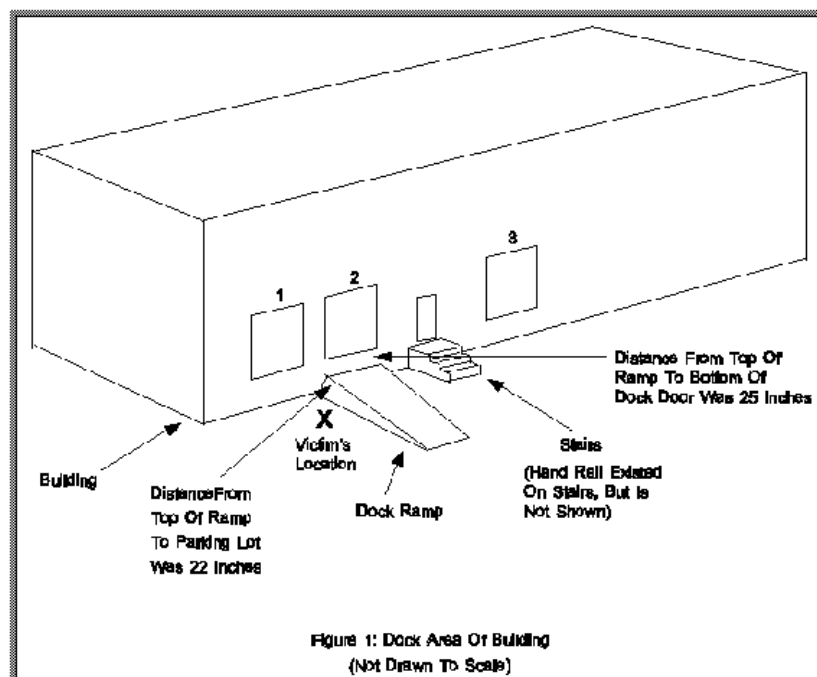
occurred at this facility. The company's corporate safety team conducted annual safety training at this facility. The facility the incident occurred at had its own safety committee which employees were required to serve on on a rotating basis. Quarterly walk through inspections were conducted by this safety committee.

On the day of the incident, workers were having a going away party for a fellow worker. Picnic tables and barbecue grills had been set up in the parking lot in the loading dock area. Loading docks 1 and 3 were used to load semi-trucks, while loading dock 2 was used to load smaller trucks, such as pickup trucks. There were approximately 20 people present. A coworker who was eating on loading dock 2 reported that the victim had just gotten a plate of food and was walking up the dock ramp to join him. As the victim was approaching the ramp he reached for the door frame with his left hand to pull himself up onto the dock and held the plate of food with his right hand. While he was pulling himself up to the dock his left hand slipped off the door frame and he fell backwards and hit his head on the parking lot pavement. The distance from the top of the ramp to the bottom of the dock door is 25 inches and the distance from the top of the ramp to the parking lot is 22 inches (figure 1). A coworker who was trained as a first responder heard someone shout out the victim's name and turned and saw the victim lying on the ground. The coworker ran to the victim and noticed blood coming from his ears. Another coworker made a 911 call and emergency medical personnel arrived shortly after being called. They transported the victim to a local hospital where he died six days later.

Although this incident occurred during an employee party, a similar situation could occur during normal workplace activities.

CAUSE OF DEATH

The death certificate was not available when this report was completed.



RECOMMENDATIONS/DISCUSSION

Recommendation #1: Employers should equip dock doors with barriers that prevent workers from using the dock as a walkway when the metal dock door is open.

Discussion: Employers should ensure that employees use the stairs, if available, rather than the ramp to enter the dock area buildings. Although stairs may not be available at all facilities with docks, workers should use the stairs if they are available. If the dock doors are kept closed except when they are being used for loading and unloading tasks they will probably not be used as walkways. During the summer months or in warm climates the dock areas of the some facilities, which are not air conditioned, may get warm. Workers may open the dock doors to let air circulate into the facilities. Barriers, such as screens, which would prevent workers from entering and exiting the dock area by means of dock doors, but would still allow air to circulate into the building should be installed. At the facility this incident took place at, stairs with hand rails on both sides were located approximately four feet from the dock ramp, but it is not uncommon for workers to use the ramp and dock door to enter and exit the building. If the dock door involved in this incident had a barrier, such as a screen, the victim may have used the stairs rather than the ramp to enter the dock and this fatality may have been prevented.

Recommendation #2: Employers should design, develop, and implement a comprehensive safety program.

Discussion Employers should ensure that all employees are trained to recognize and avoid hazardous work conditions. A comprehensive safety program should address all aspects of safety related to specific tasks that employees are required to perform. OSHA Standard 1926.21(b)(2) requires employers to “instruct each employee in the recognition and avoidance of unsafe conditions and the regulations applicable to his work environment to control or eliminate any hazards or other exposure to illness or injury.” Safety rules, regulations, and procedures should include the recognition and elimination of hazards associated with tasks performed by employees.

REFERENCES

1. Office of the Federal Register: Code of Federal Regulations, Labor, 29 CFR part 1926.21 (b)(2) U.S. Department of Labor, Occupational Safety and Health Administration, Washington, D.C., July 1, 1994.

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