



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.

THOMAS G. GALLAGHER, INC.,

Respondent.

OSHRC Docket No. 14-1638

Appearances: Theresa Schneider Fromm, Esq.
U.S. Department of Labor, Office of the Solicitor, Boston, Massachusetts
For the Complainant

James F. Laboe, Esq.
Orr & Reno, P.A., Concord, New Hampshire
For the Respondent

Before: William S. Coleman
Administrative Law Judge

DECISION AND ORDER

On August 1, 2014, a journeyman pipefitter employed by Thomas G. Gallagher, Inc. (Gallagher) at Gallagher's fabrication shop in Andover, Massachusetts, sustained a serious injury to his right hand. The injury occurred while the pipefitter was using an overhead bridge crane to hoist a pipe assembly that weighed about 5,000 pounds. The pipefitter put his hand on the pipe assembly during the hoist. When a weld within the pipe assembly suddenly broke, material within the pipe assembly abruptly shifted, smashing against his hand.

The injured pipefitter had earlier rigged the pipe assembly for the hoist by using two synthetic web slings. The parties have stipulated that the pipefitter rigged the pipe assembly incorrectly. (Stip. ¶ 5). The rigging was flawed in two respects: (1) it resulted in a “center pick,” which made the pipe assembly susceptible to teetering while suspended, and (2) one of the two slings was connected to the pipe assembly with a choker hitch around multiple pipes, which exerted excessive force upon the weld that broke during the hoist.

A compliance safety and health officer (CO) from the Andover area office of the Occupational Safety and Health Administration (OSHA) conducted an inspection on the same day of the accident, after which OSHA issued a two-item serious citation to Gallagher. (T. 69-70).

Item 1 of the citation alleges a violation of the general industry standard applicable to overhead and gantry cranes, specifically 29 C.F.R. § 1910.179(n)(3)(i), which provides that a crane’s “load shall be well secured and properly balanced in the sling or lifting device before it is lifted more than a few inches.” Item 1 alleges that Gallagher violated this standard on August 1, 2014 in that “a pipe assembly hoisted by a ... bridge crane was not well secured, nor properly balanced....” The citation proposed a penalty of \$7000 for item 1.

The Secretary amended citation item 2 before the hearing. As amended, item 2 alleges a violation of the general industry standard applicable to slings, specifically 29 C.F.R. § 1910.184(c)(9), which provides that “[w]henver any sling is used, ... [a]ll employees shall be kept clear of loads about to be lifted and of suspended loads.” Amended item 2 alleges Gallagher violated this standard in the following manner: “On or about 8/1/2014, an assembly of pipes was hoisted with a ... bridge crane with employees’ hands on it.” The Citation proposed a

penalty of \$4250 for amended item two.¹

Gallagher timely contested the citation and proposed penalties, and the Executive Secretary of the Occupational Safety and Health Review Commission (Commission) docketed the matter on November 3, 2014. The Commission's Chief Judge thereafter assigned the matter to the undersigned for hearing and decision. An evidentiary hearing was conducted in Boston, Massachusetts, on April 24, 2015, at which three persons testified – the CO, the injured pipefitter, and the injured pipefitter's foreman. The parties thereafter filed post-hearing principal briefs and reply briefs, with briefing completed on June 22, 2015.

The principal contested issues are (1) whether the Secretary proved by a preponderance of the evidence that Gallagher had constructive knowledge of each of the two alleged violative conditions, and (2) whether Gallagher proved by a preponderance of the evidence the affirmative defense of unpreventable employee misconduct.

As described below, the Secretary met his burden to prove constructive knowledge as to both alleged violations, and Gallagher failed to meet its burden to prove unpreventable employee misconduct. The two citation items are affirmed as serious violations, and a total penalty of \$3500 is assessed.

FINDINGS OF FACT

The following facts were established by at least a preponderance of the evidence:²

1. Thomas G. Gallagher, Inc. (Gallagher) operates a fabrication shop in Andover, Massachusetts, where it makes prefabricated piping systems for installation in major construction

¹ As originally issued, item 2 had alleged that Gallagher violated § 1910.179(n)(3)(v), which is part of the general industry standard for overhead and gantry cranes, and which provides: "While any employee is on the load or hook, there shall be no hoisting, lowering, or traveling." The Secretary's pre-hearing amendment to item 2 changed only the cited standard -- the description of the alleged violation and the proposed penalty were unchanged.

² If any finding of fact is in actuality a conclusion of law, it shall be deemed to be so.

projects. (T. 18, 117). Gallagher has about 258 employees and is engaged in a business that affects interstate commerce. (Stip. ¶ 1; Ex. R-4; Ex. R-1, p. 4; T. 66).

The Pipe Assembly

2. In late July 2014, employees in the fabrication shop completed the fabrication of a pipe assembly that was to be installed at a construction site known as the “Novartis project.” (T. 17-18, 137; Stip. ¶¶ 3 & 4). The pipe assembly consisted of six 32-foot long metal pipes. The photograph at Exhibit J-2 accurately depicts the completed pipe assembly’s configuration (T. 117-18), and is described as follows:

a. The pipe assembly was about 32-feet long and 4-feet wide. It weighed between 4,800 and 5,000 pounds. (Ex. R-1; T. 40). Five pipes were four inches in diameter, and one pipe was eight inches in diameter. (Ex. R-1, p.1). The pipes were arrayed parallel and side-by-side on the same plane, with the 8-inch pipe positioned as one of the outermost pipes. (T. 40). On one side of the pipe assembly, the uppermost surface of the 8-inch pipe was four inches higher than the uppermost surfaces of the 4-inch pipes. On the opposite side, the uppermost surfaces of all pipes were even.

b. The adjacent pipes of the pipe assembly were about six inches apart. On one end of the pipe assembly, metal plates were welded to adjacent pipes to maintain this 6-inch spacing. There were five such metal plates, and they were a permanent part of the pipe assembly. (T. 45, 118, 149).

c. On the other end of the pipe assembly (which was the end where the pipefitter was injured), the 6-inch spacing between adjacent pipes was maintained by an approximately four-foot long channel iron that had been welded onto the pipe assembly. The channel iron crossed over the upper surface of all five 4-inch pipes, and one of its ends abutted the side of the 8-inch pipe. The channel iron was attached to the pipe assembly by six separate welds at the points

where the channel iron contacted each pipe. The channel iron was situated about eight feet from the near end of the pipe assembly. (T. 149-151; Exs. J-2 & J-7).

d. The channel iron was not a permanent part of the pipe assembly. Rather, its purpose was to keep the pipes in place during transport to the construction site, and it was to be removed from the pipe assembly before installation. (T. 118, 149).

3. On the morning of August 1, 2014, the pipe assembly was located in the part of Gallagher's fabrication shop that housed a permanently installed overhead bridge crane. The bridge crane had been installed one month earlier. (Ex. R-1, p. 1; T. 126). The bridge crane was outfitted with a wire-rope hoist that was operated by a control unit that hung like a pendant from the crane's bridge to about three feet above floor level. (T. 118; Ex. J-2; Ex. R-1, p. 1; Ex. C-3).

4. The pipe assembly was situated underneath the bridge crane, and lay flat upon two sawhorse-type supports, both about three feet high. The sawhorse supports were wider than the pipe assembly, so the undersides of all six pipes rested directly on the supports. (Ex. J-2).

5. The pipe assembly was scheduled to be transported to the Novartis project construction site on the day of the accident, August 1, 2014. Because of its large size, Gallagher had arranged for a third-party carrier to transport it on a flatbed trailer. (T. 120, 132).

The Accident

6. The worker who was injured was a journeyman pipefitter with the initials J.T. (T. 16-17, 134-35).

7. J.T.'s immediate supervisor was the fabrication shop foreman for the pipefitters (Foreman). (T. 17, 114).

8. The accident occurred at about 10:30 a.m. on Friday, August 1, 2014. (Stip. ¶ 5). That entire workweek (the week of July 28 to August 1), the Foreman had assigned J.T. to work

on various aspects of the Novartis project. The Foreman described the Novartis project as “the big hot job at the time.” (T. 136-37; Stip. ¶¶ 3 & 4).

9. On the day of the accident, J.T. began the day working with some welders on other pipe fabrications that were also destined for the Novartis project. (Foreman testimony, T. 131 & 137). At some point later in the morning, J.T. turned his attention to the pipe assembly involved in the accident. J.T. undertook to move the pipe assembly off the two sawhorse supports and onto two four-wheeled dollies (upon which the pipe assembly later would be rolled onto the flatbed trailer).

10. The Foreman did not instruct J.T. or anyone else to move (or to refrain from moving) the pipe assembly from the sawhorse supports onto the dollies (T. 140-41), but J.T. thought that this “was the next step that needed to be done” and was “what any pipefitter would do.” (J.T. testimony, T. 18 & 26). J.T. believed that the Foreman would have expected him to put the pipe assembly on the dollies without being told to do so. (J.T. testimony, T. 26-27).

11. J.T.’s plan of action was to use the crane’s hoist to lift the pipe assembly off the sawhorse supports, move the supports out from underneath the pipe assembly, and then lower the pipe assembly onto the two dollies that were pre-positioned below it. (T. 18, 118).

12. In preparation for hoisting the pipe assembly with the bridge crane, J.T. rigged it using two synthetic web slings. (J.T. testimony, T. 28). It took J.T. “only ... a matter of minutes” to rig the pipe assembly to the crane. (J.T. testimony, T. 28). The photographs at Exhibits J-3, J-4, and J-5 accurately depict the manner in which J.T. rigged the pipe assembly. (T. 20, 40, 42-43).

13. J.T. used a choker hitch to connect one of the slings to the eight-inch pipe near the pipe's midpoint. J.T. used another choker hitch to lash the other sling around the five smaller pipes, also near their midpoints.³

14. The manner in which J.T. rigged the pipe assembly was improper in at least two respects. (Stip. ¶ 5).

a. First, rigging the pipe assembly near its midpoint with only two points of connection resulted in the load being prone to teetering longitudinally when hoisted. (T. 28, 45, 60). J.T. recognized that using such a "center pick" might require some direct intervention to keep it from teetering and to stabilize it during the hoist. (J.T. testimony, T. 22 & 28; Ex. R-7, p. 3).

b. Second, when the pipe assembly was suspended, the sling that was choked around the five smaller pipes exerted lateral force against the two outermost of those five pipes, pressuring the welds that connected the channel iron to those pipes. This pressure resulted in one of those welds breaking during the lift. (T. 28, 44, 60, 131-32).

15. The correct technique when using a choker hitch to rig a pipe assembly is to "always choke ... on a single pipe." (Foreman testimony, T. 133; *see also* CO testimony, T. 63; Stip. ¶ 5).

16. J.T. could have rigged the pipe assembly in a manner that would have avoided or mitigated the problems created by the manner in which he actually rigged it. One such manner would have been to use four synthetic web slings, with one sling connected by a choker hitch to each of the four corners of the pipe assembly. This four-sling rigging would have resulted in (1)

³ The term "choker hitch" is defined in 29 C.F.R. § 1910.184(b) as follows: "*Choker hitch* is a sling configuration with one end of the sling passing under the load and through an end attachment, handle or eye on the other end of the sling." The hitch that J.T. used to connect both slings to the pipe assembly met this definition of "choker hitch."

the pipe assembly not being prone to teetering while suspended, and (2) less pressure being exerted on the channel iron welds. (Foreman testimony, T. 127-28, 130-31; Ex. R-12).

17. The only person to witness the accident and injury (other than J.T.) was a Gallagher employee named Joseph Myles. Myles happened to be in the vicinity when J.T. was ready to move the pipe assembly onto the dollies, so J.T. asked Myles to assist.⁴ (Ex. R-4, p. 1; T. 22, 29, 86-87; *see also* T. 110-11, statement of counsel for Gallagher). J.T. positioned himself at the end of the pipe assembly nearest the channel iron, and Myles was positioned at the opposite end, near the pendant control for the hoist. (Exs. J-2 & C-3; T. 22, 29, 39, 86-87). The pipe assembly was about waist height on the two men as it rested on the sawhorse supports. (T. 28).

18. Myles operated the hoist to lift the pipe assembly high enough above the two sawhorse supports to allow the two men to move the sawhorse supports out from under the pipe assembly. Once the sawhorse supports were out of the way, Myles began to lower the pipe assembly onto the two four-wheeled dollies that were pre-positioned underneath it. (T. 28). The pipe assembly began to teeter slightly, so J.T. put his right “hand on the pipe just to lift the end up to take just a little bit of weight off it.” (J.T. testimony at T. 28). While J.T.’s hand was on the pipe assembly, the weld connecting the channel iron to the outermost 4-inch pipe broke, which resulted in that pipe slamming into the adjacent pipe and smashing J.T.’s fingers. (Stip. ¶ 5; T. 17, 44, 52, 149; Ex. J-8). With J.T.’s hand still caught between the pipes, Myles finished lowering the pipe assembly onto the dollies and then came to J.T.’s aid to help him free his hand. (T. 29; Ex. C-2).

⁴ There is no evidence of Myles’ job title, trade, training, or experience. Although both parties identified Myles as a possible witness to provide testimony in their respective cases-in-chief (Joint Pretrial Statement, p. 3), neither chose to call him.

19. An ambulance arrived and transported J.T. to the hospital. (T. 31). J.T. lost his index and middle fingers above the knuckle, and he has a permanent titanium plate in his ring finger. (T. 17).

20. The Foreman was in his office when the accident occurred, and from that location the area where the accident occurred was not visible. Neither the Foreman nor any other Gallagher supervisor observed J.T. rigging the pipe assembly or using the crane to move it off the sawhorse supports and onto the dollies. (T. 121, 133). No Gallagher supervisor had actual knowledge at the time of the accident that J.T. had rigged the pipe assembly by himself or that he had placed his hand directly on the suspended pipe assembly.

J.T.'s Training and Experience

21. J.T. has been a member of Pipefitters Local 537 labor union in Boston for about twelve years. He estimated that over his career he had worked for some "20 different companies." At the time of the accident, he had been working at Gallagher for about six months. (T. 23, 30-31, 126, 153).

22. The pipefitting trade is generally regarded to be a construction trade. (T. 104). J.T. underwent five years of formal training from Pipefitters Local 537, and during that training period his status was "apprentice." (T. 134). Upon completing that training, he achieved "journeyman" status. (T. 22-24, 134-35). J.T.'s formal training from the labor union included training in rigging that lasted about "half a semester." (T. 22-23, 114, 126). There is no evidence regarding the precise content of the rigging training that J.T. received at the union.

23. J.T. testified that "[e]very job I've been on I've done rigging," including "a lot of big stuff," such as riggings of pipes with diameters of up to 30 inches. (T. 31).

24. J.T. had not received training on rigging from any of his approximately 20 previous employers. Rather, J.T. indicated that employers of pipefitters in the Boston area rely on the

rigging “training that we get at the Union Hall.” (T. 23). The Foreman’s testimony also suggested that Gallagher relied on the rigging training that its pipefitters received at the labor union. (T. 153).⁵

25. Gallagher did not communicate any general or specific work rules or guidance to employees with respect to how to rig any given material. J.T.’s understanding was that Gallagher expected its pipefitters simply to “rig it correctly.” (J.T. testimony, T. 23).

26. J.T. testified that he had rigged the pipe assembly that was involved in the accident three separate times altogether (with the accident having been the third time). (T. 19). J.T. rigged the pipe assembly the same way all three times. (T. 20, 26; Ex. J-3).

27. The first time J.T. rigged the pipe assembly, he did so by himself. This first time was for a lift “with a fork truck and a boom lift extension” at some outdoor location at Gallagher’s facility in Andover. (J.T. testimony, T. 19, 25).

28. The second time J.T. rigged the pipe assembly was two days before the accident. He again rigged it by himself, and he did so without receiving any instructions or direction from the Foreman or anyone else. (T. 26). The purpose of rigging it the second time was to hoist the pipe assembly using the same overhead crane that was used when the accident occurred. (T. 19, 21, 25). J.T. believed that other workers may have been working with him this second time, but he was not sure of their identities. (T. 25).

29. J.T. erroneously believed that he rigged the pipe assembly properly each of the three times he rigged it.⁶ (J.T. testimony, T. 22).

⁵ The Foreman testified:

Q: Is there anything in [J.T.’s] training that would prohibit him from rigging the pipe assembly in that fashion?

A: I would imagine what he learned in the school.

30. No one at Gallagher had ever questioned the manner in which J.T. had rigged the pipe assembly or any other material. No one at Gallagher had ever instructed J.T. to refrain from rigging any material. (J.T. testimony, T. 22, 24).

31. In his six months of employment at Gallagher before the accident, J.T. regularly encountered situations that entailed rigging, including working “on some other big pipe assemblies.” (Foreman testimony, T. 126, 156). The Foreman regarded J.T.’s involvement in those riggings to be in the nature of on-the-job training. (T. 156).

32. Over the course of J.T.’s six months employment at Gallagher before the accident, the Foreman had observed his work practices and habits on a daily basis and had not observed J.T. engage in any unsafe acts or practices. (Foreman testimony, T. 131, 141, 153). In the Foreman’s estimation, J.T. “always did the right thing.” (Foreman testimony, T. 132).

33. The Foreman did not train or instruct J.T. to rig pipe assemblies in the manner that J.T. had incorrectly rigged the pipe assembly on the day of the accident. (Foreman testimony, T. 127). The Foreman testified that he had no reason to believe that J.T. would *not* have known how to rig the pipe assembly properly. (T. 154).

34. The Foreman belonged to the same labor union as J.T. (Pipefitters Local 537), and he was familiar with the training that the union provided. (T. 114).

35. The Foreman believed that the union had trained J.T. on the correct way to do “any kind of rigging,” including distinguishing between correct and incorrect methods of rigging a pipe assembly like the one involved in the accident. (Foreman testimony, T. 141, 153).

⁶ J.T. believed he was injured because a “weld failed,” not because he had rigged the pipe assembly incorrectly. (T. 22). The parties stipulated that the manner in which J.T. rigged the pipe assembly was incorrect (Stip. ¶ 5), and the evidence corroborates that stipulation.

36. The only formalized training on rigging that Gallagher provided J.T. was a ten-minute “toolbox talk” that the Foreman gave in April 2014 to a group of five workers that included J.T. (T. 23, 31, 123-26, 145, 155; Exs. R-10 and R-11). The training consisted of the Foreman reading verbatim a one-page written outline titled “Rigging.” After he read the outline, the Foreman invited questions, but there were none. (T. 145). The written outline was admitted in evidence as Exhibit R-11. (T. 145).

37. By its expressed terms, the toolbox talk was geared to “workers in the construction industry . . . working with or near rigging operations.” (T. 126, Ex. R-11).

38. The toolbox talk did not address methods of rigging pipe assemblies similar to the one involved in the accident. (Ex. R-11; T. 146).

39. One part of the written toolbox talk headlined “Lifting Practice Checklist” had ten bullet points. One of those bullet points was as follows: “Balance the load to avoid overstress on one sling leg or the load slipping free.” There is no evidence that the manner in which J.T. rigged the pipe assembly overstressed a sling leg or created a risk of the load slipping free.

40. The only part of the toolbox talk that addressed the placing of hands on a load was the following bullet point: “Keep hands and fingers from between the load and the chain.” (Ex. R-11). There is no evidence of any “chain” being involved in the rigging of the pipe assembly, and thus there is no evidence that J.T. failed to keep “hands and fingers from between the load and the chain” in rigging and hoisting the pipe assembly that injured him. (T. 145-146).

41. The final paragraph of the toolbox talk addressed the matter of using a “qualified rigger.” It provided:

Be sure to contact a “Qualified Rigger” for complete details on all rigging requirements. Employers must use qualified riggers during hoisting activities for assembly and disassembly work. Additionally, qualified riggers are required whenever workers *are*

within the fall zone and hooking, unhooking or guiding a load as well as doing the initial connection of a load to a component or structure.

(Ex. R-11) (emphasis supplied). When J.T. placed his hand directly on the suspended pipe assembly, he was “within the fall zone”⁷ and was “guiding a load” in a manner contemplated by the toolbox talk’s use of those phrases.

42. Inasmuch as the toolbox talk was by its terms “geared to workers in the construction industry,” the use of the term “Qualified Rigger” in the toolbox talk was intended to denote the defined term “qualified rigger” that is set forth in 29 C.F.R. § 1926.1401.⁸

43. There is insufficient evidence to make a finding whether Gallagher regarded J.T. to be a “qualified rigger” as that term was employed in the toolbox talk.

⁷ The term “fall zone” as used in the toolbox talk was intended to denote the definition in the construction industry standard for cranes and derricks that is codified at 29 C.F.R. part 1926, subpart CC. The term is defined in § 1926.1401 as follows: “*Fall zone* means the area (including but not limited to the area directly beneath the load) in which it is reasonably foreseeable that partially or completely suspended materials could fall in the event of an accident.”

⁸ The term “qualified rigger” does not appear in either of the cited general industry standards. The term is defined in the construction industry standards at § 1926.1401 as follows: “*Qualified rigger* is a rigger who meets the criteria for a qualified person.” The term “qualified person” is in turn defined in § 1926.1401 as follows: “*Qualified person* means a person who, by possession of a recognized degree, certificate, or professional standing, or who by extensive knowledge, training and experience, successfully demonstrated the ability to solve/resolve problems relating to the subject matter, the work, or the project.”

The parties have agreed that the cited general industry standards are applicable, not the construction industry standards. (Joint Pretrial Statement, 4/9/2015). The construction industry standards are not applicable to the operation of the bridge crane because Gallagher’s fabrication shop was not a place of employment engaged in construction work. *See* 29 C.F.R. § 1910.12(a) (providing that the standards in 29 C.F.R. part 1926 [of which subpart CC is a subpart] are applicable to “every employment and place of employment of every employee engaged in construction work”).

44. In the conduct of his investigation, the CO had concluded that the employees in the fabrication shop had received sufficient training in rigging and that J.T. had received proper training on how to rig the pipe assembly that injured him. (T. 80-81).

The Foreman and Supervision

45. At the time of the accident, the Foreman had held the position of fabrication shop foreman for pipefitters for about two years. (T. 114). Before that, the Foreman had worked for Gallagher as a construction foreman at construction sites in the field. (T. 114, 122).

46. There is no evidence of how many workers the Foreman was responsible for supervising.

47. During the vast majority of a typical workday, the Foreman is on the shop floor supervising work, though there are times when he is in his office attending to paperwork. (T. 28, 83, 117, 121-22). The Foreman testified that his usual practice throughout the workday is to “walk the shop, make sure everything was being done right” and “in a safe manner,” although he noted that the workers he supervises are generally compliant with applicable safety standards. (T. 30, 116, 134, 154).

48. The Foreman testified that at the start of each workday, the workers he supervises typically “start on what they were working on the day before,” and that when they finished he “would give them another assignment ... or whatever I needed them to work on.” (T. 120).

49. The Foreman testified that it was not typical for workers to change tasks without his knowledge, but he acknowledged that sometimes they do, such as when they finish a task and start something new. (T. 120, 137-38).

50. The Foreman testified that before the accident, he had never known J.T. to undertake a task that he had not been assigned (T. 139), or to switch tasks without the Foreman knowing.

(T. 153). All of J.T.'s assigned tasks in the several days preceding the accident had involved the Novartis project. (T. 136-37; Stip. ¶¶ 3 & 4).

51. The Foreman has more than 30 years' experience in rigging. (T. 83). In the Foreman's estimation, the journeymen pipefitters like J.T. who had been trained at Pipefitters Local 537 labor union "know what they are doing when it comes to rigging." (T. 114-15, 134-35).

52. In November 2010, when the Foreman was working as a construction foreman for Gallagher, the Foreman and most of the other foremen at Gallagher received formal "qualified rigger" training that was provided by an outside trainer. Gallagher did not provide this training to any non-supervisory employees. (T. 115, 146).

53. During the Foreman's two-year tenure as the fabrication shop foreman, the only other pipe assemblies that were similar to the one involved in the accident had also been fabricated for the Novartis project. (T. 115-16). The first such pipe assembly was fabricated around January 2014, which was before J.T. started work at Gallagher. (T. 115-16). The pipe assembly that was involved in the accident was the fourth or fifth of the pipe assemblies fabricated for the Novartis project. (T. 19, 115-16).

54. The Foreman knew on day of the accident that the pipe assembly was to be transported to the construction site on that day. (T. 139). The record is silent as to whether at the time of the accident the tractor-trailer that would transport the pipe assembly had arrived at the fabrication shop for the pick up.

55. The Foreman testified that what should have happened on the day of the accident was that after the arrival of the tractor-trailer that would transport the pipe assembly, he would "get two or three guys together, make a team, and we would rig it to the floor, get it on dollies,

and push it to the truck.” (T. 121, 132). This is what the Foreman had done when loading previously fabricated pipe assemblies for the Novartis project, and he recalled that J.T. had been involved in some of those previous efforts. (T. 133). The rigging configuration used in those previous instances was not the two-sling configuration that J.T. used on August 31, 2014. (T. 127).

56. The Foreman testified that it was not typical for workers to rig and load pipe assemblies without his direction and without his knowledge, and that he would not have assigned that task to J.T. to do alone. (T. 122-23).

57. The Foreman testified that he was always directly involved in rigging and loading large items like the pipe assembly “[b]ecause ... they're big and heavy, and ... it's ... a dangerous job to do and that's why I pick the right guys and we do it.” (T. 122-123).

58. The Foreman explained further: “We don't usually do big stuff like this. When we do smaller stuff, the guys can handle it themselves, no problem. But when they do anything big, I'm always involved with it.” (T. 123).

59. Before the accident on August 1, 2014, the Foreman did not know that twice earlier J.T. had rigged the pipe assembly that injured him, and that both of these times J.T. had rigged the pipe assembly alone. (T. 133). The Foreman mistakenly believed that in the six months before the accident, no pipe assemblies like the one involved in the accident had been rigged without his knowledge. (Foreman testimony, T. 121).

60. Prior to the accident, the Foreman had not formed a team to rig and move the pipe assembly, and there is no evidence that the Foreman had communicated to any workers that he intended to form such a team that day.

61. Prior to the accident, the Foreman had not instructed J.T. or any other employee to rig or move the pipe assembly (or to refrain from doing so). (T. 18, 26, 140).

62. If the Foreman had seen the way J.T. rigged the pipe assembly on the day of the accident, he would have stopped work and would have acted so that the pipe assembly was rigged correctly. (T. 123, 130, 133).

63. There is no evidence of whether or when the Foreman communicated to J.T. or to any other workers that the Novartis pipe assemblies or any similarly large items should be rigged only at his express direction and only under his direct supervision. If the Foreman communicated this policy to J.T. and the other workers, he did not do so in any written form.

64. Gallagher did not take reasonably diligent measures in communicating instructions to the pipefitters in the fabrication shop that large items like the Novartis project pipe assemblies were to be rigged only under the direct supervision of the Foreman. Gallagher, in the exercise of reasonable diligence, should have known that J.T. would not comply with this practice and that a violative condition could result.

Gallagher Safety Program

65. Gallagher had a 103-page corporate safety manual that was organized into 28 separate policy areas. The CO characterized the safety manual as “fairly comprehensive and progressive with regards to employee safety and health,” but also regarded its provisions to be more applicable “to workers in the field, as opposed to [workers] in the fabrication shop.” (T. 56).

66. One of the 28 policy areas in the safety manual was a one-page policy titled “Cranes and Derricks.” (Ex. J-1, p. 74). The lead paragraph of the “Cranes and Derricks” policy stated that all crane and derrick work in the company would comply with the OSHA construction

industry standard for cranes and derricks that is codified at 29 C.F.R. part 1926, subpart CC.⁹ (Ex. J-1, p. 74). The overhead crane in Gallagher’s fabrication shop was not engaged in construction work on August 1, 2014. (*See supra* footnote 8). No part of the safety manual expressly refers to 29 C.F.R. § 1910.179, which is the general industry standard for overhead cranes that the parties agree is the applicable standard for item 1 of the citation. (Joint Pretrial Statement, 4/9/2015, p. 5).

67. The lead paragraph of the one-page Cranes and Derricks policy also stated that all workers performing rigging operations for the company “will be certified as Qualified Riggers.” (Ex. J-1, p. 74).¹⁰

68. Inasmuch as the Cranes and Derricks policy expressly refers to the construction industry standard for cranes and derricks (subpart CC of part 1926), the use of the term “Qualified Rigger” in the policy was intended to denote the defined term “qualified rigger” that is set forth in 29 C.F.R. § 1926.1401. (*See supra* footnote 8).

69. There is insufficient evidence to make a finding whether Gallagher regarded J.T. to have been “certified” as a “qualified rigger,” as those terms were employed in its Cranes and Derricks policy, for purposes of rigging the large and heavy Novartis project pipe assemblies.

70. Another of the 28 policy areas in the safety manual was a three-page policy titled “Rigging.” (Ex. J-1, pp. 75-77). The “Rigging” policy does not include any specific or general

⁹The lead paragraph of the Cranes and Derricks policy provided as follows (Ex. J-1, p. 74):

All crane and derrick work will be done to comply with OSHA 1926 Subpart CC. All workers performing rigging or signaling operations will be certified as Qualified Riggers and Signaller under the following standard. Cranes and derricks include, but are not limited to: crawler cranes, truck cranes, tower cranes, overhead gantry cranes and floating derricks.

¹⁰ *See supra* footnotes 8 and 9.

work rule that would have proscribed the manner in which J.T. rigged the pipe assembly on August 1, 2014. (Ex. J-1; T. 140).

71. The “Rigging” policy includes the following bullet point: “Never stand or work under a suspended load.” (Ex. J-1, p. 75). The safety manual contained no express guidance that addresses whether or under what circumstances workers may use their hands in guiding or balancing a suspended load. (T. 58, 84).

72. Gallagher had no specific written or unwritten work rule that prohibited a worker from putting a hand directly on a suspended load, as J.T. was doing at the time of the accident. (T. 24).

73. J.T. believed that it was sometimes appropriate for workers to put a hand directly on a suspended load because “usually you need to control it so it doesn’t swing around or take off ... [o]r roll around.” (J.T. testimony, T. 24). J.T. did not believe he was violating any applicable safety standard or any Gallagher work rule by placing his hand on the suspended pipe assembly.

74. Gallagher did not take reasonably diligent measures in preventing employees from placing their hands directly on suspended loads in the fabrication shop. Gallagher did not have a work rule that prohibited employees in the fabrication shop from placing their hands on suspended loads. Gallagher’s work rules and training actually endorsed the practice of employees placing hands directly on suspended loads under certain circumstances. J.T. believed it was appropriate for him to put his hand directly on the suspended pipe assembly at the time of the accident. Gallagher, in the exercise of reasonable diligence, should have known that J.T. would place a hand on the pipe assembly while it was suspended, and that he likely would be within the fall zone of the suspended load while doing so.

75. The safety manual includes a written policy providing for progressive discipline for safety violations. (Ex. J-1, p. 99; T. 100-01). Gallagher's foremen do not have the authority to impose such discipline, but rather may only recommend disciplinary action to the company safety committee. (T. 134-136). The Foreman did not recommend that J.T. be disciplined for his actions on the day of the accident. (T. 146-47). The Foreman has never recommended that any employee be disciplined for a safety violation. (T. 135-36).

76. The only evidence that Gallagher had disciplined any worker for violation of a safety rule was a one-day suspension of an employee in April 2014 who was disciplined for standing on the mid-rail of a scissor lift. (T. 101, 103).

77. The evidence is insufficient to establish that Gallagher failed to exercise reasonable diligence in the administration of its disciplinary policy in enforcing its safety program.

78. Gallagher's corporate safety director customarily walks through the fabrication shop on a weekly basis to inspect and monitor safety compliance. (T. 29, 133-34).

79. Gallagher maintained an adequate inspection program to detect unsafe conditions. Gallagher took reasonably diligent measures to monitor compliance with safety requirements in the fabrication shop.

The Foreman's Incorrect Re-rigging of Pipe Assembly
During the OSHA Inspection

80. During the OSHA inspection on the day of the accident, the CO asked the Foreman how much the pipe assembly weighed. The Foreman responded by offering to weigh it by placing an "under-the-hook scale" on the hoist's hook. The CO accepted the Foreman's offer to weigh the pipe assembly (T. 48, 90-93), so the Foreman undid J.T.'s two-sling rigging and then re-rigged the pipe assembly using only a single synthetic web sling. The Foreman connected the two ends of the single sling to the pipe assembly by choker hitches at two points of attachment

that were near the center of the pipe assembly. One of those points of attachment was around more than a single 4-inch pipe.¹¹ (T. 49, 59, 142-44, 155; Ex. J-6).

81. After re-rigging the pipe assembly in this manner, the Foreman operated the crane to hoist the pipe assembly about six inches above the two dollies. (T. 49, 99; Ex. R-7, p. 3). The pipe assembly was “teetering a bit” and the scale’s digital reading was still fluctuating when, about 30 seconds into the lift, a weld connecting the channel iron to one of the 4-inch pipes broke. (T. 49; Ex. R-7, p. 3). The Foreman lowered the pipe assembly back onto the dollies without having obtained a definite measurement of the pipe assembly’s weight. (T. 94-95). No one was injured when the weld broke during this lift. (T. 49; Ex. R-7, p. 3).

82. During his inspection, the CO never queried the Foreman regarding the correctness of the manner in which either J.T. or the Foreman had rigged the pipe assembly on the day of the accident (T. 96, 131), and the Foreman did not volunteer any information on those subjects. (T. 55). During his inspection, the CO presumed that the manner in which the Foreman had re-rigged the pipe assembly before attempting to weigh it had been appropriate. (T. 95-97). (The CO had limited experience in rigging, and this inspection happened to be his first in which the manner of rigging became of interest. [T. 35-36, 102].)

83. The Foreman acknowledged in his testimony that (a) the manner in which he had re-rigged the pipe assembly was “not the safe way to do it,” (b) the broken weld should have been repaired before he re-rigged and hoisted the pipe assembly, and (c) he should “have put the right number of slings on it.” (T. 144-45). The Foreman explained that he was trying to

¹¹ The record is murky about which of the four-inch pipes the Foreman choked, but there is no dispute that one end of the sling was in a choker configuration around multiple four-inch pipes. While there is photographic evidence of the single sling passing through the hook of the under-the-hook scale (Ex. J-8; T. 51), there is no photograph of the two points of connection that this single sling had with the pipe assembly. (T. 49-50).

accommodate the CO's request to determine the weight of the pipe assembly, and that "I should have re-rigged it . . . but . . . I thought . . . we were just going to weigh it and – I should have welded the piece back on." (T. 152).

84. The Secretary did not cite Gallagher for any alleged violations as a consequence of the manner in which the Foreman re-rigged the pipe assembly. (Stip. ¶ 8; T. 12, 93-94).

Employer Knowledge

85. Gallagher did not have actual knowledge at the time of the accident on August 1, 2014, that J.T. had rigged the pipe assembly, and that he had done so by himself and incorrectly.

86. Gallagher should have known in the exercise of reasonable diligence that at the time of the accident on August 1, 2014, J.T. would undertake to rig the pipe assembly alone without being instructed to do so by the Foreman and outside the Foreman's direct supervision, and that a violative condition could result.

87. Gallagher did not have actual knowledge at the time of the accident on August 1, 2014, that J.T. was standing in the fall zone and had put his hand directly on the suspended pipe assembly.

88. Gallagher should have known in the exercise of reasonable diligence at the time of the accident on August 1, 2014, that J.T. would stand in the fall zone and place a hand directly on a suspended load.

Classification

89. There was a substantial probability that death or serious physical harm could result from the incorrect manner in which J.T. rigged the pipe assembly.

90. There was a substantial probability that death or serious physical harm could result from J.T.'s act of standing in the fall zone and placing his hand on the pipe assembly while it was suspended.

DISCUSSION

The Commission obtained jurisdiction under section 10(c) of the Occupational Safety and Health Act (Act) upon Gallagher's timely contest of the citation and proposed penalty. 29 U.S.C. § 659(c).

The parties have stipulated to facts that establish that Gallagher met the Act's definition of "employer" (Stip. ¶ 1) and was thus covered by the Act. 29 U.S.C. § 652(5).

To prove a violation of an OSHA safety or health standard promulgated under section 5(a)(2) of the Act, the Secretary must establish by a preponderance of the evidence that (1) the cited standard applies, (2) there was a failure to comply with the cited standard, (3) employees had access to the violative condition, and (4) the employer knew or could have known of the condition with the exercise of reasonable diligence. *Astra Pharma. Prods.*, 9 BNA OSHC 2126, 2129 (No. 78-6247, 1981) *aff'd in relevant part*, 681 F.2d 69 (1st Cir. 1982).

Item 1 -- § 1910.179(n)(3)(i)

Elements 1, 2, & 3

As noted at the outset, § 1910.179(n)(3)(i) requires that a crane's "load shall be well secured and properly balanced in the sling or lifting device before it is lifted more than a few inches." The parties agree that this standard applies. (Joint Pretrial Statement, April 9, 2015). The evidence supports the parties' understanding that § 1910.179(n)(3)(i) was applicable to the operation of Gallagher's overhead bridge crane on August 1, 2014. (T. 60).

Item 1 alleges that Gallagher violated § 1910.179(n)(3)(i) on the day of the accident in that the pipe assembly being hoisted "was not well secured, nor properly balanced." The Secretary met his burden to prove that Gallagher violated the cited standard in the manner alleged. The Foreman's testimony establishes that the pipe assembly was not properly balanced in the sling because it was susceptible to teetering longitudinally. (T. 127-28, 130-33). The

Foreman's testimony also establishes that the pipe assembly was not well secured in the sling because one of the web slings was choked around more than a single pipe. (T. 127-28, 130-33).

The preponderance of the evidence also establishes that the two Gallagher employees standing near the pipe assembly during the hoist – J.T. and Myles – were exposed to the violative condition.¹²

Element 4 - Employer Knowledge of § 1910.179(n)(3)(i) Violative Condition

To establish employer knowledge, the Secretary must prove that Gallagher knew or, with the exercise of reasonable diligence, could have known of the condition constituting the violation. *Contour Erection & Siding Sys., Inc.*, 22 BNA OSHC 1072, 1073 (No. 06-0792, 2007). The actual or constructive knowledge of an employer's supervisors and foremen is generally imputable to the employer. *Rawson Contractors Inc.*, 20 BNA OSHC 1078, 1080-81 (No. 99-0018, 2003); *A.P. O'Horo Co.*, 14 BNA OSHC 2004, 2007 (No. 85-369, 1991).

The Foreman provided uncontroverted credible testimony that he did not instruct J.T. to rig the pipe assembly and he did not observe J.T. rig it incorrectly. There is no substantial evidence that Gallagher had actual knowledge of the violative condition.¹³

¹² Gallagher has not argued in its post-hearing briefs that the Secretary failed to prove elements 2 and 3 of the Secretary's burden of proof.

¹³ J.T. testified: "I don't think [the Foreman] would say he had never seen me rig" the pipe assembly in the same configuration that J.T. had used on the day of the accident. (T. 26). The Secretary argues that this testimony "calls into question" Gallagher's claim that it did not have actual knowledge of the violative condition, but the Secretary has not presented any fully developed argument that the record as a whole supports finding that Gallagher had actual knowledge. (Sec'y Brief-in-Chief, p. 7). Even if the Secretary had made such a fully developed argument, the quoted testimony from J.T. was not developed further and by itself is far too vague and indefinite to amount to substantial evidence that the Foreman had actual knowledge.

To prove constructive knowledge, the Secretary must show that Gallagher's failure to discover an alleged violative condition was due to a lack of reasonable diligence. *See Ragnar Benson Inc.*, 18 BNA OSHC 1937, 1940 (No. 97-1676, 1999).

“In assessing reasonable diligence, the Commission considers several factors, including an employer's obligations to implement adequate work rules and training programs, adequately supervise employees, anticipate hazards, and take measures to prevent violations from occurring.” *S. J. Louis Constr. of Tex.*, 25 BNA OSHC 1892, 1894 (No. 12-1045, 2016).

Whether an employer has exercised reasonable diligence is a question of fact that “will vary with the facts of each case.” *Martin v. OSHRC*, 947 F.2d 1483, 1484 (11th Cir. 1991); *see also Centex-Rooney Constr. Co.*, 16 BNA OSHC 2127, 2129 (No. 92-0851, 1994) (finding that a preponderance of the evidence established the cited employer was reasonably diligent); *Precision Concrete Constr.*, 19 BNA OSHC 1404, 1407 (No. 99-0707, 2001) (noting that Secretary has burden of identifying what reasonable diligence required).

*Exercise of Reasonable Diligence in
Inspection/Examination of Fabrication Shop*

“[A]n employer who lacks actual knowledge can nevertheless be charged with constructive knowledge of conditions that could be detected through an inspection or examination of the worksite.” *Texas A.C.A., Inc.*, 17 BNA OSHC 1048, 1050 (No. 91-3467, 1995).

“An employer is ... chargeable with knowledge of conditions which are plainly visible to its supervisory personnel.” *Id.*, at n.4. Whether an employer should have discovered a violative condition that is plainly visible requires consideration of how long the violative condition existed. *Thos. Indus. Coatings, Inc.*, 23 BNA OSHC 2082, 2086 (No. 06-1542, 2012) (ruling

that the absence of evidence of how long a violative condition existed precludes finding that the employer could have known of the condition with the exercise of reasonable diligence.)

“Where the employer maintains an adequate inspection program, the burden is on the Secretary to demonstrate that the employer’s failure to discover the violative condition was due to a lack of reasonable diligence.” *Trinity Marine Nashville, Inc.*, 19 BNA OSHC 1015, 1017 (No. 98-0144, 2000).

Gallagher maintained and executed an adequate inspection program in the fabrication shop. (*See supra* Findings of Fact ¶¶ 47 & 78-79). Although J.T.’s rigging of the pipe assembly was plainly visible to anyone in his vicinity, the evidence is insufficient to establish that supervisory personnel failed to exercise reasonable diligence in not observing him do so. J.T. rigged the pipe assembly “in a matter of minutes” (T. 28) during one of those times when the Foreman was in his office attending to paperwork. For the vast majority of the workday the Foreman was on the floor of the fabrication shop supervising the work of the pipefitters. In view of the short duration of the violative condition, and the Foreman’s near constant presence on the fabrication shop floor, the Secretary has not established that Gallagher failed to exercise reasonable diligence in not discovering the violative condition in the course of its normal inspection and examination of the worksite. *LJC Dismantling Corp.*, 24 BNA OSHC 1478, 1481 (No. 08-1318, 2014) (finding that Secretary did not prove inspection program was inadequate where employer’s superintendent inspected the worksite multiple times a day and directed the shop steward to check that employees were engaged in safe practices, and there was no evidence of a need for more intensive monitoring); *N. Y. State Elec. & Gas Corp. (NYSEG) v. Sec’y of Labor*, 88 F.3d 98, 110 (2d Cir. 1996) (observing that it is a “patently unworkable burden on employers” to insist “that each employee be under continual supervisor surveillance”).

Adequacy of Training Programs, Work Rules, and Instructions

Even though Gallagher did not provide J.T. detailed formal training in rigging, the Secretary has not proven that Gallagher failed to exercise reasonable diligence in relying on J.T.'s union training, his years of experience as a journeyman pipefitter, and the Foreman's observations of J.T.'s generally safe work habits, in concluding that J.T. had sufficient training and experience in rigging to perform his routine work as a pipefitter. *LJC Dismantling Corp.*, 24 BNA OSHC at 1481-82 (ruling that Secretary did not establish that employer should have given employee more specific instructions on scaffolding because the Secretary failed to prove that employer should have been aware that the employee's extensive prior training and experience in scaffolding was deficient); *cf. Par Elec. Contractors Inc.*, 20 BNA OSHC 1624, 1628 (No. 99-1512, 2004) (rejecting argument that employer was not required to provide specific instructions to employees who were journeyman linemen, who had "years of training and field experience," on certain safe practices when working in the vicinity of an energized conductor -- noting that "employers cannot count on employees' common sense, experience, and training by former employers or a union to preclude the need for specific instructions").

J.T. had been trained by his union in rigging, and testimony of both J.T. and the Foreman indicated that it was customary for Boston-area employers to rely on that union training and not to provide additional extensive rigging training and instruction to journeymen pipefitters in their employ. (*See supra* Findings of Fact ¶ 24). J.T.'s uncontradicted testimony that he had not received any significant training in rigging from any of his approximately 20 employers throughout his career is particularly compelling on this point. The Secretary presented no evidence indicating that Gallagher failed to exercise reasonable diligence in not providing J.T. with detailed formal training in rigging. *See Donohue Indus., Inc.*, 20 BNA OSHC 1346, 1350-51 (No. 99-0191, 2003) (more specific instructions to trained electricians on grounding not

required because it was reasonable for employer to expect its trained electricians to be familiar with basic tenets of their trade). Indeed, in the conduct of his inspection the CO concluded, whether rightly or wrongly, that the employees in the fabrication shop had received sufficient training in rigging and that J.T. had received proper training on how to rig the pipe assembly that injured him. (T. 80-81). The Secretary presented no direct evidence that would controvert the CO's stated conclusions on J.T.'s training.

Gallagher had no work rules that either prescribed or proscribed ways of rigging the myriad types of loads that are hoisted in the Gallagher fabrication shop from day to day. As J.T. observed, Gallagher expected him and the other pipefitters simply to rig material "correctly." (T. 23). The Secretary has not demonstrated that Gallagher failed to exercise reasonable diligence by not having a work rule that explicitly prescribed or proscribed the precise manners by which to rig the type of pipe assembly that was involved in the accident.

The Cranes and Derricks policy in Gallagher's corporate safety manual provided: "All workers performing rigging ... operations will be certified as Qualified Riggers." (Ex J-1, p. 74.) The safety manual's use of the term "qualified rigger" denoted the meaning assigned to that term as set forth in subpart CC of the construction industry standards, at 29 C.F.R. § 1926.1401. (*See supra* Findings of Fact ¶ 42). However, even though Gallagher's safety manual required that all rigging be done by a "qualified rigger" as defined in subpart CC, the cited standard, § 1910.179, does not.¹⁴

¹⁴ Subpart CC of part 1926, which is applicable to cranes and derricks used in construction, requires that under certain circumstances, only a "qualified rigger" may rig the material to be lifted. Because Gallagher's overhead bridge crane was not being used in construction, subpart CC was not applicable. But even if subpart CC had been applicable to the operation of Gallagher's bridge crane, an exception in that subpart would have excepted it from compliance with the requirements of subpart CC, and instead would have made applicable most

Neither party attempted to prove or disprove whether J.T. was a “qualified rigger” as that term was used in the corporate safety manual, presumably because the parties correctly understood that subpart CC of part 1926 was not applicable to the operation of the bridge crane. (*See supra* Findings of Fact ¶ 68). Similarly, in their respective post-hearing briefs, neither party addresses the matter of whether J.T. was a “qualified rigger” as that term was used in the safety manual.

Since the matter of whether J.T. was a “qualified rigger” as that term was used in the safety manual was not litigated, the record affords no basis on which to conclude that J.T. either was or was not such a “qualified rigger.” Similarly, there is no basis on which to conclude whether J.T.’s act of rigging the pipe assembly violated the Gallagher’s written policy that only workers certified as “qualified riggers” perform rigging operations.¹⁵ (Ex. J-1, p. 74).

of the requirements of § 1910.179, which is the standard cited in item 1. This regulatory exception is set forth in § 1926.1438(a), which provides as follows:

(a) *Permanently installed overhead and gantry cranes.* The requirements of § 1910.179, except for § 1910.179(b)(1), and not the requirements of this subpart CC, apply to the following equipment when used in construction and permanently installed in a facility: overhead and gantry cranes, including semigantry, cantilever gantry, wall cranes, storage bridge cranes, and others having the same fundamental characteristics.

¹⁵ Considering J.T.’s union training and professional experience, it is entirely possible that he could reasonably be regarded to possess the knowledge and skills to have been deemed a “qualified rigger,” as that term is used in its company Cranes and Derricks policy, for many rigging tasks.

Conversely, there is circumstantial evidence that Gallagher did not deem to J.T to be a “qualified rigger.” Specifically, in the year 2010, Gallagher provided formal training for “qualified rigger” status only to certain supervisory personnel, including the Foreman. Gallagher has not provided “qualified rigger” training to any non-supervisory personnel. Moreover, contrary to Gallagher’s Cranes and Derricks policy, the content of the toolbox talk that the Foreman gave in April 2014 indicated that a “qualified rigger” was not required to be involved in each and every rigging operation. (Ex. R-11). This evidence, coupled with the Foreman’s stated practice of being directly involved in supervising the rigging of the Novartis project pipe assemblies, would support the reasonable inferences that Gallagher regarded the Foreman, but

However, to the extent that Gallagher’s safety manual created uncertainty as to whether the minimum regulatory standards for operation of the bridge crane in the fabrication shop were prescribed by applicable general industry standards rather than subpart CC of the construction industry standards, the safety manual was flawed. (*See* T. 81, 104). *See PSP Monotech Indus.*, 22 BNA OSHC 1303, 1306 (No. 06-1201, 2008) (noting that “the Secretary may prove constructive knowledge by showing that the employer failed to establish an adequate program to promote compliance with safety standards”), *citing NYSEG*, 88 F.3d at 106 (2d Cir. 1996).

“When determining the adequacy of instructions given to an employee, the Commission considers how effectively the information is communicated in light of the employee’s training.” *S. J. Louis Constr. of Tex.*, 25 BNA OSHC at 1895; *see also LJC Dismantling Corp.*, and *Par Elec. Contractors, Inc.* 20 BNA OSHC 1624. “More generalized instructions may be permissible in light of an employee’s specialized training and experience, just as they may be inadequate in light of an employee’s lack of experience, poor safety history, or lack of supervision.” *S. J. Louis Constr. of Tex.*, 25 BNA OSHC at 1896.

According to the Foreman, the procedure for rigging the large Novartis project pipe assemblies was that he would form a team and he would be directly involved in the rigging operation. He did this because the Novartis project pipe assemblies were “big and heavy, and I feel it’s ... a dangerous job to do and that’s why I pick the right guys and we do it.” (T. 122-123). The Foreman seemingly believed that pipefitters in the fabrication shop recognized and understood that the prescribed procedure for rigging operations involving large and heavy pipe

not J.T., to be a “qualified rigger,” within the meaning of that term as used in its Cranes and Derricks policy, with respect to rigging a large pipe assembly like the one involved in the accident.

assemblies like the one involved in the accident was that such rigging operations were to be started only at his direction and only under his direct supervision. (T. 121-124).

There is no evidence that addressed the method or manner by which the Foreman communicated this procedure to workers in the fabrication shop. Since there is no evidence this procedure was set forth in any written form, it is likely that he communicated it to the workers orally, if at all. In any event, whether this protocol was communicated in writing or orally or both, the weight of the evidence establishes that it was communicated inadequately.

The Foreman had not observed J.T. engage in any unsafe act or practice, and in his estimation J.T. “always did the right thing.” (T. 131, 132, 141, 153). The Foreman also believed that J.T. knew how to rig the pipe assembly properly, based on his union training and also because J.T. had worked “with us on some of the other big pipe assemblies.” (T. 126, 153, 156). The Foreman’s belief, however, does not completely square with his recognition that the Novartis pipe assemblies are “big and heavy, and I feel it’s ... a dangerous job to do and that’s why I pick the right guys and we do it.” (T. 122-123). Had the Foreman effectively communicated to J.T. that the Novartis project pipe assemblies were to be rigged only at the Foreman’s direction and only under his direct supervision, it is more likely than not that J.T. would have understood and complied with that protocol.

The fact that Joe Myles assisted J.T. in the hoist of the improperly rigged pipe assembly and apparently did not caution J.T. that doing so contravened the Foreman’s prescribed procedure, further supports the conclusion that this protocol was not adequately communicated to the fabrication shop pipefitters.

J.T. testified credibly that he believed he was doing what the Foreman would have expected him to do in acting alone and rigging the pipe assembly without the Foreman expressly

directing him to do so. J.T. had rigged the pipe assembly by himself (and without the Foreman's foreknowledge) two times before without reprimand or any other adverse consequence. In view of the Foreman's near constant presence on the shop floor, it is difficult to conceive how, following those two prior rigging operations, the Foreman failed to discern that the pipe assembly had been rigged and moved without him having been directly involved. The Foreman's lack of foreknowledge of any of the three times that J.T. did the "dangerous job" of rigging the pipe assembly, supports the conclusion that whatever instructions the Foreman communicated to J.T. as well as to other workers in the fabrication shop regarding rigging large and heavy pipe assemblies, those instructions were not communicated adequately.¹⁶

Further, the Foreman's inattentiveness in re-rigging the pipe assembly after the accident, when he substantially replicated J.T.'s improper rigging as the CO looked on, suggests that the practice of rigging pipe assemblies with only two points of attachment and with more than a single pipe choked, might not have been as uncommon a practice as believed. This might also explain, at least in part, why J.T. believed (erroneously) that he had rigged the pipe assembly correctly.

The Foreman certainly anticipated the hazard posed by even an experienced pipefitter undertaking alone and unsupervised the "dangerous job" of rigging the "big and heavy" pipe assemblies for the Novartis project. (T. 122-23). However, the Foreman failed in his supervision of even the experienced journeyman pipefitters on the rigging of those pipe

¹⁶ Both the Foreman and J.T. provided straightforward testimony, and both spoke with genuineness and sincerity. Both appeared to make honest efforts to abide by their oaths to testify truthfully. The Foreman was plainly mistaken in believing that up until the time of the accident, no Novartis project pipe assemblies had been rigged without his knowledge, when in actuality, J.T. had rigged the pipe assembly that injured him twice before without the Foreman's knowledge. It is apparent, therefore, that even though the Foreman spent most of the workday on the shop floor supervising work, there was significant activity in the shop of which he had no actual awareness.

assemblies, by failing to adequately communicate instructions that the pipe assemblies be rigged only at his expressed direction and only under his direct supervision. *Cf. Par Elec. Contractors, Inc.*, 20 BNA OSHC 1624.

Accordingly, the preponderance of the evidence establishes that the Foreman, in the exercise of reasonable diligence, should have known of the hazardous condition constituting the violation, which may be imputed to Gallagher based on his position as shop foreman. *Rawson Contractors, Inc.*, 20 BNA OSHC 1078.

Defense of Unpreventable Employee Misconduct

Gallagher argues that the violative condition was a product of J.T.'s unpreventable misconduct of using "an improper rigging technique and a failure to follow training." (Resp't Brief-in-Chief, p. 13).

To establish the defense of unpreventable employee misconduct, the employer must prove that "(1) it has established work rules designed to prevent the violation; (2) it has adequately communicated those rules to its employees; (3) it has taken steps to discover violations; and (4) it has effectively enforced the rules when violations have been discovered." *Burford's Tree, Inc.*, 22 BNA OSHC 1948, 1951-52 (No. 07-1899, 2010). "The Commission has considered these same factors in evaluating both an employer's constructive knowledge and the merits of an employer's unpreventable conduct affirmative defense." *Id.* at 1952; *S. J. Louis Constr. of Tex.*, 25 BNA OSHC at 1898, n. 17.

As discussed above, Gallagher failed to prove the second element of the affirmative defense. Specifically, Gallagher failed to establish that it adequately communicated to J.T. and to other workers in the fabrication shop that the Novartis project pipe assemblies were to be rigged only at the express direction, and only under the direct supervision, of the Foreman. For the same reasons described above in connection with evidence of constructive knowledge,

Gallagher has not established that the violation was the result of unpreventable employee misconduct.

Classification of Violation

The violation of § 1910.179(n)(3) is affirmed as serious. The failure of the load to be well secured and properly balanced in the sling could result in serious injury. (*See supra* Findings of Fact ¶ 89).

Item 2 -- § 1910.184(c)(9)

Elements 1, 2, & 3

As noted at the outset, § 1910.184(c)(9) provides that “[w]henver any sling is used, ... [a]ll employees shall be kept clear of loads about to be lifted and of suspended loads.” The parties agree that this standard applies (Joint Pretrial Statement, 4/9/2015), and the record evidence supports that understanding.

Amended item 2 alleges Gallagher violated § 1910.184(c)(9) in the following manner: “On or about 8/1/2014, an assembly of pipes was hoisted with a ... bridge crane with employees’ hands on it.” Commission precedent supports the Secretary’s contention that J.T.’s act of placing his hand directly on the suspended load violated the standard.¹⁷ J.T. was, of course, exposed to the violative condition.¹⁸

¹⁷ Before subpart CC of part 1926 became effective in the year 2010, the construction industry standard for cranes and derricks included § 1926.550(a)(19), which was identical to § 1910.184(c)(9) -- it provided as follows: “All employees shall be kept clear of loads about to be lifted and of suspended loads.” Several decisions of Commission judges have affirmed alleged violations of this identical former construction industry standard in situations where an employee had placed a hand directly on a suspended load. *See Kelly-Hill Co.*, No. 02-447, 2002 WL 31835496, at *8 (OSHRC ALJ Dec. 9, 2002) (finding violation of § 1926.550(a)(19) where employee was fatally injured while steadying a suspended load with his hands rather than with a tag line); *J. E. Dunn Constr. Co.*, No. 04-0251, 2005 WL 1927104, at *4 (OSHRC ALJ Aug. 1, 2005) (finding that employees who had guided a suspended load by hand were not “kept clear” of the load in violation of § 1926.550(a)(19)); *Boh Bros. Constr. Co., LLC*, No. 99-1590, 2000

Element 4 -- Employer Knowledge of § 1910.184(c)(9) Violative Condition

As with item 1, there is no evidence that Gallagher had actual knowledge of the violative condition. However, the weight of the evidence establishes that Gallagher's failure to discover the violative condition was due to a lack of reasonable diligence, so Gallagher is deemed to have had constructive knowledge.

Gallagher had no work rule that prohibited workers in the fabrication shop from placing hands directly on a load suspended by the bridge crane, and J.T. was never told not to do so. (T. 24). *See Danis Shook Joint Venture XXV*, 19 BNA OSHC at 1501 (defining "work rule"). To the contrary, Gallagher's safety manual indicated that all crane and derrick operations should be conducted according to construction industry standard for cranes and derricks, which allows a worker to place hands directly on suspended loads under specified limited circumstances.¹⁹ Not only was there no work rule prohibiting placing hands directly on a suspended load, J.T.

WL 385624, at *5 (OSHRC ALJ Apr. 17, 2000) (confirming employer's concession that it violated § 1926.550(a)(19) when an employee was fatally injured while attempting to push a suspended load with his hands); *see also Marathon Oil Co.*, No. 86-0670, 1987 WL 89184, at *2 (OSHRC ALJ Oct. 5, 1987) ("Unless an employee is within the fall danger zone of a particular suspended load, there is no violation of § 1910.184(c)(9)").

¹⁸ Gallagher has not argued in its post-hearing briefs that the Secretary failed to prove either that the standard was violated or that an employee had access to the violative condition.

¹⁹ Unlike the cited general industry standard relating to slings, the construction industry standard for cranes and derricks (codified in subpart CC of part 1926), which was not applicable here, seemingly allows employees to place hands directly on suspended loads. (T. 104). *See* "Cranes and Derricks in Construction," 73 Fed. Reg. 59714, 59757 (proposed Oct. 9, 2008) (to be codified at 29 C.F.R. pt. 1926) (observing that riggers "often guide crane loads manually"); *id.* at 59805 (observing that "guiding a load, even with a tag line, sometimes necessitates that the employee be positioned within the fall zone"); *see also* CO testimony at T. 104-05. Section 1926.1425 of subpart CC thus allows a worker who is "guiding a load" to be in the fall zone, but only when the following three conditions are met: "materials being hoisted must be rigged to prevent unintentional displacement"; "[h]ooks with self-closing latches or their equivalent must be used"; and the "materials must be rigged by a qualified rigger." § 1926.1425(b) & (c).

indicated that it was not unusual for him to do so because “usually you need to control it so it doesn't swing around or take off ... [or] roll around.” (T. 24).

Considering that workers in the construction industry may under some circumstances place hands directly on a suspended load (*see supra* footnote 19), and considering further that the pipefitters trade is generally regarded to be a construction industry trade (*see supra* Findings of Fact ¶ 22), Gallagher could not reasonably regard J.T.'s union training and years of work experience as having informed him not to place hands directly on a load that was suspended by the fabrication shop's bridge crane. *Cf. Par Elec. Contractors, Inc.*, 20 BNA OSHC 1624.

Gallagher's failure to have, and thus enforce, a work rule that prohibited a worker from placing hands directly on a suspended load in the fabrication shop constitutes a lack a reasonable diligence. The violative condition occurred due a lack of such reasonable diligence, so Gallagher is charged with having constructive knowledge of the violative condition.

Defense of Unpreventable Employee Misconduct

The proof that Gallagher had constructive knowledge of the violative condition effectively disproves its defense of unforeseeable employee misconduct. *Burford's Tree, Inc.*, 22 BNA OSHC 1948. The first element of the unforeseeable employee misconduct defense is that an employer “has established work rules designed to prevent the violation.” *Burford's Tree, Inc.*, 22 BNA OSHC at 1951. As discussed above, Gallagher had no work rule that prohibited placing hands directly on a suspended load, and J.T. was never instructed not to do so. The toolbox talk on rigging that J.T. attended in April 2014 did not address the subject of placing hands directly on a suspended load. Rather, the toolbox talk was geared toward workers in the construction industry, where the placing of hands directly on a suspended load is sometimes permitted under applicable standards. (*See supra* footnote 19). That toolbox talk may well have complemented

J.T.'s union training, inasmuch as the pipefitters' trade is generally regarded as a construction trade. (*See supra* Findings of Fact ¶ 22 and footnote 19).

Gallagher has failed to carry its burden to prove that the violation was the result of unpreventable employee misconduct.

Classification

The violation of § 1910.184(c)(9) is affirmed as serious. The failure to keep clear of the suspended load could result in serious injury as occurred in this case. (*See supra* Findings of Fact ¶ 90).

Penalty Assessment

The permissible range of penalties for a serious violation is from no penalty to \$7000. 29 U.S.C. § 666(b). The Commission and its judges conduct *de novo* penalty determinations and have full discretion to assess penalties based on the facts of each case and the applicable statutory criteria. *Valdak Corp.*, 17 BNA OSHC 1135, 1138 (No. 93-0239, 1995) *aff'd*, 73 F.3d 1466 (8th Cir. 1996); *Allied Structural Steel*, 2 BNA OSHC 1457, 1458 (No. 1681, 1975).

Section 17(j) of the Act, 29 U.S.C. § 666(j), requires that in assessing penalties, the Commission give “due consideration” to four criteria: the size of the employer’s business, the gravity of the violation, the employer’s good faith, and its prior history of violations. *Specialists of the S., Inc.*, 14 BNA OSHC 1910 (No. 89-2241, 1990). Gravity is the primary consideration among these four statutory criteria, and is determined by “such matters as the number of employees exposed, the duration of the exposure, the precautions taken against injury, and the likelihood that any injury would result.” *J.A. Jones Constr. Co.*, 15 BNA OSHC 2201, 2214 (No. 87-2059, 1993).

The Secretary proposed the maximum permissible penalty of \$7000 for item 1, and a penalty of \$4250 for item 2, for a total proposed penalty of \$11,250. The proposed penalties

were the product of a defined penalty calculus that determines penalty amounts based upon on certain parameters. (T. 65-68).

The CO regarded item 1 (improper rigging) to involve a “higher severity” hazard and a “greater probability” of injury resulting from the violation, thusly concluding that the overall gravity of the violation was “high gravity,” for which the Secretary’s starting point in the penalty calculus is \$7000. (T. 66-68). The CO reached this conclusion based on “the actual occurrence and the likelihood of a permanent physical injury or death resulting in an accident involving a load of this size.” (T. 65). The record does not support the CO’s apparent conclusion that the hazard from the improper rigging was of “higher” severity or that there was a “greater” probability of injury resulting. The most compelling indicator to the contrary is that the Foreman re-rigged the pipe assembly in the substantially identical way in which J.T. had rigged it, with the CO looking on. The Foreman intended to hoist the pipe assembly high enough to weigh it, and then lower it back down, which was essentially the same movement that J.T. had planned earlier. (T. 100). When the Foreman hoisted the improperly rigged pipe assembly, another weld broke, but no one was injured. There is no evidence that there was a greater probability that anyone was likely to have been injured in that incident, since, unlike J.T. earlier, everyone stayed clear of the improperly rigged suspended load. (T. 100).

The CO regarded item 2 (hand on suspended load) to be of “high severity” and “lesser probability” in concluding that the overall gravity of the violation was “moderate gravity.” (T. 66-68). The CO believed there was a lesser probability of injury from the violation because only one worker (J.T.) was exposed to the violative condition. (T. 66-68, 84-87; Ex. R-7).

As to the overall gravity of the violations, the evidence shows that two employees (not, as the CO concluded, three) were exposed to the item one violation (improper rigging) and one

employee was exposed to the item 2 violation (hand on suspended load). Employee exposure to both violations was for brief periods of time, but this brief exposure nevertheless resulted in one of those employees sustaining a serious permanent injury to his right hand. While the two violations were both causative factors in J.T.'s injury, the item 2 violation (hand on the suspended load) was a greater contributing factor to the injury than the item 1 violation (improper rigging).

The record establishes that Gallagher took precautions to prevent injury as to the item 1 violation, in that Gallagher had a procedure in place designed to prevent injury from improper rigging of large pipe assemblies like the one involved in the accident. In contrast, Gallagher had no work rule that prohibited workers from placing hands directly on loads suspended by the bridge crane.

The CO did not accord Gallagher any credit for good faith as to item 1 because the Secretary's policy is not to allow such credit for a "high gravity" violation. The CO did reduce the proposed penalty for item 2 for good faith by 15% to \$4250, based on the CO's conclusion that such credit was appropriate "for the good faith demonstrated by Thomas Gallagher's safety and health management system," which the CO regarded "to be fairly comprehensive and progressive, only containing minor deficiencies." (T. 67-68). As discussed previously, the CO's characterization of item 1 as "high gravity" is not supported by the evidence. If the CO had classified it more properly as "moderate gravity," the CO would have accorded credit for good faith for item 1 as well. (T. 65-68).

The CO did not credit Gallagher with any reduction for size, because with about 258 employees Gallagher was just slightly above the Secretary's threshold of 250 employees for a penalty reduction for size. (T. 66).

The CO did not accord any credit for compliance “history” because Gallagher had not been inspected in over five years. (T. 65). However, the evidence indicates that Gallagher maintained a generally effective safety and health program that had resulted in a generally compliant and safe workplace. (T. 55, 122, 134). Gallagher should be according some penalty credit for prior compliance history, notwithstanding the absence of any inspection in the preceding five years.

After considering all factors including gravity, size, good faith, and history, a penalty of \$1050 is assessed for item 1, and a penalty of \$2450 is assessed for item 2.

ORDER

The foregoing decision constitutes the findings of fact and conclusions of law in accordance with Federal Rule of Civil Procedure 52(a). If any finding is in actuality a conclusion of law or any legal conclusion stated is in actuality a finding of fact, it shall be deemed so, any label to the contrary notwithstanding. Based upon the foregoing findings of fact and conclusions of law, it is ORDERED that:

1. Citation 1, Item 1 for a serious violation of 29 C.F.R. § 1910.179(n)(3)(i) is AFFIRMED and a penalty of \$1050 is ASSESSED; and

2. Citation 1, Item 2, for a serious violation of 29 C.F.R. § 1910.184(c)(9) is AFFIRMED and a penalty of \$2450 is ASSESSED.

SO ORDERED.

/s/
WILLIAM S. COLEMAN
Administrative Law Judge

DATED: July 18, 2016