

THIS CASE IS NOT A FINAL ORDER OF THE REVIEW COMMISSION AS IT IS PENDING COMMISSION REVIEW

**UNITED STATES OF AMERICA
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION**

SECRETARY OF LABOR,

Complainant,

v.

WYNNEWOOD REFINING CO., LLC

and its successors,

Respondent.

DOCKET NOS. 13-0644
13-0791

Appearances:

Joshua Bernstein, Esq., Mia Terrell, Esq., Office of the Solicitor, U.S. Dept. of Labor, Dallas, Texas
For Complainant

Nicole Smith, Esq., Nicholas Hankey, Esq., DLA Piper LLP (US), Washington, D.C.
Lee M. Smithyman, Esq., Smithyman & Zakoura, Overland Park, Kansas
Edmund S. Gross, Esq., CVR Energy, Inc., Kansas City, Kansas
For Respondent

Before: Administrative Law Judge Brian A. Duncan

DECISION AND ORDER

I. Procedural History

This matter is before the United States Occupational Safety and Health Review Commission (“Commission”) pursuant to Section 10(c) of the Occupational Safety and Health Act of 1970, 29 U.S.C. § 651 *et seq.* (“the Act”). On September 28, 2012, a boiler exploded during a turnaround at the Wynnewood Refinery in Wynnewood, Oklahoma, killing two employees. In response, the Occupational Safety and Health Administration (“OSHA”) initiated an inspection of the Wynnewood Refinery on September 29, 2012. (Tr. 1379; Ex. R-1). On

October 29, 2012, Complainant initiated a second, simultaneous inspection of the worksite in response to complaints about the conditions in the refinery warehouse. (Tr. 1381; Ex. R-19). As a result of the inspections, OSHA issued two separate *Citations and Notifications of Penalty* (“Citations”) to Respondent. (Ex. R-1, R-2). The Citation for Inspection No. 663538 alleges one other-than-serious, eleven serious, and five repeat violations of the Act, with a total proposed penalty of \$234,500.00. The Citation for Inspection No. 778042 alleges one repeat, one other-than-serious, and eleven serious violations of the Act, with a total proposed penalty of \$46,600.00.¹ Both Citations were issued on March 27, 2013. (Ex. R-1, R-2). Respondent timely contested the Citations. A trial was conducted in Oklahoma City, Oklahoma beginning on September 16–23, 2014 and concluding February 10–12, 2015. The parties each submitted post-trial briefs for consideration.

Twenty-one witnesses testified at trial: (1) John Koesler, operator for Respondent; (2) Greg Kellerhall, operator for Respondent; (3) Jeff Sutton, console technician (“CT”) for Respondent; (4) James Willson, former CT for Respondent; (5) Wesley Walker, CT for Respondent; (6) Justin Sutton, operator for Respondent; (7) Kyle McCurtain, shift supervisor for Respondent; (8) Mitch Underwood, unit supervisor for Respondent; (9) Troy Stephenson, unit supervisor for Respondent; (10) Paul Howard, DCS technician for Respondent; (11) James Johnstone, Complainant’s expert; (12) Casey Perkins, Assistant Director for OSHA’s Austin, Texas Area Office; (13) Richard Hartung, Compliance Safety and Health Officer (“CSHO”); (14) David Armstrong, warehouse technician for Respondent; (15) Marcus Rambo, CSHO; (16) Dick Jackson, Process Safety Management (“PSM”) Manager for Respondent; (17) Darin Rains, current VP/GM of Respondent’s Coffeyville refinery and former operations manager at

1. Inspection No. 663538 was assigned Docket No. 13-0791. Inspection No. 778042 was assigned Docket No. 13-0644. For ease of reference, however, the Court shall refer to the inspections as the PSM Inspection and the Warehouse Inspection, respectively.

Wynnewood; (18) Janet Barker, current Voluntary Protection Plan coordinator and former Assistant Area Director for Complainant; (19) James Stanley, Respondent's expert; (20) Steve Arendt, Respondent's expert; and (21) David Johnson, former safety specialist for Respondent.

II. Jurisdiction

The parties stipulated that the Commission has jurisdiction over this proceeding pursuant to Section 10(c) of the Act. (Tr. 51). The parties also stipulated that, at all times relevant to this proceeding, Respondent was an employer engaged in a business and industry affecting interstate commerce within the meaning of Sections 3(3) and 3(5) of the Act, 29 U.S.C. § 652(5). (Tr. 51). *See Slingsluff v. OSHRC*, 425 F.3d 861 (10th Cir. 2005).

III. Factual Background

This section constitutes an overview of the operations of the Wynnewood refinery; its history of ownership; the events that occurred on September 28, 2012; and the subsequent inspections. To the extent that certain findings of fact are not included in this Section III, any additional factual findings necessary to find (or not find) that a violation has been established will be found in Section IV.C.

A. The Wynnewood Refinery

The Wynnewood refinery is a 70,000 barrel-per-day (bpd) crude oil refinery, which produces gasoline, propane, propylene, butane, fuel oils, and solvents. (Tr. 802–803; Ex. C-5, C-16). The refinery is broken into separate zones, each of which performs a different function in the refining process. The citation items in Docket No. 13-0791 (Inspection No. 663538) focus on Zone 2. Zone 2 contains the Alkylation Unit, the Fluid Catalytic Cracking Unit (FCCU), and the Wickes boiler, which caused the explosion and prompted the inspections leading to this litigation. (Tr. 92–93). The citation items in Docket No. 13-0644 (Inspection No. 778042) focus

on alleged violations in the warehouse, as well as general safety items identified throughout the refinery.

The refinery is owned and operated by Wynnewood Refining Co., LLC, which, at the time of the 2012 explosion, was a subsidiary of CVR Energy, Inc. (CVR). (Tr. 1700). CVR acquired Wynnewood from a subsidiary of The Gary-Williams Energy Company, Inc. (GWE) in a stock purchase in December 2011. (Tr. 1700). According to the evidence, there was no prior connection or affiliation between CVR and GWE. (Tr. 1701). They are completely separate, unrelated companies.

B. History of Wynnewood's Ownership

i. Gary-Williams Energy

During Complainant's presentation of the evidence, the Court heard from a number of employees and supervisors that worked at the Wynnewood refinery prior to and after its purchase by CVR. The more notable examples include: (1) Dick Jackson, who served as the refinery's PSM manager starting in 2010; (2) Troy Stephenson, who became a roving shift supervisor in 2006 and was promoted to Zone 2 supervisor in 2012, after the purchase;² (3) Mitch Underwood, who served as the Alky Unit supervisor before and after the purchase, and (4) Darin Rains, who served as operations manager prior to and after the purchase, and is now the Vice President and General Manager of the Coffeyville refinery, which is also owned by CVR. (Tr. 571, 618, 1578, 1699–1700). With a few exceptions, such as Rains and Jackson, all of the individuals that testified worked in a particular unit of the refinery.

During GWE's tenure as the owner of Wynnewood, the refinery was inspected and cited for violations of the Process Safety Management (PSM) standard, which, as is relevant to this

2. Paul Howard was his predecessor. (Tr. 684). According to Stephenson, Howard continued to serve in an advisory capacity once Stephenson took over. (Tr. 672).

case, form the basis of the repeat violations alleged by Complainant. Those violations, as well as prior boiler explosions, including incidents involving the specific boiler at issue in this case, will be discussed in further detail in the succeeding sections of this Decision. *See* Section III.C, *infra*.

In 2006, there was a fire in the refinery's alkylation unit (Alky Unit), which prompted an inspection and the issuance of citations by Complainant. (Ex. C-27). In that case, Respondent conceded that the equipment involved in the Alky Unit fire "involve[d] the use of HHCs [highly hazardous chemicals] and/or flammables in amounts that [met] the threshold quantity for PSM coverage" *Resp't Br.* at 5. The parties executed a partial settlement agreement, which became a final order of the Commission around April of 2007.³ (Tr. C-28 at 11–12 n.1).

Around the same time that the partial settlement agreement became a final order of the Commission, Respondent's employees were attempting to manually light the H-4 boiler, which is located in the refinery's boiler house. (Ex. R-46 at 1–2). During the lighting process, there was an explosion in the H-4 boiler, which injured two employees. (*Id.*). The explosion prompted another OSHA inspection, which resulted in the issuance of two citation items, each alleging violations of the general duty clause. (Ex. R-45). Respondent points out that, notwithstanding the similarity between the explosion in April 2007 and the explosion of the boiler in this case, Complainant did not issue citations pursuant to the PSM standard in 2007. The matter was settled when Complainant agreed to withdraw one of the citation items. (Ex. R-47).

Shortly after the H-4 boiler explosion, Complainant initiated an inspection pursuant to the National Emphasis Program on PSM. (Tr. 2004–2006). The focus of this particular inspection was the Fluid Catalytic Cracking Unit ("FCCU"), which introduces catalysts into crude oil to

3. The remaining citation, which addressed a flare line running from the Alky Unit, was affirmed by Administrative Law Judge Covette Rooney as a final order of the Commission on September 8, 2008. (Ex. C-28).

“strip” the product and create high octane fuels.⁴ (Tr. 256–57). The inspection lasted until March 24, 2008, at which time Complainant issued multiple citation items, alleging violations of the PSM standard. (Ex. C-25). The parties executed a settlement agreement on September 15, 2008, which became a final order of the Commission on November 10, 2008. (Ex. C-26). Respondent points out that, notwithstanding the H-4 boiler explosion just months before, there was no apparent attempt to inspect the boilers pursuant to the PSM standard. (Tr. 2010–2012)

ii. CVR Energy (Respondent)

As noted above, CVR purchased Wynnewood from GWE in December of 2011. According to Darin Rains, this was done via stock purchase. (Tr. 1700). In contrast with the relatively scant evidence regarding GWE’s involvement at Wynnewood, Rains testified that the refinery “went through some pretty drastic changes as a result of the purchase by CVR Energy.” (Tr. 1701).

Some examples of the changes noted by Rains include access to previously unavailable capital, an increase in the number of safety and supervisory operations personnel, and the regular presence of CVR corporate management. (Tr. 1701–1703). The increase in capital led to improvements in equipment—CVR spent roughly \$130 million on improvements to the refinery in the Fall 2012 Turnaround. (Tr. 1706; Ex. C-16). Rains noted, though, that the most significant changes were in the personnel arena. (Tr. 1701). Once CVR purchased the refinery, Wynnewood “substantially increased the number of people working at the facility”, including two new safety technicians and four assistant operations supervisors, whose primary role was to focus on procedure development, training, management of change (MOC) compliance, and other issues touching on PSM and occupational safety. (Tr. 1702). In addition to changes at the

4. As will be discussed later in this Decision, the Wickes boiler, which is the subject of many of the citations at issue in this case, was a part of, or at least directly adjacent to, the FCCU. (Ex. C-7, C-11).

ground level, Rains also testified that members of CVR's corporate management, including the executive vice president for operations, Robert Haugen, and the vice president for safety, health, and environment, Chris Swanberg, made regular visits to the refinery. (Tr. 1703). There is no evidence to suggest that similarly situated GWE corporate managers were so involved.

This perception of wholesale change to the organization and management of Wynnewood was shared by a number of Respondent's employees and managers. For example, Stephenson noted, "[P]rior to CVR buying us, things were not as formal We did our best but since CVR has taken over, we've formalized everything and the expectations are a lot higher in regards to safety, MOCs, procedures. Things are a lot more strict and a lot more disciplined." (Tr. 674–75). These sentiments were echoed by Paul Howard and Dick Jackson, who stated, "The new company has raised the level of the safety programs since they've taken over, and their involvement in the safety program included process safety." (Tr. 749, 1612).

C. The Wickes Boiler

The explosion that killed two employees on September 28, 2012, originated at the Wickes boiler, which is part of the FCCU located in Zone 2. (Tr. 92–93; Ex. C-7, C-11). The Wickes, as described by many of Respondent's employees, "was by far the workhorse of the plant for steam." (Tr. 360). It is one of four boilers that provide steam to the 225-pound steam header, which, in turn, routes steam for use in various processes throughout the plant. (Tr. 2057–58; Ex. C-8 to C-13). Some of those processes include providing emergency steam to the riser, which clears it of HHCs; injecting steam into the FCCU process to drive high-end products out of the crude oil, also known as steam-stripping; purging low-lying gases in the firebox of the Alky Unit heater during start-up; powering turbines to pump product; and serving as a back-up to the electric pumps. (Tr. 162–63, 236–37).

The Wickes itself is fueled by two separate fuel streams within the refinery—the refinery fuel gas (RFG) system and a natural gas fuel line. (Tr. 134–40; Ex. C-10). The RFG system, which is the primary source of fuel for the Wickes, is a fuel recycling system of sorts. Various processes throughout the plant, such as the FCCU, refine crude oil to a saleable product. As a result of these processes, a certain amount of non-condensable flammable gas remains. (Tr. 138). Though this gas cannot be converted into a saleable product, the refinery still uses it to fuel various processes throughout the plant. (Tr. 139). These “off-gases” that are produced throughout the plant are directed via pipeline to a fuel drum, where the refinery fuel gas is treated. (Tr. 1602–1603). The resulting gas mixture is then piped out of the drum into a 4.1-mile pipeline network that leads to different processes throughout the refinery, including the Wickes. (Tr. 1710–11). Such is the process for normal operations; however, in some instances, such as during a turnaround, the Wickes can be powered by natural gas alone. (Tr. 134–35).

In order to start the Wickes boiler, Respondent had to go through a fairly detailed process, which involved no fewer than three employees. (Tr. 98). The first step requires the CT to purge HHCs from the boiler’s firebox for 30 minutes by blowing air into it. (Tr. 111, 421; Ex. C-34). Once the firebox has been adequately purged, the pilot light has to be lit. (Tr. 335). After the pilot is lit, an operator is directed to open the fuel gas bypass valve, which introduces the RFG mixture into the firebox. (Tr. 335). Each operator that testified gave a slightly different description as to how this part of the process is carried out. Koesler, for example, stated that he was told to turn the bypass valve “one-quarter of a spoke” and to leave it open for 5–10 seconds, though he admitted there was not a set amount of time to keep the valve open. (Tr. 113, 116–17). McCurtain testified that he was trained to open the valve “slightly” or “just a little bit” and to close the valve if he did not achieve ignition “quickly” or “shortly”. (Tr. 518, 528). During this

process, another operator positions himself at the sight glass, which allows him to determine whether there has been a successful ignition.⁵ Once ignition is achieved, control over fuel management is handed over to the CT in the control room. (Tr. 335).

With the exception of a shutdown because of a turnaround or annual boiler inspection by the State of Oklahoma, the Wickes was operated constantly. (Tr. 376). As such, there were limited opportunities for operators and CTs to light the boiler.⁶ (Tr. 376). According to McCurtain, however, it was “not uncommon” for operators to experience a “hard start” when attempting to light the Wickes. (Tr. 516). A hard start is best characterized as a mini-explosion occurring within the firebox, typically a result of allowing too much fuel into the system. (Tr. 102–103). Koesler stated that, instead of lighting smooth, a hard start causes the boiler to “woof” or “huff” as a result of a sudden pressure increase within the firebox. (Tr. 104). In some cases, this merely caused the boiler to spew dust and smoke; in others, the structure of the boiler actually bowed outward as a result of the explosion. (Tr. 106–107, 213; Ex. C-31). In one instance, Willson, who was manning the sight glass, was actually struck by the boiler, which had bowed outward during a hard start. (Tr. 357–58; Ex. C-31).

D. The Turnaround

On September 28, 2012, Respondent was in the middle of a refinery turnaround.⁷ (Tr. 108–109). During the turnaround, the refinery was shut down and was not refining petroleum. Instead, Respondent hired multiple subcontractors to come to the refinery to repair, replace, or maintain various pieces of equipment throughout the refinery. (Tr. 1704–1706). According to

5. The Wickes boiler does not have a burner management system (BMS), which allows for remote ignition of the burner. (Tr. 100).

6. According to James Willson, who had worked at the refinery for seven years at the time of the accident said he had only lit the boiler 4 to 5 times during that period. (Tr. 376).

7. A turnaround is a period of time when the refinery shuts down temporarily to allow for improvement and maintenance projects. (Tr. 1704).

David Johnson, there could be as many as 1500 contractors working on a shift, which drastically increased the number of people present at the refinery. (Tr. 2104).

In order to facilitate repairs and maintenance, Respondent needed to produce steam to purge HHCs from various lines and equipment. (Tr. 369). This required starting up the Wickes boiler. Because the refinery was off-line and not producing fuel products, Respondent had to use natural gas to light the Wickes. (Tr. 346). According to Willson, the Wickes had been taken off-line earlier that day to make a switch of the electrical supply circuits. (Tr. 347). Due to power supply problems, the crew implemented a temporary solution by running an extension cord to a small generator, which powered the controls and interlocks of the Wickes. (Tr. 347). According to Jeff Sutton, the previous CT reported that the temporary power supply was causing the vanes, which control air flow, to malfunction. (Tr. 278–79). Eventually the problem was fixed, and Sutton began to increase the airflow to purge the Wickes firebox of any remaining HHCs. (Tr. 279).

At the conclusion of the purge, which lasted about five minutes, Sutton reduced the airflow to 15,000 cubic feet per minute (cfm) to light the pilot. (Tr. 281). While Sutton was working in the control room, Lead Operators Koesler and Willson; “A” Operators Russell Mann, Billy Smith, and Justin Sutton; and “B” Operator Steve Graves were located at or around the boiler. (Ex. R-110 at 4). Lead Operators Koesler and Willson were located at the northwest corner of the Wickes and were overseeing the lighting attempt. (Tr. 98). Mann was positioned at the fuel bypass valve, and Smith was positioned at the sight glass to verify ignition. (Ex. R-110 at 4). Justin Sutton and Graves did not have specific responsibilities related to the lighting process.

After the firebox had been purged, Mann opened the fuel gas bypass valve to introduce natural gas into the firebox. (Tr. 112). At some point in the process, Koesler instructed Mann to close the valve because they had not achieved ignition. (Tr. 126). Mann did not comply with this instruction. (Tr. 191). When Koesler confronted him, Mann informed Koesler that he was taking instructions from Willson, who was standing nearby. (Tr. 191). After a brief interaction between Willson and Koesler, Koesler moved to the north side of the boiler to check water levels. (Tr. 125). Willson continued to oversee Mann, who kept the bypass valve open.

As fuel was being introduced into the firebox, the other CT in the control room, Wesley Walker, looked at Sutton's console and noticed that the firebox was flooded with too much natural gas. (Tr. 401–402). Walker immediately radioed the operators to inform them that they should close the bypass valve. (Tr. 402). Shortly after Mann closed the valve, the boiler exploded. Smith, who was manning the sight glass, was pronounced dead at the scene, and Mann, who was critically injured in the explosion, died twenty-eight days later. (R-110).

Subsequent investigations by Respondent revealed shrapnel in the area surrounding the Wickes, and a ladder, which was attached to the west end of the boiler, that had been blown completely across the street. Additionally, investigators found that the valve was opened approximately one-and-a-half spokes and that fuel had been flowing into the firebox for approximately 5 minutes. (Ex. R-110 at 8). Many of the operators and CTs involved in the lighting were disciplined, and one of the Lead Operators, Willson, was discharged. (Tr. 95, 369; Ex. C-89).

IV. Discussion

Prior to answering the question of whether any particular standard was violated, the Court must resolve two important issues. First, the Court must determine whether the PSM standards

cited by Complainant apply to the Wickes boiler. Respondent contends that, by including the boiler within the ambit of the PSM standard, Complainant has improperly expanded the scope of the standard beyond its intended purpose, which is to “prevent[] or minimiz[e] the consequences of catastrophic releases of toxic, reactive, flammable, or explosive chemicals”. 29 C.F.R. § 1910.119. Consistent with that assertion, Respondent argues that although the boiler is physically connected to a PSM-covered process, the boiler itself is not subject to the PSM standards because it cannot contribute to, cause, or interfere in the mitigation of a catastrophic release of HHCs. *See Delek Refining Co., Ltd.*, 25 BNA OSHC 1365 (No. 08-1386, 2015). In response, Complainant has asserted multiple theories of coverage to suggest that the boiler would have just such an impact.

Second, the Court shall also address the issue of successor liability in the context of the repeat violations issued to Respondent. As previously discussed, Wynnewood Refinery changed ownership in 2011. The purchase occurred after the underlying citations were issued but before the issuance of the citations that are currently under discussion. Complainant submits that the citations were properly characterized as repeat and bases that conclusion on the substantial continuity test for successor liability, which was adopted by the Commission in *Sharon & Walter*, 23 BNA OSHC 1286 (No. 00-1402, 2010). Respondent, on the other hand, contends that the changeover in ownership resulted in changes in management practices, procedures, and culture significant enough to break the chain of liability stemming from GWE’s previous actions.

Ultimately, based on what follows, the Court finds that the PSM standards did apply to the Wickes boiler. Complainant’s application of the standard under this set of facts comports with its plain language and is consistent with its historical interpretation of the standard. The Court also finds, however, that Complainant failed to show the requisite nexus between

Wynnewood under the ownership of GWE and Wynnewood under the ownership of CVR such that liability for repeat violations survived the transfer of ownership.

A. PSM Coverage

i. The Standard – 29 C.F.R. § 1910.119

The stated purpose of the PSM standard is to “prevent[] or minimiz[e] the consequences of catastrophic releases of toxic, reactive, flammable, or explosive chemicals.” 29 C.F.R. § 1910.119. A catastrophic release, according to the standard, is “a major uncontrolled emission, fire, or explosion, involving one or more highly hazardous chemicals, that presents serious danger to employees in the workplace.” *Id.* § 1910.119(b). The standard sets a threshold quantity for various hazardous chemicals—that threshold quantity (TQ) represents the point at which a particular chemical is considered capable of producing a catastrophic release. *See id.* § 1910.119(a)(1). In this case, the operative question is whether the Wickes boiler is a part of a “process which involves a Category 1 flammable gas (as defined in 1910.1200(c)) or a flammable liquid with a flashpoint below 100 °F (37.8 °C) on site in one location, in a quantity of 10,000 pounds (4535.9 kg) or more” such that the standard applies.⁸ *Id.* § 1910.119(a)(1)(ii). Such a determination would establish a *prima facie* case for coverage; however, the Court must also decide whether the exception for HHCs “used solely for workplace consumption of fuel” applies. *See id.* § 1910.119(a)(1)(ii)(A).

As the title implies, the focus of this standard are *processes* involving highly hazardous chemicals. Insofar as a process involves a threshold quantity of HHCs, it is covered, subject to certain exceptions. A process, according to the standard, is:

[A]ny activity involving a highly hazardous chemical including any use, storage, manufacturing, handling, or the on-site movement of such chemicals, or combination of these activities. For purposes of this definition, any group of

8. For all other chemicals, one must refer to Appendix A of 29 C.F.R. § 1910.119.

vessels which are interconnected and separate vessels which are located such that a highly hazardous chemical could be involved in a potential release shall be considered a single process.

Id. § 1910.119(b). This definition indicates (1) the basic understanding of a “process” and (2) the potential boundaries for that process. This was explained in more detail in the preamble to the standard, which states:

The term “process” when used in conjunction with the application statement of the standard establishes the intent of the standard. The intent of the standard is to cover a “process” where the use, storage, manufacturing, handling or the on-site movement of a highly hazardous chemical exceeds the threshold quantity at any time. The boundaries of a “process” would extend to quantities in storage, use, manufacturing, handling or on-site movement which are interconnected and would include separate vessels located such that there is a reasonable probability that an event such as an explosion would affect interconnected and nearby unconnected vessels which contain quantities of the chemical that when added together would exceed the threshold quantity and provide a potential for a catastrophic release. In order to clarify this intent, a new sentence has been added to clarify the fact that interconnected and nearby vessels containing a highly hazardous chemical would be considered part of a single process and the quantities of the chemical would be aggregated to determine if the threshold quantity of the chemical is exceeded.

Process Safety Management of Highly Hazardous Chemicals, 57 Fed. Reg. 6356, 6372 (Feb. 24, 1992).

ii. Complainant’s Theories of PSM-Coverage

Complainant asserts multiple bases upon which the Wickes boiler should be considered a PSM-covered process. Specifically, Complainant asserts that (1) the Wickes is interconnected to a covered process through the refinery fuel gas system and steam header; (2) the Wickes is located such that a HHC could be involved in a potential release involving other PSM-covered equipment; (3) the exception for workplace fuel consumption does not apply; and (4) Respondent treated the Wickes in its own internal documentation as a PSM-covered process. In response, Respondent contends that (1) Complainant’s interpretation of the standard improperly expands the scope of what is considered a “process”; (2) the Wickes is not sufficiently close to

PSM-covered equipment such that it could be involved in a potential release; (3) the workplace fuel exception clearly applies; and (4) the fact that it applied PSM-related practices to the Wickes is only reflective of “best practices” and not an admission of coverage.

1. Interconnection

The Wickes boiler, viewed in isolation, is not a PSM-covered process. There is no single point in time where it processes, uses, or holds a threshold quantity of HHC. Thus, the determination of whether it is covered necessarily depends on its connection or location relative to other covered processes. The dispute over interconnection stems from the second sentence of the definition of the term “process”, which states that “*any* group of vessels which are interconnected and separate vessels which are located such that a highly hazardous chemical could be involved in a potential release shall be considered a single process.” 29 C.F.R. § 1910.119(b) (emphasis added). Complainant asserts that the definition establishes two separate bases upon which coverage can be established: (1) interconnected vessels; and (2) separate vessels located such that a HHC could be involved in a potential release. Respondent contends, however, that the modifier “such that a highly hazardous chemical could be involved in a potential release” is applicable to both separate and interconnected vessels, thereby grafting an additional burden of proof for establishing PSM coverage under a theory of interconnection. The Court disagrees.

This dispute stems from what is known as the Motiva Response, which was a formal interpretation issued by Complainant in response to *Motiva Enterprises., LLC*, 21 BNA OSHC 1696 (No. 02-2160, 2006). (Ex. C-3). *See also* Interpretation of OSHA’s Standard for Process Safety Management of Highly Hazardous Chemicals, 72 Fed. Reg. 31453 (June 7, 2007). In *Motiva*, the Commission grappled with what it believed to be an undefined term within the PSM

standard's TQ requirements for flammables; namely, what constituted "on site in one location". *Motiva*, 21 BNA OSHC 1696. Due to the lack of clarity within the application paragraph, and less than convincing evidence, the Commission vacated the citation and placed the onus on the OSHA to offer an "authoritative interpretation" that would be reviewed in future cases under "standard deference principles." *Id.* at *4.

In response, OSHA issued a formal interpretive document in the Federal Register. First, OSHA agreed that the language "on site in one location" in the application paragraph has considerable overlap with the definition of process. (Ex. C-3 at 1524). This was due, in part, to the fact that the definition of "process" was revised in the final rule to clarify that a single process includes both interconnected and co-located vessels, depending on proximity. (*Id.*). Due to this change, OSHA noted that "the limitation placed on application of the standard to flammable liquids and gases denoted by the related phrase 'on site in one location' no longer carries the independent weight it had before OSHA clarified the intended meaning of 'process.'" (*Id.*). However, its import was not entirely diminished, as "it continues to serve a separate purpose by operating to exclude coverage where the HHC threshold would only be met only if all amounts in interconnected or co-located vessels were aggregated but some of the amounts needed to meet the threshold quantity are outside the perimeter of the employer's facility."

Second, and more pertinent to this case, OSHA clarified the burden of proof relative to interconnected versus co-located processes by stating that the PSM standard "presumes that all aspects of a physically connected process can be expected to participate in a catastrophic release." (*Id.*). With respect to co-located processes, however, OSHA must prove that they are located such that a hazardous chemical could be involved in a potential release. (*Id.*).

Respondent takes issue with this formulation because it believes that such an interpretation is “in direct contradiction” with the plain terms of the standard. *Resp’t Br.* at 27.

Respondent’s primary argument in this regard is that “[t]he absence of punctuation between the term “interconnected” and “separate” establishes that the requirement that an HHC could potentially be involved in a release applies to both interconnected and co-located equipment.” First, it is not clear what sort of punctuation Respondent is referring to. Second, the basic structure of the sentence belies Respondent’s argument regarding plain meaning. The sentence describes two configurations on either side of the conjunction “and” and concludes that either configuration constitutes a “process” for the purposes of the PSM standard. The first configuration is “any group of vessels which are interconnected”. The second configuration is “separate vessels which are located such that a highly hazardous chemical could be involved in a potential release.” In both cases, the noun is described through the use of a dependent clause, indicated by the term “which”. In other words, there is a basic, parallel structure on either side of the “and”, which can be diagrammed as follows: “For the purposes of this definition, [A’s] which are [x] and [B’s] which are [y] shall be considered [C].” *See* 29 C.F.R. § 1910.119(b). When analyzed in this way, the Court finds that Complainant’s interpretation, as expressed through the *Motiva* response, comports with the plain meaning of the definition.

Let us assume, however, that Respondent is correct to the extent that the definition of process is ambiguous. If a determination cannot be reached based on the text and structure of the regulation, courts then turn to “contemporaneous legislative histories of that text.” *Unarco Comm. Prods.*, 16 BNA OSHC 1499 (No. 89-1555, 1993). On such contemporaneous legislative history is the preamble to the final rule. *See generally* 57 Fed. Reg. at 6356; *see also* 72 Fed. Reg. 31453. The preamble provides a clear distinction between interconnected and separate

vessels: “The boundaries of a ‘process’ would extend to quantities in storage, use, manufacturing, handling or on-site movement which are interconnected and would include separate vessels located such that there is a reasonable probability that an event such as an explosion would affect interconnected and nearby unconnected vessels which contain quantities of the chemical that when added together would exceed the threshold quantity and provide a potential for a catastrophic release.” 57 Fed. Reg. at 6372. This discussion, which provides contour to the definition of process, makes clear that the term “process” *extends* to interconnected vessels and *includes* separate vessels, insofar as such vessels could reasonably be expected to participate in a catastrophic release. Given this explanation, the Court still finds that the standard presumes the potential for a catastrophic release when vessels are physically connected.

Finally, even if the preamble is somehow considered deficient in its clarification, the Court finds that the interpretation espoused by Complainant is both reasonable and consistent with its longstanding interpretation of the issue. *See Simpson, Gumpertz & Heger, Inc.*, 15 BNA OSHC 1851 (No. 89-1300, 1992) (“The weight of such [an interpretation] in a particular case will depend on the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade, if lacking the power to control.”) (citing *General Elec. Co. v. Gilbert*, 429 U.S. 125, 142 (1976) (quoting *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944))). There is nothing patently unusual or unreasonable about considering vessels that are physically connected by pipeline to be part of the same process, nor is it unreasonable to presume that vessels connected in such a way could be involved in a potential release of HHCs. This has been Complainant’s interpretation of the standard since its inception. (Ex. C-4). Accordingly, the Court finds that

Complainant's interpretation of the standard is reasonable and, therefore, entitled to deference. *See Martin v. OSHRC (CF&I Steel)*, 499 U.S. 144, 145–46 (1991) (Secretary's interpretation of a standard, even when embodied in a citation, is entitled to deference so long as it is reasonable).

According to the P&IDs involving the Wickes boiler, it is physically interconnected to otherwise-covered PSM processes in two ways. First, the Wickes boiler is connected to both the Alky Unit and the FCCU through the RFG pipeline. (Tr. 655, 911). It is undisputed that the Alky and the FCCU are PSM-covered processes by virtue of the quantity of flammables contained in each.⁹ (Ex. C-5). Second, the Wickes is connected to virtually all of the refinery's processes through the 225-lb. steam header. (Ex. C-7). As such, Complainant has, at the very least, established a *prima facie* case for PSM coverage, because interconnected processes are presumed to have the potential to participate in a catastrophic release. However, such a presumption could be rebutted by a showing that the interconnected processes at issue could not participate in or contribute to a catastrophic release.

Perhaps anticipating the potential failure of its argument regarding the presumption associated with interconnected processes, Respondent also argues that the Wickes should not be considered interconnected to a covered process under the terms of the standard. First, Respondent suggests that the Wickes is not a "vessel" because it does not store or contain any measureable quantity of HHC. Second, Respondent argues that the concept of interconnection, as espoused by Complainant, does not merely equate to a physical connection between equipment; rather:

[T]he concept of interconnectivity is merely intended to address a situation in which connected vessels within a single process that contain quantities of HHC, such as flammable gas storage tanks, will be deemed to satisfy the threshold requirement even though the amount of flammables in each individual vessel is

9. According to the RMP that Respondent submitted to the EPA, the Alky Unit stores and/or processes 100,000 pounds of flammable liquid; the FCCU stores and/or processes 50,000 pounds. (Ex. C-5).

less than 10,000 pounds. This theory does not operate to extend coverage to any structure, regardless of its form or contents, that is physically connected to a PSM-covered process.

Resp't Br. at 29 (internal citations omitted). The Court disagrees.

The Commission dealt with a similar attempt to narrow the scope of the standard in *Delek Refining Co., Ltd.*, 25 BNA OSHC 1365 (No. 08-1386, 2015).¹⁰ In that case, OSHA alleged that the employer violated a portion of the PSM standard by failing to inspect and test its positive pressurization unit (PPU) in the control room of its own FCCU. *Delek*, 25 BNA OSHC 1365 at *6. The PPU was designed to pressurize the control room to prevent hazardous vapors, which are a byproduct of the FCC process, from entering the control room and poisoning the employees inside or causing an explosion hazard due to the presence of wiring, which could serve as an ignition source. *Id.* Delek contended that the PPU was not “process” equipment, because it was not directly involved (physically connected) in the process of converting crude oil to usable fuel.

Although the specific subsection of the PSM standard at issue in that decision was different, the Commission still had to address the question of what constitutes the boundaries of a process. The Commission made it clear that the focus of the standard—the process—was not as narrow as suggested by Respondent. According to the Commission:

[T]he PSM standard does not require that every part of a ‘process’ come into contact with hazardous materials. 29 C.F.R. § 1910.119(b) (defining ‘process’ as ‘any activity *involving* a highly hazardous chemical’) (emphasis added). Here viewing the ‘activity’ involving the FCC unit in its entirety, the PPU is part of a ‘process’ covered by the PSM standard because it is an integral part of the ‘manufacturing, handling [and] onsite movement of [highly hazardous chemicals].’”

Delek, 25 BNA OSHC 1365 at *7. Citing favorably to an OSHA Interpretation Letter from Richard Fairfax to Howard J. Feldman, the Commission noted that machinery not containing

10. *Delek* is currently on review to the Fifth Circuit Court of Appeals. Nonetheless, it still serves as precedent for the Court in this case.

HHCs can nonetheless be a part of a process insofar as such machinery is used to control, prevent, or mitigate catastrophic releases. *Id.* at *8–9.

The Court finds that Respondent places undue emphasis on individual terms such as “vessel” and “interconnected” at the expense of the focus of the standard as a whole—the process. As noted by the Commission, the definition of “process” is broad—it is *any* activity *involving* a HHC, including *any* use, storage, manufacturing, handling, or on-site movement. *See* 29 C.F.R. § 1910.119 (emphasis added). So broad, in fact, that the Commission held that the PPU in Delek’s FCC control room, although not a vessel, was part of the FCC process because it could affect or cause a release. *Id.*

In this case, the connection between the Wickes and the FCCU is more concrete: the off-gases produced by the FCCU are directed via pipeline to a fuel drum, which mixes the off-gases treats them, and directs the resulting product to the Wickes. (Tr. 857, 918). The Wickes is clearly an activity that *involves* a HHC, because it *uses* the treated off-gases from various processes around the refinery. It is, in fact, a downstream endpoint of the RFG process. (Tr. 838). During normal operations,¹¹ there are multiple processes that feed the RFG system, including the FCCU and the Alky Unit. (Tr. 920, 1098). These processes, with the exception of a turnaround, are basically running all the time. (Tr. 1706). As the Court observed during the trial, the bypass valve that controls the flow of RFG can apparently be left open indefinitely without an alarm—it was not until CT Walker happened to look over the shoulder of CT Sutton and noticed a large amount of fuel in the firebox that the order was given to shut it down.¹² (Tr. 293, 402). Further,

11. The Court would like to make a brief note regarding the distinction between normal operations and turnaround operations. During normal operations, the system is fueled by a combination of refinery fuel gas and natural gas, whereas during a turnaround, the Wickes is run by natural gas because there are no other processes running to produce the RFG. While this might call into question whether the Wickes is covered during the period of a turnaround, the Court cites favorably to Respondent’s expert, Steve Arendt, who stated that the determination of whether a process is covered does not depend on whether it is in operation or in turnaround status. (Tr. 2095).

12. In fact, Complainant has interpreted the term interconnected such that even energy-isolating devices, such as

the Wickes, which all witnesses testified is almost always running, requires a constant stream of fuel. Thus, even if the Court accepts Respondent's assessment of the RFG pipeline's capacity, which it determined to be 860 pounds of fuel, that assessment disregards the source of the fuel, such as the FCCU and the Alky, which feed the RFG system and are directly connected to the Wickes.¹³ (Tr. 1598; R-124). The Court cannot find any basis in the regulatory history or the language of the standard itself that would suggest such an arbitrary determination of what is interconnected. Accordingly, the Court finds that the Wickes was interconnected to a covered process, and, as such, should be considered a single process. *See* 29 C.F.R. § 1910.119(b).

Respondent further contends that even if the foregoing is true, the Wickes should still be exempt from coverage. According to section 1910.119(a)(1)(ii)(A), the following are exempted from PSM coverage: "Hydrocarbon fuels used solely for workplace consumption as a fuel (e.g., propane used for comfort heating, gasoline for vehicle refueling), if such fuels are not a part of a process containing another highly hazardous chemical covered by the standard." *Id.* § 1910.119(a)(1)(ii)(A). The intended scope of this rule was described in the preamble to the standard, wherein the American Petroleum Institute noted that

OSHA's intention in providing exemption (b)(1)(ii)(A) was to exclude the enormous number of small business locations across the nation which would not be covered by the proposed rule, except for their on-site storage of hydrocarbon fuels for low-risk applications such as heating, drying, and the like. Such activities are not the subject of this rule, and this exclusion is entirely appropriate.

On the other hand, interpreting this exclusion to apply to hydrocarbon fuels used for process-related applications such as furnaces, process heaters, and the like at facilities covered by the rule was not intended.

57 Fed. Reg. 6356, 6367. At the very outset, this exception had a very limited scope: small businesses that used on-site hydrocarbon fuels "for *low-risk* applications such as heating, drying,

blocks, are not sufficient in and of themselves to break the connection between two physically connected processes. (Ex. C-4 at 1530).

13. This also highlights the problematic nature of Respondent's definition of interconnection, as it imposes artificial boundaries that do not comport with the plain reading of the definition of process.

and the like.” *Id.* (emphasis added). The exception was not, however, intended to cover process-related applications such as process heaters and furnaces. *Id.* It is significant that this was recognized by API, which promulgates consensus standards covering the petroleum industry. *See, e.g.*, 72 Fed. Reg. 31453, 31454 (citing API 750 as basis for definition of “process”). Thus, the issue is, again, one of degree: Is the Wickes, as compared to process heaters and furnaces, which are explicitly not covered under the exception, properly considered a part of a process involving another highly hazardous chemical covered by the standard?¹⁴ Respondent contends that furnaces and heaters are more directly linked to a process than a boiler, because furnaces and heaters typically apply heat directly to a product, whereas a boiler merely supplies steam to a header, which directs that steam to various processes around the refinery.

The Court is not convinced by the furnace versus boiler distinction urged by Respondent, nor is it convinced that the workplace fuel exception applies. Though the preamble mentions furnaces and process heaters as specific process-related applications, the list is not exhaustive, but exemplary. *See* 57 Fed. Reg. 6356, 6367 (exception does not cover “furnaces, process heaters, *and the like*”) (emphasis added). To the extent that process heaters, furnaces, “and the like” are the examples of what is not covered by the exception, and considering Respondent’s argument that there is a qualitative difference between the manner in which a furnace is connected to a process, as opposed to a boiler, the Court will address the manner in which the Wickes is connected to other PSM-covered processes and determine whether that connection is sufficient to establish PSM coverage.

14. Complainant addressed a similar situation to the one presented here through a letter of interpretation. (Ex. C-4 at 1542). In that letter, Complainant was asked whether the use of coke oven and blast furnace gases—which are generated as a by-product during steel industry processes—as fuel for other steel mill processes would be covered by the PSM standard. (*Id.*). In response, Complainant stated that the workplace fuels exception would apply insofar as the by-product gases are not used in a process involving another highly hazardous chemical covered by the standard. (*Id.*). Although it discussed the potential coverage of a by-product recovery plant, the interpretation did not clarify the extent to which a particular fuel use is considered to be “part of a process involving another highly hazardous chemical covered by the standard.”

While the Wickes is the downstream endpoint for the RFG system, it is also a starting point for many other process-related applications. The Wickes' core function is to produce steam. That steam is used in multiple process-related applications throughout the refinery. For example: (1) When the FCC emergency shut down (ESD) system is activated, steam is directed to the riser, where it knocks down gases to prevent further catalyzing of crude oil; (2) Steam is used as a catalyst in certain reactions, driving high-end products from crude oil, also known as steam-stripping; (3) In normal operations and emergencies, steam was used as a primary source to drive turbines that pumped product and as a back-up to electric pumps; (4) In the Alky, steam is used to snuff out low-lying gases and purge fugitive HHCs from the heater prior to lighting it (in much the same way that air is used to snuff gases in the Wickes); (5) Steam is used as a heat medium in an exchanger, which transfers heat to a process; and (6) Steam hoses are used to put out small fires on a process pipe. (Tr. 162–63, 236, 239, 1716–17; Ex. C-8). On the face of it, all of these applications are a process-related to some degree. Nonetheless, Respondent contends that the steam producing system is a mere utility and that it has specifically determined that “the boiler could not cause or interfere in mitigating the consequences of a catastrophic release.” *Resp’t Br.* at 31 (citing Ex. R-84).

Respondent, much like the employer in *Delek*, urges a narrow view of the concept of process-relatedness. In *Delek*, the employer cited an OSHA Interpretation Letter, which contained language stating that “[t]he boundaries of the covered process are based on the equipment which contain [highly hazardous chemicals].” *Delek*, 25 BNA OSHC 1365 at *7.

The Commission disagreed with such a narrow reading, focusing on the following language:

OSHA does not agree that utility systems are categorically outside the scope and application of the PSM standard. It is OSHA’s long-standing position that utility systems *are* part of the PSM-covered process when employers use them to control/prevent and mitigate catastrophic releases

* * *

[T]he proper safe functioning of all aspects of a process, whether they contain [highly hazardous chemicals] or not, are important for the prevention and mitigation of catastrophic releases of [highly hazardous chemicals], due to their direct involvement in the overall functioning of the process.

As a result, it is OSHA's position that if an employer determines that a utility system or any aspect or part of a process which does not contain a [highly hazardous chemical] but can affect or cause a release . . . then, relevant elements of PSM could apply to these aspects. OSHA's position is that any engineering control, including utility systems, which meets the above criteria must be . . . inspected/tested/maintained per OSHA PSM requirements.

Id. at *8–9. Here, Respondent cites the same letter, in addition to another interpretive document, for the essentially the same proposition. (Ex. R-83, R-84).

Specifically, Respondent contends that, notwithstanding the numerous ways in which the Wickes is connected to various covered processes, it has analyzed those connections and specifically determined that the failure of the Wickes would not “cause a HHC release or interfere with the consequences of a HHC release” (Ex. R-84). Like the employer in *Delek*, Respondent places significant emphasis on the “if an employer determines” language to argue that the determination of the boundaries of a PSM-covered process “is the responsibility of the employer, not Complainant.” *Resp't Br.* at 30. While there is no doubt that the PSM standard is a performance standard, which allows an employer some discretion as to how a particular hazard should be addressed, “there is no indication in the language of the PSM standard or its regulatory history that OSHA meant to give to employers, at their sole discretion, the option of excluding equipment from the standard's coverage.” *Delek*, 25 BNA OSHC 1365 at *9. Thus, the interpretive letter states that if an employer makes a determination that a component failure in the utility system cannot affect, cause, or interfere in the mitigation of a potential release, the employer must be able to proactively demonstrate why the utility system is no longer a part of a covered process. (Ex. R-83). In other words, the determination must be reasonable. *See, e.g.,*

Siemens Energy & Automation, Inc., 20 BNA OSHC 2196 at *1 (No. 00-1052, 2005) (performance standard give a “certain degree” of discretion but meaning of standard interpreted in light of what is reasonable).

Respondent argues that it conducted the analysis of the Wickes as described above and concluded that the boiler could not cause or interfere in mitigating the consequences of a catastrophic release. Specifically, Respondent points to the testimony of Jackson, the PSM Manager, who states that he considered the failure of the Wickes and other aspects of the 225-pound steam system as part of his analysis of a loss of heat to a covered process. (Tr. 1606–1610). Jackson and Rains concluded that a failure of the Wickes would not have such an effect because the other boilers that sourced the steam system could produce sufficient steam to continue operations at the refinery and that any temporary effects would only impact product quality. (Tr. 1671–72, 1718–1725). Respondent’s expert testified similarly. (Tr. 2066–2067).

This determination, Respondent contends, was reinforced by the record evidence, including: (1) the Wickes was taken offline once per year for an annual inspection; (2) the refinery had redundancies in place such that only two of the four utility boilers were needed to contribute steam to the header. (Tr. 1719–1720). Further, Respondent also argues that the snuffing steam system, as used in the Alky heater firebox, was only for small fires and that no evidence was presented to show that such a fire could cause a catastrophic release of HHC.

The Court has a different perspective on the record evidence, as well as the sufficiency of Respondent’s determinations regarding the impact of a loss of steam on PSM-covered processes. First, the PHA/Hazop analysis performed by Jackson was, according to his testimony, focused on the impact of too little or too much heat being supplied by the Wickes and how that could cause a loss of containment. (Tr. 1606–1607). In response to a question regarding whether he was

confident that he considered a loss of steam in all PHAs for covered processes, Jackson stated, “I’m confident in that based on the questions you have to ask yourself in a HAZOP of too much heat or too little heat. And steam provides heat to our processes.” (Tr. 1607; Ex. R-93, R-94). The problem, however, is that the functions described above are not limited to supplying heat to a particular process. It is also used to snuff out fires, remove HHCs from the FCC riser in emergencies, and purge HHCs from furnace fireboxes during the lighting process. Based on the Court’s review of the PHAs, there is no indication that the impact on these safety functions was considered.

Second, in an attempt to downplay the significance of the Wickes, Raines noted that it is one of four boilers on location at the refinery and that there is a redundancy system built in to reduce the refinery’s reliance on any one boiler. (Tr. 1719). While this may be the case, there was no independent evidence, by way of PHAs or SOPs, to indicate that the system was designed this way. (Tr. 1764). Further, Respondent’s employees testified that the Wickes was the workhorse of and a main contributor to the plant’s steam system. (Tr. 171, 242–43). Respondent lent credence to that characterization by choosing the Wickes as the boiler of choice for the turnaround. Respondent recognized that problems with the Wickes and connected steam system could lead to process upsets. While those upsets likely had the most direct impact on product quality, there was also testimony that such upsets may also impact the use of certain safety measures associated with the steam system. (Tr. 238, 360, 1037, 1761, 1765). That the safety measures associated with a covered process could be affected by a boiler system upset is alone sufficient to warrant finding a connection sufficient to establish the inapplicability of the exception. *See Delek*, 25 BNA OSHC 1365 at *8 (citing favorably to OSHA Interpretation Letter stating “proper safe functioning of all aspects of a process, whether they contain [HHC] or not,

are important for the prevention and mitigation of catastrophic releases”). Just because a redundancy system is built in does not remove a particular boiler from the ambit of the standard. *See id.* (“OSHA’s position is that *any* engineering control, including utility systems, which meets the above criteria must be . . . inspected/tested/maintained per OSHA PSM requirements.”). The key is the connection to the process, and whether a failure in that connection could have an impact on a potential catastrophic release of HHCs. As testified to by Rains, certain process upsets, if left alone for a long enough, can cause a catastrophic release. (Tr. 1761). For example, what if the emergency shutdown system in the FCC Riser cannot be activated because the purported steam redundancy system failed? Under such a set of circumstances, surely it would be reasonable to conclude that a failure at the Wickes would have an impact on the system’s ability to control, prevent, and/or mitigate a catastrophic release.

As noted above, the Commission in *Delek* determined that the PPU in the control room was governed by the PSM standard. The PPU did not have a direct connection to the process; rather, it was a control to prevent the spread of harmful gases that were a result of the FCC process, which could, in turn, prevent the control room from managing the refining process. *Delek*, 25 BNA OSHC 1365 at *8. The connection of the Wickes to various processes throughout the plant was not nearly so attenuated. The Wickes provided steam, which was used directly on the various PSM-covered processes throughout the plant in both a production- and safety-related capacity. In its safety-related capacity, the steam provided by the Wickes served to control, prevent, and/or mitigate catastrophic releases through its use as a snuffing and purging agent. While such uses may not be a complete or sufficient control in and of themselves, the Court finds that such a connection is sufficient to bring the Wickes under the umbrella of the PSM standard.

At a very basic level, the Wickes connected to PSM-covered processes on the front and back end: It is fueled by off-gases from the FCCU and Alky, and, in turn, it supplies steam to those same processes. The explosion in this case provides a clear example of how physical connections between processes can lead to a catastrophic release. There was no independent, automatic control that could stop the flow of fuel to the Wickes during the lighting process; the explosion that resulted from flooding the firebox was only mitigated by the fact that CT Walker happened to notice the overflow of fuel. Independent of that, there was nothing to impede the flow of fuel to the system (although it was natural gas, the same event could have occurred with RFG). Further, to suggest, as Respondent has, that this was a worst case scenario disregards the fact that, but for CT Walker intervening, gas would have continued to flow to the firebox even after the explosion. In fact, Stephenson, the unit supervisor, testified that gas was released into the atmosphere as a result of the explosion, noting a smell of gas in the air. (Tr. 667).

In light of the foregoing, the Court finds that the Wickes boiler is a critical aspect of multiple PSM-covered processes, is not subject to the workplace fuels exception, and, therefore, was properly cited under the PSM standard under a theory of interconnection.

2. Proximity to a Covered Process

An additional basis for coverage urged by Complainant is that the Wickes, independent of its connections to covered processes, was “located such that a highly hazardous chemical could be involved in a potential release”. 29 C.F.R. § 1910.119(b). As a result of the explosion, there was significant damage to surrounding equipment, including piping and valves; and the ladder and platform, which were attached to the Wickes, were blown across the street and hit the operator shelter. (Tr. 152, 156–57, 364, 367; Ex. C-62 at 3, 4, R-110 at 19–20). Complainant contends that, in addition to the damage described above, parts of the FCCU process lines,

including the Intercat loader and process pipe racks, could have been impacted by flying shrapnel. (Tr. 204–206; Ex. C-62 at 15). Based on its location relative to other aspects of the FCCU process, as reflected in the FCCU Equipment Location Plot Plan, Complainant’s expert, Johnstone, concluded that the Wickes’ location was such that it should be considered part of the FCCU process. (Tr. 830; Ex. C-11). *See* 29 C.F.R. § 1910.119(b). Respondent contends that the Wickes is not close enough to any covered process such that a highly hazardous chemical could be involved in potential release and, therefore, should not be considered a single process with any adjacent PSM-covered processes, such as the FCCU. *See id.*

Respondent places significant emphasis on the way this particular explosion occurred to support its argument that the Wickes was not sufficiently close to a covered process to be considered a part of that process and therefore covered under the PSM standard. In particular, Respondent points out that the closest aspects of a process that contains any HHC is the FCCU reactor column, which is approximately 100 feet away. (Tr. 1214). Noting that there was no damage to equipment beyond a 10–15 foot radius, and that no release of HHC occurred, Respondent contends that this “worst-case scenario” shows that the Wickes could not participate in a catastrophic release. (Tr. 1726).

The Court disagrees. As noted by Complainant, the Wickes was centrally located in the FCCU Equipment Location Plot Plan. (Tr. 829–830, Ex. C-11). Thus, before any discussion of distance, the Court finds that the Wickes is at least situated such that it could impact co-located, covered processes, i.e., not in some remote location. As to distance, it is true that many of the covered processes are not located within the apparent radius of the blast zone (10–15 feet) as determined by Respondent; however, that assessment disregards one very large piece of shrapnel that traveled much further: the ladder and platform, which were previously attached to the

Wickes. As a result of the explosion, the ladder and platform attached to the east side of the Wickes were propelled across the street and hit the operator shelter. (Tr. 152, 156–57, 364, 367; Ex. C-62 at 3, 4). Arendt estimated the distance from the boiler to the shelter was about 40 feet. (Tr. 2071). In addition to the ladder and platform, the photographs also show a significant amount of refractory¹⁵ that had been blasted across the street at the operator shelter. (Tr. 149; Ex. C-62 at 1–4). Had the ladder and platform simply been blown in a different direction as a result of the explosion, perhaps toward the FCCU, it is reasonable to assume a catastrophic release would have occurred.

The fact that a catastrophic release from an adjacent PSM-covered process did not actually occur under these circumstances does not, in any way, establish that such an eventuality *could* not occur. See 29 C.F.R. § 1910.119(b) (deeming as a single process separate vessels “which are located such that a highly hazardous chemical *could be* involved in a potential release”) (emphasis added). The fact that a larger explosion did not occur is likely attributable to two factors: (1) CT Walker noticing the excessive flow of fuel to the firebox and directing the operators to shut it down; and (2) the Wickes was being fueled by natural gas and was not using the RFG pipeline at the time of the explosion. The Court is mindful of the fact that the explosion occurred shortly after the order to shut the bypass valve; however, the valve connecting the RFG and natural gas lines to the Wickes were within the blast radius, as exemplified in the photographs taken of the west end of the boiler after the explosion. If the boiler was running on RFG at the time, damage to the fuel lines or simply an inability to turn off the valve after the explosion could lead to a catastrophic release. Although Respondent has argued that the RFG system only contains approximately 1500 pounds of fuel gas at any given time, as noted before,

15. Refractory is a brick-like lining that is used inside of the Wickes to protect the piping from flame impingement. (Tr. 149).

that assessment does not take into consideration the source of that fuel—processes such as the FCCU and Alky. Under normal operations, the Wickes is constantly consuming fuel and the FCCU and Alky are constantly producing it. This constant loop of off-gas production and consumption leads the Court to conclude that Respondent’s attempt to place artificial boundaries on the RFG process such that a covered process would not be affected is misguided and disregards the concrete connection that exists between the Wickes and the FCCU, for example.¹⁶

Perhaps the strongest justification for deeming the Wickes to be part of a single process, and thus PSM-covered, is the potential impact on the control room. As noted above, the ladder and platform assembly, along with a significant amount of refractory, were blown across the street and into the operator shelter, which housed CT Sullivan and CT Walker. In *Delek*, the Commission found that the control room (operator shelter) and the controls associated therewith were part of the overall FCC unit process:

Delek’s refining process includes operating the FCC unit as a whole, and this is done from the FCC unit’s control room, which is kept in safe working order by the PPU. Without the PPU providing positive pressure, hydrocarbon vapors could leak into the control room and—because of the wiring there—cause the type of catastrophic explosion that the PSM standard was intended to prevent. And short of such an explosion, the toxic vapors could harm the employees inside the control room, compromising the management of the refining process. We find, therefore, that the PPU is an integral part of the overall FCC unit “process.”

25 BNA OSHC 1365 at *9. The key point in the passage above is that an incident, such as an explosion at the Wickes, which compromises the management of a PSM-covered process could cause the type of catastrophic event that the standard was designed to prevent. As such, the Commission held that even the positive pressurization unit (PPU), whose connection to a PSM-covered process is even more attenuated than the control room itself, was governed by the PSM

16. The Court also finds that the fact that the blast caused a ladder and platform to fly across a street and into an adjacent operator building (which houses the CTs) suggests that smaller pieces of shrapnel could fly much farther and, as a result, could impact covered aspects of the FCCU. However, as discussed further below, there is an even stronger basis upon which to find PSM coverage based on co-location.

standards. *Id.* at *8 (“The PPU’s regulation of the control room’s positive-pressure atmosphere makes the PPU integral to that “control”—and thus a “control” itself—because, as discussed above, entry of hazardous hydrocarbon vapors into the room could prevent the control room from managing the refining process.”).

Throughout its brief, Respondent was intently focused on whether the putative impacted process contains a threshold quantity of HHCs. The Commission made it clear that the scope of the standard’s coverage is not so narrow. Instead, the Commission takes a holistic approach to the issue: “[T]he PSM standard does not require that every part of a ‘process’ come into contact with hazardous chemicals [V]iewing the ‘activity’ involving the FCC unit in its entirety, the PPU is part of a ‘process’ covered by the PSM standard because it is an integral part of the ‘manufacturing, handling, [and] on-site movement of [highly hazardous chemicals].” *Id.* at *7. The Court sees no difference between the potential impact on the control room in *Delek* and the circumstances presented here, wherein the control room was actually in the line of fire of the explosion. Respondent was presented with direct evidence that this could be the case in 2008 when Respondent performed a blast study for the FCCU as part of the PHA revalidation of the Wickes. (Ex. R-94). At that time, Wynnewood determined that the operator shelter adjacent to the Wickes should be pressurized and hardened to meet overpressure requirements. (Ex. R-94). In other words, an integral aspect of a PSM-covered process could be impacted by an explosion at the Wickes. Nevertheless, Respondent maintained its narrow view and concluded that additional measures were unnecessary to protect process vessels and equipment in the FCCU. (Tr. 1610–1611; Ex. R-94).

Based on the foregoing, the Court finds that the Wickes was located such that an event, like the explosion that occurred in this case, could affect or cause a catastrophic release.

Accordingly, the Court finds that the Wickes boiler is subject to the PSM standards under either the interconnection or proximity theory of coverage.

3. Respondent Treated Wickes as PSM-Covered

As further support for its argument that the Wickes was a PSM-covered process, Complainant contends that Respondent essentially treated the Wickes as such. Respondent argues that, to the extent it treated the Wickes as PSM-covered, it only did so as a matter of best practices and that taking additional precautions should not subject it to liability. The Court notes that while Respondent's treatment of the Wickes, in and of itself, is not sufficient to establish PSM coverage, it undercuts Respondent's claims that it conclusively determined that the PSM standard did not apply.

Complainant identified the following as examples of the Wickes being treated as part of a PSM-covered process: (1) In 2008, the Wickes experienced a "hard start", and the incident report characterized the event as a "PSM Incident"; (2) the plot plan and various P&IDs for the FCCU include the Wickes; and (3) Respondent performed Process Hazard Analyses (PHA) and implemented Management of Change (MOC) procedures on the Wickes. (Exs. C-8 to C-13, C-18, C-19, C-31, R-110 at 162). Jackson contends that he inadvertently checked the "PSM Incident" checkbox while inputting the findings of an hourly employee that assisted in the incident investigation and that such documentation does not reflect his or Wynnewood's opinion as to PSM coverage. Further, Respondent claims that Jackson determined the Wickes was not PSM-covered when the PHA revalidation for the Wickes was performed. (Tr. 1616).

Contrary to Respondent's arguments, the Court cannot find any documentary evidence that Respondent made a conclusive determination that the Wickes was not PSM-covered. (Ex. C-4 at 1535) ("If an employer makes this determination, then, the employer must be able to

proactively demonstrate why the utility system is no longer part of the covered process.”). The problem for Respondent is that the documentation that would normally be used to establish coverage does not reflect the sort of proactive demonstration of non-coverage; rather, as the Court indicated above, the evaluations performed by, or at the request of, Respondent either lack any affirmative determination of non-coverage or should have put Respondent on notice of potential coverage. *See* Section IV.A.ii.2, *supra* (discussing blast study and potential impact on adjacent operator shelter). Instead, Jackson testified that Respondent “must have ruled out” that an explosion at the Wickes would impact adjacent processes; however, even he admitted that his conclusion was “pure speculation”. (Tr. 1620–21).

While it is true that the PSM standard is performance-based, and thus places the onus on the employer to determine how to comply, Respondent has not provided a reasonable basis for its determination. As noted above, the PHA/Hazop analysis performed by Jackson was focused on the impact of too little or too much heat being supplied by the Wickes and how that could cause a loss of containment. (Tr. 1606–1607). This analysis did not take into account numerous other ways in which a failure of the Wickes could impact other processes to which it was connected, such as snuffing steam in the Alky heater’s firebox and emergency steam to the FCC riser. This narrow view comports with Respondent’s arguments throughout and fails to account for the Wickes’ significant connections to covered processes throughout the refinery.

B. Repeat Violations and Successor Liability¹⁷

As a result of the 2012 inspection, Respondent was cited for five repeat violations, which were issued on March 27, 2013. (Ex. R-1). The citations upon which the repeat violations were based were issued to Wynnewood Refining while owned and operated by Gary Williams Energy

17. For the purpose of making the distinction clear, and for this section only, the Court will refer to the two entities involved in the purchase of Wynnewood as GWE-WR and CVR-WR. As a reminder, CVR-WR is the Respondent in this case.

(GWE), most of which became final orders of the Commission in April of 2007.¹⁸ (Ex. R-1, C-28 at 11–12, n.1). Respondent contends that the present citations are not properly characterized as repeated on three separate bases. First, Respondent contends that Complainant failed to comply with its own internal policies regarding the issuance of repeat citations because more than five years had elapsed since the underlying citations were issued. Second, Respondent contends that it should not be held liable for repeat violations that are premised on violations committed by the previous owner of Wynnewood Refinery. Third, Respondent contends that the current citations, and the citations which form the basis of the repeat characterization, are not substantially similar. Based on what follows, the Court finds that Respondent is not a successor to GWE and that the citations at issue were improperly characterized as repeated.¹⁹

Prior to analyzing the question of successor liability, the Court would like to briefly address Respondent’s argument that Complainant violated its own citation policy by issuing the repeat citations more than five years after the underlying citations were issued. According to Complainant’s Field Operations Manual, a citation will be issued as a repeated violation if “[t]he citation is issued within five years of the final order date of the previous citation or within five years of the final abatement date, whichever is later” OSHA, Field Operations Manual, *available at* https://www.osha.gov/OshDoc/Directive_pdf/CPL_02-00-159.pdf.

Four out of the five citations were nearly (but not quite) six years old by the time the current, repeat citations were issued. Respondent contends that, although there is no statutory restriction on the “look-back” period for repeat violations, Complainant’s attempt to expand the applicable look-back period beyond its stated policy creates an “unworkable framework”

18. Four out of the five underlying violations, which were part of OSHA Inspection No. 309785459, became final orders in April of 2007, after a partial settlement. (Ex. C-28). The remaining violation, which was part of OSHA Inspection No. 311001234, became a final order on November 10, 2008. (Ex. C-26).

19. This section deals primarily with the question of whether Respondent is a successor-in-interest to GWE. Because the Court finds that Respondent is not properly characterized as a successor, it will not address the substantive argument of whether the present and underlying citations are substantially similar.

wherein citations that were decades old could serve as the basis for a repeat citation.

According to the Commission, “A violation is properly classified as repeated under section 17(a) of the Act if, at the time of the alleged repeated violation, there was a Commission final order against the same employer for a substantially similar violation.” *Hackensack Steel Corp.*, 20 BNA OSHC 1387 (No. 97-0755, 2003) (citing *Jersey Steel Erectors*, 16 BNA OSHC 1162, 1167–68 (No. 90-1307, 1993), *aff’d without published opinion*, 19 F.3d 643 (3rd Cir. 1994)). “[T]he ‘time between violations does not bear on whether a violation is repeated.’” *Id.* (citing *Jersey Steel*, 16 BNA OSHC at 1168).

Just as Respondent argues here, the employer in *Hackensack* argued that the then-current version of the Field Operations Manual (the Field Inspection Reference Manual) limited repeat citations to a period of three years after the issuance of the original citation. *Id.* Citing to previous decisions, the Commission noted that the FOM and the FIRM “are only [] guide[s] for OSHA personnel to promote efficiency and uniformity, are not binding on OSHA or the Commission, and do not create any substantive rights for employers.” *Id.* (citations omitted). Accordingly, the Commission upheld the repeat characterization.

The Court finds that the enforcement policy of Complainant does not preclude the issuance of a repeat citation after more than five years. As noted by the Commission in *Hackensack*, such a policy is only a guide and does not confer rights upon employers. While Respondent’s concern regarding an ever-expanding look-back period is legitimate, the citations in this case all occurred within a six-year period, only slightly longer than the stated policy of Complainant. Because this Court is bound to follow the precedent set by the Commission, the Court rejects Respondent’s argument to vacate the repeat characterization on this basis.

Respondent’s second argument, however, is far more persuasive. The citations that form

the basis of the repeat violations in this case were issued to GWE, which owned the Wynnewood Refinery until it was purchased by CVR Energy, Inc. in 2011. (Tr. 1760). Respondent contends that it should not be held liable for repeat violations that are premised on violations committed by the previous owner of Wynnewood Refinery. Complainant argues that Respondent should be characterized as a successor-in-interest to GWE and therefore liable as a repeat offender under the Act.

The Commission addressed the issue of successor liability, albeit in a slightly different context, in *Sharon & Walter Constr., Inc.*, 23 BNA OSHC 1286 (No. 00-1402, 2010). In that case, OSHA cited Sharon & Walter Construction, Inc. (“S&W II”) for repeat violations of the construction fall protection standards. The underlying citations were issued to Walter Jensen d/b/a S&W Construction (“S&W I”). S&W I filed for bankruptcy and ceased operations approximately six weeks prior to the formation of S&W II. Walter Jensen was the sole proprietor of S&W I, as well as the president, director, and solitary shareholder of S&W II. Both companies were based in New Hampshire, and both “provided essentially the same construction services” *Id.*

The starting point of the Commission’s analysis is the language of Section 17(a) of the Act, which states, “Any employer who . . . repeatedly violates . . . the Act . . . may be assessed a civil penalty of not more than \$70,000 for each violation.” 29 U.S.C. § 666(a). Applying a plain meaning analysis to the statute, the Commission found that there is “no language in the statute that would compel restricting attribution of an employer’s violation history to the identical legal entity, nor do we find anything that would preclude attribution of a predecessor’s citation history to a successor.” *Sharon & Walter*, 23 BNA OSHC 1286 at *7. In other words, the statute is ambiguous in this context.

The Commission resolved the ambiguity by looking at the purpose of Section 17(a) in the context of the Act as a whole. *Id.* at 8 (citing *Gade v. Nat'l Solid Wastes Mgmt. Ass'n*, 505 U.S. 88, 99–100 (1992)). The Supreme Court has held that the Act “is to be liberally construed to effectuate the congressional purpose”, *Whirlpool Corp. v. Marshall*, 445 U.S. 1, 10–11 (1990), which is to “assure so far as possible every working man and woman in the Nation safe and healthful working conditions and to preserve our human resources.” 29 U.S.C. § 651(b). Thus, to carry out this purpose, the “enforcement framework creates a deterrent to an employer that might otherwise ignore potential hazards . . . and an *enhanced* deterrent against subsequent infractions ‘once alerted by a citation and final order.’” *Sharon & Walter*, 23 BNA OSHC 1286 at *8 (quoting *Dun-Par Eng'd Form Co. v. Marshall*, 676 F.2d 1333, 1337 (10th Cir. 1982)).

Given its determination that the threat of a repeat characterization is designed as a deterrent to future bad behavior, the Commission held that “section 17(a) is most reasonably read to permit, *in appropriate circumstances*, the Secretary’s application of a “repeat” characterization to cases where the employer has *altered its legal identity* from that of the predecessor employer whose citation history forms the basis of that characterization.” *Id.* at *8 (emphasis added). This reading stems from the Commission’s concern that an overly restrictive application of Section 17(a) “could ‘creat[e] an economic incentive to avoid a penalty by going out of business and, perhaps, then reincorporating under a different name.’” *Id.* (quoting *Joel Yandell*, 18 BNA OSHC 1623, 1625 (No. 94-3080, 1999) (internal citations omitted)). To the extent that such a possibility could undermine the purpose of the repeat characterization under 17(a), the Commission found it appropriate to “allow attribution of a predecessor’s citation history to a successor in appropriate circumstances.” *Id.*

At the urging of the Secretary, and after its own review of relevant case law, the

Commission determined that the substantial continuity test used by the National Labor Relations Board and the courts “promotes the Act’s goals of ensuring workplace health and safety by preserving the deterrent effect of a repeat characterization, and is appropriately adapted to a determination of the requisite nexus between a successor and predecessor’s violation history for purposes of ascribing a repeat characterization under the OSH Act.” *Id.* at *9; *see also Nat’l Labor Relations Bd. v. Burns*, 406 U.S. 272, 280–81 (1972). The Commission found that “this test enables us to fully assess the nature and extent of the distinctions and similarities between a successor and a predecessor based on criteria that are well-suited to the OSH Act and the facts of each case before us.” *Id.* (citing *Howard Johnson Co. Inc. v. Detroit Local Jt. Bd., Hotel and Rest. Employees*, 417 U.S. 249, 263, n.9 (1974) (noting successorship cases require an analysis based on “the facts of each case and the particular legal obligation which is at issue”)). In particular, the Commission noted that the substantial continuity test focuses on factors that fall into three primary categories: (1) nature of the business, (2) jobs and working conditions, and (3) personnel.

Applying the foregoing test to the facts of *Sharon & Walter*, the Commission found that S&W II was a successor to S&W I. The nature of the business—roofing and general construction—did not change. In particular, the Commission noted that both entities served customers in the same geographic area, and occupied the same office space and use the same telephone number. Further, a check drawn on an account belonging to S&W I was used to pay a debt of S&W II, and S&W II continued performance on a contract entered into by S&W I. *Id.* at *10. Because the employing entity and the nature of the business remained “essentially unchanged”, the jobs and working conditions also remained the same—both companies provided the same general construction services, which required the same tools and exposed employees to

the same hazards. *Id.*

As to the third category—personnel—the Commission noted that “continuity of personnel *who specifically control decisions related to safety and health* is certainly relevant in the context of the Act because the decisions of such personnel relate directly to the extent to which the employer complies with the statute’s requirements.” *Id.* (emphasis added). In that regard, finding that S&W II was a successor to S&W I was a fairly perfunctory exercise. As noted above, Walter Jensen was the sole proprietor of S&W I, and the president, sole shareholder, and supervisor of S&W II. Accordingly, “Jensen’s control over decision-making in both companies, including that related to employee safety and health, weighs heavily in favor of attributing S&W I’s citation history to S&W II.” *Id.* Notably, however, the Commission placed little to no weight on the continuity of nonsupervisory employees, “because those employees are not responsible for OSH Act compliance and would not have supervised its implementation.” *Id.*

In this case, there is no real dispute as to the first two categories of factors.²⁰ It is clear that the Wynnewood refinery is still in the business of refining oil, produces similar products, and services similar customers. (Tr. 1735–56; Ex. C-16). Likewise, as testified to by many of Respondent’s employees, the jobs and working conditions have remained essentially unchanged since Respondent’s purchase of the refinery from GWE. (Tr. 142). Thus, the remaining factor to consider is the continuity of personnel who control the decisions related to safety and health. The Court finds that this factor, more than the others, is particularly relevant to the issue of whether a successor should be held liable for the acts of its predecessor.²¹

20. Respondent contends that Complainant failed to establish continuity in operations and working conditions due to the implementation of more formal policies and procedures after the acquisition. These changes are more germane to the issue of continuity in personnel responsible for decision-making. While the implementation of more formal policies and procedures, especially in the arena of safety and health, may have an impact on the manner in which a job is carried out, the basic nature of the job and the conditions of the refinery did not change.

21. This sentiment was expressed by the Commission in *Sharon & Walter*, when it held that an individual’s common control over decision-making in both companies “weighs heavily” in favor of finding successor liability.

In 2007, when the original, underlying citations were issued, GWE was the owner of the Wynnewood Refinery. Nearly all of Respondent's current and former employees testified that, upon Wynnewood's acquisition by Respondent in December 2011, the new company placed significant emphasis on improving safety and health and proper implementation of PSM. (Tr. 234, 674–75, 749, 1612). This included changes to policies, procedures, and the overall culture of safety at Wynnewood Refinery. Some of the other changes noted by Respondent included: (1) nearly doubling the number of safety personnel at the refinery, including four new assistant operations supervisors, who were responsible for procedure development, compliance, PSM, and occupational safety; (2) new, high-level executives, including the Executive Vice President for Operations and the Vice President of Environmental Health and Safety, were more involved in the day-to-day operations, and were present on a frequent basis to oversee the transition from GWE; (3) a \$130 million upgrade to equipment; and (4) more formalized training programs and a renewed emphasis on “management of change” (MOC) procedures. (Tr. 1701–1703).

In support of its argument that there was continuity of personnel sufficient to find successor liability, Complainant points to the following: (1) Dick Jackson, Respondent's current PSM Manager, and Darren Rains, Respondent's former operations manager,²² were members of management before and after the acquisition; and (2) key personnel and managers, such as Koesler, Howard, Underwood, and Walker, who were present at the time of the underlying violations were still working in Zone 2 at the time of the accident. Although these individuals were responsible for implementing safety and health policies, and may have had input into them, there was no indication that these individuals were ultimately responsible for making the decision to change safety and health procedures, PSM policies, and organizational culture. *See*

Sharon & Walter, 23 BNA OSHC 1286 at *10.

22. Mr. Rains is now the Vice President and General Manager of Respondent's Coffeyville refinery.

Sharon & Walter, 23 BNA OSHC 1286 at *10 (focusing “continuity of personnel” analysis on “who specifically controls decisions related to safety and health”).

According to Darin Rains, however, there were significant changes in the management of Wynnewood. (Tr. 1703). Specifically, Rains noted that GWE management was less involved in day-to-day operations, whereas CVR’s corporate management, inclusive of its Vice President of Safety, Health, and Environment, Chris Swanberg, and Executive Vice President of Operations, Robert Haugen, were actively involved in daily operations. This, in and of itself, is a strong fact in favor of Respondent—new corporate management responsible for ultimate decision-making in the areas of operations and safety and health. It should also be noted that neither of these men, nor any of the other CVR managers, worked for GWE.

In *Sharon & Walter*, the Commission was concerned with applying section 17(a) in an overly restrictive manner such that companies could evade higher penalties by merely changing form, but it is equally problematic to be over-inclusive. Respondent notes that successor liability has not previously been imposed under circumstances such as these. In *Sharon & Walter*, the Commission was careful to note that successor liability for repeat violations should only be applied in “appropriate circumstances” and proceeded to do so based on a unique set of facts. The primary concern was manipulation—the Commission repeatedly discussed the possibility that an employer could avoid liability by “changing its legal identity for each new project” or “by going out of business and . . . reincorporating under a different name.” *Sharon & Walter*, 23 BNA OSHC 1286 at *8. When viewed through that lens, the scope of the Commission’s interpretation of section 17(a) becomes clearer: repeat violations based on successor liability would be appropriate when the cited employer “*altered its legal identity* from that of the predecessor employer” *Id.* (emphasis added). In other words, the Commission sought to

prevent manipulation of the system, not to expand liability.

The purpose of a repeat violation is to deter an employer from committing violations by drastically increasing the penalty for subsequent, substantially similar violations. *Dun-Par*, 676 F.2d at 1337. This implies that the employer was responsible for the underlying violation. While higher penalties are a deterrent, irrespective of the basis therefor, there must be some justification for increasing the penalties in the first instance. Respondent did not commit the underlying violations in this case. Drastically increasing the penalty for a violation that occurred on someone else's watch does not deter future misconduct because there was no past misconduct to deter.

Complainant seeks to circumvent this problem by arguing that CVR-WR was on notice of the underlying violations when it acquired Wynnewood from GWE-WR and is therefore responsible for any obligations stemming from them. Without citing case law, Complainant attempts to analogize economic obligations acquired in the purchase of a business and OSHA citations that were incurred by the former owner, stating:

If the new employer has notice of the obligation, then the price paid for the business will reflect that knowledge and it is fair to impose the obligation on the new employer. In the OSHA context, notice shows culpability on the part of the new employer and supports imposition of a higher repeat penalty because the new employer had notice of the violative condition but failed to prevent its occurrence.”

Compl't Br. at 28. First, a prior OSHA citation, which has become a final order of the Commission, is not an outstanding obligation. Second, notice does not, on its own, equal culpability as argued by Complainant.

The importance of notice can be seen in the distinction between a willful violation and a repeat violation. A willful violation is punishment for what an employer *knew* before it committed a violation. *See, e.g., Sharon & Walter*, 23 BNA OSHC 1286 at *5 (citing *Kaspar*

Wire Works, Inc., 18 BNA OSHC 2178, 2181 (No. 90-2775, 2000) (“The hallmark of a willful violation is the employer’s state of mind at the time of the violation—an ‘intentional, knowing, or voluntary disregard for the requirements of the Act or ... plain indifference to employee safety.’”) (citations omitted)). A repeat violation is punishment for what an employer *did* (or did not do) in the past. *See Dun-Par Eng’d Form Co. v. Marshall*, 676 F.2d 1333, 1337 (10th Cir. 1982) (“Once an employer has been cited for an infraction under a standard, this tends to apprise the employer of the requirements of the standard and to alert him that special attention may be required to prevent future violations of the standard.”). Thus, in the context of successor liability, the Court must be mindful of *who* we are holding responsible and *what* we are holding them responsible for.

The threat of increased penalties for subsequent violations only makes sense if the same employer was responsible for the underlying past violation. In the case of *Sharon & Walter*, though the “employer” was different in name, the controlling entity (Walter Jensen) did not change. What Complainant proposes—holding CVR-WR, a separate and distinct purchasing entity, responsible for what GWE-WR did in the past—expands repeat liability beyond what the Commission envisioned when it decided *Sharon & Walter*. Based on the facts and law discussed above, the Court holds that the citations issued to Respondent were improperly characterized as repeat.

C. The PSM Inspection – Docket No. 13-0791 – Inspection No. 663538

i. Applicable Law

To prove a violation of an OSHA standard, Complainant must prove, by a preponderance of the evidence, that: (1) the cited standard applied to the facts; (2) the employer failed to comply with the terms of the cited standard; (3) employees were exposed or had access to the

hazard covered by the standard, and (4) the employer had actual or constructive knowledge of the violative condition (*i.e.*, the employer knew, or with the exercise of reasonable diligence could have known). *Atlantic Battery Co.*, 16 BNA OSHC 2131 (No. 90-1747, 1994).

A violation is “serious” if there was a substantial probability that death or serious physical harm could have resulted from the violative condition. 29 U.S.C. § 666(k). Complainant need not show that there was a substantial probability that an accident would actually occur; he need only show that if an accident occurred, serious physical harm could result. *Phelps Dodge Corp. v. OSHRC*, 725 F.2d 1237, 1240 (9th Cir. 1984). If the possible injury addressed by a regulation is death or serious physical harm, a violation of the regulation is serious. *Mosser Construction*, 23 BNA OSHC 1044 (No. 08-0631, 2010); *Dec-Tam Corp.*, 15 BNA OSHC 2072 (No. 88-0523, 1993).

ii. Citation 1, Item 1

Complainant alleged a serious violation of the Act in Citation 1, Item 1 as follows:

29 CFR 1910.119(d)(3)(i)(F): Process safety information pertaining to the equipment did not include the design codes and standards employed:

The employer does not ensure process safety information pertaining to the equipment includes design codes and standards employed. In the Zone2/CAT Wickes Boiler Area the employer does not ensure process safety information pertaining to the equipment included the design codes and standards employed such as the National Fire Protection Association (NFPA) Standard 85, Boiler and Combustion Systems Hazard Code, and ASME CSD-1, sections CF-210 & CF-330, and ASME Section VI for the Wickes boiler burner and gas train exposing employees to fire and explosion hazards from potential releases of fuel gas and other flammable liquids or gases.

The cited standard provides:

Information pertaining to the equipment in the process. (i) Information pertaining to the equipment in the process shall include . . . [d]esign codes and standards employed

29 C.F.R. § 1910.119(d)(3)(i)(F).

Complainant alleges that Respondent failed to include design codes and standards in the process safety information (PSI) for the Wickes boiler and the associated gas train. In particular, Complainant notes that it requested such information during the inspection and that none was provided. Further, Howard, the former Zone 2 Supervisor, stated that he did not know what design codes and standards were employed with respect to the Wickes and gas train. (Tr. 703). Respondent contends that Complainant failed to establish that the design codes cited were applicable to the Wickes and gas train, noting NFPA 85 has a retroactivity provision that excludes equipment “that existed or were approved for construction or installation prior to the effective date of the code.” (Ex. R-130 at 85-11). Respondent also notes the boiler passed inspection by the Oklahoma Department of Labor and was approved for operation one month prior to the explosion.

As repeatedly noted by Respondent, and echoed by Complainant’s expert, Johnstone, this is a performance standard. (Tr. 873, 1117). As such, Respondent is entitled to elect which design codes and standards they wish to employ with respect to a particular piece of equipment. (*Id.*). Nevertheless, Respondent must still make a choice as to which standards or codes to apply. Herein lies the problem. Regardless of whether design codes and standards identified by Complainant in this citation item are specifically applicable to the Wickes and its gas train, Respondent failed to identify *any* design codes or standards in their PSI. (Tr. 703, 874, 1118). Further, according to Johnstone, Respondent’s P&IDs for the Wickes did not comply with any known design code or standard. (Tr. 874–75). Although the Wickes may have passed inspection with the State of Oklahoma—which may or may not have indicated compliance with certain applicable design codes or standards—this does not excuse Respondent from its obligations to

document that information under the cited standard. Accordingly, the Court finds that Respondent violated the terms of the standard.

The Court also finds that Respondent knew or could have known of the violative condition. For example, in 2007 the refinery conducted an investigation of an explosion at the H-4 boiler. (Ex. C-32). That boiler, similar to the Wickes, was designed and installed prior to the purported grandfathering date of NFPA 85. (Ex. C-32 at 4). Nonetheless, the investigation report noted that consideration should be given to the requirements of NFPA 85 with respect to the operation sequence of the H-4 boiler. (*Id.* at 13). This incident highlighted the importance of applying consensus design codes and standards to a PSM-covered process and should have placed Respondent on notice that such information would be equally applicable to the other boilers in its facility.

Further, the H-4 incident illustrated the impact of failing to utilize and apply such information to PSM-covered processes; namely, that without having proper PSI, employees are exposed to explosion and fire hazards. (Tr. 876). According to CSHO Hartung, “When you define the design code and standard, that sets forth the standard to which all engineering, design, installation and use and maintenance of that equipment will be conducted as it’s in the process, as it’s installed, again as it’s engineered and maintained.” (Tr. 1119). The purpose of the cited standard is to “enable the employer and the employees involved in operating the process to identify and understand the hazards posed by those processes involving highly hazardous chemicals.” 29 C.F.R. § 1910.119(d). If no standard or code is defined, there is no basis upon which to determine whether a particular aspect of the process “is appropriate for the operation and that it meets appropriate standards and codes” 57 Fed. Reg. at 6374. Without such a basis, the ability to identify and understand the hazards of a process is reduced, thereby exposing

employees to potential injury from explosion or fire.²³ As indicated by the incident in this case, as well as the incidents pre-dating the Wickes explosion, exposure to fire and explosion hazards can cause serious injury and/or death.

Based on the foregoing, the Court finds that Respondent violated the standard and that the violation was serious. Accordingly, Citation 1, Item 1 is AFFIRMED as a serious violation of the Act.

iii. Citation 1, Items 2(a), (b), and (c)

Complainant alleged three serious violations of the Act in Citation 1, Item 2, subparts (a), (b), and (c). Given their similarity, all three items will be addressed together. Complainant's allegations with respect to Item 2(a) are as follows:

29 CFR 1910.119(e)(3)(i): The process hazard analysis did not address the hazards of the process:

The employer does not ensure the process hazard analysis addresses the hazards of the process. In the Zone2/CAT Wickes Boiler Area the employer did not ensure the 1992 and 2008 Process Hazard Analyses addressed the hazards of the process where employees were exposed to fire and explosion hazards from potential releases of fuel gas and other flammable liquids or gasses for hazards of the process such as but not limited to:

- a) Failure to purge or adequately purge the boiler firebox prior to lighting the burner pilot.
- b) Loss of burner pilot during the initial start-up of the boiler burner.
- c) Loss of burner flame.
- d) High or prolonged fuel gas flow to the burner without a pilot or flame present.
- e) Failure of the burner to light.

The cited standard provides that “[t]he process hazard analysis shall address . . . [t]he hazards of the process. 29 C.F.R. § 1910.119(e)(3)(i).

Complainant's allegations regarding Item 2(b) are as follows:

23. The Court also finds the Oklahoma State boiler inspection is not sufficient to establish *Respondent's* compliance with *its* obligation to compile PSI. As Johnstone testified, the state inspection report did not indicate whether the design complied with any specific applicable requirements. (Tr. 1016).

29 CFR 1910.119(e)(3)(iii): The process hazard analysis did not address the engineering and administrative controls applicable to the hazards and their interrelationship, such as, appropriate detection methodologies to provide early warning of releases:

The employer does not ensure the process hazard analysis addresses the engineering and administrative controls applicable to the hazards and their interrelationship, such as, appropriate detection methodologies to provide early warning of releases. In the Zone2/CAT Wickes Boiler Area the employer did not ensure the 1992 and 2008 Process Hazard Analyses addressed the engineering and administrative controls applicable to the hazards and their interrelationships such as the appropriate methodologies to provide early warning where employees were exposed to fire and explosion hazards from potential releases of fuel gas and other flammable liquids or gasses for occurrences such as but not limited to:

- a) Failure to purge or adequately purge the boiler firebox prior to lighting the burner pilot.
- b) Loss of burner pilot during the initial start-up of the boiler burner.
- c) Loss of burner flame.
- d) High or prolonged fuel gas flow to the burner without a pilot or flame present.
- e) Failure of the burner to light.

The cited standard provides:

The process hazard analysis shall address . . . [e]ngineering and administrative controls applicable to the hazards and their interrelationships such as appropriate methodologies to provide early warning of releases. (Acceptable detection methods might include process monitoring and control instrumentation with alarms and detection hardware such as hydrocarbon sensors.)

29 C.F.R. § 1910.119(e)(3)(iii).

Complainant's allegations regarding Item 2(c) are as follows:

29 CFR 1910.119(e)(3)(iv): The process hazard analysis did not address the consequences of failure of engineering and administrative controls:

The employer does not ensure the process hazard analysis addresses the consequences of failure of engineering and administrative controls. In the Zone2/CAT Wickes Boiler Area the employer did not ensure the 1992 and 2008 Process Hazard Analyses addressed the consequences of failure of engineering and administrative controls where employees were exposed to fire and explosion hazards from potential releases of fuel gas and other flammable liquids or gasses for occurrences such as but not limited to:

- a) Failure to purge or adequately purge the boiler firebox prior to lighting the burner pilot.
- b) Loss of burner pilot during the initial start-up of the boiler burner.

- c) Loss of burner flame.
- d) High or prolonged fuel gas flow to the burner without a pilot or flame present.
- e) Failure of the burner to light.

The cited standard provides that “[t]he process hazard analysis shall address . . . [c]onsequences of failure of engineering and administrative controls” 29 C.F.R. § 1910.119(e)(3)(iv).

Respondent’s primary argument with respect to the foregoing citation is that the PSM standard does not apply, which the Court disposed of earlier in Section IV.A, *supra*. Its secondary argument is that, insofar as the Wickes is subject to PSM because of its connection to other covered processes, Complainant was required to prove that the PHAs for the Alky and the FCCU failed to contain the information alleged to be missing from the Wickes PHA. *Resp’t Br.* at 53. This argument is undercut by the fact that Respondent performed a PHA on the Wickes on two separate occasions—initially in 1992 and a revalidation in 2008.²⁴ Insofar as it performed PHAs on the Wickes, Respondent effectively treated it as a part of a process subject to the PSM standard.

A review of the disputed PHAs reveal that neither contains an analysis of the hazards identified in the foregoing citation items. (Ex. C-18, C-19). Paul Howard, who participated in both the initial analysis and subsequent revalidation, testified that both PHAs should have identified hazards, the controls, and consequences of failure, but failed to do so. (Tr. 720–23). The Court agrees and finds that the terms of the standard were violated.

The Court also finds that Respondent knew or could have known of the hazard. The PHAs, which were performed under the ownership of GWE-WR, were available to Respondent and its employees, and the 2008 PHA was effective for a period of five years. *See* 29 C.F.R. § 1910.119(e)(6). Respondent could have known, with the exercise of reasonable diligence, that the PHA for the Wickes was deficient. These deficiencies, especially as they relate to the

24. These PHAs occurred when the refinery was owned by Gary Williams Energy.

accident that occurred in this case, clearly exposed Respondent's employees to fire and explosion hazards that were otherwise left unexplained and un-analyzed in the Wickes PHA. Without a complete understanding of the hazards associated with a process, the impact of administrative and engineering controls, and the consequences of failure of those controls, employees were exposed to hazards that were potentially unknown and, if known, may not have been properly addressed with effective engineering and administrative controls. As noted above, fire and explosion hazards can lead to serious physical injuries, including (as happened in this case) death.

The Court finds that Complainant established a serious violation of the standards cited above. Accordingly, Citation 1, Items 2(a), (b), and (c) are AFFIRMED as serious violations of the Act.

iv. Citation 1, Items 3(a) and (b)

Complainant alleged two serious violations of the Act in Citation 1, Item 3, subparts (a) and (b). Given their similarity, both items will be addressed together. Complainant's allegations with respect to Item 3(a) are as follows:

29 CFR 1910.119(f)(1)(i)(A): The employer's written operating procedures covering the steps for each operating phase did not address initial startup.

The employer's written operating procedures covering the steps for each operating phase do not address initial startup. In the Zone 2/CAT Wickes Boiler Area the employer did not ensure the written operating procedures covered steps for each operating phase including initial startup such as but not limited to:

- a) The length of time in which the gas can flow to the boiler burner without the burner lighting.
- b) A description of how much the main gas valve can be opened or what the maximum pressure should/can be at the inlet to the burner.
- c) The length of time the firebox is to be purged of gas prior to or after a failed burner lighting attempt.
- d) The maximum gas pressure at the inlet to the gas train on the boiler burner.
- e) The use of natural/purchased gas versus refinery gas.

Employees were exposed to fire and explosion hazards from potential releases of fuel gas and other flammable liquids or gasses.

The cited standard states, “The employer shall develop and implement written operating procedures that provide clear instructions for safely conducting activities involved in each covered process consistent with the process safety information and shall address at least the following elements: . . . Initial Startup.” 29 C.F.R. § 1910.119(f)(1)(i)(A).

Complainant’s allegations with respect to Item 3(b) are as follows:

29 CFR 1910.119(f)(3): The operating procedures were not reviewed as often as necessary to assure that they reflect current operating practice, including changes that result from changes in process, chemicals, technology, and equipment, or changes to facilities:

The employer does not ensure operating procedures are reviewed as often as necessary to assure that they reflect current operating practice, including changes that result from changes in process chemicals, technology, and equipment, or changes to facilities. In the Zone 2/CAT Wickes Boiler Area the employer did not ensure written operating procedures were reviewed as often as necessary to assure that they reflected current operating practice. Identified errors include but not limited to:

- a) The amount of time the firebox is purged prior to attempting to light the pilot or after a failed burner lighting attempt.
- b) The level the gas control valve bypass is to be opened.
- c) The time the gas control valve bypass valve is allowed to open before the burner lights.

Employees were exposed to fire and explosion hazards from potential releases of fuel gas and other flammable liquids or gasses.

The cited standard states, “The operating procedures shall be reviewed as often as necessary to assure that they reflect current operating practice, including changes that result from changes in process chemicals, technology, and equipment, and changes to facilities. The employer shall certify annually that these operating procedures are current and accurate.” 29 C.F.R. § 1910.119(f)(3).

In response to Complainant's allegations, Respondent contends that: (1) it was not feasible to provide precise instructions on how far or how long to open the gas bypass valve because the fuel composition changes from hour to hour; (2) the instructions provided to operators during formal and on-the-job training were consistent (e.g., "no more than a spoke", "no longer than a minute") and that the operators failed to comply; and (3) the remaining deficiencies identified by Complainant are irrelevant to the boiler startup.

As to providing precise instructions regarding the bypass valve, the Court disagrees that doing so would be infeasible. According to Respondent's Formal Incident Report, an earlier iteration of the standard operating procedures (SOP) for lighting the Wickes included fairly precise instructions for opening the bypass valve, whereas the most recent version did not.²⁵ (Ex. C-30 at 13). Notwithstanding its obligation under a 2008 settlement agreement to update its SOPs, Respondent failed to include all of the earlier startup steps in its revised SOP. (*Id.* at 7). Thus, Respondent's own investigation revealed as a root cause of the explosion that the "SOP Did Not Include Critical Safety Information from Earlier Startup Procedures". (*Id.*). In addition, any claim that providing precise instructions was infeasible is belied by the same report, wherein the investigation team "was able to identify other similar equipment SOPs in Zone 2 that had more specific instructions on how long a lighting procedure was to be performed until aborting a task, and contained specific hazard warnings about the consequence of not aborting the task if light-off failed in a short time period." (Ex. C-30 at 8). Further, the fact that Respondent's employees may have received training consistent with the earlier procedure does not obviate the need to include such steps in the updated, written procedures. In fact, the effect of Respondent's

25. Specifically, the previous SOPs indicated that the valve should be opened slowly, 1/16 of an inch at a time, and no more than one spoke. (Ex. C-30 at Exhibit 42). It also indicated that fuel gas was not to exceed 1,000 MCSFD and that if ignition was not achieved to close the valve and restart the lighting sequence. (*Id.*). The "current" SOPs only instruct an operator to "LIGHT main burner by slowly opening 3-[inch] bypass valve around 20FC702 until burner lights." (*Id.* at Exhibit 44).

failure to do so is reflected in the testimony of the witnesses, each of whom gave a slightly different description of how much to open the valve and for how long. (Tr. 116–17, 215, 335, 353, 453, 518). Accordingly, the Court rejects Respondent’s argument as to infeasibility of including more precise instructions on the bypass valve and finds a violation on this basis.

As to the remaining deficiencies, first, it is not clear that the gas pressure at the bypass valve is irrelevant as Respondent suggests. Merely because the pressure valve is not in an operator’s line of sight does not render that indicator unimportant. According to Respondent’s Incident Report, “Normal operation data indicated that a 3–5 psig burner pressure is in the range to support normal operation of the boiler This data also shows that the burner pressure should have been between 1.4 to 1.8 psig.” (Ex. C-30 at 12). The Report indicates that “high burner pressure resulted in a fuel velocity that far exceeded the condition necessary to light the burner.” (*Id.*). To the extent that data available to Respondent revealed a connection between fuel pressure and the ability to light the burner, Respondent should not be absolved of including that information as a step in the lighting process merely because the operator turning the bypass valve does not have pressure information in his line of sight.

Second, the Court agrees with Respondent that the SOPs for the Wickes indicate that the firebox should be purged for 30 minutes prior to lighting the pilot and that such would be the case for starting the boiler regardless of whether it is the initial lighting attempt or an attempt to light the boiler after a failed attempt. (Ex. C-30 at Exhibit 44). However, the problem with the procedures in place at the time of the explosion was that they did not account for a failed lighting attempt at any step in the process.²⁶ (*Id.*). Thus, there was no indication, in the SOPs at least, as to what the next step in the process would be if the lighting attempt failed.

26. By comparison, the previous iteration of the SOP indicated when a lighting attempt should be aborted and what steps should be taken in the event of a failed lighting attempt. (Ex. C-30 at Exhibit 43).

Third, Respondent's argument that the process would be the same irrespective of whether the Wickes was being lit by natural gas or refinery fuel gas is equally unavailing. Respondent contends that there are only slight differences between the flame speed and flammable range of natural and refinery fuel gas and that such differences were not significant enough to affect the boiler's startup procedures. Further, Respondent contends that due to the variability of the hydrogen content of RFG, it is infeasible for Respondent to create different SOPs for every potential iteration of fuel gas. According to Respondent's Incident Report:

Differences in the flame speed and flammable range of natural gas versus hydrogen coupled with the high velocity of fuel and air flowing through the burner ring would prevent the fuel/air mixture from being lit by the pilot. Natural gas has a flammable range of 5% to 15% and a flame speed of approximately 1.0 feet/sec. Hydrogen has a flammable range of 4% to 75% and a flame speed of approximately 10 feet/sec. The velocity of the fuel moving through the burner tip along with the air flow is crucial to enable the fuel/air mixture to ignite with a stable flame at the burner tip. The lower flame speed of natural gas and the higher than normal velocity of both the fuel and air prevented the mixture from contacting the pilot flame

(Ex. C-30 at 5). While it may be infeasible to account for every iteration of fuel gas that comes through the RFG pipeline, the Court finds that is not the case for pure natural gas. According to the testimony of Respondent's employees, the Wickes runs on natural gas alone only during turnaround activities, during which time the processes which feed the RFG pipeline are offline. (Tr. 553-54). Given the investigative team's finding that the lower flame speed of the natural gas contributed to the failed lighting, and in consideration of the fact that lighting the Wickes with natural gas is a unique and seldom-used process, the Court finds that Respondent's SOPs should account for it to avoid accidents such as the one that occurred in this instance.

In addition to the foregoing, which addresses 1910.119(f)(1), the Court also finds that Respondent failed to review the SOPs as often as necessary to assure they reflect current operating practice. *See* 29 C.F.R. § 1910.119(f)(3). According to Underwood and Stephenson,

both unit supervisors for Respondent, the purpose of the review of SOPs is to make sure they are accurate and address the hazards employees are exposed to, set forth applicable operating limits, consequences of deviation, and steps to correct deviations. (Tr. 576, 651–52). Underwood stated that he personally reviewed and approved numerous versions of the SOP for lighting the Wickes prior to the explosion and admitted that the steps discussed above should have been included in the SOPs that he reviewed and approved. (Tr. 580–82, 679–80). This not only establishes Respondent’s failure to comply with 1910.119(f)(3) but also illustrates that Respondent knew or, with the exercise of reasonable diligence, could have known of the deficiencies in its SOPs.

The Court also finds that Respondent’s failure to have clear, complete, and up-to-date procedures exposed its employees to fire and explosion hazards and that such exposure had the potential to cause serious injury and/or death. (Tr. 1144). Accordingly, Complainant established its *prima facie* case.

Respondent contends that the foregoing failures were not the product of insufficient procedures, but were instead the result of unpreventable employee misconduct. In particular, Respondent notes that operators disregarded their training and opened the valve too far (approximately a spoke-and-a-half) and for too long (approximately 5 minutes). (Ex. R-110 at 9). Respondent also notes that Willson, the senior operator supervising the lighting process, instructed Mr. Mann, who was operating the bypass valve, to keep the valve open even though he was instructed to close it by Koesler.

In order to prevail on the affirmative defense of unpreventable employee misconduct, Respondent must prove that: (1) it has established work rules designed to prevent the violation, (2) it has adequately communicated those rules to its employees, (3) it has taken steps to discover violations, and (4) it has effectively enforced the rules when violations have been discovered.

W.G. Yates & Sons, 459 F.3d 604, 609 (5th Cir. 2006). First, as noted above, Respondent did not have established rules designed to prevent the violation—there was no specification in the SOP as to how long the valve should remain open or how much it should be opened. This, in and of itself, is sufficient to reject Respondent’s defense. See *Stuttgart Machine Works, Inc.*, 9 BNA OSHC 1366 (No. 77-3021, 1981) (“Respondent’s inability to unambiguously state the content of its rule casts serious doubt on whether Respondent effectively communicated any rule to its employees.”). Without specific outer limits on the process, there is no sense in which an employee can be said to comply. One of the witnesses testified that the procedure for lighting was like a dance, of sorts. (Tr. 353). Second, and relatedly, Respondent’s own Incident Report indicated that, though the operators seemed to generally understand how to safely light the Wickes, the knowledge demonstration tests revealed “that there were no specific questions regarding the lighting the burner of the Wickes boiler as part of the test.” (Ex. C-30 at 13). This indicates a failure to adequately communicate the rules to employees and is exemplified by the different characterizations each employee gave regarding how much to open the valve and for how long.

While the Incident Report findings indicate that the valve was open far too wide for far too long, this was not the sole root cause identified nor, in light of the deficient procedures identified above, was it the product of unpreventable employee misconduct. (Ex. C-30). Lighting the Wickes, as illustrated by the history of accidents associated with it, clearly requires attention to detail, whether that is being cognizant of what fraction of a spoke one is supposed to turn the bypass valve or tracking the amount of fuel flowing into the firebox. Tracking those all-too-important details is made all the more difficult by the fact that it is done infrequently—according to most witnesses, maybe once per year for the annual boiler inspection. Given that set

of circumstances, it was incumbent upon Respondent to ensure, as the law requires, a set of procedures that accounted for hazards that Respondent knew existed. That the accident itself may have been caused, in part, by the misguided actions of an employee does not absolve Respondent of liability for having insufficient procedures. *See Western Waterproofing Co., Inc.*, 7 BNA OSHC 1625 (No. 1087, 1979) (“[A]s a general rule, whether an employer is in violation of the Act does not depend on the cause of a particular accident.”); *Propellex Corp.*, 18 BNA OSHC 1677 (No. 96-0265, 1999) (finding judge mistakenly focused on cause of accident in determining whether a violation occurred). The responsibility of having adequate procedures is Respondent’s. *See Brown & Root, Inc.*, 7 BNA OSHC 2074 (No. 16162, 1979) (“The Act . . . places final responsibility for compliance on the employer. An employer cannot shift this responsibility to an employee by a work rule that is not effectively communicated and enforced.”). The failure to have adequate procedures would be a violation irrespective of whether an accident occurred, especially in light of Respondent’s history of “hard starts”.

Based on the foregoing, the Court finds that Complainant established a violation of the cited standards and that the violation was serious. Accordingly, Citation 1, Items 3(a) and (b) are AFFIRMED as serious violations of the Act.

v. Citation 1, Item 4

Complainant alleged a serious violation of the Act in Citation 1, Item 4 as follows:

29 CFR 1910.119(l)(3): Employees involved in operating a process and maintenance and contract employees whose job tasks will be affected by a change in the process were not informed of, and trained in, the change prior to start-up of the process or affected part of the process:

The employer does not ensure employees involved in operating a process and maintenance and contract employees whose job tasks will be affected by a change in the process are informed of, and trained in, the change prior to start-up of the process or affected part of the process. In the Zone 2/CAT Wickes Boiler Area the employer did not ensure employees whose job tasks were affected by a change in the process were informed of an trained on the changes prior to startup of the

process. Employees were exposed to fire and explosion hazards from potential releases of fuel gas and other flammable liquids or gasses for process changes such as, but not limited to:

- a) Standard Operating Procedures covering the start-up of the Wickes Boiler burner after the 2008 Wickes Boiler Explosion.
- b) Use of temporary power to power the Wickes boiler during the shutdown/turnaround.

The cited standard provides:

Employees involved in operating a process and maintenance and contract employees whose job tasks will be affected by a change in the process shall be informed of, and trained in, the change prior to start-up of the process or affected part of the process.

29 C.F.R. § 1910.119(l)(3).

Complainant alleges that Respondent violated the above-referenced standard by failing to inform and train employees regarding (1) changes made to the SOP for lighting the Wickes after the 2008 hard start; and (2) the change to temporary power on the day of the explosion. Respondent contends that Complainant's allegations as to the changes made to the SOP in 2008 are time-barred. As regards the use of temporary power, Respondent submits that all affected employees were informed of the use of temporary power and that Complainant failed to prove that the procedures for lighting the boiler with temporary power would be different than with grid power.

Complainant's argument on the topic of the 2008 SOP changes is somewhat confusing. Complainant asserts that important warnings contained in the SOPs prior to the 2008 explosion did not make the transition to the any set of SOPs that were approved in subsequent years. Relying on Howard's testimony, Complainant concluded that the procedures were deficient because of this failure. Complainant then goes on to argue that the failure to train on the changes that occurred in 2008 exposed employees to fire and explosion hazards. This is confusing for a couple of reasons: (1) It is not clear whether Complainant is asserting that Respondent violated

the standard because it failed to include important information in the updated SOPs, which is covered by a different standard (and an allegation already made by Complainant); and (2) If the failure to include that information is indeed the basis for the violation, then it would appear that Respondent is being charged with the responsibility to train employees on changes that should be included, but are not. To the extent that the argument is directed at the failure to account for the implementation of a ¾” bypass valve to reduce fuel flow to the firebox—neither the allegation contained in the citation item nor Complainant’s brief clarify exactly what is being asserted—CSHO Hartung admitted that the SOPs were revised in 2010, meaning that any change made to the procedures in 2008 are no longer effective, thereby obviating the need to train on such changes. Further, to the extent that Complainant is alleging that Respondent failed to train employees on the change in 2008, such an allegation is time-barred. While there is a question about the viability of the continuing violations theory, such is not applicable here where Respondent updated its procedures in 2010. In other words, the door was closed on a continuing violation theory when Respondent was no longer obligated to train on changes to the process that were no longer a part of the process. In light of the foregoing, the Court finds that Complainant failed to establish a violation of the standard based on this particular instance.

However, as regards the use of temporary power, the Court finds that it was incumbent upon Respondent to implement MOC procedures and both inform affected employees of the use of temporary power and train them regarding its use. CT Sutton, who was responsible for monitoring the control boards during the Wickes lighting, stated that the previous CT had reported trouble with the electrical components controlled by a temporary generator. (Tr. 277). In particular, CT Sutton noted that the use of temporary power was impacting the functionality of the vanes, which control air flow to the firebox. (Tr. 279). He also stated that, based on his

experience in construction, generators equipped with ground faults (as the generator in this case) can trip out for unknown reasons. (Tr. 487). In the case of the Wickes, he was concerned that they could lose power to the controls, such as the vanes, during the lighting process. (Tr. 487–88). Though he noted that a loss of power would cause the controls to go into a fail-safe position, he still “thought they ought to be aware of the situation they had.” (Tr. 488).

Clearly there was a change in the process; the Wickes boiler was typically run on grid power. None of the employees who testified could recall running the Wickes on temporary generator power before. (Tr. 278, 305, 347–48). While running on temporary power that day, the CT reported problems controlling the vanes, which have a direct impact on creating the atmosphere necessary to ignite the burner and purging the firebox prior to a lighting attempt. (Tr. 278–79). An operator expressed a safety concern over the consequences of the generator tripping and loss of power to the controls. Based on the testimony of Respondent’s employees, the Court finds that Complainant presented sufficient evidence to establish that the procedures for lighting the boiler had changed to the extent that Respondent was obligated to inform and train its employees regarding that change. To a certain extent, it could be said that Respondent, through the actions of Operator Sutton, complied with its obligation to inform affected employees of the change in the process; however, as testified to by the operators and other employees present that day, they had not received training on those changes. (Tr. 488–90).

The Court finds that Complainant has established a violation and that it was serious. There is no question that Respondent knew that temporary generator power was going to be used that day, and it does not attempt to argue that it provided training regarding the change in the process or that such a change was documented, arguing instead that the change was not material. CSHO Hartung testified that the potential failure of the generator could impact a number of

controls in the process, which could expose employees to potential fire and explosion hazards. (Tr. 1161–62). Similar concerns were expressed by Operator Sutton. (Tr. 490). Accordingly, Citation 1, Item 4, instance (a) is VACATED, and instance (b) is AFFIRMED.

vi. Citation 1, Item 5(a) and (b)

Complainant alleged two serious violations of the Act in Citation 1, Item 5, subparts (a) and (b). Given their similarity, both items shall be addressed together. Complainant’s allegations with respect to Item 5(a) are as follows:

29 CFR 1910.147(c)(4)(ii)(B): The energy control procedures did not clearly and specifically outline the steps for shutting down, isolating, blocking and securing machines or equipment to control hazardous energy.

The employer does not ensure the energy control procedures clearly and specifically outline the steps for shutting down, isolating, blocking and securing machines or equipment to control hazardous energy. In the Zone 2/CAT Wickes Boiler Area the employer did not ensure the energy control procedures for the lockout/tagout of the fuel gas and purchased gas supply lines to the Wickes Boiler burner clearly and specifically outline the steps for shutting down, isolating, blocking, and securing equipment to control hazardous energy. Employees were exposed to fire and explosion hazards from potential releases of fuel gas and other flammable liquids or gasses.

The cited standard requires energy control procedures to include “[s]pecific procedural steps for shutting down, isolating, blocking and securing machines or equipment to control hazardous energy.” 29 C.F.R. § 1910.147(c)(4)(ii)(B).

Complainant’s allegations with respect to Item 5(b) are as follows:

29 CFR 1910.147(c)(4)(ii)(D): The energy control procedures did not clearly and specifically outline the requirements for testing a machine or equipment to determine and verify the effectiveness of lockout devices, tagout devices, and other energy control measures:

The employer does not ensure the energy control procedures clearly and specifically outline the requirements for testing a machine or equipment to determine and verify the effectiveness of lockout devices, tagout devices, and other energy control measures. In the Zone 2/CAT Wickes Boiler Area the employer did not ensure the energy control procedures for the lockout/tagout of the fuel gas and purchased gas supply lines to the Wickes Boiler burner clearly

and specifically outline the requirements for testing a machine or equipment to determine and verify the effectiveness of lockout devices. Employees were exposed to fire and explosion hazards from potential releases of fuel gas and other flammable liquids or gasses. Employees were exposed to fire and explosion hazards from potential releases of fuel gas and other flammable liquids or gasses.

This section of the cited standard requires that energy control procedures to include “[s]pecific requirements for testing a machine or equipment to determine and verify the effectiveness of lockout devices, tagout devices, and other energy control measures.” 29 C.F.R. § 1910.147(c)(4)(ii)(D).

According to CSHO Hartung, this citation resulted from OSHA’s request to analyze the valve and natural gas regulator on the Wickes gas train approximately one month after the explosion. (Tr. 1176, 1285). Hartung stated that he wanted to see whether the valve was working as it was intended, as he understood that it had not been tested in a while. (*Id.*). Prior to Respondent carrying out the procedure, Hartung reviewed Respondent’s LOTO procedures. (Tr. 1178). Based on how Respondent’s employees carried out the procedure of removing the valve and regulator and his review of Respondent’s lock-out/tag-out (LOTO) procedures, Hartung cited Respondent for having deficient LOTO procedures. Respondent contends that the citation is inappropriate because the valve removal was only done at the request of CSHO Hartung. Further Respondent argues that Complainant failed to prove that anyone was exposed to a hazard as a result of the alleged LOTO deficiency.

The standard requires such LOTO procedures to be “clearly and specifically” outlined. 29 C.F.R. § 1910.147(c)(4)(ii); *see also Gen. Motors*, 22 BNA OSHC 1019 (No. 91-2834, 2007). Respondent’s LOTO procedures were deficient in two respects: (1) the procedures did not identify specific valves that may have been used to relieve energy and whether those valves should be open or closed; and (2) the procedures did not have steps for testing a machine/equipment to determine whether the lockout was effective. (Tr. 1177, 1182–83; Ex. C-

65). Respondent did not proffer any evidence to contradict these deficiency findings. Accordingly, the Court finds that the terms of the standard were violated.

Instead of attempting to establish that its procedures were complete, Respondent contends that the removal of the valve would not have occurred but for CSHO Hartung's request and that Complainant failed to prove that any of Respondent's employees were exposed to a hazard as a result of the deficient procedures. The Court agrees with Complainant. The LOTO procedure, which was in effect prior to the explosion, was deficient irrespective of when or for what reason it was implemented. CSHO Hartung testified that he requested to look at the valve approximately five days before it was removed and that he waited to perform this particular aspect of his inspection until Respondent was ready to do it. (Tr. 1178). Further, CSHO Hartung was well within his rights to request the removal of the valve for inspection, and Respondent was under an obligation to ensure that its LOTO procedures were adequate for carrying out that job.²⁷ As Complainant alleged, the procedures were not adequate.

The Court also finds that, contrary to Respondent's argument, its employees were exposed to fire and explosion hazards. While it may be the case that the Wickes had been offline since the explosion, there was no evidence to suggest that it had been completely isolated from other equipment such that the removal of the valve, which was upstream from the Wickes, did not involve the potential for release of hazardous energy. Further, and more importantly, Respondent's failure to have adequate procedures for LOTO exposed employees to fire and explosion hazards regardless of whether the Wickes had been offline. The failure to have specific LOTO procedures exposes employees to hazards each time those procedures are implemented, not just in the particular context in which the alleged deficiencies came to light.

27. It should also be noted that the work requested by CSHO Hartung was not a work activity which never occurred but for OSHA's valve examination request. As noted above, Respondent had previously done work on this valve in order to change the size and restrict the flow of gas to the firebox of the Wickes. (Tr. 311-12).

Respondent's LOTO form, which is presumably used for each LOTO procedure and modified to fit the particulars of a particular job, does not have a provision for verifying the effectiveness of energy control measures, nor is there any indication on the form or its attachment as to the position of the valves (open or closed) that were supposed to be a part of the process for isolating the bypass valve for removal. The purpose of the prescribed procedure is "to guide an employee through the lockout process." *Drexel Chem. Co.*, 17 BNA OSHC 1908 (No. 94-1460, 1997). Without an adequate guide for what is clearly a complex lockout procedure, employees may overlook critical steps in the process, which could result in an unintentional release of hazardous energy, such as hazardous hydrocarbons. Accordingly, the Court finds that Respondent's employees were exposed to a hazard.

The Court also finds that Respondent knew or, with the exercise of reasonable diligence, could have known of the hazardous condition. Not only is it the responsibility of management to ensure that adequate procedures are in place, but members of Respondent's management team were present at the time the procedures were implemented and the bypass valve was removed. Further, during his interview with CSHO Hartung, Stephenson admitted that the procedure did not indicate whether certain valves should be open or closed, nor how an employee should go about verifying that no energy remained in the system. (Ex. R-9).

Based on the foregoing, the Court finds that Respondent violated the cited standards and that the violation was serious. Accordingly, Citation 1, Items 5(a) and (b) are AFFIRMED.

vii. Citation 1, Item 6(a) and (b)

Complainant alleged two serious violations of the Act in Citation 1, Item 6, subparts (a) and (b). Given their similarity, both items will be addressed together. Complainant's allegations with respect to Item 6(a) are as follows:

29 CFR 1910.147(d)(3): All energy isolating devices that were needed to control the energy to the machine or equipment were not physically located and operated in such a manner as to isolate the machine or equipment from the energy source:

The employer does not ensure all energy isolating devices that are needed to control the energy to the machine or equipment are physically located and operated in such a manner as to isolate the machine or equipment from the energy source. In the Zone 2/CAT Wickes Boiler Area the employer did not ensure all energy isolating devices for the lockout/tagout of the fuel gas and purchased gas supply lines such as, but not limited to, the control valves (FC 702 & FC 704) and bleed valves to the Wickes Boiler were physically located and operated in such a manner as to isolate the machine or equipment from the energy source. Employees were exposed to fire and explosion hazards from potential releases of fuel gas and other flammable liquids or gasses.

The cited standard provides that “[a]ll energy isolating devices that are needed to control the energy to the machine or equipment shall be physically located and operated in such a manner as to isolate the machine or equipment from the energy source(s).” 29 C.F.R. § 1910.147(d)(3).

Complainant’s allegations with respect to Item 6(b) are as follows:

29 CFR 1910.147(d)(5)(i): All potentially hazardous stored or residual energy was not relieved, disconnected, restrained or otherwise rendered safe after the application of lockout or tagout devices to energy isolating devices:

The employer does not ensure all potentially hazardous stored or residual energy is relieved, disconnected, restrained, or otherwise rendered safe after the application of lockout or tagout devices to energy isolating devices. In the Zone 2/CAT Wickes Boiler Area the employer did not ensure all potentially hazardous stored or residual energy was relieved after the application of lockout or tagout devices such as between the two control valves (FC 702 & FC 704) on the fuel gas and purchased gas supply lines to the Wickes Boiler. Employees were exposed to fire and explosion hazards from potential releases of fuel gas and other flammable liquids or gasses.

The cited standard states, “Following the application of lockout or tagout devices to energy isolating devices, all potentially hazardous stored or residual energy shall be relieved, disconnected, restrained, and otherwise rendered safe.” 29 C.F.R. § 1910.147(d)(5)(i).

According to Hartung, the basis for Complainant’s allegations with respect to Citation 1, Item 6 is the same activity as indicated in Citation 1, Item 5; namely, Respondent’s failure to

take the steps that were required to be documented in the LOTO procedures. (Tr. 1185–87). Respondent does not contend that it complied with the requirements of the standard, and, indeed, there is no evidence to suggest that Respondent’s employees complied. Respondent failed to identify all of the energy isolating devices that were needed to remove the bypass valve and did not ensure that hazardous energy had been removed from the system. Not only does this show that Respondent failed to comply with the standards cited in Items 6(a) and 6(b), but it also illustrates the importance of specific, well-documented procedures: If Respondent had documented all appropriate isolation points, how they would be operated, and the manner in which employees could verify isolation, then such steps would probably not have been missed. *See* Control of Hazardous Energy, 54 Fed. Reg. 36644, 36670 (September 1, 1989) (noting the importance of detailed procedures in light of the need to follow directions carefully and the number of variables involved in controlling hazardous energy). Based on the evidence introduced by Complainant the Court finds that Respondent violated the cited standards.

Instead, Respondent contends that Complainant failed to establish that employees were exposed to a hazard. Specifically, Respondent argues that: (1) Hartung was present during the valve removal and would not have allowed the removal of the valve to take place if there was a serious threat of injury; and (2) the removal of the valve took place one month after the explosion, which means that any residual gas left in the pipeline would have dissipated by the time the valve was removed. First, CSHO Hartung’s presence during the removal of the valve has no bearing on whether Respondent’s employees were exposed to a hazard. There is no indication in the record that CSHO Hartung knew whether the process being followed by Respondent’s employees was safe at the time, nor is it clear at what point in time he made the determination that Respondent’s LOTO procedures were deficient. Without additional evidence,

the Court finds that CSHO Hartung's presence on the day of the valve removal does not make it any more or less likely that Respondent's employees were exposed. Second, as noted in the Court's discussion of Citation 1, Item 5, *supra*, there was no definitive indication that the valve or its associated pipes were free of hazardous energy at the time the valve was removed. The fact that the Wickes had been offline for approximately 30 days does not, of itself, obviate the need to protect against the possibility of hazardous releases of energy. Further, though the boiler was offline, there was no evidence regarding the presence of hydrocarbons in the upstream process lines, such as the natural gas and RFG lines. As such, there was still a possibility for a hazardous energy release. Accordingly, the Court finds that Respondent's employees were exposed to a hazard.

As noted above, members of Respondent's management team were present at the time the valve was being removed. Accordingly, the Court finds that it is proper to impute the knowledge of those managers to Respondent. *See Revoli Const. Co.*, 19 OSHC 1682 (No. 00-0315, 2001) (holding that knowledge of supervisors is generally imputable to employer).

Accordingly, Citation 1 Items 6(a) and 6(b) are AFFIRMED.

viii. Citation 2, Item 1

Complainant alleged a repeat violation of the Act in Citation 2, Item 1 as follows:

29 CFR 1910.119(d)(3)(ii): The employer did not document that equipment complies with recognized and generally accepted good engineering practices.

The employer did not document that equipment in the process complies with recognized and generally accepted good engineering practices. In the Zone2/CAT Wickes Boiler Area the employer did not ensure it documented the Wickes boiler burner and gas train equipment complied with recognized and generally accepted good engineering practices such as the National Fire Protection Association (NFPA) Standard 85, Boiler and Combustion Systems Hazard Code, and ASME CSD-1, sections CF-310 & CF-330, and ASME Section VI. These practices include, but are not limited to the following equipment:

1. Flame scanner/fire eyes.

2. Automatic pilot gas shutoff valve.
3. Automatic double block (positive shutoff) and automatic bleed on gas train to the burner.
4. Burner management system(s) to control firebox purge, pilot ignition, burner starting, and shutdown.

The cited standard provides:

The employer shall document that equipment complies with recognized and generally accepted good engineering practices.

29 C.F.R. § 1910.119(d)(3)(ii).

Respondent contends that the foregoing citation is duplicative of Citation 1, Item 1, which alleged a violation of 29 C.F.R. § 1910.119(d)(3)(i)(F). The present citation is issued under the same subsection (d)(3), and relates to the process safety information that Respondent is required to keep with respect to PSM-covered processes. *Id.* § 1910.119(d)(3)(iii). A brief comparison of Complainant's allegations illustrate that Complainant essentially replaced the term "design codes and standards" with "recognized and generally accepted good engineering practices" and cited the exact same design codes and standards, such as NFPA 85. According to Complainant, an employer "typically complies with [(d)(3)(iii)] by developing a list of the standards and codes used at the facility and putting it in the PSI file." *Compl't Br.* at 52. This was the exact failure alleged by Complainant in Citation 1, Item 1. *See* Section IV.C.ii, *supra*. If compliance with the standard requires documentation of RAGAGEP, and documentation of RAGAGEP requires developing a list of the standards and codes used at the facility, then the Court sees no meaningful distinction between Citation 1, Item 1 and Citation 2, Item 1. *See Capform, Inc.*, 13 BNA OSHC 2219, 2224 (No. 84-556, 1989) (finding violations duplicative where abatement of one item will necessarily result in abatement of the other item as well).

The Court finds that Citation 2, Item 1 is duplicative of Citation 1, Item 1. Accordingly, Citation 2, Item 1 is VACATED.

ix. Citation 2, Item 2

Complainant alleged a repeat violation of the Act in Citation 2, Item 2 as follows:

29 CFR 1910.119(f)(1)(ii): The employer did not implement written operating procedures that addressed operating limits; including at least the following elements: consequences of deviation and the steps required to correct or avoid deviation.

a) In the Zone 2/CAT Wickes Boiler Area the employer did not ensure the written operating procedures addressed the operating limits of the process such as, but not limited to:

1. Minimum/Maximum gas pressure to the boiler burner gas train.
2. Minimum and maximum pressure (PI 721 & PI 711) at the fuel gas inlet to the Wickes.
3. Minimum and maximum fuel gas flow to the Wickes boiler burner (FI 702).
4. Minimum and maximum combustion air flow to the Wickes boiler burner (FI-706).
5. Composition of the gas flow streams to the Wickes boiler burner (fuel gas and purchased gas) including BTU content, lower explosive limits, etc.

b) In the Zone 2/CAT Wickes Boiler Area the employer did not ensure the written operating procedures addressed the consequence of deviation from the safe upper and lower limits of the process such as, but not limited to:

1. Minimum/Maximum gas pressure to the boiler burner gas train.
2. Minimum and maximum pressure (PI 721 & PI 711) at the fuel gas inlet to the Wickes.
3. Minimum and maximum fuel gas flow to the Wickes boiler burner (FI 702).
4. Minimum and maximum combustion air flow to the Wickes boiler burner (FI-706).
5. Composition of the gas flow streams to the Wickes boiler burner (fuel gas and purchased gas) including BTU content, lower explosive limits, etc.

c) In the ZONE 2/CAT Wickes Boiler Area the employer did not ensure the written operating procedures addressed the steps to correct or avoid deviation from the safe upper and lower limits of the process such as but not limited to:

1. Minimum/Maximum gas pressure to the boiler burner gas train.

2. Minimum and maximum pressure (PI 731 & PI 711) at the fuel gas inlet to the Wickes.
3. Minimum and maximum fuel gas flow to the Wickes boiler burner (FI 702).
4. Minimum and maximum combustion air flow to the Wickes boiler burner (FI-706).
5. Composition of the gas flow streams to the Wickes boiler burner (fuel gas and purchased gas) including BTU content, lower explosive limits, etc.

Employees were exposed to fire and explosion hazards from potential releases of fuel gas and other flammable liquids or gasses.

The cited standard provides:

[O]perating procedures shall address at least the following elements
Consequences of deviation; and Steps required to correct or avoid deviation.

29 C.F.R. § 1910.119(f)(1)(ii).

This citation item addresses the same subject matter as Citation 1, Item 3—Respondent’s operating procedures. Citation 1, Item 3 addressed the procedures from the standpoint of initial startup. In this instance, however, Complainant alleges that Respondent’s operating procedures were deficient with respect to their discussion of the limits of the process, the consequences of deviation, and the steps required to correct or avoid deviation. As in Citation 1, Item 3, Respondent does not contend that it had procedures that addressed the alleged deficiencies; rather, it argues that: (1) the standard does not apply; (2) this Citation is duplicative of Citation 1, Item 3; (3) the deficiencies alleged are irrelevant to the startup of the boiler; and (4) and there is no meaningful difference between the use of natural gas and RFG.

The Court has already found that the standard applies. *See* Section IV.A, *supra*. The Court has also found that gas pressure and flow are relevant to startup operations, as subsequent data revealed not only typical operating limits, but also consequences of deviation. *See* Section IV.C.iv, *supra*. While that data may not be in the bypass valve operator’s line of sight, that does not make such information irrelevant; instead, it merely impacts the manner in which that

information is conveyed/relayed. Presumably, the availability of such information would have a fairly direct impact on the employee who is responsible for operating the valve and the manner in which they “crack the valve a small amount and for a short period of time”. *See Resp’t Br.* At 61. As to the composition of the gas flow streams, as alleged in Complainant’s fifth subpart, the Court has previously found that a meaningful difference exists between the use of RFG (which may be mixed with natural gas) and the use of natural gas alone. As to any other possible iterations of RFG, the Court cannot definitively find that each and every possibility must be accounted for, considering the variability of hydrogen. (Tr. 1712). There was not sufficient evidence to indicate whether accounting for such variability was feasible. However, to the extent that safe outer limits can be imposed, regardless of composition, the fact that RFG can be variable does not absolve Respondent of its responsibility to account for such information and variations in its operating procedures.

Respondent raises a new argument with respect to this item—that it is duplicative of Citation 1, Item 3. While the standard cited is part of the same subsection, and addresses similar subject matter (operating procedures), the citation items address separate parts of the procedures. If Respondent were to abate Citation 1, Item 3 by updating the initial startup procedures, such information would not be sufficient to comply with Respondent’s obligations to consider and document the potential consequences of deviation and the steps required to correct or avoid deviation. Thus, the citation items are not duplicative.

With respect to the issues of knowledge and exposure, the Court hereby incorporates its findings on the same issues found in Citation 1, Item 3. *See* Section IV.C.iv. With respect to characterization, the Court has already determined that Respondent is not liable for a repeat violation based on the conduct of GWE-WR. However, given that the hazards alleged in this

citation item are the same as those alleged in Citation 1, Item 3, the findings of which have been incorporated by reference, the Court finds that the violation was serious.

The Court finds that Complainant has established a violation of the cited standard. Accordingly, Citation 2, Item 2 is AFFIRMED as a serious violation of the Act.

x. Citation 2, Item 3

Complainant alleged a repeat violation of the Act in Citation 2, Item 3 as follows:

29 CFR 1910.119(g)(2): The employer did not provide refresher training at least every three years to each employee involved in operating a process to assure that the employee understands and adheres to the current operating procedures of the process.

The employer does not provide refresher training at least every three years to each employee involved in operating a process to assure that the employee understands and adheres to the current operating procedures of the process. In the Zone 2/CAT Wickes Boiler Area the employer did not ensure refresher training was provided at least every three years to each employee involved in operating the Wickes Boiler to assure that the employee understood and adhered to the current operating procedures. Employees were exposed to fire and explosion hazards from potential releases of fuel gas and other flammable liquids or gasses.

The cited standard provides:

Refresher training shall be provided at least every three years, and more often if necessary, to each employee involved in operating a process to assure that the employee understands and adheres to the current operating procedures of the process.

29 C.F.R. § 1910.119(g)(2).

According to Respondent's training records, within three years of the accident each of the individuals that were involved in starting the boiler received training and was tested with respect to various processes in Zone 2 according to job description. (Exs. C-44 to C-51).²⁸ According to those documents, Willson, Kellerhall, Operator Sutton, Mann, and Koesler were required to "describe/discuss how to start the Wickes boiler." (*Id.*). The testing for CTs Walker and Sutton

28. Similar exhibits can be found in R-201, R-202, R-204, R-212, R-214, R-219, R-221.

did not include a question regarding the Wickes startup procedure, nor did the testing for Smith, who was manning the sight glass. (*Id.*). The only question involving the Wickes posed to Smith asked for a description of “how to switch the fans on the wickes boiler.” (C-44, C-45). CT Sutton testified there is no CT-specific testing related to lighting the boiler. (Tr. 325). Respondent’s own Incident Investigation Report determined that the training did not cover the steps discussed in an earlier version of the SOP, which Respondent’s investigation team found should have been included in subsequent versions of the SOP. (Ex. C-30 at 13).

Many of the employees involved in the explosion testified they had not seen the 2008 version of the Wickes lighting procedure or the section of the Operations Manual dealing with the Wickes. (Tr. 166–70, 249, 284, 322, 539; Ex. C-35). Those same employees gave differing descriptions of how to operate the bypass valve, which controls the flow of fuel to the Wickes. All of them agreed, however, that the then-current SOPs were deficient because, at the very least, there was no indication as to how much to open the valve, or for how long. (Tr. 164, 355, 549; Ex. C-33). The Court finds there is enough deviation between the various descriptions to suggest that training was inconsistent and deficient.²⁹ Considering that the bypass valve was characterized as “very touchy” and that slight movements could drastically change the fuel flow rate to the firebox (so much so that Respondent previously attempted installing a smaller valve), Respondent had an obligation to provide more specific training and instruction to its employees. *J.K. Butler Builders, Inc.*, 5 BNA OSHC 1075 (No. 12354, 1977) (“A review of applicable case

29. Koesler stated that he was trained to open the valve “1/4 spoke”, that there was no set amount of time to leave open, and that he was told to purge “until you thought it was ok”. (Tr. 113, 116, 121). Kellerhall testified that he did not recall specific instructions other than that the valve is “very touchy” and that you “don’t want to leave it open very long.” (Tr. 219). CT Sutton testified that he told the investigator that you turn the valve about an inch. (Tr. 301). Willson testified that he had not been instructed as to any specific instructions regarding the valve, instead characterizing the process as a “dance”. (Tr. 353). McCurtain stated that he was trained to open the valve “slightly” or “just a little bit” and that if you don’t achieve ignition “quickly” or “shortly” to close the valve. (Tr. 518, 528). Finally, Howard, who provided training and testing, testified that he trained operators to “[s]lowly open it until you reach one spoke And if it does light, you move on with the procedure; if it does not, then you close it off.” (Tr. 693).

law leads us to define a work rule as an employer directive that requires or proscribes certain conduct, and that is communicated to employees in such a manner that its mandatory nature is made explicit and its scope clearly understood.”). Further, nearly all who testified, including supervisory personnel, agreed that the Wickes lighting procedures were deficient and should have included the bolded warnings contained in the 2008 lighting procedure. (Tr. 167–71, 549, 710–11, 714; Ex. C-33, C-35).

Based on the foregoing, the Court finds that Respondent violated the terms of the standard by failing to provide thorough and consistent training to its employees such that they were aware of and could execute the lighting procedure. Respondent knew or should have known of the violation because its managers were responsible for providing training and for updating, reviewing, and approving the procedures. *See Revoli Constr., Co.*, 19 BNA OSHC 1682 (No. 00-0315, 2001) (holding that actual or constructive knowledge of supervisory personnel can be imputed to their employer). Further, due to the failure to properly train its employees, Respondent exposed them to the hazard of fire and explosion, which, as described above, can cause serious injury and/or death. Accordingly, Citation 2, Item 3 is AFFIRMED as a serious violation of the Act.

xi. Citation 2, Item 4

Complainant alleged a repeat violation of the Act in Citation 2, Item 4 as follows:

29 CFR 1910.119(j)(2): The employer did not establish and implement written procedures to maintain the on-going mechanical integrity of process equipment:

The employer does not establish and implement written procedures to maintain the on-going mechanical integrity of process equipment. In the Zone 2/CAT Wickes Boiler Area the employer did not ensure written procedures were established and implemented for the testing and inspection of the Low Combustion Air Flow Fuel Gas Shut-off system safeguard. Employees were exposed to fire and explosion hazards from potential releases of fuel gas and other flammable liquids or gasses.

The cited standard provides:

The employer shall establish and implement written procedures to maintain the on-going integrity of process equipment.

29 C.F.R. § 1910.119(j)(2).

According to CSHO Hartung, Respondent failed to have an established and written procedure to maintain the mechanical integrity of process equipment. (Tr. 1060). Specifically, he noted that the refinery had relied on a breakdown maintenance system, as opposed to a preventative system of maintenance to ensure equipment was kept in working order. (Tr. 1062). Although he noted that management was well-versed in process safety management and the need for such a program, they did not have an established, written procedure in place. (Tr. 1063).

Respondent contends that Complainant failed to prove a violation of this performance-based standard, arguing that it had determined that a procedure to ensure that an air flow switch worked properly was sufficient and that Complainant is attempting to supplant its own determination of how to properly implement the requirements of the standard. Finally, Respondent contends that, insofar as its procedures were not compliant, any violation should be considered *de minimis* because the boiler was inspected annually by the State of Oklahoma. Any deficiency in procedure, therefore, would not create a hazard to employees because the boiler had been deemed safe and functional by a third party.

The Court finds that Complainant has established a violation of the cited standard. The standard requires Respondent to “establish and implement written procedures.” 29 C.F.R. § 1910.119(j)(2). The only evidence of a written procedure was a document that was labeled “Draft” in multiple locations throughout the document. (Ex. C-58). In addition, the document contained editing lines, which are associated with the “Track Changes” function in Microsoft Word. (*Id.*). There was no testimony as to whether this draft was established as the proper

procedure, nor, based on the date of the document, does it appear that Respondent was responsible for generating it in the first place. The only indication that a procedure for maintaining mechanical integrity even existed appears in the OSHA 1-B Narrative for this citation item. (Ex. R-16). In that narrative, Howard told CSHO Hartung that he could not remember whether there was a written procedure for testing the airflow interlocks, but that there was a checklist. (*Id.*). No such checklist was introduced into the record.

Based on the foregoing, it does not appear that Respondent had an established and written procedure for maintaining the on-going integrity of process equipment. Although CSHO Hartung noted that Respondent was well-versed in PSM and the necessity of such a program, this does not make up for not having one. Draft procedures, such as the one at issue, can produce confusion, especially, as here, where the procedures have edit marks, leaving the operator to guess at whether the procedure they are attempting to follow is accurate. Without specific procedures, and an established program to ensure that process equipment is functioning properly, Respondent exposed its employees to potential explosion and fire hazards. (Tr. 1158). Contrary to Respondent's argument, it is of little consequence that a third party verified the functionality of the boiler's fuel controls. The obligation to ensure the ongoing mechanical integrity of the process equipment lies with Respondent. The failure to have a thorough procedure to examine the process controls, such as safety interlocks, exposed employees to serious injury because the purpose of those interlocks is to automatically close down fuel valves in a low airflow situation. If those interlocks were to fail, or not work as intended, then the firebox could be flooded, which can lead to an explosion.

Finally, based on the fact that, at the very least, it had a draft procedure for testing the interlocks, Respondent knew or could have known of the violative condition. Accordingly, Citation 2, Item 4 is AFFIRMED as a serious violation of the Act.

xii. Citation 2, Item 5

Complainant alleged a repeat violation of the Act in Citation 2, Item 5 as follows:

29 CFR 1910.119(l)(1): The employer did not establish and implement written procedures to manage changes to process chemicals, technology, equipment, and procedures; and, changes to facilities that affect a covered process:

- a) In the Zone 2/CAT Wickes Boiler Area the employer did not ensure management of change procedures were implemented to manage changes to the process operating procedures such as, but not limited to:
 1. The amount of time the firebox is purged prior to attempting to light the pilot of after a failed burner lighting attempt.
 2. The amount that the gas control valve bypass valve is to be opened.
 3. The time that the gas control valve bypass valve is allowed open before the burner lights.
- b) In the Zone 2/CAT Wickes Boiler Area the employer did not ensure management of change procedures were implemented to manage changes to the process equipment, such as the addition of temporary power to operate the Wickes Boiler.

Employees were exposed to fire and explosion hazards from potential releases of fuel gas and other flammable liquids or gasses.

The cited standard provides:

The employer shall establish and implement written procedures to manage changes (except for “replacements in kind”) to process chemicals, technology, equipment, and procedures; and changes to facilities that affect a covered process.

29 C.F.R. § 1910.119(l)(1).

This citation item is a companion to Citation 1, Item 4, which addressed the failure to inform and train employees on the changes to the operating procedure after the 2008 explosion. The only difference is that the standard cited in the present citation item addresses Respondent’s obligation to establish and implement written procedures to manage those changes. *Compare* 29

C.F.R. § 1910.119(l)(1), *with id.* § 1910.119(l)(3). As such, the arguments proffered by Complainant and Respondent are virtually the same, as is the Court's ruling.

Complainant asserts that, with respect to instance (a), Respondent failed to implement an MOC in response to changes that were made to the equipment following the 2008 explosion; namely, the introduction of a smaller fuel gas bypass valve. (Tr. 713–14; Ex. C-19). Respondent's employees testified, and the Court agrees, that changes made to the valve size required the implementation of new written procedures as the change impacted the flow rate of fuel. After it was determined that the smaller valve would not work, Respondent reverted back to the original 3-inch valve. (Tr. 312). Notwithstanding the change back to the original, Complainant contends that Respondent's failure to update the SOP to also reflect that change constituted a violation because Respondent failed to update its SOP to reflect this change "for several years." *Compl't Br.* at 63. The problem for Complainant, however, is that the SOPs were updated to reflect the change back to the 3-inch valve in 2010. (Ex. C-36). Complainant asserts that the failure to implement MOC after the 2008 changes is a continuing violation of the standard. This would only be correct if there had been no subsequent changes to the procedure; the moment that the procedures were changed, the violation no longer continued (at least insofar as Respondent was obliged to implement written procedures for a process that no longer existed). Therefore, as to instance (a), the Court does not find a violation of the standard.

However, with respect to instance (b), the Court finds, as it did in Citation 1, Item 4, that Respondent was obligated to implement written procedures regarding the use of temporary power to light the Wickes. *See* Section IV.C.v. Since the Court has already addressed the necessity of implementing MOC with respect to the use of temporary power, it will incorporate

by reference the findings in Section IV.C.v. Based on those findings, Citation 2, Item 5, instance (a) is VACATED, and instance (b) is AFFIRMED as a serious violation of the Act.

xiii. Citation 3, Item 1

Complainant alleged an other-than-serious violation of the Act in Citation 3, Item 1 as follows:

29 CFR 1910.147(c)(4)(ii)(A): The energy control procedures did not contain a specific statement on the intended use of the procedure.

The employer does not ensure energy control procedures contain a specific statement on the intended use of the procedure. In the Zone 2/CAT Wickes Boiler Area the employer did not ensure the energy control procedures for the lockout/tagout of the fuel gas and purchase gas supply lines to the Wickes Boiler burner contain a specific statement on the intended use. Employees were exposed to fire and explosion hazards from potential releases of fuel gas and other flammable liquids or gasses.

The cited standard provides:

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

29 C.F.R. § 1910.147(c)(4)(ii)(A).

In his brief, Complainant asserts that, due to the Court's page-limit restrictions, he did not include a discussion of the merits of Citation 3, Item 1, instead opting to rest on the record evidence. *Compl't Br.* at 75. The Court has reviewed the transcript for any mention of Citation 3, Item 1 from Inspection No. 663538, which was issued by CSHO Hartung, and cannot find a single mention of either the citation item itself or 1910.147(c)(4)(ii)(A).³⁰ Although the OSHA 1-B Narrative was introduced into evidence as a preliminary matter, no subsequent discussion of that document occurs in the transcript. (Ex. R-18). Without testimony or supporting evidence, the Court is not in a position to determine whether a violation of the standard occurred, whether

30. CSHO Rambo also issued a Citation 3, Item 1 in Inspection No. 778042, which was discussed at trial.

Respondent had knowledge of the violation, or whether employees were exposed to a hazardous condition. Without such evidence, the Court finds that Complainant failed meet its burden of proving a violation of the standard. Accordingly, Citation 3, Item 1 is VACATED.

D. The Warehouse Inspection – Docket No. 13-0644 – Inspection No. 778042

i. Citation 1, Item 1

Complainant alleged a serious violation of the Act in Citation 1, Item 1 as follows:

29 CFR 1910.23(a)(2): Every ladderway floor opening or platform was not guarded by a standard railing, or swinging gate or so offset that a person cannot walk directly into the opening.

The employer does not ensure every ladderway floor opening or platform was guarded by a standard railing, or swinging gate or so offset that a person cannot walk directly into the opening. This violation was observed on or about November 26, 2012, in the Crude and Alky Units where the employer did not ensure that ladderway floor openings were guarded by standard railing, or equivalent means, exposing employees to fall hazards greater than 4 feet above the ground.

The cited standard 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.

29 C.F.R. § 1910.23(a)(2).

This citation item is based on CSHO Rambo observing two separate ladderways that were either left unguarded or had the swing gate tied back with chicken wire in the Crude and Alky Units. (Tr. 1426–28, 1492; Ex. C-72). Rambo testified he observed contractor employees working near the missing and/or tied-back swing gates, which exposed them to a fall of roughly 15–30 feet. (Tr. 1430). Because the exposed employees were contractors, Rambo determined that Respondent was liable as the correcting or controlling employer pursuant to OSHA’s Multi-

Employer Worksite doctrine. (Tr. 1435). Rambo could not determine who had created the condition or for how long it had lasted. (Tr. 1492–93).

According to David Johnson, who was a safety specialist for Respondent from 1995 to 2013, Respondent instituted a ladderway program, as it were, in response to a previous inspection citation. (Tr. 2129). In addition, Johnson testified that Respondent hired two contractors for this specific turnaround “whose sole job was to go with the safety guy and an operator to every unit, every ladderway in every unit, identify them, and then make sure that there was appropriate guarding on them.” (Tr. 2129). Pursuant to this program, Respondent ended up modifying or installing protection on over **600** different ladderway openings and placed a priority on all requests to fix such openings. (Tr. 2129–30). According to David Armstrong, Respondent’s warehouse technician, swing gates are stored in the warehouse and are issued to supervisors on request. (Tr. 1349–50).

Respondent contends that Complainant did not establish that it failed to exercise reasonable diligence such that it could have known of the violative condition, and the Court agrees. As noted above, there is no evidence indicating how long the cited condition existed. In order to determine whether Respondent could have known of the violation, there must be evidence that Respondent had the opportunity to observe it. *See Cranesville Block Co., Inc./Clark Division*, 23 BNA OSHC 1977 (No. 08-0316 *et al.*, 2012) (holding that complainant’s failure to introduce evidence regarding length of time condition existed, respondent’s inspection program, or its exercise of reasonable diligence precluded a finding of constructive knowledge). Rambo testified that he based his determination of knowledge on the fact that Dan Looney, Respondent’s Safety Manager, told him that he had observed open ladderways in the past. (Tr. 1493). Looney told Rambo that he would direct the contractor to fix or close the ladder if he

observed the conditions described above. (Tr. 1493–94). Rambo also testified that during the turnaround each unit had a supervisor and a safety technician during each shift, intimating that Respondent had the opportunity to observe the conditions. (Tr. 1434).

Whether considering the foregoing under a multi-employer theory, or just the typical employer knowledge analysis, the Court finds that Complainant has failed to prove its *prima facie* case. Whether Looney saw other open ladders at other locations at some point in time does not establish that Respondent was aware of the particular violations at issue in this citation item. In fact, in response to cross-examination, Rambo admitted that Looney told him they direct contractors and employees to close swing gates or replace them if they are open or otherwise in need of repair and that this is what a reasonable employer would do under such circumstances. (Tr. 1493–94). Complainant did not rebut Respondent’s claims that it had such a program of inspection and repair in place. Given that there was no indication as to how long these two isolated conditions existed, and considering that Respondent took extensive measures to uncover violations by implementing an inspection and repair program, the Court finds that Complainant failed to establish that Respondent knew or could have known of the condition. Accordingly, Citation 1, Item 1 is VACATED.

ii. Citation 1, Item 2

Complainant alleged a serious violation of the Act in Citation 1, Item 2 as follows:

29 CFR 1910.101(b): The in-plant handling, storage, and utilization of all compressed gases in cylinders, portable tanks, rail tankcars, or motor vehicle cargo tanks were not in accordance with Compressed Gas Association Pamphlet P-1-1965, which is incorporated by reference as specified in CFR 1910.6:

The employer does not ensure the in-plant handling, storage, and utilization of all compressed gases in cylinders, portable tanks, rail tankcars, or motor vehicle cargo tanks is in accordance with Compressed Gas Association Pamphlet P-1-1965, which is incorporated by reference as specified in CFR 1910.6. The violation was observed on or about October 29, 2012, in the welding shop the

employer did not ensure that compressed gas cylinders were stored with protective caps exposing employees to struck-by hazards.

The cited standard provides:

The in-plant handling, storage, and utilization of all compressed gases in cylinders, portable tanks, rail tankcars, or motor vehicle cargo tanks shall be in accordance with Compressed Gas Association Pamphlet P-1-1965, which is incorporated by reference as specified in § 1910.6.

29 C.F.R. § 1910.101(b).

During Rambo's inspection of the warehouse, he observed a number of compressed gas cylinders that did not have caps on them. (Ex. C-72 at 6–8). This was confirmed by Armstrong, who works in the warehouse. (Tr. 1319). Armstrong testified that the gas cylinders were used by various employees and contractors. (Tr. 1322). According to Rambo, he interviewed the maintenance superintendent, Johnny Reddell, who told him that the cylinders had been left in that condition since a dust disturbance closed down the warehouse for a week and that the caps were only placed back on the cylinders after he brought it to their attention. (Tr. 1386, 1389–90). Based on his observations and interviews, Rambo determined that Respondent violated the standard.

First, the Court rejects Respondent's argument that the cylinders in question were actively being used, rather than stored. Armstrong initially testified that the cylinders were located in the welding shop, which means that they were not in a storage location and were in use. (Tr. 1363–64). However, under cross-examination, Armstrong admitted that he did not know whether the cylinders had been used either in the last 24 hours or on any of the previous shifts. (Tr. 1372). As noted above, however, Reddell told Rambo that they placed the caps back on the cylinders after it had been pointed out to them. If the cylinders were being used, there would have been no need to place the caps on them. Further, the Court rejects the idea that because the cylinders were not in a typical storage location they are not being "stored". Other

than Armstrong's testimony as to the location of the cylinders, there was no indication that they were in use at the time of the inspection. This is supported by the fact that the various tubes and wires associated with the cylinder were neatly wrapped around the cylinder. (Ex. C-72 at 6). Because the cylinders were being stored without caps, the Court finds that Respondent violated the standard.

Second, the Court finds that Respondent knew or could have known of the condition. According to Rambo's testimony, the condition had existed for at least a week. (Tr. 1390). Admittedly, the warehouse had been closed for most of that time due to a dust disturbance that prevented employees from working in the warehouse; however, Rambo testified that there were employees working in the warehouse when he arrived.³¹ (Tr. 1389–90). The cylinders were stored in a fairly conspicuous area that could have been observed by anyone passing through. (Tr. 1320; Ex. C-72). Because it is not known who created the condition, Respondent contends that it should not be held liable as a controlling employer.

“[A]n employer with overall supervisory authority at a multi-employer work site, who has hired and entered into contractual relationships with subcontractors who are performing the work at the site, can be found liable for violations created by the subcontractors, as long as the controlling employer ‘could reasonably have been expected to prevent or abate by reason of its supervisory capacity.’” *E.P. Guidi, Inc.*, 21 OSHC BNA 1413 (No. 04-1055, 2006) (quoting *Grossman Steel & Aluminum Corp.*, 4 BNA OSHC 1185, 1188 (No. 12775, 1975)). In this case, as opposed to cases like *E.P. Guidi*, the worksite is owned and wholly controlled by Respondent. Further, Respondent's witnesses testified that, during the turnaround, each unit was assigned a Wynnewood Refining Company supervisor and safety technician to ensure compliance with

31. In that respect, the Court rejects Respondent's argument that there were no employees in the facility at the time of the inspection. *See Resp't Br.* at 70 n.22.

safety rules and, therefore, Respondent took responsibility for ensuring the safety of both employees and contractors. (Tr. 2111–2112). See *Grossman*, 4 BNA OSHC at 1188 (“The general contractor is well situated to obtain abatement of hazards, either through its own resources or through its supervisory role with respect to other contractors. It is therefore reasonable to expect the general contractor to assure compliance with the standards insofar as all employees on the site are affected.”). Finally, Armstrong testified that at least one of the supervisors was in the warehouse approximately 4–5 times per day, meaning that there was ample opportunity to view the condition, which was located in plain sight. (Tr. 1358). Thus, the Court finds that Respondent knew or could have known of the condition.

Further, the purpose of the standard is to prevent the possibility that a cylinder could become a projectile if the valve at the top is broken off. (Tr. 1388). Because there were Wynnewood employees in the warehouse at the time the violation was observed, the Court finds that they, as well as contractor employees, were exposed to the hazard, and that the violative condition was serious. (Tr. 1388). Complainant has established its *prima facie* case. Accordingly, Citation 1, Item 2 is AFFIRMED.

iii. Citation 1, Item 3

Complainant alleged a serious violation of the Act in Citation 1, Item 3 as follows:

29 CFR 1910.119(h)(2)(v): The employer did not periodically evaluate the performance of contract employers in fulfilling their obligations as specified in paragraph 1910.119(h)(3):

Wynnewood does not have a system to periodically evaluate the performance of their contractors in fulfilling their obligations as specified in paragraph 1910.119(h)(3). Wynnewood does not evaluate whether or not each contractor:

- a) Trains their employees in the work practices necessary to safely perform their job;
- b) Instructs their employees on the known potential fire, explosion, or toxic release hazards related to their job and the applicable provisions of the emergency action plan;

- c) Documents, records and maintains a record that all their employees have received and understand the training required;
- d) Assures that each employee follows the safety rules of the facility.

Contractor employees were observed exiting various process areas without signing out; not wearing appropriate eye or face protection while mixing and applying refractory products, and working on scaffolds that were not properly designed or erected. No formal process to evaluate contractor performance is in place at the refinery.

The cited standard provides:

The employer shall periodically evaluate the performance of contract employers in fulfilling their obligations as specified in paragraph (h)(3) of this section.

29 C.F.R. § 1910.119(h)(2)(v).

After conducting interviews with members of Respondent's safety department, CSHO Rambo determined that Respondent had violated the standard requiring periodic monitoring of contract employer's compliance with paragraph (h)(3) of the same standard. Rambo testified that Looney had told him that the safety department conducted self-audits but that they did not maintain documentation of their audits. (Tr. 1457). Rambo also testified that he had never been provided with documentation of contractor performance audits. (Tr. 1457). Shane Stair, a safety specialist, told Rambo that he was unsure whether they had an evaluation process for contractors, and David Johnson, who also testified, told Rambo that they did not evaluate contractors. (Tr. 1458). In light of the fact that all three of those men were a part of the safety department, Rambo testified that "it gave me a sense of no one wanted to take ownership of safety when it came to others outside of Wynnewood working inside the refinery." (Tr. 1458).

According to David Johnson, the turnaround had a significant impact on the operations of the refinery. During a normal workday, Respondent had approximately three to four safety personnel to assess safe work practices. (Tr. 2109). During a turnaround, however, Johnson stated that the safety workforce increased to 40, which included approximately 14 Wynnewood

employees. (Tr. 2110). The rest of the safety crew came from a contractor that specializes in turnarounds, Total Safety. (Tr. 2111). The crew, which was split into two shifts and broken out by zone, would review safety procedures and perform field audits. (Tr. 2113). On cross-examination, Johnson testified that “we had a system in place for our field safety people to go out and evaluate how the contractors were working safely” and included verification of those evaluations through the use of field notes. (Tr. 2149). To the extent that violations were observed, Johnson testified that the violation was abated and the offending contractor/employee was counseled; in some instances, Respondent had to go so far as to remove certain contract employees from the premises. (Tr. 2120). Johnson also testified that Respondent utilized a system known as PICS (Pacific Industrial Contractors Services), which is a third-party contractor that evaluates potential contractors based on a pre-determined set of criteria. (Tr. 2105–06). Those criteria include an evaluation of whether the contractor provides the necessary training and possesses adequate written safety programs to perform the work needed at the refinery. (Tr. 2108). Based on this testimony, Respondent contends that it exercised reasonable diligence in monitoring contractor compliance with (h)(3).

Complainant alleges that Respondent violated the standard in all respects; namely, that it failed to periodically evaluate the performance of contractors with respect to each of the duties listed under (h)(3). However, based on Respondent’s use of the PICS system to evaluate contractors, the Court finds that Respondent complied with its obligations as to (a), (b), and (c) as described in the citation item. Complainant did not present evidence to suggest that Respondent’s use of the PICS system was insufficient with respect to those issues. Rather, based on Rambo’s testimony, Complainant’s focus appears to be instance (d), which claims that Respondent failed to ensure that contract employers “assures that each employee follows the

safety rules of the facility.” 29 C.F.R. § 1910.119(h)(3)(iv). The primary bases for the allegation are, as mentioned above, the interviews conducted by Rambo and Rambo’s discovery of violative conditions around the refinery as recounted in the body of the citation.

As noted above, during the turnaround Respondent was responsible for tracking over 1500 additional contract employees at the refinery per shift. In response, Respondent put together a safety team of 40 people to track, observe, and assist these employees. However, the existence of violations, alone, is not sufficient to establish that Respondent failed to periodically evaluate the performance of its contractors. Further, though Rambo testified that multiple safety employees told him that they did not monitor the performance of contractors, Johnson provided some context for the comments made to Rambo by Looney. Specifically, Johnson said that he disagreed with Looney’s purported statement that Respondent “do[es] not oversee contractors as far as safety when they do their job.” He explained, instead, that contractor employees are required, as indicated by the standard, to oversee/ensure the safety of their own employees. *See* 29 C.F.R. § 1910.119(h)(3)(iv) (“The contract employer shall assure each contract employee follows the safety rules of the facility . . .”). Johnson then went on to discuss the manner in which Respondent evaluated its contractors from an initial and ongoing perspective. (Tr. 2105, 2109–2115). Complainant did not rebut Johnson’s testimony regarding its evaluation process; rather, it merely pointed out that Respondent failed to provide documentation of the evaluations. (Tr. 2147). The cited standard, as compared to other subsections within 1910.119, does not have a written documentation requirement; rather, it only requires Respondent to perform periodic evaluations. Based on the foregoing, the Court finds that Complainant failed to prove a violation of the standard. Accordingly, Citation 1, Item 3 is VACATED.

iv. Citation 1, Item 4

Complainant alleged a serious violation of the Act in Citation 1, Item 4 as follows:

29 CFR 1910.157(c)(1): Portable fire extinguishers were not mounted, located and identified so that they were readily accessible without subjecting the employees to injuries:

The employer does not ensure portable fire extinguishers are mounted, located and identified so that they are readily accessible without subjecting the employees to injuries. This violation was observed on or about October 29, 2012, the employer did not ensure fire extinguishers were free from obstruction and readily accessible exposing employees to the hazards of fire, trips and falls:

- a) A fire extinguisher in the warehouse was blocked by boxes.
- b) A fire extinguisher in the pump shop was blocked by a large crate and air lines.
- c) Two fire extinguishers in the welding shop were not mounted.

The cited standard provides:

The employer shall provide portable extinguishers and shall mount, locate and identify them so that they are readily accessible to employees without subjecting the employees to possible injury.

29 C.F.R. § 1910.157(c)(1).

While in the maintenance warehouse, CSHO Rambo observed a number of fire extinguishers that were not properly mounted or were otherwise not readily accessible as required by the standard. (Tr. 1391; Ex. C-72 at 18–20). Respondent contends that, notwithstanding the existence of the conditions, Complainant failed to prove how long the condition lasted or that Respondent knew or could have known of the violations. The Court finds that Complainant has established a violation of the standard.

The testimony was fairly consistent that the warehouse had an issue with blocked fire extinguishers. According to Armstrong, he observed fire extinguishers that were blocked in or were not properly mounted during the turnaround, which he attributed to the constant influx of materials coming into the warehouse to fill work orders. Though he admitted that the turnaround

was not the first time he had observed this condition. (Tr. 1324, 1330). He agreed that the extinguishers identified in Complainant's exhibits were not readily accessible and characterized the issue of blocked extinguishers as an "ongoing hazard". (Tr. 1330). Armstrong also testified that the warehouse manager's office was right next to one of the blocked extinguishers. (Tr. 1327; Ex. C-72 at 18–20). Respondent performed a self-audit at the end of August 2012, not long before Rambo's inspection. (Ex. C-74). The first item of that audit identifies multiple, blocked fire extinguishers, including one "located outside the south door of the office." (Ex. C-74). According to Rambo, Richard McCaulla, the warehouse manager, told him that he was aware that the fire extinguisher outside of his office was blocked and explained that the blockage was the result of an influx of materials and a lack of space.³² (Tr. 1392).

The Court finds, consistent with the testimony of Armstrong, that the condition of blocked or otherwise improperly mounted fire extinguishers was an "ongoing hazard" in Respondent's warehouse. Respondent's warehouse manager admitted that he was aware of blocked extinguishers and the reasons therefor; one of the blocked extinguishers was right outside his office; and an audit of the warehouse revealed this problem more than a month before CSHO Rambo's inspection in late October. Thus, Respondent knew or could have known of the condition. The Court also finds that Respondent's failure to have readily accessible fire extinguishers exposed its employees to potential fire hazards. (Tr. 1329–30). Respondent's Emergency Action Plan (EAP) indicates that properly trained employees are expected to use fire extinguishers "if the fire can be easily extinguished and you have the proper training." (Ex. C-78). As noted by Armstrong, the first minutes of a fire are critical, and precious time would be wasted in having to remove materials and boxes in order to access a fire extinguisher. (Tr. 1329).

32. The self-audit also identified Mr. McCaulla as the party responsible for correcting the blocked fire extinguishers and that he was to correct the condition by "15 Oct 12". (Ex. C-74). CSHO Rambo's inspection took place on October 29, 2012. (Tr. 1381).

Insofar as employees are expected to participate in putting out minor fires, the Court finds that the failure to have readily accessible extinguishers exposed those employees to potential burn injuries. As such, the Court finds that Complainant has established a serious violation of the cited standard. Accordingly, Citation 1, Item 4 is AFFIRMED as serious.

v. Citation 1, Item 5

Complainant alleged a serious violation of the Act in Citation 1, Item 5 as follows:

29 CFR 1910.212(a)(3)(ii): Point of operation guards were not designed and constructed as to prevent the operator from having any part of their body in the danger zone during the operating cycle:

The employer does not ensure point of operation guards are designed and constructed as to prevent the operator from having any part of their body in the danger zone during the operating cycle. This violation was observed on or about October 29, 2012, in the pump shop the employer did not ensure a Johnson horizontal band saw was provided a guard exposing employees to the hazard of contact with the point of operation.

The cited standard provides:

The point of operation of machines whose operation exposes an employee to injury, shall be guarded. The guarding device shall be in conformity with any appropriate standards therefor, or, in the absence of applicable specific standards, shall be so designed and constructed as to prevent the operator from having any part of his body in the danger zone during the operating cycle.

29 C.F.R. § 1910.212(a)(3)(ii).

CSHO Rambo identified a horizontal band saw in the warehouse that did not have proper guarding to protect against point-of-operation hazards. (Tr. 1395; Ex. C-72 at 21–25). The close-up photographs show two blades that extend lengthwise across the open space of the machine, running parallel to the name “JOHNSON” emblazoned across the top. (Ex. 72 at 23–24). As noted by Rambo, there is nothing to prevent contact with the blades during operation. (Tr. 1396–97). In response to questions about how long the saw had been in the condition observed by Rambo, Calvin Foley, who had been the pump shop supervisor for 15 years, stated that it had

been that way since he had worked there. (Tr. 1398–99). This was echoed by Johnny Reddell, Respondent’s maintenance manager. (*Id.*).

Respondent contends that Complainant failed to prove that it knew or could have known of the condition. Although Armstrong testified that there was a guard that could be removed from time to time, he seemed to be somewhat confused as to which guard was being discussed. Initially, Armstrong indicated that the saw depicted in Exhibit C-72 was guarded. (Tr. 1334; Ex. C-72 at 21). In response to questions from the Court, Armstrong testified there was no additional guarding that was removed or replaced during the turnaround, and, insofar as he discussed guarding that had been removed, he was referring to the green piece of metal with the handle, which is located on the left-hand side of the photograph in Exhibit C-72 at 21. (Tr. 1334–35). Later in his testimony, Armstrong said that he thought there was a guard in the open area, but he was not “a hundred percent sure”. (Tr. 1339). Notwithstanding that testimony, Armstrong admitted that he observed the saw without the guard, and that the last time he had observed the saw without this purported guard “was before the turnaround.” (Tr. 1341).

The Court finds that Respondent violated the standard and that the violation was serious. The saw, as observed by CSHO Rambo, was improperly guarded and exposed its users to point-of-operation hazards, such as lacerations and potential amputations. (Tr. 1396–97). The Court finds that the statements given to CSHO Rambo establish that the saw, as illustrated in Exhibit 72, was in its normal operating condition, had been in that condition for quite some time, and that such condition was known to members of Respondent’s management team. Even if the Court were to discount those statements, the Court would still find that Respondent had adequate knowledge of the violation based on Armstrong’s testimony that his supervisor’s “should’ve knew” about the saw, because they “walk by the saw as much as I do, and if I’ve seen it, then

they [sic] seen it.” (Tr. 1333). Armstrong testified that the last time he had seen this purported removable guard was before the turnaround, which means that many of his supervisors had the opportunity to observe the unguarded saw, as it was being used by “[j]ust about everyone in that warehouse” (Tr. 1332). Accordingly, Citation 1, Item 5 is AFFIRMED as serious.

vi. Citation 1, Item 6(a), (b), and (c)

Complainant alleged three serious violations of the Act in Citation 1, Item 6, subparts (a), (b), and (c). Given their similarity, both items shall be addressed together. Complainant’s allegations with respect to Item 6(a) are as follows:

29 CFR 1910.215(a)(2): Abrasive wheel(s) used on grinding machinery were not provided with safety guard(s) which covered the spindle end, nut, and flange projections:

The employer does not ensure abrasive wheels used on grinding machinery are provided with safety guards which cover the spindle end, nut, and flange projections. This violation was observed on or about October 29, 2012, in the pump shop the employer did not ensure abrasive wheels on a grinding machine were provided with safety guards covering the spindle end, nut, and flange projections exposing employees to the hazard of caught-by.

The cited standard provides that “[t]he safety guard shall cover the spindle end, nut, and flange projections, The safety guard shall be mounted so as to maintain proper alignment with the wheel, and the strength of the fastenings shall exceed the strength of the guard” 29 C.F.R. § 1910.215(a)(2).

Complainant’s allegations with respect to Item 6(b) are as follows:

29 CFR 1910.215(b)(9): The distance between the grinding wheel periphery and the adjustable tongue or the end of the peripheral member at the top exceeded one-fourth inch:

The employer does not ensure the distance between the grinding wheel periphery and the adjustable tongue or the end of the peripheral member at the top exceeded one-fourth inch. This violation was observe on or about October 27, 2012, in the maintenance shop where the distance between the grinding wheel periphery and the adjustable tongue guard on a Baldor bench grinder exceeded one-fourth inch

exposing employees to the hazard of caught-by and struck-by flying debris resulting from an exploding grinding wheel.

The cited standard provides:

Safety guards . . . where the operator stands in front of the opening, shall be constructed so that the peripheral protecting member can be adjusted to the constantly decreasing diameter of the wheel. The maximum angular exposure above the horizontal plane of the wheel spindle . . . shall never be exceeded, and the distance between the wheel periphery and the adjustable tongue or the end of the peripheral member at the top shall never exceed one-fourth inch.

29 C.F.R. § 1910.215(b)(9).

Complainant's allegations with respect to Item 6(c) are as follows:

29 CFR 1910.215(d)(3): The contact surface(s) of wheel(s), blotter(s) or flange(s) on grinding machine(s) were not flat and free of foreign matter:

The employer does not ensure the contact surfaces of wheels, blotters or flanges on grinding machines are flat and free of foreign matter. This violation was observed on or about October 27, 2012, in the maintenance shop for a Baldor bench grinder where the contact surface of a grinding wheel was not kept flat and smooth exposing employees to the hazard of struck-by flying debris from an exploding grinding wheel.

The cited standard provides that “[a]ll contact surfaces of wheels, blotters and flanges shall be flat and free of foreign matter.” 29 C.F.R. § 1910.215(d)(3).

CSHO Rambo provided ample testimony and evidence to establish a violation of the foregoing standards with respect to the bench grinder, much of which was confirmed by Armstrong and not contradicted by any other witness. (Tr. 1343). According to Rambo, the grinding wheel: (1) did not have adequate guarding to protect against point-of-operation hazards, as well as potential shrapnel hazards from a well-worn grinding disc; (2) measured nearly 2.75 inches between the wheel and the guard, when the required distance is less than one-quarter inch; and (3) was overly worn, full of indentations, and was otherwise unsafe to use. (Tr. 1401–1410; Ex. C-72 at 26–33). Thus, Respondent violated the terms of the standard.

Respondent contends, however, that Complainant cannot prove that it knew or could have known of the condition. Characterizing Armstrong's testimony as speculation, Respondent argues that Complainant failed to show that any member of management was aware of the condition. Similar to his testimony with respect to the band saw, Armstrong stated that members of the management team must have seen the condition of the wheel, considering its location in plain view, the regularity of its use, and due to the obviously non-compliant condition of the wheel itself. (Tr. 1344). The Court has no reason to doubt Armstrong's assessment, and, in light of the condition and size of the grinding wheel itself, it is clear that it had been used in a non-compliant condition for long enough for warehouse management to observe it. The Court credits Armstrong's testimony based on his intimate knowledge of the conditions and operations inside Respondent's warehouse. Thus, the Court finds that Respondent knew or, with the exercise of reasonable diligence, could have known of the condition. This condition exposed the employees, contractors, and managers that used it to point-of-operation hazards and potential struck-by hazards due to the condition of the grinding wheel itself. Both Rambo and Armstrong testified that these hazards could cause serious injury. (Tr. 1403, 1343).

Based on the foregoing, the Court finds that Complainant established a violation of the standard. Accordingly, Citation 1, Items 6(a), (b), and (c) are AFFIRMED as serious violations of the Act.

vii. Citation 1, Item 7

Complainant alleged a serious violation of the Act in Citation 1, Item 7 as follows:

29 CFR 1910.303(g)(1): Sufficient access and working space was not provided and maintained about all electric equipment (operating at 600 volts, nominal, or less to ground) to permit ready and safe operation and maintenance of such equipment:

The employer does not provide and maintain sufficient access and working space about all electric equipment (operating at 600 volts, nominal, or less to ground) to

permit ready and safe operation and maintenance of such equipment. This violation was observed on or about October 27, 2012, in the pump shop where an electrical panel was not accessible exposing employees to fire and electrical hazards.

The cited standard provides:

Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment.

29 C.F.R. § 1910.303(g)(1).

Rambo testified that the standard applies, and Respondent does not dispute that assertion. (Tr. 1412). The testimony of Rambo and the photographs of the electrical panel show that there was an obstruction in front of the panel, including a shelf and cabinet. (Tr. 1412–13; Ex. C-72 at 35). Respondent contends that Complainant failed to prove that the obstruction, as it were, was large enough to block access. Although the cited standard is couched in terms that are performance-related, the subsections of 1910.303(g)(1) indicate what constitutes sufficient access and working space. *See, e.g.*, 29 C.F.R. § 1910.303(g)(1)(i)(C) (“The work space shall be clear and extend from the grade, floor, or platform to the height required by paragraph (g)(1)(vi) of this section. However, other equipment associated with the electrical installation and located above or below the electric equipment may extend not more than 153 mm (6 in.) beyond the front of the electric equipment.”). The Court finds that, based on these parameters, the condition of the electrical panel violated the terms of the standard.

The Court also finds that Respondent knew of the condition and that its employees were exposed to it. According to CSHO Rambo, both Foley and the electrical supervisor, Eric Amparano, were aware of the blocked electrical panel. (Tr. 1414). The Court finds that their knowledge is properly imputed to Respondent. Further, the Court credits Rambo’s testimony that two individuals working in the pump shop were exposed to potential tripping hazards or

even burns if employees are not able to access the panel in an emergency. (Tr. 1413). These hazards have the potential to cause serious injuries, such as burns, contusions, or broken bones.

Based on the foregoing, the Court finds that Complainant established a violation of the standard and that the violation was serious. Accordingly, Citation 1, Item 7 is AFFIRMED.

viii. Citation 1, Item 8

Complainant alleged a serious violation of the Act in Citation 1, Item 8 as follows:

29 CFR 1910.305(b)(1)(ii): Unused openings in cabinets, boxes, and fittings, were not effectively closed:

The employer does not ensure unused openings in cabinets, boxes, and fittings are effectively closed. This violation was observed on or about October 29, 2012, in the maintenance shop where the employer did not ensure that pre-punched knockout was effectively closed on an electrical panel exposing employees to fire and electrical hazards.

The cited standard provides:

Unused openings in cabinets, boxes, and fittings shall be effectively closed.

29 C.F.R. § 1910.305(b)(1)(ii).

CSHO Rambo observed an open knockout on the panel box identified in Exhibit C-72. (Ex. C-72 at 36). A knockout is an opening to receive electrical lines into the panel box. (Tr. 1415). Rambo testified that Amparano, Respondent's electrical supervisor, told him he had orchestrated the removal a cord, which was supposed to provide power to a temporary welder. (Tr. 1416). Apparently the cord that was selected was insufficient for the power draw of the welder, so the cord was taken off, and the knockout was left open. (Tr. 1416). On cross-examination, Rambo testified that Amparano told him that the work of changing the cord was carried out by a contractor. (Tr. 1509). Nevertheless, it was still carried out at his direction. (Tr. 1509).

Respondent contends that, due to the fact that the work was performed by a contractor, Respondent had no reason to know of the violation. The Court disagrees. Rambo testified that Amparano directed the work to remove the cord, which took place around the beginning of the turnaround. (Tr. 1416–17). Rambo discovered the condition nearly two months later. (Tr. 1417). The electrical panel was located next to the restroom in a well-traveled area. (Tr. 1349). Given the location of the condition, the fact that the work to remove the cord was done at the direction of one of Respondent’s supervisors, and the length of time that the condition existed, the Court finds that Respondent, with the exercise of reasonable diligence, could have known of the condition.

Because the condition was in a well-traveled area, the Court also finds that Respondent’s employees were exposed to the hazard, which could cause shocks, burns, and potentially electrocution. (Tr. 1416). Exposure to such hazards could cause serious injury up to and including death. Based on the foregoing, the Court finds that Respondent violated the standard and that the violation was serious. Accordingly, Citation 1, Item 8 is AFFIRMED as a serious violation of the Act.

ix. Citation 1, Item 9

Complainant alleged a serious violation of the Act in Citation 1, Item 9 as follows:

29 CFR 1910.305(g)(1)(iv)(A): Flexible cords were used as a substitute for fixed wiring of a structure:

The employer does not ensure flexible cords are not used as a substitute for fixed wiring of a structure. This violation was observed on or about October 29, 2012, in the welding shop where extension cords were used as a substitute for fixed wiring exposing employees to electrical hazards.

The cited standard provides:

Unless specifically permitted otherwise in paragraph (g)(1)(ii) of this section, flexible cords and cables may not be used . . . [a]s a substitute for the fixed wiring of a structure.

29 C.F.R. § 1910.305(g)(1)(iv)(A).

While in the warehouse, Rambo observed extension cords strung over beams throughout the welding shop, including one cord that was wrapped around a metal cable. (Tr. 1417; Ex. C-72 at 37–40). He discovered that these cords were being used as the primary electrical source for a workstation. (Tr. 1417). In addition to being used as a primary power source, Rambo also observed the cords being used to “store” equipment, which was hung from the ends of the cords. (Tr. 1419; Ex. C-72 at 39–40). Amparano told Rambo that the extension cords had been used like this for years and Armstrong testified that they had been like that for “an extended period of time.” (Tr. 1345, 1420).

Respondent argues the citation should be dismissed because it alleges, at best, a *de minimis* violation of the Act. According to Respondent, there was no proof the alleged violation exposed employees to a safety and health risk; in fact, Respondent points out that none of the extension cords showed signs of damage. *See Resp’t Br.* At 76 (citing *Dover Elevator*, 15 BNA OSHC 1378 (No. 88-2642, 1991) (“A violation is *de minimis* when a deviation from the standard has no ‘direct or immediate’ relationship to employee safety.”)). The Court disagrees.

In addition to the line quoted by Respondent, the Commission in *Dover* also stated, “[N]ormally, that classification is limited to situations in which the hazard is so trifling that an abatement order would not significantly promote the objectives of the Act.” *Id.* Under the facts of this case, the Court is convinced that Complainant has established that the violation in this case has a direct and immediate relationship to employee safety and that abatement of the violation will promote the objectives of the Act. Not only were the cords draped over steel beams and cables, but those same cords were used to suspend equipment, which placed additional strain on the cords. The Act illustrates that OSHA has made the determination that

such a situation does have a direct and immediate relationship to employee safety. *See* 29 C.F.R. § 1910.303(a)(2)(x) (“Flexible cords and cables shall be protected from accidental damage, as might be caused, for example, by sharp corners, projections, and doorways or other pinch points.”). Further, Rambo testified that sharp edges, such as the metal cable and the beams, coupled with the additional weight imposed by the hanging objects, could cause a tear in the cord (or “accidental damage”). (Tr. 1419). If a tear occurs, everything that comes into contact with the exposed wiring could be energized, which would include the beams and metal cables over which the electrical cords were draped.

Based on the foregoing, the Court finds that Complainant established a serious violation of the cited standard, that Respondent knew of the condition, and that Respondent’s employees were exposed to the possibility of shock, burns, or electrocution. Accordingly, Citation 1, Item 9 is AFFIRMED as serious.

x. Citation 2, Item 1

Complainant alleged a repeat violation of the Act in Citation 2, Item 1 as follows:

29 CFR 1910.119(h)(2)(iv): The employer did not develop and implement safe work practices consistent with 29 CFR 1910.119(f)(4), to control the entrance, presence and exit of contract employers and employees in covered process areas:

The employer does not develop and implement safe work practices consistent with 29 CFR 1910.119(f)(4), to control the entrance, presence and exit of contract employers and employees in covered process areas. On or about October 25, 2012, and at times prior thereto, the employer did not ensure contract employees are properly signed in/out process units:

- a) Four (4) JV Industrial Companies employees failed to sign out of Zone 3.
- b) Two (2) LOP employees failed to sign out of the FCCU.
- c) One (1) Altair Strickland employee failed to sign out of the FCCU.
- d) One (1) Total Safety employee, two (2) OSR employees, one (1) Strategic Contract Resources employee, and one (1) Wynnewood Refining Company employee failed to sign out of the FCCU.
- e) On October 20, 2012, seven (7) Scaffolding and Erection Company employees, two (2) Strategic Contract Resources employees failed to sign out of the Alkylation Unit.

- f) On October 12, 2012, three (3) Koch employees failed to sign out of the SRU 48002 area in the Alkylation Unit.

The cited standard provides:

The employer shall develop and implement safe work practices consistent with paragraph (f)(4) of this section, to control the entrance, presence and exit of contract employers and contract employees in covered process areas.

29 C.F.R. § 1910.119(h)(2)(iv).

As part of his inspection, CSHO Rambo had to sign-in and sign-out of various units within the refinery. When he signed in, Rambo took the opportunity to review Respondent's log books. (Tr. 1445–46). His examination of the log books in the Alky Unit, the FCCU, and Zone 3 showed 24 instances of a contractor or employee failing to sign out of those areas over the course of roughly 12 days, beginning on October 12, 2012.³³ (Tr. 1449; Ex. C-72 at 9–13, C-76). As a result of his observations, Complainant issued a citation alleging that Respondent failed to enforce its sign-in/sign-out policy and, therefore, failed to adequately implement a safe work practice “to control the entrance, presence and exit of contractor employers and employees in covered process areas.” 29 C.F.R. § 1910.119(h)(2)(iv).

Respondent contends that Complainant did not prove that it failed to exercise reasonable diligence to ensure that its contractors complied with applicable safe work practices, such as signing in and out of covered process areas. In support of this proposition, Respondent points to its three-tiered system of signing into and out of process areas, inclusive of its badge process for entering the refinery, its log book for process areas, and its safe work permit process. (Tr. 2102, 2121–23). Respondent also argues that it strictly enforced its sign-in/sign-out policy through auditing work practices of contractors, as well as the sign-in/sign-out sheets for each process area. As such, Respondent argues that it took all reasonable efforts to discover violations and that

33. To clarify, the logs covered a period of approximately 12 days, not CSHO Rambo's inspection. None of the days identified included the day of the Wickes explosion.

Complainant failed to prove that it “should have known of even a single instance where a contractor failed to sign in or out.” *Resp’t Br.* at 78.

The Court agrees with Complainant. It is clear that Respondent had developed and, to a certain extent, implemented a system to control the entry into and exit from covered process areas. The problem, however, was that the system was ineffective. Respondent contends that Complainant failed to prove that it could have known of even a single instance of a contractor failing to sign out; however, it also claims that it implemented a strict auditing policy, which included reviewing sign-in/sign-out sheets on a daily basis. *Resp’t Br.* at 77. Based on the log books introduced by Complainant, the Court finds that the auditing policy was not as strict as Respondent would have it believe. One of the logs showed three contractors that failed to sign out of the SRU on October 12, 2012. (Ex. C-76). Other logs show multiple failures to sign out from the FCCU, all occurring on the same day, October 25, 2012. (Ex. C-72 at 9–13). If Respondent was reviewing the logs and contractor practices as it suggests (and, indeed, as it should have been), then it would have been readily aware of its contractors failing to sign out of covered process units. While the Court is mindful of the fact that the large number of contractors at the refinery during the turnaround makes tracking every single one difficult, that only highlights the importance of ensuring that entry into process areas is properly controlled. Thus, the Court finds that Complainant established a violation of the standard and that Respondent, with the exercise of reasonable diligence, could have known of the violation.

The Court also finds that employees were exposed to potential hazards. According to David Johnson, it is important to track the entry into and exit out of process units because “during an emergency, the most important thing is to make sure everybody is safe.” (Tr. 2138–39). Rambo testified similarly, stating that in the event of an evacuation, first responders (and

Wynnewood employees) could be exposed to fire and chemical leak hazards if they needed to enter a process unit to find a non-present subcontractor employee who simply had not signed out. (Tr. 1449). Respondent contends that the violation should not be categorized as serious because the sign-in/sign-out sheets would not be used in the event of a catastrophic release; employees are instructed to immediately leave the unit and gather at designated assembly areas. (Tr. 2123–25). Instead, Respondent states that it uses the entry badge data to determine who is on the premises in an emergency. The Court finds the standard Respondent violated addresses more than that. According to the preamble of the PSM standard, “[T]he objectives of these additional provisions were to insure that those persons operating high hazard processes are cognizant of any non-routine work that is occurring and to insure that those in responsible control of the facility are also in control of non-routine work.” (Ex. C-2 at 30). The failure to adequately track contractors and employees, doing non-routine work in covered process areas not only impacts potential rescue efforts, but it also impacts active and future work projects. If it is unclear whether certain non-routine work projects are occurring in process areas, then subsequent entrants into those areas cannot adequately assess the hazards associated with working in, energizing, or de-energizing a particular unit. Without the ability to know with certainty whether individuals are in certain area of the refinery, employees and contractors are subjected to any number of hazards that might be present, including, as is relevant to a refinery, fire and explosion hazards. Thus, the Court finds that the violation was serious.

Based on the foregoing, the Court finds that Respondent violated the standard and that the violation was serious. Accordingly, Citation 2, Item 1 is AFFIRMED.

xi. Citation 3, Item 1

Complainant alleged another-than-serious violation of the Act in Citation 1, Item 1 as follows:

29 CFR 1910.22(d)(1): In every building or other structure, or part thereof, used for mercantile, business, industrial, or storage purposes, the loads approved by the building official were not marked on plates of approved design securely affixed by the owner of the building, or his duly authorized agent, in a conspicuous place in each space to which they are related:

In every building or other structure, or part thereof, used for mercantile, business, industrial, or storage purposes, the employer does not ensure the second level storage area is designed, constructed, and maintained to support its maximum intended load. This violation was observed on or about October 29, 2012, in the warehouse the employer did not ensure the second level storage area was designed, constructed, and maintained to support its maximum intended load.

The cited standard provides:

In every building or other structure, or part thereof, used for mercantile, business, industrial, or storage purposes, the loads approved by the building official shall be marked on plates of approved design which shall be supplied and securely affixed by the owner of the building, or his duly authorized agent, in a conspicuous place in each space to which they relate. Such plates shall not be removed or defaced but, if lost, removed, or defaced, shall be replaced by the owner or his agent.

29 C.F.R. § 1910.22(d)(1).

CSHO Rambo observed a second-level storage area that did not have a posted load rating. (Tr. 1422). This area was used for storing gaskets, electrical parts, and shafts, some of which can weigh up to 150 pounds. (Tr. 1346; Ex. C-72 at 41–42). According to Rambo, McCaulla told him that the second-level storage area had never been load-rated, which was echoed by Armstrong, who testified that he had never seen a load rating for that area. (Tr. 1348).

The Court finds that Complainant established a violation of the standard. The evidence clearly shows that the second-level storage area did not have a load rating to indicate that it was capable of supporting the load of the stored materials. Respondent was clearly aware of this failure, as indicated by McCaulla's statements to Rambo and confirmed by Armstrong's testimony that the storage area had never been rated. The Court also finds that employees, including Armstrong, were exposed to the hazard of falling materials and a potentially the collapse of the storage area—without knowing the load capacity, Respondent could possibly

overload the elevated storage area. Accordingly, Citation 3, Item 1 is AFFIRMED as an other-than-serious violation of the Act.

V. Penalties

In calculating appropriate penalties for affirmed violations, Section 17(j) of the Act requires the Commission give due consideration to four criteria: (1) the size of the employer's business, (2) the gravity of the violation, (3) the good faith of the employer, and (4) the employer's prior history of violations. Gravity is the primary consideration and is determined by the number of employees exposed, the duration of the exposure, the precautions taken against injury, and the likelihood of an actual injury. *J.A. Jones Construction Co.*, 15 BNA OSHC 2201 (No. 87-2059, 1993). It is well established that the Commission and its judges conduct *de novo* penalty determinations and have full discretion to assess penalties based on the facts of each case and the applicable statutory criteria. *Valdak Corp.*, 17 BNA OSHC 1135 (No. 93-0239, 1995); *Allied Structural Steel*, 2 BNA OSHC 1457 (No. 1681, 1975).

A. Docket No. 13-0791 – Inspection No. 663538

The citation items resulting from this inspection, although they allege violations of different standards, all involve the same basic hazard in the same area of the refinery: catastrophic releases of highly hazardous chemicals in the start-up and operation of the Wickes boiler. Unfortunately, the facts of this case also illustrate the potential gravity of those violations. Two of Respondent's employees died, and many more were exposed to serious injury, as a result of the explosion that occurred on September 28, 2012. Further, due to the lack of adequate training, procedures, and hazard analysis, Respondent's employees were exposed to those same hazards each time they lit the Wickes. Respondent was aware of previous hard-starts (a colloquial term for "mini-explosion") and failed to adequately address the conditions and

procedures that contributed to them. Although the Court determined that a repeat characterization was not appropriate under the facts of this case, the Court finds that Respondent's knowledge of previous hard-starts, its subsequent failure to address the hazards associated with the process, and the potential for serious injury or death provides a sound basis for the highest penalty available for serious violations. Thus, the Court will assess a \$7,000.00 penalty for each of the following violations: Citation 1, Item 1; Citation 1, Items 2(a), (b), and (c); Citation 1, Items 3(a) and (b); Citation 1, Item 4 [allegation b]; Citation 1, Items 5(a) and (b); Citation 1, Items 6(a) and (b); Citation 2, Item 2; Citation 2, Item 3; Citation 2, Item 4; and Citation 2, Item 5 [allegation b].

B. Docket No. 13-0644 – Inspection No. 778042

The citations contained within this docket are sufficiently unique in terms of the violation and potential hazard to warrant more individualized discussion. Inasmuch as the citation items are similar, the Court shall consolidate its discussion of those items.

With respect to Citation 1, Item 2, the Court finds that the uncapped cylinders have the potential to become dangerous projectiles that could cause serious injury to the numerous people that occupied or otherwise used the warehouse during the turnaround. That said, it appears the cylinders were secured, which reduced the likelihood that an accident would occur. In light of these facts, the Court finds that a penalty of \$3,300.00, as proposed by Complainant, is appropriate.

With respect to Citation 1, Item 4, it appears that blocked fire extinguishers in the warehouse were an ongoing and pervasive problem. CSHO Rambo identified four different extinguishers in the warehouse that were blocked, not properly mounted, or both. The Court finds that nearly all of the occupants of the warehouse were exposed to a fire hazard, because

Respondent expected its employees to attempt to put out small fires with the provided fire extinguishers. However, considering that Complainant did not identify any imminent fire dangers in the warehouse, the Court finds that the likelihood of injury is low. Accordingly, the Court finds that a penalty of \$3,300.00, as proposed by Complainant, is appropriate.

With respect to Citation 1, Item 5 and Citation 1, Items 6(a), (b), and (c), the Court finds that the hazards associated with each and the gravity of the violations are fairly similar. Each of these items deals with point of operation hazards, and the equipment at issue was used by numerous employees and contractors throughout the turnaround. Both the saw and the grinder were improperly guarded and exposed operators to potential lacerations, amputations, and, in the case of the grinder, struck-by injuries due to the worn-down grinding wheel. Given the potential for serious injury, and in consideration of the number of people that used the saw and grinder, the Court finds that a penalty of \$5,500.00 is appropriate for Citation 1, Item 5, and a grouped penalty of \$5,500.00 is appropriate for Citation 1, Items 6(a), (b), and (c).

With respect to Citation 1, Item 7, the Court finds that the violation was of low gravity. While the electric panel was blocked to some extent, it was not completely inaccessible. To be sure, when it comes to possible electric shock or electrocution, time is of the essence when it comes to shutting down circuits; however, considering that the panel was still relatively accessible, the Court finds that the violation's connection to potential injury was fairly attenuated. Accordingly, the Court finds that a penalty of \$3,000.00 is appropriate.

With respect to Citation 1, Item 8, the Court finds that employees were exposed to potential electric shock, burns, or even electrocution as a result of the open knockout on the side of the electrical panel. The panel itself was in a well-traveled area, and the knockout was not properly protected. However, even though it was in a well-traveled area, the Court finds it

would be unlikely that an employee would get close enough to the condition to actually cause injury. Accordingly, the Court finds that a penalty of \$1,000.00 is appropriate.

With respect to Citation 1, Item 9, Respondent's employees were exposed to potential burns, shock, and electrocution due to the use of extension cords as a primary power source. There was no indication that the hanging cords were damaged in any way; however, given the fact that the cords were draped over metal beams and cables and Respondent's propensity to use those cords both as power source and as hanging storage, the Court finds that the potential for serious injury was increased. Accordingly, the Court finds that a penalty of \$4,400.00 is appropriate.

With respect to Citation 2, Item 1, the Court finds that a lower penalty is appropriate. When viewed in a vacuum, twenty-four instances of contractors and employees failing to sign out of a process area seems excessive. However, more than 1500 contractors were present at the refinery each shift. While the Court agrees with Complainant that such an influx of people on the premises heightens Respondent's responsibility to properly track employees and contractors that are potentially exposed to PSM-related hazards, the Court is also mindful of the challenges associated with such a large, sudden, workforce increase. In light of that fact, and in consideration of the fact that Respondent had a badge-entry system that allowed them to track all entrants onto the property generally, the Court finds that a penalty of \$2,000.00 is appropriate.

Finally, with respect to Citation 3, Item 1, the Court finds that Respondent's employees were exposed to a hazard due to Respondent's failure to calculate and post the load rating for the second-level storage area. Without knowing the load capacity, Respondent's employees could have been exposed to a collapse of the structure due to overloading. However, in light of the fact

that Complainant characterized this citation item as other-than-serious, the Court finds that its proposed penalty of \$1,000.00 is appropriate.

VI. Order

Based upon the foregoing Findings of Fact and Conclusions of Law, it is ORDERED that:

A. Docket No. 13-0791 – Inspection No. 663538

1. Citation 1, Item 1 is AFFIRMED, and a penalty of \$7,000.00 is ASSESSED.
2. Citation 1, Items 2(a), (b), and (c) are AFFIRMED, and a grouped penalty of \$7,000.00 is ASSESSED.
3. Citation 1, Items 3(a) and (b) are AFFIRMED, and a penalty of \$7,000.00 is ASSESSED.
4. Citation 1, Item 4 [allegation (b)] is AFFIRMED, and a penalty of \$7,000.00 is ASSESSED.
5. Citation 1, Items 5(a) and (b) are AFFIRMED, and a penalty of \$7,000 is ASSESSED.
6. Citation 1, Items 6(a) and (b) are AFFIRMED, and a penalty of \$7,000 is ASSESSED.
7. Citation 2, Item 1 is VACATED.
8. Citation 2, Item 2 is AMENDED to a serious violation, AFFIRMED as amended, and a penalty of \$7,000.00 is ASSESSED.
9. Citation 2, Item 3 is AMENDED to a serious violation, AFFIRMED as amended, and a penalty of \$7,000.00 is ASSESSED.
10. Citation 2, Item 4 is AMENDED to a serious violation, AFFIRMED as amended, and a penalty of \$7,000.00 is ASSESSED.
11. Citation 2, Item 5 [allegation (b)] is AMENDED to a serious violation, AFFIRMED as amended, and a penalty of \$7,000.00 is ASSESSED.

12. Citation 3, Item 1 is VACATED.

B. Docket No. 13-0644 – Inspection No. 778042

1. Citation 1, Item 1 is VACATED.
2. Citation 1, Item 2 is AFFIRMED, and a penalty of \$3,300.00 is ASSESSED.
3. Citation 1, Item 3 is VACATED.
4. Citation 1, Item 4 is AFFIRMED, and a penalty of \$3,300.00 is ASSESSED.
5. Citation 1, Item 5 is AFFIRMED, and a penalty of \$5,500.00 is ASSESSED.
6. Citation 1, Items 6(a), (b), and (c) are AFFIRMED, and a grouped penalty of \$5,500.00 is ASSESSED.
7. Citation 1, Item 7 is AFFIRMED, and a penalty of \$3,000.00 is ASSESSED.
8. Citation 1, Item 8 is AFFIRMED, and a penalty of \$1,000.00 is ASSESSED.
9. Citation 1, Item 9 is AFFIRMED, and a penalty of \$4,400.00 is ASSESSED.
10. Citation 2, Item 1 is AMENDED to a serious violation, AFFIRMED as amended, and a penalty of \$2,000.00 is ASSESSED.
11. Citation 3, Item 1 is AFFIRMED, and a penalty of \$1,000 is ASSESSED.

Date: February 5, 2016
Denver, Colorado

/s/ *Brian A. Duncan*

Judge Brian A. Duncan
U.S. Occupational Safety and Health Review Commission