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CDPH Calls for Sharply Lower Lead PEL; Berkeley Symposium Set for Nov. 13

California's Department of Public Health is recommending a revised permissible exposure limit for lead that is sharply lower than Cal/OSHA even contemplated in recent discussions on exposure.

The recommendations by CDPH's Occupational Health Branch (OHB), based on research conducted by Cal/EPA's Office of Environmental Health Hazard Assessment, will be the subject of a daylong symposium on Nov. 13 in Berkeley.

Currently, Cal/OSHA requirements set a permissible exposure limit of 50 micrograms per cubic meter of air (μm^3) in General Industry Safety Orders §5198 and Construction Safety Orders §1532.1. But since those standards went into effect in the early 1970s, much information has developed about the health effects of lead at lower concentrations, OHB says.

When the Division of Occupational Safety and Health convened an advisory committee in 2011 to discuss revising the lead standards, it circulated a draft recommending medical removal for workers showing a blood lead level of 30 micrograms per deciliter ($\mu\text{d}l$) and medical surveillance for workers with levels at or above 10 $\mu\text{d}l$. DOSH did not draft a PEL proposal, though. Even so, the recommendations prompted one unidentified stakeholder to put the committee on hold and DOSH has not reconvened it since.

That's mostly because the Division has been waiting for OHB's PEL recommendation. That agency, in turn, has been waiting for scientific modeling to be completed and peer-reviewed. Now that work is finished and OHB's resulting recommendation could cause more controversy.

OHB's Occupational Lead Poisoning Prevention Program (OLPPP) is calling for a PEL of between 0.5-2.1 μm^3 to keep



Occupational Health Branch Chief Barbara Materna announced the release of the branch's blood lead recommendations at the Oct. 4 meeting of the Cal/OSHA Advisory Committee.

Lead PEL continued on page 10704

Cal/OSHA Investigations

Worker Crushed in Conveyor Belt; Another Fatality in the 'Cone Zone'

California's Division of Occupational Safety and Health is investigating several recent workplace fatalities.

Oct. 7: An employee of R. J. Noble Co. in Orange was "sucked into a conveyor belt, crushing him," according to Department of Industrial Relations public information officer Fred Chico.

Oct. 4: DOSH learned about the death of a worker for Valley Health Care Center in Fresno who had contracted tuberculosis. The employee died on March 20.

The same day, a 19-year-old worker for Golden State Vintners in Soledad was killed after being trapped in a machine containing an auger, the *Salinas Californian* reports.

Oct. 2: A worker doing road work in Clovis was killed by a speeding motorist who was allegedly fleeing a police traffic stop. The 19-year-old worker, employed by Traffic Loops Crack Filling, was saw-cutting on a city street when he was struck by the 31-year-old driver, who is suspected of driving under the influence. (This incident likely will be handled as a criminal investigation, not by Cal/OSHA.)

Complaint Spurs Adult-Film Cites

DOSH has cited a San Francisco adult-film producer, Factory Video, Inc., for a number of alleged serious and general violations after the Division received a complaint about its

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DECISIONS

40-6985 to 40-6988

- Blattner Energy, Inc.
- Morrow Meadows Corp.
- CA Prison Industry Authority

It is 4,575 days since our last lost-time accident.

☞ lack of protection from bloodborne pathogens and sexually transmitted diseases.

DOSH alleges that the production company failed to establish and implement an effective exposure-control plan to protect workers “who had reasonable anticipated contact with blood or other potentially infectious materials.” Among the other cited violations, the Division alleges that Factory Video failed to require the use of engineering and work practice controls on the sets and did not observe the universal precautions required in General Industry Safety Orders §5193, the bloodborne pathogens standard.

Citations: Factory Video, Inc.

Title 8 Section Cited	Citation Type	Alleged Violative Condition	Proposed Penalty
GISO §5193(c)(1)	Serious	Employer did not establish and implement an exposure control plan, including engineering controls and work practices; post-exposure evaluation; and recordkeeping.	\$9,000
GISO §5193(d)(2)	Serious	Employer did not require the use of engineering and work practice controls during production activities to minimize exposure to blood or other potentially infectious materials.	\$9,000
GISO §5193(d)(1)	Serious	Employer did not observe universal precautions.	\$9,000
GISO §3212(e)	Serious	Employees were not protected from the hazard of falling through skylights.	\$7,200
LVESO §2360.3(a)	Serious	Receptacle in restroom did not have a ground-fault circuit interrupter.	\$3,600
Various	General	Ineffective IIPP; improper height on railings; missing guardrails; narrow ramps; missing ladder rungs; missing side rails on ladders; missing declination statement on hepatitis vaccine offer; load limit signs missing; substandard ladder well opening; spliced flexible cord; circuit breaker not properly labeled; power taps improperly used; conductors not in junction boxes or raceways; and other electrical hazards.	\$7,140
Total:			\$44,940

Decisions Correction

In the Oct. 4 edition of our Decisions section, the *Silva Trucking* case lists Clement Hsieh as representing the employer. In fact, Hsieh represented the Division of Occupational Safety and Health, for which he is manager of the High Hazard Compliance Unit-North, based in Oakland. Silva Trucking was represented by Steve Rand.

Standards Board's November Public Hearing

Board: Tank Rules Need Updating

A Title 8 regulation covering the safeguarding of storage tanks in flood-prone areas is seriously outdated, the Cal/OSH Standards Board staff says in proposing an update to the safety order and cross-reference to another regulation.

The proposal is in a 45-day comment period that ends with a Nov. 21 public hearing in San Diego.

General Industry Safety Orders §5605 requires that storage tanks be installed according to the National Fire Protection Association (NFPA) 30-1973 standard, which is “badly outdated and no longer available for review,” staff says. Additionally, the safety order does not elaborate about the requirements or provide further direction, and the Construction Safety Orders (CSO) do not have provisions addressing tanks located in flood-prone areas.

The remedy is to reference the 2012 version of NFPA 30 in §5605, and duplicate federal requirements from 29 CFR 1910.106(b)(5)(vi) and 1916.152(i)(5)(vi). The proposal also adds a new CSO §1550 that cross-references to §5605. “The equivalent federal standards do not refer to the NFPA 30 code for guidance,” staff notes, “but [provide] expanded details for taking precautions necessary to secure and maintain ☞



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tanks in flood prone areas.”

The public hearing is at 10 a.m. in the County Administration Center, Room 310, in San Diego. Inquiries on this proposal should be directed to Standards Board Executive Officer Marley Hart at 916-274-5721.



[Click here to see the text of the regulatory proposal.](#)

Cal/OSHA Inspections Were Down in 2012, but Violations Were Higher

California's Division of Occupational Safety and Health conducted almost 250 fewer on-site inspections in 2012 over the previous year, but it issued more citations and significantly more for serious violations.

The information comes from data released by the DOSH Program Office. In all, DOSH conducted 7,720 on-site inspections last year, versus 7,962 in 2011, a 3% decrease. The Division conducted 2% fewer complaint-related inspections and 22% fewer programmed inspections in 2012, but initiated 3% more accident-related investigations.

DOSH alleged 15,148 Title 8 violations against employers last year, a 4% rise over 2011. Alleged serious violations were up sharply, at 2,652, a 22% jump. In 2011, DOSH cited employers for 2,169 alleged serious violations. The serious rate for 2012 was 18%, versus 15% the previous year.

Agriculture, construction, manufacturing and services accounted for the great majority of the investigations as well as the violations cited.

Manufacturing had the highest rate of violations alleged as serious, at 25%. The lowest was mineral extraction, at 8%.

	On-Site Inspections	Total Violations	Serious Violations	Percent Serious
2012	7,720	15,148	2,652	18%
2011	7,962	14,552	2,169	15%
2010	8,463	17,179	3,210	19%
2009	8,450	17,477	3,307	19%
2008	10,027	21,158	4,470	21%
2007	9,259	20,222	4,660	23%
2006	8,583	19,789	4,765	24%
2005	8,176	16,467	4,044	25%
2004	7,522	16,515	4,422	27%

Event Honors a 'Compliance Sharpshooter', Eyes Safety Excellence

SAN FRANCISCO – Cal/OSHA's Voluntary Protection Program community is tight knit and cooperative, willing to share best practices, all in the name of keeping workplaces safe and workers whole.

On Oct. 2 and 3, VPP held its annual Safety Excellence Symposium, this year with a twist: The conference was held in honor of Craig Marshall, a VPP consultant who died in 2006.

It also honored an employer representative who exemplifies the VPP program. Derrick Jarvis, safety manager for E&J Gallo Co., was named Special Team Member of the Year for his efforts to mentor potential VPP employers and assist Cal/OSHA in evaluating potential Star sites.

Cal/OSHA Consultation Service, which runs the state VPP, has come to rely on STMs, as they are known, to conduct audits and help prepare sites to qualify for the program. Gallo has

	On-Site Inspections	Accident Related	Complaint Related	Programmed Inspections	Total Alleged Violations	Alleged Serious	% Alleged Serious
Agriculture	1,115	283	231	255	1,801	276	15%
Mineral Extraction	304	22	10	256	250	19	8%
Construction	2,149	524	434	538	3,866	714	19%
Manufacturing	1,042	442	333	174	3,546	893	25%
Transportation/ Public Utilities	535	174	231	69	990	165	17%
Wholesale Trade	241	78	119	23	661	95	14%
Retail Trade	546	146	304	61	1,077	100	9%
Financial/ Real Estate	97	24	54	1	157	18	12%
Services	1,447	377	635	235	2,601	352	14%
Public Admin.	244	76	138	2	199	20	10%
Totals	7,720	2,146	2,489	1,614	15,148	2,652	18%

Source: DOSH Program Office

	On-Site Inspections	Accident Related	Complaint Related	Programmed Inspections	Total Alleged Violations	Alleged Serious	% Alleged Serious
Agriculture	99	36	27	8	285	54	19%
Mineral Extraction	53	4	3	42	49	12	25%
Construction	508	122	83	181	969	207	21%
Manufacturing	292	112	90	65	1,058	291	28%
Transportation/ Public Utilities	116	32	55	8	266	58	22%
Wholesale Trade	52	23	15	11	184	29	16%
Retail Trade	158	26	74	48	300	35	12%
Financial/ Real Estate	22	5	15	0	56	4	7%
Services	343	86	127	85	584	92	16%
Public Admin.	52	15	28	1	64	14	22%
Totals	1,695	461	517	429	3,815	796	21%

Source: DOSH Program Office

been a Star site for a number of years and Jarvis has been a leading STM.

To start the two-day conference, another longtime VPP participant, Doug Hefley of Eastern Municipal Water District, remembered Marshall as “my friend and a gentleman who had a big impact on my career.” Early on, Marshall told Hefley that he needed a good safety mentor, then proceeded to volunteer as that mentor.

Consultation Manager Vicky Heza, who has served both in that program and in enforcement as deputy chief, said early in her 27-year career she worked with Marshall and called him a “sincerely kind person and an excellent safety person.” Hefley added, “He could pick out a compliance issue at 100 yards. I called him a compliance sharpshooter.”

Juliann Sum, acting chief of the Division of Occupational Safety and Health, called VPP “really, really important. We have a multifaceted program and we have to develop all the facets. You all have the programs that are the models.”

The symposium itself covered topics with both a broad focus and narrower subject matter. For instance, Dr. Najm Meshkati of the University of Southern California addressed his research into the root causes of a number of catastrophic events, including the Three Mile Island and Fukushima nuclear meltdowns, the Union Carbide chemical release in Bhopal, India, the Chernobyl



Honoring the STM of the Year: From left to right, Iraj Pourmehraban, Derrick Jarvis, Juliann Sum and Vicky Heza.

disaster in the Ukraine, and the BP Texas City and Deepwater Horizon disasters.

The major components of a large-scale, complex technical system, which Dr. Meshkati calls the HOT model, include human, organizational and technological factors. They have an interactive effect. It's a chain, and a chain is only as strong as its weakest link, he said. “Safety comes from paying attention to all three,” Dr. Meshkati said.

VPP Manager Iraj Pourmehraban addressed the perils of incentive programs and the emergence of leading indicators as a more accurate measure of safety program effectiveness.

Improperly crafted incentive programs can actually discour-

age workers from reporting injuries and illnesses, as workers and fellow employees could become reluctant to report out of fear of losing bonuses or letting the team down. “Incentives should reward reporting,” Pourmehraban said.

Leading indicators measure the things that can prevent workplace hazards instead of the results of hazards (lagging indicators). They include such things as safety meetings held and attended, training sessions, near-miss reporting, safety inspections, contractor safety and employee involvement.

“The important thing is to work on the culture, how things get done around here,” Pourmehraban said. “When nobody's looking, how do they do things?”

Other topics at the Safety Excellence symposium included comprehensive looks at machine guarding and lockout/tagout and in-depth presentations on the elements of successful VPP sites, including management commitment, employee involvement, accident analysis, contractor safety and self-inspection. Presenters included VPP consultants and – no surprise – Special Team Members.

Six Employers Cited in 2012 Central Coast Valley Fever Outbreak

A multi-agency investigation into an early 2012 outbreak of Valley Fever at a San Luis Obispo County solar power project has resulted in citations to six employers, with three of them being cited for willful violations of the serious injury/fatality reporting standard.

A total of 28 workers developed the disease, caused by fungal spores in the top layer of dirt that is disturbed and released into the air. The workers were clearing land as part of a project in Carrizo Plain in the eastern part of the county known as Topaz Solar Farm and California Valley Solar Ranch.

Valley Fever is formally known as *Coccidioidomycosis*, and also is called California Fever, San Joaquin Valley Fever and Desert rheumatism. Symptoms include a flu-like cough, fever, chest pains and aches. A large percentage of those infected have no or only mild symptoms, but a small percentage of cases are severe and even fatal. See the accompanying story about a new fact sheet on Valley Fever by the California Department of Public Health.

In the wake of the Carrizo infections, the Division of Occupational Safety and Health, CDPH and the San Luis Obispo County Public Health Department conducted joint visits to the solar project sites. Recently, DOSH issued citations to six employers, including:

CLP Resources, Inc., based in Tempe, Ariz.

Bechtel Construction Operations, of Frederick, Md.

Papich Construction Co., of Grover Beach, CA

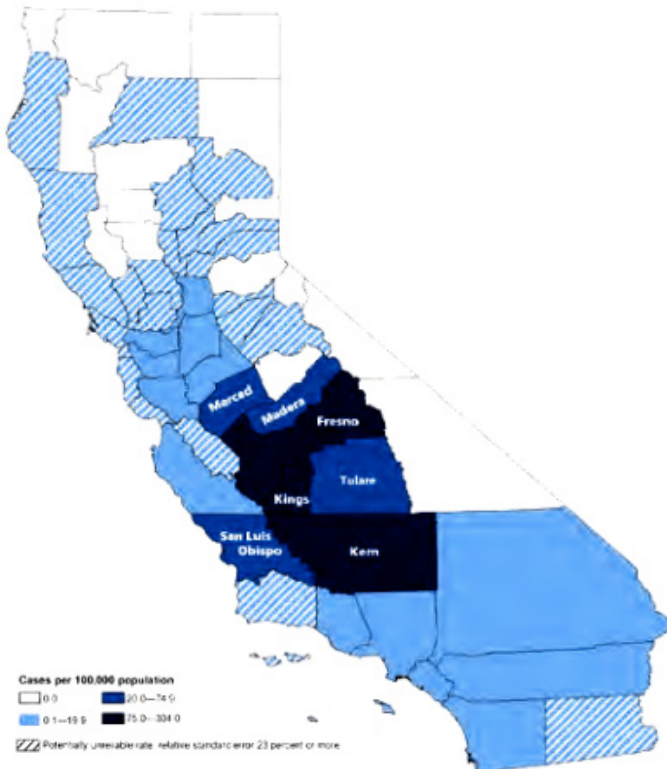
First Solar Electric, of Santa Margarita, CA

📍 **Hot Line Construction**, of Brentwood, CA

CSI Electrical Contractors, of Santa Fe Springs, CA

CLP, Bechtel and Papich all were cited for willful-regulatory violations of DOSH regulation §342(a), which requires employers to report fatalities and serious injuries within eight hours. In a number of instances, the employers did not report that employees were hospitalized for more than two days. DOSH says the employers were aware of the workers' serious illness involving hospitalization for more than 24 hours for other than observation, one of the reporting criterions.

California county-specific coccidioidomycosis incidence rates, 2011



The alleged violations come with \$25,000 in proposed penalties, which could be a record for §342(a) allegations.

The employers also were cited for alleged willful-regulatory violations of the recordkeeping standard, §14300.29, for failing to record several Valley Fever illnesses on their Log 300 forms. (Each of the allegations comes with a \$5,000 proposed penalty.) And they were cited for alleged serious violations of General Industry Safety Orders §§ 5141 and 5144 for allegedly failing to implement effective engineering controls on dust exposures to prevent the release of the spores; and failing to develop and implement a written respiratory protection program to protect employees.

CLP faces \$45,740 in possible penalties; Bechtel \$40,680; and Papich \$39,225. First Solar Electric was cited for the same §§ 5141 and 5144 violations and faces \$15,180 in penalties.

The Facts on Valley Fever

The Hazard Evaluation System and Information Service (HESIS) has published a fact sheet on the causes, control and prevention of a disease with the tongue-twisting name of *Coccidioidomycosis*, but is commonly known as Valley Fever.

California's Division of Occupational Safety and Health recently cited six employers on a Central Coast solar project after a number of workers developed Valley Fever. Workers can be exposed when soil containing the fungus is disturbed. Workers are exposed by breathing spore-containing dust.

The fungus, *Coccidioides immitis*, lives in the top two to 12 inches of soil. There is no reliable way to test soil for spores, and in certain parts of California the condition is considered endemic, particularly the San Joaquin Valley.

HESIS says construction workers, archeologists, geologists, wildland firefighters, military personnel, mining and energy industry workers and agricultural workers are at higher risk of the disease. Even small doses of the fungus, as few as 10 spores, can cause an infection. In the majority of cases, about 60%, symptoms are mild. About 5% of victims develop serious illness.

Symptoms include cough, fever, chest pain, head and muscle aches, a rash on the upper trunk or extremities, joint pain in the knees and ankles and fatigue.

In terms of prevention, HESIS suggests limiting workers' exposure to outdoor dust, such as suspending work during heavy winds, and minimizing the amount of soil that must be disturbed. When it must be disturbed, wet the soil to keep dust down.

HESIS also says employers should train workers to recognize Valley Fever symptoms and ways to minimize exposure. It also has suggestions on preventing the transport of spores and what employers should do if a worker reports symptoms.



[Click here](#) for a copy of the fact sheet.

Hot Line Construction was cited for an alleged violation of Construction Safety Orders §1509, the construction Injury and Illness Prevention Program standard, for failing to identify, evaluate, investigate and correct an unsafe work condition, with a \$560 proposed penalty. CLP, Bechtel and Papich also were cited for this alleged violation.

CSI Electrical was cited for a single alleged violation of GISO §3204(e)(3)(A) for failing to provide DOSH inspectors with employee exposure records and related documents (\$500 proposed penalty).

The federal Integrated Management Information Service does not indicate that the employers have appealed their citations, but IMIS has not been updating its database because of the federal government shutdown.

Lead PEL

continued from page 10699

most workers' BLL below 10 μ /dl over their working lifetimes.

“OLPPP has determined that having chronic blood lead levels in the range of 5 to 10 [μ /dl] poses a health risk to working adults, and we use this conclusion as our basis for recommending a health-based PEL to Cal/OSHA,” writes Kathleen Billingsley, RN, chief deputy director of policy and programs for CDPH. “Our determination is based on the available peer-reviewed health effects literature as well as government agency reviews on lead toxicity. Concern about BLLs in this range is strongly supported by the scientific evidence.”

She said that to prevent BLLs at or above 5 to 10 μ /dl, air lead levels in the workplace must not exceed an eight-hour time-weighted average concentration of 0.5-2.1 μ /m³. At the 0.5 level, 95% of workers would have a BLL of less than 5 μ /dl over a 40-year working lifetime, OLPPP says. The 2.1 PEL would translate to 95% of workers having a 10 μ /dl BLL in that span, while 57% would have a BLL of less than 5 μ /dl.

OLPPP said the recommendation reflects Fed-OSHA's determination in the original lead PEL rulemaking that “early and subclinical effects must be considered when establishing a PEL, and that the PEL must provide some margin of safety to ensure that more susceptible members of the working population will be protected over their working lifetimes,” Billingsley said.

Research shows that extended exposure to low to moderate levels of blood lead – as low as 10 μ /dl -- are associated with hypertension, a decrease in kidney function, cognitive dysfunction and adverse reproductive outcomes, she said.

Other research shows evidence of decreased glomerular filtration (the rate at which fluid filters through the kidneys) and reduced fetal growth at 5 μ /dl, Billingsley noted. She added, “While some scientists have questioned low-level lead effects on kidney function because of inconsistency in the epidemiology data” and other factors, “there is a general consensus that the epidemiological and toxicological data for cardiovascular and neurocognitive effects is consistent and strong. No threshold for the health effects of lead has been identified. Ongoing research continues to reveal health effects at lower and lower levels.”

OLPPP has concluded that a PEL that maintains BLLs under 10 μ /dl over a working lifetime would “significantly reduce” the risk of the cardiovascular and neurodegenerative effects for most workers, but that level does not provide a margin for safety for more susceptible individuals. “A more health protective approach would maintain BLLs below 5 μ /dl,” according to Billingsley.

The Nov. 13 symposium is being sponsored by U.C. Berkeley's Center for Occupational and Environmental Health and will be moderated by Dr. John Howard, director of the National Institute for Occupational Safety and Health. *Cal-OSHA Reporter* will provide details on the symposium once they are available.

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SUMMARIES OF RECENT CAL/OSH APPEALS BOARD DECISIONS

Cal-OSHA Reporter is pleased to provide, for our valued subscribers, graphs indicating cited employers' experience modification rating (X-Mods) over the designated years.

HAULAGE AND EARTH MOVING – ROLL OVER PROTECTIVE STRUCTURES

Cal. Code Regs, tit. 8, § 1596(a)(1) (2013) – The Board upheld the ALJ's decision that Employer's bulldozer operator failed to wear a seat belt while working on a slope.

DEFENSES – INDEPENDENT EMPLOYEE ACTION (IEAD)

The Board upheld the ALJ's decision that Employer failed to establish the third element of the IEAD, that it effectively enforced its safety program.

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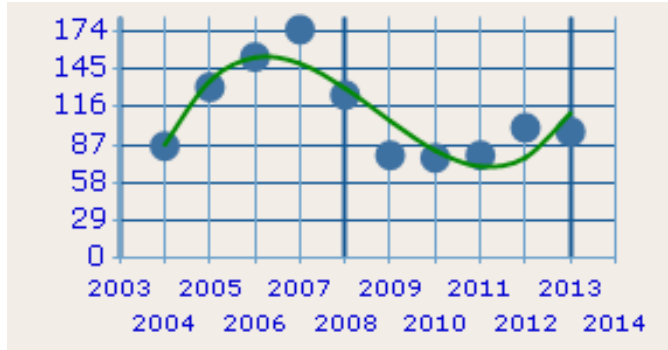
BLATTNER ENERGY INC. **40 COR 40-6985 [J22,257R]**

Digest of COSHAB's Denial of Petition for Reconsideration dated August 22, 2013, Docket Nos. 12-R2D2-0911.

Art R. Carter, Chairman.

Ed Lowry, Member.

Judith S. Freyman, Member.



THE X-MOD GRAPH FROM COMPLINE

The Board denied Employer's petition for reconsideration of an ALJ's decision dated May 22, 2013 [J 22,220].

Background. Employer, a construction company specializing in services for renewable energy projects, was constructing platforms on which windmills were to be erected. As part of that project, it was clearing space for roads that would lead to the windmills in an area that was hilly and rocky. An employee was fatally injured while cutting a new roadway in a hillside when the bulldozer he was operating rolled down a hill, ejecting him from the cab and rolling onto him as it tumbled down slope.

Following an injury accident investigation, the Division issued one citation to Employer for violation of §1596(a)(1), bulldozer operator

not wearing seat belt while working on slope. A Board ALJ issued a decision sustaining the citation and imposing a \$600 civil penalty.

The parties stipulated that §1596(a) applied to the bulldozer and required the operator to use a seat belt. It also was undisputed that the bulldozer was equipped with a working seat belt.

Denial of petition for reconsideration. Employer had a policy that seat belts were to be worn by equipment operators at all times, and that violation of the policy was grounds for termination of employment. Also, Employer had erected a sign on the road into the project area enjoining its employees to use their seat belts. The employee's supervisor typically gave daily safety briefings to his crew before work began. During one such briefing, the employee apparently expressed his opposition to wearing seat belts with his fellow operators. The supervisor did not confront him on that occasion or later about wearing a seat belt.

The ALJ concluded that the employee was not wearing his seat belt when the accident occurred. This finding was supported by Division testimony that equipment operators were not ejected from their vehicles if they were wearing a seat belt when an accident occurred. Also, the bulldozer was relatively new and its seat belt was examined after the accident and found undamaged and operational. There was no indication of stress to the webbing or metal buckle components, as might be expected if the employee had been ejected while wearing the seat belt. Moreover, he had publicly expressed opposition to wearing a seat belt, and he was ejected from the cab during the accident.

The Board next concluded that Employer did not establish the third element of the independent employee action defense (IEAD). To avoid liability through the IEAD, an employer must establish: (1) the employee was experienced in the job being performed; (2) the employer has a well-devised safety program that includes training employees in matters of safety respective to particular job assignments; (3) the employer effectively enforces the safety program; (4) the employer has a policy that it enforces of sanctions against employees who violate the safety program; and (5) the employee caused a safety infraction that the employee knew was against the employer's safety requirements (**Mercury Service, Inc.**, Cal/OSHA App. 77-1133, DAR (Oct. 16, 1980) [Digest J 14,137R]).

The parties had stipulated that Employer satisfied every element of the IEAD except the third, that it effectively enforced its safety program. The ALJ concluded that, in view of the difficult terrain and technical challenges of cutting the new road, the accentuated risk of the work, the inability to determine by sight from the ground whether the employee was wearing a seat belt, and his known antagonism toward using seat belts, Employer's supervisor did not do enough to require that the employee complied with Employer's seat belt policy. The Board agreed.

Employer's supervisor testified that he conducted seat belt audits frequently. However, there was no evidence that he discussed seat belt use with the operators collectively on the day of the accident, or individually with the employee in light of the risky assignment. The Board concurred that Employer did not satisfy the third element of the IEAD.

NOTE: According to the Appeals Board, ALJ decisions are not citable precedent on appeal, i.e., they cannot be quoted when one is appealing a citation. There is nothing in the California Code of Regulations about this: it is by Board precedent. "(U)nreviewed administrative law judge decisions are not binding on the Appeals Board." (*Pacific Ready Mix*, Decision After Reconsideration of 4-23-82, and *Western Plastering, Inc.*, Decision After Reconsideration, 12-28-93.) Decisions After Reconsideration (DARs) are precedential and may be quoted in an appeal.

FLOOR OPENINGS, FLOOR HOLES AND ROOFS – SKYLIGHTS

Cal. Code Regs, tit. 8, § 3212(e) (2013) – Employer failed to protect employees from the hazard of falling through a skylight. The Division established a serious, accident-related violation.

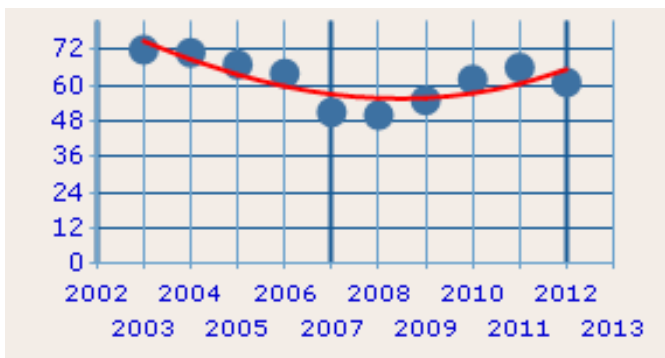
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MORROW MEADOWS CORPORATION 40 COR 40-6986 [J22,258]

Summary of COSHAB-ALJ's Decision dated August 29, 2013, Docket No. 09-R3D3-2295 (Walnut, CA).

Jacqueline Jones, Administrative Law Judge.

For Employer: Kevin Bland, Attorney.
For DOSH: Tuyet-Van Tran, Staff Counsel.



THE X-MOD GRAPH FROM COMPLINE

Following an accident inspection, the Division cited Employer, an electrical contracting company, for failure to protect employees from the hazard of falling through a skylight. Employees were installing solar panels and racking on a rooftop when an employee, who was walking next to a skylight, tripped and fell onto the skylight dome, which failed to support his weight. He fell through the skylight, causing fatal injuries.

§3212(e): Serious, accident-related violation and \$18,000 penalty affirmed. The Division cited Employer for failure to protect its employees from the hazard of existing skylights, which required Employer to use any of the alternative means of fall protection required by §3212(e), i.e., a skylight screen, guardrails, a personal fall protection system, covers, or a fall protection plan.

Employer contended that: 1) it did not violate §3212(e) because the skylight through which the employee fell was designed and built by its manufacturer to meet the strength requirements under §3212(b), as cited in §3212(e)(1), obviating the need for any of the additional fall protection methods provided in §3212(b); 2) it justifiably relied on statements and data provided by the manufacturer of the skylight, as well as the Final Statement of Reasons published by Fed-OSHA, in determining that the skylights complied with §3212(e); and 3) the violation was not serious, accident-related but rather general because Employer did not, and could not with the exercise of reasonable diligence, have known of the violation because the skylight had a latent defect that caused it to fail to withstand the weight for which it had been designed and tested.

An employee testified that he worked at the jobsite for one month prior to the accident and that the skylights were present when he started the job. Moreover, at the daily safety meeting, Employer gave an instruction that employees were not to lean on the skylight dome.

There was credible testimony that employees were working in close vicinity and within six feet of existing skylights and that Employer failed to comply with any of the five methods to protect employees, under §3212(e). Employer argued that the skylight was designed and built

by its manufacturer to meet the strength requirements under §3212(e). Employer appeared to be arguing that the dome of the existing skylight should be considered a skylight screen. The Division testified that the dome did not meet the screen requirement of §3212(e)(3). The dome of the existing skylight did not meet the cover requirement as set forth in §3212(b).

The ALJ also rejected Employer's alternative argument that it was justifiably relying on the manufacturer's data and the Fed-OSHA's Final Statement of Reasons in determining that the skylights complied with §3212(e). The person who collected the data regarding the skylight dome strength requirements was deceased and, thus, not able to explain whether the skylight dome that was tested was the same size, make and model of the skylight involved in the fatal accident. Also, test data did not appear to take factors such as degradation due to age and sunlight into consideration.

In **Pictsweet Frozen Foods**, Cal/OSHA App. 97-1896, DAR (April 16, 2001) [Digest ¶ 20,023R], the Board held that a good faith but mistaken belief that a fiberglass skylight dome constituted a skylight screen or cover capable of withstanding 200 pounds was not a defense to a serious violation. Here, there was no cover and no skylight screen. Employer's mistaken belief that the employee's weight would be supported by the skylight dome was not a defense to the serious violation.

Classification. A serious classification is shown when there is a substantial probability of serious physical harm resulting from accidents assumed to occur as a result of the violation, unless the employer can demonstrate that it did not and could not with the exercise of reasonable diligence, know of the presence of the violation (Labor Code §6432). Employer stipulated that there was a substantial probability that an employee would suffer serious physical harm or death from falling more than 37 feet onto concrete. There was unrefuted testimony that Employer instructed all workers not to lean on the skylight domes. Moreover, the general foreman testified that Employer was aware that the skylights were a hazard on the job.

Hazardous conditions, either plainly visible or discoverable and preventable by exercising reasonable diligence, constitute serious violations since the employer could have known and corrected them. (See **Fibreboard Box & Millwork Corp.**, Cal/OSHA App. 90-492, DAR (June 21, 1991) [Digest ¶ 17,705R].) Here, Employer, with the exercise of reasonable diligence, could have known of the presence of the violation.

The violation caused a serious injury. As a result, no penalty adjustments other than for Employer's size were allowed (Labor Code §6319; §336(d)). Because Employer had more than 100 employees, no adjustments were allowed.

INJURY AND ILLNESS PREVENTION PROGRAM (IIPP) – CODE OF SAFE PRACTICES

Cal. Code Regs, tit. 8, § 3203(a) (2013) – A single incident was insufficient to prove that Employer failed to maintain an effective IIPP.

INJURY AND ILLNESS PREVENTION PROGRAM (IIPP) – SYSTEM OF COMMUNICATING WITH EMPLOYEES

Cal. Code Regs, tit. 8, § 3203(a)(3) (2013) – There was insufficient evidence to support a citation for absence of a system of communications with employees about safety and health issues.

INJURY AND ILLNESS PREVENTION PROGRAM (IIPP) – PROCEDURES FOR IDENTIFYING AND EVALUATING WORKPLACE HAZARDS

Cal. Code Regs, tit. 8, § 3203(a)(4) (2013) – Employer did not have procedures that would have allowed supervisors to keep track of the operations that inmates were preparing or planning to perform using specific tools and machines. Therefore, supervisors were unable to identify and evaluate workplace hazards.

WOODWORKING MACHINES AND EQUIPMENT – FEATHERBOARDS OR SUITABLE JIGS

Cal. Code Regs, tit. 8, § 4296(a) (2013) – There was insufficient evidence that Employer failed to provide featherboards to wood shop employees.

INJURY AND ILLNESS PREVENTION PROGRAM (IIPP) – TRAINING AND INSTRUCTION ON NEW JOB ASSIGNMENTS

Cal. Code Regs, tit. 8, § 3203(a)(7)(c) (2013) – Employer assigned an inmate worker to do a stopped dado cut on a table saw, a new assignment that he had not been trained to perform. Evidence about his injury and the likelihood of a serious injury supported the serious classification.

MACHINERY AND EQUIPMENT – ADEQUATE DESIGN

Cal. Code Regs, tit. 8, § 3328(a) (2013) – The ALJ concluded that the meaning of “shall be of adequate design” in the safety order had not been explained by any Appeals Board decision, nor was there evidence about its history to aid in its construction. There was no evidence to cast doubt on the adequacy of design or operation of Employer’s table saw or blade; rather, the hazardous action was the inmate’s decision to use the saw for the specific operation. Employer’s appeal was granted.

CIRCULAR RIPSAWS MANUAL FEED – ANTI-KICKBACK DEVICES

Cal. Code Regs, tit. 8, § 4300(d) (2013) – Because the use of an anti-kickback device is not feasible during the cutting of a stopped dado, the “Class B” designation assigned to §4300 eliminates the requirement that an anti-kickback device must be used during that operation. Employer’s appeal of the citation was granted.

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CA PRISON INDUSTRY AUTHORITY 40 COR 40-6987 [§22,259]

Summary of COSHAB-ALJ’s Amended Decision dated August 21, 2013, Docket Nos. 08-R2D5-3426 through 3429 (Avenal, CA).

Martin Fassler, Administrative Law Judge.

For Employer: Debra Ichimura, Attorney.

For DOSH: Cynthia Perez, Attorney.

Following an injury accident inspection, the Division issued four citations to Employer, a public agency created by statute that employs prisoners in industrial enterprises. The incident occurred at the wood furniture factory operated by Employer at a state prison. An inmate worker injured three fingers of his left hand while operating a table saw. The ALJ noted that the Board previously rejected Employer’s arguments in **CA – Prison Industry Authority, State of California**, Cal/OSHA App. 09-2459, DDAR (Oct. 26, 2011) [Digest ¶ 21,910R] and **California Prison Industry Authority**, Cal/OSHA App. 07-2171, DDAR (June 3, 2010) [Digest ¶ 21,666R].

§3203(a): General violation dismissed; \$560 penalty vacated. The Division alleged that Employer directed the inmate to violate elements of its code of safe practices (CSP) by directing him to use a table saw to create a stopped dado in material that was less than three inches wide and less than two inches deep.

In light of precedent established by **Marine Terminal Corp dba Evergreen Terminals**, Cal/OSHA App. 08-1920, DAR (March 5, 2013) [Digest ¶ 22,190R], **Michigan-California Lumber Company**, Cal/OSHA App. 91-759, DAR (May 20, 1993) [Digest ¶ 18,284R] and **Ironworks Unlimited**, Cal/OSHA App. 93-024, DAR (Dec. 20, 1996) [Digest ¶ 19,047R], the ALJ found that evidence of a single shortcoming by Employer, in this case assignment of an employee to an activity in conflict with its CSP, was insufficient to establish a violation of the general duty under §3203(a) to “implement and maintain an effective IIPP.” Because the Division contended that this single violation constituted the violation, the ALJ granted Employer’s appeal.

§3203(a)(3): **General violation dismissed; \$0 penalty.** The Division alleged that a system of communication that encouraged employees to inform Employer about safety and health hazards without fear of reprisal was not identified.

The ALJ stated that the use of weekly safety meetings for communications from supervisors to rank-and-file employees and vice-versa is a common method of discussing safety issues with employees. The Division’s contention that the unusual nature of the prison setting, with the possibility of unusually severe disciplinary actions, cast doubt on the legitimacy of the weekly safety meetings and the suggestion box, was speculative. There was no evidence that there had been efforts by Employer to discourage employee discussion of safety issues. The ALJ granted Employer’s appeal.

§3203(a)(4): **General violation and \$560 penalty affirmed.** The Division cited Employer for failure to review, assess and evaluate the hazards to which machine operators were exposed when performing stop dado operations in the manufacture of draw rails using a specific table saw and stacked dado blade.

Evidence supported that Employer’s furniture factory did not have comprehensive procedures that would have allowed supervisors to keep track of the actions or procedures that inmates were preparing or planning to perform using specific tools and machines. The injured inmate’s supervisor testified as to gaps in Employer’s control over the work done by the inmate-workers, and that he did not know that the specific inmate worker was doing the stopped dado on the saw. The absence of that information prevented the supervisor from identifying the hazard of doing the operation on that machine.

§4296(a): **General violation dismissed; \$0 penalty.** The Division charged that featherboards or other means, devices or jigs were not provided for dadoing operations in which using a standard type guard is not feasible.

The ALJ concluded that the Division’s evidence in support of the citation was insufficient to establish a violation. The Division acknowledged that its inspector did not ask Employer’s management about the availability of featherboards. There was credible testimony that featherboards and push sticks of various sizes and shapes were easily available for wood shop employees, including the injured inmate

worker. The evidence supported that Employer provided featherboards in the wood furniture shop, specifically in the area in which the inmate was working at the time of the accident. The ALJ granted Employer's appeal.

§3203(a)(7)(c): Serious violation and \$18,000 penalty affirmed.

The Division alleged that Employer failed to provide effective training to machine operators working in the furniture factory for specific, known hazards or provide them with the ability to recognize, understand and avoid unique hazards associated with dadoing operations using a table saw. Specifically, the Division alleged that the inmate who was operating the machine failed to recognize the hazardousness of making a stopped dado with table saw and suffered injuries when a material kickback occurred.

There was evidence to support that use of the table saw was a new assignment for the inmate. His supervisor testified that he did not train the inmate for that kind of cut, and, from that testimony, the ALJ inferred that the supervisor would not have assigned the inmate to do that cut on that saw because the supervisor viewed it as inherently hazardous. The inmate told the Division that he had not undertaken that cut previously. The Division offered no evidence that he had carried out any such work previously.

The ALJ concluded that Employer had not trained the inmate to recognize the hazards inherent in the assignment. The Division testified that it reviewed the inmate's training records and found nothing about training related to a stopped dado cut. Employer offered no evidence to the contrary. The ALJ found that the inmate had not previously used the saw for stopped dado cuts and that Employer did not provide training for him about use of the table saw for making stopped dado cuts. Therefore, Employer violated §3203(a)(7)(C).

Employer attempted to advance the independent employee action defense (IEAD). To avoid liability through the IEAD, an employer must establish: (1) the employee was experienced in the job being performed; (2) the employer has a well-devised safety program that includes training employees in matters of safety respective to particular job assignments; (3) the employer effectively enforces the safety program; (4) the employer has a policy that it enforces of sanctions against employees who violate the safety program; and (5) the employee caused a safety infraction that the employee knew was against the employer's safety requirements (**Mercury Service, Inc.**, Cal/OSHA App. 77-1133, DAR (Oct. 16, 1980) [**Digest ¶ 14,137R**]).

The IEAD was not applicable here because there was no evidence to support the first or fifth elements. Moreover, although the inmate may have been experienced in use of the table saw generally, he was completely inexperienced in its use for this unusual cut, the stopped dado cut.

Classification. As in effect at the time of the accident, Labor Code §6432 provided that a violation is classified as "serious" if, assuming an accident were to occur as a result of the violation, there is a substantial probability that death or serious physical harm could result from the violation. Here, there was evidence that the inmate suffered injuries to three fingers, including a comminuted fracture of one finger, in essence shattering one bone. Other relevant evidence included: the nature of the tool or machine, a power tool with a rotating blade strong enough to cut through wood; that the inmate's hand was close to the rotating blade to carry out the task; testimony by all three witnesses that a kickback occurred; the Division's testimony that a kickback would likely draw an operator's hand into the blade and that a kickback would probably lead to serious hand injuries. There was sufficient evidence to support that if an injury were to occur in this situation, it probably would result in serious physical harm to the operator. Therefore, the evidence supported the "serious" classification.

The ALJ concluded that the evidence was insufficient that Employer, had it exercised reasonable diligence, could not have known of the inmate's activity. Employer did not have an adequate system to know when a shop employee was about to undertake a task for which

he needed training and supervision.

§3328(a): Serious violation dismissed; \$6,750 penalty vacated.

The Division alleged that Employer directed the use of a table saw that was inadequately designed to perform stopped dado operations within compliance of §§4296(a) and 4300(e).

There was no evidence that the saw was operated under unusual or improper speeds, stresses or loads; therefore, the violation could only be upheld if there was evidence that the table saw was not "of adequate design." The ALJ noted that there was no evidence that there was any flaw or shortcoming in the design of either the saw or the blade used.

The Division testified that any effort to cut a stopped dado on the saw would be inherently dangerous, because completion of the task would require the operator's hands to be close to the rotating saw blade while moving the piece up and down above the blade. The ALJ found that the required cut was not impossible with this equipment, but was more hazardous than other methods.

The ALJ found only one Board decision that construes the meaning of the requirements and prohibitions of §3328(a), **El Katrina Dairy, Inc.**, Cal/OSHA App. 81-1258, DAR (August 26, 1985) [**Digest ¶16,290R**], but there appeared to be no decision after reconsideration that considers the meaning of the phrase "machinery and equipment shall be of adequate design." The Division, in essence, argued that any other use of the saw would result in the saw being of less than adequate design. However, the ALJ found it reasonable to infer that ripping was not the only intended use of the saw, and that some dado cutting was anticipated and planned for by the manufacturer.

There was no evidence of any design flaw in the saw or the blade, nor that either the saw or the blade fell short of §3207's definition. There was evidence that the saw was not the best tool to use for the "stopped dado" cut to be made; however, it was not clear that the Standards Board intended §3328(a) to reach beyond design flaws, and to apply to employer choices about which machine to use in given circumstances. The ALJ concluded that the Division offered no persuasive argument in favor of construing the phrase at issue in a way that sustained the citation.

§4300(d): Serious violation dismissed; \$18,000 penalty vacated.

The Division cited Employer for failure to provide an anti-kickback device on a circular ripsaw, commonly a manual feed table saw, during its use in a dado operation, and that the inmate worker was seriously injured as a result of a material kickback while performing a dado operation.

The Division inspector testified that during his investigation both the injured inmate and his supervisor told him that an anti-kickback device was not used during the work leading to the accident. Both Employer's supervisor and the Division testified that a guard could not be used on the saw for this dado cut because the piece to be cut must be held over the blade, and the presence of a guard over the blade would prevent the cut from being made. Thus, the safety standard here required use of an anti-kickback device.

The Division testified that there was no anti-kickback device on the saw and that while it is feasible to use an anti-kickback device on the saw when making a through dado, it would not be feasible to use it when carrying out a stopped dado operation. The ALJ found that this testimony placed the circumstances squarely within the exception recognized or created by §4188(a) for circumstances in which compliance with a regulation is unfeasible. The Division's testimony that use of an anti-kickback device is not feasible in connection with the creation of a stopped dado, meant that, in this case, "the nature of the work ... will not permit" the use of an anti-kickback device. For that reason, there was no violation of §4300(d). The ALJ granted Employer's appeal.