



UNITED STATES OF AMERICA
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION

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SECRETARY OF LABOR
Complainant,

v.

JEWELL PAINTING, INC.
Respondent.

OSHRC DOCKET
NO. 92-3636

**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 11, 1994. The decision of the Judge will become a final order of the Commission on September 12, 1994 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 31, 1994 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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Review Commission
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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.
Ray H. Darling, Jr.
Executive Secretary

Date: August 11, 1994

DOCKET NO. 92-3636

NOTICE IS GIVEN TO THE FOLLOWING:

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SECRETARY OF LABOR,

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v.

JEWELL PAINTING, INC.

Respondent.

OSHRC
 DOCKET NO. 92-3636

Appearances:

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

Joseph H. Kasimer, Esq.
 Kasimer & Ittig, P.C.
 Falls Church, VA
 For Respondent

Before: Administrative Law Judge Robert A. Yetman

DECISION AND ORDER

This proceeding arises under § 10(c) of the Occupational Safety and Health Act of 1970, 29 U.S.C. § 651, *et seq.*, ("the Act"), to review citations issued by the Secretary pursuant to § 9(a) of the Act and a proposed assessment of penalty thereon issued pursuant to § 10(a) of the Act.

On October 29, 1992, Jewell Painting, Inc. ("Jewell") was issued two citations - one serious and one other than serious - stemming from an inspection conducted by the Occupational Safety and Health Administration ("OSHA") of a work site located at the Androscoggin River in Gilead, Maine. Jewell had been hired by CPM Construction to remove lead paint from a bridge spanning the river and then repaint it. Their portion of the

bridge project commenced in mid-July of 1992 and was completed by mid-August of 1992 (Tr. 46, 56-57, 67, 75-76, 562, 586, 676; Exhibit R-11 at 4-7).

Before beginning the paint removal process, Jewell suspended a platform underneath half of the bridge, erected a scaffolding framework up around it, and enclosed the entire area with tarp. This system was submitted to the Maine Department of Transportation in accordance with project requirements and approved (Tr. 572-74, 586, 629, 676-77; Exhibits R-18, C-10, C-11, C-21 & C-22). Jewell's employees worked inside this containment, blasting lead paint from the bridge's surface with steel shot (Tr. 76, 571, 583-84). During the blasting operation, a dust collector, attached to the containment by a hose or duct, drew contaminated air out of the enclosure. As air was pulled out of the enclosure, specially designed flaps cut into the tarps surrounding the containment opened, drawing in fresh, clean air from outside and creating a flow of air across the containment (Tr. 292-93, 315-16, 347, 574-77, 619, 622-23). Once the bridge structure was stripped of lead paint, the employees used a "vacuum classifier" to collect the paint residue and spent shot or "grits" which accumulated in the containment during the blasting process (Tr. 78, 132, 137, 294, 344, 348-49, 581-82, 710). The classifier separated the steel shot from the paint debris so that the shot could be cleaned of contaminant before being reused for the blasting operation (Tr. 132, 137, 294, 579, 581-82). The lead paint waste collected by the classifier was eventually emptied into 55-gallon drums (Tr. 130-32, 605, 692-93; Exhibit C-12 & R-11 at 11, 16).

A marked "sawhorse" barricade and yellow "Caution" tape was used to surround the containment, as well as the areas along the River's banks where Jewell's large equipment was located, clearly designating the entire section as a "lead work area" (Tr. 125-26, 166-67, 196, 669-72; Exhibits C-9, C-21, R-4, R-11 at 10 & 15, R-21, & R-22). Whenever a Jewell employee entered this area, he wore a full-length protective garment, known as a Tyvek suit, and a respirator appropriate for the type of work he was to perform (Tr. 202, 600-01, 673-74; Exhibits C-33, R-11 at 7-8, R-14). Located outside of the lead work area was a decontamination trailer which contained shower facilities and a wash station, thus allowing Jewell's employees to remove any lead dust which may have accumulated on their bodies and wash out their respirators (Tr. 79-80, 82, 489-90, 596, 679; Exhibit C-25). A water cooler containing bottled drinking water was also provided by Jewell outside the trailer (Tr. 403-04, 415, 678; Exhibit C-24, C-25 & C-27).

On August 5, 1992, OSHA Industrial Hygienist Isaac LaSalle held an opening conference with Donald Durgin, Jewell's field superintendent at the Gilead site (Tr. 67-68, 665, 668). LaSalle, accompanied by Richard Stiefken, OSHA Senior Industrial Hygienist, returned to the site the following day, but was unable to conduct an inspection of the work area because Durgin requested a search warrant (Tr. 68-69, 318-19, 333-35). On August 8, 1992, after obtaining a warrant, the industrial hygienists returned to the site to conduct the inspection (Tr. 71, 73-74, 335-36; Exhibit C-1). At that time, the blasting portion of the project was complete and Jewell was in the process of cleaning the work area with the vacuum classifier (Tr. 77-78, 294, 600, 677, 718). During their inspection, the industrial hygienists conducted air sampling for two Jewell employees engaged in the clean-up process and took wipe samples of several surfaces at the site, as well as bulk samples of different materials (Tr. 74-75, 87-89, 133-34, 139-40, 166, 337, 417-18; Exhibits C-6, C-14, C-28, C-29 & R-1). On the basis of their findings, the subject citations were issued.

Jewell filed a timely notice of contest and a hearing was held in Boston, Massachusetts from January 6, 1994 to January 7, 1994 and January 20, 1994 to January 21, 1994. Both parties have submitted post-hearing briefs and this matter is now ready for decision.

DISCUSSION

I. Serious Citation 1, Item 1

The Secretary alleges that Jewell failed to identify outlets supplying nonpotable water in its decontamination trailer as unsafe for washing purposes in violation of 29 C.F.R. § 1926.51(b)(1).¹ Specifically, the Secretary contends that the wash station located on the side of the trailer and the shower facilities located inside the trailer were not clearly labelled with the appropriate warnings.

¹ This standard provides:

Outlets for nonpotable water, such as water for industrial or firefighting purposes only, shall be identified by signs meeting the requirements of subpart G of this part, to indicate clearly that the water is unsafe and is not to be used for drinking, washing, or cooking purposes.

Because there was no source of public water available at the site and no water suppliers in close proximity, Jewell elected to pump water out of the Androscoggin River to supply the washing facilities at its decontamination trailer (Tr. 83-84, 596-97, 678-79, 681).² In making their decision, Jewell's field superintendent, Durgin, and its president, Cameron Jewell, discussed this option with the mayor of Gilead, who informed them that the river was safe for swimming and that fish caught in the river were safe to eat; therefore, he saw no problem with utilizing the water for showering and laundering purposes (Tr. 597, 679-80).³ In recognition of the fact that this water was not suitable for drinking purposes, Durgin checked with Jewell's safety consultant and was told to mark the trailer's outlets as "nonpotable" (Tr. 681). As a result, he stenciled the word "nonpotable" above the wash station and also, he claims, on the wall underneath the shower heads inside the trailer (Tr. 80, 681-83; Exhibits C-3, C-4, & R-23).⁴

Under the terms of the cited standard, it is not enough to simply label an unsafe water source as "nonpotable". Section 1926.51(b)(1) expressly provides that the sign on such an outlet must "indicate clearly" the purposes for which the water may not be used - drinking, washing, or cooking. Thus, although Jewell's employees may have understood that "nonpotable" meant the water source was unsafe, without a more definitive sign, they may not have actually understood what the water could or could not be safely used for. The parties, however, disagree over exactly what the prohibited uses of this water were. As the citation indicates, the Secretary has focused on the very purpose for which this water was used, arguing that the water was unsafe for washing or showering and therefore, should have been identified as such. Jewell, on the other hand, believed that the water was safe for

² Contrary to Jewell's interpretation of the cited standard, this water need not have been used exclusively for industrial or firefighting purposes for § 1926.51(b)(1) to apply. While the standard does include the phrase "such as water for industrial or firefighting purposes only", the "such as" portion of this language suggests that these purposes are merely illustrative and not meant to limit the standard's application.

³ The water quality classification assigned to the water in the Androscoggin River by Maine's Department of Environmental Protection confirms that it is safe for swimming and fishing but, unless treated, not for drinking (Exhibits R-13 & C-39 at 13-16).

⁴ The OSHA hygienist testified that he did not see any signs regarding nonpotability in the shower area (Tr. 490-91).

washing purposes, but unsafe for drinking purposes, as evidenced by its efforts to mark these outlets as nonpotable and the provision of a separate source of drinking water.

In either case, Jewell's attempt to label these outlets with the appropriate warnings falls short of the requirements of § 1926.51(b)(1). Whether the water was unfit for washing, unfit for drinking, or both, Jewell was required to communicate this information to its employees and failed to do so here. Thus, the alleged violation must be affirmed. The Secretary, however, has failed to demonstrate that Jewell's employees would suffer serious physical harm as the result of its failure to properly label these outlets. The only illness cited by one of the OSHA hygienists in connection with this item was a gastrointestinal tract infection which apparently could be the result of drinking untreated river water (Tr. 214-15). But the likelihood that an employee would actually ingest water from either the wash station or the shower facility when cold bottled water was available in a water cooler just a few steps away or, if he did, that he would contract such a malady that would progress to a level of "serious physical harm", is far too speculative to support classifying this violation as serious. See § 17(k) of the Act, 29 U.S.C. § 666(k). Under these circumstances, the violation is more appropriately classified as nonserious. Upon consideration of the penalty criteria found at § 17(j) of the Act, 29 U.S.C. § 666(j), I find a penalty of \$50 to be reasonable and appropriate for this violation.

II. Serious Citation 1, Item 2(a) and (b)

At the hearing, the Secretary amended this citation to group Items 2 and 3 as Item 2(a) and (b), with one proposed penalty (Tr. 43-44). Under this item, the Secretary alleges a grouped violation of § 1926.55(a) and § 1926.55(b), which provide in relevant part:

(a) Exposure of employees to inhalation, ingestion, skin absorption, or contact with any material or substance at a concentration above those specified in the "Threshold Limit Values of Airborne Contaminants for 1970" of the American Conference of Governmental Industrial Hygienists ["ACGIH"], shall be avoided.

(b) To achieve compliance with paragraph (a) of this section, administrative or engineering controls must first be implemented whenever feasible. When such controls are not

feasible to achieve full compliance, protective equipment or other protective measures shall be used to keep the exposure of employees to air contaminants within the limits prescribed in this section.

* * * *

One of the personal air samples taken by OSHA hygienists on August 8, 1992, clearly demonstrates that Ralph Williams, a Jewell employee engaged in the clean-up process at the Gilead site, was exposed to a level of lead exceeding the established permissible exposure limit ("PEL") documented in the 1970 "Threshold Limit Values" table (Tr. 86-104, 200-03, 216-17, 231-38, 246-51, 255-56, 272-75; Exhibits C-6, C-7 & C-20A).⁵ Indeed, both Cameron Jewell and field superintendent Durgin testified that based on their experience in the lead paint removal industry, they assumed that the level of lead dust generated during the removal/clean-up process would be in excess of the PEL and that no matter how many controls they implemented, the use of protective garments and respirators would be required to reduce that exposure to within an acceptable level (Tr. 587-92, 649-53, 685-86, 716-17).

In spite of this acknowledgement, Jewell challenges the validity of the air samples, contending that the OSHA hygienists failed to follow the sampling procedure set forth in OSHA Instruction CPL2-2.20B dated November 13, 1990. Although failing to follow basic testing procedures when taking an air sample can raise serious questions about the accuracy of the sample's results, none of the alleged procedural "defects" cited by Jewell warrant invalidating either the citation or the results themselves. Indeed, even though almost three days lapsed between the day that the air monitoring units were calibrated and the day that the tests were actually conducted, the calibration was still performed, as required by OSHA, "before...each day of sampling" (Tr. 181-84). Moreover, checking the air monitoring units attached to each Jewell employee approximately every three hours instead of every two hours as recommended is not a significant deviation from procedure and Jewell failed to

⁵ According to the 1970 ACGIH table, the PEL for lead over an eight-hour period is .2 milligrams (200 micrograms) per cubic meter (Tr. 86, 384-87; Exhibit C-23). The air sample taken for Williams indicated a level of exposure at an eight-hour time-weighted average of .345 milligrams (345 micrograms) per cubic meter (Tr. 87, 216-17, 600; Exhibit C-7 & C-20A). The second air sample taken by hygienists indicated a level of exposure within the established PEL (Tr. 181).

demonstrate that it had any impact upon the overall accuracy of these tests (Tr. 94-95, 184-86; Exhibit C-6). The record also contains no evidence whatsoever to indicate that the OSHA hygienists, contrary to procedure, shipped all of the samples they took during the inspection to the OSHA laboratory in one package (Tr. 197-98, 271-72). As such, the air sampling results represent a valid measure of the level of exposure to which at least one Jewell employee was exposed.

Having recognized that the level of lead dust exposure was consistently higher than the established PEL during all aspects of this project, Jewell made a serious effort at the Gilead site to reduce the exposure levels as much as possible through the use of engineering controls. These controls included the 18,000 cubic feet per meter (“cfm”) dust collector used to draw out lead-infested air from the enclosure, as well as the custom-designed vacuum classifier which allowed for the efficient removal of lead paint waste and contaminated steel shot (Tr. 309, 344-46, 378-79, 499-500, 558, 581-83, 599). According to the OSHA hygienist, the proper use of these two controls reduced the level of lead dust exposure as much as was feasible at the Gilead site (Tr. 349-50, 378, 500, 516-17).

Nonetheless, the Secretary maintains that Jewell, in accordance with the hierarchy of requirements set forth in § 1926.55(b), did not exhaust all feasible controls at this site before relying upon the use of respirators to reduce the level of lead dust exposure. Specifically, the Secretary claims that Jewell should have utilized a “make-up air” unit in conjunction with the dust collector to ensure that enough air was being introduced into the containment; continue to operate its dust collector throughout the clean-up process as performed on August 8, 1992; and implement a formal employee rotation system thereby limiting the amount of time employees actually spent inside the containment.⁶

At the hearing, the OSHA hygienist explained that a make-up air unit blows air into a containment to essentially replace the air being exhausted through the dust collector (Tr.

⁶ Two abatement methods listed in the citation - use of the “wet method” to clean up waste and a “HEPA” filtration system to decontaminate employees - are not viable options here. Using water to clean up the lead waste at this site was simply not feasible given the type of abrasive being used and the use of a HEPA system would not only have had no effect on the exposure levels experienced by employees *inside* the containment, but would be considered duplicative of the protection afforded by a decontamination trailer (Tr. 506-12, 592-96).

377, 382-83). Apparently, this maximizes the efficiency of the dust collector by ensuring that lead-infested air is being exchanged for fresh, clean air at an adequate rate (Tr. 378, 383, 501, 624-25, 722). However, the hygienist conceded that the dust collector used by Jewell at this site was sufficient enough to provide the appropriate number of “air changes” required for a containment of this size. This comment confirms the testimony of Cameron Jewell, who stated that calculations made at the start of the project in order to determine the required air flow rate for this particular containment indicated that this type of “negative air” system would be appropriate (Tr. 378, 500, 574-77, 599, 619, 646-47, 662). Furthermore, not only did the hygienist conclude that the use of the dust collector together with the vacuum classifier reduced the level of lead dust exposure as much as was feasible at this site, he agreed that these systems were “all [Jewell] could do in terms of engineering controls” (Tr. 350). As such, there is no definitive evidence indicating that the use of a make-up air unit would have improved the adequate ventilation system Jewell already had in place.⁷

At some point after the noon hour on the day of the inspection, the dust collector being used by Jewell at the Gilead site was disconnected from the containment and physically removed from the site by Jeffrey O’Regan, the owner of a bridge painting business who had leased the dust collector from Jewell (Tr. 290-92, 306-07, 311-17, 337-41, 356, 502, 688-89). The Secretary argues that use of the dust collector should not have been discontinued when employees remained still inside the containment and therefore, represents a control which Jewell could have implemented to reduce the exposure level during this operation (Tr. 346-48, 355-56, 366, 638-39, 725).⁸ Jewell maintains, however, that at the time the dust collector was disconnected, the employees had actually finished cleaning up

⁷ In fact, Cameron Jewell testified that although he owned a make-up air unit, he did not use it on this project because he believed that forcefully blowing air into the containment could disrupt the negative air system or create turbulence within the enclosure, allowing the lead dust to simply recirculate (Tr. 601-02, 619-21). However, he also indicated, and the OSHA hygienist confirmed, that if such a system was deemed necessary, it could have been designed to minimize these potential problems (Tr. 621-22, 720-22).

⁸ The Secretary attempts to correlate the removal of the dust collector with the fact that the level of lead dust to which Williams was exposed during the clean-up process was higher during the afternoon sampling period than the morning sampling period (Tr. 357-58; Exhibit C-7). There is nothing in the record, however, to suggest a direct link between the two conditions, particularly where the afternoon sampling period was twenty-six minutes longer than the morning sampling period (Tr. 359; Exhibit C-6 & C-7).

the inside of the containment and had started dismantling the structure by taking down the tarps (Tr. 292, 609, 631-37, 689, 707-09). Once the containment was no longer intact, even the OSHA hygienist admitted that the dust collector would not function as intended and operating it under such conditions would essentially be useless (Tr. 503, 599, 609-10, 689-90).

Although there was considerable debate over this issue at the hearing, I find that at the time the dust collector was removed, Jewell was indeed engaged in the process of dismantling the containment. Having reached the final stage of its project, removing the tarps was clearly a prerequisite to completing the clean-up process so that the bridge could be repainted. Once the integrity of the containment was violated, the dust collector was no longer a feasible engineering control (Tr. 504, 609-10, 644, 660). Based on the credible testimony of both Jewell's president and field superintendent, I am simply not convinced that Jewell would have disconnected the dust collector at a time when it could have still served to adequately ventilate the work area. Such an action would clearly be inconsistent with Jewell's extensive efforts, documented *supra*, to protect its employees from overexposure at this site. Moreover, the OSHA hygienist's claim that the containment was intact both at the end of the day and when he returned to the site with his wife at a later unspecified time is clearly diminished by his admission that he was too far away to actually see inside the containment and therefore did not know if anyone was inside, let alone what work, if any, was being done (Tr. 366, 502-03, 722-25). Under these circumstances, the Secretary has failed to establish that continuing the dust collector's operation during the dismantling of the containment would have benefitted Jewell's employees in any measurable way.

While the engineering controls used by Jewell at this site can be considered state of the art, the Secretary legitimately questions why no administrative or work practice controls were employed here. Specifically, the Secretary contends that had Jewell implemented a formal employee rotation program, the amount of time an employee actually spent inside the containment would have been limited, thereby reducing his exposure to the high level of contaminant (Tr. 372-74, 522, 541-45). Employing such a system would have been particularly appropriate during the clean-up process. Indeed, where the use of the dust collector, an adequate engineering control, was no longer feasible, Jewell should have

considered altering its work practices so as to reduce the actual length of time its employees were exposed to what it acknowledged to be high levels of lead dust.

Jewell disputes the claim that it did not implement any administrative controls at this site, claiming that a rotation system was actually in place at the Gilead site.⁹ Under this alleged system, Ralph Williams, whose blood lead level was high when tested during a Jewell project he worked on the month before the Gilead job, was apparently “rotated” from blasting work to clean-up work in order to minimize his exposure (Tr. 588-89, 654-56, 687, 716; Exhibit C-8).¹⁰ However, by linking this quasi-rotation policy to its monitoring of blood lead levels, Jewell does not act to reduce an employee’s lead dust exposure until his blood lead content has been elevated to a hazardous level; a true rotation program would operate to reduce exposure *before* removal or rotation becomes necessary. Thus, by focusing solely on engineering controls, Jewell failed to consider that modifying its work practices could have further reduced the exposure of its employees to harmful levels of contaminant, irrespective of the use of protective equipment. Therefore, the alleged violation must be affirmed.

In order for this violation to be considered serious, the Secretary must prove that Jewell’s employees were exposed to a level of lead dust that could have resulted in serious physical harm or death. See § 17(k) of the Act, 29 U.S.C. § 666(k). There is nothing in the record, however, to indicate that the controls Jewell had implemented, in conjunction with the respirators and protective garments worn by each employee, did not serve to reduce the level of *actual* exposure to within the established PEL. As a result, the violation must be characterized as nonserious. Upon consideration of the penalty criteria found at § 17(j) of

⁹ Contrary to Jewell’s interpretation of the cited standard, neither respirators nor decontamination facilities constitute administrative controls under the terms of § 1926.55(b) (Tr. 588, 687). As the standard indicates, the use of respirators is separate and apart from an employer’s obligation to implement feasible controls to reduce exposure and decontamination facilities do not serve to directly reduce an employee’s exposure to lead dust as measured *inside* the containment.

¹⁰ Cameron Jewell testified that the blood lead levels of Jewell employees were typically monitored every two to four months, but employees were sometimes tested more frequently depending upon the magnitude of the removal project being performed (Tr. 560-61).

the Act, 29 U.S.C. § 666(j), I find a penalty of \$50 to be reasonable and appropriate for this grouped violation.

III. Serious Citation 1, Items 4 and 5

Under these items, the Secretary alleges that Jewell failed to ensure that two containers of hazardous chemicals at the Gilead site - a 500 gallon tank of diesel fuel and a 55 gallon drum of lead paint waste - were labeled, tagged, or marked with the identity of the chemical and the appropriate hazard warnings as required by § 1926.59(f)(5)(i) and § 1926.59(f)(5)(ii), respectively.

As a combustible liquid which can pose an inhalation hazard due its hydrocarbon content, diesel fuel is considered a hazardous chemical within the meaning of the cited standard (Tr. 129). When the OSHA hygienists initially visited the Gilead site, the tank containing the fuel was labeled only with the name of its supplier, Brooks Oil Company (Tr. 124-28; Exhibits C-9 & C-10). That the tank was delivered without the required information on it does not excuse Jewell from its obligation under the cited standards to ensure that any such container in its workplace be labelled with the required information (Tr. 691-92). When the hygienists returned to the site on August 8, 1992, the tank had been labeled as "diesel", but still lacked the appropriate hazard warnings (Tr. 127-28; Exhibit C-11). As there is nothing in the record to support Jewell's contention that this fuel had been transferred to a portable container and was intended for "immediate use" within the meaning of § 1926.59(f)(7), this exception to the labelling requirements of the cited standards cannot apply.¹¹ Therefore, with regard to the diesel fuel tank, the alleged violations must be affirmed.

As noted *supra*, lead paint waste emptied from the vacuum classifier was stored in 55 gallon drums or barrels at the Gilead site (Tr. 130-32, 134, 605, 692-93; Exhibit C-12 &

¹¹ Section 1926.59(f)(7) provides:

The employer is not required to label portable containers into which hazardous chemicals are transferred from labeled containers, and which are intended only for the immediate use of the employee who performs the transfer.

R-11 at 11, 16). Thus, simply by virtue of its source, Jewell should have known that this waste would contain some amount of lead; it did not need to have the waste tested to establish this fact.¹² Recognizing that the contents were unsafe, Jewell labelled the drums as “waste”, but failed to indicate that the waste contained lead, a substance which it has already acknowledged can pose an exposure hazard (Tr. 138-39, 148-49, 195, 693; Exhibits C-12 & R-8). That Jewell’s employees were told to treat these drums as containing hazardous waste does not excuse Jewell from its obligation to comply with the specific labelling requirements of the cited standards (Tr. 607, 694). Nor has Jewell definitively shown that this waste was exempt from these standards pursuant to § 1926.59(b)(6)(i).¹³ Thus, the violations must also be affirmed with regard to the drums containing lead waste.

The Secretary, however, has failed to prove that these violations should be characterized as serious. While Jewell’s failure to label these containers properly constitutes a technical violation of the cited standards, it has not been shown that this noncompliance could have resulted in serious physical harm or death to Jewell employees. See § 17(k) of the Act, 29 U.S.C. § 666(k). As noted, employees were specifically instructed to treat the drums of waste as hazardous and keep them sealed. Similarly, those employees who had to deal with the fuel tank apparently knew what it contained; indeed, it is difficult to believe that any of Jewell’s employees did not know that the 500 gallon tank positioned near Jewell’s equipment contained some type of fuel (Tr. 692). Under these circumstances, the established violations are more appropriately classified as nonserious. Upon consideration of the penalty criteria found at § 17(j) of the Act, 29 U.S.C. § 666(j), I find a penalty of \$50 to be reasonable and appropriate for each violation.

¹² The bulk sample of the waste taken by the OSHA hygienist indicated a 30% lead content (Tr. 133, 139-47, 265-70; Exhibits C-14, C-15 & C-20A).

¹³ This subsection provides that the standards found at § 1926.59 do not apply to:

Any hazardous waste as such term is defined by the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act of 1976, as amended (42 U.S.C. et seq.), when subject to regulations issued under that Act by the Environmental Protection Agency.

IV. Serious Citation 1, Item 6

The Secretary alleges that Jewell employees were permitted to consume water from a water cooler whose spigot was contaminated with lead in violation of § 1910.141(g)(2) or, in alternative, § 5(a)(1) of the Act.¹⁴ Because § 1910.141(g)(2) applies only to “permanent places of employment”, it is obviously inapplicable to the temporary work site cited here (Tr. 434, 538, 676). See § 1910.141(a)(1). According to the Secretary, where none of the subsections found at § 1926.51, the specific construction standard dealing with sanitation, are applicable to the condition cited here, § 1910.141, the corresponding general industry standard, may be cited pursuant to the “Index of General Industry Standards Applicable to Construction” (Exhibit C-31). Any limitation, however, upon a general industry standard’s application cannot be ignored simply by virtue of its inclusion on this list (Tr. 435-37; Exhibit C-31). Indeed, the subsection which specifically restricts the applicability of § 1910.141(g)(2) to permanent places of employment, § 1910.141(a)(1), is also included in the “Index” as applicable to the construction industry (Exhibit C-31). As such, the Secretary’s case must be proven under the general duty clause.

In order to establish a violation of § 5(a)(1) of the Act, the Secretary must show that: (1) a condition or activity in the employer’s workplace presented a hazard to its employees; (2) either the cited employer or its industry recognized the condition or activity as hazardous; (3) the hazard was causing or likely to cause death or serious physical harm; and (4) a feasible means existed to eliminate or materially reduce the hazard. *Wheeling-Pittsburgh Steel Corp.*, 16 BNA OSHC 1218, 1221, 1993 CCH OSHD ¶ 30,048 (No. 89-3389, 1993). There is no question that Jewell recognized that surfaces contaminated with lead can pose a serious hazard to its employees. Indeed, Jewell’s own lead hazard control program, in effect at the time of the inspection, states that Jewell will “keep all surfaces as free as possible of accumulations of lead” (Tr. 454, 558; Exhibit C-33). Also, by requiring employees to wash their hands and face before eating or drinking and prohibiting them from entering the food and beverage consumption area with contaminated work clothing or

¹⁴ The Secretary amended the citation on March 5, 1993 to allege a violation of the general duty clause in alternative to the cited standard.

equipment, Jewell acknowledged that the presence of contamination in these areas can increase the potential for lead ingestion (Tr. 674-75; Exhibit C-33). Thus, in addition to enforcing these work rules, the water cooler was removed from the Gilead site each night and washed by Jewell's foreman in order to remove any lead accumulation (Tr. 695-96).

A wipe sample taken by the OSHA hygienists indicates that lead was present on the cooler at the time of the inspection. Samples were taken of two areas on the cooler - the spigot and the top surface - but only the result from the spigot wipe sample was cited here (Tr. 417-18, 421-28, 430-32; Exhibits C-29 & C-30). According to the OSHA laboratory's analysis, the spigot contained 100 micrograms of lead which, once converted to reflect the size of the filter and the area sampled, translates in 259.7 micrograms per 100 square centimeters (Tr. 231-38, 251-54, 262, 265, 276-77, 428-30; Exhibit C-20A & C-30).¹⁵ The hygienist testified that based upon recommendations from the Department of Housing and Urban Development regarding surface contamination, he would have expected to see a contamination level of 25 to 50 micrograms per one hundred square centimeters (Tr. 455-56, 472-80, 484-86; Exhibits C-36 & C-37).¹⁶ Thus, given the level of contaminant present on the cooler's spigot, the Secretary maintains that Jewell's efforts to keep the cooler free from lead were insufficient.

Where an employer has already taken steps to address a recognized hazard, the Secretary must, in order to sustain a violation of the general duty clause, "specify the [additional] steps a cited employer should have taken to avoid citation and...demonstrate the feasibility and likely utility of those measures." *Natl. Realty and Constr. Co, Inc.*, 489 F.2d

¹⁵ Jewell disputes the validity of the wipe sample, again claiming that the OSHA hygienists failed to follow proper testing procedures. Neither of its alleged complaints, however, warrant dismissing these test results as invalid. Clearly, the use of a template to measure the surface to be wiped was not feasible with regard to sampling the cooler's spigot (Tr. 531-32). In addition, there is nothing in the record to indicate that the OSHA laboratory's substitution of a standard blank wipe sample for a blank of the actual sampling medium used by the hygienist at this site significantly altered the final results of these tests, particularly where, as the laboratory's supervisory chemist testified, blank wipe samples rarely indicate the presence of lead and it has not been shown that the samples were mishandled in any way (Tr. 256-63, 278-79, 525).

¹⁶ Since the inspection, OSHA has issued a compliance directive indicating that it considers an acceptable level of surface contamination to be 50 micrograms of lead per 100 square centimeters (Tr. 480-81).

1257, 1268 (D.C. Cir. 1973). See also *Pelron Corp.*, 12 BNA OSHC 1833, 1836, 1986-87 CCH OSHD ¶ 27,605 (No. 82-388, 1986); *Cerro Metal Prod. Div., Marmon Group, Inc.*, 12 BNA OSHC 1821, 1822, 1986-87 CCH OSHD ¶ 27,579 (No. 78-5159, 1986). It is not enough, therefore, for the Secretary to simply recommend that Jewell periodically conduct its own wipe sampling to determine whether its work practices are keeping the water cooler sufficiently free of contaminant (Tr. 487-88, 528-29). Proof of the additional, feasible measures which Jewell should have taken to reduce the risk of lead ingestion must be specific and include evidence that persons familiar with the employer's industry would have prescribed such steps under similar circumstances. *Pelron*, 12 BNA at 1836. *Cerro*, 12 BNA at 1822-23.

The Secretary first contends that placing the water cooler on the "tongue" of the decontamination trailer contributed to its contamination and encouraged employees to use it before washing at the trailer (Tr. 403-06, 487; Exhibits C-24 & C-25). There is nothing in the record, however, to suggest that Jewell's employees, in violation of established work rules, ever drank from the cooler prior to using the wash facilities. The Secretary also cites to the cooler's close proximity to two trash barrels, one of which contained a protective Tyvek suit, and to pieces of equipment which were apparently worn by Jewell's employees in the designated lead area (Tr. 407, 412, 415-16, 440-41, 487, 529-30; Exhibits C-25, C-26, & C-27). Furthermore, at the time of the inspection, the OSHA hygienist observed two respirator filters resting on the top of the cooler, but was unable to determine whether the filters were contaminated with lead or even belonged to Jewell (Tr. 405, 417, 420, 441, 525-28, 696-97; Exhibits C-24 & C-28). But without having tested any of these items for lead, the Secretary cannot credibly argue that their presence somehow contributed to the cooler's contamination. Moreover, the Secretary has failed to demonstrate that simply moving the cooler from one side of the trailer to the other, the only alternative location proposed by the OSHA hygienist, would have reduced the likelihood of contamination from any of these alleged "sources" (Tr. 487).

In addition to relocating it, the Secretary claims that Jewell should have cleaned the cooler more frequently and strictly enforced its work rules prohibiting employees from handling the cooler with contaminated gloves or hands. However, the Secretary cannot

satisfy his burden of proving abatement by prescribing the very methods a cited employer has already undertaken. *Cerro*, 12 BNA at 1822. Indeed, for such an argument to prevail, there must be evidence demonstrating not only how the employer's efforts in this area were inadequate, but how they could have been improved. *Id.* As noted *supra*, the Secretary has produced no evidence to suggest that Jewell's enforcement of these particular work rules was deficient. Even if there were such evidence, the Secretary has not specifically shown what Jewell could have done to enhance its safety program in this respect. Similarly, while the results of the wipe samples taken during the inspection could be considered proof of the fact that cleaning the cooler once a day was insufficient, the Secretary has failed to specify how many times and to what degree the cooler would have to be cleaned in order to reduce contamination to what OSHA would consider an acceptable level. Such detailed information would be particularly relevant here where the only water available for cleaning the cooler onsite was the nonpotable water from the Androscoggin River.

Thus, the Secretary has failed to satisfy his burden of proving a specific, feasible, and effective means of abating this hazard, beyond that already employed by Jewell at this site. Since a violation has not been established, Jewell's allegation of employee misconduct with regard to the respirator filters found on top of the cooler need not be considered here. Accordingly, the alleged violation is vacated together with any penalty proposed therein.

V. Other than Serious Citation 2, Item 1

The Secretary alleges that Jewell failed to complete three of its occupational injury and illness logs "in the detail provided in the [OSHA 200] form and [its] instructions", as required by § 1904.2(a). It is undisputed that almost all of the columns on Jewell's logs for 1989, 1990, and 1991, were not totaled at the bottom of the form (Tr. 149-54; Exhibits C-16, C-17, & C-18).¹⁷ As such, the violation must be affirmed.

Jewell contends, however, that this violation should be classified as *de minimis* and I agree. A *de minimis* violation has been defined as "one in which there is technical

¹⁷ In his post-hearing brief, the Secretary withdrew instance 3(o) of this item regarding column #12 on Jewell's log for 1991 (Secretary's Primary Brief at 36-37, n.28).

noncompliance with a standard but the departure from the standard bears such a negligible relationship to employee safety and health as to render inappropriate the assessment of a penalty or the entry of an abatement order.” *Keco Indus., Inc.*, 11 BNA OSHC 1832, 1834, 1983-94 CCH OSHD ¶26,519 (No. 81-1976, 1984). On the logs in question here, only two of the columns which contained actual figures were not totaled at the bottom; the remaining columns contained no information at all and therefore, required only the insertion of a zero at the bottom. As a result, it would not be difficult for anyone examining the logs to quickly ascertain what these absent totals should be.

Where the basic purpose of the log - to accurately document the injuries and illnesses suffered by employees during a given year - was accomplished here, Jewell’s failure to tally the minimal or, in some cases, nonexistent information contained in the cited columns constitutes only a minor deviation from the literal terms of § 1904.2(a) which bears little or no relationship to the safety and health of its employees (Tr. 161-62).¹⁸ See *Anoplate Corp.*, 12 BNA OSHC 1678, 1688, 1986-87 CCH OSHD ¶27,519 (No. 80-4109, 1986) (failure to record injured employee’s job title and regular department on OSHA 200 log where small workforce and details of injury allowed for such information to be easily ascertained constitutes a technical violation of § 1904.2(a) that is appropriately classified *de minimis*). Cf. *El Paso Crane and Rigging Co.*, 16 BNA OSHC 1419, 1993 CCH OSHD ¶30,231 (No. 90-1106, 1993) (failure to sign annual log summary in violation § 1904.5(c) cannot be classified as *de minimis* violation where signature is intended to certify that the summary was examined for accuracy and there is no indication that this examination was performed). Therefore, this violation, for which no penalty was proposed, should be reclassified as *de minimis*.

VI. Other than Serious Citation 2, Item 2

¹⁸ Although specifically questioned on cross-examination on the issue, the OSHA hygienist never explained how the omission of these figures had any measurable impact upon the safety and health of Jewell’s employees (Tr. 162).

The Secretary alleges that Jewell violated § 1926.416(e)(1) when it used a frayed electric cord to power the blasting machine at the Gilead site.¹⁹ The OSHA hygienist testified that he noticed a green cord on the bridge outside the containment with exposed wiring and duct tape around it (Tr. 155-57; Exhibit C-19). According to the hygienist, the twelve volt cord ran from the compressor to the blasting machine, but because the blasting work had been completed two days prior to the inspection, he did not observe any employees operating the machine and did not know if the cord was actually energized at the time (Tr. 157-60, 213). Jewell's employees, however, apparently walked through this area on their way to and from the containment and therefore, had access to this equipment (Tr. 158).

At the hearing, Jewell's field superintendent attempted to claim that the cord was actually a blast hose which carried steel shot to the end of the blasting nozzle (Tr. 698-700). But his testimony on this issue was far from clear in that he referred to the item in question as a "green hose" and there are *two* green items pictured in the photograph of the cited condition which match this description. Moreover, it seems unlikely that steel shot could have passed through this slim "hose", especially where the photograph plainly supports the hygienist's contention that the frayed cord contained internal wiring (Exhibit C-19). Under these circumstances, a violation of § 1926.416(e)(1) has been established and the item is affirmed with no penalty assessed.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

All findings of fact relevant and necessary to a determination of the contested issues have been made above. Fed. R. Civ. P. 52(a). All proposed findings of fact and conclusions of law inconsistent with this decision are denied.

ORDER

Serious citation 1, item 1, alleging a violation of 29 C.F.R. § 1926.51(b)(1), is **AFFIRMED** as a nonserious violation and a penalty of \$50 is **ASSESSED**.

¹⁹ This standard provides that "worn or frayed electric cords or cables shall not be used."

Serious citation 1, item 2(a) and (b), alleging a grouped violation of 29 C.F.R. § 1926.55(a) and 29 C.F.R. § 1926.55(b), respectively, is AFFIRMED as a nonserious violation and a penalty of \$50 is ASSESSED.

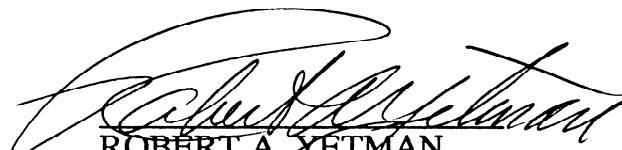
Serious citation 1, item 4, alleging a violation of 29 C.F.R. § 1926.59(f)(5)(i), is AFFIRMED as a nonserious violation and a penalty of \$50 is ASSESSED.

Serious citation 1, item 5, alleging a violation of 29 C.F.R. § 1926.59(f)(5)(ii), is AFFIRMED as a nonserious violation and a penalty of \$50 is ASSESSED.

Serious citation 1, item 6, alleging a violation of 29 C.F.R. § 1910.141(g)(2), or in the alternative, § 5(a)(1) of the Act, is VACATED together with any penalty proposed therein.

Other than serious citation 2, item 1, alleging a violation of 29 C.F.R. § 1904.2(a), is AFFIRMED as a *de minimis* violation.

Other than serious citation 2, item 2, alleging a violation of 29 C.F.R. § 1926.416(e)(1), is AFFIRMED and a zero penalty is ASSESSED.



ROBERT A. YETMAN
Judge, OSHRC

Dated: August 5, 1994
Boston, Massachusetts