

SECRETARY OF LABOR,
Complainant,

v.

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OSHRC Docket No. 95-1828

COOPER/T. SMITH STEVEDORING
COMPANY, INC.,
Respondent.

Appearances:

Joseph P. Lockett, Esquire
Office of the Solicitor
L.L.C.
U. S. Department of Labor
Nashville, Tennessee
For Complainant

David R. Peeler, Esquire
McRight, Jackson, Dorman, Myrick & Moore,
Mobile, Alabama
For Respondent

Before: Administrative Law Judge Ken S. Welsch

DECISION AND ORDER

Cooper/T. Smith Stevedoring Company, Inc. (CTS), manages a marine terminal in Memphis, Tennessee. On September 22, 1995, an employee was crushed to death when 2,800-pound metal baskets of crude rubber fell while unloading a barge. As a result of the accident, the Occupational Safety and Health Administration (OSHA) conducted an inspection. On December 4, 1995, CTS was cited for serious and “other” than serious violations under the marine terminal standards at 29 C.F.R. Part 1917. CTS contested only the serious citation (Tr. 3).

At the hearing, OSHA withdrew the alleged violations of §§ 1917.45(e)(2) and 1917.50(c)(6) (items 3 and 4). CTS withdrew its contest to a violation of § 1917.112(b)(3) (item 5) and agreed to pay the proposed penalty of \$1,700 (Tr. 6). The issues remaining in dispute involve alleged violations of §§ 1917.42(a)(1), 1917.42(a)(2), 1917.42(a)(3), and 1917.42(j)(2) (items 1a, 1b, 1c, and 2). OSHA proposed a penalty of \$2,975 for each item. OSHA alleges that CTS failed to inspect the J-hooks used during cargo handling operations and failed to discard defective J-hooks that were bent or sprung.

CTS acknowledges that it is an employer engaged in a business affecting commerce within the meaning of section 3(5) of the Occupational Safety and Health Act (Act) (Tr. 4-5).

The Accident

The marine terminal located along Riverport Road, Memphis, Tennessee, is owned by the Lash Intermodal Terminal Company. It is a large terminal where barges are lifted from the Mississippi River for loading and unloading under a roof (Tr. 16-17, 140). CTS manages and supervises the daily operations of the terminal. It also owns the gear and equipment used in cargo handling (Tr. 70). Copeston Service, Inc. (Copeston), supplies the labor to CTS (Tr. 17, 56-57).

On September 22, 1995, the day of the accident, a barge containing approximately 262¹ metal baskets of crude rubber for Goodyear was unloading at the terminal. The Goodyear contract is one of the largest commodities handled at the terminal involving several barges a week (Tr. 176-177). Each basket of rubber is approximately 53 inches long, 44 inches wide, and 42 inches high. It weighs approximately 2,800 pounds (Exhs. C-2, C-3; Tr. 22, 215). The baskets are removed from the barge by an overhead crane.

Each lift by the crane holds six baskets, two adjacent stacks of three baskets each. The lifting gear consists of a spreader bar, eight wire ropes, bungi cords, and J-hooks. The wire ropes are approximately 8 feet long, and a bungi cord ranging from 36 to 45 inches is attached to each wire rope. The bungi cord allows the wire rope to remain taut and provides resistance. To attach to the baskets, CTS uses specially manufactured hooks called “J-hooks.” The J-hooks are

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A full barge contains 262 baskets (Tr. 167).

designed to fit under the lip or rim of the baskets. The rim is tubular steel, approximately 3 inches wide, around the top of the basket. There is a 1-inch opening under the rim for the hooks to fit (Tr. 45, 157). In lifting the six metal baskets, the eight J-hooks are attached to the bottom baskets in the two adjacent stacks (Exh. C-2; Tr. 20-22).

On the day of the accident, a forklift operator and two laborers were working in the barge's cargo hole preparing the metal baskets for unloading. The unloading operation began at 6:30 a.m. (Tr. 156). After the forklift stacked six baskets, the laborers placed the J-hooks on the bottom two baskets. Working on opposite sides of the stacked baskets, each laborer placed four J-hooks, and the overhead crane lifted the six baskets from the cargo hole. After the crew unloaded approximately eighty baskets, the laborers placed the eight J-hooks on another stack of baskets (Tr. 167-168). It was approximately 9:30 a.m. The crane began lifting and tightening the wire ropes. As the laborers walked away, they heard the sound of metal on metal as one J-hook came loose and slipped from the baskets. The crane immediately stopped lifting, and the baskets shifted, falling on one of the laborers. The laborer died at the site (Tr. 158-159).

OSHA investigated the accident on September 27 and 28, 1995 (Tr. 97). The J-hooks were examined and the employees, including the gearman who selected the lifting gear, were interviewed. Based on the investigation, CTS was cited for failing to inspect the J-hooks before use and, when necessary, at intervals during use, and for failing to discard bent or sprung hooks.

Discussion

In order to establish a violation of a safety standard, the Secretary of Labor must show by a preponderance of the evidence that (1) the cited standard applies to the alleged condition; (2) the terms of the standard were not complied with; (3) employees were exposed to or had access to the violative condition; and (4) the employer knew or could have known of the violative condition with the exercise of reasonable diligence. *Seibel Modern Mfg. & Welding Corp.*, 15 BNA OSHC 1218, 1221-22, 1991-93 CCH OSHD ¶ 29,442, p. 39,678 (No. 88-821, 1991).

CTS does not dispute that the Memphis facility is a marine terminal and, thus, the Part 1917 standards are applicable. See § 1917.2(u). Also, it is undisputed that employees were exposed; CTS knew of the condition associated with the cargo handling operation; and CTS was responsible for the safety of the laborers supplied by Copeston. CTS managed and supervised the cargo handling at the terminal (Tr. 56). Its superintendent was on the deck, approximately 10 feet from the accident site, directing the unloading operation (Tr. 24). Also, the J-hooks were specially ordered by CTS for the cargo handling operations (Tr. 203).

CTS disputes that it violated the cited standards. It argues that it complied with the inspection requirements of the standards, and OSHA failed to show that bent or sprung hooks were used at the time of the accident.

I. Alleged Violations of §§ 1917.42(a)(1) and 1917.42(a)(2) (Items 1a and 1b)

The standards² require an inspection of all loose gear used in cargo handling. The gear is to be inspected before each use and, when necessary, at intervals during its use. Loose gear includes hooks such as the J-hooks used by CTS. See §1917.42(a)(1).

Facts

The gearman assembled the lifting gear, including the J-hooks, used to unload the baskets of crude rubber the night before the accident. He had worked as the gearman for one year (Tr. 228). To select the eight J-hooks for the lifting operation, the gearman testified that he used his “eyesight” and the cuff of his hand “to judge whether I could stick it up in the place where you hold it and pick up the basket and lift it up in the air.” If he thought a hook was too far bent, he stated that another hook would be chosen (Tr. 230). There were approximately twelve J-hooks from which the gearman made his selection (Tr. 143, 222). The gearman did not know the size of

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Section 1917.42(a) provides:

(1) At the completion of each use, loose gear such as slings, chains, bridles, blocks and hooks shall be so placed as to avoid damage to the gear. Loose gear shall be inspected and any defects corrected before reuse.

(2) All loose gear shall be inspected by the employer or his authorized representative before each use and, when necessary, at intervals during its use, to ensure that it is safe. Any gear which is found upon such inspection to be visibly unsafe shall not be used until it is made safe.

the J-hook's throat opening³ as originally manufactured. Also, he received no training nor was he provided any guidelines by CTS for selecting the hooks. He stated that the eight hooks selected for September 22, 1995, were those hooks he considered the best available (Tr. 236-238).

CTS's safety and loss manager testified the J-hooks were designed so that the weight of the baskets rested in the saddle of the hook and not on the hook's tip. He stated that the closer a hook was bent in an "L" shape, the more likely the J-hook could come loose from the baskets being lifted (Tr. 205-206). However, he acknowledged that CTS did not provide the gearman and supervisors with instructions or guidelines as to what constituted an unsafe hook. There was no checklist or other means provided by CTS to determine if a hook safely fit under the rim of the basket (Tr. 212).

Discussion

The issue before the court is what constitutes an "inspection" of the J-hooks under the standards. The Secretary alleges that CTS failed to inspect the J-hooks and merely selected the best available hooks without determining whether the condition of the hooks precluded its safe use (Complainant's Brief, p. 16). CTS argues that OSHA's inspection standards do not impose on an employer any specific requirements. CTS claims that its gearman performed an acceptable inspection in that his inspections resulted in discarding numerous hooks (Respondent's Brief, p. 3).

An "inspection" is defined in the marine terminal standards at § 1917.2(r) as "a complete visual examination of all visible parts of the device." The purpose or reason for requiring such visual examinations of the J-hooks, as in this case, is to prevent the use of defective or unsafe hooks. CTS acknowledges that to be a safe hook, the J-hook must fit under the rim of the basket, and the weight of the basket must rest in the throat or saddle of the hook as opposed to its tip. Section 1917.42(j)(5) requires that "loads shall be applied to the throat of the hook only." CTS accepts that the closer a J-hook is bent to an "L" shape, the more likely the hook could slip from

³The throat opening is the distance from the tip of the hook to the back of the hook (Tr. 30).

the basket. Therefore, it must be shown whether CTS's inspection of the J-hooks was designed to ensure the safe lift of the metal baskets.

The J-hooks were specially manufactured to perform the lift. The rim around the baskets provided a 1-inch opening to place the J-hooks. In order to ensure that the J-hooks properly fit under the rim and the weight of the load correctly applied to the throat, CTS needed to utilize some criteria or guideline to determine suitability (Exh. C-18; Tr. 45, 157). No such standard was shown by CTS. Instead, CTS apparently relied on the discretion of the gearman.

The gearman, however, was not trained as to what constituted a safe J-hook. He was not instructed to use any criteria or guideline in deciding whether the hooks would safely hold the baskets in the throat of the hook. He did not know the size of the hook's throat opening, as originally manufactured, to judge whether the opening had spread or increased. By failing to use any criteria or guidelines, it was not shown that CTS's inspection ensured the proper fit of the J-hooks. The gearman was not instructed on what to look for or provided any definition of a safe hook (Tr. 223).

Although the gearman had previously worked as a laborer for six months attaching the J-hooks to baskets, there was no showing that laborers were trained or made aware that the weight of the baskets needed to rest in the hook's throat and not on the tip of the hook. It was also not shown how the gearman used the cuff of his hand in selecting the hooks or that his hand had any relationship to the rim opening. Furthermore, the gearman merely described his inspection process for OSHA as selecting the best hooks available at the time.

The gearman's selection of the best hooks available does not constitute an "inspection" as contemplated by the standards. Selecting the best hooks available, without making a determination as to whether the condition of the hooks would preclude their safe use, does not satisfy the purpose or reason for requiring an inspection. Using the best available hook does not ensure that the weight of the baskets are resting in the hooks' throat or saddle. Also, the record reflects that there are only twelve hooks to choose from in selecting the best available hooks (Tr. 222).

In inspecting the J-hooks, it must be shown that such inspections accomplish the reason or purposes contemplated by the standards. In this case, this requires the use of a set of guidelines

or criteria to determine if the hook can safely perform the lift. CTS failed to make such an inspection in its selection of the J-hooks.

Accordingly, violations of §§ 1917.42(a)(1) and 1917.42(a)(2) are affirmed.

II. Alleged Violation of § 1917.42(a)(3) and 1917.42(j)(2)(Items 1c and 2)

OSHA alleges that distorted hooks were not discarded and “several hooks used in barge bay No. 5 on barge CG-200 with spreader bar #RS-2 on September 22, 1995, were bent or sprung” in violation of §§ 1917.42(a)(3)⁴ and 1917.42(j)(2).⁵ CTS asserts that the J-hooks used at the time of the accident were not bent or sprung. It argues there is no evidence the J-hooks were in the same condition prior to the accident as observed by OSHA after the accident. Also, CTS questions as inaccurate OSHA’s finding that the hook’s throat opening was 1 7/8 inches as originally manufactured.

Facts

On three occasions during its investigation, OSHA requested a certified drawing for the J-hooks used at the Memphis terminal. Each time, CTS provided the same drawing of a J-hook from its North Carolina terminal (Exh. C-4; Tr. 28-29). From this drawing, OSHA calculated the hook’s throat opening as 1 7/8 inches, which was considered the original opening’s manufactured size (Tr. 30). OSHA then measured the throat openings of the eight J-hooks used during the accident and found the openings ranged from 2 inches to 3 1/2 inches (Exhs. C-7 thru C-14). OSHA concluded that the throat openings increased from their original manufactured size of 1 7/8 inches to the following: one hook increased to 3 1/2 inches or 87 percent; two hooks increased to 3 inches or 60 percent; one hook increased to 2 3/4 inches or 47 percent; two hooks increased to 2 1/2 inches or 33 percent; and two hooks increased to 2 inches or 6 percent (Exh. C-17).

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Section 1917.42(a)(3) provides that "defective gear shall not be used. Distorted hooks, shackles or similar gear shall be

⁵Section 1917.42(j)(2) provides that "bent or sprung hooks shall be discarded."

The crane operator testified that he observed the J-hooks prior to the accident and described them as worn and a “little” stressed and sprung (Tr. 162). He also observed the hooks after the accident and described one hook as considerably worse (Tr. 163). During the hearing, he reviewed a photograph of one of the hooks but was unable to state whether its throat opening was the same as before the accident (Tr. 165).

CTS’s general manager stated that the J-hooks were ordered once a year from Mobile, Alabama, and were certified to lift 4,000 pounds (Tr. 222, 224). He testified the throat openings of the hooks he ordered were 2 1/2 inches and not 1 7/8 inches as determined by OSHA (Tr. 216). However, he acknowledged that some hooks used at the Memphis terminal were ordered prior to his employment, which was after the accident. He did not know the size of these hooks (225-226).

The gearman who selected the hooks stated that he looked at the hooks after the accident. He described the throat openings as being more spread than when he selected them (Tr. 235). He testified that the current J-hooks have throat openings of 2 1/2 inches. However, he described the current hooks as much larger than the hooks used at the time of the accident (Tr. 237).

Discussion

Sections 1917.42(a)(3) and 1917.42(j)(2) require an employer to discard distorted hooks that are bent or sprung. Although Part 1917 does not define “bent” or “sprung,” OSHA notes that § 1910.197(j)(2)(iii) of the general industry standards requires discarding hooks with a throat opening which increases by 15 percent (Tr. 28). Similarly, paragraph 10-1.2.1.3(c) of ANSI B-30.10 dated 1993 requires removing from service hooks having a throat opening exceeding 15 percent, or as recommended by the manufacturer (Exh. C-5; Tr. 34).

The court concludes that unless otherwise specified by the manufacturer, the 15 percent requirement found in the general industry and ANSI standards provides an acceptable criteria for determining a bent or sprung hook in this case. The Review Commission recognizes that another standard may be used to give meaning to an undefined, broad term in a cited standard. *Armour Food Co.*, 14 BNA OSHC 1817, 1825, 1987-90 CCH OSHD ¶ 29,088, p. 38,887 (No. 86-247, 1990); *Gold Kist, Inc.*, 7 BNA OSHC 1855, 1861, 1980 CCH OSHD ¶ 24,205, p. 29, 443 (No. 76-2049, 1979) (OSHA may use NFPA Life Safety Code as an aid in interpreting a standard). As

discussed, CTS used no definition for “bent or sprung” in determining the suitability of the hooks to safely lift the baskets.

The court also accepts OSHA’s finding that the originally manufactured size of the hook’s throat opening was 1 7/8 inches. OSHA repeatedly requested a certified drawing of the J-hooks and was provided the same drawing on three separate occasions. CTS offered no other certified drawing from which to determine the throat opening.⁶ Certified drawings of loose gear, such as hooks, are required by §1917.50(c)(6). Little weight is given to CTS’s general manager’s testimony about ordering only hooks with openings of 2 1/2 inches. The general manager did not order J-hooks until after the accident. He acknowledged that prior to his employment, there were other J-hooks at the Memphis terminal, and he did not know their size (Tr. 225-226). Also, even if the throat opening was 2 1/2 inches, as alleged by CTS, at least three of the hooks⁷ measured by OSHA would still have exceeded the 15 percent limitation (Tr. 91).

Therefore, having accepted the 15 percent limitation in defining “bent” or “sprung,” and having also found the size of the J-hook’s throat opening was 1 7/8 inches, as originally manufactured, the issue remains as to whether the openings as measured by OSHA were the same before as after the accident. CTS argues that the size of the throat openings increased because of the unexpected weight resulting from the accident. There is no evidence which hook slipped from the baskets or if it slipped because it was bent or sprung as opposed to not being properly placed under the rim. An employee testified that hooks have slipped from baskets in the past when there was not enough pressure applied (Tr. 170-172). The lack of sufficient pressure has nothing to do with whether the hook was bent or sprung.

Based on the record, the court finds that there is insufficient evidence to show the extent of the hooks’ throat openings prior to the accident, and if such openings exceeded the 15 percent

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CTS offered a drawing of a hook at the hearing (Exh. R-1). However, it was not certified and there is no scale shown. Further, although known as an issue, it was not provided to OSHA until shortly before the hearing (Exh. C-21).

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CTS agreed that it would not use the three hooks with openings measuring 3 inches and 3 1/2 inches.

limitation. OSHA's compliance officer acknowledges that the throat openings could have increased from the unexpected overloading during the accident (Tr. 113, 116). There were only two witnesses, the crane operator and the gearman, who described the condition of the hooks prior to the accident. However, their testimony provided only vague descriptions, contradicted each other, and failed to establish the size of the throat opening of any hook prior to the accident.

The crane operator generally described the condition of the hooks prior to the accident as a little worn, stressed, and sprung. His description fails to show the size of any hook's opening. There was also no showing he knew the size of the throat opening as originally manufactured. At the hearing, he agreed that one hook looked worse than before the accident. He could not testify about the other hooks.

The gearman who selected the hooks, on the other hand, testified that the throat openings were more spread open after the accident than when he selected the hooks. However, the gearman's testimony is also not particularly helpful in that, as discussed, he did not know the size of the opening, as originally manufactured. He also was unable to describe the size of the throat opening when he selected the hooks.

Therefore, the Secretary's burden of proof is not met. The unexpected weight from the accident could have increased the size of the throat openings to the degree measured by OSHA. There was no showing that such openings existed prior to the accident. Also, at least two of the hooks measured by OSHA were within the 15 percent limitation.

Accordingly, the alleged violations of §§ 1917.42(a)(3) and 1917.42(j)(2) are vacated.

III. Classification

In determining whether the violations of §§ 1917.42(a)(1) and 1917.42(a)(2) are serious within § 17(k) of the Act, OSHA must show that CTS knew or should have known, with the exercise of reasonable diligence, the presence of the violations and if there was a substantial probability that death or serious physical harm could result from the condition.

The record establishes that CTS knew of the inspection requirements of the standards in that CTS provided the hooks, and the safety manager testified that he was aware of the marine standards involving hooks (Tr. 193). As for the expected injury, the issue is whether the resulting injury would likely be death or serious harm if an accident should occur. *Whiting-Turner Contracting Co.*, 13 BNA OSHC 2155, 2157, 1989 CCH OSHD ¶ 30,148, p. 41,478, n. 5 (No. 91-862, 1993). CTS's failure to adequately inspect the hooks to ensure their safe performance, as contemplated by the standards, exposed employees to serious injury or death. The J-hooks were expected to lift six 2,800-pound metal baskets of crude rubber by properly fitting under the rim of the baskets. The inspection by CTS did not ensure the proper fit of the hooks. Accordingly, the violations of §§ 1917.42(a)(1) and 1917.42(a)(2) were serious.

IV. Penalty

The Commission is the final arbiter of penalties in all contested cases. Under § 17(j) of the Act, in determining an appropriate penalty, the Commission is required to consider the size of the employer's business, history of previous violations, the employer's good faith, and the gravity of the violation. Gravity is the principal factor to be considered.

OSHA proposed a grouped penalty for item 1 of \$2,975. However, this grouping included an alleged violation of §1917.42(a)(3) for using distorted hooks, which the court has vacated. In considering the penalty, OSHA gave CTS no credit for size and history because CTS has 300 employees and was previously cited for an OSHA violation in 1993. A maximum credit of 25 percent for good faith was also given by OSHA because of CTS's cooperation and its comprehensive safety programs (Tr. 71-73). The court accepts OSHA's findings as to size, history, and good faith. With regard to the gravity, the court finds the severity and probability in failing to properly inspect the J-hooks is moderate. At least three employees are exposed to the cargo lifting operation, and the J-hooks are regularly used several times a week. An inspection of the hooks to ensure their proper fit under the rim of the baskets is necessary for the safety of the employees. However, there is no evidence of any previous accidents involving the J-hooks or that the accident was caused by a defective hook.

Accordingly, for serious violations of §§ 1917.42(a)(1) and 1917.42(a)(2), a grouped penalty of \$2,000 is assessed.

FINDINGS OF FACT AND
CONCLUSIONS OF LAW

The foregoing decision constitutes the findings of fact and conclusions of law in accordance with Rule 52(a) of the Federal Rules of Civil Procedure.

ORDER

Based upon the foregoing decision, it is ORDERED that serious Citation No. 1 be disposed of as follows:

1. Item 1a, in violation of § 1917.42(a)(1), and item 1b, in violation of § 1917.42(a)(2), are affirmed and a grouped penalty of \$2,000 is hereby assessed.
2. Item 1c, in violation of § 1917.42(a)(3), is vacated.
3. Item 2, in violation of § 1917.42(j)(2), is vacated.
4. Item 3, in violation of § 1917.45(e)(2), is withdrawn by the Secretary.
5. Item 4, in violation of § 1917.50(c)(6), is withdrawn by the Secretary.
6. Item 5, in violation of § 1917.112(b)(3), is affirmed pursuant to CTS's withdrawal of its notice of contest, and a penalty of \$1,700 is hereby assessed.

KEN S. WELSCH
Judge

Date: February 6, 1997