United States of America
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
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SECRETARY OF LABOR Complainant, v. MURPHY ENTERPRISES, INC. DBA MURPHY Respondent.	OSHRC DOCKET NO. 93-2957

NOTICE OF DOCKETING OF ADMINISTRATIVE LAW JUDGE'S DECISION

The Administrative Law Judge's Report in the above referenced case was docketed with the Commission on August 8, 1995. The decision of the Judge will become a final order of the Commission on September 7, 1995 unless a Commission member directs review of the decision on or before that date. ANY PARTY DESIRING REVIEW OF THE JUDGE'S DECISION BY THE COMMISSION MUST FILE A PETITION FOR DISCRETIONARY REVIEW. Any such petition should be received by the Executive Secretary on or before August 28, 1995 in order to permit sufficient time for its review. See Commission Rule 91, 29 C.F.R. 2200.91.

All further pleadings or communications regarding this case shall be addressed to:

Executive Secretary
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Petitioning parties shall also mail a copy to:

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If a Direction for Review is issued by the Commission, then the Counsel for Regional Trial Litigation will represent the Department of Labor. Any party having questions about review rights may contact the Commission's Executive Secretary or call (202) 606-5400.

FOR THE COMMISSION

Ray H. Darling, Jr.

Date: August 8, 1995

Ray H. Darling, Jr.
Executive Secretary

DOCKET NO. 93-2957

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SECRETARY OF LABOR,

Complainant,

v.

MURPHY ENTERPRISES, INC., d/b/a MURPHY BROTHERS EXPOSITION,

Respondent.

DOCKET NO. 93-2957

APPEARANCES:

Margaret Terry Cranford, Esquire
Dallas, Texas
For the Complainant.

Anthony G. Parham, Esquire
W. Alan Kostel, Esquire
Dallas, Texas
For the Respondent.

Before: Administrative Law Judge Stanley M. Schwartz

DECISION AND ORDER

This is a proceeding brought before the Occupational Safety and Health Review Commission ("the Commission") pursuant to section 10 of the Occupational Safety and Health Act of 1970, 29 U.S.C. § 651 *et seq* ("the Act").

The Occupational Safety and Health Administration ("OSHA") inspected a worksite located at Henderson and Ross Avenues in Dallas, Texas, after an accident on April 13, 1993. Respondent was setting up its carnival at the site, a large parking lot, and the accident occurred when a wire rope being used to erect a ride failed, causing the death of two employees and the serious injury of another; the ride, a large Ferris wheel, is called the "Giant Wheel." As a result of the inspection, OSHA issued one serious, one willful and one

"other" citation to Respondent. Respondent contested all three of the citations, and a hearing was held August 4-9, 1994. At the hearing, the Secretary withdrew items 1a, 2-7 and 11-14 of serious citation 1 and all six items of "other" citation 3, leaving for resolution items 1b and 8-10 of serious citation 1 and items 1 and 2 of willful citation 2.

Preliminary Matters

At the beginning of the hearing Respondent filed a motion to dismiss, contending that it was engaged in construction work at the site and that because it was cited pursuant to the general duty clause and the general industry standards the citations must be vacated. The undersigned reserved on the motion, and Respondent presented evidence in support of its contention during the hearing. Respondent also presented evidence in support of its further contention that it was not the employer of the workers at the site. Both parties addressed these matters in their post-hearing briefs.

Whether Respondent was the Employer of the Workers at the Site

Respondent's contention that it was not the employer at the subject site is based on its having signed an agreement with Staff Benefits, Inc. ("SBI"), an employee leasing company based in Dallas, on February 5, 1993. Pursuant to the terms of the agreement, which ended in October of 1993, SBI agreed to:

> [M]aintain the employment of those persons recommended by Client, provided that SBI receives the necessary personnel information for each applicant in order to properly complete the requisite personnel and payroll documentation. SBI acknowledges that as employer, SBI shall have the sole responsibility for the management and supervision of said employees, including the hiring, training and termination.

See R-1, p. 1, section 2. The parties also specifically agreed SBI was "the employer of any employees provided Client under this Agreement." *See* R-1, p. 5, section 7, paragraph I.

Commission precedent is well settled that the appropriate test in determining the actual employer of particular workers is the "economic realities test." *See Loomis Cabinet Co.,* 15 BNA OSHC 1635, 1637-38, 1991-93 CCH OSHD ¶ 29,689 pp. 40,255-56 (No. 88-2012, 1992); *Vergona Crane Co.,* 15 BNA OSHC 1782, 1784, 1991-93 CCH OSHD ¶ 29,775 pp. 40,496-97 (No. 88-1745, 1992). The test sets out a number of factors to

consider, but the central inquiry is whether the alleged employer controlled the workplace and the manner and means by which employees carried out their work. *Id.* Accordingly, notwithstanding the language of the agreement set out above, the question in this case is which entity actually controlled the work environment and activities of the employees.

The record shows that Gerald Murphy, Respondent's president, has been in the carnival business all his life and that his present company has existed since 1965. The company first contracted with an employee leasing firm in early 1992, with a concern called Instaff; this arrangement ended in November 1992, after which the company entered into a similar one with SBI on February 5, 1993. Under both contracts, the leasing firm hired Respondent's employees and then leased them back to the company. The leasing firm took care of applications, payroll and withholding matters and employee benefits, and under both contracts an on-site supervisor had the authority to hire and fire employees; this person was Kurt Vomberg, Respondent's general manager from 1983 until August of 1993, who was originally hired by Murphy.[1] Pursuant to the contract with SBI, Joanne Page, another on-site individual, was in charge of the paperwork relating to employee matters and the disbursement of workers' earnings; SBI sent the paychecks to the worksites, the checks were cashed, and employees were paid in cash. In return for these services, Respondent paid the agreed-upon fee and reimbursed SBI for wages paid. Since its contract with SBI ended, Respondent has reverted to handling its own personnel matters. (Tr. 34-36; 56-58; 77; 237-41; 254-58; 264-65; 466-68; 868-72; 961-70; 981-86).

Gerald Murphy testified that two primary considerations in contracting with SBI were its safety program and its readily-available labor force, due to its agreements with other carnivals, which his company could use when needed. However, he conceded his company never used this labor force. (Tr. 998-1000). Moreover, the record indicates that SBI's safety program was consultative in nature and that while SBI held a management safety orientation and gave the company a copy of its safety manuals at one site in February and visited another site in early April it performed no safety surveys of Respondent's worksites before the accident. (Tr. 57; 65; 278-90). Finally, the record indicates that the employee safety

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[1]Vomberg left the company in August 1993. (Tr. 35; 57).

meetings which took place at the company's worksites were held by Vomberg. (Tr. 61-62; 70; 287-88).

In addition to the above, Rick Tarell, SBI's director of operations, testified SBI had no control over the employees at Respondent's sites and no control over the carnival's itinerary and operations, such as which rides were purchased, which rides were erected at sites and how rides were maintained. (Tr. 237; 247-51). Kurt Vomberg testified that Gerald Murphy was his boss the entire time he worked for the carnival, that he ran the show at Murphy's direction and took orders only from Murphy, and that as the owner Murphy had the power to fire him while he himself had the power to hire and fire the other employees; SBI handled the payroll, but Vomberg did not consider SBI his employer. Vomberg said he spoke with Murphy at least twice a week and often daily about the show's operation, that Murphy and the booking agent decided the carnival's itinerary, and that Murphy visited show sites, especially the large ones; when he did he would critique the show and point out changes he wanted made. Vomberg also said he could order equipment costing under $1,000.00 but that Murphy had to authorize purchases over that amount. (Tr. 34-40; 56-61; 65-70; 76-78).

In view of the foregoing, it is clear that Respondent, not SBI, controlled the work environment and activities of the employees. While two witnesses testified that SBI was their employer in April 1993, that Murphy did not control their activities, and that Vomberg reported to SBI, this evidence does not require a contrary ruling. (Tr. 296-300; 464-67). That SBI was the employer "on paper" does not mean it was the employer in fact. Moreover, a finding that SBI was the employer in fact is simply not supported by the record. Based on the record, Respondent was the employer at the subject site.

Whether Respondent was Engaged in Construction at the Site

Respondent contends that it was engaged in construction because the conditions cited by OSHA occurred while it was setting up its carnival and these activities and the hazards they present are the same as those in construction work. The Secretary contends the company's setup activities are not construction work and that Respondent's primary activity is the operation of its carnival.

Although both parties cite to several different cases in support of their respective positions, only *Brock v. Cardinal Indus.*, 828 F.2d 373 (6th Cir. 1987), cited by the Secretary, has precedential value and squarely addresses the applicability of the construction standards to worksites. The facts in *Cardinal* are very different from those presented here; however, it nonetheless provides guidance for the resolution of this case. Based on *Cardinal*, the threshold inquiry is whether there was a direct and tangible connection or relationship between the work activity and the worksite. *Id.* at 378-80. Once that nexus is established, factors such as the nature of the work and the employer's primary function become relevant. *Id.* at 380 n.11.

The record shows Respondent plays at sites from about ten to seventeen days, that it transports its equipment by truck and trailer, and that most sites are paved and need no special preparation. The carnival's portable offices arrive first, after which phone and water lines are connected and generators and rest rooms are set up; the rides are then brought onto the site, and it usually takes two to four days to have the shows ready to operate. About seventeen rides were put up at the subject site, with thirty-five to forty regular employees providing the skilled labor and fifteen to twenty day workers performing the unskilled labor. A crew consisting of John Tillery, the foreman of the Giant Wheel, several regular employees and a few day workers put up the subject ride; the Giant Wheel takes about fifteen hours to set up and fully assembled is 90 feet high, 88 feet wide and weighs 195,000 pounds. (Tr. 38; 73-75; 117-27; 166-67; 301-02; 328; 334-35; 356; 403-04; 473; 851-55; 872-76; 890-99; 995-98; C-22; R-3).

The setup of the Giant Wheel involves lining up the three flatbed trailers on which it is transported, leveling and connecting the trailers and putting a foundation under them, and hooking up the equipment to a generator. The right- and left-hand towers forming the triangle and center axle of the ride are raised up and bolted together, the ride's front platform is lowered onto its foundation, and the lighting system and Giant Wheel sign are installed.[2] The "sweeps," the metal pieces that make up the spokes of the wheel, are

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[2]The right and left side of the ride are determined by facing the front of the ride. (Tr. 371-72; C-3). *See also* C-23, p. 3.

chained against the right-hand towers, and a winch and cable system is used to release the sweeps and position them in the center of the triangle. This system, consisting of a right- and left-hand winch on either side of the ride and a wire rope attached to each, is used to position the sweeps so that the long and short "spreader bars" that separate the sweeps and form the spokes can be installed; two long and two short bars go between each two sweeps. This is done by pulling the sweep on the far right side away from the rest of the stack with the right-hand winch and cable. An employee 10 feet above the platform hands the short spreader bars up to two others 10 feet above him, who put them in place, and workers on the platform install the long spreader bars. The right-hand cable is then attached to the next sweep to be pulled, and the process is repeated on the left side with the left-hand winch and cable. This is done a total of twenty times, alternating from one side to the other to keep the ride in balance. Before the last spreader bars are installed, the spokes at the hub are secured by tightening up the drawing bolts on each side and locking them into place. The last spreader bars are then installed, the rim rails which drive the ride are put on, and the electric wires which power the ride are connected. The passenger gondolas are installed, the decking is completed and steps are put down, and fencing is put up. The gondolas are then cleaned, fuses and light bulbs are replaced, and minor repairs such as painting are performed, after which the ride is ready. (Tr. 353-403; C-3).

Based on the foregoing, some of the company's setup activities are similar to work occurring on construction sites. However, the setup of the Giant Wheel itself appears to be more like assembly than construction. Moreover, as noted above, the nature of the work is relevant only after the nexus between the work and the site has been established. In my view, that Respondent's equipment is portable and moves from site to site every two to three weeks with no lasting connection to those sites precludes a finding that its setup activities have the requisite nexus to its worksites so as to be considered construction work. Further, other evidence in the record convinces the undersigned that Respondent was properly cited pursuant to the general duty clause and general industry standards.

I note first that while Murphy, Tillery, and Richard Dueberry, the company's superintendent of rides, testified as to the construction aspects of setting up, all three also stated they were in the carnival business; Vomberg, moreover, described the company as an

outdoor amusement business. (Tr. 35; 293-94; 353-404; 461; 852-55; 863; 890-99; 981; 995-1000). I note also Murphy's testimony that the company's revenues were primarily derived from patron fares for rides and that when he incorporated his business he described it as "amusement." (Tr. 853; 1001). Finally, I note that C-24, the 1992 American Society for Testing and Materials ("ASTM") Standards for Amusement Rides and Devices, defines "carnival" on page 3 as follows:

> [A] mobile enterprise principally devoted to offering amusement or entertainment to the public in, upon, or by means of portable amusement rides or devices or temporary structures in any number or combination, whether or not associated with other structures or forms of public attraction.

In addition to the above, compliance officer ("CO") Gloria Conway, the OSHA CO who inspected the site, testified that she used the Office of Management and Budget's 1987 Standard Industrial Classification ("SIC") Manual to determine the company's industry and SIC code. According to Conway, the proper code for the company is 7999; that code, a general industry classification, is entitled "Amusement and Recreation Services Not Elsewhere Classified" and includes carnival operation. (Tr. 96-99; 153-54; 231-33; 1002-13). Her testimony was not rebutted by Respondent, and, pursuant to *Cardinal*, an employer's SIC code is evidence of that company's appropriate classification. *Cardinal* at 379 n.9.

Based on the record, Respondent was properly cited pursuant to the general duty clause and general industry standards. Although the company's setting up of its shows is a significant part of its overall operation, this activity, for the reasons above, does not constitute construction work. However, even assuming *arguendo* the opposite, it is apparent that the company's primary function is the operation of its carnival and Respondent cites to no precedent in support of its evident belief that an employer may move in and out of the construction and general industry standards at will based on the type of work being performed at any one particular point in time. The motion to dismiss is denied.[3]

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[3]My resolution of this matter makes it unnecessary to address Respondent's related argument that there were construction standards which were specifically applicable to the worksite.

Willful Citation 2 - Item 1

This item alleges Respondent did not conduct inspections of or have a preventive maintenance program for the hoists, or winches, and wire ropes used in setting up the Giant Wheel in willful violation of section 5(a)(1) of the Act, the general duty clause. To establish a 5(a)(1) violation, the Secretary must show that (1) a condition or activity in the employer's workplace presented a hazard to employees, (2) the employer or its industry recognized the hazard, (3) the hazard was causing or likely to cause death or serious physical harm, and (4) feasible means existed to eliminate or materially reduce the hazard. *See, e.g., Waldon Healthcare Center*, 16 BNA OSHC 1048, 1058, 1993 CCH OSHD ¶ 30,021, p. 41,151 (No. 89-2804, 1993), and cases cited therein.

The accident in this case occurred when the wire rope on the left-hand winch failed during the pulling of the last sweep on the Giant Wheel. Four employees were on the platform and three others were up on the wheel. Leon Burrell was standing on a T-bar 10 feet off the platform in order to hand the short spreader bars up to John Wagner and William Olson, who were installing them; Wagner and Olson were tied off to sweeps and standing 10 feet above Burrell on the bar they had just installed on the wheel's outside rim, and they were preparing to put the matching bar on the wheel's interior rim. John Tillery, the ride foreman, was operating the right-hand winch and directing the employees, and Billy Van Brunt, in training to be a foreman, was operating the left-hand winch. Van Brunt used the winch to pull the sweep and create the opening for Wagner and Olson to position the spreader bar. Tillery then gave Van Brunt the go-ahead to reverse the winch and close the gap; when he did the rope broke, causing the sweeps to collapse together and Burrell, Wagner and Olson to be caught in between. Burrell and Wagner were killed and Olson's leg had to be partially amputated. (Tr. 21; 117-28; 423-27; 431; 486-502).

CO Conway testified she determined pursuant to interviews with Vomberg, Dueberry and Tillery that no inspections of or preventive maintenance for the wire ropes and winches had occurred and that the two ropes being utilized had been in use since April of 1989. She also testified that based on her observing the rope that failed it should have been replaced; it had numerous broken wires, rust, kinking and flattened areas. Conway said there were

manuals at the site for the winch and Giant Wheel advising of the need to conduct winch and rope inspections and to replace defective ropes. She also said the company was told during a 1989 OSHA inspection of the need to inspect ropes and replace them upon observing defects. (Tr. 107-12; 128-40; 147-52; 190-207; 226-29; 233-35; C-18-19).

Donovan Grenz is the OSHA CO who conducted the July 1989 inspection in Minot, North Dakota. He testified the wire rope on the right-hand winch used to erect the Giant Wheel had six broken wires in one lay, that he discussed it with Richard Dueberry and told him why it was a hazard and needed to be replaced, and that he showed Dueberry how to inspect the rope. Grenz also testified that the condition was cited as a serious violation and that he believed the company intended to replace the rope. (Tr. 79-91; C-21).

The Citation

As a preliminary matter, I note that while the citation refers to both the hoists and the wire ropes it is clear from the record, and CO Conway herself testified, that the wire ropes were the focus of this case. (Tr. 200). There was a minimum of evidence in regard to the hoists, and this evidence is easily separable from that relating to the wire ropes; accordingly, the citation with respect to the hoists will be addressed first. I also note that although the citation refers to ANSI B30.7-1989 ("B30.7"), the standard for base mounted drum hoists, as the criteria with which the company was to comply as to hoist and rope inspections and maintenance, C-18, the manual for the subject winches, refers to ANSI B30.5c-1987 ("B30.5"), the standard for mobile and locomotive cranes. These standards were received in evidence as C-20 and R-7, respectively, and, based on their titles, it is unclear why the manufacturer referenced the latter and not the former.[4] However, this fact makes no difference in my disposition of this citation, for the reasons given below.

The Hoists

The record shows that C-18 was kept in the company's on-site office with the other equipment manuals, which were referred to as needed, and that both Dueberry and Tillery

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[4]While R-7 actually includes various revisions of B30.5 from 1982 to 1992, the inspection and maintenance provisions have remained substantially the same.

had access to and had reviewed C-18. (Tr. 130-36; 303-07; 329-30; 439-40; 908-11). C-18 requires the inspection of the winches before each use, preventive maintenance, and the annual disassembly and inspection of all wear items in compliance with B30.5; this latter requirement is identified as one of three procedures critical to the safe operation of the winches. *See* C-18, pp. 3, 9-10.[5] Tillery testified at length about his checking the ride equipment, including the control valves on the winches and the hydraulic lines to them, but there was no evidence the winches had ever been disassembled and inspected since the ride's acquisition in 1988. (Tr. 328; 405-19; C-25). Tillery and Dueberry had apparently never seen B30.5. (Tr. 439-40). However, C-18 itself contains extensive instructions on disassembling and inspecting the winch components. *See* C-18, pp. 9-32. Due to their positions and the instructions in C-18, Tillery and Dueberry should have been aware of the need to disassemble and inspect the winches, especially in view of my findings *infra* that the inspection and maintenance of amusement equipment is governed by manufacturers' recommendations and applicable standards and that the industry practice is to comply with such criteria. There was no evidence of any problems with any of the winch components. Regardless, based on the various warnings in C-18 that failure to follow proper procedures could cause severe injury or death, the Secretary has met his burden of showing a 5(a)(1) violation with respect to the hoists. The characterization of the violation is addressed below.

The Wire Ropes

As noted above, the wire ropes are the primary focus of this case. The Secretary contends that the failure to inspect the ropes created the hazard of employees being struck by the sweeps and sustaining serious or fatal injuries and that such failure is a recognized hazard in the industry. The Secretary also contends that the company knew or should have known of the hazard due to the manuals at the site and the previous OSHA inspection. Respondent contends that the specific standard cited pursuant to the 1989 inspection applies in this case rather than section 5(a)(1). Respondent further contends that it inspected the

[5]The circles around the items in C-18 were made by CO Conway. (Tr. 133-34).

ropes and that the record shows neither that it knew the subject rope was hazardous nor that its industry recognized the rope's condition as a hazard.

In regard to Respondent's first contention, 29 C.F.R. § 1910.180(g)(1)(ii) was the standard cited pursuant to the 1989 inspection. *See* C-21, item 3B. CO Grenz testified it was his opinion at the time that that standard applied to the ropes used with the hoists. (Tr. 91-92). The language of 1910.180(g)(1)(ii), standing alone, would appear to apply to such ropes. However, it is clear from its title and definitions that 1910.180 applies only to crawler, locomotive and truck cranes. It is equally clear that the hoists and ropes in this case do not constitute such cranes. Respondent's contention is rejected.

As to the other contentions of the parties, the finding of a 5(a)(1) violation requires a conclusion that either Respondent or its industry recognized the need to inspect and replace as necessary load-bearing wire ropes and the failure to do so as a hazard. The record shows the subject ropes were used only during the erection and dismantling of the ride and that while both ropes were replaced after the accident they had not been previously replaced since April of 1989. The record further shows the ropes were never lubricated and that Tillery's inspections of them consisted of his viewing the one he was using to pull the sweeps as it went through his hands from the drum on which it was kept; only 20 to 40 feet of the ropes were used to pull the sweeps, and while Tillery used all 160 feet of the left-hand rope to put on the rim rails and looked at it then this took place after the sweeps were pulled and did not occur with the right-hand rope. Finally, the record shows that carnival sites are generally inspected by state inspectors, that the company also hired consultants to inspect its sites, and that Tillery made daily inspections of the Giant Wheel after it was erected; however, these inspections focused primarily on ride and patron safety and did not include the wire ropes used to set up the Giant Wheel. (Tr. 309-12; 318-22; 330-42; 345; 348-53; 373-96; 404-05; 410-19; 442-60; 472-82; 489; 502-03; 630-31; 642-44; 876-82; 885-88; 899-904; 908; 922-43; 947-54; 977-78; 987-92; R-3-5).

In addition to the above, the record shows C-18-19 and C-22-23 are documents relating to the subject winches and ride that were kept in the company's on-site office and referred to as needed, and that both Dueberry and Tillery had access to and had reviewed these documents. C-18, the winch manual, states that rigging and winches should be

inspected at the start of each work shift and defects corrected immediately, that the entire length of wire ropes should be inspected pursuant to the manufacturer's recommendations, and that ropes with broken strands should be replaced and never used; C-18 also requires, as noted *supra*, yearly disassembly and inspection of all wear items according to B30.5. *See* C-18, pp. 3, 9-10. C-19 and C-22, excerpts from the Giant Wheel manual, state that winches and cables should be inspected regularly and kept in good and safe working condition, and that owners should maintain equipment according to the manufacturer's recommendations and standard industry and applicable government standards. C-23, the Giant Wheel's field inspection and test guide, states that cables, winches and rigging should be inspected for broken, worn or missing parts and that cables should be replaced if any of the following conditions exist: severe corrosion, kinking, crushing or bird caging; one strand being 75 percent broken through; a number of wires equal to the number in a strand being broken in the length of one rope lay. *See* C-23, pp. 16-17, 39. (Tr. 130-36; 303-07; 329-30; 432-40; 908-11).

Richard Dueberry has worked in carnivals for twenty-six years and has been Respondent's superintendent of rides for seven years. He testified he knew broken wires indicated the start of a problem but that he did not know before the accident the number of breaks that would make a rope dangerous. Dueberry recalled the 1989 inspection and Grenz showing him some broken wires on one of the ropes but he did not believe the condition was serious and did not recall Grenz explaining how to count the wires; Vomberg was to order a new rope but did not and he himself did not follow up as he had never had to before.[6] Dueberry also recalled Tillery advising him there were some burrs, or broken wires, on the left-hand rope when the ride was being taken down in Mesquite, Texas on April 12 to move it to the subject site; Tillery told him the burrs were catching on his gloves and that he needed a new rope but expressed no urgency about it, and while Vomberg ordered one that day and it arrived April 13 during the ride's setup it was not put on until

[6]Dueberry noted that Grenz found a number of violations, that he and Vomberg divided up the items to be corrected, and that most of these were taken care of before Grenz left; he believed Vomberg simply forgot to order a new rope. (Tr. 882-85; 901-02; 905).

after the accident. Dueberry said he did not realize the rope was hazardous and that if he had it would not have been used. (Tr. 293-94; 307-22; 863; 880-85; 892-93; 900-15).

John Tillery has worked in carnivals for thirty years and has been the Giant Wheel foreman since its acquisition in 1988.[7] He testified that he received C-23 from the manufacturer at a seminar in January 1992, that he had tried to follow C-23 to the best of his ability, and that he looked for things like severe corrosion, crushing, kinking and bird caging when passing the rope through his hands. He saw nothing like this before the accident but did notice some burrs on the left-hand rope catching on his gloves when he was taking down the ride in Mesquite; he was concerned his hand might be pulled into the winch's drive shaft and told Dueberry, who decided to buy a new rope, and while the new rope arrived before the last few pulls of the sweeps at the subject site it was not put on. Tillery said he did not replace the rope as he did not know it was a hazard, that if he had he would have replaced it immediately, and that although he knew ropes could wear out and break he thought the life of the ropes was far longer as they were only used about eight hours a month. He also said he was not present at the 1989 inspection, that C-23 was the only thing he had actually addressing rope inspection, and that while he did not realize it then he had been confused about its terminology; he had thought a strand was a group of wires and a lay was more than one group without regard to length, and that paragraph 4 on page 17 meant a group of wires could be almost completely broken through. (Tr. 328-29; 336-49; 404-05; 420-21; 432-41; 461-62; 482-86; C-25).

James Drew has been in the carnival business all his life and has had his own carnival for ten years. He testified he has had no claims for losses in eight years and that his carnival has the best safety rating in the country. He further testified he has operated a giant Ferris wheel, different than Murphy's, for fifteen years, that a steel cable is used to erect it, and that his supervisors follow manufacturers' specifications as to inspecting, lubricating and replacing such cables. (Tr. 630-38; 646-52; R-6).

William Avery is a self-employed safety consultant whose experience includes nearly fifteen years of management positions with responsibility for patron and employee safety

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[7]Tillery began working for Murphy Brothers sometime between 1986 and 1988. (Tr. 328; 345).

with two major amusement park companies. Avery testified that the industry is governed by manufacturers' recommendations as well as ASTM, OSHA and ANSI standards, that C-25, the purchase agreement for the subject ride, required the buyer to maintain equipment according to those guidelines, and that in his opinion, Murphy Brothers did not follow industry practice in regard to wire ropes. He noted that rope inspection should be done before rather than during use to assure attention to its condition; in the companies he worked for ropes used daily were spooled out and inspected daily before use, outside consultants also inspected them, and ropes were lubricated pursuant to manufacturers' criteria. Avery did not know how many broken wires would require a rope's replacement but said that the manufacturer's criteria and any appropriate standards should be referenced in deciding whether to replace a rope. (Tr. 543-604).

Dr. Craig Jerner has been a consulting metallurgical engineer with his own business since 1972; he is a licensed professional engineer with a Ph.D. in metallurgy and was a tenured university professor for seven years before becoming a full-time consultant. Dr. Jerner testified that much of his work involves metallurgical failures, that he has had a number of cases involving wire rope failures, and that he examined the subject rope over a two-day period. In his opinion, the rope failed due to its highly damaged condition and its inability to sustain the load for which it was used. He also opined the rope was not properly inspected, that if it had been it would have been replaced and the accident would not have occurred, and that the rope was the worst he had seen as far as failure from metal fatigue. (Tr. 653-66; 717-29; 735-41).

Dr. Jerner explained how wire ropes are made and noted the subject rope had a total of 199 wires; it had six outside strands made up of twenty-five wires each surrounding a core of forty-nine more wires, as shown in C-53, a diagram of the rope's makeup. He further noted that pursuant to his examination, there were numerous broken wires within 2 to 3 feet of the separation point as well as other evidence of damage, such as rust, nicking, abrasion and excessive wear; C-27-52 and C-54-61, photos Dr. Jerner took during his examination,

depict these conditions.[8] Dr. Jerner said a number of the broken wires had hooked, indicating they had been broken for some time, and that all these conditions, including the damage to the core wires he observed, occurred over time and were caused by wear and lack of lubrication and inspections and not the failure itself. He also said the right-hand rope exhibited these same conditions around the 11-foot point, the same point the left-hand rope failed, indicating this was the area of heaviest use on the ropes; both should have been replaced, or, until this could be done, the first 15 feet could have been cut off and the remainders used as these were in relatively good condition.[9] (Tr. 666-718; 729-31; 735-37; 743-45; 766; 807-10; 821-32).

Dr. Jerner discussed broken wires, one of the more visible indicators of when a rope should be replaced; C-26, the Wire Rope Users Manual, and C-20 and R-7, the ANSI standards for base mounted drum hoists and mobile and locomotive cranes, indicate ropes should be replaced when there are six broken wires in one lay (3 1/4 inches) or three broken wires in one lay of one strand, while C-23, a manual for the Giant Wheel, states ropes are to be replaced when one strand is 75 percent broken through or when a number of wires equal to the number in a strand (twenty-five in this case) is broken in one lay.[10] Dr. Jerner said R-9, a 1990 bulletin from the ride's manufacturer, followed C-23, while R-10, an update issued April 28, 1993, followed the ANSI standards. He favored the more stringent requirements, but stated that these differing criteria did not affect his opinion; in the one area where he actually counted there were at least forty broken wires, or eighty broken ends, in one lay about 2 feet from the separation point, and while he counted these with the aid of a microscope the number of broken wires and the fact that they were catching on an employee's glove should have signaled the need to replace the rope. (Tr. 668-70; 688-89; 714-22; 746-815).

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[8]C-36 shows the rope on the right-hand hoist, which Dr. Jerner also examined. (Tr. 680; 683; 696-97; 727-28; 733-34).

[9]Dr. Jerner noted the left-hand rope looked almost new 50 to 100 feet past the separation point. (Tr. 822-23).

[10]Dr. Jerner said the wire rope inspection and replacement criteria in C-20 and R-7 are essentially identical. (Tr. 757; 799-800).

In light of the foregoing, the amusement industry recognized the need to inspect and replace as necessary load-bearing wire ropes and the failure to do so as a hazard. Moreover, Respondent's conduct as to its wire ropes did not comply with industry practice. C-18-19 and C-22-23 and the testimony of Avery and Drew establish that the inspection and maintenance of amusement equipment is governed by manufacturers' recommendations and applicable standards, that the proper inspection of a wire rope requires looking at its entire length for defects before use, and that certain defects require its replacement. It is clear that Tillery's viewing of the ropes did not comply with these criteria. It is also clear that Dueberry and Tillery should have known the rope inspections were inadequate and that the ropes needed to be replaced. My reasons follow.

A number of documents in evidence address wire rope inspection and replacement criteria. The ones Dueberry and Tillery had seen are those in C-18 and C-23; Dueberry had also seen R-9. (Tr. 909). Based on those exhibits, both should have been aware of the need to inspect the entire length of the ropes before use and to discard them if they had more than twenty-five broken wires in one lay. Dueberry should also have been aware of the requirement to replace wire ropes with six broken wires in one lay after the 1989 inspection. Dueberry and Tillery testified they did not understand these requirements before the accident. I observed the demeanor of these individuals, found their testimony credible, and have no reason to believe they had actual knowledge the ropes were hazardous. Regardless, in view of their positions and the evidence of record, both should have known this was the case. This conclusion is supported by the condition of the ropes.

Dr. Jerner testified that broken wires are one of the more visible signs of when a rope should be replaced and that both ropes had numerous broken wires around the 11-foot point, the point where the left-hand rope failed. He further testified the left-hand rope had at least forty broken wires, or eighty broken ends, in one lay about 2 feet from the separation point, and that this was caused by wear and lack of lubrication and inspections and not the failure itself. Finally, Dr. Jerner testified that the number of broken wires and the fact that some were hooking on an employee's glove should have signaled the need to replace the left-hand rope. Although Dr. Jerner counted the total number of broken wires with the aid of a microscope, I am convinced Tillery in particular should have known the

rope required replacement in view of the sheer number of broken wires, the fact some were catching on his glove, and, as he himself stated, his efforts to follow C-23 to the best of his ability; in this regard, I note C-23 includes a diagram depicting a strand and the actual length of a rope lay. *See* C-23, p. 17. Based on the record, the Secretary has met his burden of proving a 5(a)(1) violation with respect to the wire ropes. The characterization of the violation follows.

Whether the Violation was Willful

To establish a willful violation, the Secretary must show it was committed "with intentional, knowing or voluntary disregard for the requirements of the Act or with plain indifference to employee safety." *Williams Enter., Inc.,* 13 BNA OSHC 1249, 1256, 1986-87 CCH OSHD ¶ 27,893, p. 36,589 (No. 85-355, 1987). As *Williams* further explains:

> A willful violation is differentiated by a heightened awareness - of the illegality of the conduct or conditions - and by a state of mind - conscious disregard or plain indifference. There must be evidence that an employer knew of an applicable standard or provision prohibiting the conduct or condition and consciously disregarded the standard. Without such evidence of familiarity with the standard's terms, there must be evidence of such reckless disregard for employee safety or the requirements of the law generally that one can infer that if the employer had known of the standard or provision, the employer would not have cared that the conduct or conditions violated it. It is therefore not enough for the Secretary simply to show carelessness or lack of diligence in discovering or eliminating a violation.

Id. at 1256-57 and p. 36,589.

It is apparent from the record that John Tillery, the ride foreman, and Richard Dueberry, the superintendent of rides and Tillery's immediate supervisor, were the individuals with primary responsibility for the Giant Wheel. I concluded above that both should have been aware of the need to conduct proper hoist and rope inspections and that they also should have known the subject ropes were hazardous. I further concluded there was no evidence either had actual knowledge the ropes, and in particular the one that failed, were hazardous. This conclusion was based on their unequivocal testimony, which I found credible, that had they known the rope was a hazard it would not have been used. Despite this testimony, it is clear that Tillery and Dueberry were negligent in the area of winch and

rope inspections with respect to the Giant Wheel. It is also clear that on the basis of the evidence set out set out above such negligence could be found to be willful. However, in light of further evidence in the record, I find that the violation was not willful.

Tillery testified the replacement rope arrived at the site at the end of the sweep-pulling operation, that it would have taken about a half hour to install it, and that it would have been more convenient to replace it later. (Tr. 347-48). However, he, Dueberry and Vomberg all testified there was no pressure to erect the ride; the show could have opened Wednesday evening if ready but was not scheduled to open until Thursday or Friday.[11] (Tr. 71-75; 420; 873). Dueberry testified he was allowed to spend the time and money he needed to ensure patron and employee safety and that he had actually shut down rides he felt were unsafe. (Tr. 888-90). Vomberg testified he had tried to run a safe show, that he had held as many as two to three safety meetings a week during their spring dates, and that the meetings addressed patron and employee safety. Vomberg further testified that Dueberry and Tillery were both the kind of men who would never knowingly put anyone in harm's way and that Gerald Murphy was very concerned about safety and did much more in this regard than other shows. (Tr. 61-62; 65-67; 70-72; 76).

Gerald Murphy testified that he has been a strong proponent of safety since he started in the business with his father and that he had initiated many policies in this regard. He said his company has only late-model equipment and spends over one million dollars a year to maintain it, that personnel safety meetings are held at every site, that Dueberry, Tillery, Vomberg and others had gone to trade seminars to keep abreast of industry and safety issues, and that the company spends around $70,000.00 a year to have its sites inspected; most states in which the carnival plays mandate such inspections, but Murphy also hires private consultants for site inspections beyond what is required.[12] Murphy noted that his policy as to equipment replacement was "safety first," that he communicated this to employees continuously, and that he himself would never run a ride he believed was

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[11]The accident occurred on Tuesday. (Tr. 74).

[12]Greg Wallace, Respondent's vice president of finance, verified the amounts spent on ride maintenance and inspections, noting the company was required to pay for state-mandated inspections. (Tr. 961; 977-78).

dangerous to anyone, whether employees or patrons. Murphy also noted that his was one of the larger carnival operations, that he had probably had 100,000 employees and 100 million patrons at his sites, and that other than the subject accident there had been no fatalities. (Tr. 834-37; 980-95).

James Drew's experience in the carnival business is set out *supra*. He testified he had been leasing rides from Murphy Brothers since 1990 and that before doing so he personally went to one of its state fair shows and viewed its equipment and operation and talked to its personnel. Drew said he did this to protect his own safety record and that having been in the business his whole life he had a good feel for the quality of a carnival. He also said a carnival's reputation becomes known in the community through the grapevine, and that in his opinion Murphy Brothers had a very good operation and very good people. (Tr. 638-43).

James Haessly worked as a safety specialist with Wisconsin's Department of Labor from 1967 until 1990; his position included inspecting carnivals to ensure ride safety pursuant to Wisconsin's amusement ride standards, and in 1980 he began inspecting Murphy Brothers due to its playing at the Wisconsin State Fair each year. Haessly testified that from February 1992 through 1993 he was employed by Gerald Murphy to perform the same types of inspections at his sites; he checked the ride equipment before, during and after it was set up, noted any problems on inspection reports, and informed the ride foremen, who usually corrected the problems unless they required the attention of Dueberry or Vomberg. Haessly further testified he prepared safety data sheets for the Giant Wheel and twenty-six other rides during this time at Murphy's request; these sheets contained setup, disassembly and operation instructions for the rides in the context of patron and employee safety. Haessly said the company's attitude towards safety was excellent, and noted the left-hand rope was replaced again in June 1993, which held up the operation of the Giant Wheel, after he found four broken wires in one lay of one strand.[13] (Tr. 921-38; 946-54).

Terry Moore has been the president of the Omaha Federation of Labor, AFL-CIO, since 1976 and has been involved in the labor movement and workplace safety for thirty-three years; he has been on safety committees in prior positions and attended OSHA

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[13]Haessly did not inspect the wire ropes before the accident. (Tr. 953-54).

training courses in the early 1980's. Moore testified he met Gerald Murphy pursuant to the Septemberfest which is held in Omaha every year; he initiated the festival in 1977 as a salute to labor and contacted Murphy as he wanted a first-class carnival and had learned of his show.[14] Moore was very concerned about patron and employee safety and investigated Murphy's carnival by visiting his show at the Nebraska State Fair and observing his employees and operation, including ride tear down; he also contacted the Nebraska Labor Commission and fair operators in other states and got nothing but excellent reports. Moore discussed safety at length with Murphy and concluded he was very strong on safety for both patrons and employees; Moore also learned the carnival had good facilities for workers and a school for their children. (Tr. 508-27; 535-41).

Moore noted that as a result of his investigations, Murphy's show has played at the Septemberfest every year since 1978. He also noted he has educated himself about carnivals and has continued to monitor Murphy's operation; he goes to at least two trade shows and visits several carnival shows, including at least three of Murphy's, each year, and during his visits looks for things like guards being in place and whether ride operators are paying attention. Moore said he has watched the setup and tear down of rides and observed that Murphy's workers use safety belts and other protection. He also said the safety of Murphy's shows is impressive and far better than others he has seen. (Tr. 520; 527-35; 540-41).

It is apparent from the foregoing Murphy Brothers has an excellent reputation within the carnival community, that this reputation is due in large part to its safety record, and that the company has spent significant funds on matters relating to safety. Gerald Murphy testified about his policies in this regard, including the use and maintenance of late-model equipment, site inspections beyond those required, frequent safety meetings and employee attendance of trade seminars. I observed Murphy's demeanor as he testified and found him sincere and believable. It was obvious from his testimony that he was a very decent man who was truly concerned about the safety of patrons and employees and that he was deeply saddened by the accident. This conclusion is supported by the testimony of Drew, Haessly

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[14]The Septemberfest is one of the largest of its kind in the country and has received a number of awards. It has industrial and educational displays, arts and crafts, circus acts, carnival rides for children and adults, and various other types of entertainment, including nationally-known acts. (Tr. 513-520).

and Moore, all of whom had a high opinion of Murphy and his carnival. While none of these individuals had checked with OSHA, all three were knowledgeable in the industry and their opinions were based on their observation of the company's operation and its reputation in the industry; moreover, while it was evident that the primary concern of Haessly and Moore was patron safety, it was equally evident that a number of things they looked at, including certain aspects of ride setup, went to employee safety. (Tr. 526-28; 533-41; 549; 648-49; 924-25; 929-31; 938-43; 947-54). In this regard, I note Murphy's testimony that his policies addressed both patron and employee safety and that of Tillery about instructing workers in hand and voice signals, using protective equipment, and staying out of the way of loads and pinch points. (Tr. 377-78; 421-23; 426-32; 989-95). I also note the above testimony of Vomberg and Dueberry about safety meetings and shutting down rides.

In concluding the violation was not willful, I am well aware of the tragic accident in this case that resulted in the loss of two lives and the serious injury of another. Based on the record, I have found that the company was not inspecting the hoists and ropes used to erect the Giant Wheel as required and that it should have known that the rope that failed was hazardous. I have also found that Tillery and Dueberry were negligent in the area of winch and rope inspections as to the Giant Wheel. Moreover, such negligence has been imputed to the company for the purpose of finding a serious violation. As noted *supra*, their negligence could also be viewed as willful in this case. However, there are some cases in which the technical application of the facts to legal tests is simply not appropriate and the sitting judge's observations must take precedence. This is such a case. My observation of Gerald Murphy's demeanor as he testified, as well as the other evidence set out above, convinced me that he is a conscientious employer and that it is inappropriate to find the company in willful violation of the alleged violation. This conclusion was not influenced by the fact that he showed tremendous emotion on the stand requiring a short recess. Rather, it was based on an analysis of all the evidence as well as a basic instinct developed over the last seventeen years as a Commission judge. It is this instinct that has tipped the scales in favor of the Respondent in this very close case. This citation is accordingly affirmed as a serious violation.

Turning to the assessment of an appropriate penalty, the Secretary proposed a penalty of $70,000.00 for this item. However, that penalty was based on the Secretary's determination that the violation was willful. In light of the serious characterization of the violation, and after giving overriding consideration to the gravity of the condition as well as considering the company's size, history and good faith, it is concluded that a penalty of $7,000.00 is appropriate for this item.

Willful Citation 2 - Item 2

This item alleges employees were not kept clear of suspended loads in willful violation of 29 C.F.R. § 1910.184(c)(9). CO Conway testified she recommended this item because she learned during her inspection that employees had been up on the Giant Wheel and on the platform below during its assembly and that they were not kept clear of the suspended sweeps as required by the standard and C-18 and C-19. (Tr. 154-59). C-18 and C-19 do, in fact, require workers to be out of the path of the sweeps when they are supported by the winch cables.[15] However, the record does not establish the alleged violation, for the following reasons.

As noted *supra*, there were four employees on the platform and three more on the wheel at the time of the accident. Leon Burrell was standing on a T-bar 10 feet off the platform handing short spreader bars up to John Wagner and William Olson; Wagner and Olson were tied off to sweeps and standing 10 feet above Burrell on the bar they had just installed on the wheel's outside rim, and they were preparing to put the matching bar on the wheel's interior rim. Tillery testified that when the rope broke the whole ride moved and the sweeps collapsed or crashed together twice; the first crash jolted Wagner and Olson from their positions and they were caught between the sweeps in the second crash, while Burrell, who dropped down from his original position when the ride began to move and wrapped himself around the T-bar, was caught in the first crash. (Tr. 423-26; 431; 489-502).

Tillery indicated the original positions of Wagner and Burrell on C-3 and C-5. He said none of the three employees was in the path of the sweeps in their original positions

[15]This information appears in item 2 on page 3 of C-18 and in the boxed area at the top of C-19.

and that Burrell would have been all right had he not moved. He also said employees had to get up on the ride to set it up, that representatives of the manufacturer had shown him how to erect the ride, and that he set it up the way he was shown. Tillery noted he told workers who got on the wheel to keep out of the way of the sweeps and the pinch points created when they were pulled, that voice and hand signals were used in part to make sure everyone was clear before pulling the sweeps, and that the workers on the platform were never in the path of the sweeps as they were 6 feet above their heads. (Tr. 377-82; 421-32; 494-97; 500).

Based on the foregoing, the Secretary has not established the alleged violation. Tillery testified employees had to be up on the wheel to set up the ride and that he erected it as the manufacturer had shown him. He further testified Wagner and Olson had fallen into the path of the sweeps after the first crash, and that Burrell would have been all right if he had stayed in his original position. Finally, he testified that the employees on the platform were not in the path of the sweeps as they were 6 feet above their heads. His testimony was not rebutted by the Secretary, and CO Conway herself conceded that employees had to be on the ride to erect it, that she did not know exactly where they were before the accident, and that they could have fallen into the path of the sweeps. (Tr. 186-90). One could speculate from the photographs that the employees up on the wheel could have been in the path of the sweeps by the very nature of the work being done. However, there was no evidence of record to support such a finding, and a violation cannot be found based on speculation alone. The Secretary has consequently not carried his burden of proof as to the alleged violation. This item is therefore vacated.

Serious Citation 1 - Item 1b

This item alleges the left-hand hoist operator did not obey a stop signal in violation of the general duty clause. CO Conway testified she recommended this item based on signed statements taken from Walter Grey, a new employee who was hooking up the left-hand rope to the sweeps, and Ennis Jackson, another new employee, that Billy Van Brunt, the left-hand hoist operator, did not stop operating the hoist when Grey told him just before it broke that the rope had caught on something; Jackson also stated he heard Tillery tell

Van Brunt to stop, and both employees told her Van Brunt's response was that the rope was all right. Conway said the ANSI standard referenced in the hoist manual requires the operator to obey a stop signal at all times, no matter who gives it. She also said this item was cited as a 5(a)(1) violation as there was no applicable general industry standard. (Tr. 161-71).

As noted above, to prove a general duty clause violation the Secretary must show that Respondent or its industry recognized the cited hazard. The ANSI standard referenced in C-18, the hoist manual, does contain the requirement Conway noted.[16] *See* R-7, section 5-3.1.3(c). Moreover, while C-18 refers to this standard only in regard to the disassembly and inspection of wear items and Tillery testified he had never seen the standard, it is clear the company recognized the cited hazard based on Tillery's further testimony that the hoist operator had to stop operating the hoist if anyone said to stop or otherwise indicated a problem. (Tr. 428; 439-40). *See also* C-18, p. 9. However, notwithstanding the company's recognition of the hazard, it is my conclusion that the Secretary has not proved the alleged violation. Tillery testified at some length about the hand and voice signals used during the sweep-pulling operation, and, as already noted, that the operator had to stop operating the hoist if anyone indicated a problem. He also testified he had trained Van Brunt in these signals and that Van Brunt followed them. (Tr. 377-82; 426-28). Although Conway testified about what Grey and Jackson told her, the Secretary did not offer the testimony of either individual at the hearing. In view of Tillery's testimony, I am disinclined to give much weight to the statements of Grey and Jackson without observing their demeanor. Based on the evidence of record, Respondent was not in violation of the general duty clause with respect to this item. This item is vacated.

Serious Citation 1 - Items 8-10

Items 8 and 9 allege that no inspections of the alloy steel chain slings used with the wire ropes during the erection of the Giant Wheel were conducted as required by 29 C.F.R. §§ 1910.184(d) and 1910.184(e)(3)(i); specifically, 1910.184(d) requires daily inspections of

[16]Although Conway referred to ANSI B30.7 rather than B30.5, both have the same requirement about obeying stop signals. *See* C-20, section 7-3.1.3(c).

slings and fastenings before use by a competent person, while 1910.184(e)(3)(i) requires in addition regular periodic inspections of slings at least yearly. Item 10 alleges that no records of the most recent month in which the slings had been inspected were available for examination in violation of 29 C.F.R. § 1910.184(e)(3)(ii). CO Conway testified she asked for inspection records and that nothing she was shown reflected inspections for the slings; she also determined from Vomberg, Dueberry and Tillery that no inspections were occurring for the hoisting mechanisms, which included the slings. Conway said that not inspecting the slings could have caused serious injury or death as they were used with the wire ropes to pull the sweeps. (Tr. 171-81; 221-26). Tillery testified he looked at the slings when putting them on each time they were used, but acknowledged his statement in his deposition that he did not inspect the slings. He also testified there was nothing on his daily inspection checklists for slings and chains. (Tr. 460-61; 469-70; 480-82; 486; R-3). The record establishes all three of the alleged violations, and items 8 through 10 are affirmed as serious violations.

A penalty of $5,000.00 was proposed for each of these items. The factors to be considered in the assessment of penalties are set out *supra*. In regard to the gravity of the condition, I note Conway's testimony that she saw no problems with the slings and that the citations were recommended solely due to the failure to inspect the slings and maintain records of the inspections. (Tr. 221-22). After giving due consideration to this factor as well as the others noted above, I conclude that a penalty of $1,000.00 for each of these items is appropriate.

Conclusions of Law

1. Respondent, Murphy Enterprises, Inc., is engaged in a business affecting commerce and has employees within the meaning of section 3(5) of the Act. The Commission has jurisdiction of the parties and of the subject matter of the proceeding.

2. Respondent was not in violation of section 5(a)(1) of the Act as alleged in item 1 of serious citation 1.

3. Respondent was not in violation of 29 C.F.R. §§ 1910.25(d)(1)(x), 1910.147(c)(1), 1910.147(c)(4)(i), 1910.147(c)(5)(i), 1910.147(c)(6)(i), 1910.147(c)(7)(i), 1910.304(f)(4), 1910.305(b)(1), 1910.305(b)(2) and 1910.305(g)(2)(ii).

4. Respondent was in serious violation of 29 C.F.R. §§ 1910.184(d), 1910.184(e)(3)(i) and 1910.184(e)(3)(ii).

5. Respondent was in serious violation of section 5(a)(1) of the Act as alleged in item 1 of willful citation 2.

6. Respondent was not in violation of 29 C.F.R. § 1910.184(c)(9).

7. Respondent was not in violation of 29 C.F.R. §§ 1904.2(a), 1910.23(d)(1)(iv), 1910.157(g)(1), 1910.303(b)(2), 1910.305(b)(1) and 1910.305(g)(2)(iii).

Order

On the basis of the foregoing Findings of Fact and Conclusions of Law, it is ORDERED that:

1. Items 1-7 and 11-14 of serious citation 1 are VACATED.

2. Items 8-10 of serious citation 1 are AFFIRMED, and a penalty of $1,000.00 for each item is assessed.

3. Item 1 of willful citation 2 is AFFIRMED as a serious violation, and a penalty of $7,000.00 is assessed.

4. Item 2 of willful citation 2 is VACATED.

5. Items 1-6 of "other" citation 3 are VACATED.

Stanley M. Schwartz
Administrative Law Judge

Date: JUL 28 1995