SECRETARY OF LABOR,	:	
Complainant,	:	
v.	:	OSHRC Docket No. 99-0758
TRINITY INDUSTRIES, AND ITS SUCCESSORS,	:	
Respondent.	:	

ORDER

This matter is before the Commission on a Direction for Review entered by former Commissioner Gary L. Visscher on August 3, 2000. The Secretary has now filed a Notice of Withdrawal of Citation Items (Notice of Withdrawal) stating that the withdrawal of the specified items resolves all issues in the case.

In view of the withdrawal by the Secretary, we conclude that no further review by the Commission is warranted. Accordingly, the Notice of Withdrawal is approved.

We incorporate the Notice of Withdrawal into this Order and we set aside the Administrative Law Judge's Decision and Order to the extent that it is inconsistent with the Notice of Withdrawal. This is the final order of the Commission.

Date: February 2, 2001

/S/

Thomasina V. Rogers
Chairman

/S/

Ross E. Eisenbrey
Commissioner

99-0758

NOTICE IS GIVEN TO THE FOLLOWING:

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UNITED STATES OF AMERICA
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION

ALEXIS H. HERMAN

SECRETARY OF LABOR,

Complainant,

v. OSHRC Docket No. 99—0758

TRINITY INDUSTRIES,

and its successors,
Respondent.

SECRETARY S NOTICE OF WITHDRAWAL OF CITATION ITEMS

In a decision dated June 12, 2000, Administrative Law Judge James Barkley affirmed citations for violations of 29 C.F.R. § 1910.147(c) (6) (ii) (Citation 1, Item 1); 29 C.F.R. § 1910 .147(d) (4) (1) (Citation 1, Item 3); and 29 C.F.R. § 1910.254 (d) (9) (iii) (Citation 1, Item 3) issued to respondent in the instant case. After review of the record, the Secretary has determined that future litigation is not warranted and therefore withdraws the citations for violations of 29 C.FR. § 1910.147 (c)(6) (ii), 29 C.F.R. 1910.147(d) (4) (i), and 29 C.F.R. § 1910

.254(d) (9) (iii) Withdrawal of these items resolves all issues in the case.

Respectfully submitted,

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/s/

_____

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SECRETARY OF LABOR, Complainant, v. TRINITY INDUSTRIES, and its successors, Respondent.	OSHRC DOCKET NO. 99-0758

APPEARANCES:

For the Complainant:
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For the Respondent:
Robert E. Rader, Jr., Esq., Rader, Campbell, Fisher & Pyke, Dallas, Texas

Before: Administrative Law Judge: James H. Barkley

DECISION AND ORDER

This proceeding arises under the Occupational Safety and Health Act of 1970 (29 U.S.C. Section 651 *et seq.*; hereafter called the "Act").

Respondent, Trinity Industries, and its successors (Trinity), at all times relevant to this action maintained a place of business at 850 Pine Street, Beaumont, Texas, where it was engaged in building rail cars and structural steel products (Tr. 78). Respondent admits it is an employer engaged in a business affecting commerce and is subject to the requirements of the Act.

On December 2-3, 1998 the Occupational Safety and Health Administration (OSHA) conducted an inspection of Trinity's Beaumont work site. As a result of that inspection, Trinity was issued citations alleging violations of the Act together with proposed penalties. By filing a timely notice of contest Trinity brought this proceeding before the Occupational Safety and Health Review Commission (Commission).

On March 7, 2000, a hearing was held in Houston, Texas. At the hearing, "repeat" citation 2, item 1 was reclassified as "serious." (Tr. 138). The parties have submitted briefs on the items remaining at issue, and this matter is ready for disposition.

Alleged Violation of §1910.147(c)(6)(ii)

Serious citation 1, item 1 alleges:

29 CFR 1910.147(c)(6)(ii): The employer had not certified that periodic inspections of the energy control procedures had been performed:

> At the facility, where the employer did not conduct and maintain yearly audits of their lock out/tag out work practices. Hazard: Electrocution.

Facts

OSHA Compliance Officer (CO) David Doucet testified that when he asked to review Trinity's certifications for the annual audits of its lockout/tagout program, Trinity's divisional safety manager, Randy Morton (Tr. 76), was only able to produce the certification for a 1996 audit (Tr. 37; Exh. C-8). Doucet testified that Morton told him that Trinity had not conducted any audits after 1996 (Tr. 37).

At the hearing Morton testified that he believed that a lockout/tagout audit had been performed in 1997, though he had been unable to find the documentation when he started with Trinity in March of 1998 (Tr. 91). Morton testified that he did a full-blown audit himself in April 1998 (Tr. 91). At the hearing, Respondent produced certification for a lockout/tagout audit dated April 28, 1998 (Tr. 41, 91-92; Exh. R-6). Morton testified that the certification had been maintained in the Beaumont plant until approximately two weeks prior to the OSHA inspection (Tr. 92-93). Morton did not know why the documentation was missing on December 3, 1998, but speculated that it may have been removed by a disgruntled employee, a plant safety manager who left on bad terms a week prior to the inspection (Tr. 93). Morton testified that, following the December 1998 inspection, he obtained a copy of the 1998 certification from his office (Tr. 92-93).

Discussion

The cited standard provides:

> The employer shall certify that the periodic inspections have been performed. The certification shall identify the machine or equipment on which the energy control procedures was being utilized, the date of the inspection, the employees included in the inspection, and the person performing the inspection.

At the hearing Trinity produced, albeit belatedly, an April 1998 lockout/tagout certification. Safety manager Morton testified that although the certification was normally maintained at the plant, copies were also maintained at his office. The cited standard does not specify where the required certifications must be maintained. Therefore, no citation is warranted solely on the basis that the required certification was not located at the plant.

It is undisputed that Trinity had no 1997 inspection certification. Trinity argues that any citation based on the 1997 certification falls outside the six-month statute of limitations set forth in §9(c) of the Act. This judge disagrees. The Commission has held that the statute of limitations does not begin to run until OSHA discovers or reasonably should have discovered a violation. *Kaspar Electroplating Corp*. 16 BNA OSHC 1518, 1991-93 CCH OSHD ¶30,303 (No. 90-2866, 1993). Nothing in the record suggests that the Secretary should have discovered the cited record keeping violation prior to the December 1998 inspection. The citation is not, therefore, barred by §9(c) of the Act.

Penalty

A penalty of $5,000.00 is proposed for this item.

The Commission has found that record keeping violations play a crucial role in ensuring safe workplaces. *See, General Motors Corp., Electro-Motive Division*, 14 OSHC 2064, 1991-93 CCH OSHD ¶29,240 (No. 82-620, 84-731, 84-816, 1991). The cited lockout/tagout certification is intended to ensure that employers maintain an adequate lockout/tagout program. Failure to audit and certify the required program increases the likelihood that procedures will not be followed and thus increase the likelihood of an accident. However, in this case, the Secretary failed to establish that Trinity's failure to document its 1997 audit had any direct effect on employee safety. Trinity maintains that the audit was performed; a subsequent 1998 audit was apparently properly performed and documented, insuring that a lockout/tagout program is in place.

Because there is no evidence that Trinity's failure to maintain certification of its 1997 audit gives rise to a substantial probability of death or serious physical harm, Citation 1, item 1 will be affirmed as an "other than serious" violation.

Trinity is a large company, with more than 250 employees (Tr. 195). CO Doucet testified that Trinity did have a written safety program, but that it was within his discretion to determine whether it was appropriate to give Trinity any credit for good faith; none was given (Tr. 196). Doucet did not give Trinity any credit for history because they had received other "serious" citations within the last three years (Tr. 196).

As noted above, the gravity of this violation was overstated. Furthermore, CO Doucet stated that Trinity did have an adequate written safety program, and provided no rational for his failure to provide Trinity with credit for good faith. Taking into account the relevant factors, this judge finds that a penalty of $1,000.00 is appropriate, and will be assessed.

Alleged Violation of §1910.147(c)(7)(i)

Serious citation 1, item 2 alleges:

29 CFR 1910.147(c)(7)(i): The employer did not provide adequate training to ensure that the purpose and function of the energy control program was understood by employees:

> At the facility, where two employees working in conjunction with each other were not utilizing the proper lock out/tag out procedures while working on the M32 Overhead Hoist Crane located on the south end of the west bay. Hazard: Electrocution.

Facts

CO Doucet testified that Trinity has a comprehensive lockout/tagout program that, if adequately communicated to its employees, would satisfy the requirements of §1910.147(c)(7)(i) (Tr. 42, 84; Exh. R-7). Randy Morton testified that all employees are required to go through new hire orientation, which includes training in Trinity's lockout/tagout program (Tr. 83; Exh. R-1). Robert Molina and Romeo Alincastre, the employees referred to in citation 1, item 2, told Doucet that they had been trained in lockout/tagout procedures (Tr. 43). Molina testified at the hearing that he was trained when he was hired at Trinity, though he was already familiar with lockout/tagout requirements (Tr. 172). Under questioning at the hearing, Molina demonstrated his comprehension of the standard's requirements (Tr. 182-85). Doucet testified that he cited Trinity, however, because Molina and Alincastre were not employing proper lockout/tagout procedures as required by both OSHA standards and Trinity safety procedures (Tr. 43); *See*, §1910.147(f), Trinity's lockout/tagout procedures, IX. **TEMPORARY RESTORATION OF POWER.**

Discussion

§1910.147(c)(7)(i) provides:

> The employer shall provide training to ensure that the purpose and function of the energy control program are understood by employees and that the knowledge and skills required for the safe application, usage, and removal of the energy controls are acquired by employees. . .

CO Doucet testified that Trinity's lockout/tagout training program was adequate to impart the knowledge and skills required by the cited standard. Both Molina and Alincastre told Doucet that they had received Trinity's training in lockout/tagout procedures. Doucet admitted that citation 1, item 2 was based solely on Molina's and Alincastre's alleged failure to follow proper procedures.

As noted by Respondent, the mere existence of a violative condition on a work site is insufficient in and of itself to establish a lack of training. In the absence of any evidence that Molina and Alincastre were not provided adequate training, or lacked the requisite knowledge and skills, the failure of those

employees to follow proper procedures is insufficient to establish the cited violation.

Serious citation 1, item 1 is VACATED.

Alleged Violation of §1910.147(d)(4)(i)

Serious citation 1, item 3 alleges:

29 CFR 1910.147(d)(4)(i): Lockout or tagout devices were not affixed to each energy isolating device by authorized employees:

> At the south end of the west bay, where an employee was replacing the electrical contacts on a M32 Overhead Hoist Crane and was not utilizing the proper lock out/tag out procedures in that the main power supply to the crane was not locked or tagged out. Hazard: Electrocution.

Facts

CO Doucet testified that during the OSHA inspection he observed Molina, one of Trinity's maintenance electricians, working on an overhead crane from a scissor lift (Tr. 29, 100, 169). Doucet testified that the crane was not locked out (Tr. 29). Molina told Doucet, and also testified at trial, that he was troubleshooting the electrical system on the new crane to ascertain why it was not working (Tr. 31, 33, 173). Morton testified that the cited crane was new and was being installed at the time of the OSHA inspection (Tr. 99). The crane would drop its block to the floor, but would not raise it; Molina and Alincastre were to test each leg of the electrical system to determine where there was a break in the current (Tr. 99). Both Morton and Molina testified that the power needed to be on to determine where the break was (Tr. 99, 132, 174). Molina stated that he was in constant radio contact with a second employee, Romeo Alincastre, who was working with him, turning the breakers off whenever Molina moved to a new location, or needed to remove a fuse, and turned it on so that Molina could check the current with his voltmeter (Tr. 30-31, 100-01, 134, 174-76).

Doucet testified that Alincastre was not at the breaker box when he first noticed Molina, and did not appear for approximately 15 minutes, during which time the breaker box was unattended (Tr. 29-32). Morton testified that Doucet overestimated the exposure time, as they were not in the area for 15 minutes (Tr. 100-01). Molina testified that Alincastre did leave the vicinity of the breaker box for three to five minutes when his supervisor called him (Tr. 188-89). Molina stated that Alincastre told him he was leaving; Molina checked with his voltmeter to make sure the power was off, and waited for Alincastre to return (Tr. 188). Molina stated that Alincastre stepped approximately 50 feet from the breaker box, and that he could have seen the breaker box from where he was standing (Tr. 189).

Both Molina and Morton testified that there was no possibility that the crane could be unexpectedly energized, because Molina knew whether the power was off or on (Tr. 101, 177).

Morton admitted, however, that it was possible for Molina to accidentally touch the contacts he was checking (Tr. 130). Moreover, Morton admitted that it was possible for anyone to turn on the unattended breaker (Tr. 130).

Discussion

§1910.147 **The control of hazardous energy (lockout/tagout).** (a) *Scope, application and purpose*.--(1) *Scope.* (i) This standard covers the servicing and maintenance of machines and equipment in which the *unexpected* energization or startup of the machines or equipment, or release of stored energy could cause injury to employees.

* * *

Subparagraph (d)(4)(i) provides:

> Lockout or tagout devices shall be affixed to each energy isolating device by authorized employees.

It is undisputed that no lockout or tagout devices were affixed to the breaker for the crane being serviced by Trinity employees Molina and Alincastre. Trinity argues that the cited standard is inapplicable in the cited circumstances because 1) employee Molina was engaged in diagnostic work, which required that the power be on, and 2) because there could be no unexpected energization of the crane.

Diagnostic work. Initially, this judge notes that §1910.147(f) does not "dispense with lockout devices when the machine or equipment must be 'alternately energized and deenergized for testing and troubleshooting.'" [Respondent's Post Hearing Brief, p. 12]. Rather, subsection (f) *Additional requirements*, requires the employer to follow specific steps in those instances where lockout/tagout devices *must be removed* in order to energize equipment in order to test the machine, *i.e.*

> . . .the following sequence of actions shall be followed: (i) Clear the machine or equipment of tools and materials in accordance with paragraph (e)(1) of this section;
> (ii) Remove employees from the machine or equipment area in accordance with paragraph (e)(2) of this section;
> (iii) Remove the lockout or tagout devices as specified in paragraph (e)(3) of this section;
> (iv) Energize and proceed with testing or positioning;
> (v) Deenergize all systems and reapply energy control measures in accordance with paragraph (d) of this section to continue the servicing and/or maintenance.

Subparagraph (f) does contemplate the need to remove energy control measures for testing purposes. In explaining subparagraph (f) in the preamble to the final standard, however, the Secretary points out that the exception is a temporary measure, which allows the removal of the lockout or tagout devices and the reenergization of the machine or equipment only for the limited time necessary for the testing of the machine, or component thereof. 54 Fed. Reg. 36644 (Sept. 1, 1989). The standard does not contemplate the circumstances cited here, *i.e,* where an employee is *not* actively engaged in

diagnostic work, but remains in an area where he may be affected by the unexpected energization of a piece of equipment. At the time CO Doucet observed the cited violation, Molina was not conducting diagnostic testing. According to Molina's testimony, Alincastre had shut the breaker off, and Molina had ceased work while Alincastre left the area to respond to a supervisor's summons. There was no need to reenergize the crane in Alincastre's absence, and nothing prevented the use of energy control measures while the diagnostic testing was held in abeyance. Moreover, the failure to use some kind of energy control measure did create a hazard. Trinity's representative, Morton, admitted both that the breaker could have been turned on in Alincastre's absence, and that Molina could have accidentally touched an electrical contact.

When a standard contains an exception to its general requirement, the burden of proving that the exception applies lies with the party claiming the benefit of the exception. *Falcon Steel Co.*, 16 BNA OSHC 1179, 1991-93 CCH OSHD ¶30,059 (No. 89-2883, 89-3444, 1993). Moreover, exemptions to the sweep of remedial legislation must be narrowly construed and limited to effect only the remedy intended. *Pennsuco Cement and Aggregates, Inc.*, 8 BNA OSHC 1379 (No. 15462, 1980). This judge cannot find that the exemption provided at subparagraph (f) was intended to deprive an affected employee of the protection provided by the standard unless that employee was actually engaged in a testing activity that requires the removal of energy isolating devices.

Unexpected Energization. In this case, Molina testified that the diagnostic work being performed required the power to be turned on every three or four minutes, and the work would have been unnecessarily slowed by the reapplication of energy control measures between each diagnostic test (Tr. 185-87). Molina therefore determined not to use lockout/tagout devices between each energization, but to prevent the unexpected energization of the equipment by stationing Alincastre at the breaker box. Molina felt that as long as he could see the breaker box, and was in radio contact with Alincastre, there was no danger of the equipment being unexpectedly energized (Tr. 185-87).

This judge agrees that there would have been no chance that the breaker would be unexpectedly energized had Molina and Alincastre completed their diagnostic as intended. However, the moment Alincastre left the breaker box unattended, the potential for another employee to unexpectedly energize the equipment presented itself. It is not relevant that Molina and Alincastre were close enough to see the breaker box at the time of the violations; nor is it relevant that the breaker box may have been unattended for 5 minutes rather than for 15. An accident takes only a moment of inattention. Trinity's representative admitted that it was possible for anyone to turn on the unattended breaker; therefore, there *was* a chance that the crane might be unexpectedly energized.

The Secretary has established the cited violation.[1]

Penalty

A penalty of $5,000.00 is proposed for this item.

Under §17 of the Act, a violation is considered serious if the violative condition or practice gives rise to a "substantial probability" of death or serious physical harm. The substantial probability of death or serious physical harm required by the Act does not refer to the probability that an accident will, in fact, result, but only that if the accident were to occur, there would be a substantial probability that death or serious physical harm would result. *Whiting-Turner Contracting Co.*, 13 BNA OSHC 2155, 1987-90 CCH OSHD ¶28,501 (No. 87-1238, 1989). The foreseeability of an injury is irrelevant in determining whether a violation is serious. *Consolidated Freightways Corp.*, 15 BNA OSHC 1317, 1991-93 CCH OSHD ¶29,500 (No. 86-351, 1991). The danger of electrocution is a serious hazard, and the cited violation was correctly classified as "serious".

One employee, Molina, was exposed to the cited hazard for between 5 and 15 minutes. CO Doucet assessed the likelihood of an accident occurring as high. This judge believes that the probability of an accident occurring was overstated. Molina is an experienced electrician, and was in radio contact with Alincastre; he was awaiting Alincastre's return to the breaker box before resuming his diagnostic. This judge finds that the chance of Molina accidentally touching a contact after a chance employee had turned on the breaker and energized the crane, is remote. However the hazard, electrocution, justifies the CO's categorization of the gravity as high.

Because the gravity of the violation was slightly overstated, and because the CO failed to explain his refusal to accord Trinity credit for good faith, a penalty of $4,000.00 is deemed appropriate, and will be assessed.

Alleged Failure to Inspect and Remove Damaged Web Sling

Serious citation 1, item 4 alleges:

29 CFR 1910.184(d): Sling(s) and fastenings were not inspected each day or during use and were not removed from service when damaged or defective:

> In the east bay at rotator #1, where the synthetic web sling (polyester) used to suspend and rotate a rail car was not inspected before and during use to determine damages and defects which render the sling not safe for use. Hazard: Failure to support the rail car, crushing of

[1] Trinity raised the issue of unpreventable employee misconduct in its answer. Trinity, however, did not specifically brief the issue, as required by the briefing order, and it is deemed abandoned. While there is some evidence in the record that can be construed as relating to this issue, this judge cannot construct legal arguments for one party.

employees.

Serious citation 2, item 1 alleges:

29 CFR 1910.184(i)(9)(iv): Synthetic web sling(s) with broken or worn stitches were not immediately removed from service:

> In the East bay at Rotator #1, where a rail car was suspended and rotated horizontally, by the use of a synthetic web sling (polyester) located at each end of the rail car. The sling on the south end of the rotator was damaged in that the stitching was severely torn. Hazard: Failure to support the rail car, crushing of employees.

Facts

Doucet testified that at approximately 10:00 a.m. during his walkaround on December 3, 1998, he observed a suspended rail car being rotated above a jig (Tr. 18, 48-49). Doucet testified that he could see that the sling that was holding up the south end of the rail car was torn (Tr. 20, 58). Doucet stated that he could plainly see red stitching against the yellow sling (Tr. 58). Doucet testified that the manufacturer places the red stitches in the sling as an early warning indicator, so that the user can easily tell when a sling is worn or torn and needs to be replaced (Tr. 20, 23). Doucet stated that the sling was later removed from the rotator, and that he had an opportunity to examine it (Tr. 201). Doucet estimated, variously, that the sling was worn or torn approximately 1 to 1-1/2 inchs or 1-1/2 to 2 inches in from the right-hand edge (Tr. 60-62, 201). Doucet testified that the tear was not a clean cut, but was the result of wear on the sling (Tr. 206). Doucet testified that Morton argued with him at the time of the inspection, insisting that the tear went only through the protective outer padding of the sling (Tr. 23-24). Doucet maintained that the wear extended into the sling itself (Tr. 140).

Randy Morton testified that there was no way for slings to become torn or cut, and that slings only "wear" as they rub against the edge of the pulley and rotator flange (Tr. 107). Morton admitted that the protective padding on the side of the cited sling "looked terrible," but maintained that the cited sling was neither torn nor cut (Tr. 105-07). Morton testified that rotator slings are approximately six inches wide, and that their protective padding just covers the edge of the sling (Tr. 120). Morton testified that depending on the nature of each lift, a sling could wear to the point where the red threads would show between the beginning of the shift and 10:30 to 11:00 a.m. (Tr. 113). He further stated that a 1-1/2 to 2 inch tear would likely involve the sling itself, as well as the padding (Tr. 121; Exh. R-22). Nonetheless, Morton stated that the cited sling had hardly any wear at all (Tr. 106).

Morton pointed out that although Trinity's safety program requires that slings showing red warning thread be removed from use (Exh. R-23, p. 11, 5.f), the visibility of red thread is *only* a

warning, and does not indicate that a sling is unsafe (Tr. 109-10). Trinity's removal standards at R-23, p. 11, 5.f exceed the requirements of the cited OSHA standards, which are otherwise identical to Trinity's removal provisions (Exh. R-23, p. 11).

Respondent introduced a portion of a sling (Exh. R-22), and several photographs of rotator slings in use (Exh. R-15 through R-21). Those exhibits were submitted as illustrative only; the sling that was involved in this matter was not produced. Complainant did not submit any photographs of the cited sling.

Doucet testified that the employees present told him that they did not inspect, or see anyone else inspect the sling that day (Tr. 51). Doucet admitted that he did not know whether the sling had been inspected before it was used (Tr. 51).

Randy Morton testified, however, that it is Trinity's policy, and that the plant managers and supervisors are told that it is necessary to inspect slings as frequently as is appropriate (Tr. 112; Exh. R-23). Morton testified that Buddy Lindgren was the supervisor in this department, and that Lindgren had been told to inspect the slings before, and during use (Tr. 113).

Buddy Lindgren testified that he was the supervisor in charge of the rotators involved in the December 3, 1999 citations (Tr. 150). Lindgren testified that he was instructed to inspect the slings daily by the general manager and by the safety department (Tr. 152). Lindgren testified that he inspects the slings at the rotator station every morning between 4:30 and 5:00 a.m. (Tr. 152). Lindgren stated that the slings are normally inspected every time a car is rolled, either by him, or by his leadman or the operator (Tr. 152, 154). Lindgren testified that he had inspected the full length of the cited sling earlier in the day on December 3, 1998 (Tr. 154). Lindgren testified that there was no cut in the sling at that time, and that it was in usable condition (Tr. 155-58).

Discussion

§1910.184(d): provides:

> Each day before being used, the sling and all fastenings and attachments shall be inspected for damage or defects by a competent person designated by the employer. Additional inspections shall be performed during sling use, where service conditions warrant. Damaged or defective slings shall be immediately removed from service.

§1910.184(i)(9)(iv) provides:

Synthetic web slings shall be immediately removed from service if any of the following conditions are present:

(i) Acid or caustic burns;
(ii) Melting or charring of any part of the sling surface;
(iii) Snags, punctures, tears or cuts;

(iv) Broken or worn stitches; or
(v) Distortion of fittings.

The evidence establishes that Trinity's supervisor, Lindgren, had inspected the cited sling earlier in the day on December 3, 1998. Lindgren further stated that it is Trinity's policy that someone, if not himself, then a leadman or the operator, inspect the slings prior to each lift. CO Doucet agreed that if slings were inspected prior to each lift, the standard would be satisfied (Tr. 54). Lindgren did not claim to have inspected the cited sling more than once on the day of the inspection, and Doucet maintained that none of the employees he interviewed had inspected the sling or were aware of anyone else conducting an inspection.

The employees Doucet interviewed, however, were identified as welders (Tr. 24), and were not the employees responsible for inspecting the sling. Neither Trinity nor the Secretary called the leadman or operator to testify as to whether the scheduled inspections were performed. Complainant relies entirely on the existence of the worn or torn sling to establish the absence of adequate inspections, arguing that if inspected, the alleged defect in the cited sling would have been discovered, and the sling removed from use prior to the inspection.

Under Complainant's theory, then, the violation cited at citation 1, item 4 depends entirely on the Secretary's establishing that the cited sling was plainly defective. This she has failed to do.

Complainant's case rests solely on the testimony of CO Doucet that the cited sling had an obvious tear which was the result of wear. The CO apparently took no photographs of the damaged sling. Trinity's representative, Morton, directly contradicted Doucet's testimony, stating that rotator slings do not tear, and that Doucet was observing only the torn protective padding. The sling introduced by Trinity tends to support Morton's statement; the sling is approximately 3/4" thick, and would not be likely to tear as a result of normal wear absent a traumatic event.

In order to prove a violation of section 5(a)(2) of the Act, the Secretary has the burden of showing, by a preponderance of the evidence, that there was a failure to comply with the cited standard. *See, e.g., Walker Towing Corp.*, 14 BNA OSHC 2072, 2074, 1991-93 CCH OSHD ¶29239, p. 39,157 (No. 87-1359, 1991), *citing Astra Pharmaceutical Products, Inc.*, 9 BNA OSHC 2126, 2129, 1981 CCH OSHD ¶25,578, pp. 31,899-31,900 (No. 78-6247, 1981). The testimony on this issue is inconclusive. Doucet had no photographic evidence to corroborate his testimony, which is disputed. This judge is, therefore, constrained to decide this matter based on the Secretary's failure to carry her burden of proof, and so finds in favor of the Respondent.

Citation 1, item 4 and citation 2, item 1 are vacated.

Alleged Violation of §1910.254(d)(9)(iii)

Other than serious citation 3, item 1 alleges:

29 CFR 1910.254(d)(9)(iii): Cables with damaged insulation or exposed bare conductors were not replace (sic):

> At the south end of the east bay, where an employee was observed utilizing a welding lead that had damaged insulation thus exposing its inner conductor. Hazard: Shock.

Facts

CO Doucet testified that he observed a welder, Dennis Duplantis, using a lead with broken insulation (Tr. 27, 166). Doucet testified that the uninsulated portion of the lead was approximately four to five feet from the welder's feet (Tr. 27). Doucet testified that there was a good probability of the welder coming into contact with the uninsulated portion of the lead and receiving a shock (Tr. 28). Doucet did not believe the shock would have been life threatening, however (Tr. 28).

Randy Morton testified that Trinity's written safety policy requires that all cables with damaged insulation be repaired or replaced (Tr. 115; Exh. R-24). Morton stated that welders are instructed to "constantly" inspect and repair their cables by taping them or removing them from service (Tr. 116).

Buddy Lundgren testified that every three or four months he talked about repairing welding cables during his five minute safety talks with the welders (Tr. 155-56). Lundgren testified that it has been his experience, that the welders keep their equipment in good shape (Tr. 156).

Richard Lisenby, a leadperson, welder/fitter for Trinity, testified that Trinity requires its welders to inspect their welding cables to make sure they're not worn or damaged (Tr. 162). Lisenby testified that welders are reminded in daily safety meetings that they are required to replace damaged leads, and that all of them are aware of the rule (Tr. 163-65). Lisenby admitted that he was not a leadman at the time of the OSHA inspection, and was not Dennis Duplantis' leadman (Tr. 166).

Discussion

Trinity does not dispute the existence of the cited condition, but argues that it had no knowledge of the violation. Doucet's testimony that the broken insulation was in plain view, four or five feet from the feet of the welder using the lead is undisputed. As noted above, a *prima facie* case of actual or constructive knowledge is made out where established violations are in plain view. *Williams Enterprises, Inc., supra.* The violation is established.

Penalty

A penalty of $1,000.00 was proposed for this item. One welder was exposed to the cited shock

hazard for an undetermined period. The gravity of the violation is low. Trinity has a safety program that requires the inspection and repair of damaged welding cables; Morton testified that there are miles of welding cables in the Trinity plant (Tr. 114).

Taking into account the relevant factors, this judge finds that the proposed penalty is appropriate.

ORDER

1. Citation 1, item 1, alleging violation of §1910.147(c)(6)(ii) is AFFIRMED as an "other than serious" violation, and a penalty of $1,000.00 is ASSESSED.

2. Citation 1, item 2, alleging violation of §1910.147(c)(7)(i) is VACATED.

3. Citation 1, item 3, alleging violation of §1910.147(d)(4)(i) is AFFIRMED as a "serious" violation, and a penalty of $4,000.00 is ASSESSED.

4. Citation 1, item 4, alleging violation of §1910.184(d) is VACATED.

5. Citation 2, item 1, alleging violation of §1910.184(i)(9)(iv) is VACATED.

6. Citation 3, item 1, alleging violation of §1910.254(d)(9)(iii) is AFFIRMED as an "other than serious" violation, and a penalty of $1,000.00 is ASSESSED.

/s/
James H. Barkley
Judge, OSHRC

Dated: June 22, 2000