CASE 9. 53-year old sales manager was killed when he was struck by a wood board he used to assist in unloading a slag tub.

On January 18, 2002, a 53-year old sales manager was killed when he was assisting in the loading of a 400-pound slag tub (80”x80”x16”) onto a truck bed. Overhead crane chains were attached to the 4 corners of the tub holding slag and the crane was used to lift the tub onto the truck. The tub was to be dumped into the truck. The employees unhooked 2 chains so the tub could be tipped. During the tipping process, the crane ran out of crane rail and couldn’t complete the tip. The victim placed a 4”x4” board under the tub to try to get the box to tip; the board was above his head. Instead of tipping forward, the tub tipped back, forcing the board he was using to try to tip the tub to come down and strike his head.

MIOSHA issued the following serious citations to the employer:

1. There employer did not furnish to each employee employment and a place of employment which is free from recognized hazards that are causing or are likely to cause death or serious physical harm to the employee in that the employer did not establish and enforce a safe procedure fro dumping slag boxes exposing employees to the hazard of uncontrolled motion from an unsecured slag box. (Act 154 PA or 1974, Se. 11(a)
2. The employer did not inspect a 10-ton overhead crane in accordance with Table 2. (Overhead and Gantry Cranes, Part 18, Rule 1872(1))
3. The employer did not assess the workplace to determine if hazards that necessitate the use of personal protective equipment are present, or are likely to be present, enabling the selection of appropriate equipment; the employer failed to identify the need for head protection for employees using an overhead crane. (Personal Protective Equipment, Part 33, Rule 3308(1))
4. The employer did not perform and record inspection of the alloy steel chain slings. (Slings, Part 49, Rule 4923(1))