

Please Post



**Naval Facilities Engineering Command Southwest  
Safety Lessons Learned Mishap Abstract**

**Mishap Type: FALL FROM HEIGHT**  
**Injury: CRUSHING/INTERNAL INJURIES**  
**Damage: None**  
**Type of Work: RENOVATION**  
**Equipment: N/A**



**DESCRIPTION OF THE MISHAP:** WG-10 construction mechanic sustained significant head and internal injuries when he fell 23 ft off of a mezzanine. Guardrail had been removed to facilitate the removal of equipment and material by a mobile crane team, and caution tape was placed to cover opening. Employee fell backwards through tape for unknown reason.

**INDIRECT CAUSE:**

- Unauthorized change/alteration
- Inadequate training
- Failed to follow requirements
- Perceptual error, slip in attention or distraction

**ROOT CAUSE:** Personnel did not use approved procedure to adequately safeguard a fall hazard once existing safeguard was removed. Personnel recognized the fall hazard, but they did not use accepted controls, such as guard rails or a personal fall arrest system.

**LESSONS LEARNED:**

- Ensure all elements of Fall Protection Program are in place and operating effectively
- Need to apply Operational Risk management when workplace conditions change
- Importance of challenging co-workers and supervisors when unsafe conditions exist

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