

UNITED STATES OF AMERICA  
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION

SECRETARY OF LABOR,

Complainant,

v.

GENERAL GLASS & WINDOW, INC.,

Respondent.

OSHRC Docket No. 99-1341

APPEARANCES:

Leslie John Rodriguez, Esquire, Office of the Solicitor,  
U.S. Department of Labor, Atlanta, Georgia  
For the Complainant

David J. Feingold, Esquire, 3300 P.G.A. Boulevard, Suite 410,  
Palm Beach Gardens, Florida  
For the Respondent

Before: G. MARVIN BOBER  
Administrative Law Judge

**DECISION AND ORDER**

This case arises under the Occupational Safety and Health Act of 1970, 29 U.S.C. 651-678 (1970) (“the Act”) to review (1) citations issued by the Secretary of Labor pursuant to section 9(a) of the Act and (2) penalties proposed pursuant to section 10(a) of the Act.

**Background and Procedural History**

On February 22, 1999, Lance Cawley, an employee of Staff Leasing, was working as a glazier for General Glass & Window, Inc. (“Respondent” or “General Glass”), when he was fatally injured at a work site located at 3220 Commerce Place, West Palm Beach, Florida.<sup>1</sup> The autopsy report stated that the cause of death was “blunt head trauma”

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<sup>1</sup>Staff Leasing was the “employer” of Mr. Cawley and Respondent’s other workers for purposes of paychecks and other administrative matters; however, under their agreement, Staff Leasing leased the employees back to Respondent, which remained responsible for providing safety training and equipment to the employees and for instructing them in their job duties. (Tr. 24-25).

consisting of multiple skull fractures and cerebral contusions and lacerations. The report of the Palm Beach County Medical Examiner stated that Mr. Cawley was injured at about 1:10 p.m. and pronounced dead at 1:45 p.m.<sup>2</sup> The report described the accident as follows:

21 panes of glass were on one side of the truck and there were no panes on the other side. The panes were measured to about 6.5 feet x 3 feet x .5 inch. The estimated weight of each pane is about 100 lbs. The panes were tied to the rack. The decedent apparently attempted to untie the panes from the rack when the entire row of glass panes tilted and fell on the decedent....There were reportedly no workers working with the decedent or in the immediate vicinity of the truck when the injury occurred.

Due to the fatality, the Occupational Safety and Health Administration (“OSHA”) inspected the work site and the circumstances surrounding the accident, and, as a result, issued a Citation and Notification of Penalty on July 8, 1999. The citation alleges two serious violations and an “other” violation and proposes a total penalty of \$11,550.00. Respondent contested the citation and proposed penalty, and an administrative trial was held in Miami, Florida on February 9, 2000.<sup>3</sup> The Secretary filed a post-hearing brief, and Respondent, electing not to file a brief, instead made a closing argument at the conclusion of the trial.<sup>4</sup>

### **Jurisdiction**

The parties agree that Respondent is an employer subject to the Act and that the Occupational Safety and Health Review Commission (“the Commission”) has jurisdiction over this case.

### **Serious Citation 1, Item 1 -- Proposed Penalty: \$5,600.00**

This item alleges a violation of section 5(a)(1) of the Act, as follows:

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<sup>2</sup>When Mr. Cawley arrived at the hospital, the staff found in his pants pocket two lighters, a pipe and a baggie containing what appeared to be marijuana. Although the toxicology report dated October 10, 1999, stated that cannabis had been detected in Mr. Cawley’s urine, the report was silent as to the amount; therefore, it was not possible to determine if Mr. Cawley’s physical abilities and mental processes could have been or were affected at the time of his death. (RX-1).

<sup>3</sup>At the trial, the Secretary withdrew Item 2 of Serious Citation 1. (Tr. 245, 260).

<sup>4</sup>The Secretary’s exhibits at the hearing were CX-1 through CX-7, and Respondent’s exhibits were RX-1 and RX-2. In addition, the Secretary agreed at the hearing to provide the undersigned with a relevant portion of OSHA’s Field Inspection Reference Manual (“FIRM”); the Secretary provided this document, which has been entered into the record as CX-8, on February 23, 2000.

The employer did not furnish to employees employment and a place of employment which were free from recognized hazards that were causing or likely to cause death or serious physical harm:

a. On or about February 22, 1999, an employee was exposed to the hazard of being crushed by a stack of approximately 20 pieces of 3 x 6 feet glass being unloaded from the back of a 1987 Chevrolet Custom Deluxe flatbed truck. A glazer was pitching glass to employees positioned on the ground after loosening a temporary 9/16 inch rope tied around the top and mid sections of the glass attached to a metal A-frame on the inside of the truck. One employee was left alone between two to five minutes after unloading 15-20 pieces of glass from one side of the flatbed. A stack of approximately 26 pieces of glass weighing approximately 1,080 pounds shifted and crushed the employee while standing on the back of the flatbed.

Feasible means of abatement include, but are not limited to:

1. Secure the stacks of glass on the outside of the A-frame where a 5-7 degree lean can be maintained during transport and unloading.
2. Provide stakes of sufficient strength and height to secure the load and minimize the amount of shift.
3. Discontinue the practice of allowing employees to walk on the back of the flatbed in the danger zone.

Section 5(a)(1), the general duty clause, requires the employer to “furnish ... 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.” The general duty clause thus focuses on an employer’s duty to prevent recognized hazardous conditions in its workplace that cause or may cause death or serious harm to its employees. *See Arcadian Corp.*, 17 BNA OSHC 1345, 1347 (No. 93-3270, 1995); Morey, *The General Duty Clause of the Occupational Safety and Health Act*, 86 Harv. L. Rev. 988, 997 (1973).

To establish a violation of section 5(a)(1) of the Act, the Secretary must prove that: (1) a condition or activity in the employer’s workplace presented a hazard to employees, (2) the cited employer or the employer’s industry recognized the hazard, (3) the hazard was causing or likely to cause death or serious physical harm, and (4) a feasible and useful means of abatement existed by which to materially reduce or eliminate the hazard. *Kokosing Constr. Co.*, 17 BNA OSHC 1869, 1872 (No. 92-2596, 1996). The Commission has defined the term “recognized hazard” as the practice or process by which the particular job is being done over which the employer has control. *Arcadian Corp.*, 17 BNA OSHA 1345, 1348 (No. 93-3270, 1995); *Pelron Corp.*, 12 BNA OSHA 1833, 1835 (No. 77-2350, 1984). The

existence of a recognized hazard may be established if the hazardous incident can occur “under other than a freakish or utterly implausible concurrence of circumstances.” *Waldon Healthcare Center*, 16 BNA OSHA 1052, 1060 (No. 89-2804, 1993); *Reich v. Arcadian Corp.*, 110 F.3d 1192, 1197 n.5 (5th Cir. 1997). The question of the precautions taken to alleviate a recognized hazards presents the issue of whether the employer has done “all it feasibly can to prevent foreseeable hazards, including dangerous conduct by its employees.” *Gen. Dynamics v. OSHRC*, 599 F.2d 453 (1st Cir. 1979).

The issue to resolve in this case is whether the Secretary has met her burden of demonstrating the elements of a section 5(a)(1) violation. The relevant testimony follows.

**James Larry Sampson**

J. Larry Sampson, Respondent’s owner, testified his company performs residential and commercial glass installation, or glazing, which includes layout work, fabricating and caulking frames, transporting panes of glass from the shop, and installing the glass into frames at the work site.<sup>5</sup> He said the employees assigned to the subject site were Charles Sampson, Lance Cawley, and David and Robert Courtemanche, and that the job consisted of installing approximately 40 panes of glass, each weighing 65 to 70 pounds and measuring about 3 feet by 6 feet by 9/16 inch.<sup>6</sup> He also said that the employees began loading the glass onto the company’s truck around 7:00 a.m. on February 22, 1999, and he described the procedure they would have used. At least one worker would have been in the bed of the truck to receive the glass, with at least two on the ground to hand the glass into the truck, and the glass would have been loaded vertically, one pane at a time, on the interior sides of the racks that were located on either side of the truck bed; for even distribution, half of the glass would have been put on the right-side rack and the other half on the left-side rack, and heavy cardboard would have been put under the glass to protect it. Once half of the panes were loaded on one rack they would be tied together in a “stack” and secured on the rack with rope, with the others panes being stacked and secured in the same manner on the other rack. Mr. Sampson stated that Mr. Cawley loaded the glass that day and that he would have

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<sup>5</sup>The terms “pane of glass” and “light of glass” are used interchangeably in the record.

<sup>6</sup>Charles Bradley Sampson, Mr. Sampson’s son, is also called “Brad” in the record. (Tr. 73).

temporarily secured each individual pane by putting a rope around it and tying the rope off until the stack was complete and could be secured on the rack. (Tr. 19-39, 70, 74).

Larry Sampson further testified that after the truck was loaded, Lance Cawley drove it to the site, while the others went in their own vehicles. The employees first did “prep” work and then began to unload the truck; Mr. Cawley untied the glass and passed it from the back of the truck to David and Robert Courtemanche, who set the glass into the frames in the building, and Charles Sampson caulked frames. Mr. Sampson explained that, to unload a stack of ten pieces of glass, “you untie the glass. You hold the glass. You ... take the rope and you tie it off. And you put it in between light one and the other nine lights. And once they’re secured off then you move to the one.” (Tr. 40-46). Mr. Sampson further explained that:

You re-secure them as you’re untying the lights that you’re after...there’s a rope knotted off on this slat. And it’s across the glass. I take it loose. I leave a knot on here. I peel the first piece of glass back. I slip that rope right down in between number one, the closest one to me. And the other nine ... I re-secure....Then I pick the first light up ... [a]nd I take it to back of the truck and set it there for the other men to pick up or hand it down to them. (Tr. 46-47).

Mr. Sampson arrived at the site after the accident, about 2:30 p.m., and talked to the employees; he also got up in the truck bed, looked at the glass and the rope, and noted there were no broken ropes. Based on his 28 years of experience, he opined that Mr. Cawley “forgot to tie the rope off” and that “the glass came over on him and killed him.” He further opined there was nothing he or the company could have done to prevent the accident; as he put it, “Lance is the one that made that decision. And I can’t, I can’t control his decisions.” Mr. Sampson said his company did not test for drugs or alcohol but that he told employees at safety meetings that no drugs or alcohol were allowed and that anyone having such substances on them was sent home. He also said his company’s method of transporting glass was the industry standard, that he had used this method since he had been in the business, and that that was why he had bought the four glass trucks his company used. (Tr. 62-73).

#### **David Courtemanche**

David Courtemanche testified that he had worked for General Glass about a year at the time of the accident and that the job was his first in the glass business. He said that Lance Cawley was the senior employee, with 20 years of experience in the industry, and that Mr.

Cawley had discussed the job with the crew that morning. He also said that the crew first did “prep” work at the site and then began unloading the stack on the left side of the truck; Mr. Cawley worked in the truck bed, he and his uncle, Robert Courtemanche, took each pane as it was handed down and then carried it to the building so it could be set in a frame, and Charles Sampson was caulking frames.<sup>7</sup> Mr. Courtemanche stated that about ten panes had been unloaded by the 12:00 lunch break and that another ten to 15 were unloaded between 12:30 and 1:00 p.m.<sup>8</sup> He and his uncle had just set a pane and were returning to the truck when they saw that the stack on the right side of the truck had fallen over to the left on top of Mr. Cawley; they took the glass off of Mr. Cawley with the help of Charles Sampson and another individual, who called the police with his cell phone, and they tied the glass back up on the right side of the truck bed. The police arrived about 20 minutes later. (88-128).

David Courtemanche further testified that based on what he saw, the only way the stack of glass could have fallen was if Mr. Cawley had untied it and then not retied it properly. He explained that the rope was still loosely around the stack after it had fallen and that he saw no broken ropes in the truck. He also explained that while the panes in a stack were not secured individually, the stack was roped together and secured such that one pane could be removed without untying the entire stack; rather, there were multiple loops around the stack and only part of the rope was loosened and slipped behind the pane being removed, which was the only one “exposed,” after which the rope was re-secured. Mr. Courtemanche said he did not believe there was anything that anyone at General Glass could have done to prevent the glass from falling on Mr. Cawley. He described Mr. Cawley as “very safe” and experienced, noting that while he was not a foreman he was the person who made sure the job ran smoothly and that everyone did what they were supposed to do. Mr. Courtemanche

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<sup>7</sup>Although Mr. Courtemanche’s testimony indicated he was unsure if the glass was loaded in four stacks of ten or two stacks of 20, the record shows it was loaded in two stacks of 20. (Tr. 90, 97-100, 108-15, 122; C-4-5).

<sup>8</sup>Mr. Courtemanche said that Mr. Cawley left the site for lunch with his wife, who picked him up, while he and the others had lunch at the job site. (Tr. 93-94, 119).

also said he had been trained by the company and that as a new employee he had not been allowed to tie off glass as only more senior workers could do that job.<sup>9</sup> (Tr. 104-07, 122-24).

**Ramona Morris**

Ramona Morris, the OSHA compliance officer (“CO”) who investigated the accident, testified that she went to the site on February 24, 1999; she spoke to the general contractor, who told her what he knew about the accident, and she phoned Larry Sampson, who advised her that the three employees at the site were not the ones who had been there the day of the accident. The CO then spoke to the three employees at the site, who told her how glass was loaded at the shop and unloaded at the job site; in particular, they said that the person who unloads unties the glass, removes one piece, and then reties the rope and takes the piece of glass to the employees on the ground. (Tr. 153, 158-67). The CO observed the company’s truck at the site, and she described how the glass was secured in it as follows:

It had a rope around the top portion of the glass and the middle of the glass. And it was leaning against the inside of the frame, which is like an “A” on the outer perimeter of it. And it had like a bar in the middle. That’s how I remember it being stacked. (Tr. 166).

CO Morris went to the office of General Glass on March 1, 1999, where she spoke with Larry Sampson. He told her about the subject job and how glass was loaded, unloaded and secured; specifically, he told her that the rope, which was 9/16-inch rope, was required to be tied around the top of the glass and the middle of the glass and that it was secured to the inside of the A-frame. The CO also spoke to the three employees who had been at the site on the day of the accident; they told her how glass was unloaded, and their statements about how it was secured agreed with what Mr. Sampson said. The CO held a closing conference with Mr. Sampson on March 24, 1999; she later phoned to advise him that the citations were being issued, and she met with him again after he had received them. (Tr. 167-73).

CO Morris said that the hazard in this case was that of “the employee being crushed by a stack of glass ” and “[b]y being placed in the immediate proximity of that glass.” (Tr. 174). As to Respondent’s specific knowledge of the hazard, she stated as follows:

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<sup>9</sup>The witness testified that the training, which was oral, was done at the company’s office and on the job; the witness also testified that Staff Leasing had provided him a binder of general safety information that included a drug policy. (Tr. 121, 125-26).

Well, they use a rope to secure the glass to the A-frame. So, they must have a reason for doing that. And the reason is probably because they don't want it to fall over on somebody, so you have to secure it. And you want to make sure that it's balanced. If it's not balanced it will tip over. So, you have to have something to hold the weight of the glass. (Tr. 177-78).

CO Morris testified that she herself had no experience in the areas of transporting and installing glass and that the first abatement means in the citation was based on information from Onruh Fabricators ("Onruh"), a glass truck manufacturer.<sup>10</sup> Onruh told her that glass trucks can be made to the specifications a company wants, based on the size of the glass it transports, but that glass is usually stored on the outside of the truck so that it leans against the A-frame at an angle such that, in the event of shifting or tilting, the glass would fall back against the A-frame rather than onto an employee; Onruh also told her that while some smaller companies use flat bed trucks, most larger companies use trucks that store the glass only on the outside of the A-frame.<sup>11</sup> In regard to the second abatement means, the CO said that she had learned of other OSHA inspections involving the transporting of materials, including glass, and that stakes could be used to secure the load.<sup>12</sup> With respect to the third means of abatement, the CO said that she determined it was very dangerous for employees to be in the back of the truck with the glass and that a different system, where employees could slide the glass out from the ground, could be used. (Tr. 176-80, 183-95).

### Discussion

In view of the evidence of record, I conclude the Secretary has not met her burden of establishing a 5(a)(1) violation. It is clear that a stack of glass falling as it did in this case could result in fatal injuries and that Respondent recognized the hazard of a stack of glass falling onto an employee. However, I am persuaded that the method General Glass used for securing glass was an effective means of eliminating the hazard. I am also persuaded that employees were adequately instructed in that method and that had it been followed at the site

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<sup>10</sup>The CO testified that there was no relevant ANSI standard and that the glass association she contacted had no information about securing glass. (Tr. 178-79, 195).

<sup>11</sup>The CO indicated that the glass trucks she herself had seen had stored the glass in this manner. (Tr. 177, 192-93).

<sup>12</sup>The CO said the pamphlet Onruh gave her showed this method, which, as she understood it, would hold each piece of glass in place and allow one piece to be slid out at a time; she also indicated the pamphlet showed primarily trucks that stored the glass on the outside. (Tr. 192-93).

the accident would not have occurred. Mr. Sampson and Mr. Courtemanche testified about how glass was loaded and unloaded and how it was secured to the racks in the company's trucks, and the opinion of both was that the stack of glass would not have fallen if Mr. Cawley had re-secured the rope properly when he began unloading the glass on the right side of the truck. I found their testimony consistent, convincing and credible, and I note in particular Mr. Sampson's many years of experience in the glazing business. I also note that the testimony of Mr. Sampson and Mr. Courtemanche was supported by what employees told the CO during the inspection and by what the CO herself observed during her inspection.

In addition to the above, there is nothing in the record to indicate that the company's method for unloading glass had not been followed before or that Respondent had any reason to believe it would not be followed at the subject site. Mr. Courtemanche testified that he was trained by General Glass and that only the more experienced workers were allowed to secure glass; he also described Mr. Cawley as very safe and experienced and the person who ensured that other workers on a job did what they were supposed to do. Mr. Courtemanche and Mr. Sampson both testified that General Glass held safety meetings, and the Secretary does not dispute the company's lack of history of previous OSHA violations. (Tr. 181-82).

My final reason for concluding that this item should be vacated is the failure of the Secretary's proof as to the abatement measures set out in the citation. The record shows that CO Morris, who formulated the measures, had no experience in or knowledge of the glazing industry other than what she learned during the inspection. The record also shows that there is no ANSI standard addressing this matter and that the glass association the CO contacted had no information about securing glass. The CO's opinion regarding the first proposed abatement measure was based on her conversation with Onruh, a glass truck manufacturer, and a pamphlet Onruh gave her. However, the Secretary offered no witnesses knowledgeable in the industry, such as an individual from Onruh or the glazing business, to bolster the CO's testimony. The Secretary also failed to offer the pamphlet Onruh provided, and she never asked the CO to identify the Onruh representative(s) to whom she spoke. In view of the

CO's lack of knowledge of the industry and the lack of any supporting evidence, the opinion of CO Morris with respect to the first proposed abatement measure is not credited.<sup>13</sup>

As to the second proposed abatement measure, the CO's opinion was evidently based on conversations with other OSHA personnel who had investigated situations relating to the transporting of materials and on the Onruh pamphlet, which apparently showed a securing method involving stakes. Again, however, the Secretary presented no witnesses or documents to support the CO's testimony, and, following the same reasoning set out in the previous paragraph, the CO's opinion relating to the second abatement means is not credited. In regard to the third abatement measure, the CO testified only that it was very dangerous for employees to be in the back of the truck and that another system, whereby employees could slide the glass out from the ground, could be used. The CO did not explain what other system might have been used, and, once more, the Secretary offered nothing to support the CO's opinion, which, like her other opinions, is rejected for lack of support in the record.

For the foregoing reasons, and on the basis of the record before me, the Secretary has not demonstrated the elements required to prove a section a 5(a)(1) violation. This citation item is accordingly vacated.

**"Other" Citation 2, Item 1 -- Proposed Penalty: \$3,500.00**

This item alleges a violation of 29 C.F.R. 1904.8(a), which provides, in pertinent part, that:

Within 8 hours after the death of any employee from a work-related incident ... the employer of any employees so affected shall orally report the fatality ... by telephone or in person to the Area Office of ... OSHA ... that is nearest to the site of the incident, or by using the OSHA toll-free central telephone number.

It is undisputed that the time of Mr. Cawley's death was 1:45 p.m. on February 22, 1999. (Tr. 55, 256; RX-1). Thus, under the terms of the standard, it would appear that Respondent was required to notify OSHA of Mr. Cawley's death no later than 9:45 p.m. It

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<sup>13</sup>In rejecting the CO's opinion, I note that General Glass is a small company and that the CO herself indicated that it is the larger companies that use trucks that transport glass only on the outsides of the trucks. I also note that James Sampson specifically testified that while he could sometimes transport glass in this manner, it was not possible in this case because the outsides of the racks on the truck did not hold that much glass; he also testified that he has utilized the same method that was used the day of the accident since he has been in the glass business, both in his own company and in working for others, and that "that's the way it's done." (Tr. 47, 51-52, 69-71).

is also undisputed that Jeff Bray, a General Glass sales person, called OSHA to report the fatality at 10:30 a.m. on February 23, 1999, and that CX-6, an “OSHA 36 Form,” is OSHA’s record of Mr. Bray’s phone call. (Tr. 54, 156-157, 169, 247). However, Larry Sampson, the owner of General Glass, testified that his son, Charles Sampson, tried to call OSHA about Mr. Cawley’s death at about 8:00 p.m. on February 22, 1999, but “he got no response.” (Tr. 71-72). CO Morris, on the other hand, testified that CX-6 was the “official record” of the accident and indicated there was no other record of any other report to OSHA about Mr. Cawley’s death. (Tr. 156-57). For the reasons that follow, I conclude that the Secretary has not met her burden of proving a violation of the standard.

CO Morris testified that during business hours, calls about fatalities are given to the OSHA duty officer for that day, who takes down the relevant information and puts it on an OSHA 36 Form; the form is passed on to the office supervisor, who assigns a CO to investigate the fatality. CO Morris further testified that after business hours, a voice mail system takes incoming calls to her OSHA area office; she indicated that the system allows callers to leave a message and also gives callers OSHA’s toll-free number to report accidents and fatalities. (Tr. 155-57, 204-06). However, the CO indicated that no one checked the voice mail system or the toll-free number system to determine if there was a record of a phone call from Respondent on the evening of the fatality. (Tr. 250-55). Moreover, while the CO said she spoke to Jeff Bray and Larry Sampson about Mr. Bray’s phone call to OSHA, she did not indicate any other discussion with them in this regard. (Tr. 246).

In addition to the above, unrebutted testimony in the record establishes that the West Palm Beach Police Department dispatcher called OSHA twice on February 22, at about 2:00 p.m. and again around 3:00 or 3:30 p.m., that the dispatcher was told on both times that OSHA personnel were on their way, and that no one from OSHA ever arrived at the site that day or contacted the Police Department as a result of the dispatcher’s calls.<sup>14</sup> (Tr. 131-37, 140-41, 145-48). CO Morris conceded she did not know if the dispatcher had called OSHA that day or if Charles Sampson had called OSHA that evening. (Tr. 206, 255).

On the basis of the record before me, I am simply unwilling to find that the Secretary has met her burden of proving that Respondent did not notify OSHA of Mr. Cawley’s death

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<sup>14</sup>Larry Sampson testified that he waited for OSHA at the site until about 5:30 p.m. and that no one from the agency ever arrived. (Tr. 63-65).

within the required time frame. A conclusion that Respondent did not violate the standard is supported by the CO's own testimony and the testimony about the dispatcher's calls to OSHA. This conclusion is also supported by the testimony of Larry Sampson, who, as noted in the preceding discussion, was a credible witness. This citation item is vacated.<sup>15</sup>

**ORDER**

Based upon the foregoing decision, the disposition of the citation items is as follows:

1. Item 1 of Serious Citation 1, alleging a violation of section 5(a)(1) of the Act, is VACATED.

2. Item 2 of Serious Citation 1, alleging a violation of 29 C.F.R. 1926.250(c), is VACATED.

3. Item 1 of "Other" Citation 2, alleging a violation of 29 C.F.R. 1904.8(a), is VACATED.

/s/

G. Marvin Bober  
Administrative Law Judge

Dated: 8/21/00  
Washington, D.C.

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<sup>15</sup>Even if Charles Sampson had not called OSHA, I would still vacate this citation item. The preamble to the standard states that the 8-hour period coincides with the "standard work shift" for most employers and provides a logical cut-off point for fulfilling the reporting requirement. *See* Fed. Reg. 15595 (1994). This language persuades me that it is reasonable to interpret the reporting period as beginning at the end of the employee's work shift, in this case, 3:30 p.m. Since Jeff Bray called OSHA at about 10:30 a.m. the next morning, his call fell within the 8-hour period.