The OSHA Files — Why Carla Valencia Died

The horrific nature of the accident that took Carla Valencia's life and the sheer disregard for worker safety involved is quite staggering. Tower owners, turfs and contractors should verify their subs' safety knowledge, and employees should stand up for their own safety.

By Dr. Bridgette Hester

If there is one question I am asked repeatedly, it is: "What really happened on that fatality? All we know is what the media said." The article series "The OSHA Files" responds to the question.

For research, I sent Freedom of Information Act requests to OSHA for every tower-related fatality from 1984 through 2013, a total of 315. I will send FOIA request for all of 2014's fatalities once the investigations have been completed. I expressly set out to obtain the files for various research purposes. It is imperative to dissect each file for as much information as possible and make the public aware for two main reasons.

First, you can't fix what's broken, if you in fact don't know what's broken. Correcting the safety problems in the wireless infrastructure industry requires a collective view of the true issues. One can speculate, read an OSHA summary or rely on the media reports, or one can order a copy of the investigation report and read it.

The second reason is to start a movement of grassroots change. If after the publication of one or more of these articles, a crew, company or foreman uses them and perhaps also orders the OSHA file to use as a learning tool, then I will have accomplished what I set out to do.

A small team of active and retired climbers and other health and safety experts familiar with (and in) the industry are combing the files with me to answer questions I have, provide insight and double-check my interpretation of information from the files (e.g., the language, acronyms, pictures and equipment). With their assistance, I intend to summarize each OSHA file.

This is not a "spank and shame the company" venture; thus, I am redacting some information in the file that was not already redacted when I received it, such as the names of the employer and tower owner. This is not an effort to protect employers or tower owners. I don't want the focus to shift from one of education to one of blame. It wouldn't be productive, and it would defeat what I want to accomplish. I will, however, provide my own commentary.

Other information (such as surviving family) was found during a persons search by the author. These are my words unless indicated by the citation "(OSHA, 2000)."

Summary of Events

On Oct. 29, 2000, the company was hired to assess and correct problems resulting from a tower having been struck by lightning several weeks before fatality incident. No written contract was made for the job, and the OSHA interview with the tower owner revealed that the tower owner worked with the company owner off and on for 25 years. He stated to the investigator that he and the company owner had discussed safety in the past, and he was "quite certain" (OSHA, 2000) that the company owner had known about safety rules.

The investigation report revealed that this was Carla Valencia's first tower-climbing job. She was reported to have been working for the company for about two weeks. She previously performed odd jobs around the house for the company owner. Valencia was not given any training. On the day of the accident, she free-climbed, and she was on the tower two or three times prior

The OSHA Files
Carla Valencia: 10/29/2000

Pertinent Information:

Inspection Number:	300581410
Date of Incident:	10/29/2000, 10:45 AM
Location:	Pecos, Texas
Gender:	Female
Age:	39
Family:	No children, and survived by both parents, three sisters, three brothers, eight nieces; 11 nephews, nine great-nieces, 10 great nephews, one great-great niece, one great-great nephew, several uncles, aunts cousins and very special friends.
Cause of Death:	"Blunt impact to torso, extremities, and head" (OSHA, 2000)
Toxicology:	Negative
Training:	NONE
Time on Job:	Approximately two weeks
Free Climbing Reported?	Yes
Company Years in Business:	25 years
Total Number Employees:	4 (including owner)
Reported to OSHA:	13:00 on 10/30/2000 (the next day).
Others Injured:	Yes, one other employee injured
Height of Tower:	500 feet
Height at Fall:	Approximately 270 feet
Tower:	Triangular, three sided (42' per side), guyed, not equipped with a climbing device
Tower Condition:	Good
Operation:	"Installing plumbing, lighting fixtures" (OSHA, 2000)

Citations:

CFR29 1910.268 (e) – Serious – "The employer did not ensure that personal protective devices, tools, and equipment were carefully inspected by a competent person before each day's use to ascertain that they were in good condition." (OSHA, 2000). Proposed penalty: $2,800.

CFR29 1910.268 (g)(1) – Serious – "Employer did not ensure all safety belts and straps were inspected by a competent person before each day's use to ascertain that they were in good condition." (OSHA, 2000)." Proposed penalty: $2,800.

Section 5(a)(1) of the Occupational Safety and Health Act of 1970 – Willful – "The employer did not furnish employment and a place of employment which were free from recognized hazards that were causing or likely to cause death or serious physical harm to employees in that employees were exposed to: Potential falls in excess of 400 feet." (OSHA, 2000). Proposed penalty: $14,000.

CFR29 1910.27 (d)(5) – Willful – "Cage protection or ladder safety devices in lieu of cage protection were not used on tower, water tank, or chimney ladders over 20 feet in unbroken length." (OSHA, 2000). Proposed penalty: $14,000.

CFR29 1910.268 (c) – Other – "The employer did not prepare a written certification record that showed each employee had received the training as required by paragraph (2) & (3) of this section." (OSHA, 2000). Proposed penalty: $400.

TOTAL FINES PROPOSED: $34,000

TOTAL FINES PAID: $34,000

to that day. A coworker on the tower with Valencia who was injured during the same incident was a 21-year veteran, by his own statements. In addition to Valencia and the injured coworker, the company owner and a third employee were present.

The Incident

Both Valencia and the injured coworker had been "hoisted up the tower on a ½-inch load line" (nylon). She was connected with pelican clip "which was hooked through a loop that had been tied in the end of the load line with a half-hitch knot. The pelican hook was attached to a D-ring on one of the seat straps to Ms. Valencia's safety belt by a small clevis." The injured employee's belt was a "tree saddle" and "was configured with a seat strap and he rode it as a boatswain's chair. Ms. Valencia was connected to the same loop in the load line by one of her safety lanyards, presumably by the 'Gorilla Hook' and she was slightly above him" (the injured coworker). "Antenna parts to be replaced were tied to the loop in the load line also. The load line was run through a 3-inch McKissick pulley that had been tied to the southeast face of the tower at about the 475-foot level by two pieces of ½-inch nylon rope. The free end of the rope had been run back down the tower through a small pulley which had been attached near the base of the tower. The rope had then been run approximately 100 feet south of the tower and then wrapped around a 'capstan head/cathead' which had been bolted to the left rear wheel of a Ford XLT Ranger pickup truck. The truck was sitting over a piece of plywood, and its left rear tire had been jacked off the ground. When witnesses arrived, the truck was sitting on a hydraulic jack. The owner was pulling on the free end of the rope to maintain the friction around the capstan head." (OSHA, 2000).

The owner and the third employee tried to control a tag line that was also looped into the load line. The pickup truck's engine stalled, and apparently when someone attempted to restart it, friction was lost and the employees fell. "It appears that the employees made contact with the guy wire connected to the tower's east leg at about the 210-foot level and rode it to the ground, coming to rest approximately 210 feet east of the base of the tower. It is not known how they rode the guy wire down; however, burn marks on Ms. Valencia's safety harness indicate she may have rode the guy wire down on her back." (OSHA, 2000).

Witnesses were working about a quarter of a mile away in a field. When they saw the accident happen, they came to the aid of the crew. When they arrived, the third employee was returning from the east anchor point to which he and the owner had walked. The witnesses asked him where the victims were. He pointed to the area and told the witnesses "he didn't think there was anything anyone could do for them." (OSHA, 2000).

The witnesses proceeded to try and render first aid and CPR to Valencia and the injured employee. In the process, Valencia's belt was cut. The witnesses asked if anyone had called 911 or if the owner or the other employee had first aid kits. They answered no, so witnesses went to the ranch house on the property where they were working when they saw the accident to get first aid supplies. The owner was observed making calls on his phone during this time, and also was observed going to the pickup truck and lowering it from the jack and removed the capstan. According to the report, neither the owner nor the other employee offered aid to the injured employee or Valencia. The report also revealed that one of the witnesses had to go to the road to flag the ambulance, and she had to tell the owner to take over CPR for Valencia. The owner was also noted to have rope burns on his hands.

The injured employee, when interviewed in the hospital, stated that he and Valencia were being raised up the tower "attached to a ½-inch nylon rope with a pelican hook clip through a half-hitch in the rope. The pelican clip was attached to his belt and she was attached to his belt." (It did not say how she was attached.) (OSHA, 2000).

He described the arrangement of the truck, cathead and rigging. He said he remembered trying to grab the tower during the fall. He stated Valencia was "too green to be up on that tower and she shouldn't have been there." (OSHA, 2000). He further stated that the owner had taught him "how to tie knots and do some rigging" and "the only training he got was what he got on his own." (OSHA, 2000). He is also reported as stating to the investigator, "You gotta stop [the owner], SOB is going to kill someone else. I told him." (OSHA, 2000).

The injured employee also admitted that both he and Valencia had free-climbed. He stated that he had been up the tower five or times that day and Valencia had only been up twice. When they fell, it was her

second time on the tower. He also stated he heard the other employee yell to the owner to restart the truck. He thought the owner forgot to press the brake before pressing the clutch, causing the rope to lose friction.

Information on the equipment revealed in the OSHA report that a tree saddle not rated for the type of work performed for this job was in use. "A 'non-locking' pelican hook was attached to the belt die seat 'D' ring by a small, screw-type clevis." (OSHA, 2000). A shock-absorbing lanyard was "attached to the same D Ring. A rope lanyard equipped with double action clips was attached to buckle side seat 'D' ring, and a knot had been tied in the rope apparently to make it shorter." OSHA, 2000). "A new safety rope equipped with double action clips and a large, double-action clip 'Gorilla Hook' was present but not attached to either belt." (OSHA, 2000).

Other notations in the file regarding equipment included descriptions such as, "the gate on the large pelican hook, which was in use, was defective. It did not always return to its fully closed position. This appears to be the result of wear, damage, and overuse." (OSHA, 2000). Another notation stated, "The clevis was worn and did not have a safety keeper to prevent its bolt from backing out while in use." (OSHA, 2000).

Before an OSHA representative arrived on the site, the owner departed and took the pickup truck with him. Two subsequent appointments were made on Nov. 1 and Nov. 3, 2000, to meet with the company owner, but the meetings never materialized. The owner's legal counsel contacted the investigator and stated that he had been retained and that his client would not be coming for meetings. Under the citation documentation and the opening conference notes, the OSHA report states that the company owner "plead the fifth to all requests for data and for all questions asked." (OSHA, 2000).

Investigator Comments

According to the investigator's conclusions, improper fall protection was used, employees were not properly trained, and no emergency action plan was in effect. Later interviews revealed that some first aid equipment was in the shelter, but none of the employees knew how to use it. "The employer failed to call 911 even though he had a cell phone on site, but instead called his wife. This delay might have contributed to the death of his employee. It appears the employer was trying to cover up the fact that the pick-up and capstan were being used in the manner that they were being used." The investigator also stated that "had it not been for the witnesses seeing the truck up on the jack and the 'capstan' installed, we may not have been able to piece the mishap together." (OSHA, 2000).

Author's Commentary

Upon reading this file for the first time, I found the horrific nature of the accident and the sheer disregard for worker safety quite staggering. In regard to this file, I would like to make a few points.

Some people people will read this and say, "That's an isolated incident," or "That doesn't happen as often as one might think." To that I say you are deluding yourself. Do I think many employers behave in this manner? No, but the ones that do are out there. This owner had operated for 25 years before a fatality befell the company and his workers. How many other companies fit this same profile? How many have been in business for more than 20 years, using similar techniques, and by the grace of God they haven't had such an incident? How many others are cutting corners to get it done when they lack the human and or material capital to do the job safely? When you look at the fact that this was 15 years ago and that there is exponentially more work now than in 2000, I believe it is still clearly a cause for concern. It is something that needs to be addressed.

The tower owner in this case, as reported by the investigative narrative, told the investigator that he had discussed safety with the company owner in the past and he was "quite certain" (OSHA, 2000) that the company owner had known about safety rules. Although they may have spoken about it, I wonder to what degree contractors really verify the knowledge of the subs they hire. For that matter, how well do turfs verify safety knowledge? Other than checking safety plans for companies and verbal verification, what stopgaps are in place to make sure that the information that is being given is accurate?

As always, instances such as this one worry me because the other employee who was injured knew unsafe work practices were happening but did nothing to report his employer. I understand that the fear of being fired is a real fear among employees, but why risk it? What can we do to protect employees more than we already do? The OSHA whistleblower program is in place, and it

is an invaluable tool for workers to utilize. However, most employees believe that the employer can generally narrow down who the reporter is (if only by assumption), and that makes the whistleblower program unappealing to the worker because he or she really doesn't feel protected.

I said at the outset that I didn't want this to be a spank-and-shame session against the employer; nevertheless, I want to give my opinion. The disregard for human life and worker safety in this case is repugnant. Not all employers behave in this manner, and I fully acknowledge that, but in this particular case, I am still spitting nails. I am fuming not only because of the disregard, but because the employees did not stand up for their own safety. Let me be clear. I do not blame the deceased or the other employees in any way, I blame the culture of the industry and find it unacceptable that employees, because of fear of retribution or loss of their livelihood, feel compelled to just "take it," and that they do not feel empowered over their workplace safety or the protection of their lives. That is unacceptable.

As a final note, I would like to give kudos to the investigator in this case. The file was detailed and complete, and the OSHA summary found online was rather extensive in this case, compared with many others that I have read.

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