CALIFORNIA State FACE Program
Fatality Assessment & Control Evaluation™

REPORT #: 25CA006 REPORT DATE: 9/17/26

DATE:
December 6, 2025

TIME:
9:06 a.m.

VICTIM:
36-year-old Hispanic male landscaping worker

INDUSTRY/NAICS CODE:
Landscaping Services/561730

EMPLOYER:
Landscaping and lawn care

SAFETY & TRAINING:
Unknown

SCENE:
Residential swimming pool surrounded by landscaping rocks, trees, and vegetation

LOCATION:
California

EMPLOYER SIZE:
3 employees

EVENT TYPE:
Drowning

A Landscaping Worker Drowns After Falling into a Pool While Wearing a Backpack Blower — California

SUMMARY

On December 6, 2025, a 36-year-old Hispanic male landscaping worker (victim) fell into a residential swimming pool and drowned. He was using a backpack leaf blower to clear debris around the pool. He was found underwater in the deep end of the pool by his co-worker. Paramedics arrived and transported him to the hospital where he died…**Read Full Report>**

CONTRIBUTING FACTORS

Key contributing factors identified in this investigation include:

- No personal flotation device (PFD) was provided or worn
- No pre-job hazard analysis (JHA) was performed
- Lack of employer emergency response plan
- Lack of water safety and swimming skills…**Learn More>**

RECOMMENDATIONS

The CA/FACE investigator determined that, in order to prevent swimming pool drownings, landscaping employers should ensure:

- Workers are provided with and wear well-maintained PFDs when working near a pool
- A JHA is performed and updated as needed
- Workers are trained in emergency response procedures
- Workers complete training in swimming proficiency and water safety… **Learn More>**

CALIFORNIA
State FACE Program
Fatality Assessment & Control Evaluation

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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 in the Occupational Health Branch, California Department of Public Health.

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INTRODUCTION

On Saturday, December 6, 2025, at approximately 8:10 a.m. a 36-year-old Hispanic male landscaping worker (victim) arrived with a co-worker to perform yard maintenance at a residential home. At approximately 9:06 a.m., the co-worker found the unresponsive victim on the bottom of the deep end of the swimming pool. There were no witnesses and no surveillance cameras at the residence. The victim's employer called 911. Emergency and firefighter personnel arrived on scene, retrieved the victim from the pool, and transported him to the hospital where he was pronounced dead at 10:50 a.m. The CA/FACE investigator received notification of the incident on Monday, December 22, 2025, from the weekly summary from the California Department of Industrial Relations Public Information Office. Attempts to contact the employer and co-worker were unsuccessful. The coroner's report, fire department report, police report and associated incident scene photos were received and reviewed.

INVESTIGATION DETAILS

On the day of the incident, the victim and a co-worker arrived at approximately 8:10 a.m. at a residential home to perform lawn care and yard maintenance. The residents were asleep and were unaware of the incident. According to the police report, at approximately 8:30 a.m. the co-worker began mowing the grass in the front yard while the victim began cleaning debris around the swimming pool wearing a backpack leaf blower in the backyard. According to the police report, the victim wore a lot of clothing and a pair of thick gloves. At around 9:06 a.m. the co-worker walked to the backyard to check on the victim because he had not seen or heard him. As he walked next to the pool, he noticed that the victim was face-down at the bottom of the deep end with the leaf blower next to his feet. The co-worker tried to call his employer, but he didn't answer so he called another co-worker (who was offsite) and told him he didn't know what to do. The offsite co-worker was able to reach the employer, who then called 911. The police estimated that there was a 10- to15-minute delay from when the co-worker first found the victim in the pool and 911 was called. Firefighter personnel arrived and removed the victim from approximately eight feet of water and transported him to the hospital at 9:30 a.m. He had no pulse at the time of arrival. Medical staff worked on the victim for about one hour and 20 minutes before pronouncing him dead at 10:50 a.m. The police report estimated that the victim was in the water about 15 minutes before he was found.

EMPLOYER

The employer was a small business that provided landscaping and lawn services. According to the Cal/OSHA investigation report, the company had three employees in addition to the owner/employer.

WRITTEN SAFETY PROGRAMS and TRAINING

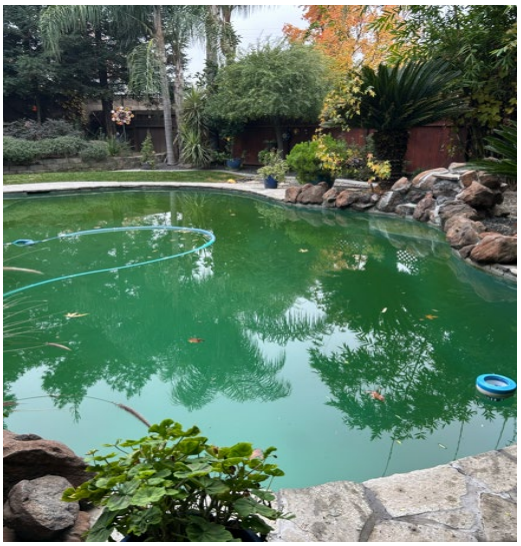
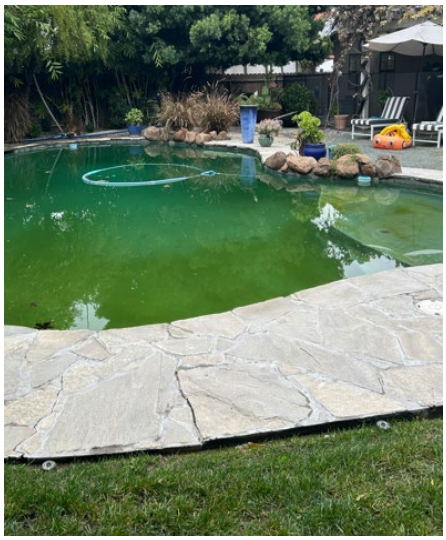
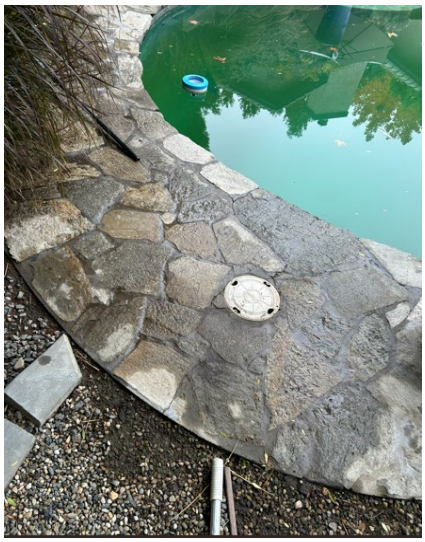
In this incident, it is not known if there was an IIPP or if the victim had received any prior safety training. Employers with fewer than 10 employees are not required to have a written Injury and Illness Prevention Program (IIPP) under Cal/OSHA §3203.

WORKER INFORMATION

The victim was a 36-year-old Hispanic male landscaping worker who worked on Saturdays for this employer. It is not known how long he had been employed with this company.

INCIDENT SCENE

The incident scene was a swimming pool in the backyard of a private home in a residential neighborhood. The kidney shaped pool had numerous rocks and plants along the edge of the deep end of the pool. Photos 1, 2 & 3 show some of the slip and trip hazards, including uneven and wet surfaces, rocks, and plants adjacent to the pool's edge. Cleaning poles were also found near the edge of the pool.

Photos 1-3: Alternate views of the pool where the victim drowned and close-up of slip and trip hazards. Photos courtesy of the police department.

WEATHER

The weather on the morning of the incident was dry with a temperature of 43 F, calm with winds 0-3 mph north to northeast, according to Weather Underground. It is unknown if the cold air and water temperature contributed to this incident.

CAUSE OF DEATH

According to the county coroner, the cause of death was drowning.

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 result in injury or fatality. California FACE investigators identified the following hazards as key contributing factors in this incident:

- No personal flotation device (PFD) was provided or worn
- No pre-job hazard analysis (JHA) was performed
- Lack of employer emergency response plan
- Lack of water safety and swimming skills

RECOMMENDATIONS / DISCUSSION

The CA/FACE investigator determined that, in order to prevent swimming pool drownings, landscaping employers should ensure:

Recommendation #1: Workers are provided with and wear well-maintained PFDs when working near a pool.

Discussion: In this incident, the victim was not wearing a PFD while he was cleaning debris away from the pool. According to the police report, the victim's brother said he wasn't a good swimmer. Employers should provide all employees who are exposed to the hazards of drowning (including landscapers, groundskeepers, and pool cleaners) with a type I, II or III US Coast Guard approved personal floatation device (§3389. Life Rings and Personal Flotation Devices). A class of self-inflating PFDs—also called automatic or inflatable life jackets—are buoyancy aids that inflate using compressed gas (usually CO_2) when immersed in water or, in

some models, when the wearer pulls a manual cord. These are less bulky and more comfortable to wear during landscaping and groundskeeping tasks. There are also manual Inflatable PFDs that inflate only when the wearer pulls the cord, and hybrid models that combine inherent buoyancy foam with an inflation system and provide some flotation even before inflation. If the victim had been wearing a PFD, he may have stayed afloat with enough time to get to the side of the pool or for his co-worker to aid in his rescue.

Recommendation #2: A JHA is performed and updated as needed.

Discussion: Prior to beginning work, the employer likely did not conduct a JHA and did not implement appropriate safety measures for his employees when working around the pool. Cal/OSHA requires all employers to develop and implement an effective IIPP (3203), and it must be a written plan for employers with ten or more employees. The eight required elements in an IIPP include:

1. Responsibility
2. Compliance
3. Communication
4. **Hazard assessment**
5. Accident/exposure investigation
6. **Hazard correction**
7. Training and instruction
8. Recordkeeping

If the employer developed and implemented the hazard assessment (#4) and correction (#6) components of an IIPP, he could have identified the risk of drowning and shared methods with his workers to prevent and/or quickly respond to someone falling into the pool. This could include wearing a PFD, having a ring buoy or life ring readily available for emergency rescue (1602), working in pairs (buddy system), and having an emergency response plan in place, which includes training in First Aid and when to call 911.

In addition, while it was unknown what model of leaf blower the victim was wearing, a typical backpack leaf blower (Photo 4) can weigh over 20 pounds, not including the weight of gasoline. Backpack blowers preferred for large jobs due to their ergonomic design and higher output, but they are very dangerous when used near water. The heavy pack is difficult to remove quickly and makes it harder to swim or wear a PFD which increases the risk of drowning. If a hazard assessment was done, perhaps safer alternatives like a handheld blower (Photo 5) or rake could have been used and the victim wouldn't have been weighed down when he fell into the pool.

Photo 4: Example of a backpack leaf blower (approx. 23 lbs.). Unknown which brand involved in this incident. Photo courtesy of STIHL.

Photo 5: Example of a handheld leaf blower (approx. 9 lbs.) Photo courtesy of HUSQVARNA.

Recommendation #3: Workers are trained in emergency response procedures.

The victim in this incident was discovered submerged in the pool by his co-worker. The police report estimated the victim was in the pool for about 15 minutes before he was found, and then 911 was not

called immediately. As a result, emergency personnel response was delayed, and the victim could not be rescued in time to save his life. Immediate notification of emergency personnel can be life saving for pool drownings. Rapid recognition, activation of EMS, rescue, and initiation of resuscitation are associated with better survival outcomes in pool incidents. In addition, a life ring and/or a long tool should have been available and workers trained to use them as rescue aids when someone is struggling to stay afloat in a pool.

Recommendation #4. Workers complete basic swimming proficiency and training in water safety.

The victim was not a good swimmer as reported by a family member. If he had successfully completed a certified swimming proficiency and water safety class, he would have acquired basic swimming and safety skills and possibly been able to self-rescue after he fell in.

RESOURCES

Division of Occupational Safety and Health – Title 8 Regulations

§1602. Work Over or Near Water

§3203. Injury and Illness Prevention Program

§3889. Life Rings & Personal Flotation Devices

Additional IIPP Resources:

The Worker Occupational Safety and Health Training and Education Program (WOSHTEP)

Injury & Illness Prevention Model Program for Non-High Hazard Employers (DIR)

INVESTIGATOR INFORMATION

This investigation was conducted and authored by David Moore, MPH, CIH, 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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