

AN ANALYSIS OF FATAL EVENTS IN THE CONSTRUCTION INDUSTRY 2007

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Prepared by: Construction Industry Research and Policy Center
University of Tennessee, Knoxville

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This report is based upon OSHA-inspected fatal events in construction during calendar 2007. The data analyzed were provided by Dr. Joseph DuBois, Director, Office of Statistical Analysis, Occupational Safety and Health Administration. William R. Schriver, Ph.D., Director Emeritus; Thomas E. Cressler II, M.S., Associate Director Emeritus and John Wagner, M. S., Research Associate II conducted the study and prepared this report. This research was supported by contract No J9F20016 with the United States Department of Labor, Occupational Safety and Health Administration. The authors are solely responsible for all interpretations, conclusions and any errors found in the report.

Executive Summary

Occupational Safety and Health Administration (OSHA) inspected 716 fatal construction incidents (excluding non-work related causes), involving 737 fatalities, in calendar year 2007. Six of the 30 proximal causes classified in this report accounted for 341 (47.6 percent) of the fatal events investigated. They were: (1) *Falls from/through Roofs*: 95 events (13.3 percent); (2) *Falls from/with Structures*: 77 events (10.8 percent); (3) *Crushed/run-over of Non-Operator of Construction Equipment*: 49 events (6.8 percent); (4) *Struck by falling object/projectile (including tip-over)*: 42 events (5.9 percent); (5) *Crushed/run-over/trapped of Operator of Construction Equipment*: 39 events (5.4 percent) and (6) *Fall from/with ladder*: 39 events (5.4 percent).

A comparison of the year-to-year ranks of the proximal causes during the 1991-2007 period shows that they are highly and significantly correlated, i.e., the individual ranks of the causes vary little from year-to-year.

Most of the fatal events involved a single victim, but 18 (2.5 percent) of the events were multi-fatality events which accounted for 39 (5.4 percent) of the fatalities.

Other findings were: (1) in 423 (59.1 percent) of the fatal events the victim was judged to be the primary initiator of the cause; in 186 events (26.0 percent) the victim was judged to be simply in the wrong place at the wrong time; in 73 events (10.2 percent) another employee was judged to be the primary initiator of the cause; in 24 events (3.4 percent) could not be classified; and in 10 events (1.4 percent) the victim and another employee were judged to be primary initiator of the cause; (2) in 685 of the events (95.7 percent) the victim was judged to be performing work at the task site when injured; in 19 events (2.6 percent) the victim was going to or from work or not working when injured; and in 12 events (1.7 percent) no classification was

possible; and (3) most fatal events happened on Wednesday with 141 events (19.7 percent) occurring that day of the week, followed by Tuesday with 138 events (19.3 percent) occurring that day; and most fatal events happened between the 13 and 14 hours (1:00 pm and 2:00 pm) with 85 events (11.9 percent) occurring during this time interval, followed by 9 and 10 hours (9:00 am and 10:00 am) with 82 events (11.5 percent) occurring during this time interval.

An examination of the causes of fatalities occurring during highway/road construction, undertaken because of its unique exposure to external hazards-vehicular traffic, found that the leading cause of these 74 fatal events was “crushed/run-over by highway vehicle” accounting for 20 events (27.0 percent). The leading contributing cause of these 20 events was when highway vehicles lost control and swerved into highway/road work sites, striking workers accounting for 7 events (35.0 percent).

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I. Introduction

This paper reports on the direct causes of fatal events in the construction industry which occurred in calendar year 2007. Fourteen earlier studies¹ by the Construction Industry Research and Policy Center (CIRPC) analyzed the causes of fatal events in this industry in 1991-1992, 1993-1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005 and 2006.

II. Data

The data analyzed in this report, provided by OSHA from Form 170's, consist of narrative descriptions of the 716 fatal events inspected by OSHA resulting from accidents which occurred in construction during calendar year 2007. In this report, as in earlier reports, analysis includes all OSHA-inspected fatal construction events regardless of Federal or State administration.

The Occupational Safety and Health Act of 1970 provides States with the option of administering the Act themselves or accepting Federal administration of the Act. Twenty-nine States and the District of Columbia chose administration under the Federal System, and the remaining 21 States and two Territories chose self-administration under State Plans².

As in the earlier studies, non-accidental fatalities on construction sites or contractor yards (such as deaths from non-work related heart attacks, strokes, seizures, etc.) and fatalities of construction workers killed off-site in traffic accidents were excluded from the analysis; these

¹ An Analysis of Fatal Events in the Construction Industry, 1991-1992 (1993), An Analysis of Fatal Events in the Construction Industry, 1993-1994 (1995), An Analysis of Fatal Events in the Construction Industry, 1995 (1996), An Analysis of Fatal Events in the Construction Industry, 1996 (1997), An Analysis of Fatal Events in the Construction Industry, 1997 (1999), An Analysis of Fatal Events in the Construction Industry, 1998 (2000), An Analysis of Fatal Events in the Construction Industry, 1999 (2001), An Analysis of Fatal Events in the Construction Industry, 2000 (2002), An Analysis of Fatal Events in the Construction Industry, 2001 (2003), An Analysis of Fatal Events in the Construction Industry, 2002 (2004), An Analysis of Fatal Events in the Construction Industry, 2003 (2005), An Analysis of Fatal Events in the Construction Industry, 2004 (2006), An Analysis of Fatal Events in the Construction Industry, 2005 (2007) and An Analysis of Fatal Events in the Construction Industry, 2006 (2008). Construction Industry Research and Policy Center, University of Tennessee, Knoxville.

² States in the Federal System are: AL, AR, CO, CT, DE, DC, FL, GA, ID, IL, KS, LA, ME, MA, MS, MO, MT, NE, NH, NJ, NY, ND, OH, OK, PA, RI, SD, TX, WV and WI. States and Territories under State Plans are: AK, AZ, CA, HI, IN, IA, KY, MD, MI, MN, NV, NM, NC, OR, PR, SC, TN, UT, VT, VI, VA, WA and WY.

fatalities accounted for about 3.5 percent of OSHA-inspected fatal construction events in 1991-2006 but about 5.2 percent in 2007. Although the Occupational Safety and Health Act of 1970 requires employers to report fatalities to OSHA within eight hours of the occurrence of the event, all fatalities on construction sites are not inspected by OSHA; for example, OSHA does not inspect fatal construction events involving independent contractors with no employees. Therefore, the results reported upon here do not provide a year-to-year analysis of changes in the absolute number of fatal events or individuals killed on construction sites.

Each narrative record typically consists of a brief description of the event leading to the fatality, although this is not always the case. Where the narrative description was omitted, inconclusive or completely unclear the event cause was coded “unknown cause or other”; otherwise each narrative was analyzed and classified into one of 31 cause categories, although a great deal of collective judgment was often required to classify the cause of many of the accidents.

This report also includes the following classification of each fatal event according to coding by the OSHA compliance officer who investigated the accident: (1) type of construction (new or addition, alteration or rehabilitation, maintenance or repair, demolition, other); (2) estimate of total project value (seven dollar-value categories beginning with “under \$50,000” and ending with “\$20,000,000 and over”); (3) 17 end-use categories, such as “single-family housing,” “multi-family building,” “commercial building,” “street or highway,” etc.; and (4) the construction operation being performed that caused the fatal event (selected from a list of construction operations such as “backfilling and compacting,” “cutting concrete pavement,” “erecting structural steel,” “installing equipment (HVAC and other,” etc.). However, CIRPC’s review of over 1200 case files of fatal construction events occurring in 1997, 1998 and 1999

revealed that coded data for an event were sometimes internally inconsistent or did not comport with corresponding narrative descriptions. Consequently, the data analyzed in this report are restricted to the direct causes of the fatal events where the authors were able, in most cases, to classify the events with relative certainty according to 31 types of causes, essentially the same types as were used in CIRPC's previous fatality studies. However, coded data are included in Appendix C for the following: (1) end-use of structure; (2) type of construction; (3) occupation of the victim(s); (4) contract value of the construction project; and (5) construction operation associated with the fatality.

In classifying the events a rule of primacy was followed for multiple-cause fatalities the first cause in the chain of causes was recorded as the cause of the fatal event. Definitions of the causes are shown in Appendix A.

III. Analysis of Fatal Events by Cause

A. Distribution of Fatal Events by Cause

Table 1 shows the cause classification system, the number of times each cause represented a fatal event in 2007, the relative frequency of each cause and the number of victims killed.³ It can be seen that "fall from/through roof" led all other causes in number of fatal events (95 or 13.3 percent of total fatal events), followed by "falls from/with structure (other than roof)" (77 or 10.8 percent). The third leading cause was "crushed/run-over of non-operator by operating construction equipment" (49 or 6.8 percent); the fourth leading cause was "struck by falling object (including tip-over)" (42 or 5.9 percent); the fifth leading cause was "crushed/run-over/trapped of operator of construction equipment" (39 or 5.4 percent);

³ Each event included at least one person killed and in several events additional workers were killed or injured.

Table 1. Construction Fatality Event Causes, 2007

Event Causes	Description	Number of Events and Victims		Percent of Events
		Events	Victims	
1.	asphyxiation/inhalation of toxic vapor	11	14	1.5
2.	caught in/struck by stationary equipment	5	5	0.7
3.	crushed from collapse of structure	22	25	3.1
4.	crushed/run-over of non-operator by operating construction equipment	49	50	6.8
5.	crushed/run-over/trapped of operator by operating construction equipment	39	40	5.4
6.	crushed/run-over by construction equipment during maintenance/modification	22	22	3.1
7.	crushed/run-over by highway vehicle	22	22	3.1
8.	drown, non-lethal fall	7	8	1.0
9.	electric shock by touching exposed wire	10	10	1.4
10.	electric shock by equipment contacting power source	36	36	5.0
		<u>Event</u>	<u>Percent</u>	
a.	ladder	4	0.6	
b.	scaffold	3	0.4	
c.	crane/lifting equipment/boom/dump truck	16	2.2	
d.	contact while handling materials such as gutters, iron rods, etc.	13	1.8	
11.	electric shock from equipment installation/tool use	33	33	4.6
12.	electric shock, other	7	7	1.0
13.	elevator (struck/crushed by elevator or counter weights)	3	3	0.4
14.	fall from/with ladder: includes collapse/fall of ladder	39	39	5.4
15.	fall from/through roof	95	95	13.3
		<u>Event</u>	<u>Percent</u>	
a.	fall off of roof	59	8.2	
b.	fall through roof other than skylight	19	2.7	
c.	fall through skylight or other opening	17	2.4	
16.	fall from highway vehicle/construction equipment	4	4	0.6
17.	fall from/with scaffold	26	27	3.6
18.	fall from/with bucket (aerial lift/basket)	18	19	2.5
19.	fall from/with structure (other than roof)	77	78	10.8
		<u>Event</u>	<u>Percent</u>	
a.	fall with collapse of structure	30	4.2	
20.	fall from/with platform or catwalk	16	16	2.2
21.	fall through opening (other than roof)	26	26	3.6

22.	fall, other or unknown	9	10	1.3
23	fire/explosion/scalding	12	18	1.7
24.	hyperthermia/hypothermia	4	4	0.6
25.	hit, crushed, fall during lifting operations	25	25	3.5
26.	struck by falling object/projectile (including tip-over)	42	43	5.9
27.	crushed/suffocation from trench collapse	31	32	4.3
28.	crushed while unloading-loading equipment/material (except by crane)	8	8	1.1
29.	shock/burn from lightning	3	3	0.4
30.	crushed other	5	5	0.7
31.	unknown cause or other	10	10	1.4

		<u>Event</u>	<u>Percent</u>
a.	Other	7	1.0

Total		<u>716</u>	<u>737</u>	<u>100.0</u>
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and the sixth leading cause was “fall from/with ladder” (39 or 5.4 percent). The number and relative frequencies of the remaining causes of the 716 fatal events analyzed may be read directly from Table 1. (Comparative frequencies for earlier years are shown in Figures B1 through B4 in Appendix B.)

At the risk of misleading the reader by over generalizing, it may be informative to describe frequently occurring specific examples of situations leading to the 11 most frequent causes of fatal events listed in Table 1.

Falls from /with/through Roofs. An inattentive roofer or laborer without fall protection walks backward and off the roof or steps into a skylight opening or on to a covered skylight opening.

Falls from/with Structures. An ironworker without fall protection slips or loses balance while erecting steel frame and falls or a carpenter or an ironworker falls as a result of a collapsing structure or structural component.

Crushed, Run-over, Non-operator. A laborer guiding trucks while backing up, a grade checker or a laborer performing site clean-up in proximity of excavating machinery is run-over after getting out of the line-of-sight of an operator/driver.

Struck by Falling Object/Projectile. There were a wide variety of situations in which this type of event occurred, and no typical pattern was evident. Examples of situations were: struck by nails from nail guns, struck by cap on a pressurized line, debris falling during demolition, equipment falling from roof and falling trees.

Crushed/Run-over...Operator. Mobile construction equipment, such as dozers and fork lifts, goes over an embankment and rolls over or rolls over when encountering uneven terrain, resulting in the crushing of the operator. (The operator may be crushed inside the equipment or crushed by the equipment while trying to escape.)

Fall from/with Ladder. Worker falls from or with a ladder because he/she overreaches or fails to secure the ladder or missteps or slips or simply loses balance.

Electric shock by equipment contacting power source. Most of these events occur when an equipment operator or worker positions or repositions a piece of equipment and the equipment contacts an overhead power line.

Electrocution from Equipment Installation. An electrician, helper or lineman working “hot” inadvertently contacts an energized source by body, un-insulated tool or jumper.

Trench Collapse. A worker is usually is in a trench without a trench box or steps outside a trench box and the trench wall collapses.

Fall from/with scaffold. A worker moving on a scaffold missteps or steps on a loose plank and falls from the scaffold. Workers also fall from scaffolds during entry/exit and fall from/ with scaffolds during assembly/disassemble.

Fall through Opening (other than roof). A worker in an unfinished structure steps backward into an open stairwell or is carrying something and fails to see the opening in the floor.

The number of victims killed by each cause is also shown in Table 1 where it can be seen that in most events only one worker was killed per event. There were 18 fatality causes where no event had multiple fatalities; only 12 fatality causes included events with multiple fatalities.

“Fire/explosion/scalding, excluding electrical burner/explosions” was the fatality cause which had the most victims killed per event, i.e., 12 events and 18 victims or 1.5 victims per event.

The Bureau of Labor Statistics (BLS) reported that during 1995-1999, 4 percent of all fatal work-related events involved multiple fatalities, and these multiple-fatality events accounted for 10 percent of the workers killed during the period. They averaged three fatalities per incident.⁴

The OSHA data for construction fatalities in 2007 show that 18 of the fatal events, 2.5 percent of fatal events, had multiple fatalities, and they accounted for 39 fatalities, 5.3 percent of the individuals killed. The multiple-fatality construction incidents averaged 2.2 fatalities per incident. It should be noted that the BLS data included homicides, and they accounted for 19 percent of their multi-fatality incidents. There were no homicides in the 2007 OSHA data. If

⁴ Drudi, Dino and Mark Zak,” Work-Related Multi-Fatality Incidents,” Monthly Labor Review, Vol. 127, No. 10, October 2004.

homicides had been reported they would have been excluded from the analysis as they have been in prior years.

Table 2 shows a comparison of the ranks of the causes in 2007 with the average rank of the causes of fatal events during the period 1991 - 2006. It can be seen that the overall rank pattern of the causes in 2007 is very similar to the rank pattern in 1991 – 2006. An overall statistical comparison of the correlation of the rank in 2007 with the average rank in 1991-2006 was calculated using a Spearman rank correlation procedure.⁵ The correlation obtained was + .92, $p < .001$, indicating that the ranks of the causes in the two time periods are highly and positively correlated, i.e., did not change significantly between 1991 – 2006 and 2007⁶. Since averaging the 1991 – 2006 ranks removed inter-year variance; a somewhat lower correlation would be expected between 2006 and 2007 ranks of causes, i.e., a measure of the short-term cycle as opposed to a longer-term trend. The Spearman rank-order correlation between 2006 and 2007 causes was calculated and found to be + .91, $p < .001$, indicating that the 1991-2005 pattern changed very little between 2006 and 2007.

The correlation result is not surprising given that the general composition of construction output, and therefore the mix of construction operations required to produce the output, was probably very similar during the time periods examined. This interpretation implies that the rank of a cause is a function of the magnitude of exposure to the cause and/or the inherent danger associated with the cause.

⁵ Sidney Siegel, Nonparametric Statistics for the Behavioral Sciences (New York: McGraw-Hill Book Co., Inc., 1956), p. 219.

⁶Five of the 719 fatal events in 2002 and 17 of 719 fatal events in 2001 had either no narrative or a narrative too incomplete to classify the cause of fatality. These records were coded as “unknown” cause; this was not done in prior years. They were omitted from the calculation of the Spearman Rank correlation in order to avoid data distortion.

Table 2. Comparison of Ranks of Causes of Fatal Events in 1991 - 2006 with 2007

<u>Event</u>	<u>1991 - 2006 Average</u>			<u>2007</u>		
	<u>Number</u>	<u>Percent</u>	<u>Rank</u>	<u>Number</u>	<u>Percent</u>	<u>Rank</u>
1. asphyxiation/inhalation of toxic vapor	8.6	1.3	22	11	1.5	20
2. caught in/struck by stationary equipment	6.3	1.0	23	5	0.7	26
3. crushed from collapse of structure	26.9	4.1	11	22	3.1	14
4. crushed/run-over of non-operator by operating construction equipment	51.7	7.9	3	49	6.8	3
5. crushed/run-over/trapped of operator by operating construction equipment	35.1	5.3	5	39	5.4	5
6. crushed/run-over by construction equipment during maintenance/modification	12.9	2.0	21	22	3.1	14
7. crushed/run-over by highway vehicle	25.3	3.9	12	22	3.1	14
8. drown, non-lethal fall	5.6	0.9	24	7	1.0	24
9. electric shock by touching exposed wire	22.8	3.5	13	10	1.4	21
10. electric shock by equipment contacting power source	43.5	6.6	4	36	5.0	7
11. electric shock from equipment installation/tool use	33.9	5.2	7	33	4.6	8
12. electric shock, other	3.6	0.6	28	7	1.0	24
13. elevator (struck/crushed by elevator or counter weights)	2.9	0.4	29	3	0.4	29
14. fall from/with ladder: includes collapse/fall of ladder	27.1	4.1	10	39	5.4	5
15. fall from/through roof	76.6	11.7	1	95	13.3	1
16. fall from highway vehicle/construction equipment	5.3	0.8	25	4	0.6	27
17. fall from/with scaffold	22.8	3.5	13	26	3.6	10
18. fall from/with bucket (aerial lift/basket)	13.8	2.1	18	18	2.5	16
19. fall from/with structure (other than roof)	55.7	8.5	2	77	10.8	2

Table 2. Comparison of Ranks of Causes of Fatal Events in 1991 - 2006 with 2007 (continued)

<u>Event</u>	<u>1991 - 2006 Average</u>			<u>2007</u>		
	<u>Number</u>	<u>Percent</u>	<u>Rank</u>	<u>Number</u>	<u>Percent</u>	<u>Rank</u>
20. fall from/with platform or catwalk	15.6	2.4	16	16	2.2	18
21. fall through opening (other than roof)	17.2	2.6	15	26	3.6	10
22. fall, other or unknown	5.0	0.8	26	9	1.3	22
23. fire/explosion/scalding	13.5	2.1	19	12	1.7	19
24. hyperthermia/hypothermia	4.9	0.7	27	4	0.6	27
25. hit, crushed, fall during lifting operations	34.4	5.2	6	25	3.5	12
26. struck by falling object/projectile (including tip-over)	27.8	4.2	9	42	5.9	4
27. crushed/suffocation from trench collapse	30.2	4.6	8	31	4.3	9
28. crushed while unloading-loading equipment/material (except by crane)	13.5	2.1	19	8	1.1	23
29. shock/burn from lightning, other	14.4	2.2	17	18	2.5	16
TOTAL	<u>656.5</u>	<u>100.0</u>		<u>716</u>	<u>100.0</u>	

The number of OSHA-inspected fatal construction events has varied over the years since 1991 as has employment in construction establishments.⁷ The trend of these fatal events per 100,000 construction establishment employees is as follows: 1991 – 1992: 13.1; 1993 – 1994: 11.8; 1995: 11.4; 1996: 10.5; 1997: 10.6; 1998: 10.4; 1999: 11.0; 2000: 9.5; 2001: 10.8; 2002: 10.7; 2003: 10.5; 2004: 11.4; 2005: 10.3; 2006: 10.1; and 2007: 9.4.

IV. Analysis by Victim’s Situation

An analysis was performed to classify the fatal events by four general categories: (1) victim(s) was primary, immediate contributor to the event; (2) person(s) other than victim(s) was primary, immediate contributor to the event; (3) no individual directly contributed to the event, the victim(s) being “at the wrong place at the wrong time”; and (4) unknown.

The first category includes, for example, most falls, crushing/run-over of operators, electrocutions other than those occurring during lifting operations, asphyxiations and hypothermia. The second category includes, for example, most crushing/run-over of nonoperators, lifting operations, loading/unloading of equipment/materials, struck by highway vehicles, falls from/with aerial lifts, and electrocutions from crane boom/tackle contacting overhead power lines. The third category includes, for example, most structure and trench collapses, struck by projectile/falling objects, and lightning.

Although the classifications were often subjective due to a lack of precise information or conflicting information, following are the results for the 716 events: (1) victim primary initiator of event: 423 events (59.1) percent; (2) victim and another employee was primary initiator: 10 events (1.4 percent); (3) person other than victim was primary initiator: 73 events (10.2 percent);

⁷ Bureau of Labor Statistics, National Employment, Hours, and Earnings.

(4) “wrong place at wrong time”: 186 events (26.0 percent); and (5) unknown: 24 events (3.4 percent).

An additional classification of the 716 fatal events was also performed to estimate the distribution of events by work status of the victim. As with the previously discussed classification of who initiated the event, the work status classifications were also subjective – perhaps even more so. Never-the-less, it may be useful in understanding in a general sense the situations in which construction fatalities occur. It was found that: (1) 685 (95.7 percent) of the fatal events involved workers performing work at their task site; (2) 19 (2.6 percent) of the events involved workers going to or from work or not working; and (3) 12 (1.7 percent) of the events could not be classified.

The first category includes, for example, many roofing fatalities, fatalities resulting from structure and trench collapses, events involving crushing/run-over of operators, electrocutions while installing electrical equipment, workers caught in stationary equipment, workers falling from/with aerial lifts and scaffolds and workers climbing/relocating on structures.

V. Analysis of Fatal Events by Day of Week and Time

The fatality data reported on OSHA Form 170 includes the date and time of day of most fatal events. Table 3 shows the distribution of fatal events by day of the week. Contrary to the popular conception that most fatalities occur on Mondays and Fridays, it can be seen that Wednesday had the largest number of events, 141, followed by Tuesday and Thursday with 138 and 131 events respectively, and Friday had the fewest number of fatal events, 108, when weekends are excluded. However, without knowing the total number of construction hours worked each day, it is not possible to conclude that any one day is more or less hazardous than another.

Table 3. Distribution of Fatal Construction Events by Day of Week, 2007

<u>Day</u>	<u>Number of Events</u>	<u>Percent</u>
Monday	129	18.0
Tuesday	138	19.3
Wednesday	141	19.7
Thursday	131	18.3
Friday	108	15.1
Saturday	57	8.0
Sunday	<u>12</u>	<u>1.7</u>
<i>Total</i>	716	100.0

Table 4 shows the distribution of fatal events by hour (military) of the day. It can be seen that the 13-14 hour period and the 9-10 hour period contained the most fatal events, 85 and 82, respectively. As pointed out previously, without knowing the total hours worked in construction each hour, it is not possible to calculate hourly event rates. However, it may be reasonably assumed that the total construction hours worked each hour during the 8-12 hour period and the 13-17 hour period are approximately equal.

Table 4. Distribution of Fatal Construction Events by Hour, 2007

<u>Hour</u>	<u>Number of Events</u>	<u>Percent</u>
0-1	3	0.4
1-2	3	0.4
2-3	6	0.8
3-4	1	0.1
4-5	5	0.7
5-6	2	0.3
6-7	4	0.6
7-8	19	2.7
8-9	64	8.9
9-10	82	11.5
10-11	73	10.2
11-12	63	8.8
12-13	54	7.5
13-14	85	11.9
14-15	75	10.5
15-16	72	10.1
16-17	44	6.1
17-18	20	2.8
18-19	15	2.1
19-20	4	0.6
20-21	7	1.0
21-22	4	0.6
22-23	5	0.7
23-24	4	0.6
Missing	<u>2</u>	<u>0.3</u>
<i>Total</i>	716	100.0

VI. Highway/Road Construction Fatalities

One might think that highway/street construction would be relatively safe, since most work activity at these sites occurs at or near ground level. Therefore, falls from elevations, the leading direct cause of construction fatalities, would have a low potential. However, in 2007, 74 workers were killed in 73 events while working on highway/street projects.

Table 5 ranks the direct causes of the fatal events by their frequency. The table shows that the leading causes were “crushed/run-over by highway vehicle” (20 events or 27.0 percent), followed by “crushed/run-over of non-operator by operating construction equipment” (18 events or 24.3 percent), and “crushed/run-over of operator of construction equipment” (12 events or 16.2 percent). Other event causes were: “struck by projectile/falling object” (7 events or 9.5 percent); “crushed by maintenance of construction equipment” (4 events or 5.4 percent); “trench collapse” (3 events or 4.1 percent); and “electric shock-crane/lifting equip/boom--contacting power source” with (2 events or 2.7 percent).

Since traffic on many or most highway/road varies by time of day, and most construction on highway/road occurs during the day, one might expect that most “crushed/run-over by highway vehicles” fatalities would occur during morning and afternoon commuting periods when traffic loads peak. Table 6 shows fatal events caused by victim being struck/run-over by highway vehicles by time of day (1- 24 hours).

It can be seen that the dawn, mid-morning, mid day and late-afternoon periods had essentially the same number of events, 4 events (20.0 percent), 3 events (15.0 percent), 4 events (20.0 percent), and 4 events (20.0 percent) respectively.

Table 5. Frequency of Fatality Causes in Highway/Road Construction, 2007

	<u>Frequency</u>	<u>Percent %</u>
Crushed/run-over by highway vehicle	20	27.0
Crushed/run-over of non-operator by operating construction equipment	18	24.3
Crushed/run-over of operator by operating construction equipment	12	16.2
Struck by falling object/projectile	7	9.5
Crushed/run-over by construction equipment during main/mod.	4	5.4
Crushed/suffocation from trench collapse	3	4.1
Electric shock by contacting power source by crane/lifting equip./boom/dump truck	2	2.7
Electric shock by touching exposed wire	1	1.4
Hit/crushed/fall during lifting operation	1	1.4
Fall from/with ladder	1	1.4
Crushed, other	1	1.4
Fall from highway vehicle/construction equipment	1	1.4
Caught in/struck by stationary equipment	1	1.4
Fall from/with bucket	1	1.4
Unknown cause-other	1	1.4
Total	74	100.0

**Table 6. Construction Fatalities Caused by “Crushed/Run-Over by Highway Vehicle”
by Time of Day, 2007**

<u>Time</u>	<u>Frequency</u>	<u>Percent (%)</u>
Early Morning: 24:00 - 5:00	2	10.0
Dawn: 5:00 - 8:00	4	20.0
Mid-Morning: 8:00 - 11:00	3	15.0
Mid-Day: 11:00 - 14:00	4	20.0
Late-Afternoon: 14:00 - 17:00	4	20.0
Evening: 17:00 - 20:00	1	5.0
Late Night: 20:00 - 24:00	<u>2</u>	<u>10.0</u>
TOTAL	20	100.0

This pattern contrasts with the timing of events in 2006 which generally comported with findings by Simpson⁸. Simpson when studying 70 injury events in highway construction found that 38.7 percent of injuries occurred during the mid-day period (11:00-14:00); 34.0 percent occurred during the mid-morning period (8:00-11:00), and 19.6 percent occurred during the late-evening period (14:00-17:00).

Although it is not possible to calculate fatality rates for these time-of-day periods without knowing the hours worked in each period, it is possible to advance a hypothesis that could partially explain the pattern of occurrence in Simpson and in the 2006 data. One hypothesis would be that fatalities and injuries in highway/road construction are a partial function of traffic loads, assuming that most highway/road construction activity occurs after the morning commuting peak and before the evening commuting peak.

Thus both OSHA’s 2006 fatality data and Simpson’s injury data appear to be affected by the mid-day traffic load. Both results are surprising, because the mid-day period likely has the fewest hours of work of any of the daytime periods since lunch is generally taken by workers

⁸ Simpson, James Mitchell. Analysis of Accidents on Tennessee Highway and Street Construction, unpublished Master’s Thesis, Department of Environmental and Civil Engineering, University of Tennessee, August 2002.

during this period. It remains to be determined if the 2007 data is an anomaly. Never-the-less, more information about the conditions which contribute to fatalities in highway/road construction caused by highway vehicles striking workers could save many lives. Therefore, it is suggested the National Institute for Occupational Safety and Health (NIOSH) investigate the conditions which contribute to highway/road construction injuries.

Since “crushed/run-over by highway vehicle” was the leading direct cause of fatal events occurring in highway/road construction, it may be helpful in protecting workers engaged in highway/road construction by looking for specific situations in which these fatalities occurred. The often brief summaries of highway construction fatalities in IMIS provided little or no information on speed limits, pavement conditions, visibility, protective barriers, work zone markings or potential impairments of vehicle operators involved in the fatalities. However, it was still possible to identify seven sub-categories of “crushed/run-over by highway vehicle”. Table 7 shows these sub-categories and their frequency.

This table shows that the largest numbers of fatal events occurred when highway vehicles lost control and swerved into work zones striking workers, accounting for 7 (35.0 percent) of the fatal events. This sub-category was followed by the situation where flaggers were struck by highway vehicles passing work zones, representing 3 (15.0 percent) of the events. Four other situations accounted each for 3 (15.0 percent) of the fatal events: workers struck by vehicles while installing signs or working on traffic signals; workers struck by vehicles which inadvertently drove into work zones; workers protected by shadow trucks crushed when vehicles rammed the shadow truck; and, workers run-over by vehicles entering poorly marked/protected work zones.

Table 7. Frequency of Sub-Categories of “Crushed/Run-Over by Highway Vehicle”, 2007

<u>Sub-Category</u>	<u>Frequency</u>	<u>Percent (%)</u>
1. highway vehicle lost control and entered (by swerving or inadvertently entering) well-identified work zone, striking victim	7	35.0
2. highway vehicle struck victim installing signs or traffic signals in unprotected work zone	3	15.0
3. highway vehicle struck victim (flagger) signaling traffic at beginning of marked work zone.	3	15.0
4. highway vehicle struck victim working (paving) in unprotected work zone	1	5.0
5. highway vehicle struck victim who walked into traffic zone	3	15.0
6. highway vehicle struck shadow vehicle protecting moving vehicle from which victim was performing work, crushing victim	0	0.0
7. highway vehicle struck victim by entering inadequately marked and protected work zone	1	5.0
8. unknown	<u>2</u>	<u>10.0</u>
TOTAL	20	100.0

APPENDIX A

Definitions of Fatality Causes

1. asphyxiation/inhalation of toxic vapor: lack of oxygen and/or inhalation of toxic gas, (excluding asphyxiation resulting from fire/explosion)
2. caught in/struck by stationary equipment: body or clothing caught pulling worker into equipment
3. collapse of structure: building or other structure falling on worker, not including falling ladder, scaffold, aerial lift/ basket, platform, with a structure, trench collapse, or wall (earthen) collapse
4. crushed/run-over of non-operator by operating construction equipment: non-operator run-over or crushed between equipment and ground or another object by an operator controlled piece of construction equipment
5. crushed/run-over/trapped of operator by operating construction equipment: includes rollover and catching of body in equipment or between equipment and ground or other object while operating the equipment*
6. crushed/run-over by construction equipment during maintenance/ modification: includes equipment/parts falling on worker while assembling or disassembling equipment
7. crushed/run-over by highway vehicle: any run-over by non-construction equipment, including trains
8. drown, non-lethal fall: non-lethal falls into water and flooding of container, trenches, etc
9. electrocution by touching exposed wire/source: body part contacting the wire/source except when installing equipment or using a tool
10. electrocution by equipment contacting wire
 - a. ladder
 - b. scaffold
 - c. crane/lifting equipment/boom/dump truck
 - d. other: contact while handling materials, e g. gutters, iron rods, painting equipment, etc.
11. electrocution from equipment installation/tool use: includes failure to de-energize equipment, inappropriate energizing, contacting energized part with tool or body, and inadequately grounded tools or exposed tool wires
12. electric shock, other and unknown cause
13. elevator (struck/crushed by elevator or counter-weights)
14. fall from/with ladder: includes collapse/fall of ladder

*Includes fatalities resulting from asphyxiation/fire/explosion/drowning of trapped operators.

15. fall from roof; fall through roof: skylight or other opening
 - a. fall off of roof
 - b. fall through roof other than skylight
 - c. fall through skylight or other opening
16. fall from vehicle (vehicle/construction equipment): falls from vehicle or equipment while in motion or at rest.
17. fall from/with scaffold: includes collapse/fall of scaffold
18. fall from/with bucket (aerial lift/basket): includes collapse/fall of bucket
19. fall from/with structure (other than roof): fall through opening in the side or through the floor (not opening in the floor) and with the structure in a collapse
 - a. fall with collapse of structure
20. fall from/with platform or catwalk (attached to structure: includes collapse/fall of platform)
21. fall through opening (other than roof): falls through stairwells, equipment openings, or other openings in a floor
22. fall, other or unknown
23. fire/explosion/scalding, excluding electrical burns/explosions
24. heat/hypothermia
25. lifting operations: failure of equipment, inappropriate lifting, and all loading and unloading by crane operations except electrocution. (Includes objects falling and striking victim during lifting operation)
26. struck by falling object/projectile (including tip-over): does not include collapse of structure, trench, earthen wall, or lifting operations
27. trench collapse: includes earthen wall
28. unloading-loading equipment/material (except by crane): includes slipping and tipping over of construction equipment/material while loading and unloading
29. lightning
30. crushed
31. unknown cause or other
 - a. other

APPENDIX B

Figure B1. Comparison of Construction Fatal Events (1995-2006 with 2007)

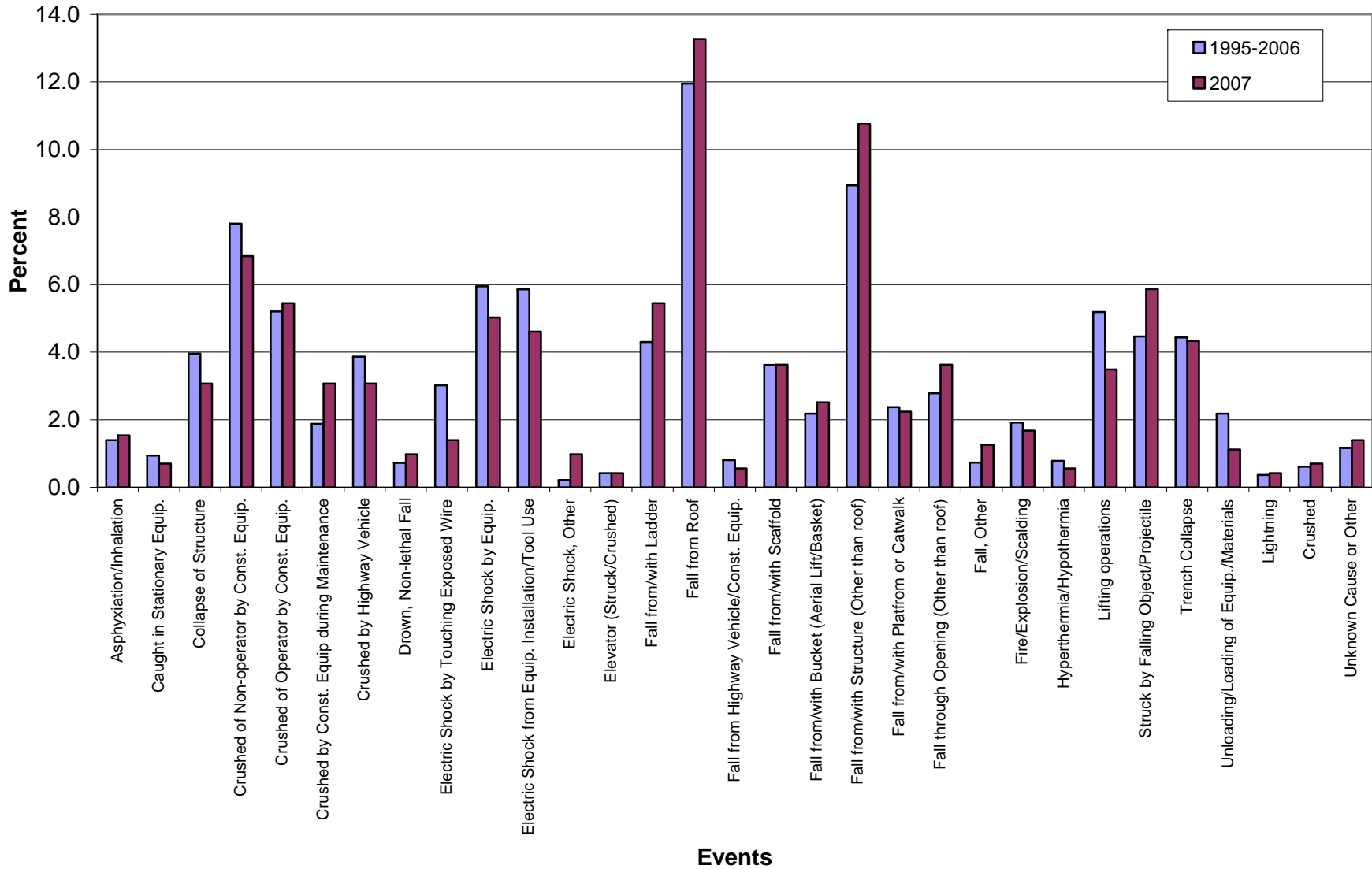


Figure B2. Comparison of Construction Fatal Events (2007)

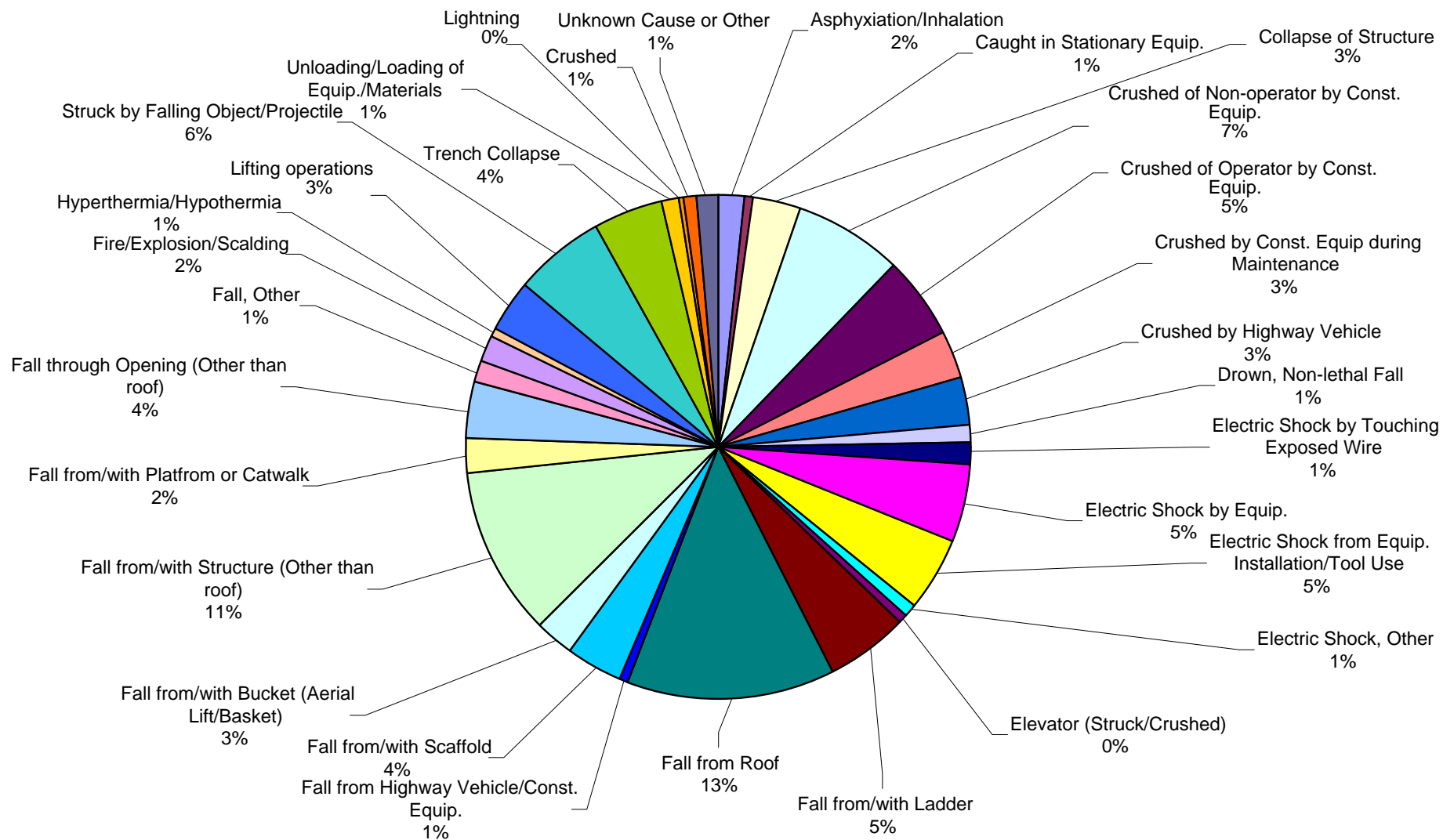


Figure B3. Comparison of Construction Fatal Events (1995-2006)

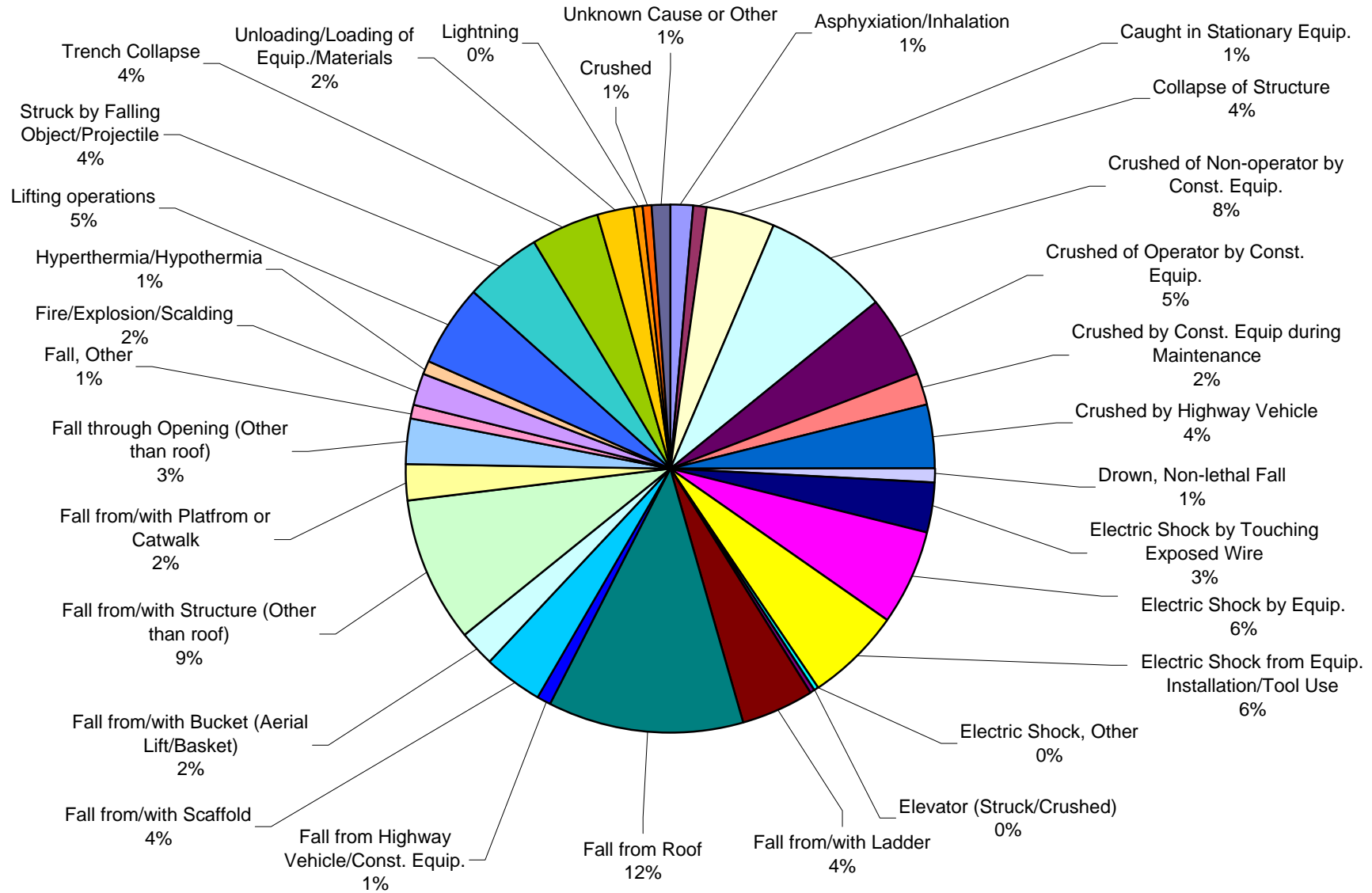
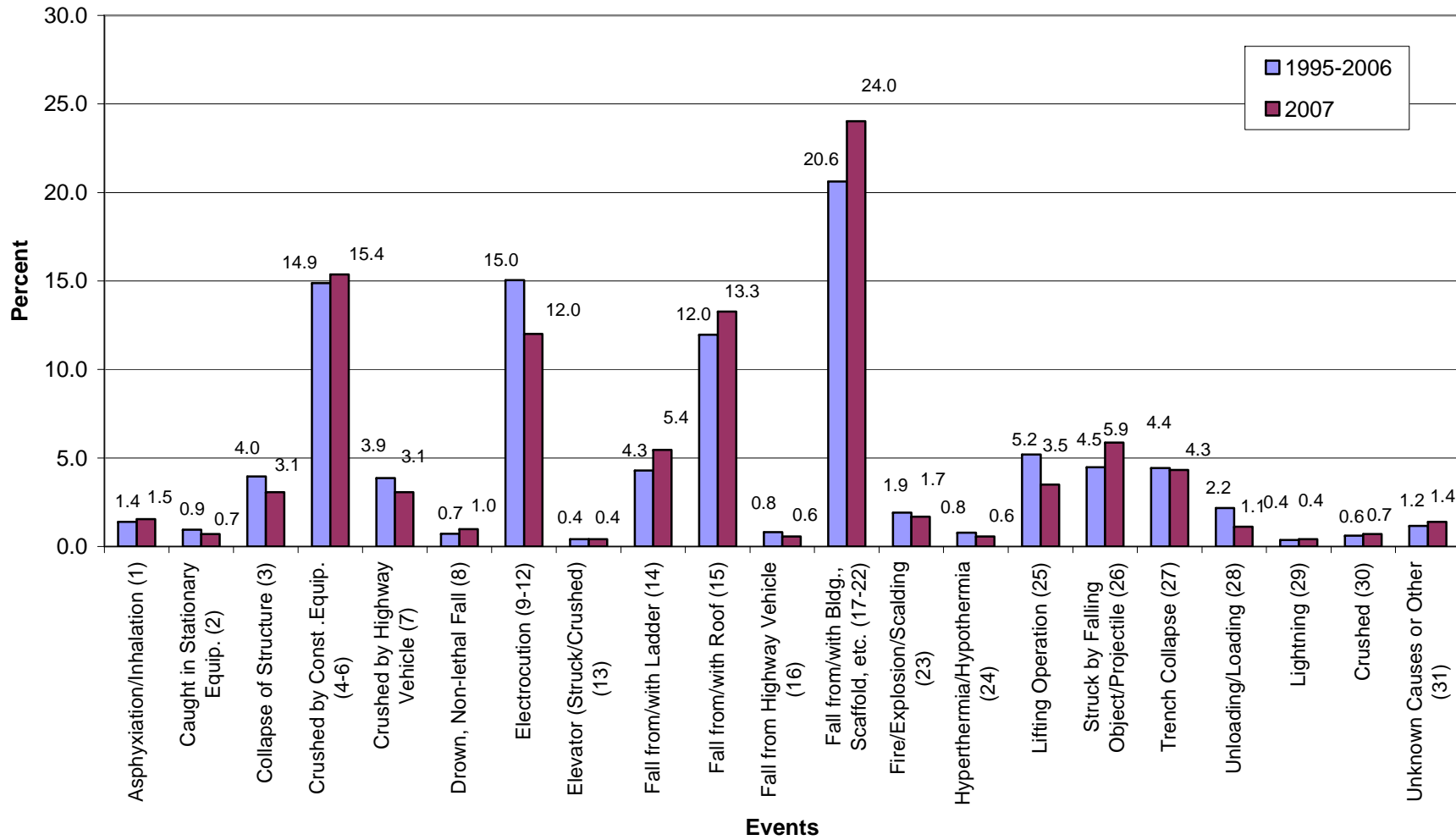


Figure B4. Comparison of Construction Fatal Events (1995-2006 and 2007)



APPENDIX C

Table C1. Construction Fatal Events by End-Use Type, 2007

End Use Type	Description	Number of Events	Percent
1	Bridge	20	2.8
2	Commercial Building	166	23.2
3	Contractor's Yard/Facility	4	0.6
4	Excavation, Landfill	8	1.1
5	Highway, Road, Street	70	9.8
6	Manufacturing Plant	33	4.6
7	Multi-Family Dwelling	73	10.2
8	Other Building	96	13.4
9	Other Heavy Construction	15	2.1
10	Pipeline	26	3.6
11	Power line, Transmission Line	15	2.1
12	Power plant	14	2.0
13	Refinery	6	0.8
14	Sewer/Water Treatment Plant	16	2.2
15	Shoreline Development, Dam, Reservoir	1	0.1
16	Single Family or Duplex Dwelling	138	19.3
17	Tower, Tank, Storage Elevator	13	1.8
18	Missing	<u>2</u>	<u>0.3</u>
		716	100.00

The coding for these data could not be verified.

Table C2. Construction Fatal Events by Type of Project, 2007

Project Type	Description	Number of Events	Percent
1	New, Addition and Alteration Construction	532	74.3
2	Maintenance, Repair and Demolition	138	19.3
3	Other	44	6.1
X	Missing	<u>2</u>	<u>0.3</u>
		716	100.0

The coding for these data could not be verified.

Table C3. Construction Fatal Events by Four-Digit SIC, 2007

Description	SIC	Number of Events	Percent
General Contractors - Single Family Houses	1521	31	4.3
General Contractors - Residential Buildings Other than Single Family	1522	15	2.1
Operative Builders	1531	4	0.6
General Contractors - Industrial Building and Warehouses	1541	16	2.2
General Contractors - Non-residential Buildings, other than Industrial and Warehouse	1542	39	5.4
Highway and Street Construction, Except Elevated Highways	1611	56	7.8
Bridge, Tunnel, and Elevated Highway Construction	1622	14	2.0
Water, Sewer, Pipeline, and Communications and Power Line Construction	1623	50	7.0
Heavy Construction, Not Elsewhere Classified	1629	27	3.8
Plumbing, Heating and Air-Conditioning	1711	32	4.5
Painting and Paper Hanging	1721	27	3.8
Electrical Work	1731	56	7.8
Masonry, Stone Setting, and Other Stone Work	1741	29	4.1
Plastering, Drywall, Acoustical, and Insulation Work	1742	12	1.7
Carpentry Work	1751	44	6.1
Floor Laying and Other Floor Work	1752	2	0.3
Roofing, Siding, and Sheet Metal Work	1761	70	9.8
Concrete Work	1771	26	3.6
Water Well Drilling	1781	3	0.4
Structural Steel Erection	1791	44	6.1
Glass and Glazing Work	1793	4	0.6
Excavation Work	1794	40	5.6
Wrecking and Demolition Work	1795	17	2.4
Installation or Erection of Building Equipment, Not Elsewhere Classified	1796	6	0.8
Special Trade Contractors, Not Elsewhere Classified	1799	<u>52</u>	<u>7.3</u>
		716	100.0

The coding for these data could not be verified.

Table C4. Construction Fatal Events by Project Value, 2007

Project Value Code	Description	Number of Events	Percent	Cumulative Percent
1	Under \$50,000	198	27.7	27.7
2	\$50,000-\$250,000	104	14.5	42.2
3	\$250,000-\$500,000	82	11.5	53.6
4	\$500,000-\$1,000,000	99	13.8	67.5
5	\$1,000,000-\$5,000,000	104	14.5	82.0
6	\$5,000,000-\$20,000,000	62	8.7	90.6
7	\$20,000,000 and over	65	9.1	99.7
8	Missing	<u>2</u>	<u>0.3</u>	100.0
		716	100.0	

The coding for these data could not be verified.

Table C5. Construction Fatalities by Construction Operation, 2007

Code	Description	Number of Fatalities	Percent of Fatalities
01	Backfilling and compacting	16	2.2
02	Bituminous concrete placement	3	0.4
03	Construction of playing fields, tennis courts	1	0.1
04	Cutting concrete pavement	4	0.6
05	Demolition	35	4.9
06	Dredging	4	0.6
07	Elevator, escalator installation	4	0.6
08	Emplacing reinforcing steel	7	1.0
09	Erecting structural steel	26	3.6
10	Erection of coffer dams, caissons	1	0.1
11	Excavation	28	3.9
12	Exterior masonry	24	3.4
13	Exterior cladding	3	0.4
14	Exterior carpentry	33	4.6
15	Exterior painting	20	2.8
16	Fencing, installing lights, signs, etc.	12	1.7
18	Forming	16	2.2
19	Forming for Piers or Pylons	6	0.8
20	Installing interior walls, ceilings, doors	20	2.8
21	Installing metal siding	1	0.1
22	Installing windows and doors, glazing	5	0.7
23	Installing culverts and incidental drainage	4	0.6
24	Installing equipment (HVAC and other)	31	4.3
25	Installing plumbing, lighting fixtures	20	2.8
26	Installing underground plumbing conduit	9	1.3
27	Interior Tile Work (ceramic, vinyl, acoustic)	1	0.1
28	Interior masonry	7	1.0
29	Interior plumbing, ducting, electrical work	16	2.2
30	Interior carpentry	18	2.5
31	Interior painting and decorating	12	1.7
32	Landscaping	4	0.6
34	Paving	23	3.2
35	Pile driving	2	0.3
36	Placing bridge deck	6	0.8
37	Placing bridge girders and beams	1	0.1
38	Plastering	2	0.3
39	Pouring or installing floor decks	4	0.6
40	Pouring concrete floor at grade	3	0.4
41	Pouring concrete for piers and pylons	1	0.1
42	Pouring concrete foundations and walls	4	0.6

Table C5. Construction Fatalities by Construction Operation, 2007 (continued)

43	Roofing	74	10.3
45	Site clearing and grubbing	11	1.5
46	Site grading and rock removal	10	1.4
47	Stripping and curing concrete	2	0.3
48	Surveying	2	0.3
50	Temporary work (buildings, facilities)	23	3.2
51	Traffic protection	12	1.7
52	Trenching, installing pipe	29	4.1
53	Waterproofing	7	1.0
55	Steel Erection, Solid Web-Bolting, Detail Work	2	0.3
56	Steel Erection Of Solid Web-Welding/Burning/Grinding	1	0.1
57	Steel Erection, Solid Web-Plumbing up	1	0.1
59	Steel Erection, Solid Web-Hoisting	2	0.3
60	Steel Erection of Open Web Steel Joists-Connecting	2	0.3
63	Steel Erection, Open Web Plumbing Up	1	0.1
66	Installation of Decking-Initial Laying Deck (Including Layout & Safety)	8	1.1
67	Installation of Decking-Final Attachment Deck (Welding/Shear Studs/Etc)	3	0.4
68	Installation of Decking-Flashing of Decking	3	0.4
70	Other Activities-Installing Ornamental and Architectural Steel	6	0.8
71	Other Activities-Post Decking Detail Work	12	1.7
00	Missing	<u>68</u>	<u>9.5</u>
		716	100.0

The coding for these data could not be verified.