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SECRETARY OF LABOR Complainant, v. DCS SANITATION MANAGEMENT, INC. Respondent.	OSHRC DOCKET NO. 93-3023

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 April 13, 1995. The decision of the Judge will become a final order of the Commission on May 15, 1995 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 should be received by the Executive Secretary on or before May 4, 1995 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:

Executive Secretary
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Petitioning parties shall also mail a copy to:

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If a Direction for Review is issued by the Commission, then the Counsel for Regional Trial Litigation will represent the Department of Labor. Any party having questions about review rights may contact the Commission's Executive Secretary or call (202) 606-5400.

FOR THE COMMISSION

Ray H. Darling, Jr.

Date: April 13, 1995

Ray H. Darling, Jr.
Executive Secretary

DOCKET NO. 93-3023

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SECRETARY OF LABOR, Complainant, v. DCS SANITATION MANAGEMENT, INC., Respondent.	OSHRC DOCKET NO. 93-3023

APPEARANCES:

For the Complainant:
Dewey P. Sloan, Jr., Esq., Office of the Solicitor, U.S. Department of Labor, Kansas City, Missouri

For the Respondent:
Patrick, M. Roby, Esq., Elderkin & Pirnie, P.L.C., Cedar Rapids, Iowa

Before: Administrative Law Judge James H. Barkley

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, DCS Sanitation Management, Inc. (DCS), at all times relevant to this action maintained a worksite at the IBP meat processing plant at 1200 Industrial Park, Madison, Nebraska, where it was engaged in janitorial services. Respondent admits it is an employer engaged in a business affecting commerce and is subject to the requirements of the Act.

On October 7, 1993, pursuant to an accident investigation of DCS' Madison worksite, the Occupational Safety and Health Administration (OSHA) issued a "willful" citation, together with proposed penalties, alleging violations of the Act. By filing a timely notice of contest Respondent brought this proceeding before the Occupational Safety and Health Review Commission (Commission).

On November 15-16, 1994 a hearing was held in Norfolk, Nebraska. The parties have submitted briefs on the issues and this matter is ready for disposition.

FACTS

During the relevant periods, DCS provided sanitation services for IBP's Madison, Nebraska meat processing plant. DCS procedures require workers to wash down IBP's meat processing equipment and floors with high pressure hot water hoses; chemical foam is then applied to the equipment to break down solid wastes, and is hosed away (Tr. 228-29). The equipment must be running during the hose down process (Tr. 229-30).

The DCS lockout/tagout program requires that equipment be locked or tagged out "whenever a DCS employee is required to physically touch, climb in, under, or on or break the plane of operation of machinery or equipment" (Exh. C-3, p. 5). New hires are shown a short videotape in English and in Spanish covering all of DCS's safety rules, including lockout/tagout (Exh. C-21, R-32). Employees are instructed in the training video never to reach into an auger, belt or conveyor to grab a piece of meat, fat, string, or solid product. (Exh. R-29, p.3). Tobin Schacher, DCS' contract manager testified that DCS employees were further instructed to hose down the running machinery from at least two feet away, and to stay away from pinch points (Tr. 168-69). Schacher testified that DCS conducted monthly safety meetings in English and Spanish, including April, July, and December 1992 safety meetings covering lockout/tagout procedures (Tr. 169, 172; Exh. R-19, R-22, R-25), and that locks were issued to the DCS cut floor clean-up crew (Tr. 172; Exh. R-27). Bernie Berigan, DCS' safety coordinator, testified that its program requires that employees be trained on individual pieces of equipment as well as in the general lockout/tagout requirements (Tr. 238-39).

Schacher stated that employees were disciplined for violations of the lockout/tagout rules with either suspension or termination (Tr. 173). Three employees

were reprimanded for lockout/tagout violations between January 1992 and the date of the accident; one was terminated (Exh. R-28). Each of the disciplined employees had suffered an injury (Tr. 183-84). Schacher stated he was unaware of any specific employee violations where no action was taken (Tr. 173, 179).

Schacher admitted that he wasn't usually on the cut floor because of his duties elsewhere (Tr. 173). He testified that he knew the DCS cleaning crew did not have much time to do its job, and suspected that DCS employees were reaching into the equipment they were cleaning while the equipment was running to avoid travelling all the way across the floor to lock out the machine (Tr. 165). Schacher stated that he did not encourage employees to bypass the lockout requirements, and that he couldn't catch them at it (Tr. 165, 179). Schacher was, however, aware of incidents where DCS employees got caught in the equipment, and admitted that IBP employees had told him, once or twice, of DCS employee's violating the lockout/tagout policy (Tr. 165). Schacher was also aware that there was a problem with "dry pickup," bones which could not be hosed out, but had to be removed by hand, at the loin saddle table (Tr. 167). Schacher knew that in 1990 an IBP employee had been killed at the same loin saddle table which is the subject of this action (Tr. 164). Schacher testified that there was no written procedure governing the removal of the dry pickup from the loin saddle table (Tr. 168).

Ervin Brabec, IBP's maintenance supervisor, testified that he worked the same shift as DCS employees approximately six days a month (Tr. 55, 68). Brabec testified that several times between 1990 and 1993 he saw DCS employees walking on tables that were running and/or reaching into tables or augurs that were not shut down, in order to clean out product (Tr. 63-64). Brabec stated that under IBP's lockout/tagout program the tables should have been locked out (Tr. 65). Brabec stated that he would signal the employee to stop and inform either Tobin Schacher, or Joel Zarate, DCS' spanish speaking supervisor, of the problem (Tr. 65). Brabec testified that Zarate generally promised to talk to the employee in question; Tobin would shrug his shoulders and walk away (Tr. 66).

Eddie Vela, IBP general maintenance, also testified that he had seen DCS employees walking on top of, and scrubbing tables that were still running (Tr. 87). Vela

stated that DCS employees would sometimes start working the same night they applied for a job (Tr. 93). Vela did not see DCS employees with lockout/tagout locks; on one occasion he saw Zarate ask an employee where his lock was. Zarate did not direct the employee, who had left his lock in a locker, to retrieve the lock (Tr. 96).

Doug Simmons, IBP's product control manager, testified that on a number of occasions between 1990 and 1993, he observed DCS employees reaching their hands into a conveyor or table to pick off product, walking on the main break tables while the tables were running, and using fat augers as ladders (Tr. 103-04). Simmons recalled incidents in 1991 and 1992 in which: 1) a DCS employee reached into a conveyor to grab a piece of fat that was spinning around a roller, catching his hand, immediately after Simmons and a DCS supervisor turned away from him during an inspection (Tr. 106); 2) an employee caught his hand in the rib belt and had to be cut loose (Tr. 107); 3) an employee caught his hand in the skinless belly belt, which had to be cut (Tr. 107). Simmons stated that he reported lockout/tagout incidents to either Schacher or Zarate. Simmons testified that these incidents were also reported to members of IBP's plant management (Tr. 105).

Steve Jarchow, IBP's safety director, also testified that he had, in 1991 and 1992, observed DCS employees working on and cleaning machinery that was not locked out, and reported it to Schacher (Tr. 115,116). On April 8, 1993, he sent Schacher a memo following an incident where Jesus Lopez, a DCS employee, caught his glove on the belt splice, pulling his hand into the belt pulley (Exh. C-6). Lopez received a written reprimand following the incident (Tr. 119; Exh. C-28).

Injury reports concerning DCS personnel were prepared for IBP management, including the plant manager, Mitz Bailey (Tr. 108). DCS' Schacher admitted that he had discussions with Bailey regarding DCS lockout/tagout problems. Schacher stated that he let his foremen know that anyone not following procedures would be suspended (Tr. 174-75).

Simmons stated that DCS' response to lockout/tagout incidents seemed to improve between 1990 and 1993; in 1993 Mitz Bailey signed an inspection report indicating that DCS' lockout/tagout program was operating satisfactorily (Tr. 106, 109). Harold Keast, DCS' midwest regional manager; Charles Andreasen, DCS operations manager; Michael

Kelly, DCS' area manager, all testified that routine inspections and audits failed to disclose problems with enforcement of the lockout/tagout program at the Madison plant (Tr. 223, 227, 252-55, 269-71). Lance White, DCS' president, testified that the company has reduced OSHA recordable injuries 64.8% since 1990, from 58.8 to 20.7 per year, (Tr. 281, 292).

As recently as October 1992, however, DCS's routine audit indicated that the safety program in Madison needed improvement in most areas, including orientation, meetings, safety checklists, lockout/tagout, and STOP check program (Exh. C-8). Moreover, Reynaldo Cervantes, an assistant area director with OSHA, testified that DCS remained above the national average of 14 for recordable injuries in the meat processing industry (Tr. 295).

On April 16, 1993, Salvadore Hernandez was cleaning the loin saddle table, when he was struck on the head and killed. The table had not been locked out, and was running at the time. (Tr. 114-15). The evidence establishes that Hernandez viewed DCS' safety videotape (Exh. R-13), attended all three of the 1992 lockout/tagout safety meetings (Exh. R-19, R-22, R-25), and when interviewed in December 1992 and March 1993, indicated that he understood the lockout/tagout requirements (Tr. 244, Exh. R-15, R-16).

Manuel Hernandez, the decedent's brother, testified that he worked for DCS for approximately a month and one half prior to the accident (Tr. 139). M. Hernandez stated that he was shown a short videotape on lockout/tagout procedures, and was taken to the area where he was going to work, where he was shown what to do (Tr. 139, 149). M. Hernandez was shown the on/off switch for the equipment he was to clean. He was not shown how to lock out the machinery, and was not issued a lock (Tr. 140). He was not told the dangers associated with failing to lock out the machinery; in fact, the supervisor himself put a rag through the machine while it was running (Tr. 141, 144). M. Hernandez stated that it was the common practice to clean the equipment without locking it out (Tr. 145, 151). M. Hernandez knew from the video that the equipment should have been locked out, but believed it was not done because there were no locks (Tr. 146).

Thomas Luna was on DCS' clean-up crew for four months. Luna stated that he was issued a lock three days after he started with DCS, but did not receive any lockout/tagout training. After the accident he was shown the panel box to lock out his machine; prior to that he merely shut off the machine with its emergency stop cable. Luna stated that it was common practice to clean the machinery without locking it out, because DCS was understaffed and the crew had to cut corners in order to get the job done. Luna stated that Joel Zarate, his supervisor, was aware of this practice. Luna further stated that after the accident the cleaning staff has doubled. Luna stated that when he worked for DCS in 1989 and 1990 it was Joel's common practice to have the Spanish speakers sign off on training documents without reading them; some were illiterate and could not read them. On the day of the accident, his clean up crew, including the "blue hats," or trainers, had left their locks in their lockers. (Exh. C-30).

Jose Hernandez worked for DCS shortly a year before the accident, and was hired again two days before the accident. J. Hernandez stated that he had not been issued a lock prior to the accident. A blue hat showed him how to shut off the machinery, but did not train him on lockout/tagout procedures. J. Hernandez stated he pulled product off the lines while the line was running, and that he had seen employees climbing on the belts while they are running. He stated that now "[i]f you get caught you will get in trouble. It wasn't like that before the accident" (Exh. C-31).

Eusebio Morelos worked for DCS on clean-up for three months. Morelos stated that upon his initial hire, a blue hat showed him the area he needed to clean and how to shut the machine off, but nothing about lockout/tagout procedures. He was not issued a lock for the first month. Before the accident Morelos cleaned the blending machine without locking it out. He never felt that he would get into any trouble for not locking out the blender because all the employees climbed over, and reached into and under the conveyors and ham and loin lines; and because Joel was on the floor and he did not do anything about it. Morelos stated that the victim was working for the first time on the loin line on the night of the accident, and that Joel, who was supposed to train him on that machine, did not show up until after the accident. Morelos stated that he could not tell the truth the first time he was interviewed because Joel was interpreting (Tr. C-32).

Jose Cortez worked on DCS's Madison clean-up crew for five months. Cortez testified that it was common practice to reach into and climb over moving belts to save time. Joel caught Cortez a couple of times picking up product from the moving belts and verbally reprimanded him; at other times Joel said nothing to him about climbing over moving belts. Cortez stated that he told Joel that there was not enough time to clean and still perform lockout/tagout. Cortez felt that he had Joel's tacit permission not to use lockout procedures. (Exh. C-33).

Jesus Lopez worked on clean-up for two months. Lopez stated that he did not receive formal lockout/tagout training until after the accident. He was issued a lock but was not told how to use it. He did not know whether the machine he was taught to clean was locked out while he was being trained, but stated that after training he simply shut the machine off. After the accident he began locking the machine out. (Exh. C-34).

Epifanio Ortiz worked on clean-up for three months. Ortiz stated that he was not trained to lock out the machine he cleaned. His training included only the location of the on/off switch. Joel watched Ortiz clean his machine without locking it out and said nothing. Ortiz did not feel that locking out the machines was required prior to the accident. (Exh. C-35).

Rudy Andaverde, a contract manager with DCS, testified that when quizzed the day after the accident, the members of the cut floor clean-up crew correctly demonstrated lockout/tagout procedures (Tr. 219-20).

DCS received OSHA citations twice in 1990 for failing to follow lockout/tagout procedures (Tr. 189; Exh. C-16 through C-19 and C-36 through C-39), including citations for failing to provide means of enforcing compliance with lockout/tagout procedures, and for cleaning machinery while it was running (Tr. 190).

Alleged Violation of 1910.147(c)(4)(ii)

Willful citation 1, item 1a alleges:

29 CFR 1910.147(c)(4)(ii): The energy control procedures did not clearly and specifically outline the scope, purpose, authorization, rules, and techniques to be utilized for the control or hazardous energy, including, but not limited to Items A-D of this section:

The specific energy control procedures developed for machines/equipment such as, but not limited to, the loin pulling table, main break conveyor, main chain, loin pace saddle table, etc. were not adequate because sufficient provisions were not made to insure the translation of these procedures to the non-English speaking employees. These failures exposed servicing employees to the hazardous release of energy during the time period of April 13, 1993 to April 16, 1993.

The cited standard provides:

(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. (ii) The procedures shall clearly and specifically outline the scope, purpose, authorization, rules, and techniques to be utilized for the control of hazardous energy. . ..

Discussion

Here the conduct complained of by the Secretary does not establish a violation of this subsection. This subsection requires the employer to develop a written lockout/tagout procedure. At the hearing the Secretary stipulated Respondent had an adequate written lockout/tagout procedure, and that the alleged objectionable conduct was Respondent's failure to communicate its procedure to its workers in Spanish (Tr. 62). The failure to adequately communicate the procedure, if any, is a training issue that should be raised under the training subsection. In light of the Secretary's stipulation and the failure of proof, this item is vacated.

Alleged Violation of §1910.147(c)(5)(i)

Willful citation 1, item 2 alleges:

29 CFR 1910.147(c)(5)(i): Locks, tags, chains, wedges, key blocks, adapter pins, self-locking fasteners, or other hardware were not provided by the employer for isolating, securing or blocking of machines or equipment from energy sources:

Servicing employee performing cleaning operations on machinery/equipment such as, but not limited to, the loin pulling table, main break conveyor, main chain, loin pace saddle table, etc. was not provided the locks required to complete energy isolation on this machinery/equipment exposing these employees to the hazardous release of energy such as occurred on April 16, 1993 which resulted in an employee fatality.

The cited standard provides:

(5) *Protective materials and hardware.* (i) Locks, tags, chains, wedges, key blocks, adapter pins, self-locking fasteners, or other hardware shall be provided by the employer for isolating, securing or blocking of machines or equipment from energy sources.

Discussion

The uncontradicted evidence establishes the cited violation. Manuel Hernandez was not issued a lock in the month and a half he worked for DCS prior to the decedent's accident, though he was told he was supposed to lock out equipment when he needed to reach into the machinery to clean it. Jose Hernandez was never issued a lock; Eusebio Morelos did not receive a lock until he had worked for DCS a month.

Respondent maintains that the statements of the employees on which this citation is based should not be credited because Hernandez is the brother of the decedent and party to a civil lawsuit based on the incident in question, and because the statements of the other two absent witnesses contain information which is contrary, in some respects, to information contained in earlier statements.

This judge finds the statements in evidence to be credible. The original employee statements were translated by a DCS supervisor, Zarate. Zarate was the supervisor on the cut floor at the time of the accident. OSHA Compliance Officer (CO) Frank Winningham testified that he had good reason to believe, based on the employees' body language, and the discrepancy between the length of their answers and the answers provided by Zarate, that the original statements were inaccurate (Tr. 199-200). The later statements of the absent witnesses are generally consistent with the testimony of IBP employees, who testified that they observed DCS employees failing to use lockout/tagout procedures and observed them on the job without locks. Moreover, the portions of those statements specifically relevant to this item are uncontradicted by any testimony or evidence submitted by DCS. DCS produced a single list of employees who received locks in December 1992 (Exh. R-27); neither M. Hernandez, J. Hernandez, nor Morales are listed. DCS produced no evidence that any locks were issued after December, 1992, though its workforce appears to consist largely of temporary or transient laborers.

The cited violation has been established and will be affirmed.

Alleged Violation of §1910.147(c)(7)(i)

Willful citation 1, item 3 alleges:

29 CFR 1910.147(c)(7)(i): The employer did not provide adequate training to ensure that the purpose and function of the energy control program was understood by employees:

> Servicing employee who performs cleaning operations on machinery and equipment such as, but not limited to, the loin pulling table, main break conveyor, main chain, loin pace saddle table, etc. training was not adequate in the specific knowledge and skills required for the safe application, use and removal of energy controls, thereby exposing the employee to the hazardous release of energy such as occurred on April 16, 1993 which resulted in an employee fatality.

The cited standard provides:

> (7) *Training and communication.* (i) The employer shall provide training to ensure that the purpose and function of the energy control program are understood by employees and that the knowledge and skills required for the safe application, usage, and removal of the energy controls are acquired by employees. The training shall include the following:
>
> (A) Each authorized employee shall receive training in the recognition of the type and magnitude of the energy available in the workplace, and the methods and means necessary for energy isolation and control.
>
> (B) Each affected employee shall be instructed in the purpose and use of the energy control procedure.
>
> (C) All other employees whose work operations are or may be in an area where energy control procedures may be utilized, shall be instructed about the procedure, and about the prohibition relating to attempts to restart or re-energize machines or equipment which are locked out or tagged out.

Discussion

The testimony of both DCS and IBP employees establishes that DCS' lockout/tagout program, though adequate as written, was not adequately communicated to DCS employees, *i.e.* they were not adequately trained. M. Hernandez stated that he was told to lock out the equipment he was assigned to clean, but was not shown how to do it, did not receive the lock he needed to do it, and was shown how to run a rag through the machine while it continued to run. Luna, J. Hernandez, Morelos, Lopez, Ortiz all testified that they did not receive formal training on locking out the equipment they were assigned to clean, did not lock it out, and only shut it off to clean it. Luna, J.

Hernandez, Morelos, Cortez and Ortiz all stated that Zarate, their supervisor, was aware of the practice and condoned it. Brabec, Vela, Simmons and Jarchow all substantiate the prevalence of lockout/tagout violations by DCS workers. Even Schacher admitted he suspected the practice, though he did not personally observe it.

The evidence establishes DCS did not make adequate efforts to train its employees to ensure that they understood the purpose and function of the lockout/tagout program. Despite lockout/tagout rules to the contrary, it was the common practice of DCS employees to climb upon and reach into the equipment they were cleaning while it continued to run. Moreover, the record shows that the practice was known to DCS supervisory personnel and had their tacit approval. Despite the prevalence of the practice, no disciplinary action was ever taken against an employee except where a violation resulted in an accident report being filed. Respondent's training, such as it existed, was undermined and rendered valueless by local management's tacit approval of widespread non-compliance with the rules.

Citation 1, item 3 is affirmed.

Alleged Violation of §1910.147(d)(1)

Willful citation 1, item 4 alleges:

29 CFR 1910.147(d)(1): The authorized employee did not have knowledge of the type and magnitude of the energy, the hazards of the energy to be controlled, and the method or means to control the energy before the authorized or affected employee turned off the machine or equipment in preparation for the shutdown.

> Servicing employee performing cleaning operations on machinery and equipment such as, but not limited to, the loin pulling table, main break conveyor, main chain, loin pace saddle table, etc. lacked knowledge of the type or hazards of the energy to be controlled as indicated by the employees use of start/stop buttons and emergency shutoff cables in place of lockout and tagout for the control of hazardous energy.

The cited standard provides:

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

Discussion

Item 4 alleges a failure to provide adequate training to authorized employees, as does item 3. Training which properly addresses the recognition of energy control hazards and the methods and means of eliminating those hazards would abate both violations. Items 3 and 4 are duplicative in that they are based on a single course of conduct by Respondent, and require the same abatement conduct. *See; J. A. Jones Construction Co.*, 15 BNA OSHC 2201, 1993 CCH OSHD ¶29,964 (No. 87-2059, 1993). Item 4 is, therefore, vacated.

Alleged Violation of §1910.147(d)(3)

Willful citation 1, item 5 alleges:

29 CFR 1910.147(d)(3): All energy isolating devices that were needed to control the energy to the machine or equipment was not physically located and operated in such a manner as to isolate the machine or equipment from the energy source.

> Servicing employee performing cleaning operations on machinery and equipment such as, but not limited to, the loin pulling table, main break conveyor, main chain, loin pace saddle table, etc. did not locate the energy isolating devices and operate them as to eliminate the hazards of the unexpected start up or the hazardous release of energy which occurred on April 16, 1993 resulting in a fatality.

The cited standard states:

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

Discussion

It is undisputed that on April 16, 1993, the loin saddle table was not turned off or locked out when S. Hernandez crawled under it, resulting in his death.

DCS raises the affirmative defense of unpreventable employee misconduct. The Commission has held that "[i]n order to establish an unpreventable employee misconduct defense, the employer must establish that the violative conduct on the part of an employee was a departure from a uniformly and effectively communicated and enforced

work rule." *Mosser Construction Co.* 15 BNA OSHC 1408, 1414, 1991 CCH OSHD ¶29,546, p. 39,905 (No. 89-1027, 1991). As discussed above, DCS' lockout/tagout program was not enforced at its Madison worksite, and so the employee misconduct defense is not available to DCS. Citation 1, item 5 is affirmed.

Willful Characterization

The record establishes that DCS' supervisory personnel routinely ignored and thereby encouraged a pattern of employee noncompliance with DCS' lockout/tagout program.

Locks were not issued in a timely manner to new employees making their compliance with lockout/tagout procedures impossible.

Despite repeated injuries and warnings from IBP personnel, neither Schacher nor Zarate, the supervisory personnel at the Madison worksite, made any effort to insure compliance with the lockout/tagout program on the cut floor. Schacher admitted he suspected employees of bypassing the lockout rule, but made no efforts to halt the practice. Zarate was aware that employees did not bring their locks with them to the cut floor, but did not require them to do so. In spite of the widespread pattern of noncompliance with lockout/tagout procedures, DCS never formally reprimanded employees unless violation of the rules resulted in an injury, triggering reporting requirements requiring disclosure of the cause of injury. Only injured employees received lockout/tagout reprimands.

The Commission has held that "[t]he employer is responsible for the willful nature of its supervisors' actions to the same extent that the employer is responsible for their knowledge of violative conditions." *Secretary of Labor v. Tampa Shipyards, Inc.* 15 BNA OSHC 1533, 1539, 1991 CCH OSHD ¶29,617, p. 40,101, (Nos. 86-360, 86-469, 1992). DCS on site management had actual knowledge that its employees routinely and repeatedly violated lockout procedures. They condoned this conduct to such an extent so as to have actively encouraged it. On occasion, such as when locks were not issued, management actually prevented compliance. The violations were properly characterized as "willful."

Penalty

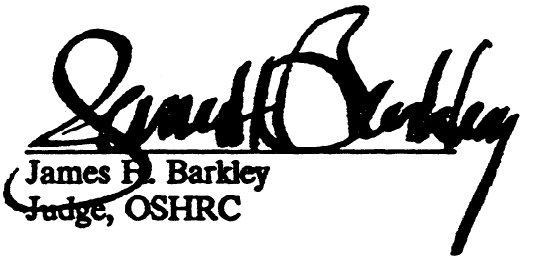
DCS is a large employer with 1,100 total employees. It was cited twice before, in October 1990, for OSHA violations, including violations of the lockout/tagout standard. The gravity of the violation could not have been greater, as evidenced by the fatality. Based on the size of the employer, the willful nature of the violation, and the gravity of the cited hazard, I find that assessment of the proposed penalty of $70,000.00 for each violation is appropriate.

Findings of Fact and Conclusions of Law

All findings of fact and conclusions of law relevant and necessary to a determination of the contested issues have been found specially and appear in the decision above. See Rule 52(a) of the Federal Rules of Civil Procedure.

ORDER

1) Willful citation 1, item 1, alleging violation of §1910.147(c)(4)(ii) is VACATED.
2) Willful citation 1, item 2, alleging violation of §1910.147(c)(5)(i) is AFFIRMED, and a penalty of $70,000.00 is ASSESSED.
3) Willful citation 1, item 3, alleging violation of §1910.147(c)(7)(i) is AFFIRMED, and a penalty of $70,000.00 is ASSESSED.
4) Willful citation 1, item 4, alleging violation of §1910.147(d)(i) is VACATED.
5) Willful citation 1, item 5, alleging violation of §1910.147(d)(3) is AFFIRMED, and a penalty of $70,000.00 is ASSESSED.



James H. Barkley
Judge, OSHRC

Dated: April 7, 1995