Oregon OSHA
Employer Knowledge Stakeholder Committee
Meeting Minutes
Oregon OSHA v. CBI Services, Inc. / Supreme Court decision
Wednesday, August 26 2015

Location: Oregon OSHA Portland Field Office Conference Room
16760 SW Upper Boones Ferry Road, Suite 200, Tigard OR 97224

Attendees:

Alta Schafer	Ian Chase
Andy Collin	Marilyn Schuster
Bryon Snapp	Michael Wood
Chris Ottoson	Nargess Shadbeh
David Douglas	Peggy Munsell
Dede Montgomery	Randy Ingraham
Eliot Lapidus	Roger Dale-Moore
Gary Beck	Rory Martindale
George Goodman	Tony Howard
Glenn Curry	

Self-introductions were made.

The group reviewed the minutes from the last meeting.
The goal is to get some level of written guidance about when the employer 'could … with reasonable diligence' have known about a violation. This is focused on knowledge of the exposing employer, not multi-employer worksites.

Michael presented several scenarios for input on if the employer had / could have had constructive knowledge or actual knowledge.

Discussion Scenario #1– Roofers & Fall Protection

Oregon OSHA initiated a fall emphasis inspection at 2 pm in the afternoon based on three roofers working at more than 10 feet without visible fall protection. During the inspection, Oregon OSHA determined that the roofers had installed anchor points earlier in the day based on direction from the job foreman, but they had not been using them. They had fall protection gear in the company truck.

During employee interviews, one of the roofers said that they had not wanted to "hassle with the harnesses." One of the other workers said that they had used the fall protection gear during the morning but that they had "forgotten to tie off" when they started up after lunch. The third worker first indicated that he didn't understand the question and, when it was translated, simply refused to answer.

The foreman was supervising several jobs in the same housing development. When interviewed, he indicated that he had checked earlier in the day to make sure that the roofers had installed the anchors. He never saw them actually using the fall protection. They had begun work on that roof that morning and he was not sure where the members of that crew had been working previously.

The two employees who participated in the interviews agreed that the employer had told them to use fall protection, but one of them said he "never really made a big deal out of it." The other employee said that the owner had told him clearly that if Oregon OSHA ever caught him without fall protection he would be fired. When asked what happened if the owner or foreman caught him without fall protection the same employee said he couldn't remember that ever happening, but he was sure he'd get his "butt chewed out."

The owner provided documentation that he had let an employee go previously for violating his fall protection rules. In that case, the employee had been the subject of an Oregon OSHA enforcement visit. The owner later faxes a document showing that the three employees caught on the roof had been sent home and told they wouldn't be needed for the rest of the work in that housing development. The owner also provided documentation showing that the three employees had all been trained in the appropriate use of fall protection and that they had each signed a document saying that they would follow all Oregon OSHA rules.

The owner was relatively confrontational during the inspection, at one point indicating that the rules were "just designed to get in the way of people trying to make a living." He also said that the roofers were "grown men who understand how to work on a roof safely, and I shouldn't have to babysit them just to get them to follow a bunch of chickens### rules written by people who haven't done an honest day's work in their lives." Finally, the owner claimed that any violations were the result of employee misconduct, saying that an Oregon OSHA consultant had told him if he had the right policies and place and provided the required gear he couldn't be cited.

The group agreed that there is more information that is needed from the foreman, and they need to see training history, policies, etc. (although the owner's understanding of the issues and the employer's responsibility is clearly in error).

Discussion Scenario #2 – Missing Guard on Machine

Oregon OSHA has conducted a routine inspection of a manufacturing plant. During the inspection, the enforcement officer noted that the guard is missing from one of three identical machines, all of which were in operation at the time of the inspection. Under both the Oregon OSHA rules and the manufacturer's recommendations, the machine is not supposed to be used when the guard is not in place. The other two machines have the guard in place.

The maintenance technician responsible for those machines indicated that the guard was not on the machine because it had been damaged when it was removed so that some work could be done on the machine. He said he was waiting to get the right parts in so that the guard could be fixed. He said he never told the floor supervisor or plant manager about the missing guard because he was embarrassed about breaking it. He was not sure how long ago it happened, but he thought that the guard had been off the machine for "a week or two."

Two of the machine operators indicated that they had noticed the missing guard. One of them indicated she was sure the guard had been missing for at least two months. The other one said he couldn't really remember, but "it's been a while." When asked whether they told anybody about the missing guard, the first one said that she'd asked the maintenance technician about it and he said he knew and would get it taken care of. The other said he didn't tell anyone, but he assumed maintenance knew about it because "that's their job." When asked if they'd been told not to operate the machines without the guard in place, the first one said she thought that had been part of the original training she received when she was hired three years ago. But one of the other machines was missing a guard for several months when she first started, and nobody ever said anything about it. The second operator said he knew that he shouldn't operate the machine without the guard but "what are you gonna do? The works gotta get done, you know?"

The floor supervisor said she had never noticed the missing guard. She walks through the plant once or twice a day, but she pointed out that the guard isn't readily visible unless you step up into the operator's station, and she hasn't had a reason to do that. She said she's noticed operators using the machines without the guards at times in that past and she's "chewed them out about it" but she's "never written anybody up over it." Neither of the two operators interviewed remembered being chewed out for using the machine without a guard, but the senior operator said she had heard about one of the other operators being "reprimanded or something" after he got injured while operating an unguarded machine.

The plant manager provided written policies showing that none of the machines were to be operated without the guards in place. The policies had been signed by each of the operators, including the two who were interviewed, at the time they were hired. The plant manager also provided records of two employees who were issued written reprimands for operating the machines without the guard in place. Both of the reprimands occurred four years ago, when one of the two operators was injured. Neither of the operators who received the reprimands works at the plant any longer.

The plant manager also provided safety committee minutes. Although the minutes include general reminders about keeping in guards in place, there are no indications of specific guards missing or corrective measures taken. The plant manager said the plant did a "safety stand-down" six months previously and checked all of the machine guarding as part of the stand-down. The plant manager said it's up to maintenance to stay on top of these issues and that employees are expected to report any problems to management. In the closing conference, the plant manager and the floor supervisor advised that the maintenance technician who had not replaced the guard and the two operators who admitted operating the machine without the guard were all being disciplined as a result.

The group largely agreed that, given the timeline, the employer could have known with the exercise of reasonable diligence.

Discussion Scenario #3 – Seatbelts & the Superintendent

Oregon OSHA is conducting a fatality investigation. The deceased was a construction superintendent driving his personal vehicle between job sites for which he was responsible.

Although he was not at fault in the accident, the Oregon State Police reports notes that the driver was not wearing his seatbelt, which contributed to the fatality.

The employer provides copies of written policy guidance indicating that all employees are to "follow all applicable rules of the road" when driving company vehicles. The company's chief operating officer acknowledges that the policy does not reference use of personal vehicles, which he describes as infrequent, but he indicates that the employees all know that they are expected to follow applicable laws whenever they are driving on company business. He indicated that he had no idea that the deceased employee did not always wear his seatbelt.

The safety director provided copies of training records, including defensive driving courses, for the deceased and for other employees. The course curriculum included the expected reminder to wear one's seatbelt at all times when driving.

In interviews with three other senior employees, they agree – two of them inaccurately reference the written policy as applying whenever driving on company business, rather than in company vehicles. Two of them also mention that the deceased frequently drove without wearing his seatbelt. One of them said that the deceased had said that he found seatbelts uncomfortable. Although all three were themselves superintendents, none of them were senior to the deceased. None of them had ever talked to anyone about the deceased's failure to wear his seatbelt.

Long-time employees on the two jobsites confirmed that the deceased rarely, if ever, wore his seatbelt, although he required his subordinates to do so. One even commented that the deceased had made him wear his seatbelt on a recent trip, even though the deceased was not doing so himself. Although they had discussed it with each other as one of his "quirks," no one was aware of anybody reporting it to senior management. Two employees remembered hearing the question of seatbelt use raised in a safety committee meeting where employees told managers not everyone used the seatbelts, but no names were used.

George thinks actual knowledge since other superintendents knew that he did this often and that knowledge can be imputed to the employer even though the employee in question is not their subordinate. Others think employee misconduct since the super refuses to wear seatbelt, but it was not clear whether that misconduct rises to the level of unpreventable employee misconduct.

Discussion Scenario #4 – Trainer Struck by Dump Truck

An employee was seriously injured when struck by a moving dump truck in a road oiling operation. The employee was an experienced driver who was training a newly assigned driver in his new duties. The dump truck was one of several that were backing down the road in order to keep a continuous flow of rock into the oil rock machine. The trucks were generally moving about 5 miles per hour. The employee, who had been riding in the vehicle for the entire shift, got out of the backing vehicle and was struck by it a few minutes later.

Because he was still behind the truck, the trainee driver could not see the trainer when the trainer was struck, although if the trainee had been looking in the mirror at the right time the trainee would have seen the trainer move behind the truck.

The employee was seriously injured and was initially admitted in critical condition. Although he is now recovering, the victim indicates that he was no memory of the events immediately before the accident occurred. He says that he does not remember getting out of the vehicle and is not sure why he would have done so. He said no one has ever told him not to get out of a dump truck when it is backing slowly. He says that as far as he knows the dump trucks have never carried a passenger before.

The trainee who was driving the truck indicates that he does not know why the trainer got out of the vehicle, but that he had done it at least twice previously – once before that day and once the previous day. In previous cases the trainer had stepped up on the running board and reentered the cab without incident as the truck backed up slowly. The trainee indicates that when the trainer got back in the first time he suggested that the trainee should stay closer in line with the other vehicles. The trainee says he thought it was "a bit weird" that the trainer got in and out of the moving vehicle but didn't want to question the senior employee about it. He said that the trainer seemed to be a bit bored and complained of getting stiff sitting in the passenger's seat, which does not have as much lumbar support as the driver's seat.

The trucking company for which both the trainer and the trainee work, contracts to haul the rock for the oiling operation. The company owner was driving one of the other trucks as part of the same operation. The owner says he never saw the trainer get out of the truck, and notes that he could not see the passenger side of the other vehicle from his cab. The owner indicates that this is the first time he has used an experienced driver to directly mentor and train a less experienced driver. The owner said he has never told any of his employees that they should not get in and out of a moving vehicle because it never occurred to him that any of them "would be that stupid." He also said that the dump trucks do not normally carry passengers. When asked about his past experience, he talked about his early days when he worked as ground crew and would sometimes "hitch a ride" on the running board of a backing dump truck in operations similar to this one.

In inspecting the accident site, the general contractor's investigator noted that there was a pile of excess rock that needed to be smoothed and the trainer appeared to have taken a shovel from the side of the dump truck. The investigator also noted that there was a partially smoked cigarette not far from the accident scene. The investigator's working theory is that the trainer, who was a smoker, got out of the vehicle "to grab a smoke and get the kinks out" and then noticed the rock build up. When he tried to smooth out the excess rock, he misjudged the timing or was not able to move out of the way quickly enough and was struck by the backing truck.

The group had more questions on this one. What was the expectation? Why wouldn't he have the driver stop? Why would he get out of a moving vehicle? Etc.

The next meeting we will lay out proposed criteria for the policy or rule. George suggested we should use the existing guidance in the Oregon OSHA FIRM rather than reinventing the wheel.

Meeting adjourned.

Next meeting:
TBD - 2016
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