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NEVADA OCCUPATIONAL SAFETY AND HEALTH

REVIEW BOARD

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CHIEF ADMINISTRATIVE OFFICER OF THE OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION OF THE DIVISION OF INDUSTRIAL RELATIONS OF THE DEPARTMENT OF BUSINESS AND INDUSTRY, STATE OF NEVADA, **Complainant,** **vs.** **LAS VEGAS PAVING CORP.,** **Respondent.**	**Docket No. LV 18-1940** **Inspection No.: 1266890**

DECISION OF THE BOARD, FINDINGS OF FACT, CONCLUSIONS OF LAW AND FINAL ORDER

This case arose out of a fatality that occurred in Las Vegas, Nevada, at the Las Vegas Boulevard-St. Rose Parkway to Silverado Ranch Boulevard jobsite, located near Las Vegas Boulevard South and Jonathan Drive, Las Vegas, Nevada. The case came on for hearing on July 13, 2022, and continued on July 14, 2022, before the Nevada Occupational Health Review Board (the Board). The Board members participating in the hearing on July 13, 2022, were Board Chairman Rodd Weber, Board Secretary William Spielberg, and Board Members Frank Milligan, Jorge Macias and Scott Fullerton. The Board members hearing the case on July 14, 2022, were Board Chairman Rodd Weber, Board Secretary William Spielberg, and Board Members Frank Milligan, Jorge Macias and Scott Fullerton.

The Board deliberated and decided the case on October 12, 2022. The Board members in attendance for the disposition of this matter on October 12, 2022, were Board Secretary William Spielberg, who chaired the meeting in the absence of Board Chairman Rodd Weber and Board Members Frank Milligan, Jorge Macias and Scott Fullerton. Las Vegas Paving Corp. (Las Vegas Paving or LVP), is the respondent in this case. LVP was represented throughout by

Dalton Hooks, Esq. of Hooks Meng & Clement. The complainant, Chief Administrative Officer of the Occupational Safety and Health Administration of the Division of Industrial Relations of the Department of Business and Industry, State of Nevada, (the State) was represented throughout by Salli Ortiz, Esq. The Board's legal counsel is Charles R. Zeh, Esq., of the Law Offices of Charles R. Zeh, Esq., who also appeared throughout all of these proceedings.

The hearings in this case were conducted in furtherance of duly provided notices. Nevada has adopted all Federal Occupational Safety & Health Standards which the Secretary of Labor has promulgated, modified or revoked and any amendments thereto. They are deemed the Nevada Occupational Safety and Health Standards. *See*, NRS 618.295(8). Jurisdiction in this matter is conferred by Chapter 618 of the Nevada Revised Statutes, NRS 618.315. All incidents referenced herein took place in the State of Nevada. The respondent is a Nevada domestic corporation with a business address of 3920 West Hacienda Avenue, Las Vegas, Nevada 89118. LVP's mailing address is 3572 North Bruce Street, North Las Vegas, Nevada 89030. Respondent conducted business and maintained a place of employment as defined by NRS 618.155, at the corner of Jonathan Drive and South Las Vegas Boulevard, Las Vegas, Nevada, 89183, where the fatality occurred.

Respondent's activities are defined in the North American Industry Classification System (NAICS) as Highway, Street and Bridge Construction (NAICS No. 237310).

The State issued its citation and notification of penalty (citation) on March 16, 2018. (Notification of Penalty, Inspection No. 1266890, AL 18-012). The investigation of the facility was conducted from September 25, 2017 through March 6, 2018, pursuant to NRS 618.375 as a result of code violations discovered at the site of the construction. By contest letter dated April 4, 2018, LVP contested the citation and penalty set forth in the referenced Citation and Notification of Penalty.

The State charged LVP as the controlling employer in a multi-employer jobsite. The State alleges that LVP failed in its responsibilities for the safety of employees on the job which are required of a controlling employer.

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The State classified the violation set forth in Citation 1, Item 1, of the complaint as a "SERIOUS" violation as follows:

> Citation 1, Item 1: SERIOUS
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> 29 CFR 1926.501(b)(4)(i): Each employee on walking/working surfaces shall be protected from falling through holes (including skylights) more than 6 feet (1.8m) above lower levels, by personal fall arrest systems, covers, or guardrail systems erected around such holes. *See,* the Complaint, p. 2.

The State alleged further in explanation of the citation:

> At the Las Vegas Boulevard - St. Rose Parkway to Silverado Ranch Boulevard jobsite, located near Las Vegas Boulevard South and Jonathan Drive, Las Vegas, Nevada 89183, Las Vegas Paving Corporation, the Controlling Employer, did not ensure that each employee on a walking/working surface was protected from falling through holes more than 6 feet above a lower level by personal fall arrest systems, covers, or guardrail systems erected around such holes. On September 25, 2017, employees of two other employers were performing media removal and inspecting manhole number 8 and were not protected from falling through the hole. An employee fell approximately 22 feet [it is alleged] through the open manhole sustaining fatal injuries as a result of the fall. In addition, three other employees were also exposed to falling into the open hole. Complaint, p. 2.

Over the course of the hearing on this matter, the State offered for admission into evidence its Exhibits numbered 1 through 3, consisting of page C1 through C225. Similarly, Las Vegas Paving offered for admission into evidence Exhibits numbered page 1 through 332. These exhibits were entered into evidence by the Board without objection from either party.

FINDINGS OF FACT

The project, the site of the fatality, was a 2.9-3.0 mile long sewer line that was being installed with Las Vegas Paving as the General Contractor of the project. The project included 77 manholes of varying depths to be installed along the 2.9-3.0 mile long sewer line.

At issue in this case is manhole number 8, the site of the fatality. Olson Precast Concrete (Olson) was the subcontractor to Las Vegas Paving on the job. Olson contracted with LVP to install for LVP the manholes the entire length of the sewer line.

This case is the companion to the Olson Precast Concrete matter, LV 18-1939, where Olson's employee, Russell A. Tracy, Jr. "fell down an opening in the earth" some 22-24 feet below and perished. In the Olson Precast case, Olson was the direct employer of the decedent. September 25, 2018, the date of decedent's death on the job, was his first day at work for Olson

Precast on this project. In the Olson Precast matter, Olson argued in LV 18-1939, that the manhole opening in the earth, the site of the fatality, was an "excavation," not a "hole" and that, therefore, since the State applied the regulation for protecting employees, in the vicinity of "holes" in LV 18-1939, the case should be dismissed because the regulations governing holes was the incorrect standard. Olson argued that the correct standard was the regulation governing "excavation sites." Olson argued further that it had met the excavation regulation requirements and, therefore, the case should be dismissed against Olson Precast.

The Board disagreed, holding that at issue was a "hole," and not an excavation. The Board determined further that the State pled the correct standard and had shown that the correct standard had been violated by Olson for failing to require personal protective equipment to be worn by employees working the "hole." Mr. Tracy was found lying at the bottom of the 24 foot deep manhole without any personal protection equipment.

Here, LVP makes the same argument that at issue is an excavation, not a hole. In any event, LVP treated manhole 8 where the incident took place as an excavation. As in LVP, case number 18-1939, the decedent, the victim in LV 18-1940, was without personal protective equipment. Thus, insofar as the underlying incident is concerned, nothing has changed factually since the Olson case. The Board has already determined in the Olson case that the opening in the ground was "a hole" and not an "excavation." *Stare decisis*, therefore, requires consistency and that means that the Board must conclude in this case that at issue presently before the Board is a "hole" and not an "excavation."

The facts surrounding the incident in Olson Precast, LV 18-1939, are the same in this dispute. The only unanswered question in both Olson and this case is how the decedent, Russell A. Tracy, Jr., fell into the hole. No one witnessed the actual incident that put Mr. Tracy, at the bottom of a 24 foot deep manhole where he was discovered without wearing any personal protective equipment.

Therefore, it is beyond dispute that:

> On 09/25/17 at approximately 10:40 a.m., the superintendent was preparing to leave the jobsite and wanted to speak to the victim before departing. The superintendent was unable to locate the victim and looked inside the manhole where the victim's body was visible at the bottom.

> The employee fell approximately 22 feet and came to rest on top of a new sewage pipe and was pronounced dead at the scene. State's Exhibit p., 5.

It is also true that the decedent, Russell Tracy, was the attendant working manhole 8 and Ralph Jaime was the entrant, working manhole 8.

The entrant was at the bottom of manhole 8 cleaning out the media that had gathered there from the finish work up the side of the manhole.

> The entrant donned a full body harness (make: Guardian Fall Protection) and connected to the self-locking snap hook on the end of the wench's steel cable. The attendant, the decedent, operated the wench [from the edge of the manhole opening] and manually lowered the entrant to the bottom of the confined space. After reaching the lower working level, the entrant began cleaning/washing the manhole and filling a bucket with media. Once the bucket was filled with media, the attendant pulled up the bucket utilizing a rope and dumped it on the ground. The process was repeated until all the media had been removed from the bottom of the manhole. The attendant, [the decedent] raised the entrant to the ground and the manhole was ready for inspection. A Senior Construction Management Inspector for Clark County Water Reclamation District performed a visual inspection of the manhole utilizing a flashlight while standing near the unguarded hole. The Superintendent for Olson Precast LLC who had just arrived on site prior to the inspection, was also standing near the unguarded hole along with a confined space entrance and attendant [the decedent]. After the inspection was completed, the Clark County Water Reclamation District inspector headed to his truck. The confined space entrance walked to the driver's side of a company vehicle .... to retrieve his tools and get some water. Shortly thereafter, the entrant and superintendent were talking about supplies near the front of the company vehicle. After their brief conversation, the superintendent walked around his passenger side of the vehicle and did not see the attendant in cite, the superintendent walked around to the passenger side. The superintendent called out attendant's last-name and then walked over to the manhole where he located the employee at the bottom of the manhole. The decedent fell approximately 22 feet and came to rest on top of a new sanitary sewer line.
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> Diameter of precast concrete manhole opening is approximately 39 inches. State's Exhibit pp. 15, 16.

This is how it happened. As stated, no one saw how Russell A. Tracy, Jr., wound up at the bottom of the hole. He was lying there, without, as indicated, any personal protective equipment. The equipment he used as the attendant working immediately adjacent the hole or manhole consisted of a tripod, rope, bucket and a hand bucket. 1 Tr.[1] 197. No one seriously considered this equipment as satisfying any personal protective equipment requirement. *See,* Tr. 1 Tr. 208.

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[1] 1 Tr. stands for the transcript of the proceeding that was held on July 13, 2022 and 2 Tr. stands for th transcript of the proceeding that was held on July 14, 2022.

To the extent that any of the conclusions of law, following, also constitute matters of fact, they are incorporated herein.

CONCLUSIONS OF LAW

To the extent that any of the statement of facts constitute conclusions of law they are incorporated herein.

The State is obligated to demonstrate alleged violations by a preponderance of the reliable evidence in the record. Findings must be based upon the kind of the evidence upon which responsible persons are accustomed to rely in serious affairs. *William B. Hopke Co., Inc*. 1982 OSHARC LEXIS 302 * 15, 10 BNA OSHC 1479 (No. 81-206, 19820 (ALJ)). The Board's decision must be based on consideration of the whole record and shall state all facts officially noticed and relied upon. 29 CFR 1905.27(b). *Armor Elevator Co.*, 1 OSHA 1409, 1973-1974 OHSD ¶ 16, 958 (1973). *Olin Const. Co. v. Occupational Safety & Health Rev. Comm'n*, 525 F.2d 464 (2d Cir. 1975). The State is obligated to demonstrate the alleged violation by a preponderance of reliable evidence in the record. *Angelica Health Care Servs. Grp., Inc. Respondent*, 14 O.S.H. Cas. (BNA) ¶ 1917 (O.S.H.R.C.A.L.J. Oct. 26, 1990).

In this case, the burden is on the State to prove by a preponderance of the evidence, a *prima facie* case exists against the Respondent for the cause of action or citation litigated against the Respondent. *See*, NAC 618.788(1), *see also, ComTran Group, Inc. v. U.S. Dept. Of Labor*, 722 F.3d 1304, 1308 (11th Cir., 2013); *Secretary of Labor v. JPC Group, Inc*., 2009 WL 2567337, Final Order Dated 2009, (O.S.H.R.B.) WL p. 2. Thus, the State must establish before the Board in order to sustain proof of a *prima facie,* proof of the following : (1) the applicability of a standard being charged; (2) the presence of a non-complying condition; (3) employee exposure or access to the non-complying condition; and, (4) the actual or constructive knowledge of the employer's violative conduct. *See, Id.*, *see also, Original Roofing Company LLC v. Chief Administrative Officer of the Nevada OSHA,* 135 Nev. 140, 143, 442 P.3d 146, 149 (2019). Actual or constructive knowledge can be proven by showing "that the employer either knew, or, with the exercise of reasonable diligence, could have known of the presence of the violative condition." *See, Pelican, LLC v. Chief Admin. Officer of Occupational Safety &*

Health Admin., Div. of Indus. Rels. of Dep't of Bus. & Indus., 136 Nev. 858 (Nev. App. 2020) (quoting *Pride Oil Well Serv.*, 15 BNA OSHC 1809, 1814 (No. 86-692, 1992)). It is also true that an employer may not contract away its legal duty to comply with the OSHA act. *Baker Tank Co./Altech*, 17 OSH Cases 117711180 (rev. Comm'n 1995); *Done Par-Engineered Form Co. The Marshall*, 676 F.2d 1333, 10 OSH cases 1561 (10th Cir., 1982).

As indicated, Olson Precast is a companion case to the instant dispute with LVP. Again, in Olson Precast, the decedent fell into a manhole dropping 24 feet from the surface and died. Olson Precast was charged with a violation of 29 CFR 1926.501(b)(4)(i) which states: "Each employee on walking/working surfaces shall be protected from falling through holes (including skylights) more than six feet (1.8 m) above lower levels, by personal fall arrests systems, covers, or guard rail systems erected around such holes."

Olson Precast contested on the grounds that 29 CFR 1926.501(b)(4)(i) was an incorrect citation with no bearing on the facts of the case. Olson Precast argued that the correct citation should have been 29 CFR 1926.501(d)(7)(i) and, therefore, given that wrong citation was pled by the State and given that Olson Precast met the terms and conditions of 29 CFR 1926.501(d)(7)(i), the case should be dismissed.

29 CFR 1926.501(d)(7)(i) states: "Each employee at the edge of an excavation six feet (1.8 m) or more in depth shall be protected from falling by guard rail systems, fences, or barricades when the excavation are not readily seen because of plant growth or other visual barrier."

The Board concluded in Olson Precast that 29 CFR 1926.501(b)(4)(i), as pled by the State, was the correct regulation to have been pled as the Board found that the employee fell into a 24 foot deep manhole with a 39 inch diameter. The Board concluded additionally that this was not an excavation case and, therefore, Olson Precast's claim that 29 CFR 1926.501(d)(7)(i) should have applied was a claim asserted in error. In this dispute, LVP makes the same argument to the Board, which the Board has already found wanting in Olson Precast. The Board has already concluded that at stake is a "manhole" not a matter of a "excavation." Nothing has changed factually since the Olson Precast case was litigated. To be consistent and honoring the

principle of *stare decisis*, the Board must insist that at issue in this case is a hole and not the case of an excavation.

The situation here, however, in LVP, involves a multi-employer situation. Las Vegas Paving was not the employer of the deceased employee. He was employed by Olson Precast. Therefore, in this case, for the State to prevail, it must establish that Las Vegas Paving was a controlling employer under the multi-employer doctrine that violated its duty to the workplace generally as a controlling employer in a multi-employer context.

In the multi-employer context, there are four classes of employers that may be cited. They are: the exposing employer, creating employer, correcting employer and controlling employer. The State alleges that Las Vegas Paving was a controlling employer. Therefore, the State must be able to show that Las Vegas Paving was, in fact, a controlling employer and that as the controlling employer, it violated its responsibility in the workplace to the deceased worker.

A controlling employer is one that can reasonably be expected to prevent or detect, or protect the violative conditions by reason of its control of the work site or a supervisory capacity. The emphasis is upon reasonablity. A controlling employer must make reasonable efforts to prevent, protect and to abate violative conditions.

This effort depends on a multitude of factors including the degree of supervisory capacity, the constructive, actual knowledge of, expertise with respective to the violative conditions, the cause of the violations, the disability of the violations, the length of time that persists and what the controlling employer knows about the sub-contractors' safety program. It does not depend upon whether a controlling employer has the manpower or expertise to address the hazard itself. It is also a duty that cannot be contracted away or abdicated.

These are the factors that must be considered when deciding whether the State has established that Las Vegas Paving was the controlling employer who also had violated its duty to the decedent and employees in the workplace. In other words, even if it was established that the decedent fell into the hole as opposed to an excavation trench, the State must also show that Las Vegas Paving had, as the controlling employer, violated its duty as described above to the employees in the workplace. OSHA Instruction, U.S. Department of Labor, Occupational Safety

and Health Administration, Directive No: CPL 2-00.124, effective date, December 10, 1999, Subject: Multi-Employer Citation Policies MECP.

Here, a violation has already been established in the Olson Precast case. As indicated, there, the Board concluded that 29 CFR 1926.501(b)(4)(i) applies, that it requires personal fall arrests systems, covers, or guard rail systems to be erected around the manhole and that Olson failed to meet the requirements of 29 CFR 1926.501(b)(4)(i) as Mr. Tracy's direct employer.

Here, by contract, LVP was in the relationship to the decedent as that of the controlling employer. The sub-contract entered into by LVP and Olson Precast specifically gave the authority to LVP to stop a job if it discovers a safety issue or violation, to shut down the job until the safety violation is corrected, and to direct that the safety violation be corrected or correct the violation itself and then charge back the cost of the correction to Olson. LVP concedes the point that it has that authority and control over the workplace. *See*, 2 Tr. 249. Las Vegas Paving was the controlling employer of the work site for the three mile sewer line which includes 70 manholes to be constructed by Olson Precast.

The question then becomes whether LVP has fulfilled its responsibilities to the decedent and the workforce of Olson Precast and other sub-contractors on the job by acting reasonably to detect or predict violative working conditions by reason of its control over the work site or in its supervisory capacity. Here, Las Vegas Paving failed in multiple ways.

Benjamin Romero was employed by Las Vegas Paving as the safety manager on this project. He had been with the company since 2008, a 14 year term. 1 Tr. 171. He was a safety manager for LVP the entire 14 years he was employed there. 1 Tr. 179. He was the safety director at the time of the incident. 1 Tr. 171.

At the time of the incident he claims, as the LVP safety director, he had a multitude of duties including checking on other jobs for safety, investigating incidents, accidents, injuries, training people, responding to accidents, traffic accidents, vandalism and theft. He was laden, in other words, with multiple responsibilities. 1 Tr. 172, 2 Tr. 267. As a safety manager, he is supposed to check for safety compliance. 1 Tr. 172.

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However, as the safety director, he did not conduct inspections of the job site daily. He was at the jobsite before the incident took place perhaps one to three times a week. 1 Tr. 173.

As for watching Olson Precast, he said that he had observed Olson Precast working on this phase of the project under their contract which is "manholes." When he did a site visit, he would see a truck, trailer and pickup with the Olson logo. 2 Tr. 259. He did not say that he saw a tripod. He did not say he saw personal fall arrest systems, covers, or guard rail systems erected around the holes as would be required by 29 CFR 1926.5601(b)(4)(i).

When asked whether he had watched Olson employees work at all, he said not often. He can't recall what Olson's employees had been doing on the job, working the manhole. He did say he was guessing at what Olson Precast employees were doing. He testified, further, that he had not seen them tie off anything. That is, he never saw them wearing personal fall arrest systems. Nevertheless, he was aware that Olson Precast had to go into the manholes in order to complete their job. But, he never observed the tripod over any of the manholes prior to the incident. 1 Tr. 191, 192, 195. Critically Mr. Romero does not recall having seen Olson employees enter into the manhole. 1 Tr. 192, 195. He also, concedes that he did not see or observe guard rail systems in place or other protective methods in use to protect employees from falls. 1 Tr. 207, 208, 2 Tr. 286. He never saw Olson tie off. 1 Tr. 192. Mr. Romero admits that he did not observe any guard rail system in place or other protective methods used to protect employees from falls. 1 Tr. 199, 208, 2 Tr. 286.

In other words, Mr. Romero's site supervision of manhole work was nearly non-existent. When asked if he watched Olson Precast work at all, his answer was “Not too often” 1 Tr., 191. And, if he did find something, he did nothing about it. *See,* 1 Tr. 207. He was, recall, the safety person in charge for this project.

Mr. Romero testified, however, he considered the manhole, the object of this incident, to be a plain view excavation. 1 Tr. 215. Therefore, he applied the excavation standard when inspecting the project rather than a "hole" standard of safety measures. He fell into the same mistake made by Olson Precast in the complaint filed against Olson Precast in LV 18-1939. *See,* 1 Tr. 215.

Hence, if Mr. Romero was actually looking at the project and evaluating performance, he was looking at it through the prism of the wrong regulation. This was not an excavation. This was a manhole with different requirements, including, pointedly, the use of personal fall arrest systems by the employees.

Mr. Romero was aware that Olson Precast had written safety policies. 2 Tr. 251. The current safety plan, however, if there was one in effect at that time, Mr. Romero had not read or reviewed it. 2 Tr. 424.

Mr. Romero said his function on the job was to stop by the job when it was one of my assigned jobs. He spent, however, a lot of his time in Boulder City at a larger job. 2 Tr. 267. It took a lot more time and he had several other jobs, plus, he was doing different types of reports. 1 Tr,. p. 172. Mr. Romero did not have the time to be a thorough safety inspector. As such, inspection was relegated to a lower level of intensity. 2 Tr. 267. To discharge his responsibilities he tried to make it out there every week. 2 Tr. 268.

That is to say, LVP assigned the safety function on this job to Mr. Romero on top of multiple other tasks that were made his responsibility. He simply did not have the time to be a thorough safety inspector on this job. Las Vegas Paving had relegated the function of safety inspection and control embodied on this job to the back bench.

Mr. Romero testified that when he did observe Olson Precast on their jobs, it was not this job. He observed Olson Precast working previous jobs. He also never met with any representatives of LVP to take any precautions to protect workers at sanitary hole number 8. He didn't talk to Olson Precast before the manhole number 8 incident. He did not see Olson working on manhole number 8, 2 Tr. 275. At the time of the incident, however, Olson Precast had already installed or constructed 20 manholes. 2 Tr. 275. Nonetheless, Mr. Romero never observed Olson Precast go inside the Hole. 1 Tr. 192, 199.

This project is also referred to as a confined space work site requiring a separate space program permit. Mr. Romero testified that he never attempted to identify the program being used by Olson for the confined space or working these manholes. 1 Tr. 196, 2 Tr. 279.

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Andy Michalsky, of Olson Precast, was the point of contact between Olson and Las Vegas Paving through Mr. Romero. Mr. Michalsky was a former safety manager for LVP. His employment at LVP overlapped Mr. Romero's employment at LVP. Mr. Michalsky left LVP to assume the Safety functions at Olson Precast, where he was employed on the date of the incident and in control of safety for Olson on this job. Due to Michalsky's history with LVP, no inspections were done. 2 Tr. 410. Also based upon LVP's reliance upon Mr. Michalsky, no harnesses were needed. 2 Tr. 414, 415. For manhole safety, LVP defaulted to Michalsky.

Mr. Romero claims that LVP conducted safety meetings at the jobsite. He states, however, these were exclusively with LVP. Olson Precast staff were not included in these safety briefings. 2 Tr. 292, 293. Mr. Romero states that he had, however, watched Andy Michalsky's crew but this was strictly on other sites, not the jobsite of this matter. 2 Tr. 296, 297. When watching Andy Michalsky's crew, the only physical items that he observed were a tripod, a form, a sign that says danger, confined space entry. Those were the only things he ever saw at the top of the manhole. 2 Tr. 297. Had to be the other job.

Mr. Romero also recalls, that he stated that based upon what he saw, there was no need for fall protection when working with these manholes. If that was his view of the situation, what kind of safety inspection would he be conducting in the first place? 2 Tr. 299.

Later in his testimony Mr. Romero stated that this was "not a manhole. It was just excavation." 2 Tr. 345, 1 Tr. 215. He admits he never went out there and observed any manhole installation or people entering the manhole on that jobsite. But he knew that they were installing manholes. 1 Tr. 192.

Mr. Romero said that Olson Precast coordinated the work schedule with Clark County Water Reclamation District only, and they coordinated, he thought, their schedule with one of the superintendents on the job. Olson Precast contracted with LVP but the scheduling went through Clark County. 2 Tr. 437, 448, 449. LVP therefor disengaged itself further with the manhole segment of the project, based upon Mr. Romero's relationship with Olson Through Mr. Michalsky. Las Vegas Paving "presumed" that Olson Precast had a safe procedure for manhole work based on company history and operations. 2 Tr. 350.

Christopher McNamara was also called to testify. He had been with LVP since 2004. He was a safety manager at the time of the incident. A safety manager is charged with going out into the field doing site evaluations for any type of possible safety violations or safety issues. 2 Tr. 354.

Mr. McNamara states that the project was identified as Las Vegas Boulevard from Saint Rose Parkway to Silverado Ranch Boulevard, Project 13132. 2 Tr. 369. According to McNamara the language of the contract supports LVP's authority to oversee work done by Olson Precast. 2 Tr. 369.

Mr. McNamara testified that in reliance upon Michalsky to do things right once Olson Precast won the bid on this job, Olson was given a direction at that point because of history and its relationship with Andy Michalsky. Because Andy Michalsky used to work for LVP, LVP didn't even do inspections of Olson's work. 2 Tr. 378. That is to say, LVP abdicated its safety responsibility to Olson Precast in connection with the manhole segment of the sewer line project.

Clark County Water Reclamation District did the inspections of the manholes. They were the party that was buying the project. 2 Tr. 378. These inspections, however, were work quality inspections, not safety inspections. 2 Tr. 448. Mr. McNamara first became familiar with Mr. Michalsky out at a jobsite in probably 2006, 2007. 2. Tr. 381.

Mr. McNamara went on to testify that he understood that Olson Precast was previously cited for a willful violation in connection with this project, that Olson was cited because Nevada OSHA found that they had not provided fall protection for employees who were working in a hole, and that is the same standard for which LVP was being cited here. 2 Tr. 384. Then he was asked with respect to this job whether he ever reviewed any of Olson Precast's written safety policies. His answer was he did not review them on this site. He didn't recall getting the book on Olson's specific policy or this specific project. He believed he looked at it on a prior project. 2 Tr. 392-393.

Mr. McNamara said he never investigated this incident. I really was not assigned to investigate it. 2 Tr. 397, 422, 442.

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The subcontract with Olson was reviewed with Mr. McNamara. Looking at paragraph 14.3 of the subcontract between Olson and LVP, Mr. McNamara agreed that it gave Las Vegas Paving a right to stop any unsafe work from Olson Precast on this jobsite. He said: "Absolutely, corrective measures must be taken and must be satisfactory to Las Vegas Paving." 2 Tr. 404. Then according to 14.3 of the contract, he said this Section of the contract gave Las Vegas Paving a right to stop any unsafe work from Olson Precast on its site. He also agreed that Olson must take corrective measures that are satisfactory to Las Vegas Paving. 2 Tr. 404.

Mr. McNamara also recalled saying that LVP would tell Olson "[] what needs to be done and then because of Andy Michalsky's history with Las Vegas Paving, no inspections were done." 2 Tr. 410.

Mr. McNamara then tried to back track by saying, he was incorrect when he said we don't inspect the work. What I should have said was that a representative gentlemen from the Water Reclamation District would inspect the work. 2 Tr. 412. Mr. McNamara conceded, however, that the District's inspections were not safety inspections. The District was inspecting for the quality of work performed. 2 Tr. 448.

Mr. McNamara testified that at one point, he had concerns about the lack of personal protective equipment being worn. He took this up with upper management. According to Mr. McNamara, we had discussions about it and what management's feelings were and then he turned and said well somebody like Andy Michalsky has been doing this a lot longer then anybody else. "They would know the safe way to do it." 2 Tr. 415. This shows management's knowledge of the need for using protective personal equipment and it is further evidence of LVP's reliance upon Michalsky. Those discussions with Michalsky and others about methodology, *i.e.*, no need for personal protective equipment, were held with people in the hierarchy of the company that were above McNamara. 2 Tr. 413-415.

Mr. McNamara also engaged in a discussion of the elements of a controlling employer as one who has general supervisory authority over the work site, including the power to correct safety and health violations, to solve or to require others to correct them. Mr. McNamara was

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asked if that sounds like the authority that Las Vegas Paving had according to the contract we just reviewed? He agreed, yes. *See,* 2 Tr. 419.

Mr. McNamara was also asked whether such control can be established by contract in the absence explicit contractual provisions by the exercise of the control in practice. He was also asked if he agreed that the Olson contract we went over says that authority was given there. 2 Tr. 419, 2 Tr. 420. His answer was yes, he agreed.

Finally Mr. McNamara was asked about Olson Precast's safety plan. He had glanced at it. Mr. Romero said the same thing, that he had glanced at it. Neither said that they had devoted any time to reading it in its entirety or detail. 2 Tr. 424-425.

This factual framework leaves the Board to conclude that the State has proved its *prima facie* case. First, a violation was established. As held in Olson Precast Las Vegas Paving, LV 18-1939, the correct regulation pertinent to the controlling of this matter is 29 CFR 1926.501(b)(4)(i) which requires the use of personal fall protection systems, covers or guard rails systems erected around the holes in the ground. In the Olson Precast case, the Board found that this regulation applied and that it was violated. There were no personal fall arrest system, covers or guard rails in evidence at the time of the incident leading to the death of Mr. Tracy.

Further, LVP treated this, the work on this manhole, as if and considered it to be a matter of excavation, not work on a project that met the definition of a hole. The upshot was if there was any inspection conducted by LVP, it was from the prism of the wrong regulation, treating the work as that of excavation of a trench, not the construction of a 24 foot hole or service of 70 holes.

LVP also admits that it was a multi-employer on this work site, if not the multi-employer on this jobsite. It had a duty, therefore, to monitor the work against the regulations dealing with holes and not a regulation dealing with trenches. If there was an inspection of the premises, it was from the view point that LVP believed they were working with trenches, not manholes. The wrong standard would, therefore, have been applied when assessing the work on the jobsite. It would not appear, however, any inspections of the manhole work were made by LVP of the manholes. At most, only indifferent inspections were made of the manhole work site.

There was also an abdication of safety responsibility to Andy Michalsky and his crew at Olson Precast to assess the safety conditions on the job. The person assigned as the primary safety person on the job was Mr. Romero. 2 Tr. 422. From his testimony, it is obvious to the Board, he was overwhelmed with responsibilities other then this project. He was incapable of devoting the time necessary to monitor the work being performed. 1 Tr. 172.

LVP, it was shown, met the definition of a multi-employer in this case. The Contract with Olson clearly gave LVP control over the manhole aspect of the job. By contract, LVP could stop the job due to unsafe conditions, require corrections to be made and charge back to Olson the cost of making corrections. LVP's safety personnel conceded that LVP had the authority of a multi-employer over the manhole segment of the job.

The State has established, therefore, a violation of the regulations for the incident underlying the complaint in this case. The State also has shown that LVP was a multi-employer who failed in its duties as a multi-employer general contractor to adequately provide for safety on the jobsite. Mr. Romero was overwhelmed with assignments. Mr. McNamara and Mr. Romero agree that they relied heavily upon Olson Precast. In fact, the evidence is that they completely relied on Olson Precast to provide for safety on the job with respect to the manholes. There is also testimony that there was a complete failure to inspect the jobsite. Accordingly, the State established an underlining violation of code or regulations. And, it established that LVP was a multi-employer on this jobsite and that as the multi-employer on this jobsite, LVP failed to discharge its responsibility which required reasonable attention to safety on the jobsite.

The Board is of the opinion that the nearly virtual abdication of safety responsibility to Michalsky and Olson Precast, the party working the manholes, does not equate with the duty to reasonably provide for a safe working environment. Unfortunately, LVP's almost complete if not total reliance upon Michalsky and the assignment of safety to an overworked safety person establish a failure by LVP to perform the functions of a multi-employer and to fully discharge its responsibilities under 29 CFR 1926.501(b)(4)(i).

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Then there is the question of multi-employer knowledge. Mr. McNamara, a safety supervisor or inspector himself, testified that there were meetings at the upper management level about whether personal fall arrest systems were necessary. Management was aware that they deferred or defaulted to Andy Michalsky on that question. Mr. Romero, was the safety manager assigned to the job. 2 Tr. 414-418. And he was the primary person for safety on the job. 2 Tr. 422.

He was fully aware of the distractions that had pushed him away with other assignments. He was also aware of the deference to Mr. Michalsky and the minimal time he could spend himself inspecting on the job, if any.

LVP was clearly aware of the realities with its approach to safety and the failure to deploy fall arrest systems on this job. Knowledge is, therefore, established by the State. The multi-employer principles and regulation 29 CFR 1926.501(b)(4)(i) clearly apply to the jobsite and the nature of the work being performed. That element of the *prima facie* case has also been established. Finally, employees were in the danger zone making the multi-employer, employer principles and 29 CFR 1926.501(b)(4)(i) pertinent to this matter. Russell A. Tracy, Jr. was found dead at the bottom of a 24 foot manhole with no fall protective equipment evident. This meant there was no fall arrest system applied, covers, or guard rail systems erected around manhole number 8.

The evidence includes an analysis of the damages assessment for the fines being levied. The respondent's defense adhered the issue of liability, not the method by which the amount of the proposed fine was calculated. The fine, itself, was unchallenged.

The evidence is overwhelming to support a finding of affirmation of the citation in this case. Accordingly, it was moved by Jorge Macias, seconded by William Spielberg, to uphold Citation 1, Item 1, including the fine assessed and pled in the amount of $6,300. The motion was adopted on a vote of 4 in favor, none against with Chairman Weber absent.

This is the Final Order of the Board.

IT IS SO ORDERED.

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On November 13, 2024 the Board convened to consider adoption of this decision, as written or as modified by the Board, as the decision of the Board.

Those present and eligible to vote on this question consisted of 3 of the current members of the Board, to-wit, Chairman Jorge Macias, Board Secretary William Spielberg and Board Member, Scott Fullerton. Tyson Hollis and Gled Bautista were not eligible to vote on this Decision. Upon a motion by William Spielberg, seconded by Scott Fullerton, the Board voted 3-0-2, (Tyson Hollis and Gled Bautista abstaining as they were not members of the Board or in attendance when the matter was decided), to approve this Decision of the Board as the action of the Board and to authorize Chairman Jorge Macias, after any grammatical or typographical errors are corrected, to execute, without further Board review this Decision on behalf of the Nevada Occupational Safety and Health Review Board. Those voting in favor of the motion either attended the hearing on the merits or had in their possession the entire record before the Board upon which the decision was based.

On November 13th, 2024 this Decision is, therefore, hereby adopted and approved as the Final Decision of the Board of Review.

Dated this 26th day of November, 2024.

NEVADA OCCUPATIONAL SAFETY AND HEALTH REVIEW BOARD

By: /s/Jorge Macias
Jorge Macias, Chairman

Notice: Pursuant to NRS 233B.130, any party aggrieved by this Final Order of the Nevada Occupational Safety and Health Review Board may file a Petition for Judicial Review to the District Court within thirty (30) days after service of this order.

CERTIFICATE OF SERVICE

I certify that I am an employee of the Law Offices of Charles R. Zeh, Esq., and that on this date I served the attached document, *Decision of the Board, Findings of Fact, Conclusions of Law and Final Order* on those parties identified below by placing an original or true copy thereof in a sealed envelope, certified mail/return receipt requested, postage prepaid, placed for collection and mailing in the United States Mail, at Reno, Nevada:

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Dated this 4th day of December, 2024.

/s/Karen Kennedy
An employee of
the Law Offices of Charles R. Zeh, Esq.

S:\Clients\OSHA\LV 18-1940, Las Vegas Paving\LV 18-1940 ADA Final Decision.wpd