MARYLAND DIVISION OF LABOR AND INDUSTRY
MARYLAND FACE PROGRAM
CASE:94024
DATE:

To:Project Officer, State FACE Project, Division of Safety Research, NIOSH, CDC

From:Maryland FACE Program, Division of Labor and Industry

Subject:45-year-old drywall installer dies after falling 5'4" from a mobile scaffold--Maryland

SUMMARY

The 45-year-old owner of a drywall installation company fell 5' 4" from a portable Baker scaffold and fatally injured himself. The victim was working on a commercial remodelling job installing metal studs to hang drywall. The Baker scaffold had no guardrails installed and no personal protective equipment (PPE) was being utilized. The victim was working and simultaneously conversing with the general contractor's site superintendent when he abruptly stopped speaking and fell forward off of the scaffold striking the concrete floor face first. The site superintendent called 911 immediately on a portable telephone, while another employee turned the victim onto his back. The site superintendent then ran downstairs to seek assistance from medical personnel in a nearby office. The first responders rendered aid until the emergency medical service personnel arrived several minutes later. The victim was taken by helicopter to the Shock Trauma Center where he was pronounced dead 84 minutes later.

The Maryland FACE investigator concluded that to prevent similar incidents in the future employers should:

develop, implement, and enforce a safety and health program that addresses safe work procedures and hazard recognition.

ensure that the structural components and safety features of scaffolds are in good working order and used in accordance with the requirements of the manufacturer.

be sure that health problems of employees which may compromise safe work practices are treated promptly to minimize the risk of injury.

INTRODUCTION

On May 19, 1994 the 45-year-old owner of a drywall installation company died from injuries sustained when he fell 5'4" from a portable Baker scaffold. On May 20, 1994 the Maryland Occupational Safety and Health Operations Supervisor contacted the Maryland FACE program to report the fatality. A site visit was made the same morning and subsequent interviews were conducted with a witness and the Occupational Safety and Health Inspector assigned to the case. Photographs of the incident site and the Medical Examiner's report were reviewed.

The employer was a sub-contractor responsible for drywall installation and other interior finish remodelling. The owner/victim had four employees working for him and had been in business for eight years. All of the employees were on the site the day of the incident. One employee was in the same part of the building as the victim, but did not witness the fall.

The employer had no written safety program and conducted no formal training for the employees. No regularly scheduled safety meetings were held, but the employer did frequently discuss safe work practices with employees and encouraged them to work safely.

INVESTIGATION

On the day of the incident the victim was installing metal studs to support new interior walls in a commercial building that was being remodelled. The victim was working from a portable rolling scaffold, the platform of which was 5'4" from the ground level. The scaffold had no guardrails in place and no other PPE was in use by the victim. The incident site was an office suite on the second floor of a two story building that had been gutted in preparation for the remodelling being performed.

The victim was working independently installing metal studs to support the drywall. The site superintendent for the general contractor came into the room and engaged the victim in conversation as he continued working. An employee of the victim was working on the opposite side of the room, but was not facing the area where the victim was working and did not witness the fall.

The site superintendent turned away from the victim and was walking away while the victim was speaking. The victim stopped speaking abruptly. The site superintendent was approximately twenty feet away when he turned to see the victim falling forward off of the scaffold. The victim struck the concrete floor face first and began to bleed immediately. The site superintendent (the witness) called 911 from the mobile phone he was carrying while the other employee ran to the victim and rolled him onto his back. The site superintendent went to a nearby medical office to seek assistance. A physician and an assistant came to the aid of the victim and rendered first aid until the EMS personnel arrived several minutes later. The victim was unconscious after falling , but briefly regained consciousness before being transported from the scene. He was taken by helicopter to the Shock Trauma Center where he was pronounced dead 84 minutes later.

It was reported that the victim had been having "dizzy spells" for several days prior to the incident. The existence of a medical complication, such as a

"dizzy spell", or a temporary loss of consciousness, may have precipitated the victim losing his balance.

CAUSE OF DEATH

The cause of death listed on the death certificate by the Office of the Chief Medical Examiner was: *hypertensive arteriosclerotic cardiovascular disease complicating multiple injuries*.

RECOMMENDATIONS/DISCUSSION

Recommendation #1:Employers should develop, implement, and enforce a safety and health program that addresses safe work procedures and hazard recognition.

Discussion: The employer had no safety and health program as required by 29 CFR 1926.20(b) which provides for the implementation of a safety and health program. A safety and health program as defined by the standard provides the regular inspection of the job-site, materials, and equipment by a competent person[1]. The presence of such a program could have prevented this injury through heightened sensitivity to hazard recognition and the establishment of safe work procedures regarding the use of safety equipment.

Recommendation #2: Employers should ensure that the structural components and safety features of scaffolds are in good working order and used in accordance with the requirements of the manufacturer.

Discussion: The employer was utilizing a scaffold that had fittings that would have allowed for the placement of guardrails that may have been able to prevent a fall from the work platform. The use of guardrails is required by 29 CFR 1926.451(a)(4) for scaffolds between four and ten feet in height.

[1] Competent person - one who is capable of identifying existing and predictable hazards in the surroundings or working conditions which are unsanitary, hazardous, or dangerous to employees, and who has authority to take prompt corrective measures to eliminate them.

Recommendation #3: Employers should be sure that health problems of employees which may compromise safe work practices are treated promptly to minimize the risk of injury.

Discussion: The employer had reportedly been having "dizzy spells" prior to his fall. Recognition of the risks involved when working at elevations should have kept this individual from exposing himself to such a hazard, given the medical complications he was experiencing.

REFERENCES

29 CFR 1926 Code of Federal Regulations, Office of the Federal Register, Washington, D.C.

Aaron Ira Schneiderman, R.N., M.P.H.
Field Investigator
Maryland FACE Program
Division of Labor and Industry

Letha Ticer
Principal Investigator
Maryland FACE Program
Division of Labor and Industry

Fatality Assessment and Control Evaluation

The Maryland Division of Labor and Industry administers the Fatality Assessment and Control Evaluation (FACE) Program under a cooperative agreement with the National Institute for Occupational Safety and Health, Division of Safety Research (NIOSH/DSR). The Maryland FACE Program performs investigations of selected occupational fatalities, prepares summary reports, and engages in prevention activities. The goal of our program is to prevent fatal work injuries in the future by studying the working environment, the worker, the task being performed, the tools employed, the energy exchange resulting in fatal injury, and the role of management in controlling how these factors interact.

NIOSH/DSR developed the FACE research protocol in the early 1980s and continues to perform FACE investigations. To increase the research and prevention activities of NIOSH/DSR, states across the nation have been invited to participate in the State FACE Project. Maryland and the fourteen states listed below currently participate in the State Based FACE Project: Alaska, California, Colorado, Georgia, Iowa, Indiana, Kentucky, Massachusetts, Minnesota, Missouri, Nebraska, New Jersey, Wisconsin, and Wyoming.

Additional information regarding this report or the Maryland FACE Program is available from:

The Maryland FACE Program
Division of Labor and Industry
501 St. Paul Place, 3rd Floor
Baltimore, Maryland 21202-2272
Phone (410) 333-8902
FAX (410) 333-1771