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| CSHO ID: | Y6421 |
| OPTIONAL REPORT | 59-16 |
| INSPECTION NUMBER: | 1172502 |
| DATE CASE OPENED: | 08/12/2016 |
| TYPE INSPECTION: | Fatality/Catastrophe |
| EMPLOYER: | The Goodyear Tire and Rubber Company<br>1901 Goodyear Blvd<br>Danville, VA 24541 |
| BUSINESS TYPE: | Rubber tire manufacturer |
| DPOR LICENSE NO.: | N/A |
| INSPECTION SITE: | 1901 Goodyear Blvd<br>Danville, VA 24541 |

## I. BACKGROUND

A. PURPOSE – This inspection was initiated as a result of an accident which occurred at the accident site listed above at 05:30 AM on August 12, 2016. This accident resulted in a fatality of Mr. William Scheier.

The accident/fatality was reported to the VOSH Roanoke Regional Office by Mr. Jim Lane, safety representative for Goodyear. Mr. Lane reported the fatality to the Roanoke Regional office on August 12, 2016 at 01:00 PM.

B. WORKSITE DESCRIPTION – The Goodyear plant in Danville VA is a large plant and manufactured multiple types of rubber tires at the facility. The fatality that occurred at the Danville plant on August 12, 2016 occurred at alpha shear #16. This fatality inspection focused on the alpha shear department only. Goodyear had a total of 13 alpha shears in the alpha shear department.

C. INSPECTION HISTORY –Below is a listing of the most recent Goodyear-Danville inspection activity (In order of the oldest to most recent—including this fatality inspection-#1172502):

1. Inspection #317686178 – Safety Complaint – Opened on 04/08/2014
2. Inspection #1089281.015 – Fatality – Opened on 09/01/2015
3. Inspection #1136814.015 – Fatality – Opened on 04/01/2016

INSPECTION HISTORY (CONTINUED)

4. Inspection #1130753.015 – Fatality – Opened on 04/12/2016

5. Inspection #1143317.015 – Safety and Health Comprehensive inspection –Opened on 04/19/2016.
6. Inspection #1168732.015 – Safety – Partial – Opened on 04/25/2016
7. Inspection #1172502.015 – Fatality – Opened on 08/12/2016

## D. CONDUCT OF THE INSPECTION

1. OPENING CONFERENCE – The opening conference was conducted with Goodyear and United Steelworkers of America union representatives on August 12, 2016. See the VOSH inspection worksheet (IW1) for a list of all persons with Goodyear and the union who attended the opening conference.

2. WALKAROUND – The walkaround was initiated on August 12, 2016 and was conducted over the course of a four week period with days spent onsite on August 12, 15, 23, 24, 30, and 31. In September the inspection continued on September 13, 14, 15, 20, 21, and 22, 2016.

3. CLOSING CONFERENCE – The closing conference will be held following the VOSH significant case file review.

## II. FINDINGS OF FACT

A. An accident occurred on August 12, 2016 at about 05:30 AM that caused fatal injuries to an electrician, Mr. William Scheier who was making adjustments to the proximity switch on alpha shear #16.

B. Alpha shear #16 was equipped with a circular cutting wheel that traveled along the alpha shear cutting table to cut rubber to the desired width as it was fed onto the shear. (Photo #3631 and #3639. See video clip #4518 – CD #3)

C. The shear had an orange clamp down device that held the rubber in place while the shear traveled down the shear table and cut the rubber. Once the rubber was cut the cutter head traveled to the starting cutter head position at the end of the clamp down device.

D. When the alpha shear is reset after a machine fault, the cutter wheel returns from the cutter head start position to the home position (all the way at the end of the alpha shear).

E. Alpha shear #16 had an opening between the end of the orange clamp down device and the home position. (See video clip #3657 –00:08-00:14)

F. The proximity switch that Mr. Scheier was adjusting was located inside the green housing of the alpha shear (home position) as shown in photos and video clips referred to above.

G. Mr. Scheier was leaning through the opening between the hold down device and the home position.

H. The area where Mr. Scheier was working had a "cage" barrier around it and the entrance door to the cage was equipped with an interlock. When the door was opened, the break of the interlock system prevented the alpha shear from operating.

I. On the opposite side of where Mr. Scheier was standing when fatally injured, guards made of expanded metal (mesh) were installed. The guards were installed on hinges and could be lowered so that area of the alpha shear could be accessed when necessary. These hinged guards had interlocks which prevented the alpha shear from operating when the guards where lowered.

J. A maintenance co-worker who was classified as a mechanic was positioned on the side of alpha shear #16 where the interlocked, hinged guards were located that were described in paragraph I.

K. The Goodyear maintenance workers considered the task of adjusting the proximity switch to be "troubleshooting" and lockout/tagout procedures were not utilized.

L. Goodyear did not have any alternative procedures to use when troubleshooting was being done to protect employees from serious injury or death due to accidental or inadvertent start up while an employee was exposed to moving parts of the alpha shear.

M. While Mr. Scheier was leaning into the alpha shear, in the area between the cutter wheel and the proximity switch, the alpha shear was reset which caused the cutter wheel to travel back toward the home position.

N. As the cutter wheel began traveling back toward the home position, Mr. Scheier was caught in between the cutter wheel and the frame work of the alpha shear at the home position area.

O. Mr. Scheier was found by a co-worker in a slumped position, immediately after the fatal accident, with the cutter wheel holding his body from falling to the floor.

P. Goodyear in-house first responders responded to Mr. Scheier and tended to him until lifesaving crew personnel arrived on scene.

Q. Mr. Scheier was pronounced dead from his injuries at the plant by EMS at 06:46 AM .

R. An autopsy was conducted and the manner of death was classified as an accident. The cause of death was blunt injuries to the chest and mechanical asphyxia.

S. A VOSH fatality inspection was opened by VOSH compliance officers (C.O.) Monty Beasley and Stuart Henderson on August 12, 2016. This fatality inspection was transferred to VOSH lead safety inspector Rusty Bambarger on August 15, 2016. C. O. Robert Farmer was assigned to assist C. O. Bambarger beginning on August 22, 2016.

T. C.Os Bambarger and Farmer conducted a walk around inspection at alpha shear #16 (the shear fatality victim William Scheier was working at) on August 23, 2016. While conducting this walk around inspection, Bambarger and Farmer found a sign that had been posted at alpha shear #16 sometime after the fatality on August 12 and Bambarger's and Farmer's return to Goodyear on August 23. The sign stated: **DANGER All Hazardous Energy Must Be Controlled Before Working In This Guarded Area.** (See Photo #3632) C. O. Bambarger asked Jim Lane for a copy of the alternative procedures but was told there was none. Bambarger was told that if alternative procedures were necessary the operator and maintenance personnel were expected to get together and talk the situation over and decide on a plan.

U. C. O.s Bambarger and Farmer conducted multiple recorded interviews statements with Goodyear employees on August 23 and 24. The Goodyear production employees were represented by the United Steelworkers union and each union member who was interviewed was offered to have a union representative present during the interview. Most interviewees preferred to be interviewed without union representation. However, a small number of union employees stated their preference to have a union representative present and in each case the request was honored by the compliance officers.

V. In addition to the observations of the alpha shear #16 by C.O.s Bambarger and Farmer, and the employee interviews there were conducted, C. O. Bambarger, scheduled management interviews for the following Tuesday, August 30, 2016. It was necessary to schedule these management interviews so that Goodyear attorneys could be present, as they requested.

W. On Tuesday, August 30, 2016, C. O. Farmer and Bambarger interviewed 10 supervisors and managers. Attorneys (2) for Goodyear refused to allow the supervisor/manager statements to be recorded. All supervisor and manager interviews were written down on VOSH Supervisor Interview Statement forms.

X. It was discovered by the compliance officers during many interviews of both production employees and supervisors/managers, that written lockout/tagout procedures, specific to the alpha shears had never been seen or used by many of the employees and supervisors/managers.

Y. The VOSH compliance officers discovered that when an alpha shear had a fault (problem causing an automatic shutdown) and the reset button was depressed, the alpha shear cutter wheel returned to the home position when a reset button was depressed. During multiple interviews where employees and supervisors/managers were asked if they knew depressing the reset button caused the cutter wheel to return to the home position, most responded that they did not know this until after the Scheier fatality occurred on August 12.

Z. C. O. Bambarger requested that alpha shear #16 be shut down and locked out using written procedures established by Goodyear to demonstrate the effectiveness of the procedures and the employee's ability to comprehend and carry out the procedures. This request was denied by Mr. Jim Lane, Regional Safety Director for Goodyear.

AA. C. O. Bambarger requested on August 23, 2016 that alpha shear #16 be simply turned off with the cutter head not in the home position so the reset button could be pressed both while the power was off in the machine and after the power was restored. Mr. Lane, denied the request stating that it would interfere with production. During supervisor/manager interviews conducted on August 30, 2016, C.O. Bambarger repeated his request to have the alpha shear #16 shut off to view the effect of the reset button to Patrick Lewis, a Littler Mendelson attorney who was representing Goodyear in the interviews. Mr. Lewis denied permission as well for the reset button demonstration.

AB. The denials by Mr. Lane to allow the lockout demonstration and the demonstration of the reset button's effect on the cutter wheel returning to home position were seen as interference with the VOSH inspection and a denial of entry to inspect items integral to determining the safety of the alpha shears.

AC. C.O. Bambarger reported this denial of entry though the appropriate VOSH channels in an effort to obtain an administrative search warrant. The appropriate documentation for the warrant was written up by the Division of Legal Support.

AD. On September 13, 2016, C.O.s Bambarger and Farmer went before a Circuit Court Judge of the City of Danville along with Commonwealth's Attorney Michael Newman and VOSH staff attorney Rob Field of the Division of Legal Support to seek the administrative search warrant. The Judge granted the warrant.

AE. The inspection warrant granted to VOSH allowed the compliance officers to view three of the 13 alpha shears to see how cutter wheel reacted and if it returned to the home position when the reset button was depressed. Additionally, the warrant allowed the compliance officers to observe Goodyear employees while performing lockout procedures on all 13 alpha shears using written procedures developed by Goodyear.