United States of America
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
1244 North Speer Boulevard, Room 250
Denver, Colorado 80204-3582

Phone: (303) 844-3409 Fax: (303) 844-3759

SECRETARY OF LABOR, Complainant, v. RAYTHEON CONSTRUCTORS, INC., and its successors, Respondent.	OSHRC DOCKET NO. 00-0128

APPEARANCES:

For the Complainant:
William W. Kates, Esq., Office of the Solicitor, U.S. Department of Labor, Seattle, Washington

For the Respondent:
David E. Jones, Esq., Ogletree, Deakins, Nash, Smoak & Stewart, PC, Atlanta, Georgia

Before: Administrative Law Judge: Stanley M. Schwartz

DECISION AND ORDER

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

Respondent, Raytheon Constructors, Inc. (Raytheon), at all times relevant to this action maintained a place of business at the Umatilla Army Chemical Depot I-84, Hermiston, Oregon, where it was engaged in the construction of an incinerator for disposal of chemical weapons and agents, the Munitions Disposal Building (MDB). Respondent admits it is an employer engaged in a business affecting commerce and is subject to the requirements of the Act.

On November 15-19, 1999 the Occupational Safety and Health Administration (OSHA) conducted an inspection of Raytheon's I-84 work site. As a result of that inspection, Raytheon was issued citations alleging violations of the Act together with proposed penalties. By filing a timely notice of contest Raytheon brought this proceeding before the Occupational Safety and Health Review Commission (Commission).

On May 2-3, 2000, a hearing was held in Portland Oregon. At the hearing the parties stipulated to the settlement of all but four items, *i.e.*, Serious citation 1, items 1, 2, 5 and 6 (Tr. 9-11). The

parties' stipulations are reflected in the Order below. The parties have submitted briefs on the items remaining at issue and this matter is ready for disposition.

Alleged Violation of §1926.50(a)

Serious citation 1, item 1 alleges:

29 CFR 1926.50(a): The availability of medical personnel was not insured for advice and consultation on matters of occupational health:

> a) On or about September 15, 1999 provisions were not made for the prompt transportation to nearby medical facilities of approximately 34 employees who were exposed to an unknown chemical. The assistance of a physician from the Umatilla Chemical Depot was refused, and the exposed employees had to wait approximately 2 hours before they were transported to a hospital.

Facts

It is undisputed that around 11:00 a.m. on September 15, 1999, during construction of the Hermiston MDB, a number of Raytheon employees were exposed to an unknown toxic chemical (Tr. 21, 35, 63, 225). Tony Kimball, a pipe fitter (Tr. 18-20), was overcome, and had to be assisted from the building by a fellow employee, steam fitter Brian Zasso (Tr. 21-22, 36). Kimball testified that he experienced pain in his lungs and stomach, had trouble breathing, became dizzy and disoriented, and vomited bile (Tr. 22-23). Zasso testified to experiencing similar symptoms (Tr. 35, 37-38, 41). After evacuating the building Kimball and Zasso testified that they and other affected employees remained outside the building until supervisory personnel instructed them to move to the lunch trailer so that everyone could be accounted for (Tr. 23-24, 37). Zasso testified that the pipe fitter foreman called for first aid, but that they were not seen by any medical personnel at that time (Tr. 39-40). Both Kimball and Zasso testified that after approximately 15 minutes more, they and other affected employees were transported by truck to Raytheon's first aid station (Tr. 26, 40). Both employees testified that they asked for medical assistance and were seen by the Emergency Medical Technicians on duty at the trailer; however, neither received any first aid; both were told only that they needed some fresh air (Tr. 26-28, 42-43). At around 1:00 p.m. Kimball and Zasso and approximately 12 other employees were also transported to Good Shepard Hospital in Hermiston via a Raytheon van (Tr. 29-30, 43-44). Kimball testified that one employee who was suffering severe respiratory distress was taken to the hospital by ambulance (Tr. 30).

Bruce Raymond, Raytheon's safety manager (Tr. 132-33), testified that he drafted Raytheon's medical implementation plan (Tr. 195; Exh. R-7). The plan provides for a physician advisor, Dr. Beverly Harn, who was to establish procedures and protocols for the paramedic staff at Raytheon's

work site, and who reviewed the paramedic's records on a monthly basis (Tr. 196-97, 232-33, 377). Raymond testified that Dr. Harn was available for consultation with the paramedics at all times (Tr. 198). Raymond testified that his staff at the Hermiston MDB included approximately 15 part-time paramedics; two paramedics were always on duty during each work shift (Tr. 135-36, 198-99). On September 15, Glen Phillips and Dale Ternes were on duty at the MDB medical infirmary (Tr. 211). Phillips and Ternes are qualified emergency medical technicians (EMTs), and were competent to provide basic first aid as well as advanced cardiac life support; both were trained to deal with hazardous materials emergencies (Tr. 135, Tr. 371-75, 379, 420-23).

Richard Jacobsen, Raytheon's manager of safety, testified that the provisions Raytheon has made to ensure access to medical advice and consultation are consistent with those made by other construction companies of similar size (Tr. 583, 587-88).

On September 15, after learning of the chemical release, the paramedics on duty attempted to assess the nature of the release, and determined that an upper respiratory contaminant of some kind was involved, though they ruled out any release of chemical munitions[1] (Tr. 211-214, 387-91, 425-26). Ternes learned there were affected employees reporting to the infirmary, and returned to the clinic (Tr. 427-28). Ternes and a third EMT from Raytheon's training department, Heather Madison, began taking vital signs, and administering oxygen (Tr. 429-30). Phillips remained on the site of the incident to account for all exposed employees, then returned to the infirmary where it appeared that everything was under control (Tr. 215, 394, 416). Phillips assisted by triaging affected employees outside the infirmary (Tr. 395-98). Phillips stated that he saw no evidence of any life threatening emergencies outside; he believed those employees needed only fresh air (Tr. 398- 400). Ternes had already had one employee who was experiencing severe respiratory distress taken to the hospital (Tr. 215, 416, 431), and was actively treating employees who were experiencing nausea and numbness inside the infirmary (Tr. 431, 442). Eventually the decision was made to transport all the affected employees to the hospital (Tr. 434).

Both Phillips and Ternes testified that they never considered calling Dr. Harn, believing it would have been a waste of time (Tr. 402-03, 435-36). Had it been necessary, Phillips stated, he would have

[1] Glen Phillips testified that all chemical munitions were stored at the depot in K block, not in the building where the employees were working, and were exposed. Phillips testified that a release could only have been caused by a "significant impact" to K block and would have affected employees both in and outside of the MDB under construction. Finally, Phillips stated that the EMTs were familiar with the symptoms of exposure to both mustard gas and the nerve agent stored at Umatilla. The exposed employees exhibited none of those symptoms (Tr. 391-92).

called the physician advisor at the hospital emergency room, where the patient would be sent (Tr. 405, 409-10). Neither Phillips nor Ternes felt that any employees they saw exhibited symptoms that were beyond their ability to address (Tr. 406, 436).

Discussion

The cited standard provides:

> The employer shall insure the availability of medical personnel for advice and consultation on matters of occupational health.

In order to prove a violation of section 5(a)(2) of the Act, the Secretary, among other things, must show by a preponderance of the evidence that (1) the cited standard applies, and (2) there was a failure to comply with the cited standard. *See, e.g., Walker Towing Corp.*, 14 BNA OSHC 2072, 2074, 1991-93 CCH OSHD ¶29239, p. 39,157 (No. 87-1359, 1991). The Secretary has failed to meet her burden on either of these elements of her *prima facie* case.

Applicability. The cited standard is clearly inapplicable to portions of the allegations found in citation 1, item 1. The item alleges that "provisions were not made for the prompt transportation to nearby medical facilities of approximately 34 employees who were exposed to an unknown chemical.. . . and the exposed employees had to wait approximately 2 hours before they were transported to a hospital." Inadequate medical transport is addressed under §1926.50(e), which requires that "[p]roper equipment for prompt transportation of the injured person to a physician or hospital, or a communication for contacting necessary ambulance service, shall be provided." The cited subsection (a) is preempted by the more specifically applicable subsection (e). No motion to amend the citation was made prior to or after the hearing. Those portions of the citation alleging inadequate transportation, therefore, are vacated.

Compliance. The record establishes that the EMTs involved in this case were qualified to render advice on occupational safety and health. Complainant does not argue that the paramedics were not "medical personnel," and this judge finds that they were "medical personnel" as contemplated by the standard. The evidence establishes that Raytheon had a medical implementation plan that provided for the presence of two EMTs at the work site infirmary at all times, and that EMTs were, in fact, available, not only for advice and consultation on matters of occupational health, but for the provision of prompt medical attention, where necessary. The facts, as set forth in the record, establish that Raytheon was in compliance with the cited standard.

Complainant's theory in this case is that Raytheon's infirmary was understaffed to handle a "potentially catastrophic" event of the nature of the September 15, 1999 incident, and that Raytheon violated the cited standard by turning down an offer of assistance from Dr. Jose Ortiz, the doctor on

staff at the Army's Depot Clinic, on September 15, 1999 (See Complainant's Memorandum of Points and Authorities, p. 8).

The standard involved does not contain specific performance guidelines. A violation of the standard, therefore, can only be found where the Secretary establishes, by a preponderance of the evidence, that a "reasonable employer" would have done more to ensure the availability of medical advice. *See; CMC Electric, Inc. v. OSHA*, (No. 99-3801, Aug.19, 2000) [slip opinion], *Armour Food Co.*, 14 BNA OSHC 1817, 1987-90 CCH OSHD ¶29,088 (No. 86-247, 1990). This judge finds that the Secretary failed to prove that Raytheon's preparations were unreasonable.

When Raytheon formulated its medical implementation plan, it consulted with the U.S. Army, and was told that the limited staffing of the Army's medical corp. prevented the Army from providing medical services for Raytheon (Tr. 219). On that basis, Raytheon made other provisions for ensuring that medical advice would be available to its employees. Raytheon's safety manager testified, without contradiction, that its preparations were comparable to those made by other similarly situated employers in the construction industry. Raytheon was involved only in construction, was not involved in the actual disposal of chemical weapons and agents, and had no reason to anticipate a catastrophic event. Complainant failed to introduce any evidence tending to show that a reasonable employer in Raytheon's position would have retained more than two full time EMTs on the work site for purposes of safety and health consultation. Rather, Complainant relies entirely on the statement of a Raytheon representative, Project Manager Jay Bluestein, who stated at a November 1, 1999 public hearing that Raytheon "should have taken help from the doctor," (Tr. 68; Exh. C-1, p. 82). Though Bluestein's statement establishes that, in hindsight, Raytheon realized that it should not have refused any help that was offered after the incident occurred, it does not establish a violation of the cited standard. As written, the standard simply does not address the issue of *post facto* offers of medical assistance.

Finally, there is no evidence that Raytheon's EMT staff , or its response to the chemical release was inadequate. It is clear from the testimony that a number of Raytheon's employees were sickened by a chemical exposure, and were, given the ultimate purpose of the facility they were building, justifiably frightened. Apparently some employees did not trust the ministrations of paramedics, and preferred to be seen by a physician. While the employees concerns are understandable, nothing in the cited standard requires the employer to guarantee that level of care on the work site. Finally, there is no evidence in the record indicating that a physician on the scene would, or could have done anything more than the EMTs.

The Secretary failed to carry her burden of proof on this item, and it is vacated.

Alleged Violation of §1926.102(a)(1)

Serious citation 1, item 2 alleges:

29 CFR 1926.102(a)(1): Eye and face protective equipment was not used when machines or operations presented potential eye or face injury:

> a) The welder's helper in the ECV area at the 122 elevation at the Umatilla Army Chemical Depot was not wearing eye protection to protect him from the welding rays.

Facts

OSHA Compliance Officer (CO) Charles Penrod testified that he conducted the November 16, 1999 inspection of Raytheon's MDB facility (Tr. 81). CO Penrod testified that as they entered an area known as the ECV area, he observed an arc welder's helper, later identified as Chuck Sheldon by Raytheon, who was wearing prescription glasses (Tr. 106, 298). Penrod stated that the glasses did not provide appropriate eye protection, because they did not have side shields (Tr. 86-87, 106). Penrod testified that the helper stood less than three feet away from the welding operation, and was exposed to the hazard of flash burns to his eyes (Tr. 89, 91). Penrod testified that he spoke to the welding foreman, identified at the hearing as Alex Jackson, and to Mike Listello, a Raytheon safety officer, about the helper's failure to wear eye protection (Tr. 90). According to Penrod, the foreman stated that he believed it was all right for the helper to forego eye protection so long as he looked away during welding (Tr. 90).

Bruce Raymond testified that Raytheon has a work rule requiring that welders' helpers use eye protection (Tr. 144-45; Exh. R-1, p.19-8, §3.2.1.2, p. 19-11, §3.2.3). Raymond testified that all new hires are made aware of the relevant rule during their orientation (Tr. 150). Each employee receives an employee handbook, which states, *inter alia*, that "when you arc/welding (sic) near other workers, they must be protected from the arc rays by noncombustible screens or must wear adequate eye protection." (Tr. 150; Exh. R-2, p. 19). New employees are instructed to read the handbook and to sign documentation indicating they have reviewed it (Tr. 150). In addition, Raymond testified that Raytheon's Job Hazard Analysis (JHA), requires welders to obtain a hot work permit from their foreman prior to welding (Tr. 176; *See also*, testimony of Don Gammell, Tr. 285). According to Raymond, the permit is to be issued only if the employees have the personal protective equipment necessary to safely perform the job (Tr. 176-77).

Raymond testified that, in addition to their initial training, Raytheon employees attend weekly toolbox safety meetings, during which these issues would be addressed (Tr. 165).

Raytheon introduced Chuck Sheldon's sign off sheet, indicating that he received his copy of Raytheon's safety hand book, and went through new hire orientation on February 11, 1998 (Tr. 300; Exh. R-18, R-19). Sheldon's name is found on an October 5, 1999 attendance roster, indicating that he received training in Raytheon's hot work policy (Tr. 291-96; Exh. R.16). Sheldon's foreman went over the hot work permit rules again at a tool box safety meeting held on October 27, 1999 (Tr. 297-98; Exh. R-17).

Raymond testified that safety personnel do safety compliance inspections several times a day, and document their observations weekly (Tr. 167-68;). Mike Listello testified that he tried to be out on the job site as much as possible during the day, every day (Tr. 526).

Don Gammell, a civil superintendent, testified that Raytheon had a progressive disciplinary system that included verbal warnings, written warnings, and dismissal, when appropriate (Tr. 283). Gammell stated that when performing daily safety inspections, or "walk downs," he would correct any deficiency, and, depending on the severity of the infraction, might report the incident to the employee's immediate supervisor (Tr. 283, 301). A verbal or written warning may result (Tr. 283). Gammell testified that he has terminated employees for safety rule violations (Tr. 323).

Raytheon introduced three warning letters issued between March 16, and June 9, 1999 reprimanding employees for failure to wear eye protection (Tr. 302; Exh. R-20). Gammell testified that Sheldon was disciplined for his failure to wear eye wear On November 16, 1999 (Tr. 319).

Gammell testified that he had not heard that Sheldon's foreman, Alex Jackson, told CO Penrod that he believed it was all right for Sheldon to merely avert his eyes during welding (Tr. 319). Gammell testified that had he learned of this, Jackson would have been questioned and counseled. A written reprimand may have been issued had Jackson admitted to making such a statement (Tr. 320). Gammell testified that Jackson had received training on the hot work safety rules (Tr. 321-22; Exh. R-16).

Discussion

Raytheon does not dispute the occurrence of the cited violation. Rather it maintains that the violation was the result of unpreventable employee misconduct. The Secretary admits that Raytheon had work rules designed to prevent the hazardous condition, but questions how effective Raytheon's safety and disciplinary program actually were, given the alleged supervisory involvement in the cited violation.

In order to establish an unpreventable employee misconduct defense, the employer must establish that it had: established work rules designed to prevent the violation; adequately communicated those work rules to its employees (including supervisors); taken reasonable steps to discover violations

of those work rules; and effectively enforced those work rules when they were violated. *New York State Electric & Gas Corporation*, 17 BNA OSHC 1129, 1995 CCH OSHD ¶30,745 (91-2897, 1995).

The evidence shows, and Complainant acknowledges, that Raytheon had a comprehensive safety plan that included a work rule requiring that employees working near arc welding operations wear eye protection (Complainant's Memorandum of Points and Authorities, p. 9). The record further shows that the exposed employee, Chuck Sheldon, participated in three separate safety programs during which Raytheon's hot work, *i.e.*, welding rules were discussed, and should have been aware that eye protection was required for welder's helpers.

Complainant argues, however, that "it remains unclear" how effective Raytheon was in its efforts to discover and correct violations of its safety rules. Raytheon's safety manager, Bruce Raymond, testified that safety compliance inspections were performed several times a day. Don Gammell testified, without contradiction, that Raytheon had a progressive disciplinary system to address violations of the work rules; Raytheon produced warning letters issued to employees violating the eye protection requirement. The Commission has held that an employer may demonstrate its "effective enforcement" of its safety rules by showing that it had in place a progressive disciplinary plan with increasingly harsh measures taken for infractions of the work rule. *Precast Services, Inc.* 17 BNA OSHC 1454, 1995 CCH OSHD ¶30,910 (93-2971, 1995). That a safety violation occurred in spite of Raytheon's efforts does not establish that its safety program was ineffectively enforced.

Raytheon has established that Chuck Sheldon's violation of Raytheon's safety rules was the result of unpreventable employee misconduct.

This judge's finding is not affected by Alex Jackson's alleged statement to CO Penrod, to the effect that no eye protection was necessary in this case. It is well settled that misconduct by a supervisor constitutes evidence that an employer's safety program is lax, *Consolidated Freightways Corp.*, 15 BNA OSHC 1317, 1991-93 CCH OSHD ¶29,500 (No. 86-531, 1991). However, it is not clear from this record whether Jackson was actually involved in the misconduct, *i.e.*, whether he was aware of the violation before Penrod brought it to his attention. This judge does not believe that Jackson's *post facto* attempts to excuse Sheldon's conduct rise to the level of misconduct. Moreover, the employer can rebut any inference of misconduct by establishing that Jackson was provided with adequate training in, and was subject to discipline for violation of relevant work rules. Don Gammell testified, and produced documentation showing that Jackson had received training in Raytheon's hot work rules. Gammell testified, again without contradiction, that Jackson would have been reprimanded had Raytheon learned of his alleged misstatement.

Because Raytheon has established the affirmative defense of employee misconduct, the citation is vacated.

Alleged Violation of §1926.403(i)(2)(i)

Serious citation 1, item 5 alleges:

29 CFR 1926.403(i)(2)(i): Live parts of electric equipment operating at 50 volts or more were not guarded against accidental contact by cabinets or other forms of enclosures, or by any of the following means: (A) by location in a room, vault, or similar enclosure that is accessible only to qualified persons; (B) by partitions or screens so arranged that only qualified persons will have access to the space within reach of the live parts; (C) by location on a balcony, gallery, or platform so elevated and arranged as to exclude unqualified persons; (D) by elevation of 8 feet or more above the floor or other working surface and so installed as to exclude unqualified persons:

> a) Circuit breakers were missing from the electrical panels in the vehicle maintenance shop and the boilermakers conex at the Umatilla Army Chemical Depot. Unused openings were covered with duct tape.

Facts

CO Penrod testified that during his inspection of Raytheon's vehicle maintenance shop, he observed a 240 volt electrical panel on which unused openings were covered with duct tape (Tr. 92, 94, 98, 100; Exh. C-2). Someone had written "Do not insert finger" on the duct tape (Tr. 98; Exh. C-2). Penrod testified that he also observed a 120 volt electrical panel that was taped in the same manner in the boilermaker's conex, which is a freight container used for temporary equipment storage and as a break room (Tr. 93-94, 100). CO Penrod stated that his electrical tester indicated that there was live electricity somewhere behind the tape (Tr. 109). Penrod did not believe duct tape was conductive, however (Tr. 109). Penrod did not check behind the tape, but agreed that someone would have to remove the tape, and insert a finger, or conductive object into the hole behind the tape to contact any live part (Tr. 110).

Bruce Bray, Raytheon's electrical construction superintendent, testified that, normally, where there is an unused space for a circuit breaker on the type of panel pictured in Complainant's Exhibit C-2, the space is covered with a plastic space-cover to prevent inadvertent contact with the circuitry behind the panel cover (Tr. 351). Bray testified that the highly adhesive duct tape which was placed on the circuit cabinets in the maintenance shop and the conex would serve the same purpose as the plastic cover, in that it would take a purposeful act to reach the energized parts one and 1-½ to 2 inches behind the tape (Tr. 353-55, 357).

Discussion

The cited standard provides:

> Except as required or permitted elsewhere in this subpart, live parts of electric equipment operating at 50 volts or more were not guarded against accidental contact by cabinets or other forms of enclosures. . .

The facts are not disputed. In two locations, live electrical equipment was guarded by an appropriate cabinet. Unused cutouts in the cabinets were covered with duct tape in lieu of plastic space covers.

Complainant maintains that duct taping the cutouts was inadequate to prevent employees from accidentally contacting live electrical parts. CO Penrod testified that employees working in the vehicle maintenance shop and/or the conex could accidentally contact live parts behind the duct tape while using the other circuit breakers on the panels (Tr. 99-101, 108). This judge does not agree.

As required by the standard, the cited electrical equipment was located within a cabinet, behind a panel, which guarded it against accidental contact. Openings in the panel were covered. In order to access any live electrical parts, an employee would have to remove the duct tape and deliberately place his finger or a conductive object into the cutout. The plain language of the cited standard cannot be interpreted to require employers to take precautions against an employee's deliberate, and inexplicable, attempt to contact live electrical parts. *See, e.g., Ormet Corporation*, 9 BNA OSHC 1829, 1981 CCH OSHD ¶25,322 (No. 76-4398, 1981)[Commission declines to read 29 CFR 1910.309(a) as requiring employer to forestall deliberate employee misbehavior].

Citation 1, item 5 is vacated.

Alleged Violation of §1926.501(b)(1)

Serious citation 1, item 6 alleges:

29 CFR 1926.501 (b)(1): Each employee on a walking/working surface with an unprotected side or edge which is 6 feet or more above a lower level shall be protected from falling by the use of guardrail systems, safety net systems, or personal fall arrest systems:

> a) There was one employee standing on the pipe support on the east side of the MDB area at the Umatilla Army Chemical Depot and was not protected from falling to the ground approximately 12-15 feet below.

Facts

CO Penrod testified that as he walked out into the yard, he observed pipefitters working on a pipe rack 12 to 15 feet overhead (Tr. 84, 102-03). One of the pipefitters, later identified as Mike Dolan

(Tr. 264), was walking on the rack, wearing a harness and lanyard, but was not tied off (Tr. 85, 103, 106). Penrod stated that Dolan tied off when Mike Listello said something to him (Tr. 104). Penrod did not know how long the employee had been unhooked (Tr. 104).

Listello told Penrod that Raytheon had a 100% tie off policy, and that the employee had been trained, and knew what the rules were (Tr. 105). At the hearing Mike Listello testified that there was no foreman in the area where Dolan was working (Tr. 530). In addition, Listello stated that there was another employee in the area when he and Penrod entered, and that the second man was properly tied off (Tr. 531). Bruce Raymond testified that the 100% tie off rule is included in Raytheon's safety manual (Tr. 146; Exh. R-1, p. 25-8, §7 *et seq.*), and in the employee handbook (Tr. 155; Exh. R-2, p. 23). New hires attend a training session during which they are instructed in the proper use of safety harnesses (Tr. 155).

Bill Nerpel, a mechanical superintendent, testified that Raytheon's 100% fall protection policy is discussed frequently during weekly safety meetings, and produced agendas for the weeks of November 18, and December 9, 1997, and March 24, April 21, June 2, August 11, September 9, October 6, November 3, and December 8, 1998, indicating that fall protection had been discussed at those meetings (Tr. 247, 249-51; Exh. R-9). Fall protection was addressed in 1999 on February 9, February 16, March 4, June 15, August 10, and October 25 (Tr. 252-54; Exh. R-9).

Dolan received his initial training on May 24, 1999 (Tr. 266, Exh. R-12). Nerpel testified that he believed Dolan's name would be found on the attendance sheets for the weekly safety meeting (Tr. 266-67).

Nerpel testified that he took part in the daily safety walkdowns described by Raymond and Gammell (Tr. 255-56, 258; Exh. R-10). Nerpel testified that where violations of the fall protection rules were observed, warnings were issued (Tr. 261-63). Raytheon introduced 14 warnings issued between February 1998 and October 13, 1999 (Exh. R-11). Mike Dolan was issued a warning letter as a result of the November 16, 1999 inspection (Tr. 265-267; Exh. R-12)

Discussion

In order to prove its *prima facie* case, the Secretary must show, by a preponderance of the evidence, that the cited employer either knew or, with the exercise of reasonable diligence, could have known of the cited condition. *See, e.g., Walker Towing Corp.*, 14 BNA OSHC 2072, 2074, 1991-93 CCH OSHD ¶29239, p. 39,157 (No. 87-1359, 1991). Where no supervisory personnel observed the violation, the Secretary must show that the employer failed to adequately train and supervise its

employees to ensure safe work practices. *See; Mosser Construction Co.*, 15 BNA OSHC 1408, 1991-93 CCH OSHD ¶29,546 (No. 89-1027, 1991).

No supervisory personnel were in the area where the cited violation was observed. CO Penrod did not know how long Mike Dolan was unsupervised, or how long, or briefly, Dolan was unhooked. The Secretary failed to show that Raytheon knew, or could have known of the cited conduct, and, therefore, did not demonstrate employer knowledge of the cited condition.

Moreover, Raytheon established that it did everything it could to prevent Dolan's misconduct. Raytheon established that it had a 100% tie off policy, which was constantly reinforced during weekly safety meetings. Raytheon's witnesses testified, without contradiction, that Dolan had been trained in Raytheon's 100% tie off policy. Raytheon witnesses testified that frequent safety inspections were conducted, and produced documentation establishing that employees were reprimanded for violations of the tie off rule. A second employee in the area was properly tied off. Mike Dolan was reprimanded for the November 16, 1999 violation.

The evidence establishes that Raytheon conducted adequate safety inspections to discover violations of the policy, and had a progressive disciplinary system to enforce it.

Because the Secretary failed to establish employer knowledge, and because Raytheon established the affirmative defense of employee misconduct, the violation is vacated.

ORDER

1. Citation 1, item 1, alleging violation of §1926.50(a) is VACATED.
2. Citation 1, item 2, alleging violation of §1926.102(a)(1) is VACATED.
3. Citation 1, item 3, and Citation 2, item 1, alleging violations of §§1926.303(c)(2) and .300(b)(7) are AFFIRMED as a single "other than serious" violation, and a combined penalty of $845.00 will be ASSESSED.
4. Citation 1, item 4, alleging violation of §1926.304(f) is WITHDRAWN.
5. Citation 1, item 5, alleging violation of §1926.403(i)(2)(i) is VACATED.
6. Citation 1, item 6, alleging violation of §1926.501(b)(1) is VACATED.
7. Other than serious citation 3, item 1, alleging violation of §1910.37(q)(6) is WITHDRAWN.
8. Other than serious citation 3, item 2, alleging violation of §1910.134(h)(2)(i) is AFFIRMED without penalty.
9. Other than serious citation 3, item 3, alleging violation of §1926.150(c)(1)(viii) is WITHDRAWN.
10. Other than serious citation 3, item 4, alleging violation of §1926.250(c) is AFFIRMED without penalty.
11. Other than serious citation 3, item 5, alleging violation of §1926.403(h) is AFFIRMED without penalty.

12. Other than serious citation 3, item 6, alleging violation of §1926.403(i)(1)(ii) is AFFIRMED without penalty.

13. Other than serious citation 3, item 7, alleging violation of §1926.404(f)(7)(iv)(C) is WITHDRAWN.

14. Other than serious citation 3, item 8, alleging violation of §1926.405(g)(1)(iii) is WITHDRAWN.

15. Other than serious citation 3, item 9, alleging violation of §1910.134(h)(2)(i) is AFFIRMED without penalty.

Stanley M. Schwartz
Judge, OSHRC

Dated: September 8, 2000