FOR IMMEDIATE RELEASE
MONDAY, FEBRUARY 27, 2012

DOI AND DOB ISSUE FINDINGS IN INVESTIGATION OF FATAL ELEVATOR INCIDENT AT 285 MADISON AVE.

ROSE GILL HEARN, Commissioner of the New York City Department of Investigation (“DOI”), and ROBERT D. LIMANDRI, Commissioner of the New York City Department of Buildings, issued their agencies’ findings in the investigation into the December 14, 2011 elevator incident at 285 Madison Ave. in which an elevator accelerated upwards from the lobby with its doors open, fatally injuring a 41-year-old woman attempting to step into the elevator.

DOI and DOB conducted a joint investigation. Investigators interviewed Transel Elevator, Inc. employees who worked on several elevators at the building, including the elevator involved in the incident, and reviewed video footage of the lobby and of the 12th floor, where some of the work was performed. In addition, DOB conducted a series of inspections and tests of the elevators at the building to determine the cause of the incident. DOI and DOB have referred their investigative findings to the office of New York County District Attorney Cyrus R. Vance, Jr. Copies of the agencies’ reports can be found at the following link:

The joint investigation found:

• Witness testimony and other evidence support the finding of a forensic examination that the safety circuit was bypassed on elevator 9, the one involved in the fatality, allowing the elevator to accelerate upwards with its doors open.

• Workers from Transel Elevator failed to follow basic safety procedures before the incident, such as placing caution tape across the elevator’s door jamb, and notifying DOB to inspect the elevators before putting them back in service, as required by the New York City Building Code.

As a result of Transel’s safety failures, DOB today suspended the Private Elevator Agency Director’s license of John Fichera, Transel’s owner, and will seek to revoke his license at an administrative hearing. The suspension prevents the company from performing any elevator upgrades, new installations, or inspections in the City pending the appointment of a new license holder. In addition, DOB has already issued 23 violations, with a minimum penalty of $117,000, to Transel, including violations for operating elevator 9 without a certificate of compliance.

DOI Commissioner Rose Gill Hearn said, “The investigation starkly showed elevator safety protocols were ignored. Investigators deconstructed the incident second-by-second to understand what went wrong. These findings are a caution to all licensed building professionals in the City, especially those in the elevator industry: City regulations safeguard New Yorkers and must be followed at all times.”

DOB Commissioner Robert D. LiMandri said, “These workers and their supervisors failed to follow the most basic safety procedures, and their carelessness cost a woman her life. New Yorkers who commute to work each day must rely on workers to maintain our buildings in a safe manner at all times, and these employees betrayed that public trust. Failing to post warning signs about the work and allowing this elevator back into service without proper safeguards are clear violations of the Building Code and their blatant disregard for the law and public safety is inexcusable. If these safety measures were in place, this tragedy would have been prevented.”
During the two-month investigation, DOB inspectors performed a series of inspections and tests on elevator 9 and its parts, including the controller or circuit wiring, motor, brake, traveling cables, and interlocking devices that control the elevator cab doors and the hoistway doors that open on the lobby floor. With assistance from consultant Lerch Bates, Inc., of Maplewood, N.J., inspectors conducted a mechanical recreation of the incident at 285 Madison Ave., while reviewing Transel Elevator records, surveillance video footage and the history of the elevator device. No program failure, brake failure, power surge, or faulty wiring is believed to have played a role in the incident.

The joint investigation found that interviews of the Transel workers, video security footage, wires found in the elevator control room, and a wire provided to investigators by a Transel mechanic support the conclusion of the forensic examination that the safety circuit on the elevator was apparently bypassed at the time of the fatal incident, allowing the car to move with its doors open. Witnesses testified that an elevator mechanic was using a “jumper” wire the morning of the incident to bypass the safety circuits and move certain elevators, including elevator 9, so workers could gain access to the tops of the elevator cabs. The use of a “jumper” wire is commonplace during maintenance and repairs and is acceptable by industry standards and DOB regulations, but it must be removed before the elevator is put back into service to avoid an unsafe condition.

The video security footage from the lobby shows that seconds before the victim attempted to enter elevator 9, two passengers entered the elevator and pressed call buttons, which would have prompted the cab to move to a higher floor. The elevator rose with the doors open, which DOB and its consultant determined is indicative of a “jumper” wire being used in the control room to bypass the door locks.

DOB has inspected all 13 elevators at 285 Madison Ave., and as of today 11 of them are safe, with two, including elevator 9, remaining out of service. A total of 34 Environmental Control Board (“ECB”) violations have been issued, 11 to the property owner, Young and Rubicam, and 23 to Transel Elevator.

In the weeks following the fatal incident, DOB inspectors conducted the largest safety sweep of elevators in the history of the Buildings Department. The accident elevator was undergoing work related to a periodic test required every five years, and as a result, the citywide sweep focused on other elevator devices with recent work applications and outstanding periodic tests. During the three-week sweep, inspectors performed inspections of 658 elevators at 169 buildings throughout the City. Of the 658 elevators, 370 were serviced by Transel Elevator, who received 71 ECB violations out of a total of 135 issued. No conditions related to the fatal incident were found by inspectors during the sweep.
February 27, 2012

Commissioner Robert LiMandri
New York City Department of Buildings
280 Broadway
New York, New York 10007

Re: 285 Madison Avenue, NY, NY
Fatal Elevator Incident

Dear Commissioner LiMandri:

The New York City Department of Investigation ("DOI") recently completed an investigation conducted in conjunction with the New York City Department of Buildings ("DOB") relating to the fatal elevator incident that occurred on December 14, 2011 at 285 Madison Avenue in Manhattan.¹

The information discussed below details the investigative findings regarding the facts and circumstances relating to the fatal elevator incident.

I. Introduction

On December 14, 2011, at approximately 9:56 a.m., a fatal elevator incident occurred at 285 Madison Avenue, Manhattan. At that time, Suzanne Hart, a 41-year old employee at Y&R (formerly Young & Rubicam) who worked at the building, attempted to enter elevator number 9, which was stationary in the lobby with two passengers inside, and its doors fully open.² Just as Hart entered the elevator cab’s doorway, the elevator accelerated upwards while its doors were still open. The moving elevator struck Hart at approximately knee level causing her to fall forward into the elevator cab. The

¹ During the course of the investigation, DOB retained the consultant Lerch Bates, Inc. to assist in the forensic investigation of the cause of the fatal elevator incident. In addition to DOI and DOB, the New York City Police Department ("NYPD") and the federal Occupational Safety & Health Administration ("OSHA") also participated in aspects of the investigation.

² 285 Madison Avenue is a 27-story building that was built in 1926. The elevator system in the building consists of a high-rise bank of six elevators (#s 1-6) and a low-rise bank of six elevators (#s 7-12). The low-rise bank of elevators services floors 1-12 with the high-rise bank of elevators serving floors 13-25.
elevator cab continued to move upward, trapping Hart between the elevator door saddle and the hoist way wall. The elevator cab came to a stop approximately 20 feet above the lobby landing sill. Hart subsequently died of her injuries at the scene of the incident.

On the morning of the incident, seven employees of Transel Elevator, Inc. ("Transel") were present at 285 Madison Avenue to work on the low-rise bank of elevators, including the number 9 elevator. Transel mechanics worked on elevator number 9 from approximately 9:25 a.m. until several minutes before the incident occurred.

Following the incident, DOI and DOB jointly reviewed camera footage from 285 Madison Avenue and conducted initial interviews of the Transel employees at the scene of the fatality. Those Transel employees were subsequently re-interviewed at DOI under oath. DOI and DOB also interviewed John Fichera, Transel’s owner and a DOB-licensed Private Agency Elevator Director, who was not present at 285 Madison Avenue at the time of the incident. In addition, DOB commenced a post-incident inspection and forensic examination of elevator number 9.

II. Review of Security Camera Video from 285 Madison Avenue

DOI reviewed numerous hours of video footage recorded at 285 Madison Avenue on December 14, 2011. Specifically, DOI’s review focused on the time period of 5:09 a.m., when Transel workers first arrived at the building, through 9:56:50 a.m., when Ms. Hart was fatally struck by elevator number 9. Below is a timeline of relevant video footage viewed with the approximate times and includes details from relevant witness testimony provided to DOI:

5:09 a.m.: Transel employees, Andrea Cammisuli and Thomas Moran arrived at 285 Madison Avenue. On the day of the incident, Cammisuli and Moran were working as “Adjusters” assigned to replace the 14th floor elevator control panel computer chips, also known as EPROMs.

7:12 a.m.: Transel Mechanic Efrain Cardona and Apprentice-Helper Jason Torzilli arrived at 285 Madison Avenue. Cardona and Torzilli were part of a Transel team who were to perform a governor recalibration of the low-rise elevators. The purpose of this recalibration was to modify the governor tripping speed so that the elevator would travel at a lower speed.

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3 Transel had been hired by Cushman & Wakefield, the building management company, to perform upgrade work for the building under DOB filing EBN 1328/11. According to EBN 1328/11, the description of the work to be performed was “reduce car speed from 600 FPM (Feet Per Minute) to 500 FPM” for the low-rise elevator bank cars. This upgrade was required to ensure that the building would pass the NYC Building Code category 5 safety test. John Fichera, Senior Vice President of Transel was the applicant of record for this filing.

4 During the investigation, DOI obtained copies of recordings from 285 Madison Avenue’s security video surveillance system from the lobby and other floors. DOI’s review focused primarily on footage from the lobby and the 12th floor where Transel workers accessed the low-rise elevators in which they conducted work. It should be noted that 285 Madison Avenue’s security camera system was not time-accurately synchronized on the day of the incident from floor to floor and were different from floor to floor by approximately one minute. Therefore, the times noted herein are approximate and reflect the time stamp on each relevant video portion reviewed during the investigation.

5 The control panel computer chips are located in the motor room on the 14th floor. The motor room is a utility room that houses the elevator motors and control panels that operate the elevator. There are no security cameras in the 14th floor motor room.
7:44 a.m.: Transel Mechanic Michael Hill and Apprentice-Helper David O’Neill arrived at 285 Madison Avenue. Hill and O’Neill joined Cardona and Torzilli in performing governor recalibration of the low-rise elevators. To do so, Transel employees worked in the 14th floor control room and on each elevator cab being recalibrated.

8:10 a.m.: Cammisuli and Moran left 285 Madison Avenue. During interviews with DOI both of these employees stated that they left at this time because they completed the replacement of the elevator control panel computer chips in the 14th floor control room.

8:20 a.m.: O’Neill and Torzilli boarded the number 7 elevator car at the lobby floor and rode to the 12th floor (top floor for the low-rise elevator) where they exited. After exiting the elevator, O’Neill held the elevator doors open and communicated on a two-way radio. The video then appears to show the elevator descending. Interviews of O’Neill and Torzilli later confirm that the elevator was in fact descending at this time so that they could access the top of the cab. From that position, using a control on the roof of the cab, they switched the elevator from “automatic” to “inspection” mode, in effect keeping the elevator stationary while they recalibrated it. When the recalibration was complete, the controls were switched back to “automatic,” which, in effect, returned the elevator into service. This process was repeated for each elevator the workers recalibrated. Subsequently, video footage shows O’Neill and Torzilli entering the number 7 elevator shaft.

8:57 a.m.: O’Neill and Torzilli emerged from the number 7 elevator shaft at the 12th floor landing.

8:58 a.m.: O’Neill and Torzilli placed an elevator hall call from the 12th floor, placed their tools to the side of the number 8 elevator door and then took an elevator car down to the lobby.

9:03 a.m.: O’Neill and Torzilli boarded the number 8 elevator car at the lobby floor and rode to the 12th floor where they exited. After exiting the elevator, O’Neill held the elevator doors open and communicated on a two-way radio. The video then appears to show the elevator descending. Interviews of O’Neill and Torzilli later confirm that the elevator was in fact descending at that time so that they could access the top of the cab. Subsequently, video footage shows O’Neill and Torzilli entering the number 8 elevator shaft.

9:22 a.m.: O’Neill and Torzilli emerged from the number 8 elevator shaft at the 12th floor landing, placed their tools to the side of the number 9 elevator door and placed an elevator hall call. Subsequently, they took an elevator car down to the lobby.

9:25 a.m.: O’Neill and Torzilli boarded the number 9 elevator car at the lobby floor and rode to the 12th floor where they exited. After exiting the elevator, O’Neill held the elevator doors open and communicated on a two-way radio. The video then appears to show the elevator descending. Interviews of O’Neill and Torzilli later confirm that the elevator was in fact descending at that time so that they could access the top of the cab. Subsequently, video footage shows O’Neill and Torzilli entering the number 9 elevator shaft.
9:54 a.m.: O’Neill and Torzilli emerged from the number 9 elevator shaft at the 12th floor landing and placed their tools to the side of the number 10 elevator door, made an elevator hall call and took an elevator car down to the lobby.

9:55 a.m.: O’Neill and Torzilli exited 285 Madison Avenue. It was later learned during interviews that they had completed their work on the number 9 elevator and had stepped out of the building to take a personal break.

9:56:11 a.m.: The number 9 elevator car hallway doors opened at the lobby, and the cab was empty.

9:56:35 a.m.: A female passenger entered the number 9 elevator car and pressed a call button.

9:56:45 a.m.: A male passenger entered the number 9 elevator car and pressed a call button.

9:56:46 a.m.: Ms. Hart is observed walking towards the number 9 elevator.

9:56:48 a.m.: Ms. Hart attempted to step into the number 9 elevator car, but the elevator cab began to rise with the doors open and struck her just below her knees.6 Ms. Hart lost her balance and partially fell into the number 9 elevator car as the elevator continued to rise up the elevator shaft.

III. Witness Testimony

On December 14, 2011, DOI and other agencies including DOB conducted preliminary interviews of the Transel employees who worked at 285 Madison Avenue on the day of the fatal elevator incident.7 During the course of these interviews, none of the Transel employees were able to explain what caused elevator 9 to move with the doors open after the car had been placed back into service. All of the employees were subsequently re-interviewed at DOI.

Michael Hill – Mechanic

On December 14, 2011, Hill was interviewed at 285 Madison Avenue at the incident scene. At this interview, Hill stated that at the time the incident occurred, elevator 9 was in full service because the upgrade work had been completed on that car. Hill also stated that he was not aware of any operational problems with elevator 9 prior to the incident and that he could not offer any explanation as to what caused elevator 9 to move with its car doors open.

On January 19, 2012, Hill was re-interviewed at DOI under oath. The following information was provided by Hill at his second interview:

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6 If the number 9 elevator was still jumped at this time, meaning a bypass wire was used to override the safety circuits and allow the elevator to operate, the elevator would have started to rise because the two onboard passengers pressed destination floors.

7 On December 14, 2011, the following Transel employees who worked at 285 Madison Avenue on the day of the incident were interviewed: Michael Hill, Andrea Cammisuli, Efrain Cardona, Thomas Moran, David O’Neill, Robert Schroeder and Jason Torzilli.
Hill stated that he has been an employee of Transel for almost 12 years and has approximately 28 years of experience in the elevator industry.

Hill said that on December 14, 2011, O’Neill and Torzilli were working on one of the elevators on the 12th floor when O’Neill told him, via two-way radio, that O’Neill could not fit his arm between the hoist and cab doors to disengage the clutch, which is a mechanical door lock, nor could he successfully reach the door lock with his tomahawk tool. Hill stated that after receiving this radio communication, he bypassed the door lock from the 14th floor motor room control panel by using a long piece of wire found in the 14th floor motor room next to a spool of wire, a common procedure known as “jumping.” Hill said that he placed a piece of wire, commonly referred to as a “jumper” wire, on two different points at the same time on the elevator control panel to bypass the elevator door locks so the helpers could gain access to the top of the elevator cabs.

Hill added that the only time he had the bypass wire on the control panel was when he had to lower the elevator cars from the 12th floor to allow O’Neill and Torzilli access to the roof of the elevators. Hill explained that once the elevator is lowered, there is no reason to continue bypassing the circuit.

Hill was specifically asked whether he had accidentally left the “jumper” wire on the motor room control panel at the time of the fatal accident, and he replied that he had not. Hill stated that if the “jumping” wire had remained attached to the number 9 elevator control panel in the motor room, O’Neill and Torzilli would have observed the elevator move at the completion of their work, as they stepped off the top of the elevator and placed the car back in “automatic” mode.

Hill said that while working in the control room on the day of the incident he kept the “jumper” wire in his hand and never left it in the circuit board. Hill said he used the “jumper” wire to lower the elevator cabs and then removed the wire from the control panel once the lowering was complete. Specifically he stated, “The wire was in my hand, that wire was being used on each controller.” Hill further stated that he did not observe or experience any errors or abnormalities while working in the motor room on December 14, 2011, and only became aware of the elevator incident after receiving a radio communication from O’Neill.

Hill said during his interview at DOI that he still had in his possession the “jumper” wire that he reportedly used at 285 Madison Avenue on the day of the incident. Following the interview, investigators accompanied Hill to a job site where he was then working and recovered what he said was the wire used at 285 Madison Ave. Hill provided DOI investigators with a green-covered wire approximately three feet long with a knot in the middle. The cover had been stripped away at both ends so that the wires were exposed. The stripped ends were straight and did not appear bent.

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8 A tomahawk tool is a hammer-shaped tool that allows a worker the ability to bypass an electrical circuit on the elevator cab.

9 During the course of the investigation it was determined that the use of a “jumper” wire is commonplace during maintenance and repairs and acceptable by industry standards and DOB regulations. However, according to DOB, in order to avoid an extremely unsafe condition, it is imperative that all “jumper” wires must be removed before an elevator is placed back into service.

10 According to DOB, a “jumper” wire which had been used to bypass a circuit on a control panel generally has a bent appearance after the wire has been attached to “set points” on an elevator control panel to bypass a circuit.
Efrain Cardona – Mechanic

Cardona was interviewed on December 14, 2011 at the incident scene and again at DOI on January 20, 2012. Cardona stated that he has been an employee of Transel for almost eight months and has approximately 28 years of experience in the elevator industry. Cardona said that on the date of the incident he was assigned to observe Hill’s recalibration in the motor room.

Cardona stated that he was unaware that Hill utilized a bypass wire to allow any of the low-rise elevators to operate while the 12th floor hall doors were open. Cardona added that he observed Hill in front of the 14th floor motor room control panel communicating on a two-way radio, but could not specifically observe what Hill was doing. Cardona explained that Hill’s back was to him and that he did not ask what Hill was doing because he was only there that day to observe work on the governor. Cardona further stated that he is familiar with elevator control panel operations and did not see a need to ask questions.

Cardona said that immediately after the incident, he saw Hill on the two-way radio and overheard him say, “I’m not going to touch the controller until I know what’s going on downstairs.” They both then proceeded to the lobby.

Cardona informed DOI that Hill told him that on the day of the incident O’Neill tried to utilize the tomahawk tool, but for whatever reason could not, so Hill had to run the car down for them. Cardona stated that although Hill did not specifically say that he used a “jumper,” based upon Cardona’s understanding, the door lock system must be bypassed in order to operate the elevator from the control room.

Cardona said that he remembered observing Hill in the moments following the incident exiting the motor room with a long “jumper” wire in hand. Cardona described it as a foot long, stripped at both ends, shaped like a “U,” green and taut.

Robert Schroeder - Mechanic

Schroeder was interviewed on December 14, 2011 at the incident scene and again at DOI on January 20, 2012. Schroeder stated that he has been an employee of Transel for almost nine years and has approximately 29 years of experience in the elevator industry.

Schroeder informed DOI that he is the assigned route mechanic for 285 Madison Avenue, which results in him visiting the building a couple of days a week to perform routine maintenance and that December 14, 2011 was one of those days. Schroeder stated that he arrived at the motor room at the time Hill and Cardona were working on the number 9 elevator governor; however, Schroeder stated that he did not participate in the governor recalibration.

Schroeder informed DOI that around the time of the elevator incident, in the 14th floor control room, he observed Hill receive an urgent call on the two-way radio but said he did not hear what was actually said. Schroeder said he subsequently exited the mechanical room with Hill and they made their way to the lobby.

Schroeder stated that he did not utilize a bypass wire in the motor room on December 14, 2011 and did not observe Hill or anyone utilizing a bypass wire. Nonetheless, Schroeder said that on the day

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11 The elevator 9 governor is located in the motor room several feet directly opposite the control panel.
of the incident, during their ride home, Hill told him that Hill had used a “jumper” wire to move the cars, but never said whether he had removed the wire prior to the elevator incident.

David O’Neill – Apprentice/Helper

O’Neill was interviewed on December 14, 2011 at the incident scene and again at DOI on January 20, 2012. O’Neill stated that he worked for Transel in 2009 for five or six months, was laid off due to lack of work, and was rehired in June 2011. O’Neill stated that he has approximately 11 years of experience in the elevator industry.

O’Neill stated that on the date of the incident he was assigned with Torzilli to perform work on the rooftops of all the low-rise elevators serviced that day. O’Neill said that to access the rooftop of the elevators, it is necessary to separate each elevator shaft’s hallway door from the elevator’s cab door via the clutch, and that on the first elevator he worked on he had a problem reaching the clutch because the space between the doors was narrow. O’Neill said that he informed Hill via a two-way radio and Hill responded that he would send the car down. O’Neill said that he had no knowledge of “jumpers” being used to lower any of the cars, but added that lowering the cars with “jumpers” is something that would have been done only via the control panel on the 14th floor. O’Neill stated that after the incident he never asked Hill how the elevator had been lowered. When asked, O’Neill said he did not observe elevator 9 move after he completed work on it and switched the car to “automatic.”

Jason Torzilli – Apprentice/Helper

Torzilli was interviewed on December 14, 2011 at the incident scene and again at DOI on January 20, 2012. Torzilli stated that he has been an employee of Transel for about a month and a half and has approximately nine years of experience in the elevator industry.

On the date of the incident, Torzilli was assigned with O’Neill to perform work on the rooftops of all the elevators. Torzilli said that O’Neill had difficulty separating the hallway door from the cab door because his arm couldn’t fit between the doors. Torzilli was informed by O’Neill that Hill would therefore lower the elevator cars from the 14th floor motor room with the doors open. Torzilli stated that he did not know how Hill lowered the cars. When asked whether he had seen elevator 9 move after it was switched to “automatic,” Torzilli said he would not have been looking at the elevator at that time.

John Fichera – Elevator Agency Director/Owner of Transel

On February 2, 2012, Fichera was interviewed at DOI. Fichera stated that he has been the owner of Transel since 2000 and has been licensed by DOB as a Private Elevator Agency Director since approximately 1997. Fichera stated that Transel has approximately 150 employees and that his duties mainly include supervision and office work. In addition, Fichera said that he reviews all documents submitted to DOB before signing them, including applications to perform upgrades or significant repairs.

Fichera was not present at 285 Madison Avenue prior to fatal incident. However, during the interview, Fichera acknowledged that DOB should have been notified by Transel about the completion of elevator work at 285 Madison Avenue before the elevators were placed back in service. However, Fichera said that he only became aware after the fatality, when he reviewed the paperwork, that the type of work Transel performed that day required a call to DOB to give DOB the opportunity to inspect the work before the elevators were returned to service. Although Fichera was the applicant of record for the
job, and DOB holds him responsible for not notifying DOB of the completed elevator work, Fichera said that Transel’s Maintenance and Repair unit had that responsibility.

IV. Wires Recovered from Motor Room

On December 22, 2011 at approximately 3:40 p.m., in the 14th floor motor control room of 285 Madison Avenue, DOI investigators and a DOB chief inspector observed two separate, eight-inch lengths of green-covered wire, which were stripped on all four ends, two of which were twisted together to form one wire of approximately 16 inches in length. The wires were observed under a metal grate floor within two feet of control panel number 9.12

V. Forensic Investigation of the Incident

On December 14, 2011, DOB responded to 285 Madison Avenue and commenced a forensic investigation of the cause of the fatal incident. The investigation was conducted by the DOB Elevator Division, with the assistance of DOB’s Forensic Engineering Unit.13 In addition, DOB retained Lerch Bates, Inc. to assist in the forensic investigation of the incident.

In order to determine the cause of the incident, the investigation team simulated failures that could have caused the incident and compared those simulations with the building’s security camera video recordings of the actual incident. The forensic investigation found that the only condition in which elevator number 9 could have moved during the incident is if the elevator was on “automatic” and the safety circuit was fully closed (by-passed). Based upon the evidence developed during the course of the investigation, DOB concluded that a portion of elevator number 9’s safety circuit, most likely the car door and hoist way locks, were overridden by a “jumper” wire allowing the car to move with the doors open.

In the Lerch Bates report regarding the forensic investigation, the investigation team noted that local and national safety code standards for elevators, including the New York City Building Code, require the installation of safety devices designed to keep the public safe while riding in an elevator. According to Lerch Bates, one of the most critical of the devices is the “safety circuit.” This circuit includes the “car door locks” and the “hoist way door locks” along with others. When this safety circuit is functioning normally and not compromised it does not allow the elevator to run if it is not completed or “made up.” However, if this safety circuit is compromised by wire “jumpers,” the mandatory safety features are disabled and the riding public is put in danger.

The Lerch Bates report further detailed that modern elevator controllers are designed with wiring terminal panels and mechanical connections points for key wiring circuits, including safety circuits. This design allows convenient installation of circuit wiring, but more importantly can provide a technician with a means to test circuit continuity. This design also allows technicians to place a clip wire “jumper” between terminals and close a circuit, providing a direct connection between two points. This “jumper” disables or “jumps out” any safety device included in the circuit. This trouble-shooting process can determine if an integral safety component has failed. However, if the wire “jumper” is left in place the required safety circuit is not functional and a potentially dangerous situation exists.

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12 According to DOB, the configuration and condition of the wires recovered from the grate immediately in front of the elevator 9 control panel are consistent with the type of “jumper” wires commonly used to bypass elevator safety circuits.

13 Chief Inspector Douglas Smith of the DOB Elevator Division was assigned as the Incident Commander for DOB. Assistant Commissioner Christopher Santulli of DOB’s Forensic Engineering Unit also participated in the investigation.
Lerch Bates noted that during the initial startup of elevator car number 9 as part of the forensic examination, the car would not move until the safety circuit was fully closed. Due to the damage to the doors, the car doors and hoist way locks were “jumped out” to move the car. When these “jumpers” were removed, the car would not move. In addition, during the testing of several scenarios, including the testing of the speed feedback tachometer and the radio frequency interference testing, if the safety circuit was open and not “jumped” the car would not move.

Lerch Bates further stated that additional control errors were tested and none were found to match the conditions of the incident.

VI. DOB Enforcement Actions

On February 27, 2012, the Buildings Special Investigations Unit filed a petition seeking revocation of Fichera’s Private Agency Elevator Director license. Fichera filed a permit, called an Elevator Building Notice (“EBN”), to reduce the speed of elevators at 285 Madison Avenue. After this work was performed, Transel was required to notify DOB in order to obtain an inspection of these elevators prior to putting them back in service. Further, these elevators were not to be put back in service until DOB issued a “Certificate of Compliance.”

On December 14, 2011, work was performed on cars 7, 8, and 9 and these elevators were put back in service without first obtaining an inspection from the DOB. Had DOB been notified, car number 9 would not have been in service on December 14, 2011 until cleared by DOB. Other charges in this petition seeking revocation of Fichera’s license relate to wiring deficiencies, failure to place caution tape on the elevators and performing work without a permit. The violations were noted in 23 Environmental Control Board summonses issued by DOB.

VII. DOI Investigative Findings

DOI’s investigative findings, which are based on witness interviews among other evidence, support the conclusion of the forensic examination that the safety circuit of elevator 9 was apparently bypassed at the time of the fatal incident thereby allowing the car to move with its doors open when Hart attempted to step into the elevator cab. Specifically, the investigation found that:

Testimony taken by DOI established that Hill was assigned to work in the control room on the day of the fatality. Cardona testified that he saw Hill exiting the 14th floor motor room with a long “jumper” wire in his hand moments following the incident. Hill informed investigators that although he did use a “jumper” wire on several occasions to bypass the door locks on elevators 7, 8, and 9, it was not connected to the control panel at the time of the fatality.

Hill testified that the “jumper” wire was only on the circuit during the time O’Neill and Torzilli accessed the roof of elevator 9 and that he removed it before the fatal incident. Hill asserted that if he had not removed the jumper wire, O’Neill and Torzilli would have seen elevator number 9 move when they switched the elevator back to “automatic.” However, Torzilli testified that he was not looking at elevator 9 after it was switched to “automatic” mode by O’Neill. O’Neill testified that he did not observe elevator 9 move after he completed work and switched the car back to “automatic.” Video security footage shows that the elevator doors closed in less than six seconds after O’Neill and Torzilli are seen stepping out of the elevator, so if the elevator moved after that time it would not have been seen.

A review of the video security footage from the lobby at the time of the incident showed that moments before Hart attempted to enter elevator 9’s cab, the two onboard passengers had pressed
buttons for destination floors, thereby calling the elevator to a higher floor. The elevator started to rise with the doors open, which according to the DOB and its consultant, suggests that the door locks were bypassed by a “jumper” wire in place in the control room.

On December 22, 2011, DOI recovered a “jumper” wire in the 14th floor control room from beneath a grate that is immediately in front of elevator 9’s control panel. Subsequent to DOI’s recovery of the “jumper” wire from the control room, Hill, at his second interview on January 20, 2012, acknowledged for the first time having used a “jumper” wire on elevator 9 on the day of the incident. However, Hill said that he had used a different “jumper” wire that was still in his possession, which he later provided to DOI. Significantly, DOB’s opinion is that the wire found in the control room on December 22, 2011 had the physical characteristics of one that had been used in a manner consistent with “jumping” a circuit, while the wire produced by Hill on January 20, 2012, did not appear to have been used for that purpose.

According to the DOB, Transel failed to follow certain necessary safety procedures and protocols when its employees performed elevator work at 285 Madison Avenue. Those failures helped create the conditions that caused the fatal incident. Two specific unsafe conditions noted were that Transel failed to place caution tape inside the elevators and to call DOB prior to putting the elevators back in service. Had Transel notified DOB to perform an inspection prior to returning elevator 9 to service, as required by code, any “jump” wire that might have been in place, or any other significant problem, could have been discovered during the inspection process.

We are also referring our investigative findings to the New York County District Attorney’s Office for any action it deems appropriate. If you have any questions or wish to discuss this matter further, please contact Assistant Commissioner Michael Carroll (212) 825-3338.

Sincerely,

Rose Gill Hearn
Commissioner
Elevator Division
ACCIDENT REPORT
Section 3010.1 of the Administrative Code

LOCATION
Borough: Manh  Address: 285 Madison Avenue
Date of Accident: 12/14/11  Time: 09:56  AM  PM  Occupancy of Building: Comm
DOB Elevator Division Response Date: 12/14/11  Time: 10:30  AM  PM
Inspector: Douglas Smith  Badge #: 1761
Type of Device:  Elevator:  Passenger  Freight  Sidewalk  Personnel Lift
□ Escalator  □ Amusement Ride  □ Material Lift  □ Wheelchair Lift  □ Other
Elevator Maintenance Company and Phone Number: Transel

PERSON(S) INVOLVED
# Involved: 1  □ Fatality or  □ Injured
Name(s) and age(s) of Person(s) Suzanne Hart age 41
Address(s) and Phone Number(s)

DEVICE
City I.D. Number: 1P14275  Incident Notification Number 13608
Type & Power of Machine: gearless - overhead traction
Manufacturer:  Model: Swift 5000 controller  Date Installed: 1986
Hoist Ropes: Number: 6  Size: 1/2 inch  Material: steel
Capacity of Car: 2200 lbs.;  Number of Passengers Allowed: 12  Speed: 500 (fpm)
Number of Floors: 12 active – 13fl sealed
Type of Operation:  □ Automatic  □ Manual
Type of Car Safety:  □ Instantaneous  □ Other:
Was the device going:  □ Up  □ Down  □ Not Moving  □ Other:
Where in the Shaft/Escherator/Ride did the Accident Occur: Lobby to 2nd floor w/cab & lobby doors open
Was the governor tripped?  □ Yes or  □ No
Was the safety applied?  □ Yes or  □ No

PRIOR INSPECTIONS
Last inspection prior to Accident: 06/15/11  Result: □ NV  □ DF  Violation - PVT # 385639
Last CAT 5 Test Date: 02/28/06  Last CAT 1 Inspection prior to Accident: 12/29/10  Result: □ S  □ U

Provide Incident / Accident Report Narrative
1. Notification Information: (Include Name/Date/Time Reported by Citizen or Agency and Responded by Buildings Dept.)
2. Description of Accident: (Explanation of What Occurred)
3. Conduct an inspection and provide inspection results and equipment damaged or not functioning prior to or as a result of the accident. Include specific terminology, detail and location of equipment involved in the accident.
4. Provide Conclusion Based On Your Inspection/Investigation.
5. Provide Pictures: (Must be specific to the items / equipment involved in the accident)

build safe live safe
I. Notification

On 12/14/11 at approximately 10:15 AM the Department of Buildings Emergency Operations Unit received a complaint from FDNY Operations that an elevator accident occurred at 285 Madison Avenue, NY, NY, on 12/14/11 at approximately 9:56 AM. DOB Emergency Operations Unit informed the DOB Elevator Division on 12/14/11 at approximately 10:20 AM of the accident.

II. Accident Description

The accident involved a building employee, Ms. Suzanne Hart, being fatally injured as she was attempting to enter the elevator cab at the lobby level due to the elevator cab, with two passengers in the cab, moving in an upward direction from the lobby landing with the elevator cab door and lobby hoistway door fully open. Ms. Hart fell into the elevator cab and onto the cab platform due to the cab saddle making contact with her lower legs. The elevator cab continued to move upward, pinning Ms. Hart between the elevator cab saddle and hoistway wall fascia. The elevator cab came to a stop approximately 20 feet above the lobby landing sill, with the cab saddle approximately 3.5 feet below the 2nd floor landing sill.

III. Inspection / Investigation #9 Elevator 12/14/11 to 1/13/12 - Summary

A. An inspection/investigation on low rise elevator #1P14275 aka #9 by the Buildings Department Elevator Division and 3rd party consultant Lerch Bates revealed the elevator cab cannot move in an upward direction from the lobby landing with the elevator cab door and lobby hoistway door open.

B. It appears a circuit bypass wire (jumper) was used on the motor room controller’s door circuit terminals to move the elevator cab with the 12th floor hoistway door open prior to the accident and not removed at the time of the accident, which caused the elevator cab to move up from the lobby landing.

C. The inspection and tests were performed on the elevator’s controller, controller wiring, RF (radio frequency) interference, machine/motor, ropes, brake, drive tachometer, governor, traveling cables, hoistway door interlocks, cab gate switch, leveling equipment, cab door operator, hoistway equipment, and pit equipment. It was found that with the cab gate switch open (gate contacts not made) and hoistway door open (interlock contacts not made), and with elevator cab level at the lobby landing or any other floor landing, the elevator control system does not initiate a run sequence and the elevator cab does not move up or down.

Signature: ____________________________ Date: 2/21/12

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V. Items Discovered at Site – DOI/BSIU Chain of Custody

Refer to BSUI (Buildings Special Investigation Unit) 212 825 3330 - 80 Maiden Lane MH.

VI. Alteration Work by Transel Elevator Company to #9 Elevator - Sequence Summary

A. Alterations to the elevator took place on 12/9/11 to 12/12/11 and 12/14/11 prior to the accident.

(1) Decrease in travel work was performed on the low rise elevators from 12/9/11 to 12/12/11 by Transel Elevator Company mechanic, Efrain Cardona, and the devices were restored to service after the work was completed to each elevator. A relay (AU1) was added and wired to the low rise control boards. An additional final limit switch, with manual reset, was mounted in each low rise elevator hoistway at the 12th floor and was piped and wired to each low rise controller. An interlock was mounted to each low rise 13th floor hoistway door and piped / wired to each controller.

(2) An alteration to the #9 controller’s program took place at approximately 6:30am on 12/14/11 to reduce the elevator’s fpm (speed) and the elevator was restored to service by Transel Elevator Company adjuster, Andrea Cammisuli.

(3) The #9 elevator was removed from service again by Transel apprentices, David O’Neill and Jason Torzilli, at approximately 9:25am and an alteration to the governor (recalibration from 600 fpm to 500 fpm) took place at approximately 9:30am by Transel elevator mechanics, Michael Hill and Efrain Cardona. The elevator was restored to service by Transel Elevator mechanics Michael Hill, Efrain Cardona and apprentices David O’Neill and Jason Torzilli at approximately 9:54am.
VII. Video Review of lobby and 12th floor #9 Elevator - Summary

A. The elevator appeared to operate normally on 12/14/11 from 7:00 am through 9:25 am, as viewed on the lobby video. The elevator cab saddle and lobby landing sill maintained their position. The elevator cab door and lobby hoistway door opened and closed normally and parked at the lobby level each time the #9 elevator was at the lobby landing. Accepting passengers from 7:00 am to 9:25 am.

B. The elevator was removed from service by Transel apprentices, David O’Neill and Jason Torzilli, at approximately 9:25 am at the lobby level. They exited the elevator cab at the 12th floor. Mr. O’Neill held the 12th floor hoistway door and cab door open with his right hand on the hoistway door and appeared to use his radio with his left hand. A moment later the elevator cab moved in a down direction, at a slow speed, until Mr. O’Neill used his radio again. Mr. O’Neill did not use a tomahawk (interlock contact by-pass tool). Mr. Torzilli was standing approximately 5 feet from the 12th floor opening. During the out of service period signage stating “caution do not enter” across the cab door frame was not in place. At approximately 9:54:27 am Mr. Torzilli and Mr. O’Neill exited the hoistway at the 12th floor and were seen leaving the lobby at approximately 9:55:20 am.

C. At approximately 9:56:46 am Ms. Suzanne Hart approached the #9 elevator, which was parked level (sitting), at the lobby with the cab door and lobby hoistway door open.

VIII. Interview Summary

A. Transel Elevator Company mechanics Michael Hill, Efrain Cardona, and Robert Schroeder were in the elevator motor room on the 14th floor at the time of the accident. The #9 elevator was removed from service by Transel apprentices, David O’Neill and Jason Torzilli, at approximately 9:25 am and an alteration to the governor (recalibration from 600 fpm to 500 fpm) took place at approximately 9:30 am on 12/14/11 and the device was restored to service by Transel elevator mechanics Michael Hill, Efrain Cardona and apprentices David O’Neill, Jason Torzilli at approximately 9:54 am. During the out of service period signage stating “caution do not enter” across the cab door frame was not in place.

B. Mr. Michael Hill stated that he used a green wire jumper and manually pressed the inspection down button on the controller to move the elevator down from the 12th floor landing to allow access to the top of car by Mr. O’Neill and Mr. Torzilli. At that time Mr. Hill took the controller off inspection and proceeded to re-calibrate the #9 governor with Mr. Cardona. Mr. Hill completed the re-calibration and allowed the #9 elevator to be returned to service by apprentices’ David O’Neill and Jason Torzilli. Mr. Hill stated he did not use the wire jumper after the top of car was initially accessed and placed on top of car inspection.
C. Mr. Efrain Cardona stated he was being instructed by Mr. Hill on the governor re-calibration procedure. Mr. Cardona saw Mr. Hill standing in front of #9 controller when it was initially removed from service, but did not hear any radio communication due to the noise in the 14th floor motor room. The governor was then re-calibrated by Mr. Hill. After the re-calibration the elevator was running and then stopped. Mr. Cardona was next to the #9 governor and Mr. Hill was in front of #9 controller. Mr. Hill was called on the radio. At that time Mr. Hill instructed Mr. Cardona and Mr. Robert Schroeder that they had an issue at the lobby with #9 elevator. Mr. Cardona stated Mr. Hill had a green wire jumper in hand and walking out of the motor room.

IX. Conclusion

A. The inspection/investigation on low rise elevator #1P14275 aka #9 revealed the elevator cab cannot move in an upward direction from the lobby landing with the gate and hoistway door circuit opened.
B. It was found that with the cab gate switch open (gate contacts not made) and hoistway door open (interlock contacts not made), with elevator cab level at the lobby landing or any other floor landing, the elevator cab does not run or move up or down.
C. It appears the cab gate and hoistway door interlock circuit was compromised (bypassed) at the #9 controller terminals (53, TDL) in the 14th floor motor room by using a circuit bypass wire (jumper) on the motor room controller’s door circuit terminals.
D. During the out of service period signage stating “caution do not enter” across the cab door frame was not in place.
E. At the time of the accident the elevator cab appeared to move up with the cab door and lobby hoistway door open at a speed that matched normal acceleration for an elevator cab leaving the lobby floor landing.
F. The investigation and testing revealed that the elevator did not leave the lobby level due to program failure, controller failure, tachometer fault, power surge/generator suicide, RF (radio frequency) interference, brake failure or improper/incorrect wiring.
G. DOB testing protocol was not followed by the applicant.
H. Elevator industry safety standards were not followed for the use of circuit bypass wire (jumpers).
X. Investigation Team and Observers

A. DOB hired Private Consultant, Lerch Bates, to assist with the accident investigation.

B. Chief Inspector Douglas Smith was assigned as the Incident Commander for DOB.

C. DOB elevator division coordinated the on site investigation and collaboration with other city agencies (DOI, NYPD, FDNY and OSHA).


Appendix

1. NYC Buildings Department Accident Report
2. Complaint work order
3. Print out of owner information
4. Print out of inspection history #9 elevator 1P14275
5. DOB elevator division ECB violations to #9 elevator
6. DOB electrical division violation/inspection report
7. PVT violation issued 6/15/11
8. EBN 1328/11 application
9. Elevator equipment numbers (city ID and device number)
10. Pictures

Signature: [Signature]  Date: 2-27-12

build safe|live safe
NYCDOB Elevator/Escalator/Amusement Ride Report

Accident
1. General Information
   - Incident Report ID: 13808
   - Street: 288 Madison Ave
   - Boro: Manhattan
   - Incident Date: 12/14/2011
   - Incident Time: 9:58 AM
   - Notified By: FD-250
   - Affiliation: FDNY
   - Phone: (347) 650-6134
   - Date Notified: 12/14/2011
   - Time Notified: 10:28 AM
   - DOB Unit Notified: Elevator
   - Contact Person: James W
   - Phone: (347) 203-8738

2. DOB Actions
   - Inspection Date: 12/14/2011
   - Inspection Time: 11:00 AM
   - Inspector: Masters
   - DOB Point Person: DOB Action: ECB Violation

3. Existing Structure Information
   - Is the building Occupied? Yes
   - Name of Owner: Young and Rubicam Inc
   - Name of Contact Person: N/A
   - Phone:

4. Elevator/Escalator/Amusement Ride Incident Information
   - Type: Elevator
   - Mode: Passenger
   - Operating at Time of incident: Yes
   - Elevator Accident?: Yes

   Data Entry Person: ZhanetaS
   Can incident location be hazardous to responders? No
   Type of Incident: Elevator/Escalator/Amusement Ride
   # Fatality: 1
   # Injury: 0
   Detail of Incident: FDNY reported that a building occupant fell between elevator shaft and elevator, pronounced DOA.

   Street Closing Details:

   DOB Action Details:
   A female employee was in the process to enter the elevator cab at the lobby level, while stepping into the elevator, elevator started moving accidentally upward with open elevator door, victim fell on the elevator platform as the car was moving upward and caused her body wedge between the elevator cab and host wall near the 2nd floor.

   Does the building included a basement? No
   Building Type: Masonry
   Building Occupancy:
   Number of Story: 13

   Model/Device: 1P14275
   Last Inspected: 1/4/2008
   Elevator Accident Number: 01/2011

   Cause / Description of Incident:
   A female employee was in the process to enter the elevator cab at the lobby level, while stepping into the elevator, elevator started moving accidentally upward with open elevator door, victim fell on the elevator platform as the car was moving upward and caused her body wedge between the elevator cab and host wall near the 2nd floor.
Overview for Complaint #: 1314532 = RESOLVED

NYC Department of Buildings
Overview for Complaint #: 1314532 = RESOLVED

Complaint at: 285 MADISON AVENUE
Borough: MANHATTAN
ZIP: 10017

Re: FDNY REPORTED A BUILDING OCCUPANT FELL BETWEEN SHAFT AND ELLEVATOR

Category Code: 62 ELEVATOR-DANGER CONDITION/SHAFT OPEN/UNGUARDED

DOB District: N/A
Special District:

Assigned To: ELEVATOR DIVISION
Priority: A

Entered By: ZSA (-) 12/14/2011 10:27:28
Received from FDNY

Received: 12/14/2011
Owner: YOUNG AND RUBICAM INC
Block: 1275
Lot: 23
Community Board: 105

Last Inspection: 12/14/2011 -- BY BADGE # 0247 MARSHALL ALPHONS0
Disposition: 12/16/2011 - A1 - BUILDINGS VIOLATION(S) SERVED
Disposition Entered By: SBY 12/16/2011 14:09:32
Comments: VIOLATION ISSUED
ECB Violation #: 382186575

Complaint Disposition History

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If you have any questions please review these Frequently Asked Questions, the Glossary, or call the 311 Citizen Service Center by dialing 311 or (212) NEW YORK outside of New York City.
## NYC Department of Buildings

### Property Profile Overview

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<th>Address</th>
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**View DCP Addresses...**  
**View Zoning Documents**  
**View Challenge Results**  
**View Certificates of Occupancy**

### Cross Streets:  
EAST 40 STREET, EAST 41 STREET

### DOB Special Place Name:  
EAST 40 STREET, EAST 41 STREET

### DOB Building Remarks:

| Landmark Status: | YES
| SRO Restricted:  | NO
| US Restricted:   | NO
| Little *E* Restricted: | N/A
| Legal Adult Use: | NO

### Special Status: N/A  
### Loft Law: NO  
### TA Restricted: NO  
### DOT Protected Street: Yes  
### Grandfathered Sign: NO  
### City Owned: NO

### Additional BINS for Building:  
NONE

## Zoning Summary

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<td>C5-2.5 - Restricted Central Commercial District</td>
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This property is not located in an area that may be affected by Tidal Wetlands, Freshwater Wetlands, or Coastal Erosion Hazard Area.  
Click here for more information

### Department of Finance Building Classification:  
C2 - OFFICE BUILDINGS

Please Note: The Department of Finance's building classification information shows a building's tax status, which may not be the same as the legal use of the structure. To determine the legal use of a structure, research the records of the Department of Buildings.

### DOF Owner Information:

- **Name:** YOUNG AND RUBICAM INC
- **Address:** 285 Madison Ave, New York NY 10017-6465

### DOF Building Information:

- **Bldg Size:** 151.00 x 175.00
- **Lot Size:** 150.57 x 175.00
- **Stories:** 8.00
- **DOB Update Date:** 02/19/2012

- **Trans Land Value:** 34,000,000
- **Tax Exempt Flag:** NO
- **Tax Exempt Class:**

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http://dob-bisweb.buildings.nycnet/bisweb-intra/PropertyProfileOverviewServlet?boro=1...

2/22/2012
## Property Profile Overview

### Actions

- OR Enter Action Type:
- OR Select from List:
  - Select...
  - Show Actions

### Boiler Records
- DEP Boiler Information
- Local Law 16/84 Compliance
- Crane Information
- After Hours Variance Permits

### Other Agency Violations

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Only FDNY and DEP Asbestos violations issued on or after January 1, 2008 are available on BISWeb.

If you have any questions please review these [Frequently Asked Questions](#), the [Glossary](#), or call the 311 Citizen Service Center by dialing 311 or (212) NEW YORK outside of New York City.
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## Elevator Inspections

**Premises:** 279 MADISON AVENUE MANHATTAN

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<td>1P14276</td>
<td>05/13/1989</td>
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<td>1429 NUGENT JOHN</td>
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<td>1P14276</td>
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<td>06/20/1990</td>
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<td>03/11/1991</td>
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</tr>
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<td>1P14276</td>
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<td>04/24/1993</td>
<td>ROUTINE</td>
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<td>0241 FORD JR CHRISTOPHER</td>
</tr>
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<td>1P14276</td>
<td>03/03/1994</td>
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<td>ROUTINE</td>
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<td>03/02/1998</td>
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<tr>
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<tr>
<td>1P14276</td>
<td>07/28/2005</td>
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<tr>
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<td>09/12/2007</td>
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<tr>
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<td>1P14276</td>
<td>06/15/2011</td>
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<td>9027 AMERICAN ELEVATOR TESTING PRIVATE ELV</td>
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<td>VIOLATION REINSPECTION VIOLATION FILED</td>
<td>1719 HARRIS RICHARD SUPERVISING</td>
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</tbody>
</table>
**NOTICE OF VIOLATION AND HEARING**

**COMMISSIONER OF THE DEPARTMENT OF BUILDINGS**
**OF THE CITY OF NEW YORK, PETITIONER, AGAINST:**

**Respondent:**
- **Name:**
- **Address:**
- **City:**
- **License No.:**
- **Projects Code:**

---

**Compliance Order to Correct Violations**

**Place of Occurrence:**
- **Address:**
- **City:**
- **Zip Code:**

**Date of Violation:**
- **Issue Date:**
- **Type:**
- **Badge No.:**
- **Area:**
- **OB:**

**Failure to Maintain:**
- **Class 3 (B2) – Cease Use**

**VOLATING CONDITION:**

<table>
<thead>
<tr>
<th>Violation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Elevator Pratt</td>
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<tr>
<td>02</td>
<td>Violating Condition</td>
</tr>
<tr>
<td>03</td>
<td>Elevator Pratt</td>
</tr>
</tbody>
</table>

---

**Resolution Options:**

- **Hearing Date:**
  - **Time:**
    - 8:30 AM
    - 10:30 AM
    - 1:30 PM

---

**Signatures:**
- **Issuing Officer:**
- **Supervisor:**
- **City of New York Building Departments:**

---

**Notice:**
- **Location:**
  - **Address:**
  - **City:**
  - **State:**
  - **Zip Code:**

---

**Original ECB Copy**

**EAS-TEC (Rev. 02/06)**

---

**For More Information:**
- **Contact:**
  - **Address:**
  - **City:**
  - **State:**
  - **Zip Code:**

**Document Reference:**
- **Violation No.:**
- **Date:**
- **Issue Date:**
- **Type:**
- **Badge No.:**
- **Area:**
- **OB:**
- **Licence No.:**
- **Projects Code:**

---

**Modification:**
- **Date:**
- **Issue Date:**
- **Type:**
- **Badge No.:**
- **Area:**
- **OB:**
- **Licence No.:**
- **Projects Code:**

---

**Issuing Officer's Signature:**

---

**Supervisor's Signature:**
NOTICE OF VIOLATION AND HEARING

COMMISSIONER OF THE DEPARTMENT OF BUILDINGS OF THE CITY OF NEW YORK, PETITIONER, AGAINST:

Respondent:

Mailing address: 561 East 75th Street, New York, NY 10021

Name:

Street:

City:

Sta:

Zip code:

Commissioner's Order To Correct Violations

Place of occurrence:

Failure to maintain a valid permit. Class 9 (1811)

Type of violation: Class 9

Date:

Hearing date:

Hearing time:

Resolution options:

Cure date:

For more information, visit: www.nycedc.gov

I personally observed the violation charged. I am not responsible for any errors or omissions in the Department's records.

Supervisor's signature:

Badge number:

UNIT CODE:

FACSIMILE:

Issuing officer's signature:

This statement is affirmed under penalty of perjury.

38220356M
NOTICE OF VIOLATION AND HEARING

VIOLENT CONDITION

<table>
<thead>
<tr>
<th>Violation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>38220370Z</td>
<td>Illegal operation</td>
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</table>

Commissioner's Order To Correct Violations

<table>
<thead>
<tr>
<th>Violation Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>38220370Z</td>
<td>Illegal operation</td>
</tr>
</tbody>
</table>

Resolution options

- Hearing Date: 8:30 AM
- Time: 1:30 PM
- Location: Environmental Control Board

For more information, please contact the Department of Buildings at 311 or go to www.nyc.gov.

This statement is attested under penalty of perjury.

38220370Z
NOTICE OF VIOLATION AND HEARING

COMMISSIONER OF THE DEPARTMENT OF BUILDINGS
OF THE CITY OF NEW YORK, PETITIONER, AGAINST

Respondent: TRANTOL
Mailing address: ELEVEN INC
374 WEST 39 ST, 4K
New York, NY 10018

Ticket: 100001
Date: 9/5/19
Issuing Officer: TONE

Commissioner's Order To Correct Violations

Place of occurrence: 374 WEST 39 ST, 4K

Failure to maintain: ELEVATOR

VIOLATING CONDITION: Missing, N/A

SUGGESTED REMEDY: File application and obtain permit

Resolution options

CURE DATE

HEARING DATE

6/3/20 at 8:30 AM

I have personally observed the violation and have submitted evidence through review of departmental records.

Issuing Officer's signature

This statement is affirmed under penalty of perjury.

38220365Y
NOTICE OF VIOLATION AND HEARING

Violation No. 38210688N

ENVIRONMENTAL CONTROL BOARD

COMMISSIONER OF THE DEPARTMENT OF BUILDINGS
OF THE CITY OF NEW YORK, PETITIONER, AGAINST:

Respondent: TWIN ELEVATOR INC

Mailing address: 325 West 34 St, New York, NY 10001

Licensor No. of Affiliated: Prelim Code:

Name: MARSHALL E.

Mailing address: Unit Code:

Place of occurrence: Manhattan, NY

Case no. 9

Commissioner's Order To Correct Violations

Date: 12/14/11

Class: 2B(9)

Type: CEASE USE

Additional information:

ELEVATOR PART

VIOLATING CONDITION

1. Unregistered, or
2. Expiring, or
3. Damaged

VIOLATING CONDITION

1. Unregistered, or
2. Expiring, or
3. Damaged

SAFETY ORDER

Date: 12/21/11

Refusal Section 808.7A

SUGGESTED REMEDY

Provide means of access

The Hearing Date is set for January 14, 2012, at 10:30 AM.

I, the undersigned officer, have personally served the notice of hearing.

I, the undersigned officer, have personally served the notice of hearing.

38210688N
Electrical Division Inspection Reporting Form

Premises Location: 285 Madison Ave

Apt./#Floor: Borough: Manhattan BIS #

Special Place Name: Additional Location Info:

Inspector Name: Felix Rivera Badge No. 2239 Pick Up Minutes 180

Type of Occupancy: (Check One Box Only)
- □ A. 1 or 2 Family
- □ E. Warehouse
- □ G. Garage
- □ H. Hotel
- □ W. School
- □ I. Hospital/Health Facility
- Z. Other
- □ C. Multi Dwelling/Other Residential
- □ F. Factory
- □ O. Office Building
- □ L. Loft
- □ J. Theater
- □ P. Other Place of Assembly
- □ K. Store (Indicate Type)

Type of Inspection: (Check Box Below)
- □ Certificate of Occupancy
- □ Complaint
- □ Other Referral
- D.O.B. Complaint M322143
- □ Pick Up
- □ Other Referral

Inspection Result:
- □ Passed
- □ Defect Noted
- □ Other No Permit

Report Issued To: (Check One Box Only)
- □ Owner
- □ Lessee
- □ Occupant
- □ Contractor
- □ Other

Defect Noted:
- □ Pick Up
- □ Scheduled Inspection

Owner/Occupant/Contractor/Lessee Name: Young & Rubicam Inc.

Address: 285 Madison Ave Borough: Manhattan Zip: 10017

Item # Defect Location or Equipment Location
3 14th Fl Elev' Machine Rm - New Branch Ckt Wiring
   - From Controller to Elevator Shaft for New Final Limit Switch
   - Replacement of #9 Cab Controls - Cab Door Restrictor Panel
   - New Safety Operator Switch
19 14th Fl Elev' Mach' Rm - 3/8" E-MC Not Properly Terminated
19 Top of Car #9 - Open exposed wiring & Defective Control Wiring
7 14th Fl Elev' Mach' Rm
22 " Final Limiter Switch
24 " " "
25 " " "
29 " " "

System Entry Date ____________ Key Punch ID ____________ INSP Area ____________ Census Track ____________

ED-55 (Rev.2005)
DEPARTMENT OF BUILDINGS NOTICE OF VIOLATION
PVT 385639

NEW YORK CITY DEPARTMENT OF BUILDINGS
NOTICE OF VIOLATION(S) AND ORDER TO CORRECT VIOLATION(S)

YOU ARE HEREBY NOTIFIED THAT THERE EXISTS A VIOLATION IN THE SUBJECT PREMISE AS DESCRIBED HEREBIN: YOU ARE HEREBY DIRECTED TO REPAIR THE VIOLATING CONDITION(S) PURSUANT TO SECTION 28-206.1 AND 28-206.2 OF THE ADMINISTRATIVE CODE OF THE CITY OF NEW YORK. IN ADDITION TO THE ITEMS CHECKED BELOW, REPAIR OR REPLACE ALLOWED DEFECTIVE, MISSING AND IMPROPERLY MAINTAINED ELEMENTS THAT CONSTITUTE TO THE MALFUNCTION OF THE DEVICE.

YOU MUST REPAIR THE VIOLATING CONDITION(S) WITHIN 30 DAYS OF ISSUANCE OF THIS NOTICE. IF THIS IS A CLASS I VIOLATION, YOU MUST REPAIR THE CONDITION IMMEDIATELY. IN ADDITION, AN AFFIRMATION OF CORRECTION MUST BE SUBMITTED, ALL REQUESTS FOR REINSPECTION TO REMOVE THIS VIOLATION FROM THE DEPARTMENT'S RECORDS MUST BE IN WRITING, INCLUDE A COPY OF THE VIOLATION AND BE ADDRESSED TO THE ELEVATOR DIVISION OF THE DEPARTMENT OF BUILDINGS, ATTENTION: VIOLATION REINSPECTION UNIT, 280 BROADWAY, 4TH FLOOR, NEW YORK, N.Y. 10007. ALL OTHER INQUIRIES MAY BE DIRECTED TO TELEPHONE (212) 666-5314.

Place of Occurrence: 25 E 40 St

Date of Violation: 6-15-14

Type: E 9627

Agency No.: I P 14275

Failure to Maintain

ELEVATOR PART

- Inside Car
- Machine Room
- Top of Car
- Outside Hoistway
- Outside Risers

Outside Hoistway

- Inside Risers

VOLATILE CONDITION

- Outside Platform

- Outside Hoistway

SUGGESTED REMEDY

- Lift Application and Obtain Permit
- Cease Use

ELEVATOR PART

VIOLATION CONDITION

SUGGESTED REMEDY

ADDITIONAL INFORMATION:

16:07:07 all tasks not checked. 16:06:07 electrical switch.

False certification is a criminal misdemeanor under sections 28-203.1 and 28-211.1 of the NYC Administrative Code, punishable by up to 1 year imprisonment and a fine of up to $25,000. It is also punishable with a civil penalty of up to $25,000.

I PERSONALLY OBSERVED THE VIOLATING CONDITIONS CITED

John Combs
PRINT INSPECTOR'S NAME

Agency Inspector's Signature

Elmvie 01 (Rev. 11/08)
**ORIGINAL**

**ELV1: Elevator Application**

Please file four (4) copies. Application must be typewritten.

---

### Filing Status

- [ ] New Building Application Number
- [ ] New Installation
- [ ] Seismic Compliance
  - Yes
  - No
- [X] Replacement / Modification

Select One:

- [ ] Electrical Application Number
- [X] No Electrical Filing Required

### Location Information

- **Borough:** Manhattan
- **Address:** 285 Madison Avenue
- **Block:** 1275
- **Lot:** 23
- **Bldg:** 1035318
- **City:** New York
- **State:** NY
- **Zip:** 10017
- **Occupancy Group:** OFFICE BUILDINGS

### Applicant Information

- **Name:** John Fichera
- **Title:** Sen. Vice President
- **License Number:** L400-001
- **Business Name:** Transal Elevator Inc.
- **Address:** 525 West 34 Street
- **City:** New York
- **State:** NY
- **Zip:** 10001
- **Phone:** 212-727-3200

### Owner Information

- **Name:** Mr. Laszlo Luka
- **Title:** Project Manager
- **Business Name:** Cushman & Wakefield, Inc.
- **Address:** 285 Madison Avenue
- **City:** New York
- **State:** NY
- **Zip:** 10017
- **Phone:** 212-210-4881

### Device Information

<table>
<thead>
<tr>
<th>Elevator Plan Numbers</th>
<th>NYC Elevator Numbers</th>
<th>NYC Elevator Numbers</th>
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<tr>
<td>1P14273</td>
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<tr>
<td>1P14274</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1P14275</td>
<td></td>
<td></td>
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</table>

**Machine Type:**

- [ ] Hydro
- [X] Traction

**Device Type:**

- [X] Passenger
- [ ] Freight
- [ ] Escalator
- [ ] Sidewalk
- [ ] Moving Walk
- [ ] Wheelchair Lift
- [ ] Personnel Hoist
- [ ] Dumbwaiter
- [ ] Private Residential Elevator
- [ ] Conveyor
- [ ] Other

### Description of Work

For more space, please use Additional Information.

All work to conform with ASME A17.1 - 2000/2003 Appendix K

- Reduce car speed from 600 FPM to 500 FPM

**Section:** 8

- **Device:** 1P14273, 1P14274, 1P14275, 1P14276, 1P14278
- **Travel:** 1, 2 to 12 = 13 stops

- **Device:** 1P14278
- **Travel:** 3, 4 to 12 = 12 stops

---

**Received:**

**Elevator Division:**

**Professional Certification:**

**Department of Buildings:**

**Stamp Number:** 1 of 2

---

**MICROFILM APPV:**

**FOR PERMIT**

---

**STATE OF NEW YORK**

**LICENSED PROFESSIONAL ENGINEER**

**NO. 095850-1**

**NOV 21 2011**

**RECEIVED**

**ELEVATOR DIVISION**

**DEPARTMENT OF BUILDINGS**

**STAMP NUMBER:** 1 OF 2
7 Location Information Please provide the same information as in section 2
Borough: Manhattan Address: 285 Madison Avenue
Block: 1275 Lot: 23 Application Number (if applicable): 13.28.11

8 General Information
Types of Motive Power
- Elevator: [ ] AC [ ] DC [ ] Main Supply: [ ] AC [ ] DC
- Travel from Floor: [ ] B, L, 2 to floor: [ ] 12
- Total travel: [ ] 156 feet Number of Stops: [ ] 13
- Capacity: 2200 lbs Speed: 600 F.P.M.
- Elevator Control: [ ] Resistance [ ] Multi-Voltage [ ] Generator Field Control [ ] Solid State
- Mode of Operation: [ ] Automatic P.B. [ ] Constant Pressure
- Hoistway: [ ] New [ ] Old
- [ ] NYC Handicap Provisions [ ] Fire Emergency Service Phase I & II

9 Cars and Counterweight
Car Inside Dimensions: 4 feet 8 in by 5 feet 7 in
- Car Inside Area: 27.1 sq. ft.
- Car Safety Type: [ ] Instantaneous [ ] Flexible Guide [ ] Gradual WC
- Counterweight Safety Type: [ ] Instantaneous [ ] Flexible Guide [ ] Gradual WC
- Top Emergency Exit: Min Area: [ ] 488 sq. in Min Side: [ ] 24 in
- Car Opening: [ ] Door [ ] Gate
- Operation: [ ] Manual [ ] Power
- Contact Type: [ ] GS Manufacturer: GAL

10 Hoistway Opening
- [ ] Door [ ] Gate
- 1 1/2 Hr Fire Rated Construction Type
- Operation: [ ] Manual [ ] Power
- Vision Panel with Grilles
- Interlocks: [ ] Locks & Contacts
- Interlocks Type: [ ] M.O. Manufacturer: GAL
- Number of Openings: 13
- Front: 13 Side: 13
- Rear: 13 Total: 13
- Self Closing Emergency Doors in Blind Hoistway
- Interlock in Blind Hoistway

11 Pit and Buffers
- Car Buffer: Engagement Speed: [ ] 610 F.P.M. Stroke: [ ] 2 feet 9 in
- Manufacturer: ABSEE
- Type: [ ] Spring [ ] Oil
- Counterweight Buffer: Engagement Speed: [ ] 610 F.P.M. Stroke: [ ] 2 feet 9 in
- Manufacturer: ABSEE
- Type: [ ] Spring [ ] Oil
- Compensation Chain Length: 76 ft
- Compensation Rope Length: ft
- Counterweight Screen: [ ] Yes [ ] No
- Occupied Space Below: [ ] Yes [ ] No

12 Machine and Machine Room
Location of Machine: 14th Floor
Manufacturer: ABSEE
- Machine Type: [ ] Oil Worm Gear Traction [ ] Basement Worm Gear [ ] Oil Hydraulic [ ] Drum [ ] Traction Gearless [ ] Drum w/ Slack Cable Switch
- [ ] Iron [ ] Steel [ ] Ultrastrength Steel
- [ ] Iron [ ] Steel [ ] Ultrastrength Steel
- [ ] Iron [ ] Steel [ ] Ultrastrength Steel
- Car Governor Ropes: Quantity: 1 Size: 1/2 Ultimate Strength: 14500
- [ ] Iron [ ] Steel [ ] Ultrastrength Steel
- Counterweight Governor: Quantity: 1 Size: 1/2 Ultimate Strength: 14500
- [ ] Iron [ ] Steel [ ] Ultrastrength Steel
- [ ] Car Governor Location: 14th Floor
- Counterweight Governor Location: 14th Floor

[Stamp: Professional Certification, Department of Buildings, Stamp Number 1 of 2]
Location Information
Please provide the same information as in section 2.

Borough: Manhattan
Address: 285 Madison Avenue
Block: 1275
Lot: 23
Application Number (if applicable): 132811

Fee Information
Estimated Cost: $25,000.00

Statements and Signatures
Falsification of any statement is a misdemeanor and is punishable by a fine or imprisonment, or both. It is unlawful to give to a city employee, or for a city employee to accept, any benefit, monetary or otherwise, either as a gratuity for property performing the job or in exchange for special consideration. Violation is punishable by imprisonment or fine or both. I understand that if I am found after hearing to have knowingly or negligently made a false statement or to have knowingly or negligently falsified or allowed to be falsified any certificate, form, signed statement, application, report or certification of the correction of a violation required under the provisions of this code or a rule of any agency, I may be barred from filing further applications or documents with the Department.

Replacement / Modification Statement
I am filing this Replacement/Modification Application for consideration under Operations Policy and Procedures Notice #26/90. I certify that no electrical or mechanical tests need to be performed in conjunction with this work.

I have assumed responsibility for making inspections during the progress and upon completion of the indicated work. Upon completion I will file Form ELV3 to sign off on the completed work and to remove all applicable violations.

Insurance Information
Compensation insurance has been secured in accordance with the requirements of the Workman's Compensation Law as follows:

Insurance Company: State Insurance Fund
Certificate/Policy No.: 957-953-3
Expiration Date: 1/1/12

Fee Estimator
Amount Due: $346.00
Amount Paid: $0

Examined and Recommended for Approval:
Examiner Name: C.S. Kim
Signature: 11/18/11

Approved:
Assistant Commissioner's Signature: City of New York
Department of Buildings

NOV 18, 2011
RECEIVED
ELEVATOR DIVISION
DEPARTMENT OF BUILDINGS
STAMP NUMBER 1 OF 2
## ELEVATOR EQUIPMENT DETAIL

285 MADISON AVENUE

**CAT 1 TEST - 2011**

<table>
<thead>
<tr>
<th>Car #</th>
<th>Device #</th>
<th>Use</th>
<th>Bank</th>
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<tbody>
<tr>
<td>1</td>
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<td>Hi-Rise</td>
</tr>
<tr>
<td>2</td>
<td>1P14268</td>
<td>Passenger</td>
<td>Hi-Rise</td>
</tr>
<tr>
<td>3</td>
<td>1P14269</td>
<td>Passenger</td>
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<td>4</td>
<td>1P14270</td>
<td>Passenger</td>
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<td>5</td>
<td>1P14271</td>
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<td>6</td>
<td>1P14272</td>
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<td>1P14273</td>
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<td>8</td>
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WARNING

WARNING.
JUMPED OUT UNLESS CAR IS ON INSPECTION IN THE
DOOR, GATE OR SAFETY CIRCUITS SHALL NEVER BE
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February 15, 2012

Donald Zeni
Lerch Bates, Inc.
515 Valley Street Suite 160
Maplewood, N.J. 07040

Re: 285 Madison Avenue Accident

A review was made of the Lerch Bates, Inc., 285 Madison Avenue, N.Y., N.Y. Accident Investigation Report dated February 8, 2012, Accident Investigation of Elevator #9 at 285 Madison Avenue, N.Y., N.Y. on site notes of Frank Arzillo and Don Zeni of February 8, 2012 and on site pictures dated February 8, 2012. The security video from this site, controller wiring diagrams and CEC Controller Logic were not reviewed as well as an onsite visit was not made.

I am in full agreement with the conclusion stated in the report for the following reasons:

Movement of the elevator in the direction AWAY from the landing with the doors open is in violation of ASME A17.1-2010 Section 2.26.1.6 and earlier editions adopted by NYC ASME A17.1-1996 Sections 210.1e including A17.1 edition adopted by NYC when the Swift 5000 modernization was done. This operation would have been identified during the acceptance inspection and periodic inspections and therefore the operation during the accident appears to be one time occurrence.

The Lerch Bates accident report page 2 last paragraph security video indicated it takes approximately 2 seconds for elevator #9 to travel the full height of the door opening which is 7ft.

Based on the time t = 2 seconds, distance d = 7ft. and the equations of motion the following can be determined.

\[ d = \frac{1}{2} a t^2 \] where \( a = \frac{dx2}{t^2} \) \( a = 7 \times 2/4 = 3.5 \text{ ft/sec}^2 \)

This is a typical acceleration rate of elevators of this vintage and indicating normal operation.

Based on this acceleration \( a = 3.5 \text{ft/sec}^2 \) determine the velocity \( v \) at a t time = 2 seconds

\[ v = at \quad v = 3.5 \text{ft/sec}^2 \times 2 \text{ sec} = 7 \text{ ft/sec} \quad 7\text{ ft/sec} \times 60 \text{ sec/min} = 420 \text{ fpm} \]

This would indicate that the elevator was approaching rated speed again indicating normal operation.
These calculations would indicate that the elevator was operating at normal rated performance on automatic operation and would not indicate a fault condition except with movement of the elevator AWAY from the landing with doors open.
Since the Lerch Bates Accident Investigation attempted many other failure modes and none simulated what occurred during the accident the only conclusion that can be drawn is that the car was placed on automatic operation with the hoistway door interlocks and car gate contacts shorted allowing the elevator to accelerate normally away from the floor approaching normal rated speed with the doors open.

In addition since it was indicated in the opening paragraph of the report suggesting how the tragedy can be prevented in the future would also be suggested in the letter. Future modernization of the control would possibly include requirements of ASME A17.1 2.26.1.5 Inspection Operation with Open Door Circuits. If provided mechanics would have a means to check for open door circuits without the use of jumpers which may have prevented this incident from occurring since this operation would be only permitted on inspection operation and automatic operation would not have occurred. These requirements were created to address the occurrence of exactly this kind of incident.

Attached find CV of Louis Capuano indicating ASME A17.1 participation.

As a New York State Professional Engineer I have signed and sealed this letter and 4 sets of 285 Madison Avenue, New York, New York Accident Investigation Reports dated February 8, 2012.

Very truly yours,

Louis Capuano P.E.
NY 071749
February 12, 2012

CURRICULUM VITAE – LOUIS M. CAPUANO

I. PERSONAL:

Date of Birth: 03/10/1940

Marital Status: Married

Children: 2 Children; Both Married

Home & Business Address: 111 Westward Ho
                        Williamsburg, VA 23188
Telephone: Cell 908-451-9785
           Home 757-345-2634
E-Mail: lou@loucapuano.com

II. Education:


III. Professional Engineers Licenses:

1. New Jersey – 24GE01784500
2. New York – 071749-1
3. Virginia – 0402 034317
4. Missouri – 022995
5. District of Columbia – PE901751

IV. Employment Record:

Westinghouse Electric Corporation, Elevator Division 7/1962 to 1989
Schindler Elevator Corporation 1989 to 11/2002
Elevator Engineering Services LLC 11/2002 to present
1. President, Elevator Engineering Services LLC 7/2011 to present. Professional Consulting and Engineering Services to the Elevator Industry for design, the development of national elevator codes and standards and to provide expert witness testimony to the legal profession. Member of the ASME A17.1 Hoistway Committee and ASME A17.7 Performance-Based Safety Code for Elevators and Escalators. Chairman of the ASME A17.1 AD Hoc Committee on Elevator Door Protection.

2. President, Elevator Engineering Services LLC 11/2002 to 7/2011. Professional Consulting and Engineering Services to the Elevator Industry for design, the development of national elevator codes and standards and to provide expert witness testimony to the legal profession. Member, Vice Chairman and Chairman of the ASME A17.1 Hoistway Committee, Ex-Officio member ASME A17.1 Standards Committee.


V. Participation in Elevator Codes and Standards.

1. Chairman of the ASME A17.1 Hoistway Committee 2001 to 2011.

2. Member and Vice Chairman of the ASME A17.1 Hoistway Committee 1990 to 2001.

3. Ex-Officio Member of the ASME A17.1 Standards Committee 2001 to 2011.
4. Member of National Society of Professional Engineers, Virginia Board of Professional Engineers and member of the American Society of Mechanical Engineers.

5. Chairman of the ASME A17.1 AD HOC Committee on Elevator Door Protection 2011 to present.

285 MADISON AVENUE
NEW YORK, NY

ACCIDENT INVESTIGATION REPORT
FEBRUARY 8, 2012

Prepared For:
NYC DEPARTMENT OF BUILDINGS
280 BROADWAY, SUITE 409
NEW YORK, NY 10007

Prepared By:
Lerch Bates, Inc.

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Section I
EXECUTIVE SUMMARY

A. INTRODUCTION

Lerch Bates, Inc. has been retained by the New York City Department of Buildings to assist in the investigation of a fatal elevator accident that occurred at 285 Madison Avenue, New York, NY on December 14, 2011. The purpose of the investigation is to determine what caused the accident and how this tragedy can be prevented in the future.

285 Madison Avenue is a 27 story building which was built in 1926. The vertical transportation system in the building consists of a high rise bank of six elevators (1-6) and a low rise bank of six elevators (7-12). The low rise bank of elevators services floors 1-12 (the 13th floor was not in service) with the high rise bank serving floors 13-25. The original elevator system was installed by AB See Elevator Company. Several of this company's major mechanical components are still functioning including the main drive machines and governors on all elevators. The controllers were modernized and replaced with Swift 5000 equipment manufactured by Computerized Elevator Control Corp (CEC) in 1986. The elevator maintenance service provider at the time of the accident was Transel Elevator Inc.

Information was provided to Lerch Bates from Department of Buildings' personnel who were on site immediately following the incident, the NYC Department of Investigations (DOI) and technicians currently working in the building to finish elevator upgrade work. Additional information from building security video (provided by NYC DOI), Transel's operations manuals, job site wiring diagrams and controller logic were also used to finalize our report.

On December 14, 2011 at approximately 9:56am the victim approached low rise elevator #9 (city ID #1P14275). In accordance with 285 Madison Avenue lobby security video, with 2 persons in elevator #9, the victim approached the elevator and just before she entered the doorway the elevator accelerated upwards. The elevator door sill struck the victim at about knee level causing her to fall forward into the moving elevator which dragged her upwards and crushed her between the door sill and the hoistway wall.

Transel Elevator Inc., the elevator service company, had been hired by building management to perform upgrade work for the building (EBN 1328/11) on the low rise bank of elevators. It can be seen from 12th floor security video that two technicians were working on elevator #9 approximately two minutes prior to the elevator accident.

B. METHODOLOGY

Introduction

To determine the cause of the accident the investigation team simulated failures that could have caused the accident and compared these failures with security video of the actual accident. Possible causes are as follows:
- Power surge
- Speed feedback tachometer failure
- Machine brake failure
- Radio Frequency (RF) interference
- Grounding, shorts and relay failures

These results of testing and operation simulations were then compared with a control car (elevator #12, city ID #1P14278) and with the security video of the accident.

On Thursday, December 29th, 2011 the investigation on elevator #9 at 285 Madison Avenue began. The elevator had been left in the state it had been immediately following the accident after the rescue and extraction teams had left the building.
After closing all of the safety switches including the pit emergency stop, the top of car emergency stop, and the side exit switch we attempted to move the elevator on inspection speed. The elevator would not move. We then placed a jumper wire over the hoistway door and car door circuits on the controller terminal block simulating that all car and hoistway locks are functioning normally and this time the elevator moved properly. It was noted that voltage and current readings were within normal parameters. We concluded that there was not a power surge within the elevator controls system and that the safety circuit was operating normally.

Continuing on 12/29/2011 and then again on Monday, 1/2/2012 the team attempted to recreate the failure assuming a speed feedback tachometer failure. The following cases were tested on elevator #9:

1. Elevator off level in Lobby and within leveling zone with the tachometer functioning normally.
   a. The car door and hoistway lock circuits were open creating a doors open scenario.
   b. The elevator leveled into the floor normally in both directions.
   c. This is acceptable movement per code (ASME A17.1 - 2.26.1.6).
2. Elevator off level in Lobby and within leveling zone with the tachometer off the drive sheave rim creating a tachometer failure.
   a. The car door and hoistway lock circuits were wired with a clip jumper wire to create a doors closed scenario.
   b. The elevator began to oscillate up and down with increasing oscillations until the car hit the bottom limit, opens the safety circuit and shuts the car down.
3. Elevator off level in Lobby and within leveling zone with tachometer off the drive sheave rim creating a tachometer failure.
   a. The car door and hoistway lock circuits were open creating a doors open scenario.
   b. The elevator would attempt to level but when it left the leveling zone it would stop.
4. Scenario #2 above was tried again at the 2nd floor to allow the oscillations to become even larger (the elevator could not hit the lower limit and open the safety circuit). The elevator began to run at an unsafe speed and the car was shut down to prevent damage.

The above scenarios were all tested to recreate a speed feedback tachometer failure with the car not level at the floor but within the leveling zone. When these were attempted with the elevator level at the floor the elevator would not move. According to building security video provided by the DOI elevator #9 was level with the lobby floor just before the accident. Therefore the elevator would not have to re-level. It was concluded that the speed feedback tachometer was working properly at the time of the accident and did not contribute to the accident.

On Thursday 1/5/2012 the team attempted to recreate the failure assuming a main brake failure:

1. A similar load (300lbs) as 2 persons in the elevator (re-creating the loading condition at the time of the accident) was put into #9. The elevator was level with the Lobby floor and the brake was lifted. It took 30 and 24 seconds for the elevator to move up approximately 2.5 feet during the 2 tests performed. This is much slower than the rate of speed during the accident.
2. With the same load (300lbs) in elevator #9 we measured the amount of time it takes the elevator to travel the full height of the hoistway door on inspection speed. It takes approximately 8 seconds. This is also much slower than the rate of speed during the accident.

According to building security video provided by the DOI it takes approximately 2 second for elevator #9 to travel the full height of the door opening which is 7 feet at the time of the accident. It was concluded that a main brake failure did not occur at the time of the accident and the elevator was not on inspection service.
The team then reviewed the building security video provided by the DOI of the accident and compared it to video made by the Department of Buildings investigative team of the control car. The following scenarios were created and recorded on Thursday 1/5/12:

1. Elevator #12 was run in the up direction with the doors open and a car call in place at normal speed and acceleration. The movement was timed from cab sill to the upper door buck. The amount of time was between 2.3 and 2.4 seconds.

2. This was compared with video of the accident in which the same movement was timed and this time was between approximately 2.1 seconds. It must be noted that the due to the angle of the security camera it is impossible to see exactly when the sill reaches the upper door buck. Additional time must be added to the video for the sill to reach the upper door buck. Adding this additional time would make the accident movement match up very close with the control timing.

3. Elevator #12 was timed on automatic from the time a car call is placed until the car begins to move in the up direction from the lobby. This time is between 11 and 12 seconds for the car to be dispatched.

4. This was also compared with the video of the accident. The time from when the first car call is placed until the car began to move is 11 seconds.

On Tuesday, 1/9/2012 and Friday, 1/13/2012 the team attempted to recreate the failure assuming Radio Frequency (RF) interference with the controller circuitry. The team used a Motorola CP 200 two-way radio for the testing. The radio was put in several locations near the elevator controller regulator board to determine if any elevator control activity could be attributed to RF interference. The regulator board is the controller component with high sensitivity to RF interference and the component that can have the biggest impact on actual elevator movement, which is why the team used this board for testing. Several scenarios were tested:

1. All scenarios with the radio more than 12 inches from the regulator board had no effect on the operation of the elevator.

2. When the radio was placed right up against the regulator board and keyed with the car in the leveling zone but not level with the floor the car would move faster than normal down onto the buffer and stop.

3. When the car was at the floor level and the radio was placed right up against the regulator board and keyed the motor generator would shut down for most tests. In no event did the elevator move during these tests.

According to building security video of the lobby floor elevator #9 was level with the lobby floor with the doors open. RF interference would have only shut down the elevator. It was concluded that RF interference did not cause the accident.

On Friday, 1/13/12 the team attempted to recreate the failure assuming other additional controller failures:

1. The elevator car was put on the car buffer to break traction and the errors were then recorded. The errors were not consistent with the accident.

2. The elevator was run up at normal speed and while in flight (about ½ way up the hoistway) the feedback tachometer was lifted to simulate a failure. The errors were again recorded and not consistent with the accident.

3. Additional controller faults were reviewed and were not relevant to the investigation.

The DOI also provided building security video of 2 Transel Elevator technicians entering the hoistway at the 12th floor on top of elevator #9 at 9:27:48am on December 14, 2011. The technicians can be seen holding open the hoistway doors without any tools applied to the hoistway interlock. While entering the two way radio elevator #9 can be seen moving slowly down (most likely on inspection) with car doors closed. The technicians then enter the hoistway on top of elevator #9 to perform repairs.

Lerch Bates, Inc
At 9:54:27am the same technicians are seen exiting the hoistway at the 12th floor and disappear from the video. At 9:55:20am the same technicians are seen in the lobby exiting the building. At 9:56:46am the victim approaches elevator #9 and the accidents occurs.

C. CONCLUSION

All elevator systems are designed and installed in accordance with Local and National code standards. For elevators the code is ASME A17.1 Safety Code for Elevators and Escalators. Elevators in New York City are designed to these same national standards with minor local code modifications. These standards include safety devices designed to keep the public safe while riding in an elevator. One of the most critical is the safety circuit. This circuit includes switches such as the emergency stop button in the elevator, the emergency stop button in the elevator pit, the travel limit switches, the car door lock and the hoistway door locks along with many others. When this safety circuit is functioning normally and not compromised it does not allow the elevator to run if it is not completed or “made up”. If this circuit is compromised by wire jumpers, the mandatory safety features are disabled and the riding public is put in danger.

Modern elevator controllers are designed with wiring terminal panels and mechanical connections points for key wiring circuits including safety circuits. This design allows convenient installation of circuit wiring, but more importantly can provide a technician with a means to test circuit continuity. The wiring and any device wired in the circuit can be tested for continuity with a test light or resistance tester. This design also allows technicians to place a clip wire jumper between terminals and close a circuit, providing a direct connection between two points. This jumper disables or “jumps out” any safety device included in the circuit. This troubleshooting process can determine if an integral safety component has failed. However, if the wire jumper is left in place and a required safety device is not functional a condition which can endanger an elevator rider or service person will be present. It is for this reason that the National Elevator Industry Inc. (NEII) Safety Handbook has very strict procedures when using wire jumpers. Transel Elevator Company’s Standard Operating Procedures & Responsibilities Manual includes the 2010 NEII Safety Handbook.

It was noted during the initial startup of elevator #9 that the car would not move until the safety circuit was fully closed. Due to the damaged to the doors the car doors and hoistway locks were jumped out to move the car. When these jumpers were removed the car would not move.

During the testing of the speed feedback tachometer we were able to simulate several unusual scenarios causing the car to move up and or down not consistent with “normal” elevator operations. However, if the safety circuit was open and the car was level with the floor the elevator would not move. It can be seen in the video of the accident that elevator #9 was level with the first floor door sill.

In testing the brake it was noted that the elevator slowly drifted in the up direction taking as long as 30 seconds to move only 2-1/2 feet. This is not consistent with video of the accident.

RF interference testing also proved unusual movement of the elevator in the down direction with the car not level with the floor. When the elevator was tested level with the lobby floor, the safety circuit engaged and the radio directly up against the regulator board the elevator would not move. In fact the elevator would shut down.

Additional control errors were tested and none were found to match the conditions of the accident.

In reviewing the security video of the actual accident and compared with the control elevator the conditions matched that of elevator #9 in automatic mode.

Lerch Bates, Inc
The only condition in which elevator #9 could have moved during the accident is if the elevator was on automatic and the safety circuit was fully closed. The security video clearly shows the doors in the open position when the elevator begins a normal ascent from the lobby floor. It is our opinion that a portion of the safety circuit, most likely the car door and hoistway locks, were overridden by a jumper at the control panel in the elevator machine room for the car to move.

Information used to compile this report:

Field Notes dated February 7, 2012 – Attached
Pictures of equipment at 285 Madison Ave - Attached
Security Video from 285 Madison – Provided by DOI
Controller Wiring Diagrams – Provided by Department of Buildings
CEC Controller Logic – Provided by Department of Buildings
Accident investigation of Elevator # 9 at 285 Madison Avenue NY, NY

On site notes Frank Arzillo/Don Zeni

February 8, 2012

Thursday 12/29/2011

Don Zeni of Lerch Bates on site at 8AM with Chief Douglas Smith from DOB, Eric Appana from Computerized Elevator Control and Joe Trapani and Richard Grima of PS Marcato Elevator. In addition elevator consultants representing the owner of the building, the managing agent, Transel elevator and DTM consulting were on site. Harry Vyas and Christopher Santulli from the NYC Dept of Buildings were also on site.

Tach bracket was bent by New York City Fire Department trying to drift car #9. Joe from PS Marcato had his men remove bracket to repair same so we could run car #9. Rim had no oil on it and was dry.

The team checked car #9

- Pit stop, top of car stop, side exit switch, car stop switch, safety plank switch, final limits,
- Interlocks, gate switch and governor which are working and wired as per prints on job site
- Brake, machine and generator
- The control is Swift 5000 and was installed in 1986
- The rim of the drive sheave where the feedback tach is located was checked.

With the motor generator turned off there is no voltage at the hoist motor armature nor current at the hoist motor armature. The motor generator is now allowed to start and the hoist motor voltage is measured between 2.16 & 2.18VDC and the current is measured between 9.8 & 9.9amps. The MG is turned on and off and the readings never go above 2.5VDC and 12 amps. The elevator was placed on panel test to run it from the machine room. Elevator #9 is then run down from the controller panel all readings normal.

The team also checked the gate switch and found it was functioning normally. A damaged wire on the car top was also investigated but it was not wired to any circuits.

At about 2:30 PM Frank Arzillo replaced Don Zeni as part of the Team.

We continued with the investigation of car #9. After checking the generator and controller with power we tried to move car without door locks or gate jumped out, but car did not move. Moved the car on inspection with locks and gate jumped and found that we needed to adjust the car rollers since the safety was rubbing the rails due to the accident. PS Marcato men adjusted rollers.

1) We started to run car #9 on inspection again in the up direction, but the brake would pick up and the car did not move. Found a bad contact of relay MC (this controls AC power) contact 13-14 in the regulator circuit. Checked wires and relay terminals; found a loose wire.
2) Test: With MC 13-14 opened and brake wire off on inspection, current builds to 176 amps in armature circuit. When brake wire was put back, car ran up 6 inches and stopped.
3) With car below lobby floor with or without doors and gate jumped, we put car on auto and car would re-level up normally.
4) With car below lobby floor and rim tach off machine sheave, when we put car on auto, car moves up and down oscillating until it goes down onto the down final limit.

5) Same as 4 but on second floor to see the oscillation with more space below car. The car again oscillates but the oscillations become bigger and bigger until the car runs down at a higher speed and we stopped the car. We had a drive fault error 27 on the monitor. The computer did not stop the car. This test was performed a few times.

**Monday 1/2/12**

1) Testing again on 2nd floor with feedback tach off rim without door locks and gate jumped, the car does not move.

2) With locks and gate jumped on 2nd floor, car below or above floor, in order to re-level car, put on auto and car would oscillate with speeds between 134 and 521 feet per minute. Then car would run down at the higher rate of speed (521 FPM) into the pit on the buffer. The MC relay dropped out and picked back up but DF relay never dropped out and the controller did not stop the car.

3) Same test as #2 a few times above and below the 2nd floor and the same thing would happen each time with drive error fault #27 and the car going down onto the down final limit and on the buffer.

4) The test from the second floor was only performed to learn what would happen if we had more travelling distance. With car #9 in the lobby, any oscillation swings would trip or hit the down final limit in a few inches below the floor, opening the safety and stopping the car.

5) Car at lobby, door locks and gate switch open, car on independent, door switch off, car on auto put 5 and 7th floor car calls in. Car did not move.

6) Same as 5 but off independent and now in service. Car did not move.

7) Same as 6 but turned door switch on and locks still open. After 5 and 7th floor car calls entered, the car opened and closed, but car did not move. Car was taken out of service by the CPU. VCR Tape at 5 min. 36 seconds.

8) Car #9 below floor, door circuit open and car re-leveled up normally and stopped.

9) Same as 8 but above floor. Same thing happened.

10) Car #9 at lobby above floor with gate open and tach feedback off rim, put car #9 on auto, car leveled down below floor and stopped when we lost DZ relay (door zone) VCR at 31 minutes. This is correct since the car should not re-level if it's out of the door zone.

11) We measured the door close time at 4.5 seconds for car #9.

12) Car #9 at lobby on auto, doors and gate jumped, put car call in, after 11 seconds car runs up normally.

13) Any time relay DH is up, the doors will close under power. If car re-levels, DH will pick up and possibly close on a person entering or exiting car. This is not a safe circuit, must be removed to avoid injury from car door hitting people. Contact of DH-5-8 around relay C- 53-54. This is unrelated to the accident and is noted here only as a safety item.

14) DH picks up when you have a signal to run.

15) Car #9 on second floor with door gate working normally on auto in service, put corridor call in lobby. After doors open at lobby, we entered the 5th floor call. The car runs up in 11 seconds.

16) Same as 15, but placed second car call to 7th floor 3 seconds after 5th floor call is placed. Car runs up in 11 seconds.

17) Looked at bits 2 and 3 in the CPU with a laptop which shows this bit to be turned off on car #9. This controls the Panic Motion Fault feature. If this was on, the car would not stop for a few
inches after we lifted the feedback tach off the rim of the machine sheave. This is unrelated to the accident because elevator #9 was level with the lobby floor at the time of the accident.

18) Due to the damage to the elevator #9 cab from the rescue efforts, sensors were damaged and we lost counts. Car will not run due to DPP sensor on top of car hitting pipes on wall at center of shaft, damaging wires on back of sensor. PS Marcato to repair sensor tonight.

**Tuesday 1/3/12**

1) Removed all MO rollers from hoistway doors for safety. This will prevent the doors from inadvertently opening on a floor.
2) Car #9 on 5th floor locks and gate jumped, sent car to lobby. After 10 seconds, put 5th floor car call in, 11 seconds later car started in the up direction normally.
3) We found out that the lights in the car were out due to missing light fuse, which was removed by PS Marcato’s men when checking cab. Replaced fuse, now door safety ray is working and car can run. Car #9 was running without the safety ray working because they were using a normally closed contact for this circuit. This is not a good idea since the doors are able to operate without power to the door safety ray since they are using the back contact. A safer way would be to use a normally open contact so when you do lose the feed to the light ray, the door will stay open and the care will not be able to run, thereby eliminating a possible hazard to the public. Nudging time is 20 second with light ray blocked.
4) Car #9 at lobby with door safety ray blocked, lock and gate jumped car #9 on auto, we placed 5th floor car call in. Car started to move up in 33 to 35 seconds. This includes nudging time of 20+ seconds plus 11-12 seconds for the dispatch of the car.
5) Same but gate not jumped and door switch on. Car does not move until gate closes to make switch.
6) We measured the Feedback tach voltage 10.05 volts up and down for reference.
7) Speed up 491 FPM and down 494 FPM
8) TFS point 9.31 volts up 9.29 down TFS should be higher than tach voltage. TFS= Tach Fault Sensor. This voltage is slightly out of adjustment but is not related to the accident.
9) SR (speed reference) 10.16 up 10.14 down
10) DH signal = if you have a signal to move it picks up. Not if you are moving as a car running circuit.
11) DF relay = Drive Fault (which never dropped out even when we had a drive error fault 27
12) For reference Douglas, Rich and I on top of car for shaft inspection. Inspection switch, stop switch, and all door locks work. Adams door restrictor was installed and 13th floor manual access limit switch also installed but no keyed switch. Greenfield was installed right to left along top of GAL door track about 7 feet.
13) For reference in pit, down final limit switch operating at about 18 inches from floor level. There is a 24 inch buffer for car. Count of 1000= floor level car stops below lobby on final limit at 950. .375 X 50 =18.75 inches

**Wednesday 1/4/12**

1) Using car #12 as control car. Door switch off for test.
2) Tach voltage= 10.16 up, 10.16 down TR to ground
3) Tach Fault TFS to ground 8.7 up, 8.8 down this is low and should be higher than tach voltage
4) Panic Motion fault is off as per bits 2, 3 same as car 9
5) Speed reference voltage 10.2 up, 10.2 volts down

[Signature]

2/5/12
6) Car #12 on 2nd floor, above the floor to test the re-level. On automatic, car levels down normally.
7) Same as #6, except below floor. Car re-leveled normally.
8) With car #12 at lobby below floor, tach off rim, car on auto to re-level car. Car oscillates and went down at a higher speed and stopped on limits and buffer. Error 30 and 20 were on monitor.
9) Same as #8 but above floor - same results.
10) Put panic motion fault bits #2 and 3 on (active). Put car on 2nd floor below floor level with rim tach off sheave. Put car on auto, car started to re-level and moved about 5 or 6" and stopped, with error fault #9 which equals panic motion fault. This feature works correctly if bits 2 & 3 are put on.
11) Tach voltage should be 5 to 10% lower than speed reference voltage.
12) Tach fault checks speed reference against pattern.
13) Performed the same test as #10 to check to see if DF relay drops out. It did not, but car did stop.
14) Date on proms 10/31/11.
15) Regulator card looks ok, no burns, etc.
16) Check speed of car 492 feet per minute up and 493 feet per minute down.
17) Testing completed on control car (#12).

Thursday 1/5/12

1) Using control car #12 again for this test. Removed MO roller (so doors do not inadvertently open on a floor) from lobby hatch door for testing purposes.
2) Hoistway door locks are jumped, gate is working. Car is on automatic and sent to 2nd floor with car call. Timed car movement from floor level to top of lobby door buck--2.4 seconds.
3) Same as 2, except put in 5th floor car call—timed run, 2.3 seconds.
4) Door still in operation and gate also jumped, put 2nd floor call in. Measured car movement, 2.3 seconds (gate starts to move as car moves up). Gate and locks jumped, doors switch off, put 2nd floor call in. 11 seconds after call is placed, car moves to 2nd floor.
5) Put door switch back on, door in operation, car at lobby, break light ray 2 times to check time it takes car to leave floor after beam is broken. Again it takes 11 seconds and doors started to close at about the same time car starts to go up.
6) Same as 5, but now we reinstalled MO roller at the lobby floor so we can see the hatch door starting to close on the video and the timeframe for the video is at 32 minutes 25 seconds. As car moves up, doors close about 3”.
7) For reference tested travel time on inspection speed to top of door buck--8 seconds.
8) Drift test travel time with 300 lbs. of test weights in car. Removed regulator wire off output and disconnected generator fields. It took 30 seconds to move 2-1/2 feet. The video time is 42 minutes 20 seconds.
9) Completed testing on car #12 and starting to test car #9.
10) On #9 car door locks jumped, gate working, car at lobby, putting in 2nd floor call, but doors won’t close because light ray is misaligned. We took the light ray out of our observations by disconnecting.
11) Timing movement of car from floor level to top buck, sending car to 2nd floor on automatic. Time was 2.3 seconds. The second stop watch was 2.4 seconds. Time on video is 12 minutes, 30 seconds.
12) Same as #11, but sent to the 5th floor, first stop watch 2.5 seconds, second stop watch 2.5 seconds.
13) Same as above, car sent to the 2nd floor, same results.
14) Now sent car to 5th floor again, both stop watches 2.3 seconds, movement floor level to top of buck.
15) Locks and gate jumped, doors not in operation, first sent car to 2nd floor, both stop watches 2.5 seconds each.
16) Same sending it to 5th floor, 1 stop watch 2.5 seconds, other 2.6 seconds, time on video 25 minutes.
17) On inspection, 8.0 seconds on one stop watch, 8.3 seconds on second stop watch, video 23 minutes 25 seconds.
18) Drift test with 300 lbs. in car – 24 seconds to move 2-1/2 feet, time on video 33 minutes 15 seconds.
19) With car in service and at the second floor, we registered a lobby corridor call, then registered 5th and 7th floor car calls to see if doors close as it moves up, with locks and gates jumped and car doors in operation. Car door starts to move at same time car goes up. Time from doors open to movement is 11.5 seconds.
20) For reference we balanced car with 900 lbs. of test weights in car. Capacity of car is 2200 lbs.
21) For reference we check resistance to ground using a mega both the armature machine fields and generator.
22) For reference we ran the car for 1 hour non-stop to various floors, top to bottom and used a VCR to capture any faults that might occur within that time frame. No problems developed and there was no change in run times at 30 minutes and 60 minutes of running the elevators non-stop.

**Monday 1/9/12**

1) Looking at video of the accident on Car # 9 at Lobby dated 12/14/11. Also video working on 12th floor.
2) Before accident doors close in about 3 seconds. Car arrives and departs lobby normally and always at floor level with no re-leveling before accident.
3) On final trip, Car # 9 arrives at lobby and is floor level. With doors still open, in about 25 seconds, person number #1 enters Car # 9 and puts a car call in for the 5th floor which was told to me by the DOI group. Eight seconds later person #2 enters and puts a call in for the 7th floor. The Elevator is level and has not re-leveled at any time. Two seconds later person #3 starts to enter with her foot at the car saddle; Elevator #9 starts to move up with doors starting to close maybe an inch or two from full open. The Elevator moves up in a normal ascent and speed with both the car gate and lobby hoistway door open.
4) The camera angle to view the lobby video at Car #9 is above the door. We could not see exactly when the sill reaches the upper door buck. The ascent from floor level to when it disappears from our site takes 1.9 to 2.1 seconds to travel. I timed this three times.
5) **Elevators on automatic cannot run with any interlock or gate open.**
6) The travel, acceleration and speed are all normal, for 500 feet per minute elevators, as seen on this video.
7) After doors open fully at lobby until doors start to close and car also starts to move is about 36 seconds.
8) As seen on video the time between doors fully open and first car call placed is 25.32 seconds. Second car call placed at 33.9 seconds. Car starts to move at 35.10 seconds.
9) It takes about 12 seconds for car to start to move after first call is placed, looking at video. This is consistent with the time of 11 seconds we have measured on Car #9 after a car call was placed in our investigation. 11 seconds was consistent on any run we timed.
10) Timed it again 35.17 seconds.
11) Waiting time as next car in lobby of about 25 seconds plus about 11 seconds = 36 seconds. This is about the same we measured for cars #9 and #12 on other test runs.
12) Doors close about 1 to 2 inches as car starts up, both at the same time.
13) Time of car movement and accident is 9:56:49 AM on 12/14/11.

Monday 1/9/12   At 285 Madison Avenue to video #9

1) Car #9 in lobby below floor with door switch off, gate switch open. Put car on auto. Car leveled up normally and stopped. Video time=50 seconds
2) Same but above floor. Car leveled down and stopped level. Video time 2.3 minutes.
3) Same as #1 but locks and gate jumped. Car moved down slowly because we had a contact failure of MC 13-14. Rich in machine room hit relay and car re-leveled up normally after contact of MC made. Video 5:10 minutes.
4) This is first time MC 13-14 failed since 12/29/11.
5) Same as #3. Leveled up and stopped. Video time 8:45.
6) Car below floor with doors and gate not jumped and tach off rim, put car on auto. Car leveled up above floor about 3 inches and stopped. Video time 11:05 minutes.
7) Same as #6 but locks and gate jumped put car on auto. Car oscillates and goes down onto final limit and buffer. Video 12:45 minutes.
8) Same as #7 but above floor. Car oscillates and went down on final limit and buffer as always. Video 16:50 minutes.
9) Radio frequency check. With car #9 on 2nd floor, locks and gate jumped and on auto we sent car to lobby. After car got up to speed Rich keyed his radio a few times holding it on the REG. board. The car was jumping into floor then went below floor and stopped. Video 21:00 minutes.
10) Same as #9 but radio was put at 19 to 20 inches from the REG. board. Car came into Lobby almost normally. Video time 23:12.
11) With car #9 above floor about 10 inches and radio on REG. board locks and gate open, car on auto. When radio was keyed car lunged down onto buffer. Video time 28:2.5
12) Same as #11 but below floor about 2 inches. Car went down again onto buffer but not as fast. Video time 34:50.
13) Same as #12 but radio at 19 inches from REG. board. Car leveled up normally. Video time 36:40.
14) Same as #12 but radio at 12 inches away from REG. board. When we put car on auto MC relay contact failed. Hit relay again and car leveled up normally as Rich keyed radio. Video time 37:50.
In machine room

17) Brake test at full speed. Opened governor safety switch after car #9 was at full speed. Car stopped in 3 to 4 feet.
18) Speed up = 482 FPM. Speed down = 493 FPM. 
19) Car #12 up speed = 484 FPM. Down speed=493 FPM. 
20) Run time for Car #12 between 12th floor and Lobby = 22.95 seconds.
21) Run time for Car #12 between 11th floor and Lobby = 20.33 seconds. 
22) NDH = Next up door hold time at lobby terminal=10 seconds.
23) NDP = 0 (No time)

Tuesday 1/10/12

Meeting at DOB 8:30 Am.  1:30, reviewing Transel’s Manuals

Friday 1/13/12

Meeting at DOB 9 AM.

1 PM back to 285 Madison Ave.

1) Running Car #9 top to bottom we still get an NTS error at 12th floor but going into lobby, it is now almost a normal run with no NTS error at lobby floor.
2) Radios used by us for testing are Motorola CP 200. 
3) We then started the radio frequency interference test. 
4) Car #9 at lobby, floor level with locks and gate not jumped. Put car on automatic and keyed radio from 36 inches down to 13 inches from REG. board with no interference or movement from car #9. At 12 inches REG. LED light starts to lite dimly and at 1 inch MG shut down with REG. LED bright, car never moved. No errors on monitor.
5) The LED REG. light comes on when the regulator board senses an error.
6) We did this a few times. Most of the time the MG shut down and the REG. LED light would stay bright. The other times the REG. LED would light dimly, but the MG set would stay running. At no time did the car move or send any error signals.
7) With Car #9 at the lobby on auto with locks and gate jumped, we sent car #9 to the 6th floor. At high speed we opened the door lock circuit. The car stopped with error #15 on the monitor and on the REG. board the V and OSC LED light were lite along with the REG.LED. The board had tripped.
8) Same as #7 but down. Same results
9) Car #9 at lobby doors jumped. Sent car to 12th floor. At high speed keyed radio (1” from REG. board) car may have increased speed by 20 FPM. Came into floor normally with no errors.
10) V and OSC LED lights should be on for normal operation. The REG. LED light is a fault indicator and if it’s dim indicates an out of regulation fault.
11) Panic motion fault is turned on or off using a laptop computer. 
12) Ran Car #9 to 11th floor and keyed radio with radio on REG. board. Tripped REG. board and car stopped. We did this a few times with very little movement of the car. It did trip REG. board twice. 
13) Car #9 at lobby on inspection, limits jumped ran car down on inspection speed on buffer to lose traction and see what error we get. Errors 27, 25, 20, and 15 left to right on monitor.
14) Car #9 on buffer cleared all errors and ran car down on auto which broke traction with only error #20.
15) Car #9 at lobby on auto, doors jumped. Placed calls for 10th and 11th floors. At full speed lifted tach from rim. Car stopped with errors 15, 24, 58, 24, reading left to right. Plus REG. TF LED fault light was lit.
16) Looked at Transel's Maintenance log book on Car #9 controller which indicates that on 10-17-2011 someone wrote he saw errors 15, 18, 15, 17 for this car.
17) Same as #15 but with errors 24, 58, 24, 0, and if we did not put the tach back onto the rim, the car still moved up at a slow speed, about 100 FPM. Car stopped after we put the tach back on the rim.
18) Completed on site field tests and investigation.