

United States of America  
**OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION**  
1924 Building – Room 2R90, 100 Alabama Street, SW  
Atlanta, Georgia 30303-3104

SECRETARY OF LABOR,

Complainant,

v.

Otis Elevator Company

Respondent.

OSHRC Docket No. 12-0817

**APPEARANCES:**

Willow E. Fort, U.S. Department of Labor  
Nashville, Tennessee 37219  
For the Complainant.

Paul J. Waters, Esquire, Waters Law Group, LLC  
1465 S. Ft. Harrison Ave.  
Clearwater, Florida 33756  
For the Respondent, *pro se*.

Before: Administrative Law Judge Stephen J. Simko, Jr.

**DECISION AND ORDER**

On September 21, 2011, an employee of Otis Elevator Company (Otis) was waiting for a co-worker atop an elevator at a construction site in Brookwood, Alabama. While waiting, the employee looked over a guardrail into the elevator shaft. The elevator car in the adjacent shaft descended, striking the employee on the back of the head and killing him.

Occupational Safety and Health Administration (OSHA) compliance safety and health officer (CSHO) Phyllis Battle arrived later that day and conducted an inspection of the worksite. As a result of her inspection, the Secretary issued a one-item citation to Otis on March 14, 2012, alleging a serious violation of the Occupational Safety and Health Act of 1970 (Act), under 29 U.S. C. § 654(a)(1), the general duty clause (§ 5(a)(1)). The Secretary proposed a penalty of \$7,000.00.

Otis timely contested the citation. The court held a hearing in this matter on July 18 and 19, 2012, in Birmingham, Alabama. Otis stipulates the Commission has jurisdiction over this proceeding under § 10(c) of the Act, and that it is a covered business under § 3(5) of the Act.

Otis contends the Secretary failed to prove the company violated § 5(a)(1). It asserts the affirmative defense of unpreventable employee misconduct on the part of the decedent. The parties have filed post-hearing briefs.

For the reasons discussed below, the court vacates the citation.

### **Background**

The Brookwood Women's Medical Center in Brookwood, Alabama, contracted with general contractor Robbins & Morton to construct a six-story addition to its facility. Robbins & Morton hired subcontractor Otis to install six elevators at the site. By September of 2011, Otis had been on the site for four or five months. An Otis crew consisting of a mechanic and an apprentice had been on the site for approximately two months, adjusting the elevators that had been installed. The final adjustment process occurs after the installation of all the units is complete. Otis fine-tunes the units before the local authority conducts its final inspection, so that the elevators may be used by the public.

Elevator #5 had been inspected by the local authority and approved for use by the general contractor as a construction (or service) car, which the general contractor and its subcontractors used to move personnel and materials to and from the floors in the new addition. Elevator #5 shared a hoistway with elevator #4. The hoistway was divided by spreader beams. At the time of the accident, elevator #5 had been used for several months as the construction car.

Otis's mechanic and apprentice had themselves used the construction car on a daily basis while working at the construction site.

On September 20, 2011, Otis's crew was unable to activate the governor for elevator #4 at the required speed, or to calibrate it. The governor acts as a safety device which causes the elevator to brake once it reaches a pre-set speed. The mechanic informed the Otis supervisor that the governor was malfunctioning. The supervisor told the mechanic and the apprentice that he would bring in a replacement governor the next day.

On September 21, 2011, the mechanic and apprentice arrived at the worksite at approximately 7:00 a.m. They sat in a truck and discussed the work assigned for them that day, which consisted of a single task—replacing the governor. They completed a written job hazard analysis. Their next step was to retrieve their tools from the cab of elevator #4, where they stored them overnight for safekeeping.

The top of the elevator unit is approximately 10 feet by 10 feet, and is surrounded on three sides by standard 42-inch guardrails, with 22-inch midrails. The side of the car top adjacent to the elevator doors was not equipped with a guardrail. The top of the unit was bisected by a crosshead, which is a set of 2-foot high beams. Otis employees operated the elevator using a yellow control box, referred to as a car top inspection station. The control station used constant-pressure, or "dead man," switches which required constant pressure to move the cars. In order to open the cab of elevator #4, the apprentice went up to either the third or fourth floor (there was no elevator access from the second floor), and moved the car down the hoistway to the bottom floor. He stood on the top of the elevator unit and used the inspection station controls to lower the elevator.

When elevator cars #5 and #4 were adjacent to each other, there was a space of 22 inches between their respective guardrails. At regular intervals, divider beams ran from the back wall to the front wall of the hoistway. The space in the hoistway between the elevator cars contained other materials, such as cables and ductwork.

After accessing the top of elevator #4, the apprentice moved the unit to the lowest level. The mechanic removed the tools from the elevator cab.

The mechanic had spoken by phone with the Otis supervisor, who told the mechanic he was running a little late but would be on site with the replacement governor soon. The mechanic told the apprentice to wait on top of elevator #4 until the supervisor arrived with the governor.

Shortly before 8:00 a.m., an employee for the general contractor who was operating elevator #5, the construction car adjacent to elevator # 4 (on top of which the apprentice waited), reported he had heard a strange noise as the construction car descended. The mechanic went to the first floor elevator doors of elevator #4 and called up to the apprentice. Receiving no answer, the mechanic ran up to the third floor and looked down the hoistway of elevator #4. He observed the apprentice lying in a fetal position atop the unit, with a serious head wound. Alerted by the mechanic, workers at the site called 911. Emergency medical personnel arrived quickly, but the apprentice's head injury was fatal.

CSHO Battle arrived at the site at approximately 10:40 a.m. By that time, medical personnel had removed the body of the apprentice. Battle conducted an inspection of the site, including interviewing employees and taking photographs of elevator #4 and its surroundings.

Based upon Battle's inspection, as well as the investigation of the Homewood Police Department and the coroner's report, the Secretary and Otis agree that the apprentice was killed as he looked over the guardrail on the side of the hoistway shared by elevator #5. His head was extended beyond the 22-inch gap between the cars. As the apprentice looked down into the hoistway, elevator #5 descended, striking the apprentice on the back of the head. The apprentice fell backward onto the top of elevator #4. Investigators observed blood and tissue on the bottom of elevator #5 near the back corner. This corroborates the investigators' conclusion that the apprentice was located in the right back corner of the top of elevator #4 when he was struck by elevator 35. The coroner's report states:

It appears while the decedent was at the back right corner of the elevator car he (decedent) appeared to be looking in the adjacent elevator shaft and was struck in the head as the elevator in the adjacent shaft descended to the bottom floor. . . The decedent was seen lying on top of the elevator car on his right side. The decedent was lying on top of the elevator car on the right back corner of the elevator car. The decedent was observed to have [an] injury to his head. I observed what appeared to be blood on the elevator car in the adjacent shaft, some of this blood appeared to be smeared down the side of this elevator car. The decedent's hard hat and light were found in the location of the adjacent elevator

shaft. I observed a small amount of blood and tissue on the bottom of the elevator car that runs adjacent to the elevator shaft.

(Exh. R-3, p. 12-2). The coroner concluded the apprentice died of a blunt force injury to the head, stating, “Death would follow such an injury immediately” (Exh. R-3, p. 12-9).

Battle held a closing conference with Otis. Initially she did not recommend the Secretary issue a citation to Otis based on her inspection. The Secretary declined to follow Battle’s recommendation and instead, on March 14, 2012, issued the instant citation.

### **The Citation**

#### **Item 1: Alleged Serious Violation of § 5(a)(1)**

The citation alleges:

Section 5(a)(1) of the Occupational Safety and Health Act of 1970: 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 struck-by hazards:

(a) On or about 9/21/11—Brookwood Women’s Center, 2010 Medical Center Drive, Birmingham, AL, lockout tagout procedures were not utilized when servicing or maintenance was being performed at the top of an elevator car.

Among other methods, one feasible and acceptable method to correct this hazard is to comply with the American National Standard A10.44-2006, Control of Energy Sources (Lockout/Tagout) for Construction and Demolition Operations, and to enforce the Company’s program of energy control procedures to ensure that before any employee performs any servicing or maintenance on a machine or equipment where unexpected energizing, startup or release of stored energy could occur and cause injury, the machine or equipment shall be isolated from the energy source and rendered inoperative. In addition the employer should comply with instructions outlined in the Otis Employee Safety Handbook, Section 10.0, Lockout Tagout Procedure, Control of Hazardous Electrical Energy—General Rules, Paragraph A which states, When work is performed on equipment where operation is not required, the equipment must be completely de-energized, locked and tagged out, and verified that the power source(s) has been removed.

*Elements of a § 5(a)(1) Violation*

Section 5(a)(1) provides that each employer “shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees.”

To prove a violation of the general duty clause, “the Secretary must show that a condition or activity in the workplace presented a hazard, that the employer or its industry recognized the hazard, that the hazard was likely to cause death or serious physical harm, and that a feasible and effective means existed to eliminate or materially reduce the hazard.” *Arcadian Corp.*, 20 BNA OSHC 2201, 2007. . . (No. 93-0628, 2004).

*ACME Energy Services dba Big Dog Drilling*, 2012 WL 4358852 at \*2 (No. 88-0088, 2012).

It is undisputed that a hazard existed for the apprentice atop elevator #4, and that it was likely to cause death or serious physical harm. He was fatally struck on the back of his head by a descending elevator. The Secretary must also establish the hazard was recognized, and that a feasible and effective means existed to eliminate or materially reduce the hazard. Hazard recognition can be established by showing either that the individual employer was aware of the hazard or that its industry as a whole was aware of the hazard.

*Recognition of Hazard by Employer*

Employer recognition may be established by showing the employer had either actual or constructive knowledge of the hazard. The Secretary has failed to establish this element.

It is undisputed that, after the apprentice lowered elevator #4 to the bottom floor, he did not have another work assignment until his supervisor arrived with the replacement governor. The one task Otis had assigned the apprentice at that point (lowering elevator #4) required him to be at the inspection station controls, located at the front right corner of the elevator top.

The CSHO agreed that Otis had no reasonable expectation the apprentice would lean over the guardrail into the adjacent elevator shaft:

Q. Now it’s correct, isn’t it, that [the mechanic] told you that [the apprentice] was supposed to sit tight at the front of the car when [the mechanic] left him after the car was brought down, right?

CSHO: Yes.

Q. Which means he was just supposed to wait for the governor to arrive on site, right?

CSHO: I'm not sure what the meant. He just said sit tight.

Q. Well, if I tell you to sit tight, that means you are going to stay where you are, right?

CSHO: Maybe.

Q. Or you might ignore me, but that's what I'm asking you to do, right?

CSHO: Yeah, right.

Q. Well, if you could look at your narrative again and you could reflect your recollection, just tell me if I read this correct on the second page. I have got a redacted version, but I have got blank someone instructed the deceased employee . . .to, quote, "Sit tight, the governor should be here shortly," end quote. Is that correct?

CSHO: Yes.

Q. And that reflects what you learned during your investigation, right?

CSHO: Correct.

Q. You learned that [the apprentice] had not been asked to do anything other than wait, correct?

CSHO: Correct.

Q. As you said in your original narrative, he was not performing work at the time of the incident, right?

CSHO: Right.

(Vol. I, Tr. 134-135).

The CSHO also agreed that the apprentice not only leaned over the guardrail to look down into the adjacent shaft, but that he actually climbed up onto the guardrail to do so. In her narrative of her inspection, the CSHO states:

[The mechanic] instructed the deceased to "sit tight, the governor should be here shortly." [The mechanic] proceeded to gather up materials and equipment [the crew] would need to install the new governor. . . . It appears the employee had moved from the front of the elevator top to the right corner at the back of the elevator. It also appears that the employee had stood on top of the guardrails surrounding the elevator car top and was looking over into the shaft of the

adjacent service elevator car, when the service elevator began to descend to the first floor. The deceased was struck by the descending elevator car.

(Exh, C-4, p. 7-2).

Otis had no actual or constructive knowledge that the apprentice would go over to the back corner of the elevator top and stand on the guardrail to peer down into the adjacent shaft. At the hearing, the Secretary suggested that a motivated employee might look around for something productive to do while waiting for his next assigned task. There is, however, no evidence the apprentice engaged in any work while waiting for the arrival of the replacement governor. Otis's supervisor, who arrived at the site shortly after the accident occurred, stated, "There would be nothing that he had to do up there. There is no work. If you had seen—if you studied some of the pictures, you could tell there was nothing to work on. He would have to sit tight right there and wait for me to get there with that governor" (Vol. II, Tr. 185-186). Furthermore, the work that was his sole assignment that day was located on the opposite side of the elevator car top. The mechanic testified, "It was our job that day replacing the governor that was on the other side—inside the handrail as far away from the elevator #5 as you can get" (Vol. II, Tr. 81).

The Secretary has failed to establish Otis knew that a hazard existed for its employee as he waited atop elevator #4 on September 21, 2011. The apprentice's sole assignment until the replacement governor arrived that morning had been to lower elevator #4 to the bottom level so the mechanic could retrieve their tools. He had completed that task and had no more work to do until the governor was on the site. A reasonable person would not expect an employee in that situation to move to the right rear corner of the elevator top, climb onto the guardrail, and stick his head into the pathway of the one other working elevator on the site.

#### *Recognition of Hazard by Industry*

The Secretary asserts the elevator industry recognizes that an adjacent elevator presents a struck-by hazard to an employee waiting atop an elevator in a shared hoistway. "Industry recognition may be shown through the knowledge or understanding of safety experts familiar with the workplace conditions or the hazard in question." *Acme at* \*3.



The Secretary's witness David Hallmark was qualified as an expert in elevator construction and installation. Hallmark is a business representative for Elevator Constructors Local #24. Prior to that position, he worked in the elevator industry for 26 years, including five years with Otis.

Hallmark testified that the "elevator industry is concerned about employees being struck by adjacent elevators" (Vol. I, Tr. 266). This concern focuses on employees who are performing actual work atop the elevator car. Hallmark testified that employees performing the final elevator installation phase may need to reach into the hoistway in order to access the electrical ductwork or to adjust the roller guide. However, as noted in the previous section, there is no evidence the apprentice attempted to do any work that required him to reach into the hoistway.

The Secretary has not established that the elevator industry recognizes a hazard to an employee from an adjacent elevator when the employee is merely moving the elevator via the inspection station controls, or waiting on a replacement part. Hallmark's testimony regarding the industry's recognition of a hazard targets employees who are in the process of performing assigned work located in the shared hoistway. His testimony does not address the situation that existed in the present case.

The Secretary has failed to establish a recognized hazard in this case.

#### *Feasibility of Abatement*

The Secretary also has the burden of establishing "that a feasible and effective means existed to eliminate or materially reduce the hazard." The Citation alleges that "one feasible and acceptable" means of abatement was to perform lockout/tagout (LOTO) protocols to:

ensure that before any employee performs any servicing or maintenance on a machine or equipment where unexpected energizing, startup or release of stored energy could occur and cause injury, the machine or equipment shall be isolated from the energy source and rendered inoperative.

Otis notes the Secretary neglects to specify which elevator it needs to lock out in order to abate the alleged hazard. The general contractor and the other subcontractors were using elevator #5 as a service elevator at the time of the accident. Hallmark stated he would have locked out both elevators #4 and #5 while the Otis crew was waiting for the supervisor to arrive

with the replacement governor. Hallmark conceded Otis's employees were not in the process of replacing the governor at the time of the apprentice's fatality: "It was my understanding they were waiting on the governor. I don't know what task they were performing otherwise" (Vol. II, p. 44).

"Feasible means of abatement are those regarded by conscientious experts in the industry as ones they would take into account in 'prescribing a safety program.'" *Beverly Enterprises*, 19 BNA OSHC 1190, 2000 (No. 91-3344, 2000). The mechanic testified he was unaware of any practice in the elevator industry that required an employer to use LOTO on an adjacent elevator when an employee is waiting atop an elevator for a replacement part. The supervisor also testified it was not industry practice to lockout an adjacent elevator when an employee is using the inspection controls to lower an elevator. He stated, "[W]e have a distance, a 20-inch rule in between any moving equipment. If you are within that distance, then we protect ourselves from the equipment. We lock and tag it out or we separate it" (Vol. II, Tr. 154). Since elevators #4 and #5 were separated by a distance of 22 inches, the LOTO rules were not operative. The apprentice had worked for 25 years in the elevator industry. The supervisor testified he trained the apprentice himself on the 20-inch rule, as well as in Otis's other workrules.

Terry Stepp is the southern regional safety manager for Otis. He provides safety training and conducts safety audits. Stepp worked as an elevator mechanic for Otis for 19 years. The court qualified Stepp as an expert in elevator construction safety and safe work practices. Stepp demonstrated a detailed knowledge of the elevator industry, which he related in a straightforward, professional manner. His testimony was specifically directed to the circumstances at issue in this case, i.e., whether it is a recognized hazard for an employee to wait atop an elevator, when the adjacent elevator is not locked out. The court accords Stepp's testimony great weight.

Stepp testified that Otis is the largest elevator company in the world and that it has the lowest incident rate in the elevator industry. He stated Otis employees are trained, as is industry custom, to use LOTO when they are required to enter or access a hoistway to perform work. Otis's safety handbook contains specific work rules designed to prevent employees from being exposed to struck-by hazards while in a shared hoistway (Exhs. R-7 and R-8). Because Otis was not engaged in either servicing or maintenance on elevator #4 at the time of the accident, using

LOTO procedures was not a feasible means of abating the alleged hazard. Furthermore, LOTO is designed to protect employees from the “unexpected energizing” of a machine or equipment. Here, elevator #5 had been used as the service elevator on a daily basis for several months. The apprentice had used the service elevator on numerous occasions.

Other subcontractors were working on the site and they used elevator #5 to move between floors. The operation of elevator #5 was not unexpected.

The Secretary has failed to prove the use of LOTO procedures was a feasible means of abatement. Item 1 of the Citation is vacated.

### **Findings of Fact and Conclusions of Law**

The foregoing decision constitutes the findings of fact and conclusions of law in accordance with Rule 52(a) of the Federal Rules of Civil Procedure.

### **ORDER**

Based upon the foregoing decision, it is ORDERED that Item 1 of Citation No. 1 is vacated and no penalty is assessed.

/s/  
**STEPHEN J. SIMKO, JR.**  
**JUDGE**

Date: November 26, 2012  
Atlanta, Georgia