

United States of America
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
1924 Building - Room 2R90, 100 Alabama Street, SW
Atlanta, Georgia 30303-3104

Secretary of Labor,
Complainant,
v.
Allegheny Rebar, Inc.,
Respondent.

OSHRC Docket No. **04-0268**

Appearances:

John M. Strawn, Esq., U. S. Department of Labor, Office of the Solicitor, Philadelphia, Pennsylvania
For Complainant

Nathan Zarichnak, Esq., Nigro & Associates, LLC, Pittsburgh, Pennsylvania
For Respondent

Before: Administrative Law Judge Nancy J. Spies

DECISION AND ORDER

Allegheny Rebar, Inc. (Allegheny), manufactures steel rebar from billets at a facility located in Glassport (in metropolitan Pittsburgh), Pennsylvania. Its physical plant, which covers an estimated 100,000 square feet, was constructed in the late 1800s or early 1900s (Tr. 24, 136).

The Occupational Safety and Health Administration (OSHA) first inspected Allegheny in 2002, although it had inspected the same facility under the previous owner. The Allegheny I inspection disclosed a substantial number of safety and health violations. As a result, in early 2003 OSHA cited Allegheny with 43 serious and one “nonserious” violations. On April 17, 2003, the parties resolved the case and signed a settlement agreement. Allegheny admitted that it violated the standards and agreed to make installment payments on a reduced penalty. OSHA understood that Allegheny would abate the violations because it was closing the plant. If it re-started operations, the violations would first be corrected.

After a further complaint and a referral, OSHA compliance officer Leah Balya and Assistant Area Director Frank Librich conducted the Allegheny II inspection from July to October 2003. As a result of the second inspection, on January 12, 2004, the Secretary issued to Allegheny three

citations. Citation No. 1 is classified as serious and alleges 24 separate violations (numbered 1 through 18). Citation No. 2 is classified as repeat and alleges 41 separate violations (numbered 1 through 41). Citation No. 3 is “other than serious.” The Secretary recommended a total penalty of \$171,300.00 for the 65 serious and repeat violations.¹

Allegheny initially contested the existence of violations and the amount of the Secretary’s proposed penalties. Prior to the hearing it stipulated that it violated each of the standards as alleged. Only the amount of the penalties remains in dispute. The Secretary contends that these penalties are minimal for a company which has shown itself to be “an industrial scofflaw” (Tr. 13). Allegheny asserts that the proposed penalties are excessive for a company and owner doing their best while attempting “to invest in a business in a precarious state” (Tr. 16).

A hearing was held on March 8, 2005, and was reconvened on April 4, 2005. The parties presented their post-hearing arguments on the record, and the case is ready for decision. For the reasons that follow, the Secretary is correct that a substantial penalty is warranted.

Background

Around 2000 the Glassport facility, which was leased to Allegheny’s predecessor, Riverview Steel, was converted into a rebar forming company (Tr. 137, 209). In 2000 OSHA Assistant Area Director (AAD) Frank Librich inspected Riverview Steel. OSHA cited that company for numerous deficiencies and recommended substantial penalties. At some point Riverview Steel ceased operations.

In 2001 Albert Samme, a citizen of Canada, bought Allegheny at a Sheriff’s sale. Samme resides in Ontario, Canada, and makes infrequent trips to Glassport. He is the sole owner of Allegheny but also owns a steel brokerage company in Canada, which is Allegheny’s lien holder (Tr. 209, 233-234). At the time of purchase, Samme considered that Allegheny “probably was in the worst condition that any mill had ever been in any country anywhere” (Tr. 209). From a safety perspective, during 2000 through 2003 the facility operated with minimal changes (Tr. 115-116).

¹ OSHA did not recommend a penalty for Citation No. 3, and it is not in issue (Tr. 5).

Allegheny I

OSHA received a formal complaint regarding safety conditions at the facility. On July 24, 2002, OSHA compliance officer Vance Delsignore began the Allegheny I inspection. Samee testified that he asked “What’s OSHA?” when informed of the proposed inspection. Samee “ran there fast because I knew it would be some —I don’t know if it’s bad news, but I walked with him around, and I said, ‘Just tell me what to do and I’ll do it’” (Tr. 227-228). Delsignore pointed out deficiencies and provided sample programs and other information regarding compliance (Tr. 142, 143). On January 21, 2003, OSHA cited Allegheny with violations carrying penalties totaling \$73,200.00. As stated, Allegheny and OSHA reached a settlement of the case on April 17. Allegheny promised abatement and agreed to make installment payments over 3 years (Exh C-1). Allegheny met none of the installment payments.

On August 6, 2004, OSHA received a “nonformal” complaint. Under its procedures, the nonformal complaint prompted a letter advising Allegheny that OSHA had a specific complaint but that it did not presently intend to investigate the complaint. A response describing abatement action was, however, requested. Allegheny did not respond to the request. OSHA then received a notification from the Emergency Medical Service (EMS) in Clairton, Pennsylvania, that a “nonfatal electrocution” occurred at the facility.

OSHA then scheduled and conducted the Allegheny II inspection, which resulted in the instant case.

Hearing Reconvened and Secretary’s Motion for Costs

The parties were afforded substantial notice before the scheduled hearing. Allegheny sought a further continuance when it petitioned for Chapter 11 in the United States Bankruptcy Court. The Trustee ultimately dismissed the petition. The parties were admonished that the rescheduled hearing of March 8, 2005, would not be continued.

On March 7, 2005, an attorney for Allegheny orally advised the Judge’s office that its primary witness, Albert Samme, had been injured in an automobile accident on March 6, 2005, and was hospitalized from his injuries. Allegheny intended to seek a continuance of the hearing. At the hearing the next morning Allegheny moved for a continuance in writing and orally. Its attorney

stated that Samme remained in a Canadian hospital and would be unable to travel to the hearing.² For the reasons stated on the record, the motion to continue the hearing was denied. Allegheny was given leave to submit a deposition of Samme or to move to reconvene the hearing at a later date.

The Secretary presented her portion of the case on March 8, including information that Albert Samme was not hospitalized in Ontario but had been at the Glassport facility that day. The hearing was adjourned, and Allegheny was required to submit an affidavit as to Samme's whereabouts on March 8. On March 14, 2005, Samme signed an affidavit which states *in toto*:

This affidavit will serve to explain why I Albert Samee was not able to attend the Court Hearing on Tuesday March 8, 2005. On Sunday March 6, 2005 I was involved in a serious car accident in Canada which resulted in the demolition of my car and broken ribs to myself. I was taken to the Canadian local Hospital for treatment and was prescribed pain medication Tylenol #4 which contains "Codeine[.]" On Tuesday March 8, 2005, the day of the hearing, I attempted to attend the hearing by having Mr. Palmerino Sacchetti³ drive me from Canada to Pittsburgh. We left Hamilton Ontario around 4:00 am, however when we arrived in Pittsburgh the intense pain and the effect of the medication precluded me from attending the hearing. I stopped at my factory in Glassport, PA because of a meeting with Cargill Ferrous International representative, I briefly m[e]t with Cargill representative, but I was not able to continue because of my painfu[l] condition. I then had Mr. Sacchetti drive me back to Canada.

Based on the Samee affidavit, the Secretary moved to close the record. She argued that Allegheny had no acceptable basis for failing to present its evidence at the March 8 hearing. The undersigned judge weighed the fact that Samme was Allegheny's only witness, that a substantial penalty was at issue, and that pain is subjective in nature, and denied the motion. The hearing was reconvened on April 4, 2005.

At the April 4 hearing, Samee's failure to appear on March 8 was the subject of evolving testimony. Rather than having been hospitalized, Samee agreed that he was not admitted to the

² Although this was not, in fact, true, Allegheny's counsel acted in good faith and in reasonable reliance on information provided by the client.

³ Palmerino Sacchetti was Allegheny's former vice-president/plant manager (Tr. 155). Allegheny informed its attorney that "Mr. Sacchetti has become very ill and he has left the Company altogether, and his whereabouts are unknown" (Tr. 7). Sacchetti's whereabouts were known, however, and he drove Samee to Pittsburgh on March 8 and April 4, 2005.

hospital but was released from the emergency room with bruised (not broken) ribs on the day of the accident (Tr. 234-235). Samee's testimony was confused throughout. As one example, in his affidavit Samee implied he attended a scheduled meeting with a Cargill representative. He testified, however, that he met the Cargill representative by happenstance (Tr. 224). Samee explained, "[W]e didn't have any meeting. We just walked with them in the mill" (Tr. 223). In later testimony, no "meeting" took place, and Samee only "sat in the car. I did not get out of the car for more than 2 minutes." Such discrepancies in the testimony raise serious questions about the basis for reconvening the hearing.

Based on the above events, the Secretary moves to recover her costs involved in participating in the reconvened April 4 hearing. Although Samee and Allegheny displayed a careless attitude toward the Commission's legal proceedings, it did not violate the Judge's Orders. This Judge determined that the case should proceed by reconvening the hearing. Frustration is unavoidable, but the matter is inappropriate for an award of costs. The Secretary's motion for costs is denied.

Remaining for decision is the amount of penalty which should be assessed in the circumstances of the case.

Discussion

Under § 17 of the Act, penalties are calculated with "due consideration" of four factors: the size of the employer's business, the gravity of the violation, the good faith of the employer, and the history of previous violations. These factors need not be accorded equal weight. The gravity of the violation is usually the most significant factor. *Orion Constr., Inc.*, 18 BNA OSHC 1867, 1868 (No. 98-2014, 1999).

OSHA seeks to standardize penalties throughout the nation by providing guidance to its personnel in the Field Inspection Reference Manual (FIRM). The Secretary established that she followed the FIRM in this case and considered the four statutory factors in arriving at her proposed penalty. The Commission, however, is the final arbiter of penalties in all contested cases. *Secretary v. OSHRC and Interstate Glass Co.*, 487 F.2d 438 (8th Cir. 1973).

Size of the Business

Allegheny's primary argument is that "size" must take into account its precarious financial condition. Because the plant is old, dilapidated, and a "money pit," it would require the expenditure

of substantial resources to bring it up to standards. Allegheny claims not to have the resources to make the expenditures or to pay “excessive” OSHA penalties.

The Secretary argues that is inappropriate to consider an employer’s financial condition in penalty calculations under the Act. She asserts that OSHA properly considered that Allegheny had 30 employees at the time of the inspection when it reduced its initial calculations by forty per cent in recognition of Allegheny’s small size (Tr. 40, 162).

The Commission must determine a reasonable and appropriate penalty in light of the four factors listed in section 17(j) of the Act. Even if as a general rule the Secretary’s penalty formula does not result in penalties which are punitive in nature, a penalty may be unduly burdensome or excessive in a specific case. The Commission has not determined whether an employer’s financial condition is an appropriate consideration in a penalty assessment. In rare occasions it has considered the impact of a total penalty on the viability of a business. See *Colonial Craft Reproductions*, 1 BNA OSHC 1063, 1065 (No. 881, 1972) (full adjustment of the penalty for size avoids “destructive penalties” where a safe and healthful workplace was secured); *Specialists of the South, Inc.*, 14 BNA OSHC 1910 (No. 89-2241, 1990). In *Interstate Lead Company*, 15 BNA OSHC 1989, 2000 (No. 89-2088P, 89-3296, 1992), Judge James D. Burroughs succinctly summarized the concept:

As a practical matter, the financial condition in certain cases must be considered. OSHA and the Commission were not created to eliminate business activity, as some employers contend. OSHA was created to preserve the health and safety of working men and women of this nation. They constitute resources in which the nation has a vital interest in protecting. Where an employer approaches its responsibility under the Act in good faith, has no detrimental history, and seeks to abate violations, it is only practical that some considerations be given to an employer’s negative financial condition and the effect of penalties assessed on the viability of the business.

The financial condition of Allegheny does not warrant consideration in the penalty calculation for two reasons. First, Allegheny has been unresponsive to ordinary enforcement mechanisms. Following the 2002 inspection, Allegheny exerted minimal or no effort to correct the violations. Allegheny could not be bothered to make safety adjustments even when compliance involved no expense. Secondly, Allegheny introduced insufficient evidence to establish its true financial status. Without a documented financial statement, it is difficult to assess Allegheny’s

financial circumstances. It is known that the United States Trustee dismissed its petition for Chapter 11 relief, indicating the existence of some assets.

Even the argument that enforcement of penalties would require closing one of the few remaining steel mills rings hollow. Allegheny is not fully operational, although it may work at partial capacity occasionally. The Act does not require employees to jeopardize their health and safety in order to subsidize a poorly funded enterprise. As stated in a related context in *American Federation of Labor, etc. v. Brennan*, 530 F.2d 109, 122, 123 (3rd Cir. 1975):

It would appear to be consistent with the purposes of the Act to envisage the economic demise of an employer who has lagged behind the rest of the industry in protecting the health and safety of employees.

* * *

Congress did contemplate that the Secretary's rulemaking would put out of business some businesses so marginally efficient or productive as to be unable to follow standards otherwise universally feasible.

The penalty credit the Secretary proposes in recognition of Allegheny small size is adopted.

Past History of OSHA Violations

Allegheny has a past history of numerous serious violations. No credit is afforded for history.

Lack of Good Faith

Weighing against a finding of good faith is the cavalier attitude Allegheny and Samee displayed towards safety and health at the facility. Allegheny had no safety programs, and no safety training for employees who worked with potentially dangerous and defective equipment. Samee repeatedly broke his agreements with OSHA and outside crane inspectors regarding "fixing" identified hazards. In spite of agreeing with OSHA and independent crane inspectors that the cranes were too dangerous to use, the cranes remained in the same defective condition. Employees were required to use them as soon as the inspectors left the facility (Tr. 161, 166). At the hearing Samee appeared unconvinced of the need to make safety changes (Tr. 217):

I think to us almost every [safety and health violation] is very easy to work with except the crane that eventually if anybody comes up with some type of financing, we have to put a brand new crane, but if I take anybody right now over there to see

what we have, there's nothing there that would be dangerous or any kind of issue for citation except that the crane is older crane. We know that for sure. It works. We've got three different people all the time looking at it. They change the ropes at any given time that they have the green light to do that for the safety.

So, I think if somebody would go there now, by all means, I told them at the guard shed, you could go at any time. I have no problem for you to go inside and inspect the place, but we're not running also.

In the Allegheny I inspection, Delsignore gave Allegheny detailed models for a LOTO and a hazard communication program. These offered step-by-step guidance for developing the programs. The hazard communication sample program was characterized as "fill-in-the-blanks" (Tr. 143). Allegheny failed to develop or implement the programs, nor could it locate the sample programs OSHA earlier provided (Tr 86-87). Whether it was correcting hazards or complying with the Commission's legal procedures, Albert Samee and Allegheny acted as if their smallest effort was far more than sufficient. Allegheny paid no part of the reduced penalty agreed to in the settlement of Allegheny I. It did not cooperate with Balya's Allegheny II inspection (Tr. 152-154, 158).

No credit is afforded for good faith.

Gravity of Violations

Usually, the most significant factor in assessing penalties is the gravity of the violation. Gravity addresses the particulars, such as some determination of the number of employees exposed to the conditions, the duration of exposure, the degree of probability that an accident would occur, or precautions taken against injury. *Agra Erectors Inc.*, 19 BNA OSHC 1063,1065, Docket No. 98-0866, 2000 (Review Commission). Considerations of gravity are discussed below.

Citation No 1–Serious Classification

Allegheny does not dispute that exposure to the hazards cited in Citation No. 1 could result in serious injury or death. As many as 25 to 30 people could be exposed to the hazards at the facility, depending on the specific circumstances. At the time of the inspection Allegheny worked two shifts of 8 to 10 hours per shift (Tr. 135). For each of the violations discussed below, Allegheny took no precautions to lessen the consequences of exposure to the hazards at the time they were first observed or during the approximate month of the inspection (Tr. 43-110).

Item 1: § 1910.106(b)(2)(vii)(a). Allegheny did not dike or provide adequate drainage for a 250 gallon diesel fuel tank. If the tank were broken or leaking, the fuel could leak into the general work area and cause a fire. The location of the tank at the entrance of the loading area where significant truck and forklift traffic existed increased the gravity of the violation. (A forklift had previously backed into the fuel tank and dented it.) Employees in the loading area and those walking through the entrance were exposed to the fire hazard (Tr. 88-89). For item 1 a penalty of \$900.00 is assessed.

Items 2a, 2b, and 2c: §§ 1910.147(c)(5)(ii)(D), 1910.147(d)(4)(ii), 1910.147(f)(3)(ii). Beyond the fact that Allegheny had no lockout/tagout (LOTO) program (cited as a repeat violation), Allegheny violated the LOTO requirements at the disconnect switch box located on the ground floor for overhead Crane #3 in three respects. Cited at item 2a, Allegheny did not identify the lock around the disconnect box with the name of the employee applying it. Cited at item 2b, the lock was not secured and would not prevent the switch from being turned on. Cited at item 2c, more than one employee worked with a single lock, failing to follow the procedures for group LOTO. Maintenance employees and those performing electrical work were exposed daily to energization of the crane, if the power were to be turned on unexpectedly. The disconnects of the one-way conductors were readily accessible on the ground, but they were operated by employees who would not always have a clear view of work up on the bridge. Because the conditions are related, grouping the items into one penalty is appropriate. The fact that the three conditions existed, however, aggravates the hazard and makes injury more likely. For items 2a, 2b and 2c a penalty of \$1,500.00 is assessed (Tr. 89-91).

Item 3: § 1910.147(d)(3). The 500-volt breaker box of the operator's pulpit could not be locked out. The power could be shut off, but no lever or lock was present on the disconnect to prevent the power from being turned back on. Employees were exposed daily to severe electrical shock if they worked on equipment and the switch was activated (Tr. 91-92). For item 3 a penalty of \$1,000.00 is assessed.

Item 4: § 1910.180(c)(2). The Grove mobile track crane had no load rating chart. The charts are used to calculate the proper load and boom angle. Without a load rating chart, the operator could overload the crane, exposing the operator to crane failure and exposing others in the area to being

hit by the falling load or falling crane parts. The hazard existed throughout the duration of the shift (Tr. 92-94). For item 4 a penalty of \$900.00 is assessed.

Items 5a and 5b: §§ 1910.180(d)(3) and 1910.180(d)(4). Allegheny did not regularly inspect specific mechanisms of the Grove mobile crane for deficiencies and did not insure that regular inspections of the entire crane were periodically scheduled. Four to seven employees were exposed daily, including the mobile crane operator and other employees who helped him in the area (Tr. 94). For items 5a and 5b a penalty of \$900.00 is assessed.

Items 6a, 6b, 6c: §§ 1910.215(a)(2), 1910.215(a)(4), and 1910.215(b)(9). These standards set out specific requirements for safety features on industrial grinders. The pedestal grinder and the Black and Decker grinder in the Machine Shop were not guarded. In addition, the Black and Decker grinder did not have properly adjusted work rests, and it had no tongue guard at all. Employees could be pulled into the spinning parts, causing injury to the hands or parts of the shoulder or face. Employees could get their hands stuck between the work rest or be hit by a shattered wheel. The hazards were aggravated because the grinder's abrasive wheel rotated downward. Employees were exposed whenever they used the grinder on an as-needed basis throughout the day (Tr. 95). For items 6a, 6b, and 6c a penalty of \$1,000.00 is assessed.

Item 7: § 1910.219(c)(4)(i). The projecting shaft ends of rotating parts of the LeBlonde lathe, the Monarch lathe, the shaft in the Three High Area, and two shafts on the #5 reducing mill were not guarded. Three to seven employees could have parts of their bodies caught in the unguarded machinery. Allegheny placed a very loose, ineffective type of shield over one of the rotating shafts that actually moved when the shaft moved (Tr. 96). For item 7 a penalty of \$900.00 is assessed.

Item 8: § 1910.253(b)(2)(ii). Allegheny stored oxygen cylinders in an area that was directly exposed to being struck by cranes and forklifts or to being dislodged by pedestrian traffic. Further aggravating the hazard, the cylinders were not secured from falling. If opened, the liquid oxygen cylinders could cause skin damage and frostbite injuries. At least seven employees were exposed to the hazards (Tr. 97). For item 8 a penalty of \$1,000.00 is assessed.

Item 9: § 1910.254(b)(4)(ii). The control apparatus for the Lincoln arc welder was not enclosed with a cover plate, exposing the wiring. Aggravating the gravity, the welder was in an area

where the roof was leaking. Four to six employees were exposed to electrical shock hazards from contact with the energized wiring of the arc welder (Tr. 98). For item 9 a penalty of \$1,750.00 is assessed.

Items 10 and 11: §§ 1910.304(a)(1); 1910.304(f)(3)(i) . Allegheny used a green coated conductor (which is commonly known to be the ground wire) as the current-carrying hot conductor to wire in an additional light for the Monarch lathe. Two machinists who operated the lathe or maintenance personnel could easily assume the green wire was the ground conductor and could receive a severe electrical shock if they touched it. In addition, the light on the lathe was on a separate circuit from the lathe and was not grounded. An electrical short from the light could energize the entire lathe frame. When observed by the compliance officers, the operators had been exposed to the hazard for approximately 2 hours that day. The Monarch lathe could be run at any time throughout the shift (Tr. 98-100). For item 10 a penalty of \$1,000.00 is assessed, and for item 11 a penalty of \$1,000.00 is assessed.

Item 12: § 1910.304(e)(1)(i). Allegheny did not use an adequate over-current protection device for the conductor at the Operator's Pulpit. This violation was noted when OSHA investigated the referral from EMS after they attended to a nonfatal, but severe, shock incident. Allegheny installed a 250-volt breaker on a 500-volt line. Breakers would trip and fuses would blow multiple times during a shift, requiring too much attention by the electricians. Rather than replacing the fuses, copper wires were run from the top to the bottom of the damaged fuses, circumventing the fuses. The employee involved in the accident was severely shocked when he sought to reset the breaker, which had electrical current running through it (Tr. 100-102). The gravity of this electrical violation is high. For item 12 a penalty of \$3,000.00 is assessed.

Item 13a and 13b: §§ 1910.305(b)(1); 1910.305(b)(1). Allegheny did not ensure that unused openings in the energized 440-volt main electrical box were properly filled. Employees stuffed their gloves into the unused openings. Further, the conductors which entered the boxes were not protected from abrasion. Dirt, dust, and moisture could coat the conductors and cause malfunctions and potential electrical shorts. Approximately seven employees were exposed to the shock hazard throughout their shifts (Tr. 102-103). For items 13a and 13b a penalty of \$900.00 is assessed.

Items 14 and 15: §§ 1910.305(b)(2); 1910.305(e)(1). Covers were missing from the outlet boxes in the machine shop, in the cooling bed area, and outside the distribution room. Various electrical cabinets and boxes were in areas saturated with water. The drains of the water reservoir in the cooling bed area, which were intended to wash the scale off the billets, were plugged with scale. The water overflowed to the outlets, and water reached the outlets from the leaking roof, described as a “waterfall” when it rained, and from the cooling bed area. Electrical cabinets and boxes were visibly rusted from contact with moisture. The wet or water soaked conditions aggravated the electrical shock hazard at the open electrical boxes. Three to four employees were exposed to the shock hazard, depending upon their duties and the time of day (Tr. 104-106). For item 14 a penalty of \$1,000.00 is assessed and for item 15 a penalty of \$1,000 is assessed.

Item 16: § 1910.305(g)(1)(i). Flexible cords were being used in an unapproved manner. They were run through the wet areas and were so damaged that the internal conductors were exposed. Extension cords ran across the floor in damp areas, near water, or on concrete saturated with water. Examples of exposed employees include: (1) the operator who sat at his station in a solid metal frame chair immediately next to the conveyor system placing and removing billets from water; and (2) employees walking in the aisles by the control panel where the water from the cooling bed overflowed. Three employees worked at the cooling bed. They and the others were exposed throughout their shifts (Tr. 106-108). For item 16 a penalty of \$2,000.00 is assessed.

Item 17: § 1910.305(g)(2)(ii). At various locations throughout the facility, Allegheny spliced flexible cords (which were less than 12 gage) rather than keeping them as a continuous length of cord. For example, spliced cords were used for a light on the Monarch lathe, for a sump pump, for an industrial fan behind the cooling bed, and for equipment which ran directly from electrical disconnect boxes or cabinets. Those cords were tied to conductors with electrical tape wrapped around them. The hazard was aggravated by the fact that employees used the spliced cords in very wet areas or on a conductive object which was unable to ground. Employees were exposed to a shock hazard of 110 to 220 volt at various times, including a minimum of 2 hours in the machine shop (Tr. 108-110). For item 17 a penalty of \$1,000.00 is assessed.

Item 18: § 1910.305(g)(2)(iii). In the furnace area, flexible cords were tied directly into the terminal screws or hook-ups without tension relief devices. Employees were exposed to a potential

electrical shock hazard if the terminal screws were pulled on the conductors (Tr. 110). For item 18 a penalty of \$900.00 is assessed.

Citation No. 2– Repeat Classification

Repeat Violations. On January 21, 2003, OSHA cited Allegheny for 43 serious items (numbered 1 through 29b) and one nonserious violation. Forty one separate violations were found to be uncorrected at the time of the Allegheny II inspection and were cited as repeat on January 12, 2004. The violations were repeat not merely because they were similar; they were *the same*. The same standard was violated under the same type of circumstances, usually with the same piece of equipment or absence of the same safety procedures and programs (Tr. 161). The Secretary is correct that the penalties assessed below should be enhanced. “Enhanced liability for a second or subsequent violation of the same or similar regulation or standard is appropriate because once an employer has been found to have violated the Act, it is reasonable to expect that extra precautions will be taken to prevent a ‘repeated’ violation.” *D.M.Sabia*, 17 BNA OSHC 1680, 1685 (No. 95-3697) (3d Cir. 1996).

Item 1: § 1910.22(a)(1). At five locations the Secretary cited “extremely poor housekeeping” where damaged metal grating, bent metal plates, and plates with corners sticking up created tripping hazards for employees working or walking in the areas. A tripping hazard presents a low gravity violation, although employees were exposed to the hazards throughout their shifts (Tr. 43-45). For item 1 a penalty of \$1,800.00 is assessed.

Item 2: § 1910.22(a)(2). The work areas were overly saturated with water or had standing water, which exposed employees to exposure from a variety of chemical substances contained in the water or to electrical shock from damaged electrical cords which ran through and immediately adjacent to pooling water. At least seven employees were exposed to the chemical hazard or to electrical shock throughout their shifts (Tr. 45). The penalty is somewhat reduced since aggravating factors were considered as violations in Citation No. 1. For item 2 a penalty of \$6,000.00 is assessed.

Item 3: § 1910.23(c)(1). Allegheny had inadequate or absent guardrails in the Billet Storage Bay, exposing employees to falls of approximately 12 feet to the floor below. Although two employees may have been directly exposed to the hazard, five others had access to the hazard when they neared the open sides of the platform (Tr. 47-48). For item 3 a penalty of \$5,000.00 is assessed.

Item 4: § 1910.24(h). Allegheny's guardrails did not adequately protect crossover areas and stairs at various places in the facility. Employees could fall from heights or fall into the rotating parts of the equipment at the rolling mill, the reducing mills, or onto the hot billets. From five to ten employees were exposed to the hazard as they walked over the stairs or to their cranes. For item 4 a penalty of \$2,500.00 is assessed.

Items 5, 6, and 7 (Lockout/tagout violations): §§ 1910.147(c)(1), 910.147(c)(4)(i), 1910.147(c)(7)(i). As discussed, OSHA provided Allegheny with a "fill in the blank" LOTO sample program during Allegheny I. That program showed how to develop machine specific lockout/tagout procedures so that employees could isolate its energy sources during maintenance. Allegheny had no training program for maintenance employees on how and where to lock out the energy sources of the machines. Without a lockout/ tagout program, employees were exposed to the hazard of being caught in machinery while they or others worked on it. The Secretary concluded that the failure to have the program contributed to the earlier nonfatal, but severe, electrical shock. A minimum of four employees were exposed to the hazard as they performed maintenance work throughout their shifts. Although repeatedly asked, Allegheny could not locate the sample LOTO program OSHA provide less than a year before (Tr 49-52). For item 5 a penalty of \$4,200.00 is assessed; for item 6 a penalty of \$2,000.00 is assessed; and for item 7 a penalty of \$2,000.00 is assessed.

Item 8: § 1910.151(b). Allegheny had not trained an individual at the facility to administer first aid. The gravity of the violation is aggravated by the fact that the facility is located across an active rail track. Emergency medical personnel might be delayed in reaching the facility. Further, employees were often exposed to conditions which could require first aid for injuries ranging from minor up to and including those resulting in death. No one in the facility was trained to administer first aid (Tr. 53). For item 8 a penalty of \$4,200.00 is assessed.

Item 9: § 1910.178(1)(1)(ii). Operators of industrial fork trucks were not adequately trained to operate their equipment. Lack of training subjected both the drivers and those working near the forklifts to the hazards of being impaled or crushed by a fork lift. Also, without training, the forklift operators were more likely to cause additional hazards, such as when the forklift operators ran into

a diesel tank. Ten or more employees working throughout the shift were exposed (Tr. 54). For item 9 a penalty of \$4,200.00 is assessed.

Item 10: § 1910.178(q)(7). Allegheny did not inspect the forklift trucks prior to and after each of the two shifts. Without maintenance checks, problems arising during the previous shift would not be disclosed. More than ten employees, including operators, were exposed to potential hazards caused if forklift deficiencies were not discovered (Tr. 55-56). For item 10 a penalty of \$1,800.00 is assessed.

Overhead Cranes and Access Bridges (Items 11 -28)

Allegheny has three overhead hoists and three overhead cranes are at its facility. The overhead hoists and Crane #2 were out of service on the days of the inspection. Cranes #1 and #3 were in operation during both inspections. Two or three days into the Allegheny I inspection, Delsignore was meeting with Albert Samee, Guisepe “Bepe” Lorandi, and others when two independent crane inspectors asked to speak with the management. Delsignore heard the crane inspectors tell Samee and the others, “Look, we red-tagged Number 1 crane, and we red-tagged Number 3 crane. There’s a multitude of very bad problems with them. You guys can’t run them. We red-tagged them.”⁴ (Tr. 144-145). Samee stated, “That’s it. Call everybody together. Send everybody home” (Tr. 149). Delsignore saw that the cranes were physically red-tagged. Allegheny told Delsignore that it planned to work out a less efficient method to move the billets by forklifts (Tr. 149). During Balya’s later inspection, the defective cranes were operating. Several employees described to her what occurred the previous summer (July 2002) during Delsignore’s inspection. The employees described that although the cranes had just been red-tagged, after OSHA and the crane inspectors left, the employees were ordered to put the cranes back into operation the next day (Tr. 161). Items 11 through 28 involve Cranes #1 and #3.

Item 11: § 1910.179(b)(5). Cranes #1 and #3 did not have their requisite rated load capacity plainly marked on the sides. Operators would be more likely to overload cranes when operating without knowledge of the rated capacity. If overloads occurred, the load or parts of the overhead crane could fall and expose workers below. Depending on which crane was being used, anywhere

⁴ The inspectors placed a red tag on the cranes. Red tags indicate that the cranes cannot be operated until repairs are made and the repairs are approved.

from the ten or more employees were subjected to the potential hazard of crane or load failure throughout the shift (Tr. 56-57). For item 11 a penalty of \$1,800.00 is assessed.

Item 12: § 1910.179(d)(1)(ii). For Crane #3 a portion of the bridge foot walk in the Scrap Bay had only about 30 inches of head room in relation to the building, although at least 48 inches is required. Employees could be struck or pinched in between the crane foot walk and the building itself. Exposure occurred when employees went up to move the crane in order to repair it or to perform such tasks as changing light bulbs. The crane operator and the maintenance workers were most often exposed to the hazard (Tr 57-58). For item 12 a penalty of \$6,000.00 is assessed.

Item 13: § 1910.179(d)(3) (referencing § 1910.23(c)(2)). For Crane #3 the bridge foot walk did not have adequate standard railings. The railings were 26 inches high and had no midrails, exposing employees to trips or falls of approximately 18 feet to the ground below. The crane operators were exposed at least four times daily as they entered and exited the crane, and maintenance personnel would use the unguarded foot walk on an as needed basis (Tr 59). For item 13 a penalty of \$2,000.00 is assessed.

Items 14, and 15: §§ 1910.179(e)(2)(i);1910.179(e)(3)(i);. Cranes #1 and #3 were missing required parts. An overhead crane must have a bridge bumper on its corners to prevent it from jarring when the crane hits the end stops. Bumpers are also required for the trolleys that ride on top of the bridge beams. Neither of the two cranes nor the trolleys had bumpers. The lack of bumpers on the trolley had the greater effect on the position and security of the load, but the crane bumpers were also necessary. Jarring can cause the load to fall or be loosened. The cranes were used on a continual basis; and although the resulting injury would be high, the probability of an accident was lower. Anywhere from three to five employees could be exposed to the hazard throughout the shift (Tr 60-62). For item 14 a penalty of \$2,000.00 is assessed, and for item 15 a penalty of \$3,000.00 is assessed.

Item 16: §1910.179(e)(4). Bridge trucks on Allegheny's overhead cranes were not equipped with rail sweeps to sweep the rails free of debris that could accumulate on the track. Debris on the track could jam between the wheel, break the wheel flange, and cause a jarring action or shock to the load. Five to ten employees, including people working on the ground below were exposed to the

hazard along the route throughout their shifts (Tr 62-63). For item 16 a penalty of \$2,000.00 is assessed.

Item 17: § 1910.179(e)(6)(i). Moving parts of the line shaft couplings and the bridge drive gears for Cranes #1 and #3 were unguarded, exposing employees to being caught by the in-running nit points of the gears. Crane operators, maintenance personnel, and technicians were exposed to the hazard throughout their shifts (Tr 63-64). For item 17 a penalty of \$4,200.00 is assessed.

Item 18: § 1910.179(f)(6)(i). Cranes #1 and #3 were not equipped with bridge brakes. The actual pedal mechanisms were disconnected and laying on the cab floors. Operators had to “plug” the crane to stop it (*i.e.*, throw the crane into the reverse direction of travel to move from forward to reverse). Since plugging doesn’t always work, the crane operator could lose the load, causing it or crane parts to fall. Five to ten employees could be exposed to the hazard (Tr 64). For item 18 a penalty of \$3,000.00 is assessed.

Item 19: § 1910.179(g)(2)(i). The crane cab for Crane #1 and the bridge foot walk for Crane #3 contained live electrical parts, which the crane operators and maintenance personnel accidentally could contact under normal operating conditions, exposing them to shock or electrocution as they worked throughout their shifts (Tr 65). For item 19 a penalty of \$6,000.00 is assessed.

Item 20: § 1910.179(g)(3)(i). Neither of the overhead cranes was equipped with a “spring return” (a manual magnetic device) so that once the operator releases the controller, it automatically goes to neutral. The device prevents an unplanned start up after a power failure. The crane operators were exposed throughout their shifts (Tr 66-67). For item 20 a penalty of \$1,800.00 is assessed.

Item 21: § 1910.179(i). Neither of the overhead cranes was provided with a warning device, such as a gong, to warn an operator that he is approaching employees on the ground. The warning device also warns employees below to move out of the way. From five to ten employees working around and underneath the cranes were exposed to being hit or crushed by the crane (Tr. 67-68). For item 21 a penalty of \$4,200.00 is assessed.

Item 22: § 1910.179(j)(2)(i). Allegheny had no program for daily inspections for the overhead cranes, although the cranes had numerous defects which would affect their safe operation. Five to ten employees, including crane operators and those on the ground below were exposed to the hazard on a daily basis (Tr 68). For item 22 a penalty of \$2,000.00 is assessed.

Item 23: § 1910.179(j)(2)(iii). Allegheny performed no monthly inspections on the crane hooks to detect cracks, large throat openings, or twists in the hook which could affect the stability of the loads, exposing employees to the hazard of being hit by the load (Tr 69). For item 23 a penalty of \$2,000.00 is assessed.

Item 24: § 1910.179(j)(3). Allegheny did not perform the required annual inspection for either Cranes #1 or #3. Five to ten employees were exposed on a daily basis to hazards related to the crane deficiencies (Tr 70). For item 24 a penalty of \$4,200.00 is assessed.

Item 25: § 1910.179(l)(1). Allegheny had no maintenance program which complied with the specification of the manufacturer of the two cranes. Five to ten employees were exposed to crane failure and being hit by falling crane parts or the load (Tr 71). The hazard is related to ones discussed with other items. For item 25 a penalty of \$2,000.00 is assessed.

Item 26: § 1910.179(l)(3)(iii)(a). Repairs or replacements of deficiencies of the cranes were not provided promptly as needed for safe operation. The magnetic cable and the connector tips for the crane magnet were damaged, which affected the amount of power available to transport the load. Columns supporting the crane rails were bent and rusted at the base, causing the crane to dip and shock the load and causing more wear and tear on the crane tracks and bridge wheels. These conditions increased the likelihood that some part of the load would fall (Tr 72-74). For item 26 a penalty of \$1,800.00 is assessed.

Item 27: § 1910.179(m)(1). Allegheny failed to conduct thorough monthly inspections of the conditions of the running ropes on the overhead cranes (and to certify the fact that it had done so). Employees were exposed to hazards related to falling loads or falling crane parts if the wire rope broke. Five to ten employees were exposed on a daily basis (Tr 74-75). For item 27 a penalty of \$1,800.00 is assessed.

Item 28: § 1910.179(n)(4)(i). The crane operators did not test the limit switches on the overhead cranes. For Crane #1 the primary hazard was that the load or the crane block could fall. If the lower and upper blocks met and the limit switch did not work, the wire rope and objects could fall on the employees below. For Crane #3 the situation was especially dangerous because it is a shorter crane, and the operator must bring the load up very close to the limit switch. Without testing

the limit switches, five plus employees were put at risk throughout their shifts (Tr 75-75). For item 28 a penalty of \$2,400.00 is assessed.

Item 29: § 1910.212(a)(1). In three areas of the facility Allegheny did not guard the rotating parts of equipment. These included, among other areas, a band saw blade, a lathe, and the pinch rolls at the cooling bed. Approximately six operators or other employees were exposed throughout their shifts (Tr 76-77, 79). For item 29 a penalty of \$3,500.00 is assessed.

Item 30: § 1910.219(d)(1). Employees were exposed to unguarded rotating pulleys on various machines. Five employees were exposed throughout the course of their work shifts as they operated or passed nearby the rotating machine parts (Tr 77). For item 30 a penalty of \$2,000.00 is assessed.

Item 31: § 1910.219(e)(1)(i). Six employees were exposed to being caught in unguarded rotating horizontal belts. Approximately six employees were exposed during their shifts (Tr 78). For item 31 a penalty of \$1,800.00 is assessed.

Item 32: § 1910.219(e)(3)(i). Six employees were exposed to unguarded vertical or incline rotating belts throughout their shifts. Employees particularly worked in close proximity to the unguarded belts at the exit end of the furnace and in the cooling bed area (Tr 78-79). For item 32 a penalty of \$2,400.00 is assessed.

Item 33: § 1910.253(b)(4)(iii). Oxygen cylinders and fuel gas cylinders were stored together, rather than being separated. In multiple areas at least eight employees were exposed to the fire hazard as they worked or walked nearby the areas throughout their shifts (Tr 80). The hazards are the same as described in item 8 of Citation No. 1. For item 33 a penalty of \$2,000.00 is assessed.

Item 34: § 1910.303(g)(2)(i). This item was involved in the EMS referral in late June 2003. The employee was exposed to live, unguarded, electrical parts and received a severe, nonfatal electrical shock. An unqualified employee accessed the live equipment inside the main circuit breaker box. In addition, other live electrical equipment were not properly guarded throughout the facility (Tr 80-81). For item 34 a penalty of \$6,000.00 is assessed.

Item 35: § 1910.305(b)(2). The 240 volt junction box behind the cooling bed was not fitted with a cover. Moisture, dirt, grease, etc., could migrate into the wiring of the junction box, creating

the potential for electric shock. Two to three people were exposed intermittently throughout the day (Tr 81-82). For item 35 a penalty of \$1,800.00 is assessed.

Item 36: § 1910.305(g)(1)(iii). Flexible cords were used for prohibited purposes, *i.e.*, for permanent wiring where they were subject to damage. Also, the cords were run through doorways, potentially damaging the conductors inside the wire. At least three employees were exposed to an electrical shock throughout the day (Tr 82). For item 36 a penalty of \$1,800.00 is assessed.

Item 37: § 1910.332(b)(1). Throughout the facility, neither alleged electricians nor unqualified maintenance personnel who performed some electrical work were trained in electrical safety related to their job assignments. From the time the OSHA inspectors began the inspection until they left the plant, none of the employees were trained on how to properly work with electricity (Tr 83). For item 37 a penalty of \$2,500.00 is assessed.

Item 38: § 1910.332(b)(2). The alleged electricians and other maintenance personnel were allowed to work on electrical control circuitry which had been de-energized (shut off) but not locked out. The employees were exposed to shocks or burns as they worked on the electrical circuitry. The employees were observed to always be working on something throughout their shifts (Tr 84-85). For item 38 a penalty of \$6,000.00 is assessed.

Item 39: § 1910.333(a). Allegheny had no electrical safety related work practices in place to prevent electrical shocks. Failure to have a work practice program which set out which employees were qualified and which were not qualified to work on electrical equipment contributed to the nonfatal electrical shock incident in June 2003. Unqualified employees were exposed to electrical shock on an as needed bases throughout their shifts (Tr 86). The hazard is related to items discussed above. For item 39 a penalty of \$2,000.00 is assessed.

Item 40: § 1910.1200(e)(1). Allegheny had no written hazard communication program. None of the employees working throughout the facility were provided with information about the chemicals they worked with. The company had not instituted any part of the sample hazard communication program OSHA previously provided (Tr 86-87). For item 40 a penalty of \$1,800.00 is assessed.

Item 41: § 1910.1200(h)(1). Allegheny did not train employees on the hazardous chemicals in their workplace, as required by the standard. Employees did not know how to read material safety

data sheets (MSDS) or where MSDSs might be located. (In fact, Allegheny had none of the required MSDSs at the facility.) Employees were exposed to a variety of chemicals in the course of performing their duties, but they were not provided with training on any of the hazardous chemicals (Tr 87-88). For item 41 a penalty of \$1,800.00 is assessed.

Conclusion

The fact that individual penalties assessed against Allegheny total what it may consider to be a substantial amount is a function of the number of violations and the number of repeat violations it committed. “The purpose of a penalty is to achieve a safe workplace, and penalty assessments, if they are not to become simply a cost of doing business, are keyed to the amount an employer appears to require before it will comply.” *Quality Stamping Products Co.*, 16 BNA OSHC 1927, 1929 (No. 91-414, 1994). *See Revoli Constr. Co.*, 19 BNA OSHC 1682, 1687 (“high penalty is necessary to induce future compliance”). In this case, Allegheny has paid no penalties despite the assessments. As the employees noted to Balya during the Allegheny II inspection (Tr. 163):

I was questioned by employees while I was conducting my inspection as to why nothing ever seems to get fixed or corrected around there. Several employees voiced, I guess, concern or they weren’t happy with the fact that OSHA comes in to do inspections, the Company gets a citation but nobody ever fixes anything . . . They even voiced some concern, and they said, “Probably nothing will get fixed after this inspection either.”

Allegheny’s attitude towards safety and health is unacceptable.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The foregoing decision constitutes the findings of fact and conclusions of law in accordance with Rule 52(a), Fed. R. Civ.P.

ORDER

Based on the foregoing decision, it is ORDERED:

All violations alleged in Citation Nos. 1, 2, and 3 are affirmed as cited. The following penalties are assessed:

Citation No. 1

Item	Standard	Penalty
Item 1	§ 1910.106(b)(2)(vii(a))	\$900.00

Item	Standard	Penalty
Items 2a, 2b, and 2c	§ 1910.147(c)(5)(ii)(D), § 1910.147(d)(4)(ii), and § 1910.147(f)(3)(ii)	\$1,500.00
Item 3	§ 1910.147(d)(3)	\$1,000.00
Item 4	§ 1910.180(c)(2)	\$900.00
Items 5a and 5b	§ 1910.180(d)(3) and § 1910.180(d)(4)	\$900.00
Items 6a, 6b, and 6c	§ 1910.215(a)(2), § 1910.215(a)(4), and § 1910.215(b)(9)	\$1,000.00
Item 7	§ 1910.219(c)(4)(i)	\$900.00
Item 8	§ 1910.253(b)(2)(ii)	\$1,000.00
Item 9	§ 1910.254(b)(4)(ii)	\$1,750.00
Item 10	§ 1910.304(a)(1)	\$1,000.00
Item 11	§ 1910.304(f)(3)(i)	\$1,000.00
Item 12	§ 1910.304(e)(1)(i)	\$3,000.00
Items 13a and 13b	§ 1910.305(b)(1) and § 1910.305(b)(1)	\$900.00
Item 14	§ 1910.305(b)(2)	\$1,000.00
Item 15	§ 1910.305(e)(1)	\$1,000.00
Item 16	§ 1910.305(g)(1)(i)	\$2,000.00
Item 17	§ 1910.305(g)(2)(ii)	\$1,000.00
Item 18	§ 1910.305(g)(2)(iii)	\$900.00
Citation No. 2		
Item 1	§ 1910.22(a)(1)	\$1,800.00
Item 2	§ 1910.22(a)(2)	\$6,000.00

Item	Standard	Penalty
Item 3	§ 1910.23(c)(1)	\$5,000.00
Item 4	§ 1910.24(h)	\$2,500.00
Item 5	§ 1910.147(c)(1)	\$4,200.00
Item 6	§ 1910.147(c)(4)(i)	\$2,000.00
Item 7	§ 1910.147(c)(7)(i)	\$2,000.00
Item 8	§ 1910.151(b)	\$4,200.00
Item 9	§ 1910.178(1)(1)(ii)	\$4,200.00
Item 10	§ 1910.178(q)(7)	\$1,800.00
Item 11	§ 1910.179(b)(5)	\$1,800.00
Item 12	§ 1910.179(d)(1)(ii)	\$6,000.00
Item 13	§ 1910.179(d)(3) & 1910.23(c)(2)	\$2,000.00
Item 14	§ 1910.179(e)(2)(i)	\$2,000.00
Item 15	§ 1910.179(e)(3)(i)	\$3,000.00
Item 16	§ 1910.179(e)(4)	\$2,000.00
Item 17	§ 1910.179(e)(6)(i)	\$4,200.00
Item 18	§ 1910.179(f)(6)(i)	\$3,000.00
Item 19	§ 1910.179(g)(2)(i)	\$6,000.00
Item 20	§ 1910.179(g)(3)(i)	\$1,800.00
Item 21	§ 1910.179(i)	\$4,200.00
Item 22	§ 1910.179(j)(2)(i)	\$2,000.00
Item 23	§ 1910.179(j)(2)(iii)	\$2,000.00
Item 24	§ 1910.179(j)(3)	\$4,200.00
Item 25	§ 1910.179(l)(1)	\$2,000.00
Item 26	§ 1910.179(l)(3)(iii)(a)	\$1,800.00
Item 27	§ 1910.179(m)(1)	\$1,800.00

