

Case 324. 33-year-old carpenter/laborer died from head injuries sustained when struck by a 3 inch by 0.131 smooth nail from a Model F350S Paslode nail gun.

A 33-year-old male carpenter/laborer died from head injuries sustained when a C Pak, 33 degree clipped head paper taped, 3 inch by 0.131 smooth nail from a Model F350S Paslode nail gun entered his eye socket and lodged in his head. The Paslode nail gun used by the decedent had been shipped with a sequential trigger, but the trigger had been “swapped out” with a contact trigger. The decedent was reattaching the entry wall to the garage wall because the entry wall was not square. To do so, he was reaching around the entry wall hanging around the corner using his right hand to hold the wall and his left hand (non-dominant) to hold the nail gun to nail inside of the wall joists back toward his body. He was not wearing any eye protection. His coworkers heard the nail gun being used and then observed him laying on the ground. The decedent got up and walked a few feet to his coworkers, told them to call for emergency response, and then collapsed. The decedent was transported to a local hospital where he died several days later. After the incident, a nail was found to be partially embedded in one of the entry wall studs. This could have been the result of a “double tap” or a nail that had not been removed from the stud as the wall was being repositioned. Either scenario may have caused the decedent to lose control of the gun. There was a mark on the stud directly next to the decedent’s left hand from the base of the 13.5-inch-long nail gun. When the gun struck the stud, the decedent may have pressed the trigger, and since his head was directly in the line of fire, and because he was not wearing appropriate eye protection, the nail entered his eye socket and lodged in his head.

MIOSHA Construction Safety and Health Division issued Serious, Repeat Serious, and Regulatory citations to the employer at the conclusion of its investigation.

SERIOUS: TOOLS, PART 19, Rule 1937(5):

A positive actuation of the operator control shall be required to propel each fastener from a powered stapler or nailer.

Use of a pneumatic nailer with a contact trigger “bump trigger” resulted in an unintended discharge of a nail, striking the operator. Employees engaged in house framing operations.

REPEAT SERIOUS: GENERAL RULES, PART 1, Rule 114(1):

An accident prevention program was not developed, maintained, and coordinated with employees—

Instance 1: No procedures developed or coordinated with employees for operating pneumatic framing nail guns with sequential and bump type triggers.

Instance 2: No coordination of safety instruction prior to issuance of pneumatic framing nail guns. Operating and maintenance manual is not being reviewed prior to assignment of tool.

Instance 3: No maintenance/enforcement for lack of personal protective equipment usage while operating a pneumatic framing nail gun.

Employees engaged in house framing operations.

The employer was previously cited for a violation of this same rule or similar condition pursuant to a MIOSHA Construction Safety Inspection at a different location conducted in 2010.

REPEAT SERIOUS: PERSONAL PROTECTIVE EQUIPMENT, PART 6, Rule 622(1):

A helmet, as prescribed in R408.40621, was not used to protect the employee where a hazard or risk of injury exists from falling or flying objects or particles or from other harmful contacts or exposures.

No helmet worn. Employee operating pneumatic nailers. Employees engaged in house framing operations.

The employer was previously cited for a violation of this same rule or similar condition pursuant to a MIOSHA Construction Safety Inspection at a different location conducted in 2010.

REPEAT SERIOUS: TOOLS, PART 19, Rule 1937(4):

The operator of a portable powered stapler or nailer and those employees within the striking distance of its fastener shall wear eye protection for, and as prescribed in rules 617, 623 and 624 of Part 6, Personal Protective Equipment, being R 408.40617, R 408.40624 of the Michigan Administrative Code.

No eye protection being worn while operating a pneumatic nailer. Employees engaged in house framing operations.

The employer was previously cited for a violation of this same rule or similar condition pursuant to a MIOSHA Construction Safety Inspection at a different location conducted in 2010.

REGULATORY: RECORDING AND REPORTING OF OCCUPATIONAL INJURIES AND ILLNESSES, PART11, Rule 1129(1):

A log of all work-related injuries and illnesses (MIOSHA 300), and/or the summary of work-related injuries and illnesses (MIOSHA 300-A), work-related injuries and illness incident report (MIOSHA 301), or equivalent forms were not kept by the establishment.

No 300 or 300A summary logs maintained for previous years. Employees engaged in house framing operations.