

**United States of America
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION**

SECRETARY OF LABOR,

Complainant,

v.

GOOD FOOD CONCEPTS, LLC d/b/a
RANCH FOODS DIRECT,

Respondent.

OSHRC Docket No. 21-0946

Appearances:

Isabella Finneman and Bryan Kaufman, Department of Labor, Office of Solicitor, Denver, Colorado,
For Complainant

Kristin White and J. Micah Dickie, Fisher Phillips, LLP, Denver, Colorado,
For Respondent

Before: Judge Christopher D. Helms – U. S. Administrative Law Judge

DECISION AND ORDER

I. Procedural History

On June 11, 2021, employee [redacted] was operating a meat grinder at a retail grocery store owned by Respondent Good Food Concepts, LLC d/b/a/ Ranch Foods Direct (Ranch Foods or Respondent), when her hand got caught in the grinder. The accident resulted in the amputation of four of her fingers. In response to an accident complaint, the Occupational Safety and Health Administration (OSHA) sent Compliance Safety and Health Officer (CSHO) David Morris to conduct a worksite inspection on June 15, 2021. As a result of the inspection, the Secretary of Labor (Secretary) issued two citations. Only Citation 1, Item 1 and Citation 2, Item 2 are relevant to this case.

Citation 1, Item 1 alleges a Serious violation of 29 C.F.R. § 1910.212(a)(1) for failing to provide a machine guard on the meat grinder. Citation 2, Item 2 alleges an Other-Than-Serious violation of 29 C.F.R. § 1904.39(a)(2) for failing to report within 24 hours a work-related incident resulting in an in-patient hospitalization. The proposed penalty for Citation 1, Item 1 is \$9,557, and the proposed penalty for Citation 2, Item 2 is \$6,827.

Ranch Foods filed a timely notice of contest, bringing the matter before the Occupational Safety and Health Review Commission (Commission). The Chief Administrative Law Judge designated this matter for conventional proceedings and assigned it to this Court on November 29, 2021. A trial was held on September 22-23, 2022. The following individuals testified: (1) Jonathan Morrill, the General Manager for the retail store; (2) [redacted], the injured employee; (3) Roger Wichman, Head Meat Cutter at the retail store; (4) Michael Callicrate, owner of Ranch Foods; (5) [redacted], Ms. [redacted]'s husband; (6) CSHO David Morris; (7) Bobbi Jo Kirby, an employee of Ranch Foods; and (8) Liesl Taylor, an employee of Ranch Foods.

After the trial concluded, both parties timely filed post-trial briefs, which were considered by the Court in reaching its decision. Pursuant to Commission Rule 90, after hearing and carefully considering all the evidence and the arguments of counsel, the Court issues this Decision and Order as its findings of fact and conclusions of law.

For the reasons discussed, both Citations are AFFIRMED.

II. Stipulations & Jurisdiction

The parties stipulated to several matters, including the jurisdiction of this Court over this proceeding and the parties before it. *See* Joint Stipulation Statement (J. Stip.) 1, 2. The parties submitted the Joint Stipulation Statement to the Court prior to trial and entered the stipulations

into the record. (Tr. 10). The Court shall incorporate by reference the Joint Stipulations and refer to them as necessary in this decision.

III. Factual Background

A. Ranch Foods & the Fillmore Street Store

Ranch Foods was a meat processing business owned by Michael Callicrate, who has been working in the meat industry for over 20 years. (Tr. 410). Ranch Foods operated a retail store located at 1228 E. Fillmore Street, Colorado Springs, Colorado (Fillmore Street store), which sold fresh beef and other meat products directly to consumers and consisted of a retail section, a butcher, and a kitchen. (Tr. 27-28, 82-83, 410). When he was in town, Mr. Callicrate visited the store twice a day, four to five times a week, and on some mornings, he would observe the meat grinder being used. (Tr. 424, 428). He oversaw operations of the store but delegated management and supervision, including discipline of employees, to John Morrill and John Wichman. (Tr. 425-26).

In June 2021, Mr. Morrill was the General Manager of the Fillmore Street store, and he had been in that position for 3 ½ years.¹ (Tr. 30). He visited the Fillmore Street store every day to pick up receipts from the night before and talk with employees about any issues or needs. (Tr. 97-98). Mr. Wichman was the head of the meat department, and he was a 17-year employee of Ranch Foods with over 50 years of experience in the meat industry. (Tr. 285, 360). There were 13 to 15 employees at the Fillmore Street store in June 2021, and the meat department consisted of Mr. Wichman, Ms. [redacted], and John Niccocia, an employee with over 50 years of experience in the meat industry. (Tr. 29, 82, 109).

¹ Mr. Morrill had previously worked for Ranch Foods as a bookkeeper between 2008 and 2015. (Tr. 40).

B. Oversight, Safety & Training

Mr. Morrill was charged with ensuring safety compliance and discipline at the Fillmore Street store, and he had the authority to remove employees for safety violations. (Tr. 30, 37). Although Mr. Morrill was the General Manager and visited the store every day, he never conducted an internal safety audit or checked the equipment in the meat department for safety issues because his daily visits were not geared toward looking for safety issues. (Tr. 38, 39, 98). If any equipment was not operating properly or posed any safety issues, he expected his employees to report those problems to him and stop using the machine. (Tr. 40, 101). Mr. Morrill and other supervisors at Ranch Foods relied on “observation by managers and other employees” to ensure that employees were working safely, although safety violations were not documented unless disciplinary action was required. (Tr. 35, 96, 115-116). Ranch Foods also posted a Code of Safe Practices in a common area, along with labor law posters and the weekly schedule. (Tr. 88, 89).

Ranch Foods did not have a formal safety and health training plan for new meat cutting employees. (Tr. 33-35, 185-86, 302-03). Employees were given a handbook, which included a general disciplinary policy, but specific safety and equipment training was left to the employees’ immediate supervisor. (Tr. 35, 93, 94, Ex. R-14). Mr. Wichman supervised the meat department and trained new meat-cutters, including Ms. [redacted]. (Tr. 86, 101, 300). He provided hands-on instruction regarding the operation of meat cutting tools and machinery, and he was responsible for ensuring that meat cutting employees were operating the machinery in a safe manner. (Tr. 35, 186, 199).

In June 2021, Ms. [redacted] had been employed at Ranch Foods for three years. (Tr. 177). She started her employment as a cashier and, a year and a half later, joined the meat department after expressing an interest in learning the trade. (Tr. 182-84). Mr. Wichman trained Ms. [redacted]

how to operate the meat grinder, and he taught her how to use a stomper—an 18-inch cylindrical tool that pushed pieces of meat down the throat of the grinder—as well as how to disassemble and clean the grinder’s components. (Tr. 201-02, 233, 301, 314, 368).

The meat grinder jammed frequently, so Mr. Wichman also trained Ms. [redacted] on how to clear a jam by reversing it and then allowing the machine to run again. (Tr. 206, 208, 370). If the jam did not clear, the operator was expected to disassemble the machine and clean it. (Tr. 368). Mr. Wichman taught Ms. [redacted] to use safety gloves while cutting meat and to wear a hair net. (Tr. 303). He did not use any videos or written materials when training Ms. [redacted] on the meat grinder, nor did he review the grinder’s manual or documents published by OSHA that explained how to safely use a meat grinder. (Tr. 199, 205-06, 307, 324).

The grinder involved in the accident consisted of a hopper, a throat, the auger, and a rotating blade. (Tr. 527-28). The operator would place chunks of meat in the hopper and push the meat with her hands toward the entrance of the throat of the grinder, at the bottom of which was the auger and blades that ground the meat. (Tr. 202, 232, 314). The operator could use a stomper to push the meat down the throat of the grinder, which was 3 inches wide and measured 4 ¾ inches in length. (Tr. 72, 74, 202). Sometimes an operator would use her fingers to dislodge meat from the walls of the throat when the stomper was ineffective. (Tr. 234, 269).

Mr. Wichman trained Ms. [redacted] to avoid using her fingers to push meat down the throat of the grinder. (Tr. 244-45). However, despite knowing it was dangerous, he frequently used his own fingers to reach up to 2 inches into the throat of the grinder because he “felt safe and comfortable” doing so based on his years of experience. (Tr. 316-18, 320) Mr. Wichman testified he knew his employees saw him put his fingers in the throat, but he would advise his employees not to do so because it was unsafe. (Tr. 245, 322). The prohibition on using one’s fingers to push

meat into the throat of the grinder was not a written rule, and Mr. Wichman never formally reprimanded anyone for doing it. (Tr. 275). In the six months prior to the accident, no one had been disciplined for the improper use of meat cutting equipment or using fingers in the operation of the meat grinder, despite its common practice among the meat grinder's operators. (Tr. 203, 270, 437).

C. The Accident & Hospitalization

On the morning of June 11, 2021, Ms. [redacted] was operating the meat grinder when it jammed. (Tr. 220). She tried to reverse the machine, but it did not work. (Tr. 220). She then noticed extra meat on the side of the throat, so she reached into the throat to push it toward the auger, at which time her hand was caught and pulled into the grinder. (Tr. 220). Mr. Wichman, who was in the room, unplugged the grinder, and other employees called an ambulance. (Tr. 225, 338). Mr. Crutcher, the Facilities Manager, was at the Fillmore Street store that day, and he tried to comfort Ms. [redacted] until the ambulance arrived. (Tr. 340, 413). Once the paramedics saw Ms. [redacted]'s condition, they debated whether to apply a tourniquet to Ms. [redacted]'s arm. (Tr. 346). Mr. Wichman testified that overhearing this conversation made him realize the seriousness of the injury. (Tr. 346-47). The paramedics ultimately transported Ms. [redacted], along with the grinder, to Penrose Emergency Hospital, where she was admitted as in-patient at 12:10 p.m. (J. Stip. 8, 10). At 1:36 p.m., Ms. [redacted] underwent emergency surgery, at which time the surgical team reversed the meat grinder's motor, freed Ms. [redacted]'s hand, and amputated four fingers. (*Id.* at 10). That evening, Ms. [redacted] was discharged from Penrose Hospital and transferred to Presbyterian/St. Luke's Medical Center in Denver, Colorado, where she remained hospitalized until June 18, 2021. (*Id.* at 12).

Mr. Crutcher notified Mr. Callicrate of the accident shortly after it occurred, and Mr. Callicrate went to Penrose Hospital, where he spoke with Ms. [redacted]'s husband, Mr. [redacted]. (Tr. 415, 417-419). Mr. [redacted] testified that he told Mr. Callicrate that Ms. [redacted] was in surgery. (Tr. 489). Mr. Callicrate gave Mr. [redacted] his business card before leaving the hospital and asked Mr. [redacted] to keep him informed of Ms. [redacted]'s condition. (Tr. 419). Mr. Callicrate did not obtain Mr. [redacted]'s contact information, nor did he ever attempt to contact Ms. [redacted] or her husband to inquire about Ms. [redacted]'s condition. (Tr. 421, 428-429, 493).

On June 12, 2021, Mr. Wichman called Mr. [redacted] to express how sorry he was about the accident and to ask whether he could help in any way. (Tr. 352). Mr. [redacted] told Mr. Wichman that the injuries were "bad," and Mr. Wichman speculated that she had lost the tips of her fingers. (Tr. 353).

Mr. Morrill learned about the accident around midday on July 11, 2021, when he received a voicemail from Mr. Crutcher. (Tr. 61). He visited the Fillmore Street store later that day and discussed what happened with the employees. (Tr. 62). He learned that Ms. [redacted]'s hand was caught in the grinder and that she was in the emergency room. (Tr. 62). However, he did not go to the hospital and, despite a history of communicating with Ms. [redacted] about attendance and injuries, he did not take any proactive measures to learn the extent of Ms. [redacted]'s condition in the days following the accident. (Tr. 66). On June 14, 2021, Mr. Morrill texted Ms. [redacted] to express how badly he felt about her accident; however, he did not inquire about her injuries, attendance, or hospitalization. (Tr. 63, 64, 493, Ex. R-20). That same day, Mr. Morrill informed Workers' Compensation that Ms. [redacted] had been hospitalized for more than 24 hours, at which time he knew she had suffered an amputation injury. (Tr. 64, 65).

D. Inspection & Citation

CSHO Morris conducted an inspection of the Fillmore Street store on June 15, 2021, after OSHA received a complaint allegation that an employee lost four fingers in a meat grinder accident. (Tr. 519). He inspected the site and meat grinder, took photographs of the meat grinder, and conducted interviews with Mr. Morrill and Mr. Wichman. (Tr. 524-25). The CSHO ultimately concluded that Ranch Foods failed to provide a method of guarding the meat grinder to protect the operator from hazards related to the point of operation, ingoing nip points or rotating parts, in violation of 29 C.F.R. § 1910.212(a)(1). (Tr. 556-57). He further concluded that Ranch Foods failed to report the accident to OSHA within 24 hours of an accident requiring hospitalization, in violation of 29 C.F. R. § 1904.39(a)(2). (Tr. 571).

IV. Discussion

To establish the violation of a safety standard under the Occupational Safety and Health Act of 1970, 29 U.S.C. §§ 651–678 (the Act), the Secretary must prove by a preponderance of the evidence: (1) the cited standard applies; (2) the employer failed to comply with the terms of that standard; (3) employees had access to the hazardous condition covered by the standard; and (4) the employer knew, or with the exercise of reasonable diligence could have known, of the violative condition. *Atl. Battery Co.*, 16 BNA OSHC 2131, 2138 (No. 90-1747, 1994). The Secretary has the burden of establishing each element by a preponderance of the evidence. *Hartford Roofing Co.*, 17 BNA OSHC 1361, 1365 (No. 92-3855, 1995).

A. Citation 1, Item 1

Citation 1, Item 1 alleges a serious violation of 29 C.F.R. § 1910.212(a)(1), which provides:

One or more methods of machine guarding shall be provided to protect the operator and other employees in the machine area from hazards such as those created by point of operation, ingoing nip points, rotating parts, flying chips and sparks.

Examples of guarding methods are - barrier guards, two-hand tripping devices, electronic safety devices, etc.

The Secretary describes the serious violation as follows:

On or before 6/11/21 the employer did not ensure that the meat grinder was guarded effectively or that tools other than hands were used for pushing small amounts of meat through the grinder when the stomper supplied by the employer was unable to push meat through the grinder. An employee lost four fingers of their right hand when trying to push meat through when the stomper was not effective. This condition exposed employees to amputation and crushing hazards.

Citation at 6.

1. The Standard Applies

To establish applicability of the standard, the Secretary must show that, in the case of machine guarding, the employee is exposed to the hazard “from the way the machine functions and how it operates.” *Dentsply US Prosthetics, LLC*, No. 16-0140, 2017 WL 7038046, at *2 (OSHRC ALJ Aug. 15, 2017) (citing *Ladish Co.*, 10 BNA OSHC 1235 (No. 78-1384, 1981) (“the cited standard is generally applicable according to its terms to the hazards presented by the moving parts of all types of industrial machinery”). Here, the Court concludes that 29 C.F.R. § 1910.212(a)(1) squarely applies to the meat grinder at issue. Specifically, the meat grinder presented a point of operation, ingoing nip point, and rotating parts hazards with the potential to cause serious injury, and Ranch Foods was required to provide one or more methods of machine guarding to protect the operator from those hazards.

Ranch Foods contends that the standard does not apply because the hazard identified by the Secretary was the result of activities covered by the lockout/tagout (LOTO) standard, 29 C.F.R. § 1910.147, which applies to “the servicing and maintenance of machines and equipment in which the unexpected energization or startup of the machines or equipment, or release of stored energy could cause injury to employees.” 29 C.F.R. § 1910.147(a)(1)(i). Ranch Foods argues that Ms.

[redacted] was clearing a jam when she was injured, which constitutes a service or maintenance activity. It contends that Ms. [redacted] should have locked out the machine, and her failure to do so resulted in injury.

The issue before the Court is whether Ms. [redacted]’s attempt to clear the jam constitutes “servicing and maintenance,” or whether it occurred in the course of “normal production operations.” The LOTO standard may apply to a jam in a machine. *See* 29 C.F.R. § 1910.147(b) (in the definition section of the LOTO standard, “servicing and/or maintenance” includes “cleaning and unjamming of machines or equipment”); *see also* *Otis Elevator Co. v. Sec’y of Labor*, 762 F.3d 116, 121 (D.C. Cir. 2014) (finding the repair of an elevator’s jammed chain violated the LOTO standard). However, its application is limited to activities “outside of normal production operations.” *Sec’y, U.S. Dept of Labor v. Action Elec. Co.*, 868 F.3d 1324, 1336 (11th Cir. 2017). “Normal production operations” is “the utilization of a machine or equipment to perform its intended production function.” 29 C.F.R. § 1910.147(b).

The Commission discussed the distinction between “servicing and maintenance activities” and “normal production operations” in *Westvaco Corp.*, which involved an injury during a machine’s set-up. No. 90-1341, 1993 WL 369040, at *5 (OSHRC Sept. 14, 1993). The Commission agreed with the Administrative Law Judge’s determination that “work performed on the machine while the machine is not being operated to actually produce its product is either servicing or maintenance”. *Id.* at *4. It concluded that the operator’s adjustments in that case occurred before normal production operations and thus fell within the definition of servicing or maintenance. *Id.* at *6. The critical fact was that the employee’s actions occurred prior to—not during—the operation of the machine. *Id.*

Here, the Court concludes that Ms. [redacted]’s unjamming of the machine fell within the grinder’s “normal production operations.” Jams in the meat grinder were common. Mr. [redacted] was actively operating the grinder when it jammed. She reached into the throat to dislodge some meat and give the grinder something to catch when she put the grinder into reverse and forward again. Putting the grinder in reverse is how Ms. [redacted] was trained to clear a jam while operating the grinder, and the use of her fingers to dislodge meat from the throat of the grinder was a tactic she learned from Mr. Wichman. Under the facts of this case, unjamming the machine was not a maintenance or servicing activity; instead, it occurred during the grinder’s normal production operations. Accordingly, the LOTO standard does not apply here, and instead the machine guarding standard applies. *See Roy Rock, LLC*, No. 18-0068, 2021 WL 3624785, at *3 (OSHRC, July 22, 2021) (holding that the LOTO standard did not apply because the operator “was still working on the machine” and his removal of a cylinder was unrelated to the machine’s “care” or “upkeep”).

2. The Secretary Established Violation of the Standard and Exposure to the Hazard

The elements of noncompliance and exposure overlap with one another in cases involving machine guarding. *Aerospace Testing All.*, No. 16-1167, 2020 WL 5815499, at *6, n3 (OSHRC, Sept. 21, 2020). Generally, the method of machine guarding “should not be predominantly dependent upon human behavior.” *Akron Brick and Block Co.*, No. 4859, 1976 WL 5896, at *2 (OSHRC, Jan 14, 1976). Instead, the purpose of the standard is to “avoid dependence upon human behavior and to provide a safe environment for employees” operating machinery, regardless of their intelligence, skills, and tendency to neglect a specified course of conduct. *Id.* (citing *Hartford Accident & Indem. Co. v. Cardillo*, 112 F.2d 11,15 (D.C. Cir. 1940)). The occurrence of an actual injury is probative of whether a machine presents a hazard, although it is not conclusive. *A.E.*

Burgess Leather Co., Inc., 5 BNA OSHC 1096, 1097 (No. 12501, 1977) *aff'd*, 576 F.2d 948 (1st Cir. 1978) (holding that actual exposure to a hazard was not negated by a favorable safety record).

Ranch Foods maintains that it complied with the machine guarding standard because the meat grinder was guarded by design and prevented an employee's exposure to the hazard. Specifically, Ranch Foods argues that the length of the throat protected the operator by distance and the narrow width of the throat ensured that an adult's hand could not enter the zone of danger. Ranch Foods also argues that operators were given a stomper, which avoided the use of an operator's fingers when pushing meat into the throat of the grinder, and that operators were warned against using their fingers inside the throat.

The Court concludes that Ranch Foods violated the machine guarding standard and, as a result, employees were exposed to a hazard. The operation of the grinder demonstrates the presence of a hazard, i.e., the auger and blades, which exposed the operator to significant risk of amputation. The fact that an accident involving the grinder had not previously occurred does not negate the presence of the hazard. *A.E. Burgess Leather Co. v. OSHRC*, 576 F.2d at 1097 (internal citations omitted); *see also Lee Way Motor Freight, Inc. v. Sec'y of Labor*, 511 F.2d 864, 870 (10th Cir. 1975) ("One purpose of the Act is to prevent the first accident."). Although Ranch Foods provided operators with a stomper, the standard expressly prohibits tools to be used in lieu of a guard. 29 C.F.R. § 1910.212(a)(3)(iii). Similarly, § 1910.212(a)(1) does not permit guarding by work rules. *See Akron Brick & Block Co.*, No. 4859, 1976 WL 5896, at *3 (OSHRC, Jan. 14, 1976) (holding that work rules relating to the use of a safety switch and hook were not a method of guarding contemplated by § 1910.212(a)(1)); *see also Gen. Elec. Co.*, 10 BNA OSHC 1687, 1690 (No. 98-1107, 2001) (holding the point of operation must have a physical guard that does not depend upon correct employee behavior).

Moreover, the design of the throat was insufficient to satisfy the requirements of the standard. To establish the exposure to a hazard required for noncompliance, the Secretary “must show that it is reasonably predictable either by operational necessity or otherwise (including inadvertence), that employees have been, are, or will be in the zone of danger.” *Fabricated Metal Prods., Inc.*, 18 BNA OSHC 1072, 1073–74 (No. 93-1853, 1997). The element of exposure is not an inquiry into the theoretical; rather, the Court must determine whether employee entry into the zone of danger is reasonably predictable. *Id.* (internal citation omitted); *see also S. Hens, Inc. v. OSHRC*, 930 F.3d 667, 681 (5th Cir. 2019) (affirming ALJ’s determination that exposure to the hazard was reasonably predictable by operational necessity because there was no guard on the conveyor, jams occurred frequently, operators were expected to clear the jams, and the tool provided was too heavy to use in all instances, resulting in the employees’ fingers getting within an inch or two of the nip point).

Here, an employee suffered a serious accident in her operation of the grinder due to the lack of a guard. Although not conclusive, the fact that Ms. [redacted] was able to access the zone of danger is probative of exposure. And, that exposure should have been reasonably foreseeable. When operating the grinder, employees put their hands in the hopper, which was approximately one inch above the top of the grinder’s throat. The testimony at trial demonstrated that all three employees who used the meat grinder inserted their fingers one to two inches inside the throat of the grinder when they were unable to dislodge meat from the side of the throat. This would put their fingers within 2 to 4 inches from the rotating auger. The Court concludes that the practice was so common that it should have been reasonably foreseeable that an operator would, by necessity or inadvertence, put their hands within the zone of danger. *See Oberdorfer Indus., Inc.*, No. 97-0469, 2003 WL 22060459, at *7 (OSHRC Aug. 29, 2003) (consolidated) (holding that

evidence of the operators' hands being three to eight inches from the unguarded rotating chucks clearly established exposure to a hazard).

Ranch Foods argues that there was no history of employees getting hurt from exposure to a hazard presented by the meat grinder. However, the occurrence of only one accident does not negate the fact that the operator's fingers were routinely in the zone of danger and exposed to a hazard during the operation of the machine. *See S. Hens, Inc.*, 930 F.3d at 681–82 (“The lack of injury history does not change the readily evident fact that a machine with a nip point lacked a physical guard.”). Thus, the Secretary established violation of the standard and exposure to the hazard.

3. The Secretary Established that Ranch Foods Knew or Should Have Known of the Hazardous Condition

To establish knowledge, the Secretary must show by a preponderance of the evidence “that the employer knew of the hazardous condition, or could have known through the exercise of reasonable diligence.” *Mountain States Contractors, LLC v. Perez*, 825 F.3d 274, 283 (6th Cir. 2016) (internal citation omitted). “When considering the question of reasonable diligence, the ALJ looks to a number of factors including: ‘an employer’s obligation to inspect the work area, to anticipate hazards to which employees may be exposed, and to take measures to prevent the occurrence.’ ” *Id.* at 285 (quoting *Kokosing Constr. Co. v. OSHRC*, 232 F. App’x 510, 512 (6th Cir. 2007) (unpublished)). The Court also considers whether the employer has adequate work rules and training programs and has adequately supervised its employees. *Precision Concrete Constr.*, 19 BNA OSHC 1404, 1407 (No. 99-0707, 2001) (internal citation omitted); *see also ComTran Grp., Inc. v. U.S. Dep’t of Labor*, 722 F.3d 1304, 1307–08 (11th Cir. 2013) (holding that an employer’s failure to implement an adequate safety program can show knowledge because, in the absence of a program, violation of safety rules is reasonably foreseeable).

Generally, the knowledge of a supervisor or foreman can be imputed to the company. *See Jersey Steel Erectors*, 16 BNA OSHC 1162, 1164 (No. 90-1307, 1993), *aff'd*, 19 F.3d 643 (3d Cir. 1994) (unpublished) (imputing constructive knowledge of supervisor to the company). However, this becomes more complicated when the supervisor himself is engaging in misconduct. In those circumstances, the supervisor's violation of safety rules cannot be imputed to the employer and the Secretary must instead establish the employer's actual or constructive knowledge based on whether the supervisor's misconduct was foreseeable. *W.G. Yates & Sons Constr. Co. Inc. v. OSHRC*, 459 F.3d 604, 609 n.8 (5th Cir. 2006); *see also Mountain States Tel. & Tel. Co. v. OSHRC*, 623 F.2d 155, 158 (10th Cir. 1980) (same). "The Secretary can meet this burden by showing that the violation was foreseeable because of inadequacies in safety precautions, training of employees, or supervision." *Cap. Elec. Line Builders of Kan., Inc. v. Marshall*, 678 F.2d 128, 130 (10th Cir. 1982).²

Here, Mr. Wichman testified that he knew the meat grinder was a dangerous machine and that placing his fingers into the throat of the grinder was unsafe. He expressly admitted that although no one should insert their fingers into the throat, he routinely did so in his operation of the grinder. Moreover, the testimony demonstrates that employees who operated the meat grinder

² The Court notes that there is a split between the Commission and some circuits on this issue. Compare *Revoli Constr* No. 00-0315, 2001 WL 1568807, at *3-4) (finding "actual or constructive knowledge of an employer's foreman or supervisor can be imputed to the employer") with *Mountain States Tel. and Tel. Co. v. OSHRC*, 623 F.2d 155, 158 (10th Cir. 1980) (holding that knowledge cannot be imputed to an employer when the noncomplying behavior is the supervisor's own). Since the Tenth Circuit could consider the matter if a petition for review were to be field, the Court relies on the precedent in that circuit. *See Kerns Bros. Tree Serv.*, No. 96-1719, 2000 WL 294514, at *4 (OSHRC, Mar. 16, 2000) ("Where it is highly probable that a Commission decision would be appealed to a particular circuit, the Commission has generally applied the precedent of that circuit in deciding the case – even though it may differ from the Commission's precedent.")

regularly inserted their fingers in the throat of the grinder to knock meat down into the auger, which would have been easily observed by Mr. Wichman or other Ranch Foods management.

Further, the misconduct by Mr. Wichman was reasonably foreseeable. The record shows that Ranch Foods did not have effective safety training or rules in place. *W. G. Yates*, 459 F.3d at 609 n.8 (holding that evidence of lax safety standards rendered the supervisor's violation of safety rules foreseeable). Ranch Foods did not give a training or safety manual to employees operating the meat grinder. Management did not observe the operation of the meat grinder for safety, nor did management oversee Mr. Wichman's training of new employees. *Hamilton Fixture*, 16 BNA OSHC 1079, 1087 (No. 88-1720, 1993) (citation omitted), *aff'd*, 28 F.3d 213 (6th Cir. 1994) (holding that an employer's obligation to inspect its workplace for hazards "requires a careful and critical examination, and is not satisfied by a mere opportunity to view equipment."). Discipline or reprimands, if issued, were not formally documented, and no employee was cited for any safety rules violations while operating the meat grinder. The inadequacies of Ranch Foods' safety training and precautions established that Mr. Wichman's own violation of safety rules was foreseeable.

Moreover, Mr. Morrill as the general manager had the responsibility to ensure that his employees worked safely, and he could discipline actions that were unsafe. Yet, he failed to examine the machines at the worksite, did not observe employees using the grinder, and did not check the equipment for safe operation. Although Mr. Morrill testified that he relied on his employees to act safely and report any safety issues with the machines, an employer cannot simply delegate the duty of safety to its employees. *See PBR, Inc. v. Sec'y of Labor*, 643 F.2d 890, 895 (1st Cir. 1981) ("[The employer] cannot escape responsibility for the violation because it warned

its employees to exercise caution. Such delegation of employee safety to the employees themselves is clearly inconsistent with the purposes and policies of the Act.”).

The Court concludes that the Secretary has met her burden to demonstrate that the standard applied and was violated, which exposed employees to a hazard. The Court further concludes that Ranch Foods knew or could have known of the hazard with the exercise of reasonable diligence. Lastly, the Court notes that there is no dispute over the classification of Citation 1 Item 1 as Serious. Under section 17(k) of the Act, 29 U.S.C. § 666(k), a violation is serious if there is a substantial probability that death or serious physical harm could result. *Conagra Flour Milling Co.*, No. 88-2572, 1992 WL 215113, at *7 (OSHRC, Aug. 18, 1992). That threshold is met here.

Accordingly, the Court now turns to the affirmative defense advanced by Ranch Foods: unpreventable employee misconduct.

4. Ranch Foods Failed to Establish Unpreventable Employee Misconduct

Ranch Foods argues that Ms. [redacted]’s intentional act of trying to unjam the grinder without ensuring it was locked out was employee misconduct. It argues in the alternative that Ms. [redacted]’s act of pushing meat down the throat of the grinder rather than using the stomper was unpreventable employee misconduct because she engaged in that misconduct despite being trained to use the stomper and how to operate and unjam the grinder safely.

To establish the defense of unpreventable employee misconduct, the burden shifts to the employer to show that it had: (1) established work rules designed to prevent the violative conditions from occurring; (2) adequately communicated those rules to its employees; (3) took steps to discover violations of those rules; and (4) effectively enforced the rules when violations were discovered. *Manganas Painting Co., Inc.*, No. 94-0588, 2007 WL 6113032, at *40 (OSHRC, Mar. 23, 2007). When the alleged misconduct is that of a supervisor, the proof of “unpreventable

employee misconduct” is more rigorous and more difficult to establish since it is the supervisor’s duty to protect the safety of employees under his supervision. *Archer-W. Contractors Ltd.*, No. 87-1067, 1991 WL 81020, at *5 (OSHRC, Apr. 30, 1991). Involvement by a supervisor in a violation is “strong evidence that the employer’s safety program was lax.” *Daniel Constr. Co.*, 10 BNA OSHC 1549, 1552 (No. 16265, 1982).

“The conventional way to prove the enforcement element is for the employer to introduce evidence of a disciplinary program by which the company reasonably expects to influence the behavior of employees.” *Precast Servs., Inc.*, No. 93-2971, 1995 WL 693954, at *1 (OSHRC, Nov. 14, 1995). “For instance, an employer may provide evidence of a progressive disciplinary plan consisting of increasingly harsh measures taken against employees who violate the work rule.” *Id.* (citing *Asplundh Tree Expert Co.*, No. 16162, 1979 WL 8540, at *7 (OSHRC, Dec. 31, 1979) (employer introduced evidence of company policy calling for a stern oral or written reprimand for the first violation, followed by discharge for a second violation)). This requires evidence that an employer enforced its safety rules and documented safety violations committed by its employees. *See Angel Bros Enters., Ltd. v. Walsh*, 18 F.4th 827, 832 (5th Cir. 2021) (holding that despite the existence of work rules and proactive steps taken to discover violations, the employer was unable to show documentary evidence that it enforced its safety rules upon discovering violations).

Here, the Court concludes that Ranch Foods had limited safety rules in place and was lax in the enforcement of those rules. If management issued warnings to employees, they were given verbally, and there was no requirement for documentation of work rule violations. Moreover, there is no evidence in the record that any Ranch Foods employees was ever actually reprimanded or disciplined for safety violations in their operation of the meat grinder.

In addition, the record shows that Ranch Foods management did not take steps to discover violations of work rules. Employees, including the meat department supervisor, reported that they routinely used their fingers to push meat into the throat of the grinder. Mr. Callicrate and Mr. Morrill had ample opportunity to observe the operation of meat cutting machinery and correct any behavior that violated safety rules. However, they did not get involved in determining whether the machinery was operating safely or address the meat grinder's frequent jamming issues. The failure of management to conduct safety reviews or observe the operation of the meat grinder is fatal to Ranch Foods' employee misconduct defense.

Accordingly, the Court AFFIRMS Citation 1, Item 1.

B. Citation 2, Item 2

Citation 2, Item 2 alleges an Other-Than-Serious violation of 29 C.F.R. § 1904.39(a)(2), a reporting standard, which provides:

Within twenty-four (24) hours after the in-patient hospitalization of one or more employees or an employee's amputation or an employee's loss of an eye, as a result of a work-related incident, you must report the in-patient hospitalization, amputation, or loss of an eye to OSHA.

The Secretary describes the serious violation as follows:

On or before 6/11/21 the employer did not report a work related amputation resulting in inpatient hospitalization to OSHA as required by this standard.

Citation at 10.

It is undisputed that Ms. [redacted] suffered a serious injury that resulted in the amputation of four fingers and in-patient hospitalization. (J. Stip. ¶ 10). It is also undisputed that Ranch Foods did not report the in-patient hospitalization to OSHA, thus violating the standard. The only inquiry left for the Court is to determine whether Ranch Foods had actual or constructive knowledge of Ms. [redacted]'s hospitalization and amputation injury, thus triggering its obligation to report.

The reporting requirements “provide the Secretary with prompt notification of serious accidents so that [s]he can take timely action to avoid further injuries.” *Lancaster Colony Corp., Candle-lite Div.*, No. 92-0958, 1993 WL 119644, at *3 (OSHRC ALJ, Apr. 5, 1993) (internal citation omitted). The Commission has found an employer to be in violation of the reporting standard even where the employer made a good faith effort to report an accident but reported it to state and local authorities instead. *See, e.g., F. F. Green Constr. Co., Inc.*, No. 1015, 1973 WL 4269, at *6 (OSHRC Nov. 26, 1973) (finding a violation of the reporting requirement where the employer reported the accident to a third party, even though the third party then timely notified the nearest OSHA office).

Here, the record demonstrates that management made no effort to report the accident to OSHA, despite its awareness of the accident and its severity. Mr. Wichman was in the room when the accident occurred, and he observed Ms. [redacted]’s inability to extract her hand from the grinder. He testified that he overheard the paramedics debating whether to apply a tourniquet to her arm, which gave him a strong indication that her injuries were severe and may involve amputation. Mr. Wichman spoke with Mr. [redacted] the day after the accident, at which time he learned that the injuries were “bad.”

Mr. Callicrate and Mr. Morrill had ample opportunity to learn the extent of Ms. [redacted]’s injuries and whether she was admitted in-patient at the hospital. Mr. Callicrate was at the hospital within hours of the accident, at which time he could have made serious inquiries as to Ms. [redacted]’s condition and treatment plan. Mr. Callicrate also spoke with employees of the Fillmore Street store after the accident, which would have informed him of the severity of the accident. Yet, Mr. Callicrate made no effort to ask about Ms. [redacted]’s condition, including whether she would be able to return to work. Similarly, Mr. Morrill spoke with the Fillmore Street

store's employees shortly after the accident and should have been aware of the severity of the accident. Yet, he failed to contact Ms. [redacted] or her husband until three days after the accident, despite previously being in regular contact with Ms. [redacted] regarding her attendance and time off requests.

Management, with the exercise of reasonable diligence, could have learned within 24 hours of the accident that Ms. [redacted] suffered an amputation and was admitted in-patient at the hospital. However, it failed to conduct any sort of investigation. An employer cannot escape liability for violating a reporting standard by failing to make reasonable efforts to gather information and make inquiries about an employee's condition and hospitalization.

Citation 2, Item 2 is AFFIRMED.

ORDER

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

1. Citation 1, Item 1, alleging a Serious violation of 29 C.F.R. § 1910.212(a)(1) is AFFIRMED, and a penalty of \$9,557 is ASSESSED.
2. Citation 2, Item 2, alleging an Other-Than-Serious violation of 29 C.F.R. § 1904.39(a)(2) is AFFIRMED, and a penalty of \$6,827 is ASSESSED.

SO ORDERED.

Dated: May 15, 2023
Denver, Colorado

/s/

Christopher D. Helms
Judge, OSHRC