United States of America
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
1924 Building - Room 2R90, 100 Alabama Street, S.W.
Atlanta, Georgia 30303-3104

Secretary of Labor, Complainant v. CME Corporation, Respondent.	OSHRC Docket No.: **16-1851**

Appearances:

Lisa A. Cottle, Esq., U.S. Department of Labor, Office of the Solicitor, Cleveland, Ohio
For the Secretary

Theodore T. Storer, Esq., Rothberg, Logan & Warsco, LLP
For the Respondent

BEFORE: Administrative Law Judge Heather A. Joys

DECISION AND ORDER

On September 15, 2016, an employee of CME fell more than 10 feet into a pit while working on a construction project at a turkey processing plant in Saint Henry, Ohio. He survived. His injuries required multiple surgeries and he remains unable to work. There is no dispute the employee fell through an unguarded opening along the edge of the level just above the pit. CME contends the opening was a point of access to the upper level from the pit which did not need to be guarded under the applicable regulations. The Secretary contends the unguarded opening was not being used as a point of access at the time and, therefore, required some form of fall protection. Resolving this mixed issue of law and fact is what is before me in this case.

Following the accident in September 2016, Compliance Safety and Health Officer (CSHO) Dan Steffen of the Occupational Safety and Health Administration's Toledo Area Office conducted an inspection of the facility at which CME was performing construction work. Based upon his findings, the Secretary issued CME a serious citation alleging a violation of 29 C.F.R. § 1926.501(b)(1) for failure to provide fall protection to the injured employee as he

worked along the edge of the pit. The Secretary proposed a penalty of $6,236.00 for this citation. The Secretary also issued an other than serious citation alleging a violation of 29 C.F.R. § 1904.39(a)(2) for failure to report the accident, for which he proposed a penalty of $3,500.00. CME timely contested the citations, bringing this matter before the Occupational Safety and Health Review Commission pursuant to § 10(c) of the Occupational Safety and Health Act of 1970, 29 U.S.C. § 651-678 (the Act). CME contests both the citation and the associated penalty of the alleged serious violation of § 1926.501(b)(1). It contests only the penalty assessed for the other than serious violation of § 1904.39(a)(2).

I held a hearing in this matter on August 16, 2017, in Detroit, Michigan. The parties filed post-hearing briefs on October 10, 2017.[1]

For the reasons discussed below, Item 1, Citation 1, is affirmed and a penalty of $6,000.00 is assessed. Item 1, Citation 2, is affirmed and a penalty of $500.00 is assessed.

JURISDICTION

The parties stipulated jurisdiction of this action is conferred upon the Commission pursuant to § 10(c) of the Act (Tr. 8). The parties also stipulated at the hearing that at all times relevant to this action, CME was an employer engaged in a business affecting interstate commerce within the meaning of § 3(5) of the Act (Tr. 8-9). Based on the parties's stipulations and the facts presented, I find CME is an employer covered under the Act and the Commission has jurisdiction over this proceeding.

BACKGROUND

The Project

CME is a commercial construction company headquartered in Fort Wayne, Indiana. It is a family-owned business with approximately 30 employees (Exhs. R-5; R-6; R-7). For certain jobs, CME uses temporary workers supplied by United Labor Group (ULG). The majority of its workforce is full-time CME employees (Tr. 243).

In 2016, CME had a contract to build an offal processing building for a turkey producer in Saint Henry, Ohio. Paul Martin was CME's site superintendent for that job (Tr. 161). Martin

[1] To the extent either party failed to raise an argument in its post-hearing brief, such argument is deemed abandoned. *See S & S Diving*, 8 BNA OSHC 2041, 2042 (No. 77-4243, 1980). Although CME raised the affirmative defense of unpreventable employee misconduct in its Answer, CME's brief does not address it. That affirmative defense is deemed abandoned.

described the building and the work CME was performing. The building consisted of three areas. The top area was a cooler. That level was elevated 4 feet above ground level to allow loading and unloading tractor trailers (Tr. 164). It was separated from the other areas of the building and the outside by insulated cooler panels.[2] The building had an area at ground level which was referred to as the mezzanine (Tr. 164). That level was accessible by a ground-level entrance with an overhead door. Below the mezzanine was the pit. The distance from the edge of the mezzanine to the pit below was 11 feet, 2 inches (Tr. 163). CME had installed a standard guardrail along the length of the edge of the mezzanine, leaving two unguarded openings in which it placed ladders to the pit (Tr. 172; Exh. C-3). Where the mezzanine and the cooler abutted was a 4-foot wall referred to as the knee wall.[3] During the relevant time period, CME was in the process of installing the cooler panels that separated the cooler from the other areas.

The cooler panels fit together in tongue and groove fashion (Tr. 167). The CME crew installed the panels in a channel that ran the length of the wall between the cooler area and the pit and the knee wall.[4] The joints between the panels and the channel were caulked to ensure an airtight seal. Two men worked on both sides of the panels screwing them in on the top and bottom (Tr. 165). To reach the panels from the pit area, the two men working on the pit side of the wall used a scissor lift.

The Accident

The injured employee was an experienced iron worker. He had been in the industry for 16 years (Tr. 96). He came to work for CME through ULG and was assigned to begin work on September 12, 2016, on the Saint Henry job. The week prior, CME had sent the injured employee to its headquarters in Fort Wayne, Indiana, for an 8-hour training session, including fall protection training (Tr. 100).

On Monday, September 12, 2016, the injured employee arrived at the worksite at 7:00 am (Tr. 103). On site were Martin and four other CME employees (Tr. 104). Martin was the only member of CME management onsite (Tr. 104). Using the scissor lift to access the area, the injured employee and his co-worker installed the panels along the wall of the upper level

[2] The fully installed cooler panels are depicted in Exhs. C-2 and C-3.
[3] This area is depicted in the photograph at Exh. C-2, which was taken by CSHO Steffen after the accident (Tr. 33-34).
[4] The channel is depicted in Exh. C-4 (*see also* Tr. 44).

adjacent to the pit. They installed panels up to the edge of the pit during the first day (Tr. 105). The following two days, the crew installed panels on the exterior walls (Tr. 106).

On Thursday, September 15, 2016, the injured employee arrived on site at 7:10 am and was told they would be installing the remainder of the panels along the knee wall from the mezzanine (Tr. 106-07). He and his co-worker went to the mezzanine level to begin to prepare the channel in which the panels were to sit, as instructed by Martin (Tr. 107-09, 177). According to Martin, he saw the injured employee cleaning the channel using his glove and asked what he was doing (Tr. 187, 200-01). Martin then left the area to prepare the panels.

Prior to beginning work with the panels, Martin had the ladder leading from the mezzanine to the pit removed from the opening. He then had another employee move a scissor lift into the area (Tr. 182). The lift was flush with the edge of the mezzanine and parallel to the wall of the cooler (Tr. 111). There was a distance of approximately 2 feet between the wall and the lift (Tr. 112).[5]

The injured employee first cleaned dust and debris from the channel and dumped the material over the edge of the mezzanine. He then began to caulk the channel. As he did so, he stood between the lift and the knee wall. At one point, he ran out of caulk and turned to reach for more from the floor of the lift behind him (Tr. 114). He turned back to continue caulking, took a step, and fell off the edge of the mezzanine to the pit, 11 feet below (Tr. 114). His co- worker called out to him, alerting Martin (Tr. 189). Martin went down the ladder on the opposite end of the mezzanine to assist the injured employee (Tr. 189). The injured employee was placed on a lift in the pit and elevated to the mezzanine. At that point, the lift on the mezzanine level had been moved out of the way (Tr. 191). Once at the mezzanine level, Martin and another

[5] On this issue, I credit the testimony of the injured employee. He testified he did not do anything "out of the ordinary" to fit in the space between the lift and the wall and had enough room to turn his body around to reach the lift (Tr. 116-17). The injured employee described himself as "a pretty big guy." (Tr. 137). To my observation, he is an average size adult man. Two feet is a reasonable estimate of the space needed to perform this task. The only evidence that contradicts the injured employee's testimony on this issue is Martin's testimony that the photographs at Exhs. C-4 and C-7, which show a 10-inch gap between the lift and the knee wall, accurately depict the position of the lift at the time of the accident. Martin conceded the photographs were taken by CME after the lift had been moved out of its original position and repositioned (Tr. 191, 197). Martin had not moved the lift into place either time, but had the employee who originally positioned the lift restage the scene after the accident prior to taking the photographs (Tr. 197-98). The employee who moved the lift did not testify. The injured employee testified the photographs are not accurate depictions of where the lift was when he was working in the area (Tr. 111-12). On this issue, the injured employee was the most competent and credible witness. He was in the best position to estimate the distance between the lift and the knee wall before the accident. He testified in a calm, forthright manner and appeared to harbor no animosity toward CME or ULG.

employee helped the injured employee to Martin's truck and transported him to the hospital (Tr. 192).

While the injured employee was being assisted, a CME employee called the company's Corporate Safety Director, Tom Smith (Tr. 193, 227). Smith drove immediately to the worksite from his office in Fort Wayne (Tr. 228). While driving, he notified ULG of the accident (Tr. 228). Neither Smith, nor any one from CME notified OSHA of the accident.

As a result of the fall, the injured employee fractured his pelvis in four places, fractured his right elbow and left wrist, suffered injury to his back, and ruptured his bladder (Tr. 124). He has undergone three surgeries to address his injuries and has been unable to return to work due to his injuries as of the date of the hearing (Tr. 125).

The OSHA Inspection

The OSHA Toledo Area Office received a complaint regarding the accident (Tr. 19). CSHO Steffen was assigned to conduct the inspection and visited the Saint Henry worksite on October 3, 2016. The project was not complete when CSHO Steffen arrived onsite, but no employees of CME were working (Tr. 20, 26). CSHO Steffen initially met with Martin. Martin accompanied him on his walk around the facility (Tr. 26). CSHO Steffen's inspection consisted of taking photographs and measurements. He also spoke with Martin. As a follow up to the onsite inspection, CSHO Steffen requested documentation from CME and contacted employees off site (Tr. 26).

As a result of his inspection, CSHO Steffen recommended CME be issued a citation alleging a serious violation of § 1926.501(b)(1) for failure to provide fall protection at the location where the injured employee fell. CSHO Steffen recommended CME be issued an other than serious citation alleging a violation of § 1904.39(a)(2) for failure to report the in-patient hospitalization of the injured employee. The Secretary proposed a penalty of $6,236.00 for the serious violation of § 1926.501(b)(1) and a penalty of $3,500.00 for the other than serious violation of § 1904.39(a)(2).

DISCUSSION

The Secretary has the burden of establishing the employer violated the cited standard. To prove a violation of an OSHA standard, the Secretary must show by a preponderance of the evidence that (1) the cited standard applies; (2) the employer failed to comply with the terms of the cited standard; (3) employees had access to the violative condition; and (4) the cited

employer either knew or could have known with the exercise of reasonable diligence of the violative condition. *JPC Group, Inc.*, 22 BNA OSHC 1859, 1861 (No. 05-1907, 2009).

Item 1, Citation 1: The Alleged Violation of 29 C.F.R. § 1926.501(b)(1)

Item 1, Citation 1 alleges a violation of § 1926.501(b)(1). Section 1926.501(b)(1) is part of Subpart M - Fall Protection. It reads:

> Each employee on a walking/working surface (horizontal and vertical surface) with an unprotected side or edge which is 6 feet (1.8 m) or more above a lower level shall be protected from falling by the use of guardrail systems, safety net systems, or personal fall arrest systems.

The Secretary alleges CME violated the standard when, on September 15, 2016, at the Saint Henry worksite, it "failed to ensure employee(s) installing insulated cooler panels in the Offal Building were adequately protected from falls." The citation specifically references the injured employee's exposure to an 11-foot, 2-inch fall from the mezzanine to the "concrete floor below."

Applicability of the Cited Standard

There is no dispute CME was engaged in construction work and the mezzanine was a walk/working surface more than 6 feet above a lower level. The issue for resolution is whether the open edge of the mezzanine through which the injured employee fell was an "unprotected side or edge" as that term is defined in the standard. Section 1926.500(b) defines an unprotected side or edge as "any side or edge (except at entrances to points of access) of a walking/working surface…" CME contends the cited area was not an "unprotected side or edge," but rather the ladder access area of the mezzanine.

It is well settled the party seeking the benefit of an exception to a legal requirement has the burden of proof to show that it qualifies for that exception. *C.J. Hughes Construction, Inc.,* 17 BNA OSHC 1753, 1756 (No. 93-3177, 1996); *Dover Elevator Co*., 15 BNA OSHC 1378, 1381 (No. 88-2642, 1991). CME has the burden to establish the area at issue falls within the exception to the definition of an unprotected side or edge.

There is little dispute the unguarded area was intended to be used as a point of access at some time. The record contains little evidence of when or how the ladder was used. Given the care CME used in erecting the guardrails, a reasonable inference can be drawn that the area was intentionally left open for the purpose of allowing ladder access to the mezzanine from the pit (or vice versa) when such access was necessary. For much of the project, and more specifically the

days prior to the accident, there was a ladder in the opening. That had been removed at the direction of Martin prior to beginning the panel installation on September 15, 2016, to accommodate the lift (Tr. 212). There was a second opening with a ladder from which the pit could be accessed available on that day (Tr. 182, 190). [6]

The question to be answered in this matter is whether the cited opening was an entrance to a point of access or an unprotected edge on September 15, 2016, the day of the accident.[7] The Secretary contends the opening did not fall under the exception to the definition because it was not being used to access the pit on the day of the accident and removal of the ladder and placement of the lift prevented the opening from being used as access to the pit. CME argues the opening was an entrance to a point of access if it is used for that purpose "at some point."[8] The Secretary has promulgated no guidance on the standard's exception or what constitutes "entrances to points of access."[9] The Commission has not issued any decision clarifying the exception. "[I]t is well settled that the test for the applicability of any statutory or regulatory provision looks first to the text and structure of the statute or regulations whose application is questioned." *Unarco Commercial Products*, 16 BNA OSHC 1499, 1502 (No. 89-1555, 1993). The standard's wording must be interpreted in a reasonable manner consistent with a common

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[6] In its brief, CME asserts the cited opening was the only access to the pit. This is contrary to the record. In making this assertion, CME misstates the record by taking the testimony at transcript page 176 out of context. The testimony, in context, was as follows:

> Q: Okay. Were you aware—other than the two ladder access points that you just mentioned, one which is reflected in C-3 and C-4 –
> A: Yes, sir.
> Q: And this other one that I think you said was at the other end of the room.
> A: Uh-huh.
> Q: In your understanding, Mr. Martin, were there any other ways to access the pit?
> A: No.

(Tr. 175-76). Martin was not confirming a single access point, as CME contends, but the two access points to the pit. CME suggests the second ladder access point about which Martin testified was a ladder inside the pit providing access from one level of the pit to another and cites to Martin's testimony at transcript page 172. At transcript page 172 Martin testified "We had two access points. This ladder access point and another ladder that went into the deeper pit. Them was our two access points because we figured we needed two because we have different levels of pit." He goes on to confirm CME installed railing around the entire pit, except for the two ladder access points. Nowhere in this testimony does Martin state the second ladder access point was within the pit. CME's assertion is easily disproved by Martin's testimony that he used this other ladder access to get into the pit to assist the injured employee after the fall which he described as an opening in the railing "just like" the cited opening (Tr. 189-90). CME's misrepresentation of the factual record does little to bolster its argument.

[7] September 15, 2016, is the only day on which the citation alleges CME was in violation of § 1926.501(b)(1).

[8] CME did not argue the terms of the standard are ambiguous. Nor did it raise the affirmative defense of lack of fair notice of the standard's requirements. Such defense would be inconsistent with its contention a reading of the plain language of the standard supports its position.

[9] The preamble to the standard provides no elucidation. *See* 59 FR 40672-01 (August 9, 1994).

sense understanding. *Globe Industries, Inc.*, 10 BNA OSHC 1596 (No. 77-4313, 1982). The words are to be viewed in context, not in isolation, and judged in light of its application to the facts of the case. *Ormet Corp.*, 14 BNA OSHC 2134, 2135 (No. 85-531, 1991). A safety standard such as § 1926.501(b)(1), and the definition at § 1926.500(b), are generally construed liberally to allow broad coverage in carrying out the congressional intent to provide safe and healthful working conditions. 29 U.S.C. § 651(b).

The Miriam Webster dictionary defines an "entrance" as "the means or place of entry." It defines a "point" as a "narrowly localized place" and "access" as "a way or means of entering or approaching." An "entrance to a point of access" is a narrowly localized way or means of entry. For the area at issue to meet that definition, it must be a means of entry to the pit from the mezzanine or vice versa. For an opening to be a means of entry it must be capable of functioning for that purpose. In other words, entry must be possible. Absent the ladder, no entry to or from the pit was possible – it was not a "way or means of entering" the pit. Once CME removed the ladder, the opening became an unguarded edge through which an employee could fall. The exception to the requirement that employees be protected from falls from unprotected edges does not apply to the cited conditions.[10]

CME's contention the opening remained an entrance to a point of access as long as it was used for that purpose "at some point" is not consistent with the language of the standard and would lead to needless exposure to fall hazards. Accepting CME's argument an employer could designate an area as a point of access, use it as such once, and leave it open in perpetuity, regardless of whether it was ever again capable of functioning as a means of entering the level below. This would permit employers to expose employees to the fall hazard addressed in the standard. Applying the standard in this way is inconsistent with a common sense understanding of the standard's terms and the purposes of the regulation and the Act.[11]

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[10] The term "point of access" is defined in Subpart X – Stairways and Ladders. Section 1926.1050(b) defines "point of access" as "all areas used by employees for work related passage from one area or level to another. Such open areas include doorways, passageways, stairway openings, studded walls, and various other permanent or temporary openings used for such travel." It is not clear the Secretary intended the definition in Subpart X to apply to Subpart M. Even if the definition in Subpart X were to apply, my analysis and conclusion regarding the applicability of the exception to the unique facts of this case would be the same.

[11] The purpose of Subpart M is to prevent falls on construction worksites. The purpose of the Act is to "prevent the first accident." *See Brock v. L.E. Myers Co.*, 818 F.2d 1270, 1275 (6th Cir. 1987).

Because the opening through which the employee fell was an unguarded edge as that term is defined in the § 1926.500(b), CME was required to provide employees with protection from falls from it on September 15, 2016, under § 1926.501(b)(1).

Failure to Comply and Employee Exposure to the Hazard

Section 1926.501(b)(1) allows employers to choose between three methods of compliance. An employer may protect employees from falls from unprotected edges by a guardrail system, safety net system, or personal fall arrest system. CME did not use any of these methods to protect employees in the cited area of the mezzanine from falls to the pit below on September 15, 2016. CME does not dispute it provided no form of fall protection. The standard was violated.

Nor is there any dispute employees were exposed to a fall hazard. The injured employee and his co-worker were working on the mezzanine level preparing the channel for panel installation. Both were working in the area near the opening. The injured employee was working close enough to have fallen off the edge. The Secretary has established employee exposure to the cited fall hazard.

Employer Knowledge

To establish employer knowledge of a violation the Secretary must show the employer knew, or with the exercise of reasonable diligence could have known of a hazardous condition. *Dun Par Engineered Form Co*., 12 BNA OSHC 1962, 1965-66 (No. 82-928, 1986). Because corporate employers can only obtain knowledge through their agents, the actions and knowledge of supervisory personnel are generally imputed to their employers, and the Secretary can make a prima facie showing of knowledge by proving a supervisory employee knew of or was responsible for the violation. *Todd Shipyards Corp*., 11 BNA OSHC 2177, 2179 (No. 77-1598, 1984); *see also Dun Par Engineered Form Co*., 12 BNA OSHC 1962 (No. 82-928, 1986) (the actual or constructive knowledge of an employer's foreman can be imputed to the employer). Actual knowledge refers to an awareness of the existence of the conditions allegedly in noncompliance. *Omaha Paper Stock Co.*, 19 OSHC 2039 (No. 01-3968, 2002). An employer is chargeable with knowledge of conditions which are plainly visible to its supervisory personnel. *A.L. Baumgartner Construction Inc*., 16 BNA OSHC 1995, 1998 (No 92-1022, 1994).

Martin was CME's supervisor on site (Tr. 104). He was aware of the existence of the unguarded edge, that the ladder had been removed, and that the injured employee was working from the mezzanine cleaning out the channel. He had instructed the injured employee and his co-worker to prepare the channel (Tr. 177). He saw the injured employee before he fell and asked what he was doing (Tr. 186). When the injured employee told him he was cleaning the

channel, Martin admitted he said, "okay, go ahead." (Tr. 187). He gave no instruction on how to continue the task (Tr. 200-01). Martin was aware the injured employee was working near an unprotected edge without fall protection. Martin's knowledge is imputed to CME.

Martin's testimony suggests he could not have anticipated the injured employee would continue his task on the mezzanine in the area between the lift and the knee wall because that space was too small. Martin testified he believed the lift was "plugging the hole." (Tr. 201). I found this testimony unconvincing.[12] There was sufficient space between the knee wall and the lift to allow the injured employee to turn his upper body. Martin's contention he assumed the injured employee would continue his cleaning task from the lift strains credibility. To complete the task as suggested would have required the injured employee to stop his work, climb into the lift, kneel down, and reach through the rails of the lift to reach the channel below (Tr. 153). The injured employee testified doing so would have been counter to instructions he had received to never "work below the basket." (Tr. 153). Martin testified he would have stood in the lift and cleaned the channel with a "house broom." (Tr. 203). There is no evidence any type of broom was available (Tr. 144, 203). Under the circumstances, the reasonable assumption was that the injured employee would continue on the easier path of working from the mezzanine, placing himself precariously close to the unprotected edge. A reasonably diligent employer would have been aware of the hazard posed.

The Secretary has established CME had knowledge of the violative condition.

Characterization

The Secretary alleges the violation was serious. A violation is serious when "there is a substantial probability that death or serious physical harm could result" from the hazardous condition at issue. 29 U.S.C. § 666(k). The Secretary need not show that there was a substantial probability that an accident would occur; only that if an accident did occur, death or serious physical harm would result. There can be little dispute the likely result of a fall of 11 feet is death or serious injury. As demonstrated by the accident in this case, such a fall can result in debilitating physical harm. The violation is serious.

The Secretary has established a prima facie case of a serious violation of § 1926.501(b)(1).

[12] Martin's demeanor suggested defensiveness. Nor has Martin's account of events been entirely consistent (Tr. 201, 250).

Affirmative Defense of Infeasibility

CME has raised the affirmative defense of infeasibility. To establish this defense, an employer must show (1) literal compliance with the terms of the standard is infeasible under the existing circumstances and (2) alternative protective measures were used or no feasible alternative measures are available. *Otis Elevator Co*., 24 BNA OSHC 1081, 1087 (No. 09-1278, 2013), *citing, Westvaco Corp*., 16 BNA OSHC 1374, 1380 (No. 90-1341, 1993). CME argues compliance is infeasible because "the nature of the work precluded CME from complying with the standard's requirements for fall protection." (*Respondent, CME Corporation's Post-Hearing Brief,* at p. 9).

There is no dispute the lift was necessary to complete the cooler panel installation along the mezzanine. Martin testified the ladder was removed from the unprotected edge prior to positioning the lift because the ladder would have been in the way of the lift.[13] CME reasons that if the ladder would have been in the way, a standard guardrail would have also been in the way. It goes on

> [b]ecause the ladder access was the only point of access between the mezzanine and pit levels, and the ladder had to be removed in order to position the lift to complete the panel installation, CME could not both comply with the cited standard, 29 C.F.R. 1926.501(b)(1) <u>and</u> perform the work.

(Respondent's brief, at p. 11, emphasis in the original).

CME's argument fails on multiple fronts. CME's contention the opening in the railing adjacent to the mezzanine was the only point of access to the pit is demonstrably false, as previously discussed (*See* footnote 6, *infra*). Even accepting CME's position a guardrail would have prevented use of the lift, it did not establish the lift needed to be in that position while the injured employee was cleaning the channel or the point at which he was exposed. More importantly, in arguing compliance was infeasible because a guardrail would have been in the way of the lift, CME ignores the language of the standard. The cited standard provides three alternative methods of compliance. CME makes no mention of why it could not have provided

[13] Martin testified that ladder had to extend 3 feet above the concrete, presumably referencing the requirement of 29 C.F.R. § 1926.1053(b)(1) which states: "When portable ladders are used for access to an upper landing surface, the ladder side rails shall extend at least 3 feet (.9 m) above the upper landing surface to which the ladder is used to gain access…"

one of the other two alternatives.[14] To establish literal compliance is impossible where a standard allows more than one method by which to do so, the employer must establish all methods are infeasible. CME's failure to even mention why it could not have used a safety net system or personal fall arrest system is fatal to its defense.

Item 1, Citation 1, alleging a serious violation of § 1926.501(b)(1) is affirmed.

Item 1, Citation 2: The Alleged Violation of 29 C.F.R. § 1904.39(a)(2)

The standard at § 1904.39(a)(2) requires an employer to notify OSHA of an in-patient hospitalization "[w]ithin twenty-four (24) hours after the in-patient hospitalization …, as a result of a work-related incident…"

CME conceded in both its responses to the Secretary's Requests for Admission (Exh. C-1) and at the hearing it was in violation of § 1904.39(a)(2) (Tr. 6). There is no factual dispute regarding the applicability of the standard. The injured employee was a temporary employee working under the exclusive control of CME who suffered a work-related injury requiring hospitalization. CME was aware of the injury and failed to report it. Safety Director Smith testified he did not report the injury to OSHA because he had immediately notified ULG of the accident (Tr. 228). He assumed because the injured employee was covered for workers compensation purposes by ULG, that ULG would make the notification to OSHA. Smith did not confirm this assumption with ULG (Tr. 228-29). The evidence establishes CME was in violation of § 1904.39(a)(2).

The Secretary proposed Item 1, Citation 2, be characterized as an other than serious violation. The Commission has defined a non-serious violation as "one in which there is a direct and immediate relationship between the violative condition and occupational safety and health but not of such relationship that a resultant injury or illness is death or serious physical harm." *Crescent Warf & Warehouse Co.*, 1 BNA OSHC 1219 (No. 1, 1973). Failure to notify OSHA of injuries prevents the agency from timely responding to accidents and addressing possible hazardous conditions. The violation has a direct impact on safety and health and is properly characterized as an other than serious violation.

Item 1, Citation 2, alleging an other than serious violation of § 1904.39(a)(2) is affirmed.

[14] Martin testified there were harnesses available for use by employees and that the lift had anchor points from which to tie off (Tr. 217).

PENALTY

The Commission, in assessing an appropriate penalty, must give due consideration to the gravity of the violation and to the size, history and good faith of the employer. *See* 29 U.S.C. § 666(j). The Commission is the final arbiter of penalties. *Hern Iron Works, Inc.*, 16 BNA OSHC 1619, 1622, (No. 88-1962, 1994), *aff'd*, 937 F.2d 612 (9th Cir. 1991) (table); *see Valdak Corp.*, 17 BNA OSHC 1135, 1138 (No. 93-0239, 1995) ("The [OSH] Act places limits for penalty amounts but places no restrictions on the Commission's authority to raise or lower penalties within those limits."), *aff'd*, 73 F.3d 1466 (8th Cir. 1996). In assessing a penalty, the Commission gives due consideration to all of the statutory factors with the gravity of the violation being the most significant. *Capform Inc.*, 19 BNA OSHC 1374, 1378 (No. 99-0322, 2001), *aff'd*, 34 F. App'x 152 (5th Cir. 2002) (unpublished). "Gravity is a principal factor in a penalty determination and is based on the number of employees exposed, duration of exposure, likelihood of injury, and precautions taken against injury." *Siemens Energy and Automation, Inc.,* 20 BNA OSHC 2196, 2201 (No. 00-1052, 2005).

In proposing penalties for both citations, the Secretary reduced the statutory maximum penalties by taking only CME's size into consideration. CME contends it is entitled to a greater penalty reduction than the Secretary assessed. I agree.

The maximum penalty for Citation 1 is $12,471.00. 29 U.S.C. § 666(b).[15] A high gravity-based penalty is warranted. Although only a few employees were exposed for a short period of time, lighting was poor, increasing the likelihood of an accident (Tr. 119-20). The severity of the resulting injury is unquestionably high (Tr. 124). CME is a small employer and, accordingly, entitled to a corresponding adjustment to the gravity-based penalty. There is no evidence in the record CME has received citations from OSHA in the past. CME presented evidence it has a lower than average injury rate for its industry; it has a comprehensive safety and health program; and makes efforts to train all its employees on its safety and health rules, including temporary employees. CME cooperated with the inspection. For these reasons, CME is entitled to reductions in the gravity-based penalty for history and good faith. *Nacirema*

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[15] In 2015, Congress passed the Federal Civil Penalties Inflation Adjustment And Improvements Act (the Inflation Adjustment Act), which directs agencies to adjust their penalties for inflation each year and requires agencies to publish "catch up" rules to make up for lost time since the last adjustments. Pursuant to the Inflation Adjustment Act, the Secretary adjusted the maximum penalty for both serious and other than serious violations to $12,471.00. The adjusted civil penalty amounts are applicable to civil penalties assessed after August 1, 2016, whose associated violations occurred after November 2, 2015.

Operating Co., Inc., 1 BNA OSHC 1001, 1002 (No. 4, 1972) ("Good faith should be determined by a review of the employer's own occupational safety and health program, its commitment to the objective of assuring safe and healthful working conditions and its cooperation with other persons and organizations" like OSHA.) The maximum penalty is reduced accordingly. A penalty of $6,000.00 is assessed for Item 1, Citation 1.

Citation 2 also carries a maximum penalty of $12,471.00. 29 U.S.C. § 666(c). The gravity of the violation is low. Although the OSHA inspection was delayed by CME's failure to report the injury, CME had corrected the hazardous condition that resulted in the injury immediately. CME's failure to report was not a deliberate attempt to conceal the accident, but the result of a good faith belief the reporting requirement would be fulfilled by ULG. *Hecfer Construction Corp.*, 2 BNA OSHC 1217 (No. 3097, 1974) (Belief one is in compliance is a factor to consider under the "umbrella" of good faith). CME is entitled to a significant reduction in the gravity-based penalty. A penalty of $500.00 is assessed for Item 1, Citation 2.

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:

1. Item 1 of Citation No. 1, alleging a serious violation of § 1926.501(b)(1), is **AFFIRMED** and a penalty of $6,000.00 is assessed.
2. Item 1 of Citation No. 2, alleging an other than serious violation of § 1904.39(a)(2), is **AFFIRMED** and a penalty of $500.00 is assessed.

SO ORDERED.

/s/

Date: November 17, 2017

HEATHER A. JOYS
Administrative Law Judge
Atlanta, Georgia