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. SPIRIT HOMES, INC., Respondent.	OSHRC Docket Nos. 00-1807 & 00-1808

DECISION

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

BY THE COMMISSION:

As a result of an inspection of a mobile-home manufacturing facility operated by Spirit Homes, Inc. ("Respondent"), the Occupational Safety and Health Administration ("OSHA") issued citations to Respondent alleging that it had committed violations of the Occupational Safety and Health Act of 1970, 29 U.S.C. §§ 651-678 ("the Act"). Respondent contested the citations, and a hearing was held by Administrative Law Judge Ken S. Welsch. The Commission directed the judge's decision for review pursuant to section 12(j) of the Act, 29 U.S.C. § 661(j). The only issue before the Commission is whether Respondent's violation of 29 C.F.R. § 1910.135(a)(1) was properly characterized by the judge as willful. For the reasons that follow, we find that the Secretary failed to prove that the violation was willful. We affirm the violation as serious, and assess a penalty of $5,000.

Background

Respondent manufactured mobile homes on an assembly line at its now-closed facility located in Conway, Arkansas. At some of the work stations along the assembly

line, scaffolds were placed around the mobile home that was being constructed. Employees worked from the scaffolds and also from the roofs of the mobile homes. Employees working on the scaffolds and roofs used various materials and tools such as plywood, roofing paper, shingles, hammers, saws, wrenches, drills, scissors, pneumatic air guns, and staple guns. While these employees were on the roof, other employees were working below, both in the interior and on the exterior of the mobile homes.

On May 12, 1999, about nine months prior to the subject inspection, OSHA issued Respondent a citation for a violation of 29 C.F.R. § 1910.135(a)(1). That standard provides: "The employer shall ensure that each affected employee wears a protective helmet when working in areas where there is a potential for injury to the head from falling objects." Specifically, the citation alleged that employees working below the scaffolds were exposed to objects falling from the work platform. The record shows that after receiving the 1999 citation, which was ultimately resolved pursuant to a settlement agreement, Respondent made efforts to eliminate the hazard of falling objects. Respondent installed several devices on the scaffolds, such as toeboards and guardrails. Respondent also provided employees with tool belts and assigned an employee to the scaffold to secure tools and materials. In addition, Respondent instituted changes to its production process by requiring employees to cut materials to size before taking them on the roofs.

On February 28, 2000, OSHA began the subject inspection of Respondent's facility. During the inspection, the compliance officers observed employees working under scaffolds and roofs of mobile homes without hardhats while other employees worked above them with tools and materials. Based on these observations, OSHA issued Respondent a citation alleging a violation of section 1910.135(a)(1). The Secretary characterized the violation as willful based on Respondent's violation of the same standard a year earlier, and Respondent's failure to require its employees to wear protective helmets when exposed to overhead hazards. The Secretary proposed a $70,000 penalty.

The judge affirmed the hardhat violation as willful. He found that because

Respondent knew of the requirements of the standard, the violation was willful "even if [Respondent] has a good faith belief that its own approach provides protection at least equivalent to OSHA's requirements." He also concluded that Respondent's "attempts to reduce the overhead hazard without complying with the standard were not shown to be adequate or effective." The judge assessed a penalty of $50,000 for the hardhat violation.

Discussion

We find that the judge erred in characterizing the hardhat violation as willful. 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 Enterp., Inc.*, 13 BNA OSHC 1249, 1256, 1986-87 CCH OSHD ¶ 27,893, p. 36,589 (No. 85-355, 1987). *See also Am. 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, 1999 CCH OSHD ¶ 31,792, p. 46,591 (No. 96-0265, 1999) (citations omitted). It is well established that a willful charge is not justified if an employer has made an objectively reasonable, good faith effort to comply with the 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, 1986-87 CCH OSHD ¶ 27,860, p. 36,478 (No. 81-263, 1987); *Asbestos Textile Co., Inc.*, 12 BNA OSHC 1062, 1063, 1984-85 CCH OSHD ¶ 27,101, p. 34,948 (No. 79-3831, 1984); *Mobil Oil Corp.*, 11 BNA OSHC 1700, 1701, 1983-84 CCH OSHD ¶ 26,699, pp. 34,124-25 (No. 79-4802, 1983) ("That the supervisor's measures were not as effective or complete as conceivable cannot be disputed, but they do not show indifference to employee safety, particularly since there was infrequent exposure and moderate risk.").

Here, there is no dispute that the Respondent was aware of the requirements of the standard, and failed to comply with those requirements. But the Secretary cannot rely on the mere existence of a violation to establish willfulness. *Hartford Roofing Co.*, 17 BNA

OSHC 1361, 1363, 1995-97 CCH OSHD ¶ 30,857, p. 42,933 (No. 92-3855, 1995) ("[T]he mere existence of prior violations do not establish that a violation was willful….there must be other evidence to support a finding of willfulness) (citation omitted); *Wright & Lopez, Inc.*, 8 BNA OSHC 1261, 1265, 1980 CCH OSHD ¶ 24,419, p. 29,777 (No. 76-3743, 1980) (citation omitted) (knowledge of a standard and a subsequent violation do not in themselves prove a willful violation). Based on the record, we find that the Secretary has failed to establish that Respondent's efforts to eliminate the overhead hazard, while unsuccessful, were so unreasonable that the company's state of mind was one of conscious disregard or plain indifference. *Beta Constr. Co.*, 16 BNA OSHC 1435, 1444-45, 1993-95 CCH OSHD ¶ 30,239, pp. 41,652-53 (No. 91-102, 1993), *aff'd without published opinion*, 52 F.3d 1122 (D.C. Cir. 1995) (citation omitted) ("An employer's unsuccessful efforts to prevent a violation are sufficient to demonstrate that the employer's state of mind was not one of disregard or indifference so long as the employer acted in an objectively reasonable manner.").

As shown in photographs in the record of the assembly line at Respondent's facility – including those photographs cited by the dissent – Respondent installed toeboards and guardrails on all the scaffolds to prevent any unsecured tools and roofing materials from being knocked off the scaffold. Respondent also reduced the presence of unsecured tools on the roofs by providing and requiring all employees to wear tool belts to secure any tools not being used. The photographs demonstrate that employees were in fact wearing these tool belts and using them to secure tools. Respondent also assigned an employee to the scaffold in a housekeeping effort to limit the number of unsecured tools and materials on the roof. In addition, Respondent instituted changes in the production process that eliminated the practice of taking large rolls of roofing paper, sheets of decking, and rolls of electrical wire onto the roof. Instead, roofing materials were cut to size before being taken onto the roof to be installed. Finally, after the subject inspection, Respondent also mounted "flip-out extensions" or "wings" on the guardrails of the scaffolds which nearly eliminated the gap between the roof and the scaffold. *See Access Equip. Sys., Inc.*, 18 BNA OSHC 1718, 1728, 1999 CCH OSHD ¶ 31,821, pp. 46,783-84

(No. 95-1449, 1999) (employer's good faith in response to citation at issue can be additional factor to take into account in determining willfulness).

We find nothing in the record to even suggest that these numerous effective measures were implemented by Respondent in a "half-hearted" manner so lacking in good faith and reasonableness as to establish willfulness.[1] *See Mobil Oil*, *supra* (significant measures to protect employees shows lack of intentional disregard or plain indifference to employee safety); *Beta*, *supra* (numerous measures to establish and implement procedures for safety monitoring were objectively reasonable and not so deficient as to constitute intentional disregard of standard's requirements or plain indifference to employee safety).

Our dissenting colleague argues that this case is analogous to *Morrison-Knudsen Co./Yonkers Contracting Co.*, 16 BNA OSHC 1105, 1993-95 CCH OSHD ¶ 30,048 (No. 88-572, 1993) ("*Morrison-Knudsen*"), in which the Commission held that the employer's efforts to eliminate the hazards associated with airborne lead were so "unreasonably limited" as to not satisfy the good faith standard. The stark deficiencies in the employer's efforts in *Morrison-Knudsen* were succinctly summarized in the intervening case of *Branham Sign Co.*, in which the Commission distinguished *Morrison-Knudsen* and found that the Secretary failed to establish willfulness based on the steps taken by the employer to eliminate the hazards:

> Among other things, the employer in *Morrison-Knudsen* did not have the proper facilities for cleaning and storing respirators to protect the employees from day-to-day accumulations of lead. Also, in disregard of its own safety program specifying that only approved respirators should be used, the employer fitted together components of two different respirator brands and could not establish that they met the requirements for approved

[1] We note that the judge also relied on a number of recorded head injuries to show that Respondent could not in good faith believe that its efforts had adequately eliminated the hazard. The record shows only two recorded head injuries during the relevant time period. We find no connection between these two head injuries and the cited hazard. One injury involved an employee who fell between the dock and the mobile home. The circumstances of the other head injury are not part of this record. Thus, neither injury provides a basis for finding a lack of good faith on Respondent's part.

> respirators. The safety program required protective clothing, but the employer did not provide it.

Branham Sign Co., 18 BNA OSHC 2132, 2135 n. 10, 2000 CCH OSHD ¶ 32,106, pp. 48,264-65 n. 10 (No. 98-752, 2000) (citations omitted). In contrast, Respondent's efforts to eliminate the hazards of falling objects were significantly more substantial relative to the risks to which the employees were exposed. *See Mobil Oil*, 11 BNA OSHC at 1701, 1983-84 CCH OSHD at pp. 34,124-25.

Our dissenting colleague additionally claims that Respondent's willful conduct is demonstrated by its "disregard" of its own fall protection plan. Similar to the cited standard, Respondent's protection plan states that the company will ensure employees wear hardhats when exposed to falling objects. As previously noted, Respondent's failure to comply with the hardhat standard is not in dispute here and without more, cannot be considered dispositive of willfulness. Similarly, a company's failure to comply with its own safety rule does not automatically establish a willful disregard of an OSHA requirement. *George Campbell Painting Corp.*, 18 BNA OSHC 1929, 1934, 1999 CCH OSHD ¶ 31,935, p. 47,390 (No. 94-3121, 1999). We see no basis to infer from Respondent's fall protection plan that the company held an unreasonable belief, lacking in good faith, that the overhead hazard could be adequately eliminated by implementing the numerous measures detailed above. As we have found, Respondent instituted not only the measures listed in its fall protection plan – such as toeboards and guardrails – but others not identified in the plan – such as tool belts, changes to the production process, and flip-out extensions. Such conduct belies the dissent's claims that the Respondent demonstrated disregard sufficient to prove willfulness.

We, therefore, find that the Secretary has failed to establish the violation was willful. We do, however, find the violation to be serious. Death or serious physical harm could result in the event of an accident.

Penalty

The Secretary proposed the maximum penalty of $70,000 for a willful violation which the judge reduced to $50,000. The Commission, pursuant to section 17(j) of the Act, 29 U.S.C. § 666(j), must give due consideration to four factors in assessing penalties: (1) the size of the employer's business, (2) the gravity of the violation, (3) the employer's good faith, and (4) the employer's prior history of OSHA violations. *See J.A. Jones Constr. Co.*, 15 BNA OSHC 2201, 2213-14, 1991-93 CCH OSHD ¶ 29,964, p. 41,033 (No. 87-2059, 1993). Respondent was a large employer with approximately 425 employees and had a prior history of OSHA violations. As to good faith, we believe that Respondent is entitled to credit based on the numerous changes instituted after both inspections.

The gravity of the violation is generally the principal element in penalty assessment. *See, e.g.*, *Orion Constr. Inc.*, 18 BNA OSHC 1867, 1999 CCH OSHD ¶ 31,896 (No. 98-2014, 1999), and cases cited therein. In evaluating the gravity of the violation, consideration is also given to other factors such as the number of employees exposed, duration of exposure, likelihood of injury, and precautions taken against injury. *J.A. Jones*, 15 BNA OSHC at 2214, 1991-93 CCH OSHD at p. 41,033. The record is not clear as to how many employees were exposed or for how long. Respondent did, however, take a number of precautions that lowered the likelihood of injury. Based on these factors, we conclude that a penalty of $5,000 for this serious violation is appropriate.

Order

Accordingly, the judge's decision affirming the violation of 29 C.F.R. § 1910.135(a)(1) as willful is reversed. The violation is affirmed as serious. A penalty of $5,000 is assessed.

SO ORDERED.

/s/
W. Scott Railton
Chairman

/s/
James M. Stephens
Commissioner

Dated: March 1, 2004

ROGERS, Commissioner, dissenting:

I respectfully dissent from my colleagues' decision to reverse the judge and affirm only a serious violation. Judge Welsch found that the violation of section 1910.135(a)(1) at issue here, for failing to ensure that affected employees wear head protection when exposed to potential head injuries, was willful. I would affirm the judge's finding.

The judge determined that Spirit Home Inc.'s ("Spirit") efforts to reduce or eliminate the overhead hazard "were not shown to be adequate or effective." I agree with Judge Welsch that Spirit's efforts to reduce the overhead hazard, after being cited previously, were incomplete. Indeed, in contrast to my colleagues, I do not believe that Spirit's efforts were objectively reasonable or that Spirit could have even had an objectively reasonable, good faith belief that its half-hearted efforts to reduce the overhead hazard were effective.

This case resembles *Morrison-Knudsen Co./Yonkers Contracting Co.*, 16 BNA OSHC 1105, 1123, 1993-95 CCH OSHD ¶ 30,048, p. 41,280 (No. 88-572, 1993) ("*Morrison-Knudsen*"), where the Commission found an employer's response to a hazard was "unreasonably limited." *Id*. at 1127, 1993-95 CCH OSHD at p. 41,284. In that case, the Commission found the violations at issue willful based in part on the company ignoring its own safety program while employees continued to fall ill from lead poisoning. *Id*. at 1126-27, 1993-95 CCH OSHD at p. 41,284-85. Here, in light of the previous citation less than ten months before for a violation of the same standard, under circumstances presenting a hazard of a similar nature, Spirit had a "heightened awareness" of its obligations under the standard. Its pre-existing record of head injuries also served to heighten its awareness of the danger of overhead hazards.[1]

[1] My colleagues argue that *Morrison-Knudsen* is distinguishable. I agree that Spirit's efforts to eliminate the hazard of falling objects exceeded those of Morrison-Knudsen to comply with the standards cited there and that the risks faced by the employees in *Morrison-Knudsen* were more grave. Nevertheless, the two cases are conceptually similar in that in determining willfulness, the Commission must engage in line-drawing to separate a willful violation from a serious violation. While Spirit is closer to that line,

Of particular relevance here, as in *Morrison-Knudsen*, is Spirit's own safety program, reflected in its fall protection plan. Spirit's fall protection plan notes that "[w]hen employees are exposed to falling objects, we ensure they wear hard hats and also implement" a variety of hazard reduction efforts such as toeboards, screens, canopies, or barricades. The safety program shows Spirit's recognition that its various hazard reduction efforts, standing alone, were unlikely to adequately reduce or eliminate the falling object hazard and that hard hats were also necessary. Yet Spirit disregarded its own safety program – in the face of its prior citation - thus differentiating its conduct from "[m]ere negligence or lack of diligence." *See American Wrecking Corp. v. Secretary of Labor*, 351 F.3d 1254, 1264 (DC Cir. 2003).[2]

My colleagues correctly note that "a company's failure to comply with its own safety rule does not *automatically* establish a willful disregard of an OSHA requirement," (emphasis added) *citing George Campbell Painting Corp.*, 18 BNA OSHC 1929, 1934, 1999 CCH OSHD ¶ 31,935, p. 47,390 (No. 94-3121, 1999) ("*Campbell*"). Of course, just as with the mere existence of a prior citation, such failure does not *automatically* establish willfulness, which depends on the total factual record. *Campbell*, however, is distinguishable based on lack of knowledge of the applicable standard. At issue in *Campbell* was whether the actions of two line supervisors, who may have disobeyed a company safety rule, were willful. If so, their actions were imputable to their employer. The Commission noted that there was no evidence that the supervisors involved were aware of the requirements of the cited OSHA standard. *Id.* In light of that lack of knowledge of the equivalence between the company safety rule and the OSHA standard, the Commission then concluded that disregard of the company's rule did not automatically establish willful disregard of an OSHA standard. *Id.* In addition, in

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in neither case did the employer make the kind of substantial efforts to comply - in the face of heightened awareness - that would be required to defeat willfulness.

[2] Spirit also disregarded its own plant industrial nurse, who had recommended to management that Spirit employees consider wearing hard hats. Her suggestion was not implemented.

Campbell, the safety rule at issue was broader than the cited standard. *Id.* at 1930, 1931 n. 7, 1999 CCH OSHD at pp. 47,386, 47,387 n. 7. Here, by contrast, as the majority concedes, there is no question that Spirit was aware of the requirements of the cited standard. In addition, Spirit's safety rule was similar to the cited standard.[3]

The photographs in the record, particularly exhibits C-62, C-65, C-66, and C-67, are especially compelling in showing a continuing exposure of Spirit's employees to falling objects, the predicate in its safety program for requiring the wearing of hard hats. These photographs clearly show the continued existence of an overhead hazard to employees without hard hats working below the scaffolds and roofs of mobile homes. The hazard is reflected in various unsecured tools and materials lying on the roof, and various work processes taking place on the roof, above employees without hard hats working immediately below. Indeed, the nature of this hazard is markedly similar to the hazard for which Spirit was cited the first time around – "the hazard of being struck by objects such as but not limited to hand tools . . . ."

These photographs also belie any notion that Spirit's efforts were either objectively reasonable or that Spirit had a reasonable, good faith belief that its efforts would adequately reduce or eliminate the hazard.[4] It is clear from the photographs that, in the words of the cited standard, "a potential for injury to the head from falling objects" remains, thus making hard hats mandatory. As the Commission pointed out in *Morrison-Knudsen*, "an unreasonable belief that abatement efforts were sufficient cannot constitute good faith." *Morrison-Knudsen*, 16 BNA OSHC 1127, 1993-95 CCH OSHD ¶ 30,048, p. 41,285. *See also Caterpillar, Inc.*, 17 BNA OSHC 1731, 1733, 1995-97 CCH OSHD ¶ 31,134, pp. 43,483-84 (No. 93-373, 1996), *aff'd* 122 F.3d 437, 441-42 (7th Cir. 1997).

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[3] My colleagues also cite to *Branham Sign Co.*, 18 BNA OSHC 2132, 2000 CCH OSHD ¶ 32,106 (No. 98-752, 2000). However, *Branham* is distinguishable because, in *Branham*, there was no evidence of prior citations. *Id.* at 2134, 2000 CCH OSHD at p. 48,263.

[4] While Spirit's installation of the "flip-out extensions" to reduce the gap between the roof and the scaffold is commendable, Spirit acted only after the inspection at issue here.

My colleagues point out that the record here does not show any actual falling object injuries attributable to the lack of hard hats between the date of the settlement of the earlier citation and the beginning of the subject inspection. However, "the goal of the Act is to prevent the first accident." *See Waldon Healthcare Center*, 16 BNA OSHC 1052, 1059, 1993-95 CCH OSHD ¶ 30,021, p. 41,152 (No. 89-2804, 1993) (consolidated). While head injuries had previously occurred, the lack of any further injuries in this short two-month period, in light of Spirit's partial efforts, was fortuitous. Even so, Spirit's own safety program, along with the visual evidence of continued potential for head injury and employee exposure, put Spirit on notice that its efforts to reduce the hazard were simply not enough and that, under both the cited standard and its own safety program, hard hats were required. Yet, Spirit failed to do what it knew it had to do under the circumstances to come into compliance with its own safety program and the cited standard – ensure the use of hard hats.[5]

Accordingly, I must dissent.

/s/
Thomasina V. Rogers
Commissioner

Dated: March 1, 2004

[5] The Secretary had proposed the maximum penalty of $70,000 for the willful violation, which the judge reduced to $50,000. While I agree with both the Secretary and the judge that the violation was willful, Spirit's efforts to reduce the hazard lowered the likelihood of injury and thus reduced the gravity. Accordingly, I would have assessed a lower penalty than that proposed by the Secretary or recommended by the judge.

Secretary of Labor, Complainant, v. Spirit Homes, Inc., Respondent.	OSHRC Docket Nos. **00-1807 & 00-1808** **(Consolidated)**

Appearances:

Raquel Tamez, Brian A. Duncan, Christopher V. Grier, Esq., Office of the Solicitor, U. S. Department of Labor, Dallas, Texas
For Complainant

Oscar E. Davis, Jr., Daniel L. Herrington, Esqs., Friday, Eldredge & Clark, Little Rock, Arkansas
For Respondent

Before: Administrative Law Judge Ken S. Welsch

DECISION AND ORDER

Spirit Homes, Inc. (SPI), manufactures mobile homes at a plant in Conway, Arkansas. On February 28, 2000, the Occupational Safety and Health Administration (OSHA) initiated safety and health inspections of the plant. After OSHA's inspections, SPI received serious, willful, and "other" than serious safety and health citations on August 25, 2000. SPI timely contested the citations.

The safety (No. 00-1808) and health (No. 00-1807) citations were consolidated for hearing. The 17-day hearing in Little Rock, Arkansas, concluded in October, 2001. SPI stipulated jurisdiction and coverage (Tr. 5).

At the hearing, the Secretary withdrew from the safety citations, citation no. 1, items 1, 2, 5, 6, 7, 10a, and 10b; citation no. 2, item 1, instance (f); and citation no. 3, items 1 and 2. From the health citations, the Secretary withdrew citation no. 1, item 1, and citation no. 3, item 1 (Tr. 21-23). The Secretary's withdrawal of citation items is approved and incorporated as part of this decision.

The following citation items remain in dispute:

The safety serious citation no. 1 alleges violations of 29 C.F.R. § 1910.24(b) (item 3) for

not providing fixed stairs to access the roofs of mobile homes; 29 C.F.R. §§ 1910.147(c)(4)(i) and 1910.147(c)(6)(ii) (items 4a and 4b) for failing to utilize lockout procedures and certify periodic inspections of energy control procedures; 29 C.F.R. § 1910.212(a)(1) (item 8) for not guarding pinch points on two presses; 29 C.F.R. § 1910.212(a)(3)(ii) (item 9a) for not guarding the points of operation on 4 sheet rock slitters; 29 C.F.R. § 1910.213(r)(4) (item 9b) for not providing complete guards for the dado blades and crosscut blades; and 29 C.F.R. §§ 1910.332(b)(1) and 1910.333(b)(2)(i) (items 11a and 11b) for not adequately training employees on the risk of electric shock and not maintaining complete written lockout procedures. The alleged serious violations propose total penalties of $22,500.

The safety willful citation no. 2 alleges violations of 29 C.F.R. § 1910.23(c)(1) or, in the alternative, § 5(a)(1) of the Occupational Safety and Health Act (Act) (item 1) for failing to guard open-sided floors or platforms 4 feet or more above the ground level; and 29 C.F.R. § 1910.135(a)(1) (item 2) for failing to ensure that employees wear protective helmets. Each alleged willful violation proposes a penalty of $70,000.

The health serious citation no. 1 alleges violations of 29 C.F.R. §§ 1910.1200(f)(5)(i) and 1910.1200(f)(5)(ii) (items 2a and 2b) for not labeling a bucket containing an adhesive with the identity of the hazardous chemicals and the appropriate hazard warnings; and 29 C.F.R. § 1910.1200(h)(1)(iii) (item 3) for not informing employees as to the location and availability of the written hazard communication program. The alleged serious violations propose total penalties of $3,000.

The health willful citation no. 2 alleges a violation of 29 C.F.R. § 1910.1200(h)(3)(ii)[1] (item 1) for failing to train employees in the physical and health hazards of chemicals in the workplace. The alleged willful citation proposes a penalty of $55,000.

SPI denies the violations, classifications, and proposed penalties. Among other arguments, SPI claims that it was attempting to comply with a December, 1999, informal settlement agreement with OSHA when OSHA initiated the current inspection in February, 2000.

For the reasons discussed, safety citation no. 1 (items 3, 4b, 4c, 4d, 9b, and 11a), safety citation no. 2 (items 1 and 2), health citation no. 1 (items 2a and 2b), and health citation no. 2

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[1]Citation incorrectly cites the standard as § 1910.1200(h)(2)(ii). The error was corrected by amendment on May 23, 2001. The incorrect standard was also cited in the 1996 citations and 1999 citations (Tr. 2100-2101, 2122).

(item 1) are affirmed. Total penalties of $89,000 are assessed. The remaining citation items are vacated or have been withdrawn by the Secretary.

The Inspection

SPI manufactures single-wide and double-wide mobile homes at a plant in Conway, Arkansas. The plant began full production in 1997. In 1998, SPI became a division of Cavalier Enterprises, Addison, Alabama. SPI employs approximately 425 employees (Tr. 63, 321, 3614, 3863, 3981).

SPI's facility is a large building, 400 feet by 550 feet, which accommodates two assembly lines, referred to as Plant 3 and Plant 4. Plant 4, on the right side of the building, manufactures double-wide homes. Plant 3, on the left side of the building, primarily manufactures single-wide homes. The mobile homes are 44 feet to 80 feet in length. The single-wide homes are approximately 16 feet wide. The double-wide mobile homes are assembled in halves, approximately 14 feet or 16 feet wide, before the halves are joined near the end of the assembly line. The roofs on the mobile homes are pitched at 2 in 12 or 3 in 12. Cabinet shops and the warehouse area are located between Plants 3 and 4. Across the street from the main building, the truss shop, welding shop, and paint area are located (Exhs. C-4, C-7; Tr. 76-77, 387, 1275, 1361-1362, 3890).

SPI's general hours of production are 7:00 a.m. to 3:45 p.m., five days a week. Each Plant produces approximately 8 mobile homes per day. SPI's former director of manufacturing is Stan Daughtry. Tom Gerard is the plant's former safety manager (Tr. 194, 550, 1015, 1321, 3472, 3861).

The production processes in Plants 3 and 4 are similar and involve moving wheeled metal chassis through various stations until the mobile home is assembled. After a metal chassis is moved into the plant, floor decking and carpeting are installed in Stations 1 or 2. The metal chassis is then rolled to the "cab part station" where interior wall partitions and cabinets are installed. After the sidewalls are installed in the "sidewall" station, the chassis is moved through a number of roofing stations where the ceiling trusses are formed and placed on top of the walls, insulation is blown in between the trusses, fireplace vents are cut, and the roof deck is installed. While the roof decking is installed, the electrical wiring, interior trim, vinyl siding, windows and doors are installed in Stations 8, 9 and 10. In Stations 11 and 12, where both sides of a double-

wide home are worked on simultaneously, the roofing paper and "shingles" are installed. The shingling, trim work, final finish and cleaning are completed in Stations 13 A/B, 14 A/B, and 15 A/B. Station 16 A/B is the final station where the mobile home is given a final inspection. The completed mobile home is then rolled outside to a storage area (Exh. C-4; Tr. 78-83, 85-88, 90-93, 785-786, 3270-3274, 3276-3277).

Prior to becoming a division of Cavalier Homes, SPI received OSHA citations alleging 12 serious, 1 willful, and 1 repeat violations on April 5, 1996. The citations were settled by amending the willful classification to serious and reducing the total penalties. The 1996 citations included a violation of § 1910.1200(h)(3)(ii) (citation no. 2, item 1) for failing to train employees on the specific hazards of chemicals used in the workplace (Exh. C-39; Tr. 2100-2102).

On May 12, 1999, SPI received OSHA citations alleging 2 serious, 1 willful, 1 repeat, and 4 "other" than serious violations (Exh. C-3; Tr. 2103). The alleged violations included failing to provide fall protection, under § 5(a)(1) of the Act, to employees working on mobile home roofs (citation no. 1, item 1); failing to provide protective helmets, in violation of § 1910.135(a)(1) (citation no. 1, item 2); failing to guard open-sided work platforms 4 or more feet above the adjacent floor, in violation of § 1910.23(c)(1) (citation no. 2, item 1); and failing to train employees on chemicals used in the workplace, in violation of § 1910.1200(h)(3)(ii) (citation no. 3, item 1). The inspection was conducted by industrial hygienist (IH) Lisa Almond (Tr. 2102). In December, 1999, the citations were settled. As part of the settlement agreement, SPI stated that "the conditions described in Citations 1, 2, 3, and 4 have been corrected." SPI also agreed to:

> [c]onduct monthly self-inspections of its entire workplace for the next twelve months beginning January 2000 and ending December 2000 and agrees to provide the OSHA Little Rock Area Office a report detailing the hazards identified and the corrections made as a result of these self-inspections (Exhs. C-3, R-16).

On February 28, 2000, OSHA initiated wall-to-wall, programmed safety and health inspections of the SPI plant. Safety compliance officer (CO) Gina Sims and IHs William Cole and Lisa Almond performed the inspection over a 12-day period (Tr. 62, 65). After the inspection, the safety and health serious, willful, and "other" than serious citations at issue were issued to SPI in August, 2000.

Discussion

Preliminary Matter

Reasonableness of the Inspection

SPI argues that OSHA's inspection was unreasonable because it was based on an improper motive, *i.e*. harassment. SPI claims that when OSHA initiated the inspection in February, 2000, it "was in the process of affecting compliance in accordance with agreed upon compliance procedures and time tables" as provided in the December, 1999, settlement agreement with OSHA.

Section 8(a) of the Act directs that an OSHA inspection be conducted in a reasonable manner, at reasonable times, and within reasonable limits. 29 U.S.C. § 657(a). To establish noncompliance with § 8(a), the record must show that OSHA substantially failed to comply with its provisions and the employer was substantially prejudiced. *Gem Industrial, Inc.*, 17 BNA OSHC 1185 (No. 93-1122, 1995). Evidence that OSHA conducted an inspection to harass an employer may be relevant to the defense. *Quality Stamping Products Co.*, 7 BNA OSHC 1285, 1287, n. 6 (No. 78-235, 1979). Section 8(a) does not apply, however, to an employer's selection for inspection. *Cody Zeigler, Inc.*, 19 BNA OSHC 1410 (No. 99-0912, 2002) *aff'd.*, 19 BNA OSHC 1777 (D. C. Cir. 2002).

There is no dispute that OSHA's 2000 inspection of SPI's plant was conducted during normal business hours, within reasonable limits, and without requiring an inspection warrant. Also, SPI participated in the walkaround inspection and was provided opening/closing conferences to discuss the purpose and inspection findings.

SPI's harassment argument is rejected. OSHA has "broad prosecutorial discretion" in deciding who to inspect and prosecute for violations of the Act. *DeKalb Forge Co.*, 13 BNA OSHC 1146, 1153 (No. 83-299, 1987). The selection of SPI for inspection and issuance of citations was not shown to be motivated for harassment purposes or had an harassing effect.

According to OSHA, SPI was selected for inspection based on neutral criteria under its Site Specific Targeting Program (SST) (OSHA Directive Number 99-3, effective from April 19 to December 31, 1999). The SST program required area offices to inspect manufacturing establishments with a high Lost Workday Injury/Illness Rate (Tr. 16).

Also, SPI represented in the 1999 settlement that the violations cited in June, 1999, had been abated when it signed the settlement agreement (Exh. C-3). OSHA's need to further inspect SPI's plant is demonstrated by the numerous alleged unsafe conditions cited in the 2000 inspection. SPI's claim of "selective prosecution" is denied. *See Vergona Crane Co.*, 15 BNA OSHC 1782, 1787-88 (No. 88-1745, 1992).

Alleged Violations

The Secretary has the burden of proving a violation.

> In order to establish a violation of an occupational safety or health standard, the Secretary has the burden of proving: (a) the applicability of the cited standard, (b) the employer's noncompliance with the standard's terms, (c) employee access to the violative conditions, and (d) the employer's actual or constructive knowledge of the violation (*i.e.*, the employer either knew or, with the exercise of reasonable diligence could have known, of the violative conditions).

Atlantic Battery Co., 16 BNA OSHC 2131, 2138 (No. 90-1747, 1994).

Although SPI's plant builds mobile homes, the construction standards in Part 1926 do not apply. The general industry standards in Part 1910 apply. The SPI plant is a manufacturing facility. It builds mobile homes on an assembly line for sale and use throughout the United States. *See Brock v. Cardinal Industries, Inc.*, 828 F.2d 373 (6th Cir. 1987)(no nexus exists between work done in factory in building modular housing units and construction site).

Docket No. 00-1808 (Safety citations)

Serious Citation No. 1, Item 3 - Alleged violation of § 1910.24(b)

The citation alleges that fixed stairs were not provided from the catwalks and mezzanines to the roofs of mobile homes in the roofing departments in Plants 3 and 4. Section 1910.24(b) provides in part:

> Fixed stairs shall be provided for access from one structure to another where operations necessitate regular travel between levels, and for access to operating platforms at any equipment which requires attention routinely during operations.

In the roofing departments (Stations 7 through 11), roof trusses, vents and decking are installed on the mobile homes. To make these installations, employees cross from the elevated catwalks or mezzanines to the roofs. The elevated mezzanines run along the outside of the first

roofing station (Station 7) the length of a mobile home and then along the end wall of the building. The elevated catwalks, also referred to as "raising platforms," are spaced equally apart from the mezzanine, the length of a mobile home, to form roofing Stations 7 - 11. The catwalks, 49 inches wide, are raised and lowered by overhead hoists to allow the mobile homes to move through the roofing stations. When in position, the catwalks are approximately 40 inches lower than a mobile home's roof. The height of a mobile home's roof to the plant's cement floor is approximately 11 feet, 4 inches. Because the catwalks are suspended by overhead hoists, they do not move left or right.

During OSHA's inspection, the catwalks had a guardrail system consisting of permanent uprights (intermediate posts) and chain railings.[2] In the guardrail system, there was a vertical ladder-like section, consisting of 4 steps, with the top step approximately level with the top chain railing and the roof of the mobile home. The ladder did not have handrails. The employees accessing the mobile home roof were expected to climb the ladder section and step across any gap or space between the catwalk and the roof (Exhs. C-4, C-40, C-43; Tr. 100-101, 103, 134, 793, 1725, 3891).

However, CO Sims observed an employee exit a mobile home roof in Plant 3 by stepping across an approximate 11-inch gap onto the top of an upright post and then down onto the catwalk. The height of the post was 43 inches (Exh. C-42; Tr. 120, 124-125, 134). In another incident, IH Cole observed an employee stepping across a 19-inch gap onto the top step of the ladder section of the guardrail before stepping onto the catwalk (Exhs. C-40, C-41; Tr. 1720-1721, 1726). Other employees were observed on the roofs and catwalks with no means of access other than stepping across the gaps (Tr. 127, 129-130). OSHA's calculations of the space in Stations 7 - 11 in Plant 3, if the mobile home was centered, show that the size of the gap or space between the catwalks and roofs ranged from 6 ½ inches to approximately 12 inches, and in Stations 7 - 10 in Plant 4, from 6 inches to 24 ½ inches (Exh. C-7). Obviously, the gaps change if the homes are not centered.

Gary Lewis, former employee, testified that when working on the double-wide mobile homes, he accessed the roofs at least twice a day. Lewis testified that roofers regularly jumped on and off the roofs and catwalks. He described roofers stepping on the uprights or chain railings

[2]After the inspection, the chain guardrail was replaced with permanent guardrails.

to get off the roof and putting their hands on the roof for support before hopping onto the roof. He said that the ladder built into the guardrails was not always used by roofers. He testified that the gaps between catwalks and roofs ranged from 24 to 36 inches (Tr. 1247-1251, 1254-1255, 1257-1258, 1274, 1277).

Bobby Hanson, assistant production manager in Plant 4 for Stations 8 through 15, testified that employees regularly accessed the roofs by climbing the ladders in the guardrails and then stepping onto the roofs. He denied seeing anyone step on the upright posts or chain railings. Hanson testified that the mobile homes are positioned in the stations so that the roof's low side, used for access, was nearest the catwalk. He acknowledged that the gaps between the roof and catwalk could be 18 inches. However, he estimated that the normal gap was 10 to 13 inches. If the gap was greater, it was caused by mis-aligning the home. Although employees were trained to use the ladders in the guardrails, there was no work rule prohibiting employees from stepping onto the upright post (Tr. 3366, 3368, 3376-3379, 3397, 3406, 3419-3420). SPI's internal safety inspections show a recurring problem with maintaining the gap at less than 12 inches (Exhs. C-14, p. 01425, C-15, p. 01935, C-16, p. 3).

Roofing supervisor Darren Davis denied that employees jumped from the roofs to the catwalks. He said that the mobile homes are positioned so that an employee could have one foot on the ladder and the other foot on the roof, although there was nothing for an employee to hold onto while stepping across (Tr. 3207-3208, 3259, 3330).

Tom Gerard, former safety manager, testified that it was common for employees to step across the gaps between the catwalks and the roofs. He stated that SPI's policy was to attempt to position the mobile homes so that the gap was 12 inches or less from the catwalk used to access the roof (Tr. 3478, 3485-3486).

SPI does not dispute that fixed stairs did not provide access to the roofs of mobile homes. SPI argues that the standard does not apply because mobile homes are intended to be private residences. SPI cites § 1910.24(a), in limiting the application of § 1910.24(b), which provides:

> This section does not apply to stairs used for fire exit purposes, *to construction operations to private residences*, or to articulated stairs, such as may be installed on floating roof tanks or on dock facilities, the angle of which changes with the rise and fall of the base support. (Emphasis added).

This argument is rejected. The mobile homes manufactured at the SPI plant are products and not private residences. While in SPI's plant, the mobile homes are being erected as part of a manufacturing process. The work is not construction but manufacturing. The mobile homes do not become private residences until purchased by the ultimate consumer.

SPI also argues that under § 1910.24(b), a "structure" or a "platform" does not include the roofs of mobile homes under construction. Section 1910.24(a) describes the fixed stair requirement to include stairs around "machinery, tanks, and other equipment, and stairs leading to or from floors, platforms or pits." SPI claims that the roofs are not floors, platforms, pits, machinery, tanks, or other equipment (SPI Brief, p. 182).

SPI's second argument is also rejected. The standard applies to structures which would include roofs under construction. In determining the application of a standard, the wording of the standard must be interpreted in a reasonable manner, consistent with common sense understanding. *Globe Industries*, 10 BNA OSHC 1596 (No. 77-4313, 1982). The words in a standard are to be viewed in context, not in isolation, and judged in light of its application to the facts of the case.

The dictionary defines "structure" as "the action of building" or "something constructed." *Webster's Seventh New Collegiate Dictionary*. Within this meaning, mobile homes are structures requiring means of access to the roofs. SPI's roofing operations necessitate regular, daily travel by employees to the roofs. The catwalks do not provide sufficient access to the roofs. The catwalks are approximately 40 inches below the roofs, and gaps in excess of 12 inches may exist to the roofs. Employees are not provided a continuous and uninterrupted means of access to the roofs. Fixed stairs are required to access one structure level to another.

Finally, SPI asserts that it is impossible to erect fixed stairs (SPI Brief, p. 186). SPI argues that (1) stairs cannot be fastened to a mobile home roof, and (2) fixed stairs cannot be constructed to comply with the standard's requirement for angle of rise and the stairway platform (Tr. 3916).

To establish a defense of infeasibility, an employer must show that (1) the means of compliance prescribed by the standard are infeasible, in that (a) its implementation is technologically or economically infeasible, or (b) necessary work operations are technologically infeasible after its implementation, and (2) there are no feasible alternative means of protection.

Beaver Plant Operations, Inc., 18 BNA OSHC 1972, 1977 (No. 97-0152, 1999). The fact that compliance is difficult or expensive is not sufficient to excuse compliance with the standard's requirements. *State Sheet Metal Co.,* 16 BNA OSHC 1155, 1160 (No. 90-1620, 1993). An employer is expected to exercise some creativity in seeking to achieve compliance and engage in limited compliance even if exact compliance is not possible. *Pitt Des Moines, Inc.,* 16 BNA OSHC 1429 (No. 90-1349, 1993), *Cleveland Consolidated, Inc. v. OSHRC,* 649 F.2d 1160, 1167 (5th Cir, 1981).

SPI fails to show either that implementing fixed stairs was technologically or economically infeasible or that necessary work operations would be affected after implementation. The standard requires fixed stairs, not permanent stairs. CO Sims described several abatement methods, including the use of mobile stairs or fixed stairs with some type of ramp which could be installed at the balcony end of the work areas (Tr. 159-160). The mobile stairs are on rollers which could be rolled in and out like a mobile scaffold. She described the fixed stairs with a type of ramp that extends and retracts onto the roof to accommodate the different heights and lengths (Tr. 162).

Also, although not necessarily in compliance with the standard's requirements, it is noted that SPI modified the ladders in the guardrails and reduced the fall hazard after OSHA's inspection. SPI installed handrails to the ladder and extended a ramp to the mobile home roof. The handrails allowed employees to hold onto something while climbing the ladder and crossing the ramp (Tr. 3916-3917).

The lack of fixed stairs to access the roofs is a serious violation. A serious violation under § 17(k) of the Act, 29 U.S.C. § 666(k), is found if the condition creates a substantial probability of death or serious physical harm and the employer knew or should have known, with the exercise of reasonable diligence, of the violative condition.

The gaps between the catwalks and roofs over which employees had to cross were as much as 19 inches, exposing employees to fall hazards in excess of 11 feet to the plant's cement floor. Such falls could cause serious injury. SPI knew of the condition, which was in plain view. SPI had been cited in 1999 for employees stepping across a gap of 30 inches from the mezzanine to the roof of a mobile home (Exh. C-3; Tr. 3956-3958).

Serious Citation No. 1, Items 4a, 4b, 4c and 4d - Alleged violations of §§ 1910.147(c)(4)(i), (c)(4)(ii), (c)(6)(i)(A), and (c)(6)(ii)

The citation alleges that lockout procedures were not consistently utilized during maintenance activities performed on weekends and evenings (item 4a); energy control procedures were not available for all equipment (item 4b); periodic inspections of energy control procedures were not conducted by an authorized employee (item 4c); and periodic inspections of energy control procedures were not certified (item 4d).

The pertinent provisions of § 1910.147(c) provide, as part of the energy control program:

> (c)(4)(i) - Procedures shall be developed, documented and utilized for the control of potentially hazardous energy when employees are engaged in the activities covered by this section.
>
> (c)(4)(ii) - The procedures shall clearly and specifically outline the scope, purpose, authorization, rules, and techniques to be utilized for the control of hazardous energy and the means to enforce compliance.
>
> (c)(6)(i)(A) - The periodic inspection shall be performed by an authorized employee other than the ones(s) utilizing the energy control procedure being inspected.
>
> (c)(6)(ii) - The employer shall certify that the periodic inspections have been performed. The certification shall identify the machine or equipment on which the energy control procedure was being utilized, the date for the inspection, the employees included in the inspection, and the person performing the inspection.

SPI's lockout/tagout (LOTO) policy is written (Exh. C-5). Under SPI's policy, all work requiring LOTO is performed by the maintenance department. At the time of OSHA's inspection, the maintenance department consisted of approximately 5 employees, including maintenance supervisor Bobby Cole, and leadman Robert Jackson. Leadman Jackson, a licensed master electrician, worked directly under maintenance supervisor Cole. On the weekends and after normal work hours, stockroom employees, including Ruby Kersten, assisted the maintenance employees (Tr. 2534-2535, 2539, 2744-2745, 2768).

SPI claims that other employees are prohibited from performing LOTO. Operators of machinery are not authorized to perform maintenance or repair work. The operators are expected to call a supervisor and maintenance (Tr. 837, 2543, 2885-2586, 3939-3940).

SPI's argument that the alleged LOTO violations are barred by the 6-month statute of limitations is rejected. OSHA initiated the inspection on February 28, 2000, and issued the

citations on August 25, 2000. The 6 months does not begin to run until OSHA discovers or reasonably should have discovered a violation. *Kasper Wire Works, Inc.*, 13 BNA OSHC 1261 (1987).

In this case, the alleged LOTO violations occurred during the relevant period. The record shows that maintenance employees worked overtime in the evenings and weekends on equipment from January, 2000, through March, 2000 (Exhs. C-5, R-33; Tr. 172, 175-176, 2594, 2633). Also, a violation is not time barred if it is considered a continuing violation until abatement or until employees are no longer exposed. *Johnson Controls, Inc.*, 15 BNA OSHC 2132, 2136 (No. 89-2614, 1993). The conditions warranting the use of LOTO procedures as cited by OSHA are continuing in nature. If found to be violations, the violations are not time barred.

Item 4a (alleged failure to consistently utilize LOTO on weekends and evenings) CO Sims did not observe any work requiring LOTO (Tr. 204). The alleged violation is based on statements by Ruby Kersten and James Rinehart, both of whom testified (Tr. 172).

Ruby Kersten, stockroom employee, testified that she assisted maintenance employees on the weekends and after hours. She helped run conduit, replaced fuses and lights, built and wired panel boxes, installed fans and fluorescent lights, and rewired an insulation blowing machine. Kersten attended LOTO training in March, 2000, and is identified by SPI as an authorized employee (Exh. R-32). When assisting maintenance employees, Kersten testified that LOTO was not always performed (Tr. 1006-1007, 1016, 1022-1023, 1082-1083, 1086-1087).

James Rinehart, maintenance employee, testified that he performed service and maintenance on various tools, machines, and equipment, including the Myteck Mark 5, Ultra Press 16, Dado Saw, and an insulation blowing machine (Tr. 2389-2390). He regularly worked on the Dado Saw and insulation blowing machine (Tr. 2390-2391). Rinehart told OSHA that LOTO was not always performed (Tr. 172, 175-176).

Supervisor Cole described Kersten's work as driving a forklift, painting, and wiring circuit boards on her bench. He testified that her work did not require LOTO (Tr. 2778). Maintenance leadman Jackson testified that while Kersten helped to install a panel box on an insulation machine, she was not exposed to energization because it was not hooked up (Tr. 2590-2591). Jackson testified that he and the other maintenance employees he observed performed LOTO every time when repairing equipment (Tr. 2586-2588, 2600-2601, 2604-2605, 2633-

2634).

The record fails to show, by a preponderance of the evidence, that Kersten or Rinehart were performing work requiring LOTO or were exposed to the hazard of electric shock from the failure to LOTO at the time of the OSHA inspection. Kersten's wiring of panel boxes on the insulation machine was not shown to require LOTO. Her wiring work was at her work bench and the panel boxes were not shown to be energized (Tr. 1079-1080). She testified that she did not know if it needed to be locked out (Tr. 1082-1083). Her other work did not expose her to energization. It did not require her to hook anything into building or machine wiring that had to be LOTO (Tr. 1081-1082, 2590-2591). She worked with wires, but her work did not bring her into contact with energized wires. She did not repair machinery or equipment. She assisted the maintenance employee. It was not shown that she knew whether the work being performed by maintenance required LOTO. For example, Kersten saw Jackson working on a saw that was not locked out, but Jackson said it was unplugged (Tr. 196, 1021).

In clarifying his statement to OSHA, Rinehart testified that the only time he did not LOTO was when he was troubleshooting a machine. In such a situation, one employee was at the panel box and another employee was at the machine. The employees used radios when testing the machine. Otherwise, Rinehart testified that when working on the machine, he performed LOTO (Tr. 2424, 2458-2460). In fact, when Rinehart was observed by maintenance supervisor Cole in approximately 1996 not locked out, he was instructed to lockout and that he would "get in trouble" if he was not locked out next time (Tr. 2460-2461). Rinehart testified that the maintenance crew only failed to LOTO when Cole or Jackson was not around and that stopped after the 1999 LOTO training (Tr. 2462).

Item 4b (alleged failure to have energy control procedures for all machinery) CO Sims testified that there were no machine specific LOTO procedures for two presses, Myteck and Ultra 16, used to make wooden roof trusses (Tr. 180, 198, 839). The presses have multiple sources of energy, including electric, pneumatic, and hydraulic. Air pressure holds the wood in the template and a hydraulic ram presses in the nail plates (Tr. 206, 2791-2792). During OSHA's inspection, both presses had been in operation for 3 years (Tr. 210). The Myteck and Ultra 16 operate essentially the same (Tr. 1518-1519, 2554). The presses are operated daily and require regular servicing (Tr. 1495, 2401-2402, 2633).

Section 1910.147(c)(4)(ii) requires that an employer's written LOTO procedures include (A) a statement of the procedure's intended use; (B) the procedural steps for shutting down, isolating, blocking, and securing the machine to control hazardous energy; (C) the procedural steps for placing, removing, and transferring LOTO devices and the responsibility for them; and (D) the requirements for testing the machine to determine and verify the effectiveness of LOTO devices and other energy control measures.

SPI's written LOTO policy includes LOTO procedures and the methods for locking out various machines, including table saws, band saws, slitters, welders, metal shears, carpet cutters, and air compressors. The policy does not specifically identify the Myteck and Ultra 16 presses (Exh. C-5; Tr. 205-206).

Although not listed, SPI argues that its LOTO policy complies because it contains LOTO procedures for similar types of machines and addresses the same types of energy. Also, SPI claims that the maintenance and repair manuals written by manufacturers of the presses satisfy the LOTO requirement (Exh. R-36; Tr. 2855).

There is no showing that during OSHA's inspection maintenance employees failed to properly perform LOTO on the Myteck and Ultra 16 presses or did not know the proper LOTO procedures[3] (Tr. 2555). Supervisor Cole and leadman Jackson testified that before anyone worked on a machine for the first time, the employee was shown how to perform LOTO (Tr. 2772-2775, 2843-2844, 2584-2586, 2595, 2604). Also, SPI had LOTO training in July, 1999, which was not machine specific (Tr. 2395-2397, 2399-2400, 2539, 2555, 3488, 3493).

Despite the employees' apparent understanding of proper LOTO procedures, SPI's written policy fails to describe those proper procedures applicable to the Myteck and Ultra 16 presses as required by the standard. The presses and their specific LOTO procedures are not identified in SPI's policy. Section 1910.147(c)(4)(ii) requires written, specific procedures. The manufacturer's maintenance manuals are inadequate. Such manuals do not identify the locations of the Plant's energy sources, which is necessary to properly perform LOTO.

Items 4c (alleged failure to conduct periodic LOTO inspections) The standard requires that the periodic inspections be performed by an authorized employee other than the ones

[3]A consultation inspection by Arkansas OSH (AOSH) in June, 1999, identifies an unspecified failure to LOTO the Myteck press (Exh. C-98, item 19). SPI notified AOSH that it corrected the violation by conducting LOTO training (Exh R-24).

utilizing the energy control procedure being inspected. The Secretary argues that SPI's inspections, if conducted, were after the maintenance employee locked out a machine and had already begun service work (Tr. 2557-2558, 2560).

During OSHA's inspection, former safety manager Gerard stated that he was the authorized person to perform periodic inspections. However, Gerard as part of his job duties did not perform maintenance work, including LOTO (Tr. 211-213). Gerard testified that he has never performed LOTO (Tr. 213, 3493-3494). Section 1910.147 defines authorized employee as a person who performs LOTO on machines. Gerard does not qualify as an authorized employee.

During the hearing, maintenance supervisor Bobby Cole testified that he and leadman Robert Jackson were responsible for assuring maintenance employees complied with the LOTO policy. They watched employees perform LOTO (Tr. 2749, 2757, 2764-2765). Jackson, however, denied performing LOTO inspections (Tr. 2559).

SPI argues that since Cole made sure employees performed LOTO correctly, he did the inspections required by the standard. SPI claims that the LOTO procedures for every machine were reviewed at one time or another. Cole and Jackson randomly walked around and observed employees performing LOTO (Tr. 217-218, 2469, 2557-2559, 2633).

The record fails to show that Cole and Jackson's observations constituted periodic inspections as contemplated by the standard. Their observations and reviews were random and sporadic without any assurance that all LOTO procedures were inspected at least annually. Cole and Jackson testified that the only time LOTO was observed was when a machine actually required servicing (Tr. 2633, 2757). The periodic inspections under the standard envisions a review of each written procedure and its utilization. Cole considered Jackson more qualified to review the written LOTO policy with employees (Tr. 2748-2749). Jackson, however, denied reviewing the policy with employees (Tr. 2551). Also, it is noted that Arkansas OSH's consultation in 1999 advised SPI of its failure to conduct periodic LOTO inspections at least annually (Exh. C-98, p. 26 of 29).

Item 4d (alleged failure to have written certifications of periodic inspections) As discussed, SPI failed to conduct periodic inspections and therefore failed to have written certifications. SPI lacked certification that inspections had been conducted. CO Sims requested the certifications, but none was provided.

SPI failed to comply, not only with the standard, but also its own LOTO policy (Exh. C-5). SPI's written LOTO policy requires the maintenance manager to "perform documented periodic inspections at least annually and certify the inspection report" (Exh. C-5, para E; Tr. 222-223). The certification required by the standard must include "the machine or equipment locked or tagged out, the date of inspection, the employees included in the inspection and the person performing the inspection."

SPI's argument that the Arkansas OSH's consultation in June, 1999, constituted an inspection and certification is rejected (Exhs. C-98, R-24). It was less than a year of the OSHA 2000 inspection. Such surveys of the plant by other entities do not satisfy the standard's requirement for the employer to certify periodic inspections of its LOTO procedures. Also, as stated, the consultation advised SPI to conduct periodic inspections at least annually.

Serious Classification of Item 4b, 4c, and 4d

SPI's argument that violations identified in items 4b, 4c, and 4d should be classified as "other" than serious is rejected. Although there is no evidence that employees improperly performed LOTO on any machine, SPI's failure to have written specific procedures for the presses and periodic inspection of all LOTO procedures could have resulted in serious injury to employees. The violations were not only as to the standard but SPI's failure to follow its own written procedures and policy. SPI should have known of the its failure to comply. The violations are serious.

Serious Citation 1, Item 8 - Alleged violation of § 1910.212(a)(1)

The citation alleges that the Myteck Mark 5 press and the Ultra 16 press in the truss shop were not fully guarded to prevent employees' exposure to the pinch point between the ram and press bed. Section 1910.212(a)(1) provides:

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

The Myteck Mark 5 and the Ultra 16 presses are used to form the wooden trusses used in mobile home roofs. Both presses operate similarly. When wooden truss members are placed into set guides on the press table, the table moves under the press, which presses a metal piece

used to connect the wooden members into the wood to form the truss. The presses require two operators. **Myteck Mark 5**

The two operators stand in front of the Myteck Mark 5 press, which is operated daily (Exh.-C-44; Tr. 239). While working in front of the press, the operators are not exposed to the point of operation (Exh. C-45; Tr. 235). Operator Gary Marshall testified that he could not reach into the point of operation while operating the press (Tr. 1492, 1520-1521). Although protected during normal operation, CO Sims considered the areas on the east side and on the back side of the press as not sufficiently guarded to prevent employee access to the point of operation (Tr. 721-722).

On the east side, an approximate 10-inch opening existed between a storage rack and a standing yellow metal guard. If inside this opening, the point of operation was 17.5 inches (Exhs. C-45, C-87; Tr. 237-239). CO Sims did not see an employee inside the opening (Tr. 241-242). Operator Marshall testified that the yellow guard prevented an operator from reaching into the point of operation (Tr. 1523-1524). The record shows no reason for an employee to reach into the point of operation on the east side (Tr. 1524).

On the back of the press, CO Sims testified that it was unguarded (Exh. C-88; Tr. 243). She speculated that employees went in the back to clean or clear jams. Also, operators regularly went to the back of the press to get nails and materials (Tr. 1493). There were stacks of boxes and movable storage carts containing lumber and nails. Because of boxes and carts, operator Marshall testified that he was unable to reach into the press (Tr. 1525-1526). There is no showing that the boxes or storage racks were ever moved. CO Sims agreed that the carts and boxes blocked the press's point of operation (Tr. 266, 725, 850).

Ultra 16

The Ultra 16 press performs the same function as the Myteck but is newer and the operators stand in front and in the back of the press. The press is operated daily (Exhs. C-47, C-47a, C-89, C-90,[4] Tr. 251, 1495). Blue storage racks for lumber used in making trusses are between the operator's work area and the press's point of operation (Tr. 247). When operating the press, CO Sims testified that operators are not exposed to the point of operation because of the storage racks (Tr. 258, 727-728). However, on the east and west ends, CO Sims considered

[4]Exhibit C-90 shows the press after SPI had modified the guard by extending the mesh guard to the storage holders.

an open area between the ends of the blue storage racks and a yellow mesh guard on the ends of the press as unguarded (Tr. 246-247, 249). The unguarded opening on the west end was 17 ½ inches wide. From the opening at the end of the press, it was 35 inches horizontally and approximately 6 ½ inches downward to the point of operation (Tr. 249,1532-1533). Although she did not observe the east end, CO Sims believed that it was the same as the west end (Tr. 858).

CO Sims speculated that the operators were exposed by the unguarded openings when cleaning or clearing jams from the press (Tr. 263-264). She was also concerned about the exposure to other employees in the area (Tr. 253-255). However, CO Sims testified that an employee had to deliberately reach into the point of operation from the unguarded openings (Tr. 763). However, she did not observe the press in operation or employees in the area of the unguarded openings (Tr. 263, 858). Also, a dumpster was located in front of the west end, which allowed only enough space for one person to pass between the dumpster and the end (Tr. 760, 762).

Operator Marshall testified that to start the press, the button was located on the east end. He also occasionally took his break at the east end (Tr. 1498-1499, 1527). He stated that the dumpster was always on the west end (Tr. 1496). He also testified that the yellow guard on the east end was not in place until the day OSHA inspected the truss shop. It had been off the press for several months (Tr. 1500, 1507-1509, 1510).

Plant manager Stan Daughtry, who conducted daily walkaround inspections of the truss shop, testified that he had not seen any guards missing from the press (Tr. 3926-3927). Maintenance supervisor Cole also denied that the guard was off the press or that the guard was replaced before OSHA inspected the area (Tr. 2818).

Maintenance leadman Jackson testified that he had removed the guards in the past but had never failed to replace them before the press was next used (Tr. 2612-2613). Jackson denied that any guards were replaced during OSHA's inspection (Tr. 2614-2615). Maintenance employee Rinehart also denied that the guard was replaced during OSHA's inspection (Tr. 2483-2484). He stated that the guard had never been off more than one day (Tr. 2484).

Discussion

As an element of the Secretary's burden of proof, the record must show that employees

were exposed or had access to the violative condition. *Walker Towing Corp.*, 14 BNA OSHC 2072 (No. 87-1359, 1991.). Employees' exposure means that employees have been, are, or will be in the "zone of danger" either during their assigned working duties, their personal comfort activities while on the jobsite, or their movement along normal routes of ingress to or egress from their assigned workplaces. *Kaspar Electroplating Corp.,*16 BNA OSHC 1517 (No. 90-2866, 1993). In machine guarding cases, "the mere fact that it was not impossible for an employee to insert his hands under the ram of a machine does not itself prove that the point of operation exposes him to injury. Whether the point of operation exposes an employee to injury must be determined based on the manner in which the machine functions and how it is operated by the employees." *Rockwell Int'l. Corp.*, 9 BNA OSHC 1092, 1097-1098 (No. 12470, 1980). The inquiry is not whether exposure is theoretically possible but whether an employee's entry into the danger zone is reasonably predictable "by operational necessity or otherwise (including inadvertence)." *Fabricated Metal Products*, 18 BNA OSHC 1072, 1074 (No. 93-1853, 1997).

In this case, OSHA failed to establish employees' exposure to the zone of danger was reasonably predictable, either by the operation of the press or inadvertence. CO Sims's speculation of exposure is not supported by the record. CO Sims concedes that an employee would have to deliberately reach into the point of operation. The purported inadequately guarded areas were far from where operators normally operated the presses. CO Sims did not observe, nor does the record reflect, that employees were in the areas of the unguarded openings; and, if in the areas, that employees would deliberately reach into the point of operation.

On the east side of the Myteck press, the opening was only 10 inches and the point of operation was 17 ½ inches from the edge of the press. There was no showing that employees had been or expected to be inside the opening for any operational reason or personal convenience. Also, the point of operation was sufficiently remote from the unguarded opening that even inadvertent exposure is unforeseeable. With regard to the back of the Myteck press, employees traveled there to obtain nails from stored boxes. However, the boxes prevented employees' access to the point of operation. It was not shown that the boxes were ever removed from the back or that operators performed any work on the press from the back.

Similarly, the Ultra 16 press was not shown to be inadequately guarded. Although the openings on the east and west ends of the press were 17 ½ inches, employees' exposure required

a reach of 35 inches horizontally and 6 ½ inches downward. It was not shown that such a reach was reasonably predictable based on operational necessity or inadvertence. Theoretical possibility is insufficient. Also, at least on the west end, there was a dumpster always present additionally inhibiting employees' exposure. Guarding by location means not only the placing of a machine in the plant but also the machine's elements or parts are installed so that no person can normally reach through, over, under, or around the hazard area. *Insulation Manufacturing Co.*, 1 BNA OSHC 3122 (1973).

The failure to guard the Myteck and Ultra presses' points of operation is vacated.

Serious Citation 1, Item 9a - Alleged violation of § 1910.212(a)(3)(ii)

The citation alleges that the sheet rock slitters in the sidewall and partition departments were not fully guarded to prevent employees' exposure to the point of operation. Section 1910.212(a)(3)(ii) provides:

> The point of operation of machines whose operation exposes an employee to injury shall be guarded. The guarding device shall be in conformity with any appropriate standards therefor, or, in the absence of applicable specific standards shall be so designed and constructed as to prevent the operator from having any part of his body in the danger zone during the operating cycle.

The 4 slitter machines cut large boards of sheet rock to the desired size. Although she did not see all of the machines, CO Sims testified that they were operated the same. The 3/8-inch sheet rock board is placed on the slitter's table and guided through upper and lower cutting blades which cut the paper covering the sheet rock. The slitter operator holds the sheet rock against the guide along the right side of the machine as the circular blades pull the board through the cutting area. After the paper is cut, the operator walks to the back side of the machine and snaps the sheet rock apart. There are approximately 8 slitter machine operators. The machines are operated daily (Exh. C-48; Tr. 267-268, 270-271, 274, 277, 859-860, 865, 3768, 3792).

The slitter machine's point of operation is between the two blades which do not retract or elevate. The top blade is 6 1/4 inches in diameter. In observing the operation of the slitter machine, CO Sims concluded that the blades on the left side were not fully guarded. The guard adequately protected the point of operation along the front, right side and rear of the blades. The front guard was approximately 4 inches wide and the blades' inserts were within the guard. The partially exposed portion on the left side of the blades was 4 inches. However, a nut and bolt

assembly partially blocked the left side (Tr. 272-273, 275, 433, 435, 866-867).

CO Sims testified that the operator's hands are kept apart approximately shoulder width as the sheet rock passes through the blades. She estimated that the operator's hands came within inches of the blades when parallel to the blades. She did not take a measurement. She testified that the operator's right hand was not exposed, just the left hand (Tr. 276-277, 412, 427-429). After OSHA's inspection, SPI redesigned the guarding and a full guard was placed around the cutting blades (Exhs. R-37, C-94, C-95; Tr. 949-950, 3778-3779, 3930).

The record in this case fails to show that employees' exposure in the zone of danger was reasonably predictable. A board of sheet rock is 6 - 8 feet long, and the operator stands behind the board as it feeds through the cutting blades. The operator uses both hands to hold and guide the sheet rock through the blades. CO Sims testified that there is no opening between the existing partial guard and the sheet rock when being fed into the blades. The operator's left hand is not exposed to the point of operation while the sheet rock is fed into the machine (Tr. 440, 863, 870, 953-954).

Operator Walter Wyatt testified that the operator feeds the sheet rock into the two blades which pulls it through, "pinching it." He holds the sheet rock against the left side guide to avoid a curved cut. The blades are located 16 inches from the front of the table, which is the closest his body comes to the blades. Wyatt said that he stops his hands at the point where the table begins because the blades pull the material through. When the sheet rock reaches the edge of the table, he walks around the table to the other end, where he retrieves the sheet rock. He does not need to keep his hands on the sheet rock until they are even with the blades. Wyatt testified that the closest his hands get to the blades is approximately 16 inches (Tr. 3768-3771, 3774-3776, 3794, 3797-3798). Director of manufacturing Daughtry testified that during OSHA's inspection, he did not see the operator's hands in the vicinity of blades (Tr. 3931-3932).

With adequate guarding in the front, right side, and back of the slitter and the nut and screw assembly on the left side, the operator's left hand was not shown to be exposed to the point of operation by operational necessity or inadvertence. The violation is vacated.

Serious Citation 1, Item 9b - Alleged violation of § 1910.213(r)(4)

The citation alleges that the points of operation on the Idaco Pet dado saw in the truss shop were not effectively guarded to prevent the operator's exposure. Section 1910.213(r)(4)

provides:

> The mention of specific machines in paragraphs (a) through (q) and paragraph (r) of this section, inclusive, is not intended to exclude other wood working machines from the requirement that suitable guards and exhaust hoods be provided to reduce to a minimum the hazard due to the point of operation of such machines.

The Idaco PET dado saw cuts notches and cross cuts in wooden boards used for trusses. The saw has separate blades for the notches and cross cuts. After the wooden board is placed on a conveyor at the saw's infeed side, the board automatically proceeds through the cross cut blade, which cuts the board to a specific length and then through the dado blades, which notches the board before it exits the saw in the back at the outfeed side. The dado blades are actually 3 or 4 blades stacked together. The saw runs continuously and is automatic with one operator infeeding the boards and another operator removing the boards from the outfeed side. The saw has operated daily for two years (Exhs. C-49, C-50, C-51, C-91, C-92, C-93; Tr. 284, 288, 292-294, 299, 306-307, 872-873, 3997).

The citation alleges employees' exposure on both the infeed and outfeed sides of the Idaco saw (Tr. 873-874). CO Sims testified that the infeed operator was "about 3 feet" from dado blades. However, the control panel, she estimated was approximately 15 inches from the cross cut blade. She did not see the cross cut blade in operation (Tr. 350, 875-876, 982-983).

CO Sims considered, however, the greatest potential exposure was to the outfeed operator (Tr. 291). As the cut boards exit the saw, the operator reaches inside a thin plastic shield, installed to reduce dust and flying chips, and lifts the boards off a conveyor. The boards are removed from the conveyor and placed on a storage rack near the saw (Exh. R-39B; Tr. 292, 3933-3934, 4005-4006). The operator, standing at the edge of the saw, is 12 inches from the point of operation (Tr. 292-293, 877). The plastic shield is approximately 1 ½ feet from the saw blades (Tr. 3934). CO Sims did not consider the plastic shield a guard because the operator placed his hands through it (Exh. C-51; Tr. 297). She is concerned about the dado serrated blades below and to the left of the conveyor where the cut boards are retrieved (Exh. C-93; Tr. 987). She opined that the operator could stick his hands into the blades to clear a jam (Tr. 284, 491-492).

The record fails to establish infeed operator's exposure. CO Sims did not see or take

measurements of the operator while the cross cut blades were in operation. She did not see the operator at the control panel. There was no showing that the operator's hands were in the zone of danger because of operational necessity or inadvertence (Tr. 2732-2733, 3939-3940).

The record, however, does establish the operator's exposure to the dado blades on the outfeed side of the saw. The plastic shield does not prevent an employee's hands from inadvertently missing the cut board or coming in low towards the dado blades. The operator has approximately 15 seconds to catch the cut board, turn around, and stack it before another board is ready (Tr. 4007). The operator's access to the zone of danger is reasonably predictable during the course of normal work duties or inadvertence. The operator stands within 12 inches of the point of operation. *Dover Elevator Co.*, 16 BNA OSHC 1281, 1285 (No. 91-862, 1993). After OSHA's inspection, SPI installed additional guarding (Tr. 750-751).

The violation is serious. The condition was visible and the subject of SPI's own safety inspection. Although the record does not reflect any injuries, the lack of guarding could cause serious injury, including amputation of the hand.

Serious Citation 1, Item 11a - Alleged violation of § 1910.332(b)(1)

The citation alleges that employees who were at risk of electric shock were not trained in and familiar with safety-related work practices. Section 1910.332(b)(1) provides:

> Employees shall be trained in and familiar with the safety-related work practices required by 1910.331 through 1910.335 that pertain to their respective job assignments.

The scope of the safety-related work practices requirements at § 1910.331(a) provides:

> The provisions of §§ 1910.331 through 1910.335 cover electrical safety-related work practices for both qualified persons (those who have training in avoiding the electrical hazards of working on or near exposed energized parts) and unqualified persons (those with little or no such training) working on, near, or with the following installations:

The installations within the standard's scope include premises wiring, wiring for connection to supply, other wiring, and optical fiber cable. The excluded work involves generation, transmission and distribution installations, communications installations, installations in vehicles, and railway installations.

The safety-related work practice standards establish safety requirements covering work

performed on or near exposed energized and de-energized parts of electric equipment, the use of personal protective equipment by employees exposed to potential electrical hazards, the safe use of portable electric equipment, electric power and lighting circuits, and testing instruments and equipment. The training required under § 1910.332(c) may be classroom or on-the-job training. The extent of the training depends on the job assignment and risk to the employee. The need for training is dictated by the hazard.

Although large electrical projects are performed by outside contractors, SPI's maintenance employees regularly perform electrical work throughout the plant (Tr. 2474, 2798-2799). Such electrical work includes replacing circuit breakers and fuses, installing and replacing electrical outlets and junction boxes, rewiring, troubleshooting, and installing fans and fluorescent lights (Tr. 1007, 1022, 1082, 1084, 1086, 1088-1089, 2390, 2413, 2561-2564, 2566-2571).

The Secretary asserts that maintenance employees received little or no training on electrical safety-related work practices (Tr. 309). CO Sims was informed that SPI had not provided safety-related work practice training to its maintenance employees. SPI did not have written safety and work practice policies or programs (Tr. 309, 315-316). There is no allegation of employees' exposure to energized parts. CO Sims did not observe any maintenance employee fail to correctly perform LOTO or improperly use a tester (Tr. 665-666).

SPI argues that the maintenance employees received LOTO training and worked with de-energized circuits only (Tr. 2396, 2762, 3673). Properly locking out the power source avoids the electric hazard (Tr. 656, 2602-2603). CO Sims testified that, if an employee correctly performed LOTO, there is no hazard of serious injury (Tr. 659-661). Therefore, SPI asserts that the LOTO training received by the employees was all that was required.

The record establishes a violation. Safety manager Gerard stated that training on electrical safety-related work practices had not been provided to the maintenance employees (Tr. 309, 315-316). There is no showing that employees were trained as required by the safety-related work practices standards on how to distinguish exposed live parts from other parts, instructions to follow when performing work on or near electrical circuits, how to determine the nominal voltage of live parts and how to replace/change outlets and receptacles, the types of electrical hazards which may be encountered, and OSHA's standards on electrical safety-related work

practices (Tr. 2419-2420, 2422-2423, 2572, 2574-2575). Such requirements are in addition to LOTO training. The hazard of working on de-energized circuits is that it may become energized, if not properly de-energized (Tr. 655). LOTO training differs from training on safety-related work practices. There is no dispute that SPI's 1999 LOTO training did not include electrical safety-related work practices (Tr. 3298-3299).

Maintenance employee Rinehart told OSHA that he received no instructions on procedures to follow when performing work on electrical circuits or on distinguishing between exposed live parts from other parts. His knowledge was based on 30 years of experience (Tr. 2419-2420, 2422-2423). Leadman Jackson, a certified electrician, also said that SPI did not train him on determining nominal voltage of live parts, electrical hazards, or safety-related work practices like installing panel boxes, outlets, junctions boxes, or replacing breakers (Tr. 2572, 2574-2575). Despite the certification and years of experience, SPI remains responsible under the standard to provide training on safety-related work practices on the machines and equipment at its plant.

The violation was serious. SPI should have known of the inadequate training, and employees were exposed to electrical hazards without the training.

Serious Citation 1, Item 11b - Alleged violation of § 1910.333(b)(2)(i)

The citation alleges that SPI did not maintain a written copy of lockout procedures to be utilized during electrical work by maintenance employees. Section 1910.333(b)(2)(i) provides:

> The employer shall maintain a written copy of the procedures outlined in paragraph (b)(2) and shall make it available for inspection by employees and by the Assistant Secretary of Labor or his or her authorized representatives.

Paragraph (b)(2), under the safety-related work practices standards, involves the locking out or tagging out of energized parts while an employee is exposed to parts of fixed electric equipment or circuits which have been de-energized. According to the note following paragraph (b)(2), the LOTO procedures that comply with § 1910.147 comply with this section. The note following § 1910.333(b)(2)(i) provides that the "written procedures may be in the form of a copy of paragraph (b) of this section."

Safety manager Gerard stated to OSHA that SPI did not have a written electrical safety-related work practices program (Tr. 309, 315-316).

SPI has a written LOTO policy (Exh. C-5). Maintenance supervisor Cole stated that SPI relied on its written LOTO policy and common sense (Tr. 2754). As discussed, SPI's LOTO policy was adequate except for the lack of procedures for the Myteck and Ultra 16 presses.

The record fails to show that SPI's employees did not have access for inspection to a copy of § 1910.333(b) in lieu of a copy of its own written work practices. CO Sims testified that she did not know if SPI had a copy of the standards or if it was available to employees. However, she assumed that a copy of the standards was at SPI (Tr. 646). Supervisor Cole testified that SPI had copies of the standards and employees knew where they were located (Tr. 2800). The alleged violation is vacated.

Willful Citation 2, Item 1 - Alleged violation of § 1910.23(c)(1) or, in the alternative, § 5(a)(1) of the Act

The citation alleges that employees working on the roofs and on step ladders adjacent to the open-sided floors of mobile homes were not provided with means of fall protection.

Section 1910.23(c)(1) provides:

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

OSHA alleges, in the alternative, a violation of § 5(a)(1) of the Act, which provides that each employer:

> shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees.

OSHA inspectors observed employees on the roofs of mobile homes and on step ladders on the floors of mobile homes. There is no dispute that the employees were not wearing personal fall arrest systems. Also, the mobile home roofs and floors did not have guardrails. The citation identifies 5 instances remaining in dispute.

Instance (a). IH Cole observed employee Samuel Sanchez without fall protection at the edge of the roof near a gap of 17 inches between the roof and catwalk, in Station 10, Plant 4. The employee was performing deck work and cutting vent holes. He was wearing a safety harness, but it was not tied off (Exh. C-52; Tr. 1730-1731). He was also observed by CO Almond close to the roof's edge (Tr. 2128-2129).

Instance (b). IHs Cole and Almond observed employees Juan Alvarez and Juan Lopez without fall protection while installing a fireplace vent on a mobile home roof in Station 10, Plant 4. The height of the roof at the peak from the plant's floor was 14 feet. The employees were 36.5 inches from the roof's edge. The edge of the roof was approximately 30 inches from the catwalk. On the roof's low side, the gap was 19 inches to the catwalk. The employees were next to the ridge beam, which was approximately 2 feet 8 inches high (Exh. C-53; Tr. 1733-1735, 1739, 2008-2009, 2130, 2133-2135, 2137).

Instance (c). CO Almond and IH Cole observed line leader Dawn Davis and employee Frank Snyder without fall protection while installing an air vent and cutting vent holes at the roof's peak in Station 10 of Plant 4. The gap between the catwalk nearest the employees and roof was 19 inches. The height of the roof's eves to the plant floor was 13.5 feet (Exhs. C-41, C-43, C-54; Tr. 1738-1739, 1746, 2125-2129, 2139-2141).

Instance (d). CO Sims observed Jesus Guardia inside a mobile home on a two-step ladder next to the open-sided floor, sawing off the top of a partition. The floor of the mobile home was 41 inches above the plant's cement floor. The step ladder was 23 inches high and less than 1 foot from the floor's edge. The employee was working from the step ladder for approximately 30 minutes (Exh. C-59, Tr. 332-333, 344-345).

Instance (e). CO Almond observed employee Jacob Lopez inside a mobile home installing interior trim from a step ladder, 32 ½ inches high, in the Plant 4 roofing department. The step ladder was 8 inches from the open-sided edge of the floor. The employee was straddling the top of the ladder. The floor was 41 inches above the plant's concrete floor (Exh. C-56; Tr. 2144-2146).

CO Almond also observed employee Juan Alvarez inside a mobile home standing atop a step ladder within 8 inches of the open-sided floor. The employee was working around the fireplace. The height of the step ladder was 32 ½ inches. The floor of the mobile home was 41

inches above the plant's floor (Exhs. C-57, C-58; Tr. 2148-2150).

Additionally, former employee June Boerner testified that she regularly cleaned trim and removed putty inside mobile homes from a 3-foot step ladder. She said that she occasionally placed the ladder within 1 foot of the open-sided floor. She testified that all employees in the final finish department used step ladders in the same manner (Tr. 1362-1364, 1369).

Discussion

Roofs of Mobile Homes

Instances (a), (b), and (c) involve employees working on the roofs installing trusses, decking, and vents in Station 10, Plant 4. Initially, the issue is whether a roof under construction on a mobile home is a "floor or platform" within the meaning of § 1910.23(c)(1). There is no dispute that a roof is not a floor. A "platform," on the other hand, is broadly defined as "a working space for persons, elevated above the surrounding floor or ground level, such as a balcony or platform for the operation of machinery and equipment." *See* § 1910.21(a)(4).

Whether the cited surface (erecting roofs for mobile homes) is a "platform" within the meaning of the standard is a question of fact. *Unarco Commercial Products*, 16 BNA OSHC 1499, 1502 (No. 89-1555, 1993) (rails and pipes located above chemical tanks are not platforms). Although broadly defined, the definition of a platform is sufficiently clear in its application. *Id.* at 1503. The roofs in Stations 7 - 10 are being erected on the mobile homes by installing the trusses, decking, and vents. The homes move through the stations at a rate of approximately 1 every hour. As the roofs are constructed and move through the stations, the surfaces upon which the employees are working is temporary and changing. The roofs under construction are temporary surfaces.

As a temporary surface, the § 1910.21(a)(4) definition of "platform" does not apply. The standard applies to permanent platforms. In *Fleetwood Homes of Texas, Inc.*, 8 BNA OSHC 2125, 2128 (No. 79-5642, 1980), the Commission, in a case involving planks cited as platforms under § 1910.23(c)(1) placed between working decks to create work bays around mobile homes on an assembly line, noted that "the Secretary's standards differentiate platforms and scaffolds based on whether they are permanent or temporary working surfaces, respectively." The Commission, in vacating the violation, concluded that the planks were scaffolds, not platforms, on the basis that the "permanent-temporary distinction relates to the construction and placement

of the device, not to the frequency or regularity of its use in the employer's operation." *Id* at 2128. Although Commission and court precedent indicates that similar guardrail requirements for platforms under the construction standards at § 1926.500 apply to temporary surfaces, the interpretations under construction are not applicable in this case because SPI's facility is general industry. *A. J. McNulty & Co., Inc*., 19 BNA OSHC 1121, 1133 (No. 94-1758, 2000), *aff'd.* 19 BNA OSHC 1769 (D.C. Cir. 2002).

Also, it is noted that the mobile homes are products manufactured by SPI. The Commission noted in an early case that "the surface of a product while it is being manufactured, assembled, and tested is not a platform as defined in Sec. 1910.21(a)(4)." *Allis-Chalmers Corporation*, 4 BNA OSHC 1227, 1228 (No. 5210, 1976). To require guardrails, the Commission noted that it could produce absurd results such as to "require the erection of guardrails on the wings and tail assemblies of large aircraft being manufactured."

Therefore, § 1910.23(c)(1) does not apply. The roofs are not "floors or platforms" as required by the standard.

In the alternative, the Secretary alleges a violation of the general duty clause at § 5(a)(1) of the Act. A general duty violation exists if the Secretary establishes that (1) a condition or activity in the employer's workplace presents a hazard to employees, (2) the employer or its industry recognizes that the condition or activity is hazardous, (3) the hazard is causing or likely to cause death or serious physical harm, and (4) a feasible means exists to eliminate or materially reduce the hazard. *Waldon Healthcare Ctr.*, 16 BNA OSHC 1052, 1058 (No. 89-2804, 1993).

The record shows that a fall hazard existed when SPI employees worked on the roofs installing trusses, vents, and decking in Stations 7 - 10, Plant 4, where the double wide homes were manufactured.[5] CO Sims testified that fall protection such as guardrails is required when a 14-foot (half of double wide) home[6] is in the roofing stations because of the increased space to the catwalks (Tr. 496-497). There is no dispute that the roofs in Stations 7 - 10 were not guarded

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[5]There is no evidence that a fall hazard existed in Plant 3 or was the subject of the alleged violation in Citation no. 2, item 1. As shown by the Secretary's calculations, the gap in Plant 3 between the roofs and catwalks, if the home is centered in the station, ranged from 6 ½ to 11 ½ inches, which the Secretary agrees is too narrow to be a fall hazard (Exh. C-7).

[6]SPI manufactures 28 and 32 foot wide mobile homes in Plant 4. In stations 7-10, only half of the mobile home is worked on in a station at a time (Tr. 88).

by guardrails, nor employees protected by fall arrest systems. The employees' work required them to be at or near the edge.

The gaps between the roofs and adjacent catwalks, if the home is centered, ranged from 6 inches to 24 ½ inches (Exh. C-7). For example, CO Sims' measured the width of Station 10 as 213 inches and, depending upon the width of the mobile home, the total gap could be 49 inches (24 ½ inches on either side) (Exh. C-7; Tr. 2012-2015). The homes, however, were not necessarily centered. If not centered, the gap, on at least one side, could be larger. As observed by OSHA, the employees worked at or near gaps of 17 and 19 inches without fall protection. Assistant production managers Hanson and Jackson agreed that an employee could fall through gaps of 18 inches (Tr. 2674, 3380). The fall to the plant's cement floor was approximately 11 feet.

The fall hazard was recognized. A hazard is deemed "recognized" when the potential danger of a condition or activity is either actually known to the particular employer or generally known in the industry *Pepperidge Farm, Inc.*, 17 BNA OSHC 1993 (No. 89-0265, 1997). A "recognized hazard" is defined in terms of conditions or practices over which the employer can reasonably be expected to exercise control. *Morrison-Knudsen Co./Yonkers Contracting Co., a Joint Venture*, 16 BNA OSHC 1105, 1121-22 (No. 88-572, 1993).

Although there is no evidence of an employee falling from the roof in Stations 7 - 10, the hazard, not any specific incident that resulted in injury, is relevant in determining the existence of a recognized hazard. *Brennan v. OSHRC*, 494 F2d. 460, 463 (8th Cir. 1974). SPI's fall protection plan states that "our employees must be protected when they are exposed to falls from unprotected sides and edges of walking-working surfaces (horizontal and vertical surfaces) which are 6 feet or more above the lower levels" (Exh. C-6, p. 01240). SPI's director of manufacturing Daughtry, who had worked in the mobile home industry for 30 years, testified that there was a 12-inch industry standard for gaps between mobile homes and catwalks (Tr. 3909). SPI's corporate safety officer Davis also referenced a 12-inch standard in his safety audits of the plant (Exhs. C-13, p. 01421, C-15, p. 01935; Tr. 2918, 2934). Also, the Secretary defines a "floor opening" for fall protection purposes as 12 inches or more, which is considered sufficient space through which an employee may fall. *See* § 1910.21(a)(2).

As another element of a § 5(a)(1) violation, the Secretary must show, not that an

identified abatement measure would prevent the hazard, but, rather, that the abatement measure would reduce the risk of severe injury from the hazard. The courts require that the proposed abatement either "eliminate or materially reduce the hazard."

The Secretary's proposed abatement measures include a guardrail system that comes down from the roof or the use of overhead cables to which a fall arrest system could be tied off similar to the overhead cables in Stations 11 - 15 in Plant 4 (Tr. 509). CO Sims testified that she had seen other mobile home manufacturers install guardrail systems that came down from the roof (Tr. 509). Also, it is noted that SPI, after OSHA's inspection, added "wings" which fold down from the catwalks to narrow or eliminate the gaps between the catwalks and roofs (Tr. 3097). SPI made no showing that abatement of the fall hazard was not feasible or that the measures proposed by the Secretary would not at least reduce the risk of a fall hazard. A § 5(a)(1) violation is established.

Step Ladder

Although the step ladders are on a floor as defined by the Secretary, § 1910.23(c)(1) does not apply to the employees as described in instances (d) and (e). Mobile home floors are 41 inches above the plant's cement floor and not 4 feet or more as required by the standard (Tr. 333). Section 1910.23 applies when the floor is 4 feet or more, not whether an employee is more than 4 feet. Further, guardrails would provide little or no protection to an employee standing on a 23-inch high ladder next to a guardrail.

With regard to a § 5(a)(1) violation, the Secretary failed to show an industry recognized hazard. There is no showing that the step ladders were not stable or that employees had received injuries from falling off the ladders. The use of the ladders near the open side were for short durations. Employee Boerner considered the ladders safe (Tr. 1440). Guardrails would not prevent an employee on a ladder from falling (Tr. 1441). It would not provide protection. Other abatement methods were not proposed by the Secretary.

Willful Classification

The § 5(a)(1) violation with regard to fall protection for employees on the roof is classified as willful. A willful violation is "one committed with intentional, knowing or voluntary disregard for the requirements of the Act, or with plain indifference to employee safety." *A. P. O'Horo Co.*, 14 BNA OSHC 2004, 2012 (No. 85-0369, 1991). An employer's

intentional disregard or plain indifference to its safety obligations can be established in various ways, including proof of prior citations or showing that an employer's state of mind was such that, if it was informed of the applicable standard, it would not care. *Morrison-Knudsen Co./Yonkers Contracting Co.,* 16 BNA OSHC 1105, 1123 (No. 88-572, 1993). A violation is not willful, however, if the employer has a good faith belief that it was not in violation. The test of good faith is objective--whether the employer's belief concerning a factual matter, or the interpretation of a rule, was reasonable under the circumstances. *General Motors Corp., Electro-Motive Div.,* 14 BNA OSHC 1064, 1068 (No. 82-630, et al., 1991).

The § 5(a)(1) violation by SPI was not willful. The Secretary relied in the alternative on the general duty clause because a specific standard did not apply. Also, although there was a 1999 fall protection citation, IH Almond stated that SPI was not cited for failing to have guardrails around the roof (Exh. C-3; Tr. 2234). She advised SPI that guardrails are not required if the mobile home was close enough to the catwalks and the catwalks extend all the way to the end of the home so that employees could not fall through (Tr. 2236). There is no showing that employees had been injured from falls from mobile home roofs. Based on the record and OSHA's observations, only Station 10 in Plant 4 presented a potential fall hazard to employees working on the roofs.

Willful Citation 2, Item 2 - Alleged violation § 1910.135(a)(1)

The citation alleges that employees were not required to wear protective helmets when walking or working under the catwalks, mezzanines, and roofs of mobile homes. Section 1910.135(a)(1) provides:

> The employer shall ensure that each affected employee wears a protective helmet when working in areas where there is a potential for injury to the head from falling objects.

Section 1910.135, like § 1910.132, must be viewed in context of the workplace and the reasonable existence of a hazard. *Cotter & Co.*, 598 F.2d 911 (5th Cir. 1979). Compliance with the standard requires protective helmets (hard hats) when an employer has knowledge of a hazard requiring the use of helmets or a reasonable person familiar with the situation, including any facts unique to the particular industry, would recognize a hazard warranting the use of helmets. *Armour Food Co.,* 14 BNA OSHC 1817 (No. 86-247, 1990). An employees' exposure to overhead hazards and the potential for injury that could be prevented by wearing protective

helmets must be reasonable. *ConAgra Flour Milling Co.*, 16 BNA OSHC 1137 (No. 88-1250, 1993).

There is no dispute that SPI's employees work on the roofs of mobile homes in Plants 3 and 4 installing vents, decking and shingles. The employees work with roofing materials such as wooden decking, roofing paper and shingles, and use tools such as hammers, saws, pneumatic air guns, knives, staple guns, and drills. Some of the tools weigh in excess of 10 pounds, and a roll of roofing paper weighs approximately 40 pounds (Tr. 360-363, 375-376, 3229, 3233).

Bobby Hanson, assistant production manager, testified that he has observed a half a roll of roofing paper fall off a roof (Tr. 3385-3388). He testified that after the incident, a new work rule was initiated which required employees to cut the paper to size on the ground before taking it onto the roof (Tr. 3389, 3395).

Darren Davis, roofing supervisor, testified that the hazards on the roof include boxes of staples and vents with sharp edges (Tr. 3236). In the past, he has dropped his utility knife and other things off of a roof. Also, his wife has dropped an unplugged saw which scratched an employee's face (Tr. 3228, 3230). Davis knew of other instances where metal retractable measuring tapes had been dropped (Tr. 3232).

Dawn Davis, line leader and wife of Darren Davis, testified that employees entering or exiting the marriage-side[7] of the mobile home were exposed to falling pieces of wooden overhang, which weigh as much as 15 pounds, being cut off at the roof's edge (Exh. C-63; Tr. 3825-3826, 3838). She said that the only warning to employees was the sound of the router cutting the wood (Tr. 3829).

While the employees worked overhead on the roofs and catwalks, CO Sims observed employees working on the outside of the mobile homes or coming in and out of the mobile homes. The employees were not wearing protective helmets. OSHA estimated that approximately 147 employees on a daily basis work in the immediate proximity of the roofing stations and are potentially exposed to the hazard of falling objects (Exhs C-65, C-66, C-67; Tr. 361-363, 375, 1758-1760).

SPI's accident and injury reports show that employees have been struck by falling objects (Exh. C-8). At least 29 head injuries were reported from April, 1997, through March, 2000. For

[7]On a double-wide mobile home, the marriage side is the open side before being joined.

example:

Gary Lewis, a former vinyl hanger, testified that he had been struck in the head on two occasions in June, 1999, and April, 2000 (Tr. 1236-1238). In 1999, he was struck by a pair of steel snips, measuring 15 inches long and weighing approximately 1 pound, which had accidentally been dropped by another employee on scaffolding. He received a mild concussion (Tr. 1238-1239, 1242). In the second incident, Lewis stated that he was struck in the head by a sheet of 8 feet by 4 feet, three-quarter inch plywood decking. His neck injury required him to wear a neck brace (Tr. 1240-1242).

June Boerner, a former line leader in final finish in Plant 3, testified that she had been struck in the head at least twice. In October, 1998, she was hit by a 35 pound roll of roofing paper that fell off the roof. She was taken to the emergency room and lost two days' work (Exh. C-8, p. 00768; Tr. 1352-1353, 1357, 1396-1397). On the same day, she said that another woman was also struck in the head by a heavy roll of insulation (Tr. 1357). In another incident in 1995, Boerner testified that she was struck in the head by a nail gun (Tr. 1353-1354, 1421-1422). Boerner's work was generally inside the mobile homes and her injuries occurred when entering or exiting the homes. Although she did not consider SPI a safe place to work, Boerner testified that she did not want to wear a hard hat because they were hot and inconvenient when working inside cabinets (Tr. 1369-1370, 1401).

Karen Cratty, former cabinet shop and rework employee, testified that she was almost struck in the head by a piece of shingle being thrown off the roof. She was not aware that hard hats were available until after the OSHA 2000 inspection. Also, she never saw any signs regarding hard hats or received any training or instruction on precautions (Tr. 1161-1163, 1194, 1211-1212).

Terry Williams, current production electrician, testified that she had been struck on the head by a disconnected air hose that fell from a catwalk in December, 1999. Williams received a concussion and lost two days of work (Tr. 2309-2310). SPI nurse Kelly Hertenstein testified that Williams sustained a second head injury when a piece of plywood decking fell off a mobile home roof in 1999 (Tr. 3718). Williams stated that her safety instruction was to "keep your eyes open" (Tr. 2307, 2309). Williams also testified that another employee, Richard Smith, had been struck in the head by a sheet of plywood in November, 1999 (Tr. 2315, 2320). Smith, in a

statement, stated that he had been struck twice, once by a hammer and once by wood decking (Exh. C-78).

SPI claims that hard hats are not required in its industry (SPI Brief p. 59). Director of manufacturing Daughtry, who has 30 years of industry experience, testified that hard hats are not mandatory in the mobile home industry (Tr. 3909-3910). SPI has a voluntary program with 60 hard hats available for employees (Exhs. R-43, R-45, R-46; Tr. 3896, 3902). SPI notes that employees such as Boerner refuse to wear hard hats because of the heat and other problems (Tr. 1400-1401). SPI also posted warning signs in English and Spanish, such as "Caution - Overhead Work," throughout the plant, which advised employees working in the area (Exh. C-60; Tr. 364, 3282-3283). Additionally, SPI asserts that it initiated several changes after the 1999 citations for hard hats which reduced the overhead hazards. These changes included (1) centering the mobile homes in the stations to reduce the gaps, (2) instructing employees on the ground to avoid overhead hazards, (3) eliminating rolls of roofing paper on the roofs by cutting them to length on the ground, and (4) using two employees to cut off the excess roof decking so that it will not fall to the ground[8] (Tr. 3284, 3295-3296, 3306, 3356, 3824-3825, 3828). Also, roofing supervisor Darren Davis initiated a verbal work rule prohibiting employees in his crew from laying tools down on the roof when not in use, unless the tools are secured (Exhs. C-96; Tr. 3237-3238, 3240). An employee was also stationed on the catwalk to take material and tools from employees on the roof (Tr. 3282). Based on these changes, SPI asserts that its injury rates declined steadily during 1996 to 2000, with no head injuries in 2001 (Exh. R-17; Tr. 3648).

Despite SPI's attempts to reduce the overhead hazards, the Secretary has established a violation. Instead of complying with the standard, SPI has attempted to reduce the hazard. However, as long as employees with tools and materials are working over the heads of employees on the ground and there are openings, the overhead hazards remain. Even if the mobile homes are centered, there are still openings through which tools or materials could fall (Exh. C-99; Tr. 2127, 2137, 3153-3154). The verbal rule by one supervisor regarding tools on the roofs was not shown to be enforced by SPI. No employee has been disciplined (Tr. 3242). It was not an SPI work rule (Tr. 3506). Safety manager Gerard testified that it was not unusual to leave tools and equipment on top of roofs (Tr. 3509). Although there may have been a decline in

[8]After OSHA's inspection, the decking is precut so there is no overhanging boards (Tr. 3827).

reported head injuries, it is not shown that the overhead hazards did not continue to exist.

In a letter dated October 19, 1999, OSHA specifically rejected SPI's voluntary hard hat proposal (Exh. C-10). Both Tom Gerard and Daughtry admitted that neither of them discussed with OSHA the propriety of a voluntary hard hat program (Tr. 3699, 3979).

SPI's Fall Protection Plan states "[w]hen employees are exposed to falling objects, we ensure they wear hart hats," and also requires additional measures such as toeboards, screens, canopies, or barricades (Exh. C-6, p. 01243). SPI failed to comply with its own plan.

Kelly Hertenstein, industrial nurse and assistant safety director, stated that she was aware that employees (Gary Lewis, Terry Williams) were struck by falling objects while working under the roofs, catwalks, and mezzanines. She testified that she tried to "get them to wear hard hats in that area. I talked to management about it but it's still not mandatory" (Tr. 3715, 3717-3718).

Willful Classification for Citation No. 2

As stated, a willful violation differs from other classifications of violations under the Act by a heightened awareness of the illegality of the conduct or conditions and by a state of mind showing conscious disregard or plain indifference. *Morrison-Knudsen Co./Yonkers Contracting Co.*, 16 BNA OSHC 1105, 1123 (No. 88-572, 1993).

SPI violation of § 1910.135(a)(1) for failing to require protective helmets is willful. On May 5, 1999, SPI received a citation for violation of § 1910.135(a)(1) (Exh. C-3). SPI certified that it had corrected the violation (Exh. C-3; Tr. 3967). SPI was even told by OSHA that it specifically rejected SPI's voluntary hard hat proposal (Exh. C-10).

SPI attempts to reduce the overhead hazard without complying with the standard were not shown to be adequate or effective. An employer who knows the requirements of the standard but decides not to comply, even if it has a good faith belief that its own approach provides protection at least equivalent to OSHA's requirements, is still in willful violation. *Reich v. Trinity Industries, Inc.*, 16 F.3d 1149, 1152 (11th Cir. 1994).

Although eliminating all overhead hazards is better than requiring personal protective equipment (PPE), the standard requires hard hats as long as a reasonable probability of injury exists. *See Keco Industries, Inc.*, 13 BNA OSHC 1161 (No. 81-263, 1982). Prior head injuries show the existence of the ongoing hazards which were not eliminated by any changes by SPI. The employees who incurred the injuries testified regarding the overhead hazards. Tools and

materials are still on the roofs, and employees continue to walk or work below.

Docket No. 00-1807 (Health citations)

Serious Citation 1, Items 2a and 2b - Alleged violations of §§ 1910.1200(f)(5)(i) and 1910.1200(f)(5)(ii)

The citation alleges that a 5 gallon plastic bucket containing adhesive in the cabinet shop in Plant 3 was not labeled, tagged, or marked with the identity of the hazardous chemicals and appropriate hazard warnings. Section 1910.1200(f)(5) provides in part:

> Except as provided in paragraphs (f)(6) and (f)(7) of this section, the employer shall ensure that each container of hazardous chemicals in the workplace is labeled, tagged or marked with the following information:
>
> (i) Identity of the hazardous chemical(s) contained therein; and
>
> (ii) Appropriate hazard warnings, or alternatively, words, pictures, symbols, or combinations thereof, which provide at least general information regarding the hazards of the chemicals, and which, in conjunction with the other information immediately available to employees under the hazard communication program, will provide employees with the specific information regarding the physical and health hazards of the hazardous chemical.

There is no dispute that a 5-gallon bucket of an adhesive was observed sitting on the floor of the cabinet shop. The bucket was not labeled. The adhesive, also known as formica glue, is manufactured as Lokweld 500 adhesive and is used by SPI to attach the laminated counter tops. It is applied by paint rollers and used on a daily basis (Exhs. C-34, pp. 01029, 00547, C-71; Tr. 1201, 1563-1564, 1568-1569, 1584, 2706, 2739, 3541-3543).

The adhesive is a hazardous chemical as defined in § 1910.1200(c).[9] SPI's Hazard Assessment and PPE Selection Worksheet identifies it as a "flammable adhesive" with a "high risk level" and a "high injury potential" (Exh. C-30, p. 01329; Tr. 3548-3549). The material safety data sheet (MSDS) describes the adhesive as extremely flammable, containing acetone, hexane isomers, n-hexamine, and toluene, which have permissible exposure limits. The potential health concerns include irritation and inflammation of the eyes and skin, and at high levels,

[9] "Hazardous chemical" is defined as "any chemical which is a physical hazard or a health hazard."

narcosis. It is toxic to blood, lungs, kidneys, liver, and the nervous system (Exh. C-34; Tr. 1575-1576).

In the cabinet shop, employee Raul Zendejas was observed applying the adhesive from the bucket. At least 3 other employees also used the adhesive from the bucket and as many as 15 employees were in the cabinet shop on a regular basis (Tr. 1201, 1582-1584, 2704-2705). Karen Cratty regularly refilled the bucket from a 55-gallon drum, located approximately 25 feet from the cabinet shop, which was labeled with appropriate flammable and health hazard warnings. Cratty testified that the 5-gallon bucket was never labeled (Tr. 1155-1156, 2701, 2703, 2713). The bucket was generally placed behind where the employees using an electric sander sanded the cabinets. OSHA observed that sanding caused sparks to fall in the area of the bucket when the sander struck nails (Tr. 1589-1590, 2707-2709).

Safety manager Gerard knew that the adhesive was used in the cabinet shop (Tr. 3541-3542). The bucket was in plain view (Tr. 1585). Eric Davis identified the unlabeled bucket of adhesive as a problem in a safety inspection on June 20, 2000 (Exh. C-21, p. 5; Tr. 3119).

SPI argues that the bucket did not have to be labeled because it was used by employees who refill the adhesive from its original container. *See* § 1910.1200(f)(7). SPI claims that the employees knew the hazards of the adhesive and could read the hazards listed on the 55-gallon drum. Also, SPI claims that the absence of a label on the 5-gallon bucket, even if a technical violation, could not expose employees to serious injury or death. The sparks from the sander did not fly directly towards the bucket (Tr. 1820-1821).

SPI's arguments are rejected. Sections (f)(6) and (f)(7) of § 1910.1200 do not apply in this case and therefore do not except SPI from complying with the labeling requirements. SPI does not assert, and the record does not show, that signs, placards, or other written materials were used in lieu of labeling, as required by § 1910.1200(f)(6). The exception at § 1910.1200(f)(7) for portable containers does not apply because it is limited to the immediate use of the employee who performs the transfer. In this case, other employees also used the adhesive from the bucket. The accumulation of dried glue on the bucket indicates repeated and prolonged use (Exh. C-71). Corporate safety director Eric Davis told OSHA that such a bucket would last a week (Tr. 1586-1587).

The record establishes serious violations of §§ 1910.1200(f)(5)(i) and 1910.1200(f)(5)(ii).

The unlabeled bucket contained a flammable adhesive and was located near the sanding operations, which produced sparks. SPI should have known of the unlabeled bucket. It was in plain view. *See American Airlines, Inc*., 17 BNA OSHC 1552, 1555 (No. 93-1817, 1996) (chemical not being used but in area accessible by employees must be labeled); *Aero Tec Laboratories, Inc*., 17 BNA OSHC 2179, 2183 (No. 94-0055, 1996)(ALJ) (even when large 55 gallon drum was labeled, a small one gallon bucket dispensed but not immediately used by employees requires labeling).

Serious Citation 1, Item 3 - Alleged violation of § 1910.1200(h)(2)(iii)[10]

The citation alleges that employees in maintenance, final finish, and frame shops were not provided with information as to the location and availability of the written hazard communication program. Section 1910.1200(h)(2)(iii) provides that employees be informed of:

> The location and availability of the written hazard communication program, including the required list(s) of hazardous chemicals, and material safety data sheets required by this section.

There is no dispute that SPI used hazardous chemicals requiring SPI to develop a written hazard communication program. SPI's written hazard program consisted of MSDSs, chemical inventory, chemical risks, and a hazard communication program (Exhs. C-34, C-35, C-36, C-37). The chemicals used on a daily basis included foam seal cleaner, propane, gasoline, brake fluid, DAP, seam fill, solvent, acetone, paint, paint thinner, and adhesives (Tr. 1255-1256, 1616, 1633-1634). There was also wood dust and welding fumes present in the plant (Exh. C-76; Tr. 1617, 1622, 1635). Although not in significant amounts, IH Cole's air monitoring detected formaldehyde, iron oxide, chromium, beryllium, and heavy metal components (Tr. 1622, 1635-1636).

The citation was based on statements from James Rinehart, Michael Suitt, Michael Severs and Sergio Manriquez (Tr. 1614). They told OSHA that they were never informed of SPI's hazard communication program (Tr. 1614).

However, the record does not support their allegations. SPI's MSDSs and written hazard communication program were in a book kept in the employees' breakroom. Employees could not clock in, get a drink of water, or go to the bathroom without seeing the big blue signs

[10]The citation alleges § 1910.1200(h)(1)(iii) which does not exist. The correct standard is § 1910.1200(h)(2)(iii).

identifying the program (Exh. R-7; Tr. 2439-2440, 2505, 3637).

Despite his statement to OSHA, maintenance leadman Rinehart testified that SPI's written program and MSDSs had been in the breakroom since 1997 (Tr. 2433-2434). In his statement to OSHA, Suitt, when asked if he had been informed about the location/availability of the MSDS, answered "Yes" (Tr. 1945). Even in Severs' statement, he stated he knew the MSDSs were in a drawer in the maintenance shop, but he did not know which drawer. Severs testified that he knew where the information was in the breakroom, but he just forgot to tell OSHA (Tr. 2505, 2507-2508). Other employees also stated that they had been informed of the location and availability of SPI's hazard communication program. IH Cole testified that a number of employees stated that they knew where the hazard communication and MSDSs were located (Tr. 1889, 1991). Employee Karen Cratty testified that she knew the book was in the breakroom, although she never looked at it and did not know what an MSDS looked like (Tr. 1205). She was told of the location in the breakroom when she started work (Tr. 1151, 1153, 1205). June Boerner also knew that the information was located in the breakroom (Tr. 1383-1384).

In addition to the breakroom, copies were in the manager's office, frame shop, and chassis shop across the street (Tr. 3875). Supervisor M. Jackson said also it was in the stockroom (Tr. 2688-2690).

The record shows that SPI's hazard communication program was placed in locations available to employees. A violation is not necessarily established because employees did not remember the location or testified that they were not familiar with the program. The program was in the employees' breakroom. IH Cole agreed. *See National Envelope Corporation*, 18 BNA OSHC 1562 (Nos. 94-2968, 94-3547, 1998) (MSDS station conspicuous by printed signs where employees must pass at least twice daily to punch in is compliance).

The violation is not established.

Willful Citation 2, Item 1 - Alleged violation of § 1910.1200(h)(3)(ii)[11]

The citation alleges that employees working with hazardous chemicals/substances, such as cellulose insulation, welding fumes, wood dust, foam seal cleaner, bleach, paint thinner, and adhesive were not trained on the health hazards. Section 1910.1200(h)(3)(ii) requires that

[11]Amended on May 23, 2001.

employees receive training on "the physical and health hazards of the chemicals in the work area."

Employee training is a "critical part" of an employer's hazardous communication program. The importance of training is to ensure "that the employees are aware that they are exposed to hazardous chemicals, that they know how to read and use labels and material safety data sheets, and that, as a consequence of learning this information, they are following the appropriate protective measures of the employer." *See* § 1910.1200, Appendix E (4)(c).

Section 1910.1200(h)(3)(ii) is a performance oriented standard designed "to allow . . . employers maximum flexibility in meeting the intent of the standard in developing programs to their own individual workplaces." OSHA Letter of Interpretation (October 15, 1990). The standard permits training on categories of hazards (flammability, carcinogenicity) or specific chemicals. However, chemical specific information must always be available. *See* § 1910.1200(h)(1). Also, it is recognized that supervisors are "frequently responsible for on the job training sessions." *See* § 1910.1200, Appendix E(4)(c). However, the employer remains ultimately responsible. In providing training, an employer's mere words of caution and general statement about health hazards are not sufficient. Training must include an explanation "of both the change in body function and the signs and symptoms that may occur to signal that change." *See* § 1910.1200, Appendix A.

SPI employed approximately 425 employees during the relevant period (Tr. 3614). SPI's training program involved training production managers, supervisors and line leaders, who in turn were supposed to train the employees in their departments. The training of supervisors included how to read and understand applicable MSDSs (Tr. 3580, 3611, 3615). Also, vendors, including representatives from Foam Seal, Thermogas, and welding products, conducted training on their products (Tr. 2807-2808, 3581-3582, 3622). According to SPI, it chose its training methods because employees often moved around in the plant after they were hired (Tr. 3878-3879).

The record reflects that, for the most part, SPI did not document its training of employees. Appendix E to § 1910.1200 explains that the standard does not require employers to create or maintain records of employees' training. Also, OSHA Directive CPL 2-2.38D, p. 14 (1998), states that "[i]t cannot be expected that employees will recall all information provided in the

training and be able to repeat it."

There is no showing that employees mishandled chemicals or failed to wear proper personal protective equipment (PPE) (Tr. 1832). Monitoring results did not show that employees were exposed to air contaminants above the PEL or chemical substances (Exhs. C-38, R-18). Prior to OSHA's inspection, SPI made certain changes, including replacing fiberglass with cellulose insulation, because it was less dusty, and replacing the use of paint thinner in final finish with orange cleaner (Exh. C-12, p. 01393; Tr. 3894).

Discussion

The OSHA citation alleges 12 instances of lack of training based on employees' statements (Tr. 1858).

Instance (a). Employees who were spraying insulation into roofs are allegedly not trained. The cellulose insulation is sprayed by 5 employees into the roofs while other employees are working inside the mobile homes (Tr. 3207, 3215-3216, 3332). The insulation is purchased by the semi-truck trailer load (Tr. 3701-3702).

The cellulose insulation used by SPI is manufactured under the product name "Cocoon Insulation." The MSDS states that "Cocoon Insulation is not considered hazardous under the criteria of the Federal OSHA Hazard Communication standard 29 C.F.R. 1910.1200." However, the insulation contains not more than 10% by weight of boric acid and nuisance dust. The MSDS identifies boric acid as hazardous under OSHA's hazardous communication standard and states that boric acid presents a hazard of emission from extreme heat or open flame (Exh. C-34, p. 01048). Also, under occupation exposure limits, the MSDS states that "Cocoon Insulation is listed/regulated by OSHA, CalOSHA, and ACGIH as 'Particulates not otherwise classified' or 'nuisance dust'."

Roofer Jerry Carter told OSHA that when he was hired, he was instructed that the insulation could cause sneezing and eye irritation (Tr. 1887-1889). IH Cole testified that Carter could not name the chemicals in the insulation or recite the health affects of boric acid (Tr. 1886-1887). Carter told him that he was not specifically trained (Tr. 1654-1655). Carter did not testify at the hearing.

Roofing supervisor Davis testified he has worked with the insulation for 8 months (Tr. 3221). He told OSHA that he was not trained on the insulation's health affects and was not

given the MSDS (Tr. 3220). Davis testified, however, that the manufacturer's representative told him about the insulation, ate some of it, and put a lighted cigarette into it. No "health aspects" were discussed (Tr. 3210-3211, 3213). Based on the representative, Davis believed that the insulation was harmless and could only cause an irritation (Tr. 3212, 3313-3314). Therefore, Davis never discussed any hazards with employees (Tr. 3217). Davis testified that he was given the MSDS but was not aware of the presence of boric acid (Tr. 3219, 3319-3320).

The record shows that SPI failed to adequately train employees exposed to the insulation's health affects from boric acid and nuisance dust. The MSDS describes the health affects.

Instance (b). Employees in the maintenance shop welding and using foam seal cleaner are allegedly not trained. The instance is based on the statement of maintenance leadman Robert Jackson. Jackson stated to OSHA that he could not remember if he was trained on the health affects of breathing welding fumes. He also stated that his training on foam seal cleaner was from a manufacturer's representative (Tr. 1659, 1890, 1892-1893). He used the cleaner one day a week (Tr. 1660).

The MSDS for welding rods used by SPI states that the health hazards include affects on the pulmonary function. The PEL for the metal compounds is 10 mg/m³ (Exh. C-34, p. 01067; Tr. 1661). Safety manager Gerard considered the welding fumes in the plant as hazardous (Tr. 3544).

Leadman Robert Jackson testified that he received specific training that included a welding safety class in 1999 given by a vendor. The training involved a video and instruction on welding safety (Exh. R-15; Tr. 2807-2808). Although he could not remember the discussion on fumes, Jackson testified that he knew the hazards of welding fumes and was sure welding was also covered in SPI's Right to Know training (Tr. 2619-2620).

With regard to the foam seal cleaner, it is used by maintenance employees to clean the foam seal guns (Tr. 2802). The record does not include the MSDS for foam seal cleaner.[12] Leadman Jackson testified that the representative's training on foam seal and cleaner included the health and physical hazards (Tr. 2620-2621). He also stated that he received OJT instruction for appropriate PPE (Tr. 2621). There is no showing that Jackson handled the cleaner contrary to

[12]The MSDSs in the record are for foam seal adhesive (Exh. C-34, pp. 01041, 01044: Tr. 1672, 1698).

the precautions in the MSDS (Tr. 1901).

Maintenance supervisor Cole testified that maintenance employees who used foam seal cleaner were trained prior to the OSHA inspection (Tr. 2801-2802, 2858-2859). Employees received foam seal safety training on June 10, 1999, by a manufacturer's representative (Exh. R-15, item 3; Tr. 3581-3582). The training included a video that discussed the hazards (Tr. 2859, 3581-3582). Cole told employees that the cleaner could blister their skin because it is caustic. He also said that employees were instructed to wear rubber gloves and safety glasses (Tr. 2804). Supervisor Cole testified that he has not seen employees mishandle the cleaner or not using gloves (Tr. 2809). According to Cole, the only employee not trained by the manufacturer's representative was Mike Severs, who had not worked with foam seal guns or cleaner at the time (Tr. 2858).

The record fails to substantiate that maintenance employees were not trained in the health affects of the cleaner, if any, and welding fumes.

Instance (c). The instance alleges that employees exposed to wood dust at the dado saw were not trained in the health and physical hazards. It was based on the statements of Tommy Manning and Greg Banks, who did not testify (Tr. 1662-1663, 1666-1667, 1903).

Wood dust is hazardous (Exh. C-34, p. 00329;[13] Tr. 1665-1667). According to the MSDS, the health hazards of wood dust include eye and nasal irritation, coughing, and wheezing. Also, depending on the species, wood dust may cause dermatitis and respiratory sensitization or irritation on prolonged repetitive contact. The wood used in the truss shop is spruce (Tr. 1901). The MSDS notes that the International Agency for Research on Cancer (IARC) classifies wood dust as a carcinogen to humans.

In reviewing the statements, IH Cole conceded that Manning, in response to the training question, actually said "No, I don't think I have" (Tr. 1909). He had heard, but not from SPI, that wood dust was a possible nasal carcinogen, and he did not wear a respirator (Tr. 1909-1910).

When asked about training, Banks responded that he was told to keep the wood dust cleaned up (Exh. C-72; Tr. 1905). He was not told that wood dust was a possible nasal carcinogen. He did not wear a respirator.

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[13]Although there are other MSDSs for wood in Exh. C-34, the MSDS from North Pacific Lumber Co. was the only one identified by IH Cole as the wood used in the truss shop (Tr. 1665).

Assistant production manager Jackson testified that employees were trained on the allergic affects of wood dust (Tr. 2735). However, he was not aware that OSHA considered wood dust a potential cancer hazard (Tr. 2735). According to IH Cole, no SPI manager knew that the dust was a possible carcinogen (Tr. 1837-1838, 1844).

SPI argues that there is no evidence that the spruce used in the truss shop was a potential nasal carcinogen. SPI notes that other MSDSs for wood used at SPI did not indicate a risk for nasal cancer. Also, air monitoring results show minimal exposure levels (Exh. R-55). Manning's exposure level was 3.2 mg/m^3 and rip saw operator Maldanado's exposure was .64 mg/m^3 (Exh. R-55, p. 00864, 00866; Tr. 1785-1787). The PEL for total dust is 15 mg/m^3 (Tr. 1785).

SPI's argument is rejected. The MSDS for the wood used in the truss shop states that it is a possible carcinogen. SPI's training should have included the health information contained on the MSDS. There is no dispute that all health information, including possible carcinogens, was not provided.

Instance (d). The instance involves employees dispensing chemicals such as industrial strength bleach, paint thinner, and formica adhesive from bulk containers in the stockroom. The employee was Ruby Kersten (Tr. 1668).

Industrial strength bleach stored in the stockroom is hazardous (Exh. C-83; Tr. 1118, 1669). The MSDS indicates that the health hazards include possible burning, watering and loss of sight; inflammation and blistering on the skin; irritation, nausea and difficulty of breathing from inhalation; and internal irritation, cramps and vomiting from ingestion.

Although the MSDS for paint thinner is not part of the record, it is commonly known that it is highly flammable (Tr. 1340). Also, final finish employee Boerner testified that she experienced some dizziness and nausea from the use of paint thinner (Tr. 1344-1345). However, at the time of OSHA's inspection, the record shows that paint thinner had to be sneaked in by employees as a cleaner because it was against SPI rules. SPI had replaced the paint thinner with an orange cleaner (Tr. 1310, 1451, 1472, 3817).

As discussed, the formica adhesive (glue), under the trade name Lokweld 500 Contact Adhesive, is a hazardous chemical. According to the MSDS, it contains acetone and toluene (Exh. C-34, p. 00547). The adhesive is used to attach the laminates to the counter tops (Tr.

1669). The potential acute health affects include skin and eye contact irritation with inflammation, itching and redness. The potential chronic health affects include toxicity to the blood, kidneys, lungs, liver, and nervous system.

Former stockroom employee Kersten's duties included maintaining large containers of chemicals, dispensing chemicals to other employees, and washing used rags containing chemicals (Tr. 997, 1002-1003, 1009). She reviewed the MSDSs and used them to label the containers with safety ratings for health, flammability, and reactivity (Tr. 1065-1066, 1075). Kersten testified that she dispensed paint thinner every day (Tr. 1003, 1046). Also, she diluted the bleach and used it to clean dirty rags daily which contained various chemicals from all over the plant (Tr. 1045, 1048-1049). Kersten's prior work experience included reading and maintaining MSDSs at an aluminum plant (Exh. R-58; Tr. 1054, 1061-1062, 2812).

Kersten testified that she had not received any training from SPI on the health problems associated with the chemicals in the stockroom (Tr. 1039-1040). She described the chemicals at her prior employment as different from those used by SPI (Tr. 1041, 1058). She testified that she trained herself and learned about the chemicals by looking at the MSDSs (Tr. 1041). She understood the ratings on the MSDSs and followed the recommendations regarding the hazards posed by each chemical she labeled or dispensed (Tr. 1075).

Supervisor Bobby Cole hired Kersten to review, dispense, and label the chemicals in the stockroom because of her background (Tr. 1052, 1061, 2812). Cole testified that stockroom employees were trained on the hazards and appropriate PPE by the vendor of industrial strength bleach (Tr. 2813-2814). He also instructed Kersten to wear gloves when using bleach to wash shop rags (Tr. 2814-2815).

Although Kersten was knowledgeable, based on her experience, the record shows that SPI failed to ensure that she was trained on the hazards of the chemicals used at its plant. Reliance on past employment is not sufficient. SPI is ultimately responsible to ensure that each employee is properly trained. There is no showing that the chemicals used by Kersten's prior employer were the same as at SPI. However, there is no showing that Kersten was injured or became ill because of any exposure to chemicals at SPI (Tr. 1074-1076).

Instance (e). The instance involves employees in the tops department who sprayed foam adhesive (sealer) on roof units. The allegation was based on a statement by Nick Walker, who

did not testify (Tr. 1670).

The MSDS for the foam adhesive includes two components which are mixed when passing through the spray gun (Exh. C-34, p. 01041, 01044; Tr. 1672). The MSDS advises employees to avoid breathing vapor or mist and contact with their eyes and skin. SPI identified the foam seal in its hazard assessment and PPE selection worksheet (Exh. C-30, p. 01337). The assessment required safety glasses and protective clothing.

Walker's interview statement of March 23, 2000, does not establish a violation (Exh. C-82; Tr. 1912-1915). Walker stated that he had used foam seal for approximately 1 year. In response to questions on training, Walker stated that he received training during OSHA's inspection and watched a video approximately 4 months earlier from the manufacturer's representative (Tr. 3581-3582). When asked if the earlier training included health affects of chemicals, Walker stated that "I think so. I don't really remember, but I think so." When asked if the video contained specific information on the health and physical affects of the chemicals he worked with, Walker stated "I really don't remember." Walker knew that foam seal could irritate the eyes, skin and lungs (Exh. C-82). He stated that he has had no allergic reactions or breathing difficulties from using the sealant. He wore safety glasses, a foam seal suit, latex gloves, boots, and a face shield when spraying the sealant. Prior to the video training, Walker stated that he had not received any training.

The record fails to establish that Walker was not trained on the sealant at the time of OSHA's inspection. His statement is vague and inconsistent. Any failure to train Walker prior to the video and instruction by the manufacturer's representative is barred by the 6-months' statute of limitations. **Instance (f)**. This instance involves employees exposed to wood dust while sawing and sanding in the cabinet department. The allegation is based on a statement from Sybal Paul, who said that she was not trained on the health and physical hazards of wood dust (Tr. 1674-1675).

The MSDS for the wood used by Paul identifies the health hazards to include eye irritation, possible allergic contact dermatitis, obstruction in nasal passages, and aggravation of pre-existing respiratory conditions or allergies (Exh. C-34, p. 01093). Depending on the species of wood, the MSDS also advises that the chronic health hazards include dermatitis, respiratory sensitization, and alleged nasal/paranasal sinus cancer.

Paul was hired by SPI on January 3, 2000, approximately one month prior to OSHA's inspection. She received training in March, 2000, after OSHA initiated its inspection in late February. Paul told OSHA that she knew where the MSDSs were located. She also stated that she had not been injured or sick from her job. Although not asked the type of wood or how often she was exposed, Paul indicated that her job included cutting wood (Tr. 1918-1919).

Milton Jackson, cabinet supervisor, testified that he informed employees of possible allergies caused by breathing wood dust (Tr. 2735). He did not tell employees that wood dust could cause nasal cancer (Tr. 2735).

Karen Cratty, who cut boards in the cabinet shop, testified that by the end of the day, there would be a large box of wood dust (Tr. 1147, 1155, 1187-1188). She did not remember Jackson telling her of the potential for allergies (Tr. 1179, 2735). She knew that copies of the MSDSs were in the breakroom (Tr. 1180).

The record establishes that Paul did not receive training on the hazards of wood dust until OSHA's inspection.

Instance (g). The instance involves employees using formica glue, seam seal solvent and paint thinner while attaching counter tops in the cabinet department. The employees allegedly not trained were Floyd Smuthers, Karen Cratty, and supervisor Milton Jackson (Tr. 1676, 1921). Smuthers, who did not testify, provided a written statement.

Formica glue (adhesive), as discussed, is a hazardous chemical (Exh. 34, pp. 00547, 01029; Tr. 1677-1678). Also, paint thinner, a known flammable, is hazardous (Tr. 1340). The MSDS for seam seal solvent was not identified by the Secretary.

Supervisor M. Jackson testified that he was not in the cabinet shop for an extended period while employees were gluing laminate (Tr. 2659-2660). He had been given the MSDS for formica glue and had seen the MSDS for paint thinner (Tr. 2679-2681). In the statement to OSHA, M. Jackson stated that he could not remember if the health affects were discussed (Tr. 2683).

Jackson testified that he was responsible for training other employees, which was done on their first day on the job (Tr. 2684-2686, 2698-2699). He stated that he reviewed the MSDSs and showed the employees the labels. He showed the employees who used the glue the label advising that it was flammable (Tr. 2695-2696, 2703). Jackson testified that he followed the same

practice with the other chemicals (Tr. 2685-2686, 2736). There is no evidence that cabinet shop employees failed to use appropriate PPE or were overexposed to the chemicals (Tr. 2727).

IH Cole testified that based on his written statement, Smuthers, who worked with the adhesive daily, had not been trained until March 15, 2000 (Tr. 1679). However, in his statement, Smuthers said that he received "some papers on it (training)" and that he had attended training in the conference room "a couple of times," the last time about a week ago (Tr. 1922). He was not asked about the first time. Also, he was not questioned to see if anyone had discussed the hazards in general or showed him the MSDS. Smuthers knew the location of the MSDSs (Tr. 1922-1923). Also, when asked if he had been trained on the physical and health hazards of formica glue, Smuthers stated "yes" (Tr. 2085).

Karen Cratty testified that plant nurse Kelly Hertenstein went over the "different chemicals and general rules and regs" when she was hired in July, 1999. It included where she "could find more information, safety" (Tr. 1168, 1171-1172). Cratty stated that she did not remember talking to manager Jackson about the chemicals, but she knew not to get chemicals in her eyes or ingest them. She also knew that glue was flammable (Tr. 1179, 1197).

The record fails to establish a violation.

Instance (h). The instance alleges that employees taping and spraying in the tops department were exposed to nuisance dust contained in the sheetrock joint compound. The allegation is based on Mike DeSalvo's statement (Tr. 1682). IH Cole observed DeSalvo working with the compound, which was used daily (Tr. 1683-1684). According to Cole, DeSalvo stated that he was not trained on the health hazards associated with the compound until March, 2000 (Tr. 1685). DeSalvo was hired on February 21, 2000, approximately one week prior to OSHA initiating the inspection (Tr. 1685). DeSalvo did not testify.

The MSDS for the sheetrock joint compound shows that the nuisance dust is hazardous. It provides that the inhalation of dust irritates the nose, throat, lungs, and upper respiratory tract (Exh. C-34, p. 01056). The MSDS also lists lung cancer as a potential from chronic overexposure. The nuisance dust was caused by sanding dried sheet rock joint compound.

SPI argues that DeSalvo used a labeled container which provided the health information (Tr. 1927). Also, while it lists lung cancer as a potential, the compound contains trace amounts of silica and less than 10% of mica. SPI's air monitoring never showed levels close to the TLV

or PEL (Exh. R-55). Therefore, SPI argues that it was reasonable to instruct on the dust's general health hazards.

Training is SPI's responsibility. During OSHA's inspection, DeSalvo was using the compound and the record fails to show that he was trained in the health hazards, even the general health hazards.

Instance (i). The instance alleges that employees stick welding in the welding shop were exposed to welding fumes and particles. The allegation is based on the statement of Michael Suitt, who did not testify (Tr. 1688-1689). Suitt started work in September, 1998 (Tr. 2060).

The MSDS for welding materials used by Suitt indicates that the health affects from short-term overexposure include dizziness, nausea, and irritation of the nose, throat or eyes (Exh. C-34, pp. 01067, 01069). Long-term overexposure may lead to iron deposits in the lungs and affects on pulmonary function. The physical hazards include potential blindness and electric shock from the welding arc.

According to IH Cole, Suitt stated that he received no training on welding's physical and health hazards (Tr. 1689). Also, he was not trained in hazard communication (Tr. 2059-2060). However, Suitt's statement indicates that he had attended safety meetings where welding safety was covered (Tr. 1944-1945). He could not remember if the meeting covered the hazards of welding fumes (Tr. 1945). He thought that someone had explained how to read and understand an MSDS. The record reflects that welding training was provided in 1999 by a welding supplier (Exh. R-15; Tr. 2807-2808). Training was also provided by safety manager Gerard after the 1996 citation (Exh. R-1; Tr. 3618). Air monitoring results show that Suitt's exposure to hazardous chemicals from welding was insignificant (Exh. R-55, p. 00868; Tr. 1790-1796).

The record fails to establish the lack of training.

Instance (j). The instance alleges that employees were not trained who used substances such as gasoline, formica adhesive, paint thinner, propane, and brake fluid in the maintenance department. The allegation was based on statements by James Rinehart and Mike Severs, who testified (Tr. 1690). Rinehart had stated that he was not trained on the health hazards associated with paint thinner, propane, formica adhesives, gasoline, and brake fluid (Tr. 1691-1692). Severs had stated that he used gasoline and brake fluid and was also not trained on the health affects (Tr. 1692-1693).

It is undisputed that gasoline, formica adhesive, paint thinner, propane, and brake fluid are hazardous chemicals as defined by OSHA.

Rinehart testified that in response to his questioning by OSHA, he understood training to mean classroom training (Tr. 2454-2455). He testified that he had received training on propane from a vendor (Tr. 2444-2445). He described the safety precautions (Tr. 1948, 2442-2443). Although Rinehart testified that he reviewed the MSDS for formica glue, he testified that he was not trained on how to read an MSDS (Tr. 2427-2428). He taught himself (Tr. 2428). Rinehart testified that his exposure to the formica glue occurred when he occasionally cleaned out the clogged spigot (Tr. 2447-2448). He always wore gloves. Rinehart also occasionally used paint thinner, which he had used for 30 years and was aware of the dangers (Tr. 2454). He knew where the MSDS was located (Tr. 2451).

IH Cole said that Severs "indicated" that he had not been trained on gasoline and brake fluid (Tr. 1692-1693). Severs had previously worked at a gas station and admittedly knew the hazards. SPI knew of Sever's past employment when he was hired (Tr. 2501-2502, 2809).

Maintenance supervisor Cole testified that he reminded employees of the dangers of the chemicals in the workplace (Tr. 2860). Severs apparently only used brake fluid one time, and it was in a labeled container (Tr. 2502-2503). IH Cole conceded that everyone knew that gasoline was flammable and not ingestible (Tr. 1946-1947). The record fails to support a violation.

Instance (k). The instance alleges that employees in final finish were exposed to formaldehyde, wood dust, and drywall dust. The allegation is based on statements by Angelique Scroggins and Sergio Manriquez, who did not testify (Exh. C-76; Tr. 1693, 1959).

Formaldehyde is an off-gas from wood materials such as floor decking, doors, and cabinet doors (Exh. C-34, p. 01073, 01099; Tr. 1694). The MSDSs provide that formaldehyde and/or wood dust may cause eye, nose, throat, and skin irritation. It notes that formaldehyde may be released in small quantities and in gaseous form. The MSDS notes that "OSHA regulates formaldehyde as a potential carcinogen for exposures exceeding 0.5 ppm" (Exh. C-34, p. 01073, 01076). It further provides that "wood products are not hazardous under the criteria of the Federal OSHA Hazard Communication standard 29 C.F.R. 1910.1200. However, formaldehyde emissions from this product and wood dust generated by sawing, sanding and machining this product may be hazardous." OSHA asserts that wood dust and possible formaldehyde were

present when employees cleaned inside the mobile homes (Tr. 1696). Scroggins stated that she cleaned cabinets, hung drapes, and did the finish work in the mobile homes (Tr. 1694). However, IH Cole fails to indicate that Scroggins actually told him she had not been trained.

Manriquez installed hardware and other things in preparing a mobile home for shipment. He did not sand or saw wood or drywall (Tr. 1963-1964). Manriquez stated that he was "kind of" trained on wood and drywall dust (Exh. C-76; Tr. 1697, 1961). He had no training on formaldehyde. He stated that he had no problems with skin and eye irritations or any feeling of sickness.

Air monitoring at the SPI plant fails to show exposure levels to any of the substances at or near the PEL (Exhs. R-18, R-55; Tr. 1798-1803). The employees in final finish were not involved in cutting or sawing the wood and the record fails to show lack of training.

Instance (l). The instance alleges employees in the roof building area sprayed foam adhesive, which contained harmful substances such as isocyanate. The alleged lack of training is based on a statement by William Stover, who did not testify (Tr. 1698). Stover told OSHA that he had not received any training on the physical and health hazards associated with foam seal prior to OSHA's inspection (Tr. 1699, 2070-2071). Stover had worked in the roofing department for a year and had sprayed foam seal for approximately 7 months (Tr. 1986, 2072).

Foam seal adhesive, according to the MSDS, is hazardous (Exh. C-34, p. 01041, 01044). SPI identified foam seal in its hazardous assessment and PPE Selection Worksheet (Exh. C-30, p. 01337). Air monitoring did not show detectable traces to the ingredients of foam seal (Exhs. R-22, R-55; Tr. 1850, 1854-1855).

The standard requires training if employees are exposed under normal conditions of use or in a foreseeable emergency. *See* § 1910.1200(b)(2). Stover had sprayed the foam adhesive for approximately 7 months and the record establishes that he was not trained.

Willful Classification For Citation No. 2, Item 1

Instances a, c, d, f, h, and l establish a violation of § 1910.1200(h)(2)(iii) for lack of training. SPI's failure to train employees was willful. SPI had been cited twice for the lack of training under § 1910.1200(h)(2)(iii) in 1996 and 1999 (Exhs. C-3, C-39; Tr. 3534). The 1996 citation was alleged as willful and the 1999 citation was alleged as repeat. Although reclassified by the parties' settlement agreements, SPI agreed that the conditions had been abated. However,

OSHA's 2000 inspection showed continued lack of training.

SPI's written hazard communication program dated December 7, 1998, provides for training for present and new employees, as well as whenever a new hazard is introduced into their work area. Its training program is to include "a description and specific information of the chemicals in the work area," the specific hazards, the proper use of the hazardous materials, PPE, and emergency procedures. Also, employees were to sign-off sheets detailing the training received (Exh. R-13). SPI failed to comply with its own written program.

SPI's reliance on department managers to conduct the training was not shown to be overseen by SPI to ensure compliance. SPI failed to accept responsibility for compliance. Without verification of content and qualifications, SPI attempted to delegate the training to vendors and line supervisors.

A 1998 hazard survey by its insurance carrier noted that SPI's training program was inadequate. The survey recommended initiating health and safety training, first of supervisors, followed by employees (Exhs. C-25, C-26; Tr. 3573).

SPI employed 425 employees. It has a high turnover of employees (Tr. 1010, 3328, 3684, 3972). Of the 30 employees interviewed by OSHA, 17 indicated inadequate training (Tr. 1648-1649).

Penalty Consideration For Safety and Health Citations

Section 11(j) of the Act requires the Commission to give "due consideration" to the size of the employer's business, the gravity of the violation, the good faith of the employer, and the history of previous violations in determining the appropriate penalty. These factors are not necessarily accorded equal weight. The gravity of the violation is the primary element in the penalty assessment. *Trinity Indus.*, 15 BNA OSHC 1481, 1483 (No. 88-691, 1992).

SPI is a large employer with approximately 425 employees (Tr. 3614). SPI received an OSHA citation in 1999 and other citations within three years of the 2000 OSHA inspection. Based on these factors, SPI is not entitled to credit for size and history. However, SPI is entitled to credit for good faith. The record shows that after SPI became a division of Cavalier Homes, Inc., and after the 1999 OSHA citation, changes were made at the plant, including installing lifelines for the roofers, maintaining an MSDS book in the employees' break room, installing guardrails on the catwalks, and posting overhead warning signs. As a result of the 2000

inspection, SPI has made additional changes.

A penalty of $5,000 is reasonable for serious safety citation no. 1, item 3, violation of § 1910.24(b). In excess of 20 employees regularly moved back and forth from the mobile home roofs and catwalks. The gaps between the roofs and catwalks over which employees had to step exceeded 12 inches. The potential fall was 11 feet 4 inches to the cement floor.

A grouped penalty of $3,000 is reasonable for serious safety citation no. 1, items 4b, 4c, and 4d, violations of § 1910.147. The 5 maintenance department employees were exposed to the failure to have written procedures for LOTO on the presses and the failure to perform and certify periodic inspections of its LOTO procedures.

A penalty of $2,500 is reasonable for serious safety citation no. 1, item 9b, violation of § 1910.213(r)(4). The dado saw is operated daily and the operator on the outfeed side is continually exposed by reaching his hands through the plexiglass curtain and into the zone of danger.

A penalty of $2,500 is reasonable for serious safety citation no. 1, item 11a, violation of § 1910.332(b)(1). The lack of training on electrical safety-related work practices affected 5 employees who regularly worked on electrical equipment.

A penalty of $5,000 is reasonable for serious violation of § 5(a)(1) of the Act. Employees working on roofs of mobile homes installing trusses, decking, and vents were exposed to fall hazards of approximately 11 feet to the cement floor. The openings around the roofs could exceed 12 inches in Plant 4.

A penalty of $50,000 is reasonable for willful safety citation no. 2, item 2, violation of § 1910.135(a)(1). SPI failed to initiate a hard hat program, despite employees receiving head injuries and a prior citation from OSHA. Although hard hats were provided on a voluntary basis, SPI chose not to require the use of hard hats. Also, SPI's attempts to change its work procedures have not eliminated the overhead hazards.

A grouped penalty of $1,000 is reasonable for serious health citation no. 1, items 2a and 2b, violations of § 1910.1200(f)(5)(i) and § 1910.1200(f)(5)(ii). There was only one unlabeled 5-gallon bucket observed by OSHA. The drum where the adhesive was obtained by employees was within 25 feet and properly labeled. Four employees were exposed to the unlabeled bucket.

A penalty of $20,000 is reasonable for willful violation of health citation no. 2, item 1,

violation of § 1910.1200(h)(3)(ii). SPI's reliance on department supervisors to conduct the training without verification by SPI was misplaced. Six instances of inadequate training were established.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

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

ORDER

Based upon the foregoing decision, it is ORDERED that:

Safety Citations (Docket No. 00-1808)

Citation No. 1

Item 1, alleged serious violation of § 5(a)(1) of the Act, is withdrawn by the Secretary.

Item 2, alleged serious violation of § 5(a)(1) of the Act, is withdrawn by the Secretary.

Item 3, alleged serious violation of § 1910.24(b), is affirmed and a penalty of $5,000 is assessed.

Items 4a, alleged serious violation of § 1910.147(c)(4)(i), is vacated.

Items 4b, 4c, and 4d, alleged serious violations of § 1910.147(c)(4)(i), § 1910.147(c)(4)(ii), § 1910.147(c)(6)(i)(a), and § 1910.147(c)(6)(ii), are affirmed and a grouped penalty of $3,000 is assessed.

Item 5, alleged serious violation of § 1910.178(m)(2), is withdrawn by the Secretary.

Item 6, alleged serious violation of § 1910.178(o)(1), is withdrawn by the Secretary.

Item 7, alleged serious violation of § 1910.178(p)(1), is withdrawn by the Secretary.

Item 8, alleged serious violation of § 1910.212(a)(1), is vacated and no penalty is assessed.

Item 9a, alleged serious violation of § 1910.212(a)(3)(ii), is vacated and no penalty is assessed.

Item 9b, alleged serious violation of § 1910.213(r)(4), is affirmed and a penalty of $2,500 is assessed.

Items 10a and 10b, alleged serious violations of § 1910.219(d)(1) and § 1910.219(f)(3), are withdrawn by the Secretary.

Item 11a, alleged serious violation of § 1910.332(b)(1), is affirmed and a penalty of $2,500 is assessed.

Item 11b, alleged serious violation of § 1910.333(b)(2)(i), is vacated and no penalty is assessed.

Citation No. 2

Item 1, alleged willful violation of § 5(a)(1) of the Act, is affirmed as serious and a penalty of $5,000 is assessed.

Item 2, alleged willful violation of § 1910.135(a)(1), is affirmed as willful and a penalty of $50,000 is assessed.

Citation No. 3

Item 1, alleged "other" than serious violation of § 1910.178(a)(6), is withdrawn by the Secretary.

Item 2, alleged "other" than serious violation of § 1910.305(g)(2)(iii), is withdrawn by the Secretary.

Health Citations (Docket No. 00-1807)

Citation No. 1

Item 1, alleged serious violation of § 1910.1030(g)(2)(i), is withdrawn by the Secretary.

Items 2a and 2b, alleged serious violations of § 1910.1200(f)(5)(i) and § 1910.1200(f)(5)(ii), are affirmed and a grouped penalty of $1,000 is assessed.

Item 3, alleged serious violation of § 1910.1200(h)(2)(iii), is vacated and no penalty is assessed.

Citation No. 2

Item 1, alleged willful violation of § 1910.1200(h)(3)(ii), is affirmed and a penalty of $20,000 is assessed.

Citation No. 3

Item 1, alleged "other" than serious violation of § 1910.133(b), is withdrawn by the Secretary.

/s/
KEN S. WELSCH
Judge

Date: August 16, 2002