

BEFORE THE ALASKA OCCUPATIONAL SAFETY AND HEALTH REVIEW BOARD

DEPARTMENT OF LABOR AND WORKFORCE)
DEVELOPMENT, DIVISION OF LABOR)
STANDARDS & SAFETY, OCCUPATIONAL SAFETY)
& HEALTH SECTION,)

Complainant,)

vs.)

SNC LAVALIN CONSTRUCTORS INC.,)

Contestant.)

) Docket No. 12-2271
) Inspection No. 314288804
) OAH No. 12-0336-OSH

DECISION AND ORDER

I. Introduction

On March 5, 2012, SNC Lavalin Constructors Inc. (Lavalin) had employees working on a new power generation plant in Anchorage, Alaska. An employee fell through a hole in a catwalk and was fatally injured. The Division of Labor Standards and Safety, Occupational Safety and Health Section (division) investigated the accident and issued one citation. Lavalin contested the citation.

A hearing was held on March 4, 2014 before Occupational Safety and Health Review Board Members Timothy O. Sharp and Thomas A. Trosvig. Board Member James Montgomery, Jr. did not participate. The record was left open to allow the parties to submit written closing arguments. After the written closing arguments were received, the Board Members were unable to reach a decision. Pursuant to 8 AAC 61.160(g), the third Board Member reviewed the entire record and deliberated with the other two Board Members.

After careful consideration of the evidence and arguments, the Board concludes that the accident was caused by unavoidable employee misconduct.

II. Facts

The underlying facts are not in dispute. Lavalin was constructing a new power generation plant for Chugach Electric. Q B was an experienced journeyman pipefitter who was employed by Lavalin. At the time of the accident, he was the foreman of a crew of approximately 10 pipefitters.

The generation plant had several tall generators, each surrounded by three levels of catwalks. The first level catwalk was 16 feet, ten inches above the ground floor. The second level catwalk was 8 to 12 feet¹ above the first level catwalk, and the third level catwalk was 8 to 12 feet above the second level. As part of the construction process, it was necessary to attach two large-diameter pipes vertically to the sides of each generator. The pipes were more than 40 feet long. Holes were cut in the catwalk so the pipes could be hoisted and then welded into the correct position.

On the afternoon of March 5, 2012, pipes had been hoisted in position. The pipes extended through the catwalk on levels two and three, but the lower ends of the pipes stopped short of the catwalk on level one. This left an unobstructed hole in the catwalk that was approximately three feet wide by five and one half feet long. This hole was left uncovered.

Towards the end of the work shift, Mr. B's crew was working on either level two or three. Mr. B went alone to level one of the catwalk to take a measurement. He was wearing his safety harness with two lanyards for attaching to anchorage points for fall protection. While on the catwalk, Mr. B fell through the hole. No one witnessed the accident, and no one heard him make any noise as he fell.

III. Discussion

A. Ruling on Motion to Amend Complaint

The citation originally issued by the division alleged a violation of 29 CFR 1226.501, which relates to fall protection. Specifically, the citation alleged a failure to provide covers over holes on a walking or working surface:

(4) Holes

* * *

(ii) Each employee on a walking/working surface shall be protected from tripping in or stepping into or through holes (including skylights) by covers.^[2]

The factual allegation to support this citation was stated as:

An employee was exposed to a fall hazard due to the employer[']s failure to ensure that a grating platform hole was covered on March 5th 2012. Two pieces of the platform grating had been removed at 9:AM to allow piping to be hoisted to the top level of the generator platform. The employee climbed to the first level

¹ The witnesses provided different estimates of this height. There was no dispute, however, that a person could not reach to the beams supporting the next higher catwalk without standing on a ladder.

² Citation 1, Item 1(Exhibit A to complaint) (quoting 29 CFR 1926.501(b)(4)(ii)).

platform of the ox transfer skid generator (OTSG) to measure the distance between the steam pipe and adjacent I-beam. The employee fell through the grate opening to the first floor. (Distance 16 feet 9 inches) there were no witnesses to the accident.^[3]

Lavalin moved for summary adjudication, arguing that subsection 501(b)(4)(ii) only applied to holes that were not more than six feet deep. Since it was undisputed that the hole in the grating was more than 16 feet above the ground floor, Lavalin argued that it was entitled to judgment in its favor as a matter of law. While the division disputed Lavalin’s legal argument, it also filed a motion to amend its complaint. It sought to change the allegation to assert a violation of 29 CFR 1926.501(b)(4)(i). This provision says

Each employee on walking/working surfaces shall be protected from falling through holes (including skylights) more than 6 feet (1.8 m) above lower levels, by personal fall arrest systems, covers, or guardrail systems erected around such holes.

The procedural rules for hearings are set out in 8 AAC 61.160 – 220. These rules are intended to “facilitate business and promote a speedy and just resolution of contested cases.”⁴ Where there is no applicable rule, the Review Board is governed by the Civil Rules of Procedure.⁵ Neither party cited to a specific regulation governing amendment of complaints. Thus, Civil Rule 15 is applied. Under Civil Rule 15, an order permitting amendment of a complaint “shall be freely given when justice so requires.”⁶

As quoted above, the example in the original citation says nothing about personal fall arrest systems. It states only that a violation occurred because the hole in the grating was not covered. The division responded by stating there is no requirement that a citation include all factual allegations. A citation must, however, “describe with particularity the nature of the violation[.]”⁷ The original citation in this case did that. It stated that an employee was exposed to a hazard because the hole in the grating was not covered.

Although the division argued that it had no intention of amending its factual allegation,⁸ it needed to do so. If the factual allegation was not changed, the division would only have been asserting that a violation occurred when an employee was exposed to a hazard *because the hole*

³ Citation 1, Item 1.

⁴ 8 AAC 61.170(b).

⁵ 8 AAC 61.170(a).

⁶ Civil Rule 15(a).

⁷ AS 18.60.091(a).

⁸ See Memorandum in Support, page 3 (“The [division] does not seek to change the example, nor does the [division] intend to alter the factual basis supporting the citation”).

in the grating was not covered. Both 29 CFR 501(b)(4)(i) and (ii) speak to protecting employees by covering holes. What the division wanted to prove at the hearing, however, was not the hole had to be covered, but that

SNC-Lavalin’s policies and practices related to personal fall arrest systems did not actually guard against the fall hazard created by the hole in the platform grating.^[9]

Nothing in the original citation alleged inadequate policies or practices. Thus, the division was raising a new factual allegation. It claimed that the hole in question was not properly protected because of inadequacies in the personal fall arrest system, which included alleged inadequacies in the policies or practices related to that system.

The Board interprets its rules in a way that will promote the just resolution of complaints. The division should have informed Lavalin earlier that it believed its policies or practices were deficient, but neither the parties nor the public should be deprived of a just resolution on the merits because of any delay that does not cause significant prejudice to the opposing party.

Lavalin argued that it would be unduly prejudiced by the amendment. It asserted “discovery is closed, the deadline for dispositive motions has passed . . . and the hearing is scheduled to occur in less than two months.”¹⁰ It noted that it had already spent time and resources addressing the original citation, and that it should not be burdened with additional litigation. This prejudice is real, but it is not sufficiently prejudicial to preclude the division’s request to amend. Under the circumstances of this case, there was time to allow a continuance if requested by Lavalin, and time to permit Lavalin to file a new dispositive motion based on the new factual allegations.

The situation here is distinguished from *State v. Bourne Contracting*¹¹ where permission to amend a complaint was denied. In *Bourne*, the Board was concerned that “Bourne is a small business in financial difficulty and is not in a position to afford legal representation to respond to the [division’s] changing theories of liability.”¹² There is no evidence that Lavalin is struggling financially, and it does not appear that the change in the factual allegations would impose more than a minimal amount of additional costs on Lavalin.

⁹ Reply Memorandum, page 4.

¹⁰ Opposition, page 8.

¹¹ Docket No. 93-1010 (Occupational Safety and Health Review Board 1994).

¹² *Bourne*, page 5.

Although a close question, the Board concluded that Lavalin would not be unduly prejudiced by the amended complaint. The Board directed the division to provide a new descriptive statement for its citation, and gave Lavalin an opportunity to request a continuance to address the amended complaint. Because the amendment was permitted, Lavalin's motion for summary adjudication was denied as moot.

B. Were Employees Protected by Fall Arrest Systems?

An employer in Alaska must protect the safety of its employees, including providing “a place of employment that is free from recognized hazards that are likely to cause serious physical harm to its employees.”¹³ In deciding whether the employer has provided a place of employment free from recognized hazards, the Board looks to the federal OSHA standards.¹⁴ Under the applicable federal standard quoted above,¹⁵ an employee is not protected from a recognized hazard if the employee is exposed to a hole more than six feet deep, and the employee does not have a personal fall arrest system or the hole is covered or has a guardrail system around it. It is undisputed that the hole was not covered or protected by a guardrail. There is also no dispute that Mr. B was not using his personal fall protection system at the time of the accident. The division has met its burden of proving that Mr. B was exposed to a hazard without adequate protection.

C. Unavoidable Employee Misconduct

1. Introduction

Even where an employee is injured, the employer is relieved of responsibility for a violation if the employer can show that the violation occurred due to unavoidable employee misconduct.¹⁶ This is an affirmative defense for which Lavalin has the burden of proof.¹⁷ To prevail on this defense, Lavalin must satisfy four requirements: 1) the employer must have a rule¹⁸ that addresses the safety concern raised by the violation; 2) the rule must have been adequately communicated to the employee; 3) the employer must take reasonable steps to

¹³ *In re Kiewit Cornerstone JV*, OAH No. 08-0640-OSH (OSHRB 2010), page 4.

¹⁴ *See* 8 AAC 61.1010 (adopting federal standards with some exceptions).

¹⁵ 29 CFR 1926.501(b)(4)(i).

¹⁶ *In re Alcan Electric Engineering, Inc.*, OAH No. 07-0079-OSH (OSHRB 2008), page 3.

¹⁷ *Alcan Electric*, pages 3 – 4.

¹⁸ This need not be a written rule. *In re Sandstrom and Sons, Inc.* OAH No. 11-011-OSH (OSHRB 2012), page 5 n 16 available at <http://aws.state.ak.us/officeofadminhearings/Documents/OSH/OSH110011.pdf>.

discover the violation; and 4) the employer must show that it enforced the rule when violations occurred.¹⁹

2. *Lavalin's Rule Concerning Fall Protection*

Lavalin required some type of “fall protection” when there was a potential to fall six feet or more.²⁰ “This shall require the use of a double lanyard by individuals required to secure themselves from falling.”²¹

This applies wherever there is a potential for any person to fall 6 feet or more, or to gain access to within 10 feet of an open edge from where there is the potential to fall 6 feet or more[.]²²

The division argues that this policy does not adequately protect employees from falls because it was impractical or infeasible for Mr. B to use his lanyard system at the location of the accident.

Use of the lanyard system required attaching one end of the lanyard to a secure tie off point. The other end was attached to a harness worn by the employee. Lavalin used a variety of means to create those tie off points, including beam straps – webbing that went around a beam – and beamers – movable devices that clamped on to a beam. There was testimony that there was a shortage of web straps and beamers, and that employees often had to spend significant amount of time trying to locate that equipment so they could use their lanyard systems to tie off.

In addition, there was testimony concerning how difficult it would have been to use the lanyard system at the location of the accident. Because there were no beamers or web straps already in place, placing them in appropriate locations would have been a multi-step process. In addition to the time it might have taken to locate the equipment, Mr. B would have needed to climb a ladder to install a beamer on the ceiling above. This first tie off would have been at least ten feet from the hole. He then would have had to place another beamer closer to the hole while tied off to the first one. He would then have had to go back to unhook the first lanyard. This process would have to be repeated several times until he had crossed the hole and taken his measurement.²³

¹⁹ *Alcan Electric*, page 4.

²⁰ Record at 204.

²¹ *Id.*

²² *Id.*

²³ A system of beamers and beam straps had been put in place on the third level where Mr. B's crew was actively working that day.

It would have been time-consuming for Mr. B to have used his fall arrest system to protect himself at the time of the accident, but that does not detract from the existence of this rule.

The Board acknowledges that for this particular hazard, a fall arrest system may not be the best method for protecting employee safety. The hole had been left uncovered for much longer than necessary for the tasks being accomplished that day. It would have been relatively easy to replace the grating or cover the hole with a sheet of plywood. However, employers need not provide the best method as long as they provide an adequate method of protection. Lavalin has shown that it had a rule in place which would have protected Mr. B if the rule had been complied with.

3. Lavalin's Rule Was Adequately Communicated

The next factor is whether employees were adequately informed of the rule. Lavalin's training materials state that some form of fall protection is required at all times at or above six feet.²⁴ The training material goes on to describe fall protection as including eliminating the hazard through engineering, guardrails, covers, and fall arrest equipment worn by the employee.²⁵ As noted above, when there is an uncovered hole with no guardrail, employees were required to use a fall arrest system within ten feet of the hole's edge.²⁶

Based on the testimony at the hearing, employees were confused about the details of this policy. Patrick Ridenour, who was a pipefitter foreman at the time, testified that employees were supposed to tie off "when you were within a certain distance to a hole in decking, when you were on the scaffold that was required for you to be tied off. Possibly when you were on not a structural foot path."²⁷ You had to have a harness on anytime you were six feet above ground, but didn't always have to tie off.²⁸ Tying off was not always required because a lot of the time the employee would be on a permanent structure like a platform or staircase where handrails or other protective devices were already installed.²⁹

²⁴ Lavalin's Exhibit 1, page 40.

²⁵ Lavalin's Exhibit 1, pages 40 – 43.

²⁶ Record at 204.

²⁷ Tr. 190

²⁸ Tr. 191.

²⁹ Tr. 191 – 192.

Another foreman, Toby Tolbert, testified that employees had to wear their harnesses 100% of the time above ground level so you could tie off if needed.³⁰

Safety Manger Steven Rowe testified that employees had to wear their harnesses anytime they were six feet or more above the ground, and they had to tie off when they were within six feet of a hole.³¹

The evidence shows that employees knew they needed to tie off near an opening, though at least some of them thought the distance was six feet rather than ten. In this case, the difference in the distance is not relevant. The relevant issue is whether Mr. B had been adequately informed that when he approached the hole on the day in question, he needed to be tied off. Lavalin has proven that it is more likely true that this policy had been communicated to him as well as to Lavalin's other employees.

4. Lavalin Took Reasonable Steps To Discover Violations

Reasonable steps were taken to discover violations of this policy. In addition to safety meetings, Lavalin had five safety professionals who conducted daily walkthroughs of the job site.³² These professionals could reasonably be expected to discover safety violations and take appropriate action when violations were discovered.

5. Lavalin Enforced The Rule When Violations Occurred

Using the fall protection was a zero tolerance policy, which meant an employee would be terminated for failing to tie off.³³ Lavalin did in fact terminate employees for this violation.³⁴

6. Summary

When a safety violation is committed by a supervisor the unavoidable employee misconduct rule is strictly construed.³⁵ In this case, Mr. B was in a supervisor position. He was expected to follow and enforce the workplace policies, including the policy of using his fall arrest system at the time of the accident. However, Lavalin has shown that 1) it had an appropriate policy in place, 2) employees were aware of the policy, 3) it took reasonable steps to discover violations, and (4) that it disciplined employees for violating the policy. Lavalin did

³⁰ Tr. 251.

³¹ Tr. 285; Tr. 295.

³² Tr. 282 – 284; 288 – 290.

³³ Tr. 285 – 286.

³⁴ Record at 268; 271; 273; 275; 277

³⁵ *In re Alan Electric Engineering, Inc.*, OAH No. 07-0079-OSH (OSHRB 2008), page 6.

what it reasonably could do to ensure that all employees tied off when they were near holes more than six feet deep.

IV. Order

Lavalin has shown by a preponderance of the evidence that the accident was caused by unavoidable employee misconduct. Accordingly, it is not responsible for the accident and citation 1, item 1, as amended on April 9, 2013, is VACATED.

ENTERED at the direction of Board Members Thomas A. Trosvig and James Montgomery, Jr.
June 3, 2014.

Signed

Jeffrey A. Friedman

Administrative Law Judge

DISSENTING BOARD MEMBER'S OPINION

I respectfully disagree with the majority's decision.

As we stated in *In re Alcan Electrical Engineering, Inc.*, the focus should be on the "effectiveness of the employer's safety program and not whether the employee misconduct is by a supervisor as opposed to an employee."³⁶ There was testimony during this hearing that the effectiveness of the safety program was undermined early on. Lavalin's safety program relied on personal fall protection which, in turn, required the use of portable anchoring devices. Unfortunately, some of the crews, particularly the Ironworkers, appropriated these devices for their own use, making them unavailable to others when needed. Management did nothing to discipline those responsible, and did not provide sufficient quality type anchors to replace those being hoarded.

Lavalin's position at this hearing was that if someone asked for an anchoring device, or went to look for one, a device would be available (at some point). Lavalin's lack of concern about the hoarding of these devices, however, communicated an underlying view to the workers that real safety was not truly held to the standards represented by Lavalin. If it is okay for one craft to hoard safety equipment so they can work more efficiently, then it is not okay for others to slow production while searching for their own safety equipment. Over time this seemed to cause a resigned malaise regarding workers' feelings towards the "seriousness" of the safety program.

³⁶ OAH No. 07-0079-OSH (OSHRB 2008), page 6.

I also do not place much weight on the fact that Lavalin gave Mr. B the title of supervisor. The idea that supervisors are expected to set an example and enforce safety rules arises from an assumption that the supervisors have additional experience with and knowledge of the company's safety culture and procedures. They are expected to have a greater degree of attachment to the company they work for because they are not temporary employees. Mr. B had only recently been hired, along with several other Journeymen pipefitters. His job with Lavalin would have ended once the construction had been completed. His appointment as the supervisor was more "the luck of the draw" based on who was available at the requested particular skill set level, than anything to do with his unique knowledge of Lavalin's safety procedures and safety culture. There is no reason to treat his actions with regard to safety equipment differently than we would treat the actions of any other short-term journeyman employee.

Finally, Lavalin's safety program seems to be more effective at showing on paper that Lavalin covered its safety responsibilities proportionally respective to potential fines and liabilities than one designed to promote safety. Lavalin used a Red Rope Zone procedure, whereby a foreman could obtain a red rope permit, and block off a danger area with red rope. But there was no evidence of management routinely inspecting these zones to see if they were effective or appropriate means to manage specific risks. Similarly, simply stating that employees were required to "tie off" when there was a risk of falling is not effective where tying off is difficult or impossible due to the lack of anchoring devices.

The ineffectiveness of Lavalin's safety policy can be clearly seen here. There was a large hole with a fifteen foot drop to a concrete floor below. The red rope may have alerted Mr. B to the presence of that hole, but there were no easily accessible tie off points, safety equipment was not always readily available, and safety practices were not regularly audited. This accident was not caused by unavoidable employee misconduct. It was the easily anticipated result of leaving a large hole in the floor uncovered in a situation where it was extremely difficult to obtain and use personal fall protection anchoring devices.

ENTERED at the direction of Board Member Timothy O. Sharp,
June 3, 2014.

Signed _____
Jeffrey A. Friedman
Administrative Law Judge

[This document has been modified to conform to the technical standards for publication.]