



STATE OF NEW YORK DEPARTMENT OF HEALTH

FATALITY ASSESSMENT AND CONTROL EVALUATION

Day Laborer at Boat Dock Drowns After Falling Into River

Case Report: 08NY021

SUMMARY

In April 2008, a male day laborer at a boat dock on a river drowned after falling into the water. The victim was retained by the dockmaster to assist with transferring floating boat docks from a storage area into the river for the beginning of the boating season. At approximately 11:00 AM, the victim and his friend were standing in the parking lot near the seawall awaiting instructions from the dockmaster when the victim reportedly tripped or stumbled and then fell into the river through an opening in the seawall barrier. Once in the water, the victim remained visible to his co-workers for only a few seconds. The workers immediately called 911. One of the co-workers dove in to save the victim, but could not locate him. None of the workers were wearing personal flotation devices (PFDs) and there were no life-rings at the scene. The New York State Police (NYSP) scuba diving team, local and State police, paramedics, and fire department responded to the scene. The victim was recovered at 1:35 PM. He was transported to a local hospital where he was pronounced dead. The medical examiner's report indicated that the victim may have consumed alcohol and over-the-counter sedative medicine prior to the incident. The cause of death was determined to be asphyxia due to drowning.

New York State Fatality Assessment and Control Evaluation (NY FACE) investigators concluded that to help prevent similar incidents from occurring in the future, employers should:

- *provide PFDs and ensure that workers wear them when working on or near water;*
- *have life-rings readily available for workers who work on or near water;*
- *provide a standard height railing or other means of fall protection where fall hazards exist;*
- *develop, implement and enforce a comprehensive written safety program for all workers that includes training in hazard recognition and the avoidance of unsafe conditions when working on or near water; and*
- *address the issues related to drug and alcohol in the workplace through enforcing a clearly defined company policy.*

Additionally:

- *Employees should strictly follow the company's drug and alcohol policy.*
- *Governmental agencies should encourage and assist the development of day labor centers to provide safe employment services to both workers and employers.*

INTRODUCTION

In April 2008, a male day laborer at a boat dock on a river drowned after falling into the water. The New York State Fatality Assessment and Control Evaluation (NY FACE) staff learned of the incident from local news media and initiated an investigation. The NY FACE investigator traveled to the incident site to observe, measure and photograph the area. The Occupational Safety and Health Administration (OSHA) investigated the incident, but later withdrew all citations since it was unable to substantiate the employer-employee relationship. The NY FACE investigator developed this report based on the information collected during the site visit and through reviewing the OSHA investigation report, the Police report, the medical examiner's autopsy report and the death certificate.

INVESTIGATION

The boat dock where the incident occurred was leased from a local municipality by the dockmaster who oversaw the operation of the docks. At the beginning of the boating season, the dockmaster had to place floating docks in the river and remove them from the river and put them into storage at season's end. He was also responsible for repair and upkeep of the docks.

The incident occurred while the dockmaster was preparing for the beginning of the boating season. He had a day laborer help him get the floating docks ready to be placed in the river. On the day before the incident, the dockmaster told the day laborer that he needed extra help with transporting and placing the docks in the water. The day laborer told the dockmaster that he had a friend (the victim) who could help. The dockmaster agreed to meet the day laborer and his friend the next morning.

According to the day laborer, he and the victim went fishing around 6:00 AM on the day of the incident. At approximately 8:00 AM they met the dockmaster and were instructed to work at the dock storage area that was a few blocks from the river. According to the dockmaster, there was no discussion of the form or the amount of payment between him and the day laborer and the victim. The day laborer later stated that he assumed that he and his friend would get paid.

While the victim and his friend worked at the storage area, the dockmaster and another worker were at the dockmaster station by the river preparing to set up the floating docks. Around mid-morning, the day laborer and the victim received a phone call from the worker who asked them to come to the station to assist him and the dockmaster in placing the docks in the river. The seawall is a concrete vertical wall that extends approximately twelve feet above the mean water surface. On the land side of the seawall are parking lots used by boaters, employees and patrons of local businesses, and the general public. A three-foot high concrete barrier sits on top of the seawall at the surface of the parking lots. There are openings at 50 foot intervals along the barrier that provide access to steel mooring cleats. Each of these openings is about 5 feet wide.

After arriving at the docks, the victim and the day laborer were standing in the parking lot near the seawall awaiting instructions when the victim reportedly tripped or stumbled and then fell into the river through an opening in the barrier (Photo 1). Once in the water, the victim remained visible to his co-workers for only a few seconds. The workers immediately called 911. One of the workers dove in to save the victim, but could not locate him. None of the workers were wearing personal flotation devices (PFDs) and there were no life-rings at the scene. The State police, paramedics, fire department and the New York State Police (NYSP) scuba diving team responded to the scene. The victim was recovered at 1:35 PM. He was transported to a local hospital where he was pronounced dead.

At the time of the recovery, the diving team recorded that the water temperature was 46 degrees Fahrenheit, underwater visibility was 1 foot, and the current at the location of the drowning incident was approximately 4 knots (nautical miles per hour) that is equivalent to 4.6 miles per hour. Although the witnesses stated that the victim may have struck his head prior to entering the water, the medical examiner's report did not indicate that any traumatic injuries were sustained during the incident. The medical examiner's report indicated that the victim may have consumed alcohol and over-the-counter sedative medicine prior to the incident. The cause of death was determined to be asphyxia due to drowning.

RECOMMENDATIONS/DISCUSSION

Recommendation #1: *Employers should provide personal floatation devices (PFDs) and ensure that workers wear them when working on or near water.*

Discussion: A U.S. Coast Guard approved PFD should be worn whenever employees are working on or near water where the danger of drowning exists. In this incident, if the victim had been wearing an approved PFD, the drowning may have been prevented and he may have remained buoyant for rescue using the employer's boat or upon the arrival of emergency services.

Recommendation #2: *Employers should have life-rings readily available for workers who work on or near water.*

Discussion: The OSHA Maritime standard (29CFR1917) requires that a U.S. Coast Guard approved 30-inch (76.2 cm) life ring, with at least 90 feet (27.43m) of line attached, shall be available at readily accessible points at each waterside work area where the employees' work exposes them to the hazard of drowning. There is insufficient information available to determine whether or not a life ring would have changed the outcome of this incident. However, a life ring should be standard equipment for work activities in which a drowning hazard exists.

Recommendation #3: *Employers should provide a standard height railing or other means of fall protection where fall hazards exist.*

Discussion: The Occupational Safety and Health Administration's (OSHA) standard for Maritime Terminals (29CFR1917) stipulates that guardrails be provided at locations where employees are exposed to floor openings or waterside edges which present a fall hazard of more than four feet or into the water. The top surface of the guardrail is required to be 42 ± 2 inches high (36 inches high if installed prior to October 3, 1983). In this incident, having a guardrail or other means of fall protection in place at the opening in the barrier wall may have prevented the victim from falling into the water.

Recommendation #4: *Employers should develop, implement and enforce a comprehensive written safety program for all workers that includes training in hazard recognition and the avoidance of unsafe conditions when working on or near water.*

Discussion: Employers should evaluate all tasks performed by workers to identify potential hazards. A comprehensive written program that addresses all identified hazards should be developed, implemented and enforced. All workers, including day workers, should receive appropriate hazard awareness and prevention training prior to performing work. Employers should evaluate each worker's competency in the recognition of hazards and knowledge of safe work practices on an ongoing basis to monitor the effectiveness of the training program and employee compliance. While the day workers in

this incident were provided instructions on the tasks that needed to be performed, it is uncertain whether or not these instructions adequately addressed the hazards of working on and near water as well as the potential for falling through the openings in the seawall barrier.

Recommendation #5: *Employers should address the issues related to drug and alcohol in workplace through enforcing clearly defined company policy.*

Discussion: Alcohol misuse is associated with loss of productivity, increased tardiness and absenteeism, and increased severity and frequency of workplace injuries and accidents. Employers should develop a drug and alcohol policy to ensure a drug or alcohol free and safe work environment.

Recommendation #6: *Employees should strictly follow company drug and alcohol policy.*

Discussion: Alcohol and work don't mix. Every employee should strictly follow the company drug and alcohol policy. No worker should report to work under the influence of alcohol or drugs or consume alcohol or drugs at work.

Recommendation #7: *Governmental agencies should encourage and assist the development of day labor centers to provide safe employment services to both workers and employers.*

Discussion: Both workers and employers can benefit from these appropriately located day labor centers. These centers can provide safety and work skill training to the job seekers; they can help enforce the rights of the day labors and ensure fair hiring processes for temporary workers. Contractors, small businesses and individual homeowners can benefit from the employment services provided by these centers.



Photo 1. The area where the victim fell. The floating docks shown here were placed in the water after the incident.

The New York State Fatality Assessment and Control Evaluation (NY FACE) program is one of many workplace health and safety programs administered by the New York State Department of Health (NYS DOH). It is a research program designed to identify and study fatal occupational injuries. Under a cooperative agreement with the National Institute for Occupational Safety and Health (NIOSH), the NY FACE collects information on occupational fatalities in New York State (excluding New York City) and targets specific types of fatalities for evaluation. NY FACE investigators evaluate information from multiple sources. Findings are summarized in narrative reports that include recommendations for preventing similar events in the future. These recommendations are distributed to employers, workers, and other organizations interested in promoting workplace safety. The NY FACE does not determine fault or legal liability associated with a fatal incident. Specific identifiers, such as names of employers and witnesses, are not included in written investigative reports or other databases to protect the confidentiality of those who voluntarily participate in the program.

Additional information regarding the NY FACE program can be obtained from:

New York State Department of Health FACE Program

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www.nyhealth.gov/nysdoh/face/face.htm