

DIVISION OF OCCUPATIONAL SAFETY AND HEALTH



Accident Investigation Summary

Reporting ID	Investigation Summary Number	OSHA-36 Number	OSHA-36 Establishment Name
0950625	201493178	101081263	Strategic Outsourcing Inc
Event Date	08/28/09	Event Time	04:50 am
Type of Event	Chain and sprocket drive injury		

Inspection Number/ Establishment Name	312913700 Strategic Outsourcing Inc
Injured/Deceased Name	[REDACTED]
Sex:	M. Male
Age:	34
Injury:	B. Hospitalized
Nature:	01 Amputation
Part of Body:	12 Hand(s)
Source of Injury:	26 Machine
Event Type:	02 Caught in or between
Environmental Factor:	01 Pinch point action
Human Factor:	17 Insufficient or lack of engineering controls
Task:	A Regularly Assigned
Substance Code:	
Occupational Code	749 - MISCELLANEOUS TEXTILE MACHINE OPERATORS

Abstract:

On 08/28/2009, the Safety Coordinator, Strategic Outsourcing, Inc. (herein: SOI) [an Professional Employer Organization: PEO] notified the Division of an occupational injury that occurred in the early morning at a Soex West Textile Recycling USA, LLC (herein: Soex) in Fresno, CA. As reported a thirty-four year old machine operator was clearing "trash fiber" from underneath a newly commissioned Chinese carding machine with a hook formed from 0.5 inch rigid conduit. The pile of fiber became large enough to cover an unguarded chain and sprocket drive that was mounted on the floor. While removing the fiber pile EE1's right thumb was pull through the chain and sprocket resulting in the amputation at

the distal joint. A previous serious injury occurred 7/29/09 at the same chain and sprocket, while the operator was performing the same task. Perimeter guarding without interlocks or other physical barrier were installed after the initial injury, although were found to be not appropriate [REF: 8 CCR 3942(a)], therefore ineffective guarding for a continuous removal operation (clean out frequency every 3 to 4 minutes). Operators were not provided training, nor were hazardous energy control procedures developed. Soex recycles clothing, rags and carpet to produce matting used in the automotive industry. Soex Fresno facility has a contracted consultant acting as the CEO. Essentially Soex does not have employees, since all employees working in the facility are leased from SOI. SOI claims to not exercise direction or control of employee and denies responsible for providing a safe working environment.

170-A NARRATIVE SUMMARY ADDENDUM

EMPLOYER: Strategic Outsourcing, Inc.

CASE FILE NO.: 312913700 **Form 36:** 101081263

SECTION I: Who reported to the Division?

Event occurred 8/28/09 at 0450 hours. Notification was made to Division by the SOI Safety Coordinator 8/28/09 at 1115 hours.

Employer reported within requirements of 8CCR 342(a).

SECTION II: Nature of the injury.

Employee suffered traumatic amputation of 1st digit of right hand interphalangeal joint.

SECTION III: EE work activity.

Employee was removing "trash fiber" from underneath a Chinese Carding machine (Sometimes: Chinese Combing Machine) with a long handled hook fabricated out of 0.5 inch rigid conduit.

SECTION IV: Statements of EE's that were witness or nearby the incident.

EE1 STATEMENT OF EVENT: Initial interview conducted at Soex West Textile Recycling USA, LLC on 1/13/10 with the Office Manager as interpreter. A subsequent interview was conducted with Jose Boria, ASE DOSH/Fresno acting as interpreter.

EE1 had been a past employee of Select Personnel assigned to the Chamblin, (the previous facility owners) since 2005, and became an employee of SOI April 2009. Previous work experience was a maintenance mechanic for 11 months.

1/13/10: EE1 verified his injuries and he claimed to be an SOI employee.

EE1 was assigned by Miguel Garcia (Plant Operations Manager/ POM) to operate the newly installed deployed carding machine, which was installed late July 2009 [reference Inspection 312913962]. EE1 verified the process: the carding machine pulls apart carpet strands into fibers by passing of rollers with tangs. The carding machine was in its shake out stage of operation/development and created a large amount of fiber (herein: trash fiber) that falls under the machine. It was necessary to remove trash fiber with an extension tool, a hook, fabricated from 0.5-inch rigid conduit to prevent jamming the machine. As the fibers extracted from the operating machine it would expand in volume to form a pile large enough to cover the chain and sprocket drive. EE1 demonstrated a two handed scoop motion to remove the fiber from the floor. EE1's hand was exposed to chain and sprocket drive amputating the 1st digit at the interphalangeal joint when pulled through the in-running nip point. EE1 claims frequency of trash fiber removal was every 3 to 4 minutes (almost continuous).

EE1 claims he was provided specific training related to the hazards to which he was exposed when he worked for Chamblin. EE1 asserted he was given training by Miguel Garcia and Alex (electrician) [NOTE: EE1 did not indicate training by SOI/SOEX. EE1 asserts that he was not being supervised because his injury occurred early in the morning before Miguel was the facility. EE2 was there although working approximately 50 feet away. EE1 identified the area where he was working from a photograph taken post event.

2/18/10: Second Interview

EE1 claims LOTO training he was provided 8/7/09 (verified by reviewing sign-in sheet) was for operation of the machine at the electrical panel and not provided a lock until after he was injured. EE1 installed the yellow perimeter guarding/fence, which was never provided with a lock nor was told to stay out of the guarded area. EE1 claims POM required him to go into the guarded area and remove the trash fiber. As reported, the guard caused a conflict with the extension tool, so that trash fiber could only be brought completely through the frame opening, which required the removal by hand. EE1 stated he had to work on his hands and knees and reach into the frame opening to remove the fiber. EE1 claimed he worked very close the unguarded chain and sprocket, but he had to remove the fiber to do his job.

EE1 asserted Paul Flor, SOI safety, told him the chain and sprocket needs to be guarded. He conveyed the message to the POM, who responded it did not need to be guarded in expletive language. EE1 felt threatened and went to work.

EE1 was asked what training he was provided 8/7/208 (NOTE: typo error 8/7/2009) and was shown the sign-in sheet for the alleged LOTO training. EE1 asserted the training was for the operation of the machine at the electrical panel, and did not address LOTO.

Again, EE1 claimed this was the first time he was working as an operator; he was not being supervised and did not receive training. In addition, EE1 provided names of other operators, Antonio Diaz, Israel, and Jobere, who were required to remove trash fiber with the carding machine in operation.

EE2 STATEMENT OF EVENT: Interview conducted at Soex West Textile Recycling USA, LLC on 1/13/10. This interview was conducted in conjunction with the accident investigation of EE2's injury July 29, 2009. EE2 was injured on the same machine and same chain and sprocket while removing trash fiber.

EE2 had been a past employee of Select Personnel assigned to the Chamblian, (the previous facility owners) since 2005, and became an employee of SOI April 2009. Previous work experience includes: 4 years as a machinists mate in the Navy; cabinet/carpentry; landscaping; bus driver.

EE2 confirmed he was working approximately 50 yards from EE1 when he was injured. As reported, the POM, requested EE2 to watch EE1 to make sure he got started OK, and then go to operate Line 4. EE2 remarked that other operators, Jose and Antonio, referred to it as a "dangerous machine" and no guard was in place when EE1 was injured. EE2 stated the frequency of removing trash fiber was 3 to 4 minutes.

EE2 Account of his injury 7/29/2009:

EE2 was assigned by Miguel (supervisor) to operate the newly installed carding machine. The carding machine pulls apart carpet strands into fibers by passing of rollers with tangs. The carding machine was in its initial stage of operation/development (in operation for 1 to 2 days) and creating a large amount of fibers that fell under the machine. It was necessary to remove trash fiber with an extension tool, a hook, fabricated from 0.5-inch rigid conduit to prevent jamming the machine. As the fibers extracted from the operating machine would expand in volume to form a pile large enough to cover the chain and sprocket drive. EE1 was using a two-handed scoop motion to remove the fiber when his hand came into contact with chain and sprocket drive. EE2's third digit of his right hand was pulled through the in-running for the chain and sprocket resulting in the soft tissue and bony amputation.

EE2 claims he was not provided specific training related to the hazards to which he was exposed. EE2 asserts that he was being supervised because there are two supervisors working at night. EE2 identified the area where he was working from a photograph taken post event.

INSPECTION OF CHINESE CARDING MACHINE: Machine was inspected on 1/13/10

At time of inspection, the machine was guarded by perimeter barrier with three interlock protected entry doors. The perimeter guarding was installed after the injury event 7/29/09. Additionally, the chain and sprocket drive was guarded with a yellow metal guard that was installed after the injury event in August 2009.

Inspection orientation is in the direction of the material flow: material intake is in the front; discharge is the rear.

Machine is located in the north-west area of the main building. Inspection was delineated to the right side of the discharge end of the machine. It is noted lighting in this area of the building is marginal. At the time of this inspection, the machine was partially disassembled for repairs. The COO explained the operation and function of the machine. Carding is the main function of the machine, which shreds twisted carpet fibers into individual fibers by passing the fibers through sets of counter rotating rollers equipped with knives. There are five electric drive motors on the machine. The machine is similar to a multi-station drum-printing machine with a large main cylinder surrounded by smaller cylinders, workers, and strippers. All cylinders have combs or teeth to shred the carpeting. Workers rotate faster and in the direction as the main cylinder, while strippers rotate in the opposite direction. Strippers clean the fiber from the workers. A vacuum source removes the fibers and transports them through ducts to a storage receiver.

At the left side of the discharge end is a chain and sprocket drive system mounted to the floor, which drives the workers and strippers. The drive is mounted close to the frame of the machine, where access to underneath the machine was identified as the clean out point.

ER provided pictures of the area post event with the chain and sprocket unguarded.

SECTION V: 8CCR standards and section that apply to incident.

1. Section – 3203(a); (a)(4)(D); 3203(a)(7): IIPP
2. Section – 3314(c); (g);(j)1): HEC
3. Section – 3942(a): Appropriate/Effective guarding
4. Section – 4070(a): Belts/Pulley, guarding
5. Section - 4075(a): Chain/Sprocket Drive, guarding
6. Section –:4051: Shaft End, guarding

SECTION VI: What was the ER or EEs doing to constitute a violation of the safety orders?

- EE1 was cleaning (removing trash fiber) with the machine in operation.
- EE operator was exposed to unguarded chain and sprocket and V-belt drive.
- EE operator was not provided training.
- LOTO procedures were not developed.
- A IIPP was not established.

SECTION VII: Summary

Root cause of the injury is the failure to provide physical barriers for chains and sprocket provide effective training to the operator and access the hazards to which operators would be exposed. Since this is the second injury event on the same machine at the same point of operation and during the same operation, removal of trash fiber, an element of willful is present. After the 7/29/09 injury, Soex and SOI were as aware of the hazard and installed a perimeter guard without interlock safety devices. As reported by EE1, SOI safety knew the chain and sprocket required guarding (no mention was made as to the v-belt and pulley system) and this fact was conveyed to the POM by EE1. POM ignored the matter, became threatening, and used expletive language towards EE1 and other EEs for bringing it up. SOI, as the co-employer, made no effort to insure EE operators were not exposed to the hazard.

The Soex facility operated in a condition of "employer in absentia", which accounts for the lack of responsibility for employee safety. Soex contracted with a SOI, a PEO, which assumes the administrative responsibility for employment, including payroll, payment of payroll liabilities, and coverage for worker's compensation, although claims to have no onsite presence nor exercised control/direction of the employees with regard to safety. The PEO's position is they are not responsible for the safety of these employees and have contracted to Soex. Although the presence of SOI is established through the management authority of the POM, who asserts he is an employee of SOI and has the authority to hire/fire and direct operations. In addition, the Board has upheld that the responsibility for safety cannot be contracted away.

Parameters of this case may have a closer relationship to a multi-employer inspection than a dual employer association where SOI is the exposing employer, Soex USA is the creating employer, and Soex GmbH is the controlling/correcting employer. SOI has contracted authority to enter the Soex facility, and would have authority for removal of employees exposed to unsafe conditions. SOI was onsite, inspected the carding machine, recognized the hazard (after the 7/29/09 injury), although made no attempt to protect EE operators from the hazard. SOI's Risk Manager asserted the Paul Flor is a qualified occupational safety consultant. This being the case, he should have evaluated the measures Soex implemented, installing perimeter guarding without the necessary elements to make it effective and appropriate [REF: T8 CCR 3942(a)]

This investigation is based on EE statements/interviews, substantive information provided by the employer, review ER's safety committee report.

A serious accident related citation is warranted in this occupational injury. Issue Cal/OSHA 170C and citations Item 1.1 thru 10.1
 Issue Date: 2/4/10

	Signature	Date
Prepared By: R. M. Frye Jr., ASE/IH	[Redacted Signature]	3-4-10
Reviewed By: DM/SR. IH	[Redacted Signature]	3/4/10