



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.

MB CONSULTANTS, LTD., d/b/a
MURRAY'S CHICKEN,

Respondent.

OSHRC Docket Nos. 12-1165 & 12-1269

Appearances: Terrence Duncan, Senior Trial Attorney
U.S. Department of Labor, Office of the Solicitor, New York, New York
For the Secretary

Thomas Benjamin Huggett, Esquire
Littler Mendelson, P.C., Philadelphia, Pennsylvania
For the Respondent

Before: William S. Coleman
Administrative Law Judge

DECISION AND ORDER

The Respondent, MB Consultants, Ltd., operates a chicken processing facility in South Fallsburg, New York. A compliance safety and health officer (CO) and an industrial hygienist (IH) for the Occupational Safety and Health Administration (OSHA) inspected the facility between November 29, 2011 and January 26, 2012. The CO conducted a workplace safety standards inspection and the IH conducted a workplace health standards inspection. As a result, on May 14, 2012, the Secretary issued a separate "Citation and Notification of Penalty" for each inspection, and the Respondent timely contested both. The contest to the Safety Citation has

been assigned docket number 12-1165, and the contest to the Health Citation has been assigned docket number 12-1269.

The Safety Citation alleged five citation items: items 1, 2 and 3 alleged serious violations of the control of hazardous energy standard (lockout/tagout), 29 C.F.R. § 1910.147; item 4 alleged three instances of a serious violation of the general machine guarding standard, 29 C.F.R. § 1910.212; and item 5 alleged a serious violation of the machine guarding standard pertaining to “mechanical power-transmission apparatus,” 29 C.F.R. § 1910.219.

The Health Citation, as amended by the Secretary’s Amended Complaint filed on February 27, 2013, set forth two one-item citations as follows: citation 1, item 1, alleged a serious violation of the hazard communication standard, 29 C.F.R. § 1910.1200; citation 2, item 1, alleged two instances of a repeat violation of the injury and illness recording standard, 29 C.F.R. § 1904.4.

The matters were consolidated for all purposes pursuant to Commission Rule 9, 29 C.F.R. § 2200.9, and a hearing on the consolidated matters was held in Albany, New York, on May 21 and 22, 2013.¹ Three witnesses testified. The Secretary presented the testimony of the inspecting CO (Stephen Billings) and the inspecting IH (John Reinemann), and the Respondent presented the testimony of Ms. Tricia Kortright, who is the Respondent’s quality control manager.

The parties filed post-hearing briefs, with briefing completed on November 26, 2013.

As described below, two citation items are vacated: (1) item 5 of citation 1 of the Safety Citation, involving the machine guarding standard at § 1910.219; and (2) item 1 of citation 2 of

¹ The page numbering for the separate transcripts for the two days of hearing both begin with page number 1. Thus, references in this decision to the separate transcripts indicate T-1 for the May 21 transcript and T-2 for the May 22 transcript.

the Health Citation, involving the injury and illness recording standard at § 1904.04. All the other citation items are affirmed, with an aggregate penalty of \$22,000.00 assessed in connection with the four affirmed Safety Citation violations, and a penalty of \$5,100.00 assessed for the single affirmed Health Citation violation.

Jurisdiction and Coverage under the OSH Act

The Commission has jurisdiction of these matters under section 10(c) of the Occupational Safety and Health Act (Act). 29 U.S.C. § 659(c).

The Respondent stipulated to facts that establish that at all relevant times it was an “employer” as defined by section 3(5) of the Act, 29 U.S.C. § 652(5), and is subject to the requirements that the Act imposes upon employers. (T-1, pp. 12-13).

Background

The Respondent, MB Consultants, Ltd., is a New York corporation with its principal office and place of business located in South Fallsburg, New York. (T-1, p. 12). The Respondent operates a poultry processing facility in South Fallsburg, where it employs approximately 300 workers. (T-1, p. 12-14).

The Respondent’s facility processes between 17,000 and 39,000 birds per operating day. (T-2, p. 79). The maximum operating speed for its production line is 90 birds per minute. (T-2, p. 80). Live birds are delivered to the facility, where they are slaughtered, processed, and eventually shipped to retailers either as “whole birds” or in parts depending on the custom order. (T-2, pp. 70-78).

OSHA commenced the Safety Inspection and the Health Inspection simultaneously on November 29, 2011, with the CO and the IH conducting an opening conference and requesting certain written materials. The Respondent’s vice president for operations, Dean Koplik, was

among the Respondent's representatives participating in the opening conference. (Ex. C-1, p. 1; T-2, p. 117).

The CO and IH did not conduct an inspection walk-through of the facility until January 26, 2012. During the walk-through, the CO was accompanied by the Respondent's quality control manager, Tricia Kortright, and its safety manager, Richard Herschel. (Ex. C-1, p. 2; T-1, p. 138).

Secretary's Burden of Proof

To establish a violation of an OSHA standard, the Secretary must prove that: (1) the cited standard applies; (2) the terms of the standard were violated; (3) one or more employees had access to the cited condition; and (4) the employer knew, or with the exercise of reasonable diligence could have known, of the violative condition. *Astra Pharm. Prods., Inc.*, 9 BNA OSHC 2126, 2129 (No. 78-6247, 1981), *aff'd in relevant part*, 681 F.2d 69 (1st Cir. 1982).

A violation is "serious" if there was a substantial probability that death or serious physical harm could result from the violative condition. 29 U.S.C. § 666(k). If the possible injury addressed by a regulation is death or serious physical harm, a violation of the regulation is serious. *Mosser Constr.*, 23 BNA OSHC 1044, 1046 (No. 08-0631, 2010); *Dec-Tam Corp.*, 15 BNA OSHC 2072, 2077 (No. 88-0523, 1993). "This does not mean that the occurrence of an accident must be a substantially probable result of the violative condition but, rather, that a serious injury is the likely result if an accident does occur." *Oberdorfer Indus. Inc.*, 20 BNA OSHC 1321, 1330-31, (No. 97-0469, 2003) (consolidated) (citation omitted).

Safety Citation Items

Safety Citation, Items 1, 2 and 3 – Control of Hazardous Energy (Lockout/Tagout), § 1910.147

Items 1, 2 and 3 of citation 1 of the Safety Inspection alleged serious violations of the general industry standard set forth in 29 C.F.R. § 1910.147, which bears the descriptive heading “*Control of hazardous energy (lockout/tagout)*” (LOTO). The LOTO standard is intended to allow employees to service and maintain machines or equipment safely, generally through the shutdown and de-energization of a production process and the isolation of energy sources. *See* Control of Hazardous Energy Sources (Lockout/Tagout): Final Rule, 54 Fed. Reg. 36644 (Sept. 1, 1989) (to be codified at 29 C.F.R. § 1910.147).

The Respondent does not dispute that the LOTO standard applies to the service and maintenance of certain machines and equipment at its facility, but rather contends that the Secretary failed to establish that it violated the standard as alleged in items 1, 2 or 3.

Safety Citation 1, Item 1 – Specific Procedural Steps, § 1910.147(c)(4)(ii)(B)

Item 1 alleges that the Respondent had violated § 1910.147(c)(4)(ii)(B) “throughout the facility” because its energy control procedures did not provide “specific steps for the shutting down, isolating, blocking and securing machine or equipment to control hazardous energy.”²

Section 1910.147(c)(4) requires that energy control procedures be “developed” and “documented,” providing specifically as follows:

(4) *Energy control procedure.* (i) Procedures shall be developed, documented and utilized for the control of potentially

² The citation item listed the following pieces of machinery and equipment as among those located “throughout the facility” that allegedly lacked specific LOTO procedures: “slaughter/kill line conveyor, crate conveyor, live bird conveyor, feather pickers, final wash machinery, oil sac cutter, ventor, cropper, long [sic] sucker, gizzard harvester, pack-out line, cut-up line, breast/wing conveyor, cone line, skinner machines, cut-up saws, repac machine, freezer tunnel etc.”

hazardous energy when employees are engaged in the activities covered by this section.

NOTE: *Exception:* [Omitted.]

(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 including, but not limited to, the following:

(A) A specific statement of the intended use of the procedure;

(B) Specific procedural steps for shutting down, isolating, blocking and securing machines or equipment to control hazardous energy;

(C) Specific procedural steps for the placement, removal and transfer of lockout devices or tagout devices and the responsibility for them; and

(D) Specific requirements for testing a machine or equipment to determine and verify the effectiveness of lockout devices, tagout devices, and other energy control measures.

The CO requested that the Respondent provide documentation on its LOTO program, and in response the Respondent provided a sixteen-page document titled “LOCK-OUT/TAG-OUT,” which was received as Exhibit C-11. (T-1, pp. 27-28, 73-75; Ex C-11). A description of Exhibit C-11 follows.

The cover page Exhibit C-11 bears the title “LOCK-OUT/TAG-OUT” and contains the following two paragraphs:

“Lockout/Tagout (LOTO)” refers to specific practices and procedures to safeguard employees from the unexpected energization or startup of machinery and equipment, or the release of hazardous energy during service or maintenance activities.

In order to ensure our employees’ safety, we have provided specific guidelines for them to follow. MB Consultants, Ltd. has required the signatures of every personnel subject to the knowledge and understanding of Lockout/Tagout.

(Ex. C-11, p. 1).

Following the cover page, the second page of Exhibit C-11 is titled “Lock-Out/Tag-Out Policy and Procedures.” This page sets forth the Respondent’s LOTO “Policy” to be as follows:

“POLICY: No employee shall undertake any work on equipment unless the equipment is fully

secured against accidental start-up, movement or release of electrical, mechanical, hydraulic, pneumatic, chemical or thermal energy.” (Ex. C-11, p. 2). This page also includes the following five-item list that is captioned “Procedure:”

1. Prior to beginning work on any piece of equipment that could start-up, move or release stored energy, the employee(s) will de-energize the equipment.
2. The employee(s) will then lock-out any valve, switch, breaker or other control which supplies energy to the equipment. The employee(s) will then attach a dated and signed tag that indicates the reason for the lockout.
3. Before carrying out any further work on the equipment, the employee(s) will appropriately test the equipment to ensure that it is de-energized.
4. Each employee who routinely is required to lock-out controls, shall be issued personal locks and keys which shall be used for isolating equipment while that employee services the particular pieces of equipment.
5. A lock will only be removed by the person who installed it. The lock will be removed only when the person who installed it is satisfied that it is safe to remove the lock and re-start the equipment.”

(Ex. C-11, p. 2).

Pages 3 and 4 of Exhibit C-11 set forth a list of 26 items of “equipment/machinery” that “is to be lockout/tagout before pre-op inspection.” This list is set out in its entirety in Appendix A to this Decision.³ As reflected in Appendix A, the list is set out in columnar format with the first column describing the item of “equipment/machinery” and a second column bearing the heading “Electrical Panel/Location.” The second column appears intended to describe the corresponding “energy isolating device” (defined in paragraph (b) of the LOTO standard as a

³ The 26 items of “Equipment/Machinery” listed, as shown in Appendix A to this Decision, are: Slaughter/Kill line; Stunner; Crate Conveyor; Live Bird Conveyor; Feather Picker #1; Feather Picker #2; Feather Picker #3; Final Wash; Oil Sac Cutter; Venter; Cropper; Long [sic] Sucker; Gizzard Harvester; Gizzard Cleaner; Chiller Screw; Pack-Out Line; Chiller rnd. Table; Cut-Up Line; Dapac; Breast/Wing Conveyors; Cone Line; Skinner Machines; Trim table; Cut-up saws; Repac Machine; Freezer Tunnel.

“mechanical device that physically prevents the transmission or release of energy”) for the item of equipment/machinery reflected in the first column, along with the location of that energy isolating device. For example, for all three “Feather Pickers,” the second column identifies “Panel #19” to be the “electrical panel” for the machines, and the location of this electrical panel is described as “In the Closet Across From All Three Pickers.” (Ex. C-11, p. 3; see Appendix A to this Decision).

Page 5 of the LOTO exhibit is a blank “LockOut/TagOut” log form with six columns as follows: Date; Equipment; Identity #; Location; Start Time; End Time. (Ex. C-11, p. 5).

Pages 7 through 11 of Exhibit C-11 are titled “Lockout-Tagout Program.” (Ex. C-11, pp. 7-11). The entirety of these pages is set forth in Appendix B to this Decision.

Each of the final five pages of the sixteen-page exhibit (Ex. C-11, pp. 12-16) appears to be a record of training in LOTO for an individual employee -- each page bears a single unique signature without any date, and two of the signatures bear the date 9/3/09.⁴ (Ex. C-11, pp. 12-16). Another page in the sixteen-page exhibit is an unsigned version of the same LOTO training material. (Ex. C-11, p. 6).

The material that the Respondent presented to the CO as representing its LOTO program and procedures does not meet the requirement of paragraph (c)(4)(ii)(B) to contain “[s]pecific procedural steps for shutting down, isolating, blocking and securing machines and equipment to control hazardous energy.” Those specific procedural steps must cover certain elements and actions that are described in paragraphs (d)(1), (2), (3) & (5) of the standard as follows:

(d) *Application of control.* The established procedures for the application of energy control (the lockout or tagout procedures)

⁴ These same five pages, with the same employee signatures (with dates of 9/3/09 for two of the signatures), are also included in Ex. C-8, pp. 1-5, which the Respondent describes as constituting training records for certain “authorized” employees. (Resp’t Post-Hr’g Br., p. 7).

shall cover the following elements and actions and shall be done in the following sequence:

(1) *Preparation for shutdown.* Before an authorized or affected employee turns off a machine or equipment, the authorized employee shall have knowledge of the type and magnitude of the energy, the hazards of the energy to be controlled, and the method or means to control the energy.

(2) *Machine or equipment shutdown.* The machine or equipment shall be turned off or shut down using the procedures established for the machine or equipment. An orderly shutdown must be utilized to avoid any additional or increased hazard(s) to employees as a result of the equipment stoppage.

(3) *Machine or equipment isolation.* All energy isolating devices that are needed to control the energy to the machine or equipment shall be physically located and operated in such a manner as to isolate the machine or equipment from the energy source(s).

* * * *

(5) *Stored energy.* (i) Following the application of lockout or tagout devices to energy isolating devices, all potentially hazardous stored or residual energy shall be relieved, disconnected, restrained, and otherwise rendered safe.

(ii) If there is a possibility of reaccumulation of stored energy to a hazardous level, verification of isolation shall be continued until the servicing or maintenance is completed, or until the possibility of such accumulation no longer exists.

“[T]he purpose of the lockout procedure is to guide an employee through the lockout process.” *Drexel Chem. Co.*, 17 BNA OSHC 1908, 1913 (No. 94-1460, 1997). The requirement of paragraph (c)(4)(ii) that “the scope, purpose, authorization, rules, and techniques to be utilized for the control of hazardous energy” be “clearly and specifically outline[d]” was intended to prevent “overgeneralization” in the description of LOTO procedures, because such “[o]vergeneralization can result in a document which has little or no utility to the employee who must follow the procedure.” *Gen. Motors Corp.*, 22 BNA OSHC 1019, 1026 (No. 91-2834E, 2007)(consolidated)(internal quotes omitted), *quoting* Control of Hazardous Energy Sources (Lockout/Tagout): Final Rule, 54 Fed. Reg. 36644, 36670 (Sept. 1, 1989). The energy control procedures must contain enough detail to provide employees with a clear understanding of the

energy control measures and procedural steps to effectively and safely control hazardous energy during servicing and maintenance activities. *See generally* Control of Hazardous Energy Sources (Lockout/Tagout): Final Rule, 54 Fed. Reg. 36644, 36670-71 (Sept. 1, 1989).

Exhibit C-11 fails to provide sufficient detail and adequate guidance for an employee to clearly understand how to safely and effectively utilize hazardous energy control measures for any particular item of machinery/equipment being serviced or maintained as required by paragraph (c)(4)(ii) of the LOTO standard.

The Respondent's LOTO program as set forth in Exhibit C-11 lists 26 items of machinery/equipment to which LOTO applies. (This list of 26 items is set forth in its entirety in Appendix A to this Decision.) For some of those 26 items, Exhibit C-11 contains only cryptic descriptions of the type and location of energy isolating device for the item, and is far from being either specific or clear. For example, for two of the items (oil sac cutter; chiller rnd. table) no location description for the designated electrical panel is provided. For another item (ventor) only the location of the electrical panel is described, without any description of the "number" on the applicable "electrical panel." The second column for both the "Cropper" and the "Trim table" provides neither a number for the applicable electrical panel number nor a location description, but instead provides respectively "Lockable Disconnect" and "Cord & Plug." The second column for the "Crate Conveyor" and the "Live Bird Conveyor" both identify the same electrical panel number, but describe slightly different locations for the same numbered panel ("across from kill rm. bathroom" vs. "outside wall of kill rm. bathroom"). The second column

entry for both the “Final Wash” and the “Long Sucker”⁵ is blank, thus providing no information about the identity or location of their respective energy isolating devices. (T-1, pp. 180-183).

The CO discovered during the inspection that the numbered “electrical panels” identified on the 26-item list were not circuit breakers as could be inferred from the use of the term “electrical panel,” but rather were individual electrical disconnect switches for the item of equipment indicated. (T-1, pp. 77-78, 143-146). The CO regarded this to be potentially confusing to an employee who relied on the list to identify the applicable energy isolating device, in that an employee might identify a numbered circuit breaker contained within an electrical control panel as the applicable energy control device, rather than a single electrical disconnect switch that bore a specific number. (T-1, pp. 146-147).

For the most part, Exhibit C-11 merely restates general performance requirements set forth in § 1910.147, with scant description of specific methods for meeting those performance requirements. The procedures are lacking in specificity and clarity in many ways, some of which are described below.

The material in Exhibit C-11 contains no procedural steps designated to apply to any specific item of machinery/equipment listed. Rather, the procedural steps contained in Exhibit C-11 are by their very terms “general,” e.g. “General Safety Guidelines” and “General Management” procedures. These “general” procedures describe the process for the development of procedures that are specific to each item of machinery/equipment, through the completion of the described “Survey For Applying Lockout/Tagout Devices” “for every piece of machinery or equipment requiring Lockout/Tagout procedures.” (Ex. C-11, p. 8; Appendix B to this Decision). The general procedures state that this survey information “will be placed into the

⁵ Other evidence of record suggests that the intended reference is to machinery that is known as the “lung sucker,” not “long sucker.” (T-1, p. 182; T-2, p. 74).

Lockout/Tagout Database.” (*Id.*). However, there is no evidence of any such survey having been conducted, or the existence of any “Lockout/Tagout Database” other than the material contained within Exhibit C-11.

There is no description of the type and magnitude of the energy to be controlled, or the hazards of the energy to be controlled, for any given item of machinery/equipment, as is required by paragraph (d)(1) of the standard. Exhibit C-11 lacks any such information even though eight items of machinery/equipment subject to LOTO (lung sucker; gizzard harvester; pack-out line; cut-up line; breast/wing conveyor; cut-up saws; repac machines; and freezer tunnel) use one or more of the following types of energy: electrical, pneumatic, high-powered water; CO₂ gas, and mechanical. (T-1, p. 13). *Cf. Drexel Chem. Co.*, 17 BNA OSHC 1908 (observing that a single procedure may be sufficient to cover different types of machines if the machines “are similar, using the same type and magnitude of energy and the same type of controls”). Exhibit C-11 fails to specify that any of these eight items of machinery/equipment have multiple forms of energy. Nor does it contain any description of the means and method of how such multiple forms of energy are isolated or controlled. For example, while the lung sucker appears to be powered by electrical energy, it uses pneumatic energy in its operation, but nothing in Exhibit C-11 indicates whether both the electrical energy and pneumatic energy are controlled through the same energy isolating device. (T-1, pp. 147-148, 182).

Although the procedures require the use of either lockout or tagout, there is nothing in the procedures that indicates what energy isolating devices, if any, are subject to tagout rather than lockout (where the device is not capable of being locked out -- *see* § 1910.147(c)(2)).

Exhibit C-11 is devoid of any information describing whether any stored or residual energy is present in any of the items of machinery/equipment, as well as any description of the

method to dissipate such stored energy, as required by paragraph (d)(5) of the standard. For example, there is no mention in Exhibit C-11 regarding the presence or magnitude of any high-pressure water energy, or the method of dissipating any such stored energy. (T-1, p. 186).

Even if Exhibit C-11 were regarded as containing the “specific procedural steps” required by paragraph (c)(4)(ii)(B), it would nevertheless constitute only a single procedural outline to be applied universally to each of the 26 items of machinery/equipment identified. In view of the variety and complexity of machine/equipment types, and in view of the variety of energy types and energy sources present in the facility, a single procedure is insufficient to specifically and clearly describe the energy control measures required to stop, de-energize, and isolate unique or different energy sources for each of the 26 items of machinery/equipment to which the procedure applies. (T-1, pp. 22-23; 181-183). *See Drexel Chem. Co.*, 17 BNA OSHC at 1913 (holding that where different machines are powered by different energy sources and require different energy control measures, a single lockout procedure is inadequate to cover the different machines).

The Respondent argues the sufficiency of its LOTO procedures should not be considered by evaluating Exhibit C-11 alone. Rather, the Respondent contends that Exhibit C-11 should be considered along with other written LOTO program that the Respondent was required to develop to comply with a requirement imposed by the Food Safety and Inspection Service (FSIS) of the U.S. Department of Agriculture (USDA). The FSIS required the Respondent to develop a LOTO program to protect the FSIS inspectors who conduct food sanitation inspections on site at the Respondent’s chicken processing facility. (Ex. C-10). (The documentation pertaining to the FSIS LOTO procedures was received in evidence as Exhibit R-2.) The Respondent’s argument is rejected.

Exhibit R-2 by its terms establishes a LOTO program for the purpose of protecting FSIS inspectors from hazardous energy during “preoperational process verification inspection or verification of preoperational or operational corrective action tasks” that the FSIS inspectors perform at the Respondent’s poultry processing facility. (Ex. R-2, p. 11). Unlike the Respondent’s LOTO program set forth in Exhibit C-11, the FSIS LOTO program does not purport to protect the Respondent’s employees from hazardous energy during their servicing or maintenance of machines or equipment.

It is significant that the Respondent did not provide Exhibit R-2 to the CO in response to the CO’s request for the Respondent’s LOTO documentation, but rather provided only Exhibit C-11. Nor did the Respondent ever mention the existence of the FSIS LOTO documentation to the CO during the course of the Safety Inspection. (E.g., T-1, pp. 27-28, 73-75, 157-158). The Respondent’s failure ever to bring the FSIS LOTO documentation to the CO’s attention strongly suggests that the Respondent did not regard those materials to constitute the documentation of LOTO procedures intended for the protection of its own employees.

Further, even considering together the LOTO materials contained in Exhibits C-11 and R-2, the combined materials would still fail to meet the requirement of paragraph (c)(4)(ii)(B) to “clearly and specifically outline” the “[s]pecific procedural steps for shutting down, isolating, blocking and securing machines or equipment to control hazardous energy.” For example, Exhibit R-2 also provides only a single general description of LOTO performance requirements that apply universally to each of 26 separate items of machinery/equipment. It is devoid of any outline of procedures that would be specific to any one of the varied and complex items of machinery or equipment at the facility.

Further, provisions in Exhibit R-2 require both FSIS employees and “plant employees” to “refer to the documented plant lockout/tagout procedures” for the following specific information:

- A. Description and location of machinery or equipment subject to lockout/tagout.
- B. Type and magnitude of the energy that the machine or equipment utilizes.
- C. Hazards of the energy.
- D. Type and location of machine or equipment operating controls.
- E. Type and location of energy isolating devices.
- F. The lockout/tagout procedure used to lockout or tagout the machine or equipment.
- G. Type of stored energy and method to dissipate or restrain.

(Ex. R-2, p. 12). As discussed above, the Respondent’s lockout/tagout procedure as reflected by Exhibit C-11 is seriously lacking in providing the specific information and procedures on the items set forth in the list quoted above.

Exhibit R-2 contains a list of same 26 items listed in Exhibit C-11, and is also in the same columnar format. (The list in Exhibit C-11 is reflected in Appendix A to this decision.) However, the list in Exhibit R-2 differs from the list in Exhibit C-11 with respect to some of the 26 items. For example, for the “stunner,” Exhibit C-11 indicates that its “electrical panel” is “Panel #17” that is located in the “hallway between Kill and Evis.,” while Exhibit R-2 indicates its electrical panel is the “stunner panel” that is located in the “pump room.”

Moreover, there are five diagrams of floor plans depicting different areas of the processing facility in Ex. R-2 that appear to designate the locations of the “lock-out/tagout” for various items of machinery/equipment. These diagrams include (a) information about some machinery/equipment that is not described in the 26-item list (e.g., “foot picker,” “thigh and drumstick deboner,” “corr vac,” “labeler,” “vacuum sealer,” “pallet wrap machine,” “scalding steam valve” location, “water valve” location), (b) information about “lock-out/tag-out”

locations for machinery/equipment that are not included in the 26-item list (e.g. “feather room exhaust fan lock-out/tag-out”), and (c) information that conflicts with the information specified in the 26-item list (e.g., a floor plan diagram indicates that the “live crate conveyor” and the “feather crate conveyor” are controlled by different electrical panels, while the 26-item list indicates that all crate conveyors are controlled by the same electrical panel). (Ex. R-2, pp. 3-6).

The information contained in Exhibit R-2 adds very little specificity to the information contained in Exhibit C-11, and rather than adding clarity, it muddles and in some respects conflicts with that information.

The great weight of the evidence establishes that the Respondent violated the LOTO standard in the manner described in item 1 of citation 1 of the Safety Citation.

The Respondent conducts LOTO whenever the plant is operating, and thus employees who implement those operations were exposed to the deficient LOTO procedures. (T-2, p. 90-91). The Respondent had actual knowledge of the violation because it developed and implemented the violative written procedures.

The violation was aptly characterized as “serious,” in that death or serious physical harm could result from an employer failing to have LOTO procedures that meet the requirements of paragraph (c)(4)(ii)(B).

Safety Citation 1, Item 2 –
Periodic LOTO Inspection, § 1910.147(c)(6)(i)

Item 2 of citation 1 alleges that the Respondent violated § 1910.147(c)(6)(i) “on or prior to 1/26/2012” on the asserted ground that “throughout the facility” the Respondent had failed to conduct a periodic (at least annual) inspection of its energy control procedure “to ensure that the

procedure and the requirements of [the LOTO] standard were being followed.”⁶ The item averred that the most recent periodic inspection had occurred in May 2008.

Section 1910.147(c)(6) provides as follows:

(6) *Periodic inspection.* (i) The employer shall conduct a periodic inspection of the energy control procedure at least annually to ensure that the procedure and the requirements of this standard are being followed.

(A) The periodic inspection shall be performed by an authorized employee other than the ones(s) utilizing the energy control procedure being inspected.

(B) The periodic inspection shall be conducted to correct any deviations or inadequacies identified.

(C) Where lockout is used for energy control, the periodic inspection shall include a review, between the inspector and each authorized employee, of that employee's responsibilities under the energy control procedure being inspected.

(D) Where tagout is used for energy control, the periodic inspection shall include a review, between the inspector and each authorized and affected employee, of that employee's responsibilities under the energy control procedure being inspected, and the elements set forth in paragraph (c)(7)(ii) of this section.

(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 of the inspection, the employees included in the inspection, and the person performing the inspection.

The Secretary points to the notation “Revised 5/27/2008” on pages 7 to 11 of Exhibit C-11 (the content of which is reflected in its entirety in Appendix B to this decision) as proof that the Respondent had last conducted an inspection in 2008.

The Respondent did not create any certification containing the information specified by paragraph (c)(6)(ii) to document that any periodic inspection had been performed. Similarly, there is no positive evidence that as part of any periodic inspection the Respondent conducted “a

⁶ Item 2 listed the same pieces of machinery and equipment that were listed with respect to item 1, except for the “live bird conveyor,” which does not appear in the list for item 2.

review, between the inspector and each authorized employee, of that employee's responsibilities under the energy control procedure being inspected,” as required by paragraph (6)(i) of the standard. The absence of any positive evidence that the Respondent conducted an inspection, including the absence of any written certification that an inspection had been conducted, is sufficient evidence from which reasonably to infer that the Respondent failed to conduct the inspection required by paragraph (c)(6)(i) of the standard.

The Respondent asserts that it complied with the standard by virtue of having renewed with FSIS, in December 2011, its “Cooperative Agreement For Lockout/Tagout Procedures Between FSIS and Official Establishments.” (See Exhibit R-2, pp. 11-14, discussed above in connection with item 1 of Citation 1) (T-2, pp. 85-87, 160-161). This argument fails for at least two reasons.

First, as discussed previously, the FSIS LOTO procedures are in place to protect FSIS employees who are on site to conduct food sanitation inspections, not to protect the Respondent’s employees while they are servicing and maintaining machinery and equipment. Thus, the Respondent’s renewal of its Cooperative Agreement with FSIS is simply not the equivalent of a periodic inspection of the Respondent’s program required by paragraph (c)(6) of the standard.

Second, there is no evidence that the renewal of Cooperative Agreement with FSIS included the elements required by paragraph (c)(6) of the standard to be inspected. For example, there is no evidence that the renewal included “a review, between the inspector and each authorized employee, of that employee's responsibilities under the energy control procedure being inspected,” as required by paragraph (6)(i)(C) of the standard.

The evidence shows that employees were exposed to the violative condition. The Respondent must conduct LOTO procedures every day that the plant operates, and thus employees who implement those operations were exposed to LOTO procedures that had not been subject to review and inspection as required by paragraph (c)(6). (T-2, p. 90-91). The Respondent had actual knowledge of the violation because its management knew that no periodic inspection of the program elements specified in paragraph (c)(6) had been conducted.

The violation is aptly classified as “serious.” If the Respondent had properly performed the required periodic inspection, the deficiencies in its procedures, as discussed in connection with item 1 of citation 1, would have been identified, and presumably quickly remedied. Death or serious physical harm could result from an employer failing to conduct at least an annual inspection to ensure that its procedures meet the LOTO standard and are being followed.

Safety Citation 1, Item 3 –
LOTO Training, § 1910.147(c)(7)(i)

Item 3 of citation 1 alleges that on and prior to 1/26/2012 the Respondent had violated § 1910.147(c)(7)(i) “throughout the facility” by not providing training on LOTO procedures to “employees exposed to and affected by the application of Lockout Tagout procedures and control devices.” Section 1910.147(c)(7)(i) provides as follows:

(7) *Training and communication.* (i) The employer shall provide training to ensure that the purpose and function of the energy control program are understood by employees and that the knowledge and skills required for the safe application, usage, and removal of the energy controls are acquired by employees. The training shall include the following:

(A) Each authorized employee shall receive training in the recognition of applicable hazardous energy sources, the type and magnitude of the energy available in the workplace, and the methods and means necessary for energy isolation and control.

(B) Each affected employee shall be instructed in the purpose and use of the energy control procedure.

(C) All other employees whose work operations are or may be in an area where energy control procedures may be utilized, shall be

instructed about the procedure, and about the prohibition relating to attempts to restart or reenergize machines or equipment which are locked out or tagged out.

The terms “affected employee” and “authorized employee” are defined in paragraph (b) of the standard (as is the term “servicing and/or maintenance,” which is used within those definitions) as follows:

Affected employee. An employee whose job requires him/her to operate or use a machine or equipment on which servicing or maintenance is being performed under lockout or tagout, or whose job requires him/her to work in an area in which such servicing or maintenance is being performed.

Authorized employee. A person who locks out or tags out machines or equipment in order to perform servicing or maintenance on that machine or equipment. An affected employee becomes an authorized employee when that employee's duties include performing servicing or maintenance covered under this section.

Servicing and/or maintenance. Workplace activities such as constructing, installing, setting up, adjusting, inspecting, modifying, and maintaining and/or servicing machines or equipment. These activities include lubrication, cleaning or unjamming of machines or equipment and making adjustments or tool changes, where the employee may be exposed to the *unexpected* energization or startup of the equipment or release of hazardous energy.

Paragraph (c)(7)(iv) sets forth a certification requirement for required training as follows: “The employer shall certify that employee training has been accomplished and is being kept up to date. The certification shall contain each employee’s name and dates of training.”

The Respondent has provided LOTO training only to those employees whom it has identified as being “authorized employees.” And the only employees it has identified as “authorized employees” are those who work in its Sanitation, Maintenance, and Quality Control departments. (T-1; p. 13; T-2, p. 90). The Respondent has not provided any LOTO training to the employees assigned to production line positions, many of whose jobs require them to work

around machines and equipment on which are performed service or maintenance under lockout/tagout. (T-2, p. 90; T-1, p. 87). Nor has the Respondent provided any training specified by paragraph (c)(7)(i)(C) to “other employees whose work operations are or may be in an area where energy control procedures may be utilized,” and who are neither “authorized” nor “affected” employees as defined.

The Respondent asserts that its production area workers are neither “authorized employees” because none lock out or tag out equipment, nor are they “affected employees” because none of their “job[s] require[] him/her to work in an area in which such servicing or maintenance is being performed,” as the definition of “affected employee” specifies.

The Respondent grounds the argument that none of the production area workers is “affected employees” on the following testimony Tricia Kortright, to the effect that no production area workers are near any machinery or equipment when servicing and maintenance under lockout/tagout is being performed:

Q. What are production employees required to do when something needs to be locked out?

A. Typically, the production employees aren't on the floor. In normal circumstances, where it would be used would be during sanitation, where the entire facility is being prepared for pre-operational inspection and there are no production employees in the establishment that time, and at that point you have just a quality control and sanitation and that's the only people in the facility at that point.

And the other time where it would be -- lockout/tagout would need to be used would be if, you know, something needs to be disassembled or maintenance done on it, and during that time you cannot have product on the floor to risk contamination. So product would be removed from the floor and there would be no production employees down there. They would be sent on break.

(T-2, pp. 90-91). Ms. Kortright testified further on cross-examination by counsel of the Secretary as follows:

- Q. So ... is it your testimony that over the three years that you have been with MB Consultants there have been instances in which the company has had to cease production during the work day to conduct repairs to its equipment?
- A. I know of situations where that has happened, and what typically happens is the product is cleared from the area and the employees are put out -- told to take lunch early.
- Q. So the non-authorized employees are asked to leave while the repairs are conducted?
- A. Correct. It's a small facility. We don't have a lot of room to move around.

(T-2, p. 162).

Ms. Kortright's testimony is far from conclusive on whether production area employees are never present on the production floor whenever service or maintenance events occur that require the execution of LOTO procedures. It is notable that she stated that production employees are not on the production floor during such activities "typically." Moreover, it is significant that nothing in the Respondent's LOTO program or procedures requires production employees to vacate the production floor at the initiation or duration of LOTO procedures.

Nevertheless, even accepting the Respondent's argument that no production area employees will ever have the status of an "affected employees" as defined in paragraph (b) of the standard, the evidence establishes that such employees are "other employees" within the meaning of paragraph (c)(7)(i)(C) of the standard. On November 17, 2011, a production floor employee who was engaged in normal production operations bypassed a partial guard on a chicken skinner machine in an effort to clear debris that had built up, resulting in a serious laceration.⁷

⁷ This injury was appropriately recorded on OSHA Form 300. (T-2, pp. 92-93, 101-102; T-1, pp. 92-93, 165-166; Ex. C-24, p. 4, #34; Ex. C-6, pp. 1-2, regarding injury to employee with initials MPA; photo of skinner machine and guard shown at Ex. C-3, p. 9).

According to Ms. Kortright, rather than attempting to clear the machine by bypassing the guard, the injured employee should have “hit the stop button” and then summoned maintenance department employees (who have been trained in LOTO as “authorized employees”) to clean or unjam the machine using lockout procedures. (T-2, pp. 92-93, 101-102). The action that the employee should have taken according to Kortright (“hit the stop button”) is one of the steps required to be taken as part of the LOTO process, as specified by paragraph (d) of the standard.⁸ Thus, accepting for purposes of this analysis the Respondent’s argument that none of its production area workers ever have the status of either “authorized” or “affected” employees, the record establishes that those employees should have received some LOTO training as “other employees” pursuant to paragraph (c)(7)(i)(C) of the standard, because their “work operations are or may be in an area where energy control procedures may be utilized.” The Respondent violated the standard by failing to provide those employees with any LOTO training.

The Secretary has established that the Respondent violated paragraph (c)(7)(i) as alleged in item 3 of citation 1.⁹

⁸ Paragraph (d)(2) is quoted in connection with the discussion regarding item 1 of citation 1, and provides in part that the “machine or equipment shall be turned off or shut down using the procedures established for the machine or equipment.” The standard contemplates that both “authorized” and “affected” employees may be involved in shutting down or turning off a machine or equipment. *See* § 1910.147(d)(1) (providing that “[b]efore an authorized or affected employee turns off a machine or equipment...”).

⁹ In view of this determination that the production area workers are “other employees” who must receive LOTO training as described in paragraph (c)(7)(i)(C), it is unnecessary to determine whether any such production area employees must receive training required for either “authorized” or “affected” employees.

The Secretary argues that the production area employee who had been injured on November 17, 2011 by a skinner machine should have received training as an “authorized employee.” The employee was injured when she bypassed a partial guard during normal production operations in an attempt to clear debris from the chicken skinner machine. (Ex. C-6, pp.1-2; Ex. C-24, p. 4; Ex. C-3, p. 9; T-1, pp. 47-48, 93, 112). The Secretary argues that this worker was an “authorized employee” because her duties included “servicing or maintenance”

The production area employees who received no LOTO training were exposed to the violative condition, most notably the production area employee who sustained an injury while attempting to clean skinner machine on November 17, 2011, without initiating LOTO procedures. The Respondent had actual knowledge that it had not trained any of its production area employees in LOTO.

The violation is aptly characterized as serious. Death or serious physical harm could result from an employer failing to provide the LOTO training required by the standard.

Safety Citation 1, Item 4 –
Machine Guarding, § 1910.212(a)(1)

Item 4 of citation 1 of the Safety Citation alleges that the Respondent violated the machine guarding standard of 29 C.F.R. § 1910.212(a)(1) on and before 1/26/2012 by failing to

activities that required her (1) to bypass a guard, and also (2) to place a part of her body in a danger zone. *See* § 1910.147(a)(2)(ii)(A) & (B), which provides as follows:

(ii) Normal production operations are not covered by this standard (See subpart O of this part). Servicing and/or maintenance which takes place during normal production operations is covered by this standard only if:

(A) An employee is required to remove or bypass a guard or other safety device; or

(B) An employee is required to place any part of his or her body into an area on a machine or piece of equipment where work is actually performed upon the material being processed (point of operation) or where an associated danger zone exists during a machine operating cycle.

Even though the Respondent does not assert “unforeseeable employee misconduct” as an affirmative defense (T-1, p. 13), the Respondent’s apparent rejoinder to the Secretary’s argument is that the injured worker’s duties did not include placing her hand in the zone of danger, and thus the employee was not “required” to perform any service or maintenance activities during normal production operations. (T-2, p. 101, lines 18-20). In view of the determination that the employee was required to receive training as an “other employee,” it is unnecessary to address this contention. Nevertheless, although not alleged as a violation, it appears likely that the actions of the employee that resulted in her injury violated the requirement that LOTO procedures be utilized for service or maintenance activities, as Kortright indicated during her testimony (T-2, pp. 92-93, 101-102). *See* § 1910.147(c)(4)(i). Among the factors that may have contributed to such a violation are (1) the absence of specific LOTO procedures for the skinner machine, (2) the absence of a periodic LOTO inspection, and (3) the absence of any LOTO training provided to the injured employee.

provide guarding for the in-running nip points on the “cutting wheel of the chicken leg splitter machine” (instance “a”) and on the “tail roll of the cone line conveyor” (instance “b”). Item 4 also alleges that on or about 11/17/2011, the Respondent failed to provide “adequate guarding” for the in-running nip point on a “chicken skinning machine” (instance “c”).

Section 1910.212(a)(1) provides as follows:

(a) *Machine guarding* -- (1) *Types of guarding*. 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.

To prove a violation of § 1910.212(a)(1), “the Secretary is required to prove that a hazard within the meaning of the standard exists in the employer's workplace.” *Buffets Inc.*, 21 BNA OSHC 1065, 1066 (No. 03-2097, 2005) (internal quotes omitted). “Specifically, the Secretary must show that employees are in fact exposed to a hazard as a result of the manner in which the machine functions and is operated.” *Id.* (internal quotes omitted). “The mere fact that it is not impossible for an employee to come into contact with the moving parts of a particular machine does not, by itself, prove that the employee is exposed to a hazard.” *Id.* Nevertheless, the “standard recognizes that [workers] do not discard their personal qualities when they go to work,” and that “[a]lthough [workers] take to the job their intelligence and skills, they also take along their emotional makeup and any tendency to neglect any specified course of conduct.” *Akron Brick & Block Co.*, 3 BNA OSHC 1876, 1878 (No. 4859, 1976).

To establish employee exposure to a hazard, “the Secretary must show either that Respondent's employees were actually exposed to the violative condition or that it is ‘reasonably predictable by operational necessity or otherwise (including inadvertence), that employees have been, are, or will be in the zone of danger.’” *S&G Packaging Co.*, 19 BNA OSHC 1503, 1506

(No. 98-1107, 2001) (quoting *Fabricated Metal Prods.*, 18 BNA OSHC 1072, 1074 (No. 93-1853, 1997)). Employee entry into the zone of danger may be reasonably predictable when such entry occurs “while in the course of their assigned working duties, their personal comfort activities while on the job, or their normal means of ingress-egress to their assigned workplaces,” *Gilles & Cotting, Inc.*, 3 BNA OSHC 2002, 2003 (No. 504, 1976), as the result of “unsafe operating procedures, poor training, or employee inadvertence” and “carelessness,” *H. B. Zachry Co. (Int’l)*, 8 BNA OSHC 1669, 1674 (No. 76-2617, 1980) (citations omitted), and also as the result of accident such as “slipping or falling,” *Fabricated Metal*, 18 BNA OSHC at 1074, n. 7.

*Instance “a” – In-running nip point
for cutting wheel of chicken leg splitter machine*

A machine known as a “chicken leg splitter” has two unguarded in running nip points where a belt circulates around two sprockets. (Ex. C-6, p. 4 [image 0020 shows the nip point for right sprocket and image 0021 shows the nip point for left sprocket]; Ex. C-28 [video clip 0018 shows nip points in motion]). The splitter machine is automated and functions without any operator attending the machine. (T-2, p. 96).

The CO described the height of the nip points to be about three feet above floor level. (T-1, p. 102, 107, 112). The nip points face an aisle or walkway, but the record is silent regarding the width of the aisle. During the inspection walk-through, the CO observed that the aisle was “extremely wet, slippery,” and that “chicken debris is predominant throughout the floor and it’s an area that’s continually high pressure hosed off which adds to the slickness of the condition.” (T-1, pp. 102, 107-108).

The CO testified that he observed employees walking “within inches” of the nip points, and that employees “daily walk through that area going from one place in the facility to another or going from one piece of equipment to another.” (T-1, p. 113). He testified further that when

he asked either Kortright or Richard Herschel (who was then the safety manager [T-1, p. 24]) about the aisle, he was informed that it was an “aisle-way where employees walked back and through the plant, back and forth through the plant, every and any employee.” (T-1, p. 191).

The CO testified that he believed that there was a “slip hazard right in front of the machine” and that “[i]t's plausible that an employee either could inadvertently walk through the area and put their hand in it and run their hand between the wheel and the chain.” (T-1, p. 112-113). In his testimony the CO asked rhetorically: “What's to prevent somebody from slipping or just not even paying attention, walking past and catching their hand in that machine[?]” (T-1, p. 191).

The CO testified that he pointed out the nip point hazard Herschel, and that “Mr. Herschel told me he recognized the hazard and he was developing additional guarding for the equipment.” (T-1, pp. 113-114, 191; Ex. C-6, p. 2).

In her testimony, Kortright did not controvert the CO's testimony that either she or Herschel, who had accompanied the CO and Kortright during part of the inspection walk-through (Ex. R-4, p. 2), had told the CO that employees pass by the splitter while it is in operation. She did testify, however, that the aisle was “kind of a dead-end,” (T-2, p. 96), seeming to suggest that employees did not frequently pass by. (T-2, pp. 97-98).

Kortright testified further that the production floor employees are given boots with soles that “have been determined to be the best boot for animal fat,” apparently suggesting that such boots provided good protection against employee slips and falls. (T-2, p. 98). Nevertheless, the record makes it apparent that employees at the facility have experienced slips or falls that have

resulted in recordable injuries, as reflected by about 9 of the 34 injuries recorded on OSHA Form 300 for the year 2011.¹⁰

The Secretary does not assert that employee exposure is reasonably predictable by the way the machine is operated, but rather claims that exposure could occur as the result of either inadvertence (e.g., a passing employee inadvertently swinging a hand into the zone of danger), or accident (e.g., a passing employee slipping and falling in the vicinity of the nip points, causing entry to the zone of danger).

A preponderance of the evidence establishes that (1) the aisle near the nip points is a route of ingress and egress of employees, (2) employees pass by the unguarded nip points while the machine is in operation, (3) the floors near the nip points are usually wet and slippery, and (4) the wet and slippery floor near the nip points presents a slip and fall hazard to employees. The Secretary has established that the unguarded nip points constitute a hazard within the meaning of § 1910.212(a)(1) and that employees are exposed to that hazard.

The Respondent had actual knowledge of the violative condition, as reflected by Herschel's statement to the CO that "he recognized the hazard and he was developing additional guarding for the equipment." (T-1, pp. 113-114; Ex. C-6, p. 2).

The Secretary has proven that the Respondent violated § 1910.212(a)(1) with respect to the unguarded nip points on the chicken leg splitter as described in instance "a" of citation item.

¹⁰ Exhibit C-24 is the OSHA Form 300 for the year 2011. The following case numbers reflect injuries from slips and falls, although the entries on the form do not indicate whether slick floors were a factor in any of the injuries: #2, "slipped and fell on a stainless steel chicken tank cutting elbow;" #4 "slipped on a small ledge causing a bruise to right heel of foot;" #5 "employee slipped and fell causing bruise to back;" #7, "fractured left ankle when slipped on steps;" #17 "cleaning a machine slipped and fell on back;" #18, "tripped and fell causing bruising to left knee;" #22 "employee slipped and fell;" #26, "employee slipped & twisted left knee while carrying buckets;" and #27, "employee slipped twisting leg, knee and ankle."

Instance “b” -- In-running nip point for
tail roll of cone-line conveyor machine

The “cone line” conveyor has cone shaped pieces that are integrated onto a conveyor belt. At the Respondent’s plant, the workstation for two employees is to stand on opposite sides of the conveyor belt and to place poultry carcasses over the moving cones on the conveyor belt, resulting in the conveyor belt moving the carcasses down the line for continued processing. The tail roll of the conveyor belt has an in-running nip point where the rotating toothed wheel meets the circulating conveyor belt. (Ex. C-28 [video clip 0010 shows the tail roll of the cone line conveyor in operation, and video clip 0011 shows the nip point]). The nip point appears to be about 18 to 24 inches above floor level. (*Id.*). The nip point is unguarded, and is accessible by an opening near the nip point that is about 3 inches high, 2.75 inches wide, and about 2 inches deep. (T-1, pp. 104-105; Ex. C-6, p. 7 [measurements shown in images 0012, 0013, and 0014]; Ex. C-28 [video clip 0011 is a close-up of nip point in motion]).

The two employees whose workstation is near the tail roll must stand about two to three feet from the nip point, and they wear snug-fitting rubber aprons that extend to the tops of their shoes. (*Id.*). There is a bucket situated on the floor in between the two employees to catch carcasses that they mishandle and drop. (*Id.*).

The CO observed that the floor around the cone line conveyor was wet and slippery from being washed with water and from the presence of poultry debris. (T-1, p. 46). The CO believed that “[i]t’s very likely, reaching down to pick up chicken, somebody could slip, lose their balance, and also put a hand in the in-running nip point which is on the bottom side of the conveyor belt with that toothed sprocket.” (T-1, pp. 54-55). The CO explained his theory of employee exposure to the nip point as follows: “So that gap measures approximately two inches on the inside where somebody could feasibly reach in or fall in, slipping, reaching for a chicken

and inadvertently pull themselves up on the machine, put their hand in there on a slippery floor. It's evident to me of an amputation hazard from in-running nip point.”¹¹ (T-1, p. 105).

According to Ms. Kortright, the employees involved in placing the carcasses onto the cones are prohibited by USDA sanitation standards from picking up poultry from the floor, so these employees would have no occasion to attempt to reach down to the floor in the vicinity of the nip point to pick up a dropped carcass while the conveyor is moving. Rather, different workers are designated to recover any dropped carcasses and then recondition them before being reprocessed. Ms. Kortright also testified that the employees whose workstation is two to three feet from the nip point are not involved in moving the bucket that is placed near their feet to catch dropped carcasses. When the conveyor is in motion, other employees use a crook to retrieve the bucket when needed, and thus do not have occasion to come near the nip point while the machine is in operation. (T-2, pp. 99-101).

The evidence fails to establish that it is reasonably predictable that any employee would be exposed to the unguarded nip point. The two employees whose workstations are nearest the nip point have no cause to place any part of their bodies or have their clothing near the nip point. Even if one of those employees were to slip and fall, the orientation of the nip point relative to

¹¹ The CO also testified that the cone line conveyor presented separate “struck by” and “entanglement” hazards from other features of the equipment that are not associated with the asserted amputation hazard presented by the in-running nip point. (See T-1, pp. 38-41, 46, 55, 102-107). The only hazard that was alleged in this instance of the citation item (as incorporated into the complaint) related to the in-running nip point. The “struck by” and “entanglement” hazards about which the CO testified will not be addressed here – neither was alleged, and the record is insufficient to support the conclusion that these unpleaded issues were actually tried or that the parties consented to do so. See *McWilliams Forge Co., Inc.*, 11 BNA OSHC 2128, 2129 (No. 80-5868, 1984) (finding post-hearing amendment of pleadings pursuant to Fed. R. Civ. P. Rule 15(b) “is proper only if two findings can be made – that the parties *tried* an unpleaded issue and that they *consented* to do so”). Accordingly, it would be inappropriate to order *sua sponte* a post-hearing amendment of the pleadings pursuant to Rule 15(b). Cf. *Fossett*, 7 BNA OSHC 1915 (No. 76-3944, 1979)(upholding judge’s *sua sponte* post-hearing amendment of complaint).

their positions makes remote the possibility that the employee's body or clothing would enter the zone of danger.

As to other employees who may come near the nip point, such as the employees who remove the bucket that catches dropped carcasses, there is no evidence that those employees would have occasion to work near the nip point and risk entering the zone of danger from a slip or fall. The Secretary's theory of an employee entering the zone of danger by accident as a result of a slip or fall is grounded in speculation and not on the evidence of record. While such contact might be possible, the weight of the evidence indicates that it would be unlikely. *Jefferson Smurfit Corp.*, 15 BNA OSHC 1419, 1422 (No. 89-0553, 1991) (finding no employee exposure to hazard where contact with "hazardous nip points, while possible, is unlikely").

The Secretary has failed to establish that the Respondent violated § 1910.212(a)(1) with respect to the unguarded nip point for the tail roll of the cone line conveyor, as described in instance "b" of the item 4 of citation 1.

*Instance "c" -- In-running nip point
for chicken skinner machine*

As discussed above in connection with item 3 of citation 1, on November 17, 2011, a production floor employee who was engaged in normal production operations bypassed a partial guard on a chicken skinner machine in an effort to clear debris that had built up and had jammed the machine. The employee sustained lacerated fingers on an in-running nip point that removes skin from chicken carcasses. (T-2, pp. 92-93, 101-102; T-1, pp. 48, 92-93, 165-166; Ex. C-24, p. 4, #34; Ex. C-6, p. 2; Ex. C-3, p. 9 (photo of skinner machine taken on 1/26/2012)). At the time of the injury on November 17, 2011, the nip point was only partially guarded by a metal strip about one inch wide. Sometime after that injury and before the inspection walk-through on January 26, 2012, the Respondent lengthened the existing guard to make it 30 inches long. The

lengthened guard is depicted in the photograph on page 9 of Exhibit C-3 and is situated directly above the “warning” sign, which was also added after November 17, 2011.¹² (T-1, pp. 47-48, 173-74, 203). The CO believed that at the time of his walk-through on January 26, 2012, the guarding of the in-running nip point complied with § 1910.212(1)(a), but that the guarding that existed at the time of the injury on November 17, 2011, did not. (T-1, pp. 174, 203).

The partial guarding of the nip point on the chicken skinner on November 17, 2011, was in violation of § 1910.212(a)(1). The injuries the employee received on that date establish both the existence of a hazard and actual exposure to that hazard. *See S&G Packaging Co., LLC*, 19 BNA OSHC 1503, 1506 (No. 98-1107, 2001). As discussed above in connection with the LOTO violations, the employee’s act of bypassing a guard to perform service that should have been done under lockout, was reasonably predictable in view of the (1) the absence of specific LOTO procedures for the skinner machine, (2) the absence of a periodic LOTO inspection, and (3) the absence of any LOTO training provided to that employee. *See Signode Corp.*, 4 BNA OSHC 1078, 1079 (No. 3527, 1976) (observing that the standard at § 1910.212(a)(1) “is plainly intended to eliminate danger from unsafe operating procedures, poor training, or employee inadvertence”). The Respondent had actual knowledge of the violative condition, as reflected by a similar injury to another employer on the skinner that had occurred on October 11, 2011, which the Respondent had also appropriately recorded on its 2011 OSHA Form 300. (Ex. C-24, p. 4; Ex C-6, pp. 1-2; T-1, pp. 92-93).

¹² The findings that the guarding was modified between November 17, 2011 and January 26, 2012, is based on the CO’s uncontroverted testimony that during the inspection walk-through on January 26, 2012, Kortright and Herschel showed the CO where additional metal had been welded onto the guard that was in place on November 17, 2011, thereby increasing its length “to prevent employees from reaching into the machine any further.” (T-1, p. 174, 203).

The Secretary has proven that the Respondent violated § 1910.212(a)(1) with respect to the partially guarded nip point on the chicken leg splitter on November 17, 2011, as described in instance “c” of the citation item.

Characterization of § 1910.212(a)(1)
Machine Guarding Violations

The two established violations of § 1910.212(a)(1) are aptly classified as serious because the possible injury addressed by the standard is death or serious physical harm. *Mosser Constr.*, 23 BNA OSHC 1044, 1046 (No. 08-0631, 2010). Serious injuries sustained by two employees in October and November 2011 while operating the chicken skinner machine confirms the appropriate characterization to be serious. (Ex. C-24, p. 4).

Safety Citation 1, Item 5 – Machine guarding for
Mechanical power transmission apparatus, § 1910.219(c)(2)(i)

Item 5 of citation 1 of the Safety Citation alleges a serious violation of the machine guarding standard of § 1910.219, which bears the descriptive heading “Mechanical power transmission apparatus.” The citation item alleges a violation of paragraph (c)(2)(i) of that standard involving an item of machinery referred to as a “wing spreader.”¹³ Section 1910.219(c)(2)(i) provides as follows:

(c) *Shafting – (1) Installation....*

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

The citation item alleges specifically that the “[h]orizontal shafting on the wing spreader is unguarded exposing employees to caught in hazards of the rotating parts.”

¹³ The machine was called “wing spreader” throughout these proceedings, although technical information prepared by the machine’s manufacturer dubs it a “wing stretcher.” (Ex. R-3, p. 2).

The purpose of the wing spreader is to fluff the wings and cause them to flop out from the carcass in a spread position so that they will be easier to cut off. (The seventeen-second video clip number MVI-0026 that is contained in Exhibit C-28 shows the wing spreader in operation.) The wing spreader accomplishes this by means of two identical rotating cylinders, upon which are affixed about 100 supple and tapered finger like protuberances, each about five inches long. The identical rotating cylinders are about four feet in length and about six inches in diameter, and are oriented horizontally with parallel axes, about four feet above the floor. The space between the parallel cylinders appears to be about 18 inches. The cylinders rotate in opposite directions at a rate of about 75 RPM. (T-1, p. 61).

Each carcass passes in between the rotating cylinders while suspended by its legs from an overhead conveyor. The speed of the line is such that it takes about two seconds for each carcass to traverse the four-foot length of the rotating cylinders and to be struck repeatedly by the rotating supple protuberances.

There is no casing or trough enclosing the rotating cylinders to protect an employee from accidental or inadvertent contact with them. The Secretary alleges that the absence of such guarding violates § 1910.219(c)(2)(i).

The Secretary has not met his burden to establish that § 1910.219(c) applies. As discussed below, § 1910.219 requires guarding of certain “horizontal shafting” that is part of a machine’s power transmission components. The evidence establishes that the rotating cylinders of the wing spreader are not a component of the machine’s power transmission apparatus, but rather constitute the machine’s point of operation. Consequently, the cylinders do not constitute “horizontal shafting” within the meaning of § 1910.219, so that section does not apply to the wing spreader’s rotating cylinders.

Section 1910.219 is contained within Subpart O, which bears the title “Machinery and Machine Guarding.” The descriptive heading of § 1910.219 is “Mechanical power transmission apparatus.”¹⁴ The heading of paragraph 1910.219(c) is “Shafting,” and the heading of paragraph 1910.219(c)(2), which is quoted above, is “Guarding horizontal shafting.”

Subpart O contains definitions that pertain exclusively to § 1910.219. These section-specific definitions are set forth in § 1910.211(f), which describes the terms defined therein to be “mechanical power-transmission guarding terms.”

Paragraph (a)(4) of § 1910.219 expressly delimits the section’s applicability to the safeguarding of power transmission apparatuses, providing as follows: “This section covers the principal features with which power transmission safeguards shall comply.”

The rotating cylinders on the wing spreader are not a part of the machine’s “power transmission apparatus,” and thus do not constitute “horizontal shafting” within the meaning of paragraph (c)(2)(i). Rather, the rotating cylinders are the machine’s point of operation. The “[p]oint of operation means that point at which cutting, shaping, or forming is accomplished upon the stock and shall include such other points as may offer a hazard to the operator in inserting or manipulating the stock in the operation of the machine.” § 1910.211(f)(8).¹⁵

The term “power transmission apparatus” is not defined anywhere in Subpart O. The term is described elsewhere by OSHA to be “all components of the mechanical system which transmit energy to the part of the machine performing the work,” and includes “flywheels,

¹⁴ Each section in the Code of Federal Regulations must “have a brief descriptive heading, preceding the text, on a separate line.” 1 C.F.R. § 21.16(b). These descriptive headings are useful for identifying the purpose of a standard. Nonetheless, in determining the scope of a standard, the Commission looks “primarily to the standard itself rather than its caption.” *Chesapeake Operating Co.*, 10 BNA OSHC 1790, 1793 (No. 78-1353).

¹⁵ Section 1910.211(f)(8) specifically defines the term “point of operation” as that term is “used in § 1910.219.” Curiously, the term “point of operation” is not actually used in § 1910.219.

pulleys, belts, connecting rods, couplings, cams, spindles, chains, cranks, and gears.”¹⁶ The prescriptive paragraphs of § 1910.219 set forth standards that pertain unmistakably to the components of a machine that transmit energy to the part of the machine that does the work (i.e., the “point of operation”). The headings of the prescriptive paragraphs reflect as much, such as the following headings: “Shafting;” “Pulleys;” “Belt, rope, and chain drives;” “Gears, sprockets, and chains;” “Guarding friction drives;” “Collars and couplings;” “Bearings and facilities for oiling;” “Guarding of clutches, cutoff couplings, and clutch pulleys;” and “Belt shifters, clutches, shippers, poles, perches, and fasteners.” The only objectively reasonable interpretation of the scope of paragraph (c)(2)(i) is that it is applicable only to horizontal shafting that is a component of a machine’s power transmission apparatus.

The two rotating cylinders on the wing spreader are not a component of the machine’s power transmission apparatus. Rather, the cylinders, to which are affixed the finger like projections that contact the bird wings, are the machine’s point of operation. Section 1910.219 thus does not apply to the rotating cylinders of the wing spreader. The Secretary has thus failed to establish that the cited standard applies. Accordingly, item 5 of citation 1 of the Safety Citation must be vacated.

¹⁶ The quoted sentence is published on OSHA’s public website on a webpage that is part of OSHA’s Machine Guarding “eTool.” That webpage also describes “three fundamental areas” that are common to all machines: “All machines consist of three fundamental areas: the point of operation, the power transmission device, and the operating controls.” This webpage was accessed at the following URL on September 16, 2014:
www.osha.gov/SLTC/etools/machineguarding/intro.html#Power%20Transmission%20Device

Health Citation Items

Health Citation 1, Item 1 – Hazard Communication Standard, § 1910.1200 (2011)

Item 1 of citation 1 of the Health Citation alleges that the Respondent violated what is commonly known as the Hazard Communication Standard (HCS), that is codified at 29 C.F.R. § 1910.1200 (2011).¹⁷ The citation item alleges that the Respondent violated paragraph (h)(1) of the HCS by failing to provide information and training to employees “on hazardous chemicals in their work area at the time of their initial assignment and whenever a new hazard was introduced into their work area.”¹⁸ The description of the alleged violation averred that the Respondent had

¹⁷ The HCS was substantially modified in March 2012. *See* Hazard Communication, 77 Fed. Reg. 17574 (March 26, 2012) (to be codified at 29 C.F.R. § 1910.1200). The Respondent is alleged to have violated the provisions of the HCS that were in effect on November 29, 2011, as set forth in the 2011 codification of the Code of Federal Regulations.

¹⁸ The 2011 version of § 1900.1200(h), applicable here, provided as follows:

(h) *Employee information and training.* (1) Employers shall provide employees with effective information and training on hazardous chemicals in their work area at the time of their initial assignment, and whenever a new physical or health hazard the employees have not previously been trained about is introduced into their work area. Information and training may be designed to cover categories of hazards (e.g., flammability, carcinogenicity) or specific chemicals. Chemical-specific information must always be available through labels and material safety data sheets.

(2) *Information.* Employees shall be informed of:

(i) The requirements of this section;

(ii) Any operations in their work area where hazardous chemicals are present; and,

(iii) 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.

(3) *Training.* Employee training shall include at least:

(i) Methods and observations that may be used to detect the presence or release of a hazardous chemical in the work area (such as monitoring conducted by the employer, continuous monitoring devices, visual appearance or odor of hazardous chemicals when being released, etc.);

(ii) The physical and health hazards of the chemicals in the work area;

(iii) The measures employees can take to protect themselves from these hazards, including specific procedures the employer has implemented to protect employees from exposure to hazardous chemicals, such as

failed to provide information and training for employees working in the “kill, evisceration and other poultry processing areas where disinfectants such as bleach solutions and peroxyacetic acid (PAA) are routinely used.”¹⁹

The Respondent has a Hazard Communication Program in place at the workplace. Pursuant to that existing program, only the employees who work in the Respondent’s Sanitation Department and the employees who handle undiluted hazardous chemicals are provided information and training that complies with paragraph (h) of the HCS. (T-2, pp. 59-60, 107-113; Exs. C-17 and C-18). The Respondent does not provide any hazard communication training and information to employees who work in the production areas of the workplace. (Ex. C-17, p. 2; Ex. C-18; T-2, pp. 59-60, 107-113). The Secretary alleges that the failure to provide such information and training to those production area employees violates paragraph (h) of the HCS.

The Respondent uses a liquid product with the commercial name “Perasafe Direct Meat” (Perasafe) as an antimicrobial agent for application on chicken carcasses. (Ex. C-32, p. 8; T-2 pp. 34, 83). Perasafe is a mixture that includes the following hazardous chemicals in the following percentages (by weight): 15% peroxyacetic acid (also known by the acronym “PAA” and as “peracetic acid”); 10% hydrogen peroxide; 35% acetic acid. (Ex. R-32, p.8). The remaining 40% of Perasafe is mostly water. (*Id.*).

appropriate work practices, emergency procedures, and personal protective equipment to be used; and, equipment to be used; and,

(iv) The details of the hazard communication program developed by the employer, including an explanation of the labeling system and the material safety data sheet, and how employees can obtain and use the appropriate hazard information.

¹⁹ The citation item identified “bleach solutions” and “PAA” as examples of disinfectants in use at the workplace to which the HCS applied. Nevertheless, there was no evidence presented pertaining to the use of any other disinfectants in the Respondent’s workplace to which the HCS would apply. (T-2, pp. 24-26).

The manufacturer of Perasafe prepared a Material Safety Data Sheet (MSDS) for the product, which the Respondent had received. This MSDS states the product has a “sharp pungent vinegar-like odor,” is corrosive to the eyes and skin, and is “irritating to the respiratory tract.” (Ex. C-32, pp. 1 & 3). It indicates further that the “signs and symptoms of exposure” to the product are as follows: “Liquid and mist are corrosive (causing burns); direct contact could cause irreversible damage to eyes including blindness and/or irreversible destruction to skin tissue. Vapor/mist will irritate nose, throat, and lungs but will usually subside when exposure ceases.” (Ex. C-32, pp. 3-4).

The Respondent uses the Perasafe at the workplace in the following manner. Employees who are designated to handle the undiluted Perasafe (and who *have* received appropriate HCS information and training) handle the undiluted product in a separate “chemical room.” There, an electronic “ratio pump” adds the Perasafe to a waterline at a ratio of approximately 7.5 ounces per 50 gallons of water to create an aqueous solution that has a concentration of PAA of no more than 200 ppm (0.02%). (T-2, pp. 34 & 83; Ex. C-32, p. 9-10). This diluted Perasafe solution is tested hourly to confirm the concentration level of PAA does not exceed 200 ppm. (T-2, pp. 82, 134-135, 149-151).

The diluted Perasafe solution travels through piping to the “pre-chill” room where it is dispensed into two “dip tanks.” (T-2, pp. 28, 75-79). The poultry carcasses (which by this point in the production process have been plucked and eviscerated) are immersed in the Perasafe solution by being dipped in and out of the dip tanks. (T-2, pp. 28, 75-79). The carcasses are then moved from the “pre-chill” room to a “chiller” and from there are moved to the “post-chill” phase of the process. After “post-chill,” the carcasses are placed on a “double conveyor,” which

conveys them to the “production area” of the facility, where the carcasses are either cut into parts or processed as a “whole bird” for final packaging and distribution. (T-2, pp. 28-29, 75-79).

As a result of the immersion in the Perasafe solution, residue of the solution remains on the carcasses as the carcasses are transported on the double conveyor through the production line. IH Reinemann provided uncontroverted credible testimony that residual droplets of the Perasafe solution on the carcasses could become “aerosolized” as the carcasses were transported along the production line, and thus become subject to both inhalation and direct contact by employees working on and around the double conveyor production line. (T-2, 28-29, 59-60, 63).

The Respondent also uses liquid chlorine bleach (also known as sodium hypochlorite) as a cleaning agent throughout the production areas of the facility. (T-2, pp. 29 & 34). The MSDS that the Respondent received on the chlorine bleach product states that the product is about 14% sodium hypochlorite, about 11% other chemicals, and about 75% water. (Ex. C-19, p. 15). The MSDS contains the following warning (Ex. C-19, p. 16):

DANGER: Corrosive, may cause severe skin irritation or chemical burns to broken skin. Causes eye damage. Do not get in eyes, on skin or clothing. Wear safety goggles or face shield and rubber gloves when handling this product. Wash after handling. Avoid breathing vapors. Vacate poorly ventilated areas as soon as possible. Do not return until strong odors have dissipated.

Elsewhere, the MSDS for the chlorine bleach product states that the signs and symptoms of inhalation exposure are as follows (Ex. C-19, p. 18):

ACUTE: Inhalation of this material is irritating to the nose, mouth, throat, and lungs. It may also cause burns to the respiratory tract with the production of lung edema which can result in shortness of breath.

CHRONIC: Repeated inhalation exposure may cause impairment of lung function and permanent lung damage.

The Respondent dilutes the chlorine bleach product with water by the same process that it uses to dilute the Perasafe product. (T-2, pp. 149-151). As with the Perasafe product, a designated employee handles the undiluted chlorine bleach product in a separate “chemical room,” where the product is added to a waterline by use of an electronic “ratio pump,” which is calibrated to create a solution that has a concentration of chlorine bleach between 100 and 200 ppm (0.01% to 0.02%). (T-2, pp. 27, 29, 34). The diluted chlorine bleach solution is tested hourly to confirm the concentration levels. (T-2, pp. 82-83, 134-135, 149-151).

The bleach solution is conveyed from the chemical room to production areas via dedicated piping. The bleach solution is dispensed from high-pressure hoses to spray floors and equipment. (T-2, pp. 83, 94-95, 136, 138-143). Employees from the Sanitation Department, who have received appropriate HCS training, perform this high-pressure spraying of the bleach solution. The high-pressure spraying occurs only when the production line is shut down and production employees are not present -- before production begins, during scheduled breaks throughout the day, and after production operations have ended. (T-2, pp. 27, 61-62, 94-95).

In addition to the use of high pressure spraying of the bleach solution during production breaks, general cleaning using chlorine bleach solution occurs throughout the production day as needed, and is done while production is in progress and production employees are present on the production floor.²⁰ (T-2, p. 136).

²⁰ For example, the Respondent’s “Sanitation Standard Operating Procedures” (SSOP) provides that all transfer tables located in the Evisceration Department “will be continuously washed with chlorinated water,” and that “[p]roduct that falls on the floor will be ... reconditioned by washing with chlorinated water.” (Ex. C-21, p. 5; T-1, p. 197). The video clip identified as MVI-0029 that is part of Exhibit C-28 shows a production worker in the Evisceration Department standing next to a stream of chlorinated water and washing her knife and gloved hands three separate times during the 24-second video clip. (T-1, pp. 44 & 67; *see also* Ex. C-21, p. 4, providing that employees in the Evisceration department “will clean and sanitize his/her knife ... as often as necessary during the dressing procedure”).

A chlorine bleach solution with a lower chlorine bleach concentration of 20 to 50 ppm (0.002% to 0.005%) is used to clean the “chiller” room. (T-2, p. 83). This lower concentration solution is also used by production line employees for personal disinfection tasks, such as cleaning dropped tools. (T-2, pp. 34, 61-62, 151). The chlorine bleach solution with a concentration of 20 to 50 ppm is created by the same type of electronic “ratio pump” that creates the higher concentration chlorine bleach solution, as well as the diluted Perasafe solution. (T-2, pp. 150-151).

During the Health Inspection, employees who worked in the production area on or near the double conveyor production line told the IH that from time to time they smelled a vinegar-like odor as well as a bleach-like odor in the production area. (T-1 208; T-2, pp. 24 & 27). The IH himself detected a “slight odor” of chlorine bleach in the production area during the Health Inspection. (T-2, p. 23). A bleach-like odor is, obviously, consistent with the presence of liquid chlorine bleach, whose “odor threshold” is only 0.3 ppm. (Ex. C-19, p. 18). A vinegar like odor is consistent with the presence of the Perasafe product, which has a “sharp, pungent vinegar-like odor” according to its MSDS. (Ex. C-32, pp. 1 & 8; Ex. C-19, p. 18). Employees also told the IH that they had experienced respiratory ailment symptoms and rashes that were consistent with the exposure symptoms described in the MSDS’s for Perasafe and chlorine bleach.²¹ (Ex. C-17, p. 1; T-1, pp. 207-208; T-2, p. 59).

The Respondent does not dispute that the HCS applies to its workplace, and indeed has implemented a hazard communication program intended to comply with that standard. The Secretary has met his burden of demonstrating that the Respondent violated the HCS in the manner alleged.

²¹ No direct evidence was presented, however, that would tend to prove that exposure to these hazardous chemicals was the cause of any of these reported symptoms.

Section 1910.1200(b)(1) requires “all employers to provide information to their employees about the hazardous chemicals to which they are exposed.” Section 1910.1200(b)(2) states that the HCS “applies to any chemical which is known to be present in the workplace in such a manner that employees may be exposed under normal conditions of use or in a foreseeable emergency.”²²

Both the undiluted Perasafe and chlorine bleach products that the Respondent uses in the workplace constitute a “hazardous chemical” to which the HCS applies pursuant to § 1910.1200(b)(1). (Ex. C-19, pp. 15-21; Ex. C-32). The Respondent implicitly acknowledges

²² Paragraph (c) of the HCS includes definitions of the following terms that are relevant to the determination of whether an employee must receive HCS information and training:

Chemical means any element, chemical compound or mixture of elements and/or compounds.

Employee means a worker who may be exposed to hazardous chemicals under normal operating conditions or in foreseeable emergencies. Workers such as office workers or bank tellers who encounter hazardous chemicals only in non-routine, isolated instances are not covered.

Exposure or *exposed* means that an employee is subjected in the course of employment to a chemical that is a physical or health hazard, and includes potential (e.g. accidental or possible) exposure. "Subjected" in terms of health hazards includes any route of entry (e.g. inhalation, ingestion, skin contact or absorption.)

Foreseeable emergency means any potential occurrence such as, but not limited to, equipment failure, rupture of containers, or failure of control equipment which could result in an uncontrolled release of a hazardous chemical into the workplace.

Hazardous chemical means any chemical which is a physical hazard or a health hazard.

Health hazard means a chemical for which there is statistically significant evidence based on at least one study conducted in accordance with established scientific principles that acute or chronic health effects may occur in exposed employees....

29 C.F.R. § 1910.1200(c) (2011).

as much by providing appropriate HCS information and training on these materials to the employees who handle the undiluted products.

Paragraph (h) of the HCS requires an employer to “provide employees with effective information and training on hazardous chemicals in their work area at the time of their initial assignment, and whenever a new physical or health hazard the employees have not previously been trained about is introduced into their work area.” As described above, both Perasafe and chlorine bleach are present in the production areas. Production area employees are “exposed” to those hazardous chemicals, notwithstanding that they are substantially diluted before being introduced in the production areas. Paragraph (h) requires employers to provide employees with information and training on a hazardous chemical that is present in an employee’s work area, making no distinction on whether the chemical is present in either its native form or in a diluted solution.

The Respondent argues that because the concentrations of Perasafe and chlorine bleach in the diluted solutions that are introduced in the production area are less than 1%, the production area employees are not required to receive HCS training on those chemicals. The Respondent grounds its argument on provisions in paragraph (d) of the HCS, which is contained in the “hazard determination” provisions of the standard. Paragraph (d) requires chemical manufacturers and importers to “evaluate chemicals produced in their workplaces or imported by them to determine if they are hazardous.” 29 C.F.R. § 1910.1200(d)(1) (2011).²³

²³ Employers that do not manufacture or import chemicals are not required to evaluate a chemical pursuant to paragraph (d) of the HCS unless such an employer “choose[s] not to rely on the evaluation performed by the chemical manufacturer or importer for the chemical to satisfy this requirement.” 29 C.F.R. § 1910.1200(d)(1) (2011). The Respondent here did not conduct any evaluation of either the Perasafe or chlorine bleach products to determine whether they constitute “hazardous chemicals” as defined in the HCS, but rather chose to rely on the evaluations performed by the manufacturers.

The Respondent relies specifically on paragraph (d)(5)(ii) of the HCS, which is addressed to whether a “mixture” of chemicals constitutes a hazardous chemical to which the HCS applies. The HCS defines the term “mixture” to mean “any combination of two or more chemicals if the combination is not, in whole or in part, the result of a chemical reaction.”²⁴ The Respondent argues that because the concentrations of liquid chlorine and of Perasafe in the diluted solutions that are present in the production areas are both less than 1%, neither constitutes a hazardous chemical subject to the HCS. Paragraph (d)(5) of the HCS provides:²⁵

(5) The chemical manufacturer, importer or employer, shall determine the hazards of mixtures of chemicals as follows:

(i) If a mixture has been tested as a whole to determine its hazards, the results of such testing shall be used to determine whether the mixture is hazardous;

(ii) If a mixture has not been tested as a whole to determine whether the mixture is a health hazard, the mixture shall be assumed to present the same health hazards as do the components which comprise one percent (by weight or volume) or greater of the mixture, except that the mixture shall be assumed to present a carcinogenic hazard if it contains a component in concentrations of 0.1 percent or greater which is considered to be a carcinogen under paragraph (d)(4) of this section;

(iii) If a mixture has not been tested as a whole to determine whether the mixture is a physical hazard, the chemical manufacturer, importer, or employer may use whatever scientifically valid data is available to evaluate the physical hazard potential of the mixture; and,

(iv) If the chemical manufacturer, importer, or employer has evidence to indicate that a component present in the mixture in concentrations of less than one percent (or in the case of carcinogens, less than 0.1 percent) could be released in concentrations which would exceed an established OSHA permissible exposure limit or ACGIH Threshold Limit Value, or

²⁴ A “chemical” as defined in paragraph (c) of the HCS may itself be a “mixture” of elements or chemical compounds. *See* footnote 22, *supra*.

²⁵ The 1% cutoff method in paragraph (d)(5)(ii) of evaluating hazardous chemicals in mixtures was eliminated by the current version of the HCS, which was effective on May 25, 2012. Hazard Communication, 77 Fed. Reg. 17574, 17710-11 (March 26, 2012) (to be codified at 29 C.F.R. § 1910.1200).

could present a health risk to employees in those concentrations, the mixture shall be assumed to present the same hazard.

The Respondent's argument fails. Paragraph (d) describes the duty that chemical manufacturers and importers have to determine whether a mixture of chemicals constitutes a hazard, and thus whether that manufacturer or importer must obtain or develop MSDS information for downstream employers pursuant to paragraph (g) of the standard. *See* Preamble to Hazard Communication Final Rule, 48 Fed. Reg. 53280, 53290-92 (Nov. 25, 1983) (to be codified at 29 C.F.R. § 1910.1200). Both the Perasafe and the chlorine bleach products that the Respondent obtains are mixtures of more than one chemical, as reflected by the respective MSDS's that the Respondent maintained for each product. (Ex. C-19, pp. 15-21; Ex. C-32). The manufacturers of those mixtures have tested each mixture "as a whole to determine its hazards," and thus pursuant to paragraph (d)(5)(i) "the results of such testing shall be used to determine whether the mixture is hazardous." *See* 48 Fed. Reg. 53280, 53336 Hazard Communication Final Rule (Nov. 25, 1983) ("The hazard determination paragraph (d) also addresses the coverage of hazardous chemicals which are mixtures.... [I]f the employer has objective test data on the mixture as an entity, that data must be used to determine the hazards"). The results of that manufacturer's testing are that both the Perasafe and the chlorine bleach products are "hazardous chemicals" as defined in the HCS. The Respondent has relied upon the manufacturers' evaluations of these hazardous chemicals, and as a result has appropriately provided hazard communication training on those chemicals to those employees whom it has recognized are exposed to the chemicals.

Once an employer knows that a hazardous chemical is present in the workplace, the employer may not circumvent the requirement of paragraph (h) to provide information and training to employees who may become "exposed" (as defined in paragraph (c) of the HCS) to

the chemical simply by diluting the chemical with water. To allow otherwise would subvert the plain intent of the HCS. Moreover, the Respondent's argument presupposes that exposure of its production area employees to Perasafe or bleach solutions with greater concentrations of the chemicals than intended would not occur as the result of accident or "foreseeable emergency" as defined in paragraph (c) of the HCS.

The Secretary has established that the Respondent violated the cited standard.

The employees in the production areas who did not receive hazard communication information and training on Perasafe and chlorine bleach were necessarily exposed to the violative condition.

The Respondent knew of the violative condition, as reflected by its decision to provide hazard communication training on the Perasafe and chlorine bleach products to other employees, but not to employees assigned to work only in the production areas.

The Secretary has carried his burden to establish the violation alleged.

The violation is established as serious. The MSDS's for both Perasafe and liquid chlorine bleach describe the hazards presented by those hazardous chemicals and the potential injuries they can inflict. The employee information and training requirements set forth in paragraph (h) of the HCS are designed to educate employees on the hazards of chemicals in their workplace so that they will be better able "to protect themselves from these hazards." § 1910.1200(h)(3)(ii).

Health Citation 2, Item 1 –
Injury and Illness Recording Standard, § 1904.4(a)

Item 1, citation 2, of the Health Inspection alleges a repeat violation of the requirement set forth in 29 C.F.R. § 1904.4(a) that employers record certain work-related fatalities, injuries or illnesses.²⁶

The Secretary alleged that the Respondent violated this standard by failing to record a workplace injury suffered by a certain employee (initials RM) on the OSHA 300 Log for Calendar Year 2011. The Secretary’s Amended Complaint alleged specifically as follows: “On or about 12/16/11, case number 121611RM, an employee was diagnosed with chronic left shoulder pain from repetitive motion at work.”²⁷

The Secretary has the burden to present evidence establishing an alleged violation. *Home Depot #6512*, 22 BNA OSHC 1863, 1864 (No. 07-0359, 2009).

An employer’s duty to record a recordable injury or illness on the OSHA Form 300 is triggered upon the employer “receiving information that a recordable injury or illness has

²⁶ Paragraph 1904.4(a) provides as follows:

(a) *Basic requirement.* Each employer required by this Part to keep records of fatalities, injuries, and illnesses must record each fatality, injury and illness that:

(1) Is work-related; and

(2) Is a new case; and

(3) Meets one or more of the general recording criteria of § 1904.7 or the application to specific cases of § 1904.8 through § 1904.12.

²⁷The original citation item alleged 10 instances of the violation and proposed a penalty of \$33,000.00. These allegations were amended by the Secretary’s Amended Complaint (dated February 27, 2013), which alleged only two separate instances, but maintained the same proposed penalty. In post-hearing briefing, the Secretary has presented argument in support of only one of the two alleged instances. The instance that the Secretary chose not to argue, which pertains to an employee with initials AH, is therefore deemed abandoned and will not be addressed. *See Ga.-Pac. Corp.*, 15 BNA OSHC 1127, 1130 (No. 89-2713, 1991). It should be noted nevertheless that the Respondent’s argument that the Secretary did not prove this alleged instance is persuasive, and that in all probability the Respondent would have prevailed on this issue even if the Secretary had not abandoned it. (Resp’t Br. p. 16).

occurred.” 29 C.F.R. § 1904.29(b)(3). Here, as described below, the Secretary has failed to present sufficient evidence to support a finding that the Respondent had received information that RM had sustained a recordable injury, and thus has failed to prove that the absence of a corresponding entry on the OSHA Form 300 was a violation of § 1904.4(a).

The Respondent received a one-page handwritten letter dated December 16, 2011 that was prepared by RM’s treating physician and that was addressed “To Whom It May Concern.” The entire body of that handwritten letter is as follows: “¶ [RM] has a left shoulder/neck injury from repetitive movement. She needs a change of position on the job. ¶ She needs to return to see me in 2 weeks Fri 12/30 for reevaluation.”²⁸ (Ex. C-23, p. 3).

The inspecting IH obtained a copy of this letter directly from the employee’s treatment provider pursuant to a medical access order. (T-1, pp. 37, 43). The record does not indicate when the IH obtained the letter from the treatment provider. The record also does not reflect whether the IH had also seen the letter during the Health Inspection during his review of the Respondent’s records. (T-1, pp. 42-43).

²⁸ The IH obtained directly from RM’s health care provider a copy of RM’s treatment record from December 16, 2011. (T-2, pp. 9 & 37; Ex. C-23, pp. 1-2). The Respondent had *not* received a copy of this treatment record before the Health Inspection was concluded on January 26, 2012. (T-2, pp. 183-184).

The “History” section of this treatment record reflects the following: “31 Y/O who works in chicken plant. [She] has retetitive [sic] motion with her left arm and shoulder and has chronic left shoulder pain. She says she has ‘the most difficult job in the plant’.... She otherwise feels well.” (Ex. C-23, p. 1).

The “Assessments” section of the treatment record included the following: (1) “Pain due to trauma, chronic – 338.41,” and (2) “Chronic pain syndrome – 338.4.” (*Id.*)

The “Treatment” section of the treatment record for the “pain due to trauma” assessment reflected the following: “Left shoulder pain due to chronic repetitive motion. I wrote letter to her employer with her permission to see if they would be willing to change her job activities.” (*Id.*, p. 2). Also, for the “chronic pain syndrome” assessment, the “Treatment” section shows that two oral medications were prescribed – ibuprofen and Flexeril. (*Id.*).

Tricia Kortright was the employee responsible for maintaining the Respondent's OSHA Form 300 throughout reporting year 2011. (T-2, p. 116, 119, 121). Kortright testified that the Respondent had located the treating physician's letter after the Health Citation was issued (i.e., after May 14, 2012). (T-2, p. 184). She testified the letter "was in our filing system out of the personnel's medical file." (T-2, p. 184). She first saw the letter after the Health Citation had been issued. (T-2, p. 184).

According to Kortright, the Respondent's injury and illness recording system is reliant upon the Respondent receiving reports of injuries and illnesses from employees. (T-2, p. 116). Upon receiving an employee's report of an injury, the Respondent would make a determination as to whether the injury was required to be recorded on the Form 300.²⁹ (T-2, p. 116). According to Kortright's uncontroverted testimony, neither RM nor any other employee reported or complained about RM having suffered an injury as referenced in the treating physician's letter. (T-2, p. 116). The Secretary presented no evidence that RM (or any other employee) had reported to the Respondent that RM had sustained an injury. (*See* T-1, pp. 39-45).

On this record, therefore, the Respondent's mere receipt and possession of the treating physician's letter is the sole evidence that bears on the issue of whether the Respondent had "receiv[ed] information that a recordable injury or illness ha[d] occurred" pursuant to § 1904.29(b)(3), thus triggering the duty to record, or to evaluate the matter further. *See* § 1904.5(b)(3) (requiring an employer to evaluate an employee's work duties and environment if it is "not obvious whether the precipitating event or exposure occurred in the work environment or away from work").

²⁹ Kortright testified that if she had reviewed both the physician's letter and the treatment record, she would have "turned it over to the workers' compensation carrier" and that "if it's deemed to be work related at that point I would record it" on the Form 300. (T-2, pp. 118-119).

As to evidence surrounding the Respondent's handling of the treating physician's letter, the record is silent regarding (1) when the Respondent received the letter, (2) how the letter was delivered to the Respondent, such as whether by mailing from the treating physician or by RM providing it to the Respondent directly, or (3) the identity and actions of the employee(s) who handled the letter. The record is unclear even on whether the "medical file" in which the letter was found pertained only to RM, or to other employees as well. (T-2, p. 184).

There is thus no evidence respecting the time and manner by which the Respondent received and processed the treating physician's letter. Moreover, there is no evidence from which to assess whether the Respondent's recordkeeping systems or procedures were either structurally flawed or simply not followed with respect to the handling of the treating physician's letter. Even assuming that the Respondent received the letter before the Health Inspection concluded on January 26, 2012, the other evidence presented is simply insufficient to support any findings as to whether, upon receipt of the treating physician's letter alone, it was unreasonable for the Respondent either (1) not to have concluded that RM had suffered a recordable injury, or alternatively (2) not to have evaluated RM's work duties and environment pursuant to 29 C.F.R. § 1904.5(b)(3) to decide whether RM had suffered a recordable injury. *Cf. Shaw Global Energy Servs., Inc.*, 23 BNA OSHC 2105, 2110, n.7 (No. 09-0555, 2012) (concluding that employer's "decision not to record was plainly unreasonable" where employer had actual knowledge that the employee could have been exposed to mercury in the work environment, and the safety manager had visited the employee at the hospital where the employee had been admitted for treatment of mercury toxicity) *aff'd* 547 Fed. Appx. 447 (5th Cir. 2013) (unpublished).

In all likelihood, there is much information that was not presented in evidence that would bear on whether the Respondent's handling of the physician's letter was reasonable in light of an employer's responsibilities to record workplace injuries or to evaluate an injury further. However, a finding one way or the other on the reasonableness of the Respondent's actions upon receiving the treating physician's letter would not be supported by a preponderance of the evidence, but rather would be based on surmise, conjecture, and speculation. *Cf. Home Depot #6512*, 22 BNA OSHC 1863 (No. 07-0359, 2009) (reversing as unsupported by a preponderance of the evidence a Commission judge's finding of fact that a Home Depot parking lot employee had sustained a head injury in a fall in the store parking lot, where the employee had been discovered unconscious on the ground of the parking lot and died two days later from "blunt head trauma").

The Secretary has failed to carry his burden to establish that the Respondent violated 29 C.F.R. § 1904.4(a), so repeat citation 2, item 1 of the Health Citation is vacated.

Penalty Assessment

For each of the three proven LOTO violations described in items 1, 2 and 3 of Safety Citation, the Secretary seeks a penalty of \$5,500.00.

For the three alleged instances of the machine guarding standard set forth in item 4 of the Safety Citation (of which only two instances were proven), the Secretary seeks a penalty of \$5,500.00.

For the proven violation set forth in item 1, citation 1 of the Health Inspection regarding the HCS, the Secretary seeks a penalty of \$5,100.00.

The Commission and its judges conduct *de novo* penalty determinations and have full discretion to assess penalties based on the facts of each case and the applicable statutory criteria. *Valdak Corp.*, 17 BNA OSHC 1135, 1138 (No. 93-0239, 1995) *aff'd*,

73 F.3d 1466 (8th Cir. 1996); *Allied Structural Steel*, 2 BNA OSHC 1457, 1458 (No. 1681, 1975). The permissible range of penalties for a serious violation is from no penalty to \$7,000. 29 U.S.C. § 666(b).

Section 17(j) of the Act, 29 U.S.C. § 666(j), requires that in assessing penalties, the Commission give “due consideration” to four criteria: the size of the employer’s business, the gravity of the violation, the employer’s good faith, and its prior history of violations. *Specialists of the S., Inc.*, 14 BNA OSHC 1910 (No. 89-2241, 1990). Gravity is the primary consideration among these four statutory criteria, and is determined by “such matters as the number of employees exposed, the duration of the exposure, the precautions taken against injury, and the likelihood that any injury would result.” *J.A. Jones Constr. Co.*, 15 BNA OSHC 2200, 2214 (No. 87-2059, 1993).

With approximately 300 employees, no penalty reductions for size are indicated.

The significant failings in the Respondent’s LOTO program, machine guarding, and the hazard communication program, weighs against reducing any penalty for good faith. (T-2, p. 54). *See Elliot Const. Corp.*, 23 BNA OSHC 2110, 2119 (No. 07-1578, 2012) (concluding that “significant failings” with respect to employee safety negated a penalty reduction for good faith).

The Secretary’s proposed penalties for the violations identified in the Safety Inspection included a 10% enhancement for history, apparently because the Respondent had been cited for an injury recording violation (29 C.F.R. § 1904.4(a)) that had become a final order of the Commission in November 2010. (T-2, p. 12-13, 48-49). The Secretary did not propose an increase in the penalty based on history for the proven violation in the Health Citation. (T-2, p. 54).

The gravity of the three LOTO violations is high. The failure to comply with the LOTO requirements endangered the safety of almost all facility employees. The penalties of \$5,500 as originally proposed by the Secretary for each of the three LOTO violations is appropriate under the statutory factors.

The gravity of the machine guarding violations described in item 4 (instances “a” and “c”) of the Safety Inspection is also high, as reflected by the injury sustained by a worker on November 17, 2011 as a result of exposure to the hazardous condition involving the chicken skinner (instance “c”). Even though the Secretary proved only two of the three alleged instances of the violation, the original proposed penalty of \$5,500 is appropriate under the statutory penalty factors.

The gravity of the violation of the Hazard Communication Standard in Citation 1 of the Health Inspection is high in view of the pervasive exposure of production line employees to hazardous chemicals and the absence of hazard communication training and information to those exposed employees. A penalty of \$5,100.00 for this violation as originally proposed by the Secretary is appropriate.

ORDER

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

1. As to OSHRC docket number 12-1165 (Safety Citation):

a. Citation 1, Item 1, alleging a serious violation of 29 C.F.R. § 1910.147(c)(4)(ii)(B) is AFFIRMED as serious, and a penalty of \$5,500.00 is assessed.

b. Citation 1, Item 2, alleging a serious violation of 29 C.F.R. § 1910.147(c)(6)(i) is AFFIRMED as serious, and a penalty of \$5,500.00 is assessed.

c. Citation 1, Item 3, alleging a serious violation of 29 C.F.R. § 1910.147(c)(7)(i) is AFFIRMED as serious, and a penalty of \$5,500.00 is assessed.

d. Citation 1, Item 4, alleging a serious violation of 29 C.F.R. § 1910.212(a)(1) is AFFIRMED as serious as to instances “a” and “c” only (as pertains to the “chicken leg splitter” and “chicken skinning machine”), VACATED as to instance “b” (as pertains to the “cone line conveyor”), and a penalty of \$5,500.00 is assessed.

e. Citation 1, Item 5, alleging a serious violation of 29 C.F.R. § 1910.219(c)(2)(i) is VACATED.

2. With regard to OSHRC docket number 12-1269 (Health Citation):

a. Citation 1, Item 1, alleging a serious violation of 29 C.F.R. § 1910.1200(h) is AFFIRMED as serious, and a penalty of \$5,100.00 is assessed.

b. Citation 2, Item 1, alleging a repeat violation of 29 C.F.R. § 1904.4(a) is VACATED.

SO ORDERED.

/s/
WILLIAM S. COLEMAN
Administrative Law Judge

Date: September 30, 2014

Appendix A to ALJ Decision in MB Consultants, Ltd. (12-1165 & 12-1269)

Pages 3 and 4 of Exhibit C-11, titled "Lockout-Tagout Program," are set forth below in this Appendix A to the Decision.

The following equipment is to be lockout/tagout
before pre-op inspection

Live Area:

Equipment/Machinery-Electrical Panel/Location

- | | |
|------------------------|---|
| 1. Slaughter/Kill Line | Panel #16/Maintenance Shop |
| 2. Stunner | Panel #17/Hallway between Kill & Evis. |
| 3. Crate Conveyor | Panel #18/Across from Kill rm bathroom |
| 4. Live Bird Conveyor | Panel #18/Outside wall of kill rm. Bathroom |

Scalder/Feather Room:

- | | |
|----------------------|-----------------------|
| 1. Feather Picker #1 | Panel #19 |
| 2. Feather Picker #2 | In Closet Across from |
| 3. Feather Picker #3 | All Three Pickers |

Evisceration Line:

- | | |
|-------------------|---------------------|
| 1. Final Wash | |
| 2. Oil Sac Cutter | Panel #20 |
| 3. Vantor | Maintenance Shop |
| 4. Cropper | Lockable Disconnect |
| 5. Long Sucker | |

[Page break between pages 3 and 4]

- | | |
|----------------------|------------------|
| 1. Gizzard Harvester | Panel #1 & 2 |
| 2. Gizzard Cleaner | Vacuum Pump Room |

Chiller:

- 1. Chiller Screw Panel #21/Tumbler rm.

Pack-Out:

- 1. Pack-Out Line Panel #6/Chiller area closet
- 2. Chiller rnd. Table Panel #10

Cut-Up:

- 1. Cut-Up Line Panel #7/In closet across from Chiller

Dapac:

Panel #5/Hallway by stairwell & panel

- 1. Breast/Wing
Conveyors Panel #22/Attached to Dapac panel
- 2. Cone Line Panel #8/Across from trim table
- 3. Skinner Machines Panel #8/Across from trim table
- 4. Trim table Cord & Plug
- 5. Cut-up saws Panel #23/Behind saws
- 6. Repac Machine Panel #9/Across from machine
- 7. Freezer Tunnel Panel #9/Across from repac machine

Appendix B to ALJ Decision in MB Consultants, Ltd. (12-1165 & 12-1269)

Pages 7 through 11 of Exhibit C-11, titled “Lockout-Tagout Program,” are set forth below in this Appendix B to the Decision.

GENERAL SAFETY MANAGEMENT

Revised 5/27/2008

LOCKOUT-TAGOUT PROGRAM

PREFACE

Lockout is the placement of a lockout device on an energy isolating device, in accordance with an accepted established procedure, that ensures the energy isolating device and the equipment being controlled cannot be operated until the lockout device has been removed.

A “lockout device” is just that – a locking device that provides a positive means for rendering a switch, valve, or any energy source inoperable. The device may be a padlock, restraining bar, chain, or any device that positively prevents a machine or piece of equipment from becoming “energized” or from releasing stored energy.

Tagout is the placement of a tagout device on an energy isolating device, in accordance with an accepted established procedure, which effectively communicates that the energy isolating device and the equipment being controlled are not to be operated until the tagout device is removed.

A “tagout device” serves as a prominent warning that can be securely attached to an energy-isolating device, which clearly communicates that a tagout condition exists. This tag is a means of identifying who locked out the machine, the date and time of day the tagout took place, and the department for which the person works. Additional information may be placed on the tag such as beeper number, extension number, etc. Tags shall be durable and securely fastened to the energy-isolating device so as not to fall off.

Tags are NEVER to be removed by anyone except the individual who is responsible for the lockout/tagout procedure.

GENERAL MANAGEMENT

Qualified employees of Company Name [sic] shall follow Lockout/Tagout procedures. Only individuals that have successfully completed the training under the company Lockout/Tagout Program are qualified and authorized to perform lockout/tagout operations. Lockout/tagout operations are to be performed:

- During servicing and/or maintenance of machines and equipment (as specified by out Lockout/Tagout Program).

- During removal or bypassing of a machine guard or other safety device.
- When placing any part of the body into an area where work is actually performed (point of operation) including danger zones with respect to a machine's normal operating cycle.
- When the authorized individual following an assessment of the work to be performed believes that unexpected energization, start up, or release of stored energy could cause injury.

Annually this Lockout/Tagout program shall be reviewed on the basis of assessing its effectiveness for controlling the release of hazardous energy. This includes Lockout/Tagout procedures, employee training and plans implementation.

GENERAL SAFETY GUIDELINES

It is the responsibility of department managers to complete the Survey For Applying Lockout/Tagout Devices for every piece of machinery or equipment requiring Lockout/Tagout procedures under their authority. This information will be placed into the Lockout/Tagout Database, and will be accessible to any authorized employee who will be performing lockout/tagout operations. The following information must be included:

- Name of the Manager/Supervisor submitting the survey.
- Name of the Department the survey was conducted for.
- Name of the machinery or equipment and their identifying numbers.
- Energy sources for each piece of machinery and equipment, and its location.
- The procedure or method required for Lockout/Tagout.
- The date of the survey and the name and initials of the employee acknowledging the accuracy of the information on this form.

All authorized employees shall use the following sequence whenever LOTO (Lockout/Tagout) procedures are required:

Identification

- Obtain the identification number for the piece of machinery or equipment requiring servicing or maintenance. Access the Survey For Applying Lockout/Tagout Devices Database. Match the identification number for the particular machinery or equipment with the identification number in the database. Access to this database is only permitted to authorized lockout/tagout trained employees
- Note the number and location of the energy sources that require locks and/or tags for the piece of equipment or machinery being serviced.
- Note the hazards identified for the piece of equipment or machinery.
- Obtain the Employee LO/TO Time Schedule form and fill in all areas that are applicable (see LO/TO Database).

Evaluation

- Review the surrounding area for other possible sources of energy transmission.
- Inspect the immediate area where locks or tags will be attached.
- Notify all employees in the general vicinity that LO/TO procedures are being implemented.

Electrical Control

- Unplug machine or piece of equipment using an electrical plug lock or a disconnect switch with padlocks, locks and tags.
- Ensure that all power sources are locked and tagged out.
- Bleed any stored electrical energy to a “zero energy state.”
- Use a tester to check that all circuits are dead.

Pneumatic Control

- Release the pressure to reach a “zero energy state.”
- Lockout the energy source using lockout valves.

Hydraulic Control

- Release pressure valve to reach a “zero energy state.”
- Lockout the energy source using lockout valves, chains, padlocks, or locks.

Fluids and Gases

- Evaluate all hoses and valves.
- Insert a blank or blind in the line.
- Use lockout valves, chains, padlocks, or locks at the isolating source.

Mechanical Control

- Release or block all stored mechanical energy. Be cautious of gravity, springs, tension and other sources of energy that are not always obvious.
- Restrain energy using blocks.
- Lockout and tagout energy using padlocks, locks, and tags.
- Recheck all areas for potential energy sources.

Documentation of LO/TO Procedures

- The Employee Lockout/Tagout Servicing and Maintenance Schedule is completed each time the employee must lockout/tagout a piece of machinery or equipment. This database chronicles the lockout/tagout times and a new entry must be completed for each lockout/tagout performed. Each time a lockout/tagout takes place, it is the responsibility of the authorized employee to fill out the following information:
 - Date
 - Equipment Name, Identity Number and Location
 - Lockout/Tagout start time. When this is completed, this form must be presented to his/her Manager/Supervisor for physical inspection of the machine or equipment.
 - Lockout/Tagout ending time.

Control Procedures

- The Manager/Supervisor will evaluate the LO/TO form and verify through the physical inspection of the equipment or machinery that all energy sources have been identified, proper locking or tagging out has occurred.

- The Manager/Supervisor shall in the company of the employee, operate the switch valve or other energy-initiating device(s) confirming its energy isolation. Both individuals shall confirm the operating controls have been returned to neutral or in the off position after the test. Stored energy in springs, elevated machine parts, rotating fly wheels, hydraulic systems, air, gas, steam or water systems must be dissipated or restrained using the methods such as repositioning, blocking, bleeding down, etc.
- The Manager/Supervisor shall observe the placement of the locks or tags with the assigned individual lock(s) and/or tag(s).
- A final inspection of the disconnected energy sources and operating controls shall be conducted to make certain the equipment shall not operate. Ensure the operating controls are returned to the OFF or NEUTRAL positions.
- The equipment is now locked out and tagged out. Employees should be notified in the immediate area of the machinery or equipment's "down" condition.

More Than One Person Lockout/Tagout

- When more than one person will be involved with maintenance or repair of a piece of machinery or equipment requiring isolation of energy source, each shall place their locks and tags on the energy isolating device.
- When the machinery or equipment cannot accept more than one lock or tag, an additional hasp or similar energy-isolating device shall be used, if feasible. Should this technique not be feasible, one lockout device can be used requiring a key, and the key shall be placed in a lockout box or cabinet that accommodates multiple employee locks to secure it. As each employee no longer needs to maintain lockout protection, they shall remove their locks from the box or cabinet.
- Managers/Supervisors shall maintain an awareness of instances where multiple lockout/tagout devices are required.

Restoring Machines and Equipment to Normal Operations

- When maintenance or servicing has been completed and the machinery or equipment is ready to be placed into normal operation, check out the immediate area to confirm that no one is exposed to any danger.
- Remove or check that all tools have been removed from the machinery or equipment.
- Confirm that all guards, pulleys, and safety devices have been reinstalled and are secure.
- Remove all locks and tags only after one final check to ensure all employees are in the clear.
- Operate the energy isolating devices to restore energy to the machine or equipment.