

SECRETARY OF LABOR,

Complainant,

v.

NUTONE, INC.,

Respondent.

OSHRC DOCKET NO. 02-1403

APPEARANCES:

Elizabeth R. Ashley, Esquire
U.S. Department of Labor
Cleveland, Ohio
For the Complainant.

John W. Fischer, Esquire
Denlinger, Rosenthal & Greenberg
Cincinnati, Ohio
For the Respondent.

BEFORE: MICHAEL H. SCHOENFELD
Administrative Law Judge

DECISION AND ORDER

Procedural History

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 at Respondent’s facility, located in Cincinnati, Ohio, during July of 2002. The inspection came about after an accident at the facility on June 19, 2002, when an overhead crane operating in a warehouse ran into and knocked over an elevated scissors lift on which two employees were working; as a result, both employees were injured. After the inspection, OSHA issued to Respondent Nutone a Citation and Notification of Penalty (“Citation”) alleging serious violations of the general industry safety standards 29 C.F.R. §§ 1910.147(d)(3), 1910.147(d)(4)(i) and 1910.179(i).

Nutone timely contested the Citation, and the Secretary filed her complaint, in which she amended Items 1 and 2 to allege a single violation of the general duty clause, section 5(a)(1) of the Act. Thereafter, Nutone filed its answer. The hearing in this matter was held on March 31 and April

1, 2003, in Cincinnati, Ohio. At the beginning of the hearing, the Secretary withdrew Item 3 of the Citation, which alleged a violation of 29 C.F.R. § 1910.197(i), leaving for resolution the alleged section 5(a)(1) violation. Both parties have filed post-hearing briefs in this matter.

Jurisdiction

In its answer, Nutone admits that the Commission has jurisdiction over this action. Nutone further admits that it is and has been at all relevant times engaged in the manufacture of electrical equipment and related activities. Finally, Nutone admits that it is and has been at all relevant times a business affecting interstate commerce and an employer employing employees in said business. I find, accordingly, that Nutone is engaged in a business affecting interstate commerce and conclude that the Commission has jurisdiction over this action and the parties.

Background

The factual background in this case is basically undisputed. Nutone is in the business of manufacturing home products such as bathroom exhaust fans, door bells and central vacuum systems. The company has about 650 employees at its facility, which consists of ten buildings on approximately 32 acres. Respondent's steel warehouse is used for delivery and storage of rolls of steel that are needed for the production process. It is a large concrete building about 110 feet wide and over 130 feet long. Its width is divided into two "bays" each 55 feet wide. The ceiling height in one bay is 22 feet, four inches and the height in the other is 15 feet. The higher of the two bays has a garage type door at one end where delivery trucks enter to have rolls of steel removed. An overhead bridge crane is used to take the steel rolls off of the delivery trucks and to place them in the storage area adjacent to the delivery area. The crane is also utilized to move rolls from the storage area to a punch press area at the end of the building opposite the delivery area. When not in use the overhead crane is parked at the end of the building next to the delivery garage door.¹ The punch press area is located towards the opposite end of the warehouse, and the crane, to move the steel rolls to that area, runs along overhead tracks² for a total distance of about 128 feet to where the

¹ The parking area is the only location where the overhead crane operator can enter or exit the crane's cab. (Tr. 95).

² The bridge of the crane essentially spans half of the width of the warehouse and moves along the tracks as noted above. The crane's cab and hook hang down from the end of the bridge that

tracks end and the drop-off point for the rolls is located; the drop-off point is just short of the punch press area.³ The crane is generally operated for an hour and a half to two hours a day on an intermittent basis. (Tr. 107-14; 125-27; 140-41; 265-68; 300-01; R-1).

On June 19, 2002, two maintenance employees, Christopher Blessing and Melvin Allen, were assigned to install a drain in the roof of the steel warehouse.⁴ To do this job, Mr. Blessing, a machine repairman, and Mr. Allen, a laborer, first had to go up on the roof of the warehouse to cut a hole and set the top of the drain unit in the hole. They next had to go inside the warehouse to install the bottom of the drain unit, bolt the unit in place, and install piping. This part of the job required a scissors lift, because the ceiling of the warehouse where the drain was located was 22 feet high. Mr. Blessing and Mr. Allen went up in the lift with Mr. Blessing operating the controls.⁵ In trying to bolt the top and the bottom of the drain unit in place, the employees discovered that the holes for the bolts were not aligned. They went down in the lift so that Mr. Blessing could get a larger drill bit, and, just a few minutes later, they returned to the warehouse, got back in the lift, and went back up to finish their work. Before going up in the lift the first time, both employees had seen Marshall Bailey, the operator of the overhead crane, using a forklift.⁶ Before going up the second time, however, neither Mr. Blessing nor Mr. Allen noticed that Mr. Bailey had begun operating the crane. As Mr. Blessing and Mr. Allen recommenced their work, both were looking up at the ceiling and were unaware the crane was coming towards them. Mr. Allen saw the crane at the last moment and shouted out a warning, but it was too late. The crane hit the lift and knocked it over, and both employees fell and

is next to the wall on that side of the warehouse, and the operator sits in the cab facing the opposite wall; the front and both sides of the cab are open, giving the operator a clear view in those three directions. (Tr. 108; 130-33; 228-31; C-19, R-1, R-20).

³ A forklift is used to move the steel rolls from that point to other areas. (Tr. 115; 268).

⁴ A roofing company was redoing the roof on the warehouse, and the drain installation work was required to be done along with the roof work. (Tr. 286; 290).

⁵ Mr. Blessing was designated the lift operator for the job, while Mr. Allen was designated Mr. Blessing's helper. (Tr. 58; 101).

⁶ Mr. Bailey was the only operator of the crane on this shift. (Tr. 119-20).

were injured; Mr. Blessing's leg was broken in six places, and Mr. Allen was badly bruised.⁷ In investigating the accident, Nutone management officials learned for the first time that Mr. Bailey had disabled the crane's alarm system that day, contrary to the company's safety rules. Mr. Bailey was subsequently terminated. (Tr. 46-53; 58-66; 71-72; 76-85; 95-101; 106-07; 115-25; 286; 290; 306-07; R-1). *See also* Statement of Facts in Joint Prehearing Statement, dated February 12, 2003.

The Alleged Violation

As noted above, the Secretary alleges a single violation of the general duty clause, section 5(a)(1) of the Act. Specifically, the Secretary's complaint alleges as follows:

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:

On or about June 19, 2002, employees working from the platform of an elevated Skyjack scissors lift in the steel warehouse between the runways of an active overhead bridge crane were exposed to being struck by the moving bridge crane or caught between the moving crane and storage/adjacent structure(s).

Among other methods, feasible and acceptable means for abating this condition include ensuring compliance with the manufacturer's specifications for operation of Skyjack scissors lift including not operating near cranes and specifications found in the American National Standard for *Self Propelled Elevating Work Platforms*, ANSI/SIA A92.6-1999, for the safe operation of scissors lifts, to include ensuring aerial lifts are not elevated/operated in the vicinity of an active overhead crane, or by taking steps to prevent inadvertent movement of the crane by blocking the path of crane travel with means such as rail clamps or stops or similar devices.

The Secretary contends that Nutone violated the general duty clause because it did not ensure the scissors lift was not operated in the travel path of the crane. She notes that the manufacturer's instructions for operating the subject lift and the ANSI standard set out above prohibit using scissors lifts near moving vehicles or cranes. She also notes that besides having a work policy that would accomplish this prohibition, other means of eliminating the hazard would be to de-energize and lock out the crane or to prevent its movement by blocking its travel path. (Tr. 7-8; 155; 167-69).

⁷ The record shows that the lift platform was 16 feet from the ground and that it was the bridge of the crane, not the hook or cab, that struck the lift. (Tr. 133; 256-59; 266-67; C-21).

Nutone contends that the Secretary's citing it under the general duty clause is inappropriate because a specific standard applies in the circumstances of this case; Nutone points out that 29 C.F.R. 1910.179(i), the standard cited in withdrawn Item 3, states that a "gong or other effective warning signal shall be provided for each crane equipped with a power traveling mechanism." Nutone also contends that, even accepting the Secretary's theory under section 5(a)(1), the company had taken the steps necessary to prevent a collision between its crane and the lift. Finally, Nutone contends that there was no recognized hazard because the accident was a result of a combination of "extreme, bizarre, unforeseeable circumstances." (Tr. 20-21).

Whether the Alleged Violation of Section 5(a)(1) is Appropriate

As noted above, Nutone contends that the 5(a)(1) Citation is improper because a specific standard, 29 C.F.R. 1910.179(i), applies in this case. The Commission has held that "[c]itation to section 5(a)(1) is inappropriate if the hazard is addressed by a standard." *Daniel Int'l, Inc.*, 10 BNA OSHC 1556, 1558 (No. 78-4279, 1982). The Commission has also held, however, that a 5(a)(1) citation will not be vacated "where the hazards presented are interrelated and not entirely covered by any single standard" or "where a specific standard does not address the particular hazard for which the employer has been cited." *Ted Wilkerson, Inc.*, 9 BNA OSHC 2012, 2015 (No. 13390, 1981) (citations omitted). *See also Coleco Indus., Inc.*, 14 BNA OSHC 1961, 1966-67 (No. 84-546, 1991). The inquiry should determine (1) whether the hazard alleged is accurately described, (2) if so, whether the specific standard addresses the cited hazard, and (3) if not, was the employer aware of this fact and did it take proper measures to mitigate the hazard. *Int'l Union, UAW v. General Dynamics Land Sys. Div.*, 815 F.2d 1570, 1577 (D.C. Cir. 1987). For the reasons set out *infra*, I conclude the Secretary has misidentified the hazard and that 29 C.F.R. 1910.179(i) applies in this case.

The record in this case shows that the crane's alarm system consists of an audible alarm and a flashing light beacon on each side of the crane's cab; the system activates automatically when the crane moves in either direction along the tracks, and there is also a foot switch or button the operator can use to sound the alarm manually if the crane is stationary. (Tr. 108-09; 163-64). The record also shows that the crane's alarm is quite loud and that it can be heard throughout the warehouse and over the other noise in the warehouse; the three employees who testified in this regard were Mr. Allen,

Richard Hawk, the facility manager, and Scott Bosecker, who is in charge of the steel warehouse, and Mr. Bosecker, when discussing the alarm, specifically testified that “[y]ou can’t miss it.” (Tr. 79; 99; 225; 235; 264; 269). Their testimony is consistent with the videotape of the crane operating (C-20). The CO who conducted the inspection opined that the crane’s alarm might not be able to be heard in the polyphloisboian conditions within the warehouse. The CO’s testimony is rejected as speculative. Although she had seen the crane operate and had heard its alarm in a video another CO had taken, she conceded that she had not inspected the crane herself nor had she seen it operate in person.⁸ (Tr. 154; 164; 171; 175-76; 183).

The record establishes that the crane is usually operated for an hour and a half to two hours a day, on an intermittent basis, to take steel rolls off of delivery trucks, deposit them in the storage area and to move them to the far end of the overhead crane’s tracks for further movement by pallet and fork lift to other areas of the plant or to the punch press area as needed. (Tr. 110-13; 126-27; 267-68). The record also demonstrates that Mr. Bailey, the crane operator, had worked for Nutone for 33 years, that he had been a crane operator since the mid-nineties, and that a former operator had showed Mr. Bailey how to operate the crane. (Tr. 106-08). Mr. Bosecker, Mr. Bailey’s supervisor, testified that he considered Mr. Bailey a proficient crane operator and that he had never seen or heard of the crane operating without its alarm before the accident. (Tr. 269-70). Mr. Allen and Mr. Hawk also testified that they were unaware of this ever happening before, and Mr. Bailey himself testified that this was the only time he had disabled the crane’s alarm. (Tr. 100; 122; 225-26). Mr. Bailey further testified that he had done so because he had had a headache and the alarm was irritating to him, and he admitted that he was aware at the time that such action was against Nutone’s safety rules. (Tr. 119; 122-24).

Nutone has a work rule prohibiting the removal or bypassing of safety devices; that rule is number 6 of the company’s general safety rules. *See* C-8. Nutone held a plant-wide safety meeting in November 1998, at which time it distributed copies of the rules and discussed them; Nutone also posted the rules on bulletin boards throughout its facility. Mr. Bailey attended the November 1998 meeting. (Tr. 123; 274; 306-09; C-8; R-2; R-8). Nutone also has a safety committee team that

⁸ Another CO began the inspection but became ill, resulting in CO Barbara Marcum taking over the inspection. (Tr. 138).

conducts monthly safety inspections; the members are Nutone's safety director, the occupational nurses, three union representatives, and supervisors and floor workers from the various departments. The team has a checklist it uses, and it inspects each manufacturing area every month. The team members solicit input from employees during the inspections, and employees often bring up safety concerns with members on their own. The inspection results are summarized in a report that is given to the department supervisors so they can take appropriate action. The steel warehouse is included in the monthly inspections, and Mr. Bosecker, the supervisor of that warehouse and two others, testified that he visits the steel warehouse at least six times a day to ensure that work is being done properly and safely. (Tr. 270; 282-83; 302-05; R-14-15). Finally, Nutone has a progressive disciplinary system for safety infractions that includes verbal and written warnings, suspension and discharge; the record shows that from January 2000 through December 2002, there were 66 verbal warnings, 12 written warnings, 12 suspensions, and one discharge. (Tr. 271; 309-11; R-3). Mr. Bosecker testified he supervised Mr. Bailey and that his discharge was due to the disabling of the crane's alarm.⁹ He further testified he had disciplined Mr. Bailey three other times during this period; these were a verbal warning in March 2000, a one-day suspension in November 2000, and a written warning in April 2001, and none related to his operation of the crane. (Tr. 269-75; R-6-9).

In addition to the above, the record shows that maintenance employees had used the lift in the warehouse before, and in the travel path of the crane, to change light bulbs. (Tr. 293). The record also shows that employees who used Nutone's lifts were trained in the safe operation of the lifts, and Michael Ralston, the facilities engineer, testified about the training he had given Mr. Blessing on November 29, 2001.¹⁰ (Tr. 193-208; R-16-18). Among other things, the training requires the operator

⁹ Mr. Bosecker said he had discharged another employee, in 1998, for being suspended on an order picker without having a safety platform or a safety belt and lanyard. (Tr. 275; R-9).

¹⁰ Nutone had three scissors lifts at the facility, all of which were Skyjack lifts. (Tr. 206). Mr. Ralston developed part of the training materials himself, from manuals from Skyjack and other manufacturers, and a company named Perpetual Motion had developed the other training materials at Nutone's request. (Tr. 196-99; 205-06; 212; 314; R-17-18). Mr. Ralston's training session with Mr. Blessing, which was one on one, consisted of Mr. Ralston covering all of the written materials verbatim with Mr. Blessing and then giving him a written test; it also included completing an evaluation of the lift and hands-on training on the lift. Mr. Ralston characterized Mr. Blessing's performance on the test and on the lift as "excellent." Mr. Ralston also conducts yearly retraining

to perform a site evaluation before lift use; it also requires the operator to read and obey the warnings on the lift, to be aware of the work area, and to watch for low clearances, overhead obstructions and other equipment operating in the area.¹¹ (Tr. 200-01; 221-22; R-17, pp. 4, 36, 37, 43, 45; R-18, pp. 2-6). Mr. Blessing and Mr. Allen both testified they were trained in lift operation, and each said he had used the lift numerous times before the accident; further, both had been in the warehouse many times, and both were familiar with the crane.¹² (Tr. 53-56; 72-73; 78; 88-89; 93-94). Timothy Dodson, the maintenance supervisor who assigned Mr. Blessing and Mr. Allen the drain installation work, was familiar with Nutone's lift training. He testified that because of that training, and Mr. Blessing's experience in using the lift, no special instructions were required for operating the lift for the subject job. He also testified that while drain installation was not something maintenance employees would typically do, plumbing and piping were regular maintenance jobs; moreover, there was nothing about the job that presented an unusual hazard, such as working in a confined space or working with equipment or chemicals the employees had not used before.¹³ (Tr. 285-94).

With respect to the events just prior to the accident, Mr. Blessing and Mr. Allen testified that they noticed that Mr. Bailey was using the forklift, and that the crane was not in use, before going up in the lift the first time. The employees did not notice that Mr. Bailey was using the crane when they reentered the warehouse because the alarm was not sounding, and both were emphatic that if

for lift operators. (Tr. 193-208; 220-24).

¹¹ One of the warnings on the lift specifically prohibits using it near moving vehicles or cranes. (Tr. 27-36; 207-08; 222-23; C-1, p. 3, C-2, p. 3; C-18, p. 4; C-20; R-17, p. 36).

¹² Mr. Blessing had worked for Nutone since 1995, had been a machine repairman for about a year, and had used the lift over 20 times. Mr. Allen had worked for Nutone for 32 years, had been in maintenance for three years, and had used the lift "quite a few" times. (Tr. 46; 56; 76-77; 88). In addition, Mr. Allen had used the lift to change light bulbs in the warehouse in the travel path of the crane, although the crane had not been operating at the time, and Mr. Blessing had utilized the lift to work on a garage door in the warehouse. (Tr. 57; 73; 88-89).

¹³ Although Mr. Blessing testified that Mr. Dodson told him that the crane would not be operating that day, Mr. Dodson testified that he made no such statement and that he would not have had such information. (Tr. 51; 287). Further, Mr. Bosecker testified he told no one the crane would not be operating that day. (Tr. 275-76). Based on the record, Mr. Blessing's testimony in this regard is not credited. (Tr. 51; 187; 275-76).

it had been they would not have gone up in the lift then. (Tr. 61; 67-68; 72; 82-84; 95-100). Mr. Bailey did not indicate whether he had seen Mr. Blessing and Mr. Allen upon their first entry, but he did testify that he saw them when they reentered the warehouse. He was using the crane by then and was in the process of taking a roll of steel over to the drop-off point by the presses. When he saw the two employees, he stopped the crane so that they could walk on across. He then restarted the crane, dropped off the roll of steel, and proceeded to return the crane to its parking area at the opposite end of the crane tracks. Mr. Bailey testified that he first saw the lift when he began operating the crane, that it was in the “down” position then, and that he did not notice anyone or any equipment around it. He also testified that he saw the two employees walking over towards the lift after he had stopped and then restarted the crane. (Tr. 116-19; 127-31). Despite these observations, however, and despite the clear view from the front and both sides of the crane’s cab, Mr. Bailey failed to notice on the way back to the parking area that the lift with the two employees on it was raised directly in the path of the crane. Mr. Bailey admitted that he would have had a clear view of the lift and the employees “if he had been looking in that direction.” (Tr. 130-31). In view of this testimony, it is apparent that Mr. Bailey was not looking in the direction the crane was traveling until Mr. Allen shouted out a warning and that this fact, together with his disabling of the alarm, was the cause of the accident.¹⁴ This conclusion is bolstered by the testimony of Mr. Blessing and Mr. Allen that if they had heard the alarm when they reentered the warehouse they would not have gone up in the lift at that time. (Tr. 72; 100).

Turning to the propriety of the alleged 5(a)(1) violation, the Citation describes the hazard in this case as employees on the platform of an elevated scissors lift being exposed to being struck by the moving bridge crane. This description is, however, incomplete for the following reasons. For the hazard in this case to have existed, two things had to happen simultaneously. First, the lift had to be raised to a position within the travel path of the crane, and second, the crane had to be operating without an effective alarm. The employer’s means of preventing the hazard was the crane’s alarm which sounded automatically upon the crane being used, as well as appropriate employee training in lift operation, as discussed *supra*. The crane’s alarm, however, was disengaged at the time of the

¹⁴ The record shows that another problem was Mr. Bailey’s failure to use a “spotter” for the lifting and lowering operations. (Tr. 119-20; 130; 276-81).

accident, which eliminated the warning that clearly would have kept the employees from going up in the lift at that time. Moreover, when questioned in this regard, the CO herself conceded that if the alarm had been sounding and the employees had heard it they would have been alerted of the crane's presence. (Tr. 183). Thus, in the situation presented here, the actual hazard was the juxtaposition of employees being on an elevated lift within the travel path of a moving bridge crane that had an alarm which was not operating. Although the Secretary disputes that the alarm was a feasible means of abatement, her position is simply not supported by the record. I find, therefore, that the Secretary has misidentified the hazard in this case. I further conclude that citing the employer under section 5(a)(1) was inappropriate because a specific standard, 29 C.F.R. 1910.179(i), was applicable to the circumstances in this case.

As set out at the beginning of this decision, withdrawn Item 3 of the Citation alleged a violation of 29 C.F.R. 1910.179(i). The terms of the standard state that, except for floor-operated cranes, a "gong or other effective warning signal shall be provided for each crane equipped with a power traveling mechanism." I note that while Nutone's contention from the beginning has been that 1910.179(i) applies in this case, the Secretary did not actually dispute the applicability of the standard at the hearing; rather, she raises the argument for the first time in her post-hearing brief. I also note that the Secretary stated at the hearing that her withdrawal of Item 3 was due primarily to her "concern that Nutone might not ... have been aware that the alarm was disengaged by the crane operator the day of the accident." (Tr. 8). Regardless, the Secretary's assertion in her brief is that the standard's intent is to warn employees on the ground, thus allowing them to avoid being under an overhead load. She points out that floor-operated overhead cranes are specifically excluded from 1910.179(i); she also points out that an operator of such a crane walks alongside the load on the ground and uses a pendant hand control, thereby making a separate alarm system on the crane itself unnecessary.¹⁵ (S. Brief, pp. 15-16). Nutone, on the other hand, asserts that 1910.179(i) addresses both hazards, that of midair collisions and that of employees on the ground exposed to overhead loads. In this regard, Nutone notes that section 1910.179(n)(3)(xi) provides as follows:

¹⁵ The CO testified essentially to this effect at the hearing; however, her statements in this regard were in the context of her opinion that the alarm was not an acceptable abatement method. (Tr. 153; 175-76).

When starting the bridge *and* when the load or hook approaches near or over personnel, the warning signal shall be sounded.

(Emphasis added.)

Nutone urges that because 1910.179(n)(3)(xi) specifies two separate conditions under which an alarm must be sounded, that is, when the bridge is started and when the load or hook approaches near or over personnel, the alarm requirement is intended to cover both of the hazards set out above. (R. Brief, pp. 11-12). After considering the terms of the standard and the arguments of the parties, I conclude that Nutone's position is the more persuasive. The use of "and" establishes two independent conditions under which an appropriate alarm must sound. The first of these contemplates the very warning that was absent at the facility at the time of the accident and resulted in the platform being within the path of the silently moving crane's bridge. This conclusion is supported by the simple fact that compliance with the standard would have abated the hazard. In light of the meaning and intent of the standard, I conclude that it is applicable and thus must also conclude that Nutone was not in violation of section 5(a)(1) as set out in the Citation. The alleged violation is accordingly vacated.

Although the foregoing is sufficient to dispose of this matter, one further issue will be addressed. As indicated *supra*, the Secretary apparently withdrew Item 3, the item alleging a violation of 1910.179(i), because she realized that the employer was unaware of the crane operator's disabling of the alarm. Thus, the Secretary herself evidently recognized that, had she proceeded with Item 3, Nutone likely would have been able to prove unpreventable employee misconduct. The test for this affirmative defense in the Sixth Circuit, where this case arose, requires the employer to show that, due to the existence of a thorough and adequate safety program which is communicated and enforced as written, the conduct of its employee(s) in violating that policy was idiosyncratic and unforeseeable. *Brock v. L.E. Myers Co.*, 818 F.2d 1270, 1277 (6th Cir. 1987).

The evidence set out above shows that Nutone had a work rule prohibiting the removal or bypassing of safety devices and that that rule was one of the facility's 24 general safety rules. The evidence also shows that these rules were discussed in a plant-wide safety meeting held in November 1998, that Mr. Bailey attended that meeting, and that he was aware he was violating the safety rules

when he disabled the crane's alarm. Finally, the evidence shows that no one was aware of the alarm being disabled before, and Mr. Bailey testified that this was the only time he had done so.

In addition to the foregoing, the evidence shows that Nutone had a safety team that conducted safety inspections of the facility on a monthly basis; a checklist was used, employee input was solicited, and a summary of the inspection results was provided to supervisors so that any noted issues or problems could be addressed. The evidence further shows that Nutone had a progressive disciplinary system, consisting of verbal and written warnings, suspension and dismissal, and that Mr. Bailey was discharged from his position pursuant to the disciplinary system.

Based upon the evidence of record, I find that Nutone had a thorough and adequate safety program that was communicated and enforced as written.¹⁶ I further find that the conduct of Mr. Bailey in violating that policy was idiosyncratic and unforeseeable. Therefore, had the Secretary not withdrawn Item 3 of the Citation, it would have been vacated in any case due to the evidence establishing the affirmative defense of unpreventable employee misconduct.

¹⁶ This finding is supported by the training, discussed *supra*, given to employees who operated scissors lifts. This finding is also supported by the fact that Nutone had quarterly maintenance done on the crane, as well as an annual inspection performed by an outside contractor, to ensure that it was working properly. (Tr. 238-40; 259-60; C-10; R-10-13).

FINDINGS OF FACT

All findings of fact necessary for a determination of all relevant issues have been made above. Fed. R. Civ. P. 52(a). All proposed findings of fact and conclusions of law inconsistent with this decision are hereby denied.

CONCLUSIONS OF LAW

1. Respondent, Nutone, Inc., was, at all times pertinent hereto, an employer within the meaning of the Act.
2. The Commission has jurisdiction over the parties and the subject matter of this case.
3. Respondent was not in violation of section 5(a)(1) of the Act.
4. Respondent was not in violation of 29 C.F.R. § 1910.179(i).

ORDER

1. Citation 1, Items 1 and 2, alleging a single violation of section 5(a)(1) of the Act, are VACATED.
2. Citation 1, Item 3, is VACATED.

/s/

Michael H. Schoenfeld
Administrative Law Judge

Dated: August 11, 2003
Washington, D.C.