**********	
In the Matter of Arbitration Between:	
ARCELORMITTAL USA, Indiana Harbor.	**Grievant: Krcoski Issue: Termination Arbitrator Docket No. 180301**
and	**Case No. 89**
UNITED STEELWORKERS, Local 1011.	
**********	

BEFORE ARBITRATOR JEANNE M. VONHOF

INTRODUCTION

The undersigned Arbitrator was appointed according to the rules of the applicable collective bargaining agreement. The hearing was held on April 10, 2018, in East Chicago, IN.

Mr. Jack Klinker, assisted by Mr. Christopher Kimbrough, Labor Relations Representatives, represented ArcelorMittal USA, Indiana Harbor, hereinafter referred to as the Employer or the Company. Mr. Al Pace, former Manager of Steelmaking Operations, #3SP; Mr. Dan Britton, Shift Manager; and Mr. Tim Halls, Division Manager, #3SP, testified on behalf of the Employer.

Mr. Alexander Jacque, District 7 Sub-district Director, represented United Steelworkers Local 1011, hereinafter referred to as the Union or the Local. Mr. Michael Krcoski, Grievant; Mr. Arnulfo Torres, Crane Operator; Mr. Bill Garbacz, Hot Metal Operator; and Mr. Jaime Quiroz, Griever, testified on behalf of the Union.

Each party had a full and fair opportunity to present evidence at the hearing. Both parties made closing arguments at the hearing.

ISSUE:

Was there just cause for the termination of the Grievant and if not, what shall the remedy be?

Background

In this grievance, the Union challenges the termination of the Grievant for an incident occurring on October 17, 2016, and for his overall work record. The Grievant had worked for the Company for a little over 20 years at the time of his discharge. He was employed as a Crane Operator at Number 3 Steel Producing (3SP) when he was terminated.

On the morning of October 17, 2016, the Grievant was assigned to operate the East Charging Crane, an overhead crane at # 3 Steel Producing. His duties were to pick up ladles filled with hot metal, deliver them to the furnace, charge the furnace, and return empty ladles and also to move slag, skimmer pots, and scrap boxes. There are two cranes in the area, and if the west crane is out of service, the Grievant is required to service the entire charge aisle with his crane.

On the morning in question, the Grievant was assigned to lift a steel ladle, loaded with hot metal, and transport it to the furnace. The full ladle weighed about 400 tons. In order to lift the ladle, the Crane Operator is to use the crane to attach two enormous J-hooks to trunnion pins, one on either side of the ladle. In this case one of the J-hooks was not attached properly, and the ladle fell into the hot metal transfer car beneath it. The falling ladle damaged the transfer car, rendering it no longer usable. The Grievant was terminated for failing to follow proper procedures, for failing to report the incident immediately, and on the basis of his overall record.

Mr. Al Pace, who was Manager of Steelmaking Operations at #3SP at the time, held that position for about 5 years. He became aware of the incident when he came in on the morning of October 17, 2016. He viewed a video recording of the incident, which was provided at arbitration, and conducted a further investigation over the next day. According to the Manager, the video demonstrates that the west J-hook was not correctly attached to the ladle, resulting in

the ladle being picked up on the point of the J-hook, rather than in the saddle of the hook, causing the ladle to slip and fall from the tip to the saddle, about 15 to 18 inches.

Pace testified that further investigation showed that just prior to the incident, there was another incident which he concluded may have exacerbated the ladle drop. During this incident, the ladle was being filled with more hot iron. The Grievant had set the ladle down and was having difficulty disengaging one of the J-hooks from the ladle. When he went to lift the ladle again, the ladle was attached by the east J-hook only, causing the ladle to drag over onto the transfer car, moving the ladle to the east. Pace concluded that the Grievant should have reported the incident, because uneven lifts—with the weight unevenly distributed between the two J-hooks—can cause problems with the crane, which should be inspected before proceeding further. The J-hooks are connected to each other with a large metal beam and are meant to be used together. (Another hook is used for single-point lifting.) The cables that lift the J-hooks are slung over drums at the top of the crane and can become twisted or even fall off the drum during an uneven lift, when slack is created in the cables attached to the J-hook which is lifting less weight than the other hook. Cables which are not seated properly on the drum may not bear weight properly, potentially causing problems with later lifts.

According to Pace, as the Grievant proceeded to make the lift after the ladle was filled, the Grievant should have waited for a blind hook check to be made by another Operator before proceeding. The Grievant could not see the west J-hook from his vantage point in the Crane Operator's cab, and needed another nearby Operator to make sure that the J-hook was properly engaged before making the lift. Pace said that the Grievant failed to request a blind hook check. According to Pace's investigation, at the moment at which the ladle dropped, the Hot Metal Operator noticed that there was a problem and came out of the pulpit and called out, "Stop!"

The Grievant was terminated in part for not reporting the incident immediately to Management. The Manager testified that the video shows that when the ladle dropped, there was a very bright splash in the ladle and that the whole area of the building shook so hard that it dislodged dust from building structures. The camera, mounted on structures on the opposite wall, shook. Pace said that these signs should have been sufficient to inform the Grievant that a serious drop had just occurred. Pace also testified that when the Operator sees the equalizer bar falling over, as it did here, he should know that there is slack in the cable, and the crane should be inspected before further use.

Pace acknowledged that there was no hot metal spilled during the incident. The Grievant waited about a half hour and delivered the ladle to the furnace and charged the furnace without further incident. However, Pace testified that standard operating procedures required the Grievant to report the incident and have the crane inspected before making another lift. The Grievant never reported the incident.

Pace discussed the Company's standard operating procedures for lifting and why they are important. He stated that the blind side hook check is very important and must be considered every time the Operator makes a lift of hot metal. Pace testified that spilling hot metal could endanger the lives and safety of the Hot Metal Operators working near where the Grievant dropped the ladle. Operators working near the area where the furnace is charged could have been endangered as well, if hot metal were spilled because the crane were not operating properly.

The Company's "job safety analysis" lists bales (hooks) not positioned properly as a hazard for dumping a ladle. Required procedures to avoid the hazard include ensuring that all bales are engaged and secure before lifting a ladle and obtaining a blind side bale check before lifting the ladle. The standard operating procedures also require blind side ladle checks and

provide detailed procedures for conducting the checks. In addition, another standard operating procedure entitled "Crane Emergencies" lists "Load suspended on J-Hook point or by one J-Hook" and "Dropped load" and "Equipment damage" as emergencies in which the Crane Operator must stop all crane movement, call for help, and permit supervision and maintenance to determine an action plan.

Pace also presented evidence of the Grievant's suspension for five days in early 2016 for a safety-related incident occurring on December 7, 2015. In that case, a 60-ton block of the auxiliary hoist hit a pedestrian walkway bridge, from a crane the Grievant was operating while transporting hot metal to the furnace, knocking over several thousand pounds of equipment. Once the Grievant struck the walkway he did not immediately stop and notify a supervisor, but instead attempted immediately to lift the auxiliary hoist again. The cables were twisted, and the crane would not operate properly to make the lift.

Pace testified that after the December 2015 incident, Management decided to retrain the Grievant before allowing him to continue as a Crane Operator. The training was conducted over an entire week. The Manager testified that this was a very unusual step, the first time he has ever seen the Company take this action.

Under questioning from the Union, Pace acknowledged that the crane was not damaged in the incident which led to the Grievant's termination. No one was injured. Since this incident, more camera angles are now visible in the Crane Operator cabs, including angles showing the blind side of the ladle. Pace denied that it was unsafe for the Hot Metal Operator to check that the J-hook was engaged, because the Operator may then walk away from the area when the lift is made.

Pace testified further that it was unusual for a ladle to be dropped, and he could only remember one other ladle drop in his five years as Manager. He testified that the hot metal car was taken out of service after this incident, because the sides of it were bowed out. At first the Company thought their employees would make the repairs, according to Pace, but later Management decided to have the repairs done by an outside contractor. Although the car was put into service in 1969, and had nicks and dents in it, it was not taken out of service until this incident.

Mr. Dan Britton, Shift Manager, has worked for the Company for 46 years, and is the architect of the Company's crane training program. He testified that employees are trained by bargaining unit Crane Operators who are selected by Britton, with the assent of the Union. He testified that the retraining provided to the Grievant in January 2016 was the first instance of such training in his 46-year tenure with the Company. He conducted one-on-one book training with the Grievant and created a special document for the Grievant and himself to sign off on each of about ten major areas of training.

Britton pointed out sections of the Crane Operator Training Manual, which he developed with the assistance of bargaining unit Crane Operators, which are relevant to this case. He pointed to information about blind side ladle checks, and reporting all "incidents," including "unplanned movement" of the crane. Britton testified that he had worked as a Crane Operator and that a dropped load would "shake the _____ out of you." He said he had a load fall an inch or two once and said, "it scared the heck out of me." Britton testified that Crane Operators are trained to report such incidents. Britton stated further that he had seen loads picked up on the point of a J-hook in the past, but he had never seen a hot metal car damaged as badly as this one, which was out for repairs for more than a month.

Mr. Tim Halls, Division Manager, # 3 Steel Producing, testified that he was familiar with the effects of this incident on the production capacity of the Department. He said that the Department normally has two hot metal pits, and two hot metal cars. With one hot metal car out of service, due to the Grievant's accident, one hot metal pit could not be used, and the production ability of the shop was reduced by 50%. He testified that the hot metal station was out of use for about two months, resulting in a loss of production amounting to $47 million. Although the Third Step Minutes listed the estimated cost of repairs at $150,000, the actual cost of repairs to the transfer car ran just over $500,000, he said.

Under questioning from the Union, Halls acknowledged that the No. 2 Caster was down during part of this period as well, which would have slowed production. Halls testified that he took this factor into account in his estimate of the lost production. He said that he counted only the lost heats from the date of November 23, 2017, when the No. 2 Caster rebuild was completed. The Union objected to this information regarding estimated losses, because it was not presented in the Third Step. The Company countered that the information was not available at the Third Step.

The Grievant testified that he has worked for the Company since 1997 and has spent all but two years working as a Crane Operator. He testified that on the day in question, he brought the ladle back into the hot metal station to be topped off. According to the Grievant, when the ladle was run back out on the transfer car, he began to "snug up" the ladle. He testified that there was no slack in the cables. However, he said he felt that something was not right with the lift. Just as he felt that something was not right, he said that Hot Metal Operator Cal Garcia, who was watching the camera inside the pulpit, said, "You don't have it Mike." The Grievant said that the Hot Metal Operator watches from inside the pulpit, and then comes out to give the Crane

Operator a visual reading. He stated further that the Hot Metal Operators are not outside the pulpit when the ladle is hooked up, for safety's sake. The Grievant testified that as he lowered the hooks, the ladle slipped off one of the J-hooks. He stated that the crane was operating correctly, and that the transfer car was not moving when he picked up the ladle.

The Grievant testified that there was no damage to the crane. He said that he does not know why the J-hook did not attach correctly. According to the Grievant, he could not see the west side of the ladle, and "you just go by feel." The Grievant said that after the drop of the ladle, he reattached the J-hooks to the ladle, and Garcia came out and told the Grievant that he had the proper attachment. The Grievant lifted the ladle and then waited about 30-45 minutes to move the ladle, because they were not ready for the ladle at the furnace. He then moved the full ladle to the furnace, charged the furnace and returned with the empty ladle.

The Grievant testified that after the ladle dropped, he did not know that the J-hook had dropped off the ladle; he thought that it had caught on the transfer car. He also testified that he did not know that the transfer car had been damaged. He testified that other Crane Operators had dropped ladles on that car, that there was "wear and tear" on the transfer car over the years, and that this was just the incident that "broke the camel's back." In response to the Company's argument that he should have known that this was a serious incident by the shaking of the crane, he testified that the crane always shakes when it is lifting a heavy load. In addition, he said that the whole building shakes whenever the crane passes by with a heavy load.

After the incident occurred, he said that he heard Garcia call Supervisor Archie Pounds over the radio and request a "test weight." He said that calling for a test weight means that something is wrong. The Grievant said that the call was made after he returned from charging the furnace. He did not know that the car was damaged, but thought that perhaps Garcia saw

something wrong with the car to cause him to call for the test weight. The Grievant did not inspect the crane to determine whether anything was wrong with it after the ladle dropped.

The Grant testified that during the incident in 2015, he was on his way to charging the heat, when his 60-ton hoist malfunctioned, and he could not keep the block from descending and striking the pedestrian walkway. He tried to remove the dropped crane equipment from the walkway and determined that the cables were not working correctly. He testified that he then put the heat on the ground and called Management. He filed a grievance over his discipline for this incident and proceeded to the second step of the grievance procedure but did not pursue it further. He said that he dropped the grievance in part because he had sent a letter to the Company complaining about a schedule change, and thought Management was upset with him about that.

Mr. Arnulfo Torres, Crane Operator, said that he hired in in 1974 and became a Hot Crane Operator in 1980. He testified that he was working on the west charging crane on the night in question. He said that Crane Operators fear operating the east crane the Grievant was operating, because that Operator is always carrying hot metal. The most experienced Operators are assigned to the east crane. Although Torres testified that he has never dropped a ladle, he knew of two other Operators who had dropped ladles after the incident at issue here. He did not know if any damage was done in those incidents. He testified further that the cars have been damaged from the test weights. Torres testified that he heard Garcia call for a test weight that night. Under questioning from the Company, he said that if a ladle is dropped, the crane shakes more than if it is not dropped, and the Crane Operator is supposed to slowly lower the ladle, controlling the speed.

Mr. Bill Garbacz, Hot Metal Operator, has worked for the Company for eight years and was working on the night of the incident. He testified that he heard Garcia call Pounds, calling

for the test weight. He did not know whether Pounds responded. He testified that he did not see anything obviously wrong with the transfer car that night, although he did not inspect it.

Mr. Jamie Quiroz testified that he was the Grievant's Griever at the time of the incident at issue here. He testified that his investigation showed that Garcia called for the test weight after the incident in question, although Garcia did not tell him exactly what he observed that led him to make the call. Quiroz testified that as a Mechanic he had worked on that transfer car many times. He testified that there was major structural damage on the car after this incident, but that there had been earlier damage to the car as well; he reiterated that this incident was the "straw that broke the camel's back." He testified that on other occasions ladles had been dropped on the car.

On rebuttal, Pace testified that after this incident occurred, the ladle could not be placed back in the hole on the hot metal car and had to be moved to the hole next to it.
He testified further that at the time of the incident, test weights were used to calibrate scales on the hot metal hole frequently; the goal was to test them at least weekly. An Operator also may request a test weight, he said, which is done daily. Requesting a test weight does not indicate that a car or crane is damaged, according to Pace. Normally, Operators call for a test weight when the tracking equipment on the cell loads on the transfer cars appears to be registering an inaccuracy, such as a screen registering all 0's, or weights appearing to be 5,000 pounds off.

The Company's Position

- The evidence shows that the Grievant dropped the ladle from the point of the J-hook about 15 to 18 inches into the saddle of the J-hook, damaging the transfer car.
- The Grievant's action resulted in $500,000 in repairs to the transfer car, as well as $47 million in lost production. More importantly, the Grievant's actions raised incredibly important safety concerns.

- The Company has several procedures in place to prevent accidents of this type, which the Grievant ignored.

- Throughout the grievance and arbitration procedure, the Grievant has not taken responsibility for his actions.

- The Grievant failed to follow the job analysis requirements for lifting hot metal ladles and the standard operating procedure for blind side hook engagement.

- If a hot metal ladle is dropped and spills, there can be catastrophic consequences, including potentially fatal injuries for nearby employees.

- The Grievant was retrained one-on-one in all Crane Operator policies and procedures in early 2016 after an incident. His attitude towards his retraining demonstrates that he did not take his safety responsibilities seriously.

- The evidence shows that the Grievant knew the policies and procedures but did not follow them. The load dropped as he was lowering it, demonstrating that he had lifted it without receiving the proper signal.

- The dropped ladle crushed a portion of the transfer car. The Grievant did not stop the crane or report the incident to Management.

- The possible consequences of a crane failure while the crane is carrying a load of hot metal include fires, explosions and possible severe or fatal injuries.

- Calling for the test weight is a red herring, since the test weight is used almost daily to calibrate the scales, and does not signal to Management that there has been damage to the transfer car or the crane.

- A full ladle weighs 400 tons, and the Grievant definitely would have been able to feel the vibrations from the ladle drop, especially since he testified that he operates in part "by feel."

- Both Company and Union witnesses provided testimony that if the ladle fell as it did here, the Operator would definitely feel the vibrations in his cab.

- Other arbitration awards in the steel industry demonstrate that termination has been upheld for employees who fail to follow safety procedures, including failing to report safety incidents. This case is even more serious, because it involves a very experienced Crane Operator who had been trained and retrained.

- The arbitration awards introduced by the Union are not relevant.

- The Company cannot allow the Grievant to continue to disregard important safety procedures and risk him continuing to cause substantial damage to Company equipment, loss of production, and significant safety dangers to other employees.

- The Company requests that the grievance be denied.

The Union's Position

- The Grievant testified that he was not aware that he was not hooked up properly to perform the lift. He was "snugging up," at the time of the accident.

- He saw that the lift was not right, and he thought he was hooked on the transfer car. When he lowered the lift, he did not realize that he was on the point of the J-hook and the load slipped.

- The Company discharged the Grievant in part for not reporting the incident immediately. However, the Grievant did not know that there was an accident to report.

- The Grievant provided testimony that the crane usually shakes when a load is being lifted, and that he did not know that the transfer car had been damaged.

- Hot Metal Operator Garcia did report the incident to Archie Pounds, as several Union witnesses testified. Pounds ignored the call for a test weight. Pounds was not present to testify at arbitration, and therefore the Union's evidence must be credited.

- The Company estimated the repairs in the Third Step Minutes at $150,000. The Company has not presented a final bill showing that the repairs cost more than that.

- The Company's cost estimates regarding lost production were not raised earlier in the grievance procedure. The No. 2 Caster was down during this period, and that limited the amount of production, showing that the Company's figures for lost production are too high.

- The Grievant is not responsible for all of the damage to the transfer car.

- The Union is concerned about safety. However, the east side crane is more difficult to operate than other cranes and this was a freak accident. The Grievant was not careless or negligent and was not responsible for the accident that happened.

- Other employees have dropped loads and caused damage to transfer cars and have not been terminated or even disciplined. This was a very old transfer car that had been damaged by other employees, and even by the use of the test weight.

- Much of the Company's argument involves the earlier incident in 2015, not the incident at issue here. The Union questions why only the Grievant was retrained, when other employees also have dropped loads or damaged transfer cars.

- In other arbitrations in the steel industry, arbitrators have concluded that termination is not appropriate when an accident cannot be clearly attributed to the Grievant's carelessness alone.

- The grievance should be sustained and the Grievant reinstated with backpay.

Findings and Decision

In this grievance, the Union challenges the termination of the Grievant for violating safety standards and procedures. The Grievant is a long-term employee, who has been employed as a Crane Operator for 18 of his 20 years with the Company. According to the Company, the Grievant's conduct on October 17, 2016 resulted in significant damage to Company property, a major loss of production, and a dangerous risk to the safety of the Grievant and other employees. The Union argues that the Grievant did not act negligently or carelessly, did not knowingly violate reporting requirements, and is not responsible for the extent of the damage or loss of production claimed by the Company.

There is little dispute between the parties about the major facts of the incident which gave rise to the Grievant's termination. The Grievant was operating the east charging crane in #3 Steel Producing on the date in question. His assignment was to use the two large J-hooks on the crane to lift a ladle of hot metal from the hot metal transfer car and move it to the furnace. As the Grievant was performing the lift, the ladle dropped onto the metal transfer car, damaging the car. Further investigation, including viewing the video recording of the incident, establishes that the west J-hook did not properly engage with the trunnion pin on the ladle. Instead of the curved saddle of the J-hook wrapping around the trunnion pin, the ladle was lifted with its west trunnion pin balanced on the point of the J-hook. The ladle fell 15 to 18 inches into the saddle of the J-

hook, crashing into the transfer car below. Although the video shows a sudden splashing in the ladle when it fell, there was no spillage of hot metal.

There is also no dispute between the parties that the J-hook which did not engage properly with the ladle's trunnion pin was on the "blind side" of the lift, that is, on the side of the ladle which the Crane Operator cannot see from the crane cab. Company procedures require that whenever a Crane Operator lifts a ladle, the Crane Operator must verify that the J-hook on the blind side of the lift is fully engaged on the trunnion pin. Both the standard operating procedures and the Crane Operator Training Student Manual for #3 Steel Producing describe the procedure to be followed for a blind side check in detail, as follows,

- The crane operator will contact an operator in the area to request a ladle check.
- The contacted employee will move to a position where the blind side trunnion is visible and give a hand signal to the crane operator that the ladle is OK to pick up if the J-hook is fully engaged. LADLE CHECKS IN THESE AREAS ARE NOT TO BE GIVEN BY RADIO OR PA.
- If at any time the J-hook observed (sic) to be NOT fully engaged give the hand signal for emergency stop.
- Repeat if necessary.

The Grievant testified that he was in the process of "snugging up" the ladle at the time the ladle fell. He stated that as he began to raise the ladle he felt that there was something wrong with the lift, and at the same time, Hot Metal Operator Garcia told him from the pulpit that he "didn't have it." The Grievant testified that as he began lowering the ladle back down, it fell.

There is no evidence in the record that there was any reason why Operator Garcia could not have observed that the J-hook was not seated properly on the trunnion pin before the Grievant began lifting. The Union suggests that it was not safe for Operator Garcia to leave the pulpit and check on the position of the J-hook, because it was dangerous for him to be located in that position so near to the full ladle when it is lifted. However, the procedure does not require him to stay in the area while the lift is made; it requires only that he check the position of the

blind side and give the Crane Operator a hand signal "to indicate that the ladle is OK to pick up if the J-hook is fully engaged." He may then return to the pulpit for safety. The procedures clarify that this check is not to be done by radio or p.a., emphasizing the importance of the Operator viewing the J-hook outside the pulpit, and giving the Crane Operator a hand signal to proceed. Bargaining unit Crane Operators were consulted on the Training Manual, and if this procedure is not safe, it is not clear why the Union would have agreed to it.

The procedures require that that the blind side check must be done before any lifting of the ladle occurs. The procedures do not mention the "snugging up" process as an exception to the requirement for a blind side check. The Grievant's testimony that the ladle fell as he lowered it provides convincing evidence that he already had begun lifting it. In addition, the hard fall of the 400-ton ladle fell into the saddle of the J-hook and then onto the transfer car, causing substantial damage to the car, is evidence that the ladle's weight was already balanced on the point of the J-hook, having been lifted off the transfer car. As this accident demonstrates, failing to check that the J-hooks are properly seated before conducting any lifting of the ladle can result in a serious accident.

This accident also makes clear why a Crane Operator cannot safely rely simply on the "feel" of a lift, in lieu of completing the visual check on the blind side as required by the Company's procedures. With his long experience as a Crane Operator, the Grievant felt that something was wrong with this lift. However, by the time he felt that something was wrong, the conditions causing the load to drop were already in play. If the blind side check had been made before he began lifting, it is likely that the problem with the J-hook's placement would have been discovered—before the Grievant felt it—and the dropped ladle been avoided.[1] The standard

[1] After the fall, the Grievant said he did not know what had caused it: he did not know that the trunnion pin was balanced on the tip of the J-hook, believing instead that the J-hook had caught on the transfer car.

operating procedures specifically identify this problem, a trunnion pin located on the point of the J-hook, as the primary reason for conducting a blind side check. If the ladle had somehow dropped after the Grievant had properly conducted the blind side check, the Union would have a stronger argument that the accident was not caused because he was negligent or careless in following the safety procedures. However, convincing evidence in this record demonstrates that the Grievant did not complete the crucial safety procedure of the blind side ladle check before he began the lift.

The Company also cited the Grievant for failing to comply with procedures which require Crane Operators to report all such incidents. The Company's standard operating procedures for crane emergencies specifically list a "dropped load" as an emergency which requires the Crane Operator to "stop all crane movement and call for help." The Grievant testified at arbitration that the ladle dropped as he lowered it, but the Union suggests that he did not realize at the time that he needed to report the incident. He testified that he did not know that the transfer car had been damaged. The Union presented evidence that the building ordinarily shakes when the crane passes by carrying a full load; that the crane shakes when it is lifting a load; and that the Crane Operator cab is located 80-100 feet above the lift. A 400-ton weight free-falling 15-18 inches and striking anything is likely to make a very loud sound, and to cause significant vibrations in the area of the collision. The video demonstrates that the force of the ladle drop onto the transfer car shook the structure of the building, triggering a huge shudder, and even shaking the opposite wall, on which the camera was mounted. The evidence from several Witnesses supports the view that the shaking from a drop of this kind would be greater than the normal shaking of the crane, and the Crane Operator would feel it through the structures of the crane. The Arbitrator concludes that the Grievant should have been able to feel the load drop in the cab, and see the

results of it around him, if there is any question regarding whether he knew that there had been a major load drop.

In addition, the evidence establishes that the Grievant knew that there had been an uneven lift by the J-hooks, which are supposed to operate together. He said he thought the west J-hook had gotten caught on the transfer car, which means he knew that the J-hooks were not lifting evenly. An uneven lift may cause slack in the cables, which may result in the cables twisting around each other or falling off the drum. There also was evidence that the bar on top of one hook fell over, indicating uneven pressure on the hooks and slack in the cables. The Grievant should have reported the incident immediately after the load dropped, as required by standard operating procedures, so that the crane could be inspected. Twisted or otherwise ineffective cables may cause a loaded ladle to tilt and spill during a lift. Here the Grievant took that risk when he completed the move of the hot metal to the furnace after the load drop, before the crane was inspected. Once the incident was discovered, the crane was taken out of operation for 20 hours for inspection.

The Union argues that the incident was effectively reported, when the Hot Metal Operator called for the test weight. However, calling for the test weight here did not communicate to Management that a crane emergency had occurred; that a load had been dropped, or that the transfer car had been struck. Calling for the test weight may mean only that the Operator is concerned about whether the scales are properly calibrated. Furthermore, the call for the test weight in this case was not made immediately after the drop, so that the crane could be inspected before any other lifts were made. Here the call was not made until after the Grievant had moved the loaded ladle to the furnace and returned to the hot metal station.

had incurred, and thus the evidence shows that it was this accident which took the car out of commission. It is also clear that the hot metal station could not be used until the transfer car was repaired and returned to service, which took several months. The No. 2 Caster was not down for the entire period of time it took to repair the transfer car, according to the undisputed evidence. Therefore, even if it is difficult to conclude exactly how much money the Company lost through this accident, the evidence establishes that there was a substantial repair cost for the transfer car, and a major reduction in the capacity for production in this Department lasting at least several weeks, resulting in very substantial costs to the Company as a result of this accident.

In determining that discharge was the proper penalty, the Company also took into account that the Grievant had another accident less than a year before the October 2016 incident, resulting in a five-day suspension. That discipline was grieved but did not proceed past the second step of the grievance procedure, and therefore remains on the Grievant's record. At that point in time, the Company took the unusual step of retraining the Grievant, requiring him to undergo an entire week-long refresher training course regarding proper crane operation. Company Witnesses testified that they could not recall the Company requiring such retraining of any other Crane Operator.

The Union argues that the Company has not discharged or even disciplined employees for every load drop, suggesting that the Grievant has been treated more harshly than other employees. However, the record does not include details of any other load drop. Therefore, there is no evidence regarding the severity of other load drops, or the disciplinary records of other employees who may have been involved in them, or whether Management was aware of them. Lacking such evidence, the Arbitrator cannot conclude that the Grievant has been treated more harshly than other employees. In this case the Grievant, a very experienced Crane Operator, was

involved in two serious accidents within a single year. In each case he failed to immediately stop his crane and report the incident. Although the Union suggests that the Company retraining him after the first incident demonstrates disparate treatment of the Grievant compared to other employees, the retraining itself is not punitive. Instead, it provided a long-term employee with the opportunity to refresh his knowledge of every important procedure associated with crane operation, rather than the Company imposing more serious discipline or discharge. Nevertheless, the Grievant had another incident ten months later, in which he failed to follow the procedure for a blind side ladle check, which is a fundamental safety procedure for a ladle lift. As Witness Britton testified, a fully-loaded ladle falling only a few inches is a frightening experience. Here, the Grievant dropped a ladle fully loaded with hot metal 15 to 18 inches, crashing onto a transfer car which then had to be taken out of service for two months for repairs. Similar to the incident 10 months earlier, he failed to report the incident immediately to ensure that his crane was inspected before it was operated any further.

The Awards cited by the Union do not involve situations similar to this case. In US Steel Case Nos. USS-46,840; 46,841; 46,842(2011), the Board concluded that the grievant had not engaged in carelessness or violations of safety rules. The evidence in the case before this Arbitrator demonstrates that the Grievant was careless and did not follow safety procedures. In US Steel Case No. USS - 45,280 (2007), the Board concluded that discharge was too severe for an employee who failed to spot check the level of iron in a ladle while it was being filled, because the employee was not directly responsible for the task of spot checking the ladle, and he had a clean disciplinary record. Here the Grievant had the responsibility to ensure that the blind side ladle check was made before he lifted the ladle, and he already had significant discipline for another safety violation. In US Steel, Case No. USS - 43,074 (2003), the Board concluded that

discharge was too severe for an employee who hit a catwalk while loading a truck, when the damage involved only scratches and repair costs of $800; and the grievant was beginning his twelfth hour of work and had asked to be removed from the job because he did not have current experience on it. In this case the Grievant had very long experience on the job, and expressed no discomfort over his assignment that day. This case is more like BHP Petroleum/GASCO Inc. v. Hawaii Teamsters & Allied Workers, 102 LA 321 (Najita, Arb. 1994), cited by the Company, where termination was upheld for an employee with ten years of service who failed to perform a crucial test and thus failed to find a gas leak. Here the Grievant failed to conduct a crucial procedure before proceeding with the lift, and there were costly consequences resulting from his conduct.

The Company employed progressive discipline with the Grievant in this case. However, it does not appear that the Grievant accepted the correction from his five-day suspension and retraining and recommitted himself to conscientiously following proper crane operating procedures. He has not offered a good reason for not conducting the blind side check which may well have prevented the accident here. The Grievant continued to use his crane without proper inspection after it had been involved in a serious incident. Nor has he accepted full responsibility for his failure to follow proper safety procedures in regard to this incident, so as to demonstrate a willingness to diligently follow safety procedures in the future. The most recent accident resulted in very large costs for repairs to Company equipment and lost production, and a risk of potential serious injury to co-workers. The termination of an employee with the Grievant's tenure is very unfortunate. However, the evidence establishes that the Company has provided consideration for the Grievant's long service, and that there is just cause for discharge.

AWARD

The grievance is denied. There was just cause for the termination.

Jeanne M. Vonhof
Labor Arbitrator

Decided this 18th day of July 2018.