United States of America
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
1120 20th Street, N.W., Ninth Floor
Washington, DC 20036-3419

SECRETARY OF LABOR, Complainant, v. JERSEY CITY MEDICAL CENTER, Respondent.	OSHRC Docket No. 17-0249

Appearances: Kate O'Scannlain, Solicitor of Labor
Jeffrey S. Rogoff, Regional Solicitor
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U.S. Department of Labor, Office of the Solicitor, New York, New York

For the Complainant

Mark J. Blunda, Esquire
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For the Respondent

Before: Covette Rooney
Chief Administrative Law Judge

DECISION AND ORDER

On Sunday, June 26, 2016, a general maintenance mechanic for Jersey City Medical Center (JCMC or Respondent) stood on an A-frame ladder in the hallway of the labor and delivery wing of Respondent's hospital to work on a ceiling fluorescent light fixture. While working on the light fixture, the mechanic received an electric shock and fell off the ladder to the ground, hitting his head. The mechanic was placed in the intensive care unit of the hospital and later died. The

autopsy report indicated that the manner of the mechanic's death was an accident caused by blunt impact injuries of the head, with a contributory cause of electrocution.

The Occupational Safety and Health Administration (OSHA) investigated this matter from June 28 to December 15, 2016 pursuant to the Occupational Safety and Health Act of 1970, 29 U.S.C. §§ 651-678 (OSH Act). During the course of the investigation, OSHA noted that another mechanic for JCMC worked on live-current during his duties devoted to electrical circuits. After its investigation, OSHA issued to JCMC a citation alleging violations of OSHA's electrical safety and training standards found at 29 C.F.R. Part 1910 Subpart S, and proposing a total penalty of $174,593. JCMC filed a timely notice of contest, bringing this matter before the Occupational Safety and Health Review Commission (Commission). A hearing was held in New York, New York from April 24 – April 27, 2018. Both parties filed post-hearing briefs and post-hearing reply briefs. As discussed below, the citations and proposed penalties are affirmed.

JURISDICTION AND COVERAGE

The record establishes that Respondent filed a timely notice of contest and that, as of the date of the alleged violation, it was an employer engaged in business affecting commerce within the meaning of section 3(3) and 3(5) of the Act. *See* Complaint & Answer at ¶¶ 3, 9; Second Amended Joint Prehearing Statement at 8-9 ¶¶ A, B. Based upon the record, the undersigned concludes that the Commission has jurisdiction over the parties and subject matter in this case, and Respondent is covered under the Act.

STIPULATIONS

The parties stipulated to the following facts:

A. Jersey City Medical Center is a not-for-profit corporation organized under the laws of the State of New Jersey and maintains its principle office at 355 Grand Street, Jersey City, New Jersey. It is a hospital doing business in the State of New Jersey.

B. Many of the materials and supplies used and/or manufactured by respondent corporation originated and/or were shipped from outside the State of New Jersey.

C. As a result of an inspection by an authorized representative of the Complainant, JCMC was issued two citations for violations on December 21, 2016. Citation No. 1 contained five (5) items and sub-items. Citation No. 2 contained one (1) item. The contested items of the citations contained six (6) items and alleged that at a worksite located at 355 Grand Street, Jersey City, New Jersey 07302, violations occurred at the places, dates and times alleged in the citations.

D. JCMC hired [the decedent][1] as a Maintenance Mechanic on or about August 5, 2015.

E. On August 4, 2016, Lawrence Dapat attempted to change a ballast. He failed to use a toggle switch lock-out device after he cut the power to a ballast.

(Second Amended Joint Prehearing Statement at 8-9.)

BACKGROUND

JCMC's physical plant consists of a seven-story hospital and approximately five or six additional auxiliary buildings. (Tr. at 293.) Out of the approximately 2,300 employees working for JCMC, including the medical professionals that provide care to patients; about 22 of them work in the Facilities Department. (Tr. 335, 538.) The Facilities Department of JCMC maintains, repairs and renovates JCMC's physical plant and facilities, performing various tasks in and around the hospital and auxiliary buildings such as changing ceiling tiles, unplugging toilets, patching walls, minor plumbing, and snow removal. *See, e.g.*, Ex. S-1 at 1 (job description for general maintenance mechanic); Tr. 38, 179, 249. The task at issue in this case is changing out a lightbulb and ballast of a fluorescent light fixture.

Incident

Respondent's security video footage shows the decedent on the ladder, arms above his head, working on something above him that is obscured in the video. (Ex. S-26 (decedent in the

[1] For personal privacy reasons, the name of the decedent has been omitted from this Decision and Order.

rear of the corridor on the ladder).) A row of lights running down the centerline of the long hallway is illuminated, as they are reflected in the floor of the long hallway, showing up as white circles. The decedent is working on what looks like a separate light alongside the centerline row of lights. *Compare* Exs. S-26 (video showing row of lights) *and* S-23 (picture of decedent's light fixture). Around the 7 second mark of the security video, all of the lights suddenly go out, the decedent falls off the ladder to the ground, and medical personnel who were passing by the ladder without concern quickly jump away from the ladder with surprise and concern. (Ex. S-26; Tr. at 457-460.) The decedent passed away a few weeks later due to this incident, and the autopsy report states that a contributing cause to the decedent's death was electrocution. (Ex. S-6 at 4.)

JCMC convened a "Root Cause Analysis" (RCA) committee shortly after the incident to determine "what happened," "how it happened," to see if "it is a process issue" and to determine "what type of remediation can be taken, what type of corrective action." *See, e.g.*, Tr. 15, 29, 77, 83, 89-93, 100, 106-107; Ex. S-9. Committee members included JCMC upper management, nurse witnesses, and the Director (Edward Grogan), the Coordinator (George Adamson) and the Electrician (Steve Okon) of the Facilities Department. (Ex. S-9 at 2.) Respondent states the following as facts:

> 84. The consensus of the RCA Committee was that [the decedent] was doing his rounds, observed something with the light, and attempted to address it. (S.N. T107).
>
> 85. The Root Cause Analysis determination was that if it was electrical work, he should not have been doing it. (S.N. T107.12).

(Resp't Br. 14.) No written work orders are in the record and no verbal instruction from any supervisor to the decedent is established directing him to work on that fluorescent light fixture on the day of the incident.

During OSHA's investigation of this incident, OSHA Compliance Safety Health Officer, Industrial Hygienist (CO) Jennifer Consalazio interviewed many members of Respondent's staff,

including another general maintenance mechanic of the Facilities Department, Lawrence Dapat. (Tr. at 247, 437-555.) Dapat is tasked with addressing fluorescent light fixtures, and written work orders are in the record establishing that Dapat was assigned the task to address light fixtures and "replace ballasts" on June 24, 2016 and July 25, 2016. (Tr. 505-508; Ex. S-3.) Dapat also testified that he "worked live," meaning working on live electric current, once so as not to interrupt the medical activity in the immediate area and also, once, he changed a ballast without "locking out and tagging out" while he was "alone in the room" on August 4, 2016. (Tr. 269-270, 290-292); *see also* Resp't Br. 27; Resp't Reply Br. 1-3.

What is a Ballast? How to Repair a Fluorescent Light Fixture

The task at issue begins when a light is out and must be turned back on. The sources in the record addressing aspects of how to repair the light fixture at issue in this case include the two electricians that testified in this case, Steve Okon[2] (JCMC's electrician) and Christopher Vanella[3] (the electrician contractor JCMC hired to investigate the incident), as well as Dapat. They all testified consistently with each other to the multi-step process that reveals the electrical hazards associated with working with the fluorescent light fixture at issue here.

Pictures in the record show that the light fixture that the decedent worked on is circular and mounted overhead in the ceiling. (Tr. at 465-467; Exs. S-20, S-23.) According to JCMC electrician Okon, the task of restoring light to this light fixture might entail more than simply

[2] Okon has been an electrician for 16 years, 10 years of which he has worked for JCMC. (Tr. at 138-139, 144, 197.) His electrical experience includes residential, industrial, warehouse and commercial spaces, replacing and installing "lighting, outlets, service entrances, digging ground and running pipes in the ground to supply power." (Tr. at 142-143.)

[3] Vanella has been an electrician for approximately 30 years, having previously worked in Local 3 in New York City, and currently at the time of the hearing owning his own business as Community Electric. (Tr. at 235-236.)

switching out the light bulb. As Okon testified, the worker first attempts to switch out the light bulb. (Tr. at 148.) If the light bulb does not illuminate, however, there are two possible additional issues that would need to be explored: (1) the power might be interrupted, or (2) the ballast of the fluorescent light fixture would need to be replaced.[4]

Okon explained that a ballast "transforms energy to start up a fluorescent light bulb," it "provides power for lighting." (Tr. at 147, 198.) Dapat testified that a ballast "is a transformer to power the fluorescent bulbs." (Tr. at 250.) The ballast that powered the light fixture that the decedent worked on was powered by 277 volts. (Tr. at 147.) Both Okon and Dapat testified that, even after the power is switched off from the circuit, there may be power leftover in the ballast that must be addressed. (Tr. at 148, 250.) Otherwise, especially in the instance of an "emergency ballast," the worker could get "quite a shock." (Tr. at 149.)

Okon testified that the preliminary procedure for changing a ballast includes the following steps: (1) de-energize the circuit, (2) lock out/tag out the circuit, and (3) verify using a non-contact

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[4] Okon testified:

> Q Are there occasions in which a ballast might have to be changed out or replaced?
>
> A Yes.
>
> Q And what would those occasions be?
>
> A When we determine that after replacing the bulb, the bulb is good, the second item likely is the ballast.
>
> Q So if you come across a light fixture that's not working you're saying that if you do the bulb first and it's not the bulb there's something wrong with the ballast?
>
> A Or the voltage supplying the ballast.
>
> Q Okay. But in what circumstances would a ballast have to be replaced?
>
> A When the bulbs are already replaced, there's no visible damage to the bulb socket that holds the bulb in place and makes a connection, and if I determine the voltage is present and it's still not working then it would be the ballast.

(Tr. at 148.)

pen tester or a meter that no residual power is leftover in the ballast.[5] (Tr. at 148-151, 222.) Vanella, the electrician contractor tasked by JCMC to investigate the light fixture after the incident,

[5] Okon testified:

Q Okay. Do you know what the proper procedure is for changing a ballast?

A I would like to assume so, yes.

Q What is your understanding of the proper procedure for changing a ballast?

A First of all I have to make sure the circuit is de-energized.

Q Okay.

A Make sure the ballast does not hold residual energy. After I de-energize the circuit and lock it out and tag it, of course, I have to make sure the ballast is not an emergency ballast which would very much give me quite a shock. And then just proceed to disconnect the light -- up wire, and otherwise...

Q And then put in the new ballast?

A Then de-mount the old ballast, place the new ballast in, reverse kind of the steps.

Q Are there further steps that have to be taken after the circuits are -- after they're de-energized or locked out and tagged out?

A Well, I have to make sure there's no energy, any energy, left in the ballast. Depending on what type of ballast it is.

Q And doesn't one have to make sure that they properly de-energize the circuit, isn't that one --

A You have to de-energize the circuit. The circuit doesn't hold the voltage -- the ballast is no longer part of the circuit because I disconnected from power, there's nothing in the circuit.

Q Okay. After one locks out and tags out does one have to verify to make sure that there's no residual energy?

A Well, there's no way to make sure unless you disconnect the wire from the ballast that powers the ballast and either connect it to the ground, you may not notice the energy, there might be not even a spark, but it's charging -- this is the old ballast, not the new ones. You have to cut the wire off or disconnect it. There's no voltage there coming from the switch.

Q Then to do the lockout/tag out procedure properly you don't have to verify that there's no -- that the wires are no longer live?

A I'm not sure if you're telling me or if you're asking me right now.

Q I'm asking is there --

A Okay.

Q After -- is there something one has to do after they lockout/tag out to make sure that the wires are no longer live? To verify that they are no longer live?

also described how he safely approached inspecting the light fixture, corroborating Okon's testimony regarding the (1) de-energization and (2) lockout/tag out steps.[6]

Once the ballast has been de-energized and grounded, the worker is now tasked to "wire and re-wire" the ballast, where the worker will be splicing or twisting wires that require a nimble

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A Yeah, the way of measuring -- there's two -- there's non-contact pen tester that you put on the line right when I open the cover for the ballast, that tells me that that's dead. There's also – I can use a meter to measure the voltage on the wire. I can put the meter lead in the wire nut that connects power to the ballast. You can confirm that way.

Q And with these two tools how close to the wires would one have to be to do the verification?

A I'm an electrician, I can get close to the wires all the time. I am right at the wire. I hold them and -- yeah.

Q The instruments that you use to test whether there's live voltage --

A Right.

Q -- how close to the wires do you have to get to be able to use them properly?

A Within a few inches away from the wires.

Q Okay. A verification that the wires are no longer live is the last step in the procedure?

A Before I start taking it apart, yes.

(Tr. at 148-151.)

[6] Vanella testified:

Q The switch, did you turn it off when you changed --

A Yes.

Q Did you lock it out --

A At that time -- yeah. At that time I realized I had a switch control, so I went up to the nurse's station, we shut the switch down and I found out that it was -- because I saw the lights go out in the corridor and I tested it again and the light was out. Okay, and I locked it out.

Q So that light was in fact controlled by that switch.

A Yeah.

Q And did you lockout and tag out?

A Yes.

(Tr. at 245.) In this account, Vanella underscores the importance of de-energizing the circuit before attempting to work on it.

touch. (Tr. at 150, 350-351.) JCMC general maintenance mechanics and its electrician do not wear voltage rated safety gloves while working on this task. (Tr. at 202, 271-272, 544-545, 547.)

Work Orders in the record establish that the decedent replaced ballasts routinely in the months leading up to the date of the incident. The Secretary summarized the evidence in his brief in the following manner:

> Exhibits S-2 and S-32 comprise the entire printout by Adamson that day for [the decedent's] Work Orders for the previous six months before his death (Tr. 502). Adamson told the CSHO that this set of Work Orders has an identifying number for [the decedent], which was 58 (Tr. 508). In Exhibit S-2:
>
> • Work Order number 138496.1 RO lists the job assignment for "replace ballast" and is dated February 28, 2016 (Tr. 503).
>
> • Work Order number 138765.1 RO lists the job assignment for "replace ballast" and is dated March 8, 2016 (Tr. 503).
>
> • Work Order number 139521.1 RO lists the job assignment for "lights out/replace ballasts" and is dated April 4, 2016 (Tr. 504).
>
> • Work Order number 139522.1 RO lists the job assignment for "lights out/replace ballast" and is dated April 4, 2016 (Tr. 504).
>
> • Work Order number 139727.1 RO lists the job assignment for "lights out/replace ballast" and is dated April 6, 2016 (Tr. 504).
>
> • Work Order number 139729.1 RO lists the job assignment for "lights out/replace ballast" and is dated April 6, 2016 (Tr. 504).
>
> • Work Order number 140717.1 RO lists the job assignment for "lights out/replace ballast in hallway" and is dated April 6, 2016.
>
> • Work Order number 140743.1 RO lists the job assignment for "lights out/change ballast" and is dated May 8, 2016 (Tr. 504).

(Sec'y Br. 7.) The Secretary also summarized the Work Orders in the record establishing that Dapat replaced ballasts during the month before and after the incident:

> Exhibits S-3 and S-33 comprise the entire printout by Adamson that day for Dapat's Work Orders for the previous month (Tr. 506). Adamson told the CSHO that this

set of Work Orders has an identifying number for Dapat, which was 55 (Tr. 508). In Exhibit S-3:

> • Work Order number 142082.1 RO lists the job assignment for "lights out/change ballast in hallway" and is dated June 24, 2016 (Tr. 508).
>
> • Work Order number 142747.1 RO lists the job assignment for "replace ballast" and is dated July 25, 2016 (Tr. 508).

(Sec'y Br. 7.) Respondent did not dispute this recitation of the work order evidence in its Reply Brief.

The Decedent Failed to De-Energize the Light Fixture

Okon investigated the light fixture shortly after the incident ("no more than a day" after the incident). (Tr. at 182.) Okon testified that he "carefully removed the ceiling tile and I noticed right away a wire, exposed wire, which should be in the ballast, it was a live wire. I immediately taped it up, put a wire nut on it. And I reported to my Director what my findings." (Tr. at 182.) Okon further testified that:

> that one wire should not be left removed. I believe it was the last thing he did when he got shocked. There was some burn marks in the ceiling grate...I inspected visually only. Put my pen tester on that wire, it was live. I put a wire nut on it. I looked around for any additional damage above the ceiling, did not find any except the burn mark. I closed the ceiling tile back on, put it back in and reported to my Director.

(Tr. at 182-183.)

Vanella also investigated the decedent's light fixture days later around June 29, 2016. (Tr. at 241-242; Tr. at Ex. S-8.) He was contracted by the Director of the Facilities Department, Edward Grogan, to see "if there's anything going on in the fixture that shouldn't have been." (Tr. at 237.) Vanella testified that when he arrived to check out the fixture, all of the corridor lights were on, and the black wire with the wing nut on it that was "feeding" the decedent's light was live with 277 volts. (Tr. at 244.) He determined that a switch at the nearby nurse's station controlled the corridor of lights and shut off the switch to determine if it also controlled the light

that the decedent had been working on. (Tr. at 244.) "At that time I realized I had a switch control, so I went up to the nurse's station, we shut the switch down and I found out that it was – because I saw the lights go out in the corridor and I tested it again and the light was out. Okay, and I locked it out." (Tr. at 245.) He then agreed that the decedent's light was controlled by that switch at the nurse's station. (Tr. at 245.) Vanella did not testify to any existence of residual power leftover in the ballast of that light fixture, he testified that he did not see any other ballast in the area, and he testified that he subsequently connected the existing ballast and "it worked." (Tr. at 245.)

As noted above, the video of the incident establishes that all of the lights in the corridor were on immediately before the decedent's incident, and then all of the lights went out immediately after decedent's incident. (Ex. S-26.) This video evidence, combined with both Okon's and Vanella's testimony that the black wire that fed into the ballast that powered the decedent's light fixture was still "live" when they investigated the fixture and that the existing ballast was still operational after Vanella hooked it back up, supports a finding that, rather than being shocked by any residual stored energy in the ballast, the decedent had instead failed to de-energize the light fixture prior to working on it. If the decedent had de-energized the circuit, the decedent's light fixture, and its ballast, would no longer have been part of the circuit of the corridor of lights, and the ensuing shock would not have affected the row of lights in the corridor like it did in the video.

The decedent was not wearing voltage rated gloves at the time of the incident. (Tr. at 546-547.)

Working Live, Failing to Lock Out/Tag Out and Other Electrical Safety Practice Failures at JCMC

Along with the decedent's incident, other record evidence establishes that Respondent's Facilities Department cultivated a prevalence of failing to follow proper protocol when working with electrical circuits. Initially, it is noted that even though Respondent asserts that the decedent

was not qualified or even authorized to change ballasts, Respondent had written work orders in place documenting that the decedent was assigned that task at least 8 times prior to the incident. As discussed later, the record also establishes that neither the decedent nor Dapat were trained in lockout/tag out procedures for this assigned task before the incident, Dapat was not trained until at least mid-July 2016, and the decedent and Dapat were addressing light fixtures and changing ballasts without this training.

Additionally, even though Associate Vice President William Cook and Director Edward Grogan both testified unequivocally that no one is authorized to work "live," the record establishes that Dapat failed to follow this basic electrical safety practice. (Tr. at 30-31, 335-336, 339-340.) Respondent does not dispute that Dapat worked "live" once, before the incident, because "they were busy working, taking patients – I think it was the lunch, they were taking the lunch orders and they needed the light fixed while there were doing it. And I couldn't shut it off, they need to see what they were doing." (Tr. at 269-270, 290-291; Resp't Br. 16.) Dapat testified the following as to his understanding of "working live":

Q Do you know what it means to work live?
A Yes.
Q Could you describe what that is, working live?
A Well basically you're working with wiring that still has electrical current.
Q And is it circuits that have not been de-energized?
A Yes.
Q And further locked out and tagged out?
A Yes.

(Tr. at 259.) In this instance therefore, the one time Dapat worked "live" *before the incident*, he not only failed to de-energize the circuit, he also failed to lock out/tag out that circuit.

The record also supports a finding that Dapat addressed light fixtures and changed ballasts regularly before the incident. (Tr. at 256.) Dapat further testified that, all of these times before the incident, he routinely failed to lock out and tag out when working on ballasts, stating that he

had never been trained in lockout/tag out procedures and that he "never even knew about lockout/tag out." (Tr. at 267.) Dapat also testified that he wore no protective gloves at all before August of 2016 "because the circuit would be off. It was working on bare wires," even though he admitted that he never locked out/tagged out the circuits at that time. (Tr. at 267, 271-272.)

Dapat also testified that he would test voltage on ballasts, before June 2016, using a multi-meter to make sure the ballasts were de-energized. (Tr. at 272.) He testified that the leads to the multi-meter "would be right on the wire." (Tr. at 272.) As Okon noted, the possibility of stored, residual energy could still be in the ballast, and could still deliver a shock to a worker even if the circuit itself had been de-energized, until the ballast was grounded. (Tr. at 150.) Okon testified that "after testing the circuit, if the voltage is not there and you de-energized," it was not necessary to wear gloves voltage-rated working on a ballast. (Tr. at 206.) Okon clarified that he believes only qualified people test circuits for changing ballasts. (Tr. at 224.) In the event an unqualified person is changing a ballast, they would "always" be exposed to the hazard because "if they're not qualified they don't know how to test it, how to – do they know what voltage is, you know." (Tr. at 224.) He then agreed it would be safer for someone to wear electrically rated gloves while verifying whether a circuit has been de-energized or locked out/tagged out because "that person is using a voltage meter that comes within inches of the circuits which may be live." (Tr. at 224.)

JCMC maintained its written Hazardous Energy Control Procedures Manual on the third floor of the hospital in the mechanical room. (Tr. at 62-63, 228, 316, 463; Ex. R-30.) Grogan duly produced this manual to CO Consalazio during OSHA's inspection on June 28, 2016. (Tr. at 463, 467-468.) Upon receiving it, CO Consalazio noted that it was a generic procedure, intended to be tailored to the site-specific equipment of JCMC. (Tr. at 469-470.) It had pages that were not filled

out and had nothing specific to the light fixtures that the general maintenance mechanics changed. (Tr. at 470; Ex. R-30.)

Management of the General Maintenance Mechanics

The multiple instances of disregard for basic electrical safety procedure at JCMC beg the question of how Respondent hired, trained and supervised its general maintenance mechanics. The record establishing the chain of command is murky, especially surrounding who was responsible for ensuring that only appropriately trained employees addressed light fixtures.

William J. Cook was Associate Vice President of Support Services at the time of the incident at JCMC. (Tr. at 12-13, 19.) Cook was responsible for administrative oversight of a number of departments, including the Facilities Department. According to Cook, the Facilities Department "performed maintenance of anything that needed to be done throughout the Medical Center." (Tr. at 13.) As the Associate Vice President, Cook "was the direct report from the Director of Facilities." (Tr. at 13.) The Director of Facilities at the time of the incident was Edward Grogan, who took over from the previous Director, Charles Church, just a few weeks prior to the incident. (Tr. at 14-15, 334.)

According to Grogan, all 22 employees in the Facilities Department reported directly to him, including Facilities Coordinator George Adamson. (Tr. at 335, 359.) As the Coordinator, Adamson was responsible for issuing work assignments. Cook testified that he did not think Adamson, as the coordinator, directly supervised any employees. (Tr. at 12-14.) Adamson "gave direction to them," but the employees reported to Director Grogan. Grogan testified that Adamson is not a supervisor, he just coordinates work assignments. (Tr. at 321.)

Adamson, on the other hand, testified that "general maintenance" reported to him. (Tr. at 362.) Adamson also stated that it is Director Grogan's responsibility to make sure that employees

received training. (Tr. at 392, 399-400). Adamson further testified that he does not "know who was trained or who wasn't trained." (Tr. at 400.) Grogan testified that he did not review the qualifications of the employees of the department during the 2-3 weeks he was on the job up to and including the day of the incident. (Tr. at 335.)

Electrician Steve Okon, General Maintenance Mechanic Lawrence Dapat, and the decedent all worked in the Facilities Department. Okon testified that he reported to Coordinator Adamson or Director Grogan. (Tr. at 152.) Okon reported to Coordinator Adamson "about updates on each task that he was assigned." (Tr. at 153.) Okon also said that he "answers to Ed [Grogan] basically"). (Tr. at 177.) Okon was also clear that he himself was not a supervisor. (Tr. at 145.) Okon, instead, testified that Dapat reported to Coordinator Adamson and that Coordinator Adamson was Dapat's supervisor. (Tr. at 158.) Dapat testified that Coordinator Adamson was his supervisor, and he also "occasionally reported with the Director [Grogan]…if there was a job to be done, when George [Adamson] is away." (Tr. at 261.) Dapat testified that he would report to Okon "after I changed the bulb and it needs a ballast I would tell Steve [Okon] and then we'd both go," and then would tell "maybe George [Adamson] after the job was completed." (Tr. at 269.) The record is unclear exactly who supervised the decedent, but the record supports a finding that his supervision was similar to Dapat's.

Charles Church, the Director of Facilities from June 2002 to June 2016 (retiring a few weeks before the incident in this case), was the Director of Facilities when the decedent and Dapat were hired in the Facilities Department. Church did not testify at the hearing, but CO Consalazio interviewed him during the investigation. (Tr. at 536.) CO Consalazio testified that Church told her that maintenance mechanics normally changed ballasts, that Adamson "finds" work for the mechanics, and that Church, as the Director, is not involved in the "day-to-day" activity. (Tr. at

536.) Church also told CO Consalazio that "he didn't think that [the decedent] was in the lockout/tag out training in 2014." (Tr. at 536.)

Adamson testified that when the decedent came to him to report that he needed to order more ballasts, Adamson asked the decedent whether he was "doing ballasts," and the decedent told him yes. (Tr. at 385.) Adamson then testified that he immediately told the decedent to stop changing ballasts and then told Church, the Director at the time, that the decedent was changing ballasts and that Adamson had told the decedent "not to do it anymore." (Tr. at 386.) Adamson testified that it was not his responsibility, it was instead the Director's responsibility, to take steps to make sure employees received training. (Tr. at 399-400.) He further testified that he would not have "that information" regarding whether an employee needed training related to his job duties (i.e. "I wouldn't know who was trained or who wasn't trained.") (Tr. at 400.)

Dapat started as a general maintenance mechanic in the Facilities Department on April 2, 2015. (Tr. at 516.) Dapat testified as to how he became general maintenance mechanic for JCMC. He testified that he used to "do the shuttle. I just shuttle people around. And one of the people I used to shuttle was Charlie Church. So I was talking with Charlie about my previous experience and when there was an opening in the general maintenance position I was talking to Charlie about that." (Tr. at 278.) Dapat testified that he applied for the position, submitted his resume and interviewed with Church and Adamson. (Tr. at 279-280.)

Dapat said that he told Church about his previous employment experience. (Tr. at 278.) Dapat testified that before working at JCMC, he worked for one year for Sica Electric, an electrical contractor. (Tr. at 282.) He testified that, while working "a little bit with an electrician," he "learned how to work on [ballasts] safely. Live." (Tr. at 282.) He explained during a deposition for this case that this project is where Sica Electric "re-lamped the whole store and just changed

the ballasts. Actually we did it live because we couldn't turn off the lights in the store." (Tr. at 295.) He testified during deposition that he told Adamson this previous electrical experience at Sica Electric. (Tr. at 294.) Dapat further testified that he did not discuss electrical safety with either Church or Adamson. (Tr. at 278, 280.) Dapat first worked for "several months" on the night shift as a general maintenance mechanic, and then switched to the day shift.[7] (Tr. at 251-252.)

During his December 7, 2017 deposition, Okon testified that Adamson never come to him to ask for feedback about Dapat's work, rather Okon testified that he took it upon himself to approach Adamson to let him know that Dapat was "doing great, you know, I watch him doing such good – doing such things, good choice, you know, basically." (Tr. at 176.) Also, during his deposition, Okon testified that he and Dapat did not talk about whether Dapat was trained in lockout/tag out or de-energization or other electrical safety work practices. (Tr. at 186.) A further excerpt from the deposition states:

> Do you remember if you submitted a position that Mr. Ortiz [Okon's previous assistant] had and he was going to help you do electrical work, were you aware of any training or experience that Mr. Dapat had in electrical work? Answer, line 6: I heard he had some experience but I doubt these things until I trained him myself.

(Tr. at 186.)

Respondent hired the decedent on August 5, 2015. (Second Amended Joint Prehearing Statement at 9; Tr. at 111.) At the time he was hired, the decedent had training in heating, ventilating and air conditioning, but no training in electrical work. (Tr. at 448-453; Exs. S-11 (high school diploma from GM Financial Center in Cooling and Conditioning); S-12 (experience certificate in telecommunications); S-13 (Certificate of Apprenticeship in Metal and Air Condition

[7] The day shift ran from 7 a.m. to 3 p.m., and the night shift ran from 3 p.m. to 11 p.m., every day of the week. (Tr. at 251-252.)

(sic)); S-14 (diplomas from Hudson Technical School in Air Conditioning and Refrigeration); S-15 (resume showing experience in Air Conditioning and Refrigeration); S-16 (Certificate of Completion from National Occupation Competency Testing Institute in HVAC).) (Sec'y Br. 12.)

Work Assignments

The record indicates that general maintenance mechanics come to address a light fixture by one of three ways: (1) a written work order assigned by Coordinator Adamson, (2) verbal instruction over the phone or radio by Coordinator Adamson, Director Grogan, or "a secretary that's taking phone calls at that moment," or (3) on their own volition while "making rounds" throughout JCMC's physical plant. (Tr. at 107, 157, 160-161, 184-185, 268, 365-366, 405-406, 484, 486.) As noted earlier, if a light is out, there are three possible ways to fix it: (1) replace the light bulb, if that does not work, (2) check if there is power to the ballast, and if that does not work, (3) replace the ballast.[8] When the Facilities Department gets a request to fix a light that has gone

[8] Dapat testified:

> Q Before the incident was one of the types of job assignments that George gave you to change ballasts?
>
> A He would just send me up saying a light's not working.
>
> Q If you got the job assignment that a light was not working what steps would you take to get the light working again?
>
> A First I would try to replace the bulb. If it's not the bulb then I would check to see if there's power to the ballast. If there is power to the ballast then we would have to replace the ballast.
>
> Q But as you testified, George merely said to you that there's a light out in the hallway and go fix it?
>
> A Yeah, basically he would ask me to take a look at it and see what the problem is.
>
> Q If you came upon a ballast -- I'm sorry, if you came upon a light fixture that was out and you made a determination that the ballast had to be replaced, would you report that to anyone?
>
> A Yes. I would -- after I changed the bulb and it needs a ballast I would tell Steve and then we'd both go.

out, Adamson testified that he did not know if it was a simple light bulb fix, or a ballast issue.[9] (Tr. at 406-407.) According to Dapat, there are "too many" light fixtures at JCMC. (Tr. at 293.)

Q Would you tell anyone else but Steve?

A Maybe George after the job was completed.

Q If you were to -- at the time that you told -- at those times that you told George that you had changed a ballast, did he have any reaction to that?

A No.

Q If you came upon -- the procedure you've described where if you came upon a light fixture that was out, you would test to see if the bulb was working and then if it wasn't the bulb and the ballast needed to be replaced, would you do those types of things by yourself?

A If Steve is not available I would do it by myself.

(Tr. at 268.)

[9] Adamson testified:

Q And does that mean a staff person in the hospital could stop a plumber and say there is a sink stopped up in 3-E, can you do something about it?

A It's happened before, you know, where somebody would stop -- my drawer is broke, can you fix it? Or my light's out, can you change the bulb, you know, things of that nature.

Q And are there occasions that that work is then performed without you assigning it?

A I believe so, sometimes. Sometimes they'll come up to me and say oh, so and so stopped me, asked me to put the wheel back on a chair or change a light in their office.

Q Do you then enter a work order?

A Yes.

Q Okay. Now, when you issue assignments connected with lights, do you know a ballast is out?

A No.

Q So what do you issue as the assignment?

A To change -- I don't know if it's a ballast. Somebody may have told me I changed the light, so I'm going to assume it's the ballast, so I would just automatically just, you know, change ballast.

Q But you're not an electrician?

A No.

Q Now, back to the work order --

The record contains at least 8 written work orders that the decedent had been assigned the task to address light fixtures and "replace ballasts" in the months leading up to the date of the incident. (T. 502-504; 638-639 (no objection that the employee number ("58") associated with the work orders was identified as the decedent's employee number); Exs. S-2, S-32.) On the day of the incident, Adamson did not issue a work order or verbal instruction or call the decedent on the radio or give him any assignment that night having to do with any kind of electrical task. (Tr. at 405.) Instead, the record establishes that the decedent came upon the light fixture during "his rounds" and addressed the light fixture on his own volition. (Tr. at 107.)

When asked about the multiple work orders documenting the fact that the decedent had changed multiple ballasts in the months leading up to the incident, Adamson testified that he only issues work orders "for the most part" and that he did not know if he created those specifically. (Tr. at 386-387.) Adamson "absolutely" denied ever giving the decedent an assignment to change ballasts. (Tr. at 384.)

Training

Respondent claims that JCMC "established extensive employee training from initial orientation through mandatory annual training and individual department training." (Resp't Br. 40.) Mary Cataudella, Vice President of Human Resources who oversees the new employee orientation program, described what the two-day orientation consists of:

> Yes, it's a two day program which starts off with the CEO and all of his administrators introducing themselves to the employees and asking the employees why they came to Jersey City, what their title is and getting them to know each other and then the day proceeds with topics such as blood born pathogen, hazardous material, infection control procedures, cultural diversity, Human Resource benefits, policies and procedures, fire safety, violent prevention in the work place.

> A I mean there could be a dozen things wrong with the fixture. I'm not going to list everything on the work order.

(Tr. at 406-407.)

(Tr. at 53.) Cataudella testified that all new JCMC employees, no matter their job title, are required to attend this two-day orientation together. (Tr. at 63-64.) All new hires, representing departments such as dietary, pharmacy, anesthesia as well as maintenance, are all taught the same lockout/tag out practices discussed, among other topics, within an hour and a half session entitled "Environment of Care & Right to Know, Safety, Equipment, & Utilities Management Security Management, Hazardous Material & Waste Mgmt." (Tr. at 63-64; Exs. R-7 at 1, R-8 at 1.) The record establishes that the decedent attended the two-orientation meeting on August 31 and September 1, 2015. (Tr. at 111, 658; Exs. R-7, R-8.) The record does not similarly establish that Dapat attended a two-day orientation meeting.[10]

In addition to this two-day new hire orientation, all JCMC employees are expected to complete annual refresher training of the same subjects covered in orientation via an online training module. (Tr. at 55-56; Exs. R-1, R-3, R-4, R-31.) Okon testified that the training in these modules "wasn't for – to educate how to do the work with electrical, it's how to do it safe. So it was just about lockout/tag out so you could work safely on anything that comes up." (Tr. at 181.) These training modules, which served as a refresher to what was taught at orientation, had nothing specifically about changing ballasts. (Tr. at 181.) The decedent did not attend the annual refresher training as the incident occurred less than a year into his first year at JCMC. (Tr. at 111-112.) Dapat testified that he recalls the annual refresher online modules shown at the hearing, but he did not know when he took the annual refresher training and the record does not establish when he took the annual refresher training. (Tr. at 286-287.) The record does establish, however, that

[10] The record does not indicate when Dapat attended new-hire orientation training. It is noted that Dapat was originally hired by JCMC as a courier, and then transferred into the Facilities Department a few months afterward. (Tr. at 247-248.)

Dapat completed a course termed "Joint Commission OSHA Compliance Course Electrical Safety" on June 30, 2014, and May 14, 2015. (Tr. at 208; Ex. R-17.)

JCMC also provided lockout/tag out training: once on April 23, 2014, and then after the incident on July 12, 2016. Neither the decedent nor Dapat attended the 2014 lockout-tag out training, as they had not been hired by that time. Rather, attendees at the 2014 training included Church (who gave the training), Adamson, Okon, and Okon's assistant at the time. (Tr. at 20-23, 31-33; Ex. R-30 at 181.) At this lockout/tag out training, Church, Adamson, Okon and Okon's assistant at the time discussed "basic lockout/tag out procedures and different complications. It was a lockout/tag out course not only for electrical, general mechanical lockout/tag out. It was a basic course for everyone to attend." (Tr. at 179-180.) Dapat attended the lockout/tag out training on July 12, 2016, after the incident. (Tr. at 288.) This lockout/tag out training discussed proper de-energization and lockout/tag out procedures for "an item that uses electric as power," although not specifically ballasts. (Tr. at 329-330).

Regarding on-the-job training, Okon was the only electrician on staff at JCMC. (Tr. at 30, 108, 138, 421.) As the only electrician on staff, Okon testified that he did *not* train the decedent at all in electrical safety, and that he never worked with the decedent, except on tasks like snow removal. (Tr. at 179.) On the other hand, Okon testified that he worked closely every day with Dapat "ever since he started," making sure Dapat "learned all the steps that I'm doing to learn [electrical] correctly," and that "as of 2016," Okon trusted Dapat "to change a simple ballast." (Tr. at 187-189.)

Dapat, in contrast, testified at his deposition that he did not start working together with Okon until after the incident and that before the incident, Dapat changed ballasts by himself. (Tr. at 256.) Dapat also testified that lockout/tag out procedures were instituted by JCMC after the

incident. (Tr. at 272-273.) Dapat testified that before he came to work at JCMC, he worked as an apprentice as an electrician, but was never trained in lockout/tag out.[11] He also testified that he did not even know about JCMC's lockout/tag out program until after the incident. (Tr. at 267.)

Deposition Discrepancies: Okon, Dapat and Grogan

The record contains several discrepancies between previous deposition testimony of Steve Okon, Lawrence Dapat, and Edward Grogan, and their own testimony at the hearing. (Tr. at 160, 175, 178, 186, 256, 281, 294-295, 313.) These discrepancies add to the murkiness of this record regarding the oversight of safety for JCMC's general maintenance mechanics. Additionally, the undersigned notes that these witnesses appeared uncomfortable and coached when they changed their story under examination by Respondent's counsel at the hearing. Their evasive testimony led to a lack of clarity in their responses. In contrast, the CO's testimony was convincing and consistent with the deposition testimony.

Steve Okon testified on December 7, 2017 at deposition that work is assigned to him by Adamson verbally over the phone or over the radio, and work could also be assigned to him by the

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[11] Dapat testified:

> Q And you said you apprenticed with an electrician?
>
> A Yes. Roughly around -- it was one of my first jobs. I used to work for Sica Electric and I used to work with an electrician and I also had my own team. Used to change lamps and ballasts in department stores.
>
> Q Did this apprenticeship -- did the person who was conducting the apprenticeship train you in lockout/tag out or de-energization?
>
> A He taught me how to de-energize circuits but there was no lockout/tag out.
>
> Q And what did he show you about de-energization?
>
> A How to turn off the breaker, you know. Turning off the circuit before you work on the wiring.
>
> Q But he didn't teach you anything about lockout/tag out?
>
> A No.

(Tr. at 267.)

Director, or "it could be a secretary that's taking phone calls at that moment." (Tr. at 160-161.) Later at the hearing, on April 24, 2018, Okon testified that he received assignments via work order, in addition to verbal assignments. (Tr. at 160.)

During his December 7, 2017 deposition, Okon testified that he never had any conversations with Church, Grogan or Adamson about the way Dapat did his lockout/tag out procedures or his de-energization procedures. (Tr. at 175, 178.) At the hearing, however, Okon testified that Grogan asked him whether Dapat was taking proper procedures, and he confirmed to Grogan "that we are doing it." (Tr. at 178.) He later testified that "I believe I must have but I don't remember." (Tr. at 226.)

Okon testified at the hearing that he and Dapat worked "side by side…ever since the day he started." (Tr. at 188.) Dapat testified that "even before the incident I was changing the ballasts with Steve [Okon]." (Tr. at 255.) Dapat, however, during his deposition on December 7, 2017, testified that he began "teaming up" with Okon after the incident, and that before the incident he changed ballasts by himself. (Tr. at 256.) Also during his deposition, Dapat testified that the extent of his communication with Adamson regarding his work with Okon consisted of Adamson asking Dapat for status updates and whether a particular job was completed. (Tr. at 281.) During the hearing, however, Dapat testified that he did not remember any communications with Adamson before June 2016 regarding work he did with Okon. (Tr. at 280.)

Under cross-examination, Dapat agreed that at his deposition that he had communicated with Adamson about his training and experience in electrical work when he "first got interviewed" for the job. (Tr. at 294.) Under redirect examination, Dapat clarified that his deposition testimony revealed that this communication with Adamson at his job interview consisted of his experience at Sica Electric, where he worked with live electricity changing ballasts. (Tr. at 295.) He had also

testified at his deposition that he discussed with Adamson that his training consisted of only "on-the-job" training and he did not discuss his knowledge of electrical safety work practices. (Tr. at 295.)

At the hearing, Grogan testified that while he knew the incident occurred on a Sunday, he did not remember exactly when he first participated in the discussions with his management team in determining what caused the incident. (Tr. at 311-312.) Grogan was then reminded by his deposition testimony that he believed that the first discussion meeting he participated in occurred the very next day after the incident, Monday. (Tr. at 312-313.)

DISCUSSION

To prove a violation of an OSHA standard, the Secretary must establish that (1) the cited standard applies, (2) there was a failure to comply with the cited standard, (3) employees had access to the violative condition, and (4) the employer knew or could have known of the condition with the exercise of reasonable diligence. *Astra Pharma. Prods.*, 9 BNA OSHC 2126, 2129 (No. 78-6247, 1981) *aff'd in relevant part*, 681 F.2d 691 (D.C. Cir. 1980). A violation is "serious" if a substantial probability of death or serious physical harm could have resulted from the violative condition. 29 U.S.C. § 666(k).

Serious Citation 1, Item 1: De-Energization

The Secretary claims that Respondent violated 29 C.F.R. § 1910.333(a)(1), which requires:

> Live parts to which an employee may be exposed shall be deenergized before the employee works on or near them, unless the employer can demonstrate that deenergizing introduces additional or increased hazards or is infeasible due to equipment design or operational limitations. Live parts that operate at less than 50 volts to ground need not be deenergized if there will be no increased exposure to electrical burns or to explosion due to electric arcs.

29 C.F.R. § 1910.333(a)(1). The Secretary alleges that:

> [g]eneral maintenance mechanics work on live 277 volt AC while changing ballasts for overhead fluorescent lights. On or about 06/26/16, a worker performing such operations received an electrical shock while working from an A frame ladder. The worker fell approximately 6 ft. to the floor below, striking his head and later died of his injuries.

(Citation at 6.)

Respondent argues that no general maintenance mechanic was ever directed or authorized to work on live current, and that only Okon and Dapat were authorized to even change ballasts. (Resp't Br. 26-28; Tr. at 340.) Therefore, Respondent argues that the Secretary failed to establish both that JCMC violated the cited standard and that it had actual or constructive knowledge of any general maintenance mechanic violating the cited standard. (Resp't Br. 28-29; Resp't Reply Br. 2-3.)

The record establishes that the cited standard was applicable here, that the standard was violated and that the decedent, JCMC's employee, was exposed to live parts on June 26, 2016. Light fixtures at JCMC ran on 277 volt current, which is greater than the 50-volt exception to the standard. (Tr. at 147. 464.) If a light fixture needed to be addressed, because for example the light had gone out, JCMC's general maintenance mechanics were initially charged with "changing a light bulb." (Tr. at 30.) If changing the light bulb failed to correct the lighting issue, two possible situations would have to be explored: either the voltage had been interrupted or the ballast was damaged. (Tr. at 148.) In exploring either situation, the employee was exposed to live current unless the light fixture was completely de-energized. As found above, the decedent did not de-energize the light fixture and was working on live current, greater than 50 volts, when he was electrocuted while working on the light fixture.[12]

[12] The record also establishes that Dapat changed ballasts, and therefore was also exposed to the possibility of live current when he changed ballasts. JCMC does not dispute that Dapat actually worked on live current at least once, before the incident, while changing a ballast and does not dispute that Dapat regularly changed

"The knowledge element of a violation does not require a showing that the employer was actually aware that it was in violation of an OSHA standard; rather it is established if the record shows that the employer knew or should have known of the conditions constituting a violation." *Peterson Bros. Steel Erection Co.*, 16 BNA OSHC 1196, 1199 (No. 90-2304, 1993), *aff'd*, 26 F.3d 573 (5th Cir. 1994). To establish whether the employer should have known of the conditions constituting a violation, the Secretary must show whether the employer:

> constructively knew of it--that is, the employer could have known with the exercise of reasonable diligence. ... Whether an employer was reasonably diligent involves a consideration of several factors, including the employer's obligation to have adequate work rules and training programs, to adequately supervise employees, to anticipate hazards to which employees may be exposed, and to take measures to prevent the occurrence of violations.

Par Elec. Contractors, Inc., 20 BNA OSHC 1624, 1627 (No. 99-1520, 2004) (citations omitted); *see also N.Y. State Elec. & Gas Corp. v. Sec'y of Labor*, 88 F.3d 98, 108 (2d Cir. 1996) (holding that Secretary bears the burden of proof regarding the issue of knowledge "even when knowledge charged to an employer is predicated on its alleged inadequate safety policy."). "The knowledge of a supervisory employee may be imputed to his or her employer." *Par*, 20 BNA OSHC at 1627.

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ballasts in his role as a general maintenance mechanic. Respondent argues that because the citation itself limited the instance of exposure to the decedent's incident on June 26, 2016, that the Secretary inappropriately expanded the scope of the charge by including Dapat's work with ballasts. (Resp't Reply Br. 2.)

Any such expansion is harmless because this violation is upheld based on the decedent's incident. The undersigned, however, finds any such amendment to the alleged violation description to this citation item would be proper, and Respondent would not be prejudiced, because Respondent had the opportunity and did fully litigate the issues surrounding Dapat for this citation item at the hearing. *See* Tr. at 249 (asking Dapat on direct examination "a series of questions about the time period before [the decedent's] incident" regarding his duties and procedures addressing light fixtures), and Tr. at 541 (CO testifying on direct examination regarding knowledge of safe electrical practices of both decedent and Dapat for Citation 1, Item 1); *N. Y. State Elec. & Gas Corp. v. Sec'y of Labor*, 88 F.3d 98, 104 (2d Cir. 1996) ("[i]n an administrative proceeding … pleadings are liberally construed and easily amended."); *Nat'l Realty & Constr. Co., Inc. v. OSHRC*, 489 F.2d 1257, 1264 (D.C. Cir. 1973)("So long as fair notice is afforded, an issue litigated at an administrative hearing may be decided by the hearing agency even though the formal pleadings did not squarely raise the issue.").

Respondent argues that changing a ballast is not the same thing as working "live." (Resp't Reply Br. 2 (asserting, "Rather, by sleight of hand, the Secretary attempts to prove knowledge of 'live' work by referring to evidence of ballast changes. They are critically different.").) Okon, however, testified that addressing a light fixture necessarily involves potential exposure to live electricity should a simple light bulb replacement be unsuccessful. (Tr. at 148.) The record establishes that the decedent routinely addressed light fixtures and "changed ballasts" documented in written work orders in the months leading up to the incident. (Exs. S-2, S-32.) These written work orders were issued by Adamson "for the most part," or at the very least, by someone who had authorization to direct the decedent to address those light fixtures. *Am. Eng'g & Dev. Corp.*, 23 BNA OSHC 2093, 2095-96 (No. 10-0359, 2012) (imputing knowledge of backhoe operator who lacked authority to hire or fire but was charged with giving work instructions and orders to other employees); *Dover Elevator Co.*, 16 BNA OSHC 1281, 1286 (No. 91-862, 1993) ("[A]n employee . . . empowered to direct that corrective measures be taken is a supervisor[].") These work orders are sufficient to impute actual knowledge to Respondent that the decedent was addressing light fixtures at JCMC and therefore was potentially exposed to live current. *Am. Eng'g & Dev. Corp.*, 23 BNA OSHC at 2095 (knowledge is imputed to the employer "through its supervisory employee.").

Additionally, Adamson testified that the decedent told him that he was changing ballasts, and that Adamson told the decedent not to change them. (Tr. at 386.) Adamson then testified that he told Church that the decedent was changing ballasts and that he had told the decedent not to change them. Church, however, told the CO that general maintenance mechanics normally changed ballasts, and that he knew that the decedent had not attended the 2014 lockout/tag out training, which Church himself ran. (Tr. at 20-23, 536.) It was also surmised by the RCA that the

decedent saw the light in disrepair while doing "his rounds" on the day of the incident and decided to address the light fixture himself. (Resp't Br. 14.) Newell testified to this fact, and CO Consalazio testified that Adamson told her that he knew that the decedent fixed items without a work order if he saw the item in disrepair while "doing rounds during the quiet part of his shift." (Tr. at 107, 486.)

Nothing in the record, moreover, establishes that JCMC took steps to ensure that the decedent did not change ballasts: the one electrician on staff did not train the decedent; no supervisor testified to the steps he took to monitor the decedent to make sure that he was not addressing light fixtures and to prevent further occurrences by the decedent; and JCMC did not provide training to the decedent in lockout/tag out or de-energization for the "simple" task of changing a ballast. These inactions add up and establish Respondent's constructive knowledge that the decedent was working with live current when he addressed light fixtures at JCMC. *Gary Concrete Prods., Inc.*, 15 BNA OSHC 1051, 1054-55 (No. 86-1087, 1991) (finding inadequate works rules and a lack of specific training or instructions on stacking techniques supported a finding of constructive knowledge). *Schuler-Haas Elec. Co.*, 21 BNA OSHC 1489, 1493-94 (No. 03-0322, 2006) (finding that employer had constructive knowledge because it could have known of the physical conditions constituting the violation); *Pride Oil Well Serv.*, 15 BNA OSHC 1809, 1814 (No. 87-692, 1992) (finding constructive knowledge when a supervisor could have discovered and eliminated the hazard with reasonable diligence).

As far as characterization, this citation item is properly characterized as serious. 29 U.S.C. § 666(k) (A violation is "serious" if a substantial probability of death or serious physical harm could have resulted from the violative condition). CO Consalazio testified that the hazard of electrocution, should it occur, was likely to cause death or serious physical harm. The decedent's

autopsy report indicates that electrocution contributed to the decedent's death in this case. This serious citation item is affirmed.

Serious Citation 1, Items 2a and 2b: Lockout/Tag Out

Item 2a: Lockout/Tag Out

The Secretary claims for Citation 1, Item 2a that Respondent violated 29 C.F.R. § 1910.333(b)(2), which requires:

> While any employee is exposed to contact with parts of fixed electric equipment or circuits which have been deenergized, the circuits energizing the parts shall be locked out or tagged or both in accordance with the requirements of this paragraph. The requirements shall be followed in the order in which they are presented (i.e., paragraph (b)(2)(i) first, then paragraph (b)(2)(ii), etc.).

29 C.F.R. § 1910.333(b)(2). The Secretary alleges that "[w]hile an employee was changing ballasts, the 277 volt circuits were not locked out or tagged after the toggle switch was turned off exposing the worker to electrocution. Violation occurred on or about 08/04/16." (Citation at 7.)

Here, the parties stipulated that, "on August 4, 2016, Lawrence Dapat attempted to change a ballast. He failed to use a toggle switch lock-out device after he cut the power to a ballast." (Second Amended Joint Prehearing Statement at 9.) With this stipulation, the parties have established that Dapat, a JCMC employee, was exposed to a de-energized circuit that he did not lockout/tag out while working on it. The cited standard applies, Dapat violated the standard, and he was therefore exposed to the hazard of unexpected re-energization while working on a de-energized circuit.

The record also establishes constructive knowledge for this citation item. *Par Elec. Contractors, Inc.*, 20 BNA OSHC at 1627 (factors considered for constructive knowledge include adequate work rules and training programs, adequate supervision, adequate anticipation of hazards, and adequate prevention measures). Here, after the incident, Grogan "scrambled" to provide his workers lockout/tag out training. (Tr. at 328-329.) While Dapat did attend this

training, he nevertheless violated the lockout/tag out rule mere weeks afterward. Nothing in the record establishes that JCMC took any steps to change its work processes, such as increase monitoring to discover rule violations, to address basic electrical safety practice failures. The chain of command is not entirely clear either as to who had authority to monitor for Dapat's safety: Okon denied any kind of supervision authority, Grogan stated that Adamson was not a supervisor and only coordinated work assignments, Adamson stated that he does not know who is trained to do which tasks, and Church stated that the Director is not part of the day-to-day activity. (Tr. at 145, 321, 400, 536.) Constructive knowledge is established. *Pride Oil Well Serv.*, 15 BNA OSHC at 1814 (finding constructive knowledge when a supervisor could have discovered and eliminated the hazard with reasonable diligence).

Respondent raises the unpreventable employee misconduct defense, asserting that JCMC cannot be responsible for "the unpreventable and inexcusable misconduct of Lawrence Dapat on August 4, 2016." (Resp't Br. 31.) Respondent claims that since Dapat attended the lockout/tag out training on July 12, 2016, after the incident and before Dapat's lockout/tagout instance, the Secretary's arguments as to Citation 1, Item 2a are without merit. (Resp't Reply Br. 3-4.)

To establish the unpreventable employee misconduct defense, Respondent has the burden to establish that: (1) JCMC has established work rules designed to prevent the violation; (2) JCMC adequately communicated those rules to its employees; (3) JCMC had taken steps to discover violations; and (4) JCMC effectively enforced the rules when violations have been discovered. *Precast Servs. Inc.*, 17 BNA OSHC 1454, 1455 (No. 93-2971, 1995) *aff'd* 106 F.3d 401(6th Cir. 1997); *see also S.J. Louis Constr.*, 25 BNA OSHC 1892, 1900 n.24 (No. 12-1045, 2016) (evaluating employer's safety program for adequacy involves same factors for evaluating constructive knowledge and the defense of unpreventable employee misconduct) *appeal docketed*,

No. 19-60224 (5th Cir. Apr. 15, 2019). As just discussed, no supervisor took steps to discover any violation of the lockout/tag out rule that Dapat learned on July 12, 2016. As this was a factor that JCMC must establish to prevail on the UEM defense, this defense is rejected for this citation item. *Pa. Power & Light Co. v. OSHRC,* 737 F.2d 350, 357–58 (3d Cir. 1984) ("The courts of appeals have consistently held that the adequacy of a company's safety program, broadly construed, is the key to determining whether an OSHA violation was reasonably foreseeable and preventable.").

This citation item is affirmed as serious because the hazard resulting from the violation of this standard could lead to death or serious physical harm. (Tr. at 541-543); 29 U.S.C. § 666(k).

Item 2b: Lockout/Tag Out Manual

The Secretary claims in Citation 1, Item 2b that Respondent violated 29 C.F.R. § 1910.333(b)(2)(i), which requires: "The employer shall maintain a written copy of the procedures outlined in paragraph (b)(2) and shall make it available for inspection by employees and by the Assistant Secretary of Labor and his or her authorized representatives." 29 C.F.R. § 1910.333(b)(2)(i). The Secretary alleges that:

> the employer did not maintain written procedures for de-energizing 277 volt circuits for employees conducting work such as changing ballasts. Violation occurred on or about 06/28/16. Procedures must include: 1) Specific statement of the intended use of the procedure, 2) Specific procedural steps for shutting down, isolating, blocking and securing machines or equipment to control hazardous energy, 3) Specific procedural steps for the placement, removal, and transfer of lockout devices or tagout devices and the responsibility for them, 4) Specific requirements for testing a machine or equipment to determine and verify the effectiveness of lockout devices, tagout devices, and other energy control measures.

(Citation at 8.)

It is undisputed that Grogan duly presented for inspection a written manual entitled "Hazardous Energy Control Procedures" that JCMC maintained in its mechanical room to the OSHA CO upon request at the inspection. (Ex. R-30.) What is in dispute is whether this manual contained "the procedures outlined in paragraph (b)(2)" of the cited standard as required for this

citation item. 29 C.F.R. § 1910.333(b)(2)(i). The Secretary claims that this manual did not meet the substantive requirements of the standard, while Respondent argues that there is no legal authority that this manual must contain specific lockout/tag out procedures for changing ballasts. (Sec'y Br. 30; Resp't Reply Br. 5-6.)

The Secretary explains the procedures listed in paragraph (b)(2) extensively in his post-hearing brief. (Sec'y Br. 30-31.) These (b)(2) provisions are plainly incorporated into the cited standard. 29 C.F.R. § 1910.333(b)(2)(i) ("Note: The written procedures may be in the form of a copy of paragraph (b) of this section.") A review of Respondent's manual reveals lockout/tag out procedures in outline format with headings such as "Preparation for Lockout or Tag Out," Sequence of Lockout or Tagout System Procedure," "Restoring Machines or Equipment to Normal Production Operations," and "Training and Annual Inspection." (Ex. R-30 at 4-9.)

As the Secretary notes, however, and Respondent does not specifically refute, this manual "from pages 4 of 181 to 12 of 181 shows that none of the procedures address the electrical safety hazards covered by the provisions of 1910.333(b), nor do they incorporate the requirements of paragraphs 1910.333(b)(2)(iii)(D) and 1910.333(b)(2)(iv)(B) according to the requirements of section 1910.333(b)(2)(i)."[13] (Sec'y Br. 31.) Respondent argues that no legal authority exists that

[13] 29 C.F.R. § 1910.333(b)(2)(iii)(D) states:

> A tag used without a lock, as permitted by paragraph (b)(2)(iii)(C) of this section, shall be supplemented by at least one additional safety measure that provides a level of safety equivalent to that obtained by use of a lock. Examples of additional safety measures include the removal of an isolating circuit element, blocking of a controlling switch, or opening of an extra disconnecting device.

29 C.F.R. § 1910.333(b)(2)(iv)(B) states:

> A qualified person shall use test equipment to test the circuit elements and electrical parts of equipment to which employees will be exposed and shall verify that the circuit elements and equipment parts are deenergized. The test shall also determine if any energized condition exists as a result of inadvertently induced voltage or unrelated voltage backfeed even though specific parts of the circuit have been deenergized and presumed to be safe. If

specifically requires this manual to address changing ballasts but does not address how its manual does not satisfy the requirements of sections 1910.333(b)(2)(iii)(D) and 1910.333(b)(2)(iv)(B).

Indeed, this manual targets mechanical lockout/tag out measures and not electrical lockout/tag out measures. As the Secretary notes, the list of inventory includes boilers, pumps and elevators, but not electrical circuits. (Ex. R-30 at 13-62.) The manual even references OSHA's mechanical lockout/tag out standard, "1910.147 'The Control of Hazardous Energy' requirements." (Ex. R-30 at 7.) The cited standard at issue here even considers this instance:

> Note 2: Lockout and tagging procedures that comply with paragraphs (c) through (f) of 1910.147 will also be deemed to comply with paragraph (b)(2) of this section provided that:
>
> [1] The procedures address the electrical safety hazards covered by this Subpart; and
>
> [2] The procedures also incorporate the requirements of paragraphs (b)(2)(iii)(D) and (b)(2)(iv)(B) of this section.

29 C.F.R. 1910.333(b)(2) (emphasis added). These required provisions specifically use electrical terminology like "circuit elements," control switches," "disconnecting devices," "electrical parts of equipment," and "voltage." 29 C.F.R. §§ 1910.333(b)(2)(iii)(D) and 1910.333(b)(2)(iv)(B). None of these electrical terms are in this 181-page manual.

Accordingly, the undersigned agrees with the Secretary that Respondent's manual does not comply with the requirements of the cited standard. The Secretary has established a violation of the cited standard for this instance. *Phoenix Roofing, Inc.*, 17 BNA OSHC 1076, 1079 (No. 90-2148, 1995) ("Employer knowledge is established by a showing of employer awareness of the physical conditions constituting the violation"), *aff'd,* 79 F.3d 1146 (5th Cir. 1996) (unpublished).

> the circuit to be tested is over 600 volts, nominal, the test equipment shall be checked for proper operation immediately after this test.

This violation is properly classified as serious because the hazard associated with violations of these standards could lead to death or serious physical harm. (Tr. at 541-543); 29 U.S.C. § 666(k).

Serious Citation 1, Item 3: Qualified Persons

The Secretary alleges that Respondent violated 29 C.F.R. § 1910.333(c)(2), which requires:

> Only qualified persons may work on electric circuit parts or equipment that have not been deenergized under the procedures of paragraph (b) of this section. Such persons shall be capable of working safely on energized circuits and shall be familiar with the proper use of special precautionary techniques, personal protective equipment, insulating and shielding materials, and insulated tools.

29 CFR § 1910.333(c)(2). The Secretary alleges that "[t]he employer did not ensure that general maintenance mechanics performing live electrical work, such as changing ballasts on 277 volt circuits, were qualified to do such work. Violation occurred on or about 6/26/16." (Citation at 9.)

A "qualified person" is defined in section 1910.331(a):

> Covered work by both qualified and unqualified persons. The provisions of §§ 1910.331 through 1910.335 cover electrical safety-related work practices for both qualified persons **(those who have training in avoiding the electrical hazards of working on or near exposed energized parts)** and unqualified persons **(those with little or no such training)** working on, near, or with the following installations.

29 CFR § 1910.331(a) (emphasis added). The term is also defined at section 1910.399: "Qualified person. One who has received training in and has demonstrated skills and knowledge in the construction and operation of electric equipment and installations and the hazards involved." 29 CFR § 1910.399.

Respondent does not dispute that the decedent was unqualified to address light fixtures by changing ballasts, although Respondent argues that "all Facilities employees are trained on electrical safety." (Resp't Br. 35.) Respondent also argues that JCMC did not violate the standard

because no supervisor directed the decedent to change the ballast on the day of the incident. (Resp't Br. 34.) Respondent states that is even conjecture that the decedent was changing a ballast, and even if he was, his actions were unauthorized. (Resp't Br. 35.) Therefore, Respondent argues "that the Secretary failed to prove that Respondent allows, or has knowledge, of unqualified maintenance mechanics working of [*sic*] live 277 volt circuits." (Resp't Br. 35.)

As an initial matter, the undersigned agrees with the Secretary that the training that was provided to the decedent at orientation by JCMC did not satisfy the requirements of the cited standard to render him a "qualified person." (Sec'y Br. 38 n.8.) A "qualified person," as defined at section 1910.331(a), requires training in the provisions of sections 1910.331 through 1910.335. 29 C.F.R. § 1910.331(a). One of these sections, 1910.332(b)(3), explicitly states: "For the purposes of 1910.331 through 1910.335, a person must have the training required by paragraph (b)(3) of this section in order to be considered a qualified person." 29 C.F.R. § 1910.332(b)(3) Note 1. As the Secretary states, a qualified person must be:

> trained in and familiar with: the skills and techniques necessary to distinguish exposed live parts from other parts of electric equipment. [1910.332(b)(3)(i)]; the skills and techniques necessary to determine the nominal voltage of exposed live parts [1910.332(b)(3)(ii)]; and the clearance distances specified in 1910.333(c) and the corresponding voltages to which the qualified person will be exposed 1910.332(b)(3)(iii).

(Sec'y Br. 38 n.8.) The cursory orientation training that all incoming personnel at JCMC attend when they are first hired does not mention or satisfy the requirements of these sections addressing live parts, nominal voltages and clearance distances of electric equipment.

Respondent's next argument that it had no knowledge that the decedent was changing ballasts and thus was exposed to live electric parts, and therefore it cannot be held accountable for it, is also flawed. As analyzed under Citation 1, Item 1, Respondent had actual and constructive knowledge that the decedent was addressing light fixtures and replacing ballasts. Adding to this

knowledge, Respondent admits that it also knew, the entire time, that the decedent was unqualified to address light fixtures and replace ballasts. This citation item is affirmed.

This violation is properly classified as serious because the hazard associated with the violation of this standard could lead to death or serious physical harm. (Tr. at 549-550); 29 U.S.C. § 666(k).

Serious Citation 1, Item 4: Protective Equipment

The Secretary alleges that Respondent violated 29 C.F.R. § 1910.335(a)(1)(i), which requires:

> (1) *Personal protective equipment*. (i) Employees working in areas where there are potential electrical hazards shall be provided with, and shall use, electrical protective equipment that is appropriate for the specific parts of the body to be protected and for the work to be performed.

29 C.F.R. § 1910.335(a)(1)(i). The Secretary claims that "[g]eneral maintenance mechanics were not provided with appropriate hand protection such as rubber insulating gloves while performing live electrical work including, but not limited to, changing ballasts which operate at 277 volts. Violation occurred on or about 06/26/18." (Citation at 10.)

To establish applicability of a general PPE standard, the Secretary must prove "that a reasonable person familiar with the circumstances surrounding the hazardous condition, including any facts unique to the particular industry, would recognize a hazard requiring the use of PPE." *Gen. Motors Corp., GM Parts Div.*, 11 BNA OSHC 2062, 2065 (No. 78-1443, 1984) (consolidated) (citation omitted), *aff'd*, 764 F.2d 32 (1st Cir. 1985); *see also Wal-Mart Distrib. Ctr. # 6016*, 25 BNA OSHC 1396, 1400-01 (No. 08-1292, 2015), *aff'd in part and vacated in part on other grounds,* 819 F.3d 200 (5th Cir. 2016) (discussing Commission precedent regarding applicability analysis). The Third Circuit, to which this case could be appealed, has held that with regard to the "reasonable person test," while industry custom and practice are relevant, the ultimate

inquiry is whether a reasonable person familiar with the factual circumstances surrounding the allegedly hazardous condition, including any facts unique to a particular industry, would recognize a hazard warranting the use of personal protective equipment. *Voegele Co. v. Occupational Safety & Health Review Comm'n.*, 625 F.2d 1075, 1078 (3d Cir. 1980); *see also Kerns Bros. Tree Serv.*, 18 BNA OSHC 2064, 2067 (No. 96-1719, 2000) (Commission generally applies law of the circuit where it is probable a case will be appealed).

The record establishes that the decedent was not wearing protective gloves when he was working on the light fixture, near an electrical hazard, on the day of the incident. (Tr. at 546-547.) The record also establishes that Respondent management knew that its Facilities Department workers did not wear gloves when working with ballasts. Respondent argues that protective gloves were inappropriate for the task of changing ballasts because Okon testified that it was impossible to work on a ballast while wearing protective gloves. (Resp't Br. 36-37; Tr. at 204-206, 232-233.) Okon, however, conceded that it *was* possible to wear those gloves while testing to see whether the ballast circuit had been de-energized or locked out/tagged out, and that it was safer for an unqualified person to wear the gloves while using a voltage meter that comes within inches of the circuits which may be live. (Tr. at 217-222, 224.) As noted above, it is undisputed that the decedent was an unqualified person working on the light fixture on the day of the incident. CO Consalazio testified that she believed gloves needed to be worn when verifying whether the ballast has been de-energized. (Tr. at 559-560.) This citation item is affirmed.

This violation is affirmed as serious because the hazard resulting from the violation in this case caused death or serious physical harm. (Tr. at 548); 29 U.S.C. § 666(k).

Willful Citation 2, Item 1: Training

Merits

The Secretary alleges that Respondent violated 29 C.F.R. § 1910.332(b)(1), which requires: "Employees shall be trained in and familiar with the safety-related work practices required by §§ 1910.331 through 1910.335 that pertain to their respective job assignments." 29 CFR § 1910.332(b)(1). The Secretary claims that:

> [t]he employer did not ensure that general maintenance mechanics were trained in safety-related work practices for electrical work such as, but not limited to, changing ballasts. An employee performing such operations received an electrical shock while working from an A frame ladder. The worker fell approximately 6 ft to the floor below, striking his head and later died of his injuries. Violation occurred on or about 06/26/16.

(Citation at 11.)

As found earlier, the decedent's job assignments included addressing light fixtures and changing ballasts. The cited standard therefore required that the decedent be trained in and familiar with the safety-related work practices required by §§ 1910.331 through 1910.335 for addressing light fixtures and changing ballasts. These sections are entitled "Scope," "Training," "Selection and use of work practices," "Use of requirement," and "Safeguards for personnel protection," and all of them applied to this training requirement for changing ballasts at JCMC. The record establishes that the decedent's only training provided by JCMC was his orientation when he first was hired as there is no other training documents for decedent in the record. *Well Solutions, Inc., Rig No. 30*, 17 BNA OSHC 1211, 1214-15 (No. 91-340, 1995)(holding that the Secretary can rely on "best available evidence" to establish decedents' lack of training and that slim showing of *prima facie* case is sufficient absent rebuttal by party who has "full possession of all the facts."). As discussed earlier, this orientation training is insufficient as it does not go into any detail regarding changing ballasts, let alone the specific requirements of sections 1910.331-1910.335 of changing ballasts. *Pressure Concrete Constr.*, 15 BNA OSHC 2011, 2018 (No. 90-2668, 1992) ("[t]he fact that [the company] failed to train [employees] in the recognition and avoidance of dangerous

conditions establishes that it had at least constructive knowledge of the inadequacy of its training program.").

Additionally, the record supports a finding that JCMC had actual and constructive knowledge that the decedent was changing ballasts in the months leading up to the incident. And while there was no work order for the day of the incident to change a ballast, the record establishes that Adamson knew that the decedent would routinely fix items without a work order while doing his rounds. (Tr. at 484, 486.) Because the task of addressing light fixtures was routine for the decedent, it is reasonably foreseeable that he would attempt to address a light fixture while he was alone on duty, making rounds, on a Sunday. The decedent was therefore exposed to the hazard of electrocution when addressing the light fixture on the day of the incident because he had not been trained in accordance with the cited standard's requirements when changing ballasts. *Bardav, Inc.*, 24 BNA OSHC 2105, 2112 (No. 10-1055, 2014) (concluding that exposure is established for training citation item when worker "engaged in excavation work without first receiving required training") citing *Gen. Motors Corp*., 22 BNA OSHC 1019, 1030 (No. 91-2834E, 2007) (consolidated) ("finding it unreasonable to require that employee be exposed to a hazard before requiring that he be trained to recognize and avoid that hazard."). This citation item is affirmed.

Willfulness

"The hallmark of a willful violation is the employer's state of mind at the time of the violation—an 'intentional, knowing, or voluntary disregard for the requirements of the Act or ... plain indifference to employee safety.)' " *Kaspar Wire Works, Inc.*, 18 BNA OSHC 2178, 2181 (No. 90-2775, 2000) (citation omitted), *aff'd*, 268 F.3d 1123 (D.C. Cir. 2001).

> [I]t is not enough for the Secretary to show that an employer was aware of conduct or conditions constituting the alleged violation; such evidence is already necessary to establish any violation .... A willful violation is differentiated by heightened

> awareness of the illegality of the conduct or conditions and by a state of mind of conscious disregard or plain indifference ....

Hern Iron Works, Inc., 16 BNA OSHC 1206, 1214 (No. 89-433, 1993); *see also Bianchi Trison Corp. v. Chao,* 409 F.3d 196, 208 (3d Cir. 2005) (A willful violation of the OSH Act "constitutes an act done voluntarily with either an intentional disregard of, or plain indifference to, the OSH Act's requirements")(internal quotes omitted).

> There must be evidence that an employer knew of an applicable standard or provision prohibiting the conduct or condition and consciously disregarded the standard. Without such evidence of familiarity with the standard's terms, there must be evidence of such reckless disregard for employee safety or the requirements of the law generally that one can infer that if the employer had known of the standard or provision, the employer would not have cared that the conduct or conditions violated it.

Williams Enters. Inc., 13 BNA OSHC 1249, 1257 (No. 85-355, 1987).

The state of mind of a supervisory employee ... may be imputed to the employer for purposes of finding that the violation was willful." *Branham Sign Co.*, 18 BNA OSHC 2132, 2134 (No. 98-752, 2000); *Elliot Constr. Corp.*, 23 BNA OSHC 2110, 2116-17 (No. 07-1578, 2012) (finding plain indifference when supervisor knew from prior experience and the day of the accident that carbon monoxide would be present and yet failed to monitor for it); *Adrian Constr. Co.*, 7 BNA OSHC 1172, 1175 (No. 15414, 1979) ("A violation is willful if the evidence shows that the employer ignored an obvious and grave danger . . . ").

Heightened Awareness

With regard to heightened awareness, the record supports a finding that the management in the Facilities Department knew that addressing light fixtures and changing ballasts required specific electrical training, and that the management knew that the decedent addressed these light fixtures and changed ballasts without having this training. *Hern Iron Works, Inc.*, 16 BNA OSHC

at 1214 ("A willful violation is differentiated by heightened awareness of the illegality of the conduct or conditions…").

The Secretary argues that JCMC's supervisory personnel knew that the decedent was working on or near electrical circuits, which required specific training in electrical safety work practices that the decedent did not have, and that they directed the decedent to work on these job assignments anyway. (Sec'y Br. 47.) Indeed, despite Respondent's assertions, the employee training for the general maintenance mechanics was not "exhaustive" with respect to addressing light fixtures. (Resp't Br. 40.) The electrical standard cited here required JCMC to train the decedent in the electrical facets of his job assignments, specifically addressing light fixtures and changing ballasts. As found above, the orientation training was insufficient to meet these requirements.

Despite failing to meet these requirements, JCMC directed the decedent to change ballasts knowing he was not trained in the electrical hazards of the procedure. Church told CO Consalazio that general maintenance mechanics normally changed ballasts, even though he also knew at the time that the decedent had not attended the 2014 lockout/tag out training, that he himself had taught. Additionally, the decedent himself notified Adamson that he was changing ballasts.

Respondent states that "there were no concerns brought to the attention of the administration relating to training or safety in the Facilities Department." (Resp't Reply Br. 9.) The undersigned agrees that the record establishes that upper management appeared uninvolved in the day-to-day management of general maintenance mechanics at JCMC. A willfulness finding, however, can be based on imputing the knowledge of mere supervisory personnel. *Caterpillar, Inc.*, 17 BNA OSHC 1731, 1732-33 (No. 93-373, 1996) (finding heightened awareness established by imputing knowledge of supervisory personnel to employer), *aff'd*, 122 F.3d 437 (7th Cir. 1997);

Access Equip. Sys., Inc., 18 BNA OSHC 1718, 1726 (No. 95-1449, 1999) (imputing knowledge of even a temporary employee who has been delegated authority over other employees).

Heightened awareness of the violative conditions is established.

Plain Indifference

Even with this heightened awareness of the violative conditions, Respondent acted with plain indifference toward the decedent's safety. Church knew that the decedent was not trained in changing ballasts, yet he also knew it was one of the decedent's normal job assignments. Even though the decedent notified Adamson that he was changing ballasts, work orders are still in the record directing him to change ballasts, and the decedent addressed the light fixture on the day of the incident.

Respondent claims that JCMC is devoted to safety based on its many "Medical Center Safety Efforts and Emphasis," and its record of zero OSHA citations. (Resp't Br. 38-40.) The Secretary argues that JCMC's multitude of safety efforts in other aspects of its business are unrelated to the safety of general maintenance mechanics working on light fixtures. The undersigned agrees. None of the safety efforts listed by Respondent, such as the Environment of Care Committee and the Quality of Safety Committee, addressed the simple supervision of workers in the Facilities Department changing a light fixture. All of the efforts presented by Respondent primarily target the safety of non-facilities personnel and patients. (Resp't Br. 39); *see, e.g.*, Exs. R-12 at 1-2 (Equipment Electrical Safety policy targeting "electrically susceptible patient" locations and requiring "All Hospital Personnel" to notify "Plant Operations" for equipment repair); R-13 at 1 (Safety Management Plan "put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people coming to the organization's facilities"); R-14 and R-15 (fire safety management plan).

Even though both Church and Adamson knew that the decedent was changing ballasts without training in that job assignment, no measures were put in place to monitor the decedent to make sure he did not change ballasts, or at the very least, train him in that job assignment. *Elliot Constr. Corp.*, 23 BNA OSHC 2110, 2116-17 (No. 07-1578, 2012) (finding plain indifference when supervisor knew from prior experience and the day of the accident that carbon monoxide would be present and yet failed to monitor for it); *Anderson Excavating & Wrecking Co.*, 17 BNA 1890, 1892-94 (No. 92-3684, 1997) (plain indifference found based in part on failure to provide safety program, training and protective equipment, combined with supervisory involvement and failure to take action after notification of violations of same standard at other sites).

This citation is properly characterized as willful.

PENALTY

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 1132, 1137 (No. 06-1036, 2010) *aff'd*, 663 F.3d 1164 (10th Cir. 2011). The gravity of the violation is generally accorded greater weight. *J. A. Jones Constr. Co.*, 15 BNA OSHC 2201, 2214 (No. 87-2059, 1993).

Joseph Czapik, OSHA's Assistant Area Director of Parsippany, reviewed the proposed penalties for this case and submitted them to the Area Director for approval to issue with the citation. (Tr. at 633-637.) Even though Respondent has no history of OSHA violations, OSHA in its discretion did not grant a reduction "to maintain an appropriate deterrent effect," for each of the proposed penalties for history. (Tr. at 635.) Similarly, neither size nor good faith were

considered as a reduction because Respondent had over 2,000 employees and because the citation alleges a willful violation and high gravity serious violations. (Tr. at 635.)

All of the serious violations were high severity based on the potential for death or serious physical harm, and because there was a fatality. (Tr. at 634.) Similarly, all of the serious violations were a greater probability because there was an actual fatality. (Tr. 634 -635.) Therefore, serious Citation 1, Item 1 was proposed at a $12,471 unadjusted penalty; serious Citation 1, Item 2a and 2b were grouped and were proposed at a $12,471 unadjusted penalty; serious Citation 1, Item 3 was proposed at a $12,471 unadjusted penalty; and serious Citation 1, Item 4 was proposed at a $12,471 unadjusted penalty.

The willful Citation 2, Item 1 was proposed with the maximum penalty, $124,709, due to no reductions for size, good faith or history for the same reasons that the serious violations were not given those reductions. (Tr. 636). It was also assigned a high severity, greater probability because of the actual fatality. (Tr. at 636.) Czapik then testified: "We had mechanics, we had general maintenance people that were engaged in working on electrical equipment that didn't have training and there was no good reason for them not to have that training." (Tr. at 637.)

Respondent has not addressed the amount of the proposed penalties in its briefs. After consideration of the statutory factors with regard to the penalties for the affirmed violations, the undersigned agrees with the penalty amounts proposed by the Secretary for each citation item. The proposed penalty amounts are assessed for each affirmed citation item.

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:

1) Citation 1, Item 1, alleging a Serious violation of 29 C.F.R. § 1910.333(a)(1), is AFFIRMED, and a penalty of $12,471 is ASSESSED,

2) Citation 1, Item 2a, alleging a Serious violation of 29 C.F.R. § 1910.333(b)(2), and Citation 1, Item 2b, alleging a Serious violation of 29 C.F.R. § 1910.333(b)(2)(i), are AFFIRMED, and a grouped penalty of $12,471 is ASSESSED,

3) Citation 1, Item 3, alleging a Serious violation of 29 C.F.R. § 1910.333(c)(2), is AFFIRMED, and a penalty of $12,471 is ASSESSED,

4) Citation 1, Item 4, alleging a Serious violation of 29 C.F.R. § 1910.335(a)(1)(i), is AFFIRMED and a penalty of $12,471 is ASSESSED,

5) Citation 2, Item 1, alleging a Willful violation of 29 C.F.R. § 1910.332(b)(1), is AFFIRMED, and a penalty of $124,709 is ASSESSED.

SO ORDERED.

/s/Covette Rooney
COVETTE ROONEY
Chief Judge, OSHRC

DATE: July 2, 2019
Washington, D.C.