NIOSH

FACE

Fatality Assessment and Control Evaluation Program

Division of Safety Research • 1095 Willowdale Road • Morgantown, West Virginia 26505 • Phone: (304)285-5916

**FACE Report Number: 2004-06** **November 2, 2004**

# *Sixteen-Year-Old Hispanic Youth Dies after Falling from a Job-Made Elevated Work Platform During Construction - South Carolina*

## SUMMARY

On March 9, 2004, a 16-year-old Hispanic construction laborer on a framing crew (the victim) was injured when he fell from a job-made elevated work platform (scaffold) and struck his head on a concrete slab 10 feet 3-inches below at approximately 3:00pm. The victim complained of a severe headache to his crew leader and to his father and uncles, who also worked on the framing crew. The construction project coordinator employed by the general contractor reportedly told the crew leader to take the youth to the hospital emergency room, less than a mile from the site. According to the victim's father, the framing subcontractor's crew leader drove him and his son to a drugstore where they purchased aspirin and, after giving aspirin to the victim, the crew leader drove them home. The crew leader returned to work and the victim's father remained at home with the victim. When the victim's uncles returned home from work at approximately 7:30 p.m., the victim was vomiting and unable to walk. The victim's father and uncles drove the victim to the crew leader's home shortly after 7:30 p.m. The crew leader drove the victim and family members to a hospital, stopping along the way at a medical clinic to seek care, but the clinic had already closed. The victim arrived at a hospital emergency room at approximately 8:30 p.m. and was pronounced dead at 9:28 p.m. by an emergency room physician.

*Incident Site*

**Fatality Assessment and Control Evaluation (FACE) Program**

The National Institute for Occupational Safety and Health (NIOSH), Division of Safety Research (DSR), performs Fatality Assessment and Control Evaluation (FACE) investigations when notified by participating states (North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, and Virginia); by the Wage and Hour Division, Department of Labor; or when a request for technical assistance is received from NIOSH-funded state-level FACE programs in Alaska, California, Iowa, Kentucky, Massachusetts, Michigan, Minnesota, Nebraska, New Jersey, New York, Oklahoma, Oregon, Washington, West Virginia, and Wisconsin. The goal of FACE is to prevent fatal work injuries by studying the work environment, the worker, the task the worker was performing, the tools the worker was using, the energy exchange resulting in fatal injury, and the role of management in controlling how these factors interact. FACE investigators evaluate information from multiple sources that may include: interviews of employers, workers, and other investigators; examination and measurement of the fatality site, and related equipment; and review of records such as OSHA, police, medical examiner reports, and employer safety procedures and training records. The FACE program does not seek to determine fault or place blame on companies or individual workers. Findings are summarized in narrative reports that include recommendations for preventing similar events in the future. For further information visit the FACE website at www.cdc.gov/niosh/face/faceweb.html or call toll free 1-800-35-NIOSH.

NIOSH investigators concluded that, to help prevent similar occurrences, employers should

- ***ensure that elevated work platforms meet safety requirements and that all employees are provided with fall protection when the potential for falls exists***

- ***ensure that injured workers are provided with appropriate emergency medical services***

- ***develop, implement, and enforce a comprehensive written safety program for all workers which includes training in hazard recognition and the avoidance of unsafe conditions. A written training plan should require training in fall protection for all employees potentially exposed to fall hazards.***

- ***ensure that workers who are part of a multilingual workforce comprehend instructions in safe work procedures for which they are assigned and understand their rights in the workplace***

- ***pursue every feasible means to obtain the authentic age of each worker hired and establish work policies that comply with child labor laws prohibiting youths less than 18 years of age from performing hazardous work including, for example, operating power-driven circular saws. Employers should communicate these work policies to all employees.***

- ***ensure that the nearest area office of the Occupational Safety and Health Administration is notified within 8 hours of a fatality or in-patient hospitalizations of three or more workers as a result of a work-related incident at their company.***

Additionally, general contractors should

- ***ensure through contract language that all subcontractors have a comprehensive safety and health program that addresses all aspects of the jobs they and their employees will perform; accident investigation and emergency services procedures; and age and employment eligibility documentation for all employees that will work on the worksite.***

Additionally, the U.S. Department of Labor and employers should

- ***consider prohibiting youth less than 18 years of age from working at a height of 6 feet or more from ladders, scaffolds, trees, structures and machinery.***

## INTRODUCTION

On March 9, 2004, a 16-year-old Hispanic construction laborer on a framing crew (the victim) was injured when he fell from a job-made elevated work platform (scaffold) and struck his head on a concrete slab 10 feet 3-inches below. He died several hours later in a hospital emergency department. On April 7, 2004, the U.S. Department of Labor (DOL), Wage and Hour Division, notified the National Institute for Occupational Safety and Health (NIOSH), Division of Safety Research (DSR) of the incident. On May 12, 2004, a DSR safety and occupational health specialist met with a federal investigator from the DOL Wage and Hour Division and reviewed findings from their investigation. On May 13, 2004, the DSR investigator visited the incident site and interviewed the construction project coordinator. The DSR investigator interviewed the subcontractor who employed the victim through an arrangement with a Hispanic crew leader. A statement taken from the crew leader by his employer several days after the incident that had been translated into English was reviewed. On May 14, 2004, the DSR investigator discussed the incident with a detective from the city police department. A telephone interview was conducted with the South Carolina Occupational Safety and Health Administration (SCOSHA) compliance officer and supervisor assigned to the case. The cause of death was obtained from the county coroner.

The victim was paid by a crew leader who was employed by a concrete and framing subcontractor who had subcontracted with the general contractor to do the framing and concrete work for a new condominium development. The framing subcontractor had been in operation for 2 years and employed 5 office staff and a crew leader who, according to the subcontractor, spoke enough English to understand instructions. The crew leader was responsible for finding Hispanic laborers to perform framing and concrete work. The crew leader had 18 Hispanic workers performing framing work at the time of the incident. The subcontractor's crew leader was responsible for finding these workers and for paying them in cash every week with money provided in a lump sum by the subcontractor. These Hispanic workers were Mexican nationals who spoke little or no English. Neither the crew leader nor the subcontractor had obtained documentation of the victim's date of birth and it is not certain if they knew that the victim was under age 18.

The general contractor had a written safety program for his employees and employed a construction project coordinator to provide oversight at the project. The general contractor's safety program did not cover employees of subcontractors. There was a statement in the contract between the general contractor and the subcontractor that stated that the subcontractor was responsible for meeting all OSHA safety and health regulations.

The framing subcontractor had a written safety and health plan written in English. The crew leader reported to the SCOSHA compliance officer that he and his crew operated under the framing subcontractor's safety program. There was no documentation of employee training for any of the employees who were performing framing work, including the victim.

The victim came to the United States from Mexico in January, 2004, to work with his father and four uncles who were already working on the framing crew assembled by the subcontractor's crew leader. The framing subcontractor had no previous history of employee fatalities.

## INVESTIGATION

The victim joined the subcontractor's framing crew about 2 weeks before the incident. The victim's uncles and father had been working with the framing crew at the condominium construction site for about 6 weeks before the incident. The crew worked Monday through Saturday from 7:30 a.m. to approximately 6:00 p.m. each day. The condominium project had begun in December 2003 and was scheduled for completion in 2005.

According to statements made by one of the victim's uncles, the victim was working with him on the second floor stairwell of condominium #48 (Photo 1) at the construction project on March 9, 2004. While the victim was cutting 2x4's with a power saw, his uncle left the area to get materials. As he was walking back with materials, the victim's uncle saw the victim falling from the elevated work platform they had constructed earlier, to a concrete slab at ground level 10 feet 3-inches below (Photo 2). The time was approximately 3:00 p.m.

According to statements made by the victim's father, who was working nearby on condominium #45, he heard a commotion and ran over to find out what had happened. He saw his son (the victim) sitting on the concrete. The victim told him he had fallen and had a severe headache. The father noticed an abrasion and a bump on his son's head but no bleeding. The construction project coordinator came to the scene after hearing the commotion and asked coworkers what had happened. According to the project coordinator, he instructed the crew leader in English to take the boy to the hospital less than a mile from the site. He told investigators that he felt that the crew leader fully understood his instructions as the crew leader spoke some English and had followed instructions given in English in the past. The framing subcontractor was not at the site at the time and was not notified; he learned of the incident several days later.

According to the victim's father, the crew leader told the victim's family members to carry the victim to his van, as the victim was unable to walk. The crew leader drove the father and his son to a drugstore where they purchased aspirin and, after giving aspirin to the victim, the crew leader drove them home. After settling the victim, who at that time was able to walk with help, into bed to rest, the crew leader returned to work and the victim's father remained at home. When the victim's uncles returned home from work at approximately 7:30 p.m., the victim was vomiting and unable to walk. The victim's father and uncles drove the victim in the family's car to the crew leader's home shortly after 7:30 p.m. The crew leader drove the victim and family members in his van to a hospital, stopping along the way at a medical clinic to seek care, but the clinic had already closed. The victim arrived at a hospital emergency room at approximately 8:30 p.m. and was pronounced dead at 9:28 p.m. by an emergency room physician. Hospital personnel informed the victim's family and the crew leader that the victim had died.

At the time of the victim's admission to the emergency room, family members told hospital personnel that the victim had fallen from his bicycle and hit his head. Because hospital personnel questioned that such extensive injury could have been caused by a fall from a bicycle, they summoned the county coroner and county police to investigate. In the meantime, county police had received several phone calls reporting that a young worker had fallen at a construction site earlier that day. Family members told city police two days later that they had been told by the crew leader to give this story about a fall from a bicycle because the family might be in trouble if police found out that the victim had been injured at work. According to the

construction project coordinator, when he asked the crew leader near the end of the workday (Tuesday, March 9) how the victim was doing, the crew leader told him that the victim was okay. When asked about the victim on March 10th and March 11th, the crew leader, who had been informed of the victim's death the evening of the fall on March 9th, again said the victim was okay. On Saturday morning, March 13, 2004, the news media arrived at the worksite early in the morning and informed the project coordinator they were doing a story on the death of a 16-year-old who had died as a result of a fall at the condominium construction site on Tuesday, March 9th. The condominium developer informed the crew leader's employer of the incident and the crew leader provided a written statement that day to his employer describing his view of what had occurred on the jobsite and related that it was the victim's family's idea, not his, to say the injury happened because of a fall from a bicycle. The crew leader also reported that when he requested the father take the victim to the hospital right after the incident, the victim's father said no that he should take them home. The crew leader's statement was given to his employer on March 13, 2004.

On March 11, 2004, the county detective referred the case to the city police department because it was determined that the victim had been fatally injured at a construction site in the city's jurisdiction. The victim's uncle and his father told a city detective that they had provided false information to the county detective at the hospital. They then described to the city detective the victim's fall at work and the events that followed, including the delay in getting medical attention for the victim. This statement was saved on tape and a copy was given to the DOL Wage and Hour Division investigator.

Because SCOSHA did not learn about the death until several days after it had occurred (the police called SCOSHA and reported the incident on March 12, 2004) and work had progressed by the time of their inspection on March 15, there was little physical evidence remaining at the site to determine the specifications of the elevated work platform from which the victim had fallen. A witness statement obtained from SCOSHA indicated that the work platform was erected between the balcony and the stairwell at the second story level, but according to the SCOSHA compliance officer, the witness was not able to describe the materials that had been used to construct the work platform. SCOSHA's on site investigation revealed that one of the scaffold boards fell with the victim. SCOSHA concluded that workers were not protected against falling from the elevated work platform or from other elevated surfaces, such as the second story stairwell structure. The employer had also failed to provide emergency services, and had not reported the victim's death to SCOSHA. DOL Wage and Hour Division's investigation revealed a violation by the employer of Hazardous Occupations Order # 14 which includes a prohibition against operation of power-driven circular saws by workers less than 18 years old. Their investigation also revealed overtime pay violations.

## CAUSE OF DEATH

The coroner's office reported that the victim's death was caused by a subdural hematoma with cerebral edema.

## RECOMMENDATIONS /DISCUSSION

***Recommendation #1: Employers should ensure that elevated work platforms meet safety requirements and that all employees are provided with fall protection when the potential for falls exists.***

Discussion: Employers are responsible for providing their workers with appropriate means for safely performing their work at elevation, and for providing adequate fall protection and hazard awareness training. OSHA requires scaffolds to meet safety specifications for design and use for different types of scaffolds [for details see 29 CFR 1926.451 (a)] and requires that all workers be protected against falling while working from a scaffold: "Each employee on a scaffold more than 10 feet (3.1 m) above a lower level shall be protected from falling to that lower level." (29 CFR 1926.451)[1]

OSHA's standard 29 CFR 1926.454 [2] identifies employers' responsibility to provide training related to hazards of work on scaffolds, including fall protection. OSHA also addresses an employer's duty to have fall protection where there are unprotected sides and edges in construction work in 29 CFR 1926.501 (b) (1)[3]: "each employee on a walking/working surface (horizontal and vertical surface) with an unprotected side or edge which is 6 feet (1.8m) or more above a lower level shall be protected from falling by the use of guardrail systems, safety net systems, or personal fall arrest systems."

Following the incident, the general contractor assigned workers to install guardrails on all stairwell platforms and balconies and these were in evidence when the DSR investigator visited the site on May 13, 2004. No scaffolds were in use at that time.

***Recommendation #2: Employers should ensure that injured workers are provided with appropriate emergency medical services.***

Discussion: OSHA has a medical services and first aid standardthat construction employers are required to meet [29 CFR 1926.50 (a-f)].[4] "The employer shall ensure the availability of medical personnel for advice and consultation on matters of occupational health"[29 CFR 1926.50(a)]. "Provisions shall be made prior to the commencement of the project for prompt medical attention in case of serious injury" [29 CFR 1926.50 (b)]. "In the absence of an infirmary, clinic, hospital, or physician, that is reasonably accessible in terms of time and distance to the worksite, which is available for the treatment of injured employees, a person who has a valid certificate in first-aid training from the U.S. Bureau of Mines, the American Red Cross, or equivalent training that can be verified by documentary evidence, shall be available at the worksite to render first aid" [29 CFR 1926.50 (c)]. "Proper equipment for prompt transportation of the injured person to a physician or hospital, or a communication system for contacting necessary ambulance service, shall be provided"[ 29 CFR 1926.50 (e).] "In areas where 911 is not available, the telephone numbers of the physician, hospital, or ambulance service, shall be conspicuously posted" [29 CFR 1926.50 (f)].

There was no policy in place at the jobsite regarding how to respond to an injury at work. The area where the incident occurred was within an area where 911 services were available, but no call was made to 911. Falls from elevation, particularly those resulting in a head injury, can lead to serious injuries that may not be immediately apparent to untrained persons. All injuries at work should be reported to the employer who

should ensure that injured workers are evaluated by trained persons who are qualified, as indicated above, to provide prompt emergency medical services.

***Recommendation #3: Employers should develop, implement, and enforce a comprehensive written safety program for all workers which includes training in hazard recognition and the avoidance of unsafe conditions. A written training plan should require training in fall protection for all employees potentially exposed to fall hazards.***

Discussion: A comprehensive written safety program should be developed for all workers which includes training in hazard recognition and the avoidance of unsafe conditions. It should then be noted in a company's comprehensive safety program that certain types of training are required. For example, employers must ensure that all of their employees with a potential for exposure to fall hazards are specifically trained in fall protection and that the training provided meets training requirements set forth in 29 CFR 1926.454[2] and in 29 CFR 1926.503.[5]

Additional information useful for training workers about fall prevention can be found in a NIOSH publication *Worker deaths by falls: a summary of surveillance findings and investigative case reports*[6] which is available through the NIOSH website at http://www.cdc.gov/niosh or by calling 1-800-356-4674. This document may serve as an additional means of communicating safe work procedures to workers.

***Recommendation #4: Employers should ensure that workers who are part of a multilingual workforce comprehend instructions in safe work procedures for which they are assigned and understand their rights in the workplace.***

Discussion: Companies that employ workers who do not understand English should identify the languages spoken by their employees, and design, implement, and enforce a multi-language safety program. To the extent feasible, the safety program should be developed at a literacy level that corresponds with the literacy level of the company's workforce. Employers should evaluate each employee's comprehension of safe work procedures through testing and observation. The program, in addition to being multi-language, should include a competent interpreter to explain workers' rights to protection in the workplace, safe work practices workers are expected to adhere to, specific protection for all tasks performed, ways to identify and avoid hazards, and who they should contact when safety and health issues arise. Had the victim's family understood that employers are responsible for obtaining necessary care for injured workers and that workers have a right to this care, emergency care might have been sought immediately following the incident.

***Recommendation #5: Employers should pursue every feasible means to obtain the authentic age of each worker hired and establish work policies that comply with child labor laws prohibiting youths less than 18 years of age from performing hazardous work including, for example, operating power-driven circular saws. Employers should communicate these work policies to all employees.***

Discussion: Employers should ensure that the authentic age of each prospective employee is determined before hire and that workers less than 18 years old are not assigned to perform prohibited work.

29 CFR 516.2 (a)(3) requires that employers have on file the date of birth for all employees under age 19 who are subject to minimum wage and overtime provisions [29 CFR 516.2 (a)(3)].[7] If employers do not fully understand the types of work prohibited for workers under the age of 18, they should contact the U.S. Department of Labor, Employment Standards Administration (ESA), Wage and Hour Division. This Division enforces child labor laws under the Fair Labor Standards Act (FLSA).

The FLSA prohibits employment of workers younger than age 18 in nonagricultural occupations which the Secretary of Labor has declared to be particularly hazardous. Hazardous Order (HO) No.14 prohibits persons below the age of 18 from operating power-driven circular saws. Child labor information can be obtained by visiting the DOL ESA website at www.dol.gov/esa. FLSA employment standards for nonagricultural occupations are listed and explained in Child Labor Bulletin 101.[8] Child labor information can also be obtained by calling or visiting offices of Federal and State child labor departments, located by using the telephone directory government pages.

Employers should meet with their workforce to communicate the company's policies regarding appropriate work assignments for young workers. They should explain that young workers are at increased risk for injury at work and reinforce the importance of assigning youths to appropriate work tasks. They should provide all staff with a description of the young worker's assignments. They should identify the person(s) responsible for supervision of young workers, inform all staff about assigned supervisors, and direct staff to notify supervisors immediately if they see young workers performing hazardous work or working outside their assigned tasks. Resources for training young workers can be found in a NIOSH *Alert: Preventing Deaths, Injuries and Illnesses of Young Workers*[9] available through the NIOSH website at http://www.cdc.gov/niosh or by calling 1-800-356-4674.

***Recommendation #6: Employers should ensure that the nearest area office of the Occupational Safety and Health Administration is notified within 8 hours of a fatality or in-patient hospitalizations of three or more workers as a result of a work-related incident at their company.***

Discussion: Within 8 hours after the death of any employee for a work-related incident or the inpatient hospitalization of three or more employees as a result of a work related incident, employers must report the fatality/multiple hospitalizations by telephone or in person to the area office of the Occupational Safety and Health Administration (OSHA), U.S. Department of Labor, that is nearest to the site of the incident. Employers may also use the OSHA toll free central telephone number, 1-800-321-OSHA (1-800-321-6742) [29CFR 1904.39(a)].[10] This early reporting allows OSHA investigators to accurately assess the hazards present and to remove other workers from potentially hazardous situations. In this incident, the employers did not report the fatality as required.

***Recommendation #7: General contractors should ensure through contract language that all subcontractors have a comprehensive safety and health program that addresses all aspects of the jobs they and their workers will perform; accident investigation and emergency services procedures; and age and employment eligibility documentation for all employees that will work on the worksite.***

Discussion: General contractors should ensure thorough contract language that all subcontractors have a comprehensive safety program that appropriately addresses the tasks their workers perform. As previously stated, in this instance a bilingual safety program may have allowed workers to better understand the safe way to perform framing work. The contractual language should address how medical services and first aid will be provided as well as a statement that all contractors will follow DOL Wage and Hour Hazardous Orders, hours of work requirements, and compensation requirements. Additionally, contract language should include statements that age and employment eligibility will be documented for each employee. General contractors should consider requiring subcontractors to provide them with a copy of the U.S. Department of Homeland Security, U.S. Citizenship & Immigration Service Form I-9 (Employment Eligibility Verification Form) for all employees used on the construction site. Immigration laws require that all workers (regardless of country of origin) prove they are authorized to work in the United States. Employers are required to attest on Form I-9 that the documentation appears to be genuine at the time of examination.[11] Form I-9 can be downloaded at ***http://uscis.gov/graphics/formsfee/forms/i-9.htm*** [Accessed August, 2004].

***Recommendation #8: The U.S. Department of Labor and employers should consider prohibiting youth less than 18 years of age from working at a height of 6 feet or more from ladders, scaffolds, trees, structures and machinery.***

Current child labor laws prohibiting especially dangerous types of work for youth (Hazardous Orders) prohibit work in roofing occupations, but do not prohibit other types of work at heights. At the request of the US Department of Labor (DOL), NIOSH recently conducted a review of the Hazardous Orders.[12] Among other recommendations, NIOSH recommended that DOL establish a new Hazardous Order to prohibit youth less than 18 years of age from working "at a height of 6 feet or more from ladders; scaffolds; trees; and structures including towers, silos, poles, oil rigs, bridges; and antennas; and machinery." This recommendation was based on a review of occupational injury data and the need for personal protective equipment and strict adherence to safe work practices to protect workers in environments with significant fall hazards. Falls consistently rank among the leading causes of occupational injury deaths.[13] An analysis of deaths of young workers for the years 1992-1997 identified 21 fatal falls to a lower level among youth less than 18 years of age.[12] The fit and effectiveness of personal fall arrest systems have not been specifically tested for young workers who may not have reached the stature and body dimensions of adult workers for whom they were designed. Although federal child labor laws do not currently restrict youth from working at heights, employers should strongly consider prohibiting this type of work given the inherent risks and questions about the ability to provide youth with adequate protection in the event of a fall.

## REFERENCES

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## INVESTIGATOR INFORMATION

This investigation was conducted by Doloris N. Higgins, Safety and Occupational Health Specialist, Fatality Investigations Team, Surveillance and Field Investigations Branch, Division of Safety Research.

*Photo 1. This photo illustrates condominium #48 (Photograph courtesy of SCOSHA).*


*Photo 2. This photo illustrates a close-up view of the condominium stairwell and balcony. A white rectangular box illustrates the approximate location of the elevated work platform from which the victim fell. The letter A is used to identify the victim's approximate location before the fall and the letter B is used to identify the victim's approximate location after the fall [Photograph courtesy of SCOSHA (the white rectangular box and letters A and B were added by the DSR investigator)].*