

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

Secretary of Labor,

Complainant

v.

Millard Refrigerated Services,

Respondent.

OSHRC Docket No. **11-0717**

Appearances:

Jeremy K. Fisher, Esquire, Office of the Solicitor, U.S. Department of Labor, Atlanta, Georgia
For Complainant

Marcel L. Debruge, Esquire & Kathryn Morris Willis, Esquire, Burr Forman, LLP, Birmingham, Alabama
For Respondent

Before: Administrative Law Judge Ken S. Welsch

DECISION AND ORDER

Millard Refrigerated Services, Inc. (MRS) is in the business of providing refrigeration and storage facilities for poultry and other products for national and international shipment from plants throughout the United States. On August 23, 2010, at a MRS plant in Theodore, Alabama, approximately 32,000 pounds of anhydrous ammonia was unexpectedly released into the atmosphere from a cracked pipe suction header on the plant's roof and a broken evaporator coil in Freezer #5. The Theodore plant was evacuated and an inspection was initiated by the Occupational Safety and Health Administration (OSHA). On February 22, 2011, OSHA issued citations to MRS for alleged violations of process safety management, emergency response, respiratory protection and recordkeeping standards at the Theodore plant.

Serious Citation No. 1 alleges MRS violated 29 C.F.R. § 1910.23(a)(2) (item 1) for the lack of swing gates at entry points to the platforms on the plant's roof; 29 C.F.R. § 1910.119(e)(3)(ii) (item 2) for failing to identify in its Process Hazard Analysis (PHA), incidents of prior ammonia leaks; 29 C.F.R. § 1910.119(f)(1)(i)(D) (item 3) for failing to instruct

employees when to close the ammonia supply in the event of a leak; 29 C.F.R. § 1910.119(g)(3) (item 4) for failing to train each employee on how to protect against ammonia inhalation; 29 C.F.R. § 1910.119(m)(4)(iv) (item 5) for failing to investigate the causal factors of an ammonia leak in January 2010; 29 C.F.R. § 1910.120(q)(3)(iv) (item 6) for allowing employees engaged in emergency response to be exposed to unknown concentrations of ammonia without respirators; 29 C.F.R. § 1910.120(q)(3)(v) and § 1910.134(g)(3)(i) (items 7a and 7b) for allowing an employee to work alone while attempting to isolate an ammonia leak; and 29 C.F.R. § 1910.120(q)(6)(iii) and § 1910.134(k)(3) (items 8a and 8b) for failing to train employees in its emergency response plan and the use of respirators. Citation No. 1 proposes total penalties of \$45,500.00.

Other than serious Citation No. 2 alleges MRS violated 29 C.F.R. § 1904.7(b)(1) (items 1, 2, and 3) for failing to identify the work related injury/illness classification for employee entries on its 2008, 2009, and 2010 OSHA 300 Logs; 29 C.F.R. § 1904.29(b)(1) (items 4 and 5) for failing to describe the injury sustained for employee entries on its 2008 and 2009 OSHA 300 Logs; 29 C.F.R. § 1904.29(b)(3) (item 6) for failing to enter each recordable injury within seven days on its 2010 OSHA 300 Log; 29 C.F.R. § 1904.32(b)(3) (item 7) for failing to have the company executive certify its 2007 OSHA 300A Log; and 29 C.F.R. § 1910.147(c)(6)(i) (item 8) for failing to conduct periodic inspections of its energy control procedures. Citation No. 2 proposes total penalties of \$7,000.00.

MRS timely contested the citations and denies the alleged violations and proposed penalties. The hearing in this matter was held on August 29-31, 2011 in Mobile, Alabama. The parties stipulated jurisdiction and coverage (Tr. 5). The Secretary withdrew Citation No. 2, item 3. On December 14, 2010, the parties filed simultaneous post-hearing briefs.

For the reasons discussed, serious Citation No. 1, items 1, 2 (in part), 4, 6, 8a and 8b and other than serious Citation No. 2, items 1, 2, 4, 5, 6, 7, and 8 are affirmed. Total penalties of \$15,250.00 are assessed. The remaining alleged violations are vacated or withdrawn by the Secretary.

The August 2010 Ammonia Release

MRS operates 35 refrigerated storage and warehouse plants for poultry and other products in the United States. It employs approximately 2,000 employees. The corporate office is located in Omaha, Nebraska (Tr. 459, 541, 576).

MRS's Theodore, Alabama plant, with access to Mobile Bay, is primarily engaged in international shipments. The plant began operation in 2005 and employed 132 employees in 2010 (Tr. 460, 544). It consists of loading/receiving docks, five freezers and two blast tunnels with 240,000 square feet of space, including approximately 192,000 square feet for refrigeration. To keep temperatures constant, the plant maintains approximately 140,000 pounds of anhydrous ammonia. This is the largest amount of ammonia of any MRS plant (Tr. 22, 30, 373).

Anhydrous ammonia (NH₃) is an irritant and corrosive that affects the skin, eyes, respiratory tract and mucous membranes. An overexposure may cause eye damage, burns in the nose, throat, and lungs, and corrosive burns of the skin. OSHA's permissible exposure limit (PEL) for ammonia is 50 parts per million (ppm) for an 8-hour time weighted average. § 1910.1000(a), Table Z-1. According to the Secretary, a person will die in 30 minutes at 1700 ppm and at 3,000 ppm; death is almost immediate (Tr. 113). OSHA's Process Safety Management (PSM) standards are triggered at 10,000 pounds of anhydrous ammonia in process or storage. § 1910.119(a), App. A.

On the evening of August 22, 2010, the Theodore plant was affected by a power outage. The plant engineer, who had been promoted from assistant in May 2010 when the former engineer was terminated for reasons unrelated to work, returned to the plant. After power was restored to the plant, the plant engineer checked the refrigeration systems and found that one booster pump would not turn on. Upon conferring with a maintenance worker who told him that it was "fine" to leave the pump off, the plant engineer went home and returned the next morning (Tr. 36, 194, 375-376, 438, 461).

On August 23, 2010, at approximately 9:00 a.m., a crane operator, who was loading pallets of frozen chickens onboard a ship at the dock, smelled ammonia from the plant, approximately 200 feet away, when he opened the cab's window. As he climbed down the crane's ladder, the operator fell and injured his leg. His supervisor notified the plant engineer of the ammonia smell and the operator was driven to the hospital (Exh. C-12; Tr. 28-29, 118, 381, 514).

Upon hearing of the ammonia smell, the plant engineer and a maintenance worker walked to Freezer #5. The engineer carried a cartridge respirator. As soon as the freezer door was opened, both employees immediately smelled ammonia and knew there was a leak (Exh. R-17; Tr. 120, 382).

After closing the freezer door, the plant engineer and the maintenance worker proceeded to the plant's roof to isolate/shut off valves to the freezer. Upon accessing the roof, the employees observed an ammonia cloud coming from a cracked pipe suction header on the roof. The engineer telephoned MRS's regional engineer who instructed him to "valve off" the two leaks (Exh. C-1; Tr. 385-386).

While the maintenance worker attempted to isolate the leaks, a mechanic with a cartridge respirator assisted him on the roof. Both employees worked in refrigeration maintenance under the supervision of the plant engineer. The plant engineer returned inside the plant and made additional telephone calls to the regional engineer and the plant's general manager (Exh. C-31; Tr. 387-388, 393, 444). The plant initiated evacuation procedures and employees were sent to the parking lot, away from the ammonia cloud.

Later, the plant engineer briefly passed out from heat exhaustion while wearing full-body HAZMAT gear at the request of the Fire Department. The full-body gear caused the plant engineer to overheat. The engineer was taken to the hospital, given an IV, and released (Tr. 393-394, 528).

According to MRS, the two leaks released approximately 32,000 pounds of ammonia and resulted in \$4 million of product losses. Approximately 150 people were taken to the hospital and released. This was the largest ammonia release in the company's history (Tr. 31, 398, 532).

MRS's Engineering Investigation Report into the ammonia release identifies as contributing factors: (1) "the hydraulic thermal shock that caused the evaporator manifold failure and roof piping failure was the result of an early termination of a defrost cycle," (2) "too many evaporators going into defrost at the same time," (3) "there was a glitch in the refrigeration control system that occurred upon the early termination of a defrost cycle," and (4) "there was operator error in the actions leading up to the failure. These were the actions after the 8/22/10 power failure and prior to the 8/23/10 ammonia release. The actions of the Operators immediately following the failures (during the evacuation release) magnified and added to the incident and damages." The Report further states that certain control systems were changed to ensure the situation would not happen in the future including setting minimum defrost times which cannot be manipulated by plant personnel. The report concludes that the damaged piping and evaporator coil were repaired by certified welders (Exh. C-13).

After receiving a media referral at approximately 11:00 a.m., OSHA Industrial Hygienist (IH) Robert Bennett initiated an inspection. Because the plant was closed by the Fire Department as a “hot zone,” he returned to the plant on August 24, 2010. He made eight trips to the Theodore plant with an OSHA safety inspector and an employee from OSHA’s national office. The OSHA inspection was expanded to a comprehensive inspection which reviewed MRS’s programs in process safety management, respirator training, emergency response and the company’s OSHA 300 Logs (Tr. 21-22, 25, 48, 213).¹

IH Bennett opined the leaks occurred because of the overpressure created by hydraulic shock which was caused when the power was restored. The hot gas and cold liquid mixed because a suction valve in the evaporator in Freezer #5 opened prematurely which caused the gas to expand and propel the liquid. Air monitoring samples inside Freezer #5 on August 23, 2010 by the Center for Toxicology and Environmental Health, L.L.C. ranged from 3,880 to 7,275 ppm for ammonia and remained above OSHA’s PEL of 50 ppm for ammonia until August 26, 2010 (Exh. C-32; Tr. 33).

Prior to August 23, 2010, the Theodore plant experienced two other ammonia incidents. One involved a leak from a cracked weld on a pipe suction header on January 6, 2010 which caused an ammonia release of 12 ppm. The crack was re-welded and MRS reported no loss of ammonia (Exh. C-7; Tr. 58-59). The other ammonia leak occurred on April 25, 2007 from an evaporator and a cracked pipe caused by hydraulic shock which released 110 pounds of ammonia (Exh. C-4).

As a result of OSHA’s inspection into the August 23, 2010 ammonia release, MRS received the citations at issue on February 22, 2011.

Discussion

In order to establish a violation of an occupational safety or health standard, the Secretary has the burden of proving: (a) the applicability of the cited standard, (b) the employer’s noncompliance with the standard’s terms, (c) employee access to the violative conditions, and (d) the employer’s actual or constructive knowledge of the violation (*i.e.*, the employer either knew or, with the exercise of reasonable diligence could have known, of the violative conditions).

¹ MRS’s claim that OSHA improperly expanded the scope of the inspection is rejected. The OSHA inspection complied with §8 of the Occupational Safety and Health Act (Act). MRS consented to the inspection. IH Bennett discussed, without objection, the expanded comprehensive inspection with the plant manager on August 24, 2010 (Tr. 49). Also, the regional engineer walked the plant with the OSHA inspectors and never objected to the inspection (Tr. 726).

Atlantic Battery Co., 16 BNA OSHC 2131, 2138 (No. 90-1747, 1994).

It is undisputed that the standards cited by OSHA apply to the Theodore plant. Also, there is no dispute that MRS, through its general manager and plant engineer, knew the procedures and conditions at the plant. MRS disputes that it failed to comply with the terms of the cited standards and that its employees were exposed to unsafe conditions.²

CITATION No. 1 – Alleged Serious Violations

Item 1 - Alleged Violation of § 1910.23(a)(2)

The citation alleges:

Phase 2³ West Side of the condensers: On or about December 8, 2010, and at times prior, the employer did not ensure that employees were protected from fall hazards. The caged ladders used to access the condenser coils were not equipped with swing gates.

Section 1910.23(a)(2) provides:

Every ladderway floor opening or platform shall be guarded by a standard railing with standard toeboard on all exposed sides (except at entrance to opening), with the passage through the railing either provided with a swinging gate or so offset that a person cannot walk directly into the opening.

During the inspection on December 8, 2010, the OSHA inspectors observed that caged ladders to platforms containing condenser coils on the plant's roof did not have swing gates or offsets at the points of entry. The platforms were approximately 15 feet above roof level and were surrounded by guardrails except where the ladders reached the platforms. The entry points from the ladders were open. Maintenance personnel used the caged ladders infrequently (once a month or less) to service the condenser coils (Tr. 214-215, 469).

MRS does not dispute that swing gates or offsets were not installed at the ladders' points of entry onto the platforms. The ladders were in plain view and used by maintenance employees to service the condenser coils. MRS was aware of the lack of swing gates and employees were exposed to a fall hazard of approximately 15 feet to the roof in the event that they stepped through or otherwise passed through the openings to ladders.

² Issues not briefed are deemed waived. See *Georgia-Pacific Corp.*, 15 BNA OSHC 1127, 1130 (No. 89-2713, 1991).

³ "Phase 1" and "Phase 2" are MRS's designation for the plant's start up. Phase 1 started operation in 2005 and Phase 2, where the leak occurred, started in 2007 (Tr. 350).

Section 1910.23(c), claimed applicable by MRS, does not apply to the condition cited by the Secretary under § 1910.23(a)(2), *i.e.* ladderways to platforms. Section 1910.23(c) applies to guardrails on an “opensided floor or platform” and specifically excludes from application the points of entry onto the platform. The swing gate provides a barrier at the point of entry through the guardrail system around the platform which is the hazard addressed by § 1910.23(a)(2). The gate swings towards the employee descending the ladder.

MRS’s estoppel argument is rejected. OSHA inspectors made approximately eight trips to the plant during the 2010 inspection and an unknown number of trips during a 2007 inspection. MRS claims that during OSHA’s earlier trips to the plant, the lack of swing gates was not brought to its attention (Tr. 243).

OSHA acknowledges that the lack of swing gates was not discussed with MRS prior to December 2010. However, there is no evidence that the caged ladders or platforms were the subject of prior OSHA inspections or even observed by the OSHA inspectors prior to December 2010. There is no showing of detrimental reliance by MRS or that OSHA misled it regarding the swing gates. The lack of a prior citation does not grant MRS future immunity from enforcement. An employer cannot rely on OSHA’s failure to issue a citation to later argue a lack of knowledge of the hazardous condition. *Columbian Art Works, Inc.*, 10 BNA OSHC 1132 (No. 78-29, 1981).

MRS’s argument that swing gates present a greater hazard to employees is also rejected.⁴ MRS failed to show that some other method of protection was preferable. In fact, MRS subsequently installed the swing gates at the Theodore plant as well as its other plants (Exhs. C-24, C-25; Tr. 483, 640). Since installing the swing gates, the general manager testified that there have been no reported injuries or employees’ complaints (Tr. 533-534). The regional engineer confirmed the lack of injuries at the plants (Tr. 724-725). Other than speculation, MRS could not show that tools carried by maintenance personnel caused a problem. The swing gates only require a push from the ladder side to open and as noted by the Secretary, the tools are carried in tool belts which MRS makes available (Tr. 723-724). Even if swing gates were not suitable, it is noted the standard permits the installation of offsets which was not argued by MRS or shown as a hazard to employees.

⁴ To establish a greater hazard defense, an employer must show (1) the hazard of compliance exceeds the hazard of noncompliance; (2) alternative means of protecting employees are unavailable; and (3) a variance under § 6(d) of the Act is unavailable or inappropriate. *Lauhoff Grain Corp.*, 13 BNA OSHC 1084, 1088 (No. 81-984, 1987).

A serious violation of § 1910.23(a)(2) is established.⁵ There is no dispute that a fall of 15 feet from the platform to the roof surface could result in an employee's death or serious injury. MRS, through the plant manager and plant engineer, knew maintenance employees accessed, although infrequently, the platforms to service the condenser coils. Even a brief or infrequent exposure to a hazard is sufficient to establish a violation. *Walker Towing Corp.*, 14 BNA OSHC 2072, 2074 (No. 87-1359, 1991).

Item 2 - Alleged Violation of § 1910.119(e)(3)(ii)

The citation alleges:

Phase 2: On or about August 23, 2010, and at times prior, the employer did not ensure that employees were protected from anhydrous ammonia hazards. The Process Hazard Analysis revalidation for Phases 1 and 2 conducted on or about May, 2010, did not take into consideration the prior anhydrous ammonia leaks from Phase 2. Specifically, on or about April 25, 2007, a rupture in lines and main header occurred on blast tunnel zone 3 resulting in approximately 110 pounds of anhydrous ammonia to be released, and on or about January 6, 2010, an unknown quantity of anhydrous ammonia was released when on blast one zone 3 a weld on a suction head cracked. This latter release was treated by the employer as an "Ammonia odor" instead of an "Ammonia Refrigeration Incident Summary.

Section 1910.119(e)(3)(ii) provides that the Process Hazard Analysis (PHA) shall include:

The identification of any previous incident which had a likely potential for catastrophic consequences in the workplace.

The PSM standards are performance oriented and seek to prevent or minimize "the consequences of catastrophic releases of toxic, reactive, flammable, or explosive chemicals." There is no dispute that the Theodore plant is a Process Safety Management (PSM) covered facility. The plant maintains 140,000 pounds of anhydrous ammonia. The threshold quantity for a PSM covered facility is 10,000 pounds for anhydrous ammonia. The regional engineer agrees the Theodore plant needs to comply with PSM and its written program purports to follow PSM guidelines (Exh. R-1; Tr. 736).

As a covered facility, the Theodore plant must have an initial PHA and revalidate the PHA every five years "to assure that the process hazard analysis is consistent with the current

⁵ A violation is serious under § 17(k) of the Act, if there is a substantial probability of death or serious physical harm from the cited condition and the employer knew or should have known of the unsafe condition.

process” and to update any changes in equipment and procedures (Tr. 54). *See* § 1910.119(e)(6). The PHA revalidation, in part, must identify any previous incidents which had a “likely potential for catastrophic consequences” in the workplace.

The Theodore plant’s initial PHA was completed on May 5, 2005 and its PHA revalidation on May 3, 2010 (Exh. C-8, p. M00354; Tr. 62). The citation alleges the plant failed to identify in its PHA revalidation the ammonia leaks in April 2007 and January 2010.

MRS does not dispute that the January 2010 incident was not included because “the concentration was not near high enough and the estimated loss wasn’t there to really go to—to add it to the PHA” (Tr. 632-633). MRS claims that the April 2007 incident was included in its PHA revalidation.

2007 Ammonia Leak

On April 25, 2007, the Theodore plant experienced the unexpected release of 110 pounds of ammonia due to hydraulic shock. The plant’s Incident Investigation Report, dated May 1, 2007, indicates that ammonia was detected in the blast tunnel and the system was isolated when a leak on the roof occurred from a crack in a 12-inch pipe suction header (Exh. C-4).

There is no dispute that the 2007 incident needed to be identified in the plant’s PHA revalidation. The incident had a “likely potential for catastrophic consequences” based on the release of 110 pounds of ammonia caused by hydraulic shock under circumstances similar to August 2010 ammonia release.

After the 2007 incident, the Theodore plant prepared a PSM Management of Change (MOC) on April 27, 2010 which identified as corrective action, the removal of “4 foot of pipe and weld new cap on end of pipe. Repair tubing on unit CS30005 test system” (Exh. C-5).

The plant also prepared a PHA Addendum on May 4, 2007 which noted that if the blast piping on the roof ruptures by hydraulic shock, the safeguard is to allow the “system valves bleed over pressure from defrost cycle” and “to watch blast system defrost at least every other month to insure valves work properly” (Exh. C-6). A six-digit reference number on the Addendum refers the plant’s 2007 Incident Investigation Report (Tr. 712).

Neither the Incident Investigation Report, nor the MOC, nor the Addendum were attached or specifically identified in the plant’s 2010 PHA revalidation. The revalidation contains no information about the 2007 incident. The Incident Report’s six-digit reference number is not on the PHA revalidation. Although not specifically addressed or referenced, the

revalidation does state that “all changes have been addressed in the PHA Addendum.” It is unclear whether this refers to the 2007 Addendum or another Addendum. Also, it is noted the plant was not following the recommendation in the 2007 Addendum, *i.e.* examine the blast system every other month. The regional engineer testified that the plant was checking the system every six months (Tr. 717).

A violation of § 1910.119(e)(3)(ii) is established. The 2007 ammonia release was not shown to be specifically identified in the plant’s 2010 PHA revalidation. The corporate project manager could not find that the April 2007 ammonia release was considered in the plant’s PHA revalidation (Tr. 589). The plant manager, who was on the revalidation team, could not recall discussing the 2007 incident during the revalidation process (Tr. 472).

MRS’s failure to identify the 2007 ammonia release in its 2010 PHA revalidation is deemed an other than serious violation with no penalty. The plant documented the 2007 incident and prepared a MOC and Addendum. Also, the PHA revalidation does reference an “Addendum” but fails to specify the 2007 Addendum which by reference code does refer to the April incident.

2010 Ammonia Leak

On January 6, 2010, the Theodore plant recorded an ammonia “odor” release concentration of 12 ppm. The former plant engineer prepared an “Ammonia Oder Investigation” and found a “weld crack on suction header / ammonia detector worked perfectly” (Exh. C-7). He recorded “0” pounds of ammonia lost. The odor release was blamed on a bad weld which was re-welded within 24 hours.

There is no dispute that the plant’s May 2010 PHA revalidation does not identify the January 2010 incident (Tr. 63). MRS argues that the standard does not require consideration of a “miniscule” amount (12 ppm) of ammonia (Tr. 279, 281).

The Secretary argues the standard presumes that any release of ammonia presents a potential for a catastrophe and thus needs to be identified in the PHA revalidation (Secretary’s Brief, p. 26). The Secretary’s *Interpretation Letter*, dated 06/02/1994, states “OSHA believes that the release of anhydrous ammonia from a workplace process containing a TQ [threshold quantity] or greater amount presents a potential catastrophic situation including potential exposure of employees and therefore is covered by the PSM standard.” Even a “near miss” of an

actual accident should be considered a situation that presents a potential for catastrophic consequences. *Interpretation Letter*, 07/12/2006.

The Secretary's interpretation is contrary to the plain language of the cited standard. As a performance standard, § 1910.119(e)(3)(ii) requires the identification of only incidents that "had a likely potential for catastrophic consequences in the workplace." A "likely potential" implies that the incident was "probably capable of becoming an actual" catastrophic situation. No such showing was made in this case. The definition of "catastrophic release" is "a major uncontrolled emission...involving one or more highly hazardous chemicals, that presents serious danger to employees in the workplace." § 1910.119(b).

The January 2010 incident was not shown to have "had likely potential for a catastrophic consequence." The release of 12 ppm is far below the OSHA's PEL of 50 ppm for anhydrous ammonia. There was "0" pounds of ammonia lost. The crack in the header was re-welded within 24 hours and there is no showing of employee exposure to a hazard. The leak was not identified as potentially uncontrollable. The plant's Emergency Action/Response Plan notes that "Small ammonia leaks are normal in the operation of the refrigeration system and do not require an evacuation" (Exh. C-8, p. M03293).

An other than serious violation of §1910.119(e)(3)(ii) is established only with regard to MRS's failure to include the 2007 ammonia release in its PHA revalidation.

Item 3 - Alleged Violation of § 1910.119(f)(1)(i)(D)

The citation alleges

Phases 1&2: On or about August 23, 2010, the employer did not ensure that the employees were protected from hazards associated with leaking anhydrous ammonia. The employer's emergency shutdown procedures did not instruct the employees to shut down the entire ammonia supply to Phases 1&2 in the event of an anhydrous ammonia leak that could not be independently isolated and did not address what the employees had to do when dealing with leaking, cracked, broken, or ruptured lines carrying anhydrous ammonia.

Section 1910.119(f)(1)(i)(D) requires an employer to include in its written operating procedures for each operating phase:

Emergency shutdown including the conditions under which emergency shutdown is required, and the assignment of shutdown responsibility to qualified operators to ensure that emergency shutdown is executed in a safe and timely manner.

On August 23, 2010, after discovering the ammonia leaks in Freezer #5 and on the roof, the plant engineer and two employees in refrigeration maintenance began closing valves on the roof to isolate the leaks. The emergency stop switch (E-stop button) was not activated (Tr. 64, 388).

MRS's Investigation Report of the August 2010 ammonia release suggests that the emergency switch should have been activated earlier by the plant engineer. The Report states that

When the facility was evacuated because of the ammonia leak the emergency stop button was not activated which would have shut down all equipment and stopped the flow of additional ammonia to the facility. By not activating the emergency stop button the refrigeration system continued to pump ammonia to the damaged area until the system shut itself off approximately one hour later on pressure cutouts (Exh. C-3).

The Secretary argues that the plant's shutdown procedures fail to instruct employees when to shut down the ammonia supply (Tr. 144, 148). IH Bennett describes MRC's written procedures as merely discussing the means for isolating ammonia leaks, and not shutting down the system (Tr. 69). The procedures lack guidance as to what employees are expected to do in the event of an uncontrollable leak (Tr. 230).

The Theodore plant's "Emergency Action/Response Plan" includes a section entitled "Shutdown Procedures" for the control of ammonia releases. It establishes the steps which are to "be performed by properly trained personnel and under the direction of ERC [Emergency Response Coordinator]" (Exh. C-9, P. M03284). The "Shutdown Procedures" instruct personnel to "locate the leak" and attempt to isolate the leak. The section entitled "Controlling an Incident," explains that "control of an ammonia leak will require that the leak be stopped... [this] usually involves simply valving off a pipe or piece of equipment." The Plan also sets out evacuation procedures in case of fire, hurricane, earthquake, and ammonia releases.

The plant's "Emergency Engine Room Shut Down" procedures states that "the emergency shutdown system could be activated after an assessment by the authorized shut down personnel" under "some" listed situations (Exh. C-10). The listed situations include natural disasters (tornado, hurricane), fire or threat of fire, the threat of explosion, the loss of compressor room structural integrity, a "major ammonia leak in Compressor Room exceeding 250 ppm concentration" and other emergencies deemed necessary by authorized personnel. The

authorized shut down personnel include the plant engineer, plant manager, regional engineer and operation engineer who have the authority to trigger the emergency shutdown switch (E-Stop button).

The fact the plant engineer did not activate the emergency stop button on August 23, 2010 does not establish a violation. The plant engineer and regional engineer as authorized shut down personnel made the decision to isolate the leaks (Tr. 388). The leaks were eventually isolated (Tr. 423, 466). The regional engineer testified that it was unnecessary to activate the stop button because a leak of this size would have automatically caused the system to shut itself off (Tr. 663).

MRS emergency shutdown procedures comply with the standard. The plant's "Emergency Action/Response Plan" and "Emergency Engine Room Shut Down" specify situations which may require shutdown when determined necessary by authorized personnel. The situations suitable for emergency shutdown include fire, hurricane, earthquake, and major ammonia releases in the control room. The August 2010 incident was not shown to fit within the listed situations. The Secretary's concern that the emergency room shut down document was not part of MRS's emergency response plan is unfounded. OSHA's performance oriented standard does not require that the situations for activating the emergency stop button be in a specific location (Tr. 147). Emergency situations are by nature unpredictable and emergency shutdown procedures need to provide for a certain amount of evaluation and flexibility.

A violation of § 1910.119(f)(1)(i)(D) is not established.

Item 4 - Alleged Violation of § 1910.119(g)(3)

The citation alleges

Phase 1 and Phase 2: On or about August 23, 2010, and at times prior, the employer did not ensure that the employees were protected from anhydrous ammonia inhalation hazards. The plant engineer in charge of the operation of the facility had not understood the training requirements of this standard.

Section 1910.119(g)(3), under PSM, provides:

Training documentation. The employer shall ascertain that each employee involved in operating a process has received and understood the training required by this paragraph. The employer shall prepare a record which contains the identity of the employee, the date of training, and the means used to verify that the employee understood the training.

According to the Secretary, the plant engineer, who was promoted to the position in May 2010, was unable to answer basic questions regarding the plant's PSM program (Tr. 128). The plant engineer could not describe concepts such as "what the PHA was, if he knew what mechanical integrity was, [and] if he knew what management of change was" (Tr. 133). When asked to explain the concept of Management of Change (MOC), the engineer testified that it was "when he got promoted from assistant engineer to plant engineer" (Tr. 232). He also did not know the PSM coverage threshold and was unclear about the hazards of ammonia (Tr. 405, 407). He claimed that he was confused. "I didn't know everything and that's why I was supported by regional help" (Tr. 408).

MRS argues the plant engineer was still receiving PSM training in August 2010. After the plant engineer's unexpected promotion in May 2010, the regional engineer was temporarily made responsible for Theodore plant's PSM program (Tr. 616-617). Although he had job responsibility for nine other plants from North Carolina to Texas, the regional engineer made regular trips to the Theodore plant to monitor the PSM program. He was also available to the plant engineer by telephone (Tr. 611, 618, 718). MRS claims the plant engineer's inability to recite technical terms verbatim does not demonstrate his lack of PSM knowledge. The plant engineer believed that he possessed a thorough working knowledge of the PSM manual because "I feel like I was being supported enough with Regional" (Tr. 451).

The standard applies to personnel "involved" with operating PSM processes. It is not restricted to personnel who have "overall control" such as the regional engineer. Even a plant engineer in training who has responsibility for MRS processes should know basic PSM principles. Prior to his promotion, the plant engineer had been employed at the Theodore plant for four years as the assistant plant engineer (Tr. 354). As plant engineer, he supervised the day to day refrigeration maintenance operations including overseeing 14 maintenance workers and mechanics (Exh. C-31). The regional engineer was not expected to supervise the plant's daily activities (Tr. 505-506).

The plant engineer's PSM training records show that in January 2008, he received for engineers the "Training requirements for ammonia system operators (1910.119(g))." The training was given by the former plant engineer and covered the elements of the plant's PSM program (Exh. R-10; Tr. 692). He was also retrained on the same subjects in February 2010. On January 24, 2009, the plant engineer received an "Operating Procedures Training Certification

Form 119(g)(2-3)” indicating that he had “demonstrated through application the necessary understanding of operating procedures of Milliard Refrigerated Services ammonia refrigeration system.” In May 2010, he was a member of the PHA revalidation team. He had also been involved with the PSM investigation into plant’s 2007 ammonia release (Tr. 714). The regional engineer considered the plant engineer to have a “very good working knowledge” of PSM that was “pretty thorough” (Tr. 700). The corporate project manager described his training as “fairly extensive training under PSM as an operator of a facility and operating the compressors and the components of the refrigeration system safely” (Tr. 600-601).

Despite receiving PSM training, the plant engineer was unable to express or show any understanding of PSM’s basic principles. He was unable to describe his training or demonstrate an understanding of the topics on which he allegedly was trained. His lack of understanding was shown in the OSHA interviews, MRS’s internal report, and his testimony at hearing. It is not unreasonable to assume that he needed additional training when he was promoted. However, that is not the issue. The issue is the lack of understanding of the training already received.

Although certified by the former plant engineer as “qualified to perform Mechanical Integrity inspections on ammonia refrigeration system(s),” the plant engineer could not recall his training or describe the concept (Exh. C-29; Tr. 403). He needed to review documents to explain mechanical integrity (Tr. 402). He also requested to review documents to explain the defrost cycle (Tr. 404). MRS Investigation Report into the August 2010 ammonia release questions his actions and lists his errors as a direct factor for the incident.

MRS’s training records fail to show the means used to verify that the plant engineer understood his training. The standard specifies that PSM training include documentation explaining how the employer determined the trainee understood the training. No such documentation was provided. There was no showing that the plant engineer was tested, quizzed or demonstrated his level of understanding. MRS’s training documentation lacks this information. Instead, the training documentation for the plant engineer under § 1910.119(g) merely includes the subject and date of the training (Exh. C-28).

A serious violation of § 1910.119(g)(3) is established. Employee exposure is shown by the MRS Incident Investigation Report which blames, in part, plant engineer’s errors in handling the August 2010 ammonia release. MRS’s knowledge is imputed by the regional engineer and the former plant engineer who were involved in his training.

Item 5 - Alleged Violation of § 1910.119(m)(4)(iv)

The citation alleges that

Throughout facility: On or about August 23, 2010, and at times prior the employer exposed employees to the hazard of exposure to ammonia gas in that they had not investigated an incident of a cracked suction header at Blast 1, zone 3, CS-6 that occurred on January 6, 2010 to determine causal factors.

Section 1910.119(m)(4)(iv) provides that an incident report shall be prepared at the conclusion of the investigation which includes at a minimum:

The factors that contributed to the incident:

MRS's incident report of the January 6, 2010 leak, termed an "Odor" Investigation, was prepared by the former plant engineer (Exh. C-7). The report describes that a mechanic reported an ammonia release of 12 ppm in Zone 3. The report states that a "weld cracked on suction header / ammonia detector worked perfectly." The abatement recommended was to "reweld crack in pipe," a task that was completed by the next day. The former engineer concluded that "0" pounds of ammonia were lost.

The Secretary argues that MRS's incident report fails to identify the underlying cause of the cracked weld. MRS's claim of a "bad weld" was inadequate (Tr. 480-481). The corporate project manager, a certified welder, testified that "it looks to me like a defect as weld that had developed a leak over expansion and contraction of several defrosts" (Tr. 566). He agreed that a bad weld and a weld that worked open by expansion of the pipe are different scenarios (Tr. 585-586). The regional engineer testified that there are many reasons a weld could crack including corrosion, over-pressurization of the pipe, or problems with the original weld (Tr. 345, 722). Instead of conducting an investigation, the Secretary maintains that MRS simply re-welded the suction header (Tr. 207).

The standard defines an "incident" that is required to be investigated as one "which resulted in, or could reasonably have resulted in a catastrophic release of highly hazardous chemical in the workplace." § 1910.119(m)(1). The ammonia "Odor" incident on January 6, 2010 was not shown to "could reasonably have resulted in a catastrophic release." Although questioned by the Secretary without support, MRS report reflects that "0" pounds of ammonia were lost and the air concentration of ammonia of 12 ppm is well below OSHA's PEL for ammonia of 50 ppm. MRS considered it a "minor leak" of ammonia (Tr. 563). Nothing in the incident report or the evidence presented by the Secretary suggests that a hydraulic hammer or

other factor occurred which could have potentially changed the “minor leak” into a catastrophic release of ammonia (Tr. 280). There was no evidence of employee exposure or that the 12 ppm release of ammonia was uncontrollable. The pipe was re-welded within 24 hours. There was connection or similarity shown between the August 2010 ammonia release and January 2010 “Odor” incident (Tr. 559). Also, even if recordable, the standard does not require identification of the underlying cause. It requires the identification of the contributing factor which in this case was the “cracked weld.”

A violation of § 1910.119(m)(4)(iv) is not established.

Item 6 - Alleged Violation of § 1910.120(q)(3)(iv)

The citation alleges:

Roof of building: On or about August 23, 2010 the employer allowed employees to be exposed to ammonia gas in unknown concentrations in that the employees wore no respirator or a cartridge type air purifying respirator when entering onto the roof to close valves to isolate the ammonia leak.

Section 1910.120(q)(3)(iv) provides:

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

The standard applies to “emergency response operations for release of, or substantial threat of releases of hazardous substances without regard to the location of the hazard.” § 1910.120(a)(1)(v). An “emergency response” is defined, in part, as “a response effort by employees from outside the immediate release area...to an occurrence which results, or is likely to result, in an uncontrolled release of a hazardous substance” § 1910.120(a)(3). If an emergency response, an employer must comply with the requirements of § 1910.120(q).

Anhydrous ammonia is a “hazardous substance” as listed by the Dept. of Transportation’s Hazardous Materials Table. *See* § 1910.120(a)(3) (citing 49 CFR § 172.101). MRS acknowledges the August 23, 2010 ammonia release was an emergency situation and the employees responding were engaged in emergency response (Tr. 739).

There is no dispute that the MRS employees who responded to the ammonia leaks on the roof did not have or wear positive pressure self-contained breathing apparatus (SCBA)

respirators. Instead, two of the employees carried cartridge respirators. A full face respirator with ammonia cartridge is “a filtering or absorption face piece that would absorb ammonia vapors from the air.” Cartridge respirators are typically rated to protect at two to three times the PEL for anhydrous ammonia (Tr. 72). A SCBA respirator maintains its own supply of clean air.

MRS performed no air monitoring on the roof (Tr. 79). However, the Secretary maintains that the inhalation effect (unconsciousness) on the crane operator approximately 200 feet from the roof demonstrates that the ammonia concentration exceeded the IDLH (Immediately dangerous to life and health) of 300 ppm (Tr. 76). At the cracked pipe suction header, it was “pure” ammonia being released (Tr. 454). The air monitoring performed in Freezer #5 recorded readings between 3,880 and 7,275 ppm of ammonia. The next day, the air monitoring showed 1,600 ppm. The levels had only dropped to 750 ppm, three days after the incident (Exh. C-32).

MRS argues that the employees were not exposed to a hazard. When the employees went to Freezer #5, there was no emergency and the employees were merely investigating a complaint of an ammonia smell. When the employees accessed the roof, they did not know the pipe suction header had cracked. The employees were approximately 200 feet from the leak. MRS maintains that there was no evidence that the atmosphere on the roof was IDLH. The employees were in the open air and could leave the roof at any time. Respirators were not necessary because the employees simply needed to watch the ammonia cloud and “maneuver around and stay away from it” (Tr. 676).

MRS’s arguments are rejected. The standard does not require actual exposure. “The standard depends not on the actual existence of such a hazard but rather on a determination ... that there is at least a potential for such a hazard.” *Wiley Organics Inc.*, 17 BNA OSHC 1586, 1597 (No. 91-3275, 1996). The standard includes potential inhalation hazards and requires SCBA respirators unless an employer’s air monitoring shows a decreased level of hazardous exposure. MRS performed no such air monitoring.

The issue is not employee exposure to the ammonia cloud but when the employees became engaged in emergency response. The stevedore supervisor notified the plant engineer of the ammonia smell outside the plant; 200 feet away. The plant engineer confirmed an ammonia leak inside the freezer. With information of leaks inside the freezer and outside the plant, the plant engineer and maintenance worker should have known of the emergency and should have

obtained SCBA respirators before initiating repair work. The mechanic who separately accessed the roof knew to retrieve a respirator (Exh. C-27). The plant initiated evacuation procedures and thus was clearly in emergency response.

Even if unaware of the ammonia leak on the roof, the plant engineer certainly saw the leak from the pipe suction header and the ammonia cloud once on the roof (Tr. 380-381). Instead of retrieving SCBA respirators, the plant engineer made a phone call to the regional engineer and instructed the maintenance worker to valve off the leak. He did not instruct the worker to wear even the cartridge respirator. At no time were SCBA respirators worn by the employees attempting to locate and isolate the leaks. The record indicates that the maintenance worker was within 15 feet of the cracked pipe suction header.

The violation of § 1910.120(q)(3)(iv) is established as serious. The standard requires SCBA type respirators for employees engaged in emergency response and exposed to hazardous substances such as ammonia leaks presenting a potential inhalation hazard. The employer must assume the concentration is hazardous unless air monitoring shows otherwise (Tr. 164). The standard does not allow for other than SCBA respirators without air monitoring. The maintenance worker who was closing valves, was working within 15 feet of the leak. According to OSHA, the leak was expelling “pure ammonia” and in that close of proximity, the concentration could have exceeded the IDLH (Tr. 76). The standard is not meant to rely on an employee’s skill, attentiveness, and luck with variable winds to avoid potential hazards. As plant engineer, his knowledge of the lack of SCBA respirators is imputed to MRS.

Items 7a and 7b - Alleged Violations of § 1910.120(q)(3)(v) and § 1910.134(g)(3)(i)

The citation alleges:

Roof of building: On or about August 23, 2010 the employer allowed employees to be exposed to ammonia gas in unknown concentrations

(1) in that an employee working alone was allowed to enter onto the roof to close valves to isolate the ammonia leak” [Item 7a, § 1910.120(q)(3)(v)]; and

(2) in that the employees entered onto the roof to close valves to isolate the ammonia leak and there were no backup personnel present at the facility if rescue were needed [Item 7b, § 1910.134(g)(3)(i)].

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

The individual in charge of the ICS shall limit the number of emergency site, in those areas of potential or actual exposure to incident or site hazards, to those who

are actively performing emergency operations. However, operations in hazardous areas shall be performed using the buddy system in groups of two or more.

Section 1910.134(g)(3)(i) provides that for all IDLH atmospheres, the employer shall ensure that:

One employee or, when needed, more than one employee is located outside the IDLH atmosphere;

MRS's Emergency Action/Response Plan under the section "Shutdown Procedures" specifies that employees work in a buddy system to control ammonia leaks (Exh. C-9). The Plan states that in the event a leak cannot be controlled "use 2 qualified people and 2 backups involving the HAZMAT team." A buddy system is "a system of organizing employees into work groups in such a manner that each employee of the work group is designated to be observed by at least one other employee in the work group." § 1910.120(a)(3).

Similarly, § 1910.134(g)(3)(i), requires that when an employee enters an IDLH atmosphere at least one other employee should be located outside the IDLH atmosphere to provide emergency rescue (Tr. 85). An IDLH atmosphere is defined as "an atmospheric concentration of any toxic, corrosive or an asphyxiate substance that poses an immediate threat to life or would cause irreversible or related adverse health effects or would interfere with an individual's ability to escape from dangerous atmosphere." § 1910.120(a)(3). According to the Secretary, the IDLH for anhydrous ammonia is 300 ppm (Tr. 155).

As discussed, the record shows that the plant engineer and a maintenance worker reached the plant's roof together, and a mechanic with a cartridge respirator joined them. While the two employees remained on the plant's roof to isolate the ammonia leaks, the plant engineer returned inside the plant (Tr. 387). The mechanic gave his respirator to the maintenance worker who was isolating the leaks. The plant engineer did not give any instructions to the employees because "they knew" what to do (Tr. 446).

The record fails to establish a violation of either standard, § 1910.120(q)(3)(v) or § 1910.134(g)(3)(i). The buddy system requires that the backup employee maintain "visual, voice, or signal line communication" with the employee working in the dangerous atmosphere. At all times, there were at least two employees on the roof. While the maintenance worker was closing off the leaks, there is no showing the mechanic failed to remain outside the hazard zone in visual contact (Tr. 165). Also, both employees may have been in voice contact by cell phone with the

plant engineer. Without evidence of a failure to maintain contact, there is no violation. The mechanic's work on the roof was not shown to be near the ammonia leak. He was approximately 200 feet from the leak upon accessing the roof (Tr. 682). The Secretary failed to establish the entire roof area constituted a "hazardous area" or an "IDLH atmosphere." No air monitoring was performed on the roof to ascertain the ammonia concentration where the employees were located (Tr. 154). There is no showing how long the maintenance worker was within 15 feet of the ammonia leak or that he was in physical contact with the leaking ammonia. The employees were not shown to have become dizzy, unconscious or exhibit other signs of ammonia exposure.

Items 8a and 8b - Alleged Violations of § 1910.120(q)(6)(iii) and § 1910.134(k)(3)

The citation alleges:

Roof of building: On or about August 23, 2010 the employer allowed employees to be exposed to ammonia gas in unknown concentrations when entering onto the roof to close valves to isolate the ammonia leak in that the employees had not been trained on the implementation of the employers emergency response plan, the classification, how to function within an assigned role in the incident command system, how to select and use proper specialized chemical personal protective equipment provided, understand hazard and risk assessment techniques, how to perform advance control, containment, and / or confinement operations within the capabilities of the resources and personal protective equipment available with the unit, understand and implement decontamination procedures, and understand termination procedures [Item 8a].

The standard allegedly violated, § 1910.120(q)(6)(iii) provides:

Hazardous materials technician. Hazardous materials technicians are individuals who respond to releases or potential releases for the purpose of stopping the release. They assume a more aggressive role than a first responder at the operations level in that they will approach the point of release in order to plug, patch or otherwise stop the release of a hazardous substance. Hazardous materials technicians shall have received at least 24 hours of training equal to the first responder operations level and in addition have competency in the following areas and the employer shall so certify:

The citation also alleges:

Roof of building: On or about August 23, 2010 the employer allowed employees to be exposed to ammonia gas in unknown concentrations in that the employees entered onto the roof to close valves to isolate the ammonia leak and these employees had not received training in the use of respirators [Item 8b].

The standard allegedly violated, § 1910.134(k)(3) provides:

The employer shall provide the training prior to requiring the employee to use a respirator in the workplace.

According to the Secretary, the two employees (maintenance worker and mechanic) in refrigeration maintenance on the roof engaged in isolating the ammonia leaks had not received training in emergency response. The maintenance worker told the OSHA inspector that they had not been trained in responding to uncontrolled releases of ammonia (Tr. 88-89). Also, the maintenance worker said that he had not received respirator training (Tr. 92).

MRS argues that there was no showing the two employees in refrigeration maintenance were exposed to a hazard and the maintenance worker had previously received HAZMAT training. He was a 20 year veteran in the refrigeration industry.

MRS's arguments are rejected. Both employees in refrigeration maintenance performed as "hazardous materials technicians" during the August 2010 ammonia release. See § 1910.120(a)(3) Definition "*Hazardous materials response (HAZMAT) team.*" As the employer, MRS was responsible for providing the required training to emergency responders regardless of whether they were exposed to a hazard in a particular incident. The Secretary requested the proper training documents for the employees' engaged in the emergency response and only received the hazardous materials 24-hour training record for the plant engineer (Exh. C-13). No such training records were provided for other two employees in refrigeration maintenance; the two employees who actually performed the work to isolate the leaks. While the maintenance worker may have received HAZMAT training in the past, his recertification was expired before the August 2010 ammonia release (Tr. 683). Also, such other training does not negate MRS's responsibility to ensure the employees as responders received the proper hazardous materials training. The actions of the two employees including working without proper or no respirators, provide further evidence of the need for training in responding to hazardous materials.

Under § 1910.134(k)(3), the maintenance worker also had not received respirator training prior to engaging in isolating the ammonia leaks on August 23, 2010 (Exh. C-26). The valves were within 15 feet of the cracked suction header. The only respirator training records provided by MRS show initial and annual respirator training certificates and true/false tests for the plant engineer and mechanic (Exhs. C-14 through C-17). There is no respirator training record for the maintenance worker. If properly trained, the maintenance worker may have known to use a

SCBA respirator or even wear the cartridge respirator given to him by the mechanic. MRS failed its responsibility to ensure that its employees received proper respirator training.

The violations of § 1910.120(q)(6)(iii) and § 1910.134(k)(3) are established as serious. MRS should have known, based on its own records, of the lack of hazardous materials training for the two employees in refrigeration maintenance and the lack of respirator training for the maintenance worker. The lack of hazardous material training and respirator training could have resulted in an employee's serious injury or possibly death.

CITATION No. 2 – Alleged Other-Than-Serious Violations

Items 1 and 2 - Alleged Violations of § 1904.7(b)(1)

The citation alleges:

2008 OSHA 300 Log: On or about August 23, 2010 the classification of the case (Columns G-J) was not completed for entries 1 through 13 [Item 1]; and 2009 OSHA 300 Log: On or about August 23, 2010 the classification of the case (Columns G-J) was not completed for entry 4 [Item 2].

Section 1904.7(b)(1) provides:

A work-related injury or illness must be recorded if it results in one or more of the following: (death, days away from work, restricted work or transfer to another job, medical treatment, loss of consciousness, and a significant injury or illness diagnosed by a physician).

OSHA requested the Theodore plant's previous three years of OSHA 300 Logs. A review of the 300 Log for calendar year 2008 shows that there were thirteen (13) recordable employee injury/illness entries. For each of the employee entries, Columns G, H, I, J (injury/illness classification) were blank (Exh. C-18). For the calendar year 2009 OSHA 300 Log, Columns G, H, I or J was blank only for employee entry 4 (Exh. C-19; Tr. 97). MRS does not dispute these columns were blank. The columns left blank identifies whether the recordable injury/illness involved a death, days away from work, job transfer or restriction, or other recordable cases.

MRS's human resource manager testified that in 2010, MRS contracted a company to enter the accident data on an online form. He testified that when OSHA requested the 300 Logs, he could not access the "real" online logs because he lacked a password and could not get in touch with the contractor to retrieve the logs (Tr. 754, 757).

An employer is required to provide the OSHA 300 Logs within four working hours of OSHA's request. § 1904.40(a). No additional logs were sent to OSHA nor presented at hearing (Tr. 767). The OSHA inspector was not aware of an electronically maintained log during the inspection. Regardless, MRS is responsible for maintaining completed 300 Logs. MRS has not shown that the omissions from its 2008 and 2009 OSHA 300 Logs were indeed corrected prior to issuance of the citation.

The violations of § 1904.7(b)(1) in items 1 and 2 are established.

Items 4 and 5 - Alleged Violations of § 1904.29(b)(1)

The citation alleges:

2008 OSHA 300 Log: On or about August 23, 2010 the injury sustained by the employee was not described in Column for Entries 1, 2, 4, 5, 6, 7, 9, 10, 13, and 14 [Item 4] and 2009 OSHA 300 Log: On or about August 23, 2010 the employer did not describe the type of injury for entries 1 and 4 [Item 5].

Section 1904.29(b)(1) provides:

You must enter information about your business at the top of the OSHA 300 Log, enter a one or two line description for each recordable injury or illness, and summarize this information on the OSHA 300-A at the end of the year.

Column F on the OSHA 300 Log requires the employer to "describe injury or illness, parts of body affected and object/substance that directly injured or made person ill (e.g. Second degree burns on right forearm from acetylene torch" (Exh C-18). The Secretary claims that MRS' 2008 and 2009 OSHA 300 Logs fail to describe the nature of the employee's injury.

A review of the Theodore plant's 300 Logs establish the violations. The plant's 2008 OSHA 300 Log shows inadequate injury descriptions under Column F for several employee entries (1, 2,4,5,6,7,9,10,13, and 14) (Exh. C-18; Tr. 100). For example, employee entry 1 fails to describe the injury actually sustained by the employee. It merely states that the employee's "left knee/pant leg got caught under wheels of forklift" and employee missed two days of work. It fails to describe the nature of the injury (contusion, strain, or laceration) to the left knee. For entry 2 which states the "employee's body was compressed into a conveyor," an MRS official testified that "he [employee] had a pulled muscle in his chest" (Tr. 767-768). This information was not on the Log. Similarly, for entry 4, the official testified that the employee suffered "contusions," which is not shown on the Log. The entry merely states employee "hit by forks of

lift being transported by a forklift.” The other employee entries identified in the citation also fail to describe the employee’s injury.

Similarly, employee entries 1 and 4 on the plant’s 2009 OSHA 300 Log fail to adequately identify the injury/illness in Column F (Exh. C-19). Entry 1 states that the employee had his “right arm caught in the mast of the forklift. It fails to explain “if it was bruised or if it was lacerated, was it amputated” (Tr. 102). According to the entry, the employee missed 354 work days indicating the injury was significant. Entry 4 states the employee was struck in the eye by a freezer door, but does not contain any information about the nature of the injury to the employee.

The violations of § 1904.29(b)(1) in items 4 and 5 are established.

Item 6 - Alleged Violation of § 1904.29(b)(3)

The citation alleges:

- a) Millard Refrigerated Services Facility: On or about August 23, 2010 the employer failed to record the injury of an employee who was exposed to ammonia gas and lost consciousness while operating a loading crane.
- b) Millard Refrigerated Services Facility: On or about August 23, 2010 the employer failed to record the injury of an employee who overhead during the emergency response and was treated and transported to the hospital for evaluation.

Section 1904.29(b)(3) provides:

You must enter each recordable injury or illness on the OSHA 300 Log and 301 Incident Report within seven (7) calendar days of receiving information that a recordable injury or illnesses has occurred.

A work injury/illness is recordable if there is an employee’s death, days away from work, restricted work or transfer to another job, medical treatment, loss of consciousness, and a significant injury or illness diagnosed by a physician § 1904.7(b)(1)(i-vi). The Secretary claims MRS failed to record on the plant’s 2010 OSHA 300 Log the “injuries” sustained by the plant engineer and the crane operator within the seven days of August 23, 2010 ammonia leaks (Exh. C-20; Tr. 103).

MRS does not dispute the two instances were not recorded on its 2010 OSHA 300 Log. The record shows that the plant engineer became overheated and briefly passed out wearing a HAZMAT suit while waiting to assist the Fire Department. He was driven to the hospital, treated, and released (Tr. 103). He did not miss any work.

The crane operator who initially smelled ammonia and fell while leaving the crane, was driven to the doctor's office and returned to work. The Plant's safety director, who drove him, testified he was not told that the operator may have lost consciousness while climbing down the ladder (Tr. 763-764). MRS's Investigation Report into the incident described the accident as a "fall from elevation," the injury as "leg lower, lungs," and medical treatment as "Doctor/Clinic" (Exhs. C-12).

A review of the record establishes both injuries as recordable. The plant engineer described his injury as "overheated" from wearing the HAZMAT suit. He was given IV at the hospital and thus received medical treatment. The crane operator told the OSHA inspector that he was sure he had passed out (Tr. 115). The operator's statement recorded in MRS's Investigation Report dated August 25, 2010 states that he "must have been unconscious for a moment" (Exh. C-12). It also states he "must have blacked out" and discusses what occurred when "he woke." The representation that neither employee missed work did not relieve MRS from recording an instance of "medical treatment" and "unconsciousness." The safety director admitted that "if I had known about the unconscious statement, then most likely it would have been recorded right then" (Tr. 765).

The violation of § 1904.29(b)(3) is established.

Item 7 - Alleged Violation of § 1904.32(b)(3)

The citation alleges:

2007 OSHA 300A: On or about August 23, 2010 the OSHA 300A Summary of Work Related Injuries and Illnesses was not signed.

Section 1904.32(b)(3) provides:

A company executive must certify that he or she has examined the OSHA 300 Log and that he or she reasonably believes, based on his or her knowledge of the process by which the information was recorded, that the annual summary is correct and complete.

There is no dispute that MRS' 300A "Summary of Work-Related Injury and Illness" Log for calendar year 2007 was not certified (signed) by a company executive (Exh. C-21). An executive's signature is important because it ensures the company's awareness and provides verification of the information. The 300A Log recorded 50 employee injuries in 2007.

The violation of § 1904.32(b)(3) is established.

Item 8 - Alleged Violation of § 1910.147(c)(6)(i)

The citation alleges:

Millard Facility: On or about August 23, 2010 and at times prior, the employer exposed employees to unexpected start-up of compressors in that the periodic inspections had not been completed for energy control procedures.

Section 1910.147(c)(6)(i) provides:

The employer shall conduct a periodic inspection of the energy control procedure at least annually to ensure that the procedure and the requirements of this standard are being followed.

The Theodore plant's written "Control of Hazardous Energy Lockout/Tag out Procedures" (LOTO) was revised in August 2005. The LOTO procedures at the plant are necessary because primarily of the compressors (Tr. 108). The plant's LOTO procedures provide for annual inspections of the procedures "by authorized employee not utilizing the procedure." The annual inspections are required to be recorded "in the lockout/tagout section of the safety manual" (Exh. C-22, p. 7). The purpose for annual inspections is to ensure that employees are properly locking out the compressors or other covered equipment (Tr. 109).

The OSHA inspector reviewed the plant's LOTO procedures and spoke to maintenance employees about the equipment, specifically the compressors that needed to be locked out. He requested the plant's record of annual inspections, but no documents were provided (Tr. 109). He was told that the plant had not performed an inspection within a year (Tr. 185). MRS has not provided any record of annual inspections of its LOTO procedures.

The violation of § 1910.147(c)(6)(i) is established.

Penalty Consideration

The Act requires that in determining an appropriate penalty, consideration must be given to the size of the employer's business, the history of any previous violations, the employer's good faith, and the gravity of the violation at issue. The most important consideration is the gravity of the violation.

MRS employs approximately 132 employees at the Theodore plant and 2,000 employees corporate-wide. It is not given credit for size. MRS is also not entitled to credit for history because the company has received prior serious citations (Tr. 82). MRS is given credit for good faith based on maintaining written safety procedures at the Theodore plant, and its cooperation throughout the OSHA inspection under difficult conditions.

A penalty of \$1,500.00 is reasonable for violation of § 1910.23(a)(2) (Citation No. 1, item 1). The ladderway is used no more than once a month by maintenance employees. The ladders were caged and the platforms, 15 feet above the roof, were surrounded by guardrails except at the points of entry.

A penalty of \$4,000.00 is reasonable for violation of § 1910.119(g)(3) (Citation No. 1, item 4). Understanding PSM is an important element in an employer's PSM training program. Although having been an assistant plant engineer for four years and receiving PSM training for two years, the plant engineer showed a lack of understanding even of basic PSM concepts. His training lacked a means of verifying of the employees' understanding.

A penalty of \$3,000.00 is reasonable for violation of § 1910.120(q)(3)(iv) (Citation No. 1, item 6). The two employees engaged in emergency response by attempting to contain the two ammonia leaks were not utilizing SCBA respirators or wearing even the cartridge respirator.

A grouped penalty of \$3,000.00 is reasonable for violations of § 1910.120(q)(6)(iii) and § 1910.134(k)(3) (Citation No. 1, items 8a and 8b). The two employees were not shown trained in hazardous materials, and one employee had not received respirator training. The two employees worked to isolate the ammonia leaks on the roof.

A grouped penalty of \$1,500.00 is reasonable for each violation § 1904.7(b)(1) and § 1904.7(b)(1) (Citation No. 2, items 1 and 2). The recordkeeping violations are of the same standard, and a grouped penalty is deemed appropriate. Although 2008 OSHA 300 Log lacked any information in Columns G, H, I, and J for all thirteen employee entries, the 2009 OSHA 300 Log was only lacking the required information for one employee entry.

A grouped penalty of \$1,500.00 is reasonable for violations of § 1904.29(b)(1) and § 1904.29(b)(1) (Citation No. 2, items 4 and 5). The recordkeeping violations are of the same standard, and a grouped penalty is deemed appropriate. As identified by OSHA, MRS failed to adequately describe the nature of the employees' injuries in Column (F) on its 2008 and 2009 OSHA 300 Logs.

A penalty of \$750.00 is reasonable for violation of § 1904.29(b)(3) (Citation No. 2, item 6). There were two instances of MRS's failure to record injuries to the plant engineer, and the crane operator on its 2010 OSHA 300 Log within seven days.

No penalty is assessed for violation of § 1904.32(b)(3) (Citation No. 2, item 7). The failure involved the lack of an executive's signature on the 2007 OSHA 300 Log. The other logs were correctly certified. This was obviously an oversight and three years old.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

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

ORDER

Based upon the foregoing decision, it is ORDERED:

Serious Citation 1

1. Violation of § 1910.23(a)(2) (item 1) is affirmed and a penalty of \$1,500.00 is assessed.
2. Violation of § 1910.119(e)(3)(ii) (item 2), is affirmed in part as other than serious and no penalty is assessed.
3. Violation of § 1910.119(f)(1)(i)(D) (item 3), is vacated and no penalty is assessed.
4. Violation of § 1910.119(g)(3) (item 4), is affirmed and a penalty of \$4,000.00 is assessed.
5. Violation of § 1910.119(m)(4)(iv) (item 5), is vacated and no penalty is assessed.
6. Violation of § 1910.120(q)(3)(iv) (item 6), is affirmed and a penalty of \$3,000.00 is assessed.
7. Violations of § 1910.120(q)(3)(v) (item 7a) and § 1910.134(g)(3)(i) (item 7b) are vacated and no penalty is assessed.
8. Violations of § 1910.120(q)(6)(iii) (item 8a) and § 1910.134(k)(3) (item 8b) are affirmed and a grouped penalty of \$3,000.00 is assessed.

Other than Serious Citation 2

1. Violations of § 1904.7(b)(1) (item 1) and § 1904.7(b)(1) (item 2), are affirmed and a grouped penalty of \$1,500.00 is assessed.
2. Violation of § 1904.7(b)(1) (item 3), is withdrawn by the Secretary.
3. Violations of § 1904.29(b)(1) (item 4) and § 1904.29(b)(1) (item 5), are affirmed and a grouped penalty of \$1,500.00 is assessed.

4. Violation of § 1904.29(b)(3) (item 6), is affirmed and a penalty of \$750 is assessed.
5. Violation of § 1904.32(b)(3) (item 7), is affirmed and no penalty is assessed.
6. Violation of § 1910.147(c)(6)(i) (item 8), is affirmed and no penalty is assessed.

Date: March 7, 2012

/s/ Ken S. Welsch
KEN S. WELSCH
Administrative Law Judge