UNITED STATES OF AMERICA
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
1120 20th STREET, N.W., SUITE 980
WASHINGTON, DC 20036-3457

Phone: (202) 606-5400
Fax: (202) 606-5050

Secretary of Labor,
Complainant,
v.
Broan-NuTone Storage Solutions, LP,
Respondent.

Region 6
OSHRC Docket No. 10-0257
OSHA Inspection No. 311951669

Notice Of Docketing
Of Administrative Law Judge's Decision

The Administrative Law Judge's Report in the above referenced case was docketed with the Commission on 8/17/2011. The decision of the Judge will become a final order of the Commission on 9/16/2011 unless a Commission member directs review of the decision on or before that date.

Any party desiring review of the judge's decision by the Commission must file a petition for discretionary review. Any such petition shall be received by the Executive Secretary on or before 9/6/2011 in order to permit sufficient time for its review. See Commission Rule 91, 29 C.F.R. 2200.91. All further pleadings or communications regarding this case shall be addressed to the Executive Secretary with a copy to the DOL Solicitor at the address below.

Executive Secretary
Occupational Safety and Health Review Commission
1120 20th St., N.W., Suite 980
Washington, D.C. 20036-3419

Charles F. James, Counsel for Appellate Litigation
Heather R. Phillips, Counsel for Appellate Litigation
Office of the Solicitor, U.S. DOL
Room S4004
200 Constitution Avenue, N.W.
Washington, D.C. 20210

If Directed for Review by the Commission, then the Counsel for Appellate Litigation will represent the Department of Labor. If you have questions, please call me at (202) 606-5400.

Date: August 17, 2011

Ray H. Darling, Jr.
Executive Secretary

This notice has been sent to:

For the Secretary of Labor:
JOSH BERNSTEIN, ESQ.
Office of the Solicitor, U.S. DOL
525 South Griffin Street,Suite 501
Dallas, TX 75202-5020

For the Employer:
William O. Ashcraft, Esq.
Ashcraft Law Firm
3900 Republic Center
325 North St. Paul Street
Dallas, TX 75201

UNITED STATES OF AMERICA
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION

Secretary of Labor, Complainant, v. Broan-Nutone Storage Solutions, LP, Respondent.	DOCKET NO. 10-0257

Appearances:

Josh Bernstein, Esq., Office of the Solicitor, U.S. Department of Labor, Dallas, Texas
For Complainant

William O. Ashcraft, Esq., Ashcraft Law Firm, Dallas, Texas
For Respondent

Before: Administrative Law Judge Patrick B. Augustine

DECISION AND ORDER

Procedural History

This proceeding is before the Occupational Safety and Health Review Commission ("the Commission") pursuant to Section 10(c) of the Occupational Safety and Health Act of 1970, 29 U.S.C. §651 *et seq.* ("the Act"). The Occupational Safety and Health Administration ("OSHA") conducted an inspection of a Broan-Nutone Storage Solutions, LP ("Respondent") facility in Cleburne, Texas, on August 27, 2009. As a result of that inspection, OSHA issued a *Citation and Notification of Penalty* ("Citation") to Respondent alleging serious and willful violations of the Act with total proposed penalties of $91,000.00. Respondent timely contested the Citation. Prior to the trial, the parties settled Citation 1 Items 1a, 1b, and 2. (Tr. 8). The *Partial Settlement Agreement* was filed on February 25, 2011. Therefore, only Citation 1 Item 3 and Citation 2 Item 1 remained in dispute at the trial conducted in Ft. Worth, Texas on March 1-2, 2011.

Jurisdiction

Jurisdiction of this action is conferred upon the Commission pursuant to Section 10(c) of the Act. The record establishes that at all times relevant to this action, Respondent was an employer engaged in a business and industry affecting interstate commerce within the meaning of Section 3(5) of the Act, 29 U.S.C. §652(5). *Slingluff v. OSHRC*, 425 F.3d 861 (10th Cir. 2005).

Applicable Law

To establish a *prima facie* violation of the Act, the Complainant must prove by a preponderance of the evidence that: (1) the cited standard applied to the condition; (2) the terms of the standard were violated; (3) one or more of the 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 Pharmaceutical Products*, 9 BNA OSHC 2126, 1981 CCH OSHD ¶25,578 (No. 78-6247, 1981).

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). Complainant need not show that there was a substantial probability that an accident would occur; she need only show that if an accident occurred, serious physical harm would result. If the possible injury addressed by the regulation is death or serious physical harm, a violation of the regulation is serious. *Phelps Dodge Corp. v. OSHRC*, 725 F.2d 1237, 1240 (9th Cir. 1984); *Dec-Tam Corp.*, 15 BNA OSHC 2072, 1993 CCH OSHD ¶29,942 (No. 88-0523, 1993).

A violation is "willful" if it is "committed 'with intentional, knowing or voluntary disregard for the requirements of the Act or with plain indifference to employee safety.'" *Kaspar Wireworks, Inc.*, 18 BNA OSHC 2178, 2000 CCH OSHD ¶32,134 (No. 90-2775, 2000); *Georgia Electric Co.,* 595 F.2d 309, 318-19 (5th Cir. 1979*); Ensign-Bickford Co. v. OSHRC,* 717 F.2d 1419, 1422-23 (D.C. Cir. 1983). The employer's state of mind is the key issue. *AJP*

Construction, Inc., 357 F.3d 70 (D.C. Cir. 2004). Complainant must show that Respondent had a "heightened awareness" of the illegality of its conduct. *Id.* Heightened awareness is more than simple awareness of the conditions constituting the alleged violation; such evidence is already necessary to establish the basic violation. *Id.* Instead, Complainant must show that Respondent was actually aware of the unlawfulness of its action or that it "possessed a state of mind such that if it were informed of the standards, it would not care." *Id.*

Stipulations

1. The Commission has jurisdiction over this proceeding under Section 10(c) of the Occupational Safety and Health Act, 29 U.S.C. Section 659(c) ("Act"), as Respondent is an employer engaged in a business affecting commerce within the meaning of Section 3(5) of the Act, 29 U.S.C. Section 652(5). (*Joint Stipulations*; Tr. 10).

2. There was a violation of the cited standard [29 C.F.R. §1910.217(c)(2)(i)(a)], with respect to the maximum distance that should have been between the tray and the bottom of the guard, as it did not meet the OSHA standard. (Tr. 26, 34, 266, 282, 334, 384).

3. The two regulations cited in this case applied to the Bliss C-150 Power Press ("Machine 31"). (Tr. 392).

Additional Factual Findings

Seven witnesses testified at the hearing: (1) LT,[1] Machine Operator and injured employee; (2) Melvin Hall, Setup Operator; (3) David Huffman, Setup Operator; (4) Robert Ortegon, Fabrication Supervisor; (5) Ruth Rodriguez, OSHA Compliance Safety and Health Officer ("CSHO"); (6) Alan Crawford, Respondent's Plant Manager; and (7) Jim Knorpp, Safety Consultant (Tr. 37, 117, 144, 183, 275, 331, 439). Based on their testimony and discussion of evidentiary exhibits, the court makes the following additional factual findings.

Respondent operates a manufacturing facility in Cleburne, Texas. (*Resp. Brief*, pp. 1-2).

[1] Due to privacy considerations, the injured employee's full name is omitted from this decision. She will be referred to only as "LT."

On July 29, 2009, LT, a Machine Operator employed by Respondent for ten years, was seriously injured when a Bliss C-150 Power Press ("Machine 31") cycled while her hand was in the point of operation, amputating her hand at the wrist. (Tr. 20, 37-38; Ex. C-13, C-14). Respondent reported the incident to OSHA and CSHO Ruth Rodriguez was subsequently assigned to conduct an investigation, which resulted in the issuance of the citation items in dispute. (Tr. 277, 291).

Robert Ortegon supervised Respondent's Fabrication Department, which included immediate supervision of all Machine Operators, such as LT, as well as Setup Operators David Huffman and Lee Hall. (Tr. 163, 174-175, 183-184, 224-225, 331-332). Mr. Ortegon was Respondent's only supervisor in the Fabrication Department. (Tr. 183). At the beginning of each shift, he assigned Machine Operators to particular machines. (Tr. 43). The two non-supervisory Setup Operators were responsible for configuring each machine for use, showing the Machine Operators how to run the product through their assigned machine, and addressing any problems or safety issues that arise while they performed their work. (Tr. 166-167). Once the Machine Operators were assigned to particular machines, and the Setup Operators had everything set up for production, Mr. Ortegon typically walked up and down the aisleways in the department observing employee production. (Tr. 46).

On July 28, 2009, the day before the accident, Mr. Ortegon assigned LT to work on Machine 31 for the first time ever. (Tr. 43). Although Mr. Ortegon typically trained Machine Operators on how to use particular presses by actually showing them the proper procedures himself, and had done so with LT in the past on other machines, he never spent any time training LT once she was reassigned to Machine 31. (Tr. 54, 214-216, 261). The only instruction she received on Machine 31 came from Lee Hall, one of the two non-supervisory Setup Operators in the Fabrication Department, which consisted of briefly showing her how to run products through the press, telling her not to put her hands inside the press, and telling her to come get him if she had any problems. (Tr. 119, 127). He did not review any machine safety features or machine

manuals with her. (Tr. 124). Mr. Hall conceded that, because he speaks English and LT speaks Spanish, he did not know whether or not LT understood his instructions. (Tr. 137).

Machine 31 operated by mechanically pulling sheet metal from a roll into the back side of the machine, lowering a die to stamp out a part from the metal, and then ejecting the stamped part out the other side of the machine. (Tr. 38; Ex. C-13A, C-13B, C-13C). The cycling of Machine 31 was executed manually by the Machine Operator, using a foot pedal. (Tr. 121). Machine Operators stood on the side of Machine 31 where the controls were located and where the finished product came out. (Tr. 40-41; Ex. C-13A, C-13B).

At the time of the accident, Machine 31 was equipped with a series of long, silver, metal tubes, which functioned as guards and could be raised or lowered by loosening and re-tightening the attached nut and washers. (Tr. 41; Ex. C-13B). With the exception of Machine 31, all other presses in Respondent's facility were equipped with "light curtains," which ensured that a press would not cycle if an employee placed any part of their body past the light sensor. (Tr. 42, 81, 121, 162, 361). In addition to being the only press in Respondent's facility without a light curtain, Machine 31 was not equipped with any other type of alternative guarding protection, such as restraint devices, two hand trips, or distance guarding through placement of the controls. (Tr. 121-122, 155, 185-186). Machine 31 was only equipped with the hard guard, which OSHA conceded would have been minimally acceptable, if it had been set correctly. (Tr. 122). In this case, the parties stipulated that the guard on Machine 31 was set in a manner that violated the guarding standard, because the opening was large enough for a Machine Operator to place her hand inside the point of operation. (Tr. 122, 145, 187, 416).

Just before the accident, LT experienced a jam in Machine 31. (Tr. 93). A finished part failed to properly eject and was stuck inside the point of operation. (Tr. 93). To resolve the issue, LT first used a nearby push rod, a long metal stick bent at each end, in an attempt to retrieve the part so she could continue working. (Tr. 93; Ex. R-17). When that failed, she next

looked for either her supervisor, Mr. Ortegon, or the Setup Operator, Mr. Hall, for assistance. (Tr. 94). She could not find either individual near her work area. (Tr. 94). She then reached under the guard to retrieve the jammed part with her hand and, while doing so, inadvertently stepped on the foot pedal, which cycled the press and amputated her hand. (Tr. 219, 405-406).

Despite having always worked on machines which were equipped with light curtains, no one ever told LT that Machine 31 did not have such a safety device, or explained any differences in working with machines without one. (Tr. 43, 45, 216). On previous machines, LT had routinely placed her hand inside the point of operation to both wipe down the machines and to retrieve the product after a machine cycled. (Tr. 49, 54, 79-81). LT had no idea that the hard guard on Machine 31 had been set up improperly on the day of her accident. (Tr. 104-105). It was not part of a Machine Operator's duties to set up, inspect, or verify that press safety features were either present or properly adjusted. (Tr. 104-105).

The only machine guard training, in Spanish, that LT recalled receiving during her ten years of employment with Respondent came from a 10-minute safety video which addressed machine guarding and point of operation safety. (Tr. 56, 196-197). Any other policies or training materials she received over the years had been in English only, and LT does not speak or read fluent English. (Tr. 56, 90, 92-93). She acknowledged that the training video discussed keeping hands out of the points of operation, but explained that the policy was contrary to the actual way she and others had done their job for years – which was to retrieve pressed pieces from the point of operation after the press cycled. (Tr. 84-86). In fact, her supervisor Robert Ortegon, while showing her how to operate various machines over the years, had put his own hands inside the points of operation to remove completed products. (Tr. 86). Even Mr. Ortegon acknowledged that Respondent's stated policy of not putting hands in the point of operation was not enforced until *after* LT's accident. (Tr. 192, 199). Plant Manager Alan Crawford also testified that if employees had to transfer material from a machine to another location, "then obviously they

have to reach into" the point of operation. (Tr. 381).

OSHA's investigation revealed that Machine 31 had been delivered to Respondent's facility in 2008, several months before the accident, and that Respondent had experienced problems with Machine 31 from the time it arrived at the Cleburne facility. (Tr. 120, 347). Certain products, as they were exiting the machine on the operator side, would curl up and jam inside the machine. (Tr. 147, 171). Mr. Ortegon was aware of this problem, as Mr. Hall and Mr. Huffman had both brought it to his attention prior to the accident. (Tr. 120, 200-202). To remedy this recurring problem with Machine 31, Mr. Lee and Mr. Huffman admitted that they always raised the guard opening on the operator side just as it was positioned on the day of the accident, so that the stamped products could eject from the machine more easily. (Tr. 120, 123, 131, 145-146, 171).

One of the most debated issues in this case was whether Mr. Ortegon, or any other member of Respondent's management team, knew before the accident that the guard was being repeatedly raised in that manner. Both Setup Operators testified that Mr. Ortegon was aware that the guard on Machine 31 was raised and that they had been specifically instructed to raise the guard to avoid damaging the products. (Tr. 120, 123, 131, 135-136, 146-149). In fact, Mr. Ortegon admitted that he had observed Mr. Huffman and Mr. Hall raising the guard during setup to allow products to more easily pass through. (Tr. 203). He later attempted to retract his testimony and reverse course by stating the exact opposite. (Tr. 204-205). However, the court notes that Mr. Ortegon's testimony was often internally contradicting. Accordingly, the court credits Mr. Hall's and Mr. Huffman's testimony over Mr. Ortegon's where they were inconsistent. The court also accepts Mr. Ortegon's initial admission that he had specific knowledge, before the accident, that Mr. Hall and Mr. Huffman raised the guard to maximize production, and rejects his later attempts to retract that admission. (Tr. 135-136, 203).

When shown a picture of the guard as it existed at the time of the accident, Mr. Ortegon

acknowledged that it was obviously out of compliance and did not prevent employees from placing their hands inside the machine. (Tr. 212, 258; Ex. C-13B, C-14D). Since the Setup Operators testified that they always set up Machine 31 in that manner, the court also finds that the condition of the guard on Machine 31 was in plain view to Mr. Ortegon at all times while he walked around the area supervising production. (Tr. 205-206). Although Setup Operators were provided with rulers to determine whether guard openings were OSHA compliant, Mr. Ortegon neither enforced their use nor disciplined Setup Operators for failing to properly set guard openings. (Tr. 162, 211). Setup Operator Huffman conceded that he did not even know the maximum allowable guard opening distance for Machine 31. (Tr. 174). In setting up Machine 31, his focus was simply to open the guard enough so that the products would not jam. (Tr. 174).

Respondent pointed to its own general safety rules in asserting that the Setup Operators, and even LT herself, were to blame for the accident in that they failed to comply with Respondent's safety policies. Respondent pointed to general policies which required employees to follow all safety rules and prohibited employees from committing acts which would endanger themselves or others. (Tr. 87; Ex. R-6). However, before the accident, there was no evidence that any of Respondent's employees had ever been disciplined, orally or in writing, for setting up guards improperly or for placing their hand in the point of operation on a press. (Tr. 198-199, 408, 412). The record clearly indicates that both of those events occurred on a regular basis. The only pre-accident disciplinary records introduced by Respondent were for issues unrelated to safety. (Tr. 188-192; Ex. R-12).

Discussion

Citation 1 Item 3

Complainant alleged a serious violation of the Act in Citation 1 Item 3 as follows:

> *29 C.F.R. §1910.217(f)(2): Supervision to ensure that correct operating procedures were being followed on mechanical power*

press(es) was inadequate: The employer does not ensure that adequate supervision is conducted for employees operating mechanical power presses. Employees are exposed to amputation and/or crushing injuries while operating mechanical power presses. This violation most recently occurred on July 29, 2009, when an employee was exposed to an amputation hazard while removing stuck work from a mechanical power press.

The cited standard provides:

29 C.F.R. §1910.217(f)(2): Operation of power presses - (2) Instruction to operators. The employer shall train and instruct the operator in the safe method of work before starting work on any operation covered by this section. The employer shall insure by adequate supervision that correct operating procedures are being followed.

The cited standard mandates that an employer provide adequate supervision of employees operating power presses so that correct operating procedures are followed. Respondent conceded that the cited standard applied to the alleged violative condition. (Tr. 392).

Even though July 28, 2009 was the first day LT had ever worked on Machine 31, Mr. Ortegon never provided her with any training or instruction on how to operate the machine, or explained the differences between Machine 31 and other machines she had worked on in the past. LT received only a brief explanation of how to run products through Machine 31 by one of the non-supervisory Setup Operators, with no explanation regarding its status as the only press without a light curtain sensor. It was not the Setup Operators job to train or supervise Machine Operators. (Tr. 163-164, 174-175, 224). Furthermore, the Setup Operator who gave LT the brief introduction to Machine 31 was unsure whether she understood any of his instructions, since

they were in English and LT speaks only Spanish. Mr. Ortegon also conceded that at the time of the accident, he was not providing LT with any direct supervision. (Tr. 213). He was off the Fabrication Department floor, in another part of the facility. (Tr. 240). Complainant established that LT, newly assigned to a press with different operating procedures and safety devices than machines she had handled in the past, received virtually no initial instruction and absolutely no supervision. The court finds that the cited standard was violated.

To establish employee exposure to a violative condition, Complainant must prove that it was reasonably predictable that employees "will be, are, or have been in the zone of danger" created by a violative condition. *Fabricated Metal Products*, 18 BNA OSHC 1072, 1995-1997 CCH OSHD ¶31,463 (No. 93-1853, 1997); *Gilles & Cotting, Inc.*, 3 BNA OSHC 2002, 1975-76 CCH OSHD ¶20,448 (No. 504, 1976). LT was exposed to the condition for two days, on July 28 and 29, 2009. The violation was properly characterized as serious because inadequate supervision on a power press could, and unfortunately did in this instance, result in serious bodily injury. As Mr. Ortegon was the only supervisor in the Fabrication Department, with supervisory responsibilities for all of the Machine Operators and Setup Operators, his knowledge of his own failure to adequately supervise LT on a new and different press on July 28th and 29th is imputed to Respondent. Citation 1 Item 3 will be affirmed.

Citation 2 Item 1

Complainant alleged a willful violation of the Act in Citation 2 Item 1 as follows:

> *29 C.F.R. §1910.217(c)(2)(i)(a): Point of operation guard(s) on mechanical power press(es) did not prevent entry of hands or fingers into the point of operation by reaching through, over, under, or around the guard(s): The employer does not ensure that point of operation guards on mechanical power presses prevent employees' hands or fingers from entering into the point of operation by reaching*

through, over, under or around the guard(s). This violation most recently occurred on July 29, 2009, when employees were exposed to amputation hazards while reaching into the point of operation to remove stuck work.

The cited standard provides:

29 C.F.R. §1910.217(c)(2)(i)(a): Safeguarding the point of operation. (2) Point of operation guards. (i) Every point of operation guard shall meet the following design, construction, application, and adjustment requirements: (a) It shall prevent entry of hands or fingers into the point of operation by reaching through, over, under, or around the guard.

It was undisputed that the standard applied to the condition and that the requirements of the standard were violated. Employee exposure to the violative condition, as well as the seriousness of the violation, were also clearly established by the fact that LT was able to reach her hand into the point of operation on Machine 31 and experienced a serious injury.

The record also established that Respondent, through the presence, supervision, and observations of Mr. Ortegon, had both direct and indirect knowledge of the violative condition. Mr. Ortegon was previously told by both Setup Operators that the guards were being raised on Machine 31 to resolve the recurring jamming problem. Mr. Ortegon testified that he had actually observed them raising the guards to facilitate production in the past. In addition, the condition of the raised guards was obvious to anyone who walked by the machine. Since Mr. Ortegon walked by Machine 31 repeatedly each day, and given the Setup Operators' testimony that the guards were always raised on Machine 31 to facilitate production, the readily apparent nature of this recurring violative condition should have been obvious to Mr. Ortegon. His heightened knowledge of the violative condition of the guard on Machine 31 is imputed to Respondent. *A.P.*

O'Horo Co., 14 BNA OSHC 2004, 1991 CCH OSHD ¶29,223 (No. 85-0369, 1991).

Lastly, the totality of the record establishes that for several months before the accident, Mr. Ortegon possessed heightened, specific knowledge of the day-to-day practice of raising the guard on Machine 31 to facilitate production, which openly and obviously eliminated the employee protection function of the guard. This constituted plain indifference to employee safety in that production quality and speed was overtly prioritized over safety. Citation 2 Item 1 will be affirmed.

Affirmative Defenses

Respondent asserted the defense of unpreventable employee misconduct to Citation 2 Item 1. To establish this defense, Respondent must show that it: (1) established work rules designed to prevent the violation, (2) adequately communicated those rules to its employees, (3) took steps to discover violations of its rules, and (4) effectively enforced the rules when violations were discovered. *Diamond Installations, Inc.*, 21 BNA OSHC 1688, 2005 CCH OSHD ¶32,848 (No. 02-2080, 2006). Respondent argued that Setup Operators David Huffman and Lee Hall, as well as Machine Operator LT, violated company policies because they were supposed to "operate their machinery in a safe manner" and were "not supposed to circumvent or bypass any kind of safety devices." (Tr. 336).

As an initial matter, the court notes that Mr. Ortegon testified that LT was a fully qualified Machine Operator and a "real good employee." (Tr. 225-226). Second, Respondent's assertion as to its policies was inconsistent with the record. Both of Respondent's Setup Operators testified that they always raised the guards on Machine 31 to facilitate production, that they were instructed to do so, that Mr. Ortegon knew of this repeated practice, and that they were never disciplined for this practice. Also, the record clearly established that Machine Operators, and Mr. Ortegon himself while training employees, regularly placed their hands in the point of operation on machinery, presumably relying on the light curtain sensors, but were never

disciplined for doing so. When LT was assigned to work on the single machine which did not have a light curtain sensor, and engaged in her normal work practices, it resulted in a tragic accident. Third, any policy or oral instruction which simply warns employees not to put their hands in the point of operation was insufficient. The Commission has long-recognized that OSHA's machine guarding standards were designed to protect employees from common human errors such as neglect, distraction, inadvertence, carelessness, or simple fatigue. *Slyter Chair, Inc.*, 4 BNA OSHC 1110, 1975-1976 CCH OSHD ¶20,589 (No. 1263, 1976); *B.C. Crocker*, 4 BNA OSHC 1775, 1976-1977 CCH OSHD, ¶21,179 (No. 4387, 1976). Fourth, even if Respondent's policies existed, there was no evidence of any attempts to monitor for compliance or to enforce those policies. Disciplinary records introduced into evidence focused primarily on employees damaging products, rather than on safety concerns. None of the records addressed the types of safety issues involved in this case. All of these facts belie the notion that the violative conduct, either on the part of the Setup Operators or LT, was either isolated or unforeseeable. *Falcon Steel Co.*, 16 BNA OSHC 1179 (Nos. 89-2883 & 3444, 1993); *Brennan v. Butler Lime and Cement Co.*, 520 F.2d 1011 (7th Cir. 1975). Accordingly, Respondent failed to establish the affirmative defense of unpreventable employee misconduct.

Penalty

In calculating the appropriate penalty for affirmed violations, Section 17(j) of the Act requires the Commission to give "due consideration" to four criteria: (1) the size of the employer's business, (2) the gravity of the violation, (3) the good faith of the employer, and (4) the employer's prior history of violations. 29 U.S.C. §666(j). Gravity is the primary consideration and is determined by the number of employees exposed, the duration of the exposure, the precautions taken against injury, and the likelihood of an actual injury. *J.A. Jones Construction Co.*, 15 BNA OSHC 2201, 1993 CCH OSHD ¶29,964 (No. 87-2059, 1993).

It is well established that 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. *Allied Structural Steel*, 2 BNA OSHC 1457 (No. 1681, 1975); *Valdak Corp.*, 17 BNA OSHC 1135 (No. 93-0239, 1995). In calculating the proposed penalties for Citation 1 Item 3 and Citation 2 Item 1, CSHO Rodriguez provided no penalty reductions for good faith, employer size, or violation history. (Tr. 280-281). Based on the totality of the circumstances in this case, including the exposure of at least one employee daily for several months after Machine 31 came to the facility, the overt actions to prioritize production over employee safety by repeatedly positioning the guard in a non-compliant position, the plain and obvious nature of the violative conditions, the actual occurrence of a very serious employee injury, and Respondent's status as a large employer with multiple facilities, the court assesses the penalties for the affirmed violations as set out below.

ORDER

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

1. Citation 1 Item 3 is AFFIRMED and a penalty of $5,000.00 is ASSESSED;
2. Citation 2 Item 1 is AFFIRMED and a penalty of $50,000.00 is ASSESSED.

Date: August 12, 2011
Denver, Colorado

PATRICK B. AUGUSTINE
Judge, OSHRC