SECRETARY OF LABOR,	:	
Complainant,	:	OSHRC Docket No. 96-0001
v.	:	
ICF KAISER ENGINEERS OF MASSACHUSETTS, INC.,	:	
Respondent.	:	

Appearances:

James Glickman, Esq.
Office of the Solicitor
U.S. Department of Labor
For Complainant

David S. Branch, Esq
Burns & Levinson
Boston, MA
For Respondent

Before: Administrative Law Judge Richard DeBenedetto

DECISION AND ORDER

ICF Kaiser Engineers of Massachusetts, INC. (AKaiser@), was cited on December 1,1995, for serious violations of three safety standards for underground construction:

29 C.F.R '1296.800 (b) (1), which states that:

> The employer shall provide and maintain safe means of access and egress to all work stations.

'1926.800 (d) (6), which provides, in part:

> *Safety instruction.* All employees shall be instructed in the recognition and avoidance of hazards associated with underground construction activities including where appropriate...mechanical equipment.

' 1926.800 (r) (4), referring to haulage equipment, states:

> In those cabs where glazing is used, the glass shall be safety glass, or its equivalent, and shall be maintained and cleaned so that vision is not obstructed.

All three standards have been applied in this case by the Secretary in connection with the underground transportation of workers by trains. OSHA's inspection, which resulted in the issuance of the citation, was actuated by an incident which occurred on June 23,1995, when a Kaiser employee, Richard White, sustained fatal injuries while attempting to enter a railcar.

Kaiser was engaged by the Massachusetts Water Resources Authority to provide construction management services for the Boston Harbor ProjectCDeer Island Related Facilities in July 1990. Among the construction services to be performed by Kaiser under the contract were Aday-to-day management of all construction activities relating to...resident engineer and inspection... project-wide safety program@ and Aday-to-day management@ of all quality assurance/quality control activities (Exh. C-16, p.2).

Although it subcontracted the construction management services responsibilities to Stone & Webster, INC. (AStone & Webster@), Kaiser still employed a few of its own personnel at the construction project, including a safety supervisor for the Boston Harbor project and two shift inspectors (or shift engineers), Richard White and Frank Verock. They, together with a number of others employed by Stone and Webster and another subcontractor, comprised a team of shift inspectors whose primary responsibility was monitoring the construction contract specifications. They were also expected to keep a sharp eye out for any safety or health problems they might encounter during the course of their rounds and, where possible, have the problems immediately corrected by the responsible party. All shift inspectors reported to Stone and Webster's field engineer who in turn reported to the resident engineer, Stone and Webster's chief supervisor at the tunnel project (Tr. 485, 497-500).

The general contractor, Kewit, Atkinson & Kenny, a Joint Venture (AKAK@), was responsible for digging the tunnel and installing and operating the underground rail system, the subject of the three citation items (Tr.15). Under its construction contract, KAK was Aresponsible for initiating, maintaining and supervising all safety precautions and programs related to safety@ at the tunnel project (Exh. R-7, 00700-33,&6.19).

At the time of the OSHA inspection in June 1995, the tunnel, which had been excavated from a vertical shaft located on Deer Island, extended eastward under Massachusetts Bay for a distance of about nine miles. KAK's underground rail system was used to transport material and all personnel

to and from work areas. The rail system consisted of locomotives which pulled the cars for carrying materials and the Amantrip@ cars which transported the personnel. Each mantrip has four seating compartments with space for six persons in each compartment. The compartments have doorless entrances on both sides. There are safety bars installed at the open sides of the mantrips, which are moved down from their vertical position by the occupants as a barrier during rail movement (Tr. 30, 110, 200, 202, 241; Exh. R-8)

The locomotives are operated by KAK's personnel with an operator and a brakeman assigned to each locomotive. Operating practices required the operator to sound the horn as a warning before the locomotive moved forward or backward. According to the Secretary's own witness, Richard Finn, a brakeman who worked on the night of the fatal accident, a standard signal system was established for directing the operator to move in either direction or to stop the movement of the locomotive. All brakemen are equipped with a flashlight and a whistle for use in signaling the operator. Finn's testimony was corroborated by several other witnesses called by the Secretary, including William Reid, KAK's third-shift foreman of the tunnel workers or Aminers@; Daniel Travers and Mark Giordani, employed by KAK as miners at the tunnel project, both testified that they were instructed by their employer not to get on or off a moving car (Tr. 68-72,89,91,98,122,127-28,132, 179-80, 261-62).

The Secretary claims, in substance, that given the physically restricted environment associated with the underground construction work which was being performed in the instant case, Kaiser should have recognized and arranged to have implemented a system for directly controlling the workers specifically for boarding and exiting the mantrip cars. Secretary's brief at 24-25. It is undisputed that there was no such system in place at the tunnel project.

The Secretary's attention was focused on the issue as a result of the of the fatal accident that occurred on June 23, 1995, when the third (or graveyard) shift was about to replace the second shift at the Aheading@, the outermost point of the tunnel where the tunnel boring machine is operated. Before reaching the heading, each shift begins the journey by entering the shaft located on Deer Island; an elevator-type hoist lowers the personnel into the tunnel. They then board the mantrip cars to be transported to their work areas. The train travels at a speed of no more than 12 miles per hour (Tr. 38).

The tunnel is equipped with a single track extending from the shaft to the Atrailing gear@, a two-level skeletal steel structure that extends some 400 feet from the heading. Just before entering the trailing gear, the locomotive must pass a switching point where the single track diverges into two parallel tracks. The trailing gear has two levels: the upper deck contains both a muck-removal conveyor system and, apparently, a ventilation system. The lower level frames the two tracks (Tr. 35-38, Exh. C-10).

At the time of the June 23,1995, incident, the personnel of the incoming and the outgoing shifts converged at the trailing gear, the outgoing shift standing by to board the mantrip cars as the incoming shift got out. During this change of shifts, the incoming train drawn by locomotive number one occupied one track while locomotive number two was parked on the second track ready to move behind and be coupled with the last incoming mantrip car on the first track, thus forming the train that would take the outgoing shift to the shaft station where they would be hoisted out of the tunnel. This was the daily routine when shifts changed at the heading.

The Secretary called six witnesses, all of whom were employed by the general contractor KAK at the time, who gave eyewitness accounts of the events that led to the death of Richard White, Kaiser's shift inspector/engineer. All of the Secretary's witnesses except Howard Neal, the brakeman for the incoming locomotive one, gave essentially consistent testimony as to what occurred. Daniel Travers, one of the miners on the second shift, was standing by the train waiting for a ride to the hoisting shaft. The train had come to a full stop, and after everyone on the incoming third shift left the mantrip car, he was just about to enter when he noticed Richard White was also in the process of entering the same car through the opposite opening of the compartment; suddenly and unexpectedly, the train moved forward without any warning, pinning White between the car and a steel beam of the trailing gear (Tr. 52-58, 103-04). Another miner, Mark Giordani, and a boring machine mechanic, David Moeller, also testified to the fact that the incoming train had moved forward unexpectedly and without warning after having come to a full and what they thought was the final stop at the trailing gear (Tr. 111-12, 143).

Richard Finn, the brakeman of locomotive two at the time of the accident, testified that after the incoming train carrying the third shift had entered the trailing gear on the right-side track, he directed locomotive two on the left track into position for coupling with the last mantrip car of the

incoming train. He testified that he was standing adjacent to the back of the last mantrip car with his hand resting against the car while he motioned locomotive two slowly forward, but just before the couplings were to be joined, the mantrip drawn by locomotive one moved forward about two feet. The movement, which was totally unexpected and without any warning, almost caused him to lose his balance (Tr. 251-56). It was this movement of the train that caused Richard White's fatal injuries.

Finn had worked as a brakeman for about 2 **2** years at the tunnel project. He testified that it was the first time he had experienced the sudden and unexpected movement of a train after it had come to a full stop at the trailing gear during a change of shifts. He stated that the procedures in handling the locomotives and cars during the shift change were routine; the locomotive's horn is sounded in the same manner as the brakemen's whistle, one warning sound for stop, two for moving forward and three for backing up. The brakeman is the last person to board the train, at which point the brakeman sounds the whistle, then the locomotive operator sounds the horn an equal amount of times before the train moves. On cross-examination, he testified that when workers were changing shifts at the heading, the process of leaving and entering the mantrip cars was done in a fairly orderly manner (Tr. 262-64, 270).

William Reid, KAK's third-shift foreman, testified that he was riding in the last mantrip car on the incoming train as it came to a full stop at the trailing gear. He remained in the car while locomotive two was being moved from the other track to couple up with the rear of the car in which he was sitting. Before the coupling was accomplished, his train moved forward Acompletely unexpected,@ which was immediately followed by the loud cry of Richard White (Tr. 168-69).

Reid also testified that there had been occasions in the past, perhaps once a month, when there was a need to move the incoming train forward after coming to a full stop on track one at the trailing gear in order to allow the outgoing locomotive some additional space to move from the second track to the first where the last car stands to be coupled with the outgoing locomotive**C** just as it happened at the time of the fatal accident; but on those prior occasions a horn was sounded before the train was moved. Until the June 23 accident, he did not consider their procedures to be hazardous (Tr. 182-83).

The Secretary argues, in substance, that the way the boarding and exiting of the mantrip cars was conducted during the shift changes at the trailing gear was extremely hazardous, which Kaiser should have recognized in view of the Acongested and chaotic circumstances@ that existed. The

Secretary claims that the Aaccident was not the result of any employee's failure to follow some procedure since no worker was waiting for any procedure. In the moments before the accident, horns on *both* [locomotives] were not blown before either moved, in any event.@ Secretary's brief at 17, 23.

The broadly worded safe access/egress standard does not expressly assign the employer responsibility for implementing a system for directly controlling the workers when entering and exiting the mantrip cars. During the rulemaking stages of drafting the proposed revisions to the tunneling regulations, the Secretary published a statement on August 5, 1983, expressing OSHA's intention of using, when possible, performance-oriented language in lieu of specification language for the purpose of allowing employers flexibility in complying with the standards:

> Summary and Explanation of the Proposal
>
> It is clear from the above discussion that during the past ten years the accident and injury toll in underground construction has continued to mount. To attempt to reduce this toll, this proposal focuses on the principle hazards of underground work and eliminates provisions of the current standards which OSHA believes to be either redundant or unnecessary for employee safety. It has also been written in straightforward, performance-based language, when possible, in order to provide flexibility and to encourage voluntary compliance by employers and employees...
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> * * *
>
> Paragraph (b) -- Access and egress. In paragraph (b) (1), the existing tunnel standard's provision (1926.800 (a) (2)) concerning safe access to the worksite has been clarified to include the word Aegress@ as well as Aaccess@....Safe means of access and egress from the site might include wooden steps leading down to a below-ground-level portal entry, a personnel hoist in a completed shaft, or a ladder meeting the requirements of Subpart L in a shaft under construction. An example of an unsafe means of access would be a tunnel bore without a walkway free of slipping and tripping hazards.
>
> As proposed, the requirement would apply both to means of access to the underground worksite itself and to work stations within the tunnel or shaft. Employees must be able to move to and from their work stations without being subject to hazards which may injure them. Safe means of access and egress to a work station in the underground construction site could include a walkway suspended from the ribs of the tunnel and running along the inside of the bore from the portal to the heading, planks laid on the floor of the tunnel between the entrance and the face, or steps leading to a workstation on the deck of the drill jumbo. Passageways used by employees to walk to and

from their work stations would be required to be maintained free of hazardous obstructions, stored materials, potholes, and protruding material. The rail system for cars transporting employees or material would also have to be properly maintained to prevent employees from being run over, hit, dumped or crushed by uncouplings, derailments, track separations, and other rail system accidents. Such precautions are essential to employee safety underground because both the space limitations and the working conditions (poor light, excessive wetness, slippery equipment surfaces) typical of tunnel and shaft construction make the hazards of slipping, tripping and falling -- that are common to all means of access and egress -- even more hazardous. The ANSI, Michigan and California standards all contain provisions addressed to these access and egress hazards (Section 4.3, Rule 408.41462, and Section 8490, respectively).

Whereas OSHA is proposing this general safe means of access provision written in performance language, other regulatory bodies or consensus groups are more specific. In addition to the general safe means of access provision in 4.3, ANSI 4.10 and 4.11 specifically require stairways or ladders where possible. Michigan specifies, in Rule 408.41462, a walkway when rail track is used. OSHA solicits comments on the adequacy of its proposed performance language. Should OSHA include some of the more specific provisions? If so, which ones and why?

Provisions to protect employees from being hit by moving haulage equipment would be required by new paragraph (b) (2).[1] There have been several deaths and a number of injuries during the past ten years due to employees being struck by haulage equipment or railcars striking objects. (Ex. 12:11, 21, 32, and 33.) One method of compliance with the proposal could be the use of refuge stations at reasonable intervals along the tunnel (roughly every 200 feet (60.96 m)). Where the narrowness of the bore precludes the use of a plankway suspended from the ribs of the tunnel, or when the nature of the earth being excavated (e.g., solid rock) would make refuge stations prohibitively costly, the employer may implement a work practice to protect employees walking or working in the vicinity of haulage cars. For example, trains could be stopped while employees pass alongside, or the train could remain still until employees have exited the passage. The employer could also require employees to be transported between the entrance and the face (walking would be prohibited). 48 Fed. Reg. LEXIS at *10, 13-14.

[1] Paragraph (b) (2) of '1926.800 reads:

The employer shall provide access and egress in such a manner that employees are protected from being struck by excavators, haulage machines, trains and other mobile equipment.

The ANSI standard mentioned by the Secretary refers to American National Standards Institute, Safety requirements for Construction of Tunnels, Shafts, and Caissons, ANSI A10.16-1981. 48 Fed. Reg. LEXIS at *4. The ANSI standard is a Anational consensus standard@ as that term is defined by section 3 (9) of the OSH Act, 29 U.S.C. '652 (9), which reads in part as follows:

> The term Anational consensus standard@ means any occupational and health standard or modification thereof which (1) has been adopted and promulgated by a nationally recognized standards-producing organization under procedures whereby it can be determined by the Secretary that persons interested and affected by the scope or provisions of the standard have reached substantial agreement on its adoption, (2) was formulated in a manner which afforded an opportunity for diverse views to be considered.

Section 4.3 of the ANSI standard, which addresses safe access to the worksite, reads as follows:

> Access. A safe means of access to all work areas shall be provided and maintained. Whenever practical, two means of access should be provided.

Both the OSHA standard and the ANSI standard address the safety of personnel in connection with the underground use of trains. The safety requirements are listed under the subtitle AHaulage@ by OSHA, '1926.800 (r), and AHaulage System@ by ANSI, section 9. OSHA's paragraph (r) (3) (i) reads as follows:

> Power mobile haulage equipment, including trains, shall have audible warning devices to warn employees to stay clear. The operator shall sound the warning device before moving the equipment and whenever necessary during travel.

Paragraph (r) (6) (ii) reads in part:

> No employee shall ride haulage equipment unless it is equipped with seating for each passenger and protects passengers from being struck, crushed, or caught between other equipment or surfaces. ...

These are the only specific duty rules contained under OSHA's haulage requirements that are relevant to the case at hand. In marked contrast to these OSHA requirements, the ANSI rules require not only audible warning devices and passenger seats, but the cars used for the transportation of workers must be provided with Aclosed sides.@ ANSI Section 9.5.1. Presumably passenger trains with closed sides

would provide a ready means of directly controlling the workers boarding and exiting the cars, a safety condition which the Secretary claims should have been present in one form or another in this case. Secretary's brief at 24-25.

To endorse the Secretary's application of the general safe access/egress regulation in this case would be an exercise in blind obeisance and would infuse a measure of incoherentness into the network of OSHA's interconnecting rules. The above-quoted comments made by the Secretary at the time the proposed rule was published as well as the language and the structural framework of the rule clearly demonstrate that the Secretary did not intend the general safe access/egress regulation to apply to getting on or off mantrip cars.

The series of OSHA regulations at '1926.800 (b) (1), (b) (2), and (b) (3) are conspicuously interrelated:

> (b) *Access and egress.* (1) The employer shall provide and maintain safe means of access and egress to all work stations.
>
> (2) The employer shall provide access and egress in such a manner that employees are protected from being struck by excavators, haulage machines, trains and other mobile equipment.
>
> (3) *The employer shall control access to all openings to prevent unauthorized entry underground.* Unused chutes, manways, or other openings shall be tightly covered, bulkheaded, or fenced off, and shall be posted with warning signs indicating AKeep Out@ or similar language. Completed or unused sections of the underground facility shall be barricaded. (Emphasis added.)

It is noteworthy that the OSHA (b) (3) regulation expressly states that the employer Ashall control access@ to all underground openings. It is also significant to note that the Secretary decided not to adopt the ANSI section 9.5.1 standard requiring personnel cars be equipped with closed sides, which would have provided a means of controlling access to and egress from the cars**C**the point of contention in this case. Instead, the Secretary opted for the haulage equipment requirement of '1926.800 (r) (6) (ii) which, while specific and not subject to doubt about seating, is vague and uncertain as to the equipment specification that would protect passengers from being struck or caught between equipment or surfaces:

> No employee shall ride haulage equipment unless it is equipped with seating for each passenger and protects passengers from being struck, crushed, or caught between other equipment or surfaces. ...

When viewing the '1926.800 construction standard as a whole and considering all of its relevant parts, the one sensible and consistent meaning of the (b) (1) general safe access/egress rule is that it applies to protecting workers as they enter and leave the tunnel and as they walk and/or work in the tunnel in proximity to mobile equipment, including trains; the (b) (1) rule has no application to the activity of entering and leaving railcars.

Even if we were to hold that the Secretary's application of the general access/egress regulation is valid, the citation could not be sustained. Inherent in a general standard is the test of whether or not a reasonable person would have recognized the hazard and the need for protective measures. *Cape & Vineyard Division v. OSHRC*, 512 F. 2d 1148, 1152 (1st Cir.1975). If an employer is shown to have actual knowledge that a practice is hazardous, the test is satisfied. *Id*. at 1152.

The Secretary's case leans heavily on three major factors. First is the November 8, 1994, shift report recorded by the fatally injured Richard White. Mr. White noted that he had encountered a Asafety problem@ at the heading when the mantrip car was stopped at the trailing gear to discharge the relieving crew. As he started to step off the car, Athe mantrip moved very quickly@ and he barely escaped injury. He noted that it was Amandatory that prior to the brakeman moving the mantrip that he checks and insures that all have dismounted or he tells the passengers to remain seated.@ He also noted that he took the matter up with the brakeman, the Ashifter in charge@ (crew foreman), and the Aswing shift walking boss@ (supervisor) (Exh. C-12).

The second major factor is the testimony of Howard Neal, who was employed by general contractor KAK as the brakeman of locomotive number one at the time of the June 23 fatal accident. Neal testified that as the train entered the trailing gear with the incoming third shift, his locomotive was approaching close to a material railcar parked just ahead on the same track. He got out of the locomotive cab in order to Akick@ the coupling device on the end of the railcar to prevent it from connecting up with the locomotive; he then directed the locomotive operator by hand signals to Aproceed in.@ He paid no attention to the mantrip cars during this activity, and no warning signals were sounded. Neal claimed that the locomotive never stopped at any time upon entering the trailing gear until the screams of Mr. White were heard: A[the locomotive] was moving all the time as we

came into the trailing gear. And I just motioned him in, to keep coming@ (Tr. 206-08). When asked on direct examination to describe the routine when shifts changed at the heading, he stated (Tr. 209):

> A Well, it was sort of like a madhouse, you know. I guess they're all ready to get out of there, and they just pile on at one time. Before the men get off the mantrip, sometimes, they're on there. That's the way they was [sic] changing.

The third major factor concerns Daniel Travers' testimony that at some unspecified time before the June 23 accident he had experienced an incident when he was getting out of a mantrip car; the train moved unexpectedly while he had just cleared his body through the steel beams of the trailing gear (Tr. 74-75). Travers also described the activities at the heading during the change in shifts as Achaotic@ (Tr. 56).

None of these three pieces of the evidence gives sustenance to the Secretary's case. That White took special notice of the Asafety problem@ of the unexpected movement of the personnel train without prior warning during the shift change, directly contradicts the Secretary's allegation that Kaiser's A[e]mployees were not instructed in the recognition and avoidance of hazards associated with underground construction activities including mechanical equipment,@ as set out in item 2 of the citation. The Secretary apparently overlooks or ignores the significance of White's recorded efforts to correct the problem by speaking with the responsible KAK supervisors and recommending that the brakeman exercise specific cautionary measures before directing movement of the train when taking on and leaving off passengers at the trailing gear. It is the tragic irony of this case that White was killed by the very set of circumstances he sought to correct. The record does not inform us as to what steps, if any, were taken by KAK to implement White's recommendations. Nor has the Secretary presented any evidence to demonstrate that White or Kaiser failed to carry out their safety responsibilities under the OSH Act when the hazard in issue became known.

Howard Neal's testimony, the second major element in the Secretary's case, provides us with three significant scenarios. First, the train on which he was assigned as the brakeman, and which White was in the process of entering when he was fatally injured, never came to a full stop, consequently no warning signal was required at the time. This scenario, of course, portrays White acting in a careless manner by attempting to enter a moving car in an extremely congested area.

Second, the actions of the personnel entering and leaving the cars during the shift changes at the trailing gear were Asort of like a madhouse@ (Tr.209). Third, the set of conditions that existed on June 23 at the heading, i.e., the brakeman directing the incoming locomotive to move forward a short distance more to give the outgoing locomotive maneuvering space**C**as transpired when White was fatally injured**C**occurred frequently (Tr. 211-12).

Howard Neal's testimony covering the three major points is unbelievable in all respects. As previously noted, the Secretary presented five witnesses who were present at the trailing gear when White was killed while attempting to enter a mantrip car. All five witnesses (Travers, Giordani, Moeller, Reid and Finn) testified that the train moved unexpectedly and without warning after having come to a full stop. Neal's testimony was also inconsistent with his own statement recorded by a police officer shortly following the accident (Exh. R-1).

Inasmuch as all the major tunnel operations are concentrated at the heading, it is not surprising that congestion is a chronic problem, particularly when maneuvering the trains for the incoming and outgoing shifts. Neal described the situation as a sort of madhouse because some of the outgoing workers were prone to enter the cars before all of the incoming shift cleared out. Neal's statement that Athey just pile on at one time@ was obviously an indulgence in hyperbole. Richard Finn, the other brakeman who testified for the Secretary, described it as Aa fairly orderly process@ (Tr. 270). The testimony of Daniel Travers, one of KAK's miners, does not really add anything to the Secretary's case. When Travers called the situation at the heading Achaotic,@ he was referring to an occasion when personnel exited the open sides of the incoming cars adjacent to railcars filled with concrete segments parked on the parallel tracks at the trailing gear. Instead of getting out on the sides leading to an open passageway to reach their work area, they apparently took the shortcut by clambering over the parked concrete segment cars (Tr.56). This situation merely goes to show what is undisputed: that the work space was narrowly restricted.

With respect to the time frame prior to the June 23 accident, Neal's testimony regarding the frequency of the conditions under which the locomotives were moved at the heading and which resulted in White's death was vague and somewhat inconsistent. At one point, he stated Ait would happen about maybe once, twice a week.@ Then he said it happened Aabout once a week, a month, sometimes@ (Tr.212). Because we are not informed otherwise, apparently we are to assume that in

every such instance, the incoming locomotive was moved at the direction of the brakeman to its final stop without a break in its continuity at the trailing gear and without the need to sound any warning signals, just as it happened on June 23, according to Neal's version of the course of events on that day.

As the record makes clear, the problem with Neal's version in that it conflicts sharply with the overwhelming credible eyewitness accounts presented by no less than five of the Secretary's own witnesses. The crucial and decisive point was starkly made by KAK's foreman, William Reid, who testified that there had been occasions before June 23 when conditions at the heading required the incoming train on one track to move forward a bit more after having come to a full stop; however, on each of those occasions audible signals were sounded before the train was moved as required by KAK's safety rules (Tr. 173).

In her brief, at 23, the Secretary mentions Daniel Travers' testimony that at some unspecified time before the June 23 accident, he had narrowly avoided injury on one occasion when the train moved unexpectedly and without warning just as he was getting out of the mantrip car at the heading (Tr. 74-75). The Secretary failed to present any evidence to indicate that Kaiser had any knowledge of this event.

It is astonishing that the Secretary would rely on Howard Neal's testimony to support her case against Kaiser. Almost at the very start of the direct examination, Neal was asked if he had looked Aat the mantrip cars at all@ on June 23 when he signaled the locomotive operator to advance the incoming train as it approached the railcar parked ahead and just before Richard White was killed. Neal's response was clear. He did not observe the mantrip cars (Tr.206). I should think it an intrinsic element as well as an elementary rule of a brakeman's job that when directing the movement of a train, particularly in a congested area where personnel are preparing to enter and leave the trains, the brakeman must pay attention to his immediate environment and the people occupying that environment. It seems a safety rule as essential and commonsensible as being watchful for oncoming traffic when crossing a street.

It is equally astonishing that the Secretary went to the trouble of calling an expert witness to enlighten us in how to correct the problem. The fact that Richard White provided a feasible solution to the safety problem in his November 8, 1994, shift report has not entered the Secretary's

calculations except as evidence that Kaiser had knowledge of the safety problem. But the record does not establish that Richard White (or Kaiser) had any reason to believe that the problem was not resolved and would recur despite the corrective actions taken by White through the responsible KAK management personnel. White's actions were entirely consistent with the performance-oriented posture announced by OSHA during the promulgation of the underground construction standards.

One final point merits observation. The compliance officer testified that before the June 23 accident, he had inspected the tunnel A[q]uite a few times,@ including at least six times when he rode in the mantrip cars and one occasion when he traveled in the cab of the locomotive. On those occasions he observed that the brakemen and the locomotive operators sounded whistles and horns, respectively, as a warning before the trains moved. During those inspections, the compliance officer did not observe anything about the operation of the rail system which caused him to believe that any condition existed which posed a hazard and needed correcting (Tr. 542-48).

The second item on the citation, which alleges that Kaiser's employees were not instructed in a safe procedure to enter and exit mantrip cars, is directly related to the first item involving the general safe access/egress issue. The Secretary's failure to prove her case in the first item renders the second nonviable.

The third item of the citation deals with the haulage-equipment regulation which requires that where glass is used on cabs, Athe glass...shall be maintained and cleaned so that vision is not obstructed.@ The compliance officer testified that the front of the locomotive cab was equipped with a Plexiglas shield which was so scratched and discolored that it was virtually impossible to see through. The shield was about shoulder-level high to the operator and brakeman who both stood up while riding in the cab. The purpose of the Plexiglas shield, according to the compliance officer, was to prevent water from splashing on the occupants of the cab (Tr. 407-08, 410). The compliance officer claimed that the shield limited the operator's vision by about 15 percent. While this claim is not substantiated by the Secretary's photographic evidence, this item of the citation had no merit for other obvious reasons (Tr. 408, 411; Exh. C-15). The cited standard, by its terms, applies to glass, not to a protective shield made of plastic or acrylic which was not installed on the cab or used as a windshield to see through. This item was dismissed during the hearing (Tr. 422).

Based upon the foregoing findings and conclusions, it is

ORDERED that the three-item citation is vacated in its entirety.

RICHARD DEBENEDETTO
Judge, OSHRC

Dated: _____
Boston, Ma