Abstract of an Accident

Accident Type: Fall From Height
Injury: Fatality
Type of Work: Exterior Insulation Installation On Four Story Structure
Equipment: Man lift, Fall Protection Equipment

DESCRIPTION OF THE ACCIDENT:
Three employees using man lifts and wearing fall protection harnesses were installing tyvek under a canopy at an approximate height of 30ft. Two men, the lift operator and a helper, were in one lift. A person working alone was having trouble starting the 2nd lift. The 1st lift operator lowered his lift, departed it and helped start the 2nd lift. After completing this task the lift operator returned to the 1st lift and resumed work. A short time later the helper turned and saw the lift operator falling and reaching for the handrails as he was descending through an open man lift gate. The lift operator fell to the concrete deck and died from the impact. The helper couldn’t remember if his harness was attached at the time of the mishap and physical evidence indicated the 2nd lift operator did not have a harness attached to an anchor point.

DIRECT CAUSE:
◆ Failure by the lift operator to connect his fall protection harness to the anchor point in the lift basket.

INDIRECT CAUSE:
◆ Improper repair of the lift gate: The lift gate was open due to improper repairs that prevented the latch from catching after the gate was swung to the closed position.
◆ Failure to follow the Activity Hazard Analysis (AHA): The AHA listed the lift gate as one of the inspection requirements and required the use of fall protection harnesses.
◆ Failure to recognize a dangerous material condition: The contractor and workers did not realize that the lift gate malfunction was life threatening.
◆ Failure to correct a material deficiency: The contractor failed to have the lift basket properly repaired or replaced even though the lift had been used on site for more than four months.
◆ Failure to properly supervise the work in progress: Proper supervision would have identified poor safety practice by workers and the lift gate would have been identified as a problem.

ROOT CAUSE:
◆ Ineffective safety enforcement on the worksite: A review indicated the contractor had no records regarding positive or negative safety enforcement actions such as; rewards for safe practices or disciplinary actions and monetary fines for poor safety practices. This led to low expectations regarding following safety regulations. Training had been conducted as required and verbal warnings for safety violations were applied but were inadequate.

LESSONS LEARNED:
◆ Safety performance by workers is a direct result of on site leadership and management. Effective safety enforcement systems implemented by managers and supervisors can ensure proper safety practices are followed at all times, thereby preventing injury and death.
◆ Use the Activity Hazard Analysis. Adherence to the AHA would have prevented the accident by helping to identify the significance of the material deficiency in the gate and ensuring proper fall protection procedures were followed.

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