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TO: Director, National Institute for Occupational Safety and Health

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

SUBJECT: Apprentice roofer falls nine feet from roof and dies in California

SUMMARY**California FACE Report #92CA012
April 15, 1993**

On September 3, 1992 a 34-year-old Hispanic male apprentice roofer (victim) died after falling nine feet from a roof which was being renovated. The victim was in the process of taking a hammer up to a co-worker when the incident occurred. He was wearing ordinary street shoes which caused him to slide down the roof about ten feet falling nine feet to a brick patio below. The victim was not wearing any personal protective equipment (PPE) at the time of the incident. He survived for three days and died on September 6, 1992 at 10:45 pm. The California FACE investigator concluded that in order to prevent future similar occurrences, employers should:

- have fall protection devices in place when employees are working on steep inclines.
- not allow employee access to hazardous areas without the proper personal protective equipment (PPE).
- provide and document employee safety training.

INTRODUCTION

On September 3, 1992 at approximately 8:45 am, a 34-year-old male apprentice roofer fell nine feet from a roof hitting his head on the brick patio below. The victim survived for three days and died on September 6, 1992. The California FACE investigator received notification of the incident from the California Occupational Safety and Health Administration's (Cal/OSHA) Bureau of Investigations office on September 15, 1992. The California FACE investigator went to the incident site on September 15 and conducted an interview with the homeowner. The employer was not working that afternoon so an interview was conducted with him a few days later. Photographs were taken during the on-site investigation. Reports were obtained from Cal/OSHA and the Cononer's office.

The employer had been in the roofing business for 15 years. He had worked at this location for seven days. There were five employees working for the employer. Two employees had the same job description as the victim. There was also a safety officer on-site. The employer had a safety program in place which consisted of written safety rules and on the job safety training. The victim had worked for the employer for three days. He had not worked on the roof before and was not wearing the proper work shoes.

INVESTIGATION

The employer was a roofing contractor who had been hired to replace the wooden shingles on a one story residential home. On the day of the incident, September 3, 1992, work began at 8:00 A.M. The roofing crew was preparing the front section of the house for a new roof. All of the employees working on this job were experienced roofers except the victim. The victim had been instructed to clean the rear area behind the house.

A co-worker had forgotten to bring his hammer up to the top of the roof, so the victim decided to climb the ladder and take it to him. The co-worker said that he saw the victim climbing up onto the roof and had told him to be careful. The victim was climbing straight up the roof rather than at an angle like an experienced roofer. The co-worker said the victim slipped and then slid down the roof falling approximately nine feet to the brick patio below. The roof was a 6:12 sloped bare plywood roof. No one witnessed the victim falling and hitting the patio.

The supervisor was not aware of the victim's attempt to climb on the roof. He said that if he had known the victim was wearing ordinary street shoes he would not have allowed him on the job site. The victim's job description according to his supervisor was to do ground work only, he was not to be on the roof. There were five co-workers and the supervisor on-site when the incident occurred.

Paramedics arrived at the scene within minutes after the incident occurred. The homeowner said that he was first aware of the incident when he walked out of his bedroom door and saw paramedics working on the victim. The victim was taken to the hospital where he died three days later on September 6, 1992 at 10:45 PM.

CAUSE OF DEATH

The Coroner's Autopsy Report stated the cause of death as craniocerebral trauma due to blunt force injury as a result of a fall from the roof of a one story building.

RECOMMENDATIONS/DISCUSSION

Recommendation #1: Employers should have fall protection devices in place when employees are working on steep inclines.

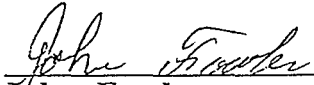
Discussion: This incident may have been prevented if there had been a railing on the edge of the roof or cushioning/airbag (fall protection device) on top of the brick patio below the roof.

Recommendation #2: Employers should not allow employee access to hazardous areas without the proper PPE.

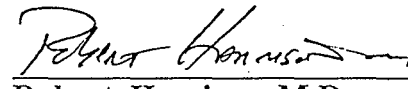
Discussion: The victim in this incident had ordinary street shoes on and no hardhat. A Standard Operating Procedure (SOP) requiring all employees to wear specific PPE (hardhats and safety shoes) could address and prevent similar incidents from occurring in the future. A safety checklist should be used on a daily basis so that supervisors can document and require the use of proper PPE by their employees.

Recommendation #3: Employers should provide and document employee safety training.

Discussion: The victim in this incident was a new employee. Employers should have a documented safety training program for their own evaluation, regarding whether an employee understands the safety rules relating to specific workplace hazards. Under Title 8 of the California Code of Regulations (CCRs) section 1510 (C) where employees are exposed to known job site hazards, they shall be instructed in the recognition of the hazard, and in the procedures for protecting themselves from injury.



John Fowler
FACE Investigator



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FACE Project Officer

April 15, 1993