BEFORE THE
STATE OF CALIFORNIA
OCCUPATIONAL SAFETY AND HEALTH
APPEALS BOARD

In the Matter of the Appeal of:	Inspection No.
HAMILTON IRON WORKS **1244 W. 196th Street** **Torrance, CA 90502** **Employer**	**1497263** **DECISION AFTER RECONSIDERATION**

The Occupational Safety and Health Appeals Board (Appeals Board or Board), acting pursuant to authority vested in it by the California Labor Code, issues the following Decision After Reconsideration in the above-entitled matter.

JURISDICTION

Hamilton Iron Works, Inc. (Employer) is a metal fabricator and develops framing for structures. Beginning July 23, 2020, the Division of Occupational Safety and Health (Division), through Associate Safety Engineer Alfred Daniel Sullivan (Sullivan), conducted an inspection of Employer's worksite.

On June 10, 2021, following an investigation, the Division issued Employer two citations alleging four violations of safety orders set forth in title 8 of the California Code of Regulations. Citation 1, Item 1, alleged a Regulatory violation for a failure to report a serious injury. Citation 1, Item 2, alleged a General violation for failure to establish, implement and maintain an Injury Illness and Prevention Plan (IIPP) that included procedures for complying with safe practices, identifying and evaluating hazards, and correcting hazards. Citation 1, Item 3, alleged a General violation for failure to wear head protection while exposed to a head injury from falling objects. Citation 2, Item 1, alleged a Serious, Accident-Related violation for failure to ensure that a load was well secured and properly balanced prior to lifting it more than a few inches. The citations assessed total penalties of $18,385.00.

For Citation 1, Items 1, 2 and 3, Employer filed a timely appeal contesting the existence of the violation. For Citation 1, Item 1, Employer also contested the reasonableness of the penalty. For Citation 2, Item 1, Employer filed a timely appeal contesting the existence of the citation, the classification, the reasonableness of abatement, and the proposed penalty. Employer also raised affirmative defenses for all citations.[1]

[1] To the extent that Employer did not present evidence in support of any specific affirmative defenses, those defenses are deemed waived. (*RNR Construction*, *Inc*., Cal/OSHA App. 1092600, Denial of Petition for Reconsideration (May 26, 2017).)

This matter was heard by Leslie E. Murad, II, Administrative Law Judge (ALJ) for the California Occupational Safety and Health Appeals Board (Appeals Board). The hearing occurred by videoconference on March 9 and 10, 2023, and May 17 and 18, 2023. Attorney Perry Poff of Donnell, Melgoza & Scates, LLP, represented Employer. Lisa Wong, Staff Counsel, represented the Division.

The ALJ issued a Decision on September 8, 2023 that affirmed each citation and affirmed the penalties as issued by the Division.

Employer filed a timely Petition for Reconsideration (Petition). Employer's Petition challenges the ALJ's affirmance of Citation 1, Items 2 and 3, and Citation 2, Item 1. Employer challenges the penalty calculations for Citation 1, Item 1, and Citation 2, Item 1. Employer contends that Citation 1, Item 2, did not provide fair notice of the violation, which Employer contends violates the notice requirements of Labor Code section 6317. Employer challenges the Serious, Accident-Related classification for Citation 2, Item 1. Finally, Employer also challenges the constitutionality of an Executive Order which extended the Division's statute of limitations to issue the citations; Employer claims the statute of limitations expired and cannot be extended by Executive Order.

ISSUES

1) Did a late report occur, requiring a penalty reduction for Citation 1, Item 1?

2) Did Citation 1, Item 2, provide fair notice?

3) Did Employer fail to establish, implement and maintain an IIPP that included procedures for complying with safe practices, identifying and evaluating hazards, and correcting hazards?

4) Did Employer fail to ensure an employee wore head protection where there was a risk of receiving head injuries from flying or falling objects and/or electric shock and burns?

5) Did Employer fail to ensure that a load was well secured and properly balanced in the sling or lifting device before it was lifted more than a few inches?

6) Was Citation 2 properly classified as Serious?

7) Was Citation 2 properly classified as Accident-Related?

8) Was the penalty properly calculated for Citation 2?

9) Was the Governor's Executive Order extending the statute of limitations permissible?

FINDINGS OF FACT

1) Eduardo Bravo (Bravo), an employee of Employer, worked in Employer's metal fabrication shop from January until June 2020.

2) On June 3, 2020, Bravo used an overhead gantry crane in an attempt to lift and move a metal frame (metal frame, frame, or load) in Employer's shop pursuant to his foreman's direction.

3) The frame consisted of a long rectangular metal beam, with approximately eleven legs or uprights jutting from one side.

4) The frame was approximately 20 feet long and weighed between approximately 800 pounds and two tons.

5) The frame sat on two metal sawhorses prior to the lift.

6) Although Bravo had previously moved similar pieces, he had never before moved anything as large as this particular frame.

7) After rotating the frame so that the legs pointed upwards, Bravo rigged the frame to the gantry crane by wrapping two chains around the middle of the rectangular frame, one on each side of the center leg or upright.

8) After rigging the frame, Bravo stood directly in front of the frame, which was within the zone of danger.

9) Bravo initiated the lift of the frame with the gantry crane, stopped it for a moment, and then reinitiated the lift.

10) During the attempted lift, the frame rotated clockwise, causing a single leg or upright to strike Bravo in the shoulder and arm.

11) The load was not well secured or properly balanced.

12) The load, or portions thereof, was lifted more than a few inches.

13) Bravo suffered a broken forearm and a laceration to his shoulder.

14) Bravo's foreman Arturo Quintero (Quintero) was present in the metal shop when the accident happened, had the opportunity to observe Bravo, but did not witness the accident.

15) After the accident, Bravo told Quintero that he thought he broke a bone and Quintero told him to report the injury to the office.

16) Bravo reported the injury to Employer's office personnel.

17) After the accident, Bravo was transported to a clinic, but the clinic said his injury was too serious to be treated there.

18) Bravo was then transported to the hospital where he was admitted, underwent surgery, and was released on June 6, 2020.

19) Bravo provided Employer his hospital paperwork eight to ten days after the accident.

20) Bravo suffered serious physical harm in the accident.

21) Employer did not notify the Division of Bravo's accident until after the Division had already commenced an inspection of Employer's worksite on July 23, 2020.

22) Employer's Code of Safe Practices states "Hard hats must be worn on job sites at all times." (Exhibit 7-A.)

23) Bravo admits he was issued a hardhat, generally understood he was supposed to wear it, but was not wearing it at the time he moved this particular load.

24) Bravo had previously been disciplined for the failure to wear his hardhat.

25) Employer had a system for disciplining employees.

26) There is a risk of head injury from flying or falling objects when using the gantry crane.

DECISION AFTER RECONSIDERATION

1) Did a late report occur, requiring a penalty reduction for Citation 1, Item 1?

Citation 1, Item 1, asserts a Regulatory violation of section 342, subdivision (a), which states:

> (a) Every employer shall report immediately to the Division of Occupational Safety and Health any serious injury or illness, or death, of an employee occurring in a place of employment or in connection with any employment. The report shall be made by the telephone or through a specified online mechanism established by the Division for this purpose. Until the division has made such a mechanism available, the report may be made by telephone or email.
>
> Immediately means as soon as practically possible but not longer than 8 hours after the employer knows or with diligent inquiry would have known of the death or serious injury or illness. If the employer can demonstrate that exigent circumstances exist, the time frame for the report may be made no longer than 24 hours after the incident.

> Serious injury is defined in section 330(h), Title 8, California Administrative Code.[2]

The alleged violation description (AVD) states:

> Prior to and during the course of the Division's investigation, the employer failed to report immediately to the Division of Occupational Safety and Health the serious injury of an employee on June 3, 2020 at their worksite.

For Citation 1, Item 1, there is no dispute that Bravo suffered a serious injury and that Employer failed to timely report Bravo's injury. The dispute turns on whether Employer should receive a penalty modification for making a late report. Employer's Petition claims that it should receive a penalty reduction for a late report. (Employer's Petition, pp. 11-13.) The Board has held that when a late report occurs it may reduce the $5,000 penalty for factors of size, history, and good faith. (*Central Valley Engineering & Asphalt*, *Inc*., Cal/OSHA App. 08-5001, Decision After Reconsideration (Dec. 4, 2012).)

Employer's Petition argues that a late report occurred because Stella Nam (Nam), Employer's Operations Manager, informed Sullivan of the accident at the commencement of the Division's investigation, and Sullivan marked the citation as corrected. (Employer's Petition, pp. 11-13.) Employer's Petition states, "The Appeals Board has held that a citation marked as 'Corrected by Inspection' shows evidence of abatement of a citation." (*Id*. at p. 12, citing *Rios Farming Company*, LLC, Cal/OSHA App. 1336276, Decision After Reconsideration (Feb 6, 2023).) In opposition, the Division argues, "[r]eporting cannot include communicating a serious injury at the opening conference or during the life of the investigation—such an interpretation would not only undermine regulatory intent but render the mandate [to report] toothless and nonexistent." (Answer, p. 9.) For reasons discussed herein, we conclude that Employer's argument is without merit, and that no late report occurred.

Bravo suffered a serious injury as defined in section 330, subdivision (h), while using an overhead gantry crane to move a frame in Employer's shop. Bravo suffered an injury requiring "inpatient hospitalization for other than medical observation or diagnostic testing[.]" (§ 330, subd. (h).) From June 3, 2020, the date of Bravo's accident, until June 6, 2020, Bravo was hospitalized and his injuries required surgical intervention.

Section 342, subdivision (a), requires that an employer report a serious injury to the Division immediately, and typically no longer than eight hours, after employer knows, or with diligent inquiry should have known, of the serious injury. (*Burbank Recycling Inc*., Cal/OSHA App. 10-0562, Decision After Reconsideration (June 30, 2014).) When assessing whether an employer possessed constructive knowledge of the serious injury (i.e., whether they would have

[2] A "serious injury" includes "any injury or illness occurring in a place of employment" "that requires inpatient hospitalization for other than medical observation or diagnostic testing[.]" (§ 330, subd. (h).)

known in the exercise of a diligent inquiry), facts that are relevant include: the type and nature of the employee's injury; the cause of the injury; any observations of the employee; steps taken to obtain or provide medical treatment; employer's efforts to determine the nature of the employee's injuries; and the timeline of events following the injury or illness. (*Ibid*., citing *Benicia Foundry & Iron Works, Inc.,* Cal/OSHA App. 00-2976, Decision After Reconsideration (Apr. 24, 2003).)

Employer did not advise the Division of the serious injury until July 23, 2020, after the Division had already commenced its inspection. However, the evidence indicates that Employer had knowledge, or with diligent inquiry would have had knowledge, of Bravo's serious injury long before that date.

Employer had constructive knowledge and, arguably, actual knowledge of the serious injury as early as June 3, 2020, the date of Bravo's accident. After the accident, Bravo immediately informed Quintero, his foreman, that he thought he broke a bone. (TR [3.9.23], pp. 29, 36, 123, 128-129, 178.) Quintero told Bravo to report his injury to Employer's office, and Bravo complied. After reporting his injury to Employer, Bravo's uncle drove him to a medical clinic for evaluation, but his injuries were too serious to be treated at the clinic. (TR [3.9.23], pp. 37-39, 101, 123-126.) Thereafter, Stella Nam (Nam), Operations Manager eventually drove him to a larger hospital for treatment. (*Ibid*.) Under these facts, Employer's constructive knowledge is beyond dispute. Bravo's report to the foreman, the fact that Bravo's injuries were too severe to be treated at the clinic, and the size and weight of the frame that hit Bravo (estimated to be up to two tons), constituted objective indicators that the injury was serious, which should have served as a basis for a timely report. (*Burbank Recycling Inc*., *supra*, Cal/OSHA App. 10-0562.) The Board has held that where "an employer receives objective indicators that suggest the injury in question may have been serious, even if it cannot be definitively resolved prior to expiration of the eight-hour reporting deadline contained in section 342(a), the employer should resolve all doubt in favor of making a timely report of the incident to the Division." (*Ibid*.) At the very least, these facts provided Employer with sufficient cause to exercise a further "diligent inquiry," as required by the regulation, whereupon Bravo's serious injury would have been promptly discovered.

Further, even assuming arguendo that Employer did not definitively know the injury was serious on June 3, 2020, Employer certainly knew, or should have known had it made a diligent inquiry, that the injury was serious when Bravo provided his Employer with his hospital paperwork eight to ten days after the accident. (TR [3.9.23], pp. 102-104, 106-107.) Therefore, it is indisputable that Employer did not provide a timely report.

The Division commenced an inspection of Employer's worksite on July 23, 2020, due to a complaint, not due to a report of an employee accident or injury. (TR [3.10.23], pp. 27, 57-58, 173-174; TR [5.17.23], pp., 186-189.) During the course of the opening conference, Nam informed Sullivan of Bravo's accident. (*Ibid*.) Nam generally advised Sullivan of the factual circumstances surrounding Bravo's accident and showed him the video taken of the accident. (TR [3.10.23], pp. 63-65, 79, 167.) Nam had concluded that Sullivan's inspection arose from the accident. (*Ibid*.) Sullivan asked Nam whether Employer had made a report. Sullivan could not recall exactly what she told him in response. She either said Employer had not called it in, or that she was unsure if Employer called it in. (TR [3.10.23], pp. 65-66, 169-170.) However, the record demonstrates no report was made prior to the Division's inspection. Sullivan found no record of any accident report by Employer prior to the inspection, and found no record of a report when he went back to the

Division's office. (TR [3.10.23], pp. 27-31, 65-66, 113-114.) Sullivan said if an accident had been reported to another Division staff member he would have eventually learned of it.[3]

We conclude that an accident report made for the first time many weeks after Employer had actual or constructive knowledge of the serious injury, and after the Division commenced a complaint-based investigation, does not constitute a late report within the meaning of section 342, subdivision (a). The purpose of the reporting requirement is to allow the Division to quickly respond to injuries or illness on the job. (*Burbank Recycling Inc*., *supra*, Cal/OSHA App. 10-0562, *citing Benicia Foundry & Iron Works, Inc.*, *supra*, Cal/OSHA App. 00-2976.) A rapid response is necessary "to inspect potentially dangerous conditions close to the time of the accident or illness and to examine any equipment that may have caused an injury or illness, or which may pose a safety or health risk to other employees." (*Ibid*.) The purpose of the reporting requirement is not served when an employer waits both several weeks, and until after the Division has already commenced its inspection, to report the injury.

We also affirm Citation 1, and find that no late report occurred, for a separate reason under these particular facts. As the Division points out in its brief, the regulation requires that the "report shall be made by the telephone or through a specified online mechanism established by the Division[.]" (§ 342, subd. (a).) At the very least, the regulation requires either an email or telephone call. (*Ibid*.) Here, the report made in person at the commencement of the Division's investigation does not satisfy these regulatory requirements.

We decline to find that a late report occurred and affirm the full penalty for Citation 1, Item 1. Employer is not entitled to any penalty adjustment.

2) Did Citation 1, Item 2 provide fair notice?

Citation 1, Item 2, asserts a General violation of section 3203, subdivision (a). That section states,

> (a) Effective July 1, 1991, every employer shall establish, implement and maintain an effective Injury and Illness Prevention Program (Program). The Program shall be in writing and, shall, at a minimum:
> […]
> (2) Include a system for ensuring that employees comply with safe and healthy work practices. Substantial compliance with this provision includes recognition of employees who follow safe and healthful work practices, training and retraining programs, disciplinary actions, or any other such means that ensures employee compliance with safe and healthful work practices.
> […]
> (4) Include procedures for identifying and evaluating work place hazards including scheduled periodic inspections to identify unsafe conditions and work practices. Inspections shall be made to identify and evaluate hazards:

[3] Sullivan notably indicated that he had marked this citation as corrected in error. (TR [5.17.23], p. 124.)

(A) When the Program is first established;
[…]
(B) Whenever new substances, processes, procedures, or equipment are introduced to the workplace that represent a new occupational safety and health hazard; and
(C) Whenever the employer is made aware of a new or previously unrecognized hazard.
[…]
(6) Include methods and/or procedures for correcting unsafe or unhealthy conditions, work practices and work procedures in a timely manner based on the severity of the hazard:
(A) When observed or discovered; and,
(B) When an imminent hazard exists which cannot be immediately abated without endangering employee(s) and/or property, remove all exposed personnel from the area except those necessary to correct the existing condition. Employees necessary to correct the hazardous condition shall be provided the necessary safeguards.
[…]

The AVD includes four instances, and states:

> Prior to and during the course of the Division's investigation, including but not limited to June 3, 2020, the employer failed to establish and implement an effective Injury and Illness Prevention Program, in that:
> Instance 1— The employer failed to implement an effective system for ensuring that employees comply with safe and healthy work practices. An employee was operating an overhead gantry crane, in an improper manner, without utilizing protective equipment that was designated by the employer. T8CCR section 3203 (a)(2).
> Instance 2— The employer failed to include procedures for identifying and evaluating workplace hazards to identify unsafe conditions and work practices within their written program. T8CCR Section (a)(4).
> Instance 3— The employer failed to implement effective procedures for identifying and evaluating work place hazards to identify unsafe conditions and work practices, such as an employee operating an overhead gantry crane, in an improper manner, without utilizing appropriate protective equipment. T8CCR Section 3203(a)(4).
> Instance 4— The employer failed to include methods and/or procedures for correcting unsafe or unhealthy conditions, work practices and work procedures in a timely manner within their written program. T8CCR Section 3203(a)(6),

Employer first claims that Citation 1, Item 2, did not provide fair notice of the alleged violation as required by Labor Code section 6317. (Petition, pp. 15-16.) Labor Code section 6317 requires, in relevant part, that "[e]ach citation shall be in writing and shall describe with

particularity the nature of the violation, including a reference to the provision of the code, standard, rule, regulation, or order alleged to have been violated." Employer states, "[a]lthough Citation 1, Item 2 quoted multiple regulatory requirements, the citation failed to allege Appellant did, or did not, do anything required by any such safety regulation such that Appellant could have been reasonably capable of anticipating the alleged violation and/or prepare its defenses." (Petition, pp. 15-16.)

After a careful review of the citation, we conclude that Employer's fair notice arguments lack merit and that the citation satisfies the notice requirement under Labor Code section 6317. Although the Division's AVD is not replete with detail, we conclude that the citation provides adequate notice of the charges. The Appeals Board has noted,

> It is well settled that administrative proceedings are not bound by strict rules of pleading. As long as an employer is informed of the substance of the violation and the citation is sufficiently clear to give fair notice and to enable it to prepare a defense, the employer cannot complain of technical flaws. [Citations.]

(*Barrett Business Services, Inc.*, Cal/OSHA App. 315526582, Decision After Reconsideration (Dec. 14, 2016).) A careful reading of the AVD demonstrates that each instance is sufficiently clear to provide fair notice to Employer to enable it to prepare a defense. The AVD appears sufficiently particular, and does not merely mimic the safety order. Each instance alleged in the citation includes a summary of the circumstances constituting the alleged violations.

Further, even assuming the citations were deficient, an employer must show prejudice in order to sustain an allegation that the description in the citation was not sufficiently particular. (*DSS Engineering Contractors, Inc.*, Cal/OSHA App. 99-1023, Decision After Reconsideration (June 3, 2002), *citing Adia Personnel Services*, Cal/OSHA App. 90-1015, Decision After Reconsideration (March 12, 1992).) No such prejudice has been demonstrated.

3) Did Employer fail to establish, implement and maintain an IIPP that included procedures for complying with safe practices, identifying and evaluating hazards, and correcting hazards?

Turning to the merits of Citation 1, Item 2, the Division's citation alleges four separate instances where it asserts that Employer's IIPP was deficiently written or deficiently implemented. The Division has the burden of proof to establish each element of the alleged violation by a preponderance of the evidence. (*National Distribution Center, LP, Tri State Staffing*, Cal/OSHA App. 12-0391, Decision After Reconsideration (Oct. 5, 2015) (*National Distribution*).) The Division must also prove employee exposure to the violative condition. (*Ibid*.) Where multiple instances are alleged, the Division need only demonstrate that one of the instances charged by the citation violates the safety order. (*Ibid*.) The ALJ's Decision affirmed Instance 1, but did not reach the other instances. (Decision, pp. 6-9.) We address each instance *seriatim*.

Instance 1:

Instance 1 alleges Employer failed to implement an effective system for ensuring employees comply with safe and healthy work practices, as required by section 3203, subdivision (a)(2). This instance does not specifically concern the written contents of the IIPP, but rather its implementation. An Employer's IIPP may be satisfactory as written, but still result in a violation if it is not implemented. (*National Distribution*, *supra*, Cal/OSHA App. 12-0391, citing *Contra Costa Electric*, *Inc*., Cal/OSHA App. 09-3721, Decision After Reconsideration (May 13, 2014).) "Proof of implementation requires evidence of actual responses to known or reported hazards." (*Ibid*., *citing Bay Area Rapid Transit District*, Cal/OSHA App. 09-1218, Decision After Reconsideration (Sep. 6, 2012).)

The AVD for Instance 1 asserts, "An employee was operating an overhead gantry crane, in an improper manner, without utilizing protective equipment that was designated by the employer. T8CCR section 3203 (a)(2)." Sullivan issued this citation because he concluded that Employer had failed to implement an effective system for ensuring employees comply with safe and healthful work practices because Bravo was operating the crane without head protection and his foreman did not correct the hazard. (TR [5.17.23], pp. 24-26.) Sullivan said one of the glaring things shown in the video is that Bravo was operating the crane without using head protection and his foreman, who was working nearby, did not correct the hazard. (TR [5.17.23], pp. 23-26.) The Decision agreed and found a violation. (Decision, pp. 6-9.)

Employer's Petition argues that the ALJ erred in affirming Instance 1. (Petition, pp. 14-15.) Employer argues that section 3203, subdivision (a)(2), "deals with methods of ensuring compliance, not hazard identification and correction as Mr. Sullivan's testimony and the Decision apparently focused on." (*Ibid*.) Employer states that section 3203, subdivision (a)(2), only requires a system for ensuring employees comply with safe and healthful work practices, and "sets forth four methods an employer may utilize to establish it was in substantial compliance[.]" (*Ibid*.) Employer claims the evidence demonstrates that it did comply with one, or more, of the four listed options (*Ibid*.) The record supports Employer's argument.

In order to prove a violation of section 3203, subdivision (a)(2), the Division has the burden to show that Employer did not have, and/or did not implement, an effective "system for ensuring that employees comply with safe and healthy work practices." (§ 3203, subd. (a)(2).) However, the Division has a difficult task. The Board has noted that "it should not be difficult for an employer to demonstrate compliance" with this subsection. (*ABM Facility Services*, *Inc*. *dba ABM Building Value*, Cal/OSHA App. 12-3496, Decision After Reconsideration (Dec. 24, 2015).) The employer has multiple options to comply with this subdivision. "'Substantial compliance' with this provision is specifically provided via the following methods: 'recognition of employees who follow safe and healthful work practices, training and retraining programs, disciplinary actions, or any other such means that ensures employee compliance with safe and healthful work practices.'" (*Marine Terminals Corp. dba Evergreen Terminals*, Cal/OSHA App. 08-1920, Decision After Reconsideration (Mar. 5, 2013) (*Marine Terminals*), quoting § 3203, subd. (a)(2).) "The listed methods are written with the disjunctive 'or,' and the final method allows for, 'any other such means that ensures compliance,' indicating that any one (or more) of the previous three methods

are sufficient to ensure compliance." (*Marine Terminals*, *supra*, Cal/OSHA App. 08-1920.) "Therefore, the Division must show that Employer did not comply with any of the four listed options under section 3203(a)(2)." (*Ibid*.)

The record demonstrates that Employer had a system for disciplining employees. The IIPP demonstrates that Employer has a policy of progressive discipline for those employees that violate safety rules, which included verbal counseling, written warnings, suspension, and termination. (Exhibit 7B.) Further, there is also evidence that demonstrates that Employer implemented that policy. During the course of Sullivan's investigation, he issued a document request, which sought numerous categories of information. (TR [3.10.23], pp. 87-89 [Exhibit 6]; TR [5.17.23], pp. 25-40.) In response, Sullivan received a document demonstrating that Bravo had been previously disciplined for failing to wear his hardhat. (TR [5.17.23], pp. 27-38, 269-272 [Exhibit H1]; TR [5.17.23], pp. 5-6.) Sullivan also testified that Bravo had actually been written-up on three occasions for not wearing a head protection (TR [5.17.23], pp. 221-222.) Additionally, during his initial inspection of the worksite, Sullivan interviewed a single employee, an office worker, who informed Sullivan that Employer both recognizes when employees perform work safely, and disciplines employees for safety violations.[4] (TR [3.10.23], pp. 202-211 [Exhibit 5].) Sullivan's notes state that the worker informed him that she had seen verbal warnings, write-ups, and employees sent home. (Exhibit 5.) Sullivan did not interview any other employees other than Bravo and this office worker. (TR [3.10.23], pp. 217-218.) Therefore, the evidence—including the very limited number of interviews conducted by the Division—preponderates to a finding that Employer maintained and implemented a system for disciplining workers.

The Division contends that even if Employer had a system for ensuring employee compliance, those systems were not effective, as required by the safety order, because Quintero did not correct Bravo's failure to wear a hardhat at the time of the accident, despite being in a position to observe Bravo. However, the Division appears to have lost sight of the subdivision it cited. The Division did not cite Employer for a violation of section 3203, subdivision (a)(6), which requires implementation of corrective measures when unsafe conditions are observed. Rather, the Division cited Employer under section 3203, subdivision (a)(2), which requires "a system for ensuring that employees comply with safe and healthy work practices." A violation of a safety rule on one specific occasion does not necessarily mean that Employer did not have such a system. (*Marine Terminals*, *supra*, Cal/OSHA App. 08-1920.) Consequently, no violation is found for this Instance.

Next, the ALJ's Decision appears to have affirmed this Instance based on Quintero's failure to correct Bravo's failure to use head protection at the time of the accident, and based on Bravo's testimony that none of his co-workers wore head protection, indicating that Employer's implementation efforts were ineffective. (Decision, p. 8 ["Bravo testified that since none of his co-workers wore their helmets, neither did he. One warning is not sufficient"].) However, there are three problems with the ALJ's decision. First, the ALJ did not carefully analyze whether Employer complied with any of the four listed disjunctive methods in section 3203, subdivision (a)(2). "The decision does not analyze the above options – any one of which, if established – would satisfy the

[4]Although some of the evidence mentioned in this paragraph may be hearsay, it may be considered when it supplements or explains other evidence, as is the case here. (See § 376.2)

requirement for ensuring compliance." (*Marine Terminals*, *supra*, Cal/OSHA App. 08-1920.) Second, as already mentioned, Quintero's failure to address the hardhat deficiency at the time of the accident is better addressed under section 3203, subdivision (a)(6), not subdivision (a)(2). Third, Bravo's testimony regarding head protection was questionable. Although Bravo did indeed state that the majority of his co-workers did not use head protection (TR [3.9.23], pp. 74-75, 120, 133, 170-172), his testimony regarding head protection was not entirely consistent. For example, Bravo said he did not know if Employer had a policy requiring the use of hardhats and could not remember if he had been warned about hardhat deficiencies. (TR [3.9.23], pp. 80-81.) However, Bravo later admitted he had been issued a hardhat and generally understood he was supposed to wear it. (TR [3.9.23], pp. 170-172, 178-179.) Bravo also admitted that he understood the right thing to do was wear his hardhat inside the metal shop. (*Ibid*.) Further, the Division's own witness, Sullivan, testified that Employer had provided Bravo three written warnings for failing to wear his hardhat, one of which was introduced into the record. (TR [5.17.23], pp. 221-222 [Exhibit H-1].) Further, when the record is viewed in its entirety, there is evidence that other co-workers, such as Quintero, wore head protection. (TR [3.9.23], p. 75.) Bravo stated that he saw that his foreman wore a hardhat. (TR [3.9.23], p. 172; see also [Exhibit J-1].) Further, during his investigation, Sullivan also noted that there was good use of personal protective equipment at Employer's worksite. (TR [3.10.23], p. 198; TR [5.17.23], pp. 23-24.) Therefore, because we find some of Bravo's testimony to be questionable as to the use of head protection and to lack credibility on that particular point, we cannot conclude that Employer failed to implement an effective system for ensuring that employees comply with safe and healthy work practices based on that testimony.[5] Because the Division has the burden of proof on all elements of an alleged violation, when the evidence is unclear, or leads to two possible inferences, the Board's practice has been to resolve such conflicts in Employer's favor. (See *Morrow Meadows Corporation*, Cal/OSHA App. 12-0717, Decision After Reconsideration (October 5, 2016).) The Board follows that practice here.

The Division has not shown that Employer failed to comply with any of the methods described in section 3203 subdivision (a)(2). Instance 1 of Citation 1, Item 2, is therefore vacated.

Instances 2 and 4:

Within Instances 2 and 4, the Division alleges that Employer's written IIPP did not contain all of the elements required by section 3203, subdivision (a). Sullivan said he issued Instance 2 because Employer's IIPP did not have written procedures, as required by section 3203, subdivision (a)(4), for identifying and evaluating workplace hazards to identify unsafe conditions and work practices. (TR [5.17.23], pp. 217-219.) Instance 4 alleges that Employer's IIPP did not have written procedures, as required by section 3203, subdivision (a)(6), to address hazard correction. (TR [5.17.23], p. 233-234.) The evidence demonstrates a violation as to both Instances.

"In order to have an effective written IIPP, an employer must, at a minimum, provide an IIPP which contains the [eight] elements enumerated in section 3203(a)." (*Mountain Cascade*,

[5] To the extent that the ALJ's decision may be construed as finding that Bravo testified credibly regarding head protection, we decline to give that determination great weight. We follow the guidance set forth in the Administrative Procedure Act pertaining to judicial review of credibility determinations, and conclude that a credibility determination will only be given great weight if it identifies specific evidence of observed demeanor, manner, or attitude of the witness. (See Gov. Code § 11425.50.) We disapprove of any decisions that hold to the contrary.

Inc., Cal/OSHA App. 01-3561, Decision After Reconsideration (Oct. 17, 2003) (*Mountain Cascade*).) Employer's IIPP did not have all required written procedures required by section 3203, subdivisions (a)(4) and (6). Specifically, Employer's IIPP does not contain the required written procedures for identifying and evaluating hazards or for correcting unsafe or unhealthy working conditions. (TR [5.17.23], pp. 217-219, 233-234 [Exhibits 7A, B, and C].) Therefore, Employer's IIPP is deficient.

The Division must also demonstrate employee exposure to the hazard the safety regulation attempts to correct by showing "actual exposure" to the zone of danger, or by demonstrating exposure under the reasonably predictable access standard. (*Benicia Foundry & Iron Works, Inc.*, Cal/OSHA App. 00-2976, Decision After Reconsideration (Apr. 24, 2003); *Dynamic Construction Services, Inc.*, Cal/OSHA App. 14-1471, Decision After Reconsideration (Dec. 01, 2016).) Employer has other employees at this worksite. Further, given the tasks conducted by these employees, including the tasks performed by Bravo at the time of the accident, we conclude that employees were exposed to hazards as a result of the written IIPP deficiencies under either exposure standard. When an employer allows employees to engage in tasks such as moving metal frames with a crane, where the frame may weigh upwards of two tons, it is essential to mitigate employee danger by having effective procedures in place to both identify and evaluate hazards and to correct them. When Employees engage in such tasks where no effective written procedures exist to protect them, they are exposed to the workplace hazards that an IIPP is required to address.

Accordingly, Instances 2 and 4 of Citation 1, Item 2, are both established and a violation is found.

Instance 3:

Instance 3 asserts that Employer failed to implement effective procedures for conducting inspections and identifying and evaluating workplace hazards as required by section 3203, subdivision (a)(4). To prove a violation of section 3203, subdivision (a)(4), based upon a failure of implementation, the Division must establish two basic elements: a triggering event occurred requiring an inspection to identify and evaluate hazards, and Employer failed to effectively implement its duty to inspect, identify and evaluate the hazard. (*OC Communications*, *Inc*., Cal/OSHA App. 14-0120, Decision After Reconsideration (Mar. 28, 2016); *Hansford Industries*, *dba Viking Steel*, Cal/OSHA App. 1133550, Decision After Reconsideration (Aug. 13, 2021).)

As to the first element, section 3203, subdivision (a)(4), requires that an employer perform an inspection under at least three sets of circumstances. An employer's duty to inspect, identify, and evaluate is triggered: (1) when the program is first established, (2) when new substances, processes, procedures, or equipment are introduced, or (3) whenever the employer is made aware of a new or previously unrecognized hazard. (§ 3203, subd. (a)(4)(A)-(C); *Hansford Industries*, *dba Viking Steel*, *supra*, Cal/OSHA App. 1133550.)

For this Instance, Sullivan identifies two hazards that Employer purportedly failed to identify and evaluate. Sullivan asserts that Bravo was not wearing his hardhat while operating the gantry crane and management failed to identify and evaluate that hazard. (TR [5.17.23], p. 222-226.) Next, Sullivan states Bravo was operating the crane in an unsafe manner because he rigged

the chains so that the center of gravity was above the anchor or attachment points. (*Ibid*.) When analyzing the first element, before determining whether Employer failed to identify and evaluate a hazard, the Board must first ask: (1) is the program newly established; (2) did the hazards identified by Sullivan constitute new substances, processes, procedures, or equipment that had been introduced to the workplace that represent a new hazard; or (3) do these hazards represent a new or previously unrecognized hazard? (§ 3203, subd. (a)(4)(A)-(C); *OC Communications*, *Inc*., *supra*, Cal/OSHA App. 14-0120.) Here, there is no allegation that Employer's program is newly established. Therefore, the preliminary questions are whether the identified hazards concern new substances, processes, procedures, or equipment, or a new or previously unrecognized hazard.

As to the first identified hazard (the absence of a head protection), the Board cannot conclude that Bravo's failure to wear a hardhat or head protection constituted a new or previously unrecognized hazard, or a new substance, process, or procedure. The record demonstrates that Employer had already identified and evaluated this particular hazard. Employer's Code of Safe Practice requires the use of a hardhat at all times at its worksite. (Exhibit 7A.) Further, the record indicates that Bravo had been previously disciplined for the failure to wear a hardhat. (Exhibit H-1.) The hardhat issue does not appear to be a new or unrecognized hazard, or a new process or procedure, triggering a new duty to identify and evaluate. To the contrary, it is an issue Employer had already identified and evaluated, and had concluded that head protection is required.

However, as to the second identified hazard (the improper lifting of the frame), the Board concludes that the lifting of this frame with the gantry crane, and the methods used to rig it, constituted a new process or procedure, and/or a new and previously unrecognized hazard. When determining whether a new hazard exists, a relevant consideration is whether that hazard is new to the particular employee. (*OC Communications, Inc*., *supra*, Cal/OSHA App. 14-0120.) Bravo testified that this particular frame had never been moved by the crane before. (TR [3.9.23], pp. 56-57.) He also said he had never moved anything that large before. (TR [3.9.23], p. 130, 152-153.) Bravo's lack of experience rigging something that large, his lack of experience generally (having been employed for only several months), and the obvious problems Bravo had while attempting to balance the load, all favor the conclusion that lifting the frame with the gantry crane was a new process or procedure, and/or a new and previously unrecognized hazard, at least as to Bravo.

Turning to the second element, Employer did not identify the hazard as it applied to Bravo, who was relatively inexperienced, and as it applied to the physics of this particular lift. Bravo had not previously moved that frame, or anything else that large, and the evidence establishes that the foreman failed to effectively identify and evaluate the safety issues that Bravo faced with this lift.

Finally, the record demonstrates exposure to a hazard. Bravo was operating the gantry crane to lift the frame, and suffered injury when the frame rotated due to improper rigging, demonstrating Bravo's exposure. (*Dynamic Construction Services, Inc.*, *supra*, Cal/OSHA App. 1005890.) Bravo was actually exposed to the hazard and was injured as a result of Employer's failure to effectively identify and evaluate this hazard.

Instance 3 of Citation 1, Item 2, is therefore affirmed.

4) Did Employer fail to ensure an employee wore head protection where there was a risk of receiving head injuries from flying or falling objects and/or electric shock and burns?

Citation 1, Item 3, asserts a General violation of section 3381, subdivision (a). That section states,

> (a) Employees working in locations where there is a risk of receiving head injuries from flying or falling objects and/or electric shock and burns shall wear approved head protection in accordance with this section.

The alleged violation description states:

> Prior to and during the course of the Division's investigation, including but not limited to June 3, 2020, the employer failed to ensure that an employee working their overhead gantry crane while exposed to the risk of head injury from falling objects, was wearing approved head protection in accordance with this section.

In order to prove a violation of section 3381, subdivision (a), the Division must establish two basic elements: (1) that an employee works in locations where there is a risk of receiving head injuries from flying or falling objects and/or electric shock and burns; and (2) the employee did not wear approved head protection.

Here, there is no genuine dispute as to the second element; it is undisputable that Bravo failed to wear head protection at the time of the accident. Rather, the dispute turns on the first element. Employer's Petition argues there is no evidence that any employee was exposed to flying or falling objections, and/or electric shocks and burns. (Petition, p. 17.) In opposition, the Division contends, "[t]he facts establish potential head injuries via flying or falling objects in the work area of the overhead gantry crane. Such objects include parts of the overhead gantry crane, including the cable and hook, the metal frame being lifted, other metal pieces or pieces akin to the metal frame at issue, and any load the crane lifts." (Answer, pp. 11-12.) The record supports the Division's argument.

Bravo used a gantry crane to move the frame. Sullivan testified there was a risk of falling objects and head injuries when working with a gantry crane; he said the load being lifted could present a hazard, as could parts of the crane itself. (TR [3.10.23], p. 116-118, 128-129.)[6] Sullivan said a hardhat would have offered some protection from a glancing head blow should the frame fall. (TR [3.10.23], p. 115.) Sullivan's testimony is credible, particularly since it is corroborated by Employer's own documents. Employer's job hazard analysis and safety instructions were introduced into evidence with no objection. (Exhibits 10 and 11.) Those documents indicated that one of the identified hazards of crane operation was "[m]aterials falling" and "material load slips," demonstrating that even Employer recognized a hazard of falling objects during operation of the

[6] Bravo also said he had lifted this piece of metal above his head at an earlier time, although he could not remember if he was standing directly underneath it. (TR [3.9.23], pp. 76-77.)

crane. (Exhibits 10 and 11.) Therefore, a risk of receiving head injuries from flying or falling objects and/or electric shock exposure has been demonstrated.

Further, we observe that the legs or uprights on the frame were higher than Bravo's head. Had Bravo been only slightly closer to the frame, the frame could have struck Bravo in the head, rather than on his shoulder when the legs rotated and fell toward the ground.

The record also demonstrates exposure to the hazard under either of the exposure standards. (*Dynamic Construction Services, Inc.*, supra, Cal/OSHA App. 1005890.) Both Bravo's use of the crane, and the facts surrounding the accident itself, demonstrate actual exposure to head injury from falling objects, as well as exposure under the reasonably predictable access standard.

Citation 1, Item 3, is affirmed.

5) Did Employer fail to ensure that a load was well secured and properly balanced in the sling or lifting device before it was lifted more than a few inches?

Citation 2, Item 1, asserts a Serious, Accident-Related violation of section 4999, subdivision (d)(2). That section states,

> (d) Moving the Load. The individual directing the lift shall see that:
> […]
> (2) The load is well secured and properly balanced in the sling or lifting device before it is lifted more than a few inches;

The alleged violation description states:

> Prior to and during the course of the Division's investigation, the employer failed to ensure that a load was well secured and properly balanced in a sling or lifting device before it was lifted more than a few inches. As a result, on or about June 3, 2020, an employee sustained a serious injury while repositioning a steel frame.

In order to establish a violation of section 4999, subdivision (d)(2), and pursuant to the plain language of the regulation, the Division must show at least three elements: (1) that a load was in a sling or lifting device, (2) that the load was not well secured or not properly balanced, or both, (3) and the load was lifted more than a few inches.

The video at Exhibit J-1 provides conclusive evidence demonstrating the first two elements were established. The load was obviously in a lifting device. Bravo used two chains to rig the load to the gantry crane. It is also evident that the load was not well-secured or properly balanced. The frame would not have rotated and struck Bravo had it been well secured and properly balanced. Sullivan also testified that, based on his investigation and view of the video, the frame was not balanced when the accident occurred. (TR [3.10.23], pp. 129-130.)

Effectively conceding the first two elements, Employer's Petition argues that, at the time of the accident, the frame was never lifted more than a few inches. (Petition, pp. 3-7.) Employer "maintains that the load (metal frame) was resting on the sawhorses when it rotated towards the injured worker." (Petition, p. 6.)

Employer may arguably be correct to the extent that it contends that no liability attaches if the load was not lifted more than a few inches. Although there are no Board decisions interpreting the "more than a few inches" requirement of section 4999, subdivision (d)(2), there are decisions by the federal Occupational Safety and Health Review Commission (OSHRC) interpreting a corresponding federal standard (29 C.F.R. §1910.170, subd. (n)(3)(1)). Those decisions indicate the standard only applies to loads lifted more than a few inches, and conclude that the standard countenances the lifting of a load a few inches for test purposes. (*Lukens Steel Company*, 1981 OSAHRC LEXIS 345, *18 (O.S.H.R.C.A.L.J. April 6, 1981); *Sun Shipbuilding & Drydock Co*., 4 OSAHRC 1020 (O.S.H.R.C. October 3, 1973).)[7]

However, we are still left with the question of what measurement constitutes "more than a few inches." Therefore, we turn to the rules of construction to determine the meaning of the phrase.

The Board first looks to plain language of the regulations, which is generally the most reliable indicator of intent. (*Department of Industrial Relations v. Occupational Safety & Health Appeals Bd*. (2018) 26 Cal.App.5th 93, 101; *Katz v. Los Gatos-Saratoga Joint Union High School Dist.* (2004) 117 Cal.App.4th 47, 54-55.) The words should be given their ordinary and usual meaning and should be construed in context. (*Borikas v. Alameda Unified School Dist.* (2013) 214 Cal.App.4th 135, 146; *Heritage Residential Care, Inc. v. Division of Labor Standards Enforcement* (2011) 192 Cal.App.4th 75, 81-83.) To obtain the ordinary meaning of a word the Board may appropriately refer to its dictionary definition. (*Heritage Residential Care Inc., supra*, 192 Cal.App.4th at 83.) Dictionaries define the word "few," in the use relevant here, to mean "consisting of or amounting to only a small number," "at least some but indeterminately small in number," and "a small number of units or individuals."[8] It is also defined to mean "Amounting to or consisting of a small number," "Being more than one but indefinitely small in number," and "An indefinitely small number of persons or things."[9] In sum, based on the dictionary definitions, the term "few" is an elastic term, which means an indefinite, small number. With those definitions in mind, the term "more than a few inches" means anything more than a small number of inches. There is no fixed criteria for what constitutes a small number. It could certainly encompass anything more than three inches. Indeed, it could perhaps encompass anything more than two inches depending on the definition utilized, as one dictionary defined the word as "Being more than one but indefinitely small in number."[10]

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[7] The Board has acknowledged the similarity between its role and the OSHRC, and in decisions after reconsideration occasionally turns to Federal Commission decisions for guidance, even if it is not required to do so. (*L&S Construction*, *Inc*., Cal/OSHA App. 10-1821, Decision After Reconsideration (Oct. 7, 2016).)

[8] Merriam-Webster Dictionary (Online) <https://www.merriam-webster.com/dictionary/few> [accessed on February 28, 2024].

[9] American Heritage Dictionary (Online) <https://www.ahdictionary.com/word/search.html?q=few> [accessed on February 28, 2024].

[10] American Heritage Dictionary (Online) <https://www.ahdictionary.com/word/search.html?q=few> [accessed on February 28, 2024].

After a careful review of all evidence and testimony in the record, including testimony regarding the video, we conclude that the Division established by a preponderance of the evidence that the frame, or at least one end of it, was lifted more than a few inches (i.e., > 3"). We reach this conclusion for several reasons, each of which is sufficient to establish this element of the violation. First, Sullivan testified in regard to the video of the accident (Exhibit J-1) and said the far side of the frame was lifted more than a few inches, which caused or allowed the frame to rotate and fall toward Bravo. (TR [3.10.23], pp. 134-138, 184-189; TR [5.17.23], pp. 104-112, 115-117, 167-168, 170-171.) Sullivan stated that the far side of the frame had been lifted several inches, which was enough for the center of gravity to change. (*Ibid*.) Notably, Sullivan, a trained Associate Safety Engineer, based his testimony on several observations, including his observation of the apex of the rigging. (*Ibid*.) Sullivan's testimony, which was not rebutted by any Employer witness, is credited to establish the frame was lifted more than a few inches. Further, Bravo also confirmed that the frame was not always touching the sawhorse during the accident; he noted it was lifted and it fell. (TR [3.9.23], p. 91-92.) Next, we infer that the accident itself would not have occurred unless portions of the frame were necessarily lifted more than a few inches. The accident itself demonstrated that the load was lifted sufficiently high to cause the load to become unstable, tilt, and fall. Finally, we also observe that the load had been lifted more than a few inches in the moments prior to the accident when Bravo was adjusting the load, and that it was not well-secured or properly balanced in those earlier instances. Indeed, at one point prior to the accident, the load swung toward Bravo.

Employer contends that portions of the frame were resting on both sawhorses at the time of the accident. (Petition, pp. 5-6.) Employer argues that the frame leaned or tilted over but never lost contact with the sawhorses. (Petition, pp. 5-6.) Employer maintains that the bottom edge of the frame remained in contact with the sawhorses while it rotated or tilted. (Petition, pp. 5-6.) However, even assuming, *arguendo*, that the Employer is correct, there was still a violation of the safety order. The lift caused the frame to tilt, causing an edge of the frame to necessarily lift off the sawhorse by more than a few inches. Here, it is beyond dispute that some portions of the load were lifted more than a few inches. We conclude that if any part of the load is lifted by more than a few inches, such that it causes the load to become unstable and fall, the requirements of the safety order have been implicated, notwithstanding that some other portions of the load remain in contact with the sawhorse. Employer's narrow construction of the safety order – i.e., that a load is not "lifted" if any portion of the load remains grounded – would be inconsistent with the Board's mandate to construe safety orders liberally to promote workplace safety. (*Carmona v. Division of Industrial Safety* (1975) 13 Cal. 3d 303.)[11]

Finally, the record demonstrates exposure to the hazard. Bravo was actually injured as the result of the failure to ensure that the load was properly secured and balanced in the sling or lifting device before it was lifted more than a few inches. (*Dynamic Construction Services, Inc.*, *supra*, Cal/OSHA App. 1005890.)

[11] We further note that the base of the frame (that is, the rectangular section upon which it was resting just before the last lift and to which the legs were attached) rotated 90 degrees during the attempted lift. As a result, the left side or edge of the rectangle raised along the entire length of the long dimension of the base, from resting on the sawhorses horizontally to vertical. The width of the base, while not specified in the record, is plainly visible to be more than a few inches, and one side of it was raised during the lift to a height sufficient that the base shifted a full 90 degrees.

Based on the evidence presented, the Division has met its burden by showing that Employer failed to ensure that the load was well secured and properly balanced before it was lifted more than a few inches. For these reasons, Citation 2 is affirmed.

6) Was Citation 2 properly classified as Serious?

a) Did the Division establish a rebuttable presumption that the citation was properly classified as Serious?

Employer's petition challenges the Serious classification for the citation. (Petition, pp. 8-9.) When determining whether a citation is properly classified as Serious, the relevant statute requires application of a burden shifting analysis.

The Division holds the initial burden to demonstrate "a realistic possibility that death or serious physical harm could result from the actual hazard created by the violation." (Lab. Code, § 6432, subd. (a).) The "actual hazard" may consist of "[t]he existence in the place of employment of one or more unsafe or unhealthful practices, means, methods, operations, or processes that have been adopted or are in use." (Lab. Code, § 6432, subd. (a)(2).) The term "realistic possibility" means that the Division's demonstration must be within the bounds of reason, and not purely speculative. (*Langer Farms, LLC*, Cal/OSHA App. 13-0231, Decision After Reconsideration (Apr. 24, 2015).)

The Division established a realistic possibility of serious physical harm. First, the injuries suffered by Bravo demonstrated a realistic possibility of serious physical harm from the actual hazard created by the violation. It is undisputed that Bravo suffered serious physical harm. (TR [3.10.23], p. 8 [stipulation].) Serious physical harm "means any injury or illness, specific or cumulative, occurring in the place of employment or in connection with any employment, that results in" "[i]npatient hospitalization for purposes other than medical observation." (Lab. Code, § 6432, subd. (e)(1).) Bravo was admitted to the hospital on June 3, 2020, underwent surgery for his broken forearm, and was released on June 6, 2020. (TR [3.9.23], pp. 39-40, 104-105.)

Sullivan also testified to a realistic possibility of serious physical harm from the actual hazard created by the violation. Sullivan testified that he is current on all Division mandated training. (TR [3.10.23], p. 26.) Because his training is up to date, he is deemed competent by operation of law to offer testimony to establish each element of a Serious violation. (Lab. Code, § 6432, subd. (g).) He testified that the hazards associated with lifting an unbalanced load include, among other things, that the load can topple, which is what occurred here. (TR [3.10.23], pp. 138-140.) When asked what kind of injuries can result from the hazard addressed by Citation 2, i.e., lifting an unbalanced load, Sullivan stated it can range from bruising, lacerations, fractures, all the way up to death, depending on how and where a person is struck, and the weight of the object. (TR [3.10.23], pp. 139-143, 145, 154, 164-166.) Sullivan testified that lacerations, fractures, and a whole series of other injuries, including death, are all realistic possible consequences of this hazard. (*Ibid*.) Sullivan noted that if this load would have struck Bravo in the head the blow would have been fatal. (TR [3.10.23], p. 143.)

The Board concludes the Division demonstrated a realistic possibility of serious physical harm from the actual hazard created by the violation.

b) Did Employer rebut the presumption?

Labor Code section 6432, subdivision (c), provides a mechanism for Employer to rebut the presumption of a Serious violation. It states:

> (c) If the division establishes a presumption pursuant to subdivision (a) that a violation is serious, the employer may rebut the presumption and establish that a violation is not serious by demonstrating that the employer did not know and could not, with the exercise of reasonable diligence, have known of the presence of the violation. The employer may accomplish this by demonstrating both of the following:
> (1) The employer took all the steps a reasonable and responsible employer in like circumstances should be expected to take, before the violation occurred, to anticipate and prevent the violation, taking into consideration the severity of the harm that could be expected to occur and the likelihood of that harm occurring in connection with the work activity during which the violation occurred. Factors relevant to this determination include, but are not limited to, those listed in subdivision (b).
> (2) The employer took effective action to eliminate employee exposure to the hazard created by the violation as soon as the violation was discovered.

Employer argues that it took all the steps a reasonable and responsible employer should take to anticipate and prevent the violation before the violation occurred, and that it took effective action to eliminate the hazard. (Petition, pp. 8-9.) However, although Employer does have some aspects of a well-devised safety plan, the burden is on Employer to rebut the presumption of a Serious violation. Employer did not offer any witnesses in its own defense. Most importantly, it did not demonstrate that it had effectively trained Bravo on the requirement to ensure that the load was well secured and properly balanced in the sling or lifting device before it is lifted more than a few inches. It is clear that Bravo did not know how to properly balance or secure this particular load. Further, there is no evidence that Employer had properly trained him how to do such a task. Despite having the burden of proof, Employer chose not to offer any witnesses or other evidence to support this defense. In the absence of such evidence Employer did not demonstrate that it took all the steps a reasonable and responsible employer in like circumstances would be expected to take to anticipate and prevent this particular violation. Therefore, the Serious classification is affirmed.

c) Was Citation 2 properly characterized as Accident-Related?

In order to sustain an Accident-Related characterization, the Division must demonstrate a "causal nexus between the violation and the serious injury." (*Sherwood Mechanical, Inc.,* Cal/OSHA App. 08-4692, Decision After Reconsideration (June 28, 2012) [other citations

omitted]).) In other words, where the evidence indicates that a serious violation caused a serious injury the violation is properly characterized as Accident-Related. (*HHS Construction*, Cal/OSHA App. 12-0492, Decision After Reconsideration (Feb 26, 2015); *MCM Construction,* Cal/OSHA App. 13-3851, Decision After Reconsideration (Feb 22, 2016).) The Division must show the violation "more likely than not was *a* cause of the injury," but need not establish the violation as the *sole* cause of the injury. (*Ibid.* [emphasis added].)

Here, the Board affirms the Accident-Related characterization. At the time of the accident, the load was neither well-secured nor properly balanced before it was lifted more than a few inches, shifted, and struck Bravo. A causal nexus exists between the violation and Bravo's serious injury.

d) Was the penalty properly calculated for Citation 2?

Employer contends that the Division failed to properly calculate the penalty for Citation 2. (Petition, pp. 10-11.) Employer contends that Sullivan's testimony demonstrated he incorrectly calculated the penalty adjustments for extent, likelihood, size, and good faith. (*Ibid*.) However, because the Board has affirmed the Serious, Accident-Related classification, most of these arguments have no merit or are irrelevant. The initial base penalty for a Serious citation is assessed at $18,000. (§ 336, subd. (c)(1).) When a citation is characterized as Serious, the only permissible adjustment is for size. (§ 336, subd. (c)(2) , (d)(7), (e)(3)(D).)

Sullivan offered a 30 percent reduction based on size. A 30 percent reduction is permissible if Employer has between 11 and 25 employees. (§ 336, subd. (d)(1).) Sullivan testified that during the opening conference Nam indicated Employer had 15 employees on average. (TR [5.17.23], p. 148-155, 203-204 [Exhibits 19-20].) Her statement was corroborated by a Form 300A from a prior year, which stated Employer had 17 employees. Sullivan concluded that Employer fell within the range of having 11 to 25 employees. This resulted in a reduction of $5,400 from the penalty for Citation 2, for a total penalty of $12,600. (TR [5.17.23], pp. 203-204.)

We conclude the penalty was correctly calculated and affirm the decision's holding that the penalties were reasonable.

7) Was the Governor's Executive Order extending the statute of limitations permissible?

Labor Code section 6317 states, "A citation or notice shall not be issued by the Division more than six months after the occurrence of the violation." It is undisputed that the Division failed to issue the citations within six months. Bravo's accident occurred on June 3, 2020, but the Division did not issue any citations until June 10, 2021, over a year later.

However, the Division's statutory deadline to issue citations was extended by three Executive Orders issued during the pertinent time periods. (*See* Governor's Exec. Order Nos. N-63-20, ¶9; Exec. Order N-71-20, ¶ 39; and Exec. Order N-08-21, ¶ 24.) These Executive Orders suspended the deadline in Labor Code 6317 until September 30, 2021. (*United Pumping Service, Inc.*, Cal/OSHA App. 1509967, Decision After Reconsideration (March 23, 2022).) Consequently, the citations, issued on June 10, 2021, were timely.

Employer makes a conclusory statement that the Governor exceeded his authority when he extended the statute of limitations for issuance of the citation by Executive Order. Employer argues that the Governor's orders improperly violated the separation of powers, and usurped the role of the Legislature. (Petition, pp. 19-20.) Employer argues the Governor's act of suspending the statute of limitations was not a proper exercise of executive powers to mitigate the effects of the COVID emergency. (Petition, pp. 18-20.)

As a preliminary matter, Employer provides no authority suggesting that the Board has jurisdiction to entertain a challenge to an Executive Order. A contention is waived by failure to cite to legal authority and to the record. (*Shimmick Construction Company*, Cal/OSHA App. 1080515, Denial of Petition for Reconsideration (March 30, 2017).) Similarly, we also observe that the Board has no authority to overturn any portion of the Emergency Services Act (ESA) as unconstitutional. (Cal. Const, Art. III § 3.5.)

However, even if the Board had jurisdiction to entertain Employer's challenge, we would conclude, and do conclude, the Governor acted within his authority under the Emergency Services Act. (Gov. Code, §§ 8550-8669.7.)

The ESA authorizes the Governor to declare a State of Emergency "in conditions of ... extreme peril to life, property, and the resources of the state" so as to "mitigate the effects of [the emergency]" in order to "protect the health and safety and preserve the lives and property of the people of the state." (Gov. Code, §§ 8550, 8558, 8625.) In such circumstances, "the State may exercise its sovereign authority to the fullest extent possible consistent with individual rights and liberties." (*California Correctional Peace Officers Assn. v. Schwarzenegger* (2008) 163 Cal.App.4th 802, 812 [other citations omitted].)

Under the ESA, during a declared a State of Emergency, the Governor may "suspend any regulatory statute, or statute prescribing the procedure for conduct of state business, or the orders, rules, or regulations of any state agency…where the Governor determines and declares that strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency." (Gov. Code, § 8571.) The ESA expressly permits the Governor to "make, amend, and rescind orders and regulations [as] necessary" during a State of Emergency, which "shall have the force and effect of law." (Gov. Code § 8567, subd. (a).) Additionally, the ESA provides that the "Governor shall, to the extent he deems necessary, have complete authority over all agencies of the state government and the right to exercise within the area designated all police power vested in the state by the Constitution and laws of the State of California in order to effectuate the purposes of this chapter. In exercise thereof, he shall promulgate, issue, and enforce such orders and regulations as he deems necessary, in accordance with the provisions of Section 8567." (Gov. Code, § 8627; see also *Newsom v. Superior Court* (2021) 63 Cal.App.5th 1099, 1113.) The police power, as exercised, is generally the power to legislate. (*Newsom*, *supra*, 63 Cal.App.5th at 1113 [citations omitted].) "The police power is the authority to enact laws to promote the public health, safety, morals and general welfare.'" (*Ibid*. [other citations omitted].)

Further, courts have noted that the Emergency Services Act, including its delegation of broad powers and authorities to the Governor in times of emergency, "is not an unconstitutional delegation of legislative power." (*Newsom*, *supra*, 63 Cal.App.5th at 1118.)

Employer's Petition fails to persuade this Board that the Governor's Executive Orders exceeded the authority provided in the ESA. To the contrary, we conclude the Governor acted squarely within his express authority and reject Employer's arguments to the contrary.

DECISION

The Board affirms Citation 1, Items 2 and 3, and Citation 2, Item 1. The Board also affirms the Serious, Accident-Related classification for Citation 2, Item 1.

The Board concludes that the penalties were properly calculated for Citation 1, Item 1, and Citation 2, Item 1.

The Board concludes that Citation 1, Item 2, provided fair notice of the violation.

Finally, the Board concludes that Governor acted within his authority when he issued Executive Orders that extended the time for the Division to issue citations.

OCCUPATIONAL SAFETY AND HEALTH APPEALS BOARD

/s/ Ed Lowry, Chair
/s/ Judith S. Freyman, Board Member
/s/ Marvin P. Kropke, Board Member

FILED ON: 06/12/2024