BEFORE THE NORTH CAROLINA OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
RALEIGH, NORTH CAROLINA

COMMISSIONER OF LABOR OF THE STATE OF NORTH CAROLINA **COMPLAINANT,** **v.** **INDUSTRIAL FABRICATORS, INC., and its successors** **RESPONDENT.**	**ORDER** **OSHANC NO. 2019-6207** **INSPECTION NO. 318171709** **CSHO ID: F5158**

THIS MATTER was before the undersigned for hearing via the Lifesize video conference platform on May 12, 2022.

The complainant was represented by Stacey A. Phipps, Assistant Attorney General; the respondent was represented by Gerald L. Liska of Mullen Holland & Cooper, PA.

Based on the evidence, consisting of testimony and admitted documents, and the post-hearing briefs of counsel, the undersigned makes the following

FINDINGS OF FACTS

1. The complainant as the Commissioner of Labor is charged by law with compliance with and enforcement of the provisions of the Occupational Safety and Health Act of North Carolina ("the Act").

2. The respondent is a North Carolina corporation which is authorized to do business in North Carolina. The respondent is a manufacturer of metal parts and provides assembly and coating services.

3. The respondent operates nine different plant locations in North Carolina and has approximately 500 employees.

4. This matter involved an inspection at the respondent's Main plant as a result of an employee partial finger amputation, which occurred on June 27, 2019. The accident was reported on July 1, 2019. This plant is located at 4328 South York Highway, Gastonia, North Carolina. The inspection by the complainant's safety and health compliance officer, George Calvery, occurred from July 2, 2019 to July 17, 2019.

5. The site of the accident was an area of the plant referred to as the press brake department, which contains ten CNC controlled press brakes. The accident occurred on a Trumpf V320 hydraulic press brake.

6. The injured employee was Juan Daniel Guzman, who was working as a temporary to permanent employee, provide by Employment Staffing Group, Inc. dba Talent Force.

7. The process involved in the accident was to take a finished flat metal piece/blank and bend it 90 degrees in the press brake. The operator stands in front of the press brake, picks up a blank part, places it on the die, and holds it in the die with both hands. While holding the part against the backgauge, the operator steps on the foot pedal control, and the press brake cycles down and puts a 90-degree bend into the part. The finished formed part is then stacked on a pallet or placed into a wire basket for further processing or shipment.

8. This inspection was only of five of the press brakes, as they were the only ones in plain view of Mr. Calvery and being operated at the time of the inspection. The employees operating the press brakes were responsible for changing dies and are considered affected employees. The employee operators changing dies used the alternate lockout procedures, which allow them to activate the emergency up button to unclamp the dies. Power cannot be removed from the press, as the hydraulic clamping system requires power to the hydraulic pump to clamp and unclamp dies.

9. Following the inspection of a fatal accident at this facility on May 14, 2015 (case file 317988012), the employer entered into a formal settlement agreement with complainant that was signed on September 29, 2016. The employer agreed to eleven specific stipulations with assigned completion dates. During this current inspection on July 2, 2019 Mr. Calvery determined that the employer had not complied with the following stipulations:

f) "Respondent will require qualified personnel to conduct hazard analysis of all operations and document hazard controls for identified hazards." No documentation was available to document that a hazard analysis had been completed. Employees interviewed were not aware of a hazard analysis being conducted.

g) "Ensure that all machine guarding is in place and effective at all North Carolina locations within 3 months." This accident occurred on a press brake machine that was not equipped with a light curtain or other protective measure to prevent the employee from contacting the point of operation or moving parts of the press. Additionally, Mr. Calvery noted that the light curtains on numerous other press brake machines had been disabled, were not functioning, and no other measure had been taken to prevent employees from contacting the point of operation or moving parts of the presses.

h) "Review and up-date all LOTO produces, to include machine specific, for controlling all energy sources within a 3-month period." During this inspection the LOTO procedures presented to Mr. Calvery for review were not equipment specific.

10. Mr. Guzman was employed by respondent as second shift press brake operator. He was hired by respondent through Talent Force on May 14, 2019. He was holding the steel blank against the backguage of the die, using his left hand, when the blank slipped. This caused an amputation of his left index finger down to the first joint. The bottom die was 1.75 inches wide, and the part he was holding was only 2.3 inches wide.

11. Mr. Guzman told Mr. Calvery that he was instructed on how to hold the part in the press brake, which was how he was holding it. This caused his hands to be inside the safe stopping distance of the machine. He was hired as a press brake operator, even though he had no experience operating a press brake. At the time of the accident, Mr. Guzman had worked 5 and ½ hours that day on the press brake and had made 450 parts. His supervisor never commented on how he was holding the parts, only the number of parts he was making. The laser safety device to protect the operator's hands had been removed from the press and the two-hand control which would also protect the operator's hands on this press did not work.

12. During the inspection, Mr. Calvery learned that the laser safety devise installed on the presses at the time they were assembled had been disabled on this and most of the other presses in the facility and no alternative protected measures had been installed on the presses to protect the operator from contact with the point of operation. Mr. Calvery confirmed that there was no point of operation guarding on press brake numbers 11, 12, 13, 14 and 15. During the inspection, Mr. Calvery observed employees using press brake numbers 11, 13, 14 and 15. Mr. Guzman was injured on press brake number 12.

13. In the manual for the Trumpf press brake it states, "Neither the owner or the operator is permitted to dismantle or shut down any safety equipment." From interviews with employees, Mr. Calvery learned that the safety devices on the press brake had been disabled by the respondent approximately 5 years before this accident. The respondent knowingly allowed the employees to operate the presses without guards and even instructed the operators in a certain way to stick their hands in the point of operation that would supposedly reduce the risk of injury, which did not work given the number of amputations occurring on respondent's equipment.

14. Per Field Operation Manual Chapter IV, paragraph F.3., a willful violation exists under the Act where the evidence shows either an intentional violation of the Act or plain indifference to its requirements. It further explains that an employer has committed an intentional and knowing violation if an employer representative was aware of the requirements of the Act, or the existence of the applicable standard or regulation, and was also aware of a condition or practice in violation of those requirements. In this case, the employer committed an intentional and knowing violation of the standard by removing/disabling the laser safety devices from the brake presses and did not implement an alternative method to protect operators from contact with the point of operation of the press brakes.

15. During the inspection, Mr. Calvery saw employee Kevin Allison operating press brake number 13 while wearing regular prescription glasses. Mr. Calvery inspected the glasses and determined they were not safety glasses.

16. Mr. Calvery determined that the respondent did not conduct a periodic inspection of the energy control procedure at least annually by interviewing the safety manager and the maintenance supervisor.

17. Affected employees such as press brake operators did not receive training on the purpose and use of energy control procedures for press brake. Only the maintenance employees received such training from respondent.

18. The respondent did not raise the affirmative defense of isolated instance of employee misconduct in its responses in this case.

19. All penalties were computed in accordance with the North Carolina Field Operations Manual.

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

CONCLUSIONS OF LAW

1. The foregoing Findings of Fact are incorporated 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 respondent violated the provisions of 29 CFR 1910.212(a)(3)(ii), as alleged in Citation No. 1, Item 1, and such violations were willful serious violations of the standard.

4. The respondent violated the provisions of 29 CFR 1910.133(a)(3), as alleged in Citation No. 2, Item 1, and such violation was a serious violation of the standard.

5. The respondent violated the provisions of 29 CFR 1910.147(c)(6)(i), as alleged in Citation No. 2, Item 2, and such violation was a serious violation of the standard.

6. The respondent violated the provisions of 29 CFR 1910.147(c)(7)(i)(B), as alleged in Citation No. 2, Item 3, and such violation was a serious violation of the standard.

Based on the forgoing Findings of Fact and Conclusion of Law, IT IS ORDERED, ADJUDGED AND DECREED as follows:

1. The respondent has violated the provisions of 29 CFR 1910.212(a)(3)(ii), which violation is affirmed as a willful serious violation of the standard, with a penalty of $70,000.00.

2. The respondent has violated the provisions of 29 CFR 1910.133(a)(3), which violation is affirmed as a serious violation of the standard, with a penalty of $1,200.00.

3. The respondent has violated the provisions of 29 CFR 1910.147(c)(6)(i), which violation is affirmed as a serious violation of the standard, with a penalty of $6,300.00.

4. The respondent has violated the provisions of 29 CFR 1910.147(c)(7)(i)(B), which violation is affirmed as a serious violation of the standard, with a penalty of $7,000.00.

5. The respondent shall pay the total penalties of $84,500.00 within ten (10) days of the filing date of this Order.

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

This 25th day of August, 2022.

Richard M. Koch

RICHARD M. KOCH
HEARING EXAMINER

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I have this date served a copy of the foregoing ORDER upon:

GERALD L. LISKA
MULLEN HOLLAND & COOPER
PO BOX 488
GASTONIA, NC 28053

By depositing same in the United States Mail, Certified Mail, Return Receipt Requested, postage prepaid at Raleigh, North Carolina, and upon:

STACEY A. PHIPPS
NC DEPARTMENT OF JUSTICE
LABOR SECTION
PO BOX 629
RALEIGH, NC 27602-0629

By depositing a copy of the same in the United States Mail, first class, postage prepaid at Raleigh, North Carolina, and upon:

NC DEPARTMENT OF LABOR
LEGAL AFFAIRS DIVISION
1101 MAIL SERVICE CENTER
RALEIGH, NC 27699-1101

via email to carla.rose@labor.nc.gov.

THIS THE 26 DAY OF August 2022.

Karissa B. Sluss

Karissa B. Sluss
Docket and Office Administrator
NC Occupational Safety & Health Review Commission
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