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. 03-0500
	:	
DCM ERECTORS, INC.,	:	
	:	
Respondent.	:	

Appearances:

Esther D. Curtwright, Esquire U.S. Department of Labor New York, New York For the Complainant.	Paul R. Levenson, Esquire Ray L. LeFlore, Esquire New York, New York For the Respondent.

Before: Chief Judge Irving Sommer

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") inspected the work site of Respondent, DCM Erectors, Inc. ("DCM"), after a fatal accident on December 6, 2002, that involved an employee of DCM. As a result of the inspection, OSHA on February 26, 2003, issued one serious citation and one "repeat" citation to DCM; the serious citation alleged violations of 29 C.F.R. §§ 1926.95(a) and 1926.761(b), while the "repeat" citation alleged a violation of 29 C.F.R. § 1926.754(e)(2)(ii). DCM contested the citations and the proposed penalties, and the hearing in this matter was held in New York, New York on December 2 and 3, 2003. Both parties have filed post-hearing briefs.

Background

The subject site was a project involving the construction of a high-rise commercial building located on Lexington Avenue in New York, New York. Bovis Lend Lease ("Bovis") was the general contractor for the project, and DCM was the subcontractor engaged to perform the structural steel erection. By the end of November 2002, the construction of the building had been completed up to the 12th floor; the 12th floor at that time consisted of corrugated steel decking, no concrete having yet been poured. A crane located on the 11th floor protruded up through and beyond a large opening in the 12th floor; the opening was about 25 feet by 25 feet. Around the crane was a red structural steel frame that supported the crane; the base of the frame was about 30 inches above the 12th floor decking, and, on the west side of the opening, the frame's base was about 2 feet away from the decking. (Tr. 6, 41-42, 139-44, 194, 235-38; Exhs. C-4, R-1, R-8).

On the morning of December 6, 2002, the12th floor deck was covered with snow due to a snowstorm. DCM employees were working on the 12th floor deck that morning, and around 8:30 a.m., one of the employees, Todd Puckett, a surveyor, was measuring the center lines to the columns in the area of the opening. After measuring at the column located near the northwest corner of the opening, Puckett proceeded to walk towards the column near the southwest corner, which required him to go around some steel beams and steel elevator dividers that were laying along the west side of the opening. Puckett then climbed over these steel materials to get to the column, and, as he did so, he slipped, fell forward and slid over the edge of the opening. The distance from the 12th floor deck to the 11th floor below was 35 feet and 5 inches, and Puckett died as a result of the fall. (Tr. 6-7, 42, 47-50, 56, 86, 114-17, 143-44, 147-48, 175-82, 185-88, 282-86, Exhs. C-4, R-1, R-2, R-8).

Bovis advised OSHA of the accident shortly after it occurred, and Compliance Officer ("CO") Robert Stewart went to the site that same day to investigate the circumstances of the fatality. Upon arriving at the site, the CO held an opening conference and then went to the accident scene; according to the CO, the 12th floor deck was so slippery it was difficult to walk on it. The CO noted that there was safety cabling on all four sides of the opening; however, he later learned from Richard Gilbert, DCM's safety director, and Larry Davis, DCM's president, that the cabling on the west side had not been in place before the accident and that it was installed immediately thereafter, and he also

learned that Arnold Van Hees, DCM's general superintendent, was the person who had directed that the cabling be put up on the west side of the opening after the accident.[1] (Tr. 6-7, 18-26, 120, 176).

During his inspection, CO Stewart obtained a written statement from Curtis Montour, a DCM ironworker and the sole witness to Puckett's fall, that described the accident.[2] The CO also spoke to a number of DCM employees, including the crew that had taken down the cabling on December 2 or 3 and the crew that had reinstalled it on December 6. Based on his conversations with those crew members and their supervisors, and on his own observations of the cabling, the CO concluded that the members of both crews had been working right at the edge of the opening without any fall protection and had been exposed to falling from the deck. He also concluded that DCM had not adequately trained its employees, in that the crew members felt that they had not been exposed to a hazard and their supervisors told him that fall protection was not required until the work was at heights of over 30 feet. (Tr. 32-34, 39-40, 44-50, 56-60, 77-85, 113-17; Exh. R-2).

One of the CO's visits to the site was on January 10, 2003, and, during that visit, Ken Kyle of Bovis told him that on the previous day, an employee of DCM had had an accident that had resulted in the loss of one of his eyes; specifically, Joseph Emerson, a connector with DCM, was hitting a bull pin with a sledge hammer without wearing any eye protection and part of the head of the pin broke off and went into his eye. The CO spoke to Gilbert and to Davis, who confirmed how the accident had occurred, and Gilbert told him that DCM supplied eye protection and instructed the employees how to use it and to wear it at all times except when walking the beams; however, Emerson told the CO that he had not been provided with eye protection, that he did not have any with him at the time of the accident, and that the rule to wear eye protection was not enforced. In

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[1]Van Hees, who was fired after the accident, told the CO he was a consultant to DCM, but Ken Kyle, Bovis' safety manager, testified that the site-specific safety plan that DCM had given Bovis had designated Van Hees as DCM's general superintendent. The CO learned from Van Hees that the cabling on the west side of the opening had been taken down on December 2 or 3 because a column had to be installed; he also learned that Van Hees had been directing the work when the cabling was removed, that he was one of the people in charge on the floor on December 6, and that he had ordered the cabling to be reinstalled between the opening and the steel beams and dividers as soon as he realized that Puckett had fallen. Van Hees said that the failure to replace the cabling had been an oversight. (Tr. 24-26, 109-11, 153-55, 164; Exh. R-7).

[2]The CO went to the site about ten times during the course of his inspection. (Tr. 124).

addition, the CO learned that there had been previous eye injuries at the site that had involved DCM employees. Based upon his inspection, the CO concluded that DCM had violated the standard mandating that employers provide and require the use of eye protection. (Tr. 87, 90-93).

"Repeat" Citation 2 - 29 C.F.R. § 1926.754(e)(2)(ii)

Item 1 of Citation 2 alleges a "repeat" violation of 29 C.F.R. 1926.754(e)(2)(ii), which provides as follows:

> Roof and floor holes and openings shall be decked over. Where large size, configuration or other structural design does not allow openings to be decked over (such as elevator shafts, stair wells, etc.) employees shall be protected in accordance with § 1926.760(a)(1).

Section 1926.760(a)(1), in turn, states that:

> Except as provided by paragraph (a)(3) of this section, each employee engaged in a steel erection activity who is on a walking/working surface with an unprotected side or edge more than 15 feet (4.6 m) above a lower level shall be protected from fall hazards by guardrail systems, safety net systems, personal fall arrest systems, positioning device systems or fall restraint systems.

To establish a violation of a specific OSHA standard, the Secretary has the burden of proving by a preponderance of the evidence that (1) the cited standard applies, (2) there was a failure to comply with the standard, (3) employees had access to the violative condition, and (4) the employer either knew of the condition or could have known of it with the exercise of reasonable diligence. *Astra Pharmaceutical Prod.*, 9 BNA OSHC 2126, 2129 (No. 78-6247, 1981).

DCM contends that it was not in violation of the cited standard because the steel beams and steel elevator dividers that were laying along the west side of the opening provided a barrier to the opening. Exhibits C-4 and R-8, photos of the area, show these materials laying along the west side of the opening, and testimony in the record indicates the materials were perhaps 3 feet high. (Tr. 116, 284-85). However, it is clear that the beams and dividers provided no protection from falling into the opening, particularly since Puckett climbed over them to get to the column where he needed to take a measurement and, in so doing, slid off the edge of the opening.[3] Moreover, while there was no testimony about how near the closest beams were to the edge of the opening, C-4 and R-8 show

[3]Gilbert himself admitted that the steel materials were not a barrier, as such, and were in fact pieces that would be installed at some point. (Tr. 285).

that the closest beams were quite near the edge, perhaps 2 to 3 feet away. Finally, DCM's contention is belied by the fact that all four sides of the opening previously had had cabling, that the cabling on the west side had been removed a few days before the accident to install a column and had not been replaced due to oversight, and that Van Hees, DCM's general superintendent, directed the cabling to be reinstalled immediately after the accident. (Tr. 18-26, 111, 120, 153-55, 164; Exh. R-7).

DCM further contends that the Secretary has not proved that it had the requisite knowledge of the cited condition. I disagree. First, footnote 1, *supra*, establishes that Van Hees was directing the work when the cabling was removed on December 2 or 3, that he was one of the individuals in charge on the 12th floor on December 6, and that he was the person who directed that the cabling be put back up after the accident; although Van Hees told the CO that he had not noticed the cabling was not there because of the steel materials in front of the opening, I find that he should have known of the condition in the exercise of reasonable diligence. (Tr. 24–26; Exh. R-7). Second, while William Kennedy, Puckett's supervisor, did not see the accident, he did see Puckett in between the steel materials and the edge of the opening after Puckett had taken his measurement at the first column. (Tr. 176-81). Third, as set out in the background portion of this decision, the CO testified that he talked to the crew that removed the cabling on December 2 or 3 and to the crew that replaced it on December 6; he also spoke with Tom Emerson and Mike Phillips, the foremen of those two crews, both of whom said that the employees had not worn fall protection and had been right at the edge of the opening to do their work. (Tr. 32-34, 39-40, 57-60, 77-80).

Based on the evidence of record, the Secretary has demonstrated the alleged violation; she has shown that the cited standard applied, that the terms of the standard were violated, that employees were exposed to the hazard created by the condition, and that DCM had knowledge of the cited condition. This citation item is therefore affirmed.[4]

The Secretary has characterized this item as both serious and repeated. The violation was clearly serious, in that it could have caused, and in fact did cause, death or serious physical injury.

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[4]In affirming this item, I have noted the testimony of Van Hees and Gilbert to the effect that the CO had stated that he believed Puckett's death had been an accident and that no citation would be issued. (Tr. 155, 279-81). The CO testified he had made no such statement and that he had told Gilbert that the incident was clearly a repeat violation. (Tr. 150-51).

With respect to the repeated characterization, a violation is properly classified as repeated if, at the time of the alleged repeated violation, there was a Commission final order against the same employer for a substantially similar violation. *Potlatch Corp.*, 7 BNA OSHC 1061, 1063 (No. 16183, 1979). The record shows that DCM was previously cited at the same work site on October 15, 2002, for an alleged violation of the same standard at issue here. *See* Exhibit C-3. The record further shows that OSHA and DCM entered into a settlement agreement in regard to the October 15, 2002 citation on November 8, 2002; in that agreement, DCM agreed that it had violated the cited standard in return for a lesser penalty. (Tr. 228-29; Exh. C-13). I conclude that the subject violation was properly classified as repeated, and this citation item is accordingly affirmed as a repeated violation.[5]

The Secretary has proposed a penalty of $50,000.00 for this citation item. The CO testified that the gravity of the violation was high, in light of the accident that occurred and the exposure of the crews that removed and reinstalled the cabling, and that the hazard was exacerbated by the snow on the deck. He further testified that no adjustments to the penalty were made for size, history or good faith, due to the size of DCM's business, its previous history of OSHA violations, and the deficiencies in its safety program. (Tr. 74-77, 83). The overriding basis for the proposed penalty is the Secretary's contention that the violation was a "second repeat." However, the Secretary was not allowed to present evidence in this regard for the reasons set out in footnote 3. In view of the evidence of record and the repeated classification, I conclude that a penalty of $25,000.00 is appropriate for this citation item. A penalty of $25,000.00 is therefore assessed.

Serious Citation 1 - Item 1 - 29 C.F.R. § 1926.95(a)

Item 1 of Citation 1 alleges a violation of 29 C.F.R. 1926.95(a), which provides as follows:

> Protective equipment, including personal protective equipment for eyes, face, head, and extremities, protective clothing, respiratory devices, and protective shields and barriers, shall be provided, used and maintained in a sanitary and reliable condition wherever it is necessary by reason of hazards of processes or environment, chemical

[5]The Secretary's citation states that the alleged violation is a "second repeat" but contains no details in the body of the citation to support that claim; moreover, while the complaint sets out the details of the "second repeat" claim it does not amend the citation to reflect those details. At the hearing, DCM objected to the Secretary's attempt to have admitted into the record proof of the "second repeat" claim. DCM's objection was sustained, and the Secretary was not allowed to submit evidence in that regard. (Tr. 64-73).

> hazards, radiological hazards, or mechanical irritants encountered in a manner capable of causing injury or impairment in the function of any part of the body through absorption, inhalation or physical contact.

The basis of this item is the eye injury that Joseph Emerson sustained on January 9, 2003, the details of which are set out in the background portion of this decision. (Tr. 87, 90). The CO determined that DCM had violated the cited standard, despite what Gilbert told him about DCM providing eye protection and instructing employees to use it, because Emerson told him that he was not given eye protection, that he did not have any with him at the time of the accident, and that the rule to wear eye protection was not enforced; the CO's determination was also based on his learning that other DCM employees had sustained eye injuries at the site. (Tr. 90-93).

At the hearing, Emerson and Gilbert essentially reiterated what they had told the CO. (Tr. 212-15, 254-55, 266-67, 288-89). In addition, Gilbert testified that the requirement to wear safety glasses was set out in DCM's site-specific safety plan that was submitted to Bovis, that DCM had 100 to 200 pairs of safety glasses on the job at any given time, and that the glasses, which were kept in DCM's job-site trailer, were always available to employees. (Tr. 257-59, 266-68; Exh. R-3a). However, Wesley Barnes, a connector who worked for DCM at the site from August 2002 through February 2003, testified that he had received no eye protection or training in eye protection until after Emerson's injury; after the accident, safety glasses were provided.[6] (Tr. 203-05). Moreover, Ken Kyle, the safety manager for Bovis at the site, testified that although DCM employees sometimes had worn eye protection, for the most part they had not; he further testified that about a week before Emerson's accident he had told Joe Kennedy, DCM's site superintendent, that "some major eye injuries" were likely to occur based on the prior eye injuries of DCM employees. Finally, Kyle discussed Exhibit C-12, copies of reports that he had made out in regard to nine eye injuries that DCM workers had sustained before Emerson's accident; he agreed that two of these had occurred despite the fact that the employees were wearing safety glasses and that glasses will not always prevent an injury. (Tr. 156-67, 196-99).

[6]While the transcript shows Barnes' first name as "Leslie," Exhibit R-10, which Barnes agreed he had signed, clearly shows his first name to be "Wesley." (Tr. 208-10).

In view of the foregoing, I find that the Secretary has met her burden of proving the alleged violation. This item is consequently affirmed as a serious violation. I also find the proposed penalty of $5,000.00 to be appropriate; the CO testified that the gravity of the violation was high, in light of Emerson's accident, and that no reductions for size, history or good faith were given. (Tr. 93-94). The proposed penalty of $5,000.00 is assessed.

Serious Citation 1 - Item 2 - 29 C.F.R. § 1926.761(b)

Item 2 of Citation 1 alleges a violation of 29 C.F.R. 1926.761(b), which states that:

> The employer shall provide a training program for all employees exposed to fall hazards. The program shall include training and instruction in the following areas:
> (1) The recognition and identification of fall hazards in the work area;
> (2) The use and operation of guardrail systems (including perimeter safety cable systems), personal fall arrest systems, positioning device systems, fall restraint systems, safety net systems, and other protection to be used;
> (3) The correct procedures for erecting, maintaining, disassembling, and inspecting the fall protection systems to be used;
> (4) The procedures to be followed to prevent falls to lower levels and through or into holes and openings in walking/working surfaces and walls; and
> (5) The fall protection requirements of this subpart.

CO Stewart's determination that the subject standard was violated was based on interviews with DCM employees. The CO testified that he spoke to DCM supervisors such as Paul Brady, one of the lead supervisors, and Tom Emerson and Mike Phillips, the foremen of the crews that had removed and replaced the cabling in front of the opening; these individuals told him they had been trained in fall protection and, in particular, Subpart R.[7] The CO also testified that further discussions with Emerson and Phillips, and with the crew members they supervised, revealed that their training was insufficient. The CO noted that Subpart R requires fall protection when employees are performing steel erection activities other than connecting work and are exposed to falls of more than 15 feet; connectors, on the other hand, must have fall protection when working at heights of over 30 feet, and, when at heights between 15 and 30 feet, connectors must wear a harness so that they can tie off if they feel the need to do so.[8] The CO further noted that when he asked why the crew

[7]Subpart R contains the OSHA standards relating to steel erection.

[8]*See* 29 C.F.R. §§ 1926.760(a)(1) and (a)(3)(b).

members had not had fall protection when removing and replacing the cabling, Emerson and Phillips told him that none was required until the fall distance was over 30 feet and that they had not believed that the fall distance to the 11th floor had been over 30 feet; in addition, the crew members told the CO that they had not felt that they had been exposed to a hazard when they were removing and replacing the cabling. (Tr. 77-85).

Richard Gilbert, DCM's safety director, testified about DCM's site-specific safety plan and its safety training. Specifically, DCM was required to submit to Bovis a site-specific safety plan that set out the safety procedures relevant to the project, how the work would progress, and any special requirements for the job.[9] All DCM employees who worked at the site were required to attend a Bovis "indoctrination," after which they went to an indoctrination held by DCM. DCM also held weekly toolbox meetings at the site that covered a variety of topics, including fall protection, and employees signed a signature sheet to verify their attendance. With respect to fall protection, DCM provided safety vests, harnesses and lanyards to its employees, and DCM had replacement fall protection equipment on the site at all times in case a worker's equipment was damaged. DCM also held training in the new Subpart R for its employees during July and August of 2001. This was accomplished by retaining a safety consultant who went to DCM's various work sites during that period and conducted the training on site; in this regard, Gilbert noted that many DCM workers were long-term employees who went from job to job with DCM, such that any training a worker received went with him to the next job. (Tr. 241-45, 249-54, 257-63, 268-75; Exhs. R-3a, R-10).

CO Stewart agreed that Gilbert had given him the foregoing information and had shown him supporting documents during the inspection. (Tr. 99-109). However, the circumstances of Puckett's accident, set out *supra*, show that DCM was not following OSHA's fall protection requirements, and what the CO learned from Foremen Emerson and Phillips and their crew members indicates that neither supervisors nor employees had a clear understanding of those requirements. (Tr. 99-109). Moreover, the Subpart R training held in 2001 cannot be considered sufficient training for employees

[9]Gilbert noted that the safety plan had specific sections on fall protection and personal protective equipment, such as harnesses and safety glasses. (Tr. 263, 266; Exh. R-3a).

at the subject site, particularly in light of the factual record in this case.[10] Finally, besides the facts relating to Puckett's fall and the CO's testimony about what Emerson and Phillips and their crew members told him, the inadequacy of the 2001 training for the subject site is further established by the testimony of Ken Kyle of Bovis; Kyle said he became aware of DCM employees being exposed to fall hazards, in that he saw a number of them "walking the steel" at heights of over 30 feet without fall protection, and that he therefore held training in the fall protection requirements of Subpart R for DCM's raising gangs at the site on October 31, 2002. (Tr. 168-72).

Based on the record, I conclude that the Secretary has demonstrated the alleged violation. This item is accordingly affirmed as a serious violation. I further conclude that the proposed penalty of $5,000.00 is appropriate. The CO testified that the gravity of the violation was high, in that the failure to provide training in Subpart R exposed employees to falls, such as the one involving Puckett; the CO further testified that no reductions were given for size, history or good faith. (Tr. 85-86). The proposed penalty of $5,000.00 for this item is assessed.

Conclusions of Law

1. Respondent DCM was in serious violation of 29 C.F.R. § 1926.95(a), as alleged in Item 1 of Citation 1.

2. Respondent DCM was in serious violation of 29 C.F.R. § 1926.761(b), as alleged in Item 2 of Citation 1.

3. Respondent DCM was in repeated violation of 29 C.F.R. § 1926.754(e)(2)(ii), as alleged in Item 1 of Citation 1.

[10]It is unclear from his testimony whether Joseph Emerson, a connector with DCM from 1999 until January of 2003, received the training given in 2001. (Tr. 212-15). However, Wesley Barnes, whose only employment with DCM was as a connector at the subject site from August 2002 through February 2003, clearly did not receive the training held in 2001. (Tr. 203-06). In addition, although both Emerson and Barnes agreed that they had signed sheets reflecting that toolbox meetings were held at the site, both testified that no actual meetings were held; rather, a sheet of paper was passed around during the coffee break that the employees signed. (Tr. 206-10, 215-16; Exh. R-10). Finally, Barnes indicated that DCM provided fall protection equipment but that, until Puckett's accident, it was up to the employee whether to wear it or not. (Tr. 204).

Order

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

1. Item 1 of Citation 1 is affirmed as a serious violation, and a penalty of $5,000.00 is assessed for this item.

2. Item 2 of Citation 1 is affirmed as a serious violation, and a penalty of $5,000.00 is assessed for this item.

3. Item 1 of Citation 2 is affirmed as a repeated violation, and a penalty of $25,000.00 is assessed for this item.

/s/

Irving Sommer
Chief Judge

Dated: June 7, 2004
Washington, D.C.