Secretary of Labor,	*	
Complainant,	*	
	*	
v.	*	OSHRC Docket No. **97-0593**
	*	
L. R. Willson & Sons, Inc.,	*	
Respondent.	*	

Appearances:

Ann G. Paschall, Esquire
Office of the Solicitor
U. S. Department of Labor
Atlanta, Georgia
For Complainant

Frank L. Kollman, Esquire
Kollman & Sheehan, PA
Baltimore, Maryland
For Respondent

Before: Administrative Law Judge Nancy J. Spies

DECISION AND ORDER

L. R. Willson & Sons, Inc. (Willson), contests a citation issued by the Secretary alleging a serious violation of § 1926.750(b)(2)(i) for failure to maintain a "tightly planked and substantial floor" within two stories or 30 feet below a portion of a tier of beams on which steel erection work was being performed. Willson was the steel erection subcontractor on the Womack Army Medical Center, a large medical facility being constructed in Fort Bragg, North Carolina. On November 11, 1996, a Willson employee fell approximately 80 feet to his death from a steel column which he was climbing.

The Occupational Safety and Health Administration (OSHA) investigated the accident from November 12, 1996, to February 4, 1997. On April 15, 1997, the Secretary issued the citation to Willson. The Secretary also issued similar citations to the U. S. Army Corps of Engineers and to Centex, the general contractor on the project.

Willson acknowledges jurisdiction and coverage. A hearing was held in this matter on January 28, 1998. The parties have submitted post-hearing briefs. Willson asserts the affirmative defense of unpreventable employee misconduct. Willson also argues that the cited standard does not apply.

For the reasons set out below, the court finds that Willson violated § 1926.750(b)(92)(i).

Background

The parties submitted the following stipulations of fact, which establish the background of the case:

1. Willson is a steel erection company.
2. Beginning in September, 1995, Willson was contracted to erect the structural steel for the new Womack Army Medical Center in Ft. Bragg, North Carolina (the "Project").
3. In connection with its work on the Project, Willson chose to comply with the general fall protection standards of Subpart M as the means of providing fall protection for its employees.
4. Willson established a 100% tie-off policy. All ironworkers had belts and double lanyards and were required to tie-off 100% of the time that they were more than six feet off the ground.
5. All Willson employees were instructed regarding compliance with the 100% tie-off policy through a written safety program that the inspecting compliance officer described as "a good comprehensive written safety and health program." The compliance officer rated the program as "above average" in his written evaluation.
6. The safety program included the imposition of fines for violations of safety rules. The largest fine was for violation of the tie-off policy.
7. Willson's employees were further instructed on fall protection at the Project through an initial orientation conducted by the general contractor and through weekly safety meetings conducted by Willson. Fall protection was discussed in at least four weekly safety meetings during the period from May 1996 through October 1996.
8. According to the compliance officer, Willson's employees felt that they had clear responsibilities for compliance with safety and health rules at the Project and believed that the employer's disciplinary program for non-compliance was fairly and evenly applied to most situations.

9. According to the compliance officer, Willson's employees told the inspecting compliance officer that they believed in the 100% tie-off policy and practiced strict compliance with it because their safety was at stake when working at heights above ground level.

10. During interviews with the compliance officer, employees stated that they had attended several safety meetings where the use of fall protection and the 100% tie-off rule was stressed and that James Willson, Vice President of Operations and Project Superintendent, had always told them to work carefully as their safety was the company's utmost concern.

11. Willson enforced its 100% tie-off policy by issuing discipline for violations, including fines, written reprimands, and discharge.

12. On November 11, 1996, Willson had two 2-man ironworker connector teams working on the north and east sides of the structure. One of the teams consisted of ironworker Bobby Anderson and his partner, Wallace Pittman.

13. Anderson was an experienced ironworker and had been a good employee since he started working at the Project. Anderson had worked as an ironworker and as a foreman for four years before being hired by Willson in May 1996. Anderson had worked for Willson for six months at the time of the accident.

14. Willson's records show that Anderson had not received any written reprimands or warnings and had attended the safety orientation training mandated and offered by the general contractor. Anderson also signed documents attesting to the fact that he had been instructed how to wear and maintain safety gear issued to him (*i.e.*, vest type full body harness, lanyard, pin cable, safety glasses, gloves, and hard hat), and he agreed to abide by all the rules, policies, terms, and conditions outlined in Willson's employee handbook. The handbook outlined several employee benefits and made reference to policies such as safety rules, hazard communication, and the safety violation fine program.

15. At approximately 3:15 p.m. on November 11, 1997, Anderson and Pittman were working on the fifth floor level and had finished bolting and connecting a vertical

column for the sixth floor. Then they tried to use a remote release mechanism to remove the metal pin that had been inserted in the lifting clip at the top of the column. Normally, a quick tug on a rope while standing at the bottom of the newly-inserted column would cause the pin to release, thus separating the crane hoisting cable from the column. This time, the lifting pin would not pop out.

16. Anderson then tried to climb the column to release the pin manually. Anderson was tied-off with one of his lanyards during this climb.

17. According to witnesses, Anderson found it difficult to climb the column because his pin cable would catch on column protrusions, and he returned to his position at the base of the cable.

18. After this attempt to release the lifting pin failed, Anderson asked the crane operator if he should climb the column and try to pop the pin out.

19. The crane operator was a Willson employee. The crane operators were in charge of the lifting of steel columns, and Anderson had been trained to listen to the instructions of the crane operator during a lift.

20. The crane operator directly and clearly told Anderson not to try to climb the column again, but rather that they would try something different instead.

21. Nevertheless, when the crane operator turned away to use the two-way radio mounted in the crane cab to call his superiors, Anderson unhooked his lanyard from his belt, leaving the lanyard attached to the pin cable, and began climbing the column without the crane operator's concurrence or permission.

22. Although the crane operator could have tried to contact Anderson with a two-way radio, he feared that he would distract Anderson in the middle of the climb.

23. Anderson climbed to within five or six feet of the top of the column and then started to slide down the column. Anderson then fell off the column to the first floor and eventually died from his injuries.

24. When Anderson unhooked his lanyard from his belt, Anderson was in direct conflict with both his employer's and the general contractor's safety rule on fall protection at the Project requiring the employees involved in steel erection

activities to tie-off using their fall arrest systems when working at heights above six feet.

25. Anderson not only disregarded this 100% tie-off rule, but he also ignored the direct instruction of Willson's crane operator, who expressly told Anderson not to climb the column.

26. No Willson supervisor knew on November 11, 1996, that Anderson unhooked his lanyard while he was on the iron, or that he attempted to climb a column to free a lifting cable while he was not tied off, in direct disobedience of the instruction of a crane operator.

27. OSHA began in inspection of the worksite on November 12, 1996. During this inspection, CSHO Banner observed that Willson had not maintained a tightly planked and substantial floor within 30 feet below Willson's ironworkers. Nevertheless, Banner did not inform Willson of any potential violations of the OSHA standards during the closing conference held on February 4, 1997.

28. During the two months following this closing conference, Banner reconsidered his position. He spoke with 5 to 10 other OSHA compliance officers and decided that Willson's failure to maintain a tightly planked and substantial floor within 30 feet was a violation of Subpart R of the Occupational Safety and Health standards, even if the employees who would be protected by this floor were securely tied off with belts and six-foot double lanyards.

29. On April 14, 1996, Banner conducted a second closing conference with Willson by telephone, during which Banner advised Willson that he was recommending that a citation be issued for violation of Subpart R. After the citation was issued, Willson filed a notice of contest, and this action followed.

30. On November 11, 1996, respondent's employees Bobby G. Anderson and Wallace Pittman were working at heights greater than 30 feet above ground level.

31. Respondent was aware that there was no tightly planked floor within two stories or 30 feet above floor or ground level below where its employees were working on November 11, 1996.

32. Installation of flooring within two stories or 30 feet of where Anderson and Pittman were working on November 11, 1996, was not impossible.

33. Installation of flooring within two stories or 30 feet of where Anderson and Pittman were working on November 11, 1996, was not infeasible.

34. Installation of flooring within two stories or 30 feet of where Anderson and Pittman were working on November 11, 1996, would not have interfered with the work being performed.

35. Willson's safety program and/or work rules in effect on or about November 11, 1996, did not contain any provisions requiring the installation of flooring or decking within two stories or 30 feet of where its employees were working.

Alleged Serious Violation of § 1926.750(b)(2)(i)

The Secretary charged Willson with a serious violation of § 1926.750(b)(2)(i). That section provides in pertinent part:

> Where skeleton steel erection is being done, a tightly planked and substantial floor shall be maintained within two stories or 30 feet, whichever is less, below and directly under that portion of each tier of beams on which any work is being performed, except when gathering and stacking temporary floor planks on a lower floor, in preparation for transferring such planks for use on an upper floor.

The Secretary has the burden of proving her case 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., 16 BNA OSHA 2131, 2138 (No. 90-1747, 1994).

Willson's stipulations establish three-fourths of the Secretary's case. Willson agrees that no tightly planked floor existed within two stories or 30 feet above floor or ground level below where its employees were working, in noncompliance with § 1926.750(b)(2)(i). Willson's

employees had access to this violative condition and Willson knew that there was no tightly planked floor as required by the standard. Willson raises the issue of applicability of § 1926.750(b)(2)(i).

Applicability

At the outset, it is noted that § 1926.750(b)(2)(i) is part of Subpart R of 29 C.F.R. Part 1926, which specifically applies to steel erection. Willson argues, however, that the fall protection standards of Subpart M should govern Willson's activities in the present case.

Before it was revised in 1994, Subpart M was entitled, "Floor and Wall Openings and Stairways." On November 25, 1986, however, OSHA proposed to revise virtually all the fall protection provisions of the construction industry standards and to consolidate those requirements, except where specifically provided otherwise, in Subpart M. *See* 51 Fed. Reg. 42718 (November 25, 1986). The "floor and wall openings and stairways" provisions were to be moved to other subparts.

As originally proposed in 1986, Subpart M did not exclude steel erection activities from coverage. OSHA initially proposed to require all construction workers, including steel erectors, to use fall protection of guardrails, belts and lanyards, or nets where working at heights above six feet. With regard to steel erection, the only exception was for ironworkers performing initial connections of structural steel. *See* 51 Fed. Reg. 42736-38 (proposed Subpart M, 29 C.F.R. §§ 1926.500(a)(2) and 1926.501). *See also* 53 Fed. Reg. 2052 (January 26, 1988). This proposal represented a substantial change for the steel erection industry, which was obligated at that time only to provide fall protection that complied with Subpart R and 29 C.F.R. § 1926.105.

The steel erection industry objected. There was no disagreement between OSHA and the steel erectors that tying off provided greater fall protection than that which existed under Subpart R. Nevertheless, the steel erection industry complained that because of the nature of the steel erection process *(e.g.*, moving from point to point), it was too difficult for steel erectors to comply with the more stringent tie-off/guardrail/net requirements.

After extending the comment period, receiving oral testimony regarding fall protection in the steel erection industry, and reopening the comment period for additional information from the industry, OSHA decided that a separate fall protection rule should be developed for the steel

erection industry, and that steel erection would be excluded from revised Subpart M. *See* 59 Fed. Reg. 40672 (August 9, 1994), 60 Fed. Reg. 5131 (January 26, 1995), and 60 Fed. Reg. 39254 (August 2, 1995). OSHA's agreement to proceed in this way was a concession resulting from the protest generated by the initial proposal.

Willson argues that, given the history of the fall protection standards in the steel erection industry, it should have the option of complying with the more stringent safety requirements of Subpart M in lieu of Subpart R. It questions why OSHA should pursue a case where the employer chose not to avail itself of, an industry-won concession while fully complying with another of the Act's fall protection standards.

Unfortunately for Willson's position, the scope section of Subpart M itself rejects Willson's approach: "Requirements relating to fall protection for employees performing steel erection work are provided in § 1926.105 and in Subpart R of this part." Section 1926.500(a)(2)(iii). In the final analysis, the case must be decided in terms of the cited standard.

Willson's point that compliance with the requirements of Subpart M provide greater safety than does compliance with the requirements of Subpart R is well-taken. However, the construction schedule could have required that the flooring be installed earlier in the work sequence, thus providing the temporary flooring required by the standard. Complying with Subpart R would have resulted in a fall distance of 20 feet (two stories) to the flooring below. Willson's efforts to use safety belts is commendable, but nothing prevented Willson from providing both the voluntary and the mandatory fall protection. Willson was not at liberty to substitute its judgment for that of the standard, and the undersigned cannot ignore the requirements of a clearly applicable standard. "Such alterations to OSHA's safety standards cannot, however, be obtained in adjudicatory proceedings before the Commission, which only concerns itself with the employer's alleged violation of the existing standard. In these proceedings, employers cannot question a standard's wisdom." *Carabetta Enterprises, Inc.*, 15 BNA OSHC 1429, 1432 (No. 98-2007, 1991).

Willson also argues that any violation of the Act arose from Anderson's unpreventable employee misconduct. The affirmative defense of unpreventable employee misconduct requires the employer to have a work rule in place designed to prevent the violative behavior. Willson had

no work rule requiring its employees to install temporary flooring in compliance with § 1926.750(b)(2)(i). A work rule requiring an employee to tie off is not a defense to an allegation regarding the failure to install temporary flooring. *Power Plant Division, Brown & Root, Inc.*, 10 BNA OSHC 1837 (No. 77-2253, 1983). There is, therefore, no reason to examine the defense in terms of compliance with other fall protection standards. Willson's affirmative defense is rejected.

Penalty Determination

The Commission is the final arbiter of penalties in all contested cases. Under § 17(j) of the Act, in determining the appropriate penalty, the Commission is required to find and give "due consideration" to (1) the size of the employer's business, (2) the gravity of the violation, (3) the good faith of the employer, and (4) the history of previous violations. The gravity of the violation is the principal factor to be considered.

Willson employed approximately 250 employees at the time of the OSHA inspection (Tr. 84). It had been cited for OSHA violations within the three years prior to the citation at issue (Tr. 45). The gravity of the violation is high. Had temporary flooring been in place at the time of Anderson's accident, he would have fallen 20 feet instead of 80 feet, perhaps improving his chances for survival.

The factor of Willson's good faith weighs heavily in this penalty determination. Willson had a good safety program, one which an OSHA compliance officer considered "above average." Willson's violation of the cited standard did not result from its indifference to safety. Rather, Willson instituted what it considered a better form of fall protection. Willson believed that a fall of up to 30 feet was not acceptable. Its 100% tie off rule, if followed, would allow for falls of no more than 6 feet (the length of a lanyard). This action deserves consideration in assessing an appropriate penalty. The Secretary proposed a penalty of $5,000.00. Given Willson's demonstrated safety efforts to provide an effective form of fall protection, the proposed penalty is deemed excessive. A penalty of $500.00 is assessed.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

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

ORDER

Based upon the foregoing decision, it is hereby ORDERED:

1. Item 1 of Citation No. 1, alleging a serious violation of § 1926.750(b)(2)(i), is affirmed and a penalty of $500.00 is assessed.

NANCY J. SPIES
Judge

Date: January 19, 1999