SECRETARY OF LABOR, Complainant, v. CAPFORM, INC., Respondent.	OSHRC Docket No. 99-0322

DECISION

Before: ROGERS, Chairman; and EISENBREY, Commissioner.

BY THE COMMISSION:

On January 20, 1999, Capform Inc. ("Capform") was issued a serious citation which alleged a violation of the Occupational Safety and Health Act, 29 U.S.C. § 651-678, ("the Act"). The citation was issued following an inspection conducted in response to a fatal accident. Capform was working as a subcontractor for a construction project at the University of Texas Southwestern Medical Center in Dallas, Texas. At the time of the accident, Capform was engaged in pouring concrete for the floors of a multi-story research facility. In the citation, the Secretary alleged that Capform violated 29 C.F.R. § 1926.21(b)(2) by failing to train its employees in the recognition and avoidance of hazards associated with the removal of shoring used to support concrete forms.[1] A penalty of $6,300

[1] The cited provision requires as follows:

> **§ 1926.21 Safety training and education.**
> (a) *General requirements.*
> . . . .
> (b)*Employer responsibility.*
> . . . .
> (b)(2) 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.

was proposed for the serious violation. Judge Robert A. Yetman affirmed the training violation and assessed the proposed penalty amount. We affirm the judge's decision.

BACKGROUND

In order to create the floors of the research facility, Capform poured concrete over reinforced steel bars and into forms supported by a structure of plywood and beams that rested on metal scaffolding. After the concrete dried, this support structure was removed in two stages, a process known collectively as "stripping." First, two 4x4 wood beams were bound together to create 13-foot long posts that were supported by screw jacks, known as "Ellis jacks." Six of these Ellis jacks and posts were placed upright in pairs underneath each 8x15 section of the floor. With the plywood structure temporarily supported by the posts, the metal scaffolding was then removed.

Before next removing the plywood structure and posts, the entire work area was cleared of all but two of Capform's employees and marked off with yellow ("Caution") or red ("Danger") tape. The two employees, standing about 28 feet apart and each equipped with a "nena," a 12-foot long metal pole with a flat metal plate welded to one end, then simultaneously pulled on the Ellis jacks at the bottom of a pair of posts. By pulling at the same time, the posts fell away from the employees, landing in the area between them. When the last pair of posts was removed from a given section of the floor, the posts, as well as the entire supporting plywood structure, collapsed into the area between the two workers. This had been Capform's standard stripping procedure since 1978 and was, according to compliance officer Gloria Jones, consistent with industry practice.

On August 11, 1998,[2] Refugio Trejo was a member of Capform's carpentry crew. He had been employed by Capform as a carpenter's helper at the Dallas worksite since June 25,

[2] Although the citation lists the accident date as August 9, 1998, witnesses for both parties testified that the accident occurred on August 11, 1998.

1998.[3] The carpentry crew, also known as the "columns and forms" crew, was responsible for setting up concrete forms in preparation for a pour. On this particular day, Capform's stripping foreman, Nicholas Salas, asked the foreman of the carpentry crew for additional workers to assist in the stripping operation because he was shorthanded. The carpentry foreman, known in the record only as Ciro, sent Salas three workers who had already completed their day's work, including Refugio Trejo and his brother, Jose Trejo.[4] Salas, who had served as a stripping foreman at Capform for six years, testified that this was the first time he had ever worked with the Trejo brothers.

Before beginning the operation, Salas gave the Trejos oral instructions in Spanish regarding the stripping procedure. Specifically, Salas testified that he told the Trejos to pull back on the Ellis jacks with the nena, to be careful, and to stay as far away as possible to avoid the materials falling from overhead when the last pair of posts was removed. Although Salas also claimed that he told the Trejos not to push in on the Ellis jacks with the nena because the posts could fall on them, there is conflicting evidence in the record as to whether Salas gave such an instruction.[5] Finally, Salas testified that Capform trains all of its employees to ask a foreman how to proceed when faced with an unfamiliar situation, an instruction which he claimed to have stated on the day of the accident.

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[3] Mr. Trejo had previously been employed by Capform as a laborer in 1994, but it is not clear how long he was employed by the company at that time.

[4] Jose Trejo testified that he had worked for Capform for four years, had performed stripping duties during the first year of his employment, and had received instructions in the stripping operation at that time.

[5] The Secretary argues that the evidence is sufficient to conclude that Salas failed to give any warning regarding the hazards of pushing in on the Ellis jacks, and that this failure violated the requirements of the standard. The judge, however, did not resolve this conflict in the evidence, either as to whether Salas ever explicitly instructed the Trejo brothers not to push in on the Ellis jacks or whether he warned them of the particular hazards of doing so. Accordingly, the judge did not base his conclusion that the instructions were inadequate on any deficiency concerning an instruction not to push. In view of our conclusion that the standard was otherwise violated, we also do not address this argument.

After 15 to 20 minutes of instruction, Salas observed the Trejo brothers successfully remove three pairs of posts from one section of the floor before leaving the area to work in another location. The accident occurred when Refugio Trejo subsequently encountered a post whose close proximity to a raised elevator shaft covering made it impossible for him to pull back on the Ellis jack with his nena. Instead, Mr. Trejo pushed in on the Ellis jack and the post fell towards him, fatally striking him in the head.

DISCUSSION

I. Did the judge err in affirming the training violation?

Under § 1926.21(b)(2), "an employer must instruct its employees in the recognition and avoidance of those hazards of which a reasonably prudent employer would have been aware." *Pressure Concrete Constr. Co.*, 15 BNA OSHC 2011, 2015, 1991-93 CCH OSHD ¶ 29,902, p. 40,810 (No. 90-2668, 1992). *See also El Paso Crane & Rigging Co.*, 16 BNA OSHC 1419, 1424, 1993-95 CCH OSHD ¶ 30,231, p. 41,620 (No. 90-1106, 1993) (to prove a violation of § 1926.21(b)(2), Secretary must show that employer "failed to provide the instructions which a reasonably prudent employer would have given in the same circumstances"). Employees must be given instructions 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." *Superior Custom Cabinet Co.*, 18 BNA OSHC 1019, 1020, 1995-97 CCH OSHD ¶ 31,422, p. 44,416 (No. 94-200, 1997), *aff'd without published opinion*, 158 F.3d 583 (5th Cir. 1998); *Concrete Constr. Co.*, 15 BNA OSHC 1614, 1619, 1991-93 CCH OSHD ¶ 29,681, p. 40,243 (No. 89-2019, 1992). An employer's instructions must be "specific enough to advise employees of the hazards associated with their work and the ways to avoid them" and modeled on any applicable standards. *El Paso Crane*, 16 BNA OSHC at 1425 nn. 6 & 7, 1993-95 CCH OSHD at p. 41,621 nn. 6 & 7.

It is undisputed that at the time of the accident, Capform did not have a written policy or written instructions regarding the stripping operation, and there was nothing in the

company's safety manual which addressed the operation.[6] However, as the Commission has stated, "section 1926.21(b)(2) does not limit the employer in the method by which it may impart the necessary training." *Concrete Constr.*, 15 BNA OSHC at 1620, 1991-93 CCH OSHD at p. 40,243. *See also GEM Industrial, Inc.*, 17 BNA 1861,1863 n.5, 1995-97 CCH OSHD ¶ 31,197, p. 43,688 n.5 (No. 93-1122, 1996), *aff'd*, 149 F.3d 1183 (6th Cir. 1998) (Commission does not require safety rules to be written as long as rules are clearly and effectively communicated to employees). Here, there is no dispute that on the day of the accident, the Trejo brothers were given some oral instructions regarding the stripping operation. The question is whether those instructions adequately identified the hazards generally associated with stripping, as well as those reasonably anticipated to be encountered in the particular circumstances confronting the Trejos, including the ways in which those hazards could be avoided. *See El Paso*, 16 BNA OSHC at 1425, n.7, 1993-95 CCH OSHD at p. 41,621, n.7 ("employers must make their rules specific enough to advise employees of the hazards associated with their work and the ways to avoid them").

The judge concluded that Capform's "supervisory personnel failed to provide the safety training contemplated by the standard" based on Capform's failure to instruct in "the proper method for removing Ellis jacks that could not be pulled out due to immovable obstructions."[7] We agree. Salas inspected the employees' work area on the day of the

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[6] According to foreman Salas, Capform had never addressed the stripping operation during weekly toolbox meetings, and the meeting outlines which Capform introduced into evidence do not include stripping as one of the topics covered. Although Jose Trejo indicated that stripping was "talk[ed] about" during weekly safety meetings, he did not elaborate.

[7] The judge faulted carpentry foreman Ciro, as well as stripping foreman Salas, for this lack of training based on testimony from safety director Wallace that during his accident investigation, he had interviewed a foreman who was standing three to four feet away from Refugio Trejo at the time of the accident. Since foreman Salas had already left the area, the judge concluded that the foreman in question must have been Ciro and also "inferred that Ciro either instructed or observed the Trejo brothers install the jack in close proximity to the covered elevator shaft opening . . . ." However, there is nothing definitive in the record to

(continued...)

accident prior to beginning the stripping operation and noticed the elevator shaft covering located under the area to be stripped. He therefore should have anticipated that it might not be possible for the employees to remove all of the posts required for the stripping operation in the manner in which he had instructed. As the Commission has stated, an employer "must make a reasonable effort to anticipate the particular hazards to which its employees may be exposed in the course of their scheduled work." *Automatic Sprinkler Corp.*, 8 BNA OSHC 1384, 1387, 1980 CCH OSHD ¶ 24,495, p. 29,926 (No. 76-5089, 1980).

At the hearing, Salas readily identified two methods of removing Ellis jacks that could not be pulled out with a nena: "tie a rope on the bottom and pull, or get . . . two 2 by 4's nailed together and hit them on the bottom [from] . . . at least 20 feet away." In fact, when asked about the "*first thing*" Refugio Trejo should have done "upon seeing that there was a problem," Salas simply replied: "Tie a rope on the bottom and pull it." (Emphasis added). Under these circumstances, including the inherently hazardous nature of the stripping operation and Refugio Trejo's apparent unfamiliarity with the stripping procedure,[8] we find Salas should have instructed the Trejos regarding an alternative method for removing an Ellis jack that could not be pulled out in the usual manner. *See E.L. Davis*, 16 BNA OSHC at 2048, 1993-95 CCH OSHD at p. 42,339 (violation of § 1926.21(b)(2) affirmed where

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[7](...continued)
establish that Ciro, who did not testify at the hearing, played any role in the events surrounding the accident, other than to lend three of his crew members to foreman Salas for the stripping operation. Accordingly, we focus our discussion of the alleged violation on foreman Salas and whether his instructions to the Trejos satisfied the requirements of the cited standard.

[8] As noted, Jose Trejo testified that he had previously performed stripping work for Capform and had received stripping instructions at that time. However, it is not clear from the record whether Refugio Trejo had ever performed stripping work during his previous employment with Capform or whether he had ever received instructions regarding the stripping operation prior to the day of the accident. Although Salas testified that only employees who had worked for Capform for at least four months were permitted to perform stripping work, he apparently made no attempt to determine whether the Trejos had prior stripping experience despite the fact that he had never worked with them before.

instructions lacked required specificity and completeness). *See also National Industrial Constructors, Inc. v. OSHRC*, 583 F.2d 1048, 1056 (8th Cir. 1978) (violation of § 1926.21(b)(2) affirmed where foreman was aware of hazardous activity but did not instruct employees accordingly). Because the Trejos were not given instructions in the methods identified by Salas, or any other method that would have enabled them to safely remove an Ellis jack under these circumstances, we affirm the violation of § 1926.21(b)(2).

II. Did the judge err in finding that Capform had failed to establish the affirmative defense of unpreventable employee misconduct?

To establish unpreventable employee misconduct, an employer must prove that it has: (a) established work rules designed to prevent the violation, (b) adequately communicated those work rules to its employees, (c) taken steps to discover violations, and (d) effectively enforced the rules when violations were discovered. *American Sterilizer Co.*, 18 BNA OSHC 1082, 1087, 1995-97 CCH OSHD ¶ 31,451, p. 44,485 (No. 91-2494, 1997). In rejecting Capform's allegation of this affirmative defense with respect to Refugio Trejo's conduct, the judge found that the company lacked written safety procedures for the stripping operation and had failed to conduct regular toolbox meetings on stripping.

However, the § 1926.21(b)(2) violation affirmed here is based not upon Refugio Trejo's actions, but on foreman Salas's failure to provide the required training. Therefore, establishing employee misconduct under these circumstances would require Capform to show that *Salas* had violated company work rules in failing to provide the necessary training. *See CMC Electric*, 18 BNA OSHC 1737, 1738-39 (No. 96-0169, 1999), *aff'd in relevant part*, 221 F.3d 861 (6th Cir. 2000) (to establish that § 1926.21(b)(2) violation was the result of unpreventable employee misconduct, employer must show that person assigned to instruct failed to give the instruction). Capform has not made this claim here, and the record does not support such a showing. For these reasons, we affirm the judge's decision to reject Capform's affirmative defense.

III. Did the judge err in assessing a penalty of $6,300?

Section 17(j) of the Act, 29 U.S.C. § 666(j), requires that when assessing penalties, "due consideration" must be given to the employer's size, the gravity of the violation, the good faith of the employer, and any prior history of violations. In assessing the proposed penalty of $6,300, the judge stated: "[I]t is clear that the [training] violation presents a high gravity factor. Furthermore, there is nothing in this record which supports a reduction of a penalty due to the Respondent's size or good faith."[9] Capform disputes the judge's characterization of the violation as "high gravity" and argues that reductions for both good faith and lack of history are warranted.[10] For the following reasons, we affirm the judge's penalty assessment.

Gravity is typically the most important factor in determining an appropriate penalty and depends upon the number of employees exposed, the duration of the exposure, the precautions taken against injury, and the likelihood that any injury would result. *J.A. Jones Constr. Co.*, 15 BNA OSHC 2201, 2214, 1991-93 CCH OSHD ¶ 29,964, p. 41,033 (No. 87-2059, 1993). Here, there is no question that the stripping operation is an inherently dangerous work activity, and therefore, the potential for serious injury or even death, as this case demonstrates, is significant. Capform's failure to provide sufficiently detailed instructions to the employees performing this hazardous work directly increased these risks.

Capform argues that the precautions it has taken to address the hazardous nature of the stripping operation, such as removing all nonessential employees from the work area and marking it off with warning tape, support reducing the gravity of the training violation. *See, e.g., New Age, Inc.*, 18 BNA OSHC 1742, 1743, 1999 CCH OSHD ¶ 31,810, p. 46,704 (No. 98-0415, 1999) (gravity ameliorated by employer's partial fall hazard protection efforts).

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[9] At the hearing, the Secretary introduced no evidence regarding how the proposed penalty was calculated. Compliance officer Jones testified that she did not calculate the penalty herself nor did she participate in its calculation.

[10] Capform, which employs approximately one thousand workers, does not challenge the penalty assessment based upon its size.

While these measures limited the number of employees exposed, the hazard facing the two employees who were exposed remained grave. Under these circumstances, we agree with the judge's characterization of the violation as high gravity.

With regard to good faith, the Commission has given consideration to various factors including the employer's safety and health program and its commitment to assuring safe and healthful working conditions. *Nacirema Operating Co.*, 1 BNA OSHC 1001, 1971-73 CCH OSHD ¶ 15,032 (No. 4, 1972). Here, the record shows that at the time of the accident, Capform had a comprehensive written safety program, as well as a written enforcement program. In the six months prior to the accident, Capform also conducted weekly toolbox meetings covering a range of general safety topics. However, as previously noted, neither Capform's safety program nor the outlines from its toolbox meetings addressed the stripping operation. In addition, the instructions that Capform did provide were insufficient under § 1926.21(b)(2), a violation which we have already characterized as high gravity. Under these circumstances, we find that a reduction for good faith would be inappropriate.

Finally, with regard to prior history, Capform claims that "[t]he record is devoid of any evidence of Capform being cited by OSHA in the past for failing to warn its employees of the hazards associated with the removal of shoring, or for violations of any other OSHA regulations." We note that Capform also speculates that a 10% reduction for lack of prior history may have already been given by the Secretary in calculating the proposed penalty of $6,300. While there is nothing in the record to verify this contention, if true, an additional reduction for the same penalty factor would be inappropriate. Moreover, given the high gravity of this violation, we do not find that any further penalty reduction is warranted. Accordingly, we agree with the judge that a $6,300 penalty is appropriate.

ORDER

We affirm a violation of § 1926.21(b)(2) and assess a penalty of $6,300 (Serious Citation 1, Item 1).

/s/
Thomasina V. Rogers
Chairman

/s/
Ross Eisenbrey
Commissioner

Dated: March 26, 2001

SECRETARY OF LABOR, Complainant, v. CAPFORM, INC. and its successors, Respondent.	OSHRC DOCKET NO. 99-0322

APPEARANCES:

For the Complainant:
David Q. Jones, Esq., Office of the Solicitor, U.S. Department of Labor, Dallas, Texas.

For the Respondent:
John Smart, Esq., Winstead Sechrest & Minick, P.C., Dallas, Texas.

Before: Administrative Law Judge: Robert A. Yetman

DECISION AND ORDER

This proceeding arises under the Occupational Safety and Health Act of 1970 (29 U.S.C. Section 651 *et seq.*; hereafter called the "Act").

Respondent, CAPFORM, INC. (Capform), at all times relevant to this action maintained a place of business in Carollton, Texas, and was engaged in the construction business. Respondent admits it is an employer engaged in a business affecting commerce and is subject to the requirements of the Act.

As a result of an investigation of Respondent's worksite located in Dallas, Texas, conducted by representatives of the Occupational Safety and Health Administration, a citation was issued on January 20, 1999 alleging one serious violation of the standard set forth at 29 C.F.R. §1926.21(b)(2) with a proposed penalty of $6,300.00. Respondent filed a timely notice of contest and a complaint and answer have been filed with this Commission. At the commencement of the hearing, the parties submitted the following stipulations:

A. Capform, Inc. is a business engaged in concrete form work, and its business operations affect interstate commerce.

B. Capform, Inc. is subject to the jurisdiction of the Federal Occupational Safety and Health Act of 1970, 29 U.S.C. §§ 801 *et seq.*

C. The Administrative Law Judge has jurisdiction in this matter.

D. The subject citations were properly served by a duly authorized representative of the Secretary upon an agent of Respondent on the date and place stated therein, and may be admitted into evidence for the purpose of establishing their issuance, and not for the truthfulness or relevancy

of any statements asserted therein.

E. The exhibits to be offered by Respondent and the Secretary are stipulated to be authentic but no stipulation is made as to their relevance or the truth of the matter asserted therein.

F. the proposed penalty will not affect Respondent's ability to continue in business.

G. On the date of the accident and the date of the inspection, Respondent maintained a worksite at U of T Southwest Medical Center located at 5901 Forest Park Road., Dallas, Texas.

H. The accident resulted in the death of Capform, Inc. Employee, Refugio Trejo.

Background

Respondent is engaged in erecting concrete reinforced buildings using concrete forms. During August 1998, Respondent was engaged as a subcontractor to construct a multistory research building for the Southwestern Medical Center at Dallas, Texas. The skeleton of the building, consisting of columns, walls and floors, was formed by reinforced poured concrete. This matter involves the construction of the concrete floor/ceiling at one level of the building. The floor is constructed by pouring concrete over reinforced steel bars supported by sheets of plywood and wood beams which, in turn, are supported by metal scaffolds placed on the floor below. When the concrete dries, the supporting scaffolds and concrete forms are removed and taken to the next higher level where the process of building forms and pouring concrete is repeated. This case is restricted to the removal of forms supporting the concrete floor.

Respondent supports the floor in sections. Each section is eight feet wide and fifteen feet long (TR 119). The sections consist of plywood supported by 2x6's supported, in turn, by 6x10 timbers (TR 115). The 2x6's are as long as sixteen feet. All of the wood frames are supported by metal scaffolds. When removing the forms, Respondent places "Ellis jacks," which consist of two 4x4's extending from floor to ceiling, and are used to support the beams and plywood. The metal scaffolding is then removed (TR 108). The Ellis jacks are placed in pairs under each side of a section with six jacks (3 sets) for each section of forms (TR 112,120). Two employees, working opposite each other, remove each set of jacks by simultaneously pulling out the bottom of each of two jacks with a twelve foot metal pole known as a "nena" (TR 90,108-109, Exh. R-33b). The nena has a flat metal plate welded to one end which is placed behind the bottom of the jack and each employee is instructed to pull the pipe to dislodge the jack. Although not clearly stated on the record, it is inferred that the forms supported by the Ellis jacks do not fall until the last two jacks supporting a section are removed.

The removal of the Ellis jacks and the collapse of the supporting beams and plywood, known as "stripping," is viewed by Respondent as a hazardous work activity. All personnel are removed from the area prior to dislodging the Ellis jacks because it cannot be determined where the support beams and plywood will go when it hits the floor (TR 114). The area is cordoned off with a tape marked "caution"

or "danger" (TR 127). Although employees have been injured in the past as a result of "stripping," no employee has been seriously injured (TR 127). The only employees allowed in the restricted area during stripping operations are the two employees assigned the task to remove the Ellis jacks (TR 114).

Respondent's foreman, Nicholas Salas, testified that he was the supervisor for the "stripping crew." He has supervised that crew for approximately six years and has twenty years' construction experience with Respondent (TR 1204,113). Salas stated that Respondent has no written safety procedures regarding the dismantling of overhead concrete forms (TR 102); however, he was verbally trained by his previous supervisor regarding the method which should be used to dismantle those forms (TR 102). According to Salas, his supervisor, who was not identified on the record, developed the stripping procedure (TR 103) but there is nothing in Respondent's safety manual that Salas is aware of regarding stripping operations (TR 103). Although Salas conducts tool box safety meetings for his crew, he has never conducted a tool box safety meeting for stripping procedures (TR 103). The investigating compliance officer testified on behalf of the Secretary that she believed that the procedure utilized by Respondent to remove forms as described above was "industry practice"; however, she stated that it may be acceptable to push the Ellis jacks in rather than out "with other precautions" (TR 45). Moreover, the compliance officer stated that the procedure utilized by Respondent to remove shoring materials did not violate any safety standard (TR 46).

On August 11, 1998,[11] Foreman Salas and his crew were engaged in "stripping" forms. However, he was shorthanded and was in a hurry to complete the job (TR 99,131). Salas learned that the "columns and forms" crew had finished their work for the day and he requested the carpenter foreman, Ciro, to send members of that crew to assist in the stripping operation. Mr. Ciro sent brothers Jose and the decedent Refugio Trejo and Able Gonzales to assist Mr. Salas' crew. Refugio Trejo had been working for Respondent since June 25, 1998 and had not performed stripping operations for Salas in the past (TR 36,40). Foreman Ciro proceeded to the work area with his crew members (TR 118).

Upon reporting to Mr. Salas, the Trejo brothers were given verbal instructions regarding the stripping operation. Since neither brother spoke English, Mr. Salas provided the instructions in Spanish. Mr. Salas testified that he specifically instructed the employees to pull out the bottom of the Ellis jacks with the nena. Because he had not previously worked with these individuals, Salas spent about twenty minutes instructing the employees and observed them remove a section of scaffolding without incident. Salas then left the area and did not observe the events which resulted in the death of Refugio Trejo.

The decedent's brother, Jose Trejo, testified through separate interpreters for Complainant and the

[11] Complainant erroneously lists the date of the accident as August 7, 1999 in the citation issued to Respondent.

Respondent regarding the training that he received from Mr. Salas. The witness testified for Complainant as follows:

Q. Have you ever been trained in removing of shoring?

A. Yes.

Q. When?

INTERPRETER BLAKE: He's been doing it for about a year.

Q. (By Mr. Jones) At the time of the accident in August of 1998 were you trained then in how to remove the shoring?

A. Yes, it was explained to me how to do the job.

Q. Was it explained to you what problems to look for?

A. No.

Q. Did anyone ever tell you not to push the shorings in?

A. I didn't hear it. That's what I said. We were just knocking the shoring down and no one explained to us.

MR. JONES: I have no further questions. (TR 84)

Mr. Trejo testified as Respondent's witness as follows:

Q. Before you started stripping shoring on August 11th did Mr. Salas instruct you and your brother on the proper way to do stripping?

A. Yes.

Q. What did he tell you?

A. How to do it and all that.

Q. What do you mean by "and all that"?

A/ He told us how to break down the material, the proper way of pulling.

Q. Anything else?

A. `No.

Q. Did Mr. Salas show you or tell you how to pull back using the long poles?

A. Yes.

Q. Did he tell you to be careful?

A. Yes.

Q. Why did you think it was important to be -- did you think it was important to be careful doing stripping?

A. Yes.

Q. Why?

A. Because there is danger and someone can get hurt.

Q. What is the danger that you have to be careful about?

A. Something can fall on you, the material, some kind of beam or something. Whatever it is up there can fall on you and get hurt. (TR 90)

Shortly after commencing the "stripping" operation, Refugio Trejo was fatally struck by the top of an Ellis jack. When asked what caused the accident, Jose Trejo, who observed the event, stated "The only thing that [Refugio] did is to push the jack in a direction that he should not have" (Tr 91).

A reconstruction of the accident revealed that an Ellis jack had been placed in close proximity to a covered elevator shaft which protruded above the surrounding floor level (Exh. R 33(b) & 33(c). The elevator shaft covering prevented the employee from pulling the jack out at the bottom. Since he was unable to pull the jack out, the deceased employee pushed it in and, in combination with his brother pulling the opposite jack outward caused the overhead materials to fall in the deceased employee's direction (TR 141). The top of the jack struck the employee inflicting fatal injuries.

Foreman Salas testified that the jack which struck the deceased was not in place when he instructed the employees nor was it in place during the time he observed the employees perform stripping operations. According to Salas, the jack was put in place after he had left the work area by Foreman Ciro's crew (TR 130). Respondent's safety director, Don Wallace, testified that he conducted an investigation of the accident and interviewed a foreman who was standing "three or four feet" behind the deceased at the time that the accident occurred (TR 161). The only foreman in the area at that time was Mr. Ciro, the supervisor of the Trejo brothers TR 118, 161). Mr. Ciro was not called as a witness by either side. However, based upon Salas' testimony that the Ciro crew installed the Ellis jack, it is inferred that Ciro either instructed or observed the Trejo brothers install the jack in close proximity to the covered elevator shaft and was within three or four feet of the deceased when the jack was pushed in (TR 161).

In response to a question as to the proper manner to remove the Ellis jack that struck Mr. Trejo, Foreman Salas stated:

A. I see two things. Number one, go to other side and tie a rope on the bottom and pull, or get like two 2 by 4's nailed together and hit them on the bottom, you know, being at least 20 feet away.

Q. Okay. Well, what would be the first thing he should do upon seeing that there was a problem?

A. Tie a rope on the bottom and pull it.

JUDGE YETMAN: Did you tell him that?

THE WITNESS: No, sir. (TR 136)

Safety Director Wallace also stated that the employee should have gone "around on the other side and pull on [the jack]" . . . . (TR 205). There is no evidence in the record that Foreman Salas, Foreman Ciro or anyone else instructed the employees to dismantle the jack in the manner described by Salas and

Wallace.

Based upon the foregoing, Respondent was issued a citation alleging one serious violation as follows:

29 CFR 1926.21(b)(2): The employer did not instruct each employee in the recognition and avoidance of unsafe condition(s) and the regulation(s) applicable to his work environment to control or eliminate any hazard(s) or other exposure to illness or injury:

> a) On and around August 7, 1998, employees shifted from alternate operations to performing stripping operations were not adequately trained to recognize and avoid the hazards associated with the removal of shoring.

Discussion

The standard cited in this matter requires employers to have an effective safety program with regular and frequent safety meetings. It is not sufficient to leave safety meetings to the discretion of foremen. *T.E. Driskell Grading Co.* 1987-90 CCH OSHD ¶28,498. Moreover, the employer must conduct regular and frequent inspections of the worksite to uncover hazardous conditions. *R&R Builders* 1991-93 CCH OSHD ¶29,531 (1991). The term "regular and frequent" is non specific; however, the Commission has defined it as that which a reasonable person familiar with the size of the worksite and the magnitude of the ongoing construction activity would understand as how often inspections should be conducted to keep track of safety hazards. *J.A. Jones Construction* 1991-93 CCH OSHD ¶29,964. It is critical that employees, especially inexperienced employees, be informed by supervisory personnel of the dangers associated with the specific hazardous activity in which they are engaged. *National Industrial Constructors, Inc.* 583 F.2d 1048 (8th Cir. (1978).

In this case Respondent argues that Foreman Salas explained the "stripping procedure" to the Trejo brothers and specifically instructed them to pull out the Ellis jacks. Moreover, according to Salas, he instructed the employees to ask for instructions in the event that they encountered any problems. However, after watching the employees for a short time, Salas left the work area and did not observe the work activity, notwithstanding the fact that the employees were not a part of his regular crew. In his absence, the conditions of the work area were changed either under the direction of Foreman Ciro or within his presence. Thus Ellis jacks were put in place without Salas' knowledge and with the concurrence of Foreman Ciro. There is no evidence in this record indicating that Foreman Salas or Ciro instructed the employees regarding the proper method for removing Ellis jacks that could not be pulled out due to immovable obstructions. In this regard, Respondent's supervisory personnel failed to provide the safety training contemplated by the standard.

Moreover, Respondent has failed to provide sufficient evidence to support the employee misconduct defense. The record reveals that Respondent did not have written safety procedures regarding

the proper manner in which to conduct "stripping" operations nor did foreman Salas conduct regular tool box safety meetings regarding the stripping operations. In this admittedly hazardous work activity, Respondent failed to provide the necessary safety instructions and supervision to inexperienced employees. Thus, the violation is AFFIRMED. Since the violation resulted in the death of an employee, it is affirmed as a serious violation.

With respect to the penalty, it is clear that the violation presents a high gravity factor. Futhermore, there is nothing in this record which supports a reduction of a penalty due to the Respondent's size o good faith. On that basis the proposed penalty in the amount of $6,300.00 is assessed for the violation.

Findings of Fact

Findings of fact relevant and necessary to a determination of all issues have been made above. *Fed. R. Civ. P. 52(a)*. All proposed findings of fact inconsistent with this decision are hereby denied.

Conclusions of Law

1. Respondent is engaged in a business affecting commerce and has employees within the meaning of Section 3(5) of the Act.

2. Respondent, at all times material to this proceeding was subject to the requirements of the Act and the standards promulgated thereunder., The Commission has jurisdiction of Respondent and the subject matter of this proceeding.

ORDER

Serious Citation 1, item 1 alleging a violation of 29 CFR §1926.21(b)(2) is AFFIRMED and a penalty in the amount of $6,300.00 is ASSESSED.

/s/

Robert A. Yetman
Judge, OSHRC

Dated: October 12, 1999