



United States of America
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
1120 20th Street, N.W., 9th Floor
Washington, DC 20036-3457

ACTING SECRETARY OF LABOR,

Complainant,

v.

GORICK CONSTRUCTION CO., INC.,

Respondent.

OSHRC Docket No. **24-1081**

APPEARANCES:

Terrence Duncan, Esq.
U.S. Department of Labor, Office of the Solicitor, New York, NY
For the Acting Secretary

Michael Rubin, Esq.
Ogletree Deakins, Phoenix, AZ
Jeff T. Leslie, Esq.
Ogletree Deakins, Dallas, TX
For the Respondent

BEFORE:

Sharon D. Calhoun
Administrative Law Judge

DECISION AND ORDER

On January 29, 2024, three workers were seriously injured when the elevated concrete slab they were working on gave way. Prior to the collapse, the workers had been tasked with dismantling a parking structure adjacent to a former department store (Boscov's) in Binghamton, New York (the "Worksite"). (Tr. 109-10, 153, 280; Exs. C-1 at 1, C-2.) The Occupational Safety and Health Administration (OSHA) was notified of the incident and visited the Worksite the following day. (Tr. 295; Ex. C-1 at 1.) When the investigation concluded, the Secretary issued a citation alleging Gorick Construction Co. (Gorick or Respondent) committed serious violations of the OSH Act.

Respondent timely contested the Citation, bringing the matter before the Occupational Safety and Health Review Commission (Commission).¹ The Secretary filed a Complaint alleging two violations of the OSH Act. As amended, the Complaint alleged Respondent violated 29 C.F.R. § 1926.501(a)(2) and 29 C.F.R. § 1926.501(b)(1).² A hearing was held in Syracuse, New York, on September 9, 2025, and September 10, 2025. Both parties submitted Post-Hearing and Reply Briefs. For the reasons set forth below, the violations are affirmed, and penalties of \$19,359 are assessed.

OSHRC HAS JURISDICTION

The parties stipulated facts supporting the Commission's jurisdiction over this matter pursuant to the Occupational Safety and Health Act of 1970, 29 U.S.C. § 659(c) (OSH Act).³ At all relevant times, Gorick was an employer engaged in a business and industry affecting interstate commerce within the meaning of sections 3(3) and 3(5) of the OSH Act, 29 U.S.C. §§ 652(3) & (5).⁴

FINDINGS OF FACT

Gorick engages in heavy construction and demolition. (Stip. 2.) It was retained to demolish a three-level parking garage located above a retail space in Binghamton, New York (the Worksite). (Tr. 109-10, 153, 280; Exs. C-1, C-2.) Todd Grubham was Gorick's project manager. (Tr. 110, 283, 290; Ex. C-2A.) He oversaw the entire project and was present at the Worksite each day. (Tr. 84, 110, 117, 154-55.) He did not testify.

¹ Stipulation 4: "Respondent timely contested the citations and penalties." (Ex. J-1).

² The Secretary moved to amend the Complaint on April 1, 2025. As part of the Motion, the proposed Amended Complaint was included. Respondent opposed the amendment. On April 16, 2025, the Court granted the Motion to Amend and accepted the amended complaint for filing. Respondent filed its Answer to the Amended Complaint on April 25, 2025.

³ Stipulation 1: "The Occupational Safety and Health Review Commission has jurisdiction in this matter." (Ex. J-1).

⁴ Stipulation 2:

Respondent, Gorick Construction Co., Inc., a corporation organized under the laws of the State of New York and doing business in the State of New York, maintaining its principal place of business at 27 Track Drive Binghamton, NY 13904, is, and at all times hereinafter mentioned, was engaged in the business of heavy construction and demolition.

(Ex. J-1). Stipulation 3: "Respondent's business affects commerce within the meaning of the OSH Act."

(Ex. J-1). Stipulation 5: "At all times relevant to this matter, Respondent was engaged in a business affecting commerce within the meaning of [S]ection 3(3) and 3(5) of the [OSH] Act and is an employer within the meaning of [S]ection 3(5) of the [OSH] Act." (Ex. J-1).

Among others, Grubham supervised David Dauley. (Tr. 154-55.) Dauley was Gorick's site supervisor and was responsible for all safety protocols at the Worksite. (Tr. 110, 153-54, 161; Ex. C-1 at 2.) Together, Grubham and Dauley determined the tasks employees and subcontractors would perform. (Tr. 110, 153-55, 160-61.) They would then instruct the employees and subcontractors accordingly. (Tr. 110, 155.) JC and WH were employed by Gorick and worked as laborers at the Worksite. (Tr. 109-111; Ex. C-1 at 2.) Their duties included removing the concrete slabs that made up each level of the parking garage. (Tr. 109-11; Ex. C-1.)

Grubham drafted the demolition and safety plans. (Tr. 234, 282; Exs. C-6, C-7A.) He then reviewed them with Gorick's Senior Project Manager and Safety Director, Matthew Williams. Together, they approved the demolition and safety plans.⁵

The Demolition Plan called for certain aspects of the work to be handled by subcontractors. (Ex. C-7.) Among others, Gorick hired Concrete Cutting and Breaking Company (Concrete Cutting). (Tr. 111, 161-62.) Concrete Cutting was tasked with cutting up each level's parking deck into 66 slabs.⁶ Concrete Cutting reported to Dauley, and he instructed them where to cut. (Tr. 111, 155-56.)

The plan called for a grid of cuts to the concrete parking deck to create slabs for removal. The cuts were referred to as north/south and east/west cuts. Each resulting concrete slab was a 5-foot-by-15-foot rectangle.⁷ The "east-west" cuts were supposed to be on the top of the I-beams

⁵ Tr. 233-34; Exs. C-6, C-7. Gorick's safety manager, who was also Williams' supervisor, Roberta Allergrino. (Tr. 180-186, 239-40; R-2.) According to Williams, Allergrino audited the Worksite the week before the incident. (Tr. 240, 242; Ex. R-2.) Williams' second-hand testimony about her [Allergrino's] report and audit was not particularly helpful. It did not reflect the conditions around the time of the incident. (Ex. R-2.) Key parts of Williams' testimony about the audit were elicited through leading questions, and although he claimed to have discussed it with Allergrino, he lacked any direct knowledge of the worksite conditions at the time of the audit. (Tr. 240, 244.) Despite Williams' claim that he helped draft the audit report, his name is not on it. (Tr. 240; Ex. R-2.)

⁶ Tr. 161-62, 289; Ex. C-1 at 2, C-2A, C-3 at 1, C-10 at 21; R-6. Respondent's expert, Matthew Gardiner, confirmed the diagram seen on page 3 of his report (Exhibit R-19), is an annotated version of Exhibit R-6. (Tr. 395-96.) The Secretary's expert, Dr. Alan Lu, used Exhibit R-6 in his report. (Ex. C-10 at 9 (confirming he reviewed the document Bates stamped "GORICK000039"), 10, 21-22.)

⁷ Tr. 163, 173-74, 194, 407-8, 423; Exs. C-1 at 2, C-10 at 9-11, 14, 24. In his initial report, the Respondent's expert, Matthew Gardiner, claimed that "no east-west cuts had been made on section 66." (Ex. R-19 at 3.) The photograph shows an east-west cut. (Ex. C-2A at 5.) Mr. Gardiner acknowledged the error in his supplemental report. (Ex. R-19 at 12.) After the surface is cut, it is not possible to see the depth of the cut. (Tr. 407-08; Exs. C-2A at 5; C-10 at 14.) However, Concrete Cutting was instructed to cut all the way through, and Dauley indicated he had no reason to believe the saw was not set at the correct depth. (Tr. 155, 164.)

that supported the parking deck.⁸ (Tr. 194, 289; Ex. C-10.) The cuts were designed to penetrate through the concrete parking deck but not cut into the supporting beams.⁹

In preparation for the cuts, Gorick employees marked the concrete parking deck with chalk lines for the north/south and east/west cuts. (Tr. 111, 155-56, 163, 351; Exs. C-1, C-2A.) The east-west chalk lines were intended to mark the center of each I-beam supporting the parking deck. (Tr. 155-56, 163, 350-51; Exs. C-1, C-10 at 10-11, R-6.)

Concrete Cutting was to use the marked chalk lines as cutting guides to make a cut from the deck's surface down through to the supporting beam support. (Tr. 155-56, 163-65, 173, 350-51; Exs. C-1, C-3, C-10 at 21, R-6.) After being cut, the slabs rested in place on the beams' flanges. (Exs. C-2A; C-3.) Each I-beam had flanges that extended across the beam's center; the flanges ranged in width from 5 inches to 14 inches. (Ex. C-10 at 26.)

After all the slabs were cut for deck Level 2, each slab had to be individually lifted by a crane from the deck's surface and then lowered to trucks at street level. (Tr. 162-63, 352.) The slabs were raised either with a vacuum lifting device or a wire sling attached to the slab. (Ex. R-19 at 2.) The vacuum method involved attaching a large suction cup to the slab and using the vacuum to move the slab. (Tr. 111, 115-16, 156, 162-63, 352; Ex. C-2A at 3.) Occasionally, when a slab's surface was uneven, the vacuum method could not be used because the suction cup would not fully adhere to the slab. (Tr. 115-16, 296, 350; Exs. C-1, C-2A at 3.) When that occurred, workers would use a steel bar to pry the slab up so that a wire sling could be inserted beneath the slab.¹⁰ With either method, the workers would stand on a slab—which also had been cut—adjacent to one being actively removed. (Tr. 115-16, 156-7; Exs. C-1, C-14.) Gorick management staff were involved in the decision to have the workers stand on a cut slab to prepare the adjacent slab for removal. (Tr. 116-17; Ex. C-2A.)

Another subcontractor, Rogers Crane Company (Rogers Crane), would use a crane to fully remove the slab from the deck either by the vacuum device or wire sling and then lower it to the trucks. (Tr. 154, 162-63; Ex. C-1.)

⁸ The north-south cuts were roughly parallel to Water Street. (Ex. C-1 at 2.)

⁹ Tr. 164. According to Dauley, the machines were set to cut at 5.5 inches deep, which was the same thickness as the work surface. (Tr. 164, 173-74.)

¹⁰ Tr. 39, 115-16, 156-57, 162-63, 296, 350, 352-53; Exs. C-1, C-2A, C-14. Respondent's expert, Matthew Gardiner, believed the pry-bar method was necessary only on a small fraction of the slabs removed. (Ex. R-19 at 5.)

BH was the signal person for Rogers Crane. (Tr. 33, 110; Exs. C-1 at 2, C-2A at 3, C-4 at 3.) From the parking deck, he alerted the crane operator when it was time to lift a slab from the deck and into the truck, which then took the materials off site for disposal. (Tr. 110-11, 115, 162-63; Ex. C-1.)

By January 29, 2024, workers had removed the top level (Level 3) of the parking deck and were working on the next level (Level 2).¹¹ Gorick had removed 63 slabs from Level 2 with three slabs remaining when an incident occurred. (Tr. 162; Exs. C-1, C-2A.) These last three slabs are identified as slabs 64, 65, and 66 in the demolition plan. (Tr. 131, 162, 353; Exs. C-10 Fig. 10, R-6, R-16, R-19 at 4.) These slabs were adjacent to each other in the southern corner of parking Level 2. (Ex. R-6.) The long (15-foot) cut edges abutted each other. In other words, the lower 15-foot edge of slab 66 abutted the upper 15-foot edge of slab 65. The lower 15-foot edge of slab 65 abutted the upper 15-foot edge of slab 64. (Ex. R-6.)

The location of these three slabs resulted in conditions different from most of the parking deck. (Ex. C-10.) First, the width of the flanges at the top of the underlying support beams was not the same. (Tr. 392-94, 411, 415, 437-38; Ex. C-10 at 22, 25-26.) The width of the beam flanges varied between just over 14 inches to 5 inches. (Ex. C-10 at 26.) The beam flange supporting slabs 64 and 65 was 5 inches. (Tr. 393-94, 414-17, 446; Ex. C-10 at 11, 21-3.) Thus, the concrete in the area of the collapse would only rest on a very narrow beam. (Tr. 414-17, 446; Ex. C-10 at 11-12, 15, 17, 25-26.) This was shown in the as-constructed drawing of the structure. (Tr. 393-94, 416; Ex. C-10)

¹¹ Exs. C-1, C-2A at 8; Tr. 379-81. Because the parking garage was on top of another building, the record includes different descriptions of the number of levels. Some witnesses focused only on the three levels of the parking structure. (Tr. 78, 97.) Dr. Lu viewed the entire structure as a whole, counting the retail space as level one and then going up three levels from there. (Sec'y Br. 2; Ex. C-10 at 9, 22.) Thus, some described the level where the collapse occurred as the second level, and others viewed it as the third level. (Tr. 44, 78, 97, 100, 138, 169-70, 380-81.)

Second, the cuts in the area of the collapse were made improperly.¹² The cut was near or at the edge of the beam flange. (Tr. 42-45, 408-9; Exs. C-2A at 5-7, C-10.) This eliminated adequate support for the slabs. (Tr. 36, 44-45; Exs. C-2A, C-10 at 13.)

Third, Gorick failed to install shoring on both ends of the three slabs.¹³ Shoring was available and had been used to support some of the slabs being removed. (Tr. 283-85, 296, 310; Ex. R-16). The last three slabs were in the southern corner of what is referred to herein as parking deck Level 2. (Ex. C-10 at Fig. 7.) In this corner, a curb abutted the parking deck along the north edge of slabs 64, 65 and 66. (Tr. 285, 353; Exs. C-10 at Figs. 4, 7, 8, 10, R-6, R-16.) Because of the curb, Gorick knew the cuts could not be made above the beam where the curb was located and that additional support (shoring) would be needed under the north edges of slabs 64, 65, and 66. (Tr. 353, 382; Exs. C-2A at 4, C-6, C-10, R-6, R-16, R-19 at 12.)

On the south edge of the three slabs, the parking deck abutted a brick building. (Tr. 353; Exs. C-10 at Figs. 4, 7-10, R-6, R-16.) Shoring under the south edge would have compensated for the narrower beam and the deviation from the marked cut location. (Tr. 387-88, 414-17; Ex. C-10.)

Gorick's Project Specific Safety Plan (Safety Plan) called for shoring the "concrete slab at north and south edges."¹⁴ It does not say shoring would be used only if a "defect" was detected. (Ex. C-6.) Yet, Williams, who never visited the Worksite, claimed the Plan's reference to shoring the edges meant shoring would be used only where there were defects or compromised sections.

¹² Tr. 42-43, 73-74, 76, 372, 374, 376, 387, 408-9, 446-47, 451; Ex. C-10 at 11-12; R-19 at 11. The report from Respondent's expert, Matthew Gardiner of ICC Forensics, is written in two parts. (Ex. R-19.) The first part offers his opinions, and the supplement responds to issues raised by Dr. Lu, the Secretary's rebuttal expert. (Ex. R-19.) Both the initial report and the supplement were received into evidence in a single document. References to the initial report and supplement will use the page of the PDF rather than the page numbers on the supplement itself. Mr. Gardiner indicated his views were "augmented" further after he issued his supplemental report. (Tr. 385.) He did not issue a further supplement to his report as required by the Scheduling Order for this matter. (12/13/24 Scheduling Order 5-6; 4/23/25 Updated Scheduling Order 2.)

¹³ (Tr. 44-45, 285, 296, 302, 353, 382; Exs. C-2A at 4-4a, C-10, R-16. Exhibit C-2A has two pages designated "page 8 of 9." (Tr. 46, 48.) The latter will be referred to as page 9 herein. During his testimony, the CO explained the photograph on page 9 does not reflect the conditions he saw during his inspection. (Tr. 45.) It shows the abatement Gorick later put into place. (Tr. 45-46.)

¹⁴ Ex. C-6. Exhibit R-3 was referred to during Williams' testimony. (Tr. 280.) As Exhibit C-6 was the same document, Exhibit R-3 was not offered into evidence. (Tr. 281-83.) The Safety Plan calls for seventeen actions. (Tr. 286; Ex. C-6.)

(Tr. 243, 283.) In other words, he asserted that the words, “north and south edges” did not have independent meaning. (Tr. 283; Ex. C-6.)

Dauley was not asked directly how he viewed the Safety Plan’s reference to shoring at the north and south edges. He indicated he used shoring if he saw deterioration or evidence of compromise. (Tr. 206, 208.) He did not use shoring based on beam width or because of the Safety Plan’s reference to such shoring. (Tr. 205-6, 208, 416; Ex. C-6.) Therefore, while temporary shoring was used on the north end of the final slabs on Level 2, the same precaution was not taken at the south end. (Tr. 44-45, 281, 283-85, 296, 381-82, 418, 429-30, 452; Exs. C-2A, C-6, C-10 at 11, 15, Fig. 9, R-3.) As a result, there was inadequate shoring when the employees were working from slab 65 at the time of the collapse. (Tr. 44, 417, 452; Exs. C-2A, C-10, R-19 at 11.)

Initially, the cut slabs were held in place by “friction and contact”. (Tr. 35-36; Ex. C-2A at 2, 4a.) The workers continued to stand on the cut slabs as more and more of the parking deck was lifted away. (Tr. 116-17, 156-57; Exs. C-1 at 2, C-2A at 4, C-10.) Shortly before the collapse, only the three slabs in the corner remained. (Ex. C-10, Figs. 4, 8, 10-12, R-6.) The vacuum would not adhere to slab 64. (Tr. 115-16, 156, 353; Ex. C-2A at 3; R-19 at 2.) Two Gorick employees stood on slab 65 as they worked with a pry bar to get enough room around slab 64 so that the sling could be inserted. (Tr. 36, 115, 148-49, 156-57, 352-53; Exs. C-1, C-2A at 4, C-14.) As they were prying slab 64, the slab the workers were standing on (slab 65) gave way, quickly followed by slab 64. (Tr. 32, 34-36, 43, 51, 131; Exs. C-1, C-2A, C-3, C-10, C-14, R-9.)

The employees working from slab 65 fell when the slab collapsed beneath them. (Tr. 115, 135.) One Gorick employee was seriously injured when his leg became trapped. (Tr. 32, 34, 38-40, 53; Exs. C-1, C-2A, C-10, C-14.) Another incurred a hand and finger injury. (Tr. 34, 38-40, 53; Ex. C-1, C-2A, C-10, C-14.) The crane signal person, BH, was also injured. (Exs. C-1, C-14.)

The combination of the misplaced cut location and the narrow beam beneath the south edge of the slab rendered the surface unable to support the employees and work that was taking place. (Tr. 34-36, 387-88, 408-10, 418, 424; Exs. C-2A at 4-4a, C-10 at 12-17, 23-25.) Gorick did not adequately account for the fact that one of the beams supporting the parking deck was narrower than the adjacent beams.¹⁵ Thus, as they worked for several minutes trying to pry up a 5’x 15’ slab,

¹⁵ Tr. 103, 393-94, 420-21, Exs. C-2A at 4, 4a, 8, C-10 at 11, 22, 26. This beam is referred to as “W14x22” or “W14.” (Ex. C-10 at 11, 26.)

the workers were standing on an inadequately supported surface. (Tr. 34-36, 38, 42, 45, 148-49; Exs. C-1, C-2A, C-10 at 10-13, 17, C-14.)

None of the workers were appropriately using fall protection when they fell. (Tr. 34, 52-53, 102, 117-18, 131-32, 143-44, 219-20, 236 460-63, 468-69; Ex. C-4 at 1, 3-4, C-14.) JC claimed new anchor points were not installed for their work to remove slabs 64-66 because it would have required an extra step, and the workers were trying to “wrap it up and get it done.” (Tr. 118; Ex. C-14.) To install a new anchor point, they would have needed to get the hammer drill to drill new holes, which would have “taken a little extra time.” (Tr. 118-19, 143-44, 462; Ex. C-14.)

The Binghamton police notified OSHA’s Syracuse Area Office of a partial collapse of a parking deck located next to the former Boscov’s department store. (Tr. 109-10, 158-59; Exs. C-1, C-2A, C-14.) OSHA assigned Compliance Safety & Health Officer (CSHO) David Pacini to investigate. (Tr. 32; Exs. C-1, C-2A.) The CSHO visited the Worksite and met with Gorick representatives. (Tr. 32-33.) He spoke with BH and WH but was unable to speak with JC. (Tr. 33-34.) At the conclusion of the investigation, the Secretary issued the Citation.

DISCUSSION

To establish the violation of a safety standard under the OSH Act, the Secretary must prove: (1) the cited standard applies; (2) the employer failed to comply with the terms of that standard; (3) employees had access to the hazardous condition covered by the standard; and (4) the employer knew, or with the exercise of reasonable diligence could have known, of the violative condition. *Atl. Battery Co.*, No. 90-1747, 1994 WL 682922, at * 6 (OSHRC Dec. 5, 1994); *Gate Precast Co.*, No. 15-1347, 2020 WL 2141954 (OSHRC Apr. 28, 2020).

The Commission generally regards the source of controlling precedent for any given case to be the court of appeals to which the Commission decision is most likely to be appealed. *Kerns Bros. Tree Serv.*, No. 96-1719, 2000 WL 294514, at *4 (OSHRC Mar. 16, 2000). *See also Reich v. Contractors Welding of W. New York, Inc.*, 996 F.2d 1409, 1413 (2d Cir. 1993) (explaining that the Commission is subject to Second Circuit precedent). If this decision were to become a final order of the Commission, Gorick could petition for judicial review in either the Second Circuit or the D.C. Circuit; the Secretary could petition for judicial review only in the Second Circuit. 29 U.S.C. §§ 660(a), (b). Gorick did not always identify that certain cases it relied on were decisions from

Administrative Law Judges (ALJ) and inaccurately referred to one as a “Commission” case.¹⁶ ALJ decisions are not binding precedent. *A.J. McNulty*, No. 94-1758, 2000 WL 1490235, at *11 n.20 (OSHRC Oct 5, 2000) (unreviewed ALJ decisions “do not constitute Commission precedent”), *aff’d*, 283 F.3d 328 (D.C. Cir. 2002).

Both sides offered expert testimony and written reports from their respective experts. While both experts were qualified, their conclusions are not entitled to equal weight. (Tr. 343, 404.) Mr. Gardiner is a civil engineer and indicated that his area of expertise was primarily crane rigging, construction and demolition incidents. (Tr. 343.) He also had experience with surface collapses. (Tr. 343-44.) He was qualified as an expert in structural stability and demolition. (Tr. 346.)

Dr. Lu’s focus is on mechanical, structural, and civil engineering. (Tr. 399-403.) He has a particular focus on concrete materials. (Tr. 400.) He was accepted as an expert in the field of mechanical and structural engineering. (Tr. 403-4.) He reviewed Mr. Gardiner’s report and listened to his testimony. (Tr. 404; Ex. C-10.) Dr. Lu concluded that Mr. Gardiner’s report included inaccurate descriptions of shoring and cutting at this worksite. (Ex. C-10 at 14.) Mr. Gardiner subsequently agreed that the shoring was only installed at one edge of the slabs prior to the collapse. (Ex. R-19 at 12.)

Dr. Lu argued Mr. Gardiner’s analysis of the slab cutting was misleading. (Tr. 418-19; Ex. C-10 at 16.) He concluded the report represented a contradictory and incomplete hazard assessment. (Tr. 419; Ex. C-10 at 14-16.) Mr. Gardiner acknowledged he was not retained to do a “complete forensic engineering analysis.” (Ex. R-19 at 12-13.) He also acknowledged the cutting

¹⁶ Resp’t Br. 3, 18, 20-21 21. It cited (1) “*Miller Insulation Co., Inc., Respondent*,” No. 19-1431, 2022 WL 682211 (CMPAU Jan. 24, 2022),” which appears to refer to *Miller Insulation Co., Inc.*, No. 19-1431, 2022 WL 682211 (OSHR CALJ Jan. 24, 2002), (2) “*Roy Johnson, d/b/a Johnson Roofing*,” 5 BL OSHC 1921 (No. 76-3803, 1977),” which appears to refer to *Roy Johnson, d/b/a Johnson Roofing*, No. 76-3803, 1977 WL 7391, (OSHR CALJ, Aug. 1, 1977), and (3) “*C.D. Smith Constr.*,” No. 06-0019, 2007 WL 3084573 (CMPAU Aug. 16, 2007), which appears to refer to *C.D. Smith Constr.*, No. 06-0019, 2007 WL 3084573 (OSHR CALJ Aug. 16, 2007). Both parties used various citation formats and did not consistently include all the relevant information for the cases they relied upon. There are multiple ALJ decisions involving Elmer W. Davis, Inc., including two issued in 2023. See *Elmer W. Davis, Inc.*, No. 21-1021, 2023 WL 2179039 (OSHR CALJ, Feb. 21, 2023) (*Elmer I*); *Elmer W. Davis, Inc.*, No. 20-1417, 2023 WL 5606693 (OSHR CALJ, July 24, 2023) (*Elmer II*); *Elmer W. Davis, Inc.*, No. 22-1210, 2024 WL 4713188 (OSHR CALJ, Sept. 30, 2024). The Secretary claimed Respondent misquoted *Elmer I* in paragraph 60 of its brief. (Sec’y Reply 19 (providing a different docket number for the case than the one Respondent’s citation used).) Respondent’s brief appears to cite to *Elmer I* but does not indicate it is quoting from any decision. (Resp’t Br. ¶60 (not using quotation marks).) Respondent’s Table of Authorities and the first reference to *Elmer I* in its brief fail to note that it is an ALJ decision, however subsequent references do.

description in the first part of the report was incorrect. (Ex. R-19 at 12.) Dr. Lu’s testimony and report effectively rebutted Mr. Gardiner’s testimony and report when in conflict.

A. Citation 1, Item 1 (as amended) – Violation of 29 C.F.R. § 1926.501(a)(2)

1. Applicability – The Cited Standard Applied to the Condition

29 C.F.R. § 1926.501(a)(2) requires employers to determine if walking/working surfaces have the strength and structural integrity to support employees safely. “Employees shall be allowed to work on those surfaces only when the surfaces have the requisite strength and structural integrity.” 29 C.F.R. § 1926.501(a)(2). Section 1926.500(b) defines the term “walking/working surface” in relevant part as follows: “Walking/working surface means any surface . . . on which an employee walks or works, including, but not limited to . . . roofs . . . on which employees must be located in order to perform their job duties.”

Gorick does not contest the applicability of the cited standard. (Resp’t Br. 19-23.) The parking deck, consisting of individual cut slabs, was a walking/working surface to which the standard applies. Employees had to stand on the slabs to perform their work. (Tr. 34-35, 115-17, 156, 442-43; Exs. C-1, C-2A.)

2. Failure to Comply

a) Requirements of the Standard

The cited standard imposes two requirements. First, employers must assess the strength and structural integrity of the walking/working surface. 29 C.F.R. § 1926.501(a)(2); *Fabi Construction Co., Inc. v. Sec’y of Labor*, 370 F.3d 29, 37 (D.C. Cir. 2004); *AGRA Erectors, Inc.*, No. 98-0866, 2000 WL 1239811, at *4 (OSHRC Aug. 31, 2000) (noting “the standard’s first sentence requires an employer to determine in advance whether a surface is safe to work on”). This requires specific action to determine if the surface could withstand the weight of the workers and equipment at the start of the work and as conditions change.¹⁷

¹⁷ *Fabi*, 370 F.3d at 37-38. In addition to *Fabi* and *AGRA*, two ALJ cases, although not binding, are particularly instructive on violations of 29 C.F.R. § 1926.501(a)(2)). See *Centimark Corp.*, No. 12-0920, 2013 WL 5793443, at *11 (OSHR CALJ Aug. 26, 2013) (citing 59 Fed. Reg. 40672, 40681 (Aug. 9, 1994) (codified at 29 C.F.R. pt. 1926), and concluding 29 C.F.R. § 1926.501(a)(2) requires a specific action to determine if the surface could support the “weight of workers, equipment, and materials”); *Elmer II*, 2023 WL 5606693, at *13 (laying plywood over a compromised surface was not sufficient to meet the requirements of 29 C.F.R. § 1926.501(a)(2)).

Second, employers must not allow employees to walk or work on surfaces that lack structural integrity. *AGRA*, 2000 WL 1239811, at *4 (employees are permitted “to work on those surfaces only when the surfaces have the requisite strength and structural integrity”); *Fabi*, 370 F.3d at 37 (upholding Commission’s conclusion that the second sentence of § 1926.501(a)(2) “require[s] that the surface be sound whenever workers are present,” and rejecting the employer’s argument the standard imposes “a duty to ensure a safe working surface only at the start of a project”). This is a performance-oriented standard, in that it allows some flexibility in the method of compliance, but the actions must be reasonable under the circumstances. *See Fabi*, 370 F.3d at 37; *Elmer II*, 2023 WL 5606693, at *9-10.

b) Inadequacy of Visual Assessment of the Work Surface

The Secretary contends Gorick failed to satisfy the first requirement because its method of assessing the slabs’ strength and structural integrity was “woefully inadequate. (Sec’y Br. 10-14.) While the standard requires an employer to determine the structural soundness of the work surface in advance, Gorick’s supervisor, Mr. Dauley, relied on a cursory visual assessment. This method was specifically rejected by the D.C. Circuit in *Fabi*.¹⁸ There, the superintendent conducted a pre-demolition survey to determine the condition of concrete slabs in a parking garage to be demolished. 370 F.3d at 32-33, 38. However, he failed to assess the impact that drilling a pilot hole in the slab would have on its strength and structural stability. 370 F.3d at 38. The hole compromised the strength and structural stability of the slab. 370 F.3d at 38. Evaluating the condition of the work surface at the start of the work was not enough. *Id.* at 37.

Dauley looked at the work surface from above and below before cutting work began.¹⁹ Concrete Cutting then began cutting through the concrete surface. (Tr. 163, 194-95; Exs. C-1, C-7A.) The north/south lines were cut first, and then the east/west cuts were done in groups of about eight slabs at a time. (Tr. 163, 194-95; Exs. C-1, C-7A, R-6.) After a section was cut, Dauley did

¹⁸ 370 F.3d at 38. *See also Centimark*, 2103 WL 5793443 at *7-8 (rejecting employer’s claim that a “cursory visual assessment qualifies as an appropriate inspection to determine the roof’s structural integrity as a walking/working surface”). Respondent tries to distinguish *Fabi* and *Centimark* based on factual differences in the work being done, while neglecting the fact that the cases involve the rejection of visual inspections to satisfy the requirements of § 1926.501(a)(2). (Resp’t Reply 3-4.) *Fabi* is particularly on point as it concerns demolition work on concrete slabs that compromised their structural integrity and led to a collapse. 370 F.3d at 32-33, 37-38.

¹⁹ Tr. 208. Respondent argued its safety program required daily job hazard analyses. (Resp’t Br. 8, 14.) No written records were produced to support this argument. (Tr. 85, Tr. 214-15, 228-31.)

not look at the surface or measure to confirm that the cuts in the work surface were sufficiently within the width of the beam's flange.²⁰ Instead, while standing on the lower level and several feet away, he looked up at the underside of the work surface to assess its strength and structural integrity.²¹ Dauley asserted if he did not see any "daylight," which would have indicated the surface was cut through and the cut was not above the beam flange, then he took no further action, unless he also saw something like "significant rust." (Tr. 81, 166, 172, 195, 206, 435.)

Dr. Lu explained concrete cutting produces a lot of dust. (Tr. 434.) The surface is then typically wet down, producing a mixture, or slurry, of water and concrete dust. (Tr. 411-12, 433-34; Exs. C-11, R-13.) The slurry can flow into the gap between slabs and limit the ability to see whether the cut was inaccurate or at the edge of the beam. (Tr. 434.) Dauley's visual inspection from a lower level did not account for dust or slurry filling the gaps that would prevent him from visually detecting the cut was inaccurate or at the edge of the beam. (Tr. 195-96, 361, 410-12, 434-35; Ex. C-10.) Further, even assuming visual inspection for "daylight" after the cutting would be sufficient, it did not account for the added effects of prying the slabs apart while standing on them after being cut. (Tr. 36, 115, 148-49, 410, 435, 457; Exs. C-2A, C-10 at 13, C-14.) While the CSHO acknowledged it was reasonable to look from beneath the work surface, he never indicated it was the only action an employer should take to ensure the work surface was adequately supported. (Tr. 82; Ex. C-2A.)

²⁰ Tr. 81, 406, 411; Ex. C-10. While the CO acknowledged it was reasonable to look beneath the work surface, he never indicated that was the only action an employer should take to ensure the work surface was adequately supported. (Tr. 82; Ex. C-2A.) Williams claimed Dauley checked the surface after the saw cuts. (Tr. 312, 321, 323.) But, Dauley explained that he checked the surface before the cutting work began and then checked on the saw cuts from below, not the surface. (Tr. 81, 208, 388, 392.) In its brief, Respondent follows Dauley's testimony and takes the position that the inspection of the cuts consisted of "visual verification from below." (Resp't Br. 9, 15.) Respondent's brief also claims Dauley's "inspection protocol" included confirming the "cutter's completion along both longitudinal edges" and "installing supplemental shoring wherever beam being could not be assured." (Resp't Br. 13, 21.) The citations do not adequately support these contentions and the statements overstate the evidence. Dauley indicated the "north/south lines" were cut "earlier in the project," but Respondent does not point to any record evidence as to when that occurred. (Tr. 163.) Dauley acknowledged the saw had a depth gauge but did not independently verify how deep any cut was or confirm the saw was set at the right depth. (Tr. 173-74.) Likewise, Respondent's claims about shoring, such as it being installed "where any uncertainty existed," are not supported by the testimony cited. (Resp't Br. 6.)

²¹ Tr. 195-96, 208, 312, 392, 435. Once the slab was cut, Dauley would look from the next bay over. (Tr. 196.) Each bay was approximately 8 slabs, with each slab being 5'x15'. (Tr. 163, 194-95; Exs. C-1, C-2A, C-10 at 10.)

During the hearing, JC claimed he also inspected the work surface. (Tr. 127-28.) He said that, like Dauley, he looked from beneath the surface to check whether the saw cut could be detected from below. (Tr. 127-28, 145.) His testimony was not supported. In his statement to police on the day of the incident, he said that when working on the last slabs, it was near the end of the day, and he just wanted to finish removing the final slabs. (Tr. 110, 118-19, 462; Ex. C-14.) JC claimed he did not want to take time to get the tools and drill a new anchor point for fall protection. (Tr. 118.) Yet, JC also claims he took it upon himself to take the additional step of going down a level to examine the slabs from underneath. (Tr. 127-28; Ex. C-14.) JC claims he completed the same “inspection” task, in the same manner as his supervisor, while also testifying he did not want to take the time go to another level to retrieve the tools needed to install an anchor point for fall protection before working on the three final slabs. (Tr. 118-19, Exs. C-2A, C-14.) JC’s testimony elicited by Gorick’s counsel did not provide details about when this visual inspection occurred or provide enough details about his background to determine if he had the requisite experience to make such an assessment. Even if JC’s testimony was credible, the visual inspection he briefly described nonetheless would not be adequate to assess the strength and structural integrity of the work surface under the circumstances. (Tr. 127-28; Ex. C-10.) JC did not provide details about when this visual inspection occurred or provide enough details about his background to determine if he had the requisite experience to make such an assessment. In any event, even if JC’s testimony was credible, the visual inspection he briefly described nonetheless would not be adequate to assess the strength and structural integrity of the work surface under the circumstances. (Tr. 127-28; Ex. C-10.) By not looking sufficiently at the cuts to realize they were not consistent with the plan, any inspection by JC also would be inadequate. (Tr. 40, 406.)

c) Failure to Adequately Verify Cut Placement and Beam Support

Like in *Fabi*, Gorick’s assessment of the work surface was inadequate to determine if it had the strength and structural integrity needed for the work being done on it. (Tr. 410, 412, 435, 455-57.) First, as implemented, Gorick’s approach did not fully account for the fact the beams were not all uniform and were significantly narrower in the southern corner of parking Level 2. (Tr. 393-94, 414-17; Ex. C-10.) The narrower width of the flange, or top, of the beam was identifiable before any cuts were made. (Tr. 36, 392-94, 416, 438.) Gorick either did not notice the beams were not uniform or did not take action to add shoring in the area with the narrower beams.

(Tr. 233-35, 392-94, 414-17, 420-21, 456; Exs. C-2a at 4, 4a, 8, C-6, C-7, C-10.) This chips away at Gorick's claim that its approach was reasonable. (Ex. C-10.)

Second, Gorick's visual inspection did not take adequate steps to ensure the cuts were made as planned or to redress potential issues from cuts off, or close to, the end of the beam flanges. (Tr. 361, 372, 374, 406; Ex. C-10.) Gorick's cutting plan was not followed in the area of the collapse. (Tr. 42-43, 73-74, 76, 372, 374, 387-88, 408-9, 446-47, 451; Ex. C-10 at 11-12, R-19 at 12 ("we do not disagree that the cut lines were improper" and "did not match the established cut lines").) Gorick could have determined whether the cut was above the beam's flange, such that adequate support remained, or that it was a few inches off, and thus the support was compromised. (Tr. 36, 42-44, 73-74, 76, 408-11, 447, 451-52; Ex. C-10.)

JC claimed he looked at the saw cuts but did not allege he took any measurements. (Tr. 127.) It was not JC's responsibility to direct the concrete cutting. (Tr. 111.) He did not explain how he would know if the cuts were made as planned and appropriate or not. His testimony does not undermine the record evidence that Gorick's approach failed to adequately take into account the impact of cutting the work surface. *See Fabi*, 370 F.3d at 37-38. No one measured the distance between the cuts to confirm the slab remained sufficiently within the width of the beam flange. (Tr. 81, 406, 410, 412, 435, 455-56; Ex. C-10.) Not measuring created the possibility of a slab resting just at the edge of the beam, where it would not have adequate support even if the concrete was not completely cut through. (Tr. 410-11, 433; Ex. C-10.) The adequacy of any surface inspection is undermined by the failure to recognize the distance of the cuts from the established chalk lines. (Tr. 195, 361, 387-8, 406, 409; Exs. C-2A, C-10.) By only looking from below, they missed an obvious issue that impacted the structural integrity of the work surface. (Tr. 361, 409; Exs. C-2A at 4-5, C-10.) As Dr. Lu stated, "I don't believe this could be missed or not detected" (Tr. 409.)

Gorick's inspection protocol was inadequate to detect if the cut was made accurately in accordance with the plan. (Tr. 223-24, 392, 410-11; Ex. C-10.) As Gorick's expert explained, by looking at the underside of the slab, the supervisor was "not going to see" the cut on top was "in the wrong location." (Tr. 387-88, 392.) Yet, cut placement directly affected whether the work surface remained adequately supported. (Tr. 223-24, 392, 406-11; Ex. C-10.) In short, Gorick's method to assess the structural integrity of the work surface was "not reliable at all." (Tr. 412.)

d) Workers Permitted to Work on Unsafe Surface

Gorick also failed to comply with the second requirement of the standard. Despite the inadequate assessment, workers were permitted to work on slabs that lacked the strength and structural integrity to support them.

Employees stood on the cut slabs to attach equipment and used pry bars to lift adjacent sections. (Tr. 39, 115-16, 149; Exs. C-1, C-2A, C-14.) Two employees and a subcontractor were working from unsupported slabs at the time of the collapse. (Exs. C-1, C-2A, C-14.) The combination of misaligned cuts and narrow beam support rendered the surface incapable of safely supporting their weight and the forces applied during the work.

e) Gorick's Rebuttal Fails

Gorick does not dispute the inspection did not identify the lack of structural integrity.²² Still, it characterizes the issue as a “latent” defect. (Resp’t Br. 18-19.) The record refutes this characterization. (Tr. 440-41, 451; Exs. C-10, R-19.) Gorick could have detected the issue through multiple means: measuring the distance between cuts, checking the size of the beams, or reviewing the original “as constructed” building plans. (Tr. 392-94, 440-41, 451; Ex. C-10.) Considering the narrowness of the support beam, Gorick should have ensured the cuts were accurate or shored the work surface from below. (Tr. 438; Ex. C-10.)

Neither Mr. Gardiner’s testimony nor his report compels a different result. To start, it is apparent that the “latent defect” theory Gorick touts is not from Mr. Gardiner’s report or grounded in his testimony, as the report does not use that term. (Tr. 440, 451; Ex. R-19.) Second, Mr. Gardiner concluded Dauley performed regular inspections, but he did not sufficiently address the Secretary’s claims about the adequacy of these inspections. (Exs. C-10, R-19 at 7-8.) Mr. Gardiner claimed the inspection was adequate because it identified the need for shoring on the north edge. (Tr. 312-13.) However, that issue was identifiable before construction began. (Tr. 353; Exs. C-6, C-10.) The Safety Plan, which was developed before work commenced, called for shoring both the south and north edges. (Tr. 285; Exs. C-6, C-10.) Mr. Gardiner acknowledged that shoring was required on

²² Resp’t Br. 19. Respondent’s brief is missing page numbers. The references herein refer to the page in the pdf and therefore include the cover sheet, Table of Contents and Table of Authorities.

the north edge because of the presence of the curb.²³ The need for shoring along the north edge was not identified solely because of the visual inspection. (Tr. 353; Ex. C-6.) Notably, the Safety Plan's instruction for shoring the south edge was not implemented.²⁴ Mr. Gardiner does not refute Dr. Lu's conclusion that shoring both edges would have been "the best and the easiest way" to address the hazard and ensure the work surface was adequately supported. (Tr. 452.)

Mr. Gardiner's testimony on the inspection of the work surface lacked precision and consistency. He claimed Dauley "did a visual inspection from up above after the saw cuts were complete." (Tr. 312.) Then, to the contrary, he argued that Dauley inspected the saw cuts "from below," so he could not detect the cuts were improper. (Tr. 361, 392.) Dauley had been on Level 2 after the slabs were cut, but he stopped short of claiming he inspected the cuts from the work surface. (Tr. 195-96.) If he had, the improper cut placement could not have been missed. (Tr. 40 ("It's obviously off"), 74, 409; Ex. C-2A.)

Mr. Gardiner also mischaracterizes the Secretary's position and Dr. Lu's report when he claimed Dr. Lu had argued for the use of a ladder to examine the concrete cuts more closely. (Tr. 373-74, 404-5, 443-44.) Rather, the Secretary contends a reasonably prudent employer would not have relied solely on a visual inspection while standing at a distance of several feet beneath the surface to see if light was coming through. (Sec'y Br. 10-11.) In the Secretary's view, this type of inspection is not adequate when the surface has been cut into slabs and employees are actively applying force to the work surface. (Sec'y Br. 10-11.) Neither Dr. Lu nor the CSHO argued an employee should have gotten on a ladder beneath the cut slabs to more closely examine the cuts. (Tr. 404-5, 456.) Instead, Dr. Lu explained that, before the surface was cut, Gorick could have visually assessed the beam widths, reviewed the building plans, or taken some measurements of

²³ Mr. Gardiner stated, the curb required the cuts to be away from the beam beneath the curb, "so they knew ahead of time that they had to provide alternative support for 64, 65, and 66 at the north end." (Tr. 353; Ex. R-19.) Dr. Lu also noted this. (Ex. C-10 at 11.)

²⁴ Exs. C-2A, C-6, C-10. Williams offered a strained view of the Safety Plan. (Tr. 281.) His claim, that the reference to shoring both edges only applied if a defect was discovered, was contradicted. (Tr. 281; Ex. C-6.) Mr. Gardiner testified that Respondent knew shoring would be needed in two places ahead of time to address issues related to curbing along the sides of the level. (Tr. 353; R-19.) Dauley was not asked his perspective of the Safety Plan's reference to shoring on the north and south edges. (Ex. C-6.) Even if the reference in the Safety Plan to install shoring along the edge was not an expression of Gorick's intent to install temporary shoring in the southern corner of parking level two, that should have been the plan because of the narrow beam flange on the south edge and the curb on the north edge. (Tr. 353, 418, 452; Exs. C-6, C-10, R-19.)

the beams. (Tr. 416.) Although he advised taking measurements or proactively shoring, he also acknowledged there were potential alternative ways to meet the standard's requirement other than what was in his report. (Tr. 404-5.) He indicated that one alternative could have included setting up a ladder adjacent to the area of the cut to confirm the continued structural integrity before permitting employees to work from the remaining slabs. (Tr. 405-6.) Dr. Lu did not assert this was the best method. It was an alternative to installing shoring on both edges. (Tr. 404-5, 445, 452; Ex. C-10.) As Dr. Lu concluded, supporting the slabs from both ends would have been the easiest way to fix the hazardous condition. (Tr. 452.)

The errors in Mr. Gardiner's initial report regarding the cutting and shoring undermine its overall credibility. (Ex. C-10.) For example, his supplemental report acknowledges shoring was used only on one side, instead of both as claimed in his initial report. (Ex. R-19.) However, Mr. Gardiner does not adequately explain why, once he learned there was less shoring in the area of the collapse, this did not impact his supplemental opinion. (Ex. R-19.) Also, Mr. Gardiner acknowledged the limited scope of his review and noted his report should not be taken as a "complete forensic analysis." (Ex. R-19 at 12-13.) He stated shoring would not have been needed at the south if the cuts had "been made along the proper cut lines." (Ex. R-19 at 12.) But the issue is that Gorick did not take sufficient steps to confirm the cuts were proper before employees were permitted to work on the slabs, which were only shored on one side. (Ex. C-10.) Mr. Gardiner rejects the suggestion to install more shoring as impractical. (Tr. 378.) However, this is a mischaracterization of what the Secretary contends a reasonably prudent employer would have done. Dr. Lu did not call for shoring every slab. His recommendation is limited to certain areas for structural reasons, and where cuts were improperly made.²⁵ Indeed, Gorick's own Safety Plan called for shoring along both the north and south edges, and Gorick took this action after the incident. (Tr. 45, 417; Exs. C-2A at 9, C-6, C-10.) Dr. Lu is more persuasive on Gorick's failure to adequately assess the work surface than Mr. Gardiner. (Ex. C-10.)

f) Gorick Failed to Comply with the Cited Standard

Despite the lack of a proper assessment, Gorick permitted employees to work on the compromised slabs. On the slabs where the incident occurred, the combination of inaccurate cuts and narrow beam width rendered the surface unable to support the weight of the employees and

²⁵ Tr. 417; Ex. C-10. This would have involved shoring the south edge of slabs 64 and 65. (Tr. 417.)

their work. The Secretary established that at least two employees worked on the unsupported slabs. After they were cut, employees stood on the slabs to attach a vacuum device. When the vacuum device could not be attached, employees used a bar to pry adjacent slabs up so a sling could be inserted underneath. (Tr. 39, 115-16, 149; Exs. R-19, C-2A, C-14.) Employees were actively working from the inadequately supported slabs. (Tr. 36, 39, 42, 115-16, 410; Exs. C-1, C-2A, C-10, C-14.)

Fabi instructs that the standard requires more than a one-time inspection of the work surface. 370 F.3d at 37-38. As the workers here demolished the deck, they were working from fewer and fewer slabs as demolition progressed. (Ex. C-10.) The final slabs rested on a beam that was narrower than the others. (Tr. 392-93, 413-17; Ex. C-10.) Looking at the slab from below was not enough to meet the requirements of the cited standard. Though the supervisor could not visually detect if a cut was just at the edge of a beam flange, Gorick could have measured the distance between the cuts and used that information in combination with the known flange width to determine if the surface had enough support on each side. (Tr. 392-93, 414-17, 456-57; Ex. C-10.) Gorick's approach did not address situations where the cuts were placed just at the edge of the beam and therefore negatively impacted the stability of the work surface. (Tr. 414-17, 435; Exs. C-11, C-10.)

Either measuring the cuts to ensure the slabs remained sufficiently supported by the beams or proactively installing shoring at both ends of the area (rather than only on one side) would have ensured the work surface was adequately supported. (Tr. 413-17; Ex. C-10.) Gorick's expert argues proper cuts would have obviated the need for shoring. (Tr. 370; Ex. R-19.) However, Gorick neither confirmed the accuracy of those cuts nor installed shoring as an alternative. Gorick's claim it was reasonably diligent in ensuring a structurally sound work surface is undermined by its choice to not use shoring under a narrow beam and instead simply do a visual assessment.

Gorick's approach was insufficient to meet the requirements of the cited standard in these circumstances. The Secretary showed the standard was violated.

3. Access to the Hazardous Condition

The Secretary showed actual exposure to the cited hazard. The same facts showing a violation also show access to the hazardous condition. *See AGRA*, No. 98-0866, 2000 WL 1239811, at *4. *See also Fabi Constr. Co.*, 1998 WL 239344, at *10 (OSHR CALJ May 8, 1998) (collapse "establishes employee exposure to the hazards created by the failure to determine whether the

walking/working surface had the strength and structural integrity to safely support employees”), *aff’d*, 370 F.3d 29. Multiple employees worked from an inadequately supported parking deck. (Tr. 115-17, 156; Exs. C-1, C-2A.) Two employees fell twelve feet when two slabs collapsed. (Tr. 34-35, 38-40; Exs. C-1, C-2A, C-14.) One employee’s legs became trapped between the collapsed concrete slabs. (Tr. 38-40; Exs. C-1, C-2A, C-14.) He was hospitalized and underwent multiple surgeries to repair his legs. (Tr. 38-40; Exs. C-1, C-2A, C-14.) Another employee injured his hand and finger. (Tr. 39-40; Exs. C-1, C-2A, C-14.) Gorick does not contest the Secretary’s claims of exposure to the hazard.

4. Knowledge

The final element of the Secretary’s burden is to establish actual or constructive knowledge of the cited condition. The relevant inquiry is not whether Gorick knew the collapse would occur, but whether there was actual or constructive knowledge of the physical condition constituting the violation. *See The Halmar Corp.*, No. 94-2043, 1997 WL 594393, at *2 (OSHRC Sept. 23, 1997) (*Halmer*) (“The test for knowledge is whether an employer knew, or, with the exercise of reasonable diligence, could have known of the presence of the violative condition”), *aff’d, without reported opinion*, 152 F.3d 918 (Table) (2d Cir. 1998); *Phoenix Roofing, Inc.*, No. 90-2148, 1995 WL 82313, at *3 (OSHRC Feb. 24, 1995) (an employer’s knowledge is directed to the physical condition that constitutes a violation), *aff’d*, 79 F.3d 1146 (5th Cir. 1996). An employer can be charged with constructive knowledge when it fails to engage in reasonable diligence to identify violative conditions. *Halmar*, 1997 WL 594393, at *2-3 (although work did not call for working near electrical wires, had employer exercised reasonable diligence, it would have anticipated that crane might contact power lines), *Calpine Corp.*, No. 11-1734, 2018 WL 1778958, at *5 (OSHRC Apr. 6, 2018) (employer had actual knowledge hole was unguarded and the fact conditions were changing did not divest the employer of its knowledge of the physical condition constituting the violation), *aff’d*, 774 F. App’x 879 (5th Cir. 2019) (unpublished); *Hamilton Fixture*, No. 88-1720, 1993 WL 127949, at *16 (OSHRC Apr. 20, 1993) (with reasonable diligence employer could have known of the cited conditions), *aff’d*, 28 F.3d 1213 (6th Cir. 1994.) This includes the duty to anticipate hazards arising from the work being performed. *Automatic Sprinkler*, 1980 WL10595, at *7 (OSHRC May 9, 1980) (employer “must make a reasonable effort to anticipate the particular hazards to which its employees may be exposed in the course of their scheduled work.”) Here, the

knowledge element focuses on Gorick's knowledge of the assessment of the surface's structural integrity and of employees working from the surface.

a) *Knowledge of the assessment and shoring*

Dauley, a supervisor, had actual knowledge of key aspects of the violative condition. He knew the scope of his own assessment, where shoring was installed, and that employees would be working on slabs 63-66 in the southern corner of Level 2. (Tr. 40-42, 153-57, 283-84; Exs. C-2A, C-6, C-10, R-19 at 5.) He knew where employees were working, how much of the surface was removed, and how they stood on the already cut slabs to perform work, including manipulating the adjacent work surface with pry bars. (Tr. 40-42, 153, 155-57; Exs. C-1, C-2A.) Likewise, the lack of shoring on the south edge of the 3-slab work area was in plain view and known by Dauley. (Tr. 44, 205-6, 284, 418, 429-31; Exs. C-2A, C-6.) *See Simplex Time Recorder Co. v. Sec'y of Labor*, 766 F.2d 575, 589 (D.C. Cir. 1985) (finding knowledge when the condition was in plain view and should have been known to management); *Nova Grp. / Tutor-Saliba, a Jt. Venture*, No. 10-0264, 2012 WL 1899708, at *4 (OSHRC May 14, 2012) (finding knowledge in part because the foreman directed employees to use an uneven storage area).

As a supervisor, Dauley's knowledge of the assessment's scope and his knowledge employees were working on the cut slabs is imputed to Gorick. *See N.Y. State Elec. & Gas Corp v. Sec'y of Labor*, 88 F.3d 98, 105 (2d Cir. 1996) (*NYSEG*) ("Knowledge or constructive knowledge may be imputed to an employer through a supervisory agent"); *Am. Eng'g & Dev. Corp.*, No. 10-0359, 2012 WL 3875599, at *2 (OSHRC Aug. 27, 2012) (knowledge may be imputed to the employer through its supervisory employee).

b) *Failure to Detect Improper Cuts*

Dauley set the cut lines and could have detected whether they were sufficiently within the beam's flange. (Tr. 42; Ex. C-10.) Instead, he only looked at the cuts from the lower level, from some distance.²⁶ Both cuts should have landed one and one-half inches to the left and right of the

²⁶ Tr. 157, 195-96, 200-1, 204, 208, 356, 388, 392, 406, 451; Exs. C-10, R-19. Williams claimed Dauley checked the working surface after the saw cuts. (Tr. 312, 321, 323.) But, Dauley explained that he checked the surface before the work began and then checked on the saw cuts from below, not the surface. (Tr. 81, 208, 388, 392.) In its brief, Respondent states that the inspection consisted of "visual verification from below." (Resp't Br. 9-10, 15.)

chalk line, respectively.²⁷ (Tr. 75-76, 386, 406-10; Ex. C-10 at Fig.10.) The cut to the left of the chalk line landed at the edge of the narrower beam beneath the slabs that collapsed. (Tr. 36, 40, 75-76, 386-88; Exs. C-2A at 4-5, C-10.) This could have been detected by looking at the work surface or measuring the distance between the cuts. (Tr. 40-43, 74-76, 323, 386-88, 406-10; Exs. C-2A, C-10.)

The CSHO estimated the erroneous left cut was approximately five to six inches from the chalk line, thus leaving slabs 64 through 66 without adequate beam support. (Tr. 40, 75-76, 406-10; Ex. C-10.) A reasonably diligent inspection should have detected the cuts deviated from the plan and prompted action to address the impact on the stability of the work surface. (Tr. 406-10; Exs. C-1, C-2A, C-10.)

The location of the saw cuts was readily detectable. (Tr. 40-42, 75-76, 406-11, 451, 455-56; Exs. C-1, C-2a, C-10.) Dauley had been on Level 2 after the cuts were made. (Tr. 117, 157, 209-11, 409; Exs. C-2A.) He could have easily seen the cuts and the chalk line. (Tr. 40, 157, 209-212, 406-11.) The fact that the cut deviated from the plan was in plain view. (Tr. 40, 195-96, 372, 406-9, 431, 455-56; Exs. C-2A, C-10.) A reasonably diligent inspection would have detected the cuts did not conform to plan and resulted in insufficient structural support.

c) Failure to account for beam width and site conditions

In addition, before the work commenced, the need for further support in the southern corner near slabs 64-65 was identifiable. (Tr. 393-94, 414-16; Exs. C-2A at 4, C-6, C-10, R-6.) The width of the top of the beams was known and included in the demolition slab layout. (Tr. 393, 416; Exs. C-2A at 4, C-10; Resp't Br. 17.) Gorick conducted an engineering survey. (Tr. 393.) Such a survey includes an examination of the steel structure and its various components. (Tr. 393-94, 416, 445; Ex. C-10 at 22-23, 27.) No one testified that either during the development of the work plans or during the work itself, that they recognized the variability in the beam sizes. (Tr. 190-97, 206-8, 223-24, 392-94, 414-18; Exs. C-7A, C-10 at 26, R-6.) Still, there is no dispute Gorick could have reviewed the drawings or done an onsite visual determination that the beams in the area of the

²⁷ According to Gorick's Demolition Plan, after the slab cuts were done, three "lines" should be visible—a chalk line down the middle and parallel cuts on the left and right. (Tr. 406; Ex. C-10 at 24.) Dr. Lu stated that the photographs show the cuts made to slabs 64-66 were not in accordance with the Plan. (Tr. 408-09; Ex. C-10). Instead, the "right" cut ended up on the beam's center line and the "left" cut landed at the beam's edge. (Tr. 408).

collapse were narrower than the others. (Tr. 414-15; Ex. C-10.) A reasonably diligent assessment would have accounted for the narrower beam width, either by shoring both edges of the work surface in this area or ensuring that the cutting was not too close to the edge of the beam flange. (Tr. 417; Ex. C-10.)

d) Awareness of Work Activities Impacting the Strength and Integrity of the Work Surface

Dauley was on the lower level for about 30-60 minutes before the collapse. (Tr. 131, 157, 169-71, 209-10; Ex. C-14.) During this time, he frequently looked up towards slabs 63-66. (Tr. 78, 170-71, 174, 211, 213; Exs. C-2A at 8, C-10, C-14.) He knew that employees were standing on the cut slabs and applying force to separate them. (Tr. 42, 156; Exs. C-1, C-2A.) Despite this, Gorick did not adequately reassess whether the slabs remained structurally sound as conditions changed during demolition. *See Fabi*, 370 F.3d at 37; *see also Kokosing Constr. Co.*, No. 92-2596, 1996 WL 749961, at *2 (OSHRC Dec. 20, 1996) (constructive knowledge based upon “the conspicuous location, the readily observable nature of the violative condition and the presence of Kokosing’s crews in the area”).

e) Secretary Met the Knowledge Requirement

The same lack of reasonable diligence that establishes a violation of the standard also supports finding the knowledge prong was met. Had Gorick exercised reasonable diligence, it would have identified the narrower support beam and the cuts that deviated from the plan. By not ensuring the slabs remained structurally sound, Gorick allowed work on an unstable surface to occur.

The Secretary met her burden and established a violation of 29 C.F.R. § 1926.501(a)(2).

B. Citation I, Item 2 – 29 C.F.R. § 1926.501(b)(1)

1. Applicability

Gorick was also cited for violating 29 C.F.R. § 1926.501(b)(1), which requires fall protection for each employee on a work surface with an unprotected edge six feet or more above a lower level. Gorick does not contest the applicability of the cited standard. The record shows Gorick was engaged in construction and employees were working on surfaces with unprotected edges 6 feet or more below a lower level. (Tr. 52, 167-68; Exs. C-2A at 4-5, C-4.)

2. Violation

Gorick contends there was no violation because it maintained and enforced a fall protection program. (Ex. C-4 at 4; Resp't Reply Br. 11.) That is not the test for determining whether Gorick complied with 29 C.F.R. § 1926.501(b)(1). The standard is violated if an employee works on a surface six feet or more above a lower level with an unprotected edge without fall protection. 29 C.F.R. § 1926.501(b)(1); *Gate Precast Co.*, No. 15-1347, 2020 WL 2141954 at *1-4 (standard violated even though workers did not come within six feet of the edge).

The Secretary met this test. Three workers fell, two of whom worked directly for Gorick. (Exs. C-1, C-2A.) All were working more than six feet above a lower level near an unprotected edge. (Ex. C-2A.) None were appropriately tied off, and they had been working without adequate fall protection for some time before the collapse. (Tr. 117-18, 131, 143-44, 218-19, 236, 460-63, 468-69; Exs. C-1, C-4, C-14.)

Dauley and JC each described the available fall protection system differently. Dauley suggested drilled anchor points were impractical and stated they were “tied to the steel” using a rope system or lifeline wrapped around an upright beam, with workers attached to the lifeline (beam/lifeline system).²⁸ To use this method, the employees needed a 50-foot horizontal lifeline with a sliding anchor and another device. (Tr. 221-23, 460-63, 468-69.) Dauley could not recall the name of the device. (Tr. 221-22.) The workers would then attach the lanyard to the sliding anchor on the lifeline. (Tr. 221-22). Dauley claims the workers were using the beam/lifeline system about two hours before the incident after detaching from the D-ring/anchor point system but acknowledged there was no photographic or other evidence of a beam/lifeline system for Level 2. (Tr. 218-20, 223.)

In contrast, JC described using a system of drilled anchor points with workers connecting to them with D-rings and lanyards (D-ring/anchor point system) before they moved into the area by slabs 64-66. (Tr. 117-18, 125, 128, 132, 135, 137, 141, 144; Exs. C-7A, C-14.) By then, no workers were tied off. (Tr. 117-8, 131; Ex. C-14.) JC did not describe being tied off to any type of beam/lifeline system (rather than attaching to an anchor point) at any point in the work. (Tr. 117-18, 132, 142, 144; Ex. C-14.) He acknowledged detaching from the anchor point but did not claim he, or any other worker, attached to a lifeline system instead. (Tr. 117-18; Ex. C-14.) JC admitted

²⁸ Tr. 218, 220-23. Dauley's direct testimony was sometimes elicited through leading questions by Respondent's counsel. (Tr. 160, 164-66, 225.)

an anchor point could have been installed in that area, but because the crew did not want to retrieve the tools, which would have taken only “a little extra time,” it was not installed. (Tr. 118, 125, 132, 144, 465; Ex. C-14.) Dauley’s suggestion it was impractical to install an anchor point is therefore rejected. (Tr. 132, 143-44, 189-90, 217, 462; Ex. C-14.)

JC’s account is consistent with the Demolition Plan and the CSHO’s findings. (Tr. 288, 460-63, 468-69; Exs. C-7A (calling for “D-Rings for Tie Off Points”), C-14.) Dauley corroborated that the anchor point/D-ring system was in use at the Worksite, including on the day of the incident. (Tr. 102, 157, 168, 179, 217-18; Exs. C-7A.) He installed anchor points and claimed he checked on the ones installed on the level where the collapse occurred. (Tr. 157-58, 179, 217; Ex. C-14.) When asked by Gorick’s counsel whether he observed workers on slabs 1-63, Dauley indicated that “everyone had their harnesses and lanyards on.” (Tr. 168.) He did not refer to them as having lifelines or being attached by rope to an upright beam.

A beam/lifeline system would not require drilled anchor points but would require identifiable 50-foot lifelines and attachments, which were not reflected in photographs or identified by the CSHO during his investigation. (Tr. 102-3, 221, 462; Exs. C-1, C-2A, C-14.) Two photos Gorick took on the day of the incident show a fall protection harness underneath the remaining slab of Level 2, but no rope or anchorage consistent with a lifeline system.²⁹ Such equipment would be needed to tie off to a beam/lifeline system rather than an installed anchor point. (Tr. 102-03, 221, 266-67, 313, 460-63.) Two other photos of the same area show no fall protection equipment.³⁰ A beam/lifeline system was neither observed by the CSHO nor described to him during his inspection. (Tr. 461-63, 468-69; Exs. C-1, C-2A, C-4, C-14.) Similarly, there is no

²⁹ Tr. 223, 295, 298, 301, 303, 325; Exs. R-9, R-10, R-11. Page 2 of Exhibit C-3 appears to be the same photograph as Exhibit R-11. (Tr. 364-65, 381.)

³⁰ Exs. C-2A at 8, R-16. Williams initially asserted Exhibit R-9, which shows a harness, was taken on the day of the inspection. (Tr. 298.) When the discrepancy between Exhibit R-9 (showing a harness) and page 8 of Exhibit C-2A (similar image showing no harness) was highlighted, he stated R-9 was taken the day before the inspection. (Tr. 298-300.) Williams did not have actual knowledge of why the scene was modified before the CO arrived but explained it was “standard practice” to collect and put the fall protection in the stairwell. (Tr. 310; Ex. R-2 at 3.) He indicated the CO saw it there the next day. (Tr. 310.) Respondent did not offer any information other than Williams’ testimony about which day he took which photograph. Nor was it explained whose harness was depicted, when it was placed on the block, or who removed it before the inspection. A harness on the block, as depicted in Exhibits R-10 and R-11, does not establish that fall protection was in use.

evidence of a safety monitoring system being in place in lieu of the harness, lanyard, and D-ring system. (Exs. C-7A, C-14; Resp't Br. 25.)

Williams did not refute the testimony of the CSHO and JC. He did not specifically refer to the lifelines or ropes or other equipment, which would be needed to tie off to a beam rather than using lanyards with an installed anchor point/D-ring system. (Tr. 236, 266-67, 313, 460-63, 468-69; Ex. R-2 at 3.) He did not mention workers detaching from a beam/lifeline system. (Tr. 236, 266-67, 313.)

Dauley's claim that after they detached from the D-rings, the workers attached themselves with lifelines to an upright beam is not credible and is rejected. (Tr. 144, 217-19, 220-23, 460-63, 468-69; Exs. C-4, C-7A, C-14.) Two employees were not using fall protection while working approximately 12 feet above a lower level with an unguarded edge. (Tr. 34, 39, 52-53, 115, 156-57, 167-68, 175; Ex. C-4.) This violated the standard's requirements.

3. Exposure

Workers were exposed to the cited condition. It is undisputed two employees and one subcontractor stood on a cut concrete slab with an unprotected edge 6 feet or more above a lower level without being tied off. (Tr. 34, 39, 52-53, 115, 167-68, 175; Exs. C-4 at 4, C-10 at 10-13, 17, C-14) All three fell approximately 12 feet and were injured. (Tr. 34, 38-40, 53, 145; Exs. C-1, C-2A, C-4.) *See George Campbell Painting Corp.*, No. 94-3121, 1999 WL 777768, at *5 (OSHRC Sept. 29, 1999) (fall proves exposure to a violation of 29 C.F.R. § 1926.501).

As with its arguments about whether the standard was violated, Gorick points to the availability of fall protection equipment and anchor points at the Worksite. (Resp't Br. 6.) It cites no precedent for this argument. The test is whether access to the open edge occurred or was reasonably predictable. *Phoenix Roofing*, No. 90-2148, 1995 WL 82313, at *3 n.6 (12 feet from unguarded skylights), *aff'd*, 79 F.3d 1146 (5th Cir. 1996); *George Campbell*, No. 94-3121, 1999 WL 777768, at *2, 5 (finding the exposure prong met even though fall protection equipment was available and employer would tell employees to use it when they were exposed to a fall hazard). The record shows there was actual access to the hazard that was reasonably predictable. (Ex. C-2A.)

4. Knowledge

As noted, to establish knowledge, the Secretary must show the employer knew or could have known of the hazard. *Calpine*, 2018 WL 1778958, at *5. "The 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*, No. 98-1192, 2001 WL 881247, at *5 (OSHRC, Aug. 2, 2001) (citation omitted), *aff’d*, 319 F.3d 805 (6th Cir. 2003); *see also S. Hens, Inc. v. OSHRC*, 930 F.3d 667, 676 (5th Cir. 2019) (*Hens*) (“The showing required to establish knowledge is of the physical conditions constituting the violation, not of the specific OSHA regulation or of the probable consequences of the violation”).

The Secretary contends Gorick had actual, or alternatively, constructive knowledge of the violative condition. (Sec’y Br. 24.) In its brief, Gorick asserts there was no actual knowledge and does not raise any arguments about constructive knowledge. (Resp’t Br. 23.) In its Reply, Gorick argues the evidence is insufficient to find constructive knowledge. (Reply Br. 12.)

Looking first at actual knowledge, Dauley knew the conditions and what was needed for appropriate fall protection. (Tr. 55, 167-68; Ex. C-4.) He knew the anchor points were not in the vicinity of where the employees were working at the time of the collapse. (Tr. 217-20.) He was aware that the employees had detached from the anchor point/D-ring system about two hours before the collapse. (Tr. 83, 218.) Dauley’s actual knowledge that the employees stopped using the fall protection system is imputable to the employer. *See NYSEG*, 88 F.3d at 105 (“Knowledge or constructive knowledge may be imputed to an employer through a supervisory agent”); *Phoenix Roofing*, No. 90-2148, 1995 WL 82313, at *3-4 (an employer’s knowledge is directed to the physical condition that constitutes a violation), *aff’d*, 79 F.3d 1146 (5th Cir. 1996).

Dauley’s claim the employees switched their fall protection method was not corroborated and is rejected. While JC supported the claim that Dauley could not see the workers on slab 65 when they were detached from anchor points, he did not corroborate Dauley’s testimony regarding a switch from using the anchor point/D-ring system to using the beam/lifeline system.³¹ Dauley could not provide key details about his claim, such as when the switch in fall protection method occurred. (Tr. 221-23, 460-63; Exs. C-2A, C-4, C-7A, C-14.) Further, Gorick did not rebut the

³¹ Tr. 132, 143-44; Ex. C-14. On this point, *Calpine* is instructive. There, a supervisor was aware of hazardous condition. 2018 WL 1778958, at *5. But conditions were changing, and the supervisor did not know the condition remained hours later. *Id.* at 6. The Commission found that the employer failed to take adequate action to confirm that opening was appropriately guarded. *Id.* at 5-7. If Dauley thought the workers switched fall protection methods or thought they would do so, he did not take adequate action to confirm the alternative approach was in use. *Id.* at 6-7. *See also Automatic Sprinkler*, 1980 WL 1059, at *7.

Secretary's evidence that the workers were using drilled anchor points as their fall protection system, such as by eliciting testimony from JC about tying off to structural steel or by presenting testimony from the other two workers involved in the incident.

The Secretary also presented circumstantial evidence of Dauley's knowledge.³² Even after moving to the lower level 30 to 60 minutes before the collapse, Dauley "quite often" checked on the workers and even offered to assist when slab 64 could not be moved by vacuum device—a point at which it is undisputed the workers were fully detached from fall protection. (Tr. 78-79, 99-100, 170, 211-13, 218; Exs. C-4, C-14, R-19 at 5.) Despite Dauley's claim that his line of sight was somewhat obstructed, the Secretary established that because most of the decking was removed at the time of the collapse, it would be plainly visible there was no beam/lifeline system the crew used for attachment. (Tr. 78-79, 99-100, 211-12, 221-23; Exs. C-2A, C-4, C-14, R-19 at 3, 5, 7.) Dauley offered a theory that the crew's lanyards could have been angled fully behind the workers in such a way as to not be visible from his position below, but he did not claim to have believed this at the time. (Tr. 222-23.)

The violation was in plain view, and Dauley was in proximity when the employees were detached. (Tr. 41, 78-79, 99-100, 211-12, 221-23; Exs. C-2A, C-4, C-14, R-19.) Constructive knowledge is present when the "physical condition" constituting the violation is "readily apparent to anyone who looked" and "indisputably should have been known to management." *Simplex*, 766 F.2d at 589. The failure to use fall protection here was not a "momentary disconnect"; the workers were detached long enough to attempt the vacuum method, communicate the failed attempt to

³² Commission precedent does not always neatly divide circumstantial evidence of actual knowledge from the constructive knowledge analysis. *See e.g., A.P. O'Horo Co., Inc.*, No. 85-369, 1991 WL 25318, at *3-4 (OSHRC Jan. 31, 1991) (finding knowledge because the supervisor observed the condition); *Stark Excavating, Inc.*, No. 09-0004, 2014 WL 5825310, at *14 (OSHRC Nov. 31, 2014) (consolidated) (supervisor either knew or purposely avoided knowledge of the condition), *aff'd*, 811 F.3d 922 (7th Cir. 2016); *Jacobs Field Servs. N. Am.*, No. 10-2659, 2015 WL 1022393, *4 n.7 (OSHRC Mar. 4, 2015) (noting that knowledge finding might be viewed as circumstantial evidence of actual knowledge). Respondent alludes to analytical ambiguity in the knowledge test in its Reply Brief. (Resp't Reply 11-12.) The Secretary here argues that the hazards were so obvious Dauley must have seen it, i.e., circumstantial evidence establishes actual knowledge, while also maintaining that even if Dauley was oblivious to the violative conditions, he should have seen them if he was doing his job properly. (Sec'y Br. 24-27; Sec'y Reply 12-17.) Such an approach to proving knowledge is permissible. *See Halmar*, No. 94-2043, 1997 WL 594393, at *2 (knowledge test requires showing the employer knew or could have known of the violative condition).

Dauley, switch to a wire sling method to remove slab 64, and work for some time to pry the slab up.³³

Dauley gave conflicting testimony regarding his supervision, first claiming he did not see the workers on slabs 64 or 65, then implying he saw them at that location but believed they were tied off. (Tr. 170-71, 174; Ex. C-14.) He ultimately offered a *post hoc* theory that every time he checked on the workers, all three lanyards attached to the 50-foot lifelines happened to be so perfectly angled behind each worker as to be invisible. (Tr. 222-23.)

Gorick asks that Dauley's testimony he frequently and diligently supervised the work be fully credited, while also accepting Dauley never noticed they were no longer tied off, including when he observed them in the southern corner of Level 2. (Tr. 41, 170, 174, 211-12; Exs. C-1, C-2A, C-4, R-19 at 3.) If Dauley's view was actually so obstructed he could not see the lifelines, his failure to determine whether fall protection was in use undercuts Gorick's claim its visual inspections were adequate.³⁴ Nevertheless, because Dauley knew the drilled anchor points had not been relocated to the collapse area, a reasonably diligent supervisor conducting genuine safety checks would have verified why he could not see any of the crew's fall protection attached to the lifelines. *See Pride Oil Well Serv.*, No. 87-692, 1992 WL 215112, at *6 (OSHRC Aug. 17, 1992) (employer could have discovered and eliminated the hazard with the exercise of reasonable diligence).

In *Thomas Indus. Coatings, Inc.*, No. 06-1542, 2012 WL 1777086, at *4 (OSHRC Feb. 28, 2012) (*Thomas*), seconds before a fall, a foreman-in-training observed, for the first time, a worker

³³ Tr. 218; Ex. C-14. There is some discrepancy in the record about when the workers ceased to be tied off. Dauley, indicated that they ceased using the anchor point/D-rings two hours before the collapse. (Tr. 218.) JC did not provide a precise time but explained that they had ceased to be tied right off before working on slab 64. (Ex. C-14.) The workers removed the slabs in order, starting with slab one and progressing to slab 66. (Ex. R-19 at 3.) Slab 64 was the last slab worked on before the collapse. (Tr. 77, 131, 162, 235; Ex. R-19.) JC explained that they were not attached at that point because they had not drilled new anchor points before starting work on that slab. (Tr. 131; Ex. C-14.)

³⁴ *Simplex*, 766 F.2d at 589; Tr. 217-22. As noted above, the Court does not credit Dauley's testimony about two different fall protection attachment methods being in use. (Tr. 461-63; Exs. C-7A at 1, C-14.) Dauley claimed the long lifelines would be connected to "upright columns" or beams rather than a fixed anchor point drilled in as described in the Safety Plan. (Tr. 220-22; Ex. C-7A.) Even if the visual inspection was insufficient to see the workers, then Dauley should have verified why he could not see any lines extending behind the workers indicate they were tied off.

in a location that was far from the anchor point.³⁵ There, the Commission held that without evidence of how long the unsafe condition had existed, it could not find the employer had not been reasonably diligent in its inspection. Here, three workers were detached from fall protection as they worked for some time, on slabs 64 and 65, in an area where the supervisor admitted he knew the drilled anchor point called for by the Safety Plan had not been installed. (Tr. 41, 79, 99-100, 157-58, 170, 179, 217-19; Ex. C-7A.)

The Secretary showed Gorick could have known that the workers were not using fall protection. As noted, Dauley knew the workers did not have an anchor point installed when they moved to work on the slabs in the area of the collapse. (Tr. 157-58, 179, 217-22.) The use of D-rings and drilled anchor points was the fall protection approach specified in the Safety Plan. (Tr. 144, 157-58, 288; Ex. C-7 at 1.) Had Gorick been reasonably diligent, it would have discovered that the employees were not using an alternative method of fall protection after they detached from the D-rings. (Tr. 218.) The violation was in plain view for some time and could have been discovered with reasonable diligence. (Tr. 174, 218; Exs. C-4, C-2A, C-14.) Dauley either saw fall protection was not in use or failed to exercise reasonable diligence when he could not see whether the workers were still attached.

5. Affirmative Defense – Unpreventable Employee Misconduct

a) *Requirements to Establish Defense*

To successfully establish an employee misconduct defense, an employer must demonstrate: (1) it has an established work rule to prevent the violative behavior, (2) it adequately communicated the rule to its employees, (3) it took steps to discover non-compliance, and (4) it effectively enforced safety rules when violations were discovered. *D.A. Collins Constr. Co., Inc. v. Sec’y of Labor*, 117 F.3d 691, 695 (2d Cir. 1997) (*Collins*); *Manganas Painting Co., Inc.*, No. 94-0588, 2007 WL 6113032, at *40-41 (OSHRC Mar. 23, 2007) (finding misconduct defense not met when employer was either not reasonably diligent in discovering violations or failed to enforce its work rule).

³⁵ No. 06-1542, 2012 WL 1777086, at *4. There was also detailed, recent instruction about fall protection with confirmation of attendance at the training by the employees involved, the foreman, and the superintendent. *Id.* at *6. In addition, there was close monitoring and enforcement of disciplining workers for violating fall protection rules. *Id.* at *7. Similar robust evidence on Respondent’s safety program was not present here.

Gorick's reliance on cases concerning constructive knowledge, rather than the unpreventable employee misconduct defense, is misplaced under the situation present here. (Resp't Br. 25-27.) In *Thomas and Stahl Roofing, Inc.*, No. 00-1268, 2003 WL 440801 (OSHRC Feb. 21, 2003) (consolidated) (*Stahl*), there was clear evidence of the employer's specific enforcement of the fall protection rule and other evidence mitigating against a constructive knowledge finding. *Thomas*, 2012 WL 1777086, at *5-7; *Stahl*, 2003 WL 440801, at *2-4. *Dover Elevator Co., Inc.*, No. 91-862, 1993 WL 275823 (OSHRC Jul. 16, 1993) (*Dover*) and *Texas A.C.A., Inc.*, No. 91-3467, 1995 WL 42340 (OSHRC Feb. 1, 1995) (*ACA*), involved violations of different standards than the one at issue here and are factually distinct from the situation at the Worksite.³⁶ While there is overlap between constructive knowledge and the affirmative defense of employee misconduct, the burden differs. *Hens*, 930 F.3d at 678 (5th Cir. 2019) (noting "the UEM inquiry often overlaps considerably with the main violation inquiry").

When knowledge of the violative condition is proved, the burden is on Gorick to prove all elements of the affirmative defense. *Collins*, 117 F.3d at 695. Here, Gorick knew or should have known that none of the workers were using fall protection. The mere existence of its safety program does not excuse the violation.

³⁶ *Dover*, 1993 WL 275823, at *7 (declining to emphasize form over the substance of the safety program); *ACA*, 1995 WL 42340, at *2-3 (no knowledge of changed conditions). Respondent also cites *Trinity Marine Nashville, Inc.*, No. 98-0144, 2000 WL 1086716 (OSHRC Aug. 2, 2000), which it recognizes was overruled by 275 F.3d 423. (Resp't Br. 25; Resp't Reply 14.) Further, that case concerned the application of Fifth Circuit precedent, which is not a relevant circuit here, and is factually different in that the Commission concluded nothing further could have been done to detect issue. 2000 WL 1086716, at *3, 5.

b) *Work Rule*

Gorick claims it had a comprehensive fall protection program that was enforced.³⁷ According to Gorick, it required employees to be tied off “100% of the time.” (Reply Br. 10.)

The language of the policy is slightly different. It details “100% fall protection,” as opposed to constant tie-off. (Ex. R-1A at 2.) The program does not refer to the specific equipment and procedures for anchoring harness and lanyards to vertical steel beams, which Gorick claimed was the alternative attachment method as people worked on slabs 64, 65 and 66. (Ex. R-1.) The program is general in nature, referring to various types of fall protection equipment. (Ex. R-1A.) It requires written site-specific plans to be developed and for the supervisor to take several steps to provide additional specificity. (Ex. R-1 at 1, 3, 17 (at #24), 20, 23.) The site supervisor was to verify compliance by preparing a written certification confirming specific training. (Ex. R-1 at 17, 23.) There is no evidence this was done at the Worksite. (Sec’y Reply 10.) As the CSHO explained, the issue is how well the program is actually followed. (Tr. 466.)

c) *Adequate Communication*

JC explained that there was a requirement to be tied off and that the need for fall protection was noted. (Tr. 125-26.) He indicated he had received fall protection training during his initial orientation with Gorick, but the record lacks evidence about the content of that training and how it related to issues and equipment at the Worksite. During his deposition, JC’s testimony differed, and he indicated he only had aerial lift training. (Tr. 111-14.) JC did not recall seeing a site-specific safety plan or the demolition plan. (Tr. 119-21.) JC acknowledged he had not used the type of fall protection system (anchor point/D-ring) in place at the Worksite before. (Tr. 147.)

³⁷ In his reply, the Secretary contends there were issues with the cites of the cases Respondent relies on to support its unpreventable employee misconduct defense. (Sec’y Reply 19.) The Court and Commission staff were able to find the cases with the information provided, both on Westlaw and the Commission’s website. Respondent included the correct case names and Commission docket numbers for these cases. (Sec’y Br. 19; Resp’t Br. 3-4.) The Secretary also claimed that Respondent misquoted *Trinity*, No. 98-0114, 2000 WL 1086716 in paragraph 84 of its opening brief. (Sec’y Reply 19.) That paragraph purports to quote *Dover*, No. 91-862, 1993 WL 275823, not *Trinity*. (Resp’t Br. ¶64.) When citing *Dover*, Respondent neglected to include “OSHC” after “BNA,” but did include the correct case name, docket number, and the citation to the CCH reporter. (Resp’t Br. 25.) The Secretary’s claim that it could not locate *Dover* with the citation information provided is curious, as the Secretary’s opening brief appears to cite to the same CCH reporter Respondent references. (Sec’y Br. 15; Sec’y Reply 19.) Contrary to the Secretary’s contention, the language Respondent quotes is present in *Dover*, albeit in a discussion about knowledge rather than unpreventable employee misconduct. *Dover*, 1993 WL 275823, at *7.

The other injured worker did not testify. Limited training records related to him are part of the record. (Exs. R-8A at 35-37, R-27 at 4-6.) The records do not include details about what was communicated, his understanding of the communication, or the relevance to work being done at this particular Worksite. According to Gorick, its program called for daily job hazard analyses and safety briefings. (Resp't Br. 8, 14.) However, no written records were introduced, to confirm the analyses or briefings occurred. (Tr. 85, 214-15, 228-31.) As the CSHO explained, the strength of the program is in its implementation. (Tr. 466.)

While JC seemed to understand the need for anchor points and fall protection, the record does not reflect he or the other injured employee had adequate instruction about "wrapping lifelines" to a beam system, which Dauley claimed was in use. (Tr. 125, 131-32, 461-63, 466; Ex. C-14.) See *Halmar*, 1997 WL 594393, at *4-5 (work rule not adequately communicated to employees and supervisors); *Armstrong Steel Erectors, Inc.*, No. 97-0250, 1999 WL 72216, at *3 (OSHRC, Feb. 12, 1999) (lack of adequate instruction about use of two lanyards). Without the "wrapping lifelines" option, Dauley knew the anchor point had not been relocated and workers were continuing to engage in work for which fall protection was required. (Tr. 218-20, 461-63; Exs. C-4, C-14.) See *Armstrong*, 1999 WL 72216, at *3 (evidence of supervisors violating 100% tie off rule supported finding defense not met). Gorick did not prove the fall protection safety plan was adequately communicated.

d) Steps to Discover Non-Compliance

Gorick also fell short in terms of discovering violations of its fall protection program. Its safety manager visited the Worksite but did not identify the lack of a written site-specific fall protection plan or that the written training records required by the program were deficient.³⁸

In terms of Dauley's onsite inspections, he knew about two hours before the collapse the employees had not relocated the anchor points as called for by the Demolition Plan. (Tr. 218; Ex. C-7.) His claim that they switched to wrapping lifelines around the upright beam is not credited.

There is no dispute here the employees had ceased to be tied off before the collapse. (Ex. C-14.) JC's testimony, when being led by Gorick's counsel, that they were on slabs 64 and 65 for

³⁸ Tr. 214-15, 228-31; Exs. R-1A, R-8A at 1, 35, R-27. Training records for JC and WH included cards certifying completion of the OSHA 10-hour training ("OSHA 10"). (Ex. R-8A.) Under Respondent's policy, the OSHA 10 must be supplemented by additional training on job specific hazards. (Ex. R-8A at 1.) No records specifically about fall protection or consistent with the certification called for by Respondent's fall protection program were provided. (Tr. 85, 214-15, 228-31.)

only a few minutes, is not credible. (Tr. 135). Dauley admitted he had left the level at least 30 minutes to an hour before the collapse, when the workers were already nearing the completion of the work on Level 2. (Tr. 166, 210-211.) During the time they worked on the last three slabs, he checked on the progress of the work “quite often.” (Tr. 170, 210-12.) Gorick’s suggested timeline of mere minutes is inconsistent with JC’s testimony that the crew first tried the vacuum method and then switched to trying to pry slab 64 up with prybars. (Tr. 115-17.) The time elapsed was long enough for them to switch removal methods and for Dauley to offer to help with the sling. (Tr. 79.) The suggested timeline is also inconsistent with evidence indicating Dauley was involved with the removal of slabs up to the last three (i.e., 63-66) and was then away for 30 minutes to an hour before the collapse.³⁹

During his testimony, JC was not clear and direct during these exchanges about the length of time. His statement to the CSHO on the day of the incident does not indicate he ceased to be tied off for only a few minutes. (Ex. C-14.) JC first said he “couldn’t tell you a number of minutes” he worked on slab 64 without fall protection. (Tr. 131.) Gorick’s counsel then mischaracterized this testimony, indicating JC “said a few minutes.” (Tr. 135.) This was not an accurate summary of JC’s testimony. (Tr. 131.) After that push by counsel, JC explained that they were on the slab before it fell, and after Dauley left the area. (Tr. 135.) Counsel then went further and suggested to JC that it was “less than five minutes.” (Tr. 135.) Dauley was not asked how long the workers were working on slabs 64 and 65, and Gorick did not offer testimony from the other workers involved in the collapse.

Despite looking at the workers “quite often” and interacting with them as they worked on slabs 64 and 65, no action was taken to address the lack of fall protection use. (Tr. 79, 131, 170-71, 174.) As the Commission has long held, it is not enough to have an exemplary program on “paper.” *Am. Sterilizer Co.*, No. 91-2494, 1997 WL 694094, at *5 (OSHRC Nov. 5, 1997). The defense requires appropriate implementation, including diligent efforts to “discover and discourage” violations. *Id.* Gorick’s evidence of diligent steps to discover violations falls short. *See Burford’s Tree, Inc.*, No. 07-1899, 2010 WL 151385, at *4-5 (OSHRC Jan. 8, 2010) (audits occurred but were inadequate).

³⁹(Tr. 166, 168-70, 210-12; Ex. C-4.) Level 2 had 66 slabs. (Ex. R-6.) Dauley had been on Level 2 until the last three slabs. (Tr. 210-12.) Slabs 64 and 65 collapsed but slab 66 remained in place. (Exs. C-2A, C-4.)

e) *Enforcement of Violations*

The final element considers whether Gorick effectively enforced violations. *GEM Indus., Inc.*, No. 93-1122, 1996 WL 710982, at *3 (OSHRC Dec. 6, 1996). The Secretary notes the lack of discipline for JC's and the other employee's failure to remain tied off. (Sec'y Reply 17-19.) Gorick disputes this characterization, citing JC's testimony the post-incident discussion was a "warning," and implying that retraining after the incident was a disciplinary measure. (Resp't Br. 27; Resp't Reply 11.)

First, Gorick cites no precedent for its claim that retraining is discipline. (Resp't Br. 27; Resp't Reply 11.) Second, JC's testimony was inconsistent. When questioned by Gorick's counsel, he indicated that he viewed the incident itself as a warning; he also flatly denied being disciplined. (Tr. 134, 145.) Williams appeared to corroborate this denial of discipline, admitting that Gorick "did not implement the true disciplinary measures as written" after the incident.⁴⁰

Third, Gorick points to no instances of formal, written enforcement of its fall protection rule. (Tr. 85.) In *TNT Crane & Rigging, Inc.*, No. 16-1587, 2022 WL 2102910, at *4-8 (OSRHC June 2, 2022), the Commission concluded there was a lack of adequate enforcement when the employer's business made it likely there would be violations of a specific work rule, but there was evidence of only one instance of enforcement.⁴¹ Gorick has been in business for eighty years and specializes in "heavy" and "large-scale" civil and structural demolition. (Tr. 237-38.) The violation worksheets indicate a size reduction was given for having 26-100 employees. (Exs. C-2A at 2, C-4 at 2.) The lack of any written enforcement violations for a company of Gorick's size and experience is unexpected. Gorick failed to carry its burden on enforcement of its safety program. *See Niagara Mohawk Power Corp.*, No. 76-2414, 1979 WL 8449, at *3 (OSHRC May 23, 1979) (defense not met without evidence of enforcement of the specific safety rule and adequate mechanisms to discover violations); *GEM*, No. 93-1122, 1996 WL 710982, at *3 ("only in a rare

⁴⁰ (Tr. 311, 313-14; Ex. R-28 at 2.) Dauley indicated he did not know if there was discipline for the failure to wear lanyards. (Tr. 175-76.) WH was not at the post-incident meeting Dauley referenced. (Tr. 38-40, 134, 176; Exs. C-1, C-2A.) Respondent also argued that JC was disciplined in the past. (Resp't Br. 17.) The testimony cited does not support this claim. JC did not refer to himself as being previously disciplined, but another employee. (Tr. 133-34.) There is no evidence that the incident JC noted was related to fall protection. Respondent produced no corroboration of any written enforcement of its fall protection rules. (Tr. 85; Exs. R-26, R-28.) Exhibits R-26 and R-28 do not relate to enforcement of fall protection rules.

⁴¹ 2022 WL 2102910, at *4-8. The Secretary cites a case with this same name, but a different Westlaw reference in his Reply. (Sec'y Reply iii, 17.)

case ... where an employer has a long, near-unblemished safety and health history, despite frequent opportunities for violations, can that employer establish that its work rule was effectively enforced by only oral reprimands”).

f) Defense Not Met

Gorick’s claims of adequate instruction and enforcement are undermined by the events on the day of the incident. Two employees failed to tie off, and there was no installed anchor point sufficiently close to their assigned work to permit it.⁴² One employee admitted the equipment was available to install another anchor point, but they did not do so. (Ex. C-14.) Two employees felt comfortable disobeying the work rule. This undercuts Gorick’s claim of adequate enforcement. The Supervisor claimed he frequently looked at employees during the time when they were detached. His supervision was either so cursory that he did not notice none of the three workers were tied off, or he did realize it but failed to act.

Gorick fails to carry its burden of proof on the affirmative defense.

C. Characterization & Penalty

The Secretary contends both violations are appropriately characterized as serious. Gorick does not dispute that if a violation occurred, it would be appropriately characterized as serious. Both items presented fall hazards of over twelve feet. (Tr. 39, 52-53, 175; Exs. C-2A, C-4.) Item 1 also presented the hazard of being stuck-by or caught between concrete. (Tr. 39-40, 53.) The record supports a serious characterization for Items 1 and 2.

Regarding penalties, the Commission must give due consideration to the violation’s gravity, the employer’s size, history, and good faith. 29 U.S.C. § 666(j); *J. A. Jones Constr. Co.*, No. 87-2059, 1993 WL 61950, at *15 (OSHRC Feb. 19, 1993). Generally, gravity is the principal factor to be considered. *Id.* Once a matter is contested, it is for the Commission to determine the appropriate penalty. *Andrew Catapano Enters.*, No. 89-1981, 1994 WL 416684, at *3 n.7 (OSHRC, Aug. 9, 1994) (“the Commission and its judges have authority to assess penalties independent of the Secretary’s proposal.”)

⁴² As discussed, the upright beam/lifeline “wrapping” method was not an alternative because of the lack of necessary equipment. (Tr. 460-63; Exs. C-7A at 1, C-14.) Employees had harnesses, lanyards, and the tools to install an anchor point. (Tr. 118, 125, 266-67; Ex. C-14.) Dauley’s testimony about a rope or lifeline system is rejected.

The Secretary proposed a penalty of \$11,292 for Item 1 and \$8,067 for Item 2.⁴³ He contends the proposed penalty appropriately reflects the gravity of the violations and the other statutory factors. (Sec’y Br. 22-23, 27.) Gorick does not raise any specific arguments about the amount of the proposed penalty.

The severity of both violations was high; the gravity of item 2’s violation was moderate, based on probability, as compared to the high gravity of item 1. (Exs. C-2A, C-4.) Two employees were injured, including one who had to be hospitalized. (Tr. 32, 34, 38-40, 53, 145; Ex. C-4.) The violations presented the potential for serious permanent injuries and death. (Tr. 42, 55-56, 266; Exs. C-2A, C-4.) The gravity and severity of the violations are such that further reductions for good faith or history are not appropriate. (Tr. 42, 55.) Gorick’s size warrants some consideration as it had fewer than 100 employees. (Exs. C-2A, C-4.)

A penalty of \$11,292 is assessed for Citation 1, Item 1. A penalty of \$8,067 is assessed for Citation 1, Item 2.

ORDER

The foregoing decision constitutes findings of fact and conclusions of law in accordance with Commission Rule 90(a)(1). 29 C.F.R. § 2200.90(a)(1). Based upon the foregoing findings of fact and conclusions of law, it is **ORDERED** that as to Citation 1:

1. Item 1, as amended, alleging a violation of 29 C.F.R. § 1926.501(a)(2), is **AFFIRMED** as a serious violation and a penalty of \$11,292 is **ASSESSED**.

2. Item 2, alleging a violation of 29 C.F.R. § 1926.501(b)(1), is **AFFIRMED** as a serious violation, and a penalty of \$8,067 is **ASSESSED**.

SO ORDERED.

/s/

Judge Sharon D. Calhoun
Administrative Law Judge

Dated: September 22, 2026
Washington, D.C.

⁴³ The maximum penalty for a serious violation was \$16,131. 89 Fed. Reg. 1810, 1820 (Jan 11, 2024).