9/2/05

Self-Employed Painter in Massachusetts Dies In Fall Of Twelve Feet From "Widow's Walk" At A Single-family Home

Investigation: #96-MA-023-01
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SUMMARY

On May 22, 1996, a 68 year old self-employed male painter died of injuries sustained in a fall of approximately twelve feet at a Massachusetts residential renovation site. The victim was working on a small porch above the front doorway, known as a "widow's walk", when the incident occurred. Apparently, the victim stepped off of a ladder on the landing and fell through the front rail which was rotten. A co-worker discovered the victim on the walkway and notified the homeowner to call an ambulance. Police and emergency medical services arrived shortly. The victim was secured and transported to a nearby baseball field where he was transported by helicopter to a regional university medical center. He was officially pronounced dead more than six hours following the incident. The MA FACE Program concluded that to prevent similar future occurrences, employers, and self-employed contractors, should:

- **perform a site survey for structurally unsound building elements and repair, remove or sufficiently mark them.**

INTRODUCTION

On May 23, 1996, the MA FACE Program was notified by local police through the occupational fatality hotline, that a 68 year old painter had died of injuries received in a fall on the previous day. An investigation was immediately initiated. Co-workers at the site that day were not reachable by telephone. Therefore, the investigation consisted of interviews with the homeowner and use of the police report.

On July 16, 1995, the MA FACE Program Director traveled to the incident site where a review of the scene took place and pictures were taken. The police report, death certificate and multiple photographs were obtained during the course of the investigation.

The victim was self-employed with no regular employees. There is no record of how long he had been working as a painter. The homeowners stated that they and others in the neighborhood had employed him many times over the years. He would solicit their business by traveling through the housing development.

INVESTIGATION

On the day of the incident, the victim and two co-workers were on the jobsite. Their task was to paint the two-story single family dwelling. The house was part of a subdivision, where many of the homes were very similar. Many of them had decorative porches over the front doors. These small porches were known as “widow’s walks”. There was no access to the porch from the inside of the house.

The victim was using a six foot step ladder on the porch. The floor surface was roofing material and there was no ceiling to the porch. The railing was the standard 32 inches high. The surface area of the landing was approximately 40 square feet, being 8 feet wide by 5 feet deep. The landing was at a height of 12 feet from the concrete pavement to which the victim fell. Though nobody witnessed the victim’s fall, he had apparently leaned on the railing when he descended the ladder.

A co-worker found the victim lying on the ground and notified the homeowner who immediately called 911 for an ambulance. The police arrived within minutes, followed immediately by an ambulance. The victim was semi-conscious and combative. He was secured by the emergency medical technicians and driven to a nearby ballfield where he was airlifted to a regional trauma center. He died later that day as a result of his injuries.

According to the police report, the railing found on the ground near the victim was severely rotted. The report also indicated that the homeowner had warned the victim about the condition of the railings and that the victim in turn had emphasized the situation with his employees. A ladder was probably used to accessed the landing, and climbing over the railing could have also increased he strain on the already weak railing structure. A survey of the area showed that many of the railings on these porches were in disrepair, probably due to their non-use.

CAUSE OF DEATH

The medical examiner listed the cause of death as multiple traumatic injuries.

RECOMMENDATIONS/DISCUSSION

Recommendation #1: Employers, and self-employed contractors, should perform a site survey for structurally unsound building elements and repair, remove or sufficiently mark them.

Discussion: In this case, the “window’s walk” was being used like a deck or porch by the painters. Yet, this element was only decorative and may not have been built strong enough to hold the weight of the crew and materials. Some houses may have these decorative elements that are not built in accordance with the local building codes because they are not intended to ever bear any loads. In this case, the railings were not maintained as well as they might have been since the deck was not designed to be used by the homeowners.

The repair and renovation of houses involves using many elements of the structure for supporting workers, ladders and/or scaffolds. Contractors should examine the structure for weak points or rotted wood in structural or protective elements such as railings, decks, floors or columns. Some building elements may appear to be structural but are in fact merely decorative. A site survey should be done prior to starting work. From this survey, a plan should be made for how the parts of the building will be accessed safely. The plan should include how the unsafe elements will be dealt with. If the homeowner is not willing, or the contractor is not able, to repair or remove these elements, then they should be clearly marked with yellow tape, or other appropriate warning device, that is a clear reminder of the danger present.

In this case, the victim may not have leaned on the rail on purpose, but could have been working so close to it that when he descended the ladder his momentum forced him into the railing. It is not sufficient protection to rely on remembering every hazardous area on the site. Avoiding the rotten rail in this instance would have required placing the ladder far enough away from the rail so that there was a “safety zone” in which to move around the landing. Placing yellow caution tape even a foot inside the rail may have been enough to create such a zone.

REFERENCES

Code of Federal Regulations, Labor 29 Parts 1926.20; 1926.500 - 503, Appendix C.