United States of America
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
1120 20th Street, N.W., Ninth Floor
Washington, DC 20036-3457

SECRETARY OF LABOR, Complainant, v. COMMERCIAL METALS COMPANY, d/b/a CMC STEEL NEW JERSEY, and its successors, Respondent.	OSHRC Docket No. 22-1556

Appearances:
Andrew Karonis, Esquire
Ndidi Menkiti, Esquire
Department of Labor, Office of the Solicitor, New York, New York
For the Secretary

Wayne E. Pinkstone, Esquire
Ogletree, Deakins, Nash, Smoak & Stewart, P.C., Philadelphia, Pennsylvania
Ryan J. Swink, Esquire
Ogletree, Deakins, Nash, Smoak & Stewart, P.C., Houston, Texas
For Respondent

Before:
Carol A. Baumerich
Administrative Law Judge

DECISION AND ORDER

This proceeding is before the Occupational Safety and Health Review Commission (the Commission) pursuant to § 10(c) of the Occupational Safety and Health Act of 1970, 29 U.S.C. § 659(c) (the Act).

Commercial Metals Company, d/b/a CMC Steel New Jersey (CMC) is engaged in the business of manufacturing steel rebar at its facility in Sayreville, NJ. (JX-14, Stip. Fact 1). In the Sayreville facility's Rolling Mill, CMC employed AR as an Assistant Roller. (*Id*., Stip. Fact 4). On May 30, 2022, AR was adjusting a stand jack located at the rear of Mill Stand #7 when the machine unexpectedly energized, and he was pulled into the machine's spindles and crushed to death. Working at or near Mill Stand #7, before the incident and when the incident happened, were Rolling Mill Shift Supervisor HH, Assistant Roller AR, and Mill Technicians CC and PH. (*Id.*, Stip. Facts 3, 4, and 13; Tr. 243, 352; JX-3; JX-3(a)).[1]

On May 31, 2022, the Occupational Safety and Health Administration (OSHA) opened an investigation related to the fatality. (JX-14, at Stip. Fact 14). On November 30, 2022, OSHA issued a three-item serious Citation and a one-item willful-serious Citation and notification of penalty (Citation) to CMC alleging violations of OSHA standard § 1910.147 entitled The control of hazardous energy (lockout/tagout).

The Secretary filed its Complaint on February 23, 2023. The Citation was attached to and made a part of the Complaint. Respondent filed an Answer and affirmative defenses on March 30, 2023. Thereafter, the Complaint and Citation were amended to revise the classification of one alleged Citation item from serious to willful-serious, and to group the two items now classified as willful-serious for penalty purposes.[2] The amended Complaint was received on January 25, 2024. Respondent's amended Answer was filed on February 12, 2024.[3]

A three-day hearing was held in Newark, New Jersey from March 11-13, 2024.[4] Both parties submitted post-hearing briefs and reply briefs.

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[1] For privacy purposes, the three employees on the work crew will be referred to as CC, PH, and AR. Likewise, in this decision, Rolling Mill Shift Supervisor Harry Hernandez most often will be referred to as HH.

[2] *See* January 25, 2024 Order granting the Secretary's Motion to amend Complaint and Citation, and February 22, 2024 Order granting the Secretary's Motion to amend, with analysis.

[3] Any defenses not pursued at hearing or in post-hearing briefing are deemed abandoned. *See Ga.-Pac. Corp.*, 15 BNA OSHC 1127, 1130 (No. 89-2713, 1991). Here, Respondent pursued no affirmative defenses in its post-hearing briefing.

[4] The witnesses who testified at the hearing were OSHA Compliance Officer (CO) Christine Sertil; CMC Safety Manager Marc Miele; CMC Rolling Mill Shift Supervisor Harry Hernandez (HH); and CMC Mill Technician CC.

In this decision, the three alleged violations at issue[5] are a part of OSHA's standard for the control of hazardous energy.[6] The total proposed penalty for the three alleged violations is $159,529.00.

Citation 1, Item 1, alleged a serious violation of 29 C.F.R. § 1910.147(c)(4)(i), stating the specific procedures for the control of potentially hazardous energy that CMC developed were not utilized to protect the employees from the hazardous energy that is associated with making adjustments to the jacks of Mill Stand #7. The proposed penalty for Citation 1, Item 1 is $14,502.

Citation 2, Item 1(a) alleged a willful-serious violation of 29 C.F.R. § 1910.147(d)(2), stating the employer CMC did not ensure equipment was shut down while making adjustments on Mill Stand #7. Citation 2, Item 1(b) alleged a willful-serious violation of 29 C.F.R. § 1910.147(d)(4)(i), stating CMC did not ensure locks were affixed to isolate energy sources while employees were adjusting the jacks on Mill Stand #7. The combined proposed penalty for Citation 2, Items 1(a) and 1(b) is $145,027.

ISSUES

The key issues in dispute are: 1) whether the Secretary has proved knowledge of the alleged violations, 2) whether Mill Stand #7 was shut down as required by the lockout procedure, and 3) whether the Secretary has proved the willful characterization for Items 1(a) and 1(b) of Citation 2.

Based on the analysis that follows, the Secretary has met its burden of establishing all elements of the violations in the Citation Items by a preponderance of the evidence. The undersigned finds that knowledge has been established for all Citation Items, and that Mill Stand #7 was not shut down as required by the lockout procedure. All Citation Items are affirmed. Regarding Items 1(a) and 1(b), of Citation 2, the undersigned finds the instant record does not establish Respondent's violations of 29 C.F.R. § 1910.147(d)(2) and 29 C.F.R. § 1910.147(d)(4)(i) were willful. The record evidence establishes these Citation Items were serious violations.

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[5] At the hearing the Secretary moved to withdraw serious Citation 1, Item 3, alleging a violation of OSHA standard 29 C.F.R. § 1910.147(f)(3), together with the proposed penalty of $14,502. Respondent did not object. The withdrawal was received. (Tr. 14-15).

[6] "29 C.F.R. subpart J applies to the work AR was engaged in at the time of the Incident." (JX-14, Stip. Law 4). Subpart J – General Environmental Controls includes §§ 1910.141 through 1910.147. The relevant standard here is 29 C.F.R. § 1910.147 entitled, "The control of hazardous energy (lockout/tagout)."

Any argument not specifically addressed below has been considered and determined to have no merit.

JURISDICTION

Based on the record, the undersigned finds Respondent, at all relevant times, was engaged in a business affecting commerce and was an employer within the meaning of sections 3(3) and 3(5) of the Act, 29 U.S.C. §§ 652(3) and (5).[7] The undersigned finds the Commission has jurisdiction over the parties and subject matter in this case.[8]

FINDINGS OF FACT

Commercial Metals Company dba CMC Steel New Jersey (CMC) is a corporation organized in the state of Texas with its principal location in Irving, Texas. (JX-14, Stip. Fact 1). CMC manufactures steel rebar at its Sayreville, New Jersey facility (Facility). (Tr. 314; JX-14, Stip. Facts 1, 2).

Marc Miele was CMC's Safety Manager at all relevant times and had been in that position since 2018. (Tr. 228, 257-58). His duties at CMC included evaluating PPE, hazard review, standard operating procedures review, training, accident investigations, and ensuring lockout/ tagout (LOTO) periodic reviews were done. (Tr. 228-29, 259-60, 273). Mr. Miele investigated the May 30, 2022 accident that resulted in AR's death by interviewing employees,[9] reviewing CMC's lockout/tagout procedures, and watching footage from an in-house video camera that recorded the accident. (Tr. 230-31). Mr. Miele concluded the accident occurred because Mill Stand #7 had not been locked out before AR began working in the back of the stand. (Tr. 231).

The Crew

Henry Hernandez (HH) was the Rolling Mill Shift Supervisor on May 30, 2022. (JX-14, Stip. Fact 3). At the time, HH had worked for CMC for about 10 years; he had been promoted to

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[7] "Respondent CMC was an 'employer' within the meaning of section 3(5) of the Act, and was engaged in commerce within the meaning of sections 3(3) and 3(5) of the Act." (JX-14, Stip. Law 3).

[8] "The Occupational Safety and Health Administration has jurisdiction over this matter, pursuant to section 10(c) of the Occupational Safety and Health Act of 1970, 29 U.S.C. 659(c), as amended." (JX-14, Stip. Law 1). "Jurisdiction of this action is conferred upon the Occupational Safety and Health Review Commission by section l0(c) of the Act." (JX-14, Stip. Law 2)

[9] During his staff interviews it was revealed that the Rolling Mill Shift Supervisor had assumed AR had followed company procedure simply because he believed AR was safe. (Tr. 248-51).

Rolling Mill Shift Supervisor the month prior, in April 2022.[10] (Tr. 312-14, 402, 429-30). As the Shift Supervisor, HH was responsible for the safety of the crew he supervised ("C crew"). (Tr. 236-37, 312-13, 399, 461-62). He could discipline employees who did not follow safety procedures. *Id.* His crew was responsible for the Rolling Mill production operation, from the hot end to the cold end.[11] (Tr. 237, 397-98). Typically, there were fourteen employees on C crew. (Tr. 236-37, 399).

Of that crew, Supervisor HH and three employees—AR, CC, and PH—were working at or near Mill Stand #7 at the time of the accident. (Tr. 397-98, 424, 447-48). AR was an Assistant Roller and had worked at CMC for about 27 years. (Tr. 288, 403; JX-14, Stip. Fact 4). The Assistant Roller works in the Rolling Mill hot end and is in charge of the integrity of the rebar going through the production area's fourteen mill stands. (Tr. 300-02). The Assistant Roller might work at any of the fourteen mill stands. *Id.* The Assistant Roller is responsible for ensuring the finished product does not have defects or abnormalities. (Tr. 403-04). When HH began working for the company as a crew member, AR trained him, and HH worked with AR for at least seven years after that. (Tr. 403, 406-07).

On May 30, 2022, CC and PH were the Mill Technicians working at or near Mill Stand #7. (Tr. 447-48). Their daily work was directed by the Assistant Roller, AR. (Tr. 451, 461). AR and the Mill Technicians reported to Shift Supervisor HH. (Tr. 461). At the time of the incident, Mill Technician PH had worked at CMC for a few months and Mill Technician CC had worked there for about a year. (Tr. 437-38, 449).

CMC's rebar manufacturing process

The steel rebar produced at CMC's New Jersey facility is made to each customer's specifications. (Tr. 234, 314; JX-14, Stip. Facts 1, 2). The rolling mill area, where the rebar is produced, is a large room with work areas based on function. There are no walls between the work

[10] During that month, Shift Supervisor HH testified that he delegated some of the daily responsibilities at the hot end to Assistant Roller AR so that HH could focus on the cold end and the furnace. (Tr. 407). HH reported to the Rolling Mill Production Manager, Arun Rahm. (Tr. 426-27). Mr. Rahm was not present on May 30, 2022. (Tr. 96, 246-47).

[11] At the time of the May 30 accident, Arun Rahm was the manager of the hot end and Steve (unknown last name) was the manager of the cold end. (Tr. 28, 96, 426-27. *But see* Tr. 28, 48 hot end manager Arun Patel (sic)).

areas. (Tr. 233-34, 300-02). The rebar rolling area has a hot end and a cold end. (Tr. 300-02, 397). The walk from the hot end to cold end is roughly two to three minutes. (Tr. 398).

Rebar production begins with melting scrap metal in the melt shop's furnace, at the hot end, to form a steel rod that will be shaped into rebar as it is processed or passes through fourteen mill stands.[12] (Tr. 298-302, 314-15, 397-98; JX-14, Stip. Fact 2). The steel rod, or bar, is called a billet as it moves through the mill stands. (Tr. 298-302). The billet is a 60-foot long, 4-sided bar, which is 4 inches wide on each side. (Tr. 298-99, 314-15). A smaller piece of the steel bar is called a bit. (Tr. 412).

The mill stands are positioned in a horizontal production line that the billet goes through starting at Mill Stand #1. (Tr. 233-34, 298-99, 300-01, 303, 314-15, 391, 397-98; JX-3; RX-8). Each mill stand modifies the steel billet in various ways to produce the rebar, such as shaping, turning, twisting, and compacting. (Tr. 299, 435). Each mill stand reduces and elongates the billet in preparation for the next stand's modification. (Tr. 322, 432-35). Within each mill stand a specific billet size, dimension, and shape, is produced, such as flat, oval, square, and round. (Tr. 315, 432-435).

After the billet has been shaped into rebar by the mill stands, it emerges at the cold end's cooling bed. (Tr. 298, 300-01, 303, 314-15, 397-98). At the cold end the rebar is cut and bundled to the customer's specifications. (Tr. 233-34, 315, 397).

Within each mill stand, the billet of hot steel passes horizontally between the guide boxes that are on the upper roll and lower roll in each mill stand. (Tr. 432-35). In the record, the stand's rolls also are referred to as stand rollers and stand wheels. (Tr. 322-23, 326-27; JX-14, Stip. Fact 5). Each stand has two spindles that power the rolls. (Tr. 322, 327). These spindles extend from the back of the mill stand. (JX-3). A "pulpit operator," who is located in a room about 15 feet above the mill floor, controls the speed of each mill stand's spindles. (Tr. 332-33). The pulpit operator can turn the spindles on and off. *Id.* During production, the top spindle turns counterclockwise, and the bottom spindle turns clockwise. (Tr. 322-23). If the spindles are

[12] "As part of the Facility's rebar manufacturing process, the Facility operates 14 electrically-powered rolling stands, numbered consecutively 'Stand 1' through 'Stand 14', which shape steel rods to finished rebar according to customers' specifications." (Tr. 233-34; JX-14, Stip. Fact 2).

turning, the rolls in the stand are turning.[13] (Tr. 323-24, 462-63, 467). The wheels or rolls of the mill stands, through which the steel rods or billets pass, occasionally require tightening or loosening to ensure the steel rods for a particular run are shaped and sized correctly. (JX-14, Stip. Fact 5). Depending on the variation required, according to a customer's specifications, a mill stand can be adjusted either by turning a large wheel on the front of the stand or by adjusting the stand's screw jack located in the rear of the rolling stand using a 55mm long-handled open end jack wrench. (JX-14, Stip. Fact 6)

At the back of each mill stand, near the location of the spindles, is the stand jack that is used to increase or decrease the size of the gap between the rolls the billet passes through, to be shaped into rebar. (Tr. 233-35, 335-37, 352). The frequency of adjusting the stand jacks varies, at times the stand jacks are adjusted multiple times per day, at other times the stand jacks are not adjusted for several days. (Tr. 235, 337). The adjustment to the stand jacks takes place in the area where the spindles move, are not covered by the stand's housing, and there is stored energy.[14] (Tr. 235, 241, 291, 337-38, 360, 455. *See* Tr. 320-21; JX-3 at video mark 00:00 to 00:05). CMC determined that the process of adjusting the mill stand screw jack while the stand was energized exposed employees to pinching or crushing hazards. (Tr. 235, 241-42, 337-38, 360; JX-14, Stip. Fact 7). CMC's policy required employees to deenergize the mill stand prior to tightening stand jacks. (Tr. 338; JX-14, Stip. Fact 8).

Down Days

Each week, the Rolling Mill has a "down" day. The down day is generally scheduled over Sunday and Monday. (Tr. 303-04). Customer rebar orders are not produced on a down day. (Tr. 303, 409, 435-36). Rebar production generally resumes with Monday's evening shift, which begins at 7:00 p.m. (Tr. 303-04).

The purpose of the down day is to provide time for the maintenance crews to make repairs and do necessary preventive maintenance. (Tr. 302-07, 409-10). For the operations crew in charge

[13] The rolls, because they have bearings, can be manually moved when the mill stand is disconnected from electrical power. (Tr. 323).

[14] The stand rolls are located inside the stand's housing. (Tr. 322, 327). When an employee is standing on the front side of Mill Stand #7, on the entry side, the moving spindle is visible to that employee. (Tr. 328-31; JX-3 at video mark 00.15.). From this position the spindle is viewed through a protective cage. *Id.*

of rebar production, it is a time to work on the equipment and make any necessary changes, such as a pass change on a mill stand roll.[15] *Id.*

On a down day, the mill stands are operated in "jog" mode, as compared to "running" mode during production. (Tr. 370, 435-36). When in jog mode, the mill stand is turned on. (Tr. 370). The spindle speed in jog mode is 80-100 rpm. (Tr. 434-36). When the machine is in running, or production, mode the speed is roughly 1,100 rpm. (Tr. 434-36).

The stand jacks, located at the back of a mill stand, are tightened or loosed to adjust the distance between the rolls on the mill stand. (Tr. 335-37; JX-14, Stip. Facts 5-6). Adjustments are needed to keep the billets at a consistent size as they pass through that mill stand. (Tr. 234-35, 325, 336-37; JX-14, Stip. Facts 5-6). The frequency of adjusting the mill stand jacks varies, at times the stand jacks are adjusted multiple times per day. *Id.* Stand jacks are adjusted during rebar production and also on a down day to prepare for the next production run. (Tr. 335-37).

Crew C and the Down Day

May 30, 2022, was a down day and the work shift began around 7:15 a.m. (Tr. 409-10). The shift began with the electricians placing a group lockout on the mill stands. (Tr. 410-11). The C crew performed a couple of passes, and pass changes that day. (Tr. 409-10). [16]

The afternoon of May 30, 2022, the C crew ran a bit through Mill Stand #7. (Tr. 411-412; JX-3). To run the bit, the group lockout on all the mill stands, placed earlier that day by the electricians, was removed. (Tr. 414). To run the bit, Mill Stand #7 was unlocked and placed in jog mode. *Id.* A bit is a small piece of the steel bar that is the shape and size of the rebar produced by the previous mill stand. (Tr. 413). Because the C crew made a pass change on Mill Stand #7, they ran the bit to clean the rust off the pass, and to check the accurate dimension of the bar that would be produced by Mill Stand #7. *Id.* The bit, which was about 2.5 feet long, was reheated in the furnace to be run through Mill Stand #7. (Tr. 412-413; JX-3). Assistant Roller AR and Mill

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[15] Within each mill stand the specific billet size, dimension, and shape, is produced as the billet moves through the entry and delivery guide boxes on the stand roll "pass." (Tr. 327, 409-10, 432-435). The pass forms the billet of hot steel into the necessary shape. (Tr. 432-35). There are multiple "passes" on each stand roll. (Tr. 410, 414, 432). After repeatedly shaping hot steel, a pass becomes worn and must be changed to a different pass on the roll. (Tr. 410, 433-34). Moving the guide boxes, on the entry and delivery side of a stand roll, to a new pass, is called a pass change. (Tr. 409-10, 433-34).

[16] That day the "setup shop guys" also took care of a roll change. (Tr. 409).

Technician CC were working at Mill Stand #7 and observed that the bit coming out of Mill Stand #7 was not sized properly and brought this issue to the attention of Supervisor HH. (JX-14, Stip. Fact 13).

Approximately two to three minutes after the bit was run, Assistant Roller AR went to the back of Mill Stand #7 to adjust the mill stand jacks. (Tr. 337; JX-3 at video mark 6:34-35). At that time, Supervisor HH was present at Mill Stand #7. Supervisor HH observed AR move to the back of Mill Stand #7 (Tr. 359-60, 380-81, 389). HH spoke to AR as he moved to the back of the mill stand. *Id.* As AR moved to the back of Mill Stand #7, Supervisor HH did not see AR follow CMC's lockout procedures nor did he hear AR notify anyone he was going to lockout the stand, ask the pulpit operator to "try out," attempt to start, the machine, nor did he hear the pulpit operator give the "all-clear signal" to proceed. (Tr. 248-51, 346-47, 361, 368, 372, 379-80, 382, 388, 417-18, 425-26).

That day, Assistant Roller AR did not shut down and lockout Mill Stand #7 before he moved to the back of the mill stand to adjust the stand jacks. (Tr. 231, 351). When AR was adjusting the stand jacks, Mill Stand #7 had been shut off by the pulpit operator, but Mill Stand #7 had not been shut down at the East Wall lockout switch as required by CMC's lockout procedure stated in the *Tightening Stand Jacks After Pass Changes* document (Tr. 352; JX-9). Had Mill Stand #7 been shut off with the Mill Stand #7 lockout switch, on the East Wall, the pulpit operator would not have been able to turn Mill Stand #7 back on. (Tr. 352).

AR's fatal incident happened because the pulpit operator turned Mill Stand #7 back on, while AR was adjusting the stand jacks at the back of Mill Stand #7. When the mill stand was turned on, AR came into contact with the bottom spindle and was pulled in between the top and bottom spindles of Mill Stand #7. *Id.*

May 30, 2022 Video

An in-house CMC video camera, located on the East Wall above and across from the row of mill stands, recorded video on May 30, 2022. (JX-3). The camera pointed to the west (the front of the mill stands). *Id.* An eight-minute, thirty-second segment of that video was admitted into evidence. *Id.* The video shows the work area with Mill Stand #6 on the left (south) of Mill Stand #7 and Mill Stand #8 to the right (north) of Mill Stand #7. (Tr. 181, 316).

A second short segment of video was admitted into evidence, as confidential, under seal. This short video segment, which shows AR disappear from view as he is pulled into the back of Mill Stand #7, is a continuation of the eight-minute, thirty-second video admitted as JX-3. (Tr. 473; JX-3(a)).

The crew members, including the Shift Supervisor appear in the video. Supervisor HH is identified by the headlamp he is wearing on his hardhat. (Tr. 349, 355-56, 360, 372-73, 374-76, 381, 387, 423-25, 452-54; JX-3). Crew member AR is identified by the top of his clean hardhat. (Tr. 349, 355-56, 359-60, 372-73, 374-76, 381, 389, 423-25, 452-54; JX-3). Mill Technician CC is identified by the top of his hardhat, which is very scuffed, and he is wearing a blue bandana. (Tr. 67-68, 349, 417-18, 423-25, 452-54, 456-57; JX-3). Mill Technician PH is identified by a white bandana under his hardhat that drapes over his neck and ears. (Tr. 53-53, 67, 349-50, 423-25, 452-54; JX-3).

During the first three minutes of the video, AR places a red-hot bar (bit) of steel approximately 2.5 feet long on the conveyor to the left of Mill Stand #7. The bit enters the rolls of the stand (entry side) and emerges on a conveyor to the right (the delivery side) of Mill Stand #7, appearing longer than when it entered Mill Stand #7. (Tr. 412; JX-3). Three employees, AR, PH, and CC, measure the bit and examine the bit with a flashlight, looking for quality issues. (JX-14, Stip. Fact 13; JX-3). The bit is then run through Mill Stand #8 and removed from the area. (JX-3). During the next minute, AR is at the front of Mill Stand #7, turning the adjustment wheel that is at the front of the stand. (JX-3).

At video mark 4:27, employees AR, CC, and Supervisor HH are standing close together, a few feet away from Mill Stand #7, in conversation about the adjustments to the bit. (Tr. 451-52; JX-3; JX-14, Stip. Fact 13). AR and HH continue talking until video mark 5:03. (JX-3). All four employees leave the view of the camera until video mark 5:20, when AR comes back into view to turn the front adjustment wheel on Mill Stand #7. (Tr. 387, 451-52). At video mark 5:24 the other three, CC, PH, and HH, step back into the view of the camera, where Supervisor HH stands to the left and within arm's reach of AR. (Tr. 451-52; JX-3). AR continues turning the front wheel until video mark 5:55. (JX-3).

At video mark 5:58, AR walks away from Mill Stand #7 toward the north and is out of the camera's view between video mark 6:02 to 6:14. (JX-3). At video mark 6:14, AR walks back into the camera's view, from the north of Mill Stand #7. He carries a long-handled wrench as he

approaches Mill Stand #7. (Tr. 374-76; JX-3). This short segment of the video shows AR moving away from Mill Stand #7 in the direction opposite of the location of the East Wall lockout switch and then approaching Mill Stand #7 fourteen seconds later, from the north, which is in the opposite direction of the lockout switch on the East Wall, which is *south* of Mill Stand #7. (Tr. 376-77; JX-3, at video mark 05:55 to 06:19).[17]

At video mark 6:19, Supervisor HH, who is still standing near Mill Stand #7, begins talking to AR and stands within arm's length of AR until video mark 6:35. (Tr. 359-60, 374-76, 380-81, 389, 417-18). At video mark 6:29, PH hands AR a long-handled wrench. At video mark 6:34-35, AR steps up and begins to squeeze through the side of Mill Stand #7 to get into the back area, while carrying a long-handled jack wrench. (JX-3). At that moment, HH is watching AR move to the back of the stand. (Tr. 359, 360, 379-81, 417-18; JX-3). AR uses a long-handled wrench to adjust the mill stand's jacks from video mark 6:49 to the end of the video at video mark 8:29. (Tr. 337, 417-18, 423-25, 347-50, 352, 389; JX-3).

Respondent's Lockout/Tagout (LOTO) Policy

Safety Manager Miele knew that lockout was necessary because turning off a machine did not prevent that machine from accidentally being turned on (energized) while someone was working—that can only be accomplished by lockout. (Tr. 233). Three documents in evidence describe Respondent's lockout policy: *Lockout/Tagout – Energy Control Program* (JX-4) (*LOTO Program)*; *Lock Out of Mill Stands for Operating Personnel* ID 6200812-RP-100 (JX-6) (*Mill Stand Lock Out*); and *Tightening Stand Jacks After Pass Changes* (JX-9) (*Tightening Stand Jacks*).

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[17] For the short fourteen-second period when AR walked away from Mill Stand #7, HH testified at the hearing that he "assumed" AR went to lockout the mill stand. (Tr. 377-79). This hearing testimony is not credited. It is inconsistent with HH's prior sworn deposition testimony and directly conflicts with HH's testimony that he "did not pay attention" to where AR was walking when he left Mill Stand #7 during that short period. *Id.* During his prehearing deposition HH testified "there was not a specific point that made [HH] think AR locked out." (Tr. 379-80). This deposition testimony is given greater weight. HH's deposition testimony is consistent with HH's hearing testimony that on May 30, 2022, HH simply was "not thinking about" whether the mill stand was locked out, his mind was focused on other things. (Tr. 381, 417-18). He was not paying attention.

HH's failure to "pay attention" or "think about" the critical status of the shut down and lockout of Mill Stand #7, before AR moved to the back of the mill stand, is corroborated by HH's admissions that he did not "pay attention" to any of the worksite safeguards in place to verify mill stand lockout. HH admitted that he did not look at the Stand Lights, he did not look at the East Wall lockout switch, he did not hear AR communicate with the pulpit operator requesting a "try out," nor hear the pulpit operator give the "all clear" signal. (Tr. 362, 372, 378-81, 417-18).

Safety Manager Miele was responsible for implementing the safety program, including training on the lockout procedures and making sure LOTO periodic reviews were done. (Tr. 228-30, 273).

With respect to the work process that is at the heart of this case, Assistant Roller AR was an authorized employee. (Tr. 241, 243). Mill Technicians PH, CC, and Supervisor HH were affected employees. (Tr. 243). Respondent's *LOTO Program* defines these roles as follows:

> "*Authorized employees*" – those employees who utilize Lockout Tagout procedures on machines or equipment to perform repair, servicing or maintenance on that equipment. These employees will be trained in the recognition of hazardous energy sources, the type and magnitude of energy available and the methods to be used in isolating and locking and/or tagging out of machines and equipment.
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> "*Affected employees*" – those employees whose job requirements include the operation or use of a machine or equipment that is being repaired, serviced or maintained and is locked out/tagged out. These employees will be instructed in the purpose and use of lockout/tagout procedures and in preventing attempts to restart machines or equipment that is locked out or tagged out by others.

(JX-4, at 1; JX-14, Stip. Facts 9-10). These definitions parallel the requirements set forth in OSHA's lockout/tagout standard at 29 C.F.R. § 1910.147(b) (definitions) and § 1910.147(c)(7) (training and communications).

In that same exhibit, *LOTO Program*, it is noted that, "The Authorized employee who locked out the equipment will be responsible for notifying all of the 'affected employees' when their machine is to be locked out." (JX-4, at 2 ¶ h; Tr. 237-38, 244-45). This parallels the requirements at 29 C.F.R. § 1910.147(c)(9) (notification of employees).

Under the section titled "Verify Isolation of Energy," the *LOTO Program* states: "Before starting work on the machine or equipment, try the 'start' or 'run' switch or other operating control to be sure that all energy has been isolated from the machine or equipment and that it will not operate." (JX-4, p. 5). This parallels the requirements at 29 C.F.R. § 1910.147(c)(4)(ii)(D) (specific requirements for testing a machine) and § 1910.147(d)(6) (verification of isolation).

The *LOTO Program* also includes requirements for training and for periodic reviews to ensure the program's requirements are being followed. (JX-4, at 8-9). This parallels the requirements of 29 C.F.R. § 1910.147(c)(6) (periodic inspection) and § 1910.147(c)(7) (training and communications).

The *Mill Stand Lock Out* procedures document provides instructions with the tools needed, safety equipment required, warnings, and steps for the lockout of a mill stand. (JX-6). It also

includes photographs that show the location of the lockout switches on the East Wall and an example of a switch that has been locked out. (JX-6).

When adjusting the stand jacks an employee is exposed to moving parts and stored energy. (Tr. 235, 338). Respondent's *Tightening Stand Jacks* document (JX-9) is specific to the task of adjusting the stand jacks at the back of the mill stand and refers directly to the procedures set forth in *Mill Stand Lock Out* procedures *(*JX-6). The activity that AR was engaged in when he was pulled into the back of the mill stand on May 30, 2022, is covered by the *Tightening Stand Jacks* procedure. (JX-9).

Locking out mill stands on the East Wall

The steps to lock out a mill stand on the East Wall were described at the hearing. On a production day, as the first step in the procedure for locking out a mill stand, the authorized employee notifies the production manager and maintenance manager that a mill stand is being locked out. (Tr. 246-47, 295, 339, 416). The notice to the production supervisor does not occur on down days. (Tr. 416, 424). On a production day, the second step in the mill stand lockout procedure is for the authorized employee to contact the pulpit operator to shut down the mill stand. (Tr. 339-40, 369, 416). Normally, when the mill stand is in jog mode, such as during a down day, the employee will not ask the pulpit operator to turn off the mill stand. (Tr. 369-71).

On a down day, and the third step on a production day, the authorized employee goes to the East Wall to turn off and lock out the specific mill stand. (Tr. 340-41). The mill stand's lockout switch, also known as a butterfly switch, is located on the East Wall. *Id.* The authorized employee places a blue equipment key lock on that specific mill stand's lockout switch. (Tr. 340-43; JX-2).[18] Each lockout switch has an on/off switch. (Tr. 343-44). The on/off switch must be turned to the off position before the blue equipment lock can be placed on the lockout switch. (Tr. 343-44, 351). Each authorized employee carries a red personal key lock. (Tr. 342-45). Next, the authorized employee places the key to the blue equipment lock in the lock box that is then locked

[18] The photo of the mill stand lockout switches, on the Rolling Mill East Wall, was taken by the CO Sertil, on May 31, 2022, the day after the Mill Stand #7 incident involving AR. The Rolling Mill was not operating that day. In the photo, all the mill stand lockout switches have a blue equipment key lock on each lockout switch. (Tr. 93-95, 102-03, 168; JX-2). The photo shows the lockout switches for Mill Stands 9 through 14. The lockout switches for Mill Stands 9 through 14 are located on the East Wall near the lockout switches for Mill Stands 1 through 8, including Mill Stand #7. (Tr. 340-41).

with the authorized employee's red personal key lock. *Id.* The authorized employee keeps the red personal key lock on his person, to ensure no one opens the lock box to retrieve the blue equipment lock key, which can unlock and re-energize the mill stand. *Id.*

The next step in the mill stand lockout procedure is the authorized employee contacts the pulpit operator to request a mill stand "tryout," to verify the mill stand is locked out, by attempting to start up the mill stand. (Tr. 250-51, 345-47, 371-72, 424-25). The authorized employee will contact the pulpit operator by radio or over the mill FEMCO (internal loudspeaker) system (Tr. 250-51, 334-35, 345-47).[19] When it is verified that the mill stand will not start, the pulpit operator will broadcast the "all-clear signal" to proceed. (Tr. 346-47, 371-72, 425-26). This may be done over the FEMCO system and over radios worn by employees. (Tr. 346-47). Supervisor HH stated that the best way to determine if a mill stand is locked out is to look at the East Wall to see if the blue lock is in place. (Tr. 362-63, 396-97; JX-2). Supervisor HH testified that when an employee is working at Mill Stand #7, a blue equipment lock on Mill Stand #7's lockout switch is visible to an employee, except when working at the delivery side of Mill Stand #7. (Tr. 362-64).

May 30, 2022, the day of AR's fatal incident, was a down day in the Rolling Mill; it was not a production day. (Tr. 435). Whether the Rolling Mill is in production, operating in running mode, or on a down day, operating in jog mode, when employees adjust the mill stand jacks, behind the mill stand, lockout/tagout is required. (Tr. 370, 436-37).

Stand Lights

The Rolling Mill's Stand Lights, a series of lights on the upper west wall behind the mill stands, indicated whether a particular mill stand was currently locked out.[20] (Tr. 235-36). A Stand Light is an approximately 18-inch x 18-inch light that displays the number of its affiliated mill stand. (JX-14, Stip. Fact 11). Safety Manager Miele stated that the purpose of the Stand Lights

[19] Rolling Mill employees and the pulpit operator communicate with one another by radio or over the FEMCO internal loudspeaker system. All mill employees have a radio set to a same radio signal channel. When a mill employee uses the radio to communicate with the pulpit operator the communication is broadcast on the radios of all mill employees. When the pulpit operator responds on the radio, it is broadcast through the FEMCO loudspeaker system, and on the radios of all the mill employees. (Tr. 250-51, 333-34, 345-47).

[20] The Stand Lights are roughly 20 feet above the floor. (Tr. 354). When an employee faces the front of Mill Stand #7, he faces west.

was to indicate whether a machine was in a locked-out status.[21] (Tr. 235-36; JX-1). A Stand Light displays one of six color codes to indicate that machine's status. (JX-2). The large, full-color sign that described the six color codes was prominently located just below the lockout switch area on the East Wall. (Tr. 87, 354; JX-2) When a mill stand is de-energized and locked out, the affiliated Stand Light displays as the color green. (JX-2; JX-14, Stip. Fact 12).

Supervisor HH testified that the Stand Lights were used to give guidance to employees about whether a mill stand was locked out. (Tr. 354, 396-97, 427-29). Supervisor HH knew there were six color schemes to the lights but stated he had not been trained on the meaning of the Stand Lights and did not know which color indicated that a machine was locked out. (Tr. 353-54, 427-30). Supervisor HH testified that to supervise the Rolling Mill employees, he was not required to know the meaning of the Stand Lights' colors. (Tr. 429-31). He testified that he didn't look at the Stand Lights "very often." (Tr. 353-54).

The Stand Light for Mill Stand #7 was generally visible to the employees working around Mill Stand #7 on May 30, 2022. (Tr. 354-58). Supervisor HH agreed, on May 30, 2022, before AR's fatal incident, he could have looked at the Stand Light for Mill Stand #7 to see if the mill stand was locked out. (Tr. 362). Supervisor HH testified that as AR moved to the back of the mill stand that day, he did not look at the Stand Light for Mill Stand #7 but said, "I definitely wish I did." (Tr. 419, 427). HH's comment that he regretted not looking at the Stand Light, and his further discussion of the Stand Lights' colors, discloses HH's general awareness of the guidance provided by the Stand Lights' colors. (Tr. 427-31). Further, given the prominence of the large, full-color sign next to the East Wall lockout switches, it is not credible HH was not aware of the meaning of the Stand Lights. (JX-2).

Lockout/tagout periodic review

Safety Manager Miele described CMC's LOTO periodic review procedure. (Tr. 269-70). Mr. Miele is responsible for making sure the LOTO periodic reviews are done. (Tr. 273). The purpose of the CMC LOTO periodic review is to evaluate the specific LOTO procedures for effectiveness, to ensure that the LOTO procedure is consistent with the work being performed, and to verify that the LOTO procedures are being used and followed by the employees. (Tr. 192, 269,

[21] Safety Manager Miele testified there was nothing in CMC's written policy that required an employee to look at the Stand Lights to verify a machine was locked out. (Tr. 254; JX-6).

275, 282, 284, 304-07). Mr. Miele testified that most periodic reviews of LOTO procedures are done on down days, on average weekly. (Tr. 282, 304-07). The Rolling Mill employees know when a LOTO periodic review is being performed; however, they do not receive advance notice of the LOTO review. (Tr. 284-85).

Prior to the May 30, 2022 Mill Stand #7 fatal incident, a LOTO periodic review of Mill Stand #7 had been conducted on May 29, 2022, the day prior. (Tr. 192, 205-06, 281-82). The Mill Stand #7 periodic review was physically conducted at the location where the mill stand locks are placed, to verify the locks were there. (Tr. 269-70; *See* Tr. 192).

Training & Discipline

In addition to the lockout safety policies discussed above (JX-4, JX-6, JX-9), CMC also has a written document that sets forth the company's "5 Cardinal Safety Rules." (Tr. 262; RX-2). Each employee receives a copy of the document that sets forth the Cardinal Rules. (Tr. 263; *See* Tr. 171). The Cardinal Safety Rules are posted in the Facility. (Tr. 169-70). The first rule is the requirement to properly lockout any machine that is being worked on and specifically states, "[y]ou must follow procedures to properly LOCK OUT any machine you are going to work on, TAG OUT the breaker and TRY OUT the machine for any possible energy still being present in that machine."[22] (RX-2) (emphasis in original).

The Cardinal Rules document includes a warning to employees – written in capital letters: "Any willful violation of the rules will result in disciplinary action which may include suspension or termination." (RX-2) (emphasis in original). Shift Supervisor HH had the responsibility to ensure employees followed the safety rules and he had the authority to discipline employees who did not follow safety procedures. (Tr. 236-37, 312-13).

Before working on the plant floor, each employee is required to have mill-stand-specific LOTO training. (Tr. 402; *See* Tr. 199). This initial week of training includes the lockout procedures for the mill stands, as well as other safety topics, including the Cardinal Rules. (Tr. 199, 229, 258-60, 401). All members of the crew working on May 30, 2022, had received this training, including Shift Supervisor HH. (Tr. 190-91, 400-02). Annual refresher LOTO training

[22] The other four cardinal safety rules relate to fall protection, overhead loads, confined spaces, and railroad safety. (RX-2).

is held for all employees each February. (Tr. 199, 260). Training on various safety topics takes place monthly for all employees. (Tr. 258-59).

Training for all employees is provided by the safety department. (Tr. 258-59, 421-22). Supervisor HH relied on the safety department for information about the type of training an employee had received, including LOTO training. (Tr. 421-23). HH did not receive any additional training when he was promoted to the position of shift supervisor. (Tr. 426-30). HH received no training regarding the meaning of the Stand Lights' colors. (Tr. 429-30).

The only LOTO-related discipline in the 12 months prior to May 30, 2022, that Safety Manager Miele could recall, was for an employee in the facility's melt shop. (Tr. 266-67, 292-93). The employee, an electrician, entered an electrical panel that was not locked out and was burned by an arc flash. (Tr. 265-66). The employee was terminated. (Tr. 265-66). The lack of lockout became known to the safety department because of the injury. (Tr. 292-93). During the OSHA inspection, Supervisor HH and the Rolling Mill cold end manager stated they had never disciplined an employee for a LOTO violation. (Tr. 188-90). At the time HH was interviewed by the CO during the inspection, HH had been a supervisor for approximately one month. (Tr. 188-89).

The Inspection

On May 31, 2022, OSHA opened an investigation at CMC's New Jersey facility due to the death of AR the prior day. (JX-14, Stip. Facts 13, 14, 15). AR died after he was pulled into the spindles of Mill Stand #7. (Tr. 352). CO Christine Sertil, from OSHA's Avenel, New Jersey office, visited the Facility on May 31, 2022. (JX-14, Stip. Fact 15). CO Sertil held an opening conference with Safety Manager Miele and walked around the Rolling Mill area taking pictures. (Tr. 28, 86-87; JX-1, JX-2, JX-3). She spoke to Shift Supervisor HH, the cold end manager, and the hot end manager. (Tr. 28; JX-14, Stip. Fact 15).

During OSHA's investigation, CMC provided the video of Mill Stand #7 recorded on May 30, 2022, by a camera in the Rolling Mill area. (Tr. 29; JX-3; JX-3(a)). During the investigation, CO Sertil received and reviewed documentation of the CMC LOTO procedures for Mill Stand #7, CMC LOTO training records, including training records for AR, the CMC LOTO audit program, and documentation of CMC's regular LOTO audits. (Tr. 190-92, 199, 205-06, 215). CO Sertil reviewed documentation of the CMC LOTO audit of Mill Stand #7 that was conducted on May

29, 2022, the day before the May 30, 2022, fatal incident that resulted in the OSHA investigation. (Tr. 192, 205-06, 281-82).

CITATIONS

To establish a violation of an OSHA standard, the Secretary must prove by a preponderance of the evidence: (1) the cited standard applies; (2) there was noncompliance with the terms of the cited standard; (3) one or more employees had access to the cited condition; and (4) the employer knew, or with the exercise of reasonable diligence could have known, of the violative condition. *Donahue Indus., Inc.,* 20 BNA OSHC 1346, 1348 (No. 99-0191, 1994); *Astra Pharm. Prod.*, 9 BNA OSHC 2126, 2129 (No. 78-6247, 1981), *aff'd in relevant part*, 681 F.2d 69 (1st Cir. 1982).

Citation 1, Item 1

Citation 1, Item 1 alleges a serious violation of 29 C.F.R. § 1910.147(c)(4)(i), which sets forth:

> (c) General . . . (4) Energy control procedure.
> (i) Procedures shall be developed, documented and utilized for the control of potentially hazardous energy when employees are engaged in the activities covered by this section.

The alleged violation description in the Citation stated that "[t]he specific procedures that the employer developed were not utilized to protect the employees from the hazardous energy that is associated with making adjustments to the jacks of Stand #7."

The Secretary asserts that Respondent, through its Supervisor HH, had actual knowledge or, alternatively, constructive knowledge of the violative conditions alleged in this Citation Item, the failure to utilize the employer CMC's specific lockout procedures to protect employees from hazardous energy when adjusting the stand jacks of Mill Stand #7. (Sec'y Br. 21, 31-35.) In defense, Respondent asserts the Secretary cannot prove that CMC knew or should have known that AR failed to use the lockout procedure for Stand #7. (Resp. Br. 1-2, 7-11; Resp. Reply 1-2, 5, 7 n.1).

Applicability & Exposure

Respondent stipulates that the cited standard applies to the work AR was doing at the time of the incident on May 30, 2022. (JX-14, Stip. Law 4). The undersigned finds the standard applies.

Employee exposure is established "either by showing actual exposure or that access to the hazard was reasonably predictable." *Nuprecon LP*, 23 BNA OSHC 1817, 1819 (No. 08-1037, 2012) (citations omitted) (*Nuprecon*). "Employees may come within the zone of danger 'while in the course of their assigned working duties, personal comfort activities while on the job or their normal means of ingress-egress to their assigned workplaces.'" *Calpine Corp.*, No. 11-1734, 2018 WL 1778958, at *3 (OSHRC, Apr. 6, 2018) (*Calpine*) *aff'd*, 774 F. App'x 879 (5th Cir. 2019) (unpublished), citing *Gilles & Cotting, Inc*., 3 BNA OSHC 2002, 2003 (No. 504, 1976). "The Secretary need not show it was certain that employees would be in the zone of danger, but he must show that exposure was more than theoretically possible." *Calpine*, 2018 WL 1778958, at *3 (finding exposure reasonably predictable where the task was on the day's assignment sheet and the likely route for the worker to carry out the task was adjacent to the unguarded opening).

Here, the zone of danger, the back of Mill Stand #7, is an area the Respondent recognized was a hazard when employees were required to adjust the mill stand's jacks. Four employees—Shift Supervisor Hernandez, Assistant Roller AR, and Mill Technicians CC, and PH—worked at Mill Stand #7 where the pass change required an adjustment to the stand jacks at the back of Mill Stand #7. Thus, it was reasonably predictable one of those employees would make the needed adjustment which would expose them to the hazard. AR was actually exposed to the hazard of unexpected energization when he adjusted the stand's jacks on May 30, 2022. Exposure is proved.

Violation of Standard

Respondent developed a general lockout policy along with specific procedures dedicated to the adjustment of the mill stand jacks. (JX-4; JX-6; JX-9). CMC's *LOTO Program* document states,

> this procedure establishes the minimum requirements for controlling hazardous energy whenever maintenance or repair is done on machinery or equipment. It is used to ensure that the machine or equipment is stopped, isolated from all potentially hazardous energy sources, locked out and tested before anyone performs any servicing or maintenance on the machine or equipment.

(JX-4, p. 1). This parallels the requirements at 29 C.F.R. § 1910.147(a)(1)(i) (scope) and § 1910.147(c)(1) (energy control program). Further, the Respondent's *LOTO Program*, *Mill Stand Lock Out,* and *Tightening Stand Jacks* documents included steps for the lockout of a mill stand. (JX-4; JX-6; JX-9).

AR was adjusting the jacks at the back of Mill Stand #7 without using the lockout procedures developed by CMC. Several procedural steps were not used, such as when AR, the authorized employee, did not notify the affected employees the machine was to be locked out (JX-4), there was no attempt to try to start the machine to verify energy was isolated (JX-4; JX-9), the switch on the East Wall was not turned off (JX-6), and a lock was not affixed to keep the switch in the off position. (JX-6; JX-9). The cited standard was violated.

Knowledge

As described in the scope of Subpart J, "[t]his standard covers the servicing and maintenance of machines and equipment in which the *unexpected* energization or start up of the machines or equipment, or release of stored energy could cause injury to employees." 29 C.F.R. § 1910.147(a)(1)(i) (emphasis in original). The purpose of a lockout policy is for employers to "establish a program and utilize procedures for affixing appropriate lockout devices or tagout devices to energy isolating devices, and to otherwise disable machines or equipment to prevent unexpected energization, start-up or release of stored energy in order to prevent injury to employees." 29 C.F.R. § 1910.147(a)(3)(i). The hazardous condition is unexpected energization when working near moving parts where the procedures developed to lockout equipment to control hazardous energy are not used.

To establish knowledge, the Secretary must show that the employer knew or with the exercise of reasonable diligence could have known of a hazardous condition. *Calpine*, 2018 WL 1778958, at *5 (citations omitted). The employer's knowledge is directed to the physical condition that constitutes a violation. *Phoenix Roofing, Inc*., 17 BNA OSHC 1076, 1079-1080 (No. 90-2148, 1995) (citations omitted), *aff'd*, 79 F.3d 1146 (5th Cir. 1996). It is not necessary to show the employer knew or understood the condition was hazardous. *Id.* "A supervisor's knowledge of the violative condition is imputable to the employer." *Calpine*, 2018 WL 1778958, at *5 (citations omitted). To establish constructive knowledge, the Secretary must show that the employer could have known of the physical conditions that were violative, with the exercise of reasonable diligence. *AJM Packaging Corp.,* No. 16-1865, 2022 WL 1102423, at *5 (OSHRC, April 1, 2022) (citation omitted) (*AJM Packaging*); *N & N Contractors, Inc*., No. 96-0606, 2000 WL 665599, at *2 (OSHRC, May 18, 2000) (citations omitted), *aff'd,* 255 F.3d 122 (4th Cir. 2001) *(N & N Contractors*).

> Reasonable diligence requires the formulation and implementation of adequate work rules and training programs to ensure that work is safe, as well as adequate supervision of employees. Reasonable diligence also requires an employer to inspect the work areas, anticipate hazards to which employees may be exposed, and take measures to prevent the occurrence of violations.

N & N Contractors, 2000 WL 665599, at *2 (citations omitted). *See AJM Packaging,* 2022 WL 1102423, at *5 (reasonable diligence also is based on an employer's enforcement of work rules when violations are discovered).

"The actual or constructive knowledge of a supervisor can be imputed to the employer." *N & N Contractors*, 2000 WL 665599, at *2 (citations omitted). *See AJM Packaging,* 2022 WL 1102423 at *6, n.10 ("supervisor's knowledge imputable to employer, but where supervisor participates in violative conduct, supervisor's knowledge only imputable where supervisor's participation was foreseeable") citing *Penn. Power & Light Co. v. OSHRC*, 737 F.2d 350, 357-58 (3d Cir. 1984); *see generally, TNT Crane & Rigging, Inc.,* No. 16-1587, 2022 WL 2102910, at *4 (OSHRC, June 2, 2022), *aff'd,* 74 F.4th 347 (5th Cir. 2023) (*TNT Crane*) ("whether a supervisor engages in misconduct alongside a subordinate or authorizes a subordinate to engage in misconduct, 'both of those scenarios involve a subordinate's violation of safety rules so it is reasonable to charge the employer with the supervisor's knowledge of the subordinate's misconduct.' ") [23] citing *Angel Bros. Enter., Ltd. v. Sec'y of Labor,* 18 F.4th 827, 833 (5th Cir. 2021).

Here, the Secretary established Supervisor HH's actual and constructive knowledge of the violative condition. Supervisor HH's knowledge is imputed to CMC.

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[23] "[U]nder both Fifth Circuit and Commission precedent, the supervisor's actual knowledge of the [crew member's] violative conduct is imputable to [the Employer] without a foreseeability showing." *TNT Crane*, 2022 WL 2102910, at *4.

The employer or the Secretary may appeal a Commission order to the federal court of appeals for the circuit in which the violation allegedly occurred or where the employer has its principal office, and the employer also may appeal to the District of Columbia Circuit. *See* 29 U.S.C. §§ 660(a) & (b). Here, the violation occurred in New Jersey, in the Third Circuit, where Respondent's Sayreville Facility is located. Respondent's principal office is in Irving, Texas, in the Fifth Circuit. The Commission has held that "[w]here it is highly probable that a case will be appealed to a particular circuit, the Commission generally has applied the precedent of that circuit in deciding the case— even though it may differ from the Commission's precedent." *Kerns Bros. Tree Serv.*, 18 BNA OSHC 2064, 2067 (No. 96-1719, 2000).

Shift Supervisor HH had actual knowledge of the physical condition that constitutes the violation. Supervisor HH was present while the crew was working at Mill Stand #7. As Shift Supervisor, HH was responsible for the safety of his crew and for disciplining the crew when they were not in compliance with CMC's safety policy. (Tr. 236-37, 312-13). HH knew that adjustments to the mill stand jacks were routine on a down day and he had been trained on CMC's policy that requires the lockout (shut down and application of a lock)[24] of a mill stand before adjustments are made. (Tr. 337-38, 350, 409-14). HH knew that the bit, which had been run through Mill Stand #7, was not sized properly so adjustments to the stand would be needed. (Tr. 411-14; JX-14, Stip. Fact 13). HH knew Mill Stand #7 was energized, in jog mode, in order to run the bit. (Tr. 414, 436). HH knew when the mill stand, on a down day, was operating in jog mode, lockout was required before employees adjust the mill stand jacks at the back of the mill stand. (Tr. 370, 436-37).

The video shows HH watching as AR, with the long-handled wrench in hand, lifts some cables to squeeze through the side of the mill stand to get to the back of Mill Stand #7.[25] (Tr. 359-60, 380-81, 389; JX-3 at 6:29 to 6:38). HH admits that he saw AR walking to the back of the Mill Stand #7. (Tr. 359-60, 380-81, 389; JX-3 at 6:17-6:37). HH admits talking with AR as AR moved to the back of Mill Stand #7. (Tr. 359-60, 380-81). HH knew Mill Stand #7 had been energized to run the bit and that he had not received confirmation that the mill stand was shut down and locked out before AR moved to the back of the mill stand to adjust the stand jacks. (Tr. 248-51, 346-47, 361-62, 368, 371-72, 379-80, 381-82, 387-88, 417-18, 425-26).

Supervisor HH had actual knowledge that the Mill Stand #7 jacks needed adjustment, which required an employee to work at the back of the mill stand. HH had actual knowledge that the mill stand must be shut down and locked out to adjust the mill stand jacks. HH had actual knowledge Mill Stand #7 had been energized to run the bit. HH had actual knowledge that Assistant Roller AR moved to the back to Mill Stand #7 to adjust the stand jacks. HH knew that he had not received confirmation that the mill stand was shut down and locked out before AR

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[24] Step 4 of *Mill Stand Lock Out* procedures requires the following: (1) "On the East Wall of the Rolling Mill, turn off the Lock Out Switch for the designated Mill Stand. (2) Lock Switch in the 'OFF' position using the designated Lock for the Mill Stand." (JX-6, at 2).

[25] CMC's procedures specify that a long-handled wrench is used to make these adjustments to the mill stand's jacks. (Tr. 229, 257-59, 335, 400-02, 421-22; JX-9).

moved to the back of the mill stand to adjust the stand jacks. HH observed and spoke to AR as he moved to the back of the mill stand.

HH's actual knowledge of the conditions and work done at Mill Stand #7 on May 30, 2022, are imputed to Respondent.

Further, Supervisor HH had constructive knowledge of the hazardous condition present on May 30, 2022, when AR moved to the back of Mill Stand #7 to adjust the stand jacks, when the mill stand had not been shut down and locked out. The Secretary contends that Supervisor HH could have known of the hazardous condition, that Mill Stand #7 was not shut down and locked out, with the exercise of reasonable diligence. (Sec'y Br. 33-35). The Secretary correctly asserts that the violative conditions, the failure of Mill Stand # 7 to be shut down and locked out before AR moved to the back to adjust the stand jacks were in plain view. *Id.* Respondent concedes that Supervisor HH's actions on May 30, 2022, demonstrate a lack of diligence, as AR moved to the back of the mill stand to adjust the stand jacks. (Resp. Br. 13; Resp. Reply 8).

Supervisor HH admits he made no effort to verify whether Mill Stand #7 was shut down and locked out before an employee moved to the hazard zone at the back of the mill stand. The conditions revealing that Mill Stand #7 was not locked out were in plain view. On May 30, 2022, Supervisor HH did not look at the Stand Light for Mill Stand #7 to see if the mill stand was locked out. (Tr. 362, 419). Supervisor HH did not look at the East Wall to see if the Mill Stand #7 lockout switch had a blue equipment lock confirming that the mill stand was shut down and locked out. (Tr. 363-64). Supervisor HH did not ask Assistant Roller AR, the authorized employee, if Mill Stand #7 had been shut down and locked out. (Tr. 361-62). As AR moved to the back of Mill Stand #7, Supervisor HH did not observe AR following CMC's lockout procedures nor did he hear AR notify anyone he was going to lockout the stand, nor ask the pulpit operator to "try out," attempt to start the machine, nor did he hear the pulpit operator give the "all-clear signal" to proceed. (Tr. 248-51, 346-47, 361, 368, 372, 379-80, 382, 388, 417-18, 425-26).

Supervisor HH's failure to take readily available steps to verify that CMC's lockout policy was followed—that Mill Stand #7 was shut down and locked out—before an employee moved to the back of the stand to adjust the stand jack, discloses negligent, inadequate supervision, and a lack of reasonable diligence.

HH's inadequate supervision, including his failure to enforce CMC's specific lockout procedures for adjusting the mill stand jacks, and failure to anticipate the hazards to which

employee AR was exposed when adjusting the stand jacks on the mill stand that was not locked out, was foreseeable. Inadequate supervision constitutes a lack of reasonable diligence. *Stanley Roofing Co*., No. 03-0997, 2006 WL 741750, *3 (OSHRC, March 3, 2006) (Employer did not exercise reasonable diligence where Employer relied upon non-supervisory employees to monitor safety compliance and notify owner and manager of hazardous conditions.) (*Stanley Roofing*). HH, as a new supervisor, received no additional training when he assumed responsibility as the shift supervisor. (Tr. 312-14, 402, 426-30). HH's testimony reveals his incomplete knowledge regarding the function and guidance provided by the Stand Lights in the Rolling Mill. (Tr. 353-54, 362, 419, 427-31). His testimony also discloses his mistaken understanding that safety responsibility could be delegated to an employee on his crew and that he could simply rely on his personal feeling that AR was a safe employee. (Tr. 248-49, 407-08). *See V.I.P. Structures, Inc.* No. 91-1167, 1994 WL 362276, *3 (OSHRC, July 8, 1994) ("Responsibility under the Act for ensuring that employees do not put themselves into any unsafe position rests ultimately upon each employer, not the employees, and employers may not shift their responsibility onto their employees.")

Had Supervisor HH exercised reasonable diligence he could have known of the hazardous condition created by Mill Stand #7 not being shut down and locked out on the East Wall. Supervisor HH's failure to exercise reasonable diligence reveals his constructive knowledge that the mill stand was not shut down and locked out when an employee worked in the hazardous location at the back of Mill Stand #7. HH's constructive knowledge that Mill Stand #7 was not shut down and locked out on May 30, 2022, when AR worked at the back of the mill stand to adjust the stand jacks, is imputed to Respondent.

Respondent asserts that AR was exposed for too short of a time (two minutes) to prove knowledge and that a supervisor is not required to constantly watch an employee. (Resp. Br. 10). These assertions are meritless. HH was standing next to AR and watched him go to the back of the mill stand where AR was exposed to the hazard. *See, Am. Airlines, Inc.*, No. 93-1817, 1996 WL 88760, *2 (OSHRC, Feb. 23, 1996) (consolidated) (constructive knowledge of non-compliant floor openings established where those "conditions were in plain view and [] supervisory personnel were present throughout the work operations"). Because HH witnessed AR's initial point of exposure, the length of time AR worked at the back of the mill before the accident occurred is not relevant. Actual and constructive knowledge are established.

Serious Characterization

The Secretary alleged the violation was serious in nature. A violation is classified as serious under section 17(k) of the Act if "there is a substantial probability that death or serious physical harm could result." 29 U.S.C. § 666(k). "The Secretary must show that death or serious physical harm is a probable consequence *if* an accident results from the violative condition—he is not required to show that an accident is itself likely." *Home Rubber Co., LP*, No. 17-0138, 2021 WL 3929735, at *5 (OSHRC, Aug. 26, 2021) (emphasis in original) (*Home Rubber*).

The Secretary asserted the violation was serious in nature due to the potential for severe injury, permanent disability, and death if lockout procedures were not utilized. (Tr. 97-99, 109, 128). Here, the specific procedures CMC developed for the control of potentially hazardous energy were not utilized; Mill Stand #7 was not de-energized and locked out when AR adjusted the mill stand jacks. (JX-4; JX-6; JX-9). When Mill Stand #7 unexpectedly energized, AR was pulled into the mill stand and fatally injured. *Id.* (Tr. 338, 352.) Thus, a serious characterization is merited for Citation 1, Item 1.

Citation 2, Item 1(a)

Citation 2, Item 1(a) alleges a willful - serious violation of 29 C.F.R. § 1910.147(d)(2), which requires:

> (d) *Application of control*. The established procedures for the application of energy control (the lockout or tagout procedures) shall cover the following elements and actions and shall be done in the following sequence: . . .
>
> (2) *Machine or equipment shutdown*. The machine or equipment shall be turned off or shut down using the procedures established for the machine or equipment. An orderly shutdown must be utilized to avoid any additional or increased hazard(s) to employees as a result of the equipment stoppage.[26]

[26] The preamble to Control of Hazardous Energy Sources (Lockout/Tagout) states that 29 C.F.R. § 1910.147 (d)(2)

> …is the starting point for all subsequent actions necessary to put the machine or equipment in a state that will permit employees to work on it safely.
>
> In many operations, activation of an electrical push-button control or the movement of a simple throw switch (electrical, hydraulic, or pneumatic) to the 'stop' or 'off' mode is sufficient to meet this provision. In other cases, however, such as those found typically in a refining or chemical process, there are control devices that do not necessarily

The Secretary alleges in Citation 2, Item 1(a) that Respondent "did not ensure equipment was shut down while making adjustments on Stand #7" on May 30, 2022.

For this Citation Item, the Secretary asserts that Respondent, through its Supervisor HH, had actual or, alternatively, constructive knowledge of the violative conditions alleged in this Citation Item, that equipment was not shut down while adjustments were made on Mill Stand #7. (Sec'y Br. 21, 31-35.)

In defense, Respondent asserts the Secretary cannot prove that CMC knew or should have known that AR failed to follow the procedure to lockout Mill Stand #7. (Resp. Br. 1-2, 7-11; Resp. Reply 1-2, 5, 7 n.1). Further, Respondent asserts this citation item must be vacated because the evidence is undisputed that Mill Stand #7 was shut down, as depicted at mark 5:54 of the video in evidence. (Resp. Br. 8, 12; JX-3). Finally, Respondent asserts that the Secretary cannot support the willful characterization for Citation 2, Item 1(a). (Resp. Br. 8, 11-12).

Applicability, Exposure, and Knowledge

Respondent stipulates that the cited standard applies to the work AR was engaged in at the time of the accident on May 30, 2022. (JX-14, Stip. Law 4). The undersigned finds the standard applies.

Exposure is also proved. The hazardous condition is unexpected energization when adjusting a mill stand's jacks. All four crew members—Supervisor HH, Assistant Roller AR, and Mill Technicians CC and PH—worked at Mill Stand #7 where it was necessary to adjust the stand jacks. It was reasonably predictable at least one of those employees would work in the hazard zone at the back of the machine, where the mill stand's jacks were located. AR was actually exposed when Mill Stand #7 energized as he was adjusting the stand jacks at the back of the mill stand. *See Nuprecon*, 23 BNA OSHC at 1818 (exposure is established "either by showing actual exposure or that access to the hazard was reasonably predictable") (citations omitted).

> address an 'off-on' or 'start-stop' condition (i.e., level controls, pressure controllers, etc.). In these instances, a series of predetermined steps may be necessary to achieve a shutdown of the machine or equipment.

Control of Hazardous Energy Sources (Lockout/Tagout), 54 Fed. Reg. 36644, 36677 (Sept. 1, 1989) (to be codified at 29 C.F.R. pt. 1910) (LOTO Final Rule Preamble).

Actual and constructive knowledge are proved for Citation 2, Item 1(a) for the reasons set forth above in Citation 1, Item 1. Shift Supervisor HH had actual knowledge that the mill stand must be shut down and locked out at the East Wall to adjust the mill stand jacks. HH had actual knowledge Mill Stand #7 had been energized to run the bit. HH watched AR move to the back of Mill Stand #7 to make those adjustments. HH knew that he had not received confirmation that the mill stand was shut down and locked out before AR moved to the back of the mill stand to adjust the stand jacks. HH made no reasonably diligent effort to determine whether the mill stand had been locked out and shut down, using any of the several methods available, including simply looking at the East Wall to verify the blue equipment lock was in place for Mill Stand #7. Knowledge is proved and imputed to Respondent through Shift Supervisor HH.

The standard was violated

Respondent violated the requirements of the cited standard. The cited standard requires the employer to conduct an orderly shutdown "using the procedures established for the machine or equipment." 29 C.F.R. § 1910.147(d)(2).

Hazardous energy standard 29 C.F.R. § 1910.147(d) provides that "five separate and distinct steps be followed in meeting the procedural requirements of paragraph (c)(1)(Procedure) . . . and that the actions be taken in the sequence presented." LOTO Final Rule Preamble, 54 Fed. Reg. at 36676-77. The standard's preamble explains that the shutdown procedure for a machine may be as simple as "the movement of a simple throw switch (electrical, hydraulic, or pneumatic) to the 'stop' or 'off' mode" or may require a "series of predetermined steps . . . to achieve a shutdown of the machine or equipment." *Id.* at 36677.

Respondent did not follow its own procedures for the shutdown of the machine in the lockout procedure. Step 4 of the procedure outlined in *Mill Stand Lockout*, states, "On the East Wall of the Rolling Mill, turn off the Lock Out Switch for the designated Mill Stand." (JX-6, p. 2). AR moved to the back of Mill Stand #7 without implementing the step that requires the lockout switch for Mill Stand #7 to be turned off at the Rolling Mill East Wall.

Respondent asserts the mill stand had been shut down at video mark 5:50-54, where Mill Technician CC is shown using his radio. (JX-3). Respondent claims this footage demonstrates CC told the pulpit operator to shut down Mill Stand #7. (Resp. Br. 11; JX-3). However, this assertion is not supported by the record. CC testified that he did not recall what he was saying at that moment. (Tr. 455). There is no other evidence in the record that CC communicated with the

pulpit operator to shut down Mill Stand #7. Importantly, CMC's procedure specifies the shutdown must be done at the mill stand's switch on the East Wall, not by the pulpit operator.

The evidence shows that the machine was not shut down in accordance with CMC's procedures. (JX-6, at 2; JX-9). The Secretary has proved the elements of applicability, employee exposure, violation of the standard, and employer knowledge. Citation 2, Item 1(a) is affirmed.

Citation 2, Item 1(b)

Citation 2, Item 1(b) alleges a willful - serious violation of 29 C.F.R. § 1910.147(d)(4)(i), which requires:

> (d) Application of control. The established procedures for the application of energy control (the lockout or tagout procedures) shall cover the following elements and actions and shall be done in the following sequence: . . . .
>
> (4) Lockout or tagout device application. (i) Lockout or tagout devices shall be affixed to each energy isolating device by authorized employees.

The Secretary alleges in Citation 2, Item 1(b) that Respondent "did not ensure locks were affixed to isolate energy sources while employees were adjusting the jacks on Stand #7."

For this Citation Item, the Secretary asserts that Respondent, through its Supervisor HH, had actual knowledge or, alternatively, constructive knowledge of the violative conditions alleged in this Citation Item, that Respondent did not ensure that locks were affixed to isolate energy sources while the Mill Stand #7 jacks were adjusted. (Sec'y Br. 21, 31-35.) In defense, Respondent asserts the Secretary cannot prove that CMC knew or should have known that AR failed to follow the lockout procedure for Stand #7. (Resp. Br. 1-2, 7-11; Resp. Reply 1-2, 5, 7 n.1). Further, Respondent asserts that the Secretary cannot support the willful characterization for Citation 2, Item 1(b). (Resp. Br. 8, 11-12).

Applicability, Violation of the Standard, Exposure, and Knowledge

Respondent stipulates that the cited standard is applicable to the work AR was engaged in on May 30, 2022, at the time of the incident. (JX-14, Stip. Law 4). It is undisputed that a lock was not affixed to Mill Stand #7's lockout switch, and AR was not protected against unexpected energization. (Tr. 231). The undersigned finds the standard applies and was violated.

Exposure is also proved. All four crew members worked at Mill Stand #7 where it was necessary to adjust the mill stand jacks that day. It was reasonably predictable at least one of those employees would work in the hazard zone at the back of the machine, where the mill stand jacks

were located. AR was actually exposed when Mill Stand #7 unexpectedly energized as he was adjusting the stand jacks of the mill stand. *See Nuprecon*, 23 BNA OSHC at 1818 (exposure is established "either by showing actual exposure or that access to the hazard was reasonably predictable") (citations omitted).

For the same reasons that apply to Citation 1, Item 1, actual and constructive knowledge are proved for Citation 2, Item 1(b). Shift Supervisor HH had actual knowledge that the mill stand must be shut down and locked out at the East Wall to adjust the mill stand jacks. HH had actual knowledge Mill Stand #7 had been energized to run the bit. HH watched AR move to the back of Mill Stand #7 to make those adjustments. HH knew that he had not received confirmation that the mill stand was shut down and locked out before AR moved to the back of the mill stand to adjust the stand jacks. HH made no reasonably diligent effort to determine whether the mill stand had been locked out and shut down, using any of the several methods available, including simply looking at the East Wall to verify the blue equipment lock was in place for Mill Stand #7. Knowledge is proved and imputed to Respondent through Shift Supervisor HH.

The Secretary has proved the elements of applicability, violation of the standard, employee exposure, and employer knowledge. Citation 2, Item 1(b) is affirmed.

Willful Characterization

The Secretary asserts Citation 2, Items 1(a) and 1(b) are willful-serious. The undersigned finds the record does not support a willful characterization.[27]

"A willful violation is differentiated by heightened awareness of the illegality of the conduct or conditions and by a state of mind of conscious disregard or plain indifference." *Stark Excavating, Inc.*, 24 BNA OSHC 2215, 2222 (No. 09-0004, 2014) (*Stark Excavating*) (citation omitted), *aff'd*, 811 F.3d 922 (7th Cir. 2016). Further,

> The Commission and courts make a distinction between mere negligence and willfulness, holding that the former is sufficient for affirming a non-willful violation, but that willfulness is characterized by an intentional, knowing failure to comply with a legal duty. *E.g., Am. Wrecking*, 351 F.3d 1254, 1264 (D.C. Cir. 2003)

[27] Respondent asserts these violations cannot be willful because the Shift Supervisor did not know that AR had not locked out the mill stand and did not see AR go back to make an adjustment to the stand's jack. (Resp. Br. 13; Resp. Reply Br. 7-9). The undersigned rejects Respondent's assertion. As discussed above, Shift Supervisor HH worked next to AR and saw AR go to the back of the mill stand without any verification that the stand was locked out. (Tr. 359-60, 380-81, 387-89; JX-3).

> (reversing willful finding where employer "should have known" of hazardous condition, court stated that willfulness requires "an intentional or conscious disregard for the applicable safety standard or for employee safety"). As the court stated in *AJP Constr., Inc. v. Secretary*, 357 F.3d 70, 75 (D.C. Cir 2004), "to sustain a willful violation, '[t]he Secretary must show that the employer was actually aware, at the time of the violative act, that the act was unlawful, or that it possessed a state of mind such that if it were informed of the standard, it would not care."' (Emphasis and citations omitted.)

Greenleaf Motor Express, Inc., 21 BNA OSHC 1872, 1875 (No. 03-1305, 2007), *aff'd*, 262 F. App'x 716 (6th Cir. 2008) (unpublished); *see also, Blue Ridge Erectors v. OSHRC*, 261 F. App'x 408, 411 (3d Cir. 2008) (*Blue Ridge*) (unpublished) ("A willful violation of the OSH Act 'constitutes an act done voluntarily with either an intentional disregard of, or plain indifference to, the OSH Act's requirements' ") (citation omitted). "Whether a violation is willful is a question of fact." *Blue Ridge*, 261 F. App'x at 411.

The undersigned finds CMC had a heightened awareness of the standard's requirements through its own safety policy. (JX-4; JX-6; JX-9). CMC's written lockout policy paralleled the OSHA requirements and included specific instructions to lockout a mill stand prior to adjusting the mill stand jacks. (JX-6; JX-9). *See Morrison-Knudsen Co.,* 16 BNA OSHC 1105, 1123-24, (No. 88-0572, 1993) ("safety program is evidence that the employer was aware of the cited standards and their requirements"); *see also, Cranesville Block Co.,* 23 BNA OSHC 1977, 1981 (No. 08-0316, 2012) (consolidated) (*Cranesville*) (heightened awareness where company's respiratory protection policy both cited to and included requirements from OSHA's standard). CMC's weekly periodic audits of the lockout policy also demonstrate a heightened awareness of the standard's requirements.[28] (Tr. 282). Further, Supervisor HH received training regarding CMC's lockout policy and procedures. (Tr. 190-91, 199, 326-27, 260, 312-13, 400-02; RX-2).

While the evidence shows that CMC had a heightened awareness of the standard's requirements for lockout, evidence does not show that CMC had the requisite state of mind to support a willful characterization either through intentional disregard or plain indifference. Viewed in context, the record as a whole discloses, on May 30, 2022 before AR began adjusting the mill stand jacks, Supervisor HH's inattention to the fact that the necessary audio and visual

[28] "The employer shall conduct a periodic inspection of the energy control procedure at least annually to ensure that the procedure and the requirements of this standard are being followed." 29 C.F.R. § 1910.147(c)(6)(i).

signals were absent (signals that would have confirmed Mill Stand #7 was locked out), demonstrates HH's negligence and a lack of diligence, not intentional disregard or plain indifference for employee safety. *See Home Rubber,* 2021 WL 3929735, at *4 (finding employer had heightened awareness, but "absent some additional evidence reflecting that the company possessed a willful state of mind" the lack of compliance with the hearing program over the years was simply negligence); *Cranesville,* 23 BNA OSHC at 1981 (employer had a heightened awareness of standard, it did not possess the requisite state of mind for willful where the evidence "demonstrates only negligence or a lack of diligence on the part of corporate management rather than, as the Secretary contends, a 'deliberate blindness' towards safety at the plant."); *see also, Babcock & Wilcox Co. v. Sec'y of Labor*, 622 F.2d 1160, 1165 (3d Cir. 1980) ("There was a lack of diligence, but not the intentional element necessary for a willful violation.").

First, there is no evidence that Respondent exhibited plain indifference to employee safety. Respondent had a written safety policy that paralleled the requirements of the OSHA standard and trained its employees on the policy. Further, Respondent conducted periodic inspections of the lockout procedures weekly, even thought it was only required to do so annually. Finally, Respondent identified the hazard associated with the adjustment of a mill stand jacks and developed a specific procedure for that task. *See Home Rubber*, 2021 WL 3929735, at *4 (noisy plant conditions insufficient to demonstrate plain indifference to audiogram requirement).

Second, there is no evidence of intentional disregard of the standard's requirements. *See Jim Boyd Constr., Inc.,* 26 BNA OSHC 1109, 1111 (No. 11-2559, 2016) (citations omitted) ("To prove intentional disregard, the Secretary must show that the employer (1) had a heightened awareness of the 'applicable standard or provision prohibiting the conduct or condition' and (2) 'consciously disregarded the standard.' ") (citations omitted). The Secretary asks the undersigned to draw the inference that the Shift Supervisor HH consciously made the decision to have AR work on the energized stand, in violation of CMC's policy. (Sec'y Br. 15). Further, the Secretary asserts that because the Shift Supervisor was inattentive and did not verify that AR followed the lockout procedure a finding of intentional disregard is supported. The undersigned disagrees.

Here, the supervisor's inattention to whether AR followed the lockout policy reflects carelessness or a lack of diligence, not an intentional disregard of the requirement to lockout Mill Stand #7. *AJP Constr*., 357 F.3d at 75 (constructive knowledge or mere negligence supports a non-willful violation, but willfulness requires conscious disregard or plain indifference to the Act's

requirements). *See Stark Excavating,* 24 BNA OSHC at 2224 (job site superintendent's heightened awareness of the OSHA excavation standard did not support willful characterization, where there was insufficient evidence that the superintendent's failure to comply "was anything more than negligence."); *Burkes Mech., Inc.*, 21 BNA OSHC 2136, 2138, 2141 (No. 04-0475, 2007) (where employer's superintendent was aware of the danger associated with working underneath the fuel wood conveyor, that had not been locked out, "his awareness establishes only constructive knowledge, not plain indifference to employee safety"); *Branham Sign Co.*, 18 BNA OSHC 2132, 2135 (No. 98-752, 2000) (based on case-specific facts, the employer's failure to monitor employee's use of safety equipment showed a lack of diligence, supporting a finding of constructive knowledge, but did not establish plain indifference where the employer provided the necessary safety equipment and had a rule that required its use); *Williams Enters. Inc.*, 13 BNA OSHC 1249, 1257 (No. 85-0355, 1987) (a violation is not willful if the Secretary only proves carelessness or lack of diligence in discovering or eliminating a violation). *See also, Active Oil Serv., Inc.,* 21 BNA OSHC 1184, 1188-89 (No. 00-0553, 2005) (*Active Oil Serv*.) (The record evidence established the foreman had constructive knowledge of the violative condition but was insufficient to support a willful characterization. Despite the foreman's sometimes lax approach to enforcing safety rules that was likely impacted by the company president's comment that the company "would never get anything done if they did things by the book," the evidence did not establish that the foreman's state of mind, at the time of the cited violation, rose to the level of plain indifference to employee safety.).

It is the Secretary's burden to establish the willful characterization of Citation 2, Items 1(a) and 1(b). *Stanley Roofing*, 2006 WL 741750, *4 ("The Secretary bears "burden of proof to show the requisite state of mind for willfulness."). *See also*, *Active Oil Serv*., 21 BNA OSHC at 1188-89. [29] The Secretary did not prove that Respondent was more than negligent. The Secretary does

[29] The Secretary asserts that Respondent's contentions that CMC reinforces its rules with weekly LOTO audits, including having conducted a LOTO periodic review of Mill Stand #7 on May 29, 2022, the day prior to AR's fatal incident, should be given little, if any, weight. The Secretary asserts Respondent produced little documentary evidence regarding the LOTO audits in support of Safety Manager Miele's testimony. (Sec'y Reply Br. 7-8; Resp. Br. 5). The undersigned rejects the Secretary's assertion. Weight is given to the Mr. Miele's testimony regarding Respondent's LOTO periodic reviews. (Tr. 269-70, 273, 275, 282, 284-85, 304-07). Mr. Miele's testimony is corroborated by the Compliance Officer who confirmed

not allege that Respondent's safety plan was not consistent with OSHA's requirements for a lockout/tagout policy. (Sec'y Reply Br. 8). There is no evidence of prior warnings or discipline to any crew member. There is no evidence that employees or the management at CMC did not take the requirement to follow the lockout policy seriously. There is no indication the crew was rushing or cutting corners that day; to the contrary, they were ahead of schedule. (Tr. 415). The Secretary does not allege that Respondent's enforcement of its lockout/tagout policy was lax. Instead, the evidence shows the company trained its employees on the lockout procedure and implemented multiple ways that lockout could be verified (locks on East Wall, Stand Lights, pulpit operator "tryout").

In summary, Respondent had a heightened awareness of OSHA's standards that require the lockout of a hazardous area that could be unexpectedly energized. *Stark Excavating,* 24 BNA OSHC at 2222 ("A willful violation is differentiated by heightened awareness of the illegality of the conduct or conditions and by a state of mind of conscious disregard or plain indifference."). However, the record does not support a finding that Respondent was either plainly indifferent to employee safety or had a conscious disregard of the standard. Thus, the willful characterization is not supported for Citation 2, Item 1(a) and Item 1(b).

The Secretary also characterized these violations as serious in nature. As set forth above, a violation is classified as serious under section 17(k) of the Act if "there is a substantial probability that death or serious physical harm could result." 29 U.S.C. § 666(k). "[T]he Secretary must show that death or serious physical harm is a probable consequence *if* an accident results from the violative condition—he is not required to show that an accident is itself likely." *Home Rubber*, 2021 WL 3929735, at *5. Here, Mill Stand #7 was not shut down, de-energized, and locks were not affixed to isolate energy sources, before AR adjusted the mill stand jacks. When Mill Stand #7 unexpectedly energized, AR was pulled into the mill stand and fatally injured. (Tr. 111-12, 128, 338, 352). Thus, a serious characterization is merited for Citation 2, Item 1(a) and Item 1(b).

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review of Respondent's LOTO audit documentation during the inspection. (Tr. 192-93, 205-06, 215). The Secretary did not rebut Respondent's contentions regarding its LOTO audit program or the LOTO audit of Mill Stand #7 on May 29, 2022.

Penalty – All Citation Items

"Once a citation is contested, the Commission has the sole authority to assess penalties." *Valdak Corp.*, 17 BNA OSHC 1135, 1138 (No. 93-0239, 1995) (citation omitted), *aff'd*, 73 F.3d 1466 (8th Cir. 1996). The Commission and its judges may consider all penalties *de novo* based on the applicable statutory criteria and the case facts. *Id.*

The maximum statutory penalty for a serious violation is $14,502.[30] Section 17(j) of the Act requires the Commission to give due consideration to four criteria in assessing penalties: the size of the employer's business, the gravity of the violation, the employer's good faith, and its prior history of violations. 29 U.S.C. 666(j). Gravity is the primary factor in the penalty assessment. *See J. A. Jones Constr. Co.*, 15 BNA OSHC 2201, 2214 (No. 87-2059, 1993).

CMC's own rule states that "[w]orking on equipment that is not locked out can result in serious or fatal injury." (JX-6, p. 1). Here, failure to shut down, deenergize, and affix locks to isolate energy sources to the mill stand, before AR adjusted the mill stand's jacks, resulted in a fatal injury. The proposed penalty amounts set forth in the Citation were assessed as high gravity due to a high severity of harm such as disability or death from the hazard and a high probability because the lockout procedures were frequently used at the facility, at least once a week.[31] The employer has over 200 employees, so there was no discount for size. (Tr. 135). OSHA provided no reduction for good faith due to the high gravity nature of the violations.[32] (Tr. 135).

The undersigned agrees with the penalty assessments set forth above. Citation 1, Item 1 is affirmed as a serious violation with an assessed penalty of $14,502. Citation 2, Items 1(a) and 1(b) are affirmed as serious violations for a grouped penalty of $14,502.

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[30] For a serious citation issued on November 30, 2022, the maximum penalty is $14,502. 87 Fed. Reg. 2328, 2336 (Jan. 14, 2022).

[31] The record reveals the frequent need to utilize CMC's lockout procedures before the mill stand jacks are adjusted. (Tr. 132-33, 234-35, 336-37; CX-2).

[32] The CO assessed a 10% penalty increase due to the company being cited in the prior five years. (Tr. 135-38). However, the 10% history increase was moot because the amount of the penalty was already at the statutory maximum of $14,502. (Tr. 137; CX-2). The undersigned further notes the proposed penalty increase for history is not supported in the record, as no evidence was introduced regarding any prior citation allegedly received by Respondent. (Tr. 26-27, 136).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

All findings of fact and conclusions of law relevant and necessary to a determination of the contested issues have been made above. *See* Commission Rule 90(a). 29 C.F.R. § 2200.90(a). All proposed findings of fact and conclusions of law inconsistent with this decision are denied.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, it is ORDERED that:

1. Citation 1, Item 1 alleging a Serious violation of 29 C.F.R. § 1910.147(c)(4)(i) is affirmed with a penalty of $14,502.

2. Citation 1, Item 3, alleging a serious violation of 29 C.F.R. § 1910.147(f)(3), withdrawn by the Secretary, is dismissed.

3. Citation 2, Item 1(a) alleging a violation of 29 C.F.R. § 1910.147(d)(2) and 1(b) alleging a violation of 29 C.F.R. § 1910.147(d)(4)(i) are affirmed as Serious violations for a combined penalty of $14,502.

SO ORDERED.

/s/ Carol A. Baumerich
Carol A. Baumerich
Judge, OSHRC

DATE: September 30, 2024

Washington, D.C.