NEVADA OCCUPATIONAL SAFETY AND HEALTH

REVIEW BOARD

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CHIEF ADMINISTRATIVE OFFICER OF THE OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, DIVISION OF INDUSTRIAL RELATIONS OF THE DEPARTMENT OF BUSINESS AND INDUSTRY,

Complainant,

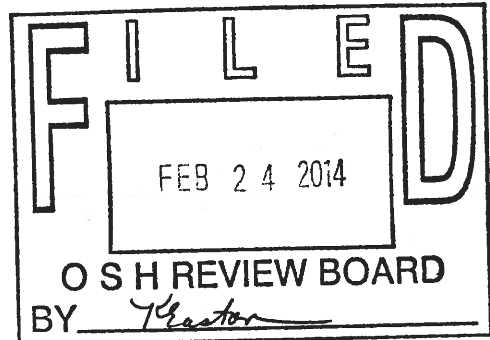
vs.

AGGREGATE INDUSTRIES - SWR, INC.,

Respondent.

_______________________________________/

Docket No. LV 13-1643



DECISION

This matter having come before the **NEVADA OCCUPATIONAL SAFETY AND HEALTH REVIEW BOARD** at hearings conducted on January 8 and 9, 2014, in furtherance of notice duly provided according to law, MR. DONALD C. SMITH, ESQ., counsel appearing on behalf of the Complainant, **Chief Administrative Officer of the Occupational Safety and Health Administration, Division of Industrial Relations** (OSHA); and MR. STEPHEN C. YOHAY, ESQ. and MR. CHRISTOPHER PASTORE, ESQ., appearing on behalf of Respondent, **Aggregate Industries - SWR, Inc.**; the **NEVADA OCCUPATIONAL SAFETY AND HEALTH REVIEW BOARD** finds as follows:

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

The complaint filed by the OSHA sets forth allegations of violation of Nevada Revised Statutes as referenced in Exhibit "A", attached

thereto. The alleged violations in Citation 1, Items 1 through 6 reference, respectively, 29 CFR 1910.146(c)(2), 29 CFR 1910.146(c)(4), 29 CFR 1910.146(c)(7)(iii), 29 CFR 1910.147(c)(4)(ii), 29 CFR 1910.147(c)(5)(ii), and 29 CFR 1910.147(c)(7)(i)(A).

Counsel stipulated to the admission of the complainant evidence packet, Exhibits 1 through 3. Respondent reserved rights of objections based upon hearsay as testimony is presented. Counsel further stipulated to admission of respondent Exhibits A, B, C, D, E, F & G.

Citation 1, Item 1, referenced 29 CFR 1910.146(c)(2). The employer was charged with failing to determine the workplace contained particularly violative **permit confined spaces** and inform exposed employees of the danger, location and requirements under the standard as more specifically cited and set forth in Exhibit A to the complaint on file herein. The violation was classified as "Serious" and a penalty proposed in the amount of $6,300.00.

Citation 1, Item 2, referenced 29 CFR 1910.146(c)(4). The employer was charged with a failure to develop and implement a written permit confined space program in compliance with the standard after deciding its employees could enter permit spaces, all as more particularly alleged in Exhibit A to the complaint on file herein. The violation was classified as "Serious" and a penalty proposed in the amount of $6,300.00.

Citation 1, Item 3, referenced 29 CFR 1910.146(c)(7)(iii). The employer was charged with a failure to document the basis for determining all hazards in a permit confined space were eliminated in accordance with the terms of the cited standard as more particularly set forth in Exhibit A to the complaint on file herein. The violation was classified as "Serious" and a penalty proposed in the amount of

$6,300.00.

Citation 1, Item 4, referenced 29 CFR 1910.147(c)(4)(ii). The employer was charged with a failure to control hazardous energy in the development and implementation of procedures and placement of lockout tagout (LOTO) devices as specifically required under the terms of the cited standard set forth in Exhibit A to the complaint on file herein. The violation was classified as "Serious" and a penalty proposed in the amount of $6,300.00.

Citation 1, Item 5, referenced 29 CFR 1910.147(c)(5)(ii). The respondent was charged with non-compliance in the procedures for identifying, implementing and restricting the use of LOTO devices in accordance with the specific requirements of the standard as set forth in Exhibit A to the complaint on file herein. The violation was classified as "Serious" and a penalty proposed in the amount of $6,300.00.

Citation 1, Item 6, referenced 29 CFR 1910.147(c)(7)(i)(A). The citation charged the employer with noncompliance under the standard for employee training requirements, the recognition of hazardous energy sources and the methods for energy isolation and control, all as more particularly set forth in Exhibit A to the complaint on file herein. The violation was classified as "Serious" and a penalty proposed in the amount of $6,300.00.

Complainant counsel introduced testimony and documentary evidence to establish the violations through Compliance Safety and Health Officer (CSHO) Mr. Corey Church. CSHO Church described his background and experience in confined space training. He testified and referenced exhibits in evidence, particularly the Exhibit 1 narrative reports, observations, interviews and determinations made as to each of the

1 violations subject of contest. He identified and testified as to the
2 photographic evidence at Exhibit 3, pages 289 through 324. Nevada OSHA
3 issued the six-item citation to respondent following investigation of
4 an August 17, 2012 accident at its Sloan, Nevada worksite involving the
5 unexpected closure of a frame door on a Telsmith horizontal shaft impact
6 crusher (Telsmith). The accident resulted in the death of respondent
7 employee, Mr. Anthony Holden. At the respondent recycle plant in Sloan,
8 Nevada, CSHO Church determined Mr. Holden, whose job classification was
9 heavy duty repairman, was "closing" the impact crusher when the
10 hydraulic frame opening system failed causing the upper rear frame to
11 retract by way of gravitational forces and inflict fatal crushing wounds
12 to Mr. Holden's body as it pinned him against the upper front frame. Mr.
13 Church testified and reported that on the catwalk surrounding the
14 crusher he observed and photographed three (3) steel bars. Based upon
15 his further investigation and interviews he found the respondent
16 employees utilized the bars as makeshift frame supports to prop open the
17 upper rear frame to prevent it from closing unexpectedly. No bar or
18 frame supports were in place at the time of the accident.
19 CSHO Church continued his testimony referencing his narrative
20 report at Exhibit 1. He determined Mr. Holden had been performing
21 various repairs on the crusher over the past several months. At
22 approximately 10:45 AM, on August 17, 2012 Mr. Holden discussed his job
23 task for the day with Mike Meeker the recycle plant assistant supervisor
24 who instructed him to "close" the impact crusher. At 11:49 AM, Kerry
25 Stewart, a leader hand, stopped by the recycle plant to remind Mr.
26 Holden of a mandatory meeting that was scheduled for 12:00 PM. While
27 walking about the area in search of Mr. Holden, he discovered Mr.
28 Holden's body trapped between the upper rear and upper front rams of the

crusher. Mr. Stewart tried working the directional control valve on the hydraulic pump in an attempt to open the upper rear from of the crusher, but discovered the pump to be inoperable. Mike Wallace, a heavy equipment mechanic, noticed the sight gauge on the pump was indicating an empty oil reservoir, which prompted the men to search for a hydraulic leak. Shortly thereafter they found remnants of a shiny liquid on the under belt conveyor, which marked a trail of hydraulic fluid that had apparently burst through a hole in a hydraulic line and traveled down the conveyor before spilling onto the ground.

CSHO Church found the respondent employer **confined space (CS)** safety plan policy was deficient due to respondent's failure to identify the impact crusher as a **permit-required confined space (PRCS)** and protect employees from the hazard exposure recognized in the OSHA standards. He also found the employer's hazardous energy control procedures deficient, which contributed to the hazards posed to employees as they worked in the confined space of the crusher. He recommended the Citation 1, Item 1 violation be issued.

Mr. Church testified he interviewed respondent employees who described the Telsmith operation, including the company "opening and closing" procedures. He specifically spoke to Mr. Michael Meeker, the assistant supervisor and safety representative who explained the Telsmith closing process and employee training. He concluded that neither Mr. Meeker, who he considered to be a management representative, nor the respondent employer considered the Telsmith to be a confined space (CS) or a permit required confined space (PRCS) when in an "open" position but did determine it to be such when in a "closed" position. During continued investigation and employee interviews, Mr. Church concluded there were inconsistent applications of the Telsmith safety

1 procedures in the "closing" process to prevent accidental closure when
2 employees performed work while exposed to dangerous internal moving
3 parts designed for crushing asphalt materials. Safety procedures for
4 utilizing steel "bars" to brace open the Telsmith door were not
5 uniformly implemented nor clearly understood by exposed employees. He
6 testified the bars were not specifically marked or identified as
7 required by the OSHA standards. Mr. Church concluded the initial
8 failure of respondent to designate the Telsmith as a confined space (CS)
9 under OSHA definitions was a violation of OSHA standards. The standards
10 required the respondent to appropriately identify the confined space
11 work areas of the Telsmith at the site as a CS/PRCS and comply with the
12 mandates to inform exposed employees, post danger signs and/or implement
13 other equally effective means to warn of the existence, location and
14 dangers posed by permit confined spaces. He concluded respondent
15 employees were exposed to serious injuries and/or death from the
16 recognized hazards. He testified an employee could be pinned between
17 the upper rear and upper front frames of the Telsmith impact crusher.
18 In fact Mr. Holden was killed when the crusher hydraulic line failed
19 when no frame support or blocking bars were in place.
20 CSHO Church identified the Exhibit 1 witness statements taken from
21 respondent employees during his investigation, including those from
22 Messrs. Meeker, Stewart, Bone and Ortiz. He testified as to the
23 inconsistencies of employee understandings on the hazard and protection
24 necessary when performing work on the open Telsmith.
25 Mr. Church further testified on his basis for recording violations
26 as to Citations 1, Items 2 through 6. He recommended Item 2 for
27 citation because the employer failed to develop and implement a written
28 permit space program in compliance with the cited standard after

deciding employee(s) would enter a permit required confined space in the Telsmith crusher.

At Item 3, CSHO Church recommended the citation because the employer failed to document the basis for determining all hazards in a permit space had been eliminated through certification in accordance with the terms of the standard. He testified the employer had incorrectly excluded the Telsmith crusher classification as a permit space and accordingly implemented no documentation or compliance in accordance with the standard.

Mr. Church testified as to the remaining three items subject of citation 1 which involved methods, devices, and training to **control of hazardous energy** as opposed to the first three citation items which applied to **confined space** violations.

At Citation 1, Item 4, CSHO Church testified that based upon his investigation, analysis, observations and interviews the employer failed to establish procedures to clearly and specifically outline the techniques to be utilized to control hazardous energy. Specific procedures under the cited standard were required for placement, removal and transfer of lockout and tagout devices (LOTO) for the Telsmith crusher, as well as specific requirements for testing the machine equipment to determine and verify the effectiveness of the devices and other energy control measures. He testified that use of makeshift metal bar(s) to block the Telsmith door closure as a secondary precaution in the event of a hydraulic failure to prevent the gravitational energy to close the door/opening were not the recognized means of protection of the manufacturer. He found the bars were not clearly designated, marked nor identified for the employees and not subject of specific safety training. There were no written procedures nor clear or specific rules

and techniques in place on use of the blocking bars or subject of training for the employees to satisfy the hazard protection required by the standard. Information obtained by CSHO Church from employee interviews and written statements taken at the time of the investigation reflected both inconsistent descriptions of the closing procedures for the Telsmith as a PRCS, and use of blocking bars for LOTO. The number of bars to be utilized, identification of which bar was specifically to be implemented, how and at what safety point were the bars to be placed were not addressed by respondent employee training. Three bars were found on the site near the Telsmith after the accident and subject of photographic evidence at Exhibit 3.

At Citation 1, Item 5, Mr. Church referred to his narrative and testified on his observations and findings that the blocking bars did not meet the OSHA standard requirements as LOTO devices. He specifically found no particular identification of the lockout devices **singularly identified** as the only devices for controlling hazardous energy associated with the approximate 10,655 lb. upper rear frame of the Telsmith that collapsed due to the forces of gravity on employee Holden after failure in the hydraulic pressure lines. The bars were not **specifically** identified, **marked** with particular paint for example, **tested** for capability of withstanding the environment to which they were exposed, nor **constructed** and printed so the exposure to weather conditions or wet conditions would not cause the markings to deteriorate. He observed and photographed the three (3) identified LOTO devices (bars) on the crusher platform. They consisted of a round pipe of approximately 58.25 inches long by 2 inches in diameter, and two 2 X 2 inch square tubing pieces, one 49.5 inches long with a 4 inch bolt welded at one end and the other a 72.25 inches with a deep socket 12.5

inches.

Mr. Church found the employee interview statements and responses inconsistent in the identification, use and number of the blocking bar LOTO devices as designated by the employer for controlling hazardous energy. Mr. Church testified as to interview statements from respondent employees Messrs. Meeker, Bone, Ortiz and McLean taken at the site. He noted and testified to the inconsistencies in the employee explanations and a failure of understanding by these employees on use of which bar is a restraining device and then how many bars and where they were to be utilized. Bar usage varied among the employees performing maintenance on the crusher. For example some employees used one piece of square tubing as a retaining bar, others used two bars. Some used the deep socket, a tool not intended as a LOTO device. The inconsistent understanding and lack of uniform training for use and application of the bars as LOTO devices and no specific "singular" identification of which bar to actually use constituted a violation of the cited standard.

At Citation 1, Item 6, Mr. Church testified he could find no evidence to support the requirement that each authorized employee received training in the recognition of applicable hazardous energy sources or the type and magnitude of the energy available in the workplace and the methods and means necessary for energy isolation and control. The training documentation and other data provided by respondent demonstrated the employees were not trained in the recognition of hazardous energy sources and the magnitude of these sources associated with the Telsmith equipped with a 10,655 lb. upper rear frame that crushed employee Holden after it succumbed to the forces of gravity as pressure failure occurred in the crusher's hydraulic lines. He reported the employer LOTO plan for the Telsmith impact

crusher did not protect employees from hazards in reference to hydraulic energy or potential energy from gravity. He again testified the safety plan and training did not specify which of the devices observed around the crusher were to be used for the lockout process, where the devices were to be installed, and the sequence in which they must be installed or removed. Nothing was written in the employer's safety manual or training program to specifically identify the appropriate bar device to be utilized nor was it identified or marked to notify the employees of safety use and procedure. Further, the device(s) did not comport with the manufacturer's manual which identified a particular apparatus to interrupt the energy force in the event of failure of the hydraulic line which was not available nor found at the worksite.

Respondent conducted witness cross-examination. Mr. Church testified he concluded the Telsmith "closed" because of a leak in the hydraulic line which failed to hold the "door" open by hydraulic pressure resulting in collapse to the closed position which crushed employee Holden. He testified there was no evidence that a bar was in place nor that a bar was even sufficient to restrain the 10,655 lb. door opening from falling during hydraulic failure. He testified in response to questioning that he found no evidence the restraining bars were not sufficient to hold the door open when in place. He further testified the Telsmith was usually cleaned from the outside, and that employee Holden was assigned other duties besides cleaning the Telsmith. He did not measure the opening of the Telsmith so could not opine on whether the bars were large enough to actually accomplish the job of restraining the door from an accidental closure. Mr. Church testified use of multiple bars requires "specific" device identification under the standards cited at Items 4 and 5. He testified the standard does not require

conformance with the manufacture manual. Mr. Church referenced his direct testimony and testified that employee witness statements were inconsistent and did not demonstrate they understood where and how the bars were to be placed. He had to rely on the site specific LOTO plan written procedure to figure out what was supposed to be done. However nothing provided **where** the bar or bars are to be placed and it was not clear whether, or when, one or two bars were to be utilized.

CSHO Church admitted respondent employees were given training on LOTO referencing page 113 of Exhibit 2. He was told by several employees that restraining bars were required as lockout devices. He additionally admitted that restraining bars are recognized as lockout devices under OSHA standard definitions and can meet the definition of an "energy isolation device".

Complainant counsel presented witness testimony from Mr. Nicholas La Fronz who identified himself as a supervising CSHO employed by Nevada OSHA. He participated in the investigation and issuance of citations to respondent.

Mr. La Fronz testified on how the standard could be violated if the Telsmith was excluded by respondent from the definition of a PRCS. He responded that the confined space applicability and violation was based upon the Telsmith being found by OSHA during the investigation to be a CS and a PRCS. He explained that to find a violation for a PRCS it must first be shown that the area was a CS. He testified the Telsmith met the OSHA standard definitions of a "confined space" (CS) (29 CFR 1910.146(b)) based particularly on subsection 2 which requires a ". . . **limited or restricted means of entry or exit . . .**". He explained in his testimony the Telsmith demonstrated restricted ingress and egress based upon limitations to access.

On cross-examination CSHO La Fronz testified the employer violated the training requirements for CS and PRCS. He identified examples of there being no evidence of training on how many LOTO bars to use, which bar is correct, where to place them, and how to assure a consistent safe employee operational procedure. He testified that specificity of procedures would include training on the **Telsmith** as a CS, which were not satisfied through the company general training documentation for other CS or LOTO in general because the specific requirements depended upon the particular hazardous equipment and the adequacy of the training and procedures. NOSHA determined the Telsmith is a confined space only when **open** based upon the hazard analysis and probability of serious injury or death in the event of a failure of the hydraulic mechanism to hold the machine open.

Complainant presented adverse witness testimony of Mr. Michael Meeker, the respondent safety representative and recycle plant assistant supervisor. Mr. Meeker testified that on August 6, 2012 he reviewed the Telsmith impact crusher and determined it was **not** a CS and accordingly no permit required as PRCS. He identified the respondent "safety plan" and at page 95 the company CS program; at page 98 the company LOTO plan and procedures. He testified the company CS program is "generic" and designed for application to restrictive spaces throughout the company worksites. He further testified the ". . . Telsmith is a CS when open, but not when closed . . ." because an employee cannot enter the unit when it is in a closed position. When open an employee can enter and do whatever work is required as there is no limit on entry or exit in the open position. He testified when the unit is open there is no limitation on ingress or egress. Mr. Meeker explained the photographs at page 315 and 317 depicting the Telsmith in an open position. He

1 noted the energy retaining bar shown in place on the photograph.
2 Mr. Meeker testified that on the day of the accident patchwork was
3 being performed on the Telsmith by deceased employee Holden. He
4 testified the OSHA standard definition for classification of a CS
5 requires something blocking entry or exit, but none existed on the
6 Telsmith. He described the three recognized stepping points to access
7 the Telsmith when open as depicted at photographic exhibit at page 307.
8 He explained the access required an employee to first step on the frame,
9 then the housing, and finally into the opening onto the rotor assembly.
10 He testified the typical foot step procedure for access did not
11 constitute any limitations or restrictions on entry or exit to meet the
12 definition of the Telsmith as a CS under OSHA standards. Mr. Meeker
13 testified he had no knowledge of "frame supports" as depicted at exhibit
14 page 190, figure 7-6 being installed as the safety plan required nor
15 ever observed any such frame support on the Telsmith. Mr. Meeker
16 admitted that a few weeks prior to the date of the accident, he reviewed
17 worksite areas of confined space at safety meetings. He further
18 testified the Telsmith was not considered a CS when conducting the
19 safety meetings on confined spaces. He admitted the entry made at page
20 256 of the exhibits identified a "Fatality Prevention Element (FPE) No.
21 6 Confined Space" for the Telsmith in his handwriting.
22 Mr. Meeker testified he determined the Telsmith crusher was not a
23 confined space (CS) at all let alone a permit required confined space
24 (PRCS). He also testified the steel bar is an **energy restraining device**
25 not a **lockout/tagout device** which is only applicable to electrical
26 components.
27 At the conclusion of complainant's case, respondent presented
28 testimony and evidence from witnesses Messrs. Martin, Meeker, and

McLean.

Mr. Martin identified himself as the regional health and safety manager of respondent. He testified the identified training documentation provided by respondent was generic because the company is part of a large conglomerate which establishes training practices, procedures and techniques for its employees in the company worldwide aggregate business. Mr. Martin testified as to respondents Exhibits A through G. He explained that specific placement of the energy control bar device would vary dependent upon the work being performed. He testified no employees were confused on placement because it simply depended upon the type of work being done so the bar would not be in the way of the work effort. He testified there were no logs or information as to employee injuries while working on the Telsmith when he reviewed the records at the time his national parent company acquired the respondent company. He testified that he did not know why Mr. Holden would have entered the Telsmith as he did or for what purpose without adding the safety bar.

Mr. Meeker, who was recalled as a witness for respondent, testified employee Holder was merely instructed to "close" the Telsmith. He explained the employees recognized the meaning of that instruction to include cleaning but all done from the outside. He testified that he never told Mr. Holder to enter the Telsmith and has no idea why he did so.

On cross-examination Mr. Meeker testified his written witness statement at page 63 was accurate except for any reference to there being "two bars" required. He denied that is what he told the CSHO. He further testified the witness statement taken by CSHO Church was incorrect at page 64 on lockout of the hydraulic as to any references

to two bars. He testified there was just one bar used to keep the door open and he never used or saw two bars near the Telsmith unit during his work as the company manager since 2001.

Mr. Glenn McLean identified himself as a crusher mechanic and six year employee of respondent. He personally entered the Telsmith to do iron repairs and welding ". . . approximately twenty plus times". When the unit was open he needed to step on three areas of the unit to access the inside. He never entered without a restraining bar in place and testified he was trained in this instruction. He further testified that when he was inside the open Telsmith he would stand on a "blow bar" on top of a rotor. He never saw Mr. Holden enter the Telsmith without a bar in place and testified he (Holden) was a very safety conscious and smart man.

Mr. McLean testified that working on the Telsmith when open during the "closing process" requires two (2) employees to safely perform the work. (Transcript page 248, lines 1-15).

On completion of evidence and testimony, counsel for complaint and respondent presented closing arguments.

Complainant asserted the burden of proof had been met with regard to all six of the violations charged in Citation 1, Items 1 through 6. At Item 1 he argued the evidence established the Telsmith was a confined space (CS) when in an open position and met the OSHA definitions for compliance requirements to implement hazard protection as a permit required confined space (PRCS). He referenced the definition of a confined space at 29 CFR 1910.146(b) and asserted that correctly classifying the Telsmith as a confined space should have been easily met. The definition standard includes three tests for a CS determination. Subsection 1 requires the area be large enough and so

configured that an employee could bodily enter and perform assigned work, which respondent admitted. At subsection 3 it must not be designed for continuous employee occupancy, also stipulated by respondent because it is a crushing unit. Section 2 is the only area of dispute by respondent but easily resolved in accordance with the plain meaning interpretation of NOSHA. Section 2 of the definition required the space have ". . . **limited or restricted means for entry or exit** . . .". Counsel asserted the evidence clearly demonstrated it was necessary to effectuate three stepping maneuvers to enter the portal of the Telsmith when in an open position. No employee could simply walk right in. The undisputed evidence was that the first limitation for entry was an approximate 23" step onto the frame, the second step required a turning motion of the body onto the flange assembly, and the third step was into the portal opening onto a standing bar (blow bar) atop the rotors. Counsel argued this restricting entry process clearly satisfies the OSHA standard definition of a CS at section 3. The evidence is proof there was "limited or restricted means for entry or exit" but the respondent failed to classify the Telsmith as a CS in violation of the cited standard.

Counsel further argued that OSHA general standards actually require a ladder for any step of 19" or more. Therefore the first access step admitted as necessary by respondent at 23" required a ladder for access to the unit. The evidence demonstrated a "limitation" because equipment was needed to effectuate entry and supports the other evidence to meet the definition of limitation on entry. Counsel further argued there are additional **limits and restrictions** to meet the definition caused by the required use of the energy blocking bar designated by the employer to hold open the door as a backup to any failure in the hydraulics. He

asserted the bar added more limitation to entry because an employee would have to "duck his head . . ." and get around the bar, depending upon the work task at that time, placement of the bar and height of the employee. Counsel argued the documentary and testimonial evidence and photographs, as well as the OSHA definition, established the Telsmith to be a confined space when open and should have been so identified by the respondent to determine, classify and protect its Telsmith workplace as a permit required space. This evidence mandated the employers compliance with the cited standard to inform and warn exposed employees by posting danger signs or any other equally effective means of the existence and location of any danger posed by permit required confined spaces as charged in Citation 1, Item 1.

Counsel further argued that Citation 1, Item 2 was established as a violation from the evidence because the employer made a decision that its employees would enter permit spaces when it directed cleaning and repair work as part of the work effort and therefore the employer should have developed and implemented a written permit space program in compliance with the standard and section. The employer did have a permit space plan but it was generic and failed to identify and implement required safety measures for the Telsmith as a CS or PRCS as subject of the testimony of respondent witnesses Meeker and Martin.

At Citation 1, Item 3, the employer failed to document that hazards in a permit space were eliminated through certification specifically as to the Telsmith because it incorrectly excluded the crusher from the definition of a restricted CS.

At Citation 1, Items 4, 5 and 6, the employer violated the LOTO standards as cited. At Item 4 the employer failed to control the energy by use of the means designated in accordance with the manufacturer

manual referencing page 190 of the exhibits. Description of the work effort describes a two man requirement and other safety procedures. Relief of hydraulic pressure was not addressed. The written procedures for LOTO were not "clear and specific". The evidence was substantial for violation and could easily be supported by comparing the manual in evidence to the specific terms of the standard alone to find a violation at Item 4 of the cited standard.

At Item 5, the LOTO devices for energy control should have been identified as mandated by the standard and ". . . be **singularly** identified . . . as the only devices used for controlling energy . . .". The employer designated a restraining or blocking steel bar; however the photographs in evidence at Exhibit 3 depicted three different bars on the Telsmith platform. If only one bar was to be used and the one equipped with a bolt welded at the end then it should have been clearly designated and marked. However no particular bar identification was described or written in the company safety manual nor specifically identified. The evidence did not show and could not be interpreted to establish the bar as "singularly identified" nor "marked". Nothing in the company training procedures or safety plan existed to inform an employee the specific bar to be used and how.

Counsel argued at Item 6 the evidence established by a preponderance demonstrated that none of the authorized employees received training on the applicable hazardous energy sources and the type or magnitude of same as required by the standard. The employer was not compliant as to "stored energy" nor the results of gravity on the unit should the hydraulic line fail. The written manual required attention to these matters. There was no evidence of compliance with the standard.

Complainant counsel concluded closing argument by asserting that the primary respondent failure in this case was to exclude identification of the Telsmith as a CS. Had it done so, all of the applicable safety measures in the cited standards would have been in place and the Telsmith hazards subject of compliance; similarly the accident may have been avoided.

Respondent presented closing argument. Counsel asserted that NOSHA failed to satisfy the burden of proof required for the finding of a violation as to any of the cited standards. He argued the threshold issue to be "applicability" of the standard, an essential element required under the complainant burden of proof. He argued there was no evidence to meet the definition of the Telsmith as a CS, referencing 29 CFR 1910.146(b) because there was no showing, or certainly evidence by a preponderance, there were any actual ". . . limited or restricted access of ingress and egress . . .". He submitted that based upon the lack of applicability the citation 1 violations must fail. Counsel asserted CSHO Church did not testify to or demonstrate any **limitations or restrictions**. Further he never inquired of anyone during his interviews, based upon his testimony, how employees enter or exit the open Telsmith. Counsel argued the reason CSHO Church never asked was because there were none obvious nor contemplated by him or in the cited standard. Only three simple steps are required to access the unit. There was no history of any employee ever having a problem with the Telsmith machine as a CS. OSHA argues now, all of a sudden, because of the unfortunate accident, the 23" step up to enter required a ladder under general OSHA standards because it's beyond 19". Therefore this need for a stepping assistance, together with other maneuvers constitute "limitation or restriction", thereby bringing the Telsmith for the first

time ever under the CS definition. Counsel argued there was no evidence the manufacturer of the Telsmith ever identified anything about it as a CS. He asserted that NOSHA uses the manufacturer manual when it is convenient, but then can't explain why there is nothing in the manual to identify the unit as a CS. There is no evidence a CS standard applies because the OSHA definition was not met at subsection number 2; 1 and 3 were stipulated as not applicable, therefore Citation 1, Item 1 must fail. At Item 2, there is no evidence whatsoever that the employer "decided" its employees would enter permit spaces because the Telsmith was never classified as a permitted space in the first place. The citation is inapplicable.

At Item 3 there can be no finding of a violation because again the respondent did not identify the Telsmith as a permit space or CS, and therefore no certification of hazard elimination required under the cited standard. Because the employer did not initially classify the space as permitted, it cannot be held responsible to **reclassify** the space or implement other measures accordingly.

At Item 4, there was no evidence presented to satisfy the burden of proof for applicability. Counsel charges the standard for electrical elements applies but only presented evidence on a bar device which is "mechanical" referencing 29 CFR 1910.147(b). The mechanical device is an "energy isolating device". The evidence clearly showed appropriate use of a bar to satisfy OSHA requirements and not that as cited for electrical components. The respondent was in compliance with the "stored energy" by utilization of the mechanical device (bar) so no violation as to the cited electrical standards which were inapplicable.

At Item 5, the cited standard requirements for LOTO were not applicable, being intended for electrical use. A restraining bar is not

a "LOTO device" but rather an "energy isolation device". Counsel asserted that complainant uses a "red herring" by referencing two or more bars. It really makes no difference because the point is an energy isolation device in the form of a bar was used and understood by all the employees. The fact that Mr. Holden, the deceased employee, failed to insert any bar device or why he even entered the unit could not be explained by anyone.

There was no violation as to Item 6 on training. It is just NOSHA attempt to overload the citation process. The manual is not a standard and there was ample evidence of extensive appropriate training throughout the record.

Counsel asserted the defense of employee misconduct would apply should the board find the existence of any violation. Any finding of a violation is rebutted based upon the inexplicable, albeit unfortunate, misconduct of Mr. Holden. "No one can explain why Mr. Holden did what he did - he was not instructed to go into the portal . . . and there was no reason why the bar was not in place if he, for some reason, needed to do so . . .". Counsel argued the safety procedures are clear in bold letters "don't go in without a bar . . .". So why was he in there without a bar in place? No one knows or can explain. There is a great deal of evidence on training, discipline, termination, and other meaningful enforcement measures. It is also worth noting that the bar is not primary, rather the hydraulic "ram" protects the unit from collapsing. However on the day of the accident there was a very unforeseeable and unpreventable failure in the hydraulic line when the oil leaked out and the accident happened through gravity forcing a closure of the unit opening.

Counsel concluded the evidence, arguments, and submitted the case

for decision.

The board in reviewing the facts, documents and testimony in evidence must measure same against the established law developed under the Occupational Safety & Health Act, Code of Federal Regulations (CFR) and Nevada Revised Statutes (NRS).

> In all proceedings commenced by the filing of a notice of contest, the burden of proof rests with the Administrator. N.A.C. 618.788(1).
>
> All facts forming the basis of a complaint must be proved by a preponderance of the evidence. *Armor Elevator Co.*, 1 OSHC 1409, 1973-1974 OSHD ¶16,958 (1973).
>
> To prove a violation of a standard, the Secretary must establish (1) the **applicability** of the standard, (2) the existence of **noncomplying conditions**, (3) **employee exposure or access**, and (4) that the **employer knew or with the exercise of reasonable diligence could have known of the violative condition.** See *Belger Cartage Service, Inc.*, 79 OSAHRC 16/B4, 7 BNA OSHC 1233, 1235, 1979 CCH OSHD ¶23,400, p.28,373 (No. 76-1948, 1979); *Harvey Workover, Inc.*, 79 OSAHRC 72/D5, 7 BNA OSHC 1687, 1688-90, 1979 CCH OSHD 23,830, pp. 28,908-10 (No. 76-1408, 1979); *American Wrecking Corp. v. Secretary of Labor*, 351 F.3d 1254, 1261 (D.C. Cir. 2003). (emphasis added)

A respondent may rebut allegations by showing:

> 1. The standard was inapplicable to the situation at issue;
>
> 2. The situation was in compliance; or lack of access to a hazard. See *Anning-Johnson Co.*, 4 OSHC 1193, 1975-1976 OSHD ¶ 20,690 (1976).

A "serious" violation is established upon a preponderance of evidence in accordance with NRS 618.625(2) which provides in pertinent part:

> . . . a serious violation exists in a place of employment if there is a **substantial probability that death or serious physical harm could result** from a condition which exists or from one or more practices, means, methods, operations or processes which have been adopted or are in use at that place

of employment unless the employer did not and could not, with the exercise of reasonable diligence, know the presence of the violation. (emphasis added)

29 CFR 1910.146(b) defines a confined space.

"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 designated for continuous employee occupancy.

See 29 CFR § 1910.146(b)(c).

A 'permit-required confined space' is defined as:

". . . if it has **one** or more of the following: 'Contains or has a potential to contain a hazardous atmosphere; contains a material that has the potential for engulfing an entrant; 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 contains **any other recognized safety or health hazard.'** The employer **must evaluate the workplace to determine if any confined spaces are permit-required spaces."** (emphasis added)

29 CFR 1910.146(c)(2) Citation 1, Item 1, imposes a **threshold requirement** for an employer to inform exposed employees if a workplace contains permit spaces by posting danger signs or any other equally or effective means of the existence or location of a danger posed by the permit spaces. At Aggregate Industries Sloan recycling plant, employees performed maintenance inside an impact crusher identified as a Telsmith Model No. 5263, without being informed of hazardous working conditions and exposure to serious injury or death by posted danger signs or other equally effective means of the existence, location and dangers posed by

work in confined spaces. Employee Holden entered the impact crusher when in an open position while performing his duties as a heavy duty repairman, and was killed due to the apparent failure of a hydraulic line which allowed the unobstructed opening to fall to a closed position thereby crushing him and causing death. Employee McLean performed iron repairs and welding inside the open Telsmith over 20 times. The employer excluded the Telsmith from classification as a confined space and permit required confined space and accordingly did not implement the CS or PRCS safety requirements of the cited standards.

The board finds that testimony of Messrs. Church, Meeker and McLean describe the means of entry into the open unit to include "limitations and restrictions for entry and exit access . . .". The three step process, maneuver(s) of the body and the height of the first initial step, were evidence of structural restrictions and limitations to meet the OSHA definition of a confined space (CS). The evidence demonstrated additional "restrictions and limitations to access". The company required placement of a safety bar into a portion of the Telsmith opening and the location depended upon the size or height of the employee, the work to be performed, and potential to "duck ones head" to work around the bar.

The substantial evidence established the Telsmith met the plain meaning definition of a "confined space" in 29 CFR 1910.146(b), the evidence was supported and corroborated. Mr. Meeker identified the Telsmith as a CS (see page 256 of exhibit in evidence) when he initially surveyed the unit and made a written survey entry it included a "FPE #6 Confined Space". Notwithstanding that initial determination, respondent excluded the Telsmith as a CS and did not classify it as a PRCS to implement the requirements of the cited standard. The evidence is

substantial, persuasive, and preponderant the Telsmith impact crusher should have been classified as a CS and a PRCS. The evidence satisfies the burden of proof to establish a violation at Citation 1, Item 1.

The evidence of hazard exposure to employee Holden, and other employees of respondent, satisfies the proof elements for the recognized dangers in the Telsmith unit to establish the classification of **serious**. It is unrefutted that no warning or danger signs were posted on the unit as required by the standard. This was the result of the employer's initial failure to identify the Telsmith as a CS. Further there is no mitigating evidence of any ". . . other equally effective means . . ." to inform employees of the dangers of the space.

At Citation 1, Item 2, the evidence does not provide a basis nor meet the burden of proof for finding a violation. The evidence does not demonstrate the employer ". . . **decided** that its employees will enter permit spaces . . .". While it is arguable the employer's failure at Item 1 to appropriately identify the Telsmith as a CS could allow an inference that an indirect "decision" was made by its own failure to initially recognize and classify the Telsmith as a confined space, violation of the specific standard terms under occupational safety and health law cannot be established by inference alone. The specific standard requires substantial evidence by a preponderance to confirm a violation. The Item 2 citation appears to be merely a follow on charge of violation by implication, logic or inference, but does not meet the burden of proof.

The specific terms of the cited standard at Item 3, measured against the evidence presented in support of same, did not satisfy the requirements for proof of violation. While the employer did indeed violate Item 1 by failing to appropriately identify and **classify** the

Telsmith as a CS, that alone is not proof of a failure to "**reclassify**" that which was not initially so classified and require the related documentation. It would be duplicitous to add a violation against the respondent for **failing to reclassify that which it did not initially classify** and cite for not **documenting** that all hazards and space, never initially determined to be a **permit space** had been eliminated.

At Citation 1, Item 4, the preponderance of credible substantial evidence established the cited standard was applicable because the respondent procedures and plans in evidence did not ". . . clearly and specifically outline the scope, purpose, authorization, rules and techniques to be utilized for control of hazardous energy . . .". The employer elected to use a hand made device consisting of one or more steel bar(s) one with a bolt welded to the end. The manufacturer recommended specific means for a backup safety control of the unit through an energy isolating device was not followed. To compound that failure, the employer safety plan, if read by an employee, directs the employee to go to the manual to determine the procedures. So while the manual is not an **enforcement** standard, it describes the manufacture safety controls to be other than that designated by the employer. The standard requires directives for clear and specific implementation of the safety requirements.

At Citation 1, Item 5, the evidence supported a finding of violation because the lockout device was not "singularly identified" nor was there credible evidence it was the "only device" used for controlling energy as required by the standard. There were three bars depicted in photographic exhibits. Employee witness statements corroborated the testimony of CSHO Church as did the photographic exhibit depicting three bars on the site. At page 113 the bar(s) are

identified as a "LOTO device". Accordingly they should have been specifically identified, painted, marked in some other fashion clearly "**singularly**" designated for there to be compliance with the cited standard. The evidence and testimony demonstrated confusion or conflicting understandings by employees as to the use of a bar, which bar, how many bars and/or the method for use.

At Citation 1, Item 6, there is insufficient evidence to find a violation for a lack of employee training in the recognition of hazardous energy sources and the magnitude of energy available in the workplace and the method and means for isolation and control.

There was substantial training in place by the respondent and in fact on a broad scale. At page 113 an employee is directed to never enter the Telsmith unit without a bar. While there was no reference to hydraulic energy or gravity energy, the plan appeared to be sufficiently compliant with the requirement of the standard as to hazardous energy sources.

Respondent asserted the defense of **unpreventable or unforeseeable employee misconduct**. However, there was insufficient evidence to establish the recognized defense of **unpreventable employee misconduct** to rebut the preponderant evidence of the violations found. The employer did not meet the legal burden to prove the necessary elements of the defense by a preponderance of evidence. This board relies upon long established Federal and OSHRC case law providing that for an employer to prevail on the defense of unpreventable or unforeseeable employee misconduct, it must meet its burden of proof by a preponderance of substantial evidence that despite safety policies in a compliant safety program which is effectively communicated and enforced, the conduct of its employee in violating the policy was unforeseeable, unpreventable or

an isolated event.

The burden of proof to confirm a violation rests with OSHA under Nevada law (NAC 618.798(1)); but after establishing same, **the burden shifts to the respondent to prove any recognized defenses.** See *Jensen Construction Co.,* 7 OSHC 1477, 1979 OSHD ¶ 23,664 (1979). Accord, *Marson Corp.,* 10 OHSHC 2128, 1980 OSHC 1045 ¶ 24,174 (1980).

Respondent asserted the recognized defense of **unpreventable employee misconduct.**

> The defense (**unpreventable employee misconduct**) has been stated in various ways, but it basically requires an employer to show that its employees were required to take protective measures that would comply with the standard and it enforced that requirement. *E.g., Brock v. L.E. Myers Co.,* 818 F.2d 1270, 13 OSH Cases 1289 (6th Cir.), *cert. Denied,* 484 U.S. 989 (1987); *Texland Drilling Corp.,* 9 OSH Cases 1023 (Rev. Comm'n 1980). The Commission has distilled its decisions as requiring **four elements of proof:** that (1) the employer has established work rules designated to prevent the violation; (2) it has adequately communicated those rules to its employees; (3) it has **taken steps to discovery violations;** and (4) it has effectively enforced the rules when violations have been discovered. *E.g., Capform Inc.,* 16 OSH Cases 2040, 2043 (rev. Comm'n 1994). Rabinowitz Occupational Safety and Health Law, 2008, 2nd Ed., pages 156.
>
> An employer has the affirmative duty to **anticipate and protect against preventable hazardous conduct by employees.** *Leon Construction Co.,* 3 OSHC 1979, 1975-1976 OSHD ¶ 20,387 (1976). **Employee misbehavior, standing alone, does not relieve an employer.** Where the Secretary shows the existence of violative conditions, an employer may defend by showing that the employee's behavior was a deviation from a uniformly and **effectively enforced work rule, of which deviation the employer had neither actual nor constructive knowledge.** *A. J. McNulty & Co., Inc.,* 4 OSHC 1097, 1975-1976 OSHD ¶ 20,600 (1976). (emphasis added)
>
> In order to establish an unpreventable employee misconduct defense, the employer must establish that it had: established work rules designed to prevent the violation; **adequately communicated those work rules** to its employees (**including**

> **supervisors**); taken **reasonable steps to discover violations of those work rules**; and **effectively enforced those work rules** when they were violated. *New York State Electric & Gas Corporation*, 17 BNA OSHC 1129, 1195 CCH OSHD ¶ 30,745 (91-2897, 1995). (Emphasis added)
>
> It is well settled that the **knowledge, actual or constructive, of an employer's supervisory personnel** will be imputed to the employer, unless the employer establishes **substantial grounds** for not doing so. *Ormet Corp.*, 14 BNA OSHC 2134, 1991-93 CCH OSHD ¶ 29,254 (No. 85-531 1991). *Consolidated Freightways Corp.*, 15 BNA OSHC 1317, 1991-93 CCH OSHD ¶ 29,500 (No. 86-531, 1991). (Emphasis added)

Employer knowledge, foreseeability, and lack of safety enforcement by **supervisory personnel** aware of hazard exposures prevents reliance upon the defense of unpreventable employee misconduct to relieve respondent of liability. The defense of unpreventable employee misconduct and the burden of proof to satisfy same requires **substantial** evidence under applicable law. There was insufficient evidence to establish the defense and rebut the proof of violation.

The facts presented in the evidence, testimony and pictorial documentation demonstrated potentially hazardous and dangerous conditions associated with the Telsmith Impact Crusher. Working near the unit and particularly any potential access or entry while it is in an "open" status is clearly a recognizable and extremely dangerous hazardous condition. There were insufficient employer work rules, training and supervision in place to prevent inadvertent employee misbehavior or a deviation from general work rules. For example, the work rules regarding the blocking bar placement and use were not specific nor sufficiently understood by the employees. The employer had direct and constructive knowledge of the hazard exposure dangers for one employee to work alone on the unit in an "open" state. It was difficult

to determine why employee Holden would have entered the open unit without a bar in place, but it is foreseeable that an employee working alone, could for no explicable reason accidentally or without good reason enter the unit, slip, fall into the opening or fail to properly **lockout** the mechanism and suffer serious injury, or as in this instance death. The result may have been prevented by an initial classification of the space as an extremely hazardous and dangerous confined space, assignment of a second safety employee during work while open, adequate employee training and specific procedure on LOTO.

Mechanic employee Glenn McLean testified the work the deceased was assigned to perform was a two man job, but the employer only sent one man. He also testified the job could not be done safely with just one man. The employer knew or with the exercise of reasonable diligence should have known the work effort could not be done safely by one man and accordingly hazardous conduct by company employee Holden was foreseeable and preventable. For example, the "safety employee" could have warned off Mr. Holden that he overlooked the safety bar or perhaps assisted him if he slipped into the unit while trying to retrieve a tool. The employer knew or should have known with the exercise of reasonable diligence that the job Mr. Holden was sent to do, requiring "close" of the Telsmith, as involved potentially very hazardous working conditions and at least required two men to perform that work safely. Notwithstanding all the safety, training no one trained Mr. Holden or other employees on the **confined space** dangers of the Telsmith. The employer failed to recognize, classify, warn or train employees by posting of dangers, signs, extra warning signs. No one from supervisory management who were aware of the hazards took the safety training steps necessary to "effectively communicate" and/or "meaningfully enforce"

1 what should have been reasonable safety requirements that might have
2 avoided the accident from occurring. While the act of employee Holden
3 appears inexplicable, and perhaps merely attributable to **employee**
4 **misbehavior**, that possibly standing along does not relieve the employer
5 through an employee misconduct defense. (See *A. J. McNulty & Co.*, supra)
6 Complainant met the statutory burden of proof and established the
7 violations as to Citation 1, Items 1, 4 and 5 by a preponderance of
8 evidence. The violations are confirmed, together with the classification
9 of Serious and penalties proposed.
10 The complainant did not meet the statutory burden of proof to
11 establish violations as to Citation 1, Items 2, 3 and 6. The
12 violations, classifications, and proposed penalties are denied.
13 It is the decision of the **NEVADA OCCUPATIONAL SAFETY AND HEALTH**
14 **REVIEW BOARD** that a violations of Nevada Revised Statutes did occur as
15 to Citation 1, Item 1, 29 CFR 1910.146(c)(2), Citation 1, Item 4, 29 CFR
16 1910.146(c)(4)(ii) and Citation 1, Item 5, 29 CFR 1910.146(c)(5)(ii).
17 The violations, Serious classifications and proposed penalties in the
18 amount of SIX THOUSAND THREE HUNDRED DOLLARS ($6,300.00) for each
19 violation, for a grand total of EIGHTEEN THOUSAND NINE HUNDRED DOLLARS
20 ($18,900.00), are confirmed and approved.
21 The Board directs counsel for the complainant, **CHIEF ADMINISTRATIVE**
22 **OFFICER OF THE OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, DIVISION**
23 **OF INDUSTRIAL RELATIONS**, to submit proposed Findings of Fact and
24 Conclusions of Law to the **NEVADA OCCUPATIONAL SAFETY AND HEALTH REVIEW**
25 **BOARD** and serve copies on opposing counsel within twenty (20) days from
26 date of decision. After five (5) days time for filing any objection,
27 the final Findings of Fact and Conclusions of Law shall be submitted to
28 the **NEVADA OCCUPATIONAL SAFETY AND HEALTH REVIEW BOARD** by prevailing

CALENDARED
DATE:

counsel. Service of the Findings of Fact and Conclusions of Law signed by the Chairman of the **NEVADA OCCUPATIONAL SAFETY AND HEALTH REVIEW BOARD** shall constitute the Final Order of the **BOARD**.

DATED: This 24th day of February 2014.

NEVADA OCCUPATIONAL SAFETY AND HEALTH
REVIEW BOARD

By /s/
JOE ADAMS, Chairman