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TO: Director, National Institute for Occupational Safety and Health

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

SUBJECT: Courtesy clerk at grocery store falls from a ladder and dies in California

SUMMARY

California FACE Report #92CA017
November 15, 1993

A 17 year-old white male courtesy clerk (victim) died after falling approximately eight feet from a ladder in a grocery store. The victim was attempting to put the ladder away for the evening when the incident occurred. This was not a part of his (victim's) usual duties as a courtesy clerk. He was attempting to help his supervisor clean up at the end of the day. The victim was last seen falling from the ladder by the janitor. The supervisor was informed and 911 was called. The victim's co-workers attempted to keep him warm until paramedics arrived. Paramedics then stabilized the victim and transported him to a local hospital. The California FACE investigator concluded that, in order to prevent future similar occurrences, employers should:

- have a documented safety training program for employees which addresses ladder safety.
- have non-slip safety devices placed on the tops and bottoms of ladders so they will not slide.
- have a documented safety training program which addresses ladder and equipment storage.
- have supervisors and employees trained in cardiopulmonary resuscitation (CPR) and First Aid, so that if an emergency occurs, someone can initiate CPR until paramedics arrive.

INTRODUCTION

On November 19, 1992, at 12:30 A.M. a 17-year-old white male courtesy clerk (victim) fell eight feet from a ladder and died several days later. The victim hit the back of his head on the concrete floor. The California FACE investigator was informed of this incident by the Cal/OSHA Bureau of Investigations (BOI) office on November 27, 1992 and responded to the location that afternoon and met with the regional safety manager for the grocery store chain. A copy of the Cal/OSHA Report and the Coroner's Autopsy Report were obtained by the California FACE investigator. Photographs were also taken of the incident site by the California FACE investigator.

The employer in this incident was a grocery store which had been in business at this location for 20 years. The store employed approximately 58 people at the time of the incident. The employer had a safety training program and safety officers on staff. According to the Cal/OSHA report the store's safety program was in compliance with most of Title 8 the California Code of Regulations (CCRs) Illness and Injury Prevention Program (IIPP) section 3203. The victim had been hired as a courtesy clerk and had worked for the grocery store for seven months. There were 10-12 employees who had the same job description as the victim. The victim was not doing his routine job at the time of the incident, but was helping to put a ladder away in the storage area. The supervisor normally did this task at the end of the work day. The supervisor was not aware of what the victim was doing at the time of the incident.

INVESTIGATION

The employer in this incident was a grocery store. The victim's job title was courtesy clerk, although he was not engaged in his normal duties at the time of the incident. The victim was in the process of putting a ladder away when he fell and hit the back of his head on the concrete floor. The victim was last seen climbing the ladder to the second floor. This was where the ladder was stored at the end of each work day.

The usual procedure for storage of the ladder was to place it against the opening on the second floor, and then to climb the back stairway and pull the ladder up from above. The ladder used in this incident was a 12 foot wooden ladder. It was used by the manager to access products on elevated shelves and to fix lighting fixtures. There were no safety devices placed on the ladder to keep it from sliding. Co-workers and the victim's supervisor found the ladder leaning against the wall rather than pulled apart (A Frame) as the ladder had been designed for use. The ladder was also found in a position that made it appear as if the ladder had slid across the wall while the victim was still on it.

A janitor was the nearest co-worker when the incident occurred. He (janitor) said that he was getting some supplies from a closet when he turned and saw the victim falling from the ladder. Co-workers were called by the janitor and informed that the victim had fallen. The supervisor called 911 and paramedics were dispatched to the scene. There were seven co-workers who came to the victim's aid. According to their statements the victim was thrashing back and forth from pain when they first arrived. Two co-workers ran out to the parking lot to get a sleeping bag from a car to keep the victim warm. The victim began to bleed from the ears and co-workers placed some towels beneath his head. Upon arrival, paramedics stabilized the victim and transported him to a local hospital. The victim died on November 24, 1992 at 8:10 a.m.

CAUSE OF DEATH

The Coroner's Autopsy Report stated the cause of death as cranio-cerebral trauma due to blunt force injury.

RECOMMENDATIONS/DISCUSSION

Recommendation #1: Employers should have a documented safety training program for employees which addresses ladder safety.

Discussion: This incident may have been prevented if the victim had received ladder safety training. The ladder was found leaning against the wall by co-workers when they responded to the scene after the incident. The ladder had been designed to stand in an A shape when in use. Under title 8 of the California Code of Regulations (CCRs) section 3203 (a) (2) employers must include in their Injury and Illness Prevention Program (IIPP) a system for ensuring that employees comply with safe and healthy work practices. Substantial compliance with this provision includes recognition of employees who follow safe and healthful work practices, training and retraining programs, disciplinary actions, or any other such means that ensures employee compliance with safe and healthful work practices.

Recommendation #2: Employers should have non-slip safety devices placed on the tops and bottoms of ladders so they will not slide.

Discussion: This incident may have been prevented if the ladder which was used by the victim had non slip safety devices placed on it. Under Title 8 of the CCRs section 3278 (e) (7) portable rung and cleat ladders shall, where possible, be used at such a pitch that the horizontal distance of the top support to the foot of the ladder is one-quarter of the working

length of the ladder (the length along the ladder between the foot and the top support). The ladder shall be so placed as to prevent slipping, or it shall be lashed, or held in position.

Recommendation #3: Employers should implement and have a written safety training program which addresses ladder storage and safety.

Discussion: This incident may have been prevented if the storage space for the ladder had been located in a more accessible area. The storage area used was on the second floor and not easily accessible to employees. Since the storage area was not located on the ground floor it was necessary to climb to the second floor and pull the ladder up. A safety training program could address this situation by identifying a new storage area on the ground floor and by making this area only accessible to certain employees.

Recommendation #4: Employers should have employees and supervisors trained in cardiopulmonary resuscitation (CPR) and First Aid, so if an emergency occurs someone can initiate CPR or First Aid until paramedics arrive.

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November 15, 1993