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. THOMAS INDUSTRIAL COATINGS, INC. Respondent.	OSHRC Docket No. 06-1542

ON BRIEFS:

Kristen M. Lindberg, Attorney; Charles F. James, Counsel for Appellate Litigation; Joseph M. Woodward, Associate Solicitor; Deborah Greenfield, Acting Deputy Solicitor; U.S. Department of Labor, Washington, DC
For the Complainant

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For the Respondent

DECISION

Before: ROGERS, Chairman; ATTWOOD, Commissioner.

BY THE COMMISSION:

Thomas Industrial Coatings, Inc. ("TIC") is an industrial painting company that contracted with the St. Louis Bridge Construction Company to sandblast and paint the Jefferson Barracks ("J.B.") Bridge in St. Louis, Missouri. On February 17, 2006, while TIC was erecting a suspended scaffold beneath the bridge, a cable supporting the scaffold snapped, causing four employees to fall, one of whom died as a result. The Occupational Safety and Health Administration ("OSHA") commenced an inspection of the worksite that day and, on August 9, 2006, issued TIC two citations—one serious and one willful—alleging violations of the Occupational Safety and Health Act of 1970 ("Act" or "OSH Act"), 29 U.S.C. §§ 651-678. Under the serious citation, the Secretary alleged two violations of construction fall protection

standards and proposed a penalty of $4,200 for each citation item. Under the willful citation, the Secretary alleged one violation of a construction standard involving the availability of lifesaving skiffs, and proposed a penalty of $56,000 for this citation item. Following a hearing, Administrative Law Judge Ken S. Welsch issued a decision affirming one of the two alleged fall protection violations and assessing the proposed penalty of $4,200. The judge also affirmed the alleged lifesaving skiff violation, but he recharacterized it as serious and assessed a penalty of $7,000.

On review before the Commission are the merits of both alleged fall protection violations, as well as the merits and characterization of the alleged lifesaving skiff violation. For the reasons that follow, we vacate both of the citation items alleging the fall protection violations, affirm the citation item alleging the lifesaving skiff violation, characterize that violation as willful, and assess a penalty of $56,000.

BACKGROUND

On the morning of February 17, 2006, TIC employees were laying "spans" or "sheets" to construct a suspended scaffold, also known as a "Safe Span," in preparation for sandblasting and painting the J.B. Bridge, which consists of two parallel bridges crossing the Mississippi River. The three employees at issue in the fall protection citation items worked on a nine-person crew that was erecting the Safe Span underneath the arched portion of the two bridges, which were connected by two permanent crosswalks, about 100 feet above the water. These three employees worked on the northernmost bridge along with another laborer and the crew foreman. The other four crew members, one of whom was a "foreman-in-training," worked on the southernmost bridge.

Late that morning, the foreman-in-training contacted Don Thomas—TIC's president and owner who served as project manager for the bridge project—to inform him that the scaffold at the J.B. Bridge had collapsed. He told Thomas that one employee had fallen into the river and three other employees were dangling from vertical lifelines. TIC responded immediately by setting up a rigging system in order to retrieve the three employees attached to vertical lifelines. With assistance from a group of firefighters who had responded to the accident, TIC rescued these three employees. The employee who had fallen into the river was not rescued and died as a result of the accident.

DISCUSSION

I. Serious Citation 1, Items 1 and 2 (Fall Protection)

Under the first citation item, the Secretary alleges that TIC violated 29 C.F.R. § 1926.451(g)(1)(i),[1] because "a fall protection system was not utilized by one [member of the work] crew erecting the temporary work platform," resulting in this employee falling "approximately . . . one hundred feet down into the river." Under the second citation item, the Secretary alleges that TIC violated 29 C.F.R. § 1926.502(d)(10)(i),[2] because "employees working from a suspended work platform did not have independent lifelines, with separate anchorage points capable of supporting at least 5,000 pounds . . . per employee attached for a complete personal fall arrest system."

The judge found that the deceased employee had failed to use a personal fall arrest system but vacated the alleged violation of § 1926.451(g)(1)(i) ("fall arrest item") on the grounds that TIC had neither actual nor constructive knowledge of that failure. However, he affirmed the alleged violation of § 1926.502(d)(10)(i) ("vertical lifeline item"), crediting the testimony of witnesses who testified that two TIC employees had shared a single vertical lifeline, and finding constructive knowledge based on the foreman-in-training's ability to have observed the violative condition. The judge also rejected TIC's affirmative defense of unpreventable employee misconduct with regard to this item, concluding that TIC had neither adequately monitored its employees' compliance with fall protection rules nor "universally administered" discipline to those employees who violated such rules.

As the judge found, the record shows that TIC failed to comply with both of the cited fall protection standards.[3] On review, the parties dispute the judge's knowledge findings with regard

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[1] Section 1926.451(g)(1)(i), as relevant here, states as follows:

> (g) *Fall protection.* (1) Each employee on a scaffold more than 10 feet (3.1 m) above a lower level shall be protected from falling to that lower level. . . . (i) Each employee on a boatswains' chair, catenary scaffold, float scaffold, needle beam scaffold, or ladder jack scaffold shall be protected by a personal fall arrest system[.]

[2] With one exception not applicable here, § 1926.502(d)(10)(i) requires that "when vertical lifelines are used, each employee shall be attached to a separate lifeline."

[3] TIC does not dispute that the deceased employee was on a scaffold "more than 10 feet . . . above a lower level" without being "protected by a personal fall arrest system." 29 C.F.R. § 1926.451(g)(1)(i). However, TIC challenges the judge's factual finding that two TIC

to these items: the Secretary challenges the judge's conclusion that she failed to establish TIC's knowledge of the violative condition alleged under the fall arrest item, and TIC challenges the judge's finding that it had knowledge of the violative condition alleged under the vertical lifeline item. Based on our review of the record, we conclude that the Secretary has failed to establish TIC's knowledge of the violative conditions alleged in both citation items.

Fall arrest item

To establish knowledge, the Secretary must prove "that the 'employer knew or could have known with the exercise of reasonable diligence of the conditions constituting the violation.' " *Contour Erection & Siding Sys., Inc.*, 22 BNA OSHC 1072, 1073, 2004-09 CCH OSHD ¶ 32,943, p. 53,787 (No. 06-0792, 2007) (citation omitted). "In assessing reasonable diligence, the Commission has considered 'several factors, including the employer's obligation to have adequate work rules and training programs, to adequately supervise employees, to anticipate hazards to which employees may be exposed, and to take measures to prevent the occurrence of violations.' " *Gen. Motors Corp.*, 22 BNA OSHC 1019, 1030, 2004-09 CCH OSHD ¶ 32,928, pp. 53,611-12 (No. 91-2834E, 2007) (consolidated) (citation omitted). Here, the Secretary claims that she established TIC's knowledge of the alleged fall arrest violation by showing that (1) the foreman-in-training observed the violative condition just prior to the accident, and (2) the crew foreman could have observed this condition "had he been paying attention." *Contour Erection & Siding Sys., Inc.*, 22 BNA OSHC at 1073, 2004-09 CCH OSHD at p. 53,787 (noting that "actual or constructive knowledge of a supervisor or foreman" can generally be imputed to employer). We find that the record does not support these claims.

On the morning of the accident, the crew foreman observed the deceased employee handing sheets and clips to another crew member as he stood on the Safe Span. At the time, the deceased employee was wearing a harness with a lanyard and rope grab that was attached to a

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employees shared a vertical lifeline. 29 C.F.R. § 1926.502(d)(10)(i). After making extensive credibility determinations, the judge relied on the testimony of several firefighters who witnessed the violative condition and discounted the conflicting testimony of TIC's employee witnesses. We accept the judge's credibility determinations, particularly those pertaining to the demeanor of the witnesses, and therefore find that two TIC employees did, in fact, share a single vertical lifeline. *Valdak Corp.*, 17 BNA OSHC 1135, 1137 n.3, 1993-95 CCH OSHD ¶ 30,759, p. 42,741 n.3 (No. 93-0239, 1995) (articulating Commission's reluctance to reject judge's credibility findings based on first hand observation of witnesses' demeanor), *aff'd*, 73 F.3d 1466 (8th Cir. 1996).

vertical lifeline, which was anchored overhead to a bridge beam. The foreman testified that he never saw the deceased employee without fall protection at any time that morning and, before their last communication, he observed that the deceased employee was tied off. The foreman then climbed up the ladder from the Safe Span to the bridge deck. At some point thereafter, the deceased employee looked up at the foreman from underneath the outside structural bridge beam—they were able to communicate with and observe one another through a two- to three-foot wide gap between the beam and parapet wall—and told him to raise the cable. The foreman testified that he could not see the deceased employee's fall protection because the deceased employee merely stuck his head and maybe one shoulder under the beam during this communication. After receiving the deceased employee's instruction, the foreman turned away from him and raised the cable. Seconds later the cable snapped, causing the platform occupied by the deceased employee and his three co-workers to fall.

Moments before the cable snapped, the foreman-in-training was working on the southernmost bridge, closely watching how the employees working with the crew foreman on the northernmost bridge were connecting two runways to a crosswalk. During his observation, the foreman-in-training saw that the deceased employee had walked underneath a beam to the other side of the northernmost bridge, but then lost sight of the deceased employee until he came back to the middle of the bridge. According to the foreman-in-training, he saw the deceased employee return to the middle of the bridge five or six seconds before the cable snapped and thought at the time that this was "a far distance for [the deceased employee] to go if he was properly tied off." But the foreman-in-training consistently stated in his testimony that he was unable to observe what fall protection equipment the deceased employee was wearing and, thus, could not have known whether the deceased employee was in fact tied off.

Based on this testimony, we find that the deceased employee's movements in the moments before the accident caused the foreman-in-training only to *question whether* the deceased employee was "properly tied off," not determine *that he was not* tied off. We find, therefore, that the record does not show that the foreman-in-training had actual knowledge of the violative condition. Additionally, although the record supports the Secretary's assertion that the crew foreman was working near the violative condition, we find that under the circumstances here, his proximity does not show that he had either actual or constructive knowledge of the deceased employee's failure to use fall protection. The foreman's view of the deceased

employee at the time of the accident was restricted by the small gap through which the employee was visible, and the last time he saw the deceased employee's lanyard—just before their last communication—it was attached to a vertical lifeline. The Secretary asserts that the foreman did not detect the violative condition because "he was too busy to adequately monitor employees and took no steps to actively discover infractions." But for the reasons discussed below in the section addressing TIC's safety program, we find the record does not show that the foreman's duties hindered his ability to effectively monitor for safety violations, or that TIC's implementation of its safety program was inadequate. *See Gen. Motors Corp.*, 22 BNA OSHC at 1030, 2004-09 CCH OSHD at pp. 53,611-12 (discussing reasonable diligence).

Additionally, as the Secretary concedes in her review brief, "[i]t is unclear, from the testimony as a whole, just how long [the deceased employee] was working without his lifeline." The accident occurred after the entire crew had returned from a work break, and there is no evidence in the record contradicting the foreman's assertion that, earlier in the morning before the accident, he had observed that the deceased employee was tied off. Absent evidence showing how long the violative condition existed, we are unable to evaluate whether a reasonably diligent inspection by the foreman, the foreman-in-training, or any other TIC supervisor would have informed TIC of the deceased employee's failure to tie off. *See, e.g.*, *Kaspar Wire Works, Inc.*, 18 BNA OSHC 2178, 2196-97, 2000 CCH OSHD ¶ 32,134, p. 48,422 (No. 90-2775, 2000) (concluding that "in the absence of any evidence indicating how long the violative conditions had been in existence, we are unable to evaluate whether [the employer] could have known of them even if it had been reasonably diligent in inspecting its equipment"), *aff'd*, 268 F.3d 1123 (D.C. Cir. 2001); *Ragnar Benson, Inc.*, 18 BNA OSHC 1937, 1940, 1999 CCH OSHD ¶ 31,932, p. 47,373 (No. 97-1676, 1999) (concluding that constructive knowledge was not shown where lack of evidence of violation's duration precluded Commission from determining whether employer could have known of conditions with exercise of reasonable diligence). Accordingly, under the circumstances here, we find that the evidence showing what TIC's supervisors saw, or could have seen with the exercise of due diligence, does not establish that TIC had knowledge of the alleged fall arrest violation.

Vertical lifeline item

TIC argues that the record fails to support a finding of knowledge of this alleged violation because there is no evidence that the foreman-in-training knew, or could have known,

of the violative condition, given his distance from the two employees at issue and the uncertainty regarding the length of time that these employees allegedly shared a single vertical lifeline. For the following reasons, we agree that the record does not establish knowledge on the part of the foreman-in-training.

From his position on the southernmost bridge, approximately 50 to 70 feet away from the two employees on the northernmost bridge, the foreman-in-training observed that the two men were "as far as 30, 40, 50 feet away from each other and then next to each other" during the course of their work. He affirmed that there were no barricades to block his view of them and acknowledged that he was able to observe their backs "the whole time" they were working across from him.[4] While this evidence shows that the foreman-in-training could probably have seen the two employees clearly enough to determine that they were attached to the same vertical lifeline, there is no evidence in the record showing how long the two employees shared the lifeline before the accident occurred or that the foreman-in-training actually saw them during that time.

Only the firefighters testified to observing these employees attached to a single vertical lifeline, and their observations were made following the accident. No evidence shows that the two employees in question were attached to the same lifeline before the crew left the platform for its work break, and no evidence indicates that more than a short period of time passed between the resumption of work and the occurrence of the accident. Based on these facts, we are unable to evaluate whether a reasonably diligent inspection by the foreman-in-training, the foreman, or any other TIC supervisor would have informed TIC that the two employees shared a single vertical lifeline. *See, e.g., Kaspar Wire Works, Inc.*, 18 BNA OSHC at 2196-97, 2000 CCH OSHD at p. 48,422; *Ragnar Benson, Inc.*, 18 BNA OSHC at 1940, 1999 CCH OSHD at p. 47,373. Accordingly, as with the fall arrest item, we find that the evidence showing what TIC's supervisors saw, or could have seen with the exercise of due diligence, does not establish that TIC had knowledge of the alleged vertical lifeline violation.

[4] In contrast with the deceased employee, who worked "facing" the foreman-in-training on the upriver side of the northernmost bridge, the two employees at issue in the vertical lifeline item worked closer to the foreman-in-training with their backs to him on the downriver side of the northernmost bridge.

TIC's safety program

Finally, the Secretary claims that TIC had constructive knowledge of the violative conditions alleged in the fall arrest and vertical lifeline items, because the work TIC performed was inherently dangerous, its employees' failure to use fall protection was foreseeable, and both the monitoring and enforcement of its safety program was inadequate. *See Omaha Paper Stock Co. v. Sec'y of Labor*, 304 F.3d 779, 785 (8th Cir. 2002) (concluding employer had knowledge of lockout/tagout violation where employer knew that machinery was inherently dangerous and that one of three employees was inexperienced and untrained, and employer reasonably could have known that employees were entering machinery to clear jams). TIC's superintendent of the J.B. Bridge project affirmed that it was "completely foreseeable" that employees would, at times, not tie off, and the dangers associated with the employees' work underneath the bridge are self-evident. However, we find that the Secretary has not established that TIC's monitoring and enforcement of its safety program was inadequate and, therefore, has not shown that TIC had constructive knowledge of the violative conditions. *Gen. Motors Corp.*, 22 BNA OSHC at 1030, 2004-09 CCH OSHD at pp. 53,611-12 (discussing reasonable diligence).

The record shows that the fall protection requirements at issue here were included as rules in TIC's safety program and that these rules were repeatedly communicated to TIC employees, including the employees who were the subject of the fall protection citation items. *See id.* (listing adequacy of work rules and training programs as factors relevant to assessing employer's reasonable diligence). Specifically, both Thomas and TIC's safety and environmental manager ("safety manager") testified that TIC held a company-wide all-day safety meeting in September 2005, during which specific changes to TIC's safety program were communicated to employees. A "large portion" of this meeting was spent on fall protection, and TIC's 100-percent tie-off and vertical lifeline rules were specifically emphasized to employees. The attendance sheet for the meeting includes the signatures and printed names for the three employees at issue in the two fall protection citation items, as well as the crew foreman and superintendent.

Further, all three employees received fall protection training from TIC during either an employee orientation or a comparable refresher course, at which time the safety manager provided a copy of TIC's safety handbook to each employee, and used "hands-on" training and discussion to teach employees the fall protection requirements set forth in the handbook,

including the 100-percent tie-off and vertical lifeline rules. Information concerning fall protection was also provided during weekly toolbox meetings: the painting crew on the J.B. Bridge project received fall protection instruction from the superintendent and foreman during such meetings at the worksite, including on February 6 and 13, 2006, just days before the February 17, 2006 accident. And on other TIC projects, the deceased employee and crew foreman participated in toolbox meetings on five different occasions between December 2004 and December 2005, during which fall protection was specifically designated as a "Tool Box Talk Topic."

Contrary to the Secretary's claim, the record does not show that TIC's efforts to monitor its employees for compliance with these fall protection rules were inadequate. *See id.* (listing adequacy of supervision as one of several factors relevant to assessing employer's reasonable diligence); *Stahl Roofing, Inc.*, 19 BNA OSHC 2179, 2182, 2002-04 CCH OSHD ¶ 32,646, p. 51,219 (No. 00-1268, 2003) (consolidated) (rejecting Secretary's argument that employer should have provided more supervision where "she failed to specify how much more would be necessary to assure compliance, what additional measures [employer] should have taken, or how [employer's] supervision was insufficient"). Rather, the evidence shows that a number of safety checks were, as a matter of course, performed by TIC: (1) an insurance company safety consultant conducted nine safety audits at TIC worksites in the St. Louis area over a two-year period, though he had not inspected the J.B. Bridge worksite; and (2) TIC's safety manager or other TIC personnel performed unannounced inspections at various TIC worksites. And, with respect to the J.B. Bridge project, the evidence shows that the safety manager had not visited the worksite before the accident occurred, but owner Thomas did so periodically and inquired about "everything," including safety. Moreover, TIC's superintendent, who worked only at the J.B. Bridge during the project, "walked the job" on a weekly basis and completed a form titled, "Supervisor's Weekly Site Safety Checklist and Record Keeping Requirements." The checklist contained a list of recordkeeping and safety issues—including ones pertaining to fall protection—that the superintendent was required to evaluate.

Further, the crew foreman, who worked alongside half of the crew, provided direct, day-to-day supervision of the employees at issue. Contrary to the judge, we find that the record does not show his duties as a working foreman and supervisor of eight fellow crew members hindered his ability to effectively monitor for safety violations. In addition to supervising the crew, he

was responsible for ensuring that employees had their equipment and for maintaining his field foreman's notebook. But the foreman's group, which included the three employees at issue in the fall protection citation items, consisted entirely of experienced laborers who had never previously been disciplined for a violation of any fall protection rule. And the other group received instruction from the foreman-in-training, as he worked directly with them. Taken together, this evidence undermines both the Secretary's position and the judge's finding that TIC's monitoring of its employees' compliance with fall protection requirements was inadequate. *See Stahl Roofing, Inc.*, 19 BNA OSHC at 2182, 2002-04 CCH OSHD at p. 51,219 (finding supervision adequate where supervisors visited each work site at least once a day, safety manager visited ten to fifteen sites a week, and company president made unannounced visits to worksites); *N.Y. State Elec. & Gas Corp.*, 19 BNA OSHC 1227, 1228-31, 2000 CCH OSHD ¶ 32,217, pp. 48,871-74 (No. 91-2897, 2000) (finding supervision adequate where, in addition to supervisory surprise audits, foreman inspected each site for safety compliance twice a day and spent thirty to forty minutes at each visit).

Additionally, we conclude that any shortcomings in TIC's enforcement of its disciplinary procedures are insufficient to establish that TIC had constructive knowledge of the violative conditions alleged here. *See Lake Erie Constr. Co.*, 21 BNA OSHC 1285, 1288-89, 2004-09 CCH OSHD ¶ 32,857, p. 52,992 (No. 02-0520, 2005) (finding constructive knowledge based in part on employer's failure to utilize disciplinary program for inadequate fall protection). The judge concluded that "discipline was not universally administered" by TIC based solely on its failure to discipline any of the employees at issue under the fall protection citation items for the violations alleged therein. The Secretary also points out in her review brief that the foreman was likewise not disciplined for the "multiple violations of the OSH Act that occurred on February 17, 2006."

We find that these circumstances alone do not establish that TIC's disciplinary program was insufficient. The record shows that TIC had instituted a new disciplinary procedure, effective in August 2005, which was discussed at the company-wide safety meeting held the following month. Under this procedure, Thomas or the superintendent could send "the entire crew," including the foreman, "home without pay for a week if one member of the crew [was] caught not wearing [fall protection equipment] or abiding by fall protection requirements." The company's disciplinary and accident reports show that it had disciplined laborers and

supervisors, sometimes using this procedure, for violations of its safety program, including those requirements relating to fall protection, and that much of this discipline was meted out in 2005, months before the accident at issue here occurred. But these reports show that neither the deceased employee nor the two employees involved in the alleged vertical lifeline violation had ever been written up for violating a fall protection rule.[5] Moreover, other than the alleged violations before us, neither the judge nor the Secretary points to another instance where a TIC supervisor failed to discipline an employee for violating a rule in TIC's safety program. Given the record as a whole, we find that TIC's decision to forgo discipline for these particular employees in this one instance does not support a finding that it failed to exercise reasonable diligence and had constructive knowledge of the conditions alleged in the fall protection items. *See Precast Serv., Inc.*, 17 BNA OSHC 1454, 1456, 1995-97 CCH OSHD ¶ 30,910, p. 43,036 (No. 93-2971, 1995) (evaluating employer's disciplinary measures in context of unpreventable employee misconduct defense, and noting that "Commission precedent does not rule out consideration of *post*-inspection discipline, provided that it is viewed in conjunction with pre-inspection discipline"), *aff'd per curiam*, 106 F.3d 401 (6th Cir. 1997) (unpublished table decision).

Accordingly, we conclude that the Secretary has not established that TIC had constructive knowledge of the conditions alleged in the fall protection items. *Kerns Bros. Tree Serv.*, 18 BNA OSHC 2064, 2067, 2000 CCH OSHD ¶ 32,053, p. 48,003 (No. 96-1719, 2000) (noting that Secretary bears burden of proof to establish all elements of alleged violation). We therefore vacate Citation 1, Items 1 and 2 for lack of knowledge.

II. Willful Citation 2, Item 1 (Lifesaving Skiff)

Under this item, the Secretary alleges a willful violation of 29 C.F.R. § 1926.106(d)[6] because "a lifesaving skiff or the equivalent was not made readily available for [TIC] employees working from a temporary, suspended, working platform beneath the [J.B.] Bridge." Thomas

[5] We note that the only disciplinary action documented for these employees involved the crew foreman and the deceased employee, who were both suspended for a week without pay while working on a different project in August 2005. Their suspensions, however, were instituted under TIC's new disciplinary procedure, and the deceased employee was punished based solely on the failure of another crew member to wear a reflective safety vest.

[6] Section 1926.106(d) states that "[a]t least one lifesaving skiff shall be immediately available at locations where employees are working over or adjacent to water."

claims that weeks before TIC's work on the J.B. Bridge commenced, he met with personnel from four businesses operating along the Mississippi River to inform them of TIC's work project and to discuss the availability of rescue boats in the event of an emergency. TIC argued to the judge that the arrangements Thomas made with these businesses complied with the requirements of the cited standard.

The judge rejected TIC's argument and affirmed the alleged violation, but he recharacterized it as serious based on TIC's contention that the company had reasonably relied on these arrangements in lieu of placing its own skiff directly underneath the J.B. Bridge. On review, TIC challenges the judge's determination that it was not in compliance with the requirements of § 1926.106(d), and the Secretary challenges the judge's recharacterization of the alleged violation as serious. Based on our review of the record, we conclude the Secretary has established that TIC willfully violated § 1926.106(d).

Merits

The judge concluded that TIC's arrangements with the businesses along the river were insufficient because the businesses made no guarantees that a rescue boat would be available and accessible at all times, and TIC personnel made no attempt to immediately contact these businesses when the need for rescue services arose on the day the scaffold collapsed. We agree with the judge.

TIC maintains that § 1926.106(d), which requires that a lifesaving skiff "be immediately available at locations where employees are working over . . . water," is a performance-oriented standard and that, by making arrangements with these businesses, TIC "acted reasonably in the unique circumstances of this project." But the record shows that TIC's efforts in this regard clearly fell short of compliance with the cited standard. Although Thomas claims to have contacted personnel at all four businesses about one month before the accident to discuss the availability of a rescue boat in the event of an emergency at the bridge, personnel from only two of those businesses confirmed that they actually met with Thomas, and they testified that no guarantees were made that a rescue boat would be available to TIC at all times. The owner of Limited Leasing Company ("LLC") told Thomas that LLC would help out "in any way possible" if needed, but the owner also admitted that the pilot of his boat would not stay on the boat "vigilant and ready to respond." As he put it, "there were never any guarantees made that [LLC] would be there . . . every day just for [TIC]." And the president of Bussen Quarries ("BQ")

admitted to speaking with Thomas, but only about permitting TIC to locate a rescue boat at another operator's site or at BQ's sand dock. BQ had no boats of its own to provide TIC with rescue services. Even if we assume that Thomas did, in fact, speak with personnel from the other two businesses he identified at the hearing, J.B. Marine and Louisiana Dock Company ("LDC"), Thomas himself admitted that neither one of these businesses had a boat or rescue service "manned . . . each and every day," or available to TIC "on standby," in the event of an emergency.

Additionally, on the day of the February 17, 2006 accident, TIC's alleged arrangements with these businesses were not implemented. Thomas testified that when he met with the personnel from each business, he received their permission to place their names and telephone numbers on an "emergency action list." The day after his meetings, Thomas informed TIC's safety manager and superintendent that the emergency action list would serve as TIC's "marine safety process." The record shows that all three men programmed the telephone numbers for personnel from at least three of the four businesses into their cell phones. The safety manager then created the emergency action list using the telephone numbers that Thomas provided, and the superintendent posted the list in the worksite office trailer, which was accessible from the bridge deck in about two minutes by car. In the event of an emergency, it was the superintendent's responsibility to contact any or all of the businesses on the list. Nonetheless, immediately after the superintendent was notified by the foreman of the accident, he called 911 and TIC's safety manager, but never attempted to call any of the businesses on TIC's emergency action list, even though he was aware of his responsibility to do so and had their telephone numbers programmed into his cell phone.[7]

[7] After being informed of the accident, TIC's safety manager, who was attending a training class in St. Louis at the time, left to retrieve a boat that TIC had previously docked with LDC. Upon reaching the dock, the safety manager was told by a boat operator there that LDC's own boat was more accessible and could reach the bridge in less time than TIC's boat. The safety manager and the boat operator therefore went downriver in LDC's boat but did not succeed in locating TIC's employee. The record shows that no one was manning TIC's boat at the time of the accident and it would have taken at least twelve to sixteen minutes for a TIC employee to reach the facility where the boat was docked. Moreover, TIC's superintendent acknowledged that "the primary source of emergency action" was TIC's arrangements with the businesses along the river rather than its own boat.

With no guarantee that a rescue boat, a skiff, or any other boat would always be available and could respond immediately in the event of an emergency, and the superintendent's failure even to attempt to implement the deficient arrangements allegedly in place or contact other boat operators using TIC's marine radio,[8] we find that TIC failed to comply with the cited standard. *RGM Constr. Co.*, 17 BNA OSHC 1229, 1236, 1993-95 CCH OSHD ¶ 30,754, p. 42,731 (No. 91-2107, 1995) (finding violation of § 1926.106(d) where employer's skiffs were not located at worksite and, thus, not "immediately available"). We also find that TIC had actual knowledge of the violative condition here, because Thomas knew none of the businesses he claims to have contacted had guaranteed an immediate response in the event of an emergency, and the superintendent knew he failed to satisfy his responsibility to contact the businesses on the emergency action list following the deceased employee's fall into the river. *Contour Erection & Siding Sys., Inc.*, 22 BNA OSHC at 1073, 2004-09 CCH OSHD at p. 53,787 (noting that "actual or constructive knowledge of a supervisor or foreman" can generally be imputed to employer); *Conie Constr., Inc.*, 16 BNA OSHC 1870, 1872, 1993-95 CCH OSHD ¶ 30,474, p. 42,090 (No. 92-0264, 1994) (imputing owner's knowledge to corporation), *aff'd*, 73 F.3d 382 (D.C. Cir. 1995). We thus conclude that the Secretary has established a violation of § 1926.106(d).

Willful characterization

The judge affirmed the violation as serious rather than willful based on TIC's claim that it reasonably relied on businesses along the river to provide emergency services because it had been advised that placing a skiff directly underneath the J.B. Bridge would be unsafe. The judge cited the testimony of several witnesses who stated that under certain conditions, such as when the river is at or near flood stage, a skiff located underneath the bridge could have presented a danger to those operating it. In light of these reservations about operating the skiff, he found that the Secretary failed to show TIC's "state of mind at the time manifested plain indifference to employee safety." The judge noted that the Secretary "[came] closer to showing [that owner] Thomas knowingly disregarded the requirements of the Act," but concluded that "[Thomas] regarded the requirements of the Act to the extent he met with the various business owners to

[8] The record shows that Channel 16 on a marine radio, typically monitored by boat operators, is used to transmit distress calls. The superintendent testified that he kept a marine radio on his desk in the worksite office trailer, but that he did not use it on the day of the accident.

discuss rescue services and listed the telephone numbers for supervisors." We disagree with the judge's determination.

"The hallmark of a willful violation is the employer's state of mind at the time of the violation—an 'intentional, knowing, or voluntary disregard for the requirements of the Act or . . . plain indifference to employee safety.' " *Kaspar Wire Works, Inc.*, 18 BNA OSHC at 2181, 2000 CCH OSHD at p. 48,406 (citation omitted).

> [I]t is not enough for the Secretary to show that an employer was aware of conduct or conditions constituting the alleged violation; such evidence is already necessary to establish any violation . . . . A willful violation is differentiated by heightened awareness of the illegality of the conduct or conditions and by a state of mind of conscious disregard or plain indifference . . . .

Hern Iron Works, Inc., 16 BNA OSHC 1206, 1214, 1993-95 CCH OSHD ¶ 30,046, pp. 41,256-57 (No. 89-433, 1993). This state of mind is evident where " 'the employer was actually aware, at the time of the violative act, that the act was unlawful, or that it possessed a state of mind such that if it were informed of the standard, it would not care.' " *AJP Constr. Inc. v. Sec'y of Labor*, 357 F.3d 70, 74 (D.C. Cir. 2004) (emphasis and citation omitted). Based on our review of the record, we conclude that TIC had a heightened awareness that the conditions at the worksite were not in compliance with the specific requirements of § 1926.106(d), but made a conscious decision to disregard those requirements. *Hern Iron Works, Inc.*, 16 BNA OSHC at 1214, 1993-95 CCH OSHD at p. 41,257.

The record shows that Thomas and several of TIC's supervisors had a heightened awareness of § 1926.106(d) and its specific requirements prior to the February 17, 2006 accident. *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."). First, Thomas testified that, since 1994, he has known that a rescue boat must be available when working over water. He claimed that on previous projects, TIC had either used its own boat and personnel for this purpose, paid others to occupy rescue boats for TIC, or arranged for nearby businesses to provide rescue services free of charge. Thomas also testified that he was "shocked" by a suggestion from BQ's president that TIC not use its small boat on the river because doing so may be dangerous, and told BQ's president "this is what's required."

Second, TIC's safety manager told the OSHA Compliance Officer that he discussed the lifesaving skiff requirement with TIC employees during safety meetings. Also, the safety manager testified that two years before the accident, he received an email from an insurance company safety consultant that included an OSHA interpretative bulletin setting forth the requirements of § 1926.106, and that he had read the email and trusted the consultant, with whom he had a longstanding relationship, to give him correct information. The safety manager further testified that during a prior project, TIC had stationed a skiff, manned at least part of the time, in the St. Louis Harbor, and that TIC had located skiffs at other projects as well.

Third, TIC's superintendent admitted that on a prior project, he had "read the OSHA rules and [he had] read in there that you may need a skiff on the job." He also admitted that the safety manager had told him "that." Indeed, the foreman of the crew involved in the February 17, 2006 accident confirmed that the superintendent knew of the skiff requirement. The foreman testified that during another bridge painting project in mid-2005 on the Missouri River, this same superintendent assigned him the task of manning a rescue boat over a two- to three-month period. Finally, this foreman testified that he was aware of the lifesaving skiff requirement based on classes and safety meetings he attended prior to February 17, 2006, and he affirmed that TIC has its own rule that "says a lifesaving skiff will be immediately available."

Despite this heightened awareness of § 1926.106(d) and its specific requirements, TIC made a conscious decision not to comply with the cited standard on the J.B. Bridge project. As noted above, TIC knew through Thomas that there was no guarantee that any of the nearby businesses Thomas contacted would be able to respond immediately with a rescue boat in the event of an emergency. Additionally, TIC's superintendent did not contact any of these businesses on the day of the accident even though he knew it was his responsibility to do so and he had ready access to TIC's emergency action call numbers on his cell phone. We find, therefore, that TIC had a heightened awareness of the illegality of its failure to comply with the cited standard, and acted with conscious disregard of the standard's requirements and employee safety. *See CBI Servs. Inc.*, 19 BNA OSHC 1591, 1605-07, 2001 CCH OSHD ¶ 32,473, pp. 50,237-39 (No. 95-0489, 2001) (concluding employer acted with conscious disregard where supervisor knew of cited standard and had heightened awareness of illegality of cited conditions), *aff'd per curiam*, 53 F. App'x 122 (D.C. Cir. 2002) (unpublished); *L.E. Myers Co.*, 16 BNA OSHC 1037, 1047-48, 1993-95 CCH OSHD ¶ 30,016, p. 41,134 (No. 90-945, 1993)

(finding conscious disregard for employee safety where employer insulated lines only when "no question" existed that failure to insulate would present "a grave risk," but otherwise "gambled" that proper clearance could be maintained without insulating lines). Indeed, the fact that TIC had recently used its boat as a rescue skiff on another bridge project, and continuously manned the boat over a period of months, shows that TIC understood what was required to comply with § 1926.106(d) but deliberately chose not to take the same steps in this case.

Under Commission precedent, "willfulness will be obviated by a good faith, albeit mistaken, belief that particular conduct is permissible." *Froedtert Mem'l Lutheran Hosp., Inc.*, 20 BNA OSHC 1500, 1510, 2004-09 CCH OSHD ¶ 32,730, p. 51,911 (No. 97-1839, 2004). Here, TIC argues that any noncompliance with the skiff requirement cannot be willful because the company had a good faith belief its arrangements for emergency assistance constituted compliance with the requirements of § 1926.106(d). We find the record does not support TIC's position. As the judge found, there is some evidence supporting TIC's claim that it could be dangerous for a small boat to be in the river during flood or near-flood conditions. But the record shows that the river was in neither of these conditions on the day of the accident and, according to the Missouri water patrolman who investigated the accident, nothing about the river's conditions that day would have precluded TIC from placing a rescue boat underneath the bridge. In fact, TIC's foreman testified that the company should have had a rescue boat underneath the bridge on the day of the accident, and it should have been the boat that he had manned for two to three months while TIC worked over the Missouri River.

Moreover, TIC admits that one of its motives for disregarding the cited standard's requirements on the J.B. Bridge project was the cost of maintaining a manned skiff, and the record also shows that its employees disliked the task. Specifically, Thomas testified that in bidding for this project, TIC included the placement of a manned boat underneath the bridge in its cost estimate. Yet, according to TIC's safety manager, one reason TIC decided not to place a boat there was its concern that any such boat could be stolen or damaged, and TIC did not want to pay someone to "drive a boat down to the J.B. Bridge and back every day." *See E. Smalis Painting Co.*, 22 BNA OSHC 1553, 1577, 2009 CCH OSHD ¶ 33,030, p. 54,366 (No. 94-1979, 2009) (finding that employer would not have complied with standard "even had it known of its obligations" because of owner's "economic concerns" and "emphasis on productivity over employee safety"). The safety manager further testified that employees viewed manning the

skiff as "boring," and that TIC was having problems "fulfilling the assignment of" this task. In any event, regardless of TIC's reasons for not using its own boat as a lifesaving skiff, Thomas's purported arrangements with the various businesses along the river cannot be considered a good faith attempt at compliance because they were voluntary, subject to availability, and provided no guarantee of reliable rescue services. And based on TIC's familiarity and prior compliance with the requirements of the cited standard, TIC could not have believed that its arrangements here were adequate. *See Conie Constr., Inc.*, 16 BNA OSHC at 1872-73, 1993-95 CCH OSHD at p. 42,090 (noting that where "approach was different than that plainly required by the standard," employer could not have acted in good faith); *see also Caterpillar, Inc.*, 17 BNA OSHC 1731, 1733, 1995-97 CCH OSHD ¶ 31,134, pp. 43,483-84 (No. 93-373, 1996) (holding willfulness was not obviated by patently inadequate abatement measures), *aff'd*, 122 F.3d 437 (7th Cir. 1997). We therefore reject TIC's assertion that it attempted in good faith to comply with the requirements of § 1926.106(d) and affirm the violation alleged in Citation 2, Item 1 as willful.

Penalty

Under section 17(j) of the OSH Act, 29 U.S.C. § 666(j), the Commission must give "due consideration to the appropriateness of the penalty with respect to the size of the business of the employer being charged, the gravity of the violation, the good faith of the employer, and the history of previous violations." The principal factor in a penalty determination is gravity, which "is based on the number of employees exposed, duration of exposure, likelihood of injury, and precautions taken against injury." *Siemens Energy & Automation, Inc.*, 20 BNA OSHC 2196, 2201, 2004-09 CCH OSHD ¶ 32,880, p. 53,231 (No. 00-1052, 2005).

The judge assessed the maximum penalty allowable under the OSH Act for a serious violation, finding that the gravity of the violation was "extremely high" because TIC's noncompliance with the standard may have contributed to its employee's death. The Secretary argues on review that we should assess her proposed penalty of $56,000. According to the Secretary, her proposed assessment "was based on the high probability and severity of harm that could result from the violation." The Secretary's proposal also included a twenty-percent reduction for business size. TIC makes no argument concerning penalty.

We agree that the gravity of the violation here is high because, regardless whether TIC's employee could have been rescued in this case, its failure to make a lifesaving skiff immediately available risked the lives of all TIC employees who worked over the river. We have factored

into our penalty assessment the size of TIC's business, accord no good-faith credit based on our finding that TIC did not make a good faith effort to comply with the cited standard, and accord no history-based penalty reduction because TIC has a history of prior violations. Based on our review of the record and the statutory penalty factors, we assess a penalty of $56,000.

ORDER

We vacate Citation 1, Items 1 and 2. Also, we affirm Citation 2, Item 1 as willful, and assess a penalty of $56,000.

SO ORDERED.

/s/
Thomasina V. Rogers
Chairman

/s/
Cynthia L. Attwood
Commissioner

Dated: February 28, 2012

United States of America
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
1924 Building - Room 2R90, 100 Alabama Street, SW
Atlanta, Georgia 30303-3104

Secretary of Labor, Complainant, v. Thomas Industrial Coatings, Inc., Respondent.	OSHRC Docket No. **06-1542**

Appearances:

Oscar L. Hampton, III, Esq., and Aaron Rittmaster, Esq.,
U. S. Department of Labor, Office of the Solicitor, Kansas City, Missouri
For Complainant

Julie O'Keefe, Esq., and John F. Cowling, Esq.,
Armstrong Teasdale, LLP, St. Louis, Missouri
For Respondent

Before: Administrative Law Judge Ken S. Welsch

DECISION AND ORDER

Thomas Industrial Coating, Inc. (TIC), is an industrial painting company. On February 17, 2006, two TIC crews were setting up a work platform beneath the Jefferson Barracks (J. B.) Bridge on the Missouri side of the Mississippi River, near St. Louis. As the crews worked, a section of the platform collapsed, leaving three employees dangling from vertical lines to which they had tied off. A fourth employee, James Belfield, was not tied off. He plunged approximately 100 feet into the Mississippi River. His body was not recovered until a fisherman found it, nine weeks later.

Occupational Safety and Health Administration (OSHA) compliance officer Steven Eterno arrived at the site shortly after TIC crew members rescued the three employees hanging from the vertical lines. Eterno inspected the site and subsequently took photographs. He also interviewed employees and other witnesses. Based upon Eterno's inspection, the Secretary issued serious and willful citations to TIC on August 9, 2006. TIC timely contested the citations.

Serious citation No. 1 alleges TIC violated 29 C. F. R. § 1926.451(g)(1)(i) (item 1) for failing to protect each employee on a catenary scaffold by a personal fall arrest system and 29 C. F. R.

§ 1926.502(d)(10)(i) (item 2) for failing to provide separate lifelines for each employee working on a suspended platform. The Secretary proposes a penalty of $4,200.00 for each item.

Willful citation No. 2 alleges TIC violated 29 C. F. R. § 1926.106(d) (item 1) for failing to have a lifesaving skiff immediately available where employees were working over or adjacent to water. The Secretary proposes a penalty of $56,000.00 for this item.

The court held a hearing in this case from September 22 through September 27, 2008. TIC stipulated jurisdiction and coverage (Tr. 5). TIC denies it violated any of the cited standards and asserts the affirmative defense of unpreventable employee misconduct for items 1 and 2 of citation No. 1.

For the reasons explained in this decision, the court vacates item 1 of citation No. 1, affirms item 2 of citation No. 1, and assesses a penalty of $4,200.00 for item 2. The court affirms as serious item 1 of citation No. 2 and assesses a penalty of $7,000.00.[1] TIC's motion to dismiss item 1 of citation No. 2, claiming the Secretary improperly promulgated § 1926.106(d) is denied.

Background

Donald (Don)Thomas, owner and president of TIC, founded the company in 1991. TIC paints industrial facilities, structures, and vessels, such as warehouses, bridges, water towers, locks, dams, casinos, barges, and tugboats (Tr. 611-613, 616). Its office is located in Pevely, Missouri. TIC's work is seasonal, with as few as four projects in the colder months and as many as twenty-four in the warmer months. Approximately 70 percent of TIC's projects are in the St. Louis, Missouri, area (Tr. 613-616). Wayne Long is TIC's safety environmental manager (Tr. 1269). Each of TIC's projects are overseen by a project manager, who is a salaried employee, and a superintendent, who may or may not be a Union painter. TIC's crews, made up of foremen and workers, are all Union painters or ironworkers. Approximately 80 percent of the Union painters work for TIC full-time (Tr. 617-618, 776, 779).

[1] The Secretary issued citations to TIC in two other fatality cases which occurred in 2006 (Docket Nos. 06-1974 and 06-1975). The two fatalities happened on a bridge repainting project in Kansas City, Missouri on May 10, 2006, and July 5, 2006. The pleadings and evidence adduced in these later proceedings which were heard in June and July 2009, were not considered in the instant case and did not influence any determination made in this decision.

The J. B. Bridge consists of a pair of tied arch bridges spanning the Mississippi River between Columbia, Illinois, and St. Louis, Missouri. It carries six lanes of traffic (three eastbound and three westbound) for Interstate 255 and U. S. Highway 50. In November 2005, TIC bid to sandblast and repaint the undercarriage and other steel components of the bridge. The St. Louis Bridge Company, the project's general contractor, awarded TIC the contract. TIC began work on the bridge on February 6, 2006, and was scheduled to complete the project by September 2006 (Tr. 620-624).

Don Thomas, who acts as project manager for TIC's larger projects, was the project manager for the J. B. Bridge. The superintendent was Kevin Sparks (Tr. 619). Alan Jackson was the foreman over one crew of four men: James Belfield, Manuel Guttierez, Severo Pasillas, and Daniel Pulido. Belfield was not a foreman and did not act in a supervisory capacity. Ironworker Tate Manning was working on the other crew as a foreman-in-training. He reported to Jackson (Tr. 618, 768, 1446).

On February 17, 2006, the TIC crews were installing a Safespan platform under the bridge, from which the workers would sandblast and paint. To install a Safespan system, employees rig cables from one abutment to the other under the bridge, then attach pans on top of the cables. When completed, the pans serve as the workers platform (Tr. 96).

Sometime after 11:00 a. m., one of the cables supporting the platform under the westbound bridge snapped, and a portion of the platform fell. Pasillas, Pulido, and Guttierez were wearing harnesses and had attached their lanyards to vertical lines anchored to the diagonal I-beams underneath the bridge. They dangled above the water. Belfield, who was wearing a harness, was not tied off to a vertical line. He plunged into the Mississippi River. Tate Martin saw him surface and go under again as he was swept down river by the current. Martin observed a tugboat coming upriver towards Belfield and assumed it would rescue him (Tr. 801-802, 1469-1474).

Various emergency personnel arrived quickly at the bridge, including firefighters from the rescue squad of the Mehlville Fire Department (M.F.D.), led by Captain Terry TenBroek. The remaining TIC employees had initiated a plan to rescue the three employees hanging from the vertical lines, and were in the process of doing so when the rescue squad arrived. Captain TenBroek determined the plan was viable (Tr. 247). He and his squad stood behind the TIC employees and assisted in hoisting the rescue line to raise the three men to the platform. None of the three men sustained serious injuries (Exh. C-34).

John O'Heron Jr. was the pilot of the tugboat *Dorothy* that Martin had seen coming upriver towards Belfield. The *Dorothy* had been moored on the outside of the dry dock at J. B. Marine, approximately 3,000 feet south of the J. B. Bridge (Tr. 226). O'Heron happened to look up at approximately 11:30 a. m. and saw the three men dangling from the bridge. Thinking he could be of assistance, O'Heron unmoored the tugboat and headed upstream toward the bridge. When he was within 300 to 500 feet of the bridge, someone on the bridge waved him off. O'Heron halted his approach. O'Heron was unaware a man had fallen into the river. No other vessel responded to the emergency situation (Tr. 197-206, 226).

The Missouri State Water Patrol began rescue and recovery efforts on the river for Belfield. Belfield had fallen from a height of approximately 100 feet. The air temperature at the time of the platform collapse was approximately 50 degrees Fahrenheit and the water temperature was approximately 38 degrees Fahrenheit. By the next day, the air temperature had dropped to approximately 5 degrees Fahrenheit. Experienced rescue personnel recognize that a fall of approximately 100 feet into a river is usually fatal. If a person does survive the fall, he or she can only survive for 5 to 10 minutes in water that is 38 degrees (Exh. C-35; Tr. 506). The Missouri State Water Patrol searched the river for five days, working in twelve-hour shifts, to no avail (Tr. 516).

Nine weeks later, on April 18, 2006, a fisherman called 911 to report he had found a man's body floating approximately two miles south of the J. B. Bridge. Foreman Alan Jackson, who was also James Belfield's cousin, was called to the scene. He identified the body as Belfield's, pointing out a USMC tattoo on his right upper arm. Belfield was still wearing his body harness (Exh. C-35).

Discussion

The Secretary has the burden of proving each violation by a preponderance of the evidence.

> In order to establish a violation of an occupational safety or health standard, the Secretary has the burden of proving: (a) the applicability of the cited standard, (b) the employer's noncompliance with the standard's terms, (c) employee access to the violative conditions, and (d) the employer's actual or constructive knowledge of the violation (*i.e.,* the employer either knew or, with the exercise of reasonable diligence could have known, of the violative conditions).

Atlantic Battery Co., 19 BNA OSHC 2131, 2138 (No. 90-1747, 1994).

Citation No. 1

Item 1: Alleged Serious Violation of § 1926.451(g)(1)(i)

The citation alleges "a fall protection system was not utilized by one of the four man crew erecting the temporary work platform. On or about February 17, 2006, this exposed employee fell approximately (100') one hundred feet down into the river." Section 1926.451(g)(1)(i) provides:

> Each employee on a boatswains' chair, catenary scaffold, float scaffold, needle beam scaffold, or ladder jack scaffold shall be protected by a personal fall arrest system[.]

The Secretary classifies the scaffolding system used by TIC as a "catenary scaffold," which § 1926.450(b) defines as "a suspension scaffold consisting of a platform supported by two essentially horizontal and parallel ropes attached to structural members of a building or other structure. Additional support may be provided by vertical pickups." Thomas agreed with this classification, describing the Safespan scaffold as "the cable system with the decking that goes on top of it that was put under all expansions . . . for Thomas Industrial Coating to do its sandblasting and painting" (Tr. 638).

TIC does not dispute the Secretary established the first three elements of proof (application, noncompliance, and employee's exposure) of the violation. It is undisputed that Belfield was not protected by a personal fall arrest system at the time of the collapse, in violation of the terms of the standard, and it is self-evident that he was exposed to the hazard of falling into the river. TIC argues the Secretary failed to establish it had actual or constructive knowledge that Belfield was not tied off when working on the scaffold the day it collapsed.

The Secretary does not claim TIC had actual knowledge Belfield was not tied off on February 17. She contends, however, Jackson, TIC's crew foreman, had constructive knowledge of the violation because "employees not properly tied-off were endemic to its worksites" (Secretary's brief, p. 11). "[W]here a supervisory employee has actual or constructive knowledge of the violative conditions, that knowledge is imputed to the employer, and the Secretary satisfies [her] burden of proof without having to demonstrate any inadequacy or defect in the employer's safety program." *Dover Elevator Co., Inc*., 16 BNA OSHC 1281, 1286 (No. 91-862, 1993). The Secretary establishes constructive knowledge by proving that, with the exercise of reasonable diligence, an employer could have known of the violative condition. An employer must make a reasonable effort to anticipate the

particular hazards to which its employees may be exposed during the course of their scheduled work.

TIC has had a written safety program since its inception in 1991. Wayne Long had been TIC's safety environmental manager for approximately ten years at the time of the hearing (Tr. 1269). TIC implemented a mandatory "100% tie-off" rule requiring any employee exposed to a fall of six or more feet to tie off using a personal fall arrest system. The personal fall arrest system used by an employee to tie off consists of a full body harness and a lanyard that the employee attaches to an anchor point (Exh. C-22, p.5; Tr. 1284).

Jackson conducted five toolbox meetings attended by Belfield in which he reviewed fall protection safety (Exh. R-22; Tr. 1461-1462). Sparks held a toolbox meeting on the J. B. Bridge project on February 13, 2006, which Belfield attended. Sparks reviewed the 100% tie-off rule (Tr. 1119, 1143). The record establishes Belfield knew he was required to tie off while on the platform.

Tate Martin, who was designated as foreman-in-training, testified that after the crews returned from their break, he noticed Belfield (Tr. 799-800):

> had walked up underneath the beam and went to the other side of the bridge, the upriver side of the northbound bridge. And, I couldn't see him, because he went underneath the beam, and then he came back and then he walked back over in the middle of the bridge to where they were working. And, then, that just looked kind of –I don't know. It just looked kind of different. . . . It just looked like it was just a far distance for him to go if he was properly tied off. . . . Probably not even five or six seconds after that, the platform fell.

Foreman Alan Jackson had worked with Belfield for a year and a half to two years prior to the platform collapse, and had never seen him fail to observe the 100% tie-off rule (Tr. 1455). Jackson testified Belfield "complied with the requirements more than just about anybody" (Tr. 1454). Jackson had watched Belfield working the morning of February 17. When Jackson initially saw him, Belfield was standing on the Safespan platform and handing sheets and clips to Manuel Guttierez. At that time, Jackson testified, "[Belfield] had his vertical lifeline, which was anchored to the beam above, and a rope grab and his harness and lanyard" (Tr. 1469).

Later that morning, at approximately 11:15 (apparently the same time Martin saw Belfield), Jackson spoke to Belfield as Jackson was standing on the bridge deck above him. Jackson could see Belfield's face through a gap between the parapet wall and a bridge beam. Jackson could not see

Belfield's body. Belfield asked Jackson to raise a cable. Jackson turned to do so, when the cable snapped (Tr.1472-1473). Jackson stated, "I just heard the pans start clattering and I immediately went back to the wall and I actually jumped from the bridge deck down to the beam. . . .I jumped to the lower beam which I had to roll underneath the guardrail to get to the Safespan platform. And that was when I came out on the platform and they were yelling that Jimmy was in the river" (Tr. 1473-1474).

The Secretary argues Jackson should have known Belfield might not tie off because it had previously disciplined employees in the past for not tying off; its "track record" indicated TIC "had every reason to know that employees were not properly tying-off" (Secretary's brief, p. 11). The record establishes TIC had continuing problems getting its employees to tie off (Exh. C-29). TIC had never disciplined Belfield for failing to tie off, however, and there is no evidence Belfield had ever before failed to tie off. Furthermore, Jackson had observed Belfield working earlier that morning, and he had been properly tied off. According to Martin, Belfield had just returned from a break. The platform collapse occurred within minutes of his return. There is no evidence Belfield was in violation of the 100% rule for more than a few minutes. Jackson's failure to detect Belfield's violative conduct in those few minutes is not evidence Jackson failed to exercise reasonable diligence.

The Secretary has failed to prove TIC could have known, with the exercise of reasonable diligence, that Belfield was not tied off at the time of the platform collapse. The record establishes Jackson had worked with Belfield for at least a year and a half, and knew him to be a safety conscious employee. Whatever the reason for Belfield's lapse in judgment, it was a momentary occurrence that Jackson could not have anticipated. Item 1 is vacated.

Item 2: Alleged Serious Violation of § 1926.502(d)(10)(i)

The citation alleges, "[E]mployees working from a suspended work platform did not have independent lifelines, with separate anchorage points capable of supporting at least 5,000 pounds (22.2 kN) per employee attached for a complete personal fall arrest system." Section 1926.502(d)(10)(i) provides:

> Except as provided in paragraph (d)(10)(ii) of this section, when vertical lifelines are used, each employee shall be attached to a separate lifeline.

TIC does not dispute § 1926.502(d)(10)(i) applies to its worksite at the J. B. Bridge. The exception noted in the standard, § 1926.502(d)(10)(ii), applies only to elevator shaft construction, which is not at issue here. The cited standard applies to situations, such as in the instant case, where employees use vertical lifelines for fall protection.

There is no dispute that Guttierez was attached to a separate lifeline. The Secretary contends, however, that Pulido and Pasillas were attached to the same vertical line. TIC argues Pulido and Pasillas were properly attached to separate lifelines that became entangled when the platform collapsed and the two men swung towards each other. Determination of whether or not TIC violated the terms of the standard hinges on witness credibility.

The Secretary's Witnesses

Captain Terry TenBroek

Captain TenBroek is a firefighter with the M. F. D. rescue squad. He led the rescue squad at the J. B. Bridge on February 17, 2006 (Tr. 231, 234). Captain TenBroek wrote a report of the incident, which states in pertinent part (Ex. C-34):

> Upon arrival at approx. 11:38 hrs I was advised by D. C. J. Hampton that there was a victim in the river and three victims hanging by tether ropes from the underside of the west-bound lanes of the bridge. There were two individuals hanging from one rope and one hanging from a second rope. I relocated my truck to the west bound lanes above the victims and my crew and I donned our rappelling harnesses and flotation devices. We, along with Pvt. T. Daniels from Fire truck 1710, descended down the superstructure of the bridge onto a cat walk adjacent to the scaffolding being constructed by the painting crew. At this point we secured ourselves to the bridge with safety ropes and then descended onto the scaffolding. Through my initial observations of the emergency scene and during the efforts to secure myself and ensure the safety of all my men I became aware of a rescue plan being initiated by the scaffolding crew. I appraised the situation and decided that their plan was viable and that my best course of action was to assist with the rescue effort in progress. My men and I worked alongside the scaffolding crew to lower a line to the two, tethered together, victims. Both men were conscious and alert and were able to assist in their own rescue by grabbing the line and hooking it to their harnesses. At this point my men and I, along with the half dozen or so men from the scaffolding crew, pulled the victims up to the scaffold.

Captain TenBroek testified that by the time he and his crew arrived on the scaffolding, one of TIC's workers (apparently Jackson) was shimmying out on a beam to attach a pulley that was used

to lower the rescue rope (Tr. 243-244). There were two or three TIC workers in front of Captain TenBroek. He was within 3 feet of the edge of the scaffold during the rescue operation (Tr. 245-246).

Captain TenBroek stated he looked over the edge of the scaffolding and saw Pulido and Pasillas hanging back to back. He concluded they were connected to one line (Tr. 236). TenBroek stated he was certain of this fact because:

> as they came up as they were pulled up, the rope was swung out to them. One of the guys grabbed the rope and hooked it on and was pulled up, and as he was pulled up to the scaffolding level, the other person stayed down below the scaffolding level because they were tethered on the same rope, and then each had individual ropes from that center rope. (Tr. 237-238)
>
> . . .
>
> [Pulido and Pasillas] were brought into the edge of the decking, into the edge of the scaffolding with one line and one man. They both came together because they were tethered together, and then one man was pulled up and onto the scaffold, and that left the other man down. (Tr. 248-249)

Thomas Daniels

Thomas Daniels is a fire fighter with the M. F. D. (Tr.168). He assisted with the rescue of the employees at the J. B. Bridge on February 17. Daniels climbed down to the platform and stood next to one of the TIC workers at the edge. He helped pull up the employees (Tr. 182). He testified Pulido and Pasillas appeared to be tethered to one line (Tr. 176). Daniels concluded they were tethered together from the manner in which they were pulled up (Tr. 181):

> They were pulled up together because, obviously, there was a lot of weight, and we pulled the first one up and the other came right after . . .[T]here was obviously a lot of weight when we started pulling them up. That's why I know that they came up at the same time because there was–obviously, when we pulled them up, the first guy was unhooked, and there was obviously weight left on that line until the next one came up.

Kevin Reis

Kevin Reis is a fire fighter with the M. F. D.(Tr. 282). He was the driver for the rescue squad that responded to the emergency at J. B. Bridge on February 17. Reis climbed down with the rest of the crew to the platform underneath the bridge. When asked what he observed once he arrived at the platform, Reis responded, "A lot of people running around and ropes hanging out at a distance.

I was able to see one person out hanging on a lifeline, and there was another line hanging pretty much directly in front of me. I couldn't see directly below me, but there was a line right in front of me, and then one out a little bit further" (Tr. 286). Reis was certain Pulido and Pasillas were tied to the same vertical line: "There was only one line hanging when we were pulling them up. I mean, it took a lot of manpower to lift them up, and all of a sudden one got up, and we got him completely standing and off the line. The other one came up like it was nothing" (Tr. 289).

Although he was questioned repeatedly on the issue, Reis was unwavering in his testimony that there was only one vertical line for Pulido and Pasillas:

> Q. [H]ow did you know they were on the same line?
>
> Reis: Because there was only one line hanging in front of me going down to where they were.
>
> . . .
>
> Q. A vertical line going down?
>
> Reis: Correct.
>
> Q. And, both employees attached to that line.
>
> Reis: Yes.
>
> Q. And you saw that?
>
> Reis: Yes.

(Tr. 290).

> Q. How many lifelines were there, where they were attached?
>
> Reis: I saw one line hanging in front of me.
>
> Q. Hanging in front of you as I'm looking out this window?
>
> Reis: Correct.

(Tr. 296).

> Q. Is it possible that there were lifelines that were twisted together?
>
> Reis: No, sir.
>
> Q. Why not?
>
> Reis: Because I could see the line clearly.

Q. You could see the line clearly in front of you?

Reis: Yes, sir.

(Tr. 297-298).

Q. Did you see a [rescue] line being dropped down?

Reis: Yes, sir, I did.

Q. One line was dropped down?

Reis: Correct.

Q. Did you see how it was attached?

Reis: No, sir, I did not.

Q. And, that was the line you pulled?

Reis: Yes, sir.

Q. Was another line dropped down to get the second guy up?

Reis: I did not see one.

. . .

Q. So, there may have been a second line?

Reis: I did not change lines when I was pulling them up. I didn't have to let go of the first rope to pull up the second victim.

(Tr. 299-300).

TIC's Witnesses

Alan Jackson

Jackson testified he observed Pulido and Pasillas tied off to separate lifelines on February 17, 2006 (Tr. 1470). After the platform collapsed, Jackson phoned Kevin Sparks, then set about rescuing the three dangling employees. Jackson testified (Tr. 1475-1476):

> We got a cable choker and a snatch block and we hung it on the diagonal beam that we had our lifelines hooked to, and I looped the rope through the snatch block and . . . then we lowered that rope down and [Pulido and Pasillas] hooked it into their harness and we pulled them up with that.

Jackson stated Pulido and Pasillas were connected to two separate lifelines: "[T]hey were wrapped up together in them. They had spun, I guess, whenever they went down" (Tr. 1476). Jackson did not look up to see whether two lines were hanging from separate anchor points

(Tr. 1476, 1521). Jackson said members of the M. F. D. rescue squad "had come down on the beam, but they never came down on to the platform to help us, that I seen" (Tr. 1478). Jackson stated only he and his crew members were pulling on the rope to hoist up the two men (Tr. 1479). When asked why the M. F. D. fire fighters testified they stood on the platform and helped pull up Pulido and Pasillas, Jackson responded, "The only reason I can think of is because they were embarrassed that they didn't do anything" (Tr. 1538).

Tate Martin

Martin testified that when Pulido and Pasillas were pulled up, they were on separate lines (Tr. 817). He conceded the M. F. D. fire fighters were on the platform, but did not help pull up Pulido and Pasillas (although later he stated the firefighters "did have their hands on the rope" (Tr. 854). He charged the fire fighters with lying about their participation in the rescue (Tr. 826). Martin stated, "I was on the front helping pull my friends up. They were back behind me" (Tr. 827). When asked how he knew what their testimony was (the witnesses were sequestered), Martin responded, "Because they were on Channel 2, Channel 4, and Channel 5 news, the next day, after the rescue, Mehlville Fire Department said that they had rescued three guys . . . I know that they said they rescued these guys. And, we were involved. It wasn't them. . . . [I]t's just kind of a needle because, you know, it was our idea, it was our rescue plan and they said it was their idea, it was their rescue plan" (Tr. 829). When asked about his apparent animosity towards the fire fighters, Martin said, "[T]he animosity is, obviously, one of our close friends died, one of our persons that we worked with. And, then, on the same–on the eve of that, of us putting our lives at risk and trying to rescue these guys, they're just going to stand up and act like they're the heroes in the front line, but actually in the back line, they weren't even hardly helping us" (Tr. 830).[2]

[2] However the television news reports presented the rescue, the fire fighters at the hearing did not claim to have rescued Pulido and Pasillas. Captain TenBroek, Thomas Daniels, and Kevin Reis each stated the TIC employees were already underway with a rescue plan when they arrived, and they stood on the platform behind them and assisted. Captain TenBroek wrote his report within a day or two of the rescue mission, stating he determined their plan was viable and he and his men offered their assistance. Referring to the TIC employees, Daniels stated, "They were good. These guys were–they knew what they were doing" (Tr. 189).

Deposition Testimony of Wayne Long

Wayne Long testified under oath in a deposition taken for a civil case arising from the platform collapse on the J. B. Bridge. In the deposition, taken on December 5, 2007, Long appeared to know Pulido and Pasillas were attached to the same vertical line (Exh. C-73, pp. 122-123):

> Q. You indicated Pulido and Severo [Pasillas] were both attached to the same safety line, albeit at different points?
>
> Long: Different, opposite ends. A hundred foot rope, and one was on that end. A hundred foot line, the other one was on that end.
>
> Q. Okay. Were both ends attached to the bridge someplace?
>
> Long: Yes.
>
> Q. Is that a problem, from Thomas's safety–Thomas's standpoint, to have two men tied off on the same safety line?
>
> Long: Yes. It's against company practice. It's against OSHA policy, because each individual has to be attached to their individual safety line.

At the hearing, Long claimed his testimony in the deposition was "one of the scenarios that I testified to" (Tr. 1364). Long stated, "I was sharing with [the attorney] the different speculations that I had heard when I was doing my investigation of what actually happened that day. I was explaining the different scenarios I was told and that was one of a few scenarios that I told him I heard" (Tr. 1429).

The excerpted deposition testimony does not support Long's claim that he was discussing different scenarios he had heard. Immediately prior to the first quoted question, Long had been talking about Belfield falling. When Long is confronted with the statement, "You indicated Pulido and Severo were both attached to the same safety line," it is not in the context of exploring different scenarios. If there are sections of the deposition clarifying that Long's statement that Pulido and Pasillas were tied off to the same line was speculative, TIC did not adduce them.

Credibility Determination

At the time of the hearing, Alan Jackson was still working as a foreman for TIC (Tr. 1446). Tate Martin was working for another company, but stated he would like to work for TIC again (Tr. 833-834). The day of the platform collapse, both Jackson and Martin were in supervisory positions and thus responsible for discovering safety infractions on the site. Both men claim to have observed Pulido and Pasillas tied off to separate vertical lines. Jackson stated the M. F. D. fire fighters were not on the platform and did not participate in the rescue of the hanging employees in any way. Martin remembers them being on the platform, and even holding the rescue rope, but angrily denies they provided any substantive assistance. Belfield, who was a cousin to Jackson and a close friend of Martin's, had just plummeted into the Mississippi River. Three of their co-workers were hanging from the bridge. Jackson and Martin were shaken by the collapse, anxious about the fate of Belfield, and confronted with the stressful (and unfamiliar) rescue of their co-workers. They were emotionally involved in the situation.

The M. F. D. rescue squad was specifically trained to handle rescue situations. Captain TenBroek, Daniels, and Reis did not know any of the TIC employees and were able to approach the situation in a professional manner not colored by emotional upset. The testimony of each fire fighter corroborates the others, as well as Captain TenBroek's written report. They were each calm in demeanor, stating their answers in a straightforward manner with no hesitations or evasions. Each of them testified Pulido and Pasillas were tied to the same vertical line. Because they assumed a secondary role in the rescue of Pulido and Pasillas, they were better able to observe the working conditions and rigging. Reis was the only eye-witness who made a point of observing that a single line descended from the anchor point above them to Pulido and Pasillas below. He gave uncontradicted testimony that only one vertical line dropped down to the employees. A fire fighter trained in rope rescues is well able to recognize whether a rope hanging directly in front of him is, in fact, a single line or two lines twisted together. The fire fighters are disinterested third-party witnesses with no reason to state the employees were tied to a single line when they were not.

Jackson and Martin, on the other hand, each have an interest in promoting the notion that Pulido and Pasillas were properly tied off to separate lines. As supervisory employees, they were responsible for safety at the site. Jackson's testimony demonstrates he was mistaken in his

observations at the time of the rescue. Only Jackson contends the fire fighters were not on the platform behind him during the rescue, a statement contradicted by every other eyewitness, including Martin. This may be due to the stress and emotional turmoil of the situation, but it raises doubts about the accuracy of Jackson's other observations, including his testimony that the employees were tied off to separate lines.

Martin, in general, was a credible witness. He was well-spoken and gave detailed answers. On the subject of the rescue, however, he was less than reliable. His demeanor changed. He became belligerent when talking about the rescue. He expressed unabated anger toward the M. F. D. fire fighters. He returned repeatedly to their purported lying in taking credit for the rescue. Although the fire fighters freely acknowledged the TIC workers initiated and carried out the rescue with only minimal assistance from them, Martin seemed obsessed with the fire fighters' perceived grab for acclaim. It is unclear whether Martin actually believes the fire fighters conspired to deprive TIC of its rightful credit, or if, by portraying the fire fighters as liars, Martin can cast doubt on their claim the employees were tied to the same vertical line. Regardless, Martin's testimony regarding the rescue and the manner in which Pulido and Pasillas were tied off is deemed unreliable.

Long was not an eye-witness to the rescue. In determining whether TIC violated the terms of the standard, the court gives no weight to Long's deposition testimony stating Pulido and Pasillas were tied to the same line.

The court resolves the conflicting testimony in favor of the fire fighters who stated Pulido and Pasillas were tied off to a single vertical line. Captain TenBroek, Daniels, and Reis were more credible in their testimony than Jackson and Martin. Reis in particular testified unequivocally and convincingly the employees were tied off to a single vertical line. The Secretary has established the terms of § 1926.502(d)(10)(i) were violated.

Employee Exposure

Pulido and Pasillas were exposed to a fall of approximately 100 feet into the Mississippi River.

Knowledge

The Secretary argues TIC had constructive knowledge of the violation. The court found in the previous section that the Secretary failed to prove TIC had constructive knowledge that Belfield was not tied off at the time the platform collapsed. This item differs in significant ways.

Belfield was a single employee who had either not tied off when he returned from break, or who had briefly unclipped his lanyard to walk over and talk to Jackson. He was not actively working on a specific task when the collapse occurred. Pulido and Pasillas, however, were working at the time of the collapse. They had to have agreed to tie off to the same line, despite their training not to do so.

Martin was designated as foreman-in-training. Although he reported to Jackson, he was in charge of the second crew. As an employee to whom authority over other employees was delegated, Martin is considered a supervisor and his knowledge may be imputed to TIC. *A. P. Horo,* 14 BNA OSHC 2004, 2007 (No. 85-369, 1991). Martin testified Pulido and Pasillas were working immediately across from his crew, so the two crews could work at the same pace and "mimic" one another (Tr. 793). Martin observed Jackson's crew working 50 to 70 feet away from him, with no barriers or obstacles blocking his view. For most of the morning, Pulido and Pasillas were working side by side each other (Tr. 798-799). Martin stated, "I was paying attention to what they were doing" (Tr. 822). Their backs were to Martin the entire time, so he could see their lanyards clipped to the line (Tr. 838).

> The Commission has held that "the conspicuous location, the readily observable nature of the violative condition, and the presence of [the employer's] crews in the area warrant a finding of constructive knowledge." *Kokosing Constr. Co.*, 17BNA OSHC1869, 1871, 1993-95CCH OSHD ¶ 31,207, p.43,723 (No. 92-2596, 1996). Additionally, constructive knowledge may be found where a supervisory employee was in close proximity to a readily apparent violation. *Hamilton Fixture*, 16BNA OSHC1073, 1089, 1993-95CCH OSHD ¶ 30,034, p.41,184 (No. 88-1720, 1993), *aff'd*, 28F.3d 1213 (6th Cir. 1994) (unpublished).

KS Energy Services, Inc., 22 BNA OSHC 1261 (No. 06-1416, 2008).

Martin was a supervisory employee working all morning across from Pulido and Pasillas, to whom he "was paying attention." The Secretary has established TIC, through Martin, had constructive knowledge of the violation.

Serious Classification

The violation of § 1926.502(d)(10)(I) is properly classified as serious under § 17(k) of the Occupational Safety and Health Act of 1970 (Act). As discussed, TIC had constructive knowledge the two employees were tied off to a single vertical line and were exposed to a fall of 100 feet if the line had not held.

Unpreventable Employee Misconduct

TIC argues if a violation of § 1926.502(d)(10)(i) is found, it is the result of unpreventable employee misconduct on the part of Pulido and Pasillas. In order to establish the affirmative defense of unpreventable employee misconduct, an employer is required to prove (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. *Precast Services, Inc.,* 17 BNA OSHC 1454, 1455 (No. 93-2971, 1995), *aff'd without published opinion,* 106 F. 3d 401 (6th Cir. 1997).

TIC declined to produce Pulido and Pasillas as witnesses to explain their misconduct to the court.

As found in the previous section, TIC had an established work rule requiring each employee to tie off to an independent vertical line when such lines were used for fall protection. The record indicates TIC communicated this rule to its employees during safety training, and toolbox talks.

TIC has failed to establish that it took steps to discover violations. TIC made some effort to perform safety checks. John Sullivan, an insurance company safety consultant working for TIC, conducted seven safety audits (four on the same project) during a two year period when TIC had 80 to 110 worksites (Tr. 345-346, 709). Although not recorded Don Thomas and Wayne Long testified they conducted periodic unannounced inspections of TIC's various worksites (Tr. 1272-1273). Kevin Sparks performed a weekly site safety checklist (Tr. 1118). Alan Jackson monitored his site and crew for violations (Tr. 1457).

Jackson, however, was responsible for two crews and was himself working. When asked how many lanyards Belfield had on his safety harness on February 17, Jackson replied, "I really don't remember. I had, what, five guys there that day" (Tr. 1493). (Actually, Jackson was in charge of two

crews totaling eight men). Jackson's work duties prevented him from adequately monitoring the employees for safety infractions. His testimony establishes he corrected safety infractions when they occurred in front of him, but he did not take steps to discover them (Tr. 1516-1517):

> Q. You didn't make sure that every single guy was tied off when they were working for you in and around February 17, 2006, did you?
>
> Jackson: Every one that I saw, I did.
>
> Q. You didn't make sure and check to make sure every single person was tied off, though, did you?
>
> Jackson: If they were in my view, they were.
>
> Q. You had two crews, right?
>
> Jackson: Yes, sir.
>
> Q. Were you splitting your time among the crews.
>
> Jackson: I stayed more with my crew than the other one.
>
> Q. With Mr. Belfield and the other three individuals?
>
> Jackson: Yes.

Although Jackson spent more time with his own crew, three out of the four violated fall protection rules on February 17. TIC has failed to establish it took adequate steps to discover violations.

TIC has also failed to establish it effectively enforced the rules when violations are discovered. Pulido and Pasillas were not disciplined for their misconduct. Long's deposition testimony, which was not considered for purposes of determining whether a violation occurred, is relevant here. Long gave his deposition on December 5, 2007, ten months after the platform collapse and ten months before the hearing in this proceeding. It is clear from the deposition that Long's investigation of the collapse caused him to realize Pulido and Pasillas were tied to a single line. Yet Long, TIC's safety environmental manager, never disciplined them. Although TIC adduced evidence that it did discipline employees for safety violations (Exh. R-29), the record establishes discipline was not universally administered when safety infractions were discovered.

Effective enforcement of the rules requires more than a well-written program. TIC's work is, as Martin agreed, "inherently dangerous" (Tr. 821). Yet Kevin Sparks acknowledged that it is "completely foreseeable" employees will not always properly tie off (Tr. 1247).

The Secretary claimed fall protection violations were "endemic" at TIC's worksites, and there is some merit to that charge. TIC has had long-standing problems getting its employees to observe safety rules (Exh. C-29). William McDonald is OSHA's area director for the St. Louis office (Tr. 320). McDonald met with Long after the Secretary issued the citations in this case. McDonald testified Long told him "he tried to comply, but he's just going to have to stamp out the stupid; he's got to get rid of the stupid. . . . [H]e said, 'Well, you know, I'm doing what I can. I'm just going to have to regulate stupid on the job sites'" (Tr. 330-331). TIC's workforce has exhibited a continuing resistance to abiding by the company's rules. Given this propensity, it cannot be said TIC effectively enforces its work rules.

TIC's employee misconduct defense must fail. Item 2 is affirmed.

Citation No. 2

Item 1: Alleged Willful Violation of § 1926.106(d)

The citation alleges, "[A] lifesaving skiff or the equivalent was not made available for employees working from a temporary, suspended, working platform beneath the Jefferson Barracks Bridge. On or about February 17, 2006, one employee fell from this platform into the Mississippi River following an unexpected collapse of the work platform." Section 1926.106(d) provides:

> At least one lifesaving skiff shall be immediately available at locations where employees are working over or adjacent to water.

The standard applies to TIC's worksite. TIC's employees were working above water, on the J. B. Bridge. Compliance officer Eterno estimated as many as 25 TIC employees were exposed to the hazard of drowning due to the lack of a rescue skiff (Exh. C-15). TIC's decision not to locate a skiff below or near the bridge was made by its president Don Thomas. TIC knew the conditions at the site.

TIC's Motion to Dismiss Item 1 of Citation No. 2

TIC filed a motion to dismiss this item on September 15, 2008, arguing the Secretary improperly promulgated § 1926.106(d). The company contends paragraph (d) was not part of the proposed Construction Safety Act (CSA) rule submitted for public comments in February 1971. Paragraph (d) did not appear until it was placed in the final rule in April 1971. Therefore, TIC argues, employers were not provided an opportunity for notice and comment.

Under § 6(a) of the Act, the Secretary was authorized to adopt national consensus standards and established Federal standards without lengthy rulemaking procedures for two years from the effective date of the Act (April 27, 1971). This authority ended April 27, 1973.[3]

Section 1910.2(h) of 29 C.F.R. defines"established Federal standards" as "any operative standard established by any agency of the United States and in effect on April 28, 1971, or contained in any Act of Congress in force on the date of enactment of the Williams-Steiger Occupational Safety and Health Act."

The Secretary initially promulgated § 1926.106(d) as a CSA standard on April 17, 1971. 36 *Fed. Reg*. 7340. The standard became effective on April 24, 1971, for advertised federal contracts, and on April 27, 1971, for negotiated federal contracts. CSA standards became effective one day before the Act came into effect. *Underhill Construction Corporation,* 526 F. 2d 53, 55 (2d Cir. 1975). Therefore, §1926.105(d) meets the definition of "established Federal standard" because it was an operative standard in effect on April 28, 1971.

The instant case is distinguishable from *L. E. Myers Co.,* 12 BNA OSHC 1609 (No. 82-1137, 1986), which TIC cites in support of its motion. In *Meyers,* the Commission found the

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[3]Section 6(a) provides:

> Without regard to chapter 5 of title 5 or to the other subsections of this section, the Secretary shall, as soon as practicable during the period beginning with the effective date of this chapter and ending two years after such date, by rule promulgate as an occupational safety or health standard any national consensus standard, and any established Federal standard, unless he determines that the promulgation of such a standard would not result in improved safety or health for specifically designated employees. In the event of conflict among any such standards, the Secretary shall promulgate the standard which assures the greatest protection of the safety or health of the affected employees.

Secretary lacked authority to make substantive changes to established Federal standards when adopting them as OSHA standards under § 6(a). Here, the CSA standard promulgated on April 17, 1971, included paragraph (d). The Secretary then adopted that standard, including § 1926.106(d) (then codified at 29 C. F. R. § 1518.106), verbatim in May 1971. She made no substantive changes to the standard.

The Commission has held that an employer cannot challenge an OSHA standard based on procedural deficiencies in the adoption of its ancestor standard under other statutes in an enforcement hearing. *General Motors Corp., GM parts Div.,* 9 BNA OSHC 1331 (No. 79-4478, 1981). An employer challenging an OSHA standard must also show it suffered prejudice resulting from the alleged procedural irregularities. *Daniel International v. OSHRC,* 656 F. 2d 925, 930 (4th Cir. 1981). TIC's motion is silent regarding any prejudice it suffered from being denied the opportunity to comment 37 years previously on paragraph (d).

The court finds TIC's motion is without merit and now denies it.

Noncompliance with the Terms of the § 1926.106(d)

The applicability of § 1926.106(d) to TIC's worksite, the exposure of the employees working on the Safespan platform, and TIC's knowledge are not in dispute. The only element of the Secretary's burden of proof at issue is whether or not TIC complied with the terms of the standard. It is undisputed TIC did not have a skiff under or near the J. B. Bridge (Tr. 109, 712).

Section 1926.106 does not define "skiff." *The American Heritage Dictionary* (Second College Ed.) defines it as, "A flat-bottomed open boat of shallow draft, having a pointed bow and a square stern and propelled by oars, sail, or motor." Area director McDonald testified the Secretary would accept other vessels, including tugboats, as complying with the standard. He stated the employer has the discretion "to choose the type of boat they decide to put at that particular point" (Tr. 1574). The standard, also, does not define "immediately available." "Immediately" means "without delay," and "available" means "accessible for use; at hand." *The American Heritage Dictionary.* TIC had fair notice of the standard. The company was aware of its requirements and had complied with it on previous bridge projects (Tr. 1366-1369, 1498).

The Secretary takes the position TIC simply ignored the requirements of § 1926.106(d). She asserts TIC "offered one excuse after another for its failure to have a rescue skiff immediately available" (Secretary's brief, p. 4). Compliance officer Eterno testified Wayne Long told him TIC had difficulty getting employees to man a skiff for jobs over water because they found it "boring" and "demeaning" (Tr. 83). Long testified TIC was worried a skiff would be stolen or damaged. In addition, TIC did not want to pay for someone to transport the boat to and from the J. B. Bridge each day (Tr. 1371).

One line of TIC's defense is that it kept an unmanned skiff at a remote location in the event of an emergency[4]. TIC claims it had a skiff located at the ACBL marina (formerly Louisiana Dock). Kevin Sparks testified he assigned himself the task of manning the rescue skiff should the need arise. His plan was to "jump into his truck and drive down to the marina and get in the boat" (Tr. 110). Sparks conceded, however, that he was away from the worksite at times, and had not assigned anyone to man the skiff should the need arise in his absence (Tr. 1182). Alan Jackson had no idea where TIC's skiff was located (Tr. 1512). Sparks estimated the drive from the bridge to the marina to be eight minutes (Tr. 1192). Compliance officers Eterno and Leland Darrow timed the trip, using the route described by Sparks, and found it took sixteen minutes (Tr. 600). This skiff was not at hand and was not accessible for use without delay. It does not meet the requirements of § 1926.106(d). Sparks did not drive to the skiff and take it out on the water the day Belfield fell in the river.

TIC's primary defense is that it made arrangements with various establishments along the Mississippi River to render assistance to the company in the event an employee fell into the river. TIC argues § 1926.106(d) is a performance standard, which allows the employer some leeway in meeting its requirements. Performance standards "require an employer to identify the hazards peculiar to its own workplace and determine the steps necessary to abate them." *Thomas Industrial Coatings, Inc.,* 21 BNA OSHC 2283, 228 (No. 97-1073, 2007). Area director McDonald agrees § 1926.106(d) is a performance standard (Tr. 1574).

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[4] Although this line of defense was raised at the hearing, TIC does not rely on it in its post-hearing brief. Issues not briefed are deemed waived. See *Georgia-Pacific Corp.*, 15 BNA OSHC 1127, 1130 (No. 89-2713, 1991).

TIC presented extensive testimony in support of its position. TIC argues these arrangements met the substantive requirements of § 1926.106(d). The Secretary contends these "arrangements" are no more than a *post hoc* rationalization for not having a skiff at the site.

The Secretary disputes various claims by TIC's witnesses addressing this issue. For the purposes of this decision, the court assumes *arguendo* that TIC's narrative set out in its brief is accurate. In summary, TIC's version of the evidence is as follows (TIC's brief, pp. 3-9):

> 1. In December 2005, Don Thomas called Mark Bussen, president of Bussen Quarry which owns riverfront land south of the J. B. Bridge. Thomas inquired about keeping a jon boat under the bridge during the project for emergency purposes. Bussen showed Thomas areas where a boat could be moored at a the Quarry and at J. B. Marine. Thomas testified Bussen recommended against it. Bussen testified, "I wouldn't go out on the river in a small boat" (Tr. 487). He told Thomas that J. B. Marine had boats and personnel at their facility "pretty much 24/7" (Tr. 481). Bussen advised Don Thomas to speak to Terry Bangert and George Foster about emergency assistance.
>
> 2. After speaking to Bussen, Thomas called George Foster and Pat Kapper of J. B. Marine, which operated the nearest tugboat service to the bridge. J. B. Marine which operates from 6:00 a. m. until 11:30 p. m. six to seven days a week, has eight harbor tugboats and during the day, one of the boats remains at J. B. Marine. Kapper stated that his company always had their marine radios on, and would assist in an emergency. He gave Thomas his office and mobile phone numbers for Thomas's site safety list.
>
> 3. Thomas then contacted Dave and Terry Bangert, the owners of Limited Leasing which is a sand dredging operation. Limited Leasing owns six tugboats and several dredges, barges, and rigs. It keeps one or two boats, a dredge, and four to ten sand barges at Bussen Quarry throughout the year. Banger told Thomas that "We work daylight hours, but we don't work Sundays, potentially" (Tr. 653). Thomas asked Bangert if he could contact him for help in an emergency, and if he could put Bangert's name and number on a site safety list as part of an emergency action plan. Bangert agreed to help in any way he could. Terry Bangert testified that they made arrangements for Limited Leasing to assist whenever TIC needed help, whether in an emergency or to move equipment. Bangert described the arrangement as an "agreement" (Tr. 467). Bangert testified that "we have worked with them before and had a relationship where we worked with them, and whether they needed equipment moved or it was an emergency, we would help them out to the best of our ability" (Tr. 469).

4. Don Thomas also met with Sam Lewis, the manager of Louisiana Dock, on January 19. They agreed that TIC could leave a boat there as a back-up for responding to an emergency and for recovering equipment at the bridge site. The boat was not the primary rescue response.

5. The record shows that companies in the river industry always assist in an emergency. TIC's expert Mark Tilford testified that there is a provision of the United States Code titled "Duty to Render Assistance," which makes the failure to render assistance a punishable offense. If boat operators are in the area when an emergency occurs, they must respond. Pat Kapper testified that providing such assistance is "a rule" (Tr. 441). He testified that J. B. Marine has, in the past, provided assistance in emergencies. Mark Bussen likewise testified that the rule on the river is that "if there's ever an emergency, everybody drops everything and helps out in emergency situations" (Tr. 488). Commercial boat operators are required to monitor marine radio channel 16, the emergency channel, at all times, and are required to respond in emergencies such as occurred in this case. TIC kept a marine radio at the job site which would allow TIC to communicate with the tugboat operators. Thomas instructed Kevin Sparks that the marine radio had remain on Channel 16.

6. The names and phone numbers for Bussen Quarry, Limited Leasing and other emergency services were placed on TIC's list of emergency numbers for the J. B. Bridge project. The list was posted in the job trailer. TIC's safety manager Wayne Long testified the emergency contact information was discussed during a project managers' meeting in January, and that he created the emergency contact numbers, directions to the hospital, and the emergency procedures. Kevin Sparks testified that Thomas told him a week or two before the job started that these names and numbers were on the list because "they were to provide . . . emergency rescue if we needed them" (Tr. 1161-1162). Sparks understood that TIC had "arranged for Sam and Mr. Bangert and their accessibility with their boats to be the primary source of emergency action" (Tr. 1193-1194). He also was informed that J. B. Marine was one of TIC's emergency contacts. He entered J. B. Marine's number and all other emergency numbers in his cell phone prior to the accident. In addition, the marinas could be contacted by marine radio. Therefore, if Sparks had to contact a marina, the marina would be able to contact the boat crew in a split second. Jackson testified that if Sparks was gone from the jobsite and the emergency numbers were needed, he would call to get the numbers or would have had someone else call who had the numbers.

7. Don Thomas testified that he made these arrangements for emergency rescue, rather than placing a small boat manned by a worker underneath the J. B. Bridge, because the river can be extremely dangerous for small boats. Pat Kapper testified that the safety of placing a jon boat on the river depends on the water level, and on a high river, it would "absolutely not" be safe (Tr. 434). He also testified that it

would be difficult for one person in a jon boat to pull a large man into the boat without falling into the water himself.

8. TIC's expert Mark Tilford testified that the Mississippi is a free-running river at the St. Louis Harbor, which means it is not dammed. Therefore, the currents cannot be controlled. The river is subject to rises and falls that are sometimes sever enough to prompt the Coast Guard to shut down the channel.

9. Corporal Louis Amighetti of the Missouri Water Patrol confirmed that the river is treacherous. On February 18, Corporal Amighetti warned Belfield's friends and relatives not to go on the river to search for Mr. Belfield because it was too dangerous. When Corporal Amighetti does a rescue operation, he likes to have at least two people on the boat so they have assistance to get someone into the boat.

Even if the court accepts TIC's version of the evidence to be true, the court finds TIC failed to comply with the terms of the standard. While TIC proved it met with some marine operators, it failed to establish it made arrangements that would meet the requirements of § 1926.106(d).

TIC did not enter into any contracts with these businesses. The "arrangements" it made were vague assurances from the businesses that they would help if they had a boat available. Any emergency assistance TIC received would be voluntary and uncompensated. Bussen did not have a boat available to send if he received a call for emergency help (Tr. 480). Bangert stated he would help TIC if he could, "But, there were never any guarantees made that we would be there, you know, every day just for them" (Tr. 476). Thomas conceded that neither Bussen nor Lewis agreed to provide any rescue service. The point of having a dedicated skiff onsite is the immediacy of the response. Calling around to various businesses to see if they had a boat available defeats the purpose of the standard.

TIC's reliance on the emergency radio channel and the "Duty to Render Assistance" is also misplaced. Response time by a random boat to an emergency call on Channel 16 is uncertain and unpredictable. Again, the immediacy of the response, which is what § 1926.106(d) is designed to ensure, is lost.

The inadequacy of TIC's plan is demonstrated by its abysmal failure when the occasion arose for TIC to implement it. When Belfield fell into the water, the very situation TIC's plan was designed to address, TIC failed to make a single call to any of its purported contacts for rescue services. Cell phone records show no one from TIC called any of the parties with whom it claims to have made

arrangements (Exh. R-30). There is no evidence TIC used its marine radio to notify anyone it had a man in the water.

The one and only boat that offered assistance to TIC was the *Dorothy*. O'Heron happened to look up and see TIC's employees dangling from the J. B. Bridge. Even though he was moored at the J. B. Marina, one of TIC's contacts, he did not hear of the situation by a phone call from TIC or on Channel 16. As he approached the bridge, he was focused solely on helping the men hanging from it. He did not know there was a man in the river. Belfield swept past the *Dorothy* unheeded.

TIC claims it did not locate a skiff under or near the bridge because the river was too dangerous. The J. B. Bridge project was scheduled to last for nine months. TIC did not seek a variance from OSHA, under § 6(d) of the Act. Instead, TIC chose to substitute its judgement for the requirements of the standard. TIC's alternate plan proved to be tragically inadequate to the emergency situation. The steps TIC took fell far short of meeting the requirements of § 1926.106(d).

The Secretary has established TIC failed to comply with the terms of the standard. Item 1 is affirmed.

Willful Classification

The Secretary classifies this violation as willful.

> A willful violation is one "committed with intentional, knowing or voluntary disregard for the requirements of the Act, or with plain indifference to employee safety." *Falcon Steel Co.,* 16 BNA OSHC 1179, 1181, 1993-95 CCH OSHA ¶30,059, p. 41, 330 (No. 89-2883, 1993)(consolidated); *A.P. O'Horo Co.,* 14 BNA OSHC 2004, 2012, 1991-93 C.H. OSHA ¶ 29,223, p. 39,133 (No. 85-0369, 1991). A showing of evil or malicious intent is not necessary to establish willfulness. *Anderson Excavating and Wrecking Co.,* 17 BNA OSHC 1890, 1891, n.3, 1995-97 C.H. OSHA ¶ 31,228, p. 43,788, n.3 (No. 92-3684, 1997), *aff'd* 131 F.3d 1254 (8th Cir. 1997). A willful violation is differentiated from a nonwillful violation by an employer's heightened awareness of the illegality of the conduct or conditions and by a state of mind, *i.e.,* conscious disregard or plain indifference for the safety and health of employees. *General Motors Corp., Electro-Motive Div.,* 14 BNA OSHC 2064, 2068, 1991-93 C.H. OSHA ¶ 29,240, p. 39,168 (No. 82-630, 1991)(consolidated). A willful violation is not justified if an employer has made a good faith effort to comply with a standard or eliminate a hazard, even though the employer's efforts were not entirely effective or complete. *L.R. Willson and Sons, Inc.,* 17 BNA OSHC 2059, 2063, 1997 C.H. OSHA ¶ 31,262, p. 43,890 (No. 94-1546, 1997), *rev'd on other grounds,* 134 F.3d 1235 (4th Cir. 1998); *Williams Enterp., Inc.,* 13 BNA OSHC 1249, 1256-57, 1986-87 C.H. OSHA ¶ 27,893, p. 36,589 (No. 85-355, 1987).

> The test of good faith for these purposes is an objective one; whether the employer's efforts were objectively reasonable even though they were not totally effective in eliminating the violative conditions. *Caterpillar, Inc. v. OSHRC,* 122 F.3d 437, 441-42 (7th Cir. 1997); *General Motors Corp., Electro-Motive Div.,* 14 BNA OSHC at 2068, 1991-93 C.H. OSHA at p. 39,168; *Williams Enterp., Inc.,* 13 BNA OSHC at 1256-57, 1986-87 C.H. OSHA at pp. 36, 589.

A.E. Staley Manufacturing Co., 19 BNA OSHC 1199, 1202 (Nos. 91-0637 & 91-0638, 2000).

The Secretary argues TIC was well aware of the requirements of § 1926.106(d), and had complied with them in the past. She contends TIC chose not to locate a skiff near the J. B. Bridge solely because it was concerned with property loss or damage, and because it did not want to pay for the daily transport of the skiff. In her estimation, TIC's decision was driven purely by economic concerns, and the company sacrificed employee safety for cost-cutting measures.

The court considers this to be a close case. The decision to rely on third party volunteers was terribly misguided. The record does indicate, however, TIC may not have been unreasonable in its belief it was not safe to place a skiff below the bridge. Bussen advised Thomas against putting a boat in the river (Tr. 487). Kapper testified a boat would be safe under normal river conditions, but not in high water (Tr. 434). In June 2004, TIC had crews working on the Poplar Street Bridge. TIC had a boat manned by Don Thomas's son and another employee underneath th bridge. The boat was swamped and capsized when a larger boat passed by (Tr. 660-661).

Corporal Amighetti testified it is dangerous to be on the river when it is at or near flood stage (Tr. 540). He also testified the temperature is a significant factor in water safety. The day after Belfield fell in the water, Corporal Amighetti warned Belfield's friends not to go on the river searching for him because it was too dangerous (Tr. 569). He stated, [W]e don't want anybody on the water when it's extremely cold outside or icy conditions occur" (Tr. 561). TIC began work on the J. B. Bridge in February, when the average low temperature is 26.5 degrees Fahrenheit (rssWeather.com). The day after Belfield fell, the temperature was 5 degrees.

Prior to the violation, Thomas determined it was too dangerous to place a boat near the J. B. Bridge. Thomas proceeded to contact various nearby establishments and discuss rescue services with them. Although he had no firm commitment from any of them to respond to an emergency if called, he made some effort to have a plan in place in the event of an emergency. While the plan was an utter failure, the Secretary has not shown Thomas's state of mind at the time manifested plain indifference

to employee safety. She comes closer to showing Thomas knowingly disregarded the requirements of the Act. The court finds, however, TIC regarded the requirements of the Act to the extent he met with the various business owners to discuss rescue services and listed the telephone numbers for supervisors. The violation is not willful.

The violation is classified as serious. A violation is serious under § 17(k) of the Act if the Secretary shows there is a substantial probability of death or serious physical harm that could result from the cited condition. There is evidence Belfield may have survived the fall. Had a skiff been immediately available, it is possible TIC could have reached him in time to save him from drowning.

Penalty Determination

The Commission is the final arbiter of penalties in all contested cases. In determining an appropriate penalty, the Commission is required to consider the size of the employer's business, history of previous violations, the employer's good faith, and the gravity of the violation. Gravity is the principal factor to be considered.

At the time of the inspection, TIC employed approximately 100 workers. The Secretary has previously cited TIC for violations of the Act. Lack of good faith was not adduced.

The gravity of the violation of § 1926.501(d)(10)(i) is high. By tying off to the same vertical line, Pulido and Pasillas greatly complicated the rescue. Had the line failed due to being overburdened by an extra person, both employees could have fallen into the river. A penalty of $4,200.00 is appropriate.

The gravity of the violation of § 1926.106(d) is extremely high. The failure to have a skiff immediately available may have contributed to Belfield's death. At the very least, having a skiff available in compliance with the standard would have increased the likelihood of recovering Belfield's body quickly, sparing his family and friends nine weeks of uncertainty. A penalty of $7,000.00 is appropriate.

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. Item 1 of citation No. 1, alleging a serious violation of § 1926.451(g)(1)(i), is vacated and no penalty is assessed;
2. Item 2 of citation No. 1, alleging a serious violation of § 1926.502(d)(10)(i), is affirmed and a penalty of $4,200.00 is assessed; and
3. Item 1 of citation No. 2, alleging a willful violation of § 1926.106(d), is affirmed as serious, and a penalty of $7,000.00 is assessed.

/s/
KEN S. WELSCH
Judge

Date: August 18, 2009
Atlanta, Georgia