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.

HABERLE STEEL, INC.,

Respondent.

OSHRC Docket No. 11-0396

APPEARANCES:

Jennifer K. Welsh, Esquire, U.S. Department of Labor, Office of the Solicitor
Philadelphia, Pennsylvania
For the Complainant.

James A. Sassaman, Sassaman LLC
Conshohocken, Pennsylvania
For the Respondent.

BEFORE: Chief Judge Covette Rooney

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"). The Occupational Safety and Health Administration ("OSHA") inspected Respondent's worksite, located in Souderton, Pennsylvania, on October 18, 2010. The inspection was triggered by an accident at the site on October 17, 2010, which resulted in a fatality. Following the inspection, on February 2, 2011, OSHA issued to Respondent a single-item serious citation alleging a violation of 29 C.F.R. 1910.176(b) and proposing a penalty of $4,900.00. The cited standard prohibits storage of material in a manner that creates a hazard.

Respondent contested the citation and the proposed penalty, and the Secretary filed her complaint. There was no indication in the citation, the notice of contest or the Secretary's complaint that this matter involved a fatality. Based on the parties' filings, the case was assigned for simplified proceedings under Rule 202 of the Commission's Rules of Procedure.[1] *See* 29 C.F.R. 2200.202. Neither party objected to that assignment. The undersigned did not learn that the case involved a fatality until a prehearing telephone conference with the parties was held on March 31, 2011. Both parties expressed a desire that the matter proceed under simplified proceedings. The parties also stated that they did not intend to engage in discovery or file any pretrial motions. The undersigned, accordingly, exercised her discretion and allowed this matter to proceed under simplified proceedings. *See* Rules 202(b), 203(a) and (c), 29 C.F.R. 2200.202(b), 203(a) and (c).

On April 21, 2011, the parties filed a joint pretrial statement that listed the documents the parties intended to offer into evidence and the witnesses they intended to have testify at the hearing. The parties stipulated to the following facts:

(1) On October 17, 2010, at an outside storage area, Haberle Steel employee Dieu Nguyen was pinned between two steel plates.

(2) Mr. Nguyen died on October 18, 2010, as a result of the injury he sustained on October 17, 2010.

(3) Mr. Nguyen was working alone when he was pinned between the plates.

The parties also stipulated to the following conclusions of law:

(1) The Commission has jurisdiction over this case under 29 U.S.C. 659(c).

(2) Haberle Steel is engaged in interstate commerce.

In a letter dated April 4, 2011, Respondent's representative filed the following affirmative defenses:

(1) The standard does not apply to the retrieval of material.

(2) The standard does not apply to non-tiered material.

(3) No employer knowledge.

[1] Simplified proceedings are appropriate for cases that do not involve complex issues of law or fact and, among other characteristics, do not involve a fatality or propose an aggregate penalty of more than $20,000.00. *See* Commission Rule 202(a), 29 C.F.R. 2200.202(a).

(4) Estoppel by virtue of previous wall-to-wall inspections.

The hearing in this matter was held on May 6, 2011, in Philadelphia, Pennsylvania. Both parties filed post-hearing briefs, and the Secretary filed a reply brief.

The Alleged Violation

The cited standard, 29 C.F.R. 1910.176(b), provides as follows:

> *Secure storage*. Storage of material shall not create a hazard. Bags, containers, bundles, etc., stored in tiers shall be stacked, blocked, interlocked and limited in height so that they are stable and secure against sliding or collapse.

The citation alleges a violation as follows:

> 29 CFR 1910.176 (b): Storage of material created a hazard (e.g., by sliding or collapsing):
> a) Storage Yard, adjacent to Bay 1 – on or about October 17, 2010, Steel plate was stored in a manner which created a hazard from tipping.

Background

Respondent, Haberle Steel, Inc. ("Respondent" or "Haberle") is a small company engaged in the business of steel fabrication for buildings, highways, and bridges. It employs about 56 employees at its two sites.[2] The firm's president, Russell Haberle, founded the company in 2002. His son, Craig Haberle, is the shop superintendent at the Souderton location, the site of the alleged violation. Respondent uses steel plates (also called sheets) as raw material during its production process. These plates are delivered to the work site in various sizes ranging up to 8 feet high, 20 feet long and up to several inches thick. The steel plates were stored outside in a storage rack in Haberle's yard. The storage rack was adjacent to a door going into Bay #1 of Haberle's shop. The storage rack consisted of vertical steel beams secured in the ground by concrete, which created several "pockets" for storing steel plates "on edge." At one end of the storage rack, two steel beams had been placed in the ground at an angle. This area, called the "short storage area," was designed for storing smaller steel plates at an angle. On the morning of October 17, 2010, at least 12 steel plates were stacked on edge in the storage rack and several smaller plates were stacked in the short storage area. (Tr. 10-11, 19-38, 52, 59-61, 75-86; Exhs. GX-3, p. 3, GX-6-7, GX-10-11, GX-15-17).

[2] The other production site is located in Delano, Pennsylvania. (Tr. 66-67).

At approximately 10:00 a.m. on October 17, 2010, employee Dieu Nguyen was found between two steel plates in the short storage area of the storage rack. The steel plate on top of Mr. Nguyen was lifted off of him by crane.[3] Mr. Nguyen was taken to the hospital, where he died the next day. No one saw what happened before the accident or the accident itself. (Tr. 11, 24, 28-29, 52-55; Exh. GX-3, pp. 2-3, Exhs. GX-6-7).

The Relevant Testimony

The Secretary called Chi Luang as a witness. On October 17, 2010, Mr. Luang had worked as a laborer for Haberle for about three years. He knew Mr. Nguyen and was familiar with the storage rack area. He knew that part of Mr. Nguyen's job was to put steel plates in the storage rack, and he had seen Mr. Nguyen perform this work "a couple of times." He had observed Mr. Nguyen move a plate by "stand[ing] on the side and mov[ing] it in." Mr. Nguyen would then remove the clamp from the plate by climbing up a steel plate or a vertical beam or by standing on a bucket.[4] (Tr. 48-50).

On the morning of the accident, Mr. Luang was working with Mr. Nguyen "at another building." Russell Haberle approached them and directed Mr. Nguyen to go outside and move steel plates that were lying on the ground into the storage rack. Later that morning, Mr. Luang went outside and found Mr. Nguyen between two steel plates that were positioned at "about a 30-degree angle." The crane was above the short storage area at that time. Using the crane, Mr. Luang and another employee, Robert Lamb, lifted the plate that was on top of Mr. Nyugen. (Tr. 51-55; Exh. GX-7, GX-11, GX-17).

The Secretary also called Richard Walters, the OSHA compliance officer ("CO") who inspected the site. The CO arrived at the site on October 18, 2010. He held an opening conference with Craig Haberle, who accompanied the CO on the inspection. The CO saw the storage rack area and the plates stored between the vertical beams. He also saw the plate that had fallen on Mr. Nguyen. The plate had been moved after the accident. The CO saw it lying flat on the ground to the left of the driveway at the site. Besides Craig Haberle, the CO also spoke to Russell Haberle and to other employees, and he took photos of what he saw at the site. (Tr. 11-12, 18-24, 28, 33-34, 46).

[3] The OSHA 1A in this case indicates that the plate that fell on Mr. Nguyen was approximately 5 feet high, 17 feet long and 7/8 inches thick; further, it weighed nearly 3,000 pounds *See* GX-3, pp. 2-3.

[4] Mr. Nyugen used an overhead crane to place the steel plates into the storage rack. He did so by attaching a clamp onto the top edge of the plate to be put in the rack. After putting the plate in the storage rack, Mr. Nyugen detached the clamp from the top of the plate. (Tr. 74-76).

The CO learned during his inspection that Mr. Nguyen was primarily a material handler and used an overhead crane for his work. To move a plate into the storage rack, a plate clamp was attached to a plate, after which the crane set the plate on edge into one of the pockets of the storage rack. To detach the clamp from the top of the steel plate, Mr. Nguyen got into a position "where he was high enough to [detach] the [clamp] from the plate." To do this, Mr. Nguyen stood on a bucket, climbed up a vertical beam, or climbed up between the plates. The CO also learned that on October 17, 2010, Mr. Nguyen was stacking plates in the vertical pockets of the storage rack. He further learned that the subject plate ("Plate #1") had been stored nearly vertically on edge just outside of the last set of vertical beams; Plate #1fell in the direction of the angled beams, and Mr. Nguyen was pinned between it and the plate next to it ("Plate #2). The CO noted that GX-7 was a recreation by management of the approximate position of the plates before the accident occurred.[5] He also noted that GX-11, one of his photos, showed the crane positioned as it had been when Mr. Nguyen was found; it also showed the yellow control box for the crane.[6] The CO concluded that, due to the location of the crane and the control box, Mr. Nguyen could not have been using the crane at the time of the accident. The CO observed a "deep indentation" in the ground immediately adjacent to a vertical beam just to the left of Plate #1, as shown in GX-7. He determined that Plate #1 created the indentation and was evidence that the plate had been stored in a vertical position. CO Walters opined that although the storage rack and Haberle's method of storing the plates in the rack was not a hazard, storing Plate #1 in a vertical position was a hazard. He further opined that Plate #1 could have been stored safely in one of the vertical pockets or by leaning it at an adequate angle towards the angled supports. (Tr. 12-38, 42-46).

Respondent called Craig Haberle, the shop superintendent, to testify. Mr. Haberle has worked for Respondent since 2002. He had previously worked for another steel

[5] Exhibits GX-6 and GX-7 are photos Craig Haberle took on October 17 and 18, 2010, respectively. Exhibits GX-10-11 and GX-15-17 are the CO's photos. GX-6 and 7 have the date and time on them, while the CO's photos do not. The CO identified Plates #1 and 2 on GX-7. (Tr. 14-15, 18-19, 25-26, 44, 47).

[6] The CO said GX-6 showed the storage rack and Plates #1 and 2 after the accident; there was a clamp on Plate #1 in GX-6, because the crane was used to lift the plate off of Mr. Nguyen. The CO asked the employees to recreate the crane's position as it was when they found Mr. Nguyen; they did so, and the CO took GX-11. The CO noted that the crane's control box, as shown in GX-11, would not have been within Mr. Nguyen's reach at the time of the accident. (Tr. 26-29, 34-35). Mr. Luong verified that GX-11 showed the location of the control box as it was when he discovered Mr. Nguyen. (Tr. 55).

fabricator, and that firm had been in the same business, and at the same location, as Respondent. Mr. Haberle testified Mr. Nguyen had trained him in the material handling job duties. He further testified Mr. Nguyen's primary job was to cut steel into smaller pieces; his secondary job was to put the steel plates in the storage rack. Mr. Haberle said the storage rack had been the same since the early 1990's. Most of the rack was designed to store larger steel plates vertically on edge, but the short storage area was designed to store the shorter steel plates at an angle. Mr. Haberle also said Mr. Nguyen, after placing a steel plate in the vertical part of the rack, would have to climb up on a bucket or ladder to reach the clamp and detach it from the steel plate. At the end of the rack, outside of the short storage area, there was a 30-inch walkway that allowed access to remove the clamp from a steel plate. The employee was able to attach and detach the clamp in the short storage area from the walkway. Before detaching the clamp, the employee would tip the plate against the angled iron and, from the walkway, detach the clamp once the plate was supported by the angled iron. Mr. Haberle agreed that while he had not recognized it as such before the accident, it was a hazard to store a plate vertically on edge in the short storage area, as shown in C-7. (Tr. 59-61, 74-81; Exhs. GX-6-7, GX-15).

Discussion

To prove a violation of an OSHA standard, the Secretary must show by a preponderance of the evidence that: (1) the cited standard applies; (2) the standard's terms were not met; (3) employees had access to the violative condition; and (4) the employer either knew or could have known with the exercise of reasonable diligence of the violation. *Astra Pharm. Prod., Inc.*, 9 BNA OSHA 2126, 2129 (No. 78-6247, 1981).

The cited standard and the alleged violation are set out above. The Secretary does not contend that Haberle's storage rack and its method of storing the steel plates in that rack violated the cited OSHA standard. She contends, rather, that the steel plate that was stored vertically on edge in the short storage area violated the standard, because there was nothing to keep it from tipping over. (Tr. 68, 88; S. Brief, pp. 7-8).

I agree with the Secretary that the first sentence of the cited standard, which prohibits storage of material in a manner that creates a hazard, applies in this case. I also agree that the terms of the standard were not met. The CO's testimony, set out above, shows that the plate that fell on Mr. Nguyen was set nearly vertically on edge just outside

of the last set of vertical beams. His testimony also shows, along with GX-7, the employer's recreation of how the plates were stored at the time of the accident, that there was nothing to prevent the plate from falling over in the direction of the angled beams. The plate's storage thus created a hazard in violation of the standard. I further agree with the Secretary that an employee was exposed to the cited hazard. Mr. Nguyen died from the injuries he sustained when the plate fell over on him. The Secretary has accordingly established the first three elements of her burden of proof.

The final element the Secretary must demonstrate is that Haberle had actual knowledge of the cited condition or that it could have known of the condition with the exercise of reasonable diligence. The Secretary asserted at the hearing that Plate #1 had been stored in the same location nearly vertically "for weeks." (Tr. 5-6). She repeats this assertion in her brief. S. Brief, p. 4. The transcript cites she notes on that page, however, do not establish how long the plate had been stored as shown in GX-7. (Tr. 20-21, 54). The CO testified only that management and employees told him that the plate had been stored as in GX-7 before it fell. (Tr. 20-21, 24). And Mr. Luang testified that while he did not recall the position of the plates in the days before the accident, his father had told him that Plate #1 was just as it was shown in GX-7 before the accident. (Tr. 53-54).

The above testimony is insufficient to show how long the cited condition had existed before the accident. The Secretary, however, also cites to Exhibit GX-3 in support of her position in her brief. S. Brief, p. 10. GX-3 is the CO's OSHA-1A, the narrative from his inspection. GX-3 states as follows on page 3, ¶ 5:

> Interviews suggested the plate had been observed stacked in its pre-accident position for over a week or possibly as long as several weeks. Management provided information that the plate was cut and moved by the victim on 7/14/10. It could not be determined if the plate had been moved since but it was unlikely.

The CO testified that Craig and Russell Haberle were the management personnel who provided him with information during the inspection. (Tr. 56). In my view, that testimony, together with the excerpt from GX-3 and the CO's other testimony set out above, is sufficient to establish that the cited condition had existed for some time before the accident and that management personnel could have discovered it with the exercise of

reasonable diligence.[7] This finding is supported by the fact that the door going into Haberle's shop, shown in GX-17, was used frequently by employees and management. And, management was in the plate storage area on a regular basis. (Tr. 18-21, 49). The condition was readily visible to anyone who walked by the storage rack. S. Brief, p. 10. I find that Haberle had constructive knowledge of the condition.

In making the above finding, I have noted the CO's statement in GX-3 indicating that no determination was made as to what exactly Mr. Nguyen was doing at the time of the accident. (GX-3, p. 3, ¶ 5). The CO learned that Mr. Nguyen was moving steel plates into the vertical storage area that day. (Tr. 31). The CO's testimony and GX-3 show that, due to the location of the crane and its control box when he was found, Mr. Nguyen was not using the crane when the accident occurred; the CO specifically testified the control box would have been out of his reach. (Tr. 34-35; GX-3, p. 3, ¶ 5, GX-11). As set out in GX-3, the CO discussed possible scenarios with Haberle during his inspection. None of the scenarios suggested Mr. Nguyen was using the crane when the accident took place. The CO concluded the most plausible scenario was that "The victim tugged at the top of the 7/8" plate for an undetermined reason, tipping it toward him while he was standing between the stacks." (GX-3, ¶ 6). Regardless of the reason for Mr. Nguyen being between the plates, I conclude that Haberle could have foreseen this eventuality.

Haberle contends that to prove knowledge in this case, the Secretary must show that it had actual knowledge of the cited condition or that a "reasonable person" familiar with the situation, including any facts unique to the particular industry, would recognize a hazard warranting the abatement set out in the citation.[8] In this regard, Haberle urges that the cited standard is a "general" standard that does not set out any specific requirements the employer must meet. R. Brief, pp. 2-5. Haberle's arguments are not persuasive. First, as the Secretary indicates, Haberle does not even address the cited condition in its brief. Instead, it contends that the Secretary has cited its "material storage operation," which is inaccurate. R. Brief, pp. 4-5; S. Reply Brief, pp. 1-2. Second, I agree with the Secretary that the cited standard is not a "general" standard and that there are no Commission cases so holding. The case Haberle relies upon is *Trinity Indus., Inc., Plant 22*, 2000 WL

[7] Respondent offered nothing to rebut the Secretary's evidence in this regard.
[8] As noted above, Haberle asserted three other defenses in its letter of April 4, 2011. Its post-hearing brief nowhere mentions the three other defenses. The three other defenses are deemed abandoned.

1262874 (No. 99-1110, 2000), an unreviewed ALJ decision. There, the Judge referenced Commission decisions addressing 29 C.F.R. 1910.132(a), the personal protective equipment standard, to find there was insufficient evidence to conclude the employer's tank-storing method was deficient and a violation of 29 C.F.R. 1910.176(b). S. Reply Brief, pp. 2-4. Finally, even if the cited standard is a "general" standard, the Secretary nonetheless prevails with respect to the knowledge element.

This case arose in the Third Circuit. That circuit has held that when the cited standard is a "general" safety standard, the Secretary has the burden of proving foreseeability, *i.e.*, that the employer could have foreseen and prevented the violation through the exercise of reasonable diligence. *Pennsylvania Power & Light Co. v. OSHRC*, 737 F.2d 350, 357-58 (3d Cir. 1984) (citations omitted). GX-3 shows the CO reviewed Haberle's written safety program and found it adequate; it also shows the CO found communication and enforcement of the program was adequate and that employees received safety training. The CO testified, however, that he saw nothing to indicate that Haberle had a work rule or policy or that it trained employees to not get in between the plates in the storage rack. (Tr. 38-39). In fact, the record establishes that Mr. Nguyen regularly got between the plates in the vertical storage area. (Tr. 17-18, 50-51, 74-75). Craig Haberle testified that removing the clamp from the plates in the short storage area could be done from outside the rack, from a walkway at the end of the short storage area. (Tr. 75-80). He did not testify about any policy or rule to prohibit workers from getting in between the plates in the short storage area. And his testimony that he was not aware until after the accident that it was a hazard to store a plate vertically on edge in the short storage area was simply not convincing. (Tr. 81). Respondent's own method for storing plates suggests that storing a plate in that manner was a hazard. Further, Craig Haberle discussed ANSI Standard Z229.1-1982, the safety requirements for fabricating structural steel and steel plate. (Tr. 69-73, 81-83; RX-1). That standard provides for storing steel plates on edge in pockets. (RX-1, p. 24, § 21.4.7). It does not provide for storing plates as Plate #1 was stored at Haberle's work site. The violation was foreseeable.

Based upon the evidence of record, the Secretary has met her burden of proving the alleged violation. Item 1 of Citation 1 is AFFIRMED as a serious violation.

Penalty Determination

The Secretary has proposed a penalty of $4,900.00 for this citation item. In assessing penalties, the Commission must give due consideration to the gravity of the violation and to the employer's size, history and good faith. *See* section 17(j) of the Act. The CO testified that the violation had high severity, due to the fact that the accident caused the death of an employee, and greater probability, in that it took almost no force for the plate to tip over. (Tr. 45-46). GX-2, the CO's OSHA 1-B worksheet, shows that the employer received a 30 percent credit due to its small size but no credit for history or good faith. I find the proposed penalty appropriate. That penalty is assessed.

Findings of Fact and Conclusions of Law

All findings of fact relevant and necessary to determination of the contested issues have been made above. *See* Federal Rule of Civil Procedure 52(a). Respondent is an employer engaged in a business affecting commerce within the meaning of section 3(5) of the Act, and the Commission has jurisdiction of this proceeding. All proposed findings of fact and conclusions of law inconsistent with this decision are denied.

ORDER

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

1. Item 1 of Serious Citation 1, alleging a violation of 29 C.F.R. 1910.176(b), is AFFIRMED, and a penalty of $4,900.00 is assessed.

/s/ Covette Rooney

Covette Rooney
Chief Judge

Date: September 6, 2011
Washington, D.C.