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. Praxair Distribution, Inc., Respondent.	OSHRC Docket No. **06-0977**

Appearances:

Janice L. Thompson, Esq., U.S. Department of Labor, Office of the Solicitor, Cleveland, Ohio
For Complainant

William S. Ross, Esq., Jeffrey L. Lauderdale, Esq., Calfee, Halter & Griswold, LLP, Cleveland, Ohio
For Respondent

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

DECISION AND ORDER

Praxair Distribution, Inc., (PDI) provides cylinder gases to customers such as welding fabrication shops and medical facilities. On December 14, 2005, PDI delivery driver Craig Thompson was delivering oxygen cylinders to the Veterans' Administration (VA) Medical Center in Cleveland, Ohio. Thompson was killed when the liftgate of the Praxair delivery truck suddenly fell, pinning his head against the loading dock.

Occupational Safety and Health Administration (OSHA) compliance officer Cynthia Evans conducted an investigation of the fatality. As a result of her investigation, the Secretary issued a citation to PDI on May 17, 2006, charging the company with a serious violation of § 5(a)(1) of the Occupational Safety and Health Act of 1970 (Act). She proposed a penalty of $ 4,500.00.

PDI contested the citation. The court held a three-day hearing in this proceeding on January 4 and 5, and February 12, 2007, in Cleveland, Ohio. Both parties have filed post-hearing briefs. PDI

asserted the affirmative defense of unpreventable employee misconduct in its answer, but did not pursue this defense at the hearing or in its post-hearing brief. PDI contends the Secretary failed to prove it knew the struck-by hazard created by the liftgate existed at the VA worksite.

The court determines the Secretary failed to establish PDI violated § 5(a)(1) as charged in this proceeding. Item 1 of Citation No. 1 is vacated.

Facts

PDI operates a number of facilities in the United States and Mexico. At its facility in North Royalton, Ohio, PDI packages and repackages oxygen, nitrogen, argon, carbon dioxide, and nitrous oxide, including custom mixtures of these gases.

PDI hired Craig Thompson as a driver and cylinder handler in June 2000, at its Canton, Ohio, facility. At that time, Thompson had 23 years of driving experience with Amerigas. In 2004, PDI transferred Thompson to its North Royalton facility. PDI assigned Thompson the "Case Western Reserve Run," which includes the VA Medical Center at issue.

PDI's delivery truck driven by Thompson was equipped with a liftgate manufactured by Ultron Lift Corporation. A hydraulic power unit provides power to two vertical hydraulic cylinders that raise and lower the liftgate platform.

On December 14, 2005, the VA Medical Center was Thompson's first scheduled stop of the day. Thompson arrived at the Medical Center's loading dock at approximately 7:12 a.m. The loading dock is equipped with a motion activated surveillance camera. The video from the camera shows 55 seconds elapsed between the time Thompson backed the delivery truck to the loading dock until the liftgate platform at the rear of the truck fell suddenly. Thompson's head was caught between the liftgate and the loading dock at the rear corner on the passenger side. The video does not show Thompson's actions once he exited the cab of the truck. There were no other employees present and no eyewitnesses. Thompson was found several minutes after the liftgate fell.

After medical personnel declared Thompson dead at the scene, the police notified PDI, who in turn called American Fleet Services (AFS). AFS repairs commercial vehicles. It has a service contract with PDI. AFS sent a vehicle to tow Thompson's delivery truck to AFS's yard. AFS towed the truck with the liftgate down in the horizontal position. Compliance officer Evans called AFS's general manager Lawrence Doyle and requested he keep all personnel clear of the truck until she

arrived to inspect it. When Evans arrived later that day, she asked Doyle to operate the liftgate. Doyle attempted to place it in its vertical (closed) position, but was unable to do so.

The Citation

The Secretary alleges PDI committed a serious violation of § 5(a)(1), the general duty clause. Section 5(a)(1) requires that each employer "[s]hall 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."

> In order to prove a violation of section 5(a)(1), the Secretary must show that a condition or activity in the workplace presented a hazard, that the employer or its industry recognized this 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 Corporation, 20 BNA OSHC 2001, 2007 (No. 93-0628, 2004). The Secretary must also show the cited employer had actual or constructive knowledge of the violative condition. *Precision Concrete Construction,* 19 BNA OSHC 1404, 1406 (No. 99-070, 2001).

The citation states:

> 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 being struck by the truck's lift gate:
>
> On 12/14/05, a delivery truck driver was preparing to unload gas cylinders from the rear of the truck. The driver was operating the control switches at the right side of the truck. The employee entered the area between the dock and the rear of the truck, at the right-hand corner of the truck. The lift gate "free-fell," fatally injuring the employee as it struck his head.
>
> Among other methods, feasible means of controlling/correcting the hazard are:
>
> 1) Take steps to prevent the lift gate from "free-falling" and to prevent the safety chains from catching on the brackets of the lift gate's top rail.
>
> 2) Establish a program for training employees in the proper and safe use of lift gates, including specific training on staying clear of the area where the platform opens.
>
> 3) Follow the lift gate manufacturer's Operator Manual for operating instructions and recommendations on maintenance and inspections.

4) Ensure the modifications to the lift gate are made in accordance with the manufacturer's recommendation so as not to compromise the integrity of the lift gate's construction or performance.

1. Did a Hazard Exist?

The first element of a § 5(a)(1) violation the Secretary must establish is that a condition or activity in the workplace presented a hazard. The hazard identified by the Secretary is "being struck by the truck's lift gate." This case resulted from the tragic death of Craig Thompson caused by his being struck on the head by the truck's lift gate. The Secretary has established the first element.

2. Was the Hazard Recognized?

The second element the Secretary must establish is that PDI or its industry recognized the hazard of being struck by the truck's lift gate. The Secretary argues PDI recognized th hazard based on a nonfatal incident in 2004, when another PDI employee was struck by a falling lift gate, and on a 2004 toolbox meeting document that warns employees about the dangers of falling lift gates (Exh. R-23).

PDI counters with the following argument regarding its recognition of the hazard (PDI's brief, p. 20, emphasis in original):

> At trial, the Secretary presented at least a colorable case of a "struck by" hazard in the delivery truck industry with respect to employees placing themselves beneath their liftgates. However, the Secretary, to the extent she was able to establish the existence of such a hazard, succeeded only in establishing that the hazard existed when the liftgate was in an *unsecured* position. The Secretary did not establish that the hazard existed when the liftgate was in its travel locks, in a secured position. . . . [A]t best, the Secretary has presented evidence only to support a finding of a recognized hazard with respect to employees placing themselves beneath *unsecured* liftgates.

PDI goes on to assert (PDI's brief, p. 21, emphasis in original):

> Although, for purposes of this Brief, Praxair does not dispute that the Secretary has identified a recognized hazard in the delivery truck industry with respect to a "struck by" hazard associated with drivers placing themselves beneath unsecured liftgates, the Secretary wholly has failed to establish that the recognized hazard at issue existed at *any* of Praxair's facilities.

PDI speaks in terms of a "recognized hazard," but the company is really arguing its employees were not exposed to the recognized hazard that exists, because the employees knew not to place themselves within the zone of a falling liftgate. In essence, PDI is arguing that it recognizes the hazard's existence, but its employees know how to avoid it.

PDI concedes the Secretary presented a "colorable case" and "does not dispute that the Secretary has identified a recognized hazard in the delivery truck industry with respect to a 'struck by' hazard" created by liftgates. Based on the record and PDI's concessions, it is determined the Secretary established being struck by an unsecured falling liftgate is a recognized hazard.

3. Was the Hazard Likely to Cause Death or Serious Physical Harm?

The hazard in the instant case caused the death of Craig Thompson. This element is proven.

4. Does a Feasible and Effective Means Exist to Eliminate or Materially Reduce the Hazard?

The Secretary proposed four methods for controlling or correcting the hazard of being struck by a falling liftgate**.** Of the four methods, only the second–training employees to stay clear of the area where the platform opens–is relevant to the hazard at issue. The other three methods address the detection and correction of mechanical failures of the liftgate, but do not address the hazard of employee exposure to the struck by hazard.

The methods recommended by the Secretary are:

1) Take steps to prevent the lift gate from "free-falling" and to prevent the safety chains from catching on the brackets of the lift gate's top rail.

The Secretary elicited testimony from several of the witnesses that from time to time the safety chains caught on the bracket of the liftgate's top rail, preventing the liftgate from opening. It was the Secretary's theory that employees would go behind the truck when this occurred, placing themselves in the zone of danger if the liftgate fell. The employee witnesses, however, testified they knew not to go behind the truck when the chains got caught. When asked if he would go behind the truck, delivery driver William Wamser responded, "Behind it? No. I got to the side and I, like, you know–for what I do in all the years, I never got right behind it. And I was leery about sticking my

head back over there too, and I wouldn't do it" (Tr. 173). Delivery driver Victor Yacaprara testified that when the chains on his truck got caught, he would look behind the truck "[m]aybe a little bit, but I never actually got behind the gate. . .[b]ecause of the risk" (Tr. 203). When the chains were caught, Yacaprara stated, "Usually, I would reclose the gate and try it again, and usually that would solve the problem" (Tr. 203).

There is no evidence that the safety chains on Thompson's truck got caught the day of his death, or that he went behind the truck because of caught chains. J. Robert Sims, Jr., a mechanical engineering consultant for Becht Engineering, was qualified at the hearing as an expert in technical failure analysis. Sims testified that even if the safety chains caught on the bracket of the liftgate, this event would not have caused the liftgate to free fall. After Thompson's death, Praxair removed the safety chains from the liftgates on trucks at its North Royalton facility and painted the liftgate railings fluorescent orange for greater visibility.

2) Establish a program for training employees in the proper and safe use of lift gates, including specific training on staying clear of the area where the platform opens.

Praxair had implemented an employee safety training program, with specific training for delivery drivers, before Thompson's fatal accident. Praxair held regularly scheduled orientation and refresher training, including a mandatory "Safety Commitment Day," when employees cease their regular duties and attend training. Praxair issues safety alerts and "Technical Operation Bulletins" (TOBs) in response to specific situations that may arise. Praxair also issues Toolbox Meeting documents for pre-shift briefings on selected topics.

In June 2004, Praxair published a Toolbox Meeting document on "Liftgates and Other 'At Risk' Behaviors" (Exh. R-23). The North Royalton facility held a meeting on this topic on June 19, 2004, attended by Thompson. The document states in pertinent part (Exh. R-23, p.2; emphasis in original):

- **Do not walk under a liftgate when it is in the up position, allow room between yourself and the rear of the truck**
- **Hydraulic Systems do not always fail in slow motion!**
- **Do not operate the liftgate while standing under it, always stand to the side**
- **Do not work on a liftgate without taking proper safety precautions**

The record establishes Praxair did have a training program in place instructing employees in the safe use of liftgates. Wamser testified it was "common sense" not to go behind the truck (Tr. 179). One of the photographs of Thompson at the scene of the accident includes a sign on the side of the truck next to the liftgate. The sign shows a pictogram of a human figure being struck on the head by a falling liftgate. Next to the pictogram is the phrase "WARNING Keep people clear of liftgate while operating" (Sealed Exh. C-5).

3) Follow the lift gate manufacturer's Operator Manual for operating instructions and recommendations on maintenance and inspections.

It was not Praxair's practice to give the drivers a copy of the operator's manual. The manual sets forth steps in a daily inspection of the liftgate and provides a sample daily checklist. The checklist includes the operation of the liftgate to see if it is in working order.

A delivery driver for Praxair began each day with an inspection of his truck, and completion of a Vehicle Inspection Report (VIR). Any defects in the liftgate were to be recorded under the section labeled "tailgate and other equipment." Wamser testified that, as part of the pretrip inspection, he generally operated the liftgate. There were occasions when he was unable to do this because the trucks were parked too close to one another. Thompson did not have this problem because he was always the first driver out and parked his truck away from the others.

4) Ensure the modifications to the lift gate are made in accordance with the manufacturer's recommendation so as not to compromise the integrity of the lift gate's construction or performance.

Following Thompson's death, AFS conducted a field service retrofit procedure prescribed by Ultron to fix the right-hand slider rail. AFS removed the cylinder mounting bracket and designed a new one.

Employer Knowledge

The Secretary contends Praxair had constructive knowledge that, on the occasions when the safety chains got caught on the bracket, the delivery drivers "were sticking their heads behind the liftgate during its operation" (Secretary's brief, p. 14). The problem with the Secretary's theory is that no evidence exists in the record that drivers were, in fact, doing this.

The Secretary states at least twice in her brief that the liftgate controls were 12 to 18 inches from the rear of the truck (Secretary's brief, pp. 4, 14). While Yacaprara stated the controls are

located "within a foot of the back of the truck" (Tr. 211), Praxair driver supervisor James Williams testified the controls were actually 2 feet from the rear of the truck (Tr. 508), and delivery driver Wamser corroborated this estimate (Tr. 193).

The normal procedure for a driver making a delivery is to exit the truck, walk to the front of the truck to chock the wheels, and then go to the rear passenger side where the liftgate controls are located. An experienced driver can usually complete these steps in 20 to 30 seconds.

The driver activates the Ultron liftgate by turning on the liftgate master switch and the amber warning lights from inside the truck. The liftgate controls on the outside of the truck consist of two toggle switches. The UP/DOWN toggle switch raises the liftgate platform until the travel ear clears the travel locks. The operator then unfolds the liftgate platform by positioning the lower toggle switch to the UP position and simultaneously positioning the upper toggle to the LEFT or OPEN position. Once unfolded, the platform is lowered to the ground by positioning the lower toggle switch to the DOWN position.

The Secretary argues that when the safety chains got hung up on the bracket, the driver could operate the toggle switches with one hand while sticking his head around the corner of the truck. When Yacaprara was asked if he could do this, he responded, "Theoretically, a big guy with a long reach, yes," but stated he had never done so (Tr. 212). Wamser, who was at pains to deny he received any training to stay clear of the rear of the truck, gave this testimony (Tr. 193-194):

> Q: Do you need one hand or two hands to operate those lifts?
> Wamser: I can use one hand, yes.
> Q: Could you be some way behind part of that liftgate while you're operating the controls?
> Wamser: Well, where the controls are positioned on my truck, behind it? No.
> Q: Okay.
> Wamser: But, we're trained that this was a - - well, I've always done this anyway - - I mean, I've done this. I don't want to say, "trained," we weren't trained; but I mean, it's always been to keep people clear, and on the truck that I drive where my controls are, I had mentioned this where the control are on the side of the truck, I have to go like this (demonstrating) to make sure nobody is coming around the other side of the truck I don't let that liftgate down on them.
> Q: So, you peer around the back of the truck?
> Wamser: You would have to go like this (demonstrating).

Q: Lean out?
Wamser: To lean back but not toward the liftgate but you have to go like this.
Q: You can't get your head around the back of the truck.
Wamser: Not from where the controls are, no, I don't think you can get your head back there.

AFS general manager Doyle also testified on this point (Tr. 145-147):

Q: Now, can the controls on the side of the truck be operated by somebody who is standing behind the truck, reaching around?
Doyle: No.
Q: Why is that?
Doyle: The normal human being cannot reach those switches. Nobody has an arm long enough to reach those switches to manipulate them and get them out of the back of the truck at the same time.
Q: Now, the switches would be operated with one hand or two hands?
Doyle: It depends on the dexterity of the individual and the climate. For example, when you're wearing cumbersome work gloves and it's cold outside, it's extremely difficult at best to manipulate two switches at the same time with one hand.
Q: Do you know what the weather was on the day of the incident?
Doyle: I know it was cold. I don't have the specifies but it was cold.
Q: Let's say it's not cold - - just a hypothetical - - let's say I stand behind this truck and reach on the side of the thing that's running the controls.
Doyle: I don't believe you could.
Q: Once you stop running the controls - - let's say you stopped running the controls, and walked around behind the truck, the truck is supposed to stop into position?
Doyle: The liftgate will stop moving because - - when you turn on a light switch in a room, the lights stay on until you turn the switch off.
Q: It's like a deadman switch? You let go of the thing - -
Doyle: Correct , a momentary switch. It will only energize the circuit as long as you are holding it in that position. As soon as you release it, it will go into the neutral position and it stops the current flow.
Q: But, it's not necessarily secure that way?
Doyle: No.

By design, the liftgate controls are located on the side of the truck, 12 inches to 24 inches from the rear of the truck body. The control switches are designed to energize the circuit only while

the two switches are held in the "on" position. When the switches are released, the electrical current flow stops and the movement of the liftgate immediately stops. The totality of the evidence establishes that it is virtually impossible for the operator to enter the area behind the truck while the liftgate is operating or moving.

This operator was wearing heavy work gloves as shown in the photographs of the accident scene (sealed Exh. C-5). All evidence at the hearing establishes that an operator wearing such gloves could operate the controls only by using both hands. He could not operate the controls with one hand and, simultaneously place his head or any other part of this body behind the liftgate. The photographs also show the entire body of the operator behind the liftgate next to the dock. After careful review of this evidence, the only logical inference is that Thompson did not have one hand on the controls when the liftgate fell.

Thompson, the driver and operator of the controls, was the only individual in the area. For him to go behind the liftgate while it was being lowered was implausible, if not impossible, and such conduct could not have been foreseen by respondent.

The Secretary insists Thompson's death resulted from his sticking his head around the corner of the truck while he was operating the liftgate switches on the side of the truck. This is speculative and not supported by the evidence. Constructive knowledge of a hazardous condition cannot be imputed to an employer if there is no proof the condition existed.

The Secretary has failed to prove any Praxair employee was operating the liftgate switches with one hand while reaching his head around the corner. Because this is the theory of her case, failure to prove this activity necessarily means she has failed to prove PDI had knowledge of it.

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 hereby ORDERED that:

Item 1 of Citation No. 1, alleging a violation of § 5(a)(1), is vacated, and no penalty is assessed.

/s/
STEPHEN J. SIMKO, JR.
Judge

Date: July 2, 2007