

# CSI Country Wide Case Study Safety Strategy Discussion

## Construction Safety Investigator



### Instructions

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The objective of this tool is to provide field supervisors with information to proactively engage workers and discuss safety related concerns that they may encounter. Safety discussions should not be limited to the subject above and should pertain to the activities that workers will be involved in that may have the potential for safety related exposures..

### Case Day:

June 8, 2005

### Accident Type:

Fall Accident - Suspended Scaffold

### Relevant laws, rules and codes may include:

1926.21(b)(2), 29 CFR 1926.451, .452, and .454

### Case:

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A 46 year-old male was fatally injured when he was pulled off of a roof and fell approximately 53 feet to the ground during building window operations..

### Accident Detail:

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The victim was located on the flat roof of a four story building, controlling a rolling roof outrigger. The victim was wearing a full-body safety harness with a retractable lanyard that was anchored to the rolling roof outrigger.

The victim's co-worker was suspended approximately five feet down the side of the building from the rolling roof outrigger.

As the victim was trying to reposition the rolling roof outrigger, it rolled to the edge of the roof and then rolled off of the roof, dragging the victim over the roof. The victim, co-worker and the rolling outrigger all fell to the ground below with the rolling roof outrigger landing on top of the co-worker.

### Reconstructive Safety Evaluation:

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- What are some of the possible causes of the accident being discussed?
- What actions could have been taken that might have prevented this accident from occurring?

**Accident Scene Conclusion:**

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The investigation revealed that the worker’s lifelines were not tied off to independent roof top anchor points. A single nylon rope with a knot tied in the middle was used to comprise the coworker’s descent control line and lifeline. The rolling roof outrigger required the use of counterweights to help stabilize the unit. The manufacturer’s required counterweight was more than three times the 200 pounds that was being used.

It appears that the victim unlocked the rolling roof outrigger’s wheels, unattached the rolling roof outrigger from the rooftop anchor point and started to roll the outrigger so the co-worker could make his way around the building’s 45 degree angle to the next side of the building.

**Preventive Safety Measures Include:**

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- Ensure that rolling roof outriggers are properly tied back at all times during use to prevent outriggers from falling off the roof.
- Ensure that anchor points for personal fall protection equipment are completely independent from descent equipment and a competent person inspects and evaluates all anchor points and rigging before each descent.
- Obtain owner’s manuals for all equipment to ensure that equipment is being used as it was designed to be used.
- Ensure that employees who perform operations using suspended scaffolds are provided training on the proper use of approved descent control devices and appropriate support systems prior to work commencing.

**Attendance Roster**

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Reference: This case was reported in the NIOSH Fatality Assessment and Control Evaluation (FACE) Program, Report #05MA038.

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