FACE Progam Prevents Workplace Fatalities

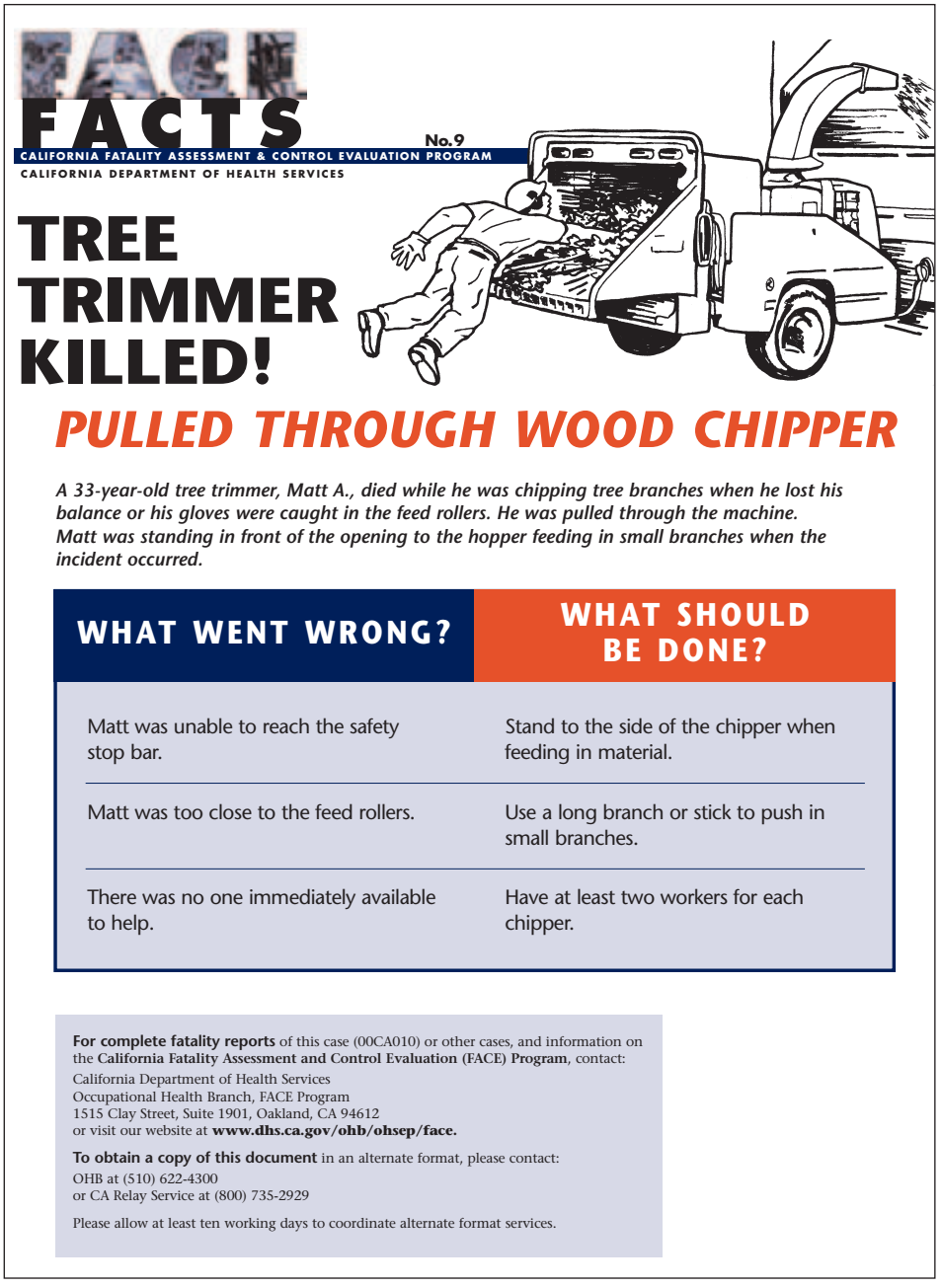
By Timothy Walsh

All across the country, the headlines are sobering: each day, on average, 16 workers die as a result of a traumatic injury on the job. The Fatality Assessment and Control Evaluation (FACE) Program was created to track and investigate such workplace fatalities in order to help prevent them. The program is funded by the National Institute for Occupational Safety and Health (NIOSH), which is part of the Centers for Disease Control and Prevention (CDC). NIOSH was created as part of the OSHAct in 1970, to provide research on occupational illnesses and accidents.

"The goal of the FACE program is to prevent occupational fatalities across the nation by identifying and investigating work situations at high risk for injury and then formulating and disseminating prevention strategies to those who can intervene in the workplace," reads a program brochure.

FACE investigators do not enforce compliance with state or federal occupational safety and health standards and do not determine fault or blame. Written reports describe the accident and provide possible prevention strategies and are distributed to those who can intervene in the workplace.

National fatality data are reviewed and specific types of fatalities are targeted for investigation if there is more that needs to be learned about a certain type of accident. In the past, national targets have included falls from elevation, electrocutions, logging and confined spaces. The current focus is on fatalities that are machine-related, occur in a street or highway work zone, or involve workers that are Hispanic or under 18 years of age. Since 1992, there have been 36 FACE investigations and seven educational materials written about incidents involving tree trimmers (see links at end of article). One case, from California



FACE FACTS
No. 9
CALIFORNIA FATALITY ASSESSMENT & CONTROL EVALUATION PROGRAM
CALIFORNIA DEPARTMENT OF HEALTH SERVICES

TREE TRIMMER KILLED!

PULLED THROUGH WOOD CHIPPER

A 33-year-old tree trimmer, Matt A., died while he was chipping tree branches when he lost his balance or his gloves were caught in the feed rollers. He was pulled through the machine. Matt was standing in front of the opening to the hopper feeding in small branches when the incident occurred.

WHAT WENT WRONG?	WHAT SHOULD BE DONE?
Matt was unable to reach the safety stop bar.	Stand to the side of the chipper when feeding in material.
Matt was too close to the feed rollers.	Use a long branch or stick to push in small branches.
There was no one immediately available to help.	Have at least two workers for each chipper.

For complete fatality reports of this case (00CA010) or other cases, and information on the **California Fatality Assessment and Control Evaluation (FACE) Program**, contact:
California Department of Health Services
Occupational Health Branch, FACE Program
1515 Clay Street, Suite 1901, Oakland, CA 94612
or visit our website at **www.dhs.ca.gov/ohb/ohsep/face.**

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OHB at (510) 622-4300
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Please allow at least ten working days to coordinate alternate format services.

This Fact Sheet was produced by the California FACE program following an accident that occurred on July 15, 2000. Employers are encouraged to post this Fact Sheet at their worksite for employees to view (download at www.dhs.ca.gov/ohb/ohsep/face/woodchipper.pdf). For the complete report on the investigation, go to www.dhs.ca.gov/ohb/ohsep/face/00CA010.htm.

FACE, involves a tree trimmer who was pulled through a wood chipper, and has been summarized into the 'FACE FACTS' fact sheet shown here.

There are two main parts of the FACE Program: the in-house program and the state-based program. The NIOSH in-house program began in 1982 and the state-based program began in 1989. The in-house program operates by having participating states voluntarily notify NIOSH about certain types of workplace fatalities. There are currently six states that participate in the in-house program: Ohio, Pennsylvania, North Carolina, South Carolina, Tennessee and Virginia. There are an additional 24 states and Puerto Rico where FACE inves-

tigations were previously conducted. There are currently 15 states that have FACE programs, mainly run through state health or labor departments. The state programs focus on targets that are set by NIOSH, but also may focus on regional issues. The following have state FACE Programs: Alaska, California, Iowa, Kentucky, Massachusetts, Michigan, Minnesota, Nebraska, New Jersey, New York, Oklahoma, Oregon, Washington, West Virginia and Wisconsin.

A FACE investigation begins

In general, the FACE process starts when a FACE office is notified, or becomes aware of a work-related fatality that meets their criteria. Reports of accidents can come from local media, police, OSHA compliance officers, coroner's offices, friends and family, etc. Once the FACE investigator chooses a case to investigate, they contact the employer by phone. The phone call is followed up by a letter that explains in detail the FACE program and the intent of the investigation. A date is set for the investigation at this point.

Usually, the FACE investigator will begin to do background research almost as soon as they hear about the fatality. This is done by reading police and OSHA reports, death certificates, Coroner's reports, and Internet searches on related topics. The investigator wants to gain as much information as possible before the actual investigation begins. The investigator visits the worksite or place of employment to gather the data necessary for the report. They interview the employer, witnesses, and other co-workers, and take pictures of the worksite and machinery involved. The investigator may try to create a reenactment of the accident. All interviews are conducted in private – the names of employers, victims, and/or witnesses are not used in written investigative reports or included in the FACE database.

Information that is collected during the on-site investigation varies with the investigator, the company, the site, and the nature of the accident. In addition to delays in hearing about the fatality, there are several other challenges that an investigator faces at the worksite: sometimes the employer may not share information, co-workers are often traumatized by the accident and have a hard time recalling what they witnessed, and safety materials must be interpreted and translated into a language that is easy to understand for the target audience.

The primary goal of all of the research is to create prevention strategies (through recommendations) to reduce the likelihood of the accident recurring. The recommendations are created as a result of research and collaboration between all of the involved groups. Employers are often asked how they think the accident could have been avoided, and similar cases will often be reviewed for comparisons. The investigators presents possible strategies based on their experience and the research. Sometimes there are difficulties in creating prevention strategies. A variety of backgrounds and experience levels of all of those who participate in the process, and a lack of information or unsubstantiated information can impede the process. If a witness points to a particular cause, but the information can't be confirmed, the information has to be omitted from the prevention strategy. Once the initial investigation is complete, the FACE investigator will create a preliminary report and review it with co-workers, industry experts, NOSH, and sometimes OSHA officials as well. Additional site visits and interviews may be necessary to answer additional questions or clear up any issues from the initial report. The reports are reviewed many times before the final report is complete.

Spreading the word

The information gathered by the investigator would be useless if it wasn't shared, so the FACE program disseminates materials once they are available. The information obtained from the process is distributed in two main forms; the "FACE-FACTS" fact sheets and the investigative reports. FACE FACTS are single page summaries of specific accidents that list recommendations and resources. The information is shared with employers, workers, trade associations, unions and other safety and health professionals. The reports and fact sheets are also available on the state and national FACE Web sites. The FACE program's goal is clear: they will continue to highlight high-risk work situations and prevent workers from being killed on the job.

Tim Walsh is a graduate student working on his doctorate in ergonomics and safety from the University of Massachusetts-Lowell. He has been an arborist for 16 years, served two years as arborist for TCIA, owned and operated his own business, worked and taught around the world.

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For more about the FACE program, go to www.dhs.ca.gov/ohb/ohsep/face or www.cdc.gov/niosh/face/. For Web links to FACE investigations, by state, since 1992, go to:

www.treecareindustry.org/content/safety/chipper_accidents.htm

Additonal related links:

DHHS NIOSH PUBLICATION NO. 99-145 Injury Associated with Working Near or Operating Wood Chippers, August 1999 - www.cdc.gov/niosh/hid8.html

Alert's

NIOSH ALERT: Request for Assistance in Preventing Falls and Electrocutions During Tree Trimming. DHHS (NIOSH) Publication 92-106, August 1992. NIOSH Publications Dissemination, Cincinnati Ohio. Phone (513)533-8287.

www.cdc.gov/niosh/92-106.html

www.public-health.uiowa.edu/face/Alerts/Cherry%20Picker.html

www.chm.msu.edu/oem/MIFACE_Alerts/Alert_Arborists.pdf