UNITED STATES OF AMERICA
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
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SECRETARY OF LABOR,	:	
Complainant,	:	
v.	:	Docket No. 90-2785
TRINITY INDUSTRIES, INC.,	:	
Respondent.	:	

ORDER

On April 29, 1993, the Secretary filed a Notice of Withdrawal of Citation Items in the above-captioned case. The Commission acknowledges receipt of the Secretary's Notice of Withdrawal and sets aside that portion of the Judge's Decision and Order affirming the alleged violations of 29 C.F.R. § 1910.252(a)(5)(v)(e) and (f). There being no matters remaining before the Commission requiring further consideration, the Commission orders the above-captioned case dismissed.

Edwin G. Foulke, Jr.
Chairman

Velma Montoya
Commissioner

Dated May 12, 1993

NOTICE OF ORDER

The attached Order by the Occupational Safety and Health Review Commission was issued and served on the following on May 12, 1993.

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Louis G. LaVecchia
Administrative Law Judge
Occupational Safety and Health
Review Commission
Federal Building, Room 7B11
1100 Commerce Street
Dallas, TX 75242-0791

FOR THE COMMISSION

Ray H. Darling, Jr.

Ray H. Darling, Jr.
Executive Secretary

UNITED STATES OF AMERICA
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
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SECRETARY OF LABOR
Complainant,
v.
TRINITY INDUSTRIES, INC.
Respondent.

OSHRC DOCKET
NO. 90-2785

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 April 16, 1992. The decision of the Judge will become a final order of the Commission on May 18, 1992 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 May 6, 1992 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
Occupational Safety and Health
Review Commission
1825 K St. N.W., Room 401
Washington, D.C. 20006-1246

Petitioning parties shall also mail a copy to:

Daniel J. Mick, Esq.
Counsel for Regional Trial Litigation
Office of the Solicitor, U.S. DOL
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200 Constitution Avenue, N.W.
Washington, D.C. 20210

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) 634-7950.

FOR THE COMMISSION

Ray H. Darling, Jr.

Date: April 16, 1992

Ray H. Darling, Jr.
Executive Secretary

DOCKET NO. 90-2785

NOTICE IS GIVEN TO THE FOLLOWING:

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SECRETARY OF LABOR,

Complainant,

v.

TRINITY INDUSTRIES, INC.,

Respondent.

OSHRC DOCKET NO. 90-2785

APPEARANCES:

Robert A. Fitz, Esquire
Dallas, Texas
For the Complainant.

Robert E. Rader, Jr., Esquire
Dallas, Texas
For the Respondent.

Marcos G. Ronquillo, Esquire
Dallas, Texas
On behalf of the Spanish-speaking witnesses.

DECISION AND ORDER

Before: Administrative Law Judge Louis G. LaVecchia

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

The Occupational Safety and Health Administration ("OSHA") conducted an inspection of Respondent's Plant 26 in Ft. Worth, Texas, pursuant to a tragic accident which occurred on April 11, 1990. As a result of the inspection, one serious and one "other" citation were issued. Respondent contested the citations, and this matter was heard on April

11, 12 and 17, 1991. A background of the facts of this case is set out below, followed by a discussion of the alleged violations.[1]

Background

Plant 26 consists of various departments engaged in the manufacture of railroad cars and parts and liquid petroleum gas ("LPG") tanks. Bay 5 is part of Department B and is dedicated exclusively to the production of LPG tanks, which arrive in that bay as open-ended rolled steel cylinders. The employees in Bay 5 weld the seams of the cylinders and then weld the ends or "heads" onto the tanks, which sit on rollers and are rotated to facilitate welding. The employees also weld pipes and other parts onto the tanks. The welding is performed with torches fueled by hoses attached to a manifold to which oxygen and natural gas are piped; regulators and valves on the manifold control the flow of gas and oxygen. (16; 22-23; 27-29; 58-62; 100-06; 171-72; 179-82; 255).

At the beginning of the shift on April 11, 1990, Armando Portales, the leadman in Bay 5, told Jesus Zurita and Raymundo Torres to install some pipes inside a particular tank.[2] The tank was 19 feet long and 8 feet high and its seam was welded and both heads were installed. There was a manway at the bottom of the tank and another opening in one of the heads. Torres entered the tank through the manway, and Zurita passed him the torch hose through the opening in the head. The hose was connected to the manifold at this time, but the lines were turned off and the torch head was disconnected. Torres connected the torch head to the hose and told Zurita he was ready, after which he exited the tank and Zurita turned on the valves to the gas and oxygen lines. At that point Zurita remembered

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[1]As issued, serious citation number 1 had sixteen items and "other" citation number 2 had two items. However, prior to the hearing the parties reached a partial settlement agreement which has been reduced to writing and is part of the record. Pursuant to the agreement, the Secretary withdrew items 6, 8 and 11 of citation 1 and withdrew the proposed penalty for item 1 of citation 2, after which Respondent withdrew its contest of citation 2. Moreover, the Secretary submitted a written notice of withdrawal after the hearing in regard to items 4, 14, 15 and 16 of citation 1. The disposition of the settled and withdrawn items are set out in my Conclusions of Law and Order, *infra*. The remaining items requiring resolution are items 1, 2, 3, 5, 7, 9, 10, 12 and 13 of citation 1.

[2]Zurita and Torres had worked at the facility about two years at this time. The other welders in Bay 5 that day were Toribio Garcia, Pedro Barrios, Humberto Solano and Roberto Carmona. (Tr. 27; 63; 342-43; 402).

some pipes he needed. He told Torres to retrieve the torch and wait for him outside the tank while he got the pipes, which were about 60 feet away. As he was returning, he heard an explosion and saw Torres, who was on fire, exiting the tank through the manway. Torres died from his injuries a few days later. (Tr. 55; 62-68; 104; 110-11; 343-54).

Gerald Forrester, the OSHA compliance officer ("CO") who inspected the site, concluded the accident was caused by Torres' failure to properly tighten the torch/hose connection and the accumulation of gas in the tank, which resulted in an explosion when Torres reentered the tank and attempted to light the torch or caused a spark in the welding cable electrode. (Tr. 224-27; 280).

Item 1 - 29 C.F.R. § 1910.252(a)(1)(iv)

Gerald Forrester testified that the plant was required to have readily available written operating procedures for welding and cutting from the manifold system, including procedures for the inspection and use of the regulators, gauges and hoses and instructions on how to perform a leak test. He said the citation was issued because the employee safety manual did not have all the required procedures. (Tr. 232-34; 271-78).

Danny Fanning has been the foreman of the LPG area for just over a year; he has 20 years experience in welding and welding supervision. He testified he tells the Bay 5 welders to check their equipment and not use it if defective, to not leave torches and lines unattended in tanks, to test for leaks by hooking up the torch and turning the valves on and off and checking the regulator for a drop in pressure, and to use a ventilator when working in an enclosed tank. Fanning said employees are instructed in these matters daily and in monthly safety meetings.[3] He also said he inspects Bay 5 monthly and on a continuous basis each day; if he finds a violation of the procedures the employee is reprimanded verbally or in writing, depending on the circumstances. Fanning noted he relies on Portales to give instructions about 50% of the time, as the Bay 5 employees are not fluent in English. He also noted bilingual employees translate at monthly safety meetings and when any safety films are shown. (Tr. 15-31; 37-53; R-1-2).

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[3]Fanning said that to the best of his knowledge, he himself had instructed Torres in the use of the welding equipment. He also said he had observed Torres and considered him a competent welder. (Tr. 29-31).

Michael Rawlings has been the manager of Plant 26 for almost two years; he has been with Trinity for eleven years and has 18 years experience in welding and welding supervision. He testified that new employees are given a safety orientation and trained in the hazards of their particular job, and that if an employee is not bilingual, an interpreter is provided. He said R-6, Trinity's employee safety manual, is given to new hires and discussed with them; it is also redistributed every twelve to eighteen months and available on request. Rawlings noted employees are given safety training on a daily basis as well as in monthly safety meetings; he identified R-1, R-4, R-7 and R-12-14 as records of meetings for Department B in which welding safety was discussed, and R-15 as a video on welding safety shown in May 1989. Rawlings also noted that plant employees interpret during all meetings and films. (Tr. 98-100; 123-24; 127-30; 135-38; 168-73; 368-70; 392-94; 401).

Rawlings said the plant had standard operating procedures to check hoses, torches, gauges and regulators, to perform leak tests by turning the system lines on and off and then checking for a drop in pressure, to use a ventilator when working in an enclosed tank, and to not leave a torch or line in a tank; if a leak is detected or a torch or line is found in a tank, the employee is to notify his foreman or leadman. Rawlings noted employees are trained in these procedures and to recognize and report defective equipment. He further noted he followed these procedures when he was a welder, and that he trained others in them when he was a foreman. He observed that some of the procedures are in R-6, some are common sense and some are communicated "one-on-one." (Tr. 141-46; 176-77; 190-91; 366-68).

Rawlings noted Fanning inspects Bay 5 monthly and daily for safety hazards, and that he himself walks through the area several times a day; if violations of plant rules are found, the employee is given a verbal warning and a written warning if necessary. Rawlings said a continued violation could result in termination or leave without pay, but that this was not a problem at the plant. He also said he had found that the employees in Bay 5 observed the rules. (Tr. 125-27; 138; 146-47; 151-53; 383-84).

Armando Portales has been a welder since 1968 and has worked at the plant for fourteen years. He testified he tells the employees under him what to do and how to work

safely pursuant to Fanning's instructions.[4] Portales noted he told Zurita and Torres how to check their hoses, how to cut and how to know when a torch was not working; he also told them to not leave torches or lines in tanks, to leak-check equipment by turning the gas on and off and checking for a drop in pressure, and to notify him if leaks were detected. Portales said he had had Zurita perform the leak test before letting him weld, and that he was aware of no instances of employees not using a blower, or ventilator, when working in enclosed tanks. (Tr. 54-56; 61; 68-70; 76; 82-83).

Toribio Garcia and Pedro Barrios have been welders at the plant for thirteen years. Each testified Fanning had given him instructions in the use of the welding equipment and had told him to check lines and hoses before using them, to make sure all connections were tight and to check for leaks by turning off the gauges and checking for a drop in pressure.[5] Both had had to demonstrate the use of a torch, and neither had ever welded in a closed tank without a blower.[6] Both had been informed of the hazards of welding, and both said interpreters were provided at monthly safety meetings and videos. (Tr. 86-97; 200-14).

Jesus Zurita testified that although he left the gas and oxygen valves open without having done the leak test, he had it in his mind that either he or Torres would perform the test when he returned.[7] He said it was not customary to leave the valves open without checking for leaks, and that neither he nor Torres, to his knowledge, had done so before. He also said torches are not normally left in tanks. Zurita noted he always used a blower when working in a closed tank; he said the blower is connected to a hose which is pulled in after the worker through the manway, and that at the time of the accident the blower hose was in front of the tank ready to be pulled inside. (Tr. 351-55; 362-64).

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[4]Although Portales testified through an interpreter, he said he understood the instructions he received at work. (Tr. 53-57).

[5]Garcia and Barrios testified through an interpreter, but indicated they understood the instructions they received at work. (Tr. 86; 90; 200; 206-07).

[6]Barrios testified R-10 looked like the extractor, or ventilator, he used. (Tr. 208; 214)

[7]Zurita testified through an interpreter. (Tr. 342).

The subject standard provides in pertinent part as follows:

> Rules and instructions covering the operation and maintenance of oxygen or fuel-gas supply equipment including generators, and oxygen or fuel-gas distribution piping systems shall be readily available.

1910.252(a)(1)(iv) does not specifically state that rules and instructions be in writing; however, such a requirement is implicit in the "readily available" language of the standard. Moreover, while no degree of specificity is provided, the clear intent of the standard is for rules and instructions to be written in sufficient detail to adequately convey the operating procedures to employees. Based on the record, R-6 was the only written information available to employees in regard to procedures for gas welding and burning. R-6 instructs employees to inspect valves, regulators and hoses to determine they are in good operating condition, and to tag out and report defective equipment. It also instructs employees to not weld on any container that has contained flammable materials until it has been cleaned and checked with a meter, and to not leave gas cutting equipment in confined areas during breaks, since "[e]ven a small leak could cause an explosion when torches are relighted." *See* R-6, pp. 6-9. R-6 does not tell employees to tighten connections, to leak-test equipment, or to use a ventilator when working in an enclosed tank. Due to the obvious importance of these rules, they were required to be included in R-6. However, it is concluded the violation is properly classified as *de minimis*, since the record shows that the failure of Torres and Zurita to follow the rules was unpreventable employee misconduct, as follows.

To demonstrate unpreventable employee misconduct, an employer must show it established and adequately communicated work rules designed to prevent the violations. It must also show it made efforts to discover violations and effectively enforced the rules when it detected violations. *Jensen Constr. Co.*, 7 BNA OSHC 1477, 1479, 1979 CCH OSHD ¶ 23,664, p. 28,695 (No. 76-1538, 1979). The record demonstrates the plant had established welding procedures which embraced the rules set out above and that employees, including Torres and Zurita, were trained in the procedures. It also demonstrates the plant made efforts to discover violations of the procedures through daily and monthly inspections, and that it enforced the procedures through disciplinary actions when violations were detected. The failure of Zurita and Torres to leak-test the equipment and, more significantly, Torres'

apparent attempt to light the improperly connected torch after it was left in the tank without using the ventilator, even after Zurita told him to wait until he returned, were clearly violations of the procedures in which both employees were trained. Based on the record, it is found the accident was the result of unpreventable employee misconduct. This citation item is accordingly affirmed as a *de minimis* violation, and no penalty is assessed.

Items 2 and 3 - 29 C.F.R. §§ 1910.252(a)(5)(v)(e) and (f)

Gerald Forrester testified the oxygen hose involved in the accident, shown in C-24, had a joint improperly held together with wire. He further testified that another part of the hose had what appeared to be a burned spot which, based on his measurements, was not caused by the accident. Forrester noted the burned spot weakened the hose and made it brittle, and that the wire would in time cut into the hose after continued pressurization and depressurization; in his opinion, either condition could cause a leak and a fire if the hose was used in an enclosed tank. Forrester said the hose should have been tested at 300 psi due to its defects, but that it should have been taken out of service in any case because of the unacceptable wire repair. He also said Portales was aware of the improper repair and had used the hose in that condition the day before the accident. (Tr. 234-42; 278-87).

Armando Portales testified he did not inspect the gas and oxygen hoses before Torres and Zurita used them the morning of the accident, but that he had inspected them one or two days before. He said he did not see any burns on them, and that while one of them was repaired badly with wire instead of the ringlets that are normally used, he leak-tested the hose and it was working properly. (Tr. 78-79; 84).

Danny Fanning testified he visually checks the entire LPG area for safety problems the first thing in the morning and throughout the day. He said his checks include welding equipment and hoses, and that if he finds defective equipment he takes it out of service and has it repaired. Fanning noted he had inspected the LPG area before the accident, but that he did not check the equipment Torres used. He also noted that Portales was a competent welder and that he would be surprised if he did not follow the rules regarding welding equipment. (Tr. 16; 25-26; 33; 38; 41; 50-51).

Michael Rawlings testified he examined the hose at the time of the inspection, and that he considered it unfit for service due to the wire splice. He said Portales was a competent welder who was trained to remove defective equipment from service, and that he would not have expected him to use the hose in that condition. His opinion was that although the splice was unacceptable, there was no hazard; the wire had not dug into the hose, and while the hose had a working pressure of 250 psi and a bursting pressure of 800 psi, it was subjected to only 120 psi. Rawlings also opined the hose would not get past one's day service due to Fanning's daily checks of the area. (Tr. 136-37; 140; 151-54; 174-75; 371-74; 394).

Jerry Riddles was Trinity's corporate safety director at the time of the accident; he is a certified safety professional with 17 years experience in the metal fabrication industry and is currently an occupational safety and health consultant. He testified he had examined the hose, and that while it should have been taken out of service because of the splice it was not unsafe due to its 800 psi bursting pressure and the fact the wire had not eaten through it. Riddles did not test the hose at 300 psi, and did not know if anyone else had. (Tr. 406-11; 427-30; 444).

1910.252(a)(5)(v)(e) provides as follows:

> Hose connections shall be clamped or otherwise securely fastened in a manner that will withstand, without leakage, twice the pressure to which they are normally subjected in service, but in no case less than a pressure of 300 p.s.i. Oil-free air or an oil-free inert gas shall be used for the test.

The record demonstrates the hose was improperly repaired, and that it had not been tested to determine whether it could withstand a pressure of 300 psi. Respondent contends no violation occurred because the Secretary failed to show the hose could not withstand 300 psi and that it was a hazard under the circumstances. I disagree. The standard, as I read it, presumes a hazard and requires the testing of hose connections at no less than 300 psi. Since no such testing was performed in this case, a violation has been established unless Respondent is able to demonstrate one of the affirmative defenses recognized by the Commission.

Respondent asserts the condition was the result of unpreventable employee misconduct. As noted *supra*, to demonstrate unpreventable employee misconduct an

employer must show it both established and adequately communicated work rules designed to prevent the violation. *Jensen Constr. Co.*, 7 BNA OSHC 1477, 1479, 1979 CCH OSHD ¶ 23,664, p. 28,695 (No. 76-1538, 1979). The 1910.252(a)(1)(iv) discussion, *supra*, shows employees were told to check welding equipment and tag it out and not use it if defective. However, the fact that not only Portales, a leadman, but also Torres and Zurita failed to tag out the hose shows employees were inadequately instructed in this rule, and Respondent's assertion of unpreventable employee misconduct is rejected. Respondent's claim that Fanning would have detected the condition is also rejected, since it is clear he did not discover it the day of the accident or the day before. This citation item is accordingly affirmed as a serious violation.

1910.252(a)(5)(v)(f) provides as follows:

> Hoses showing leaks, burns, worn places, or other defects rendering it unfit for service shall be repaired or replaced.

The CO recommended this citation item due to the wire splice and what he believed to be a burned spot on the hose. Respondent presented the testimony of Rawlings and Riddles in regard to the burned spot, which was that it did not render the hose unfit for service because it did not damage the integrity of the hose. (Tr. 375-76; 428-29). Regardless, it is clear the splice rendered the hose unfit for service, and, since Respondent failed to demonstrate unpreventable employee misconduct, that that condition violated the standard. This item is affirmed as a serious violation.

The Secretary proposed a penalty of $1,000.00 for each of these items. After giving due consideration to the employer's size, history and good faith, as well as to the gravity of the violations, it is concluded that the assessment of the proposed penalties is appropriate.

Items 5, 9 and 10

29 C.F.R. §§ 1910.252(d)(2)(iv), (xiv)(e) and (xv)

Danny Fanning testified his visual checks of the LPG area include each individual tank, and that he had inspected the subject tank at the beginning of the shift. He said the tank was new and had had nothing in it, but that if he had seen welding equipment in it, the equipment would have been removed and the tank ventilated and tested before employees

would have been allowed to work in it. Fanning noted any instructions he had given that morning had been to Portales, who knows the stages of the Bay 5 work processes and schedules the work to be done. He said that although employees did not get his approval to enter the tank and he did not specifically grant authorization to proceed, if he had seen anything hazardous he would have told Portales and the other employees in the area to not proceed until it was corrected. (Tr. 24-28; 31-35; 38-41).

Michael Rawlings testified Fanning checks the tanks every morning for any problems, such as a torch hose inside a tank, which would indicate a potentially hazardous atmosphere; if he finds such a condition, he advises Portales and the others in the area to not go in the tank until he has checked it with a meter. Rawlings further testified that if a welder finds such a condition, he is to notify his leadman or foreman. (Tr. 190-91; 383-85).

1910.252(d)(2)(iv) provides as follows:

> *Authorization.* Before cutting or welding is permitted, the area shall be inspected by the individual responsible for authorizing cutting and welding operations. He shall designate precautions to be followed in granting authorization to proceed preferably in the form of a written permit.

The record shows that Fanning inspected the subject tank and determined it was safe for welding, and that this was his normal practice each morning in regard to all of the tanks. The record also shows that had Fanning discovered a potential hazard in the tank, he would have advised Portales and the other employees in the area to not proceed until it was corrected. Fanning admitted he did not affirmatively grant authorization for welding to proceed, which requirement is implicit in the language of the standard. However, I find the plant complied with the standard's intent, which is to assure the inspection of areas in which welding is to occur and the designation of any precautions to be followed.[8] This citation item is therefore affirmed as a *de minimis* violation, and no penalty is assessed.

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[8]I conclude that inspection and designation of precautions prior to each and every entry of a tank was not required. Fanning's tank inspection procedures at the beginning of the shift, when considered in conjunction with the operating procedures employees were trained to follow as set out in item 1, *supra*, were sufficient to meet the intent of this standard. This conclusion is equally applicable to items 9 and 10, *infra*.

1910.252(d)(2)(xiv)(e) provides as follows:

> [The Supervisor] [s]hall determine that the cutter or welder secures his approval that conditions are safe before going ahead.

As noted *supra*, the record shows it was Fanning's practice to advise Portales and the other employees in the area to not proceed when he discovered hazardous conditions. The record also shows Portales instructed the employees under him as to the work to perform each morning, and that he did so the day of the accident. (Tr. 65; 344-46; 364). Although the Bay 5 welders did not secure Fanning's approval before proceeding, it is clear they would have known to not proceed had Fanning detected a hazardous condition. It is concluded the plant complied with the intent, if not the strict letter, of the subject standard. This item is accordingly affirmed as a *de minimis* violation, and no penalty is assessed.

1910.252(d)(2)(xv) provides as follows:

> *Fire prevention precautions*. Cutting or welding shall be permitted only in areas that are or have been made fire safe. When work cannot be moved practically; as in most construction work, the area shall be made safe by removing combustibles or protecting combustibles from ignition sources.

The intent of this standard, as I read it, is to require the inspection of areas in which welding is to occur to assure they are fire safe. As noted *supra*, the record establishes that Fanning inspected the subject tank and determined it was safe for welding, and that this was his normal practice each morning in regard to all of the tanks. Since the plant was in compliance with the standard, this citation item is vacated.

Item 7 - 29 C.F.R. § 1910.252(d)(2)(xiii)(c)

Gerald Forrester testified he concluded employees were not properly trained in the hazards of welding based on Torres' failure to follow plant procedures and Zurita's inability to perform the leak test. Forrester explained that he asked to see Zurita perform the test after Rawlings demonstrated it; Zurita began the test but was unable to do it, after which Portales intervened and helped him. (Tr. 251-52; 292-93; 298).

Michael Rawlings testified that after Zurita began the test, Portales intervened and showed him how without giving him the chance to finish it on his own. Rawlings said Portales was trying to be helpful, and that he did not understand they wanted Zurita to do

the test by himself. He also said he had independent knowledge of Zurita's ability to perform the test. (Tr. 378-80).

The subject standard provides as follows:

> *Management.* Management shall recognize its responsibility for the safe usage of cutting and welding equipment on its property and: [i]nsist that cutters or welders and their supervisors are suitably trained in the safe operation of their equipment and the safe use of the process.

The CO recommended this item because of Torres' failure to follow plant procedures and because he believed Zurita did not know how to perform the leak test. However, as concluded in item 1, *supra*, Torres' actions on the day of the accident constituted unpreventable employee misconduct. Moreover, Zurita's testimony set out in item 1 indicates he did know how to conduct the leak test, and Rawlings' explanation of his failure to finish the test and Portales' intervention is reasonable. Based on the record, the plant was not in violation of the subject standard. This citation item is vacated.

Item 12 - 29 C.F.R. § 1910.252(e)(4)(iv)

Danny Fanning testified the plant's normal practice is to have an attendant stationed outside a tank when someone is working in it, but that there were no safety harnesses or other means in the area to get an employee out quickly. He said only one welder or cutter would work in a tank at any one time, and that in this case, Zurita was to be outside the tank. (Tr. 35-36).

Armando Portales testified it was not the normal procedure to have an employee outside the tank when another was working inside. He said Torres and Zurita were to be in the tank at the same time, which was normal, and that while one was to weld and the other cut, they would not do both at the same time. Portales noted there was nothing to remove an employee in case of an emergency, but that there were fire extinguishers in the area. (Tr. 67-68; 72).

Jesus Zurita testified he and Torres were to have worked in the tank at the same time, one cutting or welding and the other holding the piping in place. He said this was customary, depending on the work involved, and that no one was to be stationed outside the tank. (Tr. 361-62).

Michael Rawlings testified that although there could be two employees in a tank at the same time, only one would be welding or cutting. He further testified that while there are places in the plant where employees use harnesses so that they can be pulled out in emergencies, this was not done in Bay 5; there are pipes and brackets in the tanks on which a harness or line could become tangled, and the tanks are small, such that someone can reach into the manway and get an employee out easily. Rawlings explained that although the manways are off-center, a welder going down in a tank would fall to the bottom and towards the manway because of the shape of the tank, and that even if a manway was positioned at the top the tank could be rotated to position the manway at the bottom to facilitate the removal of a welder who had lost consciousness or needed help getting out. (Tr. 150; 380-83; 397-99).

The subject standard provides as follows:

> *Lifelines.* Where a welder must enter a confined space through a manhole or other small opening, means shall be provided for quickly removing him in case of emergency. When safety belts and lifelines are used for this purpose they shall be so attached to the welder's body that his body cannot be jammed in a small exit opening. An attendant with a pre-planned rescue procedure shall be stationed outside to observe the welder at all times and be capable of putting rescue operations into effect.

Respondent contends the standard does not require safety belts and lifelines, and that removal through a manway positioned at the bottom of the tank is the quickest and easiest means of extricating an employee in an emergency. While I agree that safety belts and lifelines are not required, a violation has been established even assuming *arguendo* the validity of Respondent's assertion. The standard requires an attendant to be stationed outside whenever a welder is in an enclosed tank. Although Fanning testified this was the plant's normal practice, Portales and Zurita said it was not and Rawlings did not testify in this regard. Based on the record, it can only be concluded the plant did not require an attendant to be stationed outside when welders worked in enclosed tanks. The serious nature of the violation is obvious; accordingly, this item is affirmed as a serious violation and the Secretary's proposed penalty of $1,000.00 is assessed.

Item 13 - 29 C.F.R. § 1910.252(f)(2)(i)(c)

Gerald Forrester identified R-10 and R-11 as the two blowers he saw, and C-27 as a fax from the manufacturer of the blower which states its air flow rate is 2000 cfm. He opined one blower would not adequately ventilate an enclosed tank with two people inside, even if only one of them was welding. He further opined that C-26, a large pedestal fan he saw in Bay 5, was inadequate to ventilate an open-ended tank or a tank with only one head installed, particularly since no one was able to give him its air flow rate. Forrester did not observe the operation of the fan or the blowers.[9] (Tr. 253-66; 294-96).

Michael Rawlings testified that when welders work in enclosed tanks, the ventilators in R-10 and R-11 are used. He said a welder can have the ventilator blow air into or suck it out of a tank by attaching the hose to either the exhaust side or the intake side. Rawlings noted the ventilator has an air flow rate of 2579 cfm, based on R-16, the manufacturer's capacity specifications, and that once it is running and the air hose is attached and taken into a tank it will effect a complete air change in less than thirty seconds. (Tr. 149-51; 177; 385-88).

Rawlings further testified that when welders work in open-ended tanks, 36-inch pedestal fans are used for ventilation, and that when working in a tank with one end closed, either a pedestal fan or a ventilator can be used. Rawlings did not know the air flow rate of the pedestal fans, but said he had been in tanks when they were used. He noted they put out about three times as much air as the ventilators and create a perfect ventilation when correctly positioned. (Tr. 177-79; 391-92).

The subject standard provides, in pertinent part, as follows:

> Mechanical ventilation shall be provided when welding or cutting is done ... [i]n confined spaces or where the welding space contains partitions, balconies, or other structural barriers to the extent that they significantly obstruct cross ventilation.

Although the standard does not specify the rate of ventilation to be provided, 1910.252(f)(2)(ii) states that ventilation "shall be at the minimum rate of 2000 [cfm] per

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[9]Although Forrester's testimony about the blowers and pedestal fan pertains to item 14, which, as noted *supra*, was withdrawn by the Secretary, it is nonetheless relevant to the subject item.

welder." As noted *supra*, items 14 and 15, which alleged violations of 1910.252(f)(2)(ii) and (f)(4)(i) due to inadequate ventilation, were withdrawn by the Secretary after the hearing, which indicates a lack of proof in regard to those items. Regardless, it is clear that no violation of the subject standard occurred. C-27 shows the ventilators or blowers used in Bay 5 have an air flow rate of 2000 cfm, and the testimony set out in item 12 shows that while two welders might be in a tank at the same time, only one would be welding or cutting. The ventilators were therefore in compliance with the minimum requirement of 2000 cfm per welder. In regard to the pedestal fans, while the CO opined they were inadequate, he did not see them operate. Rawlings, on the other hand, testified the fans put out about three times as much air as the ventilators and that they created a perfect ventilation when properly positioned. Based on Rawlings's testimony, which was not rebutted, the use of the pedestal fans did not violate the standard.

The CO did not specifically testify about this item; however, based on his other testimony it would appear he recommended this item in part due to Torres' failure to use the ventilator the day of the accident. (Tr. 298). As found in item 1, *supra*, Torres' actions that day constituted unpreventable employee misconduct. Moreover, the testimony set out in item 1 demonstrates the welders in Bay 5 were instructed to use the ventilators when working in enclosed tanks, and that they in fact did so. This citation item is accordingly vacated.

Conclusions of Law

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

2. Respondent was in *de minimis* violation of 29 C.F.R. §§ 1910.252(a)(1)(iv), 1910.252(d)(2)(iv) and 1910.252(d)(2)(xiv)(e).

3. Respondent was in serious violation of 29 C.F.R. §§ 1910.252(a)(5)(v)(e), 1910.252(a)(5)(v)(f) and 1910.252(e)(4)(iv).

4. Respondent was not in violation of 29 C.F.R. §§ 1910.252(a)(5)(vi)(a), 1910.252(d)(2)(vi)(c), 1910.252(d)(2)(xiii)(c), 1910.252(d)(2)(xiv)(a), 1910.252(d)(2)(xv), 1910.252(d)(4)(ii), 1910.252(f)(2)(i)(c), 1910.252(f)(2)(ii), 1910.252(f)(4)(i) and 1910.1200(h).

5. Respondent was in nonserious violation of 29 C.F.R. §§ 1904.8 and 1910.1200(q)(11).

Order

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

1. Items 1, 5 and 9 of citation number 1 are AFFIRMED as *de minimis* violations, and no penalties are assessed.

2. Items 2, 3 and 12 of citation number 1 are AFFIRMED as serious violations, and a penalty of $1,000.00 is assessed for each item.

3. Items 4, 6, 7, 8, 10, 11, 13, 14, 15 and 16 of citation number 1 are VACATED.

4. Items 1 and 2 of citation number 2 are AFFIRMED as nonserious violations, and no penalties are assessed.

Louis G. LaVecchia
Administrative Law Judge

DATE: APR -1 1992