

# **PROGRAM-RELATED FATALITIES**

## **MICHIGAN 2010**



Management Information Systems Section  
Management and Technical Services Division  
Michigan Department of Licensing & Regulatory Affairs  
June 2011

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**INTRODUCTION**

In 2010, Michigan reported 37\* 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**

\* Note: This count has been amended to 38 due to a late notification of a program-related fatality that occurred in Michigan.

## **HIGHLIGHTS OF PROGRAM-RELATED FATALITIES, MICHIGAN 2010**

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 2010 are shown in **Table 1**, as well data from 1987 through 2010 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 2010. 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 2010, the largest number of Program-Related fatalities was reported in the Construction industry (NAICS 23) with 13 fatalities. Transportation and Warehousing (NAICS 48-49) had the second highest number with five fatalities. This was followed by Agriculture, Forestry, Fishing and Hunting (NAICS 11) which reported four fatalities.

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

Program-Related fatalities by occupation are shown in **Table 3**. The most affected occupation group with 13 program-related fatalities was Construction and Extraction. This was followed by Transportation and Material Moving with seven fatalities. Following next was Building and Grounds Cleaning and Maintenance with six fatalities and Farming, Fishing, and Forestry occupations reporting four 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 51-55 suffered the greatest number of fatalities with seven being reported. This was followed by the five-year age category of 61 and over reporting six and the age group of 46-50 reporting five fatalities. Of the 37 victims, 35 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 November recorded the highest number of program-related fatalities with six. Five were reported during the month of July and four were reported during each of the months of August and December. The months of January, May, September and October reported three 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 7**. The highest number of fatalities by day of the week shows Tuesday with 9, followed by Wednesday and Thursday with seven, and Monday and Friday with six 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 19 counties during 2010. Ten fatalities were reported in Wayne County, four were reported in Kent County, and three were reported in Calhoun County. All other counties recording fatalities experience two or fewer. Sixty-four 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 2010 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:

**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 primary engaged. Safety professionals may find this information useful for accident prevention.

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

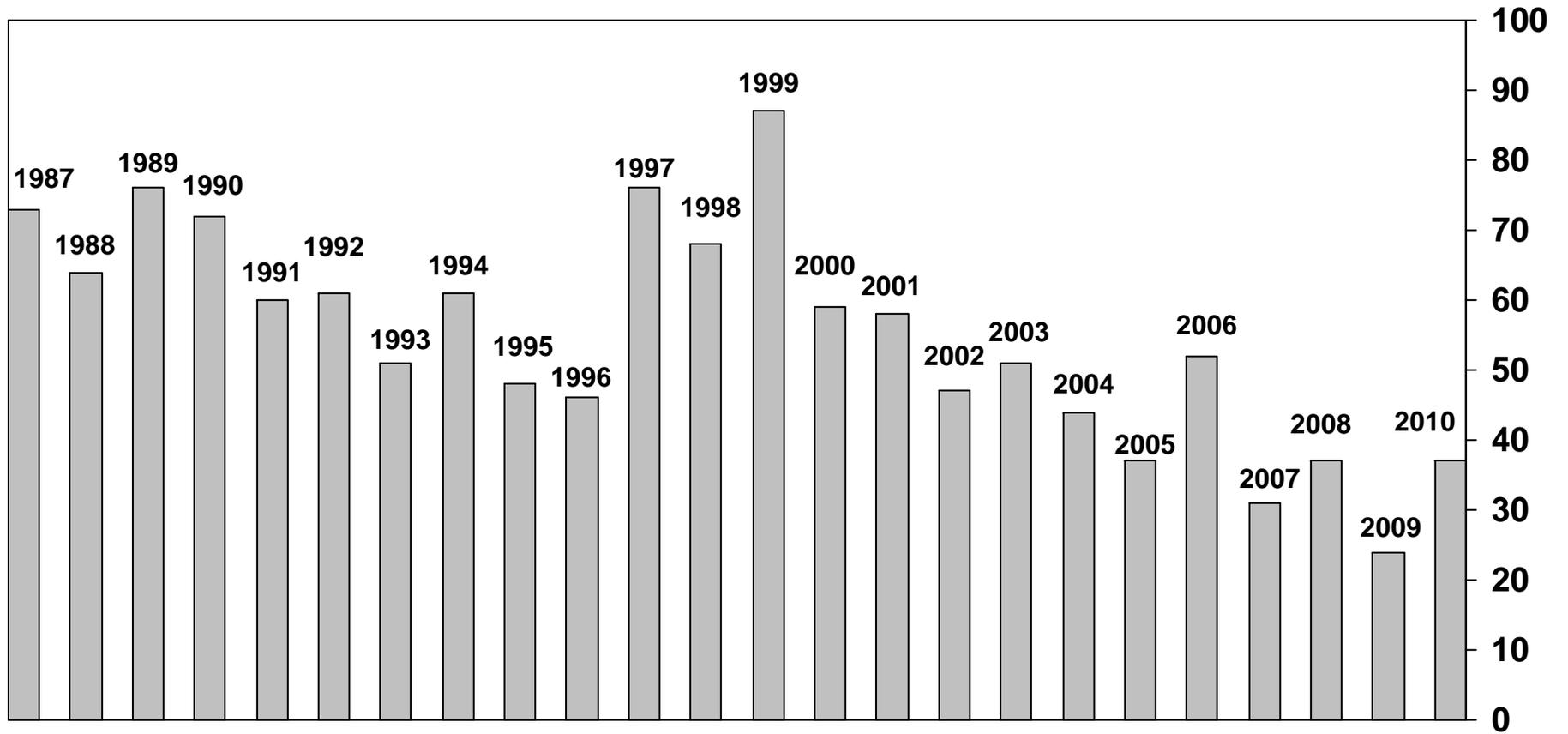
A fatality is recorded as “Program-Related” if the deceased party was employed in an occupation included in MIOSHA jurisdiction as defined in Public Act 154 of 1974, as amended, and the fatality appears to be related to one or more of the following conditions:

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  
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7150 Harris Drive, Box 30643  
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(517) 322-1851**

**FIGURE 1**  
**PROGRAM-RELATED FATALITY TRENDS**  
**MICHIGAN 1987-2010**



**TABLE 1**  
**PROGRAM-RELATED FATALITY TRENDS**  
**MICHIGAN 1987 – 2010**

<b>YEAR</b>	<b>NUMBER</b>	<b>PERCENT CHANGE FROM PREVIOUS YEAR</b>	<b>PERCENT CHANGE FROM 1987</b>
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*	54.1	-49.4

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 2010**

<b>NAICS MAJOR SECTOR</b>	<b>INDUSTRY GROUP</b>	<b>TOTAL</b>
11	AGRICULTURE, FORESTRY, FISHING AND HUNTING	4
21	MINING	0
22	UTILITIES	2
23	CONSTRUCTION	13
31-33	MANUFACTURING	2
42	WHOLESALE TRADE	1
44-45	RETAIL TRADE	0
48-49	TRANSPORTATION AND WAREHOUSING	5
51	INFORMATION	1
52	FINANCE AND INSURANCE	0
53	REAL ESTATE AND RENTAL AND LEASING	1
54	PROFESSIONAL, SCIENTIFIC AND TECHNICAL SERVICES	0
55	MANAGEMENT OF COMPANIES AND ENTERPRISES	0
56	ADMINISTRATIVE AND SUPPORT AND WASTE MANAGEMENT AND REMEDIATION SERVICES	2
61	EDUCATIONAL SERVICES	0
62	HEALTH CARE AND SOCIAL ASSISTANCE	2
71	ARTS, ENTERTAINMENT AND RECREATION	1
72	ACCOMMODATION AND FOOD SERVICES	0
81	OTHER SERVICES (EXCEPT PUBLIC ADMINISTRATION)	2
92	PUBLIC ADMINISTRATION	1
<b>TOTAL</b>		<b>37</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 2010**

<b>STANDARD OCCUPATION CODE</b>	<b>OCCUPATION</b>	<b>NUMBER OF CASES 2010</b>
17-0000	ARCHITECTURE AND ENGINEERING	1
33-0000	PROTECTIVE SERVICE	1
35-000	FOOD PREPARATION AND SERVING RELATED	1
37-0000	BUILDING AND GROUNDS CLEANING AND MAINTENANCE	6
45-0000	FARMING, FISHING AND FORESTRY	4
47-0000	CONSTRUCTION AND EXTRACTION	13
49-0000	INSTALLATION, MAINTENANCE AND REPAIR	2
51-0000	PRODUCTION	2
53-0000	TRANSPORTATION AND MATERIAL MOVING	7
<b>TOTAL</b>		<b>37</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 2010**

<b>AGE</b>	<b>NUMBER OF CASES 2010</b>	<b>PERCENT OF CASES</b>
20 and Under	3	8
21 - 25	0	0
26 - 30	2	5
31 - 35	4	11
36 - 40	3	8
41 - 45	4	11
46 - 50	5	14
51 - 55	7	19
56 - 60	3	8
61 and Over	6	16
<b>TOTAL</b>	<b>37</b>	<b>100</b>

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

**TABLE 5**  
**PROGRAM-RELATED FATALITIES BY GENDER**  
**MICHIGAN 2010**

<b>GENDER</b>	<b>NUMBER OF CASES</b>	<b>PERCENT OF CASES</b>
MALE	35	95
FEMALE	2	5
<b>TOTAL</b>	<b>37</b>	<b>100</b>

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

**TABLE 6**  
**PROGRAM-RELATED FATALITIES**  
**BY MONTH OF OCCURRENCE**  
**MICHIGAN 2010**

MONTH OF OCCURRENCE	NUMBER OF CASES 2010
JANUARY	3
FEBRUARY	1
MARCH	2
APRIL	2
MAY	3
JUNE	1
JULY	5
AUGUST	4
SEPTEMBER	3
OCTOBER	3
NOVEMBER	6
DECEMBER	4
<b>TOTAL</b>	<b>37</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 2010**

INDUSTRY GROUP	<u>DAY OF THE WEEK</u>							TOTAL
	SUN	MON	TUE	WED	THUR	FRI	SAT	
AGRICULTURE, FORESTY, FISHING & HUNTING	0	2	1	0	1	0	0	4
UTILITIES	0	0	0	0	0	2	0	2
CONSTRUCTION	0	2	3	4	2	2	0	13
MANUFACTURING	0	0	1	0	1	0	0	2
WHOLESALE TRADE	0	0	0	0	0	0	1	1
TRANSPORTATION & WAREHOUSING	0	1	1	1	1	1	0	5
INFORMATION	0	0	0	0	1	0	0	1
REAL ESTATE & RENTAL & LEASING	0	0	1	0	0	0	0	1
ADMIN. & SUPPORT & WASTE MGMT. & REMEDIAION SERV.	0	0	0	2	0	0	0	2
HEALTH CARE & SOCIAL ASSISTANCE	0	0	2	0	0	0	0	2
ARTS, ENTERTAINMENT AND RECREATION	0	0	0	0	1	0	0	1
OTHER SERVICES, EXCEPT PUBLIC ADMINISTRATION	0	1	0	0	0	0	1	2
PUBLIC ADMINISTRATION	0	0	0	0	0	1	0	1
<b>TOTAL</b>	<b>0</b>	<b>6</b>	<b>9</b>	<b>7</b>	<b>7</b>	<b>6</b>	<b>2</b>	<b>37</b>

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

**TABLE 8**  
**PROGRAM-RELATED FATALITIES BY**  
**COUNTY OF OCCURRENCE**  
**MICHIGAN 2010**

COUNTY	NUMBER OF CASES
BARRY	2
BAY	1
BERRIEN	1
CALHOUN	3
EMMET	2
GRAND TRAVERSE	1
HOUGHTON	1
ISABELLA	2
JACKSON	1
KALAMAZOO	1
KENT	4
MACOMB	2
MARQUETTE	1
MONROE	1
MONTCALM	1
OAKLAND	1
SANILAC	1
WASHTENAW	1
WAYNE	10
<b>TOTALS</b>	<b>37</b>

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

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

1. & 2. Two (2) employees were cleaning two (2) 3,000-gallon molasses tanks which contained 6 to 8 inches of a molasses feed supplement. They were cleaning them with a power washer and water. The employees had entered the first tank several times while cleaning it with no problems reported. They then went on to clean the second tank and were later found unresponsive on the bottom of the tank.

**Violations Noted:      Hazardous Communication  
   General Duty**

3. Employee was pulling volunteer corn and collapsed. In doing so, his arm made contact with the pivot irrigation equipment and he was electrocuted.

**Violations Noted:      None**

4. Employee climbed up on a grain wagon to grease parts and fell off the auger shaft. He hit his head on the barn floor, resulting in loss of consciousness and a severe head injury.

**Violations Noted:      None**

**UTILITIES:**

5. Employee was using a spark-producing abrasive wheel cutoff saw to cut steel rebar. During this operation, the employee was working within 2-feet of an open 55-gallon drum which contained waste oil and other chemicals and was within 10-feet of a parts washer containing lacquer thinner. During the operation, there was an explosion within the work area which resulted in the employee's death.

**Violations Noted:      Flammable and Combustible Liquids**

6. The employee fell from the rear tailgate of an all-terrain vehicle, striking his head on the road surface.

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

## **CONSTRUCTION:**

7. The employee was driving a front end loader down a steep embankment when he gathered speed, lost control and was thrown out the front window. He landed under the left rear tire and was crushed.

**Violations Noted:**      **General Rules**  
                                 **Mobile Equipment**

8. While owner/employee was preparing to replace a residential sewer line, the excavation collapsed.

**Violations Noted:**      **General Rules**  
                                 **Excavation, Trenching and Shoring**

9. Employee was electrocuted while welding.

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

10. The employee was underneath a skid loader repairing it in the yard when it fell onto him.

**Violations Noted:**      **General Duty**

11. Victim was found unresponsive in the bathroom. He had been working alone with chemicals in a small bathroom with no ventilation.

**Violations Noted:**      **General Rules**  
                                 **Hazardous Communication**  
                                 **Methylene Chloride**

12. Employee was cutting down beams in an abandoned building when he fell from the ladder, landing on a pile of debris.

**Violations Noted:**      **General Rules**  
                                 **Demolition**

13. An electrical lineman was connecting conductors, insulators, cross arms and equipment installations on electrical poles. While doing so, he made contact with a 4,800-volt electrical conductor that had no insulation or shielding material.

**Violations Noted:**      **Electrical Power Generation, Transmission and Distribution**

## CONSTRUCTION (CONT.):

14. An employee was buried during a cave-in while in a trench installing a sewer line.

**Violations Noted:**      **General Rules**  
                                 **Personal Protective Equipment**  
                                 **Excavating, Trenching and Shoring**

15. Employees had placed a piece of plywood into the sand next to a masonry stone wall. They then began to dig the sand away to place a foundation form under the existing wall when the stone wall fell onto one of the employees.

**Violations Noted:**      **General Rules**  
                                 **Excavating, Trenching and Shoring**  
                                 **Demolition**

16. An employee fell 16 feet from a ladder.

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

17. While performing roofing activities on a roof approximately 50-feet above the ground, employee fell through a cover to the lower level.

**Violations Noted:**      **None**

18. Employee was measuring sewer pipe from the top of a manhole and was struck by a vehicle.

**Violations Noted:**      **Signals, Signs, Tags and Barricades**

19. Employee was standing on welded frame scaffold during high winds when the scaffold overturned, crushing him.

**Violations Noted:**      **None**

## MANUFACTURING:

20. Employee was in front of a lifted load of loosely stacked wooden planks when they tipped and fell from the forks of the powered industrial truck, crushing the employee.

**Violations Noted:**      **Powered Industrial Trucks**

## MANUFACTURING (CONT.):

21. Employee was attempting to retrieve reusable totes with a stand-up forklift. After the totes were engaged on the forks, the employee attempted to backup the forklift. During this process, the employee's upper torso was outside the frame of the forklift. As the employee continued to backup, he was crushed between the frame and another stack of reusable totes that was in the line of travel of the forklift.

**Violations Noted: Powered Industrial Trucks**

#### **WHOLESALE TRADE:**

22. Employee walked between an operating excavator and a semi trailer and was struck by the excavator when it rotated.

**Violations Noted: Guarding of Walking and Work Areas**

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

23. A laborer raised a vehicle using the boom arm of the tow truck. While the vehicle was in an "up" position from the ground surface, the deceased went underneath the carriage of the vehicle to view it. The vehicle slipped or fell off the boom arm straps and crushed the employee.

**Violations Noted: General Provisions  
Automotive Service Operations**

24. An employee was discovered on the roof by another employee. He was near an air conditioning unit. He had been electrocuted.

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

25. An automobile boxcar loader was last seen by a co-worker putting an auto bridge plate between two automobile railroad boxcars. Several minutes later, a co-worker found the employee on the ground unconscious. The employee had died from multiple injuries sustained during a fall from the automotive carrier/railroad boxcar.

**Violations Noted: None**

26. Employee was removing a light fixture while using a ladder stand. The light was 10-12 feet above the floor. The employee fell off the ladder and landed on the floor.

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

#### **TRANSPORTATION AND WAREHOUSING (CONT.):**

27. Truck driver was loading sheet metal on/off this vehicle when the load dropped on him causing multiple injuries.

**Violations Noted:      None**

#### **INFORMATION:**

28. An Electrician Technician was installing a cable system on a 40-foot utility pole. He was working from a 24-foot fiberglass extension ladder leaning against the mid-section of the pole. While doing so, an overhead live 4800-volt conductor cable wire fell from the overhead cross arm making contact with him, resulting in electrocution.

**Violations Noted:      None**

#### **REAL ESTATE AND RENTAL AND LEASING:**

29. Employee tripped/slipped and fell out of his truck while exiting the cab, and hit his head.

**Violations Noted:      None**

#### **ADMINISTRATIVE AND SUPPORT AND WASTE MANAGEMENT AND REMEDIATION SERVICES:**

30. Employee had been mowing on a hillside with a grade of 19-24 degrees, on wet grass. The mower slipped at the bottom of the grade at a culvert and the mower overturned into a water-filled ditch, trapping and drowning the victim. The mower roll-over protection device had been removed.

**Violations Noted:      Powered Groundskeeping Equipment  
Recording and Reporting of Occupational Injuries and Illnesses**

31. Employee was removing trees and tree branches for a utility company and was electrocuted when he made contact with a live down wire.

**Violations Noted:      Tree Trimming and Removal**

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

32. In the evening when it was dark, an employee was instructed to take a garbage bag out to the dumpster in back of the building. There was no light over the back steps, which were concrete and covered with ice. The employee did not see the black ice and fell down the steps due to the slippery surface. She experienced a severely broken ankle and had surgery to repair the broken bones. She was discharged from the hospital and then later died at home. She died from a pulmonary embolism.

**Violations Noted:      Medical Services and First Aid  
Recording and Reporting of Occupational Injuries and Illnesses**

33. Employee was walking in the yard of the facility when she was struck by a forklift and severely injured.

**Violations Noted:      Recording and Reporting of Occupational Injuries and Illnesses  
Powered Industrial Trucks  
Floor and Wall Openings, Stairways and Skylights**

**ARTS, ENTERTAINMENT AND RECREATION:**

34. Employee was cleaning snow and ice off from a 40-foot platform when he fell through a trap door.

**Violations Noted:      None**

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

35. A maintenance supervisor told a volunteer assistant that he was going to change a light bulb. He was later found lying on the landing of the stairway. The step ladder was found leaning against the wall in the closed position. The deceased climbed onto the 42-inch high stairway opening separation wall to attempt to reach up to change the light bulb and fell.

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

36. Employee was performing maintenance on the conveyor system of a piece of equipment. It had been raised to allow him to oil and grease areas on the conveyor when the conveyor came in contact with high voltage power lines.

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

**PUBLIC ADMINISTRATION:**

37. Fire Chief was found on the floor of the fire station. He had died from head trauma.

**Violations Noted:     None**