

The Missouri Department of Health, in cooperation with the National Institute for Occupational Safety and Health (NIOSH), is conducting a research project on work related fatalities in Missouri. The goal of this project, Missouri Occupational Fatality Assessment and Control Evaluation (MO FACE), is to show a measurable reduction in traumatic occupational fatalities in the State of Missouri. This goal will be met by identifying causal and risk factors that contribute to work-related fatalities. The identification of these factors will enable more effective intervention strategies to be developed and implemented by employers and employees. This project does not determine fault or legal liability associated with a fatal incident or with current regulations. All MO FACE data will be reported to NIOSH for trend analysis on a national basis. This will help NIOSH provide employers with effective recommendations for injury prevention. All personal/company identifiers are removed from all reports sent to NIOSH to protect the confidentiality of those who voluntarily participate with the program.

FACE INVESTIGATION: # **92MO03001**

SUBJECT:

Carpenter Helper Dies Following Fall from Motorized Utility Cart in Missouri.

SUMMARY:

A 19-year-old carpenter helper died after falling out of a John Deere motorized utility cart. The victim was riding in the right side passenger seat when the cart made a sudden turn to the left and the victim fell out, striking his head on the pavement. Although the cart was equipped with hand holds and warning signs identifying this hazard, they may not have been utilized. The MO FACE investigator concluded that, in order to prevent future similar occurrences, employers should:

- * develop, implement and enforce a comprehensive safety program that includes, but is not limited to, training in hazard recognition and avoidance.**

INTRODUCTION:

On August 8, 1992, a 19-year-old carpenter helper died as a result of injuries he received falling out of a John Deere motorized utility cart. The Occupational Safety and Health Administration did not investigate the incident, because they do not have jurisdiction over government agencies in Missouri. The MO FACE Investigator conducted an investigation of the incident site and interviewed the employer and the victims supervisor. Records regarding this incident were obtained and they include the police report, the death certificate, and site photographs.

The employer in this incident is a county employment agency that conducts a Federal work/study

program. Workers enrolled in this program are utilized by a local city's parks and recreation department. The agency has been in operation for approximately 20 years, and employs 18 persons in the work/study program. Six of these workers had the same job title as the victim. The victim had been working in this program for little more than a month. The employer has a safety officer devoting up to 25% of her time to a safety and health program. The employer had written safety rules and procedures for the operation of this utility cart, as well as, for all tasks performed by employees. Workers received on-the-job and classroom training, as well as two separate orientations: one from the employment agency, and one from the parks and recreation department. The victim was not wearing any personal protective equipment at the time of the incident.

INVESTIGATION:

The employer operates a Youth Services Conservation Corps. This program employs 10 to 20 youths for six-month periods. These youths are utilized by the area parks and recreation department to build and maintain the city and county parks. This program is designed to train youths in a building trade as they complete their general-equivalency diploma. They may then have the experience and education to seek employment in the private sector.

On the day of the incident, the victim and co-workers had been participating in the construction of a covered shelter at one of the area parks. The driver and two passengers, one in a right side passenger seat (victim) and one in the utility bed, climbed into the cart and proceeded to a different area of the park. The crew was traveling along a paved parking lot area when the victim was reportedly leaning out of the right side of the cart. The driver inadvertently swerved to the left to avoid the water spray of a lawn sprinkler, which caused the victim to fall out of the passenger seat, striking his head on the pavement.

The driver immediately stopped the vehicle and went to aid the victim. Emergency personnel were summoned to the scene, and the victim was transported to a local hospital and treated for head injuries. The victim survived five days before he died of closed head trauma.

CAUSE OF DEATH:

Closed Head Trauma.

RECOMMENDATION/DISCUSSION:

RECOMMENDATION #1.

Employers should develop, implement and enforce a comprehensive safety program that includes, but is not limited to, training in hazard recognition.

DISCUSSION: Employers should emphasize the safety of their employees by developing, implementing, and enforcing a comprehensive safety program. The safety program should include, but not be limited to, training workers in the proper selection and use of personal protection equipment, along with the recognition and avoidance of hazards.

This employer did have and did enforce a comprehensive training program. We want to emphasize that all employers need to stress to their employees the importance of recognizing and avoiding all hazards in the workplace. Even with their safety program in place, and with signs placed in several highly visible areas on this vehicle warning of these potential hazards, the workers failed to comply. The workers involved in this incident just did not realize the potential hazards of traveling in this motorized cart. Employers should train supervisors and employees to recognize and avoid workplace hazards.

SIGNATURES:

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