Kentucky Labor Cabinet
Occupational Safety and Health Program
Inspection: 318098621  CSHO ID: N6859     Report Number: 012-19
Establishment: HAIER US APPLIANCE SOLUTIONS INC DBA GE APPLIANCES

Penalty Credits

Number of Employees: 12300    Size Credit: 0    Good Faith: 0    History: -10

Basis for Penalty Credits

Size: Calculated from the total maximum national employment in the previous 12 months as stated by the employer.

Good Faith: Based on the evaluation of the employer's safety and health program as summarized below.

Past History: No prior related history.

Evaluation of Employer's Overall Safety and Health Program:

History: -10%: The company had serious citations as the result of inspection 318084654 which became a final order on or about September 27, 2017, and inspection 318092111 which became a final order on or about April 25, 2018. Copies of the citations are included with this report.

Good Faith: 0%: The company had written safety and health programs, provided safety training and had a safety committee. No good faith is recommended, as violations of the lockout tagout program and multiple high severity greater probability violations are being recommended.

The company had a written hazard communication program that covered labeling, safety data sheets, chemical inventory, and training. The program appeared to be complete and no citations are recommended. A copy of the program is included with this report.

The company had a written lockout tagout program. The program had deficiencies in training, machine specific procedures, and periodic inspections. Citations are recommended. A copy of the program is included with this report.

Narrative Comments

A. Purpose and Scope of Investigation:

A Fatality Inspection was conducted at Haier Appliance Solutions, Inc. dba GE Appliances, located at 4000 Buechel Bank Road, in Louisville, Kentucky, on February 17, 2019. The February 15, 2019, incident, took place in Building AP3, where refrigerators were manufactured.

B. Description of Process:

The company performed stamping, injection molding, fabrication, and assembly operations in the building.

C. Principal Product:

Refrigerators.
D. Opening Conference Notes:

Upon arrival at the site CSHO Bendorf was met by Mr. Tom Courtney, EHS Leader Appliance Park. CSHO Bendorf presented his credentials and explained the purpose, nature, and scope of the inspection. Mr. Courtney authorized the inspection. Mr. Courtney stated his company was a union facility. An opening conference was conducted in a conference room of AP 5. Mr. Tom Courtney, Mr. Mike Groh, Global Health & Safety Leader, Ms. Dora Mudd, EHS Leader for AP5, Mr. Tim Vibbert, Plant Manager for AP5, and Mr. Dennis Peach, Union Safety Representative, and Mr. Dino Driskell, Union President were present. The details of the February 15, 2019, incident were discussed. CSHO Bendorf requested the OSHA 300 logs and annual summaries for the previous 5 years and the 301 form for the incident.

The company requested that all documents, pictures, and videos be marked as RESTRICTED TRADE - ADMINISTRATIVELY CONTROLLED INFORMATION.

E. Walkaround Inspection Notes:

A walkaround inspection was conducted in the door foam loop line for the North and South Loops. The inspection findings are explained in Section G.

F. Closing Conference Notes:

A Closing Conference was conducted on August 12, 2019 with Mr. Michael Groh, Global Health and Safety Program Director, Mr. Matt Garr, EHS Director Appliance Park, Ms. Dora Mudd, EHS Leader AP5, Ms. Andrea Bartley, Senior HR Business Partner, Mr. Tim Vibbert, AP5 Plant Manager, Mr. Dennis Peach, Union Safety Rep, and Mr. Dino Driskell, Union President. A copy of the Post Inspection Guide, Publications Request Form, and Closing Conference Checklist were provided for the company and the union.

G. Summary of Complaint, Referral, Accident or Followup Findings:

On February 15, 2019 at approximately 12:30 PM an employee was caught between a moving Fixture and a fixed set of stairs, in the South Door Loop Area, and suffered crushing type injuries. The employee was extricated from the equipment and transported to University Hospital, where he was admitted. The employee passed away on February 17, 2019 at approximately 8:10 AM from injuries sustained during the February 15, 2019, incident. Mr. Tom Courtney, EHS Leader, called to report the hospitalization on February 16, 2019 at approximately 2:44 PM. The Kentucky Labor Cabinet, Division of Occupational Safety and Health Compliance learned of the workplace fatality from a local media report.

CAUSE OF DEATH: Mr. Steve Herring, Controlman, died on February 17, 2019 from multiple blunt force trauma compression “crush” injuries involving the pelvis and abdomen. Mr. Herring was caught between a piece of moving equipment and a fixed object, on February 15, 2019 and was transported to the hospital, after being extricated from the equipment, where he remained until he passed away.
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Findings: Mr. Herring, was a Controlman, who ran the South Door Loop. The South Door Loop was a process area where refrigerator or freezer doors were loaded into fixtures, moved on a conveyor line to a foaming room where they were injected with insulation, moved on the conveyor line to a curing oven, unloaded from the fixtures via a robot, and moved to a separate conveyor line for production. There were no witnesses to the February 15, 2019, incident and no video coverage of the area. A loader, who worked farther down the line, putting liners in the fixtures, looked up and saw Mr. Herring on the side of the line flailing his arms and saying help. The employee stated in was not uncommon to see Mr. Herring, in the area he was pinned, performing his normal work. When the employee realized that Mr. Herring was in need of help, the employee left the area to get help. The employee found a 2nd shift team lead and reported the need for help, but the team lead did not have a radio.

An employee heard the screams that Mr. Herring was stuck and went to the area. The employee went to the area, saw that Mr. Herring was stuck, and sat down on the conveyor line to allow Mr. Herring to lean over and provided support. When that employee arrived at the scene, there was no one else present. The employee could see that Mr. Herring was pinned and unable to move. The employee observed that the gate was open and was able to enter the area to sit on the steps next to Mr. Herring. The employee did not press any E-stops but said the line was not moving. The employee did not see anyone lockout the equipment.

A group of management employees and maintenance employees responded to the area. The employees unboltd the stairs from the ground to remove them from the area and unbolted a fence from the robot area to move it out of the way. The employees were able to free Mr. Herring from the machinery and place him on a stretcher. Haier security/ems workers and nursing staff responded to the area to help attend to Mr. Herring. Fire fighters / EMS employees from Buechel Fire Protection District and Okalona Fire responded to the site and transported Mr. Herring from the South Foam Loop Area to an ambulance outside. He was then transported via ambulance to University Hospital.

Immediately after the injured employee left the site the company began re-installing the equipment on the South Door Loop and began an accident investigation with immediate corrective actions.

The KYOSH inspection was opened on Sunday, February 17, 2019, when it was reported, by local news media that day, that Mr. Herring had passed away. At the time of the inspection there was no normal production running in AP5, the South Loop had been suspended, and there had been changes made to the location of control buttons and computer programming for the South Loop.

CSHO Bendorf was unable to determine why or how Mr. Herring entered the Loop conveyor area with the equipment operating or able to operate. The CSHO was able to identify multiple work related reasons to enter the area in the performance of the work. Regardless of why the employee was inside the area, he was in an area with a lack of proper machine guarding and regularly entered without performing lockout tagout as required by the regulations.

The Process:
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The South Door Loop was a process area where doors were loaded into fixtures, moved on a conveyor line to a foaming room where they were injected with insulation, moved on the conveyor line to a curing oven, unloaded from the fixtures via a robot, and moved to a separate conveyor line for production. The February 15, 2019, incident occurred in the unloading area. The Controlman ran the process primarily by attending to computer screens and controls. In the unloading area, doors would occasionally get stuck in the fixtures requiring the Controlman to enter the area and manually free them. The Controlman was also responsible for cleaning the fixtures prior to the shift. The Controlman worked both inside the Loop and outside the Loop as needed. The company had a North Loop and a South Loop that both performed the same operations. The South Loop ran approximately 250 doors per day and the North Loop ran approximately 1,350 doors per day.

The conveyor was an automated self-starting and stopping process that moved the fixtures through the loop. A Fixture was a large folding device that carried doors through the loop process. It appeared similar to a die, however its purpose was to carry doors through the foaming process. The Fixture was hinged like a clamshell and would open and close as it moved through the process. The conveyor line was approximately 33.5 inches above the ground. Access to the inside of the loop was made by crossing over the conveyor line near the unloading robot. There was a Crossover Area with a gate on either side and steps on either side to allow employees to enter, climb the steps, walk across the conveyor, go down steps and exit another gate on the opposite side. The distance between the gates was 11 feet 9 inches. The fixtures that moved on the conveyor were large clamshell type holders for the doors that opened and closed to carry the doors through the loop process.

Access Gates South Loop:
In order to cross into the loop an employee had to use the access gates. An employee would push a control button next to the gate signaling a desire to open. When the process was in a stopped position, the gate would unlock and the operator could enter. Both gates had to be closed for the process to re-start. On the South Loop the unload robot could continue to operate with the access gates open. The North Loop had a programming change and the offload robot would not operate with the gates open.

Reasons to be in the area:
Crossover. Employees interviewed stated the normal procedure to enter the loop was to use the cross over area and that no lockout tagout was required. Employees would enter and exit the loop by pressing a button on the side of the gate to request an open. The conveyor system would determine when a “safe” condition existed and allow the gate to open while stopping the conveyor. The employee would cross the conveyor line and exit a gate on the opposite side and push a button on the side of that gate to request the line re-start.

The “safe” area was a programmed positioning of the fixtures so that they would be clear of the cross over area and not in a zone that had been painted red. Video included with this report, taken after the February 15, 2019, incident and after programming changes to the system depicts the gate entry process.

Clearing jammed doors. It was stated, by the group of managers on the walkaround inspection including but not limited to Mr. Tyler Jett, Area Business Leader Pre Foam Doors, Mr. Tim Vibbert, Plant Manager, AP5, that doors would regularly get stuck in the fixtures at the off load robot area, usually due to foam leaking or other issues. Employees including but not limited to employee 11, employee 12, employee 14,
employee 15, and employee 20 also confirmed that doors would regularly get stuck in the fixtures. No one contacted during the inspection contradicted the statement that doors regularly got stuck in the fixtures. If a fault occurred in the system an alarm would sound. The first step the Controlman would take would be to clear the alarm on the HMI screen and then go to enter the area and clear the jam. The alarm did not signal startup of the machine and silencing it was the first step in the process of clearing a fault. The process to unjam the door was for the Control Man to enter via gate (using the same process as crossover), walk up the conveyor line to the fixture and use a pry bar or tool to free the door, either leave the door in the fixture or push it up to the suction cups on the offload robot, leave the area, close the gate, and re-start the line. This procedure was not performed under lockout tagout and employees were exposed to the potential for unexpected energization or startup of the machines and or the release of stored energy. A citation is recommended.

Cleaning. The Controlman was responsible for cleaning the fixtures on a daily pre-shift basis. The control man would start work approximately 1 hour before normal production. Prior to production all of the fixtures would be cleaned. The cleaning involved the control man entering the conveyor area, scraping old foam residue of the fixture with putty knife type scrapers, blowing the fixtures off with compressed air, and applying a releasing agent to the fixture. This procedure was not performed under lockout tagout and employees were exposed to the potential for unexpected energization or startup of the machines and or the release of stored energy. This procedure did not take place during normal production operations.

Preventative Maintenance / Equipment Repair. Maintenance employees could work on the conveyor and door foam line equipment on an as needed repair basis or a preventative maintenance basis. The procedure for this entry was to enter under lockout tagout. The line was broken into zones so that specific areas can be locked out or the entire system could be locked out. It was stated that the maintenance employees were the only ones who performed service work on the machinery.

LOCKOUT TAGOUT
OSHA Directive CPL 02-00-147 The Control of Hazardous Energy identifies that the improper application of a safety interlock on a machine or piece of equipment would not constitute recognized good engineering practice and would not constitute effective alternative protection. The interlocked gates for the cross over area were not under the exclusive control of the employee performing the minor servicing of the equipment. The Control Man would enter the interlocked gates completely and move towards the fixture located down the conveyor line. There were two interlocked gates leading into the area with two sets of controls. In addition the conveyor line and loop process was controlled by an HMI computer screen controlled by the Control Man, and there were two of these units. One HMI was located inside the loop and one was located outside the loop. A Control Man clearing a jam from a fixture would be located in a position inside the conveyor line area where he could not maintain visual contact with both gates and both HMI screens while performing his work.

Prior to the February 15, 2019, incident, the gate “interlocks” were only a software function and they did not serve as a safety circuit. The computer programming would not allow the gates to open until the fixtures had stopped at a specified location on the conveyor and then would not allow the conveyor to
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re-start until the gate was closed and a button was pushed. The process was all software based and did not have any hardware interface for a safety circuit. After the February 15, 2019, incident a Senior Facilities Engineer added addition safety controls to the interlock system in the form of software improvements and physical safeties. Mr. Mark Miller, Senior Facilities Engineer, stated that the interlocks had been re-designed to completely disconnect all 480 volt power from the conveyor when the gates were opened.

Entry into the conveyor line area at the cross over did not meet the exception to the lockout/tagout standards. The equipment involved contained energy sources including electric, hydraulic, pneumatic, and gravitational. The employees were required to place their bodies into an area of the machine where work is performed with no safe guarding. The entry into the area did not meet the minor service exemption to the standards. The employees cleared jams on the fixture that were routine, repetitive, and integral to the use of the equipment. The employees used tools to clear the jams and had to walk on the conveyor, which was also a hazard. The conveyor line had warning stickers that indicated climbing, sitting, walking, or riding on the conveyor at any time will cause severe injury or death. KEEP OFF. The entry into the area did not utilize alternative measures providing employee protection meeting the requirements of 29 CFR 1910 Subpart O for machinery and machine guarding. The guarding of the conveyor line was not adequate. The interlocked gates did not remove the power to the assembly line or other machinery. The controls were easily defeated as the control buttons were located directly next to the gate. Employees interviewed mentioned pressing the buttons from inside the gate area to advance fixtures. Employees interviewed also stated there were instances of them being inside the gated area when another employee would pass through and re-start the line with them still inside. The railing around the conveyor line also constituted a pinch point hazard as an employee could reach through, over, or under the rail, and be struck by a moving fixture, causing caught between hazards. The railing itself demonstrated this hazard as additional bracing had been added to secure the rail and fence guarding which had been damaged from contact with moving fixtures. The gate controls and the HMI screen controls were not under the exclusive control of the operator while working inside the area. Employees and management indicated that cleaning of fixtures, which took place outside of normal production, would take place without the use of lockout tagout.

Prior to this February 15, 2019, incident, the South Loop off load robot had different programming than the North Loop off load robot. A serious accident occurred on the North Loop in the crossover area on or about 9/4/14. According to employee interviews and management interviews an employee had been struck by the robot while working in the area. After that accident the company made changes to the programming for the off load robot on the North Door Foam Loop. A Senior Facilities Engineer stated he was directed not to make the same changes to the South Foam Loop off load robot at that time.

The company did not properly conduct or certify a periodic review of the lockout tagout machine specific requirements for the Door Foam Loop operations, or the Authorized Employees working in the area. The company had previously been cited for the same violations, Repeated Serious Citations are recommended.

The decedent, Mr. Steve Herring, had been observed by a manager, Mr. Mark Miller, Senior Facilities Engineer, working in violation of lockout tagout requirements, approximately 3 weeks prior to the accident. The manager reported this to Mr. Herring’s supervisor but no lockout tagout re-training was performed or documented. The company did not effectively re-train the employee when deficiencies in lockout were
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observed. In addition there were deficiencies in re-training employees in lockout tagout when they were re-assigned to different areas with different lockout procedures. Citations are recommended.

MACHINE GUARDING
The machine guarding for the conveyor crossover area was insufficient. The gates and rails for the South Foam Loop Area were too close to moving fixtures and created the hazard of employees having body parts caught between a moving object and a fixed object. In addition, the safety interlocks for the gate were easily defeated and the interlocks did not remove the hazardous energy from the equipment. The company had previously been cited for similar violations of the machine guarding requirements. A repeated Serious Citation is recommended.

BLOCKED AISLES
The news and employees interviewed stated that the “A” Aisle was blocked by the storage of damaged refrigerators. The blocked aisle did not appear to hinder the ability to respond to the emergency and did not appear to have caused any delays or additional injuries. The company acknowledged that refrigerators were occasionally stored in the aisle blocking access for powered industrial trucks and pedestrians. A citation is recommended.

EGRESS FROM LOOP
Employees interviewed expressed concerns that there was only one way in and out of the Loop for the Controlman. They stated that the egress could be delayed if a fixture was stopped in front of the cross over gates, which would prevent the system from unlocking the gates and providing egress. Employees interviewed described being personally stuck in the area, after the February 15, 2019 incident occurred at a different time for an extended period due to the emergency stop being activated on the system. CSHO Bendorf did not witness any employees stuck in the area but did observe how the situation could occur. In addition, the normal process did not allow for immediate egress from the area. The CSHO finds that in the event of an emergency an employee could climb over the rails and exit if conditions warranted that response. A citation is recommended.

ACCIDENT RESPONSE:
An employee interviewed stated they were the first one on the scene after the accident and that when they arrived Mr. Herring was trapped between a fixture and the fixed stairs, and the conveyor was continuing to try to move the conveyor down the line. The employee stated Mr. Herring let them into the gated area. Shortly after that Mr. Tyler Jett, Area Business Leader Pre Foam Doors, arrived at the scene and activated the e-stop. Employee 9 came over and entered the cross over area to provide comfort to Mr. Herring. Multiple maintenance employees including but not limited to Mr. Dean Williams, Senior Facilities Engineer, Employee 13, Employee 18, and Employee 21, responded to the February 15, 2019, incident and worked inside the conveyor area, removing the fixed stairs and removing fence guarding for the off-load robot. Mr. Mark Miller, Sr. Facilities Engineer, stated he responded to the site and assisted with the response. He stated he isolated the energy sources and locked the equipment out. The company did not follow proper lockout tagout procedures when multiple employees responded to the February 15, 2019, incident and entered areas with the dangers of release of stored energy, unexpected start-up, and hazardous
energy sources. While employees were responding to an emergency, the failure to follow proper lockout procedures could have resulted in additional injuries to other employees.

The company has investigated the February 15, 2019, incident and believes that the most likely cause was an employee intentionally circumventing the safety systems on the South Foam Door Loop. They do not base this finding on any witness statements or any other facts presented, only that they were unable to determine any motivation for Mr. Herring to circumvent the safety systems and that the error log for the equipment did not show any errors for 45 minutes prior to the incident.

The CSHO finds that the February 15, 2019, incident could have been the result of work related activities, or could have been caused by inadvertent activation of an improperly positioned gate interlock control. Employees and management officials provided multiple reasons for a Controlman to enter the conveyor area and confirmed that such entry was routinely and permissibly made without lockout tagout. One management official confirmed that any entry into the space that could bring an employee within the operating area of the off-load robot should only have been made with lockout tagout. That manager stated he had previously observed Mr. Herring inside that area without lockout and had addressed the issue by requiring the employee to get his locks and lockout the robot, and then by reporting the concern up the supervisory chain. There was no documentation of the safety concern being reported. A recorded interview states that the concern was reported to Mr. Herrings Business Leader, Mr. Patrick Vize. The CSHO also finds that the gate access controls were located too close and were easily accessible from inside the area. Employees interviewed expressed concerns of having accidental contact with the controls from body parts or tools when closing the gate to cross over the area. Employees also expressed concerns of being in the area and having other employees cross over and using the controls when the closed the gate behind them, while they remained inside the area. The company did not meet the elements of an affirmative defense. The conduct of the employees was known to management officials. Employees regularly entered the area without utilizing lockout tagout and the company did not have adequate work rules in place to prevent the exposure. It was possible to perform work in the area under lockout tagout or to provide other entry points into the area. There was no greater hazard present by locking out the equipment or providing alternative access. The company did not have any documented discipline for Mr. Herring showing any issues with lockout tagout or any other safety concerns. Employee discipline was not further evaluated as it was stated by Mr. Tim vibbert, Plant Manager, Mr. Tyler Jett, Area Business Leader Pre Foam Doors, and the other management officials present on the walkaround inspection that it was accepted procedure for the Controlman to enter the areas including what the CSHO determined to be the operating area of the off load robot, without utilizing lockout tagout. In addition employee discipline is one of the elements of an unpreventable employee misconduct or isolated event defense, however the company must meet all of the elements of that defense for it to be considered.

PHOTOGRAPH/VIDEO SUMMARY SHEET

PHOTOGRAPHS
Kentucky Labor Cabinet  
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Inspection: 318098621  CSHO ID: N6859  Report Number: 012-19  
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Photographs taken  Yes / No: ___Yes____

Total # of photos: ___110___________

Photos taken with camera  Yes / No  #: ___Yes 110___

Photos taken from video  Yes / No  #: ___No____

Photos received from other sources Yes / No  #: ___Yes 70___

Source: Employee 21, Company 49 (27 printed, 22 digital)

Location of photos if not with this inspection: ________________________________

VIDEO

Video taken  Yes / No: ___Yes____

Location of video if not in this casefile: ________________________________

Photograph and Video Descriptions

Description: Images 1 & 2 depict the South Door Foam Loop Area and the Alternative Lockout-Tagout 30/33 Offload Zone Basic Entry procedure dated 2017.

Description: Image 3 depicts the South Loop Alternative Lockout procedure for Offload Zone Robot Programming.

Description: Images 4,5 depict red lockout locks mounted to equipment.

Description: Images 6-8 depicts the South Loop Gate Cross Over controls in the position they were moved to after the February 15, 2019.

Description: Image 9 depicts the South Door Foam Loop Area and the Alternative Lockout-Tagout 30/33 Offload Zone Basic Entry procedure.

Description: Image 10 depicts a lock in place on one of the disconnects in the South Door Loop Area.
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Description: Image 11 depict the off load robot and partial fenced area.

Description: Image 12 depicts the area where the South Loop Gate Cross Over controls had been mounted at the time of the February 15, 2019, incident. Mr. Herring was pinned just on the other side of the yellow plate area.

Description: Image 13 depicts a steel bar that had been added at some point prior to the incident to strengthen the fence guard for the off load robot, as it was stated by management officials during the walkaround inspection including but not limited to Mr. Tyler Jett, Area Business Leader Pre Foam Doors, that fixtures had hit the fence and made it loose.

Description: Images 14-17 depict the interlock switch on the gate.

Description: Images 18-24 depict control panels and lockout tagout procedures & signs.

Description: Image 25 shows the area where Mr. Herring was caught between the stairs, the conveyor line, and a fixture. He was reportedly found near the 448 stamp on the conveyor line.

Description: Images 26 & 27 depict the guardrail marked do not sit or stand where the fixtures passed through the area.

Description: Images 28-31 depicts the gate “inside the loop” on the South Loop Gate Cross Over controls had been mounted at the time of the February 15, 2019, incident on the yellow plate.

Description: Image 32 depicts the South Loop Gate Cross Over controls (inside the Loop) in the position they were moved to after the incident.

Description: Image 33 depicts a screw driver/pry bar used by Controlman to unjam doors.

Description: Images 34-42 depict lockout tagout procedures and signs on control boxes inside the South Loop.

Description: Image 43,44, & 46-49 depict the Inside the Loop Area on the South Loop.

Description: Image 45 depict the HMI screen inside the loop for the South Door Loop.

Description: Image 50 depicts a fixture & off load robot view from inside the loop.

Description: Image 51 depicts fixtures on the conveyor line.

Description: Images 52-54 depict signs on the conveyor line, including ones that read, “Danger Climbing, sitting, walking, or riding on conveyor at any time will cause severe injury or death  KEEP OFF” and
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"Warning Servicing moving or energized equipment can cause severe injury LOCK OUT POWER before servicing".

Description: Image 55 is a view of the area where Mr. Herring was found pinned.

Description: Images 56-57 depict the off load robot fence.

Description: Image 58 depicts a pry bar used by Controlmen to fix jams.

Description: Images 59-67 depict the cross over gate area to enter the loop.

Description: Image 68 depict a locator device used to keep fixtures in position for off-loading.

Description: Image 69-71 depict the off load robot gate and area.

Description: Images 72-91 depict the North Loop Area which was similar to the South Loop, including the gate cross over controls mounted next to the gate.

Description: Image 92 depicts business cards for the coroner & LMPD detective.

Description: Image 93 depicts the OSHA 300A posted in the building.

Description: Images 4-8 in Folder 2 21 19 were taken on February 21, 2019 and depict the cross over area for South Loop.

Description: Image 9 in Folder 2 21 19 were taken on February 21, 2019 and depicts the locate bar to hold the fixture for offloading.

Description: Images 10-13 in Folder 2 21 19 were taken on February 21, 2019 and depict the A aisle.

Description: Images 1-6 in Folder 3 1 19 were taken on March 1, 2019 and depict the HMI screen outside the loop for South Loop.

Description: Images 7-11 in Folder 3 1 19 were taken on March 1, 2019 and depict the IIMI screen outside the loop for North Loop.

Description: Image Blocked aisle depicts the A aisle blocked during the emergency response.

Description: Images Case Foam LOTO-Case Foam LOTO4 depict posted lockout procedures.

Description: Images Door Foam LOTO & Door Foam LOTO1 depict posted alternative procedures for offload zone basic entry.
Description: Images HMI1, HMI2, HMI3 depict the HMI screen for South Loop with messages indicating an inaccurate time stamp on the system and a message about data not being transferred.

Description: Images LOTO1 & LOTO3 show an alternative lockout procedure for Case Line.

Description: Images LOTO2 depict a revised LOTO alternative procedure created after the February 15, 2019, incident for South Loop Gate entry to remove a jammed door.

Description: Image South Loop in December – South Loop in December no. 7 depicts oil on the floor in the control panel area, which was stated to be a common occurrence. After the February 15, 2019, incident but prior to the inspection the company had called in an outside contractor to clean the area.

Description: A DVD included with this report depicts the Door Foam Loop operation for the South and North Loops.
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Inspection Contacts

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>OC</th>
<th>WA</th>
<th>FL</th>
<th>CC</th>
</tr>
</thead>
</table>

Union Information

Union Name and Local Number: IUE-CWA 83761
Address, City, State, ZIP: 5153 Poplar Level Rd., LOUISVILLE, KY 40219
Kentucky Labor Cabinet
Occupational Safety and Health Program
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Additional Mailing Information
Name ___________________________________________ Address, City, State, ZIP
KENTUCKY LABOR CABINET
Closing Conference Checklist

Name of Company: HAIER VS APPLIANCE SOLUTIONS, INC. DBA GE APPLIANCES

Mark as appropriate

Were Violations Observed (Y) (N) (N/A)
Reviewed Hazards Observed and (Y) (N) (N/A)

Standards Allegedly Violated
Discussed Types of Violations (Y) (N) (N/A)
Discussed Penalties (Y) (N) (N/A)
Discussed Posting Requirements (Y) (N) (N/A)
Encouraged Informal Conference (Y) (N) (N/A)
and Explained Procedure
Discussed Employer Option to (Y) (N) (N/A)
Contest Citations, etc.
Discussed Filing for Abatement (Y) (N) (N/A)
Extension
Discussed Follow-up Inspections (Y) (N) (N/A)
Discussed Additional Penalties (Y) (N) (N/A)
for Failure to Abate Citations
Discussed Prohibition Concerning (Y) (N) (N/A)
Discrimination Against Employees
Discussed Voluntary Compliance (Y) (N) (N/A)
(Div. of Education & Training)
Closing Conference Held with Employee Representative
Jointly (Y) (N) (N/A)
Separately (N)
N/A (N)

I acknowledge receipt of the Post Inspection Guide, and I acknowledge that the
above sections in said booklet were discussed.

SIGNATURE

TITLE: Georgie H. Postman
DATE: 8/12/07

Effective 6/1/2009
KENTUCKY LABOR CABINET
Closing Conference Checklist

Name of Company: Greene Co. Applied Union Electric

Mark as appropriate

Y  N  N/A

Were Violations Observed (Y) ( )
Reviewed Hazards Observed and Standards Allegedly Violated (Y) ( )
Discussed Types of Violations (Y) ( )
Discussed Penalties (Y) ( )
Discussed Posting Requirements (Y) ( )
Encouraged Informal Conference and Explained Procedure (Y) ( )
Discussed Employer Option to Contest Citations, etc. (Y) ( )
Discussed Filing for Abatement Extension (Y) ( )
Discussed Follow-up Inspections (Y) ( )
Discussed Additional Penalties for Failure to Abate Citations (Y) ( )
Discussed Prohibition Concerning Discrimination Against Employees (Y) ( )
Discussed Voluntary Compliance (Div. of Education & Training) (Y) ( )
Closing Conference Held with Employee Representative
   Jointly (Y)
   Separately ( )
   N/A ( )

I acknowledge receipt of the Post Inspection Guide, and I acknowledge that the above sections in said booklet were discussed.

SIGNATURE: [Signature]
TITLE: [Title]
DATE: 8-12-19

Effective 6/1/2009
KENTUCKY LABOR CABINET
Closing Conference Checklist

Name of Company

Mark as appropriate

Y  N  N/A

Were Violations Observed (✓) ( ) ( )
Reviewed Hazards Observed and Standards Allegedly Violated (✓) ( ) ( )
Discussed Types of Violations (✓) ( ) ( )
Discussed Penalties (✓) ( ) ( )
Discussed Posting Requirements (✓) ( ) ( )
Encouraged Informal Conference and Explained Procedure (✓) ( ) ( )
Discussed Employer Option to Contest Citations, etc. (✓) ( ) ( )
Discussed Filing for Abatement Extension (✓) ( ) ( )
Discussed Follow-up Inspections (✓) ( ) ( )
Discussed Additional Penalties for Failure to Abate Citations (✓) ( ) ( )
Discussed Prohibition Concerning Discrimination Against Employees (✓) ( ) ( )
Discussed Voluntary Compliance (Div. of Education & Training) (✓) ( ) ( )
Closing Conference Held with Employee Representative
   Jointly ( )
   Separately ( )
   N/A ( )

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SIGNATURE

TITLE Global H&S Program Director DATE 8/12/07

Effective 6/1/2009
KENTUCKY LABOR CABINET
Closing Conference Checklist

Name of Company [Handwritten]

Mark as appropriate

Were Violations Observed (Y) (N) (N/A)
Reviewed Hazards Observed and Standards Allegedly Violated (Y) (N) (N/A)
Discussed Types of Violations (Y) (N) (N/A)
Discussed Penalties (Y) (N) (N/A)
Discussed Posting Requirements (Y) (N) (N/A)
Encouraged Informal Conference and Explained Procedure (Y) (N) (N/A)
Discussed Employer Option to Contest Citations, etc. (Y) (N) (N/A)
Discussed Filing for Abatement Extension (Y) (N) (N/A)
Discussed Follow-up Inspections (Y) (N) (N/A)
Discussed Additional Penalties for Failure to Abate Citations (Y) (N) (N/A)
Discussed Prohibition Concerning Discrimination Against Employees (Y) (N) (N/A)
Discussed Voluntary Compliance (Div. of Education & Training) (Y) (N) (N/A)
Closing Conference Held with Employee Representative
   Jointly (Y)
   Separately (N)
   N/A (N)

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SIGNATURE [Handwritten]

TITLE [Handwritten]

DATE 8-12-19

Effective 6/1/2009