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

SECRETARY OF LABOR, Complainant, v. DUKANE PRECAST, INC., Respondent.	OSHRC DOCKET NO. 12-1646

APPEARANCES:
David J. Tanury, Esquire
Mark H. Ishu, Esquire
U.S. Department of Labor, Chicago, Illinois
For the Secretary

Paul J. Waters, Esquire
Waters Law Group, Clearwater, Florida
For the Respondent

BEFORE: Carol A. Baumerich
Administrative Law Judge

DECISION AND ORDER

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). On February 7, 2012, the Occupational Safety and Health Administration (OSHA) began an inspection of the 1807 High Grove Lane, Naperville, Illinois (worksite or facility) location of Dukane Precast, Inc. (Respondent or Dukane), in response to a

reported accident. An employee was engulfed and trapped in an aggregate sand bin or silo at Dukane's facility the prior day, February 6.

On July 25, 2012, OSHA issued to Respondent a three item serious citation and a one item willful citation and notification of penalty (citation).[1] The serious citation items allege that, on or about February 6, 2012, Respondent did not maintain a standard railing adjacent to batch plant sand bins that are permit-required confined spaces, in violation of standard 1910.23(c)(3); Respondent did not secure batch plant sand bins #1 and #2 from employee entry, in violation of standard 1910.146(d)(1); and Respondent did not prepare entry permits for permit-required confined spaces in the batch plant, known as sand bins #1 and #2, in violation of standard 1910.146(e)(1). The willful / serious citation item alleges that, on that date, Respondent did not implement procedures for immediately summoning emergency services upon discovery of an employee engulfed in sand within a permit-required confined space and Respondent did not implement procedures for preventing unauthorized co-workers from entering a permit-required confined space and attempting a rescue of an employee engulfed in sand, in violation of standard 1910.146(d)(9). The total penalty proposed is $70,000.00.

The Secretary filed a Complaint. Respondent filed an Answer that raised six affirmative defenses: (1) unforeseeable isolated occurrence / employee misconduct, (2) infeasibility / impossibility of compliance, (3) unconstitutional vagueness, (4) lack of knowledge, (5) good faith, and (6) preemption / inapplicable standard. [2]

A 4-day hearing was held in Chicago, Illinois, from June 11 through 14, 2013. Both parties filed post hearing briefs. For the reasons set forth below, the citation items are affirmed and a total penalty of $70,000.00 is assessed.

Jurisdiction

Based on the record, I find that at all relevant times Dukane was engaged in a business affecting commerce and was an employer within the meaning of Sections 3(3) and 3(5) of the Act. I also find that the Commission has jurisdiction over the parties and subject matter in this case. (Tr. 14; JX-1, Stips. 1 and 2).

[1] The Secretary's Complaint amended Citation 2, Item 1 to allege that the willful violation, in the alternative, constitutes a serious violation within the meaning of Section 17(k) of the Act. Complaint ¶ IV(b).
[2] Defenses not pursued at the hearing or in post-hearing briefs are deemed abandoned. *See Georgia-Pacific Corp.*, 15 BNA OSHC 1127, 1130 (No. 89-2713, 1991).

Background and Factual Findings[3]

The Company

Dukane is a manufacturer of precast concrete products used in building construction. (JX-1; CX-42 at 5). Dukane has three production locations in Illinois: Aurora, Plainfield, and Naperville. (Tr. 23). Approximately 90 employees worked for Dukane; 50 of those worked at the Naperville facility. (Tr. 44).

Dukane's corporate structure includes several supervisory levels: corporate officers, board members, managers, supervisors, and leadmen. In February 2012, Scott Wehrli was the corporate secretary-treasurer of Dukane and a member of the board of directors. (Tr. 45-47, 109). Dukane's president, Grant Ripper, reported to Dukane's board of directors, including Wehrli. (Tr. 47).

Dukane employed Tom Gorman as the safety director and Michelle Lenz as the human resources manager, at the time of the inspection. (Tr. 105, 110, 513-14). Gorman and Lenz also performed work for the other companies affiliated with Dukane.[4] (Tr. 441, 450, 513-514, 1034-35). Gorman reported directly to Wehrli. (Tr. 516). Lenz testified that, while Dukane's organizational chart listed Ripper as her supervisor, she received her instructions from Wehrli. (Tr. 440). Norma Trevino was a human resources specialist and reported to Lenz.[5] (Tr. 110).

At the time of the inspection, Naperville's plant manager was Don MacKenzie. MacKenzie had been the Naperville plant manager since October 2005; he started working for Dukane in 2003 as a shipping supervisor. (Tr. 850). In 2009, MacKenzie became the plant manager of both the Naperville and Plainfield production facilities. (Tr. 850). MacKenzie's direct supervisor was company president Ripper. (Tr. 1036).

Quality control supervisor Kevin McMillan and double-wall pouring operation supervisor Rudy Huerta reported to MacKenzie. (Tr. 108-09, 902). Jamie Marin and [redacted] were both leadmen at the Naperville facility. Leadmen were responsible for managing laborers, delegating work, and enforcing and abiding by safety rules. (Tr. 694-96, 1036; CX-50). Michael Morrero

[3] The factual findings are based on the credible record evidence, as discussed below, and consideration of the record as a whole. Contrary evidence is not credited.

[4] Dukane was in a family of companies which included Naperville Excavating, T&W Trucking, Diamond Ready-Mix, and Mustang Construction. (Tr. 513-514).

[5] Gorman, Lenz, and Trevino testified at the hearing. Gorman and Lenz were no longer employed by Dukane at the time of the hearing. Trevino was the human resources manager at the time of the hearing. (Tr. 435, 513, 984-85).

and Christopher Cerecedes were laborers hired through a temporary staffing company. (Tr. 114). Morrero's supervisor at Dukane was leadman [redacted]. [6] (Tr. 107-08).

The Batch Plant

The batch plant was the area of the Naperville facility where the precast concrete products were made. (Tr. 697). The concrete components, such as sand and aggregate, were stored, dispensed, and mixed in the batch plant. (Tr. 742-43, 816). The batch plant consisted of a row of 5 large bins or silos[7] with conveyor belts above and below. Each bin was approximately 25 feet tall, 10 feet wide and 18 feet deep. (CX-3, CX-4). The 5 bins abutted each other along their 18-foot sides, forming a 50-foot length of bins.[8] (CX-3, CX-4). Each bin was rectangular in shape at the top and then tapered to a cone shape at the bottom where a "clamshell gate" opened and closed. (Tr. 57-59; CX-2).

A conveyor belt running above the bins filled each bin with material or aggregate. (Tr. 914, CX-3). Gravity brought the aggregate in a bin down to a clamshell gate at its bottom, which then opened to deposit the aggregate onto the conveyor belt that ran below the bins. (Tr. 59). The conveyor belt moved the aggregate into a skip hoist, at the conveyor's end near bin #1, which then transferred the aggregate into the cement mixer. (Tr. 57; CX-2). After the concrete was mixed, it was poured into forms to create precast concrete products in the work area known as the "production floor" or "pouring floor." (Tr. 957-58).

Near the top of the bins, 20 feet above the floor, a 50-foot long elevated work platform extended parallel and immediately adjacent to the 5 bins. (CX-2). At the end of the platform, next to bin #5, a 20-foot fixed, vertical, caged ladder created the entry point to the platform. (Tr. 64; CX-2, CX-11). The platform's south side was adjacent to and ran east-to-west along the 50-foot length of bins. The north side of the platform was open to the facility and had a standard fixed guardrail running its entire length and around the end of the platform by bin #1. (CX-11, CX-15). There was no fixed guardrail or other railing along the bin-side of the platform.[9] (CX-

[6] Wehrli, MacKenzie, McMillan, Huerta, and Cerecedes testified at the hearing.
[7] The credible evidence reveals that the employees, including those in supervisory positions, interchangeably referred to the batch plant aggregate bins as either "bins" or "silos." *See* footnote 28 below.
[8] The bins are numbered sequentially starting with #1 at the end of the platform by the skip hoist through #5 at the start of the platform next to the access ladder. (Tr. 55; CX-2).
[9] The testimony of quality control supervisor McMillan that there was a guard rail next to bin #2 that he climbed over to enter bin #2, during the rescue attempt, is given no weight. (Tr. 841-42). McMillan's testimony, in this regard, is inconsistent with the description given by the other witnesses.

10). On the platform edge next to the bins, the side wall of the bin #2 extended about 27 inches above the floor of the platform. (Tr. 80-82; CX-22, CX-23). Bin #1 had a job-made wooden ladder clipped onto the side for access down into the bin from the work platform. Likewise, bin #2 had a removable fabricated metal ladder clipped onto the side for access down into the bin from the work platform. (Tr. 83, 726-30; CX-17, CX-28).

[redacted] was the leadman for the batch plant area. (Tr. 695). He was trained to operate the batch plant at each Dukane facility. (Tr. 698). Employees used the work platform to visually check the level of sand and aggregate in the bins or silos, to scrape the bin sides with a long-handled tool, and to enter the bins to level out the material.[10] (Tr. 64, 132, 155, 195, 199, 311-14, 407-08, 700-05, 727-30, 750-57, 867-68, 949; CX-11). Morrero and [redacted] entered the bins to level out the sand and aggregate. (Tr. 132, 400). One would stand as the attendant and the other would enter the bin. On the day of the engulfment, they were short-staffed so [redacted] did not take anyone with him to serve as an attendant. (Tr. 132).

The ladder in the bin allowed an employee to enter the bin to scrape down the sand crusted on the bin side. (Tr. 727). [redacted] stated that he built the wooden ladder for bin #1 in Naperville's carpentry shop. (Tr. 727-28). The metal ladder he had been using was too short;[11] he needed a longer ladder so he "had something to stand on" when he was working with the material in the bin. (Tr. 727). Morrero helped him build the ladder, take it up to the work platform, and put it in bin #1. (Tr. 728, 756-57). Plant manager MacKenzie observed [redacted] build this ladder.[12] After it was attached, the bottom of the wooden ladder was near the point where the bin started to slant toward the clamshell gate. (Tr. 727-28).

The Naperville facility produced a particular concrete product, so it was not always operational. It had restarted not long before the day of the accident; it had been non-operational for several weeks. (Tr. 386-87, 479-82, 701, 753). Because the Naperville facility had not been used recently, [redacted] had to scrape the sand crusted on the bin side to the middle of the bin to mix with new sand to prevent it from drying out completely. (Tr. 700-01). A long-handled tool was used to scrape the sand from the bin wall. (Tr. 703, 866-67) The sand's moisture content

[10] MacKenzie acknowledged that he had stood on the platform to visually check the level of the material in the bins. He also knew that [redacted] had used the platform to check the level of the bin material and to scrape sand off the bin walls with the long-handled tool. (Tr. 867-68, 949). Further, I find that MacKenzie knew employees used the platform and entered the bins or silos to level out the sand and aggregate. *See* footnotes 15 and 18 below and accompanying text.

[11] The metal ladder is shown in a photograph of bin #2 where [redacted] was engulfed. (Tr. 83; CX-17).

[12] [redacted] testimony is credited: MacKenzie's denial is not. (Tr. 728, 871-72).

was critical to achieving the right mixture of components to create the precast concrete panels. (Tr. 642, 746).

MacKenzie, the plant manager, was aware that the moisture content of the sand could cause problems with the sand flow to the conveyor. (Tr. 863-64). MacKenzie knew employees would scrape sand off the sides of a bin from the work platform with a 9-foot to 10-foot long scraper. (Tr. 866-67, 949). There had been problems with sand flow in the bins.[13] A bin wall vibrator was already attached to the external wall of at least one bin.[14] (Tr. 74; CX-7, CX-18). Additionally, a photograph of bin #2 showed the marks made, near the bottom, by a tool striking its sides to dislodge material. (Tr. 60-61, 120; CX-8).

The Engulfment & Rescue – February 6, 2012

On the day of the accident, [redacted] arrived for work at his usual time of 6:00 a.m. (Tr. 718). [redacted], a batch plant operator and leadman, had worked for Dukane since 2003 or 2004. (Tr. 694). At approximately 9:30 a.m., [redacted] finished his break and had a conversation, in the batch plant area, with the plant manager, MacKenzie. (Tr. 118-19, 699; CX-6). [redacted] discussed the issue of sand flow in the aggregate bins and told MacKenzie that he was going up to level out the sand in the bins. (Tr. 699-701). [redacted] told MacKenzie that he was going to enter the bins to level out the sand.[15] (Tr. 700-02). [redacted] wanted to move the

[13] The morning of the engulfment [redacted] discussed with MacKenzie using vibrators to knock some of the material from the bin walls, which would require placing brackets on the bins and attaching a portable vibrator. (Tr. 119-20, 699-700).

[14] During the inspection, OSHA Compliance Officer (CO) Lake observed bin wall vibrators, used to enhance the bin aggregate flow, attached to exterior bin walls. Bin #s 1, 2, and 3, did not have bin wall vibrators. (Tr. 74, 120; CX-18).

[15] MacKenzie's recollection of their discussion differs. During the inspection, MacKenzie told the CO that he understood that [redacted] was going to be cleaning around the bottom of the batch plant on the factory floor. (Tr. 118-19, 359-60, 385-86). At the hearing, MacKenzie recalled [redacted] stating that he would be working in the general area of the batch plant where the spreader normally sits. (Tr. 659-62). At the hearing, when testifying under oath, MacKenzie's recollection of his conversation with [redacted] that morning was poor. (Tr. 856-58). In contrast, [redacted] specifically remembered that he told MacKenzie that he was going up to level out sand in the bins. (Tr. 702).

MacKenzie's denial that [redacted] told him that [redacted] would enter the sand bins that morning is not credited. (Tr. 915, 940). Not only is MacKenzie's denial contrary to [redacted]' credited testimony, but MacKenzie's denial is markedly at odds with his matter-of-fact reaction upon seeing [redacted] in the sand bin that day. MacKenzie's nonchalant reaction upon seeing [redacted] in the sand bin is consistent with [redacted]' recollection of their conversation and MacKenzie's knowledge that [redacted] planned to work in the sand bins that day. *See* footnote 18 below.

I observed the demeanor of both MacKenzie and [redacted] as they testified. [redacted]' recollection of his conversation with MacKenzie was certain and candidly stated. In contrast, MacKenzie's recollection of this conversation lacked detail. MacKenzie's testimony was hesitant and revealed a poor recollection of the facts. I found [redacted] to be a more credible witness whose clear recollection of the relevant events was more trustworthy.

old material in the bin to the middle before receiving the shipment of new sand, to prevent a problem with the batches. (Tr. 700-01). MacKenzie then left the area and [redacted] climbed the access ladder, onto the work platform, and walked to bin #1. (Tr. 702-03, 859, 862).

[redacted] tied one end of a yellow rope around his waist and tied the other end to the guardrail "just in case something happened."[16] (Tr. 703-04). From the platform, [redacted] used a long-handled tool to scrape material off the side of bin #1. (Tr. 703). He then climbed down the wooden ladder into bin #1 to level out the sand. (Tr. 705). He was in bin #1 for 5 to 10 minutes. (Tr. 705). He then he climbed out and walked over to bin #2. (Tr. 706).

Again, [redacted] stood on the platform and used the long-handled tool to remove sand from the side of bin #2. (Tr. 706). Using the metal ladder, [redacted] entered bin #2 at about 9:50 a.m. (Tr. 121, 706). Shortly after Mr. [redacted] entered bin #2, the sand inside the bin began to collapse around him. (Tr. 706). As [redacted] held onto the yellow rope, the sand came up to his armpits. (Tr. 706, 713). He started screaming for help and the sand collapsed further burying him up to just below his neck. (Tr. 713). Production floor leadman Jaime Marin, who was working in the carpenter shop area, heard [redacted]' cries for help and immediately went to help. (Tr. 121, 708). Marin came up to the platform and looked "spooked" when he saw [redacted] trapped in the bin. (Tr. 121-22, 709). Immediately Marin descended the ladder into bin #2 and started to dig sand away from [redacted]. (Tr. 121-22). Quality control supervisor Kevin McMillan followed Marin to the platform and also entered the bin to assist in the rescue. (Tr. 121-22). McMillan tied another thicker rope around [redacted]; he was concerned that the yellow rope that [redacted] had around him would not be strong enough to keep [redacted] from slipping further down into the silo. (Tr. 839-40, 842)

[redacted] testified that when the sand collapsed he had trouble breathing; with each breath the sand felt tighter on his chest. (Tr. 710. *See* Tr. 378, 380). During the rescue attempt, the employees knew that [redacted] was in pain; he told the employees in the bin to get away

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Where there are conflicts between MacKenzie's testimony and the testimony of other witnesses, including [redacted], MacKenzie's testimony is not credited.

[16] [redacted] recalled, from Gorman's safety meetings that he should use a safety harness and tie-off before entering the bins. He didn't have an attachment point for a safety harness, so instead he used the yellow rope. (Tr. 703-05, 755-56. *See* also Tr. 131-32).

I observed safety director Gorman testify and found him to be a generally credible witness. [redacted]' testimony that he had received instruction from Gorman regarding safe entry into the aggregate bins is credited. Therefore, Gorman's testimony that he did not know any employees, other than maintenance employees, would enter the sand bins is given no weight. (Tr. 332, 408, 529-30, 540, 556, 618, 641-43).

from the sand at his back because the added pressure increased his pain. (Tr. 192, 201, 234-35, 274, 349-50, 711-12).

Other employees soon joined Marin and McMillan in attempting to dig [redacted] out -- first, using their hands, then shovels and buckets. (Tr. 122-23). A few minutes later, Rudy Huerta, double-wall pouring supervisor, was told employees were trying to rescue [redacted]. (Tr. 123, 715). Supervisor Huerta immediately called his boss, plant manager MacKenzie. (Tr. 874, 967). Huerta and yard supervisor Roy Meacham then went up the access ladder onto the work platform and saw [redacted] engulfed in the sand. (Tr. 123). Laborer Morrero brought laborer Cerecedes to help with the rescue, at Huerta's request.[17] (Tr. 183-84).

Using 5-gallon buckets, the rescuers formed a bucket brigade; a bucket would be partially filled and then lifted up to Huerta who then dumped the sand into bin #1. (Tr. 714-15, 838-39). The rescuers took turns in the bin; due to the physical strain of digging and lifting buckets of sand, employees had to take rest breaks during the rescue attempt. (Tr. 128).

In an attempt to prevent the further collapse of sand, the employees placed wood shoring next to [redacted]. (Tr. 716-17, 722). The employees were able to remove sand down to around [redacted]' waist. (Tr. 717). However, the employee rescuers made no further progress. (Tr. 716). The employee rescuers also attempted to extract [redacted] using the rope and a mechanical winch ("come-along"). (Tr. 130). However, this was discontinued as it did not help remove [redacted] from the sand and caused [redacted] additional pain. (Tr. 723).

Plant manager MacKenzie testified that when he learned about [redacted]' engulfment from Huerta, he went up to the platform; he saw [redacted] trapped in the sand and the other employees in the bin attempting to rescue [redacted]. (Tr. 874-76). At that time, MacKenzie saw that the sand had been removed to about the level of [redacted]' waist. (Tr. 877). Notably, MacKenzie did not express surprise to find [redacted] located in aggregate bin #2. MacKenzie's lack of surprise is consistent with [redacted]' credible testimony that [redacted] had advised MacKenzie, earlier that morning, that [redacted] planned to work that day leveling the sand in the bins.[18] (Tr. 699-701)

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[17] Both Morrero and Cerecedes were employed at Dukane through temporary employment agencies. (Tr. 114, 122-24, 278-79).

[18] MacKenzie's matter-of-fact, unsurprised, reaction to finding [redacted] located inside aggregate bin #2 is also consistent with [redacted]' credited testimony that [redacted] had previously entered the aggregate bins to level out aggregate and sand. (Tr. 700-02, 704, 727-29, 750-57). MacKenzie's unsurprised reaction is consistent with the finding herein that MacKenzie knew [redacted] had entered the aggregate bins on previous occasions to level the

MacKenzie believed the employees could free [redacted] from the sand. (Tr. 882). After a few minutes, MacKenzie left the platform because he trusted Huerta to "handle the situation." (Tr. 882). He did not order the employees out of the bin. He did not call 911 as specified in Dukane's emergency policy. MacKenzie left the batch plant area and went to the facility's shipping area. (Tr. 917). At that time, MacKenzie did not report [redacted]' engulfment to his supervisor, company president Ripper. (Tr. 919-20). Despite seeing several employees quickly working to move large amounts of heavy sand in an effort to free [redacted], plant manager MacKenzie continued on with his normal routine. MacKenzie testified that he thought because [redacted] was able to joke with him, that [redacted] was in no danger.[19] (Tr. 877-879). MacKenzie was the only person who reacted to [redacted]' engulfment with inaction and nonchalance. The others all immediately took action to rescue [redacted], recognizing the emergency unfolding and [redacted]' dire need for assistance.

[redacted] testified that "[a]fter a while, you know, of digging, then I started wondering, you know, if anybody had called the fire department." (Tr. 710). [redacted] had initially asked if anyone had called the fire department when some of the sand had been removed and he was better able to breathe. (Tr. 712). Cerecedes confirmed that shortly after employee rescuers first entered the bin, [redacted] asked if 911 had been called.[20] (Tr. 194, 274-75).

Later, when plant manager MacKenzie returned to the batch plant area,[21] Huerta shouted down that [redacted] had requested a call to 911. (Tr. 887, 920, 977). MacKenzie then asked Huerta, "Do you feel confident in getting [[redacted]] out of there?"[22] (Tr. 887). Because Huerta did not seem confident about the employees' ability to extract [redacted] from the sand, MacKenzie called 911. (Tr. 887-889). The call was made at 11:23 a.m. – about 1 ½ hours after

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material in the bins. [redacted] credibly testified that MacKenzie observed [redacted] build the wooded ladder for bin #1. (Tr. 728). *See* footnote 12 above. [redacted] credibly testified that safety director Gorman taught him to use fall protection before entering the sand bins. (Tr. 703-05, 755-56). *See* footnote 16 above. MacKenzie's denial of knowledge that any employee, other than maintenance employees, ever worked in the aggregate bins is not credited. (Tr. 865).

[19] MacKenzie's testimony that he did not believe [redacted] was in danger is not credible. MacKenzie's testimony is inconsistent with the credible testimony of the other eyewitnesses that day, the urgency in the other employees' behavior, and is not objectively plausible. (Tr. 200-05, 231-35, 239, 380, 397-98, 972, 980). *See* footnote15 above.

[20] Cerecedes had worked at a Dukane facility, as a laborer, since June 2011. (Tr. 179-80, 197). As an eyewitness to the events around the engulfment, his testimony is fully credited. I observed Cerecedes' demeanor, as he testified on direct and cross-examination. I found his testimony to be candid, unhesitant, consistent, and credible. (Tr. 178-279, 287-90).

[21] The record does not provide an exact time; however, based on the evidence, the time span from when MacKenzie left the area and then returned later, was between 45 minutes and 1 hour.

[22] This is MacKenzie's own testimony. (Tr. 887).

[redacted] became trapped. (Tr. 49).

MacKenzie then called company president Ripper to tell him that [redacted] was engulfed and that the fire department was on its way. (Tr. 889). At the time, Ripper was in a management meeting with corporate secretary-treasurer Wehrli and human resources manager Lenz in the building next door to the production facility.[23] (Tr. 443, 1013, 1035). Wehrli, Lenz, and Ripper ran to the batch plant as the fire department arrived. (Tr. 1016).

The fire department arrived within a few minutes of the 911 call. (Tr. 977). Fire department personnel immediately ordered the employee rescuers out of the bin. (Tr. 133-34, 204, 724). Paramedics administered an IV of morphine to treat [redacted] for his pain. (Tr. 724). The fire department used a vacuum truck to remove the sand from the bin. (Tr. 79). [redacted] was finally freed at approximately 3:30 p.m. – 4 hours after the fire department arrived and 5 ½ hours after he became trapped in the sand. (Tr. 724). [redacted] was transported to the hospital and treated for compression injuries. (Tr. 468). [redacted] testified that his injuries included a herniated disk and a torn meniscus. He continues to have pain in his feet and ankles. (Tr. 724-725).

Dukane's Post-Accident Response

About 30 minutes after the fire department arrived on the scene, Wehrli called an attorney, Mr. Risch, and a crisis management consultant, Ms. Chrisman. (Tr. 794, 801, 804). Chrisman, arrived at the Naperville facility later that day and stayed late into the night with Wehrli, Ripper, Lenz, MacKenzie, and others "trying to coordinate everybody's statements of exactly what happened." (Tr. 475, 920, 926-27).

Gorman, the safety director, was out of the country on vacation at the time of the accident. (Tr. 631). Both Wehrli and Lenz called Gorman several times the day of the incident and over the next three days. (Tr. 474, 632). Lenz needed to know where he kept the company's training documents, as Gorman was the custodian of the company's training documents. (Tr. 587, 633). Gorman recalled a general discussion with Lenz about labeling the bins. Even from off-site, Gorman realized that the accident had occurred in a permit-required confined space. (Tr. 633).

A general facility safety clean-up was conducted after [redacted] was rescued and before

[23] The management meeting was at the corporate office at 1805 High Grove Lane, Naperville, IL. (Tr. 1033).

OSHA arrived the next day. (Tr. 212). Lenz recommended the posting of signs on the access ladder to the work platform and on the aggregate bins to prevent future accidents and show due diligence to OSHA.[24] (Tr. 456-57, 475-78). After speaking to Gorman, she created the confined space signs, placed a sign on the access ladder, and then directed the project engineer to place the signs on the aggregate bins in the batch plant area. (Tr. 55-56, 63, 97, 457, 475-78; CX-5). The signs read: "DANGER – CONFINED SPACE – ENTER BY PERMIT ONLY" (CX-17) and "CONFINED SPACE – DO NOT ENTER!" (CX-38)

The clean-up continued the next morning, February 7, when the employees at the Naperville facility participated in a plant-wide "clean-up." (Tr. 212-19, 447-48, 457-58, 922). Anything that appeared to be a safety hazard was to be corrected. (Tr. 447-448). Cerecedes described his clean-up responsibilities as follows: "We were to get rid of any unsafe – any unsafe equipment that wouldn't pass an OSHA inspection, because I was told by [yard supervisor] Roy Meacham that [OSHA was] coming, and we had to get rid of the stuff that day." (Tr. 212). Cerecedes moved chemical containers away from the facility. He placed broken ladders in the kiln because he was told the OSHA compliance officer would not look there. (Tr. 212-16, 242-44). MacKenzie confirmed that all employees were assigned to cleaning duties that morning, to move improperly stored chemicals and remove defective equipment. (Tr. 922-925).

The OSHA Inspection

Wehrli notified OSHA that an accident had occurred at the Naperville facility. (Tr. 42-43, 1020). OSHA Compliance Officer (CO) Lake arrived at the Naperville facility around noon on February 7, 2012, the day after the accident. (Tr. 42-43). The CO requested documents from human resources manager Lenz. (Tr. 43). The CO met with corporate secretary-treasurer Wehrli to discuss the accident and Dukane's corporate structure. (Tr. 47).

CO Lake photographed the facility on February 7 and February 10, 2012. (Tr. 49-50). On February 8 and 9, CO Lake interviewed several Dukane management employees – Huerta, Lenz, MacKenzie, McMillan, Meacham and Marin. (Tr. 105). CO Lake also interviewed laborers Morrero, who reported to [redacted], and Cerecedes, who reported to Huerta. (Tr. 106-08, 114-15). He interviewed safety director Gorman and leadman [redacted] on February 14, 2012. (Tr. 105-06).

[24] Lenz had received confined space training at a prior employer. (Tr. 437, 459). Lenz recalled bringing safety issues to the attention of her supervisors, including the "lack of signage." (Tr. 442-43. *See* Tr. 634).

Dukane's Permit Required Confined Space Safety Program

Dukane had a written confined space safety program. (CX-53). Dukane's safety director, Gorman, testified that he developed the confined space program for Dukane's facilities soon after he started working for Dukane in 2000. (Tr. 514-15). Gorman testified that he was proficient with OSHA's confined space standard and had been working with it since the 1990s. (Tr. 511-12). Gorman developed Dukane's permit forms for confined space entry.[25] (CX-62; RX-14). He evaluated all three Dukane facilities, including the Naperville facility, to identify the confined spaces that were present.[26] (Tr. 525; RX-15, RX-16, RX-17). Gorman stated that it was standard procedure to share all new safety program information with his supervisor, Wehrli.[27] (Tr. 516. *See* Tr. 1010).

Gorman confirmed that he identified the aggregate bins in Naperville's batch plant as permit-required confined spaces. (Tr. 517, 520, 527-28, 611, 669; CX-2, CX-54). Gorman testified that the term silos on the Naperville confined space evaluation form included the aggregate bins – the aggregate bin was one type of silo. (Tr. 517, 527; CX-54, CX-55, RX-17). Further, Gorman acknowledged that the terms silos and bins were used interchangeably. [28] (Tr. 516, 527-28, 676, 685-86). Gorman did not recall ever placing confined space signage on the aggregate bins. (Tr. 641). There was no confined space signage on the aggregate bins or *on any other identified confined space*, at the Naperville facility or at any other Dukane facility, at the time of the engulfment accident. (Tr. 230-31, 456-57, 480-81, 641, 910-11).

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[25] A completed entry form for a permit-required confined space entry, dated November 19, 2004, into the batch plant mixer at the Plainfield facility, shows [redacted] as the authorized entrant and Gorman as the authorizing supervisor. (CX-62).

[26] Gorman testified that he evaluated the Naperville facility for its confined spaces right after it was built, which he estimated was 2002. (Tr. 515).

[27] In a memorandum dated May 29, 2002, Gorman states that the Dukane confined space program is ready and training will begin soon thereafter. Both secretary-treasurer Wehrli and company president Ripper were copied on this memo. (Tr. 520, 599-602; CX-54).

[28] The credible record evidence reveals that Dukane employees and supervisors interchangeably used the terms bins and silos to reference the aggregate bins (including the sand bins). CO Lake testified that throughout his inspection, several people used the terms bin and silo interchangeably. (Tr. 49, 134, 316). Safety director Gorman interchangeably used the terms silo and bin to refer to the aggregate bins throughout his testimony. (Tr. 509-691). Human resources manager Lenz testified: "I asked Jay to go up to the catwalk and take pictures inside all of the silos and to put up signs." (Tr. 478). Notably, during the engulfment emergency employees referred to the aggregate bin where [redacted] was trapped as a silo and this reference was readily understood. Laborer Cerecedes's testified: "Mike Morrero came running . . . and notified me that [redacted] was stuck in the silo." (Tr. 181, 183-84, 226). Quality control supervisor McMillan testified: "I grabbed the shovel, and I climbed down into the silo." (Tr. 826; *See* also Tr. 817-46). The ready reference by Dukane's employees and managers to the aggregate bins, interchangeably as bins or silos, is accorded great weight.

Gorman established Dukane's procedure to call 911 to summon rescue and emergency services for a confined space emergency. (Tr. 536-37, 593-94. *See* Tr. 328-31, 414). The confined space evaluation forms reflected this procedure. (RX-17). A completed Dukane confined space entry permit form from 2010 noted that 911 was the emergency number for rescue. (RX-14). Additionally, Gorman consulted with the head of the local Naperville rescue and fire team while developing the rescue policy.[29] (Tr. 537). Dukane's confined space emergency procedure to call 911 was communicated to employees through training. (Tr. 594).

Gorman, as safety director, was solely responsible for training employees on Dukane's confined space program. (Tr. 558). Early in his 12-year tenure at Dukane, he held monthly training for supervisors and other designated employees on a variety of safety topics, including confined spaces. (Tr. 586-87; RX-11). However, due to budget issues group training had not been held since 2007. (Tr. 559-60). Since that time he trained employees when he was notified they would be entering a confined space.[30] (Tr. 560, 586, 590). Quality control supervisor Meacham and leadman Marin, who participated in the attempted rescue, had received confined space training.[31] (Tr. 539-40; CX-56, 57, 59-61). The record reveals that [redacted] had received confined space training.[32]

The record also reveals that plant manager MacKenzie had received confined space training. Safety director Gorman believed he had trained MacKenzie regarding confined spaces. "I thought that Don MacKenzie had been trained in the confined space issues, as he's been trained in other safety issues throughout the plant." (Tr. 664. *See* Tr. 540, 619, 652). MacKenzie admitted that he could have learned about confined spaces during conversations he had with safety director Gorman. (Tr. 910). Further, Lenz testified that when she reviewed the

[29] A June 6, 2004 confined space training roster shows members of the Aurora and Moecherville fire departments were given a tour of the Aurora facility. (Tr. 622-23; CX-58).

[30] A confined space entry permit dated February 25, 2010 demonstrates this point. The training date for the entrants is the same day as the entry of the confined space. (RX-14, p.1).

[31] Meacham is on the July 9, 2002 training roster and Marin is on the 2005 roster. (CX-56, CX-59, CX-61; Tr. 144-49).

[32] While [redacted] did not recall the exact title of the training he received as permit-required "confined space" training, the record reveals that he received this training. [redacted] acknowledged his signature on the 2007 training roster. (Tr. 732-33; CX-57). In addition, the record reveals a 2004 entry permit for [redacted] to work in a confined space. (Tr. 541-42; CX-62). Also his work practices reveal that [redacted] understood there was a potential danger when he entered the aggregate bins. As discussed above, [redacted] learned from safety director Gorman to use fall protection before entering the aggregate bins. *See* footnote 16 above. Therefore, he worked with an attendant when entering the aggregate bins and, on February 6, 2012, the day of the engulfment, he used a yellow rope tied around his waist and attached to the guardrail before entering the aggregate bins. (Tr. 132, 339, 348-49, 703-04).

confined space training forms after the accident, she saw signatures for both [redacted] and MacKenzie among the documents in the file. (Tr. 490-91, 495). During his testimony, MacKenzie demonstrated a basic understanding regarding confined spaces. His employment prior to Dukane did not include work with confined spaces. (Tr. 909-10). When considered in conjunction with Gorman's and Lenz's testimony and his safety responsibilities as the plant manager, the record evidence reveals that MacKenzie did have confined spaces training prior to the engulfment accident.[33]

The record shows Dukane paid little attention to compliance with its confined space program. The record shows that safety director Gorman conducted safety inspections and walk-throughs at the three Dukane facilities from time-to-time.[34] (Tr. 240-41; RX-20). However, there was no evidence of monitoring for compliance with the permit-required confined space safety program. Most telling, Gorman did not detect the lack of warning signs for the permit-required confined spaces at the Naperville facility. Finally, the only discipline documents in evidence for non-compliance with Dukane's safety program were the warnings issued to Huerta, [redacted], and MacKenzie after OSHA issued the citations in this case to Dukane.[35] (CX-65, CX-68, CX-70).

The Citations

The Secretary's Burden of Proof

To establish a violation of an OSHA standard, the Secretary has the burden of proving that: (1) the cited standard applies; (2) the employer failed to comply with the terms of the cited standard; (3) employees had access to the violative condition; and (4) the employer either knew or could have known of the violative conduct with the exercise of reasonable diligence. *Astra Pharm. Prod., Inc*., 9 BNA OSHC 2126, 2129-30 (No. 78-6247, 1981), *aff'd in relevant part*, 681 F.2d 69 (1st Cir. 1982).

Citation 1, Item 1

Citation 1, Item 1 - This item alleges a serious violation of 29 C.F.R. § 1910.23(c)(3),

[33] MacKenzie's testimony that he had not received permit-required "confined space" training before the accident is not credited. (Tr. 853-54, 909-10). *See* generally footnote 15 above.
[34] Respondent introduced an exhibit consisting of 41 emails from Gorman to various Dukane management staff regarding what he found during a walk-through inspection at a particular facility. However, 30 of the emails were undated and only one referenced any issue related to confined spaces. (RX-20).
[35] OSHA issued the citation July 25, 2012. The disciplinary forms were dated August 6, 2012. Lenz testified that she recommended discipline before she left Dukane in April of 2012. (Tr. 455-56).

which states:

> Regardless of height, open-sided floors, walkways, platforms, or runways above or adjacent to dangerous equipment, pickling or galvanizing tanks, degreasing units, and similar hazards shall be guarded with a standard railing and toe board.[36]

The Complaint alleges that, on or about February 6, 2012, Respondent did not maintain a standard railing on the platform adjacent to batch plant sand bins which are permit-required confined spaces. A standard railing is defined as "[a] vertical barrier erected along exposed edges of a floor opening, wall opening, ramp, platform, or runway to prevent falls of persons." 29 C.F.R. § 1910.21(a)(6). A standard railing "shall consist of top rail, intermediate rail, and posts, and shall have a vertical height of 42 inches nominal from upper surface of top rail to floor, platform, runway, or ramp level." 29 C.F.R. § 1910.23(e)(1).

The Standard Applied and Was Violated

Dukane asserts that this standard is inapplicable because the platform was not "open-sided" and because the bins were not "dangerous equipment." Dukane asserts that the platform was not "open-sided" because the bin wall extended for 27 inches above the platform creating an obstruction, thus the platform was not open-sided. (R. Br. 28). This argument fails.

The photographic evidence shows the platform was open-sided. It was 20 feet above the floor with an attached guardrail running along the side of the platform not adjacent to the bins. The 27-inch extension of the bin wall, on the side of the platform immediately adjacent to the bin, is far below the 42-inch height required for a standard railing. Further, the bin wall did not close off or obstruct access into the bins. I find the platform was open-sided.

Further, Dukane asserts that the standard is inapplicable because the aggregate bins are not dangerous equipment because they do not contain caustic materials. (R. Br. 29). The cited standard addresses the hazard of an employee falling into an area where hazardous equipment is located. Here, an employee could fall into the sand bin and be subjected to an engulfment hazard, plus crushing and other injuries from the clamshell gate at the bottom of the bin. I find the bins are dangerous equipment for the purposes of this standard and therefore the standard is applicable.

Dukane also asserts that an aggregate bin is only dangerous when the batch plant is operating, i.e., when the aggregate material is being drawn down into the clamshell gate at the

[36] "(4) *Platform*. A working space for persons, elevated above the surrounding floor or ground; such as a balcony or platform for the operation of machinery and equipment." 29 C.F.R. § 1910.21(a)(4).

bottom of the bin. (R. Br. 29). This contention also fails. The batch plant was not operating when Mr. [redacted] was buried up to his shoulders. This demonstrates an engulfment hazard exists when the equipment is not operating.

Finally, Dukane points to a 1979 OSHA letter of interpretation to show that a standard railing was not required on this platform.[37] (R. Br. 28). The letter states that "[t]he 31 inch height from the working platform to the top of the galvanizing tank is less than that required for a standard guardrail. However, the 30 inch ledge width combined with the 31 inch height creates a situation where employees are effectively protected from the hazard covered by the standard." The facts set forth in the letter are very limited and are not analogous to the case at hand. In the 1979 interpretation letter, the *working platform* and *ledge* appear to be distinct, different, structural elements – not synonyms. This letter is not relevant and the comparison inapt.

In the instant case, the standard was applicable and was violated. The platform was open-sided and above (near the top) and adjacent to the aggregate bins. The aggregate bins were dangerous equipment with the hazards of engulfment in the aggregate materials stored there and injury from the mechanical clamshell gate at the bottom. Further, there was no standard railing on the bin-side of the platform. The 27-inch extension of the bin wall above the platform floor does not meet the minimum height requirement of 42 inches. *See* 29 C.F.R. § 1910.23(e)(1). The open-sided platform did not comply with the requirements of the standard.

Employees Were Exposed and Knowledge Was Proven

The Secretary established employer knowledge and that employees were exposed to the hazard. Here, Dukane employees were actually exposed to the hazard of falling into the bins from the platform. On the day of the incident, [redacted] and several other employees were on the platform next to the bins.

To establish knowledge the Secretary must prove the employer either knew, or with the exercise of reasonable diligence could have known, of the violative condition. *Dun-Par Engineered Form Co.,* 12 BNA OSHC 1962, 1965 (No. 82-928, 1986). "The actual or constructive knowledge of a foreman or supervisor can be imputed to the employer." *N&N Contractors, Inc.*, 18 BNA OSHC 2121, 2123 (No. 96-0606, 2000) (citation omitted), *petition for review denied,* 255 F.3d 122 (4th Cir. 2001). "An employee who has been delegated

[37] The letter of interpretation to Mr. Demetriades, dated November 29, 1979, can be found at https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=INTERPRETATIONS&p_id=18830.

authority over other employees, even if only temporarily, is considered to be a supervisor" for the purpose of establishing knowledge. *Access Equip. Sys.*, 18 BNA OSHC 1718, 1726 (No. 95-1449, 1999).

Here, Dukane knew that its employees used the platform and were exposed to falling into the bins. MacKenzie knew employees would scrape sand off the bin sides from the platform with the long-handled tool. He also knew that [redacted], as part of his regular job, previously had accessed the platform to check aggregate levels. He knew employees previously accessed the work platform to enter the aggregate bins to level out the bin material. Further, MacKenzie had been on the platform to check on the bin material and the lack of a railing was clearly visible from the platform. MacKenzie's knowledge of the platform's condition is imputed to Dukane. The Secretary has established actual knowledge.

The Secretary characterized this violation as serious. A violation is classified as serious if "there is substantial probability that death or serious physical harm could result" if an accident occurs. *See Compass Environmental, Inc.*, 23 BNA OSHC 1132, 1136 (No. 06-1036, 2010), *aff'd*, 663 F.3d 1164 (10th Cir. 2011). An employee falling from the work platform into the aggregate bin could experience fractures, contusions and possible engulfment. Here, an employee suffered actual serious injury related to the violations and, therefore, the classification of serious is appropriate.

Citation 1, Item 1 is affirmed as a serious violation.

Violations of the Confined Space Standard

Confined space and permit-required confined space are defined at 29 C.F.R. §1910.146(b).

> *Confined space* means a space that: (1) Is large enough and so configured that an employee can bodily enter and perform assigned work; and (2) Has limited or restricted means for entry or exit (for example, tanks, vessels, silos, storage bins, hoppers, vaults, and pits are spaces that may have limited means of entry.); and (3) Is not designed for continuous employee occupancy.
>
> *Permit-required confined space* (permit space) means a confined space that has one or more of the following characteristics: (1) Contains or has a potential to contain a hazardous atmosphere; (2) Contains a material that has the potential for engulfing an entrant; (3) Has an internal configuration such that an entrant could be trapped or asphyxiated by inwardly converging walls or by a floor which slopes downward and tapers to a smaller cross-section; or (4) Contains any other recognized serious safety or health hazard.

Citation 1, Item 2

Citation 1, Item 2 - This item alleges a serious violation of 29 C.F.R. § 1910.146(d)(1), which states:

> (d) *Permit-required confined space program* (permit space program). Under the permit space program required by (c)(4) of this section, the employer shall: (1) Implement the measures necessary to prevent unauthorized entry;[38]

The Complaint alleges that, on or about February 6, 2012, Respondent did not secure batch plant sand bins #1 and #2 from unauthorized employee entry.

The Standard Applied and Employees Were Exposed

The aggregate bins meet the definition of a permit-required confined space. The bins contained materials that could engulf a person. The bins had inwardly converging walls and floors that sloped downward to a smaller cross-section. The bins had a limited means of entry or exit, were large enough and configured such that a person could enter to do work, and were not designed for continuous occupancy. (Tr. 154-57). The standard is applicable. Further, there is no dispute that unauthorized employees were actually in bin #2 during the rescue attempt.

The Standard Was Violated

Dukane did not implement measures to prevent unauthorized entry. It did not use a physical barrier, such as a gate or lock to prevent access to the platform. (Tr. 159-60). There were no work rules that prohibited entry onto the work platform or entry into the aggregate bins. (Tr. 160-61, 207-08). There were no signs or labels to warn unauthorized personnel to not enter a permit-required confined space. (Tr. 207, 230, 640-41). However, when Dukane anticipated the OSHA inspection, warning signs were quickly and easily put in place on the access ladder to the work platform and on the aggregate bins during the plant-wide safety clean-up. (Tr. 456-57, 475-78; CX-5, CX-17, CX-38).

The Respondent argues that the difficulty of climbing the 20-foot ladder and its "remote" location in the facility prevented inadvertent access to a permit-required confined space. (R. Br.

[38] "If the employer decides that its employees will enter permit spaces, the employer shall develop and implement a written permit space program that complies with this section. The written program shall be available for inspection by employees and their authorized representatives." 29 C.F.R. § 1910.146(c)(4).

30). However, the photographs of the work area refute this. The ladder leading to the platform was clearly visible from the area of the skip hoist, which was at least 50 feet away from the ladder. (CX-6, CX-12). The ladder was not hidden from sight. Further, the standard requires prevention of unauthorized entry, not inadvertent access.

Dukane also argues that training employees whose job duties involve working in a permit-required confined space prevented unauthorized entry. (R. Br. 30). This argument is disingenuous. A simple training rule without implementation does not prevent unauthorized entry. Dukane's permit-required confined space training was limited. Between July 2007 and [redacted]' engulfment incident, there was no general confined space training conducted at Dukane. (Tr. 559-60). During that time, confined space training was limited to those employees whose work duties specifically included working with permit-required confined spaces. (Tr. 589-90). Dukane's confine space training was not provided to unauthorized employees working in and around the general vicinity of permit-required confined spaces and thereby working in the zone of danger. There was no training of unauthorized employees on which areas to avoid in the facility. It was not reasonable to believe that an unauthorized employee would know to not enter a permit-required confined space when there was no training, signage, or other indication that access was prohibited – and hazardous. I find that Dukane did not take measures to prevent unauthorized entry to sand bin #2, a permit-required confined space, and, therefore, violated the standard.

Knowledge

With reasonable diligence, Dukane could have known there were no warning signs, gates, barriers, or other means to prevent unauthorized entrance to the aggregate bins. Several factors are considered to determine reasonable diligence, including, "the employer's obligation to have adequate work rules and training programs, to adequately supervise employees, to anticipate hazards, and to take measures to prevent the occurrence of violations." *Danis-Shook Joint Venture XXV,* 19 BNA OSHC 1497, 1501 (No. 98-1192, 2001) (*Danis*), *aff'd*, 319 F.3d 805 (6th Cir. 2003) (citations omitted).

The bins were obvious; they were large and the central feature in the batch plant area. The ladder leading to the bins was also in plain view. Dukane's safety director, Gorman, had determined that the aggregate bins were permit-required confined spaces many years before. (Tr. 527, 611). Dukane's work rule that only authorized employees could enter a permit-required

confined space was not implemented. There was no training for unauthorized employees. Further, Gorman conducted walk-through inspections of the facility but never noticed there was no means of keeping unauthorized employees from entering the bins. Gorman never recalls permit-required confined space signs being placed on the aggregate bins. (Tr. 641). The Secretary has shown that, through its safety director, Dukane could have known it had no measures in place to prevent unauthorized entry and, therefore, constructive knowledge is established. Further, the evidence shows that Dukane's plant manager, MacKenzie, had actually been on the platform previously, so the lack of any warning signs or other means to prevent unauthorized access may also be imputed through MacKenzie.

The Secretary characterized this violation as serious. As discussed above a serious injury can result from the entry into the sand bin, a permit-required confined space. Citation 1, Item 2 is affirmed as a serious violation.

Citation 1, Item 3

Citation 1, Item 3 - This item alleges a serious violation of 29 C.F.R. § 1910.146(e)(1), which states:

> (e) *Permit system*. (1) Before entry is authorized, the employer shall document the completion of measures required by paragraph (d)(3) of this section by preparing an entry permit.[39]

The Complaint alleges that, on or about February 6, 2012, Respondent did not prepare entry permits for permit-required confined spaces in the batch plant known as sand bins #1 and #2.

The Standard Applied, Was Violated, and Employees Were Exposed

As discussed above, the aggregate bin was a permit-required confined space so the standard applied. There is no dispute that an entry permit was not completed when [redacted], and others, entered bin #2 and were exposed.

Knowledge

[39] An employer shall "(d)(3) Develop and implement the means, procedures, and practices necessary for safe permit space entry operations, including, but not limited to, the following: (i) Specifying acceptable entry conditions; (ii) Providing each authorized entrant or that employee's authorized representative with the opportunity to observe any monitoring or testing of permit spaces; (iii) Isolating the permit space; (iv) Purging, inerting, flushing, or ventilating the permit space as necessary to eliminate or control atmospheric hazards; (v) Providing pedestrian, vehicle, or other barriers as necessary to protect entrants from external hazards; and (vi) Verifying that conditions in the permit space are acceptable for entry throughout the duration of an authorized entry." 29 C.F.R. § 1910.146 (d)(3).

Respondent argues that the Secretary cannot prove the element of knowledge because no one, other than [redacted], expected an employee to enter a bin. However, the record establishes that [redacted]'s knowledge, as leadman, is imputable to Dukane. And, as discussed above, I find that plant manager MacKenzie knew that employees had entered the bin in the past to level the sand, knew that [redacted] was going to level out the sand that day, and easily could have known that no entry permit was completed. MacKenzie's knowledge is imputable to Dukane.

Further, an employer must make a reasonably diligent effort to monitor compliance with its safety rules, including monitoring its supervisor's oversight of safety rules. *See, e.g., Southwestern Bell Telephone Co. (SWBT)*, 19 BNA OSHC 1097, 1099 (No. 98-1748, 2000), *aff'd*, 277 F.3d 1374 (5th Cir. 2001) (citations omitted). Dukane cannot avoid culpability for its leadman's knowledge when it made no effort to determine if he, or the plant manager, made an effort to apply its safety policy. Here, there was no evidence that Dukane monitored its supervisory staff for adherence to the safety policy.[40] [redacted] knew that he had not completed an entry permit prior to entering bins #1 and #2. As the record establishes, leadman [redacted] was in a supervisory position and, therefore, his knowledge is imputed to Dukane. The Secretary has proven her prima facie case for Citation 1, Item 3.

Nonetheless, the Respondent asserts that if there was a violation of § 1910.146(e)(1) it was the result of unpreventable employee misconduct.[41] To establish the affirmative defense of unpreventable employee misconduct, "an employer must show that it had: (1) established work rules designed to prevent the violative conditions from occurring; (2) adequately communicated those rules to its employees; (3) took steps to discover violations of those rules; and (4) effectively enforced the rules when violations were discovered." *Boh Brothers Constr. Co. Inc.,* 24 BNA OSHC 1067, 1075 (No. 09-1072, 2013). A well-written work rule, alone, is not sufficient. Even when a safety program is thorough and properly conceived, lax administration renders it ineffective. *See, e.g., Hamilton Fixture*, 16 BNA OSHC 1073, 1090 (No. 88-1720, 1993) *aff'd in unpublished opinion*, 28 F.3d 1213 (6th Cir.1994).

Where, as here, the employee misconduct includes the actions of a supervisory employee, the employer faces a higher standard of proof. "Where a supervisory employee is involved, the

[40] The disciplinary action against [redacted] prior to the engulfment was not related to Dukane's safety policy. (RX-19).

[41] Respondent only asserts the affirmative defense of unpreventable employee misconduct for Citation 1, Item 3. (R. Br. 31).

proof of unpreventable employee misconduct is more rigorous and the defense is more difficult to establish since it is the supervisor's duty to protect the safety of employees under his supervision. . . . A supervisor's involvement in the misconduct is strong evidence that the employer's safety program was lax." *Archer-Western Contractors Ltd.*, 15 BNA OSHC 1013, 1017 (No. 87-1067, 1991) (citations omitted).

Dukane had a permit-required confined space safety program which included the completion of entry permits. (CX-53; CX-62). However, as discussed above, Dukane's safety program was poorly implemented. For the reasons that follow, I find that Dukane's safety program was insufficient to establish unpreventable employee misconduct.

Dukane alleges that its safety rules were communicated through its training and that its training was effective. I disagree; it was inadequate. [redacted] could not specifically recall the training he had many years before. Group training had not been conducted since 2007.[42] There was no action taken to determine if its employees understood or remembered training. This lack of follow-up was shown by the safety director's walk-through inspections which had virtually no mention of any confined space safety issues.

This was not an effective way to communicate its work rules, especially considering the lack of signage, or other means to communicate its work rules, to untrained employees to ensure their awareness of the permit-required confined spaces and to warn them of potential hazards. An employer cannot simply give an employee training and then hope for the best; it must make a serious effort to communicate its rules to its employees in a way that makes it likely the employees will follow those rules. The Commission has held that a "reasonably prudent employer would attempt to give instructions that can be understood and remembered by its employees." *Pressure Concrete Constr. Co*., 15 BNA OSHC 2011, 2017 (No. 90-2668, 1992).

Dukane did not take steps to discover violations of its permit-required confined spaces safety program. An employer must do more than have "an exemplary safety program on paper." *American Sterlizer Co.,* 18 BNA OSHC 1082, 1087 (No. 91-2494, 1997). An employer must also monitor its employee's compliance "in an effort to eliminate hazards." *Id.* Dukane's inability to detect the lack of conspicuous warning signs on the bins and the safety director's testimony that he was unsure if signs had ever been posted, demonstrate there was almost no effort to determine

[42] Safety manager Gorman testified that, due to economic conditions, group training had not been conducted in several years; training was done with an individual just before each entry. (Tr. 560, 586, 590).

if the permit-required confined space rules were implemented or followed. Dukane did not provide adequate supervision over its employees and took few measures to prevent the occurrence of a violation. In particular, it neglected to oversee the behavior of its supervisory employees who were tasked with upholding its safety policy. No permits related to the previous bin entries of [redacted] and Morrero to level the sand, at the Naperville plant, were included in the record evidence. This also illustrates a lax attitude toward implementation and enforcement of the confined space safety program.

Dukane did not adequately enforce its safety policy. The Commission generally requires an employer to show it had a progressive and consistent disciplinary policy to demonstrate adequate enforcement of its safety program. Dukane asserts that it did discipline its employees for violating its permit-required confined space program related to [redacted]'s engulfment. The Commission does allow consideration of discipline that occurred both before and after the inspection. *See, e.g., American Eng'g & Development Corp.,* 23 BNA OSHC 2093, 2097 (No. 10-0359, 2012); *Rawson Contractors, Inc.*, 20 BNA OSHC 1078, 1081 (No. 99-0018, 2003); *Valdak Corp.,* 17 BNA OSHC 1135, 1136 (No. 93-0239. 1995), *aff'd*, 73 F.3d 1466 (8th Cir. 1995).

However, there is no evidence of discipline for safety violations prior to the inspection. The post-engulfment discipline consisted of written warnings issued to Huerta, [redacted], and MacKenzie seven months after the accident -- just a few days after OSHA issued the citations in this case. Dukane's enforcement of its safety policy was inadequate. The affirmative defense of unpreventable employee misconduct fails.

The Secretary characterized this violation as serious. As discussed above, entry into the aggregate bin presented a risk of serious harm either from engulfment or the mechanical hazard of the clamshell gate. Citation 1, Item 3 is affirmed as a serious violation.

Citation 2, Item 1

Citation 2, Item 1 - This item alleges a willful violation of 29 C.F.R. § 1910.146(d)(9), which states:

> Develop and implement procedures for summoning rescue and emergency services, for rescuing entrants from permit spaces, for providing necessary emergency services to rescued employees, and for preventing unauthorized personnel from attempting a rescue;

The Complaint alleges that, on or about February 6, 2012, Respondent did not implement procedures for immediately summoning emergency services upon discovery of an employee engulfed in sand within a permit-required confined space and did not implement procedures for preventing unauthorized co-workers from entering a permit-required confined space and attempting a rescue of an employee engulfed in sand.

The Standard Applied and Employees Were Exposed

As discussed above, the bins were permit-required confined spaces. Employees were actually exposed to the hazards that are the subject of this standard – possible injury from entering the permit-required confined space to attempt rescue and from delayed summoning of emergency services. There is no dispute that several employees, not authorized to attempt rescue, were in bin #2 attempting to rescue [redacted]. There is no dispute that emergency services were delayed and only summoned for [redacted] about 1 ½ hours after he became trapped in the sand.

The Standard Was Violated and Knowledge Was Proven

Dukane asserts that it did comply with the standard because it established its 911 rescue policy and it fully implemented its procedures when it provided training to its employees and coordinated with the fire department technical rescue team. (R. Br. 24; CX-58). I disagree. Dukane did not adequately implement its rescue procedures. Dukane developed a procedure, contacted its local rescue service and provided minimal training; however, its implementation was inadequate and incomplete. It was not designed to prevent unauthorized rescue attempts and to have managers and co-workers call 911 when an employee can not get out of a permit-required confined space.

The Commission has found that a standard cannot be read in such a way as to "vitiate the very purpose of the standard's requirement." *Elliot Constr. Corp.,* 23 BNA OSHC 2110, 2113 (No. 07-1578, 2012). Further, the cited provision must be considered in the context of the permit-required confined spaces standard, 29 C.F.R. § 1910.146, as a whole. *See Custom Built Marine Constr., Inc.*, 23 BNA OSHC 2237, 2239 (No. 11-0977, 2012) (citation omitted). For example, an employer must consider the timeliness of a rescue team's response when designating its permit-required confined spaces rescue service. 29 C.F.R. § 1910.146(k)(1). Further, one of the duties of an entry attendant is to "[s]ummon rescue and other emergency services as soon as the attendant determines that authorized entrants may need assistance to escape from permit space hazards." 29 C.F.R. § 1910.146(i)(7). Finally, OSHA explained in the standard's

preamble, that the rescue requirements are intended to summon rescue when an entrant cannot get out of a confined space without assistance.[43] *See* 58 Fed. Reg. 4462 (Jan. 14, 1993).

The standard is clear – an employer must have devised and implemented its plan in such a way that it was reasonable to believe its procedure will be followed when an employee needs rescue from a permit-required confined space.[44] Training of employees can be a component of adequate implementation, but that alone is insufficient. When read in the context of the permit-required confined spaces standard as a whole, it is clear that summoning the designated rescue service is an essential part of the implementation of a rescue procedure. To not require this as part of implementation would vitiate the standard's purpose to get an employee, who is unable to self-rescue, out of the confined space. In this case, the record is clear: [redacted] was incapable of self-rescue. (Tr. 758).

Further, the record is clear that several supervisory employees made no effort to follow the company's policy to call 911 upon finding [redacted] trapped. It was only after 1½ hours of attempted rescue and a demand from [redacted] to call 911, that plant manager MacKenzie called 911. Finally, there is no evidence, beyond the program's general reference to call 911 and the limited training discussed above, that Dukane informed its employees that they should not attempt a rescue.

Respondent's contention that the many supervisors who participated in the unauthorized rescue did not know that they were engaged in a permit-required confined space rescue does not insulate Respondent from a finding that it violated the standard. Rather, the claimed ignorance of Respondent's supervisors, including plant manager MacKenzie, is graphic proof of Respondent failure to implement its permit-required confined space program.

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[43] In the preamble to the final rule, OSHA stated the following about the requirement of 29 C.F.R § 1910.146(i)(7): "The Agency agrees that there may be times when authorized entrants can perform self-rescue from the permit space in an emergency. On the other hand, OSHA is [*sic*] believes that help must be summoned if there is any doubt as to whether it will be necessary. Therefore, paragraph (i)(7) of the final rule requires attendants to summon rescue and emergency services if they determines [*sic*] that assistance may be necessary. As long as the attendant is certain that self-rescue can be performed, no rescue summons would be necessary. However, if the attendant has any doubts as to whether an authorized entrant can exit the space under his or her own power, then the attendant is required to summon rescue and emergency services." 58 Fed. Reg. 4462, 4521 (Jan. 14, 1993).

[44] Dukane asserts that the Secretary is reading additional requirements into the standard by requiring Dukane to guarantee that employees will immediately summon emergency services. It points to *Usery v. Kennecott Copper Corp.,* 577 F. 2d 1113, 1118 (10th Cir. 1977) to support this argument. In *Kennecott* the court found that a standard requiring an employer to provide ladders for scaffold access did not require the employer to ensure the use of a ladder. *Id*. The comparison to *Kennecott* is inapt. The requirement at issue in *Kennecott* was that a ladder "shall be provided." Here, the standard requires an employer to "develop and implement procedures for summoning rescue and emergency services."

Therefore, the requirements of the standard were violated and knowledge was established. Further, as discussed above, entry into the aggregate bin presented a risk of serious harm either from engulfment or the mechanical hazard of the clamshell gate, so this violation is serious in nature.

Willful Characterization

The Secretary has characterized Citation 2, Item 1 as a willful violation. A willful violation is done "with intentional, knowing or voluntary disregard for the requirements of the Act or with plain indifference to employee safety." *Burkes Mech., Inc.,* 21 BNA OSHC 2136, 2140 (No. 04-0475, 2007) (citations omitted). A willful violation differs from a serious violation by a heightened awareness and either conscious disregard or plain indifference. *Williams Enterp., Inc*., 13 BNA OSHC 1249, 1256-57 (No. 85-355, 1987).

I find that Dukane's actions support a willful characterization. The Commission has recognized that an employer's failure to follow its own safety program and the recommendations of a safety consultant can establish a willful violation. *Morrison-Knudsen Co., Inc.,* 16 BNA OSHC 1105 (No. 88-572, 1993). The Commission has held that a foreman who knowingly allows employees to work without the necessary protective equipment has acted with intentional disregard. *Rawson Contractors, Inc.,* 20 BNA OSHC 1078, 1081-82 (No. 99-0018, 2003).

Here, Dukane's safety director, Gorman, knew of the requirements for permit-required confined space rescue and that Dukane's implementation of its own policy was inadequate. Gorman developed the confined space program which sets forth the requirement to call 911 for rescue.[45] Gorman knew that training had not been done for several years. He knew that the Naperville facility contained permit-required confined spaces but had done nothing to ensure employees working in or near those spaces were properly trained or that the spaces themselves were labelled. The fact that Gorman was not onsite the day of the engulfment is irrelevant.[46] This was not a lapse in implementation that occurred on a single day. It was a pattern of conscious disregard that had been ongoing for many years.

Additionally, this evidence demonstrates Dukane's heightened awareness. In addition to

[45] Dukane's general safety policy also included the rule to call 911 in the case of an emergency, which it defined as "an unplanned event that can cause death or injury to employees." (CX-42, p. 41).

[46] The employer does not lose its "knowledge" because a supervisor is not present. Even after a supervisor is no longer employed, the employer retains the knowledge. "Heightened awareness" remains with an organization despite turnover in its personnel. *Caterpillar, Inc. v. OSHRC,* 122 F.3d 437, 440-41 (7th Cir. 1997) *aff'g*, 17 BNA OSHC 1731, (No. 93-373, 1996).

documenting its program, Dukane then evaluated its three facilities to identify and document the permit-required confined spaces in each. Dukane developed permit-required confined space entry permit forms and conducted training sessions in 2002, 2005, and 2007. Dukane coordinated with the local fire department for permit-required confined space rescue services. This evidence shows that Dukane was aware of the requirements of this standard, but chose not to fully implement its policy. Dukane made almost no effort to promote compliance with the rescue policy. There was no signage in the facility. There was no evidence that any employee was actually aware of the designated rescue procedure. Dukane's own plant manager, upon discovering that an employee was trapped, did not follow the rescue policy. This demonstrates an inadequate effort to prevent unauthorized employees from entering a permit-required confined space to rescue a trapped employee, instead of calling 911. An employer must do more than document its policy; it must also administer it. *See, e.g., Hamilton Fixture*, 16 BNA OSHC at 1090.

Further, I find that through its plant manager, Dukane exhibited plain indifference. As discussed above, MacKenzie's knowledge is imputed to Dukane. The plant manager personally witnessed [redacted] trapped in the sand bin and [redacted]' co-workers quickly working in an attempt to free him. MacKenzie did not exhibit any concern for [redacted] or for the safety of the other employees in the bin. He did not order the employee rescuers out of the bin. He simply left that area to go to the shipping yard. He then returned to the batch plant a significant time later, and only then, after being told that [redacted] demanded a call to 911, did he make the call. These actions are not objectively reasonable and demonstrate a plain indifference to employee safety.

Plant manager MacKenzie's claim that he did not consider [redacted]' engulfment to be an emergency is not credible. MacKenzie's claim is not logical and is completely at odds with the reaction of everyone else who observed [redacted] trapped in the sand that day. All others immediately recognized the grave danger [redacted] faced and immediately jumped into action in an effort to free [redacted] from the sand. A reasonable person responsible for the safety of the facility employees would not have observed this obvious emergency situation and done nothing.

Dukane relies on *AJP* and *Greenleaf* to support its position that the Secretary cannot establish a willful violation, because Dukane was not actually aware at the time the engulfment that it was violating an OSHA standard. (R. Br. 19). *AJP Constr., Inc. v. Sec'y of Labor*, 357

F.3d 70, 74-75 (D.C. Cir. 2004), *aff'g* 19 BNA OSHC 2204 (Nos. 01-0568 & 01-1474, 2003); *Greenleaf Motor Express, Inc.,* 21 BNA OSHC 1872, 1875-76 (No. 03-1305, 2007), *aff'd without published opinion*, 262 Fed. Appx. 716 (6th Cir. 2008).

Respondent's reliance on *AJP* is inapt. In *AJP*, the court found the employer's efforts to implement a fall protection plan were "incomplete, ineffective, and unenforced" and upheld the willful characterization. *AJP*, 357 F.3d at 75. It also found that the foreman's noncompliance with the fall protection plan illustrated lax implementation. *Id*. at 75. Similarly here, Dukane's plant manager did not order the unauthorized employees out of the bin and did not call 911 until [redacted] had been trapped for 1 ½ hours.

Respondent's reliance on *Greenleaf* is also misplaced. In *Greenleaf* the Commission found the employer had no previous knowledge that a tanker car was a permit-required confined space, so a willful characterization could not be supported. *Greenleaf*, 21 BNA OSHC at 1875-76. In contrast, Dukane's aggregate bin had been identified by Dukane's safety director many years before as a permit-required confined space.

Dukane asserts that it made a good faith effort to comply with the standard when it developed its rescue policy and coordinated with the local fire department. (R. Br. 23-24). The Commission has held that an employer's conduct will not be found willful if it "made a good faith effort to comply with a standard or eliminate a hazard, even though [its] ... efforts were not entirely effective or complete." *Elliot Constr. Corp.,* 23 BNA OSHC 2110, 2117 (No. 07-1578, 2012) (citations omitted). A good faith effort to comply must be objectively reasonable to negate willfulness. *Caterpillar, Inc. v. OSHRC,* 122 F.3d 437, 441 (7th Cir. 1997) *aff'g*, 17 BNA OSHC 1731, (No. 93-373, 1996). An employer's good faith belief that a violation is not hazardous does not preclude a finding of willfulness. *Secretary v. Capital City Excavating Co., Inc.,* 712 F.2d 1008, 1010 (6th Cir. 1983).

Dukane's efforts were minimal and not a good faith effort to comply. The response of all the supervisory employees that day shows that Dukane had not made a reasonable effort to implement its rescue policy. It is not objectively reasonable to believe that an employee engulfed in a sand bin is not in danger and in need of emergency services. Nor is it reasonable to believe that uninformed employees will implement the company's rescue policy. Dukane's efforts were not a good faith effort to comply with the standard or eliminate the hazard.

Dukane also relies on *Dayton Tire* to support its position that it was not plainly

indifferent because it did devise and implement a confined space program. *Dayton Tire*, 671 F.3d 1249 (D.C. Cir. 2012). In *Dayton Tire*, the court found that attempts to comply with the OSHA standard mitigated against finding plain indifference. *Id.* The court relied on the Commission's findings that "an employer is entitled to have a good faith opinion that his conduct conforms to regulatory requirements." *Id.* at 1257 quoting *C.N. Flagg & Co.*, Inc., 2 BNA OSHC 1539 (No. 1409, 1975). Further, the Circuit found that the measures taken by Dayton were done in good faith. *Id*. at 1257. No such finding is merited here.

Dukane presented evidence that its safety director conducted safety walk-throughs of its 3 facilities. Despite this alleged attention to safety, Dukane's safety director did not observe or remedy the fact that 5 very large bins, that he had previously identified as permit-required confined spaces, had no signs to indicate that entry was limited to authorized employees. Further, for many years before the engulfment incident, there was no attempt made to train or inform unauthorized employees that they should not attempt rescue, but instead call 911. This lack of minimal attention to implementation of the confined space program demonstrates that Dukane did not have an objective good faith belief that it conformed to the OSHA standard.[47]

Finally, Dukane asserts that it made a good faith effort because it summoned rescue services upon [redacted]'s demand. This assertion is untenable. As discussed above, the evidence shows that [redacted] made several requests for a rescue call. Only 1 ½ hours later, when he made a demand, the 911 call was finally made. Even then, the plant manager only called because he no longer believed the other employees could rescue [redacted] from the bin.

It is not reasonable to believe that waiting to respond to an injured employee's request for emergency services was a good faith belief or effort. It was not reasonable to believe that untrained personnel were a substitute for a call to emergency services. Dukane cannot delegate to the employee experiencing the emergency situation responsibility for notifying his supervisor that rescue services should be summoned. The Commission addressed this attempt to shift

[47] Respondent asserts that it was not cited for a training violation and that it had not been cited in prior OSHA inspections for confined space program violations. The record does not reveal that prior OSHA inspections concerned Dukane's Naperville facility. The record does not disclose which work areas were the subject of the prior inspections. (Tr. 382-83). The Commission has been clear that an employer cannot generally rely on its prior OSHA inspection history. "[T]he mere fact of prior inspections does not give rise to an inference that OSHA made an earlier decision that there was no hazard, and does not preclude the Secretary from pursuing a later citation." *Seibel Modern Mfg. & Welding Corp.*, 15 BNA OSHC 1218, 1224-25 (No. 88-821, 1991).

responsibility to an employee in *Pride Oil Well Svc.,* 15 BNA OSHC 1809, 1817 (No. 87-692, 1992).

> The Act places final responsibility for compliance with its requirements on the employer. *E.g., [Brock v. City Oil Well Service Co.,* 795 F.2d 507, 511 (5th Cir. 1986)], quoting section 5(a)(2) of the Act . . . ("each *employer* ... shall comply" with OSHA standards) (court's emphasis). An employer who has failed to address a hazard by implementing and enforcing an effective work rule cannot shift to its employees the responsibility for assuring safe working procedures. *See, e.g., Stuttgart Machine Works, Inc.,* 9 BNA OSHC 1366, 1369 (No. 77–3021, 1981). An employer "cannot fail to properly train and supervise its employees and then hide behind its lack of knowledge of their dangerous working practices." *Danco Constr. Co. v. OSHRC,* 586 F.2d 1243, 1247 (8th Cir.1978).

When viewed in its totality, the record evidence shows a laissez-faire attitude by the Respondent about the implementation of its permit-required confined spaces safety program and its emergency procedures in particular. The Secretary has established this violation as willful. Citation 2, Item 1 is affirmed as a willful violation.

Penalty

Section 17(j) of the Act requires the Commission to give due consideration to four criteria in assessing penalties: the size of the employer's business, the gravity of the violation, the employer's good faith, and its prior history of violations. Gravity is generally the primary factor in the penalty assessment. *See J. A. Jones Constr. Co.*, 15 BNA OSHC 2201, 2214 (No. 87-2059, 1993).

The Secretary has classified Citation 1, Items 1, 2, and 3 as serious violations and proposed a penalty of $4,200.00 for Item 1 and $4,900.00 each for Items 2 and 3. As discussed above, these items are all affirmed as serious violations. Item 1 was assessed as medium gravity: the severity was assessed as medium, as an employee who fell into bin #2 from the walkway access platform could suffer fractures, contusions, possibly lost consciousness, and engulfment and the probability was assessed as greater. (Tr. 152, 158-59; CX-1). Items 2 and 3 were assessed as high gravity: the severity was assessed as high due to the potential for serious harm or death and the probability was assessed as greater. (Tr. 161-62, 164-65, 429-30). A reduction, of the statutory maximum penalty of $7,000 for each serious citation item, was proposed due to the company's small size. *See* § 17(b) of the Act.

The Commission may provide a penalty reduction for good faith when considering the employer's safety and health program and its commitment to safety. *Capform*, *Inc*., 19 BNA

OSHC 1374, 1378 (No. 99-0322, 2001). Dukane has a reasonable written safety program. However, as discussed above, the program was not adequately communicated, implemented or enforced. Therefore, I find a reduction for good faith is not appropriate.

The Secretary has classified Citation 2, Item 1 as a willful violation. As discussed above, the Secretary has met his burden to show the violation is willful. Citation 2 was assessed as high gravity: the severity was assessed as high due to the high potential for death and the probability was assessed as greater. (Tr. 175). The Secretary proposed a penalty of $56,000.00 for this item based on a reduction, of the statutory maximum penalty of $70,000.00 for willful citation items, due to the company's small size. *See* § 17(a) of the Act.

I find the Secretary's penalty recommendations for both serious and willful violations are appropriate and the penalties are assessed as proposed.

Findings of Fact and Conclusion of Law

All findings of fact and conclusions of law relevant and necessary to a determination of the contested issues have been made above. *See* Fed. R. Civ. P. 52(a). All proposed findings of fact and conclusions of law inconsistent with this decision are denied.

ORDER

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

1. Citation 1, Item 1, for a violation of 29 C.F.R. § 1910.23(c)(3) is AFFIRMED as Serious and a penalty of $4,200.00 is assessed.

2. Citation 1, Item 2, for a violation of 29 C.F.R. § 1910.146(d)(1) is AFFIRMED as Serious and a penalty of $4,900.00 is assessed.

3. Citation 1, Item 3, for a violation of 29 C.F.R. § 1910.146(e)(1) is AFFIRMED as Serious and a penalty of $4,900.00 is assessed.

4. Citation 2, Item 1, for a violation of 29 C.F.R. § 1910.146(d)(9) is AFFIRMED as Willful and a penalty of $56,000.00 is assessed.

/s/
Carol A. Baumerich
Judge, OSHRC

Date: July 14, 2014
Washington, D.C.