

SERVICES TO BUILDINGS AND DWELLINGS





Maintenance Coordinator Dies After Falling from Ladder

INCIDENT FACTS

REPORT #: 71-239-2023s

REPORT DATE: May 22, 2023

INCIDENT DATE: July 21, 2021

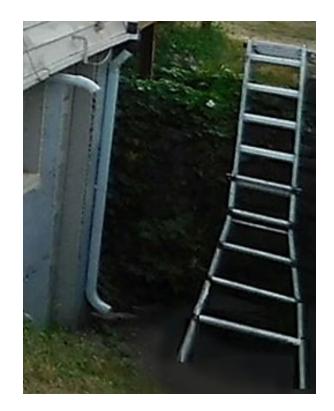
WORKER: 47 years old

INDUSTRY: Residential Real Estate Property Managers

OCCUPATION: Maintenance Coordinator

SCENE: Residential Home

EVENT TYPE: Fall













A 47-year-old maintenance coordinator died after falling from a ladder. He worked for his employer, a property management business, for three years doing general house maintenance. When the incident happened, the worker was alone, touching up the exterior paint on a one-story house being prepared for sale.









The homeowner had arrived around 1 p.m., talked briefly with the worker, and went inside to sleep. No one else saw the worker until 7 p.m., when a home appraiser found him badly injured lying on his back. He fell onto rocks and concrete at the base of an 18-foot fully extended, portable, metal articulated or multi-positional ladder. The ladder's bottom half was leaning on a 6-foot below-grade rock retaining wall near the basement entrance. The top half was resting horizontally on the ground level grass surface.









The appraiser called 911 and tried to wake the homeowner. When paramedics arrived, the worker was bleeding from his head, still breathing but unresponsive. Missed call messages on a phone found in the worker's pocket led paramedics to estimate he was on the ground for about 3 hours. He was airlifted to the hospital, where he died the next day from severe head injuries.









Investigators found:

- The employer did not ensure the ladder was secured from accidental displacement.
- The ladder was not in the self-supporting position with hinges locked, which created unstable work conditions that exposed the worker to a fall of around six feet.
- The employer did not provide documented ladder safety training and an on-site safety orientation as part of their accident prevention program (APP).
- The employer stated the ladder did not belong to them.









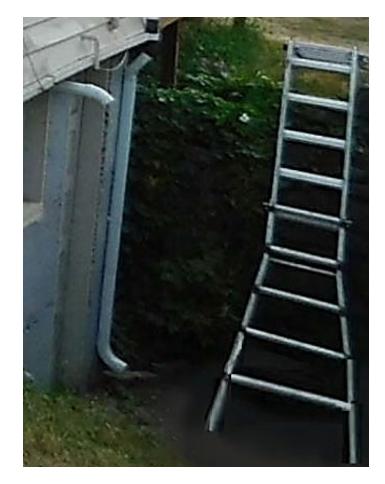


Photo 1: Bottom half of ladder against retaining wall. The worker was found on his back at the base after falling from the ladder.











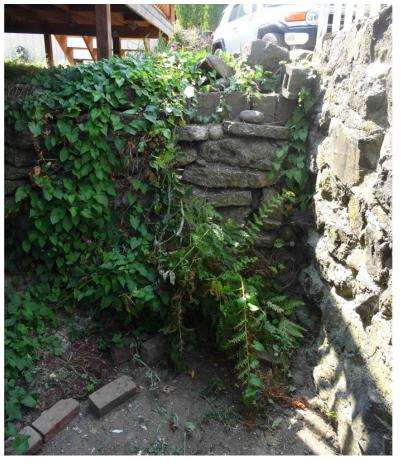
Photo 2: Below-grade 6-foot rock retaining wall and basement entrance. The ladder appeared to be used for climbing between the two levels of ground.











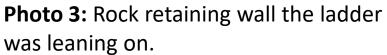




Photo 4: Loose rocks at top of retaining wall.



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WASHINGTON

State FACE Program



FATALITY NARRATIVE



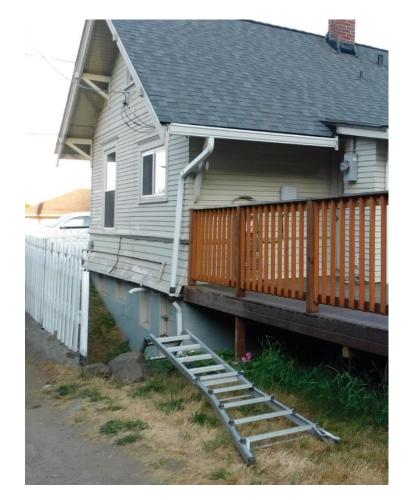


Photo 5: Unsecured top half of ladder folded over the retaining wall and resting on the grass surface.











Photo 6: View of incident scene from road. Arrow points to basement entrance area where the lone worker fell from the ladder.



WASHINGTON

State FACE Program







Requirements

- Place the ladder either: (a) With a secure footing on a firm, level support surface; or (b) Secure the ladder to prevent accidental displacement. <u>WAC 296-876-40015(1)</u>
- Train employees to recognize ladder hazards and the procedures to minimize these hazards. <u>WAC 26-876-15005(1)</u>
- Develop and implement a formal, written accident prevention program (APP) with a safety orientation that includes: (g) An on-the-job review of the practices necessary to perform the initial job assignments in a safe manner. <u>WAC 296-155-</u> <u>110(3)(g)</u>









Recommendations

To help prevent similar occurrences, employers should:

- Ensure workers use ladders according to manufacturer's safety guidelines and warnings and maintain a 3-point contact, staying near the middle of the ladder, and facing it when climbing.
- Provide training to workers in each type of ladder they will use, including how to properly inspect, set up, secure, climb, relocate, transport, maintain, and store the ladder.
- Supervise lone workers to ensure safety by visiting work sites and requiring phone check-ins.









Resources

Articulated Ladder Safety Training

American Ladder Institute

Safe Use of Extension Ladders

Occupational Safety and Health Administration (OSHA)





FATALITY NARRATIVE



This narrative was developed to alert employers and workers of a tragic incident in Washington State and is based on preliminary data ONLY and does not represent final determinations regarding the nature of the incident or conclusions regarding the cause of the fatality.

Developed by the Washington State Fatality Assessment and Control Evaluation (WA FACE) Program and the Division of Occupational Safety and Health (DOSH), Washington State Dept. of Labor & Industries. WA FACE is supported in part by a grant from the National Institute for Occupational Safety and Health (NIOSH grant# 5U600H008487). For more information visit <u>www.lni.wa.gov/safety-health/safety-research/ongoing-projects/work-related-fatalities-face</u>.

