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TO: Director, National Institute for Occupational Safety and Health

FROM: California Fatality Assessment Control and Evaluation (FACE) Program

SUBJECT: Painter falls from an apartment complex window and dies in California.

SUMMARY

California FACE Report #92CA009
April 15, 1993

A 38-year-old male Korean painter (victim) died after falling approximately 40 feet from a third story apartment complex window, where he had been doing preparation work prior to beginning a paint job. The victim was doing a routine job when the incident occurred. A ladder and a broken screen were found next to him on the concrete sidewalk below. The apartment tenant had last seen the victim removing a curtain rod from above a window. The tenant did not realize what had happened until she heard some commotion outside and looked from her window and discovered paramedics working on the victim below. The California FACE investigator concluded that, in order to prevent future similar occurrences, employers should:

- have and implement a written Injury and Illness Prevention Plan so that employees are aware of the workplace hazards and how to best avoid them.
- conduct a job site survey to identify potential hazards, implement appropriate control measures, and provide subsequent training to employees that specifically addresses all identified site hazards.
- have safety devices installed on all ladders which would prevent them from sliding.

INTRODUCTION

On May 27, 1992, a 38-year-old male Korean painter died after he fell from a third story (approximately 40 ft.) window in an apartment complex and landed on the concrete below. The incident occurred at 9:40 A.M. and the California FACE investigator was notified that afternoon, May 27, by the California Occupational Safety and Health Administration (Cal/OSHA) office. The FACE investigator went to the incident site and conducted an interview with the resident at the apartment on May 27. Reports were obtained from Cal/OSHA, the local Police, and the Coroner's office, by the California FACE investigator. Photographs were also taken of the incident site by the FACE investigator on May 27.

The employer in this incident was a small (4 employees), private painting and maintenance company. They had been in business for 5 years. The company had an on-the-job safety training program, but there was no written safety training program. There was also a safety officer with the company; however, he was not on site when the incident occurred. The victim was working alone when the incident occurred, and had been employed with the company as a painter for 21 days.

INVESTIGATION

The victim in this incident was doing preparation work prior to beginning a paint job on the interior of an apartment. This was a routine job for him and one in which he was familiar. He was last in the apartment by the tenant removing a curtain rod from above a window. He later apparently fell from that window. There were no witnesses to the actual incident. The victim was not on the ladder when last seen by the tenant. She (tenant) had gone down to do some laundry and returned approximately 15 minutes later and found the victim and ladder were gone. She later heard some commotion outside and looked out her window and saw paramedics working on the victim, on the concrete sidewalk below.

There was a new scratch mark on the south wall which curved downward from left to right and continued to the window. The mark was approximately the same height (5') as the ladder, and it was 18 1/4" long. There were no safeguards on the top or bottom of the ladder to prevent it from slipping. The employer stated that the victim was not using any Personal Protection Equipment (PPE) at the time of the incident. The only PPE which was required by the company was respiratory protection (respirators & dust masks).

The victim had extensive bruising and swelling to both his face and head. He also lost a large amount of blood and his upper right arm was broken. He was transported to the hospital by paramedics where advanced life support measures were taken. He was pronounced dead at 10:15 A.M. on May 27, 1992.

CAUSE OF DEATH

The Coroner's Autopsy Report stated the cause of death as multiple injuries due to a fall from a building.

RECOMMENDATIONS/DISCUSSION

Recommendation #1: Employers should have and implement a written Injury & Illness Prevention Plan so that employees are aware of the workplace hazards and how to avoid them.

Discussion: In this incident there were no written safety procedures for identifying workplace hazards, or how employees should avoid such hazards. Under Title 8 of the California Code of Regulations (CCRs) section 3203 (a) employers must establish, implement, and maintain an effective written Injury & Illness Prevention Program.

Recommendation #2: Employers should conduct a job site survey to identify potential hazards, implement appropriate control measures, and provide subsequent training to employees that specifically addresses all identified hazards.

Discussion: The victim in this incident was doing his routine job, however, this particular location (approximately 40 ft. above the ground) may not have been addressed during the previous on the job training sessions. An initial job site survey would determine the potential safety or health risks involved at any location.

Recommendation #3: Employers should have safety devices installed on all ladders which would prevent them from sliding.

Discussion: The victim in this incident slid sideways (based on the direction of the scratch mark) down the wall and out the window. If supports had been installed, this incident may have been prevented. Under Title 8 of the CCRs section 3279 (d) (7) & (8) employers should install footing and top supports for all ladders to prevent them from sliding.

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April 15, 1993