DATE: April 25, 1997

FROM: Minnesota Fatality Assessment and Control Evaluation (MN FACE) Program Minnesota Department of Health

SUBJECT: MN FACE Investigation 97MN008

Construction Worker Dies After Falling 9 Feet From the Ground Into The Basement Of A Town house That Was Being Constructed

SUMMARY

A 23-year-old worker (victim) died of injuries he sustained after falling 9 feet into a basement of a town house that was being constructed. On the day of the incident workers were beginning to frame the first floor of the town house. The victim was working at ground level near the basement that had been dug two months prior to the incident. A coworker of the victim immediately noticed the victim after he fell and placed a 911 call to emergency rescue personnel who responded and transferred him to a local hospital where he died the same day.

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

- whenever any work is performed in an area where the potential for a serious fall exists, the employer should ensure that fall warning devices are provided; and
 - employers should design, develop, and implement a comprehensive safety program.

INTRODUCTION

On February 4, 1997, MN FACE investigators were notified of a work-related fatal incident that occurred on February 3, 1997. An interview with the employer was conducted by a MN FACE investigator on March 28, 1997. 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.

The victim worked as a general carpenter for a construction company that builds residential single family houses and town houses. The company builds approximately 60 homes a year. The company has been in business for 2 years and employs 15 people. The victim had worked for the employer for 8 months and had no previous construction experience.

INVESTIGATION

On the day of the incident workers were beginning to frame the first floor of a town house that they had started constructing two months earlier. At the time of the incident, the concrete basement walls existed, but the concrete basement floor did not exist. The victim was working at ground level near the basement which was 9 feet deep. It is unclear what the victim was doing immediately prior to falling over the concrete basement wall and into the basement. Two of the victim's coworkers, including the job foreman, were present at the incident site. Neither of the coworkers witnessed the fall, but the job foreman noticed the victim immediately after he fell to the frozen ground. The foreman placed a 911 call to emergency rescue personnel who responded and transferred the victim to a local hospital where he died the same day.

CAUSE OF DEATH

The cause of death listed on the death certificate was blunt force craniocerebral injuries as a result of a fall from height.

RECOMMENDATIONS/DISCUSSION

Recommendation #1: Whenever any work is performed in an area where the potential for a serious fall exists, the employer should ensure that fall warning devices are provided.

Discussion: The victim was working at ground level in an area where the potential for a fall existed. He was working near the edge of a 9 foot deep basement opening. The basement hole was not marked with warning devices such as perimeter tape or warning signs to warn workers or other people who may enter the construction area that the potential for a fall exists.

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

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.

David L. Parker
1

Margee Brown, M.P.H. Safety Investigator MN FACE David Parker, M.D., M.P.H. Principal Investigator MN FACE