United States of America
**OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION**
1924 Building - Room 2R90, 100 Alabama Street, SW
Atlanta, Georgia 30303-3104

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| Secretary of Labor,<br>Complainant,<br>v.<br>Gate Concrete Products Co.,<br>Respondent. | OSHRC Docket No. **05-1505** |

Appearances:

Channah S. Broyde, Esq., U. S. Department of Labor, Office of the Solicitor, Atlanta, Georgia
For Complainant

J. Larry Stine, Esq., Wimberly, Lawson, Steckel, Weathersby & Schneider, P.C., Atlanta, Georgia
For Respondent

Before: Administrative Law Judge Ken S. Welsch

## DECISION AND ORDER

Gate Concrete Products Co. manufactures hollow core precast concrete products at a large open area plant located in Jacksonville, Florida. On April 18, 2005, Gate employee Reginald Brown reached his left hand into the unguarded engine compartment of a stalled gantry crane in an attempt to adjust the belts. At the same time, Gate maintenance supervisor Frank Lowery pushed the crane's start button, activating the engine and resulting in the amputation of two of Brown's fingers.

Occupational Safety and Health Administration (OSHA) compliance officer David Folk conducted an investigation of the incident on April 22, 2005. As a result of Folk's investigation, the Secretary issued a four-item serious citation to Gate on August 22, 2005, assessing penalties totaling $7,650.00. Gate contested the citation and penalties. The Review Commission designated this case for Simplified Proceedings under 29 C.F.R. § 2200.200.

The court held a hearing in this matter on December 8, 2005, in Jacksonville, Florida. Gate conceded jurisdiction and coverage. At the beginning of the hearing, the parties announced

settlement of items 1 and 3. The court approves the settlement agreement and adopts it as part of this decision and order.[1]

Items 2 and 4 remain in dispute. Item 2 alleges a serious violation of § 1910.212(a)(1), or, in the alternative, of § 1910.179(e)(6)(1), for exposing employees to hazards created by unguarded rotating parts of the crane engine. Item 4 alleges a serious violation of § 1910.179(e)(6)(i) for failing to guard sprocket and chain pinch points on two gantry cranes.

The parties have filed post-hearing briefs. Gate denies the allegations. Gate asserts the affirmative defense of unpreventable employee misconduct with regard to item 2. Gate asserts the standard cited in item 4 is inapplicable because a more specific standard applies to the cited conditions.

For the reasons discussed below, items 2 and 4 are vacated.

**Factual Background**

Gate uses a number of cranes, including several gantry cranes, to move large precast concrete sections throughout its plant. Reginald Brown operated a gantry crane identified as Mi-Jack 650C/0767, with a capacity to lift 60 tons.[2]

Gate's day shift started at 7:00 a.m., with a morning meeting during which the employees received their assignments. The mechanics arrived an hour earlier, at 6:00 a.m., to start up the various cranes and to check the oil and other fluid levels (Tr. 79).

On Monday, April 18, 2005, mechanic Duane Godron noted the door to the engine compartment of Brown's 650C crane was missing. He made a mental note to tell maintenance supervisor Frank Lowery about it later that morning (Tr. 206, 214). Brown arrived to begin his shift operating the 650C crane. Brown checked his crane over and noticed one of its tires was low and the engine did not sound right. Brown informed supervisor Christopher Baxter and foreman

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[1] Item 1 alleged a serious violation of § 1910.23(c)(1). The Secretary agreed to amend item 1 to allege a violation of § 5(a)(1). Gate agreed to pay the assessed penalty of $ 1,700.00. Item 3 alleged a serious violation of § 1910.79(c)(2). The Secretary agreed to amend the classification of the item from serious to "other" than serious, and assess no penalty.

[2] At the beginning of the hearing, the parties agreed to amend the citation description of the two gantry cranes at issue. Item 2 and instance (a) of item 4 originally referred to Brown's crane as "Gantry Crane No. 4." Brown's crane is now identified as Gantry Crane Mi-Jack Model 650C/0767. Instance (b) of item 4 originally identified the crane at issue as "Gantry Crane #5." This crane is now identified as "Gantry Crane Mi-Jack Model 1000AI/4034."

Sherman Hart of these problems. Baxter instructed Brown to take the crane out of service and drive it to the maintenance shop. Brown drove the crane for a few feet when it stalled. Brown went to maintenance supervisor Frank Lowery's office and told him about the problems with the crane. Lowery went with Brown back to the crane to see if he could get it started.

When Lowery saw the crane, he noticed the engine compartment door was missing. Lowery climbed up into the cab to see if he could start the engine. He determined there was a blown fuse in the ignition. Lowery left the crane and went back to his office to retrieve a fuse and a tester. Before he left, Lowery saw Brown standing by one of the crane's front tires, about 50 feet away from the crane's cab (Tr. 270, 279-280). When Lowery returned to the crane he did not see Brown. Lowery climbed back into the cab and replaced the fuse. He cranked the engine a few times. Before he did so, Lowery did not post any signs on the crane warning employees to stay away from the unguarded engine compartment. Before he cranked the engine he did not call out, "All clear," or give any other verbal indication that he was starting the engine.

While Lowery was cranking the engine, Brown was standing approximately 4 feet from the engine compartment. As the engine cranked, Brown noticed the engine belt "do an awkward wobble rotation" (Tr. 159). When the engine stopped, Brown reached into the engine to adjust the belt. As he did so, Lowery started the engine. The rotating parts of the engine amputated two of Brown's fingers and severely injured his left shoulder. At the time of the hearing, Brown had been unable to return to work (Tr. 159, 170).

Compliance officer Folk arrived at Gate's facility on April 21, 2005. The company denied Folk entry until its lawyer could arrive. Folk left and came back the next day. Gate did not allow Folk to conduct a walkaround inspection. Instead, Folk was taken to the break-room, where he could look out the window and observe the cranes being driven by him. As a result of this limited investigation, the Secretary issued the citation that gave rise to this proceeding.

## The Citation

The Secretary alleges Gate committed serious violations of the cited standards.

> To prove a violation of an OSHA standard, the Secretary must show by a preponderance of the evidence that (1) the cited standard applies, (2) there was noncompliance with its terms, (3) employees had access to the violative conditions, and (4) the cited employer had actual or constructive knowledge of those conditions.

*Southwestern Bell Telephone Co.,* 19 BNA OSHC 1097, 1098 (No. 98-1748, 2000).

## Item 2: Alleged Serious Violation of § 1910.212(a)(1) or, in the Alternative, of § 1910.179(e)(6)(i)

The alternative standards cited by the Secretary in item 2 are:

Section 1910.212(a)(1):

> 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 1910.179(e)(6)(i):

> Exposed moving parts such as gears, set screws, projecting keys, chains, chain sprockets, and reciprocating components which might constitute a hazard under normal operating conditions shall be guarded.

### Applicability of § 1910.179(e)(6)(i)

Section 1910.5(c)(1) provides:

> If a particular standard is specifically applicable to a condition, practice, means, method, operation, or process, it shall prevail over any different general standard which might otherwise be applicable to the same condition, practice, means, method, operation, or process. For example, § 1915.23(c)(3) of this title prescribes personal protective equipment for certain ship repairmen working in specified areas. Such a standard shall apply and shall not be deemed modified nor superseded by any different general standard whose provisions might otherwise be applicable, to the ship repairmen working in the areas specified in § 1915.23(c)(3).

Of the standards cited in the alternative for this item, § 1910.179 ("Overhead and gantry cranes") is more specific to the cited condition than § 1910.212 ("General requirements for all

machines"). Section 1910.179(a)(6) defines a gantry crane as "a crane similar to an overhead crane[3] except that the bridge for carrying the trolley or trolleys is rigidly supported on two or more legs running on fixed rails or other runway."

The crane at issue was referred to throughout the hearing as a gantry crane. It meets the definition of a gantry crane. The Secretary avers in her brief that § 1910.179(e)(6)(i) is the more specific standard. Gate does not dispute this in its post-hearing brief. The court concludes § 1910.179(e)(6)(i) is more specific to the cited conditions than § 1910.212(a). Accordingly, § 1910.212(a)(1) will not be considered.

**Compliance with Terms of the Standard**

It is undisputed that the door to the engine compartment of Brown's gantry crane was missing on the morning of April 18, 2005, exposing rotating parts. The terms of§1910.179(e)(6)(i) were violated.

**Employee Exposure**

The rotating parts of the engine amputated two of Brown's fingers when he reached into the engine to adjust the belt. Had the compartment door been in place, Brown would not have been able to do this. The Secretary has established employee exposure to the hazard of rotating parts.

**Employer Knowledge**

The day of the accident, April 18, was a Monday. The accident occurred between 7:15 and 7:30 a.m. Of the seven employee witnesses who testified, only Brown stated that the cover to his crane's engine compartment had been missing the week before. Brown testified the engine compartment cover had been missing for approximately one month at the time of the accident (Tr. 161).

Hollow core manager Christopher Baxter stated Brown had a habit of operating his crane in such a manner that the compartment door was torn off. He estimated Brown had torn the door off the compartment at least three times (Tr. 255). Baxter had threatened to fire Brown because of the repeated damage to his crane (Tr. 258-259). Baxter testified the door was on the crane the Friday before the accident, and had been torn off again when he got in on the following Monday

[3] An overhead crane is "a crane with a moveable bridge carrying a moveable or fixed hoisting mechanism and traveling on an overhead fixed runway structure." Section 1910.179(a)(8).

(Tr. 264-265). Saw operator Willy Thomas testified the cover had been in place the week before the accident (Tr. 229). Lead man Vernard Simmons stated he had seen the door on the engine compartment the week before (Tr. 242).

In her post-hearing brief, the Secretary dismisses the witnesses' testimony because none of them was required to inspect Brown's crane as part of his regular duties. The Secretary theorizes that the employees may not have noticed the missing compartment door the previous week if they were not specifically looking for it.

The testimony of mechanic Duane Godron, however, is more difficult to dismiss. Godron knew the door had been torn off several weeks prior to Brown's accident. He testified that another door had been fabricated and that a couple of days later the machine shop installed the newly fabricated door on the crane. In the interim, a screen was placed over the compartment (Tr. 207-208). The morning of the accident, Godron noticed the compartment door was missing and, immediately after the accident, he saw the door lying on the ground. Godron testified he said to himself, "That's the door we just put on there" (Tr. 214). Godron recognized the door as the one installed "probably a week prior, maybe two weeks." He was emphatic the door had been on the crane up until the morning of the accident (Tr. 214).

The Secretary attacks Godron's testimony as confused and self-contradictory, and refers to Godron's written statement as evidence he gave varying accounts of when he noticed the door was missing. This attack is without merit.

Godron wrote in his statement, "Company had recently made a new engine compartment door and we observed it had been torn off the morning of the accident. . . We were going to tell Boss about (missing compartment door) but by the time Boss could be told crane was being operated" (Exh. C-15). At the hearing, Godron stated he observed the compartment door was missing, "Probably when I was over there airing the tire up" (Tr. 224). The Secretary believes this contradicts Godron's testimony that he observed the fabricated door lying on the ground approximately 200 feet from the crane only after the accident had occurred (Tr. 215). The Secretary is confusing two different observations made by Godron: (1) prior to the accident, Godron looked at the crane itself, and saw that there was no door to the engine compartment; and (2) after the accident, Godron looked at the ground and saw the fabricated door lying in the dirt.

With the exception of Brown, all of the employee witnesses agree the engine compartment door was in place up until the morning of the accident. Godron in particular gave detailed testimony consistently supporting his account. Brown appeared somewhat confused in his recollection. This is understandable–he had suffered a traumatic injury during the time in question. It is not surprising his memory of the events leading up to the injury is unclear. The door of the engine compartment on his crane had been torn off on more than one occasion. Brown may have confused a previous occasion with the one at issue. The court finds Gate first became aware that the engine compartment door to Brown's crane was missing on the morning of April 18, during the first hour of the shift.

Baxter was Brown's supervisor and Lowery was the maintenance supervisor. As management personnel, their knowledge of the missing door is imputed to Gate. As soon as Brown told Baxter he was having trouble operating the crane, Baxter instructed him to take the crane to the maintenance shop for repairs (Tr. 24). Brown found Lowery in his office after Lowery attended the 6:45 managers meeting. The meeting lasted until 7:00 and Lowery estimated it takes 5 to 10 minutes to walk from the location of the meeting to his office. Sometime between 7:05 and 7:15, Lowery went to help Brown with the crane and noticed for the first time the compartment door was missing (T. 269).

After a previous OSHA inspection, Gate's owner Earl Shrimp had called a manager's meeting during which he had told management personnel that all cranes needed to be in safe working order and that all guards and engine compartment doors had to be in place. If not, Shrimp instructed them, the cranes were to be shut down until they could be repaired (Tr. 268). When Lowery saw the missing door on Brown's crane, he determined (as Baxter already had done) the crane should be taken out of service until the door could be replaced (Tr. 269-270).

All estimates of the time of the accident place its occurrence between 7:15 and 7:30. Although it is true Lowery and Baxter knew the door was missing prior to Brown's accident, they realistically had no time in which to abate the condition before Brown reached into the engine. Both Baxter and Lowery instructed that the crane be taken out of service as soon as they learned of its condition. Lowery was attempting to start the crane in order to drive it to the maintenance shop. Brown's accident occurred within 15 to 30 minutes of Baxter and Lowery's awareness of the violative condition. Under these circumstances, Gate is not responsible for exposing employees to

the rotating parts of the engine. Its management personnel had taken immediate steps to address the violative condition. Brown agreed that it was an accident (Tr. 181).

The Secretary tasks Lowery for not posting a sign on the crane warning of the missing engine door and for not calling "All clear" before his attempts to start the crane's engine. Neither of these actions are required by the cited standard. Brown was aware while standing next to the exposed engine that Lowery was seated in the cab, attempting to start the engine. Brown reached into the compartment because he saw the belt wobble when Lowery cranked the engine. It is not reasonable to expect Lowery to anticipate an experienced crane operator to reach into an exposed engine when he knows someone is in the cab attempting to start the crane.

The court finds the short period of time during which Gate had knowledge of the violative condition was not sufficient to establish the knowledge element of the Secretary's case. Lowery was attempting to remove the crane from service at the time the accident occurred. Bringing the crane into compliance with the standard was not possible in the few minutes available to Gate between its discovery of the violative condition and Brown's accident.

The Secretary has failed to establish the knowledge element of item 2. It is vacated.

**Item 4: Alleged Serious Violation of § 1910.179(e)(6)(i)**

Item 4 cites the same standard cited in item 2. The citation alleges Gate had two gantry cranes (Gantry Crane Mi-Jack 650C/0767 and Gantry Crane Mi-Jack 1000AI/4034) on each of which "the crane's sprocket and chain drive system was not guarded, exposing employees to a pinch point hazard."

**Applicability of § 1910.179(e)(6)(i)**

Gate argues § 1910.179(e)(6)(i) does not apply to the cited conditions because a more specific standard exists. Gate contends § 1910.219 ("Mechanical power-transmission apparatus") "is more specific as to mechanical power-transmission chain on the gantry crane than the 'exposed moving parts' specified in 1910.179(e)(6)(i)" (Gate's brief, p. 11). This argument is rejected.

Section 1910.179(e)(6)(i) specifically refers to "chains [and] chain sprocket," not just generic moving parts. Section 1910.219(f)(3) also addresses sprocket and chains, but the standard read as a whole appears to address stationary machines, not vehicles. The cited standard applies to gantry

and overhead cranes specifically, and mentions by name the pinch points created by chains and chain sprocket. The cited standard applies to the cited conditions.

**Compliance with Terms of the Standard**

Subpart (a) of item 4 cites two unguarded pinch points on the chain and sprocket of the inside wheel located on the side opposite the crane operator (Exhs. C-6, C-7, and C-8). The pinch points are located approximately 25 inches from the ground, 16 inches from the front, and 25 inches from the side (Tr. 47-50). Because the crane operates both forwards and backwards, pinch point hazards exist in both directions (Tr. 49).

Subpart (b) of item 4 cites two unguarded pinch points on the outside part of the wheel (Exhs. C-9, C-10, C-11, and C-12; Tr. 54). The chain and sprocket shown in Exhibits C-9 and C-12 created a pinch point on the front part of the sprocket when the crane moved forward. The pinch point was approximately 25 inches from the ground (Tr. 55).

The chains and sprockets were not guarded (Tr. 135, 168). The Secretary has established Gate was not in compliance with the terms of the standard.

**Employee Exposure**

The Secretary argues Gate's employees were exposed to the unguarded pinch points of the chains and sprockets on a daily basis because they regularly walked by the slow moving cranes, coming within 5 feet of them (Tr. 172-173). Gate routinely watered the yard to keep the dust down, so ground conditions were often muddy. The Secretary contends the muddy conditions increased the chance employees would slip and fall into the pinch points.

In order to establish exposure, the Secretary must prove Gate's employees, within reasonable predictability, were within the zone of danger created by the violative condition. *Brennan v. Gilles & Cotting, Inc.*, 504 F.2d 1255, 1263 (4th Cir. 1974), *Dic-Underhill, a Joint-Venture*, 4 BNA OSHC 1489, 14909 (No. 3042, 1976); *Adams Steel Erection*, 12 BNA OSHC 1393, 1399 (No. 84-3586, 1985). A machine guarding standard requires more than proof that employees could possibly come into contact with unguarded machinery. The Secretary must show that employees were exposed to the hazard "as a result of the manner in which the machine functions and the way it is operated." *Jefferson Smurfit Corp.*, 15 BNA OSHC 1419, 1421 (No. 89-0553, 1992).

The Secretary has failed to establish exposure to employees when the cranes were used under normal operating conditions. The record establishes the cranes were slow moving; employees walked faster than the cranes moved. The pinch point hazard existed only when the crane was moving. The employees kept clear of the cranes by a distance of 5 feet. In order for an employee to be injured by the pinch points, he would have to fall horizontally a distance of 5 feet, avoid the moving wheel, and somehow land a body part in pinch point located 25 inches above the ground. Such an occurrence is not reasonably predictable and Gate was not required to anticipate it.

No employee exposure was shown. Item 4 is vacated.

## 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:

1. Item 1 of the citation, amended in accordance with the parties' settlement from alleging a serious violation of § 1910.23(c)(1) to allege a serious violation of § 5(a)(1), is affirmed and a penalty of $1,700.00 is assessed;

2. Item 2 of the citation, alleging a serious violation of § 1910.179(e)(6)(1), or, in the alternative, of § 1910.212(a)(1), is vacated and no penalty is assessed;

3. Item 3 of the citation, alleging a serious violation of §1910.79(c)(2), is affirmed in accordance with the parties' settlement as an "other" than serious violation, and no penalty is assessed; and

4. Item 4 of the citation, alleging a serious violation of § 1910.179(e)(6)(i), is vacated and no penalty is assessed.

/s/ Ken S. Welsch
KEN S. WELSCH
Judge

Date: January 23, 2006