

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

The State of Ohio ex rel.	:	
Hamlin Steel Products, LLC, an Ohio LLC,	:	
f/k/a Hamlin Acquisition, Inc., LLC,	:	
Relator,	:	No. 10AP-1172
v.	:	(REGULAR CALENDAR)
Industrial Commission of Ohio and	:	
Christopher J. Bickett,	:	
Respondents.	:	

D E C I S I O N

Rendered on December 20, 2012

Roth, Blair, Roberts, Strasfeld & Lodge, LPA, and Christopher P. Lacich, for relator.

Michael DeWine, Attorney General, Charissa D. Payer, and Stephen D. Plymale, for respondent Industrial Commission of Ohio.

Marsh & Mittas Law Office, LLC, Bobbie L. Marsh, and William G. Mittas, for respondent Christopher J. Bickett.

IN MANDAMUS
ON OBJECTIONS TO THE MAGISTRATE'S DECISION

BROWN, P.J.

{¶1} Relator, Hamlin Steel Products, LLC, an Ohio LLC, f/k/a Hamlin Acquisition, Inc., LLC, has filed an original action requesting that this court issue a writ of mandamus ordering respondent, Industrial Commission of Ohio ("commission"), to vacate its order granting the application of respondent, Christopher J. Bickett ("claimant"), for an

additional award for a violation of a specific safety requirement ("VSSR"), and to enter an order denying the application.

{¶2} The matter was referred to a magistrate of this court pursuant to Civ.R. 53(C) and Loc.R. 13(M) of the Tenth District Court of Appeals. The magistrate issued the appended decision, including findings of fact and conclusions of law, recommending that this court deny relator's request for a writ of mandamus.

{¶3} Relator has filed objections to the magistrate's decision, asserting that (1) the malfunction at issue was the result of a "first time failure," and therefore does not support a VSSR award under Ohio law, and (2) the doctrine of unilateral negligence precludes VSSR liability. Relator first contends that the single failure exception to the specific safety requirement rule applies to excuse any alleged failure of compliance with Ohio Adm.Code 4123:1-5-10(c)(5)(e)(vi). Relator argues that the commission abused its discretion by ignoring the fact that this was a first time event, and that relator had no knowledge of the latent defect. In support, relator relies upon *State ex rel. M.T.D. Prods., Inc. v. Stebbins*, 43 Ohio St.2d 114 (1975).

{¶4} The commission and magistrate distinguished the facts of this case from *M.T.D. Prods.*, in which the Supreme Court of Ohio held that "[t]he fact that a safety device that otherwise complies with the safety regulations failed on a single occasion is not alone sufficient to find that the safety regulation was violated." *Id.* at 118. In the present case, the evidence before the commission indicated that the continuous reset button had been intentionally bypassed (by installation of an extra wire) and did not work. Thus, the commission found that, because the safety device had apparently never worked properly from the time it was bypassed, the continuous reset button did not "otherwise comply" with the rule (i.e., the facts did not indicate a one-time malfunction of a properly working safety device). We find no abuse of discretion by the commission in finding this case distinguishable from the line of cases applying the *M.T.D. Prods.* single failure exception.

{¶5} Relator also contends that claimant was unilaterally negligent in causing his injuries. Relator argues that claimant's co-worker accidentally placed the machine into "inch-mode," thinking that it was "manual mode," and that claimant accidentally placed the press into "continuous mode," thinking it was in "manual mode." Relator maintains that neither claimant nor his co-worker had authorization to perform those actions absent a supervisor's approval.

{¶6} Under Ohio law, "[e]mployee negligence bars a VSSR award only where an employee deliberately removes a safety device or otherwise renders a compliant device noncompliant." *State ex rel. Kenton Structural & Ornamental Iron Works, Inc. v. Indus. Comm.*, 91 Ohio St.3d 411, 416 (2001), citing *State ex rel. Frank Brown & Sons, Inc. v. Indus. Comm.*, 37 Ohio St.3d 162 (1988). The question of unilateral negligence "does not apply where the employee simply makes a mistake that results in injury." *Id.* at 417.

{¶7} The commission argues that the unilateral negligence rule is inapplicable to this case because there is no evidence that claimant disabled a working safety feature, i.e., there is no evidence claimant deliberately caused the reset button to be bypassed by means of a "hot wire." The commission further argues that, even if claimant and his co-worker had summoned a supervisor to reset the press, the same injury could have occurred because the continuous reset button on the press, having been intentionally bypassed, did not work.

{¶8} We agree with the commission that the doctrine of unilateral negligence is not applicable to the facts of this case. The unilateral negligence defense is viable when an employee "removes or ignores equipment or instruction that complies with a specific safety requirement." *State ex rel. Quality Tower Serv., Inc. v. Indus. Comm.*, 88 Ohio St.3d 190, 193 (2000). Thus, "unless a claimant deliberately circumvented an otherwise complying safety device, * * * an employee's conduct is not relevant to a VSSR determination." *State ex rel. Pressware, Internatl., Inc. v. Indus. Comm.*, 85 Ohio St.3d 284, 288 (1999). Here, where there is some evidence that the continuous reset button did not otherwise comply with the applicable rule, the commission did not abuse its discretion in failing to invoke the unilateral negligence doctrine.

{¶9} Based upon a review of the magistrate's decision, and an independent review of the record, we find that the magistrate has properly determined the facts and applied the pertinent law to them. Accordingly, we adopt the magistrate's decision as our own, including the findings of fact and conclusions of law contained therein, and relator's objections are overruled. In accordance with the magistrate's recommendation, relator's request for a writ of mandamus is hereby denied.

Objections overruled; writ of mandamus denied.

CONNOR and DORRIAN, JJ., concur.

APPENDIX A

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

The State of Ohio ex rel.	:	
Hamlin Steel Products, LLC, and Ohio LLC,	:	
f.k.a. Hamlin Acquisition, Inc., LLC,	:	
	:	
Relator,	:	No. 10AP-1172
	:	
v.	:	(REGULAR CALENDAR)
	:	
Industrial Commission of Ohio and	:	
Christopher J. Bickett,	:	
	:	
Respondents.	:	
	:	

MAGISTRATE'S DECISION

Rendered on May 29, 2012

Roth, Blair, Roberts, Strasfeld & Lodge, LPA, and Christopher P. Lacich, for relator.

Michael DeWine, Attorney General, and Charissa D. Payer, for respondent Industrial Commission of Ohio.

Marsh & Mittas Law Office, LLC, Bobbie L. Marsh, and William G. Mittas, for respondent Christopher J. Bickett.

IN MANDAMUS

{¶10} In this original action, relator, Hamlin Steel Products, LLC, and Ohio LLC, f.k.a. Hamlin Acquisition, Inc., LLC, requests a writ of mandamus ordering respondent Industrial Commission of Ohio ("commission") to vacate its order granting the application of respondent Christopher J. Bickett ("claimant") for an additional award for a violation of a specific safety requirement ("VSSR") and to enter an order denying the application.

Findings of Fact:

{¶11} 1. On February 22, 2006, claimant sustained a crushing injury to his left hand and forearm when the ram of a mechanical power press unexpectedly cycled while he and a co-worker were operating the press in a plant operated by Hamlin Steel Products, LLC ("Hamlin Steel").

{¶12} 2. The industrial claim (No. 06-315872) was allowed by the commission.

{¶13} 3. On July 5, 2007, claimant filed an application for a VSSR award.

{¶14} 4. The VSSR application prompted an investigation by the Safety Violations Investigative Unit ("SVIU") of the Ohio Bureau of Workers' Compensation.

{¶15} 5. On September 18, 2007, the SVIU investigator conducted an on-site visit at Hamlin Steel's plant located in Akron, Ohio. On that date, the investigator viewed and photographed the press where the injury occurred.

{¶16} 6. On September 18, 2007, during the on-site visit, the SVIU investigator interviewed Lal Teckchandani, the president and CEO of Hamlin Steel. The investigator obtained from Teckchandani an affidavit executed September 18, 2007:

[One] Although I did not observe Mr. Bickett's injury occur, I do have pertinent information.

[Two] I am the President / CEO of Hamlin Steel Products. The company purchased Hamlin Acquisition Inc. approximately seven (7) years ago and changed the name to Hamlin Steel Products.

[Three] Mr. Bickett was employed at Hamlin Steel Products as a utility worker at the time of his injury. Mr. Bickett was first employed at Hamlin Steel Products in February 25, 2002 until March 5, 2002. Mr. Bickett was let go in March 2002 because he had failed the post job offer drug test. Mr. Bickett was rehired at the company November 7, 2005. Mr. Bickett's job duties as a utility worker were operating the various presses, sorting parts, and grinding.

[Four] Mr. Bickett was provided with on the job training which was provided by the shift supervisor Jeff Sherman. Mr. Bickett was explained how to operate the press, how to operate the palm controls, and how to move the product from station to station. This training lasts approximately ten (10) minutes as this is an unskilled position. Mr. Bickett understood his job duties at the time of his injury and was

competent in performing the duties. Mr. Bickett was also provided with lock out / tag out affected training and machine guarding. This training was provided by Safety Services in 2002. The training consisted of classroom lecture, discussion, video, and a question and answer period. Mr. Bickett received a certification at the completion of this class.

[Five] Mr. Bickett was required to wear hearing protection, safety glasses, cotton gloves, and steel toes shoes. It is believed Mr. Bickett was wearing these items at the time of his injury.

[Six] Mr. Bickett's injury involved the Danly mechanical power press (model: S2-800-84 x 48, serial number 7934101). This press was purchased by the former owner of Hamlin Acquisition Inc. in approximately 1984. The press is a part revolution press, was operated in a continuous mode, and approximately six (6) months prior to Mr. Bickett's injury a second set of palm buttons was added to the press so it could be operated in the manual mode.

[Seven] Since Mr. Bickett's injury a second set of light curtains have been added to the back of the press. At the time of Mr. Bickett's injury there was a light curtain on the front of the press; however it was only functional during the continuous mode. Now both light curtains on the front and back of the press are operational during the manual mode.

[Eight] When Mr. Bickett's injury occurred the press had two operators; Mr. Bickett and Phillip Hickman. Both employees had a set of dual palm controls. Both sets of palm controls had to be pressed simultaneously in order for the press to actuate. If one employee let off of the palm buttons the press would stop immediately in its cycle. The dual palm controls are located on a movable T-stand. The T-stand was observed approximately five (5) to six (6) feet from the press bed after the injury occurred. The dual palm controls also were equipped with an emergency stop button located between the dual palm controls. This button would stop the press immediately when pressed. This emergency stop button was within reach of Mr. Bickett at the time of his injury. The emergency stop button and both of the dual palm controls functioned correctly during the post incident inspection of the press.

[Nine] The brake and anti-repeat feature was inspected during the post incident investigation. Both the anti-repeat feature and the braking system function[ed] correctly at that time.

[Ten] The press did not have any additional guarding at the time of Mr. Bickett's injury. This would include interlocked press barrier guard, die enclosure, point of operation device, fixed barrier guard, gate or movable guard, pull out device, or hold out / restraint device.

[Eleven] During the post incident investigation it was learned either Mr. Bickett or Mr. Hickman let off of the palm buttons, this stopped the press. The press was then placed into the inch mode by Mr. Bickett to bring the ram up. Mr. Bickett then placed the press into the continuous mode instead of the manual mode. Mr. Bickett and Mr. Hickman then pressed the palm buttons and the press cycled. Mr. Bickett then went into the die area to move the part to the next station and the press came down on his left hand. Mr. Bickett confirmed these events during visits at the hospital and at his residence.

[Twelve] Also during the post incident investigation it was learned there was a malfunction with the Arm Button. When the press is placed into the inch mode the arm button needs to be pressed prior to the press operating in the continuous mode. Mr. Bickett had not pressed the arm button prior to the press being actuated in the continuous mode. It was learned there was a loose wire in the relay which allowed the press to actuate in the continuous mode from the inch mode without the arm button being pressed. The only way this could happen is when the press [was] in the inch mode and was placed into the continuous mode. Hamlin Steel Products was not aware of this issue prior to Mr. Bickett's injury and not aware of this happening prior to Mr. Bickett's injury. This issue has been remedied since Mr. Bickett's injury. The press was shut down after Mr. Bickett's injury until the company completed the investigation and made the proper repairs.

[Thirteen] Mr. Bickett was not provided with any tool to place, remove, or remove stuck work from the press as none was required.

[Fourteen] The modes of the press are switched at the control panel. This area has a key which may be locked and

taken out to prevent the mode to be changed. Mr. Bickett had been instructed not to touch the control panel or the mode buttons. He was specifically instructed to have a set up person make these changes. At the time of his injury the key was in the control panel. Since Mr. Bickett's injury the company locks the control panel and takes the key out of the control panel.

{¶17} 7. On September 18, 2007, during the on-site visit, the SVIU investigator interviewed David J. O'Neill who is a safety consultant. An affidavit executed September 18, 2007 was obtained:

[One] Although I did not observe Mr. Bickett's injury occur, I do have pertinent information.

[Two] I am a safety consultant with Safety Services. I started consulting with Hamlin Steel Products in late 2000. I help Hamlin Steel Products with safety issues and workers' compensation issues. I conduct post incident investigations. I conducted the post incident investigation after Mr. Bickett's injury along with safety management and labor employees from Hamlin Steel Products.

* * *

[Four] I provided Mr. Bickett with lock out tag out for affected employees and machine guarding training when he was hired at the company in 2002. This is conducted in a classroom setting and lasted approximately one (1) hour. The training consisted of a lecture, discussion, question and answer period, and watching an approximate fifteen (15) minute video. Mr. Bickett received a certification which I have provided a copy to Investigator Riley.

{¶18} 8. On September 20, 2007, following an interview with the SVIU investigator, claimant executed an affidavit:

[One] I am the injured worker in this VSSR claim.

[Two] Hamlin Steel Products Inc. hired me in November 2005 as a utility; this was my position at the time of my injury. My job duties included operating the press, welding, grinding parts, checking parts, and cleaning.

[Three] I received approximately five (5) minutes of on the job training from another employee. At the time of my injury I understood how to perform my job duties.

[Four] I was required to wear safety glasses at the time of my injury. I was wearing safety glasses and cotton gloves at the time of my injury.

[Five] My injury occurred on press 77. I am not sure of the make or model of this press. I do not know how this press is powered. Phil Hickman and I were operating the press. The press stopped in mid cycle. Mr. Hickman brought the press back to the top. We then both pressed the palm buttons, the press went down and then came up to the top and had finished the cycle. I reached into the press to move the parts to the next stage and the press came down on my left hand.

[Six] Prior to my injury when the press stopped Mr. Hickman turned the key on the control panel to inch, pushed on a couple of buttons, and inched the press down and back up to the top. Mr. Hickman told me to press my palm controls and nothing happened. He then told me to hit his palm controls and nothing happened. Mr. Hickman came over to the platform and I noticed he had not turned the key to where it was supposed to be. I turned the key to the middle for single stroke. Both of us hit the palm buttons at the same time and the ram came down and went back up. Then I went into move the parts to the next stage and the injury occurred.

[Seven] I am sure when I turned the key it was in the single stroke mode. The key was straight up and down.

[Eight] The selector switch key was always left in the control panel. I had never seen the key out of the selector switch. I was shown how to move the selector switch key from a couple of the die setters (Jeff Sherman JR and I am not sure of the other die setters name). I was told by the die setters to move the selector switch to inch in order to move the ram back up to the top. Once the ram was at the top I was to move the selector switch to single stroke. I was never told not to move the selector switch and to get a die setter.

[Nine] When the press stopped in mid cycle one of us moved our hands. The palm buttons needed to be pressed until the die completely closed and someone had moved their hands prior to the die completely closing.

[Ten] Both Mr. Hickman and I had dual palm controls. The palm controls had an emergency stop button located between the palm buttons. The emergency stop button was not within reach when my injury occurred. The incident happened so fast I did not get a chance to press the emergency stop button. The palm buttons were approximately one (1) to two (2) feet in front of the press when my injury occurred. The palm buttons were approximately one (1) step to my right and one (1) step behind me when the injury occurred[.]

[Eleven] I am not aware of any problems with the palm controls prior to my injury occurring. If the press stopped in mid cycle on the day of my injury it was because of either Mr. Hickman or I moved our hands. There were not any problems with the palm controls.

[Twelve] Mr. Hickman and I had to press the palm buttons simultaneously and the buttons had to remain pressed until the press completed its cycle. If one or both of us let up off of the buttons the press would stop. Mr. Hickman was standing beside me when my injury occurred and neither Mr. Hickman nor I had pressed the palm buttons.

[Thirteen] The press did not have any guarding to prevent my hands from entering the area in which my injury occurred. The press was in the single stroke mode when my injury occurred. The press does have a light curtain however this was not turned on at the time of my injury. I believe the light curtain is only turned on when the press is in the continuous mode. I have never observed the light curtain operating when the press was in the single stroke mode. I am not aware of any problems with the light curtain prior to my injury occurring.

[Fourteen] After my injury occurred, Rob Bullock (plant manager), told me the wires to the light curtain had been cut and some other wires (unknown what wires) had been cut or were burned. I was not aware of this prior to my injury occurring. I do not know if management was aware of these issues prior to my injury occurring. Mr. Bullock also told me the press malfunctioned; however Mr. Bullock did not say what the malfunction was.

[Fifteen] Approximately a couple of weeks to one (1) month prior to my injury occurring the company did some rewiring on the main control. I am not sure what was done.

[Sixteen] I was not provided with any type of tool to place, remove, or remove stuck work from the press.

[Seventeen] I am not aware of any problems with the press prior to my injury occurring. I am not aware of any near misses or injuries prior to my injury occurring.

{¶19} 9. On September 20, 2007, following an interview with the SVIU investigator, Phillip Hickman executed an affidavit:

[One] I am a witness in this VSSR claim.

[Two] Hamlin Steel Products hired me in approximately 2005. At the time of Mr. Bickett's injury I was assembly. I would go where ever the foreman needed me to work; I was a helper.

[Three] Mr. [Bickett] and I were working at press 77 on the day of his injury. We were working side by side. We hit the palm buttons and the machine cycled. The ram went up to the top, we went into the press to the [sic] move the parts to the next station and the ram came down on Mr. Bickett's hand. I was able to get out of the way.

[Four] The press had stopped in mid cycle prior to Mr. Bickett's injury occurring. I believe the press stopped because I sneezed and took my hands off the buttons once the cycle had started. Mr. Bickett placed the press in the inch mode I inched the ram back to the top at the control panel. Mr. Bickett put the press in the inch mode because he was standing right there. Once the ram was inched to the top, Mr. Bickett switched the press to the manual mode. We pressed the palm buttons, the press cycled, and his injury occurred as we were moving the parts to the next station.

[Five] I am pretty sure Mr. Bickett had the press in the manual mode. Prior to the injury occurring I saw the press in the manual mode.

[Six] There was a problem with the reset button for the continuous mode. I became aware of this problem after Mr. Bickett's injury occurred. The maintenance man (Keith Swisher), said the reset button was not wired correctly. I believe he said the wires were crossed. I do not know if anyone was aware of this problem prior to Mr. Bickett's injury occurring.

[Seven] Both Mr. Bickett and I had our own set of palm buttons. We were at the front of the press, I was on the right side of the press and Mr. Bickett was on the left side of the press. The palm controls were located approximately one and one half (1 1/2) to two (2) feet from the front of the press. The blanks which were being placed on a pallet to [the] left of where we were standing. The blanks were not in between the palm buttons and the press.

[Eight] The press had a light curtain on the front of the press. The light curtain was not working and was turned off at the time of the injury. The light curtain had been messing up through out the day on the first shift. I believe Mr. Swisher turned the light curtain off during the first shift. When Mr. Bickett and I started the second shift the light curtain had already been turned off; the light curtain was not on during our shift prior to the injury occurring.

[Nine] Normally the light curtain would be on when the press was in the manual mode. The light curtain was not only used in the continuous mode but also in the manual mode.

[Ten] The key for the selector switch was left in the press at the time of the injury. This key was never taken out of the selector switch. Now the selector switch has a combination lock and only the die setters and the maintenance personnel have the combination.

[Eleven] There was not any additional guarding for the press at the time of the injury other than the two palm controls. The press was not equipped with an interlocked press barrier guard, point of operation device, die enclosure, fixed barrier guard, adjustable barrier guard, gate or movable barrier device, pull out device, or hold out / restraint device.

[Twelve] There was an emergency stop button located on both of the palm controls. The emergency stop buttons stopped the press immediately. I did not press the emergency stop button when the injury occurred; I was trying to pull Mr. Bickett out of the press.

[Thirteen] Since Mr. Bickett's injury the company has added a light curtain to the back of the press. The company now places cages on the front and back of the press when the press is running in the continuous mode. Also a sensor has been added; if the part is not in the press correctly the press will not cycle.

[Fourteen] On the day of Mr. Bickett's injury there were times where we would hit the palm buttons at the same time and the press would not cycle. We would have to take our hands off of the palm buttons and start again. I estimate this happened four (4) to five (5) times on the day of Mr. Bickett's injury prior to the injury occurring.

{¶20} 10. After the accident, Plant Manager Robert Bullock assembled an investigative team to investigate the accident. On February 24, 2006, two days after the accident, the investigative team issued a five-page "Accident Investigation" report, stating in part:

Investigation Summary

Reviewed how the press should have been operating.

The press was running a "manual" die with two operators. Therefore the light curtains were bypassed and it was set up with two manual palm button pedestals (each with two switches, one for each hand). The press is set so that it cannot come down unless all operators hands are on the palm buttons when in "manual" mode, also known as "single stroke" mode.

The press should have had the "mode" selector switch set to "single".

The press should not have started in "continuous" mode unless the press is "armed" by pressing the "continuous reset" button immediately before activating the palm buttons.

Reviewed how the press was operating.

The press mode selector switch was in the "continuous" mode. Pictures of the control panel taken right after the incident indicate the "mode" selector switch was in "continuous". The switch was still in "continuous" when the accident team observed the press.

The accident investigation team powered on the press. Attempted to activate the press by pressing the palm buttons, which did not activate the press into continuous mode (as expected).

The accident investigation team changed the mode to "inch" and moved the ram to the top of stroke. The "mode" was switched back to "continuous" engaged the palm buttons without activating the "continuous reset" button (also known

as ["arming" button) and the palm buttons engaged. The press started and went into continuous mode and cycled several times until the stop button was engaged. This was not as expected because it should not have started without pressing the "continuous reset" button immediately before activating the palm buttons.

The accident investigation team changed the mode to "single" and engaged the palm buttons. The press cycled once and stopped at the top of the stroke as expected.

The accident investigation team tested all of the palm buttons by attempting to start the press with only 3 buttons. All palm buttons were operating correctly.

The accident investigation team tested that the press did stop when in "single stroke" mode if one of the palm buttons was released prior to the bottom of the stroke. When tested several times and this function operated correctly.

Recreated the accident circumstances.

After reviewing the statements and the current functioning of the press, the accident investigation team successfully recreated what it believed to events of the incident.

[One] One of the operators hands came off of the palm buttons before it completed the stroke. (This necessitated the need to use the inch mode to restart the press.)

[Two] Operator put the mode selector switch to "inch" and raised the ram.

[Three] Both Operators moved the parts to their next stations.

[Four] Primary operator leaned over and moved the selector switched the "mode" selector switch to what he thought was "single" but went over to "continuous".

[Five] Both operators engaged their palm buttons and the press started to cycle.

[Six] After the ram reached bottom, both operators let go [o]f their palm buttons and got ready to move the parts along the die.

[Seven] As the die reached the top of the stroke, the operators were in the point of operation to move the parts along the die.

[Eight] The Ram continued to cycle downward.

[Nine] The primary Operator's left hand would have been furthest into the die when it cycled down.

Review of probable and possible root causes of the incident.

[One] The "mode" selector switch was placed in "continuous" instead of "single" by the operator.

[Two] The "continuous reset" function of the press was not operating correctly. The press should not have run in "continuous" even if incorrectly placed in this mode unless the operator "arms" the press by pressing this button. This circuit failed.

[Three] Current practice allows the Operators to enter the area near the point of operation as the ram is going up, but before the press stopped.

11. On September 20, 2007, the SVIU investigator issued a four-page report with exhibits. The report of investigation states:

[One] Mr. Teckchandani stated the company purchased Hamlin Acquisition Inc. approximately seven (7) years ago and changed the name to Hamlin Steel Products Inc. At the time of Mr. Bickett's injury the company was named Hamlin Steel Products Inc.

[Two] During the on-site investigation, Investigator Riley viewed and photographed the Danly mechanical power press * * *. The press was purchased in approximately 1984 by Hamlin Acquisition and has not been moved since the purchase. When Mr. Bickett's injury occurred the press had two operators (Mr. Bickett and Phillip Hickman), was actuated via two sets of dual palm controls, and was stamping parts. According to Mr. O'Neill both operators were on the front side of the press performing their duties. Since Mr. Bickett's injury a light curtain has been added to the back of the press and a loose wire for the arm button on the control panel has been repaired * * *.

[Three] The two operators (Mr. Bickett and Mr. Hickman) had to press the dual palm controls simultaneously and the controls had to remain pressed until the ram raises, according to Mr. O'Neill * * *. If one of the palm controls is released the press would stop immediately * * *. The post incident investigation revealed both sets of dual palm controls to be working correctly * * *. The press was equipped with a light curtain located on the front of the press; however the light curtain was not operational when the injury occurred * * *. When Mr. Bickett's injury occurred the light curtain was only activated when the press was in the continuous mode * * *. Investigator Riley asked if there was

any additional guarding in place at the time of Mr. Bickett's injury; such as an interlocked press barrier guard, die enclosure, point of operation device, fixed barrier guard, gate or movable guard, pull out device, or hold out / restraint device. Mr. O'Neill responded there was not any additional guarding as it is not required with the dual palm controls * * * .

[Four] During the incident investigation the employer learned one of the operators had let off of the dual palm controls causing the press to stop in mid cycle * * * . Mr. Bickett placed the press in the inch mode and brought the ram to the top. Mr. Bickett then placed the press in the continuous mode instead of the manual mode. Mr. Bickett and Mr. Hickman pressed the dual palm controls and the press cycled. Mr. Bickett entered the die area to move a part to the next station and the press came down on his left hand * * * . During an exhaustive inspection of the press the employer learned there was a malfunction with the continuous arming button. A loose wire allowed the press to operate in the continuous mode when the press was switched from the inch mode to the continuous mode without the continuous arming button being pressed * * * . When in proper condition the press would be placed in the continuous mode and the continuous arming button would need to be pressed prior to the machine actuating when the dual palm controls were pressed. Investigator Riley inquired if there was any type of work performed on the control panel in the month prior to Mr. Bickett's injury. Both Mr. Teckchandani and Mr. O'Neill denied any such work being performed. Mr. Tec[k]chandani informed Investigator Riley the second set of dual palm controls had been added approximately six (6) months prior to the injury occurring; however no work had been performed on the control panel * * * .

[Five] The press is equipped with a selector switch which places the press in the inch, single stroke (manual), and continuous mode. The selector switch is located on the control panel * * * . These modes may be locked into position and a key removed to prevent the selector switch from being moved. At the time of Mr. Bickett's injury it was a common practice to leave the key in the selector switch * * * . Since Mr. Bickett's injury the company has removed the key and the set up person changes the mode * * * .

[Six] Mr. Bickett was not provided with any tool to place, remove, or remove stuck work at the time of his injury,

according to Mr. Teckchandani * * *. Mr. Teckchandani explained during the incident investigation the company did not find any problems with the anti-repeat feature or the braking system * * *.

[Seven] Mr. Bickett was hired as a utility at [Hamlin] Steel Products February 25, 2002 and let go March 5, 2002. Mr. Bickett was rehired November 7, 2005 as a utility. His job duties included operating the various company presses, sorting parts and grinding, Mr. Teckchandani advised * * *. Mr. Bickett was provided with classroom training for lock out / tag out and machine guarding in 2002 * * *. Mr. Bickett was provided with on the job training in 2005 which consisted of a shift supervisor explaining the press, showing Mr. Bickett how to operate the press, and how to move the product from station to station. Mr. Teckchandani estimated this training lasted approximately ten (10) minutes * * *.

{¶21} 12. On the date of injury, i.e., February 22, 2006, Clinton G. Hoover was employed by Hamlin Steel as an electrician millwright in the maintenance department at the plant where the injury occurred. Hoover had been employed in this capacity for about two and one-half years prior to the injury. Hoover was one of the 12 members of the investigative team assembled by Bullock to investigate the accident. Hoover was asked by Bullock to do a trouble shooting examination of the press.

{¶22} 13. On November 20, 2007, Hoover was deposed on cross-examination by counsel for plaintiffs in a civil action filed in the Summit County Court of Common Pleas. Christopher J. Bickett was one of the plaintiffs who brought the action. Hamlin Steel was the defendant in the civil action. Presumably, the action was an intentional tort action involving the accident at issue here.

{¶23} 14. Hoover's deposition was recorded and transcribed. The transcript was filed by claimant as evidence to be considered by the commission in the VSSR matter.

{¶24} 15. During Hoover's deposition, the following exchanges between Hoover and plaintiffs' counsel were recorded:

Q. When you went over to the press that next morning to do the troubleshooting, tell me how you went about doing that.

A. I can't remember all the particulars of that particular morning. We verified what was -- what went on, and then we

proceeded to try to find the problem causing this -- this particular problem to happen.

Q. And how did you go about doing that?

A. We used the electrical schematic and our meters and started checking out circuitry.

Q. And did you find something that was not correct?

A. Yes, sir.

Q. What did you find?

A. We found a wire that was -- had been attached to the automatic circuitry and it did not belong there.

Q. Anything else?

A. That's -- that was the -- what we found.

Q. Okay. Now, when you say you found a wire, describe the wire to me.

A. It was what we call the hot wire.

Q. And what does that mean?

A. Best way I can explain it, like you have a light switch going to these lights. When you flip that switch on, you send a hot wire up to the bulb to turn it on, okay? That's -- when we turned the -- energize the power, this wire became energized in the circuitry.

Q. And what did the wire look like?

A. It was a red wire.

Q. When you say, "Red," was the metal of the wire red or was there a insulating --

A. Insulating.

Q. -- casing over it?

A. Pardon?

Q. There was an insulation casing over it?

A. The insulation was red.

Q. Okay. And how long was the wire?

A. That I can't really -- I wish I could answer that properly because I can't.

Q. I'm just trying to get an idea. I mean, is this a piece of wire that's 1 inch long or it is 6 inches or 18 inches or what is it?

A. I'm going to say between 12 and 15 inches, in that proximity, if my memory serves me right.

* * *

Q. Now, if I understood what you told me, you determined that -- let me back up.

Where you saw that wire attached, both at the power supply end and at the automatic circuitry end, was the wire appropriately attached in the sense that it was tightened down?

A. Yes.

Q. All right. So it appeared to you as if it had been intentionally put in that location at both ends.

MR. O'NEIL[L]: Objection.

Go ahead.

THE WITNESS: Yes.

BY MR. ROYER:

Q. In other words, it was attached; everything was tight.

A. Yes, everything...

Q. All right. Did you determine that at one end or the other of that wire that it wasn't supposed to be in that location?

A. Yes.

Q. Which end did you determine was not where it was supposed to be?

A. The wire was on the switch, the end on the switch.

Q. Okay. So you're saying that that wire was not supposed to be attached to the automatic circuitry switch.

A. Right.

Q. Was that wire supposed to be attached someplace else or should the whole wire not have been there?

A. It should not have been there.

Q. All right. Was there any proper place for that wire to be in this --

A. Not that -- my observation.

Q. So by just removing this wire completely and not replacing it, you were able to get the press functioning properly?

A. Best of my knowledge, yes.

Q. So this was not a loose wire?

A. No.

Q. This was not a wire that was just connected at the wrong place and should have been connected at a different place?

A. Say that again. I'm --

Q. That was not a wire that was connected at the wrong place and just should have been connected someplace different?

A. Right.

Q. That's not what this was.

A. No.

Q. This was an entirely extra wire that had been added into the wiring that should not have been there at all.

A. Right.

* * *

Q. Okay. Do you know who put the red wire in that press?

A. No, sir, I do not.

Q. Do you know why the red wire was put into the press?

A. No, sir, I do not.

Q. What did -- did Keith Swisher, did he see that red wire with you?

A. Yes.

Q. Was it you and Keith Swisher that determined that that red wire should not have been there?

A. If my memory serves me right, yes.

Hoover deposition, 9-11, 15-17, 27.

During Hoover's deposition, the following exchange occurred between Hoover and defendant's counsel:

Q. Do you know how long that wire was in that location, hooked up that way?

A. No, sir, I do not.

Q. Do you know how it got hooked up like that?

A. No, sir, I do not.

* * *

Q. Had anyone complained to you before that the continuous arming button did not work properly?

A. No, sir.

Hoover deposition, 34, 37.

{¶25} 16. On the date of injury, i.e., February 22, 2006, Keith A. Swisher was employed by Hamlin Steel as a mechanic/master electrician. In that capacity, he was involved in maintenance at the plant where the injury occurred. Swisher's supervisor, Marion Stokes, asked him and Hoover to examine the press to determine what happened on the date of injury.

{¶26} 17. On December 14, 2008, Swisher was deposed on cross-examination by counsel for plaintiffs in the civil action filed in the Summit County Court of Common Pleas mentioned earlier. Swisher's deposition was recorded and transcribed. The transcript was filed by claimant as evidence to be considered by the commission in this VSSR matter.

{¶27} 18. During Swisher's deposition, the following exchange between Swisher and plaintiffs' counsel was recorded:

Q. Okay. So tell me what you and Clint Hoover did.

* * *

THE WITNESS: I know we started the press up, and we cycled the press. I don't remember if it was in inch or single stroke or what it was. I also think we ran it in continuous mode also. At that point, everything seemed to be working like it should.

We -- boy, I just don't remember. Somehow we ended up in back of the press, there's a -- a big cabinet back there up against the wall where all the relays and controls, contactors, are located. We ended up back there looking at some relays, related to the continuous run circuit. Somehow, some -- something caught one of our eyes, I don't recall who it was, but something caught our eye, either a wire just hanging there or a different wire number on a relay or something that -- that told us to trace it out.

And we traced it out, and that particular wire went back over to the press to a junction box. And I don't remember if the wire was numbered wrong or if it had the right number on it and it was on the wrong terminal. I do believe it was a completely different wire. But it went to a terminal in that terminal box which stayed hot all the time, no matter where the selector switch for the inch, single stroke and continuous was located.

* * *

Q. Okay. So if I understand what you were telling me, you found a problem in the wiring of the controls on Press No. 77?

A. Yes.

Q. And the problem that you found was something that would make the continuous operation hot, as your phrased it, all the time?

A. That's correct.

Q. So that if the press -- if the -- I'm sorry. So that if the mode selector switch was turned to the continuous mode, the press would operate in the continuous mode, even if the continuous reset arming button was not pushed?

A. That's correct.

* * *

Q. The problem that you identified with the change in the wiring to the press controls removed the need to push the continuous reset button for the press to go into continuous mode?

MR. O'NEIL[L]: Objection.

BY MR. ROYER:

Q. Correct?

MR. O'NEIL[L]: Go ahead.

THE WITNESS: Yes, you're right. You did not have to push the button. But nobody knew that, nobody knew that the wiring was changed somewhere along the lines, so anybody that ever run that press, and that press did used to run in continuous mode, it just automatically flipped it over to continuous, pushed the button, hit the palm buttons, and away it went.

* * *

Q. Okay. And was that piece of wire inside that hole in the terminal strip?

A. Yes.

Q. And was the screw tightened down?

A. Yes.

Q. And the wire was crimped tight the way you would if you tightened the screw down?

A. Yes.

Q. So that end of it was all affixed the way you'd want it to be if it was intentionally put in there?

A. Right.

* * *

Q. As part of any maintenance work that you had done on Press 77 before the injury to Chris Bickett, did you ever do any of that after the second T-stand had been added?

A. Other than the lubricating, physically looking at the press to make sure everything's in the proper place, and to make sure that the press operates the way it should operate, that's -- that's about it.

Q. What were the circumstances by which you made sure that the press operated the way it should operate?

A. Start the press up, and then put it in -- in the mode, and hit the palm buttons --

Q. What would --

A. -- to cycle the press.

Q. What brought about you doing that?

A. Just to make sure that the controls and stuff worked. They do all their PMs on the off shift.

Q. All right. That would have been preventative maintenance that you were doing on Press 77?

A. That is correct.

Q. Is there -- is there anything that you did -- during that preventative maintenance inspection that you're just telling me about, is there anything you did that would have tested whether that continuous reset arming button was properly performing its function?

A. I would have to say no, 'cause how I always did it, I just followed the procedure of how everybody else has done it, and that's not on that particular press but the other presses, and I never -- I never ran that press in continuous, I just cycled it in inch and cycled it in single stroke.

Swisher deposition, 17-18, 20-21, 22-23, 27-28, 63-64.

{¶28} During Swisher's deposition, the following exchange occurred between Swisher and defendant's counsel:

Q. Were you able to determine how long it may have been hooked up that way?

A. No.

Q. Could have been hooked up for a year, 10 years, 20 years, as far as you know?

MR. ROYER: Objection.

THE WITNESS: That's right.

Swisher deposition, 75.

{¶29} 19. On July 27, 2010, a staff hearing officer ("SHO") heard the VSSR application. The hearing was recorded and transcribed for the record. Hoover and Swisher did not testify at the July 27, 2010 hearing.

{¶30} 20. Following the July 27, 2010 hearing, the SHO mailed an order on September 10, 2010 granting the VSSR application. The SHO's order explains:

Findings of Fact

By way of history, the Staff Hearing Officer finds that on the date of injury the Injured Worker was operating a mechanical power press with a co-worker, producing parts for automobiles. This press, driven by an electric motor, was designated as "Press 77" by the Employer. The press could be operated in an automatic or "continuous" mode, whereby it continuously cycled and produced parts unless stopped by the operators. It could also operate in manual or "single-stroke" mode whereby it would only cycle one time, stopping after each cycle. This mode would be used when parts were to be manually moved in the press by the operators after each cycle.

On the date of injury, the press was operating in the single-stroke mode. To run the press in this mode, the operators were each required to push two palm buttons simultaneously. These buttons were located on two "T-stands" on a platform in front of the press. All four palm buttons had to be pushed simultaneously before the press would cycle. When the press had cycled, it would stop, the operators would move the parts to different positions in the lower die, and the process would begin again when the palm buttons were pushed. If an operator stopped pushing a palm button for any reason during the cycle, the press would immediately stop. This safety feature prevented an operator from placing his hands in the danger area of the press while it cycled.

Palm buttons were not used when the press was operating in continuous mode. Instead, a second safety device known as a "light curtain" would be armed on the press when it was set up for continuous mode operation. The light curtain produced a series of light beams that covered the entry area of the press. If an object such as an operator's hand broke the beams of light, the press would automatically stop. On this particular press, the light curtain was installed vertically. As such, the light curtain could not be used in single-stroke mode because the operator would break the light beam and stop the press every time he reached in the press to insert or remove a part. Therefore, the vertical light curtain was not activated on the date of injury. After the injury, a horizontal light curtain was installed that would be operational in either single-stroke or continuous mode.

If the press stopped for any reason during its operation, the press would have to be placed into "inch mode." This would move ("jog") the slide inch by inch back to the top of the press, where it would then be ready to start a new cycle. To place the press into inch mode, a mode selector dial would be turned until the indicator pointed to that mode. A button would then be pressed until the slide reached its top "dead center" position. Once it reached this position, the dial would be switched back to the previous operating mode. If it was operating in continuous mode, a "continuous reset" button had to also be pressed to "arm" the continuous mode. The press would then be ready to resume operations.

The dial that allowed the operating mode to be selected was in an area of the press to the right of the operators, off of the platform where the operators stood. The press also had a key

that could be used to lock the dial so that only an individual with the key could change the operating mode. There was testimony that operators had been trained not to change the mode operation and were supposed to get a supervisor or die setter if a malfunction occurred and the press needed to be reset. However, the Injured Worker testified that he had been instructed or permitted to perform this function himself, although others disputed this testimony. Nonetheless, it is undisputed that the Employer's practice before the injury was to leave the key in the machine where any employee could access it.

The mode selector dial is set up with "off" to the far left, inch mode to the middle left, single-stroke mode to the middle right, and continuous mode to the far right. Mr. Regal, the Employer's former Vice President, testified that if an operator stood on the platform in front of the press and reached to change the selector switch, he could mistakenly place the press into an incorrect mode because the dial is so hard to read from that position. The Injured Worker confirmed this in his testimony.

When the press has been set up in the single-stroke mode, the palm buttons are the active safety feature of the press. If the dial is switched to the continuous mode, the light curtain does not automatically become active to protect the operator from placing his hands in the die area. Instead, a setup person must activate the light curtain. In addition, as indicated previously, the press was not supposed to run in continuous mode until the continuous reset button was pushed after the mode selector was switched to continuous mode.

On the date of injury, the Injured Worker and a coworker, Mr. Hickman, were operating the press in single-stroke mode. During one cycle, while they were pushing their palm buttons, Mr. Hickman sneezed and one of his hands came off a palm button. This caused the press to stop, as it is designed to do. Mr. Hickman indicated in his deposition testimony that he called for their supervisor to reset the machine, but no one came after approximately ten minutes. When no one came to reset the press, they decided to do it themselves. The Injured Worker testified in his deposition that they did not call for a supervisor but rather decided themselves to reset the press. Nonetheless, at some point Mr. Hickman exited the platform, walked to the control box, and placed the press into inch mode by turning the mode selector dial to the left.

He then jogged the slide back to the top, where it was ready to begin a new cycle.

Mr. Hickman then went back to his position on the platform. He and the Injured Worker individually pressed their palm buttons to be sure the press would not cycle with only one set of palm buttons engaged. When the press did not run with only one set of palm buttons depressed, they believed it was ready to run in single-stroke mode. However, the press was still in inch mode, so the Injured Worker leaned over from his position on the platform and reached to the selector switch. There is some confusion in the Injured Worker's account of what he did, at one time indicating that he was locking the key for the selector switch, another time indicating that he moved the switch from inch to single-stroke. Regardless, both the Injured Worker and Mr. Hickman believed the press was placed into single-stroke mode and was ready to begin operations again. They pressed their palm buttons simultaneously and the press cycled. The Injured Worker reached into the press to move his parts, but Mr. Hickman was momentarily delayed when his shirt sleeve caught on his T-stand. While the Injured Worker was moving his parts, the press cycled again, crushing his left hand. Following the injury, Mr. Hickman and other employees looked at the mode selector dial and saw that it had been turned to continuous mode, not single-stroke mode as the Injured Worker had intended.

Subsequent investigation by the Employer's maintenance men, Clinton Hoover and Keith Swisher, revealed that the continuous reset button had been bypassed by a "hot wire" that allowed the press to run without pushing the continuous reset button when switched to the continuous mode. Accordingly, when the press was accidentally switched to the continuous mode, it was ready to run even though neither the Injured Worker nor Mr. Hickman had pushed the continuous reset button. Thus, when the Injured Worker and Mr. Hickman pushed their palm buttons to start the press, they were unknowingly starting it in continuous mode.

Conclusions of Law

* * *

Finally, with regard to [Ohio Adm.Code 4123:1-5-10(C)(5)(e)](vi), the press at issue apparently was placed into continuous operating mode accidentally by the Injured

Worker when he reached over to turn the mode selector dial from inch mode to single stroke or to turn the key to the locked position. However, this alone should not have placed the press into continuous operating mode, as the press was designed with another safety feature that would prevent continuous mode operation in such an instance. Specifically, a "continuous reset" button was to be pushed before the press would operate in that mode. If that button was not pushed by the operator, it was not supposed to run in continuous mode. The requirement that an operator turn the mode selector to "continuous" AND push the continuous reset button conforms to this portion of the rule that requires setting the press into continuous mode AND "a separate action by the operator" before it will so run. Turning the dial to "continuous" and pushing the continuous reset button are separate actions on this press.

However, in this instance this safety device failed and the press operated in continuous mode WITHOUT the operator pushing the continuous reset button. This led directly to the Injured Worker's injury as he believed the press was in single stroke mode and therefore had his hands in the point of operation following the first stroke, not knowing that it was in continuous mode and another stroke was imminent.

Subsequent investigation by the Employer's own maintenance personnel revealed that the continuous reset button had been intentionally bypassed by the installation of an extra wire that allowed the press to be operated in continuous mode without pushing the continuous reset button. With this alteration, all that was necessary to operate in continuous mode was for the operator to select that mode – intentionally or accidentally – and start the press as normal. Of note, although the Employer at various times referred to a "short circuit" as the cause of the failure of the continuous reset button, it is clear that the continuous reset button was intentionally bypassed at some point by the installation of an extra wire. This is clear from the testimony of Mr. Hoover and Mr. Swisher. Where this wire came from and who installed it has never been proven. The press was purchased by the Employer from another manufacturer in used condition in 1980. Regardless, there is no doubt that the installation of this wire caused the continuous reset button to be ineffective in preventing the accidental operation of the press in continuous mode.

Mr. Regal testified that the Employer did not know that the continuous reset button had been bypassed because the start-up procedures for operating the press in the continuous mode always required the setup person to select the continuous mode and press the continuous reset button prior to beginning continuous mode operations. However, the ease with which the Injured Worker accidentally placed the press into continuous mode casts doubt on the assertion that press 77 had never been accidentally placed into the continuous mode in the 26 years the Employer owned this machine before the date of injury.

Nonetheless, even if this was a first-time event that had never happened before, this fact does not excuse the rule violation that occurred. It is true that generally a one-time failure of an otherwise complying safety device does not result in a finding that a specific safety requirement was violated. State ex rel. M.T.D. Products, Inc. v. Stebbins (1975), 43 Ohio St. 2d 114. Had there been an unexpected short circuit that defeated a properly functioning continuous reset button, perhaps there would be no rule violation under M.T.D. This is not the case, however, as the continuous reset button had been intentionally bypassed and did not work. In fact, this safety device apparently had never worked from the time that it was first bypassed, whatever the date. Only sheer luck had prevented such an accident from occurring before the date of injury in this claim. Thus, the bypassed continuous reset button did not "otherwise comply" with the rule and the Injured Worker's accident does not qualify as a "one-time failure" that can be excused.

The Staff Hearing Officer concludes that the Employer has violation Ohio Adm. Code 4123:1-5-10(C) (5) (e) (vi).

* * *

Conclusion

The Staff Hearing Officer finds that the Employer violated Ohio Adm. Code 4123:1-5-10(C) (5) (e) (vi) which led directly to the Injured Worker's injury. Further, the Injured Worker sustained a serious injury to his left hand that required amputation. In addition, the violation occurred not due to an accidental failure of a safety device, but because the press had been wired to bypass a safety device. Therefore, the Staff Hearing Officer orders that an additional award of compensation be granted to the Injured Worker in the

amount of 35% of the maximum weekly rate pursuant to State ex rel. Engle v. Indus. Comm. (1944), 142 Ohio St. 425.

(Emphasis sic.)

{¶31} 21. On September 30, 2010, relator moved for rehearing pursuant to Ohio Adm.Code 4121-3-20(C).

{¶32} 22. On November 10, 2010, another SHO mailed an order denying rehearing.

{¶33} 23. On December 20, 2010, relator filed this mandamus action.

Conclusions of Law:

{¶34} It is the magistrate's decision that this court deny relator's request for a writ of mandamus, as more fully explained below.

{¶35} Ohio Adm.Code 4123:1-5 sets forth specific safety requirements for "Workshop and Factory Safety."

{¶36} Ohio Adm.Code 4123:1-5-10 is captioned "Mechanical power presses."

{¶37} Ohio Adm.Code 4123:1-5-10(C) is captioned "Mechanical power press guarding."

{¶38} Ohio Adm.Code 4123:1-5-10(C)(5) is captioned "Machines using part revolution clutches."

{¶39} Ohio Adm.Code 4123:1-5-10(C)(5)(e) is captioned "Two-hand controls for single stroke," and provides:

Two-hand controls for single stroke shall conform to the following requirements:

* * *

(vi) The starting of a continuous run shall require a separate action by the operator in addition to the setting for continuous stroking of the press before actuation of the operating controls will result in continuous stroking.

{¶40} In State ex rel. M.T.D. Prods., Inc. v. Stebbins, 43 Ohio St.2d 114, 118 (1975), the court observed that the safety rule at issue "does not purport to impose absolute liability for an additional award whenever a safety device fails. The regulation

does not forewarn the employer that, in addition to providing a safety device, the safety device must also be completely failsafe."

{¶41} Noting that the purpose of the safety regulation is to provide reasonable safety for employees, the court states "[t]he fact that a safety device that otherwise complies with the safety regulations failed on a single occasion is not alone sufficient to find that the safety regulation was violated." *Id.*

{¶42} Citing *M.T.D. Prods.*, this court, in *State ex rel. Moore v. Indus. Comm.*, 29 Ohio App.3d 239, 243 (10th Dist.1985), refers to the "single failure exception to the specific safety requirement rule." The *M.T.D. Prods.* "exception" has been repeatedly the subject of VSSR cases. *State ex rel. Gentzler Tool & Die Corp. v. Indus. Comm.*, 18 Ohio St.3d 103 (1985); *State ex rel. Taylor v. Indus. Comm.*, 70 Ohio St.3d 445 (1994).

{¶43} Here, under Ohio Adm.Code 4123:1-5-10(C)(5)(e)(vi), pushing the continuous reset button was supposed to be the "separate action by the operator." That is, the press was not supposed to run in continuous mode until the continuous reset button was pushed after the mode selector was switched to continuous mode. Because the press had been improperly wired, the operator's failure to push the continuous reset button did not prevent the ram from cycling in continuous mode. Thus, due to the improper wiring, the rule's requirement for a "separate action" failed on the date of the injury.

{¶44} The issue before the commission was whether the *M.T.D. Prods.* single failure exception applied so that relator cannot be held to have violated the "separate action" requirement of the rule.

{¶45} Again, the commission explained its analysis in finding that the single failure exception did not absolve the violation:

Subsequent investigation by the Employer's own maintenance personnel revealed that the continuous reset button had been intentionally bypassed by the installation of an extra wire that allowed the press to be operated in continuous mode without pushing the continuous reset button. With this alteration, all that was necessary to operate in continuous mode was for the operator to select that mode – intentionally or accidentally – and start the press as normal. Of note, although the Employer at various times referred to a "short circuit" as the cause of the failure of the continuous reset button, it is clear that the continuous reset button was intentionally bypassed at some point by the

installation of an extra wire. This is clear from the testimony of Mr. Hoover and Mr. Swisher. Where this wire came from and who installed it has never been proven. The press was purchased by the Employer from another manufacturer in used condition in 1980. Regardless, there is no doubt that the installation of this wire caused the continuous reset button to be ineffective in preventing the accidental operation of the press in continuous mode.

Mr. Regal testified that the Employer did not know that the continuous reset button had been bypassed because the start-up procedures for operating the press in the continuous mode always required the setup person to select the continuous mode and press the continuous reset button prior to beginning continuous mode operations. However, the ease with which the Injured Worker accidentally placed the press into continuous mode casts doubt on the assertion that press 77 had never been accidentally placed into the continuous mode in the 26 years the Employer owned this machine before the date of injury.

Nonetheless, even if this was a first-time event that had never happened before, this fact does not excuse the rule violation that occurred. It is true that generally a one-time failure of a otherwise complying safety device does not result in a finding that a specific safety requirement was violated. State ex rel. M.T.D. Products, Inc. v. Stebbins (1975), 43 Ohio St.2d 114. Had there been an unexpected short circuit that defeated a properly functioning continuous reset button, perhaps there would be no rule violation under M.T.D. This is not the case, however, as the continuous reset button had been intentionally bypassed and did not work. In fact, this safety device apparently had never worked from the time that it was first bypassed, whatever the date. Only sheer luck had prevented such an accident from occurring before the date of injury in this claim. Thus, the bypassed continuous reset button did not "otherwise comply" with the rule and the Injured Worker's accident does not qualify as a "one-time failure" that can be excused.

The Staff Hearing Officer concludes that the Employer has violated Ohio Adm. Code 4123:1-5-10(C) (5) (e) (vi).

{¶46} In challenging the commission's analysis, relator argues that it was not forewarned that, on the date of injury, the press would enter continuous mode without a push on the continuous reset button due to the improper wiring.

