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

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| SECRETARY OF LABOR, | : | |
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| Complainant, | : | |
| | : | |
| v. | : | OSHRC DOCKET NO. 09-0973 |
| | : | |
| CROWN CORK & SEAL USA, INC. | : | |
| | : | |
| Respondent. | : | |

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| APPEARANCES: | Paul Spanos, Esquire.<br>Office of the Solicitor<br>U.S. Department of Labor<br>1240 East Ninth Street<br>Suite 881<br>Cleveland, Ohio 44199<br>For the Complainant | Corey V. Crognale, Esquire<br>Schottenstein, Zox & Dunn<br>250 West Street<br>Columbus, Ohio 43215<br>For the Respondent |
| BEFORE: | G. Marvin Bober,<br>Administrative Law Judge | |

***DECISION AND ORDER***

This proceeding arises under the Occupational Safety and Health Act of 1970, as amended, 29 U.S.C. § 651 *et seq*. ("the Act"). Following an injury at the worksite of Crown Cork & Seal USA, Inc., ("Crown" or "Respondent"), the Occupational Safety and Health Administration ("OSHA") conducted an inspection of respondent's worksite from May 12, 2009 through June 9, 2009. As a result of the inspection, OSHA issued to respondent a Citation and Notification of Proposed Penalty ("Citation") on July 2, 2009. Respondent filed a timely Notice of Contest pursuant to section 10(c) of the Act, bringing this matter before the Occupational Safety and Health Review Commission ("the Commission"). The citation alleges four serious

violations of the Act and proposes a total penalty of $12,000. The Secretary has filed her Complaint in this matter, after which respondent filed its timely Answer. A hearing was held in Columbus, Ohio on April 6, 2010. Both parties have filed post-hearing briefs and this matter is ready for disposition.

## BACKGROUND

Respondent has a facility at Dayton, Ohio where it cuts and forms the tops of beer and soda pop cans. On May 10, 2009, Shift Supervisor Greg Thompson gathered his crew in his office and assigned ***{redacted}*** and Don Mason to clean the Minster Mechanical Power Press. (Tr. 16, 58, 147) The cleaning was being performed because clients were coming over to tour the facility and management wanted the machines to look clean. (Tr. 157) This was only to be a cosmetic cleaning and the cleaning crew was informed that only the visible parts on the front of the machine were to be cleaned. (Tr. 157) They were only instructed to clean the drip pans and wipe the white framing and yellow guarding on the front of the machine. (Tr. 29, 59, 138, 141, 151-152, Exs. R-W-, CC, DD) To maintain production, the machines were kept running during the cleaning. (Tr. 136) Therefore, Thompson cautioned the employees not to let their cleaning towel or fingers slip into a hole in the machine and to keep their hands where they could see them at all times. (Tr. 136-137)

During the cleaning, ***{redacted}*** somehow put her hand behind a pulley that was guarded only on the front. Whether she reached around the pulley or positioned herself at the back of the machine is disputed by the parties. She felt a pull on her hand and then noticed blood. (Tr. 19) She called to her co-worker, Don Mason who came to her aid and helped her to Supervisor Thompson's office. (Tr. 31, 74) Thompson took ***{redacted}*** to the rest room to help her clean up and determine the seriousness of the injury. He told her that everything was alright but, through her glove, felt a severed finger. ***{redacted}*** then fainted and Thompson went down with her to protect her head from hitting the floor. (Tr. 164) Thompson put a pillow under her head and talked to her as she regained consciousness. (Tr. 164) In the meantime, Mason went to open the gate for the ambulance that had been called by another employee and to direct them to the injured employee. (Tr. 74-75, 164) The EMTs then transported ***{redacted}*** to the hospital (Tr. 193)

A formal complaint was filed with OSHA and an inspection was conducted beginning

May 12, 2009 (Tr. 81) As a result of that inspection, respondent was issued a serious citation alleging four violations of the Act.

Item 1 of the citation alleged a failure to comply with 29 CFR §1910.147(c)(4)(i) on the grounds that respondent failed to utilize lockout/tagout procedures when cleaning the Minster Press. A penalty of $4500 was proposed for this alleged violation.

Item 2 of the citation alleged a failure to comply with 29 CFR §1910.219(d)(1) on the grounds that the pulley on the Minster Press was not properly guarded. A penalty of $4500 was proposed for this alleged violation.

Item 3 of the citation alleged a failure to comply with 29 CFR §1910.1030(c)(1)(i) on the grounds that Crown failed to have a written Exposure Control Plan designed to eliminate or minimize employee exposure to blood borne pathogens. A penalty of $1125 was proposed for this alleged violation.

Item 4 of the citation alleged a failure to comply with 29 CFR §1910.1030(g)(2)(ii) on the grounds that Crown failed to have an adequate training program for employees with occupational exposure to blood or other potentially infectious materials. A penalty of $1875 was proposed for this alleged violation.

## The Relevant Testimony

### 1. Secretary's Witnesses

***{redacted}***

Production Operator, ***{redacted}***, has been employed by Crown for approximately 10 years. (Tr. 14-15) On May 19, 2009 she was offered overtime to clean the Minster Power Press by her Shift Supervisor Greg Thompson. (Tr. 16) She and her cleaning partner, Don Mason, were instructed to clean the tracking and framework. (Tr. 16) Specifically, she was to clean the framework and Mason was to clean the tracking. (Tr. 19) Because the machine was to keep running during the cleaning, Thompson instructed the cleaning crew to be careful. (Tr. 16-17) ***{redacted}*** also testified that Supervisor Thompson did not walk around the machine with the crew to evaluate the hazards or inspect the machine while she was cleaning it. Moreover, he did not evaluate any hazards posed by the machine. (Tr. 18)

To perform her task, ***{redacted}*** used a 10 inch by 11 inch cleaning cloth, bottles of cleaning solution, cotton gloves and a pair of rubber gloves to keep the solution from burning her hands. (Tr. 18-19) ***{redacted}*** testified that she sat down to clean the framework and that she had

to get oil out of the legs of the framework. There was some oil on the guard, so she took the cloth and went over it. (Tr. 19, 28) According to ***{redacted}***, at the time of the accident, she was sitting on the floor and the guard was right in front of her. (Tr. 28) Nobody told her not to clean the guard. To the contrary, she testified that she had cleaned it in that manner for nine years and that her co-workers also cleaned it that way. (Tr. 30) While cleaning that area, she felt something pull at her hand and then saw blood. (Tr. 19, 28)

***{redacted}*** believed that she cut her palm and told Mason. Mason escorted her to Thompson's office. She told Thompson that she was getting really sick and that she would pass out. When she woke up, Thompson was standing over her, very upset and concerned. (Tr. 31)

The parties attempted to get ***{redacted}*** to testify as to her exact location at the time of the accident. ***{redacted}*** testified that she was sitting on her posterior and reaching up to clean the framework. (Tr. 38) Exhibit R-S shows Thompson sitting under the frame on the opposite or back side of the machine. She testified that the exhibit properly depicts where she was working at the time of the injury. (Tr. 40) She further testified that she was cleaning under the frame like she always does. (Tr. 44) She remembered cleaning the sides and stooping down, but not getting under the frame. She also remembered that she was cleaning oil from the guard. Although she remembered there being a hole in the guard, she could not spot the hole in any of the photo exhibits. (Tr. 49-52) She admitted that she could not remember with certainty where she was cleaning at the time of the accident. (Tr. 51)

***{redacted}*** testified that annual training provide by Crown covers lockout/tagout (LOTO). (Tr. 34) Moreover, respondent holds a safety talk before the first shift of every week. (Tr. 35) She indicated that Ex. R-L at p. 20 of 46 shows that, at a safety meeting of November 17, 2008, they discussed injuries caused by rotating machinery and explained how a hand or glove can come into contact with it. The training went through steps to take to avoid getting in contact with moving parts. (Tr. 36) Moreover, p. 44 of the exhibit involves the hazard of getting a hand caught or crushed between a pinch point. (Tr. 37)

***{redacted}*** further testified that, every year, the company shows a film on BloodBorne Pathogens ("BBP"). The film covers what to do when an employee comes into contact with another person's blood. They are instructed to stop the bleeding and make sure the blood is contained. (Tr. 32) However, employees are not required to render first aid. (Tr. 34)

*Donald Mason*

Don Mason has been a machine repairman at Crown for 15 years. (Tr. 57) He was assigned to the cleaning crew with ***{redacted}*** by Greg Thompson. (Tr. 58) He was instructed to clean drip pans which catch oil and debris to keep it from falling on the product. (Tr. 58) Mason testified that nothing was said about turning off the machine because they were not cleaning anything that was running or had any moving parts. (Tr. 59) Immediately after being assigned to the cleaning crew, Thompson held a safety meeting where they were told of an incident where an individual put his hands where he couldn't see them and a finger slipped into a hole resulting in an injury. Therefore, they were instructed to make sure that they didn't put their hands where they couldn't see what they were doing. (Tr. 59, 70) Mason interpreted the warning to mean that you want to see what you're cleaning and wiping, and not to reach around where you can't see what you're doing. "It's just a no no." (Tr. 70) Thompson neither walked around the machines to evaluate any safety hazards nor looked at the guards on the machine to assess their safety. (Tr. 59-60) According to Mason, such assessments were not necessary because they were all aware of the hazards. (Tr. 67)

Mason testified that, at the time of the accident, he was located 8-10 feet and on the opposite side of the machine from ***{redacted}*** and was walking away from her. (Tr. 60, 76) Just seconds before the accident, he saw ***{redacted}*** either getting ready to kneel or sit at the back of the machine, as depicted in exhibit R-S. He asserted that he never saw any employee engaging in activities where ***{redacted}*** was located and did not know what she was trying to accomplish. (Tr. 73-74) After the accident, he took ***{redacted}*** to Thompson's office and then went to open the overhead doors so the emergency squad could get in. (Tr. 74-75) The emergency squad was called by electrician Ted Livingstone. (Tr. 75) Mason put towels under her head, then met the EMTs and led them to the restroom where ***{redacted}*** located. (Tr. 64, 75, Ex. S-13) He estimated that approximately 5 minutes elapsed between the time of injury and the arrival of the EMTs. (Tr. 75)

Mason testified that respondent holds annual safety meetings and also holds safety meetings at the beginning of each work week for which they must sign in. (Tr. 69, 71-72, Ex. R-L) These weekly meetings can last anywhere from half an hour to an hour. (Tr. 69) There is a big push on LOTO matters. They discuss nip points and "caught between hands hazards." (Tr. 73, Ex. R-L, p. 44) Also, they show safety articles and always point out where someone had an

accident or made a mistake and instruct them on what went wrong. (Tr. 69-71, Ex. R-L, p. 5)

Mason received company BBP training which consists of videos and classes. (Tr. 64) He couldn't recall how to report a BBP exposure incident, and did not know if Crown has an Exposure Control Plan. (Tr. 62-63) Mason testified that he takes first aid training, but is not a first responder. The company offers first aid classes which are totally voluntary. (Tr. 61) Mason stated that he took first aid training because he has always been interested in the subject. (Tr. 62) Mason acknowledged that he signed a for OSHA stating that "I am a First Aid Responder." (Tr. 65, Ex. S-13, p. 65) However, Mason testified that, while he signed the statement, he didn't write it. (Tr. 66) He further asserted that he was never required to render first aid or medical services. Also, he was never evaluated by his supervisors in the area of first aid or whether his actions were consistent with rendering first aid or medical services. (Tr. 66) In his view, the statement meant only that he was trained in first aid. (Tr. 66)

*James Lopez*

James Lopez is the OSHA Compliance Officer ("CO") that inspected the worksite after the accident. (Tr. 79) When Lopez first got to the plant, he met Mr. Goforth, the Plant Manager and waited for the union representative to appear before beginning the inspection. (Tr. 82) Lopez testified that the injury was not actually caused by the press, but by the conveyor system. (Tr. 84) According to Lopez, when he first saw the guard, he couldn't understand how the accident occurred because the pulley was fully guarded. He was told, however, that the rear guard on the pulley was added later and that, at the time of the accident it was open in the back. (Tr. 85) According to Lopez' investigation, the cleaning crew was instructed to clean the white frames as well as the drip pans, bolts and yellow guards as well as any oily spots around the machine. (Tr. 118) Moreover, he testified that the crew was expected to clean parts that had dirt, oil and grease. That included the face and side of the guard. (Tr. 122) Although the sides of the pulley were guarded, there was no back guard. In the CO's view, this rendered the guarding inadequate. (Tr. 119) It was the CO's understanding that, at the time of the accident, ***{redacted}*** was positioned to the side of the machine depicted in Ex. R-W. She was not directly in front of the yellow pulley guard. (Tr. 123-125)

The CO concluded that the LOTO training received by employees was adequate and adequately enforced. (Tr. 114-116, Ex. R-FF)

The CO also noted that under 29 CFR §1910.1030(c)(1)(i) an employer is required to have a BBP exposure plan if employees are "potentially" exposed to blood borne pathogens and had designated first aid providers. As a result of his investigation, he concluded that Crown both had such potential exposure and had designated first aid providers. (Tr. 90-91) Lopez testified that he asked to see a list of employees who received first aid training and were first aid providers. Respondent provided him with a list entitled "First Aid/CPR & Defib. Trained Personnel." (Tr. 91, Ex. S-5) According to that list, respondent had at least two employees per shift who have, as part of their responsibilities, potential exposure to blood borne pathogens and the provision of treatment for injured employees. (Tr. 91, Ex. S-5) Lopez agreed, however, that the list does not indicate that Ex. S-5 was a list of first aid responders. Indeed, he was given no position descriptions for anybody with the job responsibility of first aid responder. (Tr. 110-111, Ex. R-A, p. 20) Nonetheless, based on his interview of the operations supervisor, he concluded that Mason was trained in first aid and was expected to provide first aid to an injured employee. (Tr. 112) The CO interviewed Shift Supervisor Ron Richardson. When he was specifically asked if an employee who is a first aid responder is expected to provide first aid, he answered in the affirmative. (Tr. 93)

The CO also testified that, in his opinion, Crown was required to have first responders at the site. He pointed out that, under 29 CFR § 1910.151(b) an employer is required to have first aid responders unless a facility is in "near proximity" to the site. He testified that the Secretary has interpreted the term "near proximity" as meaning that the local EMT response time is four to six minutes. (Tr. 94-96, Ex. S-4) Here, the response time from initial injury to arrival of the EMTs was 18 minutes. (Tr. 94) However, the time from dispatch of the EMT unit to arrival at the site was two minutes. (Tr. 109, Ex. R-JJ)

Though Crown had a written BBP plan, the CO testified that the document was deficient because, in its own words, it is only a template and guide that had to be particularized for each Crown facility based on local circumstances. (Tr. 98-99, Ex. S-3, pp. 22-23) The CO pointed out, for example, that the plan did not address exposure determination or the post exposure follow up of incidents. (Tr. 99)

Finally, the CO explained how he arrived at the proposed penalties. He testified that he considered the gravity of the violations (Tr. 102), the seriousness of the violations (Tr. 103), the employer's size (Tr. 103) and respondent's good-faith. (Tr. 105)

**2. Respondent's Witnesses**

*Greg Thompson*

Greg Thompson assigned and supervised the cleaning crew on May 10, 2009. (Tr. 135) Thompson testified that ***{redacted}*** was located behind the machine as depicted in Exhibit R-S. (Tr. 156-158) She was not instructed to be there and had no cleaning responsibilities at that location. Thompson testified that on the side ***{redacted}*** was instructed to clean, there was no possibility of getting a hand caught on the backside of the guard. (Tr. 154, Ex. R-R) Thompson also testified that his conclusion regarding ***{redacted}*** location at the time of the accident was based on information gathered from Mason and ***{redacted}***. (Tr. 170) Although he insisted that ***{redacted}*** did something that was against his instructions, Thompson was unable to explain why his accident summary failed to state that she failed to follow instructions or was cleaning in an improper manner. (Tr. 139, 141-144, Ex. S-10)

Thompson testified that there were no written procedures on how to clean the machine and he did not instruct ***{redacted}*** how to clean it. (Tr. 168-169) He further testified that, had he seen employees cleaning incorrectly, he would have stopped them. Here, he did not stop ***{redacted}*** because he did not see her. (Tr. 169) However, he did not walk to the floor to inspect the machine before cleaning and did not evaluate the pulley guard to see if it was safe before the cleaning started. (Tr. 139) Moreover, he never told the crew not to clean the guard. (Tr. 139) He testified that, earlier in his career, he ran the machine that injured ***{redacted}*** and that, since that time, the machine had not changed in any significant way. (Tr. 147-148) He testified that they were cleaning only to spruce up the area because visitors were coming and that this was not intended to be an in depth cleaning. Rather, he likened it to a dog and pony show. (Tr. 157-158)

He testified that the machine was running while the crew cleaned it. He was aware of that the gears and chains were in motion, but did not order that the machine be locked out. (Tr. 136) He did not know that the back of the pulley was unguarded. (Tr.138) However, he cautioned the employees not to let their cleaning towel or fingers slip into a hole in the machine. He was aware of past injuries caused by moving parts and advised the crew that accidents could result in the loss of a finger. (Tr. 138, 169) However, the injury discussed occurred on a machine no longer at the facility. He testified that he brought it up as an example of how an employee could lose a

finger. (Tr. 148) After he assigned the crew, he went back to his office to check production numbers. (Tr. 138)

Thompson testified that, after Mason brought her into his office, he took ***{redacted}*** to the rest room to help her clean up and to see how bad her injury was. ***{redacted}*** told him that she hoped she hadn't cut off her finger. He was going to take off her glove, but felt the severed finger and stopped right then. ***{redacted}*** then fainted. He grabbed her and they both went down to the floor, with Thompson trying to keep her from hitting her head. In the meantime, Mason went to the gate to let in the ambulance and direct them to ***{redacted}***. When ***{redacted}*** regained consciousness, Mason put a pillow under her head. (Tr. 163-164)

Thompson testified that he holds weekly and monthly safety meetings Also, every Sunday a safety audit is conducted where they go through the entire plant and check the automatic sensors on the machines to ensure that they shut off the machine when a guard is open. (Tr. 148-149) The company also conducts annual LOTO training and has trained employees on the hazards of nip points. (Tr. 149) If he sees an employee failing to follow a safety practice, he stops them and shows them what they did wrong. He will then write up the incident, without naming the employee, and turn that into corporate headquarters. (Tr. 150)

Thompson further testified that he did not take first aid training from respondent, and had not taken any first aid training in years. Moreover, no employee is required to render first aid or medical services. He pointed out that he was not required to render aid to ***{redacted}***, but did so out of instinct. (Tr. 163-164, 171) He did not know if he was doing the right thing, he just wanted to help. (Tr. 171)

*Brian Lamb*

Brian Lamb has been a Plant Superintendent for seven years and has been acting Plant Manager for eight months. In total, he has been with Crown for 25 years. (Tr. 175) When he was a machine repair man, he ran the press on which ***{redacted}*** was injured. Since then, there have been no significant changes to the press. (Tr. 176) Lamb testified that Crown has 95 full time hourly employees and 12 staff members. Shifts are 12 hours long, with two shifts per day. (Tr. 176)

Lamb testified that Thompson's office was approximately 50 feet from the machine on which ***{redacted}*** was injured. (Tr. 201) When the accident occurred, Mason walked ***{redacted}***

to Thompson's office, and then went to the front gate to let in the EMTs. (Tr. 201-202) He estimated that less approximately 12-19 minutes elapsed between the time ***{redacted}*** was brought to Thompson's office until the EMTs were called. (Tr. 202) Lamb was not at the scene of the accident and, by the time he arrived at the scene, ***{redacted}*** had already been transported to the hospital. (Tr. 193) He viewed the area where the accident occurred, but couldn't prove where she was at the time. (Tr. 193) He talked to employees and went to the hospital. (Tr. 193) Afterwards, he conducted an investigation, interviewed employees and reviewed their statements. (Tr. 194)

Per instructions given by Thompson, she was supposed to clean drip pans, bolts, the black plastic and the surface of the front of the yellow pulley guards. When doing that, the employee is not exposed to moving parts because the moving parts were on the other side of the pulley. (Tr. 196) Lamb concluded that ***{redacted}*** went up underneath the conveyor when she was supposed to be wiping only the surface of the guards. Thus, she went into an area she was not asked to clean. (Tr. 195) Lamb noted that the Crown accident report stated that: "***{redacted}*** explained that she was cleaning around the frame work at the end level just like she has many times before." (Tr. 214, Ex. S-14) He did not interpret that as meaning that she was actually cleaning the back side of the guard over the conveyor. (Tr. 214) He also interpreted the statement that she had done this "many times before" to relate only to the fact that she frequently cleaned the machines. (Tr. 217) Lamb also pointed out that it was unlikely that ***{redacted}*** could have cleaned the framework from the back of the machine as depicted in Ex. R-S, because to have reached the area to be cleaned, she would have had to reach across a couple of hoses, a motor, and would have hit her forearm against a conduit that was blocking the way. (Tr. 206-208, Ex. R-S) Based on what was told to him by ***{redacted}*** and Mason, he concluded that she was in back of the machine depicted in Ex. R-S, he could not speculate on what she was doing because, in that area, there was nothing to clean. (Tr. 205-206, 216)

As a result of the investigation, ***{redacted}*** received a verbal warning and was written up for cleaning improperly. (Tr. 184, 194, Ex. R-E) She was disciplined because she was under the conveyor and not cleaning the framework. (Tr. 229) Lamb testified that there were no components that needed to be cleaned from where she was seated. ***{redacted}*** refused to sign the disciplinary notice, but it was signed by a union representative. (Tr. 184) A grievance was subsequently filed by the union. (Tr. 194)

Lamb described a safety incentive program initiated by respondent which has awarded thousands of dollars to employees for safety activities. (Tr. 185-186, Exs. R-F, R-J) He testified that this program has enhanced employee attention to safety. (Tr. 186) Lamb also testified that Crown has a progressive disciplinary policy and issue disciplinary notices whether or not an employee is injured. (Tr. 183, Ex. R-E)

The collective bargaining agreement with the union calls on the union to come into the plant and work with the company to promote safety. Moreover, the agreement sets up a safety committee which has four representatives, one supervisor from each shift along with himself and the plant manager. This committee meets monthly and discusses various issues and concerns. (Tr. 178-179, Ex. R-A) The company also performs complete daily plant audits which are performed by hourly employees on the equipment for which they are responsible. (Tr. 180, Ex. R-B) There are sign off sheets that employees sign stating that the guards are in place and secure for that area. (Tr. 180) Then, every Sunday, they perform a complete plant audit again conducted by the hourly employees . (Tr. 180, Ex. R-B) Respondent conducts one hour annual training programs (Tr. 188, Ex. R-J) There are also 13 "monthly" safety meetings, which means that in one month there are two such meetings. These meetings cover a wide variety of safety topics. (Tr. 190, Ex. R-L) Respondent also has a drug and alcohol program, but does not conduct random tests. However, they do give tests to new hires and anytime there is an accident resulting in injury or damage in excess of $5000. (Tr. 177)

Lamb testified that employees can voluntarily take first aid training, but that it was not part of their job. (Tr. 197) None of the employees' job duties require them to perform first aid or CPR. (Tr. 198) He pointed out that none of the employee job classifications involve first aid or indicate that any employee job responsibilities include the rendering of first aid. (Tr. 199, Ex. R-A) He also testified that employees were trained in BBP. (Tr. 210, 224, Ex. R-K section 9) A safety inspection held on April 5, 2009, demonstrates that respondent checks for the presence of BBP kits, which include goggles, CPR kit, plastic coveralls, and bleach. (Tr. 211, Ex. R-B at p. 9) There is no rule against any employee helping a coworker who needs medical attention or first aid, which is why they offer these programs and trainings. However, no employee would be penalized if they elected not to help an injured employee. (Tr. 200)

He pointed out that, according to his investigation, there was no blood on the floor from ***{redacted}***'s accident. If there had, it would have been cleaned by either the EMTs or the

janitorial staff. (Tr. 223) Ultimately, it is the shift supervisor's responsibility to have hazardous waste cleaned up. (Tr. 225) Lamb testified that the Moraine Fire Department is approximately 1.5 miles from the facility and that Crown has identified the fire department as the emergency medical response unit within proximity of the facility. (Tr. 200)

## Discussion

### 1. Secretary's Burden of Proof

To establish a violation of an OSHA standard, the Secretary must establish that: (1) the standard applies to the facts; (2) the employer failed to comply with the terms of that standard; (3) employees had access to the hazard covered by the standard, and (4) the employer could have known of the existence of the hazard with the exercise of reasonable diligence. *Atlantic Battery Co.,* 16 BNA OSHC 2131, 2138 (No. 90-1747, 1994).

### 2. Machine Guarding/Lockout-Tagout Items

Item 1 of the citation alleges that respondent violated 29 CFR §1910.147(c)(4)(i)[1] on the grounds that:

> Procedures were not developed, documented and utilized for the control of potentially hazardous energy when employees were engaged in activities covered by this section:
>
> In the Production area on the end level conveyor to Press #1, Minster DAS-H-200-101, the company had developed a written energy control procedure to lockout the conveyor, however, employees on the cleaning crew always cleaned the frame and guards on the conveyor while the press was in operation and exposed themselves to the in-running nip point hazards created by the inadequate

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[1] The standard provides:

29 CFR §1910.147 **The control of hazardous energy (lockout/tagout)**

* * *

(c) *General*

* * *

(4) *Energy control procedure.*

(i) Procedures shall be developed, documented and utilized for the control of potentially hazardous energy when employees are engaged in the activities covered by this section.

Note: *Exception:* The employer need not document the required procedure for a particular machine or equipment, when all of the following elements exist: (1) The machine or equipment has no potential for stored or residual energy or reaccumulation of stored energy after shut down which could endanger employees: (2) the machine or equipment has a single energy source which can be readily identified and isolated; (3) the isolation and locking out of that energy source will completely deenergize and deactivate the machine or equipment; (4) the machine or equipment is isolated from that energy source and locked out during servicing or maintenance; (5) a single lockout device will achieve a locked-out condition; (6) the lockout device is under the exclusive control of the authorized employee performing the servicing or maintenance; (7) the servicing or maintenance does not create hazards for other employees; and (8) the employer, in utilizing the exception, has had no accidents involving the unexpected activation or reenergization of the machine or equipment during servicing or maintenance.

guard on the power transmission 1” pulley belt.

It is not disputed that respondent had appropriate lockout/tagout procedures for use in shutting down the Minster Press, but that those procedures were not used because respondent chose to keep the machine running during the cleaning operation. The Secretary argues that respondent’s failure to shut down the machine, utilizing its lockout/tagout procedures, constituted a violation of the standard. Respondent, on the other hand, defends on two bases: (1) it was unnecessary to lockout the machine because had its cleaning instructions been followed, no employee would have been exposed to the unguarded rear of the pulley; and (2)the standard was not applicable because the lockout/tagout standards did not apply.

Item 2 of the citation alleged a failure to comply with 29 CFR §1910.219(d)(1)[2] on the grounds that:

> Pulley(s) with part(s) seven feet or less from the floor or work platform were not guarded in accordance with the requirements specified at 29 CFR 1910.219(m) & (o):
>
> In the Production Area on the end level conveyor to Press #1, Minster DAS-H-200-101 the guard for the power transmission 1” pulley belt approximately 18” off the ground was exposed in that it was not fully enclosed.

As with item 1, respondent asserts that this item must be vacated because, had ***{redacted}*** cleaned the machine as instructed, she would not have been exposed to the unguarded rear of the pulley. It is respondent’s position that, by cleaning in the unassigned area, ***{redacted}*** committed an act of “unpreventable employee misconduct.”

A. *Exposure*

The evidence establishes that the front of the pulley on the Minster Press was guarded and that the back of the pulley was unguarded. (Tr. 23, 125, 138, Ex. R-W) The evidence also establishes that the cleaning crew was instructed to clean oil, dirt and grease from the framework, drip pans and tracking on the front and sides of the machine. They were not instructed to clean the rear of the machine which would not be visible to

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[2] 29 CFR §1910.219 **Mechanical power-transmission apparatus.**

*  *  *

(d) *Pulleys*  *  *  *

(1) *Guarding.* Pulleys, any parts of which are seven (7) feet or less from the floor or working platform, shall be guarded in accordance with the standards specified in paragraphs (m) and (o) of this section. Pulleys servicing as balance wheels (e.g. punch presses) on which the point of contact between belt and pulley is more than six feet six inches (6 ft. 6 in.) from the floor or platform may be guarded with a disk covering the spokes.

the visitors to the plant. (Tr. 19, 29, 141, 151, 157, 162, Ex. R-W). The preponderance of the evidence also demonstrates that, as argued by respondent, ***{redacted}*** was sitting at the rear of the machine at the time of the accident. Understandably, ***{redacted}*** recollection was hazy regarding her location at the time of the accident. (Tr. 51) Nonetheless, she suggested that she might have moved to the rear of the machine. (Tr. 43) Mason also testified that ***{redacted}*** was at the rear of the machine. (Tr. 61, 73-74) Indeed, respondent introduced evidence that, had she remained on the side of the machine she was instructed to clean, a conduit near the guard of the machine made it unlikely that ***{redacted}*** could have put her arm into a position where she would have been exposed to the unguarded rear of the pulley. (Tr. 154, 208 Exs. R-DD, R-S) On the other hand, there is no significant evidence that would place ***{redacted}*** at the front of the machine.

To establish that an employee is exposed to a hazard, the Secretary must demonstrate that "employees had access to the cited hazard. She may prove access by demonstrating that, either while in the course of their assigned duties, their personal comfort activities while on the job, or their normal means of ingress-egress to their assigned workplaces, employees will be, are, or have been in the zone of danger." *Gilles & Cotting, Inc.,* 3 BNA OSHC 2002, 2003 (No. 504, 1976), quoted in *Capform Inc.*, 16 BNA OSHC 2040, 2041 (No. 91-1613, 1994). The "danger zone" is determined by the hazard presented by the violative condition. Normally, it is that area surrounding the violative condition that presents the danger to employees to whom the standard is addressed. *Seyforth Roofing Co.*, 16 BNA OSHC 2031, 2033, n.4 (No. 90-0086, 1994) *Gilles & Cotting, Inc.*, 3 BNA OSHC at 2003.

To accept respondent's assertion that, had ***{redacted}*** followed orders (i.e. had she kept to her "assigned" work duties), she would not have been exposed to the hazard, would require a conclusion that the "zone of danger" was limited to the front, and perhaps the sides, of the pulley and, therefore, that the unguarded rear of the pulley was outside of the "zone of danger." Central to its argument, is that ***{redacted}*** violated her instructions instructions by moving to the rear of the machine and cleaning in an unassigned area. The flaw in respondent's argument is that standards are intended to protect against injury resulting from an instance of inattention or bad judgment as well as from risks arising from the operation of a machine. *Trinity Industries, Inc.*, 15 BNA

OSHC 1579, at 1593-1594 (No. 88-1545 & 88-1547, 1992); *Pass & Seymour, Inc.*, 7 BNA OSHC 1961, 1963 (No. 76-4520, 1979). While the evidence establishes that Thompson instructed the cleaning crew to clean the front of the machine that would be visible to the plant's visitors, there is absolutely nothing in the record to demonstrate that Thompson ever instructed the crew not to clean the rear. While this particular cleaning was intended to be a "dog and pony show" designed to impress the visitors (Tr. 157), the evidence demonstrates that the machines were cleaned on a regular basis. (Tr. 29, 73, 217) Indeed, ***{redacted}*** testified that on the day of the accident, she cleaned the machine the way "I've always cleaned it. I've always done it that way. Everybody else that cleans it that way. I've been with them. We clean everything like that." (Tr. 29, *see also* Tr. 44).

Plant Manager Lamb testified that, although ***{redacted}*** usually cleaned in the same manner as in the day of the accident, she was never written up or otherwise disciplined for violating respondent's work rules. (Tr. 216-218) Given the usual cleaning methods used by employees, together with the lack of any specific prohibition to the crew not to clean areas other than those that would be visible to the plant's guests, it was reasonably predictable that a member of the crew would engage in her usual practice and clean beyond the limited area she was instructed to clean. If anything, the record demonstrates, not that ***{redacted}*** violated any safety rule, but that she was guilty of being an over-conscientious employee. So viewed, ***{redacted}*** was engaged in her assigned work duties when injured. Accordingly, I find that the preponderance of the evidence establishes that during the cleaning operations, it was reasonably predictable that ***{redacted}*** would clean the rear of the machine and, therefore, enter the zone of danger presented by the unguarded portion of the pulley.

B. *Knowledge/Unpreventable Employee Misconduct*

Under well-established Commission precedent, the Secretary bears the burden of proof of each element of a violation, including a showing that the employer had actual or constructive knowledge of the cited conditions. *E.g.*, *Access Equip. Sys., Inc.*, 18 BNA OSHC 1718, 1720, (No. 95-1449, 1999). The Secretary satisfies her burden of showing knowledge by establishing that the cited employer knew, or with the exercise of reasonable diligence could have known, of the violative condition. United States Steel Corp. 12 BNA OSHC 1692, 1699 (No. 79-1998,

The Commission has held that “An inquiry into whether an employer was reasonably diligent involves several factors, including the employer’s obligation to have adequate work rules and training programs, to adequately supervise employees, to anticipate hazards to which employees may be exposed, and to take measures to prevent the occurrence of violations. *Stahl Roofing Inc.,* 19 BNA OSHC 2179, 2181 (No. 00-1268, 2003)

I find that respondent either knew or, with the exercise of reasonable diligence should have known, that the rear portion of the pulley was unguarded and that employees were exposed to the hazard posed by the unguarded portion of the pulley.

First, the evidence demonstrates that respondent failed to communicate workrules adequate to warn employees of the hazard of cleaning the machine from the rear while it was in an operational mode. Indeed, it appears that the only safety instructions given by Thompson before the crew began cleaning was to warn them to be careful and to not put their hands where they couldn’t see them. (Tr. 16, 59, 70, 138)

Second, the evidence establishes that Supervisor Thompson failed to anticipate the hazards to which his employees were exposed. Thompson assigned the cleaning crew and instructed them to clean the front of the machine. Thompson knew that the machine was running and made the decision not to turn it off. (Tr. 136) Yet, Thompson testified that he did not know that the rear of the pulley was unguarded. (Tr. 138) Moreover, the evidence also establishes that Thompson did not walk around the machines to evaluate any hazards either before or during the cleaning activities. (Tr. 18, 59-60, 147) Thompson testified that had he seen ***{redacted}*** cleaning the machine from the rear, he would have stopped her. (Tr. 169) However, he was not on the floor supervising the work. Rather, he was in his office which was above the machines and had a glass window from which he could have observed the employees. (Tr. 68, 138-139, 169-170 ) Accordingly, I find that Thompson was not reasonably diligent. He neither provided adequate workrules relevant to the hazards to which employees were exposed; reviewed the worksite to anticipate the hazards to which employees were exposed; nor supervised them to ensure that they worked in a safe manner. Had Thompson exercised such reasonable diligence, he would have known of the hazard to which his employees were exposed.

There is no dispute that Thompson was the supervisor of the cleaning crew. As

such, his knowledge is imputed to respondent. *Jersey Steel Erectors*, 16 BNA OSHC 1162, 1164 (No. 90-1307, 1993), *aff'd without published opinion*, 19 F.3d 643 (3d Cir. 1994); *Tampa Shipyards, Inc.*, 15 BNA OSHC 1533, 1538, (No. 86-360, 1992). Accordingly, the Secretary has established that respondent knew, or with the exercise of reasonable diligence should have known of the violative conditions.

I find no support in the record for respondent's assertion that by cleaning the rear of the machine, ***{redacted}*** violated instruction in an act of unpreventable employee misconduct. To establish the affirmative defense of "unpreventable employee misconduct" the employer has the burden of proving: (1) that it has established work rules designed to prevent the violation, (2) that it has adequately communicated these rules to its employees, (3) that it has taken steps to discover violations, and (4) that it has effectively enforced the rules when violations are discovered. *E.g., Precast Services, Inc.*, 17 BNA OSHC 1454, 1455, (No. 93-2971, 1995), *aff'd without published opinion*, 106 F.3d 401 (6th Cir. 1997).

As noted, *supra*, although the evidence demonstrates that the cleaning crew was instructed to clean the front of the machine, there was no evidence to suggest that they were explicitly prohibited from cleaning oil and grease from the rear of the machine. Indeed, Thompson testified that he never told the crew not to clean the guard. (Tr. 1390 Moreover, the record demonstrates that, on other occasions, the crew would clean the rear of the machine. Accordingly, there is no basis for concluding that ***{redacted}*** actions were the result of "unpreventable employee misconduct."

*B. Applicability of the Lockout/Tagout Standards*

Respondent next argues that item 1 should be vacated because the lockout/tagout standards are not applicable. First, Crown argues that the lockout/tagout standards are applicable only where there is a danger of unexpected energization. Here, the machine remained in operation and, therefore, there was no possibility of accidental energization.

The purpose of the lockout/tagout standard is set out at 29 C.F.R. §1910.147(a)(3), which states:

> (3) *Purpose.* (i) This section requires employers to establish a program and utilize procedures for affixing appropriate lockout devices or tagout devices to energy isolating devices, and to otherwise disable machines or equipment *to prevent unexpected energization, start-up or release of stored energy* in order to prevent injury to employees. (emphasis added)

Moreover, the scope of the lockout/tagout standard is set forth at 29 C.F.R. §1910.147(a)(1)(i):

> *(a) Scope, application, and purpose-(1) Scope. (*i) This standard covers the servicing and maintenance of machines and equipment in which the *unexpected* energization or start up of the machines or equipment, or release of stored energy could cause injury to employees. This standard establishes minimum performance requirements for the control of such hazardous energy. (emphasis in original)

These sections would seem to imply that the lockout/tagout standards apply only when there is a hazard of unexpected energization. The matter, however, is not so simple. Although the standard sets forth appropriate procedures to protect employees from the unexpected energization of machines, it also presupposes that the power to machines will either be turned off or appropriately guarded when necessary to protect employees from operating machinery. Thus, according to 29 C.F.R. §1910.147(a)(2)(ii):

> (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 devices; 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.

Accordingly, where an employee must perform servicing or maintenance on an operating machine and that employee may, for example, have to put a part of his or her body in the danger zone of the machine, appropriate lockout/tagout procedures must be followed. This comports with statements made by the Secretary in the Preamble to the Federal Register publications adopting the lockout/tagout standards.

In the original Preamble[3] OSHA set forth the reasons for the lockout/tagout standard:

> OSHA believes that failure to control energy adequately accounts for nearly 10 percent of the serious accidents in many industries. The following accidents, taken from the NIOSH report entitled "Guidelines for Controlling Hazardous Energy

[3] The standard was adopted in 1989 and the Preamble was published at 54 Fed. Reg. 36687 (Sept. 1, 1989). Following a court challenge to the standard, the standard was remanded to the Secretary for reconsideration of certain matters not relevant here. *UAW v. OSHA*, 938 F.2d 1310 (D.C. Cir. 1991) Following that remand, the Secretary issued an addition to the original Preamble, considering the matters mandated by the court. That Preamble was published at 58 Fed. Reg. 16612 (March 30, 1993)

> During Maintenance and Servicing"…, are typical of these hazards and demonstrate the applicability of the pertinent provisions of the final standard.
>
> 1. An employee was cleaning the unguarded side of an operating granite saw. The employee was caught in the moving parts of the saw and pulled into a nip point between the saw blade and the idler wheel, resulting in fatal injuries. (Failure to shutdown or turn off the equipment to perform maintenance-1910.147(d)(2)).

54 Fed. Reg. 36646 (Sept. 1, 1989)

Further, the Preamble states:

> If the servicing is performed in a way which prevents such exposure, such as by the use of special tools and/or alternative procedures which keep the employee's body out of the area of potential contact with machine components or which otherwise maintain effective guarding, this standard will not apply. Thus, lockout or tagout is not required by this standard if the employer can demonstrate that the alternative means enables the servicing employee to clean or unjam or otherwise service the machine without being exposed to unexpected energization or activation of the equipment or release of stored energy.

54 Fed. Reg. at 36670

On remand from the DC Circuit, the Secretary reiterated her concerns:

> Accident data and other evidence showed that employees are injured or killed by uncontrolled energy during servicing/maintenance of industrial equipment…due to five factors: *Failure to stop the machine or equipment, failure to disconnect the machine or equipment from the power source before performing service or maintenance,* failure to dissipate residual energy, inadvertent reactivation of equipment, or failure to clear all necessary areas before reactivation.

58 Fed. Reg. 16616 (March 30, 1993)(emphasis added)

On this basis, it is reasonable to conclude that the purpose of the lockout/tagout standards are not merely to set forth the requirements and applicable procedures when an employee is exposed to the danger of unexpected energization, but also to require that the lockout/tagout procedures are used to shut down machinery whenever employees performing servicing or maintenance on the machine would otherwise be exposed to the danger zone of the machine. The Commission must defer to the Secretary's reasonable interpretation of standards. *Martin v. OSHRC (CF&I)*, 499 U.S. 144, 150 (1991). Accordingly, I hold that the lockout/tagout standards were properly cited in this matter.

Respondent next argues that the lockout/tagout requirements did not apply to the cleaning operation because it fell under the exemption to 29 CFR §1910.147(a)(2)(ii), which makes the

lockout/tagout standards applicable to servicing and maintenance:

> Note: *Exception to paragraph (a)(2)(ii):* Minor tool changes and adjustments, and other minor servicing activities, which take place during normal production operations, are not covered by this standard if they are routine, repetitive, and integral to the use of the equipment for production, provided that the work is performed using alternative measures which provide effective protection (see subpart O of this part.)

Crown argues that to determine whether it falls within the exception, it must prove that the work (1) is minor; (2) takes place during normal production operations; and (3) that effective alternative protection is provided. *See, Westvaco Corp.*, 16 BNA OSHC 1374, 1377 (No. 90-1341, 1993) Respondent contends that the cleaning operation was minor, that it took place during normal production operations, and that its instructions to clean the front of the machine kept employees from being exposed to the unguarded rear of the machine and, therefore, provided effective alternative protection.

Respondent reads the exception too narrowly. The unambiguous wording of the exception requires that the work must be "integral to the use of the equipment for production." Here, however, the evidence establishes that the cleaning was a "dog and pony show" and, rather than being an in-depth cleaning necessary to the use of the equipment during production was merely "spit and polish" designed only to impress visitors to the plant (Tr. 17, 157)

Further, as discussed *supra*, I find that the instructions given to the cleaning crew was wholly inadequate to provide the required "effective" alternative protection to utilizing the lockout/tagout procedures. As noted, while employees were instructed to clean the front of the machine, there is nothing in the record to demonstrate that employees were ever explicitly prohibited from cleaning the rear of the machine. Indeed, the record demonstrates that it was a common practice for employees assigned to clean the machines to engage in a more thorough cleaning including the rear of the machine where they would be exposed to the unguarded pulley. Under these circumstances, it was reasonably predictable that a conscientious employee would wipe dirt and grease from the rear of the machine. Therefore, the exception does not apply and the cleaning operation on the day of the accident fell within the purview of the lockout/tagout standards.

C. *Conclusion*

The record establishes that (1) the standards cited in both items 1 and 2 of the citation apply to the facts of this case; (2) that Crown failed to comply with both standards; (3) employees were exposed to the hazard of the unguarded portion of the pulley and (4) that the employer knew, or with the exercise of reasonable diligence could have known of the violative condition. Accordingly, I find that the Secretary established that respondent failed to comply with both 29 CFR §1910.147(c)(4)(i) and 29 CFR §1910.219(d)(1). However, while respondent violated both standards, this case presents the unusual situation where compliance with either standard would have rendered compliance with the other standard unnecessary. For example, had respondent adequately guarded the rear of the pulley, as required by 29 CFR §1910.219(d)(1), the machine would not have presented a hazard to employees, even when running during the cleaning operation. Therefore, as item 1 was drafted by the Secretary[4], it would have been unnecessary for it to engage in lockout/tagout. Conversely, had respondent utilized its lockout/tagout procedures as required by 29 CFR §1910.147(c)(4)(i), it would not have been necessary for it to guard the rear part of the pulley. Where two citation items involve substantially the same violative conduct, the Commission has the discretion to find only a single violation and assess a single penalty. *See, Cleveland Consolidated, Inc.,* 13 BNA OSHC 1114, 1118 (No. 84-0696, 1987); *Alpha Poster Service, Inc.*, 4 BNA OSHC 1883, 1884 (No.7869, 1976) Although respondent technically violated both standards, they both involve exposure to the same hazard which could have been abated by compliance with either standard. Therefore, I find it appropriate to combine the violations into one item.

Section 17(j) of the Act, 29 U.S.C. § 666(j), requires that in assessing penalties, the Commission must 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 South*, *Inc.*, 14 BNA OSHC 1910 (No. 89-2241, 1990). The Secretary proposed a penalty of $4500 for each of the two items. In arriving at the proposed penalty, the CO testified that he considered both violations to be of high gravity because of the seriousness of the violations. (Tr. 102-104). He also testified that, with 1200 employees, respondent was not entitled for any reduction for size. (Tr. 103) However, because of its good inspection history, the

[4] The item required lockout/tagout because employees were exposed to a nip point hazard that would have been abated by the use of a rear guard on the pulley.

CO allowed a 10% reduction for history. (Tr. 104) No credits were given for good faith on either items 1 or 2 because Crown made no attempt to comply with the standards. (Tr. 106)

Given these factors, I find it that a combined penalty of $7500 is appropriate. I find that this penalty adequately reflects that the violations were serious, and exposed employees to the loss of a digits if not the entire hand, and takes into consideration respondent's failure to take either of the available measures to protect its employees.

**3. Blood Borne Pathogen Violations**

Item 3 alleges that respondent violated the requirements of 29 CFR §1910.1030(c)(1)(i)[5] on the grounds that:

> The employer having employee(s) occupational exposure did not establish a written Exposure Control Plan designed to eliminate or minimize employee exposure:
> A specific exposure plan for the facility had not been developed.
>
> A penalty of $1125 was proposed for this alleged violation.

Item 4 alleges that respondent violated the requirements of 29 CFR §1910.1030(g)(2)(ii)[6] on the grounds that:

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[5] Sec. 1910.1030 **Bloodborne pathogens**.

• * * *

(c) Exposure control--(1) Exposure Control Plan. (i) Each employer having an employee(s) with occupational exposure as defined by paragraph (b) of this section shall establish a written Exposure Control Plan designed to eliminate or minimize employee exposure.

[6] Sec. 1910.1030 **Bloodborne pathogens**.

* * *

(g) *Communication of hazards to employees—*

* * *

(2) *Information and Training.*

* * *

(ii) Training shall be provided as follows:
(A) At the time of initial assignment to tasks where occupational exposure may take place;
(B) At least annually thereafter.

The minimum training requirements are set forth at 1910.1030(g)(2)(vii):

vii) The training program shall contain at a minimum the following elements:
(A) An accessible copy of the regulatory text of this standard and an explanation of its contents;
(B) A general explanation of the epidemiology and symptoms of bloodborne diseases;
(C) An explanation of the modes of transmission of bloodborne pathogens;
(D) An explanation of the employer's exposure control plan and the means by which the employee can obtain a copy of the written plan;

The training program for employees with occupational exposure to blood or other potentially infectious materials did not contain at a minimum the elements outlined in paragraphs 1910.1030(g)(2)(ii)(A) through (N):
The training program for employees with occupational exposure to blood borne or other potentially infectious materials was inadequate in that he following minimum items were not addressed:
a) an explanation of the employer's exposure plan
b) exposure incident reporting and medical follow up procedures
c) providing an opportunity for employees to ask questions and get answers.

A penalty of $1875 was proposed for this alleged violation.

Respondent does not dispute that it did not comply with items 3 and 4 as alleged. However, for both items, respondent's defense is that the blood borne pathogens did not apply to its worksite and, therefore, it was not obligated to have a written exposure plan as alleged in item 3 or provide the bloodborne pathogen training set forth in item 4. Respondent contends that any employee exposure to bloodborne pathogens did not result from the performance of their job responsibilities and, therefore, were not covered by the cited standards.

By their own terms, both standards are applicable to employees with occupational exposure to blood. Furthermore, 29 CFR §1910.1030(c)(1)(i) specifically applies to employees "with occupational exposure as defined by paragraph (b) of this section." That paragraph, 29 CFR §1910.1030(b), which sets forth the definitions applicable to the bloodborne pathogen standards states that:

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(E) An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials;
(F) An explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, work practices, and personal protective equipment;
(G) Information on the types, proper use, location, removal, handling, decontamination and disposal of personal protective equipment;
(H) An explanation of the basis for selection of personal protective equipment;
(I) Information on the hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge;
(J) Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials;
(K) An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available;
(L) Information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident;
(M) An explanation of the signs and labels and/or color coding required by paragraph (g)(1); and
(N) An opportunity for interactive questions and answers with the person conducting the training session.

Occupational Exposure means reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.

It is respondent's assertion that none of its employees had any duties from which it could be reasonably anticipated that they would have any contact with blood or other potentially infectious material. Therefore, the cited standards were not applicable. Moreover, respondent argues that, even though its employees were exposed to blood when they came to ***{redacted}*** aide, their actions fell under the "Good Samaritan" exception to the bloodborne pathogen standard.

The Secretary first contends that respondent's employees were trained as responders in the event of an accident in the facility and, therefore, could reasonably expect to come into contact with blood or other potentially infectious body fluids in the performance of their duties. The Secretary further argues, that if employees were not formally designated as responders, they were required to do so under 29 CFR §1910.151(b) which states:

**Medical services and first aid.**

*          *          *

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

The Secretary argues that she interprets the term "near proximity" in §1910.151(b) as requiring that the responding facility be able to arrive at the worksite within 3-4 minutes. (Ex. C-4)[7] According to the Secretary, it took nearly 20 minutes for the EMTs to arrive at the site. On that basis, she concludes that emergency services were not available within the requisite 3-4 minutes. Therefore, respondent was required to have designated responders on the site and was required to comply with the cited standards.

To determine whether the bloodborne pathogen standards were applicable to respondent requires the resolution of two issues: (1) could it be reasonably anticipated that employees could come into contact with infectious bodily fluids during the performance of their

[7] The document cited by the Secretary is an Interpretive letter dated May 23, 2007. In that letter, the Secretary states that the term "near proximity" in §1910.151(b): "in workplaces where serious accidents such as those involving falls, suffocation, electrocution, or amputation are possible, emergency medical services must be available within 3-4 minutes, if there is no employee on the site who is trained to render first aid."

duties or did respondent designate any employee(s) as first aid responders and, if not (2) were EMTs or other emergency medical services available within 3-4 minutes.

A. *Employee Work Duties*

According to 29 CFR §1910.1030(b), "occupational exposure" means reasonably anticipated contact with potentiallyinfectious material that "may result from the performance of an employee's duties." The issue to be resolved is what constitutes "the performance of an employee's duties?" The phrase could be interpreted to relate only to an employee's regular "assigned duties, such operating a machine. So viewed, the standards would apply if it could be reasonably anticipated that while operating that machine another employee could incur an injury that would expose him to bloodborne pathogens. Certainly, it could be reasonably anticipated that an employee, seeing a co-worker injured will come to his or her aid. However, in the Preamble to the Bloodborne Pathogen standards, the Secretary made it clear that the standards were not intended to apply to such situations. Rather, the Secretary made it clear that "the term 'employee's duties' implies the performance of duties that are part of the employee's job description. " 56 Fed. Reg. 64102 (Dec. 6, 1991)

The Secretary explained that:

> In addition to being reasonably anticipated, the contact must result from the performance of an employee's duties. An example of a contact with blood and other potentially infectious materials that would not be considered to be an "occupational exposure" would be a "Good Samaritan" act. For example, one employee may assist another employee who has a nosebleed or who is bleeding as the result of a fall. This would not be considered an occupational exposure unless the employee who provides assistance is a member of a first aid team or is otherwise expected to render medical assistance as one of his or her duties.

56 Fed. Reg. 64,101-02

Additionally, the Secretary stated at p. 64,102 that:

> Since accidents and unexpected illness can occur in any workplace, exposure to blood is a theoretical possibility in all working environments. Many worksites have employees whose duty is to provide first aid or medical assistance, and employers must provide them with the protection of the standard. However, OSHA has concluded that it would be needlessly burdensome to require that all employers, including those where none of the employees has duties that can reasonably be expected to result in contact with blood and other potentially infectious materials, implement the provisions of the standard based on the chance that an employee will have contact with blood and other potentially infectious materials while performing a task that he or she is not required to do.

Although neither the Commission nor the Federal Courts have addressed this issue, two instructive cases support the proposition that "employee work duties" do not encompass incidental contact with bloodborne pathogens in the performance of an employee's routine job functions, but rather require that the "work duties" are of the type that can "reasonably be expected" to lead to contact with potentially infectious bodily fluids.

In *Patterson Drilling Co.*, 16 BNA OSHC 1989, (No. 93-1371, 1994), an accident occurred on a worksite of an oil drilling contractor. The employee performing drilling duties had first aid training. However, this employee did not come to the assistance of the injured worker. Rather assistance was rendered by another employee who had not received first aid training.
On whether the employer was required to comply with the bloodborne pathogen standards, Judge Schwartz held:

> [T]he act of responding to an emergency, under the facts of this case, is a "Good Samaritan" act, and the fact that the individual has had first aid training does not require compliance with 1910.1030; in this regard, I note the workers who responded to the accident had not had first aid training, and that the CO himself acknowledged that such individuals are not required to comply with the standard. I also note that while employee and equipment falls are among the types of accidents which can occur on drilling sites, the Secretary's interpretation of the standard, without proper notice specifically including situations similar to the one in this case, does not require deference.

Similarly, in *Secretary of Labor, Commonwealth of Kentucky v. Irvin H. Whitehouse & Sons,* 977 S.W. 2d 250 (Kentucky CA, 1998) the Court of Appeals of Kentucky found that the bloodborne pathogens standard[8] applied to an employer who specifically designated an employee as a first aid responder. The Secretary of Labor of Kentucky argued that, even though not all of its employees had occupational exposure to bloodborne pathogens, the employer was required to comply with the standards on the basis of the single employee who was a designated first aid responder. The court agreed stating:

> The definition of occupational exposure clearly excludes incidental contact. The exposure must be reasonably anticipated as a result of the employee's duties. While the general duties of painters would not normally involve occupational exposure, Whitehouse had designated an employee to render first aid as part of his *job duties.* An employee whose duties include firstaid [sic] responsibilities automatically has occupational exposure. It can be reasonably anticipated that this individual might come into contact with blood and other

[8] Kentucky has a State Plan and has adopted Federal BBP OSHA standards as its own.

> infectious materials while performing his or her duty-the rendering of medical assistance to injured co-workers. It is irrelevant that only one employee may have such a duty; the employer is absolutely required to protect that particular employee from exposure to bloodborne pathogens. (footnote omitted)(emphasis in original)

Thus, where employees are designated first aid responders the bloodborne pathogen standards would apply. Moreover, as apparent from the Preamble, even if not explicitly designated first aid providers, the standards would still be applicable where employees could reasonably expect to be exposed to bodily fluids that might contain bloodborne pathogens (e.g. nurses, dental hygienists, etc.) *See e.g.* 56 Fed. Reg. at 64111. However, where the only employee exposure would come as a result of a "Good Samaritan" act, the standards do not apply.

The evidence demonstrates that respondent makes training in first aid and CPR available for its employees. However, in all instances the training is not required by respondent, but is completely voluntary. (Tr. 61, 197) Indeed, Mason testified that he took first aid classes because he always had an interest in the subject and wanted to be able to assist a fellow employee if he or she were injured. (Tr. 61-62) Mason further testified that, despite his first aid training, he is not a first responder. (Tr. 61) Moreover, he has never been required to render first aid or other medical services and was never evaluated by his supervisors in the area of first aid. (Tr. 66) Supervisor Thompson testified that he never received first aid training from respondent and that no employee is required, as part of their job, to render first aid or other medical services. (Tr. 163, 171) Acting Plant Manager Lamb testified that employee job duties do not require taking of either first aid training or CPR, and that nobody under his supervision is required to render either first aid or CPR. (Tr. 198) Respondent pointed out that nothing in its union contract[9] either lists first responders as a job classification or requires that first responders be appointed. (Tr. 199, Ex. R-A, see pp. 14, 20)

The CO testified that, during his inspection, he asked if Crown had designated first aid responders and requested to see a list of whom they were and when they received training. (Tr. 91) He was provided with a list of employees with first aid/CPR training and the shifts they work. (Tr. 91, Ex. S-5) The CO also testified that during his interview with Operations

[9] Respondent's employees are represented by IUE, the Industrial Division of the Communications Workers of America, AFL-CIO-CLC, Local 84-775.

Supervisor Ron Richardson, he asked him if a first aid responder is expected to provide first aid and that he answered in the affirmative. (Tr. 92-93) The Secretary also produced the statement of Don Mason which states that he was a first responder. (Tr. 64-65, Ex. S-13). However, Mason denied the truth of the statement, pointing out that, although he signed it, it was not written in his hand. (Tr. 66) Also, Crown maintains bloodborne pathogen kits, a CPR kit, plastic overalls and bleach (Exs. R-C, pp. 3-11, R-D, pp. 3-11) The Secretary argues that these kits would not be provided if it expected employees to simply withdraw and wait for emergency medical personnel to arrive. Moreover, ***{redacted}*** testified that every year they watch a film that covers what to do when one comes into contact with another's blood. The film instructs them to stop the bleeding and make sure the blood is contained. (Tr. 32) However, she also testified that their job duties do not require them to render first aid. (Tr. 33)

I find that the Secretary failed to prove, by a preponderance of the evidence, that respondent assigned any employee duties that would include the administration of first aid, CPR or any other activity that could reasonably expected to lead to contact with bloodborne pathogens. The testimony of ***{redacted}***, Mason, Thompson and Lamb all agreed that no employee is either assigned as a first aid responder or otherwise expected to render first aid assistance in the event of an incident. Against that testimony, the Secretary would have us credit that of the CO that Supervisor Richardson told him that first aid responders are expected to provide first aid. That testimony is problematic on several bases. First, the CO never testified that Richardson told him that respondent actually had first aid responders, only that first aid responders are expected to provide first aid. If that was the context of the question, Richardson's answer was both understandable and undeniably correct; the very purpose of having a first aid responder is to provide first aid. Second, unlike ***{redacted}***, Mason, Thompson and Lamb, Richardson did not testify and was not available for cross-examination. All we have is the CO's recollection of what Richardson told him. While the CO's testimony was entitled to some weight, it does not outweigh the combined testimony of the other employees who were all credible and in agreement that nobody was actually assigned or expected as part

Moreover, I am not persuaded by Mason's signed statement in which it states that he is a first responder. Mason testified that, although he signed the statement, he did not write it and he strongly denied that he was ever designated as a first responder. In light of

the testimony of the other employees, it is likely that he misunderstood the statement to imply only that he was trained in first aid and, therefore, capable of being a first responder.

Nor am I persuaded by Crown's maintenance of a list of trained first aid personnel, or it's stocking of clothing and other material that would be used in the event of a accident resulting in exposure to bloodborne pathogens. It is only prudent for any employer to maintain a list of employees who, in the event of an emergency, may be able to provide first aid or CPR. This does not necessarily imply that these employees are either required or expected to provide first aid as part of their job responsibilities. Similarly, in any industrial facility where there are operating machines, pulleys, etc, it is prudent to have on hand clothing necessary to protect any employee that may choose to respond to an accident. Even where rescue facilities, such as a local firehouse, are located in close proximity to the worksite, heavy traffic, snow, flood, or the exigencies of other emergencies may prevent them from their normal quick response.

Accordingly, I find that respondent did not designate any of its employees as first responders and that the Secretary has failed to establish that it could be reasonably anticipated that employees could reasonably be expected to have occupational exposure to blood or other potentially infectious bodily fluids.

*B. Proximity of Medical Services*

The Secretary next argues that, even if respondent did not designate any of its employees as first responders, it was required to under 29 CFR §1910.151(b). That standard states that:

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

In her brief, the Secretary argues that it has interpreted the term "near proximity" as requiring that an emergency responder must be able to arrive at the facility within 3-4 minutes. She points out that, here, the emergency responders did not arrive at respondent's facility until approximately 20 minutes after the accident. Therefore, it was required to designate a first aid responder, and by implication, was required to comply with the bloodborne pathogens standards.

Accepting the Secretary's interpretation of her standard at face value, I find that the facts do not establish that Crown was required to designate a first aid responder. Although testimony establishes that approximately 12-20 minutes elapsed between the accident and the arrival of emergency medical services (Tr. 94, 202), it also demonstrates that only 2 minutes elapsed between the time the emergency services were *called* and their arrival on the site. A statement signed by the CO indicates that he talked to the Chief Trick of the Moraine Fire Department who stated that they received the call from respondent at 8:38 pm and dispatched a unit at 8:38 pm which arrived on site at 8:40 pm. (Ex. R-JJ) This was confirmed by the Moline dispatch report which indicates that the call was received at 20:38:10, a unit dispatched at 20:38:7, and that the unit arrived onscene at 20:40:44, for a total elapsed time between call and arrival of 2 minutes and 34 seconds. (Ex. R-M). This period is consistent with the fact that the fire station is only located approximately 1.5 miles from respondent's facility (Tr. 200)

Certainly, when determining whether a facility is in "near proximity" to a worksite, the relevant time is the elapsed time from call to arrival. To consider the time from the accident to arrival injects an element of subjectivity to the determination that would render the term "near proximity" virtually meaningless. No facility, not even one located 100 feet from a worksite, is in "near proximity if time is measured from the moment of the accident, and nobody bothers to make the necessary call that leads to the dispatch of emergency medical personnel.

Accordingly, I find that the Secretary failed to establish that respondent was required to designate a first responder[10].

*C. Conclusion*

Having found that it was not reasonably predictable that employees, as part of their job duties would come into contact with bloodborne pathogens, and that respondent was not required

[10] Given that, under his own interpretation, the Secretary has failed to demonstrate a violation of 29 CFR §1910.151(b), I do not address the propriety of her interpretation. First, I do not reach the propriety of the Secretary's attempt to find a violation of one standard by alleging a violation of an uncited standard where any alleged violation of that standard was not tried by the consent of the parties. Second, 29 CFR §1910.151(b) makes no mention of having a fire department or EMT personnel in "near proximity." Rather, it requires the presence of trained first aid personnel where there is no infirmary, clinic, or hospital in near proximity. More importantly, there is nothing in the standard that requires an employer to designate a first responder. Rather, it only requires that trained first aid personnel be on the premises. In that regard, I note that, although not designated as first aid responders as part of their job duties, respondent maintained a list of personnel who were trained in both first aid and CPR. (Ex. S-5)

to designate any of its employees as first responders, I conclude that the standards at 29 CFR §1910.1030 was not applicable to respondent. Therefore, items 3 and 4 are vacated.

## ***ORDER***

Based upon the foregoing findings of fact and conclusions of law, it is **ORDERED** that (1) Citation 1, item 1 for a violation of 29 CFR §1910.147(c)(4)(i) and item 2 for a violation of 29 CFR §1910.219(d)(1) are **AFFIRMED** as one item and total penalty of $7500 is **ASSESSED;**

(2) Citation 1, item 3 for a violation of 29 CFR §1910.1030(c)(1)(i) is **VACATED;**

(3) Citation 1, item 4 for a violation of 29 CFR §1910.1030(g)(2)(ii) is **VACATED.**

**SO ORDERED.**

/s/

The Honorable G. Marvin Bober
U.S. OSHRC Judge

Dated: 22 FEB 2011
Washington, D.C.