



UNITED STATES OF AMERICA
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION

1120 20th Street, N.W. Ninth Floor
Washington, DC 20036-3457

SECRETARY OF LABOR,	:	
	:	
Complainant,	:	
	:	
v.	:	
	:	OSHRC Docket No. 00-2231
JINDAL UNITED STEEL CORP.,	:	
and its successors,	:	
	:	
Respondent.	:	

DECISION

Before: RAILTON, Chairman; and ROGERS, Commissioner.

The Occupational Safety and Health Administration (“OSHA”) inspected Jindal United Steel Corporation’s (“Jindal”) manufacturing facility in Baytown, Texas from May 10, 2000 until October 19, 2000. The Secretary cited Jindal for numerous alleged willful and serious violations of various standards under the Occupational Safety and Health Act of 1970, 29 U.S.C. §§ 651-687 (“OSH Act” or “Act”). The parties resolved, by settlement agreement and joint stipulation, all of the citations except certain items pertaining to Jindal’s alleged failure to properly record occupational illnesses and injuries in violation of 29

C.F.R. § 1904.2(a).¹ The Secretary cited the recordkeeping violations as willful on a per-instance basis, and proposed a penalty of \$9,000 for each of the violations. Administrative Law Judge James H. Barkley affirmed 110 separate recordkeeping violations, but grouped them for penalty purposes, assessing a single penalty of \$70,000 for the eighty-two items he affirmed as willful, and \$7,000 for the twenty-eight items he affirmed as other-than-serious.

On review, Jindal contests only the characterization of the eighty-two citations that the judge affirmed as willful, and argues for lower penalties. The Secretary argues that all of the violations were willful and challenges the judge's penalty grouping. The two Commission members would affirm the judge's characterization of the eighty-two willful violations, but are divided as to the characterization of the remaining twenty-eight violations and the appropriate penalty assessment for the willful violations.

Official action of the Commission requires the affirmative vote of two members on all dispositive issues. OSH Act, § 12(f), 29 U.S.C. § 661(e). In view of the absence of such agreement here and to resolve this impasse, the Commission members agree to vacate the direction for review, thereby allowing the judge's Decision and Order to become the final appealable order of the Commission with the precedential value of an unreviewed judge's decision.² See e.g., *The Timken Co.*, 20 BNA OSHC 2034 (No. 97-1457, 2004), and cases

¹ At the time these violations occurred, 29 C.F.R. § 1904.2(a) provided that:

Each employer shall, . . . (1) maintain in each establishment a log and summary of all recordable occupational injuries and illnesses for that establishment; and (2) enter each recordable injury and illness on the log and summary as early as practicable but no later than 6 working days after receiving information that a recordable injury or illness has occurred. For this purpose form OSHA No. 200 or an equivalent which is as readable and comprehensible to a person not familiar with it shall be used. The log and summary shall be completed in the detail provided in the form and instructions on form OSHA No. 200.

²Notwithstanding our action vacating the direction for review in this case, this was an appropriate case for review. The order vacating the direction for review is entered in order to allow the parties to bring finality to this case. The decisions of some United States courts

there cited. *See also* sections 10(c), 11(a) and (b), and 12(j) of the Act, 29 U.S.C. §§ 659(c), 660(a) and (b), and 661(i). Accordingly, the direction for review is hereby vacated. The separate views of the two Commission members follow.

SO ORDERED.

/s/_____

W. Scott Railton
Chairman

/s/_____

Thomasina V. Rogers
Commissioner

Dated: September 28, 2005

of appeals have rejected alternative forms of dispositions of our cases when only two members are available to decide cases. *See, e.g., Cox Brothers v. Secretary of Labor*, 574 F.2d 465 (9th Cir. 1978); *Shaw Construction, Inc. v. OSHRC*, 534 F.2d 1183 (5th Cir. 1976).

I. The characterization of Jindal's recordkeeping violations

Jindal commenced operation in 1997 at a former USX steel facility where it operates the plate mill portion of a steel manufacturing business. Jindal shares the business with Saw Pipes USA, Inc., a related company located at the same facility that manufactures steel pipe.³ The two companies share some common ownership and some managerial personnel. On review, Jindal does not dispute that it failed to properly record 74% of the recordable illnesses and injuries on its OSHA 200 log in 1998, 84% in 1999, and 53% for the first half of 2000. Having thoroughly reviewed the record in this case, Chairman Railton and Commissioner Rogers agree that the judge's factual findings are fully supported by the testimony and evidence. In addition, they would agree with the judge, for the reasons he articulated, that the recordkeeping errors attributable to employees Craig Wetherington and Lisa White were willful.

As the Commission stated in *Kaspar Wire Works, Inc.*, “[t]he hallmark of a willful violation is the employer’s state of mind at the time of the violation — an ‘intentional, knowing, or voluntary disregard for the requirements of the Act or . . . plain indifference to employee safety.’” 18 BNA OSHC 2178, 2181 (No. 90-2775, 2000) (citation omitted), *aff’d*, 268 F.3d 1123 (D.C. Cir. 2001). “[T]he Secretary must show that the employer acted voluntarily, with either intentional disregard of or plain indifference to OSHA requirements.” *Georgia Elec. Co. v. Marshall*, 595 F.2d 309, 317-319 (5th Cir. 1979). *Accord AJP Constr. Inc. v. Secretary*, 357 F.3d 70, 74 (D.C. Cir. 2004). Here, the evidence shows that Jindal managerial personnel intentionally implemented recordkeeping practices that they knew were incorrect. Gary Jones, human resources and labor relations director for Saw Pipes who hired and supervised Jindal recordkeeper Craig Wetherington, was the architect of Jindal’s recordkeeping program. Despite Wetherington’s repeated protests, Jones instructed Wetherington to record on the OSHA 200 only those injuries reported to

³We also issue today our decision vacating the direction for review in *Saw Pipes*, Docket No. 01-0422, which involves questions identical to those presented here.

workers' compensation, which excluded injuries for which Jindal absorbed the cost of an employee's lost work time and medical treatment. He also instructed that Jindal would not record on its OSHA log the injuries and illnesses of the temporary laborers who worked at the plant. Wetherington advised Jones that these recordkeeping practices were not consistent with his prior experience or with OSHA published recordkeeping guidelines, and that following them would leave "the company wide open for problems with OSHA and other people." According to Wetherington, Jones rejected his concerns and told him that if he could not comply with Jones' instructions "there's the door."⁴

Wetherington complained about Jones' recordkeeping practices to Jindal human resources manager Lisa White and plant manager Doug Gates, but to no avail. Gates told Wetherington that Jones "is the one that's running the program. It's his way." Similarly, White stated that Jones "had the final word on that. We have to go by what he says, period." Wetherington testified that when he told Gates that by following Jones' instructions he was failing to comply with OSHA recordkeeping requirements, Gates recommended that he protect himself by writing a memorandum to that effect. White corroborated Wetherington, testifying that Wetherington "had approached both myself and Doug Gates with his concerns. His concerns were that he was being directed to do this by his supervisor; however, he knew that this was a violation of the recordkeeping requirements, but he needed his job and he was fearful that if he did not do as instructed, he

⁴Although Jindal argues that the absence of a clear correlation between its OSHA log and workers' compensation claims rebuts Wetherington's testimony and belies the existence of a policy to under record, we note that neither motive nor a consistent pattern of misrecording is a prerequisite to willfulness. *Kaspar*, 18 BNA OSHC at 2183-84 (finding recordkeeping errors willful where resulting from "an overall disregard of the regulation's requirements"). Jindal's contention that it had a good faith belief that it need not record temporary laborers' illnesses and injuries is also properly rejected. As the judge noted, it was Jindal's responsibility to supervise the temporary workers which, as Wetherington advised Jones, made Jindal responsible for recording their injuries and illnesses. See *Froedtert Memorial Lutheran Hospital, Inc.*, 20 BNA OSHC 1500, 1510 (No. 97-1839, 2004) (citations omitted).

might lose his job. So it was Doug Gates and my recommendation to go ahead and just note that to the file so that he would have a cover for himself should anything ever arise.”

White also echoed Wetherington’s concerns, testifying that she was “afraid that subsequently if OSHA were to come in and do a recordkeeping audit or any kind of another audit on us, that we would be exposed to great citations from that.” Nonetheless, when White briefly assumed responsibility for completing Jindal’s OSHA logs following Wetherington’s resignation, she chose to continue the established recordkeeping practices, admitting that she knowingly failed to properly record injuries at that time. In these circumstances, Chairman Railton and Commissioner Rogers fully agree with the judge’s conclusion that Jindal intentionally disregarded its recordkeeping responsibilities in willful violation of the Act for the errors attributable to employees Craig Wetherington and Lisa White. *AJP Constr. Inc. v. Secretary*, 357 F.3d at 74 (affirming willful violation where employer knew of standards’ requirements and had notice of deficiencies in compliance).

David McIntosh succeeded Craig Wetherington as Jindal safety manager, a position he held from November 8, 1999 until June 26, 2000. Although Jindal never expressly assigned to McIntosh the responsibility for maintaining the OSHA 200 logs, McIntosh voluntarily relieved Lisa White of the task when he became concerned about the approaching February posting deadline. During McIntosh’s tenure, there were twenty-eight recordkeeping errors on Jindal’s OSHA 200 log.

For the following reasons, Chairman Railton agrees with the judge that these violations were not willful. McIntosh noticed that Jindal had been erroneously neglecting to report the occupational injuries not submitted for workers’ compensation. He testified, however, that he did not follow Jones’ “unwritten” policies, nor did he consciously fail to record a reportable injury. While McIntosh did fail to record some of the injuries that occurred in the first half of 2000, there was a marked improvement over the 84% error rate of the previous year. McIntosh attributed his errors to lack of adequate time and information, and the Secretary has provided no basis from which to conclude that they were purposeful. Based on this evidence, Chairman Railton would find that McIntosh’s decision

to reject the prior recordkeeping policies and transform Jindal's program showed that his errors were merely negligent. *See American Wrecking Corp. v. Secretary*, 351 F.3d 1254, 1264 (D.C. Cir. 2003) (finding "mere negligence" insufficient to establish willfulness).

Chairman Railton would also reject the Secretary's contention that Jindal management's "failure to inquire whether Wetherington and White's concerns were justified after McIntosh became safety manager . . . demonstrated plain indifference." In his view, although insufficient to bring Jindal fully into compliance, McIntosh's efforts transformed Jindal's recordkeeping practices, negating Jones' abject disregard for OSHA's recordkeeping requirements that Gates and White never endorsed. *Compare Caterpillar, Inc.*, 17 BNA OSHC 1731, 1732 (No. 93-373, 1996), *aff'd*, 122 F.3d 437, 440-41 (7th Cir. 1997) (affirming willful violation despite change in personnel where violation recurred in otherwise unchanged circumstances). Accordingly, Chairman Railton would affirm the judge's characterization of these twenty-eight recordkeeping violations as other-than-serious.

On the other hand, Commissioner Rogers would affirm the additional twenty-eight recordkeeping violations as willful. Jindal explicitly hired David McIntosh to replace Craig Wetherington as safety manager. McIntosh took up residence in Wetherington's former office and determined his job duties from a review of Wetherington's files. Those files enabled McIntosh to determine "what Craig had done out there," and included accident reports and incomplete OSHA logs. Based on McIntosh's own description of his orientation to the safety manager position at Jindal, management never instructed him in any of the particular requirements of his job. Rather, he was left to divine the job's dimensions based on what his predecessor had done. In these circumstances, McIntosh's denial of responsibility for the OSHA 200's, because "it was never designated as [his]," is contradictory and disingenuous. Moreover, despite McIntosh's claim that he did not follow Jones' unwritten policies and never consciously failed to record a reportable event, McIntosh admitted that there were injuries reported to him that he believed should have been recorded on the OSHA 200s, that he did not record. In view of McIntosh's

demonstrated knowledge of recordkeeping requirements, which was sufficient to inform his rejection of Jones' erroneous guidelines, Commissioner Rogers would find that his knowing failure to properly record injuries and illnesses demonstrates conscious disregard for the requirements of the Act.

Commissioner Rogers also disagrees that McIntosh's recordkeeping efforts, designed to "just [] try to keep us covered in case something like this [OSHA inspection] did happen," transformed Jindal's intentional disregard for OSHA recordkeeping into mere negligence. Jindal managers White and Gates permitted Jones to direct Jindal personnel to incorrectly record injuries and illnesses. After McIntosh replaced Wetherington, these same managers did nothing to dismantle the violative recordkeeping practices and policies that prevailed at the plant, nor did they convey to McIntosh precisely what was expected of him. Jindal cannot escape willfulness merely by allowing violative practices of which it was aware to continue, notwithstanding the change of recordkeepers. McIntosh's modest efforts cannot cure Jindal's failure to inform its new safety manager of the "pervasive and continuing nature" of the recordkeeping problem and instruct him in the correct procedures. *See Caterpillar, Inc.*, 17 BNA OSHC at 1732-33 (affirming willful violation where corporation failed to convey to new supervisors "relevant and available information it possessed and which, under the Act, it was responsible for disseminating to those entrusted with the health and safety of its employees"). Accordingly, Commissioner Rogers would affirm all 110 of Jindal's recordkeeping violations as willful.

II. Penalties

The judge affirmed 110 separate violations for Jindal's 110 recordkeeping errors, which the Secretary had cited on a per-instance basis and which the parties do not contest on review. With respect to the penalties, however, the judge rejected the Secretary's proposal of \$9,000 for each willful violation and, instead, assessed a single grouped penalty of \$70,000. On review, the Secretary challenges the propriety of the judge's grouping of the willful violations and penalty assessment.

Chairman Railton's Views

The Secretary's citation and penalty policy invoked here is guided by a strategy of compliance inducement through enhanced penalties in cases deemed "egregious/willful." Pursuant to this policy, in cases involving willful violations that meet other specified criteria, the Secretary considers departing from her usual practice of issuing a single citation and single proposed penalty for all alleged violations of the same standard or regulation. Where applied, the Secretary, instead, alleges a separate violation and proposes a separate penalty for each instance of noncompliance. *See* OSHA Instruction CPL 2.80, *Handling of Cases to be Proposed for Violation-by-Violation of Penalties*, 1 BNA OSHR Ref. File 21:9649, 9650 (October 1, 1990).

The Secretary may issue per-instance citations where supported by the language of the standard and where the record establishes the facts sufficient to support each alleged violation. *Chao v. OSHRC (Eric K. Ho)*, 401 F.3d 355 (5th Cir. 2005) (concluding that standard "can be interpreted to allow for citation on a per-employee basis" but noting absence of "employee-specific unique circumstances that could merit citation based on each failure to train an individual employee"). Recordkeeping citations based on separate and distinct recording errors meet those criteria. *E.g., Caterpillar, Inc.*, 15 BNA OSHC 2153, 2170-71 (No. 87-922, 1993).

Where the cited provision is found susceptible to per-instance citation, the Commission has generally also assessed individual penalties. However, as we recently stated in *Eric K. Ho*, "[t]he Commission has taken several steps on the road to assessing individual penalties for per-instance violations[.]" and the law in this area is "still developing." 20 BNA OSHC 1361, 1370 (No. 98-1645, 2003) (consolidated), *aff'd*, 401 F.3d 355 (5th Cir. 2005). In Chairman Railton's view, this case compels the Commission to further define the basis upon which it will determine the "appropriate" penalty assessment in cases cited under the egregious/willful policy. *See* OSH Act, section 17(j).

In this regard, Chairman Railton notes that the Secretary's decision to invoke the egregious policy to propose separate penalties is made before an evidentiary record is

compiled. In contrast, the Commission's decision to assess penalties is based upon the evidence adduced in the record as a whole following an evidentiary hearing. *See Hern Iron Works Inc.*, 16 BNA OSHC 1619, 1623 (No. 88-1962, 1994) ("evaluation of . . . penalty factors are issues of fact, the resolution of which is the exclusive province of the Commission"). As the reviewing body within the administrative process, the Commission is best able to determine whether the grounds upon which the penalties were proposed warrant application of the egregious policy at the penalty assessment stage. *See, e.g., Butz et al v. Glover Livestock Comm'n*, 411 U.S. 182 (1973). Accordingly, the Commission must evaluate whether the record evidence is sufficient to satisfy the egregious/willful criteria in determining whether to assess separate penalties for per-instance citations. To date, the Commission has never addressed the obvious gap between the Secretary's policy and evidentiary insufficiency. Such a reasoned step must be taken to ensure that the evaluation of penalty factors (issues of fact) remain the exclusive province of the Commission.

Under the Secretary's seven-factor test, per-instance penalties may be proposed when the cited violations are willful *and* egregious, in that they are particularly high gravity or the employer showed significant bad faith. The first factor plus one of the other six are required to support a recommendation for per-instance citations and penalties. The criteria are (1) the elements of a willful characterization; (2) a worker fatality, other catastrophe, or high number of injuries/illnesses; (3) persistently high injury/illness rates; (4) extensive history of prior violations; (5) intentional disregard of safety and health responsibilities; (6) clear bad faith; and (7) such a large number of violations so as to significantly undermine any safety and health program. Of course, these elements are already subsumed within the four statutorily prescribed factors upon which the Commission determines the appropriate penalty under section 17(j).

Chairman Railton would find that the evidence here is insufficient to justify per-instance penalties under the Secretary's test. The judge found that the evidence established that the violations were willful, and that Jindal intentionally disregarded its recordkeeping

responsibilities. As the essential basis of the willful characterization, however, the “intentional disregard” factor here is thoroughly redundant and, as such, cannot satisfy the “plus one” requirement of the Secretary’s seven-factor test. In the absence of any other indicia of bad faith, and because the violations are of particularly *low* gravity, application of the violation-by-violation penalty policy is not merited.

With respect to the \$5,000 minimum willful penalty contained in the Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 3101 (1990), Chairman Railton would note that the amendments are not the straitjacket that the Secretary would aver, either for the Commission or for the Secretary herself. Although the Secretary contends that it would be “clear error” to assess a penalty that is less than the “statutory minimum” for each willful violation, Congress intended some flexibility in applying the new penalty structure. As the House Conference Report states, “[t]he conferees d[id] not intend to deprive [OSHA] of the flexibility to settle cases involving willful violations, *where appropriate*, for amounts which are less than the mandatory minimums.” H.R. CONF. REP. NO. 101-964, *reprinted in* 1990 *U.S.C.C.A.N.* 2374, 2393-94 (emphasis added).

The “appropriateness” benchmark identified in the committee report is identical to that which the Commission also must satisfy in exercising its penalty-setting authority pursuant to section 17(j). A total penalty here consisting of \$5,000 for each of the eighty-two violations affirmed as willful would amount to \$410,000. That is an extraordinary and unprecedented sum for even the largest and most egregious of recordkeeping cases. These circumstances raise the question whether, under the Secretary’s approach, there would be any limit to the total penalty for cases involving large numbers of willful recordkeeping errors. The Commission has long cautioned against such a result, emphasizing that:

The key question for penalty purposes is not how many errors or omissions there [are], but what penalty is appropriate. Thus, although the Secretary may cite separate omissions to record injuries as separate violations, he may not exact a total penalty that is inappropriate in light of the four factors listed in section 17(j) of the Act: the gravity of the violations, the employer’s good faith, its size, and its history of violations.

Caterpillar, 15 BNA OSHC at 2173.

In his application of the 17(j) factors here, the judge properly considered Jindal's size of 250 employees, the lack of prior OSHA inspections, and "deliberate nature of the violations." Following well-settled precedent, he focused on the gravity of the violations as the most significant consideration in assessing the penalty. *Chao v. OSHRC (Erik K. Ho)*, 401 F.3d at 376, and cases there cited. Gravity generally includes a number of factors, including the number of employees exposed to the hazard, the duration of their exposure, the precautions taken to prevent injury, and the degree of probability that an injury would occur. *E.g. Kus-Tum Builders, Inc.*, 10 BNA OSHC 1128, 1132 (No. 76-2644, 1981). The Commission has long held, however, that recordkeeping violations are of low gravity. *See Caterpillar*, 15 BNA OSHC at 2178; *Pepperidge Farm, Inc.*, 17 BNA OSHC 1993, 2001 (No. 89-0265, 1997); *Kaspar*, 18 BNA OSHC at 2185.

Based on the record evidence, Chairman Railton agrees that in addition to the low gravity of recordkeeping violations in general, the injuries and illnesses that went unrecorded here were relatively minor. As the judge stated, "[e]ven under the Secretary's theory of the case, Respondent reported major injuries to Workers' Compensation as well as to OSHA while only the more marginal, or less serious injuries went unreported." Accordingly, based on all of the section 17(j) factors, Chairman Railton would affirm the judge's penalty assessment of a single grouped penalty of \$70,000 for Jindal's eighty-two willful recordkeeping violations.

Commissioner Rogers' Views

It is undisputed that the judge correctly affirmed separate violations for each of Jindal's separately cited recordkeeping errors, and his rulings to that effect are not on review. *Eric K. Ho*, 20 BNA OSHC at 1370; *Kaspar Wire Works, Inc.*, 18 BNA OSHC at 2185; *Caterpillar, Inc.*, 15 BNA OSHC at 2173. Both commissioners also agree that the record evidence and applicable law support the judge's characterization of the eighty-two recordkeeping violations he affirmed as willful. Commissioner Rogers believes, however, that the assessment of a single \$70,000 penalty for the eighty-two affirmed willful violations

is precluded by the OSH Act's penalty provisions. Rather, once having found eighty-two separate willful violations, the Commission *must* assess a penalty of at least \$5,000 for each such violation.

As originally passed, the OSH Act provided that an employer "may be assessed" a maximum \$10,000 penalty for "each [willful] violation." 29 U.S.C. § 666(a). Unlike the provision pertaining to serious violations, which prescribed that a penalty of up to \$1,000 "*shall* be assessed[.]" there was no minimum penalty required for a willful violation. 29 U.S.C. § 666(b) (emphasis added). In 1990, Congress revised the OSH Act's penalty provisions by increasing the penalty amounts for all violations seven-fold, and establishing a minimum penalty for willful violations as follows.

Any employer who willfully or repeatedly violates the requirements of section 654 of this title, any standard, rule or order promulgated pursuant to section 655 of this title, or regulations prescribed pursuant to this chapter, may be assessed a civil penalty of not more than \$70,000 for each violation, *but not less than \$5,000 for each willful violation.*

Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 3101 (1990), 29 U.S.C. § 666(a) (emphasis added). Accordingly, this case presents, for the first time, the question whether the Commission may now assess an aggregate penalty for multiple affirmed violations that amounts to less than \$5,000 for "each [willful] violation."

The fundamental principle of statutory construction is that statutory language is to be construed according to its plain meaning. *Caminetti v. United States*, 242 U.S. 470, 485 (1917). When the language is plain, " 'the sole function of the courts . . . is to enforce it according to its terms' " unless the result would be "absurd." *Hartford Underwriters v. Union Planters*, 530 U.S. 1, 6 (2000) (citations omitted). Thus, the first step in statutory construction is the wording of the statute itself which, if unambiguous, obviates reliance on legislative history or other external sources. *E.g.*, *Consumer Product Safety Commission v. GTE*, 447 U.S. 102, 108 (1980) ("starting point for interpreting a statute is the language of the statute itself . . . [which,] absent a clearly expressed legislative intention to the

contrary, . . . must ordinarily be regarded as conclusive”); *Arcadian Corp.*, 17 BNA OHSC 1345, 1347 (No. 93-3270, 1995) (“[i]n a statutory construction case, the beginning point must be the language of the statute, and when a statute speaks with clarity to an issue[,] judicial inquiry into the statute’s meaning, in all but the most extraordinary circumstances, is finished” (citations omitted)), *aff’d* 110 F.3d 1192 (5th Cir. 1997).

Commissioner Rogers would find that the words “not less than \$5,000 for each willful violation” mean just that. *See Connecticut Nat. Bank v. Germain*, 503 U.S. 249, 254 (1992) (explaining that Congress “says in a statute what it means and means in a statute what it says”). In her view, these words are unambiguous and can *only* be read to require that at least \$5,000 must be assessed for *each* affirmed willful violation. *See Kaspar Wire Works Inc. v. Secretary*, 268 F.3d 1123, 1130 (D.C. Cir. 2001) (finding that “plain language of the Act could hardly be clearer” that per-instance penalties are “consistent with the general principle that each violation of a statutory duty exposes the violator to a separate statutory penalty”).

The legislative history emphatically supports this interpretation, clarifying that “[i]n order to ensure that the most egregious violators are in fact fined at an effective level, the conferees . . . adopted a mandatory minimum penalty of \$5,000 for a willful violation of the OSH Act . . . [a]s a penalty floor that is not intended to become a penalty ceiling.” H.R.Rep. No. 101-881, *reprinted in* 1990 U.S.C.C.A.N. 2050, 2393-94. The seven-fold increase in all penalties exceeded the three-fold increase that would have been sufficient to keep pace with inflation, as the larger increase was deemed necessary to effectuate the “stated purpose” of the OSH Act. *Id.* at 2393. *See U.S. ex rel. Chandler v. Cook County*, 277 F.3d 969, 978 (7th Cir. 2002) (finding that “[i]t could not be more clear that Congress, in adopting [False Claims Act penalty enhancement], addressed the situation with careful precision as to what sort of damage scheme was necessary to achieve the goals of the statute”).

Congress also specifically contemplated the effect of the penalty increase in the context of willful recordkeeping violations, noting that “the mandatory minimum penalty

adopted by the conferees targets the most extreme violators[,]” which includes employers who “knowingly and intentionally violate the recordkeeping and reporting requirements” H.R.Rep. No. 101-881, *reprinted in* 1990 *U.S.C.C.A.N.* at 2393-94. The potential for significant penalty enhancement of willful per-instance recordkeeping violations would have been apparent, as the Secretary’s per-instance recordkeeping citations in *Caterpillar, Kohler, Inc.*, 16 BNA OSHC 1769 (No. 88-237, 1994); *Hern Iron Works, Inc.*, 16 BNA OSHC 1206 (No. 89-433, 1993); *Pepperidge Farm*; and *Kaspar Wire Works* all predated passage of the Omnibus.⁵ *See also* 136 CONG. REC. S15776 (daily ed. Oct. 18, 1990) (statement of Sen. Hatch) (acknowledging that “OSHA, under its egregious policy, penalized several businesses in the multimillion dollar range”).

Commissioner Rogers respectfully takes issue with her colleague’s suggestion that the conferees’ contemplation of a “settlement” exception to the minimum penalty undercuts the mandatory applicability of the minimum in a litigated case. As the conferees recognized, the settlement comments concerned “OSHA’s existing [settlement] authority . . . [as] [t]he conferees d[id] not intend to deprive the agency of [its] flexibility to settle cases” H.R.Rep. No. 101-881, *reprinted in* 1990 *U.S.C.C.A.N.* at 2394. The Secretary’s *exclusive* settlement authority, including mitigation of penalties pursuant to settlement, is derived from her unique prosecutorial role. *Cuyohoga Valley Railway Co. v. United Transportation Union*, 474 U.S. 3, 7 (1985) (“[a] necessary adjunct of [the Secretary’s sole] power is the authority to withdraw a citation and enter into settlement discussions with the employer”) (citation omitted); *Donovan v. OSHRC (Mobil Oil)*, 713

⁵Commissioner Rogers also notes that the Commission and courts have routinely referred to the amended penalty amounts as if there were no question that they establish a \$5,000 minimum willful penalty. *See MJP Constr. Co.*, 19 BNA OSHC 1638, 1649 (No. 98-0502, 2001) (referring to 29 U.S.C. § 666 (a) “which mandates a minimum penalty of \$5000 for a willful violation”); *Worldwide Mfg. Inc.*, 19 BNA OSHC 1023, 1024, 1026 (No. 97-1381, 2000); *Arcadian*, 17 BNA OSHC at 1349 (“referring to Omnibus, which “establish[ed] a \$5,000 minimum penalty for willful violations”); *Reich v. Sabia Co.*, 90 F.3d 854, 859 (3rd Cir. 1996) (noting that 1990 amendment changed “statutory landscape” “by requiring a \$5,000 minimum penalty for *willful* violations”) (emphasis in original).

F.2d 918, 927 (2nd Cir. 1983) (only Secretary has “unfettered discretionary authority to withdraw or settle a citation . . . or to settle, mitigate or compromise any assessed penalty”). Therefore, any exception, by its terms and by virtue of the Secretary’s prosecutorial authority, would apply only to the Secretary and only in the context of settlements. *See Brooks Well Servicing Inc.*, 20 BNA OSHC 1286, 1288-89 (No. 99-0849, 2003) (noting general rule of statutory construction that “exceptions are to be narrowly construed”) (citations omitted).

In agreement with her colleague, Commissioner Rogers acknowledges the Commission’s statutory duty to assess an “appropriate” penalty based on the evidentiary record. 29 U.S.C. § 666(j), § 17(j). In her view, however, a focus on the Secretary’s egregious/willful policy factors to determine whether per-instance penalties are appropriate for affirmed per-instance violations sidesteps the statutory issue. Such an approach “splits the baby” by dividing per-instance citation authority into two distinct analytical questions: whether the cited standard/regulation can be read to support per-instance citations, and whether the record evidence sufficiently supports the Secretary’s “willful plus” criteria to warrant individual penalties. Regardless of the permissibility of assessing a single grouped penalty for individually cited and affirmed violations, the amended Act simply precludes the assessment of *any* penalty that does not amount to at least \$5,000 for each affirmed willful violation. This is consistent with the Commission’s corollary limitation precluding assessment of a penalty exceeding the statutory maximum for a single violation, even were the Commission to find the maximum permissible penalty inadequate.

Nonetheless, in contrast to her colleague, Commissioner Rogers would find that assessment of a separate penalty for each of Jindal’s willful recordkeeping violations is reasonable in the circumstances of this case, and satisfies the four section 17(j) penalty criteria as well as those the Secretary has articulated in her egregious/willful policy. As with all recordkeeping violations, the Commission classifies these violations as low gravity. However, Jindal’s abysmal error rate that averaged approximately seventy percent over three years, in conjunction with a recordkeeping program specifically designed and

implemented to under record, represents a level of bad faith that clearly justifies the Secretary's lawful exercise of her discretion to cite these violations separately and the penalties that statutorily flow from it.

Commissioner Rogers also rejects the notion that the statutorily prescribed minimum penalties here would be extraordinary. Under the Act's original penalty scheme, the Commission assessed an aggregate penalty of \$210,500 for the 342 willful recordkeeping violations in *Kaspar*, amounting to an average of \$615.49 per violation. A seven-fold increase in that amount would yield a per violation penalty of \$4,308.43. In *Pepperidge Farm*, the Commission assessed a penalty of \$289,603 for the 176 willful recordkeeping violations, amounting to an average of \$1645.47 per violation. A seven-fold increase in that amount would yield a per violation penalty of \$11,518.29. Here, a \$5,000 penalty for each of Jindal's eighty-two affirmed willful violations would yield a total penalty of \$410,000, an amount well within the range of previously assessed willful penalties. In view of the mandatory minimum, and the documented Congressional intent to effectuate the "stated purpose" of the Act with a significant penalty increase, Commissioner Rogers would find that the judge exceeded his authority by assessing a single penalty that failed to amount to a dollar value equal to, or greater than, the \$5,000 statutory minimum for each affirmed willful violation. *Cf. U.S. v. ITT Continental Baking Co.*, 420 U.S. 223, 229 n.6 (1975) (noting that where statute prescribes no minimum penalty and permits, though does not require, penalties assessed as a series of daily violations rather than a single violation, trial judge's penalty assessment reviewed for abuse of discretion).

SECRETARY OF LABOR,

Complainant,

v.

JINDAL UNITED STEEL CORP., and its
successors,

Respondent.

OSHRC DOCKET NO. 00-2231

APPEARANCES:

For the Complainant:

Danielle L. Jaberg, Esq., Erica J. McGuirk, Esq., Susan Meyercord Williams, Esq., Office of the Solicitor, U.S. Department of Labor, Dallas, Texas

For the Respondent:

Thomas H. Wilson, Esq., Merritt B. Chastain, III, Esq., Julie Merten Esq., Vinson & Elkins, LLP, Houston, Texas

Before: Administrative Law Judge: James H. Barkley

DECISION AND ORDER

This proceeding arises under the Occupational Safety and Health Act of 1970 (29 U.S.C. Section 651 *et seq.*; hereafter called the “Act”).

Respondent, Jindal United Steel Corp., (Jindal), at all times relevant to this action maintained a steel manufacturing plant in Baytown, Texas. Respondent admits it is an employer engaged in a business affecting commerce and is subject to the requirements of the Act.

On May 10 through October 19, 2000 the Occupational Safety and Health Administration (OSHA) conducted an inspection of Jindal’s Baytown plant. As a result of that inspection, Jindal was issued citations alleging violations of the Act together with proposed penalties. By filing a timely notice of contest Jindal brought this proceeding before the Occupational Safety and Health Review Commission (Commission).

On August 3, 2001, the parties entered into a partial settlement agreement disposing of “serious” citation 1, in its entirety. On September 7, 2001 the parties submitted an additional agreement, disposing of “willful” citation 2, items 123 through 126. On September 11-13, 2001, a hearing on the matters remaining at issue was held in Beaumont, Texas. At the hearing the parties filed a joint stipulation in which the Secretary agreed to withdraw willful citation 2, items

7, 41, 62, and 88. Willful citation 2, items 1 through 6, 8 through 40, 42 through 61, 63 through 87, and 89 through 122, remain at issue. Each of the remaining items alleges a violation of §1904.2(a), which requires that employers record occupational injuries and illnesses. Jindal contests the recordability of 24 of the remaining items, as set forth more fully below. Jindal also disputes the Secretary's willful classification and penalties of all items. The parties have submitted briefs on the matters remaining at issue and this case is ready for disposition.

Background

Jindal purchased the subject plate steel manufacturing facility in Baytown, Texas in 1997 from USX (Tr. 46, 267-67, 526). Jindal is located on the same 59 acre tract which houses Saw Pipes USA, Inc. (Saw Pipes); both were part of an older USX steel mill facility (Tr. 583). The old USX plant produced plate steel, which was then rolled into pipes. When sold, the plant was divided into two operations, Jindal operating the plate mill, and Saw operating the pipe manufacturing division. The two companies share some common ownership; Saw Pipes holds stock in Jindal (Tr. 141, 595). Saw Pipes commenced its operations prior to Jindal's start up (Tr. 123, 265, 562-64).

Craig Wetherington testified that he interviewed for a safety and health position with Jindal on May 4, 1998 (Tr. 51). Wetherington stated that Ms. Lisa White, Jindal's human resources manager, and Gary Jones, the human resources manager for Jindal's sister company, Saw Pipes, conducted his first interview (Tr. 48, 96). He was then interviewed by Doug Gates, Jindal's plant manager, along with Ms. White (Tr. 48-49). Wetherington stated that his position had no formal job description; he was told that, if hired, his job would entail helping the company come into operational status, and dealing with basic daily safety operations (Tr. 50). Wetherington was further told that he would have "double line, or dotted line responsibility" to both Mr. Jones and Doug Gates (Tr. 49, 66-67, 76, 98-99, 113). According to Wetherington, Jones was the administrator of the safety program for both Jindal and Saw pipes, and was the "contract holder, or signature party" for both Jindal and Saw pipes' Workers Compensation policies (Tr. 66, 126). Wetherington would be required to seek permission from Mr. Jones before submitting a claim to Workers' Compensation (Tr. 65). Wetherington was hired later the same afternoon, and reported to work on May 5, 1998 (Tr. 51). Upon reporting for work,

Wetherington inspected the physical plant, and reviewed Jindal's safety program and manual, as well as the OSHA 200 logs (Tr. 51-52).

Wetherington testified that he responded to employee injuries and accidents as part of his job (Tr. 52). After he received a report of an accident he would respond to the site to determine whether additional help was needed to respond. The injured employee would then be taken to the first aid, or nurse's, station. If needed the employee could be transferred to the healthcare provider with which Jindal had a contract, or to the local emergency room (Tr. 52-54). When an accident occurred at the plant, the injured employee's supervisor created an accident report, including the name of the affected employee, the date and location of injury, and a cursory description of the incident, and injury (Tr. 56). The accident report was to be turned over to Wetherington, the duty nurse, or to Doug Gates in the daily turn report, no later than first duty day following the accident (Tr. 56; Exh. C-295 through C-331). The nurse on duty also created a chronological list of all visits to the clinic and the care provided (Tr. 58-59; Exh. C-225, C-226).

Wetherington testified that he followed up on injuries. He examined the first aid log from the on-site first aid station weekly, and checked with the affected employee or with the nurse, who received the injured employee's "return envelope" from the healthcare provider (Tr. 58-60, 77). The return envelope would list prescriptions and/or physical therapy prescribed, and any physical restrictions on the employee's activity (Tr. 58). Wetherington also signed off on medical bills submitted by the healthcare provider for treatment provided to Jindal employees (Tr. 59-64; Exh. C-168 through C-194). In addition, Wetherington stated, he was responsible for submitting Workers' Compensation forms for eligible employees (Tr. 65).

Craig Wetherington testified that during his tenure at Lowry Air Force Base, between 1983 and 1992, he attended a four day seminar covering the OSHA 200 log, and the requirements for OSHA illness and injury record keeping (Tr. 42-44). Later, while working as a safety and health director at Grant/PrideCo, Wetherington attended a second, week-long course, sponsored by OSHA (Tr. 43). Wetherington was responsible for maintaining the OSHA 200 logs for Grant/PrideCo. for five years, until 1997 (Tr. 44-45). Wetherington testified that he understood OSHA record keeping requirements, and the meaning of the terms "medical treatment," "restrictive work activity," and "lost workdays" as defined by OSHA (Tr. 42-43).

Wetherington testified that he did not fill out the OSHA 200 logs at Jindal in accordance with OSHA recording criteria. Rather, Wetherington stated, he waited to record any injuries until it was determined whether an employee's injury was sufficiently serious to be reported to Workers' Compensation. If the cost of an employee's medical treatment and lost work time was paid out of pocket by Jindal, the Texas Workers' Compensation first report of injury (TWCC 1) was not forwarded to the state. In that case, Wetherington was not to list the injury on the OSHA 200 logs (Tr. 68, 77-80). If, however, the employee faced an extended period of convalescence or surgery, his or her injury would be reported to Workers' Compensation and listed on the OSHA 200 log (Tr. 65, 68). Consequently injuries meeting OSHA recording requirements were deliberately omitted from the logs. Wetherington testified that he filled out both the Workers Compensation forms and the OSHA 200 forms in accordance with instructions provided him by Gary Jones (Tr. 68).

Within several weeks of his hire date, Wetherington testified, he had a conversation with Jones about the way the Worker's Compensation claims were handled, and the resulting discrepancies in the OSHA logs. Wetherington stated that he told Jones he did not believe the 200 log was being filled out correctly. Jones told Wetherington that he interpreted OSHA regulations differently and that if Wetherington didn't want to record injuries according to his interpretation, Wetherington could find another job (Tr. 69, 555). Wetherington stated that, on several occasions, he spoke to Jones about the recording practices for the OSHA 200 log, but quit asking when he repeatedly got the same answer to his questions (Tr. 73).

Although Jones never directly stated that it was his intent to skew Jindal's accident data, Wetherington believed that Jones was knowledgeable about OSHA reporting requirements, and could not, in good faith, have interpreted those requirements to exclude all injuries not reported to Workers' Compensation.¹ Wetherington believed that Jones' intent was to misrepresent the number of accident's at the plant, in order to obtain favorable insurance premiums for the company (Tr. 109, 115-116). Wetherington also believed that the purpose of the under-reporting was to evade inspections by OSHA by reporting a low Lost Worker Day Index [LWDI] (Tr. 109-110).

¹ Jones was trained as a lawyer, and worked for 19 years in Brown and Root's legal department, where, among his other duties he responded to OSHA complaints (Tr. 555-56).

Wetherington testified that he reported his conversation with Jones to Lisa White and Doug Gates, specifically stating that he would not be following OSHA requirements when filling out the 200 log when following Jones' instructions (Tr. 70-71, 130). He also went to Joe Hayes, a vice president at Jindal, about his concerns on a specific case (Tr. 75, 117). According to Wetherington, Hayes was not interested, and referred him back to Jones (Tr. 75-76). White and Gates told him that Jones had the final word on both Workers' Compensation issues and on the OSHA reporting requirements (Tr. 70, 104). While Gates wanted Wetherington to comply fully with OSHA requirements, he recognized Jones' authority over safety issues. He recommended that Wetherington obey his supervisor, and "cover" himself by documenting any objections he had to the way the safety program was run (Tr. 71, 119, 130; *see also* testimony of Lisa White, Tr. 160-61, Exh. 292).

On June 24, 1998, Wetherington wrote a memo for the his personnel file (Tr. 71, 73, 130-31; Exh. C-293), stating that he had asked Gary Jones about the company policy not to report injuries for which a first report of injury or illness had been completed (TWCC 1's), either to the state (Texas Worker's Compensation Commission), or to OSHA. The memo goes on to state that Jones told Wetherington "not to worry about it." Wetherington writes that after reaffirming Gary Jones' final authority over safety matters, he decided to record all first aid on the company logs, but to list on the OSHA 200 log only cases for which Workers' Compensation claims are made (Exh. C-293). Wetherington also wrote a letter to Lisa White restating his position and noting that if Gates truly wants full compliance then "we are going to have to go over Gary's head and report all injuries since the first of the year." Wetherington goes on to note "I do not really think any of us can stand that much heat" (Tr. 71, 73; Exh. C-292).

Wetherington testified that, in addition to under-reporting injuries for which claims had not been filed, he also under-reported injuries involving temporary workers. Wetherington testified that Gary Jones specifically told him that injuries suffered by temporary laborers would be reported by the agency through which the laborer was employed, and that Wetherington was not to report those injuries (Tr. 74). Wetherington testified that he told Jones this did not conform to OSHA reporting guidelines; Jones told him he interpreted the guidelines differently (Tr. 74, 93). As a result, Wetherington did not report any injuries to temporary laborers; he did not do any followup on temporary employees who had been injured (Tr. 81).

Wetherington identified the OSHA Injury and Illness Data Collection Form for 1998, which he completed and signed (Tr. 82; Exh. C-332, *see also*, Exh. C-402). Eight lost work time injuries were listed for the 1998 calendar year, which, according to Mr. Wetherington, corresponded to the number he reported on the OSHA 200 form for that year (Tr. 82-83). The 1998 logs entered into evidence actually show 7 lost work time injuries, and three injuries without lost work time (Exh. R-1, C-400).

Lisa White testified that in April 1998 she interviewed with Gary Jones and Dillip Bhargava for a position as Jindal's human resource manager (Tr. 147-49, 205). She believed Bhargava to be the president of Saw pipes and CEO of Jindal. Gary Jones offered her the position, and she accepted on April 21, 1998 (Tr. 147-49; Exh. C-334). White testified that when she was hired, Dillip Bhargava told her that, while she would be working directly under Joe Hayes, a Jindal vice president, she would be reporting through Gary Jones on any matters relating to safety (Tr. 141, 144-46, 186, 209). Ms. White further testified that she did, in fact, report to Jones on compensation claims and EEOC litigation matters throughout her employment (Tr. 150-51, 162, 181, 188). Ms. White testified that Craig Wetherington was hired three for four weeks into her employment with Jindal; prior to that, there was no safety manager on site (Tr. 151). White testified that during Wetherington's interview, Gary Jones told Wetherington that he, like her, would have dual reporting responsibility to Jones (Tr. 154).

White recalled Wetherington's concern about Jindal not turning over minor injuries, or injuries without lost work time to their insurance carrier, or reporting those claims on the OSHA 200 forms (Tr. 156-57). She stated that he was also concerned that he had been directed not to report injuries involving temporary laborers on the OSHA 200s (Tr. 157). White confirmed that she was present during Wetherington's meeting with Doug Gates, and corroborated Wetherington's version of events (Tr. 160-61, 195-97). White stated that she was familiar with the recording criteria for the OSHA 200 logs (Tr. 137-40), and realized that the injuries Wetherington was concerned about should have been recorded (Tr. 157-58). However, when Wetherington left Jindal, and White took over responsibility for the 200 logs prior to engaging a new safety manager, White followed the practices Wetherington described to her. White intentionally failed to record at least one injury [cited at item 93] she knew to be recordable, because the employee involved was a temporary worker (Tr. 168-71).

Doug Gates, Jindal's plant manager, testified that Gary Jones introduced him to Craig Wetherington in the course of Wetherington's job interview (Tr. 248-49). According to Gates, Jones told him that Wetherington would be working in the plate mill, but be reporting to Jones (Tr. 250-51, 255). Gates testified that Jindal was "fumbling around trying to start our safety program." (Tr. 252). The only direction Gates gave Wetherington was to "establish a safety program and to be in the field and make observations of the people, the equipment, things like that. . . ." (Tr. 252). Gates confirmed that Wetherington and White came to him with concerns about the way the OSHA logs were being kept. Gates understood that both Wetherington and White felt that they were being asked to keep the logs in a way that did not conform to their training. However, Gates stated, he was unfamiliar with safety and health issues and felt that Wetherington and White should be discussing their problem with Jones, who was their supervisor (Tr. 253-54, 262). Gates testified that he recommended Wetherington make Jones aware of his objections, and let Jones know that he would bear the ultimate responsibility for any problems (Tr. 255).

Gary Jones testified that in July of 1997 he was hired by Saw Pipes to bargain with the United Steelworkers Union (Tr. 556). Jones testified that Jindal began start up operations in late 1997 or early 1998, but denied that he had any role in that process (Tr. 562). Jones then went on to repeatedly contradict this statement. He testified that his supervisor, Mr. Bhargava, appointed him to act as liaison between Saw Pipes and Jindal's security department, which had a crew putting the Jindal facility in order (Tr. 564). Because he was the only human resources person at the facility, he interviewed, negotiated employment terms and hired Lisa White (Tr. 566-67). Jones claimed to have no role in safety and health decisions at either Saw Pipes or Jindal (Tr. 564). However, Jones hired Saw Pipes safety managers, Ronnie Johnson and, later, Robert Murphy (Tr. 557, 560). He interviewed Craig Wetherington, and when Wetherington left Jindal, Lisa White came to Jones to ask if Murphy could fill in as safety manager (Tr. 566-67). He established a clinic for the benefit of both Jindal and Saw Pipes employees, and arranged for its staffing (Tr. 565). Jones understood that Jindal and Saw Pipes had the same insurance carrier, but stated that he had no role whatsoever in the administration of either Saw Pipes' or Jindal's Workers Compensation program (Tr. 558, 563).

Jones testified that he was not Lisa White or Craig Wetherington's supervisor, and had no authority to fire or discipline either of them (Tr. 579-82). Jones stated he never had any conversations with any of Jindal's management concerning OSHA reporting requirements, or OSHA 200 forms (Tr. 582-83). He maintained he never told Wetherington that he did not have to report on the OSHA 200 log any injury that was not also reported to Workers' Compensation (Tr. 575). He denied telling Wetherington to under report injuries on the OSHA 200 (Tr. 576).

Jones did recall a conversation with Wetherington regarding injuries to temporary laborers. Jones testified that he gave Wetherington his reasoning for not reporting those injuries, stating that Jindal/Saw didn't supervise those laborers, that the laborers viewed the staffing agency, Labor Ready, as their employer, and that the staffing agency told him that they were maintaining an OSHA 200 log on their employees (Tr. 577). Jones, who is also an attorney, testified that he consulted the Blue Book² before discussing the issue with Wetherington (Tr. 590-94). Jones maintained he did not know how Wetherington chose to handle those injuries (Tr. 577).

Jones recalled speaking to Lisa White about Saw Pipes' practice of paying claims out of pocket to avoid Worker's Compensation claims (Tr. 577-78). According to Jones, employers in Texas can opt out of Worker's Compensation program, and that there was nothing illicit about paying small claims in-house rather than turning them over to the insurance carrier (Tr. 559). Jones stated that the in house payment of medical, or lost time claims had no relation to whether the underlying injury was reported to OSHA (Tr. 559).

David McIntosh was hired as Jindal's safety manager on November 8, 1999, about a week after first interviewing for the job (Tr. 305). McIntosh testified that he reported to Lisa White, who reported to both Doug Gates and Gary Jones (Tr. 306). McIntosh testified that he discerned his job duties partially from conversations with Lisa White, but mainly from review of Wetherington's files. From those files McIntosh determined that he was responsible for accident prevention (Tr. 313). McIntosh stated that included accident response, and analysis of the on site first aid logs (Tr. 313-16). McIntosh stated that he was never specifically assigned the task of maintaining the OSHA 200 logs or for submitting claims to Workers' Compensation (Tr. 316-

² The "Blue Book," *Record keeping Guidelines for Occupational Injuries and Illnesses*, 50 Fed. Reg. 29102 (July 17, 1985), is a compilation of interpretations of the types of injuries to be recorded. The interpretation was published following notice and a period for industry comment.

17). However, McIntosh testified, he asked Doug Gates for permission to take on Workers' Compensation, as he had prior experience in the area (Tr. 317). McIntosh testified that he was directed to ask Gary Jones if he needed any instruction on which claims were to be submitted; however, he never had any occasion to do so (Tr. 318-19).

At the hearing, McIntosh testified that responsibility for keeping the OSHA 200 log had never been specifically assigned to him (Tr. 325-26, 339, 341-42, 373-75). McIntosh assumed responsibility for the OSHA 200 logs on his own initiative at the end of 1999 when he became concerned about the approaching deadline for posting the log (Tr. 317). McIntosh knew Wetherington kept the logs when he was the Jindal's safety manager, however, and he knew that no one else was keeping them.(Tr. 332, 334, 338-39). McIntosh completed the 1999 OSHA 200 logs based on information he located from Wetherington's files (Tr. 324-25). In his December 23, 1999 Turn Report, he notes correcting and updating the OSHA 200 log for 1998. He also states: "Did the same thing for 1999, except I still need to update October through December (Exh. C-374). McIntosh's Turn Reports do not mention the OSHA 200 forms again until February, when he discussed purchasing "EZ Track" software to "stay on top of our injuries and illnesses (Exh. C-385), and setting up a data base to record injuries for 2000 (Exh. C-386). McIntosh testified that he posted the 1999 log in February of 2000 (Tr. 324-25). The log, which has eleven entries, was never updated to include any entries from October and November. Only one entry appears for December, from the 24th, the day after McIntosh noted working on the log (Exh. R-2, C-400).

McIntosh testified that, in his opinion, Jindal was under-reporting injuries; he knew there were recordable injuries that should have been, but were not entered on the OSHA 200 form because they were not reported to Worker's Compensation (Tr. 322-24). No Jindal executive ever told him that Jindal's had a policy to under-report injuries to OSHA; however, Lisa White told him that Jindal's policy on completing the OSHA report was to log only those claims turned into Workers' Compensation (Tr. 320-22, 364-65, 386). White also told McIntosh that, in accordance with Gary Jones' instructions, injuries sustained by temporary laborers were not to be recorded (Tr. 334). McIntosh testified that he told White that he disagreed with the "unwritten" recording policies (Tr. 339-40). Nonetheless, McIntosh admitted that injuries continued to be under-reported during his tenure as safety manager.

McIntosh denied any personal responsibility for the continued under-reporting, insisting that he had not specifically been assigned the job of maintaining the logs. He completed the 2000 OSHA logs, “just to keep us covered in case something like this did happen” (Tr. 328, 332). McIntosh stated that he did attempt to enter all injuries for which Workers’ Compensation claims had been filed into the OSHA log. He couldn’t be sure he recorded them all, however, because he didn’t have access to the insurance information (Tr. 385-89). McIntosh admitted that he was aware of some recordable injuries that he failed to report (Tr. 342, 350, 352, 354, 355). He testified that he did not record such injuries because he “did not have time,” “did not get enough information,” was kept “busy doing other things,” and was never specifically told it was his responsibility (Tr. 343-64). In particular, McIntosh stated, Sandeep Mishra, Jindal’s president, assigned him another project, programming each employee’s hand print into the hand scanners for time keeping purposes (Tr. 366, 379). He was also assigned ancillary duties “such as getting the truck scale fixed, getting the fence fixed, finding contractors to fix the bathrooms out in the mill” (Tr. 379). McIntosh insisted that he never made a conscious decision not to record an injury, and maintained that he ignored Jindal’s unwritten policies (Tr. 373-74). The 2000 log reflects 13 work related injuries through May of that year (Exh. R-3, C-400).

The cited violations of §1904.2(a) allege that during the relevant periods of 1998, 1999 and the first half of 2000, Jindal failed to record 75%, 86% and 55%, respectively, of all recordable injuries (Tr. 513; Exh. C-406). Jindal admits that 94 of the 118 cited injuries should have been recorded. Of the 24 citations contested by Jindal, eight are vacated, as discussed more fully below; the remaining 16 are affirmed. Taking the vacated items into account, I find that Jindal failed to record 74%, 84% and 53%, of all recordable injuries, for the 1998, 1999, and the first half of 2000. The classification of the violations as willful, and the appropriateness of the penalty are discussed below.

Violations of §1904.2(a)

As noted above, citation 2, as amended, alleges 117 violations of §1904.2. Each item reads:

29 CFR 1904.2(a): The log and summary of occupational injuries and illnesses (OSHA Form No. 200 or its equivalent) was not completed in the detail provided in the form and the instructions contained therein:

Section 1904.2(a) provides:

Each employer shall, except as provided in paragraph (b) of this section, (1) maintain in each establishment a log and summary of all recordable occupational injuries and illnesses for that establishment; and (2) enter each recordable injury and illness on the log and summary as early as practicable, but no later than 6 working days after receiving information that a recordable injury or illness has occurred.

Section 1904.12 states:

(c) *Recordable occupational injuries or illnesses* are any occupational injuries or illnesses which result in:

(1) Fatalities. . . (2) Lost work day cases, other than fatalities, that result in lost workdays; or (3) Nonfatal cases without lost workdays which result in transfer to another job or termination of employment, or require medical treatment (other than first aid) or involve: loss of consciousness or restriction of work or motion. This category also includes any diagnosed occupational illnesses which are reported to the employer but are not classified as fatalities or lost workday cases.

(d) *Medical treatment* includes treatment administered by a physician or by registered professional personnel under the standing orders of a physician. Medical treatment does not include first aid treatment even though provided by a physician or registered professional personnel.

(e) *First Aid* is any one-time treatment, and any followup visit for the purpose of observation, of minor scratches, cuts, burns, splinters, and so forth, which do not ordinarily require medical care. . .

Citation 2, items 1 through 6 and 8 through 15. Jindal does not contest the underlying violations set forth in items 1 through 15. Those items allege violations resulting from injuries occurring on February 23, March 10, April 26, May 7, June 3, June 9, June 24, August 17, 1998 August 27, August 28, October 15, October 23, November 15, December 4, and December 8, 1998. Jindal admits not only that the injuries occurring on those dates were recordable, but that Jindal management knew or should have known that (1) the injuries were recordable, and (2) the injuries were not, in fact, recorded.

Citation 2, item 16. Joe Potter, a shift maintenance foreman at Jindal United Steel, testified that he strained a muscle in his lower back while attempting to lift an oil drum (Tr. 438). Potter testified that he was given medications which he was to take for two weeks (Tr. 438). Records from the San Augustine Industrial Clinic support Potter's testimony; the clinical notes indicate that on January 13, 1999, a Dr. Arora suggested the use of a lumbar corset, ordered a course of therapy and prescribed daily doses of 75 mg of Arthrotec (Exh. C-18). Potter was released for work "with the following instructions: . . . NO EXCESSIVE . . . LIFTING OVER 25 POUNDS. . . SQUATTING. . . CLIMBING."

Recordability. Jindal maintains that the Secretary failed to prove that Joseph Potter received medical treatment for his injury, in that she failed to prove how many doses of Arthrotec Potter was prescribed, or that Arthrotec is a prescription medication. Jindal further maintains that any restrictions in activity resulting from the injury did not prevent him from performing his normal job duties.

Under Fed. R. Civ. Pro. 201(b)(2), this judge may take notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned. This judge notes that The Physicians Desk Reference lists Arthrotec as a prescription drug used mainly for treating osteoarthritis. Potter testified that he was to take the medication for two weeks.

OSHA's Record keeping Guidelines for Occupational Injuries and Illnesses (hereafter referred to as the Blue Book), contains OSHA's official interpretation of the record keeping requirements (Exh. C-403). The Blue Book states, in pertinent part, that medical treatment includes the use of prescription medications (Except a single dose administered on a first visit for minor injury or discomfort) (Exh. C-403, p. 43). Joseph Potter's injury was recordable under the plain meaning of the standard.

Knowledge. Craig Wetherington was provided with a log sheet containing two entries concerning Potter's injury, and a notation that Potter went to San Augustine Clinic (Exh. C-225, p. 12). An injury incident report was prepared, noting that Potter injured his back (Exh. C-307).

Initially, this judge notes that this, and, in fact, **all** of the cited violations were discovered during a review of records obtained, considerably after the fact, in the course of the OSHA investigation. The records reviewed were in Jindal's control or in the control of its agents. Such

documents were available for the review of Jindal's safety management at any time. Thus I find that even if Jindal's safety managers lacked specific knowledge of any of the contested injuries, they could, with the exercise of reasonable diligence, have known of the medical treatment provided to the employees named in the citations.

The Secretary has established the cited violation.

Citation 2, item 17. On January 14, 1999 Joe Edwards, a crane electrician, fell approximately six feet from a platform at Jindal's plant (Tr. 442-43). Edwards testified that he went to the clinic, but wouldn't say that he actually hurt his back (Tr. 441). The Accident Report from the San Augustine Industrial Clinic states that Edwards was restricted to ground work only, no climbing, for one week; however, Edwards testified that there was nothing that he did prior to the accident that he could not do after he fell (Tr. 444; Exh. C-19). Edwards stated that after he returned from the clinic, he went back to work.

Jindal maintains that the injury sustained by Joe Edwards did not result in any restrictions in activity that prevented him from performing his normal job duties. This judge agrees.

Section 1904.12(c)'s relationship to subparagraph (f), is explained in the Blue Book, which discusses restriction of work or motion resulting in lost workdays, stating that:

Lost workday cases involving days of restricted work activity are those cases where, because of injury or illness. . . the employee worked at his or her permanently assigned job but could not perform all the duties normally connected with it.

Restricted work activity occurs when the employee, as a result of a job-related injury or illness, is physically or mentally unable to perform *all or any part* of his or her normal assignment during *all or any part* of the workday or shift. The emphasis is on the employee's *inability* to perform normal job duties over a normal work shift.

(Exh. 403, p. 48). Edwards testified that he was not injured when he fell on January 14, 1999, and that after visiting the clinic, he returned to his normal work activities. This judge cannot find that Edward's accident was recordable as that term is defined by OSHA's own guidelines.

Item 17 is vacated.

Citation 2, items 18 through 20. These items are uncontested. Jindal admits that it failed to list on its log and summary of occupational injuries and illnesses (OSHA Form No. 200) recordable injuries suffered by its employees on January 22, January 26, and February 2, 1999.

Citation 2, item 21. On February 3, 1999 Ronnie Lindsey was moving debris with a front end loader, when the wind blew trash into his face. The day following this incident, Lindsey reported to the plant dispensary (Tr. 474-77; Exh. C-212). Lindsey was referred to the OccuCare Industrial Medicine Clinic. His eye was flushed, and a doctor provided Lindsey with a medicated eye patch, which he was to wear for 24 hours (Tr. 475-76; Exh. C-22). Lindsey was released to return to restricted duty on February 4, 1999, with instructions that he was to be released from the restriction, *i.e.* monocular vision, on February 5, 1999, if he experienced no further problems (Exh. C-22). Lindsey testified that he was in charge of the mobile equipment operators, and that his duties included moving heavy equipment (Tr. 476). Lindsey stated that he could not move the equipment with monocular vision (Tr. 477).

Jindal maintains that the injury sustained by Ronnie Lindsey did not result in any restrictions in activity that prevented him from performing his normal job duties.

The evidence establishes that Lindsey was unable to perform part of his normal assignments during his February 4, 1999 shift, the day following the onset of his injury. (Exh. C-403 pp. 48, 51, #4). According to the guidelines set forth in the Blue Book, Lindsey's injury was recordable. Jindal had constructive knowledge of the violation, as discussed at item 16. The Secretary has established the cited violation.

Citation 2, items 22 through 24. These items are not contested. Jindal admits that it knew, or should have known that on February 10, February 19, and March 6, employees suffered recordable injuries that were not recorded on Jindal's OSHA 200 log.

Citation 2, item 25. On March 12, 1999, Ronnie Lindsey was working with a front end loader when a hydraulic line broke, spraying Lindsey with hot hydraulic fluid (Tr. 477). Lindsey testified that, after a few hours, he developed a rash similar to a severe sunburn on his face, shoulders and chest, which worsened over time (Tr. 476). The nurse at Jindal's onsite dispensary washed the rash down with antibacterial soap, and gave Lindsey some lotion (Tr. 479). Lindsey returned to the dispensary for observation over the next several days before the rash subsided (Tr. 480).

Jindal maintains that the illness suffered by Ronnie Lindsey did not constitute an occupational illness, and was, therefore, not recordable. The Blue Book states that:

Under the OSH Act all work-related illnesses must be recorded, while only those injuries which require medical treatment (other than first aid), or involve loss of

consciousness, restriction of work or motion, or transfer to another job are recordable. The distinction between injuries and illnesses, therefore, has significant record-keeping implications.

The instructions for distinguishing between injuries and illnesses are form, included in the Blue Book (Exh. C-403, at p. 37)

[w]hether a case involves an injury or illness is determined by the nature of the original event or exposure which caused the case, not by the resulting condition of the affected employee. Injuries are caused by *instantaneous* events in the work environment. Cases resulting from anything other than instantaneous events are considered illnesses. . . .A single incident involving an *instantaneous* exposure to chemicals is classified as in injury.

Had Lindsey's rash resulted from a chemical exposure over time, it would certainly have been classified as a recordable occupational illness.³ Because Lindsey's injury arose out of a single incident, however, it must be classified as an injury. Injuries are only recordable when the criteria set forth in §1904.12(c) are met, *i.e.*, when the injury requires medical treatment other than first aid, or involves a loss of consciousness, or restriction of work or motion. Because the Secretary has not alleged, or shown, that Lindsey's March 12, 1999 injury involved any of the criteria set forth in §1904.12(c), this item must be vacated.

Citation 2, item 26. On the morning of April 7, 1999 William Williams reported to Jindal's on site dispensary complaining that he had suffered a contusion to his left knee when he fell down some stairs while carrying a ladder. The nurse had Williams elevate his leg and apply an ice pack for 15 minutes (Exh. C-215; C-225, JUSS 2720). Later in the day Williams returned to the dispensary, complaining of lower back pain; the on site nurse applied a heat pack (Exh. C-215, C-225). On April 8 Williams asked to be referred to a doctor, and was sent to OccuCare Industrial Medicine Clinic, where he was examined. Williams was diagnosed with thoracic

³An occupational illness “. . .is any abnormal condition or disorder other than one resulting from and occupational injury, caused by exposure to environmental factors associated with employment. It includes acute and chronic illnesses which may be caused by inhalation, absorption, ingestion or direct contact.

* * *

Occupational Skin Diseases or Disorders

Examples: Contact dermatitis, eczema or rash caused by primary irritants and sensitizers or poisonous plants, oil, acne, chrome ulcers, chemical burns or inflammations, etc.

strain; his X-rays were negative; no treatment was prescribed. Williams was released for work, with instructions not to perform any excessive lifting (Exh. C-27).

The Secretary maintains that the two injuries were recordable, because they arose out of the same incident, and involved the “[a]pplication of hot or cold compress(es) during second or subsequent visit to medical personnel.” Jindal maintains that William Williams was treated with “first aid,” and that any restrictions on activity resulting from his injury did not prevent him from performing his normal job duties. Jindal argues that the injury, therefore, was not recordable. This judge agrees.

William Williams suffered two injuries on April 7, 1999. A contusion to his left knee was treated with a single cold compress. During a subsequent visit, Williams complained of a separate injury to his back, which was treated with a single hot compress. Williams was referred to the OccuCare clinic for tests, but received no treatment. Because Williams’ bruised knee and strained back muscle are separate injuries, and because Williams received only one treatment for each injury, this judge cannot find the injuries were recordable. Citation 2, item 26 is vacated.

Citation 2, items 27 through 30. are not contested. Those items list two recordable injuries suffered by Jindal employees on April 21, and one injury on both April 23, April 27, 1999. None of those injuries were recorded on Jindal’s OSHA 200 log.

Citation 2, item 31. On April 27, 1999, Alice Carter, formerly Alice Godfrey, was bitten by a brown recluse spider⁴ while walking through the “slab yard” at Jindal’s facility (Tr. 484). Ms. Carter testified that she notified her foremen, and went to the on site clinic before being referred to a doctor at the OccuCare clinic (Tr. 482; Exh. C-33). Carter was provided with a prescription salve (Ceftin) and antibiotics, which she was to use until gone (Tr. 482; Exh. C-33). Ms. Carter testified that she “was using” the salve, but had an allergic reaction to it (Tr. 482). She returned to the clinic on May 3, 1999 (Tr. 483; Exh. C-33). The doctor prescribed a different medicine, which proved effective (Tr. 482-483). In his May 3, 1999 notes, Dr. Arora states that Carter missed work Saturday and Sunday due to the allergic reaction (Exh. C-33). However, Carter testified at the hearing that she did not miss any work either because of the spider bite, or her allergic reaction to Ceftin (Tr. 483).

⁴ Instructions on the back of the OSHA 200 Log Sheet state that “conditions resulting from animal bites, such as insect or snake bites. . . are considered injuries.” (Exh. C-403, p. 64).

Jindal maintains that Carter, was treated with “first aid” only, and that the injury, therefore, was not recordable. Jindal further maintains that Carter’s injury did not result in any lost work days.

This judge finds no reason to discount Alice Carter’s testimony that she did not lose any work days due to her injury. Dr. Arora’s notes are not necessarily contradictory, as Saturday and Sunday are not regular work days. Nor does this judge have any reason to question Ms. Carter’s testimony that she “was using” the Ceftin salve, testimony from which this judge infers Carter was prescribed multiple doses. A work related injury requiring multiple doses of a prescription medication is recordable; *see*, the Blue Book, Exh. 403, p. 43. Jindal had constructive knowledge of the violation, as discussed at item 16. The Secretary has made out the cited violation.

Citation 2, item 32. An April 29, 1999 accident report from OccuCare indicates that, on that date, William Arthur had a dressing applied to a contusion/abrasion (Exh. C-34). Arthur was released for return to work with instructions to avoid “excessive” weight bearing on his right foot (Exh. C-34). Arthur testified that his normal job activities, repairing row lines, require him to bear excessive weight on both feet (Tr. 485-86). However, Arthur could not recall this injury at all (Tr. 485).

Jindal maintains that the injury sustained by William Arthur did not prevent him from performing his normal job duties. Jindal maintains that the injury, therefore, was not recordable.

The work restriction notation in Arthur’s accident report is insufficient to show that Arthur was actually unable to perform his normal job duties over a normal work shift as a result of the cited injury. The Secretary failed to carry her burden in this instance, and this item must be vacated.

Citation 2, item 33. Jindal does not contest citation 2, item 33, which alleges that a recordable injury that occurred to J-99-20 on May 13, 1999 was not recorded on the OSHA 200 log. That item will be affirmed.

Citation 2, item 34. Nurses notes dated May 18, 1999 and an accident report from OccuCare dated May 19, 1999 indicate that on May 14, of that year, Roger Blunt was cutting steel with a torch when hot slag fell on his boot. The slag burned through his boot, Blunt was diagnosed with first and second degree burns on the instep of his left foot (Exh. C-36, C-222).

Jindal's nurse cleaned and dressed the burn with 1% Silvadene creme on May 18, and 19, 1999 (Exh. C-222). The Physician's Desk Reference states that Silvadene 1% is a prescription anti-microbial ointment, silver sulfadiazine.

Because Blunt was treated with a prescription medication on his initial *and* on a subsequent visit to Jindal's clinic, the injury should have been recorded in accordance with the instructions provided in the Blue Book.

Jindal had constructive knowledge of the violation, as discussed at item 16. Citation 2, item 34 will be affirmed.

Citation 2, items 35 through 38. Jindal does not contest these items which alleges violations regarding recordable injury that occurred May 18, June 27, July 13, July 15, 1999 was not recorded on the OSHA 200 log. Those items will be affirmed.

Citation 2, item 39. On July 23, 1999, Maria Garcia reported to Jindal's dispensary complaining of pain in her right foot (Exh. C-227). The on-site nurse directed Garcia to wrap and elevate the foot over the weekend, and take 800 mg. of Advil every six hours. Garcia was to return on July 26, 1999 if she had seen no improvement (Exh. C-227). On July 26 Garcia returned, complaining of pain and swelling in the arch of the foot. Craig Wetherington was notified and Garcia was referred to OccuCare (Exh. C-227). The OccuCare accident report states that Garcia fell off a steel plate, spraining her ankle (Exh. C-41). Doctor's notes accompanying the report indicate that Garcia was given 12 samples of Relafen 500, advised to take the medication as directed, to use ankle support, apply heat, and take Tylenol for pain (Exh. C-41). Relafen (Nabumetone), is a prescription non-steroidal anti-inflammatory (NSAID).

Because Garcia was provided with multiple doses of Relafen, a prescription drug, during her third visit to a health care provider concerning the same injury, that injury should have been recorded in accordance with the instructions provided in the Blue Book. Jindal had constructive knowledge of the violation, as discussed at item 16. Citation 2, item 39 will be affirmed.

Citation 2, item 40. Jindal admits the recordability of the injury cited at citation 2, item 40. The injury cited occurred on August 17, 1999, and that item will be affirmed.

Citation 2, item 42. On August 17, 1999, Rich Moody was bitten by an "asp," a caterpillar-like insect; Moody developed an allergic reaction to the bite (Tr. 451-52). Moody

reported to the OccuCare Clinic and received two injections, 50 mg. Benadryl and 60 mg. Kenalog.

Jindal maintains that the injured employee in this case, Rich Moody, was treated with “first aid,” and that his injury, therefore, was not recordable. This judge disagrees. Moody received two, *i.e.* multiple, doses of prescription medication. In its brief Jindal states that Benadryl is “arguably and over-the-counter medication.” However, in this case, Moody received not an oral over-the-counter form of Benadryl, but injectable Benadryl, which is indicated for the immediate amelioration of allergic reactions or anaphylaxis as an adjunct to epinephrine. The injection was administered by a health care professional, in conjunction with a second prescription drug, Kenalog. The injury was recordable. Jindal had constructive knowledge of the violation, as discussed at item 16, and item 42 is affirmed.

Citation 2, item 43. On the morning of August 19, 1999, James Sherman was stepping off the “roll grinder” when his right calf muscle began to cramp (Tr. 429). Sherman reported to the dispensary, where the nurse on duty iced down his leg for 20 minutes before referring him to OccuCare (Exh. C-229). At OccuCare, Dr. McShane tentatively diagnosed Sherman with a vessel rupture or muscle tear based on the results of a venous doppler test (Exh. C-434). Sherman believed he received an anti-inflammatory, and medication for pain (Tr. 429). McShane’s notes confirm that Sherman received samples of Celebrex and was given Tylenol for pain. Sherman was advised to ice the leg, rest and to return to work the following morning.

Jindal maintains that the Secretary failed to prove that James Sherman suffered a work related injury, or that he received treatment in excess of first aid.

Injuries arising on the employer’s premises are presumed to be work related, unless the employer shows that the injury is actually a symptom or result of an earlier non-work related event (Exh. C-403, pp. 32-34). Because Jindal introduced no evidence tending to rebut the presumption, Mr. Sherman’s injury is deemed work-related. Sherman received medical treatment, in that he was provided samples (plural) of Celebrex (celecoxib), a prescription non-steroidal anti-inflammatory drug. Sherman’s injury was recordable; Jindal had constructive knowledge of the violation, as discussed at item 16, and its failure to record the injury was a violation of the Act.

Citation 2, item 44. Respondent admits it knew or should have known that the injury cited at citation 2, item 44 should have been recorded. That injury took place on August 27, 1999. Citation 2 item 44 will be affirmed.

Citation 2, item 45. On August 30, 1999, Eddie Dietz was injured when a truck he was a passenger in struck some slabs in Jindal's sled yard (Tr. 435). Dietz testified that he struck the windshield and cut his right forearm (Tr. 433). Dietz was taken to the dispensary, where he was referred by the on-site nurse to OccuCare (Tr. 433; Exh. C-438). Dietz testified that he was given samples of muscle relaxants and antibiotics at the clinic, which he took twice a day for two to three days (Tr. 434). In earlier statements Dietz testified that he was given muscle relaxants for two days, or, pain pills and a packet of four muscle relaxers (Exh. R-29). Dr. McShane's notes from the OccuCare accident report indicate that rather than writing a prescription for Celebrex, Dietz was given samples of the medication.

While Dietz appeared to mistakenly believe that Celebrex, an anti-inflammatory, was a muscle relaxant, he was sure that he took more than one dose of the medication he was provided at the clinic. This judge finds that the cited injury was recordable. Jindal had constructive knowledge of the violation, as discussed at item 16. Item 45 will be affirmed.

Citation 2, item 46. Jindal admits citation 2, item 46, which alleges that a recordable injury that occurred at Jindal's facility on September 30, 1999. That injury was not recorded on the OSHA 200 log in violation of the Act. Item 46 is affirmed.

Citation 2, item 47. At the hearing Arthur testified that he had gotten metal in his eyes on approximately three different occasions (Tr. 490). Arthur did not recall the dates of each incident, but remembered that on one of these occasions, he was sent to the clinic, where a doctor used a magnetic needle to remove the metal from his eye (Tr. 488). Arthur also recalled being given an eye patch at that time (Tr. 488). Arthur stated that he was going home after visiting the clinic, and so did not miss any work, or worry about the eye patch (Tr. 488).

The documentary evidence establishes that on the afternoon of October 4, 1999, William Arthur reported to the San Augustine Industrial Clinic complaining of foreign bodies in his eye (Exh. C-46; C-232). At the clinic, two foreign bodies were removed from his right eye using an "alger brush." Arthur was given an eye patch medicated with Blephamide cream and released for work. The restriction, "monocular vision" was noted on his accident report (Exh. C-46). The

doctor's notes further reveal that Arthur returned the following day for a follow-up exam. At the follow up, Arthur told the doctor that he removed the patch the preceding night. He complained of a dark discharge from his right eye and of sensitivity to light. A sample of Ciloxan was provided to him (Exh. C-46).

Ciloxan (Ciprofloxacin HCl) Ophthalmic is a synthetic, sterile, multiple dose, antimicrobial for topical ophthalmic use. The recommended dosage regimen is: One or two drops instilled into the affected eye at regular intervals while awake for five to 14 days. As Ciloxan is not a single dose medication, Arthur's treatment cannot be classified as first aid, and his injury was recordable. Jindal had constructive knowledge of the violation, as discussed at item 16. Item 47 is affirmed.

Citation 2, items 48 through 61 and 63 through 66. These items are not contested. The violations allege that Jindal knew, or should have known that 18 injuries occurring at their facility on October 5, and 27, November 1, 4, 17, 19, and December 2, 4, 6, 13, 15, 28, 1999, and on January 3, 13, 29, February 15, and April 11, 2000 should have been recorded on the OSHA 200 log. Those items will be affirmed.

Citation 2, item 67. On April 13, 2000, William Arthur reported to the on-site dispensary to have his eye checked. Jindal's nurse referred him to Saint Augustine Clinic, where he was diagnosed with a corneal abrasion, given a medicated eye patch, and released for work with a restriction for monocular vision (Exh. C-69).

At the hearing, Arthur could recall being given an eye patch following an eye injury (Tr. 491). Arthur stated that he could not have done his job with monocular vision, because his depth perception would be impaired; however, Arthur stated that he did not miss any time at work because he was injured right before he was to have four or five days off, so that he did not have to take any time off (Tr. 488, 491).

Jindal contests willful citation 2, item 67, maintains that the injuries sustained by William Arthur did not prevent him from performing his normal job duties. This judge agrees. The Blue Book states that a lost time injury, involving either missed or restriction of work, occurs only if the employee would have worked during the period affected by the injury. If the employee was not scheduled to work during that period, the injury need not be counted as a lost or restricted

work time case. Because Arthur testified that he was not scheduled, and therefore did not miss any work due to his injury, that injury was not recordable. Item 67 is vacated.

Citation 2, item 68. Jindal does not contest item 68. It admits that it knew, or should have known that the April 18, 2000 injury alleged there in should have been recorded.

Citation 2, item 69. Roy Bohman testified that on April 27, 2000 he hit his head on a metal plate, sustaining a cut above his ear (Tr. 447, 450). Bohman testified that he was diagnosed with a mild concussion, and given a prescription (Tr. 447). Bohman stated that he had the prescription filled at the hospital, and took the medication for four days (Tr. 447-48). In its brief, Jindal maintains that the notes in Bohman's medical "presumably the physician's handwritten notes," which it provided in response to discovery are illegible (Jindal's Post Hearing Brief, p. 43). However, the notes clearly state that a small laceration to Bohman's left ear was infected; 500 mg. Rocephin, and 500 mg. of Cipro, both of which are prescription broad-spectrum antibiotics, were prescribed. Five days of Cipro were prescribed (Exh. C-71).

The notes corroborate Bohman's testimony that he received medical treatment in the form of multiple doses of prescription medication. The injury should have been recorded. Jindal had constructive knowledge of the violation, as discussed at item 16. Item 69 is affirmed.

Citation 2, item 70. The Secretary introduced injury reports indicating that on November 25, 1998 Brandon Aldridge slipped and cut his left arm while picking up a piece of metal (Exh. C-289). The record does not reveal whether Aldridge returned to work after his injury; however, on November 30, 1998, Aldridge visited the Baycoast Occupational Medicine Clinic complaining of back pain suffered as a result of the incident (Exh. C-72). The results of Aldridge's back exam were within normal limits (Exh. C-72). Dr. Carl C. Davis recommended daily physical therapy for three days and placed Aldridge on modified duty; Aldridge was not to engage in repetitive lifting of weight over 25 pounds (Exh. C-72). Complainant submitted a November 30, 1998 "transitional duty job offer" from Labor Ready, Aldridge's employer. The job offer states that Aldridge has been released by his medical provider for light duty and offers him an office position for 10 hours a week, at \$5.15/hour (Exh. C-289).

Jindal contests citation this item, maintaining that the injuries sustained by Aldridge did not prevent him from performing his normal job duties. Prior to Aldridge's injury he was employed by Jindal as a helper in their sheers department (Exh C-289); after his injury his

physician released him for work, with a restriction against the repetitive lifting of 25 pounds. Aldridge did not testify at the hearing, and nothing in the evidence indicates whether Aldridge's job as a helper involved the repetitive lifting of 25 pounds. This judge cannot infer from the physician's report that Aldridge was *unable* to perform all or any part of his normal assignments. Although Labor Ready offered Aldridge a transfer to light duty, nothing in the evidence indicates whether Aldridge needed or accepted that offer. This judge notes that on the same day the offer of transitional employment was made, a Labor Ready representative completed an accident investigation report in which the investigator quoted Aldridge as promising to "start paying attention to the job (Exh. C-289). This judge declines to infer from Labor Ready's offer of transitional employment that Aldridge was unable to, or even that he did not resume his normal duties at Jindal on December 1, 1998.

The Secretary has failed to carry her burden of proof on this item, and it will be vacated.

Citation 2, items 71 through 77. Jindal admits that it knew, or should have known that the injuries cited at citation 2, items 71 through 77 should have been recorded. The cited injuries, which occurred on March 2, June 3, June 17, June 29, August 12, November 10 and December 3, 1998 were not recorded on the OSHA 200 log as required under the Act, and items 71 through 77 are affirmed.

Citation 2, item 78. Complainant introduced an accident report stating that on April 21, 1998, Theresa Holub strained her right shoulder lifting 50-60 pounds of steel (Exh. C-81). Holub's medical records indicate that on April 24, 1998, she was diagnosed with shoulder strain and given a prescription for Dolobid (Exh. C-82). The Physician's Desk Reference states that Dolobid is a non-steroidal anti-inflammatory drug used to treat mild to moderate pain and relieve the inflammation, swelling, stiffness, and joint pain. The starting dose is 1,000 milligrams, followed by 500 milligrams every 8 to 12 hours, depending on the individual. Dr. John D. Dang released Holub with instructions that she was not repetitively lift 20 pounds (Exh. C-82). Kathy Cowart, the risk manager from Holub's employer, Meador Staffing Service, testified that Holub was placed on light duty for six days (Tr. 410).

This judge finds it more likely than not that the prescription Holub received was for more than one dose. Moreover, the record indicates that she was placed on light duty for six days and

did not return to her assigned duties at Jindal as a result. Her injury was recordable. Jindal had constructive knowledge of the violation, as discussed at item 16, and item 78 is affirmed.

Citation 2, item 79. Jindal does not contest item 79. That item alleges that Jindal failed to record a work related injury that occurred on June 8, 1998, though it knew, or should have known that the injury was recordable. Item 79 is affirmed.

Citation 2, item 80. Christopher Soraiz testified that while he worked at Jindal, he dropped a tool onto his right hand, causing it to swell (Tr. 470, 473). Soraiz reported the injury on April 22, 1998 (Exh. C-85). Dr. Louis F. Puig examined Soraiz on April 23, 1998 (Exh. C-86). Puig released Soraiz for restricted work, advising him not to lift over 20 pounds, push or pull over 30 pounds, or repetitively grasp with his right hand (Exh. C-86). Soraiz testified that his job included painting shelves and rearranging tools (Tr. 471). Soraiz testified that his job normally included lifting weights of over 20 pounds and pushing and/or pulling items weighing 30 pounds (Tr. 472). Soraiz is right handed, and could not paint while unable to grasp with his right hand (Tr. 472-73). Soraiz was released from restricted duty on April 28, 1998 (Exh. C-86).

According to Soraiz, the injury to his hand prevented him from performing portions of his normally assigned duties during the time his motion was restricted. Jindal maintains that Soraiz is not a credible witness and argues that his injury did not prevent him from performing his normal job duties.

This judge finds no reason to discredit Mr. Soraiz's testimony. Such testimony establishes that his injury was recordable due to the restriction of motion which resulted therefrom. Jindal had constructive knowledge of the violation, as discussed at item 16. Item 80 is affirmed.

Citation 2, items 81 through 86. Jindal admits these violations. Items 81 through 86 allege that Jindal failed to record work related injuries which occurred at its plant on February 11, March 14 April 14, May 15, and June 7, 1998 and on September 15, 1999. Because Jindal admits that it knew, or should have known that the cited injuries were recordable, items 81 through 86 are affirmed.

Citation 2, item 87. On July 30, 1999, Shaun Bishop, a precision flame cutter, suffered a burn to his left eye (Tr. 492-93; Exh. C-258). Bishop visited the Baycoast Occupational Medicine Clinic, where he received a prescription for Cortisporin ophthalmic solution, and

released for return for limited duty. Bishop was not to perform any duties requiring depth perception, and was to wear dark glasses for three days (Tr. 493-94; Exh. C-100). Bishop testified that he told the physician that there was no way he could do his assigned job with the use of only one eye. Bishop stated that he was told to take three days off work and, if the problem resolved itself, the doctor would release him for work (Tr. 494). On August 5, Bishop returned to Baycoast, and was released from care (Exh. C-100). Bishop testified that he returned to Jindal, but that his depth of field perception was not the same, and that he could no longer cut steel plate within the precise parameters required by the quality control department (Tr. 494). Bishop testified that he was eventually transferred out of the department (Tr. 494-95).

Jindal contests citation this item, maintaining that the injuries sustained by Bishop did not prevent him from performing his normal job duties, citing a physician's report, which found that the burn to Bishop's eye was completely resolved, and that the eye appeared completely normal. Mr. Bishop worked as a precision steel cutter at Jindal for only one month prior to the time of the accident (Exh. C-258), and the record is silent on Bishop's prior training and/or experience. On the existing record, this judge is unable to determine whether Bishops inability to perform as a precision cutter resulted from the cited injury.

The record does establish, however, that the injury to his eye forced Bishop to take off three days that he would otherwise have worked. As the injury resulted in lost work days, its should have been recorded (*See*, Blue Book, Exh. C-403, pp. 48-49). Jindal had constructive knowledge of the violation, as discussed at item 16. Item 87 is affirmed.

Citation 2, items 89 through 94. Jindal does not contest these items, which refer to work related injuries sustained at the Jindal plant on January 14, February 9, June 11, August 5, September 1, and October 22, 1999. Though Jindal knew, or should have known, that the cited injuries were recordable, they were not recorded in the OSHA 200 log. Items 88 through 94 are affirmed.

Citation 2, item 95. Accident reports indicate that on July 25, 1999, Bernal Hendrickson suffered a laceration to his right knee when it was struck by a metal plate (Exh. C-115, C-265). Medical records indicate that Hendrickson visited the Baycoast Clinic on August 11, 1999, at which time the cut was found to be infected. The treating physician prescribed Keflex, identified by the Physician's Desk Reference as a cephalosporin antibiotics prescribed for bacterial

infections (Exh. C-116). A Labor Ready accident report states that Hendrickson was to take the medication for one week (Exh. C-265).

Because Hendrickson was prescribed multiple doses of a prescription medication,⁵ this injury was recordable. Jindal had constructive knowledge of the violation, as discussed at item 16. Item 95 is affirmed.

Citation 2, item 96. Complainant introduced accident reports indicating that on August 24, 1999, Bernal Hendrickson was injured when hot metal slag splashed into his right eye. The documents state that Hendrickson's eye was flushed, but that on August 25, 1999, he visited the Baycoast Clinic, where he was diagnosed with a corneal abrasion and released for modified duty (Exh. C-118, C-266). The medical release states that Hendrickson was restricted from activities requiring depth perception and/or driving of company vehicles (Exh. C-118, p. 1). As a result of the medical restrictions, Hendrickson's employer, Labor Ready offered him transitional, light duty, office work. Hendrickson refused the offer. (Exh. C-117, p. 2). A Baycoast illness activity and instruction sheet states that Hendrickson was released for work, without restrictions, on August 26, 1999 (Exh. C-118, p. 2). A workers compensation injury report indicates that Hendrickson returned to work on August 26, 1999 (Exh. C-117, p. 1).

Jindal contests citation 2, item 96. Jindal maintains that the injury suffered by Bernal Hendrickson did not prevent him from performing his normal job duties. At the time of his injury Hendrickson's was employed in Jindal's "flumes" department (Exh C-266, p. 1). The record does not reveal whether Hendrickson returned to work after the incident on August 24. After seeing his physician on August 25, the physician released him for work, with a restriction against work requiring depth perception, or driving of company vehicles. Hendrickson did not testify at the hearing, and nothing in the evidence indicates whether his assigned duties in the flumes department required driving or depth perception. This judge cannot infer from the physician's report that Aldridge was *unable* to perform all or any part of his normal assignments. Although Labor Ready offered Aldridge a transfer to light duty on August 26, Hendrickson

⁵ It is irrelevant whether Hendrickson actually had the prescription filled, or took the medicine prescribed. (*see*; Jindal's Post Hearing Brief, p. 43). The Blue Book focuses on whether the injury was serious enough that medical treatment should have been provided. Therefore, once a prescription is issued medical treatment is deemed to have been provided (Exh. C-403, p. 44; C-405, p. 10/21).

turned the offer down, apparently returning to work at Jindal following his physician's removal of any work restrictions.

The Secretary has failed to carry her burden of proof on this item, and it will be vacated.

Citation 2, items 97 through 103. Jindal does not contest these items, which cite Jindal for failing to record injuries that occurred on January 11, February 23, June 25, August 2, August 23, September 17, and December 8, 1999. Because Jindal admits it knew, or should have known the cited items were recordable, items 97 through 103 are affirmed.

Citation 2, item 104. On October 19, 1999, Tempie Mize suffered a contusion to her left wrist after dropping a pressure hose on it (Exh. C-274). Ms. Mize sought medical attention at the Baycoast Clinic, where she was advised to limit the use of her left hand for four days (Exh. C-134, p. 4). On October 22 Mize returned to Baycoast, where she told medical staff that she had returned to work, and resumed her normal activities, despite their advice to modify her activities (Exh. C-134, p. 2). On that occasion, Mize received instructions to wear a brace or splint on the wrist until 10/25 (Exh. C-134, p. 1). As a result of her physician's recommendations, Mize's employer, Labor Ready offered her a transitional, light duty position. Mize declined the offer (Exh. C-133, p. 2). Workers' compensation documents show no break in Mize's employment (Exh. C-133, p. 1; C-274, p. 3).

Jindal contests citation 2, item 104. Jindal maintains that the injury suffered by Tempie Mize did not prevent her from performing her normal job duties. At the time of her injury Mize's was employed as a laborer, cleaning Jindal's basement (Exh C-274, p. 1). After seeing her physician on October 19, the physician released her for work, with instructions to modify her activity to minimize the use of her left wrist. Mize did not testify at the hearing and nothing in the evidence indicates whether her assigned duties required repetitive, or excessive use of her left wrist. Mize did tell medical personnel that she continued to perform her normal activities after sustaining the injury. Although Labor Ready offered Mize a transfer to light duty on October 22, Mize turned the offer down, apparently returning to work at Jindal. This judge cannot infer from Labor Ready's offer of light duty that Mize was *unable* to perform all or any part of her normal assignments while wearing a brace.

However, Complainant has introduced a February 6, 1998 Compliance Letter, in which the Secretary interpreted medical treatment to include the use of casts, splints and/or orthopedic

devices designed to immobilize a body part (Exh. C-405, p. 15). Ms. Mize's injury is recordable because she was ordered by her physician to wear a brace on her left wrist.

Jindal had constructive knowledge of the violation, as discussed at item 16. Item 104 is affirmed.

Citation 2, items 105 through 109. Jindal does not contest these items. Recordable injuries cited therein occurred on February 26, April 14, April 28, September 21, and October 11, 1999. Jindal admits it knew, or should have known that the cited injuries were recordable, and these five violations are affirmed.

Citation 2, item 110. On May 6, 1999, Ocie Woods, millwright helper, was injured when a piece of metal lodged in his left eye (Tr. 423; Exh. C-280). Woods sought medical attention at the Baycoast Clinic, where his eye was flushed with saline solution. Dr. Carl Davis prescribed 2 drops of Cortisporin ophthalmic solution for four days (Exh. C-144). The Physician's Desk Reference states that Cortisporin is a combination of the steroid, hydrocortisone, and two antibiotics. It is a prescription drug used to relieve inflammatory conditions such as irritation, swelling, redness, and general eye discomfort, and to treat superficial bacterial infections of the eye.

Jindal maintains that the injured employee in this case, Ocie Woods, was treated with "first aid," based on his testimony at the hearing, at which time Mr. Woods testified that he believed Dr. Davis gave him Neosporin, a non-prescription antibiotic (Tr. 423). The medical records clearly that indicate Cortisporin was prescribed. That Mr. Woods recalls a similar sounding and acting medication is not fatal to the Secretary's case. Jindal had constructive knowledge of the violation, as discussed at item 16. Item 110 is affirmed.

Citation 2, items 111 through 113. Jindal admits it knew or should have known that the cited injuries, occurring on January 28, 1999 and July 27, and October 21, 1999 should have been recorded on the OSHA 200 log. These three items will be affirmed.

Citation 2, item 114. On June 24, 1999, Greg Golden, a general laborer at Jindal, dropped a block on his left big toe (Ex. C-281). Golden sought treatment at the Baycoast clinic on the following day, where the treating physician instructed Golden to wear a "wooden shoe" for four days (Exh. C-150, p. 1). On June 28, Golden was released for a "trial of regular activity" (Exh. C-150, p.2).

Jindal maintains that the injury sustained by Greg Golden did not prevent him from performing his normal job duties. There is, in fact, no evidence establishing what Greg Golden's normal job duties consisted of. Complainant argues, however, that in a February 6, 1998 Compliance Letter, the Secretary interpreted medical treatment to include the use of casts, splints and/or orthopedic devices designed to immobilize a body part (Exh. C-405, p. 15). Complainant maintains that Mr. Golden's injury was recordable on that basis alone. There is no evidence in this record indicating that the purpose of a wooden shoe is to immobilize, rather than to merely protect a damaged toe. In the absence of such evidence there is no basis to support this item. Item 114 is vacated.

Citation 2, items 115 through 122. Jindal admits the recordability of these items, which cite injuries sustained at its facility on January 25, January 28, February 9, March 9, March 14, March 18, April 12, and April 22, 2000. Because those items were not recorded on the OSHA 200 log.

Willfulness

The Commission has defined a willful violation as one "committed with intentional, knowing or voluntary disregard for the requirements of the Act or with plain indifference to employee safety." *Valdak Corp.*, 17 BNA OSHC 1135, 1136, 1993-95 CCH OSHD ¶30,759, p. 42,740 (No. 93-239, 1995), *aff'd*, 73 F.3d 1466 (8th Cir. 1996). A series of disparate violations may be found willful based on evidence that such violations are part of a deliberate pattern, practice, or course of conduct. *See, Kaspar Wire Works, Inc. (Kaspar)*, 18 BNA OSHC 2178, 2000 BNA OSHC ¶32,134 (No. 90-2775, 2000), *appeal filed*, No. 00-1392 (D.C. Cir. Sept. 26, 2000). The Secretary need not show that the employer had an evil or malicious motive to show willfulness. "The state of mind required for a willful violation need be only knowing, voluntary, or intentional." *Id.* at 2183-84.

Temporary Laborers/through October 1999. Jindal admits it was its deliberate practice not to record injuries sustained by temporary laborers. It argues that its practice was a good faith misinterpretation of the OSHA guidelines referring to temporary workers, and so cannot, as a matter of law, be found willful. The Blue Book states, in relevant part:

If [a temporary laborer is] subject to the supervision of the using firm, the temporary help supply service contractor is acting merely as a personnel department for the using firm, and the using firm must keep the records for the

personnel supplied by the service. If the temporary workers remain subject primarily to the supervision of the supply service, the records must be kept by the service. In short, the records should usually be kept by the firm responsible for the day-to-day direction of the employee's activities.

Gary Jones testified that, prior to advising Craig Wetherington not to record injuries to temporary laborers, he reviewed Chapter IV of OSHA's Blue Book. He determined Jindal was not responsible for recording any injuries suffered by temporary laborers, because they were employees of the staffing agencies that provided them (Tr. 561-62, 588-90). Jones claimed to believe that, at one time, Labor Ready provided supervision for their own employees. His description of the relationship with Labor Ready was: "We asked for a welder. They sent us a welder. We said: 'Here's where you will be working, here's the welding machine.' And they began to work. . . ." (Tr. 595). Phil Billeaudeau, the branch manager of Labor Ready, the primary personnel agency that supplied temporary labor for both Saw Pipes and Jindal, testified that laborers supplied by Labor Ready worked under Jindal foremen; it was Jindal's responsibility to supervise the workers Labor Ready provided (Tr. 233). Jones also testified that he based his advice on his belief that Labor Ready was recording the injuries of its own employees (Tr. 590).⁶

Jindal argues that its decision not to record injuries sustained by temporary laborers is not willful as a matter of law, relying on *Froedtert Memorial Lutheran Hospital, Inc. (Froedtert)*, 1999 WL 503823 (O.S.H.R.C.), in which the judge found that, though deliberately declining to record injuries suffered by temporary employees, the Respondent's occupational health coordinator lacked the requisite "heightened awareness" of the illegality of her actions necessary to support a finding of willfulness.

As a threshold matter this judge notes that *Froedtert* is an unreviewed judge's opinion without precedential value. If *Froedtert* has any legal effect, it is of providing notice to employers that while a temporary laborer performing duties in furtherance of the using

⁶ Phil Billeaudeau confirmed that, for a time Labor Ready did record off-site injuries suffered by its laborers (Tr. 222, 231-32)

Jimmy Cain, of Mega Maintenance, testified that his staffing agency kept OSHA 200 logs tracking injuries to employees supplied to Jindal, though he never communicated that fact to anyone at Jindal (Tr. 289).

Kathleen Cowart, the risk manager at Meador Staffing Services, testified that, although she understood that it was the hiring employer's duty to record injuries and illnesses on its OSHA 200 forms for temporary laborers, Meador kept duplicate logs "just to be safe." (Tr. 412).

employer's regular business under the supervision of the hiring employer, work related injuries and/or illnesses suffered by such temporary laborer must be recorded by the employer on whose premises the injury occurred. *See; Corbesco, Inc. v. Dole*, 926 F.2d 422 (5th Cir. 1991). This judge notes that in an earlier case, *Southern Scrap Materials Co., Inc. (SSM)*, 1997 WL 735352 (O.S.H.R.C.), also cited by Jindal, the judge reached a conclusion nearly identical to that in *Froedtert*. In *SSM* Judge Welch held that the plain wording of the standard focuses on the injuries and illnesses *for the establishment*, and that the purpose of the OSHA 200 log is to identify the types of injuries and the equipment used at the time the injuries occurred. *SSM*, like *Froedtert*, held that the hiring employer was responsible for recording any illnesses or injuries to workers working at its facility, while performing the hiring employer's work. *Id.*

In any event, Jindal's reliance on *Froedtert* is misplaced. Though it is true that a finding of willfulness is not justified where the employer had a good faith opinion that the violative conditions conformed to the requirements of the cited standard, the Commission has held that the test of good faith for these purposes is an objective one. The employer's belief concerning a factual matter, or as here, concerning the interpretation of a standard, must have been reasonable under the circumstances. *Calang Corp.*, 14 BNA OSHC 1789, 1987-90 CCH OSHD ¶29,080 (No. 85-319, 1990). It is abundantly clear that Labor Ready, and the other temporary labor contractor with whom Jindal dealt, acted merely as conduit to provide labor for Jindal. Jindal was the firm responsible for the day-to-day direction of the employees' activities. According to the plain language of the Blue Book, Jindal was the firm responsible for keeping the required OSHA injury and illness records. That Labor Ready recorded injuries sustained by the temporary workers it provided does not affect Jindal's duty under the standard. For Jones, who is an attorney, and who worked in the employee relations and compliance department at Brown & Root before joining Saw Pipes (Tr. 555, 585), to have interpreted the Blue Book in any other way is not only unreasonable, but incredible. The record establishes that Craig Wetherington, who was knowledgeable in safety and health matters, and who was hired to act as Jindal's safety manager, was aware from his hire date that Jindal had a duty to record such injuries. He conveyed this information to Jones, who insisted Wetherington under report injuries or risk losing his job.

Finally, Wetherington, who was ultimately responsible for filling out the OSHA 200 logs through November 1999, admitted that he deliberately, and knowingly, *i.e. willfully*, failed to record injuries involving temporary laborers, in contravention of OSHA injury reporting requirements.

Employee Laborers/through October, 1999. Craig Wetherington also admitted that he deliberately under-reported employee injuries on the OSHA 200 logs for 1998, and 1999. He claimed to be complying with Jindal's reporting policy, a policy that he believed, and I find to have been formulated by Gary Jones. He believed that his mandate was to record on the OSHA 200 logs only cases for which a claim had been filed with Workers' Compensation. Jindal maintains that Gary Jones never devised such a policy. In support of its contention, Jindal points to the absence of a 1:1 relationship between its Worker's Compensation claims and employee injuries reported on the OSHA 200 (Jindal's Post Hearing Brief, p. 5-11). Jindal notes that more than half the injuries on the 200 log were reported to OSHA, but not to Workers' Compensation.

This judge does not find Jindal's argument persuasive. Such mathematic inconsistency does not rebut Wetherington and White's testimony that Jindal intentionally under reported injury and illness information to OSHA. The Secretary need not prove that the deliberate under reporting actually followed a particular, discernable pattern. *See, Kaspar, supra*.

Supervisory Misconduct. The employer is responsible for the willful nature of its supervisors' intentional misconduct to the same extent that the employer is responsible for its supervisors' knowledge of violative conditions. *Tampa Shipyards, Inc.*, 15 BNA OSHC 1533, 1991-93 CCH OSHD ¶29,617 (Nos. 86-360, 86-469, 1992). Once the Secretary has made a prima facie showing of willfulness based on the actions of the employer's managerial personnel, the onus is on the employer to rebut that showing by establishing that the failure to the manager to follow proper procedures was unpreventable. In particular, the employer must establish that it had relevant work rules that it adequately communicated and effectively enforced. *See; Consolidated Freightways Corp.*, 15 BNA OSHC 1317, 1991-93 CCH OSHD ¶29,500 (No. 86-531, 1991). This Jindal has completely failed to do.

In its brief, Jindal points to the testimony of vice president Joe Hayes, and plant manager Doug Gates, in which each state that they would have disciplined the safety managers, had they realized that injuries were not being properly recorded (Tr. 618-19, 271, respectively). However,

at the hearing, both Gates and Hayes testified that, though the safety manager ostensibly reported to them, they had no way of knowing whether the records were being properly maintained because they had no expertise in safety and health matters (Tr. 254, 271, 339, 616). According to Hayes, the safety manager had complete control of Jindal's safety effort; it was solely the safety manager's responsibility to keep Jindal in compliance with OSHA regulations (Tr. 616). That duty was never clearly communicated to Wetherington or McIntosh, however. Wetherington testified that he was never provided with a formal job description; he was only told that he would be dealing with basic safety operations (Tr. 50). McIntosh discerned his job duties mainly from review of Wetherington's files, and specifically denied being assigned responsibility for OSHA compliance (Tr. 316-17, 364). Neither Gates nor Hayes ever monitored either safety manager's performance, or took any affirmative steps to discover whether the safety manager was competently discharging his duties (Tr. 263, 623-24). As conditions stood, Jindal's upper management was completely insulated from any knowledge about the management, or, in this case, the mismanagement of the safety department, unless it was reported to them by the safety manager himself.

And that is exactly what transpired here. The record establishes that Wetherington put both Gates and Hayes on notice that he was recording injuries improperly based on instructions from Gary Jones. Wetherington and White complained to Gates that Wetherington had been instructed to improperly report injuries. Wetherington complained to Hayes about an injury to a temporary employee that he believed should have been reported. Rather than looking into the matter, both Gates and Hayes referred Wetherington back to Jones, the originator of the improper policy. Though Jindal maintains that Jones was a Saw Pipes employee who had no role whatsoever in Jindal's managerial hierarchy, Wetherington, White, Gates and McIntosh unanimously testified that Jones was the final authority in matters relating to Jindal's injury reporting, and acted accordingly. Neither Jones, nor anyone in Jindal's upper management made any attempt to change the lines of authority.

It is clear from the record that Jindal failed to instruct or monitor its safety manager in any way. Its management completely abrogated its obligation to ensure compliance with OSHA regulations, referring all its safety manager's questions to Gary Jones, an employee of a sister

company. Because the failure of Jindal's safety manager to follow proper procedures was not unpreventable, his willful conduct is imputed to Jindal.

Willful items 1 through 6, 8 through 16, 18 through 24, 27 through 31, 33 through 40, and 42 through 46, involving injuries sustained by Jindal employees during Craig Wetherington's tenure, are affirmed.

Items 71 through 87, 89 through 92, 94 and 95, 97 and 98, 100 through 103, 105, 107 through 112 and 114, all of which involve injuries incurred by temporary laborers during Wetherington's tenure, are affirmed as willful violations of the Act.

Items 93, 104, 106 and 113 concern injuries sustained by temporary laborers during October 1999. At that time Jindal had no safety manager. Lisa White testified that she covered the safety manager's position until David McIntosh was hired in November (Tr. 168). White stated that she investigated only one injury during that period (Tr. 168-69). White knew that the injury was recordable under OSHA criteria; however, she did not record the injury because Jindal's policy was not to report injuries sustained by temporary laborers (Tr. 137-40; Exh. C-170). The failure to record is cited at item 93, and was properly classified as willful, for the reasons discussed above.

Items 104, 106 and 113 also involve recordable injuries to temporary laborers that occurred during October 1999. The evidence establishes that it was the accepted practice at Jindal not to conduct follow up on injuries involving temporary workers, because such injuries were never recorded. Because Jindal's established practice was the direct cause of these violations, this judge finds that they were properly classified as willful.

November 1999 through May 2000. Though he was hired as Jindal's safety manager, David McIntosh denied any responsibility for completing OSHA 200 logs. McIntosh did complete them, because he knew the logs were required by law, and because he knew no one else was maintaining them. McIntosh admitted he realized Jindal was under-reporting injuries, but denied that he ever made a conscious decision not to record an otherwise recordable injury.

McIntosh specifically denied deliberately failing to record an injury merely because the injury was suffered by a temporary employee (Tr. 373). Some injuries involving temporary workers do appear on the 2000 OSHA 200 logs beginning in January (Exh. R-3, R-9). After learning that Labor Ready's Phil Billeaudeau told Lisa White in mid to late 1999 that it was

Jindal's responsibility to record any injuries incurred on Jindal's property, (Tr. 222, 228), McIntosh told management, in a February 2, 2000 Turn Report, that his research confirmed Jindal's responsibility for recording injuries and illnesses sustained by temporary laborers working at the Jindal plant (Tr. 335; Exh. C-385).

This judge finds McIntosh's testimony that he had no responsibility for the OSHA 200 logs to be disingenuous. McIntosh knew that OSHA required the logs be kept; his predecessor kept the logs in previous years; he was aware that no one else was responsible for the logs. It is clear that, despite any clear instructions on the issue, McIntosh knew the OSHA 200 logs fell within his responsibilities as safety manager. The evidence demonstrates that he first began keeping the log on December 23, 1999, basing his entries on information compiled by Craig Wetherington. In his turn reports, McIntosh stated his intent to recreate injury and illness information for the period after Wetherington's departure, and to fill in the gaps in the logs at a later date. This he failed to do. Only two injuries were recorded between December 23, 1999 and the following February when the OSHA log seems to have again come to McIntosh's attention. Ten of the 13 injuries recorded for the first half of 2000 were recorded between March 1, and April 21, 2000 (Exh. R-2; C-400). Because of McIntosh's negligent recording practices, approximately half of the injuries occurring on his watch were never reported. McIntosh blames his sporadic reporting on time constraints, and on the failure of supervisory personnel to report injuries to him in a timely manner. McIntosh insists that he never decided not to record an injury sustained by a Jindal employee, and never complied with Jindal's unwritten practice of reducing injury and illness numbers by excluding temporary laborers from the log.

This record paints a picture of a safety manager who was inattentive to the point of being negligent, resulting in the gross under reporting of injuries on the OSHA 200. Because Jindal never monitored McIntosh's performance in any way, it could not expect to discover or to prevent OSHA violations which resulted from his negligence. Jindal is, therefore, responsible for McIntosh's failure to comply with the Act. However, to establish willfulness under Commission precedent, the Secretary must prove, by a preponderance of the evidence, that McIntosh and/or Jindal were more than negligent. She must show that McIntosh, and through him, Jindal, had a "heightened awareness" of the illegality of his actions, and that his actions were knowing, voluntary or intentional. This they failed to do.

In *Kaspar, supra*, the Commission was able to infer an intent to under-record where only 1 in 8 injuries were recorded for the cited period, resulting in a 4.3% injury rate. The Commission did not base its decision solely on the sheer number of unrecorded cases, however. Rather a comparison of prior years' recording and injury rates convinced the Commission that Kaspar deliberately "chose" to change their recording practices. *Id.* at 2182-84. Because logs kept by the same record-keepers showed injury rates of up to 40% in earlier years, the Commission found it incredible that the consistent under-recording for which Kaspar was cited resulted from mere negligence or carelessness. The Commission could reach no other conclusion than that Kaspar's record-keepers knowingly ceased recording injuries during the relevant period. *Id.*

In this case, McIntosh maintains he never chose not to record a given injury; Jindal maintains that the Secretary failed to introduce any evidence establishing that his failure to comply with OSHA regulations was anything more than carelessness. McIntosh was hired by a start up company which never had an effective reporting program in place. McIntosh had been Jindal's safety manager for only seven months when the OSHA investigation began. OSHA had not previously inspected Jindal's injury and illness logs, or otherwise placed McIntosh, or Jindal on notice of specific recording requirements. Because his predecessor had actively engaged in a practice of under-recording OSHA injury rates, McIntosh inherited a recording system based on deception. McIntosh's belated start at bringing Jindal into compliance with OSHA record keeping requirements in December, 1999, and his abandonment of the logs until the following March, when a spate of entries were made, including injuries sustained by temporary workers, do not suggest an intent not to report. Rather it suggests inattentiveness, negligence, and a lack of urgency in establishing a system under which all injuries and illnesses could be accurately tracked and correctly recorded.

The Secretary has shown that McIntosh knew his predecessor under-reported injuries on OSHA logs. The Secretary has established that Lisa White told McIntosh that Jindal's unwritten policy was to report to OSHA only injuries which were incurred by Jindal employees, and which were also turned over to Workers' Compensation. The Secretary did not show, by a preponderance of the evidence, that McIntosh followed the unwritten policy, or ever deliberately refrained from recording an injury he knew was recordable. McIntosh recorded 47% of

recordable injuries for the first half of 2000, up from Wetherington's 16% for the preceding year. McIntosh's included injuries not submitted to Workers' Compensation, as well as injuries sustained by temporary laborers on the OSHA log. These facts, coupled with his denial of wrongdoing, all militate against finding that his under-reporting was intentional, or resulted from his adherence to the unwritten policy.

The Secretary did not carry her burden in establishing that the remaining failures to record were willful. In her complaint, the Secretary alleges, in the alternative, that the record keeping violations are "serious." The Commission, however, has generally classified recordkeeping violations as other-than-serious. *See, Kaspar, supra; Caterpillar*, 15 BNA OSHC at 2176-78, 1991-93 CCH OSHD at pp. 42,010-12, fn. 16. Even though recordkeeping inaccuracies "may affect employees by misleading them about the nature of their working conditions and by withholding information from organizations, other governmental agencies and individuals performing research in the safety and health field. . . ." *Johnson Controls*, 16 BNA OSHC 1048; 1993 CCH OSHD ¶30,018 (No. 90-2179, 1993), there is rarely evidence that such violations give rise to a "substantial probability" of death or serious physical harm as is required under §17 of the Act. Because Complainant failed to introduce any evidence that the cited recordkeeping violations bore a direct relationship to employee safety at Jindal's work site, items 47 through 66 and 63 through 66, all of which occurred after McIntosh became Jindal's safety director will be affirmed as other-than-serious violations.

Penalties

The Secretary proposed a penalty of \$1,062,000 for Jindal's record keeping violations. While the Secretary has often exercised her authority to group related violations and propose a single penalty for a number of related violations, she chose not to do so here. Rather the violations were individually assessed to increase the total penalty. The \$1,062,000 proposed penalty is inappropriate regardless of how it was derived.

In determining the penalty amount, the single most important factor is the gravity of the violation. It is clear that the gravity of this group of violations is based on Respondent's deliberate decision to under-report certain types of injuries, which resulted in a high percentage

of unreported injuries (Tr. 537).⁷ Because of their importance in monitoring workplace safety and measuring the effectiveness of safety programs, recordkeeping violations play an important part in ensuring the safety of the American workforce. However, in proposing a total recordkeeping penalty of over \$1,000,000 the Secretary overstates the gravity of these violations. Even under the Secretary's theory of the case, Respondent reported major injuries to Workers' Compensation as well as to OSHA while only the more marginal, or less serious injuries went unreported. A review of the unreported injuries tends to support this. Moreover, the Secretary did not prove that Jindal's under-reporting actually immunized them from inspection. *See*, Secretary's Post Hearing Brief, p. 40-42, Exh. C-407). At best, had the injuries been properly reported, Jindal would have been placed on a "supplemental" list of employers who might have been targeted for inspection in 2000 had the local OSHA area office found time. *Id.* OSHA's CO admitted that the area office did not perform many programmed inspections, and mainly responded to complaints, injuries and fatalities, and that Houston area office might also schedule a programmed inspection for a business in a hazardous industry, such as Jindal's (Tr. 532-34).

Based on a review of the violations, I cannot find that the deliberate nature of the violations, or the number of violations justifies a penalty in excess of \$1,000,000.00. While it is clear that the Secretary may propose cite multiple penalties for separate violations of the recordkeeping standard, Commission review of the proposed penalty is *de novo*, and the judge has discretion to assess a single penalty if deemed appropriate. *See, Pepperidge Farm, Inc.*, 17, BNA OSHC 1993, 1997 CCH OSHD ¶131,301; *citing, Miniature Nut and Screw Corp.* 17 BNA OSHC 1557, 1996 CCH OSHD ¶130,986 (No. 93-2535, 1996). Taking into account the Jindal's size, over 250 employees, the very low gravity of the violations, and the absence of any evidence of prior OSHA inspections (Tr. 525-526), this judge finds that a penalty of \$70,000 is appropriate. To effectuate the penalty, all willful items are grouped under one willful violation and assessed the maximum penalty of \$70,000.

With respect to the record keeping items that were found to be other-than-serious rather than willful, the gravity was overstated for the reasons noted above. All non-willful record

⁷ There was some confusion in the testimony of Ms. Singleton as to whether the gravity of each failure to record was based on the gravity of the underlying injury, or the gravity of the decision to under-report. It is clear from the individual penalties that the gravity of the underlying injury was not considered since 118 injuries were given identical penalties.

keeping items will be grouped, and a single penalty of \$7,000, the maximum allowed, will be assessed.

Spoliation

Prior to the hearing Complainant moved for a finding that Respondent had spoliated evidence and requested that a negative inference be drawn. In effect, Complainant alleges Respondent intentionally destroyed documents requested during discovery; Complainant asked that record keeping violations she believe would have been established by the missing documents be affirmed. The motion was denied with leave to raise the matter and present evidence at the hearing.

The case relied upon by Complainant, *Caparotta v. Entergy Corp.* 168 F3d 754, 756 (5th Cir. 1999), requires a finding of bad conduct by the opposing party before an adverse inference can be drawn. Complainant has failed to establish that such documents were purposefully withheld, as opposed to inadvertently misplaced, as Jindal suggests. Having failed to establish bad conduct the motion is denied.

ORDER

1. Willful citation 2, items 1 through 6, alleging violations of 1904.2(a), are AFFIRMED.
2. Willful citation 2, item 7 is WITHDRAWN.
3. Willful citation 2, items 8 through 16 are AFFIRMED.
4. Willful citation 2, item 17, is VACATED.
5. Willful citation 2, items 18 through 24 are AFFIRMED.
6. Willful citation 2, items 25 and 26 are VACATED.
7. Willful citation 2, items 27 through 31 are AFFIRMED.
8. Willful citation 2, item 32, is VACATED.
9. Willful citation 2, items 33 through 40 are AFFIRMED.
10. Willful citation 2, item 41 is WITHDRAWN.
11. Willful citation 2, items 42 through 46 are AFFIRMED.
12. Citation 2, items 47 through 61 are AFFIRMED as “other than serious” violations of the Act.
13. Willful citation 2, item 62 is WITHDRAWN.

14. Citation 2, items 63 through 66, are AFFIRMED as “other than serious” violations of the Act..
15. Willful citation 2, item 67, is VACATED.
16. Willful citation 2, items 68 and 69, are AFFIRMED.
17. Willful citation 2, item 70, is VACATED.
18. Willful citation 2, items 71 through 87, are AFFIRMED.
19. Willful citation 2, item 88 is WITHDRAWN.
20. Willful citation 2, items 89 through 95, are AFFIRMED.
21. Willful citation 2, item 96, is VACATED.
22. Willful citation 2, items 97 and 98 are AFFIRMED.
23. Citation 2, item 99 is AFFIRMED as an “other than serious” violation.
24. Willful citation 2, items 100 through 113, are AFFIRMED.
25. Willful citation 2, item 114, is VACATED.
26. Citation 2, items 115 through 118, are AFFIRMED as “other than serious” violations.
27. A single penalty of \$70,000.00 is ASSESSED for all items affirmed as willful.
28. A single penalty of \$7,000.00 is ASSESSED for all items affirmed as other-than-serious.
29. The partial Settlement agreement disposing of willful citation 2, items 123, 124, 125, and 126, having been posted, and not objected to, is hereby approved, and incorporated into this order.

/s/
James H. Barkley
Judge, OSHRC

Dated: January 3, 2002