CALIFORNIA State FACE Program
Fatality Assessment & Control Evaluation™

REPORT#: 25CA002 REPORT DATE: 9/14/2026

DATE:
May 9, 2025

TIME:
9:20 a.m.

VICTIM:
27-year-old Hispanic male warehouse worker

INDUSTRY/NAICS CODE:
Cut stone and stone product manufacturing/327991

EMPLOYER:
Importer of cut stone slabs

SAFETY & TRAINING:
No IIPP, minimal worker training

SCENE:
Warehouse

LOCATION:
California

EMPLOYER SIZE:
4 employees

EVENT TYPE:
Struck/crushed by

A Warehouse Worker Died When He Was Crushed by Stone Slabs That Fell Out of a Shipping Crate He Was Opening — California

SUMMARY

On May 9th, 2025, a 27-year-old Hispanic male warehouse worker (victim) began opening a recently delivered shipping crate that contained ten stone slabs packed in an A-frame fashion. The victim removed the front of the crate and five of the slabs. He then removed the screws that held the A-frame in place and stepped into the fall shadow of the remaining slabs. They unexpectedly fell on him, and he was crushed to death…**Read Full Report>**

CONTRIBUTING FACTORS

Key contributing factors identified in this investigation include:

- The victim was working within the slab's fall shadow
- No job hazard analysis (JHA) was performed
- Insufficient worker training…**Learn More>**

RECOMMENDATIONS

The California FACE (CA/FACE) investigator determined that, in order to prevent workers from being crushed by stone slabs, employers should:

- Ensure that workers are never located in the fall shadow of a stone slab unless the stone is secured
- Ensure that a JHA is performed and updated as needed
- Provide safety training and written safety programs for all employees… **Learn More>**

Fatality Assessment and Control Evaluation (FACE) Program

This case report was developed to draw the attention of employers and employees to a serious safety hazard and is based on preliminary data only. This publication does not represent final determinations regarding the nature of the incident, cause of the injury, or fault of employer, employee, or any party involved.

This case report was developed by the California Fatality Assessment and Control Evaluation (FACE) Program. California FACE is a NIOSH-funded occupational fatality surveillance program with the goal of preventing fatal work injuries by studying the worker, the work environment, and the role of management, engineering, and behavioral changes in preventing future injuries. The California FACE program is located in the Occupational Health Branch, California Department of Public Health.

Email | Website

INTRODUCTION

On Friday, May 9, 2025, at approximately 9:20 a.m., a 27-year-old Hispanic male warehouse worker (victim) died when he was crushed by several stone slabs that fell on him while he was opening a shipping crate. The CA/FACE investigator received notification of this incident on May 20, 2025, from the weekly summary from the California Department of Industrial Relations Public Information Office. The CA/FACE investigator contacted the employer on June 24, 2025, and visited the site of the incident on August 22, 2025, to interview the business owner/employer and one employee.

INVESTIGATION DETAILS

The day before the incident, two wooden crates of imported stone slabs were unloaded from a delivery vehicle with a forklift and placed in the warehouse. The next day, the victim and another worker were hired to unload the crates. The employer did not perform a job hazard analysis (JHA) prior to the victim and co-worker arriving on scene. They began opening one of the wooden shipping crates that contained 10 slabs of stone that were packed vertically. The crate was completely enclosed, and the stone slabs were not visible from the outside. The crate measured 7 ft. H × 10 ft. L × 2 ft. D. The stone slabs were approximately 10 ft. x 6 ft. and weighed approximately 600 pounds each (Photos 1 & 2). According to the employer, the shipping crate did not contain any markings or stickers warning about the A-frame packing method and potential for the product to move during shipment.

Photos 1 & 2: Unpacked stone slabs stored at the stone importing company involved in this incident.
Photos courtesy of CA/FACE Program.

On the day of the incident, the victim and the co-worker moved the crate with a forklift and wedged it in place with 2’ x 4’ planks, leaning it slightly backwards to prevent the stone slabs from falling out. They removed the front of the shipping crate and noticed the stone slabs were packed in an A-frame fashion, with five slabs on each side leaning towards the middle against a wooden A-frame. The slabs facing the open side of the crate were removed and placed in a steel storage rack off to the side. The victim then climbed a short wooden ladder along the left side of the crate and removed the screws that held the A-frame in place. After climbing down, for unknown reasons, he stepped into the fall shadow of the remaining slabs when they unexpectedly fell on him. The employer, who watched the workers perform the entire task from a few feet away, called 9-1-1. The co-

worker used a forklift to remove the slabs from the victim. Emergency responders stabilized the victim and transported him to the hospital where he later died.

EMPLOYER

The employer in this incident was an importer of stone and marble slabs and had been in business for 45 years. The employer had been at this location for one year and had four regular employees.

WRITTEN SAFETY PROGRAMS and TRAINING

The employer did not have an Illness and Injury Prevention Program (IIPP) or any other written safety procedures or training materials. The employer claimed the victim had an orientation training when he was hired, but the employer had no written documentation to verify it. He received no other training.

WORKER INFORMATION

The victim was a 27-year-old Hispanic male warehouse worker had been working as needed for the company for five weeks. According to the employer, he had 12 years of prior experience working for other stone importers and had experience unloading crates. It is not known how much training he had in unloading crates for prior employers.

INCIDENT SCENE

The incident scene was a warehouse that received and stored imported stone and marble slabs. A wooden shipping crate that contained ten slabs of stone was opened and the stone slabs were in the process of being removed when the incident occurred.

CAUSE OF DEATH

According to the county coroner, the cause of death was multiple blunt force injuries.

CONTRIBUTING FACTORS

Occupational injuries and fatalities are often the result of one or more contributing factors or key events in a larger sequence of events that ultimately result in the injury or fatality. The CA/FACE investigator identified the following unrecognized hazards as key contributing factors in this incident:

- The victim was working within the slab's fall shadow
- No JHA was performed
- Insufficient worker training

RECOMMENDATIONS / DISCUSSION

The California FACE (CA/FACE) investigator determined that, in order to prevent workers from being crushed by stone slabs, employers should:

Recommendation #1: Ensure that employees are never located in the fall shadow of a stone slab unless the stone is secured.

Discussion: Stone and marble slabs are extremely heavy and are typically stored on slab racks and rest on a narrow long edge. Stone slabs must be secured to prevent tipping past the absolute vertical position. Slabs can fall while being lifted or moved, if the rigging fails, if the load becomes unsecure or if the slab cracks. A fall shadow is the area on both sides of the slab where if it tips and falls it could land and crush workers in this zone (Figure 1). As lifting height increases, this danger zone expands. Employers should ensure workers are always outside of the fall shadow to prevent injuries and fatalities. To prevent fatal crush injuries, employees must never stand along the flat sides or at the center of the slab. Workers must remain at the ends of the slab, at least an arm's length away, ensuring they are always outside the fall shadow. If the victim was not in the fall shadow this incident could have been prevented.

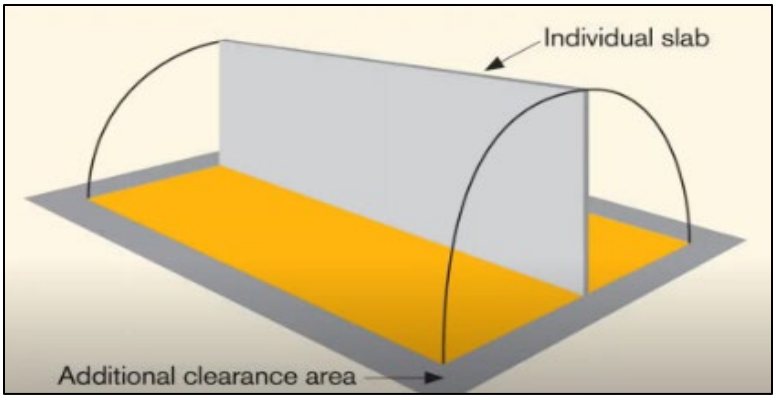

Figure 1. Example of fall shadow. The yellow area is where the slab would land if it tipped over. Courtesy of MA FACE Program.

Recommendation #2: Ensure that a job hazard analysis (JHA) is performed and updated as needed.

Discussion: A JHA is a technique that focuses on job tasks to identify hazards before they occur. It examines the relationship between the worker, the task, the tools, and the work environment. The analysis should be routinely performed to identify new, uncontrolled, and potential hazards. In this incident, the slabs were loaded in a manner that was different from industry standards. Instead of being packed vertically, they were stored in a wooden "A" frame within a crate in the shape of a triangle. Typically, slabs are loaded and secured vertically and stacked next to each other so that all the slabs face vertically in the same direction. In this incident, the employer should have assessed the hazards associated with uncrating stone slabs and how it could have been done safely before asking employees to begin the task. The JHA should begin by breaking down the tasks to be performed into steps. Each step should be evaluated to identify the hazards or potential hazards and the best equipment and tools to be used to safely complete the task. It is important to have employees participate in the JHA as they have a unique understanding of the job and can be critical to identifying hazards. Had a JHA been conducted before initiating the task, the risks associated with the incorrectly loaded slabs would have been identified, and appropriate corrective measures—such as using restraining devices or employing specialized lifting equipment—could have been put in place, thereby preventing this incident.

Recommendation #3: Provide safety training and written safety programs for all employees.

Discussion: In this case, the employer did not have a safety program or train all workers on the safe unloading of stone slabs. All employers should develop and implement safety programs to protect employees from the hazards associated with their product. Program information and worker training should be provided in the primary language spoken by employees. Cal/OSHA offers model IIPP programs that employers can use. These programs should include specific information regarding:

- Potential hazards faced by employees, including the potential for being struck and crushed by falling slabs
- How employees can control their exposure to stone slab hazards, including staying outside of the fall shadow
- How to handle slabs outside of compartmentalized slab racks and move them safely with forklifts and overhead lifts
- Effective communication between equipment operators and those assisting on the ground
- How employees can report concerns regarding stone slab hazards to their employers without fear of retaliation
- How the employer will periodically review the program and address any deficiencies
- How to ensure that training was effective and that employees are competent to perform stone slab work safely prior to the start of work. Employees should be retrained when necessary

RESOURCES

California General Industry Safety Orders (GISO – Title 8)
- Subchapter 4. Construction Safety Orders, Article 7. §1549. Piling Material. (d)
- Subchapter 7. General Industry Safety Orders
  - §3203. Injury and Illness Prevention Program
  - §3380. Personal Protective Devices. (f) Hazard assessment and equipment selection
  - §3704. Securing Loads

Cal/OSHA IIPP Resources DOSH - Publications, Research and Education

Massachusetts FACE report 19CA015

Natural Stone Institute www.naturalstoneinstitute.org/programs/safety-resources/

New Jersey FACE report #96-NJ-080-01

OSHA JHA publication www.osha.gov/Publications/osha3071.pdf.

OSHA safety and health information bulletin Hazards of Transporting, Unloading, Storing and Handling Granite, Marble and Stone Slabs | Occupational Safety and Health Administration

INVESTIGATOR INFORMATION

This investigation was conducted and authored by Hank Cierpich, CA/FACE Fatality Investigator/Consultant. Additional contributions to the report were provided by Robert Harrison, MD, MPH, CDPH FACE Project Officer; Laura Styles, MPH, FACE Research Scientist; Glenn Shor, PhD, and Ryan Furtkamp, Cal/OSHA CFOI program.

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