



2026 INSC 756

REPORTABLE

IN THE SUPREME COURT OF INDIA
CIVIL APPELLATE JURISDICTION

CIVIL APPEAL NO. 4081 OF 2014

M/S OTIS ELEVATOR CO. (INDIA) LTD.

...APPELLANT(S)

VERSUS

RASHMI HANDA & ORS.

...RESPONDENT(S)

WITH

CIVIL APPEAL NO. 1602 OF 2020

J U D G M E N T

1. Due to the limited availability of urban space, cities are growing vertically rather than horizontally. Elevators have become essential part of modern urban life. Strangers step into a small steel chamber, the doors close, and for a few moments they place their safety entirely in the hands of a mechanical system over which they have no control. In a crowded elevator, particularly at public spaces, the sense of confinement is real. The air feels heavy, personal space disappears, and the awareness of being suspended between floors naturally creates unease. The slightest jerk, an unexpected stop, or an unusual mechanical sound can quickly turn discomfort into fear, reminding every passenger that safety is not

merely expected but is a fundamental assurance that every elevator must provide.

2. Given the ever-increasing usage of passenger elevators in the modern-day urbanising societies, recognising them as a mode of vertical transportation is imperative. In this transportation, passengers have no control over the conveyance and they have to entirely rely on automation or the operator as the case may be.¹ It is not merely reasonable, but a legal necessity to impose a heightened *duty to care*, akin to that of *common carriers* in view of the intrinsic passenger vulnerability. An elevator must be construed and deemed to be a *common carrier*² and the operator, in the wider sense must undertake greater responsibility to transport passengers from floor to floor and exit safely.

3. A contract of carriage is fundamentally between the carrier and the passenger. The carrier, in the context of user of an elevator at public places will take within its sweep the manufacturer, the operator and owner of the premises provisioning its services for the users. Therefore, from the perspective of a public law identifying and provisioning effective and

¹ Such a public safety rationale is well expressed in the decision of the Supreme Court of California in *Treadwell v. Whittier* 80 Cal. 574, 22 Pac. 266 (1889) way back in 1889 -

"The aged, the helpless, and the infirm daily using these elevators. The owners make profit by these elevators, or use them for the profit they bring to them. The cruelty from a careless use of such contrivances is likely to fall on the weakest of the community. The law, therefore, throws around such persons its protection, by requiring the highest care and diligence."

² Michael D. Marrs, Carriers - Personal Injuries - Escalators and Elevators - Escalators are Not Common Carriers in Illinois, 45 Chi.-Kent L. Rev. 111 (1968), *Christie v. Griggs*, 2 Camp. 79, 170 Eng. Rpt. 1088 (1809); *Galena and Chicago Union Ry. Co. v. Yarwood*, 15 Ill. 468 (1854) and *Springer v. Ford*, 189 Ill. 430, 59 N. E. 953 (1901).

efficacious restitutionary remedies, it is appropriate to hold the manufacturer, the operator and owner of the premises as the duty bearers and shall jointly and severally be liable to safeguard the user. The principle arising out of composite negligence is well articulated in many decisions of this Court³ entitling a plaintiff/claimant to sue joint tortfeasors and recover damages. The burden of identifying the *inter se* liabilities of joint tortfeasors should not rest on the shoulders of the consumers seeking compensation for injury caused due to transportation through an elevator. For immediate relief, it is necessary for the Court to recognise the injury and assess the compensation payable at the first instance. In so far as the apportionment of the liability of the joint tortfeasors, the Courts will examine the *inter se* contractual relationship and other circumstances before passing orders apportioning the liability and compensation.

4. M/s. OTIS Elevator Company (India) Ltd. ("OTIS") is in appeal⁴ assailing the order passed by the National Consumer Disputes Redressal Commission ("NCDRC") whereby OTIS, Research and Analysis Wing ("RAW") and the Military Engineering Service ("MES") were held jointly and severally liable to pay compensation to the family of the deceased, who was crushed to death due to the malfunctioning of the elevator installed and operated by OTIS for the offices like RAW, maintained by

³ *Khenyei v. New India Assurance Co. Ltd. & Ors.* 2015 (9) SCC 273.

⁴ Civil Appeal No. 4081 of 2014 before the Supreme Court of India against the order dated 21.01.2014 of NCDRC in OP 25 of 2005.

MES. The connected appeal⁵ by the wife of the deceased is against the order of the executing court not proceeding further, awaiting the final outcome of the civil appeal filed by OTIS. The appeals filed by MES and RAW were dismissed by this Court at the admission stage without detailed consideration. OTIS being the main contestant, we have considered its appeal in detail.

Factual Overview

5. OTIS, a lift manufacturer, installed the lift in question (“the lift”) in the RAW office complex at Lodhi Road, New Delhi, in December 2001. The lift was reserved for the use of officers of the rank of Joint Secretary and above. On 24.05.2002, MES had entered into a Maintenance and Repair contract (“Maintenance Contract”) with OTIS for the upkeep of the lift.

6. On 20.03.2003, at about 10.40 a.m., a meeting of senior RAW officers concluded on the 11th floor of the RAW complex. During the descent, the lift, carrying 13 occupants including the deceased, abruptly stopped between the 6th and 7th floors. Staff from the control room opened the lift door manually on the 7th floor, switched off the main supply Miniature Circuit Breaker (“MCB”) in the Machine Room on the 11th floor, and began rescuing the stranded occupants one by one. The first officer was rescued successfully.

⁵ Order dated 02.05.2019 of NCDRC in EP No. 41 of 2019 in OP No. 25 of 2005.

7. While the deceased, the second officer being rescued, was half inside and half outside the lift cabin, the lift suddenly moved downward for about 5–7 seconds, crushing his neck between the cabin roof panel and the floor and causing his death. The lift came to rest near the 6th floor, and the remaining eleven occupants were rescued without any further issue. The death resulted in the filing of an FIR at Lodhi Colony Police Station under Section 304-A IPC. Subsequently, upon Delhi Police's request for a technical assessment of cause of failure, Prof. C.M. Bhatia was deputed for the task by Director, IIT Delhi. He submitted his Technical Investigation Report on 27.04.2003. Pursuant to the report and further investigation, a chargesheet was drawn against certain MES officers on 15.07.2003.

8. On 18.03.2005, the deceased's widow, Ms. Rashmi Handa, and their two children filed Original Petition No. 25 of 2005 before the NCDRC against OTIS, RAW and MES, claiming compensation of Rs. 1.89 crores along with interest at 20% per annum from the date of the claim.

9. OTIS resisted the complaint principally on the ground that the accident was caused by voltage fluctuation, of which it had duly informed MES, and that responsibility for the accident lay with MES's personnel, who had allegedly tampered with the Brake Release Key in the Machine Room without OTIS's knowledge, in violation of Rule 6(xiii) of the Bombay Lift Rules, 1958 (extended to Delhi) and of stickers posted by OTIS inside the lift prohibiting interference with its mechanism. RAW contended that it

was itself a “consumer” of the services of OTIS and MES, that the Commission had no jurisdiction over it, and that responsibility for maintenance vested in MES and OTIS. MES denied any negligence, relying on Clause 6.1 of Maintenance Contract with OTIS, which placed liability for accidents during the operation of the lift on OTIS as the maintenance service provider.

Impugned Order

10. By order dated 21.01.2014, the NCDRC allowed the complaint. It rejected OTIS’s objections to maintainability (founded on the absence of one complainant’s signature) and to jurisdiction (founded on the contention that the matter involved complex questions of fact), holding that the National Commission was competent to adjudicate such questions. On merits, it held OTIS deficient in service for having installed and operated the lift without a Voltage Stabiliser despite being aware of the risk, for its failure to depute site personnel or maintain attendance records, and for want of evidence of any site assessment or emergency training provided to RAW and MES. RAW and MES were held jointly and severally deficient for having failed to install the recommended stabiliser and to monitor and enforce OTIS’s compliance with the maintenance contract. MES was held liable for its failure to maintain attendance records evidencing the presence of OTIS’s site engineer.

11. The NCDRC awarded the complainants a compensation of Rs. 3,01,48,195/- with interest at 9% per annum from 20.03.2003, the date of death, payable within 90 days, failing which interest at 12% per annum would apply until realisation. Liability was apportioned such that RAW was made liable for 5% and MES for 25% of the decretal amount, with the residuary liability, i.e. 70%, cast upon OTIS.

Subsequent Proceedings

12. OTIS, MES and RAW filed separate appeals against the order dated 21.01.2014. On 16.02.2015, this Court dismissed RAW's appeal, and later, on 06.07.2017, this Court also dismissed MES's appeal for default, leaving MES's and RAW's liability under the NCDRC's order undisturbed.

13. On 19.02.2019, the complainant filed Execution Petition No. 41 of 2019 before the NCDRC seeking recovery of the decretal amount. By order dated 02.05.2019, the NCDRC dismissed the execution petition as premature, recording that RAW had complied with the order dated 21.01.2014, that OTIS's challenge to that order was pending before the Supreme Court, and that the complainant would be at liberty to file execution proceedings afresh after the appeal was decided.

14. The complainant assailed the order dated 02.05.2019 by way of a further appeal, principally on the grounds that the executing court could not go behind a decree and was bound to execute it as it stood, that the

pendency of OTIS's appeal was immaterial to the execution proceedings, and that, MES's own appeal having already been dismissed for default on 06.07.2017, MES's liability stood crystallised and could not be held in abeyance on account of OTIS's pending appeal.

Arguments

15. We heard Mr. Gopal Sankaranarayanan, learned senior counsel appearing for OTIS, Mr. Saurabh Suman Sinha, learned counsel appearing for Mrs. Rashmi Handa, and Ms. Aishwarya Bhati, learned Additional Solicitor General appearing for MES.

16. Mr. Gopal Sankaranarayanan fairly stated that the sole issue involved in this matter is the determination of liability of the concerned defendant and if that question is decided, the incidental issue relating to legality and validity of the quantum of damages need not be gone into. As regards liability he submitted that -

16.1. First, the Technical Report of Prof. C.M. Bhatia unambiguously attributes the sudden downward movement of the lift, and consequently the death of the deceased, to the manual release of the mechanical brakes through the Brake Release Key in the Machine Room, a room in the exclusive occupation and control of MES, to which no OTIS personnel had access at the relevant time.

16.2 Second, OTIS had, as early as 04.07.2002, identified voltage fluctuation as the underlying cause of the lift's persistent malfunctioning and had specifically recommended installation of a Voltage Stabiliser to MES; MES's failure to install the stabiliser despite this warning could not be visited upon OTIS.

16.3 Third, no OTIS mechanic was required to be present at the site at the time of the accident, since, under Clause 3.2 of the Maintenance Contract, the duty hours of OTIS's mechanic were 0700–1000 hours, 1230–1430 hours and 1630–1900 hours, whereas the accident occurred at approximately 1045 hours, outside these hours.

16.4 Fourth, he drew attention to the charge-sheet filed by the Delhi Police, which fixed responsibility for the accident on the employees of MES and not on OTIS. He accordingly submitted that the NCDRC erred in casting the principal share of liability, i.e. 70%, upon OTIS, and that this liability ought properly to fall on MES, in whose custody and control the Machine Room and the Brake Release Key remained at all relevant times.

17. Mr. Saurabh Suman Sinha, learned counsel for the Respondent-Consumers, drew the attention of this Court to the various clauses of the Maintenance Contract between MES and OTIS, and submitted the following –

17.1 The provisions of the Maintenance Contract cast a comprehensive and non-delegable duty on OTIS, as both the manufacturer and the maintenance contractor of the lift, to keep the lift “*in sound condition to avoid risk of accident*” under Clause 3.1, to depute a qualified mechanic on site during fixed hours daily under Clause 3.2, and to maintain attendance and complaint registers verifying discharge of these obligations under Clauses 3.3 to 3.5.

17.2 OTIS produced no attendance register, duty chart or log book to show that its mechanic discharged these obligations on the date of the accident or on any date proximate to it, notwithstanding that record shows no fewer than six formal communications between April and August 2002, and a total of nine recorded breakdowns of Lift No. 6 alone in July and August 2002, putting OTIS on repeated and continuing notice of the lift’s persistent malfunctioning.

17.3 OTIS’s own letter dated 04.07.2002 demonstrates that OTIS itself appreciated the danger posed by voltage fluctuation, yet OTIS took no further steps to ensure that the stabiliser it had itself recommended was installed, nor did it decline to certify the lift as safe for continued use in the interim, nor communicate any further reminder to MES after 04.07.2002 despite the breakdowns continuing unabated through the following two months. He accordingly submitted that Clause 6.1 of the Contract, which

places liability to pay compensation for any accident during the operation of the lift squarely on OTIS “as the contractor,” only reinforces the correctness of the NCDRC’s apportionment of 70% of the liability upon OTIS.

Analysis

18. In the present appeal, the sole issue that needs to be adjudicated is the apportionment of liability between OTIS, RAW and MES. In this context, it would be relevant to understand the contractual provisions which govern the relationship between the parties, the communications regarding the upkeep of the relevant lift, and the report prepared by Prof. Bhatia.

19. The maintenance of the building in which the lift was installed was under the overall charge and management of MES. MES contracted the repair and maintenance of all the lifts in the building to OTIS through a tender, and entered into a Repair and Maintenance Contract on 24.05.2002. The scope of the contract is detailed in Clause 1.1—

“1.1 The work under this contract covers comprehensive maintenance and repair of existing lifts regularly and systematically examining, adjusting, lubricating as required and repair including renewals/replacement of any electrical/mechanical parts for smooth and efficient functioning of lifts using only genuine parts of ‘OTIS’ Maker. All the parts which warrants repair/replacement except rubber astragals of doors safety shoes/hoist ropes sheaves shall be repaired or replaced accordingly. Replacement of Batteries and repair/maintenance of electrical fittings i.e. emergency call alarm, bell/buzor indicator, cabin fan including grills and the accessories are

covered under the contract. The necessary T & P required shall also be claimed to be included in the rate quoted by the contractor.”

20. Clauses 3.1 and 3.2 of the Contract lay down the contractor's broad responsibility -

“3.1 The contractor shall be responsible for the electrical and mechanical fittings of the lifts and maintenance of the same to keep them in sound condition to avoid risk of accident. The contractor shall stock sufficient parts/major assembly to ensure putting the lifts in working condition in shortest possible time, to avoid inconvenience to the users. The tendered rates shall be deemed to include for the above contingencies.

3.2 Maintenance and supervision shall be done by trained men for the safe operation of the lifts. The contractor shall carry out fortnightly servicing of each lift including adjustment, lubrication, repair or replacement of parts if necessary. The work of servicing shall preferably be executed on Saturday or any working day during week hours with prior written permission of the Engineer-in-Charge and record be maintained for the same so that no inconveniences is caused to the users. Shut down given for this purpose will not be exceeding 04 hours failing which GE may at his absolute discretion impose on the contractor to pay the department penalty of a sum of Rs. 1000/- per day or part of it per lift. In addition to fortnightly servicing, contractor's senior mechanic or foreman shall carry out the inspection as per maintenance schedule and make necessary (Illegible) entries in the Proforma No.1, 2 and 3 as applicable, kept in MES complaint office for this purpose. The qualified lift mechanic (One No.) is to be detailed solely for cabinet sect. building from 0700 hours to 1000 hours, 1230 hours to 1430 hours and 1630 hours to 1900 hours daily except Sunday and Gazetted holidays to attend the complaints and to check all the lifts as indicated in Sch 'A' on Ser. Page 12. In case mechanic does not attend the complaints or is not found present, a sum of Rs. 150/- per hour if mechanic left the building between 0700 hours to 1000 hours, 1230 hours to 1430 hours and 1630 hours to 1900 hours or maximum Rs.1000/- per day will be deducted from Contractor's dues as penalty.”

These provisions obligate OTIS to provide comprehensive repair and maintenance services including renewal/replacement of electrical and mechanical parts for the smooth functioning of the lifts. A qualified mechanic was to be deployed on a daily basis during the intervals of 0700–1000 hours, 1230–1430 hours and 1630–1900 hours.

21. The contract also obligates OTIS to maintain attendance registers for each shift and a complaint register for each lift, to be certified every morning. The relevant provisions are extracted hereunder—

“3.3 The contractor shall have to maintain attendance register for each shift as per the proforma attached as Appendix ‘A’ to this tender documents. The register is to be checked every day by the Engineer-in-Charge and also by GE as and when visit demand for the same.

3.4 After checking each of the passenger lift, starting with the VIP lift, every morning the OTIS lift mechanic will certify in the complaint register so being maintained for each lift every morning as under:- “Certified that lift checked at time and found fully functional in every respect” failure of which penalty as described will be applied.

3.5 It will be responsibility of the contractor to see that maintenance schedule Book is maintained properly by their senior mechanic or foreman. Register to be maintained for each lift and the same shall be produced to Engineer-in-Charge daily and get signed. Certificate in respect of functionability to give as described hereinbefore. The contractor shall attend 24 hours call book services. They shall be promptly attended and call shall not be kept pending for more than 04 hours unless it has the prior approval of the GE....”

22. The contract also contains a provision for precautions to be taken by the contractor —

“6.1 All the precautions against loss/damages shall be taken by the contractor. In case of accident during operation of lift, the contractor is liable to pay compensation as applicable...”

23. Having noted these contractual provisions, it is now necessary to examine in detail the events that have transpired about the operation of the lift, as evidenced by the correspondence between OTIS and MES in the months leading up to the incident. Between April and August 2002, OTIS was placed on repeated notice, through a series of letters and telegrams, of the persistent malfunctioning of Lift No. 6, the very lift involved in the accident. A brief description of these communications is summarised hereunder –

23.1 While OTIS started operating the lift with effect from December 2001, within 4 months of its installation, MES sent a telegram to OTIS on 03.04.2002 that the newly installed lift had been “off road” since 1220 hours that day, that OTIS’s site engineer had been absent from the premises since 02.04.2002, and that there was “heavy criticism from users” and called upon OTIS to “rectify defect urgently.” Relevant portion is extracted hereunder -

*“CA NO. CEDZ-31/99-2002 AAA PROVEN OF ONE LIFT AND
MODERNISATION LIFTS CABINET SECTT AAA LIFT NO. 06 (NEW
INSTALLED) IS. OFF ROAD SINCE 1220 DATED 03 APRIL 2002 AAA
SITE ENGINEER ROUND ABSENT SINCE 02 APR 2002 AAA HEAVY
CRITISIM FROM USERS AAA RECTIFY DEFECT URGENTY*

GARRENGER (PROJECT) WEST

Sd/-

(BV Venkatesh)

Capt”

23.2 On 14.06.2002, a further telegram to OTIS records that Lift No. 6 had again been off road since 1000 hours that day, reiterated the “heavy criticism from users,” and once more called upon OTIS to rectify the defect urgently. Relevant portion is extracted hereunder -

“CA NO. CEDZ-31/99-2000 AAA PROVEN OF ONE LIFT AND MODERNISATION LIFT AT CABINET SECTT AAA LIFT NO. 06 (NEW INSTALLED) IS OFF ROAD SINCE 1000 HRS DATED 14 JUN 2002 AAA HEAVY CRITISIM FROM USERS AAA RECTIFY DEFECT URGENTY”

GARRENGER (PROJECT) WEST
Sd/-
(BV Venkatesh)
Capt”

23.3 On 21.06.2002, a third telegram recorded that a separate lift had been out of order since 03.06.2002 and that OTIS’s own site mechanic had stated it was “*not possible to repair the same*” and that “it will remain in the same state,” while Lift No. 6 had independently been off road since 20.06.2002. The telegram recorded that “*all are annoyed with the frequent break down of these lift*” and requested “*permanent fault rectification,*” marking the matter “*urgent.*” Relevant portion is extracted –

CA NO. CEDZ-31/99-2000 AAA PROVEN OF ONE LIFT AND MODERNISATION OF TWO LIFTS IN CABINET SECTT AAA AND SYSTEM OF LIFT MORDERNISED IN 'D' BLOCK OUT OF ORDER SINCE 03 JUN 2002 AAA ON COMPLAINT YOUR SITE MECHANIC TOLD THAT IT IS NOT POSSIBLE TO REPAIR THE SAME AAA HE FURTHER TOLD IT WILL BE REMAIN IN SAME STATE AAA REQUEST TO REPLACE THE SAME IMMEDIATELY AAA LIFT NO. 06 NEWLY INSTALLED OFF ROAD SINCE 20 JUN 2002 AT 0900 H AAA (ILLEGIBLE) IN THE LIFT AAA ALL ARE ANNOYED WITH THE

FREQUENT BREAK DOWN OF THESE LIFT AAA REQUEST FOR
PERMANENT FAULT RECTIFICATION AAA MATTER URGENT.

GARRENGER (PROJECT) WEST
Sd/-
(BV Venkatesh)
Capt"

23.4 On 04.07.2002, MES internally forwarded to the Garrison Engineer (Project) West a list of breakdowns of Lift No. 6 recorded during June 2002. On the very same date, OTIS itself addressed a letter to the MES recording that its "Route Examiner" had found the voltage at the site to be *"sometimes...unbalanced which causes frequent breakdown on new lifts,"* and formally requesting installation of a *"Service Line Voltage Corrector Stabilizer of 50 KVA on each phase for the protection & safe operation of our equipments,"* together with detailed technical specifications for the stabiliser. Relevant portion of OTIS' letter is extracted –

"Dear Sir,

We were informed by our Route Examiner, that the voltage available at the site sometimes found to be unbalanced which cause frequent breakdown on new lifts & this also affect the life of the lift in long run. We would therefore request your good self, to arrange to install Service Line voltage : Corrector Stabilizer of 50 KVA on each phase for the protection & safe operation of our equipments....

*Thanking you;
Yours Sincerely
OTIS ELEVATOR COMPANY (INDIA) LIMITED"*

23.5 On 05.07.2002, MES wrote to OTIS enclosing the list of breakdowns of Lift No. 6 for June 2002 and requesting that OTIS *"detail suitable Engineer to rectify the defects at the earliest."*

23.6 On 29.08.2002, MES forwarded to HQ CWE (Project), with a copy to OTIS “*for info and necessary action,*” a consolidated list of breakdowns of Lifts No. 5 and No. 6 for the months of July and August 2002. This document records no fewer than nine separate breakdowns of Lift No. 6 alone within this two-month period. This includes stoppages between floors, doors failing to shut, and lifts becoming stuck in addition to the malfunctions already recorded in April and June 2002.

23.7 The record also discloses a further letter dated 17.02.2003, barely a month before the accident, in which the MES complained that, despite “repeated requests” made to named OTIS personnel regarding rectification of a noise defect in Lift No. 6, “*no action has been taken so far to rectify the same,*” and once again called upon OTIS to “*rectify the defects immediately*” and to “*treat the matter (as) urgent.*” This correspondence establishes that Lift No. 6 was the subject of continuing, unresolved complaints from the month following its installation until virtually the eve of the fatal accident.

24. Apart from the direct correspondence that has been brought on record, there is also the Technical Report of Lift Accident Investigation prepared by Prof. C.M. Bhatia, which concluded that the downward movement of the lift was caused by the manual release of the mechanical brakes through the Brake Release Key in the Machine Room, which had

been left accessible, and that this constituted human error. The report also noted that the lift's manual controls superseded its automatic control and interlocking systems, such that the interlocking mechanism did not register the manual release of the brakes. The relevant portion of the report reads -

“...The answer to the () mark points is that while the second officer was being rescued, the Machine Room door on the 11th floor was opened, or possibly it was left open. Somebody entered the Machine Room and released the lift brakes, through the Brake Release Key, moving it down and hence causing the accident. There is enough evidence at the site that the Brake Release Key has been used.”*

“...Since the power supply was switched off, the lift was dead and could not move through the electrical circuit, either downwards or upwards... Even if the power was switched on by somebody through turning-on the MCB, on 11th floor, the interlock control will prevent the lift from moving. Because the lift door was open and the diplomat was in the process of rescue with half of his body in and half out. It may be mentioned that all manual controls in such lifts supersede the automatic control and interlocking. Further, since the power was switched off when the brakes were released, the interlocking did not work. The lift control interlocks therefore did not recognize the release of brakes, because this action was done manually, by passing the controls. Releasing the brakes through the Brake Release Key is the only cause of accident and is due to the human error/factor beyond any element of doubt.”

25. Though the Technical Report of Prof. Bhatia concludes that releasing the brake release key is the only cause of accident, we are of the opinion that the said conclusion must be seen in the context of the Report. For the purpose of determining deficiency of service and the consequential relief of compensation, it is necessary to take note of a number of incidents giving rise to the *cause of action* which is very

different from *cause of accident*. That crucial distinction is lost in the submission advanced by OTIS. The correspondence extracted above demonstrates that the malfunctioning of Lift No. 6 was neither a passing nor an isolated occurrence, but a well-documented and continuing failure that persisted from the month following the lift's installation until shortly before the accident. At least three separate stoppages of Lift No. 6 were specifically brought to OTIS's notice between April and June 2002, and a further nine breakdowns of the same lift were recorded in July and August 2002 alone. OTIS, as the exclusive maintenance contractor under the Repair and Maintenance Contract, was directly and repeatedly notified of each of these failures.

26. Under Clause 3.1 of the Contract, OTIS, as the contractor, was "*responsible for the electrical and mechanical fittings of the lifts and maintenance of the same to keep them in sound condition to avoid risk of accident.*" This clause clearly casts a continuing and affirmative duty on OTIS, as both the manufacturer and the comprehensive maintenance contractor of the lift, to ensure that a lift reserved for the use of the senior-most officers of a sensitive government establishment did not pose a risk to the life of its users. The repair and maintenance contract is comprehensive inasmuch as under Clause 1.1 parties have contracted to ensure that OTIS' duties, covers "*comprehensive maintenance and repair of existing lifts regularly and systematically examining, adjusting,*

lubricating as required and repair including renewals/replacement of any electrical/mechanical parts for smooth and efficient functioning of lifts using only genuine parts of 'OTIS' Maker. That OTIS was simultaneously the manufacturer of the lift and its comprehensive maintenance contractor placed it in a position of unique knowledge and control over features such as the safety interlocks, the brake mechanism, and the electrical circuitry whose malfunction caused the fatal accident. This position is materially different from that of either RAW or MES, neither of whom possessed the technical means independently to assess or rectify the defects that were being reported to them.

27. It is significant to note that OTIS's own conduct establishes that it was conscious, at least since 04.07.2002, over eight months before the accident, that the persistent stoppages were also attributable to voltage fluctuation, and that a Service Line Voltage Corrector Stabiliser was necessary, "*for the protection & safe operation of our equipments*". Having itself identified the remedy, it was incumbent upon OTIS, as the party responsible under Clause 3.1 for the safe functioning of the lift, to have followed up on this recommendation, to have declined to certify the lift as fit for continued use pending installation of the stabiliser, or, at the very least, to have escalated the matter given that the breakdowns continued unabated through July and August of 2002, as recorded in the letters of 05.07.2002 and 29.08.2002. Instead of following such course of action,

the lift continued to be operated on a daily basis, carrying senior officers of RAW, without any of the safeguards that OTIS itself had identified as necessary.

28. We are unable to accept the submission on behalf of the Appellant that responsibility for the accident rests solely with MES on the ground that its personnel manually released the brakes through the Brake Release Key. While the Technical Report may attribute cause of the accident to manual release of the brakes, this finding does not, in our view, absolve OTIS of liability, for various reasons as the said manual release is not a standalone incident. This event has to be seen in the context of various factors that have been articulated.

29. First, Clause 3.2 of the Contract required OTIS's own trained mechanic to be present at the site during fixed hours daily and to attend to complaints within a stipulated period; OTIS produced no attendance register, duty chart, log book, or other contemporaneous record to establish the presence, or otherwise, of its mechanic on the date of the accident, notwithstanding that such records were required to be maintained under Clauses 3.3 to 3.5 of the very Contract on which OTIS relies. The absence of such records, which lay peculiarly within OTIS's own knowledge and custody, does not assist its case.

30. Second, and more fundamentally, the very occasion for anyone to manually operate the Brake Release Key arose because the lift, on account of a persistent and unrectified electrical malfunction, had stopped mid-operation. This vulnerability also directly flows from OTIS's failure to rectify the defects of which it stood repeatedly informed, and for which it had itself proposed a remedy.

31. Third, the stickers posted by OTIS inside the lift cautioning against interference with its mechanism, while relevant to show that manual intervention was unauthorised, cannot substitute for the affirmative steps that OTIS, as comprehensive maintenance contractor, was required to take to train RAW's and MES's personnel in the correct rescue procedure to be followed in the event of a stoppage. The NCDRC correctly found that there is no evidence OTIS ever imparted such training.

32. We find no reason to interfere with the finding of the NCDRC that OTIS was the party principally deficient in service. A party that undertakes the comprehensive maintenance of a machine, which is in the nature of a vehicle, owes a heightened duty of care towards its users. OTIS was not a stranger to the defect that culminated in the accident. It was cognizant of the problem, and it had itself proposed the remedy. Having done so, its failure to ensure that the remedy was implemented, or, alternatively, to render the lift safe by other means pending its installation constitutes *deficiency of service*.

33. As regards RAW and MES, we agree with the NCDRC that their liability is appropriately more limited than that of OTIS. RAW, as the ultimate occupier of the premises and consumer of both OTIS's and MES's services, bore a residual duty to ensure that the contracts it had sanctioned were properly performed and that reports of persistent defects were acted upon. RAW did not, however, possess the technical competence that OTIS possessed. Its deficiency accordingly relates more to a failure of oversight than to any direct role in causing the accident.

34. MES, for its part, failed to maintain the attendance registers required under Clause 3.3 to verify that OTIS's mechanic attended the site as contractually required, and it was MES's own Machine Room that was left accessible during the rescue operation a lapse of a different order from, and subordinate to, OTIS's primary responsibility for the underlying defect that necessitated the rescue in the first place. The apportionment of 70% of the liability to OTIS, 25% to MES and 5% to RAW, in our view, properly reflects the differential degree of knowledge, control and responsibility that each party bore for the accident, and calls for no interference by this Court.

Conclusion

35. For the foregoing reasons, we find no infirmity in the order of the NCDRC dated 21.01.2014 apportioning liability in the manner it did. OTIS's Civil Appeal No. 4081 of 2014 is accordingly dismissed.

36. In view of the dismissal of OTIS's appeal, the sole reason for which the NCDRC had declined to proceed with execution no longer survives. Civil Appeal No. 1602 of 2020 against the order dated 02.05.2019 is accordingly allowed, and the NCDRC is directed to proceed with her Execution Petition in accordance with law.

37. Pending applications, if any, stand disposed of. No order as to costs.

.....J.
[PAMIDIGHANTAM SRI NARASIMHA]

.....J.
[ALOK ARADHE]

**NEW DELHI;
JULY 29, 2026.**