Secretary of Labor,	*	
Complainant,	*	
	*	
v.	*	OSHRC Docket No. **96-0997**
	*	
CMH Material Handling, LLC	*	
Respondent.	*	

Appearances:

Leslie John Rodriquez, Esquire
Office of the Solicitor
U. S. Department of Labor
Atlanta, Georgia
For Complainant

Eric Berezin, Esquire
Powell, Goldstein, Frazer & Murphy, LLP
Atlanta, Georgia
For Respondent

Before: Administrative Law Judge Nancy J. Spies

DECISION AND ORDER

CMH Material Handling, LLC (CMH), sells, installs, repairs, and maintains overheard cranes. The company is headquartered in Mauldin, South Carolina. From 1991 through at least 1996, CMH replaced parts of an overhead crane located at the Lockheed Aeronautical System Co. (Lockheed) facility in Marietta, Georgia. One CMH crew was usually sent weekly from South Carolina to Georgia. On April 3, 1996, a CMH employee fell from a 40-foot high work platform to the ground below and was fatally injured. Following an investigation by the Occupational Safety & Health Administration (OSHA), the Secretary issued a two-item serious citation to CMH[1] on June 28, 1996. Item 1 alleged a violation of § 1910.23(c)(1), for failure to have guardrails on the work platform, and item 2 alleged a violation of § 1920.132(a), for failure to wear safety belts and lanyards while working from the platform.

Among other defenses, CMH asserts the employee misconduct defense for item 2. The hearing in this case was conducted in Atlanta, Georgia. Both parties submitted briefs supporting their positions on the case. For the reasons stated below, the Secretary's position prevails.

[1] Although the Secretary's citation incorrectly named "CMH Material Handling, Inc." the error was corrected by amendment in the complaint. Respondent's motion to vacate the citation because of the initial error is denied.

Background

Lockheed's overhead crane system spanned the entire length of the B-1 Building. It consisted of an elaborate system of railways which were attached to the ceiling by use of a hangar assembly (Tr. 73-74, 99). When the hangar assembly and the overhead crane were initially installed, Lockheed designed a work platform that was suspended from the hangar rail 40 feet above the ground. The platform enabled Lockheed's employees to level the overhead crane. After the installation of the overhead crane, the platform was deactivated for a number of years (Tr. 39-40).

At some point, Lockheed determined that it needed to change out the bolts that anchored the rail hangar assembly to the roof structure. In 1991 Lockheed contracted with CMH to remove and replace the bolts of the assembly system. Well into the contract, CMH's leadman at the time, Rusty Palmer, asked Lockheed if CMH could use Lockheed's elevated work platform.[2] The request was granted. CMH used the platform for about a year before the accident (Tr. 73, 99-100, 199).

The accident occurred during "the graveyard shift," as CMH's Mark Craig, Andy Lingerfelt, Robin Moore, and Jason Pitts were removing and replacing the bolts. As part of that work, Mark Craig moved to the outer end of the elevated platform to loosen one of the bolts above him. The process required a certain amount of force. (The specifications required the replacement bolts to be tightened to 600-foot pounds (Tr. 199).) When the bolt Craig was working on gave way, he lost his balance and fell from the platform to his death.

No Violation of § 8(e) Rights

CMH raises a procedural defense. CMH asserts that OSHA violated § 8(e) of the Act by failing to afford it the right to accompany the investigator during her physical inspection of the workplace. The Secretary disputes that she failed to comply with § 8(e), arguing that the actions of OSHA's investigator, Patricia Morris, were reasonable under the circumstances.

The accident occurred at 3:00 a.m. on April 3, 1996; Morris began her investigation at 11:00 a.m. on that date. CMH's three remaining employees at the Lockheed location were not present during Morris's opening conference. Lockheed had identified one of the CMH employees as a supervisor. He and the other employees were in counseling. The counselor for employee

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[2] CMH also worked from its JLG Mobile Lift, which is not in issue (Tr. 130).

assistance advised Morris that the employees were badly shaken by the death of their co-worker, who was also their friend. The employees agreed to meet Morris at Lockheed's office but did not want to return to the actual accident scene so soon. Morris accepted this and began her inspection of the accident site. Lockheed and its employee representative participated in the walkaround, but no one from CMH was present. After the physical inspection of the accident site, Morris met the three CMH employees at the office, presented her credentials to them, and interviewed each (Tr. 109-112, 153-156, 160-164).

On § 8(e) issues, the courts and the Commission emphasize that the Secretary is obligated under the Act "to afford an *opportunity* for accompaniment." *Concrete Const. Co.* 15 BNA OSHC 1614, 1617-19 (No. 89-2019, 1992) (emphasis the Commission's); *Marshall v. Western Waterproofing Co.*, 560 F.2d 947 (8th Cir. 1977). What is considered to be an opportunity for accompaniment depends upon the circumstances of the particular case. When Morris sent the request, through the counselor, to have the individual identified as CMH's supervisor meet her for the walkaround, Morris provided the opportunity for accompaniment.

Even were this not so, the absence of a "formalized offer" for accompaniment does not necessarily require that the citations be vacated. *Chicago Bridge & Iron Co. v. OSHRC*, 535 F.2d 371, 376 (7th Cir. 1976). That remedy is appropriate only if CMH establishes that it suffered actual prejudice to the presentation or preparation of its case **and** that the Secretary failed to substantially comply with the § 8(e) requirements. *Concrete Constr. Co., supra; Accu-Namics, Inc. v. OSHRC*, 515 F.2d 828, 834 (5th Cir. 1975), cert. denied 425 U.S. 903 (1976).

CMH asserts that it was prejudiced because the inspector developed the mind-set that Andy Lingerfelt was a supervisor based upon Lockheed's information and from a later interview with Lingerfelt himself. CMH suggests that this impression was erroneous and could have been altered had it been permitted to participate in the earliest stage of the inspection. The contention is rejected. Had Lingerfelt participated in the walkaround, it is not imagined that his view of his supervisory role would have differed from what he told Morris shortly after the walkaround (Exh. R-4; Tr. 161, 165). Also, since Lockheed cordoned off the accident site, CMH had the opportunity to observe what the inspector observed, lessening the disadvantage of not being among the walkaround party.

The record does not support that CMH suffered actual prejudice in its handling of the case. It does support that OSHA substantially complied with § 8(e). CMH's argument that the citation must be vacated because of a § 8(e) defect is rejected.

Alleged Serious Citation No. 1

> 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) employee access to the violative conditions, and (d) the employer's actual or constructive knowledge of the violation (*i.e.*, the employer either knew, or with the exercise of reasonable diligence could have known, of the violative conditions).

Atlantic Battery Co., 16 BNA OSHC 2131, 2138 (No. 90-1747, 1994).

Applicability of the General Industry Standards

CMH argues that the Secretary wrongly cited general industry standards. It contends that OSHA's more specific construction standards apply to the conditions OSHA cited. If so, it asserts that the general industry citation should be vacated. CMH's argument relies on the definition of "construction" at § 1910.12(b) ("work for construction, alteration and/or repair"). It posits that its "repair" of Lockheed's overhead crane falls directly within the construction definition. In *B.J. Hughes, Inc.*, 10 BNA OSHC 1545 (No. 76-2165, 1982), the Commission described the relationship between construction and general industry standards. It reaffirmed that:

> [T]he construction standards only apply to actual construction work or to related activities that are an integral and necessary part of construction work. Activities that could be regarded as construction work should not be so regarded when they are performed solely as part of a nonconstruction operation (citations omitted).

The scope of the definition of "construction" is, thus, properly limited to "actual construction work" or to work which is "integral and necessary" to it. CMH's work was neither. At Lockheed's Marietta, Georgia, facility, Lockheed manufactured aircraft and performed other support operations in aid of manufacturing. Lockheed used its overhead crane system to physically move large inventory and parts within the B-1 Building and from the dock to the building (Tr. 59). Lockheed hired CMH to replace the old anchor bolts on the overhead crane system. The fact that Lockheed or CMH may have considered the work to be "construction" is

not determinative. CMH's service of the crane system was an "integral and indispensable part" of manufacturing, not of a construction activity. Accordingly, CMH's activities are governed by the general industry standards, and its argument to the contrary is rejected.

Item 1: § 1910.23(c)(1)

The Secretary charges that CMH violated § 1910.23(c)(1) because employees worked from the portion of the elevated work platform which had insufficiently high guardrails on open sides. Section 1910.23(c)(1) provides:

> "Protection of open-sided floors, platforms, and runways."
> (1) Every open-sided floor or platform 4 feet or more above adjacent floor or ground level shall be guarded by a standard railing . . . on all open sides except where there is an entrance to a ramp, stairway, or fixed ladder.

The work area at issue is a "platform" within the meaning of the standard. Paragraph (e)(1) specifies that a "standard railing" has a top rail which is at least 42-inches high. Here, the platform had guardrails on some of its open sides. These guardrails were hinged in the middle. The top part of the guardrail folded down to the outside and rested against its bottom half. In the "up" position, the witnesses variously estimated that the rails measured from 32 to 39-inches high. In the "down" position the guardrail measured between 18 to 20-inches high. It does not appear that CMH's employees ever used the railing in the up position or that they considered the railing to be fall protection. The railings were not extended on the day of the accident (Tr. 42, 53, 125, 136-137). The terms of the standard have been violated.

The platform was approximately 30-feet long and 4½-feet wide (Tr. 69). Roughly two-thirds of the length of the platform had folding guardrails; the other third had no guardrails (Exh. C-6). For part of the time on the day of the accident, Craig and Lingerfelt worked together "between the rails." The portion of the platform nearest the guardrailed edge contained tools, a generator to provide power for electric drills, some nuts and bolts which had already been removed, and some to be installed (Tr. 81-83, 137). Given the dimensions of the platform, the people and equipment on the platform, and the area where the work was being performed, it is determined that employees were exposed to a fall hazard at the open edge near the folded-down guardrails.

Knowledge

The Secretary must establish that CMH knew, or with the exercise of reasonable diligence, could have known of the violation. The Secretary may establish constructive knowledge if a supervisor's knowledge is properly imputable to the company. *E.g., Jersey Steel Erectors,* 16 BNA OSHC 1162, 1164 (No. 90-1307, 1993).

Andy Lingerfelt, who worked from the platform with the short railings, had knowledge of the conditions. The parties disagree whether Lingerfelt was the type of supervisory employee whose knowledge can be imputed to CMH. Lingerfelt's title on the job was "installation foreman." Lingerfelt's badge request from CMH designated him as such and Lockheed interacted with him as a leadman or foreman (Exh. C-3; Tr. 61, 65). The Commission's decision in *Dover Elevator Co.,* 16 BNA OSHC 1281, 1286 (No. 91-862, 1993) (citations omitted) frames the inquiry:

> An employee who has been delegated authority over other employees, even if temporarily, is considered to be a supervisor for the purposes of imputing knowledge to an employer. . . . It is the substance of the delegation of authority that is controlling, not the formal title of the employee having this authority; an employee who is empowered to direct that corrective measures be taken is a supervisory employee . . . .

Leadmen and foremen are among the categories of supervisors whose knowledge has been imputed to their employers in the past. *E.g., Id.; Tampa Shipyards, Inc.,* 15 BNA OSHC 1533, 1537-38 (No. 86-360 & 469, 1992).

CMH contends that Lingerfelt and its other leadmen were simply the crew members designated to pay the expenses for the out-of-town crew and to keep track of the crew's hours worked. It denies that Lingerfelt had any authority over the crew or had responsibility for directing the work or the manner of the work. It contends that only its South Carolina-based manager of installation service, Marty Lambert, had authority over the crew (Tr. 206-208, 212). Lambert did not testify, but William Owens, CMH's general sales manager, did testify. Owens did not consider Lingerfelt to be a supervisor because he was not in management and could not hire, fire, or promote (Tr. 214).

Owens's testimony appeared less than completely frank and failed to explain how *weekly* directions from Lambert prevented Lingerfelt from making day-to-day decisions as to the manner in which the work was accomplished in Georgia. Owens's testimony contrasted with that of

David Horrocks. David Horrocks was a project engineer employed by an unrelated company (CDI). Lockheed contracted with CDI to provide an inspector for the project to interact directly with the various outside contractors (including with CMH) on Lockheed's behalf (Tr. 47). Horrocks was a disinterested, forthright, and credible witness.

Horrocks met once or twice a week with CMH's designated leadman. They would discuss the completed work and any problems, such as access to areas or any technical difficulties the crew had encountered (Tr. 54-55). In the weeks prior to the accident, Horrocks met with Lingerfelt in the mornings after the crew's shift. Horrocks described his contacts with Lingerfelt (Tr. 62):

> Our usual get-together to say have we got any problems, is everything going all right, what area -- I would ask them what area they're going to be working in so that when I inspected it during the day I would have -- I would have some knowledge of where they were.

Horrocks also observed Lingerfelt, as the lead person, direct work of the other crew members, noting that Lingerfelt "[s]aid A, B and C go to this position and do this work. Any time that we had any -- any conversation it was to be with Mr. Lingerfelt" (Tr. 60). If Horrocks saw an "unsafe work practice" he would have reported it to Lingerfelt "because he was . . . the lead person on the job, the person I always interfaced with" (Tr. 61).

The leadman was the liaison between the customer and the company, which was located out-of-state. In fact, it was an earlier leadman, Rusty Palmer, who had the authority to request and to accept the use the work platform from which Mark Craig fell. It is determined that Lingerfelt had the type of supervisory responsibilities which imputes his knowledge of the violation to CMH.

Adding to the rationale for finding constructive knowledge is CMH's failure to reasonably evaluate the safety of the employees on the platform. Both Horrocks and Morris considered the railings, not as guardrail, but as a "containment railing," believing that the railing was to prevent tools, parts, and miscellaneous things from coming off the platform (Tr. 54, 82, 136). Horrocks, who recalled seeing the CMH employees working on the platform on two or three occasions before the accident, never saw them working with the guardrails in the "up" position (Tr. 53, 86). Lockheed did not require CMH to use the platform; CMH requested to use it. Had CMH

inspected or reviewed the configuration of the platform, the fact that standard guardrails were not being used would have been obvious.

Once the Secretary makes a prima facie case for constructive knowledge, the burden shifts to CMH to rebut the Secretary's showing. For the reasons stated in the denial of the employee misconduct defense for item 2, below, CMH did not rebut the showing of constructive knowledge. The Secretary established the elements of the violation. The most probable result of a fall from the platform would be death. The violation is affirmed as serious.

Item 2: § 1910.132(a)

The Secretary asserts a violation of § 1910.132(a) for the employees' failure to use lifelines and lanyards on the part of the work platform which had no guardrails. The standard requires:

> Application. Protective equipment . . . shall be provided, used, and maintained in a sanitary and reliable condition wherever it is necessary by reason of *hazards of processes* . . . encountered in a manner capable of causing injury or impairment in the function of any part of the body through absorption, inhalation or physical contact.
> (Emphasis added)

The Commission has held that the language of § 1910.132 applies to fall hazards, since "processes" encompass the hazard of injury of death by falling. *Bethlehem Steel Corp.,* 10 BNA OSHC 1607 (No. 77-1545, 1982). (The platform from which employees worked was part of the work surroundings and the standard required fall protection.)

The right-hand side of the elevated platform was not constructed with guardrails. This was because the right-hand trolley was moveable and needed to accommodate the different widths of rails in the different bays (Tr. 79, 97). There were no guardrails on the right side of the platform to allow for this adjustment. The lack of guardrails was clearly visible from the ground. As part of their anticipated duties, employees worked at the open end of the platform, outside the trolley. Neither the deceased nor Lingerfelt wore safety belts while on the platform the day of the accident. Lingerfelt told Morris that they would wear body harnesses in the future (Tr. 139). The terms of the standard have been violated, and employees were exposed to the violative conditions.

Knowledge

Constructive knowledge for a general standard, such as § 1926.132, is determined under the reasonable person test. CMH supplied safety harnesses for the crew. Neither Craig nor Lingerfelt wore them. Lingerfelt reported to Morris that he found the safety belts to be uncomfortable and that it made it harder to get around. Based upon Lingerfelt's authority as a supervisor, his knowledge is imputed to CMH. Further, Horrocks never saw CMH employees using body harness or lanyards (Tr. 102). A reasonable person would have inspected a platform 40 feet above the ground and would have required employees to be tied off with body harnesses if guardrails were not available. CMH's installation manager Lambert, as well as Lingerfelt, saw Lockheed's worksite (Tr. 59).

An employer can rebut a showing of imputed knowledge by establishing that it took reasonable measures to prevent the occurrence of the violation. Facts relating to the reasonableness of CMH's efforts are discussed, below, under the employee misconduct defense.

Employee Misconduct Defense

To negate a violation on the grounds of employee misconduct, the employer must show that: (1) it established work rules designed to prevent the specific violation from occurring; (2) the work rules were adequately communicated to its employees; (3) it took steps to discover violations of those rules; and (4) it effectively enforced the rules when violations were discovered. *E.g., Gary Concrete Products Inc.,* 15 BNA OSHC 1051, 1055 (No. 86-1087, 1991).

CMH relies on a written memorandum dated January 12, 1994, to establish: the existence of its workrule, the fact that the workrule was communicated to its employees, and that the workrule was enforced. The memorandum was sent to its employees in their paychecks and posted on the bulletin board at that time (Tr. 203). The memorandum states, in pertinent part (Exh. C-7):

> We have had another major client complain about hard hats, safety glasses, and not being tethered when in the air. Not only is this policy of most of our customers, it is our policy.
>
> At all times, you are required to wear safety glasses, hard hats, and be tethered in the air. Your supervisors have been informed that the next person to violate these rules will be terminated, no exceptions. I'm sorry it has come to this, but we must have a safe work environment. (Emphasis CMH's)

It is somewhat surprising that CMH places so much emphasis on this one memorandum. The alleged workrule was prompted not by its own management, but by a customer complaint alerting CMH to a safety problem with its employees. There was no indication that the employee(s) responsible for the customer complaint in 1994 was reprimanded.

Lingerfelt was an experienced employee. Mark Craig had been on the Lockheed job from its beginning. Neither took their safety harnesses onto the platform, perhaps because they had become comfortable with the work. Employees Moore and Pitts explained that if a new employee was assigned to the job that they would ensure that the employee wore a safety harness "until he gained experience and was good at the job" (Tr. 142). Pitts wore his safety harness on the day of the accident, and reported that he always wore it when he knew that he would be working at the end of the platform from which Mr. Craig fell. Pitts also admitted to Morris, however, that there had been occasions when he worked from the end of the platform without wearing his body harness (Tr. 142). It is concluded that employees considered compliance with CMH's generally-worded workrule "to be tethered in the air" to be optional.

This conclusion is also bolstered by the fact that Lingerfelt, who was one of CMH's longest-term employees, and Mark Craig, himself a leadman on the job for a time, felt free to violate the workrule (Tr. 211). When supervisors violate a workrule, it "raises an inference of lax enforcement and/or communication of the employer's safety policy." *National Realty & Constr. Co. Inc.*, 489 F.2d 1257, 1267 n.38 (D.C. Cir. 1973). *See also, Baytown Constr. Co*, 15 BNA OSHC 1705, 1710 (No. 88-2912, 1992) (supervisor's misconduct is "strong evidence that the employer's safety program was lax"). CMH has failed to meet the elements of the employee misconduct defense.

The same facts support the finding that CMH has failed to rebut the Secretary's showing of constructive knowledge imputed through a supervisor. Item 2 is affirmed as serious.

Penalty

The Commission must give "due consideration" to the size of the employer's business, the gravity of the violation, the employer's good faith, and history of past violations in determining an appropriate penalty. *J.A. Jones Constr. Co.*, 15 BNA OSHC 2201, 2213-14 (No. 87-2059, 1993). The gravity of the violation is the primary element in the penalty assessment. *Trinity Indus.*, 15 BNA OSHC 1481, 1483 (No. 88-691, 1992).

Four employees were exposed to fall hazards from a platform 40 feet in the air. They worked for long portions of a 4-day work week on the relatively narrow platform. Employees maneuvered with tools and equipment. Bolts were removed and replaced from the outer edge of the platform without even nominal fall protection. The folded-down railings provided no real protection while employees worked from the other end of the platform. The gravity of the violation was high.

Since 1995 CMH has been a part of P&H Material Handling, a Harnischfeger Industries company. Harnischfeger Industries is a large company with thousands of workers (Standard & Poors). Some small credit is afforded for good faith in that CMH provided body harnesses for employees, even though it did not enforce their wearing. No good faith credit is appropriate for the generic safety training the employer provided (Exh. C- 8). Penalties of $5,800.00 for each violation are 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), Fed. R. Civ.P.

ORDER

Based on the foregoing decision, it is ORDERED:

1. Item 1 (§ 1910.23(c)(1)) is affirmed with a penalty in the amount of $5,800.00 assessed.

2. Item 2 (§ 1910.132(a)) is affirmed with a penalty in the amount of $5,800.00 assessed.

NANCY J. SPIES
Judge

Date: June 25, 1998