Secretary of Labor, Complainant, v. Phillips Getschow Co., Respondent.	OSHRC Docket No. 02-0529

Appearances:

Rafael Alvarez, Esq., Office of the Solicitor, U. S. Department of Labor, Chicago, Illinois
For Complainant

Daniel V. Kinsella, Esq., Rooks Pitts, Chicago, Illinois
For Respondent

Before: Administrative Law Judge Nancy J. Spies

DECISION AND ORDER

Phillips Getschow Co. (PGC) contests a citation and proposed penalties issued to it by the Secretary on March 13, 2002. The citation was issued to PGC as a result of a fatality investigation conducted by Occupational Safety and Health Administration (OSHA) compliance officer Robert Vazzi on September 19, 2001.

A hearing was held in this matter on April 15, 16, and 17, 2003, in St. Louis, Missouri. The Secretary and PGC stipulated on the record that PGC was engaged in a business affecting commerce and that the Review Commission has jurisdiction over this action. The parties also stipulated that PGC is a mechanical contractor whose business office is located in Joliet, Illinois. They further stipulated that on September 18, 2001, PGC was working at the Ameren facility located at 134 CIPS Lane in Coffeen, Illinois. PGC was removing a Pennsylvania coal crusher cage weighing 4,860 pounds (Exh. J-1). At that time, PGC employed approximately 750 employees (Tr. 6).

The citation alleged five serious violations of the Part 1926 construction standards. At the beginning of the hearing, the Secretary withdrew item 3 of the citation, which alleged a violation of § 1926.554(a)(2) for failing to ensure that the supporting structure to which an overhead hoist was attached had a safe working load equal to that of the hoist (Exh. J-2). (The

Secretary's withdrawal of item 3 will be reflected in the Order at the end of this Decision).

The remaining four items, for which the Secretary proposed penalties of $7,000.00 each, are:

Item 1: § 1926.21(b)(2)–failure to instruct each employee in the recognition and avoidance of unsafe conditions.

Item 2: § 1926.554(a)(1)–failure to indicate the safe working load of an overhead hoist, as determined by the manufacturer, and ensuring this safe working load was not exceeded.

Item 4: § 1926.554(a)(3)–failure to arrange the support for an overhead hoist so as to provide for free movement of the hoist and/or restrict the hoist from lining itself with the load.

Item 5: § 1926.554(a)(6)–failure to ensure that overhead hoists met the applicable requirements for construction, design, installation, testing, inspection, maintenance, and operation as prescribed by the manufacturer.

In its answer PGC asserted the affirmative defense of unpreventable employee misconduct. PGC presented no testimony or evidence with respect to this defense at the hearing, nor did its counsel refer to it. It is deemed abandoned. The Secretary has filed a post-hearing brief (PGC declined to do so). For the reasons set out below, it is determined that the Secretary established items 1 and 2, and one instance of item 5. The Secretary failed to prove item 4.

Background

PGC has a longstanding business relationship with Ameren Energy Generating Group, an electric utility. Although PGC does not always have employees actively working at Ameren's Coffeen coal power plant, it does maintain an office at the plant. Ameren periodically contracts with PGC to perform maintenance on its equipment there (Tr. 122, 134-135). In 2001, Ameren contracted PGC to remove four coal crushers from the Coffeen plant. PGC's assignment was to dismantle and replace the old coal crushers with new ones. PGC hired ironworkers and millwrights to perform the required tasks (Tr. 592-593).

PGC superintendent David Barone was responsible for the overall project. PGC's general foreman over the ironworkers was Andrew Macari (Tr. 378, 445-447). On September 16, 2001, PGC employees removed the first of two coal crusher cages from their housing. Millwrights took off the door to the crusher cage and loosened the bolts. The ironworkers rigged the coal crusher to a chain fall hoist and trolley fitted to an I-beam and removed the cage from the building (Tr. 453,

477).[1]

Macari assigned PGC ironworkers James Whitaker and James Camden to remove the second coal crusher cage on September 18, 2001 (Tr. 386). Whitaker and Camden suspended a two-ton trolley from the I-beam and rigged the coal crusher cage to it with a chain fall hoist. As they were moving the suspended cage, PGC millwright Frank Hackney, who had earlier loosened the bolts on the cage, returned to the area to retrieve his tool bucket. As Whitaker, Camden, and PGC employee Chris Dee tugged at the cage, the load fell from the I-beam. The cage dropped and rolled onto Hackney, pinning him against the concrete wall. Hackney died as a result of his injuries (Exh. R-14; Tr. 30-31).

OSHA assigned Robert Vazzi to investigate the fatality. He arrived at the Coffeen plant on September 19, 2001, and examined the site of the accident and interviewed employees. As a result of Vazzi's investigation, the Secretary issued the citation in the instant case.

The Citation

The Secretary alleges that PGC committed serious violations. She has the burden of proving this 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).

Item 1: Alleged Serious Violation of § 1926.21(b)(2)

The Secretary alleges that PGC committed a serious violation of § 1926.21(b)(2), which provides:

> The employer shall instruct each employee in the recognition and avoidance of unsafe conditions and the regulations applicable to his work environment to control or eliminate any hazards or other exposure to illness or injury.

The citation alleges that PCG "did not instruct the ironworkers in the recognition and

[1] The metal structure attached to the ceiling from which the trolley was suspended was not actually an I-beam. It was two "C channels" welded together back to back to form a structure similar to an I-beam (Tr. 28). Throughout the hearing, however, witnesses and attorneys referred to the welded channels as an I-beam, and it will be referred to as such in this Decision.

avoidance of the unsafe use of chain hoists and the regulations applicable to their work environment to control or eliminate the overloading of chainfall hoists and use of chainfall hoists which do not have inspection tags on them." Vazzi testified that the citation for this item was based on information that "the chain hoist itself had been used without the certification and rating posted on the side as is should be, there was no inspection tag on the chain itself or sticker that's normally there as well, the fact that they used that, the rating and use of the trolley to some extent, how it was done, the centering of the trolley, proper use of it, and the lifting of the case with the weight of the cage unknown" (Tr. 63).

PGC safety director John Bernadoni told Vazzi that PGC relied on the trade union halls to supply the company with trained skilled labor (Tr. 64). PGC contacted Daniel Bauer, business agent for Local Ironworkers 392, and asked him to provide ironworkers to do the rigging for the Ameren project. Bauer provided, among others, Andrew Macari, James Whitaker, Chris Dee, and James Camden. Dee had been through 3 years of training in the Joint Apprenticeship Program (Program), an employer-funded training program designed to provide both classroom and on-the-job training to ironworkers (Tr. 242-248, 434, 437-438).

PGC's position, as stated in its pre-hearing statement, is that the training provided by the Program, as well as its own orientation program administered to new hires and the weekly toolbox meetings held at the Ameren facility were sufficient to adequately train employees as required by § 1926.21(b)(2).

Bauer testified that Macari and Whitaker both went through the Program (Tr. 437-438). He testified that James Camden, although dispatched from Local 392, did not go through the Program (Tr. 439). Bauer stated that every member of Local 392 goes through the Program, but that it dispatches ironworkers from other locals too. An employer would not know whether an ironworker dispatched by Local 392 had been through the Program (Tr. 442-443). Bauer testified that the Joint Apprenticeship Program occasionally holds an upgrading class for journeyman ironworkers, "but most of the safety, the new regulations are done . . .on the projects," that is, the work sites to which the ironworkers have been assigned (Tr. 443-444).

Macari testified that PGC's orientation program lasted approximately an hour, and consisted of being given the company's safety manual and filling out tax forms (Tr. 388, 391). He stated that PGC had a supervisor present, who "had us to fill out the paperwork and gave us a safety manual to

read it and sign the back of it when we got done reading it" (Tr. 392). Camden told Vazzi that he received no training when he was hired by PGC but was given a copy of the safety manual "and told to read it when he had the chance" (Tr. 73).

"An employer complies with § 1926.21(b)(2) when it instructs its employees about the hazards they may encounter on the job and the regulations applicable to those hazards. *Concrete Construction Co.,* 15 BNA OSHC 1614, 1619 (No. 89-2019, 1992). The specific deficiency cited for this item is the failure to train employees in the use of chainfall hoists. PGC's use of the chainfall hoist and other similar rigging was a common occurrence at Ameren. The hoist used by PGC's employees the day of the accident was not marked with its weight capability. Typically, the manufacturer marks the rating on the side of the hoist's block (Tr. 35). Generally, PGC would test chainfall hoists and place an inspection tag on the chain listing the rating. The chainfall hoist in question was not tagged at the time of the accident (Tr. 71). Foreman Macari testified that if a hoist is not tagged or otherwise visibly rated for hoisting capability, the procedure is, "You don't use it. If you don't know what it is, you shouldn't use it" (Tr. 396). Despite this policy, there is no indication that this safety rule was part of the training of any of the ironworkers involved in the hoisting accident.

The Commission has held that while § 1926.21(b)(2) "does not limit the employer in the method by which it may impart the necessary training, an employer that places too much trust in the quality of experience and training an employee has already acquired elsewhere runs the risk of violating the standard." *Ford Development Corp.,* 15 BNA OSHC 2003, 2009 (No. 90-1505, 1992).

The Secretary has established that PGC failed to train each employee in the recognition and avoidance of the unsafe use of chainfall hoists. Such training was not a part of the PGC's orientation and onsite training. Not all of its employees had completed the ironworkers training Program. The Secretary has established a violation of § 1926.21(b)(2).

The Secretary alleges that the violation is serious. Under § 17(k) of the Act, a violation is serious if there is a substantial probability that death or serious physical harm could result from the violation. PGC's employees lifted a coal crusher cage without knowing its weight or the capacity of the chainfall hoist. The weight of the coal crusher cage exceeded the capacity of the chainfall hoist. By failing to train its employees in the safe use of chainfall hoists, PGC exposed its employees to the hazard of being crushed by the falling cage. The violation is classified as serious.

Item 2: Alleged Serious Violation of § 1926.554(a)(1)

The Secretary alleges that PGC committed a serious violation of § 1926.554(a)(1), which provides:

> The safe working load of the overhead hoist, as determined by the manufacturer, shall be indicated on the hoist, and this safe working load shall not be exceeded.

The Secretary alleges both that the safe working load of the hoist was not indicated on the hoist and that PGC exceeded the safe working load. Vazzi testified that the hoist in question was not marked, as is usual, with the rated capacity on its block. Neither was it tagged (Tr. 34, 63).

PGC's counsel showed Vazzi a photograph of a green hook with a "2," indicating a 2-ton capacity, marked on it (Exh. C-9).[2] Vazzi testified that the photograph was not taken by him, but was sent to him by Bernardoni after his closing conference with PGC (Tr. 33). Vazzi stated that despite his examination of the chainfall hoist, he did not see a marking on the day of his inspection. It is determined that the hoist mechanism was not marked with the safe working load. Even if a "2" was visible upon close inspection of the hook, it would not indicate the hoist's capacity. Vazzi stated that the hook can be replaced on the hoist, so that the "2" indicates only the capacity of the hook, not the entire hoist (Tr. 35).

Vazzi eventually concluded that the safe working load of the hoist was 2 tons (or 4,000 pounds) (Exh. R-3; Tr. 83-84). Vazzi received various estimates of the cage's weight from PGC's employees. Barone estimated its weight at 3,200 pounds. Bernardoni estimated it from 3,200 to 3,500 pounds. Macari put it at 4,000 pounds (Tr. 51). Following the accident, PGC weighed the cage and found, as the parties stipulated, that the actual weight was 4,860 pounds, thus exceeding the hoist's safe working load by 860 pounds (Exh. C-20; Tr. 56-57).

The Secretary must establish that PGC knew, or with the exercise of reasonable diligence, could have known that the cage exceeded the safe working load of the hoist. It is apparent that PGC did not have actual knowledge of the cage's weight prior to the accident. With the exercise of reasonable diligence, however, PGC could have known it. Macari stated that Barone told him the weight of the cage, but did not know how Barone obtained that information nor did he remember what the weight was (Tr. 387-388). Barone testified that he estimated the weight of the cage "by

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[2] The hook in some of the photographs appeared to be dark blue. The actual color was dark green, the PCG color (Tr. 373).

looking in the crusher door and trying to take some estimate of pound per foot those types of bars would weigh and come to some reasonably close calculation of the total weight" (Tr. 458). He did not check with Ameren or the manufacturer to see if either one knew the actual weight of the cage (Tr. 458-459). Barone testified that he was able to estimate the weight because, "I basically know what pieces of steel this size, the weight per foot; and from that, you can get some type of a calculation of what you think it would be, somewhat more of a guess, more accurate" (Tr. 463). Barone stated that he estimated the cage weighed 3,600 pounds (Vazzi testified that Barone's estimate was 3,200 pounds) (Tr. 463). It is noted that Barone's high estimate is 1,260 pounds less than the actual weight of the cage. His method of calculation failed to account for 25% of the cage's weight. When asked if it would have been a good idea to find out the actual weight, Barone conceded, "There probably should have been some pre-job information available from the plant" (Tr. 493).

PGC did not exercise reasonable diligence in determining the weight of the coal crusher cage. It made no attempt to contact the manufacturer or obtain documentation that might indicate the cage's weight. Instead, it relied on an inaccurate estimate made by its job superintendent after his brief visual inspection of the cage. Given the risks involved in miscalculating such a large weight, reasonable diligence required something more than PGC's minimal attempt to gauge the cage's weight. PGC did not have the manufacturer's safe working load marked on the hoist. It exceeded the safe working load when it lifted the coal crusher cage.

The Secretary has established a violation of § 1926.554(a)(1). Failure to comply with this standard resulted in a substantial probability that death or serious physical harm could occur to the employees using the chainfall hoist. The violation is serious.

Item 4: Alleged Serious Violation of § 1926.554(a)(3)

Section 1926.554(a)(3) provides:

> The support shall be arranged so as to provide for free movement of the hoist and shall not restrict the hoist from lining itself up with the load.

The Secretary has two bases for this allegation: (1) the I-beam had an indentation or raised area in the lower rail that prevented the free movement of the trolley and hoist, and (2) the number of spacers on the trolley were unequal and prevented the trolley from being centered (Tr. 86-87).

Inspection of I-beam

Exhibit C-12 is a photograph showing a small nick at the edge of the I-beam. It was Vazzi's opinion that this nick impeded the free movement of the hoist. He stated that PGC's employees had used the hoist earlier that day with no problem, but when they attempted to move the cage, they couldn't: "It was like it was hung up" (Tr. 90).

Based upon his interviews with PGC employees, Vazzi explained his understanding of how the accident occurred (Tr. 94):

> Mr. Camden told me what occurred during this accident. He told me that he and Jim Whitaker were moving this along the I-beam; had tried to. They ran into where they couldn't move it. It stopped and wouldn't move anymore.
>
> At that time they stopped, he went out and got Chris Dee, another ironworker. There were two ironworkers outside. Chris Dee came in to help them. He told me that Chris Dee and he and Mr. Whitaker started to push the object again to try to move it, and that it suddenly gave way, and that's when the trolley came down.

The trolley was manufactured by Saginaw Products Corporation and was rated at 2 tons (Exh. C-20; Tr. 96). According to the manufacturer's operating instructions, workers using the trolley should "[c]heck I-beam carefully so that the trolley can run smoothly without encountering weld marks, splice plates, beam irregularities, or debris which may have accumulated on beam" (Exh. C-20, p. 2).

None of the employees present at the time of the accident testified at the hearing. Vazzi wrote a narrative of his inspection on an OSHA 1A. Although he stated at the hearing that the employees did not inspect the I-beam prior to using it, but only brushed coal dust off of it, in his OSHA 1A Vazzi states (Exh. R-14, p. 4):

> The morning of the accident, two ironworkers clamped the block and tackle, chainfall style hoist onto an I-beam above the crusher and tightened the bolts with wrenches, inspected the hoist, and checked it for easy movement along the I-beam.

The Secretary offers no proof that the small nick photographed in Exhibit C-12 prevented the easy movement of the hoist. According to Vazzi's own notes, the PGC's employees had checked for easy movement prior to using the hoist. They had used the hoist earlier in the day to move another load without encountering any problems. The Secretary has made no showing that the arrangement of the hoist was deficient so as to prevent its free movement. The coal crusher cage weighed over 1,000 pounds more than the employees thought it did. The Secretary does not examine

whether this increased weight may have contributed to the difficulty in moving the cage. She has failed to establish that the nick on the I-beam constituted noncompliance with the cited standard.

Spacing of washers

When Vazzi examined the trolley, he noted that the number of washers, or spacers, was uneven inside the plate of the trolley. There were four washers to the right of the center hanger shaft inside the plate, and no washers to the left of the hanger shaft (Exh. C-10; Tr. 41). Vazzi testified that this uneven spacing restricted the hoist from lining itself up with the load (Tr. 95):

> By not being centered onto the I-beam changes the forces of the movement of the object. So it restricts it from lining up.
>
> . . .
>
> The spacers on each side would allow the tightening and clamping of this trolley onto the I-beam. It changes the central tendency of this trolley on that I-beam by placing spacers unequally on each side of the plates and the trolley itself.

The Secretary cited PGC under the following item, item 5, for violating § 1926.554(a)(6) by failing to follow the trolley manufacturer's specifications for a number of things, including the spacing of the washers. It is determined that § 1926.554(a)(6) is more applicable to the issue of spacing washers than § 1926.554(a)(3). The spacing issue as cited in items 4 and 5 is duplicative, and the Secretary has not shown that the difference of four washers on one side of the hanger shaft restricted the hoist from lining itself up with the load. The uneven spacing of the washers will be treated below. Item 4 is vacated.

Item 5: Alleged Serious Violation of § 1926.554(a)(6)

Section 1926.554(a)(6) provides:

> All overhead hoists in use shall meet the applicable requirements for construction, design, installation, testing, inspection, maintenance, and operation, as prescribed by the manufacturer.

The citation lists the following ways in which PGC failed to ensure that the hoist met the manufacturer's specifications: PGC's employees did not know the rated capacity of the hoist and did not know the weight of the load to be lifted; they did not assure that the hoist and load were in a straight line and the load centered; they did not make sure the load was free to move; they did not promptly report any malfunction; they did not make sure that all nuts were drawn up tightly; they did not make sure the trolley plates were spaced properly; they did not check the I-beam to make sure the trolley could run smoothly; and they did not ensure that the supporting structure had a load rating

at least equivalent to the load rated capacity of the trolley plus the weight of the hoist.

With the exception of the allegation that the PGC's employees did not make sure that all nuts were drawn tightly, all of the allegations are covered by the other cited items, including the item withdrawn by the Secretary. To the extent that item 5 alleges noncompliance with the manufacturer's specifications that are identical to allegations cited in the previous 4 items, item 5 is vacated as duplicative.

The manufacturer's operating instructions for the trolley specify that the washers must be evenly spaced in order to center the load (Exh. C-20; p. 3):

> The hoisting mechanism must be on the centerline of the hoist trolley. Place equal numbers of the approximately c" thick and 1/16" thick washers on each side of the hanger shaft to obtain the "A" dimension (See Figure 3) between side plates.
>
> Place equal numbers of the remaining washers between the side plates and the lock nut.
>
> . . .
>
> Observe trolley operation. Trolley should move freely with the flanges on the wheels as close as possible to the edge of the I-beam. If it appears trolley side plates could be moved closer together with freedom of movement maintained, remove an equal number of washers from each side. . .

It is undisputed that the trolley used by PGC had an unequal number of washers on each side of the hanger shaft. PGC made the point during the hearing that it had not purchased the trolley that the employees used (which PGC thought was rated for 4 tons), but that it had "migrated" into its equipment sometime in the 1980s, presumably when a PGC employee or employees decided to "adopt" it. The trolley was painted green, the color that PGC used to identify its equipment, over its original color (Tr. 44, 342). Even if PGC did not purchase the trolley, it had been in its possession for several years and PGC was responsible for its maintenance and safe use.

The Secretary has established a violation of § 1926.554(a)(6) with respect to the uneven spacing of the washers.

The only allegation not dealt with in items 1 through 4 is that the nuts on the hoist were not tightly drawn. This is based on Vazzi's examination of the hoist following the accident, when he discovered that he could turn one of the nuts by hand (Tr. 150). Yet in his OSHA-1A narrative, Vazzi stated that the employees told him that the morning of the accident, two ironworkers

"tightened the bolts with wrenches" (Exh. R-14, p. 3).[3] Vazzi conceded that the nut could have been loosened in the accident, stating, "I cannot prove one way or the other whether or not they tightened it" (Tr. 163).

The Secretary has failed to prove that PGC did not comply with the manufacturer's specifications by not tightening the nuts on the hoist prior to its use. Such noncompliance cannot be inferred from the looseness of one nut on a hoist following its collapse under a load weighing more than 2 tons.

Item 5 is affirmed only on the issue of the uneven spacing of the washers.

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.

The parties stipulated that PGC employed approximately 750 employees at the time of the accident (Tr. 6). The Secretary presented no history of previous violations. Vazzi noted that PGC was cooperative during his investigation (Exh. R-14, p.3).

The gravity of the violation of § 1926.21(b)(2) is high. PGC relied on the Joint Apprenticeship Program to train its employees and expended no real effort in ensuring that its new hires were trained in the specific hazards to which they would be exposed on the job. The employees were working with heavy equipment that required numerous safety procedures. A penalty of $7,000.00 is assessed.

The gravity of the violation of § 1926.554(a) in item 2 is also high. When working with loads whose weights are measured in tons, exceeding the safe working load can have catastrophic results. A penalty of $7,000.00 is assessed.

The gravity of the violation of § 1926.554(a)(6) in item 5 is low. The spacing of the washers, while uneven, was not shown to have dramatically restricted the hoist from lining up over the load. Only one instance of item 5 is affirmed. A penalty of $500.00 is assessed.

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[3] Vazzi clarified that in his narrative he intended "nuts" when he wrote "bolts" (Tr. 150).

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 the citation, alleging a violation of § 1926.21(b)(2), is affirmed, and a penalty of $7,000.00 is assessed;
2. Item 2 of the citation, alleging a violation of § 1926.554(a)(1), is affirmed, and a penalty of $7,000.00 is assessed;
3. Item 3 of the citation, alleging a violation of § 1926.554(a)(2), was withdrawn by the Secretary and is vacated, and no penalty is assessed:
4. Item 4 of the citation, alleging a violation of § 1926.554(a)(3), is vacated, and no penalty is assessed; and
5. Item 5 of the citation, alleging a violation of § 1926.554(a)(6), is affirmed with respect to the issue of the uneven spacing of washers, and a penalty of $500.00 is assessed.

/s/
NANCY J. SPIES
Judge

Date: September 19, 2003