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.
SAW PIPES USA, INC.
Respondent

OSHRC Docket No. 01-0422

APPEARANCES:

Gary K. Stearman, Attorney; Michael P. Doyle, Counsel for Appellate Litigation; Joseph M. Woodward, Associate Solicitor for Occupational Safety and Health; Gregory F. Jacob, Deputy Solicitor of Labor; Howard M. Radzely, Solicitor of Labor; U.S. Department of Labor, Washington, DC
For the Complainant

Thomas H. Wilson, Esq. and Sean M. Becker, Esq.; Vinson & Elkins, LLP., Houston, Texas
For the Respondent

REMAND ORDER

Before: THOMPSON, Chairman; ROGERS, Commissioner.

BY THE COMMISSION:

This case is before the Commission on remand from the United States Court of Appeals for the Fifth Circuit. *Chao v. Occupational Safety & Health Review Comm'n*, 480 F.3d 320 (5th Cir. 2007). The court reviewed the decision of Administrative Law Judge James H. Barkley, which became a final order of the Occupational Safety and Health Review Commission when the two then-sitting commissioners reached an impasse regarding the case's disposition and, therefore, agreed to vacate the Commission's direction for review. *Saw Pipes USA Inc.*, 21 BNA OSHC 1306 (No. 01-0422, 2005). On appeal, the court vacated the judge's penalty assessment, finding that he erroneously grouped separate willful violations and assessed a single grouped penalty below the statutory range mandated by section 17(a) of the Occupational Safety and Health Act of 1970, 29 U.S.C. § 666(a).

By mandate dated May 9, 2007, the court ordered the judge's decision vacated and remanded "for further proceedings in accordance with the opinion of th[e] court." Accordingly, we hereby

remand this case to the judge for further proceedings consistent with the court's opinion.

SO ORDERED.

/s/
Horace A. Thompson III
Chairman

/s/
Thomasina V. Rogers
Commissioner

Dated: August 16, 2007

SECRETARY OF LABOR Complainant, v. SAW PIPES USA, INC., and it's successors, Respondent	OSHRC Docket No. 01-0422

DECISION

Before: RAILTON, Chairman; and ROGERS, Commissioner.

The Occupational Safety and Health Administration ("OSHA") commenced an inspection of Saw Pipes USA, Inc.'s ("Saw Pipes") facility in Baytown, Texas on July 27, 2000, and subsequently cited Saw Pipes for numerous alleged willful and serious violations of various standards under the Occupational Safety and Health Act of 1970, 29 U.S.C. §§ 651-687 ("OSH Act" or "Act"). The parties resolved, by settlement agreement and joint stipulation, all of the citations except certain items pertaining to Saw Pipes' alleged failure to properly record occupational illnesses and injuries in violation of 29 C.F.R. § 1904.2(a).[1] With the exception of one grouped citation, the Secretary cited the recordkeeping violations as willful on a per-instance basis, and proposed a penalty of $8,000 for each of the violations.[2] Administrative Law Judge James H. Barkley affirmed fifty-nine separate recordkeeping violations as willful, but grouped them for penalty purposes and assessed a single penalty of $70,000.

On review, Saw Pipes contests only the characterization of the violations as willful, and argues for lower penalties. The Secretary challenges the judge's penalty grouping. The two

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[1]At the time these violations occurred, 29 C.F.R. § 1904.2(a) provided that:

> Each employer shall, . . . (1) maintain in each establishment a log and summary of all recordable occupational injuries and illnesses for that establishment; and (2) enter each recordable injury and illness on the log and summary as early as practicable but no later than 6 working days after receiving information that a recordable injury or illness has occurred. For this purpose form OSHA No. 200 or an equivalent which is as readable and comprehensible to a person not familiar with it shall be used. The log and summary shall be completed in the detail provided in the form and instructions on form OSHA No. 200.

[2]In Citation 1, Item 67, the Secretary grouped multiple instances of incorrectly recorded items into a single violation for which she proposed a single penalty. The judge affirmed some of the individual instances and vacated others.

Commission members would affirm the judge's characterization of the violations as willful, but are divided as to the appropriate penalty assessment.

Official action of the Commission requires the affirmative vote of two members on all dispositive issues. OSH Act, § 12(f), 29 U.S.C. § 661(e). In view of the absence of such agreement here and to resolve this impasse, the Commission members agree to vacate the direction for review, thereby allowing the judge's Decision and Order to become the final appealable order of the Commission with the precedential value of an unreviewed judge's decision.[3] *See e.g.*, *The Timken Co.*, 20 BNA OSHC 2034 (No. 97-1457, 2004), and cases there cited. *See also* sections 10(c), 11(a) and (b), and 12(j) of the Act, 29 U.S.C. §§ 659(c), 660(a) and (b), and 661(i). Accordingly, the direction for review is hereby vacated. The separate views of the two Commission members follow.

SO ORDERED.

/s/
W. Scott Railton
Chairman

/s/
Thomasina V. Rogers
Commissioner

Dated: September 28, 2005

[3]Notwithstanding our action vacating the direction for review in this case, this was an appropriate case for review. The order vacating the direction for review is entered in order to allow the parties to bring finality to this case. The decisions of some United States courts of appeals have rejected alternative forms of dispositions of our cases when only two members are available to decide cases. *See, e.g., Cox Brothers v. Secretary of Labor*, 574 F.2d 465 (9th Cir. 1978); *Shaw Construction, Inc. v. OSHRC*, 534 F.2d 1183 (5th Cir. 1976).

I. The characterization of Saw Pipes' recordkeeping violations

Saw Pipes manufactures steel pipe at a former USX steel facility that it shares with Jindal United Steel Corp. ("Jindal"). The two related companies share some common ownership and some managerial personnel.[4] On review, Saw Pipes does not dispute the judge's finding that it failed to properly record 63.7% of the recordable injuries and illnesses on its OSHA 200 logs for the cited period during 1998, 1999, and 2000. Having thoroughly reviewed the record in this case, Chairman Railton and Commissioner Rogers agree that the record supports the judge's conclusion that Saw Pipes' recordkeeping errors were willful.

As the Commission stated in *Kaspar Wire Works, Inc.*, "[t]he hallmark of a willful violation is the employer's state of mind at the time of the violation — an 'intentional, knowing, or voluntary disregard for the requirements of the Act or . . . plain indifference to employee safety.'" 18 BNA OSHC 2178, 2181 (No. 90-2775, 2000) (citation omitted), *aff'd,* 268 F.3d 1123 (D.C. Cir. 2001). "[T]he Secretary must show that the employer acted voluntarily, with either intentional disregard of or plain indifference to OSHA requirements." *Georgia Elec. Co. v. Marshall*, 595 F.2d 309, 317-319 (5th Cir. 1979). *Accord AJP Constr. Inc. v. Secretary*, 357 F.3d 70, 74 (D.C. Cir. 2004).

Here, during the period covered by the citations, Robert Murphey, Saw Pipes' safety manager and certified industrial safety technician, maintained Saw Pipes' OSHA 200 logs. Through his education and previous work experience, Murphey was familiar with OSHA standards and recordkeeping regulations, as well as the contents of the U.S. Department of Labor, Bureau of Labor Statistics publication entitled *Recordkeeping Guidelines for Occupational Injuries and Illnesses*. The evidence shows that Murphey worked ten-hour days, seven days a week, and that he responded to and investigated all accidents and injuries that occurred during his shift. At other times, Saw Pipes' security personnel investigated such incidents, and notified Murphey of the events thereafter. Murphey also gathered illness and injury information from the "incident reports" generated by Saw Pipes' supervisory personnel, treating physician accident reports and return-to-work restrictions, and copies of the on-site clinic log.

Murphey claims that he made every effort to follow up on accidents and incidents in order to keep the OSHA 200 log up to date, and that he never intentionally failed to record an injury that he knew was recordable. He blames his failure to properly record on inadequate information from

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[4]We also issue today a decision vacating the direction for review in *Jindal United Steel Corp*. ("*Jindal*"), Docket No. 00-2231, which involves the identical questions presented here.

supervisors and clinic staff. Although the record shows that some incident reports were delayed, we agree with the judge that Murphey's first-hand knowledge of most incidents, combined with his access to redundant sources of employee illness and injury information, belies his claim that inadequate information precluded him from properly maintaining Saw Pipes' OSHA 200 logs. *See Kaspar Wire Works, Inc. v. Secretary*, 268 F.3d 1123, 1128-29 (D.C. Cir. 2001) (finding that factual evidence belied Kaspar's claim that its actions were merely negligent or careless).

Murphey reported directly to Gary Jones, Saw Pipes' human resources and labor relations director. Jones was the architect of Jindal's recordkeeping program, through which he knowingly enforced erroneous guidelines that resulted in a large number of recording errors.[5] Jones had instructed Jindal's recordkeeper to exclude from the OSHA 200 those injuries not reported to workers' compensation, and the injuries and illnesses of temporary laborers who worked at the plant.

Although Murphey testified that Jones never told him what to record on Saw Pipes' OSHA 200 logs, Jones acknowledged having "ultimate responsibility" for the OSHA 200s. Jones also received and reviewed, along with Murphey, the supervisors' illness and injury reports, and medical bills for employees referred to the off-site clinic. As the judge noted, Jones and his staff "inherited a pre-existing reporting system" to which procedures were added that "should have increased reporting accuracy." Nonetheless, the undisputed recordkeeping data bear out the judge's observation that "[d]espite the increase in the number and expertise of safety personnel, . . . the timeliness and accuracy in recording injuries plummeted after Jones took over the management of Saw's safety department" and "did not improve when Robert Murphey took over responsibility for the logs in May 1998."

There is also evidence that Jones directly intervened to control the medical information upon which recordability would depend. The medical supervisor of Saw Pipes' on-site clinic provided unrebutted testimony that Jones attempted to persuade him to refrain from ordering restricted work for injured employees. Speaking with the doctor several times each week, Jones criticized work restriction orders, and asked in many particular instances that patient records contain "no restrictions" notations despite Jones' knowledge that the patient could not perform job-related duties.

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[5]The judge granted the Secretary's unopposed motion to make portions of the *Jindal* transcript that included this evidence part of the record here.

As a management official who actively oversaw and participated in Saw Pipes' OSHA 200 compliance, Jones is accountable for the vast errors contained in the company logs for the cited years. The evidence shows that he and Murphey fully understood the recordkeeping requirements, had actual knowledge of the employee illness and injury incidents that should have been recorded, and knowingly failed to comply with the applicable regulations. *See AJP Constr. Inc. v. Secretary*, 357 F.3d at 74 (affirming willful violation where employer knew of standards' requirements and had notice of deficiencies in compliance). Moreover, as the judge noted, Saw Pipes "crossed the line" when it "intrud[ed] into the doctor/patient relationship" by attempting to influence doctors' orders for work restrictions. Accordingly, we agree with the judge that the cited recordkeeping violations were willful.[6]

II. Penalties

The judge affirmed fifty-nine separate violations for Saw Pipes' fifty-nine recordkeeping errors, which the Secretary cited on a per-instance basis and which the parties do not contest on review. With respect to the penalties, however, the judge rejected the Secretary's proposal of $8,000 for each willful violation and, instead, assessed a single grouped penalty of $70,000.

Chairman Railton's Views

For the reasons more fully articulated in *Jindal*, Chairman Railton believes that the judge properly assessed a single $70,000 penalty for Saw Pipes' willful recordkeeping violations. In particular, Chairman Railton notes that in assessing a single combined penalty, the judge properly took into account the Secretary's own theory of the case — that Saw Pipes engaged in a single pattern and practice of willful non-reporting. As the judge stated "[t]he evidentiary path chosen by Complainant was considerably less onerous than showing willfulness in each and every instance."

Nor did the Secretary establish that these violations were willful *and* egregious. The record is devoid of evidence properly showing the requisite high gravity or significant bad faith to merit per-instance penalties under the egregious/willful penalty policy. The judge analyzed the evidence on this issue.[7] Chairman Railton would also find that the gravity of Saw Pipes' recordkeeping

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[6]The judge also properly rejected Saw Pipes' "good faith belief" defense to willfulness with respect to the temporary laborers. Saw Pipes directly supervised the temporary workers which, as Jones knew, made it responsible for recording their injuries and illnesses. *See Froedtert Memorial Lutheran Hospital, Inc.*, 20 BNA OSHC 1500, 1510 (No. 97-1839, 2004) (citations omitted).

[7]Chairman Railton notes that his colleague sidesteps the fact that it is the policy of the Secretary to distinguish between willful violations committed in a non-egregious manner from those which she characterizes as egregious/willful violations.

violations was low. As the judge noted, the unreported injuries were relatively minor, and a review of Saw Pipes' safety violations reveals no intent to cover up serious safety hazards.

Although "intentional disregard" of safety and health responsibilities is another of the willful/egregious factors that may support enhanced penalties, as Chairman Railton explained in *Jindal,* this factor "is thoroughly redundant" here as it comprises the sole basis of the willful characterization. In the absence of any other indicia of bad faith, application of the violation-by-violation penalty policy is not merited. Accordingly, Chairman Railton would affirm the judge's penalty assessment of a single grouped penalty of $70,000 for Saw Pipes' fifty-nine recordkeeping violations.

Commissioner Rogers' Views

For the reasons more fully articulated in *Jindal*, Commissioner Rogers believes that the judge exceeded his statutory authority by assessing a single $70,000 penalty for fifty-nine separate willful violations. In her view, the amended Act plainly requires that the Commission assess a penalty of at least $5,000 for each of the fifty-nine affirmed willful violations.

In particular, Commissioner Rogers takes issue with her colleague's assertion that because the evidence here shows a pattern and practice of willful non-reporting, individual willful penalties are not warranted. The OSH Act does not distinguish among theories of willfulness as a predicate for imposing the minimum willful penalty. It merely states that a penalty "not less than $5,000" must be assessed "for each willful violation." Having affirmed each of Saw Pipes' fifty-nine recordkeeping violations as willful, the Commission must apply the statutory penalty scheme as written.

Commissioner Rogers also emphasizes that Saw Pipes' managers personally completed the OSHA 200 forms, and the evidence shows that their willful noncompliance with the cited regulations was, indeed, egregious. Human resources director Gary Jones, in conjunction with safety manager Robert Murphey, were directly responsible for the sorry state of Saw Pipes' illness and injury reporting. As we noted above, they "fully understood the recordkeeping requirements, had actual knowledge of the employee illness and injury incidents that should have been recorded, and knowingly failed to comply with the applicable regulations." The evidence in this case shows such a disregard for compliance with the recordkeeping regulations that, even absent proof of employer knowledge of each recordkeeping error, "it could be inferred that if [Saw Pipes] had known of the [recordable events], it would not have cared that it was in violation of the Act." *A.E. Staley Mfg. Co.*, 19 BNA OSHC 1199, 1211, 1222 (No. 91-0637, 2000) (consolidated) (finding that

evidence established "pattern and course of conduct" demonstrating plain indifference), *aff'd,* 295 F.3d 1341, 1350-53 (D.C. Cir. 2002) (noting that knowledge regarding acts of omission can be inferred from evidence of plain indifference). In these circumstances, as in *Jindal*, Commissioner Rogers would find that Saw Pipes demonstrated "a level of bad faith that clearly justifies the Secretary's lawful exercise of her discretion to cite these violations separately and the penalties that statutorily flow from it." Accordingly, a $5,000 penalty for each of the fifty-nine willful violations would be reasonable and appropriate.

SECRETARY OF LABOR, Complainant, v. SAW PIPES USA, INC., and its successors, Respondent.	OSHRC DOCKET NO. 01-0422

APPEARANCES:

For the Complainant:

Raquel Tamez, Esq., Madeleine Le, Esq., Office of the Solicitor, U.S. Department of Labor, Dallas, Texas

For the Respondent:

Thomas H. Wilson, Esq., Julianne Merten, Esq., Michael J. Muskat, Esq., Vinson & Elkins, LLP, Houston, Texas

Before: Administrative Law Judge: James H. Barkley

DECISION AND ORDER

This proceeding arises under the Occupational Safety and Health Act of 1970 (29 U.S.C. Section 651 *et seq.*; hereafter called the "Act").

Respondent, Saw Pipes USA, Inc., and its successors (Saw), at all times relevant to this action maintained a place of business in Baytown, Texas, where it was engaged in manufacturing seamless welded line pipe (Tr. 272, 286). Respondent admits it is an employer engaged in a business affecting commerce and is subject to the requirements of the Act.

On July 27, 2000 the Occupational Safety and Health Administration (OSHA) began an inspection of Saw's Baytown, Texas work site. As a result of that inspection, Saw was issued a Willful citation alleging 67 violations of §1904.2(a). The citation alleges 66 instances in which Saw failed to list recordable injuries or illnesses on its OSHA 200 form. Item 67 alleges that 16 injuries or illnesses were incorrectly recorded. Penalties of $8,000.00 per instance were proposed. By filing a timely notice of contest Saw brought this proceeding before the Occupational Safety and Health Review Commission (Commission).

On January 22-23, 2002, a hearing was held in Houston, Texas. Pursuant to a joint statement of the parties filed at the hearing, the Secretary withdrew items 27 and 67 (subpart 16), and Saw withdrew its contest to the recordability of all but 18 of the 66 failures to record and all but 5 of the 16 items allegedly reported incorrectly. Saw continued to contest the classification of the citation as willful, and the proposed penalties. During the hearing, the Secretary also withdrew item 17 of Willful citation 1 (Tr. 157), and Saw withdrew its contest as to the recordability of items 29, 34, 38 and 49 and 63 (Tr. 146-148). Following the hearing, Complainant withdrew three of those items, numbers 29, 34, and 63 (Complainant's post-hearing brief, p. 37, 38, 47). Finally, in its post hearing brief, Saw withdrew its notice of contest to items 11 and 20 based on the testimony presented at the hearing (Respondent's post-hearing brief, p. 2). The parties have submitted briefs on the issues remaining in dispute and this matter is ready for disposition.

Facts

Robert Murphey, a certified industrial safety technician, has been Saw's safety manager since May 1998 (Tr. 64, 216; Exh. C-245). Murphey testified that, in addition to filling out the OSHA 200 logs, he is responsible for responding to and investigating all accidents and injuries that occur at the Saw facility (Tr. 65, 80-81). Plant managers and supervisors are instructed to inform him of injury accidents (Tr. 66-68). If Murphey is not in the plant, security is to be notified (Tr. 67). Security is instructed to notify Murphey, via pager or by way of a patrolman's report, of all accidents and injuries which occur outside of his shift (Tr. 69-71). Murphey testified that Saw's accident policy requires that all injuries be reported (Tr. 71, 113). Murphey testified that the reports are not always submitted in a timely manner, and that he has complained about the problem to his supervisor, Mr. Jones, to the plant manager, Mr. Turnipseed, and to the chief executive officer, Mr. Bhargava (Tr. 115).

Carroll Caudill, Saw's maintenance manager, and Kurt Brodd, Saw's plant manager, both testified that when a Saw employee is injured, he notifies his supervisor. If required, medical treatment is immediately sought for the employee (Tr. 46, 160). Brodd testified that Robert Murphey is then contacted (Tr. 160). Where a reportable injury occurs, the supervisor fills out an accident or

injury report which is submitted either to Robert Murphy, or to Murphey's supervisor, Gary Jones (Tr. 45-48, 58, 161). Brodd testified that it is Saw's policy to fill out an accident report in all cases (Tr. 162). Caudill, however, testified that reports are not always filled out for minor injuries (Tr. 58). Both Brodd and Caudill admitted that there are times when they have to be reminded to get a report to Murphey (Tr. 48, 56-57, 163, 168). However, Brodd stated that he was not aware of any accidents that were never reported to Mr. Murphey (Tr. 164).

Caudill testified, if an employee's injury is serious enough to merit a trip to the hospital, the employee must obtain a doctor's release before returning to work (Tr. 53). According to Caudill, the release is returned to the personnel department (Tr. 53). Caudill was not aware of any instances where an employee returned to work without going through personnel (Tr. 54). Dr. Jerry McShane, owner of the San Augustine Industrial Clinic, where Saw employees have been treated since early 1999, testified that accident reports, which include Return to Work (RTW) restrictions, are faxed to Saw in virtually every case (Tr. 452-53, 468). Dr. Carl Davis, a physician associated with BayCoast, which provided patient care for Saw's employers in 1998, testified that it was the practice to fax a copy of any work restrictions to Saw (Tr. 409-10). Murphey testified that because it is his job to coordinate any work restrictions an employee might have as a result of his or her injury, any paperwork documenting physician imposed work restrictions comes to him (Tr. 75, 124).

In addition to incident reports from supervisory personnel and plant security, and RTW forms from treating physicians, Murphey receives copies of the logs from the on site clinic on a monthly basis (Tr. 75, Exh. C-248, C-249, C-250). If an employee visits the on-site clinic as a result of his or her injury, the employee is required to sign in on the clinic log (Tr. 73). Murphey testified that he uses the nurse's sign in logs and any incident reports to assure that the OSHA 200 log is correct (Tr. 112).

Finally, Murphey testified that he and Gary Jones review medical bills for employees who are referred to the off-site clinic. It is his job to verify any medical expenses billed before they are paid (Tr. 72, 121).

<u>Alleged Violations</u>

Knowledge. Initially, this judge notes that all of the cited violations were discovered during a review of records obtained, considerably after the fact, in the course of the OSHA investigation. The records reviewed were in Saw's control or were contained in medical records controlled by Saw's agents. Such documents were available for the review of Saw's safety management at any time (Tr. 407, 469). Thus I find that even if Saw's safety managers lacked specific knowledge of any of the contested injuries, they could, with the exercise of reasonable diligence, have known of any medical

treatment provided or work restriction imposed on any of the employees named in the citations. For this reason, Saw's constructive knowledge of the individual violations will not be further discussed.

Willful citation 1, item 5 alleges that on March 2, 1998, Edward Giering sprained his left knee at Saw's facility. Complainant alleges that the sprain resulted in work restrictions and should have been, but was not recorded (Joint Statement, p. 1, Exh. C-12).

After spraining his knee Giering visited the Bay Coast Medical Center, where the knee was splinted in a brace supported with metal rods, which he was to wear for seven days (Giering Depo., p. 25). Giering returned to work with instructions to restrict the use of his leg, and to refrain from climbing, bending or stooping (Exh. C-12). In a deposition given on February 26, 2002, Giering, a tack welder, testified that he was instructed at the clinic to remain seated, and to keep his leg elevated (Giering Depo., p. 12). Giering stated that tried doing his job sitting the first day, but was unable to perform his regular duties in that position (Giering Depo., p. 12-13). Giering testified that he was told that he "needed to be up there," and, believing his job was on the line, he resumed his duties despite his prescribed work restrictions.

The U.S. Department of Labor, Bureau of Labor Statistics publication, *Recordkeeping Guidelines for Occupational Injuries and Illnesses*, the "Blue Book" states that:

> *Lost workday cases involving days of restricted work activity* are those cases where, because of injury or illness, (1) The employee was assigned to another job on a temporary basis, or (2) the employee worked at a permanent job less than full time, or (3) the employee worked at his or her permanently assigned job but could not perform all the duties normally connected with it.
>
> Restricted work activity occurs when the employee, because of the job-related injury or illness, is physically or mentally unable to perform *all or any part* of his or her normal assignment during *all or part* of the normal workday or shift. The emphasis is on the employee's *inability* to perform normal job duties over a normal work shift.

(Exh. C-278, p. 48).

Saw argues that Giering was not *unable* to perform his job, because, at least after his first day back, he was able to stand on his braced left leg throughout his shift. Giering admitted that, because he believed that he would lose his job if he wasn't up on the line, he chose to ignore the physician's recommended work restrictions after the first day. This judge believes it would set a poor precedent to hold that the recordability of an injury may be based solely on an employee's behavior, where such employee acts under pressure from his employer to return to his normal duties against the advice of his physician. *See,* item 32, in which on February 2, 1999 the same employee reported to OccuCare Industrial Medicine Clinic, with "persistent" left ankle sprain, after ignoring the physician's work

restrictions and returning to full duty after a January 15, 1999 sprain, again fearing the loss of his job (Giering Depo. p. 24; Tr. Exh. C-96).

Because Mr. Giering was unable to perform his normal job duties without disregarding the advice of his physician, this injury was recordable.[8] Item 5 is affirmed.

Willful citation 1, item 21 alleges that on September 24, 1998, Craig Brodd suffered a contusion to his forearm at Saw's facility. Complainant alleges that the contusion required medical treatment and should have been, but was not recorded (Joint Statement, p. 1, Exh. C-57, C-58).

Medical Records from the BayCoast Clinic indicate that Brodd reported to the clinic in the early hours of September 25, where ice and Tylenol #3 were prescribed (Exh. C-58). Brodd visited Saw's on-site clinic later in that day, at which time Helen Stipe, the nurse on duty, examined him and made a note, Tylenol #3 ⊤PD Q4H PRN, under the heading "Medications" (Exh. C-57). Complainant introduced no evidence from which this judge might ascertain the meaning of this notation.

The Blue Book states that the administration of a single dose of prescription medication on a first visit for a minor injury or discomfort is generally considered first aid treatment, and need not be recorded if the injury does not involve a loss of consciousness, or restriction of work or motion (Exh. C-278, p. 43). In the absence of any evidence that more than one dose of Tylenol #3 was prescribed, this judge cannot find that the cited injury was recordable. This item is vacated.

Willful citation 1, item 23 alleges that on September 29, 1998, Alberto Arredondo reported to the BayCoast Clinic complaining that a piece of metal had struck his right eye while he was working at Saw's facility. Complainant alleges that the resulting corneal abrasion required medical treatment and resulted in work restrictions which should have been, but were not recorded (Joint Statement, p. 2, Exh. C-63).

BayCoast's records indicate that Arredondo's vision was unaffected by the incident, however, Neosporin ophthalmic solution and an eyepatch were applied to Arredondo's eye (Exh. C-63). The physician on duty, Richard Trifiro, then released Arredondo for work with instructions to refrain from driving any equipment (Exh. C-63). Arredondo returned for observation the following day, at which time Dr. Trifiro, who was unable to visualize a foreign body in Arredondo's eye, referred him to an ophthalmologist.

Complainant failed to introduce any evidence indicating that Mr. Arredondo was ever diagnosed with an injury requiring treatment beyond a single dose of Neosporin ointment, or that the

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[8] This judge takes notice that, in a February 6, 1998 Compliance Letter, the Secretary interpreted medical treatment to include the use of casts, splints and/or orthopedic devices designed to immobilize a body part. Though this case was characterized as a restricted work activity case, it was also recordable as requiring medical treatment.

eyepatch Arredondo was required to wear interfered with the performance of his duties. Because the evidence does not establish that Mr. Arredondo suffered a recordable injury, item 23 is vacated.

Willful citation 1, item 31 alleges that on December 22, 1998, Edward Giering suffered an injury to his groin while working at Saw's facility. Complainant alleges that the groin injury resulted in work restrictions and should have been, but was not recorded (Joint Statement, p. 2, Exh. C-93).

In his February 26, 2002 deposition, Giering testified that Gary Jones sent him to the on-site nurse, and subsequently had Ray Snell, Robert Murphey's assistant, take him to the San Augustine Industrial Clinic (Giering Depo., p. 15-16). Giering returned to work with instructions to refrain from repetitive lifting until January 5, 1999 (Exh. C-93). Prior to his injury Giering was employed in the quality assurance and compliance department. Part of his job, which occupied approximately an hour and a half each day, was to move 20 to 25 pound samples of cut steel piping used in expansion rate testing (Giering Depo., p. 14-18). After the injury, Giering could no longer lift the samples, and was strictly limited to performing testing (Tr. 17-19).

As noted above, where the employee can still work at his or her permanently assigned job but cannot perform all the duties normally connected with it, that injury involves restricted work activity . In this case, Mr. Giering, because of his job-related injury was physically unable to perform a part of his normal assignment during part of the normal workday or shift. The injury was recordable, and this item is affirmed.

Willful citation 1, item 32 alleges that on January 15, 1999, Edward Giering sprained his left ankle while working at Saw's facility. Complainant alleges that the ankle injury resulted in work restrictions and should have been, but was not recorded (Joint Statement, p. 2, Exh. C-95).

At his February 26, 2002 deposition, Giering testified that he was taken to the San Augustine Clinic on Gary Jones' instructions (Giering Depo., p. 21). Giering returned to work the same day with instructions to avoid excessive bearing of weight on his left foot, squatting, and climbing (Exh. C-95). Giering testified that his job required him "[t]o climb up to the scope and to the ID and OD welders" (Giering Depo. p. 24). Giering testified that his supervisor, Hank Gosnell, implied that Giering would lose his job if he could not perform the duties associated with it; Giering stated that he ignored the medical restrictions (Giering Depo. p. 24). On February 2, 1999, Giering visited the OccuCare Industrial Medicine Clinic, where he was diagnosed with "persistent" left ankle sprain. Giering was provided with an ankle brace and instructed to avoid excessive weight bearing on his left foot until further notice (Exh. C-96).

The record establishes that Giering could not perform his normal work activities without disregarding the restrictions imposed by his physician. He ignored those restrictions because he feared

for his job, not because he felt the restrictions were unnecessary and, in fact, his injury persisted. For the reasons set forth in item 5, this judge finds that item 32 was recordable. This item is affirmed.

Willful citation 1, item 41 alleges that on March 23, 1999, Richard Lee strained his lower back while working at Saw's facility. Complainant alleges that the injury resulted in work restrictions and should have been, but was not recorded (Joint Statement, p. 2, Exh. C-120).

At the hearing, Lee testified that Robert Murphy took him to the doctor, where he was provided with samples of 850 mg. Motrin and pain killers. X-rays were taken and Lee was given instructions for physical therapy (Tr. 251-52; Exh. C-120). Lee was allowed to return to work with restrictions; he was not to engage in excessive climbing, squatting or lifting of over 25 pounds (Tr. 252; Exh. C-120). After an April 7, 1999 follow-up appointment, Lee received instructions to remain on light duty until April 12, 1999 (Exh. C-120). Lee testified that his regular duties included helping out in other departments as needed. Lee testified that he helped the grinders at the expander on a daily basis (Tr. 255). Lee stated that, while helping out, he was required to squat, climb and lift over 25 pounds (Tr. 255). It was while he was helping out that he hurt his back (Tr. 254). Lee stated that his actual position was hydro tester/ operator. That position does not require climbing, squatting, or lifting, and Lee was able to continue working as a hydro tester after his injury (Tr. 253-54).

Mr. Lee worked regularly in other departments, helping out on a daily basis. Because he was regularly assigned to assist the grinders at the expander, that duty was part of his normal job. Lee's inability to continue assisting in the expander department until his release from light duty on April 12, 1999 constitutes a recordable work restriction. This item is affirmed.

Willful citation 1, item 44 alleges that on April 8, 1999, Bobby Sindel suffered smoke inhalation while fighting a fire at Saw (Sindel Depo. p. 5-6; Exh. C-125, C-126). Complainant states that smoke inhalation is a recordable occupational illness which should have been, but was not recorded.

Sindel reported to Saw's in-house clinic on April 8, complaining of chest congestion and coughing. The nurse on duty reported that Sindel's throat was raw, but that his chest sounds were clear (Exh. C-125). Sindel was transported to OccuCare Clinic, where he was examined, and released for work without further treatment (Exh. C-125).

The Blue Book defines "occupational illness" as:

> Any abnormal condition or disorder. . . caused by exposure to environmental factors associated with employment. It includes acute and chronic illnesses or diseases which may be caused by inhalation, absorption, ingestion or direct contact.

Illnesses are to be listed in specific columns, by category. The relevant category in this case is:

7c. *Respiratory conditions due to toxic agents.* Examples: Pneumonitis, pharyngitis, rhinitis or acute congestion due to chemicals, dusts, gases or fumes;. . ..

The record does not establish that Sindel contracted an acute or chronic abnormal condition or disorder from the single exposure to smoke. Neither the in-house nurse, nor the physician at OccuCare reported finding any chest congestion (pneumonitis), or swelling of the throat (pharyngitis) or nasal passages (rhinitis). Because the Secretary failed to prove that Mr. Sindel was diagnosed with a recordable occupational illness, this item is vacated.

Willful citation 1, item 47 alleges that on June 7, 1999, Saw employee Alejandro Dominguez suffered a corneal abrasion when debris flew into his left eye while he was grinding (Tr. 151; Exh. C-131, C-132). Complainant maintains that Dominguez received medical treatment, making the injury recordable.

Dominquez testified that after his injury, the on-site nurse flushed his eye (Tr. 151). The nurse noted that she provided Dominguez with Cortisporin ophthalmic solution and an eyepatch (Exh. C-131). Robert Murphey then drove Dominguez to OccuCare (Tr. 152). The attending physician's notes indicate that he anesthetized the eye, removed a foreign body, and dosed Dominguez' eye with Blephamide, listed in the Physician's Desk Reference as a prescription medication. Dominguez was provided with an eyepatch and released with a monocular vision restriction (Tr. 132; Exh. C-132). Dominguez testified that when the discomfort did not subside the following day, Mr. Murphey took him back to the clinic, at which time the doctor checked his eye again, and again dosed it with Blephamide, before sending him to an ophthalmologist (Tr. 153; Exh. C-132).

The Blue Book states that the removal of foreign bodies embedded in the eye is almost always a recordable injury (Exh. C-278, p. 43). In this case, it is more likely than not that the debris was embedded in Dominguez's eye, as the on-site nurse was unable to removed it with flushing. Moreover Dominguez was treated on multiple visits with the prescription medication, Blephamide. Injuries requiring multiple doses of prescription medications are recordable (Exh. C-278, p. 43). Item 47 is affirmed.

Willful Citation 1, item 48 alleges that on June 25, 1999, James Jones suffered a sprained left ankle (Exh. C-133, 134). Jones' injury required a brace, which resulted in work restrictions including instructions to avoid excessive standing, weight bearing on the left foot, and climbing (Exh. C-134).

This judge takes note that in a February 6, 1998 Compliance Letter, the Secretary interpreted medical treatment to include the use of casts, splints and/or orthopedic devices designed to immobilize a body part. The Secretary's interpretation is reasonable, and this item is affirmed.

Willful Citation 1, item 67(5) alleges that on June 25, 1998 Marco Contresas strained his back while lifting ground wires (Exh. C-199, C-200). Contresas was treated at Bay Coast Clinic and was released for work with restrictions consisting of no climbing, bending, stooping, or lifting of any weight in excess of 10 pounds for five to seven days (Exh. C-201).

The injury report that Robert Murphey filed with Texas' worker's compensation states that Contresas, a welder, was performing his regular job when injured (Exh. C-198). This judge finds it more likely than not that Contresas' restrictions would prevent him from stooping or bending to lift ground wires, a part of his normal duties, and the very activity which caused his injury. Item 67(5) is affirmed.

Willful Citation 1, item 67(8) alleges that on March 11, 1999 James Hedden, a welder, strained his right wrist and hand while using a wrench. Hedden was treated, his wrist splinted and he was allowed to return to work with restrictions (Exh. C-213, C-214, C-215, C-216). Hedden was instructed to avoid excessive use of his right hand and repetitive lifting of 20 pounds or more (Exh. C-216). Hedden did not testify, and in the absence of any evidence as to his normal duties, this judge cannot find that he was unable to perform his job while observing the listed restrictions. Item 67(8) is vacated.

Willful Citation 1, item 67(11) alleges that on March 9, 2000, Gary Cooper, a millwright, cut his right thumb (Exh. C-226). After receiving stitches and a tetanus shot at the clinic, Cooper returned to work with restrictions including instructions to avoid excessive pressure and/or use of his right hand, and to keep the wound dry and clean (Tr. 394-95; Exh. C-226). At the hearing, Cooper testified that his job requires that he use power and hand tools, and that he is right-handed (Tr. 395). Cooper testified that he could perform most of his job duties using his left hand; however, he could not operate a torch, which required him to use his thumb (Tr. 397).

Using a torch was part of Cooper's job, and the restriction which prevented him from full use of his right hand was recordable. This item is affirmed.

Willful Citation 1, item 67(13) alleges that on April 18, 2000, Michael Ellison, a welder, suffered a laceration to his right palm (Exh. C- 230). After seeing the on-site nurse, Ellison went to the San Augustine clinic, where he was given stitches, and allowed to return to work with restrictions (Exh. C-231). Ellison was instructed to avoid excessive use of his right hand and to keep the wound dry and clean (Exh. C-232). On April 19, and again on April 28, Ellison returned to San Augustine at which time the attending physician noted "no welding" on his Return to Work (RTW) form (Exh. C-232). Ellison was returned to full duty on May 2, 2000.

This judge finds it more likely than not that Ellison, a welder, would be unable to perform his normal duties with a medical restriction barring him from welding. Item 67(13) is affirmed.

Willful Citation 1, item 67(15) alleges that on Don Schwartz suffered a foreign body to his right eye. After the foreign body was removed with an algar brush at the San Augustine clinic, Schwartz returned to work with instructions to refrain from excessive monocular vision (Exh. C-235). Schwartz did not testify at the hearing, and in the absence of any evidence as to his normal duties, this judge cannot find that he was unable to perform his job with restricted vision. Item 67(15) is vacated.

Willfulness

The Secretary maintains that Saw engaged in a deliberate pattern or under-reporting work place injuries in order to avoid being targeted for OSHA inspection. Complainant argues that Saw's practice of under-reporting is demonstrated by a drop in its lost workday injury and illness (LWDII) rate from 9.6 in 1996 to reported rates of 2.7, 3.1 and 4.2 in the following years, 1997, 1998, and 1999. Complainant points out that Saw's witnesses can recall no significant changes that would have impacted safety at the Saw plant during 1997 and the following years, and cannot account for the dramatic drop in the LWDII during that time. Complainant's witnesses, on the other hand, testified that they believed the drop in the rate was the result of deliberate under-reporting of minor injuries pursuant to policy developed by Gary Jones. Complainant argues that its theory explains Jones' deliberate decision not to record injuries suffered by temporary laborers, and his decision to change Saw's Standard Industrial Classification (SIC) code in 1998.

Saw maintains that the drop in the LWDII, the failure to record minor reportable injuries and injuries to temporary workers, and the change in Saw's SIC code were all attributable to unrelated misinterpretations of OSHA requirements. Saw argues that any and all misinterpretations of OSHA requirements were made in good faith. At no time did Saw intend to circumvent an OSHA inspection.

Facts

Charles Kutan is currently the production planning manager for Saw (Tr. 257). Kutan was originally hired in June 1995 to serve as Saw's human resources and safety director (Tr. 257-58). Kutan testified that, in that position, it was his responsibility, in addition to dealing with personnel issues, to investigate accidents and to maintain the OSHA 200 logs (Tr. 261). Kutan stated that he maintained the logs until mid-1997 (Tr. 261). According to Kutan, his experience prior to 1995 was in shipping (Tr. 267). In order to fulfill his new safety duties at Saw, he had to familiarize himself with OSHA regulations regarding recordkeeping by conferring with Saw's Workman's Compensation carrier, and by reading OSHA publications, including the 200 form and the Blue Book (Tr. 267-68; Exh. C-278). Kutan testified that it was his practice to list recordable injuries on the OSHA 200 as they occurred (Tr. 266). Robert Whitmore, chief of OSHA's division of recordkeeping requirements, testified that in 1996 Charles Kutan submitted an LWDII rate of 9.6 on the 1996 OSHA 196 Summary form, based on information contained in 1996 OSHA 200, the only complete year for which Kutan maintained the 200 form (Tr. 305).

Prior to joining Saw, **Gary Jones,** who is an attorney, was employed for 19 years as the employee relations representative at Brown & Root. As part of his job duties at Brown & Root, Jones dealt with a number of governmental agencies, including OSHA. He attended safety seminars, met with OSHA investigators, and responded to OSHA complaints (Tr. 182). During his tenure with Brown & Root, Jones occasionally reviewed the OSHA 200 logs (Tr. 200). He was familiar with the Blue Book (Tr. 200-01).

Jones took over as director of human relations at Saw in July 1997 (Tr. 181). Jones also acted as Saw's safety director, and his duties included ensuring compliance with OSHA reporting requirements (Tr. 206-07). In August 1997, Jones hired Ronnie Johnson to act as safety manager for Saw (Tr. 208). Jones testified that he chose Johnson because he was a medic, and was familiar with OSHA regulations (Tr. 208). Jones testified that he considered the OSHA 200 log to be Johnson's responsibility; however, at some point Jones became aware that Johnson was not keeping the log. Jones testified that, together, he and Johnson brought the log up to date (Tr. 209, 213). Jones testified that he never again consulted with Johnson about the recordability of any particular injuries (Tr. 215). According to Jones, Johnson completed and certified the 1997 OSHA 200 logs (Tr. 214; Exh. R-1). Jones, however, completed and certified the OSHA Form 196 Summary for 1997 (Tr. 207; Exh. C-276, p. 3). The LWDII rate Jones submitted for 1997 was 2.7 (Tr. 305).

Robert Murphey, who replaced Johnson as safety manager in 1998, testified that he was familiar with OSHA regulations and standards, including the Blue Book (Tr. 65). As Saw's safety

manager, he was responsible for responding to accidents and injuries and for maintaining the OSHA 200 logs (Tr. 65, 116). Though Murphey reported directly to Jones, he testified that Jones did not instruct him in the correct means of completing the logs (Tr. 64, 111, 216). As noted above, Murphey used the nurse's sign-in logs and accident and incident reports to assure the accuracy of the OSHA 200 log (Tr. 112). Murphey stated that he made every attempt to follow up on accidents and incidents at the Saw facility in order to ascertain whether all recordable injuries had been reported (Tr. 139-40). Murphey maintained that if he failed to record an injury, it was either because the nurse failed to turn over forms specifying medical treatment or work restrictions, or because supervisors failed to turn in accident reports (Tr. 124-126). Murphey completed and certified the OSHA 200 logs for 1998 and 1999, and kept the logs for the first part of 2000 (Tr. 98, 106-107, 111). Mr. Murphey was aware that LWDII rates were used to target OSHA inspections, though he did not know exactly what rates would trigger an inspection (Tr. 131). The LWDII rates for 1998 and 1999 were 3.1 and 4.2, respectively (Tr. 305). During the first half of 2000, Saw's LWDII rate was 0 (Tr. 305).

Craig Wetherington was hired in May 1998 to act as the safety director for Jindal Steel, a plate steel manufacturing facility located on the same 59 acre tract which houses Saw; both were part of an older USX steel mill facility (*See, Secretary v. Jindal United Steel Corp. (Jindal),* Docket No. 00-2231 [petition for discretionary review pending before the Commission] Tr. 583).[1] Jindal produces the plate steel which Saw uses for producing pipe. The two companies share some common ownership; Saw Pipes holds stock in Jindal (*Jindal,* Exh. A, pp. 141, 595). Wetherington was told when he was hired that Jones was the administrator of the safety program for both Jindal and Saw pipes (*Jindal,* Exh. A, pp. 66, 126), and that he had dual responsibility to both Jindal's production manager and to Gary Jones (*Jindal,* Exh. A, pp. 49, 66-67, 76, 98-99, 113). Wetherington stated that Jones instructed him not to record any injuries which were not also reported to Texas Workers' Compensation (*Jindal,* Exh. A, pp. 65, 68, 77-80). Jones also specifically told Wetherington that injuries suffered by temporary laborers would be reported by the agency through which the laborer was employed, and that Wetherington was not to report those injuries (*Jindal,* Exh. A, p. 74). Wetherington testified that when he told Jones this did not conform to OSHA reporting guidelines; Jones told him he interpreted the guidelines differently (*Jindal,* Exh. A, pp. 74, 93). As a result, Wetherington did not report any injuries to temporary laborers; he did not do any follow up on temporary employees who had been injured (*Jindal,* Exh. A, p. 81). Wetherington testified that he

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[1] Pursuant to the joint motion of the parties portions of the *Jindal* transcript were admitted and made part of this record by this judge's January 18, 2002 Order. Prior testimony from *Jindal* is labeled Exhs. A through J.

filled out the OSHA 200 forms in accordance with instructions provided him by Gary Jones (*Jindal,* Exh. A, p. 68), but told Jones he did not believe the 200 log was being filled out correctly. Jones told Wetherington that he interpreted OSHA regulations differently and that if Wetherington didn't want to record injuries according to his interpretation, Wetherington could find another job (*Jindal,* Exh. A, pp. 68-69, 555). Wetherington believed that Jones' intent was to misrepresent the number of accidents at the plant in order to evade inspections by OSHA by reporting a low LWDII (*Jindal,* Exh. A, pp. 109-10, 115-116).

Ronnie Johnson testified that Gary Jones maintained the OSHA 200 logs while he was employed at Saw (*Jindal*, Exh. E, p. 401). Johnson stated that he was aware that otherwise recordable injuries were not being recorded on the OSHA 200 logs in an attempt to keep the numbers down (*Jindal*, Exh. E, pp. 396, 402-03). According to Johnson, Jones would not record an injury if Saw paid the injured employee's medical costs in house rather than submitting a Workman's Compensation claim (*Jindal*, Exh. E, pp. 395-96). In addition, Johnson testified, he knew that Jones was not recording otherwise recordable injuries if those injuries were suffered by temporary employees (*Jindal,* Exh. E, p. 397).

Carl Davis, the Director of Occupational Medicine for the Jacinto Medical Group in Baytown Texas (Tr. 399), testified that in October 1998 he became aware that the Jacinto Medical Group supervised the Licenced Vocational Nurse (LVN) from BayCoast Medical Center who ran Saw's on-site medical facility (Tr. 400-01). On or about October 28, 1998, Davis visited the Saw facility, where he met with the LVN, Helen Stipe, Gary Jones and Robert Murphey (Tr. 402). During that visit, Davis testified, Jones took him aside and informed him that Saw "did not have recordable injuries" (Tr. 403). Davis testified that he subsequently spoke with Jones two or three times a week (Tr. 406). During those conversations, Jones often criticized Davis' decisions to restrict employees' work activities (Tr. 405). Davis testified that Jones specifically asked him to not to place employees under work restrictions (Tr. 445-46). Specifically, Davis stated:

> Well, in the course of reporting patient status to Mr. Jones and in conversations we had when he would call me, Mr. Jones was, many times, critical of the fact that restrictions had been placed on the patients' work activity. Some of them were less than friendly. They were generally critical if any restriction had been placed. He, on more than one occasion, asked me to write "No restrictions." (Tr. 405).

In December 1998, Saw terminated its contract with BayCoast (Tr. 405).[2]

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[2] At the hearing, this judge disallowed Respondent's attempts to impeach Dr. Davis' credibility by introducing evidence of a professional disciplinary action that involved neither Saw, nor any Saw employees. Such evidence was deemed irrelevant and prejudicial (Tr. 434-35, 442). In an effort to circumvent this judge's ruling, Saw has attached to its brief documents detailing actions taken by the Texas State Board of Medical Examiners in 1999

Robert Whitmore testified that OSHA's programmed inspections are based on employer LWDII rates (Tr. 364). The OSHA Occupational Injury and Illness Data Collection form, which is mailed to employers, including Saw, informs those employers that the injury an illness data collected from them "will be used to focus OSHA activities" including inspections (Tr. 365; Exh. C-274, p. 2, C-275, p. 2). The formula OSHA uses for targeting inspections changes frequently. For instance, in 1998, OSHA targeted employers for inspection if the employer's 1996 LWDII rate exceeded the average for its Standard Industrial Classification (SIC) code (Tr. 341). In 1999 OSHA used data from employers' 1997 OSHA form 196 injury summaries (Tr. 336). Employers with LWDIIs exceeding 16 were placed on OSHA's primary targeting list, while employees with LWDIIs between 10 and 16 were placed on the secondary list (Tr. 337,-339). In 2000, inspections were planned for employers reporting an LWDII of over 14 on their 1998 injury summaries (Tr. 330-31, 339). Employers reporting an LWDII between 8 and 14 were placed on a secondary list, and might or might not be inspected, depending on OSHA's workload (Tr. 331). Whitmore testified that in any given year, employers would not know what injury rate would trigger an inspection two years down the line (Tr. 340-41). However, employers with extremely low LWDII rates were "not even on [OSHA's] radar screen" (Tr. 364). According to Whitmore, OSHA has not targeted an employer with an LWDII of less than 4.6 since its inception,(Tr. 433-44).

SIC Codes. During 1995 and 1996, while Charles Kutan kept the OSHA logs, Saw listed its SIC code as 3317 Steel Pipe and Tubes (Tr. 269-70, 308; Exh. C-276, C-300). The description of the 3317 industrial code is: "Establishments primarily engaged in the production of welded or seamless steel pipe and tubes and heavy riveted steel pipe from purchased materials." Examples of the manufactured product include "pipe seamless steel-mfpm." (Exh. C-300). Charles Kutan testified that Saw was, and is, in the business of producing welded line pipe (Tr. 272). Kutan could not recall specifically telling Gary Jones Saw's SIC code, but stated that he would have shown him the paperwork, including the OSHA summaries on which the 3317 SIC code was set forth (Tr. 271, 293). Mr. Whitmore testified that during his formal interview with Dilip Bhargava, Saw's then president and CEO (Tr. 172), Bhargava told him that he believed that Saw fell under the 3317 industrial code (Tr. 391).

Whitmore testified that, in 1998, OSHA attempted to conduct a programmed inspection of Saw's facility based on Saw's 1996 LWDII rate, which at 9.55 exceeded the industry average of 5.6 for SIC 3317 (Tr. 308-09, 317-318). Gary Jones turned the OSHA inspectors away, claiming that

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(Saw's post hearing brief, Exh. D, E and F). Submission of those exhibits violates the spirit of this judge's ruling; Exhs. D, E and F are, therefore, stricken from the record and will be removed from Saw's brief.

Saw's SIC code was not 3317, but 3443 (Tr. 202-204, 232, 315, 318).[3] The description for SIC code 3443 Fabricated Plate Work (Boiler Shops) is: "Establishments primarily engaged in manufacturing power and marine boilers, pressure and nonpressure tanks, processing and storage vessels, heat exchangers, weldments and similar products, by the process of cutting, forming and joining metal plates, shapes, bars, sheet, pipe mill products and tubing to custom or standard design, for factory or field assembly." (Exh. C-301). Chuck Kutan testified that Saw never manufactured boilers, pressure or non-pressure tanks, heat exchangers and/or weldments (Tr. 272-273). Saw claims the 3443 classification was made in good faith, based on a bullet on the bottom of a second page listing possible sample products which includes "Pipe, large diameter: metal plate-made by plate fabricators." Though Saw does fabricate large diameter pipe from steel plates, Saw does not fabricate metal plate. All its plate is purchased (Tr. 110). Whitmore testified that no reasonable person could have believed that 3443 was the applicable SIC for Saw (Tr. 349-50).

Temporary employees. Saw admits that injuries suffered by temporary employees were not recorded on its OSHA 200 Logs or figured into its LWDII rates.

Robert Murphey testified that he consulted the Blue Book (Tr. 132), which states in relevant part:

> If [a temporary laborer is] subject to the supervision of the using firm, the temporary help supply service contractor is acting merely as a personnel department for the using firm, and the using firm must keep the records for the personnel supplied by the service. If the temporary workers remain subject primarily to the supervision of the supply service, the records must be kept by the service. In short, the records should usually be kept by the firm responsible for the day-to-day direction of the employee's activities.

(Exh. C-278, p. 24). Murphey, however, testified that he believed injuries to temporary workers were recorded by Labor Ready, the personnel agency that supplied Saw's temporary laborers, because the Labor Ready representative, Gary Young, once asked him for a blank 200 log (Tr. 97-98, 110, 122).

Murphey also testified that he read the instructions for filling out the OSHA injury and illness data collection form in 1998 and 1999 (Tr. 135). The form asks employers to "**Tell us about your employees and the hours they worked.**" The form directs the employer to estimate its average number of employees by "[adding] together the number of employees your establishment paid in every pay period during 1998 [and 1999]. Include all employees: full time, part time, temporary, seasonal, salaried and hourly," and divide the answer by the number of pay periods (Exh. C-274, C-275, p. 3). The form goes on to ask how many hours employees actually worked during the relevant years and

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[3] Robert Murphey claimed not to be familiar with SIC codes, but testified that when he was hired, and again in 1998 when Gary Jones turned the OSHA inspectors away, he was told Saw's SIC code was 3443 (Tr. 102-05).

directs the employer to "[i]nclude hours worked by salaried, hourly, part-time and seasonal workers, as well as hours workers subject to day to day supervision by your establishment (e.g. temporary help service workers) (Exh. C-274, C-275, p. 3). Murphey stated that he either "missed that part," or "just didn't get [it] down." (Tr. 136).

Saw argues that Murphey was not the only one who misunderstood the reporting requirements. Labor Ready, the staffing agency that provided laborers for Jindal Steel kept its own OSHA 200 log for laborers supervised by Jindal (*Jindal*, Exh. C, pp. 231-32, 562). In addition, after reviewing Chapter IV of OSHA's Blue Book, Gary Jones advised Jindal's safety manager, Craig Wetherington, not to record injuries to temporary laborers. Though Wetherington told Jones that he believed injuries suffered by temporary employees *were* recordable, Jones insisted that such injuries should be recorded by the staffing agencies that provided the laborers (*Jindal,* Exh. A, pp. 221-22; *Jindal*; Tr. 561-62, 588-90).

<u>*Discussion*</u>

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." *Valdak Corp.*, 17 BNA OSHC 1135, 1136, 1993-95 CCH OSHD ¶30,759, p. 42,740 (No. 93-239, 1995), *aff'd,* 73 F.3d 1466 (8th Cir. 1996). Moreover, a series of disparate violations may be found to be willful if there is evidence that such violations are part of a deliberate pattern, practice, or course of conduct. *See, Kaspar Wire Works, Inc. (Kaspar),* 18 BNA OSHC 2178, 2000 BNA OSHC ¶32,134 (No. 90-2775, 2000), *appeal filed*, No. 00-1392 (D.C. Cir. Sept. 26, 2000).

The Secretary maintains that Saw engaged in a deliberate pattern of under reporting in order to avoid being targeted for OSHA inspection. Saw maintains that the evidence in the record is insufficient to demonstrate Saw's motives, arguing that neither Gary Jones nor Robert Murphey knew or could have predicted the criteria OSHA would be using to target specific industries in any given year. However, any safety and health officer who knows that employers' LWDII are used to target inspections, would also know that an employer's chances of being inspected are reduced if it produces an extremely low LWDII. In any event, the Commission has held that he Secretary need not show that the employer had an evil or malicious motive to show willfulness. In other words, Complainant needn't prove *why* Saw engaged in the demonstrated practice of under-reporting. "The state of mind required for a willful violation need be only knowing, voluntary, or intentional." *Id.* at 2183-84. Complainant need only show that the demonstrated practice of under-reporting was deliberate. During the relevant time period, Saw failed to record 63.7% of all reportable cases on its OSHA 200. Of those

cases that were reported, 40.6% were erroneously listed as involving no lost or restricted work days.[4] The sheer number of unreported injuries in this case cannot be explained by simple negligence. Those numbers, when viewed in light of the testimonial evidence, discussed more fully below, are sufficient to establish that the comprehensive under-reporting of injuries and lost workdays in this case was knowing and intentional and, therefore, willful.

Charles Kutan was hired in 1995 to act as Saw's human resources and safety director. Though Kutan had no prior training in safety and health, and though he had dual responsibility for human relations and safety, Kutan managed to correctly determine Saw's SIC code, and to record injuries as they occurred. A month after Gary Jones took over as human resources director in 1997, he was able to hire a safety director, first Ronnie Johnson and then Robert Murphey, with whom he could effectively split the duties that Kutan previously handled alone. Jones, Johnson and Murphey all had considerable safety and health experience. They inherited a pre-existing reporting system under which plant managers and supervisors were to report injuries and accidents to the safety director. Additional procedures, which should have increased reporting accuracy, were instituted. An on-site clinic was established, where a Licenced Vocational Nurse (LVN) could evaluate injuries, and provide limited treatment. The on-site nurse kept a sign-in log, which the safety manager could use to double check his OSHA log. When injured employees were seen by a physician, Return To Work (RTW) forms detailing employees' work restrictions were faxed to Saw from the off-site clinic. Despite the increase in the number and expertise of safety personnel, however, the timeliness and accuracy in recording injuries plummeted after Jones took over the management of Saw's safety department. Neither Jones nor Saw provided any explanation for the drop in the LWDII on Saw's 1997 OSHA 196 summary, which was 2.7, down from 9.55 the year before. Reporting accuracy did not improve when Robert Murphey took over responsibility for the logs in May 1998. Though Murphey claimed to have made every attempt to follow up on accidents and incidents at the Saw facility in order to ascertain whether all recordable injuries had been reported, and maintained that he used available accident reports and the sign in logs from the on-site infirmary to ensure the accuracy of the OSHA 200 logs, injuries and lost workdays continued to be under-reported. LWDII rates of 3.06 and 4.18 were submitted for 1998 and 1999, respectively.

Given the reporting system available to Murphey, this judge cannot credit Saw's contention that he did not possess *actual* knowledge, either of the occurrence, or of the extent, of cited employee injuries. First, Saw points out that Murphey "relied heavily" on accident reports submitted from first

[4] These percentages reflect all injury cases occurring between January 1998 and mid-2000, adjusted to conform to this judge's ruling on the contested items as set forth above.

line supervisors, reports which Saw maintains were infrequently filled out. Saw further argues that there was not enough information on the accident forms returned from the off-site clinic for Murphey to make a determination of recordability. Finally, Saw argues that the nurses' log, on which Murphey also relied, was incomplete and failed to provide Murphey with notice of cited injuries. Saw's arguments fail because, though there were lapses in reporting, there were so many redundancies in the way injuries were reported at Saw, it would have been impossible for almost *two thirds* of reportable injuries to go unrecognized by the safety manager. For instance, Saw's justifications do not explain Murphey's failure to record:

Item 22. On September 28, 1998 Myron Ferguson suffered a laceration to his thumb. His supervisor filled out an incident report (Exh. C-60). Nurse Stipes saw Ferguson on-site, and after dressing the wound she referred him to BayCoast emergency. In her clinical notes Stipes noted "considerable" bleeding (Exh. C-61). The clinic log clearly reflects that Mr. Ferguson was sent to the emergency room (Exh. C-248, p. 4). Ferguson's wound was sutured, and his treatment was listed on the RTW form generated by BayCoast for Saw (Exh. C-62, p. 6). In this case, there was an incident report, a log entry indicating a referral to the emergency room and an RTW form stating that sutures, recordable medical treatment had been provided (Exh. C-278, p. 43). It is difficult to conceive how Murphey's failure to report this injury could have been anything other than intentional.

Item 40, Alan Edgar suffered a probable 2nd degree burn on March 22, 1999. Edgar reported the injury to Murphey on March 24; Murphey treated Edgar's burn for two days before taking him to the on-site clinic on March 26, after which Saw's nurse, Helen Stipe, treated the burn with repeated applications of a prescription antiseptic ointment (Exh. C-118). The log from the on-site clinic lists three visits by Alan Edgar; each listing contains a description of his injury and the medical treatment received (Exh. C-249, p. 5).

Saw is correct in stating that there was no accident report filed in this case. However, Murphey had actual knowledge of this injury, having treated the victim himself and taken him to the clinic nurse. He had access to the log, which details multiple repeat visits to the clinic for antiseptic dressings. The Blue Book clearly states that the "[a]pplication of **ANTISEPTICS** during second or subsequent visit to medical personnel" is recordable (Exh. C-278, p. 43). Saw's explanations do not account for Murphy's failure to record this item.

Item 42, On April 2, 1999 Jose Garza suffered 1st and 2nd degree burns to his shoulder. Bob Murphey treated the injury before sending Garza to the on site clinic. Garza also visited the OccuCare clinic, where an accident report was generated, indicating that the burns were diagnosed as 3rd degree. Ms. Stipe continued to administer repeated applications of antiseptics until April 8 (Exh. C-121, C-

122). Five separate visits to the on site clinic are listed in the clinic log; the record of each visit includes a description of the injury and the treatment administered (Exh. C-249, p. 6).

As in item 40, Murphey was shown to have actual knowledge of the unrecorded injury. Although the Blue Book clearly states that the "[a]pplication of **ANTISEPTICS** during second or subsequent visit to medical personnel" is recordable (Exh. C-278, p. 43), Murphey inexplicably failed to record this injury.

Item 51. On August 9, 1999 Reyes Garcia suffered a severe contusion to his right shin. Robert Murphey applied an ice pack to the site for 20 minutes before sending Garcia to the on-site clinic, where an additional ice pack was applied (Exh. C-142). After returning to work three days later, Garcia returned to the clinic no less than eight times for repeated treatments with ice and heat packs (Exh. C-142, C-249, p. 10). Each of the eight entries on the clinic log refers to both the shin injury and the treatment provided (Exh. C-249, p. 10).

Again, Murphey had first hand knowledge of the occurrence of this injury, and the nurses log clearly details the course of Mr. Garcia's treatment. The Blue Book clearly states that the "application of hot or cold **COMPRESS(ES)** during second or subsequent visit to medical personnel" is recordable medical treatment (Exh. C-278, p. 43). Yet Murphey failed to record this item.

The evidence establishes by a preponderance of the evidence that Murphey had actual knowledge of each of the clearly recordable injuries discussed above. This judge can only conclude that his failure to record these injuries was intentional. The Secretary made no attempt to prove that each of the cited items demonstrates such patent indicia of willfulness, and this judge declines to examine each instance for such evidence. Because the Secretary has alleged a single pattern of under-reporting, this sampling of clearly recordable injuries, of which Murphey had first hand knowledge, and yet failed to record is material evidence that Saw engaged in a deliberate practice of under-reporting.

Saw's intentional failure to record injuries sustained by temporary laborers is also evidence of an intentional practice of under-recording. Saw argues that its practice reflected its employees' good faith misinterpretation of the OSHA guidelines referring to temporary workers, and so cannot, as a matter of law, be found willful. However, though it is true that a finding of willfulness is not justified where the employer had a good faith opinion that the violative conditions conformed to the requirements of the cited standard, the Commission has held that the test of good faith for these purposes is an objective one. The employer's belief concerning a factual matter, or as here, concerning the interpretation of a standard, must have been reasonable under the circumstances. *Calang Corp.*, 14 BNA OSHC 1789, 1987-90 CCH OSHD ¶29,080 (No. 85-319, 1990). In this case it is abundantly

clear that the temporary labor contractor with whom Saw dealt acted merely as a conduit to provide labor for Saw. Saw was responsible for the day-to-day direction of the employees' activities. According to the plain language of the Blue Book, Saw was the firm responsible for keeping the required OSHA injury and illness records. The fact that the temporary agency also recorded injuries sustained by its temporary workers did not affect Saw's duty under the standard. For Jones, who is an attorney, and who worked in the employee relations and compliance department at Brown & Root before joining Saw Pipes, to have interpreted the Blue Book in any other way is not only unreasonable, but incredible. Moreover, the record establishes that Jindal's safety manager, Craig Wetherington, was not only knowledgeable in safety and health matters but specifically told Jones that the supervising employer had a duty to record such injuries. Jones not only ignored Wetherington, but instructed him to continue under-reporting Jindal's injuries or risk losing his job. Wetherington's testimony describes Jones' dealings with Jindal's safety personnel, but is strong evidence of state of mind, and of his bad faith in dealing with OSHA. Finally, Robert Murphey's claim to have "missed" those portions of the OSHA forms that clearly instructed him to include temporary workers in his calculations is no more believable than Jones' misinterpretation of OSHA regulations and is not credited.

Lastly this judge finds that Jones' inexplicable change of Saw's SIC code to the code for boiler shops constitutes additional evidence of bad faith. After reading the relevant SIC definitions, this judge agrees that no reasonable person, and certainly not a professional with Jones' experience in safety and health, could have believed that 3443 was the applicable SIC for Saw. Even if Saw is correct in arguing that Jones could not have known that changing the SIC code would affect the likelihood of an OSHA inspection, the fact remains that Jones actually turned an OSHA inspector away in 1998 on grounds that OSHA had the wrong SIC code.

This judge credits the testimony of complainant's witnesses, Craig Wetherington and Carl Davis, both of whom concluded, based on their dealings with Gary Jones, that Saw was pursuing a course of conduct intended to reduce the number of injuries reported to OSHA. Those witnesses have no stake in the outcome of this matter, and this judge finds their testimony compelling. When viewed together with the percentage of unrecorded injuries occurring during the relevant time periods, and the clear recordability of a number of those injuries, this judge can only conclude that Saw's failure to report and under-reporting of injuries was part of a pattern of deliberate, *i.e.* willful conduct.

Penalty

While the Secretary has often exercised her authority to group related violations and propose a single penalty for a number of related violations, she chose not to do so in this case. Rather the violations were assessed individually, at $8,000.00 apiece, resulting in an aggregate penalty of

$536,000.00. While it is clear that the Secretary may propose multiple penalties for separate violations of the recordkeeping standard, Commission review of the proposed penalty is *de novo,* and the judge has discretion to assess a single penalty if deemed appropriate. *See, Pepperidge Farm, Inc.*, 17, BNA OSHC 1993, 1997 CCH OSHD ¶31,301; *citing, Miniature Nut and Screw Corp.* 17 BNA OSHC 1557, 1996 CCH OSHD ¶30,986 (No. 93-2535, 1996).

Complainant's departure from grouping similar violations results in an aggregate penalty that is disproportionate to the violation and overstates its gravity. The record demonstrates that Complainant did not base the gravity of Saw's under-reporting on the severity of the actual unreported injuries, which consist mainly of minor burns, contusions and foreign bodies in the eye. Rather Complainant argues that the gravity of the violation was high because Saw attempted to avoid inspections by falsely reducing its LWDII. However, the record does not clearly establish that Saw would actually have been inspected had it reported all injuries. A review of the safety violations, which, unlike record keeping violations, pose actual safety hazards to affected employees, does not indicate that this employer was attempting to cover up serious safety hazards by deferring OSHA inspections. In fact, for safety violations found at Saw's facility during the July 2000 inspection, OSHA proposed penalties of only $82,000.00, less than 16% of the penalties assessed for the record keeping violations.

In addition, at the hearing Complainant advanced the theory that Saw engaged in a single pattern and practice of willful non-reporting. Complainant argues that having generally established such a pattern, it follows that all unrecorded and under-recorded violations were willful. Complainant made no attempt to prove that Saw willfully failed to record each individual injury. The evidentiary path chosen by Complainant was considerably less onerous than showing willfulness in each and every instance. While choosing to make a single showing of a pattern and practice of under-reporting, Complainant nevertheless seeks to have each instance of under-reporting assessed individually, as though she had proved that Saw possessed a willful state of mind in each instance.

Taking these factors into account, I find that a more appropriate penalty would be reached by grouping all record keeping instances into a single violation with a single penalty.

While the individual injuries Saw failed to record were not serious, and though Saw did not appear to be shielding a large number of safety violations by under reporting, the gravity of Respondent's under-reporting was nonetheless high. In this case, Saw crossed the line from simple non reporting to attempting to influence work restrictions ordered by Dr. Davis. Work restrictions not only make an injury reportable, but, more fundamentally, are physician's orders that embody medical treatment, containing orders necessary for the patient's recovery. To urge a physician to limit or refrain from issuing work restrictions interferes with the patient's medical treatment and intrudes on

the doctor/patient relationship. Saw, through Gary Jones, attempted to influence medical treatment to shield itself from inspections. I do not find it relevant that Dr. Davis did not yield to Saw's pressure, or that specific employees were not identified. I find that the gravity of this violation is, therefore, high and the statutory maximum penalty of $70,000.00 is appropriate.

ORDER

1. Wilful citation 1, items 1 through 16, alleging violation of §1904.2(a), are AFFIRMED.
2. Citation 1, item 17, alleging violation of §1904.2(a), is VACATED.
3. Wilful citation 1, items 18 through 20, alleging violation of §1904.2(a), are AFFIRMED.
4. Citation 1, item 21, alleging violation of §1904.2(a), is VACATED.
5. Wilful citation 1, item 22, alleging violation of §1904.2(a), is AFFIRMED.
6. Citation 1, item 23, alleging violation of §1904.2(a), is VACATED.
7. Wilful citation 1, items 24 through 26, alleging violation of §1904.2(a), are AFFIRMED.
8. Citation 1, item 27, alleging violation of §1904.2(a), is VACATED.
9. Wilful citation 1, item 28, alleging violation of §1904.2(a), is AFFIRMED.
10. Citation 1, item 29, alleging violation of §1904.2(a), is VACATED.
11. Wilful citation 1, items 30 through 33, alleging violation of §1904.2(a), are AFFIRMED.
12. Citation 1, item 34, alleging violation of §1904.2(a), is VACATED.
13. Wilful citation 1, items 35 through 43, alleging violation of §1904.2(a), are AFFIRMED.
14. Citation 1, item 44 alleging violation of §1904.2(a), is VACATED.
15. Wilful citation 1, items 45 through 62, alleging violation of §1904.2(a), are AFFIRMED.
16. Citation 1, item 63, alleging violation of §1904.2(a), is VACATED.
17. Wilful citation 1, items 64 through 66, alleging violation of §1904.2(a), are AFFIRMED.
18. Wilful citation 1, item 67(1) through 67(7) alleging violation of §1904.2(a), are AFFIRMED.
19. Citation 1, item 67(8), alleging violation of §1904.2(a), is VACATED.
20. Wilful citation 1, items 67(9) through 67(14), alleging violation of §1904.2(a), are AFFIRMED.
21. Citation 1, items 67(15) and 67(16) alleging violation of §1904.2(a), are VACATED.
22. The violations affirmed are combined for purposes of assessing a penalty. A single penalty of $70,000.00 is ASSESSED.

/s/
James H. Barkley
Judge, OSHRC

Dated: May 30, 2002