TO: Director, National Institute for Occupational Safety and Health

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

SUBJECT: Lumberyard Orderman Died from Injuries Sustained after a Laminated Beam Falls on Him in California

SUMMARY
California FACE Report #94CA012
April 24, 1995

A 41-year-old white, Hispanic male orderman (the decedent) died after a 60 foot laminated beam fell on him in a lumber yard. There were no witnesses to this incident but the employer believed the decedent was attempting to retrieve a 7" X 11 7/8" X 8' beam out from under two large laminated beams which weighed approximately 3000 lbs. each. While he was attempting to move the shorter beam out from underneath the large laminated beam onto a forklift, the large laminated beam rolled on top of him. Co-workers heard the decedent's screams and came to his aid. He was conscious when co-workers arrived so they did not attempt cardiopulmonary resuscitation (CPR) or First Aid procedures. Paramedics were summoned to the scene and arrived in approximately 5 minutes. The decedent was transported to a nearby hospital where he underwent emergency surgery. He was pronounced dead by a physician at the hospital at 2:15 am on May 12, 1994. The CA/FACE investigator concluded that in order to prevent similar future occurrences, employers should:

- provide training for employees regarding the hazards related to loading and unloading stacks of lumber.
- evaluate their current safety program and incorporate specific training procedures emphasizing the importance of controlling hazards in the workplace. These procedures should include, but not be limited to, conducting hazard evaluations before initiating work at a job site and implementing appropriate controls.
- require that employees work in pairs when their work involves retrieving lumber from under a stack.

INTRODUCTION

On May 12, 1994, a 41-year-old orderman (the decedent) died after being crushed by a laminated beam on May 11, 1994 in the lumberyard where he was employed. The CA/FACE investigator was informed of this incident by the California Occupational Safety and Health Administration's (Cal/OSHA) Bureau of Investigations office on June 16, 1994. On Wednesday June 23, the CA/FACE investigator went to the incident site and conducted an investigation. The Cal/OSHA Report and the Coroner's Autopsy Report were obtained by the CA/FACE investigator.

The employer in this incident owned and managed a 17 acre lumberyard and had been in business at the incident site location since 1959, and an additional 50 years at another location. There were 30 employees working at the lumberyard at the time of the incident, and two of whom shared similar job descriptions to that of the decedent. The decedent was a union employee and had worked with his employer for 15 years. The employer maintained a written Injury and Illness Prevention Program (IIPP) and provided on-the-job training, however the IIPP did not address procedures for removing lumber from stacks. A safety officer was on staff and was at the site when the decedent was injured.

INVESTIGATION

On the day of the incident at approximately 4:00 p.m., the decedent was working alone in the lumber yard approximately a quarter mile from the main office site. He had an order form in his possession which requested an eight foot laminated beam. This beam was located beneath two 5 1/4" X 18" X 30' beams resting on top of two 4" X 4" wood spacers (stickers). Each of the longer beams weighed approximately 3000 lbs. According to the employer, the lumber had been stacked in a typical manner. He apparently attempted to remove one of the eight foot beams from under the large beams rather than removing them first, and one of the large beams rolled on top of him. The employer stated that no one witnessed the incident or knew what the decedent had been doing prior to the incident.

When co-workers arrived at the scene they found the victim with one end of the beam resting on top of him. They moved the beam off the victim and called 911 to request an ambulance. The victim was conscious so co-workers did not initiate CPR or First Aid. Paramedics arrived in approximately 5 minutes and transported the victim to a local hospital where he underwent emergency surgery. The decedent was pronounced dead at 2:15 a.m. on May 12, 1994.

CAUSE OF DEATH

The Coroner's Autopsy Report stated the cause of death as multiple traumatic injuries to abdomen and pelvis.

RECOMMENDATIONS/DISCUSSION

Recommendation #1: Employers should provide training for employees regarding the hazards related to incorrectly loading or unloading stacks of heavy lumber.

Discussion: Although the employer in this incident maintained a written IIPP, there was no training related to the hazards of loading and unloading stacks of lumber. Training in the safe manner of moving lumber, with the clear understanding that this was a requirement of the employer's safety program may have prevented this incident. Under Title 8 of the California Code of Regulations (CCRs) section 3203 (a) (7), the employer shall provide training and instruction:

(a) when the program is first established;
(b) to all new employees;
(c) to all employees given new job assignments for which training has not previously been

received;

(d) whenever new substances, processes, procedures or equipment are introduced to the workplace and represent a new hazard;

(e) whenever, the employer is made aware of a new or previously unrecognized hazard; and

(f) for supervisors to familiarize them with the safety and health hazards to which employees under their immediate direction and control may be exposed.

Recommendation #2: Employers should evaluate their current safety program and incorporate specific training procedures emphasizing the importance of controlling hazards in the workplace. These procedures should include, but not be limited to, conducting hazard evaluations before initiating work at a job site and implementing appropriate controls.

Discussion: Once a hazard evaluation has been conducted, standard operating procedures (SOP's) should be developed and implemented by employers. A SOP for this type of situation should give specific procedures for the retrieval of stacked lumber.

Recommendation #3: Employers should require that employees work in pairs when their work involves retrieving lumber from under a stack.

Discussion: This fatality may have been prevented if the decedent had been working with a co-worker. Another worker may have been able to assist in the retrieval process and perhaps remind the decedent of the hazards involved in removing a piece of lumber when located underneath a stack of lumber.

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FATALITY ASSESSMENT AND CONTROL EVALUATION PROGRAM

The California Department of Health Services, in cooperation with the Public Health Institute and the National Institute for Occupational Safety and Health (NIOSH), conducts investigations of work-related fatalities. The goal of this program, known as the California Fatality Assessment and Control Evaluation (CA/FACE), is to prevent fatal work injuries in the future. CA/FACE aims to achieve this goal by studying the work environment, the worker, the task the worker was performing, the tools the worker was using, the energy exchange resulting in fatal injury, and the role of management in controlling how these factors interact. NIOSH-funded, state-based FACE programs include: Alaska, California, Iowa, Kentucky, Massachusetts, Michigan, Minnesota, Nebraska, New Jersey, New York, Oklahoma, Oregon, Washington, West Virginia, and Wisconsin.

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Additional information regarding the CA/FACE program is available from:

California FACE Program
California Department of Health Services
Occupational Health Branch
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