United States of America
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION

SECRETARY OF LABOR, Complainant, v. URS FEDERAL SERVICES, INC., and its successors,[1] Respondent.	OSHRC Docket No. 18-0278

Appearances:

Luis A. Garcia, Esq. & Nisha Parekh, Esq., Department of Labor, Office of Solicitor, Los Angeles, California
For Complainant

Jason S. Mills, Esq. & Justin Hanassab, Morgan, Lewis & Bockius, LLP, Los Angeles, California
For Respondent

Before: Judge Patrick B. Augustine – U. S. Administrative Law Judge

DECISION AND ORDER

I. Procedural History

While operating a grinder in a Department of Defense ("DOD") welding shop in Barstow, California, one of Respondent's employees was severely injured when the grinding stone he was using exploded. (Tr. 156). Although he was using proper protective equipment, the employee suffered a severe laceration to his head and a concussion that put him out of work for nearly six months.[2] (Tr. 58–59, 510; Ex. C-17). Subsequent investigation revealed the employee used a

1. As noted by Respondent's counsel, URS was purchased by, and became a part of, AECOM. (Tr. 28–29). Thus, the parties refer to both entities interchangeably; however, both parties stipulated URS Federal, Inc. is the "real party in interest to these proceedings." (Stip. No. 1).
2. N.M. returned to work on restricted duty after three months but did not return to full-duty status until six months after the accident.

grinding stone with an RPM (revolutions per minute) rating that did not match the RPM rating of the grinder. (Stip. No. 10; Tr. 272; Ex. C-9).

A complaint was filed with the Occupational Safety Health Administration ("OSHA") San Diego Area Office that one of Respondent's employees had been hospitalized with a work-related injury, which was not reported to OSHA. (Tr. 203). The complaint was forwarded to the Las Vegas Area Office, which dispatched Compliance Safety and Health Officer ("CSHO") Kentis Casto to conduct an inspection. (Tr. 202). Over the course of two days, CSHO Casto conducted an inspection of Respondent's worksite at the Marine Corps Logistics Base in Barstow.[3] (Tr. 311–12). CSHO Casto interviewed employees and members of management and reviewed the workplace and equipment involved in the accident. (Tr. 212–13). As a result of his inspection, CSHO Casto recommended, and Complainant issued, a Citation and Notification of Penalty ("Citation"). The Citation alleges a single-item, serious violation of 29 C.F.R. § 1910.215(d)(1) with a recommended penalty of $12,934. Respondent submitted a timely Notice of Contest, bringing the matter before the Occupational Safety and Health Review Commission ("Commission").

A trial was held on November 27–28, 2018, in Bakersfield, California. The following individuals testified: (1) Shako Leang, former supervisor for Respondent; (2) David Downing, former welder for Respondent; (3) CSHO Kentis Casto; (4) Richard Stone, Respondent's Safety Director; and (5) Aaron "Abe" Ellis, Respondent's Barstow site manager. Both parties timely submitted post-trial briefs. Based on the evidence, arguments, and relevant case law, the Court

3. CSHO Casto's inspection took place on September 21st and 25th, 2017, which was roughly one month after the employee was injured. (Tr. 56, 311–12). Although the inspection spanned a period of five days, CSHO Casto was only on-site for two days because he arrived on a Thursday, which was the last day of Respondent's work week, and returned the following Monday to conclude the inspection. (Tr. 311–12).

finds Respondent failed to exercise reasonable diligence to prevent violations of 29 C.F.R. § 1910.215(d)(1).

II. Stipulations & Jurisdiction

The parties stipulated to jurisdictional and legal matters, which were submitted by the parties as Joint Exhibit 1.[4] Based on the parties' stipulations, the Court finds the Commission has jurisdiction over the matter pursuant to Section 10(c) of the Act, 29 U.S.C. § 659(c). (Stip. No. 2). Further, the Court finds Respondent was an employer engaged in a business and industry affecting interstate commerce within the meaning of sections 3(3) and 3(5) of the Act, 29 U.S.C. § 652(5). (*Id.*). *Slingluff v. OSHRC*, 425 F.3d 861, 866–67 (10th Cir. 2005).

III. Factual Background

A. Nature of the Work

Respondent is a large design, engineering, and construction firm. (Tr. 387). As is relevant to this case, Respondent contracted with the DOD to assemble, repair, and refurbish military vehicles at the Barstow Marine Corps Logistics Base. (Tr. 103). Respondent provided roughly 376 employees to carry out various tasks in the assembly of these vehicles, which included painting, welding, steam, blasting, and others.[5] (Tr. 118, 120). Those employees, in turn, were overseen by five supervisors, most of whom had responsibility for managing multiple task areas spread out over a large area within the base. (Tr. 119). Shako Leang, who supervised the weld shop where the injured employee worked, was responsible for seven different departments, including paint shop, steam, blast, weld, Humvees for both Marines and Air Force, and tear-down. (Tr. 121). These departments were spread out all over the base. (Tr. 103–104).

4. References to the parties' Joint Stipulations will indicate the source and specific stipulation, e.g., "Stip. No. ___".
5. This is just an abbreviated list of tasks carried out by Respondent's employees, many of which were not described in detail, but all were related to the assembly of military vehicles.

In addition to the employees and supervisors supplied by Respondent, DOD had its own employees and supervisors working within each of the departments or "lines", as Leang referred to them. (Tr. 103). The employees and supervisors of Respondent and DOD worked alongside each other, but Leang testified there was no overlap in supervision: DOD supervisors supervised DOD employees, and Respondent's supervisors supervised Respondent's employees. (Tr. 146–47). Respondent's employees were required to supply their own hand tools—wrenches, screwdrivers, etc.—however, they used power tools supplied by DOD employees in the weld shop. (Tr. 49–50). This included the angle grinders and grinding stones that were used in the welding shop. According to David Downing, who had worked at the base before Respondent took over the maintenance contract and continues to do so now that Respondent's contract has expired, all welders working in the welding line would go to the tool counter to request grinders and stones/discs, which would be provided by a DOD employee. (Tr. 177).

B. The Accident

On July 25, 2018, N.M. was grinding down welds on an MRAP vehicle when his grinding stone exploded and knocked him to the ground. (Tr. 64–65). When his supervisor, Shako Leang, arrived at the scene of the accident, N.M. was lying on the ground and was bleeding from his forehead. (Tr. 58–59). Although N.M. was wearing proper protective gear, including a full-face shield, the shattered pieces of stone crashed into the shield with enough force to lacerate his forehead and cause a severe concussion. (Tr. 62–63; Ex. C-2). He was taken to the hospital where he was observed and later released. (Tr. 80). N.M. was unable to return to full duty for six months. According to CSHO Casto's investigation, N.M. had been using a 5-inch Dynabrade right-angle

grinder that was rated for 12,000 RPM with a grinding stone[6] that was only rated to 9,070 RPM. (Tr. 164, 216, 265; Ex. C-9).

C. Previous Accidents

Prior to the accident at issue in this case, two other employees were injured using grinders in the welding shop: David Downing, who testified at trial, and Abraham Abreu, who was not called as a witness. While there are similarities between the three cases, there are also notable differences in both the respective causes of the accidents, as well as what Respondent knew about the accidents themselves.

The first incident, involving Abreu, was documented in Respondent's incident and injury database and, thus, was indisputably known to Respondent. (Ex. C-5). According to the narrative in the log, on October 18, 2016, Abreu was grinding a sharp edge at an angle on a military vehicle with a cutting wheel (as opposed to the stone used by N.M.) when the rubber backing of the wheel broke off and struck him in the groin area. (Tr. 454–55; Ex. C-5). Richard Stone confirmed the basic facts recounted in the log. (Tr. 454). Stone also testified Abreu was using the appropriate grinding disc for the grinder. (Tr. 455). There was no evidence to suggest the disc exploded or that it was incompatible with the grinder, both of which were the case in the incident involving N.M.

The second incident, which involved Downing, appears somewhat similar to the incident involving N.M.; however, there are some important differences. According to Downing, in November of 2016, he was using an angle grinder and cup, similar to that used by N.M., when it "exploded" on him. (Tr. 156). Downing testified the shrapnel that released from the stone

6. Downing also referred to these stones as "cups", based on their shape. (Tr. 159). According to Downing, if the rating of the stone is lower than the grinder, the adhesive of the stone will be unable to hold it together; thus, causing the "explosion". (Tr. 168; Ex. R-2).

dislocated his thumb and left a bruise on his chest that lasted for a few weeks. (Tr. 157). After this explosion occurred, a fellow welder, Steve Peterson, approached Downing, telling him he heard the explosion. (Tr. 181). Downing, who was not going to say anything about the incident, recounted what happened to Peterson, who was also an employee safety representative. (Tr. 181). Peterson asked Downing if he "wanted to go anywhere with it". (Tr. 181). Downing responded Peterson was the "safety guy" and he should do what he needed to do. (Tr. 181). After that, Downing went back to work. At trial, Downing could not recall whether the grinding stone was compatible with the grinder he was using, nor could he identify the reason why it had exploded; though he did speculate it was possible the stone could have been dropped in transit or in the DOD shop. (Tr. 157).

As for Peterson, the "safety guy", the testimony revealed he was a member of a safety committee, which was made up of rank-and-file employees from each of the respective lines and chaired by the site manager. (Tr. 457–58). Respondent designed the committee as a boots-on-the-ground approach to identifying hazards and safety issues, including once-a-month site walkthroughs. (*Id.*). The committee members would, in turn, report those issues during their meetings, which would be relayed to management through the site manager. (Tr. 458). Unlike people working directly for Stone, employees like Peterson were not employed by the safety department, nor were they supervisors. (Tr. 457, 502). With respect to the incident involving Downing, there is no evidence Peterson brought it to the attention of the committee, the site manager, or any other supervisor.

D. Respondent's Safety and Training Program

Respondent introduced extensive documentation of its training and safety program. Stone testified Respondent provides training on general safety principles, as well as specific safety

measures, to its employees and managers. (Tr. 408–410). The general safety training course for rank-and-file employees is at orientation, as well as on an annual basis thereafter. (Tr. 409). Respondent provides managers, like Leang, with a training module called STAR, which Stone testified is designed to give managers the tools they need to lead safety successfully and to aid their employees to understand the importance of safe work practices. (Tr. 410). Stone noted he personally provided Leang with this training in approximately May of 2016. (Tr. 410).

In addition to more general training, Respondent's employees participate in tailgate training sessions that are provided every morning during what Leang referred to as morning muster. During morning muster, Leang would generally discuss safety issues, and he or a designated employee would cover an assigned safety-related topic. (Tr. 126–27; Ex. R-2). According to the documentation submitted by Respondent, N.M. participated in many of those training sessions, which covered topics such as cutting and grinding and handheld pneumatic tools. (Ex. R-2). While Leang testified he participated in and, in some cases, proctored these tailgate training sessions, he admitted he had not received substantive training in some of the specific lines for which he was responsible, including welding and grinding. (Tr. 55–56).

Respondent also implemented a process by which employees would examine their own work practices, as well as those of their fellow employees. (Tr. 444–45; Ex. C-2 at URS Barstow_000163, R-8). For example, prior to beginning work in the welding department, each employee was required to review a general Job Hazard Analysis ("JHA")—provided by DOD—specific to their job. (Tr. 430; Ex. R-2 at URSBarstow_000010). This JHA identified the general hazards and safety concerns for a specific activity within a line. (Tr. 430). In addition, each employee was required to complete a more specific task hazard analysis for the specific activity they were performing that day. (Ex. R-2). According to Leang, the purpose of this self-assessment

was to ensure individual employees were focused on the specific hazards presented by the work activity for the day. (Tr. 128–130). Coupled with the self-assessments, employees were occasionally directed by the safety supervisor to perform Behavior-Based Safety Checklists of their fellow employees to ensure safety principles were being followed. (Tr. 349–50, 441; Ex. R-8). As for Leang, he occasionally walked through the worksite to ensure employees were wearing their required PPE and performing the work safely, though he also admitted he spent a significant amount of his time in the office performing administrative work. (Tr. 113–14). These walkarounds were supposed to be supplemented by an on-site safety supervisor, who was supposed to perform walkarounds, trainings, and observations of both employees and managers. (Tr. 447–448). None of the checklists or hazard analyses mention anything about grinder compatibility.

Regarding the specific hazard at issue in this case—grinder compatibility—Respondent has a work rule requiring its employees to ensure the grinding stone has an RPM rating no less than the RPM rating of the grinder. (Tr. 347; Ex. R-5 at 3.8.2). Although it is unclear as to whether training specific to this rule was provided in orientation,[7] it appears it may have been covered in a seminar entitled "Tool Safety", which Respondent provided to its employees, including N.M., on May 25, 2016.[8] (Tr. 432–34; Ex. R-2 at URSBarstow_000013, R-3). Leang, Downing, and other employees interviewed by CSHO Casto testified they had not received this or other training on the issue of grinder/grinding stone compatibility until after the accident. (Tr. 55–57, 90, 158; Ex. C-6). According to his testimony, Downing was not employed by Respondent when the Tool Safety training had been provided; however, he admitted he had 12 years of welding experience when he was hired by Respondent. (Tr. 172–174). He admitted he was "always" aware he had to ensure

7. Downing testified his orientation training was perfunctory and was mostly geared towards signing forms. (Tr. 199).
8. Although Complainant takes issue with the training materials referencing the equivalent construction standard, the Court finds the basic requirement of ensuring RPM compatibility is the same.

compatibility between grinder and stone RPM ratings, but it was something he did not think about until after he experienced a problem (Tr. 182–83, 399, 402–403). It is unclear where Downing acquired this knowledge, but there is no evidence to suggest Respondent provided this information or otherwise inquired about Downing's prior training or knowledge of welding-related safety.

IV. Discussion

A. Law Applicable to Alleged Violation of Section 5(a)(2)

To establish a violation of an OSHA standard pursuant to Section 5(a)(2) of the Act, Complainant must establish: (1) the standard applies; (2) the terms of the standard were violated; (3) employees were exposed to the hazard covered by the standard; and (4) the employer had actual or constructive knowledge of the violation (i.e., the employer knew or, with the exercise of reasonable diligence, could have known of the violative condition). *Atlantic Battery Co.*, 16 BNA OSHC 2131, 2138 (No. 90-1747, 1994).

Complainant has the burden of establishing each element by a preponderance of the evidence. *See Hartford Roofing Co.*, 17 BNA OSHC 1361 (No. 92-3855, 1995). "Preponderance of the evidence" has been defined as:

> The greater weight of the evidence, not necessarily established by the greater number of witnesses testifying to a fact *but by evidence that has the most convincing force*; superior evidentiary weight that, though not sufficient to free the mind wholly from all reasonable doubt, is still sufficient to incline a fair and impartial mind to one side of the issue rather than the other.

Black's Law Dictionary, "Preponderance of the Evidence" (10th ed. 2014) (emphasis added).

1. Citation 1, Item 1

Complainant alleged a serious violation of the Act in Citation 1, Item 1 as follows:

> 29 CFR 1910.215(d)(2): Spindle speed(s) on grinding machine(s) were not checked before mounting to assure it did not exceed the maximum operating speed marked on the wheel:

> Welding Shop: Employees were exposed to struck by hazards when operating a DynaBrade 5" Right Angle Grinder, Model 52633, 12,000 RPM with a grinding wheel incompatible for use at speed of angle grinder.

See Citation and Notification of Penalty at 6.

The cited standard provides:

> Immediately before mounting, all wheels shall be closely inspected and sounded by the user (ring test) to make sure they have not been damaged in transit, storage, or otherwise. The spindle speed of the machine shall be checked before mounting of the wheel to be certain that it does not exceed the maximum operating speed marked on the wheel. . . .

29 C.F.R. § 1910.215(d)(1).

a. Respondent Stipulated to Standard Application, Violation, and Exposure

The parties stipulated that 29 C.F.R. § 1910.215(d)(1) is the applicable standard. (Ex. J-1 at p. 3). Further, during the trial, the parties also agreed the grinding stone did not match the spindle speed of the grinder, violating § 1910.215(d)(1), and that an employee was exposed to the hazard created by the violation. (Tr. 33–36). Thus, the only remaining issue is whether Respondent had knowledge of the violation.

b. Respondent Should Have Known of the Violation

Complainant contends Respondent had both actual and constructive knowledge of the violation at issue in this case. As to actual knowledge, Complainant contends Steve Peterson, the weld shop's representative to the safety committee, should be viewed as a *de facto* supervisor such that his knowledge of Downing's accident could be imputed to Respondent. Complainant also contends Respondent should be charged with constructive knowledge of the violation, because Respondent failed to conduct spot checks of individual welder's tools to ensure grinders and grinding stones were RPM-compatible.

In response, Respondent contends Peterson served on the committee in a merely representative capacity, meaning he had the ability to voice concerns about safety issues within

the welding department, but otherwise was not granted authority to direct or otherwise exert authority over his co-employees. As to constructive knowledge, Respondent contends it exercised reasonable diligence in the implementation of its safety program in the welding department. Further, Respondent contends the imposition of a spot-check requirement exceeds what is reasonable given what Respondent knew (or did not know) about grinder compatibility issues.

The Court disagrees. While the Court finds Respondent did not have actual knowledge of the violation, Respondent's failure to perform thorough examinations of its employees' equipment illustrates a lack of reasonable diligence and, thus, constitutes constructive knowledge of the violation.

i. Actual Knowledge

In order to establish actual knowledge of this violation, Complainant must prove Respondent knew N.M. was using an incompatible grind stone with the Dynabrade grinder. *See LJC Dismantling Corp.*, 24 BNA OSHC 1478 (No. 08-1318, 2014) (finding evidence insufficient to establish foreman knew injured employee was exposed to hazardous condition when that foreman was on a different floor when injury occurred); *see also Gary Concrete Prods, Inc.*, 15 BNA OSHC 1051, 1052–53 (No. 86-1087, 1991) (finding employer lacked actual knowledge where supervisor left work area prior to employee exposure to violative condition). Actual knowledge can be proved by showing one of Respondent's supervisors knew of the condition, in which case such knowledge is imputable to Respondent. *See Dover Elevator*, 16 BNA OSHC 1281 (No. 91-862, 1993) (citations omitted). There is no evidence Respondent actually knew N.M. was using an incompatible stone. Instead, Complainant relies on two incidents that occurred more than eight months before the injury to N.M., which forms the basis of the citation at issue. As will be shown, much of Complainant's argument on this topic is about whether Respondent should have

known N.M. was using an incompatible grinding stone, which is the standard for inquiry into whether Respondent had constructive, not actual, knowledge.

As to actual knowledge, the Court finds Complainant confuses the issue of knowledge by conflating Peterson's knowledge of Downing's accident with knowledge of the violation alleged *in this case*. First, without consideration of the specific facts of Downing's exploding grinding wheel, using Peterson's knowledge of that incident to establish actual knowledge for the purposes of this citation is improper. As recounted in Complainant's brief, the incident involving Downing occurred approximately 8 months *before* N.M.'s accident. *See Compl't Br.* at 13. What Peterson specifically knew about Downing's purported violation, which occurred outside the statute of limitations, has nothing to do with whether Respondent can be charged with actual knowledge of N.M.'s violative conduct. Complainant appears to suggest Respondent's employees consistently failed to check "[t]he spindle speed of the machine . . . before mounting"; nevertheless, that allegation has to be connected to a discrete violation. *See, e.g., N & N Contractors, Inc.*, 18 BNA OSHC 2121 (No. 96-0606, 2000) (finding Secretary failed to prove actual knowledge when there was "no evidence that Wilkinson or any other N&N supervisor observed Radzicki's conduct"). Although Peterson's knowledge, and potentially Respondent's, regarding the Downing incident is relevant to the issue of constructive knowledge, it cannot be used to establish actual knowledge of the violation alleged in this case.

Second, Complainant wants to connect the basic facts of Downing's incident to the incident involving N.M. The connection, however, is not as clear cut as Complainant suggests. Principal amongst Complainant's problems is the fact that Downing himself admitted he did not know whether the grinding cup/stone that exploded was rated at the same RPM as the grinder he was using at the time. (Tr. 157). Instead, Downing speculated the grinding stone could have been

dropped, stating, "[N]ormally they explode because of dropping." (Tr. 157). Downing testified his conversation with Peterson was brief, and there is no indication the two discussed RPMs or other potential reasons for the explosion. (Tr. 181). Thus, even if Peterson's knowledge of Downing's accident was imputable to Respondent, there is no evidence Respondent was aware Downing failed to check RPM compatibility, let alone that it was aware of the accident in the first place.

Third, notwithstanding the foregoing, Complainant failed to establish Peterson was a supervisor. To establish an individual's supervisory status, the Commission has held "job titles are not controlling and that the power to hire and fire is not the *sine qua non* of supervisory status . . . ." *Rawson Contractors, Inc.*, 20 BNA OSHC 1078 (No. 99-0018, 2003). Instead, the key question is whether the individual in question "was vested with some degree of authority over the other crew members assigned to carry out the specific job involved." *Iowa Southern Utilities Co.*, 5 BNA OSHC 1138 (No. 9295, 1977). This includes, amongst other things: the power to order that necessary steps be taken to do the job properly, ensuring that work will be done in a safe manner, ensuring compliance with OSHA regulations, and identifying and implementing corrective measures to eliminate hazards. *Rawson*, 20 BNA OSHC 1078, *Iowa Southern*, 5 BNA OSHC 1138; *see also Kerns Bros. Tree Svcs.*, 18 BNA OSHC 2064 (No. 96-1719, 2000) (crew leader responsible for seeing work done safely and properly based on written work order).

According to the testimony, Peterson was a rank-and-file welder, who was selected to serve as the welding department's representative on the safety committee. According to Aaron Ellis, former site manager for Barstow and chair of the safety committee, the committee was designed to get employees from each department involved so they could have a "direct line with management so they can express any concerns they have." (Tr. 503). The once-a-month meetings

would include discussions led by the site manager and safety supervisor, who would identify safety-related issues they had seen, as well as input from the rank-and-file. (Tr. 503–504). This was echoed by Stone, who testified the employees on the committee brought issues to management who, in turn, would be expected to address and/or solve issues brought up by the employee representatives. (Tr. 457–58). Stone further testified all employees have a duty to report injuries and incidents and that membership on the committee did not impart a heightened duty on Peterson or any other member; rather, it served as an additional channel through which such reports could be made. (Tr. 496). Clarifying the issue even further, Ellis testified Peterson "was not in any shape, form, or manner a—in any type of supervisory capacity." (Tr. 502).

The Court agrees with Respondent. In his brief, Complainant overstates Peterson's role in the arena of safety and health. Indeed, though Peterson may have participated in walkthroughs (though there is no specific evidence of this) and participated in monthly meetings in an advisory capacity, it does not appear his duties were substantially different than other employees within the welding department. The evidence shows each employee was, at one time or another, responsible for auditing his fellow employees' work practices and work station through the Behavior-Based Safety Checklist. (Ex. R-8). Peterson conducted some tailgate training sessions on safety and tool usage, but he was also just an attendee at some of these training sessions. (Ex. R-2). According to Stone and Leang, Respondent liked to use employees to conduct certain tailgate training sessions, especially those familiar with the work, because Respondent found employees receive the information better if it comes from a fellow employee. (Tr. 430). If the training were more technical or detailed, Stone testified such training would be proctored by a safety supervisor or someone else. (Tr. 430). There is no indication Respondent "relied on Representative Peterson to

ensure weld shop safety", as Complainant puts it, any more than any other employee, nor is there any indication Peterson wielded any authority over his coworkers. *See Compl't Br.* at 15.

Complainant cites to *Boh Brothers Construction* in support of its claim Peterson was a supervisor. Complainant's reliance on the Commission's decision is not only misplaced because the term "safety representative" carried a different connotation than it does in the present case, but Complainant quotes the ALJ's rationale for finding knowledge when the Commission explicitly disclaimed reliance on the ALJ's reasoning. *See Compl't Br.* at 12 (quoting *Boh Bros. Constr. Co., LLC*, 24 BNA OSHC 1067, 2013 WL 949386 at *13 (No. 09-1072, 2013)). Further, the safety representative referred to in the decision was specifically designated to "perform compliance monitoring, coordinate with foremen and supervisors, identify deficiencies, and recommend safety improvements", as well as held daily safety meetings with supervisors, ensured foremen held daily job safety analysis meetings, and administered safety presentations and orientation for new employees. *Id.* at *13. Such responsibilities far exceed those granted to Peterson and clearly indicate authority not only over rank-and-file employees but over members of the on-site management team, too.

Based on the foregoing, the Court finds (1) Complainant failed to establish Respondent had actual knowledge of the violation that forms the basis of the Citation at issue in this case, and (2) Complainant failed to establish Steven Peterson was a supervisor through whom knowledge, actual or constructive, could be imputed to Respondent.

ii. Constructive Knowledge

Alternatively, Complainant contends Respondent should have known its employees were not ensuring their grindstones and grinders were compatible had it exercised reasonable diligence. This assertion is grounded, at least in part, on CSHO Casto's initial understanding that there were

multiple incidents involving exploding grinding stones due to RPM incompatibility. (Tr. 250; Ex. C-7). Although CSHO Casto's assessment of the prevalence of grinding stone explosions was overblown, the Court nonetheless finds Respondent failed to take reasonable precautions to ensure its employees were complying with 29 C.F.R. § 1910.215(d)(2) prior to operating the DOD-issued grinders.

According to the Commission, the determination of whether an employer has exercised reasonable diligence is based on multiple factors, including "an employer's obligation to inspect the work area, anticipate hazards, take measures to prevent violations from occurring, adequately supervise employees, and implement adequate work rules and training programs." *Jacobs Field Svcs. N.A.*, 25 BNA OSHC 1216 (No. 10-2659, 2015) (citations omitted); *see also N.Y. State Elec. & Gas Corp.*, 88 F.3d 98, 106 (2d Cir. 1996) ("[C]onstructive knowledge may be predicated on an employer's failure to establish an adequate program to promote compliance with safety standards."). Whether an employer has exercised reasonable diligence "will vary with the facts of each case." *Martin v. OSHRC*, 947 F.2d 1483, 1485 (11th Cir. 1991). The Court will examine the foregoing factors in light of the facts of this case.

First, the Court finds Respondent had a work rule governing the conduct at issue here.[9] Under its rules for Hand and Power Tools, Respondent had a separate section for Handheld Grinders. (Ex. R-5 at URSBarstow_000058). Rule 3.8.2 states, "Ensure the RPM (as posted on the wheel) is equal to or greater than that posted on the grinder, the disk/wheel is the correct size for the grinder, and the type of wheel is compatible with the material being ground or cut." (*Id.* at 000059). This is sufficiently specific to cover the requirements of 29 C.F.R. § 1910.215(d)(1). The document containing the rule indicates it was current as of June 26, 2017, which was roughly

9. Although Complainant implied this and other documents were not authentic, he submitted no evidence to suggest Respondent fabricated such documents for the purposes of this case.

one month prior to the accident involving N.M. and was available on the company intranet. (Ex. R-5). Thus, at the very least, the Court finds Respondent had a rule in place at the time of the accident.

Having a rule and ensuring your employees are aware of that rule, however, are two different things. It is here, as well as under the other factors, where Respondent's case for reasonable diligence starts to break down. The problem for Respondent is one of consistency. As noted above, Respondent provided training on general safety issues and welding-specific topics through orientation, training modules, and tailgate meetings. Some of the general safety training modules were covered during orientation and revisited annually thereafter. (Tr. 409; Ex. R-2). The training modules covering the specifics of the welding department, however, were not consistently provided to ensure all welding shop employees at Barstow were trained on issues like grinder compatibility. This explains why Downing and the employees interviewed by CSHO Casto all stated they had not received such training until after the incident involving N.M.

Respondent submitted evidence of three training modules that addressed the use of grinders, one of which indicates the need to inspect the cutting wheel. (Ex. R-2 at URSBarstow_000006). The relevant training was entitled "Tool Safety" for which Respondent submitted a sign-in sheet and an associated PowerPoint presentation. (Ex. R-2 at URSBarstow_000013). While there is nothing specific to the sign-in sheet or PowerPoint that would indicate the content contained in the PowerPoint was provided during the Tool Safety seminar, Stone credibly testified that "Tool Safety" specifically refers to the content contained in the PowerPoint. (Tr. 432–33, 480–483). The PowerPoint, though it cites to the construction standard for grinding machines, nonetheless references both the RPM of the grinder and the requirement the wheel "shall be compatible with the size motor of the grinder." (Ex. R-3 at

URSBarstow _000020). While these appear, at least minimally, to cover the standard at issue here, the Court notes each of these training seminars took place one or two years before the accident in this case, leaving an employee like Downing, who started in late 2016, without such training.

The weight of the evidence suggests some of Respondent's employees received training on grinder compatibility and some did not. Welding shop supervisor Skako Leang received supervisor training, but was more or less in the dark on the substantive requirements of the seven different lines he was responsible for, including welding. (Tr. 55). N.M., along with other welding shop employees, received the training described above, but Downing and employees interviewed by CSHO Casto stated they did not receive training on this issue until after N.M.'s accident. While Downing testified he was aware of the requirement for grinder compatibility, that information is only helpful to Respondent if, when Downing was hired, it inquired into the nature of his experience and training to determine what, if any, additional training was necessary. *See, e.g., LJC Dismantling Corp.*, 24 BNA OSHC at 1481–82 (more specific instructions not necessary where employer was aware of employee's prior training). According to Downing, Respondent did not so inquire. (Tr. 187–88). Further, the responses to CSHO Casto's inquiries regarding grinding compatibility suggests whatever training Respondent provided was either ineffective or, as discussed below, not followed up on by management.

Perhaps the biggest problem for Respondent is the failure of management, whether due to understaffing or insufficient guidance, to inspect the work area and provide consistent, meaningful supervision. An employer "has a general obligation to inspect its workplace for hazards. . . , [which] 'requires a careful and critical examination, and is not satisfied by a mere opportunity to view equipment.'" *Hamilton Fixture*, 16 BNA OSHC 1073 (No. 88-1720, 1993) (quoting *Austin Comm. v. OSHRC*, 610 F.2d 200, 202 (5th Cir. 1979)). The evidence presented at trial showed

management was largely hands off when it came to inspections and supervision; instead, Respondent placed a significant amount of responsibility for conducting inspections on the employees themselves through the implementation of its Behavior-Based Safety Checklists and self-examination through the task hazard analyses.[10]

According to the testimony, Leang was the supervisor for 135 employees and 7 different shops, including the welding department, for which he was the sole supervisor. (Tr. 118–19). He testified the management team at Barstow was shorthanded, so he spent most of his time in the office performing administrative tasks and walked the floor "[w]hen I would get the chance." (Tr. 113). Even when he walked the floor, he testified he mostly checked for PPE. (Tr. 114–15). While this was based, in part, on his concern for safety, the Court finds it was also because Respondent did not provide him with sufficient training to perform a more careful and critical examination of his employees' equipment. (Tr. 57). Leang testified he had a team lead within the welding department, Sylvia De La Paz; however, other than communicating with DOD supervisors, the scope of Ms. De La Paz's responsibilities is unclear, and there is no evidence she performed inspections or otherwise provided supervision of any sort. (Tr. 144).

Respondent also had an on-site safety representative who, according to Stone, was responsible for ensuring training was taking place, that supervisors were conducting walkthroughs of the worksite, performing incident investigation, and assigning employees to perform the Behavior-Based Safety Checklist. (Tr. 149, 448). According to Leang, this position changed hands a few times during his tenure at Barstow, though at the time of the injury it was filled by a woman named Earlene Farley. (Tr. 124-125, 447). Leang testified Ms. Farley focused most of her efforts on the Task Hazard Analyses but did not spend a lot of, if any, time on training or inspections. (Tr.

10. Neither Leang nor Downing seemed familiar with the Behavior-Based Safety Checklists. (Tr. 135, 184).

125). This characterization of Ms. Farley's activities as safety supervisor was not challenged by Respondent.

This lack of supervision and inspections is also reflected in the lack of disciplinary action taken by Respondent. Although Respondent had a disciplinary policy that looks good on paper, it is not clear Respondent implemented that policy with any degree of regularity. Out of a company of nearly 92,000 employees in multiple locations around the world, Respondent submitted evidence of three documented disciplinary actions, two of which were issued in 2015 and none of which were in the welding department at Barstow (or any other welding department for that matter). (Tr. 208; Ex. R-7). The lack of evidence indicating Respondent enforced its work rules is indicative of its overall lack of managerial involvement in the inspection and supervisory process.

Respondent contends its use of the Behavior-Based Safety Checklists, task hazard analyses, and Leang's intermittent walkthroughs to inspect PPE were sufficient to satisfy its obligation to conduct inspections and provide supervision in light of the process by which its employees procured grinders and stones, the relative experience of its employees, and what Respondent knew about the problems, if any, associated with its employees using incompatible grinders and stones. Further, Respondent contends spot checks of grinding equipment to ensure compatibility is out of proportion to what reasonable diligence required under the circumstances of this case. The Court disagrees.

First, while the THAs and Behavior-Based Safety Checklists are certainly laudable efforts at engaging employees to ensure safe work habits, Respondent cannot delegate its duty to supervise and inspect its employees to the employees themselves. This is especially the case when their appointed supervisor had no experience, and thus no substantive knowledge, in the department he

was supposed to oversee; was responsible for six other departments in which he had no substantive knowledge; and had a team lead that had no discernible responsibility or authority over the employees in the welding department. Second, just as Respondent cannot delegate the responsibility to perform inspections to its employees, it cannot rely solely on DOD to ensure proper equipment is being distributed to its employees. As noted by Downing, employees could request whatever stone they wanted, depending on how quickly they wanted to get the job done. DOD did not mandate which stone should be used with which grinder, nor does it appear as if DOD exercised any control over Respondent's employees, except for allowing them to use DOD-issued tools. This is no different than a subcontractor on a multi-employer worksite, who, though not ultimately responsible for the conditions of the worksite itself, is still responsible for ensuring its employees are not exposed to a hazard. *See Associated Underwater Services*, 24 BNA OSHC 1248, 1251 ("Commission precedent require[s] an employer to detect and assess the hazards to which its employees may be exposed, even those it did not create."). Finally, though Respondent may (or may not have) been aware of prior accidents resulting from incompatible grinders and stones, it nonetheless had a responsibility to "anticipate hazards" and "take measures to prevent violations from occurring". *Jacobs Field Svcs. N.A.*, 25 BNA OSHC 1216. Given its lack of control over the tools its employees were using, the Court finds it is perfectly reasonable for Complainant to require Respondent's supervisors to perform spot checks of the equipment to ensure compliance with the applicable standards and such equipment was in safe operating condition.

The foregoing is not to say Respondent should be sending its supervisors to perform checks of everyone's equipment every time they check out a grinder from DOD, or even daily. *See New York State Elec. & Gas Corp.*, 88 F.3d 98, 109 (2d Cir. 1996) (holding constant supervisor

surveillance to be unworkable burden). Instead, such checks would be part of a surprise audit program or an explicit part of a more formal inspection program carried out by a supervisor or similarly authorized team lead. These inspections should be a small part of an otherwise comprehensive supervisory regime within any of Respondent's worksites. Given what appears to be a shortage of supervisors and team leads with little to no authority, it is understandable Leang was only able to perform cursory examinations, which were typically limited to whether the employee was wearing PPE and whether it appeared they were working in a safe manner. *See Hamilton Fixture*, 16 BNA OSHC 1073, *supra*. Leang testified he and the other supervisors were short-handed and that the safety program was poor at the Barstow location, which is reflected in the way it was implemented. (Tr. 113, 125).

Based on the foregoing the Court finds Respondent failed to exercise reasonable diligence to uncover the violation of the cited standard and thus had constructive knowledge. While this failure can be partially attributed to staffing, the Court finds Respondent, whether through Leang, Earlene Farley, or the site manager at the time, could have known of the violation through the exercise of reasonable diligence. Since each of those people are recognized members of management, the Court also finds their knowledge is properly attributable to Respondent. *See Tampa Shipyards, Inc.*, 15 BNA OSHC 1533, 1537 (No. 86-360, 1992) (holding an employee who has been delegated authority over other employees is considered to be a supervisor for the purpose of imputing knowledge to his employer). Accordingly, the Court finds Complainant established a *prima facie* violation of 29 C.F.R. § 1910.215(d)(1). Citation 1, Item 1 is AFFIRMED.

c. The Violation Was Serious

The Court finds the violation was serious within the meaning of section 17(k) of the Act. Under the Act, "a serious violation shall be deemed to exist in a place of employment if there is a substantial probability that death or serious physical harm could result from a condition which

exists … unless the employer did not, and could not with the exercise of reasonable diligence, know of the presence of the violation." 29 U.S.C. § 666(k). If the possible injury addressed by a regulation is death or serious physical harm, a violation of the regulation is serious. *Mosser Construction*, 23 BNA 1044, 1047 (No. 08-0631, 2010); *Dec-Tam Corp.*, 15 BNA 2072, 2077 (No. 88-523, 1993).

Complainant need not show that there was a substantial probability that an accident *would* occur; he need only show that if an accident occurred, serious physical harm *could* result. *See Sec'y of Labor v. Phelps Dodge Corp. v. Occupational Safety & Health Review Comm'n*, 725 F.2d 1237, 1240 (9th Cir. 1984) (emphasis added). However, the Act imposes liability "only if the employer knew, or 'with the exercise of reasonable diligence, [should have known] of the presence of the violation.'" *Florida Lemark Corp. v. Sec'y, U.S. Dep't of Labor*, 634 F. App'x 681, 687 (11th Cir. 2015) (*quotation omitted*).

The injuries suffered by N.M. clearly illustrate the seriousness of this violation. Not only did N.M. suffer a severe laceration to his head, but he received a concussion which resulted in a trip to the hospital. Due to the severity of his concussion, N.M. was not able to return to work for nearly three months and was on restricted duty for an additional three months after that. The Court finds the violation was serious.

d. Affirmative Defense - Unpreventable Employee Misconduct

Under Commission precedent, to establish unpreventable employee misconduct, an employer must prove by preponderance of the evidence that it has: (a) established work rules designed to prevent the violation, (b) adequately communicated those work rules to its employees, (c) taken steps to discover violations, and (d) effectively enforced the rules when violations were discovered. *See American Sterilizer Co. ("AMSCO"),* 18 BNA OSHC 1082, 1087 (No. 91-2494, 1997). Respondent carries the burden of proof for an affirmative defense. *Hamilton Fixture*, 16

BNA OSHC 1073, 1077 (No. 88-1720, 1993) *aff'd*, 28 F.3d 1213 (6th Cir. 1994).

1. Work Rule Has Been Established

Under its rules for Hand and Power Tools, Respondent had a separate section for Handheld Grinders. (Ex. R-5 at URSBarstow_000058). Rule 3.8.2 states, "Ensure the RPM (as posted on the wheel) is equal to or greater than that posted on the grinder, the disk/wheel is the correct size for the grinder, and the type of wheel is compatible with the material being ground or cut." (*Id.* at 000059). This is sufficiently specific to cover the requirements of 29 C.F.R. § 1910.215(d)(1). The document containing the rule indicates it was current as of June 26, 2017, which was roughly one month prior to the accident involving N.M. and was available on the company intranet. (Ex. R-5). Thus, the Court finds Respondent had a rule in place at the time of the inspection.

2. Communication of the Work Rule

Having a rule and ensuring your employees are aware of that rule, however, are two different things. It is here, as well as under the other factors, where Respondent's affirmative defense starts to break down. Respondent provided training on general safety issues and welding-specific topics through orientation, training modules, and tailgate meetings. Some of the general safety training modules were covered during orientation and revisited annually thereafter. (Tr. 409; Ex. R-2). The training modules covering the specifics of the welding department, however, were not consistently provided to ensure all welding shop employees at Barstow were trained on issues like grinder compatibility. This explains why Downing and the employees interviewed by CSHO Casto all stated they had not received such training until after the incident involving N.M.

Respondent submitted evidence of three training modules that addressed the use of grinders, one of which indicates the need to inspect the cutting wheel. (Ex. R-2 at URSBarstow_000006). The relevant training was entitled "Tool Safety." (Ex. R-2 at

URSBarstow_000013). While these appear, at least minimally, to cover the standard at issue here, the Court notes each of these training seminars took place one or two years before the accident in this case, leaving an employee like Downing, who started in late 2016, without such training. In conclusion, Respondent failed to have an effective and comprehensive communication methodology in place to ensure effective communication to all employees. Respondent failed to carry its burden on this element.

3. Steps Taken to Discover Violations

The Court finds Respondent failed to establish it took effective steps to discover violations of the cited standard. Respondent's inspection program was largely carried out by its employees through the THAs and the Behavior-Based Safety Checklists, neither of which address the requirements of § 1910.215(d)(2). Although Leang testified he performed walkthroughs of the department "[w]hen [he] would get the chance", his inspections of the welding department were limited to whether the employees were wearing PPE. This is attributable to Leang having only a surface-level understanding of what occurs in the welding shop, a lack of authority given to his team lead, and a shortage of supervision in the Barstow location overall. Respondent failed to establish this element of the affirmative defense.

4. Disciplinary Program is Lacking

Respondent failed to introduce persuasive evidence of a disciplinary regime that was more than a paper program. Although Respondent had a disciplinary policy that looks good on paper, it is not clear Respondent implemented that policy with any degree of regularity. Out of a company of nearly 92,000 employees in multiple locations around the world, Respondent submitted evidence of three documented disciplinary actions, two of which were issued in 2015 and none of which were in the welding department at Barstow (or any other welding department for that

matter). (Tr. 208; Ex. R-7). The lack of evidence indicating Respondent enforced its work rules is indicative of its overall lack of managerial involvement in the inspection and supervisory process.

Given these gaps in the implementation of Respondent's safety program, the Court finds N.M.'s, or any other employee in the welding department, behavior was neither surprising or idiosyncratic. Even if the Court accepts that the training Respondent provided in 2015/16 was sufficient to convey the requirements of the cited standard—it does not—it was not provided consistently, nor did Respondent's supervisors follow up to ensure it was being implemented, followed, or corrected when not complied with. Accordingly, the Court finds Respondent failed to prove the affirmative defense of unpreventable employee misconduct.

V. Penalty

When a citation is issued, it may include a penalty amount. *See* 29 U.S.C. § 659(a). OSHA has published a Field Operations Manual ("FOM") to, among other things, guide its employees in determining what penalty, if any, to propose for violations. FOM, Directive No. CPL-02-00-150 at 1-1, 6-1, effective April 22, 2011, *available at* 4 Employment Safety and Health Guide, (CCH), ¶7965, at 12,133, 12,139 (2015). The penalty amounts proposed in a citation become advisory when an employer timely contests the matter. *Brennan v. OSHRC*, 487 F.2d 438, 441–42 (8th Cir. 1973); *Revoli Constr. Co.*, 19 BNA OSHC 1682, 1686 n. 5 (No. 00-0315, 2001). The Secretary's proposed penalties are not accorded the same deference the Commission gives its reasonable interpretations of an ambiguous standard. *See Hern Iron Works*, 16 BNA OSHC 1619, 1621 (No. 88-1962, 1994) (rejecting Secretary's contention that his penalty proposals are entitled to "substantial weight"); *Nacirema Operating Co*., 1 BNA OSHC 1001, 1003 (No. 4, 1972) (declining to agree with the result or methodology the Secretary used to calculate the penalty). It

is the Secretary's burden to introduce evidence bearing on the factors and explain how he arrived at the penalty he proposed. *Valdak Corp*., 17 BNA OSHC at 1138; *Orion Constr. Co., Inc.*, 18 BNA OSHC 1867, 1868 (No. 98-2014, 1999) (giving less weight to the history factor as the Secretary provided little specific information)

"Regarding penalty, the Act requires that "due consideration" be given to the employer's size, the gravity of the violation, the good faith of the employer, and any prior history of violations." *Briones Util. Co.*, 26 BNA OSHC 1218, 1222 (No. 10-1372, 2016) (*citing* 29 U.S.C. § 666(j); *Jim Boyd*, 26 BNA OSHC at 1117; *Capform, Inc.*, 19 BNA OSHC 1374, 1378 (No. 99-0322, 2001), *aff'd*, 34 F. App'x 152 (5th Cir. 2002) (unpublished)). These factors are not necessarily accorded equal weight. *J.A. Jones Constr.*, 15 BNA OSHC 2201, 2216 (No. 87-2059, 1993) (*citation omitted*). When applying the penalty assessment factors, the Commission need not accord each one equal weight. *See, e.g.*, *Astra Pharm. Prods., Inc.*, 10 BNA OSHC 2070, 2071 (No. 78-6247, 1982); *Orion*, 18 BNA OSHC at 1867 (giving less weight to the size and history factors). Rather, the Commission assigns the weight that is reasonable under the circumstances. *Eric K. Ho,* 20 BNA OSHC 1361, 1379 (No. 98-1645, 2003) (Consol.), *aff'd sub nom.*, *Chao v. OSHRC*, 401 F.3d 355 (5th Cir. 2005).

a. Gravity

"The gravity of the violation is the 'principal factor in a penalty determination. Assessing gravity involves considering: (1) the number of employees exposed to the hazard; (2) the duration of exposure; (3) whether any precautions have been taken against injury; (4) the degree of probability that an accident would occur; and (5) the likelihood of injury. *See, e.g.*, *Capform, Inc.*, 19 BNA OSHC 1374, 1378 (No. 99-0322, 2001), *aff'd*, 34 F. Appx. 152 (5th Cir. 2002) (unpublished). See also *Ernest F. Donley's Son, Inc.*, 1 BNA OSHC 1186 (No. 43, 1973) (viewing

gravity as the probability of an accident's occurrence and the extent of exposure). "A lack of injuries is not a measure for determining gravity or any other penalty factor." *Altor Inc.*, 23 BNA OSHC 1458, 1468 (No. 99-0958, 2011), aff'd 498 F. Appx. 145 (3d Cir. 2012) (unpublished).

The Court finds the violation was of high gravity. Respondent's failure to inspect, at least periodically, equipment supplied by another employer exposed all the employees in the welding shop to the same hazard that put N.M. out of work and the employees were exposed for a substantial period of time each work day.

b. Size

The gravity factor focuses on treating violations of similar quality and severity alike. In contrast, the other three factors—size, history, and good faith—require consideration of circumstances pertaining specifically to the cited employer. The Commission frequently relies on the number of employees to evaluate the merits of altering a penalty for size. Respondent is a very large company, employing nearly 92,000 employees worldwide. The Court assigns no discount for the size of Respondent.

c. History

The next statutory consideration, history, examines an employer's full prior citation history, not just prior citations of the same standard. *Orion*, 18 BNA OSHC at 1868; *Manganas Painting Co.*, 21 BNA OSHC 2043, 2055 (No. 95-0103, 2007) (consol.) (history includes prior uncontested citations). Even if the prior violations were of a different degree or nature they still are properly part of the employer's history for penalty purposes. *Quality Stamping Prods., Co.*, 16 BNA OSHC 1927, 1929 (No. 91-414, 1994). Neither Complainant nor Respondent submitted evidence of Respondent's violation history, thus the Court has no basis to award a reduction based upon history.

d. Good Faith

As to the final factor, good faith, this entails assessing an employer's health and safety program, its commitment to job safety and health, its cooperation with OSHA, and its efforts to minimize any harm from the violation. *Monroe Drywall Constr., Inc*., 24 BNA OSHC 1209, 1211 (No. 12-0379, 2013); *Nacirema*, 1 BNA OSHC at 1002. Good faith can be a mitigating factor. *See, e.g.*, *Aviation Constructors, Inc.*, 18 BNA OSHC 1917, 1922 (No. 96-0593, 1999); *Pentecost Contracting Corp.*, 17 BNA OSHC at 1955.

With respect to good faith, although Respondent appears to have a good safety program on paper, the Court finds, for the reasons previously discussed, its implementation at the Barstow facility was lacking. The Court finds the penalty proposed by Complainant is appropriate in light of the aforementioned factors. Accordingly, the Court finds Complainant's penalty assessment is substantially justified and assesses a penalty of $12,934.

ORDER

The foregoing Decision constitutes the Findings of Fact and Conclusions of Law in accordance with Rule 52(a) of the Federal Rules of Civil Procedure. Based upon the foregoing Findings of Fact and Conclusions of Law, it is ORDERED that:

1. Citation 1, Item 1 is AFFIRMED as serious, and a penalty of $12,934 is ASSESSED.

SO ORDERED

/s/
Patrick B. Augustine
Judge, OSHRC

Date: September 23, 2019
Denver, Colorado