[Cite as *State ex rel. Hayes Lemmerz Internatl. Commercial Hwy., Inc. v. Indus. Comm.*, 2011-Ohio-2161.]

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

The State of Ohio ex rel. Hayes Lemmerz International Commercial Highway, Inc.,	:	
Relator,	:	
v.	:	No. 09AP-908
The Industrial Commission of Ohio and Patrick R. Conner,	:	(REGULAR CALENDAR)
Respondents.	:	

D E C I S I O N

Rendered on May 5, 2011

Black, McCuskey, Souers & Arbaugh, and *Brian R. Mertes*, for relator.

Michael DeWine, Attorney General, and *Derrick L. Knapp*, for respondent Industrial Commission of Ohio.

Dean R. Wagner and *Erica Antoniotti*, for respondent Patrick R. Conner.

IN MANDAMUS
ON OBJECTIONS TO THE MAGISTRATE'S DECISION

HENDRICKSON, J.

{¶1} Relator, Hayes Lemmerz International Commercial Highway, Inc. ("relator" or "Hayes") brings this original action seeking a writ of mandamus ordering respondent, the Industrial Commission of Ohio ("commission") to vacate a prior commission order granting a motion for rehearing brought by respondent/claimant Patrick R. Conner

("claimant"). The motion for rehearing by claimant sought to revisit a prior denial by the commission of claimant's application for an additional award based upon violation by Hayes of a specific safety requirement ("VSSR") that was allegedly the proximate cause of the injury that led to claimant's allowed claim. Because the commission granted the VSSR claim after granting the rehearing, relator argues in the alternative that this court should issue a writ ordering the commission to vacate its VSSR award and enter an order denying the VSSR application.

{¶2} Pursuant to Civ.R. 53 and Loc.R. 12(M) of the Tenth District Court of Appeals, we referred the matter to a magistrate, who has now rendered a decision and recommendation that includes findings of fact and conclusions of law and is appended to this decision. The magistrate recommends that we deny relator's request for a writ of mandamus. Both relator and the commission have filed objections to the magistrate's decision, and the matter is before the court for our independent review. For the reasons, that follow, we sustain some objections, find others to be moot, decline to adopt the magistrate's recommendation, and grant a writ vacating various commission orders and remanding the matter to the commission.

{¶3} It is settled law that in order for a writ of mandamus to issue, relator must demonstrate that (1) he has a clear legal right to the relief prayed for, (2) respondents are under a clear legal duty to perform the acts requested, and (3) relator has no plain and adequate remedy in the ordinary course of the law. *State ex rel. Berger v. McMonagle* (1983), 6 Ohio St.3d 28, 29.

{¶4} Claimant was injured in the course and scope of his employment with Hayes. His job title at the time of injury was "Military Inspector." One of his duties involved replacing the "inserts" (replaceable cutting edges) on a CNC lathe used to shape

metal wheel rims for use on military vehicles. The lathe in question was partially contained within a "manufacturing cell" (commonly referred to as the "cage," because it was defined by a chain-link fence), which also contained a robotic arm that fed unfinished rims into the lathe for shaping and removed the shaped rims afterwards. The cutting area of the lathe, described as the "lathe housing," was itself enclosed and thus formed a sub-enclosure accessed from within the cage. Part of the lathe housing was constituted by a pair of pneumatic doors that opened and closed with each cycle to permit the robotic arm to insert unfinished rims and remove them after shaping.

{¶5} The main control buttons for the lathe were located within the cage, on the outside of the lathe housing, immediately to the right of the lathe housing doors. This control panel had power on, power off, and emergency stop buttons. A further electrical power switch box for the lathe was located outside the cage, as was the main power control for the robotic arm.

{¶6} Claimant was injured while changing a cutting insert on the lathe. He testified that this process involved leaning through the open lathe housing doors, arms outstretched within the doors, to change the insert using wrenches. While claimant was engaged in this process, the pneumatic system for the automatically-activated lathe housing doors gave him audible warning that they were about to cycle, causing claimant to back up rapidly to attempt to remove his head, arms, and torso from inside the lathe housing. The lathe housing doors nonetheless struck claimant's head, causing him to fall and sustain the injuries underlying his claim.

{¶7} After claimant's claim was allowed, claimant brought an application for the additional VSSR award. The safety rule at issue is Ohio Adm.Code 4123:1-5-05(D)(1), providing that "[m]eans shall be provided at each machine, within easy reach the

operator, for disengaging it from its power supply * * *." At the first hearing ("Hearing I") on the VSSR application, a staff hearing officer ("SHO") found that the emergency stop button on the lathe control panel within the cage was within "easy reach" of claimant at the time he was performing the cutting insert change, and that it would have been impossible to place another emergency stop inside the lathe housing proper, where a worker's hands would be located during an insert change, because any controls on the interior of the lathe housing would soon have been disabled or damaged by flying steel shavings generated by the cutting process.

{¶8} Claimant then filed his motion for rehearing, arguing that the emergency stop button on the lathe control panel was not within "easy reach" when performing the task undertaken at the time of his injury. Claimant pointed out that a person in claimant's position would have had to remove his arms from within the lathe housing and reach out laterally outside the lathe housing to full extension in order to reach the emergency stop button. At the hearing to consider claimant's motion for rehearing ("Hearing II"), a different SHO concluded that the hearing officer at Hearing I had committed an obvious mistake of fact in concluding that the emergency stop button was within easy reach, and that a rehearing was thus warranted.

{¶9} The merits of the VSSR application were then addressed again ("Hearing III") by yet a third SHO, who found that claimant was an "operator" of the lathe, that he was in a "normal position" for an operator when performing an insert change, and the location of the emergency shut-off violated the rule in question because it was not within easy reach.

{¶10} Hayes then filed the present petition for a writ of mandamus to vacate the various orders of the commission. The commission itself has not in this action opposed

the request for a writ, conceding that its SHO in Hearing II erred in finding that there was an obvious mistake of fact that warranted rehearing. The commission also concedes in this action that it abused its discretion when finding in Hearing III that there was a rule violation that supported a VSSR award.

{¶11} The magistrate's report before us, in addition to the pertinent factual findings that are largely undisputed by the filed objections, makes three salient conclusions of law: (1) the SHO in Hearing II erred in concluding that there was an obvious mistake of fact warranting rehearing; (2) the commission nonetheless did not abuse its discretion in granting the rehearing because there was an additional clear mistake of law in the initial VSSR determination that warranted rehearing; and (3) a VSSR award is warranted on the facts. The magistrate accordingly recommends denying the requested writ.

{¶12} Ohio Adm.Code 4121-3-20(E)(1) governs motions seeking a rehearing: "[T]he motion shall be accompanied by new and additional proof not previously considered and which by due diligence could not be obtained prior to the prehearing conference, or prior to the merit hearing if a record hearing was held and relevant to the specific safety requirement violation." Ohio Adm. Code 4121-3-20(E)(1)(a). In addition "[a] rehearing may also be indicated in exceptional cases where the order was based on an obvious mistake of fact or clear mistake of law." Ohio Adm. Code 4121-3-20(E)(1)(b).

{¶13} The magistrate concludes that the second order of the commission issuing from Hearing II did not in fact identify an obvious mistake of fact in the order issuing from Hearing I. The magistrate so concludes because the purported obvious mistake of fact is based upon the conclusion reached in Hearing II that the original order in Hearing I had erroneously stated that the claimant had conceded that the emergency stop button was

within easy reach during the process of changing an insert. The magistrate concludes that a careful reading of the Hearing I order does not support this suggestion. The magistrate goes on to conclude, however, that, while the commission erroneously relied on a nonexistent mistake of fact in ordering a rehearing, the commission could and should have relied on the additional ground that the Hearing I order contained a clear mistake of law in stating that it was the claimant's unilateral negligence that proximately caused his injury.

{¶14} After concluding that rehearing was warranted, albeit on grounds different than those relied upon by the commission in Hearing II, the magistrate then concludes that the VSSR award granted by Hearing III is justified based on violation of applicable power-off and lock-out rules.

{¶15} Hayes brings the following objections to the magistrate's decision:

> 1. The Magistrate's Decision incorrectly concluded that the Industrial Commission did not abuse its discretion when it granted Conner's Motion for Rehearing.
>
> 2. The Magistrate erroneously concluded that Relator violated the alleged safety rules, and further, that the alleged violation was the proximate cause of Conner's injuries.
>
> 3. The Magistrate's Decision to reject Relator's theory that granting the application produces an illogical result is not supported by the evidence in the record.

{¶16} The commission brings the following objections to the magistrate's decision:

> [1.] The magistrate erred when he conducted a de novo review of the commission's order granting a rehearing.
>
> [2.] The magistrate erred when he found the third order correctly holds that claimant was the operator of the Takisawa lathe and that he was in his normal position at the time of his injury.

{¶17} Because we find that the magistrate exceeded the scope of permissible review in searching for, and applying, grounds other than those relied upon by the commission to warrant rehearing, we adopt only the initial findings of fact and reject the conclusions of law reached in the magistrate's decision. We conclude that the commission abused its discretion in granting claimant's motion for a rehearing and setting aside the order issuing from Hearing I. This conclusion largely moots the remaining issues discussed in later orders and the magistrate's decision pertaining to whether claimant was an "operator" occupying a "normal position" during the insert change, and whether emergency-stop and power-lockout regulations applied to this task.

{¶18} In this mandamus action, the limited scope of our review of the commission's determination is to ascertain whether the stated basis of the decision to grant the rehearing was appropriate. Because the magistrate has found that there was no obvious mistake of fact in the commission's initial order denying a VSSR award, the magistrate should have found that the commission did abuse its discretion in Hearing II in granting a rehearing. In the context of the mandamus action, we cannot rely on grounds not considered in the first instance by the commission, particularly since the commission now concedes as a respondent in this action that it abused its discretion granting the rehearing. A mandamus action is not a de novo review of an order or sequence or orders of the commission as part of a comprehensive process seeking only to determine whether the commission ultimately reached the correct end result. To the contrary, relator in seeking a writ places a limited question before us: Did the commission err in finding that Hearing I produced an order containing an obvious mistake of fact? Like the magistrate, we conclude that the commission did so err, but unlike the magistrate we further conclude that this is the limit of our inquiry, and of itself warrants the requested writ.

{¶19} We make no determination as to the underlying merits of the VSSR claim or the applicable rules. Our review is limited to an assessment of the commission's order granting a rehearing. The commission should be given an opportunity to consider legal and factual issues in the first instance and decide them, rather than having such issues determined in the first instance by this court in a mandamus action, which is essentially contrary to the purposes of mandamus as defined above.

{¶20} We accordingly sustain the first objections of both relator and the commission, moot all others, adopt only the initial findings of fact in the magistrate's decision, and do not adopt the conclusions of law contained therein. We find that the commission abused its discretion in granting a rehearing, and the requested writ shall issue ordering the commission to vacate its second and third orders in this matter and reinstate the first order denying the VSSR application. We do not address those aspects of the matter concerning the eventual conclusion by the commission that a VSSR award was warranted, as these issues are mooted by our conclusion in the first issue.

Objections sustained in part; writ of mandamus granted.

BROWN and FRENCH, JJ., concur.

HENDRICKSON, J., of the Twelfth Appellate District, sitting by assignment in the Tenth Appellate District.

APPENDIX

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

The State of Ohio ex rel. Hayes Lemmerz International Commercial Highway, Inc.,	:	
Relator,	:	
v.	:	No. 09AP-908
The Industrial Commission of Ohio and Patrick R. Conner,	:	(REGULAR CALENDAR)
Respondents.	:	

M A G I S T R A T E ' S D E C I S I O N

Rendered on April 30, 2010

Black, McCuskey, Souers & Arbaugh, and *Brian R. Mertes*, for relator.

Richard Cordray, Attorney General, and *Derrick Knapp*, for respondent Industrial Commission of Ohio.

Dean R. Wagner and *Erica Antoniotti*, for respondent Patrick R. Conner.

IN MANDAMUS

{¶21} In this original action, relator, Hayes Lemmerz International Commercial Highway, Inc. ("relator" or "Hayes"), requests a writ of mandamus ordering respondent Industrial Commission of Ohio ("commission") to vacate its order granting the motion for rehearing of respondent Patrick R. Conner ("claimant") regarding his application for an additional award for violation of a specific safety requirement ("VSSR"), and to enter an

order denying the motion for rehearing. In the alternative, relator requests that the writ order the commission to vacate its VSSR award and to enter an order denying the VSSR application.

Findings of Fact:

{¶22} 1. On August 17, 2005, claimant sustained severe injuries to his neck and lower back when the pneumatic doors to the Takisawa CNC lathe unexpectedly closed on him while he was replacing the cutting blade ("insert") of the lathe.

{¶23} 2. Relator uses the lathe to produce steel wheel rims for Hummers purchased by the military.

{¶24} 3. The lathe is sometimes called a trimmer. Inside the lathe housing is a small circular metal table. During the manufacturing process, a robotic arm moves a metal wheel rim into the lathe housing and onto the metal table. After the lathe's doors close, the rim spins as it is trimmed or shaved by a cutting blade or insert. When the trimming is finished, the doors open and the robotic arm removes the finished rim.

{¶25} 4. The Takisawa lathe at issue and its robot were enclosed by a chain-link fence which is sometimes called the cage. The lathe and its robot are referred to as a "manufacturing cell" which again is enclosed within a chain-link fence.

{¶26} 5. The main control buttons for the Takisawa lathe were located on the outside of the lathe housing and to the right of the lathe operator when standing immediately in front of the lathe doors. The control panel has an emergency stop button. Just above the emergency stop button, there are two power buttons. One is the power off; the other is the power on.

{¶27} 6. The main electrical power switch box for the Takisawa lathe is located at the rear of the lathe. The box has a lever to switch the power on or off. The main power

switch is outside the fenced area. Likewise, the main power control for the robot is located outside the fenced area near the entrance gate to the fenced area.

{¶28} 7. Following the commission's allowance of the industrial claim (No. 05-379110), claimant filed a VSSR application on August 2, 2007. Claimant alleged that his injury was proximately caused by relator's violation of two safety rules found at Ohio Adm.Code 4123:1-5-05(D)(1) and (2).

{¶29} 8. The VSSR application prompted an investigation by the Safety Violations Investigation Unit ("SVIU") of the Ohio Bureau of Workers' Compensation ("bureau").

{¶30} 9. On February 6, 2008, the SVIU special investigator issued her report.

{¶31} 10. The SVIU report indicates that special investigator Riley ("Riley") conducted an onsite investigation at relator's manufacturing plant on January 28, 2008. During the onsite investigation, Riley was not permitted to take photographs because of the military production. However, relator agreed to take photographs and to release them to Riley after obtaining approval for their release.

{¶32} 11. During the onsite investigation, Riley was assisted by relator's risk management director, Michael Coffman ("Coffman") and relator's health safety and environmental specialist, Catherine Taylor ("Taylor").

{¶33} 12. The SVIU states in part:

> 4 The opening in the area of the door measured twenty-nine (29) inches wide and thirty-two (32) inches high. * * * The length from the door area to the emergency stop button on the control panel measured thirty-two (32) inches. * * *
>
> 5 Ms. Taylor advised Mr. Conner was changing an insert inside the lathe when his injury occurred. The proper procedure for changing the insert was to lock out the robot, turn the lathe to the manual mode, move the insert to the proper location manually * * *, change the tip of the trimmer

> blade (insert), set the proper dimensions, turn the lathe to automatic mode * * *. Ms. Taylor further advised the lathe needed power during this procedure. Ms. Taylor continued Mr. Conner did not have the lathe in the manual mode when his injury occurred, the lathe was in the automatic mode * * *.
>
> 6 Investigator Riley asked Mr. Coffman and Ms. Taylor if there were any problems with the doors or their track at the time of Mr. Conner's injury. Mr. Coffman replied there were not any problems with either * * *. There was not any debris on the track which would have caused the doors to close * * *. Mr. Coffman continued since the lathe was in the automatic mode Mr. Conner could possibly have bumped the right limit switch and caused the lathe to cycle * * *.
>
> 7 During the on-site investigation Ms. Taylor locked out and tagged out the lathe prior to Investigator Riley entering the cage and viewing the lathe * * *. The lock out tag out area for the lathe is located on the back of the lathe outside of the cage * * *.
>
> 8 Mr. Conner was hired May 4, 1992 and was a military operator at the time of his injury, according to the employer. His job duties consisted of operating the various equipment on the military line, inspecting parts, taking parts off the conveyor, putting parts on the line, and changing inserts * * *. Ms. Taylor informed Investigator Riley Mr. Conner was provided with a combination of classroom and on the job training. * * *

{¶34} 13. SVIU special investigator Riley obtained an affidavit from claimant executed January 29, 2008. Claimant's affidavit states:

> 2 * * * [Relator] hired me May 4, 1992 on the process line. At the time of my injury I was an inspector on the military line. My job duties consisted of checking parts, loading the rim racks, putting the wheels to stock.
>
> 3 I was provided with on the job training from an experienced employee. This training lasted approximately one (1) day. I had been an inspector changing inserts on the military line for approximately a couple of months. I understood how to perform my job duties at the time of my injury. * * *
>
> * * *
>
> 5 On the day of my injury I was instructed by Namik Kirgez to change the inserts on the vertical CNC lathe. The company

had moved the lathe and it had not been in production since it was moved. As I was attempting to change the inserts on lathe I heard air escaping. This meant pressure was building up in the machine or the machine was activated. I attempted to move backward out of the machine, the doors suddenly closed striking me on the head and knocking me backward. When I went backwards my knees gave way and I caught myself on a table behind me.

6 The company had moved the entire line from the north end of the building to the south end of the building. The company was putting in automatic robots. One of the robotic arms had been crashed into the lathe during programming. The robotic arm had crashed into the doors of the lathe sometime the night prior to my injury. The arm had been removed from the lathe and I was called over to change the inserts.

7 When I arrived at the lathe I locked out and tagged out the robotic arm. There was only one place to lock out and tag out and this was just for the robotic arm. There was not [a] place to lock out and tag out the actual lathe. The power box to the lathe was located on the outside of the cage on the left side of the lathe (when facing the front of the lathe), toward the back of the lathe. This power box had a pull switch but did not have any place to lock out the power.

8 The company did not have any lock out or tag out procedure for the lathe. There was not any procedure for changing the inserts at the time of my injury.

9 Prior to my injury occurring Milt Manos walked me through locking out and tagging out the robot. I was also given a pamphlet for performing this task. I was not provided with any training to lock out and tag out any other piece of equipment including the lathe. The only lock out tag out training I received was for the robotic arm.

* * *

11 There was an emergency stop button located on the control panel. The control panel was right next to the doors involved in my injury. When my injury occurred my body was inside the lathe, I could not reach the emergency stop button until I got out of the lathe. This button shut down the entire lathe. The doors would open once the emergency stop button was activated.

12 I was shown how to change the inserts from [sic] Rick Gump. Mr. Gump told me to lock out and tag out the robotic

> arm. If the doors were open I could start to change the machines. If the doors were closed I had to cycle the machine. I was never told to turn off the lathe prior to changing the inserts. The lathe did not need power to change the inserts after the doors were open.
>
> * * *
>
> 20 Namik Kirgez called me over to the lathe about the time I was going to lunch. When I approached the lathe Namik Kirgez told me he wanted me to change the inserts. Mr. Kirgez did not give me any further instruction. Mr. Kirgez was studying the program at the control panel of the lathe while I was changing the inserts. I do not know what mode the lathe was in at the time of my injury. I did not turn off the power to the lathe because Mr. Kirgez was an engineer and I thought he knew what he was doing. Any other time if I had approached the lathe I would have shut off the power to the lathe. I did not at the time of my injury because Mr. Kirgez was there and since he was an engineer I trusted him. After my injury occurred I asked Mr. Kirgez if [he] had shut the doors and he said no.

{¶35} 14. On March 31, 2008, Catherine Beaucham ("Beaucham"), relator's new health and safety specialist, executed an affidavit. According to her affidavit, Beaucham has held this position since January 2, 2007. Her affidavit states:

> 6. The inserts must be replaced periodically, generally at least once per day. The operator changes these inserts manually. The following procedure is used to change the insert. The operator first locks out the robotic arm and then can safely enter the cell. The operator then switches the lathe from automatic mode to manual mode. This allows the operator to open the protective barrier doors and can safely access the insert. The operator uses a yellow metal bar to block open the doors. The operator then moves the insert from the home position to the center position, removes the inserts and installs a new insert. During this process, power to the lathe must be maintained so that the insert can be moved and positioned correctly. While the lathe is in manual mode and the protective barrier doors are open, the lathe will not start its operation. After the insert is changed, the operator returns the lathe to automatic mode, unlocks the robot, and resumes operation of the cell.
>
> * * *

> 8. When the lathe is in automatic mode, the protective barrier doors will automatically close prior to the lathe beginning its normal operation. This is a safety feature that prevents access to the lathe while it is in automatic mode. The protective barriers will not automatically close if the lathe is in manual mode. The reason for this is that the lathe is equipped with a two-handed start switch that the operator must activate to start the lathe if it is in manual mode. If the lathe is in manual mode, the protective barriers will not automatically close and the lathe will not start unless the operator activates the two-hand switch. Regarding Mr. Connor's [sic] injury, because the protective barriers close without activation of the two-hand switch, the lathe was in automatic mode, not manual mode.
>
> 9. Consistent with the procedure explained in paragraph 6, Mr. Conner should have put the lathe in manual mode prior to changing the insert. His failure to do so is the reason why the protective barrier doors closed as he was changing the insert. The fact that the protective barriers closed means that the lathe's safety features were working properly at the time of Conner's injury. The protective barrier doors prevented Mr. Conner from being in the lathe as the lathe began its cycle.
>
> 10. The lathe is equipped with multiple emergency stop buttons/switches. When one of the e-stop buttons is activated, the lathe instantly and completely shuts down. The protective barrier doors will not automatically open or close after an e-stop button is activated; however, the protective barrier doors can be manually opened or closed. The buttons were tested immediately after Mr. Connor's [sic] injury and were found to be working properly.

{¶36} 15. On August 18, 2008, a commission staff hearing officer ("SHO") heard relator's VSSR application. The hearing was recorded and transcribed for the record.

{¶37} 16. Following the August 18, 2008 hearing, the SHO issued an order denying the VSSR application. The SHO's order explains:

> The Staff Hearing Officer finds that the injured worker's application for a finding of Violation of a Specific Safety Requirement is denied for the reason that the injured worker has not met his burden to show that the employer was in violation of safety requirements cited by the injured worker.

In the instance the injured worker is citing ORC Sections 4123-1-5-05 (D) 1 and 2.

D) Machinery control

1) Disengaging from power supply.

Means shall be provided at each machine with an [sic] easy reach of the operator for disengaging it from the power supply. This shall not apply to rolling departments of iron and steel mills, nor to electrical power generation or conversion equipment.

2) When machines are shut down the employer shall furnish and the employees shall use a device to lock the controls in the "off" position or the employer shall furnish and the employees shall use warning tags when the machines are shut down for repair adjusting or cleaning.

The Staff Hearing Officer finds that the injured worker sustained an injury on 8/17/2005 when while standing at the trimmer house bending inside the housing in order to remove inserts the doors closed on the claimant knocking him back and injuring his low back and neck.

* * *

The Hearing Officer finds that both documentation in file and the injured workers' testimony at Hearing Indicate that the machine in which the injured worker was injured at on 8/17/2005 was a complex of two machines in which a robotic arm that was inside of a fence picked up blank steel blocks and placed them into a lathe to be trimmed down to the size which has been programmed.

Testimony at Hearing Indicates that the robotic arm had just been placed in service approximately two to four months prior to the date of injury and that the injured worker had worked on the machine since it had been placed into production.

The Hearing Officer further finds that although the robotic arm and lathe have been put into production the robotic arm had been having ongoing difficulty in operating properly in that the robotic arm instead of delivery [sic] the block of steel to the lathe for cutting would crash into the doors or make it necessary that the inserts would have to be replaced.

On 8/17/2005 the injured worker worker [sic] was instructed to work with an engineer that he had not worked with before in attempting to figure out was was [sic] wrong with the robotic arm at that time.

The injured worker indicates and testimony at hearing and documentation in file shows that he was standing in front of the housing that held the lathe, the doors where [sic] open, he was bending at the waist inside the housing turning slightly to the right with both hands out, attempting to replace the insert.

The Hearing Officer finds that the injured worker indicates that he heard a hissing sound like a pneumatic pressure release and the door started closing. The Hearing Officer finds that the injured worker testified that he pulled himself out of the housing area, but not fast enough and the doors hit him in the head knocking him back, causing him to injure his low back and neck.

At hearing, the injured worker testified and the employer agreed that the inserts had to be changed between five and twenty times a day due to the fact that the robotic arm was not working properly.

The injured worker testified that this was the first time that he had heard the release of the pressure and the first time that the doors had closed with him inside the housing area.

The employer submitted an affidavit of an Catherine Beauchnam [sic] in which she indicates how to operate the lathe while changing inserts, if must be noted that Ms. Beauchnam [sic] did not start in her position as Health and Safety Specialist until January 2, 2007 which is approx-imately two years after the claimant was injured.

She also indicates in paragraph 6 of her affidavit that the doors are held open by a strip. Pursuant to documentation in file and also, the testimony of the injured worker which was reaffirmed by the employer's representative the addition of a yellow metal bar to hold open the doors was placed after the injured worker's injury.

The Staff Hearing Officer finds that the employer has submitted a [sic] insufficient affidavit of an employee that was not working with the company that explains how the machine worked at the time of the injured worker's injury.

Therefore, the Hearing Officer will make the determination that the injured worker's explanation on the proper procedure as far as how to change the inserts on the lathe and what to do as far as turning off the power or not turning off the power. The injured worker's testimony will be seen as the proper procedure.

It must be also noted that Ms. Beachnam [sic] did not work on the machine but just observed the working of the machine approximately two years after the date of injury as indicated.

The injured worker testified that as indicated he was one of the people who changed the inserts in the lathe, injured worker testified that said changing of the inserts occur between five and twenty times a day due to the fact that the robot that was matted with the lathe did not operate properly during the two months that it was in use. The Hearing Officer finds that the whole area in which the lathe and the robot arm was enclosed by a fence and that you had to go inside the fence to do maintenance on either the lathe or the robot.

The injured worker testified that the robot arm had a lock-out tag-out procedure and that prior to him going into the lathe, he had locked out the robot so it could not be turned on by any other employee.

The Hearing Officer finds that pursuant to the injured worker's testimony and reaffirmed by the employer, the lathe did not have a lock-out tag-out feature but did have an emergency stop button on the outside of the lathe within easy reach. Both the employer and the injured worker agreed that the emergency stop was within the easy reach of an operator of the lathe. The employee who had to change the inserts had to put both arms inside the lathe in order to change the insert. There was testimony indicating that it would have been impossible to put an emergency stop inside of the lathe where it was cutting due to the sharp pieces of steel flying around.

There is some controversy considering whether the machine needed to be turned off to change inserts or according to Ms. Beachnam's [sic] affidavit the machine had to stay on when the inserts where replaced. As indicated above Ms. Beachnam [sic] did not operate the machine. The injured worker was working on the machine for approximately two months, and did operate the machine, therefore he indicates that when the machine malfunctions and inserts need to be replaced that the lathe is turned off and that the inserts

should go to the home position where an employee can reach in and change inserts. The injured worker indicated that the machine can either be in an automatic mode or a manual mode.

The injured worker indicates that he was working with an engineer that he had not had a lot of experience with and that when he placed his arms and upper body inside the lathe to change the insert he had thought that the engineer had turned off the power to the lathe but evidently due to the fact that the doors closed it was not done.

The Hearing Officer finds in the injured worker's affidavit which was prepared prior to this hearing and also in his testimony at hearing he indicates that "any other time if I had approached the lathe (to change the inserts) I would have shut off the power to the lathe". In this instance the claimant stated that he figured the engineer knew what he was doing and would turn off the lathe. The injured worker did not tell the engineer to turn off the machine, he assumed that the employee would.

The Hearing Officer finds that based on the injured worker's statements and the fact that he unfortunately relied on another employee to turn off the lathe instead of doing it himself that the injured worker's request for VSSR Award is denied.

The Staff Hearing Officer further finds that code section 4123.1-5-05 D 1, does not apply due to testimony at hearing from the injured worker indicating that there was an emergency stop on the outside of the lathe area and also a power off switch that he usually turned off prior to replacing the inserts.

The Hearing Officer finds that the code section number 2 which indicates that when the machines are shut down that the lock-out tag-out feature does not apply due to the fact that the employer had supplied adequate procedures and devices to shut off the machine prior to any employee replacing the inserts into the lathe.

The Hearing Officer finds that it was an unfortunate accident but that the employer had done all it could to ensure the injured worker's safety but the injured worker in relying on another co-worker can not put the blame on the employer, as he indicated his own decision was not to turn off the lathe prior to reaching in to replace the inserts.

> The unilateral negligence of the injured worker in not turning off the lathe was the proximate cause of the injured worker's injury.
>
> Therefore, as indicated the injured worker's request for a VSSR Award is denied.

{¶38} 17. Claimant moved for rehearing pursuant to Ohio Adm.Code 4123-3-20(E).

{¶39} 18. On January 30, 2009, another SHO mailed an order that grants the motion for rehearing and vacates the SHO's order of August 18, 2008. The January 30, 2009 SHO's order explains:

> It is the order of the Industrial Commission that the Motion for Rehearing be granted for the reason that the Injured Worker has demonstrated that the order of 08/18/2008 was based on an obvious mistake of fact, in accordance with Ohio Administrative Code 4121-3-20(C)(1)(b).
>
> Specifically, this obvious mistake of fact is the Staff Hearing Officer's finding that the Injured Worker had access to an emergency stop button that was within easy reach for him as the operator of the lathe in question.
>
> The Staff Hearing Officer finds that based on a review of the transcript that the Injured Worker, as a lathe operator, had the responsibility of periodically changing inserts. To do this work, the Injured Worker had to bend down and place both arms inside of a cage structure that housed a robotic arm and a lathe. The Injured worker while changing these inserts did not realize that the power to the lathe was not turned off, and as a result, the doors closed onto the Injured Worker causing the injuries of record.
>
> The original Staff Hearing Officer found that because the Employer did have an emerging [sic] stop button located on the "outside" of the lathe that said emergency stop button was within easy reach of the Injured Worker as the lathe operator. However, as Injured Worker's counsel pointed out, when the Injured Worker was changing the inserts he was inside of the cage structure using both arms to change the inserts. It was while the Injured Worker was at this position that he was injured. It is noted that Injured Worker testified

> that when he was inside the cage that the stop button was "not" within his easy reach * * *.
>
> While the stop button was within Injured Worker's easy reach when he was not performing the insert changing job, while the Injured Worker was changing the inserts, said stop button, being outside the cage that housed the lathe, was not within his easy reach, and the Staff Hearing Officer's contrary finding was a factual error based on this explanation.

{¶40} 19. On March 13, 2009, relator's "Senior Manufacturing Engineer" Michael Michalec ("Michalec") executed an affidavit, stating:

> 4. During the cutting process, the doors to the lathe close. This prevents anyone from accidentally accessing the cutting area during the cutting operation. Additionally, during the cutting process, large amounts of steel chips and shavings are created as the insert cuts the tire rim. These shavings fly around the interior of the lathe. The closed doors prevent the steel shavings from flying out of the lathe. The doors are one of the safety devices included on the lathes.
>
> 5. All of the lathes, including the one involved in Mr. Conner's injury, are presently equipped with multiple emergency stop buttons/switches. These buttons were also present on the lathes at the time of Mr. Conner's injury. When one of the e-stop buttons is activated, the lathe instantly and completely shuts down. The doors will not automatically open or close after an E-stop button is activated; however, the doors can be manually opened or closed.
>
> 6. The e-stop buttons are located within easy reach of the operator on the outside of the lathe. The e-stops [sic] buttons are actually located on the lathe very close to the doors that enclose the cutting area. The buttons are located on the outside of the lathe because it is not possible to install an e-stop button inside the lathe close to the inserts. The reason for this is that the button would not withstand the barrage of steel chips and shavings, which would likely damage the button to the extent that it could not be expected to correctly operate.
>
> * * *
>
> 8. When considering that e-stop buttons cannot be installed inside the lathe, the e-stop buttons were installed on the

> lathes as close as possible to the operator. The e-stop buttons are not located outside of the cage that encloses the manufacturing cell, which includes the lathe and the robot arm.

{¶41} 20. On March 16, 2009, another SHO reheard the VSSR application. The hearing was recorded and transcribed for the record. Following the hearing, the SHO issued an order finding a violation of the specific safety rule set forth at Ohio Adm.Code 4123:1-5-05(D)(1) and also finding that the violation was the proximate cause of the injury. On that basis, the SHO granted the VSSR application.

{¶42} The SHO further found that Ohio Adm.Code 4123:1-5-05(D)(2) was not applicable, and that relator's failure to furnish devices for locking out or tagging out the lathe was not the proximate cause of the injury.

{¶43} The SHO's order of March 16, 2009, explains:

> It is the finding of the Staff Hearing Officer [sic] the application for violation of specific safety requirement filed 8/20/2007 is granted to the extent of this order.
>
> The injured worker was employed as a military inspector by the named employer. The injured worker's job duties included final inspection of the inner part of wheels manufactured by the employer, changing the inserts in a lathe known as the Takisawa which were used to trim wheels to the proper dimensions, cleaning out the shards or shavings produced by the trimming process performed by the Takisawa lathe, and changing inserts on a machine known as the Baker trimmer. * * *
>
> The injured worker was injured on 8/15/2005 while changing the inserts for the Takisawa lathe. The evidence reflects the injured worker was working at approximately waist height, leaning into the right side of the lathe doorway, and reaching with both arms to change the insert when he heard air escaping, signaling the machine was about to start. * * * The injured worker attempted to back out of the machine and the pneumatic door, which automatically closes when the lathe cycles, stuck [sic] him in the forehead. The injured worker then stumbled backwards. This claim was ultimately re-cognized for multiple cervical and lumbar conditions.

On 8/02/2007 the injured worker filed an application for an additional award for violation of specific safety requirement alleging violations of Ohio Administrative Code Rules 4123:1-5-05(D)(1) and (2). In pertinent part those rules read:

Auxillary Equipment

D) Machinery control.

1) Disengaging from power supply.

Means shall be provided at each machine, within easy reach of the operator, for disengaging it from its power supply. This shall not apply to rolling departments of iron and steel mills nor to electrical power generation or conversion equipment.

2) When machines are shut down.

The employer shall furnish and the employees shall use a device to lock the controls in the "off" position or the employer shall furnish and the employees shall use warning tags when machines are shut down for repair, adjusting, or cleaning.

Analysis of Ohio Administrative Code 4123:1-5-05(D)(1)

No evidence was presented by the parties at hearing regarding whether the injured worker was the "operator" of the Takisawa lathe as required by Ohio Administrative Code Rule 4123:1-5-05(D)(1). In fact, the injured worker testified the lathe did not have an operator in the traditional sense of the word. * * *

The evidence indicates the employer of record manufactured wheels for use by the military. The injured worker presented a diagram which depicts the area of production. * * * A robotic arm would move a wheel from the rehit press to a conveyor where the wheel was sent to welders. When the welders were done with the wheel it was placed on another conveyor where the robotic arm would again pick it up and place it into the Takisawa lathe which would shave the wheel to specification. The robotic arm would remove the wheel from the lathe when it was done shaving the wheel and place it on a conveyor which took the wheel to the Moore gauge area where the injured worker inspected it. The robotic arm would then repeat this process.

The diagram presented by the injured worker reflects the entire area where the robotic arm performed its functions is

enclosed by a chain link fence. The robotic arm is roughly in the center of the fenced-in area and it has access to the rehit press, conveyors and two Takisawa lathes. The testimony presented at hearing reflects the second lathe was not installed in 2005 when the injured worker was injured and was put into operation after the date of injury.

The injured worker testified that when the robotic arm is in operation it is intended that no person would be within the chain link fence. The functions of the Takisawa lathe were programmed by an engineer prior to operation and if anyone "operated" the lathe it was the programmers.

Ohio Administrative Code Rule 3123:1-5-01(B)(92) defines "operator" as "any employee assigned or authorized to work at the specific equipment". This definition reflects an intent to define "operator" in broad terms. Also, the Ohio Supreme Court has indicated the actual job title of an injured worker is not determinative of the issue. An operator is the person "actively involved in the machine's operation". This can include the person who inspects, cleans, oils, checks for defective parts, dislodges misplaced parts, or corrects malfunctions. An operator is more than a casual observer who has "no responsibility for or participation in the machine's function." State, ex rel. Scott Fetzer Co. Halex Division, v. Industrial Commission (1998), 81 Ohio St. 3d 462.

The injured worker clearly meets the definition of "operator" under either the rule definition of the Scott Fetzer definition. The injured worker was an employee assigned and authorized to work at the lathe. One of the injured worker's undisputed job duties was changing inserts as needed. Further, the injured worker's job duties included cleaning out the shavings and the shards of the Takisawa lathe. The injured worker had some responsibilities tied to the operation of the lathe in question.

The focus of Rule 4123:1-5-05(D)(1) then becomes whether means for disengaging the power supply "within easy reach of the operator" existed on the date of injury. The Report of Investigation dated 2/6/2008 from the State of Ohio Bureau of Workers' Compensation Safety Violations Investigation Unit indicates the Takisawa lathe had an emergency stop button located 32 inches to the right (when facing the lathe) of the door opening of the lathe. This emergency stop button can be seen in Plaintiff's Exhibits 2,3, and 4 which depict a similar, but not identical, Takisawa lathe as the one involved

in the injured worker's injury. The injured worker testified that this button, identified as the large round button in the center set of controls, was actually present on the lathe which was involved in the injured worker's injury. * * *

As noted, the lathe pictured in Plaintiff's Exhibits 2,3 and 4 is not the same one involved in the injured worker's injury. * * * The control panel pictured at the bottom right, with three buttons protruding upward rather in front of the lathe, was located at the bottom of the doorway opening of the other lathe, immediately above the printed "Takisawa" sign. The panel only had two buttons and did not have the emergency stop pictured in the center of the photographs. It was undisputed that the only emergency stop button located on the Takisawa lathe which was involved in the injured worker's injury was the one located 32 inches to the right of the doorway in the center of the control panels.

The injured worker's arm length was measured at hearing to be 29 inches and the distance between his shoulders was measured to be 20 inches. * * * Therefore, from the center of the injured worker's body, the injured worker when standing to the right side of the lathe doorway as he testified he did on the date of the injury, had an arm span of 39 inches which could easily reach the emergency stop button 32 inches away.

However, the determination of whether the emergency stop button was within easy reach must consider "the position in which the operator is normally situated." State, ex rel. Harris v. Industrial Commission (1984) 12 Ohio St. 3d. 152. The injured worker's normal position when working with this lathe, whether to change an insert or to clean out shards, was to lean into the doorway of the lathe with both arms extended into the lathe. The injured worker testified that he usually changed the lathe when it was in the "home" position or to the right of the opening. * * * However, if the lathe had malfunctioned, the insert was on occasion changed in a different position within the lathe. * * *

Therefore, the injured worker's "normal position" when working with the lathe is found to be bent at the waist, leaning forward into the lathe, with both arms extended into the lathe. In this precarious position the emergency stop button was not within easy reach of the injured worker. The injured worker would have to back out from within the lathe, bring his arms out and then reach 32 inches to activate the only emergency stop button located on the Takisawa lathe

> where the injured worker's injury occurred. Therefore, a violation of Ohio Administrative Code Rule 4123:1-5-05(D)(1) has been established and is found to be the proximate cause of the injured worker's injury.
>
> * * *
>
> VSSR Additional Award Granted
>
> It is therefore ordered that an additional award of compensation be granted to the injured worker in the amount of 20% of the maximum weekly rate pursuant to State, ex rel. Engle v. Industrial Commission (1944), 142 Ohio St. 425. * * *

(Emphasis sic.)

{¶44} 21. On September 28, 2009, relator, Hayes Lemmerz International Commercial Highway, Inc., filed this mandamus action.

Conclusions of Law:

{¶45} Two main issues are presented: (1) whether the commission, through its SHO, abused its discretion by granting claimant's motion for rehearing, and (2) if there be no abuse of discretion in granting rehearing, did the commission abuse its discretion in granting a VSSR award upon the rehearing.

{¶46} The magistrate finds: (1) the commission did not abuse its discretion by granting the motion for rehearing, and (2) the commission did not abuse its discretion in granting a VSSR award upon the rehearing.

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

{¶48} Ohio Adm.Code 4123:1-5 sets forth specific safety rules for workshops and factories.

{¶49} Ohio Adm.Code 4123:1-5-05 is captioned: "Auxillary equipment."

{¶50} Ohio Adm.Code 4123:1-5-05(D) is captioned: "Machinery control." Thereunder, are the two specific safety rules at issue:

> (1) Disengaging from power supply.
>
> Means shall be provided at each machine, within easy reach of the operator, for disengaging it from its power supply. * * *
>
> (2) When machines are shut down.
>
> The employer shall furnish and the employees shall use a device to lock the controls in the "off" position or the employer shall furnish and the employees shall use warning tags when machines are shut down for repair, adjusting, or cleaning.

Turning to the first issue regarding the commission's grant of rehearing, Ohio Adm.Code 4121-3-20(E) provides:

> Within thirty days of the receipt of the order of the staff hearing officer deciding the issues presented by the application, either party has the right to file a motion requesting a rehearing. * * *
>
> (1) If the motion for reHearing Is filed, a staff hearing officer, after the expiration of the answer time, shall review the motion for rehearing under the following criteria:
>
> (a) In order to justify a rehearing of the staff hearing officer's order, the motion shall be accompanied by new and additional proof not previously considered and which by due diligence could not be obtained prior to the prehearing conference, or prior to the merit Hearing If a record hearing was held and relevant to the specific safety requirement violation.
>
> (b) A rehearing may also be indicated in exceptional cases where the order was based on an obvious mistake of fact or clear mistake of law.
>
> (2) If the motion for rehearing does not meet the criteria as outlined in paragraph (E)(1)(a) or (E)(1)(b) of this rule, the motion shall be denied without further hearing.

The SHO's order of January 30, 2009 granting rehearing ("second order") found that the SHO's order of August 18, 2008 ("first order") contained an "obvious mistake of fact."

{¶51} It should be observed that the second order improperly uses the terms "cage" or "cage structure" when the term "lathe housing" should have been used. As earlier noted, the record clearly indicates that the word "cage" refers to the "chain link fence" that enclosed the lathe and the robot. The word "cage" was never used in the administrative proceedings to refer to the lathe housing.

{¶52} The second order states: "To do this work, the Injured Worker had to bend down and place both arms inside of a cage structure that housed a robotic arm and a lathe." The record clearly indicates that claimant was required to place both arms inside of the lathe housing—not the so-called cage structure. However, the lathe housing did house the lathe itself and a robotic arm that moved into the lathe housing during the manufacturing process.

{¶53} Contrary to relator's contention here, the second order's misuse of the term "cage" or "cage structure" is not grounds for voiding the grant of rehearing. In the magistrate's view, a fair reading of the second order does not compel the conclusion that the SHO actually believed that the emergency stop button located on the lathe housing was actually located outside the fenced area. Accordingly, relator's contention in that regard is rejected.

{¶54} Notwithstanding the above analysis, the second order does fail to identify an "obvious mistake of fact" contained in the first order. The second order suggests that the original SHO erroneously believed that claimant had conceded that the emergency stop button was within his easy reach when he was inside the lathe housing replacing the insert. A close reading of the first order does not support that suggestion.

{¶55} While the second order fails to identify an obvious mistake of fact upon which rehearing can be granted, the inquiry does not abruptly end, as relator here

suggests. Clearly, a defective second order granting rehearing does not compel the conclusion that no grounds exist for granting rehearing. Grounds for granting rehearing are evident in the first order and were raised by claimant in his motion for rehearing.

{¶56} The second order should have granted rehearing on grounds that the first order contains a clear mistake of law in determining that it was claimant's unilateral negligence that proximately caused his industrial injury.

{¶57} Specific safety requirements are intended to protect employees against their own negligence and folly as well as provide them a safe place to work. *State ex rel. Cotterman v. St. Mary's Foundry* (1989), 46 Ohio St.3d 42, 47.

{¶58} The unilateral negligence defense to VSSR liability derives from *State ex rel. Frank Brown and Sons, Inc. v. Indus. Comm.* (1988), 37 Ohio St.3d 162, in which an employer was exonerated from VSSR liability because an employee had removed part of a scaffold that had been required by a specific safety requirement. *State ex rel. Quality Tower Serv., Inc. v. Indus. Comm.*, 88 Ohio St.3d 190, 192, 2000-Ohio-296.

{¶59} However, a claimant's alleged negligence is a defense only where the employer has first complied with relevant safety requirements. *State ex rel. Hirschvogel, Inc. v. Miller*, 86 Ohio St.3d 215, 218, 1999-Ohio-96. A claimant's negligence bars a VSSR award only where the claimant deliberately renders an otherwise complying device noncompliant. *State ex rel. R.E.H. Co. v. Indus. Comm.*, 79 Ohio St.3d 352, 355, 1997-Ohio-382; *State ex rel. Martin Painting and Coating Co. v. Indus. Comm.*, 78 Ohio St.3d 333, 339, 1997-Ohio-45.

{¶60} In the first order, the SHO states:

> The injured worker indicates that he was working with an engineer that he had not had a lot of experience with and that when he placed his arms and upper body inside the lathe to change the insert he had thought that the engineer

> had turned off the power to the lathe but evidently due to the fact that the doors closed it was not done.
>
> The Hearing Officer finds in the injured worker's affidavit which was prepared prior to this hearing and also in his testimony at hearing he indicates that "any other time if I had approached the lathe (to change the inserts) I would have shut off the power to the lathe". In this instance the claimant stated that he figured the engineer knew what he was doing and would turn off the lathe. The injured worker did not tell the engineer to turn off the machine, he assumed that the employee would.
>
> The Hearing Officer finds that based on the injured worker's statements and the fact that he unfortunately relied on another employee to turn off the lathe instead of doing it himself that the injured worker's request for VSSR Award is denied.
>
> * * *
>
> The Hearing Officer finds that it was an unfortunate accident but that the employer had done all it could to ensure the injured worker's safety but the injured worker in relying on another co-worker can not put the blame on the employer, as he indicated his own decision was not to turn off the lathe prior to reaching in to replace the inserts.
>
> The unilateral negligence of the injured worker in not turning off the lathe was the proximate cause of the injured worker's injury.

{¶61} The first SHO's denial of the VSSR application based upon claimant's negligence involves a clear mistake of law that, under Ohio Adm.Code 4121-3-20(E)(1)(b) created for the commission a clear legal duty to grant the motion for rehearing. That the commission failed to recognize the clear mistake of law does not automatically sanction the first SHO's determination, as relator here seems to suggest.

{¶62} Clearly, that claimant may have negligently assumed that relator's engineer had turned off the lathe, is not unilateral negligence that can be used by relator as a VSSR defense.

{¶63} Again, under the circumstances here, the commission had a clear legal duty, cognizable in this mandamus action, to grant the motion for rehearing. That the commission did so for the wrong reason does not in any way compel this court to vacate the commission's decision to grant rehearing.

{¶64} Given the above analysis, the magistrate shall now address the second issue which, as earlier noted, is whether the commission abused its discretion in granting a VSSR award upon the rehearing of the application.

{¶65} The SHO's order of March 16, 2009 ("third order") begins analysis of the applicability of Ohio Adm.Code 4123:1-5-05(D)(1) with a determination of whether claimant was the "operator" of the Takisawa lathe and, if so, what was claimant's normal operating position. This analysis is compelled by the language of the specific safety rule at issue, which states: "Means shall be provided at each machine, within easy reach of the *operator*, for disengaging it from its power supply." (Emphasis added.)

{¶66} Two cases relied upon by the third order are relevant to its analysis. In *State ex rel. Harris v. Indus. Comm.* (1984), 12 Ohio St.3d 152, the specific safety rule at issue, found at former Ohio Adm.Code 4121:1-5-05(D)(1), read the same as Ohio Adm.Code 4123:1-5-05(D)(1) at issue in the instant case. In *Harris*, the claimant, Robert Harris, was severally injured when his right hand and arm were drawn into the ink rollers of an offset printing press. The commission denied a VSSR award for the alleged violation of former Ohio Adm.Code 4121:1-5-05(D)(1). In mandamus, the *Harris* court upheld the commission's finding that the safety rule was inapplicable to Harris's position at the time of his injury. The *Harris* court explains:

> * * * Appellant could have greatly minimized his injuries had he been able to reach the controls and disengage the press from its power supply when his hand became caught. The record shows that the controls, although within easy reach of

> the operator *under normal circumstances*, could not be reached by appellant precisely because of his precarious position. Appellant argues that the rule is useless as a safety rule if it does not apply to such extraordinary circumstances as those under which he found himself on November 12, 1976.
>
> Appellees insist that it was reasonable for the commission to interpret the rule with regard to circumstances where the operator is situated for his regular duties. They argue that a different construction encompassing any or all possible situations would deprive the employer of the specificity necessary for it to comply with the particular requirement. *State ex rel. Trydle v. Indus. Comm.* (1972), 32 Ohio St.2d 257, 291 N.E.2d 748 [61 O.O.2d 488].
>
> Appellees' point is well-taken. It would be impossible to comply with Ohio Adm.Code 4121:1-5-05(D)(1) if the controls had to be within easy reach of all possible positions in which the operator could find himself around the machine. The commission acted reasonably in interpreting the rule to refer to the position in which the operator is normally situated.

Id. at 154. (Emphasis sic.)

{¶67} In *State ex rel. Scott Fetzer Co., Halex Div. v. Indus. Comm.*, 81 Ohio St.3d 462, 1998-Ohio-457, the second case relied upon by the SHO, the issue was whether the commission abused its discretion by awarding a VSSR based upon a violation of former Ohio Adm.Code 4121:1-5-11(D)(6) which required the danger zone on the die casting machine to be guarded. Finding no abuse of discretion, the court explained:

> Fetzer also argues that claimant was not entitled to the protection of Ohio Adm.Code 4121:1-5-11(D)(6) because he was the "tender," not the "operator" of the machine. This contention fails as well. Regardless of what Fetzer chose to call claimant, he was actively involved in the machine's operation. Claimant started, inspected, and cleaned the die. He operated the linkage mechanism and set die heights. He oiled the die and checked for defective parts. He was responsible for lodged parts and correcting malfunctions. He was not, therefore, a casual observer with no responsibility for or participation in the machine's function.

Id. at 197-198.

{¶68} Applying the law set forth in the *Harris* and *Scott Fetzer* cases, the third order determines that claimant was the operator of the Takisawa lathe at the time of injury and that the position claimant was in at the time of his injury was his normal position when operating the lathe. That is, claimant's normal position required him "to be bent at the waist, leaning forward into the lathe, with both arms extended into the lathe."

{¶69} In that bodily position with respect to the lathe, the third order finds that the emergency stop button was not within easy reach of claimant at the time of his injury. As explained by the third order:

> * * * The injured worker would have to back out from within the lathe, bring his arms out and then reach 32 inches to activate the only emergency stop button located on the Takisawa lathe where the injured worker's injury occurred. * * *

{¶70} Here, relator fails to seriously challenge the third order's legal analysis and determination that claimant was the operator of the Takisawa lathe and the determination of claimant's normal operating position. The only challenge can perhaps be gleaned from the following statement from relator's brief: "Rather, the rule requires a shut off switch at the position of operation, which in this case, is standing in front of the lathe. There is no dispute that when Conner stood in front of the lathe the buttons were easily reachable." (Relator's brief at 17.)

{¶71} Relator does assert that, standing in front of the lathe, is the operator's "normal position." (Relator's brief at 16.)

{¶72} Other than simply asserting that the safety rule only requires that the means for disengaging the machine from its power supply be provided within easy reach of the

claimant when he stood in front of the lathe, no real challenge to the commission's legal analysis is made.

{¶73} In any event, the magistrate finds that the third order correctly holds that claimant was the operator of the Takisawa lathe and that he was in his normal position at the time of his injury.

{¶74} Given the above analysis, relator's contention that the emergency stop button on the outside of the lathe housing was within easy reach of the claimant as he stood in front of the lathe (without reaching in) misses the mark.

{¶75} According to relator, the main electrical power switch located at the rear of the lathe outside the fenced area was within easy reach of claimant because he could have easily used that power switch to shut off power before he entered the lathe housing to change the insert. According to relator, "[i]f he was able to shut off the power to the lathe, then certainly, Relator complied with the requirement that it provide a means for Conner to do so." (Relator's brief at 15.)

{¶76} This argument is meritless for two reasons: (1) it is in effect a thinly veiled argument for unilateral negligence, and (2) it ignores the third order's analysis and determination that claimant was the operator whose normal position placed his body partially into the lathe housing.

{¶77} Clearly, relator cannot logically point to the main electrical power switch as meeting compliance with the specific safety rule at issue.

{¶78} Relator further contends that the third order's finding of a violation of Ohio Adm.Code 4123:1-5-05(D)(1) is, in effect, a finding that relator was required to install an emergency stop button inside the lathe housing when the evidence undisputedly shows that an emergency stop button cannot be so placed. This argument lacks merit.

{¶79} Contrary to relator's suggestion, it does not automatically follow that an emergency stop button must be placed inside the lathe housing in order to provide a means for disengaging the power supply within easy reach of the operator when reaching into the lathe to replace the inserts.

{¶80} As claimant conceded in his brief, "[a]ll of the parties to this matter agree that it is not possible to place an emergency stop within the cutting chamber of the machine." (Claimant's brief at 17.)

{¶81} Notwithstanding claimant's concession regarding placement of an emergency stop button within the cutting chamber, claimant had no burden to show where an easy-to-reach emergency stop button should be placed. Claimant was only required to show that, at the time of his injury, there was no means for disengaging the power supply within easy reach.

{¶82} Relator further contends that the third order fails to explain how relator's violation of the safety rule proximately caused the injury. In support of this contention, relator points to claimant's testimony at the March 16, 2009 hearing:

> [Relator's counsel] You said - - I asked you if it mattered whether safety was turned off - - or whether power was turned off to the machine or not?
>
> A. The day of the accident in '05, it didn't matter.
>
> Q. Okay. It didn't matter.
>
> So if power was on to the machine, you're telling us your injury would have occurred?
>
> A. Yes.
>
> Q. And if power was off to the machine, you're telling us your injury would have occurred?
>
> A. Yes.

(Tr. 272.)

{¶83} According to relator, claimant's testimony shows that any failure to provide a means of disengaging the power supply could not have proximately caused the industrial injury.

{¶84} Assuming for the sake of relator's argument, that claimant's testimony, if accepted as accurate, shows that any failure to provide a means of disengaging the power supply could not have proximately caused the industrial injury, that testimony did not compel the commission to find that proximate cause was lacking. The commission was not required to accept all of claimant's hearing testimony as accurate. It is the commission that weighs the evidence. Apparently, the commission's hearing officer gave this testimony little or no weight and that was well within the commission's fact-finding discretion.

{¶85} Relator further argues that the VSSR award produces a patently illogical result, citing *State ex rel. Lamp v. J.A. Croson Co.*, 75 Ohio St.3d 77, 78-79, 1996-Ohio-319. According to relator, when the lathe doors closed, they prevented claimant from being severely injured by the cutting mechanism inside the lathe housing. According to relator, because the doors acted as a safety mechanism that prevented injury, it is patently illogical to penalize relator for injuries produced by the doors. *Lamp* does not support relator's proposition that safety devices are exempt from the specific safety rules, and this magistrate is unaware of any cases that so hold. Thus, this argument lacks merit.

{¶86} Accordingly, for all the above reasons, it is the magistrate's decision that this court deny relator's request for a writ of mandamus.

/s/ Kenneth W. Macke
KENNETH W. MACKE
MAGISTRATE

NOTICE TO THE PARTIES

Civ.R. 53(D)(3)(a)(iii) provides that a party shall not assign as error on appeal the court's adoption of any factual finding or legal conclusion, whether or not specifically designated as a finding of fact or conclusion of law under Civ.R. 53(D)(3)(a)(ii), unless the party timely and specifically objects to that factual finding or legal conclusion as required by Civ.R. 53(D)(3)(b).