

Some personal identifiers have been redacted for privacy purposes.



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.

OSHRC Docket No. 19-0372

P.M.I. INTERNATIONAL STONE  
IMPORTERS,

Respondent.

Appearances:

Elena S. Goldstein, Deputy Solicitor of Labor  
Jeffrey S. Rogoff, Regional Solicitor  
Matthew M. Sullivan, Senior Trial Attorney  
U.S. Department of Labor, Office of the Regional Solicitor, New York, NY  
For the Complainant

Michael Gaviria, *pro se*  
Marlboro, NJ  
For the Respondent

Before: Covette Rooney, Chief Administrative Law Judge

**DECISION AND ORDER**

Respondent, P.M.I. International Stone Importers (“PMI”), is a company “engaged in [the] business of buying and selling stone slabs which are shipped to [R]espondent from various international locations” with its principal office and place of business located in Marlboro, New Jersey. (Joint Pre-Hr’g Statement ¶ 4.1). Following a worker’s injury on September 4, 2018, the local police referred the matter to the Occupational Safety and Health Administration (“OSHA”) for investigation. (*Id.* at ¶¶ 4.2 & 4.3) On February 20, 2019, OSHA’s investigation resulted in

the issuance of a one-item citation (the “Citation”) to Respondent, alleging a serious violation of section 5(a)(1) of the Occupational Safety and Health Act of 1970, 29 U.S.C. §§ 651-678 (the “Act”). Specifically, the Citation alleged that Respondent’s employees were “exposed to struck-by, caught in between and crushed-by hazards while they worked consistently within the fall shadow of approx. 7000 lb. bundles o[f] stone slabs without protection of bracing or supports.” (Citation at 6). The Citation proposed a penalty of \$5,304. (*Id.* at 7).

On February 28, 2019, Respondent timely filed a notice of contest, thereby bringing this matter before the Occupational Safety and Health Review Commission (the “Commission”). *See* 29 U.S.C. § 659(c). A one-day hearing was held on November 9, 2020, by way of Cisco WebEx videoconferencing technology.<sup>1</sup> The Secretary presented two witnesses: 1) the injured worker, [redacted] ; and 2) the Compliance Safety and Health Officer (“CO”) who investigated the accident, Brian Crain.<sup>2</sup> Respondent was represented by its president, Michael Gaviria, who cross-examined the Secretary’s witnesses but did not present a case-in-chief.<sup>3</sup> The Secretary filed a post-hearing brief; Respondent did not.

For the reasons that follow, the Citation is affirmed as a serious violation of section 5(a)(1) of the Act,<sup>4</sup> and a penalty of \$5,304 is assessed.

## I. Jurisdiction

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<sup>1</sup> As the undersigned noted at the start of the hearing, the ongoing COVID-19 pandemic left the availability of physical courtroom space unclear for the foreseeable future. (Tr. 4-5). The undersigned finds that the use of the WebEx technology did not deprive either party of its ability to effectively present its case, nor did it hinder the undersigned from effectively assessing the demeanor of the witnesses or examining the documentary evidence.

<sup>2</sup> Both witnesses testified succinctly, credibly, and without hesitancy, and their testimonies are therefore given significant weight.

<sup>3</sup> Mr. Gaviria joined the videoconference without a video feed but otherwise fully participated in the hearing.

<sup>4</sup> Section 5(a)(1) of the Act is commonly referred to as the “general duty clause.”

The parties stipulated that Respondent is engaged in a business affecting commerce and an employer within the meaning of sections 3(3) and 3(5) the Act, 29 U.S.C. §§ 652(3) & (5), and consented to the Commission’s jurisdiction over this proceeding. (Joint Pre-Hr’g Statement ¶¶ 5.1 & 5.2). The Commission’s jurisdiction is supported by the record. (Joint Pre-Hr’g Statement ¶¶ 4.1, 4.2, & 4.13).

## **II. Background<sup>5</sup>**

### **A. P.M.I. International Stone Importers**

Respondent is a company “engaged in [the] business of buying and selling stone slabs which are shipped to [R]espondent from various international locations.” (Joint Pre-Hr’g Statement ¶ 4.1). Mr. Gaviria has been the president of Respondent for 30 years. (Gaviria Dep. 8).<sup>6</sup> At the time the Citation was issued, Respondent employed no more than 25 employees.<sup>7</sup> The following five employees were identified at the hearing and are relevant to the events leading to the issuance of the Citation:

(1) [redacted] was a warehouse worker who had worked for Respondent for seven years. (Tr. 16). [redacted] started as a warehouse cleaner but, after working at PMI for three or four years, took on other duties such as sealing stone slabs and assisting in unloading stone slab bundles from shipping containers. (Tr. 16-17; [redacted] Dep. 8-9). Over his seven years working for Respondent, [redacted] assisted in unloading “hundreds” of shipping containers containing stone

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<sup>5</sup> The parties stipulated to thirteen factual matters touching upon disparate issues. (Joint Pre-Hr’g Statement ¶¶ 4.1 - 4.13). Rather than being set forth in their entirety, the stipulated facts will be referenced as necessary in discussing the background of the case.

<sup>6</sup> The deposition excerpts submitted by the Secretary were admitted as Exhibits C-58 to C-61 but will be referenced by the name of the deponent.

<sup>7</sup> The CO indicated that he reduced the proposed penalty by 60% based on Respondent’s size. (Tr. 183). According to the OSHA Field Operations Manual (“FOM”) (Directive CPL 02-00-163) (2019), Chapter 6, VI.B., at 6-9, effective at the time of the accident, the CO’s reduction would suggest Respondent had between 11 and 25 employees. In addition to the employees directly identified at the hearing, [redacted] testified there were four warehouse workers and one or two drivers employed by Respondent. (Tr. 17-18).

slab bundles. (Tr. 32-33, 70-71; [redacted] Dep. 22). [redacted] was the employee injured in the accident leading to the issuance of the Citation (Joint Pre-Hr'g Statement ¶ 4.4);

(2) Christopher Solan was another warehouse worker who also assisted in unloading bundles of stone slabs from shipping containers (Tr. 32; Solan Dep. 10). Mr. Solan was working with [redacted] in the same container when the accident occurred;

(3) Kevin Maher was the warehouse manager and Mr. [redacted] 's direct supervisor (Tr. 31). Mr. Maher was operating the forklift being used to unload the bundles from the shipping container. (Tr. 31);

(4) Christopher Hankins was Respondent's operations manager to whom Mr. Maher reported and who reported to Mr. Gaviria (Tr. 31-33; Hankins Dep. 7); and

(5) Brian Brown was Respondent's safety manager (Tr. 34, 47-48, 113-15).

## **B. Stone Bundles and the Fall Shadow Hazard**

One of Respondent's regular business activities involves unloading "bundles" of stone slabs from shipping containers into its warehouse. (Tr. 32-33, 70-71; Hankins Dep. 8; [redacted] Dep. 22; Solan Dep. 28-29). The bundles are delivered to Respondent in quantities of six or seven per container, with each individual bundle weighing as much as 7,000 or 8,000 pounds. (Tr. 88, 121; Gaviria Dep. 48; *see also* Exs. C-50 p.1, C-51 p.1). An individual bundle can be six to eight feet high, five to seven feet wide, and vary in thickness depending on the type of stone. (Tr. 28-29; Ex. C-2).

The bundles arrive at Respondent's warehouse in a small shipping container, which is approximately the height of the stone bundles, i.e., approximately six to eight feet high. (Tr. 28-29; Exs. C-1, C-2, C-17). Typically, the bundles are arranged in the container in two rows of three bundles each. (Tr. 23-26; Gaviria Dep. 48; Ex. C-55). The bundles are "interlocked" inside the

container, such that, if the container is viewed facing the front, the bundle on the far right would touch the front wall of the container, the next bundle would touch the back wall of the container, and so forth.<sup>8</sup> (Tr. 36-37; [redacted] Dep. 27-28; Ex. C-55). This interlocking provides some protection from the bundles falling during shipment and while unloading the bundles. (Tr. 37; [redacted] Dep. 27-28). Additionally, however, the bundles are packed with wooden “bracing,” which holds the bundles upright. (Tr. 29-30, 35-36; Gaviria Dep. 46-48). The bracing is physically attached to the bundles and the container and must be removed to unload the bundles. (Tr. 29-30, 35-36; Gaviria Dep. 48).

The unloading of stone bundles poses a safety hazard with regard to an unsecured bundle’s “fall shadow.” (Joint Pre-H’rg Statement ¶ 4.9; Tr. 51-52, 133; Gaviria Dep. 40-42; [redacted] Dep. 17-18). Respondent’s “Stone Slab Handling & Storage Safety Plan” defines the fall shadow as follows:

[T]he region swept by a slab during its toppling movement from vertical to when it stops falling. The term is used to include the complete slab and any pieces if it breaks. The term is relevant when slabs are not restrained or there is a potential for restraints to fail, (Wood supports, Strapping, etc.). “Fall shadow” is the minimum danger zone derived from the actual slab dimensions. Additional clearance around that zone must be considered and applied. The “Fall Shadow” will move with the slab/s when it’s moved by a forklift and/or by cranes.

The “Fall Shadow” may be less than the area above when there is a barrier that the slab will strike thru its fall. This barrier may be the wall of the container itself, an adjacent A-Frame or a structure put in place to limit the amount of vertical falling (Rack Systems).

(Ex. C-47 p. 8; *see also* Joint Pre-H’rg Statement ¶ 4.9).

In short, a bundle’s fall shadow is the area where an upright, unsecured bundle could potentially fall and thereby injure a worker. (Tr. 51-52, 61, 198; Ex. C-57). The fall shadow of an unsecured

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<sup>8</sup> [redacted] ’s drawing of a bird’s eye view of a packed container, Exhibit C-55, is particularly illustrative of the interlocking of the bundles.

bundle presents a crushed-by, struck-by, or caught-in-between hazard<sup>9</sup> for a worker located in the bundle’s fall shadow. (Tr. 108-09, 160-61, 172; Exs. C-50 p.1, C-51 p.1, C-52 p.1). Generally, the fall shadow for an unsecured bundle is coterminous with the area of the bundle itself. (Tr. 51-52, 198; [redacted] Dep. 17-18; Solan Dep. 18-19; Ex. C-52 p.1). However, the fall shadow could also be slightly larger if the bundle shatters when it falls or smaller if there is an object in the shadow that could limit the range of toppling. (Joint Pre-H’rg Statement ¶ 4.9; Tr. 198; Ex. C-52 p.1).

### C. PMI Safety Program and Practices

#### i. *Safety Program and Training*

To address the hazard posed by the fall shadow when unloading bundles, Respondent had, at the time of the accident, a written safety program comprised of two documents: 1) a 10-page “Stone Slab Handling & Storage Safety Plan” (“Safety Plan”); and 2) a 3-page “Health and Safety Solution” (“Safety Solution”) from a company called “WorkSafe Victoria.” (Tr. 152, 157-60; Exs. C-47, 53). Both documents recognize the existence of the hazard posed by the fall shadow when unloading stone bundles and set forth methods to address the hazard. (Exs. C-47 p. 8, C-53 pp. 1-2). More specifically, the Safety Plan states “[b]efore [s]tone crates are released from transit restraints, ensure that no person/s are in the ‘Fall Shadow’ of any Crates and/or single/groups of slabs” and “[s]tone handling employees must guide stone crates and/or slabs from the end most distant from the forklift to ensure that workers remain outside the moving ‘Fall Shadow’ Area.” (Ex. C-47 p.8). Similarly, the Safety Solution states that “[b]efore stone slabs are released from

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<sup>9</sup> According to the CO, a struck-by hazard involves any object that might strike a worker while in motion. (Tr. 106). A caught-in-between hazard involves any standing object that could possibly topple and pin a worker between the wall or the floor. (*Id.* at 107). A crushed-by hazard involves something being lifted or moved that could potentially fall and crush an employee. (*Id.*). Although the three hazards are similar, they are each considered distinct workplace hazards. (*Id.* at 107-08).

any transport restraints, ensure that no person is in the fall shadow of any slabs or crates at any time” and “[w]orkers should guide stone slabs from the end most distant from the forklift using an appropriate method to ensure that workers remain outside the moving fall shadow.” (Ex. C-53 pp. 2-3). Both documents suggest the use of “temporary restraints”<sup>10</sup> to minimize the fall shadow hazard when unloading stone bundles. (Exs. C-47 p.8, C-53 p.2).

Respondent’s employees received both the Safety Plan and the Safety Solution as part of their training with Mr. Brown and Mr. Hankins. (Tr. 13-15, 33-34, 48-49, 87, 149; Solan Dep. 18, 71). In addition, the employees watched a safety video and received hands-on training in the warehouse. (Tr. 13-15, 33-34, 48-49, 149). The fall shadow hazard posed by unloading unsecured bundles was addressed by this training. (Solan Dep. 18, 71).

*ii. Respondent’s Actual Practices*

Despite purportedly requiring its employees to remain out of the fall shadow while moving stone bundles, Respondent’s actual activities did not follow the rules set forth in its training documents. Rather, Respondent’s employees unloaded shipping containers in the following way. First, the wooden transit bracing was removed from a bundle. (Tr. 29-30, 35-36; Gaviria Dep. 48). Next, a forklift was used to drag the bundle out of the container.<sup>11</sup> (Tr. 72; Hankins Dep. 8; [redacted] Dep. 17-18). For bundles in the front row, the bundle could be supported in between the forks of the forklift. (Tr. 31, 72). However, Respondent’s forklift could not reach into the back of the container. (Tr. 60-61, 72; *see also* Exs. C-4, 16). Thus, for the back row of bundles,

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<sup>10</sup> According to the Safety Plan, temporary restraints are “wood blocks, strapping etc., to limit vertical movement of crated slabs not be removed [sic].” (Ex. C-47 p. 8). According to the Safety Solution, temporary restraints are “straps, chains or purpose-made mechanical devices to restrain slabs that aren’t being removed and to limit movement of slabs being removed only to vertical.” (Ex. C-52 p. 2).

<sup>11</sup> Attached to the bottom of the bundles were “ski-style cleats” meant to aid in dragging the bundles from the container. (Tr. 73). According to [redacted], these “ski-style cleats” were “attached to the actual bundle itself, the legs or the wood” and were meant to “help pull the bundle out straight.” (Tr. 73; *see also* [redacted] Dep. 49 (describing the cleats as “[l]ong boards nailed into the bottom of the bundles to make it come out straight.”)).

the forklift was attached to the bundle by a cable and then dragged from the container. (Tr. 37-38, 140-46; Gaviria Dep. 36; [redacted] Dep. 65; Exs. C-23, C-24, C-26).

As part of the unloading process, Respondent instructed its warehouse employees to enter the container and help “guide” the bundle while it was being dragged by the forklift. (Tr. 41-44, 70, 87). The “guiding” process involved two employees placing their hands flat on the side of the bundle, following it while it was being dragged from the container, and alerting the forklift driver if there was any “pressure,” indicating the bundle was becoming unstable. (Tr. 70, 87, 91, 94). Respondent’s method for guiding the bundles placed the two employees in the container in the fall shadow of the moving bundle. (Tr. 42, 68-69, 76, 150, 162-63; Gaviria Dep. 42; [redacted] Dep. 18; Ex. C-57). Respondent did not direct its employees to use temporary restraints at any point of the unloading process.<sup>12</sup> (Joint Pre-H’rg Statement ¶ 4.13; Tr. 39-41, 46; Solan Dep. 44-45).

*iii. Respondent’s Practices Following the Accident*

Following the accident that led to the issuance of the Citation, Respondent has modified its practices for unloading bundles from shipping containers. Workers no longer place their hands on the side of the bundle in the fall shadow to guide it; rather, they now stand in front of the bundle, outside of the fall shadow. (Tr. 84). Additionally, Respondent now requires the use of temporary restraints while the bundle is being dragged with the forklift. (*Id.* at 83-84).

**D. The Accident and OSHA Inspection**

*i. The Accident*

The accident leading to the issuance of the Citation occurred on September 4, 2018. (Joint Pre-Hr’g Statement ¶ 2; Tr. 72, 109). On that day, Messrs. [redacted], Solan, and Maher were in

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<sup>12</sup> According to [redacted], Respondent possessed “hook straps,” which were used to restrain bundles once they had been unloaded from the shipping container, but warehouse workers did not employ them when unloading the bundles. (Tr. 40).

the warehouse unloading stone slab bundles from a shipping container. (Tr. 70-73). More specifically, Mr. Maher was operating the forklift used to drag the bundles, and Messrs. [redacted] and Solan were aiding him by guiding the bundles from inside the container. (Tr. 70, 72; [redacted] Dep. 20-21; *see also* Exs. C-1, 7, 16).

The container was a typically packed container, containing six interlocked bundles of stone. (Tr. 23-24, 71; [redacted] Dep. 31; Ex. C-55). Five of the six bundles were removed without incident. (Tr. 71). The final bundle to be removed was located in the back left corner of the container. (Tr. 23-24, 71; [redacted] Dep. 31; Ex. C-55). The fall shadow hazard posed by this bundle was particularly acute for at least three reasons. First, with the other bundles having already been removed, the final bundle received no additional support from the interlocking of the bundles. (Tr. 37; *see also* Gaviria Dep. 49). Second, the final bundle's fall shadow was far larger because it was furthest from the opposite wall of the container and thereby could potentially completely fall over inside the container. (Tr. 133; Ex. C-17). In other words, the fall shadow of the final bundle comprised the entire interior of the container. (Tr. 133; Ex. C-17). Finally, Respondent's forklift was unable to reach the back of the container. (Tr. 60-61, 72, 123-24; Ex. C-4). Thus, the final bundle needed to be dragged completely unsecured until it reached the front of the container, at which point it could be steadied between the forks of the forklift.<sup>13</sup> (Tr. 79; Gaviria Dep. 49; [redacted] Dep. 30, 54-55; Solan Dep. 42).

To remove the final bundle, [redacted] removed the wooden bracing from the bundle and attached "lancing" so that it could be dragged with the forklift. (Tr. 71-72; Exs. C-23, 24, 26). Thereafter, Mr. Maher slowly started to drag the final bundle with the forklift. (Tr. 72). As the

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<sup>13</sup> It is noted that the final bundle still has wooden bracing attached for support; however, this bracing must be removed before the bundle is unloaded from the container. (Tr. 29-30, 35-36; Gaviria Dep. 48).

bundle was being dragged out, Mr. Solan and [redacted] were directly next to each other with their palms flat on the right side of the bundle. (Tr. 70; [redacted] Dep. 20-21, 46-47; Ex. C-57). Mr. Solan was nearer to the front of the container and the front right corner of the bundle, while [redacted] was further inside the container, fully on the right side of the moving bundle. (Tr. 69-70; [redacted] Dep. 46-47; Ex. C-57). This positioning placed most of Mr. Solan's body in the fall shadow of the unsecured bundle and *all* of Mr. [redacted]'s body in the fall shadow.<sup>14</sup> (Tr 68-69, 73; [redacted] Dep. 17-18, 30-31; Ex. C-57).

As Mr. Maher continued to drag out the final bundle, [redacted] saw the ski-style cleats on the bundle get caught on a bump on the floor of the container. (Tr. 73-77). At this point, the bundle started separating from the cleats, which caused the bundle to become unsteady. (Tr. 73-74, 76; [redacted] Dep. 52-53). [redacted] indicated to Mr. Maher that the bundle was becoming unsteady and told him to stop dragging it from the container. (Tr. 74; [redacted] Dep. 53). However, Mr. Solan told Mr. Maher to continue dragging the bundle. (*Id.*; [redacted] Dep. 53). Evidently, Mr. Maher agreed with Mr. Solan and continued dragging the bundle. (Tr. 75; [redacted] Dep. 53). Just as the bundle neared the front of the container, it became more unsteady and started "twisting" inside the container. (Tr. 77-79; [redacted] Dep. 53-54; Ex. C-57). Soon after, the bundle started falling inward toward the right side of the container. (Tr. 77-78; [redacted] Dep. 54; Exs. C-17, 57). When it became apparent the bundle was going to fall, Mr. Solan managed to exit the container without being struck by the falling bundle. (Tr. 79; [redacted] Dep. 54; Solan Dep. 56-

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<sup>14</sup> There is some contrary evidence in the record on this point. In a portion of his deposition submitted by the Secretary, Mr. Solan stated that once Mr. Maher started dragging the bundle, he and [redacted] were "[n]ever on the side of it." (Solan Dep. 43). In Mr. Solan's telling, he was in front of the bundle with his right hand on the side, while [redacted] was "directly parallel [to him] doing the same thing with his hand." (*Id.* at 51-52). However, Mr. Solan's account of the workers' respective positions inside the container fails to explain how the fallen bundle was able to pin [redacted] to the side of the container if he was never positioned on the side of the bundle. (Tr. 56-63; Exs. C-17, C-57). Additionally, the undersigned was able to observe [redacted]'s demeanor at the hearing and found him to be a forthright and credible witness. No such opportunity was presented for Mr. Solan. The undersigned therefore credits [redacted]'s testimony over the account of Mr. Solan.

58). However, [redacted] was unable to exit the container quickly enough and was pinned between the fallen bundle and the container wall. (Joint Pre-Hr'g Statement ¶ 2; Tr. 79-81; [redacted] Dep. 54; Solan Dep. 56-58; Exs. C-17A, 57). Ultimately, [redacted] was able to be extracted from underneath the fallen bundle but suffered a “lower leg fracture”<sup>15</sup> as a result of the accident. (Joint Pre-Hr'g Statement ¶ 4; Tr. 81).

*ii. OSHA's Inspection*

Following the accident, the local police were called to the warehouse. (Joint Pre-H'r'g Statement ¶ 3; Tr. 109). Upon learning that it was a workplace accident, the police referred the matter to OSHA. (Joint Pre-Hr'g Statement ¶ 3; Tr. 109). OSHA assigned CO Crain to investigate the matter, and he did so on the same day. (Tr. 109).

After arriving at Respondent's warehouse, the CO first spoke briefly with Mr. Brown, Respondent's safety manager, but learned he had not witnessed the accident. (Tr. 113-15). The CO then investigated the scene of the accident and took several photographs of the warehouse, the forklift, the container, and the fallen bundle inside the container. (Tr. 115-16; Exs. C-1, 2, 4, 7, 16, 17, 18, 23, 24, 26). The CO met with Messrs. Gaviria, Brown, and Hankins, at which point he received Respondent's training documents and other safety materials. (Tr. 146-47). The CO also interviewed Mr. Solan in person and [redacted] over the phone. (Tr. 148-52).

After conducting his investigation and reviewing Respondent's training and safety materials, the CO concluded that Respondent's employees had been directed to “stabilize” unsecured bundles inside shipping containers while standing in the bundles' fall shadows. (Tr. 149-54). As a result of the CO's inspection, the Secretary issued Respondent the one-item serious Citation for a violation of the general duty clause.

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<sup>15</sup> [redacted]'s deposition testimony clarifies that he suffered a broken ankle. ([redacted] Dep. 58).

### **III. Analysis**

Respondent was cited with a violation of the general duty clause, which requires that each employer “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). To prove a violation of the general duty clause, the Secretary must show 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 likely to cause death or serious physical harm; and (4) a feasible means existed to eliminate or materially reduce the hazard.

*K.E.R. Enters.*, 23 BNA OSHC 2241, 2242 (No. 08-1225, 2013); *Pegasus Tower*, 21 BNA OSHC 1190, 1191 (No. 01-0547, 2005); *see also W. World, Inc.*, 604 F. App’x 188, 192-93 (3d Cir. 2015) (unpublished); *Babcock & Wilcox Co.*, 622 F.2d 1160, 1164 (3d Cir. 1980). The Secretary must also prove that the employer knew or, with the exercise of reasonable diligence, could have known of the hazardous condition. *Cranesville Block Co., Inc.*, 23 BNA OSHC 1977, 1985 (No. 08-0316, 2012) (consolidated); *Burford’s Tree, Inc.*, 22 BNA OSHC 1948, 1950 (No. 07-1899, 2010).

Here, the Secretary alleged that Respondent violated the general duty clause as follows:

The employer did not furnish employment and a place of employment which were free from recognized hazards that were causing or likely to cause death or serious physical harm to employees in that, employees were exposed to the hazard of being struck-by, caught in between and/or crushed by stone slabs: ...

Employees who remove bundles of stone slabs from shipping containers were exposed to struck-by, caught in between and crushed-by hazards while they worked consistently within the fall shadow of approx. 7000 lb. bundles of stone slabs without protection of bracing or supports.

The employer failed to implement an effective stone slab-handling program, which addressed and[/]or eliminated the practice of working in shipping containers within the fall shadow of unsupported slabs.

The Secretary set forth five feasible means of abatement:

- 1) Implement the requirements of the Marble Institute of America “Stone Industry Health and Safety Handbook” published 2014.
- 2) Implement the requirements/recommendations of the Marble Institute of America “Safety in the Stone Business” technical guide.
- 3) Implement the requirements/recommendations of the Marble Institute of America “Safe Stone Handling II” video.
- 4) Implement the requirements/recommendations of the Marble Institute of America “Slab Clamp Safety” video.
- 5) Implement the requirements/recommendations of OSHA Safety and Health Information Bulleting SHIB 08-12-2008 “Hazards of Transporting, Unloading, Storing and Handling Granite, Marble and Stone Slabs.

Although Respondent did not put forth any evidence at trial to rebut the Secretary’s case, the Secretary nonetheless bears the burden of proof on each element of the violation by a preponderance of the evidence. *Trinity Indus., Inc.*, 15 BNA OSHC 1788, 1790 (No. 89-1791, 1992). As detailed below, the Secretary has met his burden on each element of his case.

#### **A. Existence of a Hazard**

To establish a violation of the general duty clause, the Secretary must first define the hazard at issue. *K.E.R. Enters.*, 23 BNA OSHC at 2242. “A safety hazard at the worksite is a condition that creates or contributes to an increased risk that an event causing death or serious bodily harm to employees will occur.” *Baroid Div. of NL Indus., Inc. v. Occupational Safety & Health Review Comm’n*, 660 F.2d 439, 444 (10th Cir. 1981). When the Secretary proceeds under the general duty clause he must define the hazard “in a way that apprises the employer of its obligations and identifies conditions or practices over which the employer can reasonably be expected to exercise control.” *Arcadian Corp.*, 20 BNA OSHC 2001, 2007 (No. 93-0628, 2004); *see also Waldon Health Care Ctr.*, 16 BNA OSHC 1052, 1060 (No. 89-2804, 1993) (consolidated) (“[W]hen the Secretary proceeds under the general duty clause, he must meet the same minimal criterion

regarding the nature of the alleged hazard as he does when promulgating a section 5(a)(2) standard.”). There is no requirement that there be a significant risk of the hazard coming to fruition, only that if the hazardous event occurs, it would create a significant risk of harm to employees. *Waldon Health Care Ctr.*, 16 BNA OSHC at 1060. The Commission has held that “the existence of a hazard is established if the hazardous incident can occur under other than a freakish or utterly implausible concurrence of circumstances.” *Waldon Health Care Ctr.*, 16 BNA OSHC at 1060, citing *Nat'l Realty & Constr. Co. v. Occupational Safety & Health Review Comm'n*, 489 F.2d 1257, 1265 n.33 (D.C. Cir. 1973).

The Citation framed the hazard here as “the hazard of being struck-by, caught in between and/or crushed by stone slabs.” (Citation at 1). The Citation further specified that Respondent’s employees were “exposed to struck-by, caught in between and crushed-by hazards while they worked consistently within the fall shadow of approx. 7000 lb. bundles o[f] stone slabs without protection of bracing or supports.”<sup>16</sup> (*Id.*).

The record evidence establishes the existence of the fall shadow hazard. [redacted] assisted other PMI workers to unload “hundreds” of unsecured bundles while working in the bundles’ fall shadows. (Tr. 32-33, 70-71; [redacted] Dep. 22). In his estimation, Mr. [redacted] personally observed “40-plus” bundles become unsteady inside their shipping containers while he was helping to unload them. (Tr. 42). He had been inside the container during “at least half” of these incidents. (*Id.*). [redacted] saw three bundles fall over completely inside their containers, and a number of others fall over partially. (Tr. 44). He also saw a number of bundles become unsteady under the same circumstances as the bundle that injured him, namely by getting “stuck” on the floor of the container. (Tr. 46). Although not with the frequency testified to by [redacted] ,

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<sup>16</sup> Hereafter collectively referred to as the “fall shadow hazard.”

Respondent's other employees had personally seen bundles become unsteady during the unloading process. (Gaviria Dep. 25-26; Hankins Dep. 18; Solan Dep. 31). Further still, Respondent's own training materials acknowledged the hazard associated with moving unsecured stone bundles. *See* Joint Pre-Hr'g Statement ¶¶ 4.8 & 4.9; Exs. C-47 p.6, C-52 p.1; cf. *Gen. Dynamics Land Sys. Div., Inc.*, 15 BNA OSHC 1275, 1285 (No. 83-1293, 1991) (employer's safety bulletins were evidence of its recognition of an existing hazard), *aff'd* 985 F.2d 560 (6th Cir. 1993) (table). Finally, the CO testified that he had investigated the worksite of another employer in the same industry as Respondent. (Tr. 108-09, 178). An employee of that employer was killed after being crushed by an unsecured stone slab. (Tr. 108-09, 178).

The Secretary has established the existence of the fall shadow hazard at Respondent's worksite.

## **B. Hazard Recognition**

The Secretary can establish hazard recognition either "by proof that a hazard is recognized as such by the employer or by general understanding in the employer's industry." *Integra Health Mgmt., Inc.*, No. 13-1124, 2019 WL 1142920, at \*7 (O.S.H.R.C., Mar. 4, 2019) (internal punctuation omitted). The Secretary argues that he has established both types of recognition here. Sec'y's Br. 23-26.

### *i. Respondent's recognition of the hazard*

With regard to an employer's recognition of a hazard, work rules and safety precautions taken by the employer are evidence that the employer recognized the hazard. *See Integra Health Mgmt., Inc.*, 2019 WL 1142920, at \*8 ("Work rules addressing a hazard have been found to establish recognition of that hazard."); *Waldon Health Care Ctr.*, 16 BNA OSHC at 1061 ("Commission precedent establishes that precautions taken by an employer can be used to establish recognition in conjunction with other evidence."). "While an employer's safety precautions alone do not

establish that the employer believed that those precautions were necessary for compliance with the Act ... precautions taken by an employer can be used to establish hazard recognition in conjunction with other evidence." *Beverly Enters, Inc.*, 19 BNA OSHC 1161, 1186 (No. 91-3144, 2000) (consolidated).

Here, the record demonstrates Respondent's recognition of the fall shadow hazard. Respondent's training materials both recognize and define the fall shadow hazard. Respondent's Safety Plan defines the fall shadow as follows:

[T]he region swept by a slab during its toppling movement from vertical to when it stops falling. The term is used to include the complete slab and any pieces if it breaks. The term is relevant when slabs are not restrained or there is a potential for restraints to fail, (Wood supports, Strapping, etc.). "Fall shadow" is the minimum danger zone derived from the actual slab dimensions. Additional clearance around that zone must be considered and applied. The "Fall Shadow" will move with the slab/s when it's moved by a forklift and/or by cranes.

The "Fall Shadow" may be less than the area above when there is a barrier that the slab will strike thru its fall. This barrier may be the wall of the container itself, an adjacent A-Frame or a structure put in place to limit the amount of vertical falling (Rack Systems).

(Ex. C-47 p. 8; *see also* Join Pre-Hr'g Statement ¶ 4.9).

Similarly, Respondent's Safety Solution document defines the "fall shadow" as "the region swept by a slab during its toppling movement from vertical to when it stops falling" and goes on to note that "[w]orkers have been trapped and crushed while unloading stone slabs ... often due to one or more slabs 'toppling' (i.e., falling from vertical)." (Ex. C-52 p.1).

Respondent's training materials also contain work rules designed to address the fall shadow hazard. Respondent's Safety Plan states "[b]efore [s]tone crates are released from transit restraints, ensure that no person/s are in the 'Fall Shadow' of any Crates and/or single/groups of slabs" and "[s]tone handling employees must guide stone crates and/or slabs from the end most distant from the forklift to ensure that workers remain outside the moving "'Fall Shadow' Area." (Ex. C-47

p.8). Similarly, the Safety Solution states that “[b]efore stone slabs are released from any transport restraints, ensure that no person is in the fall shadow of any slabs or crates at any time” and “[w]orkers should guide stone slabs from the end most distant from the forklift using an appropriate method to ensure that workers remain outside the moving fall shadow.” (Ex. C-53 pp. 2-3). Respondent’s employees were trained using both documents. (Tr. 13-15, 33-34, 48-49, 87, 149; Solan Dep. 18, 71). The fact that Respondent had work rules and safety protocols in place to address the fall shadow hazard is significant evidence of Respondent’s recognition of the hazard. *See Integra Health Mgmt., Inc.*, 2019 WL 1142920, at \*8 (employer’s work rule directed at workplace violence indicated employer recognized the hazard); *Waldon Health Care Ctr.*, 16 BNA OSHC at 1062 (employer’s safety manual which defined and set forth “precautionary steps” to prevent the hazard was evidence of employer’s recognition of the hazard); *Gen. Dynamics Land Sys. Div., Inc.*, 15 BNA OSHC at 1285 (safety bulletins issued by employer to employees was evidence of employer’s recognition of hazard).

The evidence also demonstrates that Respondent’s supervisory personnel recognized the fall shadow hazard. Mr. Hankins, Respondent’s operations manager, recognized the fall shadow hazard and identified the work rules designed to address it. (Tr. 31-33; Hankins Dep. 7, 21-22, 24-29). Likewise, Mr. Gaviria, Respondent’s president, recognized the existence of the fall shadow hazard. (Gaviria Dep. 16, 40-42). Because Respondent had “work rules addressing the hazard” and “through its supervisory personnel, otherwise recognized this hazard,” the Secretary has sufficiently established hazard recognition. *Integra Health Mgmt., Inc.*, 2019 WL 1142920, at \*8; *see also Beverly Enters, Inc.*, 19 BNA OSHC at 1186 (finding employer had actual recognition where “managers at the highest level of the corporation recognized the hazard posed”);

*Waldon Health Care Ctr.*, 16 BNA OSHC at 1061-62 (precautions taken by an employer can be used to establish recognition in conjunction with other evidence).

*ii. Industry recognition*

In his post-hearing brief, the Secretary also argues for a finding of industry recognition of the fall shadow hazard. Sec'y's Br. 24-26. For support, the Secretary relies on a publication from the Marble Institute of America ("MIA")<sup>17</sup> and OSHA's Safety Health and Information Bulletin ("SHIB") Number 08-12-2008. (Ex. C-50); *see also* Sec'y's Br. 25-26. As to the MIA publication, this publication was never offered into evidence and thus cannot support the Secretary's case.<sup>18</sup> As to the SHIB, which by its own terms "creates no new legal obligations" and is "advisory in nature," the undersigned does not find that it alone can establish industry recognition. *See Waste Mgmt. of Palm Beach, Div. of Waste Mgmt., Inc. of Fla.*, 17 BNA OSHC 1308, 1310 (No. 93-128, 1995) (the Commission relies on "safety experts familiar with the general workplace conditions or practice being charged" in determining whether there is industry recognition) *cf. Beverly Enters., Inc.*, 19 BNA OSHC at 1181 (recognizing that "voluntary industry codes and guidelines are evidence of industry recognition" but also relying on expert testimony to establish industry recognition); *Reynolds, Inc.*, 21 BNA OSHC 1581, 1584-85 (No. 05-0023, 2006) (ALJ referencing a SHIB along with a significant amount of other evidence to find industry recognition

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<sup>17</sup> At the hearing, the CO referenced publications and videos from the MIA in the context of feasible means of abatement. (Tr. 187-88). The CO apparently believed Respondent was a member of the MIA. (Tr. 200-201). However, Respondent's representative asserted (though he did not testify, since he was never under oath as a witness) that Respondent was *not* actually a member of the MIA, as the CO believed. (Tr. 156, 200-201). Because Respondent put forth no actual testimonial or documentary evidence on the issue, the record remains unclear as to Respondent's membership in the MIA.

<sup>18</sup> In referencing the MIA publication, the Secretary's brief alternatively cites to Exhibit C-46, which is not an admitted exhibit, and Exhibit C-47, which is PMI's "Stone Slab Handling & Storage Safety Plan." *See* Sec'y's Br. 25. The quotes attributed to Exhibit C-47 in this portion of the Secretary's brief do not appear anywhere in the document.

for a general duty clause violation). Because the only evidence of industry recognition submitted by the Secretary is the SHIB, the Secretary has failed to establish industry recognition of the hazard.

However, because the Secretary can establish hazard recognition by showing either the employer's recognition *or* industry recognition, he has sufficiently established this element of the violation. *See Integra Health Mgmt., Inc.*, 2019 WL 1142920, at \*8.

### **C. Death or Serious Physical Harm**

To determine whether a hazard is “causing or likely to cause death or serious physical harm” the Commission does not look to the likelihood of an accident or injury occurring, but whether, if an accident occurs, the results are likely to cause death or serious harm. *Babcock & Wilcox Co.*, 622 F.2d at 1164; *Beverly Enters., Inc.*, 19 BNA OSHC at 1188; *Waldon Health Care Ctr.*, 16 BNA OSHC at 1060; *R.L. Sanders Roofing Co.*, 7 BNA OSHC 1566, 1569 (No. 76-2690, 1979), *rev'd on other grounds*, 620 F.2d 97 (5th Cir. 1980).

The stone bundles Respondent’s employees handled weighed as much as 7,000 pounds. (Tr. 88; *see also* Ex. C-50 p.1 (recognizing that stone slabs can weigh thousands of pounds); C-51 p.1 (same)). The possibility of death or serious physical harm resulting from an employee being struck by a 7,000-pound bundle of stone is “supplied by [a] common sense understanding of physical law.” *Ill. Power Co. v. Occupational Safety & Health Review Comm'n*, 632 F.2d 25, 28 (7th Cir. 1980). Additional evidence in this record supports this commonsense conclusion. The CO testified that he had investigated the worksite of another employer in the same industry as Respondent. (Tr. 108-09, 178). An employee of that employer was killed after being crushed by an unsecured stone slab. (Tr. 108-09, 178). In the instant case, the accident from the falling bundle resulted in serious physical harm to [redacted] in the form of a broken bone. (Joint Pre-

Hr'g Statement ¶ 4.4); *see also Waldon Health Care Ctr.*, 16 BNA OSHC at 1060 n.6 (broken bones constitute serious physical harm even if a worker recovers with no permanent side effects). While not dispositive, the existence of an actual injury to employees from the cited hazard is evidence that the hazard presented a risk of death or serious physical harm. *See, e.g., Beverly Enters., Inc.*, 19 BNA OSHC at 1188-90 (citing actual back injuries suffered by the employer's workers as evidence that the hazard posed a risk of serious harm).

Additionally, Respondent's own training materials indicate that "a number of serious crushing incidents [involving stone slabs] ... have resulted in fatalities, amputations, and musculoskeletal injuries affecting the trunk, back, shoulders and arms." (Ex. C-52 p.1). Further still, according to OSHA SHIB 08-11-2008, at least 46 documented fatalities were associated with the handling of stone slabs from 1984-2006. (Ex. C-50 p.1); *see also MetWest, Inc.*, 22 BNA OSHC 1066, 1071 (No. 04-0594, 2007) (referencing an OSHA SHIB for a technical fact contained within it).

The Secretary has sufficiently established that the fall shadow hazard presented by the bundles was likely to cause death or serious physical harm.

#### **D. Feasible Means of Abatement**

To demonstrate a "feasible" means of abatement, the Secretary "must specify the proposed abatement measures and demonstrate both that the measures are capable of being put into effect and that they would be effective in materially reducing the incidence of the hazard." *Beverly Enters., Inc.*, 19 BNA OSHC at 1191. The Secretary must also show that the proposed abatement measures are economically feasible. *Waldon Health Care Ctr.*, 16 BNA OSHC at 1063.

As feasible means of abatement, the Citation set forth the following five methods:

- 1) Implement the requirements of the Marble Institute of America "Stone Industry Health and Safety Handbook" published 2014.

- 2) Implement the requirements/recommendations of the Marble Institute of America “Safety in the Stone Business” technical guide.
- 3) Implement the requirements/recommendations of the Marble Institute of America “Safe Stone Handling II” video.
- 4) Implement the requirements/recommendations of the Marble Institute of America “Slab Clamp Safety” video.
- 5) Implement the requirements/recommendations of OSHA Safety and Health Information Bulletin SHIB 08-12-2008 “Hazards of Transporting, Unloading, Storing and Handling Granite, Marble and Stone Slabs.”

In his post-trial brief, the Secretary specifically refers only to abatement method (2), implementing the recommendations of the MIA’s “Safety in the Stone Business” technical guide, and method (5), implementing the recommendations from OSHA SHIB 08-12-2008, as feasible means of abatement. Sec’y’s Br. 27-30. The Secretary has therefore abandoned any reliance on the rest of the abatement measures set forth in the Citation. *See Peacock Eng’g Inc.*, 26 BNA OSHC 1588, 1593 (No. 11-2780, 2017) (failing to consider abatement measures which were set forth in the citation but not addressed at the hearing); *cf. Ala. Power Co.*, 13 BNA OSHC 1240, 1246 (No. 84-357, 1987) (excluding abatement measure because it “would be unfair for us to find [a] violation for failing to institute [a] . . . method that was not raised [or] litigated below”). Furthermore, as laid out in note 18, *supra*, Exhibit C-46, which apparently was meant to be the MIA’s “Safety in the Stone Business” publication, was never offered into evidence.<sup>19</sup> Therefore, the abatement element of the Secretary’s case turns on the abatement methods set forth in OSHA SHIB 08-12-2008.

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<sup>19</sup> In passing, the Secretary cites a portion of the CO’s testimony for the assertion that “all five of the referenced publications [in the Citation] instruct stone industry employers to avoid fall shadow hazards by keeping employees away from and out of the fall shadow of unsecured slabs.” Sec’y’s Br. 28 (citing Tr. 186-89). However, of the publications listed in the Citation, only OSHA SHIB 08-12-2008 was offered into evidence. *See* Ex. C-50. The CO’s testimony as to the contents of documents not in the record will not be considered in support of the Secretary’s case. *See* Fed. R. Evid. 1002, 1003; 29 C.F.R. § 2200.71.

As a more specific proposed abatement measure, the Secretary points to the SHIB's admonition that employees should "[a]lways walk at the end of the slab. Never walk in the 'fall shadow' of a slab ... the 'fall shadow' is the area on both sides of the slab where the slab could land and topple, if it were to fall."<sup>20</sup> (Ex. C-50 p.5). The Secretary points out that Respondent already had such a rule in its training program and argues that mere enforcement of the rule by Respondent is therefore a feasible means of abatement. Sec'y's Br. 29 (citing Exs. C-47 p.8, C-52 p.2).

The Secretary's assertion that requiring workers to avoid a bundle's fall shadow altogether would materially reduce or even eliminate the risk of harm to those workers from the fall shadow hazard is a reasonable one, and there is no evidence in the record to undermine it. *Cf. Chevron Oil Co.*, 11 BNA OSHC 1329, 1334 (No. 10799, 1983) (finding that "[t]he presence of flotation devices in the water would materially reduce the likelihood of an employee drowning in the water."); *Nelson Tree Servs., Inc.*, No. 93-1665, 1994 WL 184445, at \*3 (O.S.H.R.C.A.L.J., May 9, 1994) ("Requiring workers not actually felling a tree, who may not be focused on felling conditions, to stay clear of the area in which felling operations are taking place, would plainly reduce the chance of injury to those workers."), *aff'd* 60 F.3d 1207, 1211 (6th Cir. 1995) ("[S]ubstantial evidence supports the administrative law judge's finding that there existed feasible means, which [the employer] could and should have taken, to eliminate or substantially reduce the hazard of being struck by a prematurely felled tree."). Indeed, Respondent's own training materials already required this practice as a means to reduce the risk of employee exposure to the fall shadow hazard. *Cf. Pelron Corp.*, 12 BNA OSHC 1833, 1837-38 (No. 82-388, 1986) (the

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<sup>20</sup> The Secretary also briefly mentions the use of temporary restraints. Sec'y's Br. 29. However, he has not cited to any portion of the SHIB which specifically mentions the use of temporary restraints.

Secretary failed to establish abatement measure of further training would materially reduce hazard where the employer’s “extensive” training program was already being fully enforced).

The Secretary has further shown that this proposed abatement measure is practically and economically feasible. As noted by the Secretary, Respondent already had included this abatement measure in its training materials. (Exs. C-47 p.8; C-52 p.2). Moreover, after the accident at issue here, Respondent actually implemented the Secretary’s proposed measure. Respondent now prohibits its employees from guiding bundles out of the container while in the fall shadow. (Tr. 83-84, 189-90). Instead, employees are positioned in front of the bundle with their bodies outside of the fall shadow. (*Id.*). This post-accident implementation demonstrates that the proposed abatement measure is feasible. *See Sci. Applications Int’l Corp.*, No. 14-1668, 2020 WL 1941193 at, \*8 (O.S.H.R.C., Apr. 6, 2020) (post-accident implementation of proposed abatement methods demonstrated feasibility).

The Secretary has sufficiently established a feasible means of abatement.

## **E. Knowledge**

The Secretary can establish Respondent’s knowledge of a general duty clause violation by establishing either its actual knowledge of the hazard or its constructive knowledge such that it could have learned of the hazard with the exercise of reasonable diligence. *Otis Elevator Co.*, 21 BNA OSHC 2204, 2207 (No. 03-1344, 2007); *Tampa Shipyards Inc.*, 15 BNA OSHC 1533, 1537 (No. 86-360, 1992) (consolidated). The Secretary argues that he has established both actual and constructive knowledge in this case. Sec’y’s Br. 30-33.

### *i. Actual Knowledge*

The Secretary can establish an employer’s actual knowledge of a violative condition by demonstrating that a supervisor directly observed a subordinate’s violation. *Halmar Corp.*, 18

BNA OSHC 1014, 1016 (No. 94-2043, 1997); *Ormet Corp.*, 14 BNA OSHC 2134, 2137 (No. 85-531, 1991); *H.E. Wiese, Inc.*, 10 BNA OSHC 1499, 1505 (No. 78-204, 1982) (consolidated); *Kan. Power & Light Co.*, 5 BNA OSHC 1202, 1204 (No. 11015, 1977) (holding that because the supervisor directly saw the violative conduct without stating any objection, “his knowledge and approval of the work methods employed will be imputed to the respondent”). The supervisor’s knowledge is then imputed to Respondent. *Calpine Corp.*, No. 11-1734, 2018 WL 1778958, at \*5 (O.S.H.R.C., Apr. 6, 2018); *H.E. Wiese, Inc.*, 10 BNA OSHC at 1505.

Here, on the date of the accident, Mr. Maher, the direct supervisor of Messrs. [redacted] and Solan, observed them working in the fall shadow of an unsecured bundle. (Tr. 31, 72-73; [redacted] Dep. 44-45, 52-54). Mr. Maher thus had actual knowledge of the hazardous conduct. Because Mr. Maher was a supervisor, his knowledge is imputed to Respondent. *Calpine Corp.*, 2018 WL 1778958, at \*5; *H.E. Wiese, Inc.*, 10 BNA OSHC at 1505.

*ii. Constructive Knowledge*

The Secretary can establish constructive knowledge of a violative condition by demonstrating that the employer failed to exercise reasonable diligence to uncover the condition. *Ragnar Benson, Inc.*, 18 BNA OSHC 1937, 1939 (No. 97-1676, 1999). “Reasonable diligence involves the consideration of several factors, including the employer’s obligation to have adequate work rules and training programs, to adequately supervise employees, to anticipate hazards, and to take measure to prevent the occurrence of violations.” *Danis Shook Joint Venture XXV*, 19 BNA OSHC 1497, 1501 (No. 98-1192, 2001), *aff’d* 319 F.3d 805 (6th Cir. 2003).

Here, Respondent purportedly had a work rule in place instructing employees not to work in bundles’ fall shadows while unloading them from their shipping containers. (Exs. C-50 p.8, C-52 p.2). However, that written work rule was not enforced. In fact, Respondent’s supervisors

instructed employees to act in direct contravention to that rule and stand in the fall shadows of moving bundles while unloading them from their container. Mr. Maher, Respondent's warehouse manager, Mr. Hankins, Respondent's operations manager, and Mr. Brown, Respondent's safety manager, had all instructed [redacted] and other warehouse workers to enter the shipping containers and guide the bundles out while in the bundles' fall shadows.<sup>21</sup> (Tr. 53-54; *see also* Tr. 42, 68-69, 76, 150, 162-63; Gaviria Dep. 42; [redacted] Dep. 18; Ex. C-57). Mr. Gaviria, Respondent's president, admitted that Respondent's employees regularly worked in the fall shadows of unsecured bundles.<sup>22</sup> (Gaviria Dep. 26, 40-42). According to [redacted], he had unloaded "hundreds" of stone bundles with Mr. Solan and other warehouse workers in the manner prescribed by Respondent's supervisors. (Tr. 30-33, 70-71). Respondent's supervisors directed employees to guide bundles while in their fall shadows despite recognizing the hazard it posed to those employees. *See Part III.B.i, supra.*

Respondent's complete failure to enforce its written work rule is sufficient to find that it had constructive knowledge of the violation. *Gen. Motors Corp.*, 22 BNA OSHC 1019, 1037 (No. 91-2834E, 2007) (consolidated) (finding that the employer's "widespread failure to enforce its employees' use of [lockout/tagout]" demonstrates a lack of diligence in detecting hazardous

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<sup>21</sup> In the deposition excerpts for Mr. Hankins submitted by the Secretary, Mr. Hankins stated that it was not Respondent's policy to allow employees inside container while in a bundle's fall shadow and that [redacted] broke safety protocol by doing so. (Hankins Dep. 24-25). However, he then went on to state that employees *are* allowed to be in a bundle's fall shadow so long as it's "safe," which he defined as "[t]he bundle not moving." (*Id.* at 29). The consistent testimony of [redacted], whose demeanor the undersigned was able to observe, is credited over the inconsistent deposition testimony of Mr. Hankins, whose demeanor the undersigned was not able to observe.

<sup>22</sup> In the deposition excerpts for Mr. Gaviria submitted by the Secretary, Mr. Gaviria admitted that Respondent's policy allowed for employees to be in the container while guiding stone bundles but stated that the employees were required to be on one end of the bundle or the other, not on the side of the bundle in its fall shadow. (Gaviria Dep. 26-28). However, he then stated that employees were allowed to walk in a bundle's fall shadow "so long as there's not anything wrong with the pallet at issue." (*Id.* at 42). He also stated that when a pallet breaks, an employee is "expected to get out of the fall zone, get away from the fall zone" (*Id.* at 26), a statement which makes little sense if the employees are not in the bundle's fall shadow while it is being moved. The consistent testimony of [redacted], whose demeanor the undersigned was able to observe, is credited over the inconsistent deposition testimony of Mr. Hankins, whose demeanor as a witness the undersigned was not able to observe.

conditions and enforcing work rules.”); *Atl. Battery Co., Inc.*, 16 BNA OSHC 2131, 2160 (No. 90-1747, 1994) (failure to enforce written work rule was basis for finding constructive knowledge).

The constructive knowledge of Respondent’s supervisors is imputed to Respondent. *Calpine Corp.*, 2018 WL 1778958, at \*5; *H.E. Wiese, Inc.*, 10 BNA OSHC at 1505.

#### **F. Serious Classification**

The Secretary classified Respondent’s general duty clause violation as serious. A violation is classified as serious under the Act if “there is substantial probability that death or serious physical harm could result.” 29 U.S.C. § 666(k). The Secretary need not show there was a substantial probability an accident would occur, only that if an accident did occur, death or serious physical harm could result. *Mosser Constr., Inc.*, 23 BNA OSHC 1044, 1046 (No. 08-0631, 2010).

The Commission’s test for determining whether a violation is likely to cause death or serious harm for purposes of a violation of the general duty clause is nearly identical to the test for determining whether a violation is serious for purposes of section 17(k) of the Act. *Compare Waldon Health Care Ctr.*, 16 BNA OSHC at 1060, *with Mosser Constr., Inc.*, 23 BNA OSHC at 1046. Thus, a finding that a violation is “likely to cause death or serious harm [under the general duty clause] is equivalent to a finding under section 17(k) that the violation gives rise to a substantial probability of death or serious harm.” *Gearhart-Owen Indus., Inc.*, 10 BNA OSHC 2193, 2199 (No. 4263, 1982). Accordingly, for the reasons stated in Part III.D, *supra*, Respondent’s violation of the general duty clause was serious. *Id.*; *cf. also Acme Energy Servs.*, 23 BNA OSHC 2121, 2129 (No. 08-0088, 2012) (finding a general duty clause violation was serious based on the same factors considered in finding the general duty clause violation).

#### **IV. Penalty**

Section 17(j) of the Act requires the Commission to give due consideration to four criteria in assessing penalties: the size of the employer’s business, the gravity of the violation, the employer’s good faith, and its prior history of violations. *See* 29 U.S.C. § 666(j); *Compass Envtl., Inc.*, 23 BNA OSHC 1132, 1137 (No. 06-1036, 2010), *aff’d* 663 F.3d 1164 (10th Cir. 2011). The gravity of the violation is generally accorded greater weight than the other factors. *See J. A. Jones Constr. Co.*, 15 BNA OSHC 2201, 2214 (No. 87-2059, 1993).

Here, the maximum statutory penalty for this serious violation was \$13,260.<sup>23</sup> The CO found the gravity was high in this instance. (Tr. 182). The CO reached this determination by first assessing the severity of the hazard and the probability of an accident. (*Id.*). As to severity, i.e., the “most severe injury that could potentially take place as a result of exposure to this hazard,” the CO found it was high because death could potentially result from a falling stone slab. (*Id.* at 181). As to probability, i.e., “the potential of an actual exposure resulting in injury,” the CO found it was “greater” because an actual accident did occur and resulted in the injury of Respondent’s employee. (*Id.*). The result of the CO’s assignment of severity and probability in OSHA’s system resulted in a high gravity designation, which warranted the maximum penalty. (*Id.* at 182-83).

The CO reduced the penalty by sixty percent based on Respondent’s size. (*Id.* at 183). The CO did not reduce the penalty for Respondent’s good faith because although Respondent had a safety program in place, including work rules designed to address the hazard, “the non-enforcement of those work rules” disqualified Respondent for a good faith reduction. (*Id.* at 184).

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<sup>23</sup> The Bipartisan Budget Act of 2015 incorporated the Inflation Adjustments Act of the same year and required the Secretary to increase OSHA’s statutory penalty annually. Bipartisan Budget Act of 2015, Pub. L. 114-74, § 701; 28 U.S.C. §§ 1 note and 2461 note. The Secretary assessed his penalty for this alleged violation by issuing the Citation on February 20, 2019. (Citation at 1). The maximum penalty amount was therefore governed by the Secretary’s adjustment rule effective January 23, 2019. *See* Federal Civil Penalties Inflation Adjustment Act Annual Adjustments for 2019, 84 Fed. Reg. 213, 219 (Jan. 23, 2019) (to be codified at 29 C.F.R. pt. 1903).

The CO did not adjust the penalty based on Respondent's history.<sup>24</sup> (*Id.*). With the reduction for Respondent's size, the proposed penalty for the violation was \$5,304. (Citation at 7).

The Secretary has given due consideration to all the necessary criteria established by the Act; Respondent made no contrary arguments as to the appropriate penalty. Therefore, a penalty of \$5,304 is appropriate and is assessed against Respondent.

## **ORDER**

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

1. Item 1 of Citation 1, alleging a serious violation of section 5(a)(1) of the OSH Act, is AFFIRMED and a penalty of \$5,304 is ASSESSED.

## **SO ORDERED.**

/s/Covette Rooney  
COVETTE ROONEY  
Chief Judge, OSHRC

Dated: April 19, 2021  
Washington, DC

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<sup>24</sup> Respondent had a history with OSHA involving a forklift training violation. (Tr. 154). According to the CO, Respondent was not entitled to any reduction based on this history, nor did this history "rise to the level ... for a potential negative history penalty increase." (Tr. 184).