STATE OF ALASKA

DEPARTMENT OF LABOR

OCCUPATIONAL SAFETY & HEALTH REVIEW BOARD

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STATE OF ALASKA,
DEPARTMENT OF LABOR,

Complainant,

vs.

WHITESTONE LOGGING, INC.,

Contestant.

Docket No. 91-854
Inspection No. Ni-6959-111-90

DECISION AND ORDER

This matter arises from an occupational safety and health investigation by the State of Alaska, Department of Labor (hereinafter "Department") of a fatal accident involving an employee of Whitestone Logging, Inc. (hereinafter "Whitestone") on May 14, 1990, near Cordova, Alaska.

As a result of its investigation, the Department issued four citations to Whitestone alleging "serious" violations of Alaska occupational safety and health codes. Whitestone filed a timely notice of contest, conceding the violations alleged in Citations No. 2 and No. 4 but specifically contesting Citations No. 1 and No. 3 and the accompanying penalties.

Citation No. 1, as amended by the Department, alleges a violation of Alaska Logging Code 07.115(i)(1) for failure to comply with General Safety Code 01.501(i) which requires that in isolated worksites, the employer shall at all times provide oral means of communication, such as telephone or radio, for reaching the nearest town or settlement where medical care is obtainable. The Department classified this violation as "serious" and assessed a monetary penalty of $1,000.

Citation No. 3 alleges that Whitestone violated Logging Code 07.155(f)(1) by failing to load a logging truck in such a manner that the logs rested securely and the load was stable and well-balanced before binder chains were placed on the load. This violation was also classified as "serious" and a monetary penalty of $1,000 was assessed.

A hearing was held on the contested citations on July 17, 1991 in Anchorage. The Department was represented by Assistant Attorney General Janet Crepps. Whitestone was represented by its owner, Bud Stewart. Both parties presented witness testimony, documentary evidence and arguments to the Board. Upon consideration of the evidence and arguments, the Board makes the following findings of fact, conclusions of law and order in this matter.

FINDINGS OF FACT

1. In May 1990, Whitestone Logging was harvesting logs in an area near the Sheridan Glacier approximately 15-16 miles from

Cordova, Alaska. The logging area was about 3-4 miles along logging roads from the paved Copper River Highway leading into Cordova.

2. Whitestone employees were harvesting logs with Hahn Harvester shovel loaders, then loading the logs onto trucks for transport to waiting boats.

3. On May 14, 1990, at approximately 12:15 p.m., Whitestone employee Andy Vandetta was operating a shovel loader to load some logs onto a logging truck driven by fellow employee Chris Simon. After loading the logs, Vandetta jumped out of the loader to assist Simon in wrapping the binder chains around the load. Vandetta and Simon were on opposite sides of the load. Each man took a binder chain and threw it over the top of the load to the other side.

4. In the process of wrapping the binder chains around the load of logs, one of the logs on Vandetta's side became dislodged and fell on top of him, knocking him down. The weight of the log was later estimated at 1,500 pounds.

5. When Simon reached Vandetta's side, he found him still conscious but gasping for breath and in obvious pain. Vandetta was concerned about more logs coming down on him and asked Simon to move him further out of the way.

6. There were two means of communication on the Hahn Harvester: a short-range CB radio and a longer-range 25 watt radio for the purpose of reaching Whitestone's office in Cordova.

7. Simon attempted to get help using the long-range radio but got no response from Whitestone's office. It was later established that the office manager who was responsible for monitoring the long-range radios was out of the office doing errands during the noon hour when Simon made his call for help. There was no backup person in the office to monitor the radio communication system.

8. Despite some difficulty with the radio antenna, Simon was able to use the shorter-range CB radio to communicate with other Whitestone employees who were working with another shovel loader about five minutes away by foot. The other employees tried to contact the office using their long-range radios but also got no answer. Finally, one of the employees took a company vehicle and drove to the Cordova airport several miles away where he called the rescue squad. It was estimated that about 35-40 minutes had elapsed from the time of the accident until the rescue squad was notified.

9. A rescue squad ambulance arrived at the accident scene approximately 1-1/2 hours after the accident occurred. However, because of Vandetta's condition, it was thought inadvisable to move him by ambulance over the rough logging roads. Instead, a Coast Guard helicopter was summoned which airlifted Vandetta to the hospital in Cordova. After medical authorities determined that they could not help Vandetta locally, he was flown to a hospital in Anchorage. Vandetta subsequently died from his injuries.

10. Upon being notified of the accident, the Department dispatched safety compliance officer John Nielson to investigate the accident. Nielson's investigation took place on May 15-17, 1990.

11. When Nielson arrived at the accident scene on the day following the accident, he found that the logging truck and shover loader involved in the accident had been moved from the scene. It was not clear who had authorized this equipment to be moved or why it had been moved. Only the log that fell on Vandetta remained at the accident scene.

12. During the course of his investigation, Nielson discovered that the antenna on the shovel loader's long-range radio had been broken off the day before the accident. Whitestone supervisor Perry Beecher was aware that the antenna was broken but permitted the equipment to be used the following day. Owner Bud Stewart, who was in Hoonah when the accident occurred, defended this decision on the basis that the shorter-range CB radios could still be used to contact other equipment with long-range radio capability in the event of an emergency. Stewart conceded, however, that there was no one in the office monitoring the radios at the time the call for help was made.

13. Based on his investigation, Nielson further concluded that the load of logs involved in the fatal accident was not properly stable and secure when the binder chains were wrapped around it. Nielson received various complaints that Whitestone trucks were being overloaded. Typically, logs were loaded up to

the top of the side stakes on the trucks and then additional logs were "pyramided" in the center resting on the outside logs supported by the side stakes. A typical load of logs would be stacked about 14-1/2 feet high, more than two feet above the top of the side stakes. Nielson photographed a loaded logging truck as a typical example of how Whitestone's trucks were loaded. (Exhibit 1.) There was no evidence of any other loose or falling logs on Whitestone's trucks besides the truck involved in the fatal accident.

14. Whitestone did not have written guidelines regarding the loading of its logging trucks. However, the company provided training and oral instruction regarding the proper placement of logs. The shovel operator was responsible for stacking the logs on the truck in a secure and stable manner. The truck driver was responsible for making sure the logs were properly "seated" and for securing the load with the binder chains. Shovel operators were not normally supposed to assist in wrapping the binder chains around the load. This instruction, however, was neither formally communicated nor routinely enforced by Whitestone.

15. Whitestone owner Bud Stewart felt it was entirely a subjective judgment call as to whether the load of logs in question was stable and secure when the binder chains were wrapped around it. He stated that Vandetta was a very experienced loader operator and was regarded as an expert. He also noted that both Simon and Vandetta walked alongside the loaded truck to throw the binder chains over the top, so they must have thought the load was

sufficiently stable and secure. In Stewart's opinion, the log probably fell on Vandetta as a result of his "flicking" the binder chain to make it reach the other side, knocking one of the logs out of its saddle. Stewart did not believe a safety citation was warranted every time an employee was hurt; in this case, he felt there was nothing the company could have done to prevent the accident.

16. The Department classified both contested citations as "serious" based on its conclusion that there was a substantial probability of serious injury or death in the event of an accident. Furthermore, in light of the fatality, no mitigating factors were applied to reduce the $1,000 penalty for each violation.

CONCLUSIONS OF LAW

Citation No. 1

Logging Code 07.115(i)(1) states:

> Medical and first-aid services shall be provided as specified in subsections .0501(a)-(c) and (e)-(1) of subchapter (1), General Safety Code, Alaska Occupational Safety and Health Standards.

General Safety Code 01.501(i) states:

> Isolated worksites, industries or camps shall at all times provide oral means of communication, such as telephone or radio for reaching the nearest town or settlement where medical care is obtainable.

The evidence establishes that at the time of the accident, there was no effective means of communication between the logging site and the nearest town or settlement where medical care

was obtainable, i.e., Cordova. The long-range radio on Vandetta's shovel loader had a broken antenna. The shorter-range CB could only reach nearby employees at the logging site who themselves were unable to summon help from the office in town. The Code clearly requires that communication must be available between an isolated worksite and the nearest town or settlement where medical care is obtainable; the ability to communicate with a nearby crew at an isolated worksite is inadequate to comply with the Code if the other crew is itself unable to immediately summon medical help.

The Department and Whitestone disagree as to the general working condition of the radios and the effect of the broken antenna. However, we find it unnecessary to resolve this disagreement since it is beyond dispute that there was no one at Whitestone's office or shop in Cordova to monitor the radios and provide assistance in case of emergency. Even if the long-range radios had been working perfectly, the call for help would not have been heard. It goes without saying that when a serious accident has occurred at an isolated worksite, the availability of prompt medical assistance is crucial to the prevention of occupational injuries and fatalities. Sometimes only a matter of minutes can make the difference between life and death. Here, emergency rescue authorities were not notified until about 35-40 minutes after the accident. Direct communication between the logging site and Cordova would have ensured a faster response by rescue personnel and possibly prevented the fatality.

Whitestone argues that the General Safety Code provision cited is not specific enough in defining an "isolated worksite" under the circumstances of this case. We disagree. The logging area in question was at least 15 miles out of Cordova along a rough logging road approximately 3-4 miles from the paved highway. The road was considered sufficiently rough that the injured employee was taken out by helicopter rather than by ambulance. Such a worksite is "isolated" within the meaning of the cited code provision. To be an isolated worksite, it is not required that the worksite be unreachable by road. Any worksite that is difficult to reach quickly in the event of an emergency can be considered "isolated" within the meaning of the cited code provision. Moreover, occupational safety and health standards are to be interpreted as broadly as possible to best accomplish the OSHA Act's purpose of protecting the safety and health of employees. When there is a choice of adopting two or more possible interpretations of a standard, the one best calculated to achieve accident prevention is preferred. See Rothstein, Occupational Safety and Health Law, § 126 (3d ed. 1990).

Whitestone also argues that 1991 revisions to the logging code purportedly allow radio communication within one-half mile of a subject worksite. However, there was no evidence presented that this purported code revision has been adopted and would apply to the situation in question. Even if the code has been revised as asserted by Whitestone, a 1991 revision would not apply to this case since the accident took place on May 14, 1990.

For the foregoing reasons, we conclude that Citation No. 1 should be affirmed.

Citation No. 3

Logging Code 07.155(f)(1) states:

> Logging trucks shall be loaded in such a manner that the logs rest securely and the load is stable and well-balanced before any binder is placed thereon. The binder chains shall be in place before the truck leaves the loading area.

In citing Whitestone for a violation of the above provision, compliance officer Nielson stated that it was basically a judgment call as to whether the load of logs was stable and properly balanced during the placement of the binder chains by Simon and Vandetta. Nielson relied on the fact that all of Whitestone's logging trucks were loaded in a similar manner, that is, in a pyramid fashion with the highest logs resting more than two feet above the top of the side stakes. Nielson received various employee complaints that Whitestone's trucks were overloaded in this manner. Nielson also relied on Vandetta's statement after being hit by the falling log that he wanted to be moved because he was concerned that other logs might still fall on him. It is unfortunate that Nielson was unable to gather further evidence regarding this violation because the logging truck was removed from the scene of the accident prior to his arrival.[1]

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[1] We are disturbed by this apparent violation of the Alaska OSHA Act. AS 18.60.058 provides in pertinent part:

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In its defense, Whitestone argues that it is common practice in the logging industry to load trucks well above the side stakes, and that this practice does not violate any applicable laws or regulations as long as the logs are properly seated in the truck.

We agree that the issue of whether the truck was properly loaded is essentially a judgment call. However, this does not preclude a compliance officer (or this Board) from making a decision on code compliance based on available facts and circumstances. The evidence indicates that the log which fell on Vandetta probably became dislodged as a result of "flicking" a binder chain over the load. The fact that a 1500-pound log could become dislodged by the mere flicking of a binder chain is persuasive evidence that the log was not properly seated in the truck. Logging companies and loggers are presumed to know that binder chains will be wrapped around a load of logs and therefore

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[Footnote 1 continued]:

> In the event of an employment accident which is fatal to one or more employees or which results in the overnight hospitalization of two or more employees, no equipment, material, or product related to the injury or fatality may be moved or altered until clearance is given by the Department, except when compliance with this requirement would interfere for an unreasonable length of time with work or create additional hazards.

There is no indication that it was necessary to move the logging truck or other equipment from the scene of the accident, or that the Department authorized such action. Based on the facts and circumstances known to us, we believe this should have been cited as an additional violation.

it is imperative that the logs be positioned securely enough that the action of wrapping the binder chains around them does not dislodge any of the logs. Under OSHA laws and standards, it is the employer who bears the primary legal responsibility of ensuring that safe working practices are followed by employees. This is especially true at worksites where supervisors are not present at all times to oversee and enforce safe working practices.

Whitestone contends that the fatal accident was an isolated case of poor judgment by an employee who was not supposed to be involved in wrapping the load in the first place. However, we find that Whitestone has failed to meet the established elements of the "isolated employee misconduct" defense. The employer must prove that (1) it has established rules designed to prevent the violation; (2) it has adequately communicated these rules to its employees; (3) it has taken steps to discover violations; and (4) it has effectively enforced the rules when violations have been discovered. See Rothstein, supra, § 152. We find that Whitestone did not adequately communicate its policy that shovel operators were not to assist in the wrapping of loads; that it failed to take effective steps to discover violations of this policy; and that it failed to consistently and uniformly impose any discipline on employees when violations of the policy were discovered. We thus conclude that Whitestone has failed to prove the affirmative defense that this violation occurred as a result of unpreventable or isolated employee misconduct.

For the foregoing reasons, we conclude that Citation No. 3 should be affirmed.

Classification of Violations And Assessment of Penalties

Both Citation No. 1 and Citation No. 3 were classified as "serious," each with an assessed penalty of $1,000. Whitestone did not specifically dispute the classification of either violation or the amount of the proposed penalties. Based on the evidence presented, we believe that both violations were properly classified as "serious" since they significantly increased the likelihood of serious injury or death in the event of an accident. The fact that an employee actually died is more than sufficient evidence of the seriousness of these violations. Moreover, in light of the fatality, we have been presented with no reason why any adjustment should be made to the maximum penalty amount of $1,000 authorized by law. Accordingly, both the violation classifications and the monetary penalties should be affirmed as cited.

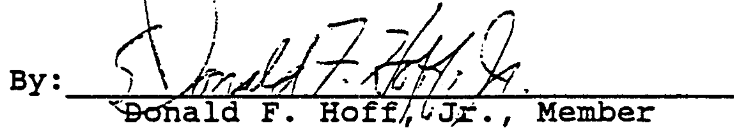
ORDER

Based on the foregoing findings of fact and conclusions of law, the Board orders as follows:

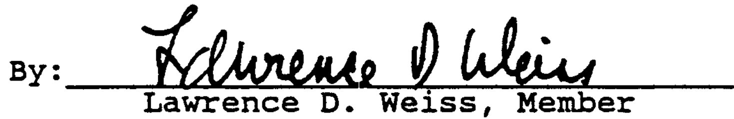
1. Citation No. 1 is affirmed with a penalty of $1,000.
2. Citation No. 3 is affirmed with a penalty of $1,000.

DATED this 21st day of August, 1991.

ALASKA OCCUPATIONAL SAFETY
AND HEALTH REVIEW BOARD



By: ______________________
Donald F. Hoff, Jr., Member



By: ______________________
Lawrence D. Weiss, Member