Secretary of Labor,

Complainant,

v.

Cincinnati, Incorprated,

Respondent.

OSHRC Docket No. 00-0955

APPEARANCES

Rorey Smith, Esq.; Office of the Solicitor; U. S. Department of Labor; Cleveland, Ohio
For Complainant

Michael S. Glassman, Esq.; Dinsmore & Shohl, L.L.P.; Cincinnati, Ohio
For Respondent

Before: Administrative Law Judge Ken S. Welsch

**DECISION AND ORDER**

Cincinnati Incorporated (CI) manufactures metal forming equipment such as brake presses and shears in Harrison, Ohio. As a result of an employee's complaint, the Occupational Safety and Health Administration (OSHA) inspected CI's bypass of the interlock system on a Jones & Lamson lathe.

On April 24, 2000, CI received a serious citation alleging a violation of 29 C.F.R. § 1910.212(a)(1) for permitting operators to partially open the lathe's door to catch and hold parts with a piece of PVC pipe during the cutoff cycle. The citation proposes a penalty of $1,800.

CI timely contested the citation and the case was designated for EZ Trial proceedings, 29 C.F.R. § 2200.200, *et seq*. The hearing was held on July 28, 2000, in Cincinnati, Ohio.

Jurisdiction and coverage are stipulated (Tr. 4-5). The parties filed post-hearing statements of position.

CI argues that the interlock was bypassed to avoid nicking the threads if the bolts were allowed to fall into a tray in the bottom of the lathe. If nicked, CI asserts that the bolts are unusable. To catch/hold the bolts, the operators used a piece of PVC pipe as a sleeve around the bolt. CI argues that the PVC sleeve protected the operators from the lathe's point of operation and rotation hazards.

For the reasons stated, the lathe's operators were in the zone of danger when holding the PVC pipe inside the lathe. The violation is affirmed.

*The Inspection*

CI manufactures large metal forming equipment such as press brakes, shears, and lasers from its plant in Harrison, Ohio. CI employs in excess of 400 hourly employees (Tr. 201-202).

Since 1979, a James & Lamson lathe is used to thread bolts[1] for the metal forming equipment (Tr. 112, 202, 209). The James & Lamson lathe is time sequenced based on a computer program designed for each part. It is a fully automated, bar-fed lathe. The lathe runs through each cycle automatically from positioning the bar stock, cutting the threads, and cutting off the finished bolts based on a computer-designed program. The lathe operator feeds the program into the lathe, observes the lathe's operation and retrieves the finished parts (Exh. JT-1; Tr. 80, 83, 121, 176-178).

For approximately 10 years, the lathe has been operated by Charles Arnold, the day shift operator, and William Torbeck, the night shift operator (Tr. 112, 174, 192). The operators run the lathe at approximately 1,500 rpm (Tr. 41, 89, 194). The bar capacity for the lathe is two inches, outside diameter (Tr. 206, 211).

The operator observes the lathe's operation through a 42-inch wide hood/door with a window (Exh. JT-1; Tr. 187, 213). To prevent the hood/door from being opened during the

[1] In addition to bolts, the lathe also makes washers (Tr. 87).

cycles, the lathe was designed with an interlock that automatically shuts it off if the hood/door is moved[2] (Tr. 34, 212-213, 152).

To prevent certain bolts[3] from falling into a tray and nicking the threads, CI bypassed the lathe's interlock with a piece of string, approximately 10 years prior to OSHA's inspection (Exh. C-1; Tr. 21, 80-81, 102). After bypassing the interlock, the lathe's operator was permitted to slide the door approximately 10 inches and reach inside with one hand to catch and hold the bolts during the lathe's cutoff cycle (Tr. 178). At least two years prior to OSHA's inspection, the operators began using, instead of their hands, a 16-inch piece of PVC pipe to place around the rotating bolt (Exh. JT-1; Tr. 81, 180).

In late February 2000, night shift lathe operator William Torbeck was suspended for three days for an incident at work (Tr. 99). In April, Torbeck filed a complaint with OSHA alleging, among other things, that the interlock on the lathe's hood/door was bypassed to permit the operator to catch bolts with a PVC sleeve during the cutoff cycle (Tr. 64-65, 95).

As a result of the complaint, OSHA safety specialist Barbara Marcum inspected the lathe on April 18, 2000. During her inspection, the lathe was not operating. Marcum did not make any measurements. Based on the inspection, she recommended the citation (Exh. C-1; Tr. 19-20, 46, 56-57).

*Discussion*

The Secretary has the burden of proving a violation.

> In order to establish a violation of an occupational safety or health standard, the Secretary has the burden of proving: (a) the applicability of the cited standard, (b) the employer's noncompliance with the standard's terms, (c) employee access to the violative conditions, and (d) the employer's actual or constructive knowledge of the violation (*i.e.*, the employer either

[2] The door slides open to access the lathe's cutting tool (Exh. JT-1).

[3] The type of bolts caught and held are generally the large bolts, in excess of 1 inch in diameter, 6 inches in length and weigh in excess of 7 pounds. Such bolts accounted for approximately 15% of the lathe's work (Tr. 114, 194-195, 211).

> knew or, with the exercise of reasonable diligence could have known, of the violative conditions).

*Atlantic Battery Co.,* 16 BNA OSHC 2131, 2138 (No. 90-1747, 1994).

CI does not dispute the application of § 1910.212(a)(1) to the Jones & Lamson lathe or that it knew the lathe's operators were catching/holding parts with a PVC sleeve. CI knew that the lathe's interlock system was bypassed. Machining department supervisor Tom Rosfeld testified that he "does not consider the interlock a necessary component of this operation" (Tr. 212).

CI asserts that catching parts during the cutoff cycle with a PVC sleeve did not violate the § 1910.212(a)(1) because there was no hazard to the operator.

Alleged Violation of § 1910.212(a)(1)

The citation alleges that CI bypassed the lathe's interlock to permit the operator to open the door in order to hold/catch parts with a PVC sleeve during the cutoff cycle. Section 1910.212(a)(1) provides:

> One or more methods of machine guarding shall be provided to protect the operator and other employees in the machine area from hazards such as those created by point of operation, ingoing nip points, rotating parts, flying chips and sparks. Examples of guarding methods are--barrier guards, two-hand tripping devices, electronic safety devices, etc.

Section 1910.212(a)(1) is a general machine guarding standard that applies to all machinery not otherwise covered by Supart O. The guarding required must be provided by a "device" that does not allow reliance upon the skill or attentiveness of employees. It is "intended to eliminate danger from unsafe operating procedures, poor training or employee inadvertence." *American Luggage Works, Inc.*, 10 BNA OSHC 1678, 1682 (No. 77-893, 1982).

Section 1910.212(a)(3)(ii) requires that the guarding device be "designed and constructed to prevent the operator from having any part of his body in the danger zone during the operating cycle." Also, § 1910.212(a)(3)(iii) discusses the use of special hand tools for placing and

removing material "without the operator placing a hand in the danger zone." However, the standard specifically provides that "[s]uch tools shall not be in lieu of other guarding required by this section, but can only be used to supplement protection provided."

The lathe's hood/door was designed as a guard to prevent an operator from accessing the lathe's point of operation, rotating parts, or being injured from flying chips and sparks during the threading or cutoff cycles. A window in the door allows the operator to observe the lathe's operations without injury (Exh. C-1). The lathe's manufacturer designed the hood/door with an interlock which automatically shut the lathe off if it is moved.

However, CI bypassed the interlock system and negated the manufacturer's safety feature. Machine Department supervisor Tom Rosfeld recognized the importance of the door. He stated that it was "there to keep coolant and chips off the operator" (Tr. 212).

CI is correct that § 1910.212(a)(1) does not require an interlock (Tr. 62, 153). Although the interlock was bypassed, CI argues that operator was not exposed to a hazard because he used a 16-inch long piece of PVC pipe as a sleeve to keep away from the zone of danger during the cutoff cycle. There is no evidence that the door was opened during any other cycle except the cutoff cycle.

The test for determining an employee's exposure to a hazard is whether it is reasonably predictable that the employee would be in the zone of danger created by a noncomplying condition. *Kokosing Constr. Co., Inc.,* 17 BNA OSHC 1869, 1870 (No. 92-2596, 1996). Is it reasonably predictable, either by operational necessity or otherwise (including inadvertence) that the employee has been or will be in the zone of danger? The inquiry is not whether the exposure is theoretically possible. *Fabricated Metal Products, Inc.,* 18 BNA OSHC 1072, 1074 (No. 93-1853, 1997). Even a brief exposure to some hazardous condition does not negate a violation or its seriousness. *Flint Engineering & Construction Co.,* 15 BNA OSHC 2052, 2056 (No. 90-2873, 1992). The zone of danger is determined by the hazard presented and is normally that area surrounding the violative condition. *RGM Construction Co.,* 17 BNA OSHC 1229, 1234 (No. 91-2107, 1995).

Day shift lathe operator Charles Arnold testified that to catch a rotating bolt during the lathe's cutoff cycle, the hood/door is moved approximately 10 inches to the left (Tr. 178). He

then reaches inside the opening with a 16-inch long piece of PVC pipe and holds it around the rotating bolt. The newly threaded bolt is rotating inside the PVC pipe during the cutoff cycle. With his right hand toward the end of the pipe, Arnold testified that his hand is approximately 18 inches from the lathe's cutting blade, point of operation (Tr. 181). Also, his hand is less than 8 inches from a turret which is stationary during the cutoff cycle (Tr. 189, 210-211). Arnold testified that in ten years of operating the lathe, he has never been hurt by any rotating parts or burned by flying chips. He stated that the chips are too heavy and fall to the bottom of the lathe (Tr. 184, 195-196). He did not believe that catching parts was unsafe; "[i]f I did, I wouldn't do it" (Tr. 185).

Machining department supervisor Tom Rosfeld testified that he was not aware of "anyone ever being injured in connection with catching parts with the PVC sleeve. Not aware of any safety complaints to the Company about catching parts in the PVC sleeve" (Tr. 203). He did not consider it to be unsafe (Tr. 205). Rosfeld is Arnold's supervisor (Tr. 209).

Night shift lathe operator William Torbeck, on the other hand, who has operated the lathe for 12 years, testified that he has been injured while catching parts with the PVC sleeve. A year ago, he bruised his knuckles against the casting of the lathe when the bolt began whipping around as it was almost cut off. He has to get the sleeve on fast for a heavy bolt and hold it with enough pressure to prevent the bolt from whipping around when cut (Tr. 79, 82, 88, 90, 103). Torbeck also testified that he has been repeatedly burned on the hand/arm by flying chips (Tr. 83, 108). He has not been cut by the chips (Tr. 106). Torbeck's complaint initiated the OSHA inspection (Tr. 19).

CI argues that Torbeck's testimony should be discounted. CI asserts that Torbeck's complaint to OSHA and his testimony at hearing was motivated by his three-day suspension and ongoing grievance against CI and not because of a safety concern. CI notes that Torbeck had operated the lathe for at least two years using the PVC pipe without filing a complaint with his union or CI (Tr. 100-101). He had also not filed any accident reports, sought medical attention or refused to operate the lathe because of any safety concern (Tr. 108-109).

Having observed his demeanor, the court finds Torbeck's testimony credible. The reason why Torbeck came forward and complained to OSHA was not shown to affect his credibility.

The fact that Torbeck has been burned by flying chips and bruised by the whipping action of the rotating part is not inconsistent with Arnold's testimony. Torbeck's injuries may have resulted from his inattentiveness, the position of his hand on the pipe, or just bad luck. Reasonable predictability includes an operator's inadvertence that he will be in the zone of danger. *Fabricated Metal Products, Inc.,* 18 BNA OSHC at 1074. "Whether the point of operation exposes an employee to injury must be determined based on the manner in which the machine functions and how it is operated by the employees." *Rockwell Intl. Corp.*, 9 BNA OSHC 1092, 1097-1098 (No. 12470, 1980).

Torbeck's testimony establishes exposure to a hazard. It is noted that Torbeck's night supervisor, to whom he had complained, was not called by CI as a witness (Tr. 90-91, 94). Rosfeld is Arnold's day supervisor (Tr. 209).

The record supports that an employee holding a piece of pipe is exposed to the rotating bolt while being cut and flying chips. The pipe was not a guard. It merely kept the operator's hand some distance from the point of operation if held properly and his hand did not slip. There was no protection for the employee's hand from rotating parts or flying chips. Arnold did not wear gloves (Tr. 196). Torbeck's testimony establishes that operators were within the zone of danger when holding a PVC pipe inside the lathe after bypassing the interlock.

Also, of concern in establishing an employee's exposure, is the fact that the lathe is time sequenced and automatically moves from cycle to cycle. The operator has to remove the PVC pipe immediately after the part is cut off because it takes less than 10 seconds for the program tape to rewind and the next cycle to start. It takes approximately 25 seconds for the lathe to perform the cutoff cycle (Tr. 126, 183). Although there is no evidence that it has occurred during production, the operator may be harmed if he fails to retrieve the part before the lathe automatically recycles. To ascertain when the cutoff cycle begins, operators depend on their experience and the sound of the lathe (Tr. 122, 178). Additionally, the lathe has in the past not operated as expected (Tr. 84). Torbeck described how the cutting tool went through bar stock too fast.

The violation is affirmed.

Serious Classification

The violation of §1910.212(a)(1) is properly classified as serious. In determining whether a violation is serious, § 17(k) of the Occupational Safety and Health Act requires a showing that there is a substantial probability of death or serious physical harm from the condition and the employer knew or should have known with an exercise of reasonable diligence of the presence of the violation. "The issue is not whether an accident is likely to occur; it is rather, whether the result would likely be death or serious harm if an accident should occur." *Whiting-Turner Contracting Co.,* 13 BNA OSHC 2155, 2157 (No. 87-1238, 1989).

CI knew that the lathe's interlock was bypassed and operators were reaching inside to catch parts with a PVC pipe during the cutoff cycle. The lathe's operators were in the zone of danger. The result of an accident was likely to be serious harm, such as bruises and burns from rotating parts and flying chips.

Penalty Consideration

The Commission is the final arbiter of penalties in all contested cases. In determining an appropriate penalty, the Commission is required to consider the size of the employer's business, history of previous violations, the employer's good faith, and the gravity of the violation. Gravity is the principal factor to be considered.

CI is a large employer with in excess of 400 hourly employees. Two operators work on the lathe. CI has not received a serious citation within the previous three years (Tr. 54, 202). There is no evidence that CI was uncooperative. After the inspection, CI stopped bypassing the lathe's interlock and catching parts in the PVC sleeve. The parts now fall into the pan. Although Arnold testified that one-third of the bolts are unusable because of nicks, there is no showing that CI is using the special trays lined with neoprene recommended by the manufacturer (Tr. 55-56, 190-191).

A penalty of $1,000 is reasonable for violation of §1910.212(a)(1). Two operators were exposed. The possible injury is burns from chips or bruised knuckles. CI's accident records do not show any recordable accidents during the cutoff cycle (Tr. 47).

## FINDINGS OF FACT AND CONCLUSIONS OF LAW

The foregoing decision constitutes the findings of fact and conclusions of law in accordance with Rule 52(a) of the Federal Rules of Civil Procedure.

## ORDER

Based upon the foregoing decision, it is ORDERED that:

Item 1, alleged violation of § 1910.212(a)(1), is affirmed and a penalty of $1,000 is assessed.

/s/
KEN S. WELSCH
Judge

Date: August 25, 2000