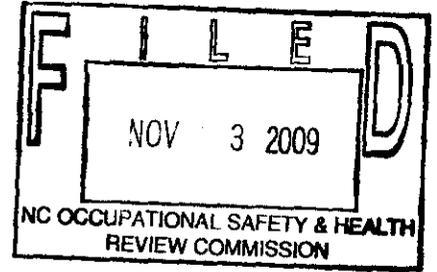


BEFORE THE NORTH CAROLINA OCCUPATIONAL SAFETY AND HEALTH  
REVIEW COMMISSION

RALEIGH, NORTH CAROLINA



COMMISSIONER OF LABOR FOR )  
THE STATE OF NORTH CAROLINA )  
 )  
COMPLAINANT, )  
 )  
v. )  
 )  
MECKLENBURG COUNTY PARKS )  
& RECREATION DEPARMENT, )  
 )  
RESPONDENT. )  
\_\_\_\_\_ )

ORDER

OSHANC NO. 2008-4820  
INSPECTION NO. 312387533  
CSHO ID NO. c1964

THIS MATTER was heard by the undersigned on June 16 and June 17 in Charlotte, North Carolina.

The complainant was represented by Newton G. Pritchett, Jr, Assistant Attorney General; respondent was represented by Philip M. VanHoy.

After hearing and receiving the evidence, and reviewing the transcript of the hearing and the post hearing briefs of the parties, the undersigned makes the following

**FINDINGS OF FACT**

1. The complainant as Commissioner of Labor of the State of North Carolina is charged by law with the responsibility for compliance with and enforcement of the provisions of the Occupational Safety and Health Act of North Carolina (the "Act").

2. The respondent is a department of Mecklenburg County, North Carolina. The respondent (not the entire County) has approximately 500 full time and 200 part time employees.

3. On June 16, 2008, complainant's Safety Compliance Officer Lori Kees conducted a fatality inspection at respondent's office and maintenance facility located at 1203 Allegheny Street in Charlotte, North Carolina.

4. This inspection was occasioned by the death of Warren Tinner, one of respondent's maintenance technicians, while Mr. Tinner was working at the maintenance facility on June 13, 2008.

5. The overall facility at 1203 Allegheny Street consists of approximately 2.5 acres of land upon which sits a 6,000 square foot "Butler" building of metal and masonry, with a storage yard and parking and other improvements. The building is divided into approximately 2,000 square feet of finished offices and 4,000 square feet of warehouse style storage for hand equipment, materials and supplies. This storage area also contained a 12 foot high cage divided into two areas for storage of tools, materials and supplies for two of the respondent's maintenance districts.

6. (Maintenance) District 1's portion of the cage is on the backside of the building. It contains industrial metal shelving on which materials and supplies are stored. In one area the shelving contained a bottom shelf approximately 3 feet off the ground and a top shelf about 7 feet 8 inches off the ground. These shelves were about 8 feet long and 3.5 feet deep.

7. The respondent supplied a Warner portable fiberglass extension ladder in this cage for use by respondent's employees to help access the upper shelving. When fully extended, the ladder reaches 20 feet; when fully compressed the ladder is 10 feet, 4 inches long.

8. Immediately before Mr. Tinner's death, he was using the ladder to access a large box of toilet tissue that was located on the 7 foot, 8 inch shelf. He apparently was able to access this shelf and the bathroom tissue box from this ladder and had thrown both some contents initially and then the box itself to the concrete floor below.

9. At that point, when Mr. Tinner was on the ladder and was to return down the ladder to the warehouse floor, the exact facts become unclear. It is unknown a) what the exact location was of the ladder, b) where Mr. Tinner was on the ladder at that point, c) what his physiological condition was, d) what caused Mr. Tinner to be unable to dismount the ladder as he mounted it, and e) the exact path Mr. Tinner's body took as it went from its final position relative to the ladder to his position on the concrete floor of respondent's warehouse facility. It is also unknown whether Mr. Tinner was conscious when he fell from the ladder.

10. At the time that Mr. Tinner was involved with the ladder on the day of his death, fellow worker Deborah McGrant was in the cage with him and was a witness to some of the events leading up to his death. She did not serve as a spotter for Mr. Tinner when he was on the ladder.

11. Ms. McGrant testified that at her request Mr. Tinner climbed the ladder to retrieve a box of toilet tissue. She said he actually went on the shelf to get control of the toilet tissue box. However, the size of the box relative to the depth of the shelf should

have allowed him to reach the box from the ladder. The height above the shelf to the top of the cage was 4 feet, 1 inch, which height would not allow Mr. Tinner to stand up.

12. Ms. McGrant further testified that Mr. Tinner had his left foot on the ladder and his right foot dangling at the time that the ladder slid to the left. Mr. Tinner fell to the floor on his face, with his arms at his sides and his hands turned with palms up behind him. The ladder did not fall, but remained standing.

13. After Mr. Tinner was on the floor, he made some groaning noises, but was unconscious when the emergency workers arrived. He died at the hospital on June 14, 2008. No autopsy was performed.

14. When Ms. Kees conducted her inspection, she was told that the ladder utilized by Mr. Tinner had been set up in the position the ladder was in when Mr. Tinner climbed it earlier that day. She took measurements, which indicated that the base of the ladder was 4 feet, 5 inches from the base of the shelf. The end of the ladder extended 1 foot, 6 inches above the ledge on the top shelf. This made the angle of declination approximately 60 degrees.

15. The fiberglass extension ladder was fully compressed and not extended. The ladder carried a manufacturer's label that showed a drawing of the recommended proper angle for upright usage of the ladder.

16. There is no OSHA standard governing the use of portable fiberglass ladders such as this ladder. There is an ANSI standard (A14.5) which addresses portable non self supporting ladders. The ANSI standard uses the word "should" in setting forth a recommendation of 75 ½ degrees as the proper angle of declination for a ladder in use.

17. Ms. Kees testified that the effect of an improper angle of declination would be to increase the likelihood that the ladder would slip.

18. There was conflicting testimony among respondent's employees as to the frequency of use of the ladder to access supplies on the upper shelves. Penni Franklin, a supervisor and Sharika Lawhorn both testified that use of the ladder was very infrequent, which Deborah McGrant testified to more frequent use. Greg Clemmer, the manager of the facility, was aware that the employees used the ladder to obtain supplies and that sometimes an employee was required to get on an upper shelf.

19. Ms. Lawhorn indicated to respondent that she had fallen from the ladder approximately two weeks before Mr. Tinner's death but she did not inform anyone in respondent's management until after Mr. Tinner's death. The respondent's personnel policy requires immediate reporting of any workplace accident or injury, which policy Ms. Lawhorn was aware of.

20. On April 16, 2008, Mr. Tinner, Ms. Lawhorn and Ms. McGrant had received formal training from the respondent in ladder safety, which included usage of

the ladder to access supplies from an upper shelf. They had all been trained in the use of a spotter at the base of the ladder.

21. The respondent engages an outside safety consultant named Debra Rogers-Lowery. Since 1998, through her firm Compliance Training Associates, Inc., she has provided safety consultative services and safety training to the respondent and other clients. She is known by many of respondent's employees as the "Safety Lady". She provided for the ladder safety training which Mr. Tinner attended and communicated with him directly on an unrelated safety issue which he raised with her before his death.

22. The respondent has a written safety program, which includes a policy on fall protection and safety standard, which includes a section on ladder safety. Usage of a ladder to access upper level shelves is covered by this policy. Training is provided annually pursuant to this policy.

23. The respondent has an active safety committee which is chaired by Ms. Rogers-Lowery and includes management and non-supervisory employees.

24. The respondent has utilized the complainant's OSHA Division's Consultative Services from time to time, and has been complimented by that Division on the effectiveness of respondent's safety program.

25. The complainant has conducted inspections of other of respondent's facilities for safety or health matters and has identified no hazards necessitating issuance of a citation.

26. In May, 2008, the respondent was recognized and accepted into the OSHA Division's public sector Star Program by the complainant, which Program recognizes safety excellence and employee participation, based on a comprehensive evaluation of the respondent's safety program and practices.

27. As a result of her investigation into the death of Mr. Tinner, Ms. Kees recommended that respondent be cited because it failed to provide safe access to its storage area. Because no specific standard of the Act was applicable, the complainant cited the respondent with a violation of the General Duty Clause, codified as N.C. Gen. Stat. §95-129(1), which reads as follows:

Each employer shall furnish to each of his employees conditions of employment and a place of employment free from recognized hazards that are causing or likely to cause death or serious injury or serious physical harm to his employees.

28. The respondent timely contested this citation.

Based on the foregoing Findings of Fact, the undersigned makes the following

## CONCLUSIONS OF LAW

1. The foregoing Findings of Fact are incorporated by reference as Conclusions of Law to the extent necessary to give effect to the provisions of this Order.
2. The respondent is subject to the provisions of the Act.
3. The complainant has failed to prove by the greater weight of the evidence a violation of the General Duty Clause (N.C. Gen. Stat. §95-129(1)).

## DISCUSSION

Despite there being some physical evidence and a partial eyewitness account, it is fair to say that, based on the evidence presented, no one on this earth knows what caused Warren Tinner to fall to his death. That said, it would be inappropriate to find that Mr. Tinner's own misconduct caused his death, as suggested by the isolated instance of employee misconduct defense. The evidence indicates that he was a safe and conscientious employee. Likewise, it would be inappropriate to find that Mr. Tinner's death was caused by a violation of the General Duty Clause by the respondent. Use of an extension ladder to retrieve supplies from a shelf is not *ipso facto* a recognized hazard likely to cause serious harm to an employee. Moreover, the respondent has a demonstrated (and recognized) record of employee safety, including the matter of ladder safety, that militates against the existence of a known hazard that has not been addressed in its safety program and practices. The burden of proof is on the complainant to establish the cause of the accident in order to show noncompliance with the Act. *See, Brooks v Cole Manufacturing Company*, 1 NCOSHD 362 (1978), *affirmed* R.B. 1979.

While there is a certain logic in workplace safety that would suggest that any workplace injury (and particularly a fatality) indicates a lapse or failure in workplace safety by that employer, common sense and the understanding of workplace reality indicate otherwise. Whether it be called "Murphy's Law" or something more prosaic such as "accidents happen", a person can be killed on the job through no fault on his part and no fault on the part of the employer. While such a situation is nonetheless tragic for the worker, his family, friends and colleagues, it does not necessarily create a violation of the General Duty Clause.

## DECISION

Based on the foregoing Findings of Fact, Conclusions of Law and Discussion, IT IS ORDERED that the citation in this matter be DISMISSED.

This 30<sup>th</sup> day of October, 2009.

  
\_\_\_\_\_  
RICHARD M. KOCH  
HEARING EXAMINER