Case 287. 55-year-old press operator was struck by a 1,650 pound bag of pressed pigment as it fell from a mezzanine as he was walking beneath the mezzanine.

A 55-year-old male press operator was struck by a 1,650 pound bag of pressed pigment as it fell from a mezzanine as he was walking beneath the mezzanine. The mezzanine barrier had gates that opened and closed to permit the loading of palletized material. Under the mezzanine was a strobe light that flashed erratically (between 1 and 20 seconds) indicating that loading activities were in process and that employees/fork trucks were not permitted in the area. The mezzanine, which was approximately 15 feet above the plant floor, was a "holding area" for further processing of the pressed pigment. A forklift operator (Operator #1) on the first floor placed a pallet with an unsecured bag of pressed pigment on the mezzanine landing. Operator #1 then placed a second pallet with an unsecured bag of pressed pigment on the mezzanine and used the second pallet to push back the first pallet. This action caused the second pallet to "ride up" and partially rest on the first pallet, rendering the second pallet unstable. Operator #1 left the area to obtain another pallet of material while a forklift operator (Operator #2) working on the mezzanine was moving the first pallet of material for further processing. When Operator #2 lifted the first pallet, the 1,650 pound bag of pressed pigment on the second pallet shifted, "rolled" off the pallet and fell from the mezzanine to the floor. The decedent was walking to his workstation and was struck by the falling bag of material. The area where the decedent was walking was not a designated walkway. Operator #2 was unaware that the bag of material struck the decedent. Operator #2 came down from the mezzanine and was in the process of finding another bag which could be used to hold the spilled pigment when she noted that the decedent was under the spilled material. Operator #2 summoned help and arriving employees attempted to clear the material from the decedent and to pull the bag off of him. The bag was too heavy for them to move, so Operator #1, who had arrived at the incident scene and had activated the firm's emergency response team, used a forklift to move the bag from the decedent. His coworkers provided first aid while awaiting the arrival of emergency response. Emergency response transported the decedent to a local hospital where he died several days later from complications of the injuries sustained.

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

SERIOUS: GENERAL PROVISIONS, PART 1, RULE 15(1):

> Materials, including scrap and debris, were piled, stacked, or placed in a container in a manner that created a hazard to an employee.
>
> Inadequate stacking, Warehousing Area.

SERIOUS: FLOOR AND WALL OPENINGS, STAIRWAYS, AND SKYLIGHTS, PART 2, RULE 213(2):

An open-sided floor or platform four feet or more above adjacent floor or ground level was not guarded by a standard barrier on all open sides, as specified in rules 230, 231, and 233(2) of Part 2:

Inadequate standard barrier, in that a section is removed and employee stands at edge exposed to fall. A section of barrier which is approximately 10 feet long is opened from a switch approximately 30 feet away.