FINAL FACE REPORT

CALIFORNIA DEPT. OF HEALTH SERVICES
FACE REPORT: 93CA00401
DATE: OCTOBER 26, 1993

TO: **Director, National Institute for Occupational Safety and Health**

FROM: **California Fatality Assessment and Control Evaluation (FACE) Program**

SUBJECT: **Plant Supervisor Falls from Loading Dock and Dies in California**

SUMMARY

A 68-year-old white male plant supervisor fell approximately six feet from a loading dock and died several days later. He (victim) was climbing down from the loading dock to help co-workers unload a truck. Co-workers heard a noise and when they turned to look they saw the victim lying on the ground. Paramedics were summoned to the scene. The CaFACE investigator concluded that, in order to prevent similar future occurrences, employers should:

- Install stairwells in pathways that employees frequently use
- Train employees to recognize and avoid hazards, and implement safe work policies including task specific procedures
- Have employees trained in first aid and cardiopulmonary resuscitation (CPR)

INTRODUCTION

On April 9, 1993 a 68-year-old white male plant supervisor (victim) fell approximately six feet and died several days later on April 12. The CaFACE investigator was informed of the incident by the

Los Angeles County Coroner's office on April 15, 1993. The investigator went to the incident site that afternoon (April 15) and interviewed the company owner and the warehouse manager. A site investigation and interviews were conducted by the CaFACE investigator, photographs were taken. A copy of the Coroner's Autopsy Report and the Cal/OSHA Report were obtained by the CaFACE investigator.

The employer in this incident was a manufacturer and distributor of bowling equipment. The company had been in operation for 55 years although the original company became two separate companies (one international and one domestic) in 1972. The victim had worked for the two companies a total of 26 years. The company had been located at the incident site for only six months. There were 48 employees who worked for the company. The victim was the only employee with the job title of plant supervisor. There were two safety officers on staff who devoted approximately 25% of their time to safety issues, and were located a short distance (within 5 minutes) from the incident site. The company provided on the job safety training, manuals, and other types of worker safety training such as forklift and electrical training. Their Illness and Injury plan met all of the requirements under the
Cal/OSHA regulations.

INVESTIGATION

On the day of the incident, at approximately 2:15 pm, the victim

fell while climbing down a six foot loading dock, striking his head on an asphalt driveway below. The surface at the site was dry. No one witnessed the victim falling, although co-workers heard a "thud" and subsequently saw the victim lying in the driveway. He (victim) had been making his way over to a truck which was parked approximately 50 yards from the loading dock.

After the incident occurred co-workers went over to the victim and observed that he was bleeding from the mouth and ears. Paramedics were immediately summoned by co-workers and one co-worker placed a shirt under the victim's head. A fire truck arrived within five minutes, but the ambulance took approximately 20 minutes to get to the incident site. The company president stated that the ambulance had gone to the wrong address before finally arriving. The victim was transported to a local hospital. Information (Form 1) obtained from the hospital stated the victim underwent a CT brain scan on April 9th which revealed a "small left subdural hematoma, diffuse edema, scattered small contusions, largest at the left frontal lobe, and left cerebellar edema..." There was no surgical intervention other than placement of an intracranial pressure monitor. The victim was on life support systems for three days before his family requested that the support be withdrawn. The victim was pronounced dead on April 12, 1993 at 7:13 p.m.

CAUSE OF DEATH

The Coroner's Autopsy Report stated the victim died from cranio-cerebral trauma due to a blunt force injury.

RECOMMENDATIONS/DISCUSSION

Recommendation #1: Employers and builders (industrial architects) should install stairwells in pathways frequently used by employees.

Discussion: The victim in this incident climbed down from the loading dock on many occasions. Since this seemed to be a pathway commonly used by the victim and other employees, a stairway should have been constructed so that employees would have had a safe and efficient means of access to the driveway. Under Title 8 of the California Code of Regulations (CCRs) section 1629 (3), stairways, ramps, or ladders shall be provided at all points where a break in elevation of 18 inches or more occurs in a frequently traveled passageway, entry or exit.

Recommendation #2: Employers should provide for training of employees in hazard recognition and avoidance, and safe work policies including task specific procedures.

Discussion: Safety awareness and training could also have alerted employees and supervisors to the unsafe behavior in the workplace in this incident. No alternative pathway to the loading dock existed other than climbing down a the victim had done.

Recommendation #3: Employers should have employees trained in

first aid and cardiopulmonary resuscitation (CPR).

Discussion: A company standard operating procedure (SOP) should address the need to have personnel at the workplace trained in CPR and first aid.