



United States of America
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
1120 20th Street, N.W., Ninth Floor
Washington, DC 20036-3457

SECRETARY OF LABOR,

Complainant,

v.

CHEWY, INC.,

Respondent.

OSHRC DOCKET NO. 19-0868

Appearances: Elena S. Goldstein, Deputy Solicitor of Labor
Tremelle I. Howard, Regional Solicitor
Karen E. Mock, Counsel
Lydia J. Chastain, Senior Trial Attorney
U.S. Department of Labor, Atlanta, Georgia
For the Complainant

Darren S. Harrington, Esq.
F. Colin Durham, Jr., Esq.
Kane Russell Coleman Logan PC, Dallas, Texas
For the Respondent

Before: Carol A. Baumerich, Administrative Law Judge

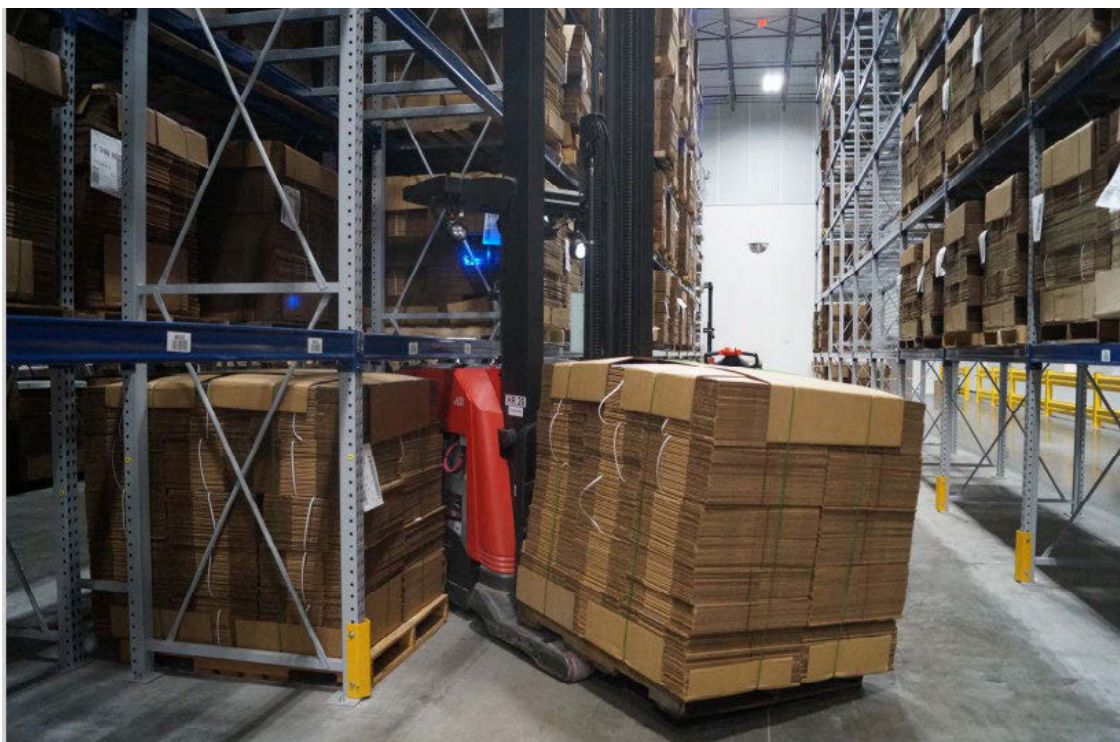
DECISION AND ORDER

Chewy, Inc., an online pet supply company, operates many warehouses. This case concerns Chewy's warehouse in Ocala, Florida, where one of Chewy's workers was pinned, crushed, and killed when the forklift he was operating passed beneath a horizontal beam of a storage rack in the Ocala warehouse.

The Occupational Safety and Health Administration (OSHA) investigated the incident at the Ocala warehouse and issued to Chewy a Citation and Notification of Penalty (Citation) on May 9, 2019. The Citation alleged two violations of the Occupational Safety and Health Act of 1970,

29 U.S.C. §§ 651-678 (the Act), one of which is adjudicated within this Decision.¹ This Citation Item alleges a serious violation of section 5(a)(1) of the Act. Commonly known as the “general duty clause,” section 5(a)(1) requires that each employer “furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees.” 29 U.S.C. § 654(a)(1).

For this Citation Item, the Secretary alleges that the conditions at Chewy’s Ocala warehouse presented an “under-ride” hazard to Chewy’s workers and proposes a \$13,260 penalty. (First Am. Compl. 3.)² Below is a picture that truly and accurately depicts the condition inside Chewy’s Ocala warehouse shortly after the incident that initiated the OSHA inspection in this case. The photo shows the lift truck frame, where the operator had been standing, under the rack system horizontal beam, and a pallet of boxes on the lift forks. (Tr. 51-52; Ex. C-12.)



(Ex. CX-12.)

¹ On March 25, 2020, the Secretary withdrew Citation 2, Item 1, which alleged an other-than-serious violation of 29 C.F.R. § 1910.176(e). (Complainant’s Notice of Vacation and Withdrawal of Citation 2, Item 1).

² The Secretary amended the original Citation on July 1, 2019, “to more accurately describe the hazard and to more closely reflect the recommendations described in OSHA’s Safety and Health Information Bulletin 07-27-2009, entitled *Standup Forklift Under-ride Hazards*.” (First Am. Compl. 2-3 ¶ VI.)

Respondent filed a timely notice of contest, bringing this matter before the Occupational Safety and Health Review Commission (Commission).³ A virtual hearing via WebEx technology was held on January 5-7, 2021. Both parties filed post-hearing briefs.

The key issues in dispute are the following: (1) Did Chewy affirmatively establish that more specific industry standards preempt the application of the general duty clause to the under-ride hazard in this case? (2) Did the Secretary establish that an under-ride hazard, as defined by the Secretary, existed at the Ocala warehouse? (3) Did the Secretary establish that Chewy and/or its industry recognized the under-ride hazard? (4) Did the Secretary meet his prima facie burden of establishing feasible means to abate the under-ride hazard at the Ocala warehouse? (5) Did Chewy overcome the Secretary's prima facie showing that feasible means of abatement existed to address the under-ride hazard at the Ocala warehouse? (6) Did Chewy know or with the exercise of reasonable diligence could Chewy have known of the under-ride hazard at the Ocala warehouse?

For the reasons discussed below, Citation 1, Item 1, as amended, is AFFIRMED and the proposed penalty of \$13,260 is ASSESSED.

JURISDICTION AND COVERAGE

The Commission gains jurisdiction to adjudicate an alleged violation of the OSH Act by an employer if the employer is engaged in a business affecting commerce within the meaning of section 3(5) of the OSH Act, and, if the employer timely contests the citation. 29 U.S.C. §§ 652(5), 659(c). The record establishes that Chewy, as of the date of the alleged violation, was an employer engaged in a business affecting commerce within the meaning of section 3(5) of the OSH Act. 29 U.S.C. § 652(5); First Amended Complaint & First Amended Answer, ¶¶ II, III. (Tr. 17-18). Chewy also timely filed a notice of contest to the Citation in this case. The undersigned concludes that Chewy is covered under the Act and that the Commission has jurisdiction over this matter.

BACKGROUND

Chewy Warehouse Worksite

³ The Commission is an independent adjudicatory agency and is not part of the Department of Labor or OSHA. 29 U.S.C. § 661. It was established to resolve disputes arising out of enforcement actions brought by the Secretary of Labor under the OSH Act and has no regulatory functions. 29 U.S.C. § 659(c).

Chewy, an online pet supply store that employs about 12,000 workers, operates “fulfillment centers,” otherwise known as warehouses, nationwide. (Tr. 167, 484; Sec’y Br. 2, Resp’t Br. 8; Ex. C-15, at 2 (Chewy’s mission is “[t]o be the most trusted and convenient online destination for pet parents everywhere.”). Chewy’s warehouses typically range in size from 600,000 to 800,000 square feet. (Tr. 590; Ex. C-9). Around the time of the incidents in this case, Chewy had seven warehouses.⁴ (Tr. 167).

Launched in 2017, Chewy’s Ocala, Florida warehouse,⁵ like its sister warehouses, is divided between an “inventory” section and a “non-inventory” section. (Tr. 45, 174, 486). The inventory section stores customer related products like dog food and cat litter. (Tr. 540-541, 604-605). The incident, however, that precipitated the OSHA inspection in this case occurred in Aisle 7 of the non-inventory section of the Ocala warehouse. (Tr. 44). The non-inventory section of the Ocala warehouse stores products that are used for the employer’s daily activities, not customer-related product. (Tr. 45). In this case, these products are pallets of “box stock, different boxes,” also known as “corrugate.”⁶ (Tr. 211, 704). The pallets are stored in six levels of “bays”⁷ within the pre-designed racking system. (Tr. 606-607; Ex. C-5). No pallets were stored at the floor level of the racking system, of non-inventory Aisle 7 or Aisle 8, at the time and in the location where the incident occurred. (Tr. 50, 54; Exs. C-5, C-8, C-13).

In the non-inventory section of the Ocala warehouse, Chewy workers utilize the powered industrial truck (PIT) Raymond Brand 750-R45TT Electric Standup Forklifts (Raymond forklift)⁸ to pull and retrieve pallets of corrugate from the bays of the pre-designed racking system.⁹ (Tr 42,

⁴ At the time of the hearing, Chewy had additional warehouse facilities. (Tr. 203, 591).

⁵ Throughout the record, Chewy’s Ocala, Florida warehouse also is referred to as the Chewy MCO facility, named after the nearest International Airport (Orlando International Airport or MCO). (Tr. 236-237, 480).

⁶ Corrugate is “just the cardboard boxes that customer shipments are packaged in to be delivered.” (Tr. 704).

⁷ A “bay” is “the space in between two of the gray vertical upright[]” posts when looking at the profile of a racking system. The “profile of the rack” is determined by how the horizontal racks or beams are situated on the vertical posts. (Tr. 605-607; Ex. C-5).

⁸ In the record and this decision, this Raymond forklift is referred to as the forklift, reach truck, lift truck, standup forklift, and dock stance forklift. (Tr. 42-46, 52-58, 89-90; Exs. J-5, C-2, C-5).

⁹ In contrast, the job task in the inventory section of the warehouse is part of the “fulfilment portion of the operation,” where Chewy workers, “on foot,” “pick” individual units (such as dog food or cat litter) off pallets, place the item in a box, and then ship it to the customer. (Tr. 174, 478, 530, 540-541, 604-605).

44-45; Exs. J-5, C-5). This job task was characterized as “a very familiar task,” and “this is a task that we [Chewy employees] had performed upwards of 30,000 times per day[.]” and “well over 20 million” times in the company’s history prior to the fatal incident. (Tr. 636-637, 640, 650-651).

The job task may be described as follows: When retrieving the pallet of corrugate from a bay within the pre-designed racking system, the Chewy operator drove the Raymond lift truck to the desired pallet’s location and stopped at a 90-degree perpendicular angle in front of that location. (Tr. 62, 228). The operator, using the forklift’s electronic controls, positioned/raised up the forklift blades to the pallet and then inserted the blades of the forklift into the pallet. (Tr. 62-63, 228-229).

Then, the forklift operator pulled the pallet from the bay and into the aisle for travel to the pallet’s desired destination. The aisles in the non-inventory section of the warehouse were 127 inches wide, from rack system to rack system on either side.¹⁰ (Tr. 62, 152, 234-235, 482, Ex. C-3, at 2). The length of the Raymond forklift was 102 inches, from the rear of the operator’s compartment to the tip of the forks that lift product. (Tr. 62, 152, Ex. C-3, at 1). Given the width of the aisle, between the racking system bays on either side, in the non-inventory section of the Ocala warehouse, as well as the overall length of the Raymond forklift, the Chewy forklift operator had 25 inches of space, at most, to pull the pallet from the bay and into the aisle for travel before the rear of the forklift breached the vertical plane of the racking system on the opposite side (to the rear of the forklift) of the aisle. (Tr. 62-63, 228-229, 396-403; Ex. C-3, at 2). Within this aisle space, the Chewy operator pulled the pallet of corrugate into the aisle by reversing the forklift and then rotating the forklift toward the desired direction of travel.

Regarding the width of the non-inventory aisles and the available space for the forklift operator to maneuver within the aisle, pallet length and “load length” were also important considerations.¹¹ (Tr. 345, 396-403). The load length considers the “overhang” of the stored

¹⁰ Chewy’s Senior Director of Fulfillment Optimization Cory Billet testified that Chewy has “a minimum aisle width that we feel comfortable allowing our operators to operate within. And that’s a 127 inches.” (Tr. 482. *See* Tr. 504-505).

¹¹ This maneuvering was termed “right angle stacking,” by the Secretary’s expert witness Guy Snowdy, who described “right angle stacking” as the turning radius of the vehicle [the dock stance lift truck], plus the load length, called the front overhang. (Tr. 345, 396-397). Mr. Snowdy testified that when the forklift operator is performing “right angle stacking,” the “turning radius, plus front overhead,” the pallet size on the lift forks, must be considered, regarding necessary aisle width. When the operator is carrying extremely long loads . . . “you’re requiring that operator to come relatively close to the adjacent racking system in the aisle.” (Tr. 345, 388, 396-403).

material, which measured “front-back” (i.e., from the face of the rack and going into the rack), on the pallet. (Tr. 608-609.) Chewy had a rule that merchandise not hang over, above, or beyond the horizontal crossbeam of the racking more than two inches. (Tr. 229, 608-09). Chewy’s Director of Safety and Loss Prevention at the time of the OSHA inspection, Craig Gage, testified that in the non-inventory sections of Chewy’s warehouses, storage material on the pallets often hung over the crossbeams more than two inches, on both front and back ends of the pallet.¹² (Tr. 211, 229). Considering the size of the pallets and stored material on the pallets, Safety Director Gage described the non-inventory aisles as “tight.”¹³ (Tr. 211, 228).

¹² Craig Gage was a credible witness. The undersigned observed him candidly testify without hesitation. Mr. Gage answered each question presented, without reframing or redefining the question before answering. Mr. Gage was Chewy’s Safety Manager at the time of the under-ride incidents directly relevant to this case. Following the under-ride incidents, Mr. Gage was involved in the initial under-ride abatement decisions made and implemented. Mr. Gage’s direct, detailed, testimony regarding the operation of the dock stance lift trucks in Chewy’s non-inventory warehouse aisles, including the violation of Chewy’s two-inch rule regarding pallet overhang, is credited. (Tr. 228-229).

In reaching this finding, the general testimony of Mr. Prater, Mr. Billet, and Mr. Rose was considered. At the time of the December 2018 fatal under-ride incident, Mr. Prater had been employed by Chewy for approximately two- and one-half months. (Tr. 680). Mr. Prater’s general testimony that Chewy does not permit or allow overhang that exceeds two inches in Chewy’s non-inventory area is not detailed or specific as to the time frame, whether during Mr. Prater’s tenure as Regional Safety Manager or later when he became Chewy’s Safety Director. This testimony is given little weight. (Tr. 720-721).

At the time of the 2018 under-ride incidents relevant to this case, Mr. Billet was Director of Chewy’s Capacity Organization. (Tr. 517-519). Mr. Billet testified that he is “not aware” of storage material on pallets “overhanging more than two inches . . . front-to-back [on the pallet], so that it’s intruding into the aisle.” (Tr. 608-609). Mr. Billet’s general statement that he lacked “awareness” is unhelpful and accorded little weight. This general statement is not specific as to the time frame referenced. Importantly, the record does not show that Mr. Billet had direct knowledge regarding the day-to-day work operations and practices in the Ocala warehouse, or in any Chewy warehouse, at the time of the 2018 under-ride incidents. (Tr. 472-541, 557-609).

Warehouse Safety Manager Rose did not specifically address pallet overhang or Chewy’s two-inch rule. Mr. Rose testified that they performed “pallet audits,” to make sure “if there was anything that could potentially fall out or fall over that we caught that beforehand.” He testified if the pallet fell over, there could be “a crushing hazard . . . product damage . . . structural damage to the floor.” (Tr. 239, 264).

¹³ Safety Director Gage clarified what he meant when he described the aisles as “tight.”

[F]or a reach truck driver to retrieve merchandise, he has to square up to the rack. In other words, he’s perpendicular to the rack. And he has to be far enough away from the rack so that he can raise his forks up to whatever pallet he’s going to pull out of there. Now he can then pull forward and he can also use the reach function on the fork to push those forward and pull that pallet out. But then when he brings it back in, . . . he has to take into account

In the non-inventory section of the Ocala warehouse, at the time of the incident, the Chewy forklift operators drove a “dock stance” Raymond forklift, also known as a “standup forklift,” in which the operator stood while driving the forklift. (Tr. 92, 159, 266-267, 355; Exs. J-5, p. 8, C-2). While in a dock stance forklift, the Chewy operator can stand sideways with respect to the forklift, which allows the operator to look in the direction of travel with relative ease (by pivoting the operator’s head 180 degrees). (Tr. 266, 355, 428-429, 672).

The height and length of the dock stance forklift used by Chewy employee Mr. RP¹⁴, whose under-ride incident precipitated this case, was measured by the OSHA Compliance Officer during the inspection. (Tr. 57-58, 61-62). The rear height of the Raymond dock stance forklift measured 51 inches from the floor to the tip of the lift truck compartment. (Tr. 61-62; Ex. C-3, at 1). The front height of the Raymond dock stance forklift measured 52 inches from the floor to the top of the lift truck compartment. *Id.* The height of the racking system lowest horizontal beam was 53 and 7/8 inches from the floor to the bottom of the horizontal rack beam. (Tr. 54, 61; Ex. C-3, at 1, C-13). Notably, at the time of the incident, the Chewy dock stance forklifts were not equipped with posts or guards around the operator’s cabin – the operator’s cabin was exposed entirely to the rear of the forklift.¹⁵ (Tr. 46, 52, 56, 342, 354; Exs. J-5, at 8¹⁶, C-6, C-12, C-14).

the length of the truck, the length of the forks and plus the length of whatever the pallet is that he has on the forks. And in non-inventory those pallets oftentimes were larger, they hung over more. . . . [W]e had, I think it was a 2-inch rule. Merchandise couldn’t hang over 2 inches above or beyond the crossbeam. But in non-inventory we always violated that rule because those pallets always hung over significantly more, 4, 5, 6 inches. But if they’re hanging over on both ends that much that adds a lot . . . of length. And so, when they would pull that pallet back in and then . . . have to bring it down they would have . . . to have their backrest very close to if not touching the crossbeam in the back.

(Tr. 228-229).

¹⁴ In the interest of personal privacy, the injured and deceased Chewy workers’ initials were used throughout the proceedings as much as possible.

¹⁵ In comparison, universal stance forklifts are equipped with four posts surrounding the operator’s cabin. (Tr. 358; Ex. J-5, at 8).

¹⁶ The Features Brochure: Raymond Trucks and Tow Tractors depicts universal stack-stance and dock stance forklifts. (Ex. J-5, at 8). The Raymond dock stance forklift depicted shows an altered version in which a post is installed on the rear of the forklift to the left of the operator and an extended backrest to the right of the operator. (Tr. 353-354; Ex. J-5, at 8). This altered version of the dock stance forklift was not used in the Ocala warehouse at the time of the incident. (Tr. 354).

The traffic day-to-day in the non-inventory aisles of the Ocala warehouse was very light.¹⁷ (Tr. 205-206, 638). As a general rule, there was no pedestrian traffic, and the forklift operator had the aisle to himself, in the non-inventory section of the warehouse. (Tr. 206-207, 638). A maximum of two Chewy operators worked in the non-inventory area of the facility, and often only one operator worked in the non-inventory area at a time. (Tr. 206, 638). As a “mechanism of efficient design,” Chewy kept the inventory and the non-inventory warehouse sections separate. (Tr. 684).

With regard to the pre-designed racking system, while Chewy is responsible for the “safety integrity of the storage rack system,” Chewy contracts with a third party, Storage Solutions Incorporated (SSI), to design the racking structure itself. (Tr. 496, 532). Chewy passes on “fulfilment optimization” information to SSI, which then designs a racking system “that supports the weight of [Chewy’s] product.” (Tr. 532-533, 536-537). After SSI designs the racking system, the racking system is assembled within Chewy’s warehouse and anchored to the floor. (Tr. 533-534). Notably, no SSI engineering specifications, drawings, or engineering testimony with regard to the Ocala warehouse racking system, before or after the system was altered as a result of the incident, are in this record.

Chewy Safety Personnel

At the time of the relevant incidents in this case, Chewy had several employees involved with warehouse safety. At the Ocala facility, there were four safety coordinators who provided safety coverage throughout the week. (Tr. 238-239). They reported to the Ocala Warehouse Safety Manager, Joshua Rose. (Tr. 236-237). Mr. Rose reported to a regional safety manager. All regional safety managers reported to the Director of Safety and Loss Prevention, Craig Gage. Mr. Gage reported to the Vice President of Operations for distribution centers nationwide, Mike Gilbert. (Tr. 163, 166–168, 217).

Caleb Prater began working for Chewy on October 3, 2018, serving as the Regional Eastern Continental Safety Manager at the time of Mr. RP’s incident. (Tr. 611, 615-616, 680). Mr. Gage subsequently left Chewy in September 2019. (Tr. 163). At that time, in September 2019, Mr. Prater became the Director of Safety and Loss Prevention. (Tr. 163, 612, 619). As discussed

¹⁷ In contrast, the other parts of the warehouse, including the inventory section, had “a tremendous amount of PIT and people interaction.” (Tr. 174).

below, Mr. Prater's description of Chewy's safety management structure after he became Chewy's Safety Director reveals that the management structure remained generally as described above.¹⁸ (Tr. 615).

First Under-Ride Incident

On July 11, 2018, five months before the fatal incident that precipitated this case, Chewy experienced an under-ride incident in the non-inventory section, of the Ocala warehouse. (Tr. 84, Ex. J-1, at 1). In the accident report, called the "GM Safety Critical Incident Recap," Ocala Warehouse Safety Manager Rose detailed the incident as follows: "TM¹⁹ BB, was pulling pallets of corrugate (98s) [the product] down. TM over-corrected his steering while joystick got hung up on his radio wire, the equipment continued to turn pinning the TM under the racking." (Tr. 84, 240-241; Ex. J-1, at 1). The accident report narrative of the incident stated, "TM BB became pinned when his high reach backed into a bay and the racking cross beam impinged on the reach cabin." (Ex. J-1, at 1). Team members and managers from safety, maintenance, and ops promptly responded and were able to free TM BB "by cutting the cross beam from the structure." *Id.* Mr. BB was transported by first responders to the Ocala Regional Emergency Room. Mr. BB sustained several broken ribs and bruising as a result of this incident. Tr. 85; Ex. J-1, at 1).

Warehouse Safety Manager Rose's accident report described the "Direct Cause" of the incident as "TM [BB] was pinned between high reach and racking." (Tr. 84-85, 171, 242, 252; Ex. J-1, at 2, 3). In the accident report two "Root Causes" are identified. "The radio wire was exposed on the front portion of [Mr. BB's] torso. Non-inventory racking in 54.5 inches from floor to beam. Reach truck cabin height dimensions are 47 [inches] to the lowest point and 51 [inches] at its highest." (Tr. 85, 171-172, 242-243, 252; Ex. J-1, at 2).

In the accident report, process changes included in the Root Cause Analysis "to ensure this type of incident cannot happen again," state "(1) Investigate lowering of the non-inventory racking

¹⁸ Also involved with the events of this case was Cory Billet, whose role is described more fully below. Beginning in or around December 2017 until the summer of 2019, Mr. Billet was the Director of the Capacity Organization. (Tr. 476, 518-519). In or around July 2019, Mr. Billet became Senior Director of Fulfillment Optimization. (Tr. 472, 476, 518).

¹⁹ Chewy refers to its employees as team members, abbreviated "TM." (Tr. 156).

to match standard MOD height. (2) While on lifts radios with wires are to be worn with wire coming from the back to the shoulder.” (Tr. 85-86, 172-173, 189, 243-244; Ex. J-1, at 3). Mr. Rose testified that the first stated process change was to lower the racking so the truck would hit the rack and stop the equipment from going under the rack. (Tr. 244).

At the time of the incident Chewy Safety Director Gage and the Regional Safety Manager²⁰ reviewed the accident report prepared by Warehouse Safety Manager Rose. Mr. Gage agreed with Mr. Rose’s recommendations in the accident report. (Tr. 170-173, 244).

Prior to his work at Chewy, Mr. Gage had ten years of experience as a safety professional in warehouse facilities, including for Amazon fulfillment. He was familiar with the under-ride hazard²¹ and had experience in responding to under-ride incidents that occurred during his tenure at Amazon.²² (Tr. 163-166, 176). At the time of Mr. BB’s under-ride incident, Warehouse Safety Manager Rose had never heard of an under-ride hazard or a roll-under hazard. (Tr. 237-240).

As a result of its investigation, Chewy determined that one “root cause” of the incident was the radio wire and sent out a “Safety Red Alert” to the staff company-wide to highlight “proper radio headset wearing” while driving the lift truck. (Tr. 172, 177, 240-241, 245-246, 252-253, 274-277; Exs. J-1, at 3; R-8). Safety Director Gage testified that Chewy also “changed” the training to ensure “the training did have the under-ride hazard noted so that operators would understand that [under-ride] is a potential hazard.” (Tr. 172, 177).

Chewy did not, at that time, make any physical changes to the facility or to the dock stance lift trucks. (Tr. 177). At that time, Safety Director Gage stated there were communications between Chewy and the forklift manufacturer Raymond regarding adding an extended backrest

²⁰ Mr. Rose testified that he believed Caleb Prater was his manager at the time of the July 2018 incident. (Tr. 244). However, Mr. Prater was not employed by Chewy until October 2018. (Tr. 666).

²¹ Mr. Gage defined the under-ride hazard as: “It’s when a piece of equipment, particularly a stand-up reach truck, forklifts, where the operator’s actually standing up in the cab, backs up underneath [a] horizontal racking crossbeam, backs up underneath that and gets pinned.” (Tr. 165).

²² Safety Director Gage testified regarding the manner Amazon chose to abate the under-ride hazard.

At Amazon we chose to lower load beams and install extended backrest[s], there’s steel-plated backrests that will protect the operator and install posts that prevent the operator from going underneath. In my mind those are the best solutions. You know, we can train operators to ensure that they understand the hazards that exists and that they are cognizant of it when they’re operating their equipment as well.

(Tr. 166. See Tr. 197-198).

and third post to the dock stance reach trucks. These changes were “declined.” Mr. Gage researched installing an aftermarket fourth post to the reach trucks. Raymond did not approve adding the aftermarket third or fourth post to the dock stance reach trucks at that time.²³ (Tr. 87-88, 137-138, 157, 177-178, 190-191; Ex. J-2. *See* Tr. 349-350, 374-375, 422-425).

With regard to the incident involving Mr. BB, Mr. Gage recommended that Chewy “look into lowering the non-inventory racking” as a potential “process change” in response to address “the under-ride.” (Tr. 172-173, 175-176, 244-245; Ex. J-1, at 3). Mr. Gage initially recommended this change to be implemented across all warehouses, including Mr. Gage’s home Dallas warehouse, in both inventory and non-inventory racking systems. (Tr. 175-176). Chewy chose not to implement that recommendation. Mr. Gage then recommended Chewy lower the rack beams in only the non-inventory aisles. (Tr. 174, 176, 244-245). According to Mr. Gage, this particular recommendation also was not approved by Chewy Vice President Mike Gilbert because “the feeling was that if we lowered the load beams even in just non-inventory, that that would somehow affect the capacity that we had for non-inventory.” (Tr. 174, 176).

Second Under-Ride Incident

In the same non-inventory section of the Ocala warehouse, while operating a similar model Raymond dock stance reach truck, without guards or extended backrests installed, with the height of the racking system horizontal crossbeams unchanged, on December 16, 2018, about five months after Mr. BB’s incident, Mr. RP’s fatal under-ride incident occurred. (Tr. 81-82, 155-157, 177). On December 16, 2018, Mr. RP was found by coworkers unresponsive, pinned between the racking in Aisle 7 and his Raymond high reach truck. (Tr. 49-50, 55-59; Ex. J-3, at 1. *See* Ex. C-5, C-6, C-8, C-12, C-14). When Mr. RP’s reach truck rode under the horizontal storage rack, he

²³ Chewy’s Field Procurement Manager Stacy Mowery sent an email inquiry to Raymond National Accounts Manager David Ritter regarding adding the aftermarket post to Chewy’s reach trucks. Mr. Ritter replied:

Raymond will not approve to have this installed on their truck. On any manufactures (sic) reach truck with a dock stance like you have you cannot have a post behind the operator. This would cause a blind spot, false sense of security and the post could protrude into the operator compartment if hit. If you have any questions please let me know. Have a great weekend.

(Ex. J-2; *See* Tr. 190, Ex. J-4, 1, App. A).

sustained a crushing injury from the rack and died, his cause of death identified by the medical examiner as compression asphyxia. (Tr. 41, 102-103; Ex. C-13, C-14).

Warehouse Safety Manager Rose investigated Mr. RP's under-ride incident. (Tr. 192, 254-262). Mr. Rose was assigned to interview witnesses and take photographs. (Tr. 192). Mr. Rose reviewed the available video footage from a surveillance camera, located on an adjacent aisle, that captured the movement of Mr. RP's reach truck at and around the time of the under-ride incident.²⁴ Mr. Rose prepared a detailed breakdown of what he saw when watching the video. (Tr. 255-259; Ex. J-3, App. C, at 5-6). The video showed the mast of Mr. RP's forklift retrieving product a couple times and coming up the specific aisle to retrieve product. The video shows Mr. RP bringing the mast all the way up, retrieving product out of this specific aisle, and then bringing the mast down. There appeared to be stops or breaks of a few seconds as he brought the mast down. (Tr. 255-258; Ex. J-3, App. C, at 5). As Mr. RP "brought the equipment or . . . the pallet down, he then slowly, not like what Mr. BB did,²⁵ it was very slow. It wasn't aggressive. He slowly kind of turned and then happened to just almost kind of coast into the racking itself."²⁶ (Tr. 255-256. *See* Tr. 195-196, 259). The video shows Mr. RP's equipment stops at the racking. Due to the location of the camera, the video does not actually show Mr. RP himself as he hit the racking. (Tr. 258).

At the time of Mr. RP's incident, there was no other traffic in Aisle 7 where the incident occurred. When reviewing the surveillance video, Warehouse Safety Manager Rose noted that

²⁴ Mr. Gage testified that there are 55 surveillance cameras at the Ocala worksite. (Tr. 213). This video footage shows "one aisle over" from Aisle 7, in the non-inventory area of the warehouse. (Tr. 213). According to Mr. Gage, "you [can't] see [Mr. RP] or the actual impact," but "you can see the forks turning. So, you can kind of surmise seeing the forks turning that what was happening with the truck obviously." (Tr. 214. *See* Tr. 223-224, 255-256).

²⁵ Warehouse Safety Manager Rose testified that he had never before seen an accident like Mr. RP's at Chewy. "[I]t was different than . . . BB's. . . . Mr. BB's has the cord and it [was] an aggressive very quick [move] which then caused Mr. BB into the racking. This move was a very slow, didn't have that much force to it." (Tr. 259).

²⁶ Mr. Rose's surveillance video review also revealed that Mr. RP's lift truck movement immediately before the under-ride was very slow. Mr. Rose's testimony is credited. (Tr. 255-256. *See* Tr. 195-196, 258-259). On cross-examination, Mr. Prater testified he did not know how fast Mr. RP was moving at the time of his under-ride incident. (Tr. 750).

there were other team members in adjacent aisles. Mr. Rose specifically noted that when Mr. RP's forklift hit the racking no one looked in the direction of the forklift rack impact. (Tr. 258).

[I]f the impact was heavy, then someone would have heard something. And not any moment [did] anyone look[] in the direction, even when Mr. RP did . . . hit the racking. So that's how I determined it to be very slow because there was really no audio indicator happening at all with other people that were in an adjacent aisle in around non-inventory.

(Tr. 258).

According to Mr. Rose, "at no point did I ever determine the root cause from [Mr. RP's] incident." (Tr. 261. *See* Tr. 254, 258-259). Mr. Rose did not create or generate a root cause or an incident report with recommendations, as he had following Mr. BB's incident. (Tr. 261). Mr. Rose provided the information from his review of the video to Safety Director Gage and to Regional Safety Manager Prater to whom Mr. Rose reported. (Tr. 261, 616, 632-633).

Safety Director Gage prepared the Fatality Investigation Report regarding Mr. RP.²⁷ (Tr. 193, 219; Ex. J-3). At the time Mr. Gage prepared the Fatality Investigation Report,²⁸ he noted there were no first-hand witnesses or direct video footage of Mr. RP's incident. Mr. Gage's report referenced electronic data recorded on the Raymond reach truck that Mr. RP was operating at the time of the incident, and Mr. Rose's detailed breakdown of the available video from an adjacent aisle, discussed above. (Tr. 195-196; 220-225; Ex. J-3, at 1-2; App. B, App. C).

Mr. Gage testified that his recollection from viewing the surveillance video was that Mr. RP "wasn't *traveling* down the aisle at high speed and then lost control." (Tr. 196) (emphasis added). Instead, according to Mr. Gage, Mr. RP was starting a turn; "he didn't travel any real distance to get any speed." (Tr. 223). Mr. Gage's recollection from viewing the surveillance video was that Mr. RP's incident "certainly happened so quickly that . . . I'm not sure what he could [have] been doing." (Tr. 223). Mr. Gage surmised that Mr. RP did not watch what was behind him or his angle because he drove up underneath the rack. (Tr. 223-224). Mr. Gage testified that

²⁷ Mr. Gage prepared the report at the direction of Chewy's legal counsel and input from Mr. Gage's direct supervisor, Mike Gilbert, Vice President of Operations. (Tr. 167, 193-197; Ex. J-3).

²⁸ The Fatality Investigation Report regarding Mr. RP was prepared close in time to Mr. RP's incident, on December 18, 2018. The report in error is dated 12/18/2019. (Tr. 230; Ex. J-3).

Mr. Rose's detailed breakdown of the available video did not note anything reckless. (Tr. 225; Ex. J-3, App. C).

Using electronic data recorded by the Raymond forklift of Mr. RP's actions, such as Mr. RP's use of the deadman pedal,²⁹ Safety Director Gage was able to determine that Mr. RP was pinned for 20-25 minutes before "somebody came over and started the equipment again[.]" (Tr. 221). Mr. Gage testified that Mr. RP's forklift "stopped right when he went up underneath, he was pinned and couldn't step on the deadman, so he couldn't move the equipment forward at that point and the equipment just stopped and shut down."³⁰ (Tr. 221-222; Ex. J-3, App. B, at 4).

The Investigation Recap in Mr. Gage's report, states that Fulfillment Specialist RP was found:

unresponsive, pinned between the racking in aisle seven and his reach truck. [RP] has been working on a Raymond High Reach, Truck ID# 26, replenishing outbound corrugate in aisle seven, when due to unknown circumstances his reach truck veered to the left of his travel path and ended up partially under a pallet cross beam [See Appendix A photo of incident] pinning him inside the cockpit of the equipment.

(Ex. J-3, at 1).

The Investigation Root Cause in Mr. Gage's report, states:

Noting that [RP] completed his pre operation checklist in only 16 second reveals that [RP] started this day operating the reach truck in a careless manner. Additionally, since the equipment was thoroughly checked by Raymond and no equipment problems were found, it can only be *deduced* that [RP] backed under the racking due to careless operation. The aisle widths, and pallet placement in this area is such that it [,] removing and placing pallets, which happens thousands of times a day at Chewy[,], can and is easily done safely without backing under the load beam.

(Ex. J-3, at 2) (emphasis added).

²⁹ "[T]he deadman is a pedal on the floor in the driver's compartment, on the floor of the equipment. [T]he driver has to stand on it at all times. If [the driver takes his] foot off of it [the deadman pedal] that stops the equipment. The deadman pedal is "an automatic brake and the equipment thinks that the operator has left the compartment, therefore, it's not running anymore[.]" (Tr. 221, 641).

³⁰ According to Mr. Gage, after ten minutes of inactivity, Mr. RP's forklift automatically shut down and logged off at 12:24:55. (Tr. 220-221.) Mr. RP's forklift next recorded movement "Operator Logon," when coworkers tried to rescue him at 12:36:25. These times were automatically recorded on Mr. RP's forklift "Deadman Hour Meter." (Tr. 220-223; Ex. J-3, at 1, App. B, at 4).

Mr. Gage testified that following Chewy's investigation they "didn't know for sure" the root cause of Mr. RP's fatal incident. (Tr. 194, 223-224. *See* Tr. 758-759). Mr. RP "likely wasn't operating in a safe manner. Maybe moving too fast, took the turn too fast. Obviously not watching his direction of travel." (Tr. 194, 223-224; Ex. J-3). Mr. Gage further testified:

You know we had had some other under-rides where some fork truck had slipped on water and slid up underneath and, you know, then the root cause was the water issue.³¹ But in this case, we couldn't find any other reason why that truck went under other than the fact that it looked like he probably wasn't paying attention.

(Tr. 194. *See* Tr. 224).

In preparing the Fatality Investigation Report regarding Mr. RP, Safety Manager Gage was told that Chewy Vice President of Operations Mike Gilbert wanted the report to focus on behavior and not to include the under-ride hazard or the shelving height in the report.³² (Tr. 196-197). The under-ride hazard is not mentioned in the report. (Ex. J-3).

As Regional Safety Manager at the time of Mr. RP's incident, Mr. Prater also participated in the evaluation and analysis of the root cause of the incident. (Tr. 633-634. *See* Tr. 722-723). Mr. Prater testified that nothing abnormal about the environmental conditions or physical circumstances was uncovered during the incident investigation. Therefore, with "the absence of any outlying factors, [the root cause] was just reckless operation of the truck." (Tr. 634). Mr. Prater stated the investigation disclosed that at the time of the incident, Mr. RP was performing a very familiar task, pulling away with non-inventory merchandise. According to Mr. Prater, the incident investigation did not disclose anything that caused Mr. RP to lose control of the forklift. (Tr. 637, 640-641).

³¹ Mr. Gage testified that "we had a number of under-rides at Chewy." (Tr. 212). One incident, in Wilkes-Barre, Pennsylvania, occurred when the operator was following a Zamboni floor cleaner that left water trailing behind it. (Tr. 212). The operator slid and "did under-ride," but, according to Mr. Gage, the operator's "back-rest was high enough that he didn't hardly go under, you know, there was some equipment damage and we reported it as a serious incident." There was a GM safety critical incident recap written on it. (Tr. 212-213; *See* Tr. 168-169). Mr. Gage's testimony, quoted in the accompanying text, reveals this under-ride occurred prior to Mr. RP's December 16, 2018, under-ride. (Tr. 194) ("You know we *had had* some other under-rides where some fork truck had slipped on water and slid up underneath . . .") (emphasis added).

³² This testimony is undisputed. Mike Gilbert was Chewy Vice President of Operations at the time of the under-ride incident and at the time of the hearing. (Tr. 167, 667-668). He was not called as a witness.

OSHA Inspection

OSHA Compliance Safety and Health Officer Gerard Driscoll investigated this matter.³³ After the Ocala Police Department reported the incident to OSHA, CSHO Driscoll was dispatched to inspect the worksite that same day. (Tr. 40-42). He testified that, when he arrived at the warehouse, the incident site was “untouched other than the moving of the stand-up forklift to rescue [the decedent],” and the employees had been sent home. (Tr. 42-43). He held an opening conference with Warehouse Safety Manager Rose, viewed the incident scene, took photographs, and measurements of the non-inventory aisle, racking system horizontal beam, and the Raymond forklift Mr. RP was operating at the time of the incident. (Tr. 41-43, 57-63, 246-247; Exs. C-3, C-5, C-6, C-7, C-8, C-9, C-12, C-13, C-14). CSHO Driscoll testified the workplace presented the safety hazard of horizontal intrusion or roll-under of the forklift operator’s compartment beneath the rack storage system. (Tr. 63). CSHO Driscoll spoke with Mr. Rose about possible methods to abate the roll-under hazard, including the possibility of lowering the racking height in the non-inventory aisles.³⁴ (Tr. 63-64, 247, 261-262).

As part of his inspection, CSHO Driscoll referred to OSHA’s published guidance, or Safety and Health Information Bulletin (SHIB), on the roll-under or under-ride hazard entitled, “Stand-up Forklift Under-ride Hazards.” (Tr. 64-65; Ex. C-2). Published on July 29, 2009, the SHIB’s depiction of the under-ride hazard based on the “height of the cab compared to the height of the horizontal rack beam,” was “very similar” to the Chewy incident here, according to CSHO Driscoll. (Tr. 69; Ex. C-2, at 2). He testified that he relied on the SHIB’s methods of abatement “as an example of what others may have recommended” when considering whether there were

³³ CSHO Driscoll works out of the Jacksonville, Florida OSHA Area Office and has been employed by OSHA for seven years. (Tr. 38-39). He currently conducts approximately 100 inspections per year, 45 percent of which are general industry related. (Tr. 40).

³⁴ The credited testimony of CSHO Driscoll and Warehouse Safety Manager Rose reveals OSHA did not *direct* Chewy to lower the racks in the Ocala warehouse non-inventory aisles. (Tr. 63-64, 247, 261-262).

While Mr. Prater testified that he was present during conversations with CSHO Driscoll, he did not testify regarding his recollection of the conversations, or the specific statements made. Rather, Mr. Prater generally testified that he “worked with the site to *interpret*, you know, those conversations and put them in - into effect.” (Tr. 705) (emphasis added). Mr. Prater’s “interpretation” that OSHA gave Chewy a “mandate” to lower the horizontal beam is not credited. (Tr. 705-706, 711). Likewise, Mr. Billet’s testimony regarding non-specific, second-hand statements, allegedly made by OSHA, is unreliable and not credited. (Tr. 489- 490, 492, 511-512, 558).

feasible means of abating the under-ride hazard at Chewy's Ocala warehouse. (Tr. 70-71; Ex. C-2, at 3-4).

The SHIB references the American National Standard ANSI B56.1-2005, paragraphs 4.5.3, 7.30, and 7.36. CSHO Driscoll reviewed the ANSI standard during the inspection. CSHO Driscoll testified that ANSI Standard B56.1 relates to stand-up forklifts, and ANSI recognizes the under-ride hazard in the warehouse environment. The ANSI standard, in Chapter 7, lists feasible means to abate the under-ride hazard in warehouse environments, including "lowering the horizontal storage beam to prevent roll-unders." (Tr. 71-73; Ex. C-2, at 3).

Also, during the inspection, CSHO Driscoll reviewed the Features Brochure Raymond Trucks and Tow Tractors, regarding stand-up forklifts, including the dock stance forklift model operated by Mr. RP when the under-ride incident occurred. (Tr. 89-92; Ex. J-5, at 8). The Raymond Brochure describes that "in some environments of use, the first level horizontal rack beams are higher than the top of the forklift power section and lower than the overhead guard. In such a situation, the potential exists for the power section to under ride the rack beam." (Tr. 90-92; Ex. J-5, at 8).

Upon CSHO Driscoll's return to the Chewy worksite two days later, he interviewed witnesses. (Tr. 81). CSHO Driscoll learned that Chewy had "indeed lowered the horizontal rack beam in the non-inventory aisles" below the height of the rear of the lift truck. (Tr. 63-64, 105, 247). Consequently, CSHO Driscoll determined that no under-ride hazard existed any longer in the non-inventory aisles at the Ocala warehouse. (Tr. 64).

CSHO Driscoll would not consider "extra wide" aisles to be a means of reducing the likelihood that a reach truck operator will strike or under-ride a rack.³⁵ (Tr. 155). He further testified, "all the training in the world isn't going to prevent you driving your forklift under a shelf." (Tr. 144).

Chewy's Post-Incident Actions

After Mr. RP's incident, Chewy lowered the horizontal beam on the pre-designed racks in the non-inventory aisles at the Ocala facility that same day or the day after, and within the next

³⁵ Chewy uses the term "extra-wide aisles" to indicate that its aisles are 12 inches wider than the minimum required by the Raymond lift truck manufacturer for safe operation of its lift trucks. (Tr. 482-483, 504-506; Resp't Br. 54-56; Sec'y Br. 23-24.)

few weeks at all the Chewy warehouses.³⁶ (Tr. 188-89, 192, 197, 207-208, 247, 583-584, 702, 735, 739). According to Warehouse Safety Manager Rose, at the Ocala warehouse, the racks were lowered by the maintenance team.³⁷ (Tr. 247-248). It took about four to five hours to complete an aisle. (Tr. 248). With the non-inventory horizontal racks lowered, it was no longer possible for the Raymond dock stance lift trucks to under-ride or roll-under the shelves. (Tr. 249). After the racks were lowered in the non-inventory aisles, Chewy's warehouses continued to operate.³⁸ (Tr. 192-193, 248).

Safety Director Gage testified that, after Chewy lowered the horizontal beam at all its warehouses, he noted an increase in reach trucks striking the lowered beam because the "the aisles were pretty tight." (Tr. 175-176, 211, 215, 226-228). Mr. Gage concluded that the Dallas Chewy forklift operators "when they're putting pallets up or putting pallets down and they're backing up they're using that crossbeam almost as a break. They're banging into it. So, we needed to fix that." (Tr. 226). He testified that the forklift operators "just needed to slow down. I mean, that was the issue there. We needed to get them to understand that impacting that beam wasn't going to be acceptable." (Tr. 212). Mr. Gage testified:

[L]et's be clear, the aisle was tight, but it was wide enough for them to bring pallets down without hitting that beam, they didn't need to hit it...It was close, it was very close, and they needed to slow down, and they needed to be careful. But backing out of . . . or backing into an inventory location, a non-inventory location did not

³⁶ Regional Safety Manager Prater had a role in the initial decision to lower the horizontal beams in the non-inventory section of the warehouse. (Tr. 704-705, 711). Thereafter, as Regional Safety Manager and later as Safety Director, Mr. Prater re-evaluated the decision to lower the horizontal beams and determined that lowering the beams increased the likelihood that the lift truck would strike the cross-members introducing additional hazards equal or greater than the under-ride hazard. (Tr. 708, 712).

³⁷ Safety Director Gage recalled that immediately following Mr. RP's fatal accident, Chewy Vice President of Operations Gilbert, and Ocala Warehouse General Manager Kushman Hanns, themselves, walked out onto the floor and began to lower the beams at the Ocala warehouse. VP Gilbert made the decision to contact all the Chewy sites and have the rack beams lowered. (Tr. 188, 207-209, 216-217).

³⁸ The floor space below the lowered beam was used for non-inventory box stock and smaller pallets. (Tr. 210-211, 248-249, 531-532). Warehouse Safety Manager Rose, Senior Director of Fulfillment Optimization Billet, and Safety Manager Prater testified that reconfiguring the racks to address the under-ride hazard reduced Chewy's non-inventory storage capacity. (Tr. 262-263, 265, 530-532, 703-706).

require that they back underneath that beam or hit that beam. They just had to operate more slowly, more deliberately.

(Tr. 233). According to Mr. Gage, all Chewy warehouses (except for one) had the same, standard, aisle widths. (Tr. 482-483). The Chewy Ocala and Dallas warehouses had the same aisle widths. (Tr. 229). After Mr. BB's and Mr. RP's under-ride incidents there is no evidence that Chewy altered or increased its standard aisle width in its warehouses.

In addition, after Mr. RP's fatal incident, Chewy management worked with manufacturers Raymond and Hyster to approve, engineer, and install a rear cabin guard for the Raymond dock stance reach trucks used in Chewy's warehouses, including the Ocala warehouse. (Tr. 198-203). This project to develop an "engineered solution" to the under-ride hazard of reach trucks riding under the horizontal beam of the racking system was principally handled by Chewy Vice President of Operations Mike Gilbert and the Vice President of Procurement for PetSmart, Chewy's parent company. (Tr. 198, 201, 217-218). Safety Director Gage was kept somewhat informed about this project. Mr. Gage prepared the "React Truck Enhanced Driver Protection Project" summary report, with attachments.³⁹ (Tr. 201, 658). Regional Safety Manager Prater was not involved in this project. (Tr. 661).

The engineered solution that Chewy developed with Raymond and Hyster was a rear cabin guard installed on the Raymond dock stance reach trucks used in Chewy's warehouses. This rear cabin fourth post had a curved design so the driver's head would not impact the post. The

³⁹ The "React Truck Enhanced Driver Protection Project" summary report states, in pertinent part:

Since the December 16th fatality at [Chewy's] Ocala Fulfillment Center [,] Chewy has been vigorously working with both Raymond and Hyster to get them to change their policy and design a rear cabin guard that would protect the driver from an under-ride hazard. After many iterations[,] Hyster and Raymond have agreed upon a design, (see Appendix C) that will not only completely protect the reach truck driver from an under-ride but will do so without adding in any additional hazards such as potential head impacts, blind spots, and impingement. This design, the result of a collaborative effort between Chewy and Raymond is set to be implemented no later than June 30th [2019].

While there were other less effective, and significantly easier solutions to implement none would have been 100 % effective as this one is. With a total investment from Chewy of over \$ 900,000, (see Appendix D), a testament to Chewy's commitment to the health and safety of its team members across the nation, this was not the least costly solution, but again, it was the one that is 100 % effective in eliminating the under-ride hazard.

(Ex. J-4, at 1, Tr. 201-202. See Ex. J-4, at 5, App. C).

engineered rear cabin post protected the reach truck driver from an under-ride, without adding hazards such as blind spots, head impacts, or impingement. (Tr. 201-202, 266, 269-271, 278; Ex. J-4, at 4, App. C).

The total cost to outfit Chewy's fleet of Raymond dock stance reach trucks, at each Chewy warehouse, with the engineered rear vertical posts was approximately \$900,000. (Ex. J-4, at 5, App. D). According to Mr. Gage, "you cannot, once you have those two posts in the rear of the driver, you cannot go underneath a load beam no matter how high or how low that load beam is, it is physically impossible to injure the driver by going underneath." (Tr. 201-202; Ex. J-4, at 5, App. C). After the post was installed on the dock stance lift trucks, there were no further under-ride incidents at the Ocala warehouse. (Tr. 272). The React Truck Enhanced Driver Protection Project summary report, with attachments, describing this abatement measure for the Raymond forklifts and associated costs, was presented to OSHA at an informal conference, by Safety Manager Gage and Respondent Counsel.⁴⁰ (Tr. 201, 225-226; Ex. J-4). According to the Secretary, "this abatement measure completely eliminated the under-ride hazard for this lift truck in Respondent's facilities." (Sec'y Br. 9-10).

Following Mr. RP's fatal incident, when Chewy opened new warehouse sites, Chewy equipped the warehouses with universal stance lift trucks, which have two rear vertical posts. (Tr. 233-234, 523-524, 527, 529, 593-954. *See* Ex. J-5, at 8). Respondent continues to evaluate the advantages or disadvantages of deploying the universal stance lift trucks in its new facilities.⁴¹ *Id.*

⁴⁰ Current Chewy Safety Director Prater testified that to his knowledge, at the Ocala warehouse, the non-inventory storage racks remain in their lowered position. He approved re-raising the non-inventory storage racks in other locations after the fourth posts were installed, due to business necessity. (Tr. 745. *See* Tr. 586).

⁴¹ Chewy Safety Director Prater testified that in a universal stance forklift, the operator has less relative ease of visibility, when compared to operating a dock stance truck. The universal stance operator has "to reposition their body within the operator's cabin" to see in each direction of travel, forward or backward. Also, the universal stance truck has two throttles and one steering wheel, requiring the operator to steer with his right hand traveling in one direction, and with his left hand traveling in the other direction. Mr. Prater testified that changing hand steering position is confusing for new operators. (Tr. 671-674. *See* Tr. 604).

The Secretary's expert witness Guy Snowdy testified the universal stance forklift is more versatile than the dock stance truck. (Tr. 355-358). Mr. Snowdy stated there are three different positions an operator may use when operating the universal stance forklift, including driving the universal stance in the dock stance position. (Tr. 355-56, 438-441; Ex. J-5, at 8).

The Secretary's expert Mr. Snowdy testified that use of the universal stance lift trucks addressed the under-ride hazard. (Tr. 361-362).

When asked whether the cost to outfit the Raymond forklifts with the Raymond engineered guards would "threaten Chewy's economic viability," Mr. Gage replied, "there would be no way, it's a multi-billion-dollar company." (Tr. 203; Ex. J-4, at 5, App. C). Mr. Prater confirmed that Chewy has grown as a company "for sure" in 2020. (Tr. 757-758). Mr. Prater testified, "well, I'd say that we achieved that growth probably in thanks to our extra wide aisle and great training. Despite these guards, we've been able to fulfill customer demand and achieve growth, yes." (Tr. 758).

Chewy Management Structure

At the time of the incidents in this case, Craig Gage was the Director of Safety and Loss Prevention at Chewy. (Tr. 163, 191-192).⁴² Mr. Gage was Safety Director from October 2017 to September 2019, when he left employment at Chewy. (Tr. 163, 616). As the Director of Safety and Loss Prevention, Mr. Gage was responsible for the seven warehouses Chewy had at the time, and he himself was based at the Dallas warehouse site. (Tr. 166-167, 175). As Safety Director, Gage was responsible for everything relating to safety, security, and retail loss prevention, including internal theft, workplace violence, workers compensation, and food safety.

When it came to workplace incidents, Mr. Gage reviewed incident reports or "recaps" prepared by the safety managers and directed by the regional safety managers. (Tr. 168-169). Mr. Gage would send these reports back to safety managers and "regionals" if he determined the report required "more detail," "better root cause," or "better process change." (Tr. 168-169). Mr. Gage would also "respond to the scene" of any serious incident, like the two fatalities he experienced

Mr. Prater agreed that the operator of the universal stance lift truck may also stand sideways. He described this operating position as "ergonomically unfriendly." (Tr. 673).

⁴² Mr. Gage has worked in safety and loss prevention in general since 1982, in industries including grocery, big box retail, and online distribution fulfillment. (Tr. 163-164). Before Chewy employed him, Mr. Gage worked for ten years with warehouse spaces – eight years at Amazon and two years at Target stores in distribution. (Tr. 164). Based on his experience of being "in charge of safety" at Amazon before his work at Chewy, Mr. Gage agreed that he was familiar with the under-ride hazard. He testified that he had previously experienced accidents involving under-rides at Amazon, "one or two instances of that where we had somebody injured." (Tr. 165-166).

while he was at Chewy, and “head up” the investigations into those serious incidents. (Tr. 169-170, 192-193).

At the time of the incidents in this case, Joshua Rose was the Ocala Warehouse Safety Manager. Mr. Rose worked for the Ocala warehouse from June 19, 2017, until mid-November 2019.⁴³ (Tr. 237). As the Ocala Warehouse Safety Manager, Mr. Rose was responsible for “the overall safety and culture of that building.” (Tr. 238).

Also, at the time of the incidents relevant to this case, July 2018 and December 2018, Cory Billet was the Director of the Capacity Organization.⁴⁴ (Tr. 517-519). According to Mr. Billet, “the capacity organization manages the storage space within our facilities.” (Tr. 473). Mr. Billet explained that “capacity organization” uses the company’s “financial forecast” to determine “how much cubic storage [] is required for inventory in all of our fulfillment centers in order to meet the [projected] sales numbers.” (Tr. 473-474). As Director of the Capacity Organization, Mr. Billet was responsible for facility storage design and racking configuration layout at all Chewy fulfillment centers. (Tr. 518, 485-486). Mr. Billet was involved with the decisions regarding the reconfiguration of the racks after the incidents involving Mr. BB and Mr. RP. (Tr. 519). Mr. Billet was not involved with the decisions regarding adding guards or not adding guards to the Raymond forklifts. (Tr. 519, 521-523).

After a year and a half as Director of the Capacity Organization, around July 2019, Mr. Billet was promoted to Senior Director of Fulfillment Optimization, where he now oversees five

⁴³ At the time of the hearing, Mr. Rose was working as the Safety Director at Fidelity Manufacturing in Ocala, Florida. (Tr. 237). Prior to working at Chewy, Mr. Rose worked in the warehousing industry at C&S Wholesale, a division of the grocery retailer Winn-Dixie, for seven and a half years. (Tr. 238). Mr. Rose testified that he has about 15 years of experience in safety, but that before the July incident in this case, Mr. Rose had never heard of an under-ride hazard. (Tr. 239-240).

⁴⁴ Mr. Billet “started [his] career at Chewy” around December 2017 as Director of the Capacity Organization. (Tr. 476, 518). Prior to starting at Chewy, Mr. Billet spent about five years at Amazon where he was responsible “for quality and customer experience for North America for their final mile delivery.” (Tr. 477). Mr. Billet also worked as a “process expert” on the “fulfillment side” of Amazon. (Tr. 477). Prior to Amazon, Mr. Billet spent eight years at Williams Sonoma, where he “ran the global supply chain optimization team” and “running fulfillment operations for the organization for one of their buildings.” (Tr. 477-478). Mr. Billet explained that “fulfillment” is the “e-commerce version of distribution where you are in the process of fulfilling the customer’s order. So, picking what was ordered, placing it in the box, and then shipping it to the customer.” (Tr. 478). Before Williams Sonoma, Mr. Billet spent three years as a Warehouse Operations Manager at Target, where 95 percent of his time was spent on the warehouse floor. (Tr. 478).

organizations within Chewy,⁴⁵ including the capacity organization, described above, and the engineering organization. (Tr. 472.) The “engineering organization is responsible for the physical design and layout of all of [Chewy’s] facilities,” and includes equipment such as powered industrial trucks. (Tr. 472-474, 476). As Senior Director of Fulfillment Optimization, Mr. Billet’s responsibilities include the design and configuration of fulfillment center racks, and the evaluation of guarding on the reach trucks used in the fulfillment centers / warehouses, including use of the fourth post on the Raymond dock stance reach truck used at the Ocala warehouse. (Tr. 485, 488-489, 519-520, 523-524, 537).

As Senior Director, Mr. Billet has responsibility for the safety and stability of the storage rack systems at Chewy’s warehouses. (Tr. 532-533). Chewy contracts with a third party, Storage Solutions Incorporated (SSI), to design the racking structure itself. (Tr. 496-497, 532). As Senior Director, Mr. Billet ensures that the correct information is passed over to SSI. SSI “consider[s] the gauge of the upright, as well as the width of the load beam,” so that the rack system designed supports the overall weight of Chewy’s product, and so that the structure created “reduces the possibility of a catastrophic failure.” (Tr. 532-533.) Mr. Billet’s organization looks at “the interaction of that racking system with powered industrial trucks.” (Tr. 532-533).

Mr. Billet has a bachelor’s degree in operations management.⁴⁶ Mr. Billet is not an engineer and has no expertise in safety outside of operations. (Tr. 496, 536, 577-578). He is not a safety expert. (Tr. 589-590). He has no certifications in powered industrial trucks. (Tr. 578).

⁴⁵ As Senior Director of Fulfillment Optimization, in addition to the capacity organization and the engineering organization, Mr. Billet also oversees the “fulfillment [center] optimization organization, the continuous improvement organization, and the WMSFC ops tech organization.” (Tr. 472, 474). The fulfillment center optimization organization is the “team of data scientists and analysts who leverage simulation software to simulate daily operations within our centers,” with the goal of “understanding overall flow within a facility” to help “build an efficient and safe operation.” (Tr. 474-475). The continuous improvement organization “owns the Lean principles” and their implementation within Chewy, and its “ultimate purpose is to eliminate waste in any one of our functions.” (Tr. 475). Finally, the WMS (warehouse management system) team “acts as a liaison between the operations team and understanding what the operational requirements are for [the software program that Chewy uses to run its facilities].” (Tr. 475-476).

⁴⁶ Mr. Billet described “operations management” as “a focus in on how you effectively run an operation. It could be manufacturing; it could be distribution. You’re primarily looking at the flow, the processes. Very heavily geared towards statistical controls and how to just keep balance and flow and keep the operation running smoothly.” (Tr. 479).

Mr. Billet is not an expert in the ANSI Standard related to the Raymond lift truck at the Ocala warehouse. (Tr. 580).

Caleb Prater is the current Director of Safety and Loss Prevention for Chewy. (Tr. 611-612, 680). Mr. Prater began working with Chewy on October 3, 2018, shortly before the December incident involving Mr. RP, but after the July 2018 incident involving Mr. BB.⁴⁷ (Tr. 666, 680). At the time of Mr. RP's incident, Mr. Prater served as the Regional Safety and Loss Prevention Manager for the eastern half of the United States and reported to Mr. Gage. (Tr. 615-616, 633). Mr. Prater succeeded Mr. Gage as the Director of Safety and Loss Prevention in September 2019. (Tr. 616). The Chewy Ocala warehouse is Mr. Prater's home office. (Tr. 703).

As the current Director of Safety and Loss Prevention, Mr. Prater oversees all Chewy's safety and loss programs. (Tr. 615). He testified that his responsibilities are:

to construct safety policy protocol, ensure that they're enforced throughout the fulfillment network[,] maintain responsibilities over loss prevention, which is essentially inventory loss control and physical security of the fulfillment centers[, and] oversee workers' compensation organizations and food safety organizations.

(Tr. 612). With regard to workplace incidents, Mr. Prater testified that he was responsible for evaluating:

the propensities for them to occur, to proactively adjust game plan for those, to mitigate or eliminate hazards wherever possible. Reactively, once an issue has taken place, to investigate physical circumstances, identify possible root causes and apply corrective actions wherever necessary to prevent recurrence.

(Tr. 612).

Significantly, Mr. Prater also has responsibilities regarding the selection of equipment used at Chewy's fulfillment centers, as well as regarding the design of Chewy's facilities. (Tr. 613-

⁴⁷ Prior to working for Chewy, Mr. Prater was an Environmental Health and Safety Manager at Amazon for four and a half years. (Tr. 629). Mr. Prater's responsibilities at Amazon included creating, implementing, and ensuring adherence to safety protocols, and establishing a culture of safety within the fulfillment centers. He managed safety specialists who were direct reports. He agreed that "Amazon's operation" was similar to Chewy's operations, in terms of fulfillment centers. (Tr. 629-630). Before working at Amazon, Mr. Prater was responsible for implementing safety protocol at a manufacturing warehouse environment utilizing powered industrial trucks at a solar sail manufacturer, and prior to that he worked at a New York based environmental health and safety consulting firm. (Tr. 630-631).

614). Mr. Prater testified that proposed equipment and rack designs pass through his safety review. Regarding equipment, Mr. Prater testified:

Once the design and engineering team brings forth specific solutions that they've identified for their fulfillment operations, my organization would be responsible for reviewing those particular pieces of equipment in context of the operating environment, to ensure we can do so safely.

(Tr. 613-614). Mr. Prater's responsibilities include evaluation of potential reach truck guards offered by manufacturers. (Tr. 668-669). Regarding the design of Chewy's facilities, Mr. Prater testified: "once a design has been completed, I am part of the review process to ensure that no identified hazards make their way to the launch of such a design." (Tr. 614, 722. *See* Tr. 489). Mr. Prater testified that he reviews the storage rack design, including review of the computer assisted design drawing, the virtual layout, the selected vendors, and "any documents that [the vendors] set forth as pertaining to the relevance of the safety of the fulfillment environment." (Tr. 614-615).

Mr. Prater has a bachelor's degree in biology, and no certifications "in terms of the industry standpoint that [are] substantial." (Tr. 631-632).

Expert Witness Testimony

The Secretary presented expert testimony from Guy Snowdy, director of training and development, and owner, of MHS Training Corporation.⁴⁸ (Tr. 298). Based on his long industry experience and specialized knowledge regarding the safe operation of powered industrial trucks and material handling in a warehouse or distribution system, Mr. Snowdy was qualified as an expert witness.⁴⁹ (Tr. 331-333, 338-339; Ex. C-1, at 13-14). Mr. Snowdy was qualified as an expert with respect to material handling equipment, including the powered industrial truck, the

⁴⁸ The company, started in 1991, provides training on lifts and cranes and material handling equipment to organizations like manufacturers, distributors, and construction companies. (Tr. 298-299). Mr. Snowdy has continuously run the company, in various different business forms, since 1991. (Tr. 299).

⁴⁹ Mr. Snowdy does not hold a college degree and is not an engineer. (Tr. 323-324). Prior to reaching opinions in this case and preparation of his expert report, Mr. Snowdy reviewed the entire OSHA investigative file, including the measurements and photographs taken by the CSHO, the OSHA report, and Chewy's accident reports. (Tr. 317-318, 332, 327). He did not visit Chewy's Ocala warehouse, nor did he interview any Chewy employees in preparing his report. (Tr. 324-325).

reach truck that is at issue in this case. (Tr. 333). He was also qualified as an expert with respect to the general storage systems regarding material handling in a warehouse or in a distribution system; however, Mr. Snowdy was not qualified as an expert with respect to Chewy's inventory needs in terms of its racking system. (Tr. 332-333). Mr. Snowdy was also qualified as an expert witness with respect to the safe operation of powered industrial trucks. (Tr. 333).

Mr. Snowdy testified that he trains about 6,000-7,000 operators and operator trainers for multiple different employers a year. (Tr. 306-308). He is qualified to train operators on all seven classes of powered industrial trucks. (Tr. 306). His operator training absolutely addresses the under-ride hazard. (Tr. 433-434). When providing his services to clients, Mr. Snowdy's primary concern is safety. (Tr. 305). He testified that he works with warehousing manufacturers "probably 70, 75 percent of what I do every day," all of which use lift trucks. (Tr. 300-302). Mr. Snowdy testified that the specific lift truck at issue in this case, the "Raymond" is "a very dominant brand in the industry." He testified that he "train[s] out a Raymond lift truck at least several times a week." (Tr. 302). Mr. Snowdy also develops safety programs for clients, including thousands of fork truck varied programs from very simple to very complex. (Tr. 303).

Mr. Snowdy also evaluates warehouse facilities and identifies the equipment that is being used in the warehouse facility to detect specific hazards for that warehouse employer. (Tr. 302). He considers current damage at the facility such as product damage, rack damage, facility damage, and pedestrian incidents, when evaluating solutions that the warehouse could implement to solve their safety issues. (Tr. 302-303). Mr. Snowdy provides incident investigations and root cause analyses for PIT incidents. (Tr. 309). He testified that he has investigated about fifty to sixty under-ride incidents, about seven or eight of which were fatalities.⁵⁰ (Tr. 310, 462).

⁵⁰ Mr. Snowdy testified that:

it would be hard pressed to find anyone in the United States that has assessed this particular issue [under-ride hazard] more than I have and have trained more people on abating those hazards than I have. Because I've been running the industry for 35 years, and that's all I've ever done. I've always focused in on material handling equipment. That's my specialty.

(Tr. 319).

Mr. Snowdy's testimony, based on his long industry experience and specialized knowledge regarding the safe operation of powered industrial trucks and material handling in a warehouse or distribution system, was helpful in understanding the evidence and making fact determinations. Fed. R. Evid. 702 ("A witness qualified as an expert witness by knowledge, skill, experience, training, or education may testify in the form of an opinion or otherwise, if . . . the expert's . . . specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue"). Mr. Snowdy's expert testimony was credible and persuasive.

Respondent did not identify or qualify an expert witness in this proceeding. (Tr. 494-495).

Worksite Training Stipulation

With regard to safety training, Mr. Prater testified that he was responsible for constructing and administering the training "for whatever job task is being conducted by the employee." (Tr. 613, 687). He is also the custodian of records for that training. (Tr. 613, 687). He testified that he is responsible to ensure employees are properly trained in the use and operation of PITs, "to ensure the work environment is free of identified hazards, and to ensure that appropriate and safe operation occurs in fulfillment centers, and that corrective actions are applied wherever necessary." (Tr. 613). With regard to operating the Raymond forklift at its Ocala facility, Mr. Prater testified that Chewy mandates its workers to always look in the direction of travel, and to always keep the forklift under control. (Tr. 681-682, 687).

Chewy's safety program and work rules are not in this record. Similarly, no written documentation or testimony regarding work rule discipline is in this record. At the hearing, the Secretary stipulated to the following: "Through its investigation, OSHA found no violation, and cited no violation of [29 C.F.R. § 1910.178(l)⁵¹]." The Secretary agreed, "that stipulation does not address whether or not Chewy's training included the under-ride hazard," and clarified that the stipulation was "nothing broader than [the stipulated statement]. There was no violation of that standard found by OSHA . . . or cited by OSHA." (Tr. 553-554. *See* Tr. 469-470).

DISCUSSION

⁵¹ Section 1910.178(l) addresses "Operator Training" for powered industrial trucks. 29 C.F.R. § 1910.178(l).

What is an Under-Ride Hazard?

Grammatically, throughout this proceeding, the parties describe the term “under-ride” in both noun and verb forms. For example, in the alleged violation description within the amended citation, the Secretary describes the under-ride hazard in this case in verb form:

The horizontal beams of the worksite’s shelving units were at a height that could enter the operator’s compartment of the Raymond brand 7000 series stand-up lift truck (“lift truck”) and strike and/or crush the operator inside the compartment, *should the lift truck under-ride a shelving unit.*

(Sec’y Br. 17; First Am. Compl. 3) (emphasis added). The Secretary also points to the description in OSHA’s SHIB, which uses a noun form:

a forklift ‘under-ride’ hazard arises when the forklift operator travels with the forks trailing and backs up toward the storage rack. *If the operator drives the forklift too far, so that the forklift passes beneath the horizontal crossbar (i.e., the operator creates an ‘under-ride’), the crossbar can enter the operator’s compartment and crush the operator inside the compartment.*

(Ex. C-2, at 2) (emphasis added). *See* (Sec’y Br. 17).

Respondent also uses the term “under-ride” in both noun and verb sense: “[i]n this phase of the operators’ training, the hazards of striking the rack, *including the under-ride*, are addressed to ensure the operators are competent and capable of operating safely in their environment without supervision,” and “[a]ll of OSHA’s proposed methods of abatement rely on the operator striking the rack *to avoid under-riding* the horizontal beam.” (*See, e.g.,* Resp’t Br. 12, 14) (emphasis added).

What is apparent from the record is that the term “under-ride” involves *the act* of the forklift traveling beneath the lowest horizontal beam. The “under-ride hazard” exists when the operator has no protection against that horizontal beam striking him/her while the forklift travels beneath it. The operative trigger for the under-ride hazard is the ability of the forklift to travel beneath the lowest horizontal beam of the storage rack. The facts of this case are analyzed accordingly.

Preemption

Respondent claims at the outset that a citation to the general duty clause was inappropriate here because the PIT standards at 29 C.F.R. § 1910.178 apply instead to an under-ride hazard.

(Resp't Br. 24-35). "Under Commission precedent, preemption by a more specifically applicable standard is an affirmative defense which the respondent must raise in its answer." *Spirit AeroSys., Inc.*, 25 BNA OSHC 1093, 1097 n.7 (No. 10-1697, 2014) (citations omitted). In its Answer, Respondent claimed,

In regard to Citation 1, Item 1, citing the General Duty Clause is not proper because a specific OSHA standard already applies to the cited hazard. 29 CFR 1910.178(n)(6) requires the operator to look in the direction of travel and 29 CFR 178(n)(15) requires the operator to negotiate turns at a safe speed. Compliance with these specific standards would effectively abate the struck-by and crushing hazards referenced in the Citation.

(Resp't First Am. Answer, 3 ¶ 12).

Respondent maintains in its post-hearing brief that the standards at 29 C.F.R. § 1910.178 preempt the general duty clause in this case. (Resp't Br. 25.) Respondent claims that "OSHA has a specific standard governing [PITs] which specifically addresses the hazard of striking structures like storage racks, including the under-ride hazard, while operating a PIT." (Resp't Br. 24.)

When analyzing preemption,

[t]he Commission has held that an applicable standard preempts application of the general duty clause. (citations omitted). In order for a specific standard to preempt the general duty clause, however, the standard must be addressed to the particular hazard for which the employer has been cited under the general duty clause. *United States Pipe and Foundry Co.*, 6 BNA OSHC 1332 (No. 11739, 1978).

Armstrong Cork Co., 8 BNA OSHC 1070, 1073 (No. 76-2777, 1980), *aff'd*, 636 F.2d 1207 (3d Cir. 1980) (citations omitted) (*Armstrong*).

The particular hazard in this case is the instance when the forklift travels beneath (i.e., under-rides) a horizontal rack beam and the worker is unprotected from that beam striking him/her as the forklift travels beneath it. Respondent argues that the training standards at section 1910.178 – requiring operators to "look in the direction of travel," and "maintain control" of the forklift – specifically address this particular hazard. (Resp't Br. 24.) To the contrary, these training standards do NOT address what happens in the event of an under-ride. Instead, the training standards are geared toward preventing the under-ride; but as the facts of this case show, under-rides occur despite operator training.

Respondent also argues that the “Safety Guards” standards at section 1910.178(e) specifically address what guarding is required on reach trucks and Respondent claims that CSHO Driscoll “admits” this. Careful review of CSHO Driscoll’s testimony cited by Respondent reveals nothing more than a regurgitation of the standard.⁵² (Resp’t Br. 24-27 citing Tr. 122-123). Legal conclusions by an OSHA compliance officer do not bind the Secretary or the Commission. See *Kasper Wire Works, Inc. v. Sec’y of Labor*, 268 F.3d 1123, 1128 (D.C. Cir. 2001) (noting “the Commission is not bound by the representations or interpretations of Compliance Officers” quoting *L.R. Willson & Sons, Inc. v. Donovan*, 685 F.2d 664, 676 (D.C. Cir.1982)); *Nat’l Realty & Constr. Co. v. OSHRC*, 489 F.2d 1257, 1264 (D.C. Cir. 1973) (*Nat’l Realty*) (the Secretary is not bound by the “narrow construction of citations issued by his inspectors,” which include compliance officers who are not legal professionals). Furthermore, section 1910.178(e)(1) addresses an overhead guard, and section 1910.178(e)(2) addresses a load guard, neither of which are a vertical post or an extended backrest. 29 C.F.R. §§ 1910.178(e)(1), (2); (Tr. 122-123). Neither guard mentioned in section 1910.178(e) specifically addresses the particular under-ride hazard for which the employer has been cited under the general duty clause in this case. *Armstrong*, 8 BNA OSHC at 1073.

Respondent also seems to claim that because section 1910.178(e) – “Safety Guards” – does not mention the guarding included in the proposed abatement measures for this citation item, that OSHA never intended for the under-ride hazard to be addressed and therefore the general duty clause cannot apply in this case. (Resp’t Br. 27) (“This is significant because OSHA identifies guarding as a proposed means of abatement to support its General Duty Clause citation.”). The

⁵² Q [Mr. Harrington] Okay. Mr. Driscoll, I want to go through this in order, but I'm going to take you down to 1910.178(e) and I'm going to do that as quickly as I can. All right. Are you familiar with this part of 1910.178?

A [CSHO Driscoll] Yes, sir, I am.

Q What does this section address?

A 1910.178, sub letter (e) says, "Safety guards."

Q All right. And you tell me if I'm wrong, but in this standard OSHA requires certain safety guards to be installed on reach trucks; is that correct?

A Correct, sir, sub numbers 1 and 2.

Q All right. And it looks like OSHA requires here under sub number 1 an overhead guard and in number 2, a load backrest; is that correct?

A Correct, sir.

Q OSHA does not require a vertical post or an extended backrest; is that correct?

A In this subsection here, no, sir. Yes, that is correct.

(Tr. 122-123).

undersigned judge rejects this line of argument as it is inconsistent with the purpose of the Act to provide a safe working environment. Additionally, the Secretary does not “require” specific reach truck guarding. Rather, the Secretary proposes reach truck guarding methods as a feasible means to materially reduce or eliminate the under-ride hazard, among other feasible abatement methods that do not involve truck guards. Further, this line of argument fails under the preemption test because, as the Secretary points out, section 1910.178 are general standards and do not specifically address the struck-by hazard posed to the operator of a forklift that underrides a rack beam. (Sec’y Br. 16-17); *Armstrong*, 8 BNA OSHC at 1073.

Respondent next argues that the preamble to section 1910.178(l) “demonstrates” that this standard “is intended to replace use of the General Duty Clause.” (Resp’t Br. 28.) Respondent claims that “[t]he hazard of running into a structure, such as the horizontal beam on a storage rack, while operating a PIT *was* previously addressed under the General Duty Clause *until* the specific standard for [PITs] was revised to abate this hazard through operator training.” (Resp’t Br. 28) (emphasis in original). Respondent also claims that the SHIB states that section 1910.178 specifically addresses the under-ride hazard in this case. (Resp’t Br. 30-31). The Secretary argues that “this is a misunderstanding of the under-ride hazard at issue in this case, which is specific to the hazard posed when the body of the lift truck is *able to ride under* the racking beam, causing the horizontal beam to enter the operator’s compartment and crush the operator.” (Sec’y Br. 15) (emphasis added). The undersigned agrees with the Secretary.

Respondent’s preemption arguments do not address the Secretary’s definition of the hazard in the event of an under-ride; instead, Respondent attempts to reframe the issue in terms of preventing an under-ride. Indeed, Respondent cites to *Alabama Power Co.*, 13 BNA OSHC 1240, 1244 (No. 84-0357, 1987) (*Alabama Power*) in support of its preemption argument. (Resp’t Br. 31-33). *Alabama Power*, however, is not a preemption case – it is a feasibility of abatement case. *Id.* (“There is no dispute that employees who come too close to trucks dumping coal at the coal pile are exposed to the hazard of being struck by an overturning truck, a hazard likely to cause serious physical harm or death.”). Respondent’s arguments regarding preventing an under-ride do not bear on this preemption analysis; instead, they are appropriately addressed below in the discussion of feasibility of abatement in this Decision.

Similarly, the preemption line of cases that Respondent relies on are not helpful to its argument. (Resp’t Br. 25, 35-38, citing *John T. Brady & Co.*, 10 BNA OSHC 1385 (No. 76-2894,

1982); *Daniel Int'l, Inc.*, 10 BNA OSHC 1556 (No. 78-4279, 1982); *A. Prokosch & Sons Sheet Metal, Inc.*, 8 BNA OSHC 2077 (Nos. 76-406 & 76-576, 1980); *Sun Shipbuilding & Drydock Co.*, 1 BNA OSHC 1381 (No. 161, 1973). In each of these cases, the Commission found that the particular hazard was addressed by a specific standard. In terms of analyzing preemption, this decision focuses on the particular hazard, as alleged by the Secretary, and whether an existing standard addresses that particular hazard. *Armstrong*, 8 BNA OSHC at 1073. The standards that Respondent points to, as well as its arguments, are general and do not specifically address the under-ride hazard in this case – when the lift-truck travels beneath a horizontal rack beam and the operator is unprotected from being struck by that beam while traveling on the lift truck.

Both parties also address the recent administrative law judge decision in *Pharmasol Corp.*, No. 16-1172, 2018 WL 5013447 (O.S.H.R.C.A.L.J., Sept. 4, 2018) (*Pharmasol*) that addressed an under-ride hazard. (Sec'y Br. 15-16; Resp't Br. 34.). While this judge's decision is not binding within the Commission,⁵³ the *Pharmasol* preemption analysis is persuasive to the undersigned regarding inadvertent under-rides, which training standards cannot by very definition address. In *Pharmasol*, the preemption defense was rejected because even adhering to section 1910.178, the under-ride hazard would still exist in the workplace due to inattention and inadvertence. *Pharmasol*, 2018 WL 5013447, at *6. Upon review, the undersigned reaches the same conclusion in this case.

Here, the Secretary's expert Mr. Snowdy testified that training alone will not fully protect an operator from the under-ride hazard. (Tr. 343-345, 378). Mr. Snowdy testified it is not possible to train an operator to never lose attention or to always operate perfectly. (Tr. 345). CSHO Driscoll and Safety Director Gage agreed that training alone would not eliminate the under-ride hazard from the worksite. (Tr. 144, 197-198).

Respondent's preemption argument is rejected.

Serious Citation 1, Item 1

The Secretary alleges that Respondent violated the general duty clause when:

On or about December 16, 2018, employees were exposed to struck-by and/or crushing hazards. The horizontal beams of the worksite's shelving units were at a

⁵³ *Leone Constr. Co.*, 3 BNA OSHC 1979, 1981 (No. 4090, 1976) (An unreviewed administrative law judge decision is not binding precedent for the Commission.).

height that could enter the operator's compartment of the Raymond brand 7000 series stand-up lift truck ("lift truck") and strike and/or crush the operator inside the compartment, should the lift truck under-ride a shelving unit.

(First Am. Compl. 3). To prove this violation, the Secretary must establish that: (1) a condition or activity in the workplace presented a hazard; (2) the employer or its industry recognized the hazard; (3) the hazard was causing or likely to cause death or serious physical harm; and (4) a feasible and effective means existed to eliminate or materially reduce the hazard. *Arcadian Corp.*, 20 BNA OSHC 2001, 2007 (No. 93-0628, 2004) (*Arcadian*). The Secretary must also show that (5) the employer knew or, with the exercise of reasonable diligence, could have known that the hazardous condition existed at its worksite. *Tampa Shipyards, Inc.*, 15 BNA OSHC 1533, 1537 (No. 86-0469, 1992) (consolidated).

1) The Under-Ride Hazard at Chewy's Ocala Warehouse

"[The] hazard must be defined in a way that apprises the employer of its obligations, and identifies conditions and practices over which the employer can reasonably be expected to exercise control." *Arcadian*, 20 BNA OSHC at 2007; *Pelron Corp.*, 12 BNA OSHC 1833, 1835 (No. 82-388, 1986) (*Pelron*). To constitute a cognizable hazard under the general duty clause, a worksite condition must pose more than the mere possibility of harm. *See, e.g., Pelron*, 12 BNA OSHC at 1835 ("Defining the hazard as the 'possibility' that a condition will occur defines not a hazard but a potential hazard."); *Pratt & Whitney Aircraft v. Donovan*, 715 F.2d 57, 64 (2d Cir. 1983) ("[T]he Secretary must show more than the mere possibility of injury; he must show that the potential hazard presents a significant risk of harm.")

On the day of the incident, the height of the bottom of the horizontal rack beam from the floor level was 53 and 7/8 inches. (Tr. 61; Ex. C-3, at 1). The height of the rear of the lift truck was 51 inches from the floor to the tip of the lift truck, and the height of the front of the lift was 52 inches from the floor to the top of the lift truck compartment. (Tr. 61-62). The width of the lift truck, from the tip of the forks where the product is lifted to the rear of the compartment, was 102 inches. (Tr. 62, 152-153). The width of the aisle was 127 inches from rack upright to rack upright on the other side. (Tr. 62). "To properly and safely lift product from the shelf on pallets, [the lift truck] needs to be a 90-degree perpendicular to the rack system." (Tr. 62). The operator of the Raymond lift truck in Chewy's Ocala warehouse in the non-inventory section had, at most,

25 inches of space to “properly and safely lift product from the shelf on pallets.” (Tr. 62-63). Based on these conditions, CSHO Driscoll stated that Chewy’s lift truck operators were exposed to a safety hazard of “a horizontal intrusion or roll-under of the operator’s compartment beneath the rack storage system.” (Tr. 63). The Secretary’s expert Mr. Snowdy also testified that the conditions present at Chewy’s Ocala warehouse presented an under-ride hazard. (Tr. 341-343).

Respondent argues that its extra-wide aisles⁵⁴ and operator training freed its Ocala workplace of the under-ride hazard, and that “the hazardous condition of striking the storage racks in this case was created by the operator’s reckless behavior.” (Resp’t Br. 38-40.) First, the record does not support the argument that either of the two Ocala under-ride incidents in this case, concerning Mr. BB or Mr. RP, was a result of reckless behavior. (Tr. 224-225). (“Mr. RP lost control for an unknown reason.” Tr. 759). Consequently, Chewy’s reliance is misplaced on the cases *Alabama Power*, 13 BNA OSHC at 1244, and *Nat’l Realty*, 489 F.2d at 1257. (Resp’t Br. 38.) Second, the efficacy of Chewy’s work methods in avoiding injury, like its aisle width and training, “is a separate inquiry from whether an alleged hazard was present. In fact, that bears on feasibility of abatement[.]” *Peacock Eng’g, Inc.*, No. 11-2780, 2017 WL 3864205, at *3 (O.S.H.R.C. Apr. 27, 2017) (*Peacock*).

Chewy forklift operators performed the job task at issue, pulling and retrieving pallets using a forklift from a pre-designed racking system, “30,000 times a day.” (Tr. 636-637, 640, 650-651). Chewy had “a number of under-rides” during a two-year period, including one at Wilkes-Barre and the two in Ocala, in warehouses with “standard” aisle widths. (Tr. 212, 229). Chewy’s work methods show that Ocala warehouse employees regularly maneuvered Raymond forklifts in 25-inch spaces. The height of a nearby horizontal member of a storage rack was such that the forklift operator was unprotected as the lift approached the beam. The Chewy forklift operator stands on the forklift, traveling with it, with no barrier between the operator and the horizontal beam. Upon striking the horizontal beam, both Mr. BB and Mr. RP sustained serious injuries. In Mr. RP’s case, the forklift’s automatic break (the deadman pedal) prevented movement of the forklift away from the horizontal beam when he was struck. (Tr. 221-222).

⁵⁴ As noted above, Chewy uses the term “extra-wide aisles” to indicate that its aisles are 12 inches wider than the minimum required by the Raymond lift truck manufacturer for safe operation of its lift trucks. (Tr. 482-483, 504-506; Resp’t Br. 54-56; Sec’y Br. 23-24)

For these reasons, the Secretary has identified “the conditions and practices” within the Ocala warehouse that establish the existence of an under-ride hazard at the time of the relevant incidents in this case.⁵⁵ *Arcadian*, 20 BNA OSHC at 2007.

2) Chewy and its Industry Recognized the Under-Ride Hazard

Hazard recognition “may be shown by proof that ‘a hazard . . . is recognized as such by the employer’ or by ‘general understanding in the [employer’s] industry.’” *Otis Elevator Co.*, 21 BNA OSHC 2204, 2207 (No. 03-1344, 2007) (quoting *Kokosing Constr. Co.*, 17 BNA OSHC 1869, 1873 (No. 92-2596, 1996)(*Kokosing*)); see *Kelly Springfield Tire Co. v. Donovan*, 729 F.2d 317, 321 (5th Cir. 1984) (*Kelly-Springfield*) (“Establishing that a hazard was recognized requires proof that the employer had actual knowledge that the condition was hazardous or proof that the condition is generally known to be hazardous in the industry.”).

“That [the employer] took some [safety] measures . . . to protect against this hazard, demonstrates that the hazard was recognized within the meaning of Section 5(a)(1).” *Wheeling-Pittsburgh Steel Corp.*, 10 BNA OSHC 1242, 1246 (No. 76-4807, 1981) (consolidated) (*Wheeling-Pittsburgh*); *Waldon Healthcare Ctr.*, 16 BNA OSHC 1052, 1061 (No. 89- 3097, 1993) (*Waldon*) (employer recognition depends on whether the employer actually knew that conditions created the hazard); see also *Mo. Basin Well Serv., Inc.*, No. 13-1817, 2018 WL 1309482, at *4 (O.S.H.R.C., March 1, 2018) (*Mo. Basin*) (supervisor’s recognition of hazard imputed to company); *Coleco Indus., Inc.*, 14 BNA OSHC 1961, 1966 (No. 84-546, 1991) (*Coleco*) (hazard recognition established through actual knowledge of supervisor).

The Secretary argues that employer recognition is established here by Mr. BB’s incident. (Sec’y Br. 18-20). Indeed, both Warehouse Safety Manager Rose and Safety Director Gage

⁵⁵ Chewy argues that the Secretary is “citing the abatement” to establish a hazard “instead of recognizing that Chewy abated the under-ride hazard through operator training and extra-wide aisles.” (Resp’t Br. 39-40). The alleged violation description of the under-ride hazard does not contain any abatement measures within it. *Mo. Basin Well Serv., Inc.*, No. 13-1817, 2018 WL 1309482, at *2 (O.S.H.R.C., March 1, 2018) (rejecting employer’s claim that the Secretary improperly defined the hazard by holding that the hazard allegation itself did not specify an abatement method).

Chewy also argues that the “Secretary mischaracterizes the nature of the alleged under-ride hazard . . . [by alleging] that Chewy’s operator was exposed to being ‘stuck-by’ the stationary storage rack, as if the stationary rack was somehow responsible for striking the operator.” (Resp’t Br. 40-42.) This argument is rejected as it does not address the Secretary’s definition of the hazard as set forth in the citation and analyzed in this Decision.

investigated Mr. BB's incident and were responsible for investigating Mr. RP's incident five months later. (Tr. 169-170, 192-193, 241-242, 254). Mr. Gage's testimony is also particularly enlightening here. Before he began working at Chewy as the Director of Safety and Loss Prevention, he previously experienced incidents involving under-rides at Amazon – “one or two instances of that where we had somebody injured.” (Tr. 165-166). Mr. Gage also testified that “we had had a number of under-rides at Chewy[.]” (Tr. 212). One incident, in Wilkes-Barre, Pennsylvania, where the operator slid on a wet floor “did under-ride,” was severe enough that “a GM critical” was written on it and, as found above, also occurred prior to Mr. RP's December under-ride incident. (Tr. 194, 212-213). These prior incidents establish recognition of the under-ride hazard at its warehouse worksite on the part of Chewy's supervisors and recognition is properly imputed to Chewy. *Mo. Basin*, 2018 WL 1309482, at *4; *Coleco*, 14 BNA OSHC at 1966.

Respondent argues that “Chewy did not recognize the existence of a struck-by hazardous condition because [the] configuration of the storage rack did not create a struck-by hazard.” (Resp't Br. 43). Respondent also argues that “Chewy abated the under-ride hazard in the particular circumstances at its worksite by properly training its operators pursuant to OSHA standard 1910.178, by designing its storage racks with extra wide aisles, and by promptly addressing and eliminating any hazards that cause operators to lose control.” (Resp't Br. 43). As noted above, Respondent's arguments here do not address the under-ride hazard as alleged by the Secretary: the instance when the forklift travels beneath (i.e., under-rides) a horizontal rack beam and the worker is unprotected from that beam striking him/her as the forklift travels beneath it.

Additionally, as Chewy's preferred safety measures against the under-ride hazard, Respondent's training and “extra-wide” aisles support a finding of employer recognition of the hazard. *Wheeling-Pittsburgh*, 10 BNA OSHC at 1246. Furthermore, the undersigned rejects Respondent's argument that the under-ride hazard was “abated” whenever Chewy promptly addressed and eliminated “any hazards that cause operators to lose control.”⁵⁶ (Resp't Br. 43).

⁵⁶ Respondent's accident investigation of Mr. BB's July under-ride incident revealed two root causes, the radio cord that interfered with the operator's reach truck control and the height of the non-inventory racking in relation to the height of the reach truck operator's compartment. (Ex. J-1, at 2-3). Following Mr. BB's incident, Respondent revised its operator instructions regarding how the radio cord must be worn. (Ex. R-8). The under-ride hazard presented by the rack height and the height of the unprotected reach truck

The problem with this post-incident solution argument is that it is contrary to the purpose of the OSH Act. *Mineral Indus. & Heavy Constr. Grp. v. OSHRC*, 639 F.2d 1289, 1294 (5th Cir. 1981) (“[t]he goal of the Act is to prevent the first accident, not to serve as a source of consolation for the first victim or his survivors.”).

Similarly, the record also supports a finding that Chewy’s industry recognizes the under-ride hazard. The Secretary’s expert witness Mr. Snowdy testified that the under-ride hazard, specifically that which was established by the conditions in Chewy’s Ocala warehouse, is recognized in the warehouse industry. (Tr. 309, 341-342, 348, 352, 373-374); *Kelly Springfield*, 729 F.2d at 322 (“The [industry] recognition standard centers on ‘the common knowledge of safety experts who are familiar with the circumstances of the industry or activity in question.’” (citation omitted)). Mr. Snowdy’s testimony that the under-ride hazard is recognized in the warehouse industry is based on his long experience and his specialized knowledge regarding the operation of powered industrial trucks and material handling in the warehouse industry. For many years, Mr. Snowdy’s work included evaluating warehouse facilities, identifying hazards, conducting incident investigations, and root cause analysis following PIT incidents. For the past decade or two, Mr. Snowdy has performed root cause investigations regarding fifty to sixty under-ride incidents, and seven or eight under-ride fatalities. (Tr. 302-303, 309-310, 319, 348-349, 374, 403-404).

Also, Mr. Snowdy testified that ANSI Standard 7.30 Operator Protection for Stand-Up, End Controlled, Narrow Aisle and Counterbalanced Truck, has included “guidance” regarding the under-ride hazard for many years, since 2000.⁵⁷ (Tr. 348, 351-353, 411-418, 447-449, 462; Ex.

operator compartment remained unabated. Consequently, Mr. RP’s fatal under-ride incident occurred in December five months later. (Tr. 375-376).

⁵⁷ ANSI/ITSDF B56.1-2009, and ANSI/ITSDF B56.1-2012, Section 7.30 Operator Protection for Stand-Up, End Controlled, Narrow Aisle and Counterbalanced Trucks, states, in part:

7.30.1 Guards or other means may be provided as part of the truck to limit intrusions into the operator’s area of horizontal members (e.g., rack beams), oriented generally transverse to the direction of travel.

(Ex. C-1, at 9-10; Tr. 351-353, 411-418).

Section 4.5 Safety Guards

4.5.3. Operator Compartment Guards. For stand up, end controlled, narrow aisle trucks, more or less guarding than specified by paras. 7.30 and 7.36 may be required to enhance safe operation. Changes shall be determined through cooperation between the user and manufacturer.

(Ex. C-1, at 6; Tr. 416-418).

C-1; at 5-12, ANSI/ITSDF B56.1-2009, and ANSI/ITSDF B56.1-2012). In his work with clients, Mr. Snowdy referenced this ANSI standard and the under-ride hazard present when the horizontal load rail was above the height of the lift truck. (Tr. 352-353).

Regarding industry recognition of the under-ride hazard, Mr. Snowdy also referenced the information in the Raymond Features Brochure,⁵⁸ the equipment manufacturer, regarding guarding fork trucks, proper equipment for the environment, and the potential for the power section of the lift truck to under ride the rack beam in some environments of use.⁵⁹ (Tr. 348, 353-354, 358-361, 374; Ex. J-5, at 8).

⁵⁸ The Raymond Features Brochure states, in part:

In some environments of use, the first level horizontal rack beams are higher than the top of the forklift power section and lower than the overhead guard. In such a situation, the potential exists for the power section to under ride the rack beam. This potential can be heightened when the truck is being maneuvered to right angle stack in an aisle with minimal clearance and/or when lower storage locations are empty. To avoid this situation, the customer should:

- Alter the design of their warehouse by adding a floor level rack beam
- Lower the first level rack beam to a point below the height of the top of the forklift power section
- Add a rack beam at the level of the overhead guard.

If the customer is unwilling or unable to alter the shelf heights, then equipping the truck with this feature may be considered. The posts or backrest are available to provide additional protection against incidental intrusions, which may occur in narrow aisles during right angle stacking or slow maneuvering. They will not provide protection against all intrusions into the operator's compartment. For trucks using a universal stack-stance compartment, rear vertical posts are installed on each side of the operator's compartment extending to the overhead guard. For trucks using a dockstance compartment, a rear vertical post is installed on the left side of the truck and an extended backrest is installed on the right side.

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- Will increase turning radius for some models of trucks
- Difficult to structure for drive-in racks
- Creates additional hazards for drive-in racks and other narrow operations
- Reduces visibility (operator, pedestrian, and efficiency concerns)
- May be a nuisance to the operator
- Increases pinch, sheer, crush, and contact points.

(Tr. 353-354, 358-361; Ex. J-5, at 8).

⁵⁹ The Secretary has established employer recognition of the under-ride hazard by Chewy management testimony, and also industry recognition of under-ride hazards based on Mr. Snowdy's testimony. That said, the undersigned notes, in the instant case, Respondent's reliance on the Commission decision in *K.E.R. Enters., Inc.*, No. 08-1225, 2013 WL 157682 (O.S.H.R.C., Jan. 9, 2013) (*K.E.R.*) to challenge the

The Secretary has established both employer and industry recognition of the under-ride hazard in this case.

3) The Under-Ride Hazard Was Likely to Cause Death or Serious Harm

The Secretary must show that Chewy's employees were exposed to a hazard likely to cause death or serious physical harm. *Arcadian*, 20 BNA OSHC at 2010 (citing *Morrison-Knudsen Co./Yonkers Contracting Co.*, 16 BNA OSHC 1105, 1122 (No. 88-572, 1993) (*Morrison-Knudsen*) ("hazard is likely to cause serious physical harm if the likely consequences of employee exposure would be serious physical harm"). "[T]he Commission has made clear [that] the criteri[on] ... [in this regard] is not the likelihood of an accident or injury, but whether, if an accident occurs, the results are likely to cause death or serious harm." *Waldon*, 16 BNA OSHC at 1060.

Here, the tragic circumstances of Mr. RP's incident on December 16, 2018, establishes that when Mr. RP's Raymond forklift rode under the horizontal beam of the pre-designed storage rack, he was struck and pinned between the beam and the Raymond forklift. He suffered compression asphyxiation injuries, was crushed, and died. (Tr. 103). These facts establish that the under-ride hazard at Chewy's Ocala warehouse was likely to cause death or serious harm.

4) Feasible and Effective Means Existed to Eliminate or Materially Reduce the Hazard

Secretary's evidence establishing warehouse industry recognition of the under-ride hazard is misplaced. (Resp't Br. 45-46; Sec'y Br. 21-22). In *K.E.R.*, the Commission held that while manufacturer safety manuals and voluntary industry standards may be probative evidence to establish industry recognition, those materials are only probative if they "contain a safety warning or suggest a link between noncompliance and a safety hazard." *K.E.R.*, 2013 WL 157682, at *3-4. Mr. Snowdy's credible expert testimony, however, in this case distinguishes the instant case from the facts before the Commission in *K.E.R.* As just discussed above, the Powered Industrial Trucks ANSI / ITSDF B56.1 standard and the Raymond Features Brochure support Mr. Snowdy's testimony that the under-ride hazard is recognized in the warehouse industry. (Tr. 351-354, 358-361, 411-418.) Also, citing *K.E.R.*, Respondent argues that the Secretary cannot rely on the OSHA Safety and Health Information Bulletin, Standup Forklift Under-ride Hazard (Ex. C-2, SHIB 07-27-2009). (Resp't Br. 45.) Respondent's argument in this regard is rejected because the very nature of the SHIB is to inform and warn about safety. *K.E.R.*, 2013 WL 157682, at *3-4. Further, the Secretary does not rely on the SHIB to establish industry recognition. (Sec'y Br. 21-22).

To establish the feasibility and efficacy of a proposed abatement measure, the Secretary must “demonstrate both that the measure[] [is] capable of being put into effect and that [it] would be effective in materially reducing the incidence of the hazard.” *Arcadian*, 20 BNA OSHC at 2011 (citations omitted). The Secretary need only show that the abatement method would materially reduce the hazard, not that it would eliminate the hazard. *Arcadian*, 20 BNA OSHC at 2011 (citing *Morrison-Knudsen*, 16 BNA OSHC at 1122). Where an employer has undertaken measures to address the cited hazard, the Secretary, in establishing efficacy, must also show that such measures were inadequate. *U.S. Postal Serv.*, 21 BNA OSHC 1767, 1773-74 (No. 04-0316, 2006).

A) Chewy’s Methods Were Inadequate

As a threshold matter, the undersigned finds that the Secretary has established that Chewy’s measures of addressing the hazard – extra wide aisles and training – were inadequate measures against the under-ride hazard at the Ocala warehouse. *U.S. Postal Serv.*, 21 BNA OSHC at 1773-74. The Secretary elicited the following testimony from Mr. Prater:

Q [Ms. Chastain] So training and extra-wide aisles -- I agree those are both good things. And the training in particular was required by OSHA. But the training and the extra-wide aisles did not prevent Mr. BB from being crushed by the horizontal beam, did it?

A [Mr. Prater] The training and extra wide aisles did not prevent the radio cord from going across his chest, if that's where -- what you're asking. I think it is, but - - so the answer would -- no, it did not.

Q And the training and the extra wide aisles did not prevent Mr. RP from under-riding the rack and being crushed as well, did it?

A Again, I think Mr. RP, some -- for some unknown reason, lost control of his truck, and struck the racks.

Q Well, -- and his excellent training did not prevent that, did it?

A In this case, Mr. RP lost control for an unknown reason. I -- I have no idea whether or not it was related or correlated in any way to the training.

(Tr. 758-759).⁶⁰ Mr. Billet agreed that the width of Chewy's aisles did not prevent Mr. BB's or Mr. RP's under-ride incidents. (Tr. 581).

The training and the aisle width are geared toward preventing an under-ride from occurring. But the facts here show that Chewy experienced "a number" of under-rides despite training and the width of the aisles. In fact, Safety Director Gage testified that after the first Ocala under-ride incident, the training was updated to ensure that it included under-ride hazards. (Tr. 177). Indeed, Warehouse Safety Manager Rose testified that he had never even heard of an under-ride hazard before Mr. BB's incident, and that he learned about it while investigating Mr. BB.'s incident. (Tr. 239-240). Consequently, Mr. BB did not have such training before operating the forklift. And despite Mr. BB's incident and subsequent actions by Chewy, Mr. RP experienced a fatal under-ride incident five months later. The updated training and the width of the aisles did not adequately address the under-ride hazard at the Ocala warehouse.

The undersigned also accords great weight to Mr. Snowdy's testimony that "absolutely" under-ride hazards can be completely eliminated through engineering controls. (Tr. 345-346, 378-382, 457). Mr. Snowdy testified that training alone would not eliminate a properly trained reach truck operator from contacting the storage rack. "It could be overshooting the turn, it could be a slick floor, it could be some malfunction of the machine. All those things could cause the truck to veer into the rail." (Tr. 436). As noted in *Pharmasol*, administrative fixes, such as training, do not eliminate the instance of an inadvertent under-ride situation. *Pharmasol*, 2018 WL 5013447, at *6. Safety Manager Gage testified that no matter what the "root cause" for each incident, why the operator ended up under the horizontal beam, a better process outcome would be to eliminate the hazard. He testified that recognizing the hierarchy of controls, it is best to look to engineering controls, administrative controls, things that can be done to "actually eliminate or mitigate the hazard," rather than to look at behavior, training. (Tr. 197-198).

Here, the record shows that instances of a wet floor, a radio cord, and an as yet unknown reason, caused a Chewy worker to lose control of his forklift, and then subsequently under-ride a rack beam in a Chewy warehouse. Mr. BB was seriously injured, and Mr. RP died, because of

⁶⁰ Mr. BB's and Mr. RP's training records are not in this record, although Mr. Prater testified that Mr. RP attended this training. (Tr. 689). No PIT training records, or PIT safety rules were offered into evidence by Chewy.

those incidents. The training and the width of Chewy’s aisles did not address the under-ride hazard in those instances.

The undersigned finds that Chewy’s methods addressing the under-ride hazard in its Ocala warehouse were inadequate. *U.S. Postal Serv.*, 21 BNA OSHC at 1773-74.

B) Physical Feasibility

The Secretary has the burden of “demonstrat[ing] both that the [proposed abatement] measures are capable of being put into effect and that they would be effective in materially reducing the incidence of the hazard.” *Beverly Enters., Inc.*, 19 BNA OSHC 1161, 1190 (No. 91-3344, 2000) (consolidated) (*Beverly*). “Feasible means of abatement are those regarded by conscientious experts in the industry as ones they would take into account in ‘prescribing a safety program.’” *Id.* at 1191 (quoting *Nat’l Realty*, 489 F.2d at 1266). An abatement method is feasible under section 5(a)(1) if the Secretary “demonstrate[s] both that the measure[] [is] capable of being put into effect and that [it] would be effective in materially reducing the incidence of the hazard.” *Beverly*, 19 BNA OSHC at 1190; see *Champlin Petroleum Co. v. OSHRC*, 593 F.2d 637, 640 (5th Cir. 1979) (“It is the Secretary's burden to show that demonstrably feasible measures would materially reduce the likelihood that such injury as that which resulted from the cited hazard would have occurred.”).

The Secretary introduced evidence of feasible and effective abatement measures that Chewy could have taken to address the under-ride hazard at the Ocala warehouse. In the citation, the Secretary listed the following abatement measures that Chewy could have implemented to address the hazard:

- Adjust the shelf heights so that the body of the lift truck below the operator’s compartment will strike the rack in the event of contact, preventing under-ride from occurring;
- Adjust the shelf heights so that the lift truck’s overhead guard will strike the rack in the event of contact, preventing under-ride from occurring;
- Install a barrier, even with the outer edge of the storage rack (such as a curb or floor level shelf), so that the bottom of the lift truck will strike the curb or shelf in the event of contact, preventing an under-ride from occurring;

- Purchase, where appropriate, standup lift trucks that have corner posts, extended backrests, rear post guards, or other features to prevent an under-ride from occurring; or
- Install rear post guards or other equivalent protections that address the under-ride hazard on existing standup lift trucks.

(First Am. Compl. 3).

Mr. Snowdy testified that “absolutely” under-ride hazards can be completely eliminated through engineering controls. (Tr. 378-379, 457). Engineering controls that he recommends include “lowering the rails to the frame height, [adding] the extended backrest, [putting] a vertical post in, [lowering] the second-tier rail to the height of the overhang guard,⁶¹ [and putting] a bottom rail in on the base of the rack system[.]” (Tr. 457. *See* Tr. 351, 378, 455-456). *Arcadian*, 20 BNA OSHC at 2011 (“[F]easible means of abatement are established if ‘conscientious experts, familiar with the industry’ would prescribe those means and methods to eliminate or materially reduce the recognized hazard.”) (citations omitted).

As noted above, Respondent lowered the horizontal racks within days of Mr. RP’s incident and outfitted its fleet of Raymond lift trucks with rear posts that effectively eliminated the under-ride hazard. (Tr. 225-226, 379-382, 441; Ex. J-4). According to the Secretary, the abatement measure of the installation of rear post guards on Chewy’s existing standup lift trucks “completely eliminated the under-ride hazard for this lift in Respondent’s facilities.” (Sec’y Br. 9-10). Further, at new sites Chewy opened after Mr. RP’s incident, Chewy equipped these sites with universal stance lift trucks, which have two rear vertical posts installed to protect the operator from the under-ride hazard. (Tr. 233-234. *See* Ex. J-5, at 8). Mr. Snowdy testified that use of the universal stance lift truck addressed the under-ride hazard. (Tr. 357-358, 361-362, 380-381). The Secretary has carried the initial burden of establishing that feasible and effective abatement measures exist to address the under-ride hazard at the Ocala warehouse. *CSA Equip. Co.*, No. 12-1287, 2019 WL 1375918, at *8 (O.S.H.R.C., Mar. 19, 2019) (citations omitted) (“That these procedures were either previously used by [the employer], or are currently being used, is prima facie evidence that both procedures were capable of being put into effect at the time of the accident.”).

⁶¹ Mr. Snowdy testified that while any one of the engineering controls listed would completely eliminate the under-ride hazard, when advising clients, he does not recommend the “overhead guard rail as a contact point,” as it is a “smaller picture to hit.” (Tr. 457-458).

The Secretary has the initial burden of proving:

that an abatement method exists that would provide protection against the cited hazard. The burden then shifts to the employer to produce evidence showing or tending to show that use of the method or methods established by [the Secretary] will cause consequences so adverse as to render their use infeasible.

Royal Logging, 7 BNA OSHC 1744, 1751 (No. 15169, 1979), *aff'd*, 645 F.2d 822 (9th Cir. 1981). If the proposed abatement “creates additional hazards rather than reducing or eliminating the alleged hazard, the citation must be vacated for failure to prove feasibility” *Kokosing*, 17 BNA OSHC at 1875 n.19. The record must show that:

the safety benefits of the Secretary’s proposed abatement method significantly outweigh its disadvantages. *See, e.g., Chevron Oil Co.*, 11 BNA OSHC 1329, 1334 (No. 10799, 1983) (finding that “[t]he benefits afforded by the use of flotation devices greatly outweighs the harm that could be caused in the unlikely event that one of these devices were to hit an employee”). *Compare Kokosing*, 17 BNA OSHC at 1875 & n.19 (finding no material reduction where Secretary failed to rebut testimony that abatement method could cause additional hazards).

ACME Energy Servs. dba Big Dog Drilling, No. 08-0088, 2012 WL 4358852, at *7 (O.S.H.R.C., Sept. 19, 2012).

Respondent claims that all the proposed abatement methods “rely on the operator to strike the rack to avoid an under-ride.” (Resp’t Br. 2). Respondent argues that “each of OSHA’s proposed methods of abatement require the operator to strike the storage rack which is (1) not designed to withstand the impact of a reach truck, and is (2) recognized as being incredibly dangerous by all the witnesses.” (Resp’t Br. 60). Respondent claims that striking the rack could lead to a “catastrophic collapse” of the racking system, causing serious injury to workers in the vicinity, and that the proposed methods of abatement only increase the frequency of striking the rack. (Resp’t Br. 62-64). Respondent also argues that striking the rack “can create a number of other crushing, pinching, impalement and amputation hazards for [the] operator other than the under-ride hazard.”⁶² (Resp’t Br. 62-63).

⁶² Very little weight is given to the “Crown Product Reference” regarding “Rear Posts for Stand-up Riders,” referenced by Respondent. (Ex. J-4, at 3). This Crown Stand-up Rider is not a lift truck used by Chewy at the Ocala warehouse. Also, this Crown Stand-up lift truck has an extended backrest to protect the operator’s compartment from the under-ride hazard, protective equipment not provided on the Raymond dock stance

Respondent sets forth evidence in the form of testimony from Senior Director of Fulfillment Optimization Billet and current Safety Director Prater that striking a rack, in any situation, is to be avoided and therefore, “Chewy instead relies on operator training and extra-wide aisles to abate the under-ride hazard.” (Resp’t Br. 61, 64). Mr. Billet testified that, since adding a post to the Raymond forklift after the December incident, “we determined that we have an increase [in] rack strike events.” (Tr. 520). As a result, Chewy is exploring a transition to a universal stance forklift for use at its warehouses.⁶³ (Tr. 523-524, 593-594, 599-604. *See* Tr. 233-234). Universal stock stance forklifts have two rear vertical posts installed, enclosing the operator’s compartment, and preventing under-ride incidents. (Tr. 159, 354-358, 593-994; Ex. J-5, at 8). “We’re still in that evaluation phase as to what is the correct solution for us given our environment.” (Tr. 527, 593-594).

Regarding striking the rack, Mr. Billet testified that, “we still believe that the width of our aisles is the best abatement we could have to prevent any operator from striking or coming in contact with the rack.” (Tr. 586. *See* Tr. 594). Mr. Billet testified he gets the information supporting the foundation of his safety analysis “in conversations that I have had with our safety organization,” specifically Caleb Prater. (Tr. 595, 604).

Mr. Prater explained that “we interpreted the lowering of the beam as to introduce an increased likelihood of striking the cross members.” (Tr. 707). “At the end of the day,” according to Mr. Prater, he concluded that lowering the horizontal beam made it “more likely to cause a

lift trucks used by Mr. BB and Mr. RP at the time of their under-ride incidents. (Tr. 425-431, 453-455, 752, 754).

In evaluating guards for Chewy’s stand-up lift trucks, Mr. Prater considered this Crown Product Reference, and the stated potential hazards created by addition of a fourth post on this Crown stand-up lift truck. (Tr. 660-666, 669-671, 752, 754). Mr. Prater’s testimony regarding potential hazards if a fourth post was installed on a Crown Stand-up Rider not used by Chewy is unhelpful.

There is no evidence that the fourth post engineered by Raymond and installed on Chewy’s dock stance lift trucks following Mr. RP’s under-ride incident caused any employee to experience severe injury or death. Rather, since installation of the Raymond engineered fourth post, only less severe injuries like forehead lacerations were reported. (Ex. J-4, at 1, 4; Tr. 270-277, 766).

⁶³ Since being promoted to his current position as Senior Director of Fulfillment Optimization around July 2019, Mr. Billet’s responsibilities now include evaluating guarding on the Raymond forklifts at Chewy’s fulfillment centers. (Tr. 519-520). Mr. Billet is not an engineer and has no expertise in safety outside of operations. (Tr. 496, 536, 577-578, 589-590, 602-604).

safety incident.” *Id.* He testified that even though lowering the beam prevents an under-ride event, “we’re trading, you know, one hazard for an equal or greater hazard. So, while again, in kind of context of the under-riding, perhaps it solves that problem, but it does so by introducing an equal or greater problem” because “it increases the likelihood of an operator striking [the] rack.” (Tr. 708).

Mr. Prater’s viewpoint is illustrated by his description of Mr. BB’s July 2018 under-ride incident. Mr. Prater testified that Mr. BB lost control of his lift truck because his radio wire entangled with his lift truck controls. The lift truck then veered into the horizontal beam, impacting Mr. BB. Therefore, according to Mr. Prater, the “root cause” of Mr. BB’s injury was the radio wire causing Mr. BB to lose control of his lift truck, and the “direct cause” of Mr. BB’s injury was his impact against the horizontal beam when Mr. BB’s out-of-control forklift veered into the horizontal beam.⁶⁴ Mr. Prater testified, “if the radio cord hadn’t wrapped around his steering wheel, then [Mr. BB] would not have lost control.” (Tr. 724). Mr. Prater likened Mr. BB’s incident to the possibility of a wet floor causing the operator to slide out of the normal aisle of travel. “That would be the equivalent of a radio cord wrapping around your steering column and causing you to lose control. Yes. And I would address that root cause if that were to surface, of course.” (Tr. 725). The following testimony reveals how Mr. Prater approaches the potential of an under-ride hazard at Chewy’s warehouses:

Q: [Ms. Chastain] You would get rid of the wet patch?

A: [Mr. Prater] Sure.

Q: You wouldn’t – you wouldn’t eliminate the under-ride hazard?

A: It’s not a – it’s not a hazard. They’re not exposed to that. They are exposed to wet floor. So, it’s a root cause versus direct cause.

Q: But what actually caused the injury was the horizontal beam crushing his ribs, correct?

A: That’s not the appropriate way to look at it. The way that – the thing that caused the injury was the thing that caused the incident, which would have been

⁶⁴ In response to, “Did you see that the safety manager at the Ocala facility identified the height of the racking as one of the root causes of Mr. BB’s accident,” Chewy Senior Director Billet testified, “I did not see that he identified it as a root cause.” (Tr. 583).

the wet floor. So, if I left the wet floor and then lowered the beam, he would've just hit a beam, and we'd be in the same circumstances. So that's why we focus on root cause, not direct cause.

(Tr. 725-726). Mr. Prater further testified:

I'm not contesting the fact that Mr. BB struck the beam and was injured. So, I want to be clear. I'm just saying that the cause of the injury is not that contact being made. The cause of the injury was the root cause -- or was -- the root cause of the injury was the cord that stole his ability to safely maneuver and operate his truck. Again, I think we can agree that, you know, that's what needs to be addressed. We need to make sure that all of our employees can maintain control of the truck, look in the direction of travel at all times and that goes back to the radio wire. It doesn't go back to hypothetical water on the floor. It doesn't go back to, you know, just losing control. You could hit a million different things once you lose control.

(Tr. 727).

Mr. Prater testified that OSHA's viewpoint of the incidents in this case as an "under-ride hazard" was not appropriate because the "root cause" was either the radio cord or a "wet floor" or when "Mr. RP lost control for an unknown reason." (Tr. 724-728, 759). Regarding OSHA's proposed abatement methods of lowering the horizontal beam or adding guards around the operator's compartment of the forklift, Mr. Prater testified that Chewy believes that "there is no safe way to strike a storage rack," and that "there is no safe speed to strike a storage rack." (Tr. 760, 765).

Despite having the burden of showing adverse consequences to the Secretary's proposed abatement methods, Respondent did not introduce any evidence specific to its racking system – such as SSI engineering specifications, drawings, or even expert testimony – into this record. The undersigned is not persuaded by Mr. Billet's and Mr. Prater's unsupported testimony⁶⁵ in the face of case facts that do not support their arguments.

For example, according to Safety Director Gage, since Chewy lowered the horizontal beam in its warehouse, the incidents of rack strikes did increase. (Tr. 175-176, 211). However, Mr.

⁶⁵ Mr. Billet testified that he did not know how many incidents of striking the racks occurred before the guards were put on the PITs and how many incidents of striking the racks occurred now that there is a rear cabin guard on the PITs. (Tr. 587-589). Regarding how many times the operators struck the horizontal beam before and after it was lowered (i.e., whether there was a measurable increase in the number of strikes on the horizontal beams in non-inventory after the beams were lowered), Mr. Prater testified that he did not know "the exact figures off the top of my head." (Tr. 739).

Gage noted that the operators were using the lowered beam as a “break,” in their maneuvering and that they had to be retrained to operate safely. (Tr. 212, 226-227). Mr. Gage testified that most of those rack strikes were noninjury related, or at least, not significant enough to warrant his attention. (Tr. 231). Warehouse Safety Manager Rose testified that injuries related to a worker striking a lift-truck post, included a worker who walked into the post after it was newly installed. That injury resulted in a forehead laceration. According to Mr. Rose, there were no fatalities associated with the increase in strikes due to the newly installed posts. (Tr. 270-272. *See* Tr. 766).

The record also establishes that Chewy operators regularly drove their lift-trucks such that they damaged racking, to the extent that Chewy had spent over \$100,000 to fix the racking in the Dallas warehouse.⁶⁶ (Tr. 215, 227). Mr. Gage testified, “So impacting the storage racking, as a general rule, it’s not a good idea. It’s nowhere near as dangerous as the under-ride because it’s much less likely to cause a catastrophic failure, particularly [where] the racking is not overloaded, which ours were not.” (Tr. 214-215). Despite multiple strikes, even requiring rack repair by an outside contractor, Mr. Gage testified that Chewy has “never, never had a catastrophic rack failure.” (Tr. 215, 227). Mr. Billet also testified that Chewy has never had any catastrophic failures of its racking system. (Tr. 582).

Mr. Snowdy testified, based on his experience in the warehouse industry, that the under-ride hazard is “by far” more serious than the potential limitations with visibility from the installation of a post on the forklift.⁶⁷ (Tr. 359-361, 384, 453-454). Mr. Snowdy testified that the

⁶⁶ Mr. Gage testified that, in the two years he was at Chewy, “we had hundreds, if not more, rack impacts.” (Tr. 215). Mr. Gages testified that, for the Dallas warehouse, Chewy spent “well over \$100,000 doing rack repair and that was all due to collisions. We would constantly find racking that had been damaged to such an [extent] that we would have to unload the entire bay all the way up and rope it off and take it out [of] inventory. Have never, never had a catastrophic rack failure.” (Tr. 215, 227).

⁶⁷ Respondent states, “[u]nlike striking the rack, Snowdy admits that abating the under-ride hazard through operator training and extra-wide aisle has no downside.” (Resp’t Br. 65-66, citing Tr. 407-408). The relevant testimony says no such thing:

Q: [Mr. Harrington] Now, is there any downside to training operators to perform maneuvers safely between the racks? Is there a negative?

A: [Mr. Snowdy] No.

Q: Okay. Is there any downside to having extra wide aisles to minimize the risk of an operator striking the rack?

A: No.

under-ride hazard is a greater hazard than a reach truck striking a rack “because the fork truck can take considerably more blunt force against a fixed object than a human body can.”⁶⁸ (Tr. 461). Mr. Snowdy also testified that it is “unlikely” that the loads supported by a racking system would collapse due to a strike event “because of the ways systems are built nowadays.” (Tr. 391, 405.) Safety Manager Gage testified that the injuries that may be sustained by a reach truck operator under-riding the storage rack horizontal beam was greater, than the injury the reach truck operator may sustain from the reach truck hitting the storage rack. (Tr. 202, 215, 231-232). “The under-ride hazard is clearly the most significant hazard.” (Tr. 202). CSHO Driscoll testified that ANSI B56.1 Chapter 7, as referenced by the SHIB, recommends lowering the horizontal storage beam to prevent roll-unders. (Tr. 71, 73).

With this evidence, the undersigned finds that the Secretary has shown that the benefits of the abatement measures implemented by Chewy to address the under-ride hazard at its Ocala warehouse significantly outweigh the less likely, and unsupported, claims of a catastrophic collapse of a pre-designed racking system in the Ocala warehouse and the less serious injuries resulting from an increase in strike events. *Chevron Oil Co.*, 11 BNA OSHC 1329, 1334 (No. 10799, 1983). The Secretary has established that the proposed methods of abatement are physically feasible and effective at addressing the under-ride hazard at the Ocala warehouse.

C) Economic Feasibility

The Secretary also has the burden to establish that the proposed abatement methods are economically feasible for the employer.

(Tr. 407-408). Neither of the questions posed to Mr. Snowdy in this interaction mentions anything about an under-ride hazard.

⁶⁸ Respondent makes much of Mr. Snowdy agreeing that the lift-truck striking a storage rack at 1 mph is the equivalent of an automobile striking the rack at 60 mph. (Resp’t Br. 32, 63 citing Tr. 387). Respondent then claims that “on this issue, the Secretary offers no formal studies, engineering analysis, or other statistical evidence demonstrating that striking the rack with the force of an automobile traveling at 60 mph is a safe way to abate the under-ride hazard.” (Resp’t Br. 65). Respondent, however, has the burden of overcoming the Secretary’s prima facie showing. Here, Mr. Snowdy testified that, in his expert opinion, the greater hazard is the under-ride hazard. (Tr. 391, 405, 453-454). Respondent did not introduce drawings that its racking system could not handle rack strikes. The record, moreover, establishes that workers regularly strike the racking system, such that the racking systems have been repaired, and despite this, no further serious injuries or deaths have been reported.

One of the criteria for determining whether a proposed measure of abatement is feasible is whether the proposed measure is cost prohibitive. Under the general duty clause, an employer is not required to adopt measures that would threaten its economic viability. One issue to consider when determining whether abatement is economically feasible is whether the cost of compliance would jeopardize a company's long-term profitability and competitiveness. Another factor relevant to that consideration is whether the employer can pass the costs on to the customer.

Waldon, 16 BNA OSHC at 1063 (citations and footnote omitted).

The Secretary contends that given Chewy's "size and sophistication," Chewy cannot "credibly argue" that the cost of any of the abatement measures proposed by the Secretary would threaten Chewy's "economic viability" or Chewy's "long-term profitability and industry competitiveness."⁶⁹ *Id.* The record supports the Secretary's contention that Chewy's economic viability has not been threatened by the abatement measures the Secretary's proposed which Chewy implemented.

Respondent claims that the proposed abatement measure of lowering the horizontal load beam "threatens the long-term economic viability of Chewy which has been operating at a loss for several years." (Resp't Br. 74). In support of this argument, Mr. Billet agreed that "in the long

⁶⁹ At the Secretary's request, Judicial Notice was taken of specific sections of the Chewy Q4 and Fiscal Year 2019 Letter to Shareholders, dated April 2, 2020. (Tr. 768-777, 468-469; Ex. C-15, at 4, 8 first two sections, and at 11) (2019 Letter to Shareholders). Respondent agrees this Shareholder Letter is authentic. (Tr. 287, 776). The Secretary represents this Shareholder Letter was part of Chewy's SEC Report, filed with the Securities and Exchange Commission. (Tr. 770, 776). Respondent does not contest this representation. *See* Fed. R. Evid. 201. *See generally*, *Bryant v. Avado Brands, Inc.*, 187 F.3d 1271, 1276-1281, 1287 (11th Cir. 1999) (When deciding a motion to dismiss a complaint alleging securities fraud, a court may judicially notice relevant documents required by and publicly filed with the SEC).

The Secretary requests the Commission take judicial notice of publicly available information in Chewy's 2019 Letter to Shareholders, stating Chewy's "reported net sales of over \$1.35 billion in the fourth quarter of 2019 alone, and net sales of \$4.85 billion in total for fiscal year 2019." (Sec'y Br., 30, citing Ex. C-15, at 4). Respondent, citing the 2019 Letter to Shareholders, sections entitled Net Loss and Adjusted EBITDA, contends Chewy has been operating at a financial loss for several years. (Resp't Br. 55, ¶ 55, n. 77, 74, n. 379, notes citing Ex. C-15, at 8). (Tr. 768-777. *See* Tr. 285-297).

In post hearing briefing, the parties again cite the specific sections of the 2019 Letter to Shareholders identified at the hearing, without further explanation of the financial statements. Generally, the 2019 Letter to Shareholders conveys Chewy's financial position as positive. "We closed 2019 on a high note with strong momentum in both top line and bottom line results[.]" (Ex. C-15, at 4) Importantly, following the hearing testimony and admissions regarding Chewy's economic viability, the 2019 Letter to Shareholders is unnecessary to resolution of the questions before the Commission in this case. Accordingly, Chewy's 2019 Letter to Shareholders is accorded limited weight. (Ex. C-15).

run, potentially,” the capacity change, caused by lowering the non-inventory aisle height of the horizontal beam, clearly threatened the economic viability of Chewy. (Tr. 586). Mr. Billet also testified that, at the time the non-inventory horizontal beams were lowered, Chewy’s economic viability was not threatened by the capacity change. (Tr. 586). Further, Mr. Billet’s later testimony suggests that the inventory capacity reduction resulting from the lowered horizontal rack beams could be resolved in future construction plans, over a few years.⁷⁰ (Tr. 591-592).

Following Mr. RP’s under-ride incident Chewy also transitioned to equipping all its new warehouses with universal stance PITs, which come with enclosed operator’s compartments that prevent under-ride incidents. (Tr. 524-527, 529, 593-594). Furthermore, Mr. Gage testified that outfitting the fleet of Raymond dock stance reach trucks with the fourth post engineered by Raymond and Hyster would not threaten Chewy’s economic viability. (Tr. 203; Ex. J-4, at 5). Mr. Billet agreed that adding the rear cabin guards to the dock stance lift trucks used in Chewy’s warehouses did not threaten Chewy’s economic viability. (Tr. 588-589). And Mr. Prater confirmed that Chewy grew as a company in 2020, even after OSHA’s proposed abatement methods were implemented by Chewy. (Tr. 757-758).

The citation proposes several feasible measures Chewy may adopt to abate the under-ride hazard in the non-inventory sections of its Ocala warehouse. Lowering the horizontal rack beam was one or several proposed feasible abatement measures. In fact, Chewy implemented two other abatement methods proposed by OSHA, adding a rear guard to its dock stance lift trucks, and deploying universal stance lift trucks when new warehouses opened. Respondent does not claim that the guarding abatement methods proposed by OSHA, and adopted by Chewy, impact Chewy’s inventory capacity or threaten Chewy’s economic viability.

⁷⁰ Mr. Billet’s later testimony.

Q [Ms. Chastain] Since doing your analysis regarding the cost of adjusting shelving in your existing facilities, how many new facilities has Chewy built?

A [Mr. Billet] Four.

Q Would it have been economically infeasible to include an extra 75,000 square feet in one of those new facilities?

A It would not have been possible for several years, given the design and the construction timelines that we are under. *So sure, we could have two years down the road*, but again, we still believe that maintaining our extra wide aisles is the best abatement measure to striking a rack.

(Tr. 591-592) (emphasis added).

Based on the above, the Secretary has established economically feasible means of abating the Ocala warehouse under-ride hazard. *SeaWorld of Fla. LLC v. Perez*, 748 F.3d 1202, 1215 (D.C. Cir. 2014) (Abatement of a hazard is economically "feasible" when it does not change the essential nature of employer's business.)

5) Knowledge

“The Secretary must show the employer knew or, with the exercise of reasonable diligence could have known of the hazardous condition...The proper inquiry here is whether [Chewy] was aware of the cited conditions its employees faced when [under-riding the rack].” *Peacock*, 2017 WL 3864205, at *6 (citation omitted); *St. Joe Minerals Corp.*, 647 F.2d 840 (8th Cir. 1981) (actual knowledge of a hazard may be gained by means of prior accidents, prior injuries, employee complaints, and warnings communicated to the employer by an employee.).

Mr. BB’s under-ride incident in July 2018 happened five months prior to Mr. RP’s incident. Mr. BB’s incident showcased the conditions of the Ocala warehouse: the height of the lowest horizontal beam, the exposure of the operator while under-riding the Raymond lift truck, and the serious injuries that resulted when the operator’s lift truck rode under the horizontal beam. Joshua Rose and Craig Gage, both safety management officials at the time, participated in the investigation regarding that incident. (Tr. 169-170, 241-242). Both Mr. Rose and Mr. Gage were still in their safety management positions five months later at the time of Mr. RP’s incident, which involved the same conditions: the height of the lowest horizontal beam, the exposure of the operator while under-riding the Raymond lift truck, and the death that resulted when the operator’s lift truck rode under the horizontal beam. (Tr. 192-193, 254).

Accordingly, both safety managers Mr. Rose and Mr. Gage knew of the violative conditions at the Ocala warehouse five months before Mr. RP’s incident. (Tr. 169-170, 192-193, 241-242, 254). This knowledge is properly imputed to Chewy. *Phoenix Roofing, Inc.*, 17 BNA OSHC 1076, 1079 (No. 90-2148, 1995) (“Employer knowledge is established by a showing of employer awareness of the physical conditions constituting the violation”), *aff’d*, 79 F.3d 1146 (5th Cir. 1996) (unpublished); *Access Equip. Sys., Inc.*, 18 BNA OSHC 1718, 1726 (No. 95-1449, 1999) (“[K]nowledge can be imputed to the cited employer through its supervisory employee.”); *Am. Eng’g & Dev. Corp.*, 23 BNA OSHC 2093, 2095 (No. 10-0359, 2012) (knowledge is imputed to the employer “through its supervisory employee.” (citation omitted)).

Unpreventable Employee Misconduct Defense

Respondent claims the unpreventable employee misconduct (UEM) defense. (Resp't Br. 87-88). To establish this affirmative defense, an employer has the burden to show that it "(1) has established work rules designed to prevent the violation; (2) has adequately communicated the rules to its employees; (3) has taken steps to discover violations of the rules; and (4) has effectively enforced the rules when violations were detected." *Rawson Contractors, Inc.*, 20 BNA OSHC 1078, 1081 (No. 99-0018, 2003). "To prove adequate enforcement of its safety rule, an employer must present evidence of having a disciplinary program that was effectively administered when work rule violations occurred." *GEM Indus. Inc.*, No. 93-1122, 1996 WL 710982, at *3 (O.S.H.R.C., Dec. 6, 1996), *aff'd*, 149 F.3d 1183 (6th Cir. 1998).

Respondent argues that "had RP been looking in the direction of travel and operating his reach truck under control he would not have struck the horizontal beam of the storage rack." (Resp't Br. 87). Respondent relies on the "Secretary's stipulation" that "RP was properly trained in these rules" to claim that it established each of the elements of the UEM defense. *Id.* The Secretary notes, however, that this stipulation "does not satisfy any of the elements of the [UEM] defense, which requires an affirmative showing that Respondent adequately communicated and enforced a specific work rule that would have addressed the under-ride hazard." (Sec'y Br. 36 n.12).

Pointing to Mr. Snowdy's testimony, the Secretary also persuasively argues that the training rules Chewy had did not address the under-ride hazard in this case: "a well-trained operator driving at a reasonable speed and looking in the direction of travel may – in a moment of inattention or distraction – under-ride a horizontal beam of a shelving unit; such an accident can occur in a split second." (Sec'y Br. 34 citing Tr. 344-345). As CSHO Driscoll testified, "all the training in the world isn't going to prevent you driving your forklift under a shelf." (Tr. 144). Furthermore, there is zero evidence in this record regarding the disciplinary process with regard to enforcing any such work rule. *Fla. Gas Contractors, Inc.*, 27 BNA OSHC 1799, 1801-02 (No. 14-0948, 2019) (employer's failure to provide documentation supporting claimed instances of discipline was a factor weighing against a UEM defense).

Respondent's UEM argument is rejected. This citation item is affirmed.

Characterization

With regard to characterization, this citation item is properly characterized as serious. 29 U.S.C. § 666(k) (A violation is “serious” if a substantial probability of death or serious physical harm could have resulted from the violative condition). As a result of the violative under-ride condition at Chewy’s Ocala warehouse, Mr. RP was crushed and killed. This citation item is affirmed as serious.

In Summary

(1) Chewy did not affirmatively establish that more specific industry standards preempt the application of the general duty clause to the under-ride hazard in this case. (2) The Secretary established that an under-ride hazard, as defined by the Secretary, existed at the Ocala warehouse. (3) The Secretary established that Chewy and its industry recognized the under-ride hazard. (4) The Secretary met his prima facie burden of establishing feasible means to abate the under-ride hazard at the Ocala warehouse. (5) Chewy failed to overcome the Secretary’s prima facie showing that feasible means of abatement existed to address the under-ride hazard at the Ocala warehouse. (6) Chewy knew or with the exercise of reasonable diligence could have known of the under-ride hazard at the Ocala warehouse. This citation item is AFFIRMED.

PENALTY

“In assessing penalties, section 17(j) of the OSH Act, 29 U.S.C. § 666(j), requires the Commission to give due consideration to the gravity of the violation and the employer’s size, history of violation, and good faith.” *Burkes Mech., Inc.*, 21 BNA OSHC 2136, 2142 (No. 04-0475, 2007). “Gravity is a principal factor in the penalty determination and is based on the number of employees exposed, duration of exposure, likelihood of injury, and precautions taken against injury.” *Siemens Energy & Automation, Inc.*, 20 BNA OSHC 2196, 2201 (No. 00-1052, 2005) (citation omitted).

CSHO Driscoll testified how the penalty for the citation item was calculated and proposed for this matter. (Tr. 106-107). For Citation 1, Item 1, OSHA proposed a penalty of \$13,260. (Tr. 106; First Am. Compl. 3). This proposed penalty took into account the high gravity of the incident, given that it resulted in the permanent physical injury and/or death of an employee. (Tr. 107). CSHO Driscoll testified that OSHA ascribed a high severity to this particular citation based upon the injuries and the fatality, and a greater probability that the incident could occur and might occur

again, if not abated. No adjustment factors were applied to this particular penalty in the discretion of the area director “to prevent future [incidents] or actually to achieve compliance.” (Tr. 107).

Respondent has not addressed the calculation of the amount of the proposed penalty in its brief. After consideration of the statutory factors with regard to the penalty for the affirmed violation, the undersigned agrees with the penalty amount proposed by the Secretary for this citation item. The proposed penalty amount is assessed in the amount of \$13,260 for Citation 1, Item 1.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

All findings of fact and conclusions of law relevant and necessary to a determination of the contested issues have been made above. *See* Fed. R. Civ. P. 52(a). All proposed findings of fact and conclusions of law inconsistent with this decision are denied.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, it is ORDERED that:

- 1) Citation 1, Item 1, alleging a Serious violation of section 5(a)(1) of the OSH Act, 29 U.S.C. § 654(a)(1), is AFFIRMED and a penalty of \$13,260 is ASSESSED.
- 2) Citation 2, Item 1, alleging an Other-Than-Serious violation of 29 C.F.R. § 1910.176(e), withdrawn by the Secretary on March 25, 2020, is VACATED.

SO ORDERED.

/s/ Carol A. Baumerich
Carol A. Baumerich
Judge, OSHRC

DATE: February 22, 2022
Washington, D.C.