United States of America
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
1120 20th Street, N.W., Ninth Floor
Washington, DC 20036-3457

SECRETARY OF LABOR, Complainant, v. BOH BROTHERS CONSTRUCTION COMPANY, LLC, Respondent.	OSHRC Docket No. 09-1072

ON BRIEFS:

Ronald J. Gottlieb, Appellate Attorney; Charles F. James, Counsel for Appellate Litigation; Joseph M. Woodward, Associate Solicitor of Labor for Occupational Safety and Health; M. Patricia Smith, Solicitor of Labor; U.S. Department of Labor, Washington, DC
For the Complainant

Walter W. Christy, Esq. and Jacob C. Credeur, Esq.; Coats Rose Yale Ryman & Lee, PC, New Orleans, LA
For the Respondent

DECISION

Before: ROGERS, Chairman; ATTWOOD, Commissioner.

BY THE COMMISSION:

On December 23, 2008, a crane operated by a Boh Brothers Construction Company ("Boh") employee tipped over on a bridge over Lake Pontchartrain, Louisiana. The crane operator fell into the lake below and later died from his injuries. Following an inspection of the worksite, the Occupational Safety and Health Administration ("OSHA") issued Boh a citation alleging two serious violations of the Occupational Safety and Health Act of 1970 ("Act" or "OSH Act"), 29 U.S.C. §§ 651-678.[1] Specifically, the Secretary alleges that Boh failed to make

[1] The citation included a third item, which is not at issue on review.

a lifesaving skiff immediately available under 29 C.F.R. § 1926.106(d),[2] and failed to operate a crane in accordance with the manufacturer's specifications and limitations under 29 C.F.R. § 1926.550(a)(1). The Secretary proposed a penalty of $5,000 for each violation.

Following a hearing, former Administrative Law Judge G. Marvin Bober affirmed the two citation items and assessed the total proposed penalty of $10,000. For the reasons discussed below, we affirm both citation items and assess a total penalty of $10,000.[3]

DISCUSSION

I. Citation 1, Item 2 - Lifesaving Skiff

A. Background

At the time of the accident, Boh was constructing two bridges over Lake Pontchartrain for the Interstate-10 Twin Span project. These bridges extend between Slidell on the north shore and New Orleans on the south shore, and both exceed five miles in length. Numerous Boh crews worked in multiple areas on and around the bridges. Boh also had a fleet of more than a dozen boats at the worksite, including crew boats and tugboats, which the company used for transporting workers and materials between work areas, as well as responding to water emergencies.

On the day of the accident, two of these boats were continuously manned by Boh employees: one by Jeffrey Jones, Boh's lead boatman, and one by Chad Byrd. Both Jones and Byrd were assigned transporting duties, along with responsibility for responding to water emergencies. Each Boh foreman working at sites across the bridge was also assigned a boat and the responsibility to operate it in the event of a water emergency. Other boats available for water rescue were docked in a boat pen at the north shore. The pen was located 150 to 200 yards away from a trailer Boh used as an office, which was staffed with at least one employee qualified to operate a boat and provide first aid.

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[2] The standard uses the term "lifesaving skiff," but the parties refer here to "boats." We consider these terms equivalent for purposes of this case and use them interchangeably throughout our decision.

[3] We deny Boh's motion for oral argument as we find that the record and briefs provide a sufficient basis upon which to decide this case. *See, e.g.*, *Manganas Painting Co.*, 21 BNA OSHC 1964, 1968 n.3, 2004-09 CCH OSHD ¶ 32,908, p. 53,386 n.3 (No. 94-0588, 2007).

When the crane tipped over at one of Boh's active work areas on the bridge near the north shore, it fell onto the bridge's guardrail. The crane operator lost consciousness and remained in the cab for two to seven minutes while other Boh employees held onto the crane to keep it from falling into the lake. Thomas Tomkins, the Boh foreman supervising the crane's operations, immediately used his cell phone to call William Moulton, Boh's senior superintendent on the project, to report the accident. Moulton, in turn, used his cell phone to place multiple calls, including one to Kenneth Solis, the company's field project manager, who was in the office trailer at the north end of the bridge, and one to Boh foreman Mark Bailey, who was also working on the north side of the bridge.[4]

By the time Bailey received Moulton's call, he had already learned of the accident from another employee who had driven to Bailey's work area to deliver some materials. Bailey had then immediately used his cell phone to call Jones, the lead boatman. Jones then used his marine radio to call Byrd, who immediately left for the accident scene. At that time, both Jones and Byrd were in their boats on the water near the south shore. After calling Jones, foreman Bailey drove to the accident scene on the bridge and was on the phone with Moulton when the crane operator fell from the crane into the water.[5] Bailey then called Jones again, who said that a boat was on its way.

It is undisputed that Byrd was between three and four miles from the accident scene when he received the call from Jones on his marine radio. Byrd's boat traveled at a maximum speed of about thirty miles per hour, and he estimated that it took him between six and ten minutes to reach the crane operator in the water from the time he received Jones's call.[6] Byrd was the first to arrive at the accident scene.

In the meantime, project manager Solis, having learned of the accident when Moulton called him, grabbed a set of boat keys before leaving the office trailer on the north shore and ran

[4] Moulton also called 911 and Boh's tugboat captains, though it is not clear from the record in what order he placed all of the calls he made.

[5] Once the crane operator floated clear of the area directly beneath the crane, the employees holding the crane let it go and it fell into the lake.

[6] We note that this is consistent with the distance between Byrd's location and the accident scene given the speed of the boat. If Byrd had been traveling at full speed for three miles, he would have arrived at the accident scene in no fewer than six minutes.

150 to 200 yards to the boat pen. He boarded one of the boats, but before he finished starting it, another boat pulled into the pen and he decided to use that boat instead. Solis then traveled 250 to 300 feet to where the crane operator was in the water, arriving at the rescue location shortly after Byrd. Solis jumped into Byrd's boat to help Byrd hold the crane operator's head above water. While supporting the crane operator, they steered the boat towards the shore where emergency personnel were waiting. The crane operator was taken to a local hospital, where he died about a week later.

B. Compliance

Section 1926.106(d) provides that "[a]t least one lifesaving skiff shall be immediately available at locations where employees are working over or adjacent to water." The Secretary claims that Boh failed to ensure that a skiff was immediately available to rescue employees "working over Lake Pontchartrain on the edge of the roadbed near the northeast end of the east bound lanes of the bridge" in the event an employee fell into the water.

The cited standard does not define the phrase "immediately available." However, before the judge and on review, both parties have agreed that a December 6, 1991 OSHA interpretation letter from the Director of OSHA's Directorate of Enforcement Programs to the International Association of Bridge, Structural and Ornamental Iron Workers ("interpretation letter") identifies factors relevant to determining whether an employer has made a lifesaving skiff immediately available.[7] *See Schiavone Constr. Co.*, 12 BNA OSHC 1105, 1108 n.4, 1984-85 CCH OSHD ¶ 27,145, p. 35,039 n.4 (No. 80-914, 1984) (Buckley, separate view) ("Post-adoption statements of intent are not dispositive, but may be accepted as an aid in interpreting a standard, particularly where, as here, both parties agree that the instruction is a useful guide to the Secretary's interpretation of the standard.") Based on our consideration of Commission precedent, the language of the standard, and the factors in the interpretation letter, we find that whether Boh

[7] These factors include: (1) the skiff must be in the water or capable of being quickly launched by one person; (2) there must be at least one person present and specifically designated to respond to water emergencies and operate the skiff at all times when there are employees above water; (3) the designated operator must either man the skiff at all times or remain in the immediate area such that the operator can quickly reach the skiff and get underway; (4) a communication system, such as a walkie-talkie, must be used to inform the skiff operator of an emergency and to inform the operator where the skiff is needed; (5) the employer must evaluate the distance to each work location; and (6) permanent brain damage can occur in a drowning victim within three to four minutes of oxygen deprivation.

made a lifesaving skiff immediately available under the cited circumstances depends upon whether it had a water rescue system in place that could be expected to rescue a worker from the water within the three-to-four-minute window before permanent brain damage can occur. *See Thomas Indus. Coatings Inc.*, 23 BNA OSHC 2082, 2089-90, 2012 CCH OSHD ¶ 33,200, p. 55,770-71 (No. 06-1542, 2012) (assessing adequacy of employer's arrangements for providing water rescue services in determining if employer violated § 1926.106(d)); *S. Scrap Materials Co.*, 23 BNA OSHC 1596, 1623, 2012 CCH OSHD ¶ 33,177, p. 55,578 (No. 94-3393, 2011) (finding, in accordance with Commission precedent, that first aid must be administered within three minutes to be effective).

In affirming the violation, the judge touched upon similar considerations in analyzing what he characterized as the "totality of relevant circumstances." Specifically, he determined that Boh's response time to the accident was prolonged by its failure to equip crew boats with the type of radios used by Boh's foremen that can receive an emergency broadcast channel. The judge also discounted the availability of boats and operators on the north shore, in part because he found that Solis "was not assigned lifesaving duties that day," and therefore, he found that the only "active crew boat operators" were located miles away from the accident. Ultimately, the judge concluded that the crane operator had remained in the water for eight to twelve minutes, and thus Boh failed to complete a rescue within three to four minutes.

On review, Boh contends that the judge erred in disregarding the rescue boats and qualified operators it had available on the north shore. According to Boh, these boats— barring "unforeseeable" incidents on the day of the accident—were capable of responding to a water emergency at the cited location within four minutes. The Secretary maintains that Boh's system lacked a means of direct communication with the available boat operators, and argues that the office trailer on the north shore was too far away from the boat pen for an operator stationed there to be considered in the immediate area.[8]

[8] The Secretary also suggests that Boh should have designated a specific individual to be responsible for water rescue on the north shore—a designation that he contends would have clarified whom employees should contact in the event of an emergency. The judge did not specifically address this issue but the record shows that in addition to Byrd and Jones, who were both designated to respond to water emergencies, all employees who were assigned to boats had water rescue as one of their responsibilities. In light of the other deficiencies we find with Boh's

As a threshold matter, we agree with Boh that the judge erred in disregarding the availability of the boats in the north shore pen and qualified operators in the office trailer, including Solis, for the purposes of evaluating Boh's compliance with the cited standard. The record supports Solis's unrebutted testimony that he knew his responsibilities included water rescue and, as shown by the events on the day in question, he was fully aware that boats were available to him in the boat pen. Thus, to the extent the judge's reference to "active crew boat operators" suggests that Boh's compliance turns solely on the proximity of its manned boats, we disagree.

Nonetheless, we find that Boh failed to have a lifesaving skiff "immediately available" at the cited location as required by § 1926.106(d) in light of a combination of factors: the nature of Boh's communication system; the distance a qualified operator stationed in the office trailer on the north shore had to traverse to access a boat; and the size of the area in which the two manned boats were assigned to operate. As to Boh's means of communicating a water emergency, the actions of Boh employees on the day of the accident demonstrate that the company relied on a system that was indirect. Although Boh had a radio system in place that, by means of an emergency broadcast channel, would have permitted direct and simultaneous communication with all personnel assigned to water rescue duties, radios capable of receiving this channel were not provided to all qualified boat operators. Indeed, Boh only issued these radios to its foremen, limiting rescue communications to a system of cell phones and, in the case of Byrd and Jones, marine radios. In fact, on the day of the accident, the two individuals who independently requested a rescue boat—foreman Tomkins, who was present at the accident scene and the first to make a call, and foreman Bailey—both used cell phones to inform intermediaries of the need for a boat before a boat was finally dispatched.[9]

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water rescue system, we need not address whether the lack of a specifically designated individual on the north shore establishes noncompliance with the cited provision.

[9] Tomkins's call, which triggered the dispatch of the boat piloted by Solis from the nearest shore to the accident scene, was an indirect communication that went through Moulton rather than directly to Solis. Foreman Bailey's call, which led to the dispatch of the boat manned by Byrd, was even more indirect than the communication to Solis. Bailey first had to receive the information about the accident, then call Jones's cell phone before Jones, having received the necessary information, could contact Byrd using his marine radio.

This communication system left less time for either a north shore boat or one of the two manned boats to launch and travel to the cited location near the north shore within three to four minutes. To use a north shore boat, a qualified operator in the office trailer had to travel 150 to 200 yards on foot along the shore between the trailer and the boat pen, as Solis did on the day of the accident. Even if it would take the operator no more than one minute to travel this distance, that amount of time would consume a quarter to a third of the three to four-minute window. That leaves only about two or three minutes for Boh's communication system to alert an operator of the need for a water rescue and for the operator to get into a boat, start the engine, travel to the cited location (which in this instance was 250 to 300 feet away), and locate and rescue the employee. Given these circumstances, we find that Boh could not have reasonably expected that a boat in the north shore pen would be "immediately available" for a water rescue at the cited location.[10]

We also find that Boh could not have reasonably relied on its two manned boats to rescue a worker near the north shore within three to four minutes. In addition to water rescue, the operators of manned boats, including Byrd and Jones, had other assigned duties, such as transporting materials and personnel between work areas. Accordingly, the manned boats could be located anywhere along the five-mile span of the bridge when the need for a water rescue might occur. With a maximum operating speed of thirty miles per hour, a crew boat that was more than two miles away from the cited location could not be expected to reach that location within three to four minutes, even if the operator was contacted directly. Indeed, on the day of the accident, Byrd, who was closer to the scene than Jones, was three to four miles away from the accident site.[11]

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[10] Boh stresses that the proper measure of whether it complied with the standard is its response time as measured from when the crane operator was actually in the water rather than from when the first call for help was made. As explained above, the relevant inquiry is the response *capability* of the system—whether Boh had a water rescue system in place that could be *expected* to deliver a boat to a particular location within three to four minutes. Thus the exact time the crane operator fell into the water has no bearing on whether Boh's system was adequate under the cited standard. *See Access Equip. Sys. Inc.*, 18 BNA OSHC 1718, 1722 n.8, 1999 CCH OSHD ¶ 31,821, p. 46,778 n.8 (No. 95-1449, 1999) (violation of standard not dependent on accident).

[11] By Byrd's own estimation, it took at least six to eight minutes for him to reach the crane operator in the water.

For all of these reasons, we find that Boh failed to comply with the cited standard because it did not have a lifesaving skiff "immediately available."

C. Knowledge

To establish knowledge, the Secretary must prove that the employer knew or, with the exercise of reasonable diligence, could have known of the conditions constituting the violation. *Contour Erection & Siding Sys., Inc.*, 22 BNA OSHC 1072, 1073, 2004-09 CCH OSHD ¶ 32,943, p. 53,787 (No. 06-0792, 2007). The knowledge of its supervisors and foremen is imputable to the employer. *Rawson Contractors Inc.*, 20 BNA OSHC 1078, 1080-81, 2002-04 CCH OSHD ¶ 32,657, p. 51,326 (No. 99-0018, 2003); *A.P. O'Horo Co.*, 14 BNA OSHC 2004, 2007, 1991-93 CCH OSHD ¶ 29,223, p. 39,128 (No. 85-369, 1991).

Here, the judge found that Boh had actual knowledge that a lifesaving skiff was not immediately available because both its safety representative and senior superintendent knew where work was taking place on the day of the accident—near the north shore—and where, according to the judge, the only manned crew boats were located—near the south shore. Boh argues that because it had rescue boats with available operators located on the north shore, it had no reason to know that a boat would be unavailable to rescue a worker at the accident site. The Secretary responds that Boh knew or should have known the specific factors that limited the availability of its boats and their operators.

We find that Boh had knowledge of the violative condition but for different reasons than those cited by the judge. Boh had a water rescue system with multiple boats and qualified operators, but the record does not establish whether Boh knew, in fact, that its system could not be relied upon to deliver a rescue boat to the cited location within three to four minutes. However, its supervisors knew the key components of this system and should have known the effect of their limitations. As discussed above, they had knowledge that (1) Boh's two manned crew boats had additional duties and, therefore, could be positioned as far as three to five miles away from the cited rescue location; (2) a qualified operator in the north shore office trailer would have to traverse 150 to 200 yards to access a boat in the pen; and (3) Boh's means of communicating the need for a rescue was indirect. Under these circumstances, we find that Boh's supervisors had knowledge that its water rescue system lacked the requisite response

capability and that knowledge is imputable to Boh.[12] *See Rawson*, 20 BNA OSHC at 1080-81, 2002-04 CCH OSHD at p. 51,326.

Accordingly, we affirm a violation of § 1926.106(d).

II. Citation 1, Item 3 - Crane Operation

A. Background

At the work area near the north shore where the accident occurred, Boh was building curbs along the edges of the bridge deck using "curb forms." Once a curb was finished in one location, Boh's laborers disengaged the curb forms, and a mobile hydraulic crane lifted the forms and then traveled up to 150 feet to deposit the forms at the next location, an operation known as "pick and carry." With rigging and attachments, each load weighed just under 3,000 pounds. It is undisputed that the bridge deck in this work area was sloped 1.43 degrees (2.5 percent) and had a downward gradient toward the north shore of 0.9 degrees (1.6 percent).

At the time of the accident, foreman Tomkins supervised the curb work near the north shore, including the operation of the crane. The decedent, who operated the crane on the day of the accident, had replaced a previous crane operator the day before. Both operators performed pick and carry operations on the uneven deck surface with the crane's outriggers retracted,[13] but each had his own way of executing the operation. The first crane operator kept the curb forms in front of the crane—both when lifting the load and while traveling with it—while the decedent swung the load from the front of the crane to the back before traveling, which meant that the load was to the side of the crane as he rotated the boom.

The night before the accident, Tomkins expressed concerns to the decedent that his practice of not always keeping the load at the front of the crane was "overextending" the crane "for not having the outriggers out." Although the decedent responded that he believed this

[12] In imputing the knowledge of two of Boh's supervisors to the company, the judge referenced the foreseeability requirement imposed by the Fifth Circuit in supervisory misconduct cases. *See W.G. Yates & Sons Constr. Co.*, 459 F.3d 604, 608-09 (5th Cir. 2006) (holding that a supervisor's knowledge of his own misconduct is imputable to the employer only if the supervisor's misconduct was foreseeable). Although this case could be appealed to the Fifth Circuit, there is no supervisory misconduct here, as the supervisors acted in accord with Boh's own rescue practices. Thus *Yates* is inapplicable. *See id.*

[13] As illustrated in the crane's manual, an outrigger is comprised of several components, including a beam, which can be extended horizontally, and a jack, located at the end of the beam, which can be deployed vertically down.

practice was safe, Tomkins asked him to "at least keep [the] boom scoped in" to its shortest length to reduce the radius of the swing. The next day, the decedent followed the foreman's instructions and moved curb forms twice without incident. The third time, the decedent did not follow these instructions, and just as he hoisted a form and began to swing it to the side, the crane tipped over.[14]

B. Compliance

Section 1926.550(a)(1) requires an employer to "comply with the manufacturer's specifications and limitations applicable to the operation of any and all cranes and derricks." The Secretary alleges that on the day of the accident, Boh failed to follow "[t]he manufacturer's specifications and/or operating limitations . . . [because] [t]he operator was allowed to repeatedly make lifts on an unlevel surface without the use of outriggers (on rubber)."[15] The operator's manual for the crane used by Boh specifically prohibits traveling with a load on an unlevel surface and requires outrigger beams to be fully extended, with the jacks just clear of the ground, during pick and carry operations.[16] In affirming the violation, the judge agreed that Boh's pick and carry operation was contrary to the manufacturer's specifications in the operator's manual because it was performed on an unlevel surface without outriggers.

On review, Boh argues that the judge failed to consider evidence that its pick and carry operation was performed in accordance with the custom of the bridge construction industry. It

[14] After the crane was pulled out of the lake and examined by Boh's equipment inspector, it was confirmed that, at the time of the accident, the crane's boom was not scoped in. The inspector also discovered that the crane's computer was programmed as if the decedent was making a lift with outriggers fully extended rather than "on rubber," i.e., with the crane supported only by its tires, which is how the decedent was operating the crane at the time of the accident.

[15] Although the citation does not mention traveling with a load, the parties clearly litigated this issue in addressing both the lifting and traveling aspects of Boh's pick and carry operation at the hearing and in their briefs.

[16] The operator's manual urges operators to avoid traveling with a suspended load when possible, but states that if travel is required, operators are to "travel by the smoothest, most level route." In the event a smooth, level route is not available, the manual states, "don't travel with a suspended load." Instead, operators are to "grade the route to provide a smooth, level path. If it is not possible to grade the route, move the load by stepping." Finally, the manual specifically states that "travel during pick and carry operations is restricted to . . . a firm, level surface." It also requires operators to prepare the crane before pick and carry operations by leveling the crane on fully extended outriggers, then "retract[ing] the outrigger jacks just clear of the ground but leav[ing] the outrigger beams fully extended."

claims that § 1926.550(a)(1) is a broadly worded standard that, under applicable precedent requires the Secretary to prove that Boh failed to comply with industry custom to establish a violation. *See Corbesco Inc. v. Dole*, 926 F.2d 422, 427 (5th Cir. 1991) (finding that if the wording of a regulation is not specific enough, other sources, including industry custom and practice, may provide notice of the required conduct). According to Boh, the bridge construction industry considers it acceptable to operate a crane "on rubber" when working on a slope similar to that of the bridge deck here, provided that certain precautions are taken. Specifically, Boh's crane expert, Emile Rome, testified that a slope greater than one degree of level can reduce the crane's capacity,[17] but as long as the operator "derate[s]" the crane—"adjust[s]" the load charts to compensate for the slope—and stays within the crane's reduced capacity, the industry considers it safe to operate the crane.

We find that Boh's reliance on *Corbesco* is misplaced. Section 1926.550(a)(1) is neither broadly worded nor imprecise. *See Corbesco*, 926 F.2d at 428. It unambiguously requires compliance with the operator's manual, which in turn provides specific guidance on this issue. The manual generally allows the operator "to compensate" for a surface that is not level by derating the crane,[18] but not when traveling. It explicitly states, "[i]f a smooth, level route is not available, don't travel with a suspended load." Instead, it requires either leveling the route or

[17] Rome did not dispute the Secretary's contention that the industry considers a surface that is within one percent of level to be "level" and noted that this is reflected in both the OSHA personnel hoisting standard then in effect and an American National Standards Institute consensus standard for personnel lifting. *See* 29 C.F.R. §1926.550(g)(3)(i)(D) ("The crane shall be uniformly level within one percent of level grade . . . ."); Crane or Derrick Suspended Platforms, 53 Fed. Reg. 29,116, 29,123 (Aug. 2, 1988); Personnel Lifting Systems, ASME B30.23-2005, 3.2.2(a)(4) ("[The operator shall] verify that the hoisting equipment is set up and maintained within 1% of level during a personnel lift."). Although Boh argues that the "within one percent" figure is applicable only to hoisting personnel because a greater measure of safety is needed there, the evidence in the hoisting personnel rulemaking was that "a crane loses between five and 30 percent of its capacity when it deviates from level by as little as one degree. Indeed, capacity charts generally are based on the assumption that hoisting cranes are within one percent of level." Crane or Derrick Suspended Personnel Platforms, 53 Fed. Reg. at 29,123. Even if we were to construe the standard and its incorporated manual as imprecise on the issue of what constitutes "level" under the manual, Boh's argument still fails because the evidence that the industry considers a surface that is within one percent of level to be "level" is unrebutted.

[18] The manual states that "when [a firm level surface] can not be attained, loads being handled must be reduced to compensate. The amount loads are reduced depends upon how good or how poor actual operating conditions are. It is a matter of judgment and experience."

moving the load by "stepping."[19] In sum, for this particular crane, the manual, and the standard that incorporates it, prohibits the industry practice claimed by Boh—compensating for slopes greater than one percent when traveling with a load by derating the crane. Moreover, the manual specifically requires that when traveling with a load, the outrigger beams must be extended and the jacks partially deployed. Thus, we reject Boh's contention that the alleged industry practice is relevant to its compliance with the cited standard.

It is undisputed that Boh was using the crane on a part of the bridge that was not level—it had a cross slope of 2.5 percent, or 1.43 degrees, and a downward slope of 1.6 percent, or 0.9 degrees. By performing pick and carry operations on this section of the bridge, Boh was not in compliance with the instructions in the operator's manual. Furthermore, despite the manual's requirement to extend outrigger beams when traveling with a load, it is undisputed that they were not extended on the day of the accident. Accordingly, we find that the Secretary has proved noncompliance with § 1926.550(a)(1).

C. Knowledge

The judge based his finding of knowledge on the following undisputed evidence: Boh's management knew curb form work involved pick and carry operations; it was common knowledge that the bridge was not level; and a Boh supervisor was present at two of the lifts the decedent made before the accident. Boh argues its pick and carry operations followed industry custom and, therefore, it lacked knowledge.

We affirm the judge. Under Commission precedent, "[t]he knowledge element is directed to the physical conditions that constitute a violation, and the Secretary need not show that an employer understood or acknowledged that the physical conditions were actually hazardous." *Danis Shook Joint Venture XXV*, 19 BNA OSHC 1497, 1501, 2001 CCH OSHD ¶ 32,397, p. 49,865 (No. 98-1192, 2001) (citation omitted), *aff'd*, 319 F.3d 805 (6th Cir. 2003). Here, Boh does not dispute that it knew the bridge in this area was sloped. In addition, foreman Tomkins supervised the decedent's pick and carry operation of the crane, and he could see that

[19] As described in the manual, "stepping" a load is a process in which the crane is leveled on outriggers, the load is hoisted from one end of the crane to the other and then released to the ground, the crane is repositioned without the load, and the process is repeated.

the outrigger beams were not extended. And Tomkins's knowledge as a supervisor is imputable to Boh.[20] *See Rawson*, 20 BNA OSHC at 1080-81, 2002-04 CCH OSHD at p. 51,326.

Accordingly, we find that the Secretary has proved that Boh had knowledge of the cited condition.

D. Unpreventable employee misconduct

Boh contends that if there was a violation, that violation was the result of unpreventable employee misconduct on the part of the decedent. To establish the affirmative defense of unpreventable employee misconduct, "an employer must show that it had: (1) established work rules designed to prevent the violative conditions from occurring; (2) adequately communicated those rules to its employees; (3) took steps to discover violations of those rules; and (4) effectively enforced the rules when violations were discovered." *Manganas Painting Co.*, 21 BNA OSHC 1964, 1997, 2004-09 CCH OSHD ¶ 32,908, p. 53,413 (No. 94-0588, 2007). In rejecting the defense here, the judge found that Boh had a work rule that required cranes to be set up on a level surface but failed to establish the defense's other elements.

On review, Boh repeats its claim that industry practice allows pick and carry operations on sloped surfaces and that its safety policy simply tracked industry practice. According to Boh, this claimed industry practice placed the responsibility for determining if the crane was being used beyond its capacity on the decedent because only the decedent could see the level indicator inside the crane and thus know how far out of level the crane was. Boh, therefore, attributes the accident to the decedent's decision to overextend the crane's boom.[21]

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[20] As with the other citation item, we find that *Yates* is inapplicable here. *See Yates*, 459 F.3d at 608-09. Imputation under this item is also based on supervisory conduct in accord with Boh's own practices, not on supervisory misconduct.

[21] Boh argues that the decedent's failure to keep the boom scoped in, as well as his error in programming the computer, led to the violation of the standard and the accident. This mischaracterizes the violation. The violation here was based on Boh's failure to comply with the manufacturer's specifications in two respects: operating the crane on an unlevel surface and failing to fully extend outrigger beams and partially deploy outrigger jacks while traveling. Both of these conditions were known to Tomkins. Whether the accident might not have occurred if the decedent had kept the boom scoped in or programmed the computer differently is, therefore, irrelevant. *See American Wrecking Corp.*, 19 BNA OSHC 1703, 1707 n.4, 2001 CCH OSHD ¶ 32,504, p. 50,400 n.4 (No. 96-1330, 2001) (consolidated) ("Determining whether the standard was violated is not dependent on the cause of the accident."), *aff'd in part*, 351 F.3d 1254 (D.C. Cir. 2003).

But this argument ignores the fact that Boh's policy of performing pick and carry operations on unlevel surfaces without outriggers is at odds with the cited OSHA requirement. The operator's manual—which the OSHA provision incorporates by reference—allows traveling with a load only on level surfaces and with the outrigger beams extended. Thus, Boh's monitoring efforts, foreman Tomkins's supervision of the pick and carry operations, and Boh's disciplinary policy are deficient because they are based on a noncompliant work rule. Therefore, we reject Boh's affirmative defense.

Accordingly, we affirm a violation of § 1926.550(a)(1).

III. Characterization and Penalty

The judge characterized the lifesaving skiff violation as serious based on employee exposure to water-related hazards such as hypothermia and drowning. And he characterized the crane operation violation as serious because performing pick and carry operations on an uneven surface adversely affected the crane's load capacity and exposed employees to serious injury or death. For each violation, the judge assessed the Secretary's proposed penalty of $5,000 based on the high gravity of the violation. Boh does not challenge the characterization or penalty of either citation item on review and we find no reason to disturb the judge's findings or the penalty amounts. *E.g.*, *KS Energy Servs., Inc.*, 22 BNA OSHC 1261, 1268 n.11, 2004-09 CCH OSHD ¶ 32,958, p. 53,925 n.11 (No. 06-1416, 2008) (affirming alleged characterization and assessing proposed penalty where characterization and penalty were not in dispute). Accordingly, we affirm both violations as serious and assess the proposed penalties of $5,000 each, for a total penalty of $10,000.

ORDER

We affirm Citation 1, Items 2 and 3 as serious violations. We assess a penalty of $5,000 for each citation item, for a total penalty of $10,000.

SO ORDERED.

/s/
Thomasina V. Rogers
Chairman

/s/
Cynthia L. Attwood
Commissioner

Dated: March 4, 2013

OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
1120 20th Street, N.W., Ninth Floor
Washington, DC 20036-3457

SECRETARY OF LABOR, Complainant, v. BOH BROTHERS CONSTRUCTION COMPANY, LLC Respondent.	OSHRC Docket No. 09-1072

Appearances:

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U.S. Department of Labor
Dallas, TX
For the Complainant

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Jacob C. Credeur, Esquire
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New Orleans, LA
For the Respondent

Before: G. Marvin Bober
Administrative Law Judge

DECISION AND ORDER

This proceeding is before the Occupational Safety and Health Review Commission ("the Commission") under section 10(c) of the Occupational Safety and Health Act of 1970, 29 U.S.C. § 651 et seq. ("the Act"). From December 24, 2008, through June 9, 2009, the Occupational Safety and Health Administration ("OSHA") conducted a fatality inspection of a Boh Brothers Construction Company, LLC ("Boh Brothers") construction site. As a result of that inspection, OSHA issued to Boh Brothers one serious citation alleging three violations of the Act and proposing a total penalty of $12,125. Boh Brothers contested the citation, and the trial in this matter took place on January 13-15, 2010, in New Orleans, Louisiana. Both parties have filed post-trial briefs.

Boh Brothers does not challenge the alleged violations' characterization. Rather, it argues that the Secretary has not established the three alleged violations, and asserts unpreventable employee misconduct as an affirmative defense to Item 3.[1]

Jurisdiction and Other Stipulations

The parties agree that jurisdiction of this action is conferred upon the Commission pursuant to Section 9(c) of the Act, and that Boh Brothers is an employer engaged in business affecting commerce. (Ex. ALJ-1.) The parties also agreed that the inspection at Boh Brothers' workplace was conducted by an authorized representative of Complainant, and that an exhibit containing a June 10, 2009 e-mail from Ray Arcement to Kenneth Geistfeld and calculations attached thereto is a true and correct copy. (*Id.*)

Sequestration of Witnesses

I held this trial in compliance with applicable sequestration rules. *See* Federal Rule of Evidence 615 (allowing court to "order witnesses excluded so that they cannot hear the testimony of other witnesses"); Commission Rule of Procedure 71; 29 C.F.R. § 2200.71 (Federal Rules of Evidence apply in Commission proceedings). *See also Geders v. United States*, 425 U.S. 80, 87 (1976) ("The practice of sequestering witnesses is twofold. It exercises a restraint on witnesses 'tailoring' their testimony to that of earlier witnesses; and it aids in detecting testimony that is less than candid."); Fed R. Evid. 615 advisory committee's note ("The efficacy of excluding or sequestering witnesses has long been recognized as a means of discouraging and exposing fabrication, inaccuracy, or collusion."); 29 Charles Alan Wright & Victor J. Gold, Federal Practice and Procedure: Evidence § 6242, at 53-54 (1st ed. 1997).

Relevant Facts

The OSHA inspection took place after an accident at the Interstate-10 Twin Span ("Twin Span") project, which involves new construction of two bridges over Lake Pontchartrain, connecting New Orleans and Slidell, Louisiana.[2] (Tr. 21.) Including their approaches, both bridges exceed five miles. (Tr. 118.) Both bridges have a cross slope

[1] Boh Brothers timely raised this affirmative defense in its Answer to the Secretary's Complaint. Commission Rule 34(b)(4); 29 C.F.R. § 2200.34(b)(4).

[2] At the trial, the parties referred to the New Orleans side as the "south shore," and the Slidell side as the "north shore." (Tr. 130, 473; C-Ex. D.)

of 1.43 degrees (2.5 percent). (Tr. 386-87, 685; Ex. ALJ-1 Att. A at 2.) The particular bridge location at issue in this matter had a downward gradient, toward the north shore, of 0.9 degrees (1.6 percent). (Tr. 386, 404, 686; Ex. ALJ-1 Att. A at 2.) Boh Brothers was responsible for the entire project, aside from the bridges' high-rise "hump" portions. (Tr. 142, 153-54.) Due to its size and the "end-on" nature of the construction, the Twin Span project was comprised of numerous work crews distributed across multiple work areas. (Tr. 206, 246, 540.)

Curb Formwork Crane Operations

One stage of the Twin Span project involved setting concrete walls along the decks' edges. Boh Brothers used curb forms by pouring and setting the concrete in one area and then removing the form to transport it elsewhere along the deck, where employees would repeat the process. (Tr. 26, 471.) The forms weighed 1,500 pounds, and Boh Brothers transported them up to 150 feet at a time via "pick-and-carry" operation with a "cherry picker," a mobile hydraulic crane with tires and an extending boom. (Tr. 25-27, 30-35, 281, 301, 305, 471; Complainant's Exhibit ("C-Ex.") F at p. 28 of 194; C-Ex. Z.)

The cherry picker that Boh Brothers used for this function was the Link-Belt RTC – 8030 Series II ("Link-Belt" or "crane"). (Tr. 278, 300-301; C-Exs. F, G.) The Link-Belt is equipped with outriggers, extendable supporting devices provided to insure safe lifts. (Tr. 297-98, 494, 604; C-Ex. F at pp. 43-45, 192 of 194.) With outriggers properly extended, the crane's tires come off the ground. The operator can make lifts from this position, but the crane becomes stationary and can move a load solely along its boom's radius. (Tr. 297; C-Ex. F at p. 44 of 194.)

The Link-Belt Operator's Manual ("manual") states:

- The crane must be level before making a lift; a three-degree side tilt can reduce capacities by 50% or more. (Tr. 289; C-Ex. F at p. 13 of 194.)
- The [mobile] crane must be level and on firm ground with the outriggers fully extended and the tires clear of the ground before beginning any operation. (C-Ex. F at p. 31 of 194.)
- If a smooth level route is not available, don't travel with a suspended load. (C-Ex. F at p. 28 of 194.)

The manual also contains general warnings that operators should not operate a damaged or poorly maintained crane, and that worn components must be replaced prior to use. (C-Ex. F at p. 21 of 194.)

The Link-Belt cab is equipped with a Microguard 434 Rated Capacity Limiter ("Microguard Limiter" or "computer"), which "monitors crane functions" and "continuously compares the load with a copy of the crane capacity chart . . . in the computer memory." (C-Ex. F at p. 54 of 194.) The computer screen indicates factors that determine a crane's capability during a lift, such as the actual load weight, load radius, boom angle, and boom length. (*Id.* at pp. 54-55 of 194.)

Foreman Tomkins' Crew and the December 23, 2008 Accident

Late in 2008, Boh Brothers hired foreman Tommy Tomkins to supervise the curb formwork near the north shore. (Tr. 469.) Tomkins took over responsibility previously assigned to Ronnie Brown, a Boh Brothers superintendent. Tomkins was scheduled to spend two days of orientation with Ronnie Brown but, as a result of a jury duty conflict, their overlap lasted one half day. (Tr. 470-71.)

The crane operator who Tomkins initially supervised was Randy Matson. (Tr. 471.) Tomkins and Matson discussed how Matson planned to perform each curb form lift, and Matson assumed responsibility upon performing the actual lift. (Tr. 303.) Tomkins testified that he observed Matson perform a pick-and-carry numerous times, and knew throughout that bridges are sloped downward toward their approaches. (Tr. 475-76, 494.) Matson testified that he performed pick-and-carry operations even though he too knew the deck was not level and was generally aware that a gradient affects load capacity. (Tr. 282-84, 303-04.) Matson also testified that the computer screen was faded, such that in daylight he would have to shade the screen to read it. (Tr. 280.) Boh Brothers had scheduled repairs for the computer screen "as soon as possible." (Tr. 640-41; C-Ex. N.)

On December 23, 2008, an accident occurred that culminated in the death of a Boh Brothers employee ("T.B."). (Tr. 686.) By that date, T.B. had replaced Matson as Tomkins' crane operator. (Tr. 476.) Tomkins' crew had just completed the walls along one edge and was preparing to start on the other side, which required transporting the curb forms across the span via pick-and-carry operation. (Tr. 479.) Assisting T.B. were

Foreman Tomkins and three employees: Richard Tomkins, Dennis Brown, and Wilson Winn. (Tr. 42, 84.) In the morning, T.B. made two lifts, and "everything went smooth." (Tr. 85.) Foreman Tomkins observed T.B. make these lifts. (Tr. 482.) When a lunch break ended at 12:30 p.m., Foreman Tomkins attended to other operations approximately 90 to 200 feet farther from the north shore, and assigned Richard Tomkins, Dennis Brown, and Winn to continue assisting T.B. (Tr. 42-43, 85, 483.) Winn testified that T.B. approached the form "at a different angle than what he was when he picked up the first two" and did not "pick it up straight." (Tr. 86.) Winn further testified that after T.B. lifted the form from that angle, the crane's tires lifted off the pavement, the form swung to the right, and the crane tilted over. (Tr. 86.) Winn thought that "the angle that [T.B.] took might have played a big part" in the crane tipping over.[3] (Tr. 86.) Winn testified that at no point that day did he observe the crane's outriggers extended. (Tr. 83.)

After toppling, the crane settled on the railing with its cab hanging over the water. (Tr. 47, 87; C-Ex. S.) Winn and Dennis Brown held onto the crane to prevent it from sliding off the bridge, and also tried to reach T.B., who remained in the cab, unresponsive. (Tr. 87, 107.) Other Boh Brothers employees assembled to hold the crane, but T.B. eventually broke through the cab and fell into the lake. (Tr. 88.) The crane also fell into the lake, avoiding T.B., who had floated a short distance. (Tr. 90-92.)

Emergency Water Rescue Operations

Employee Chad Byrd was the first to reach T.B. after the fall. (Tr. 94, 226-27.) As a Boh Brothers crew boat operator, Byrd was assigned to transport employees, "monitor the water," and provide water rescue as needed. (Tr. 113, 226.) Byrd had attended a one-day Coast Guard training, but lacked first aid or CPR skills. (Tr. 114.) He testified that if he were to see anyone fall in the water, his instructions were to "get them out." (Tr. 116.)

Byrd was located on the southern half of the lake when he learned of the accident from a supervisory crew boat operator, Jeffrey Jones, who was located on the south shore. (Tr. 117; C-Ex. D.) Jones and Byrd were the only employees assigned to a boat

[3] Dennis Brown noted that winds were high during the morning shift, and Winn supposed that wind may have contributed to the crane's toppling. (Tr. 86.) The record evidence shows, however, that conditions were fair by the time of the accident. (Tr. 86, 118.)

that day, and Jones reached Byrd by marine radio to give instructions to make a rescue "near the north shore." (Tr. 117, 144-46, 148, 220, 226.) Boh Brothers had not equipped its crew boats with radios that provided system-wide emergency channels. (Tr. 144.) Jones had received the emergency call by cell phone from Mark Bailey, a Boh Brothers superintendent on a work crew near the bridge's midpoint. (Tr. 516-17; C-Ex. D.) Bailey, in turn, had learned of the accident only after two members of his crew had driven to him from the accident scene, near the north shore. (Tr. 516.)

Byrd testified that he reached T.B. after "six to eight minutes, ten tops," considering that he had traveled three to four miles, that the boat's maximum speed was 30 miles per hour, that lake conditions were fair, and that he decelerated at some points to seek help locating T.B. (Tr. 115-121; C-Ex. D.) When Byrd reached T.B., he was unable to pull T.B. from the water. (Tr. 121.) Shortly thereafter, a second boat arrived, driven by Boh Brothers' Field Project Manager Kenneth Solis, who was on the north shore when he learned of the accident. (Tr. 121, 519, 678.) Though trained in emergency response and first aid, Solis was not assigned lifesaving duties that day. He testified that he ran 150 to 200 yards to a docked boat and drove it approximately 250 to 300 feet to T.B.'s location. (Tr. 679-80.) Solis jumped onto Byrd's boat and held T.B.'s head above water while Byrd steered toward the authorities awaiting on shore to provide T.B. first aid.[4] (Tr. 121-22, 570, 681-83.)

Boh Brothers' Safety Program

Dennis Brown testified that Boh Brothers stressed safety to its employees and was "pretty safety-conscious." (Tr. 69.) Bill Moulton, a senior superintendent from Boh Brothers' corporate safety office, testified that Boh Brothers generally dispatches a safety engineer to job sites to administer first aid and CPR training to superintendents and foremen. (Tr. 186-87.) Moulton explained that Boh Brothers accounted for the Twin Span project's "large" scope by assigning him to provide sufficient safety equipment and conduct necessary field inspections. (Tr. 205-09.) Boh Brothers also committed a Safety Representative, Lester Untereiner, to perform compliance monitoring, coordinate with foremen and supervisors, identify deficiencies, and recommend safety improvements.

[4] The authorities brought T.B. to the hospital, where T.B. died seven to ten days later. (Tr. 686.) The parties introduced neither hospital records nor the death certificate.

(Tr. 192-93, 540-42.) Untereiner testified that he held daily safety meetings with supervisors to address ongoing work and insure that foremen held daily job safety analysis ("JSA") meetings with crew members. (Tr. 540.) And weekly, Untereiner administered presentations on safety-related topics selected by the corporate safety office. (Tr. 54, 539-40, 544; Respondent's Exhibit ("R-Ex.") 13.) Untereiner also administered orientation for employees new to projects. (Tr. 541-42.)

Boh Brothers had a written safety and health plan in effect at the Twin Span project. (Tr. 542; R-Ex. 22.) The plan includes a disciplinary policy requiring foremen and supervisors to address safe work practice violations. (Tr. 546; R-Ex. 22 at 9-10.) Moulton and Untereiner both testified that under the company's "stop work" policy, supervisors and employees alike may seek to stop unsafe work practices. (Tr. 230, 568.) The record evidence contains a number of written "employee notice warnings" issued in accordance with the disciplinary policy. (R-Ex. 12.)

Moulton testified that on the Twin Span project, Boh Brothers also emphasized the importance of providing personal protective and lifesaving equipment. (C-Ex. P at p. 1 of 6; R-Ex. 13 at 189.) Twice in 2008, Boh Brothers held training on the topic, wherein it addressed "the threat of drowning" at worksites near water, warning that "minutes count" and "[t]hree to four minutes without oxygen causes permanent brain damage." (*Id.*) The training materials instructed that to prevent drowning, a lifesaving skiff should be "in the water or . . . capable of being quickly launched and able to retrieve an employee from the water no more than 3 to 4 minutes from the time it enters water." (*Id.*) Moulton agreed at the trial that this presentation was administered to foremen, supervisors, and front-line employees. (Tr. 217.) The record also contains evidence that Boh Brothers provided ring buoys as part of its personal protective equipment program. Moulton and Untereiner both testified that Boh Brothers accounted for the worksite's size by placing ring buoys on all machinery and vessels, as well as on foreman trucks. (Tr. 232-33, 552, 555.)

The OSHA Inspection

OSHA Compliance Officer Kenneth Geistfeld ("CO Geistfeld") inspected the site on December 24, 2008, the day following the accident, and returned approximately six times over the course of the inspection period. (Tr. 327-28.) One of CO Geistfeld's

observations was that he did not see any ring buoys. (Tr. 330.) On June 8, 2009, he toured a span by vehicle and photographed two-employee crews working along the edges. (C-Ex. W.) From the moving vehicle, CO Geistfeld did not observe any ring buoys. (Tr. 330.) During the inspection Boh Brothers supervisors informed CO Geistfeld that Boh Brothers had a practice of providing ring buoys on the worksite. (Tr. 335-36, 345.)

Over the course of the inspection, CO Geistfeld photographed the accident scene, familiarized himself with the Link-Belt manual, and took statements from employees about the accident and response. (Tr. 362, 364-67, 374.) He also learned that the curb formwork "pick-and carry" lifts without outriggers had been taking place for one week. (Tr. 407.) Through an information request after the inspection closed, CO Geistfeld was able to determine that the bridge surface where the accident took place was not level. (Tr. 386-88; Ex. ALJ-1, Att. A.) CO Geistfeld also concluded from his interviews that no lifesaving skiff was immediately available during the citation period. (Tr. 367.)

Discussion and Conclusions

Citation 1, Item 1 and Citation 1, Item 2 involve the Personal Protective and Lifesaving Equipment Construction ("PPE") standard. *See* 29 C.F.R. Part 1926, Subpart E. Citation 1, Item 1 alleges a violation of 29 C.F.R. § 1926.106(c), which requires the employer to provide ring buoys and make them readily available for emergency water rescue operations. Citation 1, Item 2 alleges a violation of 29 C.F.R. § 1926.106(d), which requires employers at worksites "over or adjacent to water" to make "at least one lifesaving skiff . . . immediately available." The Secretary proposes a $2,500 penalty for Citation 1, Item 1, and a $5,000 penalty for Citation 1, Item 2.

Citation 1, Item 3, involving the cranes and derricks construction standard, *see* 29 C.F.R. Part 1926, Subpart N, alleges that Boh Brothers violated 29 C.F.R. § 1926.550(a)(1) by failing to comply with the manufacturer's specifications applicable to the Link-Belt's operation. The Secretary cites two instances of such conduct, and proposes a $5,000 total penalty for Citation 1, Item 3.

In order to prove a violation, the Secretary must show that: (1) the cited standard applies; (2) there was a failure to comply with the cited standard; (3) employees had access to the violative condition; and (4) the cited employer either knew or could have

known of the condition with the exercise of reasonable diligence. *Astra Pharmaceutical Prods., Inc.*, 9 BNA OSHC 2126, 2129 (No. 78-6247, 1981), *aff'd in pertinent part,* 681 F.2d 69 (1st Cir. 1982).

The Secretary has established the first element – applicability – for each item. The Twin Span project was involved in construction on or near water, thus making applicable the cited PPE standards in Citation 1, Item 1 and Citation 1, Item 2. Boh Brothers does not argue otherwise in its brief. (Resp't Br. at 4-16.) The Link-Belt is a crane whose manufacturer provided use specifications, making applicable the cited standard in Citation 1, Item 3. Again, Boh Brothers appears not to challenge this finding. (Resp't Br. at 16-22.)

Citation 1, Item 1

The standard cited in Item 1, 29 C.F.R. § 1926.106(c), provides,

> *[r]ing buoys with at least 90 feet of line shall be provided and readily available for emergency rescue operations. Distance between ring buoys shall not exceed 200 feet.*

The Secretary alleges,

> *[o]n the roadway of the I-10 Twin-Span Bridge construction project in the area where the construction was taking place over water there were no ring buoys provided. This condition exposed the employees working on the roadway construction to a drowning hazard.*

At issue is whether the Secretary has sufficiently established noncompliance with the cited standard.

To demonstrate that ring buoys were not present to the extent required by the cited standard, the Secretary posits that ring buoys were absent on three different dates during the citation period, particularly on June 8, 2009. (Sec'y Br. at 12-14.) When CO Geistfeld inspected the worksite that day, he sighted numerous small crews while touring one of the spans by automobile. (Tr. 332-34.) The CO photographed some of the crews from the moving vehicle, and testified that he did not see ring buoys near any of them. (Tr. 330.) CO Geistfeld conceded, however, that when he passed the crews, he neither exited nor even stopped his vehicle to determine whether Boh Brothers may have placed ring buoys someplace that may have been out of his view, such as on a vessel on the lake below, or attached to portions of overhang caddies that he could not see. (Tr. 330-31,

440-41; C-Ex. W.) CO Geistfeld also conceded that he never interviewed any of the observed employees or otherwise sought to determine whether ring buoys were present beyond his vantage point. (Tr. at 439.)

Though CO Geistfeld believed Boh Brothers officials when they informed him that vessels on the lake contained ring buoys, he neglected to inspect the vessels or otherwise attempt to locate them or otherwise determine compliance with the standard. (Tr. 436.) The CO also admitted that he did not consider searching for ring buoys in places such overhang caddies. (Tr. 435.)

With less confidence, the Secretary argues that no ring buoys were present when CO Geistfeld initiated the inspection on December 24, 2008. (Sec'y Br. at 13.) Arriving at the site in response to the accident, it was that day when CO Geistfeld first considered that Boh Brothers had not provided enough ring buoys. (Tr. 330.) Nonetheless, CO Geistfeld admitted at trial that his actual findings that day probably did not support a citation. (Tr. 336.)

The Secretary also refers to the accident itself as "a real life scenario of when a ring buoy may have been needed." (Sec'y Br. at 13.) The Secretary points out that Dennis Brown and Winn both testified to not seeing ring buoys near the work area on December 23, 2008. (*Id.*) But Dennis Brown stated that Boh Brothers generally provided ring buoys, and Winn qualified his testimony by explaining that he was not necessarily looking for ring buoys while assisting the curb formwork. (Tr. 54, 95.) The Secretary also argues that Boh Brothers has not adequately shown that it provided ring buoys near the curb formwork on the day of the accident. But as the Secretary admits, the accident is "not a basis for [Citation 1, Item 1] itself." (Sec'y Br. at 13.) The Secretary also does not dispute testimony that on the day of the accident, Boh Brothers did equip the Link-Belt with a ring buoy. (Tr. 490, 555.)

All the while, Boh Brothers has offered undisputed evidence that as part of its safety policy, supervisors were aware of the ring buoy requirement and routinely provided ring buoys to particular work areas. Moulton testified that Boh Brothers addressed this policy in JSA meetings and performed inspections to ensure compliance. (Tr. 210.) He explained that because the project involved "end-on" construction, in which work locations frequently changed, "more ring buoys [were required] to be within

200 feet of an operation." (Tr. 210, 232-33, 246.) He testified that Boh Brothers used foreman trucks to ready ring buoys for distribution to equipment such as cranes and overhang scaffolding. (Tr. 210.) Testimony also shows that Boh Brothers kept ring buoys on barges, tugboats, stationary cranes, and crew boats. (Tr. 54, 552). CO Geistfeld did not appear to investigate this information's accuracy upon receiving it at the inspection. (Tr. 436.)

The cited standard requires the Secretary to show that ring buoys were not present at the worksite, or, in the very least, that ring buoys were present, but not within 200 feet of each other. 29 C.F.R. § 1926.106(c). The nature of the requirement, therefore, required CO Geistfeld to identify particular work areas where Boh Brothers failed to comply. Without calling into question CO Geistfeld's general expertise or credibility as a witness, I find that he never showed that Boh Brothers violated the cited standard. In turn, the Secretary can provide no direct testimony to support the CO's initial impressions that ring buoys were insufficiently present, and thus she has not established noncompliance. By failing to prove this element, the Secretary has not established a violation of the ring buoy standard, and Citation 1, Item 1, is vacated.

Citation 1, Item 2

The standard cited in Item 2, 29 C.F.R. § 1926.106(d), provides,

> *[a]t least one lifesaving skiff shall be immediately available at locations where employees are working over or adjacent to water.*

The Secretary alleges,

> *I-10 Twin-Span bridge construction project;* [sic] *On or about December 23, 2008, the employer failed to ensure a skiff was immediately available to retrieve employees in the event of a fall. Employees were working over Lake Pontchartrain on the edge of the roadbed near the northeast end of the east bound lanes of the bridge. Employees were exposed to a hazard of drowning.*

Although Boh Brothers equipped the project with at least seven crew boats, during the period covered by the citation, at least five of them were docked at the north shore. (Tr. 116, 220, 555.) And at the time of the accident, the only active crew boat operators were assigned duties miles away from the north shore worksite. Not only were these boats far away, but the record shows that Boh Brothers was not prepared to have a lifesaving skiff operator perform rescue duties, as Byrd testified that he was not so

specifically designated. (Tr. 116.) T.B. received first aid only after an improvised rescue involving disorganized, inefficient communication. I find that the Secretary has established a violation of section 1926.106(d).

Byrd, the closest boat operator, had to travel up to four miles to reach T.B, a distance that took him from "six to eight minutes, ten tops." (Tr. 121.)[5] And time appears to have passed even before Byrd started en route. Captain Jones – who instructed Byrd to rescue T.B. – had not heard of the accident until T.B. had already fallen. (Tr. 145-46.) Testimony from Winn and Dennis Brown – both of whom witnessed the entire turn of events and both of whom I found to be credible based on their demeanor at trial – indicates that after the crane toppled, T.B. remained in the cab for six to ten minutes. (Tr. 47, 89-90.)

The cited standard does not define "immediately available." My conclusion that Boh Brothers did not meet this requirement rests on the "'totality' of the relevant 'circumstances.'" *Atlantic Battery Co.*, 16 BNA OSHC 2131, 2168 (No. 90-1747, 1994) (citations omitted.) Boh Brothers' own safety materials state that to prevent drowning, a lifesaving skiff should be "placed in the water or so that it is capable of being quickly launched and able to retrieve an employee from the water no more than 3 to 4 minutes from the time it enters water." (C-Ex. P at p. 1 of 6; R-Ex. 13 at 189.)[6] The record demonstrates that Boh Brothers did not retrieve T.B. within this period and that T.B. was in the water for eight to twelve minutes. More so, I note that although Boh Brothers had work areas on both sides of the lake, during the citation period it had only assigned two crew boats – with speeds limited to thirty miles per hour – to the large worksite. I further note that Boh Brothers' failure to equip its crew boats with an emergency radio channel prolonged response time. Based on the foregoing, regardless of how much time actually elapsed while T.B. was in the water, I agree with the Secretary's argument that Boh

[5] Winn offered testimony consistent with Byrd's, estimating that T.B. was in the water for eight to twelve minutes before Byrd arrived. (Tr. 94.)

[6] Boh Brothers' rule appears to mirror a 1990 OSHA "Standard Interpretation," in which the Philadelphia Area Office (which does not have jurisdiction over the worksite) decided to define "immediately available" as having a lifesaving skiff that "could . . . retrieve an employee from the water no more than three (3) to four (4) minutes from the time they entered the water." (Tr. 353; C-Ex. H.) Although I note this similarity, I reach my findings without relying on the Standard Interpretation.

Brothers failed to make a lifesaving skiff "immediately available." Under the circumstances, the Secretary has established noncompliance with section 1926.106(d).

Because T.B. fell to the water during the period covering the citation, the Secretary has shown actual exposure to the cited drowning hazard. *RGM Constr. Co.*, 17 BNA OSHC 1229, 1236 (No. 91-2107, 1995) (finding violation of lifesaving skiff standard where employees were working at end of bridge but nonetheless "over water"). But the Secretary has shown that even if T.B.'s accident never occurred, employees on the deck were similarly exposed to water-related hazards – such as drowning or hypothermia – stemming from the lack of an immediately available lifesaving skiff. (Tr. 367.) *See Fabricated Metal Prods.*, 18 BNA OSHC 1072, 1074 (No. 93-1853, 1997) (requiring Secretary to establish exposure by showing that it is reasonably predictable that employees have been, are, or will be in the zone of danger); *RGM*, 17 BNA OSHC at 1234 (holding that zone of danger is "area surrounding the violative condition that presents the danger to employees"). The Secretary, therefore, has established exposure to the violative condition.

I also find that on the date covered by the citation period for Item 2, high-level Boh Brothers officials had actual knowledge that no lifesaving skiff was immediately available to make rescues near the curb formwork. Untereiner testified that he was in daily contact with foremen, which placed him in a position to know what work was taking place each day, where such work was occurring, and which foremen were assigned a boat. He and Moulton knew that if Boh Brothers boats went unused, they were available in the "pen." (Tr. 223-26, 556.) Boh Brothers supervisors, therefore, had information that on the day of the accident, the only assigned crew boats were on the south shore, but that work was taking place over water near the north shore. Their actual knowledge is imputable to Boh Brothers. *Rawson Contractors Inc.*, 20 BNA OSHC 1078, 1080-81 (No. 99-0018, 2003); *A.P. O'Horo Co.*, 14 BNA OSHC 2004, 2007 (No. 85-0369, 1991).

There is further support for a conclusion that the Secretary has proven Boh Brothers' knowledge that lifesaving skiffs were not immediately available. Boh Brothers asserts that it "had proper training and work rules in place to insure . . . compliance with the standard . . . ." (Resp't Br. at 15.) But Boh Brothers has not provided evidence that

its safety program included a process by which it monitored Moulton and Untereiner's supervisory efforts. *Southwestern Bell Tele. Co.*, 19 BNA OSHC 1097, 1099 (No. 98-1748, 2000), *aff'd* 277 F.3d. 1374 (5th Cir. 2001) (unpublished). In this regard, Boh Brothers' program is not "sufficient to make the supervisor's conduct in violation of the policy unforeseeable." *W.G. Yates & Sons Constr. Co. Inc.*, 459 F.3d 604, 608-09 (5th Cir. 2006) (hereinafter "*W.G. Yates*").[7]

Penalty

The Secretary has proposed a penalty of $5,000, which I find appropriate. In determining penalties, the Commission must give due consideration to four factors: gravity of the violation; size of the employer's business; good faith of the company; and the company's previous history of OSHA violations. *See* OSH Act § 17(j), 29 U.S.C. § 666(j). "These factors are not accorded equal weight, and gravity normally is the most significant consideration." *Aviation Constructors Inc.*, 18 BNA OSHC 1917, 1922 (96-0593, 1999). Gravity is determined by the number of employees exposed, the duration of the exposure, the precautions taken against injury, and the likelihood of an actual injury. *J.A. Jones Constr. Co.*, 15 BNA OSHC 2201, 2214 (No. 87-2059, 1993).

I find the gravity of this Item to be high. As found above, although the precise duration is undetermined, T.B. was in the water long enough to have been subject to water-related hazards. (Sec'y Br. at 19.) And although Byrd and Solis did eventually reach T.B., first aid took place only after T.B. was dragged through the water to shore. I also find that Boh Brothers could have limited exposure by dispatching boats on both sides of the lake and outfitting its boats with radios programmed to simultaneously receive initial emergency messages.

As to the other factors, CO Geistfeld did not propose a downward adjustment for size or prior history, taking into account that Boh Brothers employs 1,500 – 1,800 workers and that OSHA had previously issued citations to it. (Tr. 351.) Boh Brothers does not dispute these findings. Accordingly, I will make no downward adjustment for these two factors.

Nor do I find it appropriate to make a downward adjustment for good faith. Granted, the record does show that supervisors and employees reacted as best they could

[7] Either party may appeal this case to the U.S. Court of Appeals for the Fifth Circuit.

under the circumstances. And testimony shows that Boh Brothers has a written safety plan and is generally known for a commitment to safety. (Tr. 69; R-Ex. 22.) But as shown above, by not accounting for the size of the worksite, and not having a lifesaving skiff immediately available near the north shore curb formwork, Boh Brothers failed to follow its own written requirement. *MJP Constr. Co.*, 19 BNA OSHC 1638, 1649 (No. 98-0502, 2001) (refusing good faith reduction where employer failed to comply with own fall protection program); *Ed Taylor Constr. Co.*, 15 BNA OSHC 1711, 1718 (No. 88-2463, 1992) (balancing commendable measures of safety plan "with clearly inadequate measures taken" at particular worksite). In view of these factors, I find appropriate, and therefore assess, the Secretary's proposed penalty of $5,000.

Citation 1, Item 3

The standard cited in Item 3, 29 C.F.R. § 1926.550(a)(1), provides,

> *[t]he employer shall comply with the manufacturer's specifications and limitations applicable to the operation of any and all cranes….*

The Secretary alleges,

> *[o]n or about December 23, 2008, a Link Belt* [sic] *Model RTC-8030 Series II Crane was operated in an unsafe manner which resulted in the crane tipping over.*

The citation listed five instances allegedly demonstrating Boh Brothers' violation of section 1926.550(a)(1). Before the trial, however, the Secretary withdrew three of them. Ex. ALJ-2. The remaining instances are:

> *1: The operator was allowed to repeatedly make lifts on an unlevel surface without the use of outriggers (on rubber).*
>
> *2: The crane was not equipped as it came from the factory in that the screen on the load indicating system was faded and hard to read and two of the four outriggers were broken and being held to the crane with rope and metal strapping.*[8]

[8] The Secretary listed this instance fourth in the citation. For present purposes, I will refer to it as Instance 2. The Secretary has decided not to pursue the portion of this instance involving the outrigger pads maintenance. (Sec'y Br. at 33.)

Instance 1

The Link-Belt Operator's Manual specifies that lifts must occur on a level surface, that outriggers must be used to create a level surface, and that a cherry picker may not travel unless it is on a smooth, level surface. (Tr. 373-87; C-Ex. F at pp. 13, 28, 31, 74 of 194). The parties have stipulated that the bridge surface where the accident took place had both a cross-slope (1.43 degrees, or 2.5 percent) and a downward slope (0.90 degrees, or 1.6 percent), and was therefore not level. (Tr. 386-87, 404, 685-86, Ex. ALJ-1 Att. A at 2.)[9] Thus, the "pick-and-carry" operations that took place during the citation period did not follow specifications in the manual.

Boh Brothers emphasizes that its experienced crane operators believed the bridges' slope to be insignificant. (Resp't Br. at 19; Tr. 303-04.) The cited standard requires compliance with an operator's manual, however, and the Link-Belt manual prohibited pick-and-carry operations on an unlevel surface. Further, Boh Brothers cannot shift to its employees the responsibility of determining safe working procedures. *Pride Oil Well Serv.*, 15 BNA OSHC 1809, 1815 (No. 87-692, 1992), *citing Stuttgart Machine Works, Inc.*, 9 BNA OSHC 1366, 1369 (No 77-3021, 1981) ("[A]n employer cannot rely on one employee's training and experience as the sole means of protecting other employees. The Act places final responsibility for compliance on the employer.") In this light, the Secretary has established noncompliance with the cited standard.[10]

As to exposure, the accident itself shows that Boh Brothers employees were exposed to hazards during pick-and-carry operations on an unlevel surface, outside the manufacturer's specifications. The manual explains that the effect of an unlevel surface is reduced load capacity. (C-Ex. F at p. 24 of 194.) Not only did T.B. suffer substantial

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[9] During its case-in-chief, Boh Brothers' Safety and Health Director acknowledged that OSHA considers a surface "level" if its gradient is less than one percent. (Tr. 608.) *See* 29 C.F.R. § 1926.550(g)(3)(i)(D).

[10] In January, 2009, Boh Brothers "extracted" the crane from the lake to try to "reenact" the accident. (Tr. 397, 670-71.) I give no weight to this evidence because I do not believe Boh Brothers has shown that the recovered crane reliably depicts its condition prior to the accident. Even if the evidence were reliable, it provides no defense to Citation 1, Item 3, Instance 1, because it does not rebut the Secretary's showing that Boh Brothers allowed lifts on an unlevel surface without outriggers. For the same reasons, testimony relating to the retrieved crane provides no support for Boh Brothers' affirmative defense of unpreventable employee misconduct, *infra*.

physical harm, but the other curb formwork employees were also in close proximity to a crane operating with reduced capabilities. The Secretary, therefore, has established exposure to the cited condition.

I also find that Boh Brothers had knowledge of the violative conditions. CO Geistfeld asserted at trial that Boh Brothers "management" was aware that the curb formwork involved pick-and-carry operations, and that it was also common knowledge that the bridge was not level. (Tr. 409.) The record evidence appears to support these findings. Even prior to the week of the accident, Boh Brothers foremen were routinely under the impression that if operators were performing lifts within the cranes' capacity, then outriggers were unnecessary, regardless of whether pick-and-carry operations were taking place. (Tr. 480-82.) Specifically, Tomkins allowed the pick-and-carry operation even though he understood that bridges, including the Twin Spans, are generally engineered to be sloped. (Tr. 493-95.) He also testified that Boh Brothers provided him with a safety course during which he learned that cranes should not be operated on unlevel ground. (Tr. 494.) And he discussed with Matson just what was involved with using a cherry picker to move curb forms. (Tr. 303.) Despite his understanding, Tomkins allowed his crew to move the curb forms via pick-and-carry, while being actually present for and assisting with such operations on the morning of December 23. (Tr. 475-76.) The record shows, therefore, that during the time in question with respect to Citation 1, Item 3: T.B. was allowed to perform lifts on the Link-Belt without outriggers; T.B.'s supervisor was present for two of these lifts; and at no time did Tomkins disallow such conduct despite his training. All the while, Unterenier administered daily "safety checks" and Moulton spent "the majority of the day in the field [monitoring] for safety violations." (Resp't Br. at 20; Tr. 208-09.) And Boh Brothers actually endorses the pick-and-carry approach as "an absolute necessity." (Resp't Br. at 19.) Tomkins' decision to allow pick-and-carry operations on the bridge deck, therefore, did not amount to unforeseeable "rogue conduct." *W.G. Yates*, 459 F.3d at 609 n.8.

In light of the findings above, the Secretary has established through Instance 1 a violation of the cited standard in Citation 1, Item 3. *See Nat'l Eng'g & Contracting Co.*, 18 BNA OSHC 1075, 1079-80 (No. 94-2787, 1997) (affirming violation of section

1926.550(a)(1) where lifts without outriggers undisputedly violated manufacturer's specifications set forth in manual).

Instance 2

The Secretary also argues that Boh Brothers violated section 1926.550(a)(1) by operating the crane "not equipped as it came from the factory" insofar as the "Capacity Limiter" screen was "faded and hard to read." The Secretary has not established, however, that the faded screen constituted noncompliance with the cited standard.

Evidence does show that Matson and T.B. operated the crane while the screen was faded, and that Boh Brothers knew such conditions existed. Boh Brothers had reported the condition in its August 25, 2008, "Repair Description," and the Secretary has shown that Boh Brothers did not subsequently repair or replace the screen. (Tr. 444, 645; C-Ex. N.) The Secretary has even shown that Boh Brothers' equipment supervisor Gary Button understood the potential hazards associated with operating the crane while its screen was faded. (Tr. 646.)

Regardless of these facts, the Secretary has not shown that the screen's "faded and hard to read" condition amounted to a failure to follow the manufacturer's specifications. The applicable portion of the manual contains "no specification or limitation" on the screen's condition. (C-Ex. F. at pp. 54-55 of 194.) The manual contains general warnings against operating a damaged or poorly maintained crane, but they do not amount to "specifications and/or limitations" for the purposes of the cited standard. (C-Ex. F at p. 21 of 194.) The Secretary, therefore, cannot rely on this instance to show a violation of the particular cited standard.[11]

In summary, the Secretary has proven a violation of Citation 1, Item 3 based on Instance 1, but not on Instance 2. Accordingly, it is necessary to address Boh Brothers' affirmative defense of unpreventable employee misconduct.

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[11] In reaching this conclusion I do not condone continuing to operate a machine requiring repairs "as soon as possible." (Tr. 640; C-Ex. N.) *See Otis Elevator Co.*, 21 BNA OSHC 2204, 2208 n.6 (No. 03-1344, 2007).

Unpreventable Employee Misconduct

Establishing unpreventable employee misconduct requires proof that the employer has (1) established work rules designed to prevent the violation; (2) adequately communicated those rules to its employees; (3) taken steps to discover violations; and (4) effectively enforced the rules when violations have been discovered. *Danis Shook Joint Venture XXV*, 19 BNA OSHC 1497, 1502 (No. 98-1192, 2001), *aff'd* 319 F.3d 805 (6th Cir. 2003); *see also Sanderson Farms, Inc. v. OSHRC*, 348 Fed.Appx. 53, 57 (5th Cir. 2009) (adopting same requirement). The record evidence does indicate that Boh Brothers established a work rule intended to insure compliance with the Link-Belt manual by requiring cranes to be "set up on a level surface" when making lifts. (C-Ex. O.) As presented below, however, Boh Brothers has not established other elements of the defense, and therefore has not proven that the section 1926.550(a)(1) violation resulted from unpreventable employee misconduct.

Boh Brothers relies on the theory that "[T.B] was the only person with access to the crane's bubble level indicator and was the only person who would know how to tell if the crane was operating within acceptable specifications for a pick and carry." (Resp't Br. at 25.) The Secretary, however, has established that Boh Brothers allowed lifts on an unlevel surface without outriggers by showing that throughout the curb formwork, pick-and-carry operations took place while foremen trained to prohibit lifts from unlevel surfaces were cognizant of the deck's sloped surface. *See supra*. T.B.'s conduct in the cab is irrelevant to the Secretary's case, and any focus on it is therefore misplaced. Tomkins knowingly allowed pick-and-carry operations on the bridge deck, an unlevel surface. (Tr. 476.) Moulton and Untereiner were assigned responsibilities that included monitoring the worksite for safety violations, but they apparently did not discover this violation. (Tr. 191-92, 207-209, 539-542.) In this light, Boh Brothers did not take adequate steps to discover violations or enforce its policy that foremen and superintendents shall address unsafe work practice by either reprimanding employees, sending them home, or terminating them.[12]

[12] Boh Brothers also asserts that it enforced its safety program, having issued numerous "employee warning notices" at the Twin Span project. (Resp't Br. at 24; Tr. 546; R-Ex. 12.) Eight of the thirty examples provided as evidence, however, involve events that took place outside the citation period. (R-Ex. 12.) And none of the entries involve employee misconduct relating to cranes. *See Sanderson Farms, Inc.*, 348 Fed.Appx. at

Additional evidence shows that even though T.B. was generally considered a competent, experienced crane operator, three Boh Brothers supervisors witnessed firsthand various unsafe practices by T.B. but never reprimanded him, as Boh Brothers' disciplinary program would have required. (Tr. 240, 315, 476, 511, 612; R-Ex. 22 at 9-10.) First, Tomkins' testimony demonstrates that early in the curb formwork project he observed T.B. operating unsafely, but failed to comply with Boh Brothers' disciplinary program.

> A: . . . I told him that that didn't look like [*sic*], and he said it would be all right. . . . It just looked like he was over-extending . . . for not having outriggers out.
> ***
> Q: Ok, tell the Judge, what did you ask him?
> A: I asked him whether he was going to be safe or not.
> ***
> Q: And . . . his answer was, It's all right, or it will be all right?
> A: It will be all right, he told me.
> Q: Did you say anything to him in response?
> A: I said, Would you do me a favor and at least keep your boom scoped in.
> ***
> Q: Did he say anything when you said that to him?
> A: Not really, I mean, I just took it that it was okay with him.

(Tr. 480-82.) The colloquy shows that Tomkins questioned T.B. but never issued a "verbal warning citation," which the Boh Brothers policy would have required. (R-Ex. 22 at 9.)

But Tomkins was not the only Boh Brothers supervisor who had observed and failed to reprimand T.B. for unsafe conduct. T.B. also worked under Ronnie Brown on the Twin Span and other projects dating back to 1997. (Tr. 160.) Ronnie Brown testified that he "caught [T.B.] once or twice . . . not doing the right thing, and, you know, we questioned. We talked about it, and that's about basically what would happen, a verbal thing, saying that maybe you shouldn't have did what you done." (Tr. 161.) Ronnie Brown also testified that in an earlier portion of the Twin Span project, he observed T.B.

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57 (finding ALJ properly rejected affirmative defense where employee's purportedly unpreventable misconduct involved an employer policy unrelated to OSHA citation). Outweighing these notices is evidence that foremen allowed and participated in pick-and-carry operations on the unlevel bridge deck, but never took any disciplinary action against its crane operators for such conduct.

incorrectly operating a lattice-boom crane on a wharf. (Tr. 172.) At the trial, Ronnie Brown confirmed his statement to OSHA, "[w]hen you were (a supervisor) or foreman was standing there, [T.B.] would follow the rules. When you were not there, [T.B.] would cut corners." (Tr. 175.) Notwithstanding these observations and his responsibilities as a superintendent, Ronnie Brown never took written disciplinary action against T.B., which Boh Brothers policy would have required. Rather, Ronnie Brown deferred to T.B.'s specialized skill and took the view that "if he said he was in his chart, it was good." (Tr. 167.) *Pride Oil Well*, 15 BNA OSHC at 1815. Not only did Ronnie Brown not reprimand T.B., but his failure to share this information with Tomkins during their abbreviated transition makes it all the more difficult for Boh Brothers to demonstrate that it took adequate steps to discover the violation. (Tr. 471.)

And yet another Boh Brothers superintendent, Joe Martin, had also been troubled by T.B.'s conduct on the Twin Span project. Martin testified that his crew had "a basic disagreement with [T.B.] as to what a level environment was," but never reprimanded or refused to work with T.B. (Tr. 269-71.) This too shows that Boh Brothers supervisors failed to enforce the employer's safety plan in response to T.B.'s past unsafe practices.

In summary, Boh Brothers has not established unpreventable employee misconduct as an affirmative defense.

Penalty

The Secretary has proposed a $5,000 penalty, which I find appropriate. As with Item 2, I find the gravity of Item 3 to be high. *See supra*. Granted, Matson testified that he did not believe the slope created a safety concern, and I found him to be a credible witness based on his demeanor at trial and his crane operations experience. (Tr. 282-284; 299-300.) But the Secretary did not offer him as an expert on crane safety. I give greater weight to the Link-Belt manual, which makes clear that even seemingly minor slopes can have a great effect on a crane's load capacity, making an injury all the more likely. (C-Ex. F at p. 24 of 194.) T.B. suffered an actual grave injury, and employees nearby worked in close proximity to a crane operating with a compromised lift capacity.

As with Item 2, there shall be no downward adjustment for size or history, and nor does Boh Brothers receive a downward adjustment for good faith. I note that Boh Brothers' safety plan addressed crane safety matters, and that its foremen and crane

operators communicated about performing lifts properly. But neither common knowledge that the bridge deck was not level nor the specifications in the operator's manual stopped the foremen from allowing curb forms to be transported routinely via pick-and-carry, without outriggers. And although Boh Brothers issued numerous "employee warning notices" at the Twin Span project, none of them involved misconduct relating to crane safety. (R-Ex. 12.) *See Capform Inc.*, 19 BNA OSHC 1374, 1378 (No. 99-0322, 2001) (denying good faith reduction where written enforcement program did not reduce exposure to particular cited condition). In view of these factors, I find the Secretary's proposed penalty to be appropriate. A penalty of $5,000 is therefore assessed for Item 3.

Findings of Fact and Conclusions of Law

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

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, it is ORDERED that:

1. Citation 1, Item 1 is VACATED.
2. Citation 1, Item 2 is AFFIRMED as serious, and the court assesses the proposed penalty of $5,000.
3. Citation 1, Item 3 is AFFIRMED as serious, and the court assesses the proposed penalty of $5,000.

/s/_____
G. Marvin Bober
Administrative Law Judge

Dated: 7-26- 2010
Washington, D.C.