



The National Institute for Occupational Safety and Health (NIOSH)

Promoting productive workplaces
through safety and health research



Company President Falls to His Death from Roof

FACE 8812

INTRODUCTION

The National Institute for Occupational Safety and Health (NIOSH), Division of Safety Research (DSR), performs Fatal Accident Circumstances and Epidemiology (FACE) investigations when a participating state reports an occupational fatality and requests technical assistance. The goal of these evaluations is to prevent fatal work injuries in the future by studying: the working environment, the worker, the task the worker was performing, the tools the worker was using, the energy exchange resulting in fatal injury, and the role of management in controlling how these factors interact.

On February 23, 1988, the 29-year-old male president of a roofing company exited a manlift, and fell approximately 52 feet from the edge of a roof to a concrete entryway at ground level.

CONTACTS/ACTIVITIES

State Occupational Safety and Health Administration (OSHA) officials notified DSR concerning this fatality and requested technical assistance. On March 29, 1988, a DSR research team conducted a site visit, met with an employer representative, discussed the incident with the OSHA Compliance Officer, and photographed the incident site.

OVERVIEW OF EMPLOYER'S SAFETY PROGRAM

The victim was the president of a roofing company that employed four workers. The company, which had been in existence since August 1987, had no written safety policy or program.

SYNOPSIS OF EVENTS

A renovation project was underway at a local high school when the sub-contractor responsible for the roofing operations went out of business. The general contractor then arranged for a new sub-contractor, the victim's company, to complete the remaining roofing operations.

To provide access to the roof (which was 51 feet, 10 inches above ground level), the general contractor mounted a platform on a 60-foot, articulating hydraulic lift. Guardrails around the perimeter of the platform provided fall protection while workers were being lifted and lowered. When the platform was raised in place, access to the roof was provided by a gate on the side of the platform. Hydraulic lift controls were on the platform side opposite the gate. The lift boom was

sufficiently long to extend the platform over the edge of the roof, so that workers could easily step down onto the roof (or up onto the platform from the roof). Workers for both sub-contractors complained to the general contractor about the jerking motion of the lift.

At the the time of the incident, the new sub-contractor had finished installing the roofing materials and was ready to install the ridge cap at the top of the roof. The victim and two co-workers rode the lift to the edge of the roof. One co-worker opened the gate and stepped onto the roof. As he began to follow, the victim instructed the remaining co-worker, who was operating the lift, to lower the platform. As the co-worker activated the lift controls, the platform jerked and the victim fell from the roof. It is not known whether the platform struck the victim or if the victim was still grasping the gate when the platform jerked. Emergency medical service (EMS) personnel were summoned by school officials. The victim was transported to a nearby hospital where he was pronounced dead.

CAUSE OF DEATH

The Medical Examiner listed multiple traumatic injuries as the cause of death.

RECOMMENDATIONS/DISCUSSION

Recommendation #1: The employer should not use equipment if mechanical problems are reported. The equipment should be removed from service, thoroughly inspected, and repaired if necessary.

Discussion: The victim’s employees as well as the employees of other sub-contractors had complained to the general contractor about the jerking motion of the lift. Although the equipment had not been repaired, the victim chose to use it in order to complete the job. If the equipment had been repaired, this incident may not have occurred.

Recommendation #2: The employer should prepare a hazard analysis of each activity making up a roofing job.

Discussion: A proper hazard analysis involves three distinct steps: (1) outlining each step of a task or activity, (2) identifying all potential hazards associated with each step, and (3) developing measures for controlling each hazard. If a hazard analysis had been performed, the employer may have identified the dangers associated with personnel not being clear of moving machinery and subsequently taken measures to prevent this incident. In this case, however, the victim reportedly had a habit of pushing the platform from the roof as it began moving away. He may have been doing this when the platform suddenly jerked, causing him to lose his balance and fall. Individual behaviors are often difficult to anticipate and, therefore, difficult to control.

Recommendation #3: The general contractor should designate only qualified personnel to operate mechanical materials handling equipment.

Discussion: The general contractor allowed several sub-contractor employees to operate the equipment as needed. It is not clear if the general contractor assessed the qualifications of these individuals as operators. However, the general contractor may have been more responsive about repairing the equipment had a qualified operator complained of the problems.

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