Case 273. 37-year-old construction worker died when he was pinned between the basket of the boom lift in which he was working and a horizontal ceiling beam.

A 37-year-old male construction worker died when he was pinned between the basket of the boom lift in which he was working and a horizontal ceiling beam. The decedent was in the process of painting the ceiling beams. Without permission, he borrowed another contractor's JLG B450AJ lift. The decedent had received lift training from his employer regarding the safe use of a Genie S40 lift – he had not received additional training on the differences in the controls of the JLG lift. When the boom of the lift was positioned over the steer wheels, the steering and drive controls moved in opposite directions to the machine's motion. The JLG did not have a drive enable light or switch, as did the Genie S40, to indicate or remind the operator the basket was rotated. The direction of the drive and steering functions were opposite to the motion of the controls when the platform was positioned over the front axle end. The JLG lift was found positioned over the front axle, thus the drive control function was reversed. It appeared that the victim tried to drive forward and, because of the position of the boom and platform over the front axle, the lift traveled backward. The decedent was found pinned between the I-beam at his back and the upper controls between his stomach and chest. It is unknown how long he was pinned before another contractor employee noticed him and notified the decedent's coworkers. Coworkers, using the ground controls, lowered him 39 feet to the ground. When he was at ground level, coworkers lifted him from the basket and began CPR while awaiting emergency response arrival. The decedent was declared dead at the scene.

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

SERIOUS: GENERAL RULES, PART 1, Rule 114(2)(b)

No instructions provided to each employee regarding the operation procedures, hazards, and safeguards of tools and equipment when necessary to perform the job.

Employees engaged in steel erection and general construction activities were exposed to aerial work platforms that could cause serious physical injury and/or death. The accident prevention program did not address the hazards and procedures of using owned, borrowed, rented or leased equipment, while at the jobsite.

SERIOUS: AERIAL WORK PLATFORMS, PART 32

- RULE 3207(8)
  Training was not provided to each employee who operated the aerial work platform with instruction and training regarding the equipment before a permit was issued or reissued.--

  Employee engaged in touch up painting of structural steel operations was exposed to crush by/caught between hazards causing death, created by a JLG B450AJ.

  Instance A: The employee was not trained in the specific functions of the Function Speed Control, Telescope toggle function, Lower Boom Lift Toggle function and lack of Drive Enable Operations Switch.

  Instance B: The employee did not have a qualified person explain all decals, warnings, and instructions displayed on the JLG 450.

- RULE 3216(I)
  The aerial work platform was not being used only in accordance with the manufacturer's or owner's operating instructions and safety rules.

  Employee engaged in touch up painting of structural steel operations was exposed to crush by/caught between hazards that could have caused death, created by a JLG B450AJ. The lift was used in the area of structural beam and operated without ample room as directed by the manufacturer in the center portion of the new addition, near column line 11A, 40 feet 7/8" above the finish floor.