



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

Secretary of Labor,
Complainant

v.

Nissan North American, Inc.,
Respondent.

OSHRC Docket No.: **17-0556**

Attorneys and Law Firms:

Jean C. Abreu, Esq., U.S. Department of Labor, Office of the Solicitor, Atlanta, Georgia, for Complainant

Dana Rust, Esq. and Katherine Knight, Esq., McGuire Woods, for Respondent

JUDGE: Administrative Law Judge Heather A. Joys

DECISION AND ORDER

On July 31, 2016, a contract employee of Nissan North America, Inc., (Nissan) was replacing a motor on a robot on the first floor of the company's Canton, Mississippi, facility. While he did so, three Nissan maintenance technicians were performing a preventive maintenance inspection on a conveyor on the upper level of the facility. When the contract employee completed his task, he restarted the conveyor from the master control panel. The conveyor began to move. At that same moment, one of the technicians had placed his hand on one of the conveyor's belts. His hand was pulled into the conveyor, amputating three fingers.

Nissan timely reported the injury to the Jackson, Mississippi, Area Office of the Occupational Safety and Health Administration (OSHA). Compliance Safety and Health Officer (CSHO) James Oglesby of that office performed an inspection of the Nissan Canton facility beginning on December 2, 2016.¹ Based upon his inspection, CSHO Oglesby recommended Nissan be issued a two-item serious citation alleging failure to notify the Nissan maintenance

¹ Initiation of the inspection was delayed in order to resolve a dispute regarding employee representative participation in the inspection. That issue is not before me. Nor has Nissan raised the timeliness of the citation as an issue for resolution.

technicians of the restart of the conveyor and failure to properly train them on lockout procedures for the conveyor. The Secretary proposes a total penalty of \$ 21,140.00 for the Citation. Nissan timely contested the Citation bringing the matter before the Occupational Safety and Health Review Commission pursuant to § 10(c) of the Occupational Safety and Health Act of 1970, 29 U.S.C. § 651-678 (the Act).

I held a hearing in this matter on March 21, 2018, in Jackson, Mississippi. The parties filed post-hearing briefs on May 17, 2018.²

For the reasons discussed below, Item 1, Citation 1, is **VACATED**; Item 2, Citation 1, is **AFFIRMED**, and a penalty of \$12,675.00 is assessed.

JURISDICTION

At the hearing, the parties stipulated jurisdiction of this action is conferred upon the Commission pursuant to § 10(c) of the Act. The parties also stipulated at the hearing that at all times relevant to this action, Nissan was an employer engaged in a business affecting interstate commerce within the meaning of § 3(5) of the Act (Tr. 8). Based on the parties' stipulations and the facts presented, I find Nissan is an employer covered under the Act and the Commission has jurisdiction over this proceeding.

BACKGROUND

Nissan is an auto maker with a large facility in Canton, Mississippi. At that facility, the company employs over 6,000 individuals. Thousands of pieces of equipment are used throughout the facility in the manufacturing process. The equipment at issue is a conveyor. The conveyor is used to transfer auto bodies from one manufacturing process to another.

A portion of the conveyor is located above the main floor of the facility on the mezzanine level and is designated CP-M7.³ No production occurs on the mezzanine level; it serves only as a transfer point from one of the main level production processes to another (Tr. 157; 218). The conveyor is electrically powered. Rather than moving continuously once energized, the conveyor moves via an automated process. As an auto body moves along the conveyor, it passes by "proximity switches." As the auto body passes the proximity switch, the switch is activated,

² To the extent either party failed to raise any other arguments in its post-hearing brief, such arguments are deemed abandoned.

³ The elevated area in which the conveyor is located, as seen from ground level, is depicted in Exhibit C-2. The same area, as seen from the mezzanine, is depicted in Exhibit C-3. Exhibit R-1 contains a schematic of the conveyor.

sending a signal to the conveyor to move the auto body to the next area (Tr. 157). Brian Schuetzle, the maintenance manager for the Nissan Canton facility, described the process as follows:

The conveyor is dormant. As a unit moves into position, we block a proximity switch. When the proximity switch is blocked, the code, the program looks ahead. As it looks ahead, if the proximity switch ahead is not blocked or been set memory, then it knows that it's okay to advance that pallet unit to the next stage. Then it comes on.

(Tr. 217).

Nissan employs its own maintenance technicians to perform service and maintenance on the equipment at the Canton facility, including the conveyor (Tr. 158). It also uses contract mechanics to work on mechanical systems (Tr. 158-59). Nissan trains its maintenance technicians. That training includes orientation training performed on the employee's start date followed by a 14-week hands-on training program at Nissan's training facility. After technicians have completed the 14-week training, they receive on-the-job training on each assigned task for several weeks. Included in the orientation training is a video providing an overview of lockout procedures (Exh. C-10 and C-11). The 14-week training and the on-the-job training all include lockout training. Nissan provides locks to technicians prior to their being assigned to work at the Canton facility. Contract mechanics generally have more experience than Nissan's technicians (Tr. 158). It is not clear on this record what, if any, training Nissan provides to the contract mechanics.

At the time of the accident, Robert Looney was a maintenance supervisor at the Nissan Canton facility (Tr. 144). He supervised a crew of 20 Nissan technicians and contract mechanics. His crew was approximately equally divided between the two types of workers (Tr. 158).

At the start of the shift on July 31, 2016, Supervisor Looney distributed written work orders to his crew (Tr. 144). He assigned three Nissan maintenance technicians – Technician 1, Technician 2, and the injured employee⁴ - to perform a preventive maintenance inspection of the CP-M7 located on the mezzanine level. Technician 1 was more experienced and had, Supervisor Looney believed, performed the assigned preventive maintenance inspection previously (Tr. 151). Technician 2 and the injured employee were less experienced, having started with Nissan

⁴ The names of hourly employees, including the name of the injured employee, have been omitted for privacy.

in January of 2016.⁵ Supervisor Looney provided little instruction regarding the preventive maintenance inspection other than a general admonition to be safe (Tr. 101, 119, 250). The injured employee asked Technician 1 whether he knew how to perform the assigned inspection, to which Technician 1 replied, “No.” (Tr. 120)⁶ The injured employee then asked Technician 2 whether he knew what to do. Technician 2 told the injured employee he had done a similar inspection and would show him what the assignment involved (Tr. 120).⁷

The three technicians proceeded to the mezzanine level where Technician 2 began to show the injured employee how he had performed the assignment in the past by checking the “looseness of the belt and the conveyor, and mak[ing] sure the prox[imity] switches were working.” (Tr. 120) They checked the functioning of the proximity switches by “flagging” them or placing a flashlight in front of each switch (Tr. 123). As they did so, a light on the back of the switch turned on, indicating it was working (Tr. 141). Because the conveyor was powered down, activating the switch did not cause the conveyor to move (Tr. 140-41). The switch locked in a “memory bit” that it had been flagged (Tr. 140). In addition to checking the functioning of the proximity switches, the injured employee and Technician 2 checked the belts that operated the conveyor (Tr. 103). Both technicians did so by pulling on the belt with their hands and visually checking its teeth (Tr. 103, 137).

At the same time, a contract mechanic was replacing the motor to a robot on the first level of the facility. To do so, the mechanic had shut down and locked out some portion of the

⁵ Technician 2 and the injured employee had completed the 14-week training at Nissan’s training facility and had worked at the Canton facility approximately three months.

⁶ Technician 1 contradicted this testimony. Regarding his conversation with the injured employee, he stated:

A: Well, I just told him, “It’s a visual PM; let’s go ahead and look it over, and if you find anything wrong, write it down; if you don’t, get on with the work here,” you know.

Q: Did you tell him, you know, the equipment was hot and not to touch anything, anything like that?

A: Yes. I told him that. I hold him that, you know, the line is hot.

(Tr. 245-46). I do not find Technician 1 a credible witness. He appeared rehearsed and eager to disavow any culpability in the accident. Much of his testimony regarding his admonitions to the injured employee not to touch anything required prompting by counsel. I give this testimony no weight.

⁷ Technician 2’s testimony corroborated the injured employee’s account. He testified he had not performed this specific inspection before but had done similar orders (Tr. 103). He equivocated whether he instructed the injured employee but admitted to doing the same tasks in the same manner as the injured employee (Tr. 103, 113). I find both Technician 2 and the injured employee credible witnesses. Both are current Nissan employees. Although appearing nervous, both gave straightforward answers on direct and cross examination. Their testimony was consistent with one another and, for the most part, with prior statements. I credit the testimony of Technician 2 and the injured employee.

conveyor (Tr. 161).⁸ He was unaware employees were working on the mezzanine. None of the employees working on the robot were part of Supervisor Looney's crew (Tr. 154). Upon completion of his work, the mechanic went to the main control panel and restored power at the master start switch to advance the unit on which he had been working (Tr. 161; Exh. C-12). A buzzer sounded when power was restored to the conveyor. Neither the injured employee nor Technician 2 heard it or understood it signaled startup of the conveyor on which they were working (Tr. 106, 124; Exh. C-6). Because Supervisor Looney's crew had flagged the proximity switches, the restoration of power at the master start switch caused the conveyor to move. At the moment the conveyor began to move, the injured employee had his hand on a belt. His hand was pulled into the conveyor, amputating three fingers (Exhs. C-1; C-12; Tr. 138).

As a result of the amputation, the injured employee was unable to work for two months (Tr. 138). Upon his return, Nissan issued the injured employee a verbal disciplinary notice for not following work procedures (Tr. 196; Exh. R-2). No one else was disciplined for their actions surrounding the accident.

Nissan timely notified the Secretary about the amputation. CSHO Oglesby of the Jackson, Mississippi, Area Office conducted an investigation into the accident beginning on December 2, 2016. CSHO Oglesby determined Nissan had provided no warning to employees working on the mezzanine level of the startup of the conveyor. He also concluded neither Technician 2 nor the injured employee had been trained on lockout of the conveyor. On the basis of these findings, CSHO Oglesby recommended two serious citations be issued to Nissan. Nissan timely contested both citations and the proposed penalties, bringing the matter before the Commission.

DISCUSSION

The Secretary has the burden of establishing the employer violated the cited standard. 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) the employer failed to comply with the terms of

⁸ Maintenance Manager Schuetzle testified the contract mechanic told him he had not locked out the upper conveyor (Tr. 223). Nor would doing so be necessary in the area in which the contract mechanic was working (Tr. 223-24). According to Supervisor Looney, they discovered after the accident the employees working on the robot had wanted to test the conveyor so they "took their locks off and started the line." (Tr. 161) Muthu Viswanathan, safety manager for the Canton facility, testified the contract mechanic had locked out the conveyor at the master control panel (Tr. 206). The contract mechanic did not testify and no prior statements from him were submitted into the record. I cannot determine on this record which portion of the conveyor the contract mechanic had locked out. The record establishes only that the conveyor had been deenergized at the main disconnect.

the cited standard; (3) employees had access to the violative condition; and (4) the cited employer either knew or could have known with the exercise of reasonable diligence of the violative condition. *JPC Group, Inc.*, 22 BNA OSHC 1859, 1861 (No. 05-1907, 2009).

Item 1, Citation 1: Alleged Violation of 29 C.F.R. § 1910.147(c)(9)

Item 1, Citation 1, alleges a violation of the standard at 29 C.F.R. § 1910.147(c)(9) which states,

Notification of employees. Affected employees shall be notified by the employer or authorized employee of the application and removal of lockout devices or tagout devices. Notification shall be given before the controls are applied, and after they are removed from the machine or equipment.

As amended⁹, Item 1, Citation 1, reads:

29 CFR § 1910.147(c)(9): Affected employees were not notified before and after lockout and/or tagout devices were applied.

b. Body Shop Conveyors – On or about July 31, 2016, affected employees were exposed to amputation hazards when adequate notice was not provided before and after lockout/tagout devices were applied.

The Secretary contends Nissan failed to notify the technicians working on the mezzanine of the removal of the lockout devices and reenergization of the conveyor, resulting in its unexpected startup.

Applicability of § 1910.147(c)(9)

The cited standard falls under the regulation addressing control of hazardous energy or the lockout/tagout standard. The lockout/tagout standard “covers the servicing and maintenance of machines and equipment in which the unexpected energization or startup of the machines or equipment, or release of stored energy, could harm employees.” 29 C.F.R. § 1910.147(a)(1)(i).

The standard defines “servicing and maintenance” as

Workplace activities such as constructing, installing, setting up, adjusting, inspecting, modifying, and maintaining and/or servicing machines or equipment. These activities include lubrication, cleaning or unjamming of machines or equipment and making adjustments or tool changes, where the employee may be exposed to the *unexpected* energization or startup of the equipment or release of hazardous energy.

⁹ Item 1, Citation 1, originally alleged a violation of § 5(a)(1) of the Act or the General Duty Clause. By order of March 8, 2018, Item 1, Citation 1, was amended to allege a violation of the standard at § 1910.147(c)(9). The Secretary moved to amend the date of the alleged violation at the start of the hearing. That motion was granted over Nissan’s objection.

29 C.F.R. § 1910.147(b). The Secretary's burden to establish applicability of the standard is twofold. The Secretary must establish the activities performed by the employees fell within the category of activities recognized as servicing or maintenance. The Secretary must also show that activity exposed those employees to the hazard of unexpected energization or startup of the equipment.

There is no dispute the technicians and contract mechanics work duties involve performing servicing and maintenance work on the equipment at the Nissan Canton facility that, under certain circumstances, expose them to the unexpected energization or startup of equipment. The technicians were performing a preventive maintenance inspection. The contract mechanic was replacing a motor on a robot. As evidenced by the accident, the technicians were actually exposed to the unexpected startup of the conveyor by the contract mechanic. Nissan does not dispute the contract mechanic was performing work that required lockout. The standard applies to the work being performed on the day of the accident.

With regard to applicability of § 1910.147(c)(9), the inquiry does not end there. The Secretary must also establish the technicians were affected employees, triggering Nissan's notification obligation under the cited standard. The standard defines an affected employee as

An employee whose job requires him/her to operate or use a machine or equipment on which servicing or maintenance is being performed under lockout or tagout, or whose job requires him/her to work in an area in which such servicing or maintenance is being performed.

29 C.F.R. § 1910.147(b). In the preamble to the final rule, the Secretary further clarified,

If any employee must utilize the energy control procedure, that employee is considered to be an "authorized employee." By contrast, an "affected employee" is one who does not perform the servicing or implement the energy control procedure, but whose responsibilities are performed in an area in which the energy control procedure is implemented and servicing operations are performed under that procedure.

Control of Hazardous Energy Sources, 54 FR 36644-01 (September 1, 1989) at p. 36665. The Secretary contends the technicians inspecting CP-M7 were affected employees because the conveyor had been locked out as part of the maintenance being performed by the contract mechanic. Nissan contends the injured employee¹⁰ was not an affected employee because his job

¹⁰ Nissan incorrectly focuses exclusively on the injured employee. The Secretary contends Technician 2 and the injured employee were exposed to the hazard. Nissan's argument with regard to whether the injured employee was an affected employee would apply equally to both allegedly exposed employees.

did not require him to operate or use the equipment being serviced, nor was he in an area in which servicing or maintenance was being performed.

In his brief, the Secretary notes the status of the technicians as either authorized or affected employees may be confused (Secretary's brief at p. 9, n. 4). Unfortunately, the record as a whole provides too few facts upon which to resolve that confusion. The conveyor is used to transport auto bodies along the stages of production. The mezzanine level containing CP-M7 is a transfer point along the production line (Tr. 218). No production takes place on the mezzanine level (Tr. 218). The process of moving the auto bodies is automated. The technicians were not employees whose "job[s] require[] him/her to operate or use" the conveyor they were inspecting.

Nor does the record establish the technicians were working in an area in which lockout had been implemented and servicing or maintenance was being performed. The Secretary specifically refers to the servicing work being performed by the contract mechanic. Although he was performing servicing work, the contract mechanic was not working on the conveyor or in the area in which the technicians were working. Several witnesses consistently testified the contract mechanic was repairing one of seven robots in "body main respot." (Tr. 161; 210; 231) This area is on the main level of the facility. The record contains no explanation of what production work is performed by these robots in this area¹¹ or, importantly, the relationship of the robot to the conveyor.

The Secretary did not argue, and the record does not establish, the conveyor system is a single machine such that lockout of the entire conveyor was necessary to work on any part of it. *See Secretary v. Action Electric Company*, 868 F.3d 1324, 1330 (11th Cir. 2017). The area in which the contract mechanic was working was described as a transfer point along the conveyor to CP-M7 (Tr. 211). The conveyor system has a main power disconnect that shuts down power to the entire conveyor system (Exh. R-1). Sections or stages of the conveyor can be separately locked out (Tr. 202; 206; 223-24; Exh. R-1). On the day of the accident, the conveyor had been shut down at the main power disconnect (Tr. 199; 206; 231-32). CP-M7 was deenergized as a result. What is not established on this record is whether the contract mechanic had locked out the conveyor at the main power disconnect or only on the stage at which he was working. To perform his work on the robot, the contract mechanic could have, and may have, locked out at the local disconnect (Tr. 224). The Secretary failed to establish CP-M7 had been locked out,

¹¹ There is a passing reference to the area being a welding area (Tr. 211).

only that it had been deenergized. The requirement to notify affected employees of the removal of lockout does not apply under the circumstances.¹²

Because the record fails to establish applicability of the cited standard, Item 1, Citation 1, is **VACATED**.

Item 2, Citation 1: Alleged Violation of § 29 C.F.R. § 1910.147(c)(7)(i)

Item 2, Citation 1, alleges a violation of the standard at 29 C.F.R. § 1910.147(c)(7)(i). Section 1910.147(c)(7) covers training requirements that are to be included in an employer's energy control program. The cited subpart of § 1910.147(c)(7) states,

The employer shall provide training to ensure that the purpose and function of the energy control program are understood by employees and that the knowledge and skills required for the safe application, usage, and removal of the energy controls are acquired by employees.

Item 2, Citation 1, alleges a violation of that standard as follows:

Body Shop CP-M7 Overhead conveyor – On or about July 31, 2016, two maintenance technicians tasked to perform a PM on the CP-M7 overhead conveyor were not adequately trained on the specific lockout/tagout procedures for the conveyor system.

The Secretary contends Nissan failed to train the two technicians working on the mezzanine on the procedures for locking out CP-M7.

Applicability of § 1910.147(c)(7)(i)

As previously noted, there is little dispute, Nissan technicians perform work that is covered by the lockout standard. The Secretary contends the technicians were performing servicing and maintenance work on the day of the accident, as that term is defined in the standard. In its brief, Nissan did not argue inapplicability of the standard.

Inspection of equipment is specifically included in the definition of servicing and maintenance found at § 1910.147(b). The Commission has held where an employee is “inspecting equipment when it is stationary, the standard requires deenergization and application of lockout procedures.” *General Motors Corp.*, 22 BNA OSHC 1019, 1041 (Nos. 91-2834 and 91-2950, 2007). The inspection being conducted by the technicians was done while the conveyor was stationary and met the first part of the definition of servicing and maintenance.

¹² Exposure of the technicians to the unexpected energization of CP-M7 as a result of the contract mechanic's restart of the conveyor would appear to be the type of exposure § 1910.147 was intended to prevent (*See* 54 FR at 36647-48). The fault of the Secretary's case is his failure to cite an appropriate standard. On this I agree with Nissan, the Secretary has tried to fit a square peg into a round hole.

Addressing the applicability of the training requirements of the lockout standard in *General Motors*, the Commission held,

Where an employee's job assignment includes equipment servicing or maintenance, and it is reasonably predictable that the employee will encounter the hazard of unexpected energization while performing such work...the requirements of the lockout standard apply and training is required.

22 BNA OSHC at 1030. For the reasons that follow, the evidence establishes that exposure was reasonably predictable and training the technicians was required.

To establish exposure was reasonably predictable the Secretary must "show that it is reasonably predictable either by operational necessity or otherwise (including inadvertence), that employees have been, are, or will be in the zone of danger." *Delek Ref., Ltd.*, 25 BNA OSHC 1365, 1376 (No. 08-1386, 2015) (*citing id.*) *vacated in part on other grounds*, 845 F.3d 170 (5th Cir. 2016); *see also Rockwell Intl. Corp.*, 9 BNA OSHC 1092 (No. 12470, 1980); *Gilles & Cotting*, 3 BNA OSHC 2002 (No. 504, 1976). The zone of danger is the "area surrounding the violative condition that presents the danger to employees." *Boh Bros. Constr. Co., LLC*, 24 BNA OSHC 1067, 1085 (No. 09-1072, 2013) (*citing RGM Constr. Co.*, 17 BNA OSHC 1229, 1234 (No. 91-2107, 1995)). The technicians' assignment took them to the mezzanine level that contained CP-M7. The assignment sheet lists as tasks to be performed, among others, to "clean and inspect the condition of proximity switches;" ensure the proper alignment of "all fasteners and mounting bolts;" and to visually inspect all exposed cable and connectors and "make sure all connections are seated properly and locked in place if applicable." (Exh. R-5). Supervisor Looney provided no guidance to the technicians as to how they were to perform the tasks listed. Nor was the assignment sheet clear as to the requirements of the job.¹³ As the photographs of the area show, cleaning the proximity switches would have placed the technicians in proximity to the exposed belts¹⁴ of the conveyor or in the zone of danger (*see Exhs. C-3 and C-4*); Tr. 121-22).¹⁵

¹³ As evidence of this lack of clarity, Manager Schuetzle testified the list included inspecting equipment that was not part of CP-M7 (Tr. 221-23).

¹⁴ Nissan repeatedly refers to the injured employee bypassing guards to reach the belt. As shown in the photographs of the area, the belt the injured employee was checking was not covered in a manner that required he bypass or remove a guard (Tr. 43-44; Exhs. C-3 and C-4). Portions of the belt appear exposed. The injured employee conceded he reached over the guard (Tr. 136). The guard did not prevent the injured employee from grabbing the belt.

¹⁵ Safety Director Viswanathan, conceded the assignment required cleaning the proximity switches (Tr. 201). I found Manager Shuetzle's testimony suggesting cleaning the proximity switches could be done by putting a rag on a stick and swatting at it (Tr. 234) an unpersuasive attempt to explain away unfavorable documentary evidence.

In addressing employee exposure, Nissan focuses on the circumstances leading to the injury. This focus is misplaced. It is well recognized the Act is “designed to encourage abatement of hazardous conditions themselves, [] rather than to fix blame after the fact for a particular injury[.]” *Chaplin Petroleum Co. v. OSHRC*, 593 F.2d 637, 642 (5th Cir, 1979). Whether the technicians were required to touch the belts of the conveyor is not dispositive of the issue of access to the zone of danger. The standard is intended to protect employees from exposure to a hazard as the result of intentional conduct or inadvertence. The work assignment placed the technicians on the mezzanine, near the belts of the conveyor. The record establishes the technicians had access to the hazardous condition notwithstanding the specific conduct that resulted in the injury.

The contract mechanic was unaware employees were assigned to work on the mezzanine level when he restarted the conveyor. The technicians were unaware the conveyor had been restarted. The technicians were exposed to *unexpected* startup of the conveyor. The standard applies to the work performed by the Nissan technicians.

Violation of § 1910.147(c)(7)(i)

The cited standard sets out the employer’s obligation for initial training about its lockout program and procedures. The standard was written as a performance-oriented standard “in order to deal with the wide range of workplaces covered by the standard.” 54 FR at 36673. Employers may “use whatever method he/she feels will best accomplish the objectives of the training.” 54 FR at 36674. It sets out different training obligations for the different classes of workers covered under the standard.¹⁶

¹⁶ The standard requires an “authorized employee,” defined as “a person who locks out or tags out machines or equipment in order to perform servicing or maintenance on that machine or equipment” to be trained “in the recognition of applicable hazardous energy sources, the type and magnitude of the energy available in the workplace, and the methods and means necessary for energy isolation and control.” 29 C.F.R. §§ 1910.147(b) and 1910.147(c)(7)(i)(A). For affected employees, the standard requires instruction “in the purpose and use of the energy control procedure.” 29 C.F.R. § 1910.147(c)(7)(i)(B). The standard’s preamble further clarifies

in order to provide adequate information, any training program under this standard will need to cover at least three areas: The employer’s energy control program, the elements of the energy control procedure which are relevant to the employee’s duties, and the requirements of this Final Rule. The details will necessarily vary from workplace to workplace, and even from employee to employee within a single workplace, depending upon the complexity of the equipment and the procedure, the employee’s job duties and their responsibilities under the energy control program, and other factors. Paragraphs (c)(7)(i) (A), (B), and (C) of the standard establish the amount of training that is required for the three groups of employees: “authorized” employees, “affected” employees, and all “other” employees. The relative degree of knowledge required by these three employee groups is in descending order, with the requirements for authorized employees demanding the most effort in

The plain meaning of the terms of the cited standard provide guidance as to the objective of initial training. Employees must receive training sufficient to ensure they “acquire” the “skills” necessary for safe application, usage, and removal of energy controls. To acquire means to “get as one’s own” or “to come to have as a new or added characteristic, trait, or ability.” *Merriam Webster Dictionary* (2018). A skill is the “ability to use one’s knowledge effectively and readily in execution or performance.” *Id.* Initial training under the standard must give employees the ability to effectively and readily perform lockout procedures applicable to their assignments. This would include knowing when lockout is required and how to implement it.

The Secretary contends the technicians were inadequately trained on Nissan’s lockout program and procedures as they specifically relate to CP-M7. Nissan contends it provided sufficient initial training under the standard by providing an introductory video that covered all of the elements enumerated in the standard. Even if that video was insufficient, Nissan argues it provided additional training including 14-weeks of training at its training center and six shifts of on-the-job training shadowing an experienced technician.

It is undisputed the technicians watched the video on Nissan’s lockout program contained in Exhibit C-10. The video, which is approximately 10 minutes long, is an overview of the concepts of energy isolation and lockout. The video is too general to satisfy the requirements of the standard. It lists the six steps Nissan requires for proper lockout, but does not relate those to any particular equipment. It shows the process of attaching locks to disconnects and to doors to caged areas, but does not identify any of the equipment. It provides a list of possible energy sources, but does not identify to what equipment in the Canton facility those energy sources may apply. It explains Nissan uses placards containing disconnect procedures (*See, e.g.*, Exh. R-1), but does not explain how to read these placards. The video does not contain sufficient

training. Because authorized employees are charged with the responsibility for implementing energy control procedures, it is important that they receive training in recognizing and understanding all potentially hazardous energy sources that they might be exposed to during their work assignments, and that they also be trained in the use of adequate methods and means for the control of such energy sources. These employees are the ones authorized to implement the energy control procedure and to perform servicing of the machine or equipment. Therefore, they need extensive training in aspects of the procedure and its proper utilization, together with all relevant information about the equipment being serviced.

information to ensure the technicians had “the skills required” to utilize Nissan’s energy control procedures at the Canton facility.¹⁷

Nissan’s training does not end with the video. The record establishes during the 14-week off-site training, Nissan provided technicians with the opportunity to learn to how to apply locks using mock-ups of the robotic cells and other “trainer boards.” (Tr. 111-12,127, 215).

Technicians worked for six shifts with a more experienced technician to learn various assignments (Tr. 100, 149).¹⁸ It is not clear how, or whether, Nissan determined its employees understood or had acquired “the knowledge and skills required for the safe application, usage, and removal of the energy controls” once this training was complete.¹⁹

In contrast to the evidence describing Nissan’s training procedures, the Secretary presented un rebutted evidence Nissan did not train the technicians inspecting CP-M7 on July 31, 2016, when, or how, to lockout CP-M7 (Tr. 118, 134, 161). There is no evidence the technicians were told under what circumstances lockout of CP-M7 was required.²⁰ The technicians could have locked out CP-M7 at the main disconnect or locally on the mezzanine level (Tr. 201). Technician 2 and the injured employee were not aware of this. Manager Looney conceded he had not provided this information to either (Tr. 149; 153). Technician 2 and the injured employee did not know that upon restart of CP-M7 a buzzer would sound (Tr. 106). The injured

¹⁷ Nissan relies on Chairman Railton’s opinion in *Timken Co.*, 20 BNA OSHC 2034 (No. 97-1457, 2004) in arguing its 10-minute video was sufficient under the standard. In *Timken*, the two participating Commissioners, unable to reach consensus, vacated the direction for review, resulting in the ALJ’s decision affirming the alleged violation of the training standard becoming a final order of the Commission with the precedential value of an unreviewed ALJ decision. *Id.* at 2035. The subsequent Commission decision in *General Motors*, cited herein, did not adopt Chairman Railton’s position with regard to the requirements for initial training under the standard.

¹⁸ Contrary to Nissan’s contention in its brief, there is no evidence it provided either Technician 2 or the injured employee with its *Safety and Health Directive* on lockout prior to the accident. Nissan did not provide the technicians with its employee handbook, rather it was available to employees “online.” (Tr. 190).

¹⁹ Safety Director Viswanathan testified the online training, where Nissan suggests such testing might have occurred, was refresher training the technicians would not have had as of the date of the accident (Tr. 180-81, 185). The injured employee testified he took some online training during his 14-weeks at the training center (Tr. 129). He was unable to say whether any of that online training involved safety issues (Tr. 130).

²⁰ Supervisor Looney did not appear to know whether the technician’s assignment required CP-M7 be locked out. When specifically asked, he equivocated:

Q: And because it was a visual only PM, they didn’t need to lock out, did they?

A: They did not—oh, excuse me. No. Now, parts of that PM, they still should have locked out, because they had to inspect – you know, there’s a gray area there on the proximity switches, so they probably should have locked out anyway. But if they were going to touch the machinery, they should have locked out.

(Tr. 162. He testified the belts could have been checked by an ultrasonic device rather than by hand (Tr. 164). He later clarified, regardless of the method used, checking belts required lockout (Tr. 165).

employee was unaware of the consequence of flagging the proximity switches (Tr. 136). Both knew in general how to lockout an electric motor. Neither knew how to lockout CP-M7's motor.

Nissan contends it would have provided training on lockout of CP-M7 to the technicians had their work required it. The record does not support this contention. Safety Director Viswanathan, testified that to ensure employees acquire the skills necessary to perform lockout, Nissan's *Safety and Health Directive* of February 25, 2013, requires machine-specific training be done by supervisors in a hands-on manner (Tr. 173, 186; Exh. C-7). Nissan did so because "there's lots of pieces of equipment, and you have to lock out differently for different equipment. So it's all decided based on the job duties of the employee." (Tr. 189). Safety Director Viswanathan admitted he did not monitor whether supervisors were performing this training (Tr. 174). Supervisor Looney was unaware of this obligation. He testified he was not required to provide any training on lockout to the technicians (Tr. 149). When assigning a project that required lockout, he testified he did not go over lockout with the employee in advance (Tr. 161). There is no evidence Nissan's training program included machine-specific lockout training in practice.

The standard requires initial training be sufficient for employees to acquire the skills necessary to perform safe lockout. For the technicians working on CP-M7, Nissan's training did not meet this standard.

Employee Exposure

The evidence establishes the technicians were actually exposed to the hazard of unexpected startup of the conveyor. Even if the injured employee had never placed his hand on the belt, he and Technician 2 were exposed to that hazard.

Employees may come within the zone of danger "while in the course of assigned working duties, personal comfort activities while on the job or their normal means of ingress-egress to their assigned workplaces." *Gilles & Cotting, Inc.*, 3 BNA OSHC 2002, 2003 (No. 504, 1976); *Donovan v. Adams Steel Erection, Inc.*, 766 F.2d 804, 812 (3d Cir. 1985) ("'access,' not exposure to danger is the proper test"). The Secretary need not show it was certain that employees would be in the zone of danger, but he must show that exposure was more than theoretically possible. *Fabricated Metal Prods., Inc.* 18 BNA OSHC 1072, 1074 (No. 93-1853, 1997); *Phoenix Roofing*, 17 BNA OSHC at 1079; *Kaspar Wire Works, Inc.*, 18 BNA OSHC 2178, 2195 (No. 90-2775, 2000) (finding that it was "'reasonably predictable' that an employee would come into contact with the unguarded belt and pulley either while attempting to reposition the fan, or inadvertently while passing nearby"), *aff'd*, 268 F.3d 1123 (D.C. Cir. 2001).

Calpine Corp., 27 BNA OSHC 1014, 1016 (No. 11-1734, 2018). The technicians were on the mezzanine working in proximity to the conveyor's moving parts. As previously discussed, taking into consideration the assigned work task, the technicians would have been in the zone of danger.

Employer Knowledge

To establish employer knowledge of a violation the Secretary must show the employer knew or with the exercise of reasonable diligence could have known of a hazardous condition. *Dun Par Engineered Form Co.*, 12 BNA OSHC 1962, 1965-66 (No. 82-928, 1986). Because corporate employers can only obtain knowledge through their agents, the actions and knowledge of supervisory personnel are generally imputed to their employers, and the Secretary can make a prima facie showing of knowledge by proving a supervisory employee knew of or was responsible for the violation. *Todd Shipyards Corp.*, 11 BNA OSHC 2177, 2179 (No. 77-1598, 1984); *see also Dun Par Engineered Form Co.*, 12 BNA OSHC 1962 (No. 82-928, 1986) (the actual or constructive knowledge of an employer's foreman can be imputed to the employer); *see also W.G. Yates & Sons v. OSHRC*, 459 F.3d 604, 607 (5th Cir. 2006). Constructive knowledge is shown where the Secretary establishes the employer could have known of the cited condition with the exercise of reasonable diligence. *Par Electrical Contractors, Inc.*, 20 BNA OSHC 1624, 1627 (No. 99-1520).

Whether an employer was reasonably diligent involves a consideration of several factors, including the employer's obligation to have adequate work rules and training programs, to adequately supervise employees, to anticipate hazards to which employees may be exposed, and to take measures to prevent the occurrence of violations.

Id. citing Precision Concrete Constr. 19 BNA OSHC 1404, 1407 (No. 99-707, 2001).

According to Nissan's *Safety and Health Directive* on lockout, an employee's immediate supervisor is responsible for assuring the employee is "properly trained in lockout/tagout procedures." (Exh. C-7, p. 1). The Safety Department is responsible for conducting general lockout training, while the supervisor is responsible for machine-specific training (Exh. C-7, p. 2). Based on his testimony, this training obligation for supervisors was unknown to Supervisor Looney (Tr. 149; 161).²¹ Nor would his failure to perform this training have been known to

²¹ It is undisputed Supervisor Looney was the immediate supervisor of Technician 1, Technician 2, and the injured employee.

Safety Director Viswanathan, as he testified he did not monitor supervisors to ensure they conducted machine-specific training (Tr. 174). The only documentary record of training in the record is that showing the technicians watched the 10-minute introductory video (Exh. C-8). The evidence demonstrates a lack of diligence on the part of Nissan regarding the training required by the standard. Nissan had constructive knowledge of its failure to train the technicians on lockout procedures for CP-M7. *See General Motors*, 22 BNA OSHC at 1031.²²

The Secretary has met his burden to establish Nissan violated § 1910.147(c)(7)(i).

Unpreventable Employee Misconduct

To prevail on the affirmative defense of unpreventable employee misconduct, an employer must show that it has (1) established work rules designed to prevent the violation, (2) adequately communicated those rules to its employees, (3) taken steps to discover violations, and (4) effectively enforced the rules when violations have been discovered. *See, e.g., Stark Excavating, Inc.*, 24 BNA OSHC 2218 (Nos. 09-0004 and 09-0005, 2014), *citing Manganas Painting Co.*, 21 BNA OSHC 1964, 1997 (No. 94-0588, 2007). The affirmative defense of employee misconduct applies in situations in which the behavior of the employee creates the violative condition. Nissan mistakenly focuses on the injured employee's failure to perform his assignment properly, rather than on the violative condition, i.e. the failure to train.

To prevail on the affirmative defense of unpreventable employee misconduct for the alleged violation of § 1910.147(c)(7)(i), Nissan would have to establish it had a rule designed to prevent the failure to train employees on lockout procedures. Nissan does have such a rule contained in its *Safety and Health Directive* on lockout (Exh. C-7). That rule requires immediate supervisors to train employees on machine-specific lockout procedures. Nissan failed to present any evidence that rule was communicated to supervisors. It also failed to establish it monitored to ensure that training was being provided. To the contrary, Safety Director Viswanathan testified he did no monitoring of this requirement. Nissan documented no training beyond the

²² To establish knowledge, the Secretary need not show Nissan knew its failure to train was hazardous. Under Commission precedent, “[t]he knowledge element is directed to the physical conditions that constitute a violation, and the Secretary need not show that an employer understood or acknowledged that the physical conditions were actually hazardous.” *Danis Shook Joint Venture XXV*, 19 BNA OSHC 1497, 1501, 2001 CCH OSHD ¶ 32,397, p. 49,865 (No. 98-1192, 2001) (citation omitted), *aff’d*, 319 F.3d 805 (6th Cir. 2003). *Boh Brothers Construction Co., LLC*, 24 BNA OSHC at 1074.

initial 10-minute video containing an overview of lockout.²³ Nissan failed to establish it communicated its training obligations to supervisors or took steps to ensure employees were properly trained on lockout procedures applicable to their work assignments.

Nissan failed to establish the violation of § 1910.147(c)(7)(i) was the result of unpreventable employee misconduct.

Characterization

The Secretary alleges the violation was serious. A violation is serious when “there is a substantial probability that death or serious physical harm could result” from the hazardous condition at issue. 29 U.S.C. § 666(k). The Secretary need not show that there was a substantial probability that an accident would occur; only that if an accident did occur, death or serious physical harm would result. Training employees on lockout is necessary to ensure they know how to protect themselves from exposure to unexpected startup of machinery. As demonstrated by the injured employee’s partial amputation, the likely injury should an employee be in the zone of danger when the conveyor restarted unexpectedly is serious physical harm. Item 2, Citation 1, is properly characterized as a serious violation.

Penalty Determination

The Secretary proposed a penalty of \$12,675.00 for Item 2, Citation 1. The Commission, in assessing an appropriate penalty, must give due consideration to the gravity of the violation and to the size, history and good faith of the employer. *See* § 17(j) of the Act. The Commission is the final arbiter of penalties. *Hern Iron Works, Inc.*, 16 BNA OSHC 1619, 1622, (No. 88-1962, 1994), *aff’d*, 937 F.2d 612 (9th Cir. 1991) (table); *see Valdak Corp.*, 17 BNA OSHC 1135, 1138 (No. 93-0239, 1995) (“The [OSH] Act places limits for penalty amounts but places no restrictions on the Commission’s authority to raise or lower penalties within those limits.”), *aff’d*, 73 F.3d 1466 (8th Cir. 1996). In assessing a penalty, the Commission gives due consideration to all of the statutory factors with the gravity of the violation being the most significant. OSH Act § 17(j), 29 U.S.C. § 666(j); *Capform Inc.*, 19 BNA OSHC 1374, 1378 (No. 99-0322, 2001), *aff’d*, 34 F. App’x 152 (5th Cir. 2002) (unpublished). “Gravity is a principal factor in a penalty determination and is based on the number of employees exposed, duration of exposure,

²³ Failure of a party to present evidence under its control raises an inference that evidence would not support its position. *Capeway Roofing Systems, Inc.*, 20 BNA OSHC 1331 (No. 00-1968, 2003) (citations omitted); *see also Regina Contr. Co.*, 15 BNA OSHC 1044, 1049 (No. 87-1309, 1991).

likelihood of injury, and precautions taken against injury.” *Siemens Energy and Automation, Inc.*, 20 BNA OSHC 2196, 2201 (No. 00-1052, 2005).

The gravity of the violation is high. Unexpected startup of the conveyor exposed the technicians to serious injury over the period required to perform the preventive maintenance inspection. Nissan failed to take precautions to ensure the technicians were protected from this hazard. The mechanic performing maintenance on the robot was unaware employees were on the mezzanine level. Neither the technicians nor their supervisor was aware the mechanic had shut down the conveyor or that he would restart it while they were inspecting CP-M7. This lack of coordination increased the likelihood of injury to the technicians, warranting a high gravity based penalty.

In assessing a penalty, I have taken into account mitigating factors. Nissan is a large employer. This facility had over 6,000 employees. Nissan is not entitled to consideration for size. CSHO Oglesby testified Nissan has received a serious citation in the past (Tr. 67). The record contains no more detail regarding Nissan’s citation history. With regard to good faith, I find the serious discrepancies between Nissan’s written policies regarding training and its training practices to weigh against a finding of good faith.

Based upon the forgoing considerations, a penalty of \$12,675.00 is assessed.

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, Citation 1, alleging a serious violation of 29 C.F.R. § 1910.147(c)(9) is **VACATED**;
2. Item 2, Citation 1, alleging a serious violation of 29 C.F.R. § 1910.147(c)(7)(i) is **AFFIRMED** and a penalty of \$12,675.00 assessed.

SO ORDERED.

/s/ Heather A. Joys

Date: July 20, 2018

Administrative Law Judge
Atlanta, Georgia