



United States of America
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
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SECRETARY OF LABOR
Complainant,
v.
VICTOR MICROWAVE INC.
Respondent.

OSHR DOCKET
NO. 94-3024

**NOTICE OF DOCKETING
OF ADMINISTRATIVE LAW JUDGE'S DECISION**

The Administrative Law Judge's Report in the above referenced case was docketed with the Commission on May 16, 1996. The decision of the Judge will become a final order of the Commission on June 17, 1996 unless a Commission member directs review of the decision on or before that date. **ANY PARTY DESIRING REVIEW OF THE JUDGE'S DECISION BY THE COMMISSION MUST FILE A PETITION FOR DISCRETIONARY REVIEW.** Any such petition should be received by the Executive Secretary on or before June 5, 1996 in order to permit sufficient time for its review. See Commission Rule 91, 29 C.F.R. 2200.91.

All further pleadings or communications regarding this case shall be addressed to:

Executive Secretary
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Petitioning parties shall also mail a copy to:

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If a Direction for Review is issued by the Commission, then the Counsel for Regional Trial Litigation will represent the Department of Labor. Any party having questions about review rights may contact the Commission's Executive Secretary or call (202) 606-5400.

FOR THE COMMISSION

Ray H. Darling, Jr. /SKA

Ray H. Darling, Jr.
Executive Secretary

Date: May 16, 1996

DOCKET NO. 94-3024

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SECRETARY OF LABOR,
 Complainant,

v.

VICTOR MICROWAVE, INC.,
 Respondent.

OSHRC Docket No.: 94-3024

Appearances:

David Baskin, Esquire
 Office of the Solicitor
 U. S. Department of Labor
 Boston, Massachusetts
 For Complainant

Barrett A. Metzler, CSP
 Northeast Safety Management
 West Hartford, Connecticut
 For Respondent

Before: Administrative Law Judge Nancy J. Spies

DECISION AND ORDER

Victor Microwave, Inc. (Victor), is a small Massachusetts corporation which assembles and manufactures military components for the United States Army. On March 23, 1994, as a result of an industrial accident at Victor, an "acid cloud" engulfed employees, causing them to evacuate the premises. Two of Victor's workers were hospitalized (Tr. 32, 117). Industrial Hygienists Francis Pagliuca and Mary Hoye of the Occupational Safety and Health Administration (OSHA) investigated the incident from March 23 through June 16, 1994. Pagliuca responded to the original incident, beginning his investigation the afternoon of the accident (Tr. 403). Hoye continued the inspection, returning to Victor on several subsequent dates. On September 12, 1994, the Secretary issued Victor a serious (32 items), a willful (1 item), and an "other" (5 items) citation. Victor contested all asserted violations. Of particular dispute between the parties was whether the "emergency response"

standard of § 1910.120 applied to Victor's operation and whether an alleged violation of the hazard communication standard was willful.

Victor is owned and operated by Stephen and Robert Parks, father and son. It has been in business since 1969 (Exh. R-4). Victor partially occupies a building it owns in Wakefield, Massachusetts. It rents out a portion of the building to an unrelated company, Raytheon. Because of financial reversals the company began downsizing in November 1993. Victor decreased its shared space. Over the months of January and February, 1994, it moved a part of its business operation into the building's basement, where the incident occurred (Tr. 466). Employees performed varied duties at Victor, including machining, cleaning, and soldering parts to military specifications (Tr. 137-148). Long-term employees, James Amaral, his brother John (Jack) Amaral, and Michael Metheny testified at the hearing, as did both of the Parks.

Voluntariness of Inspection

When Pagliuca arrived at the facility after the incident, only owner Stephen Parks remained on the premises. Victor questions the voluntariness of the inspection in its brief but did not properly raise the issue in the pleadings. Stephen Parks alleges Pagliuca was allowed to inspect only because he agreed OSHA would not fine Victor (Tr. 456-457). Even if properly raised, the facts do not support the contention. Not only does Pagliuca specifically deny having made the statement, but OSHA's inspectors do not have authority or responsibility to determine whether or not an employer is fined (Tr. 311, 405). Pagliuca's participation in the inspection followed accepted procedures. His conduct was not overreaching. Pagliuca's testimony was precise and specific. Stephen Parks' testimony concerning the eventful day, which included his contact with several different agencies and the media, appeared somewhat confused. Victor has presented no credible evidence that entry was in any way coerced. *See Sanders Lead Co.*, 15 BNA OSHC 1640, 1648-49 (No. 87-260, 1992). The inspection was valid.

Serious Citation 1

Item 1: § 1910.22(a)(1)--Housekeeping

The Secretary asserts that Victor violated § 1910.22(a)(1) because one piece of aluminum stock, which Pagliuca almost tripped over during his walkaround, was lying in an aisleway of the basement work area (Exh. C-11; Tr. 407). The standard provides:

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

To establish a violation of a specific standard, the Secretary must prove that (1) the cited standard applies, (2) its terms were not met, (3) employees had access to the condition, and (4) the employer knew or could have known of it with the exercise of reasonable diligence. *Seibel Modern Manufacturing & Welding Corp.*, 15 BNA OSHC 1218 (No. 88-821, 1991).

Relying on the Secretary's photograph, Victor defends against the violation by arguing that the stock was lying against a column and out of the way of travel (Tr. 414). The photograph does not establish the distance between the column and the stock or how far it might protrude into the aisleway. In any event, the testimony of Pagliuca, a trained investigator with a specific memory of the location of the stock, is credited (Tr. 406-407). The stock was in a passageway. Nevertheless, a violation cannot be found. Before allowing the OSHA inspection, Stephen Parks explained to Pagliuca that the plant was in "one terrible state" since employees hurriedly evacuated and returned to the building only to shut off machines (456). In the chaos of the employees' evacuation from their work areas, many items were left at workstations or displaced, including Victor argues, the piece of stock in the passageway. For example, as James Amaral describes (Tr. 28):

And there was a cutoff saw there where Ralph had been working. And there was a piece of stock hanging out of it that he was cutting for these parts that I was working on. And as I was exiting, I caught that part in my stomach, which kind of knocked a little wind out of me. And I got away from that and went around it. And there was oil on the floor. . . .

Under the circumstances of the rapid evacuation and work stoppage, it is determined that Victor did not have knowledge of the "housekeeping" violation. The violation is vacated.

Item 2: § 1910.36(b)(6)

The Secretary alleges that exits from the basement work area were not properly lighted in violation of § 1910.36(b)(6). The standard provides:

(6) In every building or structure equipped for artificial illumination, adequate and reliable illumination shall be provided for all exit facilities.

Victor had no automatic or emergency lighting system (Tr. 194). Reliable illumination is required to direct employees to an exit during a power outage. Lighting for exit signs is especially important

for those working in a windowless area, such as Victor's basement. Victor speculates, but does not prove, that natural light could filter into the basement from a first floor interior door. Even assuming there was a pane in the door leading into the basement, the quantity and dependability of the natural light was neither reliable nor adequate to illuminate an exit. The violation is affirmed. Escape from fire, smoke, or chemical fumes is impeded without lights to direct employees to an exit. Severe burns, smoke inhalation or death may result. The violation is properly characterized as serious.

The Commission is the final arbiter of penalties in all contested cases. *Hern Iron Works, Inc.*, 16 BNA OSHC 1619, 1621-23, (No. 88-1962, 1994). It must give "due consideration" to the size of the employer's business, the gravity of the violation, the good faith of the employer, and the history of previous violations in determining the appropriate penalty. *J.A. Jones Constr. Co.*, 15 BNA OSHC 2201, 2213-14 (No. 87-2059, 1993). These factors are not necessarily accorded equal weight. The gravity of the violation is the primary element in the penalty assessment. *Trinity Indus.*, 15 BNA OSHC 1481, 1483 (No. 88-691, 1992).

Hoye described her recommended penalty assessments as having been calculated "exactly as the FOM [field operations manual] specified" and "much like a cookbook"(Tr. 311). Although the Secretary calculates uniform penalties that assign certain percentage discounts to statutory factors, such as size, that formula is not binding on the Commission. *Roberts Pipeline Const. Inc.*, 16 BNA OSHC 2029 (No. 91-2051, 1994). In determining the assessed penalties for this and the other affirmed violations in this case, we give a greater reduction than the Secretary recommended in some instances. Specifically weighed is the fact that many of the violations, although not duplicative, result from a single circumstance and are interrelated. Also, the small size of the company is afforded greater consideration and lowers the resulting penalty for this and other violations.

Victor employs 15 persons, including the Parks (Tr. 485). OSHA had previously contacted Victor by telephone, but it had conducted no inspection and Victor had no previous history of violation. Weighing against a finding of good faith is Victor's failure to have a safety program, safety meetings or safety training for its employees (Exh. C-8, C-9; Tr. 137, 141, 171). As discussed more fully *infra*, Victor's truthfulness in dealing with safety concerns is questionable. It cooperated with the inspection, however, and attempted early abatement. Three or more employees were

exposed to the specific hazard in the basement. The duration of exposure ranged from all day to shorter periods when other employees' duties took them there (Tr. 119, 157). There was no effective precaution taken against injury caused by the hazard. The type of chemicals used and the conditions of use made it more probable that an accident would occur. See *Caterpillar* 15 BNA OSHC 2153, 2178 (No. 87-0922, 1993). Considering these factors, a penalty of \$1,000 is assessed for failure to have emergency lighting.

Item 3: § 1910.36(b)(8)

The Secretary asserts a violation of § 1910.36(b)(8), alleging that Victor failed to have two appropriate means of egress in the basement work area. The standard provides:

(8) Every building or structure, section, or area thereof of such size, occupancy, and arrangement that the reasonable safety of numbers of occupants may be endangered by the blocking of any single means of egress due to fire or smoke, shall have at least two means of egress remote from each other, so arranged as to minimize any possibility that both may be blocked by any one fire or other emergency conditions.

The standard speaks to "the reasonable safety of numbers of occupants." It does not mandate two exits. It requires only that a second exit be available when a reasonable person informed in safety would recognize that one means of egress was insufficient. *Conagra Inc., d/b/a Conagra-Westfeeds*, 14 BNA OSHC 1771, 1774 (No. 89-0017, 1990) (ALJ). The location, size, and configuration of the work area, as well as the specific work being performed and materials used, bear on what is reasonable in a particular case.

Employees cannot escape if the only means of egress is blocked by fire or fumes. Egress may be blocked at either the inside or the outside access points. Victor's staircase out of the basement had three steps which ended at a landing. From opposite ends of that landing, the staircase split as it led upward. One set of stairs exited to the outside of the building. The other set led into the interior of the first floor (Exh. C-6; Tr. 195). Initially, it is determined that this divided stairway does not constitute two exits "remote from each other." While the split staircase obviates the hazard created when one of two outside exits is blocked, the configuration does nothing to lessen the hazard should the stairway be blocked at the basement floor. Victor had one means of egress within the meaning of the standard.

Was one means of egress reasonable? The basement work room was small, approximately 30 feet by 25 feet (Tr. 106). It was windowless and crowded. In the basement some employees cut rods, some dipped rods, and others welded, all at the same time and almost back-to-back. Additionally, a certain amount of spray painting, grinding, and other tasks were performed in the basement. Three employees were assigned to work in the area. Other employees also regularly worked there (Exh. C-6; Tr. 157). The small size of the space and number of workers might militate towards the reasonableness of one exit. However, given the volatility of the materials used and their location in reference to the exit, the small size and crowded conditions aggravated the hazard. Weighing the probability of fire, fumes, or other emergency conditions, a person informed in safety would recognize that two exits were reasonable and necessary. The anticipated injury to an employee who could not exit during an emergency would be burns, asphyxiation, or other serious injury. The violation is affirmed as serious. The assessed penalty is discussed with that for item 4.

Item 4: § 1910.37(f)(5)

The Secretary asserts that the basement stairway exited by an area of high hazard in violation of § 1910.37(f)(5). The standard requires:

(5) Exit access shall be so arranged that it will not be necessary to travel toward any area of high hazard occupancy in order to reach the nearest exit, unless the path of travel is effectively shielded from the high hazard location by suitable partitions or other physical barriers.

The Secretary characterizes the path to the basement exit as “high hazard” because of the chemicals used there (Tr. 196). He also bases the violation on the fact that oxygen and acetylene tanks were kept together in a shed near the place where one arm of the split stairway exited outside.¹

Without stating a source, the Secretary would define “high hazard” as “any operation that could produce a flammability or explosion hazard . . . or poisonous fumes,” if the amount of the substance or its potential effect was more than “incidental” (Tr. 196, 324-326). Victor argues that the term “high hazard occupancy” should be defined as “high-hazard content” in § 1910.35(f), and that if it is, the Secretary failed to establish the portion of the .35(f) definition relating to “fire.” The

¹ At hearing the Secretary argued that the spray paint operation constituted a basis for the violation. This allegation is beyond the complaint and is not considered.

terms are not identical. Moreover, the standard is written in the disjunctive. It is unnecessary to prove each alternate element. Even if “high-hazard content” were the applicable definition, it would be met. Viewing the definition in the context of this standard, if it is reasonably anticipated that an accessway or exit may become blocked because of inherent conditions there, the conditions create a “high hazard occupancy.”

The pickle and bright dip operations were located behind the basement stairway (Exh. C-6; Tr. 197). Pickle does not present the type of hazard which would block an exit. Its material safety data sheet (MSDS) describes a danger from absorption into or contact with the body (Tr. C-1). Bright dip, on the other hand, may cause a fire or emission of gases, especially where there is wood. Victor’s bright dip operation was performed in a wood-based sink. Nitric acid is considered an unstable acid, which “reacts vigorously” with substances (Exh. C-5):

[and] increases the flammability of, and can ignite many organic materials such as wood, solvents, etc., and can release toxic oxides of nitrogen. Spillage may cause fire.

Victor argues that the sink did not have to be approached in order to exit the basement. This is incorrect. A fire, explosion, or emission from the sink would easily affect the stairs (Exh. C-6). In fact, James Amaral avoided a direct route to the exit because of the emission occurring at the sink (Tr. 27). Likewise, Victor kept acetylene and oxygen cylinders near the outside exit of the split stairway. These gases, if combined, could result in a fire and could block that portion of the exit (Tr. 198). In both instances, employees would be required to reach exits by traveling toward areas of high hazard occupancy. A delay in exiting from a fire or emission or an inability to exit could result in serious injury or death.

Penalty: The penalties for items 3 and 4 are considered together. The gravity is enhanced by convergence of two conditions. Having a nitric acid solution near the only exit out of the basement is the primary consideration in both violations. Three or more employees were exposed to the potential danger of being trapped in the basement work area. The violation is affirmed as serious. A penalty of \$1,000 is assessed for item 3 and \$800 is assessed for item 4.

Item 5: § 1910.37(k)(1)

The Secretary asserts that one of the work room doors violated § 1910.37(k)(1). The standard specifies:

(1) Doors, stairs, ramps, passages, signs, and all other components of means of egress shall be of substantial, reliable construction and shall be built or installed in a workmanlike manner.

The door of a first-floor work room could not fully close and jammed against the frame. There was no striker or catch (Tr. 426). Its doorknob had been removed, according to Stephen Parks, because "people would bump it on their way by" (Tr. 461). When employees in the machine shop became aware of the emission coming from the basement, they attempted to evacuate through the knobless door. As machinist Metheny explained (Tr. 151):

I reached the door first. I had to put three fingers through where the doorknob should have been, with my other hand, grabbed my wrist and pulled the door open, because it does not shut. It jams against the framework of that door.

The evidence establishes that either the door or its frame was constructed or installed in an unworkmanlike manner. The violation is affirmed. The short delay in opening the door, however, was not shown to result in serious injury. It is properly classified as nonserious. The gravity of the violation was increased because hazardous materials were used on site, increasing the potential that a quick exit could be needed. Of Victor's fifteen employees, three to four worked primarily in the basement. The others worked on the first floor. It is unknown how many of these used the jammed door or how often they used it. A penalty of \$300 is assessed.

Item 6: §1910.101(b)--CGAP P-1-1965, §3.4.4.

The parties dispute whether Victor's placement of gas cylinders in two instances violated § 1910.101(b). The standard provides:

(b) "Compressed gases." The in-plant handling, storage, and utilization of all compressed gases in cylinders, portable tanks, rail tankcars, or motor vehicle cargo tanks shall be in accordance with Compressed Gas Association Pamphlet P-1-1965 [CGAP].

The CGAP requires gas cylinders “in use” to be protected from falling. The anticipated hazard is that a valve on compressed gas cylinders may be damaged in a fall, causing the cylinder to become a projectile (Tr. 206, 329).

In both alleged instances the gas cylinders were “in use.” A nitrogen tank in the basement (instance a) had a hose attached. An oxygen and an acetylene cylinder in the shed (instance b) had lines attached which led into the brazing area. (Exh. C-4; Tr. 205- 207, 404). The nitrogen tank in the basement and the oxygen and acetylene cylinders in the shed were not tied or chained. The conditions were readily observable. As to instance a, the nitrogen cylinder in the basement stood next to an area where stock was being cut and where the cylinders could be knocked or hit and could fall (Tr. 329). In instance b however, the cylinders in the shed were placed close together and confined in the shed (Tr. 206, 334). Keeping the cylinders in the shed was the equivalent to placing them in a cage, an acknowledged means of protecting compressed gas cylinders from falling. Hoye’s opinion that these cylinders might be displaced if a car from an adjacent parking lot ran into the back of the shed is speculative (Tr. 333). Placement of the cylinders in instance a violated the standard. It did not in instance b since the intended hazard was avoided. If an employee were hit by a flying cylinder, broken bones would be the probable result. Instance a is affirmed as serious. Instance b is vacated. Based on the penalty factors discussed, including that three employees were exposed and only one instance was affirmed, a penalty of \$800 is assessed.

Items 7, 8 and 9: §§ 1910.107(c)(6);1910.107(c)(7);1910.107(d)(10)

The Secretary charges three violations related to Victor’s spray painting operation. He alleges that an uncovered junction box within 3 feet of the spray paint cabinet was not approved for its location, in violation of §1910.107(c)(6)² (item 7). He contends that Victor violated

² Section 1910.107(c (6) provides:

“*Wiring type approved.*” Electrical wiring and equipment not subject to deposits of combustible residues but located in a *spraying area* as herein defined shall be of explosion-proof type Electrical wiring, motors, and other equipment outside of but within twenty (20) feet of any *spraying area*,... shall not produce sparks under normal operating conditions and shall otherwise conform to the provisions of subpart S....(emphasis added)

§ 1910.107(c)(7)³ (item 8) by failing to totally enclose an electric fluorescent lamp located outside the spray booth. He also charges that the exhaust system for Victor's spray painting booth had no access doors to permit overspray to be cleaned, in violation of §1910.107(d)(10)⁴ (item 9).

Initially, the parties dispute the type of paint which Victor used in its operation. When Hoye asked Robert Parks to provide MSDS "for the paint that was sprayed in the basement," Parks provided the MSDS for Carc (Tr. 327). Employees also understood that Carc was used to "touch up" the components (Tr. 75). Victor disputes this, relying on the following testimony (Tr. 427):

- Q. Could you explain what [Carc] is?
A. It's supposed to be the Army's new anti-chemical warfare paint.
Q. And what kind of paint is that?
A. Epoxy.
Q. And can you spray epoxy?
A. No, you have to have special equipment, I understand.
Q. And did you have that equipment?
A. No.

The testimony was evasive and is insufficient to negate the Secretary's showing. The paint sprayed was Carc, and it was flammable (Tr. 336).

Victor next contends that regardless of the flammability of the paint, the requirements of the standard do not apply because Victor did not have a "spraying area" as that term is defined in § 1910.107(a)(2).⁵ The definition of "spraying area" applies as a limitation when found in specific provisions of the spray finishing requirements, such as §§ 1910.107(c)(6) and (7) (items 7 and 8). *Stan Best*, 11 BNA OSHC 1222, 1230 (No. 76-4355, 1983). For these standards the Secretary must

³Section 1910.097(c)(7) requires:

"Lamps." Electric lamps outside of, but within twenty (20) feet of any *spraying area*, and not separated therefrom by a partition, shall be totally enclosed to prevent the falling of hot particles and shall be protected from mechanical injury by suitable guards or by location (emphasis added).

⁴ Section 1910.107(d)(10) provides:

"Access doors." When necessary to facilitate cleaning, exhaust ducts shall be provided with an ample number of access doors.

⁵ Section 1910.107(a)(2) defines "spraying area" as "[a]ny area in which *dangerous quantities* of flammable vapors or mists, or combustible residues, dusts, or deposits are present due to the operation of spraying processes" (emphasis added).

show that Victor's operation involved a spraying area, *i.e.*, that its operation produced "dangerous quantities" of flammable substances. The Secretary has failed to make this showing.

Of the witnesses who testified on the issue, the Amaral brothers were the most knowledgeable. When Victor reduced the size of its business in late 1993, it attempted to set up a spray painting booth in the basement. It was only partially successful since it was unable to install an adequate exhaust system for it. The booth was used, however, by painter Mark Heath to "touch up" any defects when small "mousetrap" or other imperfections occurred during the manufacturing process (Tr. 76). Heath used a small air brush for this work (Tr. 19-20). The Secretary relies on the fact that employees smelled paint fumes. In light of the close configuration of the workstations, the fact that other employees smelled the fumes does not establish the quantity of paint sprayed (Tr. 57). Hoyer did not observe the painting operation. Her assumption that employees spray painted for the entire day was incorrect (Tr. 336). The majority of the painting was done off premises. Relying on *Fusibles Westinghouse de Puerto Rico, Inc.*, 658 F.2d 21, 24 (5th Cir. 1981), the Secretary argues that the mere fact that an employer used a spray painting booth creates a presumption that the operation produced dangerous quantities of mists, vapors, or dusts. Even if the presumption applied in these circumstances, it has been rebutted. The evidence discloses only incidental spray painting activities. The Secretary has failed to establish that there were "dangerous quantities" of flammable substances. Victor did not utilize a "spraying area." Items 7 and 8 are vacated.

By its terms, § 1910.107(d)(10) (item 9) does not refer to a "spraying area" or require proof of "dangerous quantities." The general scope provisions of § 1910.107(n) applies. The standard requires access doors in the exhaust system "when necessary." Although Victor had no access door to facilitate cleaning its exhaust system (Tr. 211), the Secretary did not address whether a door was "necessary" in these limited circumstances. Item 9 is vacated.

Emergency Response Standard Allegations

Background

Victor's employees worked with solutions of "pickle" (or Turco)⁶ and "bright dip." Pickle was used to clean the copper and brass component rods. To perform this operation the rods were

⁶ Pickle is a product of Turco Products, Inc. Witnesses also referred to pickle as "Turco."

submerged into the heated pickle solution. When the components appeared sufficiently clean, usually after an hour, they were removed from the pickle and rinsed. To give the components a bright or shiny finish, they were then placed into a plating solution called "bright dip" for between 5 to 30 seconds (depending on the strength of the mixture) (Tr. 16). When copper or brass (which contains copper) was introduced into the bright dip solution, a yellow-tinged smoke would often be released. This was especially true when the solution was newly mixed (Exh. R-2; Tr. 62-64).

On March 23, 1994, employee Ralph DeMonte mixed up a new batch of bright dip and took it down to James Amaral in the basement. Amarel had just finished cleaning a number of brass rods with pickle. After rinsing, he placed one or more rods into the new batch of bright dip solution. A dense cloud of orange smoke immediately rose from the solution, presumably caused by a chemical reaction between the bright dip and the rods (Tr. 25, 62-63). The emission came "like a blanket [and] within seconds, it had consumed the whole downstairs" (Tr. 134). The release contained large amounts of nitrogen dioxide gas⁷ (Tr. 255). The emission engulfed employees in the basement and soon rose to the upper floor and to the adjoining business. James Amaral described what occurred (Tr. 25-27):

It [the fumes] blew in my face and it was burning and I couldn't see . . . And when I opened my eyes, there was this big cloud of orange smoke everywhere. So I had just thought of how Steve had yelled at Mark about Ralph getting burnt with the bright dip, that I proceeded to try and grab the rods, feel for them, because there was a cloud and you couldn't see nothing.

And I started grabbing the rods and pulling them up. Some of them had gone into the tank of bright dip. And it was getting all over me and burning me. And my mind told me, "It's time to leave." . . . And my brother was also working downstairs and Ralph was at the cutoff [saw]. So I asked Ralph to get me a fan to help push the smoke out the door. And he took off. I never seen him again. And my brother took off and he said, "Just get out of there." And when my brother left, then I left behind him. But rather than go to my left, where the bright dip was, I went to my right to go around the station and then up the stairs. . . .

. . . And I slipped in the oil. And I knew I was going to fall, so I put my hands out to stop me. And when I hit the floor, I broke this wrist. . . . And I caught my chin on

⁷ Nitrogen dioxide can be liberated from nitric acid and copper.

the cement floor. And it kind of spun me out. I saw stars, I guess you could say. . . I just could not [get up].

James' brother John Amaral warned employees on the first floor of the fast-rising emission. He asked them to "tell the boss," leave the building, and call the fire department" (Tr. 120). John then realized James was not outside with the other employees. As John described the events (Tr. 122-123):

I didn't know for sure if he was there, but I didn't want to take the chance of wasting anymore time because I knew the cloud was so bad, it was so thick, it was going to the floor and then covering the ceiling. . . . I started looking around, but I really couldn't see him. I was feeling my way around trying to feel for him. And I kind of ran down towards the back of the machines and tripped. I tripped on his body. He was on the floor unconscious.

. . . .

I tried not to breath when I went into the cloud, when I first entered it. But when I jerked my brother up off the floor, I had to breath to get up the energy and strength to drag him out of there. And I got some of this cloud in me.

. . . .

As soon as I took a breath of the stuff in, my lungs basically stopped, froze right up. I couldn't breath. I felt like I was going to pass out and possibly wouldn't make it out the door with my brother. I thought we were both going to be right there. I though I was going to die.

Both men were in obvious distress after John finally brought James out of the building. Robert and Stephen Parks advised their employees that they "were handling the situation" (Tr. 153). Raytheon employees called the fire department.

At some time after employees evacuated, but before the fire department arrived, Robert and Stephen Parks donned plastic "garbage" bags to protect their clothing and re-entered the building. They individually made several short efforts to get to the basement, holding their breaths to avoid breathing in the nitrogen dioxide. One of them finally arrived at the basement, pulled the rods out of the 5 gallon bucket of bright dip, and carried the bucket outside of the building. Although the bright dip was still emitting vapor, the emission had lessened and was at the point that it could have been handled by the basement sink exhaust system (Tr. 222, 468).

Approximately 20 minutes after the incident, Michael Metheny also re-entered the building looking for the Parks. Metheny observed the Amarals gagging and unable to catch their breaths and

believed they needed immediate medical attention. Metheny had been told that the Parks did not want anyone to go to the hospital. He sought the Parks to gain permission to take them. Metheny was about half way down the basement stairs when he saw Stephen Parks. He told Parks that the Amarals needed to go to the hospital. Parks directed his son to have them taken (Tr. 154, 173, 174). The cloud had cleared, but Metheny was not comfortable about being inside the building (173). Later, the fire department arrived and ventilated the building with large exhaust fans (Tr. 467).

Other employees took the Amarals, DeMonte and Mark Heath to a hospital where they were initially treated as if the exposure was to nitrous oxide (laughing gas) rather than nitrogen dioxide. Robert Parks provided the MSDS for nitric acid (Tr. 32, 136). Two workers from Raytheon were lying on stretchers while the Amarals were at the hospital (Tr. 32-33). James Amaral was also treated for a broken wrist. As of the date of the hearing, neither James nor John Amaral had returned to work. They described continued ill effects from the nitrogen dioxide exposure (Tr. 36-39, 129-138).

Coverage Under The standard

Subpart 1910.120 applies to “hazardous waste operations and emergency response.” Victor may arguably be covered only through § 1910.120(a)(1)(iv) of this standard. If it is, it must comply with § (q) (see § 1910.120(2)(iv)). Section 1910.120(a)(1)(iv) covers the following operations:

- (v) Emergency response operations for releases of, or substantial threats of releases of, hazardous substances without regard to the location of the hazard.

Section 1910.120(3) defines “emergency response corresponding to emergencies” as:

[A] response effort by employees from outside the immediate release area or by other designated responders (*i.e.*, mutual-aid groups, local fire departments, etc.) to an occurrence which results, or is likely to result, in an uncontrolled release of a hazardous substance.

Both definitions apply to a release of a “hazardous substance(s).” By weight, pickle contains 55 percent phosphoric acid (Exh. C-1). Bright dip is a solution of nitric acid, sulfuric acid, and water. Official notice is taken that Victor’s employees regularly used chemicals which are defined as “hazardous substances” by § 1910.120(3), *i.e.*, they are included as hazardous materials under

49 CFR 172.101. Nitrogen dioxide, which was released in large quantities on March 23, is also a “hazardous substance” under § 1910.120(3).

Not every employer which works with hazardous substances has reason to anticipate an emergency release. Victor, however, worked with large quantities of nitric acid solution, which if combined with other substances used in Victor’s processes, such as copper, could result in an emergency release (Tr. 213, 308-309, 324).

In addition to proving that there was the release of a hazardous substance, there is no coverage unless there is also an “emergency response” (or “response effort”) by employees to the release. The Secretary asserts that there were three separate responses to the release: (1) the employees, especially James Amaral, initially attempted to contain the release rather than evacuating; (2) John Amaral rescued his brother; and (3) both Stephen and Robert Parks returned to the release area to bring out the source of the emission.

The first allegation, James Amaral’s attempt to contain the emission, was not “from outside the immediate release area,” as the standard specifies, but took place at the actual release site. Based on OSHA’s subsequent clarification, John Amaral’s valiant rescue of James likewise does not constitute an emergency response.⁸ Only the Parks’ re-entry into the building to remove the emission source arguably falls within the definition of a “response.” Without question, the Parks are “employees” of Victor, regardless of their ownership interest. The Parks, who were outside the release area, returned to it to remove and to contain the source of the emission. When they re-entered the building, the hazardous emission was ongoing, although lessening. The Secretary has

⁸ OSHA’s interpretive rule regarding “voluntary employee rescue,” § 1903.14(f), became effective on December 27, 1994. Although post-dating the citation, the statement of policy clarifies that:

It is not OSHA’s policy. . . to regulate every decision by a worker to place himself at risk to save another individual. Nor is it OSHA’s policy to issue citations to employers whose employees voluntarily undertake acts of heroism to save another individual from imminent harm, [except in specifically stated circumstances]. FR Doc 94-31625.

Amaral’s rescue does not fall within one of these exceptions, even that of § 1903.14(f)(3), because John Amaral’s assigned duties were not “directly related” to the workplace operation where a life-threatening accident was foreseeable.

made a prima facie showing for coverage under the “emergency response” standard for this third alleged instance.⁹

Defenses to Emergency Response Allegations

(1) *Validity of the standard.* Victor argues that specific language in the standard is misleading and, generally, that the standard is “torturous,” confusing, and unenforceably vague.

Victor specifically challenges the validity of the standard arguing that the phrase “or *other designated* responders (*i.e.*, mutual-aid groups, local fire departments, etc.)” (emphasis added) in the definition of “emergency response” misleads an employer into believing that it has no responsibility *unless* it designates an employee to respond to emergencies. It is a well-established principle of statutory construction that the words of a standard are viewed “in context, not in isolation.” *Georgia Pacific*, 16 BNA OSHC 1171, 1174 (No 89-2806, 1993). “Other designated responders” is followed by specific examples, thus removing potential ambiguity. Contrary to Victor’s argument, a reasonable reading of the standard provides sufficient notice to the employer of what is required of it.

The more general challenge is also rejected. By necessity, some standards must be broadly worded. A standard is not impermissibly vague simply because it is broad in nature. “External, objective criteria, including the knowledge and perceptions of a reasonable person, may be used to give [the standard] meaning” *J.A. Jones*, 15 BNA OSHC 2200, 2205-2206 (No. 87-2059, 1993).

(2) *Victor’s Knowledge.* Victor used large quantities of nitric acid solution. The solution was understood to “react vigorously” with specified substances (Exh. C-5). Stephen Parks had a background in chemical engineering and long experience in the nitric acid process (Tr. 441). He considered the solution to be “very hazardous” (Tr. 450). On a smaller scale, the chemical reaction between bright dip and the copper or brass rods was common knowledge. Employees who observed the bright dip process often saw a “puff of smoke,” a “haze,” or yellow vapor (Tr. 64-65, 165). Employees on the first floor smelled the vapors and experienced a burning sensation from breathing fumes when the bright dip and pickle operations were ongoing. Michael Metheny, the machinist,

⁹ The Secretary argues that all three instances form a basis for the specifically alleged violations of the emergency response standard discussed *infra*. Unless stated otherwise, the allegations which relate to either James Amaral’s attempted containment or John Amaral’s rescue are dismissed.

complained to Robert Parks about the fumes. Parks stated that a friend who was in heating and air conditioning would see to it, but nothing had been done (Tr. 165). Victor had no real controls for the procedure. Untrained individuals were permitted to mix the solutions, and untrained employees used the solutions (Exh. C-8, Tr. 17, 47). Conditions existed for a hazardous substance release and for the occurrence of March 23, 1994. A reasonably prudent employer would have recognized this fact. Victor's knowledge informed the terms of the general standard. These facts also bear upon whether Victor knew or should have known of the conditions which constitute the emergency response allegations (items 10 - 16) for which the Secretary has the burden of proof.

Victor disputes knowledge relying on its theory that James Amaral caused the release. It speculates that Amaral added too many rods to the solution. Thus, Victor contends that the emission was unforeseeable. Amaral testified that he did not place more rods than usual into the solution. He thought additional rods may have fallen into the bucket as he attempted to control the emission (Tr. 70-71, 108). In any event, both parties theorized about the cause of the incident. For example, the Secretary suggested the emission may have resulted from having less water in the solution or a greater quantity in the pail (Tr. 309, 376). Neither party actually attempted to prove the theory. The anticipated hazard is the primary focus, not the immediate cause of the incident. If placement of additional rods in the solution yielded such an extreme reaction, the volatility of the chemicals is underscored.

(3) *Employee misconduct.* Victor also characterizes its foreseeability argument as an "employee misconduct" defense. Establishing an employee misconduct defense requires specific proof of, among other things, the existence of a work rule designed to prevent the violative conduct. *Falcon Steel Co.*, 16 NA OSHC 1179, 1193 (No. 89-3444, 1993). Victor argues that it had an oral work rule which would have prevented Amaral from placing too many rods into the solution. James Amaral was not aware Victor had restrictions on the number of rods to be placed in the bright dip solution. He himself made that determination based upon such factors as the job to be done, or the age, strength or the heat of the solution. He had substantial discretion in performing the job (Tr. 50-51, 63, 70-71, 108). Victor has not proven the existence of even an oral work rule covering the subject. Further, the conduct which precipitated OSHA's citation was that the Parks re-entered the site to control the release. Victor had no workrule directed at this conduct.

(4) *The Chemical Composition.* Finally, Victor argues in its brief that the bright dip solution was not purely nitric acid but a “much weaker solution.” Although the Secretary sought the MSDS for bright dip during the investigation and discovery, Victor did not provide it. The Secretary did not know that an MSDS for bright dip existed. Victor provided only the MSDS for nitric acid. At the hearing, Stephen Parks testified to the exact composition of the bright dip, referring to its MSDS. Bright dip is purchased from the manufacturer as 54 percent sulfuric acid, 22 percent nitric acid and 24 percent water (Tr. 445-446). Victor diluted the mixture with water by “approximately 20 percent to 30 percent” by volume (Tr. 446). As illustrated, the Secretary was unaware of the existence of a MSDS for the exact composition of the solution (Tr. 452):

Mr. Metzler: Would you go through the procedure that you wrote?

S. Parks: The first advice is to proper protective equipment, gloves, face shield, goggles, shop coat, plastic apron and to read the bright dip MSDS, then to clean the stainless steel container and cover it thoroughly.

Mr. Baskins: Excuse me. I’m sorry to interrupt you. You said the “bright dip MSDS.” Is that the nitric acid?

S. Parks: No, that’s a different one. It just says “bright dip MSDS.”

Mr. Baskins: Bright dip MSDS or bright dip preparation sheet?

S. Parks: No. This is a bright dip MSDS and this is a bright dip preparation or standard operating and mixing procedure.

* * *

Mr. Baskins: Excuse me, Mr. Parks. (Reviewing documents) I’ve never gotten a copy of the document I have in my hand, Your Honor, unless it’s exactly identical to ...---Apparently, no. It certainly isn’t. It’s absolutely not identical to C-1 [*sic*]. So this is not a document that was given to me at the deposition.

Mr. Metzler: Your Honor, I don’t want to introduce that document.

Victor did not seek to introduce the MSDS for bright dip and did not object to introduction of the MSDS for nitric acid. Victor now claims that the Secretary must show that nitric acid produces the same effects when mixed with sulfuric acid and water. While it is accepted that bright dip contains the two acids and water, it is unfair to penalize a party because it failed to present

evidence of a fact the other party prevented it from knowing. Moreover, as Stephan Parks testified, acids react more readily in solution than would straight nitric acid (Tr. 450). Regardless of the exact composition of the solution, employees unquestionably were exposed to significant and dangerous amounts of the nitrogen dioxide when gas was liberated on March 23. The argument has no effect on the decision.

Victor's defenses are rejected. It is subject to requirements of § 1910.120(q).

Item 10: §1910.120(q)(1).

The Secretary asserts that Victor did not have an emergency response plan on how to proceed in case of an emergency. Victor primarily argues that under the terms of the standard it had no obligation to have the plan. The standard provides:

(1) Emergency response plan. An emergency response plan shall be developed and implemented to handle anticipated emergencies prior to the commencement of emergency response operations. The plan shall be in writing and available for inspection and copying by employees, their representatives, and OSHA personnel. Employers who will evacuate their employees from the danger area when an emergency occurs, and who do not permit any of their employees to assist in handling the emergency, are exempt from the requirements of this paragraph if they provide an emergency action plan complying with section 1910.38(a) of this part.

Employees Stephen and Robert Parks engaged in an emergency response. The standard permits an employee to have either an emergency response plan (when there is an emergency response) or a written emergency plan which complies with § 1910.38(a) (if employees will not assist with the emergency). Victor had neither (Tr. 219). Contrary to Victor's suggestion, reliance on the basic human instinct to flee danger is not a "plan." *See Pressure Concrete Constr. Co.*, 15 BNA OSHC 2011, (No. 90-2668, 1992). Failure to have the plan could result in serious injury or death. The violation is affirmed.

Items 11a & 11b: § 1910.120(q)(3)(ii)

Both items allege a violation of the same standard. The Secretary maintains Victor violated § 1910.120(q)(3)(ii) because it failed to perform necessary site monitoring to determine which hazardous substances were present (item 11a) and did not implement the appropriate responses based on substances which would have been found (item 11b). The standard provides:

(ii) The individual in charge of the ICS [incident command system] shall identify, to the extent possible, all hazardous substances or conditions present and shall address as appropriate site analysis, use of engineering controls, maximum exposure limits, hazardous substance handling procedures, and use of any new technologies.

On March 23, 1994, Victor made no attempt to determine what conditions existed before Stephen and Robert Parks conducted an emergency response. Specifically, they did not seek to identify the hazardous gases which were expected to be present. They made no effort to utilize engineering or other controls, such as ventilating the building. Neither did they use personal protective equipment to limit their exposure to the nitrogen dioxide (Tr. 222). The standard requires separate conduct: the first requirement is to identify the substances, and the second is to appropriately control the hazard. The requirements are not duplicative, although they are inter-related. The conduct could result in serious injury or death. Items 11a and 11b are affirmed as violations of the standard. The items were grouped, and one penalty was recommended for both.

Item 12: § 1910.120(q)(3)(iv).

The Secretary charges that employees did not use self-contained breathing apparatus (SCBA) in violation of § 1910.120(q)(3)(iv). The standard provides:

(iv) Employees engaged in emergency response and exposed to hazardous substances presenting an inhalation hazard or potential inhalation hazard shall wear positive pressure self-contained breathing apparatus [SCBA] while engaged in emergency response, until such time that the individual in charge of the ICS determines through the use of air monitoring that a decreased level of respiratory protection will not result in hazardous exposures to employees.

The permissible ceiling level for nitrogen dioxide is 5 parts per million. Employees were exposed to no less than 50 parts per million of nitrogen dioxide, ten times the permissible ceiling level (Tr. 225). The specific duration of this exposure is unknown. At the time that the Parks re-entered the building to engage in the emergency response, there was, at the very least, a “*potential inhalation hazard*.” No one monitored the air before the re-entry (Tr. 221). Use of self-contained breathing apparatus (SCBA) would have protected the Parks’ respiratory systems. Attempting to hold ones breath, as the Parks did when they made their short entries into the building and trying “not to take too many breaths” obviously does not constitute an alternate means of compliance (Tr. 221- 222). Severe respiratory injury is the probable result of exposure. The violation is affirmed as serious.

Items 13 & 14 : §§ 1910.120(q)(3)(v) and 1910.120(q)(3)(vi).

The Secretary asserts that when the Parks' re-entered the building, they should have complied with § 1910.120(q)(3)(v)¹⁰ by using a "buddy system." In addition to the buddy system, the Secretary alleges that the Parks should also have had back-up personnel as required by § 1910.120(q)(3)(vi).¹¹

The "buddy system" is defined in § 1910.120(a)(3) as:

a system of organizing employees into work groups in such a manner that each employee of the work group is designated to be *observed* by at least one other employee in the work group (emphasis added).

The only credited proof offered to support items 13 and 14 is an admission Hoye attributes to Robert Parks. Parks explained to Hoye that he and his father "took turns going down into the basement to secure the area" (Tr. 225). Although both the Parks testified, neither was asked to describe the method by which they re-entered the building. Working within the buddy system would require that someone be available to observe, and if necessary, to rescue the other. Minimally sufficient evidence may establish a prima facie case. *Cf. Falcon Steel Co., supra*, 16 BNA OSHC 1190-91 ("meager" testimony of compliance officer concerning practicality of fall protection sufficient to establish violation). When one of the Parks proceeded alone into the basement to contain the emission, he could not be visually observed by the other from outside the building. The basement area was "hazardous," at least until the emission source was removed. Just a short time earlier, the Amarals illustrated the serious consequences of failing to have an individual available for rescue. Item 13 is affirmed as serious.

¹⁰ Section 1910.120(q)(3)(v) provides:

(v) The individual in charge of the ICS shall limit the number of emergency response personnel at the emergency site, in those areas of potential or actual exposure to incident or site hazards, to those who are actively performing emergency operations. However, operations in hazardous areas shall be performed using the buddy system in groups of two or more.

¹¹ Section 1910.120(q)(3)(vi) requires:

(vi) Back-up personnel shall be standing by with equipment ready to provide assistance or rescue. Qualified basic life support personnel, as a minimum, shall also be standing by with medical equipment and transportation capability.

The same evidence is not sufficient to support item 14. The Secretary contends that the Parks should have had additional personnel ready for their rescue. Stephen and Robert Parks each served in this capacity for the other. Unlike item 13, it is not necessary that back-up personnel remain in visual contact. Robert Parks was within hearing range of Stephen, as illustrated by Metheny's description (Tr. 155):

At that point, [Stephen Parks] didn't say anything [to Metheny]. He looked up. He thought he was walking past the door to the outside. You can look to the outside from where I was standing also. And he yelled up to Bob to get someone to take them to the hospital.

The fact that the two "took turns" entering the building does not create a presumption of a violation of item 14. The Secretary did not address whether rescue equipment was available, and its absence will not be presumed. The Secretary failed in his burden of proof. Item 14 is vacated.

Item 15: § 1910.120(q)(3)(vii).

The Secretary alleges that the individual in charge of the incident command system (ICS) did not designate a safety officer as required by § 1910.120(q)(3)(vii). The standard provides:

(vii) The individual in charge of the ICS shall designate a safety officer, who is knowledgeable in the operations being implemented at the emergency response site, with specific responsibility to identify and evaluate hazards and to provide direction with respect to the safety of operations for the emergency at hand.

The Secretary cited a violation of this standard because employees were allegedly allowed to return to the building before the fire department gave the "all clear." His theory appears to be that a designated safety officer would have prohibited employees from entering into the building until there was proof that the hazardous emission was below 5 parts per million of nitrogen dioxide. Although no employees did, Stephen Parks advised them that they could return to work before the fire department arrived (Tr. 228-230). Two signed employee statements were introduced into the

record under on Rule 801(d)(2)(D), Fed.R.Civ.P, to support this conclusion.¹² Excerpted questions and answers are on point (Exhs. C-8 & 9):

Q: On the day of the accident, March 23, 1994, did either Steve Parks or Robert Parks tell you it was okay to go back into the building before the fire department arrived.

A 1: Yeah, he did. Steve did. (Ralph DeMonte)

A 2: Yes, they said go back to work we'll handle this outside. That's when I jumped in my truck and left. (Robert Onorato)

Q: Did you go back into the building? If yes, was there still an odor?

A 1: No. I went to the emergency room. Then I went home.

A 2: No I did not. Even the next morning it was bad. We were still gagging.

Stephen Parks, as the individual in charge, should have designated an appropriate safety officer to monitor the emergency response. Metheny and other employees sought to act on their safety concerns. None had authority. Metheny sought out Stephen Parks in a potentially hazardous area to get authorization to take employees to the hospital. A safety officer should have been available to determine, for example, when employees could safely re-enter the building or when an exposed employees needed to go to the hospital. The evidence sufficiently establishes the violation. Death or serious respiratory injury is the probable result of failing to designate an individual to emphasize safety during a chemical release response. The violation is affirmed as serious.

¹² On May 17, 1994, Ralph DeMonte (Exh. C-8) and Robert Onorato (Exh. C-9) signed and verified answers to the Secretary's questions. Above each signature was the acknowledgment that the employee had the opportunity to read and correct the statement, which was true and correct under penalty of law. Both the Secretary and Victor stated their desire to present employee testimony. However, neither party sought to subpoena (or to enforce subpoenas) in light of the employees' stated reluctance to testify. Weight is properly afforded to the statements which are consistent with other employee testimony.

Item 16a: § 1910.120(q)(6)(i)(A)

Items 16 a - d relate to training.

In item 16a, the Secretary asserts that employees who were “first responders at the awareness level” were not adequately trained or experienced, in violation of § 1910.120(q)(6)(i)(A).¹³ The standard defines responders at this level as individuals:

who are likely to witness or discover a hazardous substance release and who have been trained to initiate an emergency response sequence by notifying the proper authorities of the release.

The Secretary argues that James and John Amaral and Ralph DeMonte acted as first responders who should have been provided with information and training to allow them to recognize the potential for a release and to take appropriate action. James Amaral and DeMonte worked with substances which reasonably may have been expected to cause an uncontrolled release. Victor, however, never designated either to initiate an emergency response sequence. Thus, the definition of “first responder at the awareness level” is not met. The Secretary has failed to establish that the standard applies to the condition cited. Item 16a is vacated.

Item 16b: § 1910.120(q)(6)(iii)¹⁴

A related charge is that the Parks were not trained when they functioned in the role of hazardous materials technicians, as required by § 1910.120(q)(6)(iii). The standard requires:

(iii) Hazardous materials technicians are individuals who respond to releases or potential releases for the purpose of stopping the release. . . [and they] shall have at least 24 hours of training equal to the first responder operations level and in addition have competency in the following areas . . .

The Parks responded to the release “for the purpose of stopping [it].” The Secretary submits that the Parks’ actions during the release provide sufficient proof that they were not trained (Tr. 233). For example, the Parks failed to monitor to determine their expected chemical exposure. Their only protective equipment was garbage bags. The Parks met the definition of hazardous materials

¹³ Section 1910.120(q)(6)(i)(A) provides:

An understanding of what hazardous substances are, and the risks associated with them in an incident.

¹⁴ At hearing, the Secretary’s motion to correct a clerical error by removing “(A)” from the citation was granted (Tr. 268).

technicians. There is a prima facie showing that the Parks were not trained. Victor did not rebut the showing. The standard has been violated. Serious injury or death is the expected result of failing to train those who seek to stop the emission. The standard is affirmed as serious.

Alternative Items 16c and 16d: §§ 1910.120(q)(6)(v)(A) or 1910.120(q)(3)(i)

The Secretary asserts alternative violations of §§ 1910.120(q)(6)(v)(A)¹⁵ and 1910.120(q)(3)(i).¹⁶ Because they are alternative violations, they are more properly designated as alternative violations of 16c. Following the Secretary's designation, he asserts that either Stephen Parks acted as an incident commander without being appropriately trained (item 16c); or alternatively, he did not function as an incident commander and "there should have been an incident plan implemented" (item 16d) (Tr. 234). Although Stephen Parks was the senior member of management present, the Secretary did not prove that he acted as either the "on scene incident commander" (referred to in .120(q)(6)(v)(A)) or as a "response official" (described in .120(q)(3)). To establish a violation, as opposed to merely asserting one, the Secretary must prove that the definitional terms of the standard are met. As Hoye acknowledged, what the Secretary really contends here is that Victor should have had and followed "the incident plan." The Secretary has cited for this failure in item 10. Since the cited standard does not apply, item 16c/16d is vacated.

¹⁵ Section 1910.120 (q)(6)(v)(A) provides:

Know and be able to implement the employer's incident command system.

¹⁶ Section 1910.120 (q)(3) provides:

Procedures for handling emergency response. (i) The senior emergency response official responding to an emergency shall become the individual in charge of a site-specific Incident Command System (ICS). All emergency responders and their communications shall be coordinated and controlled through the individual in charge of the ICS assisted by the senior official present for each employer.

Note to (q)(3)(I). - The "senior official" at an emergency response is the most senior official on the site who has the responsibility for controlling the operations at the site. Initially it is the senior officer on the first-due piece of responding emergency apparatus to arrive on the incident scene. As more senior officers arrive (*i.e.*, battalion chief, fire chief, state law enforcement official, site coordinator, etc.) the position is passed up the line of authority which has been previously established.

Penalty for Emergency Response Violations

The statutory considerations of size, good faith and past history have been discussed at item 2. Of the emergency response violations alleged, items 10, 11, 12, 13, 15 and 16b were affirmed. Only one of the asserted instances (the Parks' re-entry) was covered under the standard. James Amaral's attempted containment and John Amaral's rescue, which were penalized by the Secretary as part of his penalty calculations, are excluded from the final penalty assessments.

Considerations of the gravity include the number of persons exposed and the degree of exposure. Exposure to excessive amounts of nitrogen dioxide is considered to be of the highest gravity, capable of causing delayed and severe adverse health effects. If inhaled in sufficient quantities, nitrogen dioxide can cause pulmonary edema or death (Tr. 190). The amount of the hazardous substances Victor worked with, together with the fact that its processes were dependent on a chemical reaction between the copper or brass rods and the bright dip, increased the probability of a release. When the release occurred, the Parks' primary concern appeared to be a desire to minimize the effects of the release on its business operation (Exh. C-8 & C-9). Nevertheless, in spite of this and the severity of the hazard, the amount of penalty is moderated. Failure to have an emergency response plan or a designated safety officer exposed all employees, although the Parks were the most directly affected. Other affirmed violations exposed only the Parks. As owners of Victor, they will ultimately be responsible for the assessed penalties.

Also, the violations of this standard are interrelated. For example, items 11a & b required an assessment of conditions, followed by proper use of personal protective equipment; item 12 involved failure to use personal protective equipment; and 15 again required that an assessment be made, this time by a safety officer. The Secretary tacitly recognized this point when in his post-hearing brief he treated all emergency response allegations as if they were one violation. Based upon these considerations, the following penalties are assessed: item 10, \$3,000; item 11a & b, \$1,700; item 12, \$1,100; item 13, \$1000, item 15, \$1,000; item 16b, \$700, or a total penalty of \$8,500 for items 10-13 and 15 - 16b.

Item 17: § 1910.132(a)

The Secretary asserts two instances in which Victor failed to use personal protective equipment, in violation of § 1910.132(a). The first is that Ralph DeMonte did not wear gloves

while working with Turco; and the second is that James Amaral and the Parks did not wear the equivalent of chemical suits to protect clothing and skin when they re-entered the building during the hazardous release. The standard provides:

(a) Application. Protective equipment, . . . for eyes, face, head, and extremities, . . . shall be provided, . . . wherever it is necessary by reason of hazards of processes or environment, chemical hazards, . . . encountered in a manner capable of causing injury or impairment in the function of any part of the body through absorption, inhalation or physical contact.

On March 30, 1994, Hoye returned to conduct air monitoring of Victor's pickle (Turco) cleaning procedure.¹⁷ Although he did not regularly clean the rods, Ralph DeMonte performed the pickle operation that day. DeMonte repeatedly dipped and retrieved the rods from the pail of pickle. The chemical solution contacted his hands and lower arms (Exh. C-6). DeMonte did not wear liquid-impervious gloves, aprons or other protective equipment. The pickle solution contains phosphoric acid and 2-butoxyethanol. Pickle's MSDS notes that overexposure to the solution results in "severe irritation, possible chemical burns, possible tissue damage" (Exh. C-1). Victor recognized the need for protective equipment. In fact, Victor's "daily use procedure" for pickle required "gloves and safety glass must be worn--apron should also be worn" (Exh R-3).¹⁸

Victor argues that DeMonte cleaned the rods as an accommodation to the Secretary. This does not diminish the existence of the violation. Victor often reassigned employees based on need and had them perform a variety of tasks (Tr. 24, 39, 108). Hoye asked to monitor Victor's pickle operation. Victor told her when the procedure was to be done (Tr. 400). There was nothing to suggest that DeMonte would not have cleaned the components with pickle in any event. Victor had responsibility to assure that protective equipment was worn, regardless of which employee was exposed. Victor's knowledge of the violation was heightened because it had been specifically advised on the day of the accident that DeMonte had not used protective equipment when he mixed bright dip (Tr. 23). The violation is affirmed for instance a.

¹⁷ After the incident of March 23rd, Victor suspended its bright dip operations (Tr. 238).

¹⁸As discussed *infra*, although the procedures may have post-dated the citation, they constitute evidence that Victor recognized the hazard.

Instance b of the citation alleges that John Amaral performed an emergency rescue and that the Parks performed an emergency response:

and did not wear full body protection (level B) including hooded chemical resistant coveralls and a face shield.”

The anticipated hazard is exposure of the skin and eyes to nitrogen dioxide. Since § 1910.132(a) is a general standard, in the absence of actual knowledge, the Secretary must show that a reasonable employer would anticipate the violative conditions. Based on Victor’s working procedures, it was foreseeable that nitrogen dioxide could be liberated during the bright dip procedure. The Secretary did not prove that nitrogen dioxide affects the skin and permeates clothing. The Secretary cited nine instances of violation of the emergency response standard, which is the specific standard which governs the cited conduct. Instance b is vacated. The penalty for instance a reflects that one employee, Ralph DeMonte, was allowed to have direct exposure to hazardous chemicals without wearing protective equipment. The pickle operation is estimated to have taken one hour (Tr. 16). A penalty of \$1,200 is assessed.

Item 18: § 1910.151(c)

The Secretary charges a violation of § 1910.151(c) alleging employees were exposed to injurious corrosive materials without access to a suitable facility for eye drenching or flushing. The standard provides:

(c) where the eyes or body of any person may be exposed to injurious corrosive materials, suitable facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use.

The nitric acid contained in bright dip and the phosphoric acid in the pickle are corrosives (Exh. C-1, C-5; Tr. 239). While employees dipped the rods in and out of the solutions of pickle and bright dip, corrosive materials could splash their eyes. Victor recognized this fact. It advised employees to use a face shield or safety glasses when performing the procedure, even though employees did not always wear them (Exh. C-6; Tr. 23). An eye washing facility was required. Before Victor moved the bright dip and Turco functions to the basement, it had an eyewash facility on the first floor. After the move, a bathroom sink was to be available in the basement work area.

The sink, however, was not operational on the day of the accident. One spigot would not turn and the other had no handle (Tr. 25, 111).

There was another source of water in the basement. A hose 1 to 1½ feet long ran fresh water into one part of the two-basin split sink. The hose was used to rinse Turco from the components (Tr. 102). Victor suggests that this hose was available and suitable for emergency use. The Secretary counters that the nearness of the bright dip operation prevented the hose from being “suitable” for eye drenching. On March 23, 1994, when the emission burned James Amaral’s eyes, he groped for the bathroom sink but found it inoperable. He recalled the rinse water hose at the split sink (Tr 26):

But it’s got a rinse from bright dip, but I knew I had just only put that one part in there, so I figured I’d be okay to catch the water from the faucet, which was running steadily. And I threw down my face. And when I opened my eyes, there was this big cloud of orange smoke everywhere.

The Secretary is required to show that a water source is unsuitable for quick eye drenching in specific circumstances. *See Trinity Industries Inc.*, 15 BNA OSHC 1985, 1988 (No. 89-2316 & 89-2317, 1992). He failed to do so here. While not the most advantageous location during the massive emission of March 23, it was an acceptable source for eye drenching in most other situations. It was with this water with which Amaral successfully cleared his eyes even on March 23. The violation is vacated.

Item 19: § 1910.157(g)(1)

The asserted violation is that Victor had no educational program related to use of fire extinguishers and incipient-stage fire fighting, in violation of § 1910.157(g)(1). The standard requires:

(g) Training and education. (1) Where the employer has provided portable fire extinguishers for employee use in the workplace, the employer shall also provide an educational program to familiarize employees with the general principles of fire extinguisher use and the hazards involved with incipient stage fire fighting.

On April 18, 1994, Victor had a small fire at the foot of the basement stairs. Employee John Mattucci used a fire extinguisher to put out the fire (Tr. 242, 268). When asked by Hoye, Robert Parks admitted that Mattucci had not received training on use of extinguishers or incipient fire

fighting (Tr. 242). Victor contends that because Mattucci was able to put out the fire, he must have been trained to do so. The logic does not follow. No presumption of the sort applies. Victor provided a fire extinguisher, as was prudent for it to do. Employees were not trained in its use. The violation is affirmed. The Secretary asserts the violation is serious because individuals who lack training in incipient stage fire fighting may not recognize when the fire is beyond their control (Tr. 353). Training in use of a fire extinguisher may provide lifesaving information. It would be especially important for workspaces where volatile chemicals are used near a single exit. The gravity of the violation is high. Failure to train could be expected to result in serious burns or death. The violation is properly classified as serious. Item 19 is affirmed. A penalty of \$900 is assessed.

Item 20: § 1910.212(a)(5)

The Secretary charges that Victor violated § 1910.212(a)(5) because an exhaust fan was not adequately guarded. The standard requires:

- (5) Exposure of blades. When the periphery of the blades of a fan is less than seven (7) feet above the floor or working level, the blades shall be guarded. The guard shall have openings no larger than one-half (½) inch.

An exhaust fan was located in the window of the engineering and assembly room on the first floor, 5 to 6 feet above the floor. The fan was covered with a “chicken wire” type material. The 16-inch diameter exhaust fan was round; the chicken wire was placed around it in a rectangular shape. Hoye observed the fan on June 9, 1994. A small bench was placed perpendicular to the fan, but the bench alone would not prevent an employee’s access to the fan blades, if employees were in the area (Tr. 303-304, 359, 420). According to Hoye, the guard did not completely cover the fan blade, and an employee could put his or her entire hand into the blades . However, it was not clear from Hoye’s description where the gap existed in the wire. Stephen Parks described the wire guard as extending 18 to 20 inches around the front of the fan in a “half-cylinder shape” (Tr. 420). The Secretary presented no evidence that employees were within the zone of danger or had reason to be exposed to the alleged hazard. The Secretary failed to make his prima facie case. The violation alleged at item 20 is vacated.

Item 21a, 21b, and 22: §§ 1910.215(a)(2), 1910.215(a)(4), and 1910.215(b)(9)

The Secretary contends that a one-quarter horsepower Craftsman abrasive grinder in the basement machine shop was not adequately guarded, that its tool rest was not properly adjusted, and that it did not have a tongue guard as required by §§ 1910.215(a)(2),¹⁹ 1910.215(a)(4),²⁰ and 1910.215(b)(9)²¹. Hoye observed and described the grinder (Tr. 242-244). There is little dispute that the grinder was defective in the manners alleged.

Victor argues that the grinder was not in use. Allegedly, Victor had only recently moved the grinder to its basement location and still intended to prepare it for use. Employee Metheny, however, testified that the grinder was used to grind the tool bits in March, 1994, and that it was hooked up to an energy source (Tr. 158). He did not think it possible that the grinder was de-energized on March 23, 1994 (Tr. 178). Victor's sole evidence to dispute this testimony and to support its contention is the following question and answer (Tr. 427):

Q. Or grinder, I should say. At the time of the inspection, what was the condition of the electrical power to those grinders?

¹⁹ Section 1910.215(a)(2) provides:

(2) Guard design. The safety guard shall cover the spindle end, nut, and flange projections. The safety guard shall be mounted so as to maintain proper alignment with the wheel, and the strength of the fastenings shall exceed the strength of the guard, . . .

²⁰ Section 1910.215(a)(4) provides:

(4) Work rests. On offhand grinding machines, work rests shall be used to support the work. They shall be of rigid construction and designed to be adjustable to compensate for wheel wear. Work rests shall be kept adjusted closely to the wheel with a maximum opening of one-eighth inch to prevent the work from being jammed between the wheel and the rest, which may cause wheel breakage. The work rest shall be securely clamped after each adjustment. The adjustment shall not be made with the wheel in motion.

²¹ Section 1910.215(b)(q) provides:

(9) Exposure adjustment. Safety guards of the types described in Subparagraphs (3) and (4) of this paragraph, where the operator stands in front of the opening, shall be constructed so that the peripheral protecting member can be adjusted to the constantly decreasing diameter of the wheel. The maximum angular exposure above the horizontal plane of the wheel spindle as specified in paragraphs (b)(3) and (4) of this section shall never be exceeded, and the distance between the wheel periphery and the adjustable tongue or the end of the peripheral member at the top shall never exceed one-fourth inch.

A. There was no power.

This bare testimony does not rebut the Secretary's evidence. It is concluded that the grinder was available for use. Exposure has been established.

These standards seek to lessen the possibility that the wheel of a grinder will shatter and, if it does, to protect employees from the aftermath. If a wheel does break, its flying parts could be expected to hit exposed employees and cause cuts, bruises, and possibly broken bones. It is unknown whether employees wore protective equipment which could lessen the effects of an injury. Three employees may have been peripherally exposed, but one operator had the most direct exposure. The probability of an accident was low. A penalty of \$800 is assessed for items 21a & b and \$800 is assessed for item 22.

Item 23: § 1910.253(b)(4)(I)

The Secretary asserts that oxygen and acetylene cylinders were stored in the same shed, presenting a highly combustible combination, in violation of § 1910.253(b)(4)(i). This is also the shed where in-use cylinders were kept. The standard requires:

(4) Oxygen storage. (i) Oxygen cylinders shall not be stored near highly combustible material, especially oil and grease; or near reserve stocks of carbide and acetylene or other fuel-gas cylinders, or near any other substance likely to cause or accelerate fire; or in an acetylene generator compartment.

Victor admits that a spare oxygen cylinder and acetylene cylinders were stored in the same shed (Resp. Brief p 22). The storage area contained less than 20 feet (Exh. C-3). There was no partition separating the cylinders. Victor argues that the locked shed prevented the cylinders from falling over, eliminating any potential hazard. Further, it asserts that since the cylinders were stored outside the main work area, it was unlikely that a fire would expose employees. Differing from item 6 where in-use cylinders could become projectiles, the primary focus of this standard is injury from fire. Fire can occur even if the cylinders do not fall. The standard assumes the hazard. The cylinders should not have been stored together closer than 20 feet. Storing oxygen and acetylene in this way can cause or significantly accelerate a fire. The storage shed is adjacent to the outside exit. Even though stored outside the building, Victor's employees could be exposed to the hazard

if they were prevented from exiting to the outside because of a fire at the shed. A penalty of \$800 is assessed.

Item 24: § 1910.303(g)(2)(i)

The Secretary charges that face plates were missing from electrical outlets, exposing employees to accidental contact with live parts in violation of § 1910.303(g)(2)(i). The standard provides:

(2) Guarding of live parts. (i) Except as required or permitted elsewhere in this subpart, live parts of electric equipment operating at 50 volts or more shall be guarded against accidental contact by approved cabinets or other forms of approved enclosures, or by any of the following means . . .

The Secretary alleges two instances in which face plates were missing from electrical outlets:

(1) for the shaking machine in the shipping and receiving area; and (2) for the bathroom light switch. In both instances the outlets were without face plates. Having face plates on electrical outlets prevents hands or tools from making direct contact with live parts of the outlet. The shaking machine was being operated by employee Bob Onorate at the time of Hoyer's inspection. Since the outlet was behind the shaking machine, Hoyer's concern was that an operator or other employee might not have full vision when connecting or disconnecting it (Tr. 247). Victor argues that the outlet was protected by location because the machine was in front of it. Victor's argument is misplaced. As the Secretary suggests, the most likely exposure occurs when an employee reaches forward to place or remove the plug without a clear view. The circumstance increases the gravity of the violation. Even if the machine was not regularly plugged or unplugged, access to the hazard existed. There is always a need to disconnect power if the machine malfunctions. In the second instance, the outlet cover for the bathroom was missing. An aggravating factor in instance b is the wet conditions around the basement bathroom switch from the bright dip and Turco operations. Water will more easily conduct electricity. Both outlets were energized at 110 volts (Tr. 247-248, 303).

Victor argues that the Secretary failed to prove an employee could complete the circuit, even if live parts of the outlet were touched. The standard assumes the hazard, and such proof is not necessary. The Secretary sufficiently established exposure to the uncovered, energized outlets.

Since the uncovered outlets were in plain sight, or were observable upon minimal inspection, the employer had constructive knowledge of the violative conditions. If accidental contact occurred, the most likely outcome would be an electrical shock. Even though employees were not working at heights (where a shock can result in a fall), an electrical shock may cause a serious burn or other injury. Death is normally not to be expected. Even with aggravating factors, the probability of accidental contact was low. Considering the number of persons exposed and the short periods of exposure when either plugging in the shaking machine or using the bathroom light switch, a penalty of \$600 is assessed.

Item 25: § 1910.305(b)(2)

The Secretary charges that two electrical junction boxes were without covers, in violation of § 1910.305(b)(2). The standard provides:

(2) Covers and canopies. All pull boxes, junction boxes, and fittings shall be provided with covers approved for the purpose. If metal covers are used they shall be grounded. In completed installations each outlet box shall have a cover, faceplate, or fixture canopy.

As the Secretary's video tape illustrates, two junction boxes in the basement were without covers (Exh. C-6). One uncovered junction box was located in the ceiling. The wires were joined with screw caps but were not covered. A second junction box was also wired but was without a cover. The junction boxes were energized. Electricity was supplied to the basement area at 110 volts (Exh. C- 6; Tr. 248, 303).

Victor focuses on the standard's words "completed installations." It contends that its move was ongoing and the final installation was not "completed." Victor "moved" for at least three months (Tr. 466). Employee John Amaral wired the junction boxes. Amaral had a variety of jobs. On the day of the accident, he was not actively engaged in working on the outlets or even in wiring. He was pressure testing components (Tr. 119). Accepting Victor's argument, work would not be "completed" until an employer actually covered the outlet. This interpretation is contrary to a logical understanding of the standard.

The ceiling in the basement was relatively low. Employees soldering and cleaning components were exposed to the hazard of electrical shock at their work stations. The gravity of the

violation is increased by the fact that there was running water and pails of solutions at the split sink area. As employees lifted and dipped the relatively long copper or brass rods into the solution, contact with the uncovered boxes became more likely (Exh. C-6). The uncovered junction boxes were in plain sight. The conditions presented a hazard of electrocution, burns, or other serious injury. The violation is affirmed as serious. A penalty of \$1,200 is assessed.

Item 26: § 1910.305(g)(1)(iii)

The Secretary asserts that Victor used flexible extension cords in lieu of fixed wiring, in violation of § 1910.305(g)(1)(iii). The standard requires:

(iii) Unless specifically permitted in paragraph (g)(1)(i) of this section, flexible cords and cables may not be used:(A) As a substitute for the fixed wiring of a structure;

Victor used two extension cords which the Secretary cited as instances a and b. In instance a, one cord in the basement provided electricity to a horizontal belt sander and to a lamp for the Bridgeport press, more accurately described as the Bridgeport milling machine (Tr. 159). Metheny testified that one of two belt sanders was bolted to the bench. Both this sander and the Bridgeport lamp were energized and available for use, according to Metheny (Tr. 158-160). Metheny's personal observations are accepted as accurate for instance a. In instance b, an extension cord ran from a ceiling fluorescent light fixture to provide electricity for a lamp on the first floor (Tr. 249-250). Extension cords are subject to more damage and are usually of lower quality than fixed wiring (Tr. 249). In both instances, Hoyer observed that the outlet was too far to reach the area where electrical power was needed. The extension cords were used in lieu of fixed wiring.

Victor argues that its use of extension cords in these instances was permissible under the exceptions in .305(g)(1)(i), specifically "(B) wiring of fixtures" and "(F) connection of stationary equipment to facilitate their frequent interchange." Since it argues for application of an exception to a standard, Victor bears the burden of establishing it. Contrary to Victor's argument, subsection (B) refers to the wiring of the fixture itself, not to how the energy reaches it. It may be that the lamps located at the milling machine and on the first floor were connected to "facilitate frequent interchange." However, Victor presented insufficient facts to establish the exemption. Instances a and b are affirmed. The probability of an accident was low. A penalty of \$800 is assessed.

Item 27: § 1910.305(j)(2)(ii)

The Secretary alleges a violation of § 1910.305(j)(2)(ii), arguing that electrical outlets were installed in wet or damp locations. The standard provides:

(ii) A receptacle installed in a wet or damp location shall be suitable for the location.

The outlet in question was located directly behind the large split sink where employees performed the pickle and bright dip operations (Exh. C-2, C-6; Tr. 367). The outlet was not impervious to moisture. There was no ground fault circuit interrupter for the outlet (Tr. 251). Hoye defined the hazard as moisture entering the fixture and increasing risk of shock. Victor refers to the National Electric Code's (NEC) (1993) definition of a "wet or damp" location. He argues that the following portion of the definition has not been met:

locations under canopies, marquis, roof-open porches and light locations. An interior location subject to moderate degrees of moisture, such as some basements, some barns and some cold-storage warehouses.

Victor's argument is unclear. The provisions of the NEC are not controlling but may afford guidance in appropriate circumstances. In this case, dipping rods at the sink using a 5-gallon bucket and a large glass container filled with solution, with running water in the adjacent sink, amply meets the NEC's definition of "subject to moderate degrees of moisture." Additionally, the facts fit within a common understanding of the term "wet or damp." The violation is established. At least two individuals were subjected to the hazard of an increased electrical shock. Serious electrical shock or burns is the expected result of the hazard. Although properly classified as serious, the probability of an accident is low. A penalty of \$600 is assessed.

Item 28: § 1910.332(b)(1)

The Secretary asserts that John Amaral's duties included performing electrical work without his having proper training on safe work practices, in violation of § 1910.332(b)(1). The standard provides:

(b) Content of training. (1) Practices addressed in this standard. Employees shall be trained in and familiar with the [electrical] safety-related work practices required by 1910.331 through 1910.335 that pertain to their respective job assignments.

The Secretary informally refers to this standard as the “electrical lock-out/tag-out standard.” Its purpose is to assure that employees work only on equipment that is fully de-energized (Tr. 251). John Amaral performed electrical wiring for Victor. Amaral described this work as “small things, a few repairs, upgrades” at Victor’s facility (Tr. 117). This included the electrical work necessary for Victor to move its operation to the basement. Stephen Parks admitted Amaral had this assignment when he and Hoye discussed the uncovered junction boxes (Tr. 253). Based upon Hoye’s interviews with Amaral and Parks, she determined that Amaral performed “premises wiring . . . [b]asically, if you need an outlet moved or if you need any type of equipment hard [permanently] wired into the building, that would be the sort of work that he would do” (Tr. 252) (See § 1910.331(a)(1)). Amaral testified to working on “live” circuits because he believed shutting off the electricity would erase the computerized memory of some of Victor’s equipment. John Amaral was not a licensed electrician. While he had basic knowledge in the science of electricity, his training related to electronics, which is something different from electrical wiring (Tr. 131). Amaral had no training in the safety-related work practices specified by the OSHA electrical standards (Tr. 253-254).

In its defense, Victor contends that Amaral was “careful” while performing the electrical work. It argues the effect of any violation was, thus, mitigated. Amaral’s testimony is on point (Tr. 132):

Q. Now, when you worked on those circuits live, was there anybody else around you?

A. Most of the time.

Q. Did you make sure they couldn’t get near those circuits?

A. Yes. I would tell them ahead of time I was working on a circuit, I would tell them to, “stay away from this,” or whatever the job was that I was on.

John Amaral was not afforded required safety training. If he had, he would understand that instruction to be careful or safe is an inadequate substitution for safe work practices, either his own or those of other exposed employees. Working conditions were cramped in Victor’s basement. The gravity of the violation is high, especially considering electrical work was performed while circuits

were energized. A lack of training bears significantly on the predictable severity of exposure to electrical hazards. A penalty of \$1,750 is assessed.

Item 29: § 1910.333(b)(2)(i)

In a related charge, the Secretary asserts that Victor had no written electrical safe work practices program, as required by § 1910.333(b)(2)(i). The standard provides:

- (i) "Procedures." The employer shall maintain a written copy of the procedures outlined in paragraph (b)(2) and shall make it available for inspection by employees and by the Assistant Secretary of Labor and his or her authorized representatives.

Victor offhandedly argues that the scope provisions of § 1910.332(a) exempt it from compliance with this requirement. Since Amaral unquestionably "face[d] a risk of electric shock," the contention is specious. Nevertheless, the Secretary presented no evidence as to why failure to have an available copy of this portion of the standard would, viewed alone, result in a serious injury. The violation is affirmed, but is properly classified as nonserious. A penalty was properly assessed for Victor's failure to train Amaral (item 28), but no penalty is assessed for this violation.

Items 30 & 31: §§ 1910.1000(a)(1) and 1910.1000(e)

The Secretary asserts that Victor exposed employees to nitrogen dioxide in excess of the prescribed ceiling level of § 1910.1000(a)(1)²² (item 30) and that it did not utilize feasible administrative or engineering controls to prevent the overexposure in violation of § 1910.1000(e)²³ (item 31).

Subpart Z governs employee exposure to hundreds of substances considered to be air contaminants. These are listed on Table Z-1. Most exposure limits are expressed as an eight-hour time-weighted average. For some contaminants ("preceded by 'C'" in the Table) ceiling values are

²² Section 1910.1000(a)(1) provides:

Table Z-1. (1) Substances with limits preceded by "C"—Ceiling Values. An employee's exposure to any substance in Table Z-1, the exposure limit of which is preceded by a "C," shall at no time exceed the exposure limit given for that substance. If instantaneous monitoring is not feasible, then the ceiling will be assessed as a 15-minute time weighted average exposure which shall not be exceeded at any time during the working day.

²³ Subsection (e) provides:

To achieve compliance with paragraphs (a) through (d) of this section, administrative or engineering controls must first be determined and implemented whenever feasible.

established which "shall not be exceeded at any time during the working day" (§ 1910.1000(a)). Nitrogen dioxide is one of those substances. The ceiling limit for nitrogen dioxide is 5 parts per million (ppm). Although on March 23, 1994, the bright dip operation produced a large "orange cloud," employees were often exposed to a "yellow tinge" or vapor when copper or brass was introduced into the bright dip solution (Tr. 62). The Secretary could not sample for air contaminants associated with Victor's normal bright dip operation, because Victor discontinued it after the emergency release. The Secretary did not seek to correlate the March 23 emission of nitrogen dioxide with that produced during normal operations. Thus, proof of a violation for items 30 and 31 is Victor's stipulation that on March 23, 1994, employees were exposed to "in excess of 50 parts of nitrogen dioxide per million parts of air" (Tr. 255).

Of the four elements necessary to prove a violation, the first three are clearly met. Fifty ppm of nitrogen dioxide represents an exposure of ten times the permissible ceiling value. The terms of the standard apply and were not met on March 23. Exposure is stipulated. Of greater contention is the fourth element, whether Victor knew or should have known of the violation. For many of the same reasons discussed in relation to the emergency response violation, it is determined that Victor had the requisite knowledge. An employer's knowledge of violative conditions may be based on what was reasonably to be anticipated. Stephen Parks is a chemical engineer with an expertise in using mixed nitric and sulfuric acids (Tr. 440). Parks recognized that these mixed acids in bright dip formed "a very hazardous material." He believed employees must know "how they had to mix it and precisely how to use it" (Tr. 449).

Parks' understanding was in marked contrast to the information available to those who used bright dip. On March 23 Ralph DeMonte mixed the bright dip. DeMonte learned how to mix bright dip from watching John Mattucci (Tr. 261). When DeMonte spoke with Hoye soon after the incident, he was not sure whether he added water to the bright dip on that day. DeMonte recalled, though, that when he spilled the solution, it seemed stronger than usual and ate through the concrete block onto which it spilled. DeMonte specifically remembered filling the bucket to the top (Tr. 260-261). DeMonte complained of "burning all over" as he carried the mixture to the basement. Another employee advised Stephen Parks of DeMonte's condition. Parks sent word that DeMonte should wear protective gear when mixing bright dip. DeMonte responded, "[i]t's all set now. Don't

worry about it” (Tr. 23). James Amaral saw yellow stains on DeMonte’s arms and advised him to rinse them. DeMonte ignored Amaral and continued with his work. He repeated that the bright dip was “all set” (Tr. 24-25). Amaral noticed that although the bright dip usually filled the pail only half way, the new mixture was filled to the top. Amaral thought this was a good idea, because he could plate more of the rod into the pail. He had never been advised that the pail should not be completely full (Tr. 109).

Even for John Mattucci, who most often mixed the bright dip solution, the mixing instructions were vague. “Generally,” he added “approximately a quart of water” into the bottom of the pail before filling the pail with solution “about a half to two-thirds full” (Tr. 259). No written procedures were available for those who worked with the solution (Tr. 110-111, 259-261). Given the hazardous nature of the chemicals and the vagueness of the instructions, the Secretary has established constructive knowledge of the violation.

For the reasons previously discussed, Victor’s reliance on an employee misconduct defense is misplaced. Its factual contention that James Amaral ignored a specific work rule or that he placed excessive numbers of components in the solution were unproven. Exposure to nitrogen dioxide may cause pulmonary edema and other acute health effects (Tr. 190). Item 30 is affirmed as serious.

For item 31, the emphasis is on the feasibility of controlling the hazard by specific measures. As is required, the Secretary’s citation suggested proposed administrative or engineering controls. Initially, the Secretary recommended instituting procedures to keep pickle and bright dip separated. Only the bright dip operation was shown to produce nitrogen dioxide. There was no evidence that unintentionally combining bright dip and pickle created exposure. However, the Secretary also suggested:

- (4) develop clear and precise directions for mixing a batch of the bright dip or the pickle and insure that it is performed according to these directions.

The evidence demonstrates that such a means of abatement would be effective and feasible. Item 31 is affirmed as serious. Based upon the gravity of the violations, and considering them in context with the affirmed emergency response violations, a penalty of \$2,000 is assessed for item 30 and \$1,000 for item 31.

Items 32a and 32b: §§ 1910.1200(f)(5)(i) and 1910.1200(f)(5)(ii)

The Secretary charges that Victor did not have identifying labels or appropriate hazard warning labels on containers of hazardous chemicals, as required by §§ 1910.1200(f)(5)(i)²⁴ and 1910.1200(f)(5)(ii).²⁵ Pickle contains phosphoric acid and 2 butoxyethanol; bright dip contains nitric acid and sulfuric acid. Each is a hazardous chemical. The solutions were transferred and diluted with water on the first floor and carried to the basement sink for use. Without dispute, the 5-gallon bright dip and pickle pails did not have identifying labels or hazard warnings at the point they were ready to be used (Tr. 270-271). John Mattucci often mixed and used the solutions. However, others regularly performed one or both of the procedures. On the day of the accident, the solutions were mixed by Ralph DeMonte; John Amaral used them. Labeling as to content and health effects avoids confusion and provides vital information for those exposed to hazardous chemicals. James Amaral had no real understanding of the health effects of pickle or bright dip (Tr. 15, 18). Labeling was especially important when chemical solutions were used side-by-side, as were these two solutions.

Victor again argues for an exemption but offers no proof to support it. It states, without elaboration, that the terms of exemptions §§ 1910.1200(f)(6) and (f)(7) apply. Since Victor claims an exemption, it has the burden of proving it. Subparagraph (f)(7) permits use of other signs or labeling materials “as long as the alternative method identifies the containers.” There was no “alternative method” of identification. Subparagraph (f)(6) would forego labeling when the portable container into which the hazardous chemicals were transferred was “intended only for the immediate use of the employee who performs the transfer.” The person who mixed the chemicals did not use them. No exemptions apply. The probable result of confusing or misusing the acids is chemical burns or other exposures of a serious nature. A serious violation of these labeling standards

²⁴Section 1910.1200(f)(5)(i) requires listing “(i) Identity of the hazardous chemical(s) contained therein;”

²⁵ Section 1910.1200(f)(5)(ii) provides:

(ii) Appropriate hazard warnings, or alternatively, words, pictures, symbols, or combination thereof, which provide at least general information regarding the hazards of the chemicals, and which, in conjunction with the other information immediately available to employees under the hazard communication program, will provide employees with the specific information regarding the physical and health hazards of the hazardous chemical.

occurred. Considering the types of chemicals used, the misunderstanding of employees as to the nature of these chemicals, and the penalty factors previously discussed, a penalty of \$850 is assessed.

Willful Citation No. 2

Item 1: 1910.1200(h)

The Secretary asserts that Victor willfully violated § 1910.1200(h). The standard requires an employer to provide employees with information and training on hazardous chemicals, as specified in (h)(1) and (h)(2).²⁶ The Secretary's allegations relate to nitric acid in the bright dip, phosphoric acid and 2 butoxyethanol in pickle (Turco), and to "other soldering and plating materials." Only allegations relating to the pickle and bright dip solutions remain in issue.²⁷

OSHA's Previous Contact with Victor

In 1992, two years before the emergency release, OSHA received a nonformal complaint about Victor. The complaint described various safety and health violations, including the company's failure to have a hazard communication program or training. Nonformal complaints are handled by mail. OSHA writes to the employer requesting an answer to the complaint. Hoyer reviewed Victor's written response when it came into the OSHA office. Because she had additional questions, she called Victor and spoke to Robert Parks. Hoyer asked him to provide a copy of their hazard communication program and the dates of training. Robert Parks told her that the company did not have a hazard communication program. Hoyer then sent him a copy of the standard and a sample hazard communication program to assist Victor in developing its own program (Tr. 293-294). On December 2, 1992, Stephen Parks sent OSHA a two-page hazard communication program

²⁶Section 1910.1200(h) governs "employee information and training" and provides:

(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 . . . is introduced into their work area. . . .

(2) "Information." Employees shall be informed of:

{i} The requirements of this section; {ii} Any operations in their work area where hazardous chemicals are present; and {iii} The location and availability of the written hazard communication program, . . .

²⁷To the extent the Secretary asserts a violation for anything other than pickle and bright dip, the allegations are dismissed for insufficient evidence. The Secretary presented no specific proof for other unnamed plating solutions or for soldering compounds.

(Exh. C-10). The document detailed what information would be available to employees and specified that "training sessions will be conducted by the general manager." Victor's general manager was Robert Parks. The training sessions were to be "completed the week of December 7, 1992." OSHA made no further inquiry at the time (Exh. C-10; Tr. 294-296).

Employees' Knowledge and Training

James Amaral, Ralph DeMonte and John Mattucci worked with bright dip and pickle. The Secretary asserts that Victor should have provided the three with written information on the requirements of the standard; the identity of any operations where hazardous chemicals were present; the location and availability of written hazardous communication programs; and a list of hazardous chemicals together with their MSDS (Tr. 279).

Prior to March 23, 1994, James Amaral did not know the chemical composition of bright dip or Turco, nor did he know that there were hazards associated with chemicals in those products (Tr. 15, 18). Amaral first saw an MSDS related to bright dip (that of nitric acid) after the accident of March 23, 1994 (Tr. 33).

Amaral's knowledge came from on-the-job training and was inadequate. Around 1985 soon-to-be retired employee Peter Bayazie trained Amaral as a braiser (Tr. 47-48, 64). Bayazie explained to Amaral that pickle was "nothing more than an industrial soap" and that bright dip "was industrial strength bleach" (Tr. 47). When the chemicals burned Amaral, Bayazie told him "just rinse it off, it won't hurt you, you'll get a little burn, that's all" (Tr. 49). Amaral performed the bright dip and pickle procedures hundreds of times, without having been informed about the chemicals he used (Tr. 15, 110).

John Mattucci, as well as other employees, expressed to Amaral their belief that these chemicals "wouldn't hurt you." Amaral observed that these individuals "used [the bright dip and pickle] like water" (Tr. 65).

Likewise, Ralph DeMonte was not trained on the chemicals he mixed. De Monte responded to Hoye's question as follows (Exh. C-8):

Q. Have you ever had any kind of health and safety training where chemicals were mentioned such as "employee right to know"?

- A. No, I didn't have any training on anything. They, Bob and Steve, have told me to wear gloves and glasses before. They sometimes tell me to "be careful."

The Parks' Contentions

Since Robert Parks was to have conducted the training sessions, Hoye asked him to describe the type of training he allegedly provided. Robert Parks verified that he gave "hazard communication training to employees" (Exh. C-10; Tr. 304-305, 436). He could furnish no dates or details of the training. He had no copies of written information allegedly given to employees as part of their training. Hoye asked him why employees didn't appear to remember being trained. Robert Parks replied that "it may not have been adequate enough for it to stick" (Tr. 305).

When the Secretary deposed Robert Parks before hearing, Robert Parks restated that he trained the employees (Tr. 475-476). The Secretary also deposed Stephen Parks, who "did not remember being involved" in training employees on bright dip (Tr. 470). At hearing, however, the Parks reversed their positions. Robert Parks stated that it was his father's responsibility to train employees on hazardous chemicals (Tr. 431). Stephen Parks asserted that he had trained employees on the chemicals.

Stephen Parks described the training (Tr. 462):

- Q. Going back to the bright dip operation, did you have any controls besides the operating procedures there?
- A: No. The training of the people that were using the bright dip, their respect for the solution they were working with was the real control.
- Q. And you did the training?
- A. I did. I talked to them and explained to them.
- Q. How often did you discuss it with them?
- A. Any chance that I saw they were either mixing it or they were participating in it, I would go over and talk to them on the job Well, it was the hazard of the acid in the bright dip, the fact that that had to be treated with tremendous respect and used properly, it was a helping hand. Used improperly, it could become a hazard to your performance.

Even if this testimony were not contradicted, this is not the type of training required by the standard.

Victor argues in defense that employees possessed sufficient knowledge of the bright dip and pickle processes to create a presumption that they had been trained. The contention deserves only brief comment. There is no presumption that employees knew of the nature of hazardous chemicals or were trained on them simply because they knew how to use them.

Was the Violation Willful?

A willful violation is differentiated from others by an employer's heightened awareness of the illegality of the conduct or conditions and by a state of mind, *i.e.*, conscious disregard or plain indifference for the safety and health of employees. Logically, then, a willful charge is not justified if an employer has made a good faith effort to comply with a standard or eliminated a hazard even though the employer's efforts are not entirely effective or complete.

Falcon Steel Co., supra, 16 BNA OSHC at 1181.

Primarily because he believed that Victor deceived OSHA when it advised it would train employees in 1992, the Secretary asserts this violation was willful. The issue requires a credibility determination. In making that determination, the demeanor of the witnesses was assessed. Neither of the Parks was clear as to how, when, or whether he trained the employees. Their testimony on the issue was confused and appeared to lack candor. Also weighed are two of Victor's exhibits. Victor introduced written procedures for use of bright dip (R-2) and for Turco (R-3).²⁸ These documents do nothing to enhance the Parks' credibility. Stephen Parks estimated that the procedures were written at least 10 years earlier. However, neither document had ever been mentioned or produced in spite of having been sought in OSHA's first contact with Victor, or during the 1994 investigation. Victor never showed such procedures to Amaral, Mattucci or DeMonte, although they were the individuals who worked with the two products (Tr. 110, 259, 261).

Victor's apparent willingness to skirt legal requirements is consistent with its repeated requests to employees not to claim workplace injuries. Victor may not have considered it necessary to train individuals who had already worked with the chemicals for a number of years. Victor was

²⁸ Victor had not disclosed either the existence of Exh. R-2 and R-3 or that it intended to offer them as exhibits. Exh. R-2 and R-3 appeared so germane to the issues that some consideration was given to the fact that Victor may have had procedural confusion because it was not represented by an attorney. They were admitted over the Secretary's objection.

not free, however, to substitute its judgment for the requirements of the standard. *See Trinity Indus., Inc.*, 16 F.3d 1149 (11th Cir. 1994) . In 1992 OSHA specifically advised Victor of the requirements of § 1910.1200(h). Victor misrepresented its intention to comply with the standard. Victor knowingly permitted employees to work with hazardous chemicals without providing them with information and training necessary for their safety and health. Its decision not to train was made with conscious disregard and plain indifference. The violation is affirmed as willful.

Penalty considerations have been discussed. As stated, Victor is afforded a greater reduction than the Secretary recommends because of its small size. However as also found, Victor's attitude towards employee safety was lax at best. Pickle may cause severe irritation, chemical burns, tissue damage and severe irritation to the upper respiratory tract. Employees used the chemicals so frequently that organ damage may have been possible (Exh. C-1). Bright dip presented significant health hazards from overexposure either through skin or eye contact or by inhalation (Exh. C-5). The gravity of the violation is high. At least three employees worked with the chemicals for varying lengths of time. Protective equipment was worn in some instances, but not in others. The statute provides that not more than \$70,000 nor less than \$5,000 shall be assessed for each willful violation. A penalty of \$8,000 is assessed.

Other Citation No. 3

Item 1: § 1903.2(a)(1)

The Secretary asserts that no OSHA notice was posted at the worksite, in violation of § 1903.2(a)(1). The regulation provides:

(a)(1) Each employer shall post and keep posted a notice or notices, to be furnished by [OSHA] informing employees of the protections and obligations of the Act

Admittedly, the OSHA poster was not posted. Victor contends that there is no evidence that the Secretary furnished it with the poster, a prerequisite to finding a violation of this regulation. *Anderson Excavating and Wrecking Co.*, 11 BNA 9SHC 1837, 1839 (No. 81-1271, 1984); *Mortgage Inspectors Inc.*, 15 BNA OSHC 1950 (No. 91-1967, 1992). It seems likely that OSHA would have provided a poster during its 1992 contact with Victor, but the Secretary adduced no evidence on the point. The asserted violation is vacated.

Item 2: § 1904.2(a)

The Secretary charges Victor with failing to maintain an OSHA Log 200 of illness and injuries, in violation of § 1904.2(a). The regulation requires that:

- (a) Each employer shall . . . (1) maintain in each establishment a log and summary of all recordable occupational injuries and illnesses for that establishment; and (2) enter each recordable injury and illness on the log and summary as early as practicable but no later than 6 working days after receiving information

An employer is required to maintain a log of the job-related injuries and illnesses suffered by its employees. The log should be retained to cover the previous 5 years (Tr. 388). Victor kept no log. It asserts that it had no injuries to record and, thus, had no responsibility to keep a log. Victor incorrectly interprets the requirements of the standard. Section 1904 requires that the injury/illness record "shall be completed in the detail provided in the form and instructions on form OSHA No. 200." That form requires employers to maintain the log or an equivalent, marking zeros if no injuries occurred during the year. Moreover, the Secretary introduced credible evidence that Victor's employees suffered recordable injuries within the meaning of § 1904.8 during the period. Victor appears to have had an informal policy whereby employees were encouraged to deny that injuries were work related (Exh. C-8 & 9; Tr. 77-80, 91). In any event, the violation is established. Based on the penalty factors previously discussed, and the fact the required records were not kept for any year, a penalty of \$700 is affirmed.

Item 3: § 1910.22(d)(1)

The Secretary asserts a violation of § 1910.22(d)(1) for Victor's failure to have an approved load plate for the first floor of its facility. The standard requires:

- (d) "Floor loading protection." (1) In every building or other structure, or part thereof, used for mercantile, business, industrial, or storage purposes, the loads approved by the building official shall be marked on plates of approved design which shall be supplied and securely affixed by the owner of the building, or his duly authorized agent, in a conspicuous place in each space to which they relate. Such plates shall not be removed or defaced but, if lost, removed, or defaced, shall be replaced by the owner or his agent.

The first floor is constructed of wood, both the floor and the joists. Victor had its Matautu Coordinate Measuring Machine on the first floor. Hoye suggested that the machine, which is a

three-foot high marble table, would weigh over a thousand pounds. An unnamed employee was concerned that the floor might not withstand the weight of the machine while employees worked in the basement below. No weight capacity was posted for the first floor (Tr. 300-301). Victor questions whether any building official had authority to determine approved loads for the building. It also contends that the Secretary did not prove overloading. Victor owns the building where it conducts business (Tr. 466). It was required to have approved loads posted. Victor misunderstands the burden of proof. It is immaterial whether the Secretary established which, if any, official could approve loads. It was Victor's responsibility to secure the information and to post it. The standard is preventative. The violation occurred regardless of whether the floor was actually overloaded. The violation is affirmed as other than serious. No penalty is assessed.

Item 4: § 1910.107(g)(7)

The Secretary alleges that Victor did not post "No Smoking" signs where spray painting was performed, in violation of § 1910.107(g)(7). The standard provides:

(7) "No Smoking" signs. "No smoking" signs in large letters on contrasting color background shall be conspicuously posted at all spraying areas and paint storage rooms.

As discussed for items 7 and 8, the Secretary failed to establish that Victor sprayed "dangerous quantities" of flammable substances and, thus, that it had a spraying area. There was no contention that Victor had a paint storage room. The violation is vacated.

Item 5: § 1910.305(g)(2)(iii)

The Secretary asserts that the plug on the flexible cord of the time clock in shipping/receiving was not attached to prevent tension from being transmitted to joints or terminal screws, as required by §1910.305(g)(2)(iii). The standard specifies:

(iii) Flexible cords shall be connected to devices and fittings so that strain relief is provided which will prevent pull from being directly transmitted to joints or terminal screws.

The Secretary provided proof on point (Tr. 301). Victor does not deny the allegation (R. brief p. 35). The violation is affirmed. No penalty was recommended; none is assessed.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The foregoing decision constitutes the findings of fact and conclusions of law in accordance with Federal Rule of Civil Procedure 52(a).

ORDER

Based on the foregoing decision, it is ORDERED:

Serious Citation No. 1

Item	Standard	Disposition	Penalty
1	§ 1910.22(a)(1)	Vacated	-0-
2	§ 1910.36(b)(6)	Affirmed	\$1,000
3	§ 1910.36(b)(8)	Affirmed	\$1,000
4	§ 1910.37(f)(5)	Affirmed	\$800
5	§ 1910.37(k)(1)	Affirmed (non-serious)	\$300
6	§ 1910.101(b) CGAP P-1-1965 § 3.4.4	Affirmed	\$800
7	§ 1910.107(c)(6)	Vacated	-0-
8	§ 1910.107(c)(7)	Vacated	-0-
9	§ 1910.107(d)(10)	Vacated	-0-
10	§ 1910.120(q)(1)	Affirmed	\$3,000
11a & 11b	§ 1910.120(q)(3)(ii)	Affirmed	\$1,700
12	§ 1910.120(q)(3)(iv)	Affirmed	\$1,100
13	§ 1910.120(q)(3)(v)	Affirmed	\$1,000
14	§ 1910.120(q)(3)(vi)	Vacated	-0-
15	§ 1910.120(q)(3)(vii)	Affirmed	\$1,000
16a	§ 1910.120(q)(6)(i)(A)	Vacated	-0-
16b	§ 1910.120(q)(6)(iii)	Affirmed	\$700

16c or 16d	h§ 1910.120(q)(6)(v)(A) or § 1910.120(q)(3)(i)	Vacated	-0-
17	§ 1910.132(a)	Affirmed	\$1,200
18	§ 1910.151(c)	Vacated	-0-
19	§ 1910.157(g)(1)	Affirmed	\$900
20	§ 1910.212(a)(5)	Vacated	-0-
21a & 21b	§ 1910.215(a)(2) & § 1910.215(a)(4)	Affirmed	\$800
22	§ 1910.215(b)(9)	Affirmed	\$800
23	§ 1910.253(b)(4)(I)	Affirmed	\$800
24	§ 1910.303(g)(2)(i)	Affirmed	\$600
25	§ 1910.305(b)(2)	Affirmed	\$1,200
26	§ 1910.305(g)(1)(iii)	Affirmed	\$800
27	§ 1910.305(j)(2)(ii)	Affirmed	\$600
28	§ 1910.332(b)(1)	Affirmed	\$1,750
29	§ 1910.333(b)(2)(i)	Affirmed (non-serious)	-0-
30	§ 1910.1000(a)(1)	Affirmed	\$2,000
31	§ 1910.1000(e)	Affirmed	\$1,000
32a & 32b	§ 1910.1200(f)(5)(i) & § 1910.1200(f)(5)(ii)	Affirmed	\$850

Willful Citation No. 2

Item	Standard	Disposition	Penalty
1	§ 1910.1200(h)	Affirmed	\$8,000.00

Other Citation No. 3

Item	Standard	Disposition	Penalty
1	§ 1903.2(a)(1)	Vacated	-0-
2	§ 1904.2(a)	Affirmed	\$700
3	§ 1910.22(d)(1)	Affirmed	-0-
4	§ 1910.107(g)(7)	Vacated	-0-
5	§ 1910.305(g)(2)(iii)	Affirmed	-0-

Total penalty assessed for Citation Nos. 1, 2, and 3 is \$34,400.



NANCY J. SPIES

Judge

Dated: May 9, 1996
Atlanta, Georgia