PROGRAM-RELATED FATALITIES

MICHIGAN 2018

Management Information Systems Section
Technical Services Division
Michigan Occupational Safety and Health Administration
January 2020

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INTRODUCTION

In 2018, Michigan reported 38 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). This information was compiled from investigation data entered in the Occupational Safety and Health Administration's Information System (OIS). The conditions necessary for a fatal case to be Program-Related are defined in the NOTE ON PROGRAM-RELATED CASES (see Page 5).

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
Technical Services Division
Michigan Occupational Safety and Health Administration (MIOSHA)
530 W. Allegan Street, P. O. Box 30643
Lansing, Michigan 48909-8143
Telephone (517) 284-7790

HIGHLIGHTS OF PROGRAM-RELATED FATALITIES, MICHIGAN 2018

This Program-Related fatality information for Michigan was compiled from investigation data entered in the Occupational Safety and Health Administration's Information System (OIS). 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 7**.

PROGRAM-RELATED FATALITY TRENDS

A definition of Program-Related cases can be found on Page 5 of this report. Program-Related fatality trends for 1987 through 2018 are shown in **Table 1**, as well as data from 1987 through 2018 in **Chart 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 2018. 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 systems, 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 2018, the largest number of Program-Related fatalities were reported in the Construction industry (NAICS 23) with 10 fatalities. This was followed by Manufacturing (NAICS 31-33) with 7 fatalities.

PROGRAM-RELATED FATALITIES BY AGE AND GENDER

The distribution of Program-Related fatalities by age and gender are shown in **Tables 3 and 4**. The age group of 61 and over reported eight fatalities, the age group of 51-55 and 41-45 reported six fatalities each, and the age group of 56-60 reported four fatalities. Of the 2018 fatalities, thirty-five were male employees and three were female employees.

PROGRAM-RELATED FATALITIES BY MONTH OF OCCURRENCE

Fatality data categorized by the month of occurrence is shown in **Table 5**. The months of May and July recorded the highest number of program-related fatalities with six each, followed by September and October with five each, and then March and April with 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 6**. The highest number of fatalities by day of the week was Monday and Thursday with eight each, followed by Tuesday with seven.

PROGRAM-RELATED FATALITIES BY COUNTY OF OCCURRENCE

The distribution of fatality cases by counties shows that Program-Related fatalities were reported as occurring in twenty-two counties during 2018. Five fatalities each were reported in Wayne and Oakland Counties, four in Macomb County, three each in Saginaw and Washtenaw Counties, and two in Chippewa County. Sixty-one counties had no program-related fatalities. A complete distribution of fatality cases by county of occurrence is shown in **Table 7.**

Even though Michigan's 2018 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 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, 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)
530 W. Allegan Street, P. O. Box 30643, Lansing, Michigan 48909
Telephone (517) 284-7790

The Program-Related fatality data for Michigan are presented in the following series of **Tables 1 through 7**. 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 a "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:

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Lansing, Michigan 48909-8143
(517) 284-7790

CHART 1 PROGRAM-RELATED FATALITY TRENDS

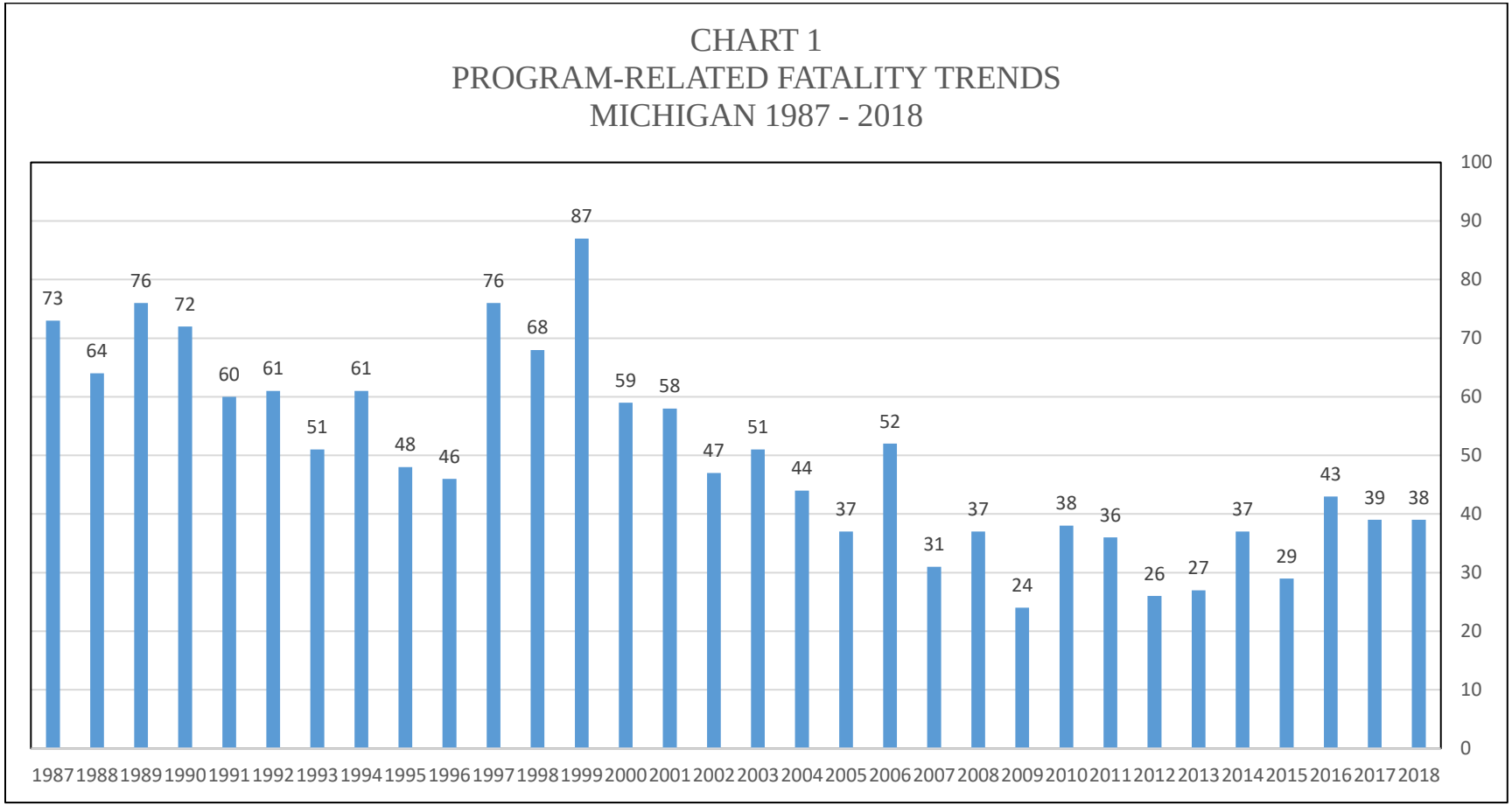

TABLE 1 PROGRAM-RELATED FATALITY TRENDS, MICHIGAN 1987 – 2018

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	-49.3
2009	24	-35.1	-67.1
2010	38*	58.3	-47.9
2011	36	-5.3	-50.7
2012	26	-27.8	-64.4
2013	27	3.8	-63.0
2014	37	37.0	-49.3
2015	29	-21.6	-60.3
2016	43	48.3	-41.1
2017	39	-9.3	-46.6
2018	38	-2.6	-47.9

Source: MISS/TSD/ MIOSHA

*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 2018

NAICS MAJOR SECTOR	INDUSTRY GROUP	TOTAL
11	AGRICULTURE, FORESTRY, FISHING AND HUNTING	2
21	MINING	1
22	UTILITIES	2
23	CONSTRUCTION	10
31-33	MANUFACTURING	7
48-49	TRANSPORTATION AND WAREHOUSING	4
54	PROFESSIONAL, SCIENTIFIC AND TECHNICAL SERVICES	1
56	ADMINISTRATIVE AND SUPPORT AND WASTE MANAGEMENT AND REMEDIATION SERVICES	5
61	EDUCATIONAL SERVICES	2
71	ARTS, ENTERTAINMENT AND RECREATION	1
72	ACCOMMODATION AND FOOD SERVICES	1
81	OTHER SERVICES (EXCEPT PUBLIC ADMINISTRATION)	1
92	PUBLIC ADMINISTRATION	1
TOTAL		**38**

Source: MISS/TSD/ MIOSHA

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.

TABLE 3 PROGRAM-RELATED FATALITIES BY AGE, MICHIGAN 2018

AGE	NUMBER OF CASES	PERCENT OF CASES
20 and Under	2	5
21 - 25	2	5
26 - 30	3	8
31 - 35	1	3
36 – 40	3	8
41 - 45	6	16
46 - 50	3	8
51 - 55	6	16
56 - 60	4	10
61 and Over	8	21
TOTAL	**38**	**100**

Source: MISS/TSD/MIOSHA

TABLE 4 PROGRAM-RELATED FATALITIES BY GENDER, MICHIGAN 2018

GENDER	NUMBER OF CASES	PERCENT OF CASES
MALE	35	92
FEMALE	3	8
TOTAL	**38**	**100**

Source: MISS/TSD/MIOSHA

TABLE 5 PROGRAM-RELATED FATALITIES BY MONTH OF OCCURRENCE, MICHIGAN 2018

MONTH OF OCCURANCE	NUMBER OF CASES
JANUARY	1
FEBRUARY	2
MARCH	3
APRIL	3
MAY	6
JUNE	2
JULY	6
AUGUST	2
SEPTEMBER	5
OCTOBER	5
NOVEMBER	1
DECEMBER	2
TOTAL	**38**

Source: MISS/TSD/MIOSHA

TABLE 6 PROGRAM-RELATED FATALITIES BY INDUSTRY GROUPS AND DAY OF THE WEEK, MICHIGAN 2018

	DAY OF THE WEEK							
INDUSTRY GROUP	**SUN**	**MON**	**TUE**	**WED**	**THUR**	**FRI**	**SAT**	**TOTAL**
AGRICULTURE, FORESTRY, FISHING & HUNTING	0	0	0	1	0	0	1	**2**
MINING	0	0	0	0	1	0	0	**1**
UTILITIES	0	0	0	0	1	1	0	**2**
CONSTRUCTION	0	2	2	1	3	1	1	**10**
MANUFACTURING	0	3	2	1	1	0	0	**7**
TRANSPORTATION & WAREHOUSING	0	0	1	1	1	1	0	**4**
PROFESSIONAL, SCIENTIFIC AND TECHNICAL SERVICES	0	0	0	0	0	1	0	**1**
ADMINISTRATIVE AND SUPPORT AND WASTE MANAGEMENT AND REMEDIATION SERVICES	0	2	1	1	0	1	0	**5**
EDUCATIONAL SERVICES	0	0	0	0	1	1	0	**2**
ARTS, ENTERTAINMENT, & RECREATION	0	1	0	0	0	0	0	**1**
ACCOMMODATIONS AND FOOD SERVICES	0	0	0	1	0	0	0	**1**
OTHER SERVICES (EXCEPT PUBLIC ADMINISTRATION)	0	0	1	0	0	0	0	**1**
PUBLIC ADMINISTRATION	0	0	0	0	0	0	1	**1**
TOTAL	**0**	**8**	**7**	**6**	**8**	**6**	**3**	**38**

Source: MISS/TSD/MIOSHA

TABLE 7 PROGRAM-RELATED FATALITIES BY COUNTY OF OCCURRENCE, MICHIGAN 2018

COUNTY	NUMBER OF CASES
ALLEGAN	1
ALPENA	1
BERRIEN	1
CASS	1
CHIPPEWA	2
GENESSE	1
GRAND TRAVERSE	1
GRATIOT	1
INGHAM	1
JACKSON	1
KENT	1
MACOMB	4
MANISTEE	1
MENOMINEE	1
MONROE	1
OAKLAND	5
OSCEOLA	1
SAGINAW	3
SAINT CLAIR	1
VAN BUREN	1
WASHTENAW	3
WAYNE	5
TOTALS	**38**

Source: MISS/TSD/MIOSHA

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

The following descriptions are captured from the OSHA Information System (OIS) as prepared by Federal OSHA staff.

AGRICULTURE, FORESTRY, FISHING & HUNTING

1. At 7:45 a.m. on April 11, 2018, an employee was moving dairy cows to feed them and/ or clean out the floor area. During work, the employee was struck or pinned by one of the animals that was moving rapidly in a penned in area. The employee was killed as a result.
2. At 10:30 a.m. on May 26, 2018, an employee was working at a soybean farm. He was monitoring the loading of soy beans into a semi-truck. He was standing on a Werner podium ladder. The semi-truck moved to distribute the soy beans evenly in the trailer. As the semi-truck was being repositioned, it came into contact with the ladder. The employee fell from the ladder, striking the back passenger portion of the truck tractor as he fell. He sustained blunt force trauma injuries to his chest and head. The narrative did not say whether he died at the time or later.

MINING

3. At 12:00 p.m. on July 12, 2018, an employee was operating a front end loader. The employee exited the vehicle's cab through the tractor's cab access ladder and became wedged between the cab of the front end loader and the ladder leading into the cab. As a result, the employee suffered asphyxiation.

UTILITIES

4. At 8:15 a.m. on June 14, 2018, Employee #1 was removing a pipe cap and flange coupling. He was standing on an eight foot step ladder, in order to gain access to the pipe. The employee loosened the flange coupling to remove the pipe cap so that a 17-foot section of the pipe could be reinstalled for the fire suppression system. The pipe was under pressure and when the flange coupling was loosened, the 10-inch diameter pipe cap struck Employee #1 in the face. Employee #1 sustained blunt force trauma to the right front of his head, resulting in an open fracture to skull, killing him.
5. At 11:00 a.m. on October 5, 2018, employees were unloading a new power pole from the truck. The line worker in charge was at the controls of the Digger Derick. Employee #1 was reaching for a set of chains on the back of the truck. The boom of the Digger Derick came in contact with the Primaries (7200 Volts) and the employee was found on the ground behind the truck. The employee received medical treatment at the scene, but later died at a local hospital.

CONSTRUCTION

6. At 1:30 p.m. on February 26, 2018, an employee was working in a trench to cap off a building sewer line. The trench measured 9 feet wide by 12 feet deep and its sides were not unsupported. During work, the trench collapsed and trapped the employee beneath the caved-in walls. The employee was killed.
7. At 10:45 a.m. on April 27, 2018, an employee was performing fire watch and controlled zone access duties in the basement located below the demolition work being performed on Boiler #4. The employee was struck in the chest and abdomen by a boiler plate that was attached to a stoker chain which was cut by torches and dropped into the basement. The employee was taken to the hospital where he died later from his injuries.
8. At 10:30 a.m. on May 23, 2018, Employee #1 was checking the temperature and density of a newly paved asphalt roadway. A loaded asphalt dump truck with a functional, operational back-up alarm struck the employee with the right side dual steer tires and caused fatal internal injuries to his chest area.
9. At 1:00 a.m. on June 14, 2018, Employee #1 and Employee #2, a night shift supervisor, were hooking up a dual axle dump trailer to a pick up truck along the right side of a traffic lane closure. Their coworkers were engaged in setting steel barriers in place for the lane closure. A northbound vehicle lost control and struck the attenuator vehicle along the right side of the roadway and rolled over, striking Employee #1 along the drivers side of the pickup. Employee #1 was wearing a class II high visibility work vest during night time operations, without high visibility reflective pants. Employee #1 was killed by the vehicle which struck him. Employee #2 was hospitalized for his injuries.
10. At 2:30 p.m. on July 31, 2018, Employee #1 was trying to locate an underground water tap that was beneath the northbound traffic lane of the M-25 interstate. The posted speed was 50 miles per hour. While bent over, looking at the reading on a locating instrument, the employee was struck by the left front corner of a passing motor vehicle. Employee #1 was hospitalized and later died from severe internal injuries.
11. At 1:00 p.m. on September 24, 2018, an employee was working on a 40 gang electrical meter bank. A large bank of electrical meters and a disconnect switch cabinet fell on the employee. The employee sustained a fractured skull and was killed.
12. At 3:30 p.m. on September 25, 2018, two employees were raking topsoil when a vehicle crossed from the far side of the road and struck both workers, killing one employee and injuring the second. The nature of the injuries were not specified in the original narrative.
13. At 1:00 p.m. on October 11, 2018, an employee was standing on an 8 foot step ladder and lost his balance, falling to the concrete floor. The employee suffered massive blunt force trauma to his head and was killed.
14. At 2:15 p.m. on October 20, 2018, an employee was performing demolition activities and was struck by a 16 foot scaffold plank when it fell approximately 90 feet. The employee was killed.

15. At 10:00 a.m. on October 25, 2018, an employee was unwinding a ground glue sprayer. The employee was walking backwards when he stepped into skylight and fell through. The employee injured his back, ribs, and head. He was sent to the hospital, where he later died.

MANUFACTURING

16. At 9:00 a.m. on July 16, 2018, an employee was setting up an ink pump on a printing press in preparation for printing. As the employee kneeled down next to the pump and made contact with the upper frame of the pump, he was electrocuted. The incident investigation determined that the pump frame was energized as a result of a damaged cord and plug on the pump.
17. At 1:30 p.m. on October 8, 2018, an employee was operating the Hitachi FR70 front end loader and slipped when he exited it's cab. The employee fell four feet to the ground and fell on his face, fracturing his facial bones and vertebra. The employee was killed. At 9:00 a.m. on July 16, 2018, an employee was setting up an ink pump on a printing press in preparation for printing. As the employee kneeled down next to the pump and made contact with the upper frame of the pump, he was electrocuted. The incident investigation determined that the pump frame was energized as a result of a damaged cord and plug on the pump.
18. At 6:15 p.m. on May 8, 2018, Employee #1 was showing a coworker how to operate a tube cutting machine in order to cut a 2.5 inch diameter tubing used to build rollers. The employee adjusted the machine speed, and the tube popped out when cut, striking the employee on the left side of his neck. He sustained a deep laceration to his neck, killing him.
19. At 3:15 p.m. on July 12, 2018, an employee was performing abrasive blasting with metal shot in a tank that measured approximately 28-29 feet long by 8-9 feet high. The employee was wearing an Apollo supplied air respirator helmet (model number: 600) and exhaust ventilation was being used in the space. For an unknown reason, the employee collapsed and stopped breathing. The employee was found by a manager that began to perform CPR. However, the employee could not be revived and was determined dead. The incident investigation reported that the medical examiner was unable to determine a cause of death or manner of death. Carbon monoxide poisoning, as well as any preexisting medical conditions were ruled out. However, it was discovered that he had not had a respiratory medical evaluation prior to wearing the helmet, nor had he received training.
20. At 8:00 p.m. on July 30, 2018, an employee was returning from an outside break location and was walking through the JL WIP area to return to her work location. While walking through the area, an overhead pipe fell and struck the employee in the head. The cast iron pipe was approximately

262 inches in length and 6 inches in diameter. The employee sustained blunt force trauma to head and neck. The employee was killed.

21. At 4:00 p.m. on August 21, 2018, an employee was handling a carbon plate and dropped it on his ankle, cutting or scratching it. The injury became infected several days later and the employee was hospitalized, later dying when the wound became septic.At 9:00 a.m. on May 17, 2018, Employee #1 was walking toward his work station. The employee tripped on the plastic banding in the walkway. He fell onto the concrete floor, fracturing his elbow and causing a fatal injury to his liver. Employee #1 was killed in the fall.
22. At 12:05 p.m. on September 5, 2018, an employee returned from lunch and had been relaxing near an intersection of a conveyor and a machine. The employee was found unresponsive and possibly electrocuted when he made contact with the conveyor and machine at the same time.

TRANSPORTATION & WAREHOUSING

23. At 8:30 p.m. on January 10, 2018, an employee was placing hooks on the rear of a flatbed truck when he was struck by another vehicle. The employee became pinned between the rear of the flatbed, and the front of the other vehicle, resulting in his death. The cause of death was attributed to severe blunt force trauma to the chest and neck.
24. At 11:35 a.m. on March 28, 2018, an employee died from a fall after being hospitalized for 12 days. At the time of the incident, the employee was operating a loader to fill semi-trailers with corn that was stored outside of a grain elevator. It was his second day on the job, performing the transferring of corn. While descending the loader's ladder, the employee fell and struck a concrete surface. There were no witnesses. The employee was found unconscious by co-workers (truck drivers) and emergency services were called. Emergency services, upon arrival, transported the employee to a nearby hospital for treatment. The employee was admitted, however, died as a result of his injuries.
25. At 10:11 a.m. on May 29, 2018, an employee was working as a tow truck operator for a firm that engaged in towing motor vehicles, or vehicle recovery. The employee responded to a call that involved a school bus with dual rear tires and one of the tires had a flat on the passenger side. The employee positioned his tow truck, or wrecker, in front of the bus. He was lying on the ground just in front of the bus trying to see what equipment he would need to pick up and tow the bus. A 2008 Ford Explorer struck the back of the bus at an extreme speed. It pushed the bus over the employee and into the back of the wrecker. The employee was crushed by the bus. Its spring shackle bolts penetrated his back, killing him.
26. At 9:00 a.m. on May 17, 2018, Employee #1 was walking toward his work station. The employee tripped on the plastic banding in the walkway. He fell onto the concrete floor, fracturing his elbow and causing a fatal injury to his liver. Employee #1 was killed in the fall.

PROFESSIONAL, SCIENTIFIC AND TECHNICAL SERVICES

27. At 6:30 a.m. on November 30, 2018, an employee was gathering feed samples at a dairy to check on nutrition. The employee walked up to face of sheer wall of bulker of corn silage when a large section broke off landing on and engulfing him. The employee died of asphyxiation.

ADMINISTRATIVE & SUPPORT & WASTE MANAGEMENT & REMEDIATION SERVICES

28. At 11:30 a.m. on April 30, 2018, an employee was dumping mulch from a dump truck and left the truck bed elevated. The truck struck and pulled down several overhead power lines and the employee attempted to manually remove the energized lines with the use of a wooden hammer handle. The employee came into contact with an energized conductor and was electrocuted.
29. At 12:00 p.m. on May 4, 2018, Employee #1 was moving mulch to different areas of the property. The employee was struck and killed by a falling willow tree limb.
30. At 7:45 a.m. on September 18, 2018, an employee was loading refuse into a garbage truck when he was struck by a passing 1997 Ford F-150 pickup truck. The employee became pinned between the garbage truck and the pickup truck and was killed.
31. At 3:45 p.m. on September 24, 2018, an employee was removing a large 12 inch diameter branch of cottonwood tree while up approximately 30 feet in a bucket truck with no fall protection worn. A line was tied to the branch and attached to tractor and tension was placed upon the branch as the tractor backed away. The employee was knocked from the bucket and fell to the ground when the cut was made on the branch and the tension was suddenly released. The employee was killed.
32. At 7:45 a.m. on December 12, 2018, an employee was working at a solid waste transfer site and was struck by a Volvo L150H Loader, killing him.

EDUCATIONAL SERVICES

33. At 8:00 a.m. on March 15, 2018, an employee was walking across a parking lot to get to his personal vehicle when he slipped and fell, fracturing his left femur. The employee died at his home residence due to the underlying cause of probable cerebrovascular accident and hypertension.
34. At 8:00 a.m. on March 23, 2018, an employee was acting as a crossing guard and was directing traffic when she was struck and killed by a motor vehicle.

ARTS, ENTERTAINMENT & RECREATION

35. At 11:45 a.m. on February 26, 2018, an employee was operating an JD Gator XUV 625i to plow a six-foot wide snow drag on a ski slope, when a snowmobile broadsided the vehicle. The employee became trapped in the plow vehicle and a fire occurred. Emergency services responded to the incident, but were too late. The employee could not be freed and was killed.

ACCOMMODATION AND FOOD SERVICES

36. At 12:00 p.m. on July 18, 2018, an employee was inspecting propane tanks. During work, the employee unplugged a box fan and an explosion occurred. He suffered third-degree burns to 80% of his body, resulting in his death.

OTHER SERVICES (EXCEPT PUBLIC ADMINISTRATION)

37. At 7:00 p.m. on December 4, 2018, an employee was working under a powered industrial truck. The powered industrial truck fell on the employee, crushing him. The employee was killed.

PUBLIC ADMINISTRATION

38. At 2:00 a.m. on August 4, 2018, an employee was performing crowd control adjacent to street and was struck by a motor vehicle, killing him.