



**OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION**  
1120 20<sup>th</sup> Street, N.W., Ninth Floor  
Washington, DC 20036-3457

**SECRETARY OF LABOR,**

**Complainant,**

**v.**

**UNIFIRST CORPORATION,**

**Respondent.**

**OSHRC DOCKET NO. 12-1304**

Appearances:

Andrew Katz, Attorney  
Margaret A. Temple, Attorney  
U.S. Department of Labor, Office of the Solicitor, New York, New York  
For the Complainant.

Bradford J. Smith, Attorney  
Sarah J. Solomon, Attorney  
Goodwin Procter, LLP, Boston, Massachusetts  
For the Respondent.

Before: Carol A. Baumerich  
Administrative Law Judge

### **DECISION AND ORDER**

#### **Introduction**

This proceeding is before the Occupational Safety and Health Review Commission (Commission) pursuant to section 10(c) of the Occupational Safety and Health Act of 1970, 29 U.S.C. § 651 *et seq.* (Act). As a result of a complaint filed with the Occupational Safety and Health Administration (OSHA), Compliance Safety and Health Officer Marc Vargas (CSHO), with assistance with CSHO James Klyza, began an inspection of UniFirst Corporation's

(Respondent’s) facility in West Caldwell, New Jersey<sup>1</sup>. The inspection involved four on-site visits to the facility, on November 3, 8, and 22 and December 8, 2011. CSHO Klyza accompanied CSHO Vargas on November 22, and December 8, 2011. (Tr. 586). The investigation took approximately six months to complete. (Tr. 156).

On April 30, 2012, OSHA issued a four-item serious citation and a three-item willful citation, to UniFirst, proposing penalties totaling \$186,000.00. Citation 1, item 1 alleges that UniFirst committed a serious violation of 29 C.F.R. § 1910.36(d)(1) because an emergency exit door was not unlocked. Citation 1, item 2 alleges that UniFirst committed a serious violation of 29 C.F.R. § 1910.157(g)(1) because route sales representatives (drivers or “RSRs”) and warehouse dockworkers had not been trained in the general principals of fire extinguisher use and the hazards involved with incipient fire-fighting. Citation 1, item 3(a) alleges that UniFirst committed a serious violation of 29 C.F.R. § 1910.1025(h)(1) by failing to maintain all surfaces as free as practicable of lead accumulations, including in a truck and in the area of the laundry sort 65/35 bins. Citation 1, item 3(b) alleges that UniFirst committed a serious violation of 29 C.F.R. § 1910.1025(l)(1)(i) by failing to provide training on the health hazards of lead to route drivers and dockworkers who worked in areas where there was potential exposure to airborne lead. Citation 1, item 4 alleges that UniFirst committed a serious violation of 29 C.F.R. § 1910.1030(d)(3)(ix) by failing to provide dockworkers with personal protective equipment, including gloves, when it was reasonably anticipated that they might have hand contact with loose soiled medical laundry that was potentially contaminated with human blood.

Citation 2, item 1 alleges that UniFirst committed a willful-serious<sup>2</sup> violation of 29 C.F.R. § 1910.1030(d)(2)(i), by failing to use engineering and/or work practice controls to eliminate or minimize the drivers’ and dockworkers’ occupational exposure to medical laundry that was potentially blood contaminated and had the potential to harbor blood contaminated syringes such as sharps. Citation 2, item 2 alleges that UniFirst committed a willful-serious violation of 29 C.F.R. § 1910.1030(f)(2)(i), by failing to make hepatitis B vaccinations available to drivers and warehouse dockworkers who came into contact with medical laundry that was potentially blood contaminated, with the potential to harbor sharps. Citation 2, item 3(a) alleges

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<sup>1</sup> There is no dispute that Respondent’s inspected worksite is located at 190 Fairfield Avenue, West Caldwell, New Jersey. Complaint para. IV. The citations set forth the town name as Fairfield, New Jersey where the inspected worksite is located. This is an apparent inadvertent error.

<sup>2</sup> Complaint paras. VI and VII describe the violations alleged in citation two as serious and willful.

that UniFirst committed a willful-serious violation of 29 C.F.R. § 1910.1030(g)(2)(ii)(A), by failing to ensure that initial training was provided to drivers and warehouse dockworkers who Respondent determined had occupational exposure to bloodborne pathogens. Citation 2, item 3(b) alleges that UniFirst committed a willful-serious violation of 29 C.F.R. § 1910.1030(g)(2)(iv), by failing to provide annual training, within one year of their previous training, to drivers who Respondent determined had occupational exposure to bloodborne pathogens.

UniFirst timely contested the citations and proposed penalties. The undersigned held a hearing in this matter on May 22, 23, and 24, July 31, and August 1, 2013, in Newark, New Jersey. The parties stipulated that at all relevant times, Respondent was engaged in a business affecting commerce within the meaning of sections 3(3) and 3(5) of the Act, and was an employer within the meaning of section 3(5) of the Act. (Tr. 15; Ex. J-1). Both parties filed post-hearing briefs.<sup>3</sup>

For the reasons discussed below, the citations are affirmed and a total combined penalty of \$186,000.00 is assessed.

## **Background**

UniFirst Corporation (UniFirst or Respondent) is an international company engaged in uniform and laundry services. (Tr. 765-66; Ex. J-1). It operates approximately 200 facilities, has more than 10,000 employees and services more than 300,000 customers. (Tr. 766, 769). At all relevant times, Respondent maintained a worksite located at 190 Fairfield Avenue, West Caldwell, New Jersey 07006.

Customers are serviced by Route Sales Representatives (“RSRs”) and Route Service Supervisors (“RSSs”)(collectively referred to as “drivers”) who pick up and sort dirty laundry and deliver clean laundry to Respondent’s customers. (Tr. 772, 1036, 1065-67). Each RSR runs a dedicated route. RSSs serve as full-time, fill-in drivers for the RSRs. (Tr. 35, 39, 373, 380). Unlike the RSRs, the RSSs do not receive a commission. (Tr. 38, 377, 422). Dockworkers at West Caldwell are responsible for loading, unloading, and sorting laundry. (Tr. 41, 691-92, 1175).

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<sup>3</sup> Joint exhibits will be designated as Ex. J followed by the exhibit number. Similarly, the Secretary’s exhibits will be designated as Ex. S-# and Respondent’s exhibits will be designated as Ex. R-#.

Eleven service routes are operated out of the West Caldwell facility. (Tr. 771, Exs. S-42 & 43). At the time of the OSHA inspection, there were 13 RSR and RSS drivers and three dockworkers. (Tr. 161). Dirty laundry was washed at Respondent’s facility in Croydon, Pennsylvania. (Tr. 767).

Richard Powell is the general manager at Croydon and oversees the West Caldwell Branch and a branch in Allentown, Pennsylvania. He is responsible for training at those locations. (Tr. 768). He visits West Caldwell every other week. (Tr. 772). Powell’s office manager / administrator at Croydon is MaryAnne Troutman. (Tr. 883, 1191-92).

The branch manager at West Caldwell is Ryan Barry who reports directly to general manager Powell. (Tr. 768, 1157, 1179). Barry’s responsibilities include overseeing all operations, sales and office functions. (Tr. 1162). Kevin Wampler and Tony Correa are district managers, also known as district service managers or DSMs, who report directly to branch manager Barry and supervise the drivers. (Tr. 40, 378-80, 1036, 1059). Wampler was hired on January 28, 2011 and Correa was hired on May 2, 2011. (Exs. S-42 & 43). [redacted] was the district service supervisor who oversaw the dockworkers. (Tr. 1194-95). He worked for Respondent from April 2010 to March 2011 and from August 2011 through March-April 2012. (Tr. 82; Ex. S-42).

### **Stipulations**

The parties stipulated that:

a. Jurisdiction of this action is conferred upon the Occupational Safety and Health Review Commission by section 10(c) of the Occupational Safety and Health Act of 1970 (29 U.S.C. 659, et seq.).

b. At all relevant times, Respondent was engaged in a business affecting commerce within the meaning of sections 3(3) and 3(5) of the Act, and was an employer within the meaning of section 3(5) of the Act.

c. At all relevant times, Respondent was engaged in uniform and laundry services and its related activities at a worksite located at 190 Fairfield Avenue, West Caldwell, New Jersey 07006.

d. As a result of a complaint by Respondent’s employee, OSHA initiated an inspection on or about November 3, 2011.

e. On or about April 30, 2012, OSHA issued two citations containing nine items to Respondent with a total proposed penalty of \$186,000.00.

f. On May 18, 2012, Respondent contested the citations at issue herein and the penalties proposed therefore, pursuant to the provisions of section 10(c) of the Act. (Ex. J-1)

### **The Secretary’s Burden of Proof**

The Secretary has the burden of establishing that Respondent violated the cited standards. To prove a violation of an OSHA standard, the Secretary must show by a preponderance of the evidence that (1) the cited standard applies; (2) the employer failed to comply with the terms of the cited standard; (3) the employees had access to the violative conditions; and (4) the employer either knew or could have known of the violation with the exercise of reasonable diligence. *See Atlantic Battery*, 16 BNA OSHC 2131, 2137 (No. 90-1747, 1994); *Astra Pharm. Prod., Inc.*, 9 BNA OSHC 2126, 2130-31 (No. 78-6247, 1981) *aff’d in relevant part*, 681 F.2d 69 (1<sup>st</sup> Cir. 1982).

### **Citation 1 – Item 1: Alleged Serious Violation of 29 CFR § 1910.36(d)(1)**

Citation 1, item 1 alleges that, on or about November 22, 2011, at Respondent’s West Caldwell worksite an emergency exit door connecting the warehouse loading dock to a northwest exterior sidewalk leading to Fairfield Avenue was locked.

Section 29 CFR § 1910.36(d)(1) provides:

Employees must be able to open an exit route door from the inside at all times without keys, tools, or special knowledge. A device such as a panic bar that locks only from the outside is permitted on exit discharge doors.

#### *Applicability of the Cited Standard.*

The undisputed evidence establishes that Respondent had a door at its facility clearly marked “EXIT.” Therefore, it was obligated under the standard to ensure that the door was unlocked and readily available for employee egress. The standard applies.

#### *Compliance with the Terms of the Cited Standard.*

During his November 2, 2011 inspection, CSHO Vargas noticed a locked glass door labeled “EXIT” leading towards Fairfield Avenue. (Tr. 159; Ex. S-1). He asked branch manager Barry and district service manager Wampler how long it had been locked. Barry replied that “it could have been six months, because there was a locksmith here that changed the locks.” (Tr. 159). The CSHO asked to have the door unlocked, but Barry did not have the key. (Tr. 160). RSS driver [redacted] testified that he tried to use the door, but it was locked. (Tr. 44). He also testified that the door was blocked with drivers’ uniforms and “a lot of unknown stuff.” (Tr. 44-45). Similarly, RSS driver [redacted] testified that there were always “old messy files, old like delivery receipts piled up in front” of the door. (Tr. 381). Both [redacted] and [redacted] testified that they never saw anyone using the door. (Tr. 46-47, 381).

The evidence establishes that the EXIT door at Respondent’s West Caldwell facility was locked in violation of the standard. There is no evidence that there was a panic bar or other device that would allow employees to exit through the door. Even though the standard requires that the door be opened without the use of a key or other special device, I note that no key was available. This exacerbated the violation, since without a key there was no way to open the door in case of an emergency.

*Employee Exposure.*

The evidence establishes that both drivers and dockworkers worked at the warehouse, including three dockworkers, thirteen drivers and their supervisor, [redacted]. (Tr. 161). Due to the failure to keep the EXIT door unlocked, each of these employees was exposed to the hazard of being trapped inside the facility in the event of a fire or other emergency (Tr. 161).

*Employer Knowledge*

The final element the Secretary must prove to establish a violation is that Respondent knew, or with the exercise of reasonable diligence should have known of the violative condition. The Secretary met this burden. Ryan Barry testified that the locks on the door were changed approximately six months before the inspection, but that he did not have a key. Therefore, Barry had actual knowledge that the door was locked in violation of the standard. Furthermore, the evidence demonstrates that, in plain view, the door was blocked by files and other materials. Barry was the West Caldwell branch manager.

Commission precedent imputes a supervisor’s conduct to the employer unless the employer demonstrates, as an affirmative defense, that the supervisor’s violative actions were the result of unforeseeable and idiosyncratic behavior. *Jersey Steel Erectors*, 16 BNA OSHC 1162, 1164 (No. 90-1307, 1993), *aff’d* 19 F.3d 643 (3rd Cir. 1994). However, the Commission generally applies precedent of the circuit to which the case will likely be appealed “even though it may differ from the Commission’s precedent.” See *Kerns Bros. Tree Serv.*, 18 BNA OSHC 2064, 2067 (No. 96-1719, 2000). This case arose in the Third Circuit which holds that, to impute the violative actions of a supervisor to the employer, the Secretary must present evidence that the supervisor’s actions were foreseeable; for example, where the Secretary demonstrates that the employer had improper training or lax safety standards. *Pennsylvania Power & Light Co. v. Occupational Safety & Health Review Comm’n*, 737 F.2d 350 (3d Cir. 1984).

Branch manager Barry never determined whether the door was unlocked. Yet, the door was installed six months earlier and he did not have a key. The door was obstructed by files and other material. Yet, he never inquired whether it was unlocked. Had Barry been reasonably diligent, he would have determined whether the door was unlocked.

Moreover, Barry reported directly to general manager Powell. (Tr. 768, 1179). As the branch manager Barry oversaw all operations, sales and office functions. (Tr. 1162). Powell testified that he visited West Caldwell every other week. (Tr. 772). Yet, even though the exit was in plain view, it remained blocked and locked. The Secretary has established that Respondent had lax or nonexistent safety rules related to the locked door and, therefore, that Respondent knew, or with the exercise of reasonable diligence, should have known of the violation.

#### *Characterization and Penalty*

Under section 17(k) of the Act, a violation is “serious” if there is “a substantial probability that death or serious physical harm could result from a condition which exists. . . .” 29 U.S.C. § 666(k). Complainant need not show that there is a substantial probability that an accident will occur; he need only show that if an accident did occur, serious physical harm could result. *Phelps Dodge Corp. v. OSHRC*, 725 F.2d 1237, 1240 (9th Cir. 1984).

The evidence establishes that in the event of a fire, a locked exit door would trap or delay employee exit and could result in injuries, such as smoke inhalation and burns, up to and

including death. (Tr. 161). As noted above, Barry did not even have a key to the door, aggravating an already seriously hazardous situation. The violation was serious.

The Secretary proposed a penalty of \$5,000.00 for this violation. Section 17(j) of the Act, 29 U.S.C. § 666(j), requires that in assessing penalties, the Commission give "due consideration" to four criteria: the size of the employer's business, the gravity of the violation, the employer's good faith, and its prior history of violations. *Specialists of the South, Inc.*, 14 BNA OSHC 1910 (No. 89-2241, 1990). These factors are not necessarily accorded equal weight; generally speaking, the gravity of a violation is the primary element in the penalty assessment. *J. A. Jones Construction Company*, 15 BNA OSHC 2201, 2214 (No. 87-2059, 1993).

The CSHO testified that the violation was of high severity because the result of an incident could be severe burns or death. However, the probability of an incident was considered “lesser.” (Tr. 162). Having more than 250 employees, Respondent was not given any penalty reduction for size. Also, UniFirst had serious violations at other locations during the past five years and, therefore, was not given any credit for safety history. (Tr. 162-164, Ex. S-30). Finally, because the inspection resulted in Respondent being cited for willful violations, no credit was given for good faith. (Tr. 163). I find that the Secretary gave proper consideration to the Section 17(j) factors and that the proposed penalty is appropriate.

**Citation 1 – Item 2: Alleged Serious Violation of 29 CFR § 1910.157(g)(1)**

Citation 1, item 2 alleges that, on or about November 3, 2011, at Respondent’s West Caldwell worksite, drivers and warehouse dockworkers, who were provided with fire extinguishers, were not trained in the general principles of fire extinguisher use and the hazards involved with incipient state fire-fighting.

Section 29 CFR § 1910.157(g)(1) provides:

Where the employer has provided portable fire extinguishers for employee use in the workplace, the employer shall also provide an educational program to familiarize employees with the general principles of fire extinguisher use and the hazards involved with incipient stage fire-fighting.

*Applicability of the Cited Standard*

The evidence establishes that the cited standard applied to Respondent. It maintained fire extinguishers at the site. Furthermore, its safety training video, facilitator reference guide on fire prevention, and safety manual demonstrate that the fire extinguishers were intended for employee use. (Exs. S-2; R-5 at 3, 4). The standard applies.

*Compliance with the Terms of the Cited Standard*

Respondent maintained approximately three fire extinguishers on the warehouse dock and other extinguishers on their trucks. (Tr. 50, 170, 382; Ex. S-2). CSHO Vargas testified that employees [redacted], [redacted], [redacted], [redacted], and [redacted] had not been trained to use the fire extinguishers. (Tr. 169-170, 177). This testimony was supported by statements taken by the CSHO from employees [redacted] and [redacted]. (Exs. S-36, p.3, lines 8-10; S-38, p.3, lines 1-4).

At the hearing, driver [redacted] testified that he was never trained on fire prevention or fire safety, was never given written materials on fire safety or fire prevention, and was never shown any videos on fire safety or fire prevention. (Tr. 51-52). He also testified that he was never trained on evacuation procedures in the event of a fire, and that, during his time at West Caldwell, there never were any fire drills. (Tr. 53-54).

Driver [redacted] testified that he was never trained on fire prevention, fire safety or how to use a fire extinguisher. (Tr. 383-84). [redacted] further testified that UniFirst never showed him a video on fire safety or prevention. He was not aware whether Respondent had a fire safety program.<sup>4</sup> (Tr. 384).

District service supervisor [redacted] told the CSHO that, several months before the inspection, he put out a fire at West Caldwell by pouring water over it rather than using a fire extinguisher. (Tr. 178, Ex. S-8, at 1).

The evidence establishes that Respondent maintained fire extinguishers at West Caldwell for employee use in the event of a fire. Respondent failed to provide an educational program to familiarize employees with the general principles of fire extinguisher use and the hazards involved with incipient stage fire-fighting as required by the standard.

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<sup>4</sup> [redacted] was a very credible witness. I observed his demeanor as he testified. His testimony revealed a good recollection of the facts, was candid, unhesitant, and without exaggeration. [redacted]'s testimony regarding all citations is credited.

*Employee Exposure*

The evidence establishes that seventeen employees, including both drivers and dockworkers were exposed to the hazard of not being trained in the proper use of a fire extinguisher to fight incipient fires. As noted above, district service supervisor [redacted] put out a fire using water instead of an approved fire extinguisher. Clearly, that incident alone exposed both [redacted] and all employees at the site to the hazard addressed by the standard.

*Employer Knowledge*

General manager Powell oversaw the West Caldwell Branch and was responsible for training. (Tr. 768). Similarly Barry and Wampler were managers at the site and, as such, knew or should have known that employees were not properly trained in the use of fire extinguishers. District service supervisor [redacted] was also aware that employees were not trained. (Tr. 170, 196). Clearly, Respondent's rules for training employees in the proper use of fire extinguishers were either nonexistent or, at best, lax. The Secretary established that if these supervisors acted with reasonable diligence, they would have known that the employees were not properly trained. Therefore, these supervisors all had knowledge of the violation. That knowledge is imputed to Respondent.

*Characterization and Penalty*

CSHO Vargas testified that the failure to train employees on fire extinguisher usage could result in employees attempting to extinguish a fire that is too large. This put employees at risk of smoke inhalation, burns, and death. (Tr. 195-96, 631). Also, an employee trying to fight a fire that is too large could become trapped. (Tr. 196). The violation was serious.

The Secretary proposed a penalty of \$7,000.00 for this item. The CSHO testified that the violation was of high severity and that there was a greater probability of an incident occurring. He noted that the facility collected material that was soiled with auto grease, oils and other combustible liquids that can combust and catch fire. (Tr. 197-98). Indeed, the evidence established that a small fire broke out approximately four months before the inspection. As discussed under item 1, no credit was given for history, good faith or the size of the employer. Considering the section 17(j) factors, I find the \$7,000.00 proposed penalty to be appropriate.

**Citation 1 – Item 3: Alleged Serious Violations of Lead Standard at 29 CFR § 1910.1025(h)(1) and 29 CFR § 1910.1025(l)(1)(i)**

*Background*

CSHO Vargas testified that during his inspection, he asked the managers if any of their clients could harbor lead. They pointed to Covanta Energy. (Tr. 208). Covanta Energy is a company that burns garbage for energy. (Tr. 36, 376). When collecting soiled clothes from Covanta, drivers [redacted] and [redacted] testified that they wore uniforms issued by Respondent that consisted of non-waterproof button-up shirts with pants or shorts. (Tr. 62-64, 393). During the summer, they wore short-sleeve shirts. (Tr. 62, 393). Both drivers picked up Covanta clothes by hand, manually placed the clothes in garbage bags, and loaded them into hampers and onto the trucks. (Tr. 61-62, 389-96).

A letter, dated August 15, 2011, from Covanta to the UniFirst West Caldwell Branch facility stated that:

[t]esting results have shown that heavy metals, mainly lead, are concentrated in our fly ash. Your workers may come into contact with the fly ash while picking up dirty laundry. While the areas your workers are in during laundry pickup are minimal exposure areas, it is still important for you to explain this to your employees.

Included in the letter were examples of signs that were posted at the Covanta laundry bins in the changing/locker rooms:

Caution  
Clothing may be contaminated with inorganic lead / arsenic.  
Do not remove dust by blowing or shaking.  
Dispose of lead / arsenic contaminated wash water in accordance with  
applicable local, state or federal regulations.  
May contain Cadmium  
Cancer Hazard  
Avoid Creating Dust  
Can Cause Lung and Kidney Disease

(Tr. 208; Ex. S-12).

***Citation 1, item 3(a)***

Citation 1, item 3(a) alleges that, on or about November 3, 2011, at Respondent’s West Caldwell worksite, Respondent failed to maintain all surfaces as free as practicable of lead

accumulations, including in a truck and in the area of the laundry sort 65/35 bins, exposing drivers and dockworkers to the hazards of lead exposure.

Section 29 CFR 1910.1025(h)(1) provides:

Housekeeping. Surfaces. All surfaces shall be maintained as free as practicable of accumulations of lead.

*Applicability of the standard*

The evidence establishes that Respondent’s drivers were exposed to dust containing lead when delivering and retrieving clothing at Covanta. Covanta warned Respondent that its employees might come into contact with fly ash containing lead. (Ex. S-12). That letter specifically warned that “[c]lothing may be contaminated with inorganic lead/arsenic. Do not remove dust by blowing or shaking.....Avoid creating dust.”

Respondent’s lead program plainly states that “surfaces should be free of accumulated lead.” (Ex. S-13, p. 12). It also requires that “[a]ll customer garments must be placed in a dissolvable bag and properly tagged prior to the pickup” to “limit UniFirst employee exposures.” (Ex. S-13, p. 10). The standard applies.

*Compliance with the terms of the standard.*

The evidence establishes that lead-covered clothing from Covanta was not contained in a way to minimize the dispersal of lead. Driver [redacted] described the Covanta soil bins as “dusty and dirty.” (Tr. 399). Driver [redacted], stated that the laundry from Covanta was “one big ball of caked dirty laundry.” The dirt was “shimmering, like a dust” and had a metallic look to it.”<sup>5</sup> (Tr. 60).

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<sup>5</sup> [redacted] was a credible witness. I observed his demeanor during the hearing and observed his honest effort to testify accurately, to the best of his recollection. Also I reviewed and considered [redacted]’s testimony in the context of the record as a whole. [redacted]’s credibility is enhanced as his testimony is corroborated by the testimony of credited witness [redacted] (see note 4 above), the credible testimony of CSHOs Vargas and Klyza, the contemporaneous employee statements prepared by CSHO Vargas during the OSHA inspection, including [redacted]’s OSHA statement (Ex. R-38), and by a careful review of the exhibits received in evidence, including Respondent’s training records, discussed in detail below. See discussion regarding citation 2, items 2, 3(a) and 3(b). Significantly, the OSHA inspection began in response to [redacted]’s inquiry to OSHA after he noticed the inorganic lead / arsenic warning placed by Covanta on its laundry bins, described in the text above. (Tr. 65-69, 71; Exs. S-9, S-12). This was a significant health and safety concern. [redacted] observed this posted warning at a time following Covanta’s August 15, 2011 letter to UniFirst advising that UniFirst’s workers may come into contact with lead contaminated fly ash when picking up Covanta’s dirty laundry. As UniFirst neglected to itself notify its employees of this hazard, [redacted]’s concern at seeing the posted warning on the Covanta laundry bin resonates as valid and credible. (Tr. 65-69, 71, 100-02, 104). [redacted]’s testimony regarding all citation items is credited.

[redacted] testified that they were not given any special procedures for handling the dusty laundry at Covanta or instructed to wear any special clothing. (Tr. 400). The employees were required to pick up and sort the Covanta clothes by hand and place them manually in garbage bags and load them into hampers. They would roll the hampers onto the trucks and then place the garbage bags into the laundry bins on the trucks. (Tr. 61-62, 392, 395). Upon returning to the West Caldwell facility, the drivers backed the trucks up to the dock where the dockworkers would pull everything out of the trucks and separate the clothes into bins. (Tr. 86). The dirty laundry would then sit in bins at the warehouse. (Tr. 200; Ex. S-26 at 7-11). A photograph taken during the inspection shows a Covanta uniform hanging in the warehouse. (Ex. S-26 at 10).

The cited standard requires that “[a]ll surfaces shall be maintained as free as practicable of accumulations of lead.” In a Standard Interpretation Letter, dated January 13, 2003, OSHA explained that “[i]n situations where employees are in direct contact with lead-contaminated surfaces, such as working surfaces or floors in change rooms, storage facilities and, of course, lunchroom and eating facilities . . . the Agency would not expect surfaces to be any cleaner than the 200 ug/ft<sup>2</sup> HUD level.”<sup>6</sup> (Ex. S-40). The CSHO testified that surfaces above the 200 ug/ft<sup>2</sup> level are not considered as free as practicable of lead accumulations. (Tr. 207).

To determine the lead levels, CSHO Vargas took wipe samples. One sample came from the back of Truck #6 (6WL wipe), and the other came from the floor in the area by the laundry bins holding Covanta laundry (BINS-W wipe). (Tr. 200; Ex. S-9 at 1, 3). The CSHO testified that, in accord with the OSHA technical manual, he took the wipe samples from a 10 X 10 square centimeter area. (Tr. 200, 573, 581-82). Laboratory testing of the samples revealed that

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Respondent’s focus on discipline [redacted] allegedly received during his employment at UniFirst, in an effort to discredit [redacted] and distract from [redacted]’s credited eyewitness testimony regarding his work experience, is given no weight. [redacted] candidly testified that he received warnings and was discharged from employment at UniFirst after the OSHA inspection began. (Tr. 99, 104-06, 110-12, 114, 137-38). [redacted]’s testimony is credited. Respondent’s evidence, testimony and exhibits, that [redacted]’s discipline predated the OSHA inspection is not credited. (Tr. 920-46, 1092-1100; Exs. R-37, 39, 40). As discussed in detail below, Respondent’s record keeping regarding training was inaccurate and untrustworthy, including unreliable and misleading dates. See discussion regarding citation 2, items 2, 3(a) and 3(b) below. Likewise, I find Respondent’s disciplinary records allegedly given to [redacted] that predate the OSHA inspection unreliable. They are given no weight.

<sup>6</sup> The Interpretive Letter explains that the purpose of maintaining surfaces clean of lead is to prevent dispersal of the lead into the air leading to employee ingestion of lead either through breathing or eating. Although entered into evidence (Tr. 644), a copy of the letter is missing from the official file. However, it is available on the official OSHA website at [https://www.osha.gov/pls/oshaweb/owadisp.show\\_document?p\\_table=INTERPRETATIONS&p\\_id=25617](https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=INTERPRETATIONS&p_id=25617)

the 6WL wipe had lead concentration levels of 209.6 ug/ft<sup>2</sup> and 513 ug/ft<sup>2</sup> for the BINS-W wipe. (Tr. 207-08; Ex. S-10)

Respondent argues that the results are unreliable. It notes that the CSHO testified that if the sample area was larger than this 100 square centimeter area, it could produce a higher concentration of lead. (Tr. 581-82). Respondent observes that the Secretary’s exhibit does not demonstrate that the sample was taken from a 10 X 10 centimeter area, and that the CSHO could not verify that the sample area was no larger than 100 square centimeters. (Tr. 581-82; Ex. S-9). Therefore, it contends, the results could not be verified and citation 1, item 3(a) should be dismissed.

I disagree. While the exhibits do not depict the specific 100 square centimeter location from where the samples were taken, the CSHO testified with assurance that a “wipe sample is taken according to [OSHA’s] technical manual and *is always* a 10 X 10 square centimeter area.” (Tr. 581). The most equivocal statement from the CSHO was that “[w]e do, to the best of our ability, take a sample accurately.” (Tr. 582). That common sense statement is hardly sufficient to diminish the CSHO’s certainty that he took the sample from the requisite area. Certainly, being taken by a human, the sample area, if measured with engineering precision, might prove to be slightly under or over the requisite 100 square centimeters. This may cast doubt on the accuracy of the 6WL wipe (209.6 ug/ft<sup>2</sup>). It does not disqualify the BINS-W wipe. With a reading of 513 ug/ft<sup>2</sup>, the CSHO would have had to take a wipe from an area well over twice the requisite size. That is simply not credible. The standard was violated.

#### *Employee Exposure*

The evidence establishes that employees were exposed to surfaces that were not clean as practicable of concentrations of lead. Employees brought the bins carrying the dirty clothes into the warehouse. From there, employees had to take the bins to the laundry for cleaning. Moreover, all of the employees walked on the dock where the BINS-W wipe was taken, and many handled the clothes. (Tr. 214). Therefore, evidence shows that employees were exposed to the hazardous condition when they worked in the area of the bins where the BINS-W wipe was taken.

#### *Employer Knowledge*

The August 15, 2011 letter to UniFirst from Covanta clearly informed Respondent that UniFirst employees were exposed to fly ash containing lead and other contaminants. It further warned UniFirst that “the clothing may be contaminated with inorganic lead / arsenic.” (Ex. S-12). Had Respondent been reasonably diligent, it would have required that the worksite be monitored for lead and discovered that its workplace had impermissible lead contamination. Yet, Respondent took no measures to ensure that the West Caldwell facility was kept free of lead brought into the worksite from ash picked up on employee clothes, or from the lead contaminated dirt and dust on the Covanta laundry. The evidence establishes that Respondent’s supervisory personnel knew or should have known of the violation.

*Characterization*

The evidence establishes that the failure to keep surfaces “as free as practicable” of lead exposed employees to various health hazards, such as damage to the central nerve system, infertility and other toxic effects. (Tr. 214-15). The violation was properly characterized as serious.

***Citation 1 – Item 3(b):***

Citation 1, item 3(b) alleges that, on or about November 3, 2011, at Respondent’s West Caldwell worksite and at client Covanta’s facility, route sales representatives (drivers) were required to pick up and dockworkers were required to work with soiled and potentially lead contaminated laundry. Respondent’s employees were not provided with any training on the health hazards of lead.

Section 29 CFR § 1910.1025(l)(1)(i) provides:

Each employer who has a workplace in which there is a potential exposure to airborne lead at any level shall inform employees of the content of Appendices A (substance data sheet for occupational exposure to lead) and B (employee standard summary) of this regulation.

*Applicability of the Cited Standard.*

The evidence establishes that UniFirst drivers were required to enter areas of Covanta where they were actually exposed to airborne lead. Lead contaminated clothing was brought into the West Caldwell facility where dockworkers and other employees were exposed to the

potential for airborne lead from both the Covanta laundry and the clothing worn by the drivers who serviced Covanta. This actual and potential exposure obligated Respondent to provide training on the hazards of lead and lead exposure to the exposed employees. The standard applies.

*Compliance with the terms of the standard.*

The Secretary established that Respondent failed to inform employees of the content of Appendices A and B of the lead standard.<sup>7</sup> CSHO Vargas testified that, during his interviews, employees [redacted],[redacted], [redacted], [redacted] and [redacted], and district service supervisor [redacted], all told him that they were not provided any training in lead. (Tr. 217). This was confirmed by drivers [redacted] and [redacted], who both testified that they were never provided training on lead. (Tr. 72, 399-401). [redacted] also testified that he was never told that the dust at Covanta contained hazardous lead. (Tr. 399). Rather, they were told that any levels of lead were low and that there was nothing to worry about. (Tr. 70, 398). Statements given to the CSHO by employee [redacted] (Ex. S-36, p.3 lines 3-7) and employee [redacted]. (Ex. S-37, p.3 line 11 from bottom) further confirmed that they were not given lead training. Also, branch manager Barry told the CSHO that the employees were not trained in the hazards of lead. (Tr. 217). Finally, Respondent’s own audit of its training establishes that the earliest lead training for drivers [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], and [redacted], and dockworkers [redacted] and [redacted], was not provided until November, 11, 2011, after the inspection began. Many of the employees were not provided lead training until January 2012. (Ex. S-44).

*Employee Exposure*

The evidence establishes that employees exposed to airborne lead were not trained as required by the standard and, therefore, were exposed to the violative condition. (Tr. 214). Both drivers [redacted] and [redacted] testified that they would get dust on themselves. (Tr. 64, 391-

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<sup>7</sup> Appendix A explains how lead exposure affects the body and sets forth the health effects of overexposure at various blood levels. Appendix B explains methods used to protect employees from lead, including air monitoring program, respiratory protection, protective clothing, hygiene facilities and practices, housekeeping, medical surveillance, medical removal, protection and training requirements.

92). [redacted] testified that he would get the dust on his arm, hands and forearm and that, when he blew his nose, black stuff would be in the tissue. (Tr. 64). Depending on the season they would wear either long or short sleeve shirts. (Tr. 62, 393). [redacted] testified that he wore regular uniforms and did not use protective clothing. (Tr. 62). They were not provided with head protection or special booties to put over their shoes. (Tr. 64). [redacted] testified that he was not aware of the potentially hazardous contents of the dust until he saw the warning stickers on the hampers. (Tr. 65).

#### *Employer Knowledge*

General manager Powell was responsible for training at West Caldwell. (Tr. 768). Especially after the August 15, 2011 memo from Covanta, he knew or should have known that employees at the West Caldwell facility were exposed to the potential of airborne exposure to lead. Yet, no lead training was given until after the OSHA inspection began. The UniFirst Environmental, Health and Safety (EHS) manual assigns the authority and responsibility for compliance with all facets of the company lead program. (Ex. S-13, p.6 at ¶2.2). Among the responsibilities of the general manager is to “[e]nsure that all applicable employees attend Lead Training.” (*id.*) The manual also states that Corporate EHS “assists in maintaining the UniFirst compliance with all applicable EHS federal and state regulations.” (Ex. S-13, p.6 at ¶3.1). Beyond that cryptic statement, however, there is nothing in the manual, or anywhere in evidence, that provides a mechanism to ensure that the general manager is meeting his obligation to provide the requisite training. Accordingly, general manager Powell’s knowledge that he failed to provide lead training is imputed to UniFirst.

#### *Characterization and Penalty*

The Secretary asserts that the violation was serious. CSHO Vargas testified that the failure to train the employees in the hazard of lead deprived them of the proper knowledge to protect themselves. (Tr. 216-17, 632). Without proper training, employees would not know that their laundry could be lead contaminated, would not know how to handle it carefully, would not try to avoid inhaling it, and would not be encouraged to wear appropriate personal protection equipment. (Tr. 217). Lead exposure can be toxic to the human body. It damages the central nervous system and other organs and can cause infertility. (Tr. 214-15) The Secretary

established that the violation could result in serious physical harm and properly characterized the violation as serious.

The Secretary proposed a combined penalty of \$4,000.00 for both items 3(a) and 3(b). In arriving at this penalty, the Secretary determined that the severity of the violation was medium and the probability of an illness occurring was lesser. (Tr. 215). As with the other items, no credit was given for history, good-faith, or employer size. (Tr. 215). I find that the proposed penalty is appropriate.

## THE ALLEGED BLOODBORNE PATHOGEN VIOLATIONS

### Exposure to Bloodborne Pathogens

All items of the citation for willful violation and one item of the citation for serious violation assert that Respondent’s employees were potentially exposed to bloodborne pathogens. Respondent vigorously disputes this assertion. Therefore, as a preliminary matter, we examine whether the Secretary established by a preponderance of the evidence that the bloodborne pathogen standard applied to Respondent’s West Caldwell facility.

According to the bloodborne pathogen standard, 29 C.F.R. § 1910.1030(b), occupational exposure “means reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee’s duties.”<sup>8</sup> (Ex. S-39). The preamble to the bloodborne pathogen standard<sup>9</sup> states that “occupational exposure” refers to contact with blood or other potentially infectious materials that can be reasonably anticipated as a part of the employee’s duties.

Actual contact would be expected during an autopsy or surgery. In these cases, blood or other potentially infectious materials come in contact with the employee’s gloves or other protective clothing. In other cases, contact may not occur each time the task or procedure is performed, but when blood or other potentially infectious materials are an integral part of the activity, it is *reasonable to anticipate* that contact may result. Examples of such tasks are *phlebotomy* and changing a surgical dressing.

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<sup>8</sup> The Bloodborne Pathogen standard, 29 C.F.R. § 1910.1030(b), states, in part:

*Other Potentially Infectious Materials* [OPIM] means (1) The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids . . . .

<sup>9</sup> “[T]he preamble to a standard is the most authoritative evidence of the meaning of the standard.” *Superior Rigging & Erecting Co.*, 18 BNA OSHC 2089, 2092 (No. 96-0126, 2000, citing *Tops Markets, Inc.*, 17 BNA OSHC 1935, 1936 (No. 94-2527, 1997), *aff’d without published opinion*, 132 F.3d 1482 (D.C. Cir. 1997).

56 Fed. Reg. 64004, 64101 (December 6, 1991)(emphasis added).<sup>10</sup>

On November 27, 2001 OSHA expounded on the definition of occupational exposure by issuing Instruction CPL-02-02-069, *Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens*. At Paragraph XIII A.2, OSHA states that “employees in the following jobs are not automatically covered unless *they have the potential* for occupational exposure.” (emphasis added). What

follows is a list of employees including “commercial laundries that service healthcare or public safety institutions.” Paragraph XIII B.6 further explains:

**“Occupational Exposure”:** The term “reasonably anticipated contact” includes *the potential* for contact as well as actual contact with blood or OPIM. *Lack of history of blood exposures among designated first aid personnel of a particular manufacturing site, for instance, does not preclude coverage.* “Reasonably anticipated contact” includes, among others, contact with blood or OPIM (including regulated waste) as well as incidents of needle sticks. For example, a compliance officer may document incidents in which an employee observes a contaminated needle on a bed or contacts other regulated waste in order to substantiate “occupational exposure.”

(emphasis added)(Ex. R-34).

Respondent argues that exposure to human blood was not reasonably anticipated. It contends that incidental exposures that are not routinely expected on the job are excluded from the definition of bloodborne pathogens. (Resp. Brief at p.9). Respondent argues that the “overwhelming” evidence is that no employee ever saw human blood or any other bodily fluid on a garment, was exposed to blood, or saw any needles or sharps at the West Caldwell facility. Testimony to the contrary was presented by the Secretary, including the statement of driver [redacted] who stated “Occasionally, you’ll see specks of blood. Maybe once.” (Tr. 440-41; Ex. S-37. See also Tr. 439). Driver [redacted] testified that he saw blood on the lapel of a doctor coat.<sup>11</sup> (Tr. 83-85, 124-27, 138-39; Ex. R-38, page 2, lines 6 -7). [redacted] also testified that he

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<sup>10</sup> As discussed below, the record reveals that the Quest and LabCorp clients serviced by UniFirst’s West Caldwell facility performed phlebotomy, drawing blood. “Phlebotomy – The act of using a syringe to collect a blood specimen through an incision or needle puncture. A phlebotomy may be performed to obtain a sample of blood for analysis . . . .” *American Medical Encyclopedia*, p. 983 (1<sup>st</sup> ed. 2003).

<sup>11</sup> [redacted] testified that he took a photograph of blood on a lab coat and sent it to CSHO Vargas. (Tr. 119-21). While Vargas testified that he did not receive the photo, reference to the blood stained coat was included in [redacted]’s OSHA statement. (Tr. 437; Ex. R-38).

saw a syringe at either a LabCorp or Quest location.<sup>12</sup> (Tr. 83-85, 118-19, 138). [redacted] testified that he told district service manager Correa about the blood he saw on the coat and the syringe, the same day he observed them.<sup>13</sup> (Tr. 83-85). Driver [redacted] testified that, while he didn't see any syringes, he would sometimes see syringe or probe caps lying at the bottom of the bins among the dirty lab coats. (Tr. 407). While he did not testify to actually seeing blood on a garment, he testified that, at the larger facilities, there were so many coats, he could not tell. He noted that he would just grab the coats in a pile and throw them into the laundry bin. (Tr. 407). Branch manager Barry testified that uncontaminated laundry was placed by the customer in a non-biohazard bag. When those bags came to West Caldwell they would be placed loose with other laundry and sorted by the warehouse workers on the dock. (Tr. 1174-75).

UniFirst rolled out its bloodborne pathogen program in March 2010. (Tr. 774-75, 1204). The program was applied to West Caldwell because it was attempting to expand its business into the healthcare market. (Tr. 774-75, 1214). In 2010 and 2011 West Caldwell serviced multiple facilities at Quest and one at LabCorp that drew and/or tested blood from patients. (Tr. 36, 75, 228, 402-04, 524, 862, 976, 1265-67; Ex. S-15). At the time of the inspection, West Caldwell was servicing 28 Quest facilities and one LabCorp facility.<sup>14</sup> (Tr. 973). All but one of the assigned routes at West Caldwell contained at least one bloodborne pathogen account. (Exs. S-42, S-43). Respondent leased fluid-resistant lab coats to these facilities and laundered them weekly. (Tr. 74, 848-50, 1049, 1200).

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<sup>12</sup> When asked during the OSHA inspection [redacted] did not inform CSHO Vargas that he had seen a sharp or needle. (Tr. 438; Ex. R-38). [redacted] was a credible witness. See note 5 above. I give [redacted]'s testimony regarding seeing the syringe weight as it is generally corroborated by the testimony of driver [redacted] that non-laundry lab items were seen mixed in with the dirty laundry, such as syringe or probe caps and rubber gloves (Tr. 407), and general manager Powell's testimony that a sharp was found in the laundry at UniFirst's Croydon facility. (Tr. 853).

<sup>13</sup> District service manager Correa was not called as a witness. This testimony is un rebutted.

<sup>14</sup> Respondent argues that, according to general manager Powell, the LabCorp facility serviced by Respondent was a testing facility that did not draw blood. (Tr. 776-78). Powell based his testimony on an email received from LabCorp that defined their activities at the Raritan facility as a testing facility and corporate office. (Tr. 777). He denied that UniFirst's West Caldwell facility serviced any LabCorp blood draw facility in New Jersey, in 2011, at the time of the OSHA inspection. (Tr. 778). However, driver [redacted] testified that while employed at UniFirst, he visited a small LabCorp facility where he had to walk through the center of the facility, past cubicles. (Tr. 405-06). He could see people sitting in chairs with their arms out with a rubber band around it and techs drawing blood. (Tr. 403). Similarly, branch manager Barry testified that the LabCorp facility serviced from West Caldwell handled blood. (Tr. 1266-67). I find the testimony of driver [redacted] to be more credible. Rather than relying on an email, he actually visited the LabCorp facility and personally saw blood being drawn at a LabCorp facility serviced from West Caldwell.

The evidence demonstrates that UniFirst was long aware that its accounts had the potential for employee exposure to bloodborne pathogens. On November 1, 2006, UniFirst issued a National Account Customer Profile for Quest. The first paragraph of the profile states in bold type:

Important...Each UniFirst Customer Service Center must process all Quest Diagnostics coats and other applicable rented items according to Universal Precautions guidelines as published by OSHA under Part 1910.1030, subpart Z, with respects to Bloodborne Pathogens.

Non-conformance to these Universal Precautions shall be deemed a cause for immediate termination on the non-conforming site, and will not require the usual 30 day advance written notice.

(Ex. S-15, p. 1)

Similarly, the National Account Customer Profile for LabCorp, dated August 1, 2009, states:

*Blood Bourne Pathogens.* Caution....laundered items *could contain* Blood Bourne Pathogens. You must follow all regulation for handling such garments including but not limited to universal precaution procedures.

Ex. S-15, p. UFC 00075 ¶3<sup>15</sup> (emphasis added).

General manager Richard Powell testified that by the time the inspection began, both Quest and LabCorp were deemed to be bloodborne pathogen accounts being serviced by West Caldwell. (Tr. 775-76)

The UniFirst training sign-in sheet from June 18, 2010 states that “All team partners *with the potential* to come in contact with bloodborne pathogens are offered the hepatitis b vaccine at no cost to the team partner.” (Ex. S-25, p.1)(emphasis added).<sup>16</sup> Similarly, the

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<sup>15</sup> In his brief, the Secretary asserts that the evidence establishes that West Caldwell also serviced doctors’ offices, including a dermatologist (Tr. 36, Ex. R-38 at 1); machine shops where people could get cut and get blood on their uniforms. (Tr. 861); and “strongly suggests” that Virgo, an EMT company, was also a client. (Ex. S-26 at 9, 10, Ex. R-38 at 1).

Regarding the machine shop clients, general manager Powell was aware that machine shop employees would get hand cuts working around very sharp metal shavings, with the reasonable expectation of blood from their hands getting onto their work uniforms. (Tr. 861-62). I give the limited evidence regarding Respondent’s machine shop clients’ limited weight.

There is no evidence establishing the nature of UniFirst’s relationship, if any, with the doctors’ offices, a dermatologist, and EMT client accounts, or the potential for exposure to blood or other bodily fluids from these clients. I find the evidence regarding Respondent’s servicing of these clients vague at best. Accordingly, I give this evidence no weight.

<sup>16</sup> Curiously, Kelley O’Leary, Respondent’s manager of performance and training, testified that the requirements of Respondent’s written bloodborne pathogen program are triggered only when there is actual exposure to blood

UniFirst Hepatitis B Vaccination Declination Form states that “I understand that *due to my occupational exposure* to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection.” (Ex. S-33)(emphasis added). Both documents were used at West Caldwell.

Before newly hired RSRs are allowed to handle a route, UniFirst requires them to undergo bloodborne pathogen training. (Tr. 841-43). At the hearing, branch manager Barry testified that, if it came to his attention that an RSR had not received the training before being assigned a route on his own, he would have him trained immediately “because their safety is the more important thing to me. They shouldn’t be on that route without receiving the proper training.” (Tr. 1227). District service manager Wampler testified that if an employee refused to watch the bloodborne training video, he would be terminated on the spot. (Tr. 1115).

UniFirst’s manager of performance and training support, O’Leary, testified that

If you might be exposed to bloodborne pathogens in your job, you will receive specialized training on how to work safely, use proper PPE, and protect yourself. We also offer team partners, who might be exposed to bloodborne pathogens as part of their job, the opportunity to receive the hepatitis B vaccine as a preventative measure at no cost to the team partner.

(Tr. 681)

Respondent asserts that the “universal precautions” called for in the profiles was a practice introduced in the 1980s during the AIDS epidemic and simply means “an approach to infection control” by which “all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV, and other bloodborne pathogens.” 29 CFR § 1910.1030(b). Respondent asserts that this is consistent with UniFirst’s policy which treats any lab coat contaminated with blood as infectious. These “universal

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contaminated laundry. (Tr. 691, 741-42; Ex. S-22, p.10). When asked whether the OSHA standards applied when there was potential as opposed to actual exposure, she responded that “we train everyone whose job may put them in a circumstance where they handle those kinds of accounts, but the actual manual says they’re not required unless the trigger is present.” (Tr. 741-42). I do not credit this testimony. Her testimony on this point was evasive, inconsistent and contradicted the statements in the Quest and LabCorp profiles.

Moreover, a policy requiring that precautions be taken only after there is actual exposure to bloodborne pathogens is contrary to the bloodborne pathogen standard that requires employee protections to be in place prior to an actual exposure incident. As discussed above, the standard applies to all occupational exposure to blood or OPIM. 29 CFR § 1910.1030(b). Occupational exposure means the reasonably anticipated contact with blood or OPIM, including the potential for contact as well as actual contact. CPL-02-02-069, Para. XIII B.6. For example, regarding the information and training required by the standard, employees assigned to tasks where “occupational exposure *may take place*, means that employees must be *trained prior* to being placed in positions where occupational exposure *may occur*.” CPL-02-02-069, Para. XIII G.4. (emphasis added); 29 CFR § 1910.1030(g)(2)(ii)(A).

precautions,” Respondent continues, do not apply where a garment is soiled but not contaminated with blood. (Resp. Brief at 13).

Respondent’s attempt to diminish the relevancy of these profiles is not convincing. Quest and LabCorp employees are not housepainters who engage in activities that are not expected to result in their coats being splattered by bloodborne contaminants. Such exposures would indeed be incidental. In contrast, Quest and LabCorp employees routinely draw human blood. Clearly, accidents would be expected to occur resulting in blood being spilled or splattered on the lab coats. The drivers and the dockworkers often pick up these lab coats en masse, easily obscuring those coats that might be contaminated. The customer profiles clearly recognize the possibility that items to be laundered from these facilities “could contain Blood Bourne Pathogens” and, therefore, require that they “must process” such items according to “universal precautions.” (Ex. S-15 at p. 1 and p. UFC 00075 ¶3). Clearly, the activities of the drivers and dockworkers involved activities that could result in “contact with blood or other potentially infectious materials that may result from the performance of an employee’s duties.” 29 C.F.R. § 1910.1030(b). This contact is not limited to laundry contaminated with blood. It can also come from a used needle hiding in the pocket of a lab coat.

Respondent’s assertion that there is no evidence of blood contamination or needles at West Caldwell misses the point. Its own Personal Protective Equipment Video expressly recognizes that “it’s very unlikely that in the course of a normal day at work you’ll be exposed to any bloodborne pathogens.” (Ex. R-31 at 1:14-1:19). General manager Powell testified that, while he was unaware of any lab coats from the West Caldwell routes being contaminated, he was aware of an incident from the Croydon facility where a sharp needle was in a coat. (Tr. 853). The purpose of the Act is to prevent the first accident. *Lee Way Motor Freight, Inc. v. Secretary*, 511 F.2d 864, 870 (10<sup>th</sup> Cir. 1975); *Elliot Constr. Corp.*, 23 BNA OSHC 2110, 2119 (No. 07-1578, 2012). The issue is not whether contaminated garments or needles were ever present at West Caldwell, but whether there was a potential for employee exposure.

Moreover, the definition of “occupational exposure” does not anticipate that the clothing handled would necessarily be actually contaminated. Rather, it requires only that contact with bloodborne pathogens be “reasonably anticipated.” Indeed, where clothing is actually contaminated with blood, the more demanding standards at 29 C.F.R. §1910.1030(d)(4)(iv) apply.

Finally, Respondent asserts that Quest was the only customer of West Caldwell that drew human blood.<sup>17</sup> It claims that Quest has a policy of burning any coat contaminated with blood. (Resp. Brief at 2, 12-13, 28, 33)(Tr. 859, 1051, 1053, 1203-07). The lab coats used by Quest are owned by UniFirst. Respondent argues that, had Quest destroyed any coats, UniFirst would have been notified to replace them. However, no UniFirst employee ever heard of a garment being destroyed by Quest. (Tr. 1054).

Respondent’s reliance on the alleged Quest policy of destroying blood soaked laundry to protect its employees from bloodborne pathogens constitutes an unacceptable attempt to shift the responsibility for the safety of its employees to a third party. *Brock v. City Well Serv.*, 795 F.2d 507, 512 (5<sup>th</sup> Cir. 1986); *Baker Tank Co.*, 17 BNA OSHC 1177, 1181 (No. 90-1786-S, 1995). Even if such a policy exists, there was no evidence to suggest how the policy is enforced, how strictly the policy is enforced, or what happens to a coat that is not “blood soaked.”

In any event, the evidence supporting Respondent’s account of internal Quest procedures at one Quest facility is hearsay and not supported by any probative evidence. (Tr. 853-59, 1205-06). Respondent points to district service manager Correa’s statement to CSHO Vargas that “a blood soaked coat has to be destroyed by the client by contract.” (Ex. R-51). Similarly, branch manager Barry testified that he met with the facility manager for Quest’s Teterboro facility, James Christie.<sup>18</sup> Christie told Barry that if anything was ever contaminated with blood Quest would destroy it on site and UniFirst was to bill Quest for the garment. (Tr. 1206-07). District Manager Wampler similarly testified to a hearsay conversation that he had with Quest’s Christie. (Tr. 1050-53). General Manager Powell generally testified that he receive an email from Christie, at Quest’s Teterboro facility, from which Powell understood that Quest would destroy a garment contaminated by blood. (Tr. 853-59).

Neither district service manager Correa nor Quest manager Christie was called by Respondent to testify. These very general comments allegedly made by the facility manager at one Quest location are hearsay, have no probative value, and raise more questions than they

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<sup>17</sup> This assertion is incorrect. As discussed above in note 14, the credited evidence reveals that blood was drawn at a LabCorp facility serviced by UniFirst’s West Caldwell facility.

<sup>18</sup> Respondent asserts that the Quest Teterboro location is a testing facility that draws no blood. (Resp. Brief at p.3). That assertion is based solely on the testimony of CSHO Vargas who admitted that he never visited the Teterboro facility. Rather, he visited the Quest website which lists Teterboro as a facility that analyzes blood products. (Tr. 473-74). I find this to be a distinction with no substance. Whether drawing blood or testing drawn blood, the relevant fact is that human blood is handled at Teterboro. In any event, the evidence is clear that other facilities serviced by West Caldwell actually draw human blood. See note 14 above.

answer.<sup>19</sup> The hearing testimony from Respondent’s witnesses, regarding their alleged perception based on conversations with a facility manager at one Quest location, is unpersuasive and given no weight. No first hand evidence regarding a Quest policy to destroy blood contaminated garments was introduced into evidence.

Significantly, district service manager Wampler and branch manager Barry testified, in detail, regarding Respondent’s policy when processing blood contaminated laundry received from Quest, apparently from one of the Quest facilities serviced by the West Caldwell Branch other than Teterboro. (Tr. 1046-48, 1062-63, 1170-71, 1174-76). Therefore, Respondent’s managers had no reasonable belief that there was a broad Quest policy to destroy contaminated lab coats generally applicable to all Quest facilities serviced by West Caldwell.

Any contention that Respondent’s managers did not understand that the bloodborne pathogen standard was applicable to the drivers and dockworkers at Respondent West Caldwell facility, based on alleged hearsay conversations with one Quest facility manager, is rejected as incredible. Any general conversations regarding this alleged policy at one Quest facility did not supersede or discontinue the specific directive in the Quest National Account Customer Profile that all Quest coats and rented items must be processed according to the Universal Precautions guidelines set forth by OSHA in the bloodborne pathogen standard. 29 CFR § 1910.1030.

I find that the preponderance of the evidence establishes that the drivers and dockworkers at West Caldwell were in jobs that have the potential for contact with bloodborne pathogens (CPL-02-02-069, Paragraph XIII A.2, B.6) and, therefore, that the UniFirst facility at West Caldwell was subject to the bloodborne pathogen standard at 29 C.F.R. § 1910.1030.<sup>20</sup>

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<sup>19</sup> For example, the record does not indicate the terms of the contract, the amount of contamination that would trigger destruction of a coat, how the policy is enforced, what happens to a coat that is not “blood soaked,” or if and how the policy would handle the hazard of contaminated needles placed in coat pockets. To highlight the problem, while district service manager Correa was told that Quest destroyed coats that were “blood soaked,” at the hearing, in response to leading questions, Respondent’s witnesses Powell, Barry, and Wampler testified that they were told by Christie that Quest destroyed coats that were only “contaminated.”

<sup>20</sup> In the recent decision *UniFirst Corp.*, 2014 WL 2119153 (No. 13-1703, 2014), Judge Gatto found that employees who handled scrubs from a surgical center did not have “occupational exposure” to blood or other pathogens. The situation in that case, however, is clearly distinguishable from the instant matter. In Judge Gatto’s case, the employees were handling only scrubs, which are worn underneath protective clothing. Judge Gatto specifically stated that “the preamble anticipates blood or other infectious materials may contact *protective clothing*, not clothing worn underneath protective clothing such as scrubs. The preamble does not presume that those layers of clothing worn beneath protective clothing are reasonably anticipated to contact blood or other infectious materials during medical procedures.” (emphasis in original). In contrast, the clothing worn in this case, external lab coats, were potentially exposed to blood.

**Citation 1 – Item 4: Alleged Serious Violation of 29 CFR § 1910.1030(d)(3)(ix)**

Citation 1, item 4 alleges that, on or about November 8, 2011, at Respondent’s West Caldwell worksite, Respondent failed to provide dockworkers with personal protective equipment, including gloves, when it was reasonably anticipated that they might have hand contact with loose soiled medical laundry that was potentially blood contaminated.

Section 29 CFR § 1910.1030(d)(3)(ix) provides:

Bloodborne pathogens. Personal Protective Equipment. Gloves. Gloves shall be worn when it can be reasonably anticipated that the employee may have hand contact with blood, other potentially infectious materials, mucous membranes, and non-intact skin . . . and when handling or touching contaminated items or surfaces.

*Applicability of the cited standard.*

Respondent’s manager of performance and training support O’Leary testified that the dockworkers should have been wearing gowns, latex gloves, and eye protection when there were contaminated laundry items present. (Tr. 692). The bloodborne standard applies when there is reasonably anticipated contact with blood or OPIM, including the potential for contact as well as actual contact. CPL-02-02-069, Para. XIII B.6. As discussed above, the evidence establishes that it could be reasonably anticipated that Respondent’s employees would have contact with blood or otherwise potentially infectious materials. Therefore, the cited standard applies.

*Compliance with the terms of the standard.*

During the inspection on November 8, 2011, CSHO Vargas asked district service managers Correa and Wampler to show him where the box of protective gloves for employees to wear was kept. They replied that they couldn’t show him because the last box just “went out.” (Tr. 223, 1061-62). Later that day, he interviewed dockworker [redacted] who told the CSHO that gloves were not currently available. (Tr. 223, 463). In his statement, [redacted] indicated that he was instructed to use protective gloves. (Tr. 463-64, Ex. S-35, p.2, lines 16-17) Driver [redacted] testified that he would wear gloves when they were available. However, sometime they were on order and not available. (Tr. 76). According to [redacted], gloves were unavailable about half the time and sometimes the size available wouldn’t fit. (Tr. 77).

Both branch manager Barry and district service manager Wampler testified that fluid resistant coats, gloves, and glasses were available, and when unavailable an order was immediately placed for more. Wampler testified that he kept the gloves locked in his office and that, when they would run out, he would order an additional four cases or 4,800 pairs. (Tr. 1057, 1061-64). A new delivery would arrive from the Croydon, Pennsylvania facility within four hours. (Tr. 1060-61, 1177-79).

In its brief, Respondent points out that, in his written answers to the OSHA questionnaire, branch manager Barry stated that employees had to ask for the gloves. When the CSHO asked why gloves hadn't been provided, he stated that “we don't give them out, the employees have to ask for them.” (Resp. Brief at 17, Ex. S-4 at 00192-00193).

The evidence establishes that generally, UniFirst made protective equipment available to its employees. However, the evidence also demonstrates that, rather than ensure that a supply of gloves were always available, Respondent's managers would often wait until the supply at West Caldwell was exhausted before ordering more. Respondent's Bloodborne Pathogen Exposure Control Program (“BBP ECP”) states that “[a]s a minimum, disposable examination gloves must be worn whenever exposure to blood or other potentially infectious material may be reasonably anticipated.” (Ex. S-22, p.14, ¶ 6.2.1). While a supply could be procured in hours, they were not available to employees, especially dockworkers, who had to continue their responsibilities, exposing them to the potential of exposure to bloodborne pathogens while waiting for the new supply to arrive.

Driver [redacted] testimony that this was not a rare occurrence, strongly suggests that it was not a coincidence that the facility just happened to be out of gloves when the OSHA inspection began. But, particularly damaging to Respondent is the statement by branch manager Barry, when referring to the gloves, that “we don't give them out, the employees have to ask for them.” (Resp. Brief at 17, Ex. S-4 at 00192-00193). Barry's statement demonstrates that UniFirst impermissibly shifted the burden of compliance onto the employees. *Burford's Tree, Inc.*, 22 BNA OSHC 1948 (No. 07-1899, 2010); *General Electric Co.*, 10 BNA OSHC 2034 (No. 79-504, 1982).

The standard clearly mandates that “gloves shall be worn.” It is the obligation of the employer to ensure that the gloves are worn. By necessity this requires the employer to ensure

that the gloves are available and in stock. It is not sufficient to wait until the supply is exhausted before ordering more. The evidence establishes that the standard was violated.

*Employee Access to the Violative Condition.*

The evidence establishes that dockworkers who handled dirty laundry from Quest and LabCorp were exposed to potential exposure to bloodborne pathogens due to the lack of appropriate protective gloves.

*Employer Knowledge*

The burden was on Respondent to ensure that the gloves were always available. Branch manager Barry's assertion that the gloves weren't handed out and that employees had to ask for them demonstrates that UniFirst lacked adequate rules and procedures to ensure that the protective gloves were always available. Therefore, Respondent knew, or with the exercise of reasonable diligence, should have known of the violative condition.

*Characterization and penalty*

Handling potentially contaminated laundry without gloves could result in employee exposure to such diseases as hepatitis B, HIV, and other bloodborne diseases. (Tr. 224-25). The violation was properly characterized as serious.

The Secretary proposed a penalty of \$5,000.00 for this item. The CSHO testified that the violation was of high gravity due to the severity of the potential diseases that may be contracted from exposure to bloodborne pathogens. As with the other items, no credit was given for the size of the employer, its history or good faith. (Tr. 224-25). I find the Secretary properly considered the statutory factors and that the proposed penalty is appropriate.

**Citation 2– Item 1: Alleged Willful- Serious Violation of 29 CFR § 1910.1030(d)(2)(i)**

Citation 2, item 1 alleges that, on or about November 3, 2011, Respondent failed to use engineering and/or work practice controls to eliminate or minimize the drivers' and dockworkers' occupational exposure to medical laundry that was potentially blood contaminated, with the potential to harbor sharps or other blood contaminated syringes. Regarding the drivers

specifically, the employer did not provide biohazard labeled nylon bags and water soluble liners for the clients’ laundry bins. The dockworkers were required to manually separate loose soiled medical laundry from the non-medical white laundry.

Section 29 CFR § 1910.1030(d)(2)(i) provides:

Bloodborne pathogens. Engineering and work practice controls shall be used to eliminate or minimize employee exposure. Where occupational exposure remains after institution of these controls, personal protective equipment shall also be used.

*Applicability of the Cited Standard.*

The standard requires that engineering and work practice controls shall be used to eliminate or minimize employee exposure to bloodborne pathogens. Respondent contends that the standard does not apply because it was not “reasonably anticipated” that employees would be required to handle contaminated laundry. (Resp. Brief at 18-19). Moreover, it is not a violation to pick up soiled, but non-contaminated clothing in containers other than biohazard bags, and the Secretary offered no proof that contaminated laundry was picked up in a non-biohazard bag. (Resp. Brief at 18-19).

As noted above, exposure to bloodborne pathogens is deemed to be “reasonably anticipated” when the record demonstrates the “potential” for such exposure. Whether this “potential” exists is a fact based issue and must be determined by the nature of the work. Where, as here, clothing is worn by lab technicians who routinely draw blood, there is a clear potential, inherent in the nature of the work, that lab clothes would be contaminated with blood. The testimony of driver [redacted] established that, at some of the larger facilities, the failure to place laundry in biohazard bags required him to grab coats into a pile and place them in the laundry bins. There were so many coats, that he could not tell whether any of them were contaminated. (Tr. 407). This is the very type of situation that the requirement for the use of biohazard bags is intended to prevent.

Respondent’s own bloodborne pathogen training video recognizes that biohazard bags are to be used to handle non-contaminated clothes. It explicitly states that “the bags we use to handle non-contaminated garments is the light blue nylon bag with the red biohazard label.” (Ex. R-11 at time mark 3:15-3:38). The standard applies.

*Compliance with the terms of the standard*

At the hearing, CSHO Vargas explained how water soluble liners are used in conjunction with the biohazard nylon bags:

[T]he procedure is, that you take the nylon—you take the nylon bag with a water-soluble liner that contains the potentially contaminated laundry, pick it up from the strings from the top, and that minimizes the employee’s exposure to the lab coats, to the potentially contaminated laundry that could harbor sharps or have blood on it; that’s the engineering control. When they take the nylon bag with the water-soluble liner that’s full of this soiled laundry, they put it in their rolling bin and take it to their truck. They replace that nylon bag with another clean, empty nylon bag that they’re supposed to have, and line it with a water-soluble liner for the client to deposit their contaminated laundry into a clean, empty hamper; that’s the engineering control.

(Tr. 229)<sup>21</sup>

The preponderance of the evidence establishes that UniFirst did not provide either the biohazard nylon bags or the water soluble liners. Drivers [redacted] and [redacted] both credibly testified that they were required to use black garbage bags to pick up laundry because the nylon bags were not always available. (Tr. 79, 406, 408). Sometimes, [redacted] just picked up the lab coats and threw them into a hamper. (Tr. 406). The majority of the time, they used black plastic garbage bags of which UniFirst had “cases and cases.” (Tr. 408).

CSHO Vargas testified that several long-term UniFirst employees he interviewed told him that nylon bags were distributed. However, they disappeared within a month after the employees were given bloodborne pathogen training on June 18, 2010. (Tr. 227-28). The prevalence of black plastic garbage bags at West Caldwell is supported by the photographic evidence, which shows the bags located around the facility. (Exs. S-9 at 2, S-26 at 7-11).

Branch manager Barry testified that biohazard bags were available in 2010 when the bloodborne pathogen program was rolled out. (Tr. 1277). However, Barry’s signed statement

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<sup>21</sup> Branch manager Barry disagreed with the CSHO’s description. According to Barry, there are two types of bags that constitute the engineering controls. Laundry containing non-contaminated clothing is to be placed in nylon bags. Garments with known contaminants are placed in a red, water soluble bag. (Ex. R-11 at time mark 3:05-3:38, 4:57-5:14). The red water soluble bags are not to be opened by employees. (Ex. R-11 at 3:05-3:15). Rather they are thrown directly into the washing machine where the bag dissolves and the clothes are treated with a process that neutralizes the contaminants. (Tr. 130, 1048, 1173, 1278) While Barry may have presented an accurate description regarding water soluble bags, the citation alleged a failure to use nylon biohazard bags with a water soluble liner. Regardless of the nature of the water soluble bags, the preponderance of the evidence clearly shows that employees were using black garbage bags, not biohazard bags.

states that, after the rollout, the nylon bags had not been at the facility “forever, that I know of. I’ve been here 1.5 years.” He explained that “I didn’t find it important.” (Tr. 253-254; Ex. S-4 at 6). Barry testified that, after he made his statement to the CSHO, he checked and learned that the biohazard bags were available at the hamper. (Tr. 1224-25) This was confirmed by district service manager Wampler, who testified that there was a hamper on the dock that contained biohazard bags. (Tr. 1055-56). This was at odds with the testimony of CSHO Vargas who testified that district service managers Wampler and Correa both told him that they never saw the nylon bags. (Tr. 227). Wampler confirmed that soiled lab coats from Quest were placed in a non-biohazard laundry bags, rather Quest would just place the lab coats on the floor for pick-up by UniFirst. It was only known blood contaminated coats that Quest would place in a biohazard bag. (Tr. 1056).

Branch manager Barry likewise testified that known blood contaminated coats would be placed by Quest in biohazard bags.<sup>22</sup> (Tr. 1170-71). Barry testified that he saw biohazard bags at Quest accounts. (Tr. 1199) He never had any awareness that the bags were not there. (Tr. 1199). This was confirmed by district service manager Wampler, who testified that UniFirst issued barcoded biohazard bags to Quest. (Tr. 1055).

Respondent’s evidence regarding the availability of biohazard bags at the West Caldwell facility was conflicting. For example, branch manager Barry asserted that after he made his statement to the CSHO that there were no biohazard bags, he learned that they were available. However, very telling was his statement that he didn’t find the biohazard bags to be important. Similarly, the CSHO testified that district service manager Wampler told him that the bags were unavailable. Yet, Wampler testified that there was a hamper on the dock that contained biohazard bags.

However, whether biohazard bags were available at West Caldwell misses the point. The standard plainly states that “[e]ngineering and work practice controls *shall be used.*” Simply having the biohazard bags located at a hamper by the dock, in a place forgotten by even the branch manager, does not suffice. Whether or not they were available in the hamper, the preponderance of the evidence clearly establishes that they were not used. Instead of biohazard bags, employees were using black garbage bags and, in some instances, their own hands to move

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<sup>22</sup> The testimony of Barry and Wampler that any blood contaminated coats would be placed by Quest in biohazard bags confirms that any alleged understanding by UniFirst managers, regarding the destruction of lab coats, was applicable to Quest’s Teterboro facility only. See text at page 25 above.

the soiled and potentially contaminated laundry from the client to the hampers in their trucks. Although the use of biohazard bags was required by the UniFirst bloodborne pathogen program, (Exs. S-17, p. 1; S-22, p. 12, ¶6.1.1; R-11 at time mark 3:05-3:38, 4:57-5:14; R-31 at time mark 11:12-11:43) the evidence, as set forth by branch manager Barry, demonstrates that management found the use of those bags “unimportant.” What Barry did not explain was how, after finding the bags to be “unimportant” and even forgetting that they were available, he attempted to enforce the requirement that his employees use the biohazard bags. The Secretary established that UniFirst did not comply with the cited standard.<sup>23</sup>

*Employee Access to the Violative Condition.*

The evidence also establishes that employees were exposed to the violation. Driver [redacted] testified that, because of the lack of biohazard bags, he often would pick up the laundry by hand and place it in his truck.

Respondent contends that there is no evidence that the dockworkers were exposed to any hazard from a failure to use biohazard bags. It contends that it was not “reasonably anticipated” that dockworkers would ever handle laundry contaminated with blood or containing sharps or other needles and that, in any event, the dockworkers wore latex protective gloves that would prevent them from contacting any bloodborne pathogens. (Resp. Brief at 19-20).

I find Respondent’s argument to be without merit. The fallacy in Respondent’s “reasonable anticipation” argument has already been discussed and need not be recounted here. That the dockworkers wore latex gloves does not excuse the failure to use biohazard bags. The cited standard plainly states that “[w]here occupational exposure remains after institution of these [engineering] controls, personal protective equipment shall also be used.” By its own terms, while the standard allows personal protective equipment, such as latex gloves, to supplement such engineering controls as biohazard bags, it does not allow such personal protective equipment to substitute for those engineering controls.

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<sup>23</sup> Even if Respondent made biohazard bags available, there is no evidence that they also provided water soluble liners. This is critical because the whole point of the bags is to make it unnecessary for employees to handle the soiled and potentially contaminated laundry. A water soluble liner inside a biohazard bag can be removed from the nylon bag together with the laundry and placed directly in the washing machine without anyone touching the laundry. The bag would dissolve during the washing procedure. Without this liner, it is far more likely that employees would have to handle the laundry.

Accordingly, I find that the Secretary has established by a preponderance of the evidence, that Respondent’s employees were exposed to the hazard of bloodborne pathogens due to UniFirst’s failure to adequately implement engineering controls, such as biohazard bags.

*Employer Knowledge*

Respondent’s bloodborne pathogen protection program clearly requires the use of biohazard bags. (Exs. S-17, p. 1; S-22, p. 12, ¶6.1.1; R-11; R-31 at time mark 11:12-11:43). The evidence establishes that, when its bloodborne protection program was first rolled out in June 2010, biohazard bags were distributed to the drivers. However, the bags disappeared after a month. (Tr. 227). Branch manager Barry testified that when he first spoke to the CSHO, he had forgotten that the biohazard bags were even available. In his own words, the requirement to use the biohazard bags was simply “unimportant.” The evidence establishes that UniFirst knew, or with the exercise of reasonable diligence, should have known of the violation.

**Citation 2 – Item 2: Alleged Willful - Serious Violation of 29 CFR § 1910.1030(f)(2)(i)**

Citation 2, item 2 alleges that, on or about November 3, 2011, Respondent failed to make hepatitis B vaccinations available to drivers and warehouse dockworkers who came into contact with medical laundry that was potentially blood contaminated, with the potential to harbor sharps. The Secretary lists two instances of the violation:

1. The employer directs route sales representatives aka drivers to pick up soiled and potentially blood contaminated laundry with the potential to harbor sharps such as contaminated syringe needles. There are five (5) Route Sales Representatives (drivers) who had not been offered the hepatitis B vaccine from 12 months to 2 months after being assigned to work.
2. The employer requires dockworkers to take loose soiled laundry and/or non-medical laundry mixed with loose soiled medical laundry that the route sales representatives (drivers) collect, and manually separate the soiled medical laundry from the non-medical white laundry. There are two warehouse dockworkers had not been offered the hepatitis B vaccine from 12 months to 5 weeks after being assigned to work.

Section 29 CFR § 1910.1030(f)(2)(i) provides:

Bloodborne pathogens. Hepatitis B vaccination shall be made available after the employee has received the training required in paragraph (g)(2)(vii)(I) and within 10

working days of initial assignment to all employees who have occupational exposure unless the employee has previously received the complete hepatitis B vaccination series, antibody testing has revealed that the employee is immune, or the vaccine is contraindicated for medical reasons.

*Applicability of the Cited Standard.*

The standard requires that, with narrow employee based exceptions, the employer make the hepatitis B vaccine available to all employees with occupational exposure to hepatitis after training and within 10 days of initial assignment. As previously discussed, the Secretary has established that the drivers and dockworkers at Respondent’s West Caldwell facility were occupationally exposed to bloodborne pathogens. The standard applies.

*Compliance with the terms of the standard*

CSHO Vargas testified that, based on his investigation, he compiled a list of seven employees who were never offered the hepatitis B vaccine. Ultimately, he concluded that “for certain” dockworkers [redacted] and [redacted] and driver [redacted] were not offered the vaccination in a timely fashion. (Tr. 286).

At the hearing, the Secretary adduced evidence that other employees were not timely offered the vaccine. Driver [redacted] testified that he was offered the hepatitis B vaccine a couple of months after beginning his route. (Tr. 414). He decided to take the vaccine and was given forms to take to the provider to demonstrate that UniFirst would pay the bill. However, he never went to get the vaccine. (Tr. 415). His testimony was supported by records generated in anticipation of litigation by general manager Powell. These records demonstrate that [redacted] was hired on August 8, 2011, trained on October 25, 2011, but never signed a waiver. (Tr. 1000-02, Exs. S-42, S-43). He was laid off in February 2012. (Tr. 373).

Driver [redacted] was hired on May 19, 2011. According to Respondent’s records, his last bloodborne pathogen training was conducted on August 15, 2011. He signed a waiver on November 2, 2011. (Exs. S-20, S-42, S-43).

Records generated by Respondent reveal that many other employees either received a waiver or began receiving the vaccine well beyond the ten days from assignment and after supposedly<sup>24</sup> receiving bloodborne pathogen training. For example:

<b>Employee</b>	<b>Hire Date</b>	<b>Last Trained<sup>25</sup></b>	<b>Date: Waiver signed (W); Received Vaccine (V)<sup>26</sup>; Neither (N).</b>
<b>Route Sales Representative (RSR) - Driver</b>			
[redacted]	July 17, 2009	March 28, 2011	Nov. 10, 2011 (W)
[redacted]	Aug. 17, 2009	March 28, 2011	Nov. 10, 2011 (W)
[redacted]	May 5, 2008	March 28, 2011	Nov. 16, 2011 (W)
[redacted]	Oct. 9, 2008	March 28, 2011	Feb. 20, 2012 (W)
[redacted]	Aug. 26, 2011	Nov. 2, 2011	Dec. 5, 2011 (V)
[redacted]	July 8, 2002	March 28, 2011	Nov. 18, 2011 (V)
[redacted]	Nov. 16, 2007	March 28, 2011	Nov. 10, 2011 (W)
<b>Route Sales Supervisor (RSS) - Driver</b>			
[redacted]	Aug. 22, 2011	Oct. 25, 2011	(N)
[redacted]	July 12, 2010	Aug. 31, 2011	(N)
[redacted]	Oct. 10, 2011	Nov. 1, 2011	(N)
[redacted]	May 19, 2011	Aug. 15, 2011	Nov. 2, 2011 (W)
[redacted]	Sept. 23, 2011	Nov. 1, 2011	(N)

<sup>24</sup> As will be discussed in the next item, the evidence demonstrates that many employees never received the training they were credited for attending.

<sup>25</sup> Respondent’s records reveal that several employees also attended an earlier training session. For purposes of this item, however, I consider only the last training date.

<sup>26</sup> I note that Ex. S-20 lists vaccination dates that differ from the dates set forth in Ex. S-42. I find the dates set forth in Ex. S-42 to be more reliable and use those dates in the chart. For example, Ex. S-20 states that driver [redacted] received his first vaccination on November 15, 2011. However, he testified that he never received the vaccine. That is accurately reflected in Respondent’s generated Ex. S-42 which shows that [redacted] never received nor declined the vaccine. I give no weight to the hearsay statements on the exhibits regarding an employee’s reason for leaving employment with Respondent, prior employment, or military status. For example, Exhibit S-42 states that driver [redacted] was terminated. The credible record testimony reveals that [redacted] was laid off. (Tr. 373, 426, 429-30).

<b>Employee</b>	<b>Hire Date</b>	<b>Last Trained</b>	<b>Date: Waiver signed (W); Received Vaccine (V); Neither (N).</b>
<b>Dockworker</b>			
[redacted]	Sept. 22, 2011	Oct. 18, 2011	April 17, 2012 (W)
[redacted]	Aug. 29, 2011	Oct. 18, 2011	Dec. 16, 2011 (V)
[redacted]	Sept. 9, 2011	Oct. 18, 2011	Nov. 28, 2012 (W)

(Tr. 1000-02; Exs. S-20, S-42, S-43).

As revealed by this chart, many of Respondent’s employees neither received the vaccine nor signed a waiver. Others either signed waivers or began receiving the vaccine long after the ten days after assignment/training required by the standard.<sup>27</sup>

Respondent makes several arguments in its defense. Respondent first argues that the only evidence the Secretary presented that either dockworkers [redacted] or [redacted] were not offered the vaccination was the CSHO’s assertion that he was told that by the employees. Respondent asserts that “[s]imply because an employee did not *sign* a hepatitis B declination form until more than ten days after the date of initial assignment or upon training is not proof that they were not offered the vaccine during this time frame.” (Resp. Brief at 22)(emphasis in original). In support of its argument, Respondent notes that district service supervisor [redacted], gave a statement to the CSHO that, before the inspection, branch manager Barry gave him forms for [redacted] and [redacted] to sign, including forms regarding the hepatitis B vaccine. (Ex. S-7, p. 1-2). This was supported by Barry’s testimony that he provided the forms to district service supervisor [redacted] for the employees. (Tr. 1196-98).

What Respondent fails to point out is that [redacted] also told the CSHO that UniFirst “made us sign” the forms, but neither he nor the employees were given bloodborne pathogen training. (Ex. S-7, p. 2). This violates the requirement that employees be given bloodborne pathogen training before being offered the vaccine. Without that training employees are not capable of making an informed decision whether to receive the vaccine. Therefore, any offer to provide the vaccine to employees before training is not valid and does not satisfy the standard.

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<sup>27</sup> The evidence reveals that, after being hired, drivers underwent a four week training period where they rode with veteran drivers before being assigned their own routes. (Tr. 843-46).

Moreover, driver [redacted] testified that he was not offered the vaccine for a couple of months after being assigned his routes, in clear violation of the standard. (Tr. 414). Although he decided to receive the vaccine and, therefore, did not sign a waiver, he never actually received the vaccine. Though not laid off until February 2012, there is no evidence that Respondent made any effort to monitor whether [redacted] received the vaccine. Moreover, Respondent generated the information used in the chart above, in anticipation of this litigation. If it had any information that employees were given a valid offer of the vaccine earlier than the dates set forth in the chart it should have been produced. Without that evidence, Respondent has failed to rebut the Secretary’s evidence which establishes a *prima facie* showing that UniFirst failed to comply with the standard.

Respondent next argues that, months before signing declination forms, its employees signed a bloodborne pathogen training sign-in form that contained an offer of the vaccine. (Resp. Brief at 23). At the end of a paragraph that contains an “Abstract” of the training program, the form states that “All team partners with the potential to come in contact with bloodborne pathogens are offered the hepatitis B vaccine at no cost to the team partner.” Driver [redacted] signed a declination form on November 2, 2011, but signed the training sign-in sheet on August 15, 2011. Dockworker [redacted] signed a declination form on April 17, 2012, but signed a bloodborne pathogen training sign-in sheet on October 18, 2011. (Exs. S-25 at p. UFC 00254; S-42; S-43). Review of the training sign-in sheets suggests many problems.

First, I find that a statement that tangentially mentions that the vaccine will be offered on top of a group sign-in sheet containing the names of 18 employees hardly qualifies as informing any individual employee that they may receive the vaccine, the number of vaccines in the series, potential side-effects of the vaccine, and their right to decline it. The insufficiency of these sign-in sheets is highlighted by the testimony of branch manager Barry who was responsible for ensuring that employees signed them. Despite ostensibly being familiar with the sign-in sheets, he testified that he was unaware that employees who refused the vaccine were required to sign a declination form. (Tr. 1279).

Second, sign-in sheets were received in evidence that purportedly were signed by the employees. (Exs. S-25 and S-32). While apparently individually signed, the dates for each of the employees appear to be entered in the same hand. As will be discussed in the next citation item, this is consistent with employee statements asserting that they were told to sign training sign-in

forms without receiving the training. (Exs. S-35, S-36, S-37, S-38). These employee statements were corroborated by district service supervisor [redacted] and district service manager Wampler. (Exs. S-6 at p. 2; S-7). The unreliability of the training forms will be considered further when discussing the allegation that Respondent did not properly train its employees on bloodborne pathogens.

Finally, Respondent asserts that this citation item is barred by the six month statute of limitation set forth in section 9(c) of the Act. 29 U.S.C. §658(c).<sup>28</sup> Specifically referencing driver [redacted] and dockworker [redacted], Respondent asserts that both employees signed bloodborne pathogen training sheets containing an offer of the vaccine more than six months before issuance of the citation. Therefore, any violation occurred before the sheets were signed which, in both instances, was more than six months before issuance of the citation.<sup>29</sup>

The argument is without merit. A violation for failing to properly inform employees of their right to receive the hepatitis B vaccine free of charge is not time barred. It is a continuing violation until the employee is properly informed about the vaccine, including its potential benefits and hazards. See *Arcadian Corp.*, 20 BNA OSHC 2001, 2013 (No. 93-0628, 2004). As noted, I find that the bloodborne pathogen sign-up sheet did not constitute a valid offer such that the employees could make an informed decision on whether to take or decline the vaccine. The employees remained in the workplace exposed to the hazard.<sup>30</sup> Therefore, the violations continued beyond the date those forms were signed.

Moreover, while UniFirst attempts to focus on just two employees, the evidence establishes that many other employees were not timely provided with the information necessary to enable them to make an informed decision whether to take or decline the vaccine within six months of issuance of the citation. For example, [redacted] and [redacted] both signed the training sign-in sheet within six months of the citation. Neither of these employees either signed a waiver or began receiving the vaccine. The above chart reveals many other employees who

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<sup>28</sup> Section 9(c) states:

No citation may be issued under this section after the expiration of six months following the occurrence of any violation.

<sup>29</sup> The citation was issued on April 30, 2012.

<sup>30</sup> See generally *AKM LLC dba Volks Constructors v. Secretary of Labor*, 675 F.3d 752, 758, 763 (D.C. Cir. 2012)(failure to guard an unsafe machine and failure to provide required employee training are examples of an employer’s continuing obligations, that an employer may continue to violate, as long as employees remain exposed to the hazard).

either did not begin receiving the vaccine or did not sign waivers within 10-days after receiving bloodborne pathogen training and within six months of issuance of the citation.

The evidence establishes that Respondent failed to comply with the standard.

*Employee Access to the Violative Condition.*

Respondent’s failure to timely offer the hepatitis B vaccine deprived employees of the opportunity to take measures to protect themselves from contracting the hepatitis B virus and exposed them to a heightened possibility of contracting the disease. As noted, hepatitis B is a serious disease that, among other things, can lead to liver disease and chronic sclerosis.

*Knowledge*

The evidence also establishes that UniFirst knew, or with the exercise of reasonable diligence should have known, of the violative condition. Respondent’s BBP ECP plainly states that “all workers whose jobs involve participation in tasks or activities with exposure to blood or other body fluids to which universal precautions apply shall receive a hepatitis B vaccine.” The manual further states that “[v]accination will be given within 10 working days of initial assignment” and that “[a]nyone declining the Hepatitis B vaccine must sign a Hepatitis B Vaccine Declination Form.” (Ex. S-22 at p. 23). General manager Powell read the manual, conveyed the requirement to branch manager Barry, and incorporated the requirement into the bloodborne pathogen training video. (Ex. R-11A at 3). Powell and Barry both testified that they were unaware that OSHA required employees who refuse the vaccine to sign a declination form.<sup>31</sup> However, Respondent’s BBP ECP required as part of the training that there would be

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<sup>31</sup> Powell and Barry’s professed ignorance of the law does not provide an excuse for their failure to ensure that the biohazard bags were being used or that employees who decline the hepatitis B vaccine sign a declination form. The Commission has long held that the knowledge required to establish a violation is not directed “to the requirements of the law, but to the physical conditions which constitute a violation of [the Act].” *Froedtert Mem. Lutheran Hosp., Inc.*, 20 BNA OSHC 1500, 1509 (No. 97-1839, 2004); *Southwestern Acoustics & Specialty, Inc.*, 5 BNA OSHC 1091 (No. 12174, 1977). *Accord, e.g., Midwest Masonry, Inc.*, 19 BNA OSHC 1540, 1544 n.6 (No. 00-0322, 2001) (“[w]hether or not employers are in fact aware of each OSHA regulation and fully understand it, they are charged with this knowledge and are responsible for compliance . . . [i]t is no defense that they did not understand the reasonable interpretation of a regulation.”) quoting *Ed Taylor Constr. Co. v. OSHRC*, 938 F.2d 1265, 1272 (11th Cir. 1991)); *Phoenix Roofing, Inc.*, 17 BNA OSHC 1076 (No. 90-2148, 1995) (“[e]mployer knowledge is established by a showing of employer awareness of the physical conditions constituting the violation [-] [i]t need not . . . be shown that the employer understood or acknowledged that the physical conditions were actually hazardous”), *aff’d without published opinion*, 17 BNA OSHC 1628 (5th Cir. 1996); *Peterson Bros. Steel Erection Co.*, 16 BNA OSHC 1196 (No. 90-2304, 1993), *aff’d*, 26 F.3d 573 (5th Cir. 1994); *George C. Christopher & Sons, Inc.*, 10 BNA OSHC 1436, 1445 (No. 76-647, 1982).

“[a]n accessible copy of the regulatory text of this standard and an explanation of its contents.” (Tr. 992-93, 1279; Ex. S-22 at p. 18). This demonstrates that the failure to impress the importance of the vaccine upon its management personnel was endemic at UniFirst.

**Citation 2 – Item 3(a): Alleged Willful - Serious Violation of 29 CFR § 1910.1030(g)(2)(ii)(A) and Item 3(b): Alleged Willful - Serious Violation of 29 CFR § 1910.1030(g)(2)(iv)**

Items 3(a) and (b) of citation 2 allege that, on or about November 3, 2011, Respondent (a) did not provide any bloodborne pathogens training to drivers and warehouse dockworkers who Respondent determined had occupational exposure to bloodborne pathogens as required by 29 CFR § 1910.1030(g)(2)(ii)(A); and (b) did not provide annual bloodborne pathogens training, within one year of their previous training, to drivers who Respondent determined had occupational exposure to bloodborne pathogens, as required by 29 CFR § 1910.1030(g)(2)(iv).

Section 29 CFR § 1910.1030(g)(2)(ii)(A) provides:

Bloodborne pathogens. Training shall be provided as follows: At the time of initial assignment to tasks where occupational exposure may take place.

Section 29 CFR § 1910.1030(g)(2)(iv) provides:

Bloodborne pathogens. Training shall be provided as follows: Annual training for all employees shall be provided within one year of their previous training.

*Applicability of the standard*

The standards require that initial and, thereafter, annual bloodborne pathogen training be provided to employees where occupational exposure may take place. As previously discussed, the Secretary has established the Respondent’s drivers and dockworkers at its West Caldwell facility were occupationally exposed to bloodborne pathogens. The standard applies.

*Compliance with the terms of the standard*

Respondent asserts that it provides bloodborne pathogen training to its employees. The training is given after the employee finishes an apprenticeship where he rides with a veteran

driver, but before he actually begins his own routes. (Tr. 843-46). Training consists of employees watching a video and then taking a test. After the test, employees are given an opportunity to ask questions of the instructor. Employees then sign an attendance sheet which is signed by the instructor. (Tr. 845-46, 998, 1075, 1165-66). The instructor is not required to watch the video with the employees. (Tr. 1079).

The evidence does not support Respondent’s assertions.

Drivers [redacted] and [redacted] testified that they were not given bloodborne pathogen training in 2011. (Tr. 89-90, 420). However, both employees signed forms stating that they were given training. (Exs. S-31, S-32, S-34, S-49, S-50) The testimony of [redacted] and [redacted] was supported by CSHO Vargas who testified that all the employees he interviewed told him that they were asked to sign training documents without actually being trained. (Tr. 316). For example, dockworker [redacted] (Ex. S-35, p.2), district service supervisor [redacted] (Ex. S-7, p.2), drivers [redacted] (Ex. S-36) and [redacted] (Ex. R-38) all gave statements to the CSHO that they did not receive the training even though they signed forms stating that they had received training. (Tr. 317-18, 324). Driver [redacted] stated that he received training in 2010, but said nothing about receiving training in 2011 (Tr. 467, Ex. S-38). Similarly, driver [redacted] stated only that he received training in 2009. He was not directly asked whether he received training in 2011. (Tr. 460-61; Ex. S-37 at p. 00269-270).

CSHO Vargas produced a statement given to him and signed by district service manager Kevin Wampler. The statement was read into the record by the CSHO, as follows:<sup>32</sup>

When Marc [the CSHO] asked me if I gave employees training documents--- training docs to sign, such as bloodborne pathogen and EAP docs, EAP refers to emergency action plan, without providing the employees with the actual training, I said yes, I did. When Marc asked me why, I said I was told to do it by my boss, the branch manager, Ryan Barry. When Marc asked which documents Ryan gave me to have employees to sign without the actual, comma, it was bloodborne pathogens, heat stress, EAP, slash, fire safety and soiled wipers. I told Ryan I didn’t feel comfortable doing it. He said they can watch the video at a later time. When Marc asked me if it is reasonable to presume that, if the OSHA inspection was not initiated, that the employees never would have seen the videos, I said yes. . . . . When I had them sign it, I said there were videos available to the employee. When Marc asked me if this is falsification of documents, in my opinion it is.

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<sup>32</sup> The statement was in the hand of the CSHO and is difficult to read. However, I find the CSHO’S reading of the statement consistent with the written statement.

Addendum:

When Marc asked me if I told anyone above Ryan in the chain of command, I said yes. I told the GM Rich Powell. He didn't say much except I'll look into it, that was after the OSHA inspection on November.

(Tr. 332-34; Ex. S-6, p.2)

District service manager Wampler testified that he was very busy and did not read his statement. Rather, he just signed it and was told that by doing so, he was agreeing that the statement was accurate. (Tr. 1105-06). Wampler denied telling the CSHO that, if not for the OSHA inspection, employees would not have been given bloodborne pathogen training. (Tr. 1119). However, he admitted that branch manager Barry asked him to give training documents to employees to sign when training was not provided. (Tr. 1108) Barry instructed Wampler to get the employees trained as soon as possible. (Tr. 1110-12). Barry specifically asked Wampler to train [redacted], [redacted], [redacted], [redacted], [redacted], [redacted] and, perhaps, one or two others. Branch manager Barry explained to him that the conference room was open where employees could sign-in, go in, watch the video, and take the test at the end. (Tr. 1077). Wampler did not watch the video with the employees and was not sure if all the employees actually watched the video. (Tr. 1080) He did witness several employees watch the video, while others told him they watched it. (Tr. 1078). Before the inspection, Wampler did not know the consequences for an employee who failed to watch the video. He just knew that they should watch it and assumed that everybody did. (Tr. 1080).

Branch manager Barry testified that he only conducted training himself one time. He then assigned the task to his management team, including district service manager Wampler. Each manager was responsible for the training of his or her employees. (Tr. 1184-85). The team was instructed to ensure that the employees were trained and that they signed the training sheets. (Tr. 1186, 1189). Barry did not recall Wampler telling him that he was uncomfortable because he was not sure that certain employees who signed the training sheets actually received the training. Had Wampler come to him with that concern, Barry would have retrained those employees that day. He denied ever telling Wampler to just get the training sheets signed. (Tr. 1190-91). He assumed that the training was done because he received the training sheets. (Tr. 1198).

In most cases, the actual instructors did not sign the sheets. (Tr. 1265). When Barry received the training sheets, he signed them as the instructor, even though he did not conduct the

training and provided no instruction. (Tr. 1193, 1256; Ex. S-25) Though he signed as an instructor, in his mind he was merely approving the signed sheets as the branch manager and certifying that the training had been accomplished. (Tr. 1192-93, 1263). Once he signed the training sheets, Barry had them sent to the Croydon branch where the sheets were entered into the corporate system by the office administrator Maryann Troutman. (Tr. 1191-92).

At the hearing the Secretary disclosed several inconsistencies with the training sign-in sheets. Barry agreed that employees should sign the sheets after receiving training and before the sheets were signed by the instructor. (Tr. 1260). Although Barry testified that employees signed the training sheets upon completion of the training he was shown sheets signed by employees several days after the training supposedly took place. He was first shown the sign-in sheet for the training that took place on March 28, 2011. Barry signed the sheet as the instructor on that same day. Yet, [redacted] dated his signature as March 30, 2011. (Tr. 1263; Ex. S-25 at p. 00245). Barry speculated that [redacted] merely got the date wrong. (Tr. 1263). It was then pointed out that [redacted] also dated his signature as March 30, 2011 and [redacted] dated his signature as April 1, 2011. (Tr. 1263-1264; Ex. S-25 at p. 00245-246). Barry offered no additional explanation why, contrary to Respondent’s policy, these employees apparently signed the sheets after Barry certified that the training took place.

Another inconsistency with Barry’s testimony involves driver [redacted]. [redacted] testified that he signed a lot of forms that were placed in front of him. (Tr. 55, 94). He stopped reading the documents and just signed them. (Tr. 133-34). Several of the documents were bloodborne pathogen training forms. (Ex. S-31, S-49, S-50). However, he testified that he was never given the training. (Tr. 89-90). At the hearing, Barry was asked if he found it unusual that the training forms indicate that driver [redacted] was trained in June 2011 and again in August 2011, two months apart. (Exs. S-31, S-49). Barry agreed that he approved the forms and noted that he wouldn’t have noticed it because the forms listed so many employees. (Tr. 1273). The Secretary then produced a training sheet signed by [redacted] on November 2, 2011. (Ex. S-50). Therefore, while the regulation requires initial training and annual training thereafter, [redacted] signed forms indicating that he was trained three times in less than five months. Branch manager Barry could only agree that if he realized this had occurred, he would have found it odd. (Tr. 1270-75).

Finally, in response to the inspection, Respondent had documents prepared summarizing the training received by employees. (Ex. S-44)<sup>33</sup> In preparing these summaries, general manager Powell and office administrator Troutman interviewed the employees to ensure that they received the training and signed the documents. (Tr. 1008-09). Several employee summaries have handwritten notations from Troutman stating that the employee asserted that the signature on the document did not belong to him or that the employee was not sure that the signature was his.<sup>34</sup>

Based on the preponderance of the evidence, I find that the Secretary has established that UniFirst failed to (a) provide timely initial training in bloodborne pathogens to employees exposed to potential contact with bloodborne pathogens and (2) failed to provide annual refresher training to those employees. The evidence demonstrates that the sign-in sheets were frequently falsified and provided an unreliable record of which employees and when employees received the requisite training. Employees who signed the sheets either testified at the hearing or gave statements to the CSHO that they did not receive the training. Several employees signed the sheets *after* branch manager Barry signed the sheets to certify that the employees who signed the sheets received the training. The legitimacy of the sheets was further undermined by driver [redacted] having signed training sheets three times within a five month period. Other sign-in sheets were signed by someone other than the employee who supposedly received the training.<sup>35</sup>

Indeed, the entire training regimen was based on an honor system. Employees were told that the conference room was open and that they could go in and watch the video. They were supposed to sign in, watch the video, and take the test. District service manager Wampler saw several employees watching the video. Others told him that they viewed it. (Tr. 1078).

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<sup>33</sup> These documents were originally offered as Respondent’s Ex. R-18. At the hearing the exhibit was redesignated as Ex. S-44. (Tr. 1012).

<sup>34</sup> [redacted]’s sheet states that the signature for the Sept. 19, 2011 medical/healthcare training was not his, but was the signature of “Kevin” (Wampler); [redacted] states that he came in late for the Oct. 18, 2011 bloodborne pathogen training and did not watch the video; [redacted] states that he did not sign the March 2, 2010 bloodborne pathogen training sheet, and was not sure if he signed the March 28, 2011 sheet (he was not sure about the veracity of his signature for several other non-bloodborne pathogen training sessions. (Ex. S-44).

<sup>35</sup> Respondent argues that the CSHO did not remember whether driver [redacted] ever told him whether he received training in 2011. (Tr. 545). Also, when writing driver [redacted]’s statement, the CSHO did not ask whether he received training in 2011. (Tr. 461-62). The fact that [redacted] and [redacted] did not specifically state or were not specifically asked about their training in 2011 does not alter the inadequacy of Respondent’s training program or the evident failure of other employees to receive the training for which they signed.

Nonetheless, he was aware of the likelihood that employees who signed the sheets did not complete the training. (Tr. 1111). As noted, the preponderance of the evidence demonstrates that it was a practice at West Caldwell to have employees sign for training they did not receive. Even district service manager Wampler who testified that he never received training on recordkeeping and posting, admitted that he signed a training sheet indicating that he received that training on March 29, 2011. (Tr. 1123; Ex. S-45).

Moreover, the evidence demonstrates that whatever training was given was not compliant with the standard. One of the elements of bloodborne pathogen training is the opportunity for questions and answers. At the hearing, branch manager Barry acknowledged the importance of the question and answer session and agreed that a manager should be available to answer questions as part of the training. (Tr. 1247, 1258). Yet, he could not remember whether he communicated the question and answer component of training to his district service managers. (Tr. 1256). Indeed, Wampler testified that Barry did not tell him what the training entailed. Barry just told him to have the employees watch the video and take a test. (Tr. 1137).

District service manager Wampler testified that, although he signed the training sheet, he never received any training on how to train. (Tr. 1123-24). Wampler’s initial training, in March 2010, consisted only of seeing the video and taking the test. (Tr. 1128). He was not aware of any other components to the training apart from the video. (Tr. 1128). He also was given bloodborne pathogen training in March and June 2011. (Tr. 1128). In both instances, Wampler only watched the video and took the test. (Tr. 1130). He did not even know that bloodborne pathogen training was required under OSHA regulations. (Tr. 1152-53).

General manager Powell testified that he expected the instructor to be in possession of the Facilitator’s Guide. (Tr. 986). However, Wampler never saw either UniFirst’s BBP ECP or the Facilitator’s Guide.<sup>36</sup> (Tr. 1125-27; Exs. S-17, S-22). Therefore, even if given the opportunity to answer questions, it is unlikely that he had received the background to provide knowledgeable answers. Similarly, Barry testified that he was not provided with a copy of either the BBP ECP or the Guide until after the inspection. (Tr. 1245-46).<sup>37</sup>

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<sup>36</sup> This Guide goes through the steps that an instructor must take when conducting the training. It includes a list of issues to emphasize, discussion points, and questions to ask after watching the video. It was supposed to be provided by UniFirst to its managers to provide bloodborne pathogen training to their employees. (Tr. 242).

<sup>37</sup> CSHO Vargas testified that he was told by Barry that he received the Facilitator’s Guide. (Tr. 294) I have reviewed branch manager Barry’s statement given to the CSHO, and find no reference to the Facilitator’s Guide.

Respondent next argues that, even if employees were not given specific bloodborne pathogen training, the evidence establishes that group training was conducted in September and October 2011 for medical healthcare accounts. (Resp. Brief at 25-26). Sign-in sheets for this training were put in evidence for drivers [redacted], [redacted], [redacted] and [redacted], and for district service supervisor [redacted]. (Ex. R-14). Thus Respondent contends, five of the six employees cited by the CSHO as not having received bloodborne pathogen training did receive training in bloodborne pathogens via the medical healthcare account training by the start of the inspection. The sixth employee, dockworker [redacted], did not receive medical healthcare account training until January 4, 2012. (Ex. R-14). Furthermore, all RSR drivers were given on-the-job training in bloodborne pathogens before they were assigned to their own routes. General manager Powell testified that an RSR trainee would observe the RSR trainer service accounts and demonstrate how the accounts are to be properly serviced. This on-the-job training lasted about four weeks. (Tr. 841-42) Branch manager Barry testified that he expected any RSR would train a new hire on how to perform his duties at a bloodborne pathogen account, including how to wear PPE correctly (Tr. 1188-89). Respondent contends that the Secretary offered no rebuttal evidence that new employees did not receive this training or that it was not materially compliant with the bloodborne pathogens regulations. (Resp. Brief at 25-26).

Again, Respondent’s arguments are not persuasive. First, UniFirst erroneously tries to place the burden on the Secretary to establish that the on-the-job training was equivalent to the bloodborne pathogen training required by the standard. If Respondent asserts that its on-the-job training was a viable alternative to a formal bloodborne pathogen training program, the burden was on UniFirst to establish equivalency. In *Trinity Industries, Inc.*, 15 BNA OSHC 1579, \*11, *aff’d in pertinent part*, 16 F.3d 1149 (11<sup>th</sup> Cir. 1994), the Secretary established a prima facie violation of the hearing monitoring standard. The Commission found that the burden then shifted to the employer to rebut the Secretary’s showing. It affirmed the citation item noting that, while the employer had an alternative monitoring regimen, it failed to establish that the monitoring it conducted fulfilled the requirements of the standard.

Here, the Respondent failed to establish that either its on-the-job training program or its health care account training was the functional equivalent of the bloodborne pathogen training

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On this point, I credit Barry’s testimony that he never received a copy of the Guide before the inspection over the recollection of the CSHO. (Ex. S-4).

program required by the standard. A compliant bloodborne pathogen training program is required at 29 CFR §1 910.1030(g)(2)(vii)(A)-(N) to contain at a minimum the following elements:

- A. An accessible copy of the regulatory text of this standard and an explanation of its contents;
- B. A general explanation of the epidemiology and symptoms of bloodborne diseases;
- C. An explanation of the modes of transmission of bloodborne pathogens;
- D. An explanation of the employer’s exposure control plan and the means by which the employee can obtain a copy of the written plan;
- E. An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials;
- F. An explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, work practices, and personal protective equipment;
- G. Information on the types, proper use, location, removal, handling, decontamination and disposal of personal protective equipment;
- H. An explanation of the basis for selection of personal protective equipment;
- I. Information on the hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge;
- J. Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials;
- K. An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available;
- L. Information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident;
- M. An explanation of the signs and labels and/or color coding required by paragraph (g)(1); and
- N. An opportunity for interactive questions and answers with the person conducting the training session.

Additionally, 29 CFR § 1910.1030(g)(2)(viii) requires that:

The person conducting the training shall be knowledgeable in the subject matter covered by the elements contained in the training program as it relates to the workplace that the training will address.

UniFirst failed to demonstrate that either the on-the-job or health care accounts training included any of these elements. Testimony of Barry and Powell that the trainees would observe how to properly service the bloodborne pathogen accounts is of little value. Although the evidence clearly establishes that the Quest and LabCorp accounts potentially exposed employees

to bloodborne pathogens, it also demonstrates that RSR drivers were not consistently using biohazard bags or wearing personal protective equipment gloves when serving these accounts. Nor is there any evidence that, as part of the training, the RSR drivers would, for example, make available a copy of the regulatory text, provide the requisite information regarding the hepatitis B vaccine, provide information on appropriate actions to take and persons to contact in an emergency involving bloodborne pathogens, explain the epidemiology of bloodborne infections and the modes of transmission of bloodborne diseases.

One of the critical elements of an adequate training program is an opportunity for interactive questions and answers. Given the unreliable and incomplete record of employee training, there is nothing in the record to establish that the RSR drivers were knowledgeable in the subject matter covered by this “alternative” training program or were qualified to field trainee questions regarding bloodborne pathogens. Moreover, the standard requires that the trainee be provided with an explanation of the employer’s exposure control plan and the means by which the employee can obtain a copy of the written plan. Both branch manager Barry and district service manager Wampler were not familiar with either Respondent’s BBP ECP or the Facilitator’s Guide. Since they were responsible for training the RSRs, it is not credible to conclude that these RSRs either knew about the Manual or Guide or how to obtain a copy of either.

#### *Employee Access to the Violative Condition.*

Respondent’s failure to timely provide its employees with the required bloodborne pathogen training deprived the employees of the knowledge necessary to protect themselves in the event of exposure to bloodborne pathogens. As noted, exposure to bloodborne pathogens can result in serious life threatening diseases, including hepatitis B and HIV. Accordingly, the evidence establishes that employees were exposed to the hazard inherent in Respondent’s failure to provide adequate bloodborne pathogen training.

#### *Knowledge*

The evidence establishes that Respondent knew that its employees were not getting the required bloodborne pathogen training. Branch manager Barry, who was trained in how to provide the training, instructed his subordinates only to make the video available to employees

and have them take a test. No effort was made to ensure that these “instructors” knew either that they were supposed to conduct a question and answer session or that these “instructors” had the knowledge to effectively conduct such a session. Barry knew that he was signing the training forms as the instructor, even though he admitted that he did not administer any training. Barry also knew that he certified that employees received the training before the employees signed the training sheets. He also instructed his subordinates to have the employees sign the forms and administer the training later. There is no evidence that Barry ever conducted a follow-up to ensure that those employees were, in fact, subsequently trained. Barry was also responsible for having employees sign the training sheets, even though he knew employees did not receive the training.

Respondent argues that general manager Powell testified that in June 2012 he asked each employee if they received training on the date they signed the training form. Each employee, except for [redacted], answered that they received the training. (Tr. 905-06). Therefore, even if there is evidence that employees were not trained, there is no evidence that the managers were aware of any failure. (Resp. Brief at 24-25). I am not persuaded.

As general manager Powell was the corporate official responsible for compliance with the bloodborne pathogen training program. (Tr. 768, 772, 958, Ex. S-22 at p.8). Powell reviewed the records in June 2012, approximately eight months after district service manager Wampler informed him that several employees may not have been trained. The evidence further demonstrates that prior to June 2012, Powell never reviewed the training sign-in sheets. Rather, branch manager Barry testified that he sent the sheets to Croydon office administrator Maryann Troutman who entered the sheets into “the system.” (Tr. 1191-92). Had Powell been reasonably diligent he would have reviewed the sheets and discovered the aforementioned inconsistencies which would have alerted him to the fact that employees were not being trained. He should have been aware of the lack of qualifications of the managers charged with conducting bloodborne pathogen training, that the training sign-in sheets were being falsified, and that employees were not being properly trained.

Accordingly, I find that the Secretary established that Respondent failed to provide initial and yearly bloodborne pathogen training as alleged in citation 2, items 3(a) and 3(b).

## Willfulness

Finally, the Secretary alleges that the three items in citation 2 were willful.

A willful violation is one “committed with intentional, knowing or voluntary disregard for the requirements of the Act or with plain indifference to employee safety. *Valdak Corp.*, 17 BNA OSHC 1135, 1136 (No. 93-239, 1995), 73 F.3d 1466 (8<sup>th</sup> Cir. 1996). The Secretary must differentiate a willful from a serious violation by showing that the employer had a heightened awareness of the illegality of the violative conduct or conditions, and by demonstrating that the employer consciously disregarded OSHA regulations, or was plainly indifferent to the safety of its employees. *Valdak Corp.*, 17 BNA OSHC at 1136. The Secretary must show that, at the time of the violative act, the employer was actually aware that the act was unlawful, or that it possessed a state of mind such that if it were informed of the standard, it would not care. *Propellex Corp.*, 18 BNA OSHC 1677, 1684 (No. 96-0265, 1999). Willfulness is negated by evidence that the employer had a good faith opinion that the conditions in its workplace conformed to OSHA requirements. *E.g., Calang Corp.*, 14 BNA OSHC 1789, 1791 (No. 85-319, 1990). “The test of good faith is an objective one, i.e., whether the employer’s belief concerning the factual matters in question was reasonable under all of the circumstances. In other words, the employer’s belief must have been ‘nonfrivolous.’” *Morrison-Knudson*, 16 BNA OSHC 1105, 1123-1124 (No. 88-572, 1993). *See Secretary v. Union Oil*, 869 F.2d 1039, 1047 (7<sup>th</sup> Cir. 1989).

Relevant to all three items, Respondent contends that the violations were not willful because it had a good faith and reasonable belief that employees at West Caldwell were not exposed to bloodborne pathogens and, therefore, that the bloodborne pathogen standards were not applicable.

Respondent asserts that UniFirst management reasonably believed that no employee would come into contact with bloodborne pathogens in a manner that would trigger applicability of the bloodborne pathogen standards. The only facilities serviced at West Caldwell that drew blood were small Quest facilities and it was the understanding of UniFirst’s managers that Quest destroyed any contaminated garment. Moreover, nobody at UniFirst heard of Quest destroying a lab coat, which further reinforced its belief that the likelihood of a Quest facility exposing a UniFirst RSR driver to a contaminated lab coat was virtually zero. Therefore, UniFirst asserts, it was reasonable that the management at West Caldwell believed that the regulations pertaining to engineering controls, training and the vaccine were a corporate requirement, not a legal one.

Respondent also asserts that any inadequacy in its implementation of the corporate bloodborne pathogen program by West Caldwell management cannot form the basis of a willful violation. It contends that because West Caldwell employees were not exposed to bloodborne pathogens, application of the bloodborne pathogen program went above the requirements of the OSHA standard. To find the violation to be willful under these circumstances would only penalize it for attempting to provide a level of safety beyond OSHA requirements. (Resp. Brief at 28-30).

The key to these arguments is whether Respondent’s belief was reasonable that its employees were not exposed to bloodborne pathogens. As Respondent points out, a violation is not willful if the employer had a good faith opinion that the violative conditions conformed to the requirements of the cited standard. As noted, the test of an employer's good faith for these purposes is an objective one -- whether the employer's belief concerning a factual matter or concerning the interpretation of a standard was reasonable under the circumstances.

Respondent’s assertion that it could not have reasonably anticipated that employees at West Caldwell would be exposed to bloodborne pathogens was not reasonable under the circumstances. Respondent knew that the Quest facilities drew blood. As such they were health care accounts. In March 2010, UniFirst began a push to acquire such accounts, many of which were serviced from West Caldwell. Respondent’s own National Account Profile for Quest unequivocally states that:

Each UniFirst Customer Service Center must process all Quest Diagnostics coats and other applicable rented items according to Universal Precautions guidelines as published by OSHA under Part 1910.1030, subpart Z, with respects to Bloodborne Pathogens.

(Ex. S-15, p.1).

Similarly, the National Account Customer Profile for LabCorp states:

*Blood Bourne Pathogens.* Caution....laundered items *could contain* Blood Bourne Pathogens. You must follow all regulation for handling such garments including but not limited to universal precaution procedures.

Ex. S-15, p. UFC 00075 ¶3. (emphasis added).

Nothing in the profile suggests that those precautions should not be taken because of the size of the Quest facility or whether Quest destroys contaminated laundry on its own premises. As noted, Respondent produced no credible evidence either that the policy actually existed or, even if it does exist, the scope of the policy, Quest enforcement policies, and whether the policy applies to contaminated or only “blood soaked” garments. Certainly, there is nothing in that policy that might prevent other contaminating agents, such as sharps, from being in the laundry. Also, as noted Respondent’s reliance on this purported Quest policy constitutes an improper attempt to shift responsibility for the safety of its employees to a third party. *Brock v. City Well Serv.*, 795 F.2d at 512; *Baker Tank Co.*, 17 BNA OSHC at 1180. West Caldwell also serviced a LabCorp facility that also handled blood. Respondent does not assert that LabCorp had a program requiring that LabCorp destroy contaminated laundry. Therefore, any reliance on the purported Quest policy to protect UniFirst employees from potential contact with bloodborne pathogens was unreasonable.

Respondent’s assertions assume that it did not encounter any contaminated garments at West Caldwell from rollout of the bloodborne protection program in March 2010 until the date of the inspection; therefore, Respondent had no reasonable expectation that such exposure would occur. However, as discussed above, the credible evidence reveals some evidence of blood stained garments and a sharp at West Caldwell.

The purpose of the Act is to prevent the first accident. *Lee Way Motor Freight, Inc. v. Secretary*, 511 F.2d 864, 870 (10<sup>th</sup> Cir. 1975); *Elliot Constr. Corp.*, 23 BNA OSHC 2110, 2119 (No. 07-1578, 2012). Respondent’s theory supposes that it was reasonable to believe that its employees could go along without the protections afforded to them under the bloodborne pathogen standard until an incident exposed them to bloodborne pathogens and the potential of serious bodily harm. West Caldwell management knew it serviced clients that drew and tested blood. They knew that such activities could result in contaminated laundry. They knew that their employees handled dirty laundry generated from these facilities. Under the totality of the circumstances, I find that its assertion that there was no reasonable expectation that employees would handle contaminated laundry to be unreasonable.

Having concluded that UniFirst could not have reasonably believed that the bloodborne pathogen standard did not apply to West Caldwell, I next explore the alleged willfulness of the

individual items. Because it forms the foundation for the willfulness of the other items, I begin by analyzing the characterization of citation 2, items 3(a) and 3(b), the training violations.

1. *Citation 2 – Item 3(a): 29 CFR § 1910.1030(g)(2)(ii)(A) and Item 3(b): CFR § 1910.1030(g)(2)(iv); Failure to Provide Initial and Annual Bloodborne Pathogen Training.*

The evidence established that Respondent willfully failed to train employees as required by the bloodborne pathogen standard. Its management routinely and intentionally falsified training sign-in sheets. West Caldwell managers intentionally required employees to sign training sign-in sheets without receiving the actual training. The sheets were certified by branch manager Barry who conducted no training and had no first-hand knowledge that the employees actually attended the training. In some instances employee signatures were forged. The training that did occur was conducted by managers who were not competent to conduct the question and answer sessions required for adequate training. These actions demonstrate a complete abdication of any responsibility to ensure employee training and establish that the violation was willful.

Respondent’s denial of irregularities with the sign-in sheets was refuted by the credited testimony of drivers [redacted] and [redacted] and the statements of drivers [redacted], [redacted], and [redacted], dockworker [redacted], district service supervisor [redacted], and district manager Wampler. Notably, not a single employee testified on Respondent’s behalf. Further undermining Respondent’s denials were the handwritten notes taken by office administrator Troutman during June 7, 2012 employee interviews that indicate several of the employee signatures on training sign-in sheets were made by someone else. Moreover, Respondent could not explain why driver [redacted] signed three sign-in sheets over a five-month period. This is strong support for [redacted]’s testimony that he was not trained, but was compelled to sign the training sheets and other documents that were placed in front of him by management.

Branch manager Barry signed bloodborne pathogen training sign-in sheets as the “instructor” in 2011 despite never serving as the instructor. The managers actually assigned to conduct the training did not sign the sheets. Although Barry attempted to justify his actions by stating that he was just approving that the training was performed, he conceded that he assumed, but did not actually know whether the training was had been conducted. (Tr. 1198, 1262-63).

Also, despite Barry’s testimony that the instructor is supposed to sign the training sheet only after the employee signs the sheet, he routinely signed the sheets before the employees were purportedly trained. Despite these irregularities in the sign-in sheets, no one at Croydon questioned these practices. To the contrary, general manager Powell admitted that, despite being responsible for training at West Caldwell, he did not examine any of the training forms as they arrived at Croydon. Rather, they went directly to Troutman for entry into UniFirst’s system. (Tr. 982).

UniFirst also failed to properly train its “instructors” regarding how to conduct bloodborne pathogen training. Barry attended bloodborne pathogen training multiple times. (Tr. 1167, 1247, Ex. S-25). He knew that the training was supposed to be interactive and, required a live instructor who would hold a question and answer session. He attended the June 18, 2010 training, which incorporated a question and answer session. (Tr. 1166-69). Barry acknowledged the importance of a question and answer session and conceded that a manager should be available to answer questions as part of the training. (Tr. 1247, 1258). Yet, district service managers Wampler and Correa were not instructed on how to conduct bloodborne pathogen training. Rather, the first time Wampler received bloodborne pathogen training, Barry only showed him where he could watch the video and nothing more. (Tr. 1123-24, 1127-28, 1248).

UniFirst asserts that management was unaware that its employees were not completing their training. It argues that Wampler’s failure to observe employees to ensure that they completed watching the videos was the result of a misunderstanding. Wampler did not believe that he was required to monitor the employees, but assumed that employees would complete the videos based on his directive. Barry relied on Wampler to have the employees complete watching the videos and assumed that the training was completed when he signed the bloodborne pathogen sign-in sheets. Respondent asserts that when the company realized that the bloodborne training requirement was not fulfilled, it took immediate steps to re-administer the training. Respondent also explains that Wampler’s failure to follow up to ensure that the training was completed was largely driven by his belief that there was no possibility that employees would come in contact with a needle or a blood contaminated garment and did not think that the

bloodborne pathogen standard applied.<sup>38</sup> Thus, at most, his failures were the result of negligence, not willfulness.

Respondent’s attempt to place the blame for the failure to provide and properly document appropriate bloodborne pathogen training onto the shoulders of district service manager Wampler is disingenuous. The evidence demonstrates that UniFirst failed to provide training to Wampler sufficient to inform him of his obligations as an instructor. It now attempts to bootstrap that failure and blame Wampler for not fulfilling those obligations. Moreover, any failures by Wampler do not exculpate Barry who was complicit in falsifying the training sign-in sheets.

Respondent next asserts that branch manager Barry was unaware that the bloodborne pathogen training was not being completed. Barry told district service supervisor [redacted] to train dockworkers [redacted],[redacted] and [redacted] in late 2011. In front of the employees, [redacted] returned with the signed training sheets. Barry logically assumed that the training had been done. Respondent argues that Barry’s failure to verify the quality of the training was not due to any disregard for the Act or indifference to employee safety, but rather in a misplaced confidence that training was occurring. *See Froedtert Memorial Lutheran Hospital, Inc.*, 1999 WL 503823, at \*18 (No. 97-1839, 2002), *aff’d* 20 BNA OSHC 1500 (2004).

Respondent’s reliance on *Froedtert Memorial Lutheran Hospital, Inc.* is misplaced. In *Froedtert*, the Judge found a training violation to be nonwillful because the company believed, in good faith, that personnel agencies were responsible for, and were providing the required training. It also attempted to provide site-specific training through the use of a buddy system where more experienced employees showed temporary workers the ropes. Finally, a high turnover of directors at the hospital demonstrated that the failure to pay attention to training was the result of negligence rather than a disregard for employee safety.

Here, UniFirst’s asserted belief that the bloodborne pathogen standard did not apply to West Caldwell was not held in good faith. The preponderance of the evidence demonstrates that the company knew that the standard applied, resulting in adoption of the company’s rollout of the bloodborne pathogen program in March 2010. Its management, from general manager Powell to branch manager Barry, failed to take adequate measures to ensure that the training program

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<sup>38</sup> As discussed above, district service manager Wampler and branch manager Barry acknowledged during their testimony that there was a need for biohazard bags and the possibility of drivers encountering contaminated garments at Quest accounts. (Tr. 1046-48, 1062-63, 1170-71, 1174-76).

was being implemented. To the contrary, Barry utterly failed to stop and, in many instances, was complicit in creating the irregularities in the sign-in sheets. He signed the sheets as the instructor even though he had no first-hand knowledge that the training was actually provided. Other times he certified the sign-in sheets before the employees signed them. Employee signatures on other sheets were forged. Also, as discussed above, the on-the-job training provided was utterly insufficient to satisfy the requirements of a valid bloodborne pathogen training program. There is no reason to conclude that Respondent could reasonably have thought differently. UniFirst seeks to place part of the blame for any failure in its training program on Hurricane Irene that devastated the region in late August 2011. (Resp. Brief at 6 n.7; Sec. Brief at 83 n.26; Tr. 919). However, the failures in the training program long preceded the hurricane, were endemic at West Caldwell, and demonstrated a plain indifference to employee safety.

Also without merit is Respondent’s contention that branch manager Barry failed to fully implement the training program, because he did not know it was an OSHA requirement. Rather, Barry believed that the training was only a requirement imposed by the company. Barry was not alone in claiming ignorance of the OSHA standards. Rather, both he and general manager Powell asserted that they did not know of the OSHA requirements until the OSHA inspection. However, Powell was aware of both the BBP ECP and the Facilitator’s Guide, both of which reference the OSHA standards. Powell also trained Barry. If Powell was unaware that UniFirst’s bloodborne pathogen program was required by OSHA, he failed to read either of these documents. This, too, displays indifference to employee safety.

Moreover, if Barry did not know that bloodborne pathogen training was a legal requirement, he knew that it was a corporate requirement. Nonetheless, Barry thought nothing of disregarding the corporate requirements and there is nothing in the record to suggest that he would have acted any differently had he known that bloodborne pathogen training was also a legal requirement. When he delegated his responsibility to district service manager Wampler, Barry told him only to make the video available to employees and have them sign the training sheets. Management at West Caldwell routinely falsified the training sign-in sheets. Barry knew that employees signed the sheets without receiving the training and excused it on the grounds that the employees would receive training later. He signed the sheets acknowledging that employees received the training before they were signed by the employees and without any first-hand knowledge that employees received the training. Employee signatures on other training

sign-in sheets were forged. This total disregard for the corporate requirements demonstrates that Barry possessed a state of mind such that if he were informed of the standard, he would not have cared. *Propellex Corp.*, 18 BNA OSHC at 1684.

This case is distinguished from *Greenleaf Motor Express, Inc.*, 21 BNA OSHC 1872 (No. 03-1305, 2007) *aff'd* 262 Fed. Appx. 716 (6<sup>th</sup> Cir. 2008). In *Greenleaf*, the employer falsified air monitoring results. Nonetheless, the Commission found a confined space violation to be nonwillful because the employer had only constructive, rather than actual knowledge that the standard applied. While the supervisor knew that he was violating company policy, there was no basis to conclude that the noncompliance demonstrated a conscious disregard of its statutory obligations. In dissent, Commissioner Rogers conceded that Greenleaf did not have actual knowledge of the violative condition, but concluded that the falsification of the atmospheric testing reports logically lead to an inference that even if the employer knew the standard applied, it would not care, thus sustaining a willful characterization.

Unlike *Greenleaf*, UniFirst did not have a good faith belief that the standard did not apply. To the contrary, the preponderance of the evidence establishes that UniFirst knew that the standard applied at West Caldwell when it began taking on medical health accounts. UniFirst's BBP ECP and Facilitator's Guide clearly indicated that the bloodborne pathogen program was based on OSHA requirements. These documents were supposed to be available to both Powell and Barry. Moreover, Powell was responsible for training Barry. Yet, Barry never received a copy of either the BBP ECP or the Facilitator's Guide. When considered in conjunction with the irregularities in the training sign-in sheets, I conclude that even if the management at West Caldwell, including Powell, knew that the standard applied, it would not care.

Respondent's failure to properly implement the training standard was not the result of any single failure. Rather, it was the final link in a chain that included inadequate instructor training, unmonitored employee training, and falsified training documents. Beginning with general manager Powell, who abdicated his responsibility to ensure that the instructors were themselves properly trained and failed to monitor the proper administration of the training program, to branch manager Barry who designated district service managers Wampler and Correa as instructors without providing them with any preparation or understanding of what was required, this series of failures demonstrates a plain indifference to both the Act and employee safety.

The Secretary proposed a combined penalty of \$55,000.00 for the two violations. The CSHO explained that employees who are not properly trained will not know how to protect themselves from the hazard of occupational exposure to blood or needle sticks and will not understand the need to immediately report any exposure incident and immediately get to a physician to be treated and evaluated. He considered the violation to serious and of high gravity because of the risk of death from infection by either hepatitis B or HIV. He also considered the probability of an incident to be lesser. No credit was given for size, history or good faith. (Tr. 343-44). I find that the Secretary properly considered the statutory factors when proposing the \$55,000.00 penalty. The proposed penalty is assessed.

2. *Citation 2 – Item 2: 29 CFR § 1910.1030(f)(2)(i) Failure to Provide Hepatitis B Vaccine.*

Respondent failed to timely offer employees the hepatitis B vaccine or have the employees sign a declination form. Respondent’s bloodborne pathogen program, applicable to West Caldwell, explicitly required that employees either receive the vaccine or sign a declination form. (Ex. S-22, p. 23; Ex. S-17). Yet, the evidence demonstrates that the vast majority of its employees neither received the vaccine nor signed a declination form until the start of the OSHA inspection. I find that the preponderance of the evidence demonstrates that UniFirst’s failure to offer employees the hepatitis B vaccine was the result of an indifference to employee safety.

Respondent asserts that its employees were offered the hepatitis B vaccine as part of the sign-in sheet they signed when watching the training video. As discussed above, the information contained on the sign-in sheet was cryptic and insufficient to inform employees of the vaccination program. Moreover, the validity of the employee signatures on these sign-in sheets is doubtful. Some of the employee signatures were forged. Others were certified by branch manager Barry before the employee signed the sheet. Virtually all were certified by Barry as the instructor, even though he did not conduct the training and had no first-hand knowledge that the employee actually attended the training.

Even if the employee attended the training and signed the form on the dates indicated, the sheets were signed before the employee was trained. These sign-in sheets clearly state that “[t]raining *will consist* of: Explanation of the risk factors and symptoms of BBP....; Information on the hepatitis B vaccine, including information on the benefits of being vaccinated, and that the vaccination will be offered free of charge.” (emphasis added) (e.g. Exs. S-46, 49, 50). The

standard requires that employees either be offered the vaccine or sign the declination sheets after training to enable the employees to make an informed decision. This is recognized in Respondent’s bloodborne pathogen training program, which states that the vaccine shall be offered “[a]fter receiving training.” (Ex. S-22, p. 23). Moreover, as discussed above, the cryptic statement that Respondent relied on to inform employees about the availability of the vaccine could not reasonably be viewed as providing employees with adequate information upon which they could make an informed decision whether to accept the vaccine. Respondent could not have reasonably believed that, by having employees sign these training sign-in sheets they fulfilled their obligation under the standard.

While the sign-in sheets were wholly inadequate to satisfy the standard, they should have, at a minimum, informed branch manager Barry and district service manager Wampler of the company’s obligation to make the vaccine available to employees. Yet, the evidence shows that West Caldwell employees were not properly given the option to receive the vaccine for months, and in some cases, years after employment.<sup>39</sup> This demonstrates an abrogation of the safety responsibilities by West Caldwell management that constitutes an indifference to employee safety.

Powell was the general manager to whom branch manager Barry reported and the management official ultimately responsible to ensure that Barry carried out the bloodborne pathogen program. Powell testified that he would visit West Caldwell every other week. One reason for his visits was to ensure that the “branch is following the processes and procedures the company expects them to follow.” (Tr. 772). That the majority of the employees were not offered the vaccine until after the inspection demonstrates that Powell never exercised his authority to ensure either that the vaccination was properly offered or that the declination forms were signed. Powell asserted that, after the bloodborne pathogen program was rolled out, he held meetings with the branch managers to go over the action plan and its implementation. (Tr. 773-774). However, branch manager Barry never saw a copy of the BBP ECP or the Facilitator’s Guide. That Barry never saw a copy of the BBP ECP and was not aware that giving employees the option to receive the vaccine was required by law was the direct omission of general manager

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<sup>39</sup> In some cases, the time between hiring and vaccine can be justified because, when first hired, health accounts were not being serviced from West Caldwell. (See e.g. RSR driver [redacted] was hired in 2002 and did not receive the vaccine until after the inspection). However, when the bloodborne pathogen program was instituted in March 2010, because health accounts were being signed for the West Caldwell Branch, there was no reasonable explanation for the failure to offer the vaccine after that time.

Powell. The totality of this evidence demonstrates that Powell was plainly indifferent to the requirements of the bloodborne pathogen standard, including the vaccine requirement. Generally, a violation is not willful if the employer made a good-faith effort to comply, even though the effort was not entirely complete. *Dec-Tam*, 15 BNA OSHC 2072, 2076 (No. 88-523, 1992); *Marmon Group, Inc.*, 11 BNA OSHC 2090, 2092 (No. 79-5363, 1984). Here, Respondent did not make a good-faith effort to comply. To the contrary, its efforts were half-hearted and incomplete and demonstrated a plain indifference to both the requirements of the Act and employee safety.

The Secretary proposed a \$55,000.00 penalty for this willful violation. The failure to timely provide the vaccine exposed employees to the possibility of contracting hepatitis B, which can ultimately lead to death. (Tr. 311). The CSHO testified that, because the outcome of the violation can be death, the severity of the violation was high. However, the CSHO also testified that the probability of an employee contracting hepatitis B was “lesser” because employees did not handle laundry from hospital beds, surgical units, or facilities that actually handle medical waste where there is a much higher possibility of contact with blood or getting stuck by a needle. (Tr. 314). As noted above, no credit was given for history, size or good faith. (Tr. 314). I find that the Secretary gave proper consideration to the factors set forth in section 17(j) of the Act and the proposed penalty is assessed.

3. *Citation 2, item 1: 29 CFR § 1910.1030(d)(2)(i); Failure to Provide Biohazard Bags*

When the bloodborne pathogen program was first rolled out, UniFirst provided West Caldwell with a supply of nylon bags. As previously noted, those bags disappeared from the workplace in a month, requiring employees to place the laundry in black plastic garbage bags and, at times, with their bare hands. (Tr. 79, 227-28, 406, 408). There is no documentation indicating how many bags were initially purchased for West Caldwell. However, general manager Powell testified that three bags were purchased for each of its 28 Quest accounts. (Tr. 807). It is not clear how many of the subsequently purchased bags were destined for West Caldwell. What is clear is that the requirement that they be used was ignored. Indeed, when the inspection began, branch manager Barry could not remember that the nylon bags were available in a hamper near the dock, explaining that he “didn’t find it important.” (Tr. 251-54; Ex. S-4 at

6). Although Barry was unaware that there were OSHA standards regulating bloodborne pathogens (Tr. 1279), he knew that UniFirst had concluded that their use was important to employee safety.

The evidence further demonstrates that branch manager Barry’s dismissal of the biohazard bag requirement was shared by other management officials. According to the CSHO, during their interviews, both district service managers Correa and Wampler thought that the biohazard bags were unavailable. Given the pervasive use of black plastic garbage bags by the RSR drivers, it strains the imagination that management was unaware that employees were not using the required biohazard bags. General manager Powell visited West Caldwell every other week. There were numbers of black plastic garbage bags lying around the facility. Yet, Powell never inquired the reason for these bags when employees were supposed to be using nylon bags.<sup>40</sup> Knowing that numerous Quest and LabCorp accounts were assigned to drivers at the West Caldwell facility, Powell never inquired about the absence of biohazard bags.

I find that the totality of the evidence demonstrates that the failure to ensure the use of biohazard bags was the result of an “indifference” to employee safety that is a hallmark of a willful violation and, therefore, that the violation was willful.

The Secretary proposed a penalty of \$55,000.00. CSHO Vargas testified that, while the probability of an accident was lesser, the severity of the violation was high. The violation could lead to hepatitis B which can cause liver disease and chronic sclerosis. It also could result in an employee contracting AIDS, which can be fatal. (Tr. 255). For reasons discussed above, no credit was given for size, history or good faith. (Tr. 259). I find that the Secretary properly considered the factors set forth in section 17(j) of the Act, and the proposed penalty is assessed.

### **Findings of Fact and Conclusions of Law**

The foregoing decision constitutes the findings of fact and conclusions of law in accordance with Rule 52(a) of the Federal Rules of Civil Procedure.

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<sup>40</sup> Garbage bags were routinely used to pick up clothes from Covanta. However, this too was against Respondent’s lead program which required lead contaminated garments to be placed in dissolvable bags. Thus, Mr. Powell could not excuse the presence of these black garbage bags because they were being used at Covanta.

**Order**

Based upon the foregoing decision, it is ORDERED that:

Citation 1, Item 1, alleging a serious violation of 29 C.F.R. § 1910.36(d)(1) is **Affirmed** and a penalty of \$5000 is assessed;

Citation 1, Item 2, alleging a serious violation of 29 C.F.R. § 1910.157(g)(1) is **Affirmed** and a penalty of \$7000 is assessed;

Citation 1, Items 3(a), alleging a serious violation of 29 C.F.R. § 1910.1025(h)(1) and 3(b), alleging a serious violation of 29 C.F.R. § 1910.1025(l)(1)(i) are **Affirmed** and a combined penalty of \$4000 is assessed;

Citation 1, Item 4, alleging a serious violation of 29 C.F.R. § 1910.1030(d)(3)(ix) is **Affirmed** and a penalty of \$5000 is assessed.

Citation 2, Item 1, alleging a willful - serious violation of 29 C.F.R. § 1910.1030(d)(2)(i) is **Affirmed** and a penalty of \$55,000 is assessed;

Citation 2, Item 2, alleging a willful - serious violation of 29 C.F.R. § 1910.1030(f)(2)(i) is **Affirmed** and a penalty of \$55,000 is assessed;

Citation 2, Items 3(a), alleging a willful - serious violation of 29 C.F.R. § 1910.1030(g)(2)(ii)(A) and Item 3(b), alleging a willful - serious violation of 29 C.F.R. § 1910.1030(g)(2)(iv) are **Affirmed** and a combined penalty of \$55,000 is assessed.

**So Ordered.**

/s/

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Carol A. Baumerich  
Judge, OSHRC

Dated: October 17, 2014