

Please Post

## Naval Facilities Engineering Command

# Abstract of an Accident

99-12

**Accident Type:** Fall from height  
**Injury:** Fatality  
**Type of Work:** Iron welding  
**Equipment:** Personal fall arrest equipment not in use

### DESCRIPTION OF THE ACCIDENT :

An ironworker fell from a slightly sloped roof, to his death, during the process of spot welding corrugated roof substrate panels. Management personnel had observed the two workers on the roof without fall protection and instructed them to tie-off. One of the ironworkers left the roof to obtain fall arrest harnesses from the contractor's trailer leaving the victim alone for a brief period. While the coworker was retrieving the fall arrest harnesses the victim fell from the roof. There were no eyewitnesses to the incident.

### DIRECT CAUSE:

The worker was not wearing personal fall arrest equipment. No guardrail or other protective system had been installed to provide fall protection in lieu of personal fall arrest systems for workers on the roof.

### INDIRECT CAUSE:

- 1) Workers involved had not been provided adequate fall hazard risk assessment training or appropriate precautionary measures.
- 2) Management personnel provided insufficient control to initiate appropriate action in a timely manner.

### LESSONS LEARNED:

Specific work plans must be in place for work involving fall hazards. In absence of perimeter guardrail system or other installed fall protection systems, a plan for anchorage and oversight inspection milestones could decrease likelihood of workers in at-risk situations. Strict conformance with USACE EM 385-1-1 Section 21, OSHA 29 CFR 1926 Subpart M and project safety requirements are essential.

Individuals designated as competent persons and involved in fall protection and arrest systems should have documented training in accordance with USACE EM 385-1-1 and 29 CFR 1926.



---

**YOUR SAFETY CONTACT IS....**