The National Institute for Occupational Safety and Health (NIOSH)

Promoting productive workplaces through safety and health research

Decapitation of a Construction Foreman

FACE 8201

INTRODUCTION

The National Institute for Occupational Safety and Health's (NIOSH's) Division of Safety Research (DSR) is currently conducting the Fatal Accident Circumstances and Epidemiology (FACE) Study. By scientifically collecting data for a sample of similar fatal incidents, this study will. identify and rank factors which increase the risk of fatal injury for selected employees.

On May 18, 1982, a 59-year-old foreman with 22 years experience was supervising construction on a subway tunnel in an eastern city. While tagging a load being moved by a crane, the foreman was struck in the head by the crane's boom and killed. The NIOSH regional consultant notified DSR about this fatality on May 18, 1982.

CONTACTS /ACTIVITIES

Subsequent to receiving notification, DSR sent a research team consisting of an epidemiologist and safety engineer to visit the company and survey the incident site on May 21, 1982. Prior to going in the field, approval for the-visit and survey was obtained from the corporate safety director who was in another state. Unfortunately, when the research team arrived, the site was closed down. Therefore, available information was obtained from an OSHA representative who was familiar with the fatal incident. A brief meeting was also held with the corporate safety director.

SYNOPSIS OF EVENTS

The deceased was handling the tagline on a crane-connected load which was being lowered into a subway work area. The crane did not have the outriggers extended nor set on the ground. As the load was being lowered, it became caught on a ledge out of the operator's sight. When this occurred, the operator thought the load was at its desired resting place and continued to lower the load line for disconnecting. As the line lowered, it became slack. The load then dropped from the ledge and with the sudden impact, the load caused the crane to tip over. The boom then lowered toward the ground and struck the deceased in the head.

GENERAL CONCLUSIONS AND RECOMMENDATIONS

The major etiologic factor for this fatal incident was the non usage of the outriggers to stabilize the crane while handling loads. The crane was probably used in this manner to minimize the street area blocked; if the outriggers had been used, another lane of traffic would have been blocked off.

It is recommended that future efforts be made to stress the importance of and strictly enforce the proper usage of outriggers on rubber-tired cranes while handling all loads. It may also be advantageous to educate personnel who tag crane loads to observe both the load and crane.

Return to In-house FACE reports

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