Meat Packing Plant Employee Dies After Fall From Platform – South Carolina

FACE 9409

SUMMARY

A 41-year-old male meat packing plant employee (the victim) died after falling from a platform during the knocking portion of a beef cattle slaughter operation. Knocking involves stunning beef cattle by an electrical shock before slaughtering them. The victim and two co-workers were working at a point in the operation when beef cattle were chased into a chute, knocked or stunned, then slaughtered. The workers were alternating the jobs of chasing, knocking, and slaughtering the cattle. At the time of the incident, the victim and a co-worker were standing on a platform in the knocking area. The platform was 29 inches high and was accessed by 2 steps. As the victim and co-worker waited for the next animal, they entered into an argument and the victim either had a seizure and fell backward, or was bumped by the co-worker and fell backward down the steps of the platform, striking his head. The second co-worker called to the supervisor for help, then ran with the supervisor to the victim. The victim was lying on his back with his feet still on the steps and his hard hat on his head. He was conscious but incoherent, and was bleeding from a cut on the left side of his head. The emergency medical service (EMS) was summoned and the EMS transferred the victim to the hospital where he died 9 days later. NIOSH investigators concluded that, in order to prevent similar incidents, employers should:

- **consider guarding all sides of elevated work platforms**
- **monitor employees for disruptive, erratic, or impaired behavior**
- **employers should consider offering employee assistance programs to provide help to employees whose job performance becomes impaired due to some medical-behavioral problem, including alcohol-related problems, drug abuse, or mental health problems.**

INTRODUCTION

On February 12, 1994, a 41-year-old male meat packing plant employee (the victim) died after falling backward off a 29-inch-high platform and striking his head on a concrete floor. On February 22, 1994, officials of the Occupational Safety and Health Administration for the State of South Carolina (SCOSHA) notified the Division of Safety Research (DSR) of this fatality, and requested technical assistance. On March 23, 1994, a DSR safety specialist traveled to the incident site to conduct an investigation. The incident was reviewed with the SCOSHA compliance officer assigned to the case and the investigating officer from the sheriff's department. Photographs of the site taken immediately following the incident were reviewed during the investigation.

The employer was a wholesale beef processing and packing plant that had been in operation for 50 years and employed 170 workers. The employer had a written safety policy and written safe work procedures. The employer provided hard hats, safety shoes, ear plugs, steel mesh aprons, and rubber, cotton, steel-mesh, and kevlar gloves to workers as necessary. Disciplinary procedures were in place that included verbal and written warnings up to dismissal. Workers were instructed to report hazards to their supervisors, and supervisors checked equipment on an ongoing basis. Forklift operators received structured training and all workers received basic training on hazard communication and confined space safety. Supervisors were responsible to see that safety rules were followed and were instructed that if alcohol abuse by a worker was suspected, or if a worker was observed acting in an impaired fashion, to send that person home and alert management of the situation. This was the first fatality experienced by the employer.

INVESTIGATION

The plant operated on a three-shift basis with slaughtering and butchering processes conducted during the first shift (7 a.m. to 5 p.m.) and plant and machinery cleanup occurring during the remaining two shifts.

Cattle were delivered to the plant in trucks and unloaded into a barn. At the appropriate time, the cattle were chased through chutes to the knocking area where they were held temporarily. A worker standing on the 232-inch-wide by 71-inch-long by 29-inch-high knocking platform then stunned the animals with an electrical charge (Figure). The platform was accessed by two steps and was guarded by guardrails on all sides but the entry. The cattle were stunned and slaughtered. After being hung on hooks, the carcasses were disemboweled, skinned and split, then taken to coolers where they were later either boned out and cut to order or shipped as hanging sides of beef.

At 3 p.m., the victim and two co-workers were working in the knocking area. The three men were alternating the jobs of chasing the cattle to the knocking area, and knocking and slaughtering the cattle.

The victim and a co-worker, standing on the 29-inch-high knocking platform, entered into an argument. The victim either lost his balance, or was bumped by the co-worker and fell backward off the knocking platform. A third co-worker saw the victim fall and called to a supervisor who was standing nearby at a meat cooler with his back to the knocking platform. The supervisor ran to the platform and found the victim lying on his back on the floor. The victim's feet were resting on the 13-inch high first step and his hard hat was still on his head, although the victim was bleeding from a cut on the left side of his head. The emergency medical service (EMS) was summoned by phone from the plant office and arrived shortly thereafter. The victim was transported to the hospital where he died 9 days later.

Plant records revealed that the victim had a history of seizures. One of the responding emergency medical technicians stated that the victim displayed symptoms that were indicative of a seizure. Toxicology results revealed that the victim had a blood alcohol level of .24. The victim had been terminated in 1992 for carrying alcohol into the plant, but was later rehired.

CAUSE OF DEATH

The medical examiner's report is not yet complete.

RECOMMENDATIONS/DISCUSSION

Recommendation #1: Employers should consider guarding all sides of elevated work platforms.

Discussion: Three sides of the elevated knocking platform were protected by guardrails at the perimeter, leaving unguarded the side where the steps were located. A spring-loaded, one-way gate could be installed on this side. The gate would have to be pulled open from inside the perimeter to access the steps, and would lessen the possibility of an inadvertent fall from the platform.

Recommendation #2: Employers should monitor employees for disruptive, erratic, or impaired behavior.

Discussion: Employees should be monitored by employers or supervisors for unusual, erratic, disruptive, or impaired behavior at the jobsite. When this type of behavior is observed, the supervisor should evaluate the situation, and the employee, and take immediate, appropriate action.

Recommendation #3: Employers should consider offering employee assistance programs to provide help to employees whose job performance becomes impaired due to some medical-behavioral problem, including alcohol-related problems, drug abuse, or mental health problems.

Discussion: Although the role of alcohol in this incident is unclear, the victim had an excessive blood alcohol level and had been previously terminated for bringing alcohol into the plant. Employer sponsored assistance programs to help restore employees to optimal performance should be made available to all employees.

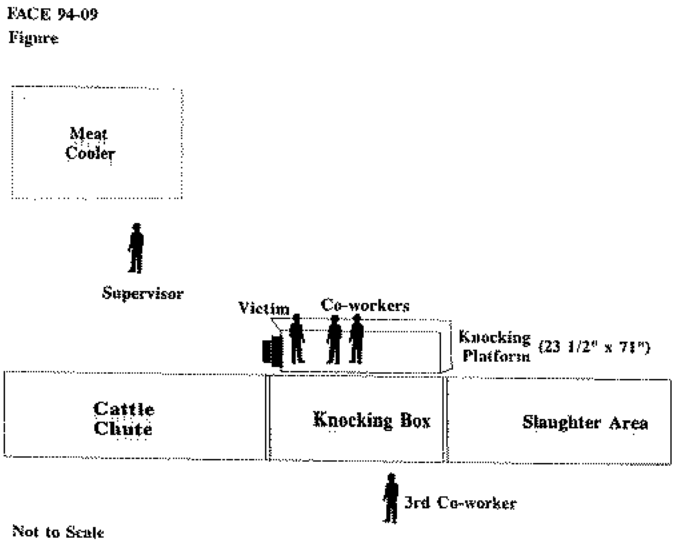

Figure.

Return to In-house FACE reports

Last Reviewed: November 18, 2015