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

SECRETARY OF LABOR,	:	
	:	
Complainant,	:	
	:	
v.	:	OSHRC DOCKET NOS. 08-0316
	:	and 08-0317
CRANESVILLE BLOCK COMPANY/	:	
CLARK DIVISION	:	
	:	
Respondent.	:	

APPEARANCES:

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For the Complainant.

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For the Respondent.

BEFORE: John H. Schumacher,
Administrative Law Judge

DECISION AND ORDER

This proceeding is before the Occupational Safety and Health Review Commission ("the Commission") pursuant to section 10(c) of the Occupational Safety and Health Act of 1970, 29 U.S.C. § 651 et seq. (Hereafter, "the Act").

FACTS

Following the receipt of a formal complaint, an occupational safety and health inspection of Cranesville's facility located at Teall Avenue in Syracuse, NY, was conducted by authorized Compliance Officers ("CO") from the Occupational Safety and Health Administration. The inspection was conducted in two parts, and ran from August 15, 2007, through January 9, 2008. The first part, consisting of a safety inspection, was conducted by CO Duane Gary. The second part was a health inspection conducted by CO Frank Strelec.

As a result of these inspections, respondent was issued several citations alleging various serious, repeat and willful violations of the Act. Respondent filed a timely notice of contest to all items and their penalties. Matters involving the alleged safety violations are designated OSHRC Docket No. 08-0317, while matters involving alleged health violations are designated OSHRC Docket No. 08-0316. The Secretary twice moved to amend the complaint regarding the health case citations, both of which were granted. Respondent filed timely Answers to the amended complaint. A hearing on this joined matter was held in Syracuse, NY, from December 1 to December 4, 2009. Both parties have filed their briefs and this case is now ready for disposition.

The Teall Avenue Operation

Cranesville Block Company, ("Respondent" or "Cranesville"), is a New York corporation engaged in the production of ready-mix concrete and related activities. Cranesville's Teall Avenue facility ("Teall") in Syracuse, NY, is a ready mix plant which

was acquired from Clark Concrete in October 2005. (Tr. 16-17). It has approximately 25 employees. (Tr. 17).

Respondent operates approximately 25 ready-mix concrete and masonry block production and distribution facilities in upstate New York, with a total of approximately 300 employees. (Tr. 16, 274-275, 683). The Teall facility consists of a ready mix concrete facility, which includes silos and bins for storing the raw materials necessary for the production of ready concrete mix, together with a maintenance garage where mechanics repair the ready mix concrete mixer trucks that deliver concrete to Cranesville's customers. (Tr. 16, 66, 73, 168-169, 475, 834, and 843). In addition to management personnel, the Teall facility employs approximately sixteen truck drivers, two mechanics responsible for maintaining on-site equipment, and one laborer. (Tr. 145, 657, 914).

The aggregate, fly-ash and micro-silica used in the production of the ready mix concrete are stored in five silos which are all at least twenty to thirty feet tall. (Tr. 264, 448, 934-935; Ex. S-11, S-13). A conveyor system carries the material up to the top of the silos and drops them into a hopper and bin. (Tr. 171-2, 449). When material is removed from a silo, it falls through automated gates, which are located inside the silo, approximately 12 feet above the ground, into a weigh hopper and then directly into a ready mix truck. (Tr. 175, 268, 942). The gates open and close using a pneumatic system controlled by electronic signals sent from a switchboard in the batch room, which is directly below the gates and weigh hoppers. (Tr. 69, 942-943). The switchboard operator, who opens and closes the gates as well as controls the conveyor system, cannot see inside the silo from his position in the batch room. (Tr. 942-943).

Mechanics enter the silos through a hatch on the top of the structure in order to perform routine maintenance work. (Tr. 168, 271, 925-926, 934; Ex. S-14). While inside, mechanics could be engulfed by material being poured into the silo if the conveyor were activated. (Tr. 172, 263; Ex. S-11, S-13). Moreover, the mechanics working on the gates could fall to the ground if the gates were unexpectedly activated by the operator in the batch room. (Tr. 175).

On the top of each silo, near the entrance hatch, is a dust collection system. This system is powered by two 208-volt motors that vacuum up dust from the materials inside the silo. (Tr. 69-70, 78, 154, 927; Ex. S-10). The dust collection system contains a bag house, which is a rectangular structure, measuring approximately four by four feet. These structures contain large vertical hanging bags, similar to domestic vacuum cleaner bags, which capture airborne particulates drawn in by the 208-volt motors. (Tr. 154, 259, 710-711). The bag houses have doors large enough for a person to enter in order to reach the bags that hang on brackets inside. (Tr. 503, 947). These brackets are moved by shaker motors that agitate the bags to loosen the captured particulates, causing them to fall into a hopper and funnel back into the silo or dust collection system. (Tr. 711, 801, 927). The shaker motors and 208-volt dust collector motors both require routine maintenance. (Tr. 927-928). Employees stand outside the bag house and reach inside to strike the bags with a stick to shake the dust loose. This procedure is similar to manually beating dust off a hanging rug. (Tr. 712, 865). However, employees enter the bag house to inspect the bags to determine if they need to be shaken, cleaned, or replaced. (Tr. 167, 404, 711-712, 801-802, 864-865, 927).

The trucks usually receive their loads of concrete automatically at the silos. Often, however, the ready-mix orders call for certain additives, such as fiber mesh, which affects the durability of the concrete, or color additive. To receive these additives, the drivers park their vehicles next to a staircase leading to a platform, which is called Stop Number One. (Tr. 25, 128-129, 399, 480). Here, the drivers exit their trucks, retrieve boxes of fiber mesh, and add the ingredients into the mixer drums manually. (Tr. 399-400, 470-471, 480, 820, Ex. S-2). To reach the drums, the drivers climb a staircase to a platform. From this platform, the drivers pour the additives through the hopper on top of the truck. (Tr. 25, 130, 399, 442, 445, 480, 789-791, Ex. S-2).

After the trucks make their deliveries, the drivers park them at the edge of one of three bays underneath the washout towers next to Section #1 of a washout pond. The mixer drums on the trucks are rinsed with water in order to minimize the residual concrete that hardens and adheres to the interior walls of the drums. (Tr. 361-363). The pond, which is divided into three sections, receives the discharge of mixed water and concrete washed out of the truck drums. (Tr. 118, 813, Ex. S-3, S-4). Section #1 is dredged regularly to reduce the slurry that gathers in the pond. During the busy summer season, the pond is dredged every few weeks. (Tr. 118, 438-439, Ex. S-6). After dredging, Section #1 can be up to 12 feet deep. (Tr. 43, 826). To keep the trucks from rolling into the pond, Cranesville placed 3 x 5 foot concrete blocks near the edge of the pond. These blocks function as wheel bumpers or chocks. (Tr. 39, 59-60, 386-387, 479 Exs. S-3, S-4).

Despite best efforts to wash out the mixer drums, accumulated hardened concrete must periodically be chipped out of these drums. (Tr. 197, 389-390, 686). This concrete

is chipped out of the drum using a hammer and chisel and, more commonly, a pneumatic jackhammer. (Tr. 194, 392, 484, 687, Exs. H-19, H-20). This hardened concrete contains respirable dust and silica. (Tr. 600-601, Exs. H-13, H-14). At the Teall Avenue plant, the drums were usually chipped by drivers or the laborer ***{redacted}***. In early 2006, Cranesville implemented a new policy where chipping would be done by designated teams of employees who would travel among the company's facilities. (Tr. 390, 732-735, 866-867). However, this policy change was never communicated to Teall management, where chipping continued to be performed by the drivers or ***{redacted}***. (Tr. 391, 453, 455-456, 466, 492, 797-798, 830).

The Inspection

1. Noise

During the inspection, laborer ***{redacted}*** was tested for noise exposure while he conducted chipping inside the mixer drum on one of the cement delivery trucks. The noise sampling revealed that ***{redacted}*** was exposed to an 8-hour Time Weighted Average (TWA) of 94.5 dBA. This exposure was obtained by sampling ***{redacted}*** with a dosimeter for 139 minutes and assuming that, for the remaining 341 minutes of the work day, he was exposed to a noise level of zero dBA. (Tr. 219, Ex. H-1). Testimony established that the time it takes to complete a chipping operation varies, and can take as long as 16 hours. (Tr. 492). Van Coughnett, who had experience chipping drums, testified that, on average, chipping takes between two and four hours. (Tr. 872).

As a result, the Secretary concluded that, under the cited standard, respondent was required to have a hearing conservation program at Teall, and that ***{redacted}*** should have been enrolled. (Tr. 222-223). According to the CO, the noise levels to which ***{redacted}***

was exposed required that he be enrolled in a hearing conservation program even if he was exposed on only one day per year. (Tr. 222).

2. Air Contaminants—The Mixing Drum

Silica

During the inspection, ***{redacted}*** was wearing a half mask respirator while performing chipping inside the mixing drums. He was tested for exposure to respirable silica by having a pump attached to his pocket or belt, which has a tube connected to a device called a cyclone which contains sampling media. The cyclone was attached to ***{redacted}*** shirt collar in his breathing zone (Tr. 226-227), and was placed outside the respirator because sampling for airborne contaminants is made without considering the use of respirators. (Tr. 228). The pump, cyclone, and sampling media were all calibrated or pre-weighed. (Tr. 232-233, Ex. H-14). The sampling was conducted for 130 minutes. It was assumed that the ***{redacted}*** had zero exposure for the remaining 350 minutes of the work day. (Tr. 231). Both cassettes and a blank control cassette were sent to OSHA laboratories. (Tr. 230). The results showed that ***{redacted}*** was exposed to 19 milligrams of silica per cubic meter, or four times the Permissible Exposure Limit (PEL) to silica over an eight hour period as permitted by 29 CFR 1910.1000 Table Z-1. (Tr. 230-231, Ex. H-14, p.2).[1]

Silica is a carcinogen. (Tr. 234). Moreover, when inhaled, silica particles can become embedded in the lungs making it very difficult for the person to breathe, causing silicosis. (Tr. 235). Silicosis is not curable. (Tr. 235).

Total dust

[1] The parties have stipulated to the accuracy of these results. (Secretary's Prehearing Statement, p.3).

Total dust includes particles that can be trapped by the nasal passages and smaller particles that can become embedded in the lungs. (Tr. 235-236). The sampling technique for dust is similar to that for silica, but a cassette without a cyclone is used. (Tr. 236). Instead, the cassette without a cyclone is placed in the employee's breathing zone. (Tr. 237). Like the testing for silica, ***{redacted}*** wore a pump on his waist with a tube leading to his collar where the cassette was clipped to his breathing zone while he was performing chipping in the mixing drum. (Tr. 237-238). The pump was calibrated. (Tr. 238-239, Ex. H-13). As with the silica testing, two cassettes were used. These cassettes, and a blank control cassette were sent to the OSHA laboratory for analysis. (Tr. 240). Though ***{redacted}*** was tested for 130 minutes, it was assumed that he had a zero exposure level for the remaining 350 minutes of the work day. (Tr. 230). The PEL for total dust is 15 milligrams per cubic meter of air. (Tr. 240). The 8-hour time weighted average showed an exposure of 29.79 milligrams per cubic meter, or about twice the PEL as set forth in 29 CFR 1910.1000 Table Z-1. (Tr. 241).

The Dust Collection System

No air sampling was done in the dust collection systems. However, the evidence demonstrates that the area was very dusty. For example, driver ***{redacted}*** testified that, when mechanic ***{redacted}*** came out of the bag house, he was so covered in cement dust that he was a "grayish color, they call it ghostly." (Tr. 505). Similarly, former driver Thomas ***{redacted}*** testified that when ***{redacted}*** came out of the bag house he "looked very white other than where the mask was around his mouth and nose." (Tr. 405). Portland cement is a commonly used product at Teall. The Material Data Safety Sheet (MSDS) for Portland cement lists silica as a main ingredient. (Ex. H-11).

DISCUSSION

Respondent stipulates that it is a corporation engaged in a business affecting commerce within the meaning of sections 3(3) and 3(5) of the Act, 29 U.S.C.§§652(3) and (5), and that it is an employer within the meaning of section 3(5) of the Act.

Hearsay

Much of the evidence in this case derives from statements made to the COs by respondent's employees. Cranesville argues that these statements constitute inadmissible hearsay. Respondent relies on Federal Rule of Evidence (FRE) 602 which states that "[a] witness may not testify to a matter unless evidence is introduced sufficient to support a finding that the witness has personal knowledge of a matter." Respondent points out that many of the citations are based on information gained by employee interviews of which the CO's had no personal knowledge and contends that the statements are inadmissible hearsay.

The argument is without merit. While FRE 602 would prohibit a CO from testifying about an issue of which he has no personal knowledge, the rule must be read in conjunction with FRE 801(d)(2) which provides that "a statement by the party's agent or servant concerning a matter within the scope of the agency or employment, made during the existence of the relationship" is not hearsay. When a CO testifies as to what was said to him directly by an employee, the CO is not presuming to give testimony on an item for which he has no personal knowledge but, rather, is testifying to what an employee had

told him. As the Commission has held, such statements related by a CO are not hearsay and are admissible. *Regina Constr. Co*., 15 BNA OSHC 1044, 1047 (No. 87-1309, 1991).

A. Safety Violations-Docket No. 08-0317

1. Citation 1 Item 1 alleges a serious violation of Section 5(a)(1)[2] of the Act on the grounds that the employer did not furnish employment and a place of employment which were free from recognized hazards that were causing or likely to cause death or serious physical harm to employees in that employees were exposed to the hazard of drowning:

a) Truck rinse rack adjacent to the pond, on or about 08/15/07: Drivers back their cement trucks down to the rinse drums. Three of the four rinse bays did not have stop blocks to prevent the trucks from rolling into the pond.

Among other methods, one feasible and acceptable abatement method to correct this hazard is to:

Install stop blocks, wheel chocks or other similar devices as used at other facilities.

A penalty of $2500 was proposed.

The evidence establishes that trucks would arrive at the washout pond as part of the process of rinsing the mixer drums of the leftover concrete after the product was delivered. While some of the trucks would move toward the pond front-in others, because

[2] Section 5(a)(1) of the Act, the General Duty Clause, states:

Section 5 Duties

(a) Each employer --

(1) shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees.

of their configuration, would have to back up to the pond, relying on both mirrors and the concrete blocks to determine when they were at the edge of the pond. (Tr. 388, 824-825, 839). A blind spot directly behind the rear-discharging trucks made the drivers especially reliant upon the stop blocks. (Tr. 388). Trucks would routinely hit the blocks. As a result, these blocks were often missing or displaced. (Tr. 40, 54, 387, 479, 816, Ex. S-4). Drivers usually remain in their cabs while the mixer drums are automatically rinsed under the washout rack. (Tr. 114-115). On occasion, however, drivers have to exit their cabs and climb a ladder on the side of the truck to rinse the exterior of the truck using a hose. (Tr. 55, 114-115, 382-384).

To establish a violation of the General Duty Clause, Section 5(a)(1) of the Act, the Secretary must establish that a condition or activity in the workplace presented a hazard, that the hazard was recognized by the employer or its industry, that the hazard was causing or likely to cause death or serious physical harm, and that there existed a feasible and effective means of eliminating or materially reducing the hazard. *Arcadian Corp.,* 20 BNA OSHC 2001, 2007 (No. 93-0628, 2004).

The evidence establishes that the failure to have secured stop blocks at the edge of the pond constitutes a hazard and that the hazard was recognized by Cranesville. When freshly dredged, the pond is approximately 12 feet deep. A driver could drown if the truck rolled into the pond due to a missing stop block. (Tr. 55-56, 109). A driver could also suffer serious physical harm if he is thrown from or jumps from the cab of the truck while trying to escape the truck as it rolls into the pond. (Tr. 55-56). Drivers climbing the ladder or otherwise exiting their cab can slip and fall into the pond, exposing them to the risk of drowning.

Respondent asserts that the Secretary failed to establish a hazard because it did not adduce evidence regarding the height of the cab or how far a truck would have to slip into the pond before water would enter the cab. The argument fails for two reasons. First, the hazard is not only that employees might drown or be injured in the cab, but also that they might fall into the pond when exiting the truck or slip from the ladder when performing their duties and into the 12-foot pond. Second, Driver Thomas ***{redacted}*** testified that he nearly drowned in the pond when he fell in the pond when climbing down the truck's ladder (Tr. 438). ***{redacted}*** fell near the edge of the pond and, though nearly six feet tall, his head was under water and his feet did not touch the bottom of the pond. (Tr. 385-386, 437-438). He nearly drowned and had to be rescued by another employee. (Tr. 385-386, 431, 438). Indeed, supervisor Andrew Williams testified that employees fell into the pond on a couple of occasions. (Tr. 817).[3]

Respondent argues that the CO only saw the stop block missing in one of the three ponds that was not used for rinsing and, therefore, failed to establish that employees were exposed to a hazard. As noted, however, substantial evidence was adduced by the Secretary to establish that the loss or dislodging of stop blocks were a regular problem encountered by the drivers. (Tr. 39, 387, 479). Respondent also challenges employee exposure on the basis of the testimony of regional manager Van Coughnett that, had he known that a stop block was missing, he would cordon off the area until the block was replaced. (Tr. 862). Importantly, however, despite the credible and substantial evidence that these blocks were often missing or displaced, there is no evidence that Van

[3] While the evidence does not establish that these incidents or **{redacted}** near- drowning resulted from the displacement of stop blocks, they are relevant to demonstrate that employees can and do fall off their trucks and, therefore, and the lack of stop blocks may result in the trucks rolling into deep water, thereby constituting a hazard.

Coughnett ever actually ordered that the affected part of the pond be rendered inaccessible.

The evidence also establishes that Cranesville recognized the hazard. Respondent provided stop blocks the sole purpose of which was to prevent trucks from rolling into the ponds. Also, water rescue equipment was available at the site for the express purpose of rescuing employees who might fall into the pond. (Tr. 40, 818). Indeed, testimony by regional manager Van Coughnett that he would cordon off an area with a missing stop block establishes respondent's awareness that the absence of a stop block creates a hazard.

The evidence also establishes that the hazard could cause death or serious physical harm. The incident where Thomas ***{redacted}*** fell into the pond and nearly drowned establishes that falling into the pond could result in a fatal accident. Although the probability of such an incident may be low, it is sufficient for the Secretary to establish that if an incident occurs the result could be death or serious physical harm. *Beverly Enterprises, Inc*., 19 BNA OSHC 1161, 1188 (No. 91-3144, 2000) (Consolidated). The Secretary has met this standard.

Finally, the Secretary established that there was a feasible method of reducing or eliminating the hazard. After the inspection, Cranesville replaced the stop blocks with a permanent steel beam. (Tr. 60-61, Ex. S-1).

The Secretary proposed a penalty of $2500 for this violation. In assessing penalties, the Commission must give due consideration to the employer's prior history and good faith, the size of the employer's business, and the gravity of the cited violations. 29 U.S.C. §666(j); *S&G Packaging Co.,* 19 BNA OSHC 1503, 1509 (No. 98-1107,

2001). The evidence demonstrates that the Secretary properly considered these factors when proposing the penalty and I find that the $2500 proposed penalty is appropriate. (Tr. 35, 62-63).

2. Citation 1 Item 2a alleges a serious violation of 29 CFR §1910.24(e)[4] on the grounds that fixed stairs were installed at an angle to the horizontal greater than 50 degrees:

a) Stairway near stop number 1, on or about 08/15/07: The fixed stair used at stop number one was installed at an angle of 55 degrees to the horizontal.

Citation 1 item 2b alleges a serious violation of 29 CFR §1910.24(h)[5] on the grounds that: Standard railing(s) were not provided on the open side(s) of all fixed industrial stairway(s) and stair platform(s):

a) Stairway, near stop number 1, on or about 8/15/2007: The fixed stair, consisting of eight risers, used at stop number one, was not equipped with standard railings.

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[4] The standard provides:

§1910.24 Fixed industrial stairs.

* * *

(e) *Angle of stairway rise.* Fixed stairs shall be installed at angles to the horizontal of between 30 degrees and 50 degrees. Any uniform combination of rise/tread dimensions may be used that will result in a stairway at an angle to the horizontal within the permissible range. Table D-1 gives rise/tread dimensions which will produce a stairway within the permissible range, stating the angle to the horizontal produced by each combination. However, the rise/tread combinations are not limited to those given in Table D-1.

[5] The standard provides:

§1910.24 Fixed industrial stairs.

* * *

(h) *Railings and handrails.* Standard railings shall be provided on the open sides of all exposed stairways and stair platforms. Handrails shall be provided on at least one side of closed stairways preferably on the right side descending. Stair railing and handrails shall be installed in accordance with the provisions of § 1910.23.

Additionally, the stairway was equipped with a platform which did not have standard railings on all open sides.

A combined penalty of $2000 was proposed for items 2a and 2b.

To establish a violation of an OSHA standard, the Secretary must establish that: (1) the standard applies to the facts; (2) the employer failed to comply with the terms of that standard; (3) employees had access to the hazard covered by the standard; and (4) the employer could have known of the existence of the hazard with the exercise of reasonable diligence. *Atlantic Battery Co*., 16 BNA OSHC 2131, 2138 (No. 90-1747, 1994).

During the inspection, the CO observed a staircase at Stop Number 1, which was installed at an angle of 55 degrees to the horizontal. Moreover, the staircase lacked railings on either side and on only one side of the platform at the top of the stairs. (Tr. 27-28, 31, Ex. S-2). Drivers use the staircase at that location regularly to get to the truck hatches in order to place the required additives in the mixer drums. (Tr. 443).

The evidence establishes that the staircase observed by the CO was under construction and only temporary. (Tr. 794, 854-856, 917-918). It is respondent's contention that employees never used the stairs in their violative condition and, therefore, that employees were not exposed to any hazard. Mechanic ***{redacted}***, who was working on the stairs, testified that installation of the new stairs took 2-5 days and that the platform was without railings for less than a day and perhaps for as little as two hours. (Tr. 917-918). ***{redacted}*** also testified that he never saw a driver use the stairs while he was working on them. (Tr. 921). He further testified that a pylon was put up and the area roped off at the end of the day when they completed work to keep people out of the area. (Tr. 918). This was confirmed by Van Coughnett, who testified that he never saw an

employee use the stairs while they were under construction and that he used a pylon near the stairs to keep employees out of the immediate area while working on the stairs. (Tr. 858).

I find, however, that the preponderance of the evidence established that employees were exposed to the stairs while in their violative condition. ***{redacted}*** testified that the railings were missing from the staircase and platform for two and a half years. (Tr. 403). Similarly, driver ***{redacted}*** testified that he used the staircase while it was in the condition depicted in Ex. S-2, without handrails and missing a railing on one side of the platform. (Tr. 481).

Plant manager Williams testified that the staircase setup observed by the CO was "very temporary, a month or two." (Tr. 793, 822). He also testified that, during that period, they were in the condition depicted in Ex. S-2 (without railings), and were used by the drivers while the mechanics fine-tuned what needed to be done to the stairs. (Tr. 794, 822). He further explained that the wooden stairs normally used had been damaged and replaced with the metal stairs. (Tr. 792-793). He also testified that it took only two or three days of work to fabricate the stairs and that rails were added soon after the inspection. (Tr. 793-794). He further explained that, shortly after the inspection, the stairs were changed to make them less steep. (Tr. 794).

The testimony of ***{redacted}***, ***{redacted}*** and Williams clearly establishes that employees used the stairs while they were in a violative condition and, therefore, that employees were actually exposed to the hazard. Indeed, Williams' testimony that the stairs were in violative condition for a month or two must be viewed in light of other

testimony that established that the stairs were integral to the drivers performance of their work and would be used several times a day. (Tr. 442, 480, 795).

The testimony of ***{redacted}*** and Van Coughnett, that they never saw an employee use the stairs while they were under construction, does not establish that the stairs were not so used, only that these two witnesses never saw them used. Indeed, testimony of both employees and plant manager Williams clearly demonstrate that the stairs were used in their violative condition.

I would also note that, although respondent points to the testimony of ***{redacted}*** and Van Coughnett that they used a pylon or ropes to restrict access to the area, exhibit S-2 shows only that a pylon was located under the staircase and, therefore, did nothing to restrict employee access. Clearly, at a minimum, the stairs were available for use by employees. *Kaspar Electroplating Corp*., 16 BNA OSHC 1517, 1521 (No. 90-2866, 1993); *Pennsylvania Steel Foundation and Machine Co.*, 12 BNA OSHC 2017, 2030 (No. 78-0638, 1986); aff'd on other grounds, 831 F.2d 1211 (3d Cir. 1987). Accordingly, the item is affirmed.

Respondent argues that, if affirmed, the violation should be characterized as *de minimis.* A *de minimis* violation is one that has no relationship to employee safety and health. *Dover Electric Co*., 15 BNA OSHC 1378, 1382 (No. 88-2642, 1991). This argument is without merit. The evidence establishes that the steepness of the stairs and the absence of all of the required railings exposed employees to a fall of as much as 5'3" and the possibility of fracture. (Tr. 31, 34). The evidence also establishes that the metal stairs became slippery when it rained. (Tr. 402). Accordingly, the violation was properly characterized as serious.

The Secretary proposed a penalty of $2000 for the combined violation. However, because the stairs were in the process of repair, demonstrating good faith on the part of respondent, I find that a reduction in the penalty is appropriate. Considering, these factors, I find that a penalty of $1000 is appropriate.

3. Citation 2 Item 1 alleges a repeat violation of 29 CFR §1910.147(c)(4)(ii)[6] on the grounds that: The energy control procedures did not clearly and specifically outline the scope, purpose, authorization, rules, and techniques to be utilized for the control of hazardous energy, including, but not limited to items (a) through (d) of this section:
a) On or about 10/18/07: Maintenance employees perform maintenance on dust collection systems, cement, flyash & aggregate silos and air compressors without equipment specific energy control procedures.
CRANESVILLE BLOCK COMPANY WAS PREVIOUSLY CITED FOR A VIOLATION OF THIS OCCUPATIONAL SAFETY AND HEALTH STANDARD OR

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[6] The standard provides:

§1910.147 The control of hazardous energy (lockout/tagout).

* * *

(c) *General*-

* * *

(4) *Energy control procedure.*

* * *

(ii) The procedures shall clearly and specifically outline the scope, purpose, authorization, rules, and techniques to be utilized for the control of hazardous energy, and the means to enforce compliance including, but not limited to the following:

(A) A specific statement of the intended use of the procedure;

(B) Specific procedural steps for shutting down, isolating, blocking and securing machines or equipment to control hazardous energy;

(C) Specific procedural steps for the placement, removal and transfer of lockout devices or tagout devices and the responsibility for them; and

(D) Specific requirements for testing a machine or equipment to determine and verify the effectiveness of lockout devices, tagout devices, and other energy control measures.

ITS EQUIVALENT STANDARD WHICH WAS CONTAINED IN OSHA INSPECTION NUMBER 307532820, CITATION NUMBER 2, ITEM NUMBER 1, ISSUED ON 08/22/05, WITH RESPECT TO A WORKPLACE LOCATED AT 774 STATE HIGHWAY 5S, AMSTERDAM, NY 12010.

A penalty of $15,000 was proposed for the violation.

The evidence establishes that Cranesville employees performed servicing and maintenance on the equipment at the Teall Avenue site. For example, the air compressor in the garage powers the pneumatic chipper and requires maintenance. (Tr. 69). On October 18, 2007, a mechanic entered the dust collection system and "replaced the motors, the breakings *(sic)* and the drive shaft." (Tr. 158). The evidence further demonstrates that ***{redacted}*** would enter the bag house to replace or maintain the dust collection bags. (Tr. 450, 504-510). These employees would be exposed to serious injury if the motors in the dust collection system were unexpectedly energized or if the employees were struck by either the rotating shafts or the dust collection bags shaken by the motors. (Tr. 78, 927).

Moreover, ***{redacted}*** would descend into the aggregate silo to perform maintenance work. (Tr. 926, 942). The batch operator, who works the gates, cannot see into the silo and, therefore, would not be able to see any mechanic working therein. (Tr. 943). If the conveyor system were energized while an employee was in the silo, he would be engulfed by aggregate material. Moreover, if the gates were energized, it could cause the employee to fall into the weigh hoppers and to the ground. (Tr. 172-173, 175).

This evidence clearly establishes that employees were exposed to the danger that machines might be unexpectedly energized and, therefore, that respondent was required

to have specific energy control procedures. Respondent's corporate policy requires the formulation of lockout-tagout (LOTO) procedures, and that a binder setting forth equipment-specific LOTO procedures be kept at each of Cranesville's facilities. (Ex. H-10, p.1). Despite this policy, no such binder was prepared for Teall. (Tr. 74-75). Kimberly Mosher, the Environmental Health and Safety Director for Cranesville, told the CO that she and a colleague, Mr. Sagarese, were responsible for developing LOTO procedures for Teall but failed to do so. (Tr. 74-75). Moreover, the CO saw no indication that appropriate procedures were under development. (Tr. 75).

Respondent asserts that the item should be vacated because, despite the lack of formal procedures, employees followed general LOTO procedures that protected them from harm. The argument fails. The standard does not provide an exception to its requirements based on employee use of general LOTO procedures, but requires the formulation of "specific" steps. Moreover, there is nothing in the standard to suggest that its terms may be satisfied by training employees in "general" LOTO procedures.

Finally, I would note that, when directed to implement a LOTO procedure, ***{redacted}*** replaced the key to the lock breakers back on the key rack rather than placing it in his pocket. (Tr. 155). Respondent asserts that this was a minor variation from proper procedure. However, by replacing the key in an area accessible to other employees, he created the possibility that another employee would take the key and reopen the locked breaker. This is the very type of incident that appropriate and specific LOTO procedures are designed to prevent. That employees followed "general" LOTO procedures may be relevant to the likelihood of an accident and, therefore, the gravity of the violation, but it does not fulfill the employer's obligations under the standard.

The Secretary asserts that the violation is repeated based on a previous citation for a violation of the identical standard, which became a final order of the Commission on August 22, 2005. (Tr. 77, 151; Exs.S-7, p. 31, S-8, p 35). Respondent asserts that the violation should not be classified as repeated because the earlier citation was issued to a different Cranesville facility under the jurisdiction of a different OSHA Area Office. Respondent points out that the OSHA FIRM (Field Inspection Reference Manual) states that a "multifacility employer shall be cited for a repeated violation if the violation recurred at any worksite within the same OSHA Area Office jurisdiction." FIRM, CPL 2.103, Ch. III, para. C.2.f.(4)(c).

The argument is without merit. The Commission has held that OSHA's FIRM, and its predecessors, are only a guide for OSHA personnel to promote efficiency and uniformity and confer no substantive rights on employer. *Hackensack Steel Corp*., 20 BNA OSHC 1387 (No. 97-0755); *Hamilton Fixture,* 16 BNA OSHC 1073, 1079 (No. 88-1720), aff'd 28 F.3d 1213 (6th Cir. 1994)(unpublished).

A violation is repeated if, at the time of the alleged repeated violation, there was a Commission final order against the same employer for a substantially similar violation. *Potlatch Corp*., 7 BNA OSHC 1061, 1063 (No. 16183, 1979). Circumstances, such as the geographical proximity of the violations, the commonality of supervisory control over the violative condition, and the time lapse between the violations bear only on the size of the penalty to be assessed, not on the "repeated" character of the violations. *Midwest Masonry Inc.,*19 BNA OSHC 1540, 1543 (No. 00-0322, 2001). The Secretary has established that there is a final order finding respondent in violation for an identical violation. Therefore, the item was properly characterized as repeated.

The Secretary proposed a $15,000 penalty for this repeat violation. The evidence demonstrates that if a machine would suddenly and inadvertently be energized while an employee is working on or in the vicinity, the result could be death or serious physical harm. (Tr. 78). Moreover, the evidence establishes that the Secretary properly considered the statutory factors when arriving at the proposed penalty. Indeed, the CO testified that the penalty proposal considered that the likelihood of an accident was "lower." (Tr. 78). Given that respondent did practice "general" LOTO procedures at the worksite, I agree. Accordingly, the proposed penalty of $15,000 is assessed.

B. Health Violations- Docket No. 08-0316

1. Citation 1 Item 1, as amended, alleges a willful or, in the alternative, a repeat violation of 29 CFR §1910.95(c)(1)[7] for failing to provide an effective hearing conservation program when: Throughout the facility, on or about 10/24/07: Laborers and drivers who clean the inside of drums of cement mixers were exposed to an equivalent noise level of 94.5 dBA (8-hr. time weighed average) during the 139 minutes sampling period. A zero increment was included for the 341 minutes not sampled.

A penalty of $55,000 is proposed for the alleged violation if willful and $17,500 if repeated.

---

[7] The standard provides:

§1910.95 Occupational noise exposure.

* * *

(c) *Hearing conservation program.* (1) The employer shall administer a continuing, effective hearing conservation program, as described in paragraphs (c) through (o) of this section, whenever employee noise exposures equal or exceed an 8-hour time-weighted average sound level (TWA) of 85 decibels measured on the A scale (slow response) or, equivalently, a dose of fifty percent. For purposes of the hearing conservation program, employee noise exposures shall be computed in accordance with appendix A and Table G-16a, and without regard to any attenuation provided by the use of personal protective equipment.

During the inspection, laborer ***{redacted}***, who was wearing ear muffs (Tr. 186), was tested for noise exposure while he conducted chipping inside the mixer drum on one of the cement delivery trucks. The noise sampling revealed that ***{redacted}*** was exposed to an 8-hour Time Weighted Average (TWA) of 94.5 dBA. This exposure was obtained by sampling ***{redacted}*** for 139 minutes and assuming that, for the remaining 341 minutes of the work day, he was exposed to a noise level of zero dBA. (Tr. 217, 219, Ex. H-1). The testimony established that the time it takes to complete a chipping operation varies, and can take as long as 16 hours. (Tr. 492). Van Coughnett, who had experience chipping the inside of mixer drums, testified that, on average, chipping takes between two and four hours. (Tr. 872).

As a result, the Secretary concluded that, under the cited standard, respondent was required to have a hearing conservation program at Teall, and that ***{redacted}*** should have been enrolled. (Tr. 222-223). According to the CO, the noise levels to which ***{redacted}*** was exposed required that he be enrolled in a hearing conservation program even if he was exposed on only one day per year. (Tr. 222). As noted, supra, ***{redacted}*** regularly conducted chipping for Cranesville at Teall.

Cranesville has a hearing conservation policy that requires the inclusion of employees who are exposed to the "action level" of 85 dBA. (Ex. H-2, p. 5). Tracking the OSHA standard, inclusion in the program requires that employees receive a baseline audiogram within 6 months of the employee's first exposure to noise equaling or exceeding a TWA of 85 dBA. The policy also requires annual audiograms, employee notification and training that includes topics such as the use, selection and care for hearing protection.

{redacted} was not included in respondent's hearing conservation program, which exposed to him to hazard of hearing loss. (Tr. 222). Indeed, the evidence strongly suggests that the company hearing protection program was never applied at Teall. For example, driver ***{redacted}***, who would occasionally chip out his truck, testified that he was never given a hearing test, believed that hearing protection was optional, and never heard of a hearing conservation program or policy. (Tr. 500-502).

Safety Director Mosher testified that chipping the mixer had been identified as an area of high noise exposure and that, at other Cranesville facilities, employees who engaged in chipping were included in the hearing conservation program. (Tr. 700-704). She testified that, even though chipping occurred at Teall, no employees from that facility were placed in a hearing conservation program. (Tr. 704). Indeed, Mosher admitted that ***{redacted}*** should have, but was not included in the program. (Tr. 704). Mosher explained that corporate policy took the chipping away from the drivers and that roving teams of employees had been designated for chipping. (Tr. 732-734). As a result, she was unaware that ***{redacted}*** continued to engage in chipping at Teall. (Tr. 771).

Operations manager Van Coughnet explained that he never told Mosher that ***{redacted}*** was performing chipping because he had no intention of sending him into a truck to perform the activity. (Tr. 869). He suggested that ***{redacted}*** should not have worked in the drum during the inspection because he had no intention of having him work in the drum during October. (Tr. 869-870). This was supported by plant manager Williams who testified that, during the inspection, ***{redacted}*** was not scheduled to perform chipping. (Tr. 834). He testified that ***{redacted}*** was asked to work in the mixer drum during the inspection only to allow the CO to conduct his tests. (Tr. 834-835).

However, Williams also testified that ***{redacted}*** remained responsible for chipping at Teall. (Tr. 797, 803). Indeed, he assumed that chipping was one of ***{redacted}*** assigned responsibilities. (Tr. 828). According to Williams, "it was just understood" that this was ***{redacted}*** job. (Tr. 797). Moreover, he never told his superiors that ***{redacted}*** needed noise training. (Tr. 807). He did not consider that informing his superiors of who was being assigned to chip was part of his procedures. (Tr. 798).

I find that this violation has been established. The evidence clearly demonstrates that ***{redacted}***, who regularly performed chipping that exposed him to an 8-hour TWA of noise in excess of 85 dBA, was not enrolled in a hearing conservation program in violation of the standard.

Respondent asserts that the items should be vacated because there is no evidence that ***{redacted}*** performed chipping within six months of the citation and, therefore, that the violation is barred by section 9(c) of the Act, 29 U.S.C. §658(c), which states that "No citation may be issued under this section after the expiration of six months following the occurrence of any violation."

The argument is without merit. Respondent's obligation to enroll ***{redacted}*** in a hearing conservation program began when he first began chipping the drums and continued as long as chipping remained one of his work duties. Indeed, the standard requires that the employee be enrolled in a "continuing" hearing conservation program "whenever" he or she is exposed to an 8-hour TWA of 85 dBA or more. That continuing

obligation did not lapse merely because ***{redacted}*** might not have engaged in chipping for six months.[8]

Respondent argues that, if there is a violation, it should not be classified as willful. It asserts that, at the time of the monitoring, ***{redacted}*** was wearing hearing protection. (Tr. 186). Moreover, after the OSHA inspection, ***{redacted}*** hearing was tested and the results indicated that he had not suffered any significant hearing loss. (Ex. H-4, p.7).[9] Cranesville further points out that it had a corporate hearing conservation program and that the only reason ***{redacted}*** was not enrolled was because its safety manager was not aware that he was performing chipping at Teall. (Tr. 771).

I find that the Secretary has established that the violation was both willful and repeated. A willful violation is one in which the employer's state of mind is that of intentional disregard of the requirements of the Act or plain indifference to employee safety. *Caterpillar Inc*., 18 BNA OSHC 1005, 1009 (No. 93-3405, 1997), aff'd, 154 3d 400 (7th Cir. 1998). While a previous citation, standing alone, is not sufficient to establish willfulness, it is evidence of a "heightened awareness" of the condition. *Sal Masonry Contractors, Inc.*, 15 BNA OSHC 1609, 1612 (No. 87-2007, 1992).

The evidence demonstrates that Cranesville was aware of the requirement to enroll in a hearing conservation program any employee exposed, even once, to noise

[8] I would also note that the standard requires that employees be given a baseline audiogram within six months of the first exposure to excessive noise. Therefore, at a minimum, the violation continued for at least six months after exposure. Adding the six month "statute of limitations" period of section 9(c) of the Act, would mean that, at most, the statute of limitations did not expire for a year after **{redacted}** last engaged in chipping.

[9] Although respondent contends that the audiogram taken shortly after the inspection demonstrated that **{redacted}** suffered no hearing loss, I note that this was the first audiogram given to **{redacted}**. Thus, it was a baseline audiogram against which future audiograms will determine whether hearing loss occurred.

levels above the TWA of 85 dBA over an 8-hour work day. Cranesville's policy, which had been in effect for approximately a year at the time of the inspection, clearly requires respondent to identify employees who are required to utilize hearing protective devices due to being exposed to noise in excess of 85 dBA. (Ex. H-2, p.5). Indeed, respondent identified eight employees for inclusion in its hearing conservation program. However, none of the eight employees worked at the Teall facility. (Tr. 701-704).

The record demonstrates management problems at Teall. Indeed, the evidence shows that Teall management changed five times in two years. (Tr. 740). Respondent attempts to use this as an excuse for the failure to implement the hearing conservation program as well as other safety and health programs. To the contrary, this turnover in the local plant management should have alerted corporate management to be more vigilant in ensuring that its safety and health obligations were being met at Teall, since that facility was constantly being run by new and untested personnel, rather than by experienced supervisors.

Yet, the evidence suggests that, rather than take the initiative to ensure that corporate safety policies were being met, Mosher relied on the constantly changing management teams to inform her whether corporate rules were being followed. For example, she testified that she had nothing to do with assigning people to chip. (Tr. 735). Indeed, rather than taking the initiative to verify that chipping was being done by the designated teams, Mosher testified that she was never notified that chipping was being conducted by personnel employed by the local facility. (Tr. 751). Mosher also testified that she was unaware that ***{redacted}*** was employed at Teall, and thought that he was still at another facility where he had worked at previously. (Tr. 770). She elaborated that

there was a communication failure and that the Teall management did not tell corporate management what was going on with the employees. Yet, despite labeling it a communication failure, she then admitted that it was not company policy for plant management to tell headquarters what was going on with employees. (Tr. 770).

Similarly, regional manager Van Coughnett testified that he never told Mosher that ***{redacted}*** needed to enter a hearing conservation program because he had no intention of ordering him into a truck to perform chipping in October 2007. (Tr. 869). However, he failed to explain why ***{redacted}***, who performed chipping on many occasions before October 2007, was not entered into a hearing conservation program based on these earlier exposures to noise. Like Mosher, Van Coughnett blamed the situation on a communication breakdown. (Tr. 870).

The evidence establishes that, despite frequent management changes at Teall, Cranesville corporate management ceded responsibility for safety to the local Teall facility management. Given the turnover rate in Teall management, Cranesville's failure to adequately monitor whether it's supervisors were properly implementing corporate safety procedures demonstrates a plain indifference to employee safety. In addition, Teall plant manager Williams testified that, despite the assignment of a special team to perform mixer drum chipping company-wide, ***{redacted}*** was responsible for chipping drums at Teall. (Tr. 803, 828). Yet Williams admitted that he never told management that ***{redacted}*** was performing duties that required his enrollment in a hearing conservation program. (Tr. 807). Moreover, there is no evidence that Williams ever took the initiative to enter ***{redacted}*** into such a program.

Cranesville also asserts that ***{redacted}*** had hearing protection that he wore during the inspection and that the protective ear muffs were provided by the company. It is respondent's position that by providing hearing protection, it demonstrated a concern for employee safety. I do not agree. To the contrary, I find that by providing hearing protection to ***{redacted}***, respondent demonstrated that, at least Teall management knew that ***{redacted}*** was exposed to high noise levels. Yet, despite this knowledge, ***{redacted}*** was not entered into respondent's hearing conservation program. This clearly demonstrates that Williams was plainly indifferent to employee safety. As the supervisor, Williams's state of mind is imputed to the employer for purposes of finding that a violation is willful. *Tampa Shipyards, Inc*., 15 BNA OSHC 1533, 1539 (No. 86-0360 & 80-0469, 1992).

Finally, I noted that respondent was previously cited for a substantially similar violation which demonstrates a "heightened awareness" of the condition.
Accordingly, I find that the violation was properly characterized as willful.
I also find that, if the violation were not willful, the violation was properly characterized as a repeat. The evidence establishes that Cranesville was cited on October 2004 for a violation of 29 CFR 1910.95(g)(i) for not providing baseline audiograms. (Ex. Tr. 290-292, H-12). That violation became a final order of the Commission via a settlement agreement on June 30, 2005. (Ex. S-9).

Respondent again argues that the violation should not be characterized as repeated because the previous citation was issued at a different Cranesville facility under the jurisdiction of a different OSHA area office. As noted, *supra*, the argument is without merit.

The Secretary proposed a penalty of $55,000 if willful and $17,500 if not willful, but repeated. In arriving at these penalties, the Secretary considered Cranesville's size, history, good faith and the gravity of the violation. (Tr. 274-277). The CO testified that the hazard posed by the violation was permanent hearing loss. Because the hazard did not present the possibility of death, he determined the violation to be of medium severity. (Tr. 278). However, he found the likelihood of hearing loss to be high due to the high decibel levels involved and because of the likelihood of weekly exposure, especially during the months of October to January. (Tr. 278-289). The CO noted that, under the FIRM, the penalty for a low gravity willful violation is $25,000 and that for a high gravity violation is $70,000. (Tr. 280). Finding the violation to be of moderate gravity, and considering the other factors relative to penalty assessment, a penalty of $55,000 was proposed. I find that the Secretary properly considered the statutory factors in issuing the proposed penalty, and I find the $55,000 proposed penalty to be appropriate.

Similarly, I find that the Secretary properly considered the statutory factors when proposing a penalty of $17,500 if the violation was found to be repeated. Accordingly, if the violation were repeated rather than willful, I find that the $17,500 proposed by the Secretary would be appropriate.

2. Citation 1, Item 2a, as amended, alleges a willful violation of 29 CFR §1910.134(a)(2)[10] for not identifying and evaluating the respiratory hazards in the workplace at the following locations:

[10] The standard provides.

§1910.134 Respiratory protection.

(a) *Permissible practice.*

* * *

a) Drum cleaning area, garage, on or about 10/24/07: The employer did not provide an appropriate respirator to the employee cleaning inside the drum of the cement mixer. (b) Dust collection systems, on or about 10/24/07: The employer did not provide an appropriate respirator to the employees who cleaned the dust collection system.

Citation 1 Item 2b alleges a serious violation of 29 CFR §1910.134(k)[11] in that the employer did not provide effective, comprehensive, understandable, and annual (or more often if necessary) training to employees who are required to use respirators: a) Throughout the facility, on or about 10/24/07: Employees wearing a half mask respirators [sic] while cleaning and maintaining the dust collection system were not provided with training on the use of respirators.

The Secretary proposed a combined penalty of $55,000 for items 2a and 2b. (Tr. 283). It is not disputed that ***{redacted}*** was exposed to levels of silica and total dusts in excess of the permissible TWA for when working in the mixer drums. The evidence also establishes that employees had to enter the bag house to inspect the bag to determine whether they need to be shaken, cleaned or replaced. (Tr. 167, 404, 711-712, 714, 801-802, 864-865, 927). ***{redacted}*** entered the bag house on a monthly basis to clean and

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(2) Respirators shall be provided by the employer when such equipment is necessary to protect the health of the employee. The employer shall provide the respirators which are applicable and suitable for the purpose intended. The employer shall be responsible for the establishment and maintenance of a respiratory protection program which shall include the requirements outlined in paragraph (c) of this section.

[11] The standard provides:

§1910.134 Respiratory protection

* * *

(k) *Training and information.* This paragraph requires the employer to provide effective training to employees who are required to use respirators. The training must be comprehensive, understandable, and recur annually, and more often if necessary. This paragraph also requires the employer to provide the basic information on respirators in Appendix D of this section to employees who wear respirators when not required by this section or by the employer to do so.

replace bags. (Tr. 450, 504-506, 508, 510, 570-571). ***{redacted}*** also entered the bag house to make repairs. (Tr. 504-506). The CO testified that Mosher told him that neither ***{redacted}*** nor ***{redacted}*** were medically evaluated, which is part of a respirator program. (Tr. 258).

At the outset, respondent argues that items 2a and 2b are barred by the six-month statute of limitations set forth in section 9(c) of the Act, 29 U.S.C. §658(c). According to respondent, there is no evidence that ***{redacted}*** or ***{redacted}*** entered the dust collection system or that ***{redacted}*** entered the cement mixing drum within six months of the inspection.

The evidence clearly establishes that, as part of their regular and continuing duties, ***{redacted}*** was required to enter the mixer drums and both ***{redacted}*** and ***{redacted}*** were required to enter the dust collection system to perform repair and maintenance. Cranesville's obligation to evaluate respiratory hazards and to provide employees with training in the use of appropriate respirators began the first time these employees performed these duties and continued as long as these employees were in a position to be called upon to enter these hazardous areas.

In this regard, the Commission has stated that for 9(c) purposes a violation of section 5(a)(2) of the Act 'occurs' whenever an applicable safety and health standard is not complied with and an employee has access to the resulting zone of danger. Therefore, it is of no moment that a violation first occurred more than six months before the issuance of a citation, so long as the instances of noncompliance and employee access providing the basis for the contested citation occurred within six months of the citation's issuance. *Central of Georgia R.R.*, 5 BNA OSHC 1209, 1211 (No. 11742, 1977).

Accordingly, I find that the violations were not barred by section 9(c) of the Act. Item 2a alleges that neither ***{redacted}*** nor ***{redacted}*** were provided appropriate respirators for use in the mixing drum (***{redacted}***) or the dust collection system (***{redacted}*** and ***{redacted}***).

The measured overexposures to dust and silica triggered the requirement under 29 CFR §1910.134(a)(2) that ***{redacted}*** be provided with an appropriate respirator for drum chipping. Based on his exposure, ***{redacted}*** should have been provided with respirator with a High Efficiency Particulate Filter (HEPA), such as a P100 cartridge.[12] (Tr. 242). He was not provided with such a filter. Rather, ***{redacted}*** had an organic filter in his respirator. (Tr. 354). The CO testified that organic filters have not been tested for dusts, and did not know if they were effective in reducing dust exposure. (Tr. 354). However, 29 CFR §1910.134(d)(3)(iv)(B) requires that filters used for protection against particulates be certified by NIOSH either as a HEPA filter or a filter certified for particulates. Because ***{redacted}*** cartridge was not certified by NIOSH as an appropriate filter, it could not qualify as an appropriate respirator under the standard.

Unlike the mixer drums, the CO did not conduct atmospheric testing of the dust collection system, and there is no evidence to support a finding that the employees were exposed to levels of either silica or dust in excess of the PELs set forth in 29 CFR 1910.1000 Table Z-1. However, to establish a violation of 29 CFR 1910.134(a)(2) the

[12] Although **{redacted}** was not provided with a P100 cartridge for his respirator, the evidence is not clear if these filters were available at the site. For example, Mosher testified that these filters were not available at Teall. (Tr. 710). On the other hand, **{redacted}** testified that, before the inspection, P100 filters were available at Teall. (Tr. 951). It is not necessary to resolve this conflict because, whether or not they were available at the site, the critical fact is that they were not provided to **{redacted}**. Williams confirmed that cartridges were available, but could not identify them. (Tr. 799-800).

Secretary need not establish that employees were exposed to excessive levels of an air contaminant. Rather, the requirements of the standard are triggered whenever respirators are "necessary to protect the health of the employee. *Snyder Well Servicing* 10 BNA OSHC 1371, 1374-76 (No. 77-1334, 1982). This has been interpreted to require a showing that the condition poses a significant risk of harm. See, e.g., *Anoplate Corp*., 12 BNA OSHC 1678, 1681-82, 1986-87 CCH OSHD ¶ 27,519, pp. 35,679-80 (No. 80-4109, 1986) (proof of significant risk is part of Secretary's burden under standard requiring protective equipment where "danger" exists). Whether there exists a significant risk depends on both the severity of the potential harm and the likelihood of its occurrence, but there is an inverse relationship between these two elements. As the severity of the potential harm increases in a particular situation, its apparent likelihood of occurrence need not be as great. *Pratt & Whitney Aircraft v. Donovan*, 715 F.2d 57, 64 (2d Cir. 1983).

The Secretary established that silica is a carcinogen. (Tr. 234). Moreover, when inhaled, silica particles can become embedded in the lungs making it very difficult for the person to breathe and cause silicosis (Tr. 235). Silicosis is not curable. (Tr. 235). Total dust includes particles that can be trapped by the nasal passages and smaller particles can become embedded in the lungs, restricting breathing. (Tr. 235-236).

The material in the dust collection system contains essentially the same components as the mixer drums. As was demonstrated by the air sampling in the mixer drum, the material that comes from the dust collection system includes substantial quantities of silica. Moreover, the evidence establishes that Portland cement is a commonly used product at Teall. The Material Data Safety Sheet (MSDS) for Portland

cement lists silica as a main ingredient. (Ex. H-11). Accordingly, I find that a preponderance of the evidence establishes that the atmosphere in the dust collection system contained silica.

As noted, *supra*, the evidence clearly demonstrates that, when exiting the dust collection system, both ***{redacted}*** and ***{redacted}*** would be coated with dust. (Tr. 405, 505). Absent the use of appropriate respirators, there was no way for these employees to avoid inhaling copious amount of these silica bearing dusts. On this evidence, I find that, given the irreversible health hazards posed by silica, the evidence establishes that employees working inside the dust collection system were exposed to a significant risk of harm,[13] and therefore, were required to wear an appropriate respirator.

{redacted} testified that, when working in the dust collection system, he would wear a half-mask respirator. (Tr. 926, 938). The evidence does not establish what type of filter he was using. However, ***{redacted}*** testified that, when he worked in the dust collection system, he would wear a half-mask respirator and, he believed, a P100 filter. (Tr. 938). I find that the evidence does not establish a violation as to ***{redacted}***. The evidence is unclear whether P100 HEPA filters were available at Teall and whether ***{redacted}*** was using this filter. The burden of establishing a violation is on the Secretary. On this record, I cannot find that the Secretary met her burden as to ***{redacted}***.

On the other hand, the evidence establishes that ***{redacted}*** wore a dust mask when working in the dust collection system. (Tr. 405). Clearly, a dust mask does not

[13] I find that the evidence is not sufficient to show that the levels of dust encountered by employees in the dust collection system were sufficient to create a significant risk of harm.

qualify as an appropriate respirator. Accordingly, I find that the violation was established as to ***{redacted}*** while working in the dust collection system.

The Secretary asserts that this violation was willful. The Secretary points out Cranesville's drum cleaning checklist, which is based on guidelines issued by the National Ready Mix Association, states that employees should wear a respirator when inside the drum if they have been fit tested. (Tr. 688, 705, Ex. H-3). Moreover, Cranesville's Respiratory Protection Policy states that the "respirators used within Cranesville Block Company were selected specifically because of the known and potential atmospheric exposures identified by the Qualitative and Quantitative Exposure Assessments performed by the contracted professional industrial hygienist." (Ex. H-5 at p.2). Despite this program, Safety Director Mosher admitted that no professional hygienist had been hired for the Teall facility, and no assessment had been made. (Tr. 709). Cranesville again argues that the failure to institute corporate safety policies at Teall was the result of poor communications due to management changes at Teall and that Mosher did not even realize that ***{redacted}*** was chipping drums.

I find the violation was properly characterized as willful. As discussed, supra, rather than excusing noncompliance, the frequent changes of management should have placed Cranesville on higher alert to ensure that the new management was properly following company safety policies. However, it was not part of Cranesville procedure for the company to either make inquiries regarding the status of its safety programs at its facilities, or for the individual facility to inform headquarters about which employee were doing what job. (Tr. 799). I find that management's attitude demonstrated a plain indifference to employee safety and, therefore, supports a finding of willfulness.

Furthermore, Williams assigned ***{redacted}*** to chip trucks, yet could not remember when ***{redacted}*** got his respirator. (Tr. 799). Indeed, Williams testified that he never gave respirators to anybody and did not even know how to distinguish between cartridges. (Tr. 799-800). This demonstrates that Cranesville hired Williams as plant manager, yet failed to hold him accountable for fundamental safety and health shortcomings that permeated the Teall facility. On this evidence, I find that Cranesville was plainly indifferent to employee safety and, therefore, willfully violated the standard.

Item 2b

The citation specifically states that respondent failed to provide effective, comprehensive, understandable and annual training "to employees who are required to use respirators." However, in the next paragraph, which sets forth a more specific statement of the violation in relationship to the conditions at the site, the citation states that employees "wearing half mask respirators" were not trained on the use of respirators while cleaning and maintaining the dust collection system. The evidence demonstrates that ***{redacted}*** only wore a half mask respirator while chipping in the mixing drums, and that, while working in the dust collection system, he wore a dust mask.[14] (Tr. 405, 506).

The evidence is undisputed that ***{redacted}*** did not receive respirator training. (Tr. 261-262, 598-599, 719-720, 807, 869). The standard is specifically applicable to "employees who are required to use respirators." As discussed in item 2a, *supra,* while working in the dust collection system, ***{redacted}*** was exposed to a significant hazard

[14] While the Secretary cites to several places in the record that, she alleges, establishes that **{redacted}** wore a respirator on those occasions, a review of those cites reveal that they refer to the mixer drums rather than the dust collection systems; (e.g. Tr. 186-187, 229, 245, 715).

and, therefore, was required to wear a respirator. Accordingly, whether he was wearing a dust mask, or a half-mask respirator, the gravamen of the violation is the fact that he was required to wear a respirator and respondent was required to provide adequate training in the use of the respirator.

The Secretary also asserts that ***{redacted}*** did not receive the appropriate training. The compliance officer testified that Mosher told him that neither ***{redacted}*** nor ***{redacted}*** were either medically evaluated for respirator usage or fit tested. (Tr. 258). This was confirmed by Mosher. (Tr. 716). Moreover, the Secretary asserts that there are no training records showing that ***{redacted}*** received respirator training. (Ex. H-6). However, ***{redacted}*** testified that he was fit tested and medically evaluated. Moreover, he testified that he would shave off his beard whenever it was necessary for him to wear a respirator. (Tr. 915-916). This was substantially supported by Williams, who testified that ***{redacted}*** knew that he had to be clean shaven to properly wear a respirator. (Tr. 831). ***{redacted}*** also testified that he had a respirator fitness certificate, but that he did not show it to the CO because he was never asked for it. (T. 939, 954). ***{redacted}*** also believed that he attached the appropriate P100 cartridge to his respirator. On this evidence, I find that the Secretary failed to establish that ***{redacted}*** was improperly trained.

The Secretary has established the violation as to ***{redacted}***. The Secretary asserts that this violation was serious. As the Secretary properly argues, the failure to train ***{redacted}*** in the proper use of respirators exposed him to the atmospheric hazards he encountered in his job, which could result in cancer or silicosis or other diminished lung capacity.

Penalty

The Secretary proposes a combined penalty of $55,000 for these two sub-items. Finding that the violation was not established in regards to ***{redacted}***, I find that a reduction in the penalty is appropriate. In assessing an appropriate penalty, I regard the willfulness of item 2a, and respondent's plain indifference to the health of ***{redacted}*** to be of primary consideration. Moreover, I must consider that this plain indifference exposed ***{redacted}***to serious health consequences, including lung cancer and silicosis. Thus, while a reduction is in order, I do not find that a simple mathematical halving of the penalty is appropriate. Considering the willfulness of the violation and its potential consequences, I find that a combined penalty of $35,000 is appropriate.

3. Citation 1 Item 3 alleges a serious violation of 29 CFR §1910.146(g)(1)[15] on the grounds that the employer did not provide training so that all employees whose work was regulated by 29 CFR §146, Permit required confined spaces, acquired the understanding, knowledge, and skills necessary for the safe performance of the duties assigned:

a) Throughout the facility, on or about 10/24/07; Permit required confined space training was not provided for employees that enter silos and drums of cement mixer trucks for cleaning and maintenance operations.

A penalty of $3500 is proposed for this alleged violation.

[15] The standard provides:

§1910.146 Permit-required confined spaces.

(g) *Training.* (1) The employer shall provide training so that all employees whose work is regulated by this section acquire the understanding, knowledge, and skills necessary for the safe performance of the duties assigned under this section.

The evidence establishes that the mixer drums and silos are permit-required confined spaces. Respondent's Mixer Drum Cleaning Procedure/Checklist (Ex. H-3), states that the mixer drums are designated as non-permit required confined spaces. However, this document requires that the drums be secured to prevent movement. This was not done. (Tr. 295). Also, the procedure requires that a ventilation fan be used to "draw air out." As discussed in Health Citation item 5, infra, the use of fans was, at best, sporadic. (Tr. 636). The CO testified that, based on these failures, the drum mixers were not reclassified as non-permit confined spaces. (Tr. 557-558, 635-636). Moreover, he noted that, to be effective, the reclassification had to be signed by a supervisor, which Ex. H-3 is not. (Tr. 635-636). Accordingly, the CO testified, without rebuttal, that the drums were permit-required confined spaces. (Tr. 557-558-635-636). Similarly, the CO testified that the bag houses/silos were also permit-required confined spaces. (Tr. 263, 604-605). Moreover, the silos are identified as permit-required confined spaces in Cranesville's Confined Space Policy (Ex. H-8, pp.4, 6-8).

The evidence indicates that employees entered these spaces, thus triggering the requirement that they be trained to ensure the safe performance of their work. (Tr. 263). Besides ***{redacted}***, the evidence establishes that ***{redacted}***, ***{redacted}***, ***{redacted}***, and ***{redacted}*** all entered the mixer drums. (Tr. 391, 455, 496, 509, 565, 597, 658, 692, 925).[16] ***{redacted}*** and ***{redacted}*** entered the bag houses. (Tr. 158, 258-259, 450, 504-506, 508, 510, 570-571, 655, 927, 937). ***{redacted}*** also testified that he entered the aggregate silo. (Tr. 937).

[16] Not all employees entered to perform chipping. For example, **{redacted}** testified that he entered the drums to patch the fins, a cutting device used to mix the concrete as the drum spins. (Tr. 924-925) Employee Para would enter the drums to perform welding. (Tr. 658).

The training certificates produced for some of these employees indicate that they were given confined space training. (I.e. ***{redacted}***, Ex. H-6 at p.11; ***{redacted}*** Ex. H-6 p. 25, ***{redacted}*** Ex. R-1). However, ***{redacted}*** denied that he placed the relevant check marks on his training certificate. (Tr. 488). He testified that he watched a few segments of the training video when it was shown, but was called away because his truck was being loaded. (Tr. 489). As to confined spaces, he testified that his only training consisted of being informed that confined spaces had a "do not enter" sign and that he wasn't allowed to go inside. (Tr. 493-494). He specifically recalled that there were no such signs on the drums. (Tr. 493-494). ***{redacted}***, who on occasion would chip the mixer drum on his truck, had a certificate that indicates that he received confined space training. (Ex. H-6, p. 3, 13). However, ***{redacted}*** testified that he never received such instruction. (Tr. 413).

Although the training certificates of both ***{redacted}*** and ***{redacted}*** indicate that they received confined space training, their testimony suggests that, at best, that training was perfunctory. For example, ***{redacted}*** testified that though his certificate indicates that he was trained, he was called away from the training session to make a delivery.[17] In any event, the evidence is unrebutted that ***{redacted}***, who regularly entered permit-required confined spaces, never received any confined space training. (Tr. 724).

[17] Although **{redacted}** testified that he did not place the checkmarks on his training certificate, he did not dispute that the signature on that certificate was his. Nor did he allege that those check marks were placed on the certificate after he signed it. Similarly, **{redacted}** asserted that he never received the confined space training as indicated on his certificate. Again, however, he did not allege that those check marks were placed there after he signed it. While this evidence does not establish that these certificates were fraudulent, their testimony, especially that of **{redacted}**, demonstrates that any training was inadequate.

{redacted} training certificate also demonstrates that ***{redacted}*** was not trained. (Ex. H-7, p.1).

Respondent argues that, even though ***{redacted}*** training certificate did not indicate confined space training, the Secretary failed to establish that he was not trained. I disagree. ***{redacted}*** training certificate is sufficient to satisfy the Secretary's burden of making a *prima facie* showing that ***{redacted}*** was not trained.[18] The burden then shifted to Cranesville to rebut that evidence. Respondent produced nothing to rebut the Secretary's evidence. Accordingly, the violation was established as to ***{redacted}***.

Respondent again argues that Cranesville had a policy of giving confined space training and that the failure to provide such training at Teall was the result of a communication failure. As noted, *supra*, the failure of Cranesville management to communicate with the Teall facility is no defense.

Accordingly, based on the failure to train ***{redacted}*** and ***{redacted}***, I find that the Secretary established the violation.[19] The failure to adequately train employees in the hazards of confined spaces was properly characterized as serious. The evidence establishes that the lack of training exposed employees to the hazard of broken bones from slips, trips and falls. (Tr. 284). The Secretary also found the likelihood of injury to be greater because of the frequency of employee entry into confined spaces. (Tr. 285).

The Secretary proposed a penalty of $3500 for this violation. I find the proposed penalty to be appropriate and assess the proposed penalty.

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[18] In her brief, the Secretary contends that both **{redacted}** and **{redacted}** told the CO that they were not trained. The record fails to support that assertion. The best that could be said is that the CO learned that **{redacted}** was not trained. (Secretary's Brief at p. 53, citing to Tr. 597, 658).

[19] Therefore, I find it unnecessary to determine whether Respondent's training of other employees was sufficient to satisfy the standard.

4. Citation 1 Item 4a alleges a serious violation of 29 CFR §1910.146(k)(2)(iv)[20] on the grounds that the employer did not ensure effected employees practice making permit space rescues at least once every 12 months, by means of simulated rescue operations in which they remove dummies, manikins, or actual persons from the actual permit spaces or from representative permit spaces:

a) Aggregate silo, on or about 12/4/07: Employees expected to perform non-entry rescues of entrants entering permit required confined spaces were not provided with drills of simulated rescues.

Citation 1 Item 4b alleges a serious violation of 29 CFR §1910.146(k)(3)(ii) on the grounds that whenever an authorized entrant entered a permit space to perform rescue

[20] The standards provides:

§1910.146 Permit-**required confined spaces.**

* * *

(k) *Rescue and emergency services.*

* * *

(2) An employer whose employees have been designated to provide permit space rescue and emergency services shall take the following measures:

(iv) Ensure that affected employees practice making permit space rescues at least once every 12 months, by means of simulated rescue operations in which they remove dummies, manikins, or actual persons from the actual permit spaces or from representative permit spaces. Representative permit spaces shall, with respect to opening size, configuration, and accessibility, simulate the types of permit spaces from which rescue is to be performed.

(3) To facilitate non-entry rescue, retrieval systems or methods shall be used whenever an authorized entrant enters a permit space, unless the retrieval equipment would increase the overall risk of entry or would not contribute to the rescue of the entrant. Retrieval systems shall meet the following requirements.

* * *

(ii) The other end of the retrieval line shall be attached to a mechanical device or fixed point outside the permit space in such a manner that rescue can begin as soon as the rescuer becomes aware that rescue is necessary. A mechanical device shall be available to retrieve personnel from vertical type permit spaces more than 5 feet (1.52 m) deep.

services, a mechanical device was not available to retrieve personnel from vertical type permit space more than 5 feet (1.524 m):

a) Aggregate Silo on or about 9/5/07: No mechanical retrieval device was available for an employee entering and inspecting an aggregate silo while wearing a harness and lifeline.

A combined penalty of $2500 is proposed for items 4a and 4b.

As alleged in item 4a, the evidence establishes that respondent's employees at the Teall facility did not practice confined space rescues. (Tr. 272). Safety director Mosher admitted that, although Cranesville's confined space program addressed rescues, they failed to train employees at Teall. (Tr. 723). She explained that, rather than perform in-house rescue, they relied on calling 911 and having the local fire department come to the site. (Tr. 723). However, before the inspection, there was no formal agreement with the fire department to perform such rescues. (Tr. 724).

As alleged in item 4b, the evidence establishes that there was no mechanical device available to rescue an employee from the silos, which are all at least 25 feet tall. (Tr. 264, 271, 272, 448, 934-935). The evidence also establishes that, around September 2007, ***{redacted}*** entered a silo and descended 20-30 feet using an interior ladder in order to repair an interior wall. (Tr. 72, 933-935, 962-964). He was wearing a harness, but without a lifeline attached. (Tr. 933-937).

Respondent argues that the items should be vacated because it had a good faith belief that any necessary rescues would be performed by the local fire department. Following the inspection, it entered a formal rescue agreement with the fire department. Cranesville's contention that the items should be vacated because it relied on the local fire department, and subsequently entered into a formal agreement with it, is without

merit. Under the standards, reliance on an off-site entity to perform rescues is allowable only when certain criteria are met. For example, under 29 C.F.R. §1910.146(k)(i), the employer is required to assess the rescue service's ability to respond to an emergency. Here, there was no such assessment. That a formal agreement was entered after the inspection demonstrates only that the violation was abated.

The Secretary having established *prima facie* violations as alleged in items 4a and 4b, and finding no merit in respondent's defenses, the violations are affirmed.

The evidence establishes that the lack of training and rescue equipment exposed employees to the hazard of concussion or engulfment by dusts. (Tr. 285-286). On this evidence, I find that the violation was properly characterized as serious. The CO determined that the violation was of high severity because of the hazard of concussion or engulfment. However, the CO also testified that, because the confined spaces were not frequently entered, there was a lesser probability of injury. The Secretary proposed a combined $2500 penalty for these violations. I find that the record establishes that the proposed penalty is appropriate and it is assessed.

5. Citation 1 Item 5a alleges a serious violation of 29 CFR §1910.1000(a)(2)[21] on the grounds that employees were exposed to an airborne concentration of Particulates Not Otherwise Regulated (total dust) listed in Table Z-1 in excess of the 8 hour Time Weighted Average concentration of 15 milligrams per cubic meter (mg/m3):

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[21] The standard provides:

§1910.1000 Air contaminants.

(a) *Table Z-1*

* * *

(2) *Other substances-8-hour Time Weighted Averages.* An employee's exposure to any substance in Table Z-1, the exposure limit of which is not preceded by a "C", shall not exceed the 8-hour Time Weighted Average given for that substance in any 8-hour work shift of a 40-hour work week.

(a) Drum cleaning operation, garage, on or about 10/24/07: A laborer cleaning inside the drum of a cement mixer was exposed to 29.8 mg/m3 of total dust (based on an 8-hour time weighted average) or 1.98 times the permissible exposure limit (PEL) of 15 mg/m3 for the 130 minutes sampled. A zero increment was included for the 350 minutes sampled.

Citation 1 Item 5b alleges a serious violation of 29 CFR §1910.1000(c)[22] on the grounds that on or about 10/24/07: A laborer cleaning inside the drum of a cement mixer was exposed to a 5.15 milligrams per cubic meter (mg/m3) of respirable quartz (silica), based on an 8-hour time weighted average, or 4.3 times the permissible exposure limit (PEL) of 1.197 mg/m3 for the 130 minutes sampled. A zero increment was included for the 350 minutes sampled.

Citation 1 Item 5c alleges a serious violation of 29 CFR §1910.1000(e)[23] on the ground that feasible administrative or engineering controls were not determined and implemented to achieve compliance with the limits prescribed in the cited standard:

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[22] The standard provides:

§1910.1000 Air contaminants.

* * *

(c) *Table Z-3.* An employee's exposure to any substance listed in Table Z-3, in any 8-hour work shift of a 40-hour work week, shall not exceed the 8-hour time weighted average limit given for that substance in the table.

[23] The standard provides:

§1910.1000 Air contaminants.

* * *

(e) To achieve compliance with paragraphs (a) through (d) of this section, administrative or engineering controls must first be determined and implemented whenever feasible. When such controls are not feasible to achieve full compliance, protective equipment or any other protective measures shall be used to keep the exposure of employees to air contaminants within the limits prescribed in this section. Any equipment and/or technical measures used for this purpose must be approved for each particular use by a competent industrial hygienist or other technically qualified person. Whenever respirators are used, their use shall comply with 1910.134.

a) Drum cleaning operation, garage, on or about 10/24/07: Engineering and/or administrative controls were not used to reduce or eliminate a laborer's exposure to silica.

A combined penalty of $5000 is proposed for items 5a, 5b, and 5c.

As discussed *supra*, ***{redacted}*** was fitted with sampling devices to determine his exposure to respirable dust and silica while working inside the mixer drum. The results of that sampling established that ***{redacted}*** was exposed to an eight hour TWA of 5.15 mg/cm of silica. The PEL for silica is 1.197 mg/cm. (Tr. 231). Thus, ***{redacted}*** was exposed to 4.3 times the PEL for silica. Similarly, the sampling established that ***{redacted}*** was exposed to an eight hour TWA of 29.79 mg/cm of respirable dust, whereas the PEL is 15 mg/cm. Therefore, ***{redacted}*** was exposed to 1.98 times the eight hour PEL for dust. (Tr. 241).

Also, as noted under Health Citation 1, item 2a, the respirator worn by ***{redacted}*** was not appropriate to protect him from exposure to the air contaminants. The evidence also establishes that Cranesville used no feasible engineering or administrative controls to reduce the level of the air contaminants. The Secretary argues that a ventilation fan could have been placed by the mixer drum hat hatch to draw out dusts. (Tr. 247). Indeed, Mosher testified that the use of ventilation fans is part of Cranesville's standard procedure, and that the use of such a fan would reduce the levels of both respirable dust and silica. (Tr. 707-709, Ex. H-3).

Again, however, she blamed the failure to implement that policy on communication failure due to changes in management. (Tr. 739). ***{redacted}*** testified that he occasionally used a fan while chipping and that he saw fans used by other employees. He testified that there was only one fan at Teall and that he would use it when it was

available. However, he also stated that he would have to hunt for a fan because the lone fan was not kept at a regular location. (Tr. 394-396).

There is no dispute that when performing chipping in the mixer drums, ***{redacted}*** was exposed to excessive levels of silica and respirable dusts. The standard clearly requires that, before respirators are used to reduce employee exposure, the employer is required to use feasible administrative or engineering controls to reduce the exposure to air contaminants. The evidence establishes that Cranesville implemented no administrative controls. There is no dispute that the use of a ventilation fan was a feasible engineering control that could reduce the hazard. Indeed, Cranesville's own written procedures require the use of ventilation fans. Although a fan was kept at the site, the evidence establishes that employees chipping the mixer drums were not required to use it and that, it was often misplaced and therefore was not available for use.[24] Moreover, the respirator ***{redacted}*** used was insufficient to effectively reduce that exposure.

Accordingly, I find that the Secretary has made a *prima facie* showing establishing the violations alleged in items 5a, 5b and 5c.

In defense, respondent asserts that ***{redacted}*** failure to use a ventilation fan during the inspection constituted an isolated occurrence. It further points out that it had a drum cleaning checklist and that ***{redacted}*** failure to utilize that checklist was a result of his lack of training that was corrected after the violation.

[24] I note that the Secretary introduced other feasible engineering controls that could reduce the hazard. For example, a vacuum device, attached at the chipping tool, is designed to suck up the dust at the point of operation. (Tr. 247, 591, 640). Also, the employee can reduce the levels of air borne contaminants by wetting the concrete from a hose. (Tr. 242-243, 246, 249, 397, 591, 640).

Respondent's arguments are not persuasive. Employee testimony establishes that the ventilation fan was only occasionally used in the mixer drums and was often misplaced and could not be located. Indeed, safety director Mosher admitted that the checklist procedures that include use of the fan, was not followed due to a failure of communication. Clearly, the failure to utilize engineering controls during the chipping operations was a regular and recurring problem at Teall. Accordingly, the record fails to support a finding that the failure to use the fan during the inspection was an isolated occurrence.

As discussed *supra,* the evidence establishes that employee exposure to excessive levels of silica and respirable dusts can result in cancer, silicosis and diminished lung capacity. Accordingly, the violations were properly characterized as serious. The Secretary proposed a penalty of $5000 for the three combined violations. The CO testified that the violations were of high severity due to the severity of the illness that could result. Moreover, the CO testified that the violations posed a greater probability of injury due to the frequency of ***{redacted}*** exposure. (Tr. 286-287).

I find that the proposed penalty is appropriate and it is assessed.

6. Citation 1 Item 6 alleges a serious violation of 29 CFR §1910.1200(h)(1)[25] on the grounds that employees were not provided information and training on hazardous

[25] The standard provides:

§1910.1200 Hazard communication.

* * *

(h) *Employee information and training.*

(1) Employers shall provide employees with effective information and training on hazardous chemicals in their work area at the time of their initial assignment, and whenever a new physical or health hazard the employees have not previously been trained about is introduced into their work area. Information and training may be designed to cover categories of hazards (*e.g.* flammability, carcinogenicity) or specific

chemicals in their work area at the time of their initial assignment and whenever a new hazard was introduced into their work:

a) Throughout the facility, on or about 10/24/07: Hazard communication information and training was not provided for laborers and drivers exposed to silica in maintenance operations including, but not limited to, drum cleaning and maintenance of the dust collection system.

A penalty of $5000 was proposed for this violation.

As noted, silica and respirable dusts are listed as hazardous substances under 29 U.S.C. §1910.1000, Table Z-1. Respondent maintained an MSDS for Portland Cement, a product at the facility, which lists silica as a main ingredient. (Ex. H-11). Moreover, as revealed by the air sampling of ***{redacted}***, employees were exposed to both silica and respirable dusts. For example, the evidence establishes that drivers, including but not limited to ***{redacted}*** and ***{redacted}***, would occasionally chip out the concrete on the mixing drums in their trucks. (Tr. 391, 394, 481-482). Employees would also enter the dust collection system which contained silica. Therefore, under the cited standard, Cranesville was obligated to provide employees "with effective information and training" on the hazards associated with those air contaminants.

What constitutes "information and training" is set forth at §1910.1200(h)(2). Under that subsection, information includes (1) information regarding where the hazardous substances are present; (2) the location and availability of the hazard communication program, including the location of appropriate MSDS. Training includes (1) methods of detecting the presence or release of the hazardous substance, (2) the

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chemicals. Chemical-specific information must always be available through labels and material safety data sheets.

physical and health hazards of the substance; (3) measures employees can take to protect themselves from these hazards, including protective procedures, appropriate work practices, and emergency procedures, and protective equipment that should be used; and (4) details of the hazard communication program including an explanation of the labeling system and the MSDS.

According to the CO, ***{redacted}*** stated that he did not know how to protect himself from silica, did not know why he wore a respirator when chipping inside the mixer drums, and did not receive the required training. (Tr. 261-262, 602). ***{redacted}*** testified that he never received hazard communications training and that the only thing he knew about silica and silicosis was that they were bad and that if silica got into your lungs you wouldn't be able to get air in. (Tr. 412). Although ***{redacted}*** signed his training certificate that indicated that he received training in hazard communication and silicosis, he had no recollection of being trained in hazard communication and had no knowledge of silicosis. (Tr. 491). The CO also determined that ***{redacted}*** and ***{redacted}***, both of whom were exposed to silica, were not given the required training. (Tr. 642, Ex. H-7, p. 1).

Respondent admits that ***{redacted}*** was not trained, but again points out that it had a hazard communications program (Ex. H-9), and blames a communications failure and points out that, after the inspection he received the appropriate training. For reasons given, *supra*, those defenses are without merit. Respondent also argues that ***{redacted}*** testified that he received training in silicosis. (Tr. 412-413). Moreover, ***{redacted}*** training certificates indicate that he received training in hazard communication and silicosis on October 30, 2006 and April 30, 2007 (Ex. H-6, pp. 3, 13). It also points out

that, although ***{redacted}*** did not recall his specific training, his training certificates for January 27, 2006 and April 30, 2006 indicate that it included silicosis training. (Tr. 487, Ex. H-6, p. 11, 27). Finally, respondent points out that the training certificates of both ***{redacted}*** and ***{redacted}*** indicate that they received silicosis training. (Exs. H-6 at p.25, R-1).

Respondent's arguments would have merit only if the standard required that the employer give its employees perfunctory and superficial training and information. Rather, the standard requires that the information and training be "effective." Although the certificates of several employees suggest that they received some form of training and information, their testimony, especially that of ***{redacted}*** and ***{redacted}*** demonstrate that any such information and training was ineffective. Effective training and information requires that employees learn more than *"Silicosis is bad!"* It must also include the matters set forth in 29 CFR§ 1910.1200(h)(2), including how employees can protect themselves from the hazards presented by the contaminants. The testimony of ***{redacted}*** and ***{redacted}*** and the evidence regarding ***{redacted}*** demonstrate that, whatever training might have been given failed to impart these matters to the affected employees.

Moreover, that employees signed a certificate stating that the training was "comprehensible" and that the employee "understood all of the material" has little weight. That an employee attests that he understood the material and that it was comprehensible does not indicate what was presented. An employee who has no knowledge of a subject may believe that he understood the material presented, but that does not establish whether that material transmitted the scope of information and training required by the standard.

Accordingly, I find no merit in respondent's argument and the item is affirmed.

The failure to properly train and inform employees as required by the standard compromised their ability to protect themselves from the hazards associated with silica and respirable dusts which, as previously discussed, can result in cancer, silicosis and diminished lung capacity. Therefore, the violation was properly characterized as serious. Given the frequency of employee exposure, I find that the gravity of the violation was high. The Secretary proposed a penalty of $5000. I find that the proposed penalty is appropriate and it is assessed.

Citation 2 Item 1a alleges a repeat violation of 29 CFR §1910.134(e)(1)[26] on the grounds that employees required to wear negative pressure respirators were not provided with a medical evaluation to determine the employee's ability to use a respirator:
a) Dust collection systems, on or about 12/14/07: Laborers wearing half mask cartridge type respirators while entering and working on the dust collection systems were not provided with medical evaluations to determine the ability to use a respirator.

Cranesville Block was previously cited for violation of this Occupational Safety and Health Standard or its equivalent standard, 29 CFR §1910.134(e)(1), which was contained in OSHA inspection #307541326, Citation 1, Item 1, issued on 9/8/2005.

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[26] The standard provides:

§1910.134 Respiratory protection.

* * *

(e) *Medical evaluation.* Using a respirator may place a physiological burden on employees that varies with the type of respirator worn, the job and workplace conditions in which the respirator is used, and the medical status of the employee. Accordingly, this paragraph specifies the minimum requirements for medical evaluation that employers must implement to determine the employee's ability to use a respirator.

(1) *General.* The employer shall provide a medical evaluation to determine the employee's ability to use a respirator, before the employee is fit tested or required to use the respirator in the workplace. The employer may discontinue an employee's medical evaluation when the employee is no longer required to use a respirator.

Citation 2 Item 1b alleges a violation of 29 CFR §1910.134(f)(2)[27] on the grounds that the Respondent did not ensure that an employee using a tight fitting face piece respirator was fit tested prior to initial use of the respirator, whenever a different respirator face piece (size, style, model or make) was used, and at least annually thereafter:

a) Dust collection systems, on or about 10/17/07: Employees required to wear half mask cartridge type respirators while entering dust collectors were not fit-tested on their respirators.

Cranesville Block was previously cited for a violation of this Occupational Safety and Health Standard or its equivalent standard, 29 CFR 1910.134(f)(1), which was contained in OSHA inspection #307541326, Citation 1, Item 2, issued on 9/8/2005. The Secretary proposed a combined penalty of $17,500 for Citation 2 items 1a and 1b.

The CO explained that, before using a respirator, employees must first be medically evaluated to determine the employees' fitness to us a respirator. He testified that it is more difficult to breath with a respirator than without. (Tr. 245). Therefore, respirators could prove a problem for an employee with emphysema, asthma, or a cigarette smoker. (Tr. 234, 244, 256-257). An employee must be medically evaluated

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[27] The standard provides:

§1910.134 Respiratory protection.

* * *

(f) *Fit testing.* This paragraph requires that, before an employee may be required to use any respirator with a negative or positive pressure tight-fitting face piece, the employee must be tested with the same make, model, style, and size of respirator that will be used. This paragraph specifies the kinds of fit tests allowed, the procedures for conducting them, and how the results of the fit tests must be used.

* * *

(2) The employer shall ensure that an employee using a tight-fitting face piece respirator is fit tested prior to initial use of the respirator, whenever a different respirator face piece (size, style, model or make) is used, and at least annually thereafter.

even if he wears his own mask, or wears it voluntarily, as a precautionary measure. (Tr. 257-258, 364).

After an employee is cleared to wear a respirator, he must be fit tested with the same make, model, style and size of respirator that will be used to ensure that there is no leakage around the perimeter of the respirator. (Tr. 252).

In her brief, the Secretary asserts that the items concerned employees ***{redacted}*** and ***{redacted}***. The evidence clearly demonstrates that both ***{redacted}*** and ***{redacted}*** entered the dust collection system. (Tr. 450, 504-506, 510, 570-571, 926, 934-935). Regarding ***{redacted}***, the evidence establishes that he was neither medically evaluated nor fit tested. (Tr. 258, 645, 771).

Item 1a cited the violation on the grounds that "employees required to wear negative pressure respirators" were not medically evaluated to determine the employee's ability to use a respirator. As with health citation 1, item 2b, however, the specifics of the violation alleged that "laborers wearing half mask cartridge type respirators" were not medically evaluated. Although ***{redacted}*** wore a half-mask respirator, ***{redacted}*** only wore dust masks while in the dust collection system. (Tr. 405, 506).

As discussed, *supra,* employees are "required" to wear respirators whenever, as is the case here, the work atmosphere presents a significant risk of harm.[28] The cited standard requires a medical evaluation to determine the employee's fitness to use a respirator before a respirator is used. Therefore, whether ***{redacted}*** was wearing a dust

[28] The CO further testified that the use of a respirator is not necessary unless the employee is exposed to levels of air contaminants in excess of the PEL. (Tr. 243). This testimony is of no relevancy for two reasons. First, OSHA Compliance Officers are not qualified to present legal conclusions. Second, as discussed, supra, he was wrong. As discussed, *supra*, respirators are required whenever the atmosphere presents a significant risk to employees, whether or not the contaminants exceed the TLV.

mask or a half mask respirator, the salient point is that, based on the significant risk to which he was exposed while working in the dust collection system, he was required to wear a respirator and should have been medically evaluated. Accordingly, I find that citation 2, item 1a was established as to ***{redacted}***.

Similarly, item 1b alleges that respondent failed to ensure that an employee using a tight fitting face piece respirator was fit tested prior to use of the respirator. The next section of the citation, which sets forth the particulars of the violation, again alleges that it relates to employees wearing respirators while working in the dust collection system. As with item 1a, although the evidence does not establish that ***{redacted}*** wore a respirator in the dust collection system, it does establish that he wore one while chipping in the mixer drum. However, regardless of what ***{redacted}*** wore in the dust collection system, the gravamen of the violation is that he wore a half-mask respirator due to exposure to atmospheric contaminants and was not provided with fit testing to ensure that the respirator functioned properly.[29]

Accordingly, I find that citation 2, item 1b was established as to ***{redacted}***.

{redacted} wore a half-mask respirator when he worked in the bag house, (Tr. 915-916, 925, 936-937), and did so as late as the summer of 2007 (Tr. 937). The CO testified that he was told by Mosher that neither ***{redacted}*** nor ***{redacted}*** were medically evaluated. (Tr. 258, 645). However, ***{redacted}*** testified that he was both medically evaluated and fit tested. (Tr. 915). ***{redacted}*** also asserted that he had a respirator fitness

[29] I also note that both the dust mask and the half-mask respirator that **{redacted}** wore were both inadequate to protect him from the air contaminants in the dust collection system. A dust mask cannot be fit tested and a fit test of the inadequate respirator would have done nothing to reduce the hazard. Clearly then, what he was wearing in the dust collection system is a matter of no real significance to this item.

certificate. (Tr. 954). He testified that he had the certificate with him, but never showed the certificate to the CO because he was never asked to produce it. (Tr. 954).

I credit ***{redacted}*** testimony. As has been well documented, safety director Mosher was dramatically uninformed regarding the safety and health situation at Teall. I see nothing to suggest that she was more informed about the safety status of ***{redacted}*** than she was about the safety status of the rest of the facility. Moreover, I find nothing to suggest that ***{redacted}*** was anything but credible regarding his own status. Certainly, ***{redacted}*** was in a better position to know whether he was medically evaluated and fit tested than was Mosher. Therefore, I find that ***{redacted}*** was both medically evaluated and fit tested as required by the standard.

Accordingly, Citation 2, items 1a and 1b are vacated as to ***{redacted}***.

The Secretary alleges that the violation is repeated. The record establishes that Cranesville was issued a citation for violations of the identical standards on September 8, 2005, and that the citation became a final order of the Commission on September 30, 2005. (Ex. S-8, p. 31). This evidence is sufficient to establish a repeat violation. *Potlatch Corp.* As previously noted, respondent's contention that the violation cannot be repeated because it was issued at a different facility under the jurisdiction of a different OSHA Area Office is without merit. Accordingly, I find that the violation was repeated.

The CO testified that he considered the violation to be of high severity because the violation exposed employees to the hazard of silicosis. (Tr. 288). He also testified that the violation posed a greater probability of injury because of the frequency that the employee was exposed to silica. (Tr. 288). Therefore, a computed gravity based penalty of $3,500 was calculated for the violation. After multiplying that amount by five because

it was a repeated violation, the Secretary proposed a combined penalty of $17,500 for this repeated violation. (Tr. 288-289). Because I find that the Secretary failed to establish a violation as to ***{redacted}***, demonstrating that, at least here, Cranesville made some attempt at compliance, I find that a reduction in the penalty is in order. In reducing the penalty, I still consider that at least one employee was exposed to a serious health hazard that could have led to cancer and death. With that consideration, I find it appropriate to reduce the penalty by $5000. Accordingly, a combined penalty of $12,500 is assessed.

Citation 2 Item 2 alleges a repeated violation of 29 CFR §1910.146(c)(2)[30] on the grounds that the employer did not inform exposed employees, by posting danger signs or by any other equally effective means, of the existence and location of and the danger posed by the permit spaces.

a) Silos, on or about 9/5/07: A mechanic entering the aggregate silo was not informed through signage, or any other means that he silos were permit required confined spaces.

b) Cement mixer drums, on or about 10/24/07, Employees entering cement mixer drums were not informed through signage, or any other means that the drums were permit required confined spaces.

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[30] The standard provides:

§1910.146 Permit-required confined spaces.

* * *

(c) *General requirements*

* * *

2) If the workplace contains permit spaces, the employer shall inform exposed employees, by posting danger signs or by any other equally effective means, of the existence and location of and the danger posed by the permit spaces.

Note: A sign reading "DANGER—PERMIT-REQUIRED CONFINED SPACE, DO NOT ENTER" or using other similar language would satisfy the requirement for a sign.

Cranesville Block was previously cited for a violation of this Occupational Safety and Health Standard or its equivalent standard, 29 CFR 1910.146(c)(2), which was contained in OSHA inspection #307532796, Citation 1, Item 3a, issued on 10/18/2004. Final order date was 8/22/05.

The Secretary proposed a penalty of $17,500 for this repeat violation.

As noted in Health Citation #1, Item 3 the mixer drums, silos and bag houses were permit-required confined spaces. Therefore, respondent was required to inform its employees, through signs or "any other equally effective means" of the location and of the danger posed by the permit spaces. The CO testified that he observed no signs or other method informing employees that the silos and drums were permit-required confined spaces or of the associated hazards. (Tr. 288). This was corroborated by ***{redacted}***, who testified that neither the mixer drums nor bag houses had signs saying that they were confined spaces. (Tr. 946-947).

Respondent argues that it provided an "equally effective means" of informing employees. It contends that ***{redacted}*** testified that he knew that the bag house, dust collector bag house, aggregate bin, and drums were confined spaces. (Tr. 946). He also received training on confined space and mixer drum cleaning. (Ex. R-1, p.1). Indeed, numerous other Cranesville employees received this training. (Exs. H-6, S-1, S-2).

Respondent also contends that the only evidence that an employee entered a confined space within the six months of the citation was the CO's testimony that he was told that an employee entered the aggregate silo on September 5, 2007. (Tr. 605). It contends that this statement made to the CO was inadmissible hearsay. Therefore, it argues that except for ***{redacted}*** entry into the mixer drum to facilitate the inspection,

there is no direct evidence that any employee entered a confined space within six months of the issuance of the citation and, therefore, that the item is barred by the six month statute of limitation of section 9(c) of the Act.

I find no merit in respondent's arguments. First, I find that the intent of the standard is to require some sort of physical warning of the presence of confined spaces and its hazards. However, assuming, arguendo, that adequate employee training is sufficient to satisfy the standard, the record fails to demonstrate that employees at Teall were effectively trained. Respondent argues that the statement of the unnamed employee that he did not receive training is inadmissible hearsay. As discussed, *supra*, statements made to a CO by an employee during the course of his or her employment are not hearsay.

At most, that the allegation was made by an unnamed employee goes to the weight of the evidence, not its admissibility. In any event there is substantial evidence that Cranesville's confined space training at Teall was deficient. The CO testified that safety director Mosher told him that ***{redacted}*** was not given confined space training. (Tr. 272). This was confirmed by Mosher. (Tr. 772). Moreover, driver ***{redacted}*** testified that he did not view the tape that constituted confined space training. (Tr. 495). Indeed, when asked what constituted a confined space he could answer only "It's got to be an enclosure of some sort." (Tr. 493). Indeed, the only training ***{redacted}*** could recall was being told that he shouldn't go into a space that says it's a confined space. (Tr. 493-

494). As noted, however, there were no signs identifying the relevant locations as confined spaces.[31]

Second, there is no merit to respondent's argument that the item is barred by section 9(c) of the Act. Respondent's argument presupposes that the signs are required only when an employee enters a confined space. However, a reading of the plain words of the standard makes it clear that it applies whenever employees work in an area that contains permit-required confined spaces. The purpose of the standard is to warn unauthorized employees that a space is permit-required, not to be entered, and the hazards associated with such entry. Nothing in the standard suggests that it applies only to employees who have actually entered such spaces.[32] Furthermore, the evidence establishes that employees were required to perform routine maintenance and repairs in the confined spaces. As a result, an employee could be required to enter a confined space at any time. Respondent has an obligation to provide the required signs before an employee might be required to enter a confined space.

Accordingly, the violation is affirmed.

The Secretary characterized the violation as repeated. The company was previously cited for a violation of the identical standard on October 18, 2004. The citation became a final order on August 22, 2005. (Ex. S-8, pp. 33-34). Again, respondent's contention that the violation should not be classified as repeated because it was issued at

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[31] **{redacted}** also testified that there was a sign by the hot water boiler that stated "Do not enter." (Tr. 494). That sign did not identify the boiler as a confined space, nor advise employees of the hazards involved. Therefore, it failed to meet the requirements of the standard. In any event, there is no evidence that there were any relevant signs by the mixing drums, bag house, or silos.

[32] In any event, the record is clear that **{redacted}** and **{redacted}** regularly entered permit-required confined spaces. (*e.g.* Tr. 450, 504-506, 508, 510, 570-571).

a different facility under the jurisdiction of a different OSHA Area Office is without merit.

On the record, I find that this violation was properly characterized as repeated.

The Secretary proposes a penalty of $17,500 for this repeated violation. The CO testified that the violation exposed employees to the hazard of engulfment in the silos and to the hazard of entrapment, slipping and falling in the mixer drums. These hazards were exacerbated if an employee should fall onto the mixer drum blades. (Tr. 289-290). The CO did not consider that these hazards posed life threatening injuries. (Tr. 290). Based on these factors, the violation was characterized as of medium severity, but with a greater probability of injury due to the frequency with which employees entered the spaces. (Tr. 290). I find that the proposed penalty properly considered the relevant statutory criteria and the proposed penalty is assessed.

ORDER

Based upon the foregoing findings of fact and conclusions of law, it is ORDERED that in Docket No. 08-0317 (Safety Citation):

(1) Citation 1, item 1 alleging a serious violation of the General Duty Clause, Section 5(a)(1) of the Act, is AFFIRMED and a penalty of $2500 is ASSESSED;

(2) Citation 1, item 2a alleging a serious violation of 29 CFR §1910.24(e) and item 2b alleging a serious violation of 29 CFR §1910.24(h) are AFFIRMED and a combined penalty of $1000 is ASSESSED;

(3) Citation 2, item 1, alleging a Repeated violation of 29 CFR §1910,147(c)(4)(ii) is AFFIRMED and a penalty of $15,000 is ASSESSED.

It is further ORDERED that in Docket No. 08-0316 (Health Citation):

(1) Citation 1, item 1, alleging a willful or in the alternative, a repeated violation of 29 CFR §1910.95(c)(1) is AFFIRMED as willful and a penalty of $55,000 is ASSESSED;

(2) Citation 1, item 2a, alleging a willful violation of 29 CFR §1910.134(a) and item 2b, alleging a serious violation of 29 CFR §1910.134(k) are AFFIRMED and a combined penalty of $35,000 is ASSESSED;

(3) Citation 1, item 3, alleging a serious violation of 29 CFR §1910.146(g)(1) is AFFIRMED and a penalty of $3500 is ASSESSED;

(4) Citation 1, item 4a, alleging a serious violation of 29 CFR §1910.146(k)(2)(iv) and item 4b, alleging a serious violation of 29 CFR §1910.146(k)(3)(ii) are AFFIRMED and a combined penalty of $2500 is ASSESSED;

(5) Citation 1, item 5a, alleging a serious violation of 29 CFR §1910.1000(a)(2), item 5b, alleging a serious violation of 29 CFR §1910.1000(c) and 5c, alleging a serious violation of 29 CFR §1910.1000(e) are AFFIRMED and a combined penalty of $5000 is ASSESSED;

(6) Citation 1, Item 6 alleging a serious violation of 29 CFR §1910.1200(h)(1) is AFFIRMED and a penalty of $5000 is ASSESSED;

(7) Citation 2, item 1a, alleging a repeat violation of 29 CFR §1910.134(e)(1) and item 1b, alleging a repeat violation of 29 CFR §1910.134(f)(2) are AFFIRMED and a penalty of $12,500 is ASSESSED;

(8) Citation 2, item 2, alleging a repeat violation of 29 CFR §1910.146(c)(2) is AFFIRMED and a penalty of $17,500 is ASSESSED.

SO ORDERED.

/s/
John H. Schumacher
U.S. OSHRC Judge

Dated: 9/13/10

Washington, D.C.