

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

In the Matter of the Appeal of:

NATIONAL STEEL AND
SHIPBUILDING COMPANY
P.O. Box 85278 M/S 27
San Diego, CA. 92186-5728

Employer

Dockets 10-R6D2-3791 and 3792

**DECISION AFTER
RECONSIDERATION**

The Occupational Safety and Health Appeals Board (“Board”), acting pursuant to authority vested in it by the California Labor Code and having taken the petition for reconsideration filed by the Division of Occupational Safety and Health, Department of Industrial Relations (“Division”) under submission, renders the following decision after reconsideration.

JURISDICTION

National Steel and Shipbuilding Company (“Employer”) is a shipbuilder. On May 20, 2010, a gantry crane operated by Employer collided with a sandblast hopper, which was used for collecting sand from sandblasting operations. The collision occurred at a place of employment maintained by Employer in San Diego, California. The Division conducted an accident inspection through Associate Safety Engineer Zohra Ali (“Ali”). On November 17, 2010, the Division cited employer for violating workplace safety and health standards codified in California Code of Regulations, Title 8, and proposing civil penalties.¹ Citation 1, Item 1 alleged a willful, serious, repeat violation of section 4991(a) [failure to control travel of crane to avoid a collision]. Citation 2, Item 1 alleged a willful serious violation of section 4994(e) [failure to analyze or give instruction prior to two crane lift].

¹ Unless otherwise specified, all references are to California Code of Regulations, Title 8.

Employer filed a timely appeal of the citations on all grounds and asserted affirmative defenses, including the Independent Employee Act Defense. Administrative proceedings were held, including a contested evidentiary hearing before an Administrative Law Judge (ALJ) of the Board. Employer was represented by Scott H. Dunham, from O'Melveny and Meyers LLP. The Division was represented by William Cregar, Division's Staff Counsel. After taking testimony and considering the evidence and arguments of counsel, the ALJ issued a Decision on March 28, 2012 ("Decision"). The Decision granted Employer's appeal and dismissed both citations. The ALJ dismissed the section 4991(a) citation on the basis of the Independent Employee Act Defense. The ALJ dismissed the section 4994(e) citation finding that the Division failed to satisfy its burden of proof as to that citation.

The Division filed a timely Petition for Reconsideration of the ALJ's Decision. The Division petitioned for reconsideration on the basis of Labor Code section 6617 (c) and (e). The Petition for Reconsideration raises several issues with the ALJ's Decision. With regard to the section 4991(a) citation, the Division argues that the Employer failed to establish the second and third elements of the Independent Employee Action Defense. As to the 4994(e) citation, the Division argues that the ALJ erred when she found that the Division failed to meet its burden of proof, and found that Employer engaged in a sufficient analysis prior to the two crane lift. The Employer filed an answer to the petition.

ISSUES

- 1) Has Employer Established the Second Element of the Independent Employee Action Defense?**
- 2) Has Employer Established the Third Element of the Independent Employee Action Defense?**
- 3) Was the Section 4991(a) Citation Properly Characterized as Serious?**
- 4) Was the Section 4991(a) Citation Properly Characterized as Willful?**
- 5) Was the Section 4991(a) Citation Properly Characterized as Repeat?**
- 6) Was the Evidence Sufficient To Show Employer Adequately Analyzed the Crane Movement, Pursuant to the Requirements of section 4994(e)?**

EVIDENCE

The Decision describes the evidence adduced at hearing in great detail. We summarize that evidence below, focusing on pertinent events that led to the issuance of the subject citations:

A. Placement of the Sandblast Hopper During Second Shift on May 19, 2010.

Employer is a shipbuilder that operates around the clock in three shifts. Large cranes are used to move large shipbuilding components and equipment throughout the shipyard. Employer engages in over 20,000 crane movements per year. Dual crane movements are common and occur at least once a week.

On May 19, 2010, during Employer's second shift which runs from 3:00 p.m. to 11:30 p.m., Employer moved and placed a sandblast hopper ("hopper"), weighing over seventeen tons, next to a lane of travel used by gantry cranes. A subcontractor, IMIA, requested the hopper be placed in that location that day, and the sandblaster had been placed in that approximate location on several previous occasions without incident. The placement of the hopper was observed and supervised by second shift Rigging Supervisor Jeff Padilla ("Padilla").

After the hopper had been placed, Padilla received a call from Kevin Luster ("Luster"), a supervisor. Luster voiced concerns to Padilla that the location of the hopper was "pretty close," referencing the nearness of the hopper to the path of travel used by cranes. In response, Padilla instructed workers to travel gantry crane seven through the lane adjacent to the hopper, to make sure that it cleared. Crane seven passed the hopper without incident. Padilla did not attempt to pass any other cranes past the hopper because no other cranes were available at the time.

Derel Meadows ("Meadows") worked as a rigger during second shift, and he observed the placement of the hopper. He said the number seven crane was the smallest crane in the yard, and crane seven only cleared the hopper by a few inches. Meadows did not believe any larger crane could clear the hopper. Prior to the end of his shift, Meadows called Luster and informed him that no other type of crane could clear the hopper. Padilla stated that he was never informed of Meadows' specific concerns.²

B. Warnings to Third Shift.

At the end of his shift, Padilla held a detailed turnover meeting with third shift Rigging Supervisor Emory Tucker Evans ("Evans"). During their meeting, Padilla discussed what Employer had accomplished during second shift. He warned Evans of the placement of the hopper, and he verbally advised Evans to

² Both Meadows and Steve Taylor, a crane operator, stated they observed the hopper leaning. However, we note that there is no evidence that either Meadows or Taylor specifically apprised management that they observed that the hopper was leaning. And it does not appear that management observed any lean.

practice caution, and make sure you can clear, when moving cranes around the hopper. Padilla told Evans to tell his people that the hopper is there and that it is close to the yellow line; the yellow line demarcated an area where there was an increased likelihood of a crane collision. Evans acknowledged the verbal warning.

At the end of his shift, Padilla also sent an email with photographs to a list of people, including Evans, advising that they had moved the hopper and advising of safety concerns regarding the hopper's new location, including the following concerns: "Close crane track clearance with Hopper and Blast Pot Assembly," and advising "Communicate with Rigging Department personnel to practice caution when traveling cranes through F-Lane." (Exhibit A.) Evans acknowledged receipt of this email.

C. Two Crane Lift By Third Shift.

During the very next shift, supervised by Evans ("third shift" which runs from 11:30 p.m. to 7:30 a.m.), Employer used two large gantry cranes (cranes fifteen and sixteen) to move an approximate 450 ton load. The weight of the load was shared between the two cranes. The cranes ran on two legs that were placed on tracks. The cranes ran on a path of travel next to the hopper. It was one of these two cranes that contacted the hopper.

Evans supervised the two-crane lift. Prior to the movement of the crane, Evans tasked riggers Randall Miller ("Miller") and Jorge Huezo ("Huezo") with ensuring that the crane tracks were clear in the direction of travel, and to ensure the crane did not collide with anything. The riggers were allegedly trained to perform this work. If they perceived an obstruction or a threat, they were required to stop the movement of the crane, warning the crane operator in sufficient time to stop and avoid the threat. The crane usually required approximately (depending on its speed) six to ten feet to come to a full stop—less if an emergency-stop (e-stop) button was pressed. Employer relies on the riggers' senses, perceptions, and training to determine when to stop a crane to avoid a collision. Each employee was equipped with a radio to signal other members of the crew, and to signal a stop if necessary.

D. Information Conveyed To Riggers.

Evans advised the riggers that the hopper was located near the crane's path of travel on two occasions. At the beginning of third shift, during a five minute meeting, Evans told Miller and Huezo about the location of the hopper and he conveyed Padilla's warning. And later, during a face to face conversation, Evans reminded Miller and Huezo a second time to keep "an eye out" for the hopper as the lead crane approached within about 100' feet of the

hopper. Huezo acknowledged that Evans warned him to “keep an eye on this hopper it might be a little too close...”³

E. Collision With Hopper.

Crane number fifteen collided with the hopper, knocking the hopper over and causing damage to the crane. No attempt to stop the crane occurred until after the crane had already collided with the hopper. Huezo had been watching the hopper as the crane neared it, but Huezo did not walk sufficiently in advance of the crane, nor did he apparently position himself in a manner, to have a clear line of sight or to stop the crane in time to avoid the collision. Miller credibly testified that Huezo, at the time of the collision, had positioned himself at the “foot” of the crane, presumably referring to the trucks. Miller’s testimony is supplemented and explained⁴ by an investigation performed by Stephen Dykeman, Superintendent of Rigging, concerning the cause of the collision. During the investigation, Huezo told Dykeman that at the time of the collision he had positioned himself between the trucks of the crane, rather than in front of the crane, which would have made it much more difficult to determine whether there would be a collision.⁵

F. Employer’s Discipline of the Riggers.

Both riggers were disciplined by Employer for failing to stop the crane. They each received a written warning and were suspended for three days. Although the specific language of the warnings slightly differed, both written warnings stated even though the employees were watching, they failed to stop the crane before it made contact with the hopper and caused the hopper to tip over and inflict damage to other equipment and put their co-workers in danger. (Exhibits 3A and 3B.) Neither rigger challenged their disciplinary action.

G. Employer’s Safety Program.

Robert Massey (“Massey”), Manager of Safety and Industrial Hygiene, directs Employer’s safety programs, establishes Employer’s policies and

³ Notably, Miller testified that no person warned him about the location of the hopper.

⁴ See Section 376.2.

⁵ Huezo offered contradictory testimony concerning his positioning and efforts to stop the collision. However, the ALJ found that this testimony was not credible, and it was contradicted by credible testimony, and we do not disturb this finding. Absent compelling evidence to the contrary, we will not disturb credibility findings made by the ALJ who was present at the hearing and able to directly observe and gauge the demeanor of the witness and weigh his or her statement in light of his or her manner on the stand. (*River Ranch Fresh Foods-Salinas, Inc.*, Cal/OSHA App. 01-1977, Decision After Reconsideration (Jul. 21, 2003)). We also note that the ALJ’s conclusion is supported by the evidence in the record.

procedures, establishes Employer's goals, and ensures that all employees receive training.

Massey testified that the Employer had a detailed and extensive Injury and Illness Prevention Program (IIPP), with over seventy individual work instructions. (Exhibit F; Exhibit 7.) Massey also detailed efforts made by the Employer to provide training to employees. Each supervisor undergoes thirty hours of OSHA training. Further, new employees receive a full day of training, and the employee receives additional training specific to their job assignment when they are assigned to a crew. There is a full-day rigging course. Employer also has multiple safety committees, including a rigging committee.

Each trade worker receives approximately an hour of training each month on safety topics. Beginning in May 2010, Employer issued a monthly newsletter called the Safety Sentinel that goes to supervisors containing information regarding employee safety. Supervisors then convey the information to their employees. In addition, Employer issues "flash grams," "safety grams" and "gang boxes" to provide topics for training. Employer also engages in spot-checks to ensure that supervisors are delivering training effectively.

Employer also has a program to sanction employees who do not follow safety rules. Massey discussed Exhibit I, which is a summary of the number of Employer's warnings, suspensions, and terminations from 2005 through 2011 due to safety violations and infractions, which evidences that Employer issued a number of warnings and suspensions, and multiple terminations due to safety infractions. For example, in 2009, Employer issued 228 warnings, 63 suspensions, and 28 terminations due to safety infractions. In 2010, Employer issued 171 warnings, 80 suspensions, and 17 terminations due to safety infractions.⁶

H. Previous Citations.

The Division introduced evidence demonstrating that Employer received three previous citations for violations of section 4991(a) [failure to control travel

⁶ Massey also testified that the Employer's safety program has been effective, as shown in Employer's Exhibits J and K. Exhibit J is a chart of the injury frequency rates for all injuries from 2005 through 2011. A frequency rate refers to the number of lost work days caused by injuries. Exhibit K is a chart of recordable injury rates from 2005 to 2011. Recordable injuries are those that require more than mere first aid. For both exhibits, the Employer's rate and industry average are charted. The Exhibits show that Employer has improved both its frequency rate and recordable rate, bringing both rates below the industry average for similar employers. (See. Exhibits J and K.)

of crane to avoid a collision] within the past three years preceding the instant collision.

On January 3, 2008, the Division issued to Employer a citation for a serious violation of section 4991(a), which proposed a penalty of \$4500. The citation stated: "Travel of the Magnetic Crane 2100 was not controlled so as to prevent collision with the Grove 18 Ton mobile hydraulic crane." Employer signed a statement of abatement, which stated:

2 way radios were provided to both crane operators to improve communication (sic) future work in this area of the shipyard involving subcontractors....

The citation was resolved via stipulation and order and a penalty of \$3,150 was assessed. (See, Exhibit 8A.)

On April 10, 2008, the Division issued to Employer a citation for a serious violation of section 4991(a), which proposed a penalty of \$5,735. The citation stated: "The travel of the crane #600 was not controlled so as to avoid collision with the high voltage panel located in the craneway." Employer signed a statement of abatement, which stated:

Crane training was revised with the assistant (sic) of a Crane Consultant Company, and operators were retrained to ensure proficiency.

The citation was resolved via stipulation and order. The citation was amended from serious to general and a penalty of \$525 was assessed. (See, Exhibit 8C.)

On July 8, 2008, the Division issued to Employer a repeat serious citation for violation of section 4991(a), which proposed a penalty of \$27,000.

The citation stated:

The travel of crane #9 was not controlled so as to avoid collision with equipment. On March 20, 2008, crane #9 collided with a sky climber that was on the crane tracks.

This is a Repeat Violation of Citation number 2, Item number 1, Inspection number 301280186, Report number 007-05, Region 6 District 2, Issued on 3/15/2005. This citation became a final order of the Board on 12/18/2006.

Employer signed a statement of abatement, which stated:

Inspection #309152882 A series of Rigging Department wide training gang boxes were held Mar 24-28 to reinforce the requirements for clear tracks prior to crane movement.

Again, the citation was resolved via stipulation and order, and a penalty of \$27,000 was assessed. (See, Exhibit 8B.)

DECISION AFTER RECONSIDERATION

Labor Code section 6617 sets forth five (5) grounds upon which a petition for reconsideration may be based:

- (a) That by such order or decision made and filed by the appeals board or hearing officer, the appeals board acted without or in excess of its powers.
- (b) That the order or decision was procured by fraud.
- (c) That the evidence does not justify the findings of fact.
- (d) That the petitioner has discovered new evidence material to him, which he could not, with reasonable diligence, have discovered and produced at the hearing.
- (e) That the findings of fact do not support the order or decision.

The Division petitioned for reconsideration on the basis of Labor Code section 6617 (c) and (e). The Board has reviewed and considered the Division's petition for reconsideration and the Employer's answer. In making this decision, the Board relies upon its independent review of the entire evidentiary record in the proceeding.

I. The Citation for Violation of Section 4991(a).

The Division cited employer for willful, serious, repeat violation of section 4991(a)⁷ [failure to control travel of crane to avoid a collision]. Although the ALJ found that the Division established a violation of this section, the ALJ found that Employer established the Independent Employee Act Defense (IEAD), which operates as a complete defense to the citation. The elements of IEAD are:

- 1) The employee was experienced in the job being performed;

⁷ The full text of section 4991(a) provides as follows: "The travel of cranes or boom-type excavators shall be controlled so as to avoid collision with persons, material, and equipment. The cabs of units (of the revolving type) traveling under their own power shall be turned on so as to provide the least obstruction to the operator's vision in the direction of travel, unless receiving signals from someone with an unobstructed view."

- 2) The employer has a well-devised safety program which includes training employees in matters of safety respective to their particular job assignments;
- 3) The employer effectively enforces the safety program;
- 4) The employer has a policy of sanctions against employees who violate the safety program; and
- 5) The employee caused a safety infraction which he or she knew was contra to the employer's safety requirements.

(See, *Mercury Service, Inc.*, Cal/OSHA App. 77-1133, Decision After Reconsideration (Oct. 16, 1980); see also, *Davey Tree Surgery Co. v. Occupational Safety & Health Appeals Bd.*, (1985) 167 Cal. App. 3d 1232, 1239.)

Employer argued that the IEAD applied based on the conduct of the riggers, and particularly Huezo. The ALJ agreed with Employer. The Division solely challenges the ALJ's finding as to the second and third elements of the IEAD.

Specifically, the Division argues that the second and third elements are not met. That is, the Division asserts that it was error to conclude Employer has a well-devised safety program which includes training employees in matters of safety respective to their particular job assignments, and that Employer effectively enforces the safety program. The Division bases this position on the following set of assertions: (1) a specific warning Meadows gave to his supervisor was not effectively disseminated to third shift; (2) the absence of any discipline for the supervisors due to their failure to effectively convey Meadows' warning; (3) the lack of detail in the riggers' disciplinary write-ups following the collision; and (4) the previous citations issued to the Employer. The Division does not specifically identify how each assertion undermines both element two and three of the IEAD. We will consider whether any of these evidentiary arguments sufficiently overcomes the second and third elements of the IEAD.

1. Second Element of IEAD.

The second element of the IEAD requires the employer to have a well-devised safety program which includes training employees in matters of safety respective to their particular job assignments. (See, *Mercury Service, Inc.*, Cal/OSHA App. 77-1133, Decision After Reconsideration (Oct. 16, 1980).) This element should be analyzed by taking a realistic view of the written program

and policies, as well as the actual practices at the workplace. (*See, Glass Pak, Cal/OSHA App. 03-750, Decision After Reconsideration (Nov. 4, 2010).*)

Here, Employer had many aspects of an overall well-devised safety program, which included appropriate training. Employer has a detailed IIPP with over seventy work instructions, including instructions specific to riggers.⁸ Employer also provides training to its employees. Supervisors undergo thirty hours of OSHA training. New employees receive a full day of training, and when they are assigned to a crew the employee receives additional training specific to their job assignment. Riggers have a full day rigging course. There is also ongoing training, as illustrated by the testimony concerning the Safety Sentinel, Gang Boxes, and Flash Grams.

Huezo's testimony also supports the conclusion that he received some training as a rigger to lookout for obstructions and threats that may interfere with the movement of the crane. Huezo testified that it was his job to look for any obstacles in the path of the crane. He also admitted that he is supposed to walk forward of the crane. He stated he usually walks twenty feet in front of the crane to help the crane avoid hitting obstacles, and to allow the crane sufficient time to stop when necessary. From the description of his usual practice, the Board concludes that he received some training in matters of safety related to his job as a rigger.⁹

Notwithstanding the foregoing, the Division presented evidence that defeats a finding that Employer had a well devised safety program which included needed training, particularly as to the section 4991(a) citation. The Evidence adduced at hearing showed that Employer received three previous citations for violations of section 4991(a) within the three years prior to the instant collision. (Exhibits 8(A), 8(B), and 8(C).) The instant collision represents the fourth instance within three years of a collision between shipyard cranes and visible obstructions resulting in Cal/OSHA citations. The Division argues that the repeat nature of shipyard crane collisions within the relatively short span of three years sufficiently demonstrates that the safety program in place is not well devised with regard to avoiding crane collisions, despite its having substantial training on other topics. The Division's argument is well-taken. A well devised safety program has multiple components, and its assessment should be made based on both the

⁸ Exhibit F is the IIPP table of contents. The ALJ noted in her Decision that Employer produced the entire IIPP at hearing, but offered only a portion of it (i.e. the table of contents) into evidence because the IIPP was so voluminous.

⁹ As further evidence of the effectiveness of Employer's safety program, Employer had safety discussions prior to the subject dual crane move. Padilla and Evans had a meeting, and exchanged email, wherein they discussed potential safety issues with the hopper. Next, at the beginning of the third shift, Evans held a pre-job meeting with the riggers where he discussed the potential obstruction.

documentation and the implementation. (*Glass-Pak, supra.*) The previous citations demonstrate the safety plan has not been effective in avoiding shipyard crane collisions. Employer did not make any effort to factually distinguish the previous citations, or show that they had differing root causes; Employer scarcely addressed these previous citations on the record.

We additionally note that there is other evidence which bolsters the finding that Employer did not have a well-devised safety program that includes training. First, Employer did not have specific written rules delineating, or providing specific guidelines, as to where riggers should position themselves in connection with the movement of the crane.¹⁰ Second, there was substantial disputed testimony regarding whether riggers were instructed not to press the e-stop button, particularly during dual crane movements, evidencing a lack of sufficient training and sufficient rules on this issue.

As a result, Employer failed to establish the second element of the IEAD defense, and the defense therefore fails.

Further, even assuming for the sake of argument that Employer established that it had a well-devised safety program and adequate training (which is denied for the reasons discussed above), the number of previously cited shipyard collisions at Employer's workplace would then establish the failure of the third element of IEAD, *i.e.* that Employer did not effectively enforce its safety program. The number of citations in a three year period demonstrates the absence of effective enforcement.

2. Classification of Section 4991(a).

We now turn to classification of the citation. The Division cited the section 4991(a) citation as serious, willful, and repeat.

1. Serious Classification.

Within its appeal, Employer challenged the serious classification for the section 4991(a) citation. After review of the record, it is clear the evidence was sufficient to support the classification.

When the citations were issued, workplace safety violations were classified as "serious" if there was a substantial probability that death or

¹⁰ Ali identified Exhibit 7 as the work instructions that riggers were supposed to follow. The instructions do not state how far riggers should be in front of the load, nor do they even specifically state that riggers should situate themselves in front of the load, or in front of the crane's direction of travel. Ali also testified that the rules do not provide guidance on when riggers should press the e-stop button.

serious physical harm could result from a violation. (Former Labor Code § 6432(a).) “Substantial probability” refers not to the probability that an accident or exposure will occur as a result of the violation, but rather to the probability that death or serious physical harm will result assuming an accident or exposure occurs as a result of the violation. (Labor Code §6432(c); section 334(c)(3).) Therefore, the Division must prove by credible evidence that a serious physical injury is more likely than not to occur as a result of the accident. (See, *Benicia Foundry & Iron Works, Inc.*, Cal/OSHA App. 00-2976, Decision After Reconsideration (Apr. 24, 2003), citing *Abatti Farms/Produce*, Cal/OSHA App. 81-0256, Decision After Reconsideration (Oct. 4, 1985).) Opinion evidence of the probability of serious injury can be considered. (*Forklift Sales of Sacramento, Inc.*, Cal/OSHA App. 05-3477, Decision After Reconsideration (Jul. 7, 2011).)

Here, the cranes were carrying an approximate load of 450 tons between them. Based on his experience with cranes, the Division’s witness, Phillip Yow, credibly testified that when a crane hits an object and stops abruptly, the load can continue to move, leading to the potential of catastrophic failure, including broken cables, collapse or breakage of the crane, overloading of a crane (on dual crane move), and loss of the load. As a result, any persons operating the crane or in the vicinity of the crane, under such circumstances, would clearly be subject to a substantial probability of death or serious physical harm.

Next, Meadows credibly testified that the hopper weighed in excess of 17 tons. If anyone had been in the path of the falling hopper after it was struck by the crane, it would have certainly resulted in death or serious physical harm. The parties stipulated that if a seventeen ton object fell on someone it would crush them. It is noted that the riggers were in the nearby vicinity of the hopper when it was struck by the crane. Dykeman also acknowledge that there was the potential that this obstacle could destroy the crane or kill someone, noting such a potential exists with any obstacle.

As a result, the Division has established that this citation was correctly cited as serious since there was substantial probability that death or serious physical harm will result from the violation. The Division presented sufficient evidence that when a load weighing multiple tons falls there is a substantial probability that death or serious physical harm will result.

Employer raises the lack of employer knowledge defense, which is solely a defense to the serious classification. Former Labor Code § 6432(b) included an affirmative defense to serious classifications based on an employer’s lack of knowledge of the violation. Former Labor Code § 6432(b) stated, “[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 Appeals Board has recognized that the employer has the burden with respect to this point, and:

To prove that Employer could not have known of the violative condition by exercising reasonable diligence, Employer must establish that the violation occurred at a time and under the circumstances which could not provide Employer with a reasonable opportunity to have detected it. (*Bickerton Iron Works, Inc.*, Cal/OSHA App. 01-4978, Decision After Reconsideration (Feb. 25, 2004); *see also, Vance Brown, Inc.*, Cal/OSHA App. 00-3318, Decision After Reconsideration (Apr. 1, 2003).)

An absence of appropriate supervision and failure to pay close attention to employees’ ongoing work may defeat this defense. (*Vance Brown, Inc.*, Cal/OSHA App. 00-3318, Decision After Reconsideration (Apr. 1, 2003).) The Appeals Board has also held that hazardous conditions, plainly visible to the naked eye, constitute serious violations since the employer could have discovered them through reasonable diligence. (*See e.g., Fibreboard Box & Millwork Corp.*, Cal/OSHA App. 90-492, Decision After Reconsideration (Jun. 21, 1991)—referring to unguarded machine parts.)

Under the facts of this case, Employer cannot establish this defense. Here, Employer cannot demonstrate that it did not, and could not, with the exercise of reasonable diligence know of the presence of the dangerous condition posed by the hopper, or that a collision could occur between the crane and the hopper. The hopper’s location, near the crane’s path of travel, was plainly visible. Further, as discussed herein, the Employer’s supervisors, Luster, Padilla and Evans, were all expressly notified that the location of the hopper could present a collision hazard. The supervisors’ knowledge regarding the location of the hopper and the potential collision hazard defeats this defense, as does the fact that it was a plainly visible obstruction.

2. The Willful Classification.

Within its appeal, Employer also challenged the willful classification for the section 4991(a) citation. The Board concludes that a willful classification is not appropriate in this matter.

Section 334(e) defines a willful violation as follows:

Willful Violation -is a violation where evidence shows that the employer committed an intentional and knowing, as contrasted with inadvertent, violation, and the employer is conscious of the fact that what he is doing constitutes a violation of a safety law; or,

even though the employer was not consciously violating a safety law, he was aware that an unsafe or hazardous condition existed and made no reasonable effort to eliminate the condition.

"Under Section 334, the Division may establish the willfulness of a violation by showing by a preponderance of the evidence that: (1) an employer intentionally violated a safety law or (2) an employer had actual knowledge of an unsafe or hazardous condition, yet did not attempt to correct it." (*Rick's Electric, Inc. v. California Occupational Safety and Health Appeals Bd.*, (2000) 80 Cal.App.4th 1023, 1034-1035, *citing*, *National Cement Co.*, Cal/OSHA 91-310, Decision After Reconsideration (Mar. 10, 1993); *see also*, *Tutor-Saliba-Perini*, Cal/OSHA App. 94-2279 et. al., Decision After Reconsideration (Aug. 20, 2001).)

Here, the Division failed to establish the first test for willfulness, *i.e.* that Employer committed an intentional and knowing violation of section 4991(a). "That standard requires the Division to prove by a preponderance of the evidence that the employer committed a voluntary and volitional, as opposed to inadvertent, act, or, in other words, that the act itself was the desired consequence of the actor's intent, and that the employer was conscious that its act violated a safety order." (*Rick's Electric, Inc. v. California Occupational Safety and Health Appeals Bd.*, (2000) 80 Cal.App.4th 1023, 1037.) While Employer certainly had knowledge that the hopper posed a collision hazard for the cranes, a preponderance of the evidence suggests that Employer, through its warnings to its supervisors and its assignment of riggers, made sincere efforts (although ultimately inadequate) to control the movement of the crane to avoid any such collision. The assignment of the riggers, and Evans' provision of warnings to the riggers regarding the location of the hopper, militates in favor of a finding that employer was not consciously violating the safety order, and that the collision was inadvertent. The requisite intent to violate the safety order is not shown.

Next, the Division failed to establish the second test for willfulness, *i.e.* that the employer had actual knowledge of an unsafe or hazardous condition, yet did not attempt to correct it. Although Employer was certainly aware that the location of the hopper posed a collision hazard, the Employer made efforts to correct and/or ameliorate the hazardous condition posed by the hopper. And we cannot say that the Employer's efforts were entirely unreasonable, although more could have been done. Evans, who was in charge of the dual crane movement, was specifically apprised via email and in person that the location of the hopper could present a collision hazard. Padilla provided detailed warning to Evans regarding the location of the hopper. Evans made reasonable efforts to ameliorate the hazard caused by the location of the hopper by assigning two riggers to ensure that a collision was avoided. Evans specifically instructed those riggers to look out for the hopper on two

occasions. Evans was also available to the riggers via radio to address any issues, and he was in the nearby vicinity. This conduct by Evans demonstrates sufficient corrective efforts to vitiate a finding of willfulness.

Although Employer certainly could have done more, we find that a preponderance of the evidence shows that the Division failed to establish that the Employer's violation of section 4991(a) was willful.

3. The Repeat Classification.

The Division also classified the citation as repeat. A repeat violation is defined as "a violation where the employer has corrected, or indicated correction of an earlier violation, for which a citation was issued, and upon a later inspection is found to have committed the same violation again within a period of three years immediately preceding the latter violation." (Section 334(d)(1).) In order to establish the repeat classification, the Division must establish:

- (1) The elements of the subsequent violation;
- (2) the final disposition of the prior citation;
- (3) that essentially similar facts existed in the prior and subsequent citations;
- (4) proof of correction of the prior violation. (*The Herrick Corporation*, Cal/OSHA App. 97-2604 Decision After Reconsideration (Mar. 28, 2001).)

The Division must also establish that the earlier citation(s) was properly served on the same employer. (*The Herrick Corporation*, Cal/OSHA App. 97-2604 Decision After Reconsideration (Mar. 28, 2001).)

Here, the Division entered Exhibits 8A, 8B, and 8C into evidence in order to establish the aforementioned elements. These exhibits generally consist of: 1) a Certification of Repeat Violation executed under penalty of perjury; 2) a copy of the previous citations; 3) a copy of either a proof of service, or certified mail receipts to establish service of the previous citations; 4) Employer's signed statement of abatement; and 5) copies of the final stipulations and orders.

With regard to the first element of a repeat citation, we find that the Division established the elements of the subsequent violation of section 4991(a), as discussed herein and within the Decision of the ALJ.

With regard to the second element, the Division presented evidence demonstrating the final disposition of the previous citations, as noted in Exhibits 8A, 8B, and 8C.

With regard to the third element, the Division presented evidence, as noted in Exhibits 8A, 8B, and 8C, that the prior citations involved essentially similar facts. Like the instant collision, the previous citations all concern collisions between shipyard cranes and visible obstructions, including other cranes, resulting in citations for violation of section 4991(a).

Next, with regard to the fourth element, the Division presented proof of correction of the prior violations. The Division presented employer signed statements of abatement. (Exhibits 8A, 8B, and 8C.)

Finally, the Division presented evidence in the form of proofs of service and certified mail receipts, which establish service of the citations on the Employer.¹¹ Further, we conclude that the citations were served and actually received based on the existence of the employer's statement of abatement and the stipulations and orders.

The Division established the repeat nature of the citation; there have been three previous citations for violation of section 4991(a) in the past three years.

4. The Penalty.

In reviewing Exhibit 2, the Division's Proposed Penalty Worksheet, we find no error in the Division's calculations. The Division properly calculated the initial base penalty for a serious violation as \$18,000. (See, section 336(c)(1).) The Division then reduced the base penalty by 25% based on a gravity-based determination that the Extent was Low. The Division also made a gravity based determination that the Likelihood was Medium due the number of employees exposed to the hazard, and the extent to which the violation has in the past resulted in injury, illness, or disease, resulting in no reduction. This resulted in a gravity-based penalty of \$13,500. (See section 336(c).) We see no error in the Division's gravity-based calculations.

The Division then multiplied the gravity based penalty by ten (x10) due to the existence of three previous citations, as discussed above. (See, section 336(g).) Ultimately, the total amount of the penalty calculated by the Division

¹¹ The Division also provided the copies of the envelope as to two of the previous citations. (See, Evidence Code section 641. "A letter correctly addressed and properly mailed is presumed to have been received in the ordinary course of mail.")

exceeded \$70,000 due to the repeat nature of the violation. However, since the penalty is capped at \$70,000 the Division proposed a penalty of \$70,000. (See, section 336(g),(h).) Again, we see no error in the Division's calculations. We find that a penalty of \$70,000 is appropriate in this matter, and so order.¹²

The aforementioned penalty calculations include no penalty for willfulness for the reasons discussed herein.

II. The Citation for Violation of Section 4994(e).

The Division also cited Employer for a serious willful violation of section 4994(e)¹³ [failure to analyze or give instruction prior to two crane lift]. The ALJ found that the Division failed to establish its burden of proof on this claim, finding that Employer did engage in a sufficient analysis.

Within its Petition for Reconsideration, the Division argues that the ALJ erred when she found that Employer's analysis was sufficient because Employer could have: 1) determined and measured the actual location and attitude (lean) of the hopper; 2) as a result of this determination recognize that Gantry crane fifteen (15) could not get by; 3) allow a margin of error to determine at what point the crane should have been stopped; and, 4) inform the riggers that a certain point could not be passed and the crane must be stopped at that point. The Division argues that a more detailed analysis would have helped avoid a collision.

Section 4994(e) requires a qualified person to analyze the operation and instruct all personnel involved in the proper position and rigging of the load, and the movements to be made. The extent of analysis required will depend on the specific circumstances of the matter. The dictionary definition of the word "analysis" is a "separation of a whole into its component parts; an examination of a complex, its elements, and their relations." (*National Steel and Shipbuilding Company (NASSCO)*, Cal/OSHA App. 10-3793, Denial of Petition for Reconsideration (Sept. 20, 2012.) Section 4994(e) does not require that Employer have a "back-up plan." (Id.)

¹² It is noted that the penalty for this citation would have exceeded \$70,000, due to the repeat nature of the citation, even if the Likelihood was determined to be Low.

¹³ The full text of section 4994(e) provides as follows: "When two or more cranes are used to lift one load, a qualified person, other than the operator, shall direct the operation. This person shall analyze the operation and instruct all personnel involved in the proper positioning and rigging of the load, and the movements to be made. A qualified person shall be in direct audible communication with both crane operators at all times to direct the lifting operation. Where two cranes or more are used to lift one load, the rating chart shall be reduced on each crane by not less than 25 percent, unless equalizer or other acceptable provisions assure safe distribution of both vertical and horizontal load to the cranes involved, in which case a lesser reduction may be applied."

Evans was in charge of the two crane lift and the required analysis, and no party has argued that he was not competent or qualified to perform the analysis.

The evidence establishes that Evans performed a sufficient analysis regarding the hopper for several reasons. Evans knew where the load needed to travel and be placed. The evidence also shows that Evans was aware and acknowledged the potential hazard created by the hopper. When Evans started his shift, both he and Padilla engaged in a detailed turnover meeting wherein Padilla specifically informed him of the possible hazard created by hopper to the crane movement, both orally, in writing, and using pictures. Evans understood the location of the hopper could be an issue. He did not simply assume the cranes would clear. He took precautions to enable the safe movement of the load.

Evans assigned riggers the task of ensuring there were no obstacles in the path of the crane, and to stop the cranes before they hit any obstruction or obstacle. He warned the riggers to be cautious of the hopper on the day of the collision. The riggers were trained to avoid collisions. The Employer relies on the riggers' senses, perceptions, and training to determine when to stop a crane to avoid a collision. The riggers were trained to walk a sufficient distance in advance of the crane to help avoid collisions and to stop the crane if necessary (although it is noted that more specific instructions on distances and on the e-stop button would have made the training more complete for this task). Evans understood the riggers training, and believed the riggers would fulfill their role.

All persons engaged in the move were within audible communication. They all had radios and were on the same frequency, and the riggers were trained to stop the movement of the load at any time if they perceived a hazard or threat. Evans was also monitoring the load and was available via radio.

Further, dual crane movements are relatively routine and happen at least once a week. Next, the placement of the hopper in this case would not necessarily cause great alarm; the hopper had been placed in that general location several times previously without incident. Although the hopper's location was close, the cranes had previously cleared the hopper. Employer also successfully ran crane number seven by the hopper which demonstrated some established clearance.

The Division did not prove that the location of the hopper and its potential impact on the move was not analyzed or considered by Evans. The other arguments raised by the Division find fault with Evan's beginning the move without pre-determining a safe margin of error, pre-determining a stopping point, or pre-determining the crane could not pass the hopper. While

hindsight makes clear these would have been good to know, and may have stopped Evans from beginning the move, the safety order only requires that a qualified person analyze the operation and provide instruction. Evans knew of the hopper's location and the collision hazard it posed. Evans received information, including pictures, regarding its location. To avoid a collision, Evans assigned riggers who are trained to observe and stop the movement of the cranes when clearance is insufficient. Evans alerted those riggers on two occasions to be mindful of the close passing clearance posed by the hopper, demonstrating that he was analyzing the issue and mindful of it. We find that Evans engaged in analysis. This is what is required by the safety order. Thus, we uphold the ALJ's decision to vacate the section 4994(e) citation.

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

OCCUPATIONAL SAFETY AND HEALTH APPEALS BOARD
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