Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

The National Institute for Occupational Safety and Health (NIOSH)

Promoting productive workplaces through safety and health research NIOSH

Photographer Falls 30 Feet to His Death Through a Skylight Floor Opening

New Jersey Case Report: 90NJ008 (formerly NJ9006)

SUMMARY

On June 1, 1990, a 40-year-old free lance photographer died as a result of a 30 foot fall through a skylight floor opening in the ceiling of a third floor school auditorium. The skylight was originally transparent to light received through two skylights in the roof of the school, which was built over 100 years ago. The skylight floor opening is in the attic between the ceiling of the auditorium and the roof of the school building. This space is approximately five feet in height. The skylight floor opening is no longer transparent since the glass was painted white. The victim and his assistant were present to take pictures of a simulated pigeon removal process for a nationally known magazine and he apparently misstepped onto the fragile skylight. FACE investigators concluded that, to prevent similar occurrences in the future, the following safety guidelines should be followed:

- Owners of buildings must ensure that their facilities are safe. All skylight floor openings must be protected by guard rails. Working areas must be adequately lighted and guarded.
- All workers must exercise up most caution when entering or working in a new environment. Workers may refuse to work in a hazardous area.

INTRODUCTION

FACE personnel learned about this fatal work-related fall from the victim's newspaper obituary (dated June 4, 1990) and informed OSHA. A joint investigation was conducted with an OSHA safety compliance officer on June 6, 1990. Photographs of the site were taken. Information about the witness' statements was derived from the OSHA file.

The victim was an internationally known photographer who owned his own company and worked on contract for several publishing businesses. He had been self employed for several years.

INVESTIGATION

The attic of the school is at the fourth floor level, accessible, through locked doors, by a steep stairway with no hand rail. The attic in which the skylight was built into the floor is reached only by a ladder. The skylight floor opening is accessible only by an unguarded 24 inch catwalk about 17 feet long which allows one to walk to and around the floor opening. The skylight is constructed of 16 glass panels, each of which measures 20 inches by 20 inches. The panels are separated by wooden moldings. Moldings measuring approximately 6 inches in width the structure into four equal parts. (See diagrams). The glass panels of the skylight were painted white and are no longer transparent.

On May, 26, 1990, a crew of workers from an environmental service company was in the school attic simulating the removal of pigeons droppings and pigeons that had roosted and died there. Although the company was not currently under contract, they previously did that type of work at the school. The victim and his assistant were present to photograph the process for p prominent magazine.

While his assistant and a company official waited on the catwalk, at the access ladder, the victim and two environmental service workers walked to, and around, the skylight floor opening. It is unclear how well lit the area was. Normally quite dark, the workers said they had supplemental lighting with them. As the photographer returned, probably bent over as he walked, instead of retracing his steps he steeped on the skylight as he walked forward and fell 30 feet to the tiled floor of the third floor auditorium. He fell through one glass panel, which measures 20 inched by 20 inches, without damaging the molding. The diagonal of the square panel measures 28.3 inches. The assumption is that he did not realize the hazard of stepping on to the skylight. A company representative stated that he verbally warned the victim and his assistant of the hazards in the area, but the victim's assistant does not remember being warned. She saw the top half of his body falling through the opening, still clutching his camera, and immediately left the attic to lend aid to the victim.

Emergency services were summoned by the victim's assistant. The rescue squad, Mobil intensive care unit, and police responded to the scene. The victim was stabilized and admitted to the local trauma center hospital where he remained comatose and died in the hospital on June 1, 1990.

CAUSE OF DEATH

The cause of death was listed as head trauma and fracture of the thoracic spine. No autopsy was performed for religious reasons.

RECOMMENDATION/DISCUSSION

Recommendation #1: All floor openings must be protected by guard rails.

Discussion: Because the attic may not have been well lit and the glass panels of the skylight were painted white, the victim may not have known he was stepping on such a fragile structure. Guardrails built around the opening would have prevented anyone from stepping on the skylight and falling through it. 29 CFR 1910.23 (a)(4) requires guard railings around a skylight floor opening. OSHA has issued citations against the owner of the environmental service company because the company allowed its employees to be exposed to the same workplace dangers, no citations could be issued by OSHA; the photographer was self-employed. The possibility of a school employee being in the attic is remote but possible and therefore he or she would be exposed to the same hazards. Owners of the buildings must assume responsibility to ensure their facilities are safe.

Recommendation #2: The attic catwalk should be protected by a guard rail.

Discussion: The catwalk is 24 inches wide, built of 8 inch planks, three abreast. If anyone steps off the catwalk he or she could fall between the floor joists and through the auditorium ceiling. A guardrail on each side would prevent this potentially dangerous occurrence.

Recommendation #3: Work and walk areas must be adequately lighted.

Discussion: The school attic is normally illuminated by one light bulb, producing very dim light. Poor lighting compounds the hazards in the area.

Recommendation #4: All workers must be aware of hazards existing in any new work situation. They should not hesitate to refuse to work in an area they perceive as dangerous.

Discussion: Whether employed by another or self-employed, workers may face hazardous situations. Those who frequently change their working environments must be especially cognizant of potential compromises of their safety.

REFERENCES

1. 29 CFR 1910.23(a)(4). Code of Federal Regulations. Washington, D.C.: U.S. Government Printing Office, Office of the Federal Register.

FATAL ACCIDENT CIRCUMSTANCES AND EPIDEMIOLOGY (FACE) PROJECT

Staff members of the FACE project of the New Jersey Department of Health, Occupational Health Service, perform FACE investigations when there is a work-related fatal fall or electrocution reported. The goal of these investigations 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.

To contact New Jersey State FACE program personnel regarding State-based FACE reports, please use information listed on the Contact Sheet on the NIOSH FACE web site. Please contact In-house FACE program personnel regarding In-house FACE reports and to gain assistance when State-FACE program personnel cannot be reached.

Back to New Jersey FACE reports

Back to NIOSH FACE Web

Page last reviewed: November 18, 2015
Content source: National Institute for Occupational Safety and Health