

# **PROGRAM-RELATED FATALITIES**

## **MICHIGAN 2011**



Management Information Systems Section  
Management and Technical Services Division  
Michigan Department of Licensing & Regulatory Affairs  
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## **INTRODUCTION**

In 2011, Michigan reported 36 Program-Related fatalities. Program-Related fatalities in Michigan are recorded and tabulated by the Management Information Systems Section (MISS), Michigan Occupational Safety and Health Administration (MIOSHA), Michigan Department of Licensing and Regulatory Affairs. 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 Licensing & Regulatory Affairs  
7150 Harris Drive, Box 30643  
Lansing, Michigan 48909-8143  
Telephone (517) 322-1851**

## **HIGHLIGHTS OF PROGRAM-RELATED FATALITIES, MICHIGAN 2011**

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 8**.

### **PROGRAM-RELATED FATALITY TRENDS**

A definition of Program-Related cases can be found on Page 8 of this report. Program-Related fatality trends for 1987 through 2011 are shown in **Table 1**, as well as data from 1987 through 2011 in **Figure 1**.

This report is an overview of how the fatalities were distributed across industry groups and occupations. 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 2011. 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 2011, the largest number of Program-Related fatalities was reported in the Construction industry (NAICS 23) with 12 fatalities. Manufacturing (NAICS 31-33) had the second highest number with eight. This was followed by Agriculture, Forestry, Fishing and Hunting (NAICS 11) which reported six fatalities.

### **PROGRAM-RELATED FATALITIES BY OCCUPATION**

Program-Related fatalities by occupation are shown in **Table 3**. The most affected occupation group with eight program-related fatalities was Construction and Extraction. This was followed by Management occupations with seven fatalities. Following next was Installation, Maintenance and Repair with six fatalities.

### **PROGRAM-RELATED FATALITIES BY AGE AND GENDER**

The distribution of Program-Related fatalities by age and gender are shown in **Tables 4 and 5**. The age groups of 46-50, 51-55 and 56-60 each reported six fatalities during 2011. This was followed by the five-year age category of 41-45 reporting five fatalities. Of the 36 victims, 34 were male employees.

### **PROGRAM-RELATED FATALITIES BY MONTH OF OCCURRENCE**

Fatality data categorized by the month of occurrence is shown in **Table 6**. The month of August recorded the highest number of program-related fatalities with six. Five were reported for the month of May and four were reported during the months of June and December. The month of March did not record any reported fatalities.

### **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 7**. The highest number of fatalities by day of the week shows Monday with 12, followed by Tuesday with nine, and Wednesday and Thursday with six fatalities each.

### **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 2011. Five fatalities were reported in Wayne County, four in Oakland County, and three were reported in Washtenaw County. All other counties recording fatalities experienced two or fewer. Sixty Michigan counties had no program-related fatalities. A complete distribution of fatality cases by county of occurrence is shown in **Table 8**.

Even though Michigan's 2011 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 onsite 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:

**Consultation Education and Training (CET) Division  
Michigan Occupational Safety and Health Administration (MIOSHA)  
Michigan Department of Licensing & Regulatory Affairs  
7150 Harris Drive, 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 8**. 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 primarily engaged. Safety professionals may find this information useful for accident prevention.

## **NOTE ON PROGRAM-RELATED CASES**

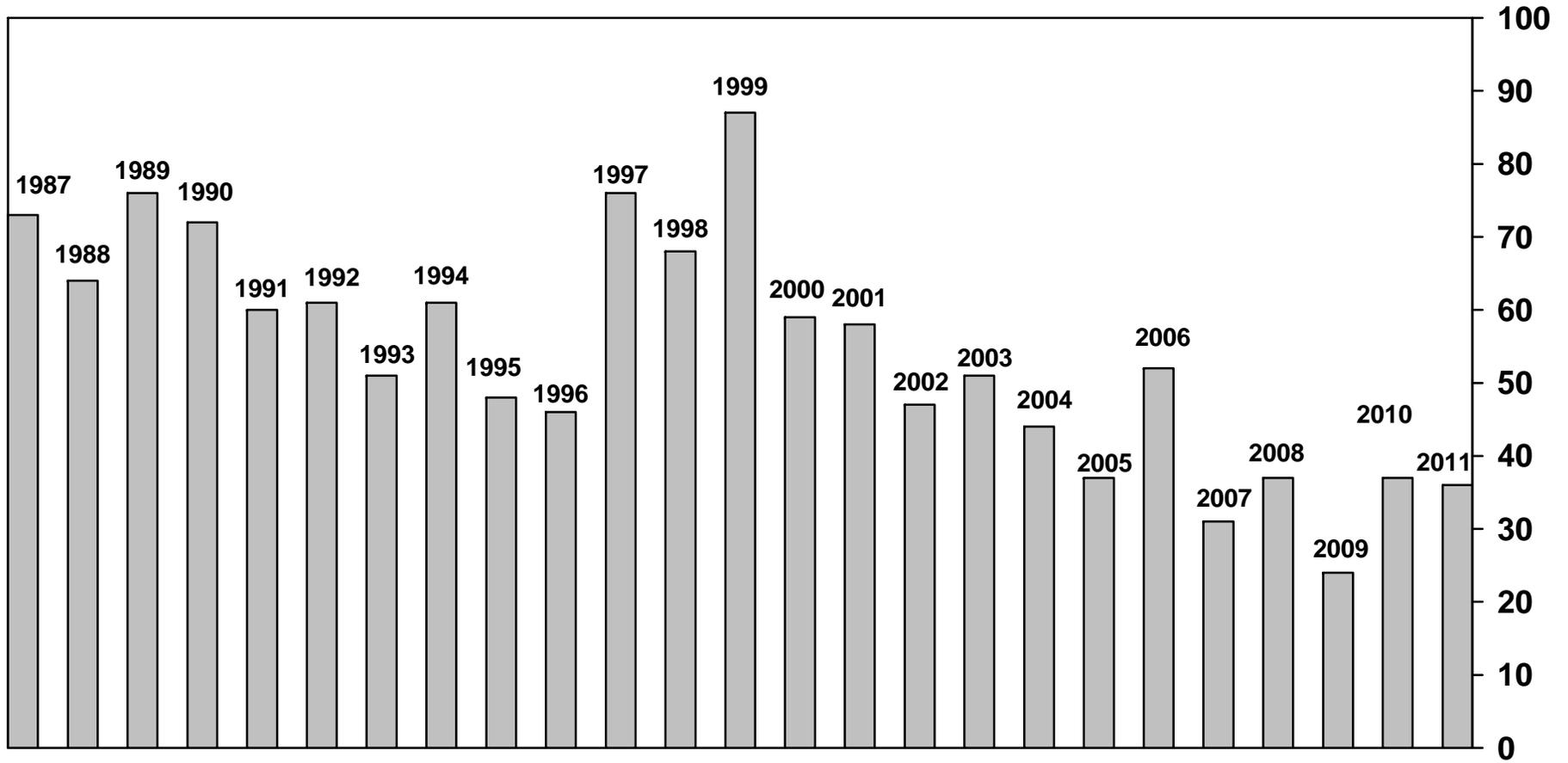
A fatality is recorded as “Program-Related” if the deceased party was employed in an occupation included in MIOSHA jurisdiction as defined in Public Act 154 of 1974, as amended, and the fatality appears to be related to one or more of the following conditions:

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)  
Michigan Department of Licensing & Regulatory Affairs  
7150 Harris Drive, Box 30643  
Lansing, Michigan 48909-8143  
(517) 322-1851**

**FIGURE 1**  
**PROGRAM-RELATED FATALITY TRENDS**  
**MICHIGAN 1987-2011**



**TABLE 1**  
**PROGRAM-RELATED FATALITY TRENDS**  
**MICHIGAN 1987 – 2011**

YEAR	NUMBER	PERCENT CHANGE FROM PREVIOUS YEAR	PERCENT CHANGE FROM 1987
1987	73	--	---
1988	64	-12.3	-12.3
1989	76	18.8	4.1
1990	72	-5.3	-1.4
1991	60	-16.7	-17.8
1992	61	1.7	-16.4
1993	51	-16.4	-30.1
1994	61	19.6	-16.4
1995	48	-21.3	-34.2
1996	46	-4.2	-37.0
1997	76	65.2	4.1
1998	68	-10.5	-6.8
1999	87	27.9	19.2
2000	59	-32.2	-19.2
2001	58	-1.7	-20.5
2002	47	-19.0	-35.6
2003	51	8.5	-30.1
2004	44	-13.7	-39.7
2005	37*	-15.9	-49.3
2006	52	40.5	-28.8
2007	31	-40.4	-57.5
2008	37	19.4	-49.4
2009	24	-35.2	-67.2
2010	38*	58.3	-48.0
2011	36	5.3	-50.7

Source: MISS/MTSD/ MIOSHA/Michigan Department of Licensing & Regulatory Affairs

Note: An amendment has been made to both the 2005 and 2010 fatality counts. They were previously reported as 36 and 37 total fatalities respectively.

**TABLE 2**  
**PROGRAM-RELATED FATALITIES**  
**BY INDUSTRY GROUPS**  
**MICHIGAN 2011**

<b>NAICS MAJOR SECTOR</b>	<b>INDUSTRY GROUP</b>	<b>TOTAL</b>
11	AGRICULTURE, FORESTRY, FISHING AND HUNTING	6
21	MINING	0
22	UTILITIES	0
23	CONSTRUCTION	12
31-33	MANUFACTURING	8
42	WHOLESALE TRADE	2
44-45	RETAIL TRADE	0
48-49	TRANSPORTATION AND WAREHOUSING	2
51	INFORMATION	0
52	FINANCE AND INSURANCE	0
53	REAL ESTATE AND RENTAL AND LEASING	0
54	PROFESSIONAL, SCIENTIFIC AND TECHNICAL SERVICES	0
55	MANAGEMENT OF COMPANIES AND ENTERPRISES	1
56	ADMINISTRATIVE AND SUPPORT AND WASTE MANAGEMENT AND REMEDIATION SERVICES	0
61	EDUCATIONAL SERVICES	1
62	HEALTH CARE AND SOCIAL ASSISTANCE	1
71	ARTS, ENTERTAINMENT AND RECREATION	1
72	ACCOMMODATION AND FOOD SERVICES	1
81	OTHER SERVICES (EXCEPT PUBLIC ADMINISTRATION)	1
92	PUBLIC ADMINISTRATION	0
<b>TOTAL</b>		<b>36</b>

Note: The industry group categories are based on the Northern American Industrial Classification System (NAICS), which is based on the activities in which the establishments are primarily engaged.

Source: MISS/MTSD/ MIOSHA/Michigan Department of Licensing & Regulatory Affairs

**TABLE 3**  
**PROGRAM-RELATED FATALITIES**  
**BY OCCUPATION**  
**MICHIGAN 2011**

<b>STANDARD OCCUPATION CODE</b>	<b>OCCUPATION</b>	<b>NUMBER OF CASES 2011</b>
11-0000	MANAGEMENT OCCUPATIONS	7
13-0000	BUSINESS AND FINANCIAL OPERATIONS	0
15-0000	COMPUTER AND MATHEMATICAL	0
17-0000	ARCHITECTURE AND ENGINEERING	0
19-0000	LIFE, PHYSICAL AND SOCIAL SCIENCE	0
21-0000	COMMUNITY AND SOCIAL SERVICE	0
23-0000	LEGAL OCCUPATIONS	0
25-0000	EDUCATION, TRAINING AND LIBRARY	0
27-0000	ARTS, DESIGN, ENTERTAINMENT, SPORTS AND MEDIA	0
29-0000	HEALTHCARE PRACTITIONERS AND TECHNICAL	0
31-0000	HEALTHCARE SUPPORT	1
33-0000	PROTECTIVE SERVICE	0
35-0000	FOOD PREPARATION AND SERVING RELATED	1
37-0000	BUILDING AND GROUNDS CLEANING AND MAINTENANCE	2
39-0000	PERSONAL CARE AND SERVICE	0
41-0000	SALES AND RELATED	0
43-0000	OFFICE AND ADMINISTRATIVE SUPPORT	0
45-0000	FARMING, FISHING AND FORESTRY	2
47-0000	CONSTRUCTION AND EXTRACTION	8
49-0000	INSTALLATION, MAINTENANCE AND REPAIR	6
51-0000	PRODUCTION OCCUPATIONS	4
53-0000	TRANSPORTATION AND MATERIAL MOVING	5
55-0000	MILITARY SPECIFIC OCCUPATIONS	0
<b>TOTAL</b>		<b>36</b>

Note: Occupations are based on the Standard Occupational Classification (SOC) coding manual.

Source: MISS/MTSD/MIOSHA/Michigan Department of Licensing & Regulatory Affairs

**TABLE 4**  
**PROGRAM-RELATED FATALITIES BY AGE**  
**MICHIGAN 2011**

<b>AGE</b>	<b>NUMBER OF CASES 2011</b>	<b>PERCENT OF CASES</b>
20 and Under	1	3
21 - 25	0	0
26 - 30	2	6
31 - 35	3	12
36 - 40	4	12
41 - 45	5	13
46 - 50	6	16
51 - 55	6	16
56 - 60	7	16
61 and Over	2	6
<b>TOTAL</b>	<b>36</b>	<b>100</b>

Source: MISS/MTSD/MIOSHA/Michigan Department of Licensing & Regulatory Affairs

**TABLE 5**  
**PROGRAM-RELATED FATALITIES BY GENDER**  
**MICHIGAN 2011**

<b>GENDER</b>	<b>NUMBER OF CASES</b>	<b>PERCENT OF CASES</b>
MALE	34	94
FEMALE	2	6
<b>TOTAL</b>	<b>36</b>	<b>100</b>

Source: MISS/MTSD/MIOSHA/Michigan Department of Licensing & Regulatory Affairs

**TABLE 6**  
**PROGRAM-RELATED FATALITIES**  
**BY MONTH OF OCCURRENCE**  
**MICHIGAN 2011**

MONTH OF OCCURRENCE	NUMBER OF CASES 2011
JANUARY	2
FEBRUARY	3
MARCH	0
APRIL	3
MAY	5
JUNE	4
JULY	3
AUGUST	6
SEPTEMBER	3
OCTOBER	1
NOVEMBER	2
DECEMBER	4
<b>TOTAL</b>	<b>36</b>

Source: MISS/MTSD/MIOSHA/Michigan Department of Licensing  
& Regulatory Affairs

**TABLE 7**  
**PROGRAM-RELATED FATALITIES**  
**BY INDUSTRY GROUPS AND DAY OF THE WEEK**  
**MICHIGAN 2011**

<b>INDUSTRY GROUP</b>	<b><u>DAY OF THE WEEK</u></b>							<b>TOTAL</b>
	<b>SUN</b>	<b>MON</b>	<b>TUE</b>	<b>WED</b>	<b>THUR</b>	<b>FRI</b>	<b>SAT</b>	
AGRICULTURE, FORESTY, FISHING & HUNTING	0	2	2	1	1	0	0	<b>6</b>
CONSTRUCTION	1	3	4	1	3	0	0	<b>12</b>
MANUFACTURING	0	4	1	2	1	0	0	<b>8</b>
WHOLESALE TRADE	0	1	0	1	0	0	0	<b>2</b>
TRANSPORTATION & WAREHOUSING	1	0	0	0	1	0	0	<b>2</b>
MANAGEMENT OF COMPANIES	0	0	0	0	0	1	0	<b>1</b>
EDUCATIONAL SERVICES	0	1	0	0	0	0	0	<b>1</b>
HEALTH CARE & SOCIAL ASSISTANCE	0	0	1	0	0	0	0	<b>1</b>
ARTS, ENTERTAINMENT AND RECREATION	0	0	1	0	0	0	0	<b>1</b>
ACCOMMODATIONS & FOOD SERVICE	0	0	0	1	0	0	0	<b>1</b>
OTHER SERVICES, EXCEPT PUBLIC ADMINISTRATION	0	1	0	0	0	0	0	<b>1</b>
<b>TOTAL</b>	<b>2</b>	<b>12</b>	<b>9</b>	<b>6</b>	<b>6</b>	<b>1</b>	<b>0</b>	<b>36</b>

Source: MISS/MTSD/MIOSHA/Michigan Department of Licensing & Regulatory Affairs

**TABLE 8**  
**PROGRAM-RELATED FATALITIES BY**  
**COUNTY OF OCCURRENCE**  
**MICHIGAN 2011**

COUNTY	NUMBER OF CASES
ALLEGAN	1
BAY	2
BERRIEN	1
CALHOUN	2
CHARLEVOIX	1
CLARE	1
CLINTON	1
DELTA	1
GENESEE	1
HURON	1
INGHAM	1
KENT	1
LAKE	1
MACOMB	1
MANISTEE	1
MONROE	1
MUSKEGON	2
OAKLAND	4
OGEMAW	1
OSCEOLA	1
OTTAWA	2
WASHTENAW	3
WAYNE	5
<b>TOTALS</b>	<b>36</b>

Source: MISS/MTSD/MIOSHA/Michigan Department of Licensing & Regulatory Affairs

**PROGRAM-RELATED FATALITY INCIDENTS  
BRIEF DESCRIPTIONS OF CASES BY INDUSTRY GROUPS**

**AGRICULTURE, FORESTRY, FISHING AND HUNTING:**

1. Employee was performing logging operation cutting clumped trees. After notching the tree and before beginning to back cut, the employee checked the location of the other employees' onsite. Observing that all employees were clear, employee began back cut. As the tree began to fall, employee observed another employee in the direction of the tree. Employee yelled out to co-worker but co-worker ran under the falling tree and was struck in the head.

**Violations Noted:      Logging**

2. Employee was run over by equipment he was servicing.

**Violations Noted:      None**

3. Elevated wooden structure with 550-gallon water tank on top, gave way and landed on employee below.

**Violations Noted:      None**

4. Employee was felling a tree during a logging operation, which sprung another tree during the fall. A dead tree broke off hitting the employee in the head.

**Violations Noted:      None**

5. Employee entered a 20 by 64 feet corn silo that contained high moisture corn. As he was standing on top of the corn, it gave way. The employee was engulfed in the corn and suffocated.

**Violations Noted:      General Duty**

6. While operating a frontend loader during a snowstorm, employee struck a 500-gallon propane tank with the bucket of the loader. Fuel from the tank then ignited, resulting in fatal burns to the employee.

**Violations Noted:      General Rules  
Welding and Cutting  
Personal Protective Equipment**

## CONSTRUCTION:

7. While performing roofing operations in a subdivision, employee was found on the ground after an apparent fall.

**Violations Noted:      General Rules  
                                 Fixed and Portable Ladders**

8. Employee came in contact with a 4600-volt power line while working on a pole barn addition.

**Violations Noted:      General Rules  
                                 Fall Protection**

9. Victim was exiting or entering the cab of a backhoe while the equipment was running. The backhoe was in a forward gear and the victim was caught between the step grate and left rear tire. The backhoe rolled forward and ran over him.

**Violations Noted:      General Rules  
                                 Mobile Equipment**

10. Employee fell into a manhole and died as a result.

**Violations Noted:      General Rules  
                                 Fall Protection**

11. While removing water lines in a crawl space of a single family residence, the employee was electrocuted.

**Violations Noted:      General Rules  
                                 Electrical Installations**

12. Employee was caught between the control panel of a boom lift and the steel beam of a structure.

**Violations Noted:      General Rules  
                                 Aerial Work Platforms**

13. While setting trusses with a crane, the trusses fell down and knocked the employee to the ground.

**Violations Noted:      General Rules  
                                 Fixed and Portable Ladders  
                                 Personal Protective Equipment  
                                 Recording and Reporting of Occupational Injuries and Illnesses  
                                 Fall Protection**

## CONSTRUCTION (CONT.):

14. Employee was electrocuted while relocating televisions and cabling above an office ceiling.

**Violations Noted:**     **Electrical Installations**  
                                  **Recording and Reporting of Occupational Injuries and Illnesses**

15. Employee was crushed beneath a hydraulic excavator.

**Violations Noted:**     **None**

16. While working on a 20-foot extension ladder changing a light bulb, the employee fell to the ground below.

**Violations Noted:**     **None**

17. Employee was either standing on the step of a dump truck or on the floor next to the step of a dump truck when he fell backwards landing on his back. He struck his head on the concrete floor causing crushing injuries to the head.

**Violations Noted:**     **None**

18. Employee fell approximately 49-feet from ladder.

**Violations Noted:**     **General Rules**  
                                  **Fixed and Portable Ladders**  
                                  **Recording and Reporting of Occupational Injuries and**  
                                  **Illnesses**  
                                  **Fall Protection**

#### **MANUFACTURING:**

19. Employee was crushed between stacker transfer and stacker frame while retrieving lumber.

**Violations Noted:**     **Accident Prevention Signs and Tags**  
                                  **The Control of Hazardous Energy Sources (Lockout/Tagout)**

20. Employee was pulled into lathe when clothing became entangled in machinery.

**Violations Noted:**     **Metalworking Machinery**

#### **MANUFACTURING (CONT.):**

21. Employee was sitting on powered feed rolls exiting a tank through a manhole. The tank was still turning, which resulted in the employee being crushed between the tank and frame of the feed rolls.

**Violations Noted:**     **General Provisions**  
                              **Abrasive Wheels**  
                              **Welding and Cutting**  
                              **Design Safety Standards for Electrical Systems**

22. Employee fell from 7-feet height to surface below and struck his head.

**Violations Noted:**     **General Duty**  
                              **Recording and Reporting of Occupational Injuries and Illnesses**

23. While cleaning a conveyor, the employee climbed up onto it and became entangled in the conveyor.

**Violations Noted:**     **General Duty**  
                              **Floor and Wall Openings, Stairways and Skylights**  
                              **Conveyors**  
                              **The Control of Hazardous Energy Sources (Lockout/Tagout)**

24. Employee had hands on each side of a 480-volt quick disconnect plug and was electrocuted.

**Violations Noted:**     **Powered Industrial Trucks**  
                              **Design Safety Standards for Electrical Systems**

25. A 1,500-pound bag of pigment fell 15-feet from the mezzanine and struck the employee, crushing him.

**Violations Noted:**     **General Provisions**  
                              **Floor and Wall Openings, Stairways and Skylights**

26. A maintenance worker was performing a belt adjustment on the belt wrapper arm at the exit end of the coating line. He contacted the line operator by radio and entered through the interlocked gate. The line operator was distracted by another operation and did not observe the maintenance worker. Believing the adjustment was completed, the line operator lowered the belt wrapper, trapping the worker between it and the machine frame. No radio confirmation was made that the worker had cleared the area and the interlocked gate did not de-energize the control panel button that controls the belt wrapper.

**Violations Noted:**     **Welding and Cutting**  
                              **The Control of Hazardous Energy Sources (Lockout/Tagout)**

## **MANUFACTURING (CONT.):**

27. Employee was adding air to a tire with a multi-piece rim. The tire and rim exploded, striking the employee whom was crouched down in front of the tire and wheel.

**Violations Noted: Automotive Service Operations**

#### **WHOLESALE TRADE:**

28. Employee returned from his delivery route and parked his truck in the loading dock area and then entered the warehouse. A second truck was backing into an adjacent dock and pulled forward after the dock lock failed to engage. The driver then exited his vehicle and had a conversation with the victim and then returned to his vehicle and again backed up and engaged the dock lock. The deceased was found a short time later by a warehouse worker standing on the dock. The victim was pinned between the trailer and wall opening.

**Violations Noted: None**

#### **TRANSPORTATION AND WAREHOUSING:**

29. Employee was in the loading dock area standing at the back of his forklift. Another forklift operator traveling with a load forward struck the employee with the freight on his forklift.

**Violations Noted: Powered Industrial Trucks**

30. As employee was fueling a semi-truck, the employee thought the fuel nozzle clicked off and he removed the nozzle from the fuel tank. Fuel was still dispensing and diesel fuel sprayed onto the employee's face, arms and body. Employee became short of breath and was transferred to the hospital. Victim died as a result of exposure to diesel fuel.

**Violations Noted: Recording and Reporting of Occupational Injuries and Illnesses  
Personal Protective Equipment**

#### **MANAGEMENT OF COMPANIES AND ENTERPRISES:**

31. A tree trimmer was tied off in a tree approximately 40-feet in air. As he cut the last tree branch, which was being tethered and controlled by a co-worker, the branch swung around and struck the tree. The tree broke in half, causing the victim to fall to the ground.

**Violations Noted: Tree Trimming and Removal  
Recording and Reporting of Occupational Injuries and Illnesses**

#### **EDUCATIONAL SERVICES:**

32. Employee was stripping the floor of one of the band room sections when he slipped on some of the stripping chemical and struck his head. He died as a result of the head injury.

**Violations Noted: Personal Protective Equipment**

#### **HEALTH CARE AND SOCIAL ASSISTANCE:**

33. A health care provider was caring for an ill patient with a strep infection. A couple of weeks later, the health care provider became ill and was admitted to the hospital. The victim later died from strep sepsis.

**Violations Noted: None**

#### **ARTS, ENTERTAINMENT AND RECREATION:**

34. Employee was standing on a section of a ride frame 35-feet above the ground with no fall protection. He was pushing a power line over with a stick to clear the ride so it could be disassembled and moved to a new site. As the ride section was being lowered, employee contacted a 4800-volt power line and fell to the street.

**Violations Noted: Personal Protective Equipment  
Electrical Safety Related Practices**

#### **ACCOMMODATION AND FOOD SERVICES:**

35. Employee was working in a restaurant kitchen. He reported feeling dizzy and disoriented. He went home and was found later unresponsive. Victim died as a result of heat exhaustion.

**Violations Noted: General Duty  
Recording and Reporting of Occupational Injuries and  
Illnesses**

#### **OTHER SERVICES (EXCEPT PUBLIC ADMINISTRATION):**

36. Employee was overcome in a structural fire of a storage/workshop area.

**Violations Noted: None**