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NEVADA OCCUPATIONAL SAFETY AND HEALTH
REVIEW BOARD

CHIEF ADMINISTRATIVE OFFICER OF THE OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, DIVISION OF INDUSTRIAL RELATIONS OF THE DEPARTMENT OF BUSINESS AND INDUSTRY,

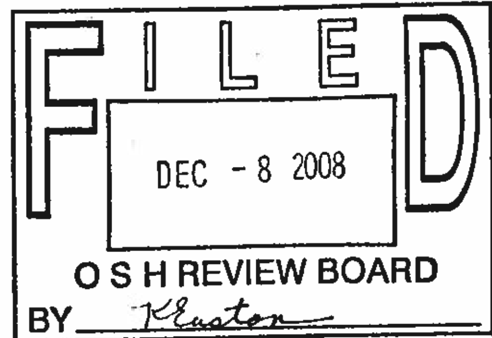
Complainant,

vs.

SCHUFF STEEL COMPANY,

Respondent.

Docket No. LV 08-1344



D E C I S I O N

This matter having come before the **NEVADA OCCUPATIONAL SAFETY AND HEALTH REVIEW BOARD** at a hearing commenced on the 8th day of October 2008 and continued on the 13th day of November 2008, in furtherance of notice duly provided according to law, MR. JOHN WILES, ESQ., counsel appearing on behalf of the Complainant, **Chief Administrative Officer of the Occupational Safety and Health Administration, Division of Industrial Relations** (OSHA); and MR. CHARLES P. KELLER, ESQ., appearing on behalf of Respondent, **Schuff Steel Company**, the **NEVADA OCCUPATIONAL SAFETY AND HEALTH REVIEW BOARD** finds as follows:

Jurisdiction in this matter has been conferred in accordance with Nevada Revised Statute 618.315.

The complaint filed by the OSHA sets forth allegations of violation of Nevada Revised Statutes as referenced in Exhibit "A", attached thereto. The complaint references violations for unsafe steel erection work practices discovered after a fatal accident occurred at the

Cosmopolitan Resort and Casino in Las Vegas, Nevada.

Citation 1, Item 1(a) charges a "serious" violation of 29 CFR 1926.754(a). The complainant alleges that the respondent employer failed to ensure that the structural stability of I-beams was maintained during the steel erection process. The violation was classified as serious due to the potential for serious injury or death. The proposed penalty for the serious violation is in the amount of FOUR THOUSAND FIVE-HUNDRED DOLLARS ($4,500.00).

Citation 1, Item 1(b) charges a "serious" violation of 29 CFR 1926.754(b)(3). The complainant alleges that the respondent employer failed to ensure that a fully planked and decked floor or nets were maintained to protect employees from recognized hazardous conditions. The violation was classified as serious due to the potential for serious injury or death. The proposed penalty for this violation is grouped with Citation 1, Item 1(a).

Citation 1, Item 2(a) charges a "serious" violation of 29 CFR 1926.756(a)(1). Complainant alleges that the respondent employer failed to ensure that its employees secured a beam with at least two bolts per connection as required in the steel erection standard prior to releasing a hoisting line. The violation was classified as serious due to the potential for serious injury or death which could reasonably result. The proposed penalty for this violation is in the amount of FOUR THOUSAND FIVE-HUNDRED DOLLARS ($4,500.00).

Citation 2, Item 1 charges a regulatory violation of Nevada Revised Statute 618.379(1). Complainant alleges that the employer failed to ensure that the accident scene was maintained for subsequent investigation. The penalty was proposed at TWO THOUSAND TWO HUNDRED FIFTY DOLLARS ($2,250.00).

Citation 2, Item 2 charges a regulatory violation of Nevada Administrative Code (NAC) 618.542(1)(c). The complainant alleges that the employer failed to maintain employee records for requirements of steel erection standards. The proposed penalty for the regulatory violation is in the amount of NINE HUNDRED DOLLARS ($900.00).

Prior to the introduction of evidence and testimony, division counsel dismissed Citation 1, Item 2(b) and the referenced violation of 29 CFR 1926.758(d). Counsel for the parties stipulated to the admission of complainant's Exhibits A, B, C and D, which included the inspection report, witness statements, worksheets, and photographs as well as respondent's Exhibit 1, a binder of materials.

Counsel for the Chief Administrative Officer presented testimony and evidence with regard to the alleged violations. Safety and Health Representative (SHR) Jarka Chmelikova testified that she inspected the work site of respondent at the Cosmopolitan Resort and Casino in Las Vegas, Nevada commencing February 1, 2008 after being directed to the facility by her supervisor based upon notification that a fatality had occurred in the workplace. The SHR testified that an iron worker was bolting a structural steel I-beam in an elevator core/shaft located on the southeast area of the property. Based upon information she obtained from witnesses, she concluded that an employee was "tied off" to the same I-beam upon which he was working with a "choker" device and a full body harness. The employee utilized a "bull pin" and "beater" to level/align holes in the beam for the final insertion of bolts and connection with nuts. While he was engaged in the work task, the I-beam separated from the embedded plates to which it was attached and fell to the ground along with the employee. The I-beam, the employee and the planks placed across the beams fell four stories from the specific work

area which was approximately 44 feet in height. Upon impact the employee was thrown to the concrete floor and sustained multiple fatal injuries to his head and body. He was transported to UMC Hospital where he was pronounced deceased.

Ms. Chmelikova testified that she believed items were removed from the accident scene before her arrival, which constituted a violation of Nevada Revised Statutes. She identified and testified with regard to various photographs stipulated into evidence. Ms. Chmelikova testified there were tools not shown in the accident scene photographs which should have been in use by the employee; however, they were shown to her later and identified as having been found behind areas "boarded over" by respondent and removed to the site office. She stated the conduct demonstrated the respondent's interference with the accident scene and a violation of Nevada Revised Statute.

SHR Chmelikova testified she cited the respondent for a violation of Item 1(a) after concluding there was a lack of structural stability due to the bolting process of a beam contrary to the steel erection requirements of the standards. She further testified that respondent did not follow its own safety rules as referenced at page 16 of Exhibit A and page 17, the worksheet format required in respondent's safety policy. She testified there was no evidence that respondent completed its "pre-task planning" and cited a violation at Item 1(a) accordingly. Ms. Chmelikova further testified she collected a bag of bolts at the accident scene on the second day of her inspection but only after the respondent or others located and tagged same. She continued her investigation and concluded from the bolts she found at the scene that only two, rather than the required four bolts were utilized to connect the beam which failed.

SHR Chmelikova testified as to Citation 1, Item 1(b). Based upon her inspection she concluded that the steel erection standards required a fully planked deck floor. The photos in Exhibit A, pages 3 and 6, depict no planks or decking in place.

At Citation 1, Item 2(a), the SHR testified she found evidence there was only one bolt utilized on each end of the beam, therefore concluded the respondent employees used a total of two, as opposed to two on each end for a total of four. Her own analysis reflected the accident cause was based upon the location of the sheared bolts and other evidence at the scene. She testified that the beam was not sufficiently "secured" when only one bolt is used on each end and the practice resulted in a shearing on one end while the subject employee was working on the opposite end.

At Citation 2, Item 2, SHR Chmelikova testified that she cited the respondent for a regulatory violation because the employer failed to produce any documents demonstrating it maintained records for employees in accordance with the requirements of the steel erection standards.

Counsel for respondent conducted cross-examination of SHR Chmelikova. She testified there were no eyewitnesses to explain the cause of the accident and therefore she was required to reconstruct same based upon her investigative findings. She admitted that she did not conduct any calculations on the shear strength of the bolts utilized at the site and admitted in evidence. Counsel inquired as to whether the SHR believed the beam held in place with only one bolt on one side while the employee was removing the bolt on the other side to which she responded in the negative. Counsel inquired of the SHR with regard to employee statements in evidence reflecting they inserted two three-quarter inch bolts on each side of the beam when initially installing

same. She responded that she was aware of the statements. Counsel further inquired as to the SHR's reliance on the steel erection standard at Citation 1, Item 1(a) referencing the stability of a steel structure when the subject area of work was a concrete elevator core and not a "steel structure." Ms. Chmelikova testified she believed the work to be steel erection and cited the respondent under the applicable standards accordingly. Counsel continued inquiry on cross-examination with regard to the applicability of the cited steel erection standards to the elevator core shaft. Counsel inquired with regard to any existence on the site of a retractable lanyard which would negate compliance with decking or planking as permitted by the standards and interpretations. The SHR responded that she saw no retractable lanyard on site near the accident scene.

Extensive cross-examination continued with regard to Citations 1 and 2. Item 1, of citation 2 charged a violation of Nevada Revised Statute 618.379(1) involving respondent's removal of property from the accident scene and interference by the parties with the accident scene. Ms. Chmelikova testified that she believed the respondent was not forthcoming with evidence and prevented her access to same. The SHR also testified that she removed bolts from the site without permission of the owner or the respondent and did not bring them forward until the time of the hearing.

At Citation 2, Item 2, counsel inquired whether the SHR was given copies of safety meeting documents and whether she received evidence of the deceased employee's attendance at fall protection meetings. Ms. Chmelikova responded in the affirmative.

At the conclusion of the complainant's case, respondent argued a motion to dismiss for lack of sufficient evidence to meet the

complainant's threshold burden of proof. The board took the motion under advisement and continued the hearing with respondent presenting its case in defense of the alleged violations.

Counsel for the respondent presented witness testimony from Mr. Rick Kempton, the general field superintendent and vice president of field operations for respondent. Mr. Kempton testified that no one removed or interfered with any property at the accident site. The respondent controlled the scene, maintained the evidence and secured the elevator core area of the accident by utilizing yellow caution tape and boarding up the shaft opening. He further testified that two bolts are required and were used on each side of every connection. Two bolts were in place on every connection he inspected after the accident. He testified that a retractable lanyard was on site at the elevator core which he observed immediately after the accident as depicted in the photographic exhibit admitted in evidence. The witness testified that he concluded the accident was caused due to the deceased employee's error in removing both nuts (2) from one end of the beam while he was trying to align holes for connection. His movement on the beam caused it to roll and slip off the two bolts, which in turn sheared the two bolts on the opposite end. He testified that the two clean cut bolts found on the shaft floor area where the beam fell supports his theory that there were two bolts in place on the opposite end of the beam which sheared off due to the weight of the employee and the beam that was disconnected completely on one side because both nuts had been removed.

On cross-examination, the witness testified that the deceased employee was a fifth level apprentice under the union program, which requires at the primary level that there always must be one bolt and nut in place while performing a final connection in a minimum two bolt-up

process. He further testified as to pages 16 and 17 of respondent's Exhibit A regarding testing and the respondent's plan for site specific training. Finally he testified that he observed two nuts and two bolts on the floor immediately after the accident and did not know what happened to them until recently learning that the SHR removed same from the scene.

Respondent presented testimony from respondent employees Gutierrez and Aviles.

Mr. Guiterrez testified he has been a safety coordinator for 20 years. He further testified as to the respondent's safety program, the scope and extent of same, and the requirements for employees to "sign off" to verify attendance at safety meetings. He reviewed the respondent's "red book" for safety training and orientation. All employees received specific safety orientation for each job and weekly "tool box" training meetings. He further testified that the employer disciplines employees for violations of safety rules or training. Mr. Gutierrez identified the signature of the deceased employee on the training documents acknowledging his attendance and receipt of training. Mr. Gutierrez also testified that respondent has disciplined employees in the past and vigorously enforces its safety program. He testified that the general contractor's employees not those of respondent boarded up areas of the accident scene to preserve evidence and not to prevent an OSHA investigation. He stated that nothing was ever removed by respondent from the elevator core area. Mr. Gutierrez testified that he saw "a couple of bolts", a bull pin and beater on the ledge below where the decedent employee was working prior to the accident and took photographs which he identified as tab 10 of respondent's exhibit binder. He completed an inventory after the accident and collected

evidence which included four bolts and four nuts. He testified that he saw at least two bolts and nuts on each side, for a total of four, of every beam in the subject core which he inspected.

Mr. Aviles testified that he is an employee of respondent and was working on the same site in the elevator core the day of the accident. He testified that he initially installed all the bolts and nuts and assured there were ". . . two in and snug on both sides of all beams . . ." As an initial installer, it is a requirement that every beam include two bolts and nuts on each side and he was "absolutely sure" that he had installed same on the beam which fell and subject of the citations. He further testified that he is very sure of his memory due to his personal practice to be very safe and because his own brother was working behind him. The close working relationship with his brother made him very sure of what he had done.

Respondent presented testimony and evidence from respondent's foreman of the bolt up crew. He identified Exhibit 4 as the company plan. He testified that he "never saw any connection made with one bolt . . ." He stated he was taught as an apprentice to always leave one connected bolt in tight while connecting the other bolt and that everyone involved in steel work is taught similarly. He testified that he was foreman of the crew working, at the time of the accident which included the deceased employee, and saw two bolts connecting each end as workers were coming up the structure to finish by adding two more for a total of four on each end of the beam structure. He testified that he observed employees, including the deceased, properly tied off while working. He said that he was five feet away from the deceased employee when the accident happened and he never saw the deceased do anything wrong.

Respondent presented testimony and evidence from Ms. Susan Winfield who identified herself as the safety engineer employed by Perini Construction, the general contractor for the Cosmopolitan job. She testified that she has 13 years experience as a safety engineer and three and one-half years with Perini Construction. She further testified that she conducted a "site specific or safety orientation" for all employees of Perini and any subcontractors on the Cosmopolitan project. She testified that all Perini job sites are "zero tolerance" and that a lack of 100% tie-off results in a penalty imposed prohibiting work on a Perini site for up to one year. She testified that she arrived on the scene of the accident four minutes after it occurred and saw the decedent on the floor in the elevator core. She testified that the elevator core was boarded up after the fall to prevent employees from looking at the site and endangering themselves but not to impede an OSHA inspection. She further testified that Perini employees, not those of respondent, tagged the tools and items found and controlled the accident site. She further testified that SHR Chmelikova was given full access to the site but spent "on and off about one hour in the elevator core." Ms. Winfield testified that she saw one bolt on the floor by the end of the beam at the point of impact after the accident. She further observed the deceased employee's equipment on the ledge from near where the beam fell, contrary to the SHR's testimony who stated she saw no equipment. Ms. Winfield identified photographic Exhibit 10 depicting the deceased employee's tools. She testified that she, on behalf of the general contractor Perini, concluded that the deceased employee "took a short cut" and used his tool to hold the beam in place rather than a bolt while removing the other bolt which resulted in his fall and death.

Respondent counsel called Mr. James Stanley as an expert witness.

Mr. Stanley identified himself as an FDR safety employee and president of the company, engaged in consulting work for the Iron Workers Union and respondent. He further testified that he was a former compliance officer (SHR) and worked his way up through private industry after having served as the former Deputy Assistant Secretary of Labor at the federal level. Mr. Stanley testified as to each of the alleged violations and provided an expert opinion regarding same. He testified that Citation 1, Item 1(a) provided no basis for a violation. The standard does not apply to the facts because the elevator core is concrete, not a steel structure. He testified that the wrong standard was relied upon. The respondent did not erect the concrete core. Structural stability has nothing to do with falling beams in the facts described and depicted as the basis for a violation. Mr. Stanley testified that the cited standard applies to only steel buildings or steel structures ". . . capable of falling down during construction." He testified that the pre-task form requirement does not relate to "structural stability" and has no bearing on the subject accident. He saw no evidence that less than two bolts were in both holes after examining the fallen beam. He concluded that the employee must have removed the bolts and inserted his alignment tool while installing the washers and nuts.

At Citation 1, Item 1(b), Mr. Stanley opined there was no violation because the standard does not apply due to the elevator core not being a multi-storied structure. He testified that the reason for the standard is to protect people working below from being hit by falling tools and to limit falls to a certain height. He identified there being 100% fall protection at the site and thus no need for decking, even if the standard was applicable. He also testified that to install decking

in an elevator shaft would constitute a "greater hazard."

At Citation 1, Item 2(a), Mr. Stanley testified the cited standard was not applicable because the "connection" was effectuated approximately seven days prior to the accident. He stated that the "connectors" initially place two bolts and nuts in each side of the beam and it is the second crew's job, which involved the deceased, to then follow to "bolt up." He testified that the accident occurred, in his opinion, because the deceased employee pulled out both bolts to attach washers and nuts, and used his tool to secure the beam.

At Citation 2, Item 1, Mr. Stanley opined there was no evidence of any intention to remove evidence or that any evidence was actually moved other than in the appropriate fashion to safeguard and maintain the work site accident scene. Mr. Stanley further testified that an SHR has no authority to remove evidence from a work site accident scene and at the federal level it is in and of itself a violation of law.

At Citation 2, Item 2, Mr. Stanley testified there is no requirement for an employer to maintain written documentation under subpart R. He disputed the SHR testimony that the safety manual was not implemented and testified that he reviewed all training and safety documentation in furtherance of same and "I don't know what else they could have done."

At the conclusion of the hearing, the complainant and respondent presented closing arguments.

The board in reviewing the evidence and testimony finds insufficient facts and competent evidence by a preponderance to establish that the employees of respondent were exposed to the hazard and death which occurred due to a failure on the part of the employer to comply with the standards cited at Citation 1, Item 1(a), 1(b) and

2(a). The board further finds that the steel erection standards are inapplicable to the subject facts and the work efforts in compliance with the workplace safety standards. The board also finds that even if the subject standards were interpreted to be applicable to the facts as cited, there is sufficient evidence in the record to establish a defense of unpreventable employee misconduct, which would excuse the employer, notwithstanding standard applicability or the burden of proof having been established/met by the complainant.

At Citation 2, Item 1 referencing the regulatory violation of Nevada Revised Statute (NRS) 618.3791, there was no evidence that the employer failed to maintain the accident scene for an investigation. To the contrary, it appeared that the respondent and the general contractor exercised reasonable judgment in safeguarding the work site and protecting other employees from either a fall hazard or exposure to other hazards that may have existed after the accident and disruption of the work project. The board need not reach any finding or conclusion as to the SHR's collection of evidence as same is not material to resolution of the matter. However, maintaining any work site for an OSHA investigation is a burden upon all parties in every accident inspection.

At Citation 2, Item 2, referencing the regulatory violation cited as Nevada Administrative Code (NAC) 618.5421(c), the board finds it is not applicable to the facts in evidence. No requirement can be found for maintaining records as cited. Notwithstanding same, the evidence demonstrated the deceased employee attended required training and safety meetings.

An employer is not required under occupational safety and health law to be the insurer of every work site against every accident. The

spirit, intent, and specific standard codification of occupational safety and health legislation is to safeguard employees from all preventable hazard exposure with the exercise of reasonable diligence and enforcement.

The tragic accident that occurred may very well have been due to unpreventable employee misconduct based upon the evidence and testimony of witnesses at the scene at the time of the accident and the expert opinion of Mr. Stanley who reconstructed the cause of the accident based on the evidence.

The long recognized elements required for the defense of employee misconduct are:

(1) The employer must establish work rules designed to prevent violation.

(2) The employer must adequately communicate work rules to its employees.

(3) The employer must take steps to discover violations of work rules.

(4) The employer must effectively enforce the work rules when violations have been discovered.

See *Jensen Construction Co.*, 7 OSHC 1477, 1979 OSHD ¶23,664 (1979). Accord, *Marson Corp.*, 10 OHSHC 2128, 1980 OSHC 1045 ¶24,174 (1980).

1. In the subject case, the unrefuted sworn testimony of four witnesses must be given weight and credibility. The testimony established there were work rules designed to prevent the violations cited. The testimony further supports the training, practices and policy of the respondent employer to assure that two bolts and nuts are inserted on each end of every beam installed. The location of the sheared bolts, the tools utilized by the deceased employee, and the facts on reconstructing the cause of the accident, leave no reasonable conclusion other than a failure based upon employee misconduct.

2. The employer adequately communicated appropriate safety work rules to its employees. The sworn testimony of the respondent employees, including Rick Kempton and general contractor employee Winfield, clearly established the rules and safety practices in place and communicated with effective enforcement.

3. The employer took reasonable measures to discover violations through the work of its foreman and as testified by Me. Guiterrez and Mr. Kempton who observed ongoing work and inspected the site after the accident.

4. The testimony of Mr. Kempton and Ms. Winfield was evidence of effective enforcement of the safety work rules at the site when violations have been discovered.

> Evidence that the employer effectively communicated enforced safety policies to protect against the hazard permits an inference that the employer justifiably relied on its employees to comply with the applicable safety rules and that violations of these safety policies were not foreseeable or preventable. Austin Bldg. Co. v. Occupational Safety & Health Review Comm., 647 F.2d 1063, 1068 (10th Cir. 1981). When an employer proves that it has effectively communicated and enforced its safety policies, serious citations are dismissed. See Secretary of Labor v. Consolidated Edison Co., 13 O.S.H. Cas. (BNA) 2107 (OSHRC Jan. 11, 1989); Secretary of Labor v. General Crane Inc., 13 O.S.H. Cas. (BNA) 1608 (OSHRC Jan. 19, 1988); Secretary of Labor v. Greer Architectural Prods. Inc., 14 O.S.H. Cas. (BNA) 1200 (OSHRC July 3, 1989).

In all proceedings commenced by the filing of a notice of contest, the burden of proof rests with the Administrator. (See NAC 618.788(1).

> All facts forming the basis of a complaint must be proved by a preponderance of the evidence. See Armor Elevator Co., 1 OSHC 1409, 1973-1974 OSHD ¶16,958 (1973).
>
> To establish a prima facie case, the Secretary (Chief Administrative Officer) must prove the **existence of a violation**, the exposure of employees, the reasonableness of the abatement

period, and the appropriateness of the penalty. See Bechtel Corporation, 2 OSHC 1336, 1974-1975 OSHD ¶18,906 (1974); Crescent Wharf & Warehouse Co., 1 OSHC 1219, 1971-1973 OSHD ¶15,047. (1972). (Emphasis added.)

The board finds that Complainant did not meet the required burden of proof to establish violations based upon the citations issued.

Based upon the above and foregoing, it is the decision of the **NEVADA OCCUPATIONAL SAFETY AND HEALTH REVIEW BOARD** that no violations of Nevada Revised Statutes did occur as to Citation 1, Item 1(a), 29 CFR 1926.754(a), Citation 1, Item 1(b), 29 CFR 1926.754(b)(3), Citation 1, Item 2(a), 29 CFR 1926.756(a)(1), Citation 2, Item 1, Nevada Revised Statute 618.379(1), and Citation 2, Item 2, Nevada Administrative Code 618.542(1)(c). The violations charged are hereby dismissed and the proposed penalties of TWELVE THOUSAND ONE HUNDRED AND FIFTY DOLLARS ($12,150.00) denied.

The Board directs counsel for the Respondent to submit proposed Findings of Fact and Conclusions of Law to the **NEVADA OCCUPATIONAL SAFETY AND HEALTH REVIEW BOARD** and serve copies on opposing counsel within twenty (20) days from date of decision. After five (5) days time for filing any objection, the final Findings of Fact and Conclusions of Law shall be submitted to the **NEVADA OCCUPATIONAL SAFETY AND HEALTH REVIEW BOARD** by prevailing counsel. Service of the Findings of Fact and Conclusions of Law signed by the Chairman of the **NEVADA OCCUPATIONAL SAFETY AND HEALTH REVIEW BOARD** shall constitute the Final Order of the **BOARD**.

DATED: This 8th day of December 2008.

NEVADA OCCUPATIONAL SAFETY AND HEALTH REVIEW BOARD

By /s/
JOHN SEYMOUR, Chairman