



**Temporary/Contingent Worker
Fatal Injuries**
*Case Studies and Prevention
Recommendations*

Oregon Institute of
Occupational Health Sciences

Agenda

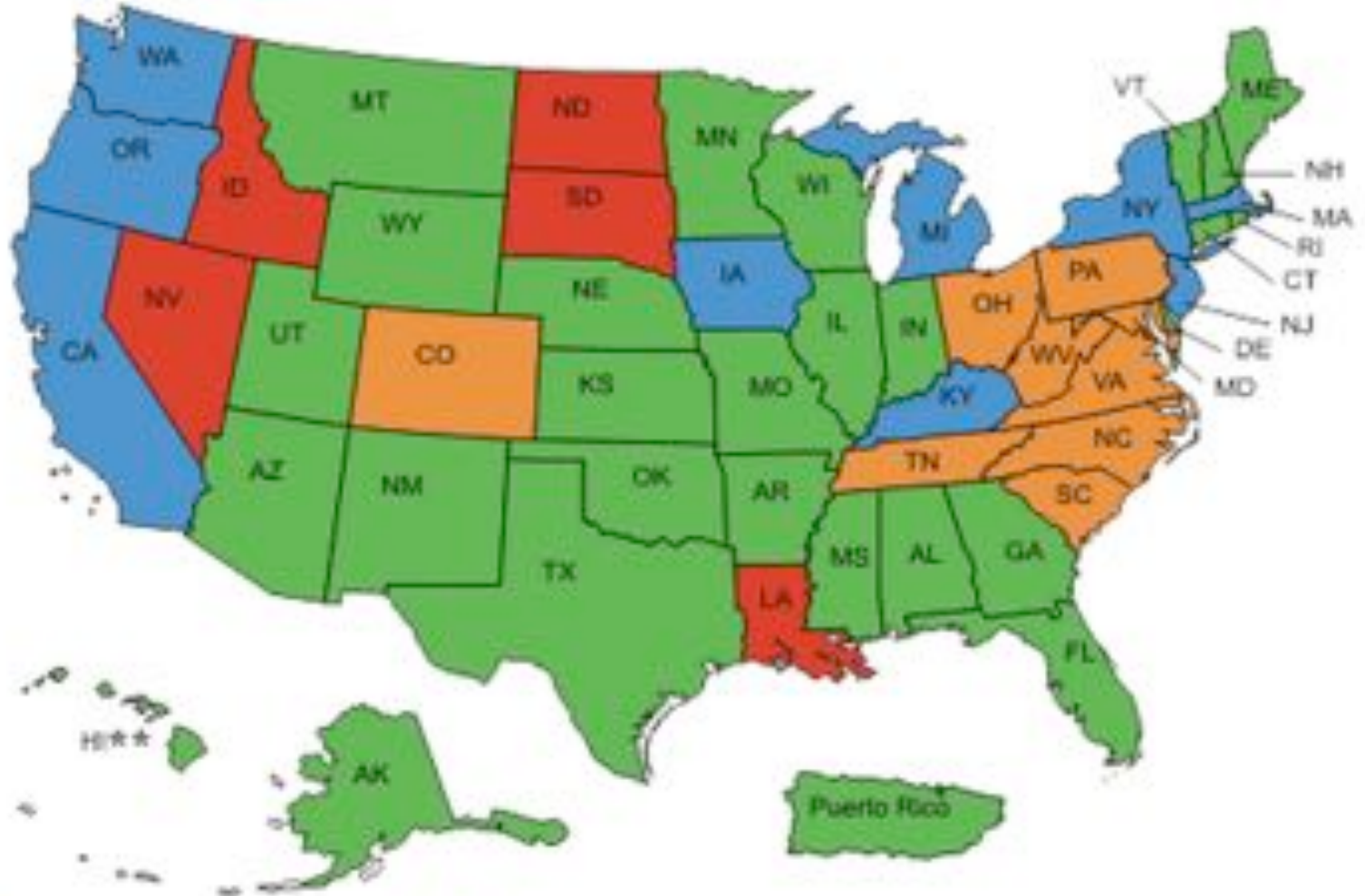
- **What is FACE**
- **OR-FACE data**
- **FACE Investigations**
- **Recommendations**
 - **FACE Investigations**
 - **Staffing Agency**
 - **Contractors**





OR-FACE

Oregon Fatality Assessment & Control Evaluation

- **NIOSH surveillance research program**
 - Began in 1982
 - Expanded to states in 1992
- **OR-FACE**
 - Joined 14 other state programs in 2002
 - 2010 only 9 states

FACE



- | | |
|--|--|
|  State FACE |  Non-FACE states where investigations have been conducted |
|  NIOSH FACE |  States where no FACE investigations have been performed |

** Technical Assistance Visit

OR-FACE Personnel



Ryan Olson, PHD
Program Director



Illa Gilbert-Jones, MS, CIH, CSP
Program Manager/Field Investigator



Melodie Bianchini
Portland State University
Student Worker

OSU MPH Student Interns

- Alexandra Varga (Biostatistics) completed
- Ashley Chase (upcoming summer)

Contract Investigators

- Construction
- Logging
- Maritime

Publications Review Panel

- Paul Moore
- Marilyn Schuster
- Dede Montgomery
- Jeff Wimer
- Dan Cain
- W. Kent Anger

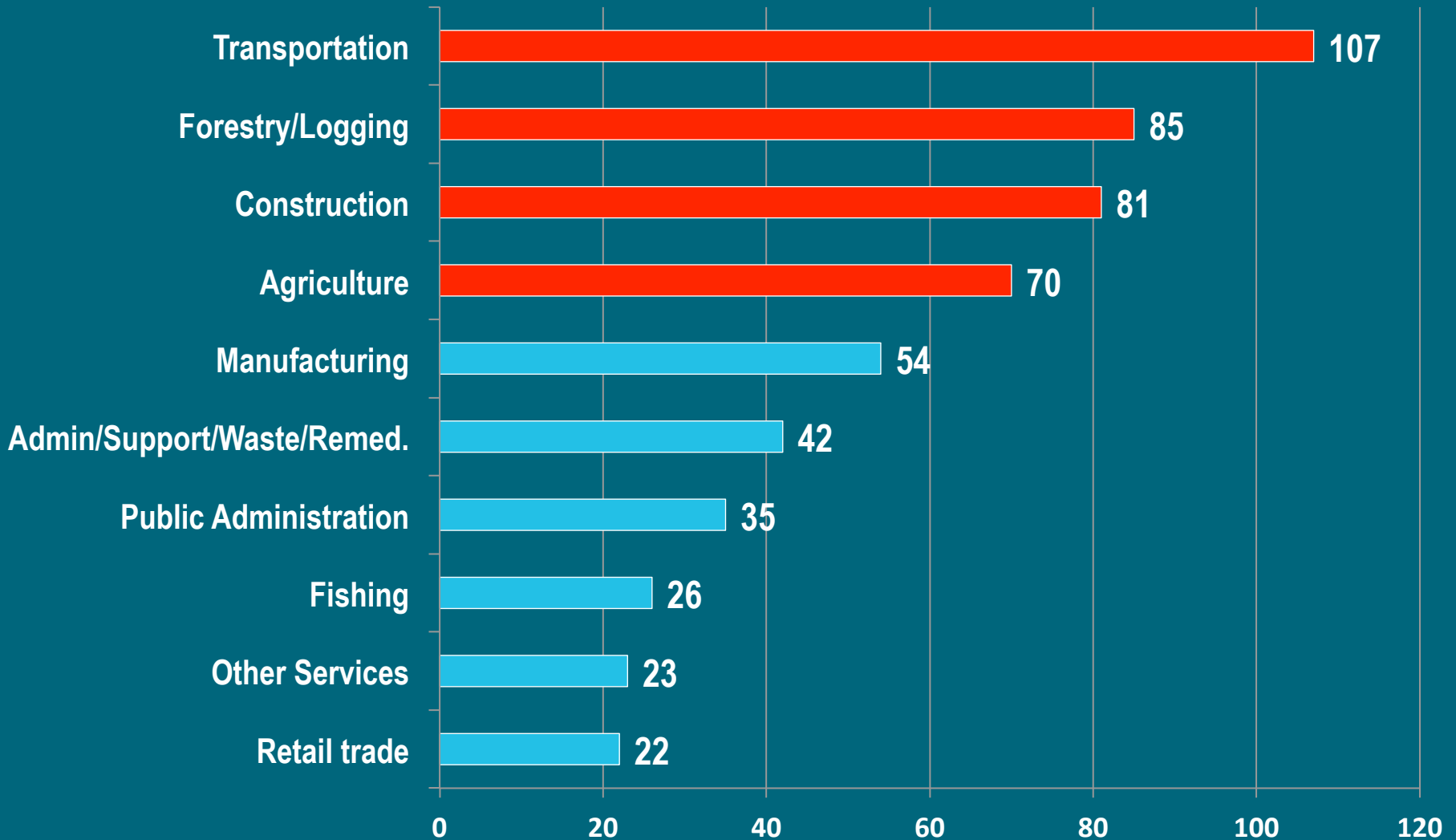
Mission

- **Prevent traumatic work-related deaths in Oregon through**
 - **Surveillance**
 - **Targeted investigation**
 - **Assessment**
 - **Outreach**



OR-FACE Worker fatalities in Oregon (2003-2013)

Top 10 industries in total number



Bureau of Labor Statistics (BLS)

Contingent workers are persons who do not expect their jobs to last or who reported that their jobs are temporary. They do not have an implicit or explicit contract for ongoing employment.

Alternative employment arrangements include persons employed as independent contractors, on-call workers, temporary help agency workers, and workers provided by contract firms.

North American Industry Classification System (NAICS)

561320 Temporary Help Services

This industry comprises establishments primarily engaged in supplying workers to clients' businesses for limited periods of time to supplement the working force of the client. The individuals provided are employees of the temporary help service establishment. However, these establishments do not provide direct supervision of their employees at the clients' work sites.

Examples:

Help supply services

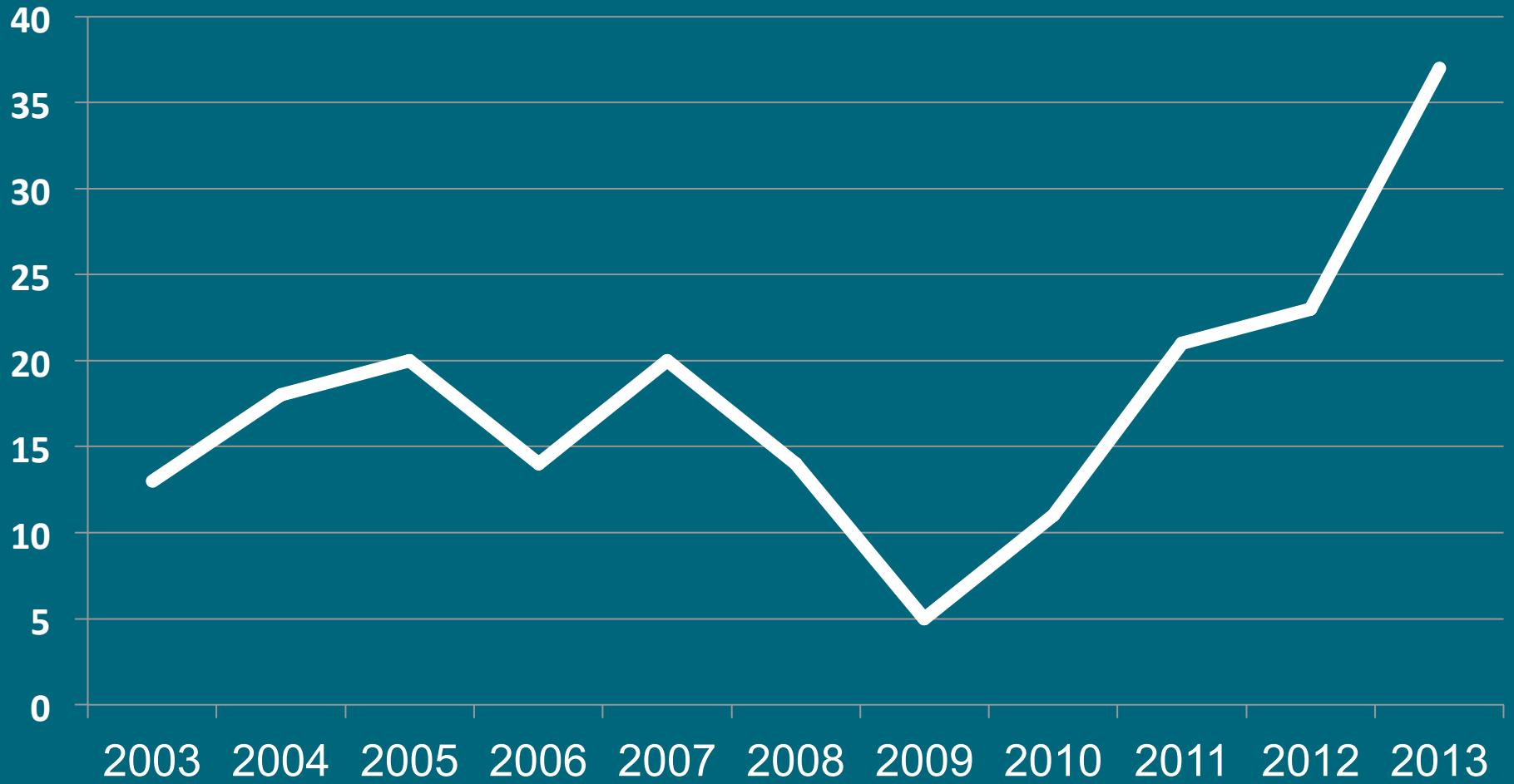
Model supply services

Labor (except farm) contractors (i.e., personnel suppliers)

Temporary employment or temporary staffing services

Manpower pools

Worker fatalities (2003-2013) NAICS 561320 (Temporary Help)



Census of Fatal Occupational Injuries (CFOI), accessed 5/20/15

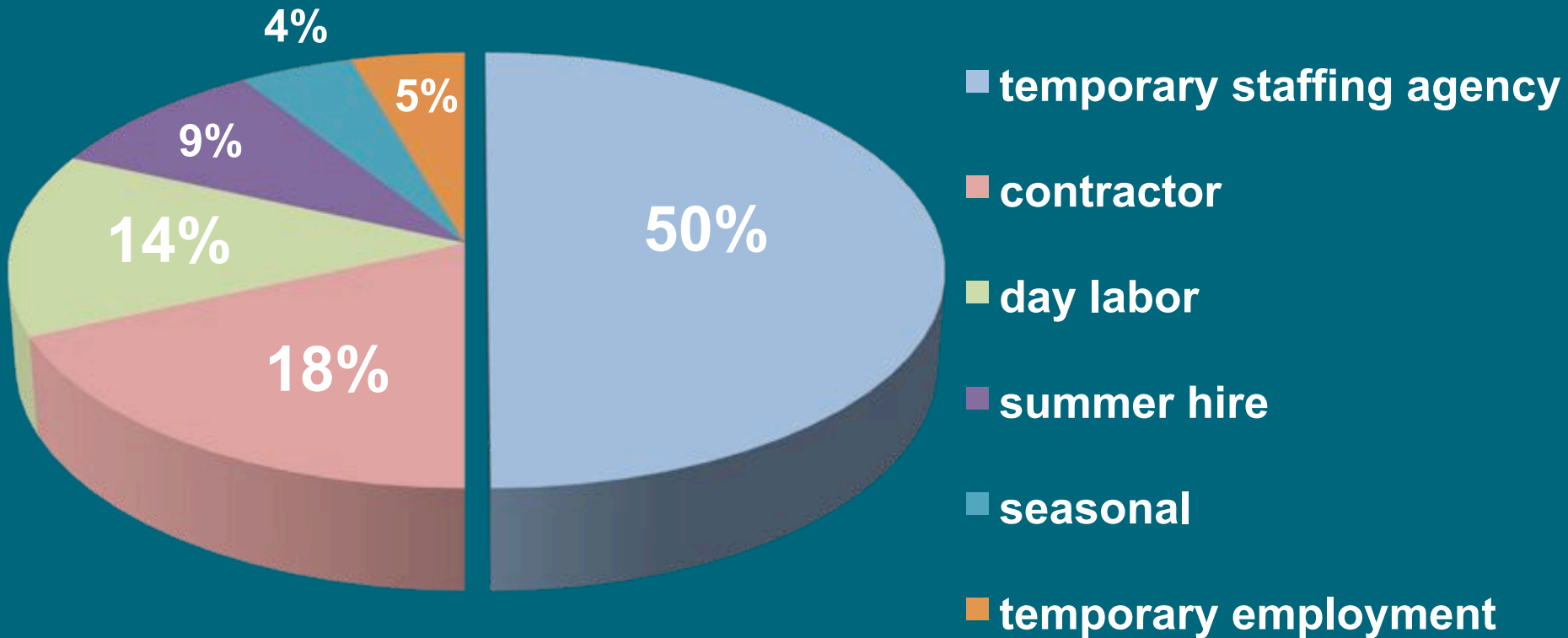
FACE Investigations (2003-2013)

Temporary and Contingent Workers

	No of Cases
California	7
Massachusetts	3
Michigan	2
New York	2
Oregon	3
Washington	2
NIOSH	3
TOTAL	22

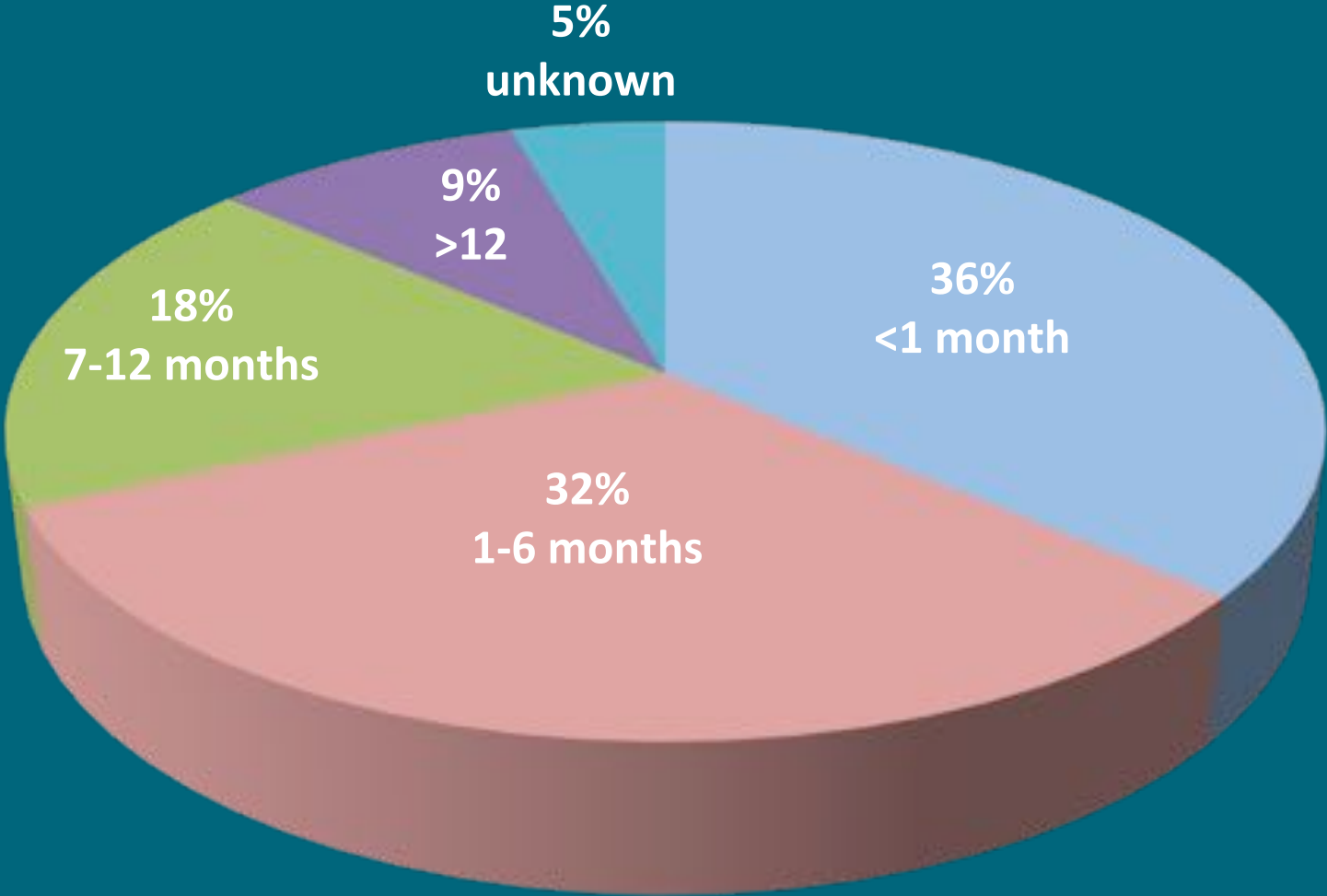
FACE Investigations (2003-2013) Temporary and Contingent Workers

Employment type



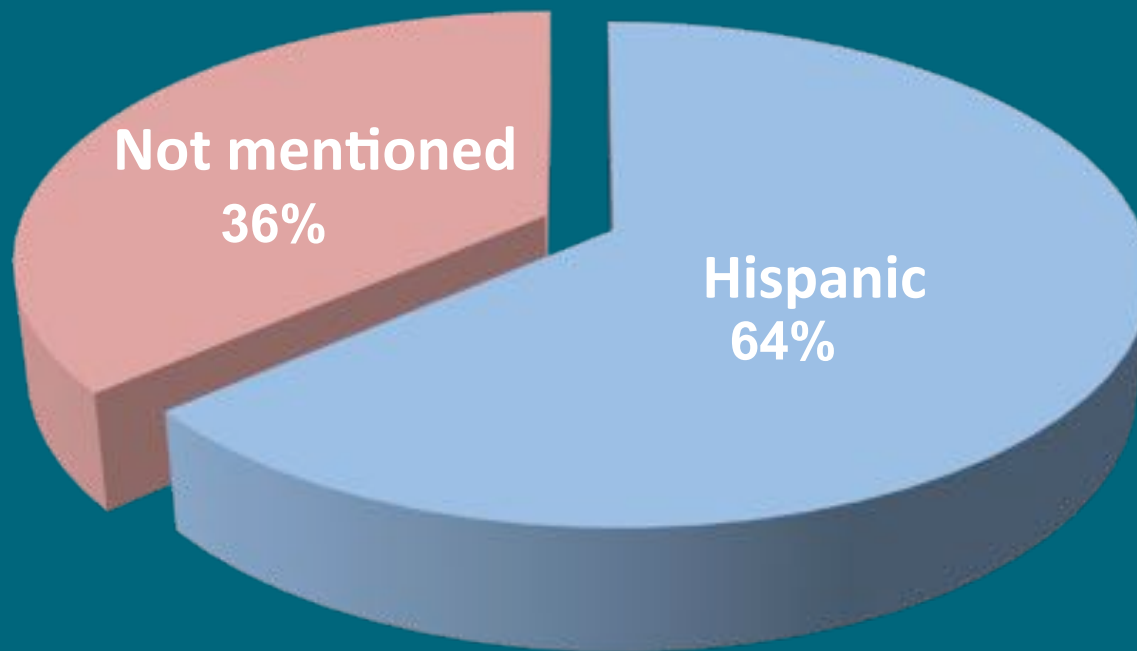
FACE Investigations (2003-2013) Temporary and Contingent Workers

Months on the job



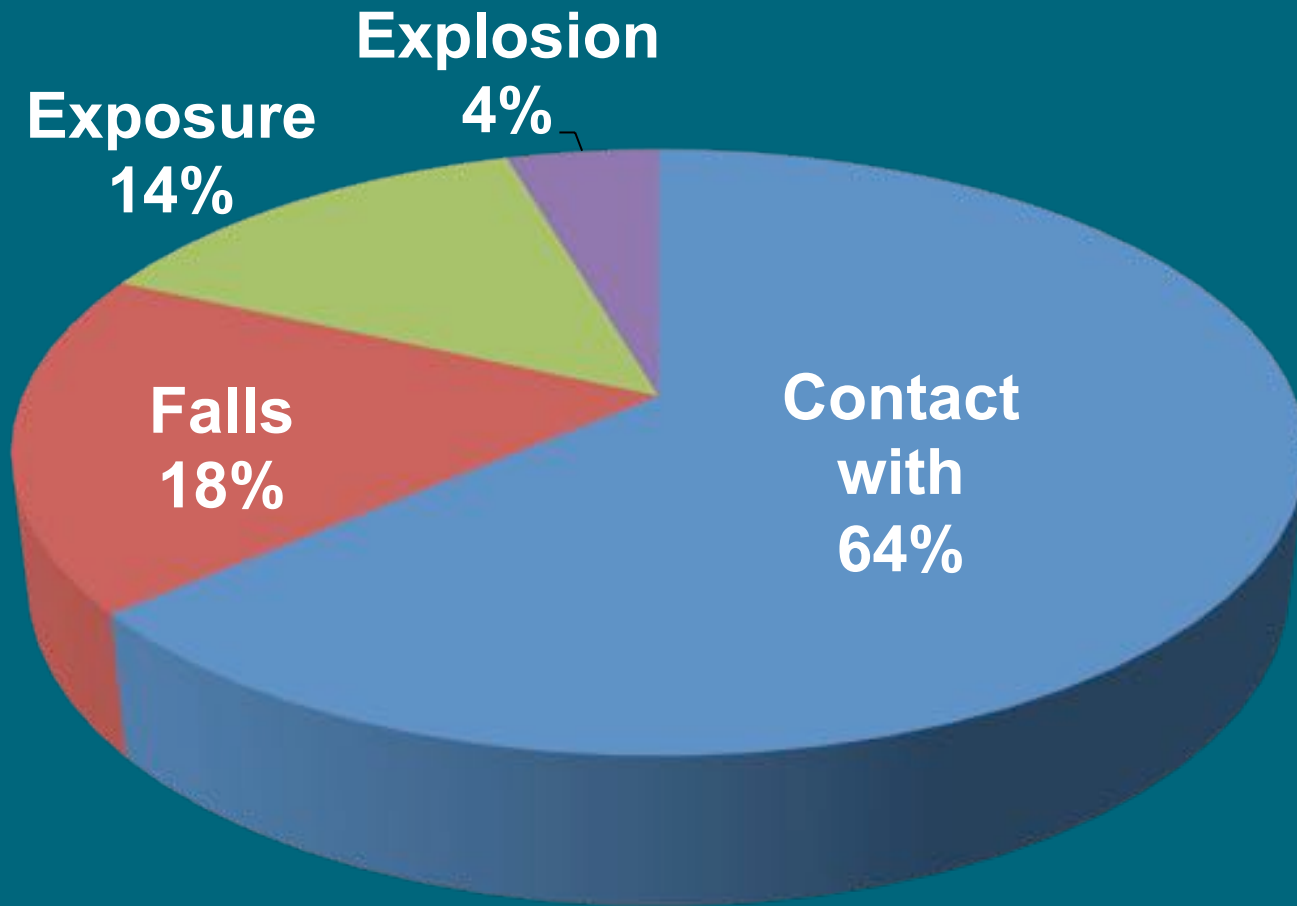
FACE Investigations (2003-2013) Temporary and Contingent Workers

Ethnicity



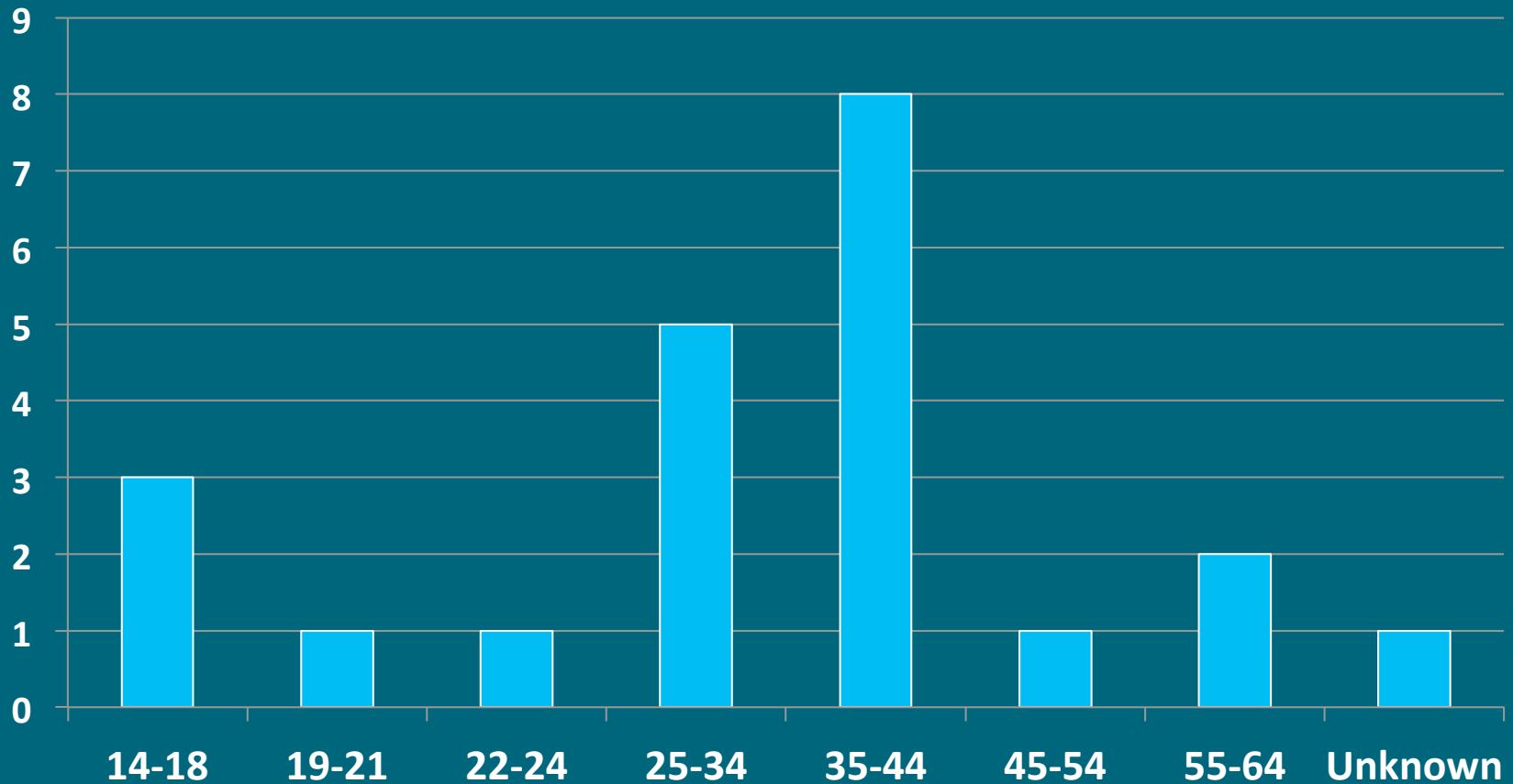
FACE Investigations (2003-2013) Temporary and Contingent Workers

Event



FACE Investigations (2003-2013) Temporary and Contingent Workers

Age Range



OR-FACE

Investigations



Contract sanitation worker killed cleaning meat blending equipment

- Host employer: Meat blending facility
- Employer: Contract sanitation company
- Work: Sanitize equipment during off-shift
- Time at job: 6 months
- Ethnicity: Hispanic
- Contributing factors:
 - Unguarded rotating equipment
 - Slippery floors
 - Long hoses (spigot distance)
 - Training (safe practices)



OREGON FATALITY ASSESSMENT AND CONTROL EVALUATION
Key Personnel: Administrator, Director, and Chief Investigator
 Oregon Health Department, 800 NE Oregon Street, Salem, OR 97331

Oregon Institute of Occupational Health Sciences



Fatality Investigation Report OR 2013-08-1

Contract sanitation worker killed cleaning meat blending equipment

SUMMARY

On April, 2013, a 40-year old sanitation worker was killed when he fell into an industrial meat blender (see Figure 1). The worker was a member of a contract cleaning crew for a meat processing facility. On the day of the incident he reported to work and began routine cleaning and sanitation. Cleaning procedures began with a hot water wash of the rotating blades and mechanical parts to remove residual meat product. The hoses used in rinsing were long, and it was a common practice for workers to wrap the excess hose around their bodies (arms and/or legs). The incident was not witnessed, but based on the cleaning process used by the worker and described by other employees, it is believed either the hose used to wash down the operating equipment fell into the hopper and the worker was pulled in while entangled in the hose or that he lost his footing on the slippery platform and fell into the blender vat. The worker's supervisor who was familiar with the sounds of the machinery, investigated the source of an unusual sound and discovered a severed hose. He then climbed the stairway onto the elevated platform above the blender and saw the worker and additional hose entangled in the blades in the blender vat. The supervisor summoned help and emergency responders were called. The worker was pronounced dead at the scene.



Figure 1. Open top of meat blender where the incident occurred.

RECOMMENDATIONS

Key words: Slipping, Contract worker, Sanitation, Machinery (NASC/NMS/TCO) Oregon Fall 3 Program
 Publication Date: December 2014 OR 2013-08-1
 This report is public information and free to copy. Page 1

Temporary mill worker killed in fall down manlift shaft

Host employer: Feed processing plant
Employer: Temporary staffing agency
Work: Cleaners
Time at job: 1 month
Ethnicity: Hispanic

Contributing factors:

- Outdated manlift (not in compliance with OSHA design requirements)
- Training/instructions and signage in English



OR-FACE OREGON FATALITY ASSESSMENT AND CONTROL EVALUATION
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Fatality Investigation Report OR 2007-57-1

Temporary mill worker killed in fall down manlift shaft

SUMMARY

On December 21, 2007, a 56-year-old clean-up worker at a food mill was killed when he fell into a manlift shaft. The worker apparently tripped or misjudged the handhold on a continuously running manlift in the mill that carried workers up and down between floors. He fell through the 2x2½-foot floor opening onto a crossbeam and was struck continuously by one of the manlift steps, which was unable to pass by him. The worker was employed through a temporary agency and was on the job 2 weeks. He was a native Spanish speaker with very limited proficiency in English, which made communication difficult. The victim had a visual impairment, which may have been a contributing factor in the fall.



CAUSE OF DEATH: Head Injuries

RECOMMENDATIONS

- Workers must follow safe procedures when using a manlift.
- Employers must ensure workers understand safe procedures and demonstrate competence using a manlift, and are physically capable to use a manlift safely.
- Employers should have the capacity to train and supervise foreign-born workers in a language they understand.
- Employers should update manlift equipment to meet current safety standards.
- Employers must ensure landing surfaces for manlifts are clear and provide safe footing.

Keywords: Falls, Manufacturing, Hispanic
Publication Date: September 7, 2010
This report is public information and free to copy.

Oregon FACE Program
OR 2007-57-1
Page 1

Temporary mill worker dies in fall from tower catwalk

Host employer: Lumber mill
Employer: Temporary staffing agency
Work: Equipment operator
Time at job: ~ 2 months
Ethnicity: Hispanic

Contributing factors:

- Unguarded, narrow walkway
- JHA didn't identify fall hazard
- No formal training by host for temporary employees



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Fatality Investigation Report OR 2005-18-1

Temporary mill worker dies in fall from tower catwalk

SUMMARY

On June 23, 2005, a 43-year-old temporary worker at a lumber planing mill, operating a tower conveyor, fell 17 ft off a catwalk in the tower, and died 2 days later. While operating the planer, the temporary worker observed broken pieces of 2x4s beginning to jam up the flow of lumber. Following standard procedure, he stopped the conveyor and stepped onto one of the catwalks that traverse the interior of the metal-beam structure in order to reach the jam. He picked up a broken 2x4 and stepped backward on the catwalk to the platform; then walked out on the catwalk a second time to retrieve another long 2x4, and backed out, dragging the board. At the end of the catwalk, he missed his footing and fell to the concrete floor below, striking his head on another machine in his fall. Emergency responders arrived within a few minutes and transported the victim to the local hospital, where he underwent immediate surgery. He later died in the hospital.



Catwalks in the tower planer provided access to areas where lumber occasionally jammed in the conveyor system.

CAUSE OF DEATH: Blunt head and chest injuries.

RECOMMENDATIONS

- Guardrails must be installed on regularly used access walkways that are 4 ft or more above the ground. If guardrails are not feasible, alternative fall protection must be employed.
- Training in safe work procedures should be provided to all workers, including temporary workers.
- Employers should conduct hazard surveys and follow through with corrective action.

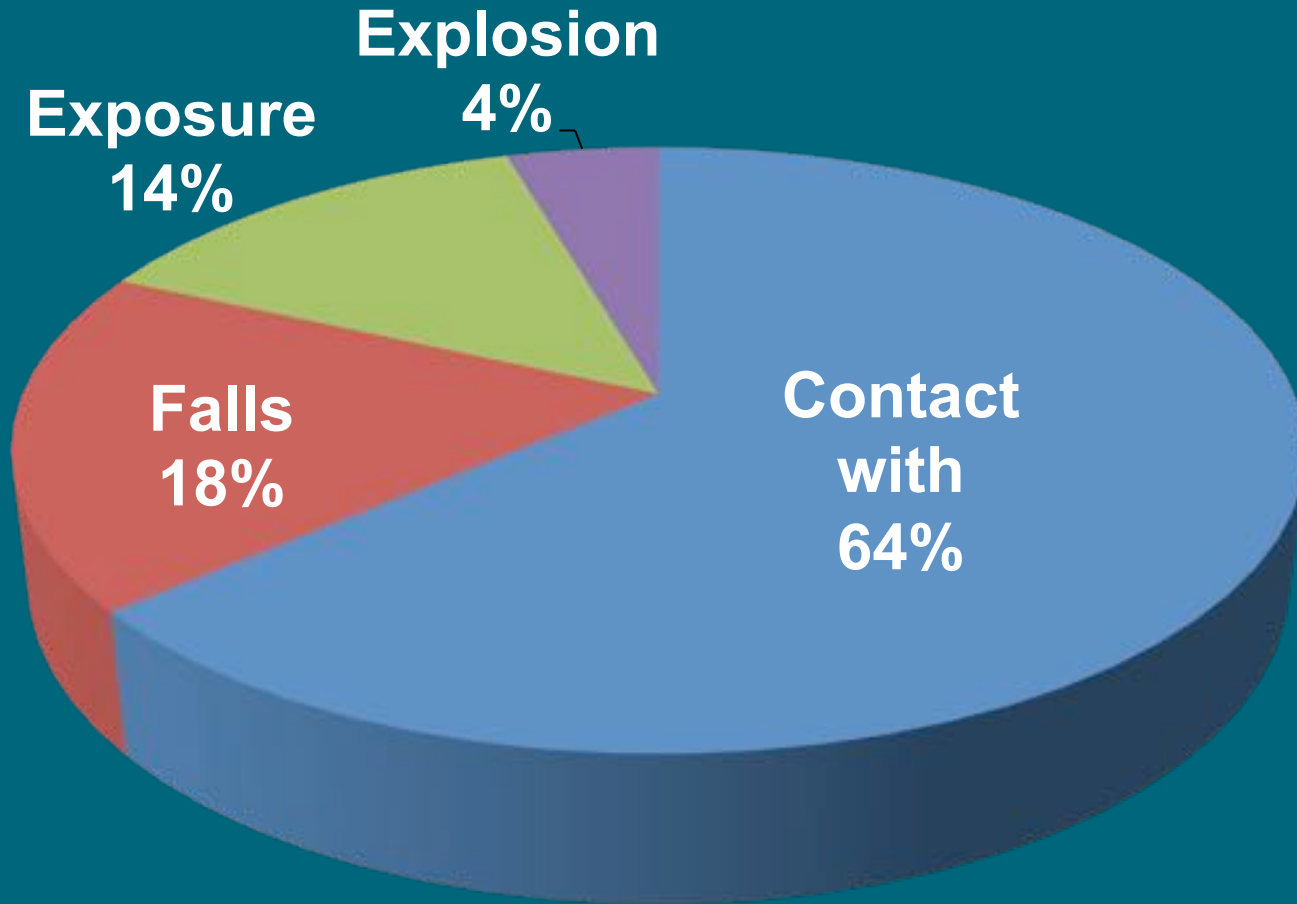
Keywords: Falls
Publication Date: October 10, 2006

Oregon FACE Program
OR 2005-18-1
Page 1

Recommendations

OR-FACE FACE Investigations (2003-2013)
Temporary and Contingent Workers

Event



FACE Investigations

Recommendations

- **Develop and implement routine procedures for hazard identification and control**
 - **Equipment guarding (rotating / moving machine parts)**
 - **Fall hazards**
 - **Legacy equipment (outdated/lack of safety features)**

FACE Investigations Recommendations

- **Training and comprehension**
 - **Hazard identification**
 - **Safe practices/procedures (LOTO)**
 - **Demonstrate competency**
- **Supervision**
 - **Observe/acknowledge safe practices/
correct unsafe practices**
 - **Review new task hazards and control**

Recommended Practices

Protecting Temporary Workers

The Occupational Safety and Health Administration (OSHA) and the National Institute for Occupational Safety and Health (NIOSH) are aware of numerous preventable deaths and disabling injuries of temporary workers. One example is the death of a 27-year-old employed through a staffing agency to work as an equipment cleaner at a food manufacturing plant. While cleaning a piece of machinery, he came into contact with rotating parts and was pulled into the machine, sustaining fatal injuries. The manufacturing plant's procedures for cleaning the equipment were unsafe, including steps in which cleaners worked near the machine while it was energized and parts were moving. Additionally, while the company's permanent maintenance employees were provided with training on procedures to ensure workers were not exposed to energized equipment during maintenance or cleaning, this training was not provided to cleaners employed through the staffing agency. Source: Massachusetts Fatality Assessment and Control Evaluation (FACE) Program, 11MA050.

OSHA /NIOSH Recommended Practices Protecting Temporary Workers

The staffing agency and the host employer are joint employers and both are responsible for providing and maintaining a safe work environment.

Staffing Agency

- **Evaluate client safety process (survey, review documentation)**
 - **Hazard identification/controls (e.g., JHAs, inspections, injury/near miss investigations)**
 - **Hazard/injury reporting**
 - **Compliance with specific safety standards (fall protection, lockout/tagout, powered industrial truck, confined space, respiratory protection, etc.)**
 - **Training and comprehension**
 - **OSHA injury/illness recordkeeping (300 log)**
 - **OSHA citations (public record, online access)**

Staffing Agency

- **Train employees**
 - Hazard identification/controls
 - Reporting requirements-what/when/who (hazard, injury, safety concerns)
- **Define scope of work in a contract**
 - Include responsibilities for specific training and hazard controls
- **Initially and periodically audit client process**

Contractors

- **Develop comprehensive safety program**
 - **Hazard identification/controls (e.g., JHAs, inspections, injury/near miss investigations)**
 - **Hazard/injury reporting-what, who, when**
 - **Specific safety standards (fall protection, lockout/tagout, powered industrial truck, confined space, respiratory protection)**
 - **Training and recordkeeping**

Contractors

- **Evaluate client safety process**
- **Define scope of work in contract**
 - **Responsibility for correcting hazards identified**
 - **Training on facility-specific controls (energy control, interlocks, fall prevention)**
- **Conduct initial and periodic JHAs of tasks**

Questions/ Comments