

**TO:Director, Occupational Health Surveillance Program,  
Massachusetts Department of Public Health**

**FROM:Massachusetts Fatality Assessment and Control  
Evaluation (MA FACE) Program Field Investigator**

**SUBJECT:Rhode Island Window Washer Dies in Seven Story  
Fall From Massachusetts Rooftop MA-93-06**

**DATE:March 4, 1994**

---

### **SUMMARY**

On May 16, 1993, a 22 year old male Rhode Island window washer fell approximately 70 feet to his death from a Massachusetts rooftop. Cleaning glass sunroom ceiling panels from the flat rooftop of a seven story building, the victim apparently became unaware of his proximity to the building's edge when he backed off the edge and plummeted seven stories to the asphalt covered ground below. The window washer was working as part of a crew, although he was not in sight of his co-workers at the time of the incident. It was not until a passerby discovered the victim on the ground that emergency medical services were summoned. The victim was transported to the regional hospital where he was pronounced dead on arrival. The Massachusetts FACE Program concluded that in order to prevent similar future occurrences, employers should:

- develop, implement and enforce a comprehensive safety program which includes fall hazard recognition training and the use of fall protection equipment;
- ensure that appropriate fall protection equipment is provided and used when employees are subjected to fall hazards.

### **INTRODUCTION**

On May 17, 1993, the state medical examiner's office telephoned the Massachusetts FACE Program through its 24 hour fatality hotline to report the death of a 22 year old window washer the previous day. On May 20, 1993, the MA FACE Field Investigator travelled to the incident site and interviewed the employer and the employees who were on-site at the time of the incident.

The police report, death certificate, assorted newspaper articles and multiple photographs were obtained during the course of the investigation.

The employer was a family owned window cleaning company which had been established in 1930.

It was taken over by the founder's grandson (current owner) in 1980. It employed a total of seven persons, three of whom shared the same occupation as the victim. The company did not employ a designated safety person or have written comprehensive safety policies and/or procedures in place at the time of the incident.

The victim, employed for only five weeks, was unemployed the two years prior. However, he had been employed in his father's window cleaning business for approximately eight years prior to his unemployment.

## **INVESTIGATION**

On May 16, 1993, a 22 year old window washer fell seventy feet to his death from a condominium complex rooftop. The victim was part of a four man crew and in his first day on the jobsite. On the day of the incident, the victim was charged with cleaning glass sunroom ceiling panels from the building's main flat roof.

The condominium complex was a square configured building consisting of a basement level and six finished living levels. Constructed to the rear side of the complex were four vertical columns of sunrooms whose three sides and seventh story roof were made primarily of thermal glass.

According to the employer and co-workers, the victim was specifically instructed where to stand on the building's main flat roof to clean the glass sunroom ceiling panels with a telescopic window cleaning pole. The discussion reportedly included orders to utilize the telescopic pole in a manner that would negate any need to be in close proximity to the edge of the main roof.

Left alone on top of the building roof to do his work, it is speculated that the victim, working in a northerly direction, was in the process of cleaning the last of four sunroom rooftops when the incident occurred. The telescopic pole, found extended over the roof's edge after the incident, suggested that the victim may have been cleaning the glass panels while moving in a backwards direction rather than from a forward moving or stationary position. In so doing, he apparently was unaware that behind him there was an approximate 8 by 12 foot square indentation in the building's configuration. It appears that as the victim maneuvered himself into position, he backed off the edge and fell seven stories to the asphalt covered ground below.

The victim was soon discovered on the ground by a passerby. Emergency medical services were summoned and the victim was transported to the regional hospital where he was pronounced dead on arrival from his injuries.

## **CAUSE OF DEATH**

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

## **RECOMMENDATIONS/DISCUSSION**

Recommendation #1:Employers should develop, implement and enforce a comprehensive safety program which includes fall hazard recognition, training and the use of fall protection equipment.

Discussion: The company did not have any written safety program, training program or designated safety officer. Comprehensive safety programs should include, but not be limited to, training workers in the recognition and avoidance of fall hazards and proper training in the selection of personal protective equipment. Daily, weekly, and/or monthly jobsite safety meetings which are conducted by a designated safety person and cover such vital areas as fall hazard recognition and the use of personal protective equipment are essential. Such meetings remind employees of the dangers associated with their occupation(s) and how best to deal with them.

Recommendation #2:Employers should ensure that appropriate fall protection equipment is provided and used when employees are subjected to fall hazards.

Discussion: In the OSHA general construction standard, fall protection is required for employees working at heights of 16 feet or greater (29 CFR 1926.500(g)). Although window washers are not specifically covered by this standard, employers should generally provide fall protection to employees who are exposed to fall hazards. Employees subjected to fall hazards should be provided with, and required to wear, safety belts/harnesses and lanyards tied off to a structural member capable of supporting a minimum dead weight of 5,400 pounds. Had the window washer in this case been using fall protection equipment, his death may have been prevented. The American Society of Mechanical Engineers (ASME) provides further detailed specifications for the proper selection and use of fall protection equipment in window washing operations.

## **REFERENCES**

1. Office of the Federal Register: Code of Federal Regulations, Labor 29 Part 1926.500 (g).
2. The American Society of Mechanical Engineers, "Safety Requirements for Window Cleaning," ANSI/ASME A39.1-1987, New York, NY.