



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

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SECRETARY OF LABOR, :

Complainant, :

v. :

LEWIS COUNTY DAIRY CORP., :

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Respondent. :

OSHRC DOCKET NO. 03-1533

Appearances:

William G. Staton, Esquire  
 Evanthia Voreadis, Esquire  
 U.S. Department of Labor  
 New York, New York  
 For the Complainant.

Susan G. Kellman, Esquire  
 Law Offices of Susan G. Kellman  
 Brooklyn, New York  
 For the Respondent.

Before: G. Marvin Bober  
 Administrative Law Judge

**DECISION AND ORDER**

This matter is before the Occupational Safety and Health Review Commission (“the Commission”) pursuant to section 10(c) of the Occupational Safety and Health Act of 1970, 29 U.S.C. § 651 *et seq.* (“the Act”). The Occupational Safety and Health Administration (“OSHA”) conducted an inspection of Respondent, Lewis County Dairy Corp. (“Lewis”), on January 29 and 30, 2003; the facility of Respondent Lewis is a kosher dairy that is located in Lowville, New York. As a result of the inspection, on July 28, 2003, OSHA issued to Lewis a 33-item serious citation, a two-item willful citation and a one-item “other” citation; the penalties proposed total \$141,000.00. Lewis filed a timely notice of contest, in which it contested the citations and proposed penalties. An administrative trial was held in this matter in New York, New York, on June 9-10 and 14-16, 2004,

and a further administrative trial was held in Syracuse, New York, on April 25 and 26, 2006.<sup>1</sup> Both parties have submitted post-trial and supplemental briefs, and this matter is ready for disposition.

### **Background**

As indicated above, Lewis operates a kosher dairy located in Lowville, New York; the facility processes milk and also produces milk products such as yoghurt, butter and cheese. On January 29, 2003, OSHA Compliance Officers (“CO’s”) Scott Schrilla and Andrew Palhof arrived at the facility to inspect it.<sup>2</sup> An employee directed them to the main office, where they met with Melissa Hirsch, the human resources manager.<sup>3</sup> The CO’s identified themselves and asked to speak to the person in charge of safety or the plant manager. Ms. Hirsch contacted Christopher Tehonica, the safety coordinator, and Karen Karelus, the quality control supervisor, and, when they arrived, the CO’s explained why they were there. The CO’s went to a room identified as being shared by Ms. Hirsch and Mr. Tehonica, and they held an opening conference with Ms. Hirsch, Ms. Karelus and Mr. Tehonica. The CO’s then went to a different room, along with Ms. Hirsch and Mr. Tehonica, to view the facility’s injury records.<sup>4</sup> When the CO’s requested the OSHA 300 illness and injury logs, both Ms. Hirsch and Mr. Tehonica stated that there were none. The CO’s next asked for any written safety programs, including a hazard communication (“HAZCOM”) program, a lockout/tagout (“LOTO”) program, and a confined space program; however, neither Ms. Hirsch nor Mr. Tehonica was aware of any such programs. (Tr. 33-37, 363, 370-72, 405-08, 424, 576-85, 742, 807, 823).

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<sup>1</sup>My initial decision in this matter, issued on March 4, 2005, dismissed the citations upon a finding that jurisdiction had not been established. On April 1, 2005, the Commission reversed and remanded, ordering that a decision on the merits be issued. Pursuant to the remand order, I issued an order on June 3, 2005, that, among other things, admitted into the record evidence of both parties that had been made offers of proof. I then held a further administrative trial to allow the parties to address the additional evidence.

<sup>2</sup>The Syracuse, New York OSHA office assigned the two CO’s to inspect the facility pursuant to a local emphasis program addressing the food processing industry. CO Schrilla was assigned to conduct the inspection, and CO Palhof, at that time a trainee, was assigned to assist CO Schrilla in the inspection. (Tr. 33-34, 481-82).

<sup>3</sup>Ms. Hirsch also apparently performed receptionist and secretarial duties. (Tr. 784, 995).

<sup>4</sup>Ms. Karelus evidently was not present at this time. (Tr. 581, 645).

The CO's conducted the walk-around inspection, accompanied by Mr. Tehonica, on January 29 and 30, 2003. The CO's saw numerous conditions they considered violations, and CO Schrilla interviewed employees and management personnel during the inspection. On February 7, 2003, CO Schrilla returned to the facility with his supervisor, Christopher Adams, the OSHA office assistant area director ("AAD"), to interview Thomas Spencer, the general manager of Lewis. CO Schrilla also went back to the facility on March 5, 2003, and obtained signed statements from Ms. Hirsch, Ms. Karelus and Ronald Stone, the plant manager. After the inspection was completed, CO Schrilla held a telephonic closing conference with Mr. Tehonica and Mr. Spencer; CO Palhof was also present for the conference. (Tr. 37-52, 361-62, 494-500, 552; C-73, C-74, C-75).

#### *Credibility Determination*

Respondent Lewis asserts in its post-trial brief that the two CO's were biased and that their testimony was not credible. Lewis further asserts that its main witness, Mr. Tehonica, was more credible because his testimony was less self serving and also because it was more consistent with other evidence in the record. I do not agree.

The testimony of CO's Schrilla and Palhof concerning the opening conference, including the documents they requested and the responses of Ms. Hirsch and Mr. Tehonica, is summarized above in the background portion of this decision. Mr. Tehonica also testified in this regard, but his testimony was very much at odds with the testimony of the two CO's. Mr. Tehonica first explained his safety responsibilities, noting that he became the safety coordinator in September 2002 and that Mr. Spencer appointed him to the position because he wanted the facility to be "fully safety organized" and because he (Mr. Tehonica) would not be "pushed around" by employees and would have the "final say" as to safety.<sup>5</sup> However, Mr. Tehonica then testified that upon arriving at the office pursuant to Ms. Hirsch's call, and after the CO's identified themselves, Ms. Hirsch started "going off" about how

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<sup>5</sup>Mr. Tehonica also testified that his first position with Lewis, in June 2000, involved construction work, that about a year later he became responsible for the facility grounds as well as the warehouse, and that his current position was warehouse supervisor and safety coordinator; he noted he was also still responsible for the facility grounds, which involved snow removal in the winter and lawn mowing in the summer, and that while his daytime work involved primarily the warehouse he spent a great deal of time on safety issues in the evenings and on weekends. Mr. Tehonica agreed that the warehouse and safety duties comprised about 75 and 25 percent, respectively, of his daytime work. (Tr. 763-64, 771-72, 825, 968-70).

she, Ms. Karelus and Mr. Stone were the authority figures in the facility and that he (Mr. Tehonica) was only the safety coordinator and had no authority to hire or fire. Mr. Tehonica also testified that after the CO's began the opening conference, he left to call Mr. Spencer and Mr. Stone; he was unable to reach Mr. Spencer and left him a message, but he reached Mr. Stone, who asked him to come by and pick him up.<sup>6</sup> According to Mr. Tehonica, he returned to the meeting for about two minutes and then, after advising Ms. Karelus, left to pick up Mr. Stone. Mr. Tehonica indicated that he returned with Mr. Stone in about 30 minutes, near the conclusion of the meeting, which ended about five minutes later. Mr. Tehonica said no one asked him anything during that time and that CO Schrilla's testimony that he had asked him (Mr. Tehonica) about safety programs was not correct. He also said he went on the inspection with the CO's because Ms. Hirsch "ordered" him to and that while he thought he should have been in control of the inspection, from the company's standpoint, it was clear that CO Schrilla mainly wanted to talk to Mr. Stone, Ms. Karelus and Ms. Hirsch; Mr. Tehonica therefore took a "code of silence," and although he answered questions the CO's asked him, he offered no other information.<sup>7</sup> (Tr. 763-67, 776-87, 995-96).

In my view, the foregoing testimony of Mr. Tehonica is simply not credible. In particular, I compare his statement that he was made safety coordinator because employees would not push him around and he would have the final say as to safety with his statement that he went on the inspection because Ms. Hirsch ordered him to and that he only answered questions and did not offer anything; I also note his testimony that Ms. Hirsch was not his supervisor and that Mr. Stone, the plant manager, did not direct him one way or the other as to the OSHA inspection. (Tr. 764-67, 782-83, 787, 995-97). Further, I found Mr. Tehonica's testimony about a number of the cited conditions in this case not credible. For example, Mr. Tehonica testified that Lewis had written safety policies in effect when he became safety coordinator; specifically, he stated that in September 2002, there were written HAZCOM, confined space and LOTO programs in place. (Tr. 767-68). His testimony about these programs on cross-examination, however, was vague and inconsistent. He first indicated he had found

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<sup>6</sup>Mr. Tehonica testified that Mr. Stone did not drive and that he picked him up every day for work. (Tr. 778).

<sup>7</sup>Mr. Tehonica also testified that he did not offer information during the inspection as Ms. Hirsch had told him to "keep [his] mouth shut." (Tr. 998-99)

the programs in Mr. Spencer's office, but he then indicated that he had also located them in various other parts of the facility. He also indicated that it had taken him three or four months to compile the documents that comprised the programs but then indicated that he had held meetings on the programs very shortly after becoming the safety coordinator.<sup>8</sup> Finally, he testified that he did not know if copies of the programs had been provided to employees previously but that he himself had not given out the programs after he became the safety coordinator.<sup>9</sup> (Tr. 999-1008, 1070-73).

In addition to the above, I observed the demeanor of the two CO's and Mr. Tehonica on the witness stand, including their body language and facial expressions. I found CO's Schrilla and Palhof to be accurate and clear in their testimony; however, I found significant parts of Mr. Tehonica's testimony to be inaccurate and equivocal. Based on these findings, and for the reasons set out *supra*, I credit the testimony of CO's Schrilla and Palhof over that of Mr. Tehonica. Accordingly, I find as fact that the beginning of the inspection occurred in the way that the CO's described it and that Ms. Hirsch and Mr. Tehonica both told the CO's that Lewis had no OSHA 300 logs and that they were unaware of any written confined space, HAZCOM or LOTO programs at the facility.

**Serious Citation 1 - Item 1**

This item alleges a violation of the general duty clause, section 5(a)(1) of the Act, stating that fiberglass ladders were in use at the facility that had damage such as cracked side rails and bent cross bracing; this item further alleges that fiberglass ladders in use at the facility had side rails with repairs and had not been inspected.

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<sup>8</sup>The safety manual of Lewis, which contains its written safety programs, was admitted as R-11. However, Mr. Tehonica conceded that the first draft of R-11 did not come out until March 2003 and that R-11 was not finalized until June 2003. (Tr. 1002-03). Moreover, Veronica Migon, a consultant with New York State Insurance Fund ("NYSIF"), Respondent's insurer at the time of the OSHA inspection, testified that she met with Mr. Spencer on February 13, 2003, and that he showed her a binder like R-11 that contained the facility's written safety programs; she told him the programs looked great but that they could not be approved until they were implemented, and she said she had learned from her consulting work at the facility that no one else was aware of the programs, including Ms. Hirsch and Mr. Tehonica. (Tr. 1233-34, 1250-51, 1260-61).

<sup>9</sup>Mr. Tehonica's deposition testimony about the programs provides further evidence that his trial testimony was not reliable. (Tr. 1008-13).

To prove a section 5(a)(1) violation, the Secretary must prove that the “cited employer failed to free the workplace of a hazard that was recognized by the cited employer or its industry, that was causing or likely to cause death or serious physical harm, and that could have been materially reduced or eliminated by a feasible and useful means of abatement.” *Pelron Corp.* 12 BNA OSHC 1833, 1835 (No. 82-388, 1986). CO Schrilla testified that he observed and photographed two portable fiberglass ladders at the facility; one had a bent and cracked side rail, as well as damaged cross bracing, and both of the ladders had repaired side rails.<sup>10</sup> Mr. Tehonica and Allen Lashbrooks, a maintenance employee, both told the CO that the ladders were used by employees and that the ladders were not inspected on a regular basis. CO Schrilla further testified that although there was no specific OSHA standard addressing fiberglass or plastic ladders, there was an ANSI standard that did; according to CO Schrilla, the ANSI standard prohibited any alteration of fiberglass ladder side rails. (Tr. 53-59, 76-78, 591-99; C-2, C-3).

In support of this citation item, the Secretary offered into evidence C-1, the 2000 revision of ANSI A14.5, the ANSI standard covering portable reinforced plastic ladder safety. (Tr. 54-58). Section 9.4.1 of the standard provides, in pertinent part, as follows:

The ladder shall be inspected periodically, preferably before each use....Where structural damage or other hazardous defect is found, the ladder shall be taken out of service and either discarded or repaired by a competent mechanic.

In addition, section 9.4.2 of the standard states as follows:

Broken or bent ladders shall be marked and taken out of service until they are repaired by a competent mechanic or destroyed in such a manner as to render them useless. The user shall not attempt to repair a defective side rail.

It is clear from the foregoing that the fiberglass ladders at the facility were not in compliance with ANSI A14.5, in that they had not been inspected as required and the side rails on both had been repaired. Further, CO Schrilla testified that the condition of the ladders was a serious hazard; employees standing on the ladders would be 4 to 6 feet from the floor, and a fall of 6 feet could result

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<sup>10</sup>Mr. Tehonica agreed that he and the CO had discussed the ladders and that he himself had seen a crack in one of them at that time. (Tr. 1024-25).

in broken bones.<sup>11</sup> (Tr. 59). Based on the evidence of record, I find that the Secretary has met her burden of proving the alleged violation.<sup>12</sup> This item is therefore affirmed as a serious violation.

The Secretary has proposed a penalty of \$1,400.00 for this item. In determining penalties, the Commission must give due consideration to the four statutory factors, that is, the gravity of the violation, the size of the employer's business, the good faith of the company and its previous history of OSHA violations. *See* section 17(j) of the Act, 29 U.S.C. § 666(j). The record shows that the cited condition was rated as having medium severity and lesser probability, for a gravity-based penalty of \$2,000.00. Further, Lewis was given 20 and 10 percent reductions for size and history, respectively; however, no reduction was given for good faith.<sup>13</sup> (Tr. 60-62).

CO Schrilla testified that the 20 percent reduction for size was based on his determining that Lewis and Ahava of California ("Ahava"), another company located in the same facility and having the same owner, Moise Banayan, together had 140 to 150 employees; he explained that Ms. Hirsch told him Lewis had 72 employees, that she also gave him employee lists for both companies showing a total of over 200 employees, and that due to what Ms. Hirsch told him and the fact that some names appeared on both lists, he concluded that the total number of employees was 140 to 150.<sup>14</sup> (Tr. 61-62, 612-14, 621-29, 1083, 1086-88; C-122, C-123). Moise Banayan, however, testified that Lewis had 45 to 55 employees during 2002 and 2003 and that Ahava had 20 to 25 employees during that period, for a total of up to 80 employees; he explained that C-122 and C-123 showed all of the employees the two companies had ever had and that the January 2003 date on C-122 and C-123 reflected only the

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<sup>11</sup>CO Palhof also testified about the cited condition and its serious nature. (Tr. 414-17).

<sup>12</sup>Lewis contends the Secretary did not specifically show that the cited hazard presented a hazard of falling and that she also did not show the hazard was one recognized in the industry. I find that the hazard of falling when a ladder is defective is obvious. I further find that the ANSI standard and the testimony of the CO's is sufficient to show the alleged violation.

<sup>13</sup>The Secretary made an offer of proof as to the ratings of the items in this case and also as to the reductions applied to the items. *See, e.g.*, Tr. 60-61. I conclude that the offers of proof are sufficient to show the basis of the proposed penalties. (Tr. 1125-35).

<sup>14</sup>CO Schrilla apparently combined the number of Lewis employees with those of Ahava because certain employees who were identified as working for Lewis, such as Cynthia Peck, were shown on the list for Ahava. (Tr. 1087).

date the documents were printed.<sup>15</sup> (Tr. 1295, 1332-35, 1344-57, 1375-76). After Mr. Banayan's testimony that the highest number of employees at the facility would have been about 80, counsel for the Secretary stated that he "accept[ed] that." (Tr. 1354-55). On the basis of the Secretary's counsel's acceptance of Mr. Banayan's testimony, I find that the total number of employees at the facility during the relevant period was about 80.

In view of the foregoing, I conclude Lewis is entitled to a 40 percent reduction of the penalty for size rather than the 20 percent about which the CO testified, in addition to the 10 percent reduction for history.<sup>16</sup> Accordingly, a penalty of \$1,000.00 is assessed for this item.<sup>17</sup>

**Serious Citation 1 - Item 2**

As amended, this item alleges a violation of section 5(a)(1), or, in the alternative, 29 C.F.R. 1910.212(a)(1); however, as the Secretary addresses only the alleged violation of the specific standard in her post-hearing brief, the alleged violation of section 5(a)(1) is deemed abandoned. This item alleges that two machines did not have the requisite guarding. The cited standard states as follows:

One or more methods of machine guarding shall be provided to protect the operator and other employees in the machine area from hazards such as those created by point of operations, ingoing nip points, rotating parts, flying chips and sparks. Examples of guarding methods are—barrier guards, two-hand tripping devices, electronic safety devices, etc.

In regard to Item 2a, CO Schrilla testified that he saw a rigid pipe threading machine in the maintenance area that had a manual on/off switch but did not have a constant pressure switch. He further testified that the machine had rotating parts on it that were driven by a very strong motor and that there had been cases documented in which severe injuries and even fatalities had occurred when constant pressure switches were not used. He explained that with machines having just an on/off switch, employees had gotten caught in the moving parts and wound around the machines. He also

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<sup>15</sup>Mr. Banayan also testified that the plant occasionally employed up to ten part-time employees during holidays. (Tr. 1295).

<sup>16</sup>OSHA's Field Inspection Reference Manual ("FIRM"), which appears on OSHA's web site ([www.osha.gov](http://www.osha.gov)), states that employers having from 26 to 100 employees are entitled to a 40 percent reduction in penalty. *See* FIRM, Chapter IV, section C.2.i.(5).

<sup>17</sup>A total reduction of 50 percent will be applied to the other penalties in this case.



explained that manufacturers offered constant pressure foot pedals that required the operator to have a foot on the pedal for the machine to work and that the machine would stop as soon as the operator's foot was taken off the pedal. The CO said that Mr. Lashbrooks and Mr. Tehonica both told him that the machine was used in the condition in which he saw it. (Tr. 62-64, 601-02).

To establish a violation of a specific standard, the Secretary must show that (1) the cited standard applies, (2) the standard was not met, (3) employees had access to the violative condition, and (4) the employer knew or could have known of the condition with the exercise of reasonable diligence. *Astra Pharmaceutical Prod.*, 9 BNA OSHC 2126, 2129 (No. 78-6247, 1981). Moreover, as Lewis notes, to establish a violation of 29 C.F.R. 1910.212(a)(1), the Secretary must:

prove that a hazard within the meaning of the standard exists in the employer's workplace. *Armour Food Co.*, 14 BNA OSHC 1817, 1821 (No. 86-247, 1990). In order to meet this burden, the Secretary must do more than show that it may be physically possible for an employee to come into contact with the unguarded machinery in question. Rather, the Secretary must establish that employees are exposed to a hazard as a result of the manner in which the machine functions and the way it is operated. *Id.*; *Rockwell Int'l Corp.*, 9 BNA OSHC 1092, 1097-98 (No. 12470, 1980).

*Jefferson Smurfit Corp.*, 15 BNA OSHC 1419, 1421 (No. 89-553, 1991).

As Lewis points out, CO Schrilla did not observe the machine operate, and it was unplugged when he saw it. (Tr. 602-04). Further, CO Schrilla did not identify the particular rotating parts that presented a hazard or describe how an employee operating the machine could have gotten caught in the operating parts. Finally, the CO's photo of the machine sheds no light on this matter, *see* C-4, and there was no evidence that anyone had ever been injured from using the machine. On the basis of the evidence of record, the Secretary has not proved the alleged violation. Item 2a is vacated.<sup>18</sup>

In regard to Item 2b, CO Schrilla testified that a conveyor that was used to convey product in the filling room had an area that was a hazard. In particular, he testified as follows:

[T]here's a portion of the conveyor where it returns, where it comes off the tail pulley, and before it gets to the first return, the bottom pulley, where the conveyor actually sagged down below the frame of the ... conveyor. And, when it sagged down, it came

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<sup>18</sup>Mr. Tehonica indicated that there was an automatic shutoff foot pedal for the machine and that he located it a day or two after the inspection in the maintenance area. However, even assuming that Lewis did in fact have a foot pedal of the type the CO described, this does not relieve the Secretary of her burden of showing a hazard as to this item. (Tr. 799-802, 1025-26).

back up, the portion of the conveyor created a pinch point on itself....It's a typical kind of conveyor you see in ... food processing ..., where they're compiled of a series of hard plastic, almost looks like a treadle kink. And, when it returns on the bottom, there are pinch points that can pinch or grab the employee's clothes. (Tr. 64-65).

CO Schrilla stated that he saw an employee walking next to the conveyor whose clothes were within 4 inches of the conveyor. He said the condition could have caused serious injuries such as broken bones and that it could have been corrected by placing a guard next to the conveyor. He also said that he spoke to Mr. Tehonica and Ms. Karelus about the condition. (Tr. 64-65, 74-75).

As Lewis notes, the CO did not give the speed at which the conveyor moved or describe its size and configuration. He also did not provide the length or width of the unguarded part of the conveyor, and he did not describe the heights of the pinch points from the floor or state specifically how an employee could be caught in them; despite his testimony about the employee walking by the conveyor, he did not state that the employee walked by the unguarded portion. Finally, as in Item 2a, there was no evidence that anyone had ever been injured by the conveyor. The Secretary has failed to demonstrate the alleged violation. Item 2b is vacated.

### **Serious Citation 1 - Item 3**

This item alleges a violation of 29 C.F.R. 1910.22(a)(1), which provides that “[a]ll places of employment, passageways, storerooms, and service rooms shall be kept clean and orderly and in a sanitary condition.” CO Schrilla testified that there was a set of stairs going from the milk receiving area to the rest of the facility and that the concrete at the top of the stairs was damaged; he saw employees using the stairs, and one was carrying two buckets of chemicals as he used the stairs. The CO said the condition created a tripping hazard and that a fall on the stairs could result in broken bones or, in the case of someone carrying chemicals, chemical burns. He also said that C-5 and C-6, two photos of the area, showed the stairs and the damaged area, respectively; he considered the violation serious due to the injuries that could have occurred. (Tr. 78-81).

Lewis does not dispute the existence of the condition; it contends, rather, that the Secretary failed to prove that the cited area was “dirty, disorderly or unsanitary.” I do not agree. One definition of “orderly” is “neat or tidy in arrangement; in good order.” *See Webster's New World Dictionary, Second College Edition* (1972). On the basis of the record, the Secretary has shown the alleged

violation, including the knowledge element, in that the condition was readily apparent. (Tr. 803-07). She has also shown the violation was serious. This citation item is consequently affirmed.

A penalty of \$1,400.00 has been proposed for this item. The record shows this item was given medium severity and lower probability, and the gravity-based penalty was \$2,000.00. (Tr. 81-82). In view of the factors noted *supra*, and the reductions applied, a penalty of \$1,000.00 is assessed.

**Serious Citation 1 - Item 4**

This item alleges a violation of 29 C.F.R. 1910.23(c)(1), setting out three instances of missing standard railings on platforms or open-sided floors. The cited standard provides, in relevant part, that:

Every open-sided floor or platform 4 feet or more above adjacent floor or ground level shall be guarded by a standard railing (or the equivalent as specified in paragraph (e)(3) of this section) on all open sides except where there is entrance to a ramp, stairway, or fixed ladder.

As to Item 4a, CO Schrilla testified that he observed a storage platform in the storage room that had no guardrails; the platform was about 7 feet above the floor and was approximately 15 by 20 feet. The CO learned that employees went up on the platform to remove materials, and Mr. Tehonica told the CO that he himself went up on the platform. (Tr. 82-83).

As to Item 4b, CO Schrilla testified that in the mixing room, a platform to the side of the batch tank was about 6 feet above the floor; employees were required to work from the platform, and there were no mid-rails on the three open sides of the platform. (Tr. 83).

As to Item 4c, CO Schrilla testified that there was a storage platform at the top of the stairs in the maintenance area that had no mid-rail on its open side; the platform was about 12 feet from the floor, and employees were required to move materials up to and down from the platform. (Tr. 83).

The CO said that these items were classified as serious violations because falls from the platforms to the concrete floors below could have resulted in serious injuries, such as broken bones. He identified C-7 and C-8 as photos of the platforms cited in Items 4b and 4c, respectively, and he marked on the photos where the mid-rails should have been. (Tr. 83-88).

Lewis contends that the Secretary did not prove that the missing guardrails exposed employees to falls as alleged. However, the evidence clearly shows that employees utilized all three of the cited platforms. Moreover, the standard, as I read it, assumes a hazard if any of the required guardrails are missing; the platform cited in Item 4a did not have any guardrails at all, and while the platforms cited

in Items 4b and 4c had the required top rails, they did not have the required mid-rails. *See* 29 C.F.R. 1910.23(e)(1), which states that a standard railing *shall* consist of a top rail, intermediate rail and posts (emphasis added). I find that the Secretary has met her burden of proving the alleged violation, including the employer knowledge element, in that the platforms were all in plain view and Mr. Tehonica used one of them himself. Item 4 is affirmed as a serious violation.

A total penalty of \$1,750.00 has been proposed for Item 4. This item was considered to have high severity and lesser probability, and the gravity-based penalty was \$2,500.00. (Tr. 88). Considering the relevant factors and the applicable reductions, a penalty of \$1,250.00 is assessed.

**Serious Citation 1 - Item 5**

Item 5 alleges a violation of 29 C.F.R. 1910.23(d)(1)(ii), which states as follows:

Every flight of stairs having four or more risers shall be equipped with standard stair railings or standard handrails as specified in paragraphs (d)(1)(i) through (v) of this section, the width of the stair to be measured clear of all obstructions except handrails....(ii) On stairways less than 44 inches wide having one side open, one stair railing on open side.

The record shows this item involved the stairs leading up to the platform that was cited in Item 4c, *supra*. CO Schrilla testified that the stairs, which were 12 feet high at the highest point, had well over four risers and that the stairs were also less than 44 inches wide. He further testified that the lack of an intermediate rail on the open side was a serious hazard as employees carried materials up and down the stairs and a fall could have resulted in injuries such as broken bones. (Tr. 88-91; C-8).

I find that the Secretary has met her burden in regard to this item. Although the stairs had a top rail, as shown in C-8, a “standard railing” consists of not only a top rail but also an intermediate rail. *See* 29 C.F.R. 1910.23(e)(1). I conclude that the standard, as written, assumes a hazard if either rail is missing. I also conclude that the testimony of CO Schrilla and C-8, his photo of the stairs, establish the alleged violation. This item is therefore affirmed as a serious violation.<sup>19</sup>

The Secretary has proposed a penalty of \$1,750.00 for this item. This item was considered to have high severity and lesser probability, and the gravity-based penalty was \$2,500.00. (Tr. 90). In view of the relevant factors and applicable reductions, a penalty of \$1,250.00 is assessed.

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<sup>19</sup>The contention of Lewis that the Secretary did not show the applicability of the standard or that the hazard was serious is rejected.

**Serious Citation 1 - Item 6**

Items 6a and 6b allege violations of 29 C.F.R. 1910.36(h)(2) and 29 C.F.R. 1910.37(a)(3), asserting an egress means was blocked by snow and ice. Those standards provide, respectively, that:

The outdoor exit route must be covered if snow or ice is likely to accumulate along the route, unless the employer can demonstrate that any snow or ice accumulation will be removed before it presents a slipping hazard.

Exit routes must be free and unobstructed. No materials or equipment may be placed, either permanently or temporarily, within the exit route. The exit access must not go through a room that can be locked, such as a bathroom, to reach an exit or exit discharge, nor may it lead into a dead-end corridor. Stairs or a ramp must be provided where the exit route is not substantially level.

CO Schrilla testified that there were two exit doors from the trailer at the site where the company's offices were located. One of the exit doors would not open when he tried it, and he discovered that this was due to the snow that had accumulated outside of the door because of the lack of an overhead covering. The CO took two photos of the condition. One, C-9, shows the inside of the door with an "EXIT" sign on it; the other, C-10, shows the outside of the exit after the snow accumulation had been cleared away. The CO further testified that the condition was a serious hazard because employees could suffer burns or smoke inhalation, or even death, if there were a fire in the trailer and they were unable to get out. (Tr. 91-94, 638-41, 730-31).

The CO's testimony and his photos clearly establish violations of the cited standards. Moreover, Lewis presented nothing to rebut the Secretary's evidence, and it does not address this item in its post-trial brief. Items 6a and 6b are affirmed as serious violations.

A total penalty of \$1,750.00 has been proposed for Item 6. This item was given a high severity and lesser probability, and the gravity-based penalty was \$2,500.00. (Tr. 95). In light of the relevant factors and applicable reductions, a penalty of \$1,250.00 is assessed.

**Serious Citation 1 - Item 7**

This item alleges a violation of 29 C.F.R. 1910.37(e), which states as follows:

Employers must install and maintain an operable employee alarm system that has a distinctive signal to warn employees of fire or other emergencies, unless employees can promptly see or smell a fire or other hazard in time to provide adequate warning to them. The employee alarm system must comply with § 1910.165.

CO Schrilla testified that he determined during his inspection that there was no alarm system at the facility; the CO made this determination by speaking with Mr. Tehonica and other employees. The CO further testified that the facility had many different rooms and dead ends and that an alarm system was necessary so that employees could exit quickly in the case of a fire or other emergency. The CO considered the lack of an alarm system a serious hazard in that employees could suffer burns or smoke inhalation if a fire occurred in the facility. (Tr. 94-98, 642-43).

The CO's testimony demonstrates the alleged violation. In addition, Mr. Tehonica admitted at the hearing that the facility had no alarm system at the time of the inspection, and Lewis does not address this item in its brief. (Tr. 814). This item is affirmed as a serious violation.

The Secretary has proposed a penalty of \$1,750.00 for this item. This item was considered to have high severity and lesser probability, and the gravity-based penalty was \$2,500.00 (Tr. 98). Based on the relevant factors and applicable reductions, a penalty of \$1,250.00 is assessed.

**Serious Citation 1 - Item 8**

Item 8 alleges a violation of 29 C.F.R. 1910.106(d)(2)(i), which provides as follows:

Only approved containers and portable tanks shall be used. Metal containers and portable tanks meeting the requirements of and containing products authorized by chapter I, title 49 of the Code of Federal Regulations ... shall be deemed to be acceptable.

CO Schrilla observed a plastic 5-gallon container in the maintenance area that was about half full; Mr. Tehonica told him that it had gasoline in it and that it was used to power a snow blower. The CO took C-11, a photo of the container, and he noted that it was not approved to store gasoline as it was not metal and did not have a self-closing valve or flame arrester. He considered the condition a serious violation; someone using the container could have spilled some of the gasoline, and, if a spark had occurred, a fire could have resulted that could have caused serious burns. (98-101).

The testimony of the CO shows the alleged violation. Mr. Tehonica admitted the condition at the hearing, and Lewis does not address this item in its brief.<sup>20</sup> (Tr. 815). Item 8 is consequently affirmed as a serious violation.

A penalty of \$1,750.00 has been proposed for this item. This item was given a rating of high severity and lesser probability, and the gravity-based penalty was \$2,500.00. (Tr. 101). In view of the relevant factors and applicable reductions, a penalty of \$1,250.00 is assessed.

**Serious Citation 1 - Item 9**

Item 9 alleges a violation of 29 C.F.R. 1910.133(a)(1), which states that:

The employer shall ensure that each affected employee uses appropriate eye or face protection when exposed to eye or face hazards from flying particles, molten metal, liquid chemicals, acids or caustic liquids, chemical gases or vapors, or potentially injurious light radiation.

The record shows that Lewis employees used caustic chemicals and sulfuric acid to clean production equipment; in addition, the material safety data sheets (“MSDS’s”) the chemical supplier provided indicated the various chemicals the employees used were hazardous and required the use of eye and face protection.<sup>21</sup> CO Schrilla testified that he spoke with employee Beverly Hirschey, who said she dispensed chemicals for cleaning purposes; she indicated she sometimes wore safety glasses but normally did not wear any eye or face protection. Another employee, who worked in the lab, told him she used sulphuric acid and generally did not wear facial protection, although she sometimes wore safety glasses, and Scott Hamill, a truck driver, told him he had to add sulphuric acid to tanker trucks and used no protection to do so. The CO observed employee Steven Edick carrying two buckets of chemicals without using any protective equipment; Mr. Edick said the buckets held caustic and acid, and he made no response when asked why he wore no protection.<sup>22</sup> CO Schrilla spoke to Mr. Stone,

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<sup>20</sup>Mr. Tehonica testified that CO Schrilla’s concern was that he was filling up the snow blower inside the facility, and he explained that he had told the CO that he filled up the blower outside. (Tr. 815). I do not credit Mr. Tehonica’s testimony in this regard, as it is clear from the CO’s testimony that his concern was the use of the plastic container itself.

<sup>21</sup>The CO observed some MSDS’s in the employee break room, and he also requested MSDS’s from the company’s chemical supplier. (Tr. 119, 280).

<sup>22</sup>CO Palhof also testified about what Mr. Edick and Ms Hirschey told him and CO Schrilla; his testimony was essentially the same as that of CO Schrilla. (Tr. 375-78, 462, 466).

who said he knew that employees did not always wear eye protection and that it was difficult to get them to do so as they found it uncomfortable. (Tr. 102-09, 118-21).

CO Schrilla further testified that not using eye and face protection was a serious hazard in that skin burns or loss of eyesight could result; he said safety glasses were inadequate, that safety goggles and a face shield were needed to protect against splashes, and that he did not see any goggles or face shields in use at the facility. The CO also said that Ms. Hirsch gave him employee accident/illness reports; one showed that in August 2002 Ms. Hirschey was pumping “CIP Cleaner” when it splashed on her face, neck and chest, and another showed that in May 2002 Charles Strickland was cleaning a vat with “LP Acid” when it splashed in his eye. (Tr. 106, 110-15, 119-20; C-83, C-84).

Mr. Tehonica testified about the personal protective equipment (“PPE”) that was available at the facility at the time of the inspection, such as face shields, goggles, glasses, aprons and gloves. He said most people were “pretty good” about wearing PPE and that Ms. Hirschey and Mr. Edick were “probably the two safest people” in the facility, but he admitted that Mr. Edick was not wearing PPE when the CO’s saw him with the buckets of chemicals. (Tr. 816-20, 842-43). Moreover, the testimony of cleaning employee Jessica Hoch that Ms. Hirschey had trained her in the proper PPE to wear for carrying chemicals and for cleaning and that she had never seen Ms. Hirschey working without the proper PPE is belied by what Ms. Hirschey told the CO’s and by C-84, the report for Ms. Hirschey noted *supra*. (Tr. 104-05, 375-76, 462, 466, 910-17). Finally, Lewis does not address this item in its brief. The testimony of the CO’s is credited, and this item is affirmed as a serious violation.<sup>23</sup>

A penalty of \$3,500.00 has been proposed for this item. This item was given a high severity and greater probability, and the gravity-based penalty was \$5,000.00. (Tr. 107). Considering the relevant factors and applicable reductions, a penalty of \$2,500.00 is assessed.

**Serious Citation 1 - Item 10**

This item alleges a violation of 29 C.F.R. 1910.138(a). That standard provides that:

Employers shall select and require employees to use appropriate hand protection when employees’ hands are exposed to hazards such as those from skin absorption of harmful

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<sup>23</sup>C-95, an excerpt from a report to Lewis dated January 16, 2002, following a survey of the facility by a representative of the New York State Insurance Fund (“NYSIF”), the insurer of Lewis, also noted the lack of appropriate PPE, such as eye and face wear, at the facility. Mr. Tehonica and Mr. Spencer were both aware of C-95. (Tr. 315, 983-94; C-95, ¶¶ 7, 13, 21).



substances; severe cuts or lacerations; severe abrasions; punctures; chemical burns; thermal burns; and harmful temperature extremes.

As in the previous item, the record shows that Lewis employees used caustic chemicals and sulphuric acid to clean equipment; the record also shows that the MSDS's for the chemicals called for the use of hand protection to protect employees from skin burns. CO Schrilla testified that he learned from the same employees he talked to about eye and face protection, that is, Beverly Hirschey, Steven Edick and Scott Hamill, that they also did not wear hand protection when dispensing and using the chemicals. The CO further testified that the failure to wear hand protection was a serious hazard because contact with the chemicals could burn the skin. (Tr. 118-22). Based on the CO's testimony, the evidence set out in the discussion relating to Item 9, *supra*, and my findings in that regard, the Secretary has established the alleged violation.<sup>24</sup> Moreover, Lewis does not address this item in its brief. Item 10 is therefore affirmed as a serious violation.

The Secretary has proposed a penalty of \$1,400.00 for this item. This item was given a rating of medium severity and lesser probability, and the gravity-based penalty was \$2,000.00. (Tr. 122). In light of the relevant factors and applicable reductions, a penalty of \$1,000.00 is assessed.

#### **Serious Citation 1 - Item 11**

Item 11 alleges a violation of 29 C.F.R. 1910.146(c)(2), which states that:

If the workplace contains permit spaces, the employer shall inform exposed employees, by posting danger signs or by any other equally effective means, of the existence and location of and the danger posed by the permit spaces.

NOTE: A sign reading "DANGER-PERMIT-REQUIRED CONFINED SPACE, DO NOT ENTER" or using other similar language would satisfy the requirement for a sign.

CO Schrilla observed tanks in the mixing area that were labeled as permit-required confined spaces; however, there were about seven tanks in the area that were not labeled as required.<sup>25</sup> He determined the tanks were permit-required confined spaces because they had limited access and hazards inside, such as rotating parts and the potential for reduced oxygen, and because employees

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<sup>24</sup>C-95 also noted the failure to use proper hand protection at the facility. *See* ¶¶ 7, 13, 21.

<sup>25</sup>CO Schrilla noted that the citation referred incorrectly to "T-9 and 16 other tanks" and that it should have referred to "T-9 and 6 other tanks." (Tr. 124, 658).

entered the tanks to clean them or to work on agitators.<sup>26</sup> The CO said the failure to label the tanks was a serious hazard; if a tank an employee entered had an oxygen-reduced atmosphere or its agitator blades started up unexpectedly, the result could be serious injury or death. He also said that C-16 was a photo he took of one of the tanks and that it was not labeled when he saw it. (Tr. 122-27).

As the Secretary notes, a “confined space” is defined at 29 C.F.R. 1910.146(b) as a space that:

- (1) Is large enough and so configured that an employee can bodily enter and perform assigned work; and
- (2) Has limited or restricted means for entry or exit (for example, tanks, vessels, silos, storage bins, hoppers, vaults, and pits are spaces that may have limited means of entry); and
- (3) Is not designed for continuous employee occupancy.

As the Secretary further notes, a “permit-required confined space” is defined at 29 C.F.R. 1910.146(b) as a confined space that has one or more of the following characteristics:

- (1) Contains or has a potential to contain a hazardous atmosphere;
- (2) Contains a material that has the potential for engulfing an entrant;
- (3) Has an internal configuration such that an entrant could be trapped or asphyxiated by inwardly converging walls or by a floor which slopes downward and tapers to a smaller cross-section; or
- (4) Contains any other recognized serious safety or health hazard.

Lewis does not address this item in its brief, and Mr. Tehonica’s testimony, that there were only two tanks that were not labeled as required, was not persuasive in light of the CO’s contrary testimony and my credibility findings set out at the beginning of this decision. (Tr. 826-27). Mr. Tehonica’s further testimony that Mr. Edick only entered the tanks part way to work on or clean the agitators was also not persuasive, especially since he then stated that Mr. Edick did “not always” go all the way into the tanks when he performed such work. (Tr. 829-31). Based on the CO’s testimony, the language of the standard, and the above definitions, I find that the Secretary has proved the alleged violation. This item is affirmed as a serious violation.

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<sup>26</sup>Ms. Karelus and Mr. Stone both told the CO that employees entered the tanks. Further, Mr. Tehonica testified that employees Steven Edick, Robert Bush and Allen Lashbrooks entered the tanks; he also testified that Mr. Edick did so more often than the other two employees, in order to clean and adjust the agitators. The CO agreed that Mr. Stone had told him that the entries were made at night, when there was no production, but he said that that made no difference with respect to the need for compliance with the standard. (Tr. 125, 128, 659, 731, 829-31).

A penalty of \$3,500.00 has been proposed for this item. This item was considered to have high severity and greater probability, and the gravity-based penalty was \$5,000.00. (Tr. 127). Based on the relevant factors and applicable reductions, a penalty of \$2,500.00 is assessed.

**Serious Citation 1 - Item 12**

Item 12 alleges a violation of 29 C.F.R. 1910.146(c)(4), which provides as follows:

If the employer decides that its employees will enter permit spaces, the employer shall develop and implement a written permit space program that complies with this section. The written program shall be available for inspection by employees and their authorized representatives.

The evidence relating to Item 11, *supra*, establishes that Lewis employees entered tanks that were permit-required confined spaces; in view of that evidence and the language of the cited standard, Lewis was required to have a written permit space program. CO Schrilla testified that such a program should state which tanks are covered, what the hazards in the tanks are, and what has to be done before entry; he also testified that Ms. Hirsch, Mr. Tehonica, Mr. Bush, Mr. Stone and Ms. Karelus all told him that they were unaware of a written confined space program. (Tr. 127-28).

Mr. Tehonica testified that he had no discussions with CO Schrilla during the inspection about a confined space program and that he never told the CO that Lewis did not have one. (Tr. 833). However, in the credibility determination discussion at the beginning of this decision, I found that Ms. Hirsch and Mr. Tehonica both told the CO's that they were unaware of any written confined space program at the facility. (Tr. 37, 363, 372, 585). I further found that Mr. Tehonica's testimony concerning the inspection and the safety programs that Lewis had was not persuasive. Based on my credibility findings, the testimony of CO Schrilla in regard to Items 11 and 12, and the fact that Lewis does not address this item in its brief, I conclude that the Secretary has demonstrated the alleged violation. This item is accordingly affirmed as a serious violation.

The Secretary has proposed a penalty \$3,500.00 for this item. This item was given a high severity and greater probability, and the gravity-based penalty was \$5,000.00. (Tr. 129). Considering the relevant factors and applicable reductions, a penalty of \$2,500.00 is assessed.

**Serious Citation 1 - Item 13**

This item alleges a violation of 29 C.F.R. 1910.147(c)(4)(i), which states that:

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.

As set out in the credibility determination portion of this decision, Lewis did not have a written LOTO program at the time of the inspection. This finding was based on the testimony of CO's Schrilla and Palhof that, when they asked about Lewis having such a program, Ms. Hirsch and Mr. Tehonica both stated that they were unaware of a written LOTO program.<sup>27</sup> (Tr. 37, 363, 371, 424). CO Schrilla also testified that although Mr. Spencer believed there was a LOTO program, and while he did come up with some specific procedures for particular machines, Ms. Karelus and Mr. Stone, as well as maintenance employees Allen Lashbrooks and Ken Yousey, all told the CO that they were unaware of any lockout procedures or of any such procedures being used. (Tr. 129-31).

Item 13a alleges Lewis did not have a specific LOTO procedure for a new machine called the Franz bottling machine, and CO Schrilla testified that there was no LOTO procedure for the machine. (Tr. 130). Item 13b alleges Lewis was not utilizing any specific procedures for locking out equipment such as the Franz bottling machine, ATS machines, agitators, pumps, separators, and whipping and cheese machines. CO Schrilla testified that Mr. Lashbrooks and Mr. Yousey were the employees who did the type of work on the cited machines that would require LOTO procedures so that unexpected startup of equipment could not cause injuries. He further testified that he observed work being done on a separator and on a cheese vat; the equipment had moving parts that required LOTO procedures, and none were being used. In addition, Mr. Lashbrooks, Mr. Yousey, Ms. Karelus and Mr. Stone all told the CO that no LOTO procedures were utilized.<sup>28</sup> The CO said the violation was serious, as being caught in moving parts could cause injuries like amputations and broken bones. (Tr. 129-31, 142). The Secretary has proved the alleged violation. Item 13 is affirmed as a serious violation.

A total penalty of \$3,500.00 has been proposed for Item 13. This item was considered to have high severity and greater probability, and the gravity-based penalty was \$5,000.00. (Tr. 131-32). In light of the relevant factors and applicable reductions, a penalty of \$2,500.00 is assessed

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<sup>27</sup>Mr. Tehonica's contrary trial testimony was not convincing. (Tr. 767-68, 833).

<sup>28</sup>Mr. Tehonica's testimony that LOTO procedures were used is rejected, and a conclusion that no LOTO procedures were utilized is supported by the failure of Lewis to address this matter in its brief. (Tr. 831, 836).

**Serious Citation 1 - Item 14**

Item 14a alleges a violation of 29 C.F.R. 1910.147(c)(5)(i), which provides that:

Locks, tags ... or other hardware shall be provided by the employer for isolating, securing or blocking of machines or equipment from energy sources.”

CO Schrilla testified that he asked Mr. Lashbrooks and Mr. Yousey if they had locks for locking out equipment; both said they did not, and Ms. Karelus and Mr. Stone were also unaware of any such locks. The CO was taken to see the facility’s two lockout boxes, but, when they were opened, there were no locks in them.<sup>29</sup> The CO identified C-17, C-18 and C-20 as his photos of the boxes. (Tr. 134-39). The CO’s testimony establishes the alleged violation.<sup>30</sup>

Item 14b alleges a violation of 29 C.F.R. 1910.147(c)(5)(ii), which provides that:

Lockout devices and tagout devices shall be singularly identified; shall be the only devices(s) used for controlling energy; shall not be used for other purposes....”

CO Schrilla testified that he did see three lockout-type locks at the facility; however, one was being used to lock a sliding door, and the other two were being used to lock up the personal cabinet of an employee.<sup>31</sup> The CO further testified that lockout locks are not to be used for other purposes because then they will not be available for locking out equipment. (Tr. 139-40). The CO’s testimony demonstrates the alleged violation.

The CO testified that the cited conditions were serious, in that severe injuries can occur when lockout locks are not used when required. (Tr. 139-40). Further, Lewis does not address Item 14 in its brief. Items 14a and 14b are consequently affirmed as serious violations.

A total penalty of \$3,500.00 has been proposed for Item 14. This item was given a high severity and greater probability, and the gravity-based penalty was \$5,000.00. (Tr. 140-41). Considering the relevant factors and applicable reductions, a penalty of \$2,500.00 is assessed.

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<sup>29</sup>CO Palhof also testified in this regard. (Tr. 372-74).

<sup>30</sup>Mr. Tehonica testified that 24 new locks were purchased at some point before the inspection, but he admitted they were not in use at the time of the inspection; further, the locks were not appropriate for lockout because one key opened all of them. (Tr. 834-35).

<sup>31</sup>The CO testified that lockout locks are different from regular locks in that the body is thinner, the shank is longer and thinner, and they are of different colors. (Tr. 139-40).

**Serious Citation 1 - Item 15**

Item 15a alleges a violation of 29 C.F.R. 1910.147(c)(7)(i). That standard states that:

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

Item 15b alleges a violation of 29 C.F.R. 1910.147(c)(6)(i). That standard states that:

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.

CO Schrilla testified that Mr. Lashbrooks, Mr. Yousey, Mr. Bush and Mr. Edick all told him that they had had no LOTO training; the CO also testified that of the procedures the facility did have, only Mr. Spencer seemed to be aware of them, and that without a program, no training or annual review could be conducted. The CO stated that failing to train employees in LOTO could cause serious injuries such as amputations and broken bones. (Tr. 141-42). Based on the CO's testimony, Mr. Tehonica's testimony that LOTO training was provided is not credited. (Tr. 836-37, 1078). Further, Lewis does not address Item 15 in its brief. Items 15a and 15b are affirmed.

A total penalty of \$3,500.00 has been proposed for Item 15. This item was given a high severity and greater probability, and the gravity-based penalty was \$5,000.00. (Tr. 142-43). Due to the relevant factors and applicable reductions, a penalty of \$2,500.00 is assessed.

**Serious Citation 1 - Item 16**

This item alleges a violation of 29 C.F.R. 1910.157(g)(1), which provides as follows:

Where the employer has provided portable fire extinguishers for employee use in the workplace, the employer shall also provide an educational program to familiarize employees with the general principles of fire extinguisher use and the hazards involved with incipient stage fire fighting.

The record shows that Lewis has 29 portable fire extinguishers in its facility. (Tr. 838). CO Schrilla testified that Mr. Tehonica, Mr. Lashbrooks and Mr. Stone all told him that employees used the extinguishers; in fact, the CO learned there had been a fire in the facility's tanker bay about a week before and that extinguishers had been used at that time. When CO Schrilla asked if employees had been trained in extinguisher use, he was told that no training had been done; the CO noted that without training, using a fire extinguisher could result in severe burns. (Tr. 142-44, 700-01).

Mr. Tehonica testified that he had given fire extinguisher training to Lewis employees in November of 2002 and that CO Schrilla had never asked him or anyone else in his presence about fire extinguisher training. (Tr. 837-42). However, based on my credibility findings *supra*, the CO's testimony is credited over that of Mr. Tehonica. Moreover, Lewis does not address this item in its brief. The record establishes the alleged violation, and this item is affirmed.

The Secretary has proposed a penalty of \$1,750.00 for this item. This item was considered to have high severity and lesser probability, and the gravity-based penalty was \$2,500.00. (Tr. 144). Based on the relevant factors and applicable reductions, a penalty of \$1,250.00 is assessed.

**Serious Citation 1 - Item 17**

This item alleges a violation of 29 C.F.R. 1910.176(b), which provides that:

Storage of material shall not create a hazard. Bags, containers, bundles, etc., stored in tiers shall be stacked, blocked, interlocked and limited in height so that they are stable and secure against sliding or collapse.

CO Schrilla testified that a storage platform in the facility's storage room had a damaged vertical support beam and horizontal support beams that had "bowing" in them; the latter beams were bowed about 3 inches, which indicated damage, and the CO circled the horizontal support beams in C-23, his photo of the bottom of the platform. The CO further testified that materials and supplies were stored up on the platform, that employees went up on the platform to retrieve and replace the materials and supplies, and that the platform was a serious hazard; if the support beams were to collapse, an employee could sustain serious injuries such as bone fractures. (Tr. 145-48).

Lewis contends that the cited standard is a general materials storage standard that does not address structural requirements for storage platforms and that the Secretary has failed to prove that the standard applies. I disagree. The first sentence of the standard states that "[s]torage of material shall not create a hazard." In addition, the CO's testimony about the damaged vertical beam and the bowed horizontal beams certainly implies that the platform was overloaded, and he expressly stated that the platform was a serious hazard. Finally, C-95, the NYSIF report, references this condition and describes the platform as "severely overloaded." It also states that the condition could result in "structural failure and collapse" and "extreme bodily harm and potential fatalities." *See* C-95, ¶ 19. Based on the record, the Secretary has proved the alleged violation. This item is affirmed as serious.

The Secretary has proposed a penalty of \$1,400.00 for this item. This item was given a rating of medium severity and lesser probability, and the gravity-based penalty was \$2,000.00. (Tr. 148). In light of the relevant factors and applicable reductions, a penalty of \$1,000.00 is assessed.

**Serious Citation 1 - Item 18**

Item 18a alleges a violation of 29 C.F.R. 1910.176(e), which states that “[c]learance signs to warn of clearance limits shall be provided.”

Item 18b alleges a violation of 29 C.F.R. 1910.304(c)(2). That standard provides as follows:

*Clearance from ground.* Open conductors shall conform to the following minimum clearances:

- (i) 10 feet—above finished grade, sidewalks, or from any platform or projection from which they might be reached.
- (ii) 12 feet—over areas subject to vehicular traffic other than truck traffic.
- (iii) 15 feet—over areas other than those specified in paragraph (c)(2)(iv) of this section that are subject to truck traffic.
- (iv) 18 feet—over public streets, alleys, roads, and driveways.

The record shows that there were overhead power lines outside of the lab area of the facility. CO Schrilla observed Lewis employees driving fork trucks underneath the lines, and Mr. Tehonica told him the lines heated the lower warehouse. The CO testified that there were no signs in the area indicating the clearance for the lines. He also testified that there was not a 12-foot clearance beneath one of the lines; he used a ruler to measure from the ground to the top of one of the fork trucks and found that distance to be about 6.5 feet, and he estimated the distance from the top of the truck to the line to be about 3 feet, for a total of approximately 9.5 feet.<sup>32</sup> CO Schrilla identified C-26 as his photo of the condition, and he circled the power line in question. The CO said the failure to have the required sign and clearance was a serious hazard; running into a line with a truck could result in electrocution or in knocking the line down and someone else being injured. (Tr. 149-54).

Mr. Tehonica testified that while he thought all three of the power lines shown in C-26 were energized at the time of the inspection, he later found out that the lowest line, the one the CO had been concerned about, was not; he explained that he and Mr. Lashbrooks had inspected both ends of the line and had discovered that neither was connected. Mr. Tehonica further testified that he had later

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<sup>32</sup>The CO stated that did not attempt to measure the distance from the top of the truck to the line because he was told the line was energized. (Tr. 151).



measured the two higher lines and had found them to be 11 feet 2 inches and 12 feet 2 inches from the ground, respectively; Mr. Tehonica then had Mr. Lashbrooks put extensions on the lines so that they were both 12 feet 10 inches from the ground. (Tr. 845-52).

Lewis did not offer any testimony as to the required clearance sign. Moreover, in view of my credibility determinations in this matter, Mr. Tehonica's testimony about the line being de-energized was not persuasive. I find, accordingly, that the lowest line was energized at the time of the inspection and that its distance from the ground, as CO Schrilla testified, was approximately 9.5 feet. The Secretary has proved both of the cited conditions, and Items 18a and b are affirmed as serious violations.

A total penalty of \$1,750.00 has been proposed for Item 18. This item was considered to have high severity and lesser probability, and the gravity-based penalty was \$2,500.00. (Tr. 152-53). In view of the relevant factors and applicable reductions, a penalty of \$1,250.00 is assessed.

**Serious Citation 1 - Item 19**

Item 19 alleges a violation of 29 C.F.R. 1910.178(p)(1). The cited standard provides that:

If at any time a powered industrial truck is found to be in need of repair, defective, or in any way unsafe, the truck shall be taken out of service until it has been restored to safe operating condition.

CO Schrilla testified that he observed a powered industrial truck in the facility's charging area that had some bare copper exposed on its charging wires. He also testified that there were employees in the area and that the condition was a serious hazard because of the potential for someone to have contacted the wires or for sparks to have caused a fire or explosion. The CO identified C-28 as his photo of the condition, and he circled the area showing the exposed wires. (Tr. 154-56).

The CO's testimony establishes the alleged violation, including employer knowledge of the condition.<sup>33</sup> Lewis did not present any evidence to rebut the CO's testimony, and it does not address this item in its brief. This item is affirmed.

A penalty of \$1,400.00 has been proposed for this item. This item was given a medium severity and lesser probability, and the gravity-based penalty was \$2,000.00. (Tr. 156). Considering the relevant factors and applicable reductions, a penalty of \$1,000.00 is assessed.

**Serious Citation 1 - Item 20**

This item alleges violations of 29 C.F.R. 1910.212(a)(1); the terms of the cited standard are set out in the discussion relating to Item 2, *supra*.

As to Item 20a, CO Schrilla observed an employee pour farmer's cheese into a hopper on top of a machine in the farmer's cheese room. The employee then pushed the cheese down with his hands, and his hands were within inches of the ingoing nip point created by the machine's two star-shaped metal wheels, which were rotating and interlocking. The CO identified C-30 as his photo of the machine, and he said that the cover, shown to the left of the machine in C-30, was on top of the machine when it was being operated. He also said that guarding could be provided either by extending the height of the cover or by placing a mesh on top so that employees could not reach the rotating metal parts. (Tr. 156-59, 162).

As to Item 20b, CO Schrilla observed a machine called the ATS filling machine in the filling room. He testified that there was a metal "plate" on the side of the machine that moved up and down and created a pinch point with the base of the machine. There were employees in the area, and he saw one employee reach in to make adjustments and to move the plastic cover that was being placed on top of the machine; in doing so, the employee's hand was within an inch of the metal plate. The CO

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<sup>33</sup>Mr. Tehonica testified that conditions like this one were detected by a daily checklist that each department would give to Cynthia Peck, the head of security; Ms. Peck, in turn, would give him the checklists, and any problems would be corrected. Mr. Tehonica also testified that his practice was to do a daily walk-through of the facility to look for safety problems; since the inspection, he also checks the wires on the facility's trucks periodically. (Tr. 804-06, 853-54, 928). Regardless, in view of the number of affirmed violations in this case, and in light of the limited amount of time that Mr. Tehonica devoted to safety at the time of the inspection, I find that the procedures Lewis had for detecting safety problems were deficient. (Tr. 771). I also find that, with the exercise of reasonable diligence, Lewis could have known of the cited condition.

identified C-29 as his photo of the machine, and he circled the plate. He said that placing a guard in front of the plate would prevent employees from getting into the pinch point. (Tr. 159-63).

Lewis does not address this item in its brief, and Mr. Tehonica testified only about the abatement of the cited conditions; specifically, he said that a new farmer's cheese machine was purchased and that a guard was made for the ATS filling machine. (Tr. 854-58). Based on the record, the Secretary has established the alleged violations. She has also shown the violations were serious; the CO testified that employees using the unguarded machines could get fingers caught, which could result in fractures. (Tr. 162-63). This citation item is affirmed.

A total penalty of \$1,750.00 has been proposed for Item 20. This item was considered to have high severity and lesser probability, and the gravity-based penalty was \$2,500.00. (Tr. 163). Based on the relevant factors and applicable reductions, a penalty of \$1,250.00 is assessed.

#### **Serious Citation 1 - Item 21**

Item 21 alleges a violation of 29 C.F.R. 1910.212(a)(5). The standard provides that:

When the periphery of the blades of a fan is less than seven (7) feet above the floor or working level, the blades shall be guarded. The guard shall have openings no larger than one-half (½) inch.

CO Schrilla observed an operating heater fan suspended from the ceiling in the silo room. He noted that two of the slats were missing from its guard, which created openings of 1.75 by 12 inches and 3.5 by 12 inches, and he measured the fan and found it to be 6 feet 3 inches from the ground. He also noted that employees walked through that area and also worked in the silo room and that the missing slats exposed employees to the rotating fan blades. The CO identified C-32 as his photo of the fan, and he stated that the condition was a serious hazard because of the potential for being struck by the fan's blades and serious injuries such as lacerations. (Tr. 163-65).

I find the Secretary has established the alleged violation; an employee, particularly one who was 6 feet or taller, could have inadvertently contacted the rotating fan blades while walking through or working in the area and been seriously injured.<sup>34</sup> This item is affirmed as a serious violation.

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<sup>34</sup>Although I have considered the case cited by Lewis, that is, *Fabricated Metal Prod., Inc.*, 18 BNA OSHC 1072, 1074 (No. 93-1853, 1997), I conclude that it does not apply to this item because the standards addressed therein are different from the one cited here.

The Secretary has proposed a penalty of \$1,400.00 for this item. This item was rated as having medium severity and lesser probability, and the gravity-based penalty was \$2,000.00. (Tr. 165). In view of the relevant factors and applicable reductions, a penalty of \$1,000.00 is assessed.

**Serious Citation 1 - Item 22**

Item 22 alleges a violation of 29 C.F.R. 1910.215(b)(9), which states as follows:

Safety guards of the types described in subparagraphs (3) and (4) of this paragraph, where the operator stands in front of the opening, shall be constructed so that the peripheral protecting member can be adjusted to the constantly decreasing diameter of the wheel. The maximum angular exposure above the horizontal plane of the wheel spindle as specified in paragraphs (b)(3) and (4) of this section shall never be exceeded, and the distance between the wheel periphery and the adjustable tongue or the end of the peripheral member at the top shall never exceed one-fourth inch.

CO Schrilla observed a pedestal grinder in the maintenance area that did not have a tongue guard on it; a tongue guard is a metal piece that comes down on top of the guard so that if the wheel breaks the piece will stay inside the guard and not come out and strike the operator. The CO identified C-33 as his photo of the grinder, and he circled the area where the guard should have been in place. The CO said that Mr. Lashbrooks told him that he used the grinder almost daily; he also said that the condition was a serious hazard because a piece of broken wheel striking the operator can cause injuries such as lacerations. (Tr. 166, 169-70).

Lewis did not rebut the CO's testimony, and it does not address this item in its brief. Further, Mr. Tehonica, who observed the condition with the CO, testified that a guard was later made for the pedestal grinder. (Tr. 858-59). In light of the CO's testimony, I find that the Secretary has shown the alleged violation. This citation item is therefore affirmed as a serious violation.

A penalty of \$1,400.00 was proposed for this item. This item was considered to have medium severity and lesser probability, and the gravity-based penalty was \$2,000.00. (Tr.). In light of the relevant factors and applicable reductions, a penalty of \$1,000.00 is assessed.

**Serious Citation 1 - Item 23**

Item 23a alleges a violation of 29 C.F.R. 1910.219(c)(2)(i). That standard provides that:

All exposed parts of horizontal shafting seven (7) feet or less from floor or working platform, excepting runways used exclusively for oiling, or running adjustments, shall be protected by a stationary casing enclosing shafting completely or by a trough enclosing sides and top or sides and bottom of shafting as location requires.

As to Item 23a(a), CO Schrilla observed an unguarded rotating shaft on an agitator motor; the shaft was in the silo room, it was attached to the end of the silo, and it was about 3 feet off the floor. The CO testified that employees walked through and worked in the area and that, as the silo room was not very wide, employees walking by the shaft would be within a foot or a foot and a half of it. The CO marked the location of the shaft on C-39, his photo of the condition. (Tr. 170-74).

In regard to Item 23a(b), CO Schrilla observed an unguarded rotating shaft with projections in the mixing area; the shaft was about 3 feet from the ground, and it was coming off of a horizontal tank. The CO testified that the shaft was 2 to 3 inches from the edge of a platform employees used and that he saw employees access the platform. The CO marked the location of the shaft on C-37, his photo of the condition. (Tr. 175-77).

As to Item 23a(c), CO Schrilla observed another unguarded rotating shaft in the mixing area; the shaft was on a floor-based pump, and it was about 1 foot off the floor, as shown in C-38, his photo of the shaft. The CO testified that he saw employees tending to the mixing tanks and that to do so they had to step over the pump, which brought them within inches of the rotating shaft. (Tr. 177-83).

With respect to Item 23a(d), CO Schrilla observed unguarded rotating shafts in the filling department; the shafts were on top of the filling machine, and they were about 5.5 feet from the ground, as shown in C-34, his photo of the condition. The CO testified that he saw employees reaching over the shafts to put caps on product containers and that, when they did so, their sleeves were almost touching the shafts. (Tr. 183-85).

CO Schrilla said the unguarded shafts were cited as serious due to the hazard of clothing being caught by and an employee being drawn into a shaft, resulting in lacerations or fractures; he also said the conditions could have been abated by putting covers on the shafts. (Tr. 171, 174, 177, 185-86).

Based on the foregoing, I conclude that the Secretary has met her burden of establishing the alleged violation. Item 23a is therefore affirmed as a serious violation.<sup>35</sup>

Item 23b alleges a violation of 29 C.F.R. 1910.219(c)(3). That standard states that:

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<sup>35</sup>In affirming the violation, I note Lewis does not address this item in its brief. I have also noted Mr. Tehonica's testimony indicating that he located the guards for the shafts later and that they were probably not in place when the CO was there due to the cleaning crew not replacing them. (Tr. 859-63). However, this testimony, even if true, does not rebut the CO's testimony.

Vertical and inclined shafting seven (7) feet or less from floor or working platform, excepting maintenance runways, shall be enclosed with a stationary casing in accordance with requirements of paragraphs (m) and (o) of this section.

CO Schrilla observed an unguarded vertical shaft on a whipping machine in the filling department; the shaft was 2.5 to 3 feet off the ground in the machine, and he saw employees walking past the machine, coming within a foot of the shaft. The CO testified that the shaft could be guarded by putting up a barrier, and he identified C-35 as his photo of the shaft; he circled the area showing the shaft. The CO further testified that the condition was cited as serious because of the potential for being caught by the shaft, which could result in broken bones and severe lacerations. (Tr. 186-88). In view of the CO's testimony, the Secretary has demonstrated the alleged violation. Item 23b is accordingly affirmed as a serious violation.<sup>36</sup>

The Secretary has proposed a total penalty of \$1,400.00 for Item 23. This item was given a medium severity and lesser probability, and the gravity-based penalty was \$2,000.00. (Tr. 188-89). Considering the relevant factors and applicable reductions, a penalty of \$1,000.00 is assessed.

**Serious Citation 1 - Item 24**

Item 24a alleges a violation of 29 C.F.R. 1910.219(d)(1), which provides as follows:

Pulleys, any parts of which are seven (7) feet or less from the floor or working platform, shall be guarded in accordance with the standards specified in paragraphs (m) and (o) of this section.

CO Schrilla observed four unguarded pulleys on a cheese vat in the cheese room; there were two 4-inch pulleys and two 7-inch pulleys, with semi-V belts between them, and they were located 4 to 5 feet above the floor. The CO testified that the pulleys were right above the vat's speed control and that employees said they had to reach up to change the speed while the vat was operating; they also said the vat had been operated without guards for well over six months, and the CO saw the guards for the pulleys leaning against a wall.<sup>37</sup> The CO further testified that the unguarded pulleys were a serious hazard because getting caught between the pulleys and the belts could result in fractures and severe lacerations. C-40 is the CO's photo of the condition. (Tr. 189-94).

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<sup>36</sup>Lewis does not discuss this item in its brief, and Mr. Tehonica's testimony addressed only the abatement of the cited condition. (Tr. 864).

<sup>37</sup>The CO did not see the vat operate as employees were cleaning it at the time. (Tr. 192).

Item 24b alleges a violation of 29 C.F.R. 1910.219(e)(3)(i), which states that “[v]ertical and inclined belts shall be enclosed by a guard conforming to standards in paragraphs (m) and (o) of this section.” The record shows that this item refers to the semi-V belts between the two pulleys, as shown in C-40, which were also unguarded; CO Schrilla testified that the hazard was the same, that is, that of being caught between the pulleys and belts. (Tr. 193-94).

Lewis contends the Secretary has not met her burden of showing exposure to the alleged hazard because the CO did not see the machine operate. I disagree. The CO testified that employees told him they had to reach up to change the vat’s speed when the vat was operating; he also testified that the speed control was right below the pulleys and that he saw the guards for the equipment leaning against the wall. (Tr. 189-92). C-40 supports the CO’s testimony, and I find that the Secretary has proved the alleged violations.<sup>38</sup> Items 24a and b are affirmed as serious violations.

A total penalty of \$1,400.00 has been proposed for Item 24. This item was rated as having medium severity and lesser probability, and the gravity-based penalty was \$2,000.00. (Tr. 194). In light of the relevant factors and applicable reductions, a penalty of \$1,000.00 is assessed.

**Serious Citation 1 - Item 25**

This item alleges a violation of 29 C.F.R. 1910.219(f)(3), which states that “[a]ll sprocket wheels and chains shall be enclosed unless they are more than seven (7) feet above the floor or platform.” CO Schrilla saw an unguarded sprocket and chain conveyor system in the dock area; the system consisted of two 10-inch-diameter sprockets and chains that were about 1.5 feet above the ground, and, when he saw it, the conveyor was moving cases to a washing machine. The CO observed an employee loading the cases into the washer, and, while he was not next to the conveyor at that time, he told the CO that he had to work right next to it when he put the cases onto the opposite end of the conveyor, at which time his hands were right next to the unguarded sprockets and chains. The CO testified that the condition was a serious hazard, in that getting caught by the sprocket and chain system could result in fractures and lacerations. C-41 is the CO’s photo of the end of the system where the employee indicated he put the cases on the conveyor. (Tr. 195, 199-200, 207).

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<sup>38</sup>Mr. Tehonica’s testimony that the vat was not in operation because maintenance was in the process of taking it apart as it was going to be replaced is not credited. (Tr. 864-67).

Lewis presented no evidence to rebut the CO's testimony, and it does not address this item in its brief. In view of the CO's testimony, I conclude that the Secretary has established the alleged violation. Item 25 is therefore affirmed as a serious violation.

A penalty of \$1,400.00 has been proposed for this item. This item was given a medium severity and lesser probability, and the gravity-based penalty was \$2,000.00. (Tr. 207). Considering the relevant factors and applicable reductions, a penalty of \$1,000.00 is assessed.

**Serious Citation 1 - Item 26**

Item 26 alleges a violation of 29 C.F.R. 1910.242(b), which provides that “[c]ompressed air shall not be used for cleaning purposes except where reduced to less than 30 p.s.i.....” CO Schrilla testified that compressed air was being used for cleaning purposes in both the cheese room and the slicing room; he tested the lines with a gauge and found both to be at 112 p.s.i. He further testified that he spoke to employees working in both areas, who told him they used the air lines for cleaning, and that Mr. Tehonica also told him that the lines were used for cleaning. The CO said the condition was serious, in that compressed air of over 100 p.s.i. can inject air under the skin and cause an embolism. He also said that he took C-42, a photo of one of the lines. (Tr. 208-12).

Lewis does not address this matter in its brief, and Mr. Tehonica testified only about abating the cited condition, that is, “reducers” were put on the air lines shortly after the inspection. (Tr. 867). The Secretary has shown the alleged violation. This item is affirmed as a serious violation.

A penalty of \$1,400.00 has been proposed for this item. This item was considered to have medium severity and lesser probability, and the gravity-based penalty was \$2,000.00. (Tr. 211). Based on the relevant factors and applicable reductions, a penalty of \$1,000.00 is assessed.

**Serious Citation 1 - Item 27**

Item 27 alleges a violation of 29 C.F.R. 1910.243(c)(1), which states that “[a]brasives wheels shall be used only on machine provided with safety guards....” CO Schrilla observed a portable angle grinder that did not have a guard, and employees he spoke to told him they used the grinder. The CO also testified that the type of guard needed was a semicircle guard that would cover part of the grinding wheel; the purpose of the guard was to keep the operator from contacting the rotating blade or being struck by a broken blade, which could cause serious injuries. (Tr. 212, 218-19).



Mr. Tehonica was present when the CO saw the grinder, and he testified that the grinder was not in use at that time; he admitted, however, that the grinder was available for use, and he also admitted that Mr. Lashbrooks used it. (Tr. 867-70, 1037-38). The evidence of record establishes the alleged violation, and Lewis does not address this item in its brief. This item is affirmed as serious.

The Secretary has proposed a penalty of \$1,400.00 for this item. This item was rated as having medium severity and lesser probability, and the gravity-based penalty was \$2,000.00. (Tr. 219-20). In view of the relevant factors and applicable reductions, a penalty of \$1,000.00 is assessed.

**Serious Citation 1 - Item 28**

Item 28a alleges a violation of 29 C.F.R. 1910.303(b)(2). The cited standard states that “[l]isted or labeled equipment shall be used or installed in accordance with any instructions included in the listing or labeling.” CO Schrilla observed a Type NM cable, which is rated to be installed inside of a wall to protect it from damage, running down a wall to the floor in plain view in the company’s main office. He tested the cable with an electrical meter called an AC sensor and found that it had electrical power going through it. C-44 is his photo of the cable. (Tr. 220-22, 256, 260).

Item 28b alleges a violation of 29 C.F.R. 1910.305(b)(1), which states that “[c]onductors entering boxes, cabinets, or fittings shall also be protected from abrasion, and openings through which conductors enter shall be effectively closed.” CO Schrilla observed another Type NM cable entering a ceiling-mounted box, not through the actual fittings, but between the cover plate and the metal box itself. He also saw that the same cable, where it exited the wall-mounted switch box, did not go through the fittings as required to prevent abrasion; rather, it went over the top of the box and in between the box and cover plate. The CO tested the cable with his AC sensor and determined that it was live. C-43 and C-45 are his photos of the cable as he saw it. (Tr. 222-27).

CO Schrilla testified the conditions cited in Items 28a and 28b were serious hazards because, if the cables had become damaged, they could have caused serious electrical shocks. (Tr. 227-28). Lewis presented no evidence to rebut the CO’s testimony, and it does not address this item in its brief. The Secretary has shown the alleged violations, and Items 28a and 28b are affirmed as serious.

A total penalty of \$1,750.00 has been proposed for Item 28. This item was given high severity and lesser probability, and the gravity-based penalty was \$2,500.00. (Tr. 228). In light of the relevant factors and applicable reductions, a penalty of \$1,250.00 is assessed.

**Serious Citation 1 - Item 29**

Item 29a alleges a violation of 29 C.F.R. 1910.303(g)(2)(i), which provides that “[l]ive parts of electric equipment operating at 50 volts or more shall be guarded against accidental contact by approved cabinets or other forms of approved enclosures....” CO Scrilla observed a panel box in the facility’s ice bank room, a small building outside of the main facility; the box was open and had parts in it, and when he tested it with his AC sensor he found it was live.<sup>39</sup> The CO testified that the open box was a hazard; the room was small, about 10 by 12 feet, maintenance employees Allen Lashbrooks and Kenneth Yousey told him they worked in the room, and someone contacting a part in the box could have been electrocuted.<sup>40</sup> The CO also testified that the box was shown on the left in C-46, his photo of the condition. (Tr. 228-30, 238-41).

Lewis notes Mr. Tehonica’s testimony that the cover was off the box because an electrical subcontractor had been working on it and had left to get a part; the subcontractor returned later that day, and the cover was replaced on the box. (Tr. 870-73). CO Schrilla agreed that the cover was on the floor in the room, but he did not recall Mr. Tehonica saying anything about a contractor working on the box. (Tr. 677). Based on my credibility findings in this case, the CO’s testimony is credited over that of Mr. Tehonica. Lewis also contends that the Secretary has not shown employee exposure to the cited condition; however, in light of the testimony of the CO and Mr. Tehonica, I find that she has. The Secretary has proved the alleged violation, and Item 29a is affirmed as serious.

Item 29b alleges five instances of violation of 29 C.F.R. 1910.305(b)(1), asserting that breaker boxes in various locations had exposed energized parts; the terms of the cited standard are set out in the discussion pertaining to Item 28b, *supra*.<sup>41</sup> CO Schrilla testified as follows in regard to Items 29b(a) through 29b(e). As to each item, he observed a breaker box with missing breakers; the missing breakers exposed the bus bar, which was energized, and the AC sensor was used to verify that each box was in fact energized. In Item 29b(a), the box was in the bottling area; C-47 is the CO’s photo of

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<sup>39</sup>The CO indicated that the box’s voltage was 110 volts. (Tr. 228-29).

<sup>40</sup>Mr. Tehonica also testified that maintenance workers went into the room, in order to check the temperature. (Tr. 872).

<sup>41</sup>The relevant portion of the standard with respect to Item 29b states that “openings through which conductors enter shall be effectively closed.”

the box, and the CO circled the area of concern in C-47. In Item 29b(b), the breaker box was in the ramp area; C-50 is the CO's photo of the box, and he circled the area of concern. In Item 29b(c), the breaker box was in the ice bank room; the box was next to the panel box cited in Item 29a, and photo C-46 shows the breaker box on the right. In Item 29b(d) the breaker box was in the lower warehouse; there is evidently no photo of this instance. In Item 29b(e), the breaker box was in the security shack, and the CO took photo C-48, which shows CO Palhof testing the box. (Tr. 231-45).

CO Schrilla also testified about employee exposure as to each instance. In Item 29b(a), in the bottling area, he saw employees walking within a foot of the box, and he noted that because the circuits in the box would have to be turned on and off, employees would be exposed to the condition. In Item 29b(b), he saw employees walking right by the box, in that it was near the ramp, and at one point, Mr. Stone was standing right by the box watching the CO's. In Item 29b(c), there were no employees in the ice bank room when CO Schrilla was there; he noted, however, that the same maintenance employees that he spoke to in regard to Item 29a would also have been exposed to this condition. In Item 29b(d), there were no employees working in the lower warehouse when he was there, but he stated that Mr. Tehonica spent about 75 percent of his time in the warehouses. In Item 29b(e), CO Schrilla saw employees in the security shack when he was there, and he pointed out that almost all of the employees had to go to the shack to clock in and out. (Tr. 234-36, 239-44).

Mr. Tehonica was present when the CO's made the foregoing observations, and he saw the AC sensor light up when they tested the boxes. (Tr. 726, 873-74). Lewis does not dispute employee exposure as to Item 29b(a), but it contends that the Secretary has not proved exposure as to the other items. I disagree. The CO testified, as to Item 29b(a), that the circuits in the box would have to be turned on and off and that employees would thus be exposed to the energized bus bar. This testimony is equally true for the other 29b instances, and the Secretary has met her burden of showing exposure. I find, therefore, that the Secretary has proved the alleged violations; she has also proved the serious nature of the violations, due to the testimony of CO Schrilla that contacting the exposed parts in the boxes could result in death. (Tr. 235-37, 240-42, 245). Item 29b is affirmed as serious.

A total penalty of \$1,750.00 has been proposed for Item 29. This item was considered to be high severity and lesser probability, and the gravity-based penalty was \$2,500.00. (Tr. 245-46). Due to the relevant factors and applicable reductions, a penalty of \$1,250.00 is assessed.

**Serious Citation 1 - Item 30**

This item alleges a violation of 29 C.F.R. 1910.304(a)(2), which provides that “[n]o grounded conductor may be attached to any terminal or lead so as to reverse designated polarity.” In the lower warehouse, CO Schrilla observed a whey truck that was plugged into an outlet with an extension cord; he used his AC sensor to test the outlet and discovered that it had reversed polarity, that is, the hot and neutral lines were wired backwards. The CO said the condition was a serious hazard; if there had been a short or a fault, any equipment plugged into the outlet could have become energized and contact with the equipment could have caused a shock or even electrocution. (Tr. 256-59).

The CO’s testimony establishes the violative condition, and Lewis presented no evidence to rebut his testimony.<sup>42</sup> Lewis contends, however, that the Secretary did not prove that it had knowledge of the outlet’s condition, noting the violation was not in plain view and that constructive knowledge therefore cannot be found. However, as set out in the discussions for Items 28, 29, 31 and 32, there were a number of other conditions in the facility that violated OSHA’s electrical standards. Moreover, as found in footnote 33, *supra*, Respondent’s procedures for detecting safety problems were deficient. Finally, C-95, the NYSIF report, notes a number of electrical hazards at the facility. *See* C-95, ¶¶ 12, 14 and 16. Under these circumstances, I find that Lewis could have discovered the cited condition with the exercise of reasonable diligence. This item is affirmed as a serious violation.

The Secretary has proposed a penalty of \$1,750.00 for this item. This item was rated as having high severity and lesser probability, and the gravity-based penalty was \$2,500.00. (Tr. 259). Considering the relevant factors and applicable reductions, a penalty of \$1,250.00 is assessed.

**Serious Citation 1 - Item 31**

Item 31 alleges a violation of 29 C.F.R. 1910.304(f)(4).<sup>43</sup> The cited standard states that “[t]he path to ground from circuits, equipment, and enclosures shall be permanent and continuous.”

As to Item 31a, CO Schrilla testified there was a fan mounted in a doorway in the silo area; he put his AC sensor on the fan’s frame and the sensor lit up, indicating the fan was not grounded, and

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<sup>42</sup>Respondent’s assertion that the AC sensor the CO used to test the outlet was not reliable is rejected for the reasons set out in the discussion pertaining to Item 31, *infra*.

<sup>43</sup>As issued, this item alleged seven instances, but, at the hearing, the Secretary withdrew instances c through e, leaving instances a, b, f and g for resolution. (Tr. 259).

he explained that the AC sensor picks up not only the presence of AC power but also detects whether equipment is grounded. The CO identified C-56 as a photo of the fan. (Tr. 259-62).

As to Item 31b, CO Schrilla testified that he used his sensor on the frame of a bottling machine, located in the bottling area, and the sensor indicated the machine was not grounded; after some discussion with plant personnel, CO Palhof used a different type of tester, which confirmed that the machine was not grounded. CO Schrilla identified C-55 as a photo of the testing of the bottling machine with the AC sensor. (Tr. 262-64, 680-81).

As to Item 31f, CO Schrilla testified that in the storage area, there was a series of light fixtures with metal holders; the AC sensor was used to test the holders, and the sensor indicated the fixtures were not grounded. The CO identified C-57 as a photo showing the testing of one of the fixtures with the sensor. (Tr. 264-65).

As to Item 31g, CO Schrilla testified that a scale in the filling room was plugged into the wall and that when he tested it the sensor indicated the scale was not grounded; he pulled the plug out of the wall and saw it had no ground pin. The CO identified C-58 as a photo of the scale. (Tr. 265-67).

CO Schrilla stated that all four conditions were hazards, in that, if any of the equipment or one of the fixtures had had a fault or a short and an employee had touched it, a shock or even electrocution could have resulted; the hazard was exacerbated in the bottling area and the filling room because those areas were wet. (Tr. 261, 264-67).

Lewis contends that the AC sensor the CO used was not a reliable means of determining whether the cited equipment was grounded, and Respondent's counsel questioned the CO extensively in that regard. However, the CO testified that the AC sensor was the device he was taught to use. He said that, according to the manufacturer's instructions, the sensor was to be placed on a metal part of the equipment in question and that if the equipment was not grounded the sensor would light up. He also said he had not found the sensor to make mistakes; in fact, when plant personnel had questioned his determination concerning the bottling machine, CO Palhof had used a different sensor, a more advanced type that actually quantified the resistance present, which had confirmed that the bottling machine was not grounded. (Tr. 677-85, 732-33, 739-40, 743).

Mr. Tehonica agreed he was present when the CO tested the equipment and that he had seen the sensor light up, but he disputed the CO's finding that the bottling machine and the light fixtures

were not grounded; he said the fixtures were disconnected before the inspection and that Mr. Spencer had tested the bottling machine after the inspection with an ohms meter and found it to be grounded. (Tr. 873-82). However, Mr. Tehonica offered no testimony as to the other two pieces of equipment. Moreover, he did not address CO Schrilla's testimony regarding CO Palhof testing the bottling machine with a different type of tester to confirm that it was not grounded. Finally, in light of my credibility determinations in this case, Mr. Tehonica's testimony is found to be unpersuasive. I conclude that the Secretary has met her burden of proving the alleged violations and that she has also shown the knowledge element, based on my findings in that regard in the discussion relating to Item 30, *supra*. Items 31a, b, f and g are affirmed as serious violations.

A total penalty of \$1,750.00 has been proposed for Item 31. This item was given high severity and lesser probability, and the gravity-based penalty was \$2,500.00. (Tr. 268). In view of the relevant factors and applicable reductions, a penalty of \$1,250.00 is assessed.

**Serious Citation 1 - Item 32**

Item 32a alleges a violation of 29 C.F.R. 1910.305(e)(1), which states that:

Cabinets, cutout boxes, fittings, boxes and panelboard enclosures in damp or wet locations shall be installed so as to prevent moisture or water from entering and accumulating within the enclosures. In wet locations the enclosures shall be weatherproof.

CO Schrilla observed two electrical boxes mounted on the wall in the mixing area; there were openings in the bottoms of the boxes, and there was also rust and water marks on the bottoms of the boxes.<sup>44</sup> The CO spoke to employees who worked in the area, as well as Ms. Karelus, and learned that the area was hosed down every night to clean it. He said the condition was hazardous because water could enter the openings and cause electrical shocks and death. He also said that C-59 was his photo showing one of the openings and CO Palhof testing the box to verify that it was energized. The CO stated that the condition could have been corrected by buying plugs for the holes. (Tr. 268-70).

The Secretary has established the alleged violation, and Lewis does not address this item in its brief. Item 32a is affirmed as a serious violation.

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<sup>44</sup>C-95, the NYSIF report, also noted "moisture and condensation" on walls and ceilings of areas where electrical equipment was located. *See* C-95, ¶ 16.

Item 32b alleges four instances of violation of 29 C.F.R. 1910.305(j)(2)(ii), asserting that receptacles exposed to water had covers that were not closed. The cited standard states that “[a] receptacle installed in a wet or damp location shall be suitable for the location.” As to Item 32b(a), CO Schrilla saw a receptacle in the cooler area that was exposed to water as its cover not closed; the receptacle was tested with the AC sensor and found to be energized, and it also had an extension cord plugged into it that went to a radio that was playing. There were watermarks on the outlet, and the CO learned the area was washed down often. C-60 is the CO’s photo of the receptacle.(Tr. 271-72).

As to Item 32b(b), CO Schrilla observed a receptacle in the cheese room that also was exposed to water; the cover was missing, the faceplate was coming away from the box, and the CO saw watermarks on the outlet and learned the area was hosed down daily. The receptacle was tested with the AC sensor and found to be energized, and there was an extension cord plugged into the receptacle that went to another radio. C-62 is the CO’s photo of the receptacle. (Tr. 273-75).

As to Item 32b(c), CO Schrilla saw a receptacle in the mixing department that was exposed to water; its cover was open, and the receptacle was cut to allow a “cheater” to go into the outlet. The receptacle was found to be energized, by means of the sensor, and an employee, Mr. Bush, told the CO the area was washed down daily. C-61 is the CO’s photo of the receptacle. (Tr. 275-77).

As to Item 32b(d), CO Schrilla observed a fourth receptacle, this one in the filling room, that was damaged and had a cover that would not close. There were conductors plugged into the receptacle, and the conductors were tested with the sensor to verify they were energized. Ms. Karelus told the CO the area was hosed down daily, and the CO saw that the receptacle had plastic wrapped around it and that there was water inside the plastic. (Tr. 277-78).

The Secretary has demonstrated the alleged violations. She has also demonstrated that the violations were serious, based upon the CO’s testimony that contact with outlets in wet locations could result in severe shocks or electrocution. (Tr. 273-78). Lewis does not address this item in its brief. Item 32b is accordingly affirmed as a serious violation.

A total penalty of \$1,750.00 has been proposed for Item 32. This item was considered to have high severity and lesser probability, and the gravity-based penalty was \$2,500.00. (Tr. 279). Based on the relevant factors and applicable reductions, a penalty of \$1,250.00 is assessed.

**Serious Citation 1 - Item 33**

Item 33a alleges a violation of 29 C.F.R. § 1910.1200(e)(1), which provides as follows:

Employers shall develop, implement, and maintain at each workplace, a written hazard communication program which at least describes how the criteria specified in paragraphs (f), (g), and (h) of this section for labels and other forms of warning, material safety data sheets, and employee information and training will be met....

The record shows that Respondent's employees used hazardous chemicals to clean equipment at the facility. (Tr. 102-06, 118-22, 280). *See also* Items 9 and 10, *supra*. The record also shows, as set out in the credibility determination part of this decision, that Lewis had no written HAZCOM program at the time of the inspection. The CO's determined this fact from asking Mr. Tehonica and Ms. Hirsch, who both said they were unaware of a written HAZCOM program.<sup>45</sup> (Tr. 37, 279-80,363, 371, 424). Further, CO Schrilla testified that various employees he talked to, *i.e.*, Mr. Lashbrooks, Mr. Yousey, Mr. Bush and Mr. Edick, confirmed there was no such program. (Tr. 279-80). Finally, as the Secretary points out, Lewis never produced a HAZCOM program during the inspection, and C-95, the NYSIF report, also notes the lack of a HAZCOM program. (Tr. 280, C-95, ¶ 9). The Secretary has established the alleged violation, and Item 33a is affirmed as a serious violation.<sup>46</sup>

Item 33b alleges a violation of 29 C.F.R. 1910.1200(h)(1), which provides that:

Employers shall provide employees with effective information and training on hazardous chemicals in their work area at the time of their initial assignment, and whenever a new physical or health hazard the employees have not previously been trained about is introduced into their work area. Information and training may be designed to cover categories of hazards (*e.g.*, flammability, carcinogenicity) or specific chemicals. Chemical-specific information must always be available through labels and material safety data sheets.

The employees noted above in Item 33a also told CO Schrilla they had not received any HAZCOM training; they knew that material safety data sheets ("MSDS's") were located in the break room, but they had not been trained in the hazards of the chemicals they worked with. In addition, CO Schrilla spoke to Ed Ayers, the representative of the company that supplied the various chemicals that

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<sup>45</sup>Mr. Tehonica's trial testimony that there was a HAZMAT program at the time of the inspection, and that he never told anyone that there was not, is not credited. (Tr. 767, 796, 891).

<sup>46</sup>The serious nature of the violation is shown by the evidence set out in Items 9 and 10.



Lewis used; Mr. Ayers stated that he had given some training to Lewis employees but not what was required by the HAZCOM standard. (Tr. 119, 281).

Mr. Tehonica testified that employees received training in the chemicals they used through film strips, safety meetings and Mr. Ayers. He said the film strips were there when he became safety coordinator and that they addressed HAZCOM information; he also said that he held about ten safety meetings before the OSHA inspection and that those meetings covered MSDS's as well as protective gear to wear when using chemicals. (Tr. 885-90, 1075-78). Mr. Tehonica admitted, however, that the training that Mr. Ayers provided did not meet the HAZCOM standard's requirements. (Tr. 1038-40). Moreover, Lewis presented no evidence to show that the film strips and safety meetings Mr. Tehonica testified about covered the required information. Finally, while Lewis disputes the applicability of the standard and the serious nature of the hazard in its brief, it does not mention Mr. Tehonica's testimony or contend that the standard was met. Based on the testimony of CO Schrilla, the Secretary has shown the alleged violation. Item 33b is affirmed as a serious violation.

A total penalty of \$1,750.00 has been proposed for Item 33. This item was given high severity and lesser probability, and the gravity-based penalty was \$2,500.00. (Tr. 282). Due to the relevant factors and applicable reductions, a penalty of \$1,250.00 is assessed.

**Willful Citation 2 - Item 1**

This item alleges both a serious and a willful violation of 29 C.F.R. 1910.132(a), which states as follows:<sup>47</sup>

Protective equipment, including personal protective equipment for eyes, face, head, and extremities, protective clothing, respiratory devices, and protective shields and barriers, shall be provided, used, and maintained in a sanitary and reliable condition wherever it is necessary by reason of hazards of processes or environment, chemical hazards, radiological hazards, or mechanical irritants encountered in a manner capable of causing injury or impairment in the function of any part of the body through absorption, inhalation or physical contact.<sup>48</sup>

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<sup>47</sup>The complaint alleges that Items 1 and 2 of Citation 2 were both serious and willful.

<sup>48</sup>As the Secretary notes, the Commission has held that 29 C.F.R. 1910.132(a) can be interpreted to require the use of fall protection. *See Cleveland Elec. Illuminating Co.*, 16 BNA OSHC 2091 (No. 91-2198, 1994). Further, C-72, an OSHA interpretation of the standard, states fall protection is required on top of "rolling stock" in the grain-handling industry. (Tr. 297-98).

As to Item 1a, CO Schrilla learned that in the milk receiving area, an employee named Kevin Morak was required to go up on top of tanker trucks to facilitate the unloading and cleaning process. The CO spoke to Mr. Morak, who said he had not worn any fall protection for his work on the tanker trucks for one and a half to two weeks.<sup>49</sup> The CO also spoke to Mr. Tehonica, who agreed that fall protection was needed and indicated that one of the harnesses that had been used had been damaged about three months before; Ms. Karelus and Mr. Stone, however, did not recall fall protection being used in the milk receiving area. CO Schrilla testified that the tops of the tanker trucks were 11 feet from the ground and that the failure to use fall protection was a serious hazard; a fall of 11 feet could result in serious injuries or death, and he knew of a case in another facility where a worker had fallen 11 feet from the top of a tanker truck, causing the worker's death.<sup>50</sup> The CO identified C-70 as his photo of the area, showing a tanker truck with its hatch open. (Tr. 282-86, 289-91).

As to Item 1b, CO Schrilla observed a tanker truck in another area of the facility, the whey waste area; he explained that whey was a byproduct of the facility's processes and that it was shipped out in tanker trucks. He spoke to an employee, Scott Hanley, who said he was a truck driver, that he got on top of the whey waste tanker trucks to open and close their hatches and to add chemicals, and that he used no fall protection when he was up on the trucks. CO Schrilla testified that the whey waste area was in an outside location and that there were no attachment points for fall protection; however, he gave examples of what could be utilized to provide protection. He also testified that the condition was a serious hazard, as a fall of 11 feet could cause serious or fatal injuries, and he identified C-69 as his photo of the tanker truck he saw in the whey waste area. (Tr. 292-97).

CO Schrilla testified that Lewis knew of the cited conditions, pointing out that the NYSIF report noted the lack of fall protection for work on tanker trucks; he also pointed out that Ms. Karelus, Mr. Stone and Mr. Tehonica all knew that fall protection was needed and was not in use and that, in

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<sup>49</sup>CO's Schrilla and Palhof both testified that they saw Mr. Morak later on that day and that he was wearing a harness that was much too big for him. (Tr. 283, 383, 474, 685-86).

<sup>50</sup>The CO measured the distance from the top of the cited tanker truck to the ground, and he noted that 11 feet is standard for most tanker trucks. (Tr. 284).

the February 7, 2003 meeting the CO had with Mr. Spencer, Mr. Spencer said he knew fall protection was needed and thought it had been ordered.<sup>51</sup> (Tr. 283, 286-88, 291, 295, 338-39, 343-46).

Lewis concedes that a “brief” violation of the cited standard existed in regard to Item 1a, noting the testimony of Mr. Tehonica that the facility had two safety harnesses and three lanyards at the time. He said that one harness and two lanyards were used in the tanker bay area, that one lanyard was kept attached to a steel pipe in the ceiling that was put in as an attachment point, and that workers who went up on the tankers tied off the lanyard on the harness to the lanyard on the pipe; he also said that a welder who was using the other harness and lanyard had burned the lanyard during his welding work about two weeks before and that the welder had taken the lanyard from the steel pipe.<sup>52</sup> Mr. Tehonica noted that he had called OSHA after the inspection and had spoken to CO Palhof about devising a different kind of fall protection system in the tanker bay area. (Tr. 787-93).

Mr. Tehonica’s testimony is not credited. First, Mr. Tehonica told CO Schrilla during the inspection that it was a harness that had been damaged about three months before the inspection. (Tr. 283, 291). Second, CO Schrilla never mentioned a steel pipe as an attachment point during his testimony, and Ms. Karelus and Mr. Stone both told him they did not recall fall protection being used in the milk receiving area.<sup>53</sup> (Tr. 283). Third, C-95, the NYSIF report, notes the lack of fall protection for work on tanker trucks. (C-95, ¶ 6). Fourth, CO Palhof testified that when Mr. Tehonica called, he and Mr. Tehonica had discussed installing an anchorage point in the ceiling; according to the CO, Mr. Tehonica said he was unsure what they could use for an anchorage point as there were pipes at the ceiling and the anchorage point needed to be below the pipes. (Tr. 381-82). Finally, while Lewis

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<sup>51</sup>AAD Adams was also present at the February 7 meeting, and his testimony about what Mr. Spencer said was consistent with that of CO Schrilla. (Tr. 499-500).

<sup>52</sup>Mr. Tehonica indicated the welder removed the lanyard as needed for his work and then replaced it and that he had failed to replace it the night before the inspection. (Tr. 789-91).

<sup>53</sup>C-73 and C-75, the written statements of Mr. Stone and Ms. Karelus, both note there was no fall protection used in the milk receiving area; in addition, C-75 states that Ms. Karelus told employees to use the pipe on the ceiling to steady themselves. I find C-73 and C-75 to be reliable, based on the factors discussed in *Regina Constr. Co.*, 15 BNA OSHC 1044, 1048 (No. 87-1309, 1991). I also find them reliable because they are consistent with other evidence in the record, *i.e.*, C-74, the written statement of Melissa Hirsch. In view of C-73 and C-75, Mr. Morak’s statement to the CO indicating his use of fall protection is not credible.

apparently had at least one harness and lanyard at the time of the inspection, it is clear that Lewis employees were not using any fall protection when they worked on the tanker trucks at the site. Item 1a is affirmed as a serious violation.

In regard to Item 1b, Lewis contends that it was not in violation of the standard because the Secretary did not prove there was a feasible means of compliance. In support of its contention, Lewis notes the following passage in C-72, the OSHA interpretation of 29 C.F.R. 1910.132:

[I]t would not be appropriate to use the personal protection equipment standard, 29 C.F.R. 1910.132(d), to cite exposure to fall hazards from the tops of rolling stock, unless employees are working atop stock that is positioned inside of or contiguous to a building or other structure where the installation of fall protection is feasible. In such cases, fall protection systems often can be and in fact are used in many facilities in the industry.

As a preliminary matter, it is unclear to me whether the reference to 1910.132(d) in the above excerpt is an error, as Lewis suggests, or whether the passage does in fact refer to 1910.132(d), which addresses hazard assessment and equipment selection. However, even assuming that the excerpt refers to 1910.132(a), I disagree with Respondent's contention. First, C-69, the CO's photo of the tanker truck in the whey waste area, shows the truck parked right next to a building. Second, CO Schrilla testified as follows with respect to systems that Lewis could have put in place:

What I've seen in the past and would work here, there's a couple different ways. One's a single point suspension where they have actually a frame that comes up and a retractable lifeline. I've seen frames with four posts in the center, in the center rail with a lifeline that moves along that rail that employees tie off. And I've seen facilities that have actual stairways and then a platform that comes down, they lower the platform right next to the truck and there's guardrails all the way around the sides. (Tr. 293-94).

On the basis of the CO's testimony, I find that the Secretary has shown that there were feasible means of compliance with the standard. Item 1b is affirmed as a serious violation.

Turning to the willful classification, the Secretary, in order to establish that a violation was willful, must show that it was committed "with intentional, knowing or voluntary disregard for the requirements of the Act or with plain indifference to employee safety." *See, e.g., Williams Enter., Inc.*, 13 BNA OSHC 1249, 1256 (No. 85-355, 1987), and cases cited therein. As *Williams* further explains:

A willful violation is differentiated by a heightened awareness – of the illegality of the conduct or conditions – and by a state of mind – conscious disregard or plain indifference. *Id.* at 1256-57.

As indicated *supra*, C-95 is an excerpt from the NYSIF report dated January 16, 2002, issued to Lewis following a survey of the facility on January 15, 2002.<sup>54</sup> (Tr. 315, 983-94). C-95 is captioned “Survey of the Workplace,” and the first paragraph of C-95 states as follows:

The results of the workplace survey that was conducted at your facility are listed below. These items are part of the overall consultation and your insurer must verify that you have complied with this section of the report upon the reinspection that must be conducted within six months of the date of receipt of this report.

C-95 then goes on to list 29 conditions that are to be addressed, some of which have been noted previously in this decision. As to the cited condition, C-95 states that “[a] proper and approved OSHA fall arrest system for tank truck sampling and loading operations must be installed. Presently, no system to protect employee on a working platform from falling.” C-95, ¶ 6. Mr. Tehonica testified that when he was appointed safety coordinator, Mr. Spencer gave him a copy of C-95 and discussed it with him. Mr. Tehonica further testified that after becoming safety coordinator, he called Veronica Migon, the NYSIF representative who had been working with Lewis to correct the conditions in C-95; Ms. Migon told him that her objective was for Lewis to be compliant so that it could lower its insurance premiums. Mr. Tehonica said that Melissa Hirsch had been working with Ms. Migon before he became safety coordinator and that he learned that Ms. Migon had been to the facility several times; he also said that Ms. Migon followed up with him and visited the facility about twice a month to make sure he was making progress on the items in C-95. (Tr. 983-93, C-99).

In addition to the above, the record shows that Ms. Hirsch was the safety coordinator before Mr. Tehonica. According to C-74, the written statement she gave CO Schrilla, Moise Banayan, the owner of Lewis, told her to meet with the NYSIF investigator after C-95 was issued, that she was the

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<sup>54</sup>As noted in footnote 23, C-95 is part of the report to Lewis after a representative of NYSIF, the insurer of Lewis at the time of the OSHA inspection, surveyed the facility; NYSIF was required to survey Lewis as its worker compensation claims exceeded the numbers set out by the New York State Department of Labor. The representative who did the survey did not testify, but Veronica Migon, the NYSIF consultant who worked with the facility to get it into compliance with C-95, did testify; she stated that although Lewis was not compliant within the requisite six-month time period, it was compliant by July 2003. (Tr. 1128-41, 1148-52, 1157, 1165-67, 1198).

safety coordinator, and that she was to “get on top of” the safety issues.<sup>55</sup> Ms. Hirsch began meeting with Ms. Migon and ordering safety equipment, and she also planned a safety meeting for June 5, 2002; before the meeting was held, however, Mr. Spencer told her to stop meeting with Ms. Migon and to do nothing else as to safety; she was also told her equipment orders had been put on “hold.”<sup>56</sup> Ms. Hirsch advised Ms. Migon what had happened, after which Ms. Migon scheduled two meetings with Mr. Spencer, but he did not appear for them. Ms. Migon also wrote to Mr. Banayan, who contacted Ms. Hirsch and asked why she was not doing anything about the safety issues; Ms. Hirsch reminded Mr. Banayan that Mr. Spencer had relieved her of that responsibility and that she had written him (Mr. Banayan) in that regard. Mr. Spencer appointed Mr. Tehonica safety coordinator in September 2002, and after that point Ms. Hirsch and Mr. Tehonica both met with Ms. Migon and worked on safety issues at the facility. In C-74, Ms. Hirsch said Mr. Tehonica had ordered fall protection for the milk receiving area and that Mr. Spencer had known of the order.<sup>57</sup> She also said that Mr. Spencer had stated that some of the items in C-95 were not needed and that others were too expensive. Finally, she said there was no cooperation from management, meaning Mr. Spencer, Mr. Banayan and others, in regard to safety.

Based on the foregoing, Lewis management, that is, Thomas Spencer, the general manager, and Moise Banayan, the owner, had specific notice of the need for fall protection for work on top of tanker trucks in January 2002 due to C-95. Despite this notice and the efforts of Ms. Migon, Ms. Hirsch and

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<sup>55</sup>Moise Banayan denied Ms. Hirsch ever had any safety responsibilities at the facility. (Tr.1307-08, 1314, 1330). However, his testimony in this regard is not supported by the record, and I find C-74 reliable for several reasons. The statements in C-74 are supported by memos Ms. Hirsch wrote to Lewis management officials when she was working on safety issues with Ms. Migon. (C-87, C-90, C-91, C-93, C-99). They are also supported by Ms. Migon’s testimony and letters she wrote to Lewis. (Tr. 1174-77, 1182-91, 1194-98; C-99, C-134, C-136, C-137). C-74 is, moreover, consistent with C-73 and C-75, the statements of Mr. Stone and Ms. Karelus, set out *supra*. Finally, C-74 meets the factors set out in *Regina Constr.*, 15 BNA OSHC at 1048.

<sup>56</sup>According to C-74, Mr. Spencer replaced Ms. Hirsch with security head Cynthia Peck, who “did not go very far” with her new safety responsibilities. *See* C-74, p. 2.

<sup>57</sup>Mr. Tehonica testified he had requested fall protection before the inspection and that he had showed the order to CO Schrilla. His testimony is supported by C-96, which is an order for fall protection and other safety equipment and a hand-written note to Mr. Spencer that the items were needed for the upcoming December 11, 2002 meeting with Ms. Migon. (Tr. 794; C-134).

Mr. Tehonica, Lewis had not complied with the requirement a year later, when the OSHA inspection took place. Besides these facts, Mr. Stone stated in C-73 that there had been no fall protection for seven to eight years in the milk receiving area. Mr. Stone said he had agreed that fall protection was necessary when Mr. Tehonica brought it to his attention, and he told Mr. Tehonica to discuss it with Mr. Spencer; when no fall protection appeared, Mr. Stone spoke to Mr. Spencer, who said that a harness and lanyard had been ordered. In his statement, Mr. Stone said he did not know why there was still no fall protection in the milk receiving area. Ms. Karelus stated in C-75 that she was aware of the need for fall protection in the milk receiving area; she also knew it was not being used and that it had been requested.

When CO Schrilla and AAD Adams met with Mr. Spencer on February 7, 2003, Mr. Spencer told them he thought fall protection had been ordered. Mr. Spencer then called the company's Brooklyn office and spoke with Yehutta Banayan, the individual responsible for purchasing, who said the fall protection had not been ordered but that it would be and would be delivered within a few days. CO Schrilla asked Mr. Spencer why the fall protection had not been ordered immediately, when the first request was put in; Mr. Spencer stated that orders relating to production were filled right away but that if an order did not involve production it would not be filled until Yehutta Banayan spoke to the owner and the owner approved the order. (Tr. 338-39, 499-500).

I find that Lewis was in willful violation of the cited standard. Lewis management had specific notice of the cited hazard in January 2002, and, notwithstanding the efforts of the NYSIF consultant and the Lewis personnel assigned to address the facility's safety issues, the cited hazard still existed a year later when OSHA arrived. Moreover, it is reasonable to infer from the record that Thomas Spencer had not followed up with the Brooklyn office to ensure the fall protection had been ordered and that Moise Banayan had made a conscious decision to not fill Mr. Tehonica's request for fall protection, even though both knew the equipment was required. Finally, even after Mr. Spencer called Brooklyn and Yehutta Banayan told him the fall protection would be ordered and would arrive in a few days, there was still no fall protection in use on the tanker trucks about a month later; this fact is established by C-73, C-74 and C-75, the statements CO Schrilla took from Mr. Stone, Ms. Hirsch and Ms. Karelus on March 5, 2003. Under the circumstances of this case, I find that the Secretary has

shown that Lewis acted with conscious disregard of the standard's requirements and/or plain indifference to employee safety. This item is accordingly affirmed as a willful violation.<sup>58</sup>

The Secretary has proposed a total penalty of \$44,000.00 for this item. This item was given a high severity and lesser probability, and the gravity-based penalty was \$55,000.00. (Tr. 296). In light of the relevant factors and applicable reductions, a penalty of \$27,500.00 is assessed.

**Willful Citation 2 - Item 2**

This item alleges both a serious and a willful violation of 29 C.F.R. 1910.151(b), which provides as follows:

In the absence of an infirmary, clinic, or hospital in near proximity to the workplace which is used for the treatment of all injured employees, a person or persons shall be adequately trained to render first aid. Adequate first aid supplies shall be readily available.<sup>59</sup>

CO Schrilla testified he asked Mr. Tehonica about first aid supplies on January 29, 2003, and that Mr. Tehonica told him there was a kit in the guard shack, where Cynthia Peck, the head of security, was stationed. He and CO Palhof went to the guard shack the next morning, and, when they looked inside the kit, it had very little in it; there was a CPR mask, a few rubber gloves, a few small gauze pads, and some tape. The CO said the kit should have had other items, such as trauma and burn dressings, larger gauze pads, and band aids, and that not having basic first aid supplies can cause an injury to be worse, particularly if it is a major injury and there is nothing to help control it before an ambulance arrives. He also said no one mentioned there were other first aid kits at the facility and that he did not see any other kits during the inspection; further, Ms. Peck indicated that the first aid supplier

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<sup>58</sup>In finding the violation willful, I have noted the testimony of Ms. Migon indicating that Ms. Hirsch and Mr. Tehonica had worked very hard to try to get the facility into compliance; in fact, in her November 22, 2002 letter to Ms. Hirsch (which is attached to C-99), she said that Mr. Tehonica had put "awesome effort" into correcting the violations. (Tr. 1215-20). *See also* C-134, C-136, C-137. However, she also testified that during the time she had worked with them, both Ms. Hirsch and Mr. Tehonica had made statements to the effect that safety was not a priority at Lewis and that their hands were tied in trying to get things done. (Tr. 1194-97).

<sup>59</sup>As the Secretary points out, the standard's terms were stated incorrectly in the citation. The standard was amended on June 18, 1998 to remove the requirement that first aid supplies be "approved by a consulting physician." *See* 63 Fed. Reg. 33,466, June 18, 1998. The language set out above correctly reflects the standard's wording at the time of the inspection.



had not been there for some time,<sup>60</sup> that one order of supplies had been returned, and that there was a lack of first aid supplies, and Ms. Karelus and Mr. Stone also indicated that there was a lack of first aid supplies in their written statements.<sup>61</sup> (Tr. 300-04, 343, 701-04, 722).

Ms. Migon, the NYSIF consultant who worked with Ms. Hirsch and Mr. Tehonica to get the facility into compliance, testified that during her site visit of November 20, 2002, she walked through all the departments with Mr. Tehonica, at which time she noticed there were no first aid kits. She spoke to Mr. Tehonica about the lack of kits, and she mentioned it to Ms. Hirsch after the walk-around; she also wrote a follow-up letter to Ms. Hirsch, dated November 22, 2002, in which she repeated that she had seen no kits and that there should be one in every department.<sup>62</sup> During a subsequent visit, Ms. Migon saw several first aid kits in the office area, and Ms. Hirsch indicated she had ordered them; Ms. Migon expressed her approval and stated they should be distributed, but Ms. Hirsch said she could not because she had been told she had to return them. (Tr. 1190-94, 1198-1200, 1229-30; C-99).

Mr. Tehonica, Ms. Peck and Moise Banayon also testified about the kits. Mr. Tehonica testified that besides the kit in the guard shack, which was a large kit, there were seven or eight smaller kits in other areas at the time of the OSHA inspection, including the office, the ATS or packaging room, the slicing room, the maintenance shop, and the cheese room. He said the kits held items such as band aids, ointments, gauze, tape and aspirin, and that he replenished the smaller kits from the guard shack kit; Ms. Peck replenished that kit by ordering supplies from Zee Medical. He also said he checked the smaller kits periodically and that there were times when he replenished them and by the next day they were half empty.<sup>63</sup> Mr. Tehonica noted that he referred the CO's to the guard shack because CO Schrilla asked him where the first aid station was; CO Schrilla never asked him about first aid supplies or other kits. He also noted that on her visits in November and December 2002, he and Ms. Migon only

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<sup>60</sup>Ms. Peck said the supplier would only visit Lewis upon request. (Tr. 704).

<sup>61</sup>The testimony of CO Palhof was consistent with that of CO Schrilla. (Tr. 366-69, 404).

<sup>62</sup>Ms. Migon first indicated she could not recall if she had asked Mr. Tehonica about first aid kits; she later testified she had because she always looked for first aid kits, fire extinguishers and eye wash stations during her site visits. (Tr. 1192-93, 1230, 1240).

<sup>63</sup>Mr. Tehonica could not recall when he last looked in the guard shack kit before the inspection, but he said there were "numerous times" when it had supplies in it. (Tr. 896-97).

walked through the areas where he had made corrections, that many of the kits were kept in cabinets, and that she never asked him about first aid kits.<sup>64</sup> Mr. Tehonica said that he never saw the November 22, 2002 letter Ms. Migon wrote and that no one ever discussed it with him. (Tr. 894-905, 1041-42, 1057-65, 1386-87, 1395-96, 1413, 1419-21, 1427, 1431-32, 1443-44, 1450-52).

Ms. Peck testified there was a large first aid kit in the guard shack and that there were also kits in the office, the maintenance shop, the ATS room and the lab at the time of the OSHA inspection.<sup>65</sup> She could not say if she looked in the kit when CO Schrilla was there, but she knew it contained ointments, a CPR mask, bandages, tape and pads; she did not recall him asking her any questions about the kit, and she also could not recall when she had last looked in the kit, although she said it would have been no more than a week before his arrival because someone would have come to the shack for first aid.<sup>66</sup> Ms. Peck further testified that she worked in purchasing at Lewis from about the end of 1998 to about the beginning of 2002, when she began working in the guard shack as head of security; she bought first aid supplies from Zee Medical when she was in purchasing, and the Zee Medical representative came automatically every six to eight weeks to replenish the kits with any items they needed. She said that once she began her security job she no longer bought first aid supplies and that Yehutta Banayan, the purchaser for Lewis, did so; however, at least once after she became head of security she had the Zee Medical representative fill the kits, and, because she did so without Yehutta Banayan's permission, the ibuprofen and possibly some other items were returned. Ms. Peck was unaware of Ms. Hirsch requesting any first aid supplies or kits in 2002. (Tr. 928-62).

Moise Banayan testified that besides the one in the guard shack, there were kits in the office, the cheese room, the slicing room and the mixing room.<sup>67</sup> He believed the kits were installed around

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<sup>64</sup>Mr. Tehonica indicated that all the employees knew where the first aid kits were and that while someone just walking through might not see them a thorough inspection would have revealed them. (Tr. 1452-53).

<sup>65</sup>Ms. Peck indicated there are eight kits now and that she was not sure if the additional kits had been purchased before or after the OSHA inspection. (Tr. 935-36).

<sup>66</sup>Ms. Peck could not remember the last time the guard shack kit was serviced before the OSHA inspection occurred. (Tr. 962).

<sup>67</sup>Mr. Banayan did not believe that there was a kit in the packing area. (Tr. 1324).

mid-2002, but he did not know what specifically was in them or how often they were filled. He said the kits Ms. Migon saw were sent back because they were purchased from a vendor that Lewis no longer used and because the number of kits was kept to a minimum due to theft; the kits were also kept only half filled and were put in tool cabinets in the departments where they were located. He also said that someone walking through the facility would not see the kits and that while Mr. Tehonica and other plant personnel knew where they were Ms. Hirsch would not have known because she did not go into the plant itself. Mr. Banayon stated he had never seen C-99 or the letter attached to it before this proceeding began and that no one, including NYSIF and Lewis personnel, had ever told him there was an issue with the first aid kits at the facility. (Tr. 1302, 1316-17, 1323-24, 1357-71).

It is clear there are some significant discrepancies in the foregoing testimony. CO Schrilla, for example, testified he asked Mr. Tehonica about first aid supplies, not a first aid station, and he and CO Palhof both testified they spoke to Ms. Peck about first aid supplies and that she made the statements set out *supra*; no one they talked to mentioned other kits, and they saw no others during the inspection. (Tr. 300-04, 367-69, 404, 701-04). Further, while the Lewis witnesses all testified about other first aid kits in the plant, their testimony about the kits' locations did not agree. (Tr. 898-99, 934-36, 1041-42, 1324, 1419-20). In addition, Ms. Peck's testimony that Zee Medical visited the facility automatically every six to eight weeks to fill the kits conflicts with her statement to CO Schrilla that Zee Medical only went to the facility at the request of Lewis; also, her testimony that she stopped ordering first aid supplies after becoming head of security is contrary to her telling the CO's that she ordered those supplies, and that she did is supported by invoices showing she placed phone orders with Zee Medical on June 9 and July 7, 2004.<sup>68</sup> (Tr. 302-03, 367-68, 704; 938-44, 951, 954, 959-60, R-12). Finally, Ms. Peck herself testified that some first aid supplies were returned, and that they were is supported by an invoice dated May 14, 2002, indicating that an entire order totaling \$84.60 was returned. (Tr. 951-52; R-12). I have already found the CO's to be credible witnesses, and based on that finding and the record as a whole, their testimony is credited over that of Ms. Peck and Mr. Tehonica.<sup>69</sup>

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<sup>68</sup>Mr. Tehonica also testified that Ms. Peck ordered first aid supplies pursuant to her job in the guard shack. (Tr. 1443-44).

<sup>69</sup>Mr. Tehonica has already been found to be a less than reliable witness, and certain of Ms. Peck's testimony, besides being contrary to that of the CO's, was simply not believable; in

I also credit the testimony of Ms. Migon about not seeing any first aid kits in the facility and mentioning this fact to both Mr. Tehonica and Ms. Hirsch.<sup>70</sup> Her letter to Ms. Hirsch of November 22, 2002, which is attached to C-99, plainly states that she did not see any kits during her November 20, 2002 visit.<sup>71</sup> Moreover, C-96 is a hand-written note Mr. Tehonica sent to Mr. Spencer stating that he needed certain supplies for the December 11, 2002 “inspection.” The list attached to C-96 sets out several items, including “first aid supplies and or kits,” and Mr. Tehonica admitted that he wrote C-96. (Tr. 1014, 1065). Also, it is clear the “inspection” he referred to in C-96 was Ms. Migon’s visit of that date, in light of C-134, her letter of December 16, 2002, after her visit of December 11, 2002.

In view of the above, I find that there were inadequate supplies in the first aid kit in the guard shack; this finding is supported by the CO’s testimony and by the statements of Mr. Stone, Ms. Hirsch and Ms. Karelus, all of which indicate there was a lack of first aid supplies. *See* C-73, C-74, C-75. I further find that other than the kit in the guard shack, there were no other first aid kits or supplies in the facility at the time of the inspection.<sup>72</sup> This finding is supported by the fact that Mr. Tehonica and Ms. Peck did not mention any other kits or supplies to the CO’s. It is also supported by the fact that the CO’s and Ms. Migon did not see any other kits in the facility during their respective inspections. Finally, it is supported by C-96, Mr. Tehonica’s request for “first aid kits and or supplies,” and by the

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this regard, I note her statements indicating she did not recall looking in the kit when the CO’s were there and that she also did not recall them asking her about the kit. (Tr. 936-37).

<sup>70</sup>I observed Ms. Migon’s demeanor as she testified, including her facial expressions and body language, and found her to be a convincing and credible witness. I also found her testimony reliable because she was a neutral witness in this matter and had no reason to support either the Secretary’s or the Respondent’s case.

<sup>71</sup>C-99 is a fax that Ms. Hirsch sent to Moise Banayan and to Ruben Baityouchoub, the company’s controller, dated December 13, 2002, concerning the efforts she and Mr. Tehonica were making in regard to getting the plant into compliance. (Tr. 1361-62).

<sup>72</sup>In so finding, I have noted R-15, a Global Equipment (“Global”) invoice, showing that Ms. Peck ordered two first aid kits in May 2001. I have also noted Mr. Tehonica’s testimony that the kits were in the slicing room and the cheese room at the time of the inspection, where they are today. (Tr. 1432-33). However, Mr. Tehonica’s further testimony indicates he “found” these kits at some point after the inspection and then contacted Global in order to obtain R-15. (Tr. 1438). I conclude, accordingly, that even if the two Gobal kits were somewhere in the plant at the time of the OSHA inspection, employees, including Mr. Tehonica, were not aware of them.

fact that Ms. Hirsch, pursuant to the testimony of Ms. Migon and Mr. Banayan, ordered several first aid kits which were then returned. In reaching this finding, I do not credit the testimony of Mr. Tehonica and Mr. Banayan indicating that Ms. Migon and the CO's did not see the other first aid kits because they were kept in cabinets; it is reasonable to infer that if this were true, Ms. Peck and Mr. Tehonica would have told the CO's, and Mr. Tehonica would have told Ms. Migon, that such was the case. Based on the record, Lewis was in violation of the cited standard. The violation was serious, in view of the testimony of CO Schrilla in that regard. (Tr. 301-03).

With respect to the willful classification, CO Schrilla testified the classification was based on management's knowledge of the lack of supplies, the returned supplies, and the fact that NYSIF had indicated the need for supplies. (Tr. 303). As noted above, C-73, C-74 and C-75 are the March 5, 2003 statements of Mr. Stone, Ms. Hirsch and Ms. Karelus. In C-73, Mr. Stone said he told Mr. Spencer first aid supplies were needed after the supplies were returned. In C-74, Ms. Hirsch stated that first aid supplies were ordered but then removed because they cost too much. In C-75, Ms. Karelus said she knew first aid supplies were lacking, that Mr. Tehonica, Ms. Hirsch and Ms. Peck had notified Yehutta Banayan and Mr. Spencer, and that it was not taken care of as it was "a money issue."

Further evidence of management's knowledge of the cited condition is C-96, the note that Mr. Tehonica sent to Mr. Spencer requesting "first aid supplies and or kits" after his November 2002 meeting with Ms. Migon; as indicated *supra*, the request was made because of Mr. Tehonica's upcoming meeting with Ms. Migon on December 11, 2002. Moreover, Mr. Banayan knew of the first aid kits that Ms. Hirsch had ordered, although he testified they were returned as they were ordered from a company Lewis no longer did business with. According to Mr. Banayan, he was not aware of C-99, the fax that Ms. Hirsch sent to him and Ruben Baityouchoub, the company's controller, until the OSHA proceeding was underway; as noted above, Ms. Hirsch attached Ms. Migon's November 22, 2002 letter to C-99. Mr. Banayan's testimony as to the reason the kits were returned is not credible, in light of other evidence, *i.e.*, C-74 and C-75, indicating that first aid supplies were returned due to their cost; this conclusion is supported by Mr. Spencer's statement to CO Schrilla, set out in the discussion relating to Citation 2, Item 1 ("Item 1"), that orders not relating to production were not filled until Yehutta Banayan spoke to Moise Banayan and the latter approved the order. (Tr. 499-500). Mr. Banayan's testimony that he never saw C-99 or the letter attached to it also appears to be

unreliable, although it is certainly possible that he did not actually read the letter or that he overlooked the part about first aid kits, especially since that part is near the end of the letter. (Tr. 1361-63).

Based on the foregoing, management officials had knowledge that the facility lacked first aid supplies. Regardless, in my opinion, the Secretary has not shown the violation was willful, especially as compared to Item 1. First, the cited condition was not one of those set out in C-95, the NYSIF report that Lewis received in January 2002; as noted in the Item 1 discussion, the lack of fall protection was included in C-95, and both Mr. Spencer and Moise Banayan had seen C-95. (Tr. 983-85; C-74, p. 1). Second, although Ms. Migon's November 22, 2002 letter, which was attached to C-99, was written notice from NYSIF that first aid kits were needed, the record does not show that Moise Banayan actually read that letter and, in particular, the part about first aid kits; likewise, there is no evidence that Mr. Spencer ever saw that letter. Third, while Mr. Spencer was evidently informed by employees that first aid supplies and/or kits were needed in May 2002 and again in November 2002, and while Moise Banayan was aware that the first aid kits Ms. Hirsch had ordered were returned, I do not believe that these circumstances, without more, are sufficient to demonstrate a willful violation. Finally, I note that when CO Schrilla asked Mr. Spencer about fall protection and first aid kits during their February 7, 2003 meeting, Mr. Spencer phoned Yehutta Banayan, who said that the fall protection and kits would be ordered and would arrive in a few days. (Tr. 338-39, 499). The record shows that unlike the fall protection, which still was lacking when CO Schrilla returned on March 5, 2003, first aid supplies and kits were ordered on February 13, 2003. *See* R-12.<sup>73</sup> Thus, it is clear that Lewis responded to CO Schrilla's questions about first aid kits on February 7 by ordering first aid kits and supplies the following week. In my view, the evidence does not establish that the violation was willful. This item is accordingly affirmed as a serious violation.

The Secretary has proposed a penalty of \$32,000.00 for this item; however, this penalty is based upon the willful classification. The record shows that this item was considered to be of low severity and lesser probability. (Tr. 304). Moreover, a gravity-based penalty of \$1,500.00 is appropriate

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<sup>73</sup>R-12, the February 13, 2003 invoice from Zee Medical, shows two first aid "cabinets" and a large number of supplies were ordered on that date. R-12 also shows that three more first aid kits and a number of supplies were ordered on August 18, 2003. Finally, R-12 shows that while Lewis had apparently not ordered first aid supplies between April 16, 2002 and February 13, 2003, the company ordered first aid supplies on a regular basis after February 13, 2003.

for a serious violation that is of low severity and lesser probability.<sup>74</sup> In view of the relevant factors and applicable reductions, a penalty of \$750.00 is assessed.

**“Other” Citation 3 - Item 1**

This item alleges a violation of 29 C.F.R. 1904.29(a), asserting that Lewis did not maintain OSHA 300 logs for 2002 and 2003. The cited standard requires the employer to use the OSHA 300 form, or equivalent forms, for recordable injuries and illnesses. The record clearly shows the alleged violation, in that, when the CO’s asked for the company’s OSHA 300 illness and injury logs, both Ms. Hirsch and Mr. Tehonica told them that there were none. (Tr. 36, 354-55). Further, Lewis does not address this matter in its brief. This citation item is affirmed as an “other” violation.

A penalty of \$1,400.00 has been proposed for this item. I find this penalty excessive, especially since it is the same amount that was proposed for many of the serious violations in this case. I conclude that a penalty of “zero” is appropriate; consequently, no penalty is assessed for this item.

**ORDER**

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

1. Items 1 through 33 of Serious Citation 1, except for Item 2, are AFFIRMED as serious violations, and a total penalty of \$44,500.00 is assessed for these items.
2. Item 2 of Serious Citation 1 is VACATED.
3. Item 1 of Willful Citation 2 is AFFIRMED as a willful violation, and a penalty of \$27,500.00 is assessed for this item.
4. Item 2 of Willful Citation 2 is AFFIRMED as a serious violation, and a penalty of \$750.00 is assessed for this item.
5. Item 1 of “Other” Citation 3 is AFFIRMED as an “other” violation; no penalty is assessed.

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G. Marvin Bober  
Judge, OSHRC

Dated: August 14, 2006  
Washington, D.C.

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<sup>74</sup>See OSHA’s FIRM, Chapter IV, section C.2.g.(2).