BEFORE THE
STATE OF CALIFORNIA
OCCUPATIONAL SAFETY AND HEALTH
APPEALS BOARD

In the Matter of the Appeal of:	Inspection No.
ANGELUS BLOCK CO., INC. **3435 S. Riverside Ave.** **Bloomington, CA 92316** **Employer**	**1113026** **DECISION AFTER RECONSIDERATION**

The Occupational Safety and Health Appeals Board (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

Angelus Block Co., Inc. (Employer) manufactures concrete building blocks and bricks, which are known as "pavers." On December 15, 2015, the Division of Occupational Safety and Health (the Division), through Senior Safety Engineer Robert Salgado (Salgado) and Associate Safety Engineer Robert Delgado (Delgado), commenced an accident investigation of Employer's work site, located at 3435 South Riverside Avenue, Bloomington, California. An employee was fatally injured by moving machine parts, while attempting to clean a sensor on a piece of large machinery which manufactures, moves, stacks, and wraps concrete paver blocks.

On June 15, 2016, the Division issued six citations to Employer, alleging fourteen violations of California Code of Regulations, title 8.[1] Five were classified as Serious, and three as Accident-Related.

Employer timely appealed. This matter was heard by Mario L. Grimm, Administrative Law Judge (ALJ) for the Board, via Zoom, on June 24 and 25, 2021, December 7 to 9, 2021, and January 12, 2022. Eugene F. McMenamin, attorney with Ogletree, Deakins, Nash, Smoak & Stewart, P.C., represented Employer. Clara Hill-Williams, Staff Counsel, represented the Division.

On May 8, 2023, the ALJ issued a Decision affirming Citation 1, Items 1, 3, 5, and 7, and vacating Citation 1, Items 2, 4, 6, and 8, and Citations 2 through 6.

The Division filed a Petition for Reconsideration (Petition) on June 6, 2023. Prior to the Board taking action on the Petition, the Division filed an Amended Petition for Reconsideration (Amended Petition), on June 12, 2023. An amended petition supersedes the original petition and

[1] Unless otherwise specified, all references are to sections of California Code of Regulations, title 8.

becomes the sole basis for relief. (*Bassett v. Lakeside Inn, Inc.* (2006) 140 Cal.App.4th 863, 869-870; *Anmaco, Inc. v. Bohlken* (1993) 13 Cal.App.4th 891, 901.) Employer timely filed an answer to the Amended Petition. The Board took the Division's Amended Petition under submission.

The Amended Petition seeks an Order from the Board reversing the ALJ's Decision with regard to Citations 2, 3, 4, 5, and 6. The Division does not, in its Amended Petition, contest the ALJ's Decision vacating Citation 1, Items 2, 4, 6, and 8, or the classifications or penalties of any alleged violations, waiving these issues. (Lab. Code, § 6618.)

In making this decision, the Board has engaged in an independent review of the entire record. The Board additionally considered the pleadings and arguments filed by the parties. The Board has taken no new evidence.

ISSUES

1. Did the Division establish, by a preponderance of evidence, that Employer failed to implement IIPP procedures to identify and evaluate hazards?

2. Did the Division establish, by a preponderance of evidence, that Employer failed to effectively train employees on hazardous energy control procedures and hazards related to cleaning, servicing, repairing, setting up, and adjusting machinery and equipment?

3. Did Employer meet all five IEAD elements to relieve it of responsibility for a violation of section 3314, subdivision (c)?

4. Did the Division establish, by a preponderance of evidence, that Employer failed to maintain machinery and equipment in service as recommended by the manufacturer?

5. Did the Division establish, by a preponderance of evidence, that Employer failed to guard hazardous moving parts of machinery or equipment?

FINDINGS OF FACT

1. On December 15, 2015, employee Jose Vega Montoya (Montoya) was fatally injured at Employer's work site while attempting to clean a sensor on a piece of large machinery or equipment, known as the Dry Side Tiger Machine, or Dry Side, which moved, stacked, and wrapped concrete paver blocks.

2. The Dry Side Tiger Machine was comprised of a system of interconnected machine components which are collectively referred to as the "cubing machine," the "cuber system," or "the Cuber."

3. Employer had a fence around the Dry Side, which encompassed approximately 4,000 to 5,000 square feet.

4. The Dry Side fence had multiple interlock safety gates for entry and exit.

5. Opening an interlock gate acted as a circuit breaker, which de-energized the Dry Side machinery, and prevented it from operating in "automatic mode," while a worker was inside the fenced area.

6. The Dry Side included a centerline conveyor, and two side conveyors, with the side conveyors being referred to as Patternmaker A and Patternmaker B.

7. The side Patternmakers were each approximately three feet, two inches high, and twenty-four inches wide, and passed through openings in the fence to enter the Dry Side.

8. The side Patternmakers were guarded underneath.

9. The conveyors transported pavers to a component called the tier table.

10. When pavers reached the edge of the tier table, a ram-like component called the product pusher (also called the paver pusher) descended from above the centerline conveyor and advanced the pavers onto the tier table.

11. A device called the cube clamp (also called the "cuber," as distinct from the term "the Cuber," which refers to the entire cuber system) then picked up the pavers, travelled along an overhead track, rotated, and stacked the tiered pavers onto pallets.

12. The operation of the cube clamp as it moved along its overhead track, or as it rotated to deposit the pavers, frequently triggered one or more of its associated sensors. A sensor error caused the cube clamp to stop, and/or an alarm to sound.

13. To avoid having to press the cube clamp's error reset button whenever one of its sensors was triggered, employees used a wooden stick to hold down an error reset button for the cube clamp, located on the cubing machine's control panel.

14. The control panel was located outside the fenced area of the Dry Side.

15. The front right corner of the cuber system control panel was nine inches from the fence.

16. There was a 21-inch opening in the fence behind the nine inch opening on the right side of the cuber system control panel.

17. Holding down the cube clamp's error reset button did not affect the operation of the product pusher.

18. The sensor error(s) triggered by the operation of the cube clamp did not affect the operation of the product pusher.

19. Wear and tear on the display screen of the cubing machine control panel, due to the use of the wooden stick on the reset button, would not cause injury.

20. Montoya had worked as an operator of the Dry Side for four to five years before becoming an operator for the Wet Side, but occasionally still assisted workers on the Dry Side.

21. Montoya climbed onto Patternmaker A and walked along the conveyor to get past the Dry Side fencing, without entering through an interlock gate.

22. Montoya did not de-energize the Dry Side machinery, including the product pusher, prior to entering the fenced area.

23. Montoya was cleaning a sensor relating to the operation of the centerline conveyor when the product pusher struck and fatally injured him.

24. Employer had a hazardous energy control procedure.

25. Employer trained and tested all employees on its hazardous energy control procedure.

26. Employer's written hazardous energy control procedure did not include separate procedural steps for each of the machines and pieces of equipment affected by the hazardous energy control procedure.

27. Montoya deliberately circumvented Employer's hazardous energy control procedure.

28. An employee could not slip, fall, slide, trip, or make any other unplanned movement under or over Patternmaker A, through the fence opening, and into the path of the product pusher.

29. An employee could not slip, fall, slide, trip, or make any other unplanned movement under or over Patternmaker B, through the fence opening, and into the path of the product pusher.

30. An employee could not slip, fall, slide, trip, or make any other unplanned movement through the nine inch opening on the side of the cuber system controller, then through the 21-inch opening, then around or over a conveyor, and into the path of the product pusher.

DISCUSSION

1. Did the Division establish, by a preponderance of evidence, that Employer failed to implement IIPP procedures to identify and evaluate hazards?

Citation 2 alleged a Serious violation of section 3203, subdivision (a)(4)(A), which provides:

> 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:
>
> (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:
>
> (A) When the Program is first established[.]

The Division alleged:

> Prior to and during the course of the investigation, including, but not limited to, on December 15, 2015, the implementation of the employer's written IIPP procedures for identifying and evaluating workplace hazards did not result in a comprehensive evaluation of the hazards present at the site.
>
> Instance 1: As a common unsafe practice, the employer permitted the use of a piece of lumber/wood which the employer positioned against the Cuber [sic] controller to physically hold/push and bypass the reset button of a sensor(s).
>
> Instance 2: As a common unsafe condition, the employer failed to identify unguarded entries to the zone of danger.

Section 3203, subdivision (a)(4), requires that employers include procedures for identifying and evaluating work place hazards in their Illness and Injury Prevention Program (IIPP). These procedures must include "scheduled periodic inspections to identify unsafe conditions and work practices." (*Brunton Enterprises, Inc.*, Cal/OSHA App. 08-3445, Decision After Reconsideration (Oct. 11, 2013).) The safety order does not require an employer to have a written procedure for each hazardous operation it undertakes; however, an employer must effectively implement the inspection procedures in its IIPP. (*Id*.)

To establish a violation of section 3203, subdivision (a)(4), based on a failure of implementation, the Division must demonstrate that the employer failed to effectively inspect, identify, and evaluate workplace hazards. (*Barrett Business Services, Inc.*, Cal/OSHA App. 12-1204, Decision After Reconsideration (Dec. 14, 2016); *OC Communications, Inc*., Cal/OSHA App. 14-0120, Decision After Reconsideration (Mar. 28, 2016).) Proof of implementation requires evidence of actual responses to known or reported hazards. (*National Distribution Center, LP*, *supra*, Cal/OSHA App. 12-0391, citing *Los Angeles County Department of Public Works*, Cal/OSHA App. 96-2470, Decision After Reconsideration (Apr. 5, 2002).) Implementation of an

IIPP is a question of fact. (*Papich Construction Company Inc*., Cal/OSHA App. 1236440, Decision After Reconsideration (Mar. 26, 2021).) Where a citation alleges multiple violative instances of a single safety order, a single proven instance is sufficient to sustain the citation. (*Barrett Business Services, Inc.*, *supra*, Cal/OSHA App. 12-1204; *Chevron U.S.A. Inc.*, Cal/OSHA App. 13-0655, Decision After Reconsideration (Oct 20, 2015).)

The Division has the burden of proving all elements of a violation by a preponderance of evidence. (*National Distribution Center*, *LP*, Cal/OSHA App. 12-0391, Decision After Reconsideration (Oct. 5, 2015).) As part of its burden, the Division must demonstrate employee exposure to the alleged violative condition. "[E]xposure to a hazard is an element of the Division's burden of proof." (*Home Depot, USA, Inc.*, Cal/OSHA App. 1011071, Decision After Reconsideration (May 16, 2017).) If the Division fails to demonstrate that a hazardous condition existed, to which employees were exposed, it follows that the Division cannot succeed in proving an alleged violation.

The Division may establish employee exposure to a violative condition either through proof of actual exposure, or by showing employee access to the zone of danger based on evidence of reasonable predictability that employees would have access to the zone of danger while in the course of assigned work duties, pursuing personal activities during work, and using normal means of ingress and egress. (*Benicia Foundry & Iron Works, Inc.*, Cal/OSHA App. 00-2976, Decision After Reconsideration (April 24, 2003).) While the "zone of danger" is a flexible concept, it is normally "that area surrounding the violative condition that presents the danger to employees that the standard is intended to prevent." (*Id.*) Here, the zone of danger is the area around moving machinery parts inside the Dry Side fencing.

Employer provided the Division with its IIPP, but the Division did not enter the IIPP into evidence. (Hearing Transcript [HT] Day 2, p. 275.) Employer introduced into evidence a 25-page excerpt of its IIPP. (Exhibit B.) Irrespective of which party introduces a piece of evidence, the ALJ may consider it in reaching a decision. (*RII Plastering, Inc., dba Quality Plastering*, Cal/OSHA App. 02-2679, Decision After Reconsideration (Jan. 23, 2009) citing *Williams v. Barnett* (1955) 135 Cal App 2d 607, 612 and *Best Roofing & Waterproofing*, Cal/OSHA App. 01-2695, Decision After Reconsideration (Mar. 17, 2003).)

The section of the IIPP introduced by Employer provides, in relevant part, "Quarterly or periodic inspections will be conducted to identify workplace hazards. […] Periodic inspections consists [sic] of identification and evaluation of workplace hazards utilizing applicable sections of the attached Hazard Assessment Checklist and any other effective methods to identify and evaluate workplace hazards." (Exhibit B, pp. 3-4.) The IIPP also provides for "unscheduled, unannounced, surprise inspections that will focus on specific safety issues or procedures." (*Id*., p. 4.)

a. Did the Division establish the violation alleged in Citation 2, Instance 1?

In Citation 2, Instance 1, the Division alleged that Employer failed to inspect, identify, and evaluate hazards as follows:

> As a common unsafe practice, the employer permitted the use of a piece of lumber/wood which the employer positioned against the Cuber [sic] controller to physically hold/push and bypass the reset button of a sensor(s).

Citation 2, Instance 1 involves a factual dispute regarding the function and operation of the Dry Side machinery. 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 *Pool Well Servicing Co*., Cal/OSHA App. 80-1127, Decision After Reconsideration (Dec. 7, 1984).)

The function of the Dry Side machinery is to move, stack, and wrap paver blocks (which are manufactured on the Wet Side) into cube shaped pallets. (Exhibit D, p. 21 [p. 7].) Within this system, pavers move on a conveyor to a ram-like component called the product pusher, which pushes the pavers onto a component called the tier table. (*Id*., pp. 21-22 [pp. 7-8].) It is not disputed that the product pusher is the component which struck and fatally injured Montoya. A component called the cube clamp then picks up the tiered pavers, travels along an overhead track, and stacks the tier of pavers onto a pallet. (*Id*.)

The Dry Side is surrounded by a fence with interlocked safety gates. (Exhibit 12-110; Exhibit L; Exhibit J; Exhibit M.) Opening a gate acts as a circuit breaker, de-energizing the entire system. (HT Day 1, pp. 41, 70, 95; HT Day 6, p. 895; Exhibit C; Exhibit D, p. 23 [p. 9].) The main Dry Side controls – which include an automatic/manual control switch, an emergency stop button, and a display screen – are located on a panel outside the fenced area. (HT Day 1, pp. 64-65; Exhibit 12-17; Exhibit 12-120; Exhibit D, pp. 23-24 [pp. 9-10]; Exhibit M.)

Based on the testimony and evidence adduced at hearing, the terms "cuber system," "cubing machine," and "the Cuber," all interchangeably refer to the entire system of interrelated machines that are collectively part of the Dry Side. However, it is important to note that the term "cuber" also specifically refers to just one part of the cubing machine: the cube clamp. (HT Day 1, p. 65; HT Day 6, pp. 935, 939-940, 944.) The Division does not allege that the cube clamp itself was involved in the accident.

In Citation 2, Instance 1, the Division contends that a hazardous condition resulted when employees used a wooden stick to hold down a particular "error reset button" on the cubing machine's control panel. The stick was on the reset button at the time Montoya entered the Dry Side. (Exhibit 12-120.) The exact purpose and function of this reset button, including what part(s) of the Dry Side machinery it affected, was part of the Division's burden of proof. The Division appears to have misconstrued the function of this particular error reset button, however. Specifically, the Division asserts that holding down this reset button restarted the entire cuber system, or "the Cuber." In fact, the record indicates that this button could restart only the cube clamp, or "cuber."

The Division alleges, "[T]he stick caused the Cuber [sic] to restart instantaneously after a sensor error had stopped it, even though an employee might be in the zone of danger." (Amended Petition, p. 14.) Division investigator Delgado testified that he formed this conclusion because, "Based on the interviews, it was brought to our attention that [Montoya] was in there because the machine had stopped. It had an error, the sensor. There was a sensor problem that they had – it had to be cleaned. That's what – that's the connection. That's the hazard. The reset button was being pressed by an object[.]" (HT Day 4, p. 634.) It appears that Delgado was told Montoya had been cleaning a sensor near the product pusher, saw the stick on the panel, and concluded there was a relationship between the two. This is the Division's primary argument. The Division asserts that the button held down by the stick caused the product pusher to restart and cycle, striking Montoya, immediately after he had cleaned obstructing debris from a sensor eye located in the zone of danger surrounding the product pusher.

The Division's argument – that using a stick to hold down this specific "error reset" button created a hazardous condition – relies, first, upon the premise that pressing this error reset button could cause the entire cuber system (i.e., "the Cuber"), and specifically the product pusher, to restart. Second, the Division's argument assumes that, if this particular button was held down in order to "restart the machine after a sensor had been triggered," then the sensor(s) affected by that reset button necessarily affected the operation of the entire cuber system, and specifically the operation of the product pusher. (Amended Petition, p. 12.)

After a careful review of the record, we find the Division failed to demonstrate that this particular reset button could restart the product pusher under any circumstance, or indeed that it affected the operation of the product pusher at all. The Division thus failed to prove that the use of the stick to hold down this particular reset button caused, and exposed employees to, the alleged hazard.

i. Did the Division establish that the reset button held down by the wooden stick related to the operation of the product pusher?

First, as noted, the Division asserts that this error reset button restarted "the Cuber," or "the machine," presumably referring to the entire cubing machine, as no parts within the system are specified. (Amended Petition, pp. 12, 14.) Delgado testified that, in his opinion, the reset button held down by the stick restarted the entire Dry Side Tiger Machine, including the product pusher. (HT Day 4, pp. 631-632, 634-635, 641; HT Day 5, pp. 800-801.)

If this assertion were accurate, then pressing or holding down this error reset button would restart the product pusher along with the rest of the cuber system. However, the record demonstrates that this particular reset button could not restart the entire cuber system (i.e., "the Cuber"), nor could it separately restart the product pusher. This is because the record indicates that this particular error reset button was related solely to the movement and operation of the cube clamp (i.e., the "cuber").

As noted, the cube clamp is the component that picks up and moves the tiered pavers onto a pallet. (HT Day 1, p. 65; Exhibit D, pp. 21, 23 [pp.7, 9].) Thomas Ray (Ray), Employer's Production Manager, identified this component as "the cuber" in a photograph of the Dry Side taken by Employer. (HT Day 6, pp. 853-854, 856; Exhibit H; Exhibit H Mod 1.) Ray explained that although both the centerline conveyor[2] and product pusher, like the cube clamp, are "part of the cuber system, they are two different pieces of equipment," and are separate pieces of equipment from the cube clamp, or "cuber." (HT Day 6, pp. 939-940.) Similarly, the testimony of David Wilson (Wilson), Employer's former Environmental Health and Safety Manager, indicated that the cube clamp, even though it is commonly referred to as the "cuber," is only one part of the cuber system. (HT Day 6, p. 970.)

Division witness Scott Becker (Becker), employed as a mechanic by Employer since 2005, testified that for at least several months prior to this incident, employees had used a wooden stick to hold down the error reset button of the "cuber." (HT Day 1, pp. 77, 82.) It appears that the operation of the cube clamp, as it moved along its overhead track, or as it rotated to deposit a tier of pavers onto a pallet, frequently triggered one or more of its associated sensors. As will be discussed in more detail below, the cuber system involved as many as twenty-five separate sensors, each with its own function. (HT Day 1, pp. 49, 50; Exhibit D, p. 32 [p. 18].)

A sensor error affecting the cube clamp caused an error message to appear on the display screen of the cuber system control panel. (HT Day 1, pp. 65, 129; Exhibit D, pp. 38-39 [pp. 24-25].) Such sensor error(s) caused the cube clamp to stop, and/or an alarm to sound. (HT Day 1, p. 51; HT Day 6, pp. 943-944, 973-974.) Becker testified that the cube clamp's reset button was held down by a wooden stick to avoid the need for employees "to keep going over there and resetting the error." (HT Day 1, p. 77.) Becker testified that the stick holding down the button "would reset the cuber so that it would continue to operate. That's all it did." (HT Day 1, p. 77.) Becker emphasized, "It keeps the trolley operating. That's all it did," referring to the overhead track along which the cube clamp moved. (HT Day 1, p. 84.)

The Division interprets Becker's testimony, that the stick was used to "reset the cuber," to mean that the stick was used to "restart the machine" and "caused the Cuber [sic] to restart," again referring, it appears, to the entire cubing machine. (Amended Petition, pp. 12, 13, 14.) However, read in context, and particularly in light of Becker's repeated attempts to clarify the limited effect of this reset button, the more reasonable interpretation is that Becker used the term "cuber" to refer not to the entire cuber system, but specifically to the cube clamp.

Ray, like Becker, testified that the button held down by the wooden stick related to the operation of "the cuber," again referring specifically to the cube clamp. (HT Day 6, p. 853.) Ray's testimony confirmed, "The purpose of that stick was to reset the error caused by the rotation of the cuber." (HT Day 6, pp. 943-944.) Ray testified that holding down this particular reset button had

[2] The Dry Side involves three conveyors – a "centerline" conveyor, and two side conveyors, referred to as Patternmaker A and Patternmaker B.

"nothing to do with" resetting or restarting either the centerline conveyor or the product pusher. (HT Day 6, pp. 937, 944.) Wilson also testified that this particular reset button did not reset or restart either the centerline conveyor or the product pusher. (HT Day 6, pp. 972-973.)

The similar testimony of Becker, Ray, and Wilson is further supported by Exhibit D, a report documenting the results of an investigation into the accident commissioned by Employer. The Division did not challenge the findings in this report. (HT Day 5, pp. 697, 699.) This report states, in reference to the error reset button on which the wooden stick was used, "Angelus Block employees described an error that occurred in the past as associated with the travel of the cube clamp and not with the Overhead Paver Pusher." (Exhibit D, p. 39 [p. 25].)

In short, the Division failed to demonstrate that holding down this particular error reset button caused, or could cause, the restart of either the entire cubing machine or the product pusher. By contrast, Employer presented evidence sufficient to rebut the Division's argument, and to demonstrate that the reset button held down by the stick could not restart the operation of the product pusher. The ALJ therefore concluded, "[T]he evidence does not indicate that the button restarts the product pusher, as asserted by the Division." (Decision, p. 17.) We agree.

ii. Did the Division establish that the cube clamp and the product pusher were controlled by the same sensor(s)?

The Division asserts that holding down this particular reset button caused the product pusher "to restart instantaneously after a sensor error had stopped it." (Amended Petition, p. 14.) The Division's argument assumes a relationship between this error reset button and the sensor(s) controlling the product pusher. Notably, however, the Division failed to provide evidence as to what sensor, or sensors, were affected by this particular reset button, or as to whether those sensors were related to the operation of the product pusher.

Becker testified that the cuber system involved as many as twenty-five separate sensors, each with its own function. (HT Day 1, pp. 49, 50. See also Exhibit D, p. 32 [p. 18].) Sensor errors within the Dry Side machinery occurred on a fairly regular basis, requiring employees to enter the fenced area in order to access the sensors and correct the errors. (HT Day 1, pp. 65, 66-67, 68, 132-133.) Only one of these sensors, referred to by Employer as sensor PHA0, was identified as related to this incident. (Exhibit D, p. 29 [p. 15]; HT Day 6, pp. 968-970.) The Division does not dispute that Montoya was attempting to clean the PHA0 sensor at the time he was fatally struck by the product pusher.

The Division did not provide evidence that holding down the error reset button in question affected the PHA0 sensor at all. Nor did the Division present evidence that any error affecting the PHA0 sensor was, or could be, related to or responsible for any errors affecting the cube clamp. Again, we note that establishing the exact purpose and function of the reset button in question, including what part(s) of the Dry Side machinery it affected, was part of the Division's burden of proof.

By contrast, Employer's unrebutted evidence indicates that the PHA0 sensor affected the operation of only certain components within the cubing system; specifically, the centerline conveyor and the product pusher. (HT Day 6, pp. 938, 939, 943; Exhibit D, p. 32-33 [pp. 18-19].) The record therefore suggests that an error affecting the PHA0 sensor could not have been overridden or reset by holding down this particular button on the control panel, which related only to sensors affecting the cube clamp.

Moreover, the Division's argument presumes that the product pusher restarted once the sensor was cleaned. In other words, the Division assumes that the product pusher was not in operation at the time Montoya entered the Dry Side and began cleaning the PHA0 sensor. On this point, the Division fails to demonstrate that product pusher stopped as result of the PHA0 error.

By contrast, Ray testified that, when the PHA0 sensor was dirty or otherwise obstructed, the centerline conveyor would stop, but the product pusher would continue to move. (HT Day 6, pp. 939, 940, 942, 943.) Ray testified, "When the sensor is cleaned, it allows the center line conveyor to run. The product pusher is – has been continually running without pushing product because the center line hasn't brought it product." (HT Day 6, p. 942.) Ray further testified that he believed the product pusher was operating at the time Montoya entered the area near the centerline conveyor and the PHA0 sensor. (HT Day 6, p. 943.) Wilson also testified that a blocked PHA0 sensor would stop the centerline conveyor, although he was uncertain whether the product pusher would be stopped. (HT Day 6, p. 969.)

Ray's testimony is supported by the findings described in Exhibit D. This report describes, in detail, the operation of the Dry Side Tiger Machine. As noted, the Division did not dispute these findings. Relevant here, Employer attempted to duplicate the circumstances of the accident, by artificially obstructing the PHA0 sensor. When this was done, the obstructed sensor caused the product pusher to cycle continuously, while the centerline conveyor remained at a stop. (Exhibit D, p. 33 [p. 19].) Employer's evidence, while experimental in nature, indicates that an obstructed PHA0 sensor would not stop the motion of the product pusher.

The ALJ therefore concluded, and we agree, that the product pusher most likely remained in operation when the PHA0 sensor was blocked, and was in operation at the time Montoya entered the zone of danger surrounding the product pusher, and attempted to clean the sensor, without first locking out power to the Dry Side Tiger Machine. (Decision, p. 21.)

Altogether, the Division's evidence does not establish that using a stick to hold down this particular error reset button on the cubing machine control panel could unexpectedly restart the product pusher, while an employee was in the zone of danger, once an error relating to the PHA0 sensor was corrected.

The Division therefore failed to demonstrate that the practice of using the stick to hold down the reset button on the control panel created the alleged hazard. If there no such hazard was created, employees cannot have been exposed to it. Thus, the Division did not prove the violation alleged in Citation 2, Instance 1.

b. Did the Division establish the violation alleged in Citation 2, Instance 2?

In Citation 2, Instance 2, the Division alleged that Employer failed to inspect, identify, and evaluate hazards as follows:

> As a common unsafe condition, the employer failed to identify unguarded entries to the zone of danger.

Citation 2, Instance 2 relates to three openings, identified by Delgado, in the fence surrounding the Dry Side. These openings are described in detail in the discussion regarding Citation 6, in which the Division alleged a failure to adequately guard hazardous moving parts of machinery or equipment. Regarding Citation 2, Instance 2, the Division argues that these openings exposed employees to the hazard of moving machine parts. (Amended Petition, pp. 14-15.)

There is no dispute that these openings existed, and that employees could, and sometimes did, access the Dry Side through these openings. Rather than enter the Dry Side through an interlock gate, the record demonstrates that Montoya climbed over the Patternmaker A conveyor in order to access a gap in the Dry Side fence. (HT Day 1, pp. 87, 91, 94; HT Day 6, pp. 860-862, 917-919, 921; Exhibit C; Exhibit E; Exhibit I.) Becker also testified that he had been "able to circumvent" the interlock gates to enter the Dry Side through these openings. (HT Day 1, p. 58.)

The Board has previously held that the existence of ongoing, unidentified workplace hazards "leads to the reasonable inference that Employer was not engaged in any kind of 'scheduled periodic inspection' program, and had no measures in place for identifying and evaluating hazards." (*Barrett Business Services, Inc*., *supra*, Cal/OSHA App. 12-1204.)[3] However, the mere existence of the fence openings does not necessarily mean that the Division succeeded in its burden of proof.

As the ALJ pointed out, "The Division did not introduce evidence of Employer's actions to identify and evaluate hazards, such as the occurrence of inspections. […] Evidence of Employer's actions would show Employer's conformity to its IIPP." (Decision, p. 16.) The ALJ concluded that without such evidence, "it is not possible to determine if Employer implemented its IIPP." (*Id*.) The ALJ reasoned that Employer may have implemented its IIPP and concluded that the openings did not create a hazard; or, in the alternative, even if the openings did amount to a hazard, such a hazard may have gone unrecognized through even diligent implementation of Employer's IIPP. (*Id*.) Ray testified that his normal duties involved a daily walkthrough of the work site. (HT Day 6, p. 910.) This indicates that Employer did engage in regular inspections to identify safety issues.

[3] "An inference is a deduction about the existence of a fact that may be logically and reasonably be drawn from some other fact or group of facts found to exist." (*Barrett Business Services, Inc*., *supra*, Cal/OSHA App. 12-1204, citing Evidence Code section 600, *Ajaxo Inc. v. E* Trade Group Inc*. (2005) 135 Cal. App. 4th 21, 50, and *International Paper Company*, Cal/OSHA App. 14-1189, Decision After Reconsideration (May 29, 2015).)

The Division therefore failed to establish Citation 2, Instance 2.

We find that the Division did not satisfy its burden of proof, with regard to either alleged Instance, to show that Employer failed to implement its IIPP. We therefore affirm the ALJ's Decision vacating Citation 2.

2. Did the Division establish, by a preponderance of evidence, that Employer failed to effectively train employees on hazardous energy control procedures and hazards related to cleaning, servicing, repairing, setting up, and adjusting machinery and equipment?

Citation 3 alleged a Serious violation of section 3314, subdivision (*l*)(1), which provides:

> Authorized employees shall be trained on hazardous energy control procedures and on the hazards related to performing activities required for cleaning, repairing, servicing, setting-up and adjusting prime movers, machinery and equipment.

The Division alleged:

> Prior to and during the course of the investigation, including, but not limited to, on December 15, 2015, the employer failed to effectively train employees on hazardous energy control procedures for the Tiger Machine (identified by the employer as the Dry Side) and hazards related to performing activities required for cleaning, repairing, servicing, setting-up and adjusting the Tiger Machine.

Section 3314 "applies to the cleaning, repairing, servicing, setting-up and adjusting of machines and equipment in which the unexpected energization or start-up of the machines or equipment, or release of stored energy could cause injury to employees." (§ 3314, subd. (a)(1).) To establish a violation of section 3314, subdivision (*l*)(1), the Division must demonstrate that the employer failed to provide effective training on its hazardous energy control procedures, such as lockout/tagout (LOTO) procedures, and on hazards related to the unexpected energization or release of stored energy while cleaning, servicing, setting up, and adjusting machinery and equipment.

The Division argues that, in this matter, Employer was cited not only for an alleged violation of section 3314, subdivision (*l*)(1), but for an alleged violation of section 3314, subdivision (g)(2)(A), which the ALJ affirmed, and which is not at issue here. Section 3314, subdivision (g)(2)(A), "requires an employer to have a hazardous energy control procedure documented in writing, that includes the separate procedural steps for safe lockout/tagout of each machine or piece of equipment." (*Langer Farms, LLC*, Cal/OSHA App. 13-0231, Decision After Reconsideration (Apr. 24, 2015); *Los Angeles County Internal Services*, Decision After Reconsideration, Cal/OSHA App. 03-4600 (June 20, 2007).) The Division proposes that a

violation of section 3314, subdivision (g)(2)(A), necessarily establishes a violation of subdivision (*l*)(1).

The Division argues, "Employer's training on hazardous energy control is insufficient because Employer's procedures on hazardous energy control did not contain required elements. […] The lack of separate written procedures for each machine implies that an effective hazardous energy control plan is not being implemented." (Amended Petition, p. 15.) The Board could conceivably infer that Employer's training was deficient based on the fact that Employer did not have all necessary procedures in writing as required by section 3314, subdivision (g)(2)(A), but such an inference is not mandatory, nor do we deem it appropriate under these particular facts.

Sections 3314, subdivision (g)(2)(A), requires Employer's hazardous energy control procedure to "include separate procedural steps for the safe lockout/tagout of each machine or piece of equipment affected by the hazardous energy control procedure." Even if we were to assume, *arguendo*, that when sections (g)(2)(A) and section (*l*)(1) are read together and harmonized, it requires Employer to train on each such individual step (a conclusion we need not reach), there is no evidence that Employer's training would have needed to be any different to comply with such a requirement, or that the training necessarily missed any required steps.

Employer presented evidence that employees, including Montoya, had received LOTO training. (Exhibit A.) Ray testified that Montoya was competent, by means of his training, to comply with Employer's LOTO procedures. (HT Day 6, p. 904.) Ray testified that the LOTO procedures were "not specific to, say, the Tiger Machine, but they are specific in their instruction on how to proceed through a safety gate and how to properly lock out a piece of equipment." (HT Day 6, p. 929.)

Becker testified that, in order to perform maintenance such as cleaning a blocked sensor, employees were trained to enter the Dry Side area through an interlock gate, which de-energized all machinery, to place a lock on the gate to ensure it remained open, then exit through the same gate, remove the lock, and restart the machinery from the main control panel. (HT Day 1, pp. 40-41, 54, 55.) Becker testified that this procedure was the same for entering the Dry Side to access all Dry Side equipment and machinery. (HT Day 1, pp. 38-39, 40, 41.) Becker further testified that all employees were both trained and tested on Employer's written LOTO procedures. (HT Day 1, pp. 71.) Becker's testimony was supported by that of Ruben Alamilla (Alamilla), employed as a machine operator by Employer, and appearing as a witness for the Division. Alamilla described the same LOTO procedure. (HT Day 1, pp. 120-121, 123.) Alamilla testified that employees received training on Employer's hazardous energy control procedures, including written material detailing Employer's LOTO procedures, and that these procedures were the same for all machinery. (HT Day 1, pp. 139-140, 142-143.) Alamilla testified that employees were tested on the material, and that this training occurred "way earlier than," and, "way before what […] happened to [Montoya]." (HT Day 1, pp. 139, 142.)

There is simply no evidence that this training was defective, nor that it did not encompass each separate procedural step for the safe lockout/tagout of each machine. Notwithstanding that there are different machines in the Dry Side, it may well be the steps for each machine are identical. We decline to make assumptions on points within the Division's burden of proof.

Further, the accident itself does not demonstrate that Employer's training was deficient. Montoya's fatal injury occurred as a result of his deliberate evasion of Employer's hazardous energy control procedures, on which he had been trained, not as a result of any deficiency in the training. Montoya did not engage in any effort to de-energize the Dry Side when he entered it by climbing over Patternmaker A, rather than using an interlock gate.

Finally, even if we were to assume that Employer's training needed additional steps, there is no evidence that Montoya was exposed to any hazard as a result of their absence. All evidence indicates that had Montoya simply complied with the well-established training, it would have eliminated any hazard by de-energizing all machines.

Employer presented training records and employee testimony to demonstrate that training on hazardous energy control procedures occurred. The testimony from Ray, Alamilla, and Becker indicated that the training was sufficient to enable employees to recognize, understand, and avoid the hazards of energized equipment in the Dry Side, notwithstanding Montoya's failure to comply with Employer's LOTO and hazardous energy control procedures.

We find the Division failed to meet its burden of proof to establish that Employer's training on hazardous energy control procedures and related hazards was insufficient. We therefore affirm the ALJ's Decision vacating Citation 3.

3. Did Employer meet all five IEAD elements to relieve it of responsibility for a violation of section 3314, subdivision (c)?

Citation 4 alleged a Serious, Accident-Related violation of section 3314, subdivision (c), which provides:

> Machinery or equipment capable of movement shall be stopped and the power source de-energized or disengaged, and, if necessary, the moveable parts shall be mechanically blocked or locked out to prevent inadvertent movement, or release of stored energy during cleaning, servicing and adjusting operations. Accident prevention signs or tags or both shall be placed on the controls of the power source of the machinery or equipment.

The Division alleged:

> Prior to and during the course of the investigation, including, but not limited to, on December 15, 2015, the employer failed to stop and de-energize or disengage the power source and block out the

> moveable mechanical part of the Tiger Machine (identified by the employer as the Dry Side) to prevent inadvertent movement, or release of stored energy during cleaning, servicing and adjusting operations at the workplace. As a result, at or about 2:11 pm on December 15, 2015, an employee sustained a fatal injury when caught between the product pusher of the center conveyor of the Tiger Machine and a steel structural member of the machine.

The ALJ found the Division met its burden of proof to establish the violation, but further found that Employer proved all five elements of the IEAD, relieving it of responsibility for the violation. An employer must establish all five elements of this affirmative defense in order to satisfy the requirements of the IEAD. These elements are:

1) The employee was experienced in the job being performed.
2) The employer has a well-devised safety program that includes training in matters of safety respective to their job assignments.
3) The employer effectively enforces the safety program.
4) The employer has a policy of sanctions which it enforces against those employees who violate its safety program.
5) The employee caused a safety infraction which he knew was contra to the employer's safety requirements.

(*Timberworks Construction, Inc*., Cal/OSHA App. 1097751, Decision After Reconsideration (Mar. 12, 2019).)

The Division disputes that Employer established any of these five elements, and thus argues that Employer did not satisfy the IEAD.

We find that Employer failed to prove the second element, which requires evidence that the employer had a well-devised safety program. Even assuming for the sake of argument that Employer satisfied the remaining four of the five IEAD requirements, it failed to prove all five, and the defense fails. (*Mercury Service, Inc.*, Cal/OSHA App. 77-1133, Decision After Reconsideration (Oct. 16, 1980).)

The second element of the IEAD requires the employer to demonstrate it has a well-devised safety program, which includes training employees in matters of safety respective to their particular job assignments. (*FedEx Freight, Inc*., Cal/OSHA App. 12-0144, Decision After Reconsideration (Dec. 14, 2016).) The Board has held that this element should be analyzed by taking a realistic view of the employer's written program and policies, as well as the actual practices at the workplace. (*Glass Pak*, Cal/OSHA App. 03-750, Decision After Reconsideration (Nov. 4, 2010).)

As discussed with respect to Citation 3, Employer presented evidence that all employees received training on LOTO and hazardous energy control procedures, and were tested on those

procedures. (Exhibit A; HT Day 1, pp. 39-40, 41, 54-55, 71, 120-121, 123, 124-125, 139-140, 142-143.) However, Employer did not have specific written LOTO procedures for each separate machine. The IEAD is premised upon an employer's compliance with its non-delegable statutory and regulatory responsibilities for ensuring safety in the workplace. (*Dade Behring, Inc*., Cal/OSHA App. 05-2203, Decision After Reconsideration (Dec. 30, 2008).) The Board has therefore held that a lack of machine-specific LOTO and hazardous energy control procedures defeats this element of the IEAD, when it is asserted as a defense to section 3314, subdivision (c). (*Blue Diamond Growers*, Cal/OSHA App. 10-1281, Denial of Petition for Reconsideration (Oct. 17, 2012); *Dade Behring, Inc*., *supra*, Cal/OSHA App. 05-2203.) The Board has reasoned that an employer's failure to comply with the legal requirement to develop machine-specific hazardous energy control procedures is a "material deficiency" in an employer's safety program. (*Dade Behring, Inc*., *supra*, Cal/OSHA App. 05-2203.) As such, Employer cannot establish the second IEAD element.

The IEAD therefore fails. Citation 4 is upheld.

4. Did the Division establish, by a preponderance of evidence, that Employer failed to maintain machinery and equipment in service as recommended by the manufacturer?

Citation 5 alleged a Serious, Accident-Related violation of section 3328, subdivision (b), which provides:

> Machinery and equipment in service shall be inspected and maintained as recommended by the manufacturer where such recommendations are available.

The Division alleged:

> Prior to and during the course of the investigation, including, but not limited to, on December 15, 2015, the Employer failed to maintain in service the equipment of the Tiger Machine (identified by the employer as the Dry Side) as recommended by the available manufacturers' (Tiger Machine Co. LTD) recommendations (Operation & Service Manual . . .)
>
> Instance 1: The employer modified the equipment by the use of a piece of lumber/wood which the employer positioned against the cuber controller to physically hold/push and bypass the reset button.
>
> Instance 2: The employer failed to ensure that the circuit breaker serving the Tiger machine dry side was not locked out in the off position while an employee was working.
>
> Instance 3: The guard did not prevent an employee from entering the zone of danger.

> As a result, at or about 2:11 pm on December 15, 2015 an employee sustained a fatal injury when the employee was caught between the product pusher and a steel structural member when the employee entered the unguarded zone of danger that was not locked out.

Section 3328, subdivision (b), requires employers to follow manufacturers' inspection and maintenance recommendations for equipment and machinery. (*Lee Way Motor Freight, Inc*., Cal/OSHA App. 82-067, Decision After Reconsideration (Jan. 17, 1986).) As the Division's Alleged Violation Description in Citation 5 refers only to maintenance, the only issue here is whether the Division's evidence established that Employer failed to maintain the Dry Side Tiger Machine in compliance with the manufacturer's available recommendations.

To establish an alleged violation, the Division must first prove the applicability of the cited safety order to the facts of the case. (*Dish Network California Service Corporation*, Cal/OSHA App. 12-0455, Decision After Reconsideration (Aug. 28, 2014); *C.A. Rasmussen*, Cal/OSHA App. 95-943, Decision After Reconsideration (Aug. 26, 1997).) The Division must also demonstrate that the employer's actions or omissions violated the manufacturer's actual maintenance recommendations, which were available to the employer. (*Spaich Brothers, Inc., dba California Prune Packing Co*., Cal/OSHA App. 01-1630, Decision After Reconsideration (Feb 25, 2005) (*Spaich Brothers*); *Baldwin Contracting Company, Inc.*, Cal/OSHA App. 97-2648, Decision After Reconsideration (Dec. 17, 2001).) Here, the Division failed to meet its burden of proof regarding either of these elements.

First, the Board has held that section 3328, subdivision (b), applies only to a manufacturer's recommendations for the maintenance and inspection, not the operation, of machinery. In *S&S Services*, Cal/OSHA App. 08-2132, Denial of Petition for Reconsideration (Sep. 9, 2010), the Board explained, "Since 'operated' is used in the previous paragraph, section 3328(a), it is not appropriate to read 'operated' into section 3328(b). And, the Board may not read terms into or out of a Safety Order." To "maintain" means "to keep in an existing state (as of repair, efficiency, or validity); preserve from failure or decline,"[4] or, "to keep in an appropriate condition, operation, or force."[5] To "operate" means "to perform a function,"[6] or, "to work, perform, or function."[7] (See also *S&S Services*, *supra*, Cal/OSHA App. 08-2132.) The Division failed to demonstrate that any of the alleged Instances related to the maintenance of the Dry Side machinery, rather than its operation.

Regarding Instance 1, Delgado testified, "The manufacturer's recommendation warns, advises against," any "alteration" of the machinery. (HT Day 3, p. 396; HT Day 4, p. 642.) When directly questioned on this topic by the ALJ, Delgado testified that, in his opinion, the stick on the control panel pertained to "maintenance" because the use of the stick amounted to an "alteration"

[4] https://www.merriam-webster.com/dictionary/maintain
[5] https://www.dictionary.com/browse/maintain
[6] https://www.merriam-webster.com/dictionary/operate
[7] https://www.dictionary.com/browse/operate

of the cuber system's control panel, meaning a failure to "maintain" the control panel in its original condition. (HT Day 4, p. 642.) This argument is tenuous at best. The more reasonable view is that using a wooden stick to hold down the reset button affected the operation of the panel and the cube clamp, rather than the maintenance of either. The evidence indicates that the stick allowed the cube clamp to continue operating, by bypassing an error message that caused it to frequently stop moving. In that sense, the stick directly related to the machine's operation.

Moreover, there is no indication that using an object to hold down a button "altered" or "modified" the control panel, any more than an employee pressing the same button with a finger would. The stick did not change the basic purpose or function of the button or the panel. As discussed with regard to Citation 2, Instance 1, multiple witnesses testified that the cube clamp frequently generated an error message, which caused its operation to stop and/or an alarm to sound. (HT Day 1, pp. 77, 84; HT Day 6, pp. 944-945, 973, 974.) The stick was used only to prevent the need for workers to continually go to the control panel, press the error reset button, and re-start the cube clamp. (HT Day 1, p. 77.) This was not a permanent modification or alteration of the control panel in the way that, for example, re-wiring it would be. Any "modification" could be undone simply by removing the stick. The Division therefore failed to demonstrate the applicability of the safety order to Instance 1.

Regarding Instance 2, Delgado observed the circuit breaker servicing the Dry Side in the "on" position following the accident, indicating that the machinery had not been locked out. (HT Day 3, p. 398.) Delgado testified, "the manufacturer states that […] the circuit breaker should be locked out in the off position when employees are working." (HT Day 4, pp. 642-643.) However, LOTO and hazardous energy control procedures pertain to the operation of machinery, by shutting down the machinery under prescribed circumstances. The Division presented no evidence indicating how, in this situation, the circuit breaker in the "on" position related to maintenance of the Dry Side. Nor did the Division present evidence that the circuit breaker was defective, malfunctioning, or otherwise improperly maintained. The Division therefore failed to demonstrate the applicability of the safety order to Instance 2.

Regarding Instance 3, Delgado testified, "[P]er the manufacturer's recommendation, it states that all guards have to be in place. In this case, there was no guard there." (HT Day 3, p. 398.) Delgado further stated, "The manufacturer, again, states all guards shall be in place, and this equipment should not be operated without the guards being in place." (HT Day 4, p. 643.) As Delgado acknowledged, the purpose of guarding is to prevent employees from coming into contact with moving (that is, operating) machine parts. Guarding, under these circumstances, relates to operation, rather than maintenance. In addition, although Delgado testified that the recommendations required all guards to be "in place," the Division presented no evidence that any part of the fence around the Dry Side was defective, missing, or damaged, so as to amount to a failure of maintenance. (HT Day 5, pp. 773-774.) The Division therefore failed to demonstrate the applicability of the safety order to Instance 3.

As the Division failed to demonstrate that any of the three cited Instances related to the maintenance of the Dry Side, Citation 5 was properly vacated. However, the ALJ vacated this citation for another, equally correct reason. The Board has held, in order to establish a violation of section 3328, subdivision (b), the Division must present evidence of what the manufacturer's available maintenance recommendations actually were. (*S&S Services*, *supra*, Cal/OSHA App. 08-2132; *Spaich Brothers*, *supra*, Cal/OSHA App. 01-1630.) It stands to reason that if the Division does not prove what the recommendations were, it cannot establish that Employer failed to follow those recommendations. The Board has reasoned that in drafting this regulation, the Standards Board "intended that the manufacturer's recommendations should be followed because the manufacturer should be most knowledgeable about the hazards associated with the use of its product." (*Sequel Contractors, Inc*., Cal/OSHA App. 99-1055, Decision After Reconsideration (Aug. 29, 2001).) The manufacturer's recommendations need not be in writing, so long as they were "available" to the employer; that is, the employer was, or should have been, aware of the recommendations. (*Baldwin Contracting Company, Inc.*, *supra*, Cal/OSHA App. 97-2648, footnote 2.)

Here, the Division introduced photographs of, and testimony from Becker and Delgado describing, the alleged violative conditions. The Division did not introduce the text of the manufacturer's recommendations for maintenance of the Dry Side Tiger Machine. Instead, Delgado testified that he had requested, and received, the "Tiger Machine manual" from Employer. (HT Day 2, p. 278.) Delgado then testified as to his recollection and interpretation of the contents of this manual, referring to the information and instructions therein as "manufacturer's recommendations." (HT Day 3, p. 395; HT Day 4, p. 643.)[8] Delgado also testified that he and Salgado met with representatives of the Tiger Machine's manufacturer, as part of the Division's investigation. The Division asserts that statements from these representatives "equate[] to a recommendation from the manufacturer." (Amended Petition, p. 19, citing *Baldwin Contracting Company, Inc.*, *supra*, Cal/OSHA App. 97-2648.) The Division's Amended Petition appears to suggest that Delgado's testimony, describing his recollections of this conversation and the manufacturer's manual, is sufficient to establish all three Instances alleged in Citation 5, without any need to introduce the manufacturer's actual recommendations. We disagree.

Section 412 of the Evidence Code provides, "If weaker and less satisfactory evidence is offered when it was within the power of the party to produce stronger and more satisfactory evidence, the evidence offered should be viewed with distrust." Here, the stronger and more satisfactory evidence would have been the Dry Side Tiger Machine manual itself. The Division offered no explanation for not presenting the actual manual containing the manufacturer's

[8] This matter is distinguishable from *Guy F. Atkinson Construction, LLC*, Cal/OSHA App.1332867, Decision After Reconsideration (Jul. 1, 2022) (*Atkinson*). In *Atkinson*, although the Division failed to move the Operator's Manual for a forklift into evidence, sections of the manual were displayed on the Zoom screen, and the Division read from the manual verbatim, without any contemporaneous objection.

maintenance recommendations, although it could have done so. Delgado's testimony describing the contents of the manual is insufficient to prove what the manufacturer's maintenance recommendations for the Dry Side machinery actually were.

Moreover, even if statements by the Tiger Machine Company representatives did amount to manufacturer's recommendations, the Division failed to demonstrate that these recommendations were "available to" Employer before the accident. In *Baldwin Contracting*, by contrast, the manufacturer of a "mobile plant" for manufacturing paving material "sent technicians to set-up and demonstrate the operation of the plant, including procedures for shutting it down and cleaning it at the end of the day." (*Baldwin Contracting*, *supra*, Cal/OSHA App. 97-2648.) The Board concluded that the manufacturer's "demonstration equate[d] to a recommendation under the meaning of section 3328(b)," and that "Employer was aware of the recommended procedure." (*Id*.) Here, the Division presented no evidence that these statements were part of any previous demonstration, instruction, or training provided by the Tiger Machine Company, which was "available to" Employer.

With regard to each Instance, the ALJ therefore concluded, "Delgado's generalized testimony is not sufficient to establish what the alleged recommendation is and its significance." (Decision, pp. 22, 23.) The ALJ reasoned, "[I]t is critical to know the exact wording of a recommendation and the context in which it appears. Textual variations and lack of context can be misleading." (*Id*. at p. 22.) We agree with the ALJ that without the Tiger Machine manual itself, there is no way to determine whether Employer failed to follow the manufacturer's recommendations.

The Division did not meet its burden of proof to establish that Employer failed to maintain machinery and equipment as recommended by the manufacturer. We therefore affirm the ALJ's Decision vacating Citation 5.

5. Did the Division establish, by a preponderance of evidence, that Employer failed to guard hazardous moving parts of machinery or equipment?

Citation 6 alleged a Serious, Accident-Related violation of section 4002, subdivision (a), which provides:

> All machines, parts of machines, or component parts of machines which create hazardous revolving, reciprocating, running, shearing, punching, pressing, squeezing, drawing, cutting, rolling, mixing or similar action, including pinch points and shear points, not guarded by the frame of the machine(s) or by location, shall be guarded.

The Division alleged:

> Prior to and during the course of the investigation, including, but not limited to, on December 15, 2015, the employer failed to adequately

> guard (fully enclose) all parts of the Tiger Machine (identified by the employer as the Dry Side) which create a hazardous action including but not limited to reciprocating, running, or similar action(s). As a result, at or about 2:11 pm on December 15, 2015, an employee sustained a fatal injury after entering the zone of danger and was caught between the product pusher of the center conveyor of the Tiger Machine and a steel structural member.

Section 4002, subdivision (a), addresses the hazard of injury to employees who come into accidental contact with moving parts of machinery. (*A. Teichert & Son, Inc. dba Teichert Aggregates*, Cal/OSHA App. 04-850, Decision After Reconsideration (Oct. 6, 2011).) To establish a violation, the Division must demonstrate that the employer failed to guard moving machine parts, and as a result, employees were exposed to accidental contact with hazardous revolving, squeezing, cutting, rolling, mixing, or similar actions. (*Arriaga USA, Inc., dba Stoneland USA*, Cal/OSHA App. 1279492, Decision After Reconsideration (Dec. 7, 2021).)

Section 3941 provides definitions relevant to this safety order. "Guarded" is defined in section 3941 as: "Shielded, fenced, enclosed or otherwise protected according to these orders, by means of suitable, enclosure guards, covers or casing guards, trough or 'U' guards, standard railings or by the nature of the location where permitted in these orders, *so as to remove the hazard of accidental contact*." (Emphasis added.) "Accidental contact," in turn, is defined in section 3941 as: "Inadvertent physical contact with ... machines or machine parts which could result from slipping, falling, sliding, tripping or any other unplanned action or movement." The purpose of a guard is therefore to prevent inadvertent or unplanned contact with hazardous moving machine parts. (*Pacific Westline, Inc.*, Cal/OSHA App.10-0278, Denial of Petition for Reconsideration (Dec. 20, 2010); *Architectural Glass & Aluminum Co., Inc.,* Cal/OSHA App. 01-5031, Decision After Reconsideration (Mar. 22, 2004); *Nursery Supplies, Inc.,* Cal/OSHA App. 99-2731, Decision After Reconsideration (Aug. 2, 2002).)

Delgado identified three openings in the Dry Side fence, which, the Division argues, exposed employees to "'accidental contact' with hazardous actions of the dry side [sic] of the Tiger Machine." (Amended Petition, p. 20.) These are the same openings discussed with regard to Citation 2, Instance 2, and Citation 5, Instance 3. The Division's Amended Petition asserts that Delgado observed these openings, and that Montoya accessed one of the openings. (*Id*., p. 19.) The Division offers no additional evidence or argument that the openings created, or exposed employees to, the alleged hazard.

a. Did the Division demonstrate that Opening 1 exposed employees to the hazard of accidental contact with the Dry Side machinery?

The Division identified Opening 1 as a gap in the Dry Side fence through which Patternmaker A travelled into fenced area. (HT Day 4, p. 637; Exhibit I; Exhibit 12-109; Exhibit

12-110.) There is no dispute that this was the opening through which Montoya accessed the Dry Side.

The record indicates that Montoya climbed onto and walked along Patternmaker A to get through the Dry Side fencing. That he did this was evidenced by a footprint, which matched Montoya's work boots, and no other employee's work boots, on the Patternmaker A conveyor. (HT Day 1, pp. 87, 91, 94; HT Day 6, pp. 860-862, 917-919, 921; Exhibit C; Exhibit E; Exhibit I.) In addition, the record indicates that the Dry Side machinery remained energized while Montoya attempted to clean the PHA0 sensor; had Montoya entered through an interlock gate, the machinery would have been de-energized. (See, e.g., HT Day 1, p. 95; HT Day 6, pp. 868, 895-896, 908.)

The Patternmaker A conveyor was approximately three feet, two inches high, and was guarded underneath. (HT Day 4, pp. 663, 665; HT Day 6, p. 866; Exhibit 12-108.) There was a gap of only a few inches between the side of the conveyor and the fence, too small for a person to pass through. (HT Day 6, p. 862; Exhibit I; Exhibit 12-109; Exhibit 12-110.) Ray testified that the conveyor formed a physical barrier to entering the fenced area. (HT Day 6, pp. 862, 865-866, 878.) In order to access the zone of danger surrounding the product pusher, once he was through the fence, the record indicates that Montoya climbed down from the conveyor and then walked an additional four to five feet to the location of the PHA0 sensor, where he was found after the accident. (HT Day 3, pp. 369-370; HT Day 6, pp 864-865; Exhibit I.)

The Division's evidence of the opening's mere existence is insufficient to demonstrate that Opening 1 exposed employees to accidental contact with the Dry Side machinery. The ALJ found that the junction where Patternmaker A entered the Dry Side fence created a barrier sufficient to prevent a person from accidentally passing through the fence opening. Indeed, Montoya had to deliberately climb onto and over Patternmaker A, and then walk four to five feet once inside the Dry Side, to reach the sensor he intended to clean. The ALJ therefore concluded, "It is not realistic that an employee could slip, fall, slide, trip, or [make] any other unplanned action or movement onto the conveyor, along it for several feet, down to the ground on the other side of the fence, and several more feet to the product pusher." (Decision, p. 24.) We agree, and find the Division failed in its burden of proof to establish that Opening 1 exposed employees to the hazard of accidental contact with the Dry Side machinery.

b. Did the Division demonstrate that Opening 2 exposed employees to the hazard of accidental contact with the Dry Side machinery?

The Division identified Opening 2 as the point where the Patternmaker B conveyor entered the fenced area. (HT Day 4, p. 637.) Patternmaker B was located on the opposite side of the centerline conveyor from Patternmaker A, and was configured in much the same way as the Patternmaker A conveyor. Like Patternmaker A, Patternmaker B was guarded underneath (Exhibit 12-112), and there were only a few inches of space between the conveyor and the fence. (Exhibit 12-113.)

For the same reasons as with Opening 1, the Division's evidence of the opening's mere existence is insufficient to demonstrate that Opening 2 exposed employees to accidental contact with the Dry Side machinery. As with Opening 1, the ALJ concluded, "It is not realistic that an employee could slip, fall, slide, trip, or [make] any other unplanned action or movement over the conveyor and through the fence opening to the hazardous action of the product pusher." (Decision, p. 25.) The ALJ further noted, "The Division did not indicate how an employee could pass through this opening other than climbing onto the conveyor and walking along the conveyor to the other side of the fence." (*Id*.) We agree, and find the Division failed in its burden of proof to establish that Opening 2 exposed employees to the hazard of accidental contact with the Dry Side machinery.

c. Did the Division demonstrate that Opening 3 exposed employees to the hazard of accidental contact with the Dry Side machinery?

The Division identified Opening 3 as a gap in the fence on the right side of the cubing machine's control panel. (HT Day 4, p. 637.) The Division's photographs show that this opening is approximately 21 inches wide. (Exhibit 12-138.)

To reach this fence opening, however, an employee would first have to pass through a nine-inch space between the front right corner of the controller and the fence. (Exhibit 12-137.) Exhibits 12-139 and 12-140 depict Delgado accessing this narrow gap; he appears to barely fit through it. Ray testified that, after passing through the nine-inch space between the control panel and the fence, then through the 21-inch fence opening, an employee would next have to walk around, or climb over, a side feed conveyor, before reaching the area near the product pusher. (HT Day 6, pp. 878-880, 884-885.) This conveyor is visible in the Division's photographs of Opening 3. (Exhibits 12-137, 12-138, 12-139, 12-140.)

The Division's evidence of the opening's mere existence is insufficient to demonstrate that Opening 3 exposed employees to accidental contact with the Dry Side machinery. The ALJ noted that Delgado was able to access and enter Opening 3, in order to take the aforementioned photos and measurements, but that his actions were deliberate, not accidental. (Decision, p. 25.) The ALJ concluded, "It is not realistic that an employee could slip, fall, slide, trip, or [make] any other unplanned action or movement through a 9-inch opening, then through a 21-inch opening, and then around a conveyor in order to reach the hazardous action of the product pusher." (*Id*.) We agree, and find the Division failed in its burden of proof to establish that Opening 3 exposed employees to the hazard of accidental contact with the Dry Side machinery.

With regard to all three openings, the ALJ determined, "The Division did not address how these openings could lead to accidental contact with the hazardous actions of the Dry Side." (Decision, p. 25.) Rather than pointing to any such evidence in the record, the Division's Amended Petition asserts, "The Tiger Machine could have been guarded by putting more fences inside the danger zone area to prevent employees from accessing the zone of danger, giving the employee the greatest opportunity to be protected." (Amended Petition, pp. 19-20.)

This may be the case. However, "[T]he law does not require perfection of a party, but rather good faith and diligence in the pursuit of his or her actions." (*Security Paving, Inc*., Cal/OSHA App. 13-0771, Denial of Petition for Reconsideration (Dec. 31, 2014) citing *Arthur J. Brewster Corp dba Prestige Kitchens, Inc*., Cal/OSHA App. 08-1121, Denial of Petition for Reconsideration (Jul. 25, 2008); accord Civ. Code § 3531 [law does not require impossibilities].) The evidence demonstrates that Employer exercised reasonable diligence to guard the area around the Dry Side, in order to prevent employees from coming into accidental contact with moving machinery.

The evidence also demonstrates that entering the zone of danger around the product pusher, without de-energizing the machinery, required deliberate and intentional action, and could not occur by accident. Montoya, more likely than not, did not intend to come into contact with the product pusher. In that sense, his fatal contact with the product pusher could be considered accidental or inadvertent. Nonetheless, Montoya deliberately circumvented both Employer's physical guards and hazardous energy controls in order to access the zone of danger.

The safety order applies specifically to accidental contact with moving machine parts. The Division's evidence did not establish that an employee could access the zone of danger through any accidental or inadvertent means. We therefore affirm the ALJ's Decision vacating Citation 6.

DECISION

For the reasons stated, the Board affirms in part and reverses in part the Decision of the ALJ as follows: Citation 2, alleging a Serious violation of section 3203, subdivision (a)(4)(A), is vacated; Citation 3, alleging a Serious violation of section 3314, subdivision (*l*)(1), is vacated; Citation 4, alleging a Serious, Accident-Related violation of section 3314, subdivision (c), is upheld, and the penalty of $18,000 sustained; Citation 5, alleging a Serious, Accident-Related violation of section 3328, subdivision (b), is vacated; Citation 6, alleging a Serious, Accident-Related violation of section 4002, subdivision (a), is vacated.

OCCUPATIONAL SAFETY AND HEALTH APPEALS BOARD

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

FILED ON: 04/25/2024