BEFORE THE SAFETY AND HEALTH REVIEW BOARD

OF NORTH CAROLINA

COMMISSIONER OF LABOR OF
THE STATE OF NORTH CAROLINA,

COMPLAINANT,

v.

FITESA NORTH AMERICA
CORPORATION,

RESPONDENT.

DOCKET NO. OSHANC 95-3339
OSHA INSPECTION NO. 111156220
CSHO ID NO. H6245

ORDER

DECISION OF THE REVIEW BOARD

This appeal was heard at or about 9:00 A.M. on the 25th day of June, 1999 in Room 2115 of the Dobbs Building located at 430 North Salisbury Street, Raleigh, North Carolina by Henry Whitesides, acting Chair and Carroll D. Tuttle, Designated Member of the North Carolina Safety and Health Review Board.

APPEARANCES

Ann Goco Kirby, Associate Attorney General, North Carolina Department of Justice, Raleigh, North Carolina for the Complainant.

Richard F. Kane, Attorney At Law, of Blakeney & Alexander, Charlotte, North Carolina for the Respondent.

ISSUES PRESENTED

1. Was the Hearing Examiner's finding that the Respondent committed a willful serious violation of 29 CFR 1910.212(a)(1) as alleged in Citation 1, Item 1, by failing to guard the incoming nip points of compression roller #2 of production line #3, supported by substantial evidence and by a preponderance of the evidence?

2. Was the Hearing Examiner's finding that the Complainant failed to prove by a preponderance of the evidence that the Respondent committed a willful violation of 29 CFR 1910.147(c)(1), the lockout/tagout standard, as alleged in Citation 1, Item 2, supported by substantial evidence and a preponderance of the evidence?

3. Was the Hearing Examiner's finding that the Respondent committed a serious violation of 29 CFR 1910.147(c)(1), the lockout/tagout standard, supported by substantial evidence and a preponderance of the evidence?

4. Was the Hearing Examiner's finding that the Respondent committed serious violations of 29 CFR 1910.132(d)(1), (f)(1) and 29 CFR 1910.133(a)(1), (all involving the Personal Protective Equipment-- PPE standard) as alleged in Citation 2, Items 1a, 1b and 1c, respectively, supported by substantial evidence and a preponderance of the evidence?

5. Was the Hearing Examiner's finding that the Respondent committed a serious violation of 29 CFR 1910.151(c), as alleged in Citation 2, Item 2, for failure to provide quick drenching facilities for the eyes and body supported by substantial evidence and a preponderance of the evidence?

6. Was the Hearing Examiner's finding that the Respondent committed serious violations of 29 CFR 1910.1030(c)(1)(i), (d)(3)(i), (d)(4)(ii)(a), (f)(2)(i) and (g)(1)(i)(A) (all involving the Bloodborne Pathogen Standard) as alleged in Citation 2, Items 3a, 3b, 3c, 3d and 3e, respectively, supported by substantial evidence and a preponderance of the evidence?

STATUTES AND REGULATIONS AT ISSUE

1. N.C. Gen. Stat § 95-127(18) which defines a serious violation as existing "if there is a substantial probability that death or serious physical harm could result from a condition which exists ... unless the employer did not know, and could not, with the exercise of reasonable diligence, know of the presence of the violation".

2. N.C.G.S. § 95-138(a) which states the following with respect to a willful violation:

> Any employer who willfully or repeatedly violates the requirements of this Article, any standard, rule or order promulgated pursuant to this Article, or regulations prescribed pursuant to this Article, may upon the recommendation of the Director to the Commissioner be assessed by the Commissioner a civil penalty of not more than seventy thousand dollars ($70,000) and not less than five thousand dollars ($5,000) for each willful violation.

3. 29 CFR 1910.212(a)(1) which provides:

> (a) Machine guarding--(1) Types of guarding. One or more methods of machine guarding shall be provided to protect the operator and other employees in the machine area from hazards such as those created by point of operation, ingoing nip points, rotating parts, flying chips and sparks. Examples of guarding methods are--barrier guards, two-hand tripping devices, electronic safety devices, etc.

4. 29 CFR 1910.147(c)(1) which provides:

> (c) "Energy control program." (1) The employer shall establish a program consisting of energy control procedures, employee training and periodic inspections to ensure that before any employee performs any servicing or maintenance on a machine or equipment where the unexpected energizing, startup or release of stored energy could occur and cause injury, the machine or equipment shall be isolated from the energy source and rendered inoperative.

5. 29 CFR 1910.132(d)(1) which provides:

> (d) Hazard assessment and equipment selection. (1) The employer shall assess the workplace to determine if hazards are present, or are likely to be present, which necessitate the use of personal protective equipment (PPE). If such hazards are present, or likely to be present, the employer shall:
>
> > (i) Select, and have each affected employee use, the types of PPE that will protect the affected employee from the hazards identified in the hazard assessment;
> >
> > (ii) Communicate selection decisions to each affected employee; and,
> >
> > (iii) Select PPE that properly fits each affected employee.

6. 29 CFR 1910.132(f)(1) which provides:

> (f) Training. (1) The employer shall provide training to each employee who is required by this section to use PPE. Each such employee shall be trained to know at least the following:
>
> > (i) When PPE is necessary;
> >
> > (ii) What PPE is necessary;
> >
> > (iii) How to properly don, doff, adjust, and wear PPE;
> >
> > (iv) The limitations of the PPE; and,
> >
> > (v) The proper care, maintenance, useful life and disposal of the PPE.

7. 29 CFR 1910.133 (a)(1) which provides:

(a) General Requirements. (1) Each affected employee shall use appropriate eye or face protection when exposed to eye or face hazards from flying particles, molten metal, liquid chemicals, acids or caustic liquids, chemical gases or vapors, or potentially injurious light radiation.

8. 29 CFR 1910.151(c) which provides:

Where the eyes or body of any person may be exposed to injurious corrosive materials, suitable facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use.

9. 29 CFR 1910.1030(c)(1)(i) which provides:

(1) Exposure Control Plan. (i) Each employer having an employee(s) with occupational exposure as defined by paragraph (b) of this section shall establish a written Exposure Control Plan designed to eliminate or minimize employee exposure.

Paragraph (b) reads as follows for the following definitions:

Occupational Exposure means reasonable anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.

Parenteral means piercing mucous membranes or the skin barrier through such events as needlesticks, human bites, cuts, and abrasions.

Other Potentially Infectious Materials means

(1) The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids;

(2) Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and

(3) HIV-containing cell or tissue cultures, organ cultures, and HIV- or HBV-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV.

10. 29 CFR 1910.1030(d)(3)(i) which provides:

(3) Personal Protective Equipment--(i) Provision. When there is occupational exposure, the employer shall provide, at no cost to the employee, appropriate personal protective equipment such as, but not limited to, gloves, gowns, laboratory coats, face shields or masks and eye protection, and mouthpieces, resuscitation bags, pocket masks, or other ventilation devices. Personal protective equipment will be considered "appropriate" only if it does not permit blood or other potentially infectious materials to pass through to or reach the employee's work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used.

11. 29 CFR 1910.1030(d)(4)(ii)(A) which provides:

Contaminated work surfaces shall be decontaminated with an appropriate disinfectant after completion of procedures; immediately or as soon as feasible when surfaces are overtly

contaminated or after any spill of blood or other potentially infectious materials; and at the end of the work shift if the surface may have become contaminated since the last cleaning.

Section (b) defines contaminated as follows: "Contaminated means the presence or the reasonable anticipated presence of blood or other potentially infectious materials on an item or surface."

12. 29 CFR 1910.1030(f)(2)(i) which provides:

Hepatitis B vaccination shall be made available after the employee has received the training required in paragraph (g)(2)(vii)(I) and within 10 working days of initial assignment to all employees who have occupational exposure unless the employee has previously received the complete hepatitis B vaccination series, antibody testing has revealed that the employee is immune, or the vaccine is contraindicated for medical reasons.

13. 29 CFR 1910.1030(g)(1)(i)(A) which provides:

Warning labels shall be affixed to containers of regulated waste, refrigerators and freezers containing blood or other potentially infectious material; and other containers used to store, transport or ship blood or other potentially infectious materials, except as provided in paragraph (g)(1)(i)(E), (F) and (G).

Having reviewed and considered the record and the briefs of the parties and the arguments of the parties, the Safety and Health Review Board of North Carolina hereby AFFIRMS the decision of the hearing examiner, and makes the following Findings of Fact, Conclusions of Law, and Order:

FINDINGS OF FACT

1. This case was initiated by a notice of contest which followed citations issued to the Respondent to enforce the Occupational Safety and Health Act of North Carolina (OSHANC or Act), N.C. Gen. Stat. §§ 95-126 et seq.

2. The Commissioner of Labor (Complainant) is responsible for enforcing OSHANC (N.C. Gen. Stat § 95-133).

3. The Respondent is an employer within the meaning of N.C. Gen. Stat § 95-127(10).

4. The Respondent, Fitesa North America Corporation is subject to the provisions of OSHANC (N.C. Gen. Stat § 95-128).

5. Respondent timely filed a notice of contest and on July 24 and July 25, 1996 and on February 19 and 20, 1997 hearings were held before the Honorable Richard Koch.

6. On October 6, 1998, the Hearing Examiner issued his order; the items of his order which are the subject of this appeal are as follows:

a. Citation 1, Item 1 was affirmed as a willful serious violation of 29 C.F.R. §1910.212(a)(1) with a penalty of $42,000.00

b. Citation 1, Item 2 was affirmed as a serious violation of 29 C.F.R. §1910.147(c)(1) with a penalty of $4,200.00.

.

c. Citation 2, Item 1a, 1b and 1c were affirmed as serious violations of 29 C.F.R. §1910.132(d)(1), (f)(1) and .133(a)(1), respectively with a grouped penalty of $900.00

d. Citation 2, Item 2 was affirmed as a serious violation of 29 C.F.R. §1910.151(c) with a penalty of $900.00.

e. Citation 2, Item 3a, 3b, 3c, 3d and 3e were affirmed as serious violations of 29 C.F.R. §1910.1030(c)(1)(i), (d)(3)(i), (d)(4)(ii)(a), (f)(2)(i), and (g)(1)(i)(A), respectively with a grouped penalty of $2,100.00.

7. The Board adopts the Hearing Examiner's findings of fact numbered 1 through 31.

Citation 1, Item 1-Willful serious violation of 29 C.F.R. §1910.212(a)(1)

8. The failure to provide machine guarding at the incoming nip point formed by the conveyor belt and the # 2 compression roller on line #3 web forming machine created the hazard that an employee could be pulled into the compression roller. (1996 T pp 70, 73-74).

9. Respondent's employees were exposed to the hazard. (1996 T pp 66-72, 75; Complainant's exhibits 1-5).

10. The hazard created the possibility of an accident, an employee cleaning the compression rollers at the incoming nip point could be pulled into and crushed by the rollers. (1996 T p74).

11. The substantially probable result of such an accident could be crushed bones and death. (1996 T pp 74-75).

12. Respondent knew of the condition that created the hazard in that the company had placed signs warning of pinch points on the machinery next to the #3 compression roller; there had been three other injuries within the previous year involving nip points; Mr. Herminio Freitas, the plant manager knew that there was a nip point on the left side of Compression Roller Number 2, he admitted to the compliance officer that he was aware of the hazards associated with this type of machinery and that he knew of two other fatalities that happened at the Respondent's South American facility and the Novatec system description which Respondent used to describe the entire process of line #3 stated the dangers of nip points created by compression rollers and conveyor belts. (1996 T pp 75-82; Complainant's exhibit 1 and 14). (1997 T pp 149-150).

13. The Respondent's failure to guard the incoming nip point formed by the conveyor belt and the # 2 compression roller on line #3 web forming machine was a willful serious violation of 29 CFR 1910.212(a)(1) in that it was one done voluntarily with an intentional disregard and/or plain indifference to the standard as is proven by the following facts:

a. The Respondent had knowledge of the standard through Danis Allison, the Personnel Administrator and chairman of the Safety Committee who had a copy of 29 CFR 1910, the Occupational Safety and Health Standards for General Industry of which 29 CFR 1910.212(a)(1) is a part; who attended a week long course put on by the Employers' Association which used the 1910 standards as a manual and during which she studied parts of the 1910 standards including hazards within the work environment and who as Chairman of the Safety Committee helped establish as one of the Safety Committee goals to "Determine / Document Safety Rules Per OSHA requirements" between March of 1994 and May of 1994 . (1997 T pp. 236, 237, 239, 252; Defendant's exhibit # 16 and #17).

b. The Respondent had knowledge of the standard through its plant manager, Herminio Freitas who knew that there was a nip point on the left side of Compression Roller #2 on line #3 formed by Compression Roller #2 and the conveyor belt, knew that a guard was required on a nip point if there was employee exposure as is required by the standard, 29 CFR 1910.212(a)(1) and knew that employees were exposed when the company performed maintenance on the left side of Compression Roller #2. (1997 T pp. 149-150, 156-157).

c. The Respondent had knowledge of the standard through Fernando Becker, the project manager and Herminio Freitas, the plant manager in that Robert Templeton, a team leader/employee involved in the setup of Line #3 told both of them of the dangers of the nip points on line #3 and of the need to guard Compression Roller #2 on Line #3. (1996 T pp 213-216, 224-225). (1997 T pp165-168).

d. The Respondent had knowledge of the condition that created the violation. (See finding of fact numbered 12 above).

e. The Respondent subsequently committed a serious violation of the standard, 29 C.F.R. §1910.212(a)(1) . (See findings of fact numbered 8-12 above).

f. The Respondent possessed a state of mind that showed an intentional disregard of the standard and/or plain indifference to the requirement of the OSH Act in that three management employees all knew about the dangers of nip points and the necessity to guard them and knew that three employees at the Mooresville plant had been caught in nip points and suffered serious injuries, however only one of the nip points was guarded (1997 T pp 149-150); the Plant Manager, Mr. Herminio Freitas knew about the nip point on compression roller #2 on Line #3 which is the nip point in which David Starnes was caught and crushed to death, knew that employees accessed the platform on the left side to perform maintenance on the machine and did not install a guard at this nip point (1997 T pp 149-150, 156-157); the Plant Manager, Mr. Herminio Freitas also knew about two previous fatalities involving employees caught in nip points that had happened at the Respondent's South American Plants (1996 T pp 77-78) (1997 T pp 144-148); Respondent's insurer Chubb Group in January of 1995, about four months before David Starnes death, performed a Workman's Compensation Audit of Respondent because of the high frequency of recorded injuries (three times the industry average) and recommended that "OSHA-mandated programs should be written and implemented per the respective standards" (Defendant's exhibit #18 and Complainant's exhibit #26) and despite all of these warnings, Respondent did not install a guard at the nip point of compression roller #2 on Line #3 which if installed could have prevented the death of David Starnes.

14. Respondent showed an intentional disregard and/or plain indifference to employee safety and health as is proven by the same facts set out in findings of fact numbered 13 above and by the facts that Respondent pushed to optimize production at the expense of safety in order to please one of the shareholders, Mr. Ling, who was dissatisfied with the production levels which limited sales (1996 T pp 223-227, 228-231; 1997 T pp 141-142; Defendant's exhibit #11); Respondent trained its employees in unsafe methods of removing wraps around the rollers and did not stop the machine to remove the wraps after being warned by one of its employees, Robert Templeton, of the dangers of cleaning the rollers while the machine was running and the necessity to stop the machine before cleaning the rollers (1996 T pp 213-217, 223-227, 234-237; 1997 T pp 165-168) and Respondent had no written procedures for the removal of the picks and wraps on the compression rollers, no written procedures prohibiting the employees from accessing the compression rollers from the platform on the left-hand side of the machine and knew that the employees accessed the machine from the left side to remove wraps (1997 T pp 157-158).

15. The penalty of $42,000.00 for this willful serious violation was calculated according to the Field Operations Manual and after giving due consideration to the size of the business, the gravity of the violation, the good faith or lack thereof of the employer and the record of violations within the previous three years, the Board finds that the penalty is fair, reasonable in amount, and assessed equitably and uniformly.

Citation 1, Item 2, Serious Violation of 29 C.F.R. §1910.147(c)(1)

16. The hazard created by the failure to develop and implement an effective lockout/tagout program created the hazard of the unexpected energization of equipment resulting in an employee being pulled into the ingoing nip point of the compression roller and the conveyor belt or in the roller falling down on an employees body part. (1996T p 120-121).

17. Employees Dale Lindley and Robert Hendren were exposed to the hazard. (1996T p 121)

18. The hazard created the possibility of an accident. (1996T p 120).

19. The substantially probable result of such an accident was serious physical injury including broken and crushed bones and even death. (1996T p 120).

20. The employer knew of the condition in that Danis Allison, Personnel Administrator and chairman of the Safety Committee admitted that the lockout/tagout program was being developed but it had not been implemented and employees had not been trained on lockout/tagout. (1996T p 122; 1997 T pp 246-247, 249, 259).

21. The penalty of $4,200.00 for this serious violation was calculated according to the Field Operations Manual and after giving due consideration to the size of the business, the gravity of the violation, the good faith or lack thereof of the employer and the record of violations within the previous three years, the Board finds that the penalty is fair, reasonable in amount, and assessed equitably and uniformly.

Citation 2, Item 1a, Serious violations of 29 C.F.R. §1910.132(d)(1)

22. The failure of the employer to perform a hazard assessment on the work environment to determine what hazards existed which necessitated the use of personal protective equipment created the hazard that employees would be injured by splashing isopropyl alcohol, surfactant, regency foam agent and/or sulfuric acid on their skin or in their eyes. (1996 T pp 258-263, 276-278).

23. Employees Robert Hendren, David Starnes and Gerald Robinson were exposed to the hazards. (1996 T pp 261-263, 286-287).

24. The hazard created a possibility of an accident that employees would spill alcohol, surfactant, regency foam agent and/or sulfuric acid on their skin or in their eyes. (1996T pp 283-284).

25. The substantially probable result of such an accident could be severe chemical burns to the eyes and skin which is a serious physical injury. (1996T pp 285-286; Complainant's Exhibits 33-36).

26. The Respondent knew or should have known about the condition in that Herminio Freitas, the plant manager and Danis Allison, the personnel director, both admitted that a hazard assessment had not been completed. (1996T p 288)

27. The use of the personal protective equipment would have reduced or eliminated the hazard. (1996T p 291).

Citation 2, Item 1b, Serious violations of 29 C.F.R. §1910.132(f)(1)

28. The failure of the employer to provide training to its employees in the use of personal protective equipment created the hazard that employees could be exposed to chemicals and could be injured by splashing isopropyl alcohol, surfactant, regency foam agent and/or sulfuric acid on their skin or in their eyes. (1996 T pp 294-295).

29. Employees Robert Hendren, David Starnes, Dale Lindley and Gerald Robinson were exposed to the hazards. (1996 T pp 296).

30. The hazard created a possibility of an accident. (1996T pp 295).

31. The substantially probable result of such an accident could be chemical burns to the eyes and skin which is a serious physical injury. (T pp 295; Complainant's Exhibits 33-36).

32. The Respondent knew or should have known about the condition in that Herminio Freitas, the plant manager and Danis Allison, the personnel director, both admitted that a hazard communication program was still in the developmental stage and the employees had not been trained. (1996T p 296)

33. The training in the use of the personal protective equipment would have reduced or eliminated the hazard. (1996T p 296-297).

Citation 2, Item 1c, Serious violations of 29 C.F.R. §1910.133(a)(1)

34. The failure of the employer to provide appropriate eye or face protection when exposed to eye or face hazards from liquid chemicals, acids or caustic liquids created the hazard that employees could be exposed to the liquid chemicals isopropyl alcohol, surfactants, de-foamer and sulfuric acid and could be injured by splashing these liquid chemicals on their skin, face or in their eyes. (1996 T pp 297-299).

35. Employees Doug Lefler, Robert Hendren, Dale Lindley and Gerald Robinson were exposed to the hazards. (1996 T pp 298-300, Complainant's Exhibit # 38)

36. The hazard created a possibility of an accident. (1996T pp 299).

37. The substantially probable result of such an accident could be chemical burns to the eyes and skin which is a serious physical injury. (T pp 299-300; Complainant's Exhibits 33-36).

38. The Respondent knew or should have known about the condition in that Herminio Freitas, the plant manager and Danis Allison, the personnel director, both admitted that a hazard communication program was still in the developmental stage and the employees had not been trained. (1996T p 301)

39. The Employer could have corrected the hazard by providing the appropriate goggles and/or face shields and reduced or eliminated the hazard. (1996T p 301).

40. The grouped penalty of $900.00 for Citation 2, Items 1a, 1b and 1c was calculated according to the Field Operations Manual and after giving due consideration to the size of the business, the gravity of the violation, the good faith or lack thereof of the employer and the record of violations within the previous three years, the Board finds that the penalty is fair, reasonable in amount, and assessed equitably and uniformly.

Citation 2, Item 2, Serious violation of 29 C.F.R. §1910.151(c)

41. The failure of the employer to provide suitable facilities for quick drenching or flushing of the eyes and body within the work area for immediate emergency use where the eyes or body of any person may be exposed to injurious corrosive materials created the hazard that employees would be unable to wash hazardous chemicals including isopropyl alcohol, Mac Alloy Starter surfactant, Triton surfactant and sulfuric acid from the skin and eyes. (1996 T pp 302-310, Complainant's Exhibits 33, 34, 36, 37and 39).

42. Employees Doug Lefler, Robert Hendren, Dale Lindley and Gerald Robinson were exposed to the hazards. (1996 T pp 298-300, 310-311; Complainant's Exhibit # 38)

43. The hazard created a possibility of an accident. (1996T pp 310).

44. The substantially probable result of such an accident could be chemical burns to the eyes and skin which is a serious physical injury. (1996T pp 310; Complainant's Exhibits 33-37).

45. The Respondent knew or should have known about the condition in that Herminio Freitas, the plant manager and Danis Allison, the personnel director, both admitted that a hazard communication program was still in the developmental stage and the employees had not been trained and they could have reasonably known there was actual exposure to these chemicals and the hazards of these chemicals from the hazard labels on the chemical containers and from the Material Safety Data Sheets for these chemicals. (1996T p 311)

46. The Employer could have installed an emergency eye wash and safety shower within 75 feet of the battery charging area and reduced or eliminated the hazard. (1996T p 313).

47. The penalty of $900.00 for this serious violation was calculated according to the Field Operations Manual and after giving due consideration to the size of the business, the gravity of the violation, the good faith or lack thereof of the employer and the record of violations within the previous three years, the Board finds that the penalty is fair, reasonable in amount, and assessed equitably and uniformly.

Citation 2, Item 3a, Serious violation of 29 C.F.R. §1910.1030(c)(1)(i),

48. The failure of the employer to establish a written exposure control plan for employees exposed to bloodborne pathogens who had the collateral duty to administer first aid and to clean up bodily fluids from equipment created the hazard that employees could be exposed to blood or other potentially infectious materials. (199T pp316-324)

49. Employees Robert Shumate and Bobby Powell were exposed to the hazards. (1996 T pp 325-326)

50. The hazard created a possibility of an accident in that the employees could contract Hepatitis-B Virus, Human Immunodefensive Viris (HIV), jaundice which could result in death. (1996T pp 324).

51. The substantially probable result of such an accident could be substantial bodily injury including death which is a serious physical injury. (1996T pp 324-325).

52. The Respondent knew or should have known about the condition in that Herminio Freitas, the plant manager and Danis Allison, the personnel director, both admitted that employees had a collateral duty to administer first aid and Danis Allison admitted that the bloodborne pathogen program was still being developed and the employees had not been trained on the bloodborne pathogen standard or exposure control. (1996T p 317, 333-334)

53. The Employer could have corrected the hazard by implementing the exposure control program and provided the training and requirements to minimize exposure to the employees. (1996T p 336).

Citation 2, Item 3b, Serious violations of 29 C.F.R. §1910.1030(d)(3)(i)

54. The failure of the employer to provide personal protective equipment (PPE) such as gloves, face shields and/or other appropriate eye protection to the employees cleaning up blood or other bodily fluids with a water hose and rags soaked in alcohol or administering first aid created the hazard that these employees could be exposed to bloodborne pathogens or other potentially infectious materials . (199T pp340-342)

55. Employees Robert Shumate and Bobby Powell and any other employees administering first aid were exposed to the hazards. (1996 T pp 341).

56. The hazard created a possibility of an accident in that the employees could contract Hepatitis-B Virus and/or Human Immunodefensive Viris (HIV), which could result in death. (1996T pp 340).

57. The substantially probable result of such an accident could be serious bodily injury including death. (1996T pp 340).

58. The Respondent knew or should have known about the condition in that Herminio Freitas, the plant manager and Danis Allison, the personnel director and chair of the safety committee, both admitted that employees had a collateral duty to administer first aid and Danis Allison admitted that the bloodborne pathogen program was still being developed, the insurance paperwork indicated that a written bloodborne pathogen standard was required by OSHA and Ms. Allison had a copy of the 1910 General Industry OSHA Standards and with reasonable diligence should have known of the hazards associated with allowing Robert Shumate and Bobby Powers to be exposed to the bodily fluids and blood. (1996T p 317, 333-334, 341).

59. The Employer could have corrected the hazard by providing the appropriate PPE to minimize the employees exposure to the blood and other bodily fluids. (1996T p 342).

Citation 2, Item 3c, Serious violations of 29 C.F.R. §1910.1030(d)(4)(ii)(a)

60. The failure of the employer to decontaminate work surfaces contaminated with blood or other bodily fluids with an appropriate disinfectant created the hazard that employees could be exposed to bloodborne pathogens or other potentially infectious materials. (199T pp342-345)

61. Employees Robert Shumate and Bobby Powell and other employees who had the collateral duty to administer first aid were exposed to the hazards in that they were cleaning up blood and other bodily fluids after the fatality with isopropyl alcohol which is not an appropriate disinfectant. (1996T pp 343, 345-346)

62. The hazard created a possibility of an accident or injury or illness in that the employees could contract Hepatitis-B Virus and/or Human Immunodefensive Virus (HIV) which could result in death. (1996T pp 345).

63. The substantially probable result of such an accident could be serious bodily injury including death. (1996T pp 345).

64. The Respondent knew or should have known about the condition in that Danis Allison, the personnel director and chair of the safety committee, admitted that employees had a collateral duty to administer first aid and that the bloodborne pathogen program was still being developed, the insurance paperwork indicated that a written bloodborne pathogen standard was required by OSHA and Ms. Allison had a copy of the 1910 General Industry OSHA Standards and with reasonable diligence should have known of the hazards associated with allowing Robert Shumate and Bobby Powers to clean up bodily fluids and blood with isopropyl alcohol. (1996T p 346-347).

65. The Employer could have corrected the hazard by providing the EPA registered tuberculocidal agent to the employees or making sure that they used bleach diluted in water to properly decontaminate working surfaces. (1996T p 347).

Citation 2, Item 3d Serious violations of 29 C.F.R. §1910.1030(f)(2)(i)

66. The failure of the employer to make available Hepatitis B vaccinations to the employees with a collateral duty to administer first aid within 10 working days after receiving first aid and CPR (cardiopulmonary resuscitation) training or within 10 working days after employees were exposed to blood or other potentially infectious materials created a hazard that employees would be exposed to the Hepatitis-B virus. (1996T pp347-350)

67. Employees Robert Shumate and Bobby Powell and other employees who had the collateral duty to administer first aid and were exposed to blood and other bodily fluids were exposed to the hazard in that they were not offered the Hepatitis-B vaccination within 10 working days of their training or their exposure. (1996T pp 348, 350)

68. The hazard created a possibility of an accident or injury or illness in that the employees could contract Hepatitis-B Virus. (1996T pp 351).

69. The substantially probable result of such an accident could be serious bodily injury including death. (1996T pp 351).

70. The Respondent knew or should have known about the condition in that Herminio Freitas, the plant manager and Danis Allison, the personnel director and chair of the safety committee, both admitted that employees had a collateral duty to administer first aid and Danis Allison admitted that the bloodborne pathogen program was still being developed, the insurance paperwork indicated that a written bloodborne pathogen standard was required by OSHA and Ms. Allison had a copy of the 1910 General Industry OSHA Standards and with reasonable diligence should have known that a Hepatitis-B vaccination should have been made available to the exposed employees and the potentially exposed employees who had the collateral duty to administer first aid.(1996T p 352).

71. The Employer could have corrected the hazard by offering the Hepatitis-B vaccination to the exposed employees and the potentially exposed employees who had the collateral duty to administer first aid. (1996T p 352-353).

Citation 2, Item 3e Serious violations of 29 C.F.R. §1910.1030(g)(1)(i)(A),

72. The failure of the employer to affix warning labels to containers used to store, transport or ship blood or other potentially infectious materials created a hazard that employees would not know what was in the containers and would be exposed to blood and other potentially infectious material.(1996T pp354-355)

73. Employees Robert Shumate and Bobby Powell and other employees who had the collateral duty to administer first aid could have been exposed to blood and other bodily fluids from the contaminated waste in the unmarked trash bags that contained bloody rags and bloody webbing. (1996T pp 354-355)

74. The hazard created a possibility of an accident or injury or illness in that the employees could contract Hepatitis-B Virus and/or Human Immunodeficiency virus. (1996T pp 356).

75. The substantially probable result of such an accident could be serious bodily injury including death. (1996T pp 356).

76. The Respondent knew or should have known about the condition in that Herminio Freitas, the plant manager and Danis Allison, the personnel director and chair of the safety committee, both admitted that employees had a collateral duty to administer first aid and Danis Allison admitted that the bloodborne pathogen program was still being developed, the insurance paperwork indicated that a written bloodborne pathogen standard was required by OSHA and Ms. Allison had a copy of the 1910 General Industry OSHA Standards and with reasonable diligence should have known that a Hepatitis-B vaccination should have been made available to the exposed employees and the potentially exposed employees who had the collateral duty to administer first aid.(1996T p 352, 357).

77. The Employer could have corrected the hazard by offering the Hepatitis-B vaccination to the exposed employees and the potentially exposed employees who had the collateral duty to administer first aid. (1996T p 358).

78. The grouped penalty of $2,100.00 for Citation 2, Items 3a, 3b, 3c, 3d and 3e was calculated according to the Field Operations Manual and after giving due consideration to the size of the business, the gravity of the violation, the good faith or lack thereof of the employer and the record of violations within the previous three years, the Board finds that the penalty is fair, reasonable in amount, and assessed equitably and uniformly.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the Board concludes as a matter of law as follows:

1. The foregoing findings of fact are incorporated as conclusions of Law to the extent necessary to give effect to the provisions of this Order.

2. The Board has jurisdiction of this cause and the parties are properly before the Board.

3. The Commissioner has proven by the preponderance of the evidence and by substantial evidence that the Respondent committed a willful serious violation of 29 CFR 1910.212(a)(1) as alleged in Citation 1, Item 1, by failing to guard the incoming nip points of compression roller #2 of production line #3.

4. The Commissioner has proven by the preponderance of the evidence and by substantial evidence that the Respondent committed a serious violation of 29 CFR 1910.147(c)(1), the lockout/tagout standard, as alleged in Citation 1, Item 2, by failing to develop and implement an effective lockout/tagout program .

5. The Commissioner has proven by the preponderance of the evidence and by substantial evidence that the Respondent committed a serious violation of 29 CFR 1910.132(d)(1), as alleged in Citation 2, Item 1a, for the failure to perform a hazard assessment on the work environment to determine what hazards existed which necessitated the use of personal protective equipment .

6. The Commissioner has proven by the preponderance of the evidence and by substantial evidence that the Respondent committed a serious violation of 29 CFR 1910.132(f)(1), as alleged in Citation 2, Item 1b, for the failure to provide training to its employees in the use of personal protective equipment.

7. The Commissioner has proven by the preponderance of the evidence and by substantial evidence that the Respondent committed a serious violation of 29 CFR 1910.133(a)(1), as alleged in Citation 2, Item 1c for the failure to provide appropriate eye or face protection when exposed to eye or face hazards from liquid chemicals, acids or caustic liquids.

8. The Commissioner has proven by the preponderance of the evidence and by substantial evidence that the Respondent committed a serious violation of 29 CFR 1910.151(c), as alleged in Citation 2, Item 2, for failure to

provide quick drenching facilities for the eyes and body.

9. The Commissioner has proven by the preponderance of the evidence and by substantial evidence that the Respondent committed a serious violation of 29 CFR 1910.1030(c)(1)(i) as alleged in Citation 2, Item 3a for the failure to establish a written exposure control plan for employees exposed to bloodborne pathogens who had the collateral duty to administer first aid and to clean up bodily fluids from equipment.

10. The Commissioner has proven by the preponderance of the evidence and by substantial evidence that the Respondent committed a serious violation of 29 CFR 1910.1030(d)(3)(i) as alleged in Citation 2, Item 3b for the failure to provide personal protective equipment (PPE) such as gloves, face shields and/or other appropriate eye protection to the employees cleaning up blood or other bodily fluids with a water hose and rags soaked in alcohol or administering first aid.

11. The Commissioner has proven by the preponderance of the evidence and by substantial evidence that the Respondent committed a serious violation of 29 CFR 1910.1030(d)(4)(ii)(a) as alleged in Citation 2, Item 3c for the failure to decontaminate work surfaces contaminated with blood or other bodily fluids with an appropriate disinfectant.

12. The Commissioner has proven by the preponderance of the evidence and by substantial evidence that the Respondent committed a serious violation of 29 CFR 1910.1030(f)(2)(i) as alleged in Citation 2, Item 3d for the failure to make available Hepatitis B vaccinations to the employees with a collateral duty to administer first aid within 10 working days after receiving first aid and CPR (cardiopulmonary resuscitation) training or within 10 working days after employees were exposed to blood or other potentially infectious materials.

13. The Commissioner has proven by the preponderance of the evidence and by substantial evidence that the Respondent committed a serious violation of 29 CFR 1910.1030(g)(1)(i)(A) as alleged in Citation 2, Item 3e for the failure to affix warning labels to containers used to store, transport or ship blood or other potentially infectious materials.

DISCUSSION

I. The willfulness of the violations.

Willful is not defined by the North Carolina Occupational Safety and Health Act but has been defined by the North Carolina Supreme Court in a 1996 case as follows:

This Court has said that a violation is deemed willful when there is shown " ' a deliberate purpose not to discharge some duty necessary to the safety of the person or property of another.' " Brewer v. Harris, 279 N.C. 288, 297, 182 S.E. 2d 345, 350 (1971) (quoting Foster v. Hyman, 197 N.C. 189, 191, 148 S.E. 36, 37 (1929)) (emphasis added).

Associated Mechanical Contractors, Inc. v. Payne, 342 N.C. 825 at 833, 467 S.E. 2d 398 (1996).

The Board follows the current view of the majority of the federal Circuit Courts of Appeals and has adopted the Commission-Intercounty definition of willful as an Act done voluntarily with either an intentional disregard of or plain indifference to the Act's requirements. See, Mark A. Rothstein, Occupational Safety and Health Law § 315, (3d ed. 1990); Intercounty Construction Co. v. OSHRC. 1974-1975 OSHD 23,638, 522 F. 2d 777 (4th Cir. 1975), certiorari denied, 423 U.S. 1072, 96 S.Ct. 854, 47 L.Ed. 2d 82 (1976)); "What Constitutes 'Willful' Violation for Purposes of §§ 17(a) and (e) of Occupational Safety and Health Act of 1970 (29 USC §§ 666(a) and 666(e))", 31 ALR Fed 551.

The Board has consistently held that a willful violation may be proven by showing the following:

1. Employer knowledge of the standard, rule, regulation or Act:

2. Knowledge of the violative condition;

3. A subsequent violation of that standard and

4. A state of mind that evokes either "intentional disregard of" the standard or "plain indifference to" the requirements of the Act.

The North Carolina Supreme Court examined these four elements in Associated Mechanical, supra, and held that "The definition and elements used by the Review Board are consistent with the definitions of willfulness expounded by this Court and quoted above". Associated Mechanical, supra, at 834. Proof of a bad intent or venial motive is not required. Prior citations for the same or similar standards may be used to prove employer knowledge, although employer knowledge of a standard may be proven by other methods.

A willful violation may also be proven by careless disregard of or plain indifference to employee safety and health. In the City of Mt. Airy, OSHANC # 91-2077, the Board stated:

> The Board adopts the view that a willful violation can be proven by conduct marked by intentional disregard of or plain indifference to employee safety and health. . . .

In reaching that conclusion the Board cited the following with approval:

> . . . the early decisions of the Commission required that the employer have knowledge that he was violating the Act but that later decisions allowed a finding of willful if the employer exhibited conduct that showed "careless disregard of employee safety". Once careless disregard of employee safety was shown there was no need to prove that the employer knew that it was violating the Act. Rothstein, supra, at 341, quoting John W. Eshelman & Sons, 9 OSHC 1396, 1981 OSHD ¶ 25,231 at 31,187 (1981).

City of Mt. Airy, OSHANC # 91-2077.

The Hearing Examiner found that "the respondent possessed a state of mind that constituted an intentional disregard or plain indifference to the safety of its employees when it did not provide guarding for its production equipment. . ." and in his discussion stated that the test for willfulness is if the "violation is done voluntarily with either an intentional disregard of or plain indifference to the requirements of the standard" and he states that "respondent had knowledge of the guarding standards".

The Board has examined the record and finds that it supports a finding of a willful violation of the guarding standard using either or both of the tests. (Findings of Fact 12-14, supra). The Respondent knew of the standard because it had placed guards on other incoming nip points in the different production lines at its Mooresville plant. Two other fatalities had occurred at the Respondent's South American affiliate and they involved cutting and cleaning material from production equipment. Several employees had their hands caught in the incoming nip points of the rollers on the production lines and had sustained serious injury. Supervisors and management knew that the employees cleaned and cut wax and polypropylene from the rollers while the production line was running. The number 3 production line was an experimental line and ran faster than the other lines (at a speed of approximately 16 mph) and the emphasis was on production. One of the employees had communicated to management the need to shut the production line down when cleaning it and was told to keep the line running. These actions on the part of management show both a state of mind that constitutes an intentional disregard or plain indifference to the safety of its employees and a state of mind that shows an intentional disregard of or plain indifference to the requirements of the standard. The record also shows that Respondent had knowledge of the standard, knowledge of the violative condition--that the incoming nip point on the compression roller in question was not guarded, and a violation of the standard.

The Hearing Examiner found that the Complainant failed to prove by a preponderance of the evidence that the Respondent committed a willful violation of 29 CFR 1910.147(c)(1), the lockout/tagout standard, as alleged in Citation 1, Item 2 but found that the Complainant did commit a serious violation of that standard. A review of the record reveals substantial evidence to support the Hearing Examiner's finding that the Complainant failed to prove by a preponderance of the evidence that the violation of the lockout/tagout standard was willful. The

Hearing Examiner, relying on dicta in City of Mt. Airy, supra, found that the fact that the Respondent had made some attempt to comply with the lockout/tagout standard precluded him from finding that the violation was willful. An ineffective attempt to comply with a standard could be a double edge sword and the same fact situation could be used to show that Respondent had knowledge of the standard, knowledge of the violative condition, and a subsequent violation of the standard. The Board does not want to punish or discourage employers from taking steps to comply with the act and have that attempt be used against them to find evidence of a willful violation. The Board is not unmindful of the fact that if the lockout/tagout standard had been fully implemented as scheduled, then this fatality could have been prevented. The Hearing Examiner's finding is supported by substantial evidence and the Board will not disturb that finding, however, the Board can imagine that the situation may arise where a delayed and inadequate attempt at compliance that results in the death of an employee may result in a willful violation.

II. The Seriousness of the Violations

In order to prove a serious violation of a specific standard, the following elements must be proven:

1. A hazard existed;

2. employees were exposed;

3. the hazard created the possibility of an accident;

4. the substantial probability of an accident would be death or serious physical injury and

5. the employer knew or should have known of the condition or conduct that created the hazard. (applying the reasonable man test developed by the Court of Appeals in Brooks v. Daniel Construction Company., 2 OSHANC 311, 73 N.C. App. 426 (Ct. of Appeals 1984).

Pursuant to Brooks v. McWhirter in order to prove a serious violation it must be shown by substantial evidence "that the violation created a possibility of an accident a substantially probable result of which was death or serious physical injury." Brooks v. McWhirter Grading Co., INC., 2 NCOSHD 115, 303 N.C. 573 (Supreme Court 1981). In addition, G.S. 95-127(18) which gives the definition of a serious violation requires an element of employer knowledge: " A 'serious ' violation shall be deemed to exist in a place of employment . . . unless the employer did not know, and could not, with the exercise of reasonable diligence, know of the presence of the violation."

If there were actual knowledge by the employer of the hazardous condition or knowledge of the hazardous condition by the employer's supervisors that is imputable to the employer, then due process would not require that the reasonable man test be employed to prove employer knowledge for element numbered five above. See, Brooks v. Daniel Construction Company., 2 NCOSHD 299, at 305 (RB 1981), affirmed, 2 NCOSHD 309, Docket No.81 CVS 5703 (Superior Ct. 1983), affirmed, 2 NCOSHD 311, 73 N.C. App. 426 (Ct. of Appeals 1984); Secretary v. Grand Union Company, 1975-1976 OSHD 23,926 at 23,927 note 3.

The Respondent asserts that none of the citations that have been assessed against it can be serious and cites conflicting testimony as the basis for its assertion. The Hearing Examiner heard the testimony of both the Respondent's witnesses and the Complainant's witnesses and gave greater credibility to the testimony of the Complainant's witnesses. The Board usually defers to the Hearing Examiner's findings as to credibility since the hearing examiner as the fact finder is in the best position to determine credibility issues.

A review of the record finds substantial evidence that all of the contested violations were serious. There is substantial evidence in the record to support the Hearing Examiner's findings that the Respondent committed a willful/serious violation of 29 CFR 1910.212(a)(1) by failing to guard the incoming nip points of compression roller #2 of production line #3 and a serious violation of 29 CFR 1910.147(c)(1), the lockout/tagout standard. There is substantial evidence in the record to support the Hearing Examiner's finding that the Respondent committed serious violations of 29 CFR 1910.132(d)(1), (f)(1) and 29 CFR 1910.133(a)(1), (all involving the

Personal Protective Equipment-- PPE standard), that the Respondent committed a serious violation of 29 CFR 1910.151(c) for failure to provide quick drenching facilities for the eyes and body, and that the Respondent committed serious violations of 29 CFR 1910.1030(c)(1)(i), (d)(3)(i), (d)(4)(ii)(a), (f)(2)(i) and (g)(1)(i)(A) (all involving the Bloodborne Pathogen Standard). (See the findings of fact under the subheading for the above mentioned standards where facts showing the five elements necessary to prove seriousness of the violation are listed).

ORDER

For the reason stated herein, the Review Board hereby **ORDERS** that the Hearing Examiner's October 6, 1998 Order in this cause is, **AFFIRMED** in all respects and Respondent is found to have committed a willful serious violation of 29 CFR 1910.212(a)(1) as alleged in Citation 1, Item 1 with a penalty of $42,000.00; a serious violation of 29 CFR 1910.147(c)(1), the lockout/tagout standard, with a penalty of $4,200.00, as alleged in Citation 1, Item 2; a serious violation of 29 CFR 1910.132(d)(1), as alleged in Citation 2, Item 1a, a serious violation of 29 CFR 1910.132(f)(1), as alleged in Citation 2, Item 1b, a serious violation of 29 CFR 1910.133(a)(1), as alleged in Citation 2, Item 1c, with a grouped penalty of $900.00 for all citations in Citations 1a,1b and 1c; a serious violation of 29 CFR 1910.151(c) with a penalty of $900.00, as alleged in Citation 2, Item 2; a serious violation of 29 CFR 1910.1030(c)(1)(i) as alleged in Citation 2, Item 3a, a serious violation of 29 CFR 1910.1030(d)(3)(i) as alleged in Citation 2, Item 3b, a serious violation of 29 CFR 1910.1030(d)(4)(ii)(a) as alleged in Citation 2, Item 3c, a serious violation of 29 CFR 1910.1030(f)(2)(i) as alleged in Citation 2, Item 3d and a serious violation of 29 CFR 1910.1030(g)(1)(i)(A) as alleged in Citation 2, Item 3e with a grouped penalty of $2,100.00 for all citations in Citations 3a, 3b, 3c, 3d and 3e; and Respondent is **FURTHER ORDERED** to pay the total penalty of $50,100.00 within 30 days of the date of this order.

This the 22nd day of May, 2000.

_____
HENRY M. WHITESIDES, ACTING CHAIR

_____
CARROLL D. TUTTLE, DESIGNATED MEMBER