

SECRETARY OF LABOR,

Complainant,

v.

INTERSTATE BRANDS CORP.,

Respondent.

OSHRC Docket No. 00-1077

DECISION

Before: RAILTON, Chairman; ROGERS and STEPHENS, Commissioners.

BY THE COMMISSION:

This case arose out of the Secretary's citation charging Interstate Brands Corp. ("IBC") with three violations of the lockout/tagout ("LOTO") standard at 29 C.F.R. § 1910.147, for failing to document and implement energy control procedures. Administrative Law Judge Covette Rooney vacated all three violations.¹ We affirm the judge.

Background

IBC operates a bakery at its facility in Wayne, New Jersey, and has installed various units to automate the baking process. This case focuses on the bulk sugar system that automatically provides sugar as an ingredient to various food mixtures. The system, which is housed in a room adjacent to the main baking facility, consists of four main components: a large storage bin; a use bin rotary valve ("rotary valve"); a sifter; and a pneumatic conveyor line. When sugar is needed for a particular product, a remote electronic signal or "call" is sent to the rotary valve, which measures out a programmed amount of sugar from the storage bin and drops it through a rubber sleeve or "boot" into the sifter. The sugar then feeds onto a pneumatic conveyor line that carries it to the use point in the baking facility where it is mixed with other ingredients.

Three circuit breaker panels located adjacent to the bulk sugar system control the electric power to the rotary valve, the sifter, and the conveyer line. The record establishes that a label is affixed to the front of each panel identifying the component whose electric power it controls. Each circuit breaker is manually operated by a switch lever that moves between an upward "on" position and a downward "off position."² The end of each lever is a rubberized handle, the upper portion of which is colored black and the lower portion is colored red. Thus, when a lever is in the upward "on" position, the red colored portion of the handle is prominently visible; when a lever is in the downward "off" position, the black colored portion of the handle is prominently visible.

On an almost daily basis, the bulk sugar system jams when a blockage called a "sugar bridge" occurs in the storage bin located above the rotary valve. When this

¹Two other lockout/tagout violations were also vacated by the judge. However, the Secretary did not seek review of these items, and they are not before us.

²The words "on" and "off" are embossed at the top and bottom, respectively, of each panel.

happens, the rotary valve spins continuously as it receives repeated remote calls for sugar, but sugar cannot be dispensed due to the blockage. IBC's established procedure for breaking up a sugar bridge requires an operator to unscrew a ½-inch plug located at the base of the storage bin above the rotary valve and insert a steel rod to break up the blockage. This procedure does not expose the operator to any hazard and does not require that power to the bin be shut off.

On January 6, 2000, IBC's chief engineer accompanied a maintenance technician, who had been directed to check the sugar storage bin for a sugar bridge, into the room that housed the bulk sugar system.³ The chief engineer testified that he believed that the bridge had occurred inside the rotary valve, which was situated beneath the storage bin and which had not previously been the location of a blockage. As noted, the rotary valve is powered by electrical energy and can be deenergized by pulling down one of the disconnect levers located on a panel in the same room as the bulk sugar system.

The chief engineer pulled down two of the three levers on the nearby panels, but he failed to pull the third disconnect for the rotary valve, despite the label identifying it as controlling the rotary valve. Because the levers were in the same room as the rotary valve and nobody could enter the room without his knowledge, he did not lockout or tagout these levers. After throwing the two levers, the chief engineer claims he visually verified that the rotary valve was not spinning.⁴ He then removed the rubber boot located just below the rotary valve and stuck his hand up into the valve. However, the valve was still rotating, and three of his fingers were amputated.⁵

The chief engineer testified that the accident occurred because he had pulled the wrong lever. According to the record, IBC required employees to visually verify that the machine was disconnected by checking that the appropriate lever was in the down or "off" position and the black side of the lever's handle – as opposed to the red side – was showing.

Item 1a

In item 1a, the Secretary alleges that IBC violated 29 C.F.R. § 1910.147(c)(4)(i) because it did not utilize energy control procedures to secure electrical power to the rotary valve while employees were engaged in maintenance operations.⁶ The gravamen of the

³It is not clear from the record why the chief engineer, who testified that he had never before dealt with this problem on the bulk sugar system, accompanied the maintenance technician on this particular occasion.

⁴This verification was possible because although the blades of the rotary valve are enclosed within a cylindrical housing, they are attached to an axel shaft, one end of which is externally visible at one end of the housing. When the valve is operating, the end of the shaft can be seen spinning. However, the chief engineer claimed that it was difficult to see whether the shaft was rotating because it was painted white to match the color of the cylindrical housing.

⁵At the time of the accident, the maintenance technician, who testified that he broke up sugar bridges on a daily basis, was ascending a ladder in order to access the plug in the storage bin that had to be removed in order for him to insert the rod used to break up the bridge.

⁶**§1910.147 The control of hazardous energy (lockout/tagout)**

....

(c) *General*

violation is that the chief engineer: (1) failed to apply locks and/or tags to the power levers; and (2) failed to properly verify that the rotary valve was isolated. The judge vacated the item finding that the Secretary failed to establish, as part of her *prima facie* case, that IBC had knowledge of the violation. Specifically, she applied the test for knowledge set forth in *Pennsylvania Power and Light Co. v. Secretary*, 737 F.2d 350 (3d Cir. 1984), and found that the Secretary failed to establish that the chief engineer's failure to properly lockout the rotary valve was foreseeable.⁷ The judge noted that the three disconnect levers were specifically labeled to enable an employee to determine which lever controlled which part of the bulk sugar system and that there were several methods to verify that a component of the system had been isolated. The judge also found that IBC adequately trained its employees, undertook inspections to discover violations, and utilized a progressive disciplinary policy. Finally, the judge noted that the chief engineer had an excellent safety record and a reputation as a safe employee.

We affirm the judge's finding that the Secretary failed to show the violation was foreseeable. As the judge held, under Third Circuit precedent, the Secretary could prove foreseeability by demonstrating the inadequacy of the company's safety program, training or supervision. *Pennsylvania Power and Light Co.*, 737 F.2d at 358. However, where a standard does not specify a particular type of abatement but rather leaves it to the employer to meet the obligations imposed by a standard, a violation is not to be considered "preventable" simply because the employer does not have a work rule that tracks the Secretary's interpretation of the governing standard. *Id.* Rather, employers should be encouraged to develop work rules that will reasonably respond to their particular working conditions. *Id.*

....

(4) *Energy control procedure.* (1) Procedures shall be developed, documented and utilized for the control of potential hazardous energy when employees are engaged in the activities covered by this section.

⁷To prove a violation of a standard, the Secretary must establish that: (1) the standard applies to the conditions cited; (2) the terms of the standard were not met; (3) employees had access to the violative conditions; and (4) the employer either knew of the violative conditions or could have known with the exercise of reasonable diligence. *Offshore Shipbuilding, Inc.*, 18 BNA OSHC 2170, 2171, 2000 CCH OSHD ¶ 32,137, p. 48-443 (No. 99-257, 2000). Under Commission precedent, the Secretary may satisfy her burden of proof as to knowledge by showing that a supervisor with the authority to direct that protective measures be taken was aware of the violation. *Rawson Contrac., Inc.*, OSHRC Docket No. 99-0018 (April 4, 2003), slip op. at pp. 3-4. However, in the Third Circuit, where this case arose, the Secretary must also show that the violation was foreseeable where, as here, the standard is a general one. *See Pennsylvania Power and Light Co. v. Secretary*, 737 F.2d 350 (3d Cir. 1984). Since this case could be appealed to the Third Circuit, we find that the judge properly applied that precedent here. *See* 29 U.S.C. §§ 660(a) and (b) (employer or Secretary may appeal Commission order to federal court of appeals for the circuit in which the violation allegedly occurred or where the employer has its principal office; employer also may appeal to District of Columbia Circuit). *See also Stahl Roofing, Inc.*, OSHRC Docket Nos. 00-1268 & 00-1637 (February 21, 2003), slip op. at p. 9 n. 5.

The evidence demonstrates that IBC has a well communicated and adequately enforced safety policy. Employees are familiar with the company's LOTO program and are directed to lockout by their supervisors. IBC has a progressive disciplinary policy that provides for a verbal reprimand, a written reprimand, a one-day suspension, a three-day suspension, and a suspension pending further investigation. Employees have specifically been disciplined for LOTO violations. This includes one employee who was suspended for being disruptive during LOTO training.

We find no merit in the Secretary's argument that IBC's LOTO program and training of supervisors was inadequate because they "had not received the training necessary to effectively isolate the electrical energy." The evidence establishes that the chief engineer involved in the accident received LOTO training from Drakes Bakeries, IBC's predecessor corporation, and that he attended a LOTO seminar given by the State of New Jersey in 1990. While the training involved general lockout/tagout procedure, there is no evidence that the hazards posed by the rotary valve were any different than those presented by other equipment at the facility such that additional training was required.⁸ To the contrary, the evidence establishes that the rotary valve was similar to other, older equipment at the plant, including a similarly engineered system for automatically obtaining flour from bulk storage. Indeed, Edward Grund, vice-president of ID Group, a safety and health consulting company, testified that IBC's lockout/tagout procedures exceeded OSHA's model plans, including the training requirements.

The Secretary also failed to demonstrate that IBC did not take adequate steps to discover violations by supervisors. Thomas Bent, IBC director of operations, testified that he spends approximately 20 percent of his time every day checking on the status of the various maintenance activities in the facility. Approximately once a week, he specifically checks that lockout/tagout procedures are being followed. On the floor, the rules are enforced on a day-to-day basis by the supervisors. Until the accident, no IBC employee had been injured by the unexpected energization of electricity. Heinz Hentschel, IBC's former chief engineer, testified that he conducted audits of the lockout/tagout procedures at least once a month. These reports were shown to OSHA two to three times over the past 10 years. We also note that IBC had no reason to suspect that the chief engineer involved in the accident was not following prescribed procedures. Not only was he considered a safe employee, his safety record and adherence to safety procedures were factors in his being chosen as chief engineer. *See Pennsylvania Power & Light*, 737 F.2d at 359 (supervisor's "unblemished safety record" at odds with his hazardous actions).

We also decline to find a violation based on testimony from the chief engineer that on previous occasions, he did not lock out other equipment when it was under his full control and could not be energized by another employee without his knowledge. As found by the judge, the Secretary failed to establish that the chief engineer's failure to lock out other equipment actually involved activities covered by the LOTO standard. *See General Motors Corp., Delco Chassis Div.*, 17 BNA OSHC 1217, 1993-95 CCH OSHD ¶ 30,793 (No. 91-2973, 1995) (consolidated), *aff'd*, 89 F.3d 313 (6th Cir. 1996). The record contains no evidence about the type of work he was performing during these earlier occasions, whether the equipment he worked on was subject to unexpected energization that could cause injury, or whether the work involved placing his hands or other body parts into a zone of danger. Therefore, this testimony does not establish that the chief

⁸At the time of the accident, the rotary valve had been installed for only a month.

engineer violated lockout procedures in the past.

Thus, we find that the record fails to demonstrate that it was foreseeable that the chief engineer would fail to use IBC's LOTO procedures to properly secure power to the rotary valve. Accordingly, Item 1a is vacated.

Items 1b and 1c

Items 1b and 1c allege that IBC failed to adequately document its energy control procedures in violation of 29 C.F.R. §§ 1910.147(c)(4)(ii)(C) and (D).⁹ Item 1b alleges a violation on the grounds that specific control procedures for different equipment in the facility (such as the rotary valve) were not included in IBC's written energy control procedure. Item 1c alleges a violation based on IBC's failure to have a procedure for verifying the effectiveness of the energy control measures in the rotary valve.

The judge vacated these items on two grounds. With regard to the rotary valve, she found that it came within the documentation exception to §1910.147(c)(4)(i)¹⁰ and that no

⁹§1910.147 The control of hazardous energy (lockout/tagout)

....

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

....

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

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

¹⁰§1910.147 The control of hazardous energy (lockout/tagout)

....

(c) *General*

....

(4) *Energy control procedure.*

Note: *Exception:* The employer need not document the required procedure for a particular machine or equipment, when all of the following elements exist: (1) The machine or equipment has no potential for stored or residual energy or reaccumulation of stored energy after shut down which could endanger employees; (2) the machine or equipment has a single energy source which can be readily identified and isolated; (3) the isolation and locking out of that energy source will completely deenergize and deactivate the machine or equipment; (4) the machine or equipment is isolated from that energy source and locked out during servicing or maintenance; (5) a single lockout device will achieve a locked-out condition; (6) the lockout device is under the exclusive control of the authorized employee performing the servicing or maintenance; (7) the servicing or maintenance does

written LOTO procedure was required prior to the date of the accident. The judge also found that the Secretary failed to present evidence relevant to other machines or equipment sufficient to determine the adequacy and applicability of IBC's written LOTO program. We affirm the judge's decision but on different grounds.

The evidence establishes that IBC had a written LOTO procedure applicable to all the equipment and machinery at its facility. We agree with the judge that there is no basis for the Secretary's claim that this single procedure was inadequate as to "other" machinery and equipment because of general statements by the chief engineer that the facility had equipment that used energy sources other than electricity and that those machines required lockout/tagout. Specifically, the Secretary did not establish how IBC's procedure for the "placement, removal and transfer of lockout devices or tag-out devices" was inadequate as to its other machines. The evidence fails to establish either the nature of the energy involved, the function of these machines, their operations, or the circumstances under which they would require lockout/tagout. Accordingly, any conclusion that IBC was required to document different procedures for these unidentified machines would be mere speculation.

We also note that OSHA reviewed IBC's written LOTO procedures in previous inspections. During an inspection in October 1995, OSHA discussed IBC's written procedures with the company and made several recommendations to improve the program, which the company made and which are reflected in IBC's current written procedures. Indeed, because of OSHA's satisfaction with IBC's program, OSHA invited the company to join its voluntary protection program. Where an employer takes affirmative measures in reliance on OSHA's recommendations, we find that the employer lacks fair notice when, on reinspection, the Secretary claims that those measures did not comply with the standard. *See Miami Industries, Inc.*, 15 BNA OSHC 1258, 1991-93 CCH OSHD ¶ 29,465 (No. 88-671, 1991), *aff'd in part without published opinion*, 983 F.2d 1067 (6th Cir. 1992). Accordingly, even if we were to find that IBC's written procedures were deficient, IBC lacked fair notice of those deficiencies.¹¹

With regard to the rotary valve, there is no evidence to suggest that IBC's written LOTO procedures were inadequate as to the placement, removal and transfer of lockout devices or tag-out devices. IBC's written procedures require employees to lockout all energy sources and apply a tag to the power source. According to his testimony, the chief engineer understood that this was precisely what he was supposed to do to isolate the rotary valve, and he knew how to accomplish that task.

Turning to whether IBC's LOTO verification process was deficient, we note that the Secretary has not maintained a consistent litigating position on this issue throughout these proceedings.¹² For the first time on review, the Secretary claims that IBC's visual

not create hazards for other employees; and (8) the employer, in utilizing this exception has had no accidents involving the unexpected activation or reenergization of the machine or equipment during servicing or maintenance.

¹¹This would not apply to the rotary valve that was installed after the earlier inspections.

¹²IBC does not dispute that one step of its written verification procedure could not be applied to the rotary valve because it required the employee to use the machine's on-off switch to verify deenergization. In this case, the rotary valve was powered by an electric motor that

verification process failed to account for the possibility that a presumably deenergized rotary valve may in fact not be spinning because it is not receiving a remote call for sugar, not because its power has been properly isolated. However, our review of the record shows that the Secretary made no attempt at the hearing to tie this alleged violation to remote calls for sugar. In her post-hearing brief to the judge, the Secretary's focus was IBC's reliance on visual verification in general; there is no mention made of remote calls or "false positives" with regard to the rotary valve. Indeed, having never been presented with this argument, the judge did not address it in her decision.

It is only on review before the Commission that the Secretary has raised this specific contention regarding visual verification of the rotary valve. We not only find nothing in the record to support her theory, but also note that IBC's visual verification process related only to the status of the appropriate disconnect lever, not the rotary valve itself. Indeed, the chief engineer's testimony demonstrates that had he closely examined the two levers he had pulled down in accordance with this verification process, the elements of which he was clearly aware, he would have discovered that he had not pulled the lever properly labeled as controlling the rotary valve.¹³ This unfortunate accident was lacked its own on-off switch. Electric power could only be disconnected at the control panel. However, the record shows that IBC required employees to use alternate methods to visually verify that a machine had been deenergized, a process that the Secretary claims, for varying reasons, was deficient with regard to the rotary valve. The fact that these alternate methods were not documented was not specifically cited by the Secretary under Item 1c. In any event, because we find that the Secretary failed to show that IBC's LOTO procedures were inadequate as to the rotary valve, we do not address the judge's finding that IBC qualified for the documentation exception set out in §1910.147(c)(4)(i).

¹³Regarding the dissent's suggestion that the chief engineer was "confused" about which lever controlled the rotary valve, we note that the record shows that all three levers were properly labeled on their respective panels and that IBC was not cited for failing to properly identify the components these levers controlled. Furthermore, the chief engineer's testimony demonstrates not only that he had previous experience with the sugar storage bin over the course of the month the rotary valve had been part of the baking process but also that he was familiar with similar equipment used in IBC's flour system.

We further note that our dissenting colleague's reliance on *Trinity Industries, Inc.*, 15 BNA OSHC 1581, 1991-93 CCH OSHD ¶ 29,662 (No. 88-1545, 1992) (consolidated), *rev'd and remanded on other grounds*, 16 F.3d 1149 (11th Cir. 1994), is misplaced. In *Trinity*, the employer was cited for failing to have an operable single-stroke mechanism on a mechanical power press as specifically required by the cited machine guarding standard. *Trinity* did not dispute that the press lacked this mechanism but attempted to excuse its failure by arguing that there was no likelihood of an accident occurring during normal operations. 15 BNA OSHC at 1593, 1991-93 CCH OSHD at p. 40,196. In rejecting this contention and affirming the violation, the Commission noted that the very term "accident" implies the occurrence of something outside the realm of normal operations and noted, as the dissent states, "standards are intended to protect against injury resulting from an instance of inattention or bad judgment..." *Id.* at 1593-94, 1991-93 CCH OSHD at p. 40,196. We do not interpret this to mean, however, that every lapse in employee judgment or lack of attention can be construed as a failure on the employer's part – especially, where an employer like IBC, in

not caused by a failure of IBC's verification process, but by the chief engineer's unforeseeable failure to follow it. Therefore, we find that the Secretary has not demonstrated that any part of IBC's LOTO procedure was inadequate.

ORDER

For reasons stated above, the judge's decision and order is affirmed and items 1a, 1b, and 1c are VACATED. It is so ordered.

/s/

W. Scott Railton
Chairman

/s/

James M. Stephens
Commissioner

Dated: April 24, 2003

contrast with Trinity, has actually taken steps to guard against such lapses. Insofar as the LOTO standard cited here is a performance-oriented one, the very development of a verification process necessarily required IBC to take into account the risks posed by employee error.

Finally, regardless of the circumstances surrounding the chief engineer's conduct on the day of his accident, the fact remains that the deficiencies which the dissent claims exist in IBC's visual verification process are simply not borne out by the evidence of record.

ROGERS, Commissioner, concurring and dissenting:

I concur with the result reached by the majority to the extent that items 1a and 1b are vacated. However, I must dissent with respect to the disposition of item 1c as I would affirm a violation of that item. I believe the verification process in the lockout/tagout procedure used by Interstate Brands Corp. (IBC) is clearly inadequate with respect to the bulk sugar system use bin rotary valve.

The majority has vacated item 1a on the ground that the Secretary failed to show the violation was foreseeable under Third Circuit case law. *Pennsylvania Power and Light Co. v. Secretary*, 737 F.2d 350 (3d Cir. 1984) (“*PPL*”).¹ In view of the language of the citation, the gravamen of the alleged violation charged by the Secretary with respect to item 1a is the failure to utilize energy control procedures with respect to the bulk sugar system use bin rotary valve, in which the conduct of the chief engineer is a factor.

The Secretary argues that the chief engineer’s conduct was foreseeable. However, the evidence leads me to conclude that even if IBC’s procedures were fully compliant, the chief engineer’s conduct would have been the same. He failed to properly verify that the rotary valve was de-energized. I agree with the Secretary’s position that IBC’s verification process was defective. But the chief engineer also failed to apply locks here, notwithstanding the fact that no deficiency has been shown in this aspect of IBC’s lockout/tagout procedure. Given *PPL*’s admonition that “the Secretary may not shift to the employer the ultimate risk of non-persuasion,” I believe, based on the totality of the evidence of record, that the Secretary has failed to prove that the chief engineer’s failure to utilize proper energy control procedures was foreseeable. *PPL*, 737 F.2d at 358. His “departure from that safe course of conduct cannot be explained by any deficiencies in” IBC’s lockout/tagout procedures and thus was not foreseeable. *Id.* at 359. Thus, under the circumstances here, I too would vacate this item.²

I also agree that item 1b should be vacated because the gravamen of the violation charged by the Secretary with respect to item 1b relates to the “procedural steps for the placement, removal and transfer of lockout devices or tagout devices and the

¹In my view, the lockout/tagout standard is a general standard for purposes of applying *PPL*’s foreseeability analysis.

²Had this citation item focused on the content of the procedures rather than their utilization, I might have come to a different conclusion.

responsibility for them.” See 29 C.F.R. 1910.147(c)(4)(ii)(C). The Secretary has not shown any deficiency with respect to that specific aspect of IBC’s lockout/tagout procedure, with respect to either the use bin rotary valve or any other machine.

However, I respectfully dissent with respect to item 1c. The gravamen of this alleged violation focuses on the adequacy of the verification procedure, where the conduct of the chief engineer is irrelevant. In my view, the verification procedure used by IBC is clearly inadequate here.

The lockout/tagout standard recognizes that human error is possible and seeks to protect employees involved in servicing operations from the potentially severe consequences of human error. For example, as the Preamble to the standard points out, “. . . even though the machine or equipment has been shut off, and even if residual energy has been dissipated, an accident can still occur if there is an inadvertent activation of that machine or equipment. Inadvertent activation can occur due to an error on the part of the employee who is conducting the maintenance or servicing activity, or by any other person.” 54 Fed. Reg. 36,644, 36,647 (1989).³

Thus, the requirement of the standard for employers to develop lockout/tagout procedures is designed to protect employees involved in servicing from injury, even if human error may be a contributing factor. The fact that human error may have occurred here does not absolve the employer when its own procedure did not even adequately address the factual circumstances at issue. The majority seems to suggest, by focusing on the chief engineer’s lapse in judgment, that the cited verification deficiencies here recede into the background. As the Commission has consistently noted, however, where a workplace accident occurs, the existence of a violation is unrelated to whether that violation caused the accident. *Cleveland Consolidated, Inc.*, 13 BNA OSHC 1114, 1116 n.1, 1986-87 CCH OSHD 27,829 at 36,427 n.1 (No. 84-696, 1987) (“the cause of an accident, and particularly whether a violation of a standard caused an accident, is not necessarily relevant to whether an employer violated a regulation”). After all, standards are intended to protect against injury resulting from an instance of inattention or bad

³At the same time, the lockout/tagout standard does not seek to make the employer the absolute guarantor of employee safety. Even the best, fully compliant lockout/tagout procedures combined with the best safety program and training cannot guarantee safety if a worker simply ignores the procedures, by, for example, refusing to affix a lock where required. But the verification procedures here were not compliant to begin with.

judgment as well as from the risks arising from a machine's operation. *Trinity Industries, Inc.*, 15 BNA OSHC 1581, 1593-94, 1991-93 CCH OSHD 29,662 at 40,196 (No. 88-1545, 1992)(consolidated), *rev'd & remanded on other grounds*, 16 F.3d 1149 (11th Cir. 1994).⁴

Notwithstanding the errors of the chief engineer, and given the gravamen of this item, the deficiencies of the verification procedure compel me to conclude that there is a violation here. First, while it might seem a simple matter to look at the appropriate lever and determine that it is in the "off" position, the record reflects that the chief engineer was somewhat confused about which lever of the three actually controlled the particular component he was servicing. This is similar to the situation any home repairman would face when trying to determine which of several switches in the circuit breaker box controlled a particular electric outlet or device. That is why a prudent home repairman, no less than a prudent employer, would utilize or provide for some extrinsic means of verification to ensure the correct switch was thrown.

While arguably an extrinsic means, visual verification also is not adequate here. The record indicates that the turning portion of the valve is painted white, as is the surrounding area, making it hard to determine if the valve has truly stopped spinning. Furthermore, even if the valve has stopped spinning, that is no guarantee that it has been successfully de-energized as the lack of activity by the valve could merely reflect the fact that there is currently no remote call for sugar - the so-called "false positive" problem. The Preamble notes the value and importance of visual inspection, but also emphasizes that "in order to verify that hazardous energy has been isolated, the authorized employee may need to use a combination of . . . methods. The appropriate combination [of verification methods] will depend upon the type of machinery or equipment involved, the complexity of the system, and other factors." 54 Fed. Reg. 36,644, 36,679 (1989).

⁴The majority tries to distinguish the *Trinity* case from the situation here by noting that IBC, in contrast to Trinity, has taken steps to guard against lapses in employee judgment. But the issue isn't whether IBC has taken steps. Rather, the issue is whether those steps are adequate and comply with the requirements of the standard.

Unfortunately, here there was no effective extrinsic means of verification.⁵ The verification process in IBC's lockout/tagout procedure spoke of turning the machine back on - after switching off the energy at the main power source - to confirm deactivation, just like a home repairman would turn off a switch in the circuit breaker box and then see if the outlet or device was still powered. Unfortunately, here, there was no separate on-off switch on the use bin rotary valve.⁶ Thus, IBC's "one size fits all" lockout/tagout procedure did not fit the sugar use bin rotary valve. In the words of the Third Circuit, IBC's procedure does not "reasonably respond to their particular working conditions and safety needs" and is not "tailored to their respective operations." *See PPL*, 737 F.2d at 358-59.

⁵Indeed, Interstate's expert, Edward Grund, conceded that the verification methods relied on by IBC had their drawbacks, noting that power disconnect switches can sometimes malfunction or be mislabeled and conceded that one couldn't test a machine merely by looking at it.

⁶Even if there were a separate on-off switch, query whether it would have been similarly ineffective as a means of verification, given the "false positive" problem discussed earlier. A more effective method of verification would have required the initiation of a remote call for sugar to see if the valve was indeed deactivated.

Accordingly, I would find a violation of item 1c based on IBC's failure to have an adequate verification process for the sugar use bin rotary valve.

/s/

Thomasina V. Rogers
Commissioner

SECRETARY OF LABOR,

Complainant,

v.

INTERSTATE BRANDS CORPORATION,

Respondent.

OSHRC Docket No. 00-1077

APPEARANCES:

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BEFORE: Administrative Law Judge Covette Rooney

DECISION AND ORDER

This proceeding is before the Occupational Safety and Health Review Commission (“the Commission”) pursuant to Section 10 (c) of the Occupational Safety and Health Act of 1970, 29 U.S.C. 651 *et seq.* (“the Act”). At all times relevant to this action, Respondent Interstate Brands Corporation (“IBC”) operated a baked goods factory at 75 Demarest Drive, Wayne, New Jersey.

On January 6, 2000, Michael Morgan, a chief engineer employed at the IBC factory, sustained an amputation injury to three fingers on his right hand while inspecting a rotary valve for a possible blockage. The ensuing OSHA inspection resulted in the issuance of one serious citation, alleging violations of the following standards: 29 C.F.R. §§ 1910.147(c)(4)(i), 1910.147(c)(4)(ii)(C), 1910.147(c)(4)(ii)(D), 1910.146(c)(6)(i)(B) and 29 C.F.R. 1910.147(c)(7)(iii)(A).

IBC filed a timely notice of contest, and a hearing was conducted on February 26 and February 27, 2001. Post hearing briefs were fully submitted on May 11, 2001, and reply briefs were fully submitted on May 18, 2001. This matter is ready for disposition.

Background

The rotary valve involved in the accident is part of a bulk sugar system, which measures and feeds sugar to use points located in other areas of the factory. The rotary valve metes out measured sugar from a sugar storage bin immediately above it, before sending the sugar through a rubber boot into a sifter. After passing through the sifter, the sugar travels through an inlet

airlock and then through a pneumatic tube to the use point. The call for sugar originates at the distant use point and travels by signal to the bulk sugar system control panel. (Tr. 20-23).

The rotary valve is powered by electrical energy that can be deenergized by pulling down a disconnect lever located on a control panel in the sugar system room. Two additional disconnect levers are located on the control panel for two other electrically powered pieces of equipment which make up the bulk sugar system. On the day of the accident, each disconnect lever had an identifying sign above it. The sign above the disconnect lever on the far right indicated that it controlled the energy to the use bin rotary valve. The disconnect levers were black on the top and red on the bottom, and the panel containing the three disconnect levers indicated that up was "on" and down was "off." There were thus three ways to determine, visually, whether a machine in the sugar use system had been isolated: first, the corresponding disconnect lever looked black; second, it was in the "down" position; and third, the lever was near the word "off." If the energy was not disconnected, the rotary valve would spin when a call from the distant use point was received, and stop spinning once the call was satisfied. (Tr. 20-21, 23, 45, 73-74, 79, 81, 82-83, 137)

IBC obtained the rotary valve one month before the accident, although there was testimony that IBC maintained a similar piece of equipment for the measurement and distribution of flour. (Tr. 26-27, 48). According to Thomas Bent, IBC's director of operations, other electrically powered equipment located at the factory may be deenergized in essentially the same manner as is the power to the rotary valve. (Tr. 108, 144-145).

The evidence demonstrates that a sugar bridge, or blockage, occurred in the sugar bin located above the rotary valve on a daily basis. Accordingly, a practice developed of inserting a 1/4-inch-thick metal rod through a small opening in the side of the sugar bin, to break up any sugar blockage inside the bin. No arms or body parts came near any rotating equipment during this procedure, and IBC did not require that the employees who used this procedure lock out the energy source. (Tr. 139-143, 302-304). With respect to the rotary valve, located below the sugar bin, Michael Morgan, the injured employee, admitted that IBC's energy control and power lockout policy required that the employee wishing to service the rotary valve, isolate and lock out the corresponding disconnect lever. (Tr. 31).

IBC's written lockout policy, as revised, had been in effect for at least six years prior to the accident. IBC asserts that this plan was refined following an earlier OSHA inspection. According to Art Agreda, a safety manager employed by IBC, an unnamed OSHA compliance officer, ("CO") inspected the site in 1995, reviewed the written policy, and indicated that it was in compliance with the OSHA standards. The CO also made two recommendations, which were

incorporated into the written plan. Agreda also testified that the CO invited Agreda to attend a “voluntary program” based on the written lockout plan. (Tr. 276-278; Exhibit S-5).

The evidence demonstrates that IBC’s safety rules were provided to IBC employees during orientation. IBC also offered annual refresher seminars on lockout procedures, and directed its supervisors to enforce the lockout rules on a daily basis. IBC administered a progressive discipline policy for safety violations, which included, first, a verbal reprimand, second a written reprimand, and third a final reprimand with a one day suspension. A fourth violation resulted in a three day suspension, and a fifth violation resulted in complete suspension, pending further investigation. Morgan had no history of safety violations before the accident of January 6, 2000. (Tr. 36, 146-149, 152-153).

The Accident and the OSHA Inspection

Morgan testified that he entered the sugar use bin room on January 6, 2000, because no sugar was released following a call from a use point in the mixing room. Charles Geiger, a maintenance technician, accompanied him. According to Morgan, the rotary valve was operating when they first entered the room. Morgan proceeded to the wall on the far side of the equipment, to the control panel containing the three disconnect levers. He turned off two of the three levers, believing that one of them operated the rotary valve. Morgan testified that he did not attempt to verify the purpose of the third lever because he wanted to determine which equipment had stopped, however, a label above the third lever identified it as controlling the “use bin rotary valve.” Morgan testified that he did not apply a lock to the levers because the room was small and contained only one door. Because he and the bulk sugar system were between the door and the power disconnects, he would know if anyone came through the door and headed towards the levers. (Tr. 22-24, 30, 74, Exhibit R-12).

Morgan believed that the rotary valve had stopped turning after he pulled down the two disconnect levers, having made this determination by looking at the shaft to the rotary valve through the column on the side. However, Morgan testified at the hearing that the rotary valve must have been operating continuously from the time he entered the room until the accident occurred. He explained that it was difficult to tell whether the rotary valve was rotating, as it was painted white on white. (Tr. 24-25, 30, 90-91, 101).

Morgan testified that he next pulled down the rubber boot attached to the bottom of the rotary valve, to determine whether there was “any material packed in there.” He then placed his right hand into the interior of the rotary valve, and the valve severed three of his fingers. Geiger, who was standing on a ladder to Morgan’s right, was the only witness to the accident. (Tr. 22-25, 37-40, 85-86).

The resulting OSHA inspection was conducted by CO Richard Brown.⁷ CO Brown testified that he visited the site on April 18 and May 3, 2000, performed off-site interviews, and reviewed IBC's OSHA 200 documents, and its lockout policy, before recommending the issuance of the Citation. A single penalty of \$4,500 was proposed for all Items. (Tr. 168-170, 175, 184-187, 244-245).

IBC's Jurisdictional and Equitable Estoppel Arguments

In its post-hearing brief, IBC for the first time, raises the argument that the Commission lacks jurisdiction because the Secretary failed to submit proof that IBC was engaged in interstate commerce. (IBC's brief, p. 31). However, IBC's answer admits that the Commission has jurisdiction over this case and that IBC is an employer engaged in interstate commerce. (IBC's answer, paragraphs "2" and "4"). Moreover, IBC failed to raise this issue at any time prior to the hearing. IBC has thus waived its right to assert a lack of jurisdiction, and its argument in this regard is rejected.

IBC also argues that the Secretary should be estopped from enforcing Citation Items 1a, 1b and 1c, because IBC's written lockout policy was developed and refined based on the comments made by an OSHA CO during a 1995 inspection of the factory. However, IBC failed to identify equitable estoppel as a defense in its answer.

Commission Rule 34(b)(3), 29 C.F.R. §2200.34(b)(3), requires a respondent to identify all affirmative defenses in its answer, and pursuant to 29 C.F.R. §2200.34(b)(4), a respondent may be prohibited from asserting such a defense. Further, longstanding Commission precedent holds that affirmative defenses may not be asserted if not raised in the answer, or as soon thereafter as practicable. *See Manti d/b/a Manti Homes* 16 BNA OSHC 1458, 1461 (No. 92-2222, 1993). Like its jurisdictional defense, IBC did not formally assert this equitable estoppel argument until it served its post hearing brief. This is clearly not, "as soon as practicable." In any event, even if IBC had raised this defense in a timely fashion, IBC did not meet its burden of showing the elements of an equitable estoppel defense. *See Erie Coke Corp.* 15 BNA OSHC 1561, 1568-1579 (No. 90-2634, 1992). In particular, IBC did not show that the CO's statements or actions in 1995 constituted a misrepresentation or affirmative misconduct.⁸

⁷ CO Kwon, who participated in the inspection, did not testify at the hearing.

⁸ In order to establish an estoppel defense against the U.S. Government, it is incumbent on the party asserting the defense to prove: "(1) a misrepresentation by another party; (2) which he reasonably relied upon; (3) to his detriment; and (4), affirmative misconduct on the part of the government." *Erie Coke Corp. Supra.* *See also Monongahella Valley Hospital v Sullivan* 945 F.2d 576 (3d Cir. 1991). IBC did not present evidence that the equipment in its facility in 1995 was the same or was substantially similar to the equipment in its factory at the time of the inspection in 2000. There is thus no evidence that a misrepresentation in 1995 was made. In any event, the one time statements of the CO do not amount to "affirmative misconduct."

The Secretary's Burden

The Secretary has the burden of proving her case by a preponderance of the evidence. In order to establish a violation of an OSHA standard, the Secretary must show (a) the applicability of the standard, (b) the employer's noncompliance with the standard's terms, (c) employee access to the violative conditions, and (d) the employer's actual or constructive knowledge of the violation, (*i.e.*, the employer knew, or with the exercise of reasonable diligence could have known, of the violative conditions). *Atlantic Battery Co.*, 16 BNA OSHC 2131, 2138 (No. 90-1747, 1994).

All citation items in this case allege violations of subsections of 29 C.F.R. §1910.147. This standard is expressly limited in scope to those cases where “the servicing and maintenance of machines and equipment in which the *unexpected* energization or start up of the machines or equipment, or release of stored energy could cause injury to employees.” 29 C.F.R. §1910.147(a)(1)(i) (*emphasis in the original*).⁹ The standard further limits the application of the standard to those actions involving the “control of energy during servicing and/or maintenance of machines and equipment.” 29 C.F.R. §1910.147(a)(2)(i). In interpreting these limitations, the Commission has held that the Secretary must show that unexpected energizing, start-up or release of stored energy could occur and cause injury. *General Motors Corp.* 17 BNA OSHC 1217 (Nos. 91-2973, 91-3116, and 91-3117, 1995), *aff'd* 17 BNA OSHC 1673 (6th Cir. 1996). The standard expressly excludes normal production operations from its application, unless while performing those functions, an “employee is required to place any part of his or her body into an area on a machine or piece of equipment where work is actually performed...” 29 C.F.R. § 1910.147(a)(2)(ii)(B). With respect to IBC's practice of using a metal rod to break up the daily sugar bridges in the sugar bin itself, the standard by its terms does not apply, as the evidence supports that that activity was a normal production operation, during which no body parts are exposed to a hazard even if sudden energization were to occur. (Tr. 139-141).

The record demonstrates, however, that Morgan was not attempting to break up a sugar bridge in the bin when he sustained his injuries. Rather, he pulled down the boot located immediately below the rotary valve and inserted his hand, because he “wanted to see if there was material packed in there.” (Tr. 22-25). IBC's accident report is in accordance with Morgan's testimony in this regard. (Exhibit S-6). I find therefore, that Morgan was inspecting for a perceived problem or jam in the rotary valve when the accident occurred. Inspecting a piece of

⁹ The terms “servicing and/or maintenance” are defined at 29 C.F.R. § 1910.147(b). They expressly include adjusting, inspecting and unjamming, where “the employee may be exposed to the unexpected energization or startup of the equipment...”

equipment, such as the rotary valve, where unexpected energization could occur, is a servicing activity as contemplated by the standard.

The record also demonstrates that the rotary valve was subject to unexpected energization. Once the disconnect lever to the machine was placed in the “on” position, the rotary valve would turn on and off, as calls for additional sugar were received. An employee performing maintenance on the valve would have no notice before the valve started to rotate. The energization of the valve was thus unexpected, and this unexpected energization was likely to cause serious personal injury, as happened to Morgan. Accordingly, I find that Morgan’s activity on the day of the accident is within both the scope and application of the standard.

IBC argues that Morgan’s activity did not fall within the scope of the standard because the rotary valve was continually in movement from the time Morgan entered the sugar system room, until the time of the accident, and Morgan knew that this was the case. Thus, according to IBC, there was no danger of *unexpected* energization. The evidence demonstrates, however, that Morgan believed that the rotary valve was not rotating when he placed his hand in it. Further, it is clear that Morgan attempted to deenergize the rotary valve, and believed he had done so. (Tr. 24-25, 98-99). The energization as to Morgan, therefore, was unexpected. In any event, even if Morgan were unsure that the valve had stopped, the violation occurred when Morgan failed to appropriately isolate and lock out the source of energy to the rotary valve, before he commenced his inspection.

IBC also argues that Morgan’s act of placing his hand in the rotary valve was not part of a servicing or maintenance operation because it was unnecessary, in that it was ultimately determined that there was no problem with the rotary valve on the day in question. As is discussed above, however, the evidence demonstrates that Morgan was in fact addressing a perceived problem related to a possible blockage in the rotary valve. The standard is not limited to cases where an inspection of a piece of equipment is ultimately determined to have been unnecessary. The standard specifically identifies “inspection” as an activity contemplated within the terms “servicing and maintenance.” 29 C.F.R. §1910.147(b).¹⁰ This argument is therefore also rejected.

¹⁰ Servicing and maintenance are defined as “(w)orkplace activities such as constructing, installing, setting up, adjusting, inspecting, modifying, and maintaining and/or servicing machines or equipment...”

Finally, IBC argues that the minor servicing exemption is applicable.¹¹ IBC bases this argument on the assumption that Morgan was attempting to break up a sugar bridge in the bin, rather than inspecting the rotary valve. As is indicated above, however, I find that Morgan was inspecting for a blockage in the rotary valve at the time of the accident. This inspection and attempt to unjam the rotary valve is not a routine, repetitive action integral to the use of the production and IBC presented no evidence that it was. To the contrary, the evidence indicates that IBC had never previously experienced a blockage in the rotary valve. (Tr. 29) IBC thus failed to establish that Morgan's activity fell within the minor servicing exemption.

Citation 1 Item 1a

The cited standard, 29 C.F.R. §1910.147(c)(4)(i), provides that "procedures shall be developed, documented and utilized for the control of potentially hazardous energy when employees are engaged in the activities covered by this section." CO Brown testified that this item was based on the accident itself, in that two employees were working on the bulk sugar system, and that one employee (Morgan) placed his hand into the rotary valve which he had not locked out. (Tr. 177). On investigation, CO Brown discovered that the rotary valve was not deenergized, that the two disconnect levers Morgan did turn off were not locked out, and that the isolation of the equipment was not verified. (Tr. 178-179). Morgan admitted that IBC's procedures required that he lock out the appropriate disconnect lever and that he did not do so on the day of the accident. (Tr. 31). There is, therefore, at least one incident when the required procedures were not utilized. The standard applies, and was violated. The evidence also demonstrates that Morgan was exposed to the hazard.¹²

The Secretary, however, failed to establish that IBC had knowledge of the violation. In addressing this issue, it is necessary to look to the Third Circuit's enunciation of the Secretary's burden to show knowledge.¹³ In *Pennsylvania Power and Light Co.* 737 F.2d 350, (3d. Cir.

¹¹ The exclusion is contained in a note to 29 C.F.R. §1910.147 (a)(2)(ii). It provides in pertinent part, that "(m)inor tool changes and adjustments, and other minor servicing activities, which take place during normal production operations are not covered by this standard if they are routine, repetitive, and integral to the use of the equipment for production...."

¹² IBC asserts that there was no employee exposure, as it was ultimately determined that the rotary valve did not require servicing or maintenance. Thus, IBC argues, Morgan's act of placing his hand in the rotary valve was unnecessary, and therefore not within the course of his assigned duties. IBC made a similar argument assertion, *supra* which was considered and rejected.

¹³ Where the law of a particular Circuit may be different from Commission precedent, the Commission will apply the law of the Circuit, where it is highly probable that the decision will be appealed to that Circuit. *Kerns Brothers Tree Service* 18 BNA OSHC 2064, 2067, (No. 96-1719, 2000). IBC maintained the factory where the alleged violations occurred in New Jersey. The Third Circuit has jurisdiction, and both parties may therefore, appeal a final Commission decision to that Court. 29 U.S.C. § 660. The Third Circuit's precedent applies.

1984), the Court reversed a Commission decision affirming a citation where the sole evidence of knowledge was the supervisor's misconduct. In so doing, the Third Circuit held that, where the standard at issue is phrased in "general terms in order to permit employers the flexibility of developing reasonable work rules for protecting their employees under conditions peculiar to the employer's particular work situation," the Secretary bears the burden of showing that a supervisor's violative conduct was foreseeable. *Id* at 357. Thus, where a crew leader, found to be a supervisor, violated a consistently enforced company policy, and where the employer's safety policy and procedures were otherwise adequate, the citation was vacated absent proof that the supervisor's misconduct, in that one instance, was reasonably foreseeable. *Id*.

As a preliminary matter, I note that the standard at issue here is phrased in performance language, in order to provide employers the flexibility to determine the amount of detail required for a particular work site. *See* Preamble to the Final Rule, 54 Fed. Reg. 36,644, 36,659-36,660 (1989). Further, it is clear from the record that Morgan, a chief engineer since 1999, has supervisory status. In particular, he supervises 30 mechanics, one clerk, one planner, three supervisors and three assistants. He also directs other employees to obey IBC's lock-out policy. (Tr. 18-19, 52). *See Tampa Shipyards, Inc.*, 15 BNA OSHC 1533, (No. 86-630, 1992).

The record, however, is devoid of any proof that Morgan's action of disobeying IBC's lockout policy on the day of the accident was foreseeable. That policy, as it applied to the rotary valve, was to isolate the power by disconnecting the appropriate lever. (Tr. 31). According to Thomas Bent, IBC's director of operations, this policy had been in effect since 1995, and, by following it, IBC's employees have been able to safely lock out equipment at the factory. (Tr. 132-133). In addition, the disconnect levers to the three pieces of equipment which made up the bulk sugar system were specifically identified, so that a worker would be able to determine which lever controlled which machine. There were also three different ways to determine whether the levers were turned on or off. (Tr. 47, 74,137). To verify isolation of the rotary valve, IBC's procedures required the employee to visually ensure that the lever was in the down position, near the word "off", and that the black side of the lever was showing. (Tr. 77-81). These requirements establish that IBC had an adequate lockout policy for the use bin rotary valve. The Secretary did not rebut this evidence, and she also failed to refute the evidence that IBC provided adequate training in lockout during orientation, during its refresher courses and on a day-to-day basis by its supervisors. (Tr. 36, 146-147). Similarly, the Secretary did not refute the evidence of IBC's progressive disciplinary procedures. (Tr. 149).

The record also demonstrates that IBC undertook to inspect for violations. Heintz Hentschel, a recently retired chief engineer at the factory, testified that he conducted monthly safety inspections, during which lockout practices of the employees were reviewed. (Tr. 290-

293). In addition, Bent testified that he spends approximately 20% of his time walking the factory and checking for safety problems in production and maintenance, which includes verifying that lockout procedures are being followed. (Tr. 142-143).

Finally, the evidence demonstrates that Morgan had a good safety record, and, in fact, was promoted to chief engineer, in part, because of that record. (Tr. 152-153). There is no evidence that Morgan had previously violated IBC's lockout procedures. Based on the record, I find that the Secretary has not met her burden of showing that Morgan's failure to follow IBC's lockout policy on January 6, 2000, was foreseeable.

The Secretary argues that the Morgan's misconduct on January 6, 2000, was foreseeable because the written lockout procedure was inadequate as applied to the rotary valve, and, during the hearing, Morgan testified that there were occasions prior to January 6, 2000, when he did not lockout a deenergized source prior to performing work on a piece of equipment.¹⁴ I am not persuaded that either argument supports a finding that Morgan's misconduct was foreseeable. First, as discussed more fully below, there was no requirement as of January 6, 2000, for IBC to document the lockout policy as it applied to the rotary valve. Thus, the issue of the adequacy of the written policy is irrelevant. Second, there was no proof that Morgan was involved in activity covered by the standard, in these earlier occasions. There is no evidence pertaining to what type(s) of work Morgan was performing during these earlier occasions, whether the pieces of equipment he worked on were subject to unexpected energization which could cause injury, or whether this prior activity involved placing his hands or other body parts into a zone of danger. Morgan's statement, therefore, does not establish that he had violated lockout procedures in the past. This citation item is accordingly vacated.

Citation 1 Items 1b and 1c

Item 1b alleges a violation of 29 C.F.R. § 1910.147(c)(4)(ii)(C), which requires that energy control and lockout procedures include "specific procedural steps for the placement, removal and transfer of lockout devices or tag-out devices and the responsibility for them." According to CO Brown, this item was issued because IBC's written policy did not list the equipment it covered, the magnitude of the energy, and the means to disconnect the energy. (Tr. 200). Item 1c alleges a violation of 29 C.F.R. § 1910.147(c)(4)(ii)(D), which requires that the written procedures contain "specific requirements for testing a machine or equipment to determine and verify the effectiveness of lockout devices, tag-out devices, and other energy

¹⁴ Specifically, Morgan testified that there were times in the past when he did not place a lock on a deenergized power source, "in similar circumstances...where the thing would be completely under (his) control," and where "there is no way that somebody could turn it on without (his) knowledge...." (Tr. 34).

control measures.” CO Brown recommended this item because he believed that IBC’s procedures did not include an effective means for verifying that the rotary valve was locked out. (Tr. 201).

An exception to the requirement that an employer document its lockout procedures for a machine or piece of equipment is contained in a note to 29 C.F.R. § 1910.147(a)(4). Specifically, the procedures need not be documented where an employer can show that “(1)...the equipment has no potential for stored or residual energy or reaccumulation of stored energy after shut down which could endanger employees; (2) the equipment has a single energy source which can be readily identified and isolated; (3) the isolation and locking out of that energy will completely deenergize and deactivate the machine or equipment; (4) the ...equipment is isolated from that energy source and locked out during servicing or maintenance; (5) a single lockout device will achieve a locked-out condition; (6) the lockout device is under the exclusive control of the authorized employee performing the servicing or maintenance; (7) the servicing or maintenance does not create hazards for other employees; and (8) the employer, in utilizing this exception, has had no accidents involving the unexpected activation or reenergization of the machine or equipment during servicing or maintenance.” According to the preamble to the final rule, this limited exception is “intended to apply to situations in which the procedure for deenergization, servicing and reenergization can be carried out without detailed interactions of energy sources, machines, and employees.” 54 Fed. Reg. 36,644, 36,670 (1989).

I find that the foregoing exception applies to the rotary valve at issue. Electricity is the only source of energy for the rotary valve, there is only one disconnect lever which needs to be locked out to isolate the rotary valve, and there is unrebutted testimony that the disconnect lever cannot store energy. (Tr. 145). The disconnect lever for the rotary valve controlled no other machines or pieces of equipment and was specifically identified by a sign located above it. IBC also established that its policy required that an employee performing servicing or maintenance on the rotary valve isolate and lock out the disconnect lever, and that only one lockout device is required. Under IBC’s procedures, the lockout device would be under the exclusive control of the authorized employee performing the servicing or maintenance on the rotary valve. Finally, as of January 6, 2000, there had been no accidents at the machine. Thus, there was no requirement prior to January 6, 2000, for IBC to develop and maintain a written lockout procedure for the rotary valve.¹⁵

¹⁵ The Secretary argues that Morgan’s accident of January 6, 2000 is a basis for finding that the eighth requirement of the exception was not met. However, IBC established the eighth element by showing that there had been no accidents prior to the occurrence of the subject accident. This is sufficient under the terms of the standard. *See* Preamble to the Final Rule, 54 Fed. Reg. 36,644, 36,670 (1989). The Secretary’s argument is rejected.

The Secretary argues that the standard was violated because IBC's written plan, as it applies to the whole factory, is insufficient. In this regard, the Secretary urges that the standard requires that a written plan identify the specific machines or pieces of equipment requiring lockout procedures, and set forth the manner in which the lockout of each such piece of equipment or machine may be verified. The Secretary's argument is unpersuasive. The standard, by its terms, does not require an employer to identify each specific piece of equipment at its plant requiring lockout procedures. Further, the preamble to the standard clarifies that the requirement that a plan provide detailed instructions does not necessitate that an employer identify each machine. In warning against creating overly complicated plans, the preamble explains that "the employer's procedures may not need to be unique for a single machine or tasks, but can apply to a group of similar machines, types of energy and tasks if a single procedure can address the hazards and the steps to be taken satisfactorily." While the plan should be detailed, there is no requirement for "a separate procedure ... for each and every machine or piece of equipment. Similar machines and/or equipment which have the same or similar types of controls can be covered with a single procedure." 54 Fed. Reg. 36,644, 36,670 (1989). Based on this language, I find the intent was not to require employers to identify each piece of equipment and to specify for each piece of equipment, the manner of verifying deenergization. *See Drexel Chemical Co.*, 17 BNA OSHC 1908 (No. 94-1469, 1997).¹⁶ *But see Akzo Nobel Chemicals, Inc.*, 18 BNA OSHC 1643 (No. 96-0062, 1998). Rather, where machines have similar controls, they may be covered under the same procedure.

The Secretary presented insufficient evidence relating to any machinery at the factory, other than the rotary valve, on which to determine the adequacy and applicability of IBC's written program. In fact, with the exception of the rotary valve, there is no evidence that any machines or pieces of equipment at the facility were subject to unexpected energization. Even if there were such evidence, there is no proof as to the appropriate manner of locking out these other machines, no proof that these other machines contained controls that were deactivated in a manner different than that of the rotary valve, and no proof that these other machines could not be locked out and verified adequately under the written policy. Based on the foregoing, Items 1b and 1c of Citation 1 are vacated.

Citation 1 Item 1d

¹⁶ Where the employer adopted, verbatim, the minimal lockout procedures contained in Appendix A to the standard, the employer was required to fill in the blanks to the form and identify information pertaining to the types and locations of machine or equipment operating controls, the types and locations of energy isolating devices, the types of stored energy and methods to dissipate or restrain energy, and the methods of verifying the isolation of the equipment. *Id.*

This Item alleges a violation of 29 C.F.R. 1910.147(c)(6)(i)(B), which requires the employer to conduct periodic inspections of the energy control procedure “at least annually to ensure that the procedure and the requirements of this standard are being followed.” CO Brown recommended the this item, based on his review of IBC’s written documents concerning energy control inspections. He testified that he reviewed audit logs which indicated that IBC had not conducted an inspection since 1996, during his inspection. (Tr. 203). Hentschel, however, testified that he conducted periodic inspections or audits of lockout procedures approximately once a month in 1997, 1998 and for part of 1999. (Tr. 290-293). Hentschel also testified that he maintained logs from his periodic audits in black books, which he showed to the OSHA CO during the subject inspection. Upon his retirement in 1999, Hentschel left the black books in IBC’s maintenance office. (Tr. 290-294, 301).

During the hearing, IBC identified only three audit logs, dated August 15, 1999, August 12, 1996 and March 9, 1996. (Exhibit S-8). No other audit logs were provided, and IBC offered no explanation as to their whereabouts. However, I watched Hentschel’s demeanor on the witness stand and find him a credible witness who responded to questions in a straightforward and candid manner. His credibility is further supported by the fact that he has since retired from the company and thus has no personal interest in any outcome. While IBC’s failure to produce all of the audit logs must be given some weight, it is not determinative, especially as there is no evidence of intentional misconduct on the part of IBC with respect to the documents. Furthermore, contrary to CO Brown’s recollection, the audit logs do, in fact, indicate that a lockout inspection took place in 1999, which leads me to believe that CO Brown may have been mistaken. Based on the weight of the evidence, I find that the Secretary failed to rebut the evidence that IBC in fact performed periodic inspections as contemplated by the standard. This Citation Item is vacated.

Citation 1 Item 1e

This Item alleges a violation of 29 C.F.R. 1910.147(c)(7)(iii)(A), which requires “(r)etraining...of all authorized and affected employees whenever there is a change in their job assignments, a change in machines, equipment or processes that present a new hazard, or when there is a change in the energy control procedures.” CO Brown suggest the issuance of this Item because IBC did not provide specific training on appropriate lockout procedures for the one-month-old use bin rotary valve. (Tr. 204).

It is not disputed that the rotary valve was only one month old on the day of the accident. Under the terms of the standard, however, it is incumbent on the Secretary to show that the new equipment presents a new hazard. The only evidence presented by the Secretary in this regard was CO Brown’s testimony that Morgan and Geiger indicated that they did not know how to

lock out the rotary valve and that they had to figure it out when they got there. (Tr. 242). During his inspection, CO Brown spent a total of 30 minutes in the bulk sugar use bin room, consisting of 15 minutes on April 18 and 15 minutes on May 3, 2000. (Tr. 205, 207). While he walked through the “crumb cake” or “dump” area and observed the “clean in place” system, he did not examine these other pieces of equipment to ascertain whether they contained hazards similar to or different from the sugar use bin rotary valve, even though he was aware that other equipment at the factory contained rotary valves. The only equipment he examined was the bulk sugar system. (Tr. 206-207, 208-209, 210-211, 257-257). In point of fact, a flour use system at the factory included a rotary valve similar to the one in the sugar use system. (Tr. 48, 144). Thus, CO Brown had no knowledge whether the sugar use bin rotary valve presented a new or different hazard, and the Secretary failed to present any evidence in this regard. The Secretary thus failed to establish that this standard applies. Item 1e is vacated.

Findings of Fact and Conclusions of Law

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

ORDER

Based upon the foregoing decision, it is hereby ORDERED that:

Citation 1, Items 1a, 1b, 1c, 1d and 1e, alleging serious violations of 29 C.F.R. §§ 1910.147(c)(4)(i), 1910.147(c)(4)(ii)(C), 1910.147(c)(4)(ii)(D), 1910.147(c)(6)(i)(B) and 1910.147(c)(7)(iii)(A), respectively, are VACATED.

/s/
COVETTE ROONEY
OSHRC, JUDGE

Dated: June 22, 2001
Washington, DC