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. S. E. Johnson Companies, Inc., Respondent.	OSHRC Docket No. 01-0456

Appearances:

Paul G. Spanos, Esq., Office of the Solicitor, U. S. Department of Labor, Cleveland, Ohio
For Complainant

Jack Zouhary, Esq., S. E. Johnson Companies, Maumee, Ohio
For Respondent

Before: Administrative Law Judge Nancy J. Spies

DECISION AND ORDER

S. E. Johnson Companies (S. E. Johnson) is a general contractor specializing in heavy construction, such as bridges and highways. On September 18, 2000, an employee of S. E. Johnson's subcontractor fell 17 feet from an elevated work platform and was severely injured. On October 18, 2000, as part of its local fall emphasis program, Occupational Safety & Health Administration (OSHA) compliance officer Steven Medlock investigated the circumstances surrounding the accident (Tr. 21-22). As a result of the inspection, OSHA issued S. E. Johnson a serious citation on February 16, 2001.

The Secretary alleges that S. E. Johnson insufficiently pre-planned for adequate fall protection in violation of § 1926.502(a)(2) (item 1). She further asserts that a section of guardrail had only one railing and that it was not anchored to withstand 200 pounds of force in violation of §§ 1926.502(b)(2) (item 2) and 1926.502(b)(3) (item 3). S. E. Johnson denies the allegations and asserts that if any violation occurred it was the result of the misconduct of the subcontractor's employee. For the reasons that follow, the Secretary failed to prove a violation for oversight and fall protection planning (item 1). The Secretary

established that S. E. Johnson failed to comply with two specifications for adequate guardrails (items 2 and 3). S. E. Johnson failed to prove its employee misconduct defense.

Background

S. E. Johnson was the general contractor for the Fort Washington Way bridge and roadway project in downtown Cincinnati, Ohio. S. E. Johnson subcontracted with J & B Steel (J&B) to perform some of the rebar and the post-tensioning work for a portion of the project. At Pier 2 Bridge 29, both companies' employees worked at the upper and lower work areas (the upper platform was level with the bridge and the lower platform was below the bridge). Although both areas originally had full guardrails, by the time three of S. E. Johnson's carpenters began to remove the concrete forms from the poured structures on September 16, 2000, an 8-foot, 6-inch section of guardrail had been removed from the edge of the lower platform near the ladder (Tr. 12-14, 22). S. E. Johnson's employees walked close to the open edge as they climbed or descended the ladder between the upper and lower platforms. Completing their work on the south end of the platform, which still had guardrails, the three moved back towards the north end of the platform, which did not have guardrails (Tr. 25).

After the employees began work in that area, S. E. Johnson's foreman Kevin Masters noticed that the guardrail section was missing. He discussed the missing guardrail with carpenter apprentice Cheyenne Fowler. Fowler suggested that he could wire in a 2 by 4-inch piece of lumber to serve as a top rail. Fowler tie wired a single piece of lumber to the ends of the two columns which spanned the distance of the missing guardrail. The crew was in a hurry to get the work finished but was also concerned with the appearance of safety compliance. When Masters saw how the edge had been guarded, he said, "it is better than nothing" (Exh. C-4). Masters advised the employees to try to stay 7 feet away from the edge, even though they had to be within 18 to 24 inches when they went up and down the ladder. When finished removing the formwork, the crew left the guardrail wired in place (Exhs. C-2, C-4; Tr. 14, 27).

On September 18, 2000, on the lower platform under the bridge, the employees of its subcontractor J&B post-tensioned ("stressed" or stretched) the bundles of cables which ran through the bridge floor and protruded out the side. S. E. Johnson's employees were also on the platform to assist with the process. To post-tension the cables J&B employees placed the large C-clamp of a "ram" (a metal fastener) around the cables, and with hydraulic pressure they stressed the cables (Exh. C-2; Tr. 13-14, 66, 96). J&B employee Timothy Ripberger waited for the progression of the work to reach him, and he sat on or rested

against the railing which Fowler had wired to the column two days before.[1] As Ripberger sat or leaned on the top rail, one of its ends slipped out of the wire. Ripberger fell backwards and hit the ground 17 feet below. He suffered severe injuries which required prolonged hospitalization (Tr. 43, 99).

After Ripberger's fall, S. E. Johnson conducted its own investigation of the accident and took statements from its employees concerning the circumstances of the incident. S. E. Johnson turned these statements over to Medlock during the course of OSHA's investigation. Medlock also interviewed employees as part of his investigation.

Discussion

> 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) employees access to the violative conditions, and (d) the employer's actual or constructive knowledge of the violation.

Atlantic Battery Co., 16 BNA OSHC 2131, 2138 (No. 90-1741, 1994).

Item 1: § 1926.502(a)(2)

The Secretary asserts that S. E. Johnson did not pre-plan for fall protection and did not have a competent person examine the guardrail system utilized in violation of § 1926.502(a)(2). The standard provides:

> Employers shall provide and install all fall protection systems required by this subpart for an employee, and shall comply with all other pertinent requirements of this subpart before that employee begins the work that necessitates the fall protection.

The Secretary contends that § 1926.502(a)(2) requires S. E. Johnson "to pre-plan the construction of its fall protection system, and have an individual competent in the inspection or construction of fall protection systems inspect the system prior to any work by employees" (Secretary's brief p. 7). Even if this interpretation were the correct one, the Secretary's proof for this violation is not compelling. S. E. Johnson's bridge and highway project had safety planning and oversight. Curt Puse, S. E. Johnson's

[1] Although S. E. Johnson originally asserted that Ripberger returned to rest against the railing after having been previously warned away, it presented no credible evidence that any warning was given. In any event, S. E. Johnson rightly contends that Ripberger followed a very unsafe practice in resting against a guardrail and in being less than fully alert on the jobsite. Ripberger's actions or the accident itself, however, are not the focus of the case. The accident may have prompted OSHA's limited investigation, but what is at issue here is the existence of a sub-standard guardrail and S. E. Johnson's knowledge of the condition.

environmental health and safety specialist, performed site inspections. The City of Cincinnati employed the safety consultant company, Parsons Brinckerhoff, to check for construction quality and to make on-site safety inspections. Additionally, safety consultant M.A.C. Paran Consulting Service, Inc., had several individuals continually on-site to walk the area reviewing it strictly for safety compliance (Tr. 90-91, 141, 165-166). S. E. Johnson's employees were aware that they needed to have guardrails in place or to use other fall protection. In general, the jobsite had fall protection and oversight at the time of the accident.

The Secretary argues that fall protection was not pre-planned because a foreman allowed placement of one sub-standard guardrail section. Proof that a foreman knew a guardrail would not meet OSHA's specifications does not automatically establish that the company failed to plan for fall protection, even though this is the limit of the Secretary's evidence here. In items 2 and 3 the Secretary cites for the guardrail's substantive defects. Had the guardrail been strong enough to withstand 200 pounds and had it also included a midrail, the Secretary would not have asserted the failure to pre-plan for fall protection. S. E. Johnson did "provide and install all fall protection systems," in spite of the fact that in one instance the fall protection used was inadequate. (*See N & N Contractors,* 18 BNA OSHC 2127, 2127-28 (No. 96-0606, 2000) where failure to enforce compliance with certain safety rules does not establish or give rise to an inference of a failure to train or instruct.)

Item 1 is vacated.

Item 2: § 1926.502(b)(2)

The Secretary asserts that no midrail or toe board was present on the section of guardrail in violation of §1926.502(b)(2), which provides:

> Midrails, screens, mesh, intermediate vertical members, or equivalent intermediate structural members shall be installed between the top edge of the guardrail system and the walking/working surface when there is no wall or parapet wall at least 21 inches (53 cm) high.

As stated, this part of the jobsite originally had full guardrails. By September 16, 2000, the section of guardrail had been removed from the lower platform, leaving an open edge measuring 8 feet, 6 inches. Three employees worked on the platform and passed within 2 feet of the open edge and were exposed to falls of 17 feet. When apprentice Cheyenne Fowler replaced the guardrail at Master's direction, he put up only one railing, by wiring it in place 40 inches above the platform floor (Tr. 29). After Ripberger fell,

S. E. Johnson's safety specialist Puse interviewed Fowler about the accident. The interview included the following exchange (Exh C-4) (emphasis and parenthetical in the original):

> **10. Why did you put [the 2-by 4] up?**
> So we wouldn't get in trouble with the safety man (*Jason Holton*). Kevin Masters said the 2x4 was better than nothing and we were in a big hurry to get the area wrecked out.
> **11. How was the area left when the crew finished working?**
> We left the 2x4 in place that was all.

During the time that only a top railing was in place on September 16 and 18, 2000, various S. E. Johnson employees, and the employees of at least one subcontractor, accessed the platform and worked within the platform's relatively close space.[2] S. E. Johnson states that its employees were not exposed to the hazard because Masters told them to stay at least 7 feet away from the edge. Regardless of how far from the edge S. E. Johnson wished its employees to stay, the work directed otherwise. Employees came within at least 2 feet of the railing just to access the platform.

Masters knew that an 8 foot, 6-inch edge of the platform was not guarded with a midrail. Not only did he comment that the top rail was "better than nothing," but the area was in plain sight during the two days that the employees worked on the platform. The actual or constructive knowledge of an employer's supervisory personnel can be imputed to an employer, unless the employer establishes some substantial grounds for not imputing it. *Ormet Corp.* 14 BNA OSHC 2134, 2137 (No. 85-531, 1991), citing *Capital City Excavating Co.*, 712 F.2d 1008, 1010 (6th Cir. 1983). Master's knowledge is properly imputed to S. E. Johnson. A guardrail without the required midrail exposed employees to falling between the top rail and floor, 17 feet to the ground below. A fall from that distance could result in death, or as it did here, in serious bodily injury.

The Secretary has established a violation of § 1926.502(b)(2).

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[2] The ladder was 18 to 24 inches from the edge of the lower platform (Tr. 29). The edge of the platform to the face of the wall measured 12 feet, 12 inches. At least four or five bundles of cables needed to be post-tensioned. The ram, which weighed over 400 pounds and encompassed 2 feet along the platform, had to be placed on each bundle in turn. According to Medlock, the usable work space on the lower platform was reduced to 8 feet, 6 inches by approximately 10 feet. Some 6 employees worked on the platform, on which tools and equipment were also placed. By necessity, employees worked within the zone of danger of the inadequately guarded edge (Tr. 15, 98, 160-161).

Item 3: § 1926.502(b)(3)

The Secretary contends that the 8 foot, 6-inch top rail was incapable of withstanding 200 pounds of force in violation of § 1926.502(b)(3). The standard provides:

> Guardrail systems shall be capable of withstanding, without failure, a force of at least 200 pounds (890 N) applied within 2 inches (5.1 cm) of the top edge, in any outward or downward direction, at any point along the top edge.

Ripberger weighed 150 pounds, and he was wearing an additional 20 pounds of tools (Tr. 100). At the hearing S. E. Johnson's attorney cross-examined Ripberger regarding his fall (Tr. 105):

> Q. There was no reason for you to be leaning on the guardrail or the railboard, correct?
>
> A. Well, when you go to pull that machine off, you've got to kind of brush up against it or lean on it or whatever to help pull the machine off. You don't really have enough room down there to work on a lot of jobs like that.
>
> Q. I appreciate they were in tight spaces. However, as I recall your testimony, you were waiting for someone else to finish a task?
>
> A. Right, so I could help pull the machine off.
>
> Q. Was anyone else leaning with you?
>
> A. Yes.

Neither party followed up on the last question and answer. S. E. Johnson now suggests that the above answer establishes that Ripberger and another employee were both leaning against the railing at the same time, thus applying a force of in excess of 200 pounds to the top rail. The undersigned cannot accept that argument. Only Ripberger fell. If two individuals were leaning against the railing, it is assumed both could have fallen. Ripberger's testimony was noticeably uncertain and confused about occurrences immediately before or after the accident. Employees observed that Ripberger leaned or sat on the railing, and they reported this fact in their interviews. However, no employee asserted that anyone other than Ripberger rested on the railing. Nor was it previously S. E. Johnson's position that they had. Finally, the time period in which any other employee may have applied weight to the railing is unclear. It is determined that Ripberger alone leaned or sat on the upper guardrail at the time he fell and that the force he applied to the top rail was less than 200 pounds.

S. E. Johnson also argues that it had no reason to suspect that the top rail would not support 200 pounds. S. E. Johnson's employee Jeremy Sergeant demonstrated to Medlock how the rail was wired (Tr. 27). Medlock concluded that the wire connections of the top rail could not hold the necessary weight without slipping. Although Medlock admitted that it could be possible to wire in a railing with sufficient support, he would not have approved the method used in this case. Paran's on-site safety specialist Jasen Holton investigated the accident shortly after it occurred. He noted that the wire used to tie up the railing was "not a very large gauge" (Tr. 84). If Holton had seen how the railing was attached before the accident, he would not have allowed it. Holton did not consider the tie wire safe or capable of holding 200 pounds without breaking or slipping (Tr. 84-86). Even S. E. Johnson's witness, safety consultant Michelle Paraniuk of Paran, stated that had she seen the wired top rail on the jobsite, she would have made the crew correct and "nail it to support a person's load" (Tr. 168).

Foreman Kevin Masters may have had another motive for approving a tie-wired top rail. It could be done quickly. Masters observed how the railing was wired to the columns. Observing it, Masters told his crew to stay at least 7 feet away from the guardrail. The following portion of the interview by S. E. Johnson's safety specialist Puse with Cheyenne Fowler supports a conclusion that speed and avoiding problems with safety personnel played a more important role in how the railing was attached than a concern for the safety of the railing (Exh. C-4) (emphasis and parenthetical in the original):

> **13. Did you ever see the safety guy Jason, that night?**
>
> No. (*Cheyenne, asked if Kevin would be told what he said and I told him no.)* He then proceeded to tell me that Kevin and the other foreman on that shift were trying to hide . . . their crew from the safety man. It seemed like a big deal to get the work done and the foreman didn't want Jason to know where Cheyenne and the rest of his crew were working.

At the hearing Masters denied telling employees to avoid the safety personnel. His demeanor during this part of his testimony did not lend credence to the statement. However, it is unnecessary to determined whether Masters sought to hide his crew from the safety personnel. The Secretary need not prove that Masters had reached the specific conclusion that the railing would not support 200 pounds. The Secretary has shown that Masters undoubtedly had knowledge of the cited condition (the tie-wired guardrail). The manner in which the railing was attached should reasonably have prompted further inquiry as to the amount of force it could withstand. Failure to have a properly secured top rail could result in a fall of 17 feet, which would most likely cause severe injuries or death.

The Secretary has established a violation of § 1926.502(b)(3). The burden now shifts to S. E. Johnson to establish its defense of employee misconduct.

Employee Misconduct

> In order to negate a violation on the grounds of employee misconduct, the employer must show that: (l) it established work rules designed to prevent the specific violation from occurring; (2) the work rules were adequately communicated to its employees; and (3) it took steps to discover violations of those rules; and (4) it effectively enforced the rules when violations were discovered. *E.g., Gary Concrete Prods, Inc.*, 15 BNA OSHC 1051, 1055 (No. 86-1087, 1991).

S. E. Johnson asserts that even if a violation occurred, it was the result of the misconduct of Timothy Ripberger in sitting or leaning on the top rail. As stated, S. E. Johnson incorrectly places the focus of its defense on Ripberger's actions, rather than on the failure of its employees to properly construct the guardrail or to remedy its defects during the period the employees were exposed to the fall hazard. Additionally, its defense addresses the conduct of a subcontractor's employee, who did not have the same safety instruction as provided to its own employees. To be considered effective a work rule most be "designed to prevent the cited violation," *Gary Concrete, supra.* S. E. Johnson did not present evidence that it has a work rule addressing the proper construction of a guardrail. S. E. Johnson did not reprimand any of its employees for tie-wiring a single top rail, in lieu of properly constructing it with a secure top rail and a midrail (152). The employee misconduct defense is rejected.

Items 2 and 3 are affirmed as serious.

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, the employer's good faith, and its past history of violations of the Act. Gravity is the principal factor to be considered. *Trinity Indus.*, 15 BNA OSHC 1481, 1483 (No. 88-691, 1992).

S. E. Johnson employed 1,500 employees at the time of the accident. It had been cited for past serious violations within the previous three years (Tr. 35-36). No credit is allowed for size or past history. The Secretary recommended that no credit be afforded for good faith because of the high gravity of the violations. Nevertheless, some credit for good faith is appropriate. S. E. Johnson has an ongoing safety program and had a full-time safety specialist. S. E. Johnson's safety personnel conducted a thorough

investigation of the fall, which further evidences the company's concern for safety. It took photographs and statements from employees, providing them to OSHA during the investigation.

Gravity considerations include the fact that three and then six employees worked near the inadequate guardrail for an extended period. Their work placed them in close proximity to the hazardous condition. The fall distance was critical, with an assumption that falls of 17 feet would result in serious injury or death; the gravity of the violations are high. The faulty top rail has a somewhat higher gravity because employees relied upon the safety of something which was, in fact, unsafe. Based on the above, a penalty of $3,500 is assessed for failure to have a midrail, and a penalty of $4,000 is assessed for failure to have a top rail which could withstand 200 pounds of force.

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), Fed. R. Civ.P.

ORDER

Based on the foregoing decision, it is ORDERED:

1. Item 1 alleging a violation of § 1926.502(a)(2) is vacated;
2. Item 2 alleging a violation of § 1926.502(b)(2) is affirmed and a penalty of $3,500 is assessed; and
3. Item 3 alleging a violation of § 1926.502(b)(3) is affirmed and a penalty of $4,000 is assessed.

/s/
NANCY J. SPIES
Judge

Date: May 20, 2002