Department of Energy
Washington, DC 20585

October 29, 2025

Ms. Kathryn McMahon, Counsel
Conn Maciel Carey LLP
5335 Wisconsin Avenue NW, Suite 660
Washington, District of Columbia 20015

RE: Harris Rebar Placing, LLC

WEA-2024-04 (Final Notice of Violation)

Dear Ms. McMahon:

Pursuant to Section 234C of the Atomic Energy Act of 1954, as amended, 42 U.S.C. § 2282c, and in accordance with Title 10 of the Code of Federal Regulations (10 C.F.R.) § 851.43, a Final Notice of Violation (FNOV) is hereby issued by the Department of Energy (DOE) to Harris Rebar Placing, LLC (HRP) for violations of DOE's 10 C.F.R. Part 851, *Worker Safety and Health Program* requirements.

This FNOV is issued following DOE's investigation into the May 25, 2023, event when an ironworker was seriously injured after falling from concrete formwork at the Fermi National Accelerator Laboratory's (Fermilab) Proton Improvement Plan II (PIP-II) linear accelerator (LINAC) construction site, and DOE's review of HRP's August 26, 2024, Reply to the Preliminary Notice of Violation (PNOV) (hereinafter "HRP's Reply") that was issued on July 10, 2024.

Pursuant to 10 C.F.R. § 851.42(c), HRP submitted HRP's Reply to provide "additional insight into the underlying facts relevant to the May 25th fall incident at the Fermilab site, and to the actions HRP has taken since that accident."[1] HRP's Reply contested the Severity Level I violation and the proposed civil penalty of $118,000, including HRP's contribution to the underlying event and degree of culpability.[2] HRP's Reply also requested that DOE "negotiate a Consent Decree focused on ensuring the safety of HRP's team working at the Fermilab PIP II LINAC project site in lieu of finalizing the PNOV," noting that "HRP has given thought to the type of commitments it would suggest be included in a Consent Decree… as a way to resolve this matter in lieu of finalization of the PNOV."[3]

DOE's review of this request was conducted within the existing framework of DOE's settlement procedures under 10 CFR § 851.41. These procedures apply at the discretion of the Enforcement Director who considers whether to pursue settlement based on the severity of the violation(s) and the potential effectiveness of outcomes from settlement

[1] HRP's Reply to Preliminary Notice of Violation, page 1.
[2] *Id.* at 9-12.
[3] *Id.* at 13-14.

discussions, such as corrective actions that can be demonstrated during a continued contractual relationship with a party. In this case, the Acting Enforcement Director did not grant settlement due to the severity of the violations, even mitigated as they are through consolidation into one Severity Level I violation.

Nonetheless, DOE thoroughly reviewed and considered HRP's Reply under 10 C.F.R. § 851.43(a) before making its "final determination whether the contractor violated or is continuing to violate a requirement of [Part 851]."[4] DOE did not reclassify the Severity Level I violation or reduce the civil penalty amount, which remains a Severity Level I violation with a total base civil penalty of $118,000. DOE has opted to provide a detailed analysis of HRP's Reply, although it is not required to do so under 10 C.F.R. § 851.43. This analysis is provided as Enclosure 1. The FNOV is provided as Enclosure 2.

Pursuant to 10 C.F.R. § 851.44, HRP may petition DOE's Office of Hearings and Appeals for review of the final notice in accordance with 10 C.F.R. Part 1003.[5] HRP's petition must adhere to the procedural requirements established in 10 C.F.R. Part 1003, *Office of Hearings and Appeals Procedural Regulations*. If HRP does not petition the Office of Hearings and Appeals within 30 calendar days of receipt of this FNOV, HRP relinquishes any right to appeal any matter raised therein, and the FNOV will become a final order as provided by 10 C.F.R. § 851.43(c).

Sincerely,

Robin M. Keeler
Acting Director
Office of Enforcement
Office of Enterprise Assessments

Enclosures: DOE's Analysis of HRP's Reply to PNOV WEA-2024-04
Final Notice of Violation
Payment Processing Instructions

cc: Angela Aparicio, Fermi Research Alliance, LLC
Russell Bailey, Rose Law Firm
Whiteny Benger-Remizzi, SC-FSO

[4] 10 C.F.R. § 851.43(a).
[5] 10 C.F.R. § 851.43(b).

Enclosure 1

DOE's Analysis of HRP's Reply to PNOV WEA-2024-04

The U.S. Department of Energy (DOE) investigated the facts associated with the May 25, 2023, event, when an ironworker was seriously injured after falling from concrete formwork at the Fermi National Accelerator Laboratory's (Fermilab) Proton Improvement Plan II (PIP-II) linear accelerator (LINAC) construction site. The ironworker was an employee of Harris Rebar Placing, LLC (HRP), a subcontractor to Whittaker Construction and Excavating, Inc. (WCEI). WCEI was the general construction contractor for Fermi Research Alliance (FRA) on the PIP-II construction project.

The fall occurred when an HRP ironworker was preparing to secure a rebar template bar to the east side of a 26.5-foot-tall concrete formwork wall. The ironworker fell backwards, striking a diagonal brace before landing on the concrete slab approximately 23 feet below. The ironworker sustained serious injuries, including head trauma, and was air lifted to a local hospital.

The investigation identified multiple instances violating DOE's regulations in 10 Code of Federal Regulations (C.F.R.) Part 851 and concluded that HRP programs had deficiencies in management responsibilities, hazard prevention and abatement, construction safety, and training and information. On July 10, 2024, DOE issued a Preliminary Notice of Violation (PNOV) to HRP. The PNOV grouped the deficiencies and cited HRP for one Severity Level I violation of 10 C.F.R. Part 851 (Part 851), *Worker Safety and Health Program*, imposing a civil penalty of $118,000. This Severity Level I classification reflects not only the actual serious physical harm to the ironworker from the fall event, but also the pervasive and programmatic nature of the noncompliances found throughout HRP's management responsibilities, hazard prevention, construction safety, and training and information, which contributed to this event.

Under 10 C.F.R. § 851.42(c), HRP submitted a "Reply to Preliminary Notice of Violation" (HRP's Reply) on August 26, 2024, to provide "additional insight into the underlying facts relevant to the May 25 fall incident at the Fermilab site, and to the actions HRP has taken since that accident."[1] HRP's Reply contested the Severity Level I violation and the proposed civil penalty of $118,000, including HRP's contribution to the underlying event and degree of culpability.[2] HRP's Reply also requested that DOE "negotiate a Consent Decree focused on ensuring the safety of HRP's team working at the Fermilab PIP-II LINAC project site in lieu of finalizing the PNOV" noting "HRP has given thought to the type of commitments it would suggest be included in a Consent Decree… as a way to resolve this matter in lieu of finalization of the PNOV."[3] DOE's review of this request was conducted within the existing framework of DOE's settlement procedures under 10 CFR § 851.41. These procedures apply at the discretion of the Enforcement Director who considers whether to pursue settlement based on the severity of the violation(s) and the potential effectiveness of outcomes from settlement discussions. In this case, the Acting Enforcement Director did not grant settlement due to the significant nature of the injuries and severity of the violations, even mitigated as they are through combination into one Severity Level I violation.

---

[1] HRP's Reply to Preliminary Notice of Violation, page 1.
[2] *Id.* at 9-12.
[3] *Id.* at 13-14.

DOE thoroughly reviewed and considered HRP's Reply under 10 C.F.R. § 851.43(a) before making its "final determination whether the contractor violated or is continuing to violate a requirement of [Part 851]."[4]

DOE is providing this analysis to address HRP's Reply to Preliminary Notice of Violation (HRP's Reply). Although DOE is not required to provide detailed information in response to a reply received for a PNOV under 10 C.F.R. § 851.43, DOE has opted to do so here. In this document, DOE responds to each fact and statement presented by HRP and notes where information presented by HRP fits into one of five categories:

1. Facts that DOE does not dispute,
2. Regulatory requirements applicable to HRP at the time of the incident,
3. HRP arguments to which DOE disagrees,
4. HRP statements that are not relevant or applicable to the citations presented in the PNOV,
5. Statements that involve other parties involved in the incident that were addressed in a separate enforcement action or outcome document and do not pertain to HRP's notice of violation.

DOE also addresses the post-event actions presented by HRP for mitigation consideration.

I. Introduction

In paragraph 1 of I. Introduction, HRP states,

> "On July 7, 2024, Harris Rebar Placing, LLC ("HRP") received the enclosed Preliminary Notice of Violation ("PNOV") concerning DOE's investigation into the May 25, 2023 workplace incident at the Fermilab site. See Attachment 1 (DOE PNOV). Pursuant to 10 C.F.R. § 851.42 and the instructions contained in the PNOV, HRP submits this response."

DOE does not dispute the statement in this paragraph.

In paragraph 1-2 of I. Introduction, HRP states,

> "I hope this correspondence provides you and your team with additional insight into the underlying facts relevant to the May 25th fall incident at the Fermilab site, and to the actions HRP has taken since that accident.
>
> This response also includes an outline of areas of commitment on which HRP would be interested in engaging with your Office as a means to resolve this matter in lieu of finalizing the PNOV. I hope this suggested approach presents an acceptable path to resolution of this matter. It is my firm belief that our suggested resolution is the path best designed to ensure that DOE and HRP achieve their common objective of ensuring the safety of HRP's workforce."

DOE acknowledges HRP's intent in submitting its Reply and the request by HRP to pursue an alternative pathway of resolution. DOE disagrees with HRP's belief about its suggested resolution

[4] 10 C.F.R. § 851.43(a).

being the best approach. As noted above, DOE's limited settlement procedures under 10 C.F.R. § 851.41 apply at the discretion of the Enforcement Director, who considers whether to pursue settlement based on the severity of the violation(s) and the potential effectiveness of outcomes from settlement discussions. In this case, the Acting Enforcement Director did not grant settlement due to the significant nature of the injuries and severity of the violations, even mitigated as they are through combination into one Severity Level I violation.

In paragraph 3 of I. Introduction, HRP states,

> "By way of background, HRP is one of the country's leading installers of concrete reinforcing steel and post-tension cables. With respect to the subject Fermilab Proton Improvement Plan – II ("PIP II") Linear Accelerator ("LINAC") project, HRP was subcontracted by Nucor Harris Rebar Midwest, LLC, to provide the requisite labor, materials, equipment, and supervision necessary to install reinforcing steel and couplers in accordance with the placing drawings and industry standard practice."

The first sentence is a general statement about HRP and is not relevant for the citations presented in the PNOV. DOE does not dispute the second sentence.

In Paragraph 3 of I. Introduction, HRP continues,

> "The PNOV issued in this matter, if finalized, could have a material impact on HRP's, and its upstream contractor, Nucor Harris Rebar Midwest's, ability to compete for contracts to install rebar from prime contractors. HRP is one of the safest installers in the country, and its commitment to continually improving to lead the industry in safety is unparalleled. Impinging on HRP's ability to compete for installation contracts rather than driving it to improve likely would negatively impact industry safety."

HRP's general statements about its standing in the industry are not relevant or applicable to the citations presented in the PNOV. Under 10 C.F.R. Part 851, DOE established "[r]equirements for a worker safety and health program that reduces or prevents occupational injuries, illnesses, and accidental losses by providing DOE contractors and their workers with safe and healthful workplaces at DOE sites; and [p]rocedures for investigating whether a violation of a requirement of this part has occurred, for determining the nature and extent of any such violation, and for imposing an appropriate remedy."[5] The future effect on HRP contracts for violations of DOE safety requirements is not relevant or applicable to the *Scope and purpose* of DOE investigations established in § 851.1(b)(2).

I.A. Factual Background

In paragraph 1 and footnote 1 of I.A. Factual Background, HRP states,

> "The workplace incident occurred on May 25, 2023, and involved [the injured worker], a certified journeyman ironworker employed by HRP.[Footnote]1 At the time of the incident, [the injured worker] was preparing to tie back vertical rebar to Doka formwork that was

[5] 10 C.F.R. § 851.1(b)(1)-(2).

> approximately 26 feet 7 inches tall. [The injured worker] was working with three other HRP ironworkers at the time of the incident. The process of tying back the vertical rebar required [the injured worker] to be positioned near the top of the formwork so that he could receive the vertical rebar, which was to be raised in place by the other ironworkers working on the opposite side of the formwork. This is a common practice in the rebar placing industry. To reach his position near the top of the formwork, [the injured worker] climbed the backside of the formwork utilizing the horizontal members of the framed formwork for foot and hand holds. This also is a common practice in the rebar placing industry."
>
> Footnote 1: "Pursuant to a collective bargaining agreement ('CBA'), HRP is restricted in its ability to hire employees outside the local union hall and mandated to rely on union workers for jobs like the Fermilab job and all other CBA-covered installation jobs."

DOE does not dispute the facts presented in paragraph one of I.A. Factual Background or footnote 1.

In the first sentence of paragraph 2 in I.A. Factual Background, HRP states,

> "Due to the elevated nature of this job task, HRP required its employees to be tied off using their arrest system (as opposed to their positioning device) 100% of the time they are working at heights."

OSHA 1926.501(b)(5) sets the minimum requirements for fall protection while on formwork and reinforcing steel, allowing the use of a personal fall arrest system (PFAS) or positioning device system (PDS) to protect workers from falls to a lower level. HRP's statement above indicates their definition of "100% tie off" requires the continuous use of a personal fall arrest system (PFAS), effectively disallowing the use of a positioning device system (PDS) as the sole means of fall protection for workers at height. This approach aligns with what is often referred to as "double tie off." While HRP's statement indicates a decision to go above and beyond the OSHA requirement, none of HRP's documentation supports that this policy was clearly established prior to the May 23, 2023, event. Additionally, multiple videos and pictures from the site on May 25, 2023 (the day of the fall event), demonstrate that 100% tie off, as defined by HRP, was not taking place on site.

HRP's claim that its requirement for double tie off means the worker is at fault for not meeting its enhanced standard is not relevant or applicable to the citations presented in the PNOV.

In paragraph 2, sentences 2 and 4 of I.A. Factual Background, HRP states,

> "HRP provided all necessary safety equipment, including fall protection PPE, to [the injured worker]. At the time of the incident, [the injured worker] was wearing a Werner brand full body harness, two Werner self-retracting lifelines, and a body positioning hook and lanyard – which comprised his personal fall arrest system…. There is no indication that the PPE was unsafe or unfit for the task."

DOE reviewed the manuals and inspected the safety equipment issued by HRP and agrees that, as individual components, the full body harness, self-retracting lifelines (SRL), and body positioning hook and lanyard components were safe for use for the task if used appropriately according to manufacturers' directions. However, each of these components has use limitations set by the manufacturer that must be considered when selecting and incorporating them into a PFAS or PDS. Those limitations were clearly defined and communicated by the manufacturer in the manuals and, in some cases, were marked directly on the equipment.[6] HRP must account for these limitations when selecting and integrating each component into the complete PFAS and PDS, including the anchorage, to prevent system failure.

In paragraph 2, sentence 3 of I.A. Factual Background, HRP states,

> "The Doka formwork was equipped with multiple integrated, engineered anchorage points for attaching a personal fall arrest system."

DOE agrees that Doka® formwork is equipped with multiple integrated, engineered anchorage points for attaching a PFAS and PDS. First, for clarity, DOE has included a graphic of a Framax panel from the Doka® manual and DOE identifies the integrated safety handles and the cross boreholes (see Figure 1).

[6] Equipment limitations are further discussed in the response to footnote 1, paragraph 2 and 3 of I.C.1.c., paragraph 1 through 6 of I.C.2.b., and I.D. below.

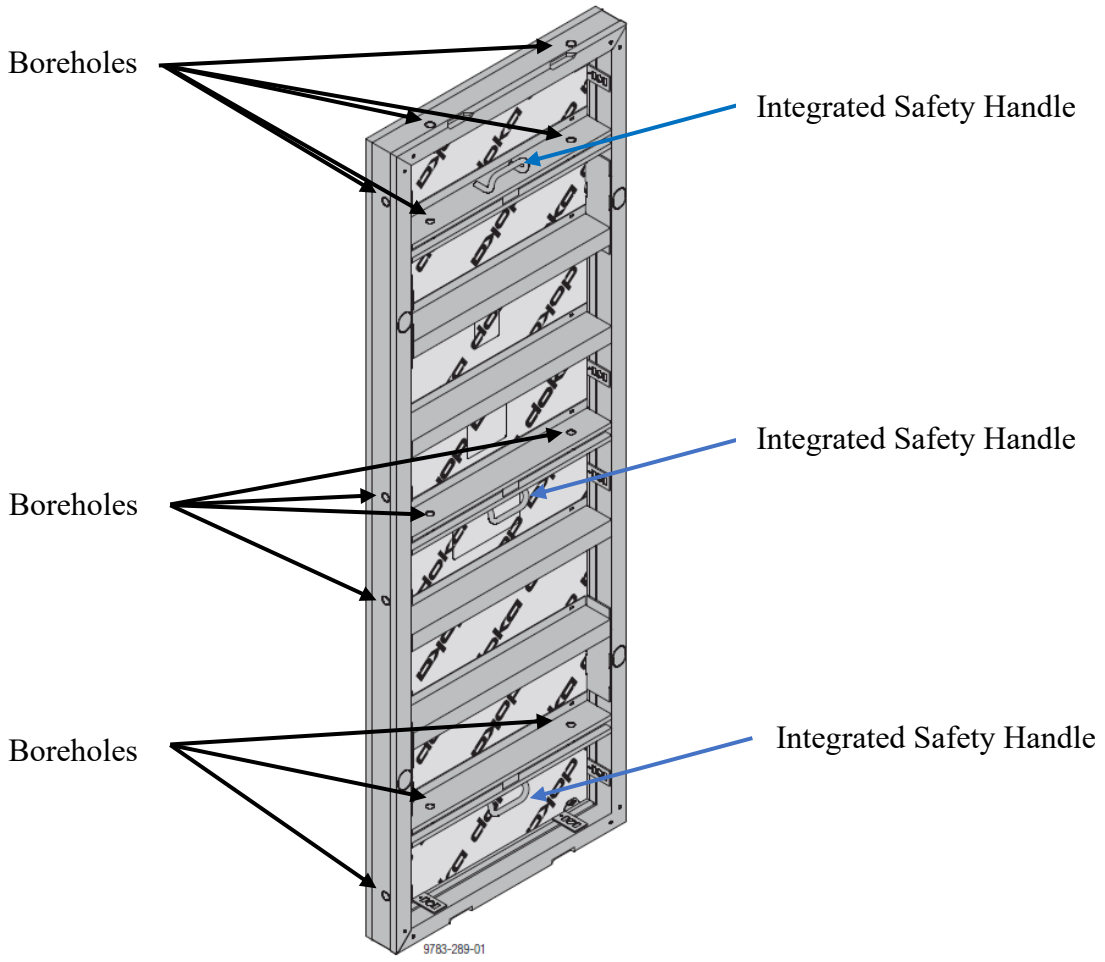


Figure 1, Except from Harris Rebar Placing DOE Response - 001083

Next, the Doka® Framed formwork Framax S Xlife User Information depicts how to connect the integrated safety handle anchorage using a standard fall protection snaphook (see Figure 2).

The attachment points shown here for personal fall arrest equipment conform to OSHA requirements.

Integrated safety handles

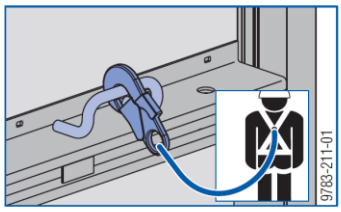
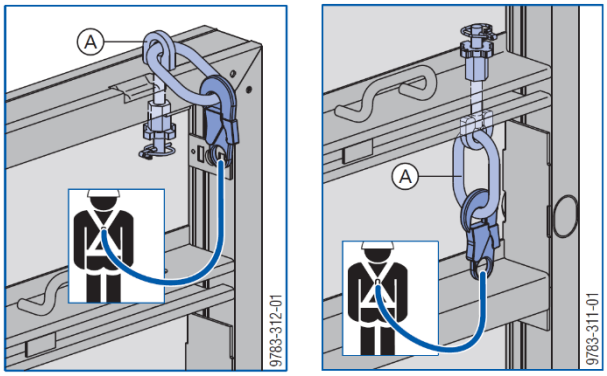


Figure 2, Except from Harris Rebar Placing DOE Response - 001084

Next, the Doka® Framed formwork Framax S Xlife User Information depicts the additional optional borehole lifting ring attachment points, how they are to be installed to create a secure anchorage, and how to connect a standard fall protection snaphook (see Figure 3).

Additionally mounted attachment points



A Lifting ring

Mounting the lifting ring:

➤ Mount the lifting ring in the cross borehole and fix it in place with the nut and a linch pin.

Figure 3, Excerpt from Harris Rebar Placing DOE Response - 001084

Finally, the Doka® Technical Newsletter 850 (NAM) depicts how to connect with a rebar or "pelican" style snaphook to either the integrated safety handle anchorage or a borehole lifting ring attachment anchorage (see Figure 4).

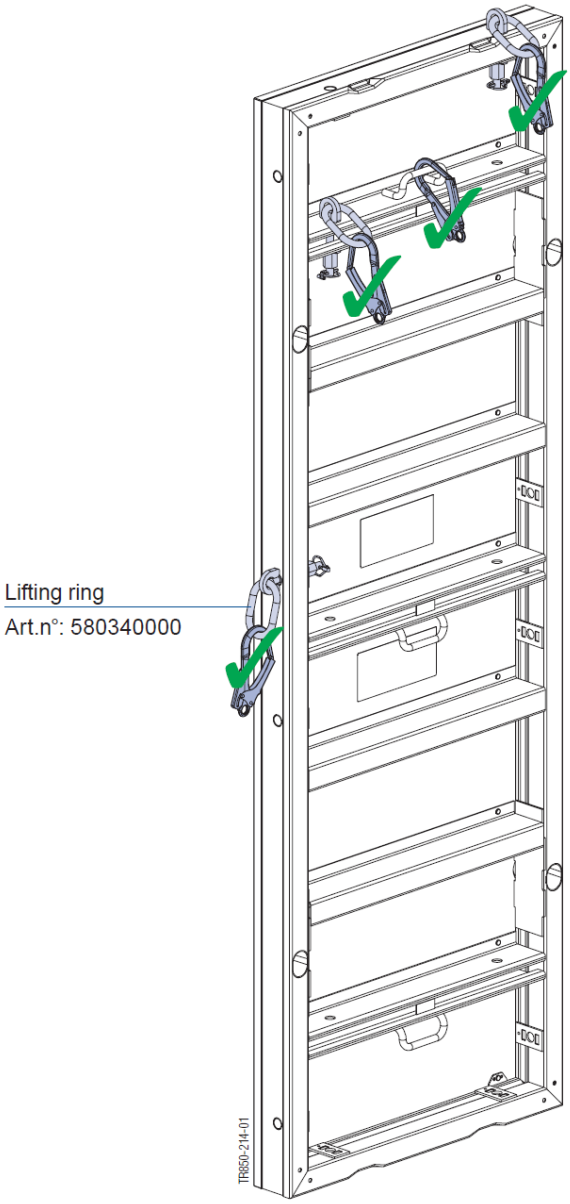


Figure 4, Excerpt from Harris Rebar Placing DOE Response - 001197

The boreholes are not OSHA-compliant anchorages without the Doka® borehole lifting ring attachment points[7].

[7] In making this determination, DOE confirmed with Doka® that connecting a pelican/rebar hook through a Doka® formwork borehole may not fully engage the pelican hook. To address the hazard of potential disengagement of the pelican hook, Doka® recommends contractors always use the Lifting Ring attachment in those locations. Therefore, DOE determined that connecting the pelican hook through the boreholes without the Lifting Ring attachment does not meet OSHA anchorage compatibility requirements in 29 C.F.R. 1926.502(d).

HRP did not install the Doka® borehole lifting ring attachment points. Therefore, the only OSHA-compliant anchorages available to the ironworkers on the face of the Doka® formwork were the integrated safety handles, as documented in the Doka® Framed formwork Framax S Xlife User Information and the Doka® Technical Newsletter 850 (NAM), the two manufacturer manuals provided to DOE by HRP.

In paragraph 3, sentences 1-4 of I.A. Factual Background, HRP states,

> "Video footage provided by Fermilab shows that [the injured worker] was climbing the formwork near a corner where two sections of perpendicular walls met. Based on a review of the video footage, [the injured worker] can be seen utilizing his personal fall arrest system while ascending the formwork. The video footage also shows that [the injured worker] completed his climb and positioned himself with his torso near the top of the formwork. There were engineered anchorage points, identical to those [the injured worker] employed to make the climb, available, accessible and well within reach of [the injured worker] where he was stationed before he fell[footnote 2]."

DOE acknowledges that the video footage shows [the injured worker] climbing at the corner of the formwork walls. However, DOE disagrees that the video is conclusive of every action [the injured worker] took when ascending the formwork and positioning himself at the top of the formwork. It is conclusive from the video that [the injured worker] attaches his PDS to an anchorage, as he can be seen clearly supported for approximately five seconds at the top of the formwork corner with his hands free of the formwork. It is also conclusive that his PFAS was not connected to an OSHA-compliant anchorage when he was at the top of the formwork as the SRL does not react to the fall in the video. This lack of an anchored PFAS is supported by the inspection of the PFAS components that indicated no deformation of any components including the SRL snaphooks and the SRL deceleration devices.

DOE disagrees that there were "engineered anchorage points… available, accessible and well within reach" at the assigned work location. As described above, the only OSHA-compliant anchorages on the formwork were the integrated safety handles. Additional evidence and reports indicate the closest integrated safety handles were below the ironworker's dorsal D-ring [8] and outside [the injured worker's] accessible radius for anchoring the PDS to complete the assigned task. DOE determined that the only independently conclusive PFAS or PDS information from the video is that the anchor for the PDS failed and that the PFAS was not connected to an anchorage, resulting in a fall greater than six feet.

In footnote 2 of I.A. Factual Background, HRP states:

> "While the ANSI/ASSP Z359.14-2021 standard that took effect last year, in 2023, now distinguishes between Class 1 and Class 2 Self Retracting Devices ("SRD") for purposes of the location of anchorage points to be used, neither DOE nor OSHA have adopted this ANSI standard. Therefore, under the applicable DOE and OSHA fall protection

[8] The dorsal D-ring is a fall protection component located on the back of a full-body harness. It serves as the primary attachment point for a fall arrest system, connecting the harness to the SRL.

> regulation, [the injured worker] would have been allowed to anchor to anchorage points above or below his dorsal D-ring."

DOE disagrees with HRP's argument in footnote 1 of I.A., that, "[the injured worker] would have been allowed to anchor to anchorage points... below his dorsal D-ring." Title 10 C.F.R. § 851.22(c) states that "[c]ontractors must address hazards when selecting or purchasing equipment, products, and services." When HRP selected and purchased Class 1 SRL devices, HRP was required to consider the limitations of the equipment and address any hazards that could arise due to the limitations of that equipment. The SRL manuals and product markings state that the Werner Bantam 6 SRLs are for anchorage at or above the dorsal D-ring. The user manual also states that, "[m]isuse of failure to heed [the manufacturer] warnings and instructions may result in injury or even death."

While DOE agrees that DOE and OSHA have not directly adopted ANSI Z359.14-2021, the ANSI design parameters are used by the manufacturer (Werner) to set equipment labeling and use limitations. The Werner Bantam 6 SRL, provided by HRP to the PIP-II workers, was marked and labeled as an ANSI certified Class 1 SRL. Therefore, anchoring the SRL below the dorsal D-ring would be outside of the design parameters set by the manufacturer, would be a misuse of the equipment, could lead to failure of the PFAS, and "… may result in injury or even death." Based on this information, incorrect anchoring of a PFAS and PDS is a foreseeable and preventable hazard. To prevent that hazard, none of the workers on the PIP-II site, including the injured worker, would have been allowed "to anchor to anchorage points… below [their] dorsal D-ring," as claimed by HRP.

In paragraph 3, sentences 5 and 6 of I.A. Factual Background, HRP states,

> "It appears from the video that [the injured worker] either did not tie off to any anchorage point once he got to his position near the top of the formwork (approximately 23 feet high) or, perhaps, may have disregarded the HRP work rule to be 100% tied off and relied on his positioning device alone to connect to a piece of equipment that was not an available anchorage point. The incident occurred when [the injured worker] fell from his position near the top of the formwork to the ground below."

As noted above, the 100% tie off requirement, as currently defined by HRP to be double tie off (which is more restrictive than the OSHA requirement), was not supported by DOE's review of evidence provided by HRP. Regarding HRP's speculation that the worker "may have disregarded the HRP rule to be 100% tied off," this is not factually supported by the evidence provided by HRP. The double tie off requirement claimed by HRP as an HRP work rule was not clearly defined as such prior to the fall event. Further, DOE disagrees with HRP's implication that it provided the injured worker with all the necessary fall protection information to work safely while on the face of the Doka® formwork at the PIP-II site. This will be discussed throughout this document.

DOE agrees that the event occurred when the injured worker fell from his position near the top of the form wall to the ground below.

In paragraph 4 of I.A. Factual Background, HRP states,

> "Because the other ironworkers were working on the opposite side of the formwork from [the injured worker], they did not witness the incident. Our onsite general foreman also was not in eyeshot of [the injured worker] when the incident occurred, nor as far as we know, were there any other eyewitnesses."

DOE does not dispute the facts presented in Paragraph 4 of I.A. Factual Background.

I.B. PNOV

In paragraph 1 of I.B. PNOV, HRP states,

> "The PNOV alleges that HRP failed to comply with applicable requirements of 10 C.F.R. § 851 and the Fermi Research Alliance ("FRA") Worker Safety and Health Program ("WSHP"). See Attachment 1 (DOE PNOV). Specifically, the concerns outlined in the PNOV relate primarily to a concern that HRP did not verify that its workers were adequately trained in fall protection pursuant to DOE's requirements that incorporate the Occupation Safety and Health Administration's ("OSHA") fall protection standard, and that HRP did not provide adequate work instruction to [the injured worker] related to the appropriate anchorage point he was to use on the [Doka®] formwork. See id. The PNOV provides that the alleged noncompliance issues constitute a Severity Level I violation with a base penalty of $118,000.00 and no mitigation. See id."

DOE disagrees with HRP's interpretations. HRP failed to develop and implement adequate fall protection measures for ironworkers climbing Doka® formwork. This applies to all ironworkers on the PIP-II site, not solely to [the injured worker]. Though the PNOV cites a training violation as a component of the Severity Level I violation, DOE's central focus remains on HRP's failure to develop and implement adequate fall protection measures. DOE combined all the violations to constitute a single Severity Level I violation with a base civil penalty of $118,000 with no mitigation.

I.C. Responsive Information

In paragraph 1 of I.C. Responsive Information, HRP states,

> "Consistent with 10 C.F.R. § 851 and industry standards, HRP historically has had a robust safety and health program that it implements at all its sites and has safety as its highest priority. We outline below the fall protection measures and requirements in place at the Fermilab PIP-II LINAC project in May 2023."

DOE acknowledges that HRP has established health and safety programs. DOE addresses the fall protection measures and requirements below.

In paragraph 1 of I.C.1. HRP's Fall Protection Measures, HRP states,

> "HRP implemented numerous fall protection measures designed to protect ironworkers engaged in elevated work over 6 feet from falling to a lower level. The fall protection measures implemented by HRP included verification of compliant and robust fall protection training, written policies, programs and procedures, regular hazard awareness field discussions, and provision of personal fall-arrest and positioning devise [sic] systems."

DOE acknowledges HRP's statements in I.C.1. Fall Protection Measures. DOE addresses concerns related to HRP's fall protection measures below.

In paragraph 1 of I.C.1.a. Written policies, programs, procedures, HRP states,

> "HRP had multiple policies, programs, and procedures in place to protect ironworkers from potential fall hazards at the Fermilab site. First, HRP implemented its Site Specific Safety Plan ("SSSP"), which addressed fall prevention and fall protection onsite and incorporated a Fall Prevention/Fall Protection Work Plan. See Attachment 2 (SSSP). Pursuant to the SSSP, this Work Plan was designed to enable HRP ironworkers to recognize fall hazards at the project and established mandatory procedures to be followed in order to prevent falls to lower levels. Each HRP ironworker allowed to work at the site, including [the injured worker], reviewed and signed off on the SSSP, and, in doing so, agreed to adhere to the procedures (unless doing so would expose to a greater hazard – in which case notification to management was required so a decision should be made as to how to proceed). See Attachment 3 (SSSP Sign-Off Sheet)."

DOE reviewed the SSSP contained in Attachment 2 and disagrees that HRP management established effective controls in the SSSP through identified planned protective measures. Specifically, in the SSSP (Attachment 2), dated December 20, 2022, HRP discusses general policy statements for fall protection, but does not discuss the specific details of the fall protection measures to be used on the PIP-II site. For example, the SSSP states, "[t]his fall protection plan addresses the use of conventional fall protection at a number of areas on the project..." However, the SSSP does not include any planning for what components HRP intends to use for the complete PFAS and PDS (including the anchorages), the component limitations, or any details on how those systems are to be used at the various work locations on the PIP-II site.

In paragraph 2 of I.C.1.a. Written policies, programs, procedures, HRP states,

> "The SSSP provided that HRP foremen were responsible for identifying and seeing that unsafe acts or conditions are corrected as required. *See* **Attachment 2** (SSSP). HRP had two foremen working at the Fermilab job site, which included a general foreman and working foreman. The general foreman was responsible for leading daily job and safety meetings, conducting daily field safety inspections, monitoring jobsite conditions, communicating potential hazards to the onsite team, and ensuring remedial action is taken as required. *See* **Attachment 4** (Declaration of [Foreman 1]). The daily field inspections were a very significant portion of both the foremen's daily responsibilities, and they took this responsibility very seriously. In particular, ensuring that HRP ironworkers followed the mandatory work instruction that they be tied off 100% of the

> time they were working at heights was a critical element of their efforts. *See id.*; *see also* **Attachment 5** (Declaration of [Foreman 2]). It was their view that any ironworker found working at heights without being 100 percent tied off with fall arrest system would be subject to immediate termination or at minimum a serious suspension from work on this job. *See id.* They were aware of the gravity with which HRP took this requirement and they enforced it rigorously. *See id.*"

DOE acknowledges the foremen's responsibilities, that they took those responsibilities seriously, and that they completed those responsibilities to the best for their abilities. HRP's statements in paragraph 2 of I.C.1.a. are not relevant to HRP's management responsibility to develop planned protective measures or to verify training adequacy.

In paragraph 3 of I.C.1.a. Written policies, programs, procedures, HRP states,

> "HRP employees were responsible for understanding and adhering to the fall prevention / protection plan, following foreman instructions, and notifying management of unsafe conditions or acts. HRP employees also knew that their foremen were available to answer any questions regarding any safety issue and had authority to stop work or not work before ensuring they fully understood how to address the hazards of their assigned tasks. *See id.*"

DOE acknowledges HRP employees' responsibilities and that they completed those responsibilities to the best of their abilities. HRP's statements in paragraph 3 of I.C.1.a. are not relevant to HRP's management responsibility to develop planned protective measures or to verify training adequacy.

In paragraph 4 of I.C.1.a. Written policies, programs, procedures, HRP states,

> "The HRP SSSP also incorporated HRP's Injury and Illness Prevention Program ("IIPP"), field practices book (the "Red Book"), and various job hazard risk analyses ("JHRAs"), all of which communicate HRP expectations related to fall prevention and protection. *See* **Attachment 6** (IIPP); **Attachment 7** (Red Book Fall Protection Excerpt); **Attachment 8** (JHRA for Building Walls in Place). As an example, Section 3 of HRP's IIPP specifically provided that employees shall comply with the company's fall protection requirements as stated in the IIPP, employee handbook, and SSSP. *See* **Attachment 6** (IIPP). The IIPP also explained that when accessing or working on vertical rebar assemblies within 10 feet of the perimeter of a building or structure, 100% fall protection shall be used at all heights. *See id.* The HRP Red Book provided similar instructions. *See* **Attachment 7** (Red Book Fall Protection Excerpt). All ironworkers at the site, prior to being allowed to work, were trained on the requirements in the SSSP, including the IIPP and Red Book, as part of the site safety orientation. [The injured worker] received this training and orientation. *See* **Attachment 9** ([the injured worker's] Red Book Sign-Off); **Attachment 10** ([the injured worker's] Orientation Sign-Off)."

DOE agrees that the general statement of policy referenced in paragraph 4 of I.C.1.a. is in place. However, DOE disagrees that these generalized policies are sufficiently detailed to meet the

requirement for developing adequate fall protection measures. For example, HRP's IIPP and Red Book set generalized policy and state, "100% fall protection shall be used at all heights." However, these documents do not require additional planning or review of the complete PFAS or PDS to ensure the development and implementation of fall protection measures to meet 100% fall protection. Additionally, as stated earlier, HRP's policy documents did not define "100% tie off" to mean the PFAS must always be anchored (as HRP previously claimed) or that HRP's policies are more restrictive than the OSHA requirements when working from the face of formwork or reinforcing steel. As discussed previously, HRP's SSSP did not include the PIP-II specific planned protective measures necessary to ensure 100% fall protection while on the face of formwork.

DOE does not dispute the orientation training or Red Book signoffs in attachments 9 and 10.

In paragraph 5 of I.C.1.a. Written policies, programs, procedures, HRP states,

> "While the IIPP and Red Book established HRP's general policies concerning fall protection, HRP also included its fall protection requirements in its job-specific hazard analyses captured in its JHRAs. HRP utilized JHRAs to identify (i) the work steps and tasks for particular jobs, (ii) the potential hazards identified for each step / task, (iii) the control / safe work procedures for each step / task, and (iv) risk ratings for each step / task with and without the safe work procedure. The JHRA for building walls in place – the job being performed at the time of the incident – identified climbing a rebar wall assembly as a potential job task and falls from height as a potential hazard associated with this task. *See* **Attachment 8** (JHRA for Building Walls in Place). To mitigate the potential for falls from height, the JHRA specifically instructs that "100% tie off" must be followed. *See id.*"

DOE agrees that the JHRA requires 100% fall protection. However, as discussed previously, the JHRA did not include the PIP-II specific planned protective measures necessary to ensure 100% fall protection while on the face of formwork, including PFAS and PDS use limitations, to include anchorage specifications necessary to achieve 100% tie off.

In paragraph 6 of I.C.1.a. Written policies, programs, procedures, HRP states,

> "Through its SSSP, IIPP, Red Book, and JHRAs, HRP established its written mandatory fall protection requirements and expectations with respect to the work being performed at the time of the incident – and these included that ironworkers performing work over 6 feet are required to be tied off at all times."

DOE agrees that the HRP's SSSP, IIPP, Red Book, and JHRA establish general policy statements regarding fall protection, including 100% fall protection. DOE notes that the IIPP and Red Book require fall protection at all heights and the JHRA, included as Attachment 8, dated December 20, 2022, states, "[m]ust be tied off at or over 4 feet." The SSSP does not contain a statement that requires ironworkers to be tied off at all times. However, as stated above, the HRP SSSP, IIPP, Red Book, and JHRA do not include the PIP-II specific planned protective measures necessary to ensure 100% fall protection while on the face of formwork,

including PFAS and PDS use limitations, to include anchorage specifications necessary to achieve 100% tie off.

In paragraph 1 of I.C.1.b. Hazard awareness training and discussion, HRP States,

> "As or more important, in addition to the initial training and orientation with the SSSP, including the IIPP and Red Book, HRP utilized the JHRAs to promote discussion concerning job tasks and safe work procedures as part of its daily job task analysis ("JTA"). *See* **Attachment 11** (Example JTAs). HRP's JTA process permitted the ironworkers to discuss the specific job tasks for a given day along with the safety work procedure for the job tasks. *See id.* Applicable JHRAs are referenced in, and attached to, the daily JTA. *See id.* The JTA process established by HRP is a means of ensuring that the initial training and review of hazards and associated mandated controls are carried throughout the project on a continual, daily basis. *See id.* The JTA form created by HRP is designed to require team discussions on a daily basis regarding the job tasks to be performed, potential hazards associated with the job tasks, any extraordinary conditions, and the safe work procedures needed to address the potential hazards and conditions present. *See id.* HRP personnel are required to sign the daily JTA, acknowledging that they have (i) read the JHRAs associated with the tasks identified in the JTA and (ii) been trained to perform the tasks safely. *See id.*"

DOE does not dispute that ironworkers were permitted to discuss safety topics and daily job tasks. However, the safety information presented in Attachment 11 does not include the PIP-II specific planned protective measures necessary to ensure 100% fall protection while on the face of formwork. This omitted critical details such as PFAS and PDS use limitations, and specific anchorage specifications necessary to achieve 100% tie off. DOE acknowledges that HRP had toolbox talk pages that included slip, trips, and falls [on the same level]; falling through holes; guardrails; and inspection of a full body harness to prompt discussion. However, those topics are not relevant to the violations in the PNOV.

In paragraph 2 of I.C.1.b. Hazard awareness training and discussion, HRP States,

> "It is important to understand the importance of the daily field JTA meetings. This is the opportunity foremen and workers have to engage with each other, talk about the task ahead, and discuss hazards or questions associated with that task if there is any confusion or lack of information *before* the task is conducted. The JTA provides the general topics for discussion, but the dialog in the field, while not documented, provides the opportunity and mechanism for driving safety and ensuring the understanding of hazards. The paperwork does not reflect the dialog; it identifies the topics generally to be discussed.[footnote3]"

DOE acknowledges that HRP conducted safety JTA meetings, and that foremen and workers discuss hazards in the field. However, the HRP JTA documents do not show that HRP developed planned protective measures necessary to ensure 100% fall protection while on the face of formwork at the PIP-II site. Specifically, these documents omitted details regarding PFAS and PDS use limitations, and anchorage specifications necessary to achieve 100% tie off.

In footnote 3 of I.C.1.b. Hazard awareness training and discussion, HRP States,

> "[Footnote 3] In addition to the above, as it does at all of its worksites nationwide, HRP also conducted pre-job toolbox talks with the ironworkers to discuss various safety topics twice per week. At the Fermilab site in May, HRP held regular safety toolbox talks covering numerous safety topics. Relevant topics to this matter were a discussion about: (i) slips, trips, and falls, an (ii) a discussion about ensuring that each worker inspect their full body harness before use. *See* **Attachment 11** (Example JTAs)."

DOE acknowledges that HRP conducts the toolbox talks. However, as discussed above, the topics presented in footnote 3 are not relevant to the violations in the PNOV.

In paragraph 3 of I.C.1.b. Hazard awareness training and discussion, HRP States,

> "On May 25, 2023, HRP ironworkers completed their JTA, which identified (i) working with cranes, (ii)setting columns, and (iii) building walls in place as the job tasks for the day. The respective JHRAs for these tasks were attached to the JTA form. *See* **Attachment 12** (May 25, 2023 JTA). Both the JHRA for setting columns and building walls in place contemplate working from heights identify falls from height as a potential hazard, and instruct that 100% tie off is required. *See id.* [The injured worker] and the other ironworkers onsite signed the May 25, 2023 JTA form. *See id.* [the injured worker] also participated in the discussion. It was clear to his supervisors that he understood the hazard at issue (fall from heights), the responsibility he had to be tied off with this fall arrest system 100% of the time, and how to tie off. *See* **Attachment 4** (Declaration of [Foreman 1]); **Attachment 5** (Declaration of [Foreman2])."

DOE acknowledges that the JTA was completed on May 25, 2023, and that [the injured worker] signed the JTA form. DOE also acknowledges that HRP identified fall from heights as a hazard and that the foremen completed the discussions to the best of their abilities. However, as stated above, the JTA documents do not include the PIP-II specific planned protective measures necessary to ensure 100% fall protection while on the face of formwork, including PFAS and PDS use limitations, to include anchorage specifications necessary to achieve 100% tie off.

In paragraph 1 of I.C.1.c. Personal fall-arrest and positioning device systems, HRP States,

> "While 10 C.F.R. § 851 does not have a specific fall protection standard for work performed on formwork or reinforcing steel, Part 851 incorporates OSHA's standards at 29 C.F.R. Part 1926, which does. Pursuant to OSHA's construction standards, each employee on the face of formwork or reinforcing steel, "shall be protected from falling 6 feet (1.8m) or more to lower levels by personal fall arrest systems, safety net systems, or positioning device systems." 29 C.F.R. §1926.501(b)(5). HRP complied with OSHA's construction standard by providing ironworkers with personal fall arrest and positioning devise [sic] systems and requiring their use. As noted above, at the time of the incident, [the injured worker] was wearing a Werner brand full body harness, two Werner self-retracting lifelines, and a body positioning hook and lanyard. This was the exact

> protective equipment required by the OSHA construction standard for the work being performed."

DOE agrees that 10 C.F.R. Part 851 incorporates 29 C.F.R. Part 1926, which includes fall protection provisions, specifically 1926 Subpart M, Fall Protection. Title 29 C.F.R. § 1926.500(b), defines a PFAS "as consisting of an anchorage, connectors, body harness and may include a lanyard, deceleration device, lifeline, or suitable combinations of these." HRP's statement above does not recognize that anchorage is part of the complete fall protection system. HRP relied on workers' previous knowledge and training to determine the OSHA-compliant anchorages at each work location instead of planned protective measures.

DOE agrees, as stated previously, that HRP provided [the injured worker] with a Werner brand full body harness, two Werner self-retracting lifelines, and a body positioning hook and lanyard and that these components were being worn at the time of the event. However, DOE disagrees with HRP's implication that it provided a complete PFAS or PDS system because HRP did not include planned anchorages as part of the complete system. Instead, HRP relied on prior knowledge and training to determine the OSHA-compliant anchorages at the work locations.

Title 29 C.F.R. § 1926.500(b) defines a PDS as "a body harness system rigged to allow an employee to be supported on an elevated vertical surface, such as a wall, and work with both hands free while leaning." However, HRP did not develop planned protective measures to ensure there was an OSHA-compliant anchorage at the work location. Therefore, HRP did not develop planned protective measures to provide a suitable combination of PFAS or PDS components to protect employees on the face of formwork from falling 6 feet or more to lower levels.

In paragraph 2 and 3 of I.C.1.c. Personal fall-arrest and positioning device systems, HRP States,

> "Notwithstanding the OSHA/DOE regulation, HRP had implemented at the Fermilab site a mandatory fall protection requirement that went beyond the regulatory compliance requirements. HRP required 100% tie off *with the provided self-retracting lifelines* while working at heights. Use of a positioning device alone to tie off was not permitted by HRP (even though compliant with OSHA and DOE regulations). HRP's fall protection measures implemented at the Fermilab site met DOE's Part 851 requirements."

First, DOE recognizes that HRP stated in planning and policy documents that ironworkers were required to implement 100% tie off. However, DOE disagrees that HRP clearly established the interpretation of "100% tie off *with the provided self-retracting lifelines*." Title 29 C.F.R. § 1926.501(b)(5) allows workers on reinforcing steel and formwork to be protected from falling 6 feet or more by a PFAS or PDS. To date and as discussed above, HRP has not provided documentation to show that it requires workers to anchor their PFAS when using their PDS. Such a policy would be more restrictive than the regulatory requirements for workers on the face of formwork and reinforcing steel.

Second, DOE disagrees that HRP met DOE's Part 851 requirements for fall protection on the PIP-II site. HRP's planned protective measures were inadequate and failed to provide ironworkers with a complete PFAS or PDS. Both the PFAS and PDS systems require OSHA-compliant anchorages as components. Specifically:

- HRP's planned protective measures did not include the manufacturer's anchorage information necessary to achieve 100% fall protection. The [Doka®] Framed formwork Framax S Xlife User Information and [Doka®] Technical Newsletter 850 (NAM) outline compliant anchorages, including integrated safety handles and mounted attachment points (e.g., formwork boreholes with lifting ring attachments). HRP did not ensure the installation of the Doka® borehole lifting ring attachments on the formwork. Therefore, the integrated safety handles were the only OSHA-compliant anchorages on the Doka® formwork at the PIP-II site. See Figures 1, 2, 3, and 4 above.

- HRP selected large pelican/rebar hooks as PFAS and PDS components to connect through the Doka® formwork boreholes. However, these hooks are incompatible with Doka® formwork boreholes, a violation of OSHA standards 1926.502(d)(5) and (6) and 1926.502(e)(7) and (8). DOE discussed with Doka®, as noted in footnote 2 above, that connecting a pelican/rebar hook through a Doka® formwork borehole without the borehole lifting ring attachment is not a manufacturer approved anchorage.

- The two Werner self-retracting lifelines are designed, rated, and marked to be connected only for anchorage connections above the dorsal D-ring of the worker. However, the only OSHA compliant anchorages available at the location of the assigned task (i.e., the integrated safety handles) were below the injured worker's dorsal D-ring.

- The OSHA compliant anchorages (i.e., the integrated safety handles) were outside the ironworker's accessible radius for connecting their PDS at the location of the assigned task.

Therefore, HRP failed to provide OSHA-compliant anchorages for both the PFAS and PDS at the work location (i.e. the top of the Doka® formwork near the corner), a violation of 10 C.F.R. Part 851.22(a), 851.23(a)(7), 851.24(b), and 851, Appendix A, section 1, Construction Safety.

Additionally, as discussed above, HRP argued that the ironworker "would have been allowed to anchor to anchorage points above or below his dorsal D-ring." DOE inspected the components involved in the fall event and found that each of these components provided by HRP was appropriate for use as components of a complete PFAS or PDS. However, every component has limitations that must be understood and properly integrated into the planning, assembly, and use of the complete PFAS and PDS. By disregarding these limitations, HRP failed to recognize and address the hazard of unintentional disengagement and potential failure of the PFAS or PDS.

For example, the SRLs issued by HRP at the PIP-II site were clearly marked "Class 1 Anchor at or above dorsal D-ring" on the SRL housing and in the user manual. The Werner Bantam 6 manual, provided to DOE by HRP, explicitly states "[c]ompliant fall protection equipment must

always be used as it was designed…. Failure to follow all instructions and limitations on the use of Self-Retracting Lifelines (SRL) may result in serious injury or death." The manual also specifies a free fall limit of two feet. HRP's practice of allowing the ironworker to anchor the Class 1 SRL below the dorsal D-ring violated these specifications, which could result in a free fall exceeding 2 feet and increases the risk of PFAS failure.

Therefore, HRP failed to address the hazard of unintentional disengagement and potential failure of the PFAS or PDS by disregarding the design specifications and limitations of the components used in the PFAS and PDS, a violation of 10 C.F.R. Part 851.22(c).

In paragraph 1 of I.C.2 Alleged Short Commings, HRP states,

> "While HRP implemented adequate fall protection measures for ironworkers climbing [Doka®] formwork, the PNOV identifies certain areas where DOE contends HRP's fall protection measures were inadequate. *See* **Attachment 1** (DOE PNOV). Specifically, the PNOV alleges that HRP's SSSP and JHRA stated "100% tie-off," but that HRP did not develop work instructions that included identification of formwork anchorage points. *See id.* Additionally, the PNOV alleges that HRP relied on previous training by labor unions, but did not verify the adequacy of that training or ensure that a competent person trained ironworkers on the specific personal fall arrest or positioning device systems. *See id.* According to the PNOV, these alleged shortcomings contributed to the underlying event. *See id.*"

DOE disagrees that HRP implemented adequate fall protection as previously described.

Following its comprehensive review of HRP's reply, DOE reaffirms the violations identified in the PNOV and their contribution to the fall event on May 25, 2023, at the PIP-II site.

In paragraph 1 of I.C.2.a. Work Instruction identifying formwork anchorage points, HRP states,

> "First, as a base legal matter, there is nothing in the law or any other relevant legal standard that imposes a requirement to specifically identify anchorage points. The PNOV does not cite to any legal standard or regulation that requires individual anchorage points to be identified.[Footnote 4]"

DOE disagrees that HRP was not required to identify anchorage points. Title 10 C.F.R. § 851.22 states, "[c]ontractors must establish and implement a hazard prevention and abatement process to ensure all identified potential hazards are prevented or abated in a timely manner. (1) For hazards identified…controls must be incorporated in the appropriate…procedure. (2) For existing hazards identified in the workplace, contractors must:…(iii) [p]rotect workers from dangerous safety and health conditions." Subsection (c) states that "[c]ontractors must address hazards when selecting or purchasing equipment, products, and services." Title 10 C.F.R. § 851, Appendix A states that "[f]or each separately definable construction activity…the construction contractor must: …(1) [p]repare…an activity hazard analysis…. Such analyses must: (i) identify foreseeable hazards and planned protective measures; (ii) address further hazards revealed by supplemental site information…."

Title 29 C.F.R. § 1926.500(b) states, "(a) [p]ersonal fall arrest system…consists of an anchorage, connectors, a body belt or body harness and may include a lanyard, deceleration device, lifeline, or suitable combinations of these"; "Anchorage means a secure point of attachment for lifelines, lanyards or deceleration devices." Further, 29 C.F.R. § 1926.502(d)(15) states, "Anchorages used for attachment of personal fall arrest equipment shall be independent of any anchorage being used to support or suspend platforms and capable of supporting at least 5,000 pounds (22.2 kN) per employee attached, or shall be designed, installed, and used as follows: (i) as part of a complete personal fall arrest system which maintains a safety factor of at least two; and (ii) under the supervision of a qualified person."

Title 29 C.F.R. § 1926.500(b) states, "Positioning device system means a body belt or body harness system rigged to allow an employee to be supported on an elevated vertical surface, such as a wall, and work with both hands free while leaning;" 29 C.F.R. § 1926.502(e)(1) states, "Positioning devices shall be rigged such that an employee cannot free fall more than 2 feet (.6 m)" and (b) states, "Positioning devices shall be secured to an anchorage capable of supporting at least twice the potential impact load of an employee's fall or 3,000 pounds (13.3 kN), whichever is greater."

HRP's planned protective measures did not identify or address the foreseeable hazard of an ironworker on the Doka® formwork, relying on potentially inadequate previous knowledge or training, selecting an anchorage incapable of supporting 5000 pounds to complete the PFAS or selecting an anchorage incapable of supporting twice the potential impact load or 3000 pounds for the PDS. As discussed earlier, HRP selected equipment to anchor to Doka® formwork locations that are incompatible connections (e.g. pelican hooks directly to boreholes) and did not account for equipment limitations (e.g. Class 1 SRLs anchored below the dorsal D-ring). Therefore, HRP's documented planned protective measures, (100% fall protection with no additional details) did not meet 10 C.F.R. Part 851 requirements by failing to identify the specific anchorages necessary to ensure ironworkers on the face of the Doka® formwork could appropriately implement the complete PFAS and PDS. Further, these violations extend to the planned protective measures for every ironworker on the face of formwork at the PIP-II site, not just the injured worker.

In footnote 4 of I.C.2.a. Work Instruction identifying formwork anchorage points, HRP states,

> "[Footnote4] Note that in the review of HRP's SSSP and JHRA by FRA, no deficiency in these documents related to fall protection was noted. FRA also issued no comments in Section 3 of the submittal, "Fall Prevention/Fall Protection Work Plan."

DOE acknowledges the facts presented in footnote 4 and has addressed concerns related to FRA through other means not pertinent to the HRP investigation and notice of violation.

In paragraph 2 of I.C.2.a. Work Instruction identifying formwork anchorage points, HRP states,

> "More important, [Doka®] formwork is well-known and understood in the industry. Certified journeymen ironworkers recognize [Doka®] and other types of formwork well and climb this formwork regularly. Only journeymen ironworkers, highly trained and

> skilled professionals, familiar with this and many types of formwork were hired by HRP. The familiarity includes a familiarity with the anchorage points on [Doka®] formwork."

DOE acknowledges the ironworkers on the PIP-II site were certified journeymen. However, the violations pertain to the HRP documented planned protective measures. The ironworkers familiarity, whether individual or collectively, regarding anchorage points on Doka® formwork is not relevant to HRP's management responsibility to develop planned protective measures to ensure worker have all the information necessary to correctly implement the complete PFAS and PDS provided by HRP at the PIP-II site.

In paragraph 3 of I.C.2.a. Work Instruction identifying formwork anchorage points, HRP states,

> "We are confident that [the injured worker] knew how to identify [Doka®] formwork engineered anchorage points for a number of reasons. First, the video of [the injured worker's] climb to the position near the top of the [Doka®] formwork on May 25th appears to show him using these anchorage points. Additionally, both the general foreman and the work foreman knew the anchorage points on [Doka®] formwork based on their journeymen experience and training. *See* **Attachment 4** (Declaration of [Foreman 1]); **Attachment 5** (Declaration of [Foreman 2]). In fact, on the day of the incident, [Foreman 2] had climbed the subject [Doka®] formwork earlier in the day in order to tie back a rebar column. *See* **Attachment 5** (Declaration of [Foreman 2]). He located himself near precisely where [the injured worker] was located that afternoon when he fell. *See id.* [Foreman 2] immediately understood the anchorage points available for his use from that location. *See id.* Accordingly, having been similarly trained, and with numerous years of experience, they understood [the injured worker] to have knowledge of the appropriate anchorage points for [Doka®] formwork. Neither in the JTA meeting that morning where building walls in place was discussed, nor at any other time, did [the injured worker] express any questions or concerns about the identity or location of the [Doka®] formwork anchorage points. *See* **Attachment 4** (Declaration of [Foreman 1]); **Attachment 5** (Declaration of [Foreman 2])."

DOE acknowledges that HRP is confident [the injured worker] knew how to identify Doka® formwork engineered anchorage points. However, HRP's Title 10 C.F.R. Part 851 violations of management responsibilities regarding hazard prevention and abatement, safety and health standards, construction safety, and training and information, pertain to the inadequate documented planned protective measures and inadequate verification of training for the PIP-II site.

In paragraph 1 through 6 of I.C.2.b. Certification of ironworker fall protection training, HRP states,

> "The PNOV also alleges that HRP relied on previous training by labor unions but did not verify the adequacy of that training or ensure that a competent person trained ironworkers on the specific personal fall arrest or positioning device systems. *See* Attachment 1 (DOE PNOV). This is incorrect. HRP did verify the adequacy of ironworker training by confirming that the ironworkers performing work at the Fermilab site were qualified

journeyman ironworkers with the requisite knowledge, skills, and ability to safely perform the rebar placing work. All HRP labor on this project was provided in accordance with a collective bargaining agreement ("CBA") with Iron Workers Local Union No. 1 ("Local 1"), which required the rebar placing work to be performed by union ironworkers. New hires, such as [the injured worker], are required to complete HRP's employee information packet, which includes a certification by the responsible HRP hiring authority of the appropriate union classification (i.e. Foreman, Journeyman, Apprentice, etc.). *See* **Attachment 13** (Excerpts of [the injured worker's] New Hire Information Packet). Here, HRP's Superintendent certified that [the injured worker] was a journeyman ironworker. *See id.*

The PNOV points to the OSHA construction standard and the fall protection training requirements contained in 29 C.F.R. § 1926.503 in support of this contention. *See* **Attachment 1** (DOE PNOV). Section 1926.503(b)(1) provides that employers shall verify compliance with § 1926.503(a)'s training requirements by preparing a written certification record. 29 C.F.R. § 1926.503(b)(1). The written certification record shall contain the name or the identity of the employee trained, the date(s) of the training, and the signature of the person who conducted the training or the signature of the employer. *Id.* However, if the employer relies on training conducted by another employer or completed prior to the effective date of the section, the certification record shall indicate the date the employer determined the prior training was adequate rather than the date of actual training. *Id.*

In promulgating the OSHA standard, OSHA noted that it does not require retraining of employees, provided the employee can demonstrate the ability to recognize the hazards of falling and the procedures to be followed to minimize fall hazards as required by § 1926.503(a). *See* 59 Fed. Reg. 40672 (Aug. 9, 1994). OSHA recognizes that in many cases, an employer will be unable to identify the date on which the previous training was provided. Therefore, when employers relying on previous training prepare their certification records, they shall indicate the date the employer determined the prior training was adequate rather than the date of actual training. *Id.*

Here, in addition to the initial site safety orientation, HRP specifically relied on the previous fall protection training the journeymen ironworkers received during the course of their ironworker apprenticeship program, whether through Local 1 or otherwise. According to Local 1, [the injured worker's] local, the apprenticeship curriculum consists of 40 weeks of training where students attend school in the evenings for 24 to 36 hours per month and receive on-the-job training during the day.[5] Among other classes, the apprenticeship program requires an OSHA 30-hour course as a prerequisite.[6] The Local 1 apprenticeship is a three-year program that include structural and reinforcing steel classes and training.[7] Once an apprentice completes the apprenticeship program, he or she becomes a journeyman ironworker.

The HRP ironworkers who performed work at the Fermilab site, including [the injured worker], were journeymen ironworkers who went through the Local 1 or an equivalent ironworker apprenticeship program. Through their respective apprenticeship programs,

> the journeymen ironworkers, including [the injured worker], received fall protection training that was adequate to address fall protection hazards.
>
> The PNOV does not appear to allege that the ironworkers' fall protection training, upon which HRP relied, was inadequate. Instead, the PNOV states that HRP did not verify the adequacy of that prior training or ensure that a competent person trained ironworkers on the specific personal fall arrest or positioning device systems. See Attachment 1 (DOE PNOV). Again, by employing journeymen ironworkers for the Fermilab project, a requirement of the applicable CBA with Local 1, HRP understood that the ironworkers performing work were trained and qualified in accordance with Local 1's comprehensive apprenticeship program, which included fall protection training. HRP confirmed that the ironworkers, including [the injured worker], were in fact journeymen in the initial onboarding process. By doing so, HRP determined that their prior training was adequate. Accordingly, HRP complied with §1926.503(b)(1)."

DOE disagrees that verifying current journeyman status equates to verifying prior fall protection training was adequate. DOE's investigation revealed that the ironworkers had not received training to address changes in fall protection equipment labeling and use limitations that were implemented in 2021 by the fall protection industry manufacturers, including Werner. These changes rendered prior fall protection training obsolete, requiring retraining per 29 C.F.R. § 1926.503(c), and 10 C.F.R. § 851.25. Therefore, DOE determined that HRP failed to either:

1. Train ironworkers at the PIP-II site on the use and limitations of the PFAS and PDS components provided by HRP, a violation of 10 C.F.R. § 851.25(a) and (b) and 29 C.F.R. § 1926.503(a); or

2. Verify that the previous fall protection training adequately addressed the use and limitations of the PFAS and PDS components provided by HRP, a violation of 29 C.F.R. § 1926.503(b).

In footnotes 5, 6, and 7 of I.C.2.b. Certification of ironworker fall protection training, HRP states,

> "[Footnote 5] https://www.iwlocal1.com/news-details/news/curriculum/13466/39421; https://www.iwlocal1.com/news-details/news/apprenticeship-applications/13461/55346
> [Footnote 6] https://www.iwlocal1.com/news-details/news/curriculum/13466/39422
> [Footnote 7] https://www.iwlocal1.com/news-details/news/curriculum/13466/39423"

DOE reviewed the links in footnotes 5, 6, and 7 and did not find evidence that Local 1 fall protection training adequately addressed the specific equipment issued by HRP on the PIP-II site.

In paragraph 8 of I.C.2.b. Certification of ironworker fall protection training, HRP states,

> "HRP's written certification process for training verification at the Fermilab site in place in the Spring 2023 admittedly could be improved. However, the certification in this instance does not indicate an inadequacy in the training of [the injured worker] or his fellow ironworkers. Failure to document a training record is not a "serious" violation. *See*

> 10 C.F.R. § 851, App. B ("A serious violation shall be deemed to exist in a place of employment if there is a potential that death or serious physical harm could result from a condition which exists, or from one or more practices, means, methods, operations, or processes which have been adopted or are in use, in such place of employment."). In considering whether an employer's violation of § 1926.503(b)(1) constituted a "serious" violation, the Occupational Safety and Health Review Commission ("OSHRC") has concluded that the failure to sign or properly document a training record does not create a substantial probability that death or serious physical harm could occur. *Safway Scaffolding d/b/a Safway Servs., Lp (Named As Safway Scaffolding, d/b/a Safway Servs., Lp), Respondent.*, 24 O.S.H. Cas. (BNA) ¶ 1845 (O.S.H.R.C.A.L.J. Aug. 1, 2013). Here, as in the *Safway* case, any paperwork deficiency does not merit a finding of a serious violation (in OSHA parlance) or a Level 1 violation (in DOE's language).[8]"

In paragraph 8 of I.C.2.b., HRP argues that DOE categorized the training citation as a Severity Level I violation. DOE exercised discretion when issuing the PNOV by grouping multiple violations, including training, into a single Severity Level I violation, as stated in paragraph three of the PNOV. As such, the training violation is not a unique Severity Level I violation but instead contributes to the overall single Severity Level I violation in the PNOV.

In footnote 8 of I.C.2.b. Certification of ironworker fall protection training, HRP states,

> "[Footnote 8] While DOE and OSHA are separate agencies with separate regulatory regimes, DOE has chosen to adopt OSHA's fall protection standard rather than develop an independent standard. By adopting the OSHA standard, DOE of course must also follow case law interpretations of the OSHA fall protection standard."

DOE disagrees with HRP's argument in footnote 8 that DOE must follow OSHA case law interpretations. DOE is not legally bound by OSHA case law interpretations while enforcing DOE regulations. While DOE has adopted several OSHA regulations, such as 29 C.F.R. § 1926 Subpart M, DOE and OSHA are separate agencies. OSHA case law interpretations do not have legal bearing on DOE's enforcement of its own regulations under 10 C.F.R. Part 851.

In paragraph 1 through 6 of I.C.2.c. Contribution to the underlying event, HRP states,

> "The PNOV contends that the alleged shortcomings in HRP's fall protection measures contributed to the underlying event; however, given the facts and circumstances surrounding the incident, there is no clear indication that these alleged shortcomings contributed in any way to the incident. *See* **Attachment 1** (DOE PNOV).
>
> As noted above, HRP had multiple policies and procedures in place that were designed to protect ironworkers engaged in elevated work over 6 feet from falling to a lower level. These written policies and procedures included the SSSP, IIPP, Red Book, and JHRAs. *See* **Attachment 2** (SSSP); **Attachment 6** (IIPP); **Attachment 7** (Red Book Fall Protection Excerpt); **Attachment 8** (JHRA for Building Walls in Place). HRP adequately communicated these work rules to the ironworkers, including [the injured worker], through jobsite orientation and daily JTA discussions, during which the job tasks and safe

work procedures were discussed. *See* **Attachment 11** (Example JTAs). Notably, on the day of the incident, the JTA discussion included a review of the JHRA for building walls in place, which contains HRPs 100% tie off requirement for elevated work. *See* **Attachment 12** (May 25, 2023 JTA). [The injured worker] and the other ironworkers participated in the JTA discussion and signed the daily JTA form, acknowledging that they read the applicable JHRAs and were trained to *and understood how to* perform the job tasks safely. *See id.* HRP's foremen are confident that included understanding the appropriate tie-off points on [Doka®] formwork. *See* **Attachment 4** (Declaration of [Foreman 1]); **Attachment 5** (Declaration of [Foreman 2]).

HRP also took active steps to detect potential violations of its work rules. In fact, HRP is, at every site including the Fermilab site, rigorous and diligent in its efforts to ensure the safety of its teammates and that safety rules and practices are being followed. This requirement is baked into the HRP process. At Fermilab, for instance, the SSSP requires that the project foreman conduct continual observational safety checks and assess the safety of the operations assigned. *See* **Attachment 2** (SSSP). The foreman also was responsible for seeing that unsafe acts or conditions were corrected. *See id.* The foreman at the site, both the general foreman [Foreman 1], and the working foreman, [Foreman 2], were diligent in their daily walk-arounds and continually monitored the site for unsafe conditions. *See* **Attachment 4** (Declaration of [Foreman 1]); **Attachment 5** (Declaration of [Foreman 2]). As an example, [Foreman 2] recalls on a previous occasion identifying formwork that was shaky due to being braced with 2x4s. [Foreman 2] communicated this to the other HRP ironworkers and reaffirmed their right to refuse unsafe work until the condition was addressed. *See* **Attachment 5** (Declaration of [Foreman 2]).

[Foreman 2] and [Foreman 1] were very focused on and aware of the importance of assuring that ironworkers working at heights were fully tied off. *See* **Attachment 4** (Declaration of [Foreman 1]); **Attachment 5** (Declaration of [Foreman 2]). On the morning of the incident, [Foreman 2] recalls observing [the injured worker] working at heights and being fully tied off as he was required to be. *See* **Attachment 5** (Declaration of [Foreman 2]). HRP had no reason to believe that later that afternoon, after lunch, [the injured worker] were not employing the same commitment to the mandatory work instruction to remain 100% tied off using one's fall arrest gear when working at heights.[Footnote 9]

In addition to the daily safety walk-around inspections, HRP foremen also conducted and documented monthly site safety inspections. *See* **Attachment 14** (Example Monthly Inspections). HRP also instructed all employees to notify the foreman of any unsafe acts or conditions. Finally, HRP had in place a progressive safety violation disciplinary policy, which served as an effective measure to enforce HRP's safety rules if violations were discovered. *See* **Attachment 15** Disciplinary Policy). The safety violation disciplinary policy is contained in the IIPP and Red Book.

Thus, the PNOV's allegation that shortcomings in HRPs fall protection measures contributed to the underlying event is misplaced. HRP (i) had established work rules requiring 100% tie off for elevated work, (ii) communicated these work rules to the

> ironworkers, (iii) had methods for discovering violations of the rules, and (iv) methods for enforcing the rules if violations were discovered. With no eyewitnesses, we cannot definitively identify the root cause of the incident; however, it was not driven by inadequate training of [the injured worker], inadequate verification of [the injured worker's] training by HRP, or a lack of understanding of the [Doka®] formwork anchorage points by [the injured worker].

DOE disagrees with HRP's arguments in I.C.2.c. Contribution to the underlying event. HRP argues that:

(i) HRP had established work rules requiring 100% tie off for elevated work.
   a. While DOE acknowledges that HRP had a 100% tie off rule for elevated work, as discussed above, the PNOV cited HRP for not developing appropriate work planning to describe *how* ironworkers were to achieve 100% fall protection while on the face of Doka® formwork.

(ii) That HRP communicated these work rules to the ironworkers.
   a. The PNOV did not cite HRP for communication of work rules.

(iii) That HRP had methods for discovering violations of the rules.
   a. The PNOV did not cite HRP for discovering rules violations.

(iv) That HRP had methods for enforcing the rules if violations were discovered.
   a. The PNOV did not cite HRP for enforcement work of rules violations.

Further, HRP's regulatory violations for inadequate planned protective measures and inadequate verification of training apply to every ironworker on the PIP-II site, not just [the injured worker]. HRP's regulatory violations, as discussed above, relate to programmatic weaknesses that left every ironworker at the PIP-II site exposed to a fall greater than six feet while working on the face of the Doka® formwork due to inadequate planned protective measures and inadequate training verification.

In footnote 9 of I.C.2.c. Contribution to the underlying event, HRP states,

> "[Footnote 9] After lunch on May 25th, [the injured worker] either knowingly or inadvertently did not follow HRP's mandated requirement to be tied off while working at heights using his fall arrest gear. Thus, even if [the injured worker] did attach his positioning device inappropriately to a non-compliant anchorage point for reasons that are not understood by HRP, reliance on this device for fall protection violates HRP's fall protection requirements, which are well understood by the Fermilab team. A drug abuse screening test was run on [the injured worker] upon arrival at the hospital immediately after the incident. We are unsure whether DOE has obtained a copy of the test results. OSHA and the OSHRC have long recognized the affirmative defense of unpreventable employee misconduct, which requires an employer to demonstrate (i) that it had established work rules designed to prevent the violation, (ii) that it had adequately communicated the rules to its employees, (iii) that it had taken steps to detect violations,

> and (iv) that it effectively enforced the rules upon discovering violations. *See Compass Steel Erection, Inc.*, 17 O.S.H. Cas. (BNA) ¶ 1513 (O.S.H.R.C.A.L.J. Oct. 10, 1995). HRP recognizes that this is not an OSHA proceeding; however, [the injured worker's] failure to follow HRP's mandatory fall protection requirements should be considered for mitigation purposes."

HRP's regulatory violation are programmatic in nature and existed irrespective of [the injured worker's] actions on May 25, 2023.

In paragraph 1 of I.C.3. Mitigation, HRP states,

> "Pursuant to DOE regulations, determinations regarding the severity of the preliminarily identified infraction included in the PNOV and the accompanying penalty may be adjusted based on mitigating circumstances. Based on the facts presented herein and circumstances surrounding the underlying incident, if DOE contends that the violations as alleged in the PNOV occurred, at minimum, we believe there are mitigating circumstances that support adjusting the PNOV's severity determination and penalty prior to finalizing it.[Footnote 10]"

As noted above, DOE exercised discretion by categorizing multiple violations as one Severity Level I violation. Doing so constituted mitigation of civil penalties for the individual violations. DOE declines HRP's request that DOE additionally mitigate the remaining civil penalty on the combined Severity Level I violation due to the seriousness of the event, which resulted in significant physical harm to the ironworker and revealed programmatic noncompliances. Therefore, adjustment of the Severity Level and additional mitigation of the civil penalty is not warranted.

In footnote 10 of I.C.3. Contribution to the underlying event, HRP states,

> "[Footnote 10] Thus, inadvertent violations are viewed differently from those where there is gross negligence, deception, or willfulness. In addition to the severity of the underlying violation and level of culpability involved, DOE will also consider the position, training, and experience of those involved in the violation. For example, a violation may be deemed to be more significant if a senior manager of the organization is involved rather than a foreman or non-supervisory employee. Other factors that will be considered in determining the civil penalty amount are the duration of the violation (how long the condition has presented a potential exposure to workers), the extent of the condition (number of instances of the violation), the frequency of exposure (how often workers are exposed), the proximity of the workers to the exposure, and the past history of similar violations."

DOE concludes that the violations are programmatic in nature which are the responsibility of senior management officials who own and develop the programmatic process and expectations. DOE disagrees with the implication by HRP that the culpability of this event lies solely with [the injured worker]. The HRP fall protection programs and process are insufficient to address the planning necessary to implement a complete PFAS or PDS on Doka® formwork. Further, DOE

exercised discretion by issuing a single Severity Level I violation as opposed to issuing violations for every occurrence an ironworker on the PIP-II site climbed Doka® formwork without appropriate planning for the complete PFAS and PDS or every instance that fall protection training was not verified and documented.

In paragraph 1 of I.C.3. Mitigation, HRP states,

> "A better outcome, however, from a worker safety standpoint, would be to allow HRP to enter into a Consent Decree with DOE applicable to all future work at the Fermilab PIP II LINAC project. This would provide DOE with additional assurance that HRP would ensure the protection of its workforce, and would provide HRP an opportunity to commit to improvements in its safety programs and processes beyond those that were in place at the time of the incident."

To the extent that HRP is requesting settlement with DOE through its request for a "Consent Degree," DOE's limited settlement procedures under 10 CFR § 851.41 apply at the discretion of the Enforcement Director who considers whether to pursue settlement based on the severity of the violation(s) and the potential effectiveness of outcomes from settlement discussions. Here, the "Consent Decree" described in HRP's Reply is not a procedural pathway toward resolution of a violation under DOE's regulations based in part on the following:

1. The severity of the workers' injuries.

2. The preventable nature of the fall event.

3. The systemic nature of HRP's fall protection issues extends throughout the organization and requires action beyond the PIP-II project.

In paragraph 1 of I.C.3.a. Degree of Culpability, HRP states,

> "As noted above, HRP has a robust safety and health program that it implements at all its worksites, including the Fermilab site. For HRP and its ironworkers, safety is paramount, and this commitment to safety is reflected in HRP's outstanding safety record leading up to this incident. For the Bourbonnais, Illinois region, HRP had not had any significant incidents nor even an OSHA recordable injury for over one thousand days prior to the subject incident. This is a testament to the training, quality, and competency of HRP's management and teammates, and their commitment to adherence with HRP's robust safety and health programs and expectations.

DOE disagrees that HRP's fall protection program is sufficiently robust as it overly relies on workers' experience to implement a complete PFAS and PDS, as opposed to thorough planned protective measures. Further, HRP's training verification does not account for evolving specifications and use limitations of fall protection equipment.

In paragraph 2 of I.C.3.a. Degree of Culpability, HRP states,

> "DOE has expressed a concern that [the injured worker] may have not understood the appropriate anchorage points on the [Doka®] formwork, but no evidence of such a lack of understanding has been identified. In fact, this assumption runs contrary to the great bulk of evidence that indicates that [the injured worker] did indeed know of the available anchorage points on the [Doka®] formwork and had used them on his ascent to his position to perform his work task of threading the rebar wire through the formwork. There is no reason that [the injured worker] could not have tied off to those same anchorage points before beginning work."

DOE identified that HRP failed to ensure that ironworkers were trained by a competent person in the use and operation of PFASs and PDSs. DOE noted that, specifically, HRP had relied on previous training by labor unions but did not verify the adequacy of that training or ensure that a competent person trained ironworkers on the specific PFAS and PDS used on the PIP-II LINAC project. Based on those findings, DOE determined that ironworkers did not have a clear understanding of the use and operation of the HRP-issued PFAS or PDS while climbing Doka® formwork. DOE gathered extensive evidence in its investigation demonstrating that HRP selected and provided fall protection equipment, but did not ensure clear communication of the design limitations to the workers at the PIP-II site.

First, HRP selected Class 1 SRLs but did not present evidence that it clearly communicated or documented that anchoring below the dorsal D-ring with a Class 1 SRL was contrary to the design specifications and increased the potential for failure of the PFAS.

Second, HRP selected large pelican hooks to anchor through the Doka® formwork boreholes, which is an incompatible connection. To form a compatible connection, HRP must install the Doka® required borehole lifting ring fall protection anchorage attachments. HRP did not do so, thus increasing the hazard of PFAS and PDS system disengagement from the incompatible connection. DOE found that HRP did not install necessary components to provide a compatible connection to use the Doka® formwork boreholes as anchorages. This evidence further demonstrates that HRP did not understand critical anchorage information when using Doka® formwork. Therefore HRP, as an organization, was ill-equipped to evaluate individual worker understanding of Doka® formwork anchorage.

HRP continues to state "confidence" that the ironworkers, including [the injured worker], knew how and where to anchor on Doka® formwork. As noted above, DOE's investigation revealed that HRP did not demonstrate sufficient understanding to appropriately evaluate individual worker knowledge regarding the issued PFASs and PDSs. No evidence was provided to indicate the fall protection programs ensured the necessary fall protection planning was completed or that important information, including component limitations, was presented to the ironworkers prior to the incident. Additionally, the post event training did not address the limitations of the PFAS and PDS components, including the Doka® formwork anchorages, to ensure a similar event would not happen in the future.

In paragraph 1 of I.C.3.b. Duration of violation, HRP states,

> "While HRP cannot definitively identify the root cause of the incident, it likely was due to instantaneous and unforeseeable conduct of a qualified journeyman ironworker failing to tie off when he was atop the formwork. This act was contrary to HRP's site safety rules, general practices, and job instructions, which were all effectively communicated to HRP's ironworkers and enforced by HRP's foremen. The ironworker's failure to maintain 100% tie off while near the top of the form wall was unknown to HRP and unexpected by HRP."

DOE disagrees with HRP that the root cause(s) are unidentifiable. HRP implies that stating "100% tie off" constitutes a complete plan. As stated in the Werner manual, "[t]he complete fall arrest system must be planned (including all components, calculating fall clearance, and swing fall)". HRP relied on the injured worker's experience with Doka® formwork instead of planning the complete PFAS and PDS. Also, HRP did not clearly communicate policy that goes beyond minimum OSHA requirements. Therefore, DOE concludes that the root causes are HRP's programmatic issues of inadequate planning of the complete fall protection systems and inadequate verification that the injured worker's previous fall protection training addressed information necessary to understand the complete PFAS and PDS issued by HRP. These root causes are independent of the injured worker's actions at the top of the formwork and address the issue that all workers were exposed to the potential for failure or inadvertent disengagement of the PFAS and PDS while on Doka® formwork at the PIP-II site.

In paragraph 2 and 3 of I.C.3.b. Duration of violation, HRP states,

> "Additionally, video footage of the incident appears to show that [the injured worker] was using his personal fall arrest system during his ascent, including moments before reaching his position near the top of the formwork. For reasons unknown to HRP, [the injured worker] did not have either of his self-retracting lifelines attached to the formwork anchorage points at the time of the incident. It is unknown precisely how long [the injured worker] was in this position without being 100% tied off, but the video evidence suggests it was less than one minute. Accordingly, the ironworker's violation of HRP's 100% tie off work rule was extremely brief in duration, exclusively controlled by the ironworker, and virtually impossible to discover by HRP due to the location of personnel.
>
> While we understand from our meeting that DOE may be aware of incidents when employees were working at heights at the site without being tied off, such behavior was not condoned by HRP leadership or supervisors and was not seen during any of the daily site safety observations (or at any other time) by HRP site leadership. *See* **Attachment 4** (Declaration of [Foreman 1]); **Attachment 5** (Declaration of [Foreman 2]). HRP work foreman, [Foreman 2], is aware of one instance when HRP employees were identified as violating safety rules (two employees on one ladder). *See* **Attachment 5** (Declaration of [Foreman 2]). However, after reviewing video surveillance with general contractor, Whittaker Construction and Excavation, Inc. ("Whittaker"), it was determined that these employees were another contractor's employees, not HRP employees."

DOE acknowledges the video footage, but DOE disagrees it is conclusive. There is additional video and photographic evidence that provides additional context. However, the programmatic violations cited in the PNOV are independent of the actions of the individual workers.

In I.C.3.c. Prompt corrective actions, HRP states,

> "After the underlying incident occurred, work at the Fermilab site was stopped. Accordingly, HRP was limited in the corrective actions that it could take at the site until work began again months later. Notwithstanding, HRP took immediate steps to improve onsite safe work practices well in advance of resuming work onsite.
>
> Specifically, HRP took the following corrective actions:
>
> (i) Conducted a general safety stand-down with the foremen at the Fermilab site and all other HRP foremen in the Bourbonnais, Illinois division ("all Foremen") to review HRP policies, procedures, and expectations. *See* **Attachment 16** (Post-Incident Foremen Safety Training).
>
> (ii) Conducted refresher fall protection training with all foremen.
>
> (iii) Conducted refresher harness inspection training with all foremen.
>
> (iv) Conducted refresher harness fitment training with all foremen.
>
> (v) Implemented updated to the JHRA process and forms and trained all foremen on JHRA updates, use, and recordkeeping.
>
> (vi) Updated the JHRA for building walls in place. *See* **Attachment 17** (Post-Incident JHRA for Building Walls in Place). This included enhancements to job steps and safe work procedures – including reference to [Doka®] formwork anchor points.
>
> (vii) Updated the SSSP to include additional detail for fall prevention / fall protection work plan and enhanced JHRAs. *See* **Attachment 18** (Post-Incident Updated SSSP).
>
> (viii) Worked with Whittaker and FRA to complete all return to work requirements.
>
> We understand from our August 21st meeting that DOE has an impression that HRP resisted Whittaker's direction following the incident that HRP use permanent Self-Retracting Lifelines ("SRL") going forward when working at elevated levels. *This is not accurate.* HRP did not resist the use of permanent SRLs; HRP expressed concern to Whittaker that use of permanent SRLs may create a lateral swing that posed a danger to its team if they were not spaced properly, and that HRP wanted to ensure that the SRLs were spaced and located appropriately to avoid this lateral swing risk. This was the *only concern and the only basis for hesitancy* expressed by HRP. Ultimately, to ensure lateral swing risk did not present a risk, HRP installed its own permanent SRLs appropriately spaced to ensure the safety of its teammates."

DOE acknowledges HRP's recognition of the severity of the event and that HRP stopped work, conducted an investigation, and implemented corrective actions. However, DOE's investigation

revealed that HRP's investigation was insufficient, overly focused on personnel error, and failed to identify deficiencies in the HRP fall protection program. Further, DOE determined that HRP's corrective actions, including retraining workers in fall protection, were inadequate. Specifically, the updated SSSP and JHRA lacked detailed work instructions on how to achieve "100% fall protection," and the post-event training did not address formwork-specific anchorages or equipment limitations. Additionally, the post event training focused heavily on harness fitment and inspection. DOE acknowledges that harness fitment is important, but DOE's investigation did not identify it as an issue in the May 25, 2023, fall event.

In I.C.3.d. Commitment going forward, HRP states,

> "There is always more than can be done to improve safety. HRP has given thought to the type of commitments that it would suggest be included in a Consent Decree to resolve this matter. These commitments fall into the following three categories:
>
> (1) Possibility of additional onsite supervision from a well-trained safety professional or experienced teammate.
>
> (2) Additional training provided by HRP in critical safety areas before allowing ironworker journeymen to work at the site, including refresher training to update the understanding of ironworkers trained earlier in their careers.
>
> (3) Sharing our commitment and specific improvements to safety within the rebar installation industry to competitors less steeped in safety knowledge or understanding, through trade association forums or other industry vehicles.
>
> HRP is open to developing specific commitments around these topics outlined herein, but also open to other suggestions from DOE, including commitments related to ANSI's new fall protection standard, as a way to resolve this matter in lieu of finalization of the PNOV."

DOE acknowledges HRP's proposed commitments and encourages HRP to pursue these additional actions. However, for the reason presented above in DOE's response to I.C.3. Mitigation, DOE declines to enter into a Consent Order with HRP regarding the May 25, 2023, fall event at the PIP-II site, as requested by HRP for a "Consent Decree."

In I.D. Conclusion, HRP states,

> "For the reasons set forth above, we request that DOE work with HRP to negotiate a Consent Decree focused on ensuring the safety of HRP's team working at the Fermilab PIP II LINAC project site in lieu of finalizing the PNOV. Should DOE move forward with the PNOV and issue a Final Notice of Violation ("FNOV"), HRP reserves all rights to raise additional legal and/or factual issues in its appeal of the FNOV.
> We appreciate your serious consideration of this response and thank you for your time and interest in our work at the Fermilab project site."

DOE, as demonstrated herein, has given serious consideration to HRP's reply to the PNOV. However, based on the foregoing reasons outlined above and the summary below, modification of the PNOV is not warranted.

Section I.1 of the PNOV stated that HRP failed to develop and implement adequate fall protection measures for ironworkers climbing and working on Doka® formwork. Specifically, HRP's processes failed to fully identify and plan the protective measures to address the fall hazard as required by 10 C.F.R. Part 851 related to Doka® formwork anchorages. HRP's Site Specific Safety Plan (SSSP) and job hazard risk analysis (JHRA) required "100% tie off," but HRP failed to plan for and develop work instructions for identifying anchorage points on Doka® formwork for a personal fall arrest system (PFAS) or positioning device system (PDS). These findings demonstrate that the Severity Level I violation is driven not only by the actual serious physical harm to the ironworker, but also by the pervasive and systemic nature of HRP's programmatic noncompliances in hazard prevention, construction safety, and training, which collectively created the conditions for this event.

HRP's reply argues that it follows robust safety and health programs and attributes the underlying cause of the event to the instantaneous and unforeseeable conduct of the worker, alleging the ironworker was noncompliant with HRP's 100% fall protection requirements.

However, DOE's investigation revealed that HRP's planned protective measures were inadequate and failed to provide workers with a complete PFAS or PDS. Both the PFAS and PDS systems require OSHA-compliant anchorages as components. The [Doka®] *Framed formwork Framax S Xlife User Information* and [Doka®] *Technical Newsletter 850 (NAM)* outline compliant anchorages, including integrated safety handles and mounted attachment points (e.g., formwork boreholes with lifting ring attachments). Specifically:

- HRP's planned protective measures did not include the manufacturer's anchorage information necessary to achieve 100% fall protection. HRP also failed to ensure the installation of the Doka® borehole lifting ring attachments on the formwork, which were necessary components to provide compatible connections to use the Doka® formwork boreholes as anchorages.

- HRP selected large pelican/rebar hooks as PFAS and PDS components to connect through the Doka® formwork boreholes. However, these hooks are incompatible with Doka® formwork boreholes, a violation of OSHA standards 29 C.F.R. § 1926.502(d)(5) and (6) and 29 C.F.R. § 1926.502(e)(7) and (8).

- The two Werner self-retracting lifelines are designed, rated, and marked to be connected only for anchorage connections above the dorsal D-ring of the worker. However, the only OSHA-compliant anchorages available at the location of the assigned task (i.e., the integrated safety handles) were below the injured worker's dorsal D-ring.

- The OSHA-compliant anchorages (i.e., the integrated safety handles) were outside the injured worker's accessible radius for connecting their PDS at the location of the assigned task.

Therefore, DOE's investigation revealed that HRP failed to provide OSHA-compliant anchorages for both the PFAS and PDS at the work location (i.e., the top of the Doka® formwork near the corner), a violation of 10 C.F.R. §§ 851.22(a), 851.23(a)(7), 851.24(b), and Appendix A, section 1, *Construction Safety*.

HRP's reply to the PNOV also stated that it provided ironworkers with PFASs and PDSs consisting of a Werner brand full-body harness, two Werner self-retracting lifelines, and a body positioning hook and lanyard. Additionally, HRP argues that the [injured worker] "would have been allowed to anchor to anchorage points above or below his dorsal D-ring." DOE inspected the components involved in the fall event and found that while each of these components provided by HRP was appropriate for use as part of a complete PFAS or PDS, each has limitations that must be adhered to for safe use. By disregarding these limitations, HRP failed to recognize and address the hazard of unintentional disengagement and potential failure of the PFAS or PDS.

For example, the self-retracting lifelines (SRLs) issued by HRP at the PIP-II site were clearly marked "Class 1 Anchor at or above dorsal D-ring" on the SRL housing and in the user manual. The Werner Bantam 6 manual, provided to DOE by HRP, explicitly states "[c]ompliant fall protection equipment must always be used as it was designed…. Failure to follow all instructions and limitations on the use of Self-Retracting Lifelines (SRL) may result in serious injury or death." The manual also specifies a free fall limit of two feet. HRP's practice of allowing the ironworker to anchor the Class 1 SRL below the dorsal D-ring violated these specifications, which could result in a free fall exceeding 2 feet and increases the risk of equipment failure.

Therefore, DOE determined that HRP failed to address the hazard of unintentional disengagement and potential failure of the PFAS or PDS by disregarding the design specifications and limitations of the components used in the PFAS and PDS. This constitutes a violation of 10 C.F.R. § 851.22(c).

Section I.2 of the PNOV stated that HRP failed to ensure a competent person trained workers in the use and operation of the PFAS and PDS components issued by HRP for use on the PIP-II site. Instead, HRP relied on prior training provided by labor unions (e.g., Local 1) without verifying the adequacy of that training or ensuring that workers received site-specific instruction from a competent person on the use and limitations of the PFAS and PDS fall protection systems provided by HRP.

In its reply, HRP argued that it verified the adequacy of fall protection training by confirming that the workers on site were qualified journeyman ironworkers with the requisite knowledge, skills, and ability to perform rebar placing work safely. HRP provided website links to the Local 1 apprenticeship training curriculum as additional supporting evidence.

However, DOE's investigation revealed that the ironworkers had not received training to address changes in fall protection equipment labeling and use limitations that were implemented in 2021 by the fall protection industry manufacturers, including Werner. These changes rendered prior

fall protection training obsolete, requiring retraining per 29 C.F.R. § 1926.503(c) and 10 C.F.R. § 851.25. Therefore, DOE determined that HRP failed to either:

1. Train ironworkers at the PIP-II site on the use and limitations of the PFAS and PDS components provided by HRP, a violation of 10 C.F.R. §§ 851.25(a) and (b) and 29 C.F.R. § 1926.503(a); or

2. Verify that the previous fall protection training adequately addressed the use and limitations of the PFAS and PDS components provided by HRP, including anchorages, a violation of 29 C.F.R. § 1926.503(b).

HRP's reply contends that the training citation does not merit a Severity Level I violation. As described in the PNOV, DOE grouped multiple violations, including training violations, into a single Severity Level I violation. As such, the training violation contributes to the overall Severity Level I violation.

HRP's reply also argues for mitigating the PNOV's severity determination. DOE exercised discretion by categorizing the violations as one Severity Level I violation. DOE determined the Severity Level based on the seriousness of the event, which resulted in significant physical harm to the ironworker and revealed significant programmatic noncompliances. Therefore, adjustment of the severity level is not warranted.

Additionally, HRP's reply states that mitigating factors support the reduction in the civil penalty amount. DOE acknowledges HRP's recognition of the severity of the event and that HRP stopped work, conducted an investigation, and implemented corrective actions. However, DOE's investigation revealed that HRP's investigation was insufficient, overly focused on personnel error, and failed to address deficiencies in its fall protection program. DOE's investigation further revealed that HRP's corrective actions, including retraining workers in fall protection, were inadequate. Specifically, the updated SSSP and JHRA lacked detailed work instructions on how to achieve "100% fall protection," and the post-event training did not address formwork-specific anchorages or equipment limitations. As a result, civil penalty mitigation for HRP's corrective actions is not warranted.

Enclosure 2

Final Notice of Violation

Harris Rebar Placing, LLC
Fermi National Accelerator Laboratory

WEA-2024-04

The U.S. Department of Energy (DOE) conducted an investigation into the facts and circumstances surrounding the May 25, 2023, event when an ironworker was seriously injured after falling from concrete formwork at the Fermi National Accelerator Laboratory's (Fermilab) Proton Improvement Plan II (PIP-II) linear accelerator (LINAC) construction site. The ironworker was an employee of Harris Rebar Placing, LLC (HRP), a subcontractor to Whittaker Construction and Excavating, Inc. (WCEI). At the time of the event, WCEI was under contract with Fermi Research Alliance (FRA) as the general construction contractor for the PIP-II construction project.

On July 10, 2024, DOE issued a Preliminary Notice of Violation (PNOV) to HRP with a proposed civil penalty of $118,000 for one Severity Level I violation of 10 C.F.R. Part 851 (Part 851), *Worker Safety and Health Program*. DOE received HRP's reply to the PNOV on August 26, 2024, in which HRP contested the Severity Level I violation, including HRP's contribution to the underlying event and degree of culpability. HRP also requested that DOE negotiate a "Consent Decree" in lieu of finalizing the PNOV. DOE declines to consider settlement with HRP's request for a "Consent Decree" due to the significant nature of the injuries and severity of the violations. DOE thoroughly considered HRP's reply and found HRP's reasons were insufficient for PNOV modification. DOE's investigation identified regulatory noncompliances revealed by the fall event, which are listed below.

I. VIOLATION

Management Responsibilities, Hazard Prevention and Abatement, Safety and Health Standards, Construction Safety, and Training and Information

Title 10 C.F.R. § 851.10, *General requirements*, subsection (a), states that "[w]ith respect to a covered workplace for which a contractor is responsible, the contractor must: (1) [p]rovide a place of employment that is free from recognized hazards that are causing or have the potential to cause death or serious physical harm to workers; and (2) [e]nsure that work is performed in accordance with: (i) [a]ll applicable requirements of [Part 851]; and (ii) [t]he worker safety and health program for that workplace."

Title 10 C.F.R. § 851.20, *Management responsibilities*, subsection (a), states that "[c]ontractors are responsible for the safety and health of their workforce and must ensure that contractor management at a covered workplace…(1) [e]stablish written policy, goals, and objectives for the worker safety and health program…."

Title 10 C.F.R. § 851.22, *Hazard prevention and abatement*, subsection (a), states that "[c]ontractors must establish and implement a hazard prevention and abatement process to ensure all identified potential hazards are prevented or abated in a timely manner. (1) For hazards identified…controls must be incorporated in the appropriate…procedure. (2) For existing hazards identified in the workplace, contractors must…(iii) [p]rotect workers from dangerous safety and health conditions." Subsection (c) states that "[c]ontractors must address hazards when selecting or purchasing equipment, products, and services."

Title 10 C.F.R. § 851.23, *Safety and health standards*, subsection (a), states that "[c]ontractors must comply with the following safety and health standards that are applicable to the hazards at their covered workplace:…(7) Title 29 [C.F.R.] Part 1926, *Safety and Health Regulations for Construction*…."

Title 10 C.F.R. § 851.24, *Functional areas*, subsection (a), states that "[c]ontractors must have a structured approach to their worker safety and health program which at a minimum, include provisions for the following applicable functional areas in their worker safety and health program:…construction safety…." Subsection (b) states that "[i]n implementing the structured approach required by [subsection] (a) of this section, contractors must comply with the applicable standards and provisions in appendix A of this part, entitled 'Worker Safety and Health Functional Areas.'"

Title 10 C.F.R. § 851, *Appendix A to Part 851 – Worker Safety and Health Functional Areas*, section 1, *Construction Safety*, subsection (a), states that "[f]or each separately definable construction activity…the construction contractor must…(1) [p]repare…an activity hazard analysis…. Such analyses must: (i) identify foreseeable hazards and planned protective measures; (ii) address further hazards revealed by supplemental site information…."

Title 10 C.F.R. § 851.25, *Training and information*, subsection (a), states that "[c]ontractors must develop and implement a worker safety and health training and information program to ensure that all workers exposed or potentially exposed to hazards are provided training and information on that hazard in order to perform their duties in a safe and healthful manner." Subsection (b) states that "[t]he contractor must provide: (1) [t]raining and information for new workers, before or at the time of initial assignment to a job involving exposure to a hazard; (2) [p]eriodic training as often as necessary to ensure that workers are adequately trained and informed; and (3) [a]dditional training when safety and health information or a change in workplace conditions indicates that a new or increased hazard exists."

Title 29 C.F.R. § 1926.501, *Duty to have fall protection*, subsection (b)(5), states that "[e]ach employee on the face of formwork…shall be protected from falling 6 feet (1.8 m) or more to lower levels by personal fall arrest systems [PFASs]…or positioning device systems [PDSs]."

Title 29 C.F.R. § 1926.502, *Fall protection systems criteria and practices*, subsection (d)(15), states that "[a]nchorages used for attachment of personal fall arrest equipment shall be… designed, installed, and used as follows…(i) as part of a complete [PFAS]…." Subsection (e) states that "[PDSs]…(i) shall be rigged such that an employee cannot free fall more than 2 feet."

Title 29 C.F.R. § 1926.503, *Training program*, subsection (a)(1), states that "[t]he employer shall provide a training program for each employee who might be exposed to fall hazards… and shall train each employee in the procedures to be followed in order to minimize these hazards." Subsection (a)(2) states that "[t]he employer shall assure that each employee has been trained…by a competent person qualified in…(iii) [t]he use and operation of [PFASs]…and other protection[s] to be used [e.g., PDS]." Subsection (b)(1) states that "[t]he employer shall verify compliance with paragraph (a) of this section by preparing a written certification record…. If the employer relies on training conducted by another employer…the certification record shall indicate the date the employer determined the prior training was adequate…."

Fermi Research Alliance (FRA) *Worker Safety and Health Program*, revision 15, September 28, 2022, *Executive Summary*, states that "[t]he requirements of the WSHP [Worker Safety and Health Program] apply to…subcontractors. FRA communicates WSHP requirements through FESHM [Fermilab Environment, Safety and Health Manual]…. FRA also expects all subcontractors to comply with WSHP requirements provided to them in the subcontract *ESH Requirements Document*, Division 1, section 013100…. The FESHM 7000 series, *Occupational and Subcontractor Safety*, defines this process." Section 2.1, *Construction Safety*, states that "[a]ll subcontractors who perform work at Fermilab sites must comply with the provision of 10 C.F.R. 851 Worker Safety and Health Program. FRA flows down these requirements to subcontractors and their employees through Contract terms and conditions…. All Subcontractors are required to have their own Construction Safety Plan and/or [Hazard Analysis], depending upon the complexity of the project, in place prior to starting work."

FRA FESHM 7010, *Construction ES&H Program*, August 2022, section 7.6.1, states that "[a]ll fall hazards equal to or greater than six (6) feet will have 100% fall protection for all Subcontractor's and/or Sub-tier subcontractor's employees." Section 7.6.4 states that "[a]ll workers using [a] fall arrest harness must be specifically trained in their use." Section 013100, *Environmental, Safety, and Health Requirements*, subsection 1.11, *Hazard Analysis*, paragraph D.6, states that "[s]pecific procedures in the area of fall protection…may be required as job conditions dictate…." Section 3.4, *Subcontractor Training*, paragraph A.2, states that "[a]ll Subcontractors performing work at Fermilab shall provide to their employees any necessary ES&H [environment, safety, and health] training as may be required by federal…regulations and as appropriate for their Subcontract activities…." Paragraph C states that "[s]ubcontractors shall maintain on-site…any and all occupational safety…records…includ[ing]…training records…for…Fall Protection." Section 3.7, *Fall Protection*, states that "[a]ll fall hazards…greater than six (6) feet will have 100% fall protection for all Subcontractor and Sub-tier employees."

FRA FESHM 7060, *Fall Protection Program*, February 2021, section 4.0, *Program Description*, states that "[a]ny…subcontractor…exposed to a fall hazard…must be trained…[in] the selection and use of…personal fall arrest equipment. For all construction activities, the fall hazard cannot be at or greater than six (6) feet." Section 5.1, *Education and Training Requirements*, states that "[a]ny…subcontractor involved in work activities and exposed to a fall hazard must be trained [in] the use of fall protection equipment. At a minimum, the training shall include…[t]he procedures…to minimize fall hazards, [t]he correct way to use…fall protection systems, [and] [i]dentification of required anchor points…."

FRA *Subcontract Number 6904363 For Construction of the PIP-II Linac Complex Between FRA and Whittaker Construction and Excavating, Inc.*, December 16, 2022, section 3.7, *Fall Protection*, states that "[a]ll fall hazards…greater than six (6) feet will have 100% fall protection for all Subcontractor and Sub-tier employees."

WCEI *Safety Manual for [Fermilab]*, July 2015, chapter 7.1, *Subcontractor Job Safety Rules*, *General Safety and Health Provisions*, states that "[c]ontractor requires full compliance with requirements of the Occupational Safety and Health Standards (29 C.F.R. 1926)…by subcontractor…. Subcontractor shall comply with said requirements, standards, and regulations, and require and be directly responsible for compliance therewith on the part of its…subcontractors."

WCEI *Subcontract Agreement No. 2022003-014 with Nucor Harris Rebar Midwest, LLC, PIP-II Linac Complex*, December 13, 2022, states that "[s]ubcontractors and their [s]ubcontracts shall comply with…[a]ll provisions of Federal, State and Local Law…." *Additional Provisions and Conditions of Subcontract*, paragraph 15, states that "[s]ubcontractor shall comply with…all safety measures initiated by…Contractor…or… Owner…and with all applicable laws,…rules, [and] regulations…." Paragraph 16 states that "Every provision of the General Contract required to be incorporated into subcontracts is hereby incorporated to the extent directly related to Subcontractors scope of work."

HRP *Installation Subcontract Agreement Harris Contract No.03722672*, January 16, 2023, states that "Nucor Harris Rebar Midwest LLC (hereinafter 'Subcontractor' [and] Harris Rebar Placing, LLC…(hereinafter 'Installer')." *Article 9 – Safety* states that "[i]nstaller…warrants that it has fully implemented a comprehensive and fully supervised Safety Program…and agrees to be bound by the more stringent requirements of O.S.H.A…and all applicable health and safety standards." *Article 15 – Laws, Regulations, and Ordinances*, paragraph b, states that "Installer shall comply with all Federal…laws [and] regulations…applicable to the Work under this Agreement." *Exhibit "B" Health and Safety Policy*, states that "[i]t is our responsibility to ensure…complete compliance with all Occupational Health and Safety laws, including Regulations and Standards. We meet this objective by:…5. Hazard Correction – Fix the hazards…6. Training – Train all Managers, Supervisors and Team Members to perform work safely and recognize and respond to hazards…." *Exhibit "B" Installer's Safety Responsibilities and Requirements*, paragraph 2, states that "[t]he Installer shall comply with all applicable laws, regulations…and conditions of each Contract, and rules or orders of any public authority having jurisdiction relating to safety…." Paragraph 3 states that "[t]he Installer is responsible to make certain that all personnel are properly trained and instructed in all jobs which require specific training and/or competency to meet all applicable [Occupational Safety and Health Administration] regulations…and Federal law…." Paragraph 7 states that "[t]he Installer is responsible for providing Personal Protective Equipment and for training in the proper use…."

HRP *Field Practices (Red Book)*, April 2018, *Safety Responsibilities*, states that "[m]anagement will ensure…[a] competent person is appointed as a supervisor…[and] [p]roper training for all teammates…. This includes…specific training and appropriate refresher training…[m]easures and procedures required by law are carried out in the workplace…. Supervisors/[f]oremen will ensure [t]eammates are…properly trained on the use of protective equipment…appropriate to the

work performed." *General Jobsite Safety Rules* states that "[s]pecific fall protection requirements will be noted in the Site-Specific Safety Plan per project." *Training* states that "[t]raining will be conducted…according to regulatory standards."

HRP *Injury and Illness Prevention Program (IIPP) Section 1*, revision 1, March 22, 2023, *Placing Manager Responsibilities*, states that "[i]t is [HRP's] responsibility…to ensure…a…safe work environment for all employees. This shall be accomplished by complete compliance with all [o]ccupational [h]ealth and [s]afety laws including [r]egulations and [s]tandards, assisted by ongoing…safety training programs…." *[HRP] Contractor Representative - Field Safety Responsibilities*, states that "[m]anagers…[t]rain all employees in the safe performance of their jobs. This includes…specific training." *Foreman/General Foreman Responsibilities*, states that "[foremen are] responsible to train…workers in the safe performance of their duties."
HRP *IIPP Section 6,* revision 0, January 31, 2013, *Training*, states that "[i]t is the responsibility of the supervisors to train and to supervise workers in the safe performance of their duties…keeping records of any instruction [or] training…."

HRP *Site Specific Safety Plan, PIP-II-LINAC Complex*, December 20, 2022, *Section 1: Introduction*, states that "[i]t is the responsibility of the Project Superintendent to oversee the Project Safety Program…. It is the responsibility of the…Foreman to implement and enforce this Site Specific Safety Plan…." *Section 3: Fall Prevention/Fall Protection Work Plan* states that "[t]he purpose of this plan is to…[e]nsure that employees are trained…prior to placing reinforcing steel…. This plan is designed…to establish the procedures…to prevent falls to lower levels…. It is the responsibility of the on-site safety supervisor to implement this fall protection plan."

Doka® *Framed formwork Framax S Xlife, User Information, Instructions for assembly and use*, 999783014, January 2019, *Basic safety warnings, user target groups*, page 4, states that "[a]ll persons working with the product…must be familiar with…all the safety instructions…. In all cases, users must ensure compliance with the national applicable laws, standards and rules…." *Attachment points for personal fall arrest equipment*, page 17, states that "[t]he attachment points shown…for [PFAS] conform to OSHA requirements…" and are illustrated via diagram.
Doka® Technical Newsletter 850, *Anchorage points for personal fall arrest system (PFAS)*, January 10, 2017, page 1, states that "[t]his Technical Newsletter shows the OSHA regulations compliant anchorage points for attaching a [PFAS] to Doka formwork systems." Further, on page 2, a diagram of the Framax S Xlife panel shows the manufacturer-approved, OSHA-compliant PFAS anchorage points.

Werner® *User Instructions, Bantam™ Self Retracting Lifelines, Bantam 6*, November 2021, page 1, states that "WARNING!…[b]efore using a fall arrest system, users must be trained in the safe use of the system, as required by OSHA 29 CFR…1926.503, or local safety regulations." *GENERAL SAFETY INFORMATION*, page 2, states that "3. [d]o not use or install equipment without proper training from a 'competent person' as defined by OSHA 29 CFR 1926.32(f)." *Use Instructions*, page 3, states that "2. [b]efore using a [PFAS], employees must be trained in accordance with [the] requirements of OSHA 29 CFR… 1926.503 in the safe use of the system and its components…" and "4. [t]he complete fall arrest system must be planned (including all components, calculating fall clearance, and swing fall) before using." *Anchorages*, page 3, states that "[a]ll anchorages to which the SRL attaches must meet the requirements of…OSHA 29 CFR…1926."

Contrary to the above requirements, HRP failed to comply with applicable requirements of 10 C.F.R. Part 851 and the FRA WSHP. Specific examples include the following:

1. HRP failed to protect ironworkers from fall hazards while working on formwork above six feet. Specifically, HRP did not develop and implement adequate fall protection measures for ironworkers climbing Doka® formwork. HRP's Site Specific Safety Plan and job hazard risk analysis stated "100% tie-off;" however, HRP did not develop work instructions that included identification of formwork anchorage points. Consequently, an ironworker fell approximately 23 feet from the face of formwork because they did not attach their PFAS or PDS to a manufacturer-approved, OSHA-compliant anchorage point, resulting in serious injuries.

2. HRP failed to ensure that ironworkers were trained by a competent person in the use and operation of PFASs and PDSs. Specifically, HRP relied on previous training by labor unions (i.e., Ironworkers Local 1) but did not verify the adequacy of that training or ensure that a competent person trained ironworkers on the specific PFAS and PDS used on the PIP-II LINAC project. Consequently, ironworkers did not have a clear understanding of the use and operation of the HRP-issued PFAS or PDS while climbing Doka® formwork.

Collectively, these noncompliances constitute a Severity Level I violation.
Base Civil Penalty – $118,000
Proposed Civil Penalty (no mitigation granted) – $118,000

II. Administrative Appeal

Pursuant to 10 C.F.R. §§ 851.43(b) and 851.44(a), HRP may petition DOE's Office of Hearings and Appeals for review of the FNOV within 30 calendar days of receipt of the FNOV. HRP's petition must conform with the procedural requirements set forth in 10 C.F.R. Part 1003, *Office of Hearings and Appeals Procedural Regulations*. If HRP does not petition the Office of Hearings and Appeals for review within 30 calendar days of the receipt of the FNOV, HRP relinquishes any right to appeal any matter in the FNOV, and the FNOV, including the civil penalty assessed, will constitute a final order.

III. Civil Penalty Remittance

If HRP chooses not to contest the FNOV, the total proposed civil penalty of $118,000 must be remitted within 30 calendar days after receipt of this FNOV. Remittance of payment must be submitted via electronic funds transfer (EFT) or automated clearing house (ACH) transfer to DOE through the U.S. Treasury. The Office of Enforcement must be copied at enforcementdocketclerk@hq.doe.gov when the electronic payment is submitted to the U.S. Treasury. Instructions for remitters sending payments in U.S. dollars via EFT or ACH transfer are enclosed. This FNOV will constitute a final order upon remittance of the civil penalty.

Robin M. Keeler
Acting Director
Office of Enforcement
Office of Enterprise Assessments

Washington, DC
This 29th day October 2025