

**THIS CASE IS NOT A FINAL ORDER OF THE REVIEW COMMISSION AS IT IS PENDING COMMISSION
REVIEW**

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 (H₂S) 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 H₂S and 5% for oxygen. Normal readings are 20.9% for oxygen and zero for H₂S. SJL's *Confined Space Entry Program* advises that an oxygen level of 6% or less "respiration ceases, coma, fatal within minutes" and that H₂S 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).¹

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).

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

¹ 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.

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.²

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.* H₂S. 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.

² 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 H₂S 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 H₂S 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) The Hazard

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 H₂S 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 H₂S and a low oxygen level (Tr. 321-322). The death of two employees from H₂S toxicity and asphyxia from a low oxygen level after entering the manhole demonstrates that a hazardous condition was present.

(2) Recognized Hazard

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 H₂S 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 H₂S toxicity and asphyxia from low oxygen levels inside a manhole for an active sewer line. OSHA classifies H₂S 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 H₂S 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 H₂S 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 H₂S 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 H₂S 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 H₂S 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 H₂S 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).³

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 "there was a plug in the manhole in the backyard at the end of County Road 321. [Crew leader]

³ 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).

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.”⁴

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 H₂S was an inherent hazard at an active sewer line. An evaluation would have involved the same H₂S 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 H₂S 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, it needed to be deflated (Tr. 266). The removal of the plug on November 18, 2011, was done inside the manhole (Exh. C-25).

⁴ 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).

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 H₂S 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 H₂S (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 on 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 confined space hazards. Two employees including the crew leader died of H₂S 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