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NEVADA OCCUPATIONAL SAFETY AND HEALTH

REVIEW BOARD

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CHIEF ADMINISTRATIVE OFFICER OF THE OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION OF THE DIVISION OF INDUSTRIAL RELATIONS OF THE DEPARTMENT OF BUSINESS AND INDUSTRY, STATE OF NEVADA, **Complainant,** **vs.** **WESTCOR CONSTRUCTION,** **Respondent.**	**Docket No. LV 18-1952**

DECISION OF THE BOARD

This matter came on for hearing before the Nevada Occupational Safety and Health Review Board on February 11 and 12, 2020, in furtherance of a Notice duly provided according to law. Salli Ortiz, Esq., appeared on behalf of the complainant, the Chief Administrative Officer of the Occupational Safety and Health Administration Division of Industrial Relations or Department of Business and Industry, State of Nevada (the State or OSHA). Representing the respondent, Westcor Companies, LLC, dba Westcor Framing, Exhibit 1, pp. 1, 3, and 8, was Raymond Perez, II, Esq., of Jackson Lewis, Atlanta, Georgia (the company or Westcor). Board of Review members at the hearing were Chairman, Pro-tem, Rodd Weber, and Board members James Halsey, Frank Milligan and Lance Semenko. There being four members of the Board present to hear this matter with at least one representing management and one member representing labor in attendance, a quorum was present to hear the matter and conduct the

business of the Board.

The evidentiary portion of these proceedings was concluded on February 11, 2020. The Board commenced deliberations on February 12, 2020. The same Board members were present at that time. The Board voted to resolve the matter upon conclusion of deliberations on February 12, 2020, with the Board affirming Citation 1, Item 1, and rejecting Citation 1, Item 2, the only two matters brought against Westcor during these proceedings.

Jurisdiction is not disputed and is conferred in accordance with NRS 618.315. And, Nevada has adopted all Federal Occupational Safety and Health Standards which the Secretary of Labor has promulgated, modified or revoked. Any amendments thereto shall be deemed Nevada Occupational Safety and Health Standards. *See*, NRS 618.295(8).

The State's complaint sets forth the allegations of the two citations, aforementioned, which the State claims constituted violations of the Nevada Revised Statutes and Regulations. At the outset of the hearing, the State offered for admission into evidence Exhibits 1 through 3, consisting of 111 pages. Counsel for Westcor objected to the introduction of evidence of all portions of the State's evidentiary package containing statements of persons who would not be present to testify on the grounds of relevancy and hearsay. Mr. Perez also objected to the introduction of photographs into evidence because of the lack of foundation.

In addition, the State had a video disk that was part of the evidence package that was offering for admission into evidence. There was, however, no provision in the facilities wherein the hearing was to be held to play the disk and so Ms. Ortiz excluded the disk from the evidentiary package.

Exhibits 1 through 3, pages 1 through 111 were admitted into evidence over the objection Mr. Perez, *see,* Tr. p., 13;22-25, *see also,* Tr. p., 14;7-8.

Westcor offered no documents for admission into evidence at the outset of the hearing, reserving the right to do so during the course of the proceedings. Subsequently, during its defense of the matter, Westcor offered into evidence Exhibit A, entitled Safety & Health Policy and General Safety Rules for Westcor Companies, updated January 13, 2012. The pages for this Exhibit were unnumbered. Exhibit A, was admitted into evidence, *see*, Tr. p., 83. Later in the

hearing, Westcor also offered into evidence Exhibit B, consisting of three one-page Westcor Companies' warehouse and yard walk-through reports, dated December 14, 2017, February 13, 2018 and January 9, 2018. Exhibit B was also admitted into evidence, *see*, Tr. p., 132;19.

Briefly, Westcor is a residential framing sub-contractor, Exhibit 1, p. 8., and it is a domestic limited liability company, qualified to do business and organized under the laws of the State of Nevada, Exhibit 1, p. 1. The President of the company is Michael A. Coronado, who is also a Director, Exhibit 1, p. 2. The business is located at 5620 Stephanie Street, Las Vegas, Nevada, which is the site of the incident. Exhibit 1, pp. 2, 3.

The injured worker in this matter was Angel De Jesus Gonzalez Zavala (Angel). Exhibit 1, p. 17. Emanuel Rios was the Safety Manager on the job for Westcor and Mario Lucero was the Framing Components Manager. Exhibit 1, p. 9.

The incident took place on February 23, 2018. Exhibit 1, p. 22. The matter was an employer referral or self-report to OSHA. Exhibit 1, p. 11. On February 24, 2018, at approximately 10:00 o'clock a.m., Pam Guttman, Director of Business and Operations for Customized Safety and Quality Solutions, a company representing Westcor Framing, contacted the Occupational Safety and Health Administration (OSHA) and reported a work related incident at the Westcor facility located at 5620 Stephanie Street, Las Vegas, Nevada. The accident was described as follows, an employee cut off his middle and ring finger, to the first knuckle while working at the facility, Exhibit 1, p. 11.

According to Emanuel Rios, Safety Manager, the employee was pushing two pieces of 2 x 4 lumber along the table of a Comet II radial arm saw (unknown model and/or serial number) with his left hand to a pre-measured mark when the lumber got stuck and stopped moving. The employee's hand, however, continued to move and make contact with the running saw blade. The employee (Angel) was taken by ambulance to a hospital where he was treated and released a short time later. Exhibit 1, p. 11.

The site of the incident is where the company's offices are located, as well as a warehouse area and the area where the Comet II radial arm saw was located. Tr., p. 77. Customized Safety and Quality Solutions, also has office space in Westcor's facility. Tr., p. 77. Westcor has 300

employees. Tr., p. 120.

Angel is a "cutter," Tr., p. 89, meaning he operates the saw 9 hours a day, Tr., p. 29, which caused the injury. It also means that he is the only saw operator, Tr., p. 89, who used the saw to cut 2 by 4s to pre-measured lengths for delivery to the construction site. *See,* Tr., p. 80.

As a result of the injury, the State charged Westcor in Citation 1, Item 1, for a violation of 29 CFR § 1910.213(h)(1) which provides in pertinent part that the,

> ... sides of the lower exposed portion of the blade [for radial blade saws] shall be guarded to the full diameter of the blade by a device that will automatically adjust itself to the thickness of the stock and remain in contact with stock being cut to give maximum protection possible for the operation being performed.

In this instance, the State alleges that the employee, Angel,

> ... was moving two (2) pieces of 2 by 4 lumber along the table's pre-measured mark when the lumber got stuck and stopped moving. The employee's hand continued to move, making contact with the rotating saw blade. The sides of the lower exposed portion of the blade were not guarded to the full diameter exposing the employee to a rotating saw blade. Contact with the running blade resulted in serious lacerations to the operator's fingers. Complaint, Exhibit 1, p. 47.

This Citation was labeled "Serious."

The State also charged Westcor in Citation 1, Item 2, for a violation of 29 CFR § 1910.213(h)(4) which provides that for radial saws, their "[i]nstallation shall be in such a manner that the front end of the unit will be slightly higher than the rear, so as to cause the cutting head to return gently to the starting position when released by the operator." Here, the State alleges that the:

> ... radial arm saw, equipped with an automatic return device, did not return gently to the starting position behind the rip fence when the pull handle was released by the operator. Leaving the running blade in front of the rip fence increases the chances of contacting the running blade which could cause severe lacerations or finger/hand amputations.

Citation 1, Item 2, was also listed as "Serious." *See*, Complaint, Exhibit 1 p.48.

Pursuant to NAC 618.788, the burden throughout is upon the Chief or Complainant to prove the two citations. This requires proof of a *prima facie* case which entails a showing of: (1) the applicability of the OSHA Regulation to the matter at hand; (2) noncompliance with the OSHA Regulation; (3) employee exposure to the hazardous condition, the subject of the OSHA

Regulation; and (4) the employer's actual or constructive knowledge of the wrongful conduct. *See, Original Roofing Co., LLC v. Chief Administrative Officer of the Occupational Safety and Health Administration,* 135 Nev. 140, 442 P.3d. 146, 149 (2019).

In main, Westcor offers the rogue employee defense to the two citations. Westcor claims that Angel removed two of the links from the daisy chain which provided the guard to protect hands from being involved with the saw blade. He had no permission to tamper with the daisy chain guard. The removal of the two links was virtually undetectable and the removal of the two links shortened the chain, removing the protection otherwise provided against being cut by the saw blade. The shortened chain was the direct and proximate cause of the saw carving up Angel's hand and there was nothing, therefore, that Westcor could do to guard against injury under these circumstances. According to Westcor's third-party safety person, the fault laid entirely with Angel. Westcor was blameless, *see*, Tr., p. 144, because the removal of the two links was virtually undetectable. Angel was at fault, not Westcor, and as a result, Citation 1, Item 1, should be dismissed against Westcor.

For Citation 1, Item 2, it was Westcor's position that the State failed to produce any proof that at the time of the incident, the radial arm of the Comet II saw would not gently settle back in the off-use position. Hence, Citation 1, Item 2, should be dismissed for the want of proof of a violation.

The Board of Review agrees in part with Westcor and in part with the State. It concludes that the State met its burden for Citation 1, Item 1, also holding that Westcor failed to prove the rogue employee defense to Citation 1, Item 1. The Board concurred with Westcor, however, that the State failed to show that the radial arm of the Comet II saw would not gently settle back in its original position. Hence, the Board of Review concludes that Citation 1, Item 2 should be dismissed for the want of proof of a violation.

STATEMENT OF FACTS

The factual discussion, above, is incorporated into this Statement of Facts. Additionally, insofar as Citation 1, Item 1 is concerned, there is really no dispute over the facts resulting in the injury (amputation to the first knuckle of the middle finger and ring finger) to the left hand of the

cutter, or saw operator, Angel Zavala (Angel). Tr., p. 89. Nick LaFronz, the State's District Manager for the Las Vegas District Office, Tr., 16, was the State's first and main witness. He admittedly never investigated the work site or interviewed any of the witnesses to the incident. Tr., pp. 16, 49-51. Renato Magtoto fulfilled that function, but he did not testify as he was no longer employed by the State and unavailable to testify, apparently. Tr., p. 18. Mr. LaFronz filled Mr. Magtoto's shoes at the hearing. His testimony in support of Citation 1, Item 1, consisted of a summary of the contents of the investigation narrative and witness statements taken by Mr. Magtoto, all of which were already admitted into evidence. *See*, Tr., p. 14, wherein State's Exhibits 1-3, consisting of pages 1 through 111, including photographs, Exhibit 1, pages 56-66 were admitted into evidence.

Angel's interview disclosed that he worked from 5:30 a.m., to 2:30 p.m., depending upon how fast they finish the job for the day. They sawcut the whole house. He has two other workers, Rene and Rody, that work with Angel to make up his crew. Tr., p.23. They do the nailing of everything they [actually Angel] cut. Exhibit 1, p. 17. According to the narrative, Angel stated: "I am their supervisor." Exhibit 1, p. 17.

Angel, thought it was around 7:30 a.m., when he grabbed a 2 by 4 and was going to cut the bottom. He tripped sliding the 2 by 4 on the bench of the saw. He believes something impeded the wood or the wood got stuck on the bench of the saw (tracks) and his hand jumped, hitting the blade of the saw. Then, he saw blood starting to come out. He thought it was just a small cut, but then he saw his two fingers were cut. He told Rody to call Mario Lucero. Mario came out and called the ambulance. The ambulance came five minutes later and took Angel to Sunrise Hospital. Exhibit 1, p. 17. According to the State, this is Angel's version of the overt incident.

Westcor conducted its own investigation into the incident. According to Westcor, the overt incident, the slicing of the left hand, happened on February 23, 2018 at approximately 7:30 a.m., at 5620 Stephanie Street, Las Vegas, in the warehouse/pre-cut area. Angel's supervisor is listed as Mario Lucero. Exhibit 3, p. 70.

The report states that "Angel grabbed the wood and laid it on the table. He then moved

the wood along the table to a pre-measured mark in order to cut the wood to the desired size. When attempting to place the 2 x 4's, the 2 x 4's got stuck, causing his left hand to continue to move and went into the running blade." Exhibit 3, p. 70.

The report included the question, "What exactly caused the injury and how did it happen?" The answer according to Westcor was: "Wood getting stuck along the table while hand was in motion causing his [Angel's] hand to continue motion into the moving saw blade. Saw guard was missing several links which were removed without authorization." Exhibit 3, p. 70.

There is little difference between Westcor's understanding of the incident contained in its own post-incident investigation report and Angel's version of the event offered up by the State. Westcor's report, however, interjects the issue of "missing links." As indicated, the saw blade on the Comet II radial arm saw is guarded or protected by a daisy chain comprised of a series of links connected together. *See*, Exhibit 1, photographs pp. 56-66, and in particular, pp. 56, 56A, 57, and 57A. *See also*, Tr., p. 94.

After the incident, Emanuel Rios, the Safety Director for Westcor, Tr., p. 74, conducted his own investigation into the incident. During this investigation, Rios discovered, hidden in some paperwork behind where the saw was situated, Tr., p. 109, two links from the saw's daisy chain guard which had been removed from the saw. Angel admitted that he was the person who had removed the links from the daisy chain that had been installed to keep hands away from the saw blade. Tr., pp. 98, 99, 112, 155.

According to Rios, the fact that links were missing from the chain was not readily apparent to the eye. Tr., p. 100. According Garo Injasoulian (Garo), the owner of Westcor's third-party safety consultant, Customized Safety & Quality Solutions, Tr., pp. 79, 125, 126, one would need the specifications for the saw from the manufacturer for use to take measurements of the chain in order to determine if chain links were missing, thereby compromising the security the chain link guard is to provide. Tr., pp. 171-172. The fact that the saw's chain link guard was compromised by missing links was not readily apparent. Tr., p. 143. According to Rios, if links are missing, that is not something that you could just determine looking at the machine itself or

from the chain, alone. Tr., p. 100.

Garo's company audited Westcor's equipment every two weeks. Tr., p. 103. Garo inspected the premises and equipment a week before the incident. Tr., pp. 130, 141, 143. He saw no problems with the saw at that time whatsoever. Tr., pp. 130, 141.

Angel never disclosed how long it had been since he removed the links from the chain. Tr., p. 99. Angel told Rios he had no idea why he removed the links. Tr., p. 100. Angel had no authority to tamper with the saw such as the removal of the links from the chain. No one had that authority. Tr., p. 101. No one else discovered the fact that links were missing other than Rios. Tr., p. 101. Rios disclosed his discovery of the two links from the saw's daisy chain guard to Renato, the investigator. Tr., pp. 101, 102. Renato did not discover the missing links himself. *Ibid.*

The removal of the links from the daisy chain was lethal to Angel and a clear and present danger to a stranger who might have been called upon to operate the saw. Tr., p. 162. The daisy chain provides the safety guard for the saw when being used. It is intended to guard the full diameter of the blade by automatically adjusting itself to the thickness of the stock and remaining in contact with the stock being cut to give maximum protection possible for the operation being performed. 29 CFR § 1910.213(h)(1). By removing the links from the chain, the evidence reveals that the chain was shortened so that the lower portion of the blade is not guarded to the full diameter of the blade. Thus, the saw blade was exposed to Angel's hand or vice versa. Either way, the shortened chain exposed the blade and this opening was a breach in the integrity of the security that the daisy chain was required to provide.

The failure to have a proper guard was confirmed by the photos. Tr., p. 37. *See*, Exhibit 1, pp. 57-63, 65 and 66 (the photos). Thus, the Board finds that the missing links were the direct and proximate cause of the injury by amputation to Angel's left hand. Tr., pp. 31, 32, 33, 34 and 37.

At the time of the incident, Angel was the lead on the saw. He was a supervisor. Tr., p. 106. He supervised his own work. Tr., p. 106. As indicated, he was also the supervisor of two other employees who were his nailers. Tr., p. 23. No one, however, was responsible for

supervising Angel while he was actively cutting and working the saw. Tr., p. 107.

Angel was a direct report to Mario Lucero, the Framing Components Manager, Exhibit, p. 9. Mario only inspected the quality of Angel's work. Tr., p. 106. That is to say, Mario Lucero assigned work to Angel but, as Angel was the lead on the building crew, he supervised the work at the pre-cut saw stage once the work is handed off to him. Tr., p. 117. Mario Lucero had no responsibility for providing safety instructions to Angel, Tr., p. 124. He also had no responsibility for overseeing any safety aspects of Angel's work. Tr., pp. 102, 106, 107. It was not Mario's responsibility to inspect the equipment, such as Angel's saw. Tr., p. 78. No one supervised Angel's operation of the saw but Angel. He was left to his own devices. Tr., p. 107.

The company has a safety manual. But, according to Rios, who was in charge of safety, or at least a member of a safety committee, the safety manual does not have a section that deals specifically with saws. Tr., pp. 115, 116. The safety committee consisted of Rios, Lucero and Garo. Tr., p. 104. Rios is also unsure if the manual goes over the steps an employer is supposed to take to ensure that employees are not nullifying safety guards or devices. Tr., p. 116. Angel was trained in the operation of the saw by his predecessor. Tr., p. 117. The content of this training is undocumented. Angel also went through orientation at Westcor, when he was hired. Tr., p. 88. The content of this training is also undocumented. Tr., p. 119, *see also*, Tr., p. 123-124. Nonetheless, according to Angel, he had received training from another industry and the only training he got from Westcor was something that looks like an unintelligible F/L, which was never explained. Tr., p. 30. Angel claimed he had OSHA-10 training. Tr., p. 64.

The company's Health and Safety Policy Manual, *see*, Exhibit A, is supposed to be updated annually. But, it was last updated on January 13, 2012. Tr., p. 110. The incident took place on February 23, 2018, by way of comparison.

Angel was disciplined for his role in the overt incident causing the slicing of his left hand. Tr., pp. 122-123. The discipline consisted of only an oral discussion with Angel about his wrongdoing. He wasn't fined. He wasn't docked pay or required to stay home without pay. Mr. Rios thought that the amputation, itself, was punishment, enough, as he would relive what he did wrong every time he looked down at his hand, and saw the amputation. *Ibid.*

The meting of this "discipline," such as it is, was a part of the company's disciplinary program. It consisted of three steps, with the third violation, though not required, most likely winding up in a termination. Tr., p. 84.

Turning to Citation 1, Item 2, an alleged violation of 29 CFR § 1910.213(h)(4), this regulation deals with radial arm saws, specifically, the need for the radial arm when in use to slide gently back to the starting position. Tr., p. 40, Exhibit 2, pp. 67-69. This can be facilitated by the elevation of the front end of the saw, so that the arm will glide gently to the starting position. Exhibit 2, p. 67. The intention is to avoid the potential for a rebound of the saw blade. Exhibit 2, p. 69, Federal OSHA letter of interpretation. Tr., p. 41.

The State relies, here, upon two photographs, Exhibit 1, pp. 64 and 64A, both dated April 11, 2018. Both show a photo of a protractor sitting on the saw in question with the note on photo 64, that the gage on the protractor read zero degrees. The Board concludes that this was to show that the saw bed was flat, rather than at an elevation from the front end, to facilitate a gentle glide back to the start position as described in the OSHA letter of interpretation of 29 CFR § 1910.213(h)(4), which, itself, provides that "[i]nstallation shall be in such a manner that the front end of the unit will be slightly higher than the rear, so as to cause the cutting head to return gently to the starting position when released by the operator." These photos purportedly provided visible proof that the saw violated this regulation due to a flat reading of the protractor.

The State, however, produced no testimony that the condition depicted in the photographs was representative of the condition of the saw on February 23, 2018, the date of the overt incident and the date of this alleged violation.

Then, according to Garo, who had witnessed the saw in action the week before, he never saw any issues or problems with the saw not returning back to the original starting point, and he actually saw the saw functioning. Tr., p. 141. And, according to Rios, he did not see any issue with the retraction of the saw. Prior to the incident, Angel had never seen any issues with the retracting arm of the blade. Tr., p. 93. Also, before the incident, Angel never raised any concerns or issues about the use of this table saw with Rios. Tr., pp. 82, 89.

DISCUSSION

The resolution of Citation 1, Item 1, revolves around the requirements of *Original Roofing*, which provides under certain circumstances for the imputation of an errant supervisor's knowledge of his own conduct in the work place to employers to satisfy the knowledge element of a *prima facie* case. Before addressing that issue, however, the Board finds and concludes that the other three elements of a *prima facie* case were established by the State. It could not be seriously argued otherwise for Citation 1, Item 1.

The regulation at issue, 29 CFR § 1910.213(h)(1) applies. It deals on its face with radial saws and a radial saw was being used by Angel. There was also a violation of the regulation because by removing the links to the chain guarding the radial saw blade, it shortened the chain so that it could not guard the full diameter of the blade by a device and automatically adjust itself to the thickness of the stock in order to remain in contact with stock being cut to give maximum protection possible for the operation being performed. 29 CFR § 1910.213(h)(1). The removal created a gap, exposing Angel's hand to the saw blade and a serious injury resulted.

Angel was, therefore, also exposed to a hazardous condition. Removing the links created a gap in the integrity of the security the daisy chain was intended to provide. Exposure to a hazardous condition, the radial and rotating saw blade, is established.

The Board finds, therefore, that these three elements of a *prima facie* case have been shown. Tr., pp. 36, 37. This leaves the last element to consider, employer knowledge. The Board concludes that employer knowledge is shown by imputing to Westcor, Angel's knowledge of his own misconduct, the removal of the links from the daisy chain, thereby creating a gap in the integrity of the security the daisy chain was required to provide.

Original Roofing sets the standard for imputing a supervisor's knowledge, here, of his own misconduct to the employer to satisfy the knowledge requirement of a *prima facie* case. There, the Nevada Supreme Court explained: "Employer knowledge is established by demonstrating that the employer either knew, or, with the exercise of reasonable diligence, could have known of the presence of the violative condition." *Pride Oil Well Serv.*, 15 BNA OSHC 1809, 1814 (No. 86-692, 1992) (discussing federal OSHA criteria). Generally, an employer is

imputed with a supervisor's knowledge of deviations from OSHA's safety rules to encourage employers to exercise reasonable diligence to ensure OSHA compliance by their employees. *See, Adm'r of Div. of Occupational Safety & Health v. Pabco Gypsum,* 105 Nev. 371, 373, 775 P.2d 701, 702-03 (1989)." *Original Roofing, supra* at 140.

While that is the general rule, it is not always the case as the Court went on to explain when the supervisor is the miscreant: "Ultimately, however, 'a supervisor's knowledge of his own malfeasance is *not* imputable to the employer where the employer's safety policy, training, and discipline are sufficient to make the supervisor's conduct in violation of the policy unforeseeable.' *W.G. Yates*, 459 F.3d at 608-09." *Id.*, at 144.

The test is foreseeability. The Court in *Original Roofing* affirmed the Board's decision that imputation of the supervisor's knowledge of his own misdeeds was inappropriate because, as outlined in the decision, the employer's safety policy, training and discipline were comprehensive. *Original Roofing, supra* at 144. With all that effort put into training, safety, discipline and the like, it would be unforeseeable for the employer to predict or think that his supervisor would go off and commit a wrongdoing in defiance of all that effort on the part of the employer, to provide a safe working environment.

The converse is also, then, true. Where the employer's effort to train, provide for safety, and provide for discipline is indifferent, it is not unforeseeable that a supervisor would go off and commit a wrongdoing, and thus, under those circumstances, it would be reasonable and fair to impute to the employer, the supervisor's knowledge of his own wrongdoing.

That is the situation, here. For the reason's set out above, the Board finds and concludes that Westcor's approach to safety, training, and discipline, was indifferent, such that it is appropriate to impute to Westcor management, Angel's knowledge that he removed the links from the daisy chain creating an untenable, dangerous condition.

Westcor's response to Angel's misconduct was a verbal warning. He lost no time as a disciplinary measure. He lost no pay as a disciplinary measure. The Safety Manual did not address the radial saw. There was no written documentation of any training Angel received. Angel said he received no training from Westcor, only training from another industry, except for

some kind of training symbolized by an unintelligible initial. Tr., p. 30. Westcor never bothered to explain to the Board the significance of the initials. Also, Angel was truly left to his own devices. Neither Rios nor Lucero took any responsibility for monitoring the safety aspects of Angel's use of the radial blade saw.

The Board finds and concludes, therefore, that based upon *Original Roofing* and the facts, Angel's knowledge of his wrongdoing is imputable to Westcor management. Employer knowledge is shown, and thus, all four elements of a *prima facie* case has been established by the State.

This leaves what appears to be Westcor's reliance upon the rogue employee to defend against Citation 1, Item 1. The elements of a rogue employee defense are proof the employer has established work rules which operate to prevent the violation, proof the employer has adequately communicated those rules to the employees and proof the employer had effectively enforced the rules when violations have been discovered. *See, Sanderson Farms, Inc. v. OSH RC*, 348 Fed. Ap'x. 53, 57, 22 OSH Cases 1889 (5th Cir., 2009).

The Board finds and concludes, here, that Westcor has not established a rogue or unpreventable employee misconduct defense. There are several reasons for this, including that Westcor admits that its safety plan does not include safety information about the use of the radial blade saw. The safety manual does not have a section that deals specifically with saws. Tr., pp. 115, 116. And, as also explained, Rios is unsure if the safety manual goes over the steps an employer is supposed to take to ensure that employees are not nullifying safety guards or devices. Tr., p. 116. This is enough, without more, to eliminate the unpreventable employee misconduct defense.

But, there is more. As explained, above, Westcor's approach to safety was indifferent. Angel was left to his own devices. And, there was no testimony describing a comprehensive training program which effectively would have communicated to Angel that he should not tamper with safety devices. Finally, there was no testimony about a robust disciplinary program. Angel was only talked to about what is otherwise a very serious problem.

The Board of Review, therefore, finds and concludes based upon the preponderance of

the evidence, that the State has proven a violation of 29 CFR § 1910.213(h)(1). Citation 1, Item 1, is affirmed.

The Board also finds and concludes that the fine of $10,000 for this offense is appropriate, given the serious nature of the offense, the gravity of the offense, and the likelihood that this circumstance could occur again. This is especially true, given the clandestine nature of the violation. Even Westcor's safety consultant testified that the removal of the links was not readily apparent to the naked eye. An unsuspecting operator could, then, have used the radial saw and been subject to the same calamity suffered by Angel. Tr., pp. 142, 155, 171, 172. Also, it was never disputed that the violation was serious because of the possibility of death or, as in this case, amputation from an encounter with the radial blade of the saw. Tr., pp. 43, 44. The severity was deemed high, also, given the permanent nature of possible injuries. Tr., p. 44.

Turning to Citation 1, Item 2, it is well established that proof of all four elements of a *prima facie* case must be shown for a violation to be affirmed. A failure, therefore, to prove just one of the four elements of a *prima facie* case defeats a claim that there has been a violation or an OSHA regulation. *See, Original Roofing, supra* at 141.

Therein lies the problem for the State in connection with Citation 1, Item 2. To show a violation, one of the *prima facie* case elements, the State relies upon photographs in evidence of a protractor sitting on the bed of the saw, Exhibits 64 and 64A, to prove that the saw bed did not have the slant required by 29 CFR § 1910.213(h)(4), to allow the saw arm to slide gently back to its start position. The photos are dated April 11, 2018. The incident took place February 23, 2018. No one was called to testify that the condition of the saw depicted in these two photographs, was also the condition of the saw on February 23, 2018. Angel, Rios and Garo all testified that prior to February 23, 2018, they witnessed the saw in use and saw no problem with the slide of the saw.

The Board finds and concludes that the State failed to establish, through credible evidence, that there was a problem with the glide and slide of the saw as of February 23, 2018. Therefore, the Board finds and concludes that Citation 1, Item 2 cannot be sustained for the want of proof of a violation because there is no showing that as of February 23, 2018, the radial saw

would not glide gently back to its original start position as required by 29 CFR § 1910.213(h)(4). 2Tr., p. 26.[1] With no proof of a violation of a regulation, there can be no proof of a *prima facie* case and therefore, the Board is unable to sustain Citation 1, Item 2 for the want of proof that 29 CFR § 1910.213(h)(4) was violated as alleged.

Accordingly, on February 12, 2020, it was moved by Frank Milligan, seconded by Lance Semenko, to uphold Citation 1, Item 1, including the fine of $10,000 and all other relief as pled in the State's complaint. The motion was approved on a vote of 4 in favor and none against.

Then, as to Citation 1, Item 2, it was moved by Frank Milligan, seconded by Lance Semenko, to vacate and, therefore, not to uphold Citation 1, Item 2. The motion was approved on a vote of 4 in favor and none against. Citation 1, Item 2 is accordingly dismissed with prejudice.

The Board ordered that counsel for the complainant submit proposed Findings of Fact and Conclusion of Law to the Nevada Occupational Safety and Health Review Board consistent with this Decision and serve copies on opposing counsel within 20 days from the date of this decision. After five days time for filing any objections, the final Findings of Fact and Conclusions of Law shall be submitted to the Nevada Occupational Safety and Health Review Board by prevailing counsel. Service of the Findings of Fact and Conclusions of Law signed by the Chairman of the Nevada Occupational Safety and Health Review Board shall constitute the Final Order of the Board.

On August 27, 2020, the Board convened to consider adoption of this decision, as written or as modified by the Board, as the decision of the Board.

Those present and eligible to vote on this question consisted of four of the five current members of the Board, to-wit, Board Secretary Rodd Weber, members James Halsey, Frank Milligan and Lance Semenko. Upon a motion by Rodd Weber, seconded by Frank Milligan, the Board voted 4-0-1 (Ingersoll abstaining), to approve this Decision of the Board as the action of the Board and to authorize the Secretary, Rodd Weber, after any grammatical or typographical

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[1] "2Tr." refers to the transcript of the deliberations on February 12, 2020, "Tr." refers to the transcript of the proceedings on February 11, 2020.

errors are corrected, to execute, without further Board review, this Decision on behalf of the Nevada Occupational Safety and Health Review Board.

On August 27, 2020, this Decision is, therefore, hereby adopted and approved as the Decision of the Board of Review.

Dated this 31st day of August, 2020.

NEVADA OCCUPATIONAL SAFETY AND HEALTH REVIEW BOARD

By: */s/Rodd Weber*
Rodd Weber, Board Secretary

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that I am an employee of the Law Offices of Charles R. Zeh, Esq., and that on this date I served the attached document, *Decision of the Board*, on those parties identified below by placing an original or true copy thereof in a sealed envelope, certified mail/return receipt requested, postage prepaid, placed for collection and mailing in the United States Mail, at Reno, Nevada:

Salli Ortiz, Esq.
DIR Legal
400 West King Street, Suite 201
Carson City, NV 89703

Raymond Perez, II, Esq.
Jackson Lewis
171 17th Street, NW, Suite 1200
Atlanta, GA 30363

Dated this 8th day of September, 2020.

Employee of
The Law Offices of Charles R. Zeh, Esq.

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