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

Secretary of Labor, Complainant v. Southern Hydro Vac, LLC, Respondent.	OSHRC Docket No. **20-1000**

Representatives:

Matthew K. McClung, Esq.
U.S. Department of Labor, Office of the Solicitor, Nashville, TN, for Complainant

Travis W. Vance, Esq., David I. Klass, Esq. and Nicholas S. Hulse, Esq.
Fisher & Phillips, LLP, for Respondent

JUDGE: Administrative Law Judge Heather A. Joys

DECISION AND ORDER

On November 18, 2019, an employee of Southern Hydro Vac, LLC, (Southern), was killed when he was crushed by the closing tailgate door of a hydro vacuum truck owned and operated by Southern. The Birmingham Area Office of the Occupational Safety and Health Administration (OSHA) investigated the accident. As a result of that investigation, the Secretary of Labor issued Southern a citation alleging a serious violation of § 5(a)(1) of the Occupational Safety and Health Act of 1970 (the Act), known as the general duty clause. The Secretary alleges Southern had failed to provide a place of employment free from the recognized hazard of an employee being caught between the truck's tailgate door and the tank body of the truck while the employee is washing out the truck. Southern timely contested the citation, bringing the matter before the Commission. The Secretary proposes a penalty of $13,494.00 for the violation.

The parties stipulated, and the record supports a finding, that the Commission has jurisdiction over this action pursuant to § 10(c) of the Act (Tr. 11). The parties also stipulated, and the court finds, that at all times relevant to this action, Southern was an employer engaged in

a business affecting interstate commerce within the meaning of § 3(5) of the Act, 29 U.S.C. § 652(5) (Tr. 11).

The undersigned held a hearing on April 5, 2022, in Tuscaloosa, Alabama. The parties filed post hearing briefs on June 27, 2022. After consideration of the record and arguments of the parties, the citation is **VACATED**.

STIPULATED FACTS

Prior to the hearing, the parties stipulated to the following findings of fact:

1. Respondent performs hydro evacuation services.

2. Respondent utilizes GapVax hydro vacuum trucks in its operations.

3. On November 18, 2019, Respondent performed work for customer Pike Electric at 5158 Old Montgomery Highway in Tuscaloosa, Alabama.

4. On November 18, 2019, Respondent's employees, WD and AW[1] worked as the crew on the project in Tuscaloosa, Alabama. WD drove the truck and AW was a passenger.

5. WD and AW performed the work in Tuscaloosa, Alabama, using Respondent's hydro vacuum truck number 3064.

6. Upon completion of the hydro evacuation project in Tuscaloosa, Alabama, Respondent's employees WD and AW traveled in Respondent's hydro vacuum truck to a dump site in Reform, Alabama.

7. On November 18, 2019, AW was fatally injured in an accident at the Reform Alabama, dump site after he was caught between the tailgate door and the truck as the door was closing.

8. WD and AW participated in safety training on September 13, 2019.

9. During the September 13, 2019, safety meeting, employees including AW, were provided refresher training regarding the dangers associated with hydro evacuation, including those involving the rear gate and tank body.

10. As a result of the accident OSHA conducted an inspection of the worksite.

11. OSHA issued a citation and notification of penalty to Respondent as a result of its inspection.

[1] The employees' initials have been used in place of their names to protect their privacy.

12. Respondent timely filed a notice of contest regarding the citations and notifications of penalty, in which it contested all issues and matters relating to the citation, including abatement dates and proposed penalties.

(Tr. 9-11).

BACKGROUND

Southern is in the business of performing hydro-evacuation services, using hydro vacuum trucks to excavate around utilities (Tr. 83). The process involves using high-pressure water to create mud around underground utility lines which can then be vacuumed out by the truck (Tr. 83). Once excavated, the mud is transported on the truck to a dump site for off-loading (Tr. 83). Southern operates 13 vacuum trucks daily (Tr. 83). The company estimates it performs the dumping operation 4600 times per year (Tr. 100). Until the present accident, Southern had no injuries associated with its process.

The Dumping Process

Each of Southern's vacuum trucks is operated by a two-man crew. The crew leader operates the truck (Tr. 129). The second crew member is either a trained tech or an apprentice (Tr. 129). Among other tasks, the tech or apprentice is responsible for guiding the truck while the operator drives and washing out the bed[2] of the truck during the dumping process.

Jan Enlow, Southern's field services supervisor, described the dumping process for the record. Upon arrival at the dump site, the tech gets out of the truck and guides the operator into position. The operator watches the tech in the rearview mirrors located on either side of the truck's cab (Tr. 85). Once in position, the operator exits the cab in order to raise the bed of the truck and open the tailgate door. Both operations are done using controls located behind the cab on the driver's side of the truck (Tr. 87; Exhs. R-26 and R-25). Meanwhile, the tech takes out the hose used for washing the truck from a similar location on the passenger side of the truck (Tr. 87). When the bed is raised and the tailgate door is opened, the collected mud flows out while the tech rinses the bed (Tr. 102). After the tech is done rinsing the bed, he signals the operator to lower the bed and move the truck forward (Tr. 93, 102). The operator lowers the bed and moves the truck forward until the tech signals to stop (Tr. 93). The tech then hoses off the back of the truck to clean the seals (Tr. 97, 108-09). When he is done rinsing the back of the truck, he gives the operator a signal that he is leaving the area and it is "okay to close the tailgate." (Tr. 98).

---

[2] At the hearing the term "bed" was used for the part of the truck that holds the mud. In photographs it appears to be an enclosed tank rather than an open truck bed.

According to Enlow, the hand signals used are chosen by the operator and tech and may differ from team to team (Tr. 106). WD and AW had agreed that AW would make a "C" shape with his hand to indicate the operator was clear to close the tailgate door (Tr. 134). The operator closes the tailgate door while the tech cleans himself off and puts the hose away (Tr. 99). The operator and the tech then get back in the cab and return to the excavation site.

The bed and tailgate door operate by hydraulics. The controls are spring loaded (Tr. 89). As a result, the operator must apply constant pressure to the controls for the bed and tailgate door to move (Tr. 89). It takes approximately 30 seconds for the tailgate door to close completely (Tr. 39; Exh. R-33). The operator cannot see the back of the truck during this process. Nor can he see the tech while he is replacing the hose (Tr. 104).

The Accident

In 2019, WD and AW were working for Southern on a project for the company's client, Pike Electric, in Montgomery, Alabama.[3] WD was the operator and AW acted as the tech. The two had been working together for approximately six months (Tr. 57). WD had a longer tenure with Southern than AW (Tr. 132-33). Both had received training with Southern on its safety and health program and taken the OSHA 10-hour training class (Exhs. R-6; R-7; R-14; R-15; R-16). Both had been subject to disciplinary actions in the past (Exhs. R-13 and R-17).

On November 19, 2019, after leaving the Pike Electric excavation site, WD and AW traveled to a dump site in Reform, Alabama. They had previously hauled mud to the Reform dump site. When they arrived at the dump site, AW directed WD to the dump area (Tr. 33). Once the truck was in position, WD got out of the cab and raised the bed of the truck using the controls on the side of the truck (Tr. 33). He then opened the tailgate door. Once the mud was out of the bed of the truck, WD got back in the cab and drove the truck forward (Tr. 33). WD waited in the cab while AW cleaned the back of the truck, watching in the passenger side rearview mirror for AW to signal him to close the tailgate door (Tr. 34). According to WD's statement, when he saw AW make a "C" shape with his hand, WD got out of the cab and closed the tailgate door using the controls on the side of the truck (Tr. 34).

Once the tailgate door was closed, WD went back to the cab and waited for AW to complete his clean-up operations (Tr. 34). When AW did not return to the cab in a reasonable

[3] No witness to the events leading up to the accident testified at the hearing. Information about the accident is taken from the parties' stipulated facts and CSHO McWilliams's testimony regarding the statement WD provided to her.

amount of time, WD went to the back of the truck and found AW caught between the tailgate door and the back of the truck (Tr. 35). AW later died of his injuries.

The Inspection

The Birmingham Area Office of OSHA initiated an investigation of the fatal accident. Compliance Safety and Health Officer Jennifer McWilliams conducted the investigation (Tr. 22-24). CSHO McWilliams went to the dump site the day after the accident, where Southern's truck was still located. The only individual onsite was a third-party representative of Southern. CSHO McWilliams conducted an opening conference over the phone. While on site that day, she took photographs of the truck and reviewed the documents in the truck (Tr. 25; Exhs. G-1; G-2; G-3; and G-4).

CSHO McWilliams conducted the remainder of the investigation off site. She interviewed WD several weeks later. She also observed the operation of a similar truck and took a video of the tailgate door being opened and closed (Tr. 62-64; Exh. R-33).

Based upon her investigation, CSHO McWilliams recommended the Secretary issue Southern a citation alleging a serious violation of the general duty clause. Southern timely contested the citation.

The Citation

The citation alleges a serious violation of the general duty clause, § 5(a)(1) of the Act. Section 5(a)(1) requires each employer to "furnish to each of his employees' employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees." 29 U.S.C. § 654(a)(1). The citation alleges as follows:

> The employer did not furnish employment and a place of employment which were free from recognized hazards that were causing or likely to cause death or serious physical harm to employees when they were exposed to crushing hazards:
>
> (a) On or about 11/18/2019 - 831 Loop Road, Reform, AL 35481, employees were exposed to caught-between and/or struck-by hazards from a GapVax hydro-vacuum truck's tailgate door while washing out the tank.

As a feasible means of abatement, OSHA proposed:

> Among other methods, feasible and acceptable methods to correct this hazard would be to verify that employees were not in the danger zone before and during an operation to open and close the tailgate door or raise or lower the tank and when employees are washing out the tank; and place warning or danger signs on

> the tank near the tailgate to warn employees of the crushing hazard between the tailgate and tank.

DISCUSSION

Elements of a § 5(a)(1) Violation

To establish a violation of the general duty clause, the Secretary must show that:

> (1) a condition or activity in the workplace presented a hazard; (2) the employer or its industry recognized the hazard; (3) the hazard was likely to cause death or serious physical harm; and (4) a feasible means existed to eliminate or materially reduce the hazard…The Secretary must also show that the employer knew or, with the exercise of reasonable diligence, could have known of the hazardous condition. *Tampa Shipyards, Inc*., 15 BNA OSHC 1533, 1537 (No. 86-0469, 1992).

USH of Westwood Pembroke, Inc., No. 17-0737, 2022 WL 774272, at *2 (OSHRC March 3, 2022).

Whether an Activity or Condition at the Site Constituted a Hazard

The Commission has held that as part of his burden of proving a § 5(a)(1) violation, the Secretary "must define the cited hazard in a manner that gives the employer fair notice of its obligations under the Act by specifying conditions or practices over which the employer can reasonably be expected to exercise control." *Otis Elevator Co.*, No. 03-1344, 2007 WL 3088263, at *3 (OSHRC September 27, 2007). A condition or practice presents a hazard where "employees [are exposed] to a 'significant risk' of harm." *A.H. Sturgill Roofing, Inc*., No. 13-0224, 2019 WL 1099857, at *2 (OSHRC February 28, 2019), *quoting, Beverly Enters., Inc*., No. 91-3144, 2000 WL 34012177, at *10-11 (OSHRC October 27, 2000)(consolidated)). To establish the existence of the hazard, the Secretary must show the "hazardous incident can occur under other than a freakish or utterly implausible concurrence of circumstances." *Waldon Health Care Ctr*., No. 89-2804, 1993 WL 119662, at *11 (OSHRC April 2, 1993)(consolidated), *citing Nat'l Realty & Constr. Co., v. OSHRC*, 489 F.2d 1257, 1265 n. 33 (D.C. Cir. 1973).

The Secretary defined the hazard in this case as a caught-between or struck-by hazard caused by the closing tailgate door "while washing out the tank" (Tr. 37).[4] It is not "freakish or

[4] The citation can be read to address the caught-between or struck-by hazard of the tailgate door closing for any reason. The Commission has long held citations are to be liberally construed. *Ericson Air-Crane, Inc*., No. 07-0645, 2012 WL 762001, at *2 (OSHRC March 2, 2012). The only hazard the parties litigated, however, was that created by the intentional closing of the tailgate door. The Secretary never argued the hazard was created by an unexpected closing of the tailgate door during the washing process and presented no evidence showing how or why the tailgate door might unexpectedly close. Nor does the Secretary's proposed abatement method address unexpected closing of the tailgate door.

utterly implausible" an employee could be caught between the tank and the closing tailgate door. No physical barrier prevents the employee from entering the area while the tailgate door is being closed. The operator is unable to see whether an individual is in the hazardous area while operating the tailgate door. The accident here is evidence of the significant risk of harm posed by such a circumstance. The conditions at the dump site[5] posed a hazard.

In its post-hearing brief, Southern argues the Secretary has not established a hazard during the washing process because he has failed to show exposure to a hazard during normal operations. In so arguing, Southern relies on *Peacock Engineering, Inc.,* No. 11-2780, 2007 WL 3864205 (OSHRC April 27, 2017).[6] Southern's reliance on this decision is misplaced. In its decision, the Commission overturned the portion of the Administrative Law Judge's decision that found the Secretary, who had alleged a § 5(a)(1) violation, had failed to establish exposure to an amputation hazard. The Commission held the judge had conflated the Secretary's burden of proving existence of a hazard with his burden of proving whether feasible means existed to materially reduce the hazard. *Id*. at *2. The Commission held proof of employee exposure can be inferred when the hazard and likelihood of harm elements of a general duty clause violation are established. '"Implicit in the…elements [of hazard and likelihood of harm] is the necessity for establishing employee exposure to the cited hazardous condition."' *Id*. at *5, *quoting Grossman Steel & Aluminum Corp*., No. 76-2834, 1978 WL 7095, at *2 (OSHRC October 18, 1978). The Commission found the Secretary established employee exposure through the actual exposure that caused the amputation. Here, AW's tragic death establishes actual exposure to the crushing hazard presented by the closing of the tailgate door.

Southern similarly conflates the hazard element of the general duty clause violation with the abatement element. "The efficacy of [the employer's] work methods in avoiding injury ... is a separate inquiry from whether an alleged hazard was present." *Peacock Engineering*, 2007 WL 2864205, at *3. Whether Southern's work practices prevent exposure to the alleged hazard is

[5] There is no dispute the dump site was "a place of employment." Both the Commission and the courts of appeals have consistently found that a "place of employment" includes any location where employees have been assigned work duties. *Safeway Inc.*, No. 99-316, 2003 WL 1070420, at *2 (OSHRC March 12, 2003)(Rogers, separate opinion), *aff'd* 382 F.3d 1189 (10th Cir. 2004).

[6] The case citation in Southern's post-hearing brief is incorrect. Southern uses the citation for a related Commission decision decided the same day but that does not address a general duty clause violation. The citation provided herein is the citation for the decision upon which the court assumes Southern intended to rely.

relevant to whether the Secretary has established a feasible means of abatement that would eliminate or materially reduce the hazard, not the existence of the hazard.

With regard to the existence of a hazard, the Secretary's burden is not to show "a 'significant risk' of the hazard coming to fruition, only that if the hazardous event occurs, it would create a 'significant risk' to employees." *Waldon Health Care*, 1193 WL 119662, at *11; *citing Kelly Springfield Tire Co. v. Donovan*, 729 F.2d 317, 322-25 (5th Cir. 1984). Although it is not necessary for the tech to enter the hazardous area while washing out the truck, nothing prevents him from doing so. If the tech enters the hazardous area while the operator is closing the tailgate door, he is exposed to a significant risk of harm, as evidenced by the accident here.

Based upon the foregoing, the undersigned finds the Secretary has established the existence of a hazard at Southern's worksite that posed a significant risk of harm.

Whether the Activity or Condition was a Recognized Hazard

A recognized hazard is a practice, procedure or condition under the employer's control that is known to be hazardous by the cited employer or the employer's industry. *Pelron Corp.*, No. 82-388, 1986 WL 53616, at *3 (OSHRC June 2, 1986). The Secretary did not present any evidence of industry recognition of the hazard, arguing Southern's training materials establish Southern's recognition of the hazard. The document upon which the Secretary relies is a "Safety Blast" Southern presented to its employees on September 13, 2019 (Exh. G-7). This Safety Blast states one of the hazards associated with vacuum trucks is a "[c]rushing hazard between rear gate and tank body."

The Secretary's singular reliance on the Safety Blast is problematic. "The Commission has been reluctant to rely solely on an employer's safety precautions to find hazard recognition absent other 'independent evidence.'" *Mid South Waffles, Inc., d/b/a Waffle House #1283*, No. 13-1022, 1029 WL 990226, at *5 (OSHRC February 15, 2019), *citing*, *Pepperidge Farm, Inc.*, No. 89-0265, 1997 WL 212599, at *14 (OSHRC April 26, 1997). The Secretary presented no other independent evidence of recognition. Nor did the Secretary provide context for the Safety Blast. Allen Kempson, Southern's division operations manager, testified he administered the Safety Blast (Tr. 133-34). He did not expand on the nature of that training, other than to point out the existence of the hazard caused by the pinch point between the truck's bed and tailgate door. In addition to referring generally to a crushing hazard, the document reads, "When washing out the tank, secure lockout of rear door hatch with safety device to prevent crushing hazard." (Exh.

G-7). This is the only other reference to the crushing hazard in the document. Reading the document as a whole, a reasonable inference can be drawn that the hazard referenced is that created by the unexpected closing of the tailgate door due to failure to secure a lockout device rather than that created by the intentional closing of the tailgate door.

The Secretary did not address the hazard of unexpected closing of the tailgate door. In her testimony, CSHO McWilliams testified the hazard was "being struck by or crushed by, caught between that door and the tank body." (Tr. 37) She went on to testify at length regarding the process by which the door is opened and closed by the hydraulic controls. She made no mention of an unexpected closing of the tailgate door. In his brief, the Secretary states

> Here, the evidence shows that the process that employees followed when dumping material from the hydro vacuum trucks presented a hazard to employees. The driver cannot see the back of the truck while operating the hydraulic controls located on the driver side (Tr. 34). Techs use hand signals to communicate to the drivers when to open and close the tailgate, but the drivers observe these hand signals through side mirrors. (Tr. 104). Additionally, the truck are approximately 44 feet long. (Tr. 106). This process provides significant opportunity for miscommunication. Furthermore, even if no miscommunication occurs, employees are still in danger if they do not clear the path of the moving tailgate as it is closing, and drivers have no way to verify that employees are outside the zone of danger.

(Secretary's Post-Hearing Brief at pp. 3-4). The Secretary has failed to establish the Safety Blast addressed the hazard as he defined it. The record does not contain evidence of other training or work rules designed to address the hazard. There were no prior similar incidents at Southern or any other employer in the industry.

The Secretary has failed to establish Southern recognized the existence of the hazard of an employee having his body in the hazardous area while the operator is closing the tailgate door. The tech stands at the back corner of the passenger side of the truck while rinsing out the mud (Tr. 97). He does not stand directly behind the tailgate because that would put him in the path of the outflowing mud (Tr. 97). He stands in the same location when hosing down the seals of the truck after the bed has been lowered (Tr. 98). While the operator closes the tailgate door, Southern's procedures require the tech to be on the opposite side of the truck, near the cab, putting away the hose and other equipment (Tr. 99). There is no reason for the tech to be in the hazardous area while washing out the bed or while the operator is closing the tailgate door (Tr. 99). Southern was not on notice its process created a hazard. The Secretary has failed to establish

the activity or conditions at Southern's worksite, as specifically described in the Citation, was a recognized hazard.

Whether Feasible Means of Abatement Exist That Would Materially Reduce the Hazard

Even if the Secretary had shown Southern recognized the alleged hazard, he failed to prove there is a feasible means of abatement that would eliminate or materially reduce the hazard. At the hearing and in his post-hearing brief, the method of abatement the Secretary proposed was the institution of a rule requiring the operator have all personnel within his line of sight while he is closing the tailgate door. Had AW been in WD's line of sight while the WD operated the controls of the tailgate door, AW could not have been in the hazardous area and would not have been caught between the closing tailgate door and the bed of the truck. "Because OSHA is designated to encourage abatement of hazardous conditions themselves, however, rather than to fix blame after the fact for a particular injury, a citation is supported by evidence which shows the preventability of the *generic* hazard, if not this particular instance." *Champlin Petroleum Co. v. OSHRC*, 593 F.2d 637, 642 (5th Cir. 1979). It is not enough for the Secretary to show his proposed abatement might have prevented the accident, he must show the methods undertaken by Southern to address the hazard were inadequate.

> Where "an employer has existing safety procedures, the burden is on the Secretary to show that those procedures are inadequate." *SeaWorld of Fla. v. Perez*, 748 F.3d 1202, 1215 (D.C. Cir. 2014). The Secretary may do so by demonstrating that "there was a more effective feasible means by which [the employer] could have freed its workplace of the hazard." *Ala. Power Co.*, 13 BNA OSHC 1240, 1243-1244 (No. 84-357, 1987) (citing *Cerro Metal Prods. Div., Marmon Grp., Inc.*, 12 BNA OSHC 1821, 1822 (No. 78-5159, 1986)). Alternatively, the Secretary may demonstrate that an employer's existing safety procedures were inadequate by showing that the employer failed to properly communicate those procedures to its employees, failed to take steps to discover noncompliance with those procedures, or failed to effectively enforce those procedures in the event of noncompliance. *See Ala. Power Co.*, 13 BNA OSHC at 1244 (citing *Inland Steel Co.*, 12 BNA OSHC 1968, 1976 (No. 79-3286, 1986)).

Roadsafe Traffic Sys., Inc., No. 18-0758, 2021 WL 5994023, at *6 (OSHRC December 10, 2021).

The Secretary presented insufficient evidence of the inadequacy of Southern's procedures to protect employees from being caught in the closing tailgate door during the washing out process. As previously discussed, there is no operational need for the tech to be in the hazardous area during the washing out process or while the operator closes the tailgate door. The operator

does not close the tailgate door until the tech has signaled his work is complete. The tech signals from a location that is not in the path of the closing tailgate door. He then moves to an area farther from the closing tailgate door. To the extent employees follow this procedure, there is no exposure to the hazard of being crushed by the closing tailgate door.

The Secretary argues his proposed abatement method requiring "line of sight verification" of the location of the tech by the operator before he closes the tailgate door eliminates the potential for miscommunication regarding the tech's location and ensures he is not in the hazardous area. The only testimony the Secretary presented to establish the efficacy and feasibility of this method was that of CSHO McWilliams.[7] Because she had not observed the operations at the dump site, CSHO McWilliams could not testify whether those operations ever placed the tech in the hazardous area. Consequently, she could not testify whether the proposed abatement reduced the hazard of the tech being in the hazardous area. Nor did the Secretary present sufficient evidence in his case in chief to establish the inadequacy of Southern's safety procedures based upon inadequate training or oversight.

The Secretary did not present sufficient evidence his proposed abatement was feasible. CSHO McWilliams testified Southern had implemented line of sight verification but did not identify the source of that information. The Secretary presented no other evidence regarding Southern's procedures after the accident. The Secretary's evidence is insufficient to meet the Secretary's burden to establish the existence of a more effective, feasible means of abatement that would materially reduce the hazard.

Based upon the record as a whole, the court finds the Secretary failed to meet his burden to establish a violation of the general duty clause at Southern's worksite. In so finding, the court is not insensitive to the fact a tragic accident occurred which may have been preventable. However, the court's decision must be limited to the specific allegations contained in the Citation and the evidence presented. The Secretary's evidence is insufficient to establish the violation as alleged. Item 1, Citation 1 is **VACATED**.

---

[7] CSHO McWilliams's testified from memory which, by her own admission, was incomplete (Tr. 29). She testified she interviewed DW "a couple of weeks" after the accident (Tr. 29). She did not testify she spoke with any other Southern employees. She did not observe the operations at the dump site (Tr. 52). She did not investigate operations at any other hydro-evacuation company (Tr. 52, 61). She took no measurements of the truck or determine the sight lines around the truck (Tr. 61). Based upon the limitations of her investigation and her incomplete recollection, the court gives CSHO McWilliams's testimony little weight. Her testimony regarding the efficacy and feasibility of the Secretary's proposed abatement is given no weight.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

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

ORDER

Based on the foregoing decision, it is hereby **ORDERED**:

Items 1, Citation 1 are **VACATED,** and no penalty is assessed.

SO ORDERED.

/s/_____________________________
Heather A. Joys
Administrative Law Judge, OSHRC

Dated: September 6, 2022
Atlanta, GA