

1 NEVADA OCCUPATIONAL SAFETY AND HEALTH

2 REVIEW BOARD

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4 **AUG - 5 2002**

5 **DIR
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6 CHIEF ADMINISTRATIVE OFFICER
7 OF THE OCCUPATIONAL SAFETY AND
8 HEALTH ENFORCEMENT SECTION,
9 DIVISION OF INDUSTRIAL RELATIONS
10 OF THE DEPARTMENT OF BUSINESS AND
11 INDUSTRY,

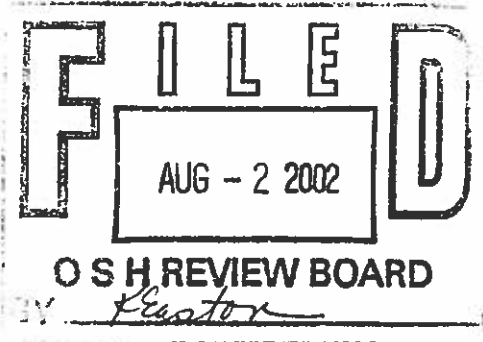
Docket No. RNO 01-1274

12 Complainant,

13 vs.

14 DEPRESSURIZED TECHNOLOGIES
15 INTERNATIONAL, INC.,

16 Respondent.



17 DECISION

18 This matter having come before the NEVADA OCCUPATIONAL SAFETY
19 AND HEALTH REVIEW BOARD at a hearing commenced on the 10th day of
20 April, 2002, and continued on May 15 and 16, 2002 and concluded on
21 July 10, 2002, in furtherance of notices duly provided according to
22 law, MR. JOHN WILES, ESQ., counsel appearing on behalf of the
23 Complainant, Chief Administrative Officer of the Occupational Safety
24 and Health Enforcement Section, Division of Industrial Relations
25 (OSHES); and MR. NOEL MANOUKIAN, ESQ., appearing on behalf of
26 Respondent, Depressurized Technologies International, Inc.; the
27 NEVADA OCCUPATIONAL SAFETY AND HEALTH REVIEW BOARD finds as follows:

28 Jurisdiction in this matter has been conferred in accordance
with Nevada Revised Statute 618.315.

The complaint filed by the OSHES sets forth allegations of

1 violations of Nevada Revised Statutes as referenced in Exhibit "A",
2 attached thereto.

3 Citation 1, Item 1 charges a "willful" violation of NRS
4 618.375(1) commonly known as the "General Duty Clause". Complainant
5 alleges that the respondent employer failed to effectively evaluate
6 the foam extraction process relating to the respondent's aerosol can
7 recycling business. The aerosol personal care products recycled by
8 the respondent contained highly flammable propellants such as
9 isobutane and propane. It is alleged that respondent failed to
10 adequately capture the flammable propellants, and that as a result
11 thereof, the atmosphere in the work environment became volatile and
12 exceeded the lower explosive limit resulting in a fire and explosion
13 in which an employee eventually died, and four other employees were
14 seriously injured when they sustained first, second and third degree
15 burns.

16 Citation 1, Item 2a and Item 2b were grouped together.
17 Citation 1, Item 2a charges a "willful" violation of 29 CFR
18 1910.1343(e)(1). Complainant alleges that the respondent employer
19 did not provide medical evaluations to employees before they were
20 required to wear respirators in connection with their work at the
21 respondent's aerosol can recycling plant. Citation 1, Item 2b
22 alleges a "willful" violation of 29 CFR 1910.134(f)(2). The
23 complaint alleges that the respondent employer did not ensure that
24 employees who were required to use a tight-fitting facepiece
25 respirator were fit tested as required by the regulation prior to
26 the initial use of the respirator. The proposed penalty for the
27 grouped willful violations is the amount of SIXTY THREE THOUSAND
28 DOLLARS (\$63,000.00).

1 Citation 2, Item 1a alleges a "serious" violation of 29 CFR
2 1910.178(c)(2)(i). The complainant alleges that the respondent
3 employer did not provide the required power-operated industrial
4 truck that was appropriate for use around high concentrations of
5 flammable vapors and gasses such as isobutane and propane. Citation
6 2, Item 1b and Citation 2, Item 1a were grouped together. Citation
7 2, Item 1b alleges a violation of 29 CFR 1910.178(l)(1)(i). The
8 complaint alleges that the respondent employer failed to make sure
9 that employees that were required to operate powered industrial
10 trucks, received operator training for the safe operation of the
11 vehicle as required by the regulation. The proposed penalty for the
12 "serious" violations referenced in Citation 2, Item 1a and Citation,
13 Item 1b, is in the amount of FIVE THOUSAND SIX HUNDRED DOLLARS
14 (\$5,600.00).

15 Citation 2, Item 2 alleges a "serious" violation of 29 CFR
16 1910.307(b). The complaint alleges that the respondent employer
17 failed to provide approved and safe wiring methods and installations
18 consistent with a class 1, division 1 environment. The violation
19 referenced as Citation 2, Item 2 was classified as "serious" because
20 of an alleged hazard that could cause death or serious bodily
21 injury. The proposed penalty for the citation is in the amount of
22 FIVE THOUSAND SIX HUNDRED DOLLARS (\$5,600.00).

23 Citation 2, Item 3 alleges a violation of 29 CFR
24 1910.1200(h)(1). The complaint alleges that the respondent's
25 employees were not provided with effective information and training
26 with respect to the hazardous chemicals that were present in their
27 work area at the time of their initial assignment and whenever a new
28 hazard was introduced into their work area. The complaint alleges

1 that the respondent's employees did not recognize the dangers that
2 were presents with respect to the extremely flammable products and
3 propellants that were contained in the aerosol cans that they were
4 recycling. The violation was classified as "serious" due to the
5 existence of an alleged hazard which could cause death or serious
6 bodily injury. The proposed penalty for the serious violation is in
7 the amount of FIVE THOUSAND SIX HUNDRED DOLLARS (\$5,600.00).

8 Citation 3, Item 1 alleges a violation of 29 CFR
9 1910.132(f)(4). The complaint alleges that the respondent employer
10 did not verify that it had provided the training required by the
11 regulation through a written certification that met the requirements
12 of the regulation. The violation was classified as "other" because
13 the alleged violative condition would not result in death or serious
14 bodily injury. The proposed penalty for the "other" violation is in
15 the amount of EIGHT HUNDRED DOLLARS (\$800.00).

16 FACTS

17 On the evening of September 17, 2001, an explosion and fire
18 occurred at the aerosol can recycling facility that was owned and
19 operated by respondent Depressurized Technologies International,
20 Inc. (DTI) located at 2185 Park Place (Meridian Business Park),
21 Minden, Nevada. Employees that were working on the night shift at
22 DTI suffered first, second and third degree burns, and one of the
23 employees later died from injuries that were sustained in the fire
24 and explosion. On the evening of September 17, 2001, DTI's
25 employees were puncturing aerosol cans in order to remove the
26 contents for recycling. The employees were using a plastic lined
27 wire mesh container comprised of four sides. One employee could
28 work per side. The aerosol can would be punctured, and the contents

1 would flow from the can into the plastic lined container. A diagram
2 of the manual decanting device was prepared by supervisor Brigido
3 Beranza, and introduced into evidence as respondent's Exhibit M.
4 The manual decanting device included a hood in which an air hose was
5 inserted to provide suction that was designed to evacuate vapors
6 from the aerosol cans that were punctured to a filtration system.
7 However, at the time of the accident on September 17, 2001, the
8 exhaust hood was not installed and operational. The manual
9 decanting device was located within a 40-foot metal ocean shipping
10 container that was located within the DTI building.

11 In addition to the manual decanting device, there was also an
12 employee puncturing aerosol cans over a 55 gallon drum that was
13 located immediately outside of the 40 foot metal ocean shipping
14 container. The 55 gallon drum had no vapor recovery apparatus
15 associated with it. At approximately the same time that an employee
16 sat on an electrically operated forklift truck, the explosion
17 occurred which caused the employee injuries. Terrence Taylor, a
18 fire captain and investigator from the East Fork Fire and Paramedic
19 District in Minden, Nevada, stated that it was his opinion that
20 volatile gasses had accumulated as a result of the manual decanting
21 process that was taking place on the evening of September 17, 2001.
22 It was Captain Taylor's opinion that the electrically powered
23 forklift truck had provided the spark that ignited the flammable
24 gasses.

25 DISCUSSION

26 A. Nevada Revised Statute (NRS) 618.375(1).

27 NRS 618.375(1) is as follows:

28 "Duties of employers. Every employer shall:

1 1. Furnish employment and a place of employment
2 which are free from recognized hazards that are
3 causing or are likely to cause death or serious
 physical harm to his employees."

4 The obligation that is imposed by NRS 618.375(1) is commonly
5 referred to as the "general duty" clause. In the present case,
6 Walter Gonzalez, the president, sole director and designated safety
7 coordinator for DTI testified that he knew and understood the
8 hazards that were present in recycling the products that DTI
9 recycled at its Minden, Nevada facility. Mr. Gonzalez was aware
10 that many of the aerosol cans that were received by DTI contained
11 highly flammable propellants such as isobutane and propane.

12 DTI had, prior to moving to Minden, Nevada in the early part
13 of 2001, operated an aerosol can recycling facility in Morgan Hill,
14 California. At the California facility, decanting of aerosol cans
15 using an automatic machine that had been designed and patented by
16 Walter Gonzalez began in December 1994. Manual decanting of aerosol
17 cans also took place at DTI's California facility before the move to
18 Nevada. Most of DTI's California employees moved with the company
19 to Nevada in the early part of 2001. Other employees rejoined the
20 company at DTI's Nevada location in July 2001. Not all of DTI's
21 California employees made the move, but most did eventually rejoin
22 the company in Nevada by July 2001.

23 The aerosol can process descriptions prepared by DTI related
24 to 1) receiving, 2) sorting, 3) degassing, 4) decapping, 5)
25 decanting, and 6) crushing. (Exhibits 1 through 6 inclusive.) All
26 of the documentation that was provided by DTI to the complainant's
27 representatives pertained to the Morgan Hill, California operation.
28 No specific written documentation pertaining to the Minden, Nevada

1 operation was provided by DTI, and no written documentation
2 pertaining to the manual decanting process was provided.

3 The testimony and evidence established more than just a
4 lackadaisical attitude on the part of DTI with respect to employee
5 safety at the Minden, Nevada facility. This course of conduct was
6 entirely inconsistent with the fact that Mr. Gonzalez, as well as
7 Ms. Gonzalez, were very aware of the highly flammable nature of the
8 propellants and some of the products contained in the aerosol cans
9 that were being recycled at the Minden, Nevada facility. Mr.
10 Gonzalez states in his resume that he has "Over 15 years of
11 experience in waste management, emergency control and response
12 procedures." (Exhibit D) Additionally Mr. Gonzalez has worked as
13 an environmental health and safety manager for a separate employer
14 in California, not related to DTI, from February 1994 to the present
15 time. (Exhibit D) The evidence established that while the Morgan
16 Hill, California facility of DTI had been tested and reviewed by
17 outside consultants, no such testing and review had taken place at
18 the Nevada facility from the opening in early 2001 through the date
19 of the accident on September 17, 2001.

20 The citation relating to NRS 618.375(1) has been cited as
21 "willful". In order to find a willful violation, evidence must be
22 present to support a finding that the violation was committed with
23 (1) intentional knowing, or (2) voluntary disregard for Occupational
24 Safety and Health requirements, or (3) with plain indifference to
25 employee safety. Williams Enter., 13 BNA OSHC 1249, 1256 (No. 85-
26 355, 1986). The focal point of a willful classification is the
27 employer's state of mind at the time that the violation is
28 committed. Brock v. Morello Brothers Construction, 809 F.2d 161,

1 164 (1st Cir. 1987). A willful charge is not justified if an
2 employer has made a good faith effort to comply with the standard or
3 eliminate a hazard, even though the employer's efforts are not
4 entirely effective or complete. A.G. Mazzocchi, Inc., 2000 OSHD
5 ¶32,095 at p. 48,202.

6 In the present case, the testimony and evidence established a
7 voluntary disregard and plain indifference on the part of DTI with
8 respect to employee safety. Members of DTI's management had
9 knowledge of safety requirements, and had knowledge that its
10 employees were engaged in a manual decanting process involving
11 highly flammable propellants. In spite of this, inadequate measures
12 were taken to provide a place of employment that was free from
13 recognized hazards that were most definitely likely to cause death
14 or serious physical harm of the type that in fact occurred on the
15 evening of September 17, 2001.

16 B. 29 CFR 1910.134(e)(1) and 29 CFR 1910.134(f)(2).

17 Because of the dangerous nature of the contents of the aerosol
18 cans that were recycled at the DTI Minden, Nevada facility,
19 employees were required to wear respirators. 29 CFR 1910.134(e)(1)
20 requires an employer to provide a medical evaluation to determine an
21 employee's ability to use a respirator before the employee is fit
22 tested, or required to use the respirator in the work place. 29 CFR
23 1910.134(f)(2) requires that employees be fit tested prior to the
24 initial use of a respirator, and whenever a different respirator is
25 to be used and annually thereafter. The testimony and evidence was
26 uncontradicted that the only employee that had ever received the
27 medical evaluation required by 29 CFR 1910.134(e)(1) was supervisor
28 Brigido Beranza. This occurred when Mr. Beranza was hired as an

1 employee at the Morgan Hill, California facility of DTI. No
2 employee at the Nevada facility of DTI was medically fit tested as
3 required by the regulation. Dora Gonzalez, who was the manager of
4 DTI's Nevada facility, was aware of the medical evaluation
5 requirement. In spite of this knowledge, the employees were not
6 medically evaluated because in Ms. Gonzalez' own words, she did not
7 get around to it because of the press of other obligations.
8 Supervisor Brigido Beranza testified that Ms. Gonzalez had stated to
9 him that the medical evaluation was necessary, and that it would be
10 done at some undefined date in the future. The medical evaluations
11 never occurred.

12 Supervisor Brigido Beranza assisted employees with the fit
13 testing of their respirators. However, the procedures utilized by
14 Mr. Beranza did not comply with all of the requirements for
15 respirator fit testing. During Mr. Beranza's testimony, he stated
16 that he had no familiarity with the fit testing procedures contained
17 in 29 CFR 1910.134, Appendix A, when he reviewed Exhibit 78 which is
18 a copy of those procedures.

19 The testimony and evidence unequivocally establish that DTI
20 was not complying with the requirements imposed by 29 CFR
21 1910.134(e)(1) and 29 CFR 1910.134(f)(2). This noncompliance
22 occurred even though both Mr. Gonzalez and Ms. Gonzalez testified
23 that they were aware of the requirements. Thus, once again the
24 testimony and evidence established a level of voluntary disregard
25 and plain indifference with respect to employee safety. The
26 essentials for a willful violation as cited by the complainant were
27 found to be present.

28 C. 29 CFR 1910.178(c)(2)(i) and 29 CFR 1910.178(l)(1)(i).

1 At the DTI facility in Minden, Nevada, the employees used an
2 electric fork lift identified as Type E, Caterpillar Model 70,
3 H2126. Photographs of the forklift are contained in the record as
4 Exhibits 52, 53 and 54. The testimony and evidence established that
5 the forklift truck used by DTI for use in and around the type of
6 volatile vapors that were potentially present in all aspects of the
7 recycling processing that was taking place at DTI's Minden, Nevada
8 facility was inappropriate and inconsistent with the prohibition
9 imposed by 29 CFR 1910.178(c)(2)(i). The testimony of DTI's
10 employees and supervisor Beranza established that the training for
11 an operator of the forklift did not comply with the requirements of
12 29 CFR 1910.178(1)(1)(i). It was necessary for employees to use the
13 forklift to move materials in connection with the processing of
14 aerosol cans at DTI's Minden, Nevada facility. The testimony
15 established that DTI's forklift operator training consisted of some
16 advice from supervisor Beranza followed by actual operation of the
17 forklift. The brief instruction provided by supervisor Beranza
18 simply did not meet the requirements of the regulation.

19 A serious violation occurs where there is a substantial
20 probability of death or serious injury as a result of the condition.
21 NRS 618.625(2); Division of Occupational Safety and Health v. Pabcc
22 Gypsum, 105 Nev. 371, 372, 775 P.2d 701 (1989). In this instance,
23 the use of the forklift truck at the DTI facility in an environment
24 containing highly flammable gasses, coupled with inadequate operator
25 training, did create a substantial probability of death or serious
26 injury to employees.

27 D. 29 CFR 1910.307(b).

28 29 CFR 1910.307(b) requires that "equipment, wiring methods,

1 and installations of equipment in hazardous (classified) locations
2 shall be intrinsically safe, approved for the hazardous (classified)
3 location, or safe for the hazardous (classified) location."
4 Photographs of DTI's wiring in the vicinity of the ocean shipping
5 container where the manual decanting process took place were
6 introduced into evidence as Exhibits 55, 56 and 57. Joan Tiewarney,
7 who is employed as a safety and health inspector by the complainant,
8 testified that the conduit and receptacles depicted in Exhibits 55,
9 56 and 57 do not comply with the standard imposed by 29 CFR
10 1910.307(b). In her testimony, Ms. Tiewarney referenced Exhibits 25
11 and 26. Exhibit 25 is an excerpt from the National Electrical Code
12 1993, and Exhibit 26 is an excerpt from the Fire Protection
13 Handbook, 14th Edition, which references Class 1, Division 1
14 locations. Ms. Tiewarney explained that a Class 1, Division 1
15 location exists where hazardous concentrations of flammable gasses
16 or vapors exist continuously, intermittently, or periodically under
17 normal conditions. Given the fact that most of the aerosol cans
18 that were being recycled at DTI's Minden, Nevada facility contained
19 highly flammable propellants, and in some cases flammable contents,
20 the complainant did establish that a Class 1, Division 1, location
21 existed at DTI's facility. Ms. Tiewarney indicated that DTI had
22 installed standard conduit and receptacles as depicted in Exhibits
23 55, 56 and 57, and that the installation did not comply with the
24 regulations requirements.

25 The board finds that the failure of DTI to provide equipment,
26 wiring methods and installations of equipment in the hazardous
27 classified location created a substantial probability that death or
28 serious injury could result from the violative condition. The

1 reason for the regulation is to eliminate possible ignition sources
2 in an environment where explosive gasses are known to exist.
3 Consequently the board finds a serious violation of 29 CFR
4 1910.307(b).

5 E. 29 CFR 1910.1200(h)(1).

6 The complainant alleges that DTI failed to provide effective
7 information and training on hazard chemicals that were present in an
8 employee's work area at the time of their initial assignment and
9 whenever a new hazard was introduced into their work area. The
10 testimony and evidence established that DTI did provide some
11 training to its employees with respect to hazardous chemical.
12 (Exhibits J, K, L). The regulation requires that employers "provide
13 employees with effective information and training." (Emphasis
14 added.) The testimony of the former and existing employees of DTI
15 established that the employees did not fully appreciate the extent
16 of the hazards that were presented by the propellants and chemicals
17 that were contained in the aerosol cans that they were processing on
18 a daily basis. In particular, there was employee confusion as to
19 whether or not aerosol cans containing water based gels were
20 hazardous. On the evening of September 17, 2001, employees were
21 working with aerosol cans containing water based gels without the
22 benefit of the vapor extraction system being utilized. The
23 testimony of several of the employees who were working on September
24 17, 2001 indicated that they felt that there was no explosion risk
25 associated with the processing of aerosol cans containing water
26 based gels. Clearly this was not the case. Thus, one must
27 reasonably conclude that DTI failed to provide the "effective
28 information and training" as required by 29 CFR 1910.1200(h)(1).

1 The failure to provide the required training created a condition
2 containing a substantial probability of death or serious injury.

3 F. 29 CFR 1910.132(f)(4).

4 DTI provided very little written documentation to complainant
5 with respect to employee training, except for Exhibits J, K and L
6 which were training materials relating to three employees. No
7 written evidence was provided that other employees had received the
8 training required by the regulation. The testimony unequivocally
9 established that DTI did not comply with the requirement set forth
10 in 29 CFR 1910.132(f)(4). There was evidence that DTI did in fact
11 provide training to its employees. This was testified to by the
12 former and existing employees of DTI, and was verified by supervisor
13 Beranza, Ms. Gonzalez and Mr. Gonzalez. However, no written records
14 for the employees, other than the three previously referenced, were
15 produced by DTI. This does not comply with the regulation. The
16 board finds that the failure to comply with the requirements of 29
17 CFR 1910.132(f)(4) did not create a condition where there was a
18 probability of death or serious injury to employees. Consequently,
19 the classification of the citation as "other" is appropriate.

20 CONCLUSION

21 Based upon the above and foregoing, it is the decision of the
22 Nevada Occupational Safety and Health Review Board as follows:

23 1. A willful violation of Nevada Revised Statutes did occur
24 as to Citation 1, Item 1, NRS 618.375(1). A penalty in the amount
25 of SEVENTY THOUSAND DOLLARS (\$70,000.00) for the willful violation
26 is imposed.

27 2. A willful violation of Nevada Revised Statutes did occur
28 as to Citation 1, Item 2(a) and Citation 1, Item 2(b), respectively

1 29 CFR 1910.134(e)(1) and 29 CFR 1910.134(f)(2). A penalty for the
2 willful violations is imposed in the amount of TWENTY THOUSAND
3 DOLLARS (\$20,000.00).

4 3. A serious violation of Nevada Revised Statutes did occur
5 as to Citation 2, Item 1(a) and Citation 2, Item 1(b), respectively
6 29 CFR 1910.178(c)(2)(i) and 29 CFR 1910.178(1)(1)(i). A penalty
7 for the serious violations is imposed in the amount of FIVE THOUSAND
8 SIX HUNDRED DOLLARS (\$5,600.00).

9 4. A serious violation of Nevada Revised Statutes did occur
10 as to Citation 2, Item 2, 29 CFR 1910.307(b). A penalty is imposed
11 for the serious violation in the amount of FIVE THOUSAND SIX HUNDRED
12 DOLLARS (\$5,600.00).

13 5. A serious violation of Nevada Revised Statutes did occur
14 as to Citation 2, Item 3, 29 CFR 1910.1200(h)(1). During the
15 board's deliberations on July 10, 2002, a penalty in the amount of
16 TEN THOUSAND DOLLARS (\$10,000.00) was imposed for this serious
17 violation. However, the maximum penalty that can be imposed for a
18 serious violation, in furtherance of NRS 618.645, is in the amount
19 of SEVEN THOUSAND DOLLARS (\$7,000.00). Consequently, a penalty in
20 the amount of SEVEN THOUSAND DOLLARS (\$7,000.00) for the serious
21 violation of 29 CFR 1910.1200(h)(1) is imposed.

22 6. A violation of Nevada Revised Statutes did occur as to
23 Citation 3, Item 1. A penalty for the "other" violation is imposed
24 in the amount of EIGHT HUNDRED DOLLARS (\$800.00).

25 The Board shall serve Findings of Fact and Conclusions of Law
26 signed by the Chairman of the **NEVADA OCCUPATIONAL SAFETY AND HEALTH**
27 **REVIEW BOARD**. Service of the Findings of Fact and Conclusions of
28 Law signed by the Chairman of the **NEVADA OCCUPATIONAL SAFETY AND**

1 HEALTH REVIEW BOARD shall constitute the Final Order of the BOARD.

2 DATED: This 2nd day of August, 2002.

3 NEVADA OCCUPATIONAL SAFETY AND HEALTH
4 REVIEW BOARD

5 /s/

6 _____
7 THOMAS A. JENNINGS, CHAIRMAN

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1 NEVADA OCCUPATIONAL SAFETY AND HEALTH

2 REVIEW BOARD

3 Docket No. RNO 01-1274

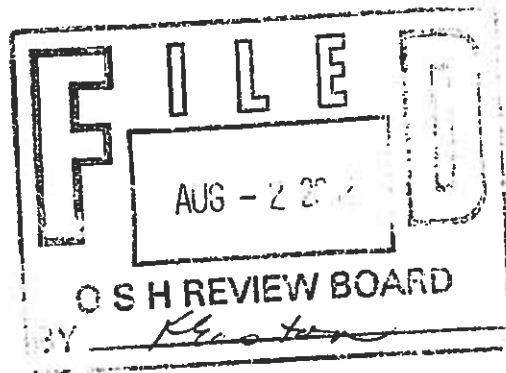
4 CHIEF ADMINISTRATIVE OFFICER
5 OF THE OCCUPATIONAL SAFETY AND
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7 DIVISION OF INDUSTRIAL RELATIONS
8 OF THE DEPARTMENT OF BUSINESS
9 AND INDUSTRY,

10 Complainant,

11 vs.

12 DEPRESSURIZED TECHNOLOGIES
13 INTERNATIONAL, INC.

14 Respondent.



15 CERTIFICATE OF MAILING

16 Pursuant to NRC 5(b), I certify that I am an employee of
17 SCARPELLO, HUSS & OSHINSKI, LTD., and that on August 2, 2002, I
18 deposited for mailing, certified mail/return receipt requested, at
19 Carson City, Nevada, a true copy of the DECISION addressed to:

20 John Wiles, Esq.
21 DIR Legal
22 1301 North Green Valley Parkway
23 Suite 200
24 Henderson NV 89014

25 Noel Manoukian, Esq.
26 1466 Hwy. 395
27 Gardnerville, NV 89410

28 DATED: August 2, 2002

29 *Karen A. Easton*
30 KAREN A. EASTON

31 SUBSCRIBED and SWORN to before me
32 this *2nd* day of August, 2002.

33 *[Signature]*
34 NOTARY PUBLIC

