

**BEFORE THE  
STATE OF CALIFORNIA  
OCCUPATIONAL SAFETY AND HEALTH  
APPEALS BOARD**

In the Matter of the Appeal of:

KNOTT'S BERRY FARM  
8039 Beach Boulevard  
Buena Park, CA 90620

Employer

Docket Nos. 01-R3D1-4331  
and 4332

**DECISION AFTER  
RECONSIDERATION**

The Occupational Safety and Health Appeals Board (Board) issues the following decision after reconsideration, pursuant to the authority vested in it by the California Labor Code. The Board took under submission the petition for reconsideration, filed by the Division of Occupational Safety and Health in this matter, on January 23, 2003.

**JURISDICTION**

Knott's Berry Farm (Employer) operates an amusement park located at 8039 Beach Boulevard, Buena Park, California. Following an accident investigation conducted between August 2 and August 20, 2001, the Division cited Employer for violating sections 342(a) and 4075(a) of the occupational safety and health standards contained in California Code of Regulations, Title 8. Employer timely appealed the citations and a hearing was held before an Administrative Law Judge (ALJ) on August 15, 2002 and December 10, 2002. The ALJ rendered a decision on December 23, 2002 that granted Employer's appeals. The Division submitted a petition for reconsideration on January 23, 2003 and the Board took the petition under submission on March 12, 2003. Employer submitted an answer to the petition on February 13, 2003.

**FINDINGS AND REASONS  
FOR  
DECISION AFTER RECONSIDERATION**

The Board has fully reviewed the record in this case, including the testimony at the hearing and the documentary evidence admitted, the arguments of counsel, the decision of the ALJ, and the arguments and authorities presented in both the petition for reconsideration and the answer to

the petition. In light of all of the foregoing, we find that the ALJ's decision was proper, that the decision was based on substantial evidence in the record as a whole, and that the findings of fact support the decision. Therefore, we adopt the attached ALJ's decision in its entirety and incorporate it into our decision by this reference.

**DECISION AFTER RECONSIDERATION**

The decision of the ALJ dated December 23, 2002 is reinstated and affirmed.

CANDICE A. TRAEGER, Chairwoman  
ROBERT PACHECO, Member

OCCUPATIONAL SAFETY AND HEALTH APPEALS BOARD  
FILED ON: May 31, 2007

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**DECISION**

**Background and Jurisdictional Information**

Employer operates a park with amusement rides. Between August 2, 2001, and August 20, 2001, the Division of Occupational Safety and Health (the Division), through Associate Cal/OSHA Engineer Jag Dhillon, conducted an accident inspection at a place of employment maintained by Employer at 8039 Beach Boulevard, Buena Park, California (the site). On August 24, 2001, the Division

cited Employer for the following alleged violations of the occupational safety and health standards and orders found in Title 8, California Code of Regulations<sup>1</sup>:

<u>Citation</u>	<u>Section</u>	<u>Type</u>	<u>Penalty</u>
2	4075(a) [sprocket chain drive guard]	Serious	\$18,000
1	342(a) [report of serious injury]	Regulatory	\$300

Employer filed timely appeals contesting the existence of the alleged violations.

This matter came on regularly for hearing before Dale A. Raymond, Administrative Law Judge for the California Occupational Safety and Health Appeals Board, at Anaheim, California on August 15, 2002 and December 10, 2002. Employer was represented by Boyd F. Jensen II, Attorney. The Division was represented David W. Pies, Staff Counsel. Affected employee Erin Velazquez was represented by Larry M. Lipke, Attorney. Oral and documentary evidence was presented by the parties and the matter was submitted on December 10, 2002.

### **Law and Motion**

On July 17, 2002, the Division filed a written motion to amend Citation 1 to allege a violation of § 3999(a). On August 6, 2002, the motion was denied in writing as untimely by Administrative Law Judge Jack L. Hesson.

On August 15, 2002, Employer moved, over the Division's objection, to enforce a settlement agreement. The motion was denied without prejudice. Employer renewed its motion in writing on September 25, 2002. The Division filed a response on October 7, 2002. Employer filed a reply on November 5, 2002. The motion was denied in writing on November 12, 2002.

On August 15, 2002, Attorney Larry M. Lipke (Lipke) moved, without objection, for party status on behalf of injured employee Erin Velazquez (Employee). Good cause appearing therefor, the motion was granted.

On August 15, 2002, Employer moved, without objection, to expand the scope of its appeals to include the classification of the violations and the reasonableness of the proposed penalties. Good cause appearing therefor, the motion was granted.

Employer stipulated that the injury to employee Erin Velazquez was serious as defined in § 330(h).

### **Docket 01-R3D1-4332**

Citation 2, § 4075(a), Serious

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<sup>1</sup> Unless otherwise specified, all references are to Sections of Title 8, California Code of Regulations.

## Summary of Evidence

The Division cited Employer for failure to guard a sprocket chain drive.

Jag Dhillon (Dhillon), Associate Cal/OSHA Engineer, testified that on August 2, 2001, he opened an investigation of an accident that happened on July 9, 2001. He held an opening conference with Safety Manager Donald Maus (Maus). Maus said that Employer had done its own accident investigation. Maus took Dhillon to the Bigfoot Rapids unloading area where the accident occurred. Maus told Dhillon that their employee, Erin Velazquez (Velazquez), was injured when she accidentally stepped off the unloading platform onto a “diverter arm” or “positioning gate<sup>2</sup>,” catching her foot and resulting in amputation of four toes. The terms “diverter arm” and “positioning gate” are used interchangeably here.

Dhillon observed the unloading operation on the day of his inspection and took photographs. He labeled the unloading platform and diverter arm on Exhibit 3, which was a photograph he took.

When a handicapped guest needs to unload from a boat, the arm swings to send the boat into a channel for handicapped guests. The arm has a wheel at the end nearest the unloading platform around which parallel rectangular wooden boards rotate. (Exhibits 3, 4, G, and H.) Rotation of the boards pushes boats along the water channel. The top of the arm was six inches below the unloading platform. (Exhibits 3, 4, G and H). Maus told Dhillon that Employer installed a guard on the arm over the wheel immediately after the accident. Maus gave Dhillon copies of photographs he took of the arm immediately after the accident showing the arm before and after the guard was put in place. (Exhibit 4). Dhillon never saw the arm without the guard in place. At the hearing, Dhillon identified and labeled the wheel, sprocket and chain in question. (Exhibit 4). Dhillon testified that the boards were attached to the chain.

Based upon the above, Dhillon issued Citation 2 for a violation of § 4075(a).

Dhillon testified that he classified the violation as serious because the most likely injury in the event of an accident caused by the violation was amputation. He based this opinion on his training and his investigations of accidents involving sprocket and chain drives. He determined that the citation was accident-related because the injury would not have occurred if a guard were in place.

Using Exhibit 2, Dhillon explained that the proposed penalty was calculated by beginning with an \$18,000 base. Because a serious violation caused a serious injury, and Employer had over 100 employees, no reductions were allowable. (Rule 336(c)(3).)

On cross-examination, Dhillon testified that he did not have any experience with vertical conveyor belts before this investigation. He further testified that the wood slats were connected to a chain driven by a motor located in the middle of the diverter arm. Dhillon acknowledged that Employer had a good safety record and a fairly good training program, but added that it was

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<sup>2</sup> Employer referred to the “diverter arm” as the “positioning gate.” Employer stipulated at hearing that they were the same thing.

not relevant when a serious violation caused a serious injury. Employer had a standard operating procedure, but it was not relevant for a guarding violation.

Donald Maus, Safety Manager, testified for Employer that has worked for Employer for about nine years. Maus has inspected the gate 50 to 60 times and the ride has been examined multiple times by independent safety inspectors who specialize in amusement park rides. The gate complied with the safety requirements of TUV. TUV is the European safety organization which has stricter standards than its American equivalent. The positioning gate was a vertical conveyor belt. The wheel at the end of the belt was a spacing wheel for a conveyor. The top of the gate was six to seven inches below the unloading platform. A motor in the back drove the system. A motor in the middle swung the gate across the channel.

### **Findings and Reasons for Decision**

**The Division did not establish that § 4075(a) applied to Employer. Citation 2 is dismissed and the penalty is set aside.**

The Division cited Employer under § 4075(a), which provides as follows:

All gears, sprockets and sprocket chain drives located 7 feet or less above the floor or working level shall be guarded.

The Division has the burden of proving a violation, including the applicability of the safety order, by a preponderance of the evidence. (See *Howard J. White*, Cal/OSHA App. 78-741, Decision After Reconsideration (June 16, 1983).) In order for § 4075(a) to apply, the Division must show that Employer had a chain and sprocket mechanism, and that it was located seven feet or less above the working level. The Division has not met this burden for two reasons.

First, the Division did not establish that there was a sprocket or a chain. In Exhibit 4, Dhillon identified some parts as a chain and a sprocket, but his labels are not conclusive. The General Industry Safety Orders do not specifically define “sprocket” or “chain.” Under established rules of statutory and regulatory interpretation, the ordinary meaning of words applies in the absence of a special definition. (*Lungren v. Deukmejian (Roberti)* 45 Cal.3d 727, 735; *Sierra Production Service, Inc.*, Cal/OSHA App. Decision After Reconsideration (Aug. 13, 1987).)

The ordinary meaning of “sprocket” as defined in the *Dictionary of Scientific and Technical Terms*, Fourth Edition (McGraw-Hill 1898) is “A tooth on the periphery of a wheel or cylinder to engage in the links of a chain, the perforations of a motion picture film, or other similar device.” The relevant definition of “chain” from the same source is “1. A flexible series of metal links or rings fitted into one another; used for supporting, restraining, dragging, or lifting objects or transmitting, porting, restraining, dragging, or lifting objects or transmit power. 2. A mesh of rods or plates connected together, used to convey objects or transmit power.” (*Id.*)

The Division's definition of "sprocket"<sup>3</sup> presented at hearing (Exhibit 6) is "Any of various toothlike projections arranged on a wheel rim to engage the links of a chain."

Here, Exhibit 4 shows projections on a wheel or cylinder that fit between the slats. These projections appear to be rectangular at the top and appear to extend the entire depth of the gate. They do not appear to be tooth shaped or toothlike. Dhillon testified that the slats appeared to be made of wood. Exhibit 4 shows the slats to be rectangular and to be parallel to each other. A chain requires the links to be attached. The mechanism cited simply does not fall within the definition of sprocket or chain.

Third, Dhillon and Maus both testified that the surface of the "diverter arm" or "positioning gate" was six inches below the unloading platform. The safety order requires the chain and sprocket to be located at or above the working level. As there was no intention that an employee step on top of the gate, it cannot be considered a working level.

Accordingly, the Division has not met its burden to prove that § 4075 applies, although some other safety order may apply. Citation 2 is dismissed and the penalty is set aside.

### **Docket 01-R3D1-4331**

Citation 1, § 342(a), Regulatory

### **Summary of Evidence**

The Division cited Employer for failure to timely report a serious injury to the Division.

Jag Dhillon, Associate Cal/OSHA Engineer testified that the Division became aware of Velazquez's accident from a telephone call from Employer at 10:00 a.m. on July 10, 2001. The telephone call informed the Division that four of Velazquez's toes on her right foot had been amputated. Maus told Dhillon that the accident happened at about 4:00 p.m. on July 9, 2001. Maus gave Dhillon a written statement (Exhibit 5) from security guard Rigo Hernandez (Hernandez) that said blood was dripping from Velazquez's right boot when Hernandez arrived at the site. Velazquez was immediately taken to the hospital. Based upon the above, he issued Citation 1 for a regulatory violation of § 342(a).

Using Exhibit 2, Dhillon explained that the proposed penalty was calculated by beginning with a \$500 base for a regulatory violation. Penalty adjustments of 40% (30% for maximum good faith; 10% for maximum history) reduced the proposed penalty to \$300. No other adjustments were allowable.

Safety Manager Don Maus (Maus) testified that Employer did not report the accident earlier because they could not get information from the hospital and Employer had no reason to believe that Velazquez's injury was serious. He was notified about 4:00 p.m. on July 9, 2001 of the accident. Maus went to the site. Velazquez was being taken off the dock. A security vehicle

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<sup>3</sup> The Division identified the source only as "American Dictionary of the English Language."

was present to take her to the hospital. Maus saw Velazquez's right boot. It was a heavy black boot in good condition with no sign of penetration or puncture. Velazquez's right foot was already wrapped when Maus arrived.

Velazquez was taken to Anaheim Memorial hospital. Maus asked his nurse to call them. She was informed that Velazquez was transferred to UCI hospital due to possible vascular complications. The nurse made two or three telephone calls to UCI, but had difficulty getting information. At about 7:30 to 8:00 p.m., the nurse was told that Velazquez was with the doctor and she would be fine. The next morning, Maus asked his assistant to call UCI at 9:00 a.m. The call was made at about 9:30 a.m., at which time Employer found out that one of Velazquez's toes on her right foot had been amputated at about 8:30 p.m. the night before. Later in the day, he found out that four toes had been amputated.

### **Findings and Reasons for Decision**

#### **The Division did not establish a violation of § 342(a). Citation 1 is dismissed and the penalty is set aside.**

The Division cited Employer under § 342(a), which provides as follows:

Every employer shall report immediately by telephone or telegraph to the nearest Division Office of 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.

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.

The parties agreed that Velazquez received a serious injury as a result of an accident that happened on July 9, 2001 at about 4:00 p.m., and that the Division was notified on July 10, 2001 at 10:00 a.m. Employer's duty to report a serious injury begins to run when the Employer knew or with diligent inquiry would have known of the serious injury. There was no evidence that Employer had actual knowledge of the serious injury before 9:30 a.m. on July 10, 2001.

The issue is whether Employer made diligent inquiry. The Division argued that Employer was put on notice because Employer knew that considerable blood came out of Velazquez's boot and because she was transferred to a second hospital due to vascular problems. The Appeals Board recently held that knowledge that an injured employee has been taken to a hospital by itself does not trigger an employer's duty to report. (*Daily Breeze*, Cal/OSHA App. 99-3429, Decision After Reconsideration (Apr. 12, 2002).) An employer's duty is triggered where an employer has enough information to make it practically possible to report the injury as

serious. (*Alpha Beta Company*, Cal/OSHA App. 77-853, Decision After Reconsideration (Nov. 2, 1979).) In *Welltech Incorporated*, Cal/OSHA App. 90-784, Decision After Reconsideration (Aug. 22, 1991), the time for Employer to report an accident began the day following surgery to the injured employee because that was the time employer learned enough information to report the injury as serious.

The instant case is like *Welltech Incorporated*. Maus credibly testified that he saw Velazquez's foot after it was bandaged, and that he expected that all she would receive was stitches from a deep laceration. That testimony was not refuted and is credited. Maus's testimony that his employees made telephone calls to the hospital, but were unable to get information about the seriousness of the injury before 8:00 p.m. was credible. Although his testimony about the calls made by his assistants is hearsay, his testimony about his own knowledge is not hearsay. Maus's conduct was not that of an employer trying to avoid reporting. It is found that Employer's duty to report began at 9:30 a.m. on July 10, 2001, when Employer learned of the amputation the previous night. As Employer reported the accident within eight hours, it is found that Employer complied with the reporting requirements of § 342(a).

Accordingly, Citation 1 is dismissed and the penalty is set aside.

### **Decision**

It is hereby ordered that the citations are established, modified, or withdrawn as indicated above and set forth in the attached Summary Table.

It is further ordered that the penalties indicated above and set forth in the attached Summary Table be assessed.

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DALE A. RAYMOND  
Administrative Law Judge

DAR:mc

Dated: December 23, 2003