FATALITY NARRATIVE

INCIDENT FACTS

REPORT #: 71-168-2018s
REPORT DATE: March 12, 2018
INCIDENT DATE: March 21, 2017
VICTIM: 61 years old
INDUSTRY: Siding Contractors
OCCUPATION: Contractor/Sider
SCENE: Apartment complex under construction
EVENT TYPE: Fall
A 61-year-old siding contractor died when he fell 23 feet from an apartment building balcony. On the day of the incident, he was working as a subcontractor at an apartment complex under construction. He and two other employees were installing trim and soffits on the exterior of the building. He was working alone on a third floor balcony of the building preparing to install a soffit.

He climbed a 4-foot stepladder to measure a part of the soffit that extended out beyond the balcony and its temporary wooden guardrails. In order to position himself, he took one foot off the stepladder and placed it on the top guardrail. The guardrail came loose and he fell off the balcony, landing on a concrete sidewalk below.

EMS responders took him to a hospital where he died.
Investigators determined that the temporary guardrails on the balcony, and many others throughout the five building development, were improperly installed by a framing contractor.

The original guardrails on the incident balcony had been removed by a siding contractor and his employees so that they could install moisture barriers on the building exterior. When they replaced the guardrails, they also did so improperly.

The project general contractor did not ensure that the guardrails were installed and maintained in a safe manner.
Photo 1. Incident scene on a third floor balcony of the apartment building under construction. The sider who was standing on the stepladder put one foot on top of the temporary wooden railing. As he did so, the railing came loose and he fell 23 feet to a sidewalk below.
Photo 2. Incident scene showing third floor balcony of the apartment building (circled) where the sider was working. He was standing on an a stepladder, and as he reached above to take measurements for a soffit, he put one foot on top of a temporary wooden railing. The railing came loose and he fell 23 feet to the sidewalk below.
Incident apartment building with temporary wooden balcony railings. Photo 3 shows the railings shortly after the victim fell from the third floor balcony. Photo 4 shows the same building with temporary railings installed properly.
Photo 5. Railing (not incident railing) at job site showing multiple nails. Workers needed to remove railings to install moisture barriers on the building.
Requirements

• General contractors have a responsibility to ensure the safety of their worksite, not only for their employees, but also for subcontractors and their employees. See WRD 27.00

• Develop a written fall protection work plan including each area of the workplace where the employees are assigned and where fall hazards of 10 feet or more exist. See WAC 296-155-24611(2)
Requirements

- Ensure that appropriate fall protection is provided, installed, and implemented when employees are exposed to fall hazards of 4 feet or more to the ground or lower level when on a walking/working surface. See [WAC 296-155-24609](#)

- Conduct walk-around safety inspections of job sites. See [WAC 296-155-110(9)](#)
Recommendations

• General contractors should convey firm expectations for using fall protection to employees and subcontractors before the job starts. During the job they should visit sites to monitor for compliance and take corrective action.

• All contractors should ensure that appropriate fall protection is used by workers. In this incident, for example, an extra guardrail could have been installed or workers could have used a personal fall arrest system.

• Consider using safer alternatives to ladders for working at height, such as a mobile baker scaffold with guardrails or a portable lift platform.
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Resources

Fall Protection, Washington State Dept. of Labor and Industries.
http://www.lni.wa.gov/Safety/Topics/AtoZ/fallprotect/
This bulletin 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 Washington State Fatality Assessment and Control Evaluation (FACE) Program and the Division of Occupational Safety and Health (DOSH), Washington 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# 2U60OH008487). For more information visit www.lni.wa.gov/Safety/Research/FACE.