



The National Institute for Occupational Safety and Health (NIOSH)

Promoting productive workplaces
through safety and health research



Carpenter Dies After Falling 17 Feet From A Scaffold– South Carolina

FACE 9415

SUMMARY

A 28-year-old male carpenter (the victim) died after falling from a scaffold and striking his head on the ground. The victim and two co-workers had been assigned to install soffit board around the roof overhang of a private residence that was under construction. A co-worker observed the victim standing on the scaffold platform, nailing a board to the roof overhang, when he either lost his balance and fell, or became ill and fell onto the scaffold. He sat upright and started leaning to his right. At that time, a co-worker yelled to another co-worker in the area, to grab the victim as he might fall off the scaffold. Seconds later, the victim toppled off the unguarded scaffold, 17 feet to the ground, striking his head. The co-workers ran to the victim and found him unconscious and not breathing. One co-worker started cardiopulmonary resuscitation, while the other co-worker called for an ambulance. The ambulance and coroner arrived about the same time and the coroner pronounced the victim dead at the scene. NIOSH investigators concluded that, to prevent similar occurrences, employers should:

- **provide adequate guarding on scaffolding**
- **develop, implement, and enforce a comprehensive written safety program**
- **utilize contract language that requires sub-contractors to implement a site-specific safety and health program prior to the initiation of work**
- **routinely conduct scheduled and unscheduled workplace safety inspections**
- **encourage workers to actively participate in workplace safety.**

INTRODUCTION

On June 22, 1994, a 28-year-old male carpenter (the victim) died from injuries received in a 17-foot fall from a scaffold. On July 23, 1994, officials of the South Carolina Occupational Safety and Health Administration (SCOSHA) notified the Division of Safety Research (DSR) of this fatality, and requested technical assistance. On September 21, 1994, a DSR safety specialist conducted an investigation of this incident. The incident was reviewed with the employer, county coroner, and SCOSHA compliance officer assigned to the case. Police and coroner's reports were obtained during the investigation.

The employer was a roofing contractor that had been in business for 12 years and employed four workers, all of whom were carpenters. The employer had no written safety program, but informal safety talks were said to have been given at each job- site. The victim had been employed for 1 day prior to the incident, and had about 4 years experience as a carpenter. This was the first fatality experienced by the employer.

INVESTIGATION

The employer had been subcontracted to do outside trim work at a residence under construction in a private residential housing community. The house was a two-story wood and aluminum structure, and work had been in progress for about 2 days prior to the incident.

On the day of the incident, the workers (victim and two co-workers), arrived at the jobsite about 6:30 a.m., and were assigned to install soffit boards around the roof overhang of the house. Two carpenter's bracket scaffolds (i.e., scaffolds consisting of wood or metal brackets supporting a platform), were erected on opposite sides of the house. The scaffold from which the victim fell was 17 feet high and the platform consisted of one board (2-inches thick by 12-inches wide, which extended to a length of about 29 feet and was about 18 inches from the wall of the house. The platform, which was not protected by any guardrails, was supported by five pieces of angle iron irregularly spaced and attached to the studs of the house (Figure). The victim had been working from the platform nailing soffit boards to the overhang of the roof when the incident occurred. He was observed by a co-worker bending over, just prior to falling to the platform. It is unknown whether the victim became ill or lost his balance and fell to the platform; however, earlier that morning the victim had been complaining of chest pains but refused to go to the hospital for an examination. After the victim fell to the scaffold platform, he sat upright and began leaning over to his right. The co-worker on the ground had witnessed the event and yelled to the other co-worker, who was inside the house by the bay window, to grab the victim as he might fall off the platform. Seconds later, the victim toppled off the end of the unguarded scaffold, 17 feet to the ground, striking his head. The co-workers ran to the victim and found him unconscious and not breathing. One co-worker started cardiopulmonary resuscitation, while the other co-worker called for an ambulance. The ambulance and coroner both arrived about 10 minutes after being notified and the coroner pronounced the victim dead at the scene.

CAUSE OF DEATH

The coroner's report listed the cause of death as severe head injury and fractured cervical spine.

RECOMMENDATIONS/DISCUSSION

Recommendation #1: Employers should provide adequate guarding on scaffolding.

Discussion: The victim was nailing soffit boards to a roof overhang while standing on an unguarded scaffold platform. Guarding of the scaffold platform, as required by CFR 1926.451 (a)(4), which states "Guardrails and toeboards shall be installed on all open sides and ends of platforms more than 10 feet above the ground or floor," was not present.

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

Discussion: The employer did not have a written safety program. The development, implementation, and enforcement of a comprehensive safety program should reduce and/or eliminate worker exposures to hazardous situations. The safety program should include, but not be limited to, protecting scaffold platforms with appropriate guardrailing and toeboards, the recognition and avoidance of fall hazards, and the use of appropriate safety equipment such as safety nets or safety belts and lanyards.

Recommendation #3: Employers should utilize contract language that requires sub-contractors to implement a site specific safety and health program prior to the initiation of work.

Discussion: General and subcontractors should use contract language that requires all subcontractors to identify how they intend to implement a site-specific safety and health program prior to the initiation of work. Subcontractors' safety programs should be consistent and compatible with the general contractor's safety program. The contract should contain clear and concise language as to which party is responsible for a given safety or health issue. Any differences should be negotiated before work begins. Once the provisions for these responsibilities have been established, the respective parties should ensure that the provisions of the contract regarding safety and health are upheld.

Recommendation #4: Employers should routinely conduct scheduled and unscheduled workplace safety inspections.

Discussion: Employers should be cognizant of the hazardous conditions at jobsites and take an active role to eliminate them. Additionally, scheduled and unscheduled safety inspections should be conducted by a competent person to ensure that jobsites are free of hazardous conditions. Even though these inspections do not guarantee the elimination of occupational injury, they do demonstrate the employer's commitment to the enforcement of the safety program and to the prevention of occupational injury.

Recommendation #5: Employers should encourage workers to actively participate in workplace safety.

Discussion: Employers should encourage all workers to actively participate in workplace safety and should ensure that all workers understand the role they play in the prevention of occupational injury. In this instance, the victim was working from a platform 17 feet from the ground without any guarding. Workers and co-workers should look out for one another's safety and remind each other of the proper way to perform their tasks. Employers must instruct workers of their responsibility to participate in making the workplace safer. Increased worker participation will aid in the prevention of occupational injury.

REFERENCES

29 CFR 1926.451 (a)(4) Code of Federal Regulations, Washington, D.C.: U.S. Government Printing Office, Office of the Federal Register.

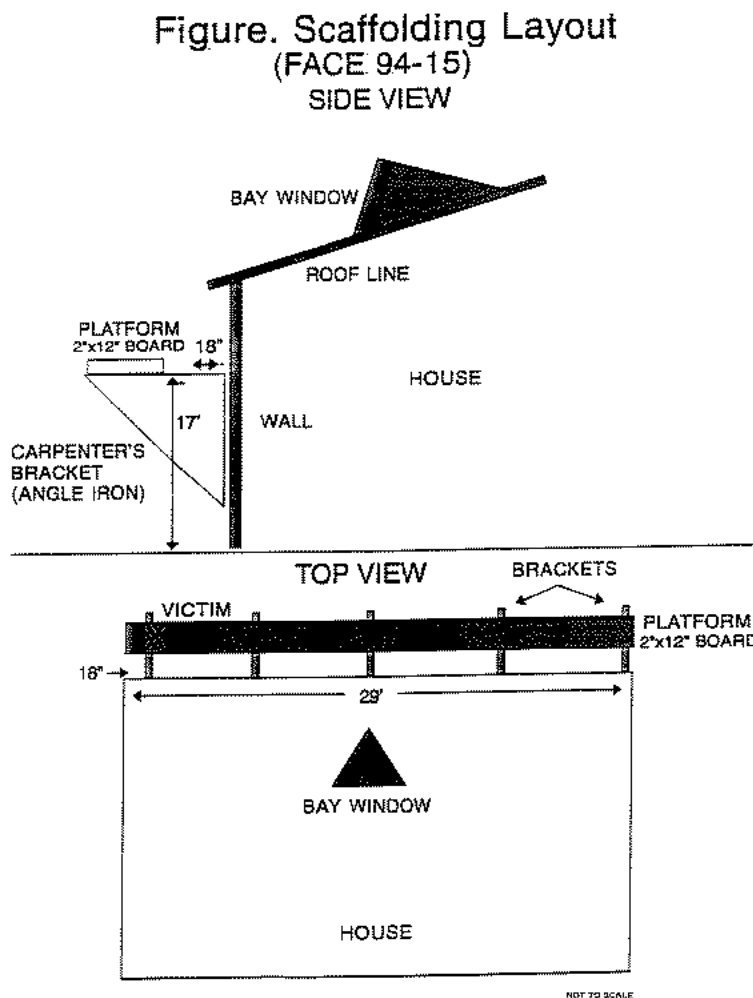


Figure.

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Not helpful

Very helpful