BEFORE THE SAFETY AND HEALTH REVIEW BOARD
OF NORTH CAROLINA
RALEIGH, NORTH CAROLINA

COMMISSIONER OF LABOR FOR
THE STATE OF NORTH CAROLINA,

COMPLAINANT,

v.

DANIS HEAVY CONSTRUCTION COMPANY

RESPONDENT.

DOCKET NO. OSHANC 97-3537
OSHA INSPECTION NO. 125272831
CSHO ID NO. L9240

ORDER

APPEARANCES:

Complainant:
Ralf F. Haskell
Special Deputy Attorney General
North Carolina Department of Justice

Respondent:

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BEFORE:

Hearing Examiner: Carroll D. Tuttle

THIS CAUSE came on for hearing and was heard before the undersigned Carroll D. Tuttle, Administrative Law Judge for the Safety and Health Review Board of North Carolina, on October 1, 1998, at the Safety and Health Review Board, 217 West Jones Street in Raleigh, North Carolina.

The Complainant was represented by Mr. Ralf F. Haskell, Special Deputy Attorney General. The Respondent was represented by Gary W. Auman, an attorney with the law firm of of Dunlevey, Mahan & Furry, of Dayton, Ohio. James S. Schenck, IV, with the law firm of Patton, Boggs, LLP, of Raleigh, North Carolina, appeared as local counsel for Respondent.

Based upon the evidence presented at the hearing, and upon the admissions made by Respondent in its Answer to the Complaint and in its Response to Complainant's First Request For Admissions, and with due consideration of the arguments and contentions of all parties, the undersigned makes the following Findings of Fact and Conclusions of Law and enters an Order accordingly.

FINDINGS OF FACT

1. This case was initiated by a Notice of Contest received by the Complainant, North Carolina Department of Labor, on or about February 14, 1997 contesting a citation issued January 28, 1997 to Respondent, Danis Heavy Construction Company (now Davis Environmental Industries, Inc.), to enforce the Occupational Safety and Health Act of North Carolina (OSHANC or Act) (N.C.G.S. § 95-126 *et seq.*).

2. Complainant, the North Carolina Department of Labor, by and through its Commissioner, is an agency of the State of North Carolina charged with inspection for, compliance with, and enforcement of the provisions of the Act (N.C.G.S. § 95-133).

3. Respondent (hereinafter called "Danis"), is an Ohio corporation, which was authorized to do business in North Carolina. Beginning in January 1996 Danis was performing construction work and maintained an office in Jacksonville, North Carolina. Danis employed approximately four hundred (400) employees company wide at the time.

4. Danis is subject to the provisions of the Act (N.C.G.S. § 95-128) and is an employer within the meaning of N.C.G.S. § 95-127(9).

5. The undersigned has jurisdiction over the case (N.C.G.S. § 95-135).

6. During the period between December 28, 1996 and December 31, 1996, Howard J. Laurie, a Compliance Safety Officer (CSO) with the Occupational Safety and Health Division, North Carolina Department of Labor, conducted an occupational safety and health (OSH) inspection of Danis' construction site located at 44 North Marine Boulevard in Jacksonville, North Carolina. The inspection was initiated as a result of a report of an accident (fatality) having occurred at the site.

7. On December 28, 1996, prior to beginning his inspection, CSO Laurie conducted an opening conference with Mr. John Blatt, Danis' Project Superintendent. During the opening conference CSO Laurie presented his credentials and explained the scope and purpose of the inspection. Approval for the inspection was granted by Mr. Blatt.

8. During the inspection CSO Laurie conducted a walk-a-round of the site, took photographs, interviewed witnesses, obtained a diagram of the building under construction, made diagrams which witnesses identified and marked, and obtained written statements. CSO Laurie also performed a review of and, among other things, received copies of Danis' OSHA 200 logs, Field Employment Personnel Manual, Employee Safety and Health Handbook, and contracts. CSO Laurie also reviewed Danis' safety and health program.

9. On December 31, 1996 CSO Laurie held a closing conference with Danis. Present at the closing conference on behalf of Danis were Charles Black, Safety Director; John Blatt, Project Superintendent; Greg Black, QVC Manager; and, Larry Gillan, counsel for Danis.

10. On January 28, 1997, as a result of the inspection, and in order to enforce the Act, Complainant issued to Respondent the following citation:

Citation Number One, Item 1,

A serious violation of 29 CFR 1926.501(b)(4)(i) in that each employee on a walking/working surface was not protected from falling through holes more than 6 feet (1.8 m) above the lower levels by personal fall arrest systems, covers, or guardrail systems erected around such holes; **or, in the alternative,**

A serious violation of 29 CFR 1926.502(a)(2) in that Respondent did not provide and install fall protection systems required by this subpart for an employee and did not comply with all other pertinent requirements of this subpart before that employee began the work that necessitated the fall protection; **or, in the alternative,**[(1)]

A serious violation of 29 CFR 1926.501(b)(3) in that employees in a hoist area were not protected from falling 6 feet (1.8m) or more to lower levels by guardrail systems or personal fall arrest systems, and that when guardrail systems or portions thereof were removed to facilitate the hoisting operation, and an employee leaned through the access opening or out over the edge of the access opening to receive or guide equipment or materials, the employee was not protected from fall hazards by a personal fall arrest system.

11. In December, 1996, Danis was the general contractor at the City of Jacksonville's main pump station project located at 44 North Marine Boulevard in Jacksonville, North Carolina (hereinafter "the site"), and was in the business of constructing buildings and other structures and managing or supervising subcontractors engaged in such construction work. Respondent provided all concrete work and mechanical installation and coordinated the efforts of all subcontractors.

12. On December 28, 1996 Danis was doing construction work on the main pump station at the site. The project included the construction of a two story main pump station building.

13. The main pump station building was being constructed with one floor (the dry pit) below ground and one floor at ground level. Approximately eighty percent (80%) of the construction on the building was complete at the time of the inspection.

14. The main pump station building was a concrete structure with a brick veneer exterior walls and a wooden roof. The dry pit on the lower level had a concrete floor and walls, and concrete columns and support beams to support the slab (floor) above. Pumps were being installed in the dry pit. A stairway lead to the upper (ground) level.

15. The surface of the ground floor level was concrete and constituted a walking/working surface. This floor had a 68 inch by 68 inch hole or opening (5 feet square) creating an access to the dry pit below. The opening was covered by two metal grates. A four-inch lip around the interior of the opening supported the grates. The grates were approximately three inches thick.

16. The distance from the opening on the ground floor to the floor level below was approximately 27 feet. The distance between the front (north) edge of the pump station ground level floor and the front (north) edge of the floor opening was approximately two and one-half (2 ½) feet.

17. On December 28, 1996 Wayne Harper was Danis' carpenter foreman in charge of supervising Danis' construction work crews at the site. Mr Harper's responsibilities as foreman included supervising the construction of the pump station, as well as for the

safety of Danis' employees. Mr. Harper, however, did not know how many Danis employees were on the construction site that day.

18. An independent contractor masonry crew was supposed to have been at the site at 7:00 a.m. on December 28, 1996 to do block work on the North end of the pump station building near where the floor opening was located. While waiting for the masons to arrive, the Danis construction work crew performed alternative work, including bolting pipe flanges and doing clean-up in the dry pit of the pump station.

19. Between 8:00 and 8:30 a.m. on December 28, 1996 Mr. Harper learned that the masons were not going to show up at the job site.

20. At around 9:00 a.m. Mr. Harper decided to place three check valves, which weighed between 150 and 300 pounds, into the pit. The change in work plans was discussed with the Danis work crew which included Gary Chapman, Chester Kilgore (the deceased) and Samuel "Tim" Jones.

21. Mr. Harper then returned to the storage trailer. As he went to the storage trailer he observed this crew in the storage yard adjacent to the forty-ton crane which was to be used to lift and deliver the check valves through the ground floor opening to the dry pit below. The crane was located at the left front (northwest) corner of the pump station.

22. The crew's task was to remove the large grates from the floor opening with the crane in order to lower the check valves into the pit. Jerry Smith was the crane operator.

23. Removal of each grate normally took seven to eight minutes. Gary Chapman was the signal man for the crane operator; his assistance was needed at all times while the crane was being operated in that a pair of concrete columns blocked Mr. Smith's vision of the grate area. The concrete columns were 24 inches from the (north) edge of the hole or opening.

24. As Mr. Harper was returning to the pit area Mr. Jones ran toward him, telling him to call 911 because a man had fallen. Mr. Harper instructed Mr. Jones to make the call.

25. Mr. Harper proceeded to the pump station building and went downstairs into the dry pit where he observed Chester Kilgore lying unconscious on the concrete floor. Kilgore had fallen from the ground floor through the floor hole or opening and later died as a result of his injuries.

26. Mr. Kilgore lay on the floor below the pit opening; he wore no safety harness or safety belt and was not tied off to anything.

27. Mr. Harper remained in the pit with Mr. Kilgore until the paramedics arrived. The paramedics entered the pit by way of the stairwell.

28. Mr. Harper did not remove any guardrails, did not order that any guardrails be removed, and did not see anyone removing any guardrails on the day of the accident. After leaving the pit, Mr. Harper did not look to see if any guardrails were in place.

29. Following the accident, the employees left the work site early.

30. At 3:04 pm on December 28, 1996, CSO Laurie received a call from his supervisor regarding the accident at the Jacksonville pump station work site. At 3:09 pm he contacted Danis' superintendent, Mr. John Blatt. At 3:20 p.m. CSO Laurie arrived at the construction site where he met Mr. Blatt. After the opening conference, Mr. Blatt gave Laurie a brief tour of the site.

31. During this tour CSO Laurie and Blatt went to the pump station building where the accident had occurred. Laurie observed the 5 foot square floor opening through which Mr. Kilgore had fallen.

32. A guardrail with a mid-rail was located on one (south) side of the opening. This was a free standing guardrail with feet and was not bolted or otherwise attached to the floor or other object.

33. A single two-by-four rail was stretched between the two concrete columns on the far (opposite/north) side of the hole or opening. This single guardrail was installed after the accident.

34. The other two (east and west) sides of the opening were unguarded.

35. CSO Laurie returned to the work site on Sunday, December 29, where he met with Charles Blatt, the safety director, Greg Black, the QEC manager and safety committee member, R.W. Arthur, the senior claims consultant for American Contractor's Insurance Group, and John Black, superintendent. CSO Laurie conducted a second opening conference with them in the parking lot near the office trailer, after which they started toward the pump station.

36. On the way to the pump station Mr. Harper approached CSO Laurie and stated that the accident was his fault. Harper stated that he had made the choice not to use fall protection. Harper explained that he had made this choice in that all the hard jobs

had already been accomplished and that this job, which was simply to open the grate, put stuff in the hole, and close it up, was just too easy.

37. The group, including Mr. Harper, then went to the pump station where Laurie continued gathering information for the investigation.

38. When they arrived at the building, Mr. Black, Mr. Blatt and Mr. Harper briefly described to Laurie the basic scenario of what the job entailed and what was being done when the accident occurred.

39. Gary Chapman joined the group as they reached the area of the building where the opening was located. Dawn Dice, Samuel Jones and Jerry Smith were also at the pump station. CSO Laurie talked with Mr. Chapman on the ground floor of the pump station near the opening to the pit, and with Mr. Jones and Ms. Dice at the lower level beneath the pit opening. Laurie also talked with Mr. Smith, the crane operator.

40. CSO Laurie was provided a diagram of the ground floor of the building which he used while talking with each of these employees at the pump station (Complainant's Exhibits No. 20).

41. Mr. Chapman, who was working with Kilgore at the time of the accident, described to Laurie the exact scenario of what he, Kilgore and other crew members were doing at the time of the accident, including how they had removed the grates and what their work plan was. As Mr. Chapman was talking with Laurie about what had occurred, he pointed his finger to where he was standing, to where Mr. Kilgore was, to where they had placed the grates after they had been removed, to where the crane was located and to where he stood while signaling the crane. CSO Laurie took some photographs and measurements of the area and discussed the lack of guardrails and fall protection with both Chapman and Harper.

42. The plan was for the Danis crew to take three check valves and put them downstairs into the pit area. In order to do this they had to remove the two grates covering the opening. A choker from the crane was fed through one grate from above and Mr. Jones, who was in the pit below, then climbed a ladder in order to attach the choker to the grate from underneath. A foot long metal bolt was slipped through the eye of the choker to assist in lifting the grate. The grate was then lifted and removed by the crane.

43. Following the removal of the first grate, Mr. Kilgore, who was on the ground floor level, climbed onto the remaining grate to feed the choker through. Kilgore then leaned over the opening to attach the choker (and eye bolt) underneath the grate. Mr.

Kilgore climbed off the grate to which he had attached the choker. The second grate was then removed by the crane.

44. After the grates were removed they were placed to the left (northeast side) of the opening on top of dunnage, which was located within two feet of the opening. The dunnage consisted of pieces of wood laid down so that the grates could be placed on top of them, leaving space below for choker attachment purposes.

45. Mr. Kilgore stood between one of the columns on the outside (north) wall of the building and the northeast corner of the opening in order to be able to squat down and unhook the cable as each grate was placed on the dunnage. This placed Kilgore within two feet of the opening.

46. The next phase of the operation was for Mr. Kilgore to attach the chocker of the crane to the ladder in order to pull it out of the opening.

47. Mr. Kilgore stood up from disconnecting the choker from the second grate. This placed him standing between the Northeast edge of the grate and the concrete column. As he stood up, Mr. Kilgore turned toward the opening, took a step, and fell through the hole or opening to the floor below. This occurred at approximately 11:00 a.m.

48. At the time Kilgore fell through the opening, both he and Chapman were working within 24 inches of the unprotected opening.

49. At the time Kilgore and Chapman were removing the grates there were no guardrails between them and the hole or opening.

50. Neither Kilgore nor Chapman were wearing any fall arrest protection at the time they were removing the grates and getting ready to remove the ladder in preparation for delivery of the three check valves into the pit area. When asked why fall protection was not being used, Chapman explained that Mr. Harper, the foreman, had said that it was not necessary.

51. At the time that Kilgore fell, Jones was in the pit holding the base of the ladder steady so that Mr. Kilgore could get onto the ladder and attach the choker.

52. As Mr. Kilgore fell he hit the ladder, made a futile attempt to grab the ladder, and then continued to fall to the floor directly beneath the opening.

53. CSO Laurie returned to the site on December 29 to continue his investigation. Laurie was provided a sketch of the building (Complainant's Exhibit No. 20). Laurie showed this sketch to Chapman, Jones, Dice and Smith while talking with them at the

pump station. The employees, including Chapman, used the sketch in describing for Laurie the locations of people and what activity was going on at the time of the accident.

54. While at the pump station Mr. Harper again told Laurie that it [the accident] was his fault for having made a bad choice not to use fall protection.

55. After talking with the Danis employees at the pump station and taking photographs and making measurements, Laurie went to the Danis Office trailer where he made photocopies of the sketch provided him. Laurie then drew his measurements, employee locations, *et. seq*., upon the copies.

56. CSO Laurie then proceeded to sit down with each employee, on an individual basis, and go over again, in detail, all the things they had talked about in order to make sure that his information was correct (Complainant's Exhibits Nos. 21-26). Each of the employees agreed with and signed each of the sketches.

57. CSO Laurie then asked each of the employees to write out a statement for him (Complainant's Exhibits Nos. 27, 28, 32).

58. CSO Laurie also obtained a written statement from Mr. Harper (Complainant's Exhibit No. 27). Officer Laurie went over the statement with Mr. Harper and questioned him about what was meant by certain statements. In his written statement, which differed from his earlier oral statements, Mr. Harper for the first time stated that there was no feasible means to use body harnesses, so guardrails were used. He further stated that one [guardrail] was not in place at the time of the accident.

59. When questioned by CSO Laurie as to what he meant by "not feasible," Harper stated that there was no place to hook off to. Laurie then pointed to the overhead structure of the pump station building and stated that it could have been used for tying off the employees. In fact, when Laurie returned to the site on December 31, tie-off points with harnesses were installed on this overhead portion of the structure.

60. CSO Laurie returned to the fatality worksite on December 31. Laurie had requested that the grates, which had been replaced, be removed in order for him to take additional photographs of the opening. He had also asked that guardrails be installed all the way around the opening so that it would be safe for him to take pictures.

61. When he arrived CSO Laurie noted that, besides guardrails being installed, two or three tie-offs with harnesses attached to them had been installed on the upper structure of the pump house. The tie-offs were wire rope that had been looped around the upper

structure of the pump house. Mr. Laurie pointed out the harnesses to Mr. Harper and said, "that looks like it's feasible to have fall protection to me." In response, Mr. Harper shrugged his shoulders.

62. Mr. Harper testified on recall by Danis that he had examined the grate area and dry pit prior to 7:00 a.m. on December 28, 1996 and that guardrails were present around all four sides of the floor opening, including between the concrete columns on the North side; that the guardrails consisted of a top rail and a mid-rail; and, that each foot piece (or brace) of each guardrail were bolted to the concrete floor.

63. Mr. Harper further testified that on the morning of December 28, 1996 each brace or foot piece had two anchor bolts attached to it; that the guardrails were bolted down with 6 to 6 1/4 inch long thunderstuds or quick bolts, which were driven into the concrete with a drill hammer; that removing the guardrails by unbolting them would leave the studs sticking up from the concrete; that if removed to facilitate the removal of the grates the employees knew that the guardrails would have to have been replaced; and, that if the studs were cut off or driven into the concrete after removal of the guardrails, they would also have had to have been replaced.

64. On cross-examination, Mr. Harper admitted that he observed no evidence following the accident of the allegedly removed guardrails. Further, upon examining photographs taken by CSO Laurie of the floor opening, he could not see any evidence of there having been any bolts or studs used to secure the guardrails to the floor.

65. CSO Laurie did not observe any evidence of any guardrails which may have been removed from around the ground floor hole prior to the Danis employees beginning preparations to deliver the check valves to the dry pit, including evidence of any bolts or studs having been inserted into the concrete floor. Additionally, review of the photographs taken of the area shortly following the accident does not indicate the presence of any moved or dismantled guardrails, or the presence or indication that any studs or bolts had been inserted into the concrete floor surrounding the opening. Further, the one existing guardrail at the South end of the hole or opening was not bolted or otherwise secured to the floor, but stood on free standing legs. Moreover, the single rail placed between the columns on the North side of the hole following the fall was tied off to the columns. Finally, the guardrails later erected around the hole were also not bolted to the floor, but were nailed together.

66. At no time during the inspection did Harper say that the employees acted contrary to his orders in the manner and method in which they went about trying to deliver the check valves to the pit area.

67. Harper at no time stated to CSO Laurie that any guardrails had been removed by the employees without his knowledge between the time he had last observed the area on the morning of December 28, 1996 and when he returned after the accident.

68. 29 CFR 1926.501 (b)(4)(i) provides that "[e]ach employee on walking/working surfaces shall be protected from falling through holes (including skylights) more than 6 feet (1.8 m) above lower levels, by personal fall arrest systems, covers, or guardrail systems erected around such holes."

69. Based upon findings of fact numbers 61 through 65, as well upon Mr. Harper's admissions to CSO Laurie that he was at fault for having allowed the employees to work around the floor opening without appropriate fall protection, the undersigned finds that Mr. Harper's testimony that guardrails were present around all four sides of the floor opening on the morning of the accident is not credible.

70. There were no guardrails on either the East or West sides of the hole or opening prior to and at the time work was commenced at the site on the morning of December 28, 1996.

71. The single guardrail between the columns across the front (North) wall of the pump station had been removed prior to Harper's assigning the employees the job of delivering check valves to the pit. This was in order to facilitate the work to be done by the masons who were expected to arrive at 7:00 a.m. that morning. Therefore, there was no guardrail across the north end of the hole or opening at the time work commenced on the morning of December 28, 1996.

72. The single guardrail, which was not reinstalled until after the accident, did not comply with the requirements of 29 CFR 1926.502(b) in that, among other reasons, there was no midrail.

73. At the time Mr. Kilgore fell through the floor opening, both grates covering the five foot square hole or opening had been removed. Mr. Kilgore was standing within 24 inches of the uncovered floor opening.

74. Mr. Chapman was also standing less than 24 inches from the uncovered floor opening.

75. At the time of Kilgores fall, there were no guardrails between Mr. Kilgore or Mr. Chapman and the hole or opening.

76. Additionally, neither Kilgore or Chapman were wearing personal fall arrest protection.

77. The top of the ladder in the pit was against the north side of the opening, where the single rail was located. The grate over this portion of the opening had been removed first.

78. It would not have been possible for someone to have reached from outside the guardrail on the south side of the opening and attach the cable to the top of the ladder located on the north side. Further, in order for the employees to have reached the ladder from outside of where the single rail had been located on the north side of the opening, they would have had to stood on the ground, reached twenty-four inches across the concrete floor, and then eighteen to twenty-four inches into the opening below the level of the concrete. This was an impossibility.

79. As illustrated by Mr. Kilgore's fall through the floor opening, the lack of guardrails on three sides of the opening and the failure of Danis' employees to use personal fall arrest protection equipment when making preparations to deliver the check valves presented the possibility that an employee could fall through the uncovered five foot square hole or opening to the floor of the pit area below.

80. As further illustrated by the death of Mr. Kilgore, the likely injury which would occur as a result of an employee falling through the opening to the concrete floor twenty seven feet below was death.

81. Mr. Harper knew, or should have known, that the Danis employees were exposed to the uncovered and unguarded hole or opening and that they were not wearing personal fall arrest protection equipment.

82. The proposed penalty of $7,000 was calculated in accordance with the North Carolina Operations Manual, was appropriate to the gravity of the violation, the probability of an accident, and the size, good faith and history of the company.

83. Danis presented evidence concerning its overall safety training program, including a safety manual and weekly tool box meetings. Respondent's training program, however, only minimally covers fall protection. Further, it does not set out out or explain the OSH standards concerning fall protection. This should be specifically covered due to Danis' continued requirement that employees work near floor holes or openings.

84. Danis did not present substantial evidence that it had adequately communicated its work rules to either Mr. Kilgore, Mr. Chapman or the other employees on the worksite.

85. The preponderance of the evidence shows that Mr. Harper was aware that at least one set of guardrails (on the north side of the opening) was not in place when he assigned the employees to deliver the check valves through the opening to the floor below. Further, an inspection of the work area would have revealed that there were no guardrails on two other sides (east and west) of the opening.

86. The preponderance of the evidence shows that Mr. Harper was aware that the Danis employees were not wearing or utilizing personal fall arrest protection devices such as a safety belt with laynard at the time they were preparing to deliver the check valves to the pit room.

87. The preponderance of the evidence fails to show that Danis effectively enforced its disciplinary policy. For example, no warnings were given for any safety violations from the beginning of the Jacksonville pump station project in January 1996 through the time of the accident on December 28, 1996; neither Mr. Harper, the foreman, nor any of the employees were warned or disciplined as a result of the violation which resulted in the fall on December 28, 1996; Danis policy does not adequately specify its three classifications of violations, but leaves it up to the discretion of the foreman or project superintendent; no investigation or written report was conducted or prepared by Danis as a result of the accident; Mr. Blatt, the Project Superintendent, was not aware of Danis' policy that foremen were subject to disciplinary action; and, Danis presented only two employee warnings from other projects which were dated prior to December 28, 1996.

Based upon the foregoing Findings of Fact, the undersigned Hearing Examiner concludes as a matter of law the following:

CONCLUSIONS OF LAW

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

2. This Court has jurisdiction of this cause and the parties are properly before the Court.

3. Respondent is subject to the provisions of the Act (N.C.G.S. § 95-128) and is an employer within the meaning of N.C.G.S. § 95-127(9).

4. Respondent violated 29 CFR 1926.501(b)(4)(i) by failing to protect each employee from falling through the hole more than 6 feet (1.8 m) above the lower levels.

5. The proposed penalty of $7,000 was calculated in accordance with the North Carolina Operations Manual and is appropriate.

6. Respondent has failed to meet its burden of proving that the violation was the result of isolated employee misconduct.

ORDER

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

1. Citation One, Item 1, alleging a serious violation of 29 CFR 1926.501(b)(4)(i) is hereby affirmed; and,

2. The proposed penalty of $7000.00 is affirmed and shall be paid within ten (10) days of the filing date of this Order.

This the 27th day of June, 2000.

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Carroll D. Tuttle
Administrative Law Judge Presiding

1. Complainant's motion to amend the Citation to include this alternative violation was allowed at the hearing.