On January 6, 2014, a 34-year-old ironworker died when he fell from a mast scaffold. The incident happened at a multi-story commercial building construction project site. The victim’s employer is a provider of steel erection services and was a subcontractor on this project. The victim had worked as an ironworker for 10 years. He had been with his employer for 11 months; four of these months had been spent at this site. On the day of the incident, three employees were rigging and welding a tube steel eyebrow beam into place between the building’s 9th and 10th floors. That morning the victim and another employee operated the power-driven twin mast scaffold to raise the work platform to the work area. This type of scaffold is also known as a mast climbing work platform or mast climber. Working from the scaffold, the victim and another employee welded half of the beam into place. The third employee was on the roof rigging the beam sections and signaling the crane operator. After receiving and temporarily attaching the second half of the beam, the victim unhooks his lanyard’s pelican hook from the scaffold frame and began walking along the scaffold to where he would have to step down onto a 2’x4’ platform in order to access the point to be welded. Two employees observed the victim, who was not tied off, trip over a welding cable and fall into an opening between the building and the scaffold. He fell 72 feet from the scaffold to the concrete road below. Investigators determined, among other things, that the unprotected opening between the scaffold platform and the building was 55 inches; that neither vertical nor catenary lifelines were available on the section of the scaffold where the victim fell; employees were not properly trained in fall protection measures or in the operation and use of the mast scaffold; and the scaffold and its components were not inspected by a competent person.

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This narrative was developed to alert employers and employees of a tragic loss of life of a worker in Washington State and is based on preliminary data ONLY and does not represent final determinations regarding the nature of the incident or conclusions regarding the cause of the fatality. Developed by WA State Fatality Assessment and Control Evaluation (FACE) Program and the Division of Occupational Safety and Health (DOSH), WA State Dept. of Labor & Industries. The FACE Program is supported in part by a grant from the National Institute for Occupational Safety and Health (NIOSH grant# 5 U60 OH008487-09). For more information, contact the Safety and Health Assessment and Research for Prevention (SHARP) Program, 1-888-667-4277.