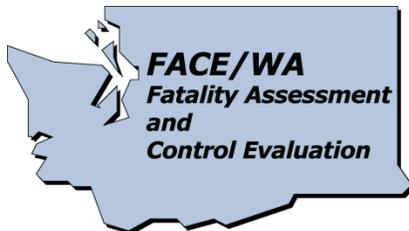


# Crane Operator Dies after Falling From Crane Turntable Deck in Washington State



Investigation: # 10WA046  
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SHARP Report: # 52-22-2011\_summary

The WA Fatality Assessment and Control Evaluation (FACE) Program has published a new Fatality Investigation report. These reports describe work-related fatal incidents and provide specific recommendations that may have prevented the incident from occurring. We hope that they are disseminated and used for formal or informal educational opportunities to help prevent similar incidents.

## **SUMMARY**

In July of 2010, a 61-year-old male crane operator was fatally injured when he fell from a mobile hydraulic crane's turntable deck while attempting to dismount from the crane. Two employees of a construction crane service company were dispatched by their employer to an elementary school where they were to lift an HVAC unit to the top of a school building. The crane operator (victim) and oiler set up the 120-ton mobile hydraulic crane in preparation for the lift when they discovered that there was an electrical problem causing the telescoping boom to not function. The operator made telephone contact with the company electrician who indicated that he would be there shortly to make repairs.

The two workers decided to go and wait in the shade. The victim's coworker dismounted from the turntable deck at the rear of the crane and turned away from the victim who was also about to dismount. The coworker then heard the victim make an exclamation and he turned to see him falling head first to the concrete sidewalk 4 to 5 feet below. A call was made by another contractor to emergency medical services (EMS). EMS and police responded and the victim was transported to a hospital. He died of his injuries nine days later.

## **RECOMMENDATIONS**

To prevent similar occurrences in the future, the Washington State Fatality Assessment and Control Evaluation (FACE) investigation team recommends that employers who use cranes and other mobile equipment should follow these guidelines:

- **Identify and address fall hazards associated with workers mounting and dismounting from cranes and other mobile equipment.**
- **Ensure that cranes and other mobile equipment have safe, well designed access systems.**
- **Maintain mobile equipment access systems and walking and working surfaces in a safe and useable condition.**
- **Consider the safety needs of older workers.**

To access the full version of this investigation report along with the detailed recommendations and discussions section, go to [www.lni.wa.gov](http://www.lni.wa.gov) and enter **52-22-2011** into the search box.