Inspection Narrative

Establishment Name: Southern Investments, LLC
Legal Entity: A. Corporation
Type of Business: plastics recycling

Additional Citation Mailing Addresses
Olgetree, Deakins, Nash, Smoak & Stewart
ATTN: H. Bernard Tisdale III
201 South College St, Ste 2300
Charlotte, NC 28244

Authorized Employee Representatives

Employer Representatives Contacted

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<tr>
<th>Name</th>
<th>Title</th>
<th>Function</th>
<th>Walk Around?</th>
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Entry: 07/27/12
Opening Conference: 07/27/12
Walkaround: 07/31/12 12:00
First Closing Conference: 12/19/12 09:05
Second Closing Conference
Exit: 08/15/12
Case Closed

Penalty Reduction Factors

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Followup Inspection? Y
Reason: fatality, WS, WO, S, NS
SAFETY AND HEALTH NARRATIVE

INSPECTION NUMBER Southern Investments, LLC
316630227

INTRODUCTION

This inspection resulted from a fatality notification by the Reidsville Police Department on July 27, 2012. Mr. Doug Jones, District VI Supervisor, proceeded to 401 Madison St., Reidsville, NC. The facility at this location was Southern Investments, LLC. An incident had occurred at approximately 2:30 p.m. on July 27, 2012; resulting in Mr. Christopher Michael Webb being caught in a set of separator blades and killed.

The victim was still entrapped in the blade system when Mr. Jones arrived. An abbreviated opening conference was conducted with Mr. Jones gathered limited company administrative information with points of contacts, mailing address, and the name of a potential witness to the accident. Since emergency response personnel were attempting to recover the victim, Mr. Jones informed that a Compliance Safety and Health Officer (CSHO) from the Winston-Salem office would be returning on Monday July 30, 2012 to continue the investigation. Mr. Jones informed that he would need to have additional administrative information, including but not limited to safety and health programs/policies, OSHA 300 logs with summaries and training documents available on Monday for the CSHO to review. Prior to exiting the facility, Mr. Jones was able to make several photos from the rear of the blades in which the victim was still entangled. He also conducted a brief walk around of the facility accompanied by Mr. Jones exited the facility.

Mr. Jones assigned the fatality investigation to CSHO Rayborn on the morning of July 30, 2012. The CSHO was briefed on the accident and points of contact at the facility. Mr. Jones handed over all his field notes and photos to CSHO Rayborn at that time. Mr. Jones also informed the CSHO that he was going to request an expansion of the inspection from Tim Childers, West Bureau Chief, based on potential serious hazards observed during the brief walk around on Friday, July 27, 2012. Hazards observed included but were not limited to machine guarding, electrical, lighting, and housekeeping.

CSHO Rayborn began her investigation by contacting the Reidsville Police Department to obtain a copy of the investigation report and to interview officers who responded. Mr. Jones the report would be ready for pick-up Monday afternoon. After contacting the Reidsville Police Department, the CSHO was redirected to the Detective Unit to speak with CSHO Rayborn met with at the Reidsville Police Department on Monday, July 30, 2012 prior to lunch. The CSHO presented her credentials and explained the nature of her visit and the need to continue the fatality investigation. had been at the site throughout the call and had prepared a CD copy of all photos taken at the scene. The CSHO asked to review the photos with her so she could ask any questions might be able to answer. reviewed the photos, described the set-up of the machine to the best of knowledge and some procedures that needed to be done to recover the victim from the machine. A public record copy of the police report was provided to the CSHO along with the CD copy of photos.

The CSHO exited the police department and proceeded to Southern Investments, LLC on Madison St. CSHO Rayborn met with of Southern Investments, LLC and presented her credentials. The CSHO explained the investigation had been transferred to her for completion. agreed to allow the inspection/investigation to continue.

The CSHO gathered the limited administrative information that was available. The employer had a Hazard Communication Binder with several Material Safety Data Sheets and a generic written program. The program didn't contain the required elements including but not limited to a HAZCOM coordinator, training and a chemical inventory. stated the company followed minimum lock-out/tag-out procedures. provided the CSHO with a binder
for one of the production lines. The binder contained a flow diagram of the 50B line with electrical panels identified. A copy of an "Appendix A to 1910.147 - Typical Minimal Lockout Procedure" was also in the binder. The employer had a similar binder for each line/process. A copy of the 50B line "LO/TO" is attached.

[Redacted] stated the company had not maintained any safety and health programs/policies and had not conducted any type of training. [Redacted] had not maintained OSHA 300 logs for the years 2009, 2010, and 2011, although there had been at least two recordable injuries during this time.

CSHO Rayborn instructed the owner and office staff how to complete OSHA 300 logs. The CSHO again requested a copy of any and all safety and health programs/policies, training documents and LO/TO audits. [Redacted] had a LO/TO program and that was all. The CSHO questioned if a hazard/personal protective equipment assessment had been conducted for each of the job tasks that presented or was likely to present a hazard to employees. [Redacted] stated the assessment had not been done. [Redacted] had provided gloves (leather and cotton), safety glasses, earplugs and respirators for employee use.

The CSHO requested information for Mr. Christopher Michael Webb's next of kin. [Redacted] did not have any information on the next of kin.

CSHO Rayborn was able to conduct an employee interview with [Redacted] A written statement was obtained in which the CSHO asked questions, the employee answered, and the CSHO documented the statement. The CSHO made sure to review the statement with the employee word for word two times to ensure accuracy prior to requesting the employee's signature. [Redacted] stated the statement was true and factual to the best of the employee's knowledge. The statement is included. Upon completion of the interview, the CSHO briefed [Redacted] on what to expect with the inspection/walk around the following day. Again the CSHO requested copies of all safety and health programs/policies and training documents be provided the next day. The CSHO exited the facility with plans to conduct a walk around the following day.

Southern Investments, LLC had a SIC code of 9999 for not otherwise classified and a NAICS code of 325991, custom compounding of purchased resins. However, the CSHO determined the SIC 5093, plastic scrap, more appropriately described the company operations. Southern Investments LLC purchased baled recyclable plastic (milk jugs, detergent bottles, landscape nursery trays, medical test tubes, etc) and 275-gallon plastic totes from various companies. The plastics were sent through a series of grinders depending on the material. The ground materials were then shipped by Southern Investments LLC to the customer for further processing.

District Supervisor Doug Jones informed CSHO Rayborn that West Bureau Chief, Tim Childers, had given permission to expand to a comprehensive inspection based on the potential hazards observed by Supervisor Jones on July 27, 2012 during his brief walk around of the facility.

To date, the only documentation provided to the CSHO by the employer has been a copy of the 50B line diagram with a copy of "Appendix A to 1910.147 - Typical Minimal Lockout Procedures" and an MSDS for Synthetic Compressor Fluid, All Grades.

[Redacted] contacted CSHO Rayborn early morning July 31, 2012. [Redacted] stated there were many things which needed to be addressed in the facility including safety programs development and training, but management was ignoring or stressing that production was more important. [Redacted] stated that the HAZCOM and LO/TO documents shown to the CSHO the previous day did not exist prior to the fatality. [Redacted] stated that Chris Webb had only worked at the facility for about two months and had never been properly trained on the 50B line. [Redacted] asked [Redacted] to allow them to establish and implement safety and health policies/programs and to conduct training with the employees. [Redacted] had experience with the safety and health aspects of running a company and knew safety needed to be addressed at the facility. [Redacted] had attended numerous training sessions provided by OSHA.

[Redacted] had been approached on several occasions regarding safety and health within the facility, but had responded that production had to be done first. [Redacted] had been injured and no records were maintained or reports filed.

The CSHO was not provided information pertaining to the employees injured even though the CSHO requested the information several times from [Redacted] The employee stated there might be another employee with a different company.
in New York, owned by [redacted].

An OSHA 36 and 170 were completed by CSHO Rayborn on July 31, 2011.

CSHO Rayborn and CSHO trainee Buddy Amerson arrived at the site on July 31, 2012 to continue the fatality investigation and a comprehensive safety inspection. The CSHOs initially addressed the area in which the fatality occurred. The CSHOs made several photos, took measurements and drew sketches of the 50B line. [redacted] explained the company purchased recyclable plastics from other companies and ground/shredded the jugs, bottles, etc. into small particles which were sold to other companies to make plastic products.

The CSHOs conducted a partial walk around and conducted numerous employee interviews. It was determined they would have to return another day to complete a walk around of the remainder of the facility.

CSHO Rayborn determined during employee discussions that the plastic recyclable materials which had been in the hopper and had been contaminated with Mr. Webb's blood, body fluid and possibly tissue had not been removed and disposed of as regulated waste. [redacted] was instructed by EMS personnel that the area with contamination needed to be properly cleaned and the contaminated plastic recyclables needed to be disposed of properly. However, the contaminated recyclable materials were sent through the grinder and processed for distribution to a customer.

Upon returning to the field office, CSHO Rayborn briefed Supervisor Jones on the findings and progress of the inspection/investigation. At this point, Supervisor Jones and CSHO Rayborn attempted to contact Jane Gilchrist for further guidance. After consulting the Attorney General's Office, the CSHO proceeded to determine what happened to the contaminated materials, where the ground material was at that point, if it had been shipped, if so by what carrier and to what customer.

On August 1, 2012, CSHO Rayborn spoke by phone to the office staff at Southern Investments. [redacted] left for Florida to attend Mr. Webb's funeral.

On August 2, 2012, the CSHOs returned to the facility in an attempt to determine what steps were taken to dispose of the contaminated recyclables. [redacted] stated the materials had been sent through the grinder and were in a bin to be shipped. [redacted] insisted the material not be shipped. [redacted] had dumped the ground plastics into the "30 yard" - a roll-off dumpster used by the company. [redacted] was told to clean the area and to "pour bleach on the blood and stuff on the machine." [redacted] swept up any materials beneath the hopper. [redacted] didn't use any type of personal protective equipment. CSHO Rayborn informed [redacted] that the entire 50B line should be considered contaminated since blood, body fluid, and possibly human tissue, was run through it. The CSHO also advised [redacted] to contact the local waste disposal department and/or the third party owner of the dumpster in which the materials were disposed in to see what additional precautions, if any, needed to be taken. The CSHO also advised that there were local cleaning companies that could provide assistance with the decontamination of the 50B line, if needed. The CSHO informed [redacted] that waste disposal, regulated or otherwise, was out of NCDOL jurisdiction.

CSHO Rayborn and Trainee Amerson spoke with [redacted] was very willing to assist with questions and describing the exact locations and the conversations had with [redacted], and Mr. Webb prior to the incident. The CSHOs focused their attention on the 50B line where the fatality took place. The CSHOs exited the facility.

Mr. H. Bernard Tisdale III of Oglethorpe, Deackins, Nash, Smoak & Steward, P.C., counsel for Southern Investments, left a voicemail for CSHO Rayborn. CSHO Rayborn referred Mr. Tisdale to Jane Gilchrist. Ms. Gilchrist contacted CSHO Rayborn and stated that she would be out of the office for a week. She had referred Mr. Tisdale to Linda Kimbell.

CSHO Rayborn received an email from the Attorney General's Office (AG office), informing her that Mr. Tisdale wanted to know what information she needed. The AG office informed the CSHO that further contact with the company would be routed through that office. The AG office would in turn contact Mr. Tisdale. An additional visit to the facility was scheduled for August 15, 2012.

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CSHO Rayborn and Trainee Amerson returned to Southern Investments on August 15, 2012 to conduct additional employee interviews and clarify some photos, measurements, and questions.

CSHO Rayborn escorted the CSHOs to collect dust samples, take measurements and make additional photos. Employee interviews were conducted. The CSHO exited the facility.

CSHO Rayborn attempted to contact Mr. Tisdale on December 13, 2012 to conduct a closing conference. A voice mail message was left requesting a return call. Mr. Tisdale returned the call and said he would be out of the office that day and would call the CSHO the following day.

On December 14, 2012, Mr. Tisdale called and left a voice mail for the CSHO to return his call. CSHO Rayborn attempted to contact Mr. Tisdale and left a message for a return call.

CSHO Rayborn contacted Mr. Tisdale on December 17, 2012. A closing conference was scheduled for Wednesday, December 19, 2012 via phone. Mr. Tisdale stated he would be the only one attending the closing conference and that the citation packet should be mailed to his address instead of the company. CSHO Rayborn consulted with the Attorney General’s office and Doug Jones to ensure that was acceptable and both agreed. An OSHA 59 was faxed to Mr. Tisdale and a copy was mailed to his office for signature upon completion of the closing conference.

A closing conference was conducted with Mr. Tisdale on December 19, 2012. Mr. Tisdale reviewed and signed a copy of the OSHA form 59, then faxed a copy to CSHO Rayborn.

SITE DESCRIPTION

Southern Investments LLC was located at 401 Madison St, Reidsville, NC. The building appeared to be an old tobacco warehouse. The facility consisted of a masonry and steel building covering approximately 28,000 square feet. A metal dome hut/building had been attached to the rear of the warehouse. The rest of the dirt lot behind the warehouse was cluttered with numerous types of materials for possible recycling.

PROCESS DESCRIPTION

Southern Investments, LLC was listed on the internet as www.donaldsouthern.com. The company is a plastics recycling facility, specializing in grinding, sorting, chipping and tolling of all type of plastics. Chipping is the process of separating lighter, finer particles from the heavier materials, such as in the cyclone bag houses and wash line. Southern Investment collected recyclable materials from several industries, re-processed the materials and return the material to its original source for reuse. This process is referred to as tolling. Various plastics, milk jugs, detergent bottles, 275-gallon totes, landscape flower pots, etc were received then sent through a cutting and grinding process then dried. The finished products varied in size. Finished products were shipped to customers for plastic processing.

The facility operations consisted of four lines, 50B, 30B, 1400 and chipping line (wash line). The 50B, 30B and 1400 lines were named for the Cumberland grinders included in each line, Model 50B, 30B and x1400. The 50B and x1400 lines were used for larger products, while the 30B was for small thinner products. The wash line consisted of two operations. One was to wash then dry the material. The other was a "dry" cleaning in which the materials were cycloned to separate dirt and other particles such a fiber materials, ferrous metals, and paper.

Office employees entered the facility at the dock on the north end of the building. The CSHO understood the facility to be an old tobacco warehouse. Upon entering the warehouse, offices were on the right and a garage door was on the left. The door led to a metal dome building which was attached to the back of the warehouse. Bales of compacted recyclable bottles and jugs and stacks of 275-gallon plastic totes, with one side cut out, were on the left past the garage door. The area became darker as you walked further into the building.

On the left side of the aisle (east) was the 50B line. The line was named after the grinder, a Cumberland 50B. The bale loading platform was almost directly in front of the main office door. The compacted bales of plastic bottles and jugs normally came in two sizes. The largest measured approximately 32" deep, 45" wide and 34" high. The other bales were just a little smaller; no small bales were available for measurement. The larger bales were strapped with five pieces of 12-gage wire. The smaller bales were secured with three wires. Bales were loaded on a platform which was 101" above the floor using a forklift. The platform was designed to be floor mounted but had been retrofitted to raise it to the current height. The platform had a conveyer belt on it as some point, but it had been removed because it wasn’t.

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working. After three bales were loaded on the platform, the employee used a metal, fixed ladder to access the platform. The employee climbed on top of the bales and used bolt cutters to cut the wires. The wires were then pulled off of the bales and dropped over the edge of the platform to a container below. The employee exited the platform, turned on the separator blades, using the start button on the control panel to the right of the ladder and used the forks of the forklift to slowly push the bales against the separator blades, which broke apart or separated the compacted jugs and bottles.

The platform was approximately 78" wide and 152" from the open (west) end to the separator blades (east). There were two holes on each side of the platform at the loading (west) end, measuring 14" x 19". The north and south sides of the platform was equipped with metal walls. Although side walls partially enclosed a portion of the platform, a large area was not provided with any type of fall protection. Employees working on the walking surface were subjected to a fall from approximately 101" to the concrete floor. When employees were standing on top of the bales, the fall height to the floor was approximately 135". Employees did not use any type of personal fall arrest devices and standard guardrails were not provided around approximately one half of the platform working surface.

A metal ladder, welded to the platform, was used to access the work area. The ladder was 99" high with 7 steps leading to the platform. The steps were 24" wide, had a rise of 13" and a depth of 5". The angle of the ladder from the access point of the platform to the floor was 70 degrees. The base of the ladder was approximately 41" from the base of the work platform. The edge of the 24" access area was approximately 104" from the rotating separator blades. There was an unguarded gap on each side of the ladder. On the loading end of the platform, the gap from the ladder to the support beam was approximately 3.5". The distance between the ladder access and the upright wall of the platform was approximately 8".

The separator blades were 12" x 16.5" x 3/16" metal pieces on two four inch square shafts which ran across the east end of the platform, one shaft on top of the other. The bottom shaft was driven by a 3 hp motor on the south side of the platform with a slave pulley on the opposite end pulling the top shaft. The blades rotated in a clockwise direction. As the blades beat the bales apart, the plastic recyclables fell into a hopper/feeder. The employees stated they tried to keep the feeder full at all times.

Once the first bale was torn apart and into the feeder, the employee would load another bale onto the platform. The employee would then climb up on the platform and onto the bales and cut the wires on the middle bale, which had been the third bale. The separator blades were normally left running according to employee interviews. The process was repeated.

A 8" auger in the bottom of the hopper fed the jugs and bottles onto a conveyor belt for sorting. A second operator worked on the sorting line. The employee removed trash and metal from among the plastics. The conveyor carried the recyclables up to the grinder. Another 8" auger carried the ground material from the base of the grinder up the auger housing. A 7.5" x 7.5" opening in the auger housing allowed the ground material to fall into a storage/shipping bin.

The 1400 line was just past the 50B line on the left (east) side of the facility. Recyclable materials were loaded into a bin on a table approximately 36" above the floor. The bin dumped directly backward, using hydraulics, onto a sorting conveyor. The conveyor carried the material to the Cumberland 1400 grinder. The 1400 grinder was connected to a cyclone and a 4-bag house. The bottom of one of the bags was open and a clear plastic sleeve was attached. The plastic sleeves connected a series of 45-55 gallon cardboard barrels lying on the floor. The barrel and plastic sleeve served as a "job-made" duct system. The duct ran to the exit door behind the grinder. A large exhaust fan was placed at the end of the duct. Employees stated that the duct was used to try to control the dust created in the facility when landscaping trays were processed. The landscape trays had a layer of potting soil on them. The ground material was released into a storage/shipping bin.

The maintenance storage area and shop was past the 1400 line in the warehouse. The wash line was at the south end of the production area. The wash line consisted of a "wet" cleaning and a "dry" cleaning process. Wet cleaning was done by running the ground material through plain water and a drying process. A cyclone with a six-bag house was at the end of the wet process. The storage/shipping bin under the cyclone was full and overflowing onto the floor. The "dry" cleaning process ended with another cyclone. Fine dust piles up to 2" deep were observed in the area around both of the cyclones in the wash line. The floor area of the wash line had standing water. The electrical panels, 400-volt, were on the south wall. These panels were used as the main switches for the wash line. The panels were on 1" pieces of metal. The water was underneath the panels and ran out into the floor. Employees had to walk into and stand in the water to use the electrical switches.

A storage area and loading dock were at the far south end of the building.
A small employee break area was provided on the right of the aisle just passed the office area. Several large pieces of unused equipment was stored past the break area.

The 30B line was next on the right side of the building. Recyclable materials were loaded into a bin. The bin was hydraulically lifted to a sorting area over 72" above the floor. The operator stood on a 72.5" high platform which had a top rail that was 36" high and a midrail that was 19" high. The platform was accessed by a portable ladder stand. The steps on the ladder had been welded back in place and the frame was warped. The wheels/casters had been removed from the ladder stand. The recyclable material was pushed into a hopper with an 8" auger which fed the Cumberland 30B grinder. The ground material was augered to a storage/shipping bin.

A metal dome building had been attached to the back of the warehouse. The exit door on the north end of the building was broken and the frame was falling out of the wall. Employees used sawzalls to cut a side out of the 275-gallon totes in this area. The floor was concrete. Power was supplied to the area by an extension cord that was run out a hole in the wall of the metal building, outside, in through a window of the warehouse to a 110-volt outlet. A power strip was plugged into the extension cord. Portable equipment and other extension cords were plugged into the power strip. The totes were received unlabeled and without Material Safety Data Sheets. Employees stated they had no idea what had been contained in the totes. [REDACTED] stated some had contained ink, [REDACTED] didn’t know what the others had contained. Any residual chemicals in the totes were dumped into a batch in the bottom of a 55-gallon plastic drum. [REDACTED] had no idea if the chemicals were flammable or if they were compatible. A flexible conduit in this building had energized, 110-volt, electrical wires hanging out of it. The conduit had been tugged behind an I-beam to get it out of the way. These bare wires could have energized the entire building. The concrete floor in the area was often wet with the chemicals which had been in the totes.

The back storage lot was cluttered and unorganized. The ground surface traveled by forklifts was littered with debris and was uneven.

ACCIDENT FINDINGS

On July 27, 2012, Southern Investments, LLC was conducting routine recycling operations. [REDACTED] was to work with Mr. Chris Webb on the 30B line. The 30B line's main process was baled recycled milk jugs, detergent and other bottles. [REDACTED] met with Mr. Webb and discussed what work had to be done. Mr. Webb went to work with the bales and [REDACTED] was on the belt. Around 2:30 pm, [REDACTED] heard Mr. Webb yell and saw him fall by the bales.

Employees stated there was no established procedure to stop or lockout the blades while on top of the bales. [REDACTED] thought [REDACTED] should push the stop button on the control panel as [REDACTED] accessed the work platform. The control panel was located directly to the right of the ladder. The employees stated they had never been told they should stop the blades or lock the machine prior to cutting the straps. They stated that they would push the start button when they went back down the ladder to use the forklift to push the bales. Employees stated that once the blades were started, they usually were not turned off until all the bales were processed.

Employees stated that sometimes they missed a wire strap and the separator blades would catch it and break it loose. They also stated that the wires would wrap around the shaft of the blades and have to be cut loose. No specific procedures had been developed to conduct this task.

[REDACTED] saw Mr. Chris Webb on top of the bales cutting the wires as he was standing by the conveyor belt sorting materials. [REDACTED] looked up and saw Mr. Webb, then looked back down at the materials on the conveyor. [REDACTED] heard a yell, looked up and saw Mr. Webb "going down, I thought he had fell". [REDACTED] immediately hit the stop button on the control panel beside [REDACTED] to stop the conveyor. [REDACTED] ran to the portable ladder on the back side of the hopper to see if [REDACTED] could help Mr. Webb. [REDACTED] saw Mr. Webb in the "augers", he was between the "augers". [REDACTED] stated that the blades were stopped with one blade stuck in his back and one was between his neck, shoulder and face. [REDACTED] ran to the ladder to access the platform to turn off the machine so it would not start again. Employees stated that the "auger motor" would shut down if it got jammed by a hard object like a piece of metal. [REDACTED] turned off the breaker. The breaker was in a box to the right of the control panel at the top of the ladder. [REDACTED] stated [REDACTED] knew [REDACTED] could not help him, so [REDACTED] went to look for someone else". [REDACTED] told [REDACTED] Chris was stuck in the machine. [REDACTED] told [REDACTED] Chris was caught, called 911. [REDACTED] went up the portable ladder behind the hopper to see if [REDACTED] could help Chris and realized he was dead. [REDACTED] went up the ladder to the platform and made [REDACTED] way past
the bales and saw Chris had been pulled into the "augers" and was dead. He said his head was crushed by one of the blades.

The Reidsville Police Department notified the NCDOL of the accident. Supervisor Doug Jones immediately proceeded to the job site. He was able to make a limited amount of photos since climbing onto the platform exposed him to a fall hazard. He conducted a brief opening conference with the Reidsville Fire Department, and the Reidsville Rescue Squad, stated during interviews that members of the fire department had to use the department's LO/TO equipment because the company didn't have LO/TO equipment or procedures in place to conduct LO/TO.

EMS had difficulty recovering Mr. Webb from machine. They had to dismantle parts of chain and sprockets, then cut the upper shaft. Supervisor Jones wasn't able to access the area and decided to exit the facility. He informed the owner a CSHO would return on Monday, July 30, 2012 to continue the investigation.

COMPLAINT/REFERRAL FINDINGS

N/A

UNUSUAL CIRCUMSTANCES

Upon returning to the Winston field office on July 30, 2012, CSHO Rayborn spoke with CSHO Mary Perkinson who remembered having inspected several years prior. CSHO Perkinson printed a summary of the citations she still had on PC CSHO from that inspection. She stated that she thought other inspections had been conducted at the facility, American Recycled Plastics, Inc. CSHO Rayborn spoke with CSHOs Hogan and O'Brien who also remembered American Nursery Products, LLC. CSHO Rayborn decided to print history reports for both American Recycled Plastics, Inc and American Nursery Products, LLC. A total of six inspections had been conducted in the two facilities from November 1998 to April 2003. Two inspections for American Recycled Plastics in November 1998 and March 1999. Four inspections were conducted at the American Nursery Products facility; December 2001, August 2002, February 2003, and April 2003. A review of the inspections indicated numerous citations for the violations of the same NC OSH standards. CSHO Rayborn reviewed these findings with Supervisor Jones, who requested the CSHO obtain a complete file copy of all the inspections. A spreadsheet was developed by Trainee Amerson to provide an overview of these previous inspections. See the spreadsheet included in the case file.

On September 27, 2012, CSHO Rayborn and Trainee Amerson met with the Reidsville Fire Department and informed the CSHOs that Southern Investments had commenced recycling operations in the warehouse on Madison St in 2009. Stated the company did not receive or request any type of permits or inspections through the city or fire department prior to beginning operations. A fire inspector happened to drive by the warehouse and noticed it had been occupied and processing was underway. Conducted an initial fire inspection on July 27, 2009. The following deficiencies were noted during the inspection:

- Exit signs-inoperable
- Heating-unsatisfactory
- Fire suppression system-not maintained since 2002, one valve was closed
- Electrical-unsatisfactory, wiring not in a conduit, junction boxes not covered, breaker panel not covered
- Staff-not trained in the use of fire extinguishers
- Fire doors-not closed and operational
- Fire extinguisher-not provided in the metal dome building
- LP gas cylinders-stored in the building
- Fire extinguishers-not mounted on forklifts

A follow-up inspection was conducted on August 17, 2009 and the deficiencies had not been corrected. A second follow-up was conducted on September 16, 2009 and all items were corrected.

An annual fire inspection was conducted by the Reidsville Fire Department on July 26, 2012. During that visit, the inspector found fire extinguishers were not inspected/maintained and the fire suppression system had not been maintained since August 2009 after the initial inspection.

An interview was conducted with assisting with the inspection of Southern Investments on
July 26, 2009: [redacted] observed two employees working on top of the platform of the 50B line during the inspection. One employee was on top of the bales. The other employee was close to the separator blades, kicking material into the hopper: [redacted] was concerned for the safety of the employees working by the rotating blades. [redacted] knew it was a problem and were addressing it. [redacted] didn’t feel comfortable with the employees working close to the rotating blades and thought there should be some type of safety guards or mechanisms in place.

[redacted] was leaving the facility after recovering Mr. Webb when approached by [redacted] who thought to be employees of the company. [redacted] asked [redacted] if there was someone to clean up the area after an incident. [redacted] informed [redacted] there were several companies in the area. [redacted] suggested they refer to the yellow pages for biohazard clean-up.

During the walk around of the facility, the CSHOs observed that the fire suppression system had not been maintained since August 2009. A citations could not be issued for this potential hazard because NCOSSH standard did not require a fire suppression system. An emergency action plan and fire prevention plan also were not required.

CSHO Rayborn contacted the Rochester, NY federal OSHA field office in an attempt to determine if any accidents/incidents had been reported concerning Southern Recycled Plastics. The Assistant Area Director could not find any information in the federal database pertaining to the company. [redacted] contacted CSHO Rayborn on October 1, 2012. [redacted] wanted to know how the inspection was coming along. The CSHO informed [redacted] the case file would be routed through the administrative process and when complete, the CSHO would contact the company or that the AG’s office would contact the company attorney, Mr. Tisdale to schedule a time to conduct a closing conference.

PENALTY ADJUSTMENTS

1. HISTORY ADJUSTMENT:

A 0% reduction of the Gravity Based Penalty was given to Southern Investments, LLC because of the willful citation recommended in the inspection.

2. SIZE ADJUSTMENT:

A 60% reduction of the Gravity Based Penalty was given to Southern Investments, LLC due to the number of employees employed in the establishment. 13 total employees.

3. GOOD FAITH CALCULATIONS:

A 0% reduction of the Gravity Based Penalty was given to Southern Investments, LLC due to lack of safety and health programs and training and willful citations being issued.

4. COOPERATION:

A 0% reduction of the Gravity Based Penalty was given to Southern Investments, LLC due to willful citations being issued.

60%

Total Penalty Adj.
Recommend issuing the attached citations.

<table>
<thead>
<tr>
<th>CSHO Signature</th>
<th>Date</th>
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<tr>
<td>[Signature]</td>
<td>10/3/12</td>
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Accompanied By
Citation and Notification of Penalty

Company Name: Southern Investments, LLC
Inspection Site: 401 Madison St, Reidsville, NC 27320

Citation 1 Item 4 Type of Violation: Willful Serious

29 CFR 1910.212(a)(1): One or more methods of machine guarding was not provided to protect the operator and other employees in the machine area from hazards such as those created by points of operation, ingoing nip points, rotating parts, and flying chips and sparks:

a) facility, 50B line - guards were not provided to protect operators from rotating separator blades.
b) facility, 1400 line - a 7.5" x 7.5" area of an 8" auger blade was not guarded.
c) facility, 1400 line - return area of the conveyor belt was not guarded.
d) facility - dump bins on the 30B, 1400 and wash line were not guarded.

Date By Which Violation Must be Abated: 12/28/2012
Proposed Penalty: $28000.00

Citation 1 Item 5 Type of Violation: Willful Serious

29 CFR 1910.212(a)(3)(ii): Point(s) of operation of machinery were not guarded to prevent employee(s) from having any part of their body in the danger zone(s) during operating cycle(s):

a) facility, maintenance shop - a guard was not provided on the Colchester lathe, unknown model and serial number.
b) facility, maintenance shop - a guard was not provided on the Bridgeport milling machine, model 6-1155, serial # J-109880.

Date By Which Violation Must be Abated: 12/28/2012
Proposed Penalty: $28000.00

See pages 1 through 6 of this Citation and Notification of Penalty for information on employer and employee rights and responsibilities.