

A **30 year old male** employee **fell 12'** from a ladder during the course of assisting with the installation of an elevated screw conveyor/auger. The employer is a rendering facility that converts animal byproducts to high-protein ingredients for animal feed.

The employer was hired to install upgraded overhead augers and other similar equipment in a rendering facility. The facility converts used cooking oil and slaughterhouse byproducts into a meat and bone meal which is used as a high- protein ingredient in animal feed. The Meal Storage Room, which stores large piles of the meat and bone meal prior to transport, is where the fall incident occurred.

On the day of the incident, three employees were working together to install a new overhead auger (auger 3) in the meal storage room. The general orientation of the auger had been established (roughly North to South), so the employees were working together to fine tune the auger's alignment to existing equipment (auger 1 & 2). Employee 3 was adjusting auger 1's alignment from a scissor lift at the Northwest corner of the room; he was facing the North wall at the time of the fall. Employee 2 was straddling an existing auger (auger 1) near auger 3's South end; he was facing the North wall while looking at a level, as auger 3 only needed to be adjusted slightly to be in the correct position. Employee 1, the victim, climbed a ladder that was placed near Employee 2's straddled auger (auger 1) at the Southwest corner of the room; it appeared to be his intention to reach a nearby chain come-a-long positioned over auger 2 to adjust auger 3's level.

Even though Employee 2 was only approximately 2 feet away from Employee 1, his back was to the ladder and also to Employee 1. Interviews of both employees reveal that neither saw the fall happen. Employee 2 stated that he was talking to Employee 1 as he ascended the ladder, and he was looking at the level the entire time during the ascension. As these two employees were talking, Employee 2 said he heard a sound, so he turned his head to look. Employee 2 saw the victim on the concrete floor below, so he began yelling for help; 911 was called very shortly afterward.

Based on this investigation, no violations were found that directly pertained to the death of the victim; however, there was one violation was found during the course of the inspection.

Citation(s) as Originally Issued

A complete inspection was conducted at the accident scene. Some of the items cited may not directly relate to the fatality.

Citation 1 Item 1

Type of Violation: Serious

\$1750

29 CFR 1926.502(d)(15)(ii): Anchorages used for attachment of personal fall arrest systems were not designed, installed and used under the supervision of a qualified person:

In that two-anchorage constructed of wire rope and Crosby clamps used for the installation of overhead augers were not designed, installed, and used under the supervision of a qualified person.





