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OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
1120 20th Street, N.W., Ninth Floor
Washington, DC 20036-3457

SECRETARY OF LABOR,

Complainant,

v.

MAHLE ENGINE COMPONENTS USA, INC.,

Respondent,

and

I.A.M. & A.W. DISTRICT LODGE 54 &
LOCAL LODGE 1471,

Authorized Employee Representative

OSHRC Docket No. 13-0490

APPEARANCES:

Paul Spanos, Esquire,
U. S. Department of Labor,
Office of the Solicitor, Cleveland, Ohio
For the Secretary

Douglas J. Suter, Esquire,
Hahn Loeser & Parks, Columbus, Ohio
For the Respondent

Don Riffe, Jr., Business Representative,
District Lodge 54 & Local Lodge 1471, New Mitton, West Virginia
For Employees

BEFORE: Keith E. Bell
Administrative Law Judge

DECISION AND ORDER

This proceeding is before the Occupational Health and Safety Review Commission (“the Commission”) pursuant to section 10(c) of the Occupational Safety and Health Act of 1970, 29 U.S.C. § 659(c) (“the Act”). On October 12, 2012, the Occupational Safety and Health

Administration (“OSHA”) began an inspection of MAHLE Engine Components USA, Inc.’s (MAHLE’s or Respondent’s) McCannelsville, Ohio facility. On March 4, 2013, OSHA issued a three-item citation for violations of the lead standard at 29 C.F.R. § 1910.1025, *et seq.*, with a total proposed penalty of \$84,000.00.

MAHLE filed a timely notice of contest bringing this matter before the Commission. A two-day hearing was held in Cleveland, Ohio on May 20-21, 2014. Both parties have submitted post-hearing and reply briefs.

The Secretary alleges that MAHLE violated the housekeeping, hygiene and medical surveillance provisions of the lead standard.¹ Two of the items were characterized as repeat violations and one was characterized as a serious violation.

For the following reasons, I find the Secretary did not prove the alleged violations by a preponderance of evidence and, therefore, vacate all three citation items.

I. Jurisdiction

MAHLE is an employer engaged in interstate commerce and an employer under the Act. *See* Answer at 1. Respondent stipulated that OSHA has jurisdiction over the workplace that was the subject of the inspection. *See* Respondent’s Pre-Hearing Statement, p. 6. Based upon the record, I find that at all relevant times MAHLE was engaged in a business affecting commerce and was an employer within the meaning of sections 3(3) and 3(5) of the Act. I find that the Commission has jurisdiction over the parties and subject matter in this case.

II. Findings of Fact²

A. MAHLE’s McCannelsville, Ohio Facility

MAHLE produced coils of coated steel used to make components for the automotive industry. (Tr. 262). Approximately 110 employees worked at the McCannelsville, Ohio facility, which MAHLE purchased in 2006. (Tr. 108, 277). The facility consisted of a north building and a south building. (Tr. 278). The south building housed MAHLE’s finishing department.

¹ The alleged violation of the housekeeping provision of the lead standard was cited as a serious violation; the alleged violation of the hygiene provision of the lead standard was characterized as a repeat violation, and the alleged violation of the medical surveillance provision of the lead standard was characterized as a repeat violation. The repeat violations were related to an August 31, 2009 citation which the parties settled on May 25, 2010. (CX-5, CX-6).

² Record exhibits are referenced as RX for Respondent, CX for Secretary, and JX for joint exhibits.

(Tr. 278). In the finishing department, employees modified lead-coated steel coils on finish mills or cut it for special applications.³ (Tr. 230, 266).

The north building housed the casting department and had two casting lines. (Tr. 278; RX-9, p. 3). MAHLE generally operated the casting lines for three shifts per day. (Tr. 64, 323). To produce a coil of lead-coated steel, a steel strip was cleaned, preheated to 2,000°F, and then cast with the molten bronze alloy. (RX-9, p. 3; Tr. 262). The bronze alloy consisted of 20% lead. (RX-9, p. 3). Next, the strip moved to the quench chute where it was cooled with quench oil and then machined to a specified thickness to produce the coated steel. (RX-9). The coated steel was either sent out to other plants to create products, such as bearings and bushings, or sent to MAHLE's finishing department. (Tr. 262).

Lead fumes were released at certain stages in the casting process. (RX-9, p. 3). Through air monitoring, MAHLE determined that lead exposure was at or above the action level⁴ in one area of the casting department. (Tr. 262). This area – the lead zone – was outlined with floor tape. (Tr. 263; RX-9, p. 4).

There were four work positions in the casting department: a welder at the front of the casting line, a person working on the “pots,” a person working at the chute area, and another at the end of the line removing the coils and running the front loader. (Tr. 265-66). Two of these work positions were in the lead zone: one near the beginning of the casting line by the pots of molten alloy and one next to the quench oven. (Tr. 224, 263, 266). Employees wore portable air purifying respirators (PAPRs) while working in the two lead-zone work positions. (Tr. 266). The other two work positions in the casting department were not in the lead zone, so PAPR was not used.⁵ (Tr. 266).

Each casting department employee was cross-trained in both lead-zone work positions and non-lead-zone work positions. (Tr. 224, 261). The employees regularly rotated between a lead zone position and a non-lead zone position to minimize lead exposure.⁶ (Tr. 261).

³ Air monitoring in the finishing department showed there was no employee exposure to lead over the action level. (Tr. 267).

⁴ The action level (AL) is 30 µg/m³ averaged over an 8-hour period. 29 C.F.R. § 1910.1025(b).

⁵ On rare occasions there was a “dump” in the casting department and all employees wore PAPR at that time. (Tr. 266).

⁶ [Redacted], a finishing department employee, testified that he had previously been assigned to the casting department and was trained for three positions there. Every two weeks he rotated between a position that was inside the lead zone and outside of the lead zone. (Tr. 224). As a finishing department employee he occasionally filled-in for a casting department employee when there was an unforeseen employee shortage. (Tr. 225).

Occasionally, an employee assigned to the finishing department filled-in for a casting department employee. (Tr. 225, 229, 273-74). When a finishing department employee filled in for a casting department employee he only worked in a lead-zone position if he had recently been a casting department employee. (Tr. 273).

B. MAHLE's Lead Exposure Control Plan

MAHLE's lead exposure control plan included several methods to mitigate its employees' lead exposure: administrative controls, respiratory controls, engineering controls, and decontamination procedures. Administrative controls included rotating employees in and out of the work positions with the highest lead exposure. Respiratory controls, such as PAPRs, were used when an employee worked in the lead zone. Engineering controls included forced air ventilation and HEPA air filters in the break room. (Tr. 270; RX-9, p. 5).

A key component in MAHLE's lead exposure control plan was its decontamination procedures. MAHLE had two levels of decontamination for its employees – Level One and Level Two.⁷ (RX-6, p. 4). Level Two was used at the end of an employee's shift before leaving for the day and Level One was for breaks during a work shift. (Tr. 269; RX-6, p. 4). The Level One decontamination process for an employee taking a break took about 17 minutes. (Tr. 268). An employee went through the Level One decontamination process multiples times during a work shift. (Tr. 268).

MAHLE's decontamination process had two levels with several steps for each level. First, for the Level One process, the employee washed his hands and face and boots upon leaving the casting department. (Tr. 267-69; RX-6, p.4). Second, he moved into the downdraft booth of Decontamination Room One. The downdraft booth used a burst of air from overhead to remove lead as the employee turned around and the air was pulled through filters beneath the employee's feet. (Tr. 267-268). Third, the employee removed his PAPR or hardhat, cleaned the PAPR and PAPR locker, placed the cleaning wipes in the hazardous waste bin, and stored the PAPR in its locker. Finally, he completed the respirator maintenance log, washed and stored his hard hat on a hook, washed his hands and face again, and exited Decontamination Room One. (RX-6, p. 4; Tr. 267-69). Employees walked on a sticky mat to remove lead from shoes. (Tr. 267).

⁷ This reflects the process that was in place at the time of the OSHA inspection during the fall and winter of 2012. (Tr. 267).

For Level Two decontamination, first, the employee completed the steps of Level One decontamination. Then, he proceeded into the downdraft booth at Decontamination Room Two. (RX-6, p.4). Next, he used the boot wash and washed his hands and face. (RX-6, p.4). Then, the employee proceeded to the dirty side of the locker room to remove his used work uniform, which he placed in a container for the laundry service. (Tr. 269). Thereafter, he showered and proceeded to the clean side of the locker room. Finally, he dressed in the clothing he wore to work and left for the day. (Tr. 269).

In addition to its internal controls and procedures, MAHLE contracted with four companies for lead-related services: Cintas, ServiceMaster, Genesis Healthcare System (Genesis) and Helix Environmental (Helix). Cintas collected and cleaned MAHLE's contaminated work clothing. (Tr. 269). ServiceMaster provided both general cleaning services throughout the facility and cleaning in the areas with potential lead accumulation. (CX-23; Tr. 288-89). Dr. Eric Newsome, of Genesis, was the occupational health physician for MAHLE's medical surveillance program. (Tr. 407). Dr. Newsome reviewed the results from the blood tests for the employees' lead and zinc protoporphyrin (ZPP) levels.⁸ (Tr. 407).

In 2007, MAHLE retained Ralph Froehlich of Helix for consulting on industrial hygiene issues. (Tr. 310; JX-1, p. 12). Froehlich provided general consulting and conducted on-site industrial hygiene reviews of MAHLE's facility. During a facility visit, he assessed and tested for occupational health hazards and possible employee exposure. (JX-1, p. 13). Froehlich visited MAHLE's facility in 2009, 2010, and three times in 2012. (JX-1, pp. 12-13, 36). Froehlich's May 22, 2012 facility-wide review assessed several employee safety and health issues, such as personal protective equipment, noise, airborne dust, lead, copper, tin and hydrocarbons. (JX-1, p. 36, 38). Froehlich prepared a 45-page report based on the results of the May 2012 review. (CX-8).

C. The OSHA Inspection

OSHA Compliance Officer (CO) Lupariello began the inspection at MAHLE's McConnellsville, Ohio facility on October 12, 2012. (Tr. 40). No MAHLE safety professionals were available that day, so he returned on October 15, 2012, to conduct the walk-around inspection of the facility. (Tr. 41). During the walk-around, the CO took photographs and

⁸ John Feather, plant manager, testified that the union contract required the 6-month blood testing schedule for casting line employees and blood testing for employee transfers from the finishing department. (Tr. 272).

collected four wipe samples to test for lead accumulation.⁹ (Tr. 41). Following the chain-of-custody procedure, these samples were sent to OSHA's Salt Lake Technical Center (SLTC) laboratory for analysis.¹⁰ (Tr. 42). The laboratory results from the analysis showed no detectable level of lead in the four samples collected by the CO on October 15. (Tr. 43; RX-1, p. 48).

After reviewing the October sampling results, the CO determined he had not sampled enough areas to get a representative sample of lead exposure at MAHLE's facility.¹¹ (Tr. 44-45). He returned to the facility on December 10, 2012, and took six wipe samples from various areas in the break room and locker room.¹² (Tr. 43). Based on the laboratory report for the December 2012 samples, the CO determined that four of the sampled surface areas had excessive lead levels.¹³ (Tr. 52-54).

III. The Secretary's Expert

Just prior to the commencement of the hearing, the Respondent filed a motion *in limine* to exclude the testimony of OSHA's proposed expert witness, Dr. Michael Hodgson. *See* Motion *In Limine*. Respondent conceded that Dr. Hodgson was qualified; however, objected on the basis that his opinions were not relevant or based on reliable information.

Federal Rule of Evidence 702¹⁴ governs testimony by experts. In *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993), the Court stated that FRE 702 places a

⁹ At MAHLE's request, Froehlich also collected lead wipe samples on October 15, 2012. (JX-1, p. 25).

¹⁰ The CO described the procedure as, "[w]henver I take a sample, whether it be a wipe, bulk, air, you know, pretty much you name it, anything besides a direct reading sampling, as with a noise decimeter [*sic*] or something, we apply a chain-of-custody label. As soon as it takes off [*sic*], it's capped or screwed, depending on what the container is, and then the sample number, date and who took the sample, which would have been me, is written on it, affixed to it. And then from that point it's then taken back to the office, boxed up, sent to Salt Lake Technical Center, where when they receive it they put their own receiving brand on that label, affix it to their own documents and continue the chain of custody." (Tr. 48).

¹¹ The record reveals that the CO went back to retest at the suggestion of his supervisor, Linda Harrington, because it seemed unlikely to have a non-detectable lead result in a facility with known lead emissions during its production process.

¹² CO Lupariello was accompanied by Linda Harrington for the December 10, 2012 visit. He conducted the wipe sampling and Harrington reviewed MAHLE's records. (Tr. 253). Harrington's title was not adduced; however, testimony shows she was CO Lupariello's supervisor. (Tr. 247, 253). Harrington had conducted an inspection of the same MAHLE facility in 2009 which had resulted in one positive result for lead contamination. (Tr. 236).

¹³ The details of the laboratory report and my concerns about the meaning of its results are discussed below.

¹⁴ Federal Rule of Evidence 702 provides that:

If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise, if (1) the testimony is based on sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.

“gatekeeping” duty upon trial courts to determine whether expert testimony is relevant and reliable before allowing its admission. *Daubert* at 593-94, 597.

After applying the *Daubert* factors, I found that Dr. Hodgson’s testimony would assist me in understanding the technical issues in this matter and denied the Respondent’s motion. Dr. Hodgson was accepted as an expert witness. (Tr. 36).

Dr. Hodgson’s testimony was helpful in understanding the serious medical effects of long-term lead exposure. His testimony did support the Secretary’s assertion that low levels of continuous lead exposure can result in serious long-term health effects. In particular, Dr. Hodgson stated that the data demonstrating the serious health effects of cumulative exposures substantiated the lead standard’s focus on the importance of housekeeping and its requirement to keep surfaces as free of lead as practicable. (Tr. 177-78; CX-28, CX-29, CX-33). Therefore, Dr. Hodgson’s testimony is accorded some weight regarding the health effects of lead exposure.

However, his testimony was not helpful in determining the ultimate issues of this case: the amount of surface lead that was “practicable” in MAHLE’s facility; the adequacy of MAHLE’s change room; and, whether MAHLE was adequately providing blood tests to its exposed employees.

IV. The Secretary’s Burden of Proof

To establish a violation of an OSHA standard, the Secretary must prove that: (1) the cited standard applies; (2) the terms of the standard were violated; (3) one or more employees had access to the cited condition; and (4) the employer knew, or with the exercise of reasonable diligence could have known, of the violative condition. *Astra Pharm. Prods.*, 9 BNA OSHC 2126, 2129 (No. 78-6247, 1981), *aff’d in relevant part*, 681 F.2d 69 (1st Cir. 1982). The Secretary has the burden of proving her case by a preponderance of the evidence. *Id.*

V. Citation 1, Item 1 – Serious Violation of 29 C.F.R. § 1910.1025(h)(1)

MAHLE was cited for an alleged serious violation of 29 C.F.R. § 1910.1025(h)(1) which provides:

(h) *Housekeeping--(1) Surfaces*. All surfaces shall be maintained as free as practicable of accumulations of lead.

The Secretary alleges that Respondent did not keep surfaces in the break room adequately free of lead accumulation. In particular, the Secretary alleges that the table and the lunch pail storage area in the break room were not adequately free of lead accumulation.

MAHLE argues that even if an employee had touched the lead in the break room, a single exposure would not result in harm. (Resp. Br. 5, 12). However, the Secretary's expert, Dr. Hodgson, explained that serious health effects are the outcome of long-term cumulative exposure to low lead levels. (Tr. 177-78). I find the Secretary's position, that a one-time exposure of lead is serious because of its long-term effects¹⁵ is supported by the evidence. MAHLE's argument is rejected.

A. The standard applies.

The standard is applicable. There was no dispute that lead emissions resulted from MAHLE's production operation. MAHLE had a significant program to control lead exposure. (Tr. 261-68; RX-9). Based on MAHLE's testing, one area of the facility was designated a lead zone because it was at or above the action level (AL) of 30 µg/m³. (Tr. 263; RX-9, pp. 3-4). The lead zone was in the casting department. (Tr. 263). OSHA did not dispute the accuracy of MAHLE's designation of its lead zone. Because MAHLE has known lead emissions in an employee work area, I find the standard applies.

B. The employees had access to the cited condition.

CO Lupariello testified that MAHLE employees routinely used the break room to rest their feet, take a break, eat lunch, or make phone calls. (Tr. 67). The Plant Manager testified that the break room was routinely used by employees in the casting department. (Tr. 288). However, Respondent argues there was no proof an employee actually touched the sampled surfaces in the break room so there was no proof an employee was actually exposed to lead. (Resp. Br. 5).

Proof of actual employee exposure to lead is not required. Commission case law has consistently stated that exposure is measured by an employee's access to the hazard. *See Phoenix Roofing, Inc.*, 17 BNA OSHC 1076, 1079 (No. 90-2148, 1995), *aff'd without published opinion*, 79 F.3d 1146 (5th Cir. 1996). MAHLE's employees used the break room; therefore, I find the Secretary proved employee access to the cited condition

¹⁵ 43 Fed. Reg. 52952, 52954 (Nov. 14, 1978) (discussion of health effects from long-term lead exposures).

C. The Secretary did not prove the standard was violated.

The Secretary did not prove that the standard's terms were violated. In particular, the Secretary did not prove that MAHLE exceeded the practicable level of lead accumulation in its break room.

The Secretary alleges that MAHLE did not keep surfaces in the break room adequately free of lead accumulation.¹⁶ The Secretary based this citation item on two wipe samples the CO collected on December 10, 2012. The Secretary alleges that one sample taken from the break room table showed a lead concentration at 526 $\mu\text{g}/\text{ft}^2$ and the other sample taken under a lunch pail showed a lead concentration at 280 $\mu\text{g}/\text{ft}^2$. (Tr. 56-57; CX-2, CX-3). The evidence the Secretary provided to demonstrate the non-compliant lead contamination levels is not sufficient to support the citation because the sampling results are not credible and the Secretary did not establish what the practicable level of lead accumulation would be for MAHLE's break room.

1. The Secretary's Sampling Results

The CO collected six wipe samples during his December 10, 2012 inspection of MAHLE's facility. Four of the samples tested positive for surface lead -- two of the samples were from the break room and two from the locker (change) room.

The Secretary submitted three documents to support its assertion that the December 10 samples showed unacceptably high lead concentrations: Complainant's Exhibit Two, the CO's conversion calculations; Exhibit Three, the CO's inspection worksheet; and Exhibit Four, the laboratory results from OSHA's Salt Lake Technical Center (SLTC). (CX-2, CX-3, CX-4).

Exhibit Two consists of handwritten calculations related to four samples designated as: S-12 (locker #20 handle); S-14 (lunch table); S-15 (lunch storage area under pail); and S-16 (locker #34 handle). (CX-2). The calculations on this exhibit converted the SLTC laboratory results to a per-foot-squared measurement. (Tr. 55).¹⁷

Complainant's Exhibit Three is the CO's handwritten worksheet (inspection worksheet) that was completed the day of the inspection. (CX-3). This inspection worksheet was labeled as number 78065, for six wipe samples designated as: S11 men's locker room bench; S12 locker

¹⁶ The Secretary also refers to "massive lead" contamination in the south building's break room. (Sec. Br. 10). However, there is no indication that the break room in the south building was sampled during the CO's visit. If the Secretary is referencing the samples taken by Froelich on May 22, 2012, the point is inapt. The six month statute-of-limitations for conditions on May 2012 expired before the citation here was issued on March 4, 2013. See § 9(c) of the Act.

¹⁷ It appears the CO converted the results for comparison to the 200 $\mu\text{g}/\text{ft}^2$ HUD level.

#20 handle; S13 men's locker room bench; S14 lunch table; S15 lunch pail storage area; and S16 men's locker #34. (CX-3).

Complainant's Exhibit Four is the SLTC laboratory's sampling report for number 78065. (Tr. 48, 55). The SLTC report notes that the samples were received with the chain-of-custody seals intact on December 17, 2012, and the analysis was completed on December 28, 2012. The laboratory results were designated as submission numbers: S1, S2, S3, S4, S-15, and S-16. (CX-4).

The Secretary asserts, based on the SLTC report and the CO's conversion calculations, that four of the areas tested had excessive levels of lead:¹⁸ locker #20 handle 1,536 $\mu\text{g}/\text{ft}^2$; break room table 526 $\mu\text{g}/\text{ft}^2$; lunch pail storage area 280.6 $\mu\text{g}/\text{ft}^2$; and locker #34 handle 918.4 $\mu\text{g}/\text{ft}^2$. (Tr. 56-58; CX-2). However, there are four primary issues with using the data from these three exhibits to support the alleged violations.

The first issue is that the sampling date and shipping date of the SLTC report did not correspond to the CO's December 10 collection date. (CX-4). The 78065 SLTC report had a "sampling date" of October 15, 2012, not December 10, 2012, as alleged by the Secretary.¹⁹ (CX-4). The shipping date on the 78065 SLTC report was recorded as October 17, 2012 (prior to the CO's December 10 collection date). (CX-4). The CO testified that, even though the 78065 SLTC laboratory report had a date of October 15²⁰, he knew the report was actually for the December 10, 2012 samples because "these are the six samples that I took, along with the blank from that day. And it directly corresponds with the – with my actual sampling worksheet." (Tr. 53). The CO also testified that he believed the October 15 date on the 78065 SLTC report had been mistakenly carried forward by the SLTC laboratory from an earlier report related to samples he had submitted to SLTC in October. (Tr. 52). Respondent did not stipulate that the results shown in Complainant's Exhibit Four represented results from the samples taken by the CO on December 10, 2012. (Tr. 54).

¹⁸ According to the Secretary, the final converted results for the samples with detectable levels of lead were: S-12 1,536 $\mu\text{g}/\text{ft}^2$; S-14 526 $\mu\text{g}/\text{ft}^2$; S-15 280.6 $\mu\text{g}/\text{ft}^2$; and S-16 918.4 $\mu\text{g}/\text{ft}^2$. (Tr. 56-58; CX-2).

¹⁹ Secretary's counsel noted that the results must be from the CO's December samples because "there won't be any evidence that this is sampling from any other date." I find this explanation unhelpful. (Tr. 54).

²⁰ The laboratory report for the prior October samples had sampling report number 78005 reflected a sampling date of October 15, 2012. The report shows a received-in-lab date of October 26, 2012 and analysis completed on November 2, 2012. The samples on the October 15 report were designated as S1, S2, S3, and S4. (RX-1, pp. 48-50).

Second, the sample (submission) numbers on the 78065 SLTC laboratory report do not match those from the CO's 78065 inspection worksheet. (CX-3, CX-4). The laboratory report shows results for samples S1, S2, S3, S4, S-15, and S-16. (CX-4). There are no samples designated as S1, S2, S3, and S4 on the CO's 78065 (December 10, 2012) inspection worksheet. The CO's sample numbers were from S11 through S16. No one from the lab testified, or otherwise verified, that the results reported in SLTC 78065 report were related to the samples collected by the CO on December 10, 2012. (CX-4). There was no explanation for discrepancy in the sample numbers.

Third, the meaning of the numerical results on the SLTC laboratory report is not in the record. There was no testimony, affidavit, or other evidence from laboratory personnel describing or verifying the results and the meaning of those results.²¹ (Tr. 52-53). Instead, the Secretary chose to let the lab samples "sort of speak for themselves...." (Tr. 53). For example, there was no information in the report that described the meaning of a particular result, such as the result "12.2000" under the category of "Lead, inorganic" for submission number S-15. (CX-4). There was no supplemental report that described and explained the results. In particular, there was no description of the relative unit of measurement that the reported lead results were based upon (i.e., per square foot, per cubic foot, etc.).

The meaning of the laboratory results on the SLTC report is essential because the CO's final calculated lead concentration levels are based on results in the SLTC report. For example, with respect to sample S12 taken on December 10, 2012, the CO testified that the lead concentration, after the conversion to square-foot, was 1,536 $\mu\text{g}/\text{ft}^2$ based on the SLTC laboratory result of "64 micrograms." (Tr. 56; CX-2). However, the SLTC report, which purported to provide the results of the December 10 sampling, had no sample or submission designated as "S12." (CX-4). Further, there was no "64 micrograms" result for lead on the SLTC report for any sample number analyzed. (CX-4). Consequently, the CO's calculated lead concentration for S12 cannot be reconciled with the SLTC report.

Fourth, there was no evidence to verify the chain-of-custody procedures upon receipt at the SLTC laboratory. In particular, there was no explanation of why the sample (submission) numbers for the laboratory report (S1 through S4, S-15, S-16) do not match the CO's submitted

²¹ The parties agreed prior to the hearing that the lab personnel would not have to testify and that the report would speak for itself. (Tr. 53). Respondent did not stipulate that the results on CX-4 represent the results for the sampling the CO conducted on December 10, 2012. (Tr. 53-54).

sample numbers (S11 through S16). (CX-4, CX-3). No one from the laboratory confirmed the results on the SLTC laboratory report were from the samples collected by the CO on December 10. On its face, the SLTC laboratory report cannot be reconciled with the CO's inspection worksheet.

When viewed as a whole, I am not confident in the data the Secretary relied upon to support his allegations. The CO used the SLTC laboratory results to calculate a squared-foot lead concentration. (Tr. 56-58). There is not a dispute that the report was from SLTC and generally related to lead sampling; however, the meaning of the reported results is not in evidence. The report, standing on its own, is incomplete and does not explain the value of a particular reported result. For example, without its relative unit of measure, a reported result of 12.2 micrograms is not useful. Despite the fact that the Secretary did not call anyone from the lab to testify regarding the sampling results, Respondent did not object to their admission into evidence as Complainant's Exhibit #4. (Tr. 49). Therefore, the issue before me is one of credibility rather than admissibility.

Questions of credibility, the weight of evidence and the inferences to be drawn from evidence are determinations to be made by the administrative fact-finder. *N.L.R.B. v. Publishers Printing Co., Inc.*, 650 F.2d 859, 860 (6th Cir. 1981). The assessment of weight for a piece of evidence is separate from the issue of admissibility. *See In re Scrap Metal Antitrust Litig.*, 527 F.3d 517, 530-31 (6th Cir. 2008). Not all admissible evidence necessarily carries the same weight. *Id.*

Here, the inconsistencies between the sampling and shipping dates, the designations of the sample numbers, and unexplained discrepancies in numbers used for the CO's calculations diminish the credibility of the SLTC report and its results. Further, the government's attempt to explain these inconsistencies, through the CO, sheds more heat than light on the issue of credibility since the CO did not analyze the samples, nor did he prepare this report. (Tr. 52). Moreover, the scientific nature of the report makes it impossible for me to accord this evidence any meaningful weight in the absence of testimony or other validation from the SLTC laboratory analyst. Therefore, I find that the SLTC report and the resulting calculations are not credible and thus cannot support the Secretary's allegation of lead contamination at MAHLE.

2. Allowable Level Of Lead Accumulation

The Secretary asserts that samples collected from MAHLE's break room show unacceptable accumulations of surface lead. The Secretary used the Department of Housing and Urban Development's (HUD's) hazard threshold of 200 µg/ft² as the baseline to determine a violative level of surface lead. (Sec. Br. 13; CX-32).

With respect to the housekeeping requirement at 29 C.F.R. § 1910.1025(h)(1), the cited standard does not establish a maximum acceptable concentration of lead for surfaces. It requires the employer to keep surfaces "as free as practicable of accumulations of lead." When the lead standard was promulgated in 1978, OSHA explained that a housekeeping program was necessary to manage lead exposures not otherwise mitigated through engineering controls. OSHA stated that the acceptable concentration of surface lead was dependent on the conditions at a particular facility.

OSHA's view is that a rigorous housekeeping program is necessary to keep airborne lead levels below permissible limits but that the obligation should be measured by a standard of practicability. [citation omitted] This contemplates a regular housekeeping schedule *based on exposure conditions at a particular plant* and the capability for emergency cleanup of spills or other unexpected sources of exposure. (emphasis added).

43 Fed. Reg. 52994 (Nov. 14, 1978).

Further, in OSHA's 1993 compliance directive,²² it continued its position by stating: "This requires a regular housekeeping schedule adapted to exposure conditions at a particular site." CPL 02-02-058, *Lead Exposure In Construction; Interim Final Rule -- Inspection and Compliance Procedures*, Dec. 13, 1993.²³

In 2003, OSHA provided additional guidance on the requirement for surfaces to be as "free as practicable" of lead in a January 13, letter of interpretation:²⁴

The term "practicable" was used in the standard, *as each workplace will have to address different challenges* to ensure that lead-surface contamination is kept to a minimum. It is OSHA's view that a housekeeping program which is as rigorous as "practicable" is necessary in many jobs to keep airborne lead levels below permissible exposure conditions at a particular site. . . .

²² The construction standard's housekeeping requirement for lead is identical to the standard at issue here. "(h) *Housekeeping*--(1) All surfaces shall be maintained as free as practicable of accumulations of lead." 29 C.F.R. § 1926.62(h)(1). Thus, the related compliance directive is instructive on OSHA's position.

²³ This directive was accessed at https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=DIRECTIVES&p_id=1570.

²⁴ An agency's letter of interpretation is entitled to deference when it is reasonable and consistent with the language of the standard. *See Martin v. OSHRC (CF&I Steel)*, 499 U.S. 144, 151 (1991).

The role of the Compliance Safety and Health Officer (CSHO) is to evaluate the employer's housekeeping schedule, the possibility of exposure from these surfaces, and *the characteristics of the workplace*.

In situations where employees are in direct contact with lead-contaminated surfaces, such as working surfaces or floors in change rooms, storage facilities and, of course, lunchroom and eating facilities, OSHA has stated that the Agency *would not expect surfaces to be any cleaner* than the 200-ug/ft² HUD level. As discussed above, for other surfaces such as rafters, *no specific level can be set to define how "clean is clean" nor what level of lead contamination meets the definition of "practicable."* The intent of this provision is to ensure that employers regularly clean and conduct housekeeping activities to prevent avoidable lead exposure, such as those potentially caused by re-entrained lead dust. (emphasis added).

(Exh. C-32).²⁵ This 2003 guidance continued OSHA's position that the standard does not specify a particular surface lead concentration level to establish a violation; instead, each workplace must be evaluated based upon its particular conditions. Further, OSHA clarified that the standard's purpose was to have an employer to "regularly clean" to control avoidable lead exposure. The 200 µg/ft² HUD level is only referenced as the level that OSHA does not expect a surface to be cleaner than.

Nonetheless, the Secretary relies on the 200 µg/ft² HUD level to determine that MAHLE has violated the requirements at 1910.1025(h)(1). This is inapt for three reasons. First, OSHA did not set forth the 200 µg/ft² HUD level as the maximum level of surface lead for compliance; it was set forth as the level that OSHA does not expect a surface to be *cleaner* than. Second, the 200 µg/ft² HUD level is not incorporated into the standard's requirement.²⁶ Finally, using this level to establish a violation does not take into consideration what is practicable for MAHLE's facility, which the standard requires. *See Thomas Indus. Coatings, Inc.*, 21 BNA OSHC 2283, 2287 (No. 97-1073, 2007) ("[P]erformance standards . . . are interpreted in light of what is reasonable.")

The Secretary asserts that the practicable lead level for MAHLE is a result of "non-detectable." (Sec. Br. 7-8). The Secretary bases his position on the results from the CO's October 2012 lead sampling at MAHLE. (Tr. 96-97). This argument fails for two key reasons. First, the operational status of MAHLE's casting line around the time of each lead sampling was

²⁵ OSHA's January 13, 2003 letter of interpretation addressed to Mr. Frank White can be accessed at https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=INTERPRETATIONS&p_id=25617.

²⁶ The CO admitted that the HUD level was not a requirement of the standard. (Tr. 62).

not considered. Lead emissions were produced during the normal operation of the casting line.²⁷ Additionally, MAHLE occasionally had a “dump” in the casting department which produced higher lead emissions. Further, at several times throughout the year the casting line was not operational, so no lead emissions were produced. It is reasonable that MAHLE’s practicable amount of surface lead could vary depending on the casting line’s operational status.

Second, in *Atlantic Battery*, the Commission rejected the Secretary’s argument that a “non-detectable” finding alone was a basis to determine what is practicable. *Atlantic Battery Co.*, 16 BNA OSHC 2131, 2162 (No. 90-1747, 1994) (finding that the employer had a diligent cleaning schedule and that it was “not practicable” for the employer to implement a more stringent housekeeping program). In its analysis, the Commission considered the employer’s “substantial efforts to comply with its obligation under the cited standard” through daily cleaning. Similarly, MAHLE implemented several measures to mitigate the accumulation of lead in its facility and also increased its cleaning schedule to three times per day (once per shift) in 2010. (Tr. 271). Thus, OSHA’s sampling results of October 2012 do not establish the practicable lead level for MAHLE.

The Secretary also asserts that MAHLE’s high lead results were due to ServiceMaster’s improper cleaning method. (Sec. Br. 2, 11). The evidence is insufficient to support this assertion. During the December 10, 2012 inspection, the CO testified that he had observed ServiceMaster staff using a “dry” method to clean with a dirty rag: “I didn’t see a wet bucket or a clean bucket, a rinsing bucket or multiple cloths.” (Tr. 49-50). The CO explained, “[a]s I was getting ready to sample, the cleaning staff there was -- had just finished wiping all the surfaces down. They were on their way out when I was getting ready to sample.” (Tr. 47). The CO’s inspection worksheet from December 2012 included his notation of “freshly cleaned surfaces.” (Tr. 47, 49-50; Exh. C-3). The CO testified that he also observed ServiceMaster cleaning during the October inspection, but did not document that observation. (Tr. 47, 49, 140-42).

The CO’s observation is the only evidence regarding ServiceMaster’s use of an ineffective cleaning method. To the contrary, Froehlich testified he had observed the use of a wet cleaning method.²⁸ (JX-1, p. 23). Additionally, the plant manager was surprised because MAHLE’s training specified the use of a wet cleaning method, MAHLE provided lead-cleaning

²⁷ In 2012, the casting line had two-week shutdowns in July, November, and at year-end. (Tr. 274-75).

²⁸ Mr. Froehlich observed cleaning at MAHLE’s facility during his visits even though he was not asked to critique the cleaning process. He observed the use of a “wet cleaning” method. (JX-1, p. 23).

products for ServiceMaster's use, and rags could be cleaned in the same area the CO observed the dry-method cleaning. (Tr. 281).

A determination of whether ServiceMaster's cleaning was inadequate cannot be made without specific facts about how the cleaning was performed the day of the inspection and if that was indicative of the generally utilized cleaning method. A one-time observation, and its resulting assumption, does not establish that ServiceMaster was generally using an inadequate cleaning method. Further, if ServiceMaster generally used an ineffective cleaning method it seems unlikely that OSHA's October sampling could have resulted in non-detectable lead levels. When asked to explain how this could occur, the CO supposed that maybe they "got lucky" and "cleaned right" that day. (Tr. 61).

The record is insufficient to support the assertion that ServiceMaster was generally using inadequate cleaning methods at the MAHLE facility.

Further, the Secretary made much of its assertion that ServiceMaster did not always clean three times per day. (Tr. 10; Sec. Br. 8-9). The Secretary attempted to prove this point by showing that there were not three initialed cleaning log entries for each day. (Tr. 299-300; Sec. Br. 8). ServiceMaster utilized cleaning logs to show when each area in the MAHLE facility had been cleaned with an employee's initials on a checklist. (Tr. 297, 300; CX-16). The Secretary claims that MAHLE made a "promise" to change its cleaning schedule to three times per day as a part of its settlement agreement with OSHA from a 2009 inspection. (Tr. 10). However, the cited standard does not specify the frequency of cleaning and the Secretary has not presented evidence to show that cleaning three times per day is the sole means to maintain surface lead at a practicable level. This argument is rejected.

D. The Secretary did not prove employer knowledge of the cited condition.

The Secretary must prove the employer either knew, or with the exercise of reasonable diligence, could have known of the violative condition. *Dun-Par Engineered Form Co.*, 12 BNA OSHC 1962, 1965 (No. 82-928, 1986)(*Dun-Par*). The employer's knowledge is directed to the physical conditions that constitute a violation. *Phoenix Roofing, Inc.*, 17 BNA OSHC 1076, 1079-1080 (No. 90-2148, 1995), *aff'd without published opinion*, 79 F.3d 1146 (5th Cir. 1996) (*Phoenix*). The Secretary need not show that an employer understood or acknowledged that the physical conditions were actually hazardous. *Id.*

The actual or constructive knowledge of an employer's supervisory personnel can be imputed to an employer, unless the employer establishes substantial grounds for not imputing it. *Ormet Corp.*, 14 BNA OSHC 2134, 2137 (No. 85-531, 1991), citing *Donovan v. Capital City Excavating Co.*, 712 F.2d 1008, 1010 (6th Cir. 1983). The Sixth Circuit, where this case arises, follows Commission precedent that knowledge of a supervisor will be imputed to the employer to establish knowledge of the violation. *Danis Shook Joint Venture XXV v. Sec'y of Labor*, 319 F.3d 805, 812 (6th Cir. 2003), *aff'g* 19 BNA OSHC 1497 (No. 98-1192, 2001).

Here, the Secretary asserts that MAHLE knew about excessive lead levels from Helix's report and because the CO's informed MAHLE that he had observed ServiceMaster's improper cleaning technique. (Tr. 140-41; Sec. Br. 9). However, the CO was unsure at which visit, October or December, he told MAHLE's safety manager of his concerns about ServiceMaster's cleaning method. (Tr. 141-42). Thus, the CO's discussion with MAHLE does not establish knowledge of possible inadequate lead cleaning prior to the December inspection.

Also, Helix's 2012 lead sampling results do not support knowledge prior to the December inspection. The record is clear that Helix collected widespread samples throughout MAHLE's facility on May 22, 2012. However, there is no evidence as to when the resulting 45-page report was completed and sent to MAHLE. (CX-8). Also, there is no evidence about the usual elapsed time between Helix's collection of samples and a report's submission to the client to infer a possible date. Thus, this report cannot be used to establish MAHLE's knowledge of inadequate cleaning. The evidence does not show that any of MAHLE's supervisory personnel had actual knowledge of any excessive lead contamination or that the break room was not as free of lead as practicable.

To establish constructive knowledge the Secretary must show that with reasonable diligence MAHLE could have known of the condition of high lead concentration in its break room. Because the standard requires an employer to determine what method it will use to mitigate lead accumulations, the employer's actions are assessed in light of what is reasonable. *See Assoc. Underwater Servs.*, 24 BNA OSHC 1248, 1250 (No. 07-1851, 2012) (*AUS*); *Thomas Indus. Coatings, Inc.*, 21 BNA OSHC 2283, 2287 (No. 97-1073, 2007) (*Thomas*). An employer's conduct is evaluated in its totality and by "whether a reasonable employer would have done more." *Capform, Inc.*, 16 BNA OSHC 2040, 2042 (No. 91-1613, 1994) (*Capform*).

The Secretary asserts that ServiceMaster's cleaning was inadequate and if MAHLE had adequately supervised ServiceMaster, it would have known of inadequate cleaning and the likelihood of excessive lead contamination. (Sec. Br. 8, 11). The Secretary states that MAHLE's oversight of ServiceMaster was insufficient because it did not monitor the cleaning reports, it did not observe ServiceMaster's cleaning methods, and it did not ensure that ServiceMaster understood the hazards of lead. (Sec. Br. 8).

First, the Secretary asserts that MAHLE did not review ServiceMaster's cleaning reports to determine if ServiceMaster was cleaning the break room three times per day. I disagree. I find that ServiceMaster did routinely review ServiceMaster's cleaning reports.

After a 2009 OSHA inspection, in which MAHLE was cited for inadequate housekeeping, MAHLE increased the cleaning schedule for ServiceMaster from twice a day to three times a day. (Tr. 64, 271, 295). This was done to coincide with the three work shifts per day that MAHLE typically ran. (Tr. 64, 271, 323). MAHLE also developed a cleaning log for ServiceMaster's use. (RX-8, p.19). The cleaning log included a daily checklist of each area to be cleaned and a space for the ServiceMaster employee to initial each time an area was cleaned during the day. (RX-8, p.19). A ServiceMaster supervisor collected these logs and submitted them to MAHLE's purchasing office each week. (Tr. 286, 356).

The Secretary presented several cleaning reports to show there were instances when the reports were not initialed to show an area had been cleaned three times on a particular day. (Tr. 285-86, 297; CX-16; RX-8, pp. 22-23). MAHLE effectively refutes this evidence.

The plant manager, John Feather,²⁹ testified that the instances generally coincided with times that the casting line did not operate for three shifts per day or was shut down. (Tr. 300, 304). During a shut-down, MAHLE did not process lead. (Tr. 325-26). Feather stated that he did not expect ServiceMaster to clean three times each day when all three shifts were not in production or the casting line was not operating. (Tr. 300, 325-26). Feather stated that MAHLE did routinely review the cleaning reports to make sure ServiceMaster was following the three-times-per-day schedule. (Tr. 295-97). Additionally, each week a ServiceMaster supervisor went to the facility to spot-check the cleaning and turn in the cleaning reports. (Tr. 356). Kim

²⁹ Feather worked for MAHLE a total of 11 years and became the McConnelsville plant manager in 2010. (Tr. 257, 278).

McNeish, the supervisor for ServiceMaster's cleaning porters, had weekly discussions with MAHLE management to address cleaning issues. (Tr. 364, 369).

A January 2011 email also shows MAHLE reviewed the cleaning reports from ServiceMaster. (RX-8, p. 16). In that email to ServiceMaster, MAHLE noted that it had observed improvements in the cleaning after the change to three times per day and asked for additional improvements, such as timing the cleaning to occur just after a shift change. (RX-8, p. 16). I find that MAHLE did actively review the cleaning reports to determine if ServiceMaster was following the cleaning schedule and that its review was reasonable.

Second, the Secretary asserts that if MAHLE had observed ServiceMaster's cleaning it would have known that ServiceMaster used an ineffective method (dry cloth) to clean.³⁰ (Sec. Br. 8, 11). The CO testified that he had observed ServiceMaster cleaning during both of his visits; however, only his December inspection worksheet records this observation plus he was unsure when he had informed MAHLE management of his observation. (Tr. 47, 49, 140-41).

MAHLE also monitored the effectiveness of cleaning by using a quick-test stick to detect surface lead. (Tr. 279-280). This quick-test was routinely done throughout the facility to evaluate cleaning. The quick-test stick immediately indicated the presence (but not the amount) of lead. (Tr. 279-280). As an example, Feather stated that a quick-test had indicated lead was present on the employees' time clock. MAHLE presented the problem to ServiceMaster and found the time clock was not being cleaned. MAHLE immediately required ServiceMaster to routinely clean the time clock. (Tr. 280).

The evidence shows that MAHLE did oversee the facility's cleaning. MAHLE routinely addressed issues regarding cleaning methods, provided lead cleaning solutions and provided training to ServiceMaster that noted wet mops and wet rags were needed to prevent re-entry of lead into a clean environment. (Tr. 281, 293, 295-96; RX-8, p. 4). Cleaning issues were addressed weekly with a ServiceMaster supervisor. (Tr. 369). Further, the evidence does not show that the plant manager had reason to believe ServiceMaster was using a dry-cloth method.³¹ (Tr. 281). It is not reasonable to expect MAHLE to continuously observe ServiceMaster's cleaning. I find that MAHLE took reasonable measures to oversee

³⁰ The only record evidence of ServiceMaster utilizing a dry method of cleaning was the CO's testimony that he had seen the cleaning during his visits.

³¹ I noted Feather's demeanor during his testimony. His surprise appeared to be genuine. This, coupled with the record evidence, indicates Feather did not have any knowledge of a dry-method cleaning being used. (Tr. 281).

ServiceMaster's cleaning methods and, in particular, its use of a quick-test stick to detect the presence of lead on surfaces.

Third, the Secretary asserts that MAHLE should have known ServiceMaster's cleaning was inadequate because ServiceMaster was not a lead cleaning specialist and, therefore, not properly trained in lead hazards and cleaning. (Sec. Br. 11). The evidence does not support this assertion.

MAHLE provided training and information to ServiceMaster, including its lead exposure control plan. (RX-8, p. 13; RX-9). ServiceMaster reviewed MAHLE's lead exposure control plan and its management employees attended MAHLE's training. (Tr. 282-83, 351, 355-56, 362-63; RX-8, p. 10). The evidence shows that MAHLE made continuous efforts to educate ServiceMaster's management about the hazards of lead at its facility. I find that MAHLE's efforts to inform ServiceMaster of the lead hazards at the facility were reasonable.

As a whole, the record shows that MAHLE made reasonable efforts to have effective cleaning for the break room and did not have knowledge that cleaning may have been inadequate. The Secretary did not establish constructive knowledge.

The Secretary did not prove that the standard's terms were violated or that MAHLE had knowledge of the violative condition by a preponderance of the evidence. Citation 1, Item 1 is vacated.

VI. Citation 2, Item 1 – Repeat Violation of 29 C.F.R. § 1910.1025(i)(2)(i)

MAHLE was cited for a repeat violation of 29 C.F.R. § 1910.1025(i)(2)(i) which provides:

29 C.F.R. § 1910.1025 (i) *Hygiene facilities and practices.* (2) *Change rooms.* (i) The employer shall provide clean change rooms for employees who work in areas where their airborne exposure to lead is above the PEL, without regard to the use of respirators.³²

The Secretary alleges that MAHLE did not provide clean change rooms for employees that are exposed to amounts of lead above the permissible exposure limit (PEL).

A. The standard applies.

The standard is applicable. MAHLE's casting line produced lead emissions. And, there was no dispute that the lead zone in the casting department could expose an employee to

³² “[T]he employer must provide adequate shower and washing facilities, clean rooms for changing clothes, and filtered air lunchrooms for employees who have exposure above the PEL.” 43 Fed. Reg. 52952, 52994 (Nov. 14, 1978).

amounts of lead over the PEL³³. (JX-1, p. 48; CX-12). Because MAHLE had employees that worked in the lead zone, I find the standard applies.

B. *The employees had access to the cited condition.*

I find employees had access to the cited condition. Employee exposure is measured by an employee's access to the hazard. *See Phoenix*, 17 BNA OSHC at 1079. Two employees per casting line per shift worked within the lead zone. (Tr. 266). Employees in the casting department routinely worked in the lead zone and used the change rooms (locker rooms). Employee exposure is established.

C. *The Secretary did not prove the standard was violated.*

The Secretary did not prove that the standard's terms were violated. The sampling results the Secretary relies upon are not credible and the Secretary did not establish the maximum acceptable lead level for a clean change room.

The evidence shows that MAHLE provided a locker room (change room) for its employees that worked in the lead zone. While the specific configuration of the locker room is unknown, the evidence establishes that it had a "clean" side and a "dirty" side. (Tr. 71-72, 114, 269; CX-8, p. 12). As a part of his daily routine, an employee stored his street clothes in a clean locker and changed into his work clothing. At the end of the shift, he removed his contaminated work clothing and left it in a designated container on the dirty side for pick-up by the cleaning service. (Tr. 269).

The Secretary alleges that MAHLE's locker room was not "clean" and the CO stated that "clean change rooms should be free of lead contamination." (Sec. Br. 12; Tr. 71). This citation item is based on two wipe samples the CO collected from MAHLE's locker room on December 10, 2012.³⁴ The evidence offered by the Secretary to support the excessive lead concentrations in the change room is not sufficient. As discussed above, I find the SLTC report and the resulting calculations are not credible. (CX-3, CX-4, CX-5). Therefore, the lead sampling results offered by the Secretary cannot be used to show a violation of the cited standard.

³³ The permissible exposure limit (PEL) is lead at concentrations over 50 $\mu\text{g}/\text{m}^3$ averaged over an 8-hour period. *See* 29 C.F.R. § 1910.1025(c)(1).

³⁴ It is unclear from the evidence if the lockers sampled were those on the "clean" side or on the "dirty" side of MAHLE's locker room. The Secretary alleges that the sample from the handle of locker #20 showed a lead concentration of 1536 $\mu\text{g}/\text{ft}^2$ and that the sample from the handle of locker #34 showed a lead concentration of 918.4 $\mu\text{g}/\text{ft}^2$. (Tr. 55-56, 58, 73; CX-2, CX-3).

Additionally, the Secretary did not establish what the acceptable lead level for MAHLE's change room would be. The cited standard does not establish a maximum acceptable concentration of lead for the change room; it requires the employer to provide a "clean change room." When the standard was promulgated in 1978, OSHA explained this requirement as follows:

The standard reiterates specifications . . . pertaining to the type of change room an employer must provide. OSHA believes it is essential that employees have *separate storage areas for street and work clothing to prevent cross-contamination between the two*. This provision coupled with showering and the prohibition on wearing work clothing home *will minimize employee exposure to lead after the work shift ends* because it reduces the period in which work clothes coated with lead dust may be worn." (emphasis added).

43 Fed. Reg. 52952, 52995 (Nov. 14, 1978).

In 2003, OSHA provided additional guidance on the requirements for a "clean" change room through an interpretive letter:³⁵

In situations where employees are in direct contact with lead-contaminated surfaces, such as working surfaces or floors in change rooms, storage facilities and, of course, lunchroom and eating facilities, OSHA has stated that the Agency *would not expect surfaces to be any cleaner than the 200-ug/ft² HUD level*. As discussed above, for other surfaces such as rafters, *no specific level can be set to define how "clean is clean"* nor what level of lead contamination meets the definition of "practicable." The intent of this provision is to ensure that employers regularly clean and conduct housekeeping activities to prevent avoidable lead exposure, such as those potentially caused by re-entrained lead dust.³⁶ (emphasis added).

(Exh. C-32). This letter clearly states that "no specific level can be set" to define clean. Further, in its 1978 description of the rule, OSHA focused on whether a separate change area was provided to prevent the contamination of the employees' street clothes from the lead-contaminated work clothes, not the level of cleanliness of the change room. *See* 43 Fed. Reg. 52952, 52995 (Nov. 14, 1978).

I find that the Secretary has not demonstrated that MAHLE's designated clean change room did not meet the requirements of the cited standard. Thus, I find the Secretary did not prove the terms of this standard were violated.

³⁵ An agency's letter of interpretation is entitled to deference when it is reasonable and consistent with the language of the standard. *See Martin v. OSHRC (CF&I Steel)*, 499 U.S. 144, 151 (1991).

³⁶ OSHA's January 13, 2003 letter of interpretation addressed to Mr. Frank White can be accessed at https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=INTERPRETATIONS&p_id=25617.

D. The Secretary did not prove employer knowledge of the cited condition.

The Secretary must prove the employer either knew, or with the exercise of reasonable diligence, could have known of the violative condition. *Dun-Par*, 12 BNA OSHC at 1965. The Secretary asserts that MAHLE knew of excessive lead levels from Helix's 2012 facility-wide review and report and from the CO's discussion of ServiceMaster's poor cleaning methods with MAHLE management. (Tr. 140-41; Sec. Br. 9). However, the evidence does not show when Helix provided the report to MAHLE and thus cannot be used to establish knowledge. As with the citation item discussed above, the evidence does not show that the CO notified MAHLE about possible inadequate cleaning prior to the December inspection.

Thus, there is no evidence to show that any of MAHLE's supervisory personnel had actual knowledge of excessive lead contamination in its change room prior to the December inspection. Actual knowledge is not established.

The Secretary alleges if MAHLE had adequately supervised ServiceMaster, it could have known of inadequate cleaning and, therefore, a likelihood of excessive lead contamination. (Sec. Br. 8, 11). Constructive knowledge is established if the Secretary shows that, with reasonable diligence MAHLE would have known of the condition of high lead concentration in its change room. *See AUS*, 24 BNA OSHC at 1250; *Thomas*, 21 BNA OSHC 2287. An employer's conduct is evaluated in its totality and by "whether a reasonable employer would have done more." *Capform*, 16 BNA OSHC at 2042.

I find that MAHLE's actions were reasonable. As discussed above, MAHLE actively reviewed the cleaning reports to determine if ServiceMaster was following the cleaning schedule, it routinely addressed cleaning issues, and it used a quick-test stick which detected surface lead to verify cleaning. As a whole, the record shows that MAHLE's oversight of ServiceMaster was reasonable. The Secretary did not establish constructive knowledge.

The Secretary did not prove that the standard's terms were violated or that MAHLE had knowledge of the violative condition by a preponderance of the evidence. Citation 2, Item 1 is vacated.

VII. Citation 2, Item 2 – Repeat Violation of 29 C.F.R. § 1910.1025(j)(2)(i)(A)

MAHLE was cited for a repeat violation of 29 C.F.R. § 1910.1025(j)(2)(i)(A) which provides:

29 C.F.R. § 1910.1025 (j) (2) *Biological monitoring* -- (i) Blood lead and ZPP level sampling and analysis. The employer shall make available biological monitoring in the form of blood sampling and analysis for lead and zinc protoporphyrin levels to each employee covered under paragraph (j)(1)(i) of this section on the following schedule: (A) At least every 6 months to each employee covered under paragraph (j)(1)(i) of this section;

29 C.F.R. § 1910.1025 (j)(1)(i), which is incorporated by reference provides that “[t]he employer shall institute a medical surveillance program for all employees who are or may be exposed at or above the action level for more than 30 days per year.”

The Secretary alleges that MAHLE did not provide blood testing to its employees every 6 months as required by the standard. (Sec. Br. 14).

A. The standard applies.

The standard is applicable. Respondent does not dispute that employees working in the lead zone of the casting department were exposed above the action level more than 30 days per year. Casting department employees were assigned to the lead zone positions more than 30 days per year. (Tr. 273). Thus, the requirement to provide biological monitoring every 6 months for those employees applies.

B. The employees had access to the cited condition.

Employee exposure is measured by an employee’s access to the hazard. *See Phoenix*, 17 BNA OSHC at 1079. The casting line was a critical part of MAHLE’s production process and operated most of the year. Employees assigned to the casting line routinely worked within the lead zone. (Tr. 262-66, 270). Therefore, employees worked for more than 30 days per year in an area above the action level. Employee exposure is established.

C. The terms of the standard were not violated.

This standard requires blood sampling for lead and ZPP levels at least every 6 months for an employee that is, or may be, exposed more than 30 days per year at or above the action level. To determine which employees must be tested every 6 months, the Secretary must first establish

which employees were, or were expected to be, exposed at or above the action level more than 30 days in a year.³⁷

Here, the Secretary asserts that five employees ([Redacted], [Redacted], [Redacted], [Redacted], and [Redacted]) were exposed and not tested as required. (Sec. Br. 15-16). The Secretary selected these five employees in two ways. First, based on the CO's interviews certain employees were assumed to routinely work in the casting department. Second, the Secretary appears to have used MAHLE's lead and ZPP blood testing reports for the 2012 calendar year³⁸ to determine which employees had not been tested every 6 months (seemingly based on a name that appeared once on a report with no other reported result 6 months before or after that date). (Sec. Br. 16; CX-13). The Secretary provided no evidence of which MAHLE employees actually worked in the casting department for more than 30 days in a year or those employees eligible to fill-in for a casting department employee in that year. (Tr. 139).

1. [Redacted]

The allegation that [Redacted] was not adequately tested was based on a statement from the human resources director to the CO that [Redacted] was a supervisor in the casting department. (Tr. 83-84). The CO stated that he did not base exposure for [Redacted] on incidental exposure (i.e., popping his head into the lead zone); instead, he based it on [Redacted] working as a supervisor in the lead zone. (Tr. 137-138).

However, the plant manager explained that [Redacted]'s job duties as a supervisor do not require him to be in the lead zone, so testing was not required. (Tr. 265). Only two of the work positions on the casting line were in the lead zone. (Tr. 265-66). There is no evidence that [Redacted] worked in either of the two lead zone positions. Finally, in a signed affidavit, [Redacted] stated "[m]y job seldom requires me to be in the lead zone areas other than for short period [sic] of time to observe the operation; I do not recall how many times I would have been in the lead zone in 2012 but I do not believe it was over 30 instances." (RX-7).

I find that the evidence does not demonstrate that [Redacted] actually worked, or was anticipated to work, in the lead zone more than 30 days in a year; therefore, testing every 6 months was not required. The Secretary did not prove that the Respondent's testing for [Redacted] was not compliant with the cited standard.

³⁷ The record provides no information on when a year begins or ends for purposes of the cited standard.

³⁸ The blood testing results were in three separate reports -- one for the time frame 01/01/12 to 10/15/2012, the second for 11/14/12 to 11/16/12, and the third for 12/5/12 to 12/5/12. (CX-13)

2. [Redacted]

The allegation that [Redacted] was not adequately tested was based on the CO's interview with [Redacted] in which he told the CO he had not received any recent blood tests. (Tr. 134). However, the CO could not recall when he interviewed [Redacted].³⁹ (Tr. 137). The plant manager explained that [Redacted] had been on an extended leave-of-absence (6 month lay-off) during 2012, so [Redacted] was tested after he returned to work and the casting lines were restarted in December. (Tr. 274). The blood testing records confirm that [Redacted] received blood testing on December 5, 2012. (CX-13, p. 17).

I find the Secretary provided no evidence that [Redacted] had been working during a time in 2012 that was more than 6 months from his previous blood testing. Further, the evidence supports Respondent's assertion that [Redacted] was tested upon return from his leave-of-absence. The Secretary did not prove that the Respondent's testing for [Redacted] was not compliant with the cited standard.

3. [Redacted]

The Secretary alleges that [Redacted]⁴⁰ was not tested between January 2, 2012, and July 25, 2012. (Sec. Br. 16). The lab testing reports show that [Redacted] was tested on July 25, 2012, and again on December 5, 2012. (CX-13, p. 1,7).

The plant manager testified that when MAHLE anticipated a finishing department employee might be needed back on the casting side, that employee was tested. (Tr. 273-74). [Redacted] was assigned to the finishing department and only occasionally worked in the casting department when it was short-staffed.⁴¹ (Tr. 223, 225, 273). [Redacted] was unsure when, during 2012, he had worked in casting department's lead zone. (Tr. 232-33).

The Secretary did not provide information showing that [Redacted] worked in the lead zone more than 30 days in a year or that MAHLE anticipated he might work there for more than 30 days in a year's time. Therefore, the evidence is insufficient to show that [Redacted] was required to be tested between his January and July 2012 testing. The Secretary did not prove that the Respondent's testing for [Redacted] was not compliant with the cited standard.

³⁹ The notes from this interview are not in the record and the date of the interview is not in the record.

⁴⁰ [Redacted] was the sole MAHLE employee witness called by the Secretary.

⁴¹ [Redacted] testified, "I'm on the finished side and at times if there's a shortage of personnel or something, I may be required to go to the cast side even though I'm on the finished side now." (Tr. 255).

4. [Redacted]

OSHA identified [Redacted]'s testing as non-compliant based on the CO's general understanding that everyone listed on a blood testing report was assigned to the casting department. [Redacted] had not been specifically identified as a casting department employee. (Tr. 130-32). The Secretary alleged that more than 6 months elapsed between [Redacted]'s blood tests; records show he was tested on January 19, 2012, and then again on November 14, 2012. (Sec. Br. 16; CX-13, p. 4, 9).

[Redacted] confirmed that [Redacted] was assigned to the finishing department, not the casting department. (Tr. 226). [Redacted] did not know when or if [Redacted] had worked on the casting line in 2012. (Tr.226, 231). Again, the Secretary provided no evidence as to when [Redacted] worked, or was expected to work, in the casting department during 2012. Therefore, the evidence is insufficient to show that [Redacted] was not tested when he worked, or was expected to work, in the lead zone more than 30 days in a year. In other words, because [Redacted] was assigned to the finishing department it is unknown when or if MAHLE anticipated he would fill-in at the casting department's lead zone during 2012. The Secretary did not prove that the Respondent's testing for [Redacted] was not compliant with the cited standard.

5. [Redacted]

The Secretary alleges that [Redacted]'s blood testing was non-compliant because more than 6 months elapsed between tests. (Sec. Br. 16). The records show [Redacted] was tested on January 20, 2012, and then again on November 15, 2012, ten months later. (CX-13, p. 4, 9). Here again, it appears that [Redacted]'s selection as an exposed employee was based on the CO's general understanding that all employees on a blood testing report were assigned to work in the casting department. (Tr. 130-32). The record is silent on whether [Redacted] was assigned to the casting or finishing department.

[Redacted] testified that [Redacted] took a three-month leave of absence during 2012. (Tr. 232). Again, the Secretary provided no evidence as to whether [Redacted] ever worked, or was expected to work, in the lead zone for more than 30 days during a time when he had not been tested. The Secretary did not prove that Respondent's testing for [Redacted] was not compliant with the cited standard.

I find the Secretary has not shown that any MAHLE employee with actual or expected exposure above the action level more than 30 days had not been tested every 6 months as

required. To the contrary, the record evidence shows routine and regular testing of many MAHLE employees. (Exh. CX-13). The Secretary did not prove that MAHLE violated the terms of the standard.

D. The Secretary did not prove employer knowledge of the cited condition.

The Secretary alleged MAHLE knew of the standard's requirement because it had been cited for the same requirement in 2009. (Sec. Br. 17; CX-5, p. 25; CX-6). The Secretary must prove the employer either knew, or with the exercise of reasonable diligence, could have known of the violative condition. *Dun-Par*, 12 BNA OSHC at 1965.

The Secretary did not provide evidence that MAHLE knew that any of the five identified employees didn't have blood testing as required by the standard. To the contrary, MAHLE's plant manager testified that everyone that worked in the casting department or was expected to work there was tested every 6 months, even if they did not work in one of the lead-zone work positions. (Tr. 273-74). Further, MAHLE tested any finishing department employee that might potentially move over to fill-in on the casting line. (Tr. 273).

The Secretary did not prove that the standard's terms were violated or that MAHLE had knowledge of the alleged violative condition.⁴² Citation 2, Item 2 is vacated.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

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

⁴² In his post-hearing brief the Secretary alleged that "enormous" lead contamination in the MAHLE facility resulted in many MAHLE employees with blood lead levels above 30 µg/100 dL. (Sec. Br. 6). The Secretary did not cite MAHLE for a violation of any standard regarding employee blood levels. This allegation is not addressed.

ORDER

Based upon the foregoing findings of fact and conclusions of law, it is **ORDERED** that:

1. Citation 1, Item 1, alleging a Serious violation of 29 C.F.R. § 1910.1025(h)(1), is VACATED.
2. Citation 2, Item 1, alleging a Repeat violation of 29 C.F.R. § 1910.1025(i)(2)(i), is VACATED.
3. Citation 2, Item 2, alleging a Repeat violation of 29 C.F.R. § 1910.1025(j)(2), is VACATED.

/s/

Keith E. Bell
Judge, OSHRC

Dated: May 20, 2015
Washington, D.C.