

BEFORE THE ALASKA OCCUPATIONAL SAFETY AND HEALTH REVIEW BOARD

State of Alaska, Department of Labor and)
Workforce Development, Division of Labor)
Standards and Safety, Occupational Safety)
and Health Section,)
)
Complainant,)
)
v.)
)
Hartman Construction & Equipment, Inc.,)
)
Contestant.)

Docket No. 15-2286
Inspection No. 1071374
OAH No. 16-0192-OSH

DECISION AND ORDER

I. Introduction

On June 16, 2015, employees of Hartman Construction & Equipment, Inc. (“HCE”) were replacing wastewater pipe in a trench within a subdivision in Anchorage owned by a principal of HCE. One of the employees, T N, was standing in the trench when one wall of the trench collapsed, trapping him up to about his waist in tons of soil and rubble. Mr. N suffered grievous injuries and died shortly after HCE employees had dug him out of the collapsed material. The Alaska Department of Labor, Division of Labor Standards and Safety, Occupational Safety and Health Section (AKOSH) investigated the incident and issued a citation to HCE.¹ HCE contested each of the items in the citation.

A hearing was held on October 5 through 7, 2016 before Occupational Safety and Health Review Board members Keith Montgomery, Anthony E. Barnard, and Thomas A. Trosvig. Testimony was taken from David Hartman, Derek Hartman, AKOSH chief of enforcement James “Ron” Anderson, AKOSH safety enforcement officer Seth Hansen, Municipality of Anchorage plan review engineer and inspector Pamela Ronning, State of Alaska Medical Examiner Dr. Cristin Rolf, and Dr. Norman Means, a former Alaska medical examiner called as an expert witness by HCE. The record was left open to allow the parties to submit written closing arguments. After the written closing arguments were received, the Board members conferred and reached a decision. After carefully considering the evidence and arguments

¹ AKOSH issued one citation containing eight separate “items” to HCE; throughout this proceeding, however, the parties and the Board often referred to the items as separate citations.

presented by the parties, the Board finds HCE liable for five willful violations of OSHA standards, as further described below.

II. The citation

The eight items of the citation issued by AKOSH to HCE are briefly described below. AKOSH classified each of the items as “willful-serious” violations, see No Name a penalty of \$70,000 for each violation, for a total proposed penalty of \$560,000.² Each of the items cites a specific section of federal OSHA regulations, because AKOSH has by regulation adopted the federal regulations covering trench and excavation safety.³

1. Citation 1, Item 1

AKOSH alleges in this item (“item 1”) that HCE violated the “general duty clause” of AS 18.60.075(a)(4), which requires that the “employer shall do everything necessary to protect the life, health, and safety of employees including ... (4) furnishing to each employee employment and a place of employment that are free from recognized hazards that, in the opinion of the commissioner, are causing or are likely to cause death or serious physical harm to the employees.”⁴

2. Citation 1, Item 2

AKOSH alleges in this item (“item 2”) that HCE violated 29 CFR 1926.651(c)(2), “specific excavation requirements,” which requires that in trenches that are at least four feet deep, the employer must provide means of egress in the form of stairways, ladders or ramps no more than 25 feet apart.⁵

3. Citation 1, Item 3

AKOSH alleges in this item (“item 3”) that HCE violated 29 CFR 1926.651(j)(1), “specific excavation requirements,” which requires: “Adequate protection shall be provided to protect employees from loose rock or soil that could pose a hazard by falling or rolling from an excavation face. Such protection shall consist of scaling to remove loose material; installation of protective barricades ... as necessary to ... stop and contain falling material; or other means that provide equivalent protection.”⁶

² Willful-serious violations are the most severe level of citation that AKOSH can impose on an employer.

³ 8 AAC 61.1010(b).

⁴ Contestant’s Exh. A, p. 5 (AKOSH’s citation was entered into the record as part of HCE’s exhibits).

⁵ *Id.*

⁶ Contestant’s Exh. A, p. 6.

4. Citation 1, Item 4

AKOSH alleges in this item (“item 4”) that HCE violated 29 CFR 1926.651(j)(2), “specific excavation requirements,” which requires that “[e]mployees shall be protected from excavated ... materials ... that could pose a hazard by falling or rolling into excavations,” by requiring that such materials be placed or kept “at least 2 feet from the edge of excavations.”⁷

5. Citation 1, Item 5

AKOSH alleges in this item (“item 5”) that HCE violated 29 CFR 1926.651(k)(1), “specific excavation requirements,” which requires that “[d]aily inspections of excavations, the adjacent areas, and protective systems shall be made by a competent person for evidence of a situation that could result in possible cave-ins... or other hazardous conditions.”⁸

6. Citation 1, Item 6

AKOSH alleges in this item (“item 6”) that HCE violated 29 CFR 1926.652(a)(1)(ii), “requirements for protective systems,” which requires that employees “in an excavation shall be protected from cave-ins by an adequate protective system ... except when [e]xcavations are less than 5 feet ... in depth and examination of the ground by a competent person provides no indication of a potential cave-in.”⁹

7. Citation 1, Item 7

AKOSH alleges in this item (“item 7”) that HCE violated 29 CFR 1926.652(b)(1)(i), “requirements for protective systems,” which requires that “[e]xcavations shall be sloped at an angle not steeper than one and one-half horizontal to one vertical (34 degrees measured from the horizontal)”¹⁰

8. Citation 1, Item 8

AKOSH alleges in this item (“item 8”) that HCE violated 29 CFR 1926.652(c)(2)(i), “requirements for protective systems,” which requires that “[d]esign of support systems, shield systems, or other protective systems that are drawn from manufacturer’s tabulated data shall be in accordance with all specifications ... issued or made by the manufacturer.”¹¹

⁷ Contestant’s Exh. A, p. 7.

⁸ Contestant’s Exh. A, p. 8.

⁹ Contestant’s Exh. A, pp. 8-9.

¹⁰ Contestant’s Exh. A, p. 9.

¹¹ Contestant’s Exh. A, p. 10.

III. Findings of Fact

Based on a review of all the evidence presented by the parties in this matter, the Board makes the following findings of fact pertinent to the incident that resulted in the death of T N.

A. Factual background

HCE is an Alaska corporation owned by David Hartman and Linda Hartman. The subdivision where the incident in question occurred, called the No Name subdivision, is located at No Name Avenue and No Name Street in Anchorage.¹² It is owned by Mr. Hartman in his individual capacity.¹³ At the time of the incident in June 2015, the Hartmans and HCE had been involved in the development of the subdivision for at least ten years and had invested considerable sums in its development.¹⁴

Mr. Hartman testified on direct examination during the hearing that prior to receiving the citation at issue in this matter, neither he nor HCE had ever been cited by AKOSH for a safety violation, and specifically not for a trench-related safety violation. Under cross-examination, however, his recollection having been refreshed by documents shown to him by AKOSH's counsel,¹⁵ Mr. Hartman admitted that his sworn testimony had been incorrect. He acknowledged that in fact HCE had received such a citation for allegedly unsafe trench work at the No Name subdivision in 2005. Mr. Hartman asserted that he had simply forgotten about the 2005 citation when responding to questions from HCE's counsel. Mr. Hartman recalled that the matter concerned work performed by an HCE subcontractor and that HCE had retained counsel, had contested the citation, and had entered into a settlement agreement to resolve the matter.¹⁶

In the late summer and fall of 2014, HCE was involved in doing trench work in the subdivision as part of the installation of water pipes along No Name Ave. On October 16, 2014, Mr. Hartman received an email from Kent Kohlhase, Pamela Ronning's supervisor in the

¹² SOA 000001 (subdivision agreement).

¹³ David Hartman testimony.

¹⁴ *Id.*

¹⁵ AKOSH did not timely disclose these documents to HCE, as required by the Board's pre-hearing scheduling order, and in fact first disclosed the existence of these documents during Mr. Hartman's cross-examination on the final day of the hearing, October 7, 2016. AKOSH's counsel explained that AKOSH staff were not aware of the documents until discovering them on the morning of October 7; they had not been found prior to the hearing, because at that time staff had only searched for HCE-related documents dating back five years before the June 2015 incident. Because of the late disclosure, the 2005 documents were not admitted into the record, but AKOSH was allowed to show them to Mr. Hartman to refresh his recollection.

¹⁶ David Hartman testimony.

Municipality of Anchorage (“MOA”) Development Services Department, stating the following concerns:

Looking at the middle picture in the right hand column, it appears that trench is not shored or otherwise configured to conform with OSHA trench standards. I strongly recommend that you review the OSHA standards and ensure that your excavations and operating procedures are in compliance.¹⁷

When Mr. Hartman was questioned about this email at the hearing, the referenced photograph of the trench in question was not attached to the email or otherwise available for his review.¹⁸ Mr. Hartman testified that he did not recall exactly where the trench referenced in the email was located. He did recall other details, however, testifying that “I studied the picture and I didn’t see any problem with what he was alluding to;” he further recalled that the trench in question was “very sloped,” and that he “didn’t believe there was any problem with what they were doing there.” He testified that, based on this belief, he and HCE took no additional precautions in their trench work in the subdivision as a result of receiving Mr. Kohlhase’s email.¹⁹ Neither party questioned Mr. Hartman regarding his emailed response to the Kohlhase email, in which he stated “Will do. This was an unusual case as we were trying to maneuver in tight quarters.”²⁰

The following year, certain wastewater piping in the vicinity of the No Name Ave. roadbed was determined by MOA to not meet municipal codes, so HCE was required by MOA to dig up and replace the pipe. Beginning in mid-June, therefore, HCE dug a trench parallel to and on the north side of the No Name Ave. roadbed (moving from east to west), and began the process of replacing the pipe. The process involved digging the trench to a depth under the pipe; removing the pipe; replacing it with new pipe; covering the pipe with specified material; then refilling the trench in one-foot “lifts,” using the material that had been dug from the trench (referred to as “spoil”). That material would then be mechanically compacted by HCE workers. After the compacting was checked and approved by an engineer, additional one-foot lifts would be put in

¹⁷ SOA 000698. HCE objected to admission of this email, because AKOSH did not offer it for admission until the administrative law judge conducting the hearing for the Board suggested it might be relevant, after AKOSH had rested its case. After discussion regarding HCE’s objections was held outside the presence of the Board, the email was admitted so that AKOSH could question David Hartman regarding its content. As further discussed below, the Board did not find Mr. Hartman’s testimony regarding the email credible.

¹⁸ It is noted that, although the photograph in question was not available for review at the hearing, it appears to be located at SOA 000785. The Board has not reviewed the photograph or otherwise considered it in its deliberations in this matter.

¹⁹ David Hartman testimony.

²⁰ SOA 000698.

place and compacted, until the trench was refilled to a certain depth. The trench would not be completely filled in until after the new wastewater pipe had passed an MOA inspection.²¹

The trench had reached a length of approximately 100 feet at the time of the incident in question on June 16, 2015. As the trench had been extended from the east to the west, its depth gradually increased due to fluctuations in the height of the adjacent roadbed.²² At the time of the incident, the south wall of the trench (adjacent to No Name Ave.) at the site of the accident was approximately six feet tall, while the north wall of the trench was approximately four feet tall. The piles of material excavated by HCE in digging the trench, so-called “spoil piles,” however, were placed immediately to the north of the trench wall, effectively increasing the height of the north wall by several feet.²³ Both the north and south walls of the trench were nearly vertical, rather than being sloped or benched as required under OSHA regulations.²⁴

At that time, to the east of the trench in question, there was an unused section of roadbed in front of a building occupied by EP Roofing, running parallel to but at a lower level than the No Name Ave. roadbed being used by traffic in and out of the subdivision. In late May or early June 2015, a small section of the edge of the No Name Ave. roadbed broke off or “sloughed” into the lower roadbed area to the north.²⁵ Mr. Hartman placed orange traffic cones around the slough area to warn vehicles of the dropoff. Although the Hartmans were fully aware of this slough, they took no additional precautions in their work in the No Name Ave. trench as a result of observing the slough.

At the time that HCE was performing its excavation work along No Name Ave., Mr. Hartman was generally aware of the AKOSH regulations regarding protection of employee safety in trench work.²⁶ However, he was not aware of many of the specific requirements of the regulations, and he did not conduct any research, undertake any training or educational efforts, or make inquiries to knowledgeable persons or agencies to learn the specific requirements.²⁷

As of the early summer of 2015, HCE employed only Mr. Hartman and his two sons,

²¹ David Hartman testimony.

²² *Id.*

²³ Anderson testimony. Photographs of the site show that the additional height added by the spoil piles varied along the length of the trench.

²⁴ The trench was benched to a minor degree near its east end, far away from the site of the accident.

²⁵ David Hartman testimony. Neither David Hartman nor Derek Hartman could recall exactly when this slough occurred.

²⁶ *Id.*

²⁷ *Id.*

Derek and Chad Hartman. T N was hired by HCE in late May or early June of 2015 to work as a laborer. Mr. Hartman testified that as of the date of the accident, Mr. N had not “even been employed long enough to fill out the paperwork to receive a paycheck.”²⁸

B. The accident

Other than T N, David Hartman was the only witness to the actual trench collapse itself on June 16, 2015. Mr. Hartman and his two sons, Derek and Chad, were the only witnesses to the attempted rescue of Mr. N. Chad Hartman did not testify at the hearing. The following discussion of the facts, therefore, is primarily based on David and Derek Hartman’s testimony, while taNo Name into account the Board’s credibility findings as discussed below.

On the morning of June 16, 2015, T N sent a text to Mr. Hartman saying that he was not feeling well; Mr. Hartman replied that he should take the day off.²⁹ As a result Mr. N was not at the jobsite during the morning hours. Mr. Hartman and his sons spent the morning excavating a portion of the wastewater pipe that they were in the process of replacing. On that morning, Scott Crowther, an engineer under contract to HCE to test soil compaction in the trench as it was being refilled, was on the jobsite. During the morning, both of the Hartman sons were in the trench handling the pipe and compacting soil, and Mr. Crowther was in the trench performing compaction testing.³⁰ At about noon, Derek and Chad Hartman went to eat lunch with their mother, Linda Hartman, near an adjacent building about 200 feet away from the excavation, while Mr. Hartman continued worNo Name.³¹ Mr. Crowther apparently left the jobsite for lunch.

At this point in time, there were no ladders in the trench; there was a sloping dirt ramp at the east end of the trench.³² Mr. Crowther’s testing equipment and HCE’s soil compacting machines were sitting at the bottom of the trench in the area near its west end where compacting and testing had been done that morning.³³

While the others ate lunch, Mr. Hartman was operating a small Hitachi excavator at the west end of the trench, digging out soil from around and beneath a sewer pipe that ran perpendicular to the axis of the trench, in preparation for installing another piece of wastewater

²⁸

Id.

²⁹

David Hartman testimony.

³⁰

Ronning testimony.

³¹

David Hartman testimony; Derek Hartman testimony.

³²

David Hartman testimony; Anderson testimony.

³³

See, e.g., Exhibit D17; David Hartman testimony.

pipe underneath the sewer line. Mr. Hartman testified that he was concentrating on that task when he saw Mr. N out of his peripheral vision, standing in the trench about 30 to 40 feet away (to the east). According to Mr. Hartman, he was surprised to see Mr. N on the jobsite and in the trench, and he told him they were done worNo Name in the trench and he needed to get out of there. Seconds later, in Mr. Hartman’s words a “massive chunk of earth came off of the south side of the excavation and crushed him up against the hard north-face wall” of the trench, burying him about up to his waist.³⁴

Mr. Hartman testified that Mr. N turned away from the collapsing earth to try to escape, and was facing north when forced up against the wall. Mr. Hartman immediately “walked” the small excavator to a point directly opposite (south) of where N was trapped, and extended the excavator arm to attempt to dig out the soil collapsed against Mr. N. Mr. Hartman determined, however, that the arm was too short to be of any useful effect. At about the same time, Mr. Hartman yelled to his wife and sons to come and help. Derek Hartman then jumped in a larger Hitachi excavator and walked it a few yards to put it in position to dig out the collapsed material. First Chad Hartman, and moments later David Hartman, jumped in the trench and directed Derek’s maneuvering of the excavator arm and bucket to keep it away from Mr. N. David Hartman testified that only two or three scoops of the excavator bucket were needed to cause most of the collapsed material to fall away from Mr. N. Both David and Derek Hartman also testified that the bucket never came closer than about two feet from Mr. N.³⁵ David and Chad Hartman completed the process of digging him out with shovels and their hands. According to David Hartman, Mr. N was freed from being entrapped within three to four minutes of the trench collapse.³⁶ Derek Hartman stated that Mr. N remained conscious and was talNo Name until shortly after he was freed.³⁷

In the meantime, Mrs. Hartman called 911 to report the accident. Anchorage Police Department (“APD”) and Fire Department (“AFD”) personnel arrived on the scene within a few minutes of the initial call. APD and AFD personnel did not go into the trench, because Municipal policy prohibited them from going into an unstabilized and dangerous excavation. Eventually AFD personnel provided an extension ladder on which the Hartmans placed Mr. N,

³⁴ David Hartman testimony.

³⁵ *Id.*; Derek Hartman testimony.

³⁶ David Hartman testimony.

³⁷ Derek Hartman testimony

and he was lifted out of the trench.

Mr. N had suffered grievous injuries to his pelvis area, which included “comminuted” fractures of the pelvic bone (i.e., fractures at multiple points of the bone) and numerous traumatic injuries to organs and blood vessels in the groin area. He was still alive when the Hartmans freed him from being entrapped by the collapsed trench material, but he died shortly after being lifted out of the trench. The cause of Mr. N’s death was blood loss from injuries to his blood vessels and organs.

AKOSH investigator Seth Hansen and chief of enforcement Ron Anderson arrived at the accident scene shortly after Mr. N had passed away. Mr. Hansen and Mr. Anderson spoke with several of the APD officers on the scene, at least one of whom opined that Mr. N appeared to have been “gutted with a spoon,” suggesting that one of the excavators had caused his injuries.³⁸ Mr. Hansen and Mr. Anderson briefly spoke with the Hartmans and engineer Scott Crowther.³⁹ The Hartmans commented at that time that Mr. N’s injuries must have been caused by the tape measure that had been hanging down from his belt when he got into the trench; they speculated that the blade of the tape measure released from its case and the pressure of the collapsed trench material caused the blade to lacerate Mr. N’s arteries. Hansen and Anderson did not formally interview the Hartmans, but arranged to do so in the near future.⁴⁰ At some point in the aftermath of the accident, an APD officer apparently removed dark soil-like material from one of the tines on the bucket of the small excavator for the purpose of having it tested to determine if it contained blood.⁴¹ However, no testimony or other evidence was presented at the hearing as to whether such testing was actually performed or, if so, the results of the testing.

C. Expert testimony

1. Dr. Rolf

AKOSH did not present testimony from a retained expert witness regarding Mr. N’s injuries or the cause of his death. AKOSH instead called as a witness Dr. Cristin Rolf, the state medical examiner who performed Mr. N’s autopsy. After the autopsy, Dr. Rolf authored a death certificate and an autopsy report, both of which were entered into the record as part of HCE’s

³⁸ The names of these APD officers were not recorded by Mssrs. Hansen and Anderson.

³⁹ Crowther confirmed at that time that he had not witnessed the trench collapse.

⁴⁰ David, Derek and Chad Hartman all participated in formal interviews with AKOSH about three weeks later, at which time they were represented by HCE’s then-counsel, Kevin Brady.

⁴¹ Exh. B2, pp. 17, 23 (APD evidence form; Seth Hansen written narrative); *compare* Exh. B1, p. 6 (photo of excavator blade with dark material) and Exh. B1, p. 7 (photo of same excavator blade with no material) (color versions of these photographs are at SOA 002452 and 002453, respectively).

exhibit B2. The death certificate, dated June 23, 2015, describes the cause of Mr. N's death as "open fractures of pelvis; crushing and blunt impacts of trunk and legs" and describes "how injury occurred" as "struck by construction equipment at worksite."⁴² Dr. Rolf's autopsy report, dated June 17, 2015, states the cause of death as "open comminuted fractures of pelvis and visceral injuries," due to "crushing and blunt impacts of trunk and legs."⁴³ Regarding impact from construction equipment, the autopsy report states "body recovered from collapsed material of ditch by backhoe equipment."⁴⁴

In her testimony, Dr. Rolf described Mr. N's injuries and clarified that the cause of his death was blood loss from the grievous injuries to his blood vessels and organs in the groin area. Dr. Rolf opined that Mr. N would have become unconscious almost immediately ("within seconds or a minute") after suffering the injuries and would have died within just a few minutes.⁴⁵ When HCE's counsel questioned her regarding the difference between her cause of death notations on the death certificate and in the autopsy report, Dr. Rolf acknowledged that the death certificate was finalized on June 23, 2015, after the autopsy report had been finalized and after she had spoken with AKOSH investigators.⁴⁶ She stated that she could not definitively state that Mr. N was struck by construction equipment, but that in her opinion his injuries were caused by being struck by either the excavator bucket or a large, very hard piece of debris being pushed into his body by the excavator bucket. She acknowledged that his injuries could have been caused by the impact from the collapsed trench wall material, but opined that this was very unlikely.⁴⁷

2. Dr. Means

HCE retained Dr. Norman Means, an experienced physician and former Alaska medical examiner, to testify on its behalf. Dr. Means testified as an expert in pathology. He did not examine Mr. N's body, but he reviewed the state's death certificate, autopsy report and a selection of photographs and documents relating to the incident,⁴⁸ including the autopsy

⁴² Dr. Rolf testimony; Exh. B2, p. 1 (death certificate).

⁴³ Exh. B2, p. 2 (autopsy report).

⁴⁴ *Id.*

⁴⁵ Dr. Rolf testimony.

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ A list of the documents and photographs reviewed by Dr. Means was appended to a letter that he authored regarding Mr. N's death prior to the hearing. Exh. B. Although HCE's counsel characterized this letter as an expert report from Dr. Means, it is actually a letter to the chief medical examiner for Alaska setting forth a critique of the state's investigation, and it does not set forth Dr. Means' opinions regarding the mechanism by which Mr. N was

photographs, and he interviewed David Hartman regarding the incident. Based on his review, he concluded that he agreed with Dr. Rolf's assessment of Mr. N's cause of death – he bled to death after suffering “catastrophic crushing, blunt force injuries to his pelvis.”⁴⁹ He testified that he had no objections to Dr. Rolf's specific findings and that he thought the autopsy “was skillfully done;” however, he did have “differences of opinion” regarding how Mr. N received his injuries. He testified that he found no evidence to support the conclusion that Mr. N was struck by an excavator, and that he concluded, to a reasonable degree of medical certainty, that Mr. N's injuries were caused by a mechanism other than being struck by an excavator. He opined that the mechanism that caused the blunt force injuries was that when Mr. N was engulfed by the collapsed, moving trench material, he was “subsequently slammed, with great force, into the opposite wall or the lip of the trench.”⁵⁰ The violent collision of Mr. N's body with the north wall of the trench, according to Dr. Means, essentially caused the tissues in Mr. N's pelvic area to exceed their elasticity and rupture.⁵¹ Dr. Means also testified that David Hartman told him during his interview that Mr. N was facing the north wall, away from the excavators, when he was entrapped by the collapsing trench, and that this factual element played a key role in Dr. Means' conclusions regarding the mechanism of injury. He stated that for Mr. N's injuries to have been caused by the excavator bucket striking him, or by material being pushed against him by the excavator bucket, he had to have been facing the opposite direction than that described by Mr. Hartman, i.e., towards the south wall of the trench.⁵² Regarding the length of time that Mr. N could have survived after suffering his injuries, Dr. Means testified that a phenomenon known as “tamponade” allowed Mr. N to survive for a longer period than that suggested by Dr. Rolf – essentially the pressure of the mass of material pressing against Mr. N's body compressed his torn blood vessels and stopped or restricted blood loss from those vessels until the pressure was relieved, when he was dug out of the entrapment.⁵³ It was not until that point that he started to bleed out and then rapidly lost consciousness.⁵⁴

When asked how his opinion would change if it were demonstrated that Mr. N had been facing toward the south trench wall and the excavators, Dr. Means testified that he “would have

injured. The letter, therefore, did not give notice of Dr. Means' key testimony at the hearing.

⁴⁹ Dr. Means testimony.

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² *Id.*

⁵³ *Id.*

⁵⁴ *Id.*

real problems” tying together the pattern of injuries with the posture of his body towards the excavator; in his opinion he would see injuries along Mr. N’s back which did not appear on his body. Dr. Means opined, in essence, that he could not reconcile the injuries with a scenario where Mr. N was not facing the north wall.⁵⁵

D. Credibility of Witnesses

David Hartman was the only witness to the actual collapse of the trench, and he and Derek Hartman were the only persons giving testimony who witnessed the rescue of T N. David Hartman’s sworn testimony was less than credible in certain critical respects. Although his demeanor and manner while testifying were calm, even, and sincere, his explanations regarding his prior trench-related problems simply lacked credibility. First, he denied ever having been cited by AKOSH for a prior trench violation; then after being shown AKOSH documents establishing that he had received just such a citation in 2005, he claimed he had simply forgotten about the event. This was an event where Mr. Hartman had hired counsel, had contested the citation and had filed an appeal with the Department of Labor – an event he would be unlikely to forget. The Board found Mr. Hartman’s explanation for his sworn testimony that he had never been cited by AKOSH to lack credibility.

In a similar vein, Mr. Hartman’s explanation regarding the email he received from Kent Kohlhasse in 2014 also does not stand up to scrutiny. Mr. Hartman testified that he recalled receiving the email, in which Mr. Kohlhasse warned that a trench on the HCE jobsite appeared to not be “configured to conform with OSHA trench standards.” He further testified that he had examined the photograph attached to the email, he had reviewed OSHA trenching standards, as suggested by Mr. Kohlhasse, and he had concluded there was no problem because the trench was “very sloped” and was properly configured. This testimony, however, fails to explain why Mr. Hartman sent an email in response to Kohlhasse, stating: “Will do. This was an unusual case as we were trying to maneuver in tight quarters.” Mr. Hartman’s contemporaneous, written response was in effect an acknowledgement that Mr. Kohlhasse’s assessment of the trench in the photograph had some validity. Otherwise, if Mr. Hartman had truly concluded that the trench was properly configured, he undoubtedly would have said as much in his response email, rather

⁵⁵ *Id.*

than explaining that “tight quarters” had affected HCE’s work.⁵⁶ Mr. Hartman’s self-serving denial at the hearing that there was no trenching problem in 2014 lacked credibility.

Mr. Hartman’s comments to Mr. Anderson during his formal interview also raised doubts about his credibility. Mr. Hartman told Mr. Anderson that HCE had not used a trench box on June 16, 2015, because no work was ongoing in the trench that day and HCE was in the process of backfilling. It was false for Mr. Hartman to imply that no employee had been in the trench that morning or would be in the trench later in the day, as both the Hartman boys and Scott Crowther had been in the trench that morning, and HCE’s compactors and Mr. Crowther’s testing equipment were still sitting in the trench when the collapse occurred, which meant that at minimum, someone would have had to get back into the trench to remove the equipment. Mr. Hartman’s comments to Mr. Anderson were a transparent attempt to deflect liability for the accident in the trench, and they undermined his credibility with the Board.⁵⁷

Derek Hartman’s testimony also lacked credibility in some respects. Like his father, Derek told Mr. Anderson that HCE did not use a trench box on June 16, 2015 because no work was occurring in the trench that day. This statement was contradicted by sworn testimony at the hearing that at least Derek, his brother and Scott Crowther had been in the trench in the morning, and someone would have had to reenter the trench in the afternoon to remove equipment. Derek also told Mr. Anderson that compactors with remote controls were used in the trench that day so that employees didn’t have to be in the trench to compact the backfilled material. This statement was contradicted by sworn testimony that the compactors in the trench on June 16, 2015 did not have remote controls. Both of these contradictions undermined Derek’s overall credibility, in the judgment of the Board.

E. Ultimate issue factual findings

1. *David Hartman’s knowledge of OSHA standards.* As a result of AKOSH’s citation issued to HCE in 2005, and Kent Kohlhasse’s email to David Hartman in 2014, David Hartman and by extension, HCE, were on notice that HCE’s work was potentially out of

⁵⁶ Mr. Hartman also failed to explain at the hearing how he could have reached a reliable conclusion that the trench was properly configured, given his sworn testimony at the hearing that he did not know the precise terms of OSHA’s standards regarding protective measures in trenches and excavations.

⁵⁷ During the formal interview, Mr. Hartman also noted that Mr. N bled to death, and he tried to shift the blame to first responders’ unwillingness to enter the trench when they arrived on the scene, arguing that if they hadn’t been “afraid” to get in the trench, Mr. N would have lived. Mr. Hartman’s statement was not credible, as no one who saw Mr. N’s injuries could credibly assert that first responders might have saved him if they had jumped in the trench and treated his injuries more quickly.

compliance with OSHA trench safety standards.⁵⁸ Yet Mr. Hartman took no steps to educate himself about what the standards consisted of, relying instead on his lifetime of “on-the-job” training and experience in the construction industry to know and understand how to safeguard employee safety in HCE’s trench work. As a result, according to Mr. Hartman’s explicit testimony, although he was aware of the existence of OSHA standards governing trench safety, including spoil pile setback, benching and sloping requirements, he “was not aware of what those standards were.” Thus, Mr. Hartman did not know the standards HCE needed to meet in order to ensure that the No Name Ave. trench was in compliance and safe for HCE’s employees in 2015. However, he knew, or should have known, that whatever those terms consisted of, HCE was likely not in compliance.

2. *HCE’s safety culture.* Both David Hartman and Derek Hartman testified that HCE’s safety culture was based upon their long experience in doing construction work and upon employees always wearing their protective gear, always looking out for each other, and always keeping an eye out for dangerous conditions. David Hartman testified that he regularly inspected the jobsite and in particular the No Name Ave. trench, by being observant, paying attention, and always looking out for cracks, fissures or some other sign that the trench walls might pose a dangerous condition. He testified that he would have stopped work on the jobsite if he had seen any such signs.

The Hartmans cared for each other and for T N, and they tried to use what they believed to be common sense in furtherance of employee safety. But this simply was not enough. At least as to the No Name Ave. trench, HCE’s safety culture of relying on experience and common sense, while ignoring the specific, clear OSHA requirements for trenches and excavations, was woefully inadequate. Given the lax approach to safety, it was only a matter of time before a trench cave-in occurred; unfortunately, Mr. N was in the wrong place at the wrong time and suffered the consequences.

3. *The slough to the east of the accident site.* Only a few weeks before the June 16, 2015 accident, a small section of the edge of the No Name Ave. roadbed sloughed into the adjacent, lower roadbed area to the north. This slough was of the same material that would later collapse into the No Name Ave. trench and entrap Mr. N. Mr. Hartman’s explanation that the

⁵⁸ Mr. Hartman’s vague admission during his interview with Mr. Anderson that he “came up a bit short” is further support for this finding.

slough to the east was caused by rain and by heavy trucks driving out of the adjacent EP Roofing lot misses the point; the slough demonstrated that those roadbed materials lacked cohesiveness and could break off, and that fact put HCE on notice that precautions needed to be taken in the No Name Ave. trench.

4. *Use of the excavator in the rescue of T N.* The lack of physical evidence (e.g., blood on the excavator bucket or tines) to support AKOSH's assertion that one of HCE's excavators caused Mr. N's injuries, combined with Dr. Means' testimony offering a plausible alternative explanation for the cause of those injuries, undermined AKOSH's showing on this question. The Board finds that AKOSH did not prove by a preponderance of the evidence that the injuries were caused by one of the excavators.⁵⁹ The Board also finds, however, that use of the excavators in the rescue was, in and of itself, a dangerous practice.

5. *Mechanism of injury.* The Board also finds that HCE did not prove by a preponderance of the evidence that Dr. Means' explanation of the mechanism of injury is correct to a reasonable degree of medical certainty. The key factor here is the Board's determination that David and Derek Hartman lacked credibility in their testimony, because their statements that Mr. N was facing **towards the north wall of the trench, away from the excavators**, were critical to Dr. Means' conclusions. In addition, the Board finds that certain aspects of the physical appearance of Mr. N's injuries in the detailed photographs of his body do not appear to be consistent with Dr. Means' opinion regarding the mechanism of injury — the edges of the gaping wound seem too uniform to have occurred in the manner described by Dr. Means. In the Board's view, the appearance of the wound supports the theory that the excavator played a contributory role in the injury. In addition, even though the Board has found that AKOSH did not prove the role of the excavators in the mechanism of injury, nonetheless the testimony of Dr. Rolf carried more weight with the Board than that of Dr. Means, because Dr. Rolf directly and closely examined Mr. N's injuries, whereas Dr. Means was only able to review the autopsy photographs.

IV. Discussion

A. Proof of Violation

⁵⁹ In addition, although not proven by a preponderance of the evidence, the Board believes it is possible that Mr. N's injuries were caused or exacerbated by one of the excavators increasing the pressure on Mr. N of the collapsed material pressing against his body. This scenario was supported by Dr. Rolf's testimony, based on her first-hand examination of the body, that the injuries were caused by either the excavator bucket itself or by hard debris being pushed into his body by the excavator bucket.

To establish a violation of an OSHA standard, AKOSH must prove by a preponderance of the evidence that (1) the cited standard applies; (2) there was a failure to comply with the cited standard; (3) one or more employees were exposed or had access to the violative condition; and (4) the employer knew or could have known of the existence of the violative condition with the exercise of reasonable diligence.⁶⁰ AKOSH argues that it met its burden as to all eight of the items at issue in this matter. As further discussed below, HCE contends that AKOSH failed to meet its burden as to most of the items, but it concedes that it is liable for three violations.

B. Willfulness

As noted above, AKOSH classified each of HCE's alleged violations as willful. AKOSH contends that HCE acted in conscious disregard for and plain indifference to employee safety, and failed to take necessary precautions after (a) being cited for trenching violations in the No Name subdivision in 2005, (b) being warned by the Kohlhasse email eight months before the accident that its trench work there was out of compliance with OSHA standards, and (c) seeing the same or similar roadbed materials slough off to the east, just a few weeks before the accident.

Willfulness is not defined in AKOSH's governing statutes and regulations, nor in federal OSHA regulations. Applicable caselaw, however, has set forth a clear definition of the term. To prove that an OSHA violation is willful, AKOSH must establish that the violation was committed with intentional, knowing or conscious disregard for the requirements of OSHA standards, or with plain indifference to employee safety.⁶¹ Willful violations may be alleged for violations of either specific standards or the general duty clause.⁶² An employer may be found to have willfully violated an OSHA standard, under the "plain indifference" prong of the definition, even where the employer was unaware of the terms of the OSHA standard in question.⁶³ No showing of the employer's bad motive or malicious intent is required.⁶⁴ An employer "who substitutes his own judgment for the requirement of a standard or fails to correct a known hazard

⁶⁰ See Mark A. Rothstein, *Occupational Safety and Health Law*, § 102 (4th ed. 1998) (hereinafter "Rothstein"); see also 8 AAC 61.205(I) (burden of proof for citations and penalties is upon the Department by a preponderance of the evidence).

⁶¹ *Whitewater Engineering Corp.*, Docket No. 99-2131, at 39 (Alaska OSH Rev. Bd. 1999); *Asbestos Textile Co., Inc.*, 12 OSHC 1062, 1063 (OSHRC 1984); *National Steel and Shipbuilding Co. v. OSHRC*, 607 F.2d 311, 313-16 (9th Cir. 1979); see generally Rothstein, *Occupational Safety and Health Law*, §315.

⁶² See, e.g., *Ensign-Bickford Co. v. OSHRC*, 717 F.2d 1419, 1422-23 (D.C. Cir. 1983); see also Rothstein, *Occupational Safety and Health Law*, §315 at 371.

⁶³ *Valdak Corp. v. Occupational Safety & Health Review Comm'n*, 73 F.3d 1466, 1469 (8th Cir. 1996).

⁶⁴ *National Steel*, 607 F.2d at 314.

commits a willful violation even if the employer does so in good faith.”⁶⁵ To prove willfulness, AKOSH must establish that “the [employer] was aware of the risk, knew that it was serious, and knew that he could take effective measures to avoid it, but did not – in short, that he was reckless in the most commonly understood sense of the word.”⁶⁶

HCE argues that willful violations are exceedingly rare, that the accident that took Mr. N’s life was a freak occurrence, and that even if certain of its trench safety practices may have been negligent, they do not rise to the level of willful violations.⁶⁷ HCE cites the Board’s *Whitewater* decision,⁶⁸ arguing that “[t]his is no *Whitewater*,” where the employer had been “informed by its own expert(s) that an avalanche was imminent, but deliberately chose to ignore the warning to save a few bucks.”⁶⁹ The Board finds that this case is more closely analogous to *Whitewater* than HCE contends. Here HCE had been cited by AKOSH for a trench violation ten years before, it had recently been warned that one of its trenches was out of compliance with OSHA safety standards, and it had just seen the slough of similar roadbed materials not far from the site where the accident would occur; yet HCE deliberately chose to continue with business as usual in its trench work practices. HCE’s argument that these prior events are distinguishable from the June 2015 trench collapse misses the point – any one of these prior incidents should have been sufficient to spur HCE to at least learn the specific terms of the OSHA standards applicable to its trench work and make a reasonable effort to comply with those standards. The Board views HCE’s “business as usual” approach and clearly deficient trench safety practices as going hand-in-hand with Mr. Hartman’s ownership of the subdivision and his obvious incentive to complete the work as quickly and cheaply as possible.

HCE also attempts to counter AKOSH’s willfulness arguments by pointing to supposed advice and/or a lack of warning from Scott Crowther and Pamela Ronning regarding the safety of the trench and soil conditions.⁷⁰ First, as to Mr. Crowther, at numerous times throughout the hearing HCE obliquely referred to his alleged expertise in the area of soil dynamics, his apparent

⁶⁵ *Id.*

⁶⁶ *Stark Excavating, Inc. v. Perez*, 811 F.3d 922, 925 (7th Cir. 2016), citing *Dukane Precast, Inc. v. Perez*, 785 F.3d 252, 256 (7th Cir. 2015).

⁶⁷ In this context, HCE cites the portion of the AKOSH Field Operations Manual pertaining to **criminal/willful violations**; however, here we are dealing only with willful violations. HCE’s Closing Brief at 29-30. There is no indication in the record that AKOSH is pursuing criminal sanctions against HCE or the Hartmans for Mr. N’s death.

⁶⁸ *Whitewater Engineering Corp.*, Docket No. 99-2131 (Alaska OSH Rev. Bd. 1999).

⁶⁹ HCE’s Closing Brief at 29.

⁷⁰ *See, e.g.*, HCE’s Closing Brief at 24.

failure to point out any dangerous conditions in the trench, and his alleged comments to Mr. Anderson that the trench collapse could only have been caused by an earthquake or some other drastic external cause. However, HCE listed Mr. Crowther as a witness, caused a subpoena to be issued and served to assure his appearance, and even discussed his likely testimony during its opening statement, but then chose not to call him to testify.⁷¹ Accordingly, HCE will not now be heard to argue that alleged advice from Mr. Crowther somehow excused its violations regarding the hazards of the No Name Ave. trench, or that it carries any weight as a counter to AKOSH's willfulness arguments.⁷²

Second, HCE's repeated reference to an alleged lack of warning from Pamela Ronning is unavailing. Ms. Ronning's responsibility on this project was to inspect Mr. Crowther's work, which involved the grading and soil compaction at the bottom of the trench, and to review conformance of the project work to the approved project plans. Simply stated, her job as the Municipal inspector did not encompass trench safety concerns. Therefore, the allegation that she never told the Hartmans that the trench was unsafe carries no weight.

The Board finds that HCE was aware of the risk associated with the No Name Ave. trench, knew that it was a serious risk, and knew that it could take effective measures to avoid it, but did not do so – in short, HCE demonstrated a reckless disregard for and plain indifference to employee safety and the requirements of the applicable OSHA regulations. The Board, therefore, concludes that each of HCE's violations of OSHA standards were willful, as further discussed below.

C. HCE's Concession

In its closing brief, HCE concedes that it violated three OSHA standards and is liable for **item 2** (means of egress not provided), **item 4** (spoil piles too close to the trench edge), **and a combination of items 6 and 7** (inadequate protective measures in the form of trench boxes and sloping/benching).⁷³ HCE argues that it is not liable for the other items and that none of the items should be deemed willful violations.

D. Item 1

⁷¹ HCE never gave any indication that Mr. Crowther was unavailable or needed some sort of scheduling accommodation to testify.

⁷² In addition, HCE never established that Mr. Crowther's responsibilities on the project covered anything more than testing soil compaction at the bottom of the trench as it was refilled. The record reflects that the stability or instability of the trench walls, and HCE's compliance with OSHA standards, were not his responsibility.

⁷³ HCE's Closing Brief at 16-17, 19, 23-24, 28.

In this item, AKOSH alleges that HCE violated the “general duty clause” of AS 18.60.075(a)(4), which requires that the “employer shall do everything necessary to protect the life, health, and safety of employees including ... (4) furnishing to each employee employment and a place of employment that are free from recognized hazards that, in the opinion of the commissioner, are causing or are likely to cause death or serious physical harm to the employees.”⁷⁴

HCE argues that this item cannot be sustained because AKOSH cannot meet the first element of its required proof, i.e., that the cited standard applies to HCE’s practices at the No Name Ave. trench. HCE’s argument is based on the premise that the general duty clause has no application where a specific standard applies to the alleged violation. Because OSHA has promulgated specific standards governing trench and excavation-related safety, HCE argues, the general duty clause cannot be the basis for a citation in this case. HCE cites AKOSH’s Field Operations Manual (“FOM”) in support of this argument. The relevant section of the FOM states as follows: “The general duty clause shall be used only where there is no standard that applies to the particular hazard and in situations where a recognized hazard is created in whole or in part by conditions not covered by a standard.”⁷⁵

The Board agrees that as a general matter, the general duty clause should only be used where there are no specific OSHA standards applicable to the workplace violation. In this case, however, HCE’s argument fails because the Board finds that there is no specific OSHA standard covering (1) use of an excavator in a rescue attempt such as occurred on June 16, 2015 – such a practice is dangerous and could have caused or contributed to Mr. N’s fatal injuries, and (2) a woefully inadequate safety culture such as HCE’s. As to the former point, the Board has already found that, whether or not Mr. N’s fatal injuries were directly caused by one of the excavators, the use of the excavators was extremely dangerous and put Mr. N at risk of serious injury or death. As to the latter point, the Board finds that HCE’s approach to safety in its trench work

⁷⁴ Contestant’s Exh. A, p. 5.

⁷⁵ AKOSH Field Operations Manual, December 4, 2015, at 4-20 (AKOSH’s counsel has represented that this version of the FOM does not differ in any material respect from the version in effect as of June 16, 2015). Neither party provided authority for whether the FOM carries the force of law or is simply a manual describing AKOSH policies and procedures. The FOM contains a disclaimer that states, in pertinent part “This manual is intended to provide instruction regarding some of the internal operations of [AKOSH], and is solely for the benefit of the AKOSH. ... The contents of this manual are not enforceable by any person or entity against the Alaska Department of Labor and Workforce Development or the State of Alaska.” FOM, at Exec. Summary, p. 1. In the absence of contrary authority, the Board views the FOM as a manual that does not carry the force of law.

was so inadequate and resistant to improvement or correction that only a fatal accident could cause HCE to change its ways and actually learn and implement the specific OSHA standards that applied to HCE's work.

HCE also makes a separate and distinct argument that the general duty clause has no application here. HCE contends first that the general duty clause citation must be based on the assumption that Mr. N's injuries were actually caused by impact from an excavator. HCE then argues: "[T]he use of the excavators allegedly creating the hazard occurred during the rescue efforts, and were not otherwise a hazard related to the type of work being conducted at the site. In other words, there is no evidence that there was a hazard of being struck by or crushed by heavy equipment as applied to the work actually being conducted at the site."⁷⁶ HCE presents no legal authority in support of this argument.

The Board rejects HCE's argument. The Board has found that the general duty clause applies here because (1) HCE's safety culture was woefully inadequate, and (2) even if it was not proven that Mr. N was fatally injured by one of the excavators, use of the excavator(s) in the rescue put him at risk of severe injury. HCE's argument here can be summarized as "we created an unsafe environment, and we used an unsafe method to try to rescue Mr. N from that unsafe environment, but because our use of that method was not part of the actual work we were doing on the jobsite, AKOSH cannot cite us for using that method." This argument fails, because it is for precisely this type of scenario that a general duty clause violation is appropriate. The general duty clause requires that HCE provide its employees "employment and a place of employment that are free from recognized hazards that . . . are causing or are likely to cause death or serious physical harm to the employees."⁷⁷ HCE's inadequate safety culture and blatantly dangerous trench work practices created an extremely unsafe workplace. Its unsafe practice of using its excavators to try to free Mr. N from the collapsed trench caused by its own dangerous trench work practices put him at risk of serious physical harm or death. The general duty clause violation, therefore, is upheld.

Based on the prior discussion of willfulness, the Board also upholds Item 1 as a willful violation. HCE was on notice from its 2005 citation and the 2014 Kohlhasse email that there were problems with the general safety culture of the company and with its approach to trench

⁷⁶ HCE Closing Brief at 12-13.

⁷⁷ AS 18.60.075(a)(4).

and excavation work, and its principals failed to remedy these problems, in reckless disregard and plain indifference to the safety of its employees.

E. Item 2

In this item, AKOSH alleges that HCE violated 29 CFR 1926.651(c)(2), “specific excavation requirements,” which requires that in trenches that are at least four feet deep, the employer must provide means of egress in the form of stairways, ladders or ramps no more than 25 feet apart.⁷⁸ HCE concedes liability for this item, but argues that it was not a willful violation. The Board finds that AKOSH met its burden of proving that HCE’s failure to provide means of egress from the trench was done in conscious disregard for and plain indifference to employee safety. The Hartmans acknowledged knowing that they were required to provide means of egress from the trench, and based on their extensive experience in the construction industry, they were “aware of the risk, knew that it was serious, and knew that they could take effective measures to avoid it, but did not.”⁷⁹ The Board, therefore, upholds item 2 as a willful/serious violation.

F. Item 3

AKOSH alleges in this item that HCE violated 29 CFR 1926.651(j)(1), “specific excavation requirements,” which requires: “Adequate protection shall be provided to protect employees from loose rock or soil that could pose a hazard by falling or rolling from an excavation face. Such protection shall consist of scaling to remove loose material; installation of protective barricades ... as necessary to ... stop and contain falling material; or other means that provide equivalent protection.”⁸⁰

HCE argues that it performed adequate scaling and that, in any event, the accident was not caused by unscaled materials falling from the edge of the trench. It also argues that this citation should merge with item 4 (spoil piles stored too close to the trench edge).

The Board finds that, to the extent that the “barricades” reference in this item can be interpreted to pertain to trench boxes and other protective systems, it is duplicative of item 6. Regarding the scaling requirements covered by this item, the Board finds that AKOSH did not meet its burden of proving by a preponderance of the evidence that HCE failed to comply with

⁷⁸ *Id.*

⁷⁹ *Stark Excavating, Inc. v. Perez*, 811 F.3d 922, 925 (7th Cir. 2016), *citing Dukane Precast, Inc. v. Perez*, 785 F.3d 252, 256 (7th Cir. 2015).

⁸⁰ Contestant’s Exh. A, p. 6.

29 CFR 1926.651(j)(1) in a manner that exposed employees to a dangerous condition. Based on the evidence presented at the hearing, it was not clearly established whether scaling was or was not performed on the No Name Ave. trench, nor whether HCE's scaling practices played any role in the incident that resulted in T N's death. Item 3, therefore, is overturned.

G. Item 4

AKOSH alleges in this item that HCE violated 29 CFR 1926.651(j)(2), "specific excavation requirements," which requires that "[e]mployees shall be protected from excavated ... materials ... that could pose a hazard by falling or rolling into excavations," by requiring that such materials be placed or kept "at least 2 feet from the edge of excavations."⁸¹ HCE concedes that it violated this requirement. HCE, however, also argues that "there is no evidence that these spoil piles actually caused any injury to any employee," and that the spoil piles actually were compliant with the regulation at some points along the course of the No Name Ave. trench.⁸²

The Board finds that HCE violated 29 CFR 1926.651(j)(2) by placing spoil piles less than two feet from the edge of the trench along most of its length, including in the near vicinity of the actual accident site, and that these spoil piles exposed employees to a dangerous condition. Regarding HCE's argument that this violation never "actually caused any injury to any employee," the Board finds that the spoil piles on the north wall of the trench may have impeded Mr. N's ability to egress the trench at the time of the accident, exacerbating the risk posed by HCE's violations regarding protective systems. The Board further finds that this violation was properly determined by AKOSH to be willful, in that HCE was on notice of its deficient trench work practices, it obviously was aware of the dangers associated with the trench, it took no reasonable steps to learn the OSHA requirements applicable to spoil piles, and if it had taken such steps, it could have remedied its non-compliance with reasonable effort.

H. Item 5

With this item, AKOSH alleges that HCE violated 29 CFR 1926.651(k)(1), "specific excavation requirements," which requires that "[d]aily inspections of excavations, the adjacent areas, and protective systems shall be made by a competent person for evidence of a situation that could result in possible cave-ins... or other hazardous conditions."⁸³ A competent person is someone who is capable of identifying dangerous conditions on the jobsite and has the authority

⁸¹ Contestant's Exh. A, p. 7.

⁸² HCE's Closing Brief at 19.

⁸³ Contestant's Exh. A, p. 8.

to take corrective measures to eliminate those conditions.⁸⁴

HCE argues that Mr. Hartman was a “competent person,” based on his many years of experience in the construction industry. HCE further argues that in fact Mr. Hartman did conduct at least daily inspections, and that AKOSH employee Mr. Hansen conducted the same inspection that Mr. Hartman frequently did and was unable to discern any signs of a potential cave-in (e.g., fissures in the soil, cracks in the trench walls, or material starting to slough off the walls). What HCE’s arguments fail to address is that Mr. Hartman’s “inspections,” to the extent that they occurred, did not reveal the fatal flaws in the configuration of the trench. If Mr. Hartman had been a “competent person,” his inspection would have shown that the trench was inadequately sloped or benched and that trench boxes therefore needed to be in place whenever an employee was in the trench. He would have known that the near vertical walls of the trench at the accident site had to be composed of stable rock to be in compliance with OSHA standards,⁸⁵ and that they undisputedly were not composed of stable rock - they were composed of previously excavated and consolidated roadbed material. Upon seeing the prior slough to the east of the accident site, he would have realized that the walls of the No Name Ave. trench were composed of the same or similar materials and therefore they posed an extreme hazard.

Based on the evidence presented at the hearing, the Board finds that HCE violated 29 CFR 1926.651(k)(1) by failing to have a competent person inspect the No Name Ave. trench on a daily basis. Furthermore, the Board finds that this violation was appropriately classified as willful by AKOSH – if HCE had heeded the prior notice provided by its 2005 citation and the 2014 Kohlhasse email, as well as the previous slough to the east of the accident site, it could easily have engaged a competent person to provide the necessary inspections and take corrective measures to protect employee safety. Its failure to do so was willful.

I. Items 6 and 7

Item 6 alleges that HCE violated 29 CFR 1926.652(a)(1)(ii), “requirements for protective systems,” which requires that employees “in an excavation shall be protected from cave-ins by an adequate protective system ... except when [e]xcavations are less than 5 feet ... in depth and examination of the ground by a competent person provides no indication of a potential cave-

⁸⁴ 29 CFR 1926.32(f).

⁸⁵ 29 CFR 1926.652 App. B, table B1.

in.”⁸⁶ With item 7, AKOSH alleges that HCE violated 29 CFR 1926.652(b)(1)(i), “requirements for protective systems,” which requires that “[e]xcavations shall be sloped at an angle not steeper than one and one-half horizontal to one vertical (34 degrees measured from the horizontal)”⁸⁷ As mentioned above, HCE concedes that it violated these two OSHA standards, but it also argues that these provisions are “alternative types of protective systems,” that both systems are not required, and therefore the two citations should be merged or combined.⁸⁸

Although conceding liability for a combination of items 6 and 7, HCE also argues repeatedly in its closing brief that “evidence of benching” in the trench indicates that it made an effort to comply with OSHA requirements. The Board rejects this contention – it has carefully reviewed the photographic evidence of the trench and the specific accident site, and to the extent any benching at all was done by HCE, it was **minimal** and of no useful effect.

HCE also argues that AKOSH failed to establish that the absence of additional sloping or benching contributed to the accident in question. This argument clearly lacks merit. The Board finds that the nearly vertical slope of the north wall contributed directly to the collapse of the wall onto Mr. N – if the north wall had been sloped anywhere near the 34% slope required by the OSHA standards, any slough or collapse of the wall would have been far less dangerous than the wall collapse that took place on June 16, 2015.

Regarding items 6 and 7, the Board does agree that they should be merged, as suggested by HCE. HCE is correct that if it had properly sloped or benched the trench, AKOSH would not have issued a citation for failure to use a trench box, and vice versa. Therefore, based on the evidence presented at the hearing, the Board finds that HCE is liable for one violation of the protective systems standards covered by 29 CFR 1926.652(a)(1)(ii) and 29 CFR 1926.652(b)(1)(i).

The Board also finds that this violation was appropriately classified as willful by AKOSH. As discussed above, HCE was put on notice that it was out of compliance with OSHA trenching standards, and instead of taking steps to correct its non-compliance, it continued its “business as usual” approach and put its employees at risk. Even Mr. Hartman’s own testimony demonstrated HCE’s sorely inadequate approach to trench safety – he acknowledged that “earth falls frequently,” he acknowledged that he did not know the terms of the applicable

⁸⁶ Contestant’s Exh. A, pp. 8-9.

⁸⁷ Contestant’s Exh. A, p. 9.

⁸⁸ HCE’s Closing Brief at 24-25.

OSHA trench safety standards, yet even at the hearing he still felt that his own judgment that the trench was safe justified his failure to make the trench safe. HCE's actions in this case strongly resemble the description of a willfully violating employer set forth by the D.C. Circuit in an often-cited OSHA decision - an employer that either "was actually aware ... that the act was unlawful, or that ... possessed a state of mind such that if it were informed of the standard, it would not care."⁸⁹ HCE's failure either to use a trench box or to properly slope or bench the trench excavation demonstrated a conscious disregard for and plain indifference to employee safety, and therefore it constituted a willful violation.

J. Item 8

With this final item, AKOSH alleges that HCE violated 29 CFR 1926.652(c)(2)(i), "requirements for protective systems," which requires that "[d]esign of support systems, shield systems, or other protective systems that are drawn from manufacturer's tabulated data shall be in accordance with all specifications ... issued or made by the manufacturer."⁹⁰ This item concerns the trench boxes that were not in use at the time of the June 16, 2015 accident but were allegedly stored on the jobsite. The specific basis for the item is that the manufacturer's specifications for use of HCE's trench boxes were not available for inspection by AKOSH at that time. Mr. Anderson's testimony established that the trench boxes were not evident to him and Mr. Hansen when they visited the jobsite on June 16 and 17, 2015, and so they were unable to examine the manufacturer's specifications to determine if the boxes were of the proper design for use in the No Name Ave. trench.

The Board finds that AKOSH did not meet its burden of proving by a preponderance of the evidence that HCE failed to comply with 29 CFR 1926.652(c)(2)(i) in a manner that exposed employees to a dangerous condition. The salient point concerning protective systems that led to Mr. N's death, simply stated, was HCE's failure to use them. In that context, whether the manufacturer's information on the trench boxes was available for AKOSH inspection was superfluous.⁹¹ Item 8, therefore, is overturned.

K. Penalties

Alaska law provides that an employer who commits a willful violation "may be assessed

⁸⁹ *AJP Constr., Inc. v. Sec'y of Labor*, 357 F.3d 70, 74 (D.C. Cir. 2004); *Sec'y of Labor v. GP Roofing & Construction*, 2014 WL 2178034 (OSHR April 11, 2014).

⁹⁰ Contestant's Exh. A, p. 10.

⁹¹ HCE also argues that the specifications were on the disassembled trench boxes at the jobsite and that AKOSH staff never sought to inspect them. AKOSH did not effectively rebut this factual assertion at the hearing.

by the commissioner [of Labor] a civil penalty of not more than \$70,000 for each violation.”⁹² The law also provides that the commissioner “shall give due consideration” to factors such as the size of the employer’s business and the “gravity of the violation” in determining the amount of the penalty.⁹³ A Department of Labor regulation provides, however, that the Board, in deciding cases before it, “is not bound by the department's classification of a violation or the commissioner's ... assessment of a penalty for a violation.”⁹⁴

AKOSH proposed the maximum \$70,000 penalty for each of the eight items in its citation to HCE – totaling \$560,000. HCE argues that the penalties should be drastically reduced, in part because it is a very small company (HCE had only four employees, including Mr. N, as of June 16, 2015). HCE cites to the FOM in support of its arguments (at times citing inapplicable sections of the FOM covering criminal/willful violations). However, as mentioned above, the FOM is a policy manual that does not carry the force of law. The FOM therefore does not bind the Board in its penalty assessments.

The Board finds that HCE’s willful violations of items 1, 4, 5, and the combined items 6 and 7, should each carry the penalty of \$66,500. These penalties represent a 5% reduction in recognition of HCE’s small size; the relatively small reduction is a reflection of the Board’s view that the gravity of each of these violations was extreme and led to the death of T N. The Board finds that HCE’s willful violation of item 2 should carry a penalty of \$35,000 – a 50% reduction – in recognition of HCE’s small size and of the fact that this violation had far less of a causal connection with Mr. N’s fatal injuries than the other violations.

V. Order

1. Citation 1, item 1 is AFFIRMED as a “willful, serious” violation. The penalty for this violation is \$66,500.

2. Citation 1, item 2 is AFFIRMED as a “willful, serious” violation. The penalty for this violation is \$35,000.

3. Citation 1, item 3 is OVERTURNED.

4. Citation 1, item 4 is AFFIRMED as a “willful, serious” violation. The penalty for this violation is \$66,500.

5. Citation 1, item 5 is AFFIRMED as a “willful, serious” violation. The penalty for this

⁹² AS 18.60.095(a).

⁹³ AS 18.60.095(h).

⁹⁴ 8 AAC 61.140(h).

violation is \$66,500.

6. Citation 1, items 6 and 7 are AFFIRMED as a single “willful, serious” violation. The penalty for this violation is \$66,500.

7. Citation 1, item 8 is OVERTURNED.

DATED: 3/1/17 By: Signed
Keith Montgomery, Chair
Occupational Safety & Health Review Board

DATED: 2/28/17 By: Signed
Tom Trosvig, Member
Occupational Safety & Health Review Board

DATED: 3/1/17 By: Signed
Tony Barnard, Member
Occupational Safety & Health Review Board

RIGHT TO APPEAL
[AS 18.60.097]

A person affected by an order of the Occupational Safety and Health Review Board may obtain judicial review of the order by filing a notice of appeal in the Superior Court as provided in the Alaska Rules of Appellate Procedure. The **notice of appeal must be filed in the Superior Court within 30 days** from the date that the decision appealed from is mailed or otherwise distributed to the appellant. **If a notice of appeal is not timely filed, the order becomes final and is not subject to review by any court.**

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