

PROGRAM-RELATED FATALITIES

MICHIGAN 2006



Management Information Systems Section
Management and Technical Services Division
Michigan Department of Labor
& Economic Growth
September 2007

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INTRODUCTION

In 2006, Michigan reported 52 Program-Related fatalities. Program-Related fatalities in Michigan are recorded and tabulated by the Management Information Systems Section, Michigan Occupational Safety and Health Administration (MIOSHA), Michigan Department of Labor and Economic Growth. The sources of data include the Basic Report of Injury - Form 100 and telephone reports of fatalities to MIOSHA. The conditions necessary for a fatal case to be Program-Related are defined in the NOTE ON PROGRAM RELATED CASES (see Page 8).

The intention of this report is to promote an understanding of what constitutes a Program-Related fatality and to assist in the continued effort of preventing and reducing fatal cases. Information presented in this report may be of special interest to employers, employees, safety professionals and consultants. Any inquiries regarding this report may be addressed to:

Management Information Systems Section
Management and Technical Services Division
Michigan Occupational Safety and Health Administration (MIOSHA)
Michigan Department of Labor & Economic Growth
7150 Harris Drive, Box 30643
Lansing, Michigan 48909-8143
Telephone (517) 322-1851

HIGHLIGHTS OF PROGRAM-RELATED FATALITIES, MICHIGAN 2006

This Program-Related fatality information for Michigan was compiled from the "Employers Basic Report of Injury," Workers Disability Form 100s, and from direct telephone reports of fatalities to MIOSHA. Only fatal cases that are Program-Related, as defined by MIOSHA, are compiled. Therefore, the data does not include fatalities resulting from heart attacks, homicides, suicides, personal motor vehicle accidents, and aircraft accidents. The figures are shown in **Tables 1 through 12**.

PROGRAM-RELATED FATALITY TRENDS

A definition of Program-Related cases can be found on Page 8 of this report. Program-Related fatality trends for 1985 through 2006 are shown in **Table 1**, as well as **Figure 1**.

This report is an overview of how the fatalities were distributed across industry groups, occupations, sources of injury or illness, events or exposures, parts of body affected, and nature of injury or illness. Frequencies of fatalities by age group, gender, month of occurrence, and counties of occurrence are also provided.

PROGRAM-RELATED FATALITIES BY INDUSTRY

Table 2 shows the distribution of Program-Related fatalities by industry groups in 2006. This was determined by the job being performed by the employee at the time of the accident. Beginning in 2003, the industry group category is based on the Northern American Industry Classification System (NAICS), which groups establishments into industries based on the activities in which they are primarily engaged. Prior to 2003, the industry group category was based on the Standard Industrial Classification (SIC) of the employer. Due to the substantial differences between the current and previous classification system, the results by industry in 2003 and thereafter constitute a break in series and users are advised against making comparisons between the 2003 industry categories and the results for previous years.

During 2006, the largest number of Program-Related fatalities was reported in the Construction industry (NAICS 23) with 27 fatalities.

PROGRAM-RELATED FATALITIES BY OCCUPATION

Program-Related fatalities by occupation are shown in **Table 3**. The most affected occupation group with 19 Program-Related fatalities was Construction and Extraction followed by Transportation and Material Moving with nine fatalities. These were followed by Production occupations, as well as Installation, Maintenance and Repair occupations each reporting seven fatalities.

PROGRAM-RELATED FATALITIES BY SOURCE OF INJURY OR ILLNESS

The sources of injury or illness leading to Program-Related fatalities during 2006 are listed in **Table 4**. Thirteen fatalities were reported for the category of Floors, Walkways, Ground Surfaces; seven were reported for Parts and Materials; and six fatalities were reported for the categories of Persons, Plants, Animals and Minerals, as well as Highway Vehicle, Motorized. All other sources contributed four or fewer fatalities.

PROGRAM-RELATED FATALITIES BY EVENT OR EXPOSURE

Table 5 shows Program-Related fatalities by event or exposure. Of these, 12 victims Fell to a Lower Level and 12 were Struck by an Object. Six fatalities were the result of coming in Contact with Electric Current.

PROGRAM-RELATED FATALITIES BY PART OF BODY

Parts of the body affected by fatal injury or illness are shown in **Table 6**. The data shows that Cranial Region, including Skull, accounted for 19 fatalities. Multiple Body Parts accounted for 17 fatalities and nine fatal injuries or illnesses were specified for Body Systems.

PROGRAM-RELATED FATALITIES BY NATURE OF INJURY OR ILLNESS

Details of the nature of injuries and illnesses causing Program-Related fatalities are given in **Table 7**. The nature of the fatal injuries or illnesses reported Multiple Intracranial Injuries accounting for 17 fatalities. Intracranial Injuries and Injuries to Internal Organs, as well as Other Combinations of Traumatic Injuries and Disorders each reported eight fatalities. Electrocutions, Electric Shocks accounted for six fatalities. These categories accounted for approximately 25 percent of the total program-related fatalities that occurred in 2006.

PROGRAM-RELATED FATALITIES BY AGE AND GENDER

The distribution of Program-Related fatalities by age and gender are shown in **Tables 8 and 9**. The age groups of 46-50 and 56-60 suffered the greatest numbers of fatalities reporting eight each. These were followed by the five-year age categories of 26-30 and 41-45 each reporting seven fatalities and the age group of 31-35 reporting six fatalities. Of the 52 victims, all 52 were male employees.

PROGRAM-RELATED FATALITIES BY MONTH OF OCCURRENCE

Fatality data categorized by the month of occurrence is shown in **Table 10**. The month of August recorded the highest number of fatalities with 11. Seven Program-Related fatalities were reported during the month of February, while the months of May and December each recorded six fatalities. The months of April and October recorded five fatalities each.

PROGRAM-RELATED FATALITIES BY INDUSTRY GROUPS AND DAYS OF THE WEEK

Program-Related fatalities by industry groups and days of the week are shown in **Table 11**. The highest number of fatalities by day of the week shows Wednesday with 14; followed by Monday with nine; Thursday with eight; Tuesday and Friday with seven; Sunday with six; and Saturday with one Program-Related fatality.

PROGRAM-RELATED FATALITIES BY COUNTY OF OCCURRENCE

The distribution of fatality cases by counties shows that Program-Related fatalities were reported as occurring in 23 counties during 2006. Eight fatalities were reported in Macomb County; seven were reported in Oakland and Wayne counties; four fatalities in Kent County; and three fatalities in Genesee County. A complete distribution of fatality cases by county of occurrence is shown in **Table 12**.

Even though Michigan's 2006 total Program-Related fatality cases are far less than the thousands of cases reported nationwide, the consequences of these on-the-job deaths in terms of human suffering, lost workdays, decreased production, and increased compensation rates are all too significant to be overlooked.

In order for Michigan to reduce the number of on-the-job fatality cases, it requires a conscious effort on the part of employers to recognize and comply with MIOSHA standards, develop and implement safe working procedures and assure that employees observe and practice these procedures. The MIOSHA program offers on-site consultation and consultation, education and training (CET) opportunities to employers and employees alike to help them achieve this goal.

Those Michigan employers, who would like to request education and training services, as well as onsite consultation programs, may contact:

**Michigan Occupational Safety and Health Administration (MIOSHA)
Consultation Education and Training (CET) Division
Michigan Department of Labor & Economic Growth
Box 30643, Lansing, Michigan 48909
Telephone (517) 322-1809**

The Program-Related fatality data for Michigan are presented in the following series of **Tables 1 through 12**. A brief description of how the Program-Related fatalities occurred is also provided following the series of tables. The descriptions are listed by industry groups based on the North American Industry Classification System (NAICS), which is based on the activity in which the establishment is primary engaged. Safety professionals may find this information useful for accident prevention.

NOTE ON PROGRAM-RELATED CASES

A fatality is recorded as “Program-Related” if the deceased party was employed in an occupation included in MIOSHA jurisdiction as defined in Public Act 154 of 1974, as amended, and the fatality appears to be related to one or more of the following conditions:

1. The incident was found to have resulted from violations of MIOSHA safety and health standards or the “general duty” clause.
2. The incident was considered to be the result of a failure to follow a good safety and health practice that would be the subject of a safety and health recommendation.
3. The information describing the incident is insufficient to make a clear distinction between a "Program-Related" and "non-Program-Related" incident, but the type and nature of the injury indicates that there is a high probability that the injury was the result of a failure to adhere to one or more MIOSHA standards, the “general duty” clause, or good safety and health practice.

Any inquiries may be addressed to:

MANAGEMENT INFORMATION SYSTEMS SECTION
MANAGEMENT AND TECHNICAL SERVICES DIVISION
MICHIGAN OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (MIOSHA)
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