United States of America
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
1120 20th Street, N.W., Ninth Floor
Washington, DC 20036-3457

SECRETARY OF LABOR,

Complainant,

v.

PIEDMONT MECHANICAL, INC.,

Respondent.

OSHRC Docket No. 11-2562

REMAND ORDER

Before: ROGERS, Chairman; ATTWOOD, Commissioner.

BY THE COMMISSION:

The Occupational Safety and Health Administration issued a serious citation and a willful citation to Piedmont Mechanical, Inc. alleging violations of the Occupational Safety and Health Act of 1970, 29 U.S.C. §§ 651-678, with a total proposed penalty of $138,600. On June 13, 2013, Administrative Law Judge Ken S. Welsch issued a decision in which he affirmed all but one of the citation items; characterized all of the affirmed violations as serious; and assessed a total penalty of $18,400. The Secretary filed a petition with the Commission on July 3, 2013, only seeking review of the judge's decision to characterize one of the affirmed violations—instance "a" of Citation 2, Item 1a—as serious rather than willful. Piedmont filed an opposition to the Secretary's petition several days later. The case, which arises in the Eleventh Circuit, was directed for review on July 11, 2013.

Almost two weeks later, the Eleventh Circuit issued a decision in *ComTran Group, Inc. v. DOL*, 722 F.3d 1304 (11th Cir. 2013), a case in which the court held that where "the Secretary seeks to establish that an employer had knowledge of misconduct by a supervisor, [he] must do more than merely point to the misconduct itself. To meet [his] prima facie burden, [he] must put forth evidence independent of the misconduct[,]" such as "evidence of lax safety standards." *Id.* at

1316. Because it is unclear if the issue of knowledge as presented in the case before us is affected by the court's decision in *ComTran*, we remand this case in its entirety to the judge for him to consider the applicability of the Eleventh Circuit's decision. *See Kerns Bros. Tree Serv.*, 18 BNA OSHC 2064, 2067, 2000 CCH OSHD ¶ 32,053, p. 48,003 (No. 96-1719, 2000) (stating that Commission generally applies precedent of circuit to which case will likely be appealed "even though it may differ from the Commission's precedent"). Depending on the judge's resolution of this issue, he may allow the parties to "further develop[]" the record. *ComTran*, 722 F.3d at 1318.

In addition, we note that in concluding that the violation alleged in the citation item raised by the Secretary's petition was not willful, the judge confined his analysis to whether the superintendent's knowledge and conduct, imputed to Piedmont, established a willful state of mind—he did not address the knowledge and conduct of Piedmont's foreman. If on remand the judge reaffirms this citation item, he should also address whether the Secretary has established a willful violation based on the state of mind of Piedmont's foreman. *See Branham Sign Co.*, 18 BNA OSHC 2132, 2134, 2000 CCH OSHD ¶ 32,106, p. 48,263 (No. 98-752, 2000) ("The state of mind of a supervisory employee, his or her knowledge and conduct, may be imputed to the employer for purposes of finding that the violation was willful.").

Accordingly, we remand this case to the judge for further proceedings consistent with this order.

SO ORDERED.

/s/
Thomasina V. Rogers
Chairman

/s/
Cynthia L. Attwood
Commissioner

Dated: September 26, 2013

United States of America

OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
1924 Building-Room 2R90, 100 Alabama Street, SW
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SECRETARY OF LABOR, Complainant v. PIEDMONT MECHANICAL, INC., Respondent.	OSHRC Docket No. 11-2562

APPEARANCES:

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For Respondent

BEFORE: Administrative Law Judge Ken S. Welsch

DECISION AND ORDER

Piedmont Mechanical, Inc. (PMI) is a pipeline installation contractor in LaGrange, Georgia. On March 12, 2011, employees of PMI were laying pipe in an excavation dug by Jim Boyd Construction, Inc. (JBC) for a natural gas project at the Marine Corps Logistics Base in Albany, Georgia. While laying the pipe, the boom on a crane lifting the pipe into the excavation contacted an overhead power line. An employee of PMI in the excavation was severely burned. After receiving a complaint on the accident, a compliance officer with the Occupational Safety and Health Administration (OSHA) initiated an inspection of the worksite on March 16, 2011. As a result of the OSHA inspection, serious, and willful citations were issued to PMI, as well as JBC, on September 6, 2011. PMI timely contested the citations.

The serious citation alleges PMI violated 29 C.F.R. § 1926.652(c) (item 1) for failing to connect sections of the trench shields with spreader bars; 29 C.F.R. § 1926.652(g)(1)(ii) (item 2) for failing to keep trench shields flush against the side walls of the trench; 29 C.F.R. § 1926.1402(d))

(item 3) for failing to set up a telescoping boom crane on secure soil to support the crane; 29 C.F.R. § 1926.1412(d)(1) (item 4a) for failing to inspect the telescoping boom crane before operating the crane; and 29 C.F.R. § 1926.1412(e)(1) (item 4b) for failing to inspect on a monthly basis the telescoping boom crane. The serious citation proposes total penalties of $13,300.00.

The willful citation alleges PMI violated 29 C.F.R. § 1926.651(k)(2) (item 1a) for failing to remove employees in a 10-foot trench without cave-in protection until necessary precautions were taken to ensure safety; 29 C.F.R. § 1926.652(a)(1) (item 1b) for allowing employees to work in a trench without cave-in protection; and 29 C.F.R. § 1926.1408(a)(2) (item 2) for failing to determine if any part of the crane, load line, or load could get closer than 20 feet of an overhead energized power line. The willful citation proposes total penalties of $125,300.00.

A hearing was held in Atlanta, Georgia, on August 21-22, 2012. The hearing was consolidated with related citations issued to JBC (Docket No. 11-2259). There is no dispute regarding jurisdiction and coverage (PMI Answer). The parties filed post hearing briefs on March 4, 2013. The Court's Decision involving JBC is also issued on this date.

PMI denies the alleged violations, the willful classifications, and the reasonableness of the proposed penalties. PMI argues that the Secretary failed to meet her burden of proof to establish the violations. With regard to citation items involving the March 12, 2011, incident, PMI asserts a lack of knowledge and employee misconduct.[1]

For the reasons discussed, serious Citation No 1, items 2, 3, 4a, and 4b are affirmed and total penalties of $8,000.00 are assessed. Citation No. 1, item 1 is vacated. Willful Citation No. 2, items 1a, 1b, and 2 are affirmed as serious and total penalties of $10,400.00 are assessed.

Background

PMI is engaged in pipeline installation. PMI is located in LaGrange, Georgia and employs approximately 75 employees (Tr. 412).

In 2011, PMI was contracted to install the pipeline for a project to convert landfill gas to energy at the Marine Corps Logistics Base in Albany, Georgia (Tr. 13-14, 17). Chevron, Inc. was the construction manager and SCS Energy was the general contractor for the project (Tr. 616). PMI's installation work included running, laying, setting and welding the pipe (Tr. 137, 616-

1 Issues not briefed are deemed waived. See *Georgia-Pacific Corp*., 15 BNA OSHC 1127 (No. 89-2713, 1991).

617). According to PMI's safety and human resources director, 95 percent of PMI's work was in "racks and ceilings" and 5 percent was underground (Tr. 748). The trenches in which the pipes were laid were dug and constructed by JBC, the excavation contractor.

JBC was subcontracted to do the trenching work on the site. It was responsible for excavating, supplying and installing the trench shields, and performing sloping and benching as needed. When the job was bid, the trenches were to be less than 5 feet deep (Tr. 52, 102, 638, 748-749). However, it soon became apparent that, due to the configuration of the pipes, the trench would have to be substantially deeper (Tr. 34, 102, 126). Ultimately, the depth of the trench ranged from 2-12 feet (Tr. 34, 102, 396). The trench was approximately 600 feet long (Tr. 171, 396). Power cables ran both parallel and perpendicular to the trench (Tr. 43-44, 289). It is undisputed that the trench was dug in Type B soil (Tr. 395). At the time of the inspection, the trench had been opened for 3-4 months (Tr. 87).

The original plans called for the trench to be protected with hydraulic shoring. Once it was determined that the trench would have to be both deeper and wider than planned, United Rentals, the equipment rental company informed JBC that the hydraulic shoring should not be used. Instead, United Rental recommended that the trench be protected by trench shields or boxes (Tr. 102). Trench boxes come in various sizes. They ranged from 6 to 8 feet in height and 12 to 20 feet in length (Tr. 26). Some were double-walled and some were single-walled (Tr. 25, 89).

On Saturday, March 12, 2011, PMI was using a carry-deck crane with a 40-foot boom to place the pipe in the trench (Exh. C-12; Tr. 138, 142). When the operator swung the boom to the left to bring pipe over to the trench, the boom contacted an overhead power line. A PMI employee in the trench was badly burned (Tr. 174-176).

As a result of the accident, an inspection was conducted by a safety and health compliance officer (CO) for OSHA (Tr. 388). Pursuant to the inspection, PMI was issued citations alleging violations of the OSHA trenching and crane standards.

Discussion

To establish a violation of an OSHA standard, the Secretary must show that: (1) the standard applies to the facts; (2) the employer failed to comply with the terms of that standard; (3) employees had access to the hazard covered by the standard; and (4) the employer had actual or constructive knowledge of the violation (*i.e.* the employer knew, or with the exercise of reasonable diligence could have known, of the violative condition). *Atlantic Battery Co.,* 16

BNA OSHC 2131, 2138 (No. 90-1747, 1994).

There is no dispute that the cited excavation and crane standards applied to PMI. The definition section of the *Excavation* standards (Subpart P) provide that "[t]his subpart applies to all open excavations made in the earth's surface" and that "[e]xcavations are defined to include trenches." *See* 29 C.F.R. § 1926.650(a). PMI employees were working inside the excavation. Accordingly, the cited excavation standards applied to PMI's worksite.

The definition section of *Cranes and Derricks in Construction* standards (Subpart CC) provide that "[t]his standard applies to power-operated equipment, when used in construction, that can hoist, lower and horizontally move a suspended load. Such equipment includes, but is not limited to: . . . industrial cranes (such as carry-deck cranes). . ." 29 C.F.R. § 1926.1400(a). On March 12, 2011, PMI was using a carry-deck crane to install pipe in the trench (Tr. 142, 246, 278). Accordingly, the cited crane standards applied to PMI's worksite.

Employee Misconduct Defense

1. *Background*

The evidence is undisputed that PMI employees worked in the trench, primarily to lay pipe as part of the project (Tr. 417, 420, 427, 431, 439). PMI's superintendent oversaw the work (Tr. 281). PMI's competent person at the site also acted as the leadman or foreman at the site (Tr. 408, 563, 604, 808, 819, 833, 846).

On Saturday, March 12, 2011, PMI's crew arrived in the morning and had a meeting to discuss their work for the day (Tr. 284). PMI's superintendent had not yet arrived at the site and instructions were given by the competent person (Tr. 703). The plan called for PMI to continue running pipe from the boiler house to the condensate receiving tank (Tr. 137-138). A Chevron official in charge of safety on the base told the superintendent that the unprotected portions of the trench had to be stepped back and that the task would be accomplished by Saturday. However, when the crew arrived on Saturday, the trench had not been stepped back (Tr. 624-625, 640). The competent person phoned the superintendent, who had not yet arrived at the site, and told him that the trench had not been stepped back and that it did not look safe to enter (Tr. 150). The superintendent responded that the crew had to get the pipe in the unprotected area of the trench by the end of the day (Tr. 150). The superintendent decided to allow the employees to finish their work only in areas protected by a trench box (Tr. 625).

The competent person told the superintendent that he would not put anyone in the unprotected

areas of the trench and that he would wait for him to arrive (Tr. 150-151). When the superintendent arrived at the site, the competent person went to the work trailer and asked the superintendent to look at the trench (Tr. 151). At the side of the trench, the competent person again told the superintendent that he did not think it was safe to enter (Tr. 153). The superintendent testified that he told the competent person not to put employees in the trench. He instructed the competent person that the crew should throw cross-ties into the trench to prevent the pipes from lying on the ground. They were then to lower the pipes into the trench and onto the cross bars with a lull (Tr. 624-625).[2] According to the competent person, the superintendent replied that Chevron was pushing hard for them to get the pipes in (Tr. 153). The superintendent testified that when he and the competent went to the trench, he explained the process in detail in front of other employees (Tr. 624, 684).

Apparently, the competent person misinterpreted his instructions from the superintendent that the pipe had to be placed in the trench as an order to put the men in the trench (Tr. 151-154). The competent person testified that he could not recall actually being told to have employees enter the trench, but that he didn't "see how he thought I could get it in there without putting the employee in" (Tr. 227). However, he also testified that the superintendent told him that he didn't care how the work got done and to "just throw the cross ties in and throw the pipe on top of it" (Tr. 227-228).

Around lunchtime, after the superintendent returned from an errand, some members of the crew came up to him and informed him that the competent person told them that they couldn't get in the trench to install the pipe. He replied "No, you can't get in the trench, but we are going to install the pipe" (Tr. 629). He repeated his explanation how to place the pipes inside the trench with the lull (Tr. 630). He told the employees to explain the method to the competent person and to tell him that "we're not getting in the trench" (Tr. 683).

The superintendent did not realize that employees entered the trench until the accident occurred (Tr. 630). The competent person testified that he was concerned that just placing the pipes into the trench without adequate support would void the warranty on the pipes (Tr. 203). He was not aware of any way to protect the pipes without getting into the trench. Therefore, he made the decision to have the crew enter the trench on his own (Tr. 204, 212-214).

2. *PMI's Employee Misconduct Defense*

2 A "lull" is an all-terrain forklift with a high reach (Tr. 138).

PMI argues that the competent person ignored the superintendent's specific instructions not to allow the crew to enter the trench. Therefore, it contends that the unprotected trench violations on March 12, 2011, were the result of unpreventable employee misconduct (PMI's Brief, p. 18).

To establish the "unpreventable employee misconduct" defense, the burden is on the employer to show: (1) that it has established work rules designed to prevent the violation; (2) that it has adequately communicated these rules to its employees; (3) that it has taken steps to discover violations; and (4) that it has effectively enforced the rules when violations are discovered. *E.g., Precast Services, Inc.*, 17 BNA OSHC 1454, 1455, (No. 93-2971, 1995), *aff'd without published opinion*, 106 F.3d 401 (6th Cir. 1997). Where the alleged misconduct is that of a supervisory employee, an employer must show that it took all feasible steps to prevent the accident, including adequate instruction and supervision of its employee. *Archer-Western Contractors, Inc.*, 15 BNA OSHC 1013, 1016 (No. 87-1067, 1991), *petition for review denied*, 978 F.2d 744 (D.C. Cir. 1992).

The competent person formerly had been a supervisor for PMI, but had been demoted due to health and other personal problems (Tr. 740-741). PMI's safety director testified that the reasons for the competent person's demotion were his difficulty in completing tasks and his failure to ensure that everything was safe prior to starting jobs (Tr. 745). According to the safety director, the superintendent did not explain the task assignment to the full understanding of the competent person (Tr. 799). PMI's investigation report stated that there was "unclear communication" from the superintendent, and "insubordination" from the competent person (Exh. C-38; Tr. 763). Among the conclusions of the report:

* Assessment of area incomplete for all hazards.
* Task assignment not explained in regards to how the task was to be completed with Full understanding.
* Insufficient training in recognized hazards in regards to excavation and trenching confined spaces confined spaces and use of cranes.

Among the recommended corrective actions in the report was "Training for entire crew in regards to excavation and trenching…." (Exh. C-38).

Clearly, PMI's own investigation revealed that the superintendent failed to adequately communicate to employees that they were forbidden to enter the trench. Also, one of the reasons the competent person was demoted from supervisory status was his inability to follow safety

rules. The superintendent understood that some of the crew would follow the competent person due to his former position (Tr. 685). Yet, knowing this, rather than explicitly designating another crew member as leadman, PMI allowed him to continue in that position with the responsibility of carrying out instructions which included the admonition not to allow employees to enter the trench. In this regard, the superintendent testified that, in his view, the competent person had the responsibility to instruct the crew that they should not get into the trench (Tr. 701). Coupled with the competent person's established difficulty in following orders, when the competent person indicated confusion over his instructions, it was incumbent upon the superintendent to ensure that his orders were understood and would be followed. Indeed, the superintendent testified that he "should have been more readily involved to let that happen to make sure that they understood more what I had in mind for them to do. Communications problem" (Tr. 697).

As noted, one of the elements of the "unpreventable employee misconduct defense" is adequately communicated work rules. The testimony of the superintendent, the PMI safety director, and the PMI investigation report demonstrates that communication at the worksite was inadequate. PMI failed to establish the affirmative defense of employee misconduct.

Serious Citation

Citation No. 1, item 1- Alleged Violation of § 1926.652(c)

The citation alleges a serious violation of 29 C.F.R. § 1926.652(c) on the grounds that "at the trenching area-on or about March 7-11, 2011, employees worked inside the 10-12 foot deep trench where several sections of the trench shields were not connected together with the spreader bars, exposing employees to cave-in hazards." The Secretary proposes a penalty of $3,500.00.

Section 1926.652(c) provides:

> *Design of support systems, shield systems, and other protective systems.* Designs of support systems shield system, and other protective systems shall be selected and constructed by the employer or his designee and shall be in accordance with the requirements of paragraph (c)(1); or in the alternative, paragraph (c)(2); or in the alternative, paragraph (c)(3); or, in the alternative, paragraph (c)(4) as follows: . . .
> (2) Option (2) – Designs Using Manufacturer's Tabulated Data.
> (i) Design of support systems, shield systems, or other protective systems that are drawn from manufacturer's tabulated data shall be in accordance with all specifications, recommendations and limitations issued or made by the manufacturer.
> (ii) Deviation from the specifications, recommendations, and limitations issued or made by the manufacturer shall only be allowed after the manufacturer issues specific written approval.
> (iii) Manufacturer's specifications, recommendation, and limitations and manufacturer's approval to deviate from the specifications, recommendations, and limitations shall be in

written form at the jobsite during construction of the protective system. After that time this data may be stored off the jobsite, but a copy shall be made available to the Secretary upon request.

The trench boxes consist of two metal plates (shields) which are secured by four spreader bars that normally fit into slots on the plates (Tr. 27-28). The assembly instructions contained in the tabulated data JBC received from United Rentals indicate that spreader bars and pins are to be used to secure the boxes. The instructions state that "[a]ny modifications or alterations not allowed unless approved in writing. . ." (Exh. C-4, pp. 1, 5, 6, 7, 8, 11, 12, 14, 15, and 17, para. 6 under *Limitations*). The instructions also state that "[a[ny use of a trench shield without efficiency spreaders and pins *or equal* will void the tabulated data and warranty (Ex. C-4, at pp. 13 and 16, para. 12) (*emphasis added*). On two trench boxes, JBC could not place all four spreader bars into the precut slots because pipes were in the way. Instead, JBC welded two of the four spreader bars into place where they could not be fitted into the slots. The pipes were laid above the spreader bars (Exhs. C-8, C-11; Tr. 53-55, 62, 71, 77, 80, 98).

The CO admitted that, during the inspection, he did not notice that the spreader bars were welded to the panels (Tr. 406, 516, 526, 605). Nonetheless, the CO testified that the citation was justified because by welding the spreader bar, rather than using the pins, JBC deviated from the manufacturer's instructions without written permission required by the assembly instructions. The CO also determined by looking at the photo of the trench, that the trench box was not adequately designed (Tr. 524).

In her brief, the Secretary questions whether the spreader bars were actually welded to the plates and contends that JBC superintendent's assertion that he welded the spreader bars under the installed pipe is not credible. At the hearing, the JBC superintendent testified that the welding was performed by a PMI welder, but did not identify the welder (Secretary's Brief, pp. 13-14; Tr. 53-54, 371).

The Secretary's argument is rejected. As discussed, JBC, not PMI, was responsible for the installation of the trench shields. Although PMI employees were exposed as workers in the trench, the record lacks sufficient evidence that PMI knew or should have known of the manufacturer's instruction and limitations on installing trench shields. The fact that a PMI employee welded the spreader bars does not establish PMI's knowledge of the manufacturer's instructions and limitations. JBC was responsible for obtaining and installing the trench shields.

Also, this same citation item was vacated as to JBC (Decision in JBC case issued this date). As discussed in the Decision, the testimony of JBC's superintendent is found credible with regard to the welding of the spreader bars. The CO never denied that the spreaders were welded. Rather, the CO testified only that he "was not aware" that the welds were made (Tr. 406). At the hearing, a PMI welder testified that it was he who welded the trench boxes, thereby corroborating the superintendent's assertion (Tr. 710). This was confirmed by the PMI superintendent who testified that his employees welded the spreader bars (Tr. 621).

With the record establishing that the spreader bars were welded to the plates, the crux of the Secretary's argument is that written permission to weld the spreader bars was not obtained from the manufacturer. Even if PMI was responsible based on knowledge of the manufacturer's instruction, the instruction requires the use of the pins "or equal." This demonstrates that the manufacturer envisioned situations where the pins could not be used and explicitly allowed substitution where the substitution would be equal to the pins. By these terms, any method used that is "equal" to the pins would not be considered a modification or alteration requiring written approval.

Under the cited standard, the employer is required to obtain written approval for any "[d]eviation from the specifications, recommendations, and limitations issued or made by the manufacturer." However, the manufacturer's instructions clearly allow the use of the pins or *equal.* In *Honey Creek Contracting, Co.,*1998 WL 138687, *7; 18 BNA OSHC 1652, 1655 (No. 97-0353, 1998), *petition for review vacated*, the employer was cited for welding a metal plate to one end of a trench box that the Secretary alleged was inconsistent with the manufacturer's recommendations. The Judge observed that "the clear meaning of what is required to show a violation of the standard is that the box was either used or maintained in a manner which was inconsistent with the manufacturer's recommendations." The Court agrees with the Judge's interpretation. The burden is on the Secretary to demonstrate that the welds were not *equal* to the pins.

The Secretary has adduced no evidence that the welds were not equal to use of the pins. The CO admitted that he had no basis to determine whether the welds were equal to the pins (Tr. 519). His conclusion that the trench was deficient is based on his knowledge rather than on the manufacturer's recommendations (Tr. 526). His opinion was formed only after issuance of the citation, since the CO did not even realize that the spreader bars were welded to the shields until after he recommended the citation. His conclusion was based on viewing photographs of the

trench rather than his actual physical inspection of the welds. Unlike JBC's superintendent, who is a certified competent person, the CO has no certifications (Tr. 389). Besides his compliance officer training, his experience with trenches was limited to 25 trench inspections with only half of those involving trench boxes (Tr. 390, 486). His only experience with trench boxes has been as a safety inspector (Tr. 488).

In contrast, the JBC superintendent who was also the competent person, testified that, based on his knowledge and training as a competent person, the welds were an appropriate way to connect the panels and did not diminish the structural integrity of the shields (Tr. 55). He determined the strength of the welds by ascertaining the size of the welding rods used by the welder (Tr. 56). The superintendent testified that he talked with United Rentals and asked for their permission to weld the boxes. United Rental told him verbally that the method he was using did not hinder the structural strength of the trench box (Tr. 57-58, 91). In the superintendent's opinion as a competent person, welding was an appropriate method of connecting the panels (Tr. 55). The trench was also inspected by Marine Base Safety who had no objection to the condition of the trench boxes (Tr. 95).

The record is devoid of any evidence that the welds were not equal to the pins or otherwise constituted an alteration or modification contrary to the instructions requiring written permission from the manufacturer. The Secretary failed to meet her burden of establishing that PMI knew, or should have known, of the manufacturer's instructions and that welding the spreader bars was not equal to pinning them.[3]

PMI's violation of § 1926.652(c) is not established.

Citation No. 1, item 2 - Alleged Violation of § 1926.652(g)(1)(ii)

The citation alleges a serious violation of 29 C.F.R. § 1926.652(g)(1)(ii) on the grounds that "at the trenching area-on March 12, 2011, employees worked inside a 10-12 foot deep trench where several sections of the trench shields were not flush against the side walls of the trench, exposing employees to crush-by and 'struck-by hazards."[4] The Secretary proposes a penalty of $3,500.00.

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3 The CO also claimed that a spreader bar failed to connect the end plate to the trench box (Exh. C-31 at E; Tr. 522-523). However, there was no slot for the installation of a spreader bar to the end piece. *Id.* The CO did not know how the manufacturer intended the end plate to be installed and based his recommendation to cite on his own opinion (Tr. 525).

4 The same alleged violation is cited against JBC; separate Decision issued this date.

Section 1926.652(g)(1)(ii) provides:

Shields shall be installed in a manner to restrict lateral or other hazardous movement of the shield in the event of the application of sudden lateral loads.

The CO identified several locations where the trench boxes were not flush with the wall of the trench (Exhs. C-7, C-26, C-32; Tr. 423-426). The CO did not identify the distances, but in the photographs, they appear to be at least 12 inches. This is particularly true with Exhs. C-26 and 32, which demonstrate a substantial distance between the shield and the trench wall (Tr. 426). According to the CO's observations, the trench boxes were not jammed into the ground, which would have helped anchor the shields (Tr. 535-536).

PMI points out that the shields were flush with the trench at the bottom, and that the gap existed only at the top (PMI's Brief, p. 15). PMI asserts that it is not practical to expect a trench shield to be flush with the wall. Trench shields are dragged into the trench. Therefore, by definition, the trench must be wider than the shield.

The CO agreed that trench boxes need not be flush against the wall. Rather, the shields should be close enough to restrict lateral movement in the event of a cave-in or material falling between the wall and the box (Tr. 530, 607). Where the shields cannot be flush with the wall, the Secretary asserts that the gap should be filled with dirt. The CO admitted that the only evidence he had that the trenches were subject to lateral movement was his personal opinion, based on the photographic exhibits and his understanding of the facts (Tr. 540).

As in the *Honey Creek* case, the Secretary asserted that a violation of the standard could be established where any gap existed. Rejecting that position, the Judge stated that the mere fact that gaps exist is not sufficient to establish that the trench was subject to lateral movement. *Honey Creek Contracting Co.,* 18 BNA OSHC *Id.* at 1655.

Here, however, the gaps were substantial and, in several places, far exceeded what was necessary to insert the trench shields. Similarly, the exhibits demonstrate that the gaps went far beyond what might normally be expected due to the natural deviation in the size of a trench along its length. The evidence establishes that the gaps were of the size that was specifically intended to be addressed by the standard. Had a collapse occurred, the momentum of the collapse and the quantity of material that could have fallen into the gaps could well have been sufficient to cause lateral movement of the shields.

The evidence establishes that employees of PMI were exposed to the hazardous conditions. PMI employees were working in the trench all week before the accident (Tr. 427).

Employees told the CO that they were laying pipe as fast as JBC was installing the trench boxes. Indeed, they were right behind JBC as they were installing the trench boxes (Tr. 430-431).

The evidence also demonstrates that PMI knew, or with the exercise of reasonable diligence should have known, of the hazardous condition. PMI's competent person directing the crew was charged with ensuring that the trench was constructed safely and in accordance with OSHA standards. The gaps between the trench shields and the trench were obvious and in plain view. As the leadman or foreman on the site, the competent person's knowledge is imputed to PMI. *Jersey Steel Erectors*, 16 BNA OSHC 1162, 1164 (No. 90-1307, 1993), *aff'd*, 19 F.3d 643 (3rd Cir. 1994).

PMI argues that the competent person's knowledge should not be imputed to PMI. It asserts that he did not possess supervisory authority. The competent person was sent to the site as a lead person only and had no authority to hire or fire (Tr. 695, 739). PMI points out that the competent person used to be a supervisor, but health and personal problems caused him to be demoted (PMI's Brief, pp. 17-18; Tr. 741). It was the PMI superintendent who had authority on the site to deal with quality problems for PMI. It contends that the superintendent had neither actual nor constructive knowledge of the hazard.

PMI's argument is without merit. An employee who has been delegated authority over other employees, even if only temporarily, is considered to be a supervisor for the purposes of imputing knowledge to an employer. *Kerns Brothers Tree Service*, 18 BNA OSHC 2064, 2068-2069 (No. 96-1719, 2000); *Tampa Shipyards Inc.*, 15 BNA OSHC 1533, 1537 (No. 86-630, 1992); *See also Access Equipment*, 18 BNA OSHC 1718, 1726 (No. 95-1449, 1999)(employee who was "in charge of" or "the lead person for" one or two employees who erected scaffolds "can be considered a supervisor"). This is true, even where the lead man holds no official supervisory authority. *John H. Quinlan, d/b/a Quinlan Enterprises,* 17 BNA OSHC 1194, 1196, n.2 (No. 92-0756, 1995).

PMI's safety director and human resources officer, testified that the competent person was sent to the site as a lead person (Tr. 738, 808, 846). The safety director further explained that, at PMI, a lead man and a foreman are equivalent. The task of a lead man/foreman is to take supervisory and daily tasks from the supervisor and make sure that they are carried out (Tr. 846). The lead man directs the other members of the crew based on his understanding of the supervisor's instructions (Tr. 847). The safety director identified the competent person to the CO as the

foreman (Tr. 819). PMI's superintendent testified that, due to the competent person's previous position as a supervisor, the crew looked up to him (Tr. 685). A PMI welder testified that the competent person was the boss and that he had to take instructions from him because he worked with him many times (Tr. 724). The competent person was a foreman and his knowledge is imputable to PMI.

The evidence also establishes that the violation was serious. Under § 17(k) of the Act, a violation is "serious" if there is "a substantial probability that death or serious physical harm could result from a condition which exists.. . ." 29 U.S.C. § 666(k). The Secretary need not show that there is a substantial probability that an accident will occur; she need only show that if an accident occurred, serious physical harm could result. *Whiting-Turner Contracting Co.,* 13 BNA OSHC 2155, 2157 (No. 87-1238, 1989).

The evidence establishes that, if the trench failed or material fell into the gap, the shields were not constructed to restrict lateral movement and employees working within could have been killed or seriously injured (Tr. 432). The violation was serious.

PMI's serious violation of 29 C.F.R. § 1926.652(g)(1)(ii) is established.

Citation No. 1, item 3 – Alleged Violation of § 1926.1402(b)

The citation alleges a serious violation of 29 C.F.R. § 1926.1402(b) on the grounds that "[a]t the trenching area-on March 12, 2011, employees were using a Broderson telescoping boom crane that was not set up on secure soil to support the crane, exposing employees to struck-by hazards." The Secretary proposes a penalty of $3,500.00.

Section 1926.1402(b) provides:

> The equipment must not be assembled or used unless ground conditions are firm, drained, and graded to a sufficient extent so that, in conjunction (if necessary) with the use of supporting materials, the equipment manufacturer's specifications for adequate support and degree of level of the equipment are met. The requirement for the ground to be drained does not apply to marshes/wetlands.

In order to assist in placing the pipe into the trench, PMI used a carry-deck crane. The evidence establishes that on March 12, 2011, PMI did not have pads under the outriggers to support them, as required by the standard. When the crane is set up, the outriggers are extended to lift the crane off of the ground to give it more stability (Exhs. C-13, C-14; Tr. 297). If the crane is set up on soft ground, pads are placed under the outriggers to keep it from sinking and tipping over while lifting material (Tr. 297-298, 452-54, 456). When the CO inspected the location of the

crane, it was set up on dirt, not concrete. PMI crane operator who moved the crane and set it up, confirmed it was set on dirt (Tr. 298). He testified that pads were available, but that they were simply overlooked (Tr. 298). The photographs show no sign of concrete in the area where the crane was stationed (Exhs. C-5, C-6, C-20, C-35). PMI's safety director noted in her Accident Report that the crane was placed in a congested area where there was "visible instability of banks of trench" (Exh. C-38, p. 2). One of the outriggers had sunk into the dirt to the point where the plate was not visible (Exhs. C-13, C-14; Tr. 454).

The evidence also establishes that employees were exposed to the hazard. The crane operator was exposed by virtue of being in the crane which was in danger of tipping over. Also, the crane was located by the trench where PMI employees were working. Had the crane slipped or tipped over, those employees were exposed to the hazard of the falling crane. Finally, the competent person, who was operating as the flagman, was exposed to the hazard (Tr. 457).

PMI knew or, with the exercise of reasonable diligence should have known, of the violation. The crane operator testified that the pads were available, but that he and the competent person simply "overlooked that" (Tr. 298). This clearly establishes that, with the exercise of reasonable diligence, the competent person should have known of the violation. As noted, *supra*, the competent person was the leadman/foreman at the site. As such, his knowledge is imputed to PMI.

The violation was serious. Had the crane tipped over onto employees, the result would have been death or serious harm (Tr. 458). PMI's violation of § 1926.1402(b) is established.

Citation No. 1, items 4a and 4b – Alleged Violation of § 1926.1412(d)(1) and § 1926.1412(e)(1)

Item 4(a) alleges a serious violation of 29 C.F.R. § 1926.1412(d)(1) on the grounds that "[a]t the trenching area-on March 12, 2011, the Broderson telescoping boom crane was not inspected before operating the crane that day, exposing employees to struck-by hazards." The Secretary proposes a grouped penalty for items 4a and 4b of $2,800.00.

Section 1412(d)(1) provides:

> A competent person must begin a visual inspection prior to each shift the equipment will be used, which must be completed before or during that shift. The inspection must consist of observation for apparent deficiencies. Taking apart equipment components and booming down is not required as part of this inspection unless the results of the visual inspection or trial operation indicate that further investigation necessitating taking apart equipment components or booming down is needed. Determinations made in conducting

the inspection must be reassessed in light of observations made during operation. At a minimum the inspection must include all of the following: [. . .]

The standard proceeds to list items to be inspected on the crane such as, electrical apparatus, control mechanisms, fluid levels, hooks and latches, ropes, and cab windows.

Item 4(b) alleges a serious violation of 29 C.F.R. § 1926.1412(e)(1) on the grounds that "[a]t the trenching area-on March 12, 2011, the Broderson telescoping boom crane had been operated at the site since January 2011 and had not been inspected on a monthly basis, exposing employees to struck-by hazards."

Section 1926.1412(e)(1) provides:

Each month the equipment is in service it must be inspected in accordance with paragraph (d) of this section (each shift).

The crane was rented by PMI from a rental company called RSC and arrived on the site in January 2011 (Tr. 647-648). PMI's superintendent testified that RSC was supposed to come out once a week to maintain and check all the equipment. However, he did not know who at PMI was responsible to ensure that RSC actually performed the inspections (Tr. 647). To his knowledge, PMI did not get any inspection reports (Tr. 648). The crane operator testified that he did not conduct a monthly inspection of the crane (Tr. 294). He did not prepare any checklists or conduct a hazard assessment (Tr. 294). He also agreed that cranes should be inspected weekly, but he did not provide any written documentation of such an inspection to his supervisors (Tr. 295). According to the crane operator, the superintendent never asked for an inspection report on the crane. Moreover, he had no idea who monitored the inspection of the cranes (Tr. 296).

The crane operator claimed he performed daily inspections. Normally, however, his daily inspection consisted only of walking around to check that there were no flat tires and that no fluids were leaking. The crane operator testified that on March 12 he only looked to see if the tires were okay. He likened his "inspection" that day to when "you walk to your car and you see you don't have a flat tire and you just go on" (Tr. 324). This evidence establishes that PMI conducted neither daily nor monthly inspections of its crane.

PMI contends that RSR was responsible for conducting the monthly inspections. It also asserts that the superintendent never ordered the crane to be used that day. Rather, employees were supposed to lower the pipes into the crane with the lull. There is no evidence that the

superintendent knew that the crane was being used. Also, the violation was the result of employee misconduct which as discussed previously is rejected. PMI's other arguments are also without merit.

PMI seeks to be excused from the responsibility of conducting a monthly inspection because RSC was obligated to conduct the inspections. However, there is no evidence that RSC conducted these inspections. Nor is there any evidence that PMI checked to ensure that the monthly inspections were conducted. PMI was in possession of the crane and its employees were exposed to the hazards created by the lack of a proper monthly inspection.

"An employer may carry out its statutory duties through its own private arrangements with third parties, but if it does so and if those duties are neglected, it is up to the employer to show why he cannot enforce the arrangements he has made." *Froedtert Memorial Lutheran Hospital, Inc.,* 20 BNA OSHC 1500, 1508 (quoting *Central of Georgia R.R. Co. v. OSHRC*, 576 F.2d 620, 624 (5th Cir. 1978)). *See also*, *Baker Tank Co./Altech*, 17 BNA OSHC 1177, 1180 (No. 90-1786-S, 1995) (an employer cannot "contract away its legal duties to its employees or its ultimate responsibility under the Act by requiring another party to perform them).

PMI has introduced no evidence that it made any effort to enforce RSR's obligation to conduct regular inspections of the crane. Moreover, any obligation by RSR to conduct weekly inspections did not extend to the daily inspections required by the standard and which PMI failed to conduct.

PMI's attempt to assert a lack of knowledge and employee misconduct for the failure to conduct a daily inspection is also without merit. The evidence demonstrates that PMI failed to ensure that RSR was conducting the inspections. PMI's superintendent was responsible for ensuring that RSR conducted its inspections, but neither asked for nor received any inspection reports (Tr. 167, 296, 647-648). The superintendent could not identify anyone at PMI who was responsible for ensuring that RSR conducted the inspections (Tr. 647). Similarly, the superintendent did not provide the safety director any documentation regarding daily or monthly crane inspections (Tr. 804-805). Reasonable diligence includes inspecting the worksite and anticipating hazards. *Halmar Corp.,* 18 BNA OSHC 1014, 1016 (No. 94-2043, 1997) , *aff'd without published opinion* , 152 F.3d 918 (2d Cir. 1998). Had PMI officials exercised reasonable diligence, they would have known that the crane was not being properly inspected.

The crane operator's testimony establishes that his daily inspection of the crane consisted merely

of checking for oil leaks and flat tires. This falls far below the checks required by the standard. On March 12, the crane operator did not conduct even this cursory look. That the superintendent may not have been aware that the crane was being used is of no consequence. The competent person was certainly aware that the crane was being used and, as foreman, his knowledge is imputed to PMI. Also, there is no evidence that PMI had any enforced work rules requiring a daily inspection of the crane. The crane operator could not even name who, at PMI, was responsible for monitoring that the crane was properly inspected (Tr. 296).

The evidence establishes that employees were exposed to the hazard of the uninspected crane. Employees were working in the trench where the crane was lowering the pipes. The flagman who worked near the crane, and the crane operator were also exposed to the violative conditions. The violations identified in items 4a and 4b were serious. Had the crane failed while picking up or carrying a load, it could have fallen upon the exposed employees resulting in death or serious harm (Tr. 460-461).

PMI's violations of § 1926.1412(d)(1) and § 1926.1412(e)(1) are established.

Willful Citation

Citation No. 2, item 1a and 1b – Alleged Violations of § 1926.651(k)(2) and § 1926.652(a)(1)

Item 1a alleges a willful violation of 29 C.F.R. § 1926.651(k)(2) on the grounds that (a) "[a]t the trenching area-on March 12, 2011, employees were not removed from the 10-foot deep by 100-foot long trench with type-B soil, where there was no cave-in protection, exposing employees to cave-in hazards. The competent person notified the project superintendent the trench was not safe." and (b) "[a]t the trenching area-on March 12, 2011, employees were not removed from the 10-12 feet deep area with type-B soil with the trench shields 2-4 feet below the top of the trench, exposing employees to cave-in hazards. The competent person notified the project superintendent the trench was not safe." The Secretary proposes a grouped penalty of $56,000.00 for items 1a and 1b.

Section 1926.651(k)(2) provides:

> Where the competent person finds evidence of a situation that could result in a possible cave-in, indications of failure of protective systems, or other hazardous conditions, exposed employees shall be removed from the hazardous area until the necessary precautions have been taken to ensure their safety.

Item 1b alleges a willful violation of 29 C.F.R. § 1926.652(a)(1) on the grounds that (a)

"at the job site-on March 12, 2011, employees worked inside the 10-foot deep by 100-foot long trench with type-B soil, where there was no cave-in protection, exposing employees to cave-in hazards," and (b) at the job site-on March 12, 2011, employees worked inside the 10-12 feet deep trench with type-B soil, with the top of the trench shields 2-4 feet below the top of the trench, exposing employees to cave-in hazards."

Section 1926.652(a)(1) provides:

> Each employee in an excavation shall be protected from cave-ins by an adequate protective system designed in accordance with paragraph (b) or (c) of this section except when:
>
> (i) Excavations are made entirely in stable rock; or
> (ii) Excavations are less than 5 feet (1.52m) in depth and examination of the ground by a competent person provides no indication of a potential cave-in.

The Secretary argues that PMI employees worked in areas of the trench that lacked an appropriate protective system. In instance "a," the employees worked in an area 10 feet deep that did not contain trench boxes or other cave-in protection (Exhs. C-5, C-6, C-29). The competent person/lead man testified that on March 12 he worked all over the trench, including those portions that had no protection (Tr. 168). According to the CO, the competent person knew that employees were working in the unprotected area of the trench, yet allowed employees to enter (Tr. 449). This was confirmed by a PMI pipefitter, who testified that he saw three PMI employees in an unprotected area of the trench (Tr. 310).

In instance "b," there were trench boxes that did not extend to the top of the trench (Exhs. C-7, C-11, C-32). According to Appendix B to the excavation standards, trench boxes or shields in trenches dug in Type B soil, need to extend at least 18 inches above the top of the trench or the soil needs to be sloped away from the box. Figure B-1.2 states: "3. All excavations 20 feet or less in depth which have vertically sided lower portions shall be shielded or supported to a height at least 18 inches above the top of the vertical side. All such excavations shall have a maximum allowable slope of 1:1." The accompanying figure demonstrates that the top of the shield may not be below the top of the vertical side.

The CO testified that the top of most of the trench boxes were between 2 and 4 feet below the top surface of the ground (Exhs. C-7, C-11; Tr. 435-436). When marking the space on the photograph, the CO specifically drew the arrows from the top of the trench shields to the bottom of the concrete pad (Exh. C-11; Tr. 436). JBC's superintendent testified that the distance from

the top of the trench to the concrete pad was greater than 18 inches (Tr. 63). Exhibit R-7 shows that the distance between the top of the shield to the top of the concrete at the pictured location was 25 inches. The section of the trench with trench boxes measured 9-12 feet deep (Tr. 495).

The CO testified that the area marked "E" on exhibit C-7 had a slight angle, but did not know the slope (Tr. 562). He testified that he did not measure the slopes at the areas where he found gaps between the top of the shields and the top surface of the ground (Tr. 561-562, 587). However, the CO explained that, in his view, there was no need to measure the slope because the walls were nearly vertical (Tr. 503). JBC's superintendent testified that the area marked "B" on exhibit C-7 was not sloped at all (Tr. 40). He testified that the trench was sloped in other areas "to some degree " (Tr. 107).

In its brief, PMI points out that, under 29 C.F.R. §1926.650(b) "faces" or "sides" "means the vertical or inclined *earth* surfaces formed as a result of excavation work" (e*mphasis added)*. Therefore, PMI argues, the 18-inch limit imposed by the standard applies only to the soil and does not include the thickness of any concrete slab sitting above the earthen surface (PMI's Brief, p. 27).

PMI argues that in the only area of the trench specifically measured, depicted in exhibit R-7, the distance from the top of the shield to top of the surface was measured at 2 feet and 1 inch (PMI's Brief, p. 16; Tr. 581-582). PMI argues that the concrete slab was 12-18 inches thick.[5] Therefore, the exposed earth was only 13-17 inches thick. PMI contends that the gaps between the shields and the trench wall were estimated at 7-13 inches wide. According to PMI, this evidence demonstrates that the trench could have been sloped at the required 1:1 ratio. Having failed to actually measure the slope, the Secretary has failed to meet her burden of establishing the violation (PMI's Brief, p. 27).

PMI confuses the gap between the shields and the trench walls with a slope. A vertical rise of soil above a trench shield is not a slope and does not provide protection against a collapse of that soil simply because it is recessed from the shield.[6] Under PMI's argument, 5 feet of vertical soil above a shield would be permissible if the gap between the shield and the trench were also 5 feet. To comply with the standard, the soil *above* the trench shield must be sloped at a maximum angle

5 JBC's superintendent testified that the slab was 1 foot thick (Tr. 86).

6 Moreover, the concrete slab superimposed a load over the vertical layer of soil which could only exacerbate the hazard of collapse.

of 1:1 ratio. The CO testified that the trench was nearly vertical. This was corroborated by the JBC superintendent who admitted that the area depicted in exhibit C-7 was not sloped and that, in other areas, the trench was only sloped "to some degree" (Tr. 107). That the trench was not properly sloped is further established by the photographic exhibits which demonstrate that the trench walls were nearly vertical. Regardless of the distance of the soil from the trench shields, the operative fact is that the soil above the trench shields were minimally sloped or not sloped at all. Also, there were areas of the trench where the gap was substantially smaller. Even under PMI's theory, these areas would have been in violation of the standard.

PMI employees were exposed to the violative condition in item 1b. The employees were working in the trench all week before the accident (Tr. 427). The employees told the CO that they were laying pipe as fast as JBC was installing the trench boxes. Indeed, they were right behind them as JBC was installing the trench boxes (Tr. 430-431). Through his interviews with PMI employees, the CO determined that PMI employees were working in areas of the trench on March 11, 2011, where the trench shields went no higher than ground level (Tr. 439).

PMI knew, or with the exercise of reasonable diligence should have known, of the violations in items 1a and 1b. The violations were in plain view. PMI's superintendent was present at the worksite each day that PMI crews worked and he walked the site several times a day to see how work was progressing (Tr. 644). As superintendent, it was the superintendent's responsibility to make sure that everyone was following the safety rules (Tr. 643). PMI's competent person was also present and oversaw the pipe installation. In addition to being able to identify hazardous conditions, the competent person must have the "authorization to take prompt corrective measures to eliminate them." See 29 C.F.R. § 1926.650. The competent person's role as a lead man overseeing the pipe work in the trench is consistent with the authority required of a competent person. He inspected the trench the morning of the accident, before work began (Tr. 169).

Both PMI's competent person and its superintendent saw the way the boxes were installed, with the boxes placed 2-4 feet below the existing concrete slab and the one box that was installed correctly. They were both present the day of the accident and looked at the trench, so they knew it had not been stepped back. Indeed, the competent person warned the superintendent that he thought that the trench was unsafe (Tr. 149-150, 153). Therefore, through its supervisors, PMI

had actual knowledge of the unprotected portions of the trench and the improper way the trench boxes were installed in the trench.

Also, it is noted that the excavation was dug in previously disturbed, Type B soil. The competent person oversaw the crew using heavy equipment to put pipes in the trench. The morning of the accident, he noticed a crack in the wall and mud in the bottom of the trench. He concluded the recently excavated and unprotected area of the trench was unstable and unsafe for entry (Tr. 148-149, Ex. C-6). Thus, he had actual knowledge of conditions that warranted either not allowing the crew to enter or removing the workers if they did enter.

PMI's violations of § 1926.651(k)(2) and § 1926.652(a)(1) are established.

Willful Classification

The Secretary cited PMI's violations of § 1926.651(k)(2) (item 1a) and § 1926.652(a)(1) (item 1b) as willful. A violation is "willful" if it was committed with intentional, knowing or voluntary disregard for the requirements of the Act or with plain indifference to employee safety. *Continental Roof Systems, Inc*., 18 BNA OSHC 1070, 1071 (No. 95-1716, 1997). The employer's state of mind is the key issue. *AJP Construction, Inc*., 357 F.3d 70, 74 (D.C. Cir. 2004). The Secretary must differentiate a willful from a serious violation by showing that the employer had a heightened awareness of the illegality of the violative conduct or conditions, and by demonstrating that the employer consciously disregarded OSHA regulations, or was plainly indifferent to the safety of its employees. *Valdak Corp.,* 17 BNA OSHC 1135, 1136 (No. 93-0239, 1995), *aff'd* 73 F.3d 1146 (8th Cir. 1996). In the Eleventh Circuit, where this case arises, a violation is willful where either (1) the employer knew of an applicable standard prohibiting the conduct or condition and consciously disregarded the standard, or (2) although it did not know of an applicable standard's requirements, "it exhibited such 'reckless disregard for employee safety or the requirements of the law generally that one can infer that the employer would not have cared that the conduct or conditions violated the standard.'" *Fluor Daniel v. OSHRC*, 295 F.3d 1232, 1240 (11TH Cir. 2002)(quoting *J.A.M. Builders v. Herman*, 233 F.3d 1350, 1355 (11th Cir. 2000)).

PMI's competent person/lead man was in charge of overseeing the employees' work activities. The evidence also establishes that he had substantial and progressive medical and personal problems that lead to his removal as a supervisor. Yet, because of his experience and history with many of the crew members, he was allowed to operate as a lead man. As a lead man, the

competent person was a conduit between the superintendent and the crew when the superintendent could not be at the site. The evidence also establishes that the competent person did not fully understand the superintendent's directive to keep employees out of the trench on March 12, 2011. Although, as suggested by the PMI investigation report, the superintendent should have made extra efforts to ensure that his orders were understood, his failure to do so does not rise to the level of willfulness.

The circumstances surrounding employee entry into the unprotected portions of the trench are unclear from the record. The Secretary argues that having employees enter the unprotected area of the trench demonstrates that, even if he had been informed of the OSHA requirements, the superintendent would have ignored them (Secretary's Brief, p. 35). Such argument is not supported by the record. The evidence fails to demonstrate that the superintendent was aware that employees were entering the unprotected trench (Tr. 255-258, 630).

Moreover, the trench was inspected by SRS, Chevron, and Base Safety, none of whom voiced any objection or expressed any concern about the trench box installation (Tr. 50, 93-95). With twenty years in construction, focused mainly in piping, the superintendent's experience in trenching was minimal (Tr. 615). He testified that this project was the first time his work involved trenches (Tr. 614). Thus, he was reliant upon his competent person and the inspections of SRS, Chevron, and Base Safety in determining whether the trench was safe.

Under these circumstances, the elements of a willful violation were not established.

Although not willful, the evidence establishes that the violations in items 1a and 1b were serious. The employees were exposed to a hazard that could have resulted in serious injury. That the top portion of the trench contained a concrete slab does not diminish the hazard. Had the trench failed, everything above the failure, including the concrete slab, would fall into the trench. Moreover, even if the slab somehow stayed intact, the collapsing soil below it would pose a hazard to employees. Rocks, soil and debris falling from the top of the trench to employees below could have resulted in serious physical harm (Tr. 442).

Citation No. 2, item 2 – Alleged Violation of § 1926.1408(a)(2)

The citation alleges a willful violation of 29 C.F.R. § 1926.1408(a)(2) on the grounds that "[a]t the trenching area and below the overhead power lines-on March 12, 2011, the employer did not determine if any part of the Broderson crane, load line, or load could get closer that [sic] 20 feet to the overhead energized 12.4 kV power line, exposing employees to an electrical shock

hazard." The Secretary proposes a penalty of $56,000.00.

Section 1926.1408(a)(2) provides:

Before beginning equipment operations, the employer must:

* * *

(2) Determine if any part of the equipment, load line or load (including rigging and lifting accessories), if operated up to the equipment's maximum working radius in the work zone, could get closer than 20 feet to a power line. If so, the equipment must meet the requirements in Option (1), Option (2), or Option (3) of this section, as follows: [. . .]

The relevant options require either deenergizing the lines, maintaining a 20-foot clearance, or maintaining a clearance based on a Table.

Around lunch time, the crane operator and the competent person moved the Broderson crane and set it up within 10 feet of the overhead power line that was 40 feet above the ground (Tr. 171, 466). When relocating the crane, they did not discuss any hazards they might encounter if they moved the crane (Tr. 177, 300). The crane was used to place the pipes into the trench. It had an extension boom which could extend 40 feet (Tr. 142). The boom retracted to 20 feet. The crane had a radius of 360 degrees (Tr. 143). The pipes ranged from 20 to 40 feet in length (Tr. 314). The crane operator was receiving signals from the competent person who was acting as the flagger. He was relaying instructions from the pipefitter in the trench (Tr. 140, 291-292). The competent person was aware of the power lines. Both he and a pipe fitter told the crane operator to watch out for the lines (Tr. 249). However, they never discussed whether the lines were energized, and the crane operator did not realize that they were energized until the accident occurred (Tr. 292). According to the competent person, the crane operator was not able to see the power line because the sun was obscuring his vision (Tr. 172).

One of the pipe fitters was standing in the trench between two pipes. He signaled to the competent person to bring the crane closer. As he grabbed the hoop on the pipe, the competent person heard a sound that he recognized as electricity. As a result, the pipe fitter was severely injured (Tr. 136, 175-176). This evidence establishes that the crane either came into contact with or came within 20-feet of the energized line in clear violation of the cited standard.

PMI argues that the citation should be vacated. It asserts that employees were instructed to use the lull, not the crane, to place the pipes in the trench. Also, employees were instructed not to enter the trench. Had these orders been followed, the accident would not have happened (PMI's Brief, p. 29). Indeed, the employees involved were disciplined for disobeying orders. PMI's defenses lack merit.

As discussed *supra*, the evidence demonstrates that PMI's competent person/lead man knew that employees were working in the trench. His knowledge is imputed to PMI. Also, while employees were instructed to place the pipes in the trench with the lull, there is no evidence that they were specifically prohibited from using the crane. When they decided to move the crane, the crew never discussed the power lines, even though they were aware of its presence. Moreover, the competent person was operating as the flagman and gave the directions that led the crane to contact the power line. Yet, he attempted to place the blame on the crane operator with the excuse that the sun was in the operator's eyes. The evidence demonstrates that the accident was the result of a failure of training and communication (Exh. C-38; Tr. 763). PMI points out that its employees were disciplined for the events of March 12. Certainly, effective discipline is a necessary part of an adequate safety program which must include adequate training and communication. However, standing alone, employee discipline is of little consequence where, before the accident, training and communication are inadequate.

Also, the superintendent testified that he saw that the crane was moved to the trench and that employees were trying to set the pipes (Tr. 630). Indeed, he instructed the competent person not to set the pipes, yet said nothing about the power lines. Therefore, the superintendent had actual knowledge that the crane was being operated in proximity to the power lines, yet took no measures to ensure that adequate distances were maintained.

PMI's violation of § 1926.1408(a)(2) is established.

Willful Classification

The Secretary asserts that PMI's violation of § 1926.1408(a)(2) was willful. The Secretary argues that the crew had been working a grueling schedule, was way behind schedule and was being pressured to get the job done. The superintendent instructed the crew to place the pipes in the trench without entering, but did not show them how to do it, even though they never did it that way before. Instead, he relied on their experience to carry out his vague and misunderstood orders (Secretary's Brief, p. 41). The Secretary further asserts that safety was lax, especially that Saturday. The competent person shifted his focus away from safety and toward carrying out the superintendent's direction. Also, the superintendent chose to work in his trailer, even though he knew the competent person was struggling with his instruction. Even when two pipe fitters told the superintendent of the competent person's confusion, he did nothing. Progress on the project was first, safety was second (Secretary's Brief, p. 42).

The record demonstrates that PMI was working a tight schedule and was under pressure to complete the job. Some employees worked seven days a week, for as many as 16 hours a day (Tr. 641-642). Indeed, on the day of the accident, Chevron offered the crew a steak dinner if they got all the pipes in the trench-no matter what it took (Tr. 226). As a result of the pressure, it is clear that PMI got sloppy. For example, the crane operator did not conduct his usual inadequate inspection of the crane and both the competent person and the crane operator failed to place the pads under the outriggers. However, the competent person's medical problems were a significant factor in the superintendent's inability to adequately communicate his instructions. Although he failed to ensure that the competent person understood his instructions, the Secretary's assertion that he did nothing is not borne out by the record. To the contrary, as noted *supra*, the superintendent repeated his instructions several times, including at least once while in front of other employees. In any event, none of these other violations (inadequate crane inspections and lack of pads) were cited as willful.

The pressure the crew was under was likely a major factor in its sloppiness. However, there is no evidence that PMI ever made a decision to place the job over employee safety. The evidence fails to establish that the failure to maintain the required distance from the power line was committed with "intentional, knowing, or voluntary disregard for the requirements of the Act or with plain indifference to employee safety. The Secretary failed to differentiate willful conduct from a serious violation by showing that PMI had a heightened awareness of its unsafe activity near the overhead power lines by demonstrating that PMI consciously disregarded OSHA regulations, or was plainly indifferent to the safety of its employees. No such showing was made here. The violation of § 1926.1408(a)(2) was not willful.

Nonetheless, the violation of § 1926.1408(a)(2) was serious. As demonstrated by the accident, the failure of an employer to keep a crane the appropriate safe distance from a power line can result in death or serious physical harm, including death and serious burns (Tr. 470).

Penalty Considerations For Citations Nos. 1 and 2

Section 17(j) of the Act, 29 U.S.C. § 666(j), requires that in assessing penalties, the Commission give "due consideration" to four criteria: the size of the employer's business, the gravity of the violation, the employer's good faith, and its prior history of violations. These factors are not necessarily accorded equal weight; but generally gravity of a violation is the primary element in the penalty assessment. *J. A. Jones Construction Company*, 15 BNA OSHC 2201, 2214 (No. 87-

2059, 1993).

With only 75 employees, PMI is considered a medium-size employer and credit is given for PMI's size (Tr. 412). PMI is also entitled to credit for good faith and history based on having a safety director and written safety program and the lack of prior OSHA inspections (Exh. R-16; Tr. 736, 857-858).

A penalty of $2,500.00 is reasonable for PMI's violation of § 1926.652(g)(1)(ii) (Citation No. 1, item 2). The severity of the violation was high because if the shields failed, employees could get hurt. However, the probability of an incident was considered low.

A penalty of $3,000.00 is reasonable for PMI's violation of § 1926.1402(b) (Citation No. 1, item 3). The crane without pads was placed near the trench where employees were working. The crane operator admitted that it was "overlooked" (Tr. 298).

A grouped penalty of $2,500.00 is reasonable for PMI's violations of § 1926.1412(d)(1) and § 1926.1412(e)(1) (Citation No. 1, items 4(a) and 4(b)). There is no showing that adequate crane inspections were made. Although the likelihood of an accident was low, had one occurred the results could have been death or serious harm. The gravity was moderate.

A grouped penalty of $5,000.00 for PMI's serious violations of § 1926.651(k)(2) and § 1926.652(a)(1) (Citation No. 2, items 1a and 1b). Having found the violations were serious, and not willful, a substantial reduction in the penalty is required. The violations were of high severity due to the potential seriousness of any injuries had the trench collapsed (Tr. 443). The possibility of a trench collapse was heightened because of the heavy equipment operating in the area, particularly from vibrations from the crane that was being used.

A penalty of $5,400.00 is reasonable for PMI's serious violation of § 1926.1408(a)(2) (Citation No. 2, item 2). Finding that the violation was serious, but not willful, a substantial penalty reduction is required. As demonstrated by the accident, the likelihood of an accident was high and the results of an accident were severe (Tr. 470). Therefore, the gravity of the violation was high.

Findings of Fact and Conclusions of Law

The foregoing decision constitutes the findings of fact and conclusions of law in accordance with Rule 52(a) of the Federal Rules of Civil Procedure.

Order

Based upon the foregoing decision, it is ORDERED that:

1. Citation No. 1, item 1, alleging a serious violation of 29 C.F.R. § 1926.652(c) is vacated.

2. Citation No. 1, item 2, alleging a serious violation of 29 C.F.R. § 1926.652(g)(1)(ii) is affirmed and a penalty of $2,500.00 is assessed.

3. Citation No. 1, item 3, alleging a serious violation of 29 C.F.R. § 1926.1402(b) is affirmed and a penalty of $3,000.00 is assessed.

4. Citation No. 1, items 4(a) and 4(b), alleging a serious violations of 29 C.F.R. § 1926.1412(d)(1) and 29 C.F.R. § 1926.1412(e)(1) are affirmed and a grouped penalty of $2,500.00 is assessed.

5. Citation No. 2, items 1a and 1(b), alleging a willful violations of 29 C.F.R. § 1926.651(k)(2) and 29 C.F.R. § 1926.652(a)(1) are affirmed as serious violations and a grouped penalty of $5,000.00 is assessed.

6. Citation No. 2, item 2, alleging willful violation of 29 C.F.R. § 1926.1408(a)(2) is affirmed as a serious violation and a penalty of $5,400.00 is assessed.

SO ORDERED.

/s/ Ken S. Welsch
Ken S. Welsch

Administrative Law Judge
Dated: June 10, 2013
Atlanta Georgia