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

COMMISSIONER OF LABOR FOR THE STATE OF NORTH CAROLINA,	)	**DOCKET NO.: 2023-6599**
	)	**INSPECTION NO.: 318262284**
	)	**CSHO ID: C4570**
Complainant	)	
	)	
v.	)	**ORDER**
	)	FILED
EGGER WOOD PRODUCTS, LLC, and its successors	)	JUN 8 2026
	)	
Respondent	)	NC OSH Review Commission
	)	

THIS MATTER was before the undersigned for hearing via the Lifesize video conference platform on March 13, 2025, beginning at 10:00 am.

Complainant was represented by Monique D. Nketah, Esq., Assistant Attorney General, North Carolina Department of Justice; and the Respondent was represented by John J. Doyle, Jr., Esq. of Constangy, Brooks, Smith, & Prophett, LLP.

This matter involves the tragic death of Alex Baker, who was a husband, a father, a son, a brother, a friend, and, as is legally relevant here, an employee of Respondent. Neither party hereto, nor the undersigned, seeks in any way to diminish the terrible impact of Mr. Baker's death on his family and friends by virtue of the proceedings in this matter.

Based on the evidence received at the hearing on the merits of this citation, which consists of extensive testimony, videos, and a variety of documents all of which were admitted into evidence, and after considering the post-hearing briefs of the parties and the legal arguments contained therein, the undersigned makes the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACTS

1. Complainant is the Commissioner of Labor of the State of North Carolina ("Complainant" or the "Commissioner") and is charged by law with the administration of, compliance with, and enforcement of the provisions of the Occupational Safety and Health Act of North Carolina, N.C. Gen. Stat. § 95-133 et seq. (the "Act").

2. Complainant's statutory responsibilities include, among other things, making inspections and issuing citations under the provisions of the Act, as well as bringing enforcement proceedings such as the instant action.

3. Respondent Egger Wood Products, LLC ("Respondent") is a Delaware Limited Liability Company that is authorized to conduct business in North Carolina. Respondent maintains a place of business and manufacturing plant in Linwood, North Carolina.

4. Respondent is in the business of manufacturing wood products such as particle board and thermally fused laminated boards used in the furniture, flooring, and interior design industries.

5. Respondent is an "employer" within the meaning of N.C.G.S. § 95-127(11) and all of Respondent's employees referred to in the Complaint in this matter are "employees" within the meaning of N.C.G.S. § 95-127(10).

6. During the period between March 23, 2023, and September 19, 2023, Compliance Safety and Health Officer ("CSHO") Sam Atassi, employed by the North Carolina Department of Labor, inspected Respondent's worksite located at 300 Egger Parkway, Linwood, North Carolina (the "Site" or the "Facility").

7. Officer Atassi properly entered onto Respondent's Site and properly conducted the inspection pursuant to a fatality report.

8. Wesley Adkins (Respondent's Health and Safety Manager) granted permission for the Compliance Officer to conduct the inspection.

9. Officer Atassi testified that Respondent cooperated fully with his investigation and provided all the information he sought.

10. In the course of his inspection, Officer Atassi interviewed a number of witnesses.

11. For some – but not all – of these witness interviews, Officer Atassi hand-wrote "witness statements" that he then had the witnesses sign.

12. Officer Atassi later produced typed versions of these statements. The witnesses never saw and did not sign the typed versions.

13. Officer Atassi did not write or otherwise obtain witness statements from Mr. Atkins or the relevant supervisor, Jose Maria, despite the fact that he interviewed both of them.

14. Based on Officer Atassi's investigation, a citation was issued on September 21, 2023, alleging in Citation Number One Item 001 a Serious violation of 29 C.F.R. § 1910.47(c)(4)(i), in that:

> **a) facility, building 118, Tech Logistics, Schelling Saw FH6 - where employees required to perform service and/or maintenance activities such as unjamming equipment did not utilize energy control procedures. On or about March 23, 2023, an employee was fatally injured while attempting to unjam the Schelling saw when the pneumatically controlled pressure bar unexpectedly engaged, pinning the employee between the machine and the bar.**

15. For the alleged violation, the Complainant calculated the proposed penalties and proposed abatement dates according to the procedures set forth in the Complainant's North Carolina Operations Manual.

16. The gravity-based penalty was calculated as $15,625.00.

17. Respondent did not contest the hazard, the exposure, the substantial probability of an accident that could and did occur, or the penalty.

18. Complainant did not contest that Respondent had a detailed and legally compliant safety program that included training on, among other things, mandatory lock-out/tag-out ("LOTO") procedures.

19. The facility contains heavy machinery, including a Schelling Saw. The Schelling Saw has a loading side where large wood products are loaded onto the machine, opposite the saw side which cuts the product into smaller pieces.

20. Near the loading side, the Schelling Saw has a 15-foot-long pressure beam that lowers to hold the material in place while the saw cuts it. The Schelling saw uses electric energy, but the pressure beam is powered by pneumatic energy. Aside from the loading side and the cutting side, the Schelling saw is enclosed by a security fence around its perimeter. There also is a side door to permit access onto the machine.

21. It was on and within this Schelling Saw that the fatality occurred.

22. On March 23, 2023, Egger employee Jason Blackwood was operating the Schelling Saw to cut boards for testing in the Company lab. Mr. Blackwood had operated this saw "off and on" for approximately 1.5 years, although he was not assigned as a Schelling Saw Operator at the time of the accident.

23. At the time of the accident, Mr. Blackwood worked on the CNC machine, but the CNC machine was down that day so he was running cuts on the Schelling Saw for testing as an alternative to the CNC machine.

24. While Mr. Blackwood was operating the Schelling Saw on March 23, 2023, it malfunctioned in some way. Mr. Blackwood was unable to testify to exactly what the problem was, but described it has having "jumped the track" and, as a result, the pressure beam became stuck in the lower position.

25. Mr. Blackwood was not responsible for maintenance or repairs to the Schelling Saw.

26. He reported the malfunction of the Schelling Saw to Supervisor Maria, who was working in another area of the Facility at the time. Supervisor Maria [not Mr. Blackwood] called Respondent's maintenance department to dispatch maintenance personnel to assess and repair the Schelling Saw.

27. Maintenance dispatched mechanics Toy Brown and Alec Baker to repair the Schelling Saw.

28. The three individuals present at this time (and the time of the accident) were Mr. Blackwood, Mr. Brown, and Mr. Baker.

29. Both Mr. Brown and Mr. Baker had completed LOTO and other safety training as part of their employment with Respondent. Likewise, Mr. Blackwood had been trained on Respondent's mandatory LOTO procedures.

30. While attempting to diagnose the issue with the Schelling Saw, Mr. Baker climbed up on top of the Schelling Saw. He did not follow Respondent's LOTO procedures prior to climbing onto the machine.

31. Various other of Respondent's mechanics whom Officer Attasi interviewed and who signed statements written by Officer Attasi stated that they would never have climbed up onto the Schelling Saw without following the LOTO procedure both as to the electrical energy and pneumatic energy.

32. While on top of the Schelling Saw, Mr. Baker and Mr. Brown instructed Mr. Blackwood to move the pressure bar up and down using the controls so they could observe the beam's movement.

33. As reflected in surveillance video from Respondent's video system, Mr. Baker put his head into the gap between the pressure beam and the steel frame of the saw. While his head was in this gap (with the Schelling Saw fully energized both electrically and pneumatically), the pressure beam suddenly moved up, pinning Mr. Baker's head and neck between the pressure beam and the steel frame. Mr. Baker suffered fatal injuries.

34. There was no dispute that Mr. Baker did not follow LOTO procedures on which he had been trained prior to inserting his head into the gap between the pressure beam and the steel frame of the Schelling Saw.

35. Respondent argues that, based on the evidence of record, Complainant cannot carry its burden of proving that Respondent had actual or constructive knowledge of the condition or conduct that created the safety hazard.

36. In the alternative, Respondent argues that the hazard at issue was the result of unpreventable and/or isolated employee misconduct.

37. Complainant asserts that Respondent had actual or constructive knowledge of the condition or conduct that created the safety hazard at issue because Mr. Blackwood was acting as a supervisor via supervisory authority delegated to him by Respondent (via Supervisor Maria) because Mr. Blackwood was a "Material Flow Administrator" or "MFA," which was a "lead" position and served in a supervisory capacity in the absence of a higher-level supervisor.

38. According to an addendum to the witness statement for Mr. Blackwood, which was written by Officer Attasi and was dated May 12, 2023, Mr. Blackwood told Officer Attasi that he was a "MFA," which was a "lead" position and "makes sure things [were] flowing well."

39. According to Officer Attasi's notes of his telephone interview with Supervisor Maria, which occurred on July 26, 2023 (more than four months after the incident and fatality), Supervisor Maria stated that Mr. Blackwood was a MFA and that the MFA was a "lead" position who could make decisions in the absence of a supervisor. Officer Attasi did not write a written statement for Supervisor Maria to sign following his interview.

40. Officer Attasi's notes also indicated that Mr. Adkins told him that the MFA position was a "lead" position.

41. At the hearing, however, Mr. Blackwood testified that he was not, in fact, a MFA but was merely training to be a MFA. Mr. Blackwood also testified that he never completed the MFA training and never actually became a MFA.

42. Mr. Blackwood's personnel file, which was admitted into evidence at the hearing as Respondent's Exhibit 3, has no references to Mr. Blackwood serving as a MFA and, instead, reflects that he was, at all relevant times, a "Process Operator."

43. Further, at the hearing, Supervisor Maria testified that he had no recollection of stating to Officer Attasi that a MFA could make decisions in the absence of a supervisor. Additionally, Supervisor Maria expressly denied that he ever told Officer Attasi that Mr. Blackwood was a MFA.

44. Mr. Adkins testified at the hearing that he did not recall the MFA position being a "lead" position and did not recall telling Officer Attasi that. He also did not recall telling Officer Attasi that the MFA position was 'one step below' a supervisor.

45. Randel "Randy" Fowler (Area Manager), who was Mr. Blackwood's third-level supervisor, testified at the hearing that the MFA position was **not** a "lead" position and did not have supervisory responsibility. Further, Mr. Fowler testified that Mr. Blackwood had never served as a MFA.

46. Based on all the evidence presented at the hearing, at no time during the events that led to Mr. Baker's death on/in the Schelling Saw was Mr. Blackwood acting as if he was a 'supervisor' of any description. He acted at all times as merely the operator of the Schelling Saw.

47. Mr. Blackwood did not call the Maintenance Department himself when the Schelling Saw malfunctioned; rather, he reported the malfunction to Supervisor Maria, who called the Maintenance Department.

48. Mr. Blackwood did not oversee or supervise the actions of Mr. Brown and Mr. Baker in any way including, without limitation, ensuring they followed LOTO procedures when Mr. Baker physically climbed onto the machine; rather, he followed their instructions to move the pressure beam up and down. As he testified at the hearing, he was not even in a position to see what Mr. Baker was doing.

49. In short, Mr. Blackwell's actions on March 23, 2023, were the actions of a machine operator (or "Process Operator") not a supervisor or 'lead.'

50. Complainant has the burden of proof with reference to Citation Number One – Item 001, including that Respondent had actual or constructive knowledge of the condition or conduct that created the hazard. The weight of the evidence adduced at the hearing did not carry this burden.

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. Respondent is subject to the provisions of the Act.

3. There is insufficient evidence to conclude, by a preponderance of the evidence, that Respondent had actual or constructive knowledge of the condition or conduct that created the hazard that led to the tragic death of Mr. Baker.

4. Complaint has, therefore, failed to carry its burden of proof as to the fifth element of its *prima facie* case.

5. To the extent necessary to give effect to the provisions of this Order, the undersigned agrees with and incorporates by reference as if fully set forth, the "Argument" section of Respondent's Post-Hearing Brief from the beginning of that section on page 14 through the end of subsection B thereof on page 23.

6. It is unnecessary to consider Respondent's asserted affirmative defense of isolated employee misconduct.

BASED ON THE FOREGOING FINDINGS OF FACT AND CONCLUSIONS OF LAW, IT IS ORDERED, ADJUDGED AND DECREED AS FOLLOWS:

1. Citation Number 1 - Item 001, an alleged Serious violation of 29 CFR 1910.147(c)(4)(i) is **DISMISSED**.

2. Each party shall bear its own costs and attorney's fees.

IT IS SO ORDERED, this the 8th day of June, 2026.

Brian S. Clarke, Hearing Examiner
bclarke.ncoshrc@outlook.com

CERTIFICATE OF SERVICE

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

JOHN J DOYLE JR.
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MONIQUE NKETAH
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NC DEPARTMENT OF LABOR
GENERAL COUNSEL'S OFFICE

via email.

THIS THE 8 DAY OF June 2026.

PAUL E. SMITH
CHAIRMAN

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