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.	:	OSHRC DOCKET NO. 03-0399
	:	
UNIVERSAL MARITIME SERVICE CORP.,	:	
	:	
Respondent.	:	

APPEARANCES:

Vivien V. Ranada, Esquire
William G. Staton, Esquire
U.S. Department of Labor
New York, New York
For the Complainant.

James P. Philbin III, Esquire
Sarah Martinez, Esquire
Morgan, Lewis & Bockius LLP
New York, New York
For the Respondent.

BEFORE: Irving Sommer
Chief Judge

DECISION AND ORDER

This proceeding is before the Occupational Safety and Health Review Commission ("the Commission") pursuant to section 10(c) of the Occupational Safety and Health Act of 1970, 29 U.S.C. § 651 *et seq*. ("the Act"). The Occupational Safety and Health Administration ("OSHA") conducted an inspection of Respondent's workplace at APM Terminals in Elizabeth, New Jersey, on July 8 and 9, 2002; the inspection took place pursuant to a fatal accident that occurred on July 7, 2002, involving an employee of Respondent. As a result of the inspection, OSHA issued to Respondent a two-item citation alleging serious violations of 29 C.F.R. 1918.85(g) and 29 C.F.R. 1918.85(j)(1)(iii). Respondent contested the citation, and a hearing in this matter took place in New York, New York, on September 9, 2003. Both parties have submitted post-hearing briefs.

Background

Respondent, Universal Maritime Service Corp. ("UMSC"), operates a marine terminal container-handling facility at APM Terminals in Elizabeth, New Jersey. The marine terminal operates 24 hours a day, seven days a week, and approximately 17 ships arrive at the terminal each week to deliver and pick up cargo. Cargo is generally packed in inter-modal containers, and such containers are usually stacked on top of each other on the ships onto which they are loaded. The containers are typically lifted from the dock area and placed on board ship by means of gantry cranes that have automatic lifting capability; specifically, an operator in an overhead gantry crane lowers a spreader device that locks automatically onto the top of a container, lifts it and then places it in a designated area on the ship. For various reasons, about ten containers a week are lifted with auxiliary gear that consists of four cables, each with a hook at the end, that must be attached manually to the containers; thus, a worker must access the top of the container to attach the hooks before the lift and to detach them after the lift. (Tr. 17-18; 21; 35-37; 80-81; Exh. R-5, Nos. 2-6 & 10-13).

On the evening of July 7, 2002, at Berth 80 at the subject site, a crane operator was loading containers onto the ship the Majestic Maersk ("the Majestic"); the containers were approximately 40 feet long, 8 feet high and 8 feet wide. The crane operator was unable to get a "lock" on one of the containers to be loaded and was therefore required to make the lift with the use of auxiliary gear. The container was lifted and then set down on the Majestic on the first level of Bay 70 in between a stack of three containers on one side and a stack of two containers on the other side; when the container was set down, three of the four vessel locks activated, locking the container in place. The container was situated such that its 40-foot sides were protected by the 40-foot sides of the stacked containers on either side, but the 8-foot-wide sides of the container, which faced the front and the rear of the ship, were not so protected.[1] At about 11:00 p.m., Jaime Nieves, a longshoreman employed by UMSC, proceeded to go up on top of the container to detach the auxiliary gear hooks from the four corners of the container. To access the container, Mr. Nieves climbed up a ladder to get to the catwalk in front of the container, climbed over the catwalk's guardrails, and then stepped over the space in between the catwalk and the container. Once on top of the container, Mr. Nieves detached the hook from one

[1]The container's rear edge was above the lasher bridge, while its front edge was above the poop deck; in addition, a catwalk ran along the container's front edge. (Tr. 11-13; 52; 60-63).

corner of the container. However, before he could detach the other hooks, the crane operator, apparently believing that Mr. Nieves was finished, suddenly lifted the container; the force of the lift was such that the vessel locks broke and the container swung up and down 6 to 10 feet, causing Mr. Nieves to fall from the container to the poop deck below. Mr. Nieves struck his head on the deck and subsequently died. (Tr. 9-21; 28-32; 36-42; 46-55; 60-63; Exhs. C-1-2).

The OSHA Compliance Officer ("CO") who was assigned to conduct the subject inspection arrived at the site at about 10:00 a.m. on July 8, 2002. After holding an opening conference, the CO and representatives of UMSC went to the scene of the accident.[2] The CO first went to the poop deck, where the employee had fallen. The CO then went up on the catwalk that was in front of the container, as shown in Exhibit C-1, and he observed the top of the container, as shown in Exhibit C-2.[3] The CO measured the gap between the side of the catwalk and the front edge of the container to be 18 inches; he also measured the catwalk's guardrails and found the top rail to be 42 inches and the mid-rail to be 22 inches. The CO did not go on top of the container, and he took no other measurements at the site. The Majestic was ready to leave and was waiting for the CO to finish his inspection, and it left the port at 1:00 that afternoon. (Tr. 9-15; 31-32; 39; 42-54; 58; 61-63; 99; Exhs. C-1-2).

The CO returned to the site on July 9, 2002. He further observed the container, which had been kept at the terminal, and he learned that the accident was due to the crane operator's belief that Mr. Nieves had given him the signal to lift the auxiliary gear. The CO concluded there was no OSHA standard that would have prevented the accident but that UMSC had nonetheless violated two OSHA standards. The CO determined that a violation of 29 C.F.R. 1918.85(g) had occurred when Mr. Nieves stepped over the 18-inch gap without fall protection; he estimated the container to be 8 feet high and the "shelf" the container sat on to be about 10 feet from the poop deck, and a fall through the gap to the poop deck would have been around 18 feet. The CO additionally determined that a violation of 29 C.F.R. 1918.85(j)(1)(iii) had occurred when Mr. Nieves detached the hook at the corner of the container without any fall protection; each hook fit in a hole at the corner of the container, and while

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[2]The actual inspection did not begin until around 11:30 a.m. (Tr. 15).

[3]UMSC took photo C-1 at about 2:00 a.m. on July 8, 2002, and the CO took photo C-2 when he was observing the top of the container from the catwalk. (Tr. 11).

Mr. Nieves was protected along the 40-foot sides because of the stacked containers on either side, he had no protection from falling through the gap at the front of the container or from falling from the rear of the container to the lasher bridge. (Tr. 13-19; 28-30; 33; 45-50; 58-67).

Citation 1 - Item 1 - 29 C.F.R. 1918.85(g)

Item 1 of the citation alleges a violation of 29 C.F.R. 1918.85(g), which provides as follows:

> A safe means of access shall be provided for each employee required to work on the top of an intermodal container. Unless ladders are used for access, such means shall comply with the requirements of § 1917.45(j) of this chapter.

To demonstrate a violation of a specific standard, the Secretary has the burden of proving (1) the applicability of the cited standard, (2) noncompliance with the terms of the standard, (3) employee access to the violative condition, and (4) employer knowledge, either actual or constructive, of the violative condition. *Astra Pharmaceutical Prod.*, 9 BNA OSHC 2126, 2129 (No. 78-6247, 1981). The Secretary contends that she has met her burden of proof with respect to all four elements, based upon the facts of this case and the testimony of the CO. UMSC, on the other hand, contends that the Secretary has not met her burden of proving the alleged violation.

As UMSC points out, a fall hazard exists in regard to the cited standard when an employee works within 3 feet of the unprotected edge of a work surface that is 8 feet or more above the adjoining surface and 12 inches or more, horizontally, from the adjacent surface. *See* 29 C.F.R. 1918.2 (definition of fall hazard). The CO testified to this effect, and he also testified that if the fall distance in this case was less than 8 feet, or if the gap between the catwalk and the edge of the container was less than 12 inches, then the condition would not have been a fall hazard under the standard; in fact, the CO essentially admitted that if the requisite measurements were not met, even by a fraction of an inch, then the standard would not apply. (Tr. 30; 43; 47; 51; 58; 66-67). Thus, it is critical to the Secretary's case to establish that the fall distance was at least 8 feet and that the gap was at least 12 inches at the point where Mr. Nieves crossed over. I conclude that the Secretary has failed to prove the 8-foot fall distance. I further conclude that the Secretary has also failed to prove that the point where Mr. Nieves stepped over the gap was 12 inches or more.

I note first that the CO admitted that he never measured the height of the container and that he simply "guestimated" its height to be 8 feet. (Tr. 46; 49; 63). The CO testified that "the height of [the] container is always going to be 8-foot."(Tr. 47). He also testified that he "knew that the

container was [8 feet]" and that there were "certain things that I didn't have to measure." (Tr. 49). However, the CO offered no testimony whatsoever about how he arrived at this information. Further, while the record shows that the CO had conducted over 800 inspections, only about 25 had involved marine terminals and he had been on only 10 to 15 ships. (Tr. 8; 29; 34). Finally, the CO himself admitted that at the beginning of the inspection he "didn't know what [he] was looking at yet" and that after the first day of the inspection he "really had not understood the site yet." (Tr. 13-15). In my opinion, this evidence demonstrates the CO's lack of familiarity with marine terminals and ships and renders his failure to measure the container's height even more significant.

There were other problems with the CO's testimony about his inspection. For example, he first testified that Mr. Nieves could have fallen through the gap all the way to the poop deck below, which would have been a fall, based on his estimates, of about 18 feet. (Tr. 17). On cross-examination, however, he essentially agreed that the "shelf" the container sat on, as shown in several of the photos making up Exhibit R-5, would have prevented a fall to the poop deck and that the employee would only have fallen to the shelf.[4] (Tr. 47-51; 57-58; 104). He also agreed that the catwalk was actually lower than the top of the container by one to three inches. (Tr. 51; 58). It is clear that the container's sitting on the shelf and the catwalk's being lower than the container would have made a difference in the fall distance in this case. Despite this fact, the CO failed to measure the distance either from the top of the container to the shelf or from the catwalk to the shelf. (Tr. 45-51; 57-58).

Turning to the gap between the catwalk and the container, the CO testified that his 18-inch measurement was made at the point where the catwalk and the container were the farthest apart as he assumed that that was the point where the employee had crossed over due to the location of the first hook that he detached. (Tr. 13; 28; 56-57). The CO conceded, however, that there were places on the catwalk that were closer to the container and that he had taken no other measurements of the gap. (Tr. 42-44; 52-54). In particular, the CO admitted the employee could have crossed over where the bracing was located on the catwalk, as shown in the first photo in Exhibit R-5, and that that distance would have been less than 18 inches. (Tr. 54-57). The CO also admitted that the company had questioned

[4]R-5 consists of 16 photos taken in May of 2003 of various aspects of the Majestic; the photos include several views of the ship's catwalk that Mr. Nieves used to access the container, the poop deck area, and containers like the one in this case. (Tr. 5-6; 43; 47).

his measurement at the closing conference and had sent him a copy of a photo showing an individual measuring the distance from the bracing to the container to be 13 inches.[5] Finally, the CO admitted that there was a lip or protrusion above the bracing that would have been even closer, "probably 12 inches," and that the employee could have stepped on the protrusion and crossed over at that point. (Tr. 99-104). During his examination of the CO, counsel for UMSC suggested that the protrusion over the bracing would have been a good place to cross over because the employee could have steadied himself by holding onto the stacked container next to the subject container, and, while the CO's response was that this was an "opinion," I find it just as likely, if not more likely, that the employee crossed over at this point than at the point the CO measured. (Tr. 56-57). I further find that, because the CO did not measure this point, which may well have been less than 12 inches, the Secretary has not demonstrated employee exposure to a gap of 12 inches or more, as required.[6]

In finding that the Secretary has not met her burden of proof with respect to this citation item, I am well aware of the fatal accident in this case. However, as the CO testified at the hearing, the citation was not issued because of the circumstances of the accident, but, rather, because of the employee's failure to tie off and his alleged exposure to a fall hazard under the cited standards. (Tr. 33; 66-67; 98). I am also well aware of the fact that UMSC has work rules requiring employees to use fall protection when working on the tops of containers and exposed to fall hazards. *See* Exh. C-4, p. UMSC0000877, and Exh. C-5, p. UMSC0001290. Regardless, it was the Secretary's burden in this case to establish the requisite measurements, and this she has failed to do. The Secretary's obligation to demonstrate the alleged violation by a preponderance of the reliable evidence of record requires more than estimates, assumptions and inferences, especially where, as here, the standard incorporates specific distances as an integral part of its requirements. As I stated in an earlier decision, in which a trenching citation was vacated because the CO had not made the requisite measurements with

[5]UMSC's counsel utilized the photo, Exhibit R-9, for purposes of illustration during the hearing but did not seek its admission into the record. The photo, which is not of the Majestic itself but of a sister ship of the Majestic, shows catwalk bracing with a lip or protrusion over it similar to what is depicted in the first photo in Exhibit R-5. (Tr. 100-04).

[6]In so finding, I note that even if the employee did cross over the gap at the point the CO measured, the Secretary has nonetheless not shown a violation of the cited standard because she has failed to establish a fall distance of 8 feet or more.

respect to two different trench boxes at the site, "[t]he Secretary's reliance on mere conjecture is insufficient to prove a violation ... [findings must be based on] 'the kind of evidence on which responsible persons are accustomed to rely in serious affairs.'" *William B. Hopke Co., Inc.*, 1982 OSAHRC LEXIS 302 *15, 10 BNA OSHC 1479 (No. 81-206, 1982) (ALJ) (citations omitted). For all of the foregoing reasons, Item 1 of Citation 1 is VACATED.

Citation 1 - Item 2 - 29 C.F.R. 1918.85(j)(1)(iii)

Item 2 of the citation alleges a violation of 29 C.F.R. 1918.85(j)(1)(iii), which provides as follows:

> The employer shall ensure that each employee on top of a container is protected from fall hazards by a fall protection system meeting the requirements of paragraph (k) of this section.

The CO testified that the same distance requirements, that is, those set out in 29 C.F.R. 1918.2, applied to this standard as to the one cited in Item 1, *supra*. (Tr. 47; 51; 57; 66-67). The CO further testified that Item 2 was issued because of the employee's exposure to a fall of 8 feet or more from both the front and the rear of the container. (Tr. 17). However, the discussion in regard to Item 1 establishes that the Secretary failed to prove a fall distance of 8 feet or more from the front of the container. Moreover, while the CO testified that the fall distance from the rear of the container would have been 8 feet to the lasher bridge below; he admitted that, just as he had not measured the fall distance from the front of the container, he had likewise not measured the fall distance from the rear of the container.[7] (Tr. 60-63). The Secretary has not demonstrated the requisite 8-foot fall distance from either the front or the rear of the container. Item 2 of Citation 1 is accordingly VACATED.

[7]The CO also testified that if the employee had missed the lasher deck, which extended 5 to 6 feet beyond the container, then the employee could have actually fallen from the rear of the ship itself, for a total fall distance of 38 feet. (Tr. 17; 27). As UMSC points out, however, for this to happen, the employee would essentially have had to make a running leap from the rear of the container. Without further proof that this could actually occur, the CO's testimony is rejected.

Conclusions of Law

1. Respondent, UMSC, was not in violation of either 29 C.F.R. 1918.85(g) or 29 C.F.R. 1918.85(j)(1)(iii), as alleged in Items 1 and 2, respectively, of Citation 1.

Order

Based upon the foregoing Findings of Fact and Conclusions of Law, it is ordered that:

1. Items 1 and 2 of Citation 1 are VACATED.

/s/
Irving Sommer
Chief Judge

Dated: March 11, 2004
Washington, D.C.