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

Secretary of Labor, Complainant, v. Denaka Partners, LP, dba Home Rubber Company, Respondent.	OSHRC Docket No. **21-0718**

Appearances:

Terrence Duncan, Esq., Office of the Solicitor, U.S. Department of Labor, New York, NY
For Complainant

Randall C. Schauer, Esq., Fox Rothschild LLP, Exton, PA
For Respondent

BEFORE: Administrative Law Judge Sharon D. Calhoun

DECISION AND ORDER

Denaka Partners, LP, d/b/a Home Rubber Co. (Denaka),[1] manufactures rubber products, such as hoses and belts, at its Trenton, New Jersey, facility. On December 18, 2020, an employee was adjusting blade depth on an operating Slitter mill when he lost his balance, and his shirt sleeve caught in the mill, pulling his arm into the mill, and resulting in its amputation. Denaka notified the Occupational Safety and Health Administration (OSHA) of the accident. OSHA assigned Compliance Safety and Health Officer (CSHO) Tracy Townsend to inspect the worksite and, based on her investigation, issued a Citation and Notification of Penalty (Citation) to Denaka on June 14, 2021, alleging serious and willful violations of the Occupational Safety and Health Act of 1970, 29 U.S.C. §§ 651-678 (Act).

[1] Denaka is the corporate name for Home Rubber. (Tr. 21.) The names were used interchangeably at trial, but OSHA issued the citation to Denaka and the notice of contest was filed by Denaka. Therefore, the Court uses Denaka throughout this opinion.

Denaka timely contested the Citation on July 2, 2021. The Secretary filed a Complaint on September 2, 2021, and Denaka filed its Answer on September 23, 2021. The Secretary filed an Unopposed Motion to Amend the Complaint and Citation on November 7, 2022, to withdraw Citation 1, Item 1, a serious violation of 29 C.F.R. § 1910.219(c)(2)(i), alleging Denaka did not guard the Slitter mill to protect the operator from being caught in the rotating shaft while utilizing the on/off buttons.[2] (Am. Compl., 6.) The Secretary also amended Citation 2, Item 1, which alleges a willful-serious violation of the machine guarding standard at § 1910.212(a)(1), to include the withdrawn serious allegation. Citation 2, Item 1, also alleges Denaka did not guard the Slitter mill's rotating parts while employees adjusted material on spools and adjusted the depth of knife blades. In Citation 2, Items 2, and 3, the Secretary alleges Denaka violated § 1910.1030(f)(2)(1), by failing to timely offer the Hepatitis B vaccination series to first aid responders, and § 1910.1030(g)(2)(i), for failing to provide an occupational exposure training program to employees assigned to conduct cleanup operations. In the Amended Complaint, the Secretary proposed a penalty of $247,705 reduced to $236,000 in the post-hearing brief. (Am. Compl., 11; Sec'y Post-Hr'g Br. at 25.)

For the reasons set forth herein, the Court affirms Citation 2, Items 1 and 2, and recharacterizes them as serious, affirms Citation 2, Item 3, as willful, and assesses a total penalty of $87,963.10.

JURISDICTION AND COVERAGE

The Court held a hearing on December 1 and 2, 2022, in Trenton, New Jersey. Both parties filed post-hearing briefs on February 13, 2023. The parties stipulated Commission jurisdiction over this matter pursuant to section 10(c) of the Act. (Exh. J-1, Facts 1; Law 1.) The parties also stipulated Denaka was engaged in business affecting commerce under § 3(3) and § 3(5) of the Act, because materials and supplies used by Denaka originated outside New Jersey and products manufactured by Denaka were shipped outside New Jersey. (Exh. J-1, Facts 3 and 4; Law 2.) Therefore, the Court finds it has jurisdiction under § 10(c) of the Act and Denaka is a covered employer under § 3(5) of the Act.

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[2] Commission Rule 102, 29 C.F.R § 2200.102, provides the Secretary may withdraw a citation "at any stage of a proceeding." Further, "the Secretary's decision to withdraw a citation against an employer under the Act is not reviewable by the Commission." *Cuyahoga Valley Ry. Co. v. United Transp. Union* 474 U.S. 3, 7 (1985). The Court acknowledges the Secretary's withdrawal disposes of Citation 1, Item 1, and on November 8, 2022, granted the Secretary's Unopposed Motion to Amend Complaint, which included withdrawal of Citation 1, Item 1.

STIPULATIONS

The parties submitted the following stipulations as a joint exhibit:

1. The Occupational Safety and Health Review Commission has jurisdiction over this matter.

2. Respondent, Denaka partners dba Home Rubber Co., is a corporation organized under the laws of the State of New Jersey and doing business in the State of New Jersey, maintaining its principal office and place of business at 31 Woolverton Road, Trenton, New Jersey, 08605, is and at all times hereinafter mentioned was engaged in the manufacture of Rubber (sic) products.

3. The materials and supplies used and / or manufactured by Respondent corporation originated and / or were shipped from outside the State of New Jersey.

4. Respondent for all relevant times, engaged in business affecting commerce by handling goods and or materials which had been moved in commerce.

5. Beginning on or about December 18, 2021, OSHA's Marlton, New Jersey field office began an investigation of Respondent's manufacturing facility at the above address.

6. The investigation began after Respondent reported the occurrence of an incident at its facility in which one of its employees (sic) left hand and arm were amputated while he was working on its Slitter / Rewind machine.

7. At the conclusion of its investigation, OSHA issued the citations and penalties that are at issue in this case.

8. Respondent timely contested the citations and penalties.

(Exh. J-1.)

BACKGROUND

Denaka manufactures mechanical and industrial rubber products, such as hoses, belts, tubes, gaskets, and sheet rubber, in small volumes upon request, rather than mass-producing items. (Tr. 258-59.) After Denaka receives a design order from a customer, employees begin the manufacturing process by mixing and compounding rubber specifically for that order. (Tr. 258-59.) Employees then use Denaka's mills and machines to create the finished product. (Tr. 259.) Its products, which range from tiny rubber gaskets to hoses which convey oil from a ship to shore, are "in virtually every industry in the U[nited] S[tates] and Canada." (Tr. 259.) Denaka, at the time of the accident and currently, employees approximately 35 employees. (Tr. 260.)

Denaka's mill room is roughly 120 feet long by 50 to 60 feet wide and contains a variety of colanders, hoists, vents, and mills, including a Slitter mill.[3] (Tr. 262; Exh. R-32.) To operate the Slitter mill, a roll of material starts at a cardboard core and is fed underneath a small roller called a counter, then over the steel roller at the top of the mill. (Tr. 278.) The bar above the steel roller holds knife blades in place, which can be spaced and removed depending on a specific job's requirements. (Tr. 278; Exh. C-2 at 7.) After the blades cut the fabric, and depending upon the job, a similar roll on the other side of the Slitter mill gathers the cut material on the uptake roll. (Tr. 278-79.)

On the rare occasion when the blades stopped cutting correctly (*i.e.*, not deep enough to cut through the fabric) or became misaligned, employees, prior to the accident, would sometimes adjust them while the Slitter mill was still operating. (Tr. 134-35, 137-38, 141, 240, 247; Exh. 2 at 3.) Employees also adjusted the rolls of material by hitting them with tubes while the Slitter mill was operating. (Tr. 137-38, 144-45, 159, 252.) Although the Slitter mill could be turned off to make adjustments, by doing so, "the rolls would lose alignment" making it "harder to do the job." (Tr. 142.) Following the accident, employees do not adjust the blades while the Slitter mill is operating. (Tr. 229, 247-48.) Red buttons located on both the front and the back of the Slitter mill allow employees to shut it off, either during an emergency or normal operations. (Exhs. R-2, R-5, C-2 at 7; Tr. 280.)

On December 18, 2020, Denaka president Richard Balka directed employees S.H. and M.L. to complete a final product run after they had completed inventory. (Tr. 133.) M.L. mixed the rubber and S.H. cut it into 4-inch strips on the Slitter mill. (Tr. 133; Exh. C-2 at 3.) S.H., who was standing in front of the mill to operate it, noticed one of the Slitter's blades was not correctly cutting rubber. (Tr. 133-34.) He stepped closer to the mill to reach up with his right hand to tap the top of the blade to put it into place. [4] (Tr. 134; Exh. C-2 at 3.) As he was doing so, he lost his balance and his left shirt sleeve "got stuck in the roll,"[5] which was collecting the cut material and is approximately 28 inches off the floor. (Tr. 134; Exh. C-2 at 3.) S.H. was unable to extract his

[3] The Slitter mill was also referred to as a "splitter rewind machine" and "duck cutter" at trial. (Tr. 43, 226.)

[4] It is unclear from the record what S.H. was using to tap down the blade at the time of accident, but he testified he would use "a tube, similar like a tube" to tap the blades. (Tr. 144.) The "Slitter roll," where the material is cut, is approximately 20 inches above the rotating spool. (Exh. C-2 at 3, 7.)

[5] The roll referred to here is the also called the rotating spool or rotating shaft, which gathers material after it is cut by the blades.

arm from the rotating spool, which eventually pulled his arm off. (Exh. C-2 at 3.)

M.L. did not see the accident, but when he came back to the Slitter, he saw S.H. on the ground under the mill with his left arm severed.[6] (Tr. 244, 282; Exh. C-2 at 7-8.) S.H.'s arm and hand were found lodged in the roll of product, which had to be cut away to remove them. (Exh. C-2 at 7.) Denaka employee S.F. alerted Balka of the accident and then called 911. (Tr. 281-82.) While S.F. waited for the ambulance, M.L. and Balka attended to S.H., covering him up with a blanket and then assisting the emergency medical technicians. (Tr. 282.) M.L. and Denaka employee P.R. then retrieved trash bags and Balka retrieved bleach. (Tr. 282.) They used rags and bleach to clean up the accident area and disposed of the rags, S.H.'s clothing, and their nitrile gloves into a trash bag for appropriate disposal. (Tr. 283.) Denaka Controller Stacey Hepner notified OSHA's Marlton, New Jersey, office and the company's worker's compensation carrier later that day. (Tr. 207.)

Denaka, through third-party Capital Health, had trained some employees on bloodborne pathogens, as well as first aid and CPR, and it had used American Heart Association student workbooks as part of the training program. (Tr. 87, 94, 117, 160; Exhs. C-5 (first aid), C-8 at 1-2, 4 (pathogens).) Denaka also had trained employees on first aid and CPR in 2017, which discussed the use of PPE, handwashing, and notification procedures in the event of an accident, however this training was not site specific. (Exh. C-4 at 3.) Emails sent by Hepner to OSHA provide the company's designated first aid responders included, among others, Balka and M.L. (Exhs. C-3 at 6, C-9 at 4; Tr. 210-11.) A designated first aid responder is "[s]omebody who would respond in the event of first aid or cleanup of blood from equipment." (Tr. 91.) However, Balka testified at trial Denaka did not have a designated team or group of employees who would be expected to clean up blood. (Tr. 302-03.) Denaka also did not offer the Hepatitis B vaccination to employees who had completed bloodborne pathogen training or to its designated first aid responders before the accident and did not have declination forms on file.[7] (Tr. 47-48; Exhs. C-3 at 4, 7, 9-11, C-9 at 4.) Following the 2020 accident, it offered the Hepatitis B vaccine to all three employees involved in

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[6] The OSHA violation worksheet provides another Denaka employee eventually stopped the mill, but it does not indicate exactly how it was stopped. (Exh. C-2 at 3.) The worksheet describes the main operational switch as being approximately 13 inches from the rotating spool or bar. (Exh. C-2 at 3, 7.)

[7] Hepner did not name P.R., among other employees, as a designated first responder in an e-mail to CSHO Townsend during the investigation. (Exh. C-9 at 4.) However, she attached an American Heart Association "First Aid, CPR, AED" certification card issued to P.R. in 2017 for a training conducted by a third-party Capital Health. (Exh. C-3 at 10.) Balka testified that the first aid and bloodborne pathogen trainings were offered to all employees. (Tr. 302.)

the cleanup. (Tr. 283.) P.R. and Balka signed waivers declining the shots the Monday following the Friday accident, and Hepner called the clinic to arrange the vaccination for M.L., who received his first dose on December 23, 2020, and eventually completed his series. (Tr. 208, 283; Exh. C-3 at 2; Exh. R-30.)

Regarding Denaka's bloodborne pathogen program, Hepner provided to OSHA in an email following the accident, the company "do[es] not have a written program for Bloodborne pathogens." (Exh. C-8 at 3.) Balka also testified the company had no formal pathogen plan or policy prior to 2020. (Tr. 306-07.) However, the company had previously provided OSHA with a bloodborne pathogens policy, which contained portions of a National Safety Council workbook, as proof of abatement following a 2016 inspection and investigation. (Exhs. C-7 (Denaka), C-6 (NSC); Tr. 64-65, 307.)

2020 Accident Inspection and Safety History

CSHO Townsend conducted a workplace inspection on Monday, December 21, 2020, and continued her investigation over the next several months.[8] (Tr. 95.) As part of her investigation, CSHO Townsend received information on machine guarding, vaccinations, training, and the company's bloodborne pathogens program from Hepner. She also reviewed Denaka's inspection and violation history, which included citations in 2010, 2012, and 2016. CSHO Townsend consulted her supervisor, Assistant Area Director Marie Lord, who had inspected the Denaka facility following the 2016 accident. CSHO Townsend also reviewed the case file regarding the 2016 accident and resulting citation. (Tr. 95-97, 167-68.) The 2016 accident involved a Denaka employee's hand being pulled into the nip point while he was feeding raw material onto the Chrome mill's steel rollers. *Home Rubber Co., LP*, No. 17-0138, 2021 WL 3929735, at *1 (OSHRC Aug. 26, 2021). Although he freed his hand by reversing the rollers, four of his fingers were later surgically amputated at a hospital. *Id.* Following the 2016 accident, two Denaka employees used rags and bleach to clean up blood from the area.[9] *Id.*

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[8] CSHO Townsend joined OSHA in 2011 and estimated she had conducted a few hundred inspections during her time with the agency. (Tr. 36.)

[9] Among other things, OSHA cited Denaka for serious violations of § 1910.212(a)(1) (for failing to guard the rotating arm on another machine, called the Kobe mill), § 1910.1030(f)(2)(i) (for failing to timely make the Hepatitis B vaccination available to employees), and § 1910.1030(c)(1)(i) (for failing to develop and implement a written bloodborne pathogen exposure control plan). (Exhs. C-2 at 11-13, C-3 at 15-16, C-4 at 8-10.) OSHA also cited Denaka for failing to guard the point of operation on the Chrome mill, the Kobe mill, Mill One, and Mill Three, in violation of § 1910.212(a)(3)(ii), which is another provision of the machine guarding standard. (Exh. C-2 at 16-19.) The machine guarding violations and bloodborne pathogen exposure control plan violations were affirmed, and on review the

AAD Lord had observed the Slitter mill in 2016, however she did not ask Denaka to operate the mill and did not see it actually operating.[10] (Tr. 176-77, 294-95.) AAD Lord also reviewed a 1999 audit inspection report for Denaka's facility, which Balka's former partner had obtained through a voluntary OSHA audit program. (Exh. C-11; Tr. 274-75.) Among other things, the third-party consultants conducting the audit observed that "Denaka's procedures for machinery guarding appear to be inconsistently implemented" because "guards are in place on some fixed equipment but missing on others." (Exh. C-11 at 8.) The consultants recommended Denaka develop "a formal program for machinery guarding" based upon the "requirements in 29 CFR Subpart O, 1910.211 through 1910.219." (*Id.*) According to Balka, Denaka added some guarding to machines throughout the facility following the audit. (Tr. 276.)

OSHA also inspected Denaka's facility in 2010 and 2012 and issued citations which alleged machine guarding violations. (Exh. R-36.) In 2010, Denaka and OSHA settled a serious citation alleging violations of § 1910.219(e)(3)(i) (requiring employers to enclose vertical and inclined belts with a conforming guard), § 1910.219(f)(1) (requiring employers to guard gears according to a method set forth in the standard), and § 1910.303(g)(1)(ii) (requiring employers to guard normally enclosed live electrical parts that are exposed for inspection or servicing, if in a passageway or general open space) for a total penalty of $1,463. (*Id.* at 1.) In 2012, they settled a serious citation alleging violations of § 1910.212(a)(1) (requiring machine guarding to protect the operator and employees from hazards) and § 1910.303(g)(1) (requiring employers to provide and maintain sufficient access and working space for safe operation and maintenance of electric

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Commission affirmed the Hepatitis B vaccination violation. *Home Rubber*, 2021 WL 3929735, at *1, 11-12.

These mills are described in the 2016 violation worksheet. (Exh. C-2 at 18.) The Chrome mill, according to worksheet, "is operated to make a specialty rubber product. Raw rubber is fed into the mill and then additional rubber and or powdered chemicals are added to the mix. All ingredients have to be hand fed into the mill due to the nature of the material that is produced." (*Id.*) The Chrome mill had no guarding features at the time of the 2016 incident. (*Id.*)

To make products containing carbon black on Mill Three, an employee places a block of rubber "onto the cylinders and [it is] pulled into the machine creating a smooth sheet." (*Id.*) The employee adds "[p]owdered chemicals and oils . . . to the rubber using a shovel as the cylinders on the machine are spinning. The sheet is cut several times by hand, pulled out of the cylinders and then put back in. Finished sheets of rubber are removed by the same cutting process." (*Id.*) Mill One is used in the same manner but without the carbon black. (*Id.*)

The Kobe mill, according to the worksheet, "is also known as the warm up mill. Finished sheets of rubber are placed into the cylinders to warm up the rubber prior to feeding it into the calendar machine. Employees also hand cut this rubber, pull it out of the cylinders and then feed it back into the cylinders." (*Id.*)

[10] As a result of her observations, OSHA also cited Denaka for a torn strain relief on an electrical cable that attaches to control panel for the Slitter mill, as well as torn strain reliefs on two other mills, in violation of § 1910.305(g)(2)(iii). *Home Rubber*, 2021 WL 3929735, at *54 (ALJ). The judge affirmed this serious citation item and penalty of $3,742, and the Commission did not consider this citation item on review. *Id.*

equipment) for a total penalty of $3,108. (*Id.* at 2.) Denaka also settled without penalty an other-than-serious citation alleging a violation of § 1910.146(c)(2), which requires employers to inform employees of the existence, location, and danger posed by permit spaces. (*Id.* at 1.) At trial, Balka testified that the 2012 inspection and citation did not involve the mills involved in the 2016 citation or the Slitter in the current citation. (Tr. 273.)

OSHA primarily based its decision to issue a willful citation in the instant matter on these previous citations and the factual circumstances surrounding the 2016 accident. (Tr. 97, 192-93.)

Credibility and Conflicting Testimony

The Court credits the testimony of CSHO Townsend. Her recollection of events and conversations that occurred during her investigation was consistent with her investigation summary, OSHA violation worksheets, as well as email exchanges with Denaka employees. (Exhs. C-1, C-2, C-3, C-4, C-5, C-8, C-9.) Similarly, the Court credits the testimony of AAD Lord regarding her involvement in the 2020 accident inspection and citation.

Slitter Machine Operation

Regarding the machine guarding citation, S.H. testified he did not often tap the blades to adjust them while the Slitter mill was running. (Tr. 141.) In his deposition, he testified either Debra Steele, who was the production manager at the time of the accident, or Balka saw him hitting the blade while the mill was moving. (Tr. 136.) S.H. also testified he observed M.L. hitting the blade while the mill was operating. (Tr. 137.) M.L. testified he had observed employees adjusting the blades with a mallet while the mill was operating. (Tr. 240.) He also testified he had tapped down the blades while the mill was running. (Tr. 247.) He later contradicted himself and said he had only seen others tap down the blades while the mill was running. (Tr. 249-50.) M.L. testified the Slitter mill must now be turned off to adjust the blades. (Tr. 241, 247-48.) However, at his deposition, he stated the blades could not be adjusted while the mill is moving. (Tr. 242-43.) Denaka employee W.C., who began working for the company in February 2020, testified he did not adjust blades at the top of the Slitter mill while it was operating. (Tr. 229-30.)

Steele, who left the company in April 2022, testified she observed employees operating the Slitter mill but did not see them adjust blades while the mill was operating. (Tr. 159.) She observed operators occasionally use a mallet or similar tool to realign material coming through the roll. (Tr. 159.) Balka testified he had never seen or been informed of employees adjusting the blades while the Slitter mill was operating. (Tr. 285-86.)

Based upon the above testimony, the Court credits the injured employee S.H.'s testimony he adjusted the blades while the Slitter mill was operating and observed others doing so. That managers may not have observed Slitter mill operators adjusting the blades while the mill was operating, and that a current employee does not make these adjustments, do not establish employees did not previously engage in this behavior, including at the time of the 2020 accident. Testimony from employees and managers establishes the Slitter mill was rarely used, or at least used less frequently than other mills. (Tr. 136, 141, 224.) The Court concludes employees, prior to the 2020 accident, occasionally adjusted and tapped down the Slitter mill's blades while it was operating.

Vaccine Testimony

Turning to the vaccine citation, Lord testified that during the 2016 closing conference she, Balka, and Hepner "discussed provision of the Hepatitis B vaccination to any employees who were designated as either first aid responders or to clean up blood or bodily fluids after an exposure event." (Tr. 173.) In her testimony during the Commission proceeding for the 2016 citations, she said the vaccine violation "was issued because a Hepatitis B vaccination was not provided, was not offered and/or provided to employees required to clean up blood." (Tr. 187.) Hepner testified, based upon her participation in the 2016 opening and closing conferences and communications with OSHA, that it was her understanding the vaccine "was [to be offered] at the time of an accident." (Tr. 206, 209.) Balka similarly testified it was not his understanding from the 2016 citation and conferences the vaccine should be offered to someone who had been trained in bloodborne pathogens or designated a first aid responder. (Tr. 301-02.)

Based upon this conflicting testimony and the fact these conferences took place six years prior to the trial in the current case, the Court declines to make a finding on whether these discussions were limited to offering the vaccine following a potential exposure event or included the requirement to offer the vaccine within ten days to employees who had received bloodborne pathogen training. As discussed below, the Court finds although OSHA's basis for the previous citation was Denaka's failure to offer the vaccine to employees within ten days of cleaning up after the May 6, 2016, accident, OSHA made no affirmative representations to the company that the other part of the standard's provision, directing employers to offer the vaccine with ten days of initial assignment, did not apply.

Bloodborne Pathogens Response and Training

Steele testified that an outside company trained a group of Denaka employees on first aid and bloodborne pathogens exposure. (Tr. 160.) W.C. testified he had safety, CPR, first aid, bloodborne pathogens, mill rescue, and forklift training as a Denaka employee and that the CPR and first aid training had been in January 2021 or 2022. (Tr. 230-31.) M.L. testified he had received first aid training prior to the 2020 accident, which was meant to allow him to respond to accidents involving blood at the facility. (Tr. 252-53.) Balka testified Denaka "would not let someone who was not trained clean bodily fluids," but the company in 2016 had "no designated team [and] no first responders." (Tr. 302.) Similarly, he testified the company did not have a designated team in 2020, although it "offered the trainings that we do to every employee in the factory and in the office without an expectation that they're going to need to use it for any purpose." (Tr. 303.) Balka also testified Denaka offered first aid, CPR, and bloodborne pathogens trainings and insurance company resources to employees following the 2016 accident, but the company did not have a formal, written bloodborne pathogen control and incident response plan at the time of the 2020 accident. (Tr. 306-07.) Hepner testified it was her understanding designated first aid responders are employees trained in first aid, not necessarily designated to respond to an incident. (Tr. 210-211; Exh. C-9 at 4.) She testified Denaka would not call or alert a specific group of employees in the event of an incident involving blood, such as the one at issue in 2020. (Tr. 211.) She did not recall any discussion with OSHA as to the meaning of the term "designated first aid responder" and did not contact CSHO Townsend about the meaning of the term designated first responder. (Tr. 211, 215.) In response to inquiries regarding designated first aid responders during the investigation, Hepner sent a list of employees and American Heart Association CPR/first aid cards for M.L., Balka, and P.R. to CSHO Townsend. (Exhs. C-9 at 4; C-3 at 7, 9-11.) CSHO Townsend confidently testified Hepner sent the names and cards for employees trained in first aid and CPR and it established these employees were in fact designated first aid responders within the meaning of the standard. (Tr. 48-50.)

The Court finds the above testimony credible. It establishes Denaka trained its employees in CPR and first aid, and it had designated first aid responders either expected or directed to clean up blood and bodily fluids at the facility.

The Citation

Following the inspection and investigation, OSHA cited Denaka for three willful violations

of Section 5(a)(2) of the Occupational Safety and Health Act of 1970, and the standards thereunder found at 29 C.F.R. § 1910.212(a)(1), 29 C.F.R. § 1910.1030(f)(2)(i), and 29 C.F.R. § 1910.1030(g)(2)(i).

ANALYSIS

To prove a violation of section 5(a)(2) of the Act, the Secretary must establish "by a preponderance of the evidence that (1) the cited standard applies, (2) there was a failure to comply with the cited standard, (3) employees had access to the violative condition, and (4) the cited employer either knew or could have known of the condition with the exercise of reasonable diligence." *Astra Pharm. Prods.*, 9 BNA OSHC 2126, 2129 (No. 78-6247, 1981), *aff'd in pertinent part*, 681 F.2d 69 (lst Cir. 1982).

Machine Guarding

The Secretary alleges in Citation 2, Item 1:

> 29 C.F.R. § 1910.212(a)(1): Types of guarding. One or more methods of machine guarding were not provided to protect the operator and other employees in the machine area from hazards such as those created by point of operation, ingoing nip points, rotating parts, flying chips and sparks. Examples of guarding methods are barrier guards, two-hand tripping devices, electronic safety devices, etc.
>
> a) Mill Room: Slitter/rewinder was not provided with a guard to protect the operator from being caught in rotating parts. Employees exposed to caught-in hazards while adjusting the material on the spools on the take-up bar. Employees stand in front of and when more than one take-up bar is used stand in between the rotating take up bars while winding product on the spools on or about 12/18/2020.
>
> b) Mill Room: Slitter/rewinder was not provided with a guard to protect the operator from being caught in rotating parts. Employees are exposed to caught in hazards while adjusting the depth of the knife blade while the machine is running on or about 12/18/2020.
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> c) Mill Room: The shaft to the Slitter/rewinder machine was not provided with a guard to protect the operator from being caught in the rotating shaft while utilizing the on/jog/off buttons on or about 12/18/2020.

(Am. Compl. VI.)

Whether the Cited Standard Applies

Denaka argues the injury did not occur at the Slitter's "point of operation," which is defined in § 1910.212(a)(3)(i) as "the area on a machine where work is actually being performed upon the material being processed," but rather at the rotating spool which was gathering up the cut material.

(Resp't Post-Hr'g Br. at 6.) Therefore, according to Denaka, the cited provision of the machine guarding standard does not apply. (*Id.*) The Court finds this argument unpersuasive, as it ignores the plain text of the provision. Section 1910.212(a)(1) also requires guarding to protect employees from hazards created by "ingoing nip points, rotating parts, fly chips and sparks." 29 C.F.R. § 1910.212(a)(1). Rotating parts are enumerated in the machine guarding requirements, and the Secretary alleges the rotating shaft was unguarded. Therefore, the Court finds that the cited standard applies. *See S & G Packaging Co.*, 19 BNA OSHC 1503 (No. 98-1107, 2001) (machine guarding violation affirmed where employee suffered injuries by contacting unguarded rotating drive rollers).

Whether Denaka Violated the Standard

The cited standard, § 1910.212(a)(1), is a performance standard, "which means 'it states the result required . . . , rather than specifying that a particular type of guard must be used.' " *Aerospace Testing All.*, No. 16-1167, 2020 WL 5815499, at *3 (OSHRC April 15, 2020) (quoting *Diebold, Inc.*, 3 BNA OSHC 1897, 1900 (No. 6767, 1976) (consolidated), *rev'd on other grounds*, 585 F.2d 1327 (6th Cir. 1978)). "Performance standards 'require an employer to identify the hazards peculiar to its own workplace and determine the steps necessary to abate them.' " *Aerospace Testing*, 2020 WL 5815499, at *3 (quoting *Thomas Indus. Coatings, Inc.*, 21 BNA OSHC 2283, 2287 (No. 97-1073, 2007)). Here, it is undisputed Denaka did not provide any guarding for the Slitter mill's rotating shaft. (Exhs. C-2 at 3, 7, R-2; Tr. 277.) The record establishes the rotating shaft posed an amputation hazard, which required Denaka to guard the Slitter mill pursuant to § 1910.212(a)(1). *See S & G Packaging*, 19 BNA OSHC 1503 at *3 (existence of a hazard established based upon employee injuries and record evidence that machine rollers were not guarded). The Court finds Denaka did not comply with the standard.

Whether Employees Had Access to the Violative Condition

To establish access, "the Secretary must show either that Respondent's employees were actually exposed to the violative condition or that it is 'reasonably predictable by operational necessity or otherwise (including inadvertence), that employees have been, are, or will be in the zone of danger.' " *S & G Packaging*, 19 BNA OSHC 1503, at *3 (quoting *Fabricated Metal Prods.*, 18 BNA OSHC 1072, 1074, (No. 93-1853, 1997)). Here, S.H.'s injury establishes actual exposure to the violative condition set forth in paragraph (b) of Citation 2, Item 1, which alleges employee exposure to caught in hazards while adjusting knife blades. *See S & G Packaging*, 19 BNA OSHC

1503, at *3 (Employee's "injuries establish actual exposure to the unguarded drive rollers."); *see also Phoenix Roofing, Inc.*, 17 BNA OSHC 1076, 1079 (No. 90-2148, 1995) (employee's fall through a skylight established actual exposure to a fall hazard), *aff'd without published opinion*, 79 F.3d 1146 (5th Cir. 1996).

The Court also finds that the Secretary proved access to the violative condition was reasonably predictable. Commission precedent provides the zone of danger "is . . . the 'area surrounding the violative condition that presents the danger to employees the standard is intended to prevent.' " *Dover High Performance Plastics*, No. 14-1268, 2020 WL 5880242, at *2 (OSHRC Sept. 25, 2020) (quoting *RGM Constr. Co.*, 17 BNA OSHC 1229, 1234 (No. 91-2107, 1995)). The relevant inquiry involves assessments of the configuration of the machine and how employees position themselves near the machine. *See ConAgra Flour Milling Co.*, 16 BNA OSHC 1137, 1149-50 (No. 88-1250, 1993) (finding exposure where employees worked 1 to 1.5 feet away from unguarded parts and neither the operation nor the configuration of the machine would prevent the employees from approaching them), *rev'd in part on other grounds*, 25 F.3d 653 (8th Cir. 1994); *Mosser Constr. Co.*, 15 BNA OSHC 1408, 1411, (No. 89-1027, 1991).

Here, the record establishes it was reasonably predictable Denaka employees, either through their assignments or inadvertence, would be in the area surrounding the violative condition—the unguarded rotating shaft— that presents danger to employees. Although Denaka employees did not have an operational necessity to contact the unguarded rotating spool while adjusting the blades, this action brought their hands, arms, and upper bodies within the zone of danger, exposing them to inadvertent contact with the spool. *See S & G Packaging*, 19 BNA OSHC 1503, at *3 (machine operators had no operational necessity for contacting rollers, but checking paste application process put their heads and upper bodies within the zone of danger); *Fabricated Metal Prods.*, 18 BNA OSHC 1072, at *3 n.7 (No. 93-1853) ("Our inquiry then is whether the employees' proximity to the machines makes it reasonably predictable that they will enter these zones of danger by slipping or falling.").

The Slitter's roll was at the top, tip of the triangular-shaped machine, 20 inches from the rotating spool, which is located lower on the outside of the triangle. (Exh. C-2 at 3, 7-8.) The blades at the time of the accident were spaced out from one side of the Slitter roll to the other to cut four-inch strips of nylon fabric. (*Id.* at 3, 7.) An employee attempting to adjust any of these blades would be near the unguarded rotating spool, given the configuration of the machine. *See RGM Constr.*,

17 BNA OSHC at 1234 (the zone of danger is "that area surrounding the violative condition that presents the danger to employees which the standard is intended to prevent").

As to the Secretary's allegations in paragraphs (a) and (c)—exposure to the rotating shaft while adjusting spools on the take up bar and exposure while using the on/jog/off buttons—the record supports an exposure/access finding for each. Employees performed both tasks while the Slitter mill was running. (Tr. 137-38, 142-43, 145, 148 (material), 289 (jogger); Exh. C-2 at 4.) And both tasks required employees to enter the zone of danger. First, employees adjusting the spools themselves would place their hands directly into the zone of danger to adjust materials on the rotating shafts.[11] (Tr. 137-38, 142-43, 145, 148, 248, 252; Exh. C-2 at 4.) And second, operating the on/jog/off buttons required employees to be roughly 13 inches away from the unguarded rotating spool, which is nearer than when they adjusted the blades, placing them in the zone of danger. (Exh. C-2 at 3, 7-9.) For these reasons, the Secretary has established access to the unguarded rotating shaft.

Whether Denaka Had Knowledge of the Violative Condition

To establish the knowledge element, "the Secretary must prove that the employer knew or, with the exercise of reasonable diligence, should have known of the conditions constituting the violation." *Cent. Fla. Equip. Rentals, Inc.*, 25 BNA OSHC 2147, 2155 (No. 08-1656, 2016) (citing *Jacobs Field Servs. N. Am.*, 25 BNA OSHC 1216, 1218 (No. 10-2659, 2015)). "The actual or constructive knowledge of the employer's foreman or supervisor can be imputed to the employer." *Jersey Steel Erectors*, 16 BNA OSHC 16 BNA OSHC 1162, at *2 (No. 90-1307, 1993), *aff'd*, 19 F.3d 643 (3d Cir. 1994). Here, Denaka offers several unpersuasive arguments as to why it did not have knowledge of the violative condition. Denaka asserts it did not know S.H. was adjusting the blades while the Slitter was operating, because employees infrequently used the Slitter mill. (Resp't Post-Hr'g Br. at 7-9.) It also asserts it did not have knowledge of the violative condition because the Secretary did not indicate during previous investigations the Slitter lacked machine guarding. (*Id.* at 10.)

These arguments fail. The Secretary need not establish Denaka management knew S.H. adjusted the blades while the Slitter was operating. The Secretary must only establish "that the employer was aware of the physical conditions constituting the violation." *S & G Packaging*, 19

[11] It is unclear from the record whether the material was at times being adjusted on the roll before it was cut or after it was cut.

BNA OSHC 1503, at *4. Here, the physical condition is the lack of guarding on the Slitter mill's rotating shaft, and the record establishes Denaka knew of this violative condition. Steele testified she saw employees operating the Slitter mill.[12] (Tr. 159.) Balka testified the mill had not been modified since he purchased the company nearly 25 years before the accident. (Tr. 277.) Moreover, CSHO Townsend's investigation notes provide Balka told her he had observed S.H. operating the mill. (Exh. C-2 at 4.) Therefore, Balka would have observed the Slitter's lack of guarding. *See S & G Packaging*, 19 BNA OSHC 1503, at *4 (actual knowledge established where compliance officer testified the plant manager and safety manager told her they were aware of unguarded condition). CSHO Townsend's notes and photographs provide Balka also demonstrated how the unguarded Slitter mill works.[13] (Exh. C-2 at 4, 8; Tr. 44-45.)

The Commission also has found an employer is aware of the physical conditions constituting the violation when the conditions are in the open, plainly visible to anyone walking by, and supported by photographic evidence in the record. *See S & G Packaging*, 19 BNA OSHC 1503, at *4. Here, photographs in the record establish the Slitter mill was in plain view, such that company management was at least able to observe it was not guarded. (Exhs. C-2 at 3, 7-9, R-2.)

Denaka also posits a fair notice argument by alleging it did not have knowledge of the violative condition since the Secretary did not indicate during previous inspections and investigations the Slitter lacked guarding or required it. (Resp't Br. at 10.) The Court finds this argument unpersuasive. It is well-settled that "the mere fact of prior inspections does not give rise to an inference that OSHA made an earlier decision that there was no hazard, and does not preclude the Secretary from pursuing a later citation." *Seibel Modern Mfg. & Welding Corp.*, 15 BNA OSHC 1218, at *7 (No. 88-821, 1991). Furthermore, the record does not support a finding OSHA

[12] Townsend also testified that Steele said she had observed employees operating the Slitter mill. (Tr. 45.) Her investigation notes also state that Steele said she observed S.H. operating the Slitter mill. (Exh. C-2 at 4.)

[13] Even assuming the violative condition is related to employees adjusting the blades while the Slitter mill was running and management did not observe this practice, management could have discovered the practice with the exercise of reasonable diligence. Employees testified they learned to operate the Slitter from more senior employees and observation, rather than any formal training and there was no evidence in the record of a work rule forbidding this practice. S.H testified he learned to operate the Slitter mill by helping other people, including Walter, who managed the mill room, and Jose, another employee who had worked on the mill. (Tr. 132-33.) S.H. also said he did not receive formal training from HR on how to operate the mill. (Tr. 133.) Denaka management did not train its employees to correctly use the Slitter, did not take steps to discover how employees used the mill, and did not discipline employees when they used it incorrectly. *See Precision Concrete Constr.*, 19 BNA OSHC 1404, 1407 (No. 99-0707, 2001) (To determine whether an employer exercised reasonable diligence, the Commission considers, among other things an "employer's obligation to have adequate work rules and training programs, to adequately supervise employees. . . .").

affirmatively represented to Denaka the Slitter, which was not involved in the 2016 amputation accident, complied with machine guarding requirements. *Compare S & G Packaging*, 19 BNA OSHC 1503, at *4 n.12 ("[T]here is no evidence that OSHA made any representations that deprived Respondent of fair notice of the standard's requirements.") and *Columbian Art Works, Inc.*, 10 BNA OSHC 1132, at *1 (No. 78–0029, 1981) (record did not establish compliance officer informed employer it was in compliance with machine guarding standard), *with Miami Indus., Inc.*, 15 BNA OSHC 1258, 1264 (No. 88-671, 1991) (OSHA's affirmative representations that agency considered the employer in compliance with guarding standard deprived employer of fair notice), *aff'd in relevant part and set aside in part without published opinion*, 983 F.2d 1067 (6th Cir. 1992). Denaka's " 'continuing obligation' " to comply with the Act does not absolve it of its failure to provide machine guarding on the Slitter. *Seibel Modern Mfg.*, 15 BNA OSHC 1218, at *7 (quoting *Lukens Steel Co.*, 10 BNA OSHC 1115, at *11 (No. 76–1053, 1981)).

The Court finds the Secretary has established all elements of her burden of proof for Citation 2, Item 1.

Hepatitis B Vaccination

The Secretary alleges in Citation 2, Item 2:

> 29 C.F.R. § 1910.1030(f)(2)(i): The Hepatitis B vaccination was not made available within 10 working days of initial assignment to all employee(s) with occupational exposure.
> a) Facility: The employer did not offer the Hepatitis B vaccine series to designated first aid responders and employees who conducted cleanup operations after an incident involving blood or other potentially infections [sic] materials, on or about 12/18/2020.

(Citation at 8.)

Whether the Cited Standard Applies

The standard generally requires employers to offer the Hepatitis B vaccine to employees within 10 working days of initial assignment, such as after they have received required bloodborne pathogen training, and to all employees who have occupational exposure, such as after a workplace incident. 29 C.F.R. § 1910.1030(f)(2)(1). It defines occupational exposure as "reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance." 29 C.F.R. § 1910.1030(b). Here, the Secretary asserts the standard applies to M.L., among others, because Denaka trained and designated him as a first aid responder in 2017, and he responded to and cleaned up blood after

the 2020 amputation accident. (Sec'y Post-Hr'g Br. at 15.) Denaka argues that although it trained some employees in first aid and bloodborne pathogens, it did not have any designated first aid responders or a set group of employees expected to respond to an incident. (Resp't Post-Hr'g Br. at 13.)

The Court is not persuaded. The 2016 accident, and the nature of the work performed with machines and knives, demonstrate Denaka could reasonably anticipate designated first aid responders or employees otherwise trained to respond would, during an incident response, have occupational exposure to blood resulting from performance of their first aid and cleanup duties. *Cf. Am. Recycling & Mfg. Co. v. Sec'y of Labor*, 676 F. App'x 65, 72 (2d Cir. 2017) (unpublished) (rejecting violation where employer could not reasonably anticipate contact with blood during their work duties). That Denaka offered such training also reinforces a finding the company has at a minimum employees expected to respond in the event of an incident. The standard, § 1910.1030(f)(2)(i), applies to the cited condition.

Whether Denaka Violated the Standard

The Secretary argues Denaka violated the standard due to Denaka's failure to offer M.L. the vaccine within 10 working days of his initial assignment as a designated first aid responder. (Sec'y Post-Hr'g Br. at 15.) Instead, Denaka offered the vaccine three days after the 2020 accident to which M.L. responded. (*Id.*) Denaka, which was cited by OSHA for a violation of the same standard following the 2016 accident and investigation, argues Balka's understanding was OSHA issued the previous citation on the basis the company did not offer the vaccine within ten days of the 2016 exposure event. (Resp't Post-Hr'g Br. at 11.) It asserts Balka did not understand the standard required Denaka to offer the vaccine to employees once they were trained to respond to incidents involving occupational exposure to bloodborne pathogens. (*Id.* at 11-12.)

The Court is not persuaded by Denaka's fair notice argument. Denaka, again, does not point to any affirmative representations by OSHA that the first part of the standard's provision regarding offering the vaccine after initial assignment does not apply. *See S & G Packaging*, 19 BNA OSHC 1503, at *4 n.12 ("[T]here is no evidence that OSHA made any representations that deprived Respondent of fair notice of the standard's requirements."). Denaka merely asserts Balka's understanding that OSHA's previous citation was based upon the company's failure to offer the vaccine within ten days of occupational exposure resulting from the 2016 accident. (Resp't Post-Hr'g Br. at 14 ("To be sure, in 2016, OSHA cited Denaka for not offering the vaccine at the time

of cleanup and exposure to potentially contaminated materials."); Tr. 206 (Hepner), 299, 301 (Balka).) It appears, from the evidence adduced at trial, this was OSHA's basis for the previous citation, as Denaka had not designated any first aid responders at the time of the 2016 accident. (Exh. C-3 at 15-16; Tr. 187, 194 (employees were assigned on the date of the May 6 accident).) However, Denaka failed to present any evidence OSHA represented it did not need to offer the vaccine to employees after they had received required bloodborne pathogen training, and nothing precludes OSHA from issuing a citation based upon Denaka's failure to offer the vaccine after initial assignment.

Implicit in Denaka's argument OSHA did not previously inform the company of its obligation to offer the vaccine to employees within ten days of initial assignment (training), is a claim the standard's provision is unclear or it lacked notice from the provision's text. Even if Denaka had explicitly raised this argument, the Court would reject it. Whether Denaka knew its conduct violated the standard, the company was aware of the conditions—its failure to offer the vaccine after initial assignment—underlying the violation. *See Froedtert Mem. Lutheran Hosp., Inc.*, 20 BNA OSHC 1500, at *11 (No. 97-1839, 2004) (rejecting employer's argument it lacked notice that it was required to comply with vaccination requirement because the "Commission has long held that the knowledge required to establish a violation is not directed 'to the requirements of the law, but to the physical conditions which constitute a violation of [the Act].' " (quoting *Sw. Acoustics & Specialty, Inc.*, 5 BNA OSHC 1091, 1092 (No. 12174, 1977); *see also Midwest Masonry, Inc.*, 19 BNA OSHC 1540, 1544 n.6, (No. 00-0322, 2001) ("[w]hether or not employers are in fact aware of each OSHA regulation and fully understand it, they are charged with this knowledge and are responsible for compliance . . . . [i]t is no defense that they did not understand the reasonable interpretation of a regulation") (internal citations omitted).

Denaka's reading of the standard is also contrary to established Commission precedent, as well as the interpretation of Commission judges and appeals courts. *See Froedtert*, 20 BNA OSHC 1500, at *12 ("The standard . . . requires only that the vaccine be 'made available' to exposed employees within ten days of initial assignment."). Recently, a Commission judge found an employer failed to comply with the standard when it did not offer employees the Hepatitis B vaccine within ten working days of assignment to its injury response team. *Wal-Mart Stores E., LP*, 26 BNA OSHC 1756, at *19 (No. 16-0272, 2017) (ALJ). The Commission denied the employer's petition for review and the U.S. Court of Appeals for the Eighth Circuit affirmed the

judge's decision. *Wal-Mart Stores East, LP v. Acosta*, 919 F.3d 1073 (8th Cir. 2019). The Eighth Circuit found the judge correctly "relied on testimony from Wal-Mart's AP manager in charge of the SIRT team during the relevant time period, who conceded he failed to offer the vaccine to certain SIRT volunteers after they had completed their training." *Id.* at 1080. Here, the arguments advanced by Denaka, as well as Balka and Hepner's testimony they were unaware of the need to offer the vaccine in the absence of an exposure event, amount to a concession the company similarly failed to offer the vaccine to employees after they completed their bloodborne pathogens training.

Whether Employees Had Access to the Violative Condition

M.L. was a designated first aid responder and, as he testified, Denaka did not offer the vaccine to him within ten days of completing his training or at any time before the 2020 amputation accident. (Tr. 243-44, 253; Exh. C-3 at 4.) Previous accidents and the nature of work at the facility, which involved working with and near machines and knives, made designated first aid responder exposure reasonably foreseeable within the meaning of the standard. *See Offshore Shipbuilding, Inc.*, 18 BNA OSHC 2169, at *8 (No. 97-257, 2000) ("[D]esignated first aid providers . . . might be exposed to bloodborne pathogens in rendering assistance to a fellow employee who had been injured . . . . [and g]iven the nature of the work being done . . . an injury that would cause bleeding was reasonably foreseeable."). Although Lord testified employees did not end up having an exposure to bloodborne pathogens because they wore gloves while cleaning up after the accident, actual exposure is not a prerequisite under the standard for the requirement to offer the vaccine. (Tr. 171.) As noted above, the standard also defines occupational exposure as "reasonably anticipated . . . contact with blood or other potentially infectious materials that may result from the performance." 29 C.F.R. § 1910.1030(b). The Court therefore finds the Secretary has established access to the violative condition.

Whether Denaka Had Knowledge of the Violative Condition

To establish knowledge, the Secretary must either establish the employer knew or, with the exercise of reasonable diligence, should have known of the physical conditions constituting the violation. *Cent. Fla. Equip. Rentals, Inc.*, 25 BNA OSHC at 2155. The Court notes the physical condition here is Denaka's failure to offer employees the vaccine within ten days of completing bloodborne pathogen and first aid training, which Denaka does not dispute. Instead, Denaka claims it was unaware of the requirement to offer the vaccine after training since OSHA had not raised

this requirement during the previous inspection and citation conferences. (Resp't Post-Hr'g Br. at 11-13.) Denaka also argues it did not have designated first aid responders to whom it was required to offer the vaccine absent an exposure, because it offers the training to all employees. (*Id.* at 13-14.) The Secretary argues Balka assigned M.L. to clean up the area around the Slitter mill following the accident, despite knowing Denaka had not offered him the vaccine. (Sec'y Post-Hr'g Br. at 17.) Further, the Secretary notes Balka and M.L. had both received first aid and bloodborne pathogen training in 2017, according to Steele, who, along with Hepner, also confirmed M.L. was a designated first aid responder. (*Id.*)

The evidence adduced at trial establishes actual knowledge. Denaka did not offer M.L. and other first aid responders the vaccine within ten days of completing their training and prior to the 2020 accident. Balka testified that after the 2020 accident Denaka "offer[ed] the vaccination immediately [to M.L., P.R., and me] because we just assigned these people to clean up blood." (Tr. 305). Similarly, Hepner, who arranged the vaccination appointments and waivers following the accident, testified it was her "understanding . . . that they were to be offered [the vaccine series] at the time of the incident." (Tr. 209; 245.) Because Balka is president of Denaka and Hepner is a management employee, their knowledge that Denaka had not offered the vaccine to M.L. following his training is imputable to the company. Therefore, Denaka, despite its misunderstanding of the standard's command, knew of the violative condition.

The Court finds the Secretary has established all elements of her burden of proof for Citation 2, Item 2.

Training Violation

The Secretary alleges:

Citation 2, Item 3

> 29 C.F.R. § 1910.1030(g)(2)(i): The employer did not ensure that each employee with occupational exposure participated in a training program.
> a) Facility: The employer did not provide training on the minimum required elements of 29 C.F.R. § 1910.1030(g)(2)(vii)(a) [sic] through (g)(2)(vii)(N) for employees who were assigned to conduct cleanup operations after an incident involving blood or other potentially infections [sic] materials, on or about 12/18/2020.

(Citation at 9.) The cited standard provides "[t]he employer shall train each employee with occupational exposure in accordance with the requirements of this section. Such training must be

provided at no cost to the employee and during working hours. The employer shall institute a training program and ensure employee participation in the program." 29 C.F.R. § 1910.1030(g)(2)(i). Among other things, the training must contain the text of the standard, an explanation of the employer's control plan and where the employee can obtain a written copy of it, an explanation of methods to recognize tasks that involve exposure, vaccine information, reporting requirements following the exposure incident, and procedures for responding to an exposure incident. *See* 29 C.F.R. §§ 1910.1030(g)(2)(vii)(a)-(g)(2)(vii)(N).

Whether the Standard Applies

The Secretary argues the standard applies to Denaka's designated first aid responders, as well as other employees with occupational exposure. (Sec'y Post-Hr'g Br. at 22 (citing Tr. 48, 252-53; Exh. C-4 at 2).) The Court agrees. M.L. and P.R. were among the employees who required training due to the fact they responded to the underlying accident, and M.L. also was a designated first aid responder. (*Id.* at 22 (citing Tr. 160, 164, 244).) Denaka does not dispute the applicability of the standard.

Whether Denaka Violated the Standard

Generally, "[t]o establish noncompliance with a training standard, the Secretary must show that the cited employer failed to provide the instructions that a reasonably prudent employer would have given in the same circumstances." *N & N Contractors, Inc.*, 18 BNA OSHC 2121, at *7 (No. 96-0606, 2000) (citing *Archer-Western Contractors*, 15 BNA OSHC 1013, 1019-20 (No. 87-1067, 1991)). The cited standard here enumerates the elements of a compliant training, therefore the Court declines to apply a reasonable employer standard. *Compare* employer-specific reporting requirements, contacts, methods, plans, and training intervals found in §§ 1910.1030(g)(2)(vii)(a)-(g)(2)(vii)(N) *with* general fall protection training requirements allowing employee discretion in §§ 1926.503(a)(2)(i)-(vii) *and* "broadly-worded training standard" found at § 1910.134(a) & (b). *Am. Sterilizer Co.*, 18 BNA OSHC 1082, at *3 (No. 91-2494, 1997). The Secretary asserts Denaka's training program was deficient because the company did not meet several requirements contained in the standard and therefore failed to train its employees. (Sec'y Post-Hr'g Br. at 22.) Among other things, the company lacked a written bloodborne pathogens control plan that was specific to the company and its worksite, according to the Secretary. (*Id.* at 23.) The Secretary argues further, assuming Denaka had a control plan, it failed to explain, among other things, how employees could obtain a copy, who managed the program, what constitutes an exposure, which

types of PPE to use and where to find them, and an explanation of procedures employees must follow after an incident. (*Id.*)

The Court finds testimony from Denaka employees and management establishes it provided some training in first aid, CPR, and bloodborne pathogens to its employees. (Tr. 230-31, 252-53, 307-08; Exhs. C-5, C-6, C-7, C-8.) As evidence of its program, Denaka points to American Heart Association bloodborne pathogen student workbooks Hepner provided to OSHA during the investigation. (Exhs. C-5, C-8.) CSHO Townsend also testified Hepner sent the National Safety Council's Bloodborne Pathogens workbook as evidence of abatement. (Tr. 62-64, 126; Exh. 6.) The Court finds, however, Denaka's training program was inadequate, and therefore the company violated the standard. The documents relied upon by Denaka and set forth in the record neither address the company's policies, practices, and procedures nor the conditions at its facility, all of which are required by the standard. *See O'Brien Concrete Pumping, Inc.*, 18 BNA OSHC 2059, at *4 (No. 98-0471, 2000) ("What matters is the content of this training, and whether it specifically addressed both the hazards associated with their work and the applicable OSHA standards.") (citing *El Paso Crane*, 16 BNA OSHC 1419, 1425 nn.6 & 7 (No. 90-1106, 1993). An examination of the National Safety Council and American Heart Association documents reveals, as CSHO Townsend testified, they were not "site specific" items Denaka was "training their employees on, such as their site specific exposure control plan, you know, what do they do if they get blood on them, who are they supposed to report it to." (Tr. 56); *cf. Atl. Battery Co.*, 16 BNA OSHC 2131, at *51 (No. 1994) (vacating hazard communication training violation where evidence in the record did not support OSHA inspector's conclusion employees had not been trained). CSHO Townsend also credibly testified to a number of other deficiencies in the generic plans, such as a lack of information regarding PPE and where to go to seek treatment in the event of exposure. (Tr. 56-57.)

Denaka asserts it complied with the standard because, although it cannot point to a specific document, it communicated the information required by the standard to its employees and conducted several training courses on bloodborne pathogens and first aid, including one before the accident. (Resp't Post-Hr'g Br. at 15 (citing Tr. 206; Exhs. C-4 at 3, C-5, C-8).) Denaka also asserts it trained employees on when to notify supervisors, how to report incidents, and where to find personal protective equipment, even if these items were not memorialized in a written plan. (*Id.* at 15 (citing Tr. 307-08).) The Commission has recognized that in certain circumstances company safety rules, policies, and instructions do not need to be written so long as they are clearly and

effectively communicated to employees. *See Capform, Inc.*, 19 BNA OSHC 1374, at *2 (No. 99-0322, 2001) ("[T]he Commission has stated, 'section 1926.21(b)(2) does not limit the employer in the method by which it may impart the necessary training.' " (quoting *Concrete Constr. Co.*, 15 BNA OSHC 1614, 1920 (No. 89-2019, 1992)). However, this argument is inconsistent with the standard at issue here, which requires the training program contain, at a minimum, "[a]n explanation of the *employer's exposure control plan* and the means by which the employee can obtain *a copy of the written plan*." 29 C.F.R. § 1910.1030(g)(2)(vii)(D) (emphasis added). *See Jesco, Inc.*, 24 BNA OSHC 1076, at *2 (No. 10-0265, 2013) ("If the wording is unambiguous, the plain language of the standard will govern, even if [a party] posits a different interpretation."); *Am. Fed'n of Gov't Emps., Local 2782 v. FLRA*, 803 F.2d 737, 740 (D.C. Cir. 1986) ("regulations are to be read as a whole, with each part or section . . . construed in connection with every other part or section") (internal quotation marks and citation omitted). The record establishes Denaka's training did not contain an explanation of its exposure control plan and the company did not have a written control plan, both of which were required by the standard. Hepner recognized this in an email to CSHO Townsend, which stated "we do not have a written program for [b]loodborne pathogens." (Exh. C-8 at 3.) And at trial, Balka testified he "underst[ood] we should have had this program written down." (Tr. 306-08.) As Denaka did not have a written plan, the Court finds Denaka employees did not receive the training required by the standard. The standard was violated.

Whether Employees Had Access to the Violative Condition

As CSHO Townsend testified, Denaka's designated first aid responders, such as M.L., could be exposed to bloodborne pathogens hazards, such as HIV, Hepatitis B and C, without a proper training program. (Tr. 57.) The Court finds the Secretary has established the access element. Denaka provided P.R., M.L., and others with a training program that did not meet the requirements of the cited standard, and M.L. and P.R. responded to an accident involving bloodborne pathogens. *See Offshore Shipbuilding*, 18 BNA OSHC 2169, at *2 (affirming training violation of confined space standard where untrained employee was in a ballast tank and therefore "exposed to the conditions the standard was intended to protect against"). Indeed, even if the accident and corresponding response had not occurred here, the Court finds Denaka's designated first aid responders were exposed to the hazardous condition due to Denaka's inadequate bloodborne pathogen program training. *See Bardav, Inc.*, 14 BNA OSHC 2105, at *10 (No. 10-1055, 2014) (citing *Gen. Motors Corp.*, 22 BNA OSHC 1019, 1030 (Nos. 91-2834E & 91-2950, 2007)

(unreasonable to require actual employee exposure to a hazard before requiring training to recognize and avoid that hazard)).

Whether Denaka Had Knowledge of the Violative Condition

Several factors establish Balka not only knew training on a compliant bloodborne pathogens exposure control plan was required for employees, but he also knew the training was inadequate. Balka was aware training was required because Denaka had been cited for a violation of the same standard following the 2016 accident, and this item was affirmed by the judge and did not reach the Commission on review. *Home Rubber*, 2021 WL 3929735, at *57 ("Mr. Balka knew a bloodborne pathogen policy and training were needed but did not ensure the policy and training were developed and implemented.") (ALJ). The fact Denaka actually trained its employees establishes it knew training was required by the standard. (Tr. 306.) But, as discussed above, Hepner and Balka, both management officials at Denaka during and after the 2016 investigation, knew the training was deficient in that the company failed to present a written bloodborne pathogens control plan setting forth facility and company-specific information. (Exh. C-8 at 3, Tr. 306-08.) Denaka had actual knowledge of the violative condition.[14]

The Court finds the Secretary has established all elements of her burden of proof for Citation 2, Item 3.

CHARACTERIZATION OF THE VIOLATION

The Secretary characterized the violations as willful-serious. A serious violation is established when there is "a substantial probability that death or serious physical harm could result [from a violative condition] . . . unless the employer did not, and could not with the exercise of reasonable diligence, know of the presence of the violation." 29 U.S.C. § 666(k). "This does not mean that the occurrence of an accident must be a substantially probable result of the violative condition but, rather, that a serious injury is the likely result if an accident does occur." *ConAgra Flour*, 16 BNA OSHC 1137, at *7.

Here, CSHO Townsend testified the machine guarding violation was serious "[b]ecause it resulted in an injury that was beyond first aid treatment." (Tr. 45.) As the accident demonstrates,

[14] Alternatively, and at a minimum, the record establishes Denaka's constructive knowledge of the violative condition. With the exercise of reasonable diligence, Denaka could have known training on a site-specific bloodborne pathogens exposure control plan was required and its training program was deficient. Hazards at the worksite, including knives and machinery, as well as its designation of first aid responders, put Denaka on notice that bloodborne pathogens exposure control plan training was required.

serious injury is the likely result if employee exposure to the unguarded rotating spool occurs. Townsend also testified the Hepatitis B vaccine violation was serious "[b]ecause Hepatitis B would result in treatment beyond first aid." (Tr. 50.) The Secretary asserts the bloodborne pathogens control plan training violation is also serious. As CSHO Townsend testified, "HIV, Hepatitis B and C would all result in treatment beyond first aid treatment." (Tr. 58.) This testimony is consistent with Commission precedent recognizing the serious nature of exposure and potential exposure to bloodborne pathogens based upon the effects of Hepatitis B. *See, e.g.*, *Home Rubber*, 2021 WL 3929735, at *12 n.17 ("Hepatitis B can result in 'serious liver' diseases, with about one third of infected individuals experiencing 'severe' symptoms including jaundice, extreme fatigue, anorexia, nausea, and abdominal pain, and some developing 'Fulminant hepatitis' which is '85% fatal even with the most advanced medical care.'" (quoting 56 Fed. Reg. 64,004, 64,009 (Dec. 6, 1991)); *Waldon Health Care Ctr.*, 16 BNA OSHC 1052, at *11 (No. 89–2804, 1993) ("a person who contracts the HBV virus is likely to suffer death or serious physical harm'). The Court therefore finds the cited violations can result in serious injuries or death.

The Secretary characterized each of the cited "serious" violations as willful. To prove a willful citation, the Secretary must show that an employer's violations of the Act were "committed with intentional, knowing or voluntary disregard for the requirements of the Act, or with plain indifference to employee safety."[15] *Tampa Shipyards Inc.*, 15 BNA OSHC 1533, 1539 (No. 86-360, 1992) (consolidated). "To prove intentional disregard, the Secretary must show that the employer (1) had a heightened awareness of the applicable standard or provision prohibiting the conduct or condition and (2) consciously disregarded the standard." *Jim Boyd Constr., Inc.*, 26 BNA OSHC 1109, 1111 (No. 11-2559, 2016) (internal quotations omitted). The employer's state of mind is the key inquiry. *See Propellex Corp*., 18 BNA OSHC 1677, 1684 (No. 96-0265, 1996) ("The Secretary must show that the employer was actually aware, at the time of the violative act,

[15] The Court notes Denaka is a New Jersey company and the worksite in this case is located in New Jersey, which is within the jurisdiction of the U.S. Court of Appeals for the Third Circuit. Since it is probable that any Commission decision will be appealed to the Third Circuit, the Court briefly discusses the law of that circuit to the extent it differs from Commission precedent. *See Kerns Bros. Tree Serv.*, 18 BNA OSHC 2064, 2067 (No. 96-1719, 2000) (Under 29 U.S.C. §§ 660(a) and (b), the "employer or Secretary may appeal Commission order to federal court of appeals for circuit in which violation allegedly occurred, or where employer has its principal office; employer also may appeal to District of Columbia Circuit[.]"). Although the Third Circuit frames its willfulness test as "an 'obstinate refusal to comply' with safety and health requirements[,] that [test] 'differs little from' the Commission and majority-circuit test." *George Campbell Painting Corp.*, 17 BNA OSHC 1979, 1982 (No. 93-984, 1997) (quoting *Universal Auto Radiator Mfg. Co. v. Marshall*, 631 F.2d 20, 23 (3d Cir.1980)). Because there is no practical difference between the Third Circuit's test and the Commission's test, the Court discusses Commission precedent in its analysis.

that the act was unlawful, or that it possessed a state of mind such that if it were informed of the standard, it would not care.").

Machine Guarding Violation

The Secretary argues the machine guarding violation was willful because Denaka had heightened awareness of the cited requirement yet waited until after the 2020 accident to abate the hazard. (Sec'y Post-Hr'g Br. at 11.) Specifically, the Secretary claims Denaka did not install any guarding on the Slitter mill until 22 years after the audit, five years after the 2016 accident on a different mill that resulted in an employee's four fingers being amputated, and one month after the accident at issue that resulted in the amputation of S.H.'s left arm. (*Id.* at 11-12.) Even then, Denaka's choice of guarding, a foot pedal, was inadequate. (*Id.* at 12.) The Secretary asserts Denaka only installed a light curtain when this case reached trial. (*Id.*) The Secretary contends the Court should reject Denaka's argument that the violation is not willful due to OSHA not specifically citing the company for failing to guard the Slitter mill because OSHA's failure to previously cite the company does not amount to approval of the condition. (*Id.* at 13.)

Denaka argues the machines cited in 2016 for guarding violations were substantially different from the Slitter mill, and, in any event, Lord viewed the Slitter mill and even issued a citation for a piece of electrical equipment on it. (Resp't Post-Hr'g Br. at 18.) Denaka asserts "[b]ecause [i]t did not have 'heightened awareness' of the standard, [it] could not have 'consciously disregarded that standard.' " (*Id.* at 18 (quoting *Home Rubber*, 2021 WL 3929735, at *2 (internal quotations omitted)).)

The Court agrees with the Secretary that Denaka had a heightened awareness of OSHA's machine guarding requirements as a result of the 1999 audit report, as well as previous machine guarding citations issued in 2010, 2012, and 2016. *See MVM Contracting Corp.*, 23 BNA OSHC 1164, 1167 (No. 07-1350, 2010) (employer's heightened awareness of OSHA standard's requirements established where supervisor was previously informed of requirements). Denaka also knew the Slitter mill was unguarded because Balka testified the company had not changed or modified the mill since he had purchased the company, he had observed employees operating the mill, and it was in plain view on the facility floor. Further, Balka's heightened awareness for the purposes of finding the violation willful is imputable to Denaka. *See Branham Sign Co.*, 18 BNA OSHC 2132, at *2 (No. 98-752, 2000) ("The state of mind of a supervisory employee, his or her knowledge and conduct, may be imputed to the employer for purposes of finding that the violation

was willful.").

Despite Balka's heightened awareness of the machine guarding requirement, the Court finds the Secretary failed to establish Balka had heightened awareness of the illegality of the cited conditions. Although Balka was aware of the machine guarding standard and knew the Slitter mill was unguarded, the Secretary has failed to show Balka was aware the unguarded mill did not comply with the standard. *See Stark Excavating, Inc.*, 24 BNA OSHC 2215, at *7-8 (Nos. 09-0004 & 09-0005, 2014) ("Based on our review of the record, we find the Secretary has not shown that the superintendent was, in fact, aware that the excavation was noncompliant."), *aff'd*, 811 F.3d 922 (7th Cir. 2016). OSHA did not allege the Slitter mill lacked guarding in any of the previous guarding citations, and the 1999 audit report recommended guarding generally, rather than guarding specifically for that mill. Moreover, as discussed above, AAD Lord observed the Slitter mill at rest in 2016, and OSHA cited Denaka for a torn strain relief on an electrical cable that attaches to control panel for the mill, rather than machine guarding. *Home Rubber*, 2021 WL 3929735, at *54 (ALJ). While the Court agrees with the Secretary that OSHA's previous failure to cite Denaka for failing to guard the Slitter mill does not amount to approval of the violative condition, the Secretary has failed to show Denaka had the requisite state of mind regarding the Slitter mill's lack of guarding to support a willful violation of the standard. *See Hern Iron Works, Inc.*, 16 BNA OSHC 1206, at *8 (No. 89-433, 1993) ("A willful violation is differentiated by heightened awareness of the illegality of the conduct or conditions and by a state of mind of conscious disregard or plain indifference when the employer committed the violation."). The Court therefore characterizes the machine guarding violation set forth in Citation 2, Item 1 as Serious.

Hepatitis B Vaccine Violation

The Secretary again argues Denaka's failure to offer the Hepatitis B vaccine to employees within ten days of initial assignment as designated first aid responders was willful since the company had heightened awareness of the requirements of the standard. (Sec'y Post-Hr'g Br. at 18.) Specifically, the Secretary argues Balka admitted he knew the requirements of the standard, which was confirmed by AAD Lord's testimony she told him about the standard during the 2017 closing conference and gave him OSHA's fact sheet containing the requirements of the standard. (Sec'y Post-Hr'g Br. at 18, 20 (citing Exh. C-3 at 18).) The Secretary argues the 2016 citation also made clear the company was required to offer the vaccine after initial assignment, rather than after exposure. (*Id.* at 20 (citing Exh. C-3 at 15).) In addition to the documentation provided by OSHA,

the Secretary further asserts documents Denaka handed over to the agency during the 2016 and 2020 investigations support a finding the company was aware of the standard's requirements. Denaka provided OSHA the National Safety Council's workbook, which contains, among other things, the vaccination standard, as well as the American Heart Association's workbook, which provides employers should make the vaccine available. (*Id.* at 19-21 (citing Exhs. C-6, C-7, C-8).) Balka's conduct, according to the Secretary was willful because he had access to all this information and decided not to offer the vaccine sooner. (*Id.* at 19.)

Denaka argues it did not intentionally, knowingly, or voluntarily disregard OSHA standards in offering the vaccine to employees who cleaned up the area around the Slitter mill immediately following the 2020 accident. (Resp't Post-Hr'g Br. at 23.) Denaka again recites OSHA did not instruct it "to offer the vaccine ***at the time of training***" and the record demonstrates it took steps to ensure the safety of its employees based upon OSHA's representations following the 2016 accident. (*Id.*) Due to its good faith efforts to comply with the standard's provision, Denaka asserts any failure on its part to timely offer the vaccine does not amount to a willful violation of that provision. (*Id.* at 23-24.)

As set forth above, Denaka's interpretation of the standard is flawed, and the fact OSHA neither previously cited the company for failing to offer the vaccine after the trainings occurred, nor instructed it to do so, does not relieve the company of its duty to comply. Denaka also was aware of the standard. It was included in the 2016 citation and related judge's decision, as well as in the NSC workbook. *See Home Rubber*, 2021 WL 3929735, at *56 (ALJ); Exhs. C-6 at 59, R-27 at 42. Denaka also was aware it did not offer the vaccine to employees after they had completed their bloodborne pathogens training or within ten days of becoming designated first aid responders, as evidenced by the fact it offered the vaccine after the December 2020 accident.

However, the Court finds the Secretary failed to establish Denaka acted with the requisite state of mind to support a willful violation. Denaka offered the vaccine series to the employees who responded to the 2020 accident on the Monday following the Friday accident. (Tr. 208.) P.R. and Balka signed waivers, and M.L. received his first dose on December 23, 2020. (Tr. 208, 283; Exh. C-3 at 2; Exh. R-30.) By offering the vaccine, albeit after the exposure event, Denaka did not act with plain indifference to employee safety. Further, the timing of Denaka's vaccine offer to its employees is consistent with its flawed understanding of the standard, which the company believed required it to do so within ten days of the exposure event. Therefore, the Court finds Denaka's

violation of the standard was negligent rather than willful. *See Gen. Motors Corp.*, 22 BNA OSHC at 1043 ("[T]he Commission and courts distinguish 'between mere negligence and willfulness, holding that the former is sufficient for affirming a non-willful violation, but that willfulness is characterized by an intentional, knowing failure to comply with a legal duty.'" (quoting *Manganas Painting Co.*, 21 BNA OSHC 1964, 1991 (No. 94-0588, 2007)). The Court therefore characterizes the hepatitis B vaccination violation set forth in Citation 2, Item 2 as Serious.

Bloodborne Pathogens Control Plan Training

The Secretary also argues Denaka's failure to train its employees regarding the hazards associated with exposure to bloodborne pathogens was willful. The Commission has found an employer's failure to train its employees is willful where it had general knowledge of the standard and failed to provide a compliant training program. *See Gen. Motors Corp.*, 22 BNA OSHC 1019, at *33; *E. Smalis Painting, Co.*, 22 BNA OSHC 1553, at *26 (No. 94-1979, 2009) (affirming training violation as willful where employer was on notice of requirements due to discussion at previous proceeding and failed to train in accordance with the standard). The Secretary asserts Denaka managers had a heightened awareness of the standard's training requirements from their involvement in the 2016 accident investigation. (Sec'y Post-Hr'g Br. at 24.) At trial, Balka admitted Denaka did not have a written bloodborne pathogens exposure control plan at the time of the accident, such that it could have trained its employees on the plan. (*Id.*) This, according to the Secretary, was despite Denaka's representations to OSHA it had abated the 2016 violation. (*Id.*) Therefore, the Secretary contends, Denaka showed plain indifference to employee health. (*Id.*)

Denaka argues it has, in response to the 2016 investigation and citation, made a "conscious effort to comply with" the standard and this is supported by evidence it offered and employees received bloodborne pathogen and first aid trainings prior to the 2020 accident. (Resp't Post-Hr'g Br. at 24.) Denaka asserts even if its training "neglected to include certain required elements . . . mere lapses cannot support a finding of willfulness under the law." (*Id.* at 25.)

The record supports a finding Denaka took some steps following the 2016 accident to train its employees regarding bloodborne pathogens and first aid. In 2017, third-party Capital Health conducted a bloodborne pathogen training and first aid training. (Tr. 160, 252-53; Exh C-3 at 9-11.) In 2021 or 2022, the company also provided Hepatitis B training as part of a larger training on CPR and first aid. (Tr. 232.) Balka testified Denaka "offer[s] every employee the opportunity to be trained on bloodborne pathogens," and Denaka "had a round of training for bloodborne

pathogens and first aid" since the 2016 accident. (Tr. 302.) Balka also testified Denaka's bloodborne pathogens exposure control plan and training is "all in the [American Heart Association] book . . . . All of our employees know how and when and where to report accidents and things of that nature. . . . Everybody knows where to get them. Everybody knows where to get their PPE." (Tr. 307-08.) Balka added, "Frankly, I understand we should have had this program written down. I don't see how it would be anything that our employees don't currently fully understand." (Tr. 308.)

The American Heart Association workbook, provided by Hepner as Denaka's exposure control plan, meets some requirements of the standard. The workbook explains epidemiology and symptoms of bloodborne diseases (§ 1910.1030(g)(2)(vii)(B)) and explains how bloodborne pathogens are transmitted (§ 1910.1030(g)(2)(vii)(C)). (Exh. C-8 at 9-10.) The workbook also contains information on selecting PPE (§ 1910.1030(g)(2)(vii)(H)) and recognizing biohazard symbols (§ 1910.1030(g)(2)(vii)(M)). (Exh. C-8 at 12-13, 16-17.) Based upon Balka's testimony, Denaka may have given employees some site-specific instruction on PPE and steps to take and persons to contact in an emergency involving blood (§ 1910.1030(g)(2)(vii)(J)).

However, these are only five of fourteen enumerated minimum requirements in the standard. The workbook provides there are two parts to this training course; the first being the material in the workbook, and "[t]he second part is training you must receive on your employer's site-specific exposure control plan."[16] (Exh. C-8 at 6.) The workbook also recognizes "[t]his course is designed to meet Occupational Safety and Health Administration (OSHA) requirements when used with site-specific training." (*Id.*) In the absence of a site-specific exposure control plan, Denaka's program and training did not include "[a]n accessible copy of the regulatory text of this standard and an explanation of its contents" (§ 1910.1030(g)(2)(vii)(A)); "[a]n explanation of the employer's exposure control plan and the means by which the employee can obtain a copy of the

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[16] The workbook also provides:

> The exposure control plan is a set of rules and procedures specific to your workplace. The plan is designed to protect you and your coworkers from being exposed to bloodborne pathogens and to care for workers who have been exposed to bloodborne pathogens. Your employer will provide this training.
>
> ****
>
> This workbook refers to the exposure control plan several times. When you see the icon to the left, that means you can find more information in your company's exposure control plan.

(Exh. 8 at 6.)

written plan" (§ 1910.1030(g)(2)(vii)(D)); "[a]n explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials" (§ 1910.1030(g)(2)(vii)(E)); "[a]n explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, work practices, and personal protective equipment" (§ 1910.1030(g)(2)(vii)(F)); "[i]nformation on the types, proper use, location, removal, handling, decontamination and disposal of personal protective equipment" (§ 1910.1030(g)(2)(vii)(G)); "[i]nformation on the hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge" (§ 1910.1030(g)(2)(vii)(I)); "[a]n explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available" (§ 1910.1030(g)(2)(vii)(K)); and "[i]nformation on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident" (§ 1910.1030(g)(2)(vii)(L)).[17]

The standard also directed Denaka to "train each employee with occupational exposure" and to "institute a training program, and ensure employee participation." 29 C.F.R. § 1910.1030(g)(2)(i). But Denaka merely "offers" bloodborne pathogens training to all its employees, according to Balka, rather than requiring employees who respond to incidents to attend training. Further, Denaka was required to provide the training "at least annually" after the initial training. 29 C. F.R. §1910.1030(g)(20(ii)(B). There is no evidence in the record Denaka trained employees on an annual basis between the 2017 training and the December 2020 accident.

Arguments advanced by both the Secretary and Denaka, as well as Denaka's efforts to comply, establish the company had a heightened awareness of the standard's command to "ensure that each employee with occupational exposure participated in a training program." 29 C.F.R. § 1910.1030(g)(2)(i). In 2016, the Secretary alleged Denaka "did not develop a written bloodborne pathogen Exposure Control Plan" and did not "ensure . . . a training program was provided to employees." (Exh. R-27 at 40-41; s*ee* Exh. C-4 at 9-10.) Balka learned during the 2016 accident proceeding that Denaka's written policy "was merely a pamphlet from the National Safety

[17] The final requirement is "[a]n opportunity for interactive questions and answers with the person conducting the training session." 29 C.F.R. § 1910.1030(g)(2)(vii)(N). It is unclear from the record whether Denaka's employees had the opportunity to ask questions in the third-party training. Because Denaka did not provide training on a site-specific exposure control plan, the Court finds employees did not have the opportunity to ask questions.

Council," and the company admitted in its brief "it did not have a written Exposure Control Plan for bloodborne pathogens." *Home Rubber*, 2021 WL 3929735, at *55 (ALJ) (citing Resp't Br. at 35). Accordingly, the judge found Denaka violated the standard's requirements to have a written plan and provide training.[18] *Home Rubber*, 2021 WL 3929735, at *55 (ALJ); *see E. Smalis,* 22 BNA OSHC 1553, at *26 (heightened awareness of standard established where judge had emphasized importance of training requirement in earlier proceeding and settlement order).

Despite Denaka's acknowledgement it lacked a written exposure control plan, the judge's ruling affirming the related citation items, and Denaka's failure to challenge it on review, the company still did not create and train its employees on a site-specific written exposure control plan in the fifteen months leading up to the 2020 accident. Therefore, it could not train each employee with occupational exposure in accordance with § 1910.1030(g)(2)(i) and the requirements of §§ 1910.1030(g)(2)(vii)(a)-(g)(2)(vii)(N). Balka, who testified he participated in the 2017 generic workbook training, would have seen the workbook's references to an "employer's site-specific exposure control plan," yet he disregarded both theses references and the standard's command to create and train on such a plan. (Tr. 306; Exh. C-8 at 6-8, 13, 16, 18, 20, 23, 24, 25, 29, 31, 33.) This establishes Balka knew Denaka's bloodborne pathogens training program was deficient as he was actually taking the workbook training. Balka confirmed as much during the current proceeding by testifying he knew Denaka did not have a written bloodborne pathogen exposure control plan, which is required by the standard and the bedrock of the training. (Tr. 306-08.)

While the Court recognizes physical conditions for the 2016 citations regarding machine guarding and vaccination were different from the 2020 accident citation, such that Denaka did not act with an intentional, knowing, or voluntary disregard for the Act, the record simply does not allow the same finding regarding this item. Denaka, through Balka, knew of both the physical conditions creating the violation—Denaka's lack of a written exposure control plan—and the standard's requirements—to conduct training based upon a written, site-specific exposure control plan. Despite Balka's knowledge, Denaka did not create its own written plan and train its employees accordingly. These deliberate, knowing actions are far from what Denaka calls "mere lapses."

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[18] The judge issued her opinion in September 2019, and Denaka did not seek review of the citation items alleging serious violations of § 1910.1030(c)(1)(i) (written exposure control plan) and § 1910.1030(g)(2)(i) (training). (Resp't Pet. for Rev. at 11.)

Because Denaka offered some training on bloodborne pathogens (albeit with the knowledge it did not meet the standard's requirements) the Court rejects the Secretary's argument Denaka has acted with plain indifference towards employee safety. However, based upon Denaka's knowledge of the standard and knowledge that it was not providing a compliant training program, the Court finds Denaka acted with intentional, knowing or voluntary disregard for the requirements of the Act. *See A. G. Mazzocchi, Inc.*, 22 BNA OSHC 1377, at *13 (No. 98-1696, 2008) (affirming willful characterization despite partial compliance, because employer's "incomplete efforts" to distribute relevant reports did not negate its decision to knowingly withhold required information). Here, Denaka "has been previously cited for [a] violation[] of the standard[] in question, is aware of the requirements of the standard[], and is on notice that violative conditions exist." *J.A. Jones Constr. Co.*, 15 BNA OSHC 2201, at *9 (No. 87-2059, 1993). Therefore, the Secretary has "shown [Denaka] was actually aware, at the time of the violative act, that the act was unlawful." *Propellex Corp.*, 18 BNA OSHC at 1684. Accordingly, the Court finds the Bloodborne Pathogens Control Plan Training violation set forth in Citation 2, Item 3 is properly characterized as willful.

PENALTY DETERMINATION

The Commission considers "the appropriateness of the penalty with respect to the size of the business of the employer being charged, the gravity of the violation, the good faith of the employer, and the history of previous violations." 29 U.S.C. § 666(j). Gravity, according to the Commission, "is a principal factor in the penalty determination and is based on the number of employees exposed, duration of exposure, likelihood of injury, and precautions taken against injury." *Siemens Energy & Automation, Inc*., No. 00-1052, 2005 WL 696568, at *3 (OSHRC Feb. 25, 2005) (citation omitted); *see also Natkin & Co. Mech. Contractors*, No. 401, 1973 WL 4007, at *9, n.3 (OSHRC April 27, 1973) ("Gravity, unlike good faith, compliance history and size, is relevant only to the violation being considered in a case and therefore is usually of greater significance. The other factors are concerned with the employer generally and are considered as modifying factors.").

AAD Lord testified the severity of the violation of § 1910.212(a)(1) (machine guarding) was high because the violation led to an amputation. (Tr. 168.) She also testified the probability of injury was greater because, "in this case, the injury did, in fact occur." (Tr. 168.) Therefore, the gravity was high. (Tr. 168.) As to the penalty, AAD Lord testified there was an automatic reduction

of 30% for employer size.[19] (Tr. 169.) OSHA did not make a good faith reduction because it characterized the proposed violation as willful and did not make a history reduction because it had inspected the company in the past five years and issued citations. (Tr. 169.) It proposed an adjusted penalty of $95,572 penalty for this item. The Court agrees with OSHA's analysis that the gravity was high based upon severity and probability. Because the Court finds this violation is serious rather than willful, it assesses the maximum serious penalty of $13,653 and reduces it by 30% based upon the size of the employer. *See* 86 Fed. Reg. 2964, 2969-70 (Jan 14, 2021) (maximum for a serious penalty assessed after Jan. 15, 2021, but on or before Jan. 15, 2022). Therefore, the Court assesses a penalty of $9,557.10 for Citation 2, Item 1.

Regarding the violation of § 1910.1030(f)(2)(1) (vaccination), AAD Lord testified the severity was high due because the type of injury that could occur, such as Hepatitis, "can have long-term detrimental effects." (Tr. 170.) However, she said the probability was lesser because employees were not exposed, and they were wearing personal protective equipment during the 2020 accident clean up. (Tr. 170.) Therefore, the gravity was moderate. (Tr. 170.) OSHA proposed a $117,024 penalty and adjusted it to $70,214. (Tr. 170.) Curiously, OSHA and AAD Lord noted a 30% reduction for Denaka's size. (Exh. C-3 at 1-2; Tr. 170.) However, OSHA appears to have reduced the penalty by roughly 40%. The Court agrees with OSHA's analysis that the gravity was moderate because the severity was high and the probability was lesser. However, because the Court recharacterizes the violation as serious, it assesses an adjusted penalty of $8,192 for Citation 2, Item 2, which reflects a similar percentage reduction to the one proposed by the Secretary.

AAD Lord also said the gravity of the violation of § 1910.1030(g)(2)(i) (bloodborne pathogen exposure control plan training) was moderate. She again testified the severity was high because the type of injury that could occur, such as Hepatitis B, "can have long-term detrimental effects." (Tr. 171.) She also testified the probability was lesser because employees, although they had occupational exposure as defined by the standard, were not actually exposed and were wearing personal protective equipment during the 2020 accident clean up. (Tr. 171.) The Court notes the citation carried a penalty of $81,919 for this item, which reflects a roughly 30% reduction from $117,024. (Citation at 9-10.) However, the violation worksheet for this item noted, and AAD Lord testified, that OSHA proposed an adjusted $70,214 penalty based upon the size of Denaka. (Tr.

[19] Denaka had approximately 35 employees at the time of the 2020 accident, according to Balka. (Tr. 260.)

171; Exh. C-4 at 1-2.) The Secretary did not seek to amend the penalty amount for this item between the filing of the Amended Complaint and trial.

Because this amount is less than what the Secretary originally sought, and the Court finds AAD Lord's testimony regarding its appropriateness credible, the Court will enter the penalty proposed at trial. The Court also finds this penalty amount appropriate based upon Denaka's disregard for the standard. Although this citation item is for a training violation, Denaka's failure to train its employees on a compliant bloodborne pathogens exposure control plan is especially egregious considering its knowledge of the standard, directions in the workbook it relied upon to create a site-specific plan, citation history, and warnings from the Commission. The Court affirms Citation 2, Item 3, as willful and assesses a penalty of $70,214.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

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

ORDER

Based upon the foregoing decision, it is ORDERED that:

1. Citation 2, Item 1, alleging a violation of 29 C.F.R. § 1910.212(a)(1), is **AFFIRMED**, recharacterized as serious, and a penalty in the amount of $9,557.10 is assessed.
2. Citation 2, Item 2, alleging a violation of 29 C.F.R. § 1910.1030(f)(2)(1), is **AFFIRMED**, recharacterized as serious, and a penalty in the amount of $8,192 is assessed.
3. Citation 2, Item 3, alleging a willful violation of 29 C.F.R. § 1910.1030(g)(2)(i), is **AFFIRMED** and a penalty of $70,214 is assessed.

SO ORDERED.

/s/_____
Sharon D. Calhoun
Administrative Law Judge, OSHRC

Dated: May 17, 2023
Atlanta, GA