BEFORE THE SAFETY AND HEALTH REVIEW BOARD
OF NORTH CAROLINA
RALEIGH, NORTH CAROLINA

COMMISSIONER OF LABOR FOR
THE STATE OF NORTH CAROLINA,

COMPLAINANT,

v.

CHARLOTTE PIPE & FOUNDRY
COMPANY,

RESPONDENT.

DOCKET NO. OSHANC 2003-4275
OSHA INSPECTION NO. 306236753
CSHO ID NO. P1547

ORDER

THIS MATTER was heard by the undersigned on April 21, 2004 in Charlotte, North Carolina.

The complainant was represented by Sonya M. Calloway, Assistant Attorney General; the respondent was represented by Beverly A. Carroll of Kennedy Covington Lobdell & Hickman.

Prior to taking evidence, counsel for the parties advised the undersigned that the violation alleged in Citation 1, Item 1 was not at issue because respondent had previously admitted a violation of the cited standard and paid the proposed penalty. That Citation item related to respondent's failure to have energy control procedures which did not clearly and specifically outline the scope, purpose, authorization, rules and techniques to be utilized for the control of hazardous energy.

After hearing and receiving the evidence and hearing the arguments of counsel, the undersigned makes the following:

FINDINGS OF FACT

1. The complainant as Commissioner of Labor of the State of North Carolina is charged with responsibility for and compliance with the Occupational Safety and Health Act of North Carolina (the "Act").

2. The respondent is a corporation engaged in the business of manufacturing commercial pipe, with its headquarters in Charlotte, North Carolina. It employs 1500 employees overall and 512 employees at the inspection site of 1335 South Clarkson Street, Charlotte, North Carolina.

3. From February 25, 2003 to March 10, 2003, Mark Earles, a health compliance officer with the complainant, conducted a purported fatality inspection at respondent's South Clarkson Street facility. This inspection was conducted as a result of notification by respondent to complainant that one of respondent's employees, Brian Guthrie, had been injured at the respondent's facility and subsequently died.

4. The respondent's South Clarkson Street facility is a metal foundry, making metal and plastic pipe and fittings. The inspection conducted by Mr. Earles was limited to the "hot dip" pipe department.

5. Mr. Earles conducted an opening conference with Eddie Kennedy, the respondent's safety director. In the course of his inspection, he interviewed respondent's employees Rex Morton, Leon Morrison, Jeff McCorkle and Curtis Hagler.

6. From these employee interviews, Mr. Earles learned that Mr. Morton was a utility man helping Mr. Guthrie doing maintenance work on a leaking hydraulic line on a scissor lift/bundling table.

7. This scissor lift was manufactured by American Lifts. It was used to facilitate packaging or bundling multiple pipes after completion of the manufacturing process. The table could be raised or lowered to accommodate different sized pipes and bundles.

8. The scissor lift has three different types of energy: the electric energy which would operate the hydraulic pump; hydraulic energy which would push the table up and down when it was being operated and hold it in position; and gravitational energy which occurred when the table was in a raised position and the hydraulic pressure keeping the table up was released.

9. Mr. Guthrie was a maintenance man with the respondent in the hot dip department. His responsibilities included maintaining and repairing the scissor lift/bundling table.

10. On the occasion of his injury, Mr. Guthrie was working on this table, attempting to repair one of the hydraulic lines on the piece of equipment. At the time of the repair, the lift table was raised and Mr. Guthrie was working beneath it.

11. When Mr. Guthrie loosened the connections on the hydraulic line, the line blew off, releasing the hydraulic pressure and causing the raised table to fall to the base of the machine, striking Mr. Guthrie in the back and pinning him underneath it.

12. Because of the weight of the table, it took four men (those interviewed by Mr. Earles indicated above) to manually lift the table off Mr. Guthrie.

13. Mr. Guthrie finished his shift and minimized his injuries when asked about it. He later went to the hospital for his injuries. Prior to his death he told his supervisor that he made a mistake that caused the table to fall on him, but he was not specific as to what was his mistake. The undersigned specifically finds that this generalized admission of error does not evidence deliberate disregard of training or workplace rules. However, his death was apparently due to a drug overdose and not as a direct result of his injuries from the scissor lift/bundling table.

14. Mr. Guthrie locked out and tagged out the electric energy for the scissor lift by turning off the main switch and putting his lock on it. He did not lock out and tag out the gravitational energy by placing a block under the raised table, chaining it up or engaging the safety latches on the machine.

15. There is no evidence that Mr. Guthrie knew about the safety latches on the machine or that he had been trained in their use.

16. Mr. Earles requested of the respondent its written safety procedure for the scissor lift/bundling table and the training provided to Mr. Guthrie. The respondent provided these records to Mr. Earles. Mr. Earles did not request training records as to other employees. These records showed no specific training on safety procedures as to the scissor lift table and particularly no training or safety procedure for neutralizing the gravitational or hydraulic energy of the scissor lift table. However, there was considerable evidence of written safety rules and procedures and training of respondent's employees generally.

17. The applicable standards do not require the safety procedure and training records to be specific as to each piece of equipment, but the standards do require that the safety procedures and training be specific as to each type of energy.

18. The failure to lock out the gravitational energy created the possibility of an accident the substantially probable result of which would be crushing injury or death.

19. The proposed penalties were calculated pursuant to the directives of the complainant's Field Operations Manual.

20. Exhibit No. 6 introduced by complainant showed a write-up of this incident, termed a "Corrective Action Report". It indicates a violation of safety regulations by not "properly" locking out equipment. It states that employee (Mr. Guthrie) was "told over and over again" about properly locking out equipment. Mr. Guthrie's supervisor, Robert Scott, testified "told over and over" meant "trained over and over", but the undersigned specifically finds that training involves more than just being told and that this phraseology connotes repeated admonitions to Mr. Guthrie about following proper procedures. Moreover this exhibit also states "The nature of this close call will result in disciplinary action", but there is no evidence of disciplinary action.

Based on the foregoing Findings of Fact, the undersigned makes the following:

CONCLUSIONS OF LAW

1. The foregoing Findings of Fact are incorporated by reference as Conclusions of Law to the extent necessary to give effect to the provisions of this Order.

2. The respondent is subject to the provisions of the Act.

3. The complainant did not prove by the greater weight of the evidence that Mr. Guthrie was not trained in the recognition of hazardous energy sources.

4. The complainant did not prove by the greater weight of the evidence that all energy isolating devices were not physically located and operated.

5. The complainant proved by the greater weight of the evidence that all potentially hazardous stored or residual energy was not relieved, disconnected, restrained or otherwise rendered safe.

6. The respondent failed to prove by the greater weight of the evidence the affirmative defense of isolated instance of employee misconduct.

7. The complainant has failed to prove by the greater weight of the evidence that Mr. Guthrie did not verify the isolation and deenergzation of the scissor lift/bundling table.

Based on the foregoing Findings of Fact and Conclusions of Law, IT IS ORDERED as follows:

1. Citation 1, Item 2 is dismissed.

2. Citation 1, Item 3a is dismissed.

3. Citation 1, Item 3b, is affirmed as serious violation of 29 CFR 1910.147 (d)(5)(i) with a penalty grouped of $1,750.00.

4. Citation 1, Item 3c is dismissed.

5. The penalty shall be paid within twenty (20) days of the date of this Order.

6. All violations not previously abated shall be immediately abated.

This 31st day of May, 2004.

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RICHARD M. KOCH
HEARING EXAMINER