BEFORE THE
STATE OF CALIFORNIA
OCCUPATIONAL SAFETY AND HEALTH
APPEALS BOARD

In the Matter of the Appeal of: **BIGGE CRANE & RIGGING, CO.** **10700 Bigge Ave.** **San Leandro, CA 94577** **Employer**	Inspection No. 1380273 **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

Bigge Crane & Rigging, Co. (Employer, or Bigge) provides cranes, personnel lift equipment, and operational personnel to contractors for use on construction sites. On February 14, 2019, the Division of Occupational Safety and Health (the Division), through Assistant Safety Engineer Barney Brenes (Brenes), commenced an accident investigation at 101 Oyster Point Boulevard[1], South San Francisco, California, 94080 (job site), after a report of an injury at the site on February 11, 2019. The job site was a multi-employer worksite. Employer was a subcontractor at the site, and provided equipment and labor to the general contractor. An employee of Employer struck an employee of another subcontractor with a construction personnel hoist (CPH), seriously injuring that employee.

On August 9, 2019, the Division issued one Citation to Employer, alleging a Serious, Accident-Related violation of California Code of Regulations, title 8,[2] section 1509, subdivision (a), referencing section 3203, subdivisions (a)(4) and (a)(6) [failure to identify, evaluate, and correct workplace hazards associated with operating the CPH]. Employer timely appealed the citation.

This matter was heard by Kerry Lewis, Administrative Law Judge (ALJ) for the Board, on August 3, 2022. ALJ Lewis conducted the hearing from Sacramento, California, with the parties and witnesses appearing remotely via the Zoom video platform. Fred Walter, attorney at Conn Maciel Carey, LLP, represented Employer. Quoc-Anh Mitchell Dao, staff counsel, represented the Division.

[1] The citation and Division's documents refer to "181" Oyster Point Boulevard, but the parties stipulated that the address was "101." The contracts between Employer and the general contractor, Hathaway Dinwiddie, reference "101" Oyster Point Boulevard.
[2] Unless otherwise specified, all references are to sections of California Code of Regulations, title 8.

On November 2, 2022, the ALJ issued a Decision upholding Citation 1, its Serious, Accident-Related classification, and the proposed penalties. The ALJ also concluded that Employer was citable as the creating employer (i.e., the employer that created the cited hazard) on the multi-employer worksite under section 336.10, subdivision (b); and that Employer's role as primary employer in the dual employment situation did not relieve Employer of responsibility for the violation.

Employer filed a timely Petition for Reconsideration (Petition). On January 9, 2023, the Division filed a response opposing the Petition.[3]

Employer's Petition disputes each of the ALJ's abovementioned findings, along with several findings of fact. Employer argues that it maintained an effective IIPP, including procedures to identify and correct hazards, and that the Citation was misclassified as Serious.[4] Employer argues it was not the creating employer; rather, the creating employer was the sub-contractor whose employee was injured by the actions of Employer's employee. Employer argues that it satisfied its safety obligations as primary employer, by maintaining an effective IIPP, providing its employees with appropriate training, and adequately supervising the job site. Issues not raised in Employer's Petition are deemed waived. (Lab. Code, § 6618.) Each of these arguments is detailed below.

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 that Employer, through its employee, failed to effectively identify, evaluate, and correct workplace hazards associated with operating a CPH?
2. Was Employer a "creating employer" pursuant to section 336.10?
3. Did Employer, as the primary employer of a leased employee, satisfy its safety responsibilities at the job site?
4. Was the Citation properly classified as Serious?

FINDINGS OF FACT

1. On February 11, 2019, Ryan Sanders (Sanders), employed as a foreman for California Drywall, suffered a serious injury while spraying fireproofing material on the exterior of a commercial building under construction.
2. Bigge (the cited Employer) and California Drywall were subcontractors of the general contractor, Hathaway Dinwiddie (Hathaway).

---

[3] The Board took the Petition under submission on January 10, 2023. The Division's Answer preliminarily argues that Employer failed to serve the Petition on the Division. The Petition includes a Certificate of Service declaring that the Petition was served on the Division by email on December 5, 2023. The Division disputed that it received this email. Employer then filed a motion, on January 11, 2023, requesting that the Board find the Petition was timely served. On February 10, 2023, the Division filed a notice of non-opposition to Employer's motion, having examined its internal records and determined that Employer made a good-faith effort to timely serve the Petition on all parties.

[4] Employer does not dispute the Accident-Related characterization, waiving the issue. (Lab. Code, § 6618.)

3. Employer leased to Hathaway a construction personnel hoist (CPH) and an employee, Daniel Avilan, to operate the CPH.

4. Avilan's job as hoist operator for Employer required him to conduct a daily safety inspection of the CPH, and to transport workers and equipment between floors at the job site.

5. Workers who needed to travel to another floor verbally contacted Avilan through a radio call box, one located on each floor and one in the CPH, to summon him to their location.

6. The CPH moved up and down on a vertical track (the hoistway), on the outside of the building, and the hoistway was clearly visible from the walkway up to the CPH door.

7. On February 11, 2019, Avilan entered the CPH shortly after 6:00 a.m. and promptly moved the CPH toward the upper floors, without having looked upward prior to entering, or otherwise inspected the hoistway for obstructions.

8. At the time of the accident, Sanders was standing on a scissor lift, which was extended into the hoistway so that Sanders could access the exterior wall of the building

9. The CPH struck the scissor lift upon which Sanders was standing and crushed Sanders between the CPH and the structure of the building.

10. Avilan would have seen that the hoistway was obstructed if he had looked up before entering and moving the CPH.

11. Avilan's routine practice at the beginning of his shift was to take the CPH directly to the top of the building without inspecting the path of travel prior to ascending.

12. Employer did not identify that Avilan's regular practice of taking the CPH to the top floor to conduct his daily inspection was contrary to Employer's expectations, or violated any safety rules.

13. Avilan was not a supervisor or manager.

14. Employer has a comprehensive written Injury and Illness Prevention Program.

15. Employer's safety program sets forth the expectation that its employees are expected to assist in the identification of hazards while they are working.

16. The accident on February 11, 2019, would not have occurred if Avilan had identified the hazard of an employee and scissor lift in the hoistway, and ensured that the hazard was mitigated before ascending to the upper floors with the CPH.

DISCUSSION

1. Did the Division establish that Employer, through its employee, failed to effectively identify, evaluate, and correct workplace hazards associated with operating a CPH?

Section 1509, subdivision (a), which is applicable specifically to the construction industry, provides, "Every employer shall establish, implement and maintain an effective Injury and Illness Prevention Program in accordance with section 3203 of the General Industry Safety Orders." Section 3203 requires employers to establish, maintain, and implement an effective IIPP meeting minimum requirements as set forth in the regulation. Citation 1 referenced two subdivisions of section 3203, subdivision (a), which provides, in relevant part:

> (a) Effective July 1, 1991, every employer shall establish, implement and maintain an effective Injury and Illness Prevention Program (Program). The Program shall be in writing and, shall, at a minimum:
>
> (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;[…]
>
> (B) Whenever new substances, processes, procedures, or equipment are introduced to the workplace that represent a new occupational safety and health hazard; and
>
> (C) Whenever the employer is made aware of a new or previously unrecognized hazard.
>
> […]
>
> (6) Include methods and/or procedures for correcting unsafe or unhealthy conditions, work practices and work procedures in a timely manner based on the severity of the hazard:
>
> (A) When observed or discovered [.]

The Division's Alleged Violation Description stated:

> Prior to and during the course of the inspection, including but not limited to February 11, 2019, the employer failed to implement an effective Injury and Illness Prevention Program in the following instance:
>
> The employer failed to identify, evaluate, and correct workplace hazards associated with operating a construction personnel hoist when there are open areas above the required hoistway enclosures where persons, parts, and/or equipment may extend out into the pathway of the hoist [T8CCR 3203(a)(4) and (a)(6)].

> As a result, an employee (the scissor lift operator) of California Drywall Co. was seriously injured when the construction personnel hoist operated by an employee of Bigge Crane and Rigging Company struck the bottom of the scissor lift platform extension when it was placed beyond the safety screen/gate thereby pinning the employee between the handrail of the scissor lift and a structural Ibeam above. [Sic.]
>
> This citation is being issued in accordance with section 336.10 Multi-employer Worksites.

Even where an employer maintains a comprehensive written IIPP, the Division may still establish a violation by demonstrating the employer failed to effectively implement it, as was the case here. (*OC Communications, Inc*., Cal/OSHA App. 14-0120, Decision After Reconsideration (Mar. 28, 2016); *Contra Costa Electric, Inc*., Cal/OSHA App. 09-3271, Decision After Reconsideration (May 13, 2014).) Proof of implementation requires evidence of actual responses to known or reported hazards. (*National Distribution Center, LP / Tri-State Staffing*, Cal/OSHA App. 12-0391, Decision After Reconsideration (Oct. 5, 2015) (*NDC / Tri-State*).)

Although Employer's IIPP does not include specific written procedures for CPH operations, this does not render the IIPP insufficient. (*Brunton Enterprises, Inc*., Cal/OSHA App, 08-3445, Decision After Reconsideration (Oct. 11, 2013).) While Employer takes primary responsibility, throughout the IIPP, for inspecting, identifying, and correcting hazards, the IIPP also contains a number of provisions which require non-supervisory employees to reasonably participate in implementing the safety program. For example, it provides, "Each day, before you begin work, inspect the area for any dangerous conditions." (Exhibit 7.) Employees are further directed to "Know and obey safe work practice rules," and to "constantly be aware of conditions in all work areas that can produce or lead to injuries." (*Id*.) The ALJ concluded, and we agree, that Employer did have a comprehensive written IIPP, but failed to ensure that procedures for inspecting, identifying, evaluating, and correcting hazards were effectively implemented.

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 new workplace hazards. (*Barrett Business Services, Inc*., Cal/OSHA App. 12-1204, Decision After Reconsideration (Dec. 14, 2016).) Here, the new hazard was the scissor lift extending into the path of the CPH.

To establish a violation of section 3203, subdivision (a)(6), based on a failure of implementation, the Division must demonstrate that Employer failed to correct a hazard when it is "observed or discovered." (§ 3203, subd. (a)(6)(A); *MCM Construction, Inc.*, Cal/OSHA App. 13-3851, Decision After Reconsideration (Feb. 22, 2016.).) Correcting the hazard would require first observing that Sanders was working in the hoistway, and then waiting to move the CPH until the hoistway was clear of obstruction.

In the immediate case, the Division's evidence demonstrates that Employer, through Avilan, failed to effectively implement its IIPP, because Employer did not ensure that Avilan identified, evaluated, and corrected the hazard resulting from the employee working in the hoistway. Employer failed to ensure that Avilan's safety practices included looking up to check

the hoistway, or confirming in any other way that the path was clear, before operating the CPH for the first time at the start of his shift.

The record indicates that Avilan provided inconsistent factual accounts of the events leading to the accident. Avilan initially testified at hearing that he had been moving the CPH towards the top floor as part his usual daily inspection. (HT, pp. 173:6-13, 175:1-7, 180:8-15, 181:9-15, 186:8-11.) However, Avilan's hearing testimony conflicted in some respects with his statements immediately after the accident. According to the records of the Division and Employer, Avilan stated, immediately following the accident, that he had received a radio call and could not understand what the caller was saying, but heard the noise of the fireproofing spray gun in the background, and assumed someone wanted him to bring the CPH to a higher floor. (Exhibits 4, 5, 6, 8.) This version of events is corroborated by statements made by Sanders and another California Drywall employee, Francisco Cruz (Cruz), to the Division that Cruz had radioed Avilan in an attempt to warn him not to raise the CPH to the fourth floor. (Exhibits 6, 9.) It is further corroborated by Sanders' testimony that he saw Cruz using the callbox moments before Avilan ascended in the CPH. (HT, pp. 71:22-72:9.) Avilan also stated that he normally did not respond to any calls before 6:30 a.m., but made an exception to his usual procedure because the CPH had already been in use by an unidentified worker, who Avilan saw exiting the CPH as he approached the job site. (Exhibits 4, 5.)

When presented with his original statements, Avilan conceded that, due to the passage of time and the trauma of the accident affecting his memory, his statements made contemporary to the incident were the more correct and reliable version of events. (HT, pp. 175:14-16, 186:4-7, 186:12-187:1, 188:8-17, 192:11-18.) We give greater weight to Avilan's original account of the events leading up to the accident, to the extent it differed from his hearing testimony.

When Avilan received the radio call from Cruz, although he could not make out Cruz's warning not to ascend to the fourth floor, he recognized the sound of the fireproofing sprayer. (Exhibits 5, 6.) Avilan testified at hearing that his usual practice was to radio back and ask for clarification when he did not understand a radio call, but his statements made contemporary to the accident, which Avilan acknowledged were truthful and accurate, indicate he did not do so on that occasion. (HT, pp. 185:6-10, 186:4-16, 187:6-22, 188:1-17; Exhibits 4, 5, 6.) Sanders testified that the fireproofing sprayer was so "extremely loud" that he required ear protection while using it. (HT, pp. 48:19-22, 50:2-20.) This indicates that Avilan was, or should have been, aware that Sanders was working in the building. Yet, Avilan still made no effort, either by visual inspection or verbal confirmation, to ensure that the CPH's path was clear before ascending.

Avilan's statements made immediately after the accident confirmed that he did not check the hoistway for obstructions, or otherwise confirm that it was safe to move the CPH, when he ascended in response to Cruz's radio call. (Exhibits 4, 5, 6, 8.) Further, there was no visual impediment preventing Avilan from inspecting the hoistway prior to moving the CPH. A photograph of the jobsite shows that the CPH and hoistway were plainly visible on the outside of the building. (Exhibits J, J-MOD1.) This was not an enclosed elevator shaft. The CPH moved up and down on a vertical track attached to the exterior of the building being constructed, and the hoistway was fully exposed. The building at that point had no walls; it was essentially an open structure, allowing a view into each floor. The portion of the scissor lift that extended into the hoistway was overhanging the edge of the building. (HT, p. 35:13-18.) Sanders testified that there were lights visible on the fifth floor, one floor above where he and Cruz were working. (HT, pp.

48:2-3, 70:1-3.) It is also reasonable to infer that, despite the pre-dawn hour, Sanders and Cruz were not working blindly in the dark, and, if needed, had lighted their work area in some way. An object protruding past the edge of the building and into the hoistway would therefore have been visible from the outside of the building. The ALJ thus reasonably concluded, and the Board agrees, that the scissor lift extending into the hoistway could be seen, and would have been detected, had Avilan simply looked up.

Even if Avilan had moved the CPH as part of his inspection, rather than in response to a radio call, the evidence demonstrates deficiencies in Employer's typical inspection procedures. Bigge's Director of Environmental Health and Safety, Michael McCarthy (McCarthy) described Employer's expected procedures for inspecting the CPH. He testified that a CPH operator would typically begin his or her daily inspection on the first floor, "when the hoist operator enters the hoist," by going through a checklist and documenting the results in an inspection log. (HT, pp. 220:15-221:6, 222:5-16, 225:9-226:8.) The operator would then perform a calibration check, which involved travelling to the top floor, and descending one floor at a time. (HT, pp. 220:17-221:6, 222:5-8, 225:15-226:4, 226:12-17.) McCarthy listed a number of steps involved in a CPH operator's daily inspection, but none of that testimony, or any other evidence provided by Employer, indicated that checking the hoistway for obstructions was part of Employer's expected inspection procedures. It can therefore be reasonably "inferred that there was a lack of a procedure for discovering and correcting hazards such as a person working in the hoistway at the start of the workday." (Decision, p. 13; Evid. Code, §§ 412, 413.)

Avilan testified that, upon entering the CPH, his usual inspection procedure after closing the doors was to test the controls by proceeding immediately to the top floor. (HT, pp. 152:12-14, 153:1-8, 157:16-22, 159:15-16, 171:5-17, 172:2-16.) He stated that he would go through the items on the inspection checklist while on the top floor, in order to avoid distractions. (HT, pp. 152:8-16, 153:8-22, 162:2-12.) He testified that checking the hoistway for obstructions before entering or raising the CPH was not part of his usual inspection procedure. (HT, pp. 159:10-16.) .) He testified that on the morning of the accident, he arrived at the worksite, entered the CPH, immediately began ascending towards the top floor pursuant to his inspection, and struck Sanders before he reached the top. (HT, pp. 170:12-171:1, 172:12-21, 176:7-15.) .)

Based on this testimony, it does not appear that Avilan's routine inspection method diverged substantively from the expected procedure described by McCarthy; it differed in that Avilan preferred to perform the majority of the inspection, and the documenting paperwork, after travelling to the top floor, rather than while on the first floor, so that he would not be interrupted by workers requesting transport before he completed the inspection. As Employer itself argues, McCarthy characterized Avilan's method as "unusual," but not as improper. (Petition, p. 7; HT, p. 222:9-16.) Indeed, McCarthy testified that Avilan received no discipline following the accident, because Employer found "no fault on his part." (HT, p. 206:8-13.) Employer's argument that it maintained effective procedures to identify hazards is therefore unpersuasive.

To the contrary, Avilan's routine failure to conduct an external check of the areas around the CPH and the hoistway, before attempting to move the CPH at the start of the day (either in response to a radio call or as part of his routine inspection procedures), demonstrates that Employer failed to implement effective inspection procedures to identify, evaluate, and correct hazards associated with operating the CPH. Checking the path of the CPH for obstructions prior to moving it for the first time that day would seem to be a simple yet important safety precaution. In this

instance, failure to do so not only caused serious injury to Sanders, but also damaged the CPH. (Exhibit 3.) This outcome could have been avoided by inspecting the hoistway before moving the CPH.

Avilan testified, "I would think that somebody would want to speak to me in person" to warn him of any obstruction in the hoistway (HT, p. 177:13-19), and that if "somebody is working in the manway, I get talked to in person. I have never had anybody call me on the radio telling me, hey, we're going to be in the manway." (HT, p. 182:9-13.) He stated that he was not informed by the laborer exiting the CPH that Sanders was working above (Exhibit 5; HT, p. 168:9-11), or by Hathaway that Sanders would be fireproofing in the hoistway that morning. (Exhibit 4; HT, p. 194:9-14.) This testimony implies that Avilan relied on being told the hoistway was obstructed, rather than inspecting it for obstructions, before moving it at the start of the day. However, Bigge cannot assign its own safety responsibilities to others so easily. We therefore conclude that, regardless of the reason Avilan ascended in the CPH on that occasion, Employer did not implement appropriate safety precautions to detect obstructions and to avoid moving the CPH when an obstruction might be present.

Employer argues that the accident was an "isolated incident." (Petition, p. 7.) The Board has long held that "the defense of independent employee action [IEAD] established by *Mercury Service, Inc.*, OSHAB 77-1133, Decision After Reconsideration (Oct. 16, 1980) substantially incorporates the defense of isolated incident." (*Campbell Construction*, Cal/OSHA App. 78-1258, Grant Of Petition For Reconsideration And Decision After Reconsideration (Aug. 31, 1984); see also *RNR Construction, Inc.*, Cal/OSHA App. 1092600, Denial of Petition for Reconsideration (May 26, 2017), fn. 7.) The Board has thus long declined to consider the "isolated incident" defense outside the IEAD context.

Here, Employer does not raise the IEAD to assert that Avilan knowingly failed to comply with its inspection practices or any other safety rules. Moreover, while the accident itself may have been an isolated incident, Avilan regularly, and as a matter of standard practice, moved the CPH at the start of the day without ensuring the hoistway was clear. Avilan's testimony demonstrated that his routine daily safety inspections did not include checking the hoistway for obstructions before moving the CPH. Even if the defense were available to Employer, it would not be persuasive.[5]

Employer also argues that Avilan was "in the process of" conducting a safety inspection at the time of the accident. (Petition, p. 7.) Employer asserts this inspection procedure "had been successful in the past" and the mere fact that an accident occurred "does not demonstrate the Employer's IIPP lacked a system of hazard identification and evaluation." (*Id.*, citing *Brunton Enterprises, Inc.*, *supra*, Cal/OSHA App, 08-3445.) In *Brunton Enterprises, Inc.*, the Board held, "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.'" (*Id.*)

---

[5] We also note that the IEAD would not be satisfied if Employer did assert it here. There is no indication that Avilan knowingly violated any of Employer's safety rules by failing to check the hoistway for obstructions. (*Mercury Service, Inc.*, *supra*, Cal/OSHA 77-1133.)

This argument is rejected for several reasons. First, as noted, Employer here was not cited for deficiencies in its written IIPP, but for a failure to implement those procedures. Second, the evidence indicates that Avilan was not, in fact, conducting a safety inspection at the time of the accident. Third, even if Avilan had moved the CPH as part of a safety inspection, Employer's established inspection procedures would not have been effective in identifying the hazard of moving the CPH when the hoistway was obstructed. An employer's IIPP need not contain a written procedure for every operation, but the practices and procedures an employer adopts must be effective in implementing the goals of the IIPP.

The evidence thus demonstrates that Employer was deficient in implementing procedures for identifying, evaluating, and correcting hazards related to the operation of the CPH. Employer failed to ensure that Avilan checked the hoistway for obstructions, failed to ensure that Avilan detected Sanders working in the hoistway, and failed to ensure that Avilan did not move the CPH until he knew the hoistway was clear. The Division established a violation of section 1509, subdivision (a), with reference to section 3203, subdivisions (a)(4) and (a)(6).

2. Was Employer a "creating employer" pursuant to section 336.10?

Section 336.10 is the multi-employer worksite regulation promulgated by the Director of the Department of Industrial Relations. (See also Lab. Code, § 6400.) (*Airco Mechanical Inc.*, Cal/OSHA App. 99-3140, Decision After Reconsideration (Apr. 25, 2002).) The Division cited Employer as a "creating employer," in accordance with this regulation.

Section 336.10 identifies four categories of citable employers on multi-employer worksites:

> (a) The employer whose employees were exposed to the hazard (the exposing employer);
>
> (b) The employer who actually created the hazard (the creating employer);
>
> (c) The employer who was responsible, by contract or through actual practice, for safety and health conditions on the worksite; i.e., the employer who had the authority for ensuring that the hazardous condition is corrected (the controlling employer); or
>
> (d) The employer who had the responsibility for actually correcting the hazard (the correcting employer).

An employer falling into one or more of these four categories may be cited "when the Division has evidence that an employee was exposed to a hazard in violation of any requirement enforceable by the Division." (§ 336.10.) These categories are also codified in Labor Code section 6400, subdivision (b). Further, Labor Code section 6400 provides, "Every employer shall furnish employment and a place of employment that is safe and healthful for the employees therein." (Lab. Code, § 6400, subd. (a).) An employer therefore "may be cited regardless of whether their own employees were exposed to the hazard." (Lab. Code, § 6400, subd. (b); see also *McCarthy Building Companies, Inc.*, Cal/OSHA App. 11-1706, Decision After Reconsideration (Jan. 11, 2016);

Electrical Systems and Instrumentations, Cal/OSHA App. 316695469, Decision After Reconsideration and Order of Remand (Sep. 22, 2017).)

The creating employer – i.e., the employer who actually creates a hazard on a multi-employer worksite – is responsible for any citation that results from that hazard. (*Trimms Scaffolding*, Cal/OSHA App. 00-4146, Decision After Reconsideration (Dec. 3, 2002); *Cal Energy Operating Corp.*, Cal/OSHA App. 09-3675, Decision After Reconsideration (Nov. 12, 2010).) Here, the ALJ found Employer to be the creating employer for the cited hazard of failing to identify, evaluate, and correct hazards related to operating the CPH. We agree.

Employer argues that it was not the creating employer and therefore is not citable in this matter. Employer asserts that the hazard was created by California Drywall, "whose foreman Sanders placed himself in the way of harm by working in the hoistway without providing notice to Bigge or Avilan and without taking any precautions to prevent the accident." (Petition, p. 9.) Employer's Petition raises the question of whether "there may be more than one creating employer on a multi-employer worksite." (*Id*.) However, as we explain below, there may be more than one creating employer on a multi-employer worksite, where two or more employers create hazards which result in, or contribute to, the same incident or accident.

Sanders working in the hoistway did create a hazard, as the ALJ recognized. (Decision, p. 9.) In fact, the record indicates that the Division cited California Drywall, as an exposing and creating employer (HT, pp. 135:14-19, 136:16-20), for Serious, Accident-Related violations of section 1509, subdivision (a) [failure to effectively identify hazards] and section 3646, subdivision (b) [failure to use an elevated platform in accordance with manufacturer's instructions]. (Exhibits 6, Q.)[6]

Bigge may not shift its own responsibility for safety at a multi-employer worksite to another employer, however. (See *DeSilva Gates Construction*, Cal/OSHA App. 01-2742, Decision After Reconsideration (Dec. 10, 2004).) Further, the Division is not restricted by the plain language of the regulation from citing more than one employer for separate violations in the same category, just as it is not restricted for citing the same employer in multiple categories.

The Division cited California Drywall for "failure to identify potential hazards, such as moving equipment in the area to avoid collision (i.e., hoist temporary elevator)" prior to using the scissor lift. (Exhibit Q.) Bigge, on the other hand, was cited for failure to inspect, identify, evaluate, and correct hazards associated with operating the CPH itself. These are separate and distinct hazards, and thus separate citable violations, involving two creating employers. The fact that California Drywall created one hazardous condition does not absolve Bigge for creating another hazardous condition.

It reasonably follows that more than one employer on a multi-employer worksite may be cited as a "creating employer," even when the hazardous conditions these employers create relate to the same accident or incident. The fact that Employer cannot find any Board precedent specifically stating such a holding is irrelevant. (Petition, p. 9) Such matters would involve separate employers, and thus separate citations and separate appeals, if any. Nonetheless, based on the plain language of the regulation, it is reasonable to conclude that more than one employer on a multi-

[6] Exhibit 6, the Division's Redacted Narrative Summary, confirms that this accident investigation involved both Hathaway (Inspection No. 1380233) and California Drywall (Inspection No. 1380148), as well as Bigge.

employer worksite may be held liable as a creating employer, when those employers create separate hazardous conditions that cause or contribute to the same accident or incident. This interpretation is also consistent with the long standing rule that safety orders are to be given a liberal interpretation to safety legislation for the purpose of achieving a safe working environment. (*Carmona v. Division of Industrial Safety*, (1975) 13 Cal.3d. 303 at 313; *Department of Industrial Relations v. Occupational Safety & Health Appeals Bd.* (2018) 26 Cal.App.5th 93.)

As detailed above, the record demonstrates that Bigge created the hazardous condition for which it was cited, by failing to ensure that Avilan identified and corrected the hazard of moving the CPH while Sanders was working in the hoistway. Bigge was therefore properly cited as a "creating employer" under section 336.10 of the multi-employer worksite regulations. (*Trimm's Scaffolding*, *supra*, Cal/OSHA App. 00-4146.) The ALJ's finding on this issue is affirmed.

3. Did Employer, as the primary employer of a leased employee, satisfy its safety responsibilities at the job site?

In some instances, an employee may have two employers. In such "dual employment" situations, the "primary employer" loans or leases employees to the "secondary employer." (*Sully-Miller Contracting Company v. CA Occupational Safety and Health Appeals Board* (2006) 138 Cal. App. 4th 684, 693-694 (*Sully-Miller*).) The secondary employer has the right to control the daily work activities of the primary employer's employees, whether such control is actually exercised or not. (*MCI Worldcom, Inc*., Cal/OSHA App. 00-440, Decision After Reconsideration (Feb. 13, 2008); *NDC / Tri-State*, *supra*, Cal/OSHA App. 12-0378.) Here, there is no dispute that Bigge was Avilan's primary employer.

The Cal/OSH Act mandates that every employer has a non-delegable duty to its employees to furnish "a place of employment that is safe and healthful," and that every employer "shall do every other thing reasonably necessary to protect the life, safety, and health of employees." (Lab. Code, §§ 6400, 6401.) Labor Code 6401.7, subdivision (a), further provides, "Every employer shall establish, implement, and maintain an effective injury prevention program," which must include, among other elements, a "system for identifying and evaluating workplace hazards, including scheduled periodic inspections to identify unsafe conditions and work practices," and "methods and procedures for correcting unsafe or unhealthy conditions and work practices in a timely manner." (Lab. Code, § 6401.1, subd. (a)(2), (3).)

To carry out these legislative mandates, the Occupational Safety and Health Standards Board (Standards Board) promulgated section 3203, subdivision (a), which largely echoes the language of Labor Code section 6401.7, subdivision (a). The Board has thus held that the requirements of section 3203, subdivision (a), apply equally to both primary and secondary employers. (See, e.g., *Manpower*, Cal/OSHA App. 98-4158, Decision After Reconsideration (May 14, 2001).)

A primary employer maintains responsibility for the health and safety of its employees when those employees are leased or loaned to a secondary employer. (See, e.g., *Sully-Miller Contracting Co.*, Cal/OSHA App. 99-896, Decision After Reconsideration (Oct. 30, 2001) [aff'd by Sully-Miller, *supra*, 138 Cal. App. 4th 684] ; *Staffchex*, Cal/OSHA App. 10-2465, Decision After Reconsideration (Aug. 28, 2014); *NDC / Tri-State*, *supra*, Cal/OSHA App. 12-0378.) A primary employer's non-delegable duties to its leased employees include the establishment and

implementation of an effective IIPP; adequate and appropriate training; and adequate oversight and supervision, including periodic inspections of the secondary employer's worksite. (*Id*. See also Lab. Code, § 6401.7, subd. (a).) Regarding the duty to establish and implement an effective IIPP, the Board has emphasized, "each employer remains ultimately responsible to ensure implementation as to all employees subject to the IIPP requirements, and employers cannot escape liability for a violation of their duties, or for a failure of implementation, by arguing that they contracted or delegated away, or otherwise reassigned, their statutory and regulatory responsibilities." (*NDC / Tri-State*, *supra*, Cal/OSHA App. 12-0378.)

Employer asserts it satisfied its duties to its leased employees. However, Employer cannot be said to have satisfied its duties as a primary employer, because, as discussed, it failed to ensure the effective implementation of its IIPP. Although Avilan was fortunate enough to escape injury on this occasion, the hazard at issue here does not relate only to the safety of other subcontractors' employees, but to Bigge's employees as well.

Employer contends that it "shared safety responsibilities" with Hathaway, and that it was Hathaway which failed to provide a safe workplace, by failing to inform Bigge or Avilan that Sanders might still be working in the hoistway after 6:00 a.m., and/or by failing to lock out the CPH. (Petition, pp. 5, 6, fn. 5.) As noted above with regard to the duties of employers on multi-employer worksites, it may be true that Hathaway also failed in its duty, but that does not abrogate Bigge's duty to ensure that its employee effectively implemented its IIPP by checking the area for hazards before beginning work, as Employer's contention that it "shared" responsibility logically implies.

The Board has held, "There may be certain circumstances where one employer's actual implementation of an IIPP on another employer's behalf may satisfy both employers' duties under section 3203." (*NDC / Tri-State*, *supra*, Cal/OSHA App. 12-0378.) The Board has not explicitly described what those circumstances might be, but there is no need to do so here. Indeed, Employer presented no evidence that such a cooperative effort occurred. Bigge maintained control of the CPH, its operation, and its maintenance; Bigge alone was responsible for conducting daily safety inspections of the CPH. (Exhibit N.) Employer's argument that it is not responsible for the cited violation, because Hathaway failed to notify it of Sanders's work in the hoistway, is therefore unpersuasive.

Employer further asserts that its "access to the Construction Site was hampered by" the terms of its contract with Hathaway. (HT, p. 239:11-16; Petition, p. 5.) In support of this argument, Employer cites an addendum to its contract with Hathaway, stating that Hathaway "shall supervise and have exclusive right to control the [CPH] Operators" provided by Bigge. (Exhibit A.) This argument must be rejected. The Board has explicitly declined to permit primary employers to assert, as an affirmative defense, that they have contracted or delegated their responsibilities for workplace safety to the secondary employer. (*Staffchex*, *supra*, Cal/OSHA App. 10-2465.) As the ALJ correctly pointed out, "the mere fact that Employer's role in the employment relationship with Avilan was that of a primary employer" does not relieve Employer of responsibility for the violation. (Decision, p. 10.)

Turning to Employer's failure to effectively implement its IIPP, the Board has held that both employers in a dual employment situation "retain ultimate responsibility" for supervision and inspection of a secondary employer's worksite. (*Sully-Miller Contracting Co*., *supra*, Cal/OSHA App. 99-896; *Manpower*, *supra*, Cal/OSHA App. 98-4158.) This duty falls within the scope of section 3203, subdivision (a)(4), the safety order under which Employer was cited. (*Id*.) Section 3203, subdivision (a)(4), requires periodic inspections to identify, evaluate, and correct hazards. In the dual employment context, it is the primary employer's non-delegable duty to exercise adequate oversight and supervision of leased employees, to identify hazardous conditions and unsafe work practices on secondary employers' job sites.

Employer argues that it was not responsible for the "day to day" safety of its employees, or the employees of other subcontractors, on a secondary employer's jobsite. (HT, p. 239:9-16.) McCarthy testified that "we have a lot of jobsites," making it impractical for Employer's Health and Safety team to inspect each secondary employer's jobsite more than once every three months. (HT, p. 204:8-16.) The ALJ properly rejected this argument. (Decision, p. 10.) While, as the ALJ noted, even daily inspections by Employer might not have detected the specific circumstance of Sanders working in the hoistway after 6 a.m., more frequent inspections and more thorough oversight could, and should, have identified that Avilan regularly failed to check the hoistway before moving the CPH for the first time each day, including as part of his daily safety inspection. Employer therefore failed to appropriately supervise its leased employee.

Ultimately, Employer failed in its safety responsibilities at the jobsite, including adequate supervision and oversight, because it failed to effectively implement the hazard inspection, identification, evaluation, and correction provisions of its IIPP. Employer failed to exercise adequate oversight, which could have identified the unsafe work practice of Avilan routinely not checking the hoistway for obstructions, as part of his daily inspection, before moving the CPH.

As discussed in detail above, the Division's evidence established a violation of section 3203, subdivision (a)(4). As the Division's Answer succinctly states, "The underlying facts remain the same under a dual employer analysis. […] Employer did not implement its own safety plan because the Employer did not ensure that Daniel Avilan identified, evaluated, and corrected the hazard resulting from an employee working in the pathway of the [CPH][.]" (Answer, p. 6.) Employer therefore failed to fulfill its responsibilities, as a primary employer, for employee safety on a secondary employer's jobsite.

4. Was the Citation properly classified as Serious?

Employer's Petition does not dispute that the Division met its burden to establish a rebuttable presumption that the violation was properly classified as Serious, as provided by Labor Code section 6432, subdivision (a), thereby waiving the issue. (Lab. Code, § 6618.)

The actual hazard created by the violation was operating the CPH without awareness of people or objects in the hoistway. A rebuttable presumption therefore exists that Employer's failure to ensure an employee followed its IIPP procedures to identify, evaluate, and correct hazards while operating a CPH resulted in a realistic possibility of serious physical harm, injury, or death. (Lab. Code, § 6432, subd. (a).) The parties stipulated that Sanders suffered serious physical harm. (HT, p. 54.)

Employer argues that it did not know, and could not, with the exercise of reasonable diligence, have known of the violation. (Lab. Code, § 6432, subd. (c).)

Labor Code section 6432, subdivision (c), provides:

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

Once the Division establishes the presumption that the citation was properly classified as Serious, the burden shifts to the employer to rebut that presumption. To do so here, Employer first argues that the violation "occurred at a time and under circumstances in which there was no reasonable opportunity to detect it." (Petition, pp. 9-10, citing *Vance Brown, Inc.*, Cal/OSHA App. 00-3318, Decision After Reconsideration (Apr. 1, 2003).) Employer asserts that Avilan himself was not a supervisor or manager, no Bigge management was present at the job site, and therefore Employer had no "opportunity and ability" to identify "the hazard posed by Sanders's position in the hoistway." (*Id*. at p. 10.)

Preliminarily, we note that the Board's decision in *Vance Brown, Inc.*, *supra*, Cal/OSHA App. 00-3318, addressed a previous version of Labor Code section 6432, which was repealed in 2010. Subdivision (b) of that older version provided, in its entirety, "Notwithstanding subdivision (a), a serious violation shall not be deemed to exist if the employer can demonstrate that it did not, and could not with the exercise of reasonable diligence, know of the presence of the violation." The two elements for establishing an employer's lack of knowledge, which appear in the current iteration of Labor Code section 6432, subdivision (c), did not appear in the pre-2010 version of the section. The "reasonable opportunity" test relied upon by Employer is thus no longer relevant.[7]

[7] The Board created this test to address another change to Labor Code section 6432, which took effect in 1999. Prior to 1999, the Division had the burden to prove that the employer knew, or with the exercise of reasonable diligence

Moreover, Employer incorrectly identifies the hazardous condition as Sanders's presence in the hoistway. Again, Employer attempts to shift the blame to Hathaway, California Drywall, Sanders, and the unidentified worker who Avilan claimed he saw exiting the CPH, for failing to alert Avilan or Bigge to Sanders's presence. (Petition, pp. 10-11.) The cited violation, however, alleged a failure to effectively implement Employer's IIPP. The resulting actual hazard was Avilan's failure to identify, evaluate, and correct the hazard of an obstructed hoistway before moving the CPH for the first time that day.

Employer fails to demonstrate that it "took all the steps a reasonable and responsible employer in like circumstances should be expected to take, before the violation occurred, to anticipate and prevent the violation," (Lab. Code, § 6432, subd. (c)(1).) It asserts merely that it satisfied its duties as a primary employer, and that this "demonstrates that it exercised the reasonable diligence of a general [sic] employer in a dual employment setting to ensure that the workplace was safe." (Petition, p. 10.) First, as discussed, the evidence demonstrates that Employer did not satisfy its responsibilities as a primary employer, because it failed to effectively implement its IIPP, which resulted in the actual hazard now at issue. Second, this argument is irrelevant to the classification of the violation.

McCarthy testified that he was familiar with both Employer's IIPP and with Employer's expected inspection procedures for CPH operators. (HT, pp. 219:11-14, 220:2-11.) Employer provided no evidence that its expected procedures included checking the hoistway. The Board therefore infers that, at minimum, Employer had constructive knowledge that its procedures for CPH operators did not include checking the hoistway for obstructions before moving the CPH. For this reason alone, Employer cannot be said to have taken all reasonable steps to anticipate and prevent the violation, and cannot rebut the presumption established by the Division.

Regarding the second element, Employer argues that it "took immediate steps to determine the cause of the accident." (Petition, p. 11.) Again, this is irrelevant. Employer offers no evidence that it "took effective action to eliminate employee exposure to the hazard created by the violation as soon as the violation was discovered." (Lab. Code, § 6432, subd (c)(2).) Instead, McCarthy testified, a text was sent to all CPH operators "reminding them of the hazards of the jobsite and that people will put themselves in the path of their hoist without communicating to them. So, they needed to be vigilant. Quite honestly, there's really not a whole lot you can do if somebody makes a decision to put themselves in the line of fire." (HT, p. 216:8-16.) There is no indication that Employer took affirmative steps such as re-training its CPH operators, or even explicitly instructing them that the operator has the responsibility to ensure the hoistway is clear. Employer's minimal efforts here, which consisted of a group text message warning CPH operators of the hazard, but nothing more, combined with McCarthy's attitude towards addressing the hazard

---

would have known, of the violative condition. The "reasonable opportunity" test thus addressed the new burden on the employer to affirmatively establish that it did not know, nor could have known with the exercise of reasonable diligence, of the violative condition. (*Sunrise Window Cleaners*, Cal/OSHA App. 00-3220, Decision After Reconsideration (Jan. 23, 2003); *C.C. Meyers Incorporated*, Cal/OSHA App. 95-4063, Decision After Reconsideration (June 7, 2000).)

("there's really not a whole lot you can do…") fall far short of the required standard, under Labor Code section 6432, subdivision (c)(2), for establishing the second element.

Accordingly, Employer did not rebut the presumption that the violation was properly classified as Serious.

DECISION

For the reasons stated, the Decision of the ALJ is affirmed. Citation 1, its Serious classification, and the proposed penalties are upheld.

OCCUPATIONAL SAFETY AND HEALTH APPEALS BOARD

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

FILED ON: 04/07/2023