SECRETARY OF LABOR, Complainant, v. RANDALLS FOOD AND DRUGS, INC., and its successors, Respondent.	OSHRC DOCKET NO. 02-1398

APPEARANCES:

For the Complainant:
Colleen B. Nabhan, Esq., Madeleine Le, Esq., Office of the Solicitor, U.S. Department of Labor, Dallas, Texas

For the Respondent:
James J. Gonzales, Esq., Holland & Hart, LLP, Denver, Colorado

Before: Administrative Law Judge: Robert A. Yetman

DECISION AND ORDER

This proceeding arises under the Occupational Safety and Health Act of 1970 (29 U.S.C. Section 651-678; hereafter called the "Act").

Respondent, Randalls Food and Drugs, Inc. (Randalls), at all times relevant to this action maintained a place of business at 10700 Telge Rd., Houston, Texas, where it was engaged in warehousing perishable foodstuffs. Respondent admits it is an employer engaged in a business affecting commerce and is subject to the requirements of the Act.

Between January 28 and March 26, 2002, the Occupational Safety and Health Administration (OSHA) conducted an inspection of Randalls' Houston work site. As a result of that inspection, Randalls was issued citations alleging violations of §1910.119 [Process safety management of highly hazardous chemicals] of the Act, together with proposed penalties. By filing a timely notice of contest Randalls brought this proceeding before the Occupational Safety and Health Review Commission (Commission).

On June 26, 2003, a hearing was held in Houston, Texas. At the hearing, Complainant moved to amend citation 1, items 2a and 3. The amendments were unopposed, and were approved (Tr. 19-20). The citations, as amended, are reproduced below. The parties have

submitted briefs on the issues, as amended, and this matter is ready for disposition.

Alleged Violation of §1910.119(e)(5)

Serious citation 1, item 1 alleges:

29 CFR 1910.119(e)(5): The employer did not establish a system to promptly address the process hazard analysis team's findings and recommendations:

(a) On or about 1/28/02, not all recommendations made by the PHA team had been completed or followed up on.

The cited standard requires:

(e) *Process hazard analysis.* (1) The employer shall perform an initial process hazard analysis (hazard evaluation) on processes covered by this standard . . . .

* * *

(4) The process hazard analysis shall be performed by a team with expertise in engineering and process operations. . . .
(5) The employer shall establish a system to promptly address the team's findings and recommendations; assure that the recommendations are resolved in a timely manner and that the resolution is documented; document what actions are to be taken; complete actions as soon as possible; develop a written schedule of when these actions are to be completed; communicate the actions to operating, maintenance and other employees whose work assignments are in the process and who may be affected by the recommendations or actions.

Facts

In 1998, pursuant to the requirements of §1910.119, Randalls conducted a process hazard safety analysis (PHA) addressing its anhydrous ammonia refrigeration system (Tr. 69, 94; Exh. C-K). In 2000, Randalls followed up with an addendum to the 1998 analysis (Tr. 70; Exh. C-B). During her 2002 inspection of Randalls' work site OSHA Compliance Officer (CO) Melody Smith (Tr. 90-91) found that the 2000 addendum failed to document what, if any, actions had been taken to resolve recommendations made following the original 1998 study (Tr. 94-95). Specifically, Smith testified that Randalls failed to document the resolution of "Recommended Action Items" Nos. 6, 13, 16 and 21 (Tr. 98, 103).

Michael Sawyer, a registered professional engineer and process safety consultant, testified that anhydrous ammonia is a hazardous chemical based on its toxicity (Tr. 60). Employees exposed to low concentrations of ammonia can experience shortness of breath; in high concentrations, approximately 300 parts per million, ammonia envelops the body and freezes the

lungs (Tr. 61-62). The refrigeration system at Randalls' plant number one contains approximately 12,000 pounds of anhydrous ammonia (Tr. 93).

In 1998 Randalls hired Sawyer to facilitate the process hazard analysis of its anhydrous ammonia refrigeration system (Tr. 41-42). Sawyer worked with a team from Randalls consisting of Doug Wesley, Chris Conant, Joel Diaz, Joe Salsada and Patrick Bloski (Tr. 341, Exh. C-K). Chris Conant was the team's process safety management (PSM) coordinator (Tr. 341). In their 1998 report, the team identified a number of potential hazards in Randalls' process, which were ranked by priority on a scale of 1 through 4 (Tr. 71-75, 83). According to the 1998 report, those hazards ranked No. 1 were deemed unacceptable, and required priority action by management (Tr. 76; Exh. C-K). Those hazards ranked No. 2 were "undesirable" and a plan to prevent or mitigate their consequences was to be developed after all issues assigned a No. 1 had been addressed (Tr. 76; Exh. C-K). Items assigned a No. 3 were to be addressed as time permits (Tr. 76).

Recommended Action Item (RAI) No. 6 states that:

> The volume of the Ammonia Receiver and the size of the pressure relief system seem to indicate that the relief system may be undersized. There is no available information at the warehouse regarding the sizing of the relief system for the Receiver. (Exh. C-K, HazOp Recommendation Status, p. 6).
>
> The team recommends that Randalls:
>
> Consider conducting an engineering study of the Ammonia Receiver, R-0001 safety relief valves and the Receiver's connection into the Emergency Relief Station in regard to the adequacy to protect the Receiver upon overpressure conditions. (Exh. C-K, HazOp Recommendation Status, p. 6).

CO Smith testified that if the relief valves are not big enough to relieve an over-pressure situation, the ammonia receiver could rupture, exposing employees to large quantities of anhydrous ammonia (Tr. 147). Randalls' PSM team itself rated the severity of the risk as "major," *i.e.,* it found that an incident could result in a "[l]arge hazardous materials release with serious off-site impact and [was] more likely than not to cause immediate or long term health effects." (Tr. 107, Exh. C-K, p. 16). The team rated the probability of an incident as "occasional," *i.e.,* ". . .members of the team have knowledge of a similar incident at another facility or this condition could occur here in the next 1-10 years." (Exh. C-K, p. 17). The priority of the item was ranked No 1 (Tr. 107).

During her inspection, CO Smith reviewed Randalls' 2000 addendum to its 1998 analysis. With regard to RAI No. 6, the addendum states: "Ongoing/5% Valves replaced - All others will be replaced by 7012001." (Tr. 99; Exh. C-B, p. vi). Chris Conant, the lead-man on Randalls' refrigeration crew, and the PSM coordinator for the 1998 analysis, told CO Smith that the valves cost as much to test as to replace, and that the decision had been made to replace them during preventive maintenance rather than testing them (Tr. 99-102, 143-46; *See also*, testimony of Douglas Wesley, Tr. 292-93). According to Conant, Randalls had no schedule for completing replacement of the valves. As of March 26, 2002, the valves had not been replaced (Tr. 99, 100).

Douglas Wesley, Randalls' maintenance supervisor, testified that he participated in the preparation of the 1998 process hazard analysis, and the 2000 addendum (Tr. 283-85). According to Wesley, as of January 2002, when the OSHA inspection began, Randalls was awaiting the completion of a study from a consultant, Carter & Burgess (Tr. 286-88). Wesley testified that the Carter & Burgess study revealed that the relief valves in use were too small (Tr. 346). Within three weeks of the completion of the study, the relief valves were changed out (Tr. 288-89). Wesley also testified, incomprehensibly, that there was no connection between the Carter & Burgess study and the decision to change out the relief valves (Tr. 288). According to Wesley, Randalls had already purchased the valves following completion of their own study of the issue, and had scheduled them for replacement prior to July 2001 (Tr. 289, 292-94). Randalls' failure to address the issue immediately, and, alternatively, to contract for a second study from Carter & Burgess was not documented (Tr. 100, 294).

RAI Nos. 13 and 16 were ranked as priority No. 3 (Tr. 78). The hazard addressed was described as "inadequate engineering control, whereby ammonia vapors may be inadvertently released to the atmosphere during routine maintenance." (Exh. C-K, Recommendation Status Summary, p. 4). RAI Nos. 13 and 16 recommend that Randalls "consider the installation of dedicated (hard piped) depressurization lines" between compressors C2-004 and C2-005, and between compressors C2-001, C2-002, and C2-003, respectively. The lines were to be installed on the suction side of each compressor, so that the compressors could be depressurized without venting ammonia to the atmosphere (Tr. 106; Exh. C-K, Recommendation Status Summary, p. 4). CO Smith testified that at the time of the inspection, employees were depressurizing the compressors by discharging ammonia into a bucket of water, resulting in a release of ammonia

gas to the atmosphere (Tr. 105, 170). Both RAI Nos.13 and 16 were deemed serious hazards by the team, *i.e.*, they felt the release of hazardous materials could result in a recordable injury to an exposed employee, impact the community off site, and require "Agency notification" (Exh. C-K, p. 16). The subject compressors had been operating for 20 years without a hard pipe depressurization line (Tr. 295), and the team ranked the probability of an incident as "seldom," *i.e.*, members of the team have knowledge of a similar incident at another facility or, this condition could occur here in the next 10 to 100 years (Exh. C-K, p. 17).

Randalls' 2000 addendum to its 1998 analysis states that these items were reviewed, and would be completed by July 7, 2001 (Exh. C-B, p. vi) During his interview, Chris Conant told Smith that Randalls had not followed up on the team's recommendations because, while depressurizing the compressors, Randalls' maintenance personnel released ammonia gas in concentrations of only 10-20 parts per million. In addition, employees wore respirators during the operation. According to Conant, no employees were exposed to the hazardous gas (Tr. 105-06, 169-71).

Douglas Wesley testified that Randalls had determined that a hard pipe was unnecessary (Tr. 296-97). Instead, valves were installed on the compressors. According to Wesley, the compressors are now depressurized by running flexible ammonia-rated hoses between the compressors and depressurizing one into another (Tr. 296). Wesley testified that the decision to use the hoses was made in 2000; the hoses were in use by July 2001 (Tr. 297). Wesley stated that his crew was aware that the flexible hoses were available, because they had installed the valves and purchased the hoses (Tr. 301-02). Neither the decision to use hoses, nor the installation of the valves and hoses was documented (Tr. 297).

RAI No. 21 cites inadequate administrative controls that might expose maintenance personnel to ammonia, and recommends that Randalls consider preparation of line breaking and lockout and tagging procedures along with the installation of isolation valves on evaporators so that maintenance and isolation of equipment may be conducted in a safe manner (Exh. C-K, Recommendation Status Summary, p. 6). CO Smith testified that employees performing maintenance on the refrigeration equipment have to break into lines through which anhydrous ammonia circulates. Without proper procedures and means for isolating those lines, employees could be exposed to the hazardous chemical (Tr. 110). The item was ranked No. 1 by the PSM

team; the severity was rated "major" and the probability was rated "frequent," meaning that members of the team "have knowledge of a similar incident at another facility in the past 0-1 year, or this condition could occur here in the next 0-1 year" (Exh. C-K, p. 17).

Randalls' 2000 addendum to its 1998 analysis states that this item was reviewed, "and will be done when there is a major pump down" (Exh. C-B, p. vi). Conant told CO Smith that the system still needed isolation valves. According to Conant, the valves would be added as the pumps went down (Tr. 109). Wesley, however, stated that the valves were added in 2001 by Terminal Processing, a refrigeration company (Tr. 299, 301), and that the refrigeration crew was aware of the additions, though the addition of the valves was never documented (Tr. 299, 301).

Wesley testified that the need for isolation valves was for convenience rather than employee safety. Prior to the addition of isolation valves, if work had to be done on the evaporator, the whole system was pumped down, the repairs performed, and the system started back up (Tr. 298-99). The addition of isolation valves could save six hours on the turnaround (Tr. 299).

Wesley was aware of the OSHA inspection, knew OSHA inspectors had asked to see Randalls' PSM analysis, and was present at a March 26, 2002 interview during which the PSM issues were addressed (Tr. 93, 281, 343-344). However, he testified, he was never specifically asked about the abatement of the PSM issues and did not volunteer any information regarding abatement prior to the hearing in this matter (Tr. 281, 286, 299-300, 343-344, 346).

Discussion

In order to prove a violation of section 5(a)(2) of the Act, the Secretary must show by a preponderance of the evidence that (1) the cited standard applies, (2) there was a failure to comply with the cited standard, (3) employees had access to the violative condition and (4) the cited employer either knew or could have known of the condition with the exercise of reasonable diligence. *See, e.g., Walker Towing Corp.*, 14 BNA OSHC 2072, 2074, 1991-93 CCH OSHD ¶29239, p. 39,157 (No. 87-1359, 1991).

Appendix A to 29 C.F.R. §1910.119 lists those hazardous chemicals to which the standard applies when present in quantities exceeding the stated threshold amounts. The standard applies to anhydrous ammonia in quantities exceeding 10,000 pounds. Because Randalls' refrigeration system used 12,000 pounds of anhydrous ammonia, the standard is

applicable.

Randalls argues that it did comply with the cited standard by resolving the items addressed in its 1998 PHA analysis and the 2000 addendum. According to Randalls, neither rejecting PHA recommendations, nor failing to take timely action on adopted recommendations constitutes a violation of the cited standard. In addition, Randalls argues that its failure to promptly address the listed PHA recommendations did not, in itself, create a hazard.

Compliance. 29 C.F.R. §1910.119(e)(5) requires employers to assure that the recommendations of its PSM team are resolved in a timely manner and that the resolutions are documented. In regard to subparagraph (e)(5), the preamble to the Final Rule states:

> . . . In this way, when a team recommendation is incorrect, the employer can analyze it and then document in writing why the recommendation is not being adopted or is being adopted with modification. 57 Fed. Reg. 6356 (February 24, 1992).

Once the employer has resolved what actions are to be taken, the standard requires it to develop a written schedule of when such actions are to be completed. The resulting actions schedule is to be communicated to operating, maintenance and other employees who may be affected by the recommendations or actions. Finally, the standard requires that, when a recommended action is adopted, the employer complete the action "as soon as possible."

> . . . OSHA believes that when an employer decides that a recommendation requires action, then an employer shall develop a written schedule of the actions, which are to be completed. It is OSHA's intention that the actions to be taken as a result of a process hazard analysis recommendations be completed as soon as possible. In most cases OSHA believes that employers will be able to complete these actions within a one or two-year time frame, but notes that in unusual circumstances longer completion periods may be necessary.

RAI No. 6. The evidence establishes that Randalls adopted this recommendation of the PSM team, and resolved to replace the undersized relief valves on the ammonia receiver. According to Wesley, the larger valves had been purchased. The 2000 addendum to the 1998 PHA states that replacement was ongoing and would be completed by July 1, 2001. The remaining valves were not replaced until after the OSHA inspection, which was completed in March 2003. Randalls provided no documentation justifying its delay in installing the valves. It introduced no evidence documentation citing a need to conduct further study of the issue. Randalls' only witness, Doug Wesley, was unable to provide a coherent explanation for the 2002

Carter & Burgess study, instead stating that there was no connection between the study and Randalls decision to change out the valves. Moreover, during OSHA's closing conference Wesley failed to volunteer any information about the Carter & Burgess study, or about the status of the other RAIs, even though that information may have forestalled the issuance of the above captioned citation. What is clear, is that once replacement of the valves was undertaken in earnest, it took less than three weeks to completely replace all the valves on the ammonia receiver.

The record shows that Randalls failed to comply with the cited standard in regard to RAI No. 6. Once Randalls resolved to take action on the PHA team's recommendation, it was required under the terms of the standard to complete that action in accordance with the written schedule it had developed, or to document the reasons for failing to complete the actions. Randalls failed to complete the scheduled replacement of the relief valves as soon as possible or to document the reasons for that failure. The violation is established.

RAI Nos. 13 & 16. According to Doug Wesley, Randalls revised this recommendation before adopting it. Nonetheless, the 2000 addendum to the PHA stated that corrective actions addressing the perceived hazard would be completed by July 7, 2001. At the hearing, Wesley testified that valves and ammonia-rated hoses were installed on the cited compressors by the scheduled completion date. That testimony directly contradicts the information provided to CO Smith by the lead man, Chris Conant, who testified that the compressors were still being vented into buckets of water by employees using respirators. Conant's statements were made during the OSHA inspection, and as lead man he was in the best position to know what methods were actually being used. Wesley's version of events was offered only during the hearing; his testimony was largely incoherent and, in part, internally inconsistent; his manner was hostile to the Secretary. Where inconsistent, therefore, Conant's statements are credited over those of Wesley's. Seen in that light, the record shows that Randalls failed to comply with the cited standard in regard to RAI Nos. 13 and 16. Randalls failed to take prompt action in accordance with the written schedule it had developed, or to document the reasons for failing to complete the actions. Randalls failed to install valves and ammonia rated hoses on the listed compressors as soon as possible, or to document the reasons for not doing so. The violation is established.

Moreover, even if the valves and hoses were installed in 2001, as Wesley claims, a

violation has been established. Section 1910.119(e)(5) requires the employer to document and communicate to affected employees the corrective actions which have been taken in response to the PHA. Wesley admitted that the resolution of these items was not documented. Though Wesley claimed that the crew was aware of the changes, the refrigeration crew was still depressurizing the compressors by a means that released gas into the atmosphere, and protecting themselves from exposure with respirators. Clearly the decision to depressurize compressors by venting one into the other was not communicated to affected employees. Because Randalls' alleged resolution of this recommendation was not documented or communicated to affected employees, this violation is established.

RAI No. 21. The 2000 addendum to the PHA states that this recommendation was adopted and that isolation valves would be installed on the evaporators when a major pump was down. At the hearing, Wesley testified that isolation valves were installed in 2001. As discussed above, Wesley's testimony was not credible and so is discounted.

Even accepting Wesley's testimony, however, a violation has been established. As noted above, §1910.119(e)(5) requires the employer to document and communicate to affected employees the corrective actions which have been taken in response to the PHA. Wesley admitted that the resolution of these items was never documented. Though Wesley claimed that the crew was aware of the changes, Conant, the lead man in Randalls' refrigeration crew, told CO Smith that the system still needed isolation valves. No lockout/tagout procedures were produced. The evidence shows that the alleged, but undocumented addition of isolation valves was not communicated to affected employees. No lockout/tagout procedures for their use were developed or used. Because Randalls' resolution of this recommendation was not completed, documented or communicated to affected employees, this violation is established.

The existence of a hazard. Most OSHA standards include requirements or prohibitions that by their terms must be observed whenever specified conditions, practices or procedures are encountered. These standards are predicated on the existence of a hazard when their terms are not met. Therefore, the Secretary is not required to prove that noncompliance with these standards creates a hazard in order to establish a violation. *Austin Bridge Company*, 7 BNA OSHC 1761, 1979 CCH OSHD ¶23,935 (76-93, 1979). When a standard prescribes specific means of enhancing employee safety, a hazard is presumed to exist if the terms of the standard

are violated. *Clifford B. Hannay & Son, Inc.*, 6 BNA OSHC 1335, 1978 CCH OSHD ¶22,525 (No. 15983, 1978). Section 1910.119(e)(5) prescribes a specific course of action intended to protect employees from a specific hazard, *i.e.,* exposure to hazardous chemicals used in the employer's processes, in this case, anhydrous ammonia. That Randalls recognized the existence of the cited hazard is clear from the PHA created by its PSM team. For instance RAI No. 6, the most serious action item, was intended to decrease the likelihood of an "eventual over-pressurization of [the] Ammonia Receiver resulting in catastrophic rupture" (Exh. C-B, HAZOP Recommendation Status, p. 6). That the anticipated rupture did not occur during the almost four years Randalls waited to deal with this problem does not obviate the existence of the hazard addressed by the standard or justify dismissal of the citation, as suggested by Respondent.

Penalty

A penalty of $5,000.00 was proposed for the violation cited at item 1. In determining the penalty the Commission is required to give due consideration to the size of the employer, the gravity of the violation and the employer's good faith and history of previous violations. The gravity of the offense is the principle factor to be considered. *Nacirema Operating Co.*, 1 BNA OSHC 1001, 1972 CCH OSHD ¶15,032 (No. 4, 1972). In determining the gravity of the violation the judge must consider: (1) the number of employees exposed to the risk of injury; (2) the duration of exposure; (3) the precautions taken against injury, if any; and (4) the degree of probability of occurrence of injury. *Kus-Tum Builders, Inc.* 10 BNA OSHC 1049, 1981 CCH OSHD ¶25,738 (No. 76-2644, 1981).

Randalls is a large employer, with more than 250 employees in the cited facility (Tr. 113). In the event of an accident, the four refrigeration maintenance employees as well as employees in the surrounding area could be exposed to a serious hazard (Tr. 122). CO Smith testified that there was a high probability that, should a release of anhydrous ammonia occur, employees would be killed or seriously injured, suffering chemical burns to skin and tissue (Tr. 110-11, 123). The dangers posed by Randalls' failure to address the cited items had existed since the 1998 PHA study. Though some precautions were taken to prevent employee exposure to ammonia, *i.e.,* the use of respirators during decompression, it is clear that Randalls made little or no effort to promptly address the most serious hazard identified by the study. Only 5% of the undersized relief valves had been replaced in the almost four years since the PHA, though

Randalls claimed to have appropriately sized valves on hand, and could have changed them out in a matter of weeks.

The serious nature of the accident which could have resulted from Randalls' indifference to process safety, combined with its history of prior OSHA violations (Tr.114) justify assessment of the proposed penalty of $5,000.00.

Alleged Violations of §1910.119(f)

The cited standard provides, in relevant part:

> *Operating procedures* (1) The employer shall develop and implement written operating procedures that provide clear instructions for safely conducting activities involved in each covered process consistent with the process safety information and shall address at least the following elements.
> (i) *Steps for each operating phase:*
>
> * * *
>
> (D) Emergency shutdown including the conditions under which emergency shutdown is required, and the assignment of shutdown responsibility to qualified operators to ensure that emergency shutdown is executed in a safe and timely manner.
>
> * * *
>
> (G) Startup following a turnaround, or after an emergency shutdown.
> (ii) *Operating limits:*
> (A) Consequences of deviation; and
> (B) Steps required to correct or avoid deviation.

Serious citation 1, item 2a alleges:

29 CFR 1910.119(f)(1)(i)(D): The employer's written operating procedures covering the steps for each operating phase did not address emergency shutdown including the conditions under which emergency shutdown is required, and the assignment of shutdown responsibility to qualified operators to ensure that emergency shutdown is executed in a safe and timely manner:

(a) On or about 1/28/02, written operating procedures did not address emergency shut down and the conditions under which shut down is required, such as, but not limited to ammonia leaks, loss of compressors, and/or relief valve(s) going off.

Facts

Doug Wesley testified that Randalls' refrigeration system is computerized (Tr. 303). Safe operating parameters are entered into the computer, and if the system exceeds those parameters, the system will automatically shut down (Tr. 303). The computer is backed up with mechanical

devices that will shut the compressors down in the event the computer fails (Tr. 303). In the event that both the computer and the mechanical safeguards fail, there is a manual shut-off button, which can be engaged by the operator on duty (Tr. 304). Randalls' written operating procedures state at paragraph 4 :

> 4. Emergency Shutdown
>
> - A major leak must be evident in any of the zones to warrant an emergency shutdown.
> - Extremely high discharge pressure, due to no running water, can warrant an emergency shutdown.
> - In the event an emergency shutdown is required, pushing the EMERGENCY SHUTOFF button on the wall of the maintenance room will safely turn off the entire system.

(Tr. 116-18, 308; Exh. C-C, p. 4).

Doug Wesley testified that the operator on duty could be required to manually shut down the entire system in the event of a major leak, overheating, or high discharge levels, should both the computerized and manual limits fail (Tr. 308, 310-11, 353). It might also be necessary to manually shut down the system to avoid burning up the motors in the event one leg of the three phase electrical power is lost (Tr. 308-09). According to Wesley, all of the operators in the refrigeration department are trained to check for leaks by smell, with a digital sensor, or with sulphur sticks (Tr. 348-49). Burning a sulphur stick in the presence of ammonia gas will result in a white cloud (Tr. 349). Ammonia gas is flammable at concentrations of 16-25% (Tr. 351). However, Wesley testified that, with the training he had, he knew better than to put a sulphur stick into a flow of liquid or gas (Tr. 351). Wesley admitted that neither the location of all the valves or the proper procedures for checking for leaks are written (Tr. 347, 349, 352).

Wesley acknowledged that the written procedures do not tell employees how to recognize high discharge levels (Tr. 355). However, permissible discharge levels are set forth in Randalls' Exh. R-1, containing technical operating specifications and standard operating procedures for Randall's accumulators, pumps, compressors, and evaporators (Tr. 355, 357; Exh. R-1).

Randalls' written operating procedures do not clearly assign the duty of pressing the manual shut down button to the operator on duty.

Discussion

The Secretary maintains that Randalls' written procedures are deficient in that they fail to

include, in a single document, appropriate means for identifying a "major" leak, or determining whether discharge levels are excessive. They do not address the loss of a single leg of power. The procedures fail to specifically assign shutdown responsibility to maintenance personnel. The Secretary cites *Albemarle Corporation,* 18 BNA OSHC 1730, 1999 CCH OSHD ¶31,816 (Nos. 93-0848, 93-1715, 1999), in which the Commission held that although §1910.119(f)(1) is a performance standard, it plainly states that the employer's written operating procedures must provide clear instructions for safely conducting each activity in the covered processes. The required written operating procedures must address *all* of the steps for each operating phase. The Commission referred to the preamble to the PSM standards, which specify that the appropriate means of performing each task and procedure directly and/or indirectly related to a covered process must be clearly written and communicated to employees so as to ensure that safe operating procedures are consistently followed. *Id.; citing,* 57 Fed.Reg. at 6379.

Randalls' witness, Wesley, admitted that though the operators in the refrigeration department are trained in the appropriate means of checking for leaks, those procedures are not written anywhere. Nothing in the emergency shutdown procedures clearly instructs employees that the permissible discharge levels may be found in the individual technical specifications found at Respondent's exhibit R-1. Nothing in Randalls' shutdown procedures specifically assigns the responsibility for shutting down the system to maintenance personnel. Randalls' written operating procedures are deficient in the stated areas, and this item is affirmed.

Serious citation 1, item 2b alleges:

29 CFR 1910.119(f)(1)(i)(G): The employer's written operating procedures covering the steps for each operating phase did not address startup following a turnaround, or after an emergency shutdown:

(a) On or about 1/28/02, at the site located at 10700 Telge Rd. Houston, TX 77095

Facts

At paragraph seven, Randalls' operating procedures states:

7. Start Up After an Emergency Shutdown

- Check all packings on valves before starting the system.
- Make sure the cause of the emergency has been properly repairs (sic).
- Continue with regular start up operations.

(Tr. 317; Exh. C-C, p. 4-5). CO Smith testified that the start-up procedures were not sufficiently

detailed (Tr. 131). She admitted, however, that she was not familiar with regular start-up operations (Tr. 131). Randalls introduced detailed initial start-up instructions, under paragraph 1 of Randalls' standard operating procedures (Exh. C-C, p.1). The start-up procedures list 10 steps, and include safe suction and discharge pressure readings (Exh. C-C, p. 1).

Discussion

Where, as here, the Secretary fails to suggest additional provisions the employer should have included, the employer's procedures cannot be found deficient. This item is vacated.

Serious citation 1, item 2c alleges:

29 CFR 1910.119(f)(1)(i)(G)(ii)(A): The employer's written operating procedures covering the steps for each operating phase did not address consequences of deviation beyond such operating limits:

(a) On or about 1/28/02, written operating procedures did not address the consequences of deviations such as, but not limited to, deviating from accumulator pressures, compressor output rates, as well as suction and discharge pressure.

Facts

CO Smith testified that Randalls' operating procedures did not state what the consequences were of deviating from accumulator pressures, compressor output rates and suction and discharge pressures (Tr. 134-35). Operating limits, and the consequences of exceeding them are set forth in a separate document (Tr. 355, 357; Exh. R-1). For instance, Respondent's Exh. R-1 states that the Hansen NH3 pumps operate between 60-75 psi, and that a high pump discharge may engage the pressure relief valve; Operating the 17 Accumulator in excess of 150 psig may overload the compressors, engage the pressure relief valves, and, at high ammonia levels, trigger a mechanical shutdown of the compressors. (Exh. R-1, p. 1, 3).

Discussion

Randalls' technical operating specifications specifically set forth the consequences of exceeding operating limits. The Secretary has not established the violation set forth in this item, and it is vacated.

Serious citation 1, item 2d alleges:

29 CFR 1910.119(f)(1)(i)(G)(ii)(B): The employer's written operating procedures covering the steps for each operating phase did not address the steps required to correct or avoid deviation beyond such operating limits:

(a) On or about 1/28/02, written operating procedures did not address steps to correct or avoid deviations from operating limits such as, but not limited to, deviating from accumulator pressures, compressor output rates, as well as suction and discharge pressure.

Facts

CO Smith testified that Randalls' operating procedures did not instruct employees how to avoid deviating from the system's operating limits, nor did it set forth the means of correcting such deviations (Tr. 139). During the OSHA inspection Chris Conant told CO Smith that the refrigeration crew had been trained in the procedures to avoid deviations, but that the procedures had never been reduced to writing (Tr. 139, 141). According to Conant, Randalls employs experienced workers who are trained verbally (Tr. 139).

Discussion

Nothing in the operating procedures appears to address the proper methods of correcting imbalances in the system. Because the standard requires that such instructions be reduced to writing, this item will be affirmed.

Penalty

A single penalty of $5,000.00 was proposed for Randalls' violation of §1910.119(f). The gravity of the affirmed violations is high, as noted by the Secretary. An employee faced with a decision to make an emergency shutdown may not know whether he has the authority to do so. He may not have at hand the information needed to determine whether conditions exceed system limits, or may be corrected. CO Smith testified that the absence of adequate written procedures could lead to a failure to shut down the system, and to a catastrophic release of anhydrous ammonia (Tr. 122-24). Exposure to ammonia may result in death and/or serious injuries to exposed employees in the area of the refrigeration system (Tr. 129). The probability of an accident occurring is reduced due to the use of multiple automated systems monitoring the temperature, pressure and discharge levels.

Taking into account Respondent's size, prior history, the gravity of the violations, and the dismissal of two of the cited items, a penalty of $2,000.00 is appropriate and will be assessed.

Serious citation 1, item 3 alleges:

29 CFR 1910.119(j)(4)(i): Inspections and tests were not performed on process equipment to maintain its mechanical integrity:

(a) On or about 1/28/02, inspections and tests were not performed on relief valves, the

ammonia receiver and its associated piping.

The cited standard provides:

(4) *Inspection and testing.* (i) Inspections and tests shall be performed on process equipment.

Facts

Complainant stipulated that Randalls visually inspects its ammonia receiver, its pressure relief valves and its associated piping daily (Tr. 336-39). CO Smith testified that it was the Secretary's position that visual inspection was inadequate (Tr. 255). Though she was unable to state what kinds of tests Randalls should have performed, CO Smith testified that inspections or tests on the internal workings of Randalls' relief valves were required (Tr. 255). Wesley and Conant told her that it was not cost effective, and was potentially destructive to perform tests on the relief valves. Both stated that, in accordance with industry standards, and as part of its mechanical integrity program, Randalls determined instead to replace the valves on a five-year schedule to insure that they would "pop" at the pressure for which the valves were rated (Tr. 143, 293, 359-62). According to Wesley, the valves had been replaced only once after 20 years (Tr. 362). The Secretary's expert, Sawyer, opined that, in the industry, replacement of relief valves is commonly substituted for testing(Tr. 81).

Discussion

The evidence in the record establishes that, at some point, Randalls planned to replace its relief valves once every five years. The Secretary bases this item on the fact that, as of the hearing, the valves had been replaced only once, after 20 years. It is unclear, however, when Randalls developed its mechanical integrity plan, or whether it replaced the valves within five years of that time, in accordance with the plan. Because the Secretary failed to show, by a preponderance of the evidence, that Randalls failed to comply with its own plan, or to show what additional steps it should have taken to ensure compliance with §1910.119(j)(4)(i), this item is vacated.

Findings of Fact

Findings of fact relevant and necessary to a determination of all issues have been made above, Fed.R.Civ.P 52(a). All proposed findings of fact inconsistent with this decision are hereby denied.

Conclusions of Law

1. Respondent, Randalls Food and Drugs, Inc., is engaged in a business affecting commerce and has employees within the meaning of Section 3(5) of the Act.
2. Respondent Randalls Food and Drugs, Inc. at all times material to this proceeding, was subject to requirements of the Act and the standards promulgated thereunder. The Commission has jurisdiction of Respondent and the subject matter of this proceeding as it relates to said Respondent.
3. At the time and place alleged, Respondent was in violation of the standards set forth at 29 CFR §§1910.119(e)(5), 1910.119(f)(1)(i)(D) and 1910.119(f)(1)(ii)(B). Said violations were serious within the meaning of the Act.
4. Respondent was not in violation of the standards set forth at 29 CFR §§1910.119(f)(1)(i)(D) or 1910.119(f)(1)(ii)(B).
5. Respondent was not in violation of the standards set forth at 29 CFR §§1910.119(f)(1)(i)(D) or 1910.119(j)(4)(i).

ORDER

1. Citation 1, item 1, alleging violation of 29 CFR §1910.119(e)(5) is AFFIRMED, and a penalty of $5,000.00 is ASSESSED.
2. Citation 1, items 2a and 2d , alleging violation of 29 CFR §1910.119(f)(1)(i)(D) and (f)(1)(ii)(B) are AFFIRMED, and a penalty of $2,000.00 is ASSESSED.
3. Citation 1, items 2b and 2c, alleging violation of 29 CFR §1910.119(f)(1)(i)(G) and (f)(1)(ii)(A) are VACATED.
4. Citation 1, item 3, alleging violation of 29 CFR §1910.119(j)(4)(i) is VACATED.

/s/

Robert A. Yetman
Judge, OSHRC

Dated: October 27, 2003