Case 184. 19-year-old laborer at a grain elevator died due to complications from a fall into a railway car hopper containing corn that was in the process of being unloaded.

A 19-year-old male laborer at a grain elevator died due to complications from a fall into a railway car hopper containing corn that was in the process of being unloaded. While wearing his fall protection harness and attached to the fall arrest on the operator work platform, the decedent had unloaded corn from some rail cars and had moved the rail cars ahead on the rail siding. He unhooked his harness and descended from the platform. Another coworker informed him that two railcars required unloading. The decedent climbed up the ladder to the 16-foot high operator booth where his fall protection device and operator controls were located. The rail cars were moved into position for unloading. The decedent moved the first car ahead and the car was spotted into position over an in-ground pit. The first rail car's three bins were emptied without incident. The second rail car was spotted into position and the dump chute opened. The first bin was emptied and the decedent advanced the rail car to empty the second bin, which held 1,533 cubic feet of corn. At some point during the process, the decedent stepped off of the operator platform at the operator control booth and onto the top of the rail car. He was not attached to the fall arrest system. He fell into the corn still being dumped out the bottom and became engulfed. A coworker came into the area and saw a hard hat lying under the rail car and observed clothing in the corn still pouring from the rail car chute. This coworker ran to the dump chute and grabbed the clothing and pulled the decedent from the chute and through the about one foot clearance area between the bottom of the rail car chute and the in-ground pit grating. When the decedent was clear of the rail car, this coworker began to clear the decedent's air way and began CPR. Shortly thereafter, another employee came into the area and was given instruction on how to perform CPR. Sometime during the rescue operation, an in-company radio call had been made for help and EMS was contacted. EMS arrived and took over the resuscitation efforts. The decedent was transported to a local hospital where he died several weeks later from complications of the injury.

MIOSHA General Industry Safety and Health Division issued the following alleged Serious citation and Safety Recommendations at the conclusion of its investigation.

SERIOUS:

MICHIGAN OCCUPATIONAL SAFETY AND HEALTH ACT, ACT 154, P.A 1974, AS AMENDED SECTION 11(a).
The employer shall furnish to each employee, employment and a place of employment, which is free from recognized hazards that cause or are likely to cause death or serious physical harm to the employee.

The employer failed to insure that the fall protection usage was enforced for employees working on top of railway cars exposed to a fall hazards of approximately 16 feet.

Among others, one feasible and acceptable abatement method to correct this violation is to enforce the use of fall protection, installation of barrier guarding around the opened covers of rail cars, or prohibiting employees from getting onto the tops of the rail cars.

SAFETY RECOMMENDATIONS:

(1) Install mirrors and lighting to allow employees to see inside and under railcars from the operator stations when unloading corn to in ground conveying systems.
(2) Establish and document an inspection program according to the manufacturer's recommendations to assure that employees are inspecting the body harness and fall arrest systems before each usage.