

United States of America
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
1924 Building – Room 2R90, 100 Alabama Street SW
Atlanta, Georgia 30303-3104

Secretary of Labor,

Complainant,

v.

United Launch Alliance, LLC,

Respondent.

OSHRC Docket No. **15-2237**

Appearances:

Dane L. Steffenson, Esquire, U.S. Department of Labor, Office of the Solicitor, Atlanta, Georgia
For the Secretary

Carla J. Gunnin, Esquire, Jackson Lewis, P.C., Atlanta, Georgia
For the Respondent

BEFORE: Administrative Law Judge Sharon D. Calhoun

DECISION AND ORDER

United Launch Alliance, LLC, (ULA) provides spacecraft launch services to the United States government. On July 28, 2015, one of its technicians suffered the amputation of two fingers while working on a component of a launchpad at Cape Canaveral Air Force Station (CCAFS) in Cape Canaveral, Florida. On August 3, 2015, the Occupational Safety and Health Administration (OSHA) conducted an investigation of the incident. As a result of the investigation, the Secretary issued a Citation and Notification of Penalty to ULA on November 25, 2015, alleging, as Item 1, a serious violation of 29 C.F.R. § 1910.212(a)(1) for failing to provide machine guarding, exposing employees to nip points. The Secretary proposed a penalty of \$5,000.00 for Item 1.

ULA timely contested the Citation. The Court held a hearing in this matter on July 29, 2016, in Orlando, Florida. The parties filed briefs on November 8, 2015. ULA contends the launchpad component at issue is not a machine, thus the cited machine guarding standard does not apply. Alternatively, ULA argues that, if the launchpad component is a machine, a subsection of the lockout/tagout (LOTO) standard is more applicable than 29 C.F.R. §

1910.212(a)(1) and Item 1 should be vacated. ULA also contends the Secretary failed to establish it had knowledge of the violative condition.

Upon consideration of the record, the Court determines 29 C.F.R. § 1910.212(a)(1) applies to the cited condition and the LOTO standard does not apply. The Secretary established all elements of the cited violation. Accordingly, the Court **AFFIRMS** Item 1 and assesses a penalty of \$5,000.

BACKGROUND

In 2006, Lockheed Martin and The Boeing Company formed ULA as a joint venture (Tr. 205). ULA has several worksites across the United States. The worksite at issue is at the CCAFS in Cape Canaveral, Florida. ULA launches rockets from two launch complexes there, Space Launch Complex 41 (SLC-41) and Space Launch Complex 37 (SLC-37). The incident at issue occurred at SLC-37 (Tr. 28).

Assigned Task

The ULA technicians in this case work in the horizontal integration facility (HIF) at the CCAFS (Tr. 78). Their job is to “[a]ssemble and test rockets.” (Tr. 28) Technician #2 (the employee who was injured) explained the pre-launch process:

When you bring the rocket in, we assemble it, first stage, second stage, and the spacecraft, and then we put it on the EPT [elevated platform transporter], take it to the pad, put it on the pad, on the erector launcher, and raise it up, and basically plug it in, put all the platforms in for all the different people to work on, the electricians and all. We set it up with the handrails and platforms and floors and decking and all, where everybody can get to do their job.

(Tr. 78)

After a rocket is launched, the technicians retrieve the launch mating unit (LMU) (“what the rocket stands on before it launches.” (Tr. 80)). To do so, the crew members need to secure the LMU pallet or aft platform (used to transport the LMU to and from the launchpad) to the fixed pad erector (FPE) by connecting the struts of the pallet to the strut captures located beneath the surface of the launchpad (Exh. JT-2 (the capture is the blue component); Tr. 29-30). The other ends of the struts connect to the LMU (Tr. 82).

The strut captures are a small part of the FPE. The FPE, which is approximately 200 feet long and 20 feet wide, is a “real big hydraulic ram” that erects the rocket from a horizontal to vertical configuration (Exh. JT-8A; Tr. 30-31). Once the ends of the struts are connected to the

underground strut captures and the other ends are connected to the LMU, according to Technician #2, “the EPT drives under [the] white aft platform and you lift it up and you drive it down to the HIF to work on the LMU. All we’re doing is removing the launch platform, is all we [are] doing.” (Tr. 82) The FPE components lie beneath the surface of the launchpad. Sections of mesh grating cover much of the FPE. FPE components, such as the strut capture at issue, can be accessed by removing a section or sections of the grate (Tr. 36).

Testing the Capture and Piston

The capture operates as a clevis (a U-shaped bracket) through which a clevis pin, in the form of a piston, is inserted once the strut is in place, locking it in. Prior to connecting the strut to the capture, the technicians are assigned to test and lubricate the piston. The testing is done by “exercising” the piston-- “extending it and retracting it to make sure it [is] lubricat[ing] and work[ing] properly before [the technicians] put the blue strut in place.” (Tr. 40) This task is unique to SLC-37. It is done once every mission. ULA launches “two to five” rockets a year from SLC-37 (Tr. 41-2).

To access the capture, the technician removes a yellow grate section. He then pulls out a pip pin, which is a safety mechanism used to lock the piston in place. The technician uses compressed air pressure to extend and retract the piston. One end of an air hose is connected to the air source on a wall several yards from the capture. Then, with the air pressure on, the technician connects the other end of the hose to one of two nipples located approximately 9 inches from the edge of the capture. One nipple extends the piston and the other retracts it. The technician must kneel on the concrete surface or on the grating, support himself with one hand, and lean down and connect the end of the active air hose to one of the nipples. Immediately upon connection to the extension nipple, the piston shoots forward through the clevis (Exhs. JT-1 (p.40 of 94) & JT-4; Tr. 48-55, 100-101).

ASOP Huddles and Fishbones

Prior to any task, the engineer meets with the technicians and holds an “ASOP huddle” (Assignment, Situation, Obstacles, and Procedure), during which they discuss possible obstacles and any personal issues (hunger, fatigue, etc.) that may impede accomplishing the task (Tr. 172). The crew also does a “fishbone” analysis, during which they discuss the procedure at hand to identify any problems or hazards that may arise. The fishbone analysis is based on a causal

diagram (resembling a fish skeleton) designed to break down (in successive layers of detail) root causes that potentially could create a problem (Tr. 171-172, 211). Engineer Marty Turner testified he did a specific fishbone analysis with his crew on July 28, 2015.

Those fishbones cover the entire procedure. This procedure covers delivering this pallet to the fixed pad erector. It covers securing to the fixed pad erector. It covers the actual fixed pad erector going vertical, coming back down, and disconnect. We were only doing a very short portion of that. So I went into detail as we went along, step by step, on what the hazards were.

(Tr. 173)

The July 28, 2015, Accident

ULA's day shift starts at 7:30 a.m. (Tr. 44, 79). The morning of July 28, 2015, engineer Turner and a crew of four technicians met at SLC-37 to retrieve the LMU. Turner held an ASOP huddle with the technicians (Tr. 43). As engineer, Turner directed the tasks (Tr. 45, 68-69, 84). He did not assign tasks to specific technicians—he explained what needed to be done for each step and a technician would volunteer to do it. Technician #1 stated, "Most of our tasks are run basically, you know, the people would more or less volunteer. . . . [W]hen you're working with four people, everybody kind of jumps in and tries to help out. And so when this part of the task started, you know, [Technician #2] was the first to go and do it." (Tr. 47)

At approximately 9:00, Technician #2 began the process of testing the capture piston. He had performed this task three or four times in the previous five years (Tr. 80, 85). Technician #1, who observed the process, testified,

[Technician #2] was supporting himself, because everything is –the nipples in Joint Exhibit 2 are underground, you know? I mean they're only a couple inches, but you're on your knees and you have to support yourself somehow. . . . [H]e was on his knees and was supporting his weight on his, you know, left hand, while he was trying to connect the nipple, the air hose on the nipple. And because the parts were worn, and I think that was the main problem, is the parts were worn and they didn't connect easily.

(Tr. 72-73)

Technician #2 agreed he had difficulty connecting the hose to the nipple.

[W]e always do a dry run with the pin to make sure that it goes through, so it goes through all of the holes right there. And that's what I was doing when I was plugging in the air to the part that runs the pin in. And sitting out on the beach you can see how everything gets rusty. And we had already been putting all of

these heavy cables and torquing the beat down on the aft pallet. And I was literally just soaking wet sweating and I had gloves on. And I had my one hand right there on top of the blue [capture], where I could watch the pin come through. And I was plugging it in, and I was literally kneeling down on the grating. And it's not like kneeling on the carpet; it kind of hurts your knees. . . . And when I went to plug the air nipple in, I was having a hard time getting it in because it was kind of rusty. And as soon as it went in, it knocked me off balance and my hand just slid right in that hole. And I had gloves on, and it just took the ends of my fingers off. I mean, we're talking, you couldn't cough that quick.

(Tr. 85-86) Technician #2 lost the ring finger and the little finger of his left hand in the incident.

OSHA Inspection

CSHO Melissa Hay went to SLC-37 on August 3, 2015 (because the worksite is an Air Force Station, CSHO Hay needed to receive clearance before she could investigate the July 28 accident) (Tr. 124). She held an opening conference and conducted a walkaround inspection of the accident site, during which she took measurements and photographs (Tr. 127). With the grate covering removed from the opening to the capture, the opening measured 31 inches in length and 29 inches in width (Exh. JT-3; Tr. 135). The distance between the top of the capture (where Technician #2 placed his hand for support) to the area through which the piston extends is 2¹/₂ inches (Exh. JT-5; Tr. 136). CSHO Hay recommended the Secretary cite ULA for a serious violation of § 1910.212(a)(1), which the Secretary did on November 25, 2015.

JURISDICTION AND COVERAGE

ULA timely contested the Citation and Notification of Penalty on December 18, 2015. The parties stipulate the Commission has jurisdiction over this action and ULA is a covered business under the Act (Tr. 8). Based on the parties' stipulations and the record evidence, the Court finds the Commission has jurisdiction over this proceeding under § 10(c) of the Occupational Safety and Health Act of 1970, 29 U.S.C. §§ 651-678 (Act), and ULA is a covered employer under § 3(5) of the Act.

CITATION NO. 1

The Secretary's Burden of Proof

To establish a violation of a safety or health OSHA standard, the Secretary must prove: (1) the cited standard applies; (2) its terms were violated; (3) employees were exposed to the violative condition; and (4) the employer knew or could have known with the exercise of

reasonable diligence of the violative condition. *See Astra Pharm. Prods., Inc.*, 9 BNA OSHC 2126, 2129 (No. 78-6247, 1981), *aff'd in pertinent part*, 681 F.2d 69 (1st Cir. 1982).

Item 1: Alleged Serious Violation of § 1910.212(a)(1)

Item 1 of Citation No. 1 alleges, “At Space Launch Complex 37 on Cape Canaveral Air Force Station, employees were exposed to amputation hazards when the strut capture pin was tested without being properly guarded to protect the operator. This violation was discovered on or about August 3, 2015.”

Section 1910.212(a)(1) provides:

One or more methods of machine guarding shall be provided to protect the operator and other employees in the machine area from hazards such as those created by point of operation, ingoing nip points, rotating parts, flying chips and sparks. Examples of guarding methods are—barrier guards, two-hand tripping devices, electronic safety devices, etc.

(1) Applicability of the Cited Standard

The Capture Component Is a Machine

Section 1910.212(a)(1) is found in *Subpart O—Machinery and Machine Guarding* of the general industry standards. Therefore, in order for the cited standard to apply to the cited capture, the Secretary must establish the capture is a machine. *Subpart O* does not define *machinery* or *machine*. A dictionary definition of *machine* is “an apparatus using or applying mechanical power and having several parts, each with a definite function and together performing a particular task.” *New Oxford American Dictionary*, 3rd ed. 2010. Page 40 of 94 of Exhibit JT-1 shows a diagram of the capture with its various parts labeled. The capture is an apparatus through which a piston is extended and retracted using compressed air flowing from a source through a hose attached to a nipple on the capture component. Compressed air is a mechanical power used to extend and retract the piston in and out of the clevis, accomplishing the particular task of securing and releasing the pallet struts, as needed.

ULA contends the capture is not a machine:

[I]n the *Raven Industries* case, machinery is described as an assemblage of machines or mechanical apparatuses and a machine is an “apparatus consisting of interrelated parts with separate functions, used in the performance of some kind of work.” *Raven Industries Inc.*, 4 OSAHRC 897, 901-2 (ALJ Brenton Sept. 1973). The clevis pin is merely a connecting device. It is not a machine that has several interrelated parts; rather, it is simply the device that connects two fixtures together

– the LMU and FPE, to allow the rocket to be raised onto the launch pad. In *United States Steel Corp.*, the Court relied upon the 6th Circuit’s definition of a machine as “a device or combination of devices by means of which energy can be utilized or a useful operation can be performed... [and that a machine can be] adapted to rendering a mechanical service or to the fabrication of material so as to change its form or produce a desired product.” See *United States Steel Corp.*, 1976 OSAHRC LEXIS 663, *6-8 (ALJ Burroughs March 1976) (citing *Nestle-Le Mur Company v. Eugene*, 55 F.2d 854, 857 (6th Cir. 1932).

(ULA’s brief, p. 8)

The two Review Commission cases from the 1970s cited by ULA are unreviewed ALJ decisions with no precedential force. In referring to only the clevis pin and calling it a connecting device, ULA is omitting the effect of pneumatic pressure, flowing through the hose connected to the nipple, on the piston in extending and retracting it. ULA narrows its focus to one isolated part of the component, ignoring how the interrelated parts work as a whole.

ULA also contends § 1910.212(a)(1) is intended to apply only to machinery that is used to produce a product. “The standard was intended to cover machinery used for processing of materials not simply a connection point. . . . The clevis pin at issue here is merely connecting two separate pieces of equipment. The clevis pin and strut assembly that connects the two fixtures (LMU and FPE) are not devices that have an energy source or are used to fabricate material or produce a desired product.” (ULA’s brief, p. 8) This argument ignores Commission precedent, which seeks to protect employees working near machines from exposure to crushing and amputation hazards, regardless of the task being performed:

We hold that section 1910.212 applies to machine hazards that arise during inspection, cleaning, and maintenance. We do so primarily because section 1910.212 establishes requirements for the protection of operators and other employees in the machine area from hazards without regard to whether such hazards are created during production or non-production operations. Section 1910.212 does not employ the terms ‘production’ or ‘maintenance’ or otherwise distinguish between production and maintenance. As the facts of this case clearly demonstrate, if a machine is activated during maintenance and commences its operating cycle, the operator can be exposed to injury in the same manner and degree as he can during ordinary production; the operating characteristics of this press were also not materially changed by the maintenance being performed.

General Electric Company, 10 BNA OSHC 1687, 1690 (No. 77-4476, 1982).

Section 1910.212(a)(1) requires the employer to guard against hazards “such as those

created by point of operation, ingoing nip points, rotating parts, flying chips and sparks.” The alleged violation description of Item 1 does not identify which hazard was created by the piston and clevis. In his brief, the Secretary states, “It is undisputed that the Device has a moving part that creates nip points and a crushing hazard.” (Secretary’s brief, p. 9) Turner stated, “[W]e really had to be concerned with the pinch points of the connection, of course.” (Tr. 175) As is evident from the injuries to Technician #1, the activation of the piston during the testing of the component exposed the technician to crushing and amputation hazards. The photographs of the capture show three separate locations where an employee’s hand may be crushed against a section of the clevis or the concrete wall next to where the clevis is placed (Exhs. JT-2, JT-3, and JT-4).

The Court determines the capture component, comprising the clevis, piston, nipples, air hose, and compressed air source, is a machine within the meaning of § 1910.212(a)(1).

The LOTO Standard Does Not Apply

ULA argues that if the Court determines the capture component is a machine, a more specific standard applies. “See 29 C.F.R. § 1926.20(d)(1) (“[i]f a particular standard is specifically applicable to a condition, practice, means, method, operation, or process, it shall prevail over any different general standard which might otherwise be applicable to the same condition, practice, means, method, operation, or process”); *Vicon Corp.*, 10 BNA OSHC 1153, 1157, 1981 CCH OSHD ¶ 25,749, p. 32,159 (No. 78-2923, 1981) (claim that a general standard is preempted by a more specific standard is an affirmative defense), *aff’d*, 691 F.2d 503 (8th Cir. 1982) (Table).” *Brand Energy Sols. LLC*, 25 BNA OSHC 1386, 1388 (No. 09-1048, 2015).

ULA states, “[M]achine guards may be removed during the performance of maintenance and repair activities. . . . [O]nce the grate over the equipment was removed to conduct maintenance, the lockout/tagout standards apply and the proper standard to have cited would have been lockout/tagout, not machine guarding.” (ULA’s brief, p. 9) In making this argument, ULA overlooks the key element of “unexpected” energization as a requisite to application of the LOTO standard.

Section 1910.147(a)(1)(i) provides (emphasis in original):

This standard covers the servicing and maintenance of machines and equipment in which the *unexpected* energization or start up of the machines or equipment, or release of stored energy, could harm employees. This standard establishes

minimum performance requirements for the control of such hazardous energy.

“By its terms, the lockout standard's scope provision limits the applicability of the regulation to machines that could cause injury if they were to start up unexpectedly.” *Reich v. Gen. Motors Corp.*, 89 F.3d 313, 315 (6th Cir. 1996). Here, the energization of the piston in the capture component was not unexpected—it was the task assigned. Technician #2 stated, “[W]e always do a dry run with the pin to make sure that it goes through, so it goes through all of the holes right there. And that’s what I was doing when I was plugging in the air to the part that runs the pin in. . . . And I had my one hand right there on top of the blue [capture], where I could watch the pin come through.” (Tr. 85). Technician #2 was not subject to the unexpected energization of the piston. He was the person who volunteered to energize it.

We conclude that the plain language of the lockout standard unambiguously renders the rule inapplicable where an employee is alerted or warned that the machine being serviced is about to activate. In such a situation, “energization” of the machine cannot be said to be “unexpected” since the employee knows in advance that machine startup is imminent and can safely evacuate the area. The standard is meant to apply where a service employee is endangered by a machine that can start up without the employee's foreknowledge. In the context of the regulation, use of the word “unexpected” connotes an element of surprise, and there can be no surprise when a machine is designed and constructed so that it cannot start up without giving a servicing employee notice of what is about to happen.

Gen. Motors Corp., 89 F.3d at 315.

Not only did the Technician #2 receive notice that the capture piston was starting up, he was the one starting it. The LOTO standard is not more specific to the cited condition than § 1910.212(a)(1).¹

¹ This case is distinguishable from *Otis Elevator Co. v. Sec’y of Labor*, 762 F.3d 116 (D.C. Cir. 2014), in which the Court of Appeals for the D.C. Circuit affirmed the Commission’s finding the LOTO standard applied where an employee was injured while unjamming the gate of a freight elevator. “The Commission explained that the applicability of the lockout/tagout standard turns not on the mechanic's subjective prediction of how the machine would operate at the moment of repair, but rather on whether there was a potential for the unexpected release of stored energy that could cause injury to the mechanic or others. The Commission found such potential in this case because, as the mechanic testified, he could not predict when the jam would yield, making the sudden release of the chain “unexpected” within the meaning of 29 C.F.R. § 1910.147(a)(1)(i).” *Id.* at 120. Here, unlike an employee working to release a jammed component who was subject to stored energy, Technician #2 was engaged in the startup of the component and knew the piston would extend as soon as he connected the hose to the extension nipple.

(2) Terms of § 1910.212(a)(1) Were Violated

Under section 1910.212(a)(1), the Secretary is required “to prove that a hazard within the meaning of the standard exists in the employer's workplace.” *ConAgra Flour Milling Co.*, 16 BNA OSHC 1137, 1147, 1993-95 CCH OSHD ¶ 30,045, p. 41,241-42 (No. 88-1250, 1993) (citing *Armour Food Co.*, 14 BNA OSHC 1817, 1821, 1987-90 CCH OSHD ¶ 29,088, p. 38,883 (No. 86-247, 1990)), *rev'd on other grounds*, 25 F.3d 653 (8th Cir. 1994). Specifically, the Secretary “must show that employees are in fact exposed to a hazard as a result of the manner in which the machine functions and is operated.” *Id.* (citing *Jefferson Smurfit Corp.*, 15 BNA OSHC 1419, 1421, 1991-93 CCH OSHD ¶ 29,551, p. 39,953 (No. 89-553, 1991)). The mere fact that it is not impossible for an employee to come into contact with the moving parts of a particular machine does not, by itself, prove that the employee is exposed to a hazard. *Armour Food*, 14 BNA OSHC at 1821, 1987-90 CCH OSHD at p. 38,883.

Safeway #2555, & Its Successors, 2005 WL 858056 at *1(No. 03-1072, 2005).

ULA does not dispute the Secretary's contention the capture component was not guarded at the time of the accident. The nip points of the capture are usually guarded by the yellow grate that covers it. In order to perform the piston testing and servicing tasks, the technicians must remove the grate and the pip pin that locks the piston in place. Turner was aware of the hazards created by removing the grate and the pip pin. In his fishbone analysis discussed with the technicians prior to testing the capture piston, he addressed “the crushing potential if your hand's inside this area.” (Tr. 187) He testified, “I said when we activate the [piston], be sure to stay clear, it moves quickly, don't have your hands near there.” (Tr. 188) He acknowledged the technician connecting the air hose was required to place himself in proximity to the nip points of the capture. “At the time you had to be kneeling close enough to make the connection to the retract or extend ports.” (Tr. 188) The Secretary has established the technician engaged in activating the capture piston with the active air hose was exposed to nip points that could cause crushing or amputation injuries.² No guards were on the component at the time of the technician's injury.

CSHO Hay testified the capture could have been guarded by distance if the order in which the ends of the air hose were connected was reversed. “[I]f they had used an uncompressed hose attached to the nipple and then pressurized it from the other end, then

² The Secretary did not establish the technician connecting the air hose is exposed to a hazard when the hose is connected to the extension nipple before it is connected to the compressed air source.

distance could have been obtained that would have reduced or eliminated the exposure.” (Tr. 134-135) The Secretary has established ULA failed to comply with the terms of the standard.³

(3) Employees Had Access to the Violative Condition

To establish access under Commission precedent, the Secretary must show either that Respondent's employees were actually exposed to the violative condition or that it is “reasonably predictable by operational necessity or otherwise (including inadvertence), that employees have been, are, or will be in the zone of danger.” *Fabricated Metal Prods.*, 18 BNA OSHC 1072, 1074, 1998 CCH OSHD ¶ 31,463, pp. 44,506-07 (No. 93-1853, 1997) (citing *Gilles & Cotting, Inc.*, 3 BNA OSHC 2002, 2003, 1975-76 CCH OSHD ¶20,448, p. 24,425 (No. 504, 1976)).

S & G Packaging Co., LLC, 19 BNA OSHC 1503, 1506 (No. 98-1107, 2001).

The amputation of Technician #2’s fingers establishes actual exposure to the nip points of the capture component. *Phoenix Roofing, Inc.*, 17 BNA OSHC 1076, 1079 (No. 90-2148, 1995), *aff’d without published opinion*, 79 F.3d 1146 (5th Cir. 1996) (fact that an employee fell through a skylight unquestionably established actual exposure to a fall hazard). Access to the violative condition was reasonably predictable. The technician activating the capture piston was required by operational necessity to kneel near the capture and support himself on one hand, placing it within the zone of danger. *RGM Constr. Co.*, 17 BNA OSHC 1229, 1234 (No. 91-2107, 1995) (holding that the zone of danger is “that area surrounding the violative condition that presents the danger to employees [that] the standard is intended to prevent”).

The Secretary has established Technician #2 had access to the violative condition.

(4) Employer Knowledge

[T]he Secretary can prove employer knowledge of the violation in one of two ways. First, where the Secretary shows that a supervisor had either actual or

³Although ULA did not assert the affirmative defense of unpreventable employee misconduct, it makes numerous references to Technician #2’s purportedly unprecedented action in placing his hand on the capture for support (*e.g.*, “No one had ever been observed placing their hand in the area where [Technician #2] placed his hand on the day of the incident. (Tr. 176, Lines 3-7; Tr. 176, Lines 19-22). There was no work reason to place one’s hand in the area where [Technician #2] placed his hand. (Tr. 201, Lines 1-3; Tr. 221, Lines 10-16). Moreover, there was no expectation that anyone would ever place a hand in the area where [Technician #2] placed his hand. (Tr. 193, Lines 20-23). Had Mr. Turner observed [Technician #2’s] hand in the area where he placed it, Mr. Turner would have told [Technician #2] to move his hand. (Tr. 176, Lines 3-7)).” (ULA’s brief, p. 3) First, it is incorrect that the placement of Technician #2’s hand was a singular event. Technician #1 testified, “I was talking to a fellow yesterday and he said he did the same thing in the past.” (Tr. 73) Second, and most importantly, § 1910.212(a)(1) is designed to protect employees despite their misjudgments. *See Signode Corp.*, 4 BNA OSHC 1078, 1079 (No. 3527, 1976) (observing that the standard at § 1910.212(a)(1) “is plainly intended to eliminate danger from unsafe operating procedures, poor training, or employee inadvertence”).

constructive knowledge of the violation, such knowledge is generally imputed to the employer. *See Georgia Elec. Co. v. Marshall*, 595 F.2d 309, 321 (5th Cir.1979); *New York State Elec. & Gas Corp.*, 88 F.3d at 105; *see also Secretary of Labor v. Access Equip. Sys., Inc.*, 18 O.S.H. Cas. (BNA) 1718, at (1999). An example of actual knowledge is where a supervisor directly sees a subordinate's misconduct. *See, e.g., Secretary of Labor v. Kansas Power & Light Co.*, 5 O.S.H. Cas. (BNA) 1202, at (1977) (holding that because the supervisor directly saw the violative conduct without stating any objection, "his knowledge and approval of the work methods employed will be imputed to respondent").

ComTran Grp., Inc. v. U.S. Dep't of Labor, 722 F.3d 1304, 1307–08 (11th Cir. 2013).

The Secretary contends actual knowledge of the violative conduct may be imputed to ULA because engineer Marty Turner was present during the accident and watching Technician #2 perform the assigned task. Turner conceded he did so. "I was within probably 3 feet of him during the task. . . . [Y]es, we were watching." (Tr. 176)

ULA argues Turner was not a supervisor. This argument is contradicted throughout the record. Even though he characterized Turner as just a "rank and file engineer," Technician #1 clearly recognized Turner as the person in charge of the task.

Q.: And who is in charge of what's going to—

Technician #1: Marty Turner. He was the engineer.

Q.: Who directs what task, one at a time, that each of—

Technician #1: Marty Turner.

Q.: --you techs are going to perform?

Technician #1: Marty Turner.

(Tr. 45)

Technician #1 also referred to Turner as a "task leader" and the person with overall responsibility for safety (Tr. 68-69). Technician #2 identified Turner as the "engineer that's the team lead." (Tr. 83) He stated he was "like the main person in charge, the engineer. They're the ones who give us the direction." (Tr. 84)

Turner explained his responsibility on the worksite:

[A]s engineers, we are like the task leaders or the assistant test conductors. There's several terms they use, PICs is one of them, person in charge. We control

like the leader for a specific management to work our jobs. So we direct them in the course of performing the specific tasks. . . . Most of the procedures we work are authored by engineers. And then on a specific task you would assign—they're assigned to your task when you go through the procedure, and you know, more or less direct that job through completion.

(Tr. 169)

Turner's authority is well above the minimum threshold the Commission has set for employees to be considered supervisory personnel.

The Commission has long recognized that "an employee who has been delegated authority over other employees, even if only temporarily, is considered to be a supervisor" for the purpose of establishing knowledge. *Access Equip. Sys.*, 18 BNA OSHC at 1726, 1999 CCH OSHD at p. 46,782. In deciding whether an employee qualifies as a supervisor, "[i]t is the substance of the delegation of authority that is controlling, not the formal title of the employee having this authority." *Dover Elevator Co.*, 16 BNA OSHC 1281, 1286, 1993 CCH OSHD ¶ 30,148, p. 41,480 (No. 91-862, 1993) See *Access Equip. Sys.*, 18 BNA OSHC at 1726, 1999 CCH OSHD at p. 46,782 (knowledge imputed from "a leadman ... 'in charge of' ... two [other] employees," whom the employer's general manager "considered ... to be 'like the lead person for' [those two employees]"); *Iowa S. Utils. Co.*, 5 BNA OSHC 1138, 1139, 1977-78 CCH OSHD ¶ 21,162, p. 25,945 (No. 9295, 1977) (knowledge imputed from a "temporary working foreman ... vested with some degree of authority over the other crew members assigned to carry out the specific job involved"); *Mercer Well Serv., Inc.*, 5 BNA OSHC 1893, 1894, 1977-78 CCH OSHD ¶ 22,210, p. 26,722 (No. 76-2337, 1977) (imputing knowledge of employee "considered to be in charge of the crew when [his supervisor] was not present").

Am. En'g & Dev. Corp., 23 BNA OSHC 2093, 2095-2096 (No. 10-0359, 2012).

Here, Turner's authority over the technicians was not temporary and was not contingent on his supervisor's absence from the worksite. As engineer, Turner was the person who led the ASOP huddles and fishbone analyses, determined the tasks to be performed, and directed the tasks. He was accepted as part of the hierarchy of authority on the worksite. Turner had supervisory authority over the technicians and his knowledge of the violative conduct is imputed to ULA.⁴

⁴ ULA contends Turner "was denied counsel during his [OSHA] interview, an action that is generally only reserved for non-management employees. Moreover, Complainant's counsel took the position that Mr. Turner was not a member of management by severely redacting the statement that was taken by the compliance officer with Mr. Turner. This is an action that is typically reserved for informants and has typically been applied only to non-management employees." (ULA's brief, n. 2) ULA argues the CSHO's denial of Turner's request for counsel

Furthermore, the Secretary has also established constructive knowledge of the violative conduct.

An example of constructive knowledge is where the supervisor may not have directly seen the subordinate's misconduct, but he was in close enough proximity that he should have. *See, e.g., Secretary of Labor v. Hamilton Fixture*, 16 O.S.H. Cas. (BNA) 1073, at *17–19 (1993) (holding that constructive knowledge was shown where the supervisor, who had just walked into the work area, was 10 feet away from the violative conduct). In the alternative, the Secretary can show knowledge based upon the employer's failure to implement an adequate safety program, *see New York State Elec. & Gas Corp.*, 88 F.3d at 105–06 (citations omitted), with the rationale being that—in the absence of such a program—the misconduct was reasonably foreseeable.

ComTran, 722 F.3d at 1308.

ULA had written procedures, authored by an engineer or engineers, for testing and servicing the capture piston (Tr. 169). Technician #2 was following this procedure, in the presence of Turner and three other technicians, when the accident occurred. Turner testified that starting up the piston extension with the air hose already active is “the way the procedure was written the first time I was there as an observing engineer and the way it has been performed for however many times we performed this.” (Tr. 189) Turner conceded an alternative method of completing the task would be to connect the hose to the nipple at the capture first and then to connect the other end of the hose to the air source. That way, the technician connecting the hose next to the capture could stand up, step back, and observe the motion of the piston once another technician connected the hose to the air source. No one would be exposed to the nip points of the capture. When asked why ULA did not use this alternative method, he stated technicians preferred methods that allowed for a quick disconnect, or Q.D.

[I]f you’re using a compressed air source, you typically do have energized hoses with Q.D. That’s the whole principle of the quick disconnect, is you can change what you’re using, whether it be a pin or a drill or something that you’re using. You have that source, and it’s just a, I guess a shop practice to have those Q.D.s there, and the procedure was written and their training had been that way, and it

“surely casts doubt on the credibility of the compliance officer’s testimony.” (*Id.*) The credibility of the CSHO is not an issue in this proceeding. The Court relies on the testimony of the ULA employees who testified at the hearing in determining the Secretary established each of the elements of the violation in this case. OSHA’s treatment of Turner as a non-management employee prior to the hearing has no effect on the Court’s conclusion, based on the testimony of ULA employees, that Turner was a supervisor whose actual knowledge may be imputed to ULA.

was never questioned, and that's why it was performed that way. . . . Just on-the-job training. You know, that's how the technicians would learn this operation, by seeing the guys before them that did it[.]

(Tr. 192)

As Turner acknowledges, the written procedure and the technicians' on-the-job training instructs the technicians in the procedure, ensuring the technician connecting the hose at the capture will have access to the capture's nip points. This employee exposure is a foreseeable consequence of the sequencing of the procedure as taught.

David Micka is ULA's system safety and health and environmental affairs manager (Tr. 205). He investigated the accident on behalf of ULA and took responsibility for cleaning the blood from the capture area (Tr. 208). Micka instructed technicians to connect and disconnect the ends of the air hose for him. He instructed the technicians to connect the hose at the capture first and then connect the other end to the air source. When asked why he proceeded this way, he responded,

One, if you've ever worked with air tools and all, you know it's very difficult to make a connection when you have pressure on the line. Also, it's just a better way to do it because nothing's going to happen in proximity to where I'm positioned if it's connected at the piston first and then at the source. Then it will move when [I'm] . . . telling somebody to do that, it does it when I want it to, not when it wants to.

(Tr. 210)

Micka stated if he had written the procedure for testing and servicing the capture piston, he would have instructed to "always connect at the piston first and then go connect at the other end." (Tr. 210) Post-accident, Micka testified, "[T]he procedure's been changed and no one's been allowed to [connect to the air supply first]. It's very explicit." (Tr. 212)

At the time of the accident, ULA's written procedure and training for testing and servicing the capture piston exposed the connecting technician to the capture's nip points. ULA's management and its engineers had constructive knowledge of the written procedure and training. The violative activity was foreseeable.

The Secretary has established actual and constructive knowledge of the violative conduct. A violation of § 1910.212(a)(1) is established.

Classification of the Violation

The Secretary classified the violation of § 1910.212(a)(1) as serious. A serious violation is established when there is “a substantial probability that death or serious physical harm could result [from a violative condition] . . . unless the employer did not, and could not with the exercise of reasonable diligence, know of the presence of the violation.” 29 U.S.C. § 666(k). The Court finds that serious physical harm is the likely result if an employee’s hand is exposed to the nip points of the capture at issue, as evidenced by the amputation of two of the technician’s fingers. The violation is serious.

PENALTY DETERMINATION

The Commission is the final arbiter of penalties in all contested cases. “In assessing penalties, section 17(j) of the OSH Act, 29 U. S. C. § 666(j), requires the Commission to give due consideration to the gravity of the violation and the employer’s size, history of violation, and good faith.” *Burkes Mechanical Inc.*, 21 BNA OSHC 2136, 2142 (No. 04-0475, 2007). “Gravity is a principal factor in a penalty determination and is based on the number of employees exposed, duration of exposure, likelihood of injury, and precautions taken against injury.” *Siemens Energy and Automation, Inc.*, 20 BNA OSHC 2196, 2201 (No. 00-1052, 2005).

ULA stipulates it has 526 employees at CCAFS and approximately 3,200 employees nationwide (Tr. 138). CSHO Hay testified she could find no history of OSHA inspections of ULA (Tr. 139). The record establishes ULA is attentive to safety, incorporating ASOP meetings and fishbone analyses into its everyday procedure. The violative conduct at issue, however, was part of its written procedure and its technicians were trained to perform the task in an unsafe manner. As Micka pointed out, simply reversing the order in which the ends of the air hose are connected provided a feasible, economical abatement of the hazardous condition. No credit is given for good faith.

One employee was exposed to the hazard, for a short period of time. The likelihood of injury in this instance was high and ULA took no precautions against it. The Court assesses a penalty of \$5,000.00 for Item 1, as proposed by the Secretary.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The foregoing decision constitutes the findings of fact and conclusions of law in accordance with Fed. R. Civ. P. 52(a).

ORDER

Based on the foregoing decision, it is hereby ORDERED:

Item 1 of Citation No. 1, alleging a violation of § 1910.212(a)(1), is **AFFIRMED** and a penalty of \$5,000.00 is assessed.

SO ORDERED.

Date: March 7, 2017

/s/ _____

SHARON D. CALHOUN
Administrative Law Judge
Atlanta, Georgia