

## Framer Struck by Beam after Falling from Scissor Lift

### INCIDENT FACTS

**REPORT #:** 71-258-2024s

**REPORT DATE:** September 25, 2024

**INCIDENT DATE:** September 11, 2023

**WORKER:** 41 years old

**INDUSTRY:** New Single-Family Housing Construction

**OCCUPATION:** Construction Framer

**SCENE:** Apartment complex construction site

**EVENT TYPE:** Struck by / Crushed by



# ***FATALITY NARRATIVE***



A 41-year-old framer fell from a scissor lift and was then struck by a 418-pound wooden beam. He worked for his employer, a residential framing subcontractor, for two weeks, and was learning on-the-job.

The framer was assisting a co-worker at the construction site of a new apartment complex. Their plan was to use two scissor lifts in tandem to raise and insert a glulam wooden beam into the side of a horizontal I-beam over eight feet above the concrete floor. The wooden beam was 22-feet long, 22.5-inches wide, and 3.5-inches thick. They aligned the lifts about 10-feet apart and placed the beam broadside down across the lifts' top guardrails but did not secure it. It was 6.5 feet above the floor. The workers expected to complete the task in two hours, without rushing.

The workers were standing on the floor at opposite ends of the beam. The framer was out of view of his co-worker at the rear of the other lift. He unexpectedly went up the steps or climbed the side of his lift and fell on his back. The beam then fell off the lift on top of him. The co-worker saw the beam fall and ran over to help. He lifted the beam off the injured framer and notified two onsite superintendents who called 911 and began CPR. First responders came shortly after and pronounced the framer dead at the scene from severe head injuries.

Following the incident, investigators found:

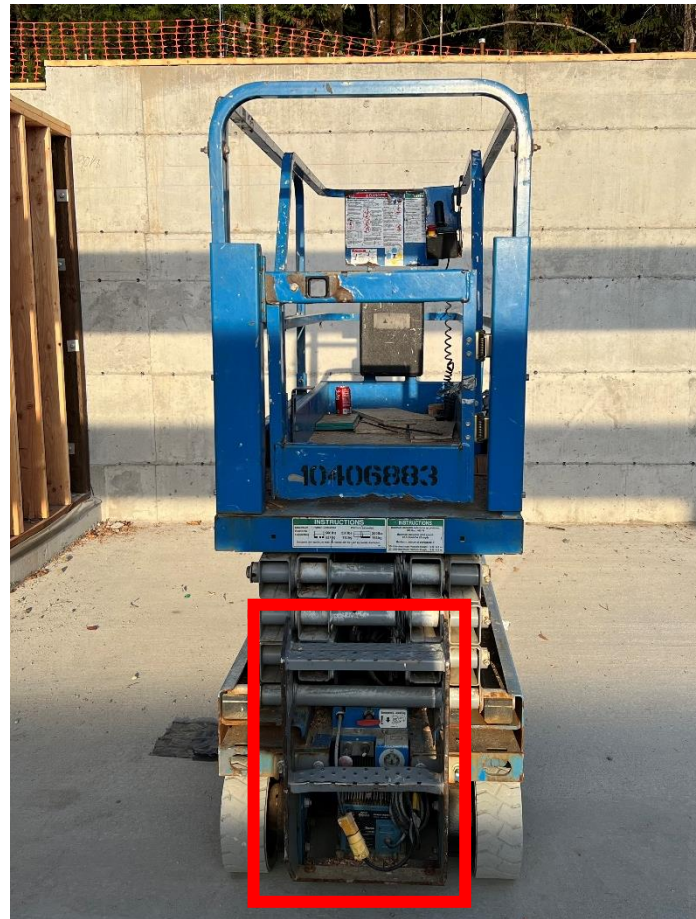
- The framer was not trained and authorized to use the lift. His co-worker also had limited knowledge of the hazards of placing and elevating materials on the platform guardrails.
- The employer and workers' supervisor knew of the lift manufacturer's warnings not to put materials on the guardrails. They were unaware of any safer material lifting equipment options.
- Lift operators and helpers at the site spoke Spanish and could not read the employer's job hazard assessment (JHA) for the installation task, which was written in English only. The company's accident prevention program (APP), including a scissor lift operator's checklist, was also in English only.

# FATALITY NARRATIVE



**Photo 1.** Scissor lift from incident.

# FATALITY NARRATIVE



**Photo 2.** Rear view of lift with steps shown in red outline.

# FATALITY NARRATIVE



**Photo 3.** Top guardrail of lift platform.





**Photo 4.** Fallen wooden beam and second lift at incident site.

## Requirements

Employers must:

- Make sure elevating work platforms are used only for their intended purpose as specified by the manufacturer. See [WAC 296-869-60005](#)
- Make sure personnel are trained before they are permitted to operate an aerial lift. See WAC [296-869-20025](#)

## Recommendations

FACE investigators concluded, that to help prevent similar occurrences, employers should:

- Use forklifts, cranes, or contractor material lifts to elevate construction materials, not scissor lifts.
- Develop and have supervisors enforce APP policies, JHAs, and standard operating procedures (SOPs), for safe use of elevating work platforms, such as scissor lifts.
- Have APP policies, JHAs, and training resources translated to the worker's preferred language.

## **Recommendations**

- Train operators using the manufacturers' manual and highlight warnings not to put materials on guardrails or have them exceed the confines of the guardrails unless approved by the manufacturer.
- Discuss safe use of elevating work platforms at pre-job crew meetings and monthly safety meetings.

## **Resources**

[Free Safety and Health Consultation Program](#)

Washington State Dept. of Labor & Industries

# 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 injury.*

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# 5U60OH008487). For more information visit [www.lni.wa.gov/safety-health/safety-research/ongoing-projects/work-related-fatalities-face](http://www.lni.wa.gov/safety-health/safety-research/ongoing-projects/work-related-fatalities-face).