BEFORE THE NORTH CAROLINA OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION

COMMISSIONER OF LABOR FOR
THE STATE OF NORTH CAROLINA,

COMPLAINANT,

v.

METRO UTILITY COMPANY, INC.

RESPONDENT.

DOCKET NO. OSHANC 2004-4392
OSHA INSPECTION NO. 307388314
CSHO ID NO. Q2620

ORDER

THIS MATTER was heard by the undersigned on January 26, 2005 and on March 22, 2005 in Charlotte, North Carolina.

The complainant was represented by Linda Kimbell, Assistant Attorney General; the respondent was represented by Philip Van Hoy. Also present was Christopher D. Mauriello, representing the Estate of James Fults and Barbara Fults, Administratrix of the Estate.

There were no preliminary matters or motions to consider in this case, although at the start of this hearing counsel for the complainant moved to dismiss the citations against Testa and Wirth, Inc., an entity affiliated with respondent, which citations were identical to those in this matter. That motion was allowed and that result is reflected in a separate order filed in that case.

After hearing and receiving the evidence and considering the arguments of counsel, the undersigned makes the following:

FINDINGS OF FACT

1. The complainant as Commissioner of Labor of the State of North Carolina is charged with responsibility for and compliance with the Occupational Safety and Health Act of North Carolina (the "Act").

2. The respondent is a utility contractor located in Charlotte, North Carolina and employs 5 persons presently, but employed 12 persons at the time of the inspection by the complainant.

3. Beginning on January 2, 2004, complainantÆs safety compliance officer Scott Powell conducted an accident partial inspection at respondentÆs jobsite located at Station 115 in Mooresville, North Carolina.

4. Mr. Powell was summoned to the jobsite by an employee of the Iredell County EMS because a trench collapse had occurred, causing an injury to one of respondent's employees and a fatality to another of respondent's employees.

5. Mr. Powell was accompanied by Jerry Barker, another of complainantÆs safety compliance officers.

6. Station 115 is a multifamily residential project. The respondent was working on the second phase of the project. On December 29, 2003, the respondent had commenced installing 8 inch terra cotta pipe underground and was so engaged on January 2, 2004.

7. When Messrs. Powell and Barker arrived at the jobsite, rescue operations were in progress. The injured employee of respondent, Mitchell Williams, was out of the trench and was being airlifted to the hospital. The other employee, James Fults, was still in the trench. The accident occurred approximately 2:40 p.m. on January 2, 2004. Approximately 7:10 p.m., Mr. FultsÆ body was removed from the accident site.

8. At the time of the accident, the respondent had excavated a trench to install the pipe.

9. The respondent's general working procedure for installing the pipe was to excavate the trench with a trackhoe, install the pipe, then cover the pipe with dirt.

10. At the time of the accident, the respondent had the following employees on site: Mitchell Williams, a truck driver and pipe layer; James Fults, a pipe layer; Jesse White, who identified himself to the compliance officer as a foreman; James Stevens, a foreman and trackhoe operator who identified himself to the compliance officer as the employee in charge of the jobsite; and Walter Sisk, who would hook up the pipe section and help lower it into position in the trench.

11. Another respondent employee, John McCarroll, would bring the pipe to the jobsite and install pipe. The pipe sections are 5 feet in length and weigh from 120 -130 pounds.

12. Since each section of pipe must be laid at a special grade, an employee in the trench was assigned the task of determining that the pipe section being installed was at the correct grade. Also the employees in the trench were required to fit the pipe pieces together as a new pipe section was lowered into the trench.

13. The respondent was using a trench box in its pipe installation activities. This trench box was 8 feet high, 16 feet long, and 2 feet wide in its interior dimension and 3 feet wide overall.

14. At the time of the accident and inspection, the respondent had 187 feet of open excavation. The compliance officers measured the excavation at the site of and after the accident and determined that the trench was 11 feet deep, 3 feet wide from top to bottom originally, but 8 feet wide at the top after the collapse. Other evidence indicated without contradiction that immediately before the accident the trench was 14.6 feet deep at the point where it collapsed.

15. The compliance officers conducted interviews of the employees who were on the site at the time of the accident. From these employees the compliance officers learned the following:

a) Mitchell Williams and James Fults were in the trench at the time of the accident. These employees would stand inside the trench box while the pipe was lowered.

b) However, on the day of the accident and other days on this project, these employees were frequently out of the trench box while in the trench, fitting the pipe pieces together and taking measurements of the grade.

c) Because of the narrow interior width of the trench box, the pipe fittings and the grade measurements could not be accomplished inside the trench box, so those activities were always undertaken outside the trench box.

d) James Stevens had 20 years experience in excavation work and had had competent person training.

e) Jesse White had 4 years experience in excavation work and had had competent person training.

f) With the exception of the competent person training of Messrs. Stevens and White, none of the employees on the site had received any formal training in excavation safety from the respondent.

g) Both Mr. Williams and Mr. Fults were in the trench outside the trench box at the time of the cave in. Mr. Fults was killed from the cave in and Mr. Williams was injured.

16. The respondent was aware that the excavated depths would consistently exceed 8 feet on this project, because the average manhole depth was 9 feet and the tie-in of this project to the existing line was at a manhole 13 feet in depth.

17. The records of the respondent's provided to the compliance officers did not indicate any specific or formal training of the respondents' employees concerning excavation safety.

18. The respondent had a ladder in the trench at the time of the accident, but it was located at Manhole No. 16, which was 55 feet away from where the respondent's employees were working.

19. According to the employee interviews, the employees climbed on the trench box to enter and exit the trench, both before and after the accident.

20. The compliance officers observed a spoil pile on the edge of the trench on the side which collapsed. They measured the distance of the edge of the spoil pile from the edge of the trench and determined it was less than 2 feet in distance. This condition is shown in the complainant's exhibits.

21. According to the employee interviews and testimonial evidence, no employee of respondent conducted a daily inspection of the trench, the adjacent areas and the protective systems for the trench and adjacent areas, despite the fact that the respondent had two competent persons, Messrs. Stevens and White, on the jobsite.

22. The compliance officers observed a web sling belonging to respondent used to lower pipe into the trench. From direct visual observation, the compliance officers determined that this sling was worn, with cuts and abrasions on it at the point where it connected around a piece of pipe. However, the respondent presented evidence that a destructive test indicated the sling broke upon being subjected to weight of 7100 pounds.

23. While the sling supported a piece of pipe, the employees of respondent would be in close proximity to the sling in order to guide the pipe into the trench and the proper location for the piece of pipe.

24. The evidence is uncontroverted that the soil in which the trench was excavated was Class C soil.

25. In respondent's job hierarchy, the foreman reported directly to William Harrington, respondent's vice president, who was not always on the jobsite supervising the work. The evidence is contradictory as to whether he was on the jobsite daily, but the evidence is clear that he was not on the jobsite enough to direct the work and the crew, leaving that to Messrs. Stevens and White.

26. The testimony is also conflicting concerning the daily presence and usage of the trench box on the jobsite. However, it is clear from the evidence that the trench box that the respondent was using on this job at the time of the accident was too short for the depth of the trench and too narrow to allow the respondent's employees to perform their work within its protection.

27. The employees were required by the constraints of the trench box to leave the box to check the grade for the next pipe section and to fit the next pipe section. The only time they were within the trench box was during the excavation for the next pipe section. This procedure was repeated each time a new section of pipe was laid.

28. The respondent's employees all testified that the respondent provided no specific excavation training itself and undertook no real efforts to ascertain if the employees had received any prior training. Instead, it relied on the employee's length of service with other employers as of the date of hiring and made no inquiry into specific excavation training. The respondent's safety handbook at the time of the accident contained no specific references to excavation. The respondent provided an excavation training class for its employees and revised its safety handbook after the accident.

29. The conditions existent on the jobsite on the date of the accident regarding safety and compliance with the Act were the same or similar conditions that had occurred on that job for a number of other days. To the extent that Mr. Harrington was periodically present on the job and supervised the work, he knew or through the exercise of due diligence should have known of the existence of these conditions. To the extent he was not present, he delegated his authority and responsibility to supervise safety for his employees on the jobsite to the foremen, Messrs. Stevens and White. That delegation made the foremen's knowledge of conditions on the jobsite the knowledge of the respondent.

30. For each alleged violation of the Act, the substantially probable result of a violation of the Act would range from broken bones to death.

31. The proposed penalties were calculated in accordance with complainant's standard operations manual.

Based on the foregoing Findings of Fact, the undersigned makes the following:

CONCLUSIONS OF LAW

1. The foregoing Findings of Fact are incorporated by reference as Conclusions of Law to the extent necessary to give effect to the provisions of this Order.

2. The respondent is subject to the provisions of the Act.

3. The respondent knew or should have known with the exercise of due diligence the standards with reference to excavation in the conditions it encountered on the jobsite and knew or should have known with the exercise of due diligence that its employees were consistently violating the trenching standards in laying pipe outside the trench box and in using a trench box that was clearly too small for the conditions in which the work was being performed. Such circumstances indicated that the violation of the standard was being committed voluntarily or with intentional disregard of the standard or with demonstrated plain indifference to the Act.

4. The respondent had knowledge of these violations through Mr. Harrington. Mr. Harrington as an officer of the respondent active in the business and responsible, by his own testimony, for daily supervision of this work, knew or should have known, with the exercise of due diligence, that the trench box was too small and narrow and that the employees were constantly outside the trench box and in harm's way when they were performing the customary tasks to which they were assigned; namely, laying the pipe for the line they were constructing. His delegation of the daily responsibility for employee safety to the foremen causes their knowledge to be that of the respondent.

5. The complainant has proved by the greater weight of the evidence a willful serious violation of 29 CFR 1926.652(a)(1) as described in the citation item and the complaint.

6. The complainant has proved by the greater weight of the evidence a serious violation of 29 CFR 1926.21(b)(2) as described in the citation item and the complaint.

7. The complainant has proved by the greater weight of the evidence a serious violation of 29 CFR 1926.651(c)(2) as described in the citation item and the complaint.

8. The complainant has proved by the greater weight of the evidence a serious violation of 29 CFR 1926.651(j)(2) as described in the citation item and the complaint.

9. The complainant has proved by the greater weight of the evidence a serious violation of 29 CFR 1926.651(k)(1) as described in the citation item and the complaint.

10. The complainant has not proved by the greater weight of the evidence that the condition of the web sling was likely to cause an injury the substantially probable result of which was a serious injury.

Based on the foregoing Findings of Fact and Conclusions of Law, IT IS ORDERED as follows:

1. Citation 1, Item 1 is affirmed as a willful serious violation of 29 CFR 1926.652(a)(1) with a penalty of $28,000.00.

2. Citation 2, Item 1 is affirmed as a serious violation of 29 CFR 1926.21(b)(2) with a penalty of $2,800.00.

3. Citation 2, Item 2 is affirmed as a serious violation of 29 CFR 1926.651(c)(2) with a penalty of $2,800.00.

4. Citation 2, Item 3 is affirmed as a serious violation of 29 CFR 1926.651(j)(2) with a penalty of $2,800.00.

5. Citation 2, Item 4 is affirmed as a serious violation of 29 CFR 1926.651(k)(1) with a penalty of $2,800.00.

6. Citation 2, Item 5 is affirmed as a nonserious violation of 29 CFR 1926.251(e)(8)(iii) with no penalty.

7. All penalties shall be paid within thirty (30) days of the date of this order.

8. All violations not previously abated shall be immediately abated.

This 30th day of September, 2005.

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RICHARD M. KOCH
HEARING EXAMINER