

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

In the Matter of the Appeal of:

BRUNTON ENTERPRISES, INC.  
8815 Sorenson Avenue  
Santa Fe Springs, CA 90670

Employer

Docket Nos. 08-R3D3-3445  
through 3448

**DECISION AFTER  
RECONSIDERATION**

The Occupational Safety and Health Appeals Board, acting pursuant to authority vested in it by the California Labor Code and having taken this matter under submission hereby renders the following decision after reconsideration.

**JURISDICTION**

Brunton Enterprises (Employer) is a structural steel company. On March 4, 2008, the Division of Occupational Safety and Health (Division) conducted an investigation at a worksite located at 4000 Ontario Center Parkway, Ontario, California. On August 22, 2008, the Division issued a citation to Employer alleging five violations of Title 8, Cal. Code of Regulations.<sup>1</sup>

Employer filed a timely appeal and an evidentiary hearing was held before an Administrative Law Judge (ALJ) of the Board on March 19, and June 9-10, 2009. The ALJ issued her decision (Decision) on August 26, 2009, finding that Employer committed two of the five alleged violations. The remaining three violations were dismissed.

The Division and Employer each petitioned for reconsideration; and both parties answered each other's petitions.

**ISSUE**

Was the ALJ Decision correct?

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<sup>1</sup> All references are to Title 8, California Code of Regulations, unless otherwise noted.

## EVIDENCE

The summary of evidence from the ALJ Decision is incorporated herein. Employer was the structural steel contractor working at the jobsite. On the day of the accident, a three-man crew was assigned to install an approximately 14-foot long piece of tubular steel frame (hereinafter, “frame”) into the elevator hoistway.<sup>2</sup> (See exhibits 2A-2D and 11.) The crew consisted of a foreman (Mr. Shilts) and two ironworkers. The frame was brought by forklift to the skybox level<sup>3</sup> where the crew then placed it on a dolly to facilitate movement towards the elevator hoistway opening. Since the dolly was not wide enough to support the entire frame (visually, the dolly would just “sit” in between the two parallel lengths of steel), the crew placed a piece of 4x4 lumber on top of the dolly that was long enough to span the entire width of the frame. (Employer’s Ex. C, Exs. 2A-D.) With this “frame-lumber-dolly” arrangement, the dolly could then be used to wheel the frame across the floor.

The crew wheeled the frame across the skybox level towards the elevator hoistway, stopping once the wheels of the dolly touched the bottom guard rail (or “toeboard”) around the hoistway opening. At this point, the crew attached slings to the front end of the frame, where the “header” section was located. (See Ex. 2B with “header” labeled; see Ex. 3, sling arrangement.) The slings were then connected to the load bearing chain (“load line”) that was part of a chainfall hoisting device. The chainfall device had been previously setup and attached to an I-beam located above the opposite side of the hoistway opening, directly across from where the dolly/frame assembly had come to a rest against the toeboard. (See Ex. 2A, showing location of chainfall and header.) With the chainfall now attached to the slings, the plan was to pull the frame across and over the elevator hoistway opening, bringing the front end of the frame to a rest on the opposite edge.<sup>4</sup>

Up to this point, the safety railings around the opening were still in place, and there is testimony that Mr. Shilts and the others believed that the frame could be moved across the opening without having to dismantle any of the safety rails. However, once the chainfall was activated and the loadbearing line connected to the frame began to pull up on the frame, the chain almost immediately began rubbing up against the mid-rail. Rather than have the mid-rail break in half from the force, Shilts stopped the operation and had one of his crewmembers disassemble both the mid-rail and the toe board. The top railing remained in place.

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<sup>2</sup> The parties refer to the frame as a “U-frame.” We simply refer to it as a “frame.”

<sup>3</sup> The skybox level is 33 feet and 5 inches above the main concourse level. (Ex. 4.)

<sup>4</sup> After laying the frame horizontally, the crew planned to position the frame vertically and lower the frame into the hoistway for eventual permanent placement.

At this point, Shilts was positioned inside the frame (meaning between the two lengths of steel) and kneeling down behind the dolly. He had one hand on the dolly and the other on the frame, possibly in an attempt to both steady the frame and to keep the dolly from falling, should it get too close to the opening. The other two crewmembers were at different locations: one was behind Shilts and positioned at the rear of the frame; the other was positioned across the hoistway opening (facing Shilts) in order to work the chainfall device. Shilts was not wearing fall protection.

The crewmember behind Shilts warned him that the “spreader bar” (a horizontal bar located at the rear of the frame, see Ex. 2D) might possibly hit Shilts from behind, and said something to the effect of, “You may want to watch out... you’ve got that bar behind you.” Shilts looked back at the bar, nodded his head to indicate he would be alright, and then decided to continue with the operation. Shilts then told the crewmember stationed at the chainfall device to go ahead and start pulling on the chainfall.

Once the chainfall was activated and the frame began to move, the crew lost control of the frame. Its front end suddenly moved forward and down into the opening, with its back end consequently rising up and then moving forward and down into the opening as well.<sup>5</sup> Shilts attempted to stand up but was caught by the spreader bar. The bar pushed him forward – his forehead hitting and breaking through the top safety railing – and he fell 33.5 feet through the opening to the concrete surface below. He died as a result of his injuries.

### **REASONS FOR DECISION AFTER RECONSIDERATION**

Both parties allege that the ALJ acted in excess of her powers, that the evidence does not justify the findings of fact, and that the findings of fact do not support the Decision. (Labor Code §§ 6617(a), (c), (e).) Since, cumulatively, the parties challenge the ALJ’s findings on all five violations; we address their arguments citation by citation.

#### 1.) Citation 1-1 : General Violation of Section 3203(a)(4)

Section 3203(a)(4) requires that employers include procedures for identifying and evaluating work place hazards in their Injury and Illness Prevention Programs. These procedures must include “scheduled periodic inspections to identify unsafe conditions and work practices.” (Section 3203(a)(4).)

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<sup>5</sup> The entire frame fell into the opening and ended up being suspended at a position under the skybox level. (See Ex. 11, showing view from floor below skybox level.)

The ALJ ruled against the Division, finding that the crew members had identified and evaluated the hazard before them, and decided to use a procedure that had been successful for them in the past. Shilts was also warned that he might get hit by the frame should it fall, but nevertheless gave the okay to continue with the operation. (Decision, p. 6, bottom.) We agree with the ALJ's finding that although this procedure was not the safest method, "that does not demonstrate that Employer's IIPP lacked a system of hazard identification and evaluation." (*Ibid.*)

The Division argues that the warning giving by the crewmember and Shilts' assessment of the hazard did not equate to a procedure for identifying and evaluating work place hazards. (Division Pet., pp. 7-8.) We agree with the Division on this point. Section 3203(a)(4) requires that employers include "*procedures* for identifying and evaluating work place hazards *including scheduled periodic inspections* to identify unsafe conditions and work practices." (Section 3203(a)(4) [emphasis added].) Therefore, the crew's identification and evaluation of the hazard in front of them – an "on the spot" recognition – is not, in itself, evidence that Employer has *procedures* in place for identifying and evaluating workplace hazards. It also certainly is not proof that scheduled periodic inspections were occurring.

However, this distinction does not relieve the Division of its burden of proving the violation by a preponderance of the evidence. (*Howard J. White, Inc., Howard White Construction, Inc., Cal/OSHA App. 78-741, Decision After Reconsideration* (Jun. 16, 1983).) Here, the testimony by the Division witness was almost entirely centered on the specific accident that occurred, and how Employer could have made the operation safer by using different methods and/or using more employees. (Decision, p. 6.) The Division witness even remarked that section 3203(a)(4) requires that an IIPP "must include some procedure for *any operation that creates a hazard* for an employee." (Cross Examination (Jun. 9, 2009), Tape #1024.)

Such testimony is at odds with the text of the regulation. Section 3203(a)(4) contains no requirement for an employer to have a written procedure for each hazardous operation it undertakes. What is required is for Employer to have procedures in place for identifying and evaluating workplace hazards, and these procedures are to include "scheduled periodic inspections." (Section 3203(a)(4).) The Division's testimony regarding the lack of specific procedures for the operation at hand is not relevant, and the evidence in the record does not otherwise disclose that Employer's IIPP lacked procedures to identify and evaluate hazards.

For these reasons, we agree with the ALJ and find that the Division failed to prove a violation of section 3203(a)(4). Citation 1, Item 1 is dismissed.

2.) Citation 1-2 : General Violation of Section 4999(e)(1)

Section 4999(e)(1) states that, “During hoisting: (1) There shall be no sudden acceleration or deceleration of the moving load.” Section 4885 further defines a “hoist motion” as “that motion of a crane which raises and lowers a load.”

The ALJ affirmed the violation, based on Employer stipulating to the fact that the load<sup>6</sup> was being hoisted, and a finding that the load suddenly accelerated when it fell into the opening. (Decision, p. 3, fn. 2, and p. 9.)

Employer denies that it ever stipulated to the load being hoisted, and also argues that the two crewmembers testified that the frame was moving horizontally (only) and not upward immediately before the accident. (Employer Petition, p. 7.) Employer contends that since the chainfall was, in its view, not being used to raise or lower a load at the time of the accident, the operation did not qualify as a “hoisting operation” under section 4885. (*Id.* at p. 7.)

In regards to the alleged stipulation, we agree with Employer and find that it did not stipulate to the load being hoisted.<sup>7</sup>

That being said, we nevertheless rule against Employer, as the evidence shows that the frame was moved vertically as well as horizontally. (Employer’s Petition, p. 7.) Although Employer contends that the two crewmembers assisting Shilts testified that the frame only moved horizontally, this simply is not true. (*Ibid.*) For instance, the crewmember behind Shilts testified that the chainfall was pulling the dolly, and as soon as the dolly reached the hole, the front of the frame suddenly “catapulted down” into the hole, with the back of the frame then coming up and catching Shilts from behind. Additionally, the crewmember operating the chainfall testified that while the chainfall was pulling on the frame, the frame moved “towards [him] *and up* at the same time.” This is credible and consistent testimony, from both eyewitnesses to the event, that the frame was being moved in an upward as well as horizontal direction. We therefore conclude Employer was hoisting the frame when it suddenly accelerated and fell into the opening, in violation of section 4999(e)(1).

Additionally, we point out that the parties’ focus on the events just moments before the accident’s occurrence is unnecessarily narrow. Here, it is without question that the frame was hooked up to the chainfall device and was

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<sup>6</sup> The ALJ also found that the slings used to attach the chainfall to the frame qualified as part of the load. (Decision, p. 9.) Since the ALJ’s Decision, the Board has found otherwise: load attaching equipment (such as blocks, shackles, and slings) are not considered part of the load. (See *Michels Corp dba Michels Pipeline Construction*, Cal/OSHA App. 07-4274, Decision After Reconsideration (Jul. 20, 2012).

<sup>7</sup> Employer stipulated that the penalties were properly calculated, but we cannot find a stipulation as to hoisting in the record.

being pulled by the chainfall when the frame suddenly moved forward and fell down into the hole. (Decision, p. 9.) The frame undisputedly moved a vertical distance – from its position at the skybox level above the hole, to its eventual, hanging position in the opening below the skybox level – during the time it was connected to the chainfall device. (See Exhibit 11.) This necessarily involved a vertical movement of the frame while connected to the chainfall, and establishes that Employer was conducting a hoisting operation when the frame suddenly fell into the hole.

For these reasons, we find that Employer violated section 4999(e)(1). The \$650 penalty is affirmed.

3.) Citation 2 : Serious Violation of Section 4999(d)(3)

Section 4999(d)(3) requires that “the hook shall be positioned over the load in such a manner as to prevent swinging of the load when lifted.” The Division inspector testified that the chainfall hook was at an angle to the load, and when lifted at an angle a swinging effect would occur unless tag lines are used. (Decision, p. 9.) The ALJ ruled against the Division, finding that the inspector’s theory on how the accident occurred was not corroborated by the two crewmembers who witnessed the event. (Decision, p. 10.)

We agree with this finding. Neither eyewitness gave an explanation as to why the frame moved or how the hook’s positioning caused the load to move. (*Ibid.*) Nor was there any testimony by either witness regarding any swinging that occurred. In fact, even if we were to infer that some swinging occurred, the evidence would support that the swinging possibly occurred only *after* the frame fell down and into the hole, coming to a rest suspended in the ceiling. However, there is no evidence that would lead us to believe that any swinging occurred “when lifting” the frame, which is required to be proven in order to establish a violation of section 4999(d)(3).

For these reasons, we affirm the ALJ’s ruling and dismiss the citation.

4.) Citation 3 : Serious Violation of Section 1670(a)

The Division cited Employer for violating section 1670(a):

- (a) Approved personal fall arrest, personal fall restraint or positioning systems shall be worn by those employees whose work exposes them to falling in excess of 7 1/2 feet from the perimeter of a structure, unprotected sides and edges, leading edges, through shaftways and openings, sloped roof surfaces steeper than 7:12, or other sloped surfaces steeper than 40

degrees not otherwise adequately protected under the provisions of these Orders.

Shilts was not wearing any fall protection while working near the elevator shaft opening and consequently fell in. “The task he was performing exposed him to the hazard of approaching and then falling into the shaft, and he was not wearing any fall protection equipment.” (Decision, p. 11.) The ALJ therefore correctly found that a violation occurred. Employer also stipulated to a substantial probability of serious injury should an employee fall down the opening, and the ALJ likewise correctly affirmed the Serious classification. (Decision, p. 12.)

In its petition, Employer does not dispute the existence of the violation, but rather asserts that the ALJ should have dismissed the citation because the violation was caused by the intentional act of misconduct by its foreman, Shilts. (Employer Petition, p. 8.) Specifically, Employer argues that both the Independent Employee Act and Unforeseeable Violation defenses apply to the facts of this case. (*Ibid.*) We do not agree.

The Independent Employee Act Defense (IEAD) is a Board-created affirmative defense that requires an employer to establish five different elements.<sup>8</sup> (See *Davey Tree Surgery Co. v. Occupational Safety & Health Appeals Bd.* (1985) 167 Cal.App.3d 1232, 1239.) Employer argues that the ALJ ignored the evidence as applicable to the IEAD, and should not have rejected the IEAD based on the supervisor status of Shilts. (Employer’s Petition, p. 9.)

We find that the ALJ correctly rejected the defense. The Board has long held, and the courts have confirmed, that the IEAD is not applicable when a supervisor or foreman commits the violation. (See *Davey Tree*, *supra*, 167 Cal.App.3d at pp. 1241-1242 [foreperson exception to IEAD is reasonable and upheld]; *City of Sacramento, Dept. of Public Works*, Cal/OSHA App. 93-1947, Decision After Reconsideration (Feb. 5, 1998).) In fact, the court in *Davey Tree* said that the supervisor exception is not a true “exception,” but rather a situation where the employer has not met the third element required under the IEAD. (*Davey Tree*, *supra*, 167 Cal.App.3d at pp. 1242-43.) The ALJ therefore appropriately rejected the IEAD based on the foreman status of Shilts.

The same logic holds true for the “Unforeseeability Defense,” otherwise known as the *Newbery* defense. In *Newbery Electric Corp. v. Occupational Safety*

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<sup>8</sup> (1) The employee was experienced in the job being performed; (2) Employer has a well-devised safety program which includes training employees in matters of safety respective to their particular job assignments; (3) Employer effectively enforces the safety program; (4) Employer has a policy which it enforces of sanctions against employees who violate the safety program; and (5) The employee caused a safety infraction which he or she knew was contra to the Employer’s safety requirement.

*& Health Appeals Bd.* (1981) 123 Cal.App.3d 641, a supervising electrician was electrocuted when he installed a light pole too close to a high voltage line. The Division cited Newbery for failing to maintain the required distance to the power line. On review, the court dismissed the citation finding that the employee committed an “unforeseeable,” and therefore not punishable, act. The court highlighted that the employee had previously installed thousands of light poles without incident, knew that he had to maintain a certain clearance from the power line and had in fact refused to install poles in close proximity to high voltage lines before, and was an experienced electrician who acted in a supervisory role over his crew. (*Id.* at pp. 649-651.) In light of this and other reasons, the court ruled that Newbery could not have foreseen that the employee would not follow the written instructions or the clearance rule which he was familiar with. (*Id.* at pp. 650-651.)

*Gaehwiler v. Occupational Safety & Health Appeals Bd.* (1983) 141 Cal.App.3d 1041, articulated the elements of the *Newbery* defense:

A violation is deemed unforeseeable, therefore not punishable, if none of the following four criteria exist:

- (1) that the employer knew or should have known of the potential danger to employees;
- (2) that the employer failed to exercise supervision adequate to assure safety;
- (3) that the employer failed to ensure employee compliance with its safety rules; and
- (4) that the violation was foreseeable.

(*Gaehwiler v. Occupational Safety & Health Appeals Bd.* (1983) 141 Cal.App.3d 1041, 1045.)

Employer argues that it meets these criteria. (Petition, pp. 11-12.) However, an employer cannot utilize the *Newbery* defense when a supervisor commits the violation. (*Davey Tree Surgery Co. v. Occupational Safety & Health Appeals Bd.* (1985) 167 Cal.App.3d 1232, 1243 [employer necessarily fails the second prong of the *Newbery* defense when a supervisor violates a safety order].) The Board has also previously considered this issue and denied the *Newbery* defense when a supervisor committed the violation. (See *Hollander Home Fashions*, Cal/OSHA App. 10-3706, Denial of Petition for Reconsideration (Jan. 13, 2012), citing *MCI Worldcom, Inc.*, Cal/OSHA App. 00-440, Decision After Reconsideration (Feb. 13, 2008) [*Newbery* defense fails since supervisor’s knowledge is imputed to employer].)

Employer cites to *Frank M. Booth, Inc.*, Cal/OSHA App. 06-4703, Denial of Petition for Reconsideration (Jan. 27, 2009) and *Dade Behring, Inc.*, Cal/OSHA

App. 05-2203, Decision After Reconsideration (Dec. 30, 2008), to support its argument that the Independent Employee Act and *Newbery* defenses apply even when a supervisor commits the violation. (Petition, p. 11.) However, these authorities are not on point.<sup>9</sup>

To begin with, in *Dade Behring*, the Board allowed the employer to present the IEAD, but only because a *non*-supervisor committed the violation. In fact, the Board affirmatively stated that had it been established that the employee was a supervisor, the IEAD would not have been allowed. (*Dade Behring, supra*, fn. 16, [“The Appeals Board has long held that the defense of independent employee act is not available in those situations where a foreman or supervisor commits the safety violation.”].)

Next, in *Frank M. Booth*, the ALJ disallowed the Newbery defense specifically based on the fact that a supervisor committed the violation. On appeal, the Board agreed with the ALJ, and found that because decedent was a foreman, employer knew or should have known that the pipe decedent was working on was pressurized and therefore the violation was foreseeable. (*Frank M. Booth, supra*.) The Board noted this was an appropriate application of *Davey Tree, supra*, and that the actions of foremen are imputed to their employers. (*Davey Tree, supra*, 167 Cal.App.3d at p. 1243 [employer necessarily fails the second prong of the *Newbery* defense when a supervisor violates a safety order].)

Employer’s arguments are accordingly rejected. Citation 3 and the corresponding penalty are affirmed.

#### 5.) Citation 4-1 : Serious Violation of Section 3328(e)

At the time of the violation, section 3328(e) read as follows:

Machinery and equipment components shall be designed, secured, or covered to minimize hazards caused by breakage, release of mechanical energy (e.g., broken springs), or loosening and falling.

The Division alleged that (1) the dolly was not designed for such a wide and large load, and (2) the dolly and frame were not secured to minimize the hazards caused by loosening and falling. (Decision, p. 13; Citations, Ex. 1.)

In regards to the allegation that the dolly was inadequately designed, the ALJ rejected this argument based on insufficient evidence to make a

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<sup>9</sup> The petition further argues that under federal precedent, Employer would not be responsible for the decedent's actions. (Petition, pp. 11-12.) However, federal OSHA precedents and policies do not control. (*Frank M. Booth, Inc.*, Cal/OSHA App. 06-4703, Denial of Petition for Reconsideration (Jan. 27, 2009); *Janco Corporation*, Cal/OSHA App. 99-565, Decision After Reconsideration (Sep. 27, 2001), citing *United Air Lines, Inc. v. Occupational Safety and Health Appeals Board* (1982) 32 Cal.3d 762 and *Skyline Homes, Inc. v. Occupational Safety and Health Appeals Board* (1981) 120 Cal.App.3d 663.)

determination as to whether or not the dolly was designed for such a large load. (Decision at p. 14.) We agree with this finding.

Furthermore, we point out that even if we were to assume that Employer actually designed the dolly,<sup>10</sup> and even if the Division proved, as it alleged, that the dolly was “not designed for such a wide and large load,” the safety order would not apply in the first place. Section 3328(e) requires that “equipment components shall be designed... *to minimize hazards caused by breakage, release of mechanical energy (e.g., broken springs), or loosening or falling.*” (Section 3328(e) [emphasis added].) Therefore, a dolly that simply is “not designed for such a wide and large load” is not in violation of the safety order, as it would need to be shown that the dolly’s components were not designed “to minimize hazards caused by breakage, released mechanical energy, or loosening or falling.”

Finally, regarding the allegation that the frame and dolly were not secured to minimize loosening and falling, the ALJ appropriately found that the safety order did not apply. (Decision, p. 14.) The ALJ noted, and we agree, that “nothing in the record shows that the frame’s components or the dolly’s components were not designed, secured or covered to minimize the risk of the components breaking, loosening or falling.” (*Id.* at p. 15.) Furthermore, there was no evidence that any component of the frame or any component of the dolly broke loose and fell. (*Ibid.*)

The Division witness also admitted that he cited Employer for violating section 3328(e) because “the whole dolly fell into the hole.” However, this is exactly why the safety order does *not* apply to these facts, as no components of the frame or the dolly broke loose and fell. Citation 4 is dismissed and the penalty set aside.

ART R. CARTER, Chairman  
ED LOWRY, Member  
JUDITH S. FREYMAN, Member

OCCUPATIONAL SAFETY AND HEALTH APPEALS BOARD  
FILED ON: October 11, 2013

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<sup>10</sup> The Division inspector testified that he could not confirm who manufactured the dolly, but was told (by an unidentified person) that it may have “possibly been made in Employer’s shop.”