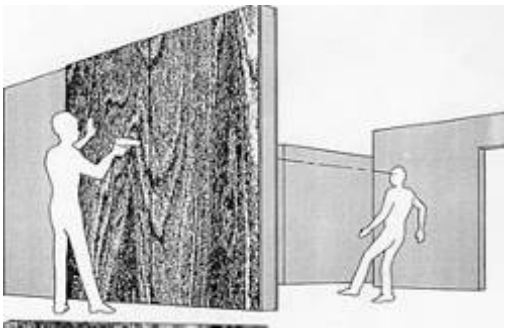
ACCIDENT REPORT
FATAL FACTS

ACCIDENT SUMMARY No. 2

Accident Type:	Struck by Nail
Weather Conditions:	N/A
Type of Company:	General Contractors
Size of Work Crew:	17
Union or Non-union:	Union
Worksite Inspection?:	No
Designated Competent Person on Site?:	No
Employer Safety and Health Program?:	No
Training and Education for Employees?:	No
Craft of Deceased Employee(s):	Carpenter
Age;Sex	22; Male
Time of the Job:	3:00 p.m.
Time at the Task	Unknown



BRIEF DESCRIPTION OF ACCIDENT

A carpenter apprentice was killed when he was struck in the head by a nail that was fired from a powder actuated tool. The tool operator, while attempting to anchor a plywood form in preparation for pouring a concrete wall, fired the gun causing the nail to pass through the hollow wall. The nail travelled some twenty-seven feet before striking the victim. The tool operator had never received training in the proper use of the tool, and none of the employees in the area were wearing personal protective equipment.

INSPECTION RESULTS

Section not listed on original

ACCIDENT PREVENTION RECOMMENDATIONS

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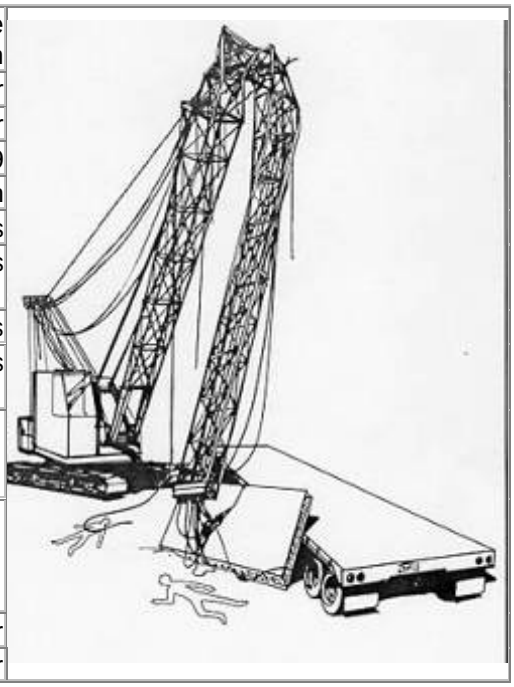
NOTE: *The case here described was selected as being representative of fatalities caused by improper work practices. No special emphasis or priority is implied nor is the case necessarily a recent occurrence. The legal aspects of the incident have been resolved, and the case is now closed.*

ACCIDENT REPORT
FATAL FACTS

ACCIDENT SUMMARY No. 4

Accident Type:	Struck by Collapsing Crane Boom
Weather Conditions:	Clear
Type of Company:	General Contractor
Size of Work Crew:	9
Union or Non-union:	Union
Worksite Inspections Conducted:	Yes
Designated Competent Person on Site (1926.20(b)(2)):	Yes
Employer Safety Health Program:	Yes
Training and Education for Employees:	Yes
Craft of Deceased Employee(s):	3. Iron Worker 4. Management Trainee
Age & Sex	3. Ironworker-35; male 4. Management Trainee-26; male
Time on the Job:	1 hour
Time on Task:	1 hour



BRIEF DESCRIPTION OF ACCIDENT

A crew of ironworkers and a crane operator were unloading a 20-ton steel slab from a low-boy trailer using a 50-ton crawler crane with 90-foot lattice boom. The operator was inexperienced on this crane and did not know the length of the boom. Further, no one had determined the load radius. During lifting, the load moved forward and to the right, placing a twisting force on the boom. The boom twisted under the load, swinging down, under and to the right. Two employees standing 30 feet away apparently saw the boom begin to swing and ran. The boom struck one of the employees - an ironworker - on the head, causing instant death. Wire rope struck the other -- a management trainee -- causing internal injuries. He died two hours later at a local hospital.

INSPECTION RESULTS

Section not listed on original

ACCIDENT PREVENTION RECOMMENDATIONS

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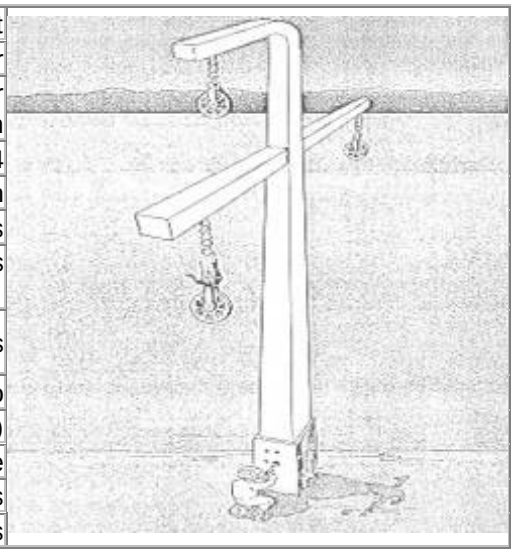
ACCIDENT REPORT
FATAL FACTS

ACCIDENT SUMMARY No. 8

Accident Type:	Struck by Falling Object
Weather Conditions:	Clear
Type of Operation:	Transmission Tower Construction
Size of Work Crew:	4
Union or Non-union	Union
Competent Safety Monitor on Site:	Yes
Safety and Health Program in Effect:	Yes
Was the Worksite Inspected Regularly:	Yes
Training and Education Provided:	No
Employee Job Title:	Groundman (Framer)
Age & Sex:	24-Male
Experience at this Type of Work:	2 Years
Time on Project:	3 Days



BRIEF DESCRIPTION OF ACCIDENT

Ball and socket connectors are used to attach conductor stringing blocks to insulators on the arms of 90 foot metal towers of electrical transmission lines. Normally stainless steel cotter keys secure the ball and socket connector in place. In this case, however, black electrical tape was wrapped around the socket to keep the ball in place rather than a cotter key. The tape apparently stretched and the ball came loose, dropping the stringing block approximately 90 feet onto the head of an employee below, one of a four-man erection crew.

INSPECTION RESULTS

As result of the its investigation, OSHA issued citations alleging three serious and two other-than-serious violations.

OSHA's construction safety standards include several requirements which, if they had been followed here, might have prevented this fatality.

ACCIDENT PREVENTION RECOMMENDATIONS

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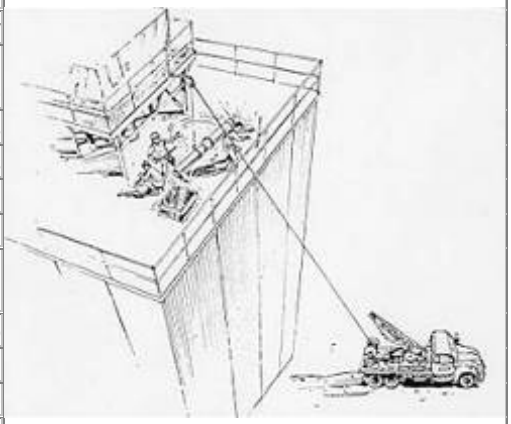
ACCIDENT REPORT
FATAL FACTS

ACCIDENT SUMMARY No. 51

Accident Type:	Struck By
Weather Conditions:	Clear/Cool/Windy
Type of Operation:	Construction Maintainence
Size of Work Crew:	3
Collective Bargaining	Yes
Competent Safety Monitor on Site:	No
Safety and Health Program in Effect:	No
Was the Worksite Inspected Regularly:	Inadequate*
Training and Education Provided:	No
Employee Job Title:	Laborer
Age & Sex:	33-Male
Experience at this Type of Work:	18 Weeks
Time on Project:	1 Day



BRIEF DESCRIPTION OF ACCIDENT

Employees were dismantling grain spouts at a grain elevator. Sections of the spout were connected by collars. A ten foot section of a spout weighing 600 pounds was being pulled through a vent hole by a 5-ton winch. As the spout was being pulled through the opening to the outside, the spout became wedged at the point where the collar was to pass through. Several employees used pry bars to free the collar which was under tension. The spout popped out of the vent striking and killing an employee who was standing beside the spout. * Employer provided but did not require use of hard hats.

INSPECTION RESULTS

As a result of its investigation, OSHA issued two citations alleging serious violations. The employee should have been able to recognize that this situation was hazardous. Additionally, the investigation revealed that this employee was not wearing personal protective equipment in this hazardous situation. Had he been wearing a hard hat this death might have been prevented.

ACCIDENT PREVENTION RECOMMENDATIONS

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