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. S. J. LOUIS CONSTRUCTION OF TEXAS, Respondent.	OSHRC Docket No. 12-1045

ON BRIEFS:

Kimberly A. Robinson, Attorney; Heather R. Phillips, Counsel for Appellate Litigation; Joseph M. Woodward, Associate Solicitor of Labor for Occupational Safety and Health; M. Patricia Smith, Solicitor of Labor; U.S. Department of Labor, Washington, DC
For the Complainant

Steven R. McCown, Earl M. (Chip) Jones, III, Russell M. Zimmerer; Littler Mendelson, Dallas, TX
For the Respondent

DECISION

Before: ATTWOOD, Chairman; MACDOUGALL, Commissioner.

BY THE COMMISSION:

S. J. Louis Construction of Texas is a large underground utility contractor headquartered in Mansfield, Texas. On November 3, 2011, two SJL employees entered a manhole for an active sewer line in Fairview, Texas, and died from hydrogen sulfide (H_2S) toxicity and asphyxia due to low oxygen concentration. Following this accident, the Occupational Safety and Health Administration conducted an inspection and issued SJL a serious citation alleging three

violations of the general industry permit-required confined spaces standard, 29 C.F.R. § 1910.146, with a proposed penalty of $6,930 for each violation. Prior to the hearing before former Administrative Law Judge Ken S. Welsch, the Secretary moved to amend the citation to allege, in the alternative, a serious violation of section 5(a)(1), the general duty clause of the Occupational Safety and Health Act of 1970, 29 U.S.C. § 654(a)(1), with a proposed penalty of $6,930.[1]

In his decision, the judge granted the Secretary's amendment, finding that the cited general industry standards did not apply because SJL's employees were engaged in construction work.[2] The judge affirmed a serious violation of section 5(a)(1) of the Act and assessed a $5,000 penalty. For the reasons that follow, we vacate the citation.

BACKGROUND

In July 2010, the North Texas Municipal Water District contracted with SJL to begin the second phase of a project to redesign and reconstruct distribution sewer lines for the North Texas wastewater treatment system. This second phase—a two-mile long project that traversed public and private residential property—involved rehabilitating the existing 60-inch sewer line, installing new manholes, rehabilitating existing manholes, and establishing odor control measures. While relining the existing sewer line in February 2011, SJL placed an inflatable rubber plug in a connecting pipe to prevent the passing of sewer odor and overflow from an adjacent sewer line.

In early November 2011, about a month after SJL had completed most of the project, the Water District began getting odor complaints from homeowners who lived near the sewer line. A Senior Inspector for the Water District contacted an SJL Project Coordinator about the complaints. In response, SJL dispatched a three-person crew, one of whom served as the Crew Leader. When the crew arrived at the worksite, they smelled "fumes" and Crew Member B needed a handkerchief to cover his face. A placard on a pole at the manhole warned that the sewer line was active. The crew removed the cover to the manhole. Inside was a concrete ledge

[1] The general duty clause states: "Each employer shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees." 29 U.S.C. § 654(a)(1).

[2] The judge also rejected SJL's argument that the general duty clause was preempted by 29 C.F.R. § 1926.21(b)(6) (training requirements for employees required to enter confined spaces during construction work). SJL does not challenge this ruling on review.

about five feet below the surface where the connecting pipe with the rubber plug was located. It is undisputed that prior to entering the manhole, the Crew Leader did not discuss either the dangers of entry or emergency procedures with the crew, nor did he perform any air monitoring, complete an entry permit as required by SJL's confined space program, wear personal protective equipment, ventilate the space, or set up rescue equipment.[3]

Once inside the manhole, the Crew Leader became incapacitated and told the two crew members that he could not get out. Crew Member A told Crew Member B to retrieve a rope from the truck. When Crew Member B returned with the rope, he found Crew Member A lying face down inside the manhole, partially on the ledge, but he could not see the Crew Leader.[4] The parties stipulate that the two employees "died as a result of [H_2S] toxicity and asphyxia due to low oxygen concentration within a sewer while at work." Fire department personnel who responded to the accident tested the air inside the manhole shortly after arriving on the scene and obtained readings of 60 parts per million (ppm) for H_2S and 5% for oxygen. The record shows that normal readings are zero for H_2S and 20.9% for oxygen.[5]

DISCUSSION

The Secretary alleges that SJL violated the general duty clause by exposing its employees to the "hazards of asphyxiation when it allowed [them] to enter [a] sewer manhole[], a permit[-] required confined space, without taking necessary precautions to ensure safe entry and rescue."[6]

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[3] On the center console inside the truck the Crew Leader drove to the site was a calibrated gas monitor, as well as a blank entry permit.

[4] There is no evidence in the record indicating Crew Member A's reason for entering the manhole. The Crew Leader's body was found the next day at a reservoir one mile away.

[5] SJL's confined space program advises that at an oxygen level of 6% or less "respiration ceases, coma, fatal within minutes" and that H_2S has a threshold limit value of 10 ppm and is immediately dangerous to life or health at 100 ppm.

[6] Under the general industry standard, a permit-required confined space is defined as a confined space that has one or more of the following characteristics:

> (1) Contains or has a potential to contain a hazardous atmosphere; (2) Contains a material that has the potential for engulfing an entrant; (3) Has an internal configuration such that an entrant could be trapped or asphyxiated by inwardly converging walls or by a floor which slopes downward and tapers to a smaller cross-section; or (4) Contains any other recognized serious safety or health hazard.

29 C.F.R. § 1910.146(b).

To prove a general duty clause violation, the Secretary must establish that: (1) a condition or activity in the workplace presented a hazard; (2) the employer or its industry recognized the hazard; (3) the hazard was causing or likely to cause death or serious physical harm; and (4) a feasible and effective means existed to eliminate or materially reduce the hazard. *Arcadian Corp.*, 20 BNA OSHC 2001, 2007 (No. 93-0628, 2004). He must also prove that the employer had knowledge of the hazardous condition. *Burford's Tree, Inc.*, 22 BNA OSHC 1948, 1950 (No. 07-1899, 2010), *aff'd*, 413 F. App'x 222 (11th Cir. 2011) (unpublished).

On review, SJL disputes the judge's findings that it had knowledge of the hazardous condition and that the Secretary established a feasible means of abatement. It also raises the defense of unpreventable employee misconduct. As discussed below, we find that the Secretary did not prove that SJL had knowledge of the hazardous condition and vacate the citation on this basis. Although, in these circumstances, we need not reach SJL's other arguments, we have considered them and would find that they are supported by the record.

The Secretary must prove that an employer had either actual or constructive knowledge—in other words, that the employer knew or, with the exercise of reasonable diligence, should have known of the hazardous conditions constituting the violation. *Burford's Tree*, 22 BNA OSHC at 1950. In assessing reasonable diligence, the Commission considers several factors, including an employer's obligations to implement adequate work rules and training programs, adequately supervise employees, anticipate hazards, and take measures to prevent violations from occurring. *See id.* (citing *Danis Shook Joint Venture XXV*, 19 BNA OSHC 1497, 1501 (No. 98-1192, 2001), *aff'd*, 319 F.3d 805 (6th Cir. 2003)). Under both Commission precedent and the law of the Fifth Circuit, to which this case could be appealed,[7] the actual or constructive knowledge of a supervisor can be imputed to the employer. *Rawson Contractors Inc.*, 20 BNA OSHC 1078, 1080-81 (No. 99-0018, 2003); *W.G. Yates & Sons Constr. Co. v. OSHRC*, 459 F.3d 604, 608 n.6

[7] Under the Act, an employer may seek review in the court of appeals in the circuit in which the violation occurred, the circuit in which the employer's principal office is located, or the District of Columbia Circuit. 29 U.S.C. § 660(a). The Secretary may seek review in the circuit in which the violation occurred or in which the employer has its principal office. 29 U.S.C. § 660(b). This case arose in Texas, which is in the Fifth Circuit. In general, "[w]here it is highly probable that a Commission decision would be appealed to a particular circuit, the Commission has . . . applied the precedent of that circuit in deciding the case—even though it may differ from the Commission's precedent." *Kerns Bros. Tree Serv.*, 18 BNA OSHC 2064, 2067 (No. 96-1719, 2000) (citation omitted).

(5th Cir. 2006). However, in cases involving a supervisor's knowledge of his own misconduct, the Fifth Circuit requires that the Secretary also prove that the supervisor's participation in the violative conduct was foreseeable by showing that the employer's safety policy, training, and discipline are inadequate. *Yates*, 459 F.3d at 608-09.

The Secretary claims that SJL had constructive knowledge of the hazardous condition on the basis that the company: (1) provided insufficient instructions to the Crew Leader regarding his work assignment; and (2) had a deficient safety program. The judge agreed that the instructions SJL's supervisors gave the Crew Leader before he went to the worksite were inadequate, and therefore concluded that constructive knowledge was established. On review, SJL argues that the judge erred in reaching this conclusion because the record shows that the instructions provided to the Crew Leader were reasonable given what the company knew about the Crew Leader's work history, training, and demonstrated understanding of confined space hazards and how to perform his job.

For the following reasons, we agree with SJL and find that the Secretary has not met his burden of establishing constructive knowledge. We also find that, under the Fifth Circuit's precedent, the Secretary's knowledge burden cannot be met by imputing to SJL the Crew Leader's knowledge of his own misconduct because the Secretary has not shown that the Crew Leader's actions were foreseeable.

Instructions

The instructions given to the Crew Leader on the day before the accident were the result of a chain of conversations involving various individuals. First, the Senior Inspector for the Water District contacted SJL's Project Coordinator and asked him to send someone from SJL to determine whether "there was a plug in the manhole in the backyard" near the odor complaints and, if there was, to remove the plug. The Project Coordinator, in turn, informed SJL's North Texas Area Manager about his discussion with the Water District's Senior Inspector. The Area Manager told the Project Coordinator to contact the Crew Leader and tell him to "evaluate" the location. According to the Area Manager, he "wanted an evaluation by [the Crew Leader] to know what, where and why," i.e., to determine where the manhole was located and its accessibility, which he stated could be affected by its location in a residential neighborhood and

the presence of such things as dogs or fences.[8] The Area Manager also told the Project Coordinator that, after the Crew Leader's evaluation, SJL "would schedule a [different] crew" to remove the plug—most likely a "fit testing" crew authorized to enter a hazardous atmosphere requiring the use of a breathing apparatus.

The Project Coordinator—the only SJL supervisor who spoke directly with the Crew Leader—stated that after his conversation with the Area Manager, he contacted the Crew Leader and told him that the Water District's Senior Inspector "had called and said there was a plug that was in the manhole" at the location in question. The Crew Leader then asked: " 'Will we need to get into the manhole to remove the plug?' " The Project Coordinator told him: " 'I don't know. Why don't you get with [the Senior Inspector] and take a look?' " According to the Project Coordinator, the Crew Leader said he would call the Senior Inspector, who testified that when the Crew Leader contacted him, he told the Crew Leader "to remove [the plug] if it was there" and "[i]f you go out there and find it and you all take it out, give me a call." Crew Member B testified that on the day before they went to the worksite, Crew Member A told him that they would be going with the Crew Leader the next day to remove the plug because "the Company told [the Crew Leader] that we needed to take out the plug."[9]

When determining the adequacy of instructions given to an employee, the Commission considers how effectively the information is communicated in light of the employee's training. *See LJC Dismantling Corp.*, 24 BNA OSHC 1478, 1481-82 (No. 08-1318, 2014) (finding adequacy of employee's prior training relevant to assessing sufficiency of employer's instructions); *Gary Concrete Prods. Inc.*, 15 BNA OSHC 1051, 1055 (No. 86-1087, 1991) (finding both training and instructions "too general" to be effective, Commission found company's "failure . . . to provide [the supervisor] with specific training or instructions on proper stacking techniques clearly illustrates the inadequacy of the company's safety instructions"); *Pride Oil Well Serv.*, 15 BNA OSHC 1809, 1815 (No. 87-692, 1992) ("[T]he real problem was

[8] The Area Manager's testimony as to whether he also instructed the Project Coordinator to tell the Crew Leader to determine what would be needed to actually remove the plug is inconsistent. The Area Manager acknowledged his instructions did not direct the Crew Leader to evaluate "what it would take to remove the plug" or the atmospheric condition of the manhole. At the same time, he testified that the Crew Leader was supposed to "find out what we needed to do to get in there" and that there could have been more to what the Crew Leader would have reported back than just the manhole's location and accessibility.

[9] *See infra,* footnote 15.

that Pride had failed to formulate and implement adequate work rules and training programs to ensure that [the employee] had been informed of the appropriate safety considerations.").

More generalized instructions may be permissible in light of an employee's specialized training and experience, just as they may be inadequate in light of an employee's lack of experience, poor safety history, or lack of supervision. *Compare LJC*, 24 BNA OSHC at 1481-82 (more specific scaffold instructions not necessary where employer was aware of employee's prior scaffold training), *and Donohue Indus., Inc.*, 20 BNA OSHC 1346, 1350-51 (No. 99-0191, 2003) (more specific instructions on grounding not required because it was reasonable for employer to expect trained electricians to be familiar with basic tenets of their trade), *with Gary Concrete*, 15 BNA OSHC at 1054-56 (instructions inadequate in light of insufficiently specific work rules, insufficient training, inability of supervisor to see operation, and employee's safety-deficient work history). *See also Thomas Indus. Coatings, Inc.*, 23 BNA OSHC 2082, 2088 (No. 06-1542, 2012) (foreman's effectiveness in supervising safety was not hindered by his other duties when employees he monitored were "experienced laborers" and had not previously been disciplined for violating any fall protection rules); *Danis Shook*, 19 BNA OSHC at 1502 (lack of supervision "impermissible in view of [employer's] failure to adequately train its employees and adopt specific work rules").

In assessing the instructions given here to the Crew Leader, the judge found that both the Project Coordinator and the Area Manager knew that: (1) the manhole was a confined space and evaluation of the manhole would involve H_2S—an inherent hazard at an active sewer line; (2) the Crew Leader was not authorized to perform permit-required confined space jobs; and (3) the Crew Leader's trailer containing the equipment necessary for entry into the manhole had broken down the day before the accident.[10] In addition, the judge found that SJL "would have known how to remove the plug" because SJL had installed it (i.e., implying that the company knew

[10] The equipment referenced by the judge included a ventilation blower and hose and rescue equipment. Crew Member B testified that the trailer had broken down the day before the accident, but he did not indicate whether the equipment was still in the trailer when someone from SJL came to pick it up. SJL's Safety Director said he knew about the trailer's return to SJL's equipment yard but not about the return of any equipment. In fact, the record shows that, after the accident, the equipment in question was found at the Crew Leader's house, where he had left it on the morning of the accident.

entry would be necessary).[11] The judge also noted that the Area Manager testified that "[i]t wouldn't have surprised [him] had [the Crew Leader] decided to pop the lid and evaluate" the manhole. Based on these findings, the judge concluded that the instructions given to the Crew Leader were "ambiguous," "inadequate," and "vague" because they did not specifically address: (1) the appropriate procedures and equipment necessary to perform the evaluation; (2) whether the Crew Leader should remove the plug; (3) whether entry was necessary to remove the plug; and (4) the hazards of entry.

We disagree that the instructions were inadequate. At the outset, we note that it is clear that both the Secretary and the judge are under the mistaken impression that the Crew Leader was prohibited from entering *any* permit-required confined space. In fact, the record shows that the Crew Leader was authorized to enter such spaces as long as a breathing apparatus was not required—in other words, the atmosphere can be rendered safe with the use of ventilation. Thus, while it is true that the instructions given to the Crew Leader did not make clear that he was not to enter the manhole and not to remove the plug, we find that such instructions were not required because his confined-space training included information on whether and when he could enter such a space.

Nor did SJL have to account for the possibility that the Crew Leader might not recall, or even disregard, his confined space training and the limitation on the conditions under which he was permitted to enter a confined space. In fact, about one month before the accident, at a worksite similar to the one at issue here, the Crew Leader told the Area Manager and SJL's Safety Director, after evaluating the conditions, that he could not do the necessary work because it required entering a confined space with an unsafe atmosphere, and, therefore, an SJL crew authorized to use breathing apparatus was needed.[12] This shows that the Crew Leader fully

[11] The judge noted that "the 12-inch connection line with the plug was approximately 5 feet below the surface. There is no showing that the plug could be seen from outside the manhole. To remove the plug, it needed to be deflated. The removal of the plug [after the accident] was done [from] inside the manhole."

[12] The Secretary attempts to cast doubt on this prior incident based on SJL's failure during discovery to produce time sheets showing that the Crew Leader was working on October 3, 2011, exactly one month to the day before the accident. The judge, however, credited and relied on the Area Manager's and the Safety Director's testimony regarding this prior incident. In addition, SJL did produce a time sheet—"Inspection from 9/27"—reflecting that work was performed at the relevant job site within a week of October 3. Thus, we find that the absence of

understood the confined space training SJL had provided him on three separate occasions since 2005, including training he received on September 17, 2011, about six weeks before the accident.[13] Moreover, the Crew Leader had at least 22 years of experience in the underground utility industry, including about seven years at SJL, during which time he had a spotless safety record.

Viewed in this light, we find that the instructions given to the Crew Leader were adequate. The Area Manager acknowledged that when he directed the Project Coordinator to have the Crew Leader "evaluate" the site, the Area Manager anticipated that the Crew Leader might do more than just determine the manhole's location and accessibility. This was not unreasonable since the Crew Leader was authorized to enter a confined space when a breathing apparatus was not needed, and the Crew Leader had previously demonstrated that he understood this limitation. In short, both the Crew Leader's training and the equipment SJL had provided him—ventilation and rescue equipment, a permit entry form, and a gas monitor—were commensurate with that authorization.

As for the Project Coordinator, his account of what he told the Crew Leader shows that he pointed out the problem—a plug in a manhole at a specific location[14]—and in response, the Crew Leader asked: "Will we need to get into the manhole to remove the plug?" The Crew Leader's question demonstrates that he recognized the plug at this worksite needed to be removed and understood generally that entering a manhole is not always necessary when removing a plug—a point confirmed by Crew Member B and SJL's Safety Director. In response, the Project Coordinator told the Crew Leader to contact the Water District's Senior Inspector and "take a look"—in essence, to determine if entry would be required to remove the plug. Accordingly, no further instructions were necessary—the Crew Leader's evident understanding that the assignment could involve entry into the manhole and even removal of the

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an October 3 timesheet does not diminish or discredit the consistent testimony of both the Area Manager and the Safety Director.

[13] The record reflects that, in addition to this confined space training, SJL provided the Crew Leader with safety training on at least three other occasions during this timeframe.

[14] We note that the Project Coordinator's testimony refutes SJL's contention on review that "none of the relevant parties even knew if a plug was in the sewer line."

plug was consistent with his authorization to enter manholes if a breathing apparatus was unnecessary.[15]

To the extent the evidence shows that the instructions did not rule out entering the manhole to either assess the situation or remove the plug, we find that the instructions were nonetheless adequate because the Crew Leader was authorized to enter any confined space that did not require a breathing apparatus and had been trained accordingly. In such circumstances, SJL could presume that the Crew Leader would have understood that if a breathing apparatus was required, he would not attempt to enter the manhole. Finally, we find no basis to conclude that the Project Coordinator's instructions were inadequate just because the instructions did not account for the possibility that the Crew Leader thought he was being told—contrary to his training—to enter the manhole even if using a breathing apparatus was necessary. Indeed, the evidence does not rule out that some plugs may be removed by entering the manhole *without* a breathing apparatus.[16]

Because SJL's supervisors were aware of the Crew Leader's spotless safety record, extensive experience, and training, including his recently-demonstrated understanding of that training, we find it was reasonable for SJL to instruct him to evaluate the worksite and remove the plug, confident he would understand—without the reminders and specificity the Secretary claims reasonable diligence required—that if entry was required for any reason, he was to do so *only* if a breathing apparatus was not needed. *Compare LJC*, 24 BNA OSHC at 1481-82 (instructions sufficient in light of employee's extensive training, experience, and no evidence of safety violations), *Thomas Indus.*, 23 BNA OSHC at 2088 (supervision adequate for experienced laborers with no history of violating pertinent safety rules), *and Cerro Metal Prods. Div., Marmon Grp, Inc.*, 12 BNA OSHC 1821, 1824 (No. 78-5159, 1986) (reliance on employee justifiable in light of employee's extensive training, lengthy experience, and fine work record), *with Danis Shook*, 19 BNA OSHC at 1502 (finding impermissible employer's reliance on inadequately trained employee to recognize and avoid hazards in absence of specific work rules

[15] Crew Member B's testimony that Crew Member A told him "the Company told [the Crew Leader] that we needed to take out the plug" is consistent with the Crew Leader having construed the Project Coordinator's call as potentially including plug removal.

[16] Although the Area Manager testified that, based on "prior access to the job site in various areas," he "most likely" would have scheduled a "fit-testing" crew to remove the plug, he did not state he would always use that type of crew whenever entry was necessary to remove a plug.

ensuring work was safely performed), *Pride Oil Well,* 15 BNA OSHC at 1815 (finding company's lack of adequate work rules and training regarding oxygen-deficient atmospheres established constructive knowledge), *and Gary Concrete*, 15 BNA OSHC at 1054-55 (finding company failed to exercise reasonable diligence based on its assignment of difficult task to inadequately trained and unsupervised employee with a history of safety-deficient job performance).

Accordingly, we find the Secretary has not established that SJL's supervisors had constructive knowledge of the Crew Leader's unauthorized entry into the manhole based on the instructions they gave him.

Safety Program

The Secretary also claims SJL had constructive knowledge based on its deficient safety program, specifically its alleged failure to adequately enforce its work rules.[17] *See Burford's Tree*, 22 BNA OSHC at 1950 (when assessing constructive knowledge, the Commission considers the employer's obligations to have adequate work rules and training programs, adequately supervise employees, anticipate hazards to which employees may be exposed, and take measures to prevent the occurrence of violations); *Active Oil Serv. Inc.*, 21 BNA OSHC 1184, 1187 (No. 00-0553, 2005) (same); *Pride Oil Well*, 15 BNA OSHC at 1814 (same). We disagree.

The Secretary does not dispute the judge's finding that SJL has established work rules in its written confined space program designed to prevent unprotected entry into a hazardous confined space, as well as a safety policy that requires employees to test the atmosphere before entering any confined space. As the judge also found, SJL has a training program that regularly covers the company's work rules in various training sessions, including the confined space training program held two months before the accident which the Crew Leader and both crew members attended.[18] The Secretary characterized SJL's confined-space-training PowerPoint

[17] Neither the judge nor SJL address the Secretary's contention in the context of constructive knowledge but both address the factors used to evaluate this argument in their discussions of SJL's unpreventable employee misconduct affirmative defense, which relies on the same factors. *See Burford's Tree,* 22 BNA OSHC at 1951-52 (factors for evaluating constructive knowledge are the same for evaluating unpreventable employee misconduct affirmative defense).

[18] We note that both the judge and the Secretary fault SJL for having no record of providing confined space toolbox talks to the Crew Leader and his crew in the months before the accident.

presentation as lacking substance, but the presentation was only one part of SJL's extensive training program and served as a discussion guide, not a recitation of all required information. SJL also uses performance tests to determine if employees understand the training provided.[19]

We also disagree with the judge's and the Secretary's reliance on the conduct of both the Crew Leader and Crew Member A on the day of the accident as evidence of their lack of training. The Crew Leader's conduct was not only contrary to his usual practice and training, but also inconsistent with his demonstrated understanding of confined space hazards just a month before the accident. In addition, Crew Member B testified that he had seen the Crew Leader using air-monitoring equipment and completing confined space permits in the past and that, prior to the accident, he had never seen the Crew Leader fail to measure the air quality in a confined space. The Area Manager testified that he too had never observed the Crew Leader "take any shortcuts" and that no one had ever complained to him that the Crew Leader was committing an unsafe act. Indeed, compelling evidence of SJL's training-program effectiveness is demonstrated by Crew Member B's testimony. He and his brother, Crew Member A, received the same training from SJL. Despite the tragic circumstances faced on the day of the accident, Crew Member B expressly credited that training with saving his life.

With regard to discovering violations of its work rules, SJL has a full-time safety director and five field safety supervisors who conduct random and planned field safety audits, which,

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However, an employer is not required to hold toolbox talks, let alone address and document issues in such talks that are already discussed in other training forums. What is required is that an employer's work rules be adequately communicated. *See, e.g., New Eng. Tel. & Tel. Co.*, 11 BNA OSHC 1501, 1503-04, 1508, 1510 (No. 80-6519, 1983) (finding work rule adequately communicated—despite no mention of toolbox talks—where included in written safety procedures and discussed at two employee-attended safety meetings, one of which was held two months before incident).

[19] The Secretary points out that Crew Member A and Crew Member B each made an error on one of these tests. We find this fact insufficient to prove that SJL did not adequately communicate its safety rules to its employees. First, SJL's Field Safety Supervisor characterized the question the two employees answered incorrectly as a "trick question" because the correct answer was not one of the multiple-choice question's options. Second, we find no basis to conclude that a perfect test score would be required to show that SJL's training program was effective. Commissioner MacDougall notes that imposing this requirement may create a disincentive to employers to conduct such testing.

contrary to the judge's finding, did include audits of the Crew Leader and both crew members.[20] *See Stahl Roofing Inc.*, 19 BNA OSHC 2179, 2182 (No. 00-1268, 2003) (consolidated) (safety director's unannounced visits as part of monitoring system deemed adequate); *N.Y. State Elec. & Gas Corp.*, 19 BNA OSHC 1227, 1231 (No. 91-2897, 2000) (same); *Burford's Tree*, 22 BNA OSHC at 1950-51 (discussing audits as a means to discover safety violations). The Secretary claims that errors on SJL's completed entry permits demonstrate it failed to take adequate steps to discover violations.[21] Out of approximately 40 permits introduced into evidence, the Secretary points to errors on six, two of which he asserts reflect failures to record atmospheric testing results. *Compare Dana Container, Inc.*, 25 BNA OSHC 1776, 1780-82 (No. 09-1184, 2015) (finding employer did not take adequate steps to discover violations where each of 28 permits introduced into evidence had at least one error or omission), *appeal docketed*, No. 16-1087 (7th Cir. Jan. 14, 2016). Of those two permits, one omits the testing results but notes that the confined space was hazardous, which indicates that the atmosphere was tested and the results known. The other permit, contrary to the Secretary's mistaken assertion, does include the testing results—but they are listed on another page of the permit. The remaining errors cited by the Secretary reflect a failure to record the PPE or isolation required, or the presence of any special hazards.[22] However, as the record shows, SJL's field safety supervisors examine completed entry permits, immediately note whether there are any deficiencies, and discuss with the

[20] The Crew Leader was supervising a crew during a planned audit on July 13, 2011, although it is not clear if Crew Member A or Crew Member B were part of that crew. In addition, Crew Member A and Crew Member B were part of an audit on February 8, 2011.

[21] SJL contends that the Secretary can only consider entry permits issued within the Act's six-month statute of limitations, which would include only the one permit for the November 18, 2011, removal of the plug. *See* 29 U.S.C. § 658(c) ("No citation may be issued under this section after the expiration of six months following the occurrence of any violation."). The Secretary, however, introduced the permits as evidence that SJL employees were not complying with the company's own safety rules; he was not attempting to establish OSHA violations predating the one alleged in the citation here. Thus, we consider the permits for this limited purpose. *See, e.g.*, *Cleveland Wrecking Co.*, 24 BNA OSHC 1103, 1110 (No. 07-0437, 2013) (although time-barred incidents could not support a violation, such "near miss" evidence can be considered to show that employer "had actual knowledge that additional or different protection was necessary under the circumstances" (internal alterations and citation omitted)).

[22] Given that SJL conducts audits and imposes discipline, as discussed below, but has not disciplined employees for lack of PPE or failing to isolate confined spaces, it appears that these were documentation failures rather than failures to use or implement the required measures.

employee the importance of properly documenting atmospheric testing and properly completing entry permits. Thus, we find that these few errors do not amount, as the Secretary suggests, to employee violations that are too numerous to find that SJL's safety rules were effectively enforced. *See Am. Eng'g & Dev. Corp*., 23 BNA OSHC 2093, 2097 (No. 10-0359, 2012) (finding one occasion of delayed discipline insufficient to find employer failed to adequately enforce its safety rules).

Finally, SJL's disciplinary log shows that over the two-year period predating the OSHA inspection, SJL warned and suspended employees on dozens of occasions for safety violations, four of which were for confined space violations during 2009.[23] Although, as the Secretary points out, the log shows no disciplinary records related to confined space issues following a 2009 verbal warning, the log shows that SJL implemented a progressive disciplinary policy for safety violations. *See Stahl*, 19 BNA OSHC at 2182 (finding progressive discipline program sufficient to establish adequate enforcement element of reasonable diligence). We find that, in light of SJL's record of numerous safety-related disciplinary actions, the lack of evidence that the Crew Leader or his crew members were disciplined shows simply that they had not committed safety violations for which they would be subject to discipline, rather than, as claimed by the Secretary, that discipline with respect to this crew, or employees in general, was lax. *See Am. Eng'g*, 23 BNA OSHC at 2097 (discipline adequate where employer had progressive disciplinary program and had imposed extensive discipline for safety violations in year prior to incident); *Thomas Indus.*, 23 BNA OSHC at 2088-89 (discipline adequate where employer had disciplined employees for violations of its safety program and disciplinary reports show that employees involved in fall protection violation at issue had never been disciplined for personally violating fall protection rules). On the contrary, the record shows that when SJL discovered safety work rule violations, corrective informal training was provided and other corrective measures, including disciplinary actions, were taken. *See Aquatek Sys. Inc.*, 21 BNA OSHC 1400, 1402 (No. 03-1351, 2006) (finding that verbal reprimand demonstrates employer enforced safety rules).

[23] The log tracks who was disciplined, the type of discipline, and whether it was a first, second, or third infraction. Safety-related discipline included warnings as well as suspensions, which varied in duration from one day to one week. The log shows that none of the employees had more than two safety-related infractions.

Accordingly, we find that the Secretary has not established that SJL's safety program was deficient such that it should have known with the exercise of reasonable diligence that the Crew Leader would "enter [a] sewer manhole[], a permit[-]required confined space, without taking necessary precautions to ensure safe entry and rescue." *Compare Active Oil*, 21 BNA OSHC at 1187 (finding several problems with the employer's safety program, including that supervisor and three crew members entering a tank felt free to disregard the company's established confined space safety procedures; eight-hour refresher training conducted shortly before accident was simply a session in "what to tell OSHA" about a previous fatal accident; and company president made a comment in owner's and supervisor's presence that "they would never get anything done if they did things by the book"), *and Pride Oil Well*, 15 BNA OSHC at 1814 (finding there was no work rule and employees had no training in the hazards of, and procedures necessary for, oxygen-deficient atmospheres).

Imputation

The only remaining theory for proving knowledge rests on imputing the Crew Leader's knowledge of his own misconduct, which in the Fifth Circuit requires proof that his misconduct was foreseeable. *See Yates*, 459 F.3d at 608-09; *Rawson*, 20 BNA OSHC at 1080-81. Foreseeability is established by showing that the employer's safety policy, training, and discipline are inadequate. *Id.* As we have already concluded that SJL's safety program was adequate, the Crew Leader's misconduct was not foreseeable. Accordingly, we find that the Secretary has not established that SJL had knowledge of the violative conduct, and we vacate the citation.[24] *See Burford's Tree*, 22 BNA OSHC at 1950.

[24] Although we need not reach the issue of whether the Secretary established the existence of a feasible and effective means of abatement, we note that the record would not support finding that the Secretary established this element. The Secretary acknowledges that the specific proposed abatement measures identified in his amended complaint "were either already contemplated in SJL's Confined Space Entry Manual or had already been implemented at SJL." According to the Secretary, "[f]ollowing the manual's instructions would have materially reduced or eliminated the hazard because it would have protected [the decedents] from exposure to the hazardous atmosphere in the manhole and provided for rescue in the case of any unforeseen emergencies." Where an employer has undertaken to address the hazard alleged under a general duty clause violation, the Secretary must prove that the employer's methods—in this case SJL's comprehensive confined space safety program—were inadequate, *see U.S. Postal Serv.*, 21 BNA OSHC 1767, 1773-74 (No. 04-0316, 2006), which in turn requires consideration of the same factors analyzed above, *see Conn. Light & Power Co.*, 13 BNA OSHC 2214, 2217-18 (No. 85-1118, 1989). Here, we have found that SJL's program was adequate; so, the Secretary has not

SO ORDERED.

/s/
Cynthia L. Attwood
Chairman

/s/
Heather L. MacDougall
Commissioner

Dated: February 5, 2016

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met his burden of proving that the measures SJL had undertaken to address the hazard were inadequate.

Having vacated the citation, we also need not reach SJL's alleged affirmative defense of unpreventable employee misconduct. However, given that the elements necessary to establish the defense are essentially the same factors used to analyze the adequacy of an employer's safety program when determining constructive knowledge, the record would support finding that SJL established the defense. *See Burford's Tree,* 22 BNA OSHC at 1951-52 (factors for evaluating constructive knowledge are the same for evaluating unpreventable employee misconduct affirmative defense).

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. J. Louis Construction of Texas, Respondent.	OSHRC Docket No. 12-1045

Appearances: Josh Bernstein, Esq., and Mia Franklin Terrell, Esq.,U. S. Department of Labor, Office of the Solicitor, Dallas, Texas
For the Complainant

Earl Jones, Esq., and Russell Zimmer, Esq. Littler Mendelson, Dallas, Texas
For the Respondent

Before: Administrative Law Judge Ken S. Welsch

DECISION AND ORDER

S.J. Louis Construction of Texas (SJL) is a large underground utility contractor with an office in Mansfield, Texas. On November 3, 2011, two SJL employees, including the crew leader, died from hydrogen sulfide toxicity (H_2S) and asphyxia due to a low oxygen concentration after entering a manhole for an active sewer line in Fairview, Texas. The crew leader entered the manhole to evaluate or to remove an inflatable plug in a connecting line. SJL had installed the plug earlier in the project to prevent odor and overflow from an adjacent sewer line. As a result of an investigation by the Occupational Safety and Health Administration (OSHA), SJL received a citation on May 1, 2012, alleging three serious violations of the confined space standards at 29 C.F.R. § 1910.146. SJL timely contested the citation.

The serious citation alleges that SJL violated 29 C.F.R. § 1910.146(d) (item 1) for failing to ensure a permit-required confined space was evaluated and measures implemented to prevent unauthorized entry; 29 C.F.R. § 1910.146(f) (item 2) for failing to provide the required information for compliance with entry permit and authorized entry; and 29 C.F.R. § 1910.146(k)(1)(i) (item 3) for failing to evaluate a prospective rescuer's ability to respond to a

rescue where there are known hazards. The citation proposes a penalty of $6,930.00 for each alleged serious violation.

The Secretary of Labor's motion to amend the citation was granted on August 24, 2012, to allege in the alternative a serious violation of § 5(a)(1) of the Occupational Safety and Health Act (Act) with a proposed penalty of $6,930.00. The amendment alleges SJL allowed employees to enter a manhole, a permit-required confined space, without taking necessary precautions to ensure safe entry and rescue. The Secretary states that the § 5(a)(1), general duty clause, is applicable if it is determined that the SJL crew was engaged in construction work instead of general industry work covered by the § 1910.146.

The hearing was held on October 24-26, 2012 in Dallas, Texas. The parties stipulated jurisdiction and coverage (Tr. 4). The parties' post-hearing briefs were filed on February 13, 2013.

SJL denies the alleged violations and asserts the cited standards at § 1910.146 are not applicable to the construction related work being performed by the crew. Also, if a violation is found, SJL claims that it lacked knowledge of the crew leader's entry into the manhole and that such entry should be considered unpreventable employee misconduct.

For the reasons discussed, the confined space standards at § 1910.146 do not apply because the crew's work did constitute ongoing construction activity. The serious violation of § 5(a)(1) of the Act, in the alternative, is affirmed and a penalty of $5,000.00 is assessed.

The Accident

SJL is a large underground utility contractor headquartered in Mansfield, Texas. SJL employs approximately 300 employees and maintains other offices in Austin and San Antonio, Texas (Tr. 200-201).

In July 2010 the North Texas Municipal Water District (North Texas) contracted SJL to begin Phase 2 of the Rowlett-Cottonwood Project (RCP). RCP was a project to redesign and reconstruct distribution sewer lines for the North Texas wastewater treatment system of stations and pipelines. Phase 1 of the project, also performed by SJL, had started in 2004 and involved constructing a new sewer line that ran parallel to an existing line. Phase 2 involved rehabilitating the existing 60-inch sewer line, the installation of new manholes, rehabilitating existing manholes, and establishing permanent odor control measures. The completion date of Phase 2 was set for May 10, 2011 (Exh. R-1; Tr. 284, 288).

By early September, 2011, SJL had completed the Phase 2 rehabilitation of the existing sewer lines and manholes when representatives of North Texas and SJL conducted a walk-through of the project. As a result of the walk-through, the parties developed a punch list of items to be completed (Tr. 202-203).

On Tuesday, November 1, 2011, North Texas requested SJL to locate and remove a rubber plug, if still in place, in a manhole in Fairview, Texas. North Texas had received odor complaints from homeowners and wanted the 12-inch connecting pipe unblocked. The inflatable plug had been placed in the connecting pipe by SJL in February 2011 while relining the existing sewer line. It was installed to prevent the passing of sewer odor and overflow from the adjacent sewer line. The plug was approximately 16 inches in diameter when inflated and 12 inches in length (Exh. C-15; Tr. 120, 127-128, 211, 251, 253). The removal of the plug was not on the parties' punch list (Tr. 117, 279).

On Thursday, November 3, 2011, at approximately 7:00 a.m., an SJL crew consisting of the crew leader who had worked 8 years for SJL and two brothers (a finisher and a helper), arrived at the location of the manhole which was in the backyard of a private residence. The crew was considered a small support crew mostly involved in erosion control, landscaping, and maintenance work. When the crew approached the manhole they saw and could smell "fumes." The helper needed a handkerchief to cover his face. A placard at the manhole warned that the sewer line was active (Exh. C-1; Tr. 26, 41-42, 51-52, 189, 346).

The manhole opening was 24 inches in diameter and was covered. Inside the manhole, there was a concrete ledge approximately 5 feet below surface where the connecting pipe with the rubber plug was located. Below the ledge, the new 5-foot relined sewer line had been installed (Tr. 209-210).

The crew removed the cover. Before entering the manhole, the crew leader did not perform any air monitoring, complete the company confined spacer entry permit, and was not wearing proper personal protective equipment (PPE) such a face mask with oxygen. There was also no discussion about rescue nor did the crew have equipment available for non-entry rescue (Tr. 26-27).

After removing the cover, the crew leader climbed a ladder down to the concrete ledge. Once inside, the crew leader became incapacitated and told the brothers that he could not get out. The helper was sent by his brother to retrieve a rope from the truck. When the helper returned

with the rope he found his brother inside the manhole, partially on the ledge. He could not see the crew leader. The helper did not call 911 because of the trauma and he did not know the street address. Instead, he went to a homeowner who called 911 ((Tr. 30-32, 330).

At approximately 8:00 a.m., the Fairview Fire Department arrived at the manhole; not knowing it was for a sewer line. After arriving, the officers observed the steam coming from the manhole and smelled sewer gas. With an air monitoring device, the Fire Department obtained readings at 10:42 a.m. of 60 ppm for H_2S and 5% for oxygen. Normal readings are 20.9% for oxygen and zero for H_2S. SJL's *Confined Space Entry Program* advises that an oxygen level of 6% or less "respiration ceases, coma, fatal within minutes" and that H_2S has a Threshold limit Value (TLV) of 10 ppm and is Immediately Dangerous to Life or Health at 100 ppm (Exhs. C-2, C-6, pp. 9-10; Tr. 47-48, 50, 57).

Because of the Fire Department's lack of confined space training, another Fire Department was called to retrieve the finisher from the manhole. The crew leader was not found until noon the next day at a reservoir approximately one mile from the manhole (Tr. 63-64, 90-91). The parties stipulated that the two employees "died as a result of hydrogen sulfide toxicity and asphyxia due to low oxygen concentration within a sewer while at work" (Tr. 106).

On November 3, 2011, at approximately 11:00 a.m., OSHA compliance safety and health officers initiated an investigation into the accident. After taking photographs, interviewing potential witnesses, and gathering documents, the serious citation was issued to SJL on May 1, 2012 (Tr. 434-435, 450)

The rubber plug was removed from the connecting line by another SJL crew on November 18, 2011. To remove the plug, the employee entered the manhole and deflated the plug (Exh. C-5; Tr. 123, 129). SJL's *Supervisor Report of Incident,* dated November 5, 2011, concluded that to prevent reoccurrence, "[a]dhere to strict confined space procedures as thought [taught] in employee training. Any action item with known hazards should be relayed to the safety department so that production and safety work cooperatively" (Exh. C-13).

Discussion

Application of § 1910.146 or § 5(a)(1)of the Act

As an initial issue, the parties dispute whether SJL's removal of the plug was general industry or construction work. The OSHA citation alleges SJL's violations of the confined space standards at § 1910.146 are applicable to general industry.

The Secretary does not dispute that SJL's work on the RCP was construction work, covered by Part 1926 construction standards. She argues that by November 3, 2011, however, SJL had completed the construction work on the project and the removal of the plug was maintenance work covered by the § 1910.146 (Secretary Brief, p. 13). The Phase 2 rehabilitation work had been completed in early September 2011 and the only work remaining was the punch list of items to be completed, which consisted of seeding and shrubbery replacement (Tr. 113, 203). The removal of plug was not on the punch list.

SJL argues that the work performed by the crew on November 3, 2011, was construction work. Although the installation of the line was complete, its work on the project continued as part of completing the Phase 2 contract.

The court agrees with SJL. OSHA's general industry standards at § 1910.146 are not applicable to construction work. Section 1910.146(a) specifically states "[T]his section does not apply to agriculture, to construction, or to shipyard employment…." The Secretary in her recent *Semiannual Agenda of Regulations* acknowledges that the confined space standards at § 1910.146 have "not been extended to cover employees entering confined spaces while engaged in construction work because of unique characteristics of construction worksites." 78 FR 1598-01 (January 8, 2013).[25]

OSHA defines "construction work" as "work for construction, alteration, and/or repair, including painting and decorating." 29 C.F.R. § 1910.12(b). Work that involves upgrading existing equipment such as relining (slip lining) an existing sewer line is considered "alteration work" and therefore, construction work. *Jimerson Under-Ground Inc.*, 21 BNA OSHC 1459, 1461 (No. 04-0970, 2006).

[25] The Secretary's proposed confined space standards for construction were published for comment and public hearing on November 28, 2007. 72 FR 67351. The Secretary anticipates a final rule in July 2013.

SLJ, as an underground utility contractor, is in the construction business. The Secretary agrees that SJL's installation of a new sewer line, slip lining the existing sewer line, and rehabilitating manholes was construction work (Secretary Brief, p. 13). North Texas' request to remove the plug from the connecting pipe was necessary to SJL's completion of RCP. Although the RCP contract set a completion date of May 3, 2011, SJL was still working to complete the contract. By November 2011, the work on the project was ongoing as evident by the punch list (Tr. 116-117, 270).

The placement of the plug in the connecting line and its removal was an integral part of SJL's work to upgrade by slip lining the existing sewer line. It allowed SJL to install the slip lining without being subjected to possible sewer gas and overflow from the adjacent sewer line. The plug removal was a "follow-up" to the construction work of relining the sewer line. Until the plug was removed, the project was ongoing and SJL had not completed its contractual obligations. SJL remained obligated to remove the plug (Exh. R-5; Tr. 120, 211, 271).

SJL had placed the plug in the connecting line in February 2011 during the slip lining work and remained responsible for its removal. North Texas, as the construction contractor, requested SJL to remove the plug, if still present, to open the connecting line to the adjacent sewer line.

The Secretary concedes that as part of RCP, SJL was "contractually obligated to place plugs to control flow and odor" and "to remove the plugs when necessary." The plugs were "a temporary measure which SJL would eventually need to remove" (Secretary's Brief, p. 4-5). Since SJL installed the plug to assist it in its slip lining process, SJL was responsible to remove it as part of its construction work.

The reference to OSHA's § 1910.146 *Confined Space* standards in SJL's written *Confined Space Entry Program* and its audits of work on the project do not render the standards applicable for enforcement purposes (Exhs. C-6, C-18). The *Program* provides that although § 1910.146 "excludes construction, it has set the tone for confined space entry in all industries, including construction" (Exh. C-6, p. 27). As explained by the SJL Field Safety Supervisor, "I put this regulation [§ 1910.146] because that is the only regulation that has any kind of safety practices for our workers" (Tr. 500). The framework of § 1910.146 was used by SJL to create its confined space program for its construction work. OSHA's Letter of Interpretation (July 10, 2006) provides that "[W]hile the scope of OSHA's general industry standard for confined spaces

excludes construction, one of the ways an employer can meet its General Duty Clause obligation for protecting against confined space hazards in construction is use procedures that accord with the general industry confined space standard at 29 C.F.R. § 1910.146."

Section 1910.146 confined space standards did not apply to SJL's plug removal work. Section 5(a)(1), as alleged by the Secretary in the alternative, is deemed applicable because the work was construction work and the Secretary lacks specific confined space standards for construction. [26]

SJL's Alleged § 5(a)(1) Violation

The Secretary's serious § 5(a)(1) alleges;

> S.J. Louis exposed its employees to the recognized hazards of asphyxiation when it allowed its employees to enter sewer manholes, a permit required confined space, without taking necessary precautions to ensure safe entry and rescue.

Section 5(a)(1) of the Act provides:

> Each employer -
>
> > (1) shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees.

The manhole at issue was confined space and, because it contained an active sewer line, there was potential exposure to an atmospheric hazard, *i.e.* H_2S. Under § 1926.21(b)(6)(ii), applicable to construction work, a "confined or enclosed space" is defined as:

> any space having a limited means of egress, which is subject to the accumulation of toxic or flammable contaminants or has an oxygen deficient atmosphere. Confined or enclosed spaces include, but are not limited to, storage tanks, process vessels, bins, boilers, ventilation or exhaust ducts, sewers, underground utility vaults, tunnels, pipelines, and open top spaces more than 4 feet in depth such as pits, tubs, vaults, vessels.

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[26] SJL's argument that § 5(a)(1) is preempted by § 1926.21(b)(6) is rejected because the §5(a)(1) allegation presents a different hazard (SJL's Brief, p. 11 fn 34). Section 1926.21(b)(6) requires employees in construction work who are required to enter confined or enclosed spaces receive training "as to the nature of the hazards involved, the necessary precautions to be taken, and the use of protective and emergency equipment required." The citation, as amended to allege a § 5(a)(1) violation, does not involve SJL's failure to train employees. The amended allegation involves SJL's failure to take "necessary precautions to ensure safe entry and rescue. *Ted Wilkerson, Inc.,* 9 BNA OSHC 2012 (No 13390, 1981). *Also, see* 29 C.F.R. § 1910.5(c).

The manhole's opening was 24 inches in diameter. The rubber plug was located at a ledge approximately 5 feet underground and above an open 5-foot active sewer line. SJL was aware of the potential presence of H_2S and low oxygen in an active sewer line and considered a manhole a confined space which contained potential atmospheric hazards (Tr. 130, 319). SJL's air monitoring prior to November 3, 2011, showed potential atmospheric hazards of H_2S and low oxygen levels (Exh. C-12; Tr. 134-135).

OSHA's definitions for "confined space" and "permit-required confined space" are adopted by SJL in its written *Confined Space Entry Manual*. The manual recognizes that a manhole is a confined space and provides that "[E]very confined space is considered to be a permit-required confined space until it can be demonstrated that the space has been evaluated and it has been determined that the space is unlikely to have potential hazards or the hazards have been eliminated" (Exh. C-6, pp. 26, 28, 29; (Tr. 133, 319).

To establish SJL's violation of § 5(a)(1), the

> Secretary must prove that (1) there was an activity or condition in the employer's workplace that constituted a hazard to employees, (2) the cited employer or the employer's industry recognized the hazard, (3) the hazard was causing or likely to cause death or serious physical harm, and (4) feasible means existed to eliminate or materially reduce the hazard. *Waldon Healthcare Center*., 16 BNA OSHC 1052, 1058 (No. 89-2804, 1993).

(1) <u>The Hazard</u>

A "hazard" is defined in terms of conditions or practices deemed unsafe over which an employer can reasonably be expected to exercise control. *Morrison-Knudson Co./Yonkers Contracting Co., A Joint Venture,* 16 BNA OSHC 1105, 1121-1122 (No. 88-572, 1993).

Exposure to H_2S and an oxygen-deficient environment were potential hazards inside a manhole for an active sewer line. SJL agrees that the manhole exposed employees to the potential hazards associated with H_2S and a low oxygen level (Tr. 321-322). The death of two employees from H_2S toxicity and asphyxia from a low oxygen level after entering the manhole demonstrates that a hazardous condition was present.

(2) <u>Recognized Hazard</u>

A hazard is deemed recognized when the potential danger of a condition or activity is either actually known to the particular employer or generally known in the industry *Pepperidge*

Farm Inc., 17 BNA OSHC 1993, 2003 (No. 89-0265, 1997). A recognized hazard is defined in terms of preventable consequence of the work operation.

The employees who entered the manhole were exposed to H_2S toxicity and asphyxia from a low oxygen level. Although SJL disputes that it knew the employees would enter the manhole, SJL clearly recognized the potential hazards of H_2S toxicity and asphyxia from low oxygen levels inside a manhole for an active sewer line. OSHA classifies H_2S as an air contaminant with an acceptable ceiling concentration of 20 ppm and an acceptable maximum peak for an 8-hour shift of 50 ppm for 10 minutes. See § 1910.1000 Table Z-2. After three hours with an open manhole, the fire department recorded an H_2S reading of 60 ppm and an oxygen level of 5% (Exh. C-2).

SJL recognized that the manhole contained the potential for atmospheric hazards. The Safety Director conceded that the H_2S hazard inside the manhole was recognized by the underground utility contractor industry (Tr. 325).

(3) Hazard Was Likely to Cause Death or Serious Physical Harm

The record shows that employees' exposure to H_2S toxicity and a low oxygen level in a manhole was likely to cause death or serious harm. SJL does not dispute that entering a manhole without conducting pre-entry air monitoring and not wearing proper protective equipment constitutes a recognized hazard that is likely to cause serious harm (Tr. 321-322). The *Manual* acknowledges that working in a confined space and the potential exposure to H_2S could have health consequences and even cause death (Exh. C-6, p. 35). SJL's training materials state that 63 people die each year as a result of working in confined spaces (Exh. C-16; Tr. 313). On November 3, 2011, the two employees who entered a manhole with an active sewer line died from H_2S toxicity and asphyxia for a low oxygen level.

(4) Feasible Means to Eliminate Or Materially Reduce the Hazard

As the final element of a § 5(a)(1) violation, the Secretary must show that the proposed abatement will eliminate or materially reduce the hazard. *Cardinal Operating Company,* 11 BNA OSHC 1675, 1677 (No. 80-1500, 1983). The proposed abatement measures are judged by what a reasonable person familiar with the conditions in the industry would have instituted.

The citation identifies the following "[F]easible and acceptable abatement methods to correct this hazard include, but are not limited to:

1. Implement the measures necessary to prevent unauthorized entry;
2. Identify and evaluate the hazards of permit spaces before employees enter them;
3. Review the permit space program, using the canceled permits and revise the program as necessary to ensure that employees participating in entry operations are protected from permit space hazards;
4. Ensure that the entry permit identifies the measures used to isolate the permit space and to eliminate or control permit space hazards before entry;
5. Ensure that the entry permit identifies the rescue and emergency services that can be summoned and the means for summoning those services;
6. Ensure that the entry permit identifies equipment, such as personal protective equipment, testing equipment, communications equipment, alarm systems, and rescue equipment, to be provided; and,
7. Evaluate a prospective rescuer's ability to respond to a rescue summons in a timely manner, considering the hazard(s) identified."

There is no dispute that the means of abatement identified by OSHA are available to SJL and, if followed, would reduce or eliminate the hazard of H_2S toxicity and low oxygen level if employees worked in a manhole at an active sewer line. SJL's *Confined Space Entry Manual* states that "[b]y testing the atmosphere, implementing your company confined space entry plan and preparing for emergencies, you can reduce the unforeseen dangers of confined space entry" (Exh. C-6, p. 24). SJL's written confined space entry procedures would have abated the hazards if implemented at the manhole worksite.

The manhole was at an active sewer line. The crew saw and smelled "fumes." Despite these warnings, the crew leader entered the manhole without performing air monitoring; without completing a confined space entry permit; without placing an air hose in the manhole to force in air; and without wearing proper personal protective equipment (Tr. 25-26).

The elements of a § 5(a)(1) violation are established.

SJL's Knowledge

A general duty clause violation under § 5(a)(1) requires the Secretary to also show that the employer knew or with the exercise of reasonable diligence could have known of the violative condition. *Active Oil Service, Inc.*, 21 BNA OSHC 1184, 1186 (No. 00-0553, 2005). To establish this element, the actual or constructive knowledge of a supervisor is generally

imputed to the employer based on a supervisor's assumed delegated authority. However, when the violative conduct is committed by the supervisor, the Secretary has the burden of showing the supervisor's conduct was "foreseeable" in order to impute his knowledge. *W.G Yates & Sons Construction, Co.*, 459 F.3d 604, 608-609 (5th Cir. 2006) (supervisor's malfeasance is imputed to an employer where the employer's lack of sufficient safety policy, training, and discipline makes the supervisor's conduct in violation of the policy foreseeable).[27]

SJL argues the Secretary failed to show that the company should have foreseen its procedures would not be followed by the crew leader's entry into the manhole. According to SJL, the crew leader was sent to the site to locate the plug and to evaluate the worksite. He was not instructed to enter the manhole (Tr. 136, 205).

SJL's argument that the crew leader's conduct was not foreseeable and not imputed is rejected. The knowledge of the violative condition is imputed to SJL based on the knowledge of his supervisors, the Vice President and the Project Coordinator, who instructed the crew leader's work at the manhole. His supervisors should have known with the exercise of reasonable diligence of the crew leader's unsafe conduct. Because of their vague and inadequate instructions, it was foreseeable that the crew leader would enter the manhole without adequate precautions.

On November 2, 2011, the Vice President identified the crew leader as available to handle the odor complaint from North Texas. He testified that he directed the Project Coordinator to instruct the crew leader "to run by there and take a look, find out where the plug is, find out what we needed to do to get in there, and we would schedule a crew to do it" (Tr. 206). He asked the Project Coordinator to have the crew leader perform an evaluation of the worksite to determine whether the sewer line was "plugged" and, if so, what equipment and procedures would be needed to remove the plug. Clearly SJL would have known how to remove the plug because SJL had installed the plug in February 2011.

The Project Coordinator did not testify. In his Declaration, the Project Coordinator stated that he telephoned the crew leader after the conversation with the Vice President and told him

[27] The Commission applies the precedent of the circuit where a decision would probably be appealed, even though it may differ from Commission precedent. *Kerns Brothers Tree Service*, 18 BNA OSHC 2064, 2067 (No. 96-1719, 2000).

"there was a plug in the manhole in the backyard at the end of County Road 321. [Crew leader] asked me, 'Will we need to get into the manhole to remove the plug?' I answered, 'I don't know." (Exh. C-7). The Project Coordinator affirmed that he never told the crew leader "that he should go in the manhole. Nor did I ever tell [crew leader] at any time that he would not need equipment."[28]

The supervisors' instructions to the crew leader were vague and ambiguous. At the time of their conversations, the Vice President and Project Coordinator knew that the manhole was probably at an active sewer line because SJL had completed the slip lining installation. They knew the manhole was a confined space and that H_2S was an inherent hazard at an active sewer line. An evaluation would have involved the same H_2S issues which were present throughout the majority of RCP (Tr. 130-131). Despite their knowledge, there was no discussion with the crew leader regarding entry into the manhole other than "I don't know," the potential hazards associated with an active sewer line including H_2S exposure, the appropriate procedures and equipment to perform an "evaluation" or if he should remove the plug.

The crew leader had not previously performed hazardous confined space work at RCP (Tr. 168). Instead, the crew leader was assigned to maintenance and landscaping tasks such as removing and installing plants (Tr. 157-158). He was not authorized to enter a manhole with a hazardous atmosphere and was not cleared to use the required breathing equipment. The crew leader had not been fit tested to wear a respirator (Tr. 512-513). He was not authorized to perform permit-required confined space jobs (Tr. 166). Also, the crew leader's equipment trailer with the necessary confined space entry and rescue equipment had broken down the day before the accident (Tr. 25).

Further, the Vice President testified that "It wouldn't have surprised me had [the crew leader] decided to pop the lid and evaluate" the manhole even though it was outside his instruction. The Vice President was not surprised "because of us having been on that job for those two miles prior" (Tr. 209).

The 12-inch connection line with the plug was approximately 5 feet below the surface. There is no showing that the plug could be seen from outside the manhole. To remove the plug,

[28] The Declaration of the Project Coordinator was admitted under Rule 801(d)(2), Federal Rules of Evidence and given weight as an admission of a supervisor. The Declaration was prepared by SJL and given to OSHA (Tr. 139).

it needed to be deflated (Tr. 266). The removal of the plug on November 18, 2011, was done inside the manhole (Exh. C-25).

The Project Coordinator's conversation with the crew leader failed to specifically instruct him not to enter the manhole or remove the plug, although the crew leader asked. As advised by the Vice President, the Project Coordinator also told the crew leader to contact North Texas. In his conversation with the North Texas Senior Inspector, the crew leader informed him that he was going to the site and check it out (Tr. 275). The Senior Inspector told the crew leader that "If you go out there and find it [plug] and you all take it out, give me a call" (Tr. 276). He testified that "Well, if I told him to go and the plug was still there, I'm sure I asked him to remove it if it was there. It wouldn't do any good just to go look at it" (Tr. 282). Although North Texas was not the crew leader's employer, the crew leader was instructed to contact North Texas, thus adding to the confusion of his assignment.

Based on vague and ambiguous instructions and the crew leader's lack of proper equipment, SJL's should have known with the exercise of reasonable diligence of the crew leader's unsafe entry into the manhole.

The Secretary has met her burden of establishing SJL's violation of § 5(a)(1) of the Act unless SJL can show unpreventable employee misconduct.

Employee Misconduct Defense

As an affirmative defense, SJL argues that the crew leader's entry into the manhole was unpreventable employee misconduct. In order to establish the defense, SJL must show that it has (1) established work rules designed to prevent the violation, (2) adequately communicated these rules to its employees, (3) taken steps to discover violations, and (4) effectively enforced the rules when violations are discovered. *American Sterilizer Co*., 18 BNA OSHC 1082, 1087 (No. 91-2494, 1997).

According to SJL, employees are provided training and education concerning the hazards associated with confined space work (Exhs. R-7, R-8, C-16; Tr. 311). It trains employees to treat every confined space as a potentially permit required until it is evaluated and determined otherwise (Tr. 317). On September 17, 2011, less than two months before the accident, SJL held confined space field safety training that included the use of gas monitors and other equipment necessary for confined space entry and non-entry rescue. The September 17 training was attended by the crew leader and crew (Exh. R-6; Tr. 388). SJL maintains that the crew leader

was never observed performing unsafe acts (Tr. 190). He was observed using air monitoring equipment and completing confined space permits (Tr. 40-41).

On approximately October 3, 2011, the crew leader informed SJL that his crew could not do the sewer line work after he evaluated the conditions and found that the manhole contained a hazardous environment. The crew leader reported to SJL that there was a blockage and a fit-tested crew needed to perform the repair (Tr. 150-151, 191, 223, 403). SJL claims that based on this incident, SJL trusted the crew leader to provide the level of detail needed to evaluate the manhole so that a proper crew could be assigned to remove the plug.

SJL's employee misconduct defense is rejected. SJL acknowledges that the crew leader was a supervisor and part of "management" although at the lowest level (SJL's Brief, p. 17). The crew leader had worked for SJL for approximately 8 years and had in excess of 20 years of experience in the underground utility industry (Tr. 208).

There is no dispute that the crew leader's entry into the manhole was improper. He failed to complete the confined space permit; failed to monitor for atmospheric hazards; failed to wear proper PPE; and failed to set up the proper non-entry rescue equipment (SJL's Brief, p. 21-22; Tr. 26, 370-371). SJL concedes that "both employees entered the manhole in a manner that clearly violated Respondent's strict Company policy on confined space entry and/or rescue" (SJL's Brief, p. 1-2).

As discussed, SJL's instruction to evaluate the manhole was vague and ambiguous. When the crew leader asked if he needed to enter the manhole, the Project Coordinator merely answered "I don't know." There is no record that the crew's work was audited by SJL and that the employees were subject to disciplinary actions (Tr. 334-335, 346, 427). SJL was unable to show that any tool box talks involving confined space hazards were given to the crew (Tr. 339, 362-363). The testimony of the helper shows that the crew never considered the manhole a confined space or that there was a potential for H_2S or low oxygen hazards despite observing and smelling sewer odor. The placard at the manhole warned the crew that the sewer was active.

The crew leader had a working 4-gas monitor and a confined space permit form in his truck (Exh. R-9; Tr. 194, 409-410, 493). Despite having the monitoring equipment in his truck, there was no attempt to test the atmosphere at the manhole. The crew leader's entry into the manhole was made without proper protective precautions. He entered the manhole to evaluate or to remove the plug without the necessary equipment to perform the task. Despite any training,

he entered the manhole without considering the manhole a confined space and without verifying the atmospheric hazards of an active sewer.

The crew leader exhibited no understanding of proper confined space entry and rescue procedures. ``Where a supervisory employee is involved, the proof of unpreventable employee misconduct is more rigorous and the defense is more difficult to establish since it is the supervisor's duty to protect the safety of employees under his supervision . . . . A supervisor's involvement in the misconduct is strong evidence that the employer's safety program was lax." *Archer-Western Contractors Ltd.*, 15 BNA OSHC 1013, 1017 (No. 87-1067, 1991). The fact that a supervisor would feel free to breach a company safety policy is strong evidence that the implementation of the policy is lax. *United Geophysical Corp.,* 9 BNA OSHC 2117, 2123 (No. 78-6265, 1981).

The other two employees on site also showed no understanding of the potential atmospheric hazards in a confined space. The helper testified that he did not know about H_2S (Tr. 25-26). He further testified that the crew leader would not normally have a discussion about emergency rescue procedures at the job (Tr. 32). The finisher died apparently attempting a rescue by entering the manhole without proper rescue equipment. The crew's job on RCP did not involve confined space entry. It was a small support crew involved in erosion control, clearing, landscaping, and maintenance work (Tr. 189).

SLJ's employee misconduct is not established.

Serious Classification

The Secretary properly classified the § 5(a)(1) violation as serious. A serious violation under § 17(k) of the Act is established when there is a substantial probability of death or serious physical harm that could result from the cited condition and the employer knew or should have known of the violative condition. 29 U.S.C. § 666(k).

As discussed, SJL should have known that the crew leader would fail to follow proper confined space procedures based on ambiguous and unclear instructions. The death of two employees on November 3, 2011, shows that the failure to make a proper confined space entry or rescue may result in death or serious injury.

Penalty Consideration

Section 17(j) of the Act requires that when assessing penalties, the Commission must give due consideration to four criteria: (1) the size of the employer's business, (2) the gravity of

the violation, (3) the good faith of the employer, and (4) the prior history of violations. 29 U.S.C. § 666(j). The gravity of the violation is the primary consideration in assessing penalties. *Trinity Industries, Inc.,* 15 BNA OSHC 1481, 1483 (No. 88-2691, 1992).

SJL is a large company with approximately 300 employees. SJL is entitled to credit for history because of a lack of a serious citation within the past three years. SJL is also entitled to good faith credit based an adequate safety program including a written confined space program, a full time safety director, and regular training.

A penalty of $5,000.00 is reasonable for SJL's serious violation of § 5(a)(1). There were three employees exposed to the hazards associated with improper confined space entry and rescue. The crew failed to exhibit any understanding or appreciation of confine space hazards. Two employees including the crew leader died of H_2S toxicity and asphyxia from a low oxygen level.

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) of the Federal Rules of Civil Procedure.

ORDER

Based upon the foregoing decision, it is ORDERED:

1. Citation No. 1, item 1, alleged serious violation of § 1910.146(d), is vacated as not applicable;
2. Citation No. 1, item 2, alleged violation of § 1910.146(f), is vacated as not applicable;
3. Citation No. 1, item 3, alleged violation of § 1910.146(k)(1)(i), is vacated as not applicable; and
4. Citation No. 1, item 1, in the alternative, alleged violation of § 5(a)(1) is affirmed and a penalty of $5,000.00 is assessed.

/s/
Ken S. Welsch
Judge

Date: March 25, 2013
Atlanta, Georgia