United States of America
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
1120 20th Street, N.W., Ninth Floor
Washington, DC 20036-3457

SECRETARY OF LABOR, Complainant v. NEW YORK ELEVATOR, INC., Respondent	OSHRC DOCKET NO. 05-1190

Appearances:

Suzanne L. Demitrio, Esquire U.S. Department of Labor New York, New York For the Complainant.	Paul J. Waters, Esquire Reed Smith, LLP Washington, D.C. For the Respondent.

Before: Irving Sommer
Chief Judge

DECISION AND ORDER

This proceeding is before the Occupational Safety and Health Review Commission ("the Commission") pursuant to section 10(c) of the Occupational Safety and Health Act of 1970, 29 U.S.C. § 651 *et seq*. ("the Act"). The Occupational Safety and Health Administration ("OSHA") conducted an inspection of a work site of Respondent, New York Elevator, Inc. ("Respondent" or "NYE"). The work site was located in New York, New York, and the inspection took place on May 25 and 26, 2005, following an accident involving an NYE employee at the site on May 24, 2005. As a result of the inspection, on July 13, 2005, OSHA issued to NYE a two-item serious citation; the first item alleged a violation of section 5(a)(1) of the Act, the general duty clause, and the second item alleged a violation of 29 C.F.R. 1926.21(b)(2). Respondent NYE contested the citation items and the penalties proposed for the items, and the hearing in this matter was held on January 18, 2006, in New York, New York. Both parties have filed post-hearing briefs.

Background

On May 24, 2005, three employees of NYE were working on the two passenger elevators in an office building located at 14 East 60th Street, New York, New York. The job at the site involved modernizing the building's elevators, which included the two passenger elevators and a freight elevator, and two of the employees, Dominic Lanzilotta and Vincent Iacono, had been working at the site for about five months; Lanzilotta and Iacono had worked together on a regular basis for over a year, and Lanzilotta, the mechanic at the site, had had four years of experience as an elevator mechanic, while Iacono, the helper at the site, had had over six years of experience as a helper. The third employee at the site that day was Robert Lattimore, an adjuster with NYE; Lattimore had had 21 years of experience as an elevator mechanic, and, as an adjuster, he went to sites to troubleshoot in situations in which the regular crew could not resolve a particular problem. Lattimore had worked with Iacono at previous sites. (Tr. 48, 61-62, 75-77, 85-88, 100, 112-19, 126, 130).

The NYE employees were working in the elevator motor room in the building's basement. The motor room contained the machinery and controllers, and the hoists, shafts and counterweights, for both elevators, and, as a result, the room was crowded with equipment to the extent that a worker on one side of the room could not see a coworker on the other side of the room; further, to go from one side of the room to the other, the employees had to exit through one door and reenter through another.[1] Exhibit C-6, a diagram of the room Lanzilotta drew at the hearing, shows a large area, called the pit, directly beneath the hoist way for the two elevators. The equipment for each elevator was alongside the pit and included, on either side, a generator, a machine than ran the elevator, a dispatcher, and a controller. The elevators themselves did not descend into the motor room, stopping 15 to 20 feet above, such that an employee could stand and work safely in the pit. The counterweights for the elevators were also located on either side of the pit, as shown in C-6. When an elevator went up to the top of the building, its counterweight descended somewhat into the motor room, and, to protect anyone in the motor room from contacting a moving counterweight, each counterweight had guards on it. The guards were large pieces of sheet metal that covered both sides of the counterweights to a height of 6 feet. (Tr. 9, 12, 37-39, 43-46, 59, 67, 79-85, 94, 121-25; C-4).

[1]Mr. Lanzilotta said the motor room is usually in one room and the hoist, shaft and counterweights in another; he described the subject room as "a very confined space." (Tr. 78).

On May 24, 2005, the employees were engaged in cutting the electrical connections from the left elevator, which was to remain running, to the right elevator, which was being redone and was shut down and locked and tagged out; Lattimore had been assigned to go to the site that day because Lanzilotta was having problems cutting the right elevator out of the system.[2] Lanzilotta was working on the dispatcher for the right elevator, Lattimore was working on the dispatcher for the left elevator, and Iacono was pulling the cut cable through a raceway that was mounted about 5 feet high on the back wall behind the elevators' counterweight guards; the cable went from the right dispatcher to the left dispatcher through the raceway, and Iacono was standing in the pit area to pull the cable. At about 10:30 a.m., Lattimore heard his name called, and, when he looked up, he saw Iacono up above him; Iacono was on the other side of the left elevator's counterweight guard, and he was being crushed by the counterweight. Lanzilotta arrived at that point, as he had heard screaming, and he and Lattimore both ran to the lobby to use the service key to call the elevator down. Lanzilotta then told the building supervisor to call 911, and he ran back downstairs; Lanzilotta found Iacono on the floor of the pit, and he stayed with him until emergency personnel arrived. Iacono suffered a serious crushing injury to his leg; he also sustained some head injuries, and he had no memory of what had happened. (Tr. 12-13, 17-18, 34-39, 45-46, 50, 68, 73, 85-96, 114-18, 124-25, 137-38).

OSHA Compliance Office ("CO") Robert Stewart conducted an inspection of the work site on May 25, 2005, and he interviewed Lanzilotta and Lattimore at NYE's main office the following day. Neither employee actually witnessed what had occurred, and neither knew why Iacono was up in the area where they found him; however, they indicated their belief to the CO that Iacono had climbed up the fixed ladder in the pit area and that he had had one leg on top of the ladder and the other leg on top of the counterweight guard when the accident took place. (Tr. 8-13, 45-48).

Citation 1, Item 1

This item alleges a violation of section 5(a)(1), the general duty clause. As both parties note, to prove a general duty clause violation, the Secretary must show that (1) there was an activity or condition in the employer's workplace that constituted a hazard to employees, (2) either the cited employer or its industry recognized that the condition or activity was hazardous, (3) the hazard was

[2]The elevators are referred to herein as "left" and "right" due to their locations on C-6.

causing or likely to cause death or serious physical harm, and (4) there were feasible means to eliminate the hazard or materially reduce it. *See, e.g, Well Solutions, Inc.*, 17 BNA OSHC 1211, 1213 (No. 91-340, 1995), and cases cited therein. In addition, the Secretary must show that the employer had actual or constructive knowledge of the violation. *See, e.g., Tampa Shipyards, Inc.*, 15 BNA OSHC 1533, 1535 (Nos. 86-360 & 86-469, 1992).

Item 1, as amended in the Secretary's complaint, alleges that:[3]

> [E]mployees were exposed to the hazard of being caught in and/or struck by moving equipment parts by working in an elevator control room where all energized equipment parts were not locked out or tagged out.

The abatement methods in Item 1, as amended, include the employer's energy control program and ANSI Standards Z244.1-93 and Z244.1-2003, which address the lockout/tagout of energy sources.[4]

As to the first and third elements noted above, the Secretary contends that the counterweight posed a hazard to employees which was likely to cause serious injury or death, in that Iacono's leg was struck and crushed by the left elevator's descending counterweight. However, the record shows the counterweight was guarded up to a height of 6 feet, and CO Stewart agreed the guarding on the counterweight complied fully with all applicable code provisions. (Tr. 12, 38-39, 73-74). The record further shows that neither Lanzilotta nor Lattimore knew why Iacono was in the area up above the counterweight guarding, that they did not know he had gotten up there until the accident took place, and that there was no reason for him to be there. (Tr. 46-48, 104-06, 126-27). Finally, the record shows that Iacono and Lanzilotta had been working in the motor room for some weeks and that the counterweight's operation, while quiet, was obvious; the record also shows that Iacono was an experienced helper who was fully trained in his job capacity, that he had performed work like that that was being done on the day of the accident many times before, and that he was known to be a safe worker. (Tr. 88-90, 98-102, 105-06, 118-22, 126-27). Consequently, while the CO opined that the left elevator should have been locked out to prevent Iacono from being caught inadvertently in the

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[3]As issued, Item 1 alleged an employee had placed a part of his body in the runway of an adjacent operational counterweight while snaking wires for another elevator, on or about 5/24/05.

[4]As issued, Item 1 described the abatement methods as the employer's energy control program and ANSI Z244.1-93.

counterweight, he essentially conceded that the counterweight posed a hazard to Iacono because of his unexplained presence up above the guarding.[5] (Tr. 24-25, 38-39, 45-46).

As to the second element, the Secretary points to Exhibit R-1, NYE's lockout/tagout ("LOTO") program,[6] which states, on Page 1 of Section 14, as follows:

> Unless it is not feasible (i.e. inspecting, troubleshooting or observing), employees will not perform any work on equipment where there is a potential to come in contact with energized mechanical or electrical hazards until all sources of energy have been de-energized, grounded, or guarded to protect the employees.[7]

The CO testified that the foregoing provision complied with the ANSI standards set out in the citation and that locking out the left elevator would have prevented the accident. (Tr. 24-29, 51). Lanzilotta and Lattimore testified, and the CO conceded, that the left elevator had to be energized for the work being done.[8] (Tr. 42, 91, 101-02, 117, 129-34). The CO nonetheless opined that due to Iacono's work, which required him to be near the counterweight, the left elevator should have been locked out, especially in view of the cramped situation in the motor room. (Tr. 24-25, 31-32, 50-52). The CO agreed, however, that Iacono, due to his experience and training, should have been aware of the counterweight and its operation; he also agreed the three employees had had extensive training in NYE's safety manual, including the LOTO procedures. (Tr. 13, 45, 48-51, 55, 66-67).

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[5]The CO additionally opined that an employee could have placed a hand on top of the counterweight guard and lost the hand when the counterweight descended. (Tr. 73). However, based on the CO's testimony, set out above, that the counterweight guarding complied with all applicable code provisions, this particular opinion of the CO is accorded little weight.

[6]The caption "ThyssenKrupp Elevator Company Safety Manual" appears on R-1. The record shows that ThyssenKrupp owns NYE. *See* J-1, pages 6-7. (J-1 is the deposition transcript of David Smith, the regional ThyssenKrupp safety manager over NYE at the time of the accident. The parties stipulated that Smith was unavailable as a witness and that his deposition would be admitted as J-1, along with Exhibits 1-3 and 5-11 from that deposition. (Tr. 4-5; J-1, pp. 4-7)).

[7]This same provision is in the elevator industry's Field Employees' Safety Handbook. *See* J-1, Exhibit 5, page 32. *See also* J-1, Exhibit 2. The record shows all NYE employees received the handbook. (J-1, pp. 68-71).

[8]The record shows that the left elevator had to remain energized so that Lattimore would know which connections to sever; further, Lanzilotta and Lattimore both testified that without the left elevator there would have been no passenger service in the building and that it was standard practice to maintain service to the extent possible. (Tr. 42, 91, 101-02, 117, 129-34).

As to the fourth element, the Secretary contends the feasible means of abating the hazard was to lock out the left elevator, pursuant to NYE's LOTO program. The Secretary also contends NYE does not dispute the left elevator should have been locked out, once Iacono's work exposed him to the hazard of the counterweight, based on NYE's response to one of her interrogatories, as follows:

> Prior to the accident, [Iacono] was supposed to be pulling the wires through a raceway that was positioned in a safe location, which [was] not exposed to the hazard of a moving counterweight. Only after all wires had been pulled to the extent possible from this location should he then have moved to the common panel itself after communicating that fact to Mr. Lattimore, disconnecting power to the elevator unit and implementing lockout/tagout procedures.

(Exhibit C-8, pp. 10-11). *See also* Secretary's Brief, p. 7. Further, the Secretary notes the deposition testimony of David Smith, the safety manager over NYE at the time of the accident, as follows:

> A And once he got to the point that he had to be in this area, which was the counterweights and the other selector –
> Q He's referring to the left-hand area –
> A Lattimore should have been informed and the car shut down.

(J-1, p. 55). *See also* Secretary's Brief, p. 7. The Secretary concludes that "Respondent agrees that Mr. Iacon[o] could not complete his assigned task without communicating with Mr. Lattimore and locking out the left elevator." Secretary's Brief, p. 7.

However, in its April 4, 2006 filing, NYE points out that it does in fact dispute that the left elevator should have been shut down and LOTO utilized.[9] It notes that the CO himself agreed that the area where Iacono had been working was safe and that both Lanzilotta and Lattimore had told him there was no reason for Iacono to be above the counterweight guard to accomplish his task. (Tr. 38, 47-48). It also notes that the purpose of the interrogatory response was to establish that if for some reason Iacono had determined that he needed to be in a location that would expose him to a hazard, he should have told Lattimore and/or Lanzilotta and implemented LOTO procedures. Finally, NYE notes the further deposition testimony of David Smith, as follows:

[9]On April 4, 2006, NYE filed a motion for leave to file a reply brief. The Secretary filed her opposition to the motion on April 6, 2006. NYE's motion was denied, in my order of April 26, 2006; however, I noted in the order that the statements set out in the filings of both parties would be considered in reaching a decision on the merits.

Q So for pulling the cable which he was pulling, had he locked out everything he needed to?
A Yes, ma'am.

See J-1, p. 60. *See also* NYE's April 4, 2006 filing, pp. 1-2. Based on the record, the Secretary's contention is rejected, and I find that the Secretary has not met her burden of proving that, under the circumstances of this case, the left elevator was required to be shut down and locked and tagged out.

While the foregoing is sufficient to dispose of this matter, I further find, for completeness of record, that the Secretary has not met her burden of demonstrating that NYE had either actual or constructive knowledge of the cited condition. As NYE points out, the CO admitted there was no actual knowledge of the cited condition. (Tr. 12, 45-48, 60-61). In addition, Lattimore and Lanzilotta both testified that they did not know Iacono had climbed up above the counterweight guard before the accident, that there was no reason for him to have done so, and that they could not see Iacono or hear him working from where they were. (Tr. 94, 104-06, 125-27).

As to constructive knowledge, *i.e.*, whether NYE could have known of the cited condition in the exercise of reasonable diligence, NYE points out that there is no evidence that it should have anticipated that Iacono would climb above a counterweight guard and expose himself to a moving counterweight; in fact, the evidence shows Iacono was known to be a safe worker and that there was no reason to believe he would put himself in harm's way as he did on the day of the accident. (Tr. 47-48, 106, 126-27). There is likewise no evidence that the cited condition existed for such a period of time that NYE should have known of it. Nothing in the record indicates how long Iacono was up above the counterweight guard, and the CO agreed it might have been only seconds. (Tr. 60-61). Further, Lattimore and Lanzilotta could not see or hear Iacono from where they were, making it unlikely they would have promptly discovered the condition. (Tr. 43-44, 94, 105, 125-26).

Finally, NYE points out that the Secretary did not show its safety program, including training and enforcement, was inadequate. NYE clearly had a safety program and a specific rule requiring LOTO to be utilized, unless it was infeasible, where there was a potential for employees to come in contact with energized mechanical or electrical hazards. *See* R-1. The CO acknowledged that NYE's safety program was adequate, and he testified the employees at the site had had extensive training in the program, including the LOTO procedures. The CO also acknowledged that Iacono was fully trained in his job duties, that he should have been aware of the counterweight and its operation, and

that Iacono had had sufficient experience that NYE was about to begin sending him out on jobs as a "temporary mechanic." (Tr. 13, 45, 48-51, 55, 65-67). In addition, the record shows that Iacono was familiar with the motor room because he and Lanzilotta had been working there for a number of weeks before the day of the accident.[10] (Tr. 99, 106).

As to enforcement, the record establishes NYE inspected its work sites and had a progressive disciplinary system for safety rule violations. Supervisors visited the sites they were responsible for and also did "audits" of their sites from time to time.[11] David Smith, the safety manager over NYE in May 2005, testified he conducted safety audits of sites and that if he found a hazardous condition he would fill out a form and give it to the supervisor, who would correct the problem.[12] Smith would also issue a citation to the employee involved, and the citation, whether verbal or written, was documented and would go into the employee's file with a copy to the union.[13] A major violation, such as not using LOTO when it was required, would be documented as a written citation, and retraining would be required; a repeated major violation would result in termination.[14] Smith testified that citations for LOTO violations were issued during his tenure but that no terminations occurred; however, the record shows that Smith was the safety manager for only six months before he moved on to his present position of branch manager. (J-1, pp. 4-5, 67-68, 93-107, 110-13; R-5).

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[10]The CO's opinion that the employees at the site should have talked about the specific hazards in the motor room, *i.e.*, its cramped condition and the left elevator's counterweight, has been considered and rejected in the discussion relating to Item 2, *infra*. (Tr. 14, 50, 65-66).

[11]An audit consisted of a supervisor or the safety manager inspecting the site for safety problems. (J-1, pp. 110-11). Lanzilotta testified his supervisor visited the subject site weekly; during most visits, problems on the job were discussed, and once a month the supervisor would hold a safety meeting at the site. Lanzilotta further testified that no audits had taken place on any of his jobs but that he had heard of them occurring at other sites. (Tr. 89-93, 96-97).

[12]Smith testified that he had audited as many sites as he could but that he did not audit all of them. (J-1, pp. 66, 110-11).

[13]Smith testified that supervisors and branch managers also issued citations for safety violations and that he would be aware of them because he would receive a phone call about the situation as well as a copy of the citation. (J-1, pp. 106-07).

[14]Terminating an employee required the approval of ThyssenKrupp's director of safety and health. (J-1, pp. 101-02).

In her brief, the Secretary states that "[a]lthough Respondent had a written progressive discipline program, Respondent's safety director testified that Respondent was precluded by the union contract from imposing any meaningful penalties for violations of safety rules." *See* Secretary's Brief, p. 8. Smith did testify, in fact, that the union, due to the labor contract, did not recognize suspensions without pay.[15] (J-1, pp. 97-98). However, he did not testify, as the Secretary asserts, that NYE was precluded from imposing any meaningful penalties. Rather, he testified as set out above, and his testimony is supported by R-5, copies of citations issued to employees. I find that documented verbal and written citations, coupled with required retraining for a major violation and termination for a repeated major violation, is sufficient enforcement of NYE's safety program under Commission precedent. In this regard, I note NYE's citing to the decision in *Aquatek Sys., Inc.*, 21 BNA OSHC 1400 (No. 03-1351, 2006), wherein the Commission found that that employer's safety program, work rule and discipline and enforcement program, all of which were verbal and not written, were adequate and were sufficient to rebut the Secretary's prima facie showing of knowledge. *Id*. at 1401-02. Here, by contrast, NYE's safety program, work rule and discipline program were in writing, and Smith's testimony and R-5 show the safety program was enforced. Based on the record, the Secretary has not met her burden of proving knowledge. This citation item is accordingly vacated.

Citation 1, Item 2

This item alleges a violation of 1926.21(b)(2), which states that:

> The employer shall instruct each employee in the recognition and avoidance of unsafe conditions and the regulations applicable to his work environment to control or eliminate any hazards or other exposure to illness or injury.

Item 2, as amended in the Secretary's complaint, alleges a violation as follows:[16]

> Respondent did not provide site-specific instructions as to what the hazards of this worksite were and how to avoid such hazards, including but not limited to how to lock

[15]In her filing of April 6, 2006, the Secretary notes Smith's similar testimony in another deposition relating to a parallel case that involved the same parent company (ThyssenKrupp) as well as the same safety program. Smith's testimony in this deposition, dated February 8, 2006, indicated the issue of the union's failure to recognize suspensions without pay had been rectified.

[16]As issued, Item 2 alleged that an employee was not provided with instructions on how to snake wires to the opposite side of an active counterweight, on or about 5/24/05.

out or tag out equipment/machinery at this site and how to avoid energized equipment at this site.

To prove a violation of an OSHA standard, the Secretary must show that (1) the cited standard applies, (2) its terms were not met, (3) employees had access to the violative condition, and (4) the employer knew of the violative condition or could have known of it with the exercise of reasonable diligence. *Astra Pharmaceutical Prod.*, 9 BNA OSHC 2126, 2129 (No. 78-6247, 1981).

As NYE notes, the CO admitted at the hearing that NYE had a good safety program and that the employees at the site had been trained in the program and to recognize safety hazards and to work safely. At one point, the CO testified as follows:

> Q: Did you learn anything about training of the workers?
> A: Oh yes. I saw that they did have extensive training with respect to where there was a company safety manual. They had tool box talks. There was a program in the safety manual that they had been train[ed] in called lock out tag out which the company implemented and trained them in and basically the program just to summarize says that whenever you're working on something that's live and operational such as an elevator you would like to lock out and tag out that instrument so you don't get caught in it if it inadvertently starts up.

(Tr. 13).

The CO repeated several times that the employees at the site were trained and experienced and that they knew how to do their work safely and to recognize safety hazards (Tr. 45, 48-51, 55, 65). He nonetheless opined that site-specific training on the hazards in the motor room, *i.e.*, the cramped space and moving counterweight, was required, in light of Iacono's proximity to the counterweight when he was pulling wires through the runway. The CO said the three employees should have "put their heads together" and discussed what they were going to do before starting work; he also said there should have been a plan to lock out the left elevator when that became necessary. (Tr. 14, 31-32, 50, 65). The CO conceded, however, that the standard did not contain the words "site specific" and that the three employees were trained "generally" to recognize counterweight hazards, electrical hazards, and how to perform lockout/tagout. (Tr. 65). Further, the record clearly shows that Iacono was familiar with the motor room, since he and Lanzilotta had been working there for several weeks, and that he knew where the counterweights and their guards were; the record also shows he had done the same work many times previously, that he had done such work with Lanzilotta and with Lattimore before, and that his experience was such that NYE was going to begin sending him out on jobs as a

"temporary mechanic." (Tr. 99-102, 105-06, 118, 121-22). Finally, Lanzilotta and Lattimore both testified that they all knew what had to be done that day and that there was no need to have a discussion about it. (Tr. 89-90, 103-04, 115, 135-36). Under these circumstances, the CO's opinion that site-specific training was required is rejected as supposition.[17] (Tr. 70-72). I find that NYE was not in violation of the cited standard. This item is therefore vacated.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is ORDERED that:

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

2. Item 2 of Citation 1, alleging a serious violation of 29 C.F.R. 1926.21(b)(2), is VACATED.

/s/

Irving Sommer
Chief Judge

Dated: June 1, 2006
Washington, D.C.

[17]The CO's opinion that there should have been a plan to lock out the left elevator when that became necessary is also rejected, in light of my conclusion in the discussion relating to Item 1, *supra*, that the Secretary failed to show that the left elevator was required to be shut down and locked out and tagged out under the circumstances of this case.