UNITED STATES OF AMERICA
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION

SECRETARY OF LABOR, Complainant, v. BERGELECTRIC CORP., Respondent.	DOCKET NO. 17-1284

Appearances:

Nancy E. Steffan, Esq., U.S. Department of Labor, Office of the Solicitor, Los Angeles, California
For Complainant

Johnathan S. Vick, Esq., Atkinson, Andelson, Loya, Rudd & Romo, Cerritos, California
For Respondent

Before: Administrative Law Judge Brian A. Duncan

DECISION AND ORDER

Procedural History

Respondent was hired to install the electrical system for a renovation of the San Manuel Casino in Highland, California, which is located on a tribal reservation. (Tr. 56-57). On April 29, 2017, while installing conduit above the ceiling, one of Respondent's employees fell 24 feet to the floor of the casino. (Stip. Nos. 10, 13; Tr. 63, 65). The employee, whom the Court will refer to as R.S., suffered broken ribs and fractures to his spine. (Tr. 63). Subsequent investigation revealed R.S. was not connected to a fall protection device at the time of his fall. (Tr. 65).

The matter was initially referred to Cal-OSHA, who subsequently referred the matter to federal OSHA because the casino was located on tribal lands, which are subject to federal

jurisdiction. (Tr. 56–57). Compliance Safety and Health Officer (CSHO) Eric Christensen initiated an OSHA inspection with a phone call to Calvin King, Respondent's safety manager. (Tr. 62). CSHO Christensen traveled to the casino a few days later. At the conclusion of his inspection, CSHO Christensen recommended, and Complainant issued, one other-than-serious and three serious violations of the Act. The three serious violations were targeted at Respondent's fall protection program, while the other-than-serious violation addressed Respondent's failure to properly document R.S.'s fall on an OSHA 300 log. *Citation and Notification of Penalty*. Respondent timely submitted its notice of contest, bringing the matter before the Commission.

A trial was conducted in Los Angeles, California on September 25–26, 2018. Seven witnesses testified at trial: (1) CSHO Eric Christensen; (2) Calvin King, Respondent's Safety Manager; (3) Dan Chancellor, Superintendent for the San Manuel Casino Project; (4) Wendy McBride, Respondent's Chief Risk Officer; (5) Edward Valdez, General Foreman for the San Manuel Casino Project; (6) Rodney Poole, General Foreman; and (7) Pete Evans, Foreman. Both parties timely submitted post-trial briefs for the Court's consideration.

Jurisdiction & Stipulations

The parties stipulated that the Commission has jurisdiction over this proceeding pursuant to Section 10(c) of the Act and that, at all times relevant to this proceeding, Respondent was an employer engaged in a business and industry affecting interstate commerce within the meaning of Sections 3(3) and 3(5) of the Act, 29 U.S.C. § 652(5). (Tr. 25). *See Slingluff v. OSHRC*, 425 F.3d 861 (10th Cir. 2005). The parties also stipulated to other factual matters, which were read into the record.[1] (Tr. 24–27).

[1]. References to the parties' stipulations shall be as follows: "(Stip. No. ___)".

Factual Background

The San Manuel Casino project involved the renovation of a 20,000 square-foot space. (Tr. 267). As noted above, Respondent was responsible for the installation of electrical systems. The project was broken down into two phases, known as "Elvis" and "Priscilla". (Stip. Nos. 11, 12). During the Elvis phase of the project, Respondent set up a Technomedia presentation, which required the installation of electricity and support for large-scale LED screens. (Tr. 147, 203). Upon completion of the Elvis phase, Respondent transitioned to the Priscilla phase, which focused on the installation of the remaining electrical systems. (Tr. 145, 163). The events of this case occurred during the Priscilla phase of the project.

According to foreman Valdez, the electrical installation at the San Manuel Casino was a little different than other projects. (Tr. 206). Normally, Respondent prefers to install electrical conduit and wire prior to the installation of the ceiling, also referred to as the "hard lid", because you can perform all of the work from a scissor lift instead of climbing inside the ceiling. (Tr. 206). In this case, however, the general contractor had the ceiling installed prior to the installation of the necessary electrical wiring because other aspects of the project were behind schedule. (Tr. 206–207). Thus, Respondent's employees were required to work along the beams in the space *above* the drywall ceiling, which was 24 feet above the ground. (Stip. No. 10). To access the area above the hard lid, a hole was cut in the drywall, which allowed a scissor lift basket to enter. (Tr. 72; Exs. C-25, C-27, C-28).

Due to the unique work space above the hard lid, Respondent developed an Activity Hazard Analysis (as it does with all projects) to address the specific hazards its employees would encounter. (Tr. 146). According to safety manager King, Respondent used virtually the same

AHA for the Priscilla project as it did for the Elvis project. (Tr. 145). Valdez explained that the hazards to which Respondent's employees were exposed were basically the same in both instances with the exception of the Technomedia portion of the Elvis phase, which required more equipment, people, and planning. (Tr. 203). In lieu of re-writing the AHA for the same basic hazards, Valdez determined the Elvis AHA adequately addressed the hazards encountered during the Priscilla project and that employees and foremen could address any peculiarities about the Priscilla project using the same guidelines. (Tr. 203). As it relates to the present case, the AHA contained the following provisions to address fall hazards above the hard lid:

- "Equipment that will be utilized for this operation will be 5 Beam straps in conjunction with five 30-foot yo-yo's and a scissor lift."

- "Workers will use a scissor lift to access the hard lid area. From the scissor lift, workers will connect one beam strap and yo-yo to the angle support beam. Workers will then place plywood onto the framing of the hard lid. One worker will then access the hard lid area and secure the plywood decking. Workers will then pass additional precut three-quarter inch plywood to the hard lid area. Workers shall secure the plywood decking to the framing of the hard lid to ensure all workers have a safe walking-working surface. Additional fall protection beam straps and 30-foot yo-yos will be installed on separate support beams. The competent person in fall protection *will then* inspect the fall protection system and walking-working surface *before any additional workers access the hard lid area*."

(Ex. C-2 at 1–2) (emphasis added). The AHA also provided information on equipment, rescue plans and procedures, training, inspection, and other hazard-related issues; however, the primary focus herein will be on the two provisions recited above.

<u>April 27, 2017 – The "Near-Miss"</u>

On Thursday, April 27, 2017, an employee named Perry was assigned to hang conduit below the hard lid. (Tr. 170). To accomplish this, Perry was supposed to use the scissor lift to access the ceiling and string the conduit from the bottom. (Tr. 220–22). Instead, Perry opted to

use the scissor lift to go above the hard lid.[2] As Perry was walking along the beams above the hard lid, he slipped and his foot broke through the drywall. (Tr. 163–64). Perry did not fall any further, however, because he was properly equipped with the necessary fall protection equipment: beam strap, yo-yo, and harness. (Tr. 170; Ex. C-2). Perry did not install the plywood decking prior to working above the hard lid, but foreman Valdez remedied that problem by having decking installed later that day. (Tr. 164). Dan Chancellor later noticed the hole left in the drywall by Perry's foot and directed Valdez to conduct tailgate refresher training on fall protection and the AHA the next morning, April 28, 2017. (Tr. 169). Perry was given a verbal warning for going above the hard lid without permission. (Tr. 163).

Although Complainant refers to this incident as a "near miss" to support its constructive knowledge arguments, the Court views it somewhat differently. It appears simply to be an incident in which an employee was in an elevated work area, using appropriate fall protection equipment, when his foot slipped off a steel beam onto ceiling drywall, resulting in a small hole. Though Respondent did not give him permission to be up there, no apparent fall protection violations were involved.

April 28, 2017

The following morning, per Chancellor's direction, Valdez and Evans held refresher tailgate training on the AHA and associated fall protection requirements, including the provision regarding the installation of plywood decking above the hard lid. (Tr. 85–86, 275–76; Ex. C-16). Later the same day, Evans directed Ron Castro and R.S. to stage conduit and materials above the hard lid for conduit installation the following day. (Tr. 278). According to Evans, Castro had worked above the hard lid about ten times during the San Manuel casino project. (Tr. 277).

[2]. According to Valdez, this would make the job easier insofar as Perry would not need to repeatedly raise and lower the scissor lift to access the area below the hard lid. (Tr. 221).

Castro and R.S. had been working in another area of the casino but were added to Evans' crew after they had completed their other tasks. (Tr. 278).

The basic nature of the job, according to Evans, was to run conduit from "Point A to Point B". (Tr. 278). Because it was late in the day, though, Evans told them, "[I]t's towards the end of the day so just get your material gathered, stage it above the lid, and then we can start a full day tomorrow." (Tr. 278). "Staging", according to Evans, involved loading all the necessary materials into the lift, unloading them onto the beams just above the lid to the side of the scissor lift entrance, and securing them to the framework. (Tr. 279). Evans testified that neither Castro nor R.S. needed to exit the lift to stage the materials for the next day. (Tr. 279–80).

However, according to interviews conducted after the accident in this case, Castro got out of the lift on the afternoon of April 28, 2017. (Tr. 282). He exited the lift basket to install a beam strap (anchor) at a location close to where work would be occurring the next day. (Tr. 94–95). To accomplish this, Castro attached a lanyard to his harness, looped the lanyard around a beam, and attached the clip back onto itself. (*Id.*). He then crawled along the beams above the hard lid, attached the beam strap, and returned to the scissor lift. (Tr. 95). Castro's excursion out of the basket, above the hard lid, lasted approximately five minutes. (Tr. 95). There is no evidence that R.S. left the lift on April 28th. Other than R.S., no one saw Castro crawl along the beams above the hard lid during those five minutes. (Tr. 282).

April 29, 2017 – The Accident

The next day, Respondent's crews met at the work trailer at 5:00 a.m. (Tr. 275). During that meeting, Evans talked to Castro about the specifics of his assignment, including safety, fall protection, plywood decking, and how the conduit would be installed. (Tr. 287). Afterward, Castro and R.S. traveled to the casino, which was about 100 or so yards away from Respondent's

trailer. (Tr. 284). Evans then met with Valdez to discuss the plan for the day and resolve any outstanding issues. (Tr. 287–88). After that, Evans testified he went into the casino, during which time he checked on the multiple crews under this supervision and answered questions from his lead men. (Tr. 289). Around 7:45 a.m. that morning, while Evans' was checking on various crews, R.S. crashed through the hard lid and fell 24 feet to the casino floor. (Tr. 288–89). According to Evans, he was approximately 60–80 feet away from where R.S. fell. (Tr. 92).

According to Chancellor, Castro and R.S. had been above the hard lid for approximately one hour at the time R.S. fell.[3] (Tr. 66). Post-accident investigations by Respondent and Complainant revealed violations of both Respondent's AHA, and OSHA fall protection regulations, occurring above the hard lid. In particular, CSHO Christensen testified that the following occurred while R.S. and Castro were working above the hard lid:

- Once above the hard lid and out of the scissor lift, R.S. and Castro connected their lanyards (yo-yos) to the same beam strap (anchor point);
- R.S. complained to Castro that his lanyard was restricting his movement, to which Castro responded that R.S. needed to keep it on;
- No plywood decking was installed in the work area above the hard lid;
- R.S.'s lanyard was found hanging from a notch in an angle beam, indicating it was neither attached to the beam strap nor to the D-ring on the back of R.S.'s harness.

(Tr. 64, 95–96, 124, 153; Ex. R-58).

Evans testified he was waiting for Castro to call him that morning while he was making his rounds, so that he could perform a competent person inspection of their fall protection and decking, but Castro never called. (Tr. 301–302). According to Evans, this was standard

[3]. CSHO Christiansen said Castro initially told him that he and R.S. were connected to the same beam strap for about an hour, though the CSHO also testified Castro later told him they were in this position for nearly an hour-and-a-half or more. (Tr. 96). Since it is unclear when exactly R.S. and Castro entered the hard lid, it is difficult for the court to determine with any degree of certainty how long they were up there. The general consensus, however, appears to be around an hour. At some point in that period, R.S. apparently disconnected his lanyard, leading to his fall.

procedure and required by the AHA. (Tr. 301). Otherwise, Evans testified, he would have been waiting around at the bottom of the scissor lift waiting for Castro to complete the installation of fall protection and decking while he could have been performing other duties. (Tr. 301). Evans said he could have gone by and yelled up to the workers from the ground (through the hole in the ceiling with the scissor lift in it), but instead was waiting for the call from Castro, who was familiar with the process. (Tr. 302).

Discussion

Citation 1, Item 1a

> Complainant alleged a serious violation of the Act in Citation 1, Item 1a as follows:
>
> 29 CFR 1926.501(b)(1): Each employee on a walking/working surface with an unprotected edge which was 6 feet (1.8 m) or more above a lower level was not protected from falling by the use of guardrail systems, safety net systems, or personal fall arrest systems.
>
> Hard lid area above the new gaming expansion: On April 29, 2017, employee(s) installing conduit were not protected from falling to the lower level. Employees were exposed to a fall hazard of at least 24 feet.

Citation and Notification of Penalty at 8.

The cited standard states;

> *Each employee on a walking/working surface (horizontal and vertical surface) with an unprotected side or edge which is 6 feet (1.8 m) or more above a lower level shall be protected from falling by the use of guardrail systems; safety net systems; or personal fall arrest systems.*

29 C.F.R. § 1926.501(b)(1).

Citation 1, Item 1b

> Complainant alleged a serious violation of the Act in Citation 1, Item 1b as follows:
>
> 29 CFR 1926.502(d)(6)(iii): Snaphooks shall not be engaged to a Dee-ring to which another snaphook or other connector is attached:
>
> Hard lid area above the new gaming expansion: On April 29, 2017, two workers concurrently connected their self-retractable lanyards to a single anchorage

connector strap while installing conduit. Employees were exposed to a fall hazard of at least 24 feet.

Citation and Notification of Penalty at 7.

The cited standard states;

Unless the snaphook is a locking type and designed for the following connections, snaphooks shall not be engaged:

…

to a dee-ring to which another snaphook or connector is attached.

29 C.F.R. § 1926.502(d)(6)(iii).

Citation 1, Item 2

Complainant alleged a serious violation of the Act in Citation 1, Item 2 as follows:

29 CFR 1926.502(d)(6)(i): Snaphooks were connected directly to webbing, rope, or wire rope.

Hard lid area above the new gaming expansion: On April 28, 2017, the Guardian self-retractable lanyard was wrapped around a structural member of the building and then hooked directly to itself. Employees were exposed to a fall hazard of at least 24 feet.

Citation and Notification of Penalty at 8.

The cited standard states;

Unless the snaphook is a locking type and designed for the following connections, snaphooks shall not be engaged:

…

directly to webbing, rope, or wire rope.

29 C.F.R. § 1926.502(d)(6)(i).

To establish a violation of an OSHA standard, Complainant must prove, by a preponderance of the evidence, that: (1) the cited standard applied to the facts; (2) the employer failed to comply with the terms of the cited standard; (3) employees were exposed or had access to the hazard covered by the standard, and (4) the employer had actual or constructive knowledge

of the violative condition (*i.e.*, the employer knew, or with the exercise of reasonable diligence could have known). *Atlantic Battery Co.*, 16 BNA OSHC 2131 (No. 90-1747, 1994).

The Court has grouped the foregoing citation items for discussion because Respondent admits the standards applied, were violated, and that its employees were exposed to the hazard resulting from the violations.[4] *Resp. Brief* at 9. The real dispute is the element of employer knowledge. Complainant asserts that Respondent's foremen should have been aware of the violations occurring above the hard lid ceiling because their employees broke fall protection rules on three consecutive days (the purported "near miss" on April 27th when Perry stepped off a beam; Castro connecting his lanyard to itself for five minutes on April 28th; and the April 29th accident itself). Thus, Complainant concludes, Respondent failed in at least one of the following respects: clearly defined rules, adequate training, conducting timely and thorough inspections of the workplace, or implementing a progressive disciplinary program. Respondent contends it could not have known about the violations committed by R.S. and Castro because they were out of view while above the hard lid, its foremen provided frequent fall protection training, as recently as the morning of April 28th, and Respondent had a documented history of progressive enforcement of its safety rules.

It is undisputed that Respondent did not have *actual* knowledge of the fall protection violations alleged in Citation Items 1(a), 1(b), or 2. (Tr. 119, 122). To establish *constructive* knowledge of a violation, Complainant must prove that "with the exercise of reasonable diligence, Respondent should have known of the hazardous conditions constituting the violation." *S.J. Louis Constr. of Texas*, 25 BNA OSHC 1892 (No. 12-1045, 2016). The operative term is "reasonable diligence". According to the Commission, "Reasonable diligence involves consideration of several factors, including the employer's obligation to have adequate

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[4]. Citation 2, Item 1 will be dealt with at the conclusion of the Court's discussion of the fall protection items.

work rules and training programs, to adequately supervise employees, to anticipate hazards, and to take measures to prevent the occurrence of violations." *Danis Shook Joint Venture XXV*, 19 BNA OSHC 1497, 1501 (No. 98-1192, 2001), *aff'd*, 319 F.3d 805 (6th Cir. 2003). The obligation to inspect (i.e., adequate supervision) for hazards "requires a careful and critical examination, and is not satisfied by a mere opportunity to view equipment." *Hamilton Fixture*, 16 BNA OSHC 1079, 1087 (No. 88-1720, 1993).

The hard lid was situated 24 feet above a 20,000 square-foot floor space. (Tr. 267). As recounted in Evans's testimony, the area above the hard lid was almost completely obscured from below except for the cut-outs that served as entry points for the scissor lift. (Tr. 292–293). When the scissor lift was in use, the area above the lid was further obscured by the lift itself. (Ex. 266–67). Poole testified that he (nor other supervisors) could not have seen any of the cited fall protection violations from the ground level. (Tr. 257–58; Ex. C-41). The Court agrees. As illustrated in the photos of the framework above the hard lid, even CSHO Christensen admitted it was difficult to identify the beam straps and anchor points while viewing the hard lid *from the elevated scissor lift*, let alone from 24 feet away on the ground, through an obstructed hole in the ceiling. (Tr. 71–74; Ex. C-29, C-35, C-36, C-37). For that matter, the Court had a hard time identifying the referenced locations in the photographs. (Ex. C-20, C-21, C-40 at 3). Thus, any suggestion Respondent's foremen could have known of the violations based on their ability to see them from the ground is rejected. *Cf. Simplex Time Recorder Co. v. Sec'y of Labor*, 766 F.2d 575, 589 (D.C. Cir. 1985) (finding constructive knowledge where non-compliant conditions and everyday practices of employees "were readily apparent to anyone who looked—*and* indisputably should have been known to management").

Likewise, the factors listed by the Commission to determine whether Respondent exercised reasonable diligence weigh in favor of Respondent. As discussed in more detail below, the Court finds Respondent provide extensive training, supervision, and discipline such that it could not have foreseen R.S. and Castro's disregard for the rules.

Work Rules & Training

Complainant suggests that Respondent's safety program was deficient because employees committed fall protection violations previously. However, simply because Respondent's employees committed a safety violation does not, of itself, establish inadequate training. *See, e.g., N&N Contractors, Inc.*, 18 BNA OSHC 2121 (No. 96-0606, 2000) (finding evidence that certain employee practices were violative did not *per se* establish existence of a training violation). Instead, a review of Respondent's training regime shows that it was thorough in terms of its content, regularity, and its utilization of classroom and on-the-job, practical training.

From the point that they are hired, Respondent's employees receive frequent training on fall protection. (Tr. 155; Ex. C-39). This starts with orientation, when employees are introduced to the employee handbook and Illness and Injury Protection Program (I2P2). (Tr. 140; Ex. C-38, C39). After orientation, employees are provided with both targeted tailgate training and site-specific training, which are memorialized on sign-in sheets that indicate when training occurred, who attended, and what was discussed. (Tr. 244; Ex. R-13 to R-27). King, Poole, and Valdez all described how employees are given practical demonstrations about the proper method for putting on and setting up fall protection equipment, including attaching one yo-yo (lanyard) to one beam strap (anchor). (Tr. 139–146, 204, 247; Ex. C-2). Specifically, King testified about the standard fall protection kits, which came with one beam strap, one lanyard, one harness, and one

carabiner. (Tr. 142–43). The foreman, in turn, would demonstrate how to set up the fall arrest system and how to inspect it. (Tr. 143–44). King's testimony was echoed by Valdez, who said he provided employees with "show-and-tell" training on the proper way to "put a harness on, adjust[] it, and show[] how it all worked with one beam strap and a yo-yo." (Tr. 204).

This training directly implicates the alleged violations in this case, including the proper method for attaching lanyards (yo-yos), restrictions on the number of lanyards per anchor point, and the removal of one's lanyard while working at height. Further, Respondent provided fall protection training per the AHA's guidelines multiple times in the year leading up to the accident, including the day before. (Tr. 90, 144, 246; Ex. C-15, C-16, R-12, R-13, R-16, R-20 to R-22). *See Thomas Indust. Coatings, Inc.*, 23 BNA OSHC 2082 (No. 06-1542, 2012) (finding employer adequately communicated rules through orientation, refresher, and hands-on training, all of which were documented). Indeed, the AHA itself indicates the manner in which fall protection equipment should be oriented and connected: (1) "Equipment that will be utilized for this operation will be 5 beam straps *in conjunction with* 5, 30-foot yo-yos . . . ."; and (2) "From the scissor lift, workers will connect *one beam strap and yo-yo* to the angle support beam." (Ex. C-2). When viewed collectively, the AHA, regular fall protection training, and hands-on demonstration of fall protection equipment, illustrate that Respondent had work rules designed to address the cited standards and implemented training to ensure compliance with those rules.

In his assessment of Respondent's safety program, CSHO Christensen acknowledged that he did not "find any deficiencies noted with the training content." (Tr. 126). The Court agrees. Respondent had a well-documented training regime that was implemented at orientation, at regular intervals thereafter, and in response to any event indicating further training might be required. Although CSHO Christensen testified that Castro told him[5] he thought it was ok to

[5] Mr. Castro was not called to testify at trial. Although this out-of-court statement was introduced into the record,

attach two lanyards to one beam strap, Castro also told the CSHO he believed Respondent's preference was one lanyard to one beam strap. (Tr. 96–97). While this testimony is somewhat equivocal, it also comes to the Court second-hand from the CSHO; whereas the testimony regarding Respondent's training program and rules came from the direct trial testimony of multiple members of Respondent's management team. Accordingly, the Court finds this factor weighs in favor of Respondent.

Workplace Inspections

One of the hallmarks of the reasonable diligence inquiry is the obligation to inspect the workplace. *See Thomas Industrial Coatings*, *supra* (finding supervision adequate where weekly, documented inspections are performed by upper management and evidence illustrates direct, day-to-day supervision of employees); *Tex. A.C.A., Inc.*, 17 BNA OSHC 1048, 1050 (No. 91-3467, 1995) (finding no constructive knowledge based on inadequate inspection because Secretary failed to prove inspections were not reasonably diligent); *but see N & N Contractors, Inc.*, 18 BNA OSHC 2121, 2124 (NO. 96-0606, 2000) (constructive knowledge found where employer was aware its employees regularly violated a work rule). Complainant argues that Respondent failed to exercise reasonable diligence with respect to the area above the hard lid because (1) the AHA required a competent person inspection prior to employees beginning work on April 29th, which had not yet occurred at the time of the accident; (2) R.S. and Castro's foreman, Evans, knew they were in the hard lid, as evidenced by the elevated scissor lift; and (3) Evans was onsite and "all over that casino" for at least an hour while R.S. and Castro were above the hard lid on April 29th. Respondent, on the other hand, argues that it performed regular inspections of all work areas, including above the hard lid, and that Complainant misunderstands how the inspection requirements of the AHA were employed. Based on what follows, the Court

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the Court notes Respondent's inability to cross-examine on the point.

finds Complainant failed to prove Respondent's workplace inspection practices were deficient, and therefore should have known of the violations occurring above the hard lid during the five minute period on April 28th or at the time of the accident on April 29th.

According to Valdez, the AHA for activities above the hard lid was very clear. (Tr. 198). First, workers that travel above the hard lid were directed to attach a beam strap and yo-yo to an angle support beam while still inside the scissor lift. (Ex. C-2 at 1). Second, workers were then directed to place plywood onto the metal framework of the hard lid. Third, one worker would access the hard lid and secure the decking, pieces of which would be passed to the worker from the other worker(s) still inside the lift, with additional fall protection beam straps and yo-yos.[6] Finally, in the words of the AHA, "the competent person *will then* inspect the fall protection system and walking-working surface before any additional workers access the hard lid area." (Ex. C-2 at 2) (emphasis added). Thus, according to this policy, the mandate for a foreman to inspect the fall protection equipment and working surface arose *after* everything was properly set up.

According to Evans and Valdez, this procedure played out the same way each time. Employees would be sent up into the hard lid, where one of them—the one with the most experience—would tie-off, then install the other fall protection connections and decking, while the other handed off materials from the lift. (Tr. 208–211). After the fall protection was installed, but before electrical work began, the installer would call down to one of the available competent persons, who would then perform an inspection of the fall protection and decking to ensure it was safe for additional workers. (Tr. 276–77). The installer was instructed to call the competent person to inspect because the foremen had other responsibilities to perform at the

[6]. According to Valdez, the purpose of the decking was to provide a safer working surface, not as a means of fall protection. (Tr. 207–208).

worksite. (Tr. 288, 301–302). To Evans, it did not make sense to wait at the bottom of the lift waiting for Castro to complete the installation of the fall protection when he could be performing other inspections and duties until they were ready. (Tr. 301). The Court agrees.

Contrary to the arguments of Complainant, the Court does not see a contradiction between Evans' deposition and trial testimony. In his deposition, Evans stated he was going to perform his competent person inspection of the hard lid fall protection system "as soon as he could". (Tr. 296). At trial, he described the process recounted above, and testified he was going to conduct his inspection "[a]s soon as [Castro] called me." (Tr. 295). Evans clarified that he meant as soon as both time and circumstances—namely, the call from Castro in conjunction with whatever he was doing at that moment—would permit. (Tr. 295). The procedure described by Evans, Valdez, and Poole was memorialized in the AHA and appears to have been a practice Castro was aware of given his familiarity with working above the hard lid.

Evans testified that Castro had worked above the hard lid at least 10 times prior to the events of April 28–29, 2017, and therefore knew of the proper process for the installation and review of fall protection systems. (Tr. 277). *See SJ Louis Constr. of Texas*, *supra* (finding generalized instructions adequate when crew leader had been provided extensive training on hazard at issue and illustrated understanding of that training on multiple occasions). There is no evidence Castro or R.S. had ever been disciplined while working above the hard lid or for any other fall protection-related violation. Castro and R.S. had attended multiple tailgate training sessions addressing the hard lid AHA, including one session that took place on the morning of April 28th. Evans further testified that, on the morning of April 29th, he discussed the job and the AHA with R.S. and Castro before they went into the hard lid, including safety and fall protection, the plywood working surface, and the specifics of the conduit installation. (Tr. 287).

The Court finds Respondent's process of inspection, as written in the AHA and carried out in practice, demonstrated reasonable diligence based on the work involved.

For similar reasons, the Court rejects Complainant's claim that Respondent should have known Castro exited the scissor lift for five minutes on April 28th while inappropriately connecting his lanyard. *See LJC Dismantling Corp.*, 24 BNA OSHC 1478, (No. 08-1318, 2014) (finding condition was not present long enough to establish constructive knowledge when employee had been properly trained, workday was only two hours old, foremen were on a different floor, and employee had not finished making preparations to do work). There was no indication that a foreman was in the area, let alone in a position to see that Castro had wrapped his lanyard around a beam and back on to itself. Second, Castro was only instructed to stage material for the next day, which did not require exiting the scissor lift and, therefore, did not require a competent person inspection per the AHA. Finally, Respondent provided training that morning on the proper use of fall protection above the hard lid, which both Castro and R.S. attended.

Respondent had a thorough inspection regime on the San Manuel project. In addition to their own required inspections, the general contractor (Penta) required Respondent to perform both weekly inspections and daily checklists in each work area. (Tr. 253, 285; Ex. R-34). The daily checklists, according to Evans, were like a scaled down version of their own AHA. (Tr. 285). The checklists were designed to identify hazards and make crew members aware of their surroundings prior to beginning a job. (Tr. 228, 285). Once filled out, each member of the crew reviewed and signed the checklist. (Tr. 285; Ex. R-34). R.S. and Castro filled out one of these checklists for their work above the hard lid on April 29th. (Tr. 286–87). Similarly Respondent's foremen performed weekly site inspections, which were also documented. (Tr. 253–54; Ex. R-

31). With respect to the San Manuel Casino project, the Court finds Respondent's inspection regime was thorough and responsive to the hazards present at the worksite. This factor weighs in favor of Respondent.

Disciplinary Program

Constructive knowledge often hinges on an examination of how (or whether) the cited employer executed its disciplinary policy. *See Florida Gas Contractors, Inc.*, 2019 WL 995716 at *9 (No. 14-0948, 2019) (finding employer failed to enforce safety rules because employer only had one documented record of written discipline, failed to document any instance of verbal discipline, and did not discipline when audits uncovered violations). In some cases, employers have a "paper policy" but fail to implement the necessary measures to make that policy effective. *Rawson Contractors, Inc.*, 20 BNA OSHC 1078 (No. 99-0018, 2003) (rejecting employee misconduct defense when employer had a written program but could not provide corroborating evidence that employees were ever disciplined). However, when an employer provides evidence of a policy and substantiates its effectiveness through the introduction of documented disciplinary actions and corrective training, the Commission typically finds such a program to be adequate. *See SJ Louis*, *supra* (finding disciplinary program effective where, even though log failed to show specific disciplinary actions related to a particular hazard past 2009, the log showed a progressive policy for all safety violations); *American Eng'g & Dev. Corp.*, 23 BNA OSHC 2093 (No. 10-0359, 2012) (finding a single instance of delayed discipline insufficient to find employer failed to enforce rules when: (1) employer had progressive program; (2) issued 50–70 warnings, suspensions, and terminations in year before incident; and (3) multiple warning notices resulted in further discipline, including suspension).

Respondent falls into the latter category of employer. Not only did Respondent have a thorough and progressive policy, but it also took disciplinary action according to the requirements of the policy. (Ex. C-39 at p. 30, C-38 at p.15, C-42 to C-46). In the exhibits introduced by Respondent, the Court identified multiple fall-protection-related Corrective Action Notices (CANs) issued by Respondent in the years leading up to the incident at issue here.[7] (Ex. R-41, R-42). In some instances, the CANs were the first written notification of an employee's violation of safety rules; however, in at least two of them, the employee was on their final notice for repeated violations of fall protection rules. (Ex. R-41 at Berg 1015, 1008). In this case, Castro, Chancellor, Evans, and Valdez were all later suspended for three days for their involvement in these fall protection violations above the hard lid.[8] The Commission has noted that delayed discipline for a disputed violation does not necessarily indicate lax discipline; rather, such actions must be viewed against the backdrop of the employer's disciplinary program as a whole. As described at length above, the Court finds Respondent's program to be thorough and well-implemented.

Based on the foregoing, the Court finds Complainant failed to establish Respondent knew or, with the exercise of reasonable diligence, could have known of the violative conditions. The April 27th purported "near miss" was not a fall protection violation, and therefore, does not contribute to Complainant's constructive knowledge argument. The April 28th incident lasted for five minutes, above the ceiling, out of plain view of any supervisor, and was only discovered during interviews relating to the April 29th accident. Respondent had clear policies and rules to address violations, required supervisors to monitor and inspect for compliance, and implemented

[7]. Many disciplinary notices were for non-safety related violations, such as attendance. These did not play a role in the Court's decision; though it is notable that, even in the realm of conduct violations, Respondent seemed consistent in its application of progressive discipline. (Ex. R-43)

[8]. A CAN was drafted for R.S.; however, because he has not returned to work, the notice has not been issued. (Tr. 184; Ex. C-46). Perry was verbally disciplined for working above the hard lid without permission. (Tr. 170).

discipline when rule violations were discovered. As such, the Court finds Complainant failed to prove that Respondent did not act with reasonable diligence to discover the fall protection violations alleged in this case. Accordingly, Citation 1, Items 1a, 1b, and 2 will be VACATED.

Citation 2, Item 1

Complainant alleged an other-than-serious violation of the Act in Citation 2, Item 1 as follows:

> 29 CFR 1904.29(b)(1): A log of all recordable work-related injuries and illnesses (OSHA form 300 or equivalent) was not completed in the detail as required by the regulation:
>
> San Manuel Casino project: The description of an injury that occurred on April 29, 2017, was not completed in detail on the OSHA Form 300. The location of the event was not recorded and the injury was described as "Multiple injuries: Body Systems and Multiple Body Systems" when fractures resulted from a fall event.

Citation and Notification of Penalty at 8.

The requirements of the cited standard are simple: "You must enter information about your business at the top of the OSHA 300 Log, enter a one or two line description for each recordable injury or illness and summarize the information on the OSHA 300A at the end of the year." 29 C.F.R. § 1904.29(b)(1). Section 1904.29(a) requires an employer to use an OSHA 300, OSHA 300A, and OSHA 301 forms or their functional equivalent. *See* 29 C.F.R. § 1904.29(a). An "equivalent form", according to the Act is "one that has the same information, is as readable and understandable, and is completed using the same instructions as the OSHA form it replaces." 29 C.F.R. §§ 1904.29(a), (b)(4). In this item, Complainant contends Respondent was in violation because it did not include the full description for R.S.'s injury as indicated at the top of the OSHA 300 form, which requires three separate pieces of required information: (1) injury or illness, (2) parts of body affected, and (3) the object or substance causing the injury or illness. As noted in the violation description, Respondent did not indicate the specific injury suffered, the

part of the body affected, nor the object causing the injury. Instead, Respondent's form only reported a general summary: "Multiple Injuries" to "Multiple Body Systems". (Ex. C-4). This did not comply with the requirements of the standard. Thus, Complainant established a *prima facie* violation of the cited regulation.[9]

Respondent does not dispute that it violated the standard; however, it has requested a 25% reduction in Complainant's proposed penalty for good faith, which is consistent with the maximum discount Complainant can give under its Field Operations Manual. *See* OSHA Field Operations Manual, CPL-02-00-160 at 6-6 (August 2, 2016). Respondent premised this request on the fact that it had a written safety and health plan that was thorough and consistently enforced. Complainant already provided a 10% reduction for Respondent's history. (Tr. 116; Ex. C-59 at 10).

Pursuant to Section 17(j) of the Act, the Court is required to give due consideration to four criteria: (1) the size of the employer's business, (2) the gravity of the violation, (3) the good faith of the employer, and (4) the employer's prior history of violations. Gravity is the primary consideration and is determined by the number of employees exposed, the duration of the exposure, the precautions taken against injury, and the likelihood of an actual injury. *J.A. Jones Construction Co.*, 15 BNA OSHC 2201 (No. 87-2059, 1993). It is well established that the Commission and its judges conduct *de novo* penalty determinations and have full discretion to assess penalties based on the facts of each case and the applicable statutory criteria. *Valdak Corp.*, 17 BNA OSHC 1135 (No. 93-0239, 1995); *Allied Structural Steel*, 2 BNA OSHC 1457 (No. 1681, 1975).

[9]. As noted by Complainant, employee access to a hazard is not an element of Complainant's burden for a recordkeeping violation. *See Gen. Dynamics. Corp.*, 15 BNA OSHC 2122, 2132 n.17 (No. 87-1195, 1993). Further, the records were in Respondent's possession, and Respondent was obligated to maintain them. As such, Respondent knew or, at the very least, could have known the accident and injury records were deficient.

Respondent's description of the accident, injury, and cause in the 300 log was the equivalent of leaving the entry blank. At the top of each column of the 300 form, OSHA provides an example of how to correctly document an injury in the log. (Ex. C-4). For example, in column (F), the example provides "e.g. Second degree burns on right forearm from acetylene torch". (*Id.*). When compared to this example, Respondent's entry for R.S. was woefully deficient. For that matter, other entries on the log were also deficient in one manner or another, with many missing the "where" and the "object/substance that directly injured or made the person ill". (Ex. C-4). As such, the Court finds the penalty assessed by Complainant was appropriate for the violation. In assessing its penalty, Complainant gave due consideration to Respondent's history of violations, the gravity of a record-keeping violation, and Respondent's size. The Court finds no reason to depart from the proposed penalty. (Tr. 115–116).

Order

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

1. Citation 1, Item 1a is VACATED;
2. Citation 1, Item 1b is VACATED;
3. Citation 1, Item 2 is VACATED; and
4. Citation 2, Item 1 is AFFIRMED, and a penalty of $1,630 is ASSESSED.

/s/ Brian A. Duncan

Judge Brian A. Duncan
U.S. Occupational Safety and Health Review Commission

Date: June 7, 2019
Denver, Colorado