United States of America
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
1120 20th Street, N.W., Ninth Floor
Washington, DC 20036-3457

Secretary of Labor, Complainant, v. American Recycling & Manufacturing Co., Inc., Respondent.	OSHRC Docket Nos. 13-1101 & 13-1102 CONSOLIDATED FOR DISCOVERY AND TRIAL PURPOSES

APPEARANCES:

Susan B. Jacobs, Esquire,
U.S. Department of Labor, Office of the Solicitor,
Region II, New York, New York
For the Secretary

Alan J. Knauf, Esquire,
Knauf Shaw LLP,
Rochester, New York
For Respondent

BEFORE: Dennis L. Phillips
Administrative Law Judge

DECISION AND ORDER

This proceeding is before the Occupational Safety and Health Review Commission (the Commission or OSHRC) pursuant to section 10(c) of the Occupational Safety and Health Act of 1970, 29 U.S.C. § 659(c) (the Act). On December 3, 2012, upon being notified of an amputation accident, the Occupational Safety and Health Administration (OSHA) initiated a safety

inspection of American Recycling & Manufacturing Co., Inc. (ARM or Respondent) at its facility located in Rochester, New York. OSHA opened a second related health inspection on January 30, 2013.

On May 30, 2013, OSHA issued a citation and notification of penalty (first citation) for OSHA inspection number 767103 with inspection dates from December 3, 2012 through January 24, 2013. The first citation was docketed with the Commission as Docket No. 13-1101. OSHA issued a second citation and notification of penalty (second citation) on May 30, 2013, for OSHA inspection number 860783 with an inspection date of January 30, 2013. The second citation was docketed with the Commission as Docket No. 13-1102. The two dockets were consolidated for discovery and trial purposes.

ARM was cited for a total of eighteen items for the two inspections. Sixteen items were characterized as serious violations and two as willful violations. The citations alleged violations of the housekeeping, egress, forklift (forklift, or powered industrial trucks), machine guarding, electrical, control of hazardous energy (lockout/tagout) (LOTO), hazardous materials, bloodborne pathogen standards and one violation of the General Duty Clause (section 5(a)(1) of the Act). Penalties totaling $159,400 were proposed for these violations.

On June 13, 2013, ARM contested the citations pursuant to section 10(c) of the Act to bring this matter before the Commission.

A four-day hearing was held in Buffalo, New York, October 20-23, 2014. Both parties filed post-hearing briefs and reply briefs. The Secretary presented four witnesses: Steven Lebron, wood shop employee; Joel Rivera, wood shop supervisor; Nick Donofrio, OSHA compliance officer (CO); and CO Kimberly Mielonen. A Spanish-language interpreter was

present to translate for the testimony of Mr. Lebron.[1] ARM presented six witnesses: Armando Santiago, ARM president, Chief Executive Officer, and majority owner; Douglas Miller, Respondent's expert; Karl Joslin, plant manager; Duane Cansdale, maintenance employee; Tanka Khadka, wood shop employee; and Joseph Meindl, Vice President, operations manager and minority owner. (Tr. 55-59, 67, 103, 159, 183, 427, 479-81, 529, 697, 748, 878, 894; Ex. 2, p. 2).

For the reasons that follow the Court affirms all citation items except Citation 1, Item 11b of Docket 13-1101 and assesses penalties totaling $154,800.

Stipulated Facts

The parties stipulated the following facts in their joint pre-hearing statement for both Docket No. 13-1101 and Docket No. 13-1102.

> a. Respondent American Recycling & Manufacturing, Inc., is a corporation doing business in the State of New York, maintaining its principal office and place of business at 58 McKee Road, Rochester, New York 14611 and is engaged in the production of wood packaging materials and pallets.
>
> b. Many of the materials and supplies used and/or manufactured by Respondent originated and/or were shipped from outside the State of New York and the Respondent was and is engaged in a business affecting commerce within the meaning of sections 3(3) and 3(5) of the OSH Act and is an employer within the meaning of section 3(5) of the OSHA Act.
>
> c. On or about May 30, 2013, Complainant issued two citations to Respondent alleging violations at a worksite located at 58 McKee Road, Rochester, New York.
>
> d. By letter dated June 13, 2013, Respondent timely notified Complainant of its intent to contest the citations.

(Tr. 48-51; Joint Pre-Hearing Statement (Jt. Pre-Hr'g. Stmt.), pp. 10-11).

The parties also stipulated during trial that the training mentioned in Exhibit S was not done as of February 1, 2013. (Tr. 943; Ex. S).

[1] Mr. Lebron could not read English as of the day his left hand was amputated. (Tr. 88).

Stipulated Applicable Principle of Law

The parties stipulated to the following applicable principle of law in their joint pre-hearing statement for both Docket Nos. 13-1101 and 13-1102:

> Jurisdiction of this action is conferred upon the Occupational Safety and Health Review Commission by section 10(c) of the OSH Act.

(Tr. 51; Jt. Pre-Hr'g. Stmt., p. 11).

Jurisdiction

Based upon the record, the Court finds that ARM, at all relevant times, was engaged in a business affecting commerce and was an employer within the meaning of sections 3(3) and 3(5) of the Act, 29 U.S.C. §§ 652(3) and (5). The Court concludes that the Commission has jurisdiction over the parties and subject matter in this case.

Background & Relevant Facts

ARM produced wood packaging materials, "xerox" blocks,[2] and pallets to the specifications of its customers. Customers used the pallets to stock food. ARM's facility was about 100,000 square feet in size. It consisted of a wood shop, loading dock area, warehouse area, and offices near the front of the building. The wood shop included several pieces of woodworking equipment, including radial arm, Mattison, panel, Baker and pop-up saws, SHODA CNC and core cutter machines, and a pallet stacker. ARM had between 38-58 employees at its facility in Rochester, New York as of December 3, 2012. Many of ARM's employees spoke Spanish as a first language and others, Nepali. (Tr. 71, 83, 109-10, 164-65, 208, 256-59, 319, 416, 484, 737, 895, 910, 922-24, 934; Ex. T, p. 1).[3]

---

[2] Films were stored on xerox blocks that were made of particle wood. (Tr. 109).

[3] There is inconsistent testimony about the number of employees who spoke English. The languages, other than English, that were spoken were Spanish and Nepali. CO Donofrio testified that on December 3, 2012 either Mr. Knauf or Mr. Santiago told him that 90 percent of ARM's employees spoke Spanish. Mr. Santiago stated almost all

ARM Management

Mr. Santiago is the president and majority owner of ARM. His duties were primarily related to human resources and financial issues. He "very rarely" went into the woodworking shop prior to December 3, 2012. Mr. Meindl is the vice-president and a minority owner of ARM. His duties were sales, operations oversight, and he "managed the managers." Mr. Meindl was routinely out of the office for sales duties about 2 weeks a month. When Mr. Meindl was in the office, he was in the woodshop area several times a day.[4] Alan Knauf was the other minority owner of ARM.[5] Messrs. Meindl and Knauf each own 24 percent of ARM. (Tr. 480-81, 519, 524, 894, 909-12).

Mr. Joslin was the plant manager[6] at the time of the OSHA inspections. He began employment with ARM on Labor Day of 2012, so had only been an employee a few months at the time of the inspections. Mr. Joslin ended his employment at ARM in August, 2013. Mr. Joslin was hired because of his experience with woodworking, maintenance, and safety programs. Mr. Meindl testified that Mr. Joslin's responsibilities were to evaluate the facility, improve production, update safety procedures, and improve quality control. (Tr. 495, 699-700, 731, 737, 901-03).

ARM had several plant managers during the two years that preceded Mr. Lebron's accident. Plant Manager Chris Mangold quit in the Spring of 2012. Paul Suhr, his predecessor,

---

the employees were bilingual while Mr. Rivera stated only five spoke English. Mr. Meindl testified that he did not know how many employees spoke English. Mr. Joslin testified that 10-15 employees did not speak English and admitted that sometimes there was a language barrier. Both Messrs. Rivera and Santiago speak Spanish and English. Mr. Rivera was hired to translate Spanish at ARM's facility. There were no plant employees to translate for the employees that were from Nepal. When asked how he communicated with the Nepalese employees, Mr. Rivera stated "we had to put it together as much as we can. It was very challenging." The Court agrees with the Secretary and concludes that the majority of ARM's employees did not speak English. (Tr. 106, 110, 129, 410, 415, 481-83, 737, 895; S. Br. 5).

[4] Respondent makes an issue that Mr. Rivera testified that Mr. Meindl was in the wood shop "40 times" a day. (Tr. 108). The Court finds that, while Mr. Rivera's language was hyperbolic, it was still credible. The Court finds that Mr. Rivera was conveying that he saw Mr. Meindl in the production areas of the facility frequently.

[5] Mr. Knauf is an attorney and represents ARM in the instant case.

[6] Mr. Joslin was also referred to as the operations manager. (Tr. 737).

ended his employment with ARM in 2011. Mr. Rivera was the acting plant manager until Mr. Joslin was hired on Labor Day. (Tr. 493-95, 524-26, 900-01, 915).

Messrs. Mangold and Meindl hired Mr. Rivera in the Fall, 2011. Mr. Rivera testified that he was hired to handle quality control issues and translate English part specifications into Spanish.[7] He had been a car salesman prior to working for ARM; he had no prior woodworking experience. Nonetheless, he was put in charge of the woodshop on his first day of employment because the prior woodshop manager quit. Mr. Rivera initially reported to Mr. Mangold. (Tr. 104-07, 141).

As the woodshop supervisor, Mr. Rivera supervised 20-30 employees.[8] He assigned work orders to the wood shop employees, operated a forklift in the warehouse area, and used the woodworking equipment. Mr. Rivera also supervised the new and recycled pallets department located in the warehouse area, so he was generally either in the wood shop or warehouse areas. Mr. Rivera testified that he expressed concerns about safety to Messrs. Mangold, Joslin, and Meindl. (Tr. 108-12, 157; Ex. G, p. ARM 38).

On September 3, 2012, Mr. Joslin was hired to generally manage the facility and to oversee safety, work orders, and employees. In Mr. Joslin's words, he was hired to "make the place shipshape and make it money." Mr. Joslin had seven years of prior experience with a mattress company, where he received safety training, performed safety audits, and was on the safety committee. In an October 9, 2012 email, Mr. Joslin updated Mr. Meindl on adjustments

[7] Mr. Santiago testified that Mr. Rivera was not hired for quality control and translation. Mr. Rivera testified that his job duties were changed on his first day of employment. Mr. Santiago's assertion about why Mr. Rivera was initially hired is not credible; Mr. Santiago was rarely in the wood shop and did not hire Mr. Rivera. The Court finds it likely that Mr. Santiago was not aware of the specifics of Mr. Rivera's employment interview. (Tr. 104, 107, 520).

[8] After Mr. Joslin was hired, Mr. Rivera served as a supervisor at ARM. (Tr. 495).

he made to the duties of the supervisors, Messrs. Rivera, Robert Hess, and Robert Hart.[9] Mr. Joslin was in the wood shop every day, for most of the day. Soon after he was hired, he requested authorization to hire a new maintenance supervisor. Mr. Joslin hired Duane Cansdale, as the maintenance supervisor, sometime after October 16, 2012 because he believed the previous maintenance employee, Anieal Rodriguez,[10] did not have the necessary skills to adequately fix and maintain the equipment. Anieal Rodriguez was reassigned to assist Mr. Cansdale with maintenance and to work in the shipping department. (Tr. 106-08, 698-700, 711, 714, 738, 748, 903; Ex. G, pp. ARM 38, 40).

At the time of the hearing, Messrs. Cansdale, Lebron, Rivera, and Joslin no longer worked for ARM. Mr. Rivera was laid off in March, 2013. Mr. Lebron never returned to work after his December 3, 2102 accident and was unemployed at the time of the hearing. Mr. Joslin left ARM in August, 2013. Mr. Cansdale's employment with ARM lasted about eight months and he was working for another employer at the time of the hearing. (Tr. 67, 82, 140-42, 731, 748).

The Accident[11]

On the morning of the accident, at about 7:00 a.m., Mr. Rivera assigned orders to the employees. He assigned an order to build pallets for a customer, "Flower City," to Messrs.

---

[9] Mr. Hart is the supervisor in charge of cores, shipping and receiving. Mr. Hess is the supervisor responsible for assembly, end boards, the panel saw, and Shoda CNC machine. (Tr. 128, 218; Ex. G, p. ARM 38).

[10] ARM's Training Attendance Log shows Anieal Ruiz Rodriguez signing in for Forklift Operator Safety Training conducted on December 6, 2012. ARM's Safety Committee Meeting Agenda for December 11, 2012 shows "Anibal Ruiz Rodriguez (Manny)" in attendance. CO Donofrio identified his name as Anieal Ruiz Manny Rodriguez. In this decision, the Court will refer to this employee as Anieal Rodriguez. (Tr. 729-30; Exs. I, p. ARM 215, 220, P, p. ARM 935).

[11] Unless otherwise specified, descriptions of ARM's facility are as they existed prior to the accident of December 3, 2012.

Lebron and Carlos Martinez.[12] Mr. Rivera testified that Mr. Lebron generally assembled the pallets and "xerox blocks," because he was a "smaller guy."[13] He said that all employees in the wood shop floated between jobs and orders. They did not have individually assigned job titles. None of the employees occupied positions titled as saw operators or wood cutters. After making the assignment, Mr. Rivera left the wood shop floor and went to Mr. Joslin's office to translate a call.[14] (Tr. 83-85, 109-10, 129-31, 149-51, 155-56; Ex. T, p. 21).

Mr. Lebron was twenty years old and had worked for ARM about 18 months. Mr. Rivera hired him and was his supervisor. Mr. Lebron testified that he did "[b]asically everything" when he worked at ARM. He worked with machines, including a wood cutter and saws, including the No. 5 pop-up saw (pop-up saw).[15] Mr. Lebron stated that he had not received any training when he began work at ARM. He also had not received any safety training while working at ARM. (Tr. 68-79, 88; Exs. 25, 55, T, p. 1).

When building the wood pallets on December 3, 2012, Mr. Lebron got the wood, and placed the wood on the pop-up saw table where it was measured. Messrs. Lebron and Martinez used the pop-up saw to cut wood needed to build the pallets. The pop-up saw's blade was housed in its cabinet when it was not cutting wood stock. A foot pedal was pressed to activate the blade; once activated, the blade rose vertically through a slot in the top surface of the

---

[12] Mr. Rivera testified that orders from Flower City usually called for building 15 pallets. The pallets were square in shape and contained seven wooden slats. (Tr. 84-85, 131).

[13] Mr. Lebron was five feet, three inches tall. (Tr. 86).

[14] Mr. Rivera testified that cutting the legs made of wood for a new pallet was generally considered a two-person job. Pallet legs were cut from big pieces of wood that were slid onto the saw where they were cut into four-foot or five-foot pieces. (Tr. 149-50).

[15] Prior to working at ARM, he had no experience working with machines and saws. Mr. Rivera showed him how to operate the saws at ARM. He showed Mr. Lebron how to operate the pop-up saw in April, 2012. He observed Mr. Lebron working at the pop-up saw a couple of times before December 3, 2012. Mr. Rivera also said that he sometimes assigned Mr. Lebron to assist employees who operated the pop-up saw. Mr. Rivera said that it was not unusual for Mr. Lebron to be loading the wood into the pop-up saw. "Once in a while he would do it but not very often." (Tr. 69-71, 101, 154-57).

cabinet.[16] Before the blade rose up through a slot in the cabinet, an overhead hood (also sometimes referred to as a "hold down" or "arm") simultaneously came down to cover the top portion of the spinning blade. Additionally, once lowered, the hood was supposed to hold the piece of wood in place for the cut.[17] (Tr. 82-85, 89, 156, 180-81, 187-91, 297, 359-60, 767; Exs. 26-29, 30, at "A" and "D", 53, 55, at "I").

Mr. Lebron testified that he had worked with Mr. Martinez at the pop-up saw five or six times before December 3, 2012. While standing at the discharge side of the pop-up saw early in the morning at about 8:45 a.m.,[18] Mr. Lebron loaded the wood onto the pop-up saw.[19] Mr. Martinez' job was to "press the pedal to activate the saw and then take the cut piece away." As Mr. Lebron positioned a piece of four inch wide wood to be cut on the saw table, his hand was over the slot area where the blade rose and made the cut, its point of operation. He testified that he could not put the wood into position to be cut without putting his hand above the saw blade. There was no guard or other device that prevented Mr. Lebron from placing his hand at the point where the blade made a cut in the wood stock.[20] Mr. Lebron testified that the distance between the cabinet's top surface and the bottom of the hood that was above was not "more than a foot." Mr. Lebron testified that he was not warned to not place his hand at the blade's point of

---

[16] CO Donofrio testified that the first push of the foot pedal lowered the hood and the second push activated the saw. (Tr. 393). Mr. Rivera testified that workers positioned the pedal "where their [] feet will land when they're cutting, because the pieces of wood they're cutting, they're really heavy. They're probably 80 pounds." (Tr. 150).

[17] CO Donofrio testified that the pop-up saw's hood did not fully lower onto the wood being cut when he first observed the pop-up saw on December 3, 2012. He said that there was a gap of approximately two and a half inches, so that the hood did not make a seal over the wood. (Tr. 189-90; Ex. 28).

[18] The discharge side of the pop-up saw is the side of the saw cabinet that does not have a table. Mr. Miller positioned Mr. Lebron as standing at Exhibit 30, p. 30, at "B" at the time of the accident. (Tr. 844-46; Exs. 55, U, p. 30).

[19] A button was pressed to get the pop-up saw to operate. Mr. Rivera testified that the wood shop employees were told that the pop-up saw was supposed to have its power off when wood was loading onto the saw for cutting. He further said that "even if the power is off, the blade will come up even if it's not running, because it's air, it's controlled by air, and the air gets released by the pedal. So even if it's off, that blade is going to come up." He also said that the arm will come down too. The saw blade continued to run until the foot pedal was stepped on a second time to stop it. (Tr. 89, 96-97, 152-53, 156; Ex. 55).

[20] A guard is a barrier that prevents exposure to an identified hazard. (Ex. Y, p. 12).

operation. He also testified that he had not seen warning signs on the saw and that he could not read English.[21] (Tr. 86-91, 96-97, 99, 101, 152, 343, 407-08, 844, 912; Exs. 26, 55, T, p. 1).

At the moment Mr. Lebron was positioning the wood onto the pop-up saw, Mr. Martinez, without looking, stepped on the uncovered pop-up saw's foot pedal.[22] The saw blade, activated by the foot pedal, came up through the slot and instantly amputated Lebron's left hand.[23] While in Mr. Joslin's office, Mr. Rivera heard screaming and an employee ran in to tell them that Mr. Lebron was hurt.[24] Mr. Joslin recalled that Mr. Hess ran to tell him there was an accident and blood was "all over the place." Mr. Joslin called 911 and told Mr. Hess to make sure Mr. Lebron was being taken care of. Several employees and supervisors took Mr. Lebron to the break room. A few minutes later the ambulance arrived and took Mr. Lebron to the hospital. Mr. Lebron was hospitalized for 3 weeks as a result of the accident. (Tr. 85-89, 101, 129-30, 147, 718-19; Exs. 26, 55).

Mr. Joslin testified that he roped off the area and sent the other employees home for the day. Messrs. Joslin, Fernando Rodriguez and Anieal Rodriguez cleaned up the blood. They put on gloves, face masks and used a bleach solution for the cleanup. They bagged the cleaning materials, placed them in metal containers, and had someone take them away.[25] None of the

---

[21] All of the signs at the pop-up saw were in English. (Tr. 155).

[22] Mr. Lebron testified that he believed that Mr. Martinez tripped on the pedal and did not intentionally activate it. (Tr. 95-96).

[23] Mr. Meindl testified that the foot pedal "was a dual-action pedal, like a [] see-saw, that when you hit one side, it would activate the saw. When you hit the other side it would deactivate it." There was no other equipment at ARM that was operated by a foot pedal. (Tr. 914).

[24] Mr. Rivera testified:

Q And what happened that day [December 3, 2012]?

A Well, I was sitting with Karl [Joslin], and we hear screaming. So I got up, and I come out of the office, and I see one of the workers coming towards me saying that Steven got cut, but the worker that came around the corner had a - - like a shirt with something inside. So I'm – I thought I got the wrong name of the worker at first, and when he opened the shirt, it was a hand in there…." (Tr. 129).

[25] Mr. Joslin stated he had training from a prior employer about cleaning up blood. He thought Mr. Anieal Rodriguez also had training in blood cleanup from a prior employer. (Tr. 719).

employees were offered any medical care, such as a hepatitis shot, after the cleanup. (Tr. 138, 442, 450, 718-19, 741-42).

The First Inspection

CO Donofrio started his investigation of ARM on December 3, 2012 in response to a reported amputation accident at ARM's facility.[26] He arrived about an hour after the accident. He described the building as "an old Kodak building" that "was a hundred thousand square feet." CO Donofrio returned to the facility three more times to interview employees and continue his investigation of safety issues, including those identified by employees. CO Donofrio was at ARM's facility on four dates – December 3, 2012, December 4, 2012, December 19, 2012, and January 24, 2013. (Tr. 161-67, 233, 247, 290, 316, 912).

CO Donofrio began his inspection by holding an opening conference with Messrs. Knauf and Santiago. CO Donofrio explained the procedure for an OSHA inspection. He collected basic information about the company, including its safety program. Mr. Santiago showed CO Donofrio ARM's safety manual. CO Donofrio discussed the company's safety program with Messrs. Knauf and Santiago. CO Donofrio explained that he would be taking photographs and measurements. He explained that he was there to investigate the accident; however, if he saw any other apparent hazards, he was required to investigate those as well. Finally, he explained that he would hold a closing conference with them to summarize the results of his inspection and advise them of the employer's post-inspection rights. Neither Mr. Santiago nor Mr. Knauf objected to the CO's inspection of the facility. (Tr. 161-65, 501-04; Ex. A).

[26] Mr. Donofrio is a safety specialist who has worked for OSHA for nine years. He has conducted about 500 inspections for OSHA. (Tr. 160-61). Amputations are among the most severe and disabling workplace injuries that often result in permanent disability. The U.S. Bureau of Labor Statistics 2005 annual survey data indicated that there were 8,450 non-fatal amputation cases in private industry. (Ex. Y, p. 7).

Mr. Meindl testified that he also spoke with CO Donofrio that day.[27] Mr. Meindl escorted CO Donofrio out to the production area. Mr. Meindl testified that the accident scene was not changed prior to the CO's arrival. He was unsure if the blood had been cleaned up; he knew the pop-up saw had not been moved.[28] (Tr. 912-14).

On December 3, CO Donofrio took several photographs of the dust accumulations, the pop-up saw and other equipment in the woodworking shop. He noted that that pop-up saw was not bolted to the floor and that the foot pedal was not guarded. The foot pedal was six feet away from the cabinet of the saw. He also noted that the overhead hood of the pop-up saw was not properly adjusted to come down to the top of wood stock. Before he left that day, CO Donofrio recommended that ARM: 1) install a cover over the foot pedal to prevent accidental activation, and 2) bolt down the pop-up saw to the floor. (Tr. 91, 163, 177-79, 190-91, 216-17, 228-32, 289-90, 295-98, 380, 390-91, 504; Exs. 3-5, 7, 8, 11, 26-28, 51-52, 55).

CO Donofrio returned to ARM's facility the following day, December 4, 2012. He took photographs throughout the facility of saws and equipment, a non-functional exit door, and electrical issues. He noted that the pop-up saw had been bolted to the floor.[29] On December 19, 2012, the CO took more photographs and a video of the pop-up saw operating.[30] On January 24,

---

[27] Mr. Meindl was at ARM's facility on December 3 and estimates he found out about the accident roughly 15 minutes after it happened. (Tr. 911).

[28] Photographs show the floor appeared to have been cleaned; however, it appears there were still blood stains on the popup saw. (Exs. 11, 51).

[29] ARM's "Safety Issues - December 5, 2012" worksheet notes the Pop Up Saw had been bolted to the floor. The Court finds this is not a conflict to the CO's testimony; the worksheet shows that several items were completed by 12/5/2012. ARM's Safety Meeting minutes also state that by December 11, 2012, the pop-up saw had been "bolted to the floor to eliminate movement." Mr. Joslin testified that everything that OSHA recommended be done to the pop-up saw was done by December 11, 2012. He said OSHA's recommendations "were probably done by the end of the day [December 3, 2012]" or "[p]retty close to it." The Court finds that CO Donofrio observed the saw bolted down on December 4 and ARM updated its worksheet on December 5 to reflect the abatement. (Tr. 726; Exs. I, pp. ARM, 216, ARM 221, J, p. ARM 303).

[30] The CO was unsure of the date of the video. The CO knew it was not December 3 which is confirmed by the lack of visible dust on the floor. The video shows the hood had been adjusted to have no gap, so it is unlikely this adjustment had been made by December 4. The CO took dust samples during his January visit. The Court infers the video was taken on December 19, 2012. (Ex. 53).

2013, CO Donofrio returned to ARM's facility to collect samples of the wood dust. (Tr. 178, 187-190, 203, 211, 233, 247, 289-90, 308-09, 312, 316-17, 321, 381; Exs. 6, 9, 25, 35-41, 42, 51, 53, 55).

CO Donofrio conducted interviews with employees and management during his December visits to the facility. (Tr. 186, 217, 223-24, 258, 260, 278, 292, 318; Ex. T). He used an interpreter for several of the employee interviews.[31] (Tr. 415).

OSHA issued two citations for CO Donofrio's inspection on May 30, 2013. The citations consisted of sixteen items, fourteen were characterized as serious and two as willful. OSHA Inspection Number 767103, conducted by CO Donofrio, was docketed as Docket No. 13-1101. (Tr. 167-68; Ex. 1).

The Second Inspection

On January 30, 2013, CO Mielonen opened a health inspection.[32] CO Donofrio made a referral for a health inspection when he learned that ARM employees had cleaned up blood after the December 3 accident. CO Mielonen held an opening conference with Mr. Joslin, who consented to the inspection. At the time, Mr. Joslin told CO Mielonen that ARM did not have a written exposure control plan for bloodborne pathogens. However, he told her he had been trained on blood cleanup at his previous employer. (Tr. 428-30, 441, 449).

Mr. Joslin was escorting CO Mielonen to the area of Mr. Lebron's injury when she saw an employee, Mr. Cansdale, working near the ceiling in a plastic bin lifted by a forklift. CO Mielonen testified that she saw no adequate fall protection in use. She photographed Mr. Cansdale working near the ceiling. In an interview, Mr. Cansdale told her he was hardwiring

[31] An interpreter was not required for Messrs. Rivera, Hart, and Hess. (Tr. 415).

[32] CO Mielonen was an industrial hygienist who worked for OSHA for 24 and one-half years. She has a Bachelor of Arts degree in biology and has conducted over 600 OSHA safety and health inspections. (Tr. 427-28).

equipment to replace the temporary wiring for equipment in the woodworking shop. (Tr. 430-36; Exs. 57, 59).

From her investigation, CO Mielonen determined that three ARM employees had been exposed to blood during the cleanup on December 3, 2012. OSHA issued a second citation for CO Mielonen's inspection on May 30, 2013. The citation consisted of two items characterized as serious. The citation alleged a violation of OSHA's bloodborne pathogen standard and a violation of the General Duty Clause. Her inspection, OSHA Inspection number 860783, was docketed as Docket No. 13-1102. (Tr. 441-43, 450).

ARM's Expert

ARM retained Mr. Miller to evaluate its facility and assist in correcting potential safety hazards. Mr. Miller is the president of Occupational Safety Consultants (OSC) in Rochester, New York, which was formed in 2001.[33] OSC provides services to a variety of businesses; including municipalities, utilities, construction and manufacturing. Mr. Miller provides risk management and injury prevention consultation, which includes training, writing procedures, and facility inspections. He teaches courses on OSHA standards at the Rochester Institute of Technology. (Tr. 529-35, 538; Ex. W; R. Br. 21).

Mr. Miller visited ARM's facility twice. The first visit was on December 7, 2012, for about three hours. He saw, photographed, and measured the pop-up saw and its foot pedal. He also looked at radial arm, Baker, and dismantler saws. During his first visit, he primarily addressed the woodworking area. The second visit was in June, 2013, for three to four hours, after ARM had received its OSHA citations. He again looked at saws, floor holes, and the door

[33] He attended, but did not graduate from, St. Bonaventure University for four years. Mr. Miller has not published any writings (excluding blogs) and does not hold any certifications. (Tr. 537-38, 576, 642; Ex. V, p. 4).

that had been marked as an exit.[34] During both visits, Mr. Miller took photographs and made general observations of the facility. He spoke with Mr. Santiago on December 7, 2012, and Messrs. Santiago and Meindl in June, 2013. He reviewed the citations, cited standards, letters of interpretation, compliance directives, and publications. Mr. Miller prepared a report for ARM dated August 11, 2012.[35] His report was based in part on his own observations in the facility, and in part on information conveyed by Messrs. Santiago and Meindl. Mr. Miller testified that he had not spent an exorbitant amount of time on his consultation for ARM. On the fourth and final day of the trial, he estimated that he had worked on the case only about 20 hours through, and including, October 21, 2014.[36] (Tr. 586, 592-603, 618-19, 645, 801-02, 814; Exs. U, W).

The Court found Mr. Miller to be qualified as an expert in: 1) occupational safety, as to safe practices; 2) typical woodworking industry practices associated with: a) machine guarding, b) relocating machinery, c) exposure control plans, d) bloodborne pathogens, e) housekeeping, f) dust, g) clear passage and exits, and h) floor hazards; and 3) the following topics: a) dust, b) exits, c) hazardous energy control procedures, d) machine guarding, e) electrical standards relating to power taps, f) hazard communication (Hazcom) procedures, and g) exposure control plans relating to bloodborne pathogens. The weight the Court gives to Mr. Miller's expert opinions is lessened by the sources and timeliness of the information he considered. The Court gives greater weight to his opinions based on his personal observations at ARM. Further, the Court notes that the weight it gives to Mr. Miller opinions is reduced by the limited nature of the information that was provided to him by ARM, and the little amount of time that he actually spent on his consultation. (Tr. 635-36).

---

[34] Mr. Miller testified that the pop-up saw had been removed from the facility by his second visit. (Tr. 602).
[35] Mr. Miller's expert report and testimony did not include any commentary on Docket No. 13-1101, Citation 1, Items Nos. 6, 7, 9, 11b, 12, and 14b; as well as Docket No. 13-1102, Citation 1, Item No. 1. (Tr. 582-83, 643-44; Ex. W).
[36] The Secretary did not depose Mr. Miller prior to the trial. (Tr. 587).

ARM's Safety Program

ARM had a safety manual and employee handbook which it asserts contained employee work rules. ARM's safety manual, dated November 2010, was created by its human resources provider, Paychex. It was generic and not site specific. It called for ARM to write its own site-specific procedures to manage or comply with lockout/tagout and hazard communication. No specific machines or chemicals at ARM were listed in it. (Tr. 165-66, 409, 485, 896; Ex. A).

ARM also included a few safety rules in its employee handbook, which was printed in English and Spanish, and dated 2011. Mr. Santiago claimed that all the employees received the employee handbook and the Spanish version was provided on request. The 130-page employee handbook covered employment related topics; eleven pages were related to safety.[37] (Tr. 491-93; Exs. B, C).

Affirmative Defenses

Respondent asserted five affirmative defenses in the parties' Joint Pre-Hearing Statement. For an affirmative defense, Respondent carries the burden of proof. *Hamilton Fixture*, 16 BNA OSHC 1073, 1077 (No. 88-1720, 1993) *aff'd* 28 F.3d 1213 (6th Cir. 1994)(unpublished table decision).

[37] For example, under the employee responsibility section in the handbook, it states that an employee can "[u]se, adjust and repair machines and equipment only if you are trained and qualified." The hazard communication guidelines (a total of 2 paragraphs in length) stated:

> Our company may use some chemicals (e.g., cleaning compounds, inks, etc.) in some of its operations. You should receive training and be familiar with the handling, use, storage and control measures related to these substances if you will use or likely be exposed to them. Material Safety Data Sheets (MSDS) are available for inspections in your work area. You must follow all labeling requirements. . . . For additional information, please refer to our company's written Hazard Communication Program. (Ex. B, pp. ARM 1068, 1072).

1) ARM asserts the defense of unpreventable employee misconduct for Docket No. 13-1101, Citation 1, Items 1a, 1b, 10 and Citation 2, Items 1, 2 and for Docket No. 13-1102, Citation 1, Item 1. The merits of this defense are discussed below at Items 1 and 2 of Citation 2 for Docket No. 13-1101. For the reasons set forth below this defense fails for all items.

2) ARM asserts the defense of design defect/deficiencies or failures to warn by manufacturers and distributors of equipment for Docket No. 13-1101, Citation 1, Items 9, 10 and Citation 2, Items 1 and 2 and for Docket No. 13-1102, Citation 1, Item 1. Respondent did not pursue this defense in its post-hearing brief. The Court deems this affirmative defense to be abandoned. *See Ga.-Pac. Corp.*, 15 BNA OSHC 1127, 1130 (No. 89-2713, 1991).

3) ARM asserts the defense of vague, inapplicable and/or unenforceable standards for Docket No. 13-1101, Citation 1, Items 1a, 1b, 7, 10 and Citation 2, Item 1, and for Docket No. 13-1102, Citation 1, Item 1. Respondent did not pursue this defense in its post-hearing brief. The Court deems this affirmative defense to be abandoned. *Id.*

4) The defense, for all citation items, that Respondent acted in good faith to comply and abated the hazards after they were identified. Respondent did not provide case law with respect to this defense, except for the citations characterized as willful, discussed below. Because Respondent did not pursue this defense for the other citation items in its post-hearing brief, the Court deems this defense to be abandoned for those citation items. *Id.*

5) The defense that OSHA exceeded the proper scope of its inspection under applicable regulations, the Fourth Amendment, and informed consent with respect to Docket no. 13-1101, Citation 1, Items 2, 11a, 11b, and 13. Mr. Miller testified that the exit door in warehouse D was not in plain view from the area of the pop-up saw. Although his expert written report stated that the violations set forth in Citation 1, Items 11a, 11b, and 13, concerned areas outside the room

where the pop-up saw was, he testified at trial, during direct examination, that he could not recall if these violations occurred in the same room or not. (Tr. 793-94; Answer, pp. 5-6; Ex. W, p. 7; R. Br. 27-28).

The Court finds that OSHA did not exceed the scope of its inspection at ARM's facility. Both COs Donofrio and Mielonen received consent before inspecting the facility. Commission law states that "[i]f the employer consents to an OSHA inspection . . . the employer may not later challenge the inspection on Fourth Amendment grounds, if it is within the scope of that consent." *Cody-Zeigler, Inc.*, 19 BNA OSHC 1410, 1411-12 (No. 99-0912, 2001) (citations omitted). Section 8(a) of the Act, authorizes the inspection of any "area, workplace or environment where work is performed" at "reasonable times, and within reasonable limits and in a reasonable manner." 29 U.S.C. § 657(a). ARM did not show that: 1) CO Donofrio was unreasonable in which areas of the facility he inspected, 2) management objected to the consent, or 3) its consent was limited. ARM's argument fails. (Tr. 163-64, 428-29).

Secretary's Burden of Proof

To establish a violation of an OSHA standard, the Secretary must show by a preponderance of the evidence that: 1) the cited standard applies; 2) the terms of the standard were violated; 3) the employer knew, or with the exercise of reasonable diligence could have known, of the violative condition; and 4) one or more employees had access to the cited condition. *Astra Pharm. Prods.*, 9 BNA OSHC 2126, 2129 (No. 78-6247, 1981), *aff'd in relevant part*, 681 F.2d 69 (1st Cir. 1982).

CITED STANDARDS AND DISCUSSION

Docket No. 13-1101

Citation 1, Item 1a

The Secretary cited ARM for a serious violation of 29 C.F.R. § 1910.22(a)(1) which requires:

> a) *Housekeeping*. (1) All places of employment, passageways, storerooms, and service rooms shall be kept clean and orderly and in a sanitary condition.

Citation 1, Item 1b

The Secretary cited ARM for a serious violation of 29 C.F.R. § 1910.22(a)(2) which requires:

> (2) The floor of every workroom shall be maintained in a clean and, so far as possible, a dry condition.

For Citation 1, Items 1a and 1b, the Secretary alleges that accumulation of combustible wood dust in ARM's facility created a fire and explosion hazard. ARM asserts there was no violation because the amount of dust accumulated in the wood shop was not sufficient to present a combustion hazard. Further, ARM asserts the cited standard does not require a workplace to be dust-free and the standard does not specify what amount of dust presents a hazard. (Tr. 650; Ex. 1, pp. 5-6; S. Br. 40, R. Br. 22-23).

Applicability

The Secretary alleges accumulations of combustible wood dust created a fire and explosion hazard in ARM's wood shop. The Commission has held that "the standard is directed not merely to sanitation but to all hazards arising from poor housekeeping,…." *Pratt & Whitney Aircraft*, 9 BNA OSHC 1653, 1659 (No. 13401, 1981). Further, the Commission has recognized 29 C.F.R. § 1910.22(a)(1) is applicable to the hazard of fire and explosion resulting from combustible dust accumulations. *Farmers Coop. Grain & Supply Co.*, 10 BNA OSHC 2086, 2087 (No. 79-1177, 1982); *see also, Con Agra, Inc. v. Sec'y.,* 672 F.2d 699, 702 (8th Cir. 1982) (finding housekeeping standard is applicable where combustible dust of one-half to three inches presented a fire or explosion hazard), *Bunge Corp. v. Sec'y,* 638 F.2d 831, 834 (5th Cir. 1981) (noting housekeeping standard was not "impermissibly expanded to include fire and explosion

hazards" from combustible dust accumulations). ARM does not dispute that it generates combustible wood dust in its production area. The Court finds the standard applies. (S. Br. 40, R. Br. 22).

Violation of the Standard[38]

Respondent does not dispute that dust was present or that wood dust could be combustible. However, ARM asserts that all of the five elements needed to present an explosion hazard were not present. There are five elements necessary to initiate a dust explosion: 1) combustible dust (fuel); 2) ignition source (heat); 3) oxygen in the air (oxidizer); 4) dispersion of dust particles in the air (suspension); and 5) confinement of the dust cloud.[39] The parties do not dispute that the third element, oxygen, was in the air of the wood shop area. Only the first three elements are needed for a fire to occur. These first three elements are commonly referred to as the "fire triangle." (Tr. 341, 650-51; Ex. X, pp. 5, 7; R. Br. 22-23).

The Fuel Element – combustible dust[40]

The Secretary has established that the wood dust at ARM was combustible. During his January 24, 2013 visit to ARM's facility, CO Donofrio collected two bulk samples of wood dust from the panel saw frame and floor. OSHA's Analytical Laboratory in Salt Lake City, Utah,

---

[38] ARM asserts that Arthur Dube, the Area Director of OSHA's Buffalo office, sent an undated letter to ARM that indicated, in part, that "since no OSHA standard applies and it's not considered appropriate at this time to [] invoke § 5(a)(1), the general duty clause of the … Act, no citation will be issued for these [dust] hazards." The letter was not entered into evidence and only limited testimony was presented as to its existence. ARM does not cite to any specific factors in support of its argument that "the Secretary has trumped up his charges." The Court does not view ARM's reference to a part of Mr. Dube's undated letter as estopping OSHA from issuing Citation 1, Item 1, to ARM on May 30, 2013. *See U.S. v. Ulysses-Salazar*, 28 F.3d 932, 937 (9th Cir. 1994) (noting estoppel requires a showing that the government's wrongful act will cause serious injustice, and the public's interest will not suffer undue damage if estoppel is imposed); *Fluor Daniel*, 19 BNA OSHC 1529, 1533 (No. 96-1729, 2001) (consolidated) (same), *aff'd* 295 F.3d 1232 (11th Cir. 2002). (Tr. 345-46; R. Br. 22-23, R. Reply Br. 12).

[39] These five elements are often together referred to as the "Dust Explosion Pentagon." (Ex. X, p. 5).

[40] OSHA's Hazard Communication Guidance for Combustible Dusts, OSHA 3371-08 2009, states that "[c]ombustible dusts are fine particles that present an explosion hazard when suspended in air under certain conditions." It further defines combustible dust "as a solid material composed of distinct particles or pieces, regardless of size, shape, or chemical composition, which presents a fire or deflagration hazard when suspended in air or some other oxidizing medium over a range of concentrations." Types of dusts from which combustible dust explosions could occur include wood dust. (Ex. X, pp. 3, 5).

determined the wood dust tested positive for explosibility. The OSHA Air Sampling Report stated with regard to both samples: "Results for Kst Test for explosibility: Sample was tested to determine if the material is explosive. The testing was done using a BoM 20 liter low turbulence chamber. Testing produced a positive result, this material is explosive."[41] The MSDS for the wood products used by ARM also indicate that wood dust presents an explosion risk when in contact with heat or ignition sources, and accumulation should be minimized. ARM did not dispute that the wood dust in ARM's facility had a combustible nature. The Secretary has proved the wood dust at ARM's facility was combustible in nature. (Tr. 232-39, 653; Exs. 6, p. 1, 8, 45, p. 3,[42] 46, p. 3,[43] 48, p. 2,[44] 49, p. 2, 50, p. 3[45], W, p. 2).

To demonstrate dust accumulation, CO Donofrio observed and documented four instances of excess wood dust accumulation by measuring the dust (except for the dust on the ceiling bar joists) and photographing the dust accumulations on December 3, 2012. The Secretary supports Citation 1, Item 1a, with three instances of excess wood dust accumulation that were observed by CO Donofrio on December 3, 2012: a) one inch of accumulation on the

---

[41] CO Donofrio testified:
Q And looking at page 1 of Exhibit 6, what were the results of the lab's analysis of the two bulk samples of wood dust that you submitted?
A The testing produced a positive result for explosibility.
Q Both samples?
A Yes.
Q What hazard existed from the accumulations of wood dust in the American Recycling facility?
A It would be a fuel, if there was a fire and it could create or lead to a dust explosion.
(Tr. 233-34).

[42] The MSDS for Trupan MDF states: "Cutting, sanding, and machining these products may produce dust, which may be an explosion risk when in contact with heat sources." (Ex. 45, p. 3).

[43] The MSDS for Flakeboard particleboard states: "Sawing, sanding, or machining particleboard could result in the by-product wood dust. Wood dust may present a strong to severe explosion hazard if a dust cloud contacts an ignition source." (Ex. 46, p. 3).

[44] The MSDS for Temple-Inland particleboard and Medium Density Fiberboard (MDF) states: "Sawing, drilling, sanding, or machining this product could result in the creation of wood dust and or lingo-cellulosic fibers/dust. Avoid generating dust, fine dust dispersed in air in sufficient concentrations, and in the presence of an ignition source is a potential explosion hazard." (Exs. 48, p. 2, 49, p. 2).

[45] The MSDS for Uniboard particle and medium and high density fiber boards, raw and laminated states: "Sawing, sanding and/or machining particleboard and fiberboards can produce wood dust. Wood dust may present a strong explosion hazard if high dust concentrations come into contact with an ignition source." (Ex. 50, p. 3).

horizontal ceiling bar joists twelve to fifteen feet above the panel saw's dust collector; b) wood dust accumulations of ½ inch to 3 inches on the corner frame of the dust collector in the panel saw area; and c) wood dust accumulations of ¼ inch to 1 inch on the frame of the panel saw. On December 3, 2012, CO Donofrio also observed an accumulation of ½ inch to 1 inch of wood dust on the walkway behind the panel saw, the condition cited at Citation 1, Item 1b. (Tr. 178, 227-33, 343; Exs. 1, 3-5, 7-8, 51; S. Br. 40).

ARM asserts the standard does not indicate how clean a work area must be or how much dust accumulation presents a hazard; therefore, the Secretary is unreasonably interpreting the standard to require a particular level of cleanliness. To the contrary, the National Fire Protection Association's (NFPA) *Standard for Prevention of Fires and Explosions in Wood Processing and Woodworking Facilities*, (NFPA 664), 2012 edition, states that "it shall be considered to have an explosion hazard where dust accumulations exceed 3.2 mm (1/8 inch) . . . ."[46] The dust accumulations at ARM's facility exceeded the amount considered a hazard. The Court finds the Secretary has proved the first element of an explosion hazard existed at ARM's facility. (Ex. CC, p. 664-12, at ¶ 6.4.2.2; R. Br. 23).

The Ignition Source (Heat) Element

CO Donofrio testified the saws in the woodshop were potential ignition sources for the wood dust in the ARM facility. Mr. Miller also testified that saw blades could create sparks. Further, through employee interviews, CO Donofrio found there had been at least one prior incident where wood dust had caught fire at ARM.[47] Mr. Rivera testified that "sometimes the

[46] Mr. Miller testified that dust accumulations greater than 1/32 of an inch do "[n]ot necessarily" create an explosion hazard. He opined that there was no evidence of a dust explosion hazard at ARM "at the time [he] was there." He was not present at ARM during CO Donofrio's December 3, 2012 inspection. Mr. Miller admitted that he "didn't see the same conditions, I don't believe, when I was there." (Tr. 660).

[47] Messrs. Rivera and Hart told CO Donofrio that there had been a fire at one of the woodworking locations a few weeks before the initial OSHA inspection. Mr. Miller testified that he was unaware of this fire. (Tr. 241-42, 807).

[wood] dust, the particles would light up on fire alone, start smoking." The Secretary has proved the second element, an ignition source, was present in the facility.[48] (Tr. 120, 241-42, 342, 807; Ex. T, pp. 10, 12, 25).

The Elements of Dispersion in Air and Confinement of the Dust Cloud

For the fourth element, suspension (dispersion of dust in the air), the accumulations of dust on the ceiling bar joists establish that the dust had been suspended in the air at some point. Mr. Miller testified that he did not see any measurements by OSHA of dust in the air. Mr. Miller stated that on his December 7, 2012 visit, he saw only normal amounts of dust from woodworking production that had been swept into piles and barrels of sawdust, but saw no freely suspended dust in the air. However, Mr. Miller agreed that the CO's photographs from December 3 showed wood dust on the ceiling joists. Mr. Santiago acknowledged that bags in the dust collection system had been leaking.[49] The bar joists were directly above the dust-collection system. ARM's assertion that dust had never been dispersed in the air is rejected. Dust accumulations on the ceiling joists and Mr. Santiago's admission that bags leaked show that dust had been dispersed in the air. (Tr. 510, 526, 650-52, 657-58, 660, 807; Exs. 3-4, 5, 7-8).

For the fifth element, confinement, ARM relies on Mr. Miller's opinion that there was no means to confine the amount of dust present on December 3, 2012 to the extent necessary to result in a combustible dust exposure. Mr. Miller provided inadequate support for his opinion. He admitted that he did not see the same conditions when he visited ARM's facility as CO Donofrio observed on December 3, 2012. He did not measure the area where the dust seen by

[48] The Court finds that the first three elements needed for a fire existed at ARM on December 3, 2012.
[49] Mr. Miller testified that he did not "fully recall" what Mr. Santiago told him about leaks in some of the filters. He did recall recommending to Mr. Santiago that relocation of the dust-collection system outside the facility would be the best option. Mr. Miller made the suggestion "[t]o avoid large accumulations of dust in the future." (Tr. 660, 808).

CO Donofrio was present.[50] He offered no calculations or compilations to support his opinion. He conducted no tests. He said during direct examination that "I don't know if I fully recall" when testifying about the dust-collection system and what Mr. Santiago may have told him about leaks in it. Mr. Miller did not address a fire that had occurred at one of the woodworking locations just a few weeks before the initial OSHA inspection. He did not refute the results of OSHA's Analytical Laboratory that found both material samples to be "explosive." The wood shop area at ARM was in an enclosed building that could confine a dust cloud.[51] The NPFA 664 states "an enclosure of any type, including but not limited to silos, dust collectors. . . . rooms, and buildings where a deflagration hazard exists" is an explosion hazard. The Court finds that space where the dust was located on December 3, 2012 in ARM's enclosed building provided sufficient confinement for a dust cloud. (Tr. 651, 654, 660, 802, 805; Exs. W, p. 3, CC, NFPA 664-7, at ¶ 3.3.12; R. Br. 23).

The Secretary has proven the standards cited at items 1a and 1b were violated in that all five elements needed to create a dust explosion hazard were present at ARM's facility on December 3, 2012.

Employee Exposure

The Secretary must show that an employee was either actually exposed to the zone of danger, or that exposure was reasonably predictable. *Consol. Grain & Barge Co.*, 23 BNA OSHC 2055, 2065 (No. 10-0756, 2011) (citations omitted). The predictability of exposure can be determined through "evidence that employees while in the course of assigned work duties,

[50] He testified that someone told him that the dust was located in a room that was about 28,000 square feet. (Tr. 654; Ex. W, p. 2).

[51] *See Vitakraft Sunseed, Inc.*, No. 12-1811, 2014 WL 5794302 at *10 (O.S.H.R.C.A.L.J. Sept. 30, 2014) (finding employees working in close proximity to dust room measuring 10-12 feet wide, 15-20 feet deep, and 12-15 feet tall exposed to the fire and explosion hazard from non-compliance with the housekeeping standard where 2-3 inches of dust found on the walls was combustible).

personal comfort activities and normal means of ingress/egress would have access to the zone of danger." *Phoenix Roofing, Inc.*, 17 BNA OSHC 1076, 1079 n.6 (No. 90-2148, 1995), *aff'd without published opinion*, 79 F.3d 1146 (5th Cir. 1996).

The evidence establishes, and there is no dispute that employees, including Messrs. Rivera, Lebron and Martinez, routinely worked in the woodshop area where CO Donofrio documented the dust accumulations. Employees were exposed to the hazard of fire or explosion from combustible dust that can cause loss of life or injury. (Tr. 242, 246; Ex. X, p. 3).

Employer Knowledge

The Secretary must prove the employer either knew, or with the exercise of reasonable diligence could have known, of the violative condition. *Revoli Constr. Co.*, 19 BNA OSHC 1682, 1684 (No. 00-0315, 2001). The employer's knowledge is directed to the physical condition that constitutes a violation. *Phoenix Roofing, Inc.*, 17 BNA OSHC at 1079-80. It is not necessary to show that the employer knew or understood the condition was hazardous. *Id.*

ARM had a dust collection system to collect the wood dust that was generated as a part of ARM's daily production. Both Messrs. Meindl and Santiago were aware that there were significant accumulations of dust regularly present in the wood shop. Mr. Meindl expected employees to spend the last 15 minutes of their shift in dust cleanup. Mr. Meindl admitted that sometimes a bag in the dust collection system broke and dust "would fly all over the place."[52] CO Donofrio testified that Mr. Meindl told him that he was aware that wood dust can be explosive. ARM's president, Mr. Santiago, admitted that he knew a dust collector bag had leaked and that dust was on the ceiling joists on December 3, 2012. Mr. Santiago testified that some of the dust systems in the facility worked better than others; when a dust bag broke while it

[52] On December 3, 2012, Mr. Meindl told CO Donofrio that he was aware of the dust accumulation and that ARM had a problem with its dust collector and one of the bags had been leaking. (Tr. 228-29).

was being changed dust would end up back on the floor and require a special weekend cleanup. (Tr. 164-65, 240, 510, 526, 921).

The Secretary established that ARM management knew that wood dust was present in its wood shop and the bags in the dust collection system leaked adding extra accumulations of dust in the wood shop. The Court finds that ARM did not keep its woodworking shop, including its floor, in a clean, orderly and sanitary condition. The Court finds that the standard is applicable, its terms were violated, employees were exposed and ARM had knowledge of the condition. The Secretary has proved his prima facie case for this citation item.[53] (Tr. 510, 526, 921; Answer, p. 1).

Serious Characterization & Penalty Amount

A violation is classified as serious under section 17(k) of the Act if "there is substantial probability that death or serious physical harm could result" if an accident occurred. 29 U.S.C. § 666(k); *Compass Envtl., Inc*., 23 BNA OSHC 1132, 1136 (No. 06-1036, 2010), *aff'd*, 663 F.3d 1164 (10th Cir. 2011). The Court finds that a serious injury is the likely result if a fire or explosion occurred. Employees working in the wood shop were exposed to fire and explosion hazards. The Secretary properly classified Items 1a and 1b as serious. (Tr. 233-34, 242-43, 246).

The maximum penalty for a serious violation is $7,000. 29 U.S.C. § 666(b). Section 17(j) of the Act requires the Commission to give due consideration to four criteria in assessing penalties: the size of the employer's business, the gravity of the violation, the employer's good faith, and its prior history of violations. *Compass Envtl., Inc.*, 23 BNA OSHC at 1136. The

[53] ARM also asserted the affirmative defense of unpreventable employee misconduct for this item in the joint pre-hearing statement. ARM asserted the misconduct was Mr. Joslin, as plant manager, not ensuring the dust was removed. It is unclear to the Court if it still pursued this defense in its post-hearing brief. This defense is discussed at Citation 2, Items 1 and 2 below. For the same reasons discussed below, the defense fails for this citation item.

gravity of the violation was assessed as high severity and greater probability. There were no penalty reductions for good faith or history; however, a 30% reduction was given due to the small size of the employer. The proposed penalty of $4,900 is affirmed. (Tr. 244-49).

Citation 1, Item 2

The Secretary cited ARM for a serious violation of 29 C.F.R. § 1910.36(d)(1) which requires:

> (d) An exit door must be unlocked. (1) Employees must be able to open an exit route door from the inside at all times without keys, tools, or special knowledge. A device such as a panic bar that locks only from the outside is permitted on exit discharge doors.

The Secretary alleges that on or about December 4, 2012, a door in the southeast part of the warehouse D area was marked as an exit door and did not open because it had no handle and was welded shut. (Tr. 247; Ex. 1, p. 7; S. Br. 44).

Applicability

ARM asserts that the standard does not apply because few people worked in warehouse D and the door led to an area that someone would not want to exit to; *i.e.* an elevated platform that did not have a guardrail and an area that was enclosed by a security fence. The record is clear that the door was marked as an exit.[54] The photographs taken by CO Donofrio and Mr. Miller show an exit sign prominently displayed by the door. During his June, 2013 visit, Mr. Miller advised ARM to remove the exit sign because the door was not an appropriate exit.[55] ARM removed the sign immediately thereafter. The Court finds that the door was marked as an exit. (Tr. 247, 511, 661-63, 810, 926-27; Exs. 9, U, pp. 39-40; R. Br. 23).

Violation of the Standard

[54] Mr. Santiago testified that the door had an exit sign on it. (Tr. 511).
[55] Mr. Miller admitted that the exit sign could indicate to an employee that the door was an exit employees should use in the event of an emergency. (Tr. 811).

ARM argues that the door could be opened. ARM's expert noted that the door opened easily when he observed it in June, 2013. However, ARM's expert did not observe the door until 6 months after CO Donofrio documented the condition. CO Donofrio testified that he did not attempt to open the door because it had no handle and there appeared to be some welds on it. CO Donofrio's December 4, 2012 photograph shows foam insulation along the bottom of the door and the missing handle.[56] The assertion that the door was easily opened is contradicted by ARM's Internal Corrective and Preventative Action Form dated December 20, 2012, which noted the door "has no door knob and won't open."[57] The standard requires an exit door to be unlocked and require no keys or special knowledge to open. The Court finds that on December 4, 2012 the south east metal exit door in Warehouse D was missing a handle and did not open. (Tr. 247-48, 662, 810; Exs. 9, L, p. ARM 283; R. Br. 23-24).

Employee Exposure

CO Donofrio testified that employees were exposed to fire, flames, or smoke hazards because the door would not open. He also said that Messrs. Rivera and Martinez, and four or five other ARM employees, were exposed to the hazard. ARM asserts that the warehouse area was typically unmanned so there was no exposure to the hazard. However, the record shows employees regularly worked in the warehouse D area. Mr. Miller testified that a few people would be in the warehouse D area throughout the day. Mr. Rivera testified that he and other forklift operators worked in the warehouse D area. Mr. Meindl testified that forklifts went into

[56] When shown Exhibit 9 at trial, Mr. Meindl admitted that the doorknob was missing in the photograph. The Secretary has alleged that the door "was welded shut," however, the substance around the edge of the door was foam insulation. Mr. Meindl testified that the door was not welded shut. The Court finds that there is insufficient evidence to support a finding that the door was welded shut on December 4, 2012. The Court finds that foam insulation surrounded the bottom of the door. The Court further finds that the door was missing its handle and Mr. Rivera had not been able to open it, without keys, tools, or special knowledge; or otherwise. (Tr. 925, 936; Exs. 1, p. 7, 9).

[57] In its response to an interrogatory concerning abatement measures taken, ARM stated that "The door was not necessary, but is [sic] has now been opened." (Ex. 2, p. 23).

the area. (Tr. 928). The Court rejects ARM's assertion that employees rarely worked in this area; employee exposure is established. (Tr. 117, 248-49, 662; R. Br. 23).

Employer Knowledge

Where a "condition is 'readily apparent to anyone who looked,'" an employer has been found to have constructive knowledge. *A. L. Baumgartner Constr., Inc.*, 16 BNA OSHC 1995, 1998 (No. 92-1022, 1994). The record establishes that at least three of ARM's supervisors, including Messrs. Meindl, Joslin, and Rivera, knew of the door's condition.[58] Mr. Rivera testified that the door did not open.[59] Mr. Meindl stated that foam was around the door to keep animals out, indicating he knew of the door's condition.[60] ARM's knowledge is imputed from Messrs. Rivera, Meindl and Joslin. (Tr. 120-21, 925; Ex. 9).

The Court finds that the standard is applicable, its terms were violated, employees were exposed and ARM had knowledge of the condition. The Secretary has proved his prima facie case for this citation item.

Serious Characterization & Penalty Amount

The Secretary properly classified Citation 1, Item 2 as serious. Employees would be exposed to fire and smoke hazards when attempting to use a non-functioning exit door. The gravity of the violation was assessed as high severity and lesser probability. There were no penalty reductions for good faith or history; however, a 30% reduction was given due to the small size of the employer. The proposed penalty of $3,500 is affirmed. (Tr. 248-51).

---

[58] CO Donofrio testified that during interviews, Messrs. Meindl and Joslin told him that they knew that the door was missing its handle. (Tr. 250).

[59] Mr. Rivera testified as follows:
Q [] Looking at Exhibit 9, Mr. Rivera, what is this a picture of?
A A door that you couldn't open.
Q Any why couldn't it be opened?
A It had no handle, and even if you try and kick it and stuff, it was just sealed tight.
(Tr. 121; Ex. 9).

[60] Mr. Rivera testified that he thought that the foam insulation at the bottom of the door prevented it from opening. (Tr. 121-22; Ex. 9).

Citation 1, Item 3

The Secretary cited ARM for a serious violation of 29 C.F.R. § 1910.147(c)(1) which requires:

§ 1910.147 The control of hazardous energy (lock out/tagout). …

> (c) *General* (1) *Energy control program*. The employer shall establish a program consisting of energy control procedures, employee training and periodic inspections to ensure that before any employee performs any servicing or maintenance on a machine or equipment where the unexpected energizing, start up or release of stored energy could occur and cause injury, the machine or equipment shall be isolated from the energy source, and rendered inoperative.[61]

The Secretary alleges that ARM had not established an adequate energy control (LOTO) program, including no machine-specific procedures, training, or periodic inspection to protect employees from unexpected energization.[62] ARM asserts that it had a hazardous energy control (LOTO) program and the cited standard does not apply to the saws that were identified in the citation. (Ex. A, § XXII; R. Br. 23-24).

Applicability

An Energy control program, including energy control procedures, is required whenever an employee is required to service and/or maintain a machine or equipment when there is potential for the machine or equipment to energize, start up, or release stored energy without sufficient advance notice to the employee.[63] *Dayton Tire, Bridgestone/Firestone*, 23 BNA OSHC 1247, 1250-51 (No. 94-1374, 2010), *aff'd in relevant part* 671 F.3d 1249 (D.C. Cir.

---

[61] OSHA's lockout/tagout standard "establishes minimum performance requirements for controlling hazardous energy and it is intended to complement and augment machine safeguarding practices" during servicing/maintenance activities. These activities include replacing machine parts*; e.g*., replacing machine saw blades. (Ex. Y, p. 22).

[62] The citation alleged that "on or about 12/3/12 throughout the facility; employees are involved in service and maintenance activities, such as but not limited to, replacing saw blades on the Baker saw, Ma[tt]ison rip saw, radial arm saw, panel saw, without the employer developing and implementing a hazardous energy control program which includes procedures, employee training, and inspections related to the control of hazardous energy during these events." (Ex. 1, p. 8).

[63] According to § 1910.147(b), "servicing and/or maintenance" specifically includes activities that "include lubrication, cleaning or unjamming of machines or equipment and making adjustments or tool changes, …."

2012). *See also Gen. Motors Corp., Delco Chassis Div.*, 17 BNA OSHC 1217, 1218 (No. 91-2973, 1995)(consolidated)(holding employers shall establish energy control procedures when employee is expected to interact with machine or equipment that can unexpectedly energize, start up, or release stored energy and cause injury), *aff'd sub nom. Reich v. Gen. Motors Corp.*, 89 F.3d 313 (6th Cir. 1996). The LOTO standard applies to the "servicing and maintenance of machines and equipment in which the *unexpected* energization or start up of machines or equipment" could injure an employee. 29 C.F.R. § 1910.147(a)(1)(i)(emphasis in original).

In his citation and complaint, the Secretary alleges the LOTO standard applies to the lubrication, cleaning, unjamming, making adjustments or tool changes, including replacing blades, of the panel, Mattison rip, radial arm, and Baker saws, at ARM's facility on about December 3, 2012.[64] CO Donofrio testified that "lockout is required whenever employees are exposed to the unexpected startup of a machine and their work is in [] or near the point of operation where, if the equipment started up unexpectedly, they could be injured." ARM asserts that the LOTO standard is not applicable to the cited saws because: 1) the Radial arm saw was a piece of cord and plug connected electric equipment, 2) the panel and Mattison rip saws did not need equipment specific procedures since they had single energy sources,[65] 3) although the Baker saw had two energy sources, only one was needed to be de-energized when blades were changed, and 4) changing a saw blade is a minor tool change, adjustment or minor servicing activity

[64] In his post-hearing brief, the Secretary alleged the same for ARM's pop-up saw and Shoda CNC machine. The pop-up saw and Shoda CNC machine were not specifically identified in Citation 1, Item 3, or the complaint with regard to 29 C.F.R. § 1910.147(c)(1). As the Secretary neither alleged a violation of Citation 1, Item 3, regarding the pop-up saw or the Shoda CNC machine, in the citation or complaint, nor moved to amend either or both, the Court does not include the pop-up saw and Shoda CNC machine within the scope of Citation 1, Item 3. *See* section 9(a) of the Act, which states: "Each citation shall be in writing and shall describe with particularity the nature of the violation, …."

[65] According to § 1910.147(b), "Energy source" is defined as "[a]ny source of electrical, mechanical, hydraulic, pneumatic, chemical, thermal, or other energy."

that takes place during normal production operations which qualifies all of its saws for an exception to the standard set forth at 29 C.F.R. § 1910.147(a)(2)(ii). (Tr. 254-70; Ex. 1, p. 8; S. Br. 46, R. Br. 18, 23-24).

29 C.F.R. § 1910.147(a)(2)(iii)(A) states that the "standard does not apply to the following: (A) Work on cord and plug connected electric equipment for which exposure to the hazards of unexpected energization or start up of the equipment is controlled by the unplugging of the equipment from the energy source and by the plug being under the exclusive control of the employee performing the servicing or maintenance." Mr. Meindl testified that the radial arm saw worked when it was "plugged in." He said that when its blade was changed the worker unplugged the saw, unscrewed the blade and installed a new blade. Mr. Miller also testified that the radial arm saw was an "all electric" piece of "cord-and-plug" equipment. He said that he believed that it did not have a second energy source. Both Messrs. Meindl and Miller said the single electric power source that powered the radial arm saw could be readily identified and isolated. As such, it would be under the employee's control. The Secretary did not refute their testimony. In his post-hearing brief, the Secretary did not identify the radial arm saw as a saw with a multiple energy source. The radial arm saw did not require a lockout procedure. It was a cord and plug-operated machine.[66] The Court finds that the Secretary did not prove that the LOTO standard applied to ARM's radial arm saw. The evidence shows the radial arm saw

[66] *See S. Scrap Materials Co., Inc.*, No. 94-3393, 1997 WL 735352, at * 39 (O.S.H.R.C.A.L.J. November 24, 1997) (showing alleged lockout/tagout violation vacated for cord and plug-operated machine that did not require a lockout procedure).

meets the exclusion set forth in 29 C.F.R. § 1910.147(a)(2)(iii)(A).[67] (Tr. 665-66, 923-24; Exs. 25, U, pp. 8-10; S. Br. 46, R. Br. 18, 24).

ARM also asserts the standard is not applicable and it did not need an Energy control program consisting of energy control procedures, employee training and periodic inspections for the panel and Mattison rip saws because they each had single energy source and did not require equipment specific procedures. CO Donofrio testified that the Mattison saw had two energy sources; electricity and air, that were required to be controlled prior to performing service activities.[68] ARM admits it did not have any machine-specific procedures.[69] ARM asserts machine-specific procedures for the panel and Mattison rip saws were not required because of the energy control procedure documentation exception at 29 C.F.R. § 1910.147(c)(4)(i). It asserts that the general LOTO procedure in its safety manual were adequate for these machines. The exception to machine-specific procedures states:

> *Exception*: The employer need not document the required procedure for a particular machine or equipment, when all of the following elements exist: (1) The machine or equipment has no potential for stored or residual energy or reaccumulation of stored energy after shut down which could endanger employees; (2) the machine or equipment has a single energy source which can be readily identified and isolated; (3) the isolation and locking out of that energy source will completely deenergize and deactivate the machine or equipment; (4) the machine or equipment is isolated from that energy source and locked out during servicing or maintenance; (5) a single lockout device will achieve a locked-out condition; (6) the lockout device is under the exclusive control of the authorized employee performing the servicing or maintenance; (7) the servicing or maintenance does not create hazards for other employees; and (8) the employer, in utilizing this exception, has had no accidents involving the

[67] *See Tops Markets, Inc.*, 17 BNA OSHC 1935, 1936 (No. 94-2981, 1997) (noting lockout/tagout requirements of the standard will not apply to cord and plug connected equipment if the equipment is unplugged and the plug is in the exclusion control of the servicing employee). (Ex. Y, p. 44).
[68] There is no photograph in the record of a Mattison saw.
[69] Mr. Joslin told CO Donofrio that ARM had not developed procedures to control potentially hazardous energy. Mr. Rivera also testified that ARM did not have a lockout/tagout program before December 3, 2012. (Tr. 113, 264).

> unexpected activation or reenergization of the machine or equipment during servicing or maintenance.

(Tr. 255, 811; Ex. W, p.4; R. Br. 24-25).

Mr. Miller testified that the panel and Mattison rip saws did not require an equipment-specific procedure because they had a single energy source that could be readily identified and isolated. ARM limited its argument to whether the panel and Mattison rip saws had single energy sources. Mr. Miller opined that machine-specific procedures were only needed if multiple energy sources must be isolated to service a machine, or if a guard or other device must be removed or bypassed to service and maintain a machine. Mr. Miller is incorrect.[70] More is required. All eight elements must exist to qualify for an exception to the documentation of a machine-specific LOTO energy control procedure. *See Drexel Chem. Co.*, 17 BNA OSHC 1908, 1914 (No. 94-1460, 1997) (Employer failed to introduce evidence to support its claim that its machines met the elements of the exception). ARM has the burden to prove it qualifies for this exception. *Kaspar Wire Works, Inc.*, 18 BNA OSHC 2178, 2194 (No. 90-2775, 2000) ("respondent bears burden of proving entitlement to exceptions …."), *aff'd*, 268 F.3d 1123 (D.C. Cir. 2001). To qualify for the exception to machine-specific procedures, ARM must submit evidence to show that it meets all of the eight elements for the exception. *See Drexel Chem. Co.*, 17 BNA OSHC at 1914 (finding employer did not "introduce evidence to support its claim" that its equipment qualified for the exception). ARM has failed to meet its burden to establish that the documentation exception applies to the panel and Mattison saws. (Tr. 664-66, 813; Ex. W, pp. 3-4; R. Br. 18, 24).

---

[70] *See Basic Grain Prods, Inc.*, 24 BNA OSHC 2024, 2032 (No. 12-0725, 2013) (Finding 29 C.F.R. § 1910.147(c)(4)(i) standard applies where equipment had different sources of energy and employer did not argue any exceptions applied, including the documentation exception); *but see Interstate Brands Corp.*, 20 BNA OSHC 1102, 1106 (No. 00-1077, 2003) (noting judge vacated 29 C.F.R. § 1910.147(c)(4)(ii)(C) and (D) violations for rotary valve that came within documentation exception and no written LOTO procedure required).

There is conflicting evidence whether there were one or two energy sources for the panel saw. The "Lock Out – Tag Out Process for panel Saw" procedures show that the panel saw had two energy sources, electric and pneumatic. Mr. Miller agreed ARM's "Lock Out Tag Out Procedure for panel Saw" shows that the panel saw had more than one energy source. Mr. Meindl testified that the panel saw was both electronic and pneumatic. CO Donofrio also testified that the panel saw had two energy sources, air and electricity. The Court observed Mr. Miller's demeanor during his direct examination on this point and found it to be hesitant, tentative, and unsure as to whether the panel saw had only a single energy source. He said "[i]f I recall correctly", "I think it was all electric", and "I don't believe it did [have a second energy source]." He was less than certain, and not persuasive on this topic. During cross examination, Mr. Miller testified, without qualification, that the panel saw had more than one energy source. Based upon ARM's written procedures and the above testimony, the Court finds that the panel saw had more than one energy source. ARM has also provided insufficient evidence to support that elements one and three through eight of the exception actually exist for the Mattison rip saw or all eight elements for the panel saw. (Tr. 258, 665, 728-29, 813-14, 924; Exs. 16-17, N, p. ARM 94, R, p. 10).

The Court finds the documentation exception does not apply to the panel and Mattison rip saws because ARM did not present evidence to address each of the eight elements necessary to qualify for the documentation exception. Further, Mr. Miller's opinion on whether a machine qualified for the documentation exception was not based on the eight required elements. The Court finds the cited standard applies.

ARM further asserts that the LOTO standard is not applicable and it did not need an Energy control program consisting of energy control procedures, employee training

and periodic inspections for its Baker saw because only one of its two energy sources needed to be de-energized when its blades were changed. CO Donofrio testified that Baker saw had two energy sources, air and electricity, that were required to be controlled prior to performing these service activities.[71] Mr. Miller testified that machine-specific procedures were only needed if multiple energy sources must be isolated to service a machine, or if a guard or other device must be removed or bypassed to service and maintain a machine. He said that machine-specific procedures were not required for the Baker saw because only one, the electrical, of its two energy sources had to be locked out during a saw blade change. He also testified that the other energy source, pneumatic or air, "wouldn't necessarily have to be disconnected" in order to replace the blade. He said the servicing worker would have to at least "release some air to release tension" when replacing a blade. This would leave some residual pneumatic energy and the Baker saw would not be completely de-energized. As discussed above, equipment servicing and maintenance is not limited to just replacing saw blades. Mr. Miller agreed that, depending on the maintenance activity, it might be necessary to isolate both the electrical and pneumatic energy sources on the Baker saw. For the reasons stated above, the Court also finds the documentation exception does not apply to the Baker saw because ARM did not present evidence to address each of the eight elements necessary to qualify for the documentation exception. (Tr. 664-65, 668-69, 815-16).

ARM also asserts that changing a saw blade is a minor tool change, adjustment or minor servicing activity that takes place during normal production operations which qualifies for the exception to paragraph (a)(2)(ii), which states:

[71] ARM admits the Baker saw had two energy sources, electric and pneumatic. Photographs of the Baker saw are at exhibits 13 and 14. (Tr. 254-57, 922; R. Br. 24).

> NOTE: *Exception to paragraph (a)(2)(ii)*: Minor tool changes and adjustments, and other minor servicing activities, which take place during normal production operations, are not covered by this standard if they are routine, repetitive, and integral to the use of the equipment for production, provided that the work is performed using alternative measures which provide effective protection (See subpart O of this part). 29 C.F.R. § 1910.147 (a)(2)(ii).

ARM relies on its expert's report and testimony to support its position. (Ex. W, p. 4; R. Br. 25). In his expert report, Mr. Miller stated: "Changing the blades on these pieces of equipment is a minor tool change or adjustments [*sic*] or minor servicing activities, which takes place during normal production operations, and are routine, repetitive, and integral to the use of the equipment for production, and is performed using alternative measures which provide effective protection." (Ex. W, p.4).

To prove the minor servicing exception applies, ARM must show: 1) the tool changes and adjustments or servicing activities were minor; 2) they were performed during normal production operations; and 3) effective alternative protection was provided. *Westvaco Corp.*, 16 BNA OSHC 1374, 1378 (No. 90-1341, 1993). As the party claiming the exception, ARM has the burden to prove it qualifies for the exception. *Kaspar Wire Works, Inc.*, 18 BNA OSHC at 2194. ARM's argument fails on all three points.

First, ARM must show the tool changes and activities were minor. CO Donofrio testified that changing a saw blade was not considered a minor servicing activity. Mr. Miller testified that a minor servicing activity includes activities such as lubricating equipment which can occur without removing a machine guard or locking out equipment. Mr. Miller said that he did not witness any employees performing any minor servicing activity, was not familiar with how ARM employees changed saw blades, did not observe blades changed on any of the machines at ARM, and acknowledged that saw blades pose serious hazards. When asked if minor servicing activities, including blade adjustments, would not be required to go through lock-out/tag out, he

testified that "I don't know if I would say that." He said that "you would want to deenergize them [the saws] as a practice[.]" ARM's evidence does not support the assertion that replacing a saw blade is a minor adjustment or tool change. The Court finds that replacing a saw blade on the equipment in ARM's wood shop is not a minor tool change, adjustment, or activity. (Tr. 406, 672-73, 819-22, 837).

Second, ARM must show that changing a blade is part of the normal production operation. Normal production operations are defined as the "utilization of a machine or equipment to perform its intended production function." 29 C.F.R. § 1910.147(b). The Commission has held that "adjustments made to *prepare* for normal production operations cannot, at the same point in time, be adjustments that are made 'during normal production operations'" (emphasis added). *Westvaco Corp.,* 16 BNA OSHC at 1379. Mr. Miller's testimony on this point contradicts his report. His report states: "Changing the blades . . . takes place during normal production operations." In contrast, he testified that changing a saw blade is part of the overall production process, but it is not a part of the "normal production operation" and "[y]ou wouldn't change a blade during a normal production operation. ARM's "Safety Issues – December 5, 2012" worksheet indicates that the Maintenance Department was responsible for making all blade changes for the panel Saw. The Court finds that changing saw blade is not a part of the normal production operation. (Tr. 823, 834, 837; Exs. I, p. ARM 216, W, p. 4).

Finally, to qualify for the exception, ARM must show it provided effective alternative procedures for its equipment. ARM has failed to do so. Mr. Miller testified that "dropping the energy source . . . within the viewing distance of a person performing that work . . . is an alternative method that would provide equivalent protection." He provides no additional

rationale. ARM's assertion that the panel saw had only one energy source, which could be readily identified and isolated by an employee, has been discredited. As the Court has found, the panel saw had two energy sources. ARM does not show that any of its alternative means were actually utilized by employees when servicing or maintaining the panel, Mattison rip, or Baker saws. Further, ARM does not offer proof that these alternative means are as equally effective as the standard's requirements. ARM presented insufficient evidence to establish that it provided any effective alternative protection for employees who performed service and/or maintenance on the panel, Mattison rip, and Baker saws. (Tr. 666, 671-72; Ex. W, p. 4; R. Br. 24).

ARM did not prove the minor servicing exception applies to its panel, Mattison rip, or Baker saws. The Court finds the cited LOTO standard applies to activities in ARM's facility, including the lubrication, cleaning, unjamming, making adjustments or tool changes, and replacing blades, on the panel, Mattison rip, and Baker saws.

Violation of the Standard

ARM asserts there is no violation because its safety manual included a LOTO program. The cited standard requires a LOTO program to include procedures, training, and periodic inspections. The safety manual that Paychex prepared for ARM includes a LOTO section. The 11-page section notes that training, inspections, and written procedures are required and that management must, among other things, "[e]valuate the potential hazards of specific equipment" and "[e]stablish written LO/TO procedures for each individual or group of similar machines in place." However, the forms provided in the manual to assist an employer with establishing its procedures, assessments, and training were blank. For example, a form entitled "LOTO Program Assessment" is a checklist an employer could use to determine if a piece of equipment requires a lockout process and if the necessary procedures and locks are provided for an employee's use.

There is no evidence that anyone at ARM did this assessment or followed any of the other listed requirements to implement a LOTO program as outlined in its safety manual. The LOTO section in ARM's safety manual does not reference any particular equipment or machine nor does it make any reference to ARM's workplace. There were no specific or general procedures for lockout of ARM's equipment. General procedures for lockout/tagout are not acceptable. A written lockout/tagout program should include: 1) the names of affected employees; 2) the types and magnitudes of energy involved; 3) the hazards involved; 4) the methods that should be used to control energy sources; 5) the types and location of the machines and energy isolating devices; 6) the types of stored energy and methods to dissipate or restrain energy; and 7) the method of verifying the isolation of the equipment at issue. *Drexel Chem. Co.*, 17 BNA OSHC at 1913. Furthermore, Mr. Joslin admitted to CO Donofrio during the inspection that ARM did not have lockout/tagout program and Mr. Rivera testified that ARM did not have a lockout/tagout program before the accident. The information in the safety manual simply outlined what was generally required to establish a LOTO program, *i.e.*, training, inspections, and procedures. ARM admits that it did not train its employees. The Secretary asserts that ARM did not conduct adequate inspections in accordance with the standard. *See* 29 C.F.R. § 1910.147(c)(6) (Energy control procedures to be conducted at least annually). ARM did not specify whether adequate inspections were done in accordance with the standard. *See* 29 C.F.R. § 1910.147(c)(6). There is no evidence in the record that shows ARM conducted annual inspections. The Court finds that ARM did not establish an Energy control program that consisted of energy control procedures, employee training and periodic inspections for the Baker, Mattison rip, and panel saws. (Tr. 113, 252, 261-62; Ex. A, § XXII, pp. 2, 12-20; S. Br. 45, R. Br. 24-25).

Mr. Miller testified that ARM's safety manual was "somewhat of a boilerplate program" that "did not have equipment-specific energy control procedures." The Court's review of ARM's safety manual reveals there was no guidance or procedure that an employee could utilize to control a saw's energy sources while replacing the blade. The information in the safety manual is generic and not specific to any type of machine or equipment. (Tr. 664, 811).

The Court rejects ARM's assertion its safety manual included an adequate LOTO program. The evidence shows that the program in ARM's safety manual was boilerplate and not adapted to its facility. Further, there was no attempt to implement any of the manual's general guidelines prior to OSHA's inspection. During OSHA's inspection, Mr. Joslin told CO Donofrio that ARM did not have a lockout program. Mr. Rivera testified that ARM did not have a lockout/tagout program before December 3, 2012. He said that he was never trained at ARM on how to isolate power to machines. He also stated that the employees working in the wood shop were never trained on lockout/tagout before December 3, 2012. Mr. Rivera also testified that ARM did not use any equipment, such as locks or keys, to lock out machinery before December 3, 2012. The Court finds ARM did not have a compliant LOTO program. (Tr. 113-14, 252).

Employee Exposure

Through employee interviews conducted during the OSHA inspection, CO Donofrio determined that ARM's employees, including Messrs. Roberto James and Anieal Rodriguez, were servicing and maintaining equipment, including many types of saws, in the woodworking shop. This included activities such as the lubrication, cleaning, unjamming, making adjustments or tool changes, and replacing blades on the Baker, Mattison rip, and panel saws. CO Donofrio also determined that ARM did not develop and implement a hazardous energy control program,

including procedures, employee training, and inspections.[72] Both Messrs. Santiago and Meindl testified that the maintenance staff changed the blades and were expected to keep the machines operational and safe. The Court finds on December 3, 2012 ARM's employees were exposed to the hazard of unexpected energization while servicing and maintaining the Baker**,** panel, and Mattison rip saw. (Tr. 251-61, 521, 897; Exs. 1, p. 8, K, pp. ARM 1, 3, N, p. ARM 98).

Employer Knowledge

ARM's safety manual outlines the general responsibilities and requirements of a LOTO program. It states that equipment must be evaluated to identify potential hazards and that "up-to-date written procedures . . . for both routine and non-routine service and maintenance work" are necessary along with training for employees. ARM's manual establishes actual knowledge that an energy control (LOTO) program was required. The Secretary has established knowledge. (Ex. A, § XXII, pp. 2-8).

The Court finds that the standard is applicable, its terms were violated, employees were exposed and ARM had knowledge of the condition. The Secretary has proved his prima facie case for this citation item.

Serious Characterization & Penalty Amount

The Secretary properly classified Citation 1, Item 3 as serious. Employees were exposed to cuts, crushing, laceration, and amputation injuries from working on equipment without proper lockout procedures.[73] The gravity of the violation was assessed as high severity and greater probability. There were no penalty reductions for good faith or history; however, a 30% reduction was given due to the small size of the employer. In light of the Court's exclusion of the radial arm saw from the scope of the proven violation, the Court finds that proposed penalty

[72] CO Donofrio testified that by not having an energy control program for employees who serviced machines, employees could be cut, crushed, and exposed to amputation and lacerations hazards. (Tr. 260).
[73] Mr. Miller admitted that changing saw blades is dangerous unless the equipment is first de-energized. (Tr. 816).

of $4,900 is excessive.[74] Instead, the Court finds a penalty of $4,400 is appropriate.[75] (Tr. 260-63).

Citation 1, Item 4

The Secretary cited ARM for a serious violation of 29 C.F.R. § 1910.147(c)(4)(i) which requires:

> (4) *Energy control procedure*. (i) Procedures shall be developed, documented and utilized for the control of potentially hazardous energy when employees are engaged in the activities covered by this section.

The Secretary alleges that ARM did not develop, document or use machine-specific procedures for the service and maintenance of equipment such as, changing saw blades on the Baker, Mattison rip, and panel saws.[76] The Secretary asserts that because the equipment had more than one energy source, machine-specific procedures are required and any exception does not apply.[77] ARM asserts that it had a general energy control procedure and argues that the cited standard does not apply to the saws that were identified in the citation. (Tr. 263-64; Ex. A, § XXII; S. Br. 49-50, R. Br. 24).

Applicability

ARM asserts that § 1910.147(c)(4)(i) standard is not applicable to the cited saws for the same reasons it asserted with regard to the § 1910.147(c)(1) violation set forth in Citation 1, Item 3. For the reasons described above for Citation 1, Item 3, the Court finds

---

[74] Respondent has asserted that the penalties proposed by the Secretary are too large. (R. Br. 44).
[75] The Court has the authority to assess a penalty that is lower than the one proposed by the Secretary. *See* sections 10(c) and 17(j) of the Act.
[76] The citation 1, Item 4, alleged that "[o]n or about 12/3/12 throughout the facility; employees are involved in service and maintenance activities, such as but not limited to, replacing saw blades on the Baker saw, Mattison rip saw, radial arm saw, and panel saw, without the employer developing, documenting, or utilizing hazardous energy control procedures related to the control of hazardous energy during these events." (Ex. 1, p. 9).
[77] *See Drexel Chem. Co*., 17 BNA OSHC at 1913-14 (holding that specific procedures are required when machines have multiple energy sources).

the § 1910.147(c)(4)(i) standard inapplicable to the radial arm saw, but applicable to the Baker, Mattison rip and panel saws at ARM. (R. Br. 18, 24).

Violation of the Standard

ARM did not have any machine-specific procedures. Because it did not prove that any exception was applicable, the Court finds ARM violated the terms of the standard for the reasons stated above with regard to Citation 1, Item 3.

Employee Exposure

CO Donofrio testified that he observed equipment or machines, including the Baker, Mattison rip and panel saws, at ARM for which procedures were required to be developed, documented and utilized for the control of potentially hazardous energy when employees were engaged in servicing and/or maintenance activities. As discussed above with regard to Citation 1, Item 3, it is not disputed that ARM's employees changed the blades and performed other maintenance services on its woodworking equipment. CO Donofrio further testified that Messrs. James and Anieal Rodriguez were exposed to serious cuts, laceration, amputation, and broken bones by ARM not having procedures for the control of potentially hazardous energy for employees who performed service and maintenance activities on the Baker, Mattison rip and panel saws. The Court finds that on December 3, 2012 ARM's employees were exposed to the hazard of unexpected energization. (Tr. 253, 264; Ex. 1, p. 9).

Employer Knowledge

ARM's safety manual outlines the responsibilities and requirements of a LOTO program, including the requirement to have procedures with "sufficient detail" to give an employee control over hazardous energy sources. Mr. Santiago knew there was a safety manual. Mr. Meindl was routinely in the wood shop and operated the equipment on occasion, so he knew that equipment

had multiple energy sources. Further, ARM management knew its maintenance employees were responsible for providing service to the shop's machines. This establishes actual knowledge of the hazardous condition that machine-specific procedures were not available for equipment. The Secretary has established knowledge. (Ex. A, § XXII, p. 3).

The Court finds that the cited standard is applicable, its terms were violated, employees were exposed and ARM had knowledge of the condition. The Secretary has proved his prima facie case for this citation item.

Serious Characterization & Penalty Amount

The Secretary properly classified Citation 1, Item 4 as serious. Employees were exposed to cuts, crushing, laceration, and amputation injuries. The gravity of the violation was assessed as high severity and greater probability. There were no penalty reductions for good faith or history; however, a 30% reduction was given due to the small size of the employer. In light of the Court's exclusion of the radial arm saw from the scope of the proven violation, the Court finds that proposed penalty of $4,900 is excessive. Instead, the Court finds a penalty of $4,400 is appropriate. (Tr. 265-67).

Citation 1, Item 5

The Secretary cited ARM for a serious violation of 29 C.F.R. § 1910.147(c)(5)(i) which requires:

> (5) *Protective materials and hardware*. (i) Locks, tags, chains, wedges, key blocks, adapter pins, self-locking fasteners, or other hardware shall be provided by the employer for isolating, securing or blocking of machines or equipment from energy sources.

The Secretary alleged that ARM did not provide the necessary hardware to isolate the Baker, Mattison rip, radial arm, or panel saws from energy sources during service and maintenance activities. ARM asserts that locks and tags were at ARM's facility and the §

1910.147(c)(5)(i) standard is not applicable to the cited saws because: 1) the radial arm saw was a piece of cord and plug connected electric equipment, 2) changing a saw blade is a minor tool change, adjustment or minor servicing activity that takes place during normal production operations which qualifies all of its saws for an exception to the standard, and 3) the saws had a readily identifiable isolating device in close proximity to the person performing the maintenance. (Tr. 114, 267-69; Exs. 1, p. 10, N, p. ARM 98; S. Br. 51, R. Br. 18, 25).

Applicability

For the reasons stated above with regard to Citation 1, Item 3, the Court has already found that the Lockout/Tagout standard does not apply to ARM's radial arm saw. Likewise, for the same reasons identified above, the Court finds that ARM does not qualify for any minor servicing exception to the § 1910.147(c)(5)(i) standard. The Court finds the cited standard applies to the Baker, Mattison rip, and panel saws.

Violation of the Standard

CO Donofrio testified that he saw equipment or machines at ARM that required hardware to isolate, secure or block machines from energy sources during service and maintenance work. ARM asserts that all the hardware needed to isolate, secure or block equipment from an energy source was available for use by its employees. However, ARM's assertion is not supported by the evidence. (Tr. 268-70).

Mr. Miller's testimony on the issue of lockout equipment was equivocal and vague. In his report, Mr. Miller stated:

> ARM did provide some Lockout/Tagout equipment, as it is my understanding that there were locks and tags at the facility. I also witnessed the uses of some locks and tags during my initial visit to the facility in December of 2012. The hardware that was at the

> facility would have been sufficient for the isolation of energy sources for the equipment identified, if necessary.

He testified that when he visited the facility on December 7 he did see some tags, hasps and locks that could be used for lockout, but could not recall how many were available.[78] However, Mr. Miller also stated that he provided additional lockout equipment to ARM during his December 7, 2012 visit. This suggests that ARM did not have adequate hardware to lockout the equipment in the wood shop. (Tr. 670; Ex. W, p.4).

CO Donofrio testified that during his investigation, Mr. Joslin and the maintenance staff told him that ARM had no hardware to isolate, secure or block machines from being energized during maintenance tasks.[79] Mr. Rivera testified that, prior to the accident, he did not know about lockout procedures, and tags and locks had not been used to lockout machinery. In its Response to First Set of Interrogatories, ARM stated that "[t]here was some lockout hardware, but it had not been installed for all equipment." (Tr. 113-14, 268; Ex. 2, p.7).

The Court finds Mr. Miller's assertion that adequate lockout hardware was available on December 3, 2012 unconvincing. Mr. Miller was not present at ARM on December 3, 2012. Whatever equipment he provided during visit four days later was neither specifically identified as to the type of lockout hardware it was, nor identified as lockout hardware to be utilized with a particular type of saw. His use of the phrase "it is my understanding that there were locks and tags at the facility" suggests that the basis for his knowledge was second-hand. (Tr. 838).

ARM has not identified sufficient evidence to support its assertion that on December 3, 2012 the saws had readily identifiable isolating devices available and in close proximity to the person performing maintenance. This combined with CO Donofrio's testimony that Mr. Joslin

---

[78] The Court observed Mr. Miller's testimony and found it unpersuasive. Mr. Miller couched his testimony with hesitation and qualification. He said "I believe, if I recall, I saw some tags…. I don't recall the numbers."
[79] Mr. Joslin did not refute CO Donofrio's testimony when he testified at the trial.

had no knowledge of lockout hardware during the OSHA inspection and Mr. Rivera's testimony he knew nothing about lockout, demonstrates that ARM did not provide adequate hardware, including locks, tags, chains, wedges, key blocks, adapter pins, and self-locking fasteners, to its employees on December 3, 2012 to lockout the Baker, Mattison rip, and panel saws.

Employee Exposure

CO Donofrio testified that Messrs. James and Anieal Rodriguez were exposed to amputation or broken bones by ARM not providing locks to employees who performed service and maintenance that allowed them to first control or secure energy sources. As discussed above, ARM employees changed saw blades and made repairs to the equipment in the wood shop. CO Donofrio testified that the lockout/tagout procedures applied when an employee changed the blade on one of the saws**.** Employee exposure is established. (Tr. 270-72, 352).

Employer Knowledge

Mr. Rivera testified that prior to the OSHA inspection, ARM did not use any hardware to lockout a machine's energy source. As a supervisor, Mr. Rivera's actual knowledge can be imputed to ARM. Further, with reasonable diligence other ARM management personnel could have easily determined whether lockout hardware was available for use in the wood shop. Mr. Rivera was a supervisor in the wood shop which included the pallet area, and routinely used the saws. Mr. Meindl was in the wood shop on a regular basis and also used the equipment. With reasonable diligence, ARM could have known it did not have adequate lockout hardware for its equipment. (Tr. 112-14, 137, 268, 736, 935).

The Court finds that the standard is applicable, its terms were violated, employees were exposed and ARM had both actual and constructive knowledge of the condition. The Secretary has proved his prima facie case for this citation item.

Serious Characterization & Penalty Amount

The Secretary properly classified Citation 1, Item 5 as serious. Employees were exposed to cuts, laceration, and amputation injuries. The gravity of the violation was assessed as high severity and greater probability. There were no penalty reductions for good faith or history; however, a 30% reduction was given due to the small size of the employer. In light of the Court's exclusion of the radial arm saw from the scope of the proven violation, the Court finds that proposed penalty of $4,900 is excessive. Instead, the Court finds a penalty of $4,400 appropriate. (Tr. 270-72).

Citation 1, Item 6

The Secretary cited ARM for a serious violation of 29 C.F.R. § 1910.147(c)(7)(i) which requires:

> (7) *Training and communication*. (i) The employer shall provide training to ensure that the purpose and function of the energy control program are understood by employees and that the knowledge and skills required for the safe application, usage, and removal of the energy controls are acquired by employees. The training shall include the following: (A) Each authorized employee shall receive training in the recognition of applicable hazardous energy sources, the type and magnitude of the energy available in the workplace, and the methods and means necessary for energy isolation and control. (B) Each affected employee shall be instructed in the purpose and use of the energy control procedure. (C) All other employees whose work operations are or may be in an area where energy control procedures may be utilized, shall be instructed about the procedure, and about the prohibition relating to attempts to restart or reenergize machines or equipment which are locked out or tagged out.

The Secretary alleges that ARM did not provide adequate training on lockout/tagout procedures for its employees that provided service and maintenance to the radial arm, Mattison rip and Baker saws. (Tr. 272-73; Ex. 1, p. 11).

To prove a training violation, the Secretary must show that the employer "failed to provide the instructions that a reasonably prudent employer would have given in the same circumstances." *Compass Envtl., Inc.*, 23 BNA OSHC at 1134 (citations omitted). Further, the

employer's instructions must be "specific enough to advise employees of the hazards associated with their work and the ways to avoid them." *O'Brien Concrete Pumping, Inc.*, 18 BNA OSHC 2059, 2061(No. 98-0471, 2000).

Applicability and Employee Exposure

ARM's employees were engaged in service and maintenance of the Mattison rip and Baker saws.[80] ARM was required to train its employees on the purpose and function of its energy control (LOTO) program. CO Donofrio testified that employees involved in service and maintenance activities had not been trained on the procedures to use prior to performing such work. He observed the saws at ARM that required employees to be trained on lockout/tagout. Mr. Santiago confirmed that ARM's maintenance employees were responsible for maintenance and repairs of machines, including changing the saw blades. CO Donofrio testified that Messrs. James and Anieal Rodriguez were exposed to lacerations and broken bones through not receiving the required lockout training. The Court finds the cited standard applies and employees were exposed. (Tr. 272-75, 521).

Violation of the Standard

Mr. Joslin told CO Donofrio that ARM's employees "had not conducted the training on lockout."[81] Mr. Rivera testified that he was not trained on lockout/tagout before December 3, 2012. ARM admits that it did not provide adequate lockout/tagout training to its employees. Mr. Cansdale, an employee in the maintenance department, confirmed he had not received any

[80] As discussed above with regard to Citation 1, Items 3 through 5, the Lockout/Tagout standard does not apply to the radial arm saw, and it is excluded from the scope of the violation at Citation 1, Item 6. *See* 29 C.F.R. § 1910.147(a)(2)(iii)(A).

[81] ARM's safety manual stated lockout/tagout training records "will be maintained." There are no training records in the trial record that show that lockout/tagout training was conducted at ARM before December 3, 2012. (Ex. A, Vol. 2, § XXII, p. 8).

training on energy control procedures. Mr. Miller agreed there was no lockout/tagout training for employees prior to the inspection. The Court finds ARM did not conduct lockout/tagout training and that it violated the cited standard.[82] (Tr. 113, 273, 752, 812; Ex. 2, p. 7; R. Br. 25).

Employer Knowledge

ARM management knew it had not provided LOTO training to its employees and this knowledge is imputed to ARM. Mr. Rivera testified he had not received any training prior to the accident. Mr. Joslin told CO Donofrio no training was provided prior to the inspection. Further, ARM's safety manual stated that employees must be trained in LOTO procedures. The Court finds ARM had knowledge that it had not trained its employees. (Tr. 113, 273, 351; Ex. A, Vol. 2, § XXII, p. 8).

The Secretary has proved that the standard is applicable, ARM's employees were exposed to the hazard, were not adequately trained, and the employer knew or could have known that its employees were not trained. The Secretary has proved his prima facie case for this citation item.

Serious Characterization & Penalty Amount

The Secretary properly classified Citation 1, Item 6 as serious. Employees working on the Mattison rip and Baker saws without adequate training were exposed to injuries including amputation, laceration, and broken bones. The gravity of the violation was assessed as high severity and greater probability. There were no penalty reductions for good faith or history; however, a 30% reduction was given due to the small size of the employer. In light of the Court's exclusion of the radial arm saw from the scope of the proven violation, the Court finds

[82] *See Teichert Constr.*, 578 Fed.Appx. 647, 649 (9th Cir. 2014) (finding trucks were not inspected where no safety sheets in evidence); *U.S. ex rel. Compton v. Midwest Specialties, Inc.*, 142 F.3d 296, 303 (6th Cir. 1998) (noting the absence of a record of an event is probative of the fact that the event did not occur); *Wiley v. United States*, 20 F.3d 222, 227 (6th Cir. 1994)(same).

that proposed penalty of $4,900 is excessive. The proposed penalty of $3,900 is affirmed. (Tr. 274-76).

Citation 1, Item 7

The Secretary cited ARM for a serious violation of 29 C.F.R. § 1910.176(a) which requires:

> (a) *Use of mechanical equipment*. Where mechanical handling equipment is used, sufficient safe clearances shall be allowed for aisles, at loading docks, through doorways and wherever turns or passage must be made. Aisles and passageways shall be kept clear and in good repair, with no obstruction across or in aisles that could create a hazard. Permanent aisles and passageways shall be appropriately marked.

The Secretary alleged ARM did not keep its aisles and passageways clean and in good repair where its forklifts operated. Floor holes in two areas presented a hazard in the wood shop's loading dock area and in an aisle in the warehouse area. Specifically, the Secretary alleged that on or about December 3, 2012 there was a floor hole on the surface of the loading dock ramp, measuring 11 x 11 inches square and 3 to 4 inches in depth, at the southwest dock ramp in the wood shop area where forklifts traveled. The Secretary also alleged that at the same time there was a floor hole in the aisle between the two racks of shelves, measuring 7 inches in width and 1.5 inches deep, at Warehouse D, where forklifts operated. (Tr. 276-79, 927-28; Exs. 1, at p. 12, 21-24; S. Br. 53-54).

ARM agrees that the holes existed and does not dispute that forklifts operated in the loading dock or warehouse areas; however, ARM asserts the holes presented no hazard to forklift operation. (Tr. 614-16; Ex. U, at pp. 34, 36-38; R. Br. 25-26; Answer, p. 2)

Applicability & Employee Exposure

There is no dispute the standard is applicable. Employees, including Messrs. Rivera and David Pacheco, used forklifts in the two areas where the holes existed. Mr. Rivera testified that

forklifts travelled over the floor holes. CO Donofrio's photographs show tire tracks near the hole in the wood shop's dock area. Mr. Meindl confirmed that forklifts were operated in both areas. CO Donofrio saw at least two or three forklifts operating during his inspection. CO Donofrio testified that forklift operators could sustain knee and ankle injuries and broken bones when driving into floor holes. The Secretary has proved employee exposure to the cited hazard. (Tr. 118-20, 277-82, 355, 928-31; Exs. 21-24).

Violation of the Standard

In December, 2012, CO Donofrio measured and photographed two floor holes where forklifts were used.[83] The dock next to the wood shop area had a floor hole that measured approximately 11 x 11 inches square and was 3 to 4 inches in depth. The second hole, located in an aisle in Warehouse D, was approximately 7 inches in diameter with a hole in its center that was 1 ½ inches in depth. (Tr. 276-81; Exs. 21-24, U, at pp. 37-38).

Mr. Rivera testified that he had to be careful because the forklift would tilt and about half of the load fell off when it hit one of these holes. He stated that a load did not spill every time, it generally occurred "once a week or so." At one time, he painted one of the holes orange in an attempt to make it more visible to a forklift driver. Mr. Rivera also testified that some of the solid tires on the forklifts had chunks missing making them "wobble." (Tr. 118-20, 148; Exs. 21-24).

Mr. Miller testified that he believed neither hole presented a hazard or could make a forklift unstable. He testified that he did not believe it was necessary for a floor surface to be smooth and even for safe forklift operations. Mr. Miller observed, measured and photographed floor holes in June, 2013, several months later. He measured a tire on one of the forklifts at

[83] CO Donofrio could not recall which day in December 2012 or January 2013 he took the photographs. Because CO Donofrio testified that his January visit was specifically to collect wood dust samples, the Court finds the photographs were taken during one of the three December, 2012 visits to the facility. (Tr. 278-79).

"nearly 12 inches" at its smallest point. Based on the tire's size and the size of the holes, Mr. Miller concluded it was not possible that a forklift's load could shift or fall after driving over a hole. Mr. Miller admitted his opinion was based on a "visual calculation" and not based on any research about the relationship between tire size and forklift stability on uneven surfaces. (Tr. 613-14, 673-76, 682, 838-40; Exs. U, pp. 34, 37-38, W, p. 5).

Further, Mr. Miller admitted he had no information, other than CO Donofrio's photographs, about the condition of the holes when CO Donofrio observed them in December, 2012. The hole in Warehouse D photographed by Mr. Miller in June, 2013, does not appear in the same condition as when photographed by CO Donofrio in December, 2012.[84] (Tr. 686, 838; Exs. 21-24, U, pp. 4, 37-38).

ARM also asserts that the forklifts did not tip and drop product. Mr. Meindl testified that loads could not be falling off a forklift every week because it would appear on the inventory report he reviews. However, Mr. Meindl acknowledged the inventory report only applied to pallets prepared for customer orders and not to other materials being moved by forklift. Mr. Joslin confirmed that forklift drivers handled other materials, such as the pallets, that ARM repaired for reuse. Thus, a review of the inventory reports would not show loads falling off a forklift. (Tr. 736, 929-30, 937-38).

The Secretary has proved the cited standard was violated. Mr. Miller's opinion that the holes could not affect a forklift's stability was based on neither observation of the forklifts in use nor any data for forklift stability. To the contrary, Mr. Rivera's testimony is based on his personal experience working in the wood shop and driving the forklifts. Based upon personal

[84] The hole in Warehouse D photographed by Mr. Miller in June, 2013 had a steel mesh cover partially on top of it. Also, there are fasteners visible in Mr. Miller's photographs on the floor. There is no steel mesh cover or fasteners in CO Donofrio's photograph of the hole at Warehouse D. Mr. Miller opined that the steel mesh cover partially over the hole might have been ARM's attempt at abating the hazard and then the mesh cover was damaged. (Tr. 685-87; Exs. 24, U, at pp. 37-38).

observations of Mr. Rivera's demeanor during his testimony, the Court finds Mr. Rivera's testimony on this subject entirely credible.

The Secretary has proved that the areas where forklifts operated were not kept in good repair and the floor holes presented a hazard.

Employer Knowledge

Mr. Rivera's knowledge, as a supervisor, is imputed to ARM. The holes were plainly visible and with reasonable diligence other ARM management personnel could have observed the holes in the area the forklifts travelled. The Secretary has proved employer knowledge.

The Court finds that the standard is applicable, its terms were violated, employees were exposed and ARM had knowledge of the condition. The Secretary has proved his prima facie case for this citation item.

Serious Characterization & Penalty Amount

The Secretary properly classified Citation 1, Item 7 as serious because employees were exposed to knee and ankle injuries and broken bones when driving into floor holes. The gravity of the violation was assessed as medium severity and greater probability. There were no penalty reductions for good faith or history; however, a 30% reduction was given due to the small size of the employer. The proposed penalty of $4,200 is affirmed. (Tr. 282-83).

Citation 1, Item 8

The Secretary cited ARM for a serious violation of 29 C.F.R. § 1910.178(l)(1)(i)which requires:

> (l) Operator training. (1) *Safe operation.* (i) The employer shall ensure that each powered industrial truck operator is competent to operate a powered industrial truck safely, as demonstrated by the successful completion of the training and evaluation specified in this paragraph (l).

The Secretary alleges that ARM allowed its employees to operate forklifts without training. To prove a violation of a training requirement the Secretary must show "that the cited employer failed to provide the instructions that a reasonably prudent employer would have given in the same circumstances." *Compass Envtl., Inc.*, 23 BNA OSHC at 1134. "An employer's instructions must be 'specific enough to advise employees of the hazards associated with their work and the ways to avoid them,' and modeled on the applicable OSHA requirements." *O'Brien Concrete Pumping, Inc.*, 18 BNA OSHC at 2061 (finding the employer had provided training; however the training was inadequate because it lacked specific instructions and left each employee to develop his own methods). (Tr. 283-84; Ex. 1, p. 13; S. Br. 55).

Applicability, Violation, Employer Knowledge and Exposure

The standard is applicable and employees were exposed to the hazard. Respondent admits that it had not trained all the employees that operated forklifts as of December 3, 2012.[85] CO Donofrio observed employees driving forklifts, but saw no records at ARM that showed that its employees had received forklift training.[86] Messrs. Rivera and Lebron testified that they operated forklifts at ARM and had no training. Mr. Rivera testified that four or five employees that operated forklifts were not trained. Mr. Rivera read the information posted on the forklift to learn how to operate it. Mr. Joslin testified that he knew the forklift drivers needed to be trained and had ordered materials to train all of ARM's forklift drivers.[87] In an October 9, 2012 email, Mr. Joslin told Mr. Meindl that help was needed to provide "forklift training for our employees."

[85] CO Donofrio testified that he believed two employees "possibly had been trained." The identity of these two employees is not in the trial record. (Tr. 356).

[86] ARM's Safety Manual called for Forklift training records to be retained. There are none in the trial record. (Ex. A, Vol. 1, § XVII, p. 6). *See Teichert Constr.*, 578 Fed.Appx. at 649 (finding trucks were not inspected where no safety sheets in evidence), *U.S. ex rel. Compton v. Midwest Specialties, Inc.*, 142 F.3d at 303 (6th Cir. 1998)(noting the absence of a record of an event is probative of the fact that the event did not occur); *Wiley v. United States*, 20 F.3d at 227 (6th Cir. 1994)(same).

[87] CO Donofrio testified that Mr. Joslin admitted to him during the OSHA inspection that ARM's forklift operators had not yet been trained. (Tr. 284).

Messrs. Rivera's and Joslin's knowledge is imputed to ARM. (Tr. 70-71, 117-18, 148, 167, 284-86, 356, 703, 839; Ex. G, pp. ARM 38-41; R. Br. 26).

The Court finds the standard is applicable, its terms were violated, employees, including Messrs. Anieal Rodriguez, Pacheco, Rivera, Lebron, Jose Morales, and Luis Nieves, were exposed to the hazard, serious injury and death, and ARM management knew training had not been provided.[88] The Secretary has proved his prima facie case for this citation item. (Tr. 285-87).

Serious Characterization & Penalty Amount

The Secretary properly classified Citation 1, Item 8 as serious. Employees operating forklifts trucks without training were exposed to serious injury and death. The gravity of the violation was assessed as high severity and greater probability. There were no penalty reductions for good faith or history; however, a 30% reduction was given due to the small size of the employer. The proposed penalty of $4,900 is affirmed. (Tr. 285-88).

Citation 1, Item 9

The Secretary cited ARM for a serious violation of 29 C.F.R. § 1910.213(h)(4) which requires:

> (h) *Radial saws*. . . . (4) Installation shall be in such a manner that the front end of the unit will be slightly higher than the rear, so as to cause the cutting head to return gently to the starting position when released by the operator.

Specifically, the Secretary alleged that the condition of the radial arm saw #4 in ARM's wood shop on about December 3, 2012 "was such that after making the cut, the saw did not return to the starting position creating a contact with moving saw blade hazard." (Tr. 288-89; Ex. 1, p. 14).

[88] CO Donofrio also testified that untrained forklift operators also put other employees in the operating area at risk of being struck by moving forklifts. (Tr. 287).

On his December 19, 2012 visit, CO Donofrio tested the saw and observed that it would not automatically return to its starting position upon release, as it was designed to do. He testified that this "created a contact hazard with the moving saw blade."[89] Messrs. Lebron and Rivera both used the radial arm #4 saw and testified that the blade did not properly return to its starting position automatically when released.[90] Mr. James also regularly used the saw. ARM admits the saw was not properly returning to its starting position.[91] Mr. Rivera's knowledge as a supervisor is imputed to ARM. (Tr. 73-74, 112, 115-17, 288-92, 357-58; Ex. 25; R. Br. 26).

The Court finds that the standard is applicable, its terms were violated, employees were exposed and ARM had knowledge of the condition. The Secretary has proved a violation of the cited standard.

Serious Characterization & Penalty Amount

The Secretary properly classified Citation 1, Item 9 as serious. Employees working on the radial arm saw were exposed to cut and amputation injuries. The gravity of the violation was assessed as high severity and greater probability. There were no penalty reductions for good faith or history; however, a 30% reduction was given due to the small size of the employer. The proposed penalty of $4,900 is affirmed. (Tr. 292-93).

Citation 1, Item 10

The Secretary cited ARM for a serious violation of 29 C.F.R. § 1910.213(r)(4) which requires:

---

[89] CO Donofrio further testified:
Q [] Now, what part of the radial arm saw should have returned to the starting position after release?
A The motor, saw blade hood, the entire assembly of the radial arm saw needs to return to this position as shown in the photograph after use." (Tr. 290).
[90] Mr. Lebron testified that he had to apply pressure to push the blade back into the correct position. (Tr. 74).
[91] ARM's Internal Corrective and Prevention Action Form, dated December 18, 2012, stated that the radial arm saw "does not return" and that it "was purchased in this condition." (Tr. 733; Ex. L, p. ARM 275).

> (r) *Miscellaneous woodworking machines.* . . . (4) The mention of specific machines in paragraphs (a) thru (q) and this paragraph (r) of this section, inclusive, is not intended to exclude other woodworking machines from the requirement that suitable guards and exhaust hoods be provided to reduce to a minimum the hazard due to the point of operation of such machines.[92]

The Secretary alleges the blade (point of operation) of the pop-up saw was not adequately guarded when cutting wood stock.[93] Point of operation is defined as "that point at which cutting, shaping, boring, or forming is accomplished upon the stock." 29 C.F.R. § 1910.211(a)(1). CO Donofrio testified that the pop-up saw's point of operation was "[w]here the saw blade popped up through the slot on the saw." Respondent asserts the saw was guarded and any additional guarding for the pop-up saw was not: 1) supplied by the manufacturer, 2) typical in the industry, or 3) feasible. (Tr. 215-16; Exs. 28, at "A", W, p. 5; S. Br. 57, R. Br. 26-27).

Applicability

The applicability of the standard is not in dispute. The hazardous condition relates to the use of the pop-up saw during normal production operations. The cited standard applies.

Violation of the Standard

The Secretary asserts the pop-up saw's overhead hood was not adjusted to provide suitable guarding. The pop-up saw's blade was housed in a cabinet when it was not cutting wood stock. CO Donofrio testified that he measured the entire saw blade at 18 to 20 inches in diameter. The cabinet protected the employee from the saw blade and other moving parts when the machine was on and the blade was not making a cut. Above the cabinet's surface, the "hold down" hood was over the area of the blade. When the foot pedal was depressed the first time,

---

[92] "Point of operation guarding. (i) Point of operation is the area on a machine where work is actually performed upon the material being processed. (ii) The point of operation of machines whose operation exposes an employee to injury, shall be guarded. The guarding device shall be in conformity with any appropriate standards therefor, or, in the absence of applicable specific standards, shall be so designed and constructed as to prevent the operator from having any part of his body in the danger zone during the operating cycle." 29 C.F.R. § 1910.212(a)(3)

[93] The first citation issued May 30, 2013 included two instances of a violation for Citation 1, Item 10; the Secretary withdrew instance (b) at the start of the trial. (Tr. 17-18, 294).

the hood came down to cover the top portion of the spinning blade and hold the stock being cut in place.[94] The blade rose up through the cabinet to make the cut when the foot pedal was depressed the second time. When the cut was completed, the blade descended back inside the cabinet. CO Donofrio testified that when the saw operator was cutting a piece of wood that was six inches across, the remaining 12 to 13 inches of the saw blade was an exposed hazard. The hood was designed to stop at the top edge of the wood stock being cut and hold the stock down. For example, if the wood stock was 2 inches thick, the hood should be set to come down to 2 inches above the cabinet's surface in order to "hold down" the wood being cut. (Tr. 181, 187-88, 297, 359-60, 367, 757-60, 766-67; Exs. 1, p. 15, 26-30, 53, U, p. 30, at "A").

On December 3, 2012, CO Donofrio photographed the pop-up saw and measured the distance between the top of the wood stock being cut and the bottom of the hood.[95] The pop-up saw had not been changed since the accident occurred earlier that day. The hood was lowered to its lowest position for the photographs. The hood did not touch the wood stock resulting in a 2 ½ inch gap between the top edge of the wood stock and the hood.[96] As a result, the hood did not touch and hold the wood stock being cut. CO Donofrio identified the area of the pop-up saw that should have been guarded to prevent employee exposure to the saw blade. (Tr. 189-91, 295-98, 358-59, 363, 766-67, 914; Exs. 26, at "A", 27-28).

A large screw on the side of the hood adjusted the hood's height. A caution sign posted on the hood stated, "Keep this hold down adjusted to within 1/4" and 3/8" of top of wood being cut, per saw instruction sheet." Messrs. Joslin and Meindl told CO Donofrio that at the time of

---

[94] The "hold down" hood holds the wood stock in place only when it is properly adjusted.

[95] Mr. Meindl testified that the condition of the pop-up saw did not change between the time of Mr. Lebron's accident and when CO Donofrio arrived at the ARM facility on December 3, 2012. While not specifically testified to, it appears the wood was the same piece being cut at the time of the accident. Blood is visible in the photograph. (Tr. 914; Ex. 27).

[96] The Court notes that the wood in the photograph appears to be the same wood that Mr. Lebron was cutting at the time of the accident. (Ex. 27).

the accident no adjustments had been made to the hood since its purchase in April, 2012. (Tr. 360-61, 768; Exs. 27, U, p. 5).

On December 19, 2012, CO Donofrio recorded a video of the action of the pop-up saw. The video shows that the hood drops down, as the saw blade comes up through the slot to make the cut. (Tr. 188). In the video, the hood lowered fully with no significant gap between the wood stock and the hood. CO Donofrio testified that the pop-up saw functioned similarly on December 3, 2012; however, on December 3 there was the 2 ½ inch gap between the wood stock and the hood. (Tr. 187-90, 297-98; Exs. 28, 53).

The Court finds the Secretary has proved that ARM did not adjust the hood to provide adequate protection on December 3, 2012.

ARM asserts that a 5-inch wide piece of plexiglass horizontally attached to the hood of the pop-up saw was a guard because it created an additional distance of 6 inches from the point of operation. CO Donofrio testified that when he first observed the pop-up saw on December 3, 2012, it did not have an adequate guard. He said that the plexiglass was not a guard because it did not prevent access to the point of operation; *i.e.* the saw blade and the slotted area it rose into when activated by the foot pedal. ARM was required to guard this point of operation and failed to do so. During his testimony, Mr. Miller consistently referred to the piece of plexiglass as an "awareness barrier" and not a guard.[97] Mr. Miller never saw the pop-up saw actually cut wood. The Court finds the plexiglass awareness barrier was not a suitable guard. (Tr. 202, 215, 296-97, 598, 604, 608, 613, 759-60; Exs. 27, at "A" and "B", 30, at "D", 55, at "E", U, pp. 1-3; R. Br. 26-27).

[97] The Court notes the plexiglass was attached to the hood, so when the hood was up, the plexiglass was as well. (Ex. 26).

Signage on the saw explained that additional guarding might be needed. The sign on the side of the pop-up saw's cabinet stated:

> The necessary shields or guards vary with individual installations. The owner or user must provide the required safety guards not furnished with this equipment….
>
> Do not operate this equipment without the required safety guards….
>
> Make sure machine is guarded before applying power.

This signage makes it clear that the manufacturer anticipated the guard that was originally attached to the saw could be inadequate for certain conditions and that the user would need to determine if additional guarding was required. ARM's argument that additional guarding was not needed because it was not provided by the manufacturer is rejected. Mr. Miller testified that he was not of the opinion there was no requirement to guard the pop-up saw if a guard was not provided by the manufacturer. (Tr. 139-40, 223, 298-99, 751, 841; Exs. 29, I, p. ARM 216).

ARM also asserts that it was not standard practice in the industry to have more guarding on this saw beyond what was there on December 3, 2012; *i.e*. a hood. Other than a general statement that an adjustable or self-adjustable guard was common in woodworking equipment, ARM offered no additional information about the industry standard for guarding on a pop-up saw. ARM's assertion that additional guarding beyond the hood is not the industry norm is unsubstantiated and rejected. (Ex. W, p. 5; R. Br. 27).

The Court finds that the pop-up saw was not adequately guarded. Mr. Rivera testified that the pop-up saw did not have any guard before December 3, 2012. The pop-up saw's overhead hood had not been adjusted to maximize its protection. The Court finds that the overhead hood was insufficient to serve as an adequate guard.[98] Further, ARM made no efforts to obtain other suitable guarding for the pop-up saw. The Secretary has proved ARM violated the terms of the standard. (Tr. 123,131).

[98] CO Donofrio testified that the hood only partially guarded the saw blade on December 3, 2012. (Tr. 358).

Employee Exposure

The Secretary has established that employees were using the pop-up saw and were exposed to an amputation hazard due to inadequate guarding. Mr. Miller testified that the pop-up saw operator could put his hand in a position of danger if he reached underneath the hood. Messrs. Lebron, Rivera, and Khadka testified they had used the pop-up saw.[99] Mr. Lebron was using the saw on the day of the accident. He testified that there was nothing on the pop-up saw that prevented him from placing his arm and hand over the area of the saw blade, where they were at the time his hand was amputated. Instructions to "[k]eep this hold down adjusted to within 1/4" and 3/8" of top of wood being cut" and to "[n]ever place hands or fingers under this guard" were on the side of the hood that was opposite to where Mr. Lebron was positioned at the time of the accident. These instructions were not visible to Mr. Lebron at the time of the accident and he could not read or understand them anyway. (Tr. 84-88, 112, 123, 137, 299, 761-62, 768, 888-89; Exs. 26, U, p. 5).

Employer Knowledge

Both Messrs. Meindl and Rivera used the pop-up saw. Mr. Rivera knew the pop-up saw did not have a guard. The knowledge of Messrs. Meindl and Rivera is imputed to ARM. The Court finds the Secretary has proved ARM knew the pop-up saw was inadequately guard. (Tr. 123, 137, 918).

The Court finds that the standard is applicable, its terms were violated, employees were exposed and ARM had knowledge of the condition. The Secretary has proved his prima facie case for this citation item.

Infeasibility

[99] CO Donofrio testified that Mr. Martinez was also exposed to the hazard. (Tr. 299).

Because infeasibility is an affirmative defense, Respondent carries the burden of proof. *Hamilton Fixture*, 16 BNA OSHC at 1077. To prove the defense of infeasibility the employer must show that the means of compliance set forth in the standard were infeasible under the circumstances and that either an alternative means of protection was used or there was no feasible alternative means of protection available. *V.I.P. Structures, Inc.*, 16 BNA OSHC 1873, 1874 (No. 91-1167, 1994). Infeasibility can be either economic or technological. *Id.* The Commission expects "employers to exercise some creativity in seeking to achieve compliance." *Gregory & Cook, Inc.*, 17 BNA OSHC 1189, 1191 (No. 92-1891, 1995).

First, ARM has not proved that the compliance required by the guarding standard was infeasible under the circumstances. ARM purchased the pop-up saw from an online auction in April, 2012, but never obtained the name of the manufacturer and did not make an inquiry about available guarding. ARM did not correctly use the attached hood. A plate attached to the hood plainly stated it must be adjusted to accommodate the size of wood stock so that a space of no greater than 3/8-inch existed between the stock and the bottom of the hood. The plexiglass "awareness barrier" was not a substitute for an adequate guard. (Ex. T, p. 2).

Second, ARM did not present evidence that it made any efforts to devise an alternative method, or that no other feasible means of protection was available. The "Caution" sign on the pop-up saw's cabinet shows that guarding was feasible, anticipated and required. ARM has failed to satisfy its burden of proof to establish infeasibility as an affirmative defense. ARM's affirmative defense of infeasibility is rejected.[100] (Tr. 298-99; Ex. 29).

Serious Characterization & Penalty Amount

[100] ARM also asserted the affirmative defense of unpreventable employee misconduct for this item in the joint pre-hearing statement. It is unclear to the Court if it still pursued this defense in its post-hearing brief. This defense is discussed at Citation 2, Items 1 and 2 below. For the same reasons discussed below, the defense fails for Citation 1, Item 10.

The Secretary properly classified Citation 1, Item 10 as serious. Employees working on the pop-up saw without adequate guarding were exposed to laceration and amputation injuries. The gravity of the violation was assessed as high severity and greater probability. There were no penalty reductions for good faith or history; however, a 30% reduction was given due to the small size of the employer. The proposed penalty of $4,900 is affirmed. (Tr. 299-301).

Citation 1, Item 11a

The Secretary cited ARM for a serious violation of 29 CFR § 1910.303(b)(2) which requires:

> (b) *Examination, installation, and use of equipment* . . . (2) Installation and use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling.

The Secretary alleges that on December 19, 2012 a relocatable power tap (RPT) in the core cutter area was not used in accordance with its listing and labeling instructions when it used an extension cord as its power source for a portable light, portable sander, personal radio, and motor for the Core Tech machine, exposing employees to a fire hazard. (Tr. 301-02; Ex. 1, p. 16; S. Br. 61).

Respondent argues that this citation item should be vacated because the RPT was not overloaded and in plain view of the area that generated the complaint; *i.e*. the pop-up saw in the woodshop area.[101] ARM asserts the RPT was outside the proper scope of the inspection. Mr. Joslin testified that the core cutter area was in the same room as the wood shop and could be

[101] Respondent also asserted that the Secretary had changed his basis for the citation without warning at the hearing or in his post-hearing brief. Respondent asserts that the citation listed the hazard as the "potential for overload." However, Respondent is incorrect. The first citation stated that the RPT in the core cutter area that was being used to power 4 pieces of equipment "was not used or installed in accordance with instructions included in the listing or labeling." Citation 1, Item 11a did not specify that potential for overload was the issue – the issue was off-label use of the RPT. Respondent chose to argue that the RPT was not overloaded. The Court finds that the Secretary did not change the basis for the citation and Respondent's argument is baseless as a defense to it. (Ex. 1, p. 16; R. Br.14, R. Reply Br. 14).

seen. The core cutter area was just 50 feet from the wood shop area. The Court finds the core cutter area was visible from the location of the pop-up saw. As discussed earlier, CO Donofrio's observation of this violation was within the proper scope of his inspection. (Tr. 736-37; R. Br. 28).

Applicability and Employee Exposure

CO Donofrio testified that ARM's use of the RPT to supply power to the light, sander, radio and motor exposed Mr. Khadka to a fire hazard. The Court finds that the standard is applicable and employee exposure is established. There is no dispute the standard applies to ARM's facility. Mr. Khadka operated the core cutter machine that was plugged into the RPT establishing employee exposure to the hazard. (Tr. 306-07, 888).

Violation of the Standard

The Secretary has proved it is against the labeling and instructions to connect an RPT to an extension cord. The Underwriters Laboratory (UL) guide for use of relocatable power taps states, "[r]elocatable power taps are intended to be directly connected to a permanently installed branch circuit receptacle. Relocatable power taps are not intended to be series connected (daisy chained) to other relocatable power taps *or to extension cords*." (emphasis added) (Tr. 774; Ex. 38; S. Br. 61).

During his December 19, 2012 visit to ARM's facility, CO Donofrio observed and photographed a RPT in the core cutter area that was used to supply power to 4 pieces of equipment: 1) the motor of the core cutter machine, 2) a portable light, 3) a portable sander, and 4) a personal radio. The core cutter was plugged into the RPT. The RPT was plugged into an extension cord. The CO photographed the extension cord plugged into the wall outlet. ARM

does not dispute that the pieces of equipment were plugged into the RPT.[102] Mr. Miller testified that the RPT was plugged into the extension cord. The RPT was not being used by ARM in accordance with UL instructions. The Secretary proved that ARM violated the terms of the standard. (Tr. 301-05, 316, 371, 775, 848; Exs. 35-37; R. Br. 27-28).

Employer Knowledge

There is no evidence of actual knowledge by a supervisor or manager. The Commission has held that constructive knowledge may be found when an employer was not reasonably diligent in checking the work place for violations. *Texas A.C.A., Inc.*, 17 BNA OSHC 1048, 1050 (No. 91-3467, 1995). One of Mr. Joslin's tasks was to create a better work flow. Mr. Joslin stated that they were "streamlining all the time" to create efficiencies in the equipment configuration. Mr. Miller confirmed that the core cutter was a piece of equipment in a temporary position. Managers, and in particular, Mr. Joslin were integral to the design of the lean manufacturing set up. The RPT in the core cutter area was plainly visible, and with reasonable diligence, Mr. Joslin could have known that when placed in this temporary configuration the RPT would be plugged into an extension cord as its power source. Constructive knowledge is imputed through Mr. Joslin. (Tr. 307, 506, 715, 775, 849-50).

The Court finds that the standard is applicable, its terms were violated, employees were exposed and ARM had constructive knowledge of the condition. The Secretary has proved his prima facie case for this citation item.

Citation 1, Item 11b

The Secretary cited ARM for a serious violation of 29 C.F.R. § 1910.304(g)(5) which

[102] In making these plug-in findings, the Court is cognizant of CO Donofrio's later negative responses to questions as to whether the RPT was plugged into the extension cord or the core cutter was plugged in. Neither party raised these seeming contradictions with the CO's preceding testimony that they were plugged in. The Court resolves any discrepancy with CO Donofrio's response to a subsequent question where he stated that there was a missing pin on the RPT's plug, thereby effecting whether a proper plug-in connection was, or could be, made. (Tr. 370-74, 848).

requires:

> (5) *Grounding path*. The path to ground from circuits, equipment, and enclosures shall be permanent, continuous, and effective.

The Secretary alleges on December 19, 2012 the RPT in the core cutter area being used to supply power to a portable light and sander, personal radio, and motor for the Core Tech machine was missing its grounding pin and thus the grounding path was not continuous, exposing employees to contact with electrical current. (Tr. 308; Ex. 1, p. 17; S. Br. 61).

As with item 11a above, Respondent's argues that this condition was outside the proper scope of CO Donofrio's inspection. As discussed above, the RPT in the core cutter area was within the proper scope of the inspection. Respondent's argument is rejected. (R. Br. 28).

Applicability and Employee Exposure

CO Donofrio testified that the missing ground pin on the RPT plug exposed Mr. Khadka to an electrical shock hazard. The Court finds that the standard is applicable and employee exposure is established. There is no dispute the standard applies to ARM's facility.[103] The core cutter was plugged into the RPT, which was missing its grounding pin at the male end. Mr. Khadka operated the core cutter machine that was plugged into the RPT establishing employee exposure to the hazard. (Tr. 307, 310, 372, 775, 848, 888).

Violation of the Standard

The CO observed and photographed the missing ground pin on the plug of the RPT. The core cutter machine was plugged into the RPT with a missing ground pin. The path to ground was not continuous and effective. The standard was violated. (Tr. 308-10, 372; Exs. 39, at "A", 40).

Employer Knowledge

[103] Mr. Miller did not address this citation item in his expert report. (Ex. W).

The Secretary asserts the RPT was in plain view and visible to any member of management working in the area. There is no evidence ARM's supervisory employees had actual knowledge of the missing grounding pin on the RPT plug-in. The Commission has held that constructive knowledge may be found when an employer was not reasonably diligent in checking the work place for violations. *Texas A.C.A., Inc.*, 17 BNA OSHC at 1050. The RPT plug with its pin missing shown in the photograph taken by CO Donofrio on December 19, 2012 looks old and worn. It was readily visible to CO Donofrio during his walk through the core cutter area. The Court finds that an ARM supervisor, acting with reasonable diligence, walking through the area would have also identified the hazard. The Secretary has established constructive knowledge. (Tr. 307-09; Ex. 39).

The Court finds that the standard is applicable, its terms were violated, employees were exposed, and ARM had constructive knowledge of the missing grounding pin on the RPT plug. Citation 1, Item 11b is affirmed.

Serious Characterization & Penalty Amount

The Secretary properly classified Citation 1, Items 11a and 11b, as serious. Employees working on the equipment plugged into the 'unsafe' noncompliant power tap were exposed to shock and burn hazards.[104] The gravity of the violation was assessed as medium severity and greater probability. There were no penalty reductions for good faith or history; however, a 30% reduction was given due to the small size of the employer. The proposed penalty of $4,200 is affirmed. (Tr. 311).

Citation 1, Item 12

[104] Citation 1, Item 11a stated the alleged violation exposed employees to a fire hazard. Mr. Miller opined that the equipment plugged into the RPT did not create a risk of fire. CO Donofrio testified that the violation exposed employees to a burn and shock hazard. Citation 1, Item 11a is affirmed to the extent that employees were exposed to a burn and shock hazard, and not as to a fire hazard. (Tr. 310-11, 774-75).

The Secretary cited ARM for a serious violation of 29 C.F.R. § 1910.305(b)(1)(ii) which requires:

> (b) *Cabinets, boxes, and fittings* -- (1) *Conductors entering boxes, cabinets, or fittings*. . . . (ii) Unused openings in cabinets, boxes, and fittings shall be effectively closed.

The Secretary alleges an opening in the electrical disconnect box was not effectively closed on December 4, 2012. The disconnect box controlled the power to the panel saw dust collector motor. The opening allowed combustible wood dust to accumulate inside the electrical box creating a fire hazard. (Tr. 311-15, 372-73; Exs. 1, p. 18, 41, at "B"; S. Br. 62).

The Court finds, and there is no dispute, the cited standard is applicable. On December 4, 2012, CO Donofrio saw and photographed a knockout missing on the local disconnect for the panel saw dust collector cyclone motor. He testified that wood dust was accumulated on the disconnect box. He further testified that the missing knockout created a fire hazard because "it would allow wood dust to enter the electrical contacts inside the box leading to the possibility of a fire starting inside the box." He said that Messrs. Rivera, Lebron, Martinez, and James were exposed to the fire hazard and resulting burns. ARM admits the disconnect box had an unused opening that was not closed. The disconnect box was in the wood shop area near the pop-up and panel saws so employees were exposed to the hazard. Further, the disconnect box was in the area of the shop where Mr. Rivera routinely worked and was in plain view. Mr. Rivera's knowledge is imputed to ARM. (Tr. 137, 312-14, 372-73; Ex. 41, at "A"; R. Br. 28).

The Court finds that the standard is applicable, its terms were violated, employees were exposed and ARM had knowledge of the condition. The Secretary has proved his prima facie case for this citation item.

Serious Characterization & Penalty Amount

The Secretary properly classified Citation 1, Item 12 as serious. ARM did not provide a reason for its assertion that the violative condition was not serious. Employees working in the vicinity of the disconnect box were exposed to burn hazards from a fire starting in the disconnect box. The gravity of the violation was assessed as medium severity and greater probability. There were no penalty reductions for good faith or history; however, a 30% reduction was given due to the small size of the employer. The proposed penalty of $4,200 is affirmed. (Tr. 313-15, 809; R. Br. 28).

Citation 1, Item 13

The Secretary cited ARM for a serious violation of 29 C.F.R. § 1910.305(g)(1)(iv)(A) which requires:

> (g) *Flexible cords and cables* -- (1) *Use of flexible cords and cables*. . . . (iv) Unless specifically permitted otherwise in paragraph (g)(1)(ii) of this section, flexible cords and cables may not be used: (A) As a substitute for the fixed wiring of a structure;

The Secretary alleges that extension cords were used in lieu of fixed wiring in two instances, for the core cutter area (instance a) and for the pallet stacker machine (instance b). ARM asserts that it was using extension cords to supply power because the equipment was in a temporary configuration; they were not a substitute for fixed wiring. (Tr. 315-16; Ex. 1, p. 19; S. Br. 63, R. Br. 28).

Applicability

ARM asserts that because the equipment was in a temporary configuration the standard is not applicable. ARM provides no case law that an exception for temporarily located equipment is allowed. The Court finds no basis to provide an exception to the requirements of the standard. ARM's argument is rejected and the Court finds the standard is applicable. (R. Br. 28; R. Reply 15).

Violation of the Standard

CO Donofrio testified that on December 19, 2012 he observed and photographed a flexible extension cord that was being used to supply power to a RPT[105] that was supplying power to 4 pieces of equipment: 1) the motor of the core cutter machine, 2) a portable light, 3) a portable sander, and 4) a personal radio, in the core cutter area. Mr. Miller also testified that he saw the RPT plugged into the extension cord (instance a). His expert report stated that "extension cords were used to supply power for temporary equipment configurations, and not as a substitute for fixed wiring." Mr. Miller admitted that this was "not the most appropriate use" of an RPT and extension cord. CO Donofrio also testified he observed and photographed an extension cord being used to supply power to the control pedestal for the pallet stacker (instance b). (Tr. 302, 316-17, 775, 851; Exs. 1, at p. 19, 35-36, 42; Ex. W, p. 6).

ARM argues there is no violation because the equipment was in its temporary configuration as a part of ARM's lean manufacturing work flow study. As noted above, this argument fails. There is no exception to the requirements of the standard for temporary equipment locations. For instance a, the Court finds that an extension cord was used in lieu of fixed wiring to power the RPT in the core cutter area in violation of the standard. (Tr. 775; R. Br. 28).

For instance b, the Secretary alleges that the control pedestal for the pallet stacker machine used an extension cord for its power supply. The photograph at Exhibit 42, at "B", shows the plug (male end) for the control pedestal near to the female end of an orange extension cord. CO Donofrio testified that he did not see the control pedestal plugged into the extension cord at the time of his inspections. (Tr. 316-17, 321-22, 374; Ex. 42, at "B").

Employee Exposure

[105] This is the same RPT that is the subject of Citation 1, Items 11a and 11b above. (Tr. 373).

CO Donofrio testified that the use of the extension cord to provide power to the RPT that was supplying power to 4 pieces of equipment exposed Mr. Khadka to an electrocution hazard for instance a. Mr. Khadka testified that he used the core cutter machine at the time of the inspection. The Court finds the Secretary has proved employee exposure to the hazardous condition for the first instance. (Tr. 307, 318, 888).

However, for instance b, the Secretary did not prove that the pallet stacker had been used or was expected to be used by any employee in this location in the wood shop on or about December 19, 2012.[106] CO Donofrio was unable to identify any employee, by name or position, that was exposed to a hazard relating to the use of an extension cord to supply power to the control pedestal for the pallet stacker. He testified that the pallet stacker was not plugged in. He never saw the extension cord plugged into the pallet stacker. The Secretary must show that an extension cord was used or likely to be used to supply power to the pallet stacker by an employee. The record is silent as to whether the pallet stacker was being used on about December 19, 2012, or who used it at or about that time. The Secretary has not proved employee exposure to the hazard for Citation 1, Item 13b. (Tr. 318-22, 374).

Employer Knowledge

The Secretary asserts the extension cord supplying power to the core cutter machine was in plain view and with reasonable diligence ARM could have known of its use. ARM states that Mr. Joslin and other management had moved the equipment around to create a lean manufacturing set-up. Management should and could have known that permanent wiring was not available in the temporary location of the core cutter and that an extension cord would be used to power the equipment. Mr. Joslin was responsible for implementing the lean

[106] CO Donofrio testified that a fire could result in second-degree burns to any employee that used an extension cord to supply power to the power tap in the pallet stacker. (Tr. 317).

manufacturing plan to improve efficiency. It is reasonable that he could have known that flexible wiring would be used in lieu of fixed wiring when a piece of equipment was relocated. The Secretary has proved constructive knowledge in instance a. (Tr. 318, 506, 715, 849-50; Ex. 36).

The Court finds for instance a: the standard is applicable, its terms were violated, at least one employee was exposed and ARM had knowledge of the condition. The Secretary has proved his prima facie case for Citation 1, Item 13a, only. The Secretary did not prove employee exposure for Citation 1, Item 13b.

Serious Characterization & Penalty Amount

The Secretary properly classified this citation item as serious. Employees were exposed to burn and electrocution hazards from the improper use of extension cords to power equipment. The gravity of the violation was assessed as medium severity and greater probability. There were no penalty reductions for good faith or history; however, a 30% reduction was given due to the small size of the employer. The Secretary proposed a penalty of $4,200 for Citation 1, Item 13, that contained two instances at a) and b). The proposed penalty is excessive in light of the Court vacating Citation 1, Item 13b). The penalty is lowered to $2,100. (Tr. 317-20).

Citation 1, Items 14a & 14b

For Citation 1, Item 14a, the Secretary cited ARM for a serious violation of 29 C.F.R. § 1910.1200(e)(1), which requires:

> (e) *Written hazard communication program.* (1) Employers shall develop, implement, and maintain at each workplace, a written hazard communication program which at least describes how the criteria specified in paragraphs (f), (g), and (h) of this section for labels and other forms of warning, safety data sheets, and employee information and training will be met, and which also includes the following: (i) A list of the hazardous chemicals known to be present using a product identifier that is referenced on the appropriate safety data sheet (the list may be compiled for the workplace as a whole or for individual work areas); and,

> (ii) The methods the employer will use to inform employees of the hazards of non-routine tasks (for example, the cleaning of reactor vessels), and the hazards associated with chemicals contained in unlabeled pipes in their work areas.

For Citation 1, Item 14b, the Secretary cited ARM for a serious violation of 29 C.F.R. § 1910.1200 (h)(1), which requires:

> (h) Employee information and training. (1) Employers shall provide employees with effective information and training on hazardous chemicals in their work area at the time of their initial assignment, and whenever a new chemical hazard the employees have not previously been trained about is introduced into their work area. Information and training may be designed to cover categories of hazards (e.g., flammability, carcinogenicity) or specific chemicals. Chemical-specific information must always be available through labels and safety data sheets.

For item 14a, the Secretary alleges that ARM did not develop, implement and maintain a written hazard communication program. For item 14b, the Secretary alleges that on about December 3, 2012 ARM failed to train its employees on the hazardous chemicals present in the workplace. ARM concedes that it did not provide training to its employees; however, it asserts that its safety manual included a written hazard communication program.[107] (Tr. 322-24; Exs. 1, pp. 20-21, 2, p. 13, A, § XX; S. Br. 64-65, R. Br. 28).

Applicability

The standard defines a hazardous chemical as "any chemical which is classified as a physical hazard or a health hazard, a simple asphyxiant, combustible dust, pyrophoric gas, or hazard not otherwise classified." 29 CFR § 1910.1200(c). ARM had several hazardous chemicals at its facility, including liquefied compressed gas, solvents, cleaners, and combustible wood dust. Respondent does not dispute the requirements of the cited standards apply to its

[107] In its post-hearing reply brief, ARM alleges that the Secretary has changed his theory of the case; instead of alleging ARM had no program, the Secretary instead alleges the program was deficient. The Court finds this argument is without merit. The citation issued May 30, 2013 included a reference to the adequacy of the program: "[t]he employer did not develop, implement, and/or maintain at the workplace, a written hazard communication program which describes how the criteria specified in 29 CFR 1910.1200 (f), (g), and (h) will be met." *See* Citation. (Ex. 1, p. 20; R. Reply Br. 15).

workplace. The Secretary has shown hazardous chemicals were present at ARM's facility; the Court finds the standard applies. (Tr. 325-27, 330; Exs. 43-50; R. Br. 28).

Violation of Standard

CO Donofrio testified that during his [December 3, 2012] inspection, he determined that employees used and handled hazardous chemicals, such as liquefied petroleum (LP) gas, and various solvents and cleaners, including LPS, a flammable aerosol. He also saw that employees were exposed to combustible dust. He testified that employers were required to have a written hazard communication program that met the criteria of 29 C.F.R. § 1910.1200(e)(1). Mr. Joslin told him that ARM did not have a written hazard communication program. Mr. Rivera testified that he never saw a hazard communication program. CO Donofrio testified that he looked at the hazard communication section of ARM's safety manual and found it to be generic in nature and not site specific. He said it did not specifically address what particular actions ARM took or describe how ARM would inform employees about hazardous chemicals, where it kept MSDS, and other required information. It did not list any of the specific chemicals located at ARM's facility. ARM's Employee Handbook's Hazard Communication section also failed to list any chemicals present at the facility.[108] (Tr. 111, 166, 322-25, 375, 408-09, 742. 852-53; Exs. 43, A, Vol. 1, § XX, B, p. ARM 1072).

ARM asserts that it did not violate the standard cited in item 14a because it had a Hazcom program in its safety manual. ARM's safety manual includes a section entitled "Hazard Communication Safety Program."[109] It states that an employer must "[c]omplete the written program" and "[m]aintain a written hazard communication program." It also refers the employer to an "attached form for a sample program template." The form entitled "Hazard

[108] Although ARM had some MSDS at the facility, they were written in English and the majority of the workers at ARM did not communicate using English. (Tr. 110, 376-377, 410, 415, 701, 744; Exs. 44-50).
[109] Section XX is comprised of nine pages and seven pages of blank forms. (Ex. A, § XX, pp. 3-21).

Communication Written Program" states its purpose is "to document how the Hazard Communication requirements are met." It called for ARM to fill in information relating to "General" requirements, "Hazard Warning Labels", "MSDS for Company Made or Manufactured Chemicals", "Contractors or Off-site Work", and "Information and Training." (Tr. 325, 503-04, 522; Ex. A, § XX, ¶ 3.1.4, pp. 3, 5; R. Br. 28).

Mr. Miller reviewed the Hazcom section of ARM's safety manual as part of his general assessment. Mr. Miller testified that ARM's manual included forms entitled, "Hazard Communication Written Program," "Hazard Communication Program Assessment Checklist," and "Chemical Inventory List" that had not been completed by anyone. Mr. Miller also testified that ARM had not provided a list of chemicals it used at its facility for his review. There is no evidence that the Hazard Communication Written program was ever completed or that any of these three forms were ever populated or filled-in at ARM before December 3, 2012.[110] (Tr. 851-53; Ex. A, § XX, pp. 13-19).

One of the Hazcom standard's requirements is that an employer must compile a "list of the hazardous chemicals known to be present using a product identifier that is referenced on the appropriate safety data sheet (the list may be compiled for the workplace as a whole or for individual work areas)." 29 C.F.R. § 1910.1200(e)(1)(i). The Court's review of the safety manual shows there was no compiled list of the hazardous chemicals as required by the standard. ARM's employee handbook simply stated that "our company may use some chemicals." (Exs. A, § XX, p. 19, B, p. ARM 1072).

As part of an adequate Hazcom program an employer is also required to have "the workplace copies of the required safety data sheets . . . readily accessible during each work shift

[110] There is also no evidence that the form entitled "Training Attendance Roster Hazard Communication" was ever completed before December 3, 2012. (Ex. A, § XX, p. 21).

to employees when they are in their work area(s)." 29 C.F.R. § 1910.1200(g)(8). Mr. Santiago thought the MSDS were located in three areas of the facility: the front office, the light assembly area, and the wood shop. However, Mr. Santiago admitted that he rarely went to the wood shop. On direct examination, Mr. Meindl testified that, prior to the inspection, the MSDS were kept in the front office area. Mr. Joslin testified that, at the time of the inspection, he was not aware of a Hazcom program at ARM that listed the chemicals in the work place. Mr. Rivera testified that he never saw a hazard communication program at ARM. Because Mr. Santiago spent little time in the wood shop area, the Court credits Mr. Meindl's testimony. Further, the MSDS only being located in the front office is consistent with the testimony of Messrs. Joslin and Meindl that they had not seen any information about hazardous chemicals. The Court finds that even though Messrs. Meindl and Santiago knew the location of the MSDS, employees were not aware of the MSDS information and thus it was not readily accessible.[111] The Court finds the written Hazcom section in ARM's safety manual does not meet the requirements of an adequate Hazcom program. ARM had the blank forms for a Hazcom program, but its program lacked any filled-in substance. (Tr. 111, 512, 524, 742, 931).

With respect to Item 14b, CO Donofrio testified that employers are required to provide employees with effective information and training on hazardous chemicals in their work area at the time of their initial assignment, and whenever a new hazard that the employees had not been previously trained on was introduced into their work area. He testified that ARM's employees had not been trained on the hazards of chemicals that they were exposed to. As an example, he said that forklift operators had not been trained on the hazardous properties of LP gas, flammability and cryogenic nature of LP gas. He learned through employee interviews that employees that used solvents and cleaners had not been trained on the flammable hazards of

[111] Mr. Miller testified that he did not know if ARM had MSDS sheets. (Tr. 777).

those cleaners and solvents. He also learned that employees in the wood shop who worked around combustible wood dust were unaware that it may present an explosion hazard. Mr. Joslin told CO Donofrio that employees had not been trained on the hazards of chemicals that they worked with. CO Donofrio testified that there were no training markers on hazardous chemicals in ARM's safety manual. He said that he observed hazardous chemicals, such as LP gas, and various solvents and cleaners, including LPS, in ARM's facility that required training on hazardous chemicals. (Tr. 329-30; Ex. 1, p. 21; Ex. A, § XX, ¶ 3.1.7, p. 6).

ARM admits that it had not provided Hazcom training. Mr. Rivera did not receive any training on hazardous chemicals at ARM. Mr. Joslin stated there had been no training in the few months he had worked for ARM prior to the OSHA inspection. Mr. Rivera did not know what MSDS were. The only hazardous chemical training provided by ARM was done after the December 3, 2012 inspection. The Court finds that ARM did not provide training as required by the standard. (Tr. 111, 330, 742-44; Ex. Q; R. Br. 28).

The Secretary has proved that ARM violated the requirements of the standards cited for Items 14a and 14b.

Employee Exposure

With regard to Citation 1, Item 14a, CO Donofrio testified that Mr. Khadka (core cutter operator) and Messrs. Anieal Rodriguez, Pacheco, Rivera, Lebron, Morales, and Nieves (Forklift operators) were exposed to flammable and explosive materials hazards because ARM did not have a written Hazcom program. All the employees working in the wood shop area were exposed to the chemically treated wood and to the combustible dust. Forklift drivers were exposed to LP gas, and other employees were exposed to solvents and cleaners. (Tr. 323-29; Ex. 44).

With regard to Citation 1, Item 14b, CO Donofrio testified that the same employees identified above (with regard to citation 1, Item 14a) were exposed to fire hazards, second-degree burns, and possibly death by ARM not providing employees with training on hazardous chemicals. (Tr. 330-31).

The Secretary has established employee exposure to the hazard.

Employer Knowledge

Mr. Santiago knew that ARM had a safety manual. ARM's safety manual included a section entitled "Hazard Communication Safety Program" which provided guidelines for an employer to set up a Hazcom program. The manual stated that the employer must "maintain a written hazard communication program" that must, among other things, contain a list of hazardous chemicals, describe protective measures, and provide training. Mr. Santiago's knowledge is imputed to ARM. (Tr. 527; Ex. A, § XX, p. 3).

The Court finds that the standard is applicable, its terms were violated, employees were exposed and ARM had knowledge of the condition. The Secretary has proved his prima facie case for this citation items14a and 14b.

Serious Characterization & Penalty Amount

The Secretary properly classified Citation 1, Items 14a and 14b, as serious. Employees working with hazardous chemicals were exposed to fire, burns, or death from flammable or explosive chemicals. Items 14a and 14b were combined for penalty assessment. The gravity of the violation was assessed as high severity and greater probability. There were no penalty reductions for good faith or history; however, a 30% reduction was given due to the small size of the employer. The proposed penalty of $4,900 is affirmed. (Tr. 328-32).

Citation 2, Item 1

The Secretary cited ARM for a willful[112] violation of 29 C.F.R. § 1910.212(b) which requires:

> *General requirements for all machines*. (b) Anchoring fixed machinery. Machines designed for a fixed location shall be securely anchored to prevent walking or moving.

Specifically, the Secretary alleged that "the #5 pop-up saw used to cut wood to length walked, moved and changed location during operation since it was not secured or anchored creating an amputation hazard caused by contact with the saw blade" in the wood shop on about December 3, 2012. The Secretary alleges the pop-up saw was not securely anchored to prevent walking or moving. ARM asserts that the pop-up saw's weight served to anchor it in place and the Secretary did not provide credible evidence that the machine "walked" or moved as a result of operation. (Ex. 1, p. 22; S. Br. 36).

Applicability

The Secretary asserts the standard applies because the saw was designed for a fixed location, it was not designed to be portable. CO Donofrio testified that a pop-up saw is designed to be used in a fixed location. He said that "[a]t the bottom of each leg, there was a tab that was parallel to the floor with a hole in that tab that allowed it to be anchored or secured to the floor." He made this observation on December 3, 2012 during his inspection. There were no wheels on the bottom of the pop-up saw. (Tr. 178-79, 194-95; Exs. 51, 55 at "G"; S. Br. 37; S. Br. 36).

ARM asserts that because Mr. Cansdale had to drill holes through the plates on the cabinet's legs, it was not designed to be in a fixed location. Mr. Rivera testified that two maintenance employees anchored the pop-up saw to the floor an hour after the accident. Mr. Cansdale drilled holes in the concrete floor and used three-quarter-inch lag bolts that were in

[112] The Secretary also provided the basis for a serious violation for this citation item. *See* section 17(k) of the Act, 29 U.S.C. § 666(k). (S. Br. 33, 39).

stock to anchor the pop-up saw to the floor.[113] Mr. Meindl testified that it took Mr. Cansdale less than an hour to bolt the pop-up saw to the floor. Mr. Cansdale could not remember if he had to drill a hole in the plates on the legs. (Tr. 138-42, 749-52, 914-15; Ex. 55; R. Br. 29).

It is not dispositive of the issue whether the saw was designed for fixed location(s), if the plates (tabs) attached to the saw's legs had pre-drilled holes before Mr. Lebron's accident, or whether Mr. Cansdale had to drill them out afterwards. Nonetheless, the evidence shows that Mr. Cansdale was able to use materials in stock at ARM and bolt the saw to the floor without undue difficulty, and in a short time. A comparison of the photographs of the pop-up saw's legs shown in Exhibit 51 taken December 3, 2012 before the saw was bolted into the floor and Exhibit 55 taken after the legs were bolted to the floor shows no bolt in the tab on one of the legs in Exhibit 51, and what looks like a pre-drilled hole in the tab. The Court finds that based upon the above photographs and CO Donofrio's December 3, 2012 observations, the pop-up saw's leg plates had tabs, with holes in them, at the bottom of each leg of the pop-up saw before Mr. Lebron's accident where bolts could be used to affix the saw to the floor. (Tr. 178-79; Exs. 51, 55).

ARM further asserts that because the pop-up saw was in a temporary position it was not required to be anchored. ARM had been experimenting with different equipment configurations in its wood shop to determine the most efficient work flow. According to Mr. Meindl, the pop-up, Baker, and radial arm saws were all moved by the managers on a Saturday to create a work cell for production efficiencies; the permanent position of the pop-up saw had not been determined at the time of the accident. (Tr. 932-33; R. Br. 29).

The pop-up saw had been in three different work stations in the eight months since ARM purchased the saw. At the time of the accident, the pop-up saw had been in that work position

[113] Mr. Cansdale did not say that he drilled holes in the pop-up saw's leg plates.

for at least three weeks.[114] Following ARM's logic, the pop-up saw would only be securely anchored to the floor when management decided it was in its permanent position. (Tr. 128, 131, 148, 194, 932).

The text of the standard is clear; a machine designed for use in a fixed location, i.e., non-portable, must be securely anchored to prevent walking or moving. A temporary work flow configuration does not change the nature of the machine's design. The cited standard does not provide for an exception to the requirement to secure the saw. ARM's assertion that it had not determined the permanent location of the pop-up saw does not affect the requirement to securely anchor the pop-up saw as of December 3, 2012.

The Court finds the pop-up saw was designed for a fixed location and the standard applies.

Violation of the Standard

The pop-up saw was not anchored or bolted to the floor prior to, or at the time of, the accident on December 3, 2012. ARM asserts that it was not required to bolt down the pop-up saw to anchor it because its own weight served as the anchor. Mr. Miller testified that he did not know the weight of the pop-up saw. Evidence was not adduced to establish how much weight would be sufficient to anchor the saw in place or how much the pop-up saw weighed. Mr. Miller testified that he did not know if he observed the pop-up saw in operation before it was bolted to the floor.[115] He, nonetheless, opined that "the likelihood of it moving or walking was very – very slim." The Court rejects ARM's assertion that the saw was anchored by its own weight during operation. (Tr. 79, 131, 177, 779-80, 786-87; Ex. W, p. 6; R. Br. 29).

[114] Mr. Meindl estimated the saw had been in that spot for three weeks. Mr. Rivera estimated it had been two months. CO Donofrio recalls being told "a couple of weeks" during his inspection. (Tr. 131, 148, 194, 932).
[115] Since Mr. Miller first visited ARM on December 7, 2012, the Court finds that his observations of the pop-up saw were made after it was bolted to the floor.

ARM also asserts that the pop-up saw did not walk or move as a result of its operation so there was no need to anchor the saw. The Secretary established the saw "walked" as a result of its operation through Mr. Rivera's testimony, which the Court credits on this issue.[116] He regularly used the pop-up saw. He testified that the pop-up saw gradually moved (walked) as a result of vibrations during operation.[117] He had asked maintenance to bolt the saw in place, but was told they did not have the right bolts or drill.[118] Mr. Rivera testified that after the saw moved about a foot or so out of place it was pushed back into place.[119] Because the pop-up saw was gradually moving out of place, it would get too close to other machines. As a result, an employee would be working too close to the running belts of another machine. ARM's own repair documents demonstrate the saw would get too close to another piece of equipment. The document entitled "Safety Issues December 5, 2012" notes the pop-up saw was located "[t]oo close to [the] Mattison" saw. (Tr. 112, 123-25, 131, 143-44, 182-83; Ex. I, p. ARM 216; R. Br. 29).

Nonetheless, ARM asserts that the saw did not walk during operation and that five witnesses testified accordingly, Messrs. Santiago, Meindl, Joslin, Cansdale, and Khadka.[120]

---

[116] Mr. Rivera testified as follows:
Q Any other issues with the pop-up saw?
A It would move, too, when you would use it, because it wasn't bolted down. Let's say you use it for ten minutes and just stacking wood because you keep using it, and you would turn around and the machine would move while it was running from the vibration.
(Tr. 123-24).

[117] *See Oberdorfer Indus., Inc.*, 20 BNA OSHC 1321, 1329 (No. 97-0469, 2003) (consolidated) (noting § 1910.212(b) applies when the evidence establishes that a machine is unstable.).

[118] The record does not show whether this request was before or after Mr. Cansdale was hired. Mr. Joslin stated that he hired Mr. Cansdale because prior maintenance staff was unable to adequately repair and maintain the equipment.

[119] During Mr. Rivera's testimony on this issue, he spoke clearly and assuredly and displayed no intent to deceive the Court.

[120] ARM asserted that Mr. Lebron testified that the saw did not move. Mr. Lebron's testimony was about the location of the saw, not whether it walked or moved during operation. (Tr. 79-80; R. Br. 29).

ARM also asserts that Mr. Rivera is not credible and his testimony should not be believed.[121] (R. Br. 29).

Of the five witnesses identified by ARM, only Messrs. Khadka and Meindl had ever operated the saw.[122] Mr. Khadka had used the pop-up saw occasionally "a long time ago." Mr. Meindl testified that he was generally out of the office two weeks per month on sales calls, so he did not use the pop-up saw often. (Tr. 886-90, 918, 935).

The Court finds ARM's assertion that five witnesses contradict Mr. Rivera's testimony that the pop-up saw walked is not persuasive. Three of those witnesses never operated the pop-up saw, and neither Messrs. Khadka nor Meindl routinely used the saw. Further, as an owner of the company, Mr. Meindl's testimony that the saw did not walk is self-serving and not persuasive. ARM also asserts that the walking of the pop-up saw did not cause the Mr. Lebron's injury. This is a moot point.[123] The Secretary is not required to show an actual injury occurred to support a violation.[124] *See Kaspar Electroplating Corp.,* 16 BNA OSHC 1517, 1524 (No. 90-2866, 1993); *see also Whirlpool Corp. v. Marshall*, 445 U.S. 1, 12 (1980) ("The Act does not

---

[121] The Court finds ARM's attacks on Mr. Rivera's credibility to be unfounded. Having observed his courtroom demeanor closely, the Court finds Mr. Rivera to be a very credible witness. His testimony was direct, persuasive, and presented without hesitation or evasion.

[122] Mr. Khadka claimed that he never saw the pop-up saw move on its own. By the time of Mr. Lebron's accident, Mr. Khadka had worked at ARM for about two years. However, Mr. Khadka testified that he only used the pop-up saw occasionally, and it had been a long time since he had used it. In fact, he could not remember how many times he had used the pop-up saw. Mr. Khadka further testified that at the time of the accident, he was running the core cutter machine. Mr. Cansdale testified that he never saw the pop-up saw move on its own, but he worked as a mechanic for ARM and never operated the pop-up saw himself. He was also newly hired as of Mr. Lebron's accident. Mr. Santiago rarely went into the wood shop area. Mr. Rivera, who used the pop-up saw regularly, credibly testified that the pop-up saw would move on its own during use. (Tr. 112, 125, 131, 524, 748, 752, 880, 886-90).

[123] CO Donofrio testified that he believed that "machine walking" was a contributing factor to Mr. Lebron's injury. He said this was so "because the foot pedal was tethered to the pop-up saw, and each time the pop-up saw moved because it was not anchored, it changed the relative position of the foot pedal that activated the saw, increasing the likelihood of possible unintended or accidental activation because of its changing location." (Tr. 380-81). Mr. Martinez's view at the foot pedal of Mr. Lebron's left hand could change as the pop-up saw moved.

[124] Mr. Miller agreed that a citation can still be valid even where no one is injured. (Tr. 854).

wait for an employee to die or become injured. It authorizes the . . . issuance of citations in the hope that these will act to prevent deaths or injuries from ever occurring.”). (R. Br. 29).

The Court finds that pop-up saw was not securely anchored and ARM did not comply with the requirements of the cited standard as of December 3, 2012.

Employee Exposure

CO Donofrio testified that a cut hazard existed from the pop-up saw not being anchored to prevent movement. He said that the walking of the saw could cause the foot pedal and blade to change positions, increasing the likelihood of an unintended activation of the saw. The Secretary proved employees were exposed to the cut hazard. Mr. Lebron testified that eight or ten of his fifteen co-workers used the pop-up saw. Mr. Rivera testified that “around five guys” normally operated the pop-up saw. He said that sometimes employees used it “five times a week all day. Sometimes two times a week. Sometimes we don’t use it at all.” He said that he used the pop-up saw “at least two or three times a week.” Messrs. Rivera, Khadka, and Lebron had all used the pop-up saw. Mr. Lebron was using the saw when the accident occurred. The Court finds employee exposure is established. (Tr. 75-85, 112, 125-27, 137, 202, 227, 886-90; Exs. 26, 55).

Employer Knowledge

The Secretary asserts that Messrs. Meindl, Joslin and Rivera all knew that the pop-up saw was not bolted to the floor. Knowledge is directed to the physical conditions that constitute the violation and does not require the employer to know or understand the condition was hazardous. *Phoenix Roofing, Inc.*, 17 BNA OSHC at 1079-1080. (S. Br. 36).

Mr. Rivera knew the saw was not bolted to the floor, that it moved as a result of its operation, and that he had requested the saw be bolted down.[125] He said that after it moved about "a foot, foot and a half," the employees moved it back. Mr. Rivera stated that he had told Messrs. Mangold, Meindl, and Joslin that the pop-up saw moved on its own. He said he discussed the issue with Mr. Mangold on several occasions. He recalled an instance where he brought Mr. Mangold to the pop-up saw to use it and Mr. Mangold encountered problems with the pop-up saw moving. He also said that he discussed it "very often" with Mr. Joslin because Mr. Joslin was in charge of safety. In response, Mr. Joslin told Mr. Rivera that he would "bring it up to Joe [Meindl]." Mr. Rivera testified that Mr. Meindl told him: "We'll take care of it." ARM never took any action to anchor the pop-up saw before December 3, 2012.[126] Mr. Rivera's actual knowledge as a wood shop supervisor is imputed to ARM. Messrs. Mangold, Meindl and Joslin's actual knowledge that the pop-up saw was not anchored is also imputed to ARM.[127] (Tr. 123-25, 131-35, 143-44, 740).

The Machine Guarding Program Assessment checklist in ARM's safety manual also supports employer knowledge. It stated: "Is equipment designed for a fixed location secured to prevent tipping, walking or moving?" (Ex. A, § XXIII, *Machine Guarding Safety Program*, p. 10). Mr. Santiago knew ARM had a safety manual.

---

[125] Mr. Rivera testified:
Q Prior to the accident, had the pop-up saw ever moved on its own while it was being used?
A Yes.
Q How often?
A Every time it was used.
(Tr. 131, 143).

[126] ARM's management told CO Donofrio that the pop-up saw was not anchored because management was "trying to establish work flow." (Tr. 193).

[127] Mr. Rivera testified that Mr. Meindl told him that "we need to make money with it [pop-up saw], that's what we bought it for, …", after Mr. Rivera refused to use the pop-up saw because it was unpredictable and the blade was coming up real hard and fast. On December 4, 2012, Mr. Rivera told CO Donofrio that he refused to run the pop-up saw about four months ago [August, 2012] because it was not bolted down or the pedal covered. (Tr. 137, 396-97; Ex. T, p. 7).

The Court finds the Secretary has proved the element of employer knowledge. The Secretary has proved the cited standard applies, employees were exposed, its terms were violated and employer knowledge. The Secretary proved a violation of the standard. Citation 2, Item 1 is affirmed.

Unpreventable Employee Misconduct

ARM asserts the affirmative defense of unpreventable employee misconduct (UEM) for Citation 2, Item 1. Specifically, that Mr. Lebron engaged in misconduct by placing his arm near the saw's point of operation and Mr. Joslin engaged in misconduct by not having the pop-up saw secured. (Jt. Pre-Hr'g. Stmt., p. 15).

Unpreventable employee misconduct is an affirmative defense that must be proved by the employer. *Am. Eng'g & Dev. Corp.*, 23 BNA OSHC 2093, 2096 n.4 (No. 10-0359, 2012). To prove unpreventable employee misconduct, the employer must establish four elements.[128] ARM must prove it: 1) established work rules designed to prevent the violation; 2) adequately communicated safety rules to its employees; 3) took steps to discover violations of the rules; and 4) effectively enforced the rules when a safety violation was detected. *Rawson Contractors, Inc.*, 20 BNA OSHC 1078, 1081 (No. 99-0018, 2003).

Work Rules -- When there are no, or minimal, work rules the employer's defense fails. *See Superior Custom Cabinet Co.*, 18 BNA OSHC 1019, 1022-23 (No. 94-200, 1997); *Capform, Inc.*, 16 BNA OSHC 2040, 2043 (No. 91-1613, 1994). The work rule must adequately address the cited hazard, must be clear, and cannot be too general. *See Beta Constr. Co.*, 16 BNA OSHC 1435, 1444 (No. 91-102, 1993).

[128] The Secretary must first prove its "*prima facie* case before the affirmative defense comes into play." *N.Y. State Elec. & Gas Corp. v. Sec'y*, 88 F.3d 98, 106-07 (2nd Cir. 1996).

Even though ARM's safety manual was generic in nature and not tailored to ARM's workplace it included a work rule that stated: "Is equipment designed for a fixed location secured to prevent tipping, walking or moving?" The Court finds that ARM had a work rule that addressed the requirement to secure equipment to prevent unintended movement or walking. There is no evidence that ARM implemented this requirement. (Tr. 166; Ex. A, § XXIII, *Machine Guarding Safety Program*, p. 10).

Communication of Safety Rules -- The Commission has upheld the UEM defense where employees are well-trained and knew the rules; however, where inadequately communicated, the defense fails. *See*, e.g., *Danis- Shook Joint Venture XXV*, 19 BNA OSHC 1497, 1499-1501 (No. 98-1192, 2001), *aff'd,* 319 F3d 805 (6th Cir. 2003). ARM admits that it did not train employees on its work rules. The Court finds that ARM did not adequately communicate its work rules to its employees.

Steps to Discover Violations -- The employer must make a reasonably diligent effort to monitor compliance with its safety rules, including monitoring its supervisor's oversight of safety rules. *See N&N Contractors, Inc.*, 18 BNA OSHC 2121, 2125-26 (No. 96-0606, 2000), *aff'd* 255 F.3d 122 (4th Cir. 2001). ARM presented no evidence that it monitored its employees for compliance with its work rule. The Court finds ARM did not make a reasonably diligent effort to determine if its employees or supervisors were following the rules in its safety manual.

Enforcement of Safety Rules -- An employer must show it has a progressive and consistent disciplinary policy that enforces its safety program. *Rawson Contractors, Inc.*, 20 BNA OSHC at 1081. ARM presented no evidence of a disciplinary policy. The Court finds ARM did not enforce its safety rules.

ARM's unpreventable employee misconduct defense for Citation 2, Item 1 fails because it did not adequately communicate its work rules to its employees, it did not monitor its employees for compliance, and it did not enforce its safety rules.

Willful Characterization

The Secretary properly classified this citation item as willful.[129] A willful violation is "one committed 'with intentional, knowing or voluntary disregard for the requirements of the Act or with plain indifference to employee safety.'" *Burkes Mech., Inc.*, 21 BNA OSHC 2136, 2140 (No. 04-0475, 2007) (quoted cases omitted). The Secretary must show that "the employer was actually aware of the unlawfulness of the action or that it 'possessed a state of mind such that if it were informed of the standards, it would not care.'" *Revoli*, 19 BNA OSHC at 1692. The Second Circuit follows Commission precedent by finding that "willful violations are characterized by an employer's 'heightened awareness of the violative nature of its conduct or the conditions at its workplace.'" *Chao v. Barbosa Group, Inc*., 296 Fed.Appx. 211, 212-13 (2nd Cir. 2008)(unpublished) citing *MJP Constr. Co., Inc.*, 19 BNA OSHC 1638, 1647 (No. 98-0502, 2001), *aff'd* 56 F. App'x. 1 (D.C. Cir. 2003)(not selected for publication).

ARM showed plain indifference to employee safety by its lax attitude about safety, its inattention to its safety manual, and a lack of good faith efforts to comply with the standard. (S. Br. 38). No one at ARM mentioned any attempt at complying with applicable OSHA requirements. ARM's generic safety manual included a "machine guarding program assessment" checklist, which had a rule very similar to OSHA's requirement to securely anchor a

[129] The Secretary asserts that in addition to being willful, this violation is serious. Section 17(k) of the Act states that a violation is serious if there is a substantial probability that death or serious harm could result from the violative condition. 29 U.S.C. § 666(k). An amputation requiring three weeks of hospitalization occurred as a result of the foot pedal being accidentally activated. The Secretary proved this citation item is also a serious violation. (Tr. 101; S. Br. 33).

machine to prevent walking.[130] This checklist item addressed the same hazard and also required the machine to be secured. Despite this requirement in its safety manual, ARM's managers claim they were unaware of the requirement to securely anchor the pop-up saw. There is no evidence that any owner or member of upper management (e.g. Messrs. Santiago and Meindl) attempted to become knowledgeable about or implement any of the requirements of the standard or ARM's own safety manual. This demonstrates plain indifference to employee safety.

ARM also failed to provide warning instructions in the language its employees could read. For example, the pop-up saw had several instructions and warnings posted on the machine. The posted warnings were in English. Lebron testified that he could not read English. It is reasonable to assume that several other employees were also not fluent in written English. ARM demonstrated its indifference to safety by not providing posted signs in the language its employees could read. (Tr. 743, 843).

Additionally, ARM made little to no effort to train its employees or supervisors on safety matters. The only safety training that had been provided was to a few of its employees for forklift operations; several employees that regularly operated forklifts were not trained, including Mr. Rivera. (Tr. 70, 106, 113, 273, 720, 742).

ARM seemed to have a nonchalant attitude about safety in its facility. ARM admits there was a "lapse" in safety compliance after Mr. Suhr retired in 2011 and before Mr. Joslin was hired in September, 2012. ARM does not explain why no efforts were made to have an effective safety program. Instead, ARM blames the lapse on its interim manager, Mr. Mangold. (R. Br. 40).

---

[130] "Is equipment designed for a fixed location secured to prevent tipping, walking or moving?" (Ex. A, § XXIII, p. 10).

ARM cannot absolve itself of responsibility by blaming one of its prior managers. ARM provided no evidence that it performed any oversight of its manager's safety efforts. An employer must also monitor its supervisors' compliance with its work rules. *S.W. Bell Tel. Co.*, 19 BNA OSHC 1097, 1099 (No. 98-1748, 2000), *aff'd* 277 F.3d 1374 (5th Cir. 2001)(not selected for publication). For example, Mr. Santiago assumed that Mr. Suhr had tailored the generic safety manual to ARM's workplace; however, he made no effort to verify this had been done. Nor, did owners or upper management attempt to take interim safety measures prior to hiring Mr. Joslin in September, 2012. In particular, they had Mr. Rivera, who had no safety training prior to December 3, 2012 or woodworking experience prior to working at ARM, stand-in as the acting plant manager before Mr. Joslin was hired. An employer cannot blindly rely on its supervisors to implement a safety program. (Tr. 110).

The Secretary must also demonstrate "the employer had a 'heightened awareness' of the illegality of the conduct." *Diamond Installation, Inc.*, 21 BNA OSHC 1688, 1692-93 (No. 02-2080, 2006)(consolidated); *see also, A. Schonbek & Co. Inc. v. Sec'y*, 646 F.2d 799, 800 (2d Cir. 1981) (A willful violation is defined "as one done either with an intentional disregard of, or plain indifference to, the statute."). Numerous complaints about the pop-up saw informed management there were safety issues with it and created a heightened awareness. Mr. Lebron complained twice a week about issues with the pop-up saw.[131] Mr. Rivera complained to Messrs. Mangold, Joslin and Meindl many times about the fact the pop-up saw moved during its operation and was getting too close to other equipment in the wood shop.[132] Mr. Rivera

[131] Mr. Rivera told CO Donofrio during an interview that right after ARM received the pop-up saw: 1) he began receiving complaints from employees concerned about its safe operation, 2) the employees were concerned that when they used the saw, it would move and change positions, and 3) the employees were concerned about a cut hazard. (Tr. 183-84).

[132] Mr. Rivera told CO Donofrio during an interview that he had told ARM management, including Messrs. Meindl and Joslin, that the pop-up saw was moving or moved during operation. Mr. Joslin testified that no one told him the pop-up saw moved or walked on its own. Based upon its observations of the courtroom demeanor of Mr. Joslin, the

complained to Messrs. Mangold and Joslin that employees did not want to use the pop-up saw because it was "real unpredictable." Mr. Joslin told Mr. Rivera to "[j]ust find the guys who want to run it [pop-up saw]." ARM generally asserts that Mr. Rivera is not a credible witness. The Court disagrees and finds him to be a credible witness after closely observing his courtroom demeanor during his testimony. His testimony is consistent with his statement to CO Donofrio during the investigation, which was several months prior to being laid-off by ARM. (Tr. 80-81, 124-25, 133-37, 183-84, 206; Ex. T, p. 7).

The Secretary asserts that in addition to being willful, this violation is serious. Section 17(k) of the Act states that a violation is serious if there is a substantial probability that death or serious harm could result from the violative condition. 29 U.S.C. § 666(k). CO Donofrio testified that employees were exposed to possible death or serious physical harm due to the pop-up saw not being securely anchored to prevent movement while operating. The pop-up saw's movement caused employees to be exposed to pinch points of other nearby machines and cut hazards from accidental activation of the saw.[133] (Tr. 123-24, 204; S. Br. 39).

On the whole, ARM had a nonchalant and dismissive attitude toward safety. The Court affirms a willful characterization for this citation.

Penalty Amount

The statutory maximum penalty for a willful violation is $70,000. 29 U.S.C. § 666(a). Employees were exposed to being caught in the pinch points of other equipment because the unintended movement of the pop-up saw placed them too close to other equipment. Employees

---

Court finds this testimony to not be credible. At times, his testimony appeared to be evasive. He did not remember that there was a dust collector bag leaking for more than a month prior to Mr. Lebron's accident. He did not remember that the pop-up saw's pedal was tethered to an air hose. He testified that he was "[p]robably" aware that the pop-up saw's foot pedal was not covered. (Tr. 186, 713, 738-39).

[133] Pinch points develop when two parts move together and at least one moves in rotary or circular motion. They occur whenever machine parts move toward each other or when one part moves past a stationary object. Typical pinch points include gears, rollers, belt drives, and pulleys. (Ex. Y, p. 10).

were also exposed to cut hazards because the movement of the saw put it further away from the foot pedal, making it more likely it could be accidentally activated. This citation item was assessed as low severity and lesser probability resulting in a gravity-based penalty of $40,000. The Secretary does not provide a good faith discount for willful violations. Because ARM had not been inspected previously there was no penalty reduction for history. A 20% reduction was applied due to the small size of the employer. The proposed penalty of $ 32,000 is affirmed for Citation 2, Item 1. (Tr. 124, 207-09, 225; Ex. 1, p. 22).

Citation 2, Item 2

The Secretary cited ARM for a willful[134] violation of 29 C.F.R. § 1910.213(b)(6)which requires:

> *Woodworking machinery requirements*. (b) Machine controls and equipment. . . .
> (6) Each operating treadle shall be protected against unexpected or accidental tripping.

Specifically, the Secretary alleges the foot pedal for the pop-up saw was not guarded or covered resulting in an accidental activation of the saw causing an amputation injury on December 3, 2012 in ARM's woodworking shop. Respondent does not dispute there was no guard over the foot pedal; however, it asserts that the pop-up's saw foot pedal is not a treadle, the manufacturer did not provide a guard, and employees did not complain about a missing guard. (Ex. 1, p. 23; S. Br. 24, R. Br. 30-31; Answer, p. 3).

Applicability

The pop-up saw's cutting action and blade was activated by depressing the attached foot pedal. Respondent asserts the standard does not apply because the foot pedal is not a treadle; a treadle is used to power a machine when it is pumped by a person's foot.[135] Respondent also

[134] The Secretary also provided the basis for a serious violation for this citation item. (S. Br. 33, 39).
[135] The Secretary asserts that Respondent raised this argument for the first time in its post-hearing brief. The Court points out that applicability of the standard is a part of the Secretary's prima facie case.

asserts that because the machine has a foot pedal and not a treadle, it was not on notice of the requirement to guard the foot pedal. (Tr. 77; R. Br. 30-31).

To support its position, ARM relies on three internet documents. ARM cited to Wikipedia and dictionary.com to support its argument that a treadle is used on a machine to power the machine by foot-power instead of electricity. The other site ARM relies on, "Union Hill Antique Tools," states that a "[t]readle powered machine provided a treadle of metal or wood under the tool [and] . . . just by pumping the treadle up and down could set the drive belt in motion." The Court notes this site is dedicated to manually powered woodworking equipment manufactured from 1870 to 1937.[136] (R. Br. 30-31).

The Secretary argues that the same Wikipedia entry Respondent relies on also supports the Secretary's position: "treadles have been used to power a range of machines including . . . wood saws." The Secretary states this supports his position that the foot pedal, which actuates the cutting action of the saw, meets the "common sense" definition of treadle in the context of this standard. When asked what a treadle was, CO Donofrio testified that it was a foot pedal that operates a machine.[137] Mr. Miller also consistently referred to the pop-up saw's foot pedal as a treadle during his testimony. For example:

> Q: Okay. And have you dealt with pedals as far as operation of machines with pedals?
> A: Yes, we deal -- pedals, treadles, there's a variety of different terms. They'll be used on a variety of different pieces of equipment. There are -- there's a very brief standard in the woodworking section that does cover treadles. You will find more stringent information under Section 217, which covers mechanical power presses, which is a very common way that a mechanical power press would be actuated. . . . all operated by foot pedals or treadles."

---

[136] *See* http://www.tooltimer.com/barnes.html accessed May 27, 2015.

[137] Mr. Donofrio testified as follows:
Q And just for clarification, what was the operating treadle for the pop-up saw?
A It was the foot pedal that was tethered to the pop-up saw by the air lines."
(Tr. 210, 217; Ex. 51, at "A").

And, when Mr. Miller was identifying the pictures he took of the pop-up saw at ARM's facility he answered, "[t]hat is actually a picture of the treadle that was covered at the time." (Tr. 210, 389, 569, 609; Ex. U, p.7; S. Reply Br. 3).

When he evaluated the validity of this citation item for ARM, Mr. Miller referred to the foot pedal of the pop-up saw. Mr. Miller referenced the OSHA publication, *"Safeguarding Equipment and Protecting Employees from Amputations,"*[138] which sets forth the requirement to guard a foot pedal.[139] This shows that Mr. Miller also considered the foot pedal on the pop-up saw was a treadle as intended by the standard.[140] This publication included a photograph of a guarded foot pedal, which was very similar in appearance to the foot pedal for ARM's pop-up saw. This document, which was published in March 2007, also provides notice that OSHA considers the food pedal is a treadle for the purpose of this standard.[141] (Exs. 51, W, p. 6, Y, p. 16 at Figure 15).

ARM also relies on Mr. Santiago's testimony that a treadle was a device on his grandmother's sewing machine. Mr. Santiago's duties at ARM were financial and administrative in nature. He rarely went to the wood shop area. The Court finds his testimony on whether the pop-up saw had a treadle is not dispositive. (Tr. 481, 507-08, 524; R. Br. 31).

"When the meaning of a standard cannot be determined from its language or the available legislative history, deference will be given to the Secretary's interpretation if it is reasonable,

---

[138] Ex. Y, OSHA Publication 3170-02R 2007. The Court notes this publication is freely available on OSHA's website at https://www.osha.gov/Publications/osha3170.pdf.

[139] The publication states "[f]oot controls must be guarded to prevent accidental activation by another employee or by falling material." *See also* the American National Standard Institute's standards for Safety of Machinery – General Requirements and Risk Assessment (ANSI B11-0.2010), § 7.2.5 (Operator interface/controls) (Operator interfaces shall be "located, positioned or safe guarded to prevent unintentional activation). (Exs. Y, p. 21, FF, p. 40).

[140] Mr. Miller went on to opine that the OSHA publication did not require a foot pedal to be anchored (which was not at issue in this case). (Ex. W, p. 7).

[141] "OSHA Issues Revised Guide to Help Protect Employees from Amputation." *See* https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=NEWS_RELEASES&p_id=13945.

taking into account such factors as the consistency with which the interpretation has been applied, adequacy of notice to regulated parties, and the quality of the Secretary's elaboration of pertinent policy considerations." *Oberdorfer Indus., Inc.,* 20 BNA OSHC at 1329, citing *Martin v. OSHRC*, 499 U.S. 144, 157-58 (1991). To merit deference, the Secretary's interpretation must be reasonable and "sensibly conforms to the purpose and wording of the regulation[ ]."[142] *Union Tank Car Co.*, 18 BNA OSHC 1067, 1069 (No. 96-0563, 1997).

The Court finds the Secretary's position that the food pedal to the pop-up saw is a treadle as contemplated by the cited standard is reasonable and makes sense in the context of the requirements for woodworking equipment. The Court finds the standard applies to the pop-up saw.

Violation of the Standard

ARM does not dispute that the foot pedal was not guarded. Additionally, Mr. Miller testified that it was his opinion that ARM should have guarded the foot pedal.[143] Instead, ARM argues that the standard covers treadles and not foot pedals, and the manufacturer did not provide a guard for the pedal. These two arguments are inapt. (Tr. 787; Ex. 2, p. 14; R. Br. 30-31).

The record establishes the pop-up saw was purchased from an online auction in April, 2012. ARM did not know the name of the saw's manufacturer. ARM purchased the pedal separately from Grainger on April 26, 2012.[144] In his report, Mr. Miller wrote that the

---

[142] Factors to consider in evaluating the reasonableness of the Secretary's interpretation are the consistency of the interpretation, quality of the policy rationale, and adequacy of notice. *Union Tank Car Co.*, 18 BNA OSHC at 1069. A review of the OSHA website revealed no conflicting interpretation or change in policy on what a treadle is.

[143] Mr. Miller testified upon direct examination:
Q And did you believe – or did you believe that the pedal should be – should have been guarded?
A I did.
(Tr. 787).

[144] Mr. Meindl testified that when ARM purchased the pop-up saw it came with a foot pedal that did not have a guard on it. He said ARM replaced the pop-up saw's foot pedal in June, 2012, because Mr. Rivera had reported a problem with the prior foot pedal causing the saw to stick. Mr. Meindl testified that the replacement pedal did not

"manufacturer did not provide a guard for the foot pedal." In his testimony, he clarified this was in reference to the purchase of the foot pedal, not the saw, and was based on information provided by Mr. Santiago.[145] (Tr. 195, 506-07, 525-26, 786, 857-58, 939; Exs. E, W, pp. 6-7).

Photographs taken by Mr. Miller on December 7, 2012 show the pedal with a toe guard over it.[146] Because a cover for the pedal was obtained within days after the accident, the Court finds that ARM previously chose to purchase and use a pedal without a toe guard.[147] Mr. Miller testified that it took "a few minutes" to install a guard on the foot pedal. With the new cover, employees have to slide their feet into the cover in order to activate the pedal. ARM's argument that a toe guard was not available from the manufacturer is rejected. (Tr. 139-40, 223, 609, 613-14, 751, 790; Ex. U, pp. 7, 29).

ARM also asserts that it did not know a guard was needed because there was no request from an employee for a guard. This argument fails. An employer cannot formulate its safety program based on employee complaints or requests. *See M.V.P. Piping Co., Inc.*, 24 BNA OSHC 1350, 1352 (No. 12-1233, 2014) (finding it improper to rely on employees to "tell him if they felt safe enough"); *Burford's Tree, Inc.*, 22 BNA OSHC 1948, 1951 (No. 07-1899, 2010) (finding employer cannot solely rely on employees to report seatbelt inoperable), *aff'd* 413 F. App'x. 222 (11th Cir. 2011)(not selected for publication). The Court finds that ARM had a duty to comply with the standard and cannot rely on employee complaints to implement safety measures.

---

come with a guard on it. Upon viewing the April 26, 2012 invoice, Mr. Meindl corrected his testimony and stated that he had been mistaken about the date the replacement pedal was purchased. (Tr. 915-17; Ex. E).

[145] Mr. Miller had not seen the April 26, 2012 invoice for the foot pedal's purchase prior to preparing his report or testifying at the hearing. (Tr. 857-58).

[146] ARM's Safety Meeting minutes also state that by December 11, 2012 it had improved the operation of the pop-up saw by installing a "one way" switch pedal "that lets the clamp and blade retract as soon as you take your foot off of it." (Ex. I, p. ARM 221).

[147] ARM's "Safety Issues – December 5, 2012" worksheet states the problem of the "Pedal not safe" was resolved by December 5, 2012 by a "Change to single action Pedal, bolt to floor and cover." (Ex. I, ARM 216).

The Secretary proved that ARM violated the terms of the standard by not providing a guard or other protection for the foot pedal to prevent accidental activation.

Employee Exposure

The record shows that, prior to the accident, the foot pedal was not guarded. On the day of the accident, the foot pedal was approximately 6 feet away from the saw.[148] CO Donofrio testified "that the foot pedal for the pop-up saw number 5 was not covered" in any way during his December 3, 2012 inspection. Any employee using the saw was exposed to accidental activation of the blade and an amputation hazard if someone tripped or inadvertently pressed on the pedal, which actually occurred on December 3, 2012. Messrs. Rivera, Khadka, and Lebron had all used the pop-up saw. Employee exposure to the hazardous condition is established. (Tr. 75-85, 112, 132, 137, 210, 216, 221, 226, 886-90; Exs. 26, 51, 55).

Employer Knowledge

Under Commission precedent, knowledge is directed at the violative condition; it is not necessary to show that the employer knew or understood the condition was hazardous. *Phoenix Roofing, Inc.*, 17 BNA OSHC at 1079-80.

Mr. Santiago testified that he had seen the foot pedal prior to the accident and it did not have a cover or guard. Mr. Meindl had operated the saw, so would have seen the pedal's unguarded condition, and that it could be tripped over.[149] Mr. Rivera had used the saw on multiple occasions, knew the pedal could be tripped over, and knew the pedal was not covered or guarded. Mr. Rivera testified that the pedal never had a cover. Mr. Joslin admitted that he knew

[148] Mr. Lebron testified that the pedal area was often dirty and the dirt covered up the wires leading from pop-up saw to the foot pedal. Mr. Rivera testified that employees were encouraged to have the pedal as close to the pop-up saw as possible. (Tr. 77-78, 152).

[149] Mr. Rivera testified that he complained about the unguarded, insecure pedal two or three times and that Mr. Meindl's response was: "We'll take care of it." He said he first complained to Mr. Mangold, and also witnessed Mr. Mangold tell Mr. Meindl "a few times about it." ARM took no action to cover or secure the pedal before December 3, 2012. (Tr. 135-36, 398-99; Ex. T, p. 21).

the foot pedal had no guarding. Messrs. Rivera, Hart and Hess complained to management about the pedal not being covered.[150] Actual knowledge of the hazardous condition can be imputed through each of these supervisory employees. The Court finds the Secretary has established knowledge that the pedal was not covered or otherwise guarded. (Tr. 132-34, 217-18, 221, 401-03, 413, 525, 739, 917-18).

The Secretary has proved the standard was applicable, its terms were violated, employees were exposed, and knowledge of the condition. A violation of the cited standard is affirmed.

Unpreventable Employee Misconduct

ARM also asserts the affirmative defense of unpreventable employee misconduct for Citation 2, Item 2. ARM asserted Mr. Lebron engaged in misconduct by placing his arm near the point of operation and Mr. Joslin engaged in misconduct by not having the pop-up saw secured. As discussed above, ARM has the burden to prove this defense. *Am. Eng'g. & Dev. Corp.*, 23 BNA OSHC at 2096 n.4. ARM had a work rule that addressed the hazard of accidental activation by tripping over the foot pedal. ARM's manual stated: "Specific controls must be in place to assure that equipment cannot be accidentally tripped to activate the machine." This requirement addresses the same hazard as the cited standard and requires the same measures to control the hazard ("shall be protected against unexpected or accidental tripping"). 29 C.F.R. § 1910.213(b)(6). ARM had a work rule to address this hazard and ARM made no attempt to implement this work rule until after the accident on December 3, 2012. (Ex. A, § XXIII, *Machine Guarding Safety Program*, p. 5; Jt. Pre-Hr'g. Stmt., p. 15).

[150] On January 24, 2013, Mr. Rivera told CO Donofrio that when he told Mr. Joslin about the pop-up saw's pedal and cover, Mr. Joslin said the saw did not come with a cover from the manufacturer, OSHA does not demand it, and "we need the parts!." He also told CO Donofrio that the pop-up saw would activate even if you kicked it. He said he told this to Mr. Joslin three to four times and that Mr. Joslin said "They were going to fix it." But, ARM never did before December 3, 2012. (Tr. 399-401, 413; Ex. T, pp. 22-23).

As discussed above, ARM's unpreventable employee misconduct defense for Citation 2, Item 2 fails because it did not adequately communicate its work rules to its employees, it did not monitor its employees for safety compliance, and it did not enforce its safety rules.

Willful Characterization

The Secretary properly characterized this citation item as willful.[151] A willful violation is "one committed 'with intentional, knowing or voluntary disregard for the requirements of the Act or with plain indifference to employee safety.'" *Burkes Mech., Inc.*, 21 BNA OSHC at 2140. The Second Circuit follows Commission precedent by finding that "willful violations are characterized by an employer's 'heightened awareness of the violative nature of its conduct or [workplace] conditions.'" *Chao v. Barbosa Group, Inc.*, 296 Fed. Appx. at 212-13, citing *MJP Constr. Co., Inc.*, 19 BNA OSHC at 1647.

The Court finds that the Secretary has proved that ARM had a heightened awareness of the hazard and acted with plain indifference. Multiple employee complaints about the foot pedal provided a level of heightened awareness to management.[152] Mr. Lebron complained that the pedal was "free" (loose). Mr. Lebron testified that he had complained to Mr. Rivera twice a week about the foot pedal. Mr. Rivera's response to Mr. Lebron's complaints was that he was going to talk to Messrs. Santiago and Meindl. Mr. Rivera complained about the foot pedal to Messrs. Mangold, Meindl, and Joslin.[153] Mr. Rivera testified that "the pedal was just everywhere

[151] The Secretary asserts that in addition to being willful, this violation is serious. Section 17(k) of the Act states that a violation is serious if there is a substantial probability that death or serious harm could result from the violative condition. 29 U.S.C. § 666(k). An amputation, requiring three weeks of hospitalization occurred as a result of the foot pedal being accidentally activated. The Secretary has proved that this citation item is also a serious violation. (Tr. 101; S. Br. 33).

[152] The Court notes that the standard does not require a guard over the foot pedal; it requires implementation of a control to prevent "unexpected or accidental tripping." The type of control is not specified by the standard.

[153] CO Donofrio testified that Mr. Rivera told him during an interview that after he told Mr. Meindl directly about his concern of not having the foot pedal guarded and the hazard of accidental or unintentional activation, Mr. Meindl's response was that ARM needed production and to continue to use the saw. Mr. Rivera complied with Mr. Meindl's order and continued to use the saw without the foot pedal being covered. (Tr. 224).

. . . you had to look for the pedal every time you cut something." During employee interviews, CO Donofrio found that two additional ARM supervisors were also concerned about the foot pedal moving around and someone inadvertently stepping on it.[154] (Tr. 77, 80-81, 94, 132-33, 217-20, 392, 397-98, 401-02, 411-13, 886; Exs. G, p. ARM 38, T, pp. 11, 25).

ARM was plainly indifferent to employee safety. The pop-up saw was regularly used by both employees and supervisors, including Messrs. Meindl and Rivera. Mr. Rivera used the saw two or three times a week. Mr. Meindl used the pop-up saw on occasion and took no steps to prevent accidental activation. Mr. Rivera knew of the employee's concerns about the foot pedal, knew the foot pedal moved about, yet still assigned employees to use the pop-up saw. (Tr. 137, 918-19).

At the hearing, Messrs. Meindl and Joslin stated they did not know of any complaints about guarding the foot pedal. Yet, management had been put on notice there were problems with the foot pedal and it could be far away from the saw and hard to find. This provided a heightened awareness of problems with the foot pedal. (Tr. 713, 934-35).

During the inspection, Mr. Meindl told CO Donofrio that "many people tell him many things about what's going on in the shop. He said that he may have been told about the foot pedal not being covered. He could not recall." The Court finds CO Donofrio's testimony credible. The CO related what he was told at the inspection, which was close in time to the accident and conditions surrounding it. The hearing was 22 months later giving Mr. Meindl's memory time to fade. The Court viewed Mr. Meindl's testimony about the foot pedal self-serving and less credible. (Tr. 220-21; Ex. T, p.14).

---

[154] The supervisors were Messrs. Hart and Hess. Mr. Hart complained to Messrs. Meindl and Joslin about the foot pedal. Mr. Hess told CO Donofrio he had complained to Mr. Meindl about the foot pedal. (Tr. 130, 217-20, 224, 392, 401-02, 411-13, 701; Exs. G, p. ARM 38, T, pp. 11, 25).

Mr. Joslin also testified that he was not aware of complaints about guarding the foot pedal. He was aware that the foot pedal was not covered and that it was connected to the pop-up saw by an air hose; however, he "hadn't given it much thought." Mr. Joslin testified that he had worked for seven years at a mattress company where he was a member of the safety committee on which he performed safety audits and took part in setting up the company's safety program, prior to working for ARM. Mr. Meindl testified that Mr. Joslin was hired to be plant manager by ARM because of his woodworking and safety experience.[155] Despite Mr. Joslin's safety experience, he took no steps to deal with the employees' and his own concerns about the foot pedal. (Tr. 698, 713, 739-40, 902).

In addition, ARM chose to purchase a replacement foot pedal without a guard or other protection against accidental tripping in late April, 2012. This foot pedal was attached to the pop-up saw with a six to seven foot air hose, allowing the pedal to be a significant distance from the saw, which increased the likelihood of tripping and accidental activation of the blade. (Tr. 132, 182, 780, 866, 916-17; Ex. E).

Management's assertion that it was unaware of problems with the foot pedal is disingenuous. Even with the generic nature of its safety manual, ARM's manual included a clear requirement to protect employees from accidental activation of equipment by tripping. The Court finds the requirement in ARM's safety manual contributed to its heightened awareness of the hazard. *See Morrison-Knudsen Co.,* 16 BNA OSHC 1105, 1127 (No. 88-572, 1993) (finding the employer's safety program considered with other evidence established a "willful awareness of responsibilities."). (Ex. A, § XXIII, *Machine Guarding Safety Program*, p. 5).

Despite employee complaints, supervisor's use of the saw, and hiring a new plant manager to oversee safety in September, 2012, no efforts were made to secure, guard or

[155] It is unclear from the record the extent of woodworking experience Mr. Joslin acquired at a mattress company.

otherwise protect the foot pedal from accidental activation before Mr. Lebron's accident. ARM ignored its own safety rule. ARM's lack of training for its employees (and supervisors) further demonstrates its indifference to employee safety. Finally, ARM was able to guard the foot pedal with minimal cost and effort after the accident. This shows an indifference to implement even simple safety measures.

The Court finds the actions, and inaction, of ARM's supervisors and managers demonstrate plain indifference to employee safety. The Court finds that willfulness has been established and affirms a willful violation of 29 C.F.R. § 1910.213(b)(6).

ARM asserts that a willful violation does not apply because it acted in good faith to comply with the standard, the standard was unclear and it was at most, negligent, not willful. First, ARM asserts that a willful characterization is not appropriate because it acted in good faith. ARM argues that Mr. Joslin did not know of the requirement to cover the foot pedal, and thus ARM had a good faith belief that it was in compliance. This assertion fails. The employer has the burden of proof on good faith. *Morrison-Knudsen Co.,* 16 BNA OSHC at 1127. An employer's good faith belief that it was in compliance with OSHA requirements can negate willfulness if it is not unreasonable. *See Id.,* at 1127-28. (R. Br. 37, 39).

ARM's argument that it reasonably believed it was in compliance is undermined by its own safety manual. The safety manual included a requirement to protect the foot pedal from accidental activation. Further, Mr. Joslin had prior safety experience and was hired to improve safety at ARM's facility. Under these conditions, it is not reasonable for the Court to conclude that ARM exhibited good faith in failing to cover the foot pedal. (Ex. A, § XXIII, p. 5).

ARM asserts that it had made great improvements in implementing safety measures after Mr. Joslin was hired. The Court recognizes that it appears Mr. Joslin was attempting to improve

safety at ARM's facility by arranging for needed forklift training. However, that does not mitigate ARM's willfulness with regard to this citation item. An employer's unsuccessful efforts must be objectively reasonable to demonstrate the employer's state of mind was not one of disregard or indifference. *Beta Constr. Co.*, 16 BNA OSHC at 1445. In *Beta*, the Commission found that the employer "plainly acted in an objectively reasonable manner and thus manifested good faith through the establishment and implementation of its comprehensive safety program." *Id.* The Commission distinguished *Beta* from its earlier decision in *Sal Masonry Contractors, Inc.*, 15 BNA OSHC 1609, 1611, 1613 (No. 87–2007, 1992), where willfulness was not negated because the employer had implemented minimal measures to provide for employee safety. *Id.* (R. Br. 40).

ARM's actions were not reasonably objective. Much like the employer in *Sal Masonry*, ARM's safety efforts were minimal. First, ARM obtained a generic safety manual from Paychex, which it did not adapt to its facility, as was necessary. Second, it appears none of ARM's management read the safety manual. Third, they did not train its employees on safety rules. Fourth, Mr. Joslin was hired just a few months before the accident. ARM cannot defer its responsibility for implementing safety in its facility to a single person. It was required to have safety protections in place before Mr. Joslin was hired, as well as thereafter.

ARM also relies on *Dayton Tire*, 671 F.3d at 1256, to assert that the Secretary can only show plain indifference if an employer made no effort to address safety concerns.[156] ARM's

[156] ARM cites to *U.S. v Ladish Malting Co.*, 135 F.3d 484, 490 (7th Cir. 1998), to assert that the Secretary must prove actual knowledge to establish willfulness. (R. Br. 36). However, this reliance is not dispositive. In *Dukane Precast, Inc. v. Perez*, 785 F.3d 252, 256 (7th Cir. 2015)(citations omitted), the Seventh Circuit clarified that a finding of willfulness under the OSH Act does not require an employer to have actual knowledge, but instead found a willful characterization was supported where the employer "was aware of the risk, knew that it was serious, and knew that he could take effective measures to avoid it, but did not – in short, that he was reckless in the most commonly understood sense of the word." In *Dukane*, the plant manager did not act even after seeing the employee trapped in a confined space and buried up to his waist in sand.

comparison to *Dayton* is out of place. In *Dayton*, the court found that the employer's attempts to comply with the OSHA standard mitigated against a finding of plain indifference. The D.C. Circuit relied on the Commission's findings that "an employer is entitled to have a good faith opinion that his conduct conforms to regulatory requirements." *Id*., at 1257, quoting *C.N. Flagg & Co*., *Inc*., 2 BNA OSHC 1539 (No. 1409, 1975). Further, the D.C. Circuit found that the safety measures taken by Dayton demonstrated good faith. *Id*. No such finding is merited here. (R. Br. 37).

ARM made little effort to address its safety concerns. It made almost no effort to train its employees (including supervisors), did not tailor its safety manual to its facility or post machine warnings in alternate languages for non-English readers, and seemed to place all responsibility for safety on one manager that it had hired a few months before the accident. ARM provided no evidence that it attempted to follow OSHA standards. ARM has not demonstrated it had a reasonable good faith belief that it was providing adequate safety measures before December 3, 2012.

ARM further relies on *McKie Ford, Inc. v. Sec'y of Labor*, 191 F.3d 853, 856-57 (8th Cir. 1999) to show that negligence or carelessness cannot be used to establish willfulness. (R. Br. 36). This case does not support Respondent's position. *McKie Ford Inc*. points out that it is difficult to discern negligent behavior from plainly indifferent conduct. *Id.* It states that "[a]n employer need not harbor malicious motives or possess a 'specific intent'. . . to commit a willful violation." *Id.*, citing *Ensign–Bickford Co. v. OSHRC*, 717 F.2d 1419, 1423 (D.C. Cir. 1983) (same). In *McKie Ford, Inc.*, the Eighth Circuit Court found substantial evidence to support a willful designation where the employer had a prior accident with a freight elevator, yet continued to allow employees to routinely use the freight elevator. *McKie Ford, Inc. v. Sec'y of Labor*, 191

F.3d at 856-57. Here, ARM had ample notice that employees had concerns about the foot pedal. Its safety manual contained a rule that the foot pedal must be protected, yet ARM took no corrective action.

ARM also asserts the cited standard is unclear; even if it had read the OSHA standard it would not have known what was needed to comply. This argument fails as well. "[R]egulations are to be read as a whole, with each part or section . . . construed in connection with every other part or section." *Custom Built Marine Constr., Inc.*, 23 BNA OSHC 2237, 2239 (No. 11-0977, 2012). First, the standard clearly states the purpose is to protect a foot pedal from accidental activation. It does not dictate a particular method to the employer. An employer can choose an effective method suitable to its workplace. There is no evidence that ARM could not understand the requirement of the standard. Not being aware of the standard is not the same as not understanding the meaning of the standard. Second, ARM's own safety manual included a requirement to protect foot pedals from accidental activation by tripping. ARM knew that the foot pedal activated the blade of the pop-up saw. It made no effort to implement a control to prevent accidental activation. ARM's argument that it did not understand the requirements of the standard is rejected. (R. Br. 41).

The Court rejects ARM's arguments that a willful characterization is not merited; the Court affirms a willful characterization for this citation item.

Penalty Amount

The statutory maximum penalty for a willful violation is $70,000. 29 U.S.C. § 666(a). The gravity of the violation is the primary factor to consider when determining the penalty amount. This citation item was assessed as high severity and greater probability. There were no penalty reductions for good faith or history; however, a 20% reduction was given due to the

small size of the employer. Willful violations do not qualify for a good faith discount. Because ARM had not been inspected previously there was not a penalty reduction for history. The proposed penalty of $56,000 is affirmed for Citation 2, Item 2. (Tr. 208-09, 225-26).

Docket No. 13-1102

Citation 1, Item 1

The Secretary cited ARM for a serious violation of section 5(a)(1) of the Act, also known as the "General Duty Clause." Section 5(a)(1) requires an employer to "furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees." 29 U.S.C. § 654(a)(1); *Usery v. Marquette Cement Mfg. Co.*, 568 F.2d 902, 909 (2d Cir. 1977). An actual injury is not required for the Secretary to prove a section 5(a)(1) violation. *Usery*, 568 F.2d at 910. Citation 1, Item 1 alleged a violation as follows:

> The employer did not furnish employment and a place of employment which were free from recognized hazards that were causing or likely to cause death or serious physical harm to employees in that employees were exposed to the hazard of being crushed or seriously injured in a fall while being elevated in a basket on a forklift truck without the benefit of adequate means of fall protection:
>
> Production Area – On or about January 30, 2013, an employee was observed working from a plastic basket which was raised by a Hyster forklift truck in order to gain access to the ceiling area where the maintenance employee was hard-wiring the Core Cutter. The maintenance employee was exposed to a fall of approximately 12 feet to the concrete floor below.
>
> Among other methods, several feasible and acceptable abatement methods to correct this hazard include: 1) Only operator-up high lift trucks have been designed to lift personnel. If a work platform is used on trucks designed and intended for handling material, the requirement of ASME B56.1-2000 Section 4.17.2 and 4.17.3 shall be met for the protection of personnel, 2) use an alternate safe means to access the electrical components at the ceiling area such as a scissors lift, and 3) provide training to employees on the safe means to access electrical equipment at ceiling heights.

Respondent argues the citation should be vacated because the employee in the basket was installing permanent wiring to replace temporary wiring in the wood shop area. (R. Br. 31).

The Secretary's Burden of Proof and Applicability

To prove a violation of the General Duty Clause, the Secretary "must demonstrate that: 1) a condition or activity in the workplace presented a hazard, 2) the employer or its industry recognized the hazard, 3) the hazard was likely to cause death or serious physical harm, and 4) a feasible and effective means existed to eliminate or materially reduce the hazard." *Otis Elevator Co*., 21 BNA OSHC 2204, 2206 (No. 03-1344, 2007); *see also, Usery*, 568 F.2d at 909-10. The Secretary must also show that the employer knew or with the exercise of reasonable diligence could have known of the hazardous condition. *Id.*; *Otis Elevator Co*., 21 BNA OSHC at 2206.

The General Duty Clause is applicable where no specific standard applies to the cited condition. *N.Y. State Elec. & Gas Corp.*, 17 BNA OSHC 1129, 1130 (No. 91-2897, 1995), *aff'd in relevant part*, 88 F.3d 98 (2nd Cir. 1996). The Secretary asserts there is no specific OSHA standard that addresses the cited hazard. Respondent does not dispute this assertion. The Court finds that the General Duty Clause is applicable to the cited hazardous condition. (Tr. 432; S. Br. 67).

The Condition Presented a Hazard

The evidence shows that Mr. Cansdale was working without fall protection 12 feet above the concrete floor in a plastic basket (also referred to as a "plastic tote") supported by a forklift. The plastic basket was a bin typically used to store manufacturing parts and not designed for lifting personnel on a forklift. Mr. Cansdale was installing permanent electrical wiring to replace temporary wiring in the wood shop. ARM acknowledges that the basket was not an "approved" device for lifting personnel. The Court finds Mr. Cansdale was working from a plastic basket

not approved for lifting personnel and without adequate fall protection. The Secretary proved the condition presented a hazard. (Tr. 428-36, 452, 462-64; Exs. 57, p. 6, 59; R. Br. 31).

Recognition of the Hazard

Under the General Duty Clause, a "hazard is deemed 'recognized' when the potential danger of a condition or activity is either actually known to the particular employer or generally known in the industry." *Pepperidge Farm, Inc.*, 17 BNA OSHC 1993, 2003 (No. 89-265, 1997); *see also Pratt & Whitney Aircraft, Div. of United Tech. Corp. v. Sec'y,* 649 F.2d 96, 101 (2d Cir. 1981). CO Mielonen testified that the hazard described in the citation was recognized by industry standard. The Court finds the hazard was recognized by both the industry and ARM. (Tr. 436; Ex. 60, at pp. 14-15).

Proof of recognition can be demonstrated through industry's recognition of the hazard. *See Nat'l Realty*, 489 F.2d 1257, 1265 n.32 (D.C. Cir. 1973). The American Society of Mechanical Engineers' (ASME) Safety Standard for Low Lift and High Lift Trucks (ASME B56.1-2000) provides at § 4.17.1 that "[o]nly operator-up high lift trucks have been designed to lift personnel." The plastic basket lifted by the forklift was not designed for or approved for lifting personnel. In addition, ASME B56.1-2000, § 4.17.2(c) states: "Whenever a truck is used to elevate personnel, the following precautions for the protection of personnel shall be taken . . . (c) be certain that required means such as railings, chains, cables, body belt(s) with lanyard(s), or deceleration devices, etc. are in place and properly used." Mr. Cansdale was not using any fall protection equipment while working from the plastic basket 12 feet about the ground. (Tr. 432, 439; Ex. 60, p. 14).

An employer's work rule can also establish recognition of the hazard. *Ted Wilkerson, Inc.,* 9 BNA OSHC 2012, 2016 (No. 13390, 1981). ARM's safety manual includes a section

entitled "Fall Protection (Personal Fall Arrest System) Safety Program." This section states that "hazards of potential falls at heights of 4 feet and above (or 6 feet and above at construction sites) will be addressed," employees should "[u]tilize fall protection systems and equipment, as needed or required," and "fall protection systems are required when . . . working in an aerial lift bucket." This shows that ARM recognizes the need to provide fall protection when employees are working from heights of 4 feet or more. *See Otis Elevator Co*., 21 BNA OSHC at 2207 (recognizing employer's own work rule established recognition of hazard). (Ex. A, § XIV, pp. 1-3).

The "obvious and glaring" nature of a hazard may also be sufficient for showing employer recognition. *Kelly Springfield Tire Co., Inc. v. OSHRC,* 729 F.2d 317, 321 (5th Cir. 1984). Here, Mr. Cansdale was working in plain view in a plastic tote about twelve feet above the concrete floor without any fall protection. CO Mielonen quickly observed the hazard while walking toward the scene of Mr. Lebron's accident. The Court finds the hazard to have been obvious and glaring. (Tr. 430, 439; Ex. 59).

The Court finds that both ARM and the industry recognized the fall hazard when working at heights without proper fall protection; recognition of the hazard is established.

The Hazard Was Likely to Cause Death or Serious Harm, and Employee Exposure

Determination of whether a hazard can cause serious harm is not based on the likelihood that an injury will occur, instead it is whether there is a likelihood that death or serious physical harm could result if an accident occurs. *Compass Envtl., Inc.*, 23 BNA OSHC at 1136. Respondent asserted the hazard was not serious, but provided no explanation to support this position. The Court finds that a fall of 12 feet to a concrete floor is likely to cause death or

serious harm. The evidence shows that Mr. Cansdale was exposed to a fall hazard that could result in serious injury or death. (Tr. 432, 436, 440).

Feasible Means to Mitigate the Hazard

The Secretary must demonstrate a feasible abatement exists to prove a General Duty Clause violation. *Whirlpool Corp. v. OSHRC*, 645 F. 2d at 1098. The Secretary "must specify the proposed abatement measures and demonstrate both that the measures are capable of being put into effect and that they would be effective in materially reducing the incidence of the hazard." *Beverly Enterp., Inc.*, 19 BNA OSHC 1161, 1190 (No. 91-3144, 2000) (consolidated). The Secretary is not required to show the abatement would eliminate the hazard, he "need only show that the abatement method would materially reduce the hazard." *Arcadian Corp.*, 20 BNA OSHC 2001, 2011 (No. 93-0628, 2004).

CO Mielonen testified that fall protection could have been provided to Mr. Cansdale. The Secretary asserts the fall hazard could have been abated by using a device approved to lift personnel and the use of personal fall protection equipment as recommended in the ASME B56.1-2000 industry standard. ARM's safety manual indicates the Secretary's proposed abatement is similar to its own safety rules. Additionally, ARM's safety manual states the workplace shall be assessed for fall hazards and appropriate fall protection systems should be used. ARM did not assert that the abatement proposed by the Secretary was not feasible or would not materially reduce the hazard. The Court finds the abatement measures proposed could materially reduce the fall hazard and were feasible to implement. (Tr. 438-39; Exs. 60, A, § XIV, p. 2; S. Br. 69).

Employer Knowledge

The Secretary has proved that ARM knew or could have known of the hazardous condition. Actual knowledge is established through ARM's admission that Mr. Joslin knew Mr. Cansdale was working in the plastic basket.[157] ARM seems to suggest that Mr. Joslin's knowledge cannot be imputed because the company's officers were unaware of Mr. Cansdale's work activity. This is rejected. A supervisor's knowledge can be imputed to the employer; knowledge by a corporate officer is not required. *See Rawson Contractors, Inc.*, 20 BNA OSHC at 1080. (Ex. 58, p.6).

Additionally, constructive knowledge is established. With reasonable diligence, ARM management could have known that its maintenance employee was working without fall protection 12 feet above the floor in a plastic basket not designed to lift personnel. Mr. Cansdale was installing permanent wiring to correct the use of temporary wiring in the wood shop.[158] Mr. Cansdale testified that his work was assigned to him by either Messrs. Joslin or Meindl. Mr. Joslin testified that he went over the maintenance list with Mr. Cansdale each day to determine the assignments for that day. Further, Mr. Cansdale was working in plain view in the wood shop. Mr. Joslin could have known, with reasonable diligence, that Mr. Cansdale was not using adequate fall protection or an approved personnel lifting device. (Tr. 435-39, 709, 752-53; Ex. 59).

ARM acknowledges that Mr. Cansdale's work "may have been a violation"; however, because he was installing permanent wiring to replace temporary wiring there should be no citation. ARM provided no case law to support its position. Correcting a safety hazard does not

[157] In an interrogatory response, "Respondent admits that the plant manager knew that Mr. Cansdale was in the basket, but not company's officers." (Ex. 58, p.6).
[158] During the hearing, Mr. Cansdale, a witness for Respondent, provided no testimony regarding this citation item, or the work he was doing when CO Mielonen photographed him. (Tr. 747-55).

provide an exception from following safety standards. ARM's argument is without merit. (R. Br. 31).

The Court finds that the standard is applicable, its terms were violated, employees were exposed and ARM had knowledge of the condition.[159] The Secretary has proved his prima facie case for this citation item.

Serious Characterization & Penalty Amount

ARM asserts that if it is a violation it was not a serious hazard.[160] The Court finds the Secretary properly classified this citation item as serious. Working 12 feet above a concrete floor can result in serious injury or death. The gravity of the violation was assessed as high severity. There were no penalty reductions for good faith or history; however, a 30% reduction was given due to the small size of the employer. The proposed penalty of $3,500 is affirmed. (Tr. 436, 439-41; R. Br. 31).

Citation 1, Items 2a & 2b

For Citation 1, Item 2a, the Secretary alleged a violation of 29 C.F.R. § 1910.1030(c)(1)(i) which stated:

> *Bloodborne pathogens*. . . . (c) Exposure control--(1) Exposure Control Plan. (i) Each employer having an employee(s) with occupational exposure as defined by paragraph (b) of this section shall establish a written Exposure Control Plan designed to eliminate or minimize employee exposure.

For Citation 1, Item 2b, the Secretary alleged a violation of 29 C.F.R. § 1910.1030(g)(2)(i) which stated:

[159] ARM also asserted the affirmative defense of unpreventable employee misconduct for this item in the joint pre-hearing statement. ARM asserted the misconduct was Mr. Cansdale put himself in the plastic basket on his own initiative and with the knowledge of the plant manager, but not ARM's officers. It is unclear to the Court if it still pursued this defense in its post-hearing brief. This defense is discussed at Citation 2, Items 1 and 2 above. For the same reasons discussed above, the defense fails for this citation item.

[160] In support of this argument, Respondent stated, "[t]he problem was that the device the worker was in was not 'approved,' even though"[.] The sentence ends at its mid-point without completion. There was no further clarification of this point in ARM's reply brief filed with the Court. The basis for ARM's argument is unintelligible. (R. Br. 31).

> *Bloodborne pathogens*. . . . (g) *Communication of hazards to employees* . . . . (2) *Information and Training*. (i) The employer shall train each employee with occupational exposure in accordance with the requirements of this section. Such training must be provided at no cost to the employee and during working hours. The employer shall institute a training program and ensure employee participation in the program.

For item 2a, the Secretary alleges that ARM did not develop or implement a written Exposure Control Plan designed to eliminate or minimize employee exposure to bloodborne pathogens. For item 2b, the Secretary alleges that three employees with potential occupational exposure to blood were not trained. CO Mielonen testified the citation was based on the cleanup of blood by three employees; not for assisting an injured coworker. (Tr. 447-48; Ex. 57, p. 8; S. Br. 69-71).

ARM admits that two of its employees, Messrs. Joslin and "Manny" [presumably Anieal Rodriguez] cleaned up blood in the wood shop on December 3, 2012. However, ARM asserts the citations should be vacated for three reasons. First, the standard is not applicable because its employees do not have occupational exposure to bloodborne pathogens. Second, any exposure that occurred on December 3, 2012, was due to a "Good Samaritan" act and not subject to citation. Finally, ARM asserts there was no violation because its safety manual included a written exposure control plan and two exposed employees were adequately trained. (Ex. A, § V; R. Br. 12, 33).

Applicability

The Secretary asserts that ARM's employees had occupational exposure to blood. Occupational exposure is defined as ". . . reasonably anticipated skin, eye, mucous membrane or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties." 29 C.F.R. § 1910.1030(b).

ARM does not dispute that at least two of its employees, Messrs. Joslin and Anieal Rodriguez, were exposed to the blood during cleanup; however, ARM asserts that any exposure was the result of a "Good Samaritan act," which provides an exception to the standard. (Tr. 719; R. Br. 33).

ARM's expert stated that ARM employees do not have occupational exposure to blood because ARM employees are not required or expected to perform CPR, first aid, or other emergency assistance. Mr. Miller opined that because no one at ARM was designated for cleanup there was no occupational exposure to blood. Mr. Miller's opinion was based in part on OSHA CPL 02-02-069, an OSHA Letter of Interpretation, dated December 4, 1992 (Valentini letter), and an OSHA Letter of Interpretation, dated December 13, 2010 (Rucker letter).[161] As discussed below, these items do not support ARM's position that it and the blood cleanup activity accomplished by its employees that occurred after the accident on December 3, 2012 were not subject to the Occupational Exposure to Bloodborne Pathogens standard. (Tr. 799-800, 860-61, 864; Ex. W, pp. 7-8, Z).

OSHA explained the Good Samaritan exception in compliance directive CPL-02-02-069 entitled, *Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens.*[162]

> This definition [occupational exposure] does not cover "Good Samaritan" acts (i.e. voluntarily aiding someone in one's place of employment) that result in exposure to blood or other potentially infectious materials from voluntarily assisting a fellow employee, although OSHA encourages employers to offer follow-up procedures to these employees in such cases.

ARM asserts the Valentini letter supports its position that the Good Samaritan exception extends beyond assisting an employee in an emergency. ARM argues it extends to the cleanup of blood.

---

[161] ARM withdrew the Valentini letter as a trial exhibit. (Tr. 944).
[162] Ex. Z; CPL 02-02-069 dated November 27, 2011 is available at https://www.osha.gov/OshDoc/Directive_pdf/CPL_2-2_69.pdf

ARM misconstrues this letter. ARM relies on "Scenario 4" of the Valentini letter[163] to show that Good Samaritan acts related to work-related injuries are not considered "occupational exposure." Scenario 4 in the Valentini letter answers the question of whether the type of injury (work-related or not) is relevant to a determination of Good Samaritan exception.[164] Scenario 4 does not address the cleanup of blood; the Valentini letter does not support ARM's position. (R. Reply Br. 16-17).

The Secretary asserts the Good Samaritan exception is limited to when an employee provides assistance to an injured coworker, not to cleanup. As noted in the preamble to the bloodborne pathogen standard:

> An example of a contact with blood and other potentially infectious materials that would not be considered to be an 'occupational exposure' would be a 'Good Samaritan' act. For example, one employee may assist another employee who has a nosebleed or who is bleeding as the result of a fall. 56 Fed. Reg. 64004, 64101-02 (Dec. 6, 1991)(to be codified at 29 C.F.R. part 1910.1300). (Tr. 445-48, 466; S. Br. 71).

The Court finds that the cleanup of blood done here does not qualify as a Good Samaritan act. The Good Samaritan exception applies when an employee is assisting an injured employee. Good Samaritan acts are acts that occur when an employee is "voluntarily aiding someone in one's place of employment." Here, the victim had left the area and employees were cleaning up the work area, not assisting the victim. ARM's assertion that its employees' exposures were the result of a Good Samaritan act is rejected. (Tr. 860; Ex. Z, p. 6).

---

[163] This letter, dated December 4, 1992, to Mr. Valentini can be accessed at https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=INTERPRETATIONS&p_id=20948

[164] "Scenario 4: This applies to every workplace and relates to where the line is drawn between 'occupational exposure' and 'good Samaritan acts.' A fact sheet circulated by OSHA, contains the statement 'Good Samaritan acts such as assisting a co-worker with a nose blood would not be considered occupational exposure.' My question is: 'Would a worker assisting a blooding co-worker with a work related injury still be considered a good Samaritan or does the worker have occupational exposure?' Answer: 'Good Samaritan' acts are not covered under the standard regardless of the particular type of injury involved. The work-relatedness of the injury is not the determining factor; rather coverage is invoked when, as stated above, an employee is expected to render assistance as part of his or her job duties." (R. Br. 33).

Respondent relies on the Rucker letter to suggest the cited standard only applies to "employees who are designated to provide first aid or medical assistance as a part of their job duties."[165] However, Respondent misconstrues the meaning of the letter. In the Rucker letter, OSHA states that all employees designated to render first aid are covered by the requirements of the Bloodborne Pathogens standard:

> The OSHA Bloodborne Pathogens standard is applicable to ***all occupational exposure to blood*** or other potentially infectious material (OPIM), as defined by the standard. [29 CFR 1910.1030(a).] The term "occupational exposure' is defined as "...reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties." (emphasis added.)

OSHA does not limit the coverage of this standard to only those employees tasked with providing first aid services; it clarifies the standard is applicable to all occupational exposure, including the provision of first aid services. Any employee who has occupational exposure to blood is included within the scope of the standard; except those performing Good Samaritan acts on a person. A lack of history of blood exposures at a facility does not preclude coverage. Respondent's assertion to the contrary is rejected. (Tr. 443-44; Ex. Z, p. 5; R. Reply Br. 16).

ARM asserts that, because Messrs. Joslin and Anieal Rodriguez, were not expected or assigned to provide first aid or other assistance, the standards do not apply. The Secretary asserts that the standards do apply and occupational exposure was reasonably anticipated by ARM for two reasons. First, CO Mielonen testified that OSHA considers it reasonable to expect exposure to blood from injuries in the woodworking industry. Second, ARM's Logs of Work-Related Injuries and Illness for 2011 and 2012 list four events that likely caused bleeding: 1) a cut on the hand from a dismantler resulting in 51 days away from work; 2) a puncture from stepping on a nail resulting in 6 days away from work; 3) an abrasion from a saw resulting in 4 days away

[165] This letter, dated December 13, 2010, to Catherine Rucker can be accessed at https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=INTERPRETATIONS&p_id=28835

from work; and 4) a puncture wound in the wood shop resulting in 2 days away from work. (Tr. 122-23, 443-45, 465; Ex. 61; R. Reply 16-17).

The Court agrees with the Secretary and finds that it is reasonable to anticipate employee exposure to blood in ARM's woodworking shop. ARM's injury log includes accidents that were more likely than not to result in bleeding, especially in light of the significant number of days away from work. Further, the Court finds that it is reasonable to expect cuts and other injuries that result in bleeding for employees engaged in woodworking activities.[166] An injury on woodworking equipment exposes employees to blood on the machine and during cleanup.

OSHA's Valentini letter states at Scenario 2 that "[a]n employee whose job includes the cleaning and decontaminating of contaminated areas or surfaces would be considered to have occupational exposure." Because blood-related injuries are reasonably anticipated in a woodworking facility, it is not reasonable for ARM to simply assert that it does not expect its employees to come in contact with blood. ARM cannot avoid responsibility by claiming it does not assign post-injury cleanup as a job duty or by not training its employees to avoid potential bloodborne pathogens in the event of an injury. It is reasonable to expect injuries that result in bleeding will occur at its facility. Someone at the facility must be tasked with the responsibility to clean the work area or ensure that employees are not exposed to blood.

Based on the evidence provided, the Court concludes that it was Messrs. Fernando Rodriguez, Anieal Rodriguez, and Joslin's job responsibility to cleanup blood after an injury. Mr. Anieal Rodriguez worked in ARM's maintenance department. Both he and Mr. Joslin, who supervised his boss, Mr. Cansdale, had some prior safety training. It was incumbent on them to

[166] "Courts are entitled to base conclusions upon common sense where the facts so warrant. *Usery v. Marquette Cement Mfg. Co.*, [citation omitted] (in reversing the Commission's finding in favor of the employer, held that 'it scarcely requires expertise in the industry' to recognize that a certain practice was hazardous)." *Carlyle Compressor Co., Div. of Carrier Corp. v. OSHRC*, 683 F.2d 673, 677 n.9 (2nd Cir. 1982).

clean up the blood after the accident. The Secretary has proved that it is reasonable to anticipate occupational exposure to blood at ARM's worksite and therefore the standard is applicable. The Court finds ARM is required to have a written exposure control plan and provide training to protect its employees from bloodborne pathogens.

Violation of the Standard

CO Mielonen testified that Mr. Joslin told her that ARM did not have a written exposure control plan. Both Messrs. Joslin and Rivera testified that ARM did not have an employee exposure plan. ARM asserts its safety manual included an exposure control plan and two exposed employees, Messrs. Joslin and Ruiz, were each properly trained.[167] ARM admits it did not implement its limited exposure control plan. (Tr. 138, 441, 464, 741; Ex. 58, p. 4; R. Reply Br. 16).

The relevant section in ARM's safety manual was four pages in length and entitled, "*Blood and Bodily Fluids (Incidental) Exposure Safety Program*" and stated it "applies to all locations within company buildings or facilities where incidents involving exposures to a person's blood or bodily fluids may occur." One of the listed requirements was to "[d]ocument and maintain written processes and procedures in work areas where exposure could potentially occur." ARM provided no evidence to show that any processes or procedures had been developed or implemented. ARM asserts procedures were unnecessary because no one was assigned to clean up after an injury. The program in ARM's safety manual was incomplete because it did not include the required written procedures. (Ex. A, § V, pp. 2-3).

[167] ARM asserts that proper precautions were taken by Messrs. Ruiz and Joslin during the cleanup. Mr. Joslin explained that after the accident he and Mr. Ruiz donned masks and gloves, cordoned off the area, and used a bleach solution to clean up the area. A disposal company took away the containers of contaminated materials. (Tr. 719; R. Reply Br. 16).

The Court finds that ARM did not have an adequate written exposure control plan designed to eliminate or minimize employee exposure to bloodborne pathogens.

The Secretary also asserts that ARM did not provide training to its employees with occupational exposure to bloodborne pathogens. CO Mielonen testified that training in an exposure control plan would include, among other things, cleanup procedures, personal protective equipment to wear during cleanup, disposal procedures, an explanation of ARM's exposure control plan, and the right to Hepatitis B vaccination and testing. (Tr. 448-49).

Mr. Joslin told CO Mielonen that he had received some training from a previous employer and that the other two employees who helped him with the clean-up had not received any training from ARM. ARM admits it did not provide training; however, it asserts there was no violation because two employees that were exposed to blood on December 3, 2012 had been trained at each of their prior employers. Mr. Joslin testified that he had been trained and cleaned up blood at his previous employer. Mr. Joslin further testified that Anieal Rodriguez also had unidentified safety training from a prior employer. No additional information was adduced about the nature of Anieal Rodriguez's safety training, who the prior employer was, its content, or when it occurred. Further, Mr. Joslin did not provide the basis for his belief that Anieal Rodriguez had prior training. The record is silent also as to ARM providing training to Fernando Rodriguez. Mr. Joslin testified that he did not know if anyone had ever cleaned up blood at ARM before December 3, 2012. ARM provided no training in occupational exposure to bloodborne pathogens to Messrs. Joslin, Anieal Rodriguez, or Fernando Rodriguez. (Tr. 449, 718-20; Ex. 58, pp. 4-5).

Even if two exposed ARM employees were trained at their respective prior employers, it does not lessen ARM's responsibility to train its employees. ARM cannot rely on an employee's

prior unidentified and undocumented training and experience as a substitute for providing training on the hazards in its workplace. *See A.P. O'Horo Co.*, 14 BNA OSHC 2004, 2009-10 (No. 85–369, 1991) (finding employer had an unimplemented written safety program, did not provide training, and instead relied on employee's prior experience). Additionally, an employer cannot shift its duties to provide safe working conditions to its employees. *Pride Oil Well Serv.*, 15 BNA OSHC 1809, 1815 (No. 87-692, 1992). There is no evidence, other than a general inquiry about Mr. Joslin's prior safety experience during the hiring process, that ARM determined what his particular experience and safety training encompassed.

The Court finds that ARM did not provide occupational exposure to bloodborne pathogen training to its employees as required by the standard. The Secretary has proved that ARM did not comply with the terms of the standards cited at Citation 1, Items 2a and 2b.

Employee Exposure

CO Mielonen testified that three employees were exposed to blood or other potentially infectious materials, which can result in contraction of HIV, hepatitis B and hepatitis C, by ARM failing to properly train its employees or not having a written exposure control plan.[168] On December 3, 2012, Messrs. Joslin, Fernando Rodriguez and Anieal Rodriguez[169] cleaned up blood after Mr. Lebron's amputation accident.[170] The Court finds that three ARM employees had occupational exposure; employee exposure is proved. (Tr. 138, 442, 450, 719, 741).

Employer Knowledge

[168] Messrs. Joslin and Anieal Rodriguez were not offered hepatitis shots after they cleaned up the blood. (Tr. 741-42).
[169] Mr. Rivera testified that two maintenance employees cleaned up the blood after the accident with bleach and water. CO Mielonen identified Fernando Rodriguez as an employee, in addition to Messrs. Joslin and Anieal Rodriguez, that was also exposed to the blood. The record shows Fernando Rodriguez signing into Forklift Operator Safety Training conducted on December 7, 2012. (Tr. 138-42, 442, 450; Ex. P, p. ARM 934).
[170] CO Mielonen testified that Mr. Joslin told her that he had helped in the blood clean up. (Tr. 443).

Knowledge is directed at the violative condition; it is not necessary to show that the employer knew or understood the condition was hazardous. *Phoenix Roofing, Inc.*, 17 BNA OSHC at 1079-80. As discussed above, four recorded events from ARM's Injury Log show past injuries where exposure to blood could have occurred. ARM's safety manual states the employer should assess "where exposures or potential exposures are present." ARM's safety manual and its OSHA 300 Injury Log demonstrate ARM's actual knowledge of the potential for an employee exposure to bloodborne pathogens. (Ex. A, § V, p. 3).

Knowledge is proved through ARM's injury log and its safety manual. The Court finds that the standard is applicable, its terms were violated, employees were exposed and ARM had knowledge of the condition. The Secretary has proved his prima facie case for this citation item.

Serious Characterization & Penalty Amount

The Secretary properly classified these citation items as serious. Contact with blood can expose employees to serious diseases, including HIV, hepatitis B and hepatitis C. The statutory penalty of $7,000 was reduced to $5,000 for gravity. There were no penalty reductions for good faith or history; however, a 30% reduction was given due to the small size of the employer. The proposed penalty of $3,500 is affirmed. (Tr. 450-51).

Findings of Fact and Conclusions of Law

All findings of fact and conclusions of law relevant and necessary to a determination of the contested issues have been made above. *See* Fed. R. Civ. P. 52(a). All proposed findings of fact and conclusions of law inconsistent with this decision are denied.

ORDER

Based upon the foregoing findings of fact and conclusions of law, it is **ORDERED** that:

Docket No. 13-1101 (Inspection #767103)

1. Citation 1, Item 1a, alleging a serious violation of 29 C.F.R. § 1910.22(a)(1) and Citation 1, Item 1b, alleging a serious violation of 29 C.F.R. § 1910.22(a)(2), are AFFIRMED, and a penalty of $4,900 is assessed.

2. Citation 1, Item 2, alleging a serious violation of 29 C.F.R. § 1910.36(d)(1), is AFFIRMED, and a penalty of $3,500 is assessed.

3. Citation 1, Item 3, alleging a serious violation of 29 C.F.R. § 1910.147(c)(1), is AFFIRMED,[171] and a penalty of $4,400 is assessed.

4. Citation 1, Item 4, alleging a serious violation of 29 C.F.R. § 1910.147(c)(4)(i), is AFFIRMED,[172] and a penalty of $4,400 is assessed.

5. Citation 1, Item 5, alleging a serious violation of 29 C.F.R. § 1910.147(c)(5)(i), is AFFIRMED, [173] and a penalty of $4,400 is assessed.

6. Citation 1, Item 6, alleging a serious violation of 29 C.F.R. § 1910.147(c)(7)(i), is AFFIRMED, [174] and a penalty of $3,900 is assessed.

7. Citation 1, Item 7, alleging a serious violation of 29 C.F.R. § 1910.176(a), is AFFIRMED, and a penalty of $4,200 is assessed.

8. Citation 1, Item 8, alleging a serious violation of 29 C.F.R. § 1910.178(l)(1)(i), is AFFIRMED, and a penalty of $4,900 is assessed.

9. Citation 1, Item 9, alleging a serious violation of 29 C.F.R. § 1910.213(h)(4), is AFFIRMED, and a penalty of $4,900 is assessed.

10. Citation 1, Item 10, alleging a serious violation of 29 C.F.R. § 1910.213(r)(4), is AFFIRMED, and a penalty of $4,900 is assessed.

---

[171] This affirmance excludes a finding of a violation relating to the radial arm saw.
[172] This affirmance excludes a finding of a violation relating to the radial arm saw.
[173] This affirmance excludes a finding of a violation relating to the radial arm saw.
[174] This affirmance excludes a finding of a violation relating to the radial arm saw.

11. Citation 1, Item 11a, alleging a serious violation of 29 C.F.R. § 1910.303(b)(2), and Citation 1, Item 11b, alleging a serious violation of 29 C.F.R. § 1910.304(g)(5), are AFFIRMED, and a penalty of $4,200 is assessed.

12. Citation 1, Item 12, alleging a serious violation of 29 C.F.R. § 1910.305(b)(1)(ii), is AFFIRMED, and a penalty of $4,200 is assessed.

13. Citation 1, Item 13a), alleging a serious violation of 29 C.F.R. § 1910.305(g)(1)(iv)(A), is AFFIRMED, and a penalty of $2,100 is assessed. Citation 1, Item 13b) is VACATED.

14. Citation 1, Item 14a, alleging a serious violation of 29 C.F.R. § 1910.1200(e)(1), and Citation 1, Item 14b, alleging a serious violation of 29 C.F.R. § 1910.1200(h)(1) are AFFIRMED, and a penalty of $4,900 is assessed.

15. Citation 2, Item 1, alleging a willful violation of 29 C.F.R. § 1910.212(b), is AFFIRMED, and a penalty of $32,000 is assessed.

16. Citation 2, Item 2, alleging a willful violation of 29 C.F.R. § 1910.213(b)(6), is AFFIRMED, and a penalty of $56,000 is assessed.

Docket No. 13-1102 (Inspection # 860783)

17. Citation 1, Item 1, alleging a serious violation of Section 5 (a)(1) of the Act is AFFIRMED, and a penalty of $3,500 is assessed.

18. Citation 1, Item 2a, alleging a serious violation of 29 C.F.R. § 1910.1030(c)(1)(i), and Citation 1, Item 2b, alleging a serious violation of 29 C.F.R. § 1910.1030(g)(2)(i) are AFFIRMED, and a penalty of $3,500 is assessed.

SO ORDERED.

/s/ Dennis L. Phillips
The Honorable Dennis L. Phillips
U.S. OSHRC Judge

Dated:
Washington, D.C.