# Secretary of Labor, Complainant,

v.

#### OSHRC Docket No. 00-0535

Performance Site Management, Respondent.

Appearances:

Anthony M. Stevenson, Esq. U. S. Department of Labor Office of the Solicitor Cleveland, Ohio For Complainant Corey V. Crognale, Esq. Schottenstein, Zox & Dunn Columbus, Ohio For Respondent

Before:

Administrative Law Judge Nancy J. Spies

#### **DECISION AND ORDER**

Performance Site Management (Performance) is engaged in site development and related activities in the construction industry. Following a fatality investigation by Occupational Safety and Health Administration (OSHA) compliance officer James Denton, the Secretary issued to Performance a four-item serious citation on February 15, 2000. Item 1 alleges a violation of § 1926.20(b)(2) for failure to have a safety program which required inspection after each change of a trackhoe bucket. Item 2 alleges a violation of § 1926.21(b)(2) for failure to enstruct employees in how to safely use the bucket changing equipment. Item 3 alleges a violation of § 1926.651(a) for permitting employees to work underneath equipment loads. Item 4 alleges a violation of § 1926.652(a)(1) for failure to provide cave-in protection for employees in an excavation. Performance denies the factual allegations and contends that it has not violated the standards.

Prior to the hearing, the Secretary withdrew item 3, and the item will be vacated. A hearing on items 1, 2, and 4 was conducted on September 21, 2000, in Columbus, Ohio. The parties filed briefs, and the case is ready for decision. For the reasons stated below, the Secretary failed to establish violations of items 1 and 2 but proved item 4.

#### **Background**

In September 1999, Performance began laying underground utilities for an Ashton Woods housing project in Cleves, Ohio. Performance assigned its PC 650 utility crew to install the sanitary and storm sewer lines at the site. The crew used an 80-ton Komatsu PC 650 trackhoe to perform this work. In 1992 Performance added a hydraulic Hendrix J.B. "Quick Coupler" hitch to the trackhoe arm of the Komatsu PC 650. This allowed the operator to quickly detach and re-attach various trackhoe buckets, depending on the work to be done. The trackhoe operator changed buckets an average of 75 to 100 times per day (Tr. 189-191, 214, 336, 340).

The crew consisted of superintendent John Young, foreman Danny Peters, tailman Jim Ruckman, pipelayer Gene Wells, and operators Mike Dill and Barney Ankerman. Young supervised the other employees and operated the trackhoe (Tr. 21, 345-346).

## The Equipment

The quick coupler connected an anchor plate at the end of the trackhoe arm to an anchor plate permanently affixed to the bucket. The operator positioned the quick coupler directly over the anchor plate on the bucket and positioned its two hooks to grasp onto the lower attachment pin of the bucket. Once he engaged the lower hooks, he tilted the coupler forward and the hydraulic clamp engaged the upper attachment pin of the bucket plate. The operator controlled the hydraulic clamp by a switch in the cab of the trackhoe (Exh. R-7, R-8; Tr. 28).

The switch in the cab, which was located out of the operator's line of sight, had three settings: release, neutral and lock. The release position disengaged the latch that held the bucket, the neutral position held the latch open, and the lock position held the bucket's top clamps with a spring action and hydraulic force. The operator had to place the switch into the locked position to secure the bucket. A buzzer sounded when the switch was in the release position. The coupler may temporarily hold the bucket even if the switch is incorrectly in the neutral position. Routinely, when the coupler was seated, the operator moved the control switch from release to lock and waited a few seconds for the clamps to close. At that point the buzzer ceased, although the buzzer also ceased if the switch was in neutral. Through on-the-job training, Young learned to test whether the bucket was secured. It was his practice to scrape the teeth of the newly connected bucket on the ground and then raise and

curl the bucket outward. If the bucket stayed on the arm after that maneuver, the operator began work (Exh. C-1, pp. II-III, R-7, R-8; Tr. 27-29, 42, 46).

## The Accident

On October 28, 1999, the crew continued its installation of 36-inch storm sewer pipe. Young began digging with the trackhoe bucket while Gene Wells and Ruckman entered a portion of the excavation to check the grade and to determine where Young should make the next cut. The men noticed that one of the horizontal pins extended out from the bucket, and they so notified Young. Young disconnected the bucket from the coupler and, using the coupler itself, pushed the pin back into place (Tr. 346-348). Young reconnected the bucket. As he again brought the bucket into the excavation to make the next cut, the bucket disconnected about 1 foot above the excavation, dropped to the ground and into the excavation, pinning Wells against the sewer pipe. Emergency Medical Service personnel from the fire department and sheriff's office rescued Wells from the excavation and transported him to the hospital, where he later died from his injuries (Tr. 372-373).

## **Discussion**

In order to establish a violation of an occupational safety or health standard, the Secretary has the burden of proving: (a) the applicability of the cited standard, (b) the employer's noncompliance with the standard's terms, (c) employees access to the violative conditions, and (d) the employer's actual or constructive knowledge of the violation.

Atlantic Battery Co., 16 BNA OSHC 2131, 2138 (No. 90-1741, 1994).

#### Items 1 and 2: §§ 1926.20(b)(2) and 1926.21(b)(2)

OSHA focuses on the adequacy of Performance's safety program and its training efforts with regard to the task of attaching a bucket to the trackhoe's quick coupler.

The Secretary asserts that Performance violated § 1926.20(b)(2) because its safety program failed to require inspections to ensure a proper connection between the quick coupling device and the trackhoe bucket. Section 1926.20(b)(2) requires:

Such programs shall provide for frequent and regular inspections of the job sites, materials, and equipment to be made by competent persons designated by the employers

The Commission has held that, under § 1926.20(b)(1), an employer may be expected to conform its safety program to employees' known duties. *J.A. Jones Const. Co.*, 15 BNA OSHC 2201, 2206 (No. 87-2059, 1993). Section 1910.20(b)(2) requires inspections of equipment necessary to detect and correct hazards of which a reasonably prudent employer would be aware. Here, the Secretary contends that each newly attached bucket should be inspected (or otherwise tested as the manufacturer specified) to prevent an incomplete attachment of the bucket.

Item 2 presents a related inquiry. Did Performance violate § 1926.21(b)(2), as the Secretary alleges, by failing to instruct employees to recognize and avoid making an incomplete connection between the quick coupling device and the bucket? Section 1926.21(b)(2) requires:

The employer shall instruct each employee in the recognition and avoidance of unsafe conditions and the regulations applicable to his work environment to control or eliminate any hazards or other exposure to illness or injury.

To prove a violation of § 1926.21(b)(2), the Secretary must show that Performance failed to instruct employees on "(1) how to recognize and avoid the unsafe conditions which they may encounter on the job, and (2) the regulations applicable to those hazardous conditions (citation omitted)." *O'Brien Concrete Pumping Inc.*, 18 BNA OSHC 2059, 2061 (No. 98-0471, 2000). The instruction should be modeled on applicable OSHA requirements and must be specific enough for employees to understand what the hazards are and how they can be avoided. *Id*.

Performance maintains that its operator was trained to and did inspect the bucket connection by conducting a test dig after each attachment before work began. The Secretary disputes the adequacy of the procedure because she asserts that Performance relied too heavily on the absence of the sounding buzzer, which could indicate that the switch was still in neutral, as well as that it was properly locked. The Secretary also questions the adequacy of the test dig, asserting that it differed from the manufacturer's guidelines for testing the bucket connection.

The Secretary's position has two problems. She cannot point to a standard which governs the bucket attachment procedure, and she has not shown that Performance's test differed in a significant way from the manufacturer's instruction. The Secretary implicitly argues that §§ 1910.20 and .21 turn the manufacturer's guidelines into requirements for use under the general duty clause, and require the guidelines to be reflected in an employer's safety program and training. The Secretary

failed to support her position that the safety program and training standards applied, even without reference to another OSHA standard.

Further, the manual of the Hendrix Quick Coupler contains the following information on how to test the connection between the quick coupler and the bucket (Exh. C-1, p.8):

# Test Only

Move Electrical Quick Coupler control switch to "Neutral" position. Coupler should not open. Lower bucket until <u>only</u> bottom side of the bucket teeth touch the ground. Raise tracks 6" in the air by powering down boom. Bucket should remain attached.

Try to curl bucket out. Coupler should remain attached.

Two years before the accident, Hendrix's sales representative Kenneth Garriot and Performance discussed how to test the connection between the bucket and the coupler. Garriot told him (Exh. C-6, p.11):

[W]hen you hook up to the bucket with the Quick Coupler, you turn the lock or the switch to the lock position. You need to pick the bucket up and stick the teeth in the ground and try to pry the bucket and the coupler apart at that time.

Young described the test he routinely performed as he attached a new bucket. He locked the switch, listened for the buzzer to shut off, lifted the bucket while scraping its teeth on the ground and extended the bucket outward (Tr. 339-340). He believes that he did this immediately prior to the accident (Tr. 33, 35). Performance asserts that it instructed its employees about the need to check the connection this way and advised them what could happen if the check was not made.

The tragic accident indicates that the bucket was not properly secured at that time. The Secretary did not show, however, that training operators to scrap the ground with the bucket teeth and to curl it out differed in a practical way from touching the bucket's teeth to the ground and curling it out. As far as the evidence went, either procedure could have been an effective test of whether the bucket was completely engaged.

The Secretary failed to prove that the employer violated §§ 1926.20(b)(2) and .21(b)(2) when it did not incorporate the manufacture's specific test into its safety program and training. The violations are vacated.

#### <u>Item 4: § 1926.652(a)(1)</u>

The Secretary asserts that Performance violated § 1926.652(a)(1) by failing to protect employees from cave-ins while they worked in an excavation.

Section 1926.652(a)(1) requires:

Each employee in an excavation shall be protected from cave-ins by an adequate protective system designed in accordance with paragraph (b) or (c) of this section except when: (i) Excavations are made entirely in stable rock; or (ii) Excavations are less than 5 feet (1.52 m) in depth and examination of the ground by a competent person provides no indication of a potential cave-in.

By the time Denton arrived at the worksite on the morning after the accident, the excavation had been filled and the equipment moved to a new site. However, the evidence presented establishes the type of soil, the dimensions of the excavation, and the fact that the excavation walls were not properly sloped or shored. Performance took photographs of the open excavation after the accident. The rescue personnel, as well as the employees, described the soil as consisting of clay, loam, and rock (Tr. 61, 69, 78-79). Foreman Peters previously classified the soil as Type B (Exh. C-3; Tr. 372). Denton, who conducted over 2,000 inspections, also classified the soil as Type B based on the photographs and the description of the soil (Tr. 97, 118). As part of deputy sheriff Michael Harmon's investigation of the accident, a Performance employee measured the depth of the excavation as 14 feet, with a bottom width estimated to be 54 inches. The excavation was 7 to 8-feet wide at the top (Tr. 89-92).

Deputy Harmon recalled that the excavation walls were "straight up and down," although when referring to a photograph of the trench, he noted that one side appeared to be somewhat sloped (Tr. 84). Emily Ashcraft, employed by the local fire department, had to be lowered into the excavation to render emergency medical treatment to Gene Wells. She recalled that trench walls were "pretty much straight up and down" (Tr. 69). Performance's photographs of the excavation at the time of the accident are consistent with the credible testimony of Harmon and Ashcraft. Although basically at a 90° angle, one side of the excavation was partially sloped towards the top. There can be no dispute, however, that the excavation was not sloped as required for Type B soil, *i.e.*, at a  $45^{\circ}$  angle.<sup>1</sup>

Performance used trench boxes during the majority of the excavation work on the project. When problems were discovered with welds on the ladders, the trench boxes were removed from the site. Work continued without the trench boxes (Tr. 119). Superintendent Young knew that the excavation may not have been "sloped to OSHA regulations" (Tr. 52). He dug the excavation and observed employees in the excavation as they worked with him. "The knowledge, actual or constructive, of an employer's supervisory personnel will be imputed to an employer, unless the employer establishes substantial grounds for not imputing that knowledge." *Ormet Corp.*, 14 BNA OSHC 2134, 2137, citing *Capital City Excavating Co.*, 712 F.2d 1008, 1010 (6th Cir. 1983). Performance established no grounds to avoid imputing Young's knowledge of the violation to it.

Lastly, Performance's argument that a violation of the standard should be classified as de minimis since the trench walls were allegedly stable is rejected. A de minimis violation has no "direct or immediate" relationship to employee safety and is normally "limited to situations in which the hazard is so trifling that an abatement order would not significantly promote the objectives of the Act." *Dover Elevator Co.*, 15 BNA OSHC 1378, 1382 (No. 88-2642, 1991). The likelihood of an accident is not the issue. A cave-in in a narrow excavation 14 feet deep would probably result in severe crushing injuries leading to suffocation or death and is not a trifling hazard. The violation is properly classified as serious.

## Penalty

The Commission is the final arbiter of penalties in all contested cases. In determining an appropriate penalty, the Commission is required to consider the size of the employer's business, its history of previous violation, its good faith, and the gravity of the violation. The gravity of the violation is the principal factor to be considered. The gravity of this violation is high. Two employees were exposed to a potential cave-in while performing a variety of jobs inside of the excavation (Tr. 62-64). The narrowness and height of the trench increased the probability that an accident could occur. Performance is a medium-sized employer with 350 employees. OSHA had not

<sup>&</sup>lt;sup>1</sup> A proper slope for Type B soil would have resulted in a top width of 24.5 feet and appropriate sloping for both sides of the trench.

previously investigated it, and it has no prior violations. Performance has an ongoing safety program which mandates use of precautions against cave-ins, even though they were not implemented as they should have been. Some credit for good faith is appropriate. A penalty of \$4,300 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:

- 1. Item 1 (§ 1926.20(b)(2)) is vacated.
- 2. Item 2 (§ 1926.21(b)(2)) is vacated.
- 3. The Secretary withdraws Item 3 (§ 1926.651(a)), and it is vacated.
- 4. Item 4 (\$1926.652(a)(1)) is affirmed, and a penalty of \$4,300 is assessed.

/s/ NANCY J. SPIES Judge

Date: February 26, 2001