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

SECRETARY OF LABOR, Complainant, v. GREENLEAF MOTOR EXPRESS, INC., Respondent.	:	OSHRC Docket No. 03-1305

APPEARANCES:

Eve Marie Stocker, Attorney; Daniel J. Mick, Counsel for Regional Trial Litigation; Ann Rosenthal, Counsel for Appellate Litigation; Joseph M. Woodward, Associate Solicitor for Occupational Safety and Health; Howard M. Radzely, Solicitor of Labor; U.S. Department of Labor, Washington, DC
For the Complainant

Thomas R. Wyatt, Esq.; David S. Farkas, Esq.; Ross, Brittain & Schonberg Co., L.P.A., Cleveland, Ohio
For the Respondent

DECISION

Before: RAILTON, Chairman; ROGERS and THOMPSON, Commissioners.

BY THE COMMISSION:

Before the Commission are seven citation items issued to Greenleaf Motor Express, Inc. (Greenleaf) under the Occupational Safety and Health Act of 1970, 29 U.S.C. §§ 651-678 (OSH Act), for alleged violations of the permit-required confined space standard set forth under 29 C.F.R. § 1910.146.[1] The citations were issued to Greenleaf following a fatality investigation by the

[1] These items are as follows: Serious Citation 1, Item 2 (29 C.F.R. § 1910.146(c)(2)); Item 3 (29 C.F.R. §1910.146(d)(4)(i)); and Item 4(a) (29 C.F.R. §1910.146(d)(4)(viii)) and 4(b) (29 C.F.R. §1910.146(d)(9)). Willful Citation 2, Item 1(a) (29 C.F.R. §1910.146(d)(3)(iv)) and 1(b) (29 C.F.R. §1910.146(d)(4)(ii)); Item 2 (29 C..F.R. §1910.146 (d)(5)(i)); Item 3 (29 C.F.R. §1910.146(d)(6)); and
(continued …

Occupational Safety and Health Administration (OSHA) at Greenleaf's tanker transport facility in Ashtabula, Ohio. Administrative Law Judge Covette Rooney affirmed these items as alleged – three serious and four willful – and assessed a total penalty of $115,750.

On review, Greenleaf does not dispute noncompliance with the cited provisions. At issue is whether its tankers were permit-required confined spaces, and whether Greenleaf knew that its tanks had the potential to contain a hazardous atmosphere. Also on review is whether the judge erred in affirming four of the items in question as willful and in excluding the testimony of Greenleaf's expert witness. For the following reasons, we affirm the citation items in question, characterize the four willful items as serious, and assess a total penalty of $26,150.[2]

Background

Greenleaf operates a tanker transport business that includes transferring titanium dioxide slurry between two plants at the nearby chemical manufacturing facility of its client, Millennium Chemicals (Millennium). The transfer process requires that Greenleaf's tankers be pressurized to facilitate offloading, for which there were two hoses in Millennium's offload area — one containing plant air and the other containing nitrogen, a substance that displaces oxygen. Operators employed by Millennium hooked up either the nitrogen or plant air line to an intake valve located on the side of each tanker in order to pressurize the tanker for unloading. The hose attached to the nitrogen line had been marked as containing nitrogen until about two months prior to the accident which resulted in the citation in contest. The identification of the nitrogen hose, as such, was removed by painters during routine maintenance.

Following the slurry transfer operations, Greenleaf's tankers return to its facility where Greenleaf employees pressure-wash them with plain water while standing inside the tankers. The tanker cleaning operations occur nearly daily, and require entry through a thirty-three inch diameter manhole located on top of the tankers. The assigned cleaner places a ladder, light, and pressure washer down into the tanker, and washes the tanker walls from the inside with pressurized plain water.

Item 4(a) (29 C.F.R. §1910.146(d)(10)) and 4(b) (29 C.F.R. §1910.146(e)(1)).

[2] We deny Greenleaf's motion for oral argument because the record and briefs provide a sufficient basis upon which to decide this case. *See AAA Delivery Services, Inc.*, 21 BNA OSHC 1219, 1221, n.4 (No. 02-0923, 2005).

On the evening of December 20, 2002, Greenleaf employee Jeremy Imrie performed slurry transfers at Millennium's facility. According to the unrebutted testimony of Millennium personnel, nitrogen was used that night to pressurize the tanker that Mr. Imrie operated. On the morning of December 21, 2002, Greenleaf assigned Mr. Imrie the task of cleaning the tanker that he had operated the previous evening. Shortly after Mr. Imrie commenced work, Greenleaf personnel found him dead inside the bottom of the tanker.

Discussion

A. Permit-required Status of Greenleaf's Tankers

Greenleaf has stipulated that its tankers are confined spaces as defined by 29 C.F.R. § 1910.146(b), but disputes the judge's finding that its tankers are permit-required confined spaces. A confined space is permit-required if it "[c]ontains or has a potential to contain a hazardous atmosphere," which includes the following:

> *Hazardous atmosphere* means an atmosphere that may expose employees to the risk of death, incapacitation, impairment of ability to self-rescue (that is, escape unaided from a permit space), injury or acute illness from one or more of the following causes:
> . . . .
> (3) Atmospheric oxygen concentration below 19.5 percent or above 23.5 percent . . . .

29 C.F.R. § 1910.146(b).

As the judge found, the record here clearly establishes that the tanker in which the accident occurred contained a hazardous atmosphere and, therefore, was properly characterized as a permit-required confined space. Upon discovering Mr. Imrie on the floor inside the tanker, Greenleaf personnel summoned the fire department for help. Paramedic Michael Sandella testified that when he arrived at the facility within minutes of Greenleaf's call, he placed an Industrial Scientific No. 412 air monitoring device inside the tanker, and it immediately sounded an alarm and digitally registered an oxygen reading of eleven percent.[3] This level is substantially below the standard's lower permissible threshold of 19.5 percent oxygen. Thus, the eleven percent oxygen concentration that existed in the tanker shortly after the accident establishes that it contained an oxygen deficient atmosphere on December 21, 2002. Accordingly, we find that the tanker was properly classified as permit-required

[3] Sandella testified that he was fully trained in the use of the monitoring device, and the record supports the judge's finding that the device was properly calibrated prior to its use at Greenleaf.

under the standard.[4] *See Mobile Premix Concrete, Inc.*, 18 BNA OSHC 1010, 1012 (No. 95-1192, 1997) (relying on fatal engulfment accident in finding hopper to be a permit-required confined space).[5]

B. Knowledge

The Secretary's burden of proving a violation includes showing that the cited employer had actual or constructive knowledge of the violative condition. *E.g.*, *Precision Concrete Constr.*, 19 BNA OSHC 1404, 1406 (No. 99-0707, 2001). Because the record fails to establish Greenleaf knew of Millennium's nitrogen use in the slurry offload process, we see no basis on which to find here that Greenleaf had actual knowledge that its tankers were permit-required. Indeed, there is no evidence that Greenleaf supervisory personnel observed or had been told that the nitrogen hose, located in the slurry offload area, had been used to pressurize Greenleaf's tankers. Nor is there any evidence that Greenleaf otherwise knew that its tankers had the potential to become oxygen deficient. It is undisputed that Greenleaf had not experienced any adverse atmospheric incidents inside the tankers prior to Mr. Imrie's accident that would have alerted it to the potential of such hazards, and its consultant's report designating the tankers as permit-required does not identify the basis of that determination.

Constructive knowledge is established where the evidence shows that the employer "could have known about [the cited condition] with the exercise of reasonable diligence." *Hamilton Fixture*, 16 BNA OSHC 1073, 1087 (No. 88-1720, 1993), *aff'd without published opinion*, 28 F.3d 1213 (6th Cir. 1994). In assessing reasonable diligence, the Commission has considered "several factors, including the employer's obligation to have adequate work rules and training programs, to adequately supervise employees, to anticipate hazards to which employees may be exposed, and to take measures to prevent the occurrence of violations." *Precision Concrete Constr.*, 19 BNA OSHC at 1407. In addition to an

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[4] In these circumstances, we reject Greenleaf's contention on review that expert testimony was necessary to establish the applicability of the cited standards. *See Suttles Truck Leasing, Inc.*, 20 BNA OSHC 1953, 1962-63 (No. 97-0545, 2004) (consolidated) (finding absence of expert testimony "not fatal" to tankers' permit-required classification where other evidence established permit status).

[5] Unlike the judge, in reaching our conclusion that the tanker was a permit space, we place no reliance here on the designation of Greenleaf's tankers as permit-required in the report of Greenleaf's consultant. As Greenleaf argues, designation of a location as a permit-required confined space is based on whether the location is a permit space as defined by the standard, not on the results of an employer's evaluation of it. *See Mobile Premix*, 18 BNA OSHC at 1012-13 (affirming classification of hoppers as permit-required confined spaces despite employer's and consultant's good faith belief to the contrary).

employer's "general obligation to inspect its workplace for hazards,"[6] the confined space standard specifically requires that an employer "evaluate the workplace to determine if any spaces are permit-required confined spaces." 29 C.F.R. § 1910.146(c)(1).

Reasonable diligence clearly required Greenleaf to make greater efforts to discover whether Millennium used nitrogen to pressurize the tankers for a number of years. The hose supplying the nitrogen was located approximately ten feet from Millennium's plant air hose in the slurry offload area. The testimony of Raymond Beckwith, a field operator for Millennium, established that, based on his experience, it was more likely that nitrogen, not plant air, would to be used to pressurize the tankers. He testified that Millennium's plant air was not always working, but that "[w]e always have [nitrogen]," which he used "around 90 percent" of the time. Beckwith's testimony, along with that of the other Millennium employee who testified, shows that at least some of Millennium's employees routinely used the nitrogen to pressurize Greenleaf's tankers, including the tanker Mr. Imrie drove the night before his accident. Greenleaf manager Robert Herron accompanied Mr. Imrie on two slurry deliveries at Millennium's facility that night. At that time, Mr. Herron observed that there was more than one pressurizing hose available to hook up to the tanker, and had also known that Millennium had nitrogen gas available in another part of its facility. Greenleaf general supervisor Louis Malensek testified that he, too, had observed a nitrogen line in a different area of Millennium's facility, and was aware of the hazards associated with nitrogen-caused oxygen displacement.[7] Had Greenleaf asked Millennium what substances it used to pressurize the tankers, or had it inspected Millennium's workplace in the slurry offload area, it could have known of Millennium's nitrogen use. *Cf. Active Oil Service Inc.*, 21 BNA OSHC 1092, 1095-96 (No. 00-1482, 2005) (concluding that fuel tank servicing contractor violated cited standard where, after observing pyro-oil in tanker it was hired to clean and being told of its flashpoint, contractor failed to inquire further to "obtain available information to determine whether pyro-oil was a flammable material and not a combustible material as [it] had assumed").[8]

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[6] *Hamilton Fixture*, 16 BNA OSHC at 1087.

[7] Mr. Malensek also testified that he and was familiar with the confined space training materials in use at Greenleaf, which contain a description of nitrogen-induced atmospheric hazards.

[8] We reject Greenleaf's contention that it exercised reasonable diligence by testing the atmosphere of its (continued …

In these circumstances, we find that Greenleaf's failure to make reasonable inquiries regarding the substances Millennium introduced into its tankers establishes that Greenleaf failed to exercise reasonable diligence and, therefore, had constructive knowledge of the potential for its tankers to contain atmospheric hazards. Accordingly, we affirm all seven citation items on review.

C. Willful Characterization

The Commission and courts make a distinction between mere negligence and willfulness, holding that the former is sufficient for affirming a non-willful violation, but that willfulness is characterized by an intentional, knowing failure to comply with a legal duty. *E.g.*, *Am. Wrecking*, 351 F.3d 1254, 1264 (D.C. Cir. 2003) (reversing willful finding where employer "should have known" of hazardous condition, court stated that willfulness requires "an intentional or conscious disregard for the applicable safety standard or for employee safety"). As the court stated in *AJP Constr. Inc. v. Secretary*, 357 F.3d 70, 75 (D.C. Cir 2004), "to sustain a willful violation, '[t]he Secretary must show that the employer was actually aware, at the time of the violative act, that the act was unlawful, or that it possessed a state of mind such that if it were informed of the standard, it would not care.'" (Emphasis and citations omitted.)

The judge affirmed the four items contained in Citation 2 as willful. She found that Greenleaf knew its tankers were permit-required, implemented and trained its employees in the requirements of its confined space program that tracked the requirements of the standard, and then ignored its own program without any credible explanation. As discussed above, however, the record fails to support finding that Greenleaf had actual knowledge of the violative conditions. In the absence of such knowledge, the evidence that Greenleaf falsified its atmospheric testing reports as well as Mr. Malensek's apparent dishonesty in claiming that he would have monitored Mr. Imrie's tank entry had he known about it, shows only a failure to comply with company procedures that Greenleaf did not know were required under the Act. *See George Campbell Painting Corp.*, 18 BNA OSHC 1929, 1934-35, 1999 CCH OSHD ¶ 31,935, p. 47,390 (No. 94-3121, 1999) (finding failure to use fall protection required by company rule was not willful where supervisor lacked knowledge that it violated the Act). In these circumstances, we find no basis on which to conclude that Greenleaf's non-compliance with

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tankers prior to employee entry. Although its own work rules provided for such testing, the evidence (continued …

the cited provisions demonstrated a conscious disregard of its statutory obligations.[9] *See Am. Wrecking*, 351 F.3d at 1264 (observing that willfulness requires actual rather than constructive knowledge that the conditions violate the statute or regulations, "'for otherwise we are back to negligence'") (citation omitted). Accordingly, we affirm the four violations alleged under Citation 2 as serious.[10]

D. Exclusion of Greenleaf's Expert Witness

As a final matter, Greenleaf contends on review that the judge erred in granting the Secretary's motion to exclude Greenleaf's proffered expert testimony. The judge based her ruling on Greenleaf's untimely disclosure of its proposed expert ten days after the deadline to which the parties had earlier agreed, and her dissatisfaction with the expert's qualifications in his proposed area of expertise as well as his ability to assist her in understanding the delineated issues.

Greenleaf admits that its disclosure was made after the deadline specified in the scheduling order, but contends for the first time on review that the Secretary had orally agreed to an extension of time. Greenleaf acknowledges that any such agreement is not contained in the record, and the Secretary denies that it occurred, explaining that Greenleaf merely notified her that the expert's report was forthcoming. Greenleaf provided no explanation to the judge for its delay, nor did it request that it be

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shows that Greenleaf was aware that those rules were not being followed.

[9] Commissioner Rogers concedes that the record does not establish that Greenleaf had actual knowledge of the violative condition. However, she believes a willful characterization is nonetheless justified based on a reasonable inference regarding Greenleaf's state of mind. In that regard, she notes the falsification of the atmospheric testing reports, which on their face cross-reference various provisions of the permit-required confined space standard. She further notes Mr. Malensek's disingenuousness in claiming he would have monitored Mr. Imrie's tank entry had he known about it, reflecting some awareness that the permit-required confined space standard may have in fact applied. In her view, this record evidence logically leads to an inference that even if Greenleaf knew the standard applied here, "'it would not care,'" thus sustaining a willful characterization. *AJP Constr. Inc. v. Secretary*, 357 F.3d 70, 75 (D.C. Cir 2004) (emphasis and citations omitted). Accordingly, Commissioner Rogers would agree with the judge's disposition and find these four violations willful.

[10] The Secretary alleged that these violations were serious in addition to willful. As the fatality here demonstrates, non-compliance with the cited standards can cause death or serious physical harm. *See Mobile Premix*, 18 BNA OSHC at 1012 ("[a]s demonstrated by the fatal engulfment. . ., the [condition] can unquestionably. . . cause death"). With respect to the three items affirmed under Citation 1, Greenleaf does not dispute the serious characterization.

excused or assert that it was harmless. Under these circumstances, we conclude that the judge properly found that Greenleaf's disclosure of its proposed expert was untimely. *Cf. Poulis-Minott v. Smith*, 388 F.3d 354, 358 (1st Cir. 2004) (noting that under Federal Rules of Civil Procedure timely expert disclosure is mandatory, but belatedly proffered evidence admissible if delay was "'substantially justified or harmless'") (citation omitted); *Jersey Steel Erectors*, 16 BNA OSHC 1162, 1165-66 (No. 90-1307, 1993) (upholding judge's sanction excluding evidence not revealed in pre-hearing submissions where evidence deemed not critical to defense and its admission prejudicial to Secretary), *aff'd*, 19 F.3d 643 (3d Cir. 1994).

Greenleaf also contends that the expert testimony "would have established conclusively that the tankers were not [permit spaces]." Federal Rules of Evidence, Rule 702 provides for the admission of expert testimony that "will assist the trier of fact to understand the evidence or to determine a fact in issue." *See also Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579 (1993) (setting forth criteria for assessing reliability of expert testimony); *Kumho Tire Co. v. Carmichael*, 526 U.S. 137 (1999) (principles of *Daubert* apply to scientific, technical, and other areas of specialized knowledge). Based upon our review of the expert's preliminary report that Greenleaf submitted to the judge, we find that the record supports the judge's conclusion that the proffered testimony would not satisfy the Rule 702 criteria as it relates to the question of whether the tankers were permit spaces. The report does not address any factual issue that required scientific or technical expertise to understand, nor did it rely on any methodology to support the stated opinions. Moreover, although unknown by the judge until the hearing, the fire department's air monitoring inside Greenleaf's tanker is objective evidence that is dispositive of the disputed issue. The expert's report does not address the air monitoring at all.

Under these circumstances, just as there was no need for the Secretary to submit expert testimony on this issue, neither was there any basis for the judge to reconsider her decision to exclude the testimony of Greenleaf's expert. *See Arcadian Corp.*, 20 BNA OSHC 2001, 2009-10 n.7 (No. 93-0628, 2004) (because record is clear on issue, there was no scientific or technical dispute necessitating expert testimony). *See also Nimely v. City of New York*, 414 F.3d 381, 398 (2nd Cir. 2005) (ruling that judge erred by admitting expert testimony amounting to credibility assessments of other witnesses' testimony as it would not "'assist the trier of fact'" but "'attempts to substitute the expert's judgment for the jury's'") (citation omitted). Accordingly, we conclude that the judge's exclusion of the expert was not an abuse of discretion.

E. Penalties

With respect to the items on review, the judge assessed the proposed penalties based on her finding that the severity of all of the cited conditions was high, but that the probability was greater for some than for others. The compliance officer testified that the proposed penalty amounts reflected a sixty percent reduction for Greenleaf's small size and a reduction for its lack of prior citation history.

Greenleaf does not contest the appropriateness of the penalty amounts with respect to size, gravity, or history, though it argues that its safety program and inspection compliance showed good faith. *See* OSH Act § 17(j), 29 U.S.C. § 666(j). As the judge found, however, Greenleaf's non-compliance with its own program undermines any good faith claim. Moreover, we find that Greenleaf's falsification of atmospheric testing reports further demonstrates a lack of good faith. In these circumstances, we concur with the judge's penalty assessments for the items she affirmed as serious, and adjust only the amounts for the willful items we have reclassified as serious.

Therefore, based on our assessment of the section 17(j) factors, we find that the following penalty amounts are appropriate here: Serious Citation 1: Item 2 - $750, Item 3 - $1,500, and Item 4(a) and (b) - $1,500 (combined). Willful Citation 2: Item 1(a) and (b) - $5,600 (combined), Item 2 - $5,600, Item 3 - $5,600, and Item 4(a) and (b) - $5,600 (combined).

Order

Accordingly, we affirm Items 2, 3, 4(a) and 4(b) of Serious Citation 1 as characterized and assess the total proposed penalty of $3,750 for these items. We also affirm Items 1(a), 1(b), 2, 3, 4(a) and 4(b) of Willful Citation 2, but characterize these violations as serious and assess a total penalty of $22,400 for these items.

SO ORDERED.

_/s/_____
W. Scott Railton
Chairman

_/s/_____
Thomasina V. Rogers
Commissioner

_/s/_____
Horace A. Thompson, III
Commissioner

Dated: January 29, 2007

United States of America
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
1120 20th Street, N.W., Ninth Floor
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SECRETARY OF LABOR, Complainant, v. GREENLEAF MOTOR EXPRESS, INC., Respondent.	OSHRC DOCKET NO. 03-1305

Appearances:

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For the Complainant.

Thomas R. Wyatt, Esquire
Ross, Brittain & Schonberg Co., L.P.A.
Cleveland, Ohio
For the Respondent.

Before: Administrative Law Judge Covette Rooney

DECISION AND ORDER

This proceeding 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"). Respondent, Greenleaf Motor Express, Inc. ("Greenleaf"), is in the business of transporting materials both locally and over state lines. It maintains a facility in Ashtabula, Ohio, at which it performs the cleaning and maintenance of its trucks and tank trailers. (Tr. 42). Greenleaf employs mechanics, tank cleaners and truck drivers, and it admits that it is an employer engaged in a business affecting commerce within the meaning of section 3(5) of the Act and that it is subject to the requirements of the Act.

On December 23, 2002, OSHA Compliance Officer ("CO") Reinaldo Rivera, an industrial hygienist, and OSHA CO Rick Dvorak were assigned to conduct an investigation of a fatality that had occurred at the Greenleaf facility on December 21, 2002. As a result of the inspection, on June 20, 2003, Greenleaf was issued serious, willful and other-than-serious citations alleging violations

of OSHA's confined spaces standard. Greenleaf brought this matter before the Commission by filing a timely notice of contest, and a hearing was held before the undersigned on March 2 and 3, 2004, in Cleveland, Ohio. Counsel for the parties have submitted post-hearing briefs and reply briefs.

Factual Background

Greenleaf uses tank trailers to haul a number of materials, and one of its operations involves taking titanium dioxide in the form of "slurry" from one plant to another at Millennium Chemicals ("Millennium"), a chemical company also located in Ashtabula that makes titanium-based products.[1] Greenleaf's cleaning operations are performed in the tank room at its Ashtabula facility, where a variety of tank trailers are cleaned. The only tanks that tank cleaners are required to enter are those that are used to haul slurry. The tank room is essentially a bay large enough to accommodate a tank trailer in addition to a holding tank on the side to collect residual material for recovery. (Tr. 63-65, 228-29, 232, 283). One of the tank trailers used to transport slurry is depicted in Exhibit C-3, and the dimensions of such tanks are set out in Exhibit C-7.

Greenleaf's tank room operations are supervised by the tank room lead man, a working supervisor whose duties include supervising the tank room work, completing entry permits, and training tank cleaners. The lead man answers to Louis Malensek, the facility's general supervisor. At the time of the accident, Ricky Snyder was the tank room lead man, and Jeremy Imrie was the other person employed to clean tank trailers.[2] Mr. Snyder was trained by Earl Jeffers, a former lead man, who was trained by David Lane, another former lead man. (Tr. 44-45, 151-53, 226-27, 234).

The tank cleaner enters the tank to be cleaned through a manhole located on the top and in the center of the tank; the manhole, with a diameter of 32 to 33 inches, is the only means of entry to and exit from the tank. The tank cleaner hooks up hoses to the end of the tank for drainage and puts a ladder and a light down into the tank along with a pressure washer. The tank cleaner then washes the walls inside the tank with a pressurized hose that utilizes only water; the cleaning process

[1]Titanium dioxide is a white pigment used in virtually every white or colored item in everyday use. Slurry is the pigment with water added to it. (Tr. 65).

[2]The transcript consistently refers to Jeremy Imrie as "Jeremy Emery." However, the proper spelling of his last name, as shown in Exhibit R-3, is "Imrie".

typically takes from a half hour to an hour and 15 minutes.[3] Tank cleaning is done on an almost daily basis, and one former tank cleaner testified he cleaned 30 to 50 tanks per month. In 1994, Greenleaf contracted with Charles Management ("Charles") to conduct a confined space analysis of Greenleaf's tanks and to develop a confined space program. That program specifically designates the tank trailers used to haul slurry as permit-required confined spaces and sets out permit-required confined space procedures; among the procedures is monitoring for oxygen deficiency and ensuring that oxygen levels are from 19.5 percent to 20.5 percent. The program also covers the need for ventilation and the completion of an entry permit as well as the need for an attendant, communication equipment, and training of entrants. Besides the Charles program, Greenleaf had its own confined space training materials and a commercial training pamphlet prepared by J.J. Keller & Associates ("J.J. Keller"). These addressed the hazards of confined spaces, including atmospheric hazards; they also specified procedures employees were to follow in confined space entry, such as completion of permits, atmosphere testing and monitoring, attendant and training requirements, ventilation of the confined space, and emergency and rescue procedures. (Tr. 13, 46-47, 151-52, 231-33, 281, 285; Exhs. C-12, pp. 10-12, 17-20; C-13; C-14, pp. 2-10; C-15, pp. 8-19; C-18).

Jeremy Imrie was hired twice by Greenleaf. He was first hired and trained in confined space tank cleaning procedures in May of 2002. He worked for Greenleaf for approximately two months, left, and then came back the week of the fatal accident. On December 20, 2002, Mr. Imrie was assigned to perform the slurry transfers between the two Millennium facilities. Because it was the first time he had done this work, Greenleaf Garage Manager Robert Herron, who had made similar deliveries, was assigned to accompany Mr. Imrie. Mr. Herron went with Mr. Imrie on two of these

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[3]The tank cleaning instructions that were part of the training that employees received required workers to wear proper safety apparel, including a rubber suit, rubber boots and gloves, a hard hat, safety goggles, and a face shield and a respirator. The instructions also required the checking of all hoses; checking the pressure gauge to make sure the tank was not under pressure; and visually inspecting the tank's interior and then dropping a spinner into the tank, hooking up the hoses, and spinning the trailer three times and draining it between each spin. Finally, the instructions required dropping a hose and light into the tank and entering the tank with a safety harness on and an attendant outside; looking for stains or visual defects and cleaning the tank; and, after exiting, spinning the tank three times, checking it and closing the hatch, and making out a cleaning report and listing any repairs made. (Exh. R-3).

runs before leaving Mr. Imrie to complete the remainder of the transfers on his own. The tank trailer being used for the deliveries was Tank Trailer 174 ("Tank 174"). (Tr. 215-20, 232-34).

Millennium has Greenleaf perform titanium dioxide transfers between its plants on a routine basis, and the procedure is the same for each transfer; slurry is picked up at one plant and taken to the other. Upon arriving at the plant receiving the slurry, the driver signs in at the gate, after which the plant is notified that a delivery is being made; an operator then goes to the area where the slurry is to be off-loaded to assist the Greenleaf driver. Millennium had no written procedures about how to perform off-loading. (Tr. 65, 75, 125-26, 218-20, 439, 447, 453-54, 457; Exh. C-16).

At the hearing, Millennium operators and Greenleaf drivers described the off-loading process. First, a hose leading to Millennium's tanks is attached to an outlet at the bottom of the tank trailer. Another hose is then attached to a valve at the top of the tank trailer or to a pipe on the side leading to the top. This second hose uses either pressurized plant air or nitrogen to assist in the removal of the slurry from the truck. The two hoses are 10 to 12 feet away from one another, and on December 20, 2002, neither hose was marked with identification.[4] Raymond Beckwith and Jason Weeston, two operators from Millennium, testified that they utilized either compressed plant air or nitrogen for this process; the choice of air was based upon variables such as proximity and which line was operable. Millennium operators normally performed the hookup of these hoses, and there was no procedure for informing Greenleaf drivers whether plant air or nitrogen was being used. (Tr. 68-72, 75-78, 92-94, 106, 113, 119, 125-28, 137-38, 146, 440, 447, 454, 458).

On the evening preceding the accident, Mr. Beckwith was the operator assisting Mr. Imrie to off-load, and he stated that he had used nitrogen to pressurize the tank trailer. He further stated that during the second load he informed Mr. Imrie that he would "trim back on [the nitrogen]" when Mr. Imrie complained that the loading process at the other plant was taking too long because there was too much pressure in the tank. It was his impression that Mr. Imrie had no real understanding of nitrogen, and he believed that Mr. Imrie was only concerned with the pressure and that he could have used the term "soup" and gotten the same response. (Tr. 80-82, 110-11).

[4]Mr. Beckwith testified that up until two months before the accident, the nitrogen had been marked, but, due to the plant being painted, the markings had been removed. (Tr. 77, 106).

The following day, which was Saturday, December 21, 2002, Mr. Imrie returned to the Greenleaf facility to clean out Tank 174. Mr. Malensek testified that he would have been the attendant that day and that after Mr. Imrie had pulled Tank 147 into the tank room at about 9:30 a.m., he (Mr. Imrie) told Mr. Malensek that there was sludge in the bottom. He also told him he had to pick up his daughter around10:00 a.m. that day, and Mr. Malensek advised him to just rinse the tank from the top so that he would not have to worry about getting dirty. Mr. Malensek further testified that it would not have been possible to clean the tank in 30 minutes and that the "pre-wash" would get a lot of the material out that one would not normally have to be in the tank to remove with the pressure washer.[5] Mr. Herron assisted Mr. Imrie to connect the hose going from the unloading valve on the tank to the holding tank, and he then went to the office and had coffee with Mr. Malensek. At about 10:00 a.m., when Mr. Herron entered the tank room to notify Mr. Imrie of the time, he found Mr. Imrie unconscious in the bottom of the tank. Mr. Herron immediately jumped into the tank, even though, as he testified, he had little training in confined space entry and was unaware of Greenleaf's emergency procedures. Mr. Herron also testified that before he entered the tank, he did not summon any rescue service or follow any confined space entry procedures to ensure that the tank was safe to enter. Mr. Herron then summoned Mr. Malensek, who also entered the tank without first taking any precautionary steps. (Tr. 222-24, 235, 247-51, 254-57).

The Ashtabula Fire Department went to the scene after receiving a call reporting a man down in a tank at Greenleaf. Upon arriving, Paramedic Michael Sandella was met by a representative of Greenleaf who said that the tank contained titanium dioxide. Mr. Sandella put on a self-contained breathing apparatus and climbed into the tank, where he saw the lifeless victim laying on his back and wearing a rain suit. Mr. Sandella had seen no signs on the tank indicating what was in it, and he ordered Mr. Malensek, who was in the tank and struggling to breathe, to leave. Mr. Sandella took readings of the atmosphere, and he noted that as soon as the monitoring device was handed down

[5]Mr. Malensek noted that he had not been involved that long with tank cleaning but that this was his suggestion; he also noted that he told Mr. Imrie that he could finish cleaning the tank when he got back. (Tr. 249).

to him in the tank the alarm sounded and registered an 11-percent oxygen reading.[6] He also noted there was a light in the tank, as well as a ladder, a pressure washer and a garden hose; however, he saw no monitoring device, ventilation equipment or alarm system, and Mr. Imrie did not have on a respirator or a harness. (Tr. 12-19, 224; Exh. C-1).

Stipulated Facts

The parties have stipulated to the following facts:

1. Tank cars used by Greenleaf Motor Express in the transport of titanium dioxide are confined spaces as that term is defined in 29 C.F.R. § 1910.146(b).

2. Titanium dioxide vapors do not pose an inhalation hazard.

3. Tank Trailer No. 174 was used to transport titanium dioxide on at least December 20, 2002.

4. Tank Trailer No. 174 was driven by Jeremy Imrie on December 20, 2002.

5. Jeremy Imrie was the last individual to drive Tank Trailer No. 174 prior to the December 21, 2002 accident.

6. Jeremy Imrie did not complete a confined space entry permit prior to entering Tank Trailer No. 174 on December 21, 2002.

7. Jeremy Imrie did not use a safety line or body harness when entering Tank Trailer No. 174 on December 21, 2002.

8. Prior to December 21, 2002, Greenleaf Motor Express had no ventilation equipment available for employee use at its facility at 4606 State Road in Ashtabula, Ohio.

9. No attendant was present when Jeremy Imrie entered Tank Trailer No. 174 on December 21, 2002.

The Secretary's Burden of Proof

The Secretary has the burden of proving her case by a preponderance of the evidence. In order to establish a violation of an OSHA standard, the Secretary must show (a) the applicability of the cited standard, (b) the employer's noncompliance with the standard's terms, (c) employee access to the violative condition, and (d) the employer's actual or constructive knowledge of the violation

[6]The unrebutted evidence shows that the instrument used to take this measurement, an Industrial Scientific TMX 412, had been properly calibrated (Tr. 15-16, 28-30, 39; Exh. C-2).

(*i.e.*, the employer either knew, or with the exercise of reasonable diligence could have known, of the violative condition).[7] *Atlantic Battery Co.*, 16 BNA OSHA 2131, 2138 (No. 90-1747, 1994).

Serious Citation 1 - Item 1 - 29 C.F.R. 1910.132(a)

This item alleges a violation of 29 C.F.R.1910.132(a), which provides as follows:

> 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.

The Secretary alleges that fall protection was not provided for a tank cleaner who was required to stand on top of the tank to open the hatch and manipulate a water hose into the tank before entering it. I find that a fall hazard requiring the use of personal protective equipment existed and that Greenleaf failed to require the use of such equipment. The record establishes that to enter a tank, an employee had to climb a ladder on the side of the tank and onto a platform that was 4 feet by 4 feet. From the top of the tank, the employee opened the hatch to get the water hose inside and also placed a ladder inside so he could enter the tank; the top of the tank was narrow and the sides sloped down, presenting a fall hazard. (Tr. 158, 300-01; Exhs. C-3, C-7).The parties have stipulated that on December 21, 2002, Mr. Imrie did not use a safety line or body harness to enter Tank 174. Further, the record shows that a worker on top of a tank could have fallen 10 to 12 feet to the ground, which could have resulted in death or an injury such as a leg fracture. (Tr. 300-03).

To prove a violation of the cited standard, the Secretary must show either that the employer had actual notice of the need for protective equipment or that a reasonable person familiar with the circumstances would recognize a hazard warranting the use of protective equipment. *See Peavey*

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[7]An inquiry into whether an employer was reasonably diligent involves a number of factors, including the employer's obligation to have adequate rules and training programs, to adequately supervise employees, to anticipate hazards, and to take measures to prevent the occurrence of violations. Lack of reasonable diligence may also be shown by evidence of an employer's failure to take measures to prevent the occurrence of violative conditions. *Stahl Roofing, Inc.*, 19 BNA OSHC 2179, 2181 (No. 001268, 2003), citing to *Precision Concrete Constr.*, 19 BNA OSHC 1404, 1407(No. 99-707, 2001).

Co.,16 BNA 2022, 2024 (No. 89-2836, 1994), and cases cited therein. Greenleaf had actual notice of the need for fall protection equipment in light of its confined space entry procedures, as set out *supra*. *See* Exhibits C-12, p.11, and C-14, p. 5. Despite this knowledge, Greenleaf management did not require employees to wear and use fall protection when climbing up onto tanks, as is clear from Mr. Imrie's actions on the day of the accident. (Tr. 19, 50, 158-59, 301). Greenleaf also had constructive knowledge of the cited condition, in that an employer's failure to properly instruct its employees on a necessary safety precaution will establish the Secretary's prima facie case of constructive knowledge of the violation.[8] *Brock v. L.E. Myers Co.*, 818 F.2d 1270,1277(6th Cir. 1987), *cert. denied*, 484 U.S. 989 (1987). Based on the record, I find that the Secretary has met her burden of proving the alleged violation.

I also find that the violation was properly classified as serious, as there was a substantial probability that a fall of 10 to 12 feet from the top of a tank to the floor below would result in death or serious physical harm. (Tr. 300-03). *See also* section 17(k) of the Act, 29 U.S.C. § 666(k). Finally, I find that the Secretary's proposed penalty of $1,500.00 is appropriate. In assessing penalties, the Commission is required to give due consideration to the gravity of the violation and to the employer's size, history and good faith. *Merchant's Masonry, Inc.*, 17 BNA OSHA 1005, 1006-07 (No. 92-424, 1994). The most significant of these factors is the gravity of the violation. *Id*. CO Rivera testified that he considered the severity of the condition to be high and the probability of an accident occurring as greater, and the gravity-based penalty was reduced due to the small size of the employer's business and its lack of history of previous OSHA citations; he further testified, however, that no credit for good faith was given because Greenleaf had violated provisions of its own safety program.[9] (Tr. 302-03). The Secretary's proposed penalty of $1,500.00 is assessed.

The Permit-required Confined Spaces Items

The other items in this case involve OSHA's permit-required confined spaces standard. That standard, found at 29 C.F.R. 1910.146, contains requirements for practices and procedures to protect

[8]Greenleaf's failure to properly train employees is set out on pages 11-12 of this decision.

[9]The CO considered these same factors and gave reductions for the company's size and lack of history of OSHA violations in arriving at all of the proposed penalties in this case.

employees from the hazards of entry into confined spaces. Section 1910.146(c)(1) requires an employer to evaluate its workplace to determine if any spaces are permit-required confined spaces.[10] The record shows that Greenleaf had Charles do such an evaluation in 1994, and Charles determined that Greenleaf's slurry-transporting tanks were in fact permit-required confined spaces. Greenleaf provided the Charles program to CO Rivera and told him it was in effect at the time of the accident, and the CO described the program as having information about "[h]ow to enter the tank safely, the permitting and assigning [the] space as [a] permit required confined space."[11] (Tr. 289; Exh. C-12). Although section 1910.146(c)(7) provides for the reclassification of a permit-only space to a non-permit confined space, Greenleaf presented no credible evidence that the tanks were ever reclassified

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[10]Section1910.146(b) defines "confined space" 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." A "hazardous atmosphere" is an atmosphere "that may expose employees to the risk of death, incapacitation, impairment of ability to self-rescue (that is, escape unaided from a permit space), injury, or acute illness from one or more of the following causes: ... (3) Atmospheric oxygen concentration below 19.5 percent or above 23.5 percent." An "oxygen deficient atmosphere" is one "containing less than 19.5 percent oxygen by volume." Finally, a "permit-required confined space" is a "confined space that has one or more of the following characteristics: (1) Contains or has a potential to contain a hazardous atmosphere."

[11]Greenleaf's written Confined Space Entry Procedure and Permitting System identifies confined spaces as tank transports which are defined as having limited openings for access and escape; containing unfavorable natural ventilation; and as a space not designed for continuous occupancy. "Tank transports" are also listed in the program under the summary of Greenleaf's confined spaces; and Greenleaf's role in such spaces is described as cleaning, mucking or drying. The "space location" identified under the confined space analysis is the "Transport tanker for titanium dioxide as a slurry." The hazard assessment for this space is, in relevant part, as follows:

- Atmospheric - Monitor for oxygen deficiency;
- Space Operations - Transport slurry;
- . Equipment - Pressure washer;
- . Falls - Wear body harness;
- . Entry/Exit - Manhole entry;
- Personal Protective Equipment - Rubber suit, boots, gloves, face shield;
- Ventilation Requirement - Open hatch and draw monitor for oxygen;
- Exceptional Rescue Requirements - Life line.
- Test Requirements - Oxygen level 19.5 to 20.5 (Exh. C-12, pp. 7, 9-11)

to non-permit status or that it had made a determination that all hazards had been eliminated prior to allowing employee entry.[12] To the contrary, the fact that Greenleaf continued providing confined space entry training to employees and completing entry permits strongly suggests that there was no change to the status of the slurry-transporting tanks. (Tr. 232, 238-40, 260; Exhs. R-3, R-4, C- 15). Further, the 11-percent oxygen reading the paramedic obtained on December 21, 2002, corroborates the fact that the tanks had the potential to contain hazardous atmospheres. Accordingly, at the time of the alleged violations, Greenleaf's slurry-transporting tank trailers were permit-required confined spaces as defined by the standard and the standard applied to the cited conditions.

The critical issue in resolving the alleged violations is whether Greenleaf had knowledge that the tank trailers used to transport slurry contained or had the potential to contain a hazardous atmosphere. Under Commission precedent, the Secretary makes out a prima facie case of knowledge by establishing that the employer either knew or with the exercise of reasonable diligence could have known of the presence of the hazardous condition. *Pride Oil Well Serv.*, 15 BNA OSHC 1809, 1814 (No. 87-692, 1992). The knowledge element is directed to the physical conditions that constitute a violation, and the Secretary need not show that an employer understood or acknowledged that the physical conditions were actually hazardous. *Phoenix Roofing, Inc.*, 17 BNA OSHC 1076, 1079-80 (No. 90-2148, 1995), *aff'd without published opinion*, 79 F.3d 1146 (5th Cir. 1996). Actual or constructive knowledge of an employer's foreman can be imputed to the employer. *A. P. O'Horo*, 14 BNA OSHC 2004, 2007 (No. 85-369, 1991); *Dun-Par Engineered Form Co.*, 12 BNA OSHC

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[12]Despite his acknowledgment that the J.J. Keller pamphlet applied to the tanks that contained slurry and that he followed portions of the permit-required confined space program, General Supervisor Malensek testified that it was his understanding that slurry tanks were a non-confined space. He also testified that while he did not know when the change in status was made, he based his understanding on a statement made by David Lane, a former lead man, when he (Mr. Malensek) became the general supervisor. (T. 227, 261-65). I give no credence to this testimony, as the record has no other evidence of a change in the status of the tanks. Furthermore, in light of his alleged understanding, I find his response to the following question incredible:

Q If Jeremy Emery, if you knew Jeremy Emery was going to get in there to clean that tank what would you have done?

A I would have, we would have tested the air atmosphere and everything. You know, I mean, what was supposed to have been in my knowledge, you know, of what I've been trained on. (Tr. 258).

Such inconsistencies in testimony cast serious doubt on the credibility of Mr. Malensek.

1962, 1965-1966 (No. 82-928, 1986). Greenleaf was aware that its employees entered the trailer tanks for cleaning purposes, and I find that Greenleaf had constructive knowledge of the violations because the evidence shows that, had its supervisors exercised reasonable diligence, they could have discovered and eliminated the cited hazards. *See Pride*, 15 BNA at 1814. It is undisputed that there were no formalized procedures for off-loading, and no one from Greenleaf did anything to determine what procedures were being followed at Millennium in regard to off-loading. In addition, Greenleaf's management realized that there were two types of compressed air at Millennium and never took steps to inspect the off-loading area in order to anticipate hazards.[13] (Tr. 75, 186-87, 218, 221, 237, 457). The record is thus devoid of any measures taken to prevent the alleged violations.

In the Sixth Circuit, where this case arose, "the Secretary makes out a prima facie case of the employer's awareness of a potentially preventable hazard upon the introduction of proof of the employer's failure to provide adequate safety equipment or to properly instruct its employees on necessary safety precautions....[A]n employer 'cannot fail to properly train and supervise its employees and then hide behind its lack of knowledge concerning their dangerous working practices.'" *Danis-Shook Joint Venture XXV v. Secretary of Labor,* 319 F.3d 805, 811 (6th Cir.2002), citing to *A/C Elec. Co. v. OSHRC*, 956 F.2d 530, 535 (6th Cir. 1991). It is clear from the record that Greenleaf did not properly train its employees, including Mr. Imrie, in confined space entry procedures, and the lack of training is also apparent due to the fact that, at the time of the accident, Mr. Imrie did not have on a respirator or a harness; he also had no communication equipment with

[13]Mr. Malensek conceded that he knew that there were two types of compressed air at the Millennium facility and that he had seen a marked nitrogen hose in an area across the street from the off-loading area. He also conceded the J.J. Keller pamphlet states that "oxygen is replaced by other gases" and gives nitrogen as an example of such a gas. He testified that he had never seen any lines marked as nitrogen in the off-loading area before December 2002 and that he would not have expected nitrogen to have been used to off-load slurry. (Tr. 237, 245-46; Exh. C-15, p. 9). This testimony, without more, does nothing to negate the responsibility of Mr. Malensek to have inspected the area where his employees performed off-loading, to have anticipated hazards, and to have taken measures to prevent the cited conditions. Such reasonable diligence was especially incumbent upon him in view of the fact that there were no written procedures for off-loading.

him, and there was no ventilation equipment or alarm system in use.[14] (Tr. 19, 45-51, 57, 152-59, 161, 223-24). Another indication of Mr. Imrie's inadequate training was his lack of understanding of the consequences of using nitrogen in the off-loading process. (Tr. 19, 110-11, 152-56). Further, management was aware that its permit-required confined space procedures were not being used, and the evidence shows that employees were encouraged not to follow those procedures. (Tr. 158-59, 162-63). For all of these reasons, and those in the preceding paragraph, the Secretary has demonstrated that Greenleaf had the requisite knowledge of the alleged violations.

Serious Citation 1 - Item 2 - 29 C.F.R. 1910.146(c)(2)

This item alleges a violation of 29 C.F.R. 1910.146(c)(2), which provides as follows:

> 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.

The Secretary alleges that employees were not informed of the confined space hazards of Tank 174 by danger signs or other equally effective means. The standard requires that, once it is determined that a permit-required confined space exists, the employer is obligated to inform exposed employees by using a sign or some other effective means of the existence and location of the permit space and the hazards it presents. The record establishes that since 1994, Greenleaf had procedures stating that the slurry-transporting tanks were permit-required confined spaces. On December 21, 2003, Tank 174 had a hazardous atmosphere consisting of 11 percent oxygen, and there were no signs on the tank to inform employees of the danger posed by entry into the tank.[15] Moreover, CO Rivera's investigation and testimony adduced at the hearing revealed that no signs had ever been posted on such tanks. (Tr.13, 306-08, 311, 449, 458; Exh. C-12).

Based on the foregoing, I find that the Secretary has proved the alleged violation and that the violation was properly classified as serious. I agree with the CO's determination that the severity of

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[14]Mr. Snyder, the tank room lead man and entry supervisor, acknowledged the lack of proper training with respect to confined space entry procedures. (Tr. 45-51, 234). Commission precedent is well settled that an employee who has been delegated authority over other workers, even temporarily, is considered to be a supervisor for the purpose of imputing knowledge to an employer. *Tampa Shipyards, Inc.*, 15 BNA OSHC 1533 (Nos. 86-360 & 86-469, 1992).

[15]The EMS report indicated Mr. Imrie died in this atmosphere. (Tr. 17-18; Exh. C-1).

the violation was high and the probability of an accident occurring was lesser, and I conclude that the proposed penalty of $750.00 is appropriate. (Tr. 312-14.) This item is affirmed as a serious violation, and a penalty of $750.00 is assessed.

Serious Citation 1 - Item 3 - 29 C.F.R. 1910.146(d)(4)(i)

This item alleges a violation of 29 C.F.R. 1910.146(d)(4)(i), which requires the employer to provide, maintain and ensure the use of "[t]esting and monitoring equipment needed to comply with paragraph (d)(5) of this section."

The Secretary alleges that the oxygen meter kept at the site to monitor levels inside the tank trailors was not calibrated. The record clearly shows that Greenleaf had a Minigard 2 oxygen meter at its facility that was not properly maintained. At the time of the inspection, the meter had missing calibration hoses and the calibration cylinder was not properly placed in the box. In addition, management could not provide any records to establish the meter had been calibrated, and CO Rivera testified that when he asked Mr. Malensek to show him how to calibrate the meter, Mr. Malensek was awkward and held it upside down. (Tr. 315-18). Further, Mr. Malensek conceded at the hearing that neither he nor Mr. Imrie knew how to calibrate the meter, and Mr. Synder, the tank room lead man, testified that he did not know how to calibrate air monitoring equipment until January 2003 and that he had not even known Greenleaf had such equipment. (Tr. 48-49, 260-61).

As written, the standard requires the employer to maintain monitoring equipment, and Greenleaf's own training materials recognized that monitoring devices should be tested and calibrated on a routine basis to ensure accuracy. (Exh. C-15, pp. 15-16). The record plainly establishes the alleged violation, and I find that the violation was properly classified as serious. I agree with the CO's conclusion that the severity of the condition was high and the probability of an accident was greater, and I find the proposed penalty of $1,500.00 appropriate. (Tr. 312-14.) This item is therefore affirmed as a serious violation, and a penalty of $1,500.00 is assessed.

Serious Citation 1 - Items 4a and 4b - 29 C.F.R. §§ 1910.146(d)(4)(viii) and (d)(9)

Item 4a alleges a violation of 29 C.F.R.1910.146(d)(4)(viii), which requires the employer to provide, maintain and ensure the use of "[r]escue and emergency equipment needed to comply with paragraph (d)(9) of this section, except to the extent that the equipment is provided by rescue services."

Item 4b alleges a violation of 29 C.F.R. 1910.146(d)(9), which requires the employer to:

> Develop and implement procedures for summoning rescue and emergency services, for rescuing entrants from permit spaces, for providing necessary emergency services to rescued employees, and for preventing unauthorized personnel from attempting a rescue.

In Item 4a, the Secretary alleges that a body harness and safety line were not used by an employee who entered Tank 174 for cleaning purposes on December 21, 2002. This standard requires the employer to provide the equipment necessary for safe entry into and rescue from permit spaces, to maintain that equipment properly, and to ensure its proper use by employees. 58 Fed. Reg. 4462, 4497 (1993). Paragraph (d)(9) requires the employer to implement procedures for rescuing entrants from permit spaces, and rescue equipment includes a body harness and a safety line so that, in case of an emergency, an entrant can be pulled out of the space efficiently and without the need for others to enter the space. (Tr. 321). The record shows that Mr. Imrie did not wear a safety harness when he entered Tank 174 on December 21, 2002. (Tr. 19, 224, 319). The record also shows that Greenleaf's Lead Men Lane, Jeffers and Snyder had not worn harnesses and did not train any of their tank cleaners to wear them. (Tr. 45, 50, 57, 153). During the inspection, Mr. Malensek showed CO Rivera the two harnesses that Greenleaf had; it appeared to the CO that one had been used and that the other, which had no safety line, had never been used. (Tr. 320-21).

Greenleaf contends that the standard merely requires the employer to provide a harness and a safety line. (R. Post-Hearing Brief, p. 42). However, the standard clearly states not only that the employer must provide such equipment but that it must also "ensure that employees *use* that equipment."(Emphasis added). Greenleaf's contention is rejected.

Greenleaf also contends that Mr. Imrie was only asked to clean the tank from the outside and that he was not told to enter the tank on the morning of December 21, 2002. (R. Post-Hearing Brief, pp. 31-33, 42). Mr. Malensek testified that he advised Mr. Imrie to just rinse the tank from the top so he would not have to worry about getting dirty, as Mr. Imrie had to pick up his daughter in 30 minutes; Mr. Malensek also testified it would not have been possible to clean the tank in 30 minutes and that the "pre-wash" would have gotten a lot of material out of the tank without Mr. Imrie having to enter it. However, Mr. Malensek admitted he was not that familiar with tank cleaning procedures then and that his instruction to "pre-wash" the tank was his "suggestion" to Mr. Imrie. (Tr. 247-49).

Moreover, as the Secretary notes, Mr. Jeffers, a person very familiar with the cleaning process, testified he had never cleaned a tank in that manner. (Tr. 159-60, 169-70). Mr. Jeffers' testimony, as well as the fact that Mr. Imrie did get in the tank, casts serious doubt on Mr. Malensek's claimed "suggestion."[16] Regardless, even if Mr. Malensek did tell him to rinse the tank from the top, it is clear that Mr. Imrie would have had to get in the tank later that day to finish cleaning it, at which time he would have been exposed to the hazardous atmosphere in the tank without the benefit of a harness and safety line.[17] (Tr. 235). Greenleaf's contention is rejected, and I find that the Secretary has proved the alleged violation. I also find the violation was properly classified as serious.

In Item 4b, the Secretary alleges that retrieval equipment and respirators were not used and that emergency services were not summoned until after entry was made when employees entered Tank 174 on December 21, 2002, to rescue a worker. The cited standard requires that rescue procedures include procedures for summoning rescue and emergency services and for preventing unauthorized rescue (that is, rescue by employees who are prohibited by the standard from performing this function). 58 Fed. Reg. at 4501 (1993). Greenleaf's confined space programs acknowledged these requirements. (Exhs. C-14, p. 7, C-15, p.12). The record shows that Mr. Herron and Mr. Malensek attempted to rescue Mr. Imrie without retrieval equipment or respirators and without following any emergency procedures, which exposed them to an oxygen-deficient atmosphere. (Tr. 14-15, 19, 223, 256). The record also shows that neither individual was familiar with procedures for rescuing entrants from permit spaces. (Tr. 223-24, 261-62). Furthermore, during his investigation, CO Rivera interviewed employees about rescue procedures and found no one who was familiar with any procedures meeting the standard's requirements; even Mr. Malensek could not clearly articulate any rescue procedures.[18] (Tr. 322). I find that the Secretary has proved the alleged violation and that this item is properly classified as serious.

Based on the foregoing, Items 4a and 4b are affirmed as serious violations. The items have been grouped for penalty purposes and the total penalty proposed is $1,500.00. I agree with the CO's

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[16]Mr. Malensek's lack of credibility was previously noted in footnote 11, *supra*.

[17]Mr. Imrie's accident shows that employees did not use harnesses and safety lines when entering the tanks, as does the testimony of Lead Men Lane, Jeffers and Snyder that they had not worn harnesses and had not trained any of their tank cleaners to wear them. (Tr. 45, 50, 57, 153).

[18]Mr. Snyder corroborated the lack of rescue procedures at the hearing. (Tr. 50-51).

conclusion that the severity of the conditions was high and the probability greater. (Tr. 321). I find the proposed penalty appropriate, and a total penalty of $1,500.00 is assessed for Items 4a and 4b.

Serious Citation 1 - Item 5 - 29 C.F.R. 1910.146(g)(2)(ii)

Item 5 alleges a violation of 29 C.F.R. 1910.146(g)(2)(ii), which requires the employer to provide training to each affected employee "[b]efore there is a change in assigned duties."

The Secretary alleges that Greenleaf did not retrain Mr. Imrie upon his rehire on December 17, 2002. The record shows that Mr. Imrie was first hired in mid-May of 2002, that he was hired as a truck driver, and that he received training in trucking and in confined space entries; specifically, he watched a film and took tests on trucking and permit-required confined spaces, he received a manual about tank room methods and procedures, and he was issued protective gear such as a respirator, rubber outerwear, and safety glasses and a face shield.[19] The record further shows that Mr. Imrie left Greenleaf in June 2002 because he wanted to be a truck driver and did not want to clean tanks and that when he was rehired in December 2002 he was hired as a truck driver. (Tr. 323-24; Exh. R-3). CO Rivera agreed that Mr. Imrie left Greenleaf in June of 2002 because he wanted to be a driver and did not want to clean tanks but nonetheless concluded that Mr. Imrie had not cleaned tanks before his rehire in December 2002. (Tr. 323-24). Greenleaf, however, asserts that Mr. Imrie cleaned tanks in May 2002, that he left because he wanted to be a driver, and that when he returned he was hired as a driver but still had tank-cleaning duties; Greenleaf also asserts that because Mr. Imrie's tank-cleaning duties did not change, the cited standard does not apply. (R. Post-Hearing Brief, p. 44).

The preamble to this standard indicates that training is required before there is a change in permit space operations that presents a hazard about which an employee has not previously been trained. 58 Fed. Reg. at 4513. Based on the foregoing, I find that Mr. Imrie was trained in permit-required confined spaces in May of 2002 and that he cleaned tanks before leaving Greenleaf in June 2002. This finding is supported by the record and, in particular, by the CO's own testimony; it is also supported by Mr. Snyder's testimony that he and Mr. Imrie cleaned a tank together in December 2002

[19]The tests Mr. Imrie took included an authorized entrant test, an attendant test, an entry supervisor test, and a rescue and emergency services test. *See* Exhibit R-3.

and that it was his impression that Mr. Imrie knew how to clean a tank better than he did. (Tr. 41, 50).[20] I conclude that the Secretary has not shown that Mr. Imrie was assigned to clean tanks for the first time upon returning to Greenleaf in December 2002, such that there was a change in his assigned duties within the meaning of the standard. This item is vacated.[21]

Willful Citation 2 - Items 1a and 1b - 29 C.F.R. §§ 1910.146(d)(3)(iv) and (d)(4)(ii)

Item 1a alleges a violation of 29 C.F.R. 1910.146(d)(3)(iv), which requires "[p]urging, inerting, flushing, or ventilating the permit space as necessary to eliminate or control atmospheric hazards."

Item 1b alleges a violation of 29 C.F.R. 1910.146.(d)(4)(ii), which requires the employer to provide, maintain and ensure the use of "[v]entilating equipment needed to obtain acceptable entry conditions."

The Secretary alleges that Tank174 was not purged or ventilated prior to entry on December 21, 2002, and that there was no equipment to ventilate Tank174 on December 21, 2002, when an oxygen-deficient atmosphere was present. The requirements for a permit-required confined space program include purging and ventilating the atmosphere of a space that is immediately dangerous to life and health to make it safe for employee entry. The record shows that Greenleaf's confined space program and training materials had this requirement. (Exhs. C-12, p. 11, 16-17, C-15, p. 15). However, despite this requirement, the record shows, and the parties have stipulated, that Greenleaf had no equipment to ventilate its permit-required tank trailers, resulting in the oxygen-deficient atmosphere in Tank 174 not being eliminated before Mr. Imrie's entry on December 21, 2002. (Tr.19, 45, 153, 261, 327; Stipulation of Fact No. 8). In addition, Mr. Snyder and Mr. Malensek were also exposed to the hazardous atmosphere in Tank 174. In view of the record, I find that the Secretary has met her burden

[20]The Secretary asserts in her post-hearing brief, with transcript authority, that Mr. Snyder assisted Mr. Imrie in cleaning his first tank. (S. Brief, p. 20). My review of the transcript does not persuade me that this event had been Mr. Imrie's first tank-cleaning job. (Tr. 49-50).

[21]In vacating this item, I have noted the CO's testimony indicating that the training Mr. Imrie received was inadequate. (Tr. 325). However, this citation item alleges a failure to retrain, which, for the reasons set out above, the Secretary has not proved.

of proving both of the alleged violations. The classification of Items 1a and 1b, as well as the other alleged willful items, is set out following the discussion with respect to Item 4 of Willful Citation 2

Willful Citation 2 - Item 2 - 29 C.F.R. 1910.146(d)(5)(i)

This item alleges a violation of 29 C.F.R. 1910.146(d)(5)(i), which requires the employer to "[t]est conditions in the permit space to determine if acceptable entry conditions exist before entry is authorized to begin." The Secretary alleges that no testing of atmospheric conditions inside Tank 174 was conducted before entry on December 21, 2002. The record shows that the atmosphere inside Tank 174 on the day of the accident was 11 percent oxygen; the record also shows the tank was a permit-required confined space that had not been reclassified as a non-permit space. Both management and employees acknowledged that although an air monitor was present, no testing was done prior to December 21, 2002. (Tr. 45-50, 54, 152-53, 333-34). Furthermore, former employee Mr. Jeffers testified that he was specifically instructed by David Lane, his supervisor when he worked in the tank room, to not test a tank's atmosphere before entry but, rather, to complete the entry permit by fabricating a number that was within the acceptable range and filling in the permit with that number.[22] (Tr. 153, 156-58). Based on the record, I find the Secretary has demonstrated the alleged violation.

Willful Citation 2 - Item 3- 29 C.F.R. 1910.146(d)(6)

This item alleges a violation of 29 C.F.R. 1910.146(d)(6), which requires the employer to "[p]rovide at least one attendant outside the permit space into which entry is authorized for the duration of entry operations."[23] The Secretary alleges that on December 21, 2002, an employee entered Tank 174 and there was no attendant available when entry was made. The record establishes that there was no attendant stationed outside of Tank 174 on the day of the accident. Mr. Herron initially assisted

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[22]Although Mr. Jeffers was admittedly fired for absenteeism, I observed his demeanor on the witness stand and found his testimony credible, consistent and convincing. I therefore credit his testimony, notwithstanding the circumstances of the termination of his employment.

[23]The significance of this requirement is set out in the standard's preamble, which states that "stationing an attendant to monitor permit space entry is a critical element of an effective permit space program ... an attendant's ability to communicate with the authorized entrants and with the designated rescue and emergency services maximizes the likelihood that information on hazards arising in permit spaces will be transmitted in time for safe evacuation or rescue of entrants." 58 Fed. Reg. at 4499.

Mr. Imrie in connecting the hose going from the unloading valve on the tank to the holding tank, but he then left and joined Mr. Malensek in the office for coffee. (Tr. 222, 251, 255-56). Moreover, Mr. Malensek conceded that he would have been the attendant that day, but the record plainly shows that he did not perform that function that day; Mr. Malensek also conceded that he knew the attendant requirement was not being followed. (Tr. 247, 256, 262). It is clear that had an attendant been present on the day of the accident, a more expedient rescue could have occurred. In view of the evidence of record, I find that the Secretary has met her burden of proving the alleged violation.

Willful Citation 2 - Items 4a and 4b - 29 C.F.R. §§ 1910.146(d)(10) and (e)(1)

Item 4a alleges a violation of 29 C.F.R. 1910.146(d)(10), which requires the employer to "[d]evelop and implement a system for the preparation, issuance, use, and cancellation of entry permits as required by this section."

Item 4b alleges a violation of 29 C.F.R. 1910.146(e)(1), which requires the employer, before entry is authorized, to "document the completion of measures required by paragraph (d)(3) of this section by preparing an entry permit."

The Secretary alleges that on December 21, 2002, Greenleaf failed to implement a system for the preparation, issuance, use and cancellation of entry permits and that, consequently, no permit documenting that Tank 147 was safe for entry was prepared before Mr. Imrie entered the tank. The importance of the permit requirement is set out in the standard's preamble, which states that:

> The single most important feature of the permit system is the creation and use of an entry permit. An employer uses the permit to authorize employees to enter permit spaces and to document the measures taken to protect authorized entrants from permit space hazards ... you need to prepare a written permit system because that is the only way that you can ensure that people have looked at the various hazards that exist and have decided what has to be done or if nothing has to be done. If you do not provide a permit, it is left to the evaluation of the individual, and all of us, as people, can forget something. 58 Fed. Reg. at 4506.

It is clear from the record that while Greenleaf had a program that addressed the completion of entry permits, the company failed to effectively implement the system outlined in the program. (Tr. 338-40). Mr. Snyder testified that he did not fill out any permits before the accident, including the occasion when he entered a tank with Mr. Imrie, at which time he was his supervisor. (Tr. 48-50). Mr. Jeffers testified that he completed permits but that the permits were falsified; he further testified that

he was instructed to do so by his supervisor during training. (Tr. 156-58).[24] In addition, the parties stipulated that no permit was completed before Mr. Imrie's entry into the tank on December 21, 2002. (Stipulation of Fact No. 6). Based on the foregoing, I conclude that the Secretary has established both of the alleged violations.

The Classification of Items 1-4 of Willful Citation 2

The foregoing violations have been classified as serious and willful. The violations were clearly serious, in light of Mr. Imrie's accident. As to the willful classification, the Commission has defined a willful violation as one committed "with intentional, knowing or voluntary disregard for the requirements of the Act or with plain indifference to employee safety." *Williams Enter., Inc.,* 13 BNA OSHC 1249, 1256 (No. 85-355, 1987). *See also American Wrecking Corp. v. Secretary of Labor,* 351 F.3d 1254, 1262 (D.C. Cir. 2003); *Western Waterproofing Co., Inc. v. Marshall,* 576 F.2d 139, 142 (8th Cir. 1978). "The Secretary must show that the employer was actually aware, at the time of the violative act, that the act was unlawful, or that it possessed a state of mind such that if it were informed of the standard, it would not care." *Propellex Corp.,* 18 BNA OSHC 1677, 1684 (No. 96-0265, 1999) (citations omitted). The Sixth Circuit, where this case arose, has held that "a willful violation is action 'taken knowledgeably by one subject to the statutory provisions in disregard of the action's legality.'" *National Engineering & Contracting Co. v. Herman*, 181 F.3d 715, 721 (6th Cir. 1999) (citation omitted). The Sixth Circuit has also held that a willful violation occurs where the employer is "conscious" of the requirements of a rule and "nonetheless ... consciously continues" in its contrary practice. *Donovan v. Capital City Excavating Co.,* 712 F.2d 1008, 1010 (6th Cir. 1983).

I find that the record demonstrates that Greenleaf was aware of the OSHA standards prohibiting the cited conduct and that it consciously disregarded those standards. Greenleaf's comprehensive permit-required confined space program and training materials, developed in 1994, set out procedures

[24]Mr. Malensek testified that permits were being completed during the two-month period before the accident but that no one was reviewing them to ensure they were properly completed. (Tr. 234-35, 241). However, Exhibit C-13 contains 20 tank-cleaning reports covering November 21, 2002, through December 13, 2002, for which there are no corresponding confined space entry permits. Thus, at least 20 entries were made without permits during this period.

that were in compliance with OSHA's permit-required confined spaces standard.[25] The confined space hazard analysis that Charles performed identified Greenleaf's slurry-transporting tank trailers as permit-required confined spaces because of the potential for atmospheric hazards. *See* Exh. C-12, pp. 9-11. There is no credible evidence that these tanks were ever reclassified, and the record shows that employees continued to be trained in the requirements of the standard. Moreover, management acknowledged that it was aware of the provisions in its program and that employees were being trained in those provisions. Despite this knowledge, and for no articulated reason, Greenleaf ignored its own program and failed to implement the practices and procedures that would have protected its employees from the hazards of entry into permit-required confined spaces. (Tr. 45-59, 152-54, 158-63, 223, 229, 232, 247, 265; Exhs. C-8, C-9, C-12, C-14, C-15).

Management's conscious disregard was demonstrated by the specific testimony of Mr. Snyder and Mr. Malensek. Mr. Snyder, for example, acknowledged that he was trained to stay outside the tank while Mr. Imrie cleaned it but that he did not do it that way. (Tr. 57). Mr. Malensek testified that he was aware that the company had a confined space program, and he conceded that the program classified the slurry-transporting tank trailers as permit-required spaces; however, he then said such tanks were considered non-permit spaces, but he offered no explanation in that regard. (Tr. 231-32). Mr. Malensek also testified that he knew the company was not fully following the J.J. Keller pamphlet the entire time he was a supervisor; he said he did not make that decision, noting that it was the general practice not to follow the materials, and that he just allowed it to continue. (Tr. 262-63). The Commission has recognized that an employer's failure to follow its own safety program and the

[25]The program requires an entry permit system, monitoring the atmosphere, the presence of an attendant and the use of communication equipment, and training of entrants. *See* C-12, pp. 10-11, 17-10. Greenleaf also had its own confined space training materials and the J.J. Keller training pamphlet; these documents addressed the procedures employees were to follow during entries, including completing permits and testing the atmosphere, having an attendant, ventilation of the space, and emergency and rescue procedures. *See* C-14, pp. 4-10, C-15, pp. 9-19. Finally, the tank cleaning procedures posted in the tank room mirror the requirements of the company's program and the OSHA standard; for example, they require the tank cleaner to test the oxygen content, to wear a harness, and to always have an attendant available. *See* C-8.

recommendations of a safety consultant can establish a willful violation.[26] *Morrison-Knudsen Co., Inc.*, 16 BNA OSHC 1105 (No. 88-572, 1993).

Based on the facts of this case and the foregoing Commission precedent, I find that all of the items set out in Citation 2 (specifically, Items 1a, 1b, 2, 3, 4a and 4b) are properly classified as willful violations. These items are consequently affirmed as willful violations.

Penalty Assessment for Items 1-4 of Citation 2

The Secretary has proposed a penalty of $28,000.00 each for Items 1 through 4 of Citation 2.[27] I agree with the CO's conclusion that the severity of these violations was high and that the probability of an accident occurring was greater, particularly in view of Mr. Imrie's death. (Tr. 329-39). I also find appropriate the proposed penalty of $28,000.00 for each of these items. A penalty of $28,000.00 each is accordingly assessed for Items 1 through 4 of Citation 2.[28]

"Other" Citation 3 - Item 1 - 29 C.F.R. 1910.146(d)(12)

This item alleges a violation of 29 C.F.R. 1910.146(d)(12), which requires the employer to "[d]evelop and implement procedures ... necessary for concluding the entry after entry operations have been completed."

The Secretary alleges that Greenleaf violated the cited standard because it did not have any procedures in place for concluding entry into the tank trailers. In this regard, the preamble to the standard states as follows:

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[26]Commission precedent is well established that a willful charge is not justified if an employer has made an objectively reasonable, good faith effort to comply with a standard or to eliminate a hazard, even though the employer's efforts are not entirely effective or complete. *Keco Indus., Inc.*, 13 BNA OSHC 1161, 1169(No. 81-263, 1987); *Asbestos Textile Co., Inc.*, 12 BNA OSHC 1062, 1063(No. 79-3831, 1984). The record contains no evidence to support a finding that Greenleaf acted in good faith.

[27]The Secretary has grouped Items 1a and 1b, and Items 4a and 4b, for penalty purposes and has proposed a single penalty of $28,000.00 each for Item 1 and Item 4.

[28]In assessing these penalties, I have noted that while the CO gave a credit of 60 percent for size in regard to the serious items, he gave a credit of 50 percent for size with respect to the willful items. (Tr. 303, 313, 318, 321, 326, 329-39). However, upon giving due consideration to the facts and circumstances of this case, I find that a penalty of $28,000 for each of the willful items is appropriate.

> The cancellation of the permit would alert the employer to take the appropriate measures for the shut down of the space, the closing of the entry portal, and the return of the space to normal operating conditions. Without these procedures, employees would be exposed to such hazards as being locked inside the space, accidentally entering the space, and possible fire or explosion when the space is returned to its normal operating mode....[Additionally] the standard ensures the orderly transition between periods when entry is authorized and periods when entry is not authorized.

58 Fed. Reg. at 4501. The conclusion of an entry permit also ensures that, should an employee leave a permit space and return, a new permit is completed to verify that conditions are still safe. The undisputed evidence of record establishes that there are no dates on Greenleaf's entry permits that indicate that the permits have been concluded. (Tr. 342-44; Exh. C-18).

Based on the foregoing, the Secretary has met her burden of proving the alleged violation. This citation item is therefore affirmed. As to the classification of this item, an "other" violation is one that has a direct and immediate relationship between the violative condition and occupational safety; however, unlike a serious violation, the probability of death or serious physical injury does not exist. I find that this item is properly classified as "other," and it is accordingly affirmed as such. No penalty was proposed for this item, and none is assessed..

Findings of Fact and Conclusions of Law

The foregoing decision constitutes my findings of fact and conclusions of law in accordance with Federal Rule of Civil Procedure 52(a).

ORDER

Based upon the foregoing, it is hereby ORDERED that:

1. Item 1 of Citation 1 is AFFIRMED as a serious violation, and a penalty of $1,500.00 is assessed.

2. Item 2 of Citation 1 is AFFIRMED as a serious violation, and a penalty of $750.00 is assessed.

3. Item 3 of Citation 1 is AFFIRMED as a serious violation, and a penalty of $1,500.00 is assessed.

4. Item 4 of Citation 1 is AFFIRMED as a serious violation, and a penalty of $1,500.00 is assessed.

5. Item 5 of Citation 1 is VACATED.

6. Item 1 of Citation 2 is AFFIRMED as a willful violation, and a penalty of $28,000.00 is assessed.

7. Item 2 of Citation 2 is AFFIRMED as a willful violation, and a penalty of $28,000.00 is assessed.

8. Item 3 of Citation 2 is AFFIRMED as a willful violation, and a penalty of $28,000.00 is assessed.

9. Item 4 of Citation 2 is AFFIRMED as a willful violation, and a penalty of $28,000.00 is assessed.

10. Item 1 of Citation 3 is AFFIRMED as an other-than-serious violation, and no penalty is assessed.

/s/

Covette Rooney
Judge, OSHRC

Dated: June 21, 2004
Washington, D.C.