OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION

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SECRETARY OF LABOR,	:	
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Complainant,	:	
	:	
v.	:	OSHRC DOCKET NO. 03-0641
	:	
LOURDES HOSPITAL,	:	
	:	
Respondent.	:	

Appearances: Marc G. Sheris, Esquire
U.S. Department of Labor
Office of the Solicitor
New York, New York
For the Complainant.

James S. Gleason, Esquire
Leslie Prechtl Guy, Esquire
Hinman, Howard & Kattell, LLP
Binghamton, New York
For the Respondent.

Before: COVETTE ROONEY
Administrative Law Judge

DECISION AND ORDER

This proceeding is before the Occupational Safety and Health Review Commission ("the Commission") pursuant to section 10(c) of the Occupational Safety and Health Act of 1970, 29 U.S.C. § 651 *et seq.* ("the Act"). Respondent, Lourdes Hospital ("Lourdes "), at all times relevant to this case maintained a hospital in Binghamton, New York. The parties stipulated that Lourdes is an employer engaged in a business affecting commerce within the meaning of section 3(5) of the Act and that it is subject to the requirements of the Act.

From November 26, 2002 to February 3, 2003, the Occupational Safety and Health Administration ("OSHA") conducted a complaint-initiated inspection of Lourdes. (Tr. 127). As a result of the inspection, Lourdes was issued one citation alleging two serious violations of the bloodborne pathogens ("BBP") standard and one citation alleging two "other" violations of the

lockout/tagout ("LOTO") standard. The total proposed penalty for the citations was $3,250.00. Lourdes contested the citations and penalties, and a hearing was held in Binghamton, New York on October 8 and 9, 2003. The parties have briefed the issues, and this matter is ready for disposition.

Stipulations

The parties stipulated to the following facts:

1. Many of the materials and supplies used and/or manufactured by respondent corporation originated and/or were shipped from outside the State of New York.

2. Our Lady of Lourdes Memorial Hospital, Inc., is a not-for-profit corporation that maintains a hospital located at 169 Riverside Drive, Binghamton, New York.

3. Lourdes Hospital has a number of operating rooms in which surgical procedures are performed on patients.

4. Lourdes Hospital employs registered nurses and surgical technicians who work in these operating rooms.

5. Amando Mata, M.D., David Dreyfuss, M.D., Mark Walker, M.D., and Bipin Patel, M.D., have privileges to perform surgical procedures at Lourdes Hospital, and did have those privileges in November of 2002. These physicians did perform surgeries at Lourdes Hospital on or about November 26, 2002.

6. An OSHA Compliance Officer was present at Lourdes Hospital on November 26, 2002 and interviewed several Lourdes Hospital employees. Two citations were issued to Lourdes Hospital on February 5, 2003.

Motion to Dismiss

At the commencement of the hearing, Lourdes made a motion to dismiss, claiming it had not been given adequate notice of the circumstances and dates which the Secretary alleges resulted in violations of the BBP standard; Lourdes also claimed it had not been given appropriate notice so as to allow it to prepare a defense. (Tr. 6-9). Lourdes maintains that because it had inadequate notice of the charges it was deprived of due process. I find that the citation and complaint in this matter gave Lourdes adequate notice of the allegedly hazardous conditions found at its workplace and the standards those conditions allegedly violated. It is clear from the evidence that Lourdes was also told at the time of the OSHA inspection of the incidents leading to both citations and the time period

during which they allegedly occurred. OSHA Industrial Hygienist ("IH") Francis Strelec held a closing conference with Lourdes representatives Joseph D'Antuono, Susan Russell and Sue Surgent on February 3, 2002, at which time he discussed the alleged violations with them. (Tr. 158-60). Any confusion as to the exact dates on which specific events occurred was the result of faulty and/or conflicting memories of the witnesses and in no way hindered Lourdes from mounting a complete defense to the allegataions in this matter. Lourdes' motion is therefore denied.

The Inspection

IH Strelec testified that upon his arrival at the hospital, he conducted an opening conference with various employer representatives, including Sue Surgent, human resources director, Wayne Mettier, vice-president, Susan Russell, director of preoperative services, and Joseph D'Antuono, safety director. He told them what the scope of the inspection would be, and he requested copies of Lourdes' OSHA 200 logs and exposure control plan. IH Strelec then conducted a walkaround inspection with these same representatives. As part of the inspection, the IH examined the operating room, which was not in use at the time; he also examined some instruments, including sharps and passing pans, and he interviewed employees. (Tr. 128-29).

Serious Citation 1, Item 1

This item alleges a violation of 29 C.F.R. 1910.1030(d)(2)(i), which provides as follows:

> 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.

The Secretary alleges that on or about November 26, 2002, in the Lourdes operating rooms, physicians performed hand-to-hand transfers of contaminated sharps to nurses without using work practice controls, including, but not limited to, the use of passing pans.

To prove a violation of a specific standard, the Secretary must establish the applicability of the cited standard, the employer's noncompliance with the standard, employee access to the noncomplying condition, and the employer's knowledge of the violation (*i.e.*, that the employer either knew, or could have known with the exercise of reasonable diligence, of the violative condition. *E.g., Rockwell Int'l Corp.*, 17 BNA OSHC 1801, 1806 (No. 93-228, 1996).

Lourdes, the employer in this matter, is a hospital that provides medical and surgical care to the sick and the injured. The record in this case shows that physicians had staff privileges at Lourdes,

which meant that they could admit patients to the hospital; in so doing, the physicians were bound to follow the hospital's rules and regulations or be subject to discipline by the hospital. During the course of surgery, the physicians were assisted by and directed the work of circulating nurses and surgical technicians employed by the hospital. (Tr. 168-69, 172, 195-97, 350-51, 367-71). Exhibits C-3 and R-43 set out the policies and work practices that Lourdes required everyone working in its operating rooms to follow. As the employer, Lourdes was responsible for ensuring that its employees (in this case, the surgical technicians and circulating nurses) were not exposed to hazards.[1]

The BBP standard was promulgated in 1991 to eliminate or minimize occupational exposure to blood and other potentially infectious materials because they may contain BBP's, such as hepatitis B virus, which causes Hepatitis B, and human immunodeficiency virus, which causes Acquired Immunodeficiency Syndrome or AIDS. To comply with the standard, healthcare employers are required to prepare a written exposure control plan to eliminate or minimize employee exposure to BBP's. The plan requires employers to adopt the use of universal precautions, engineering controls, work practice controls and protective equipment. *See* 56 Fed Reg. 64175 (1991), as amended, 66 Fed Reg. 5318 (2001). The BBP standard is written in performance-oriented language, giving the employer the opportunity to implement the controls that best suit the safety of its employees. A performance standard differs from a specifications standard in that, rather than directing specific measures to be taken whenever a hazard identified by the Secretary is present, it allows the employer, within the standard's general guidelines, to identify the hazards peculiar to its own workplace and determine the steps necessary to abate them. Generally, performance standards state the required result without specifically mandating how that result is to be achieved. *See Diebold, Inc.*, 3 BNA OSHC 1897(No. 6767, 1976); *General Motors Corp.*, 8 BNA OSHC 1465 (No. 78-2128 1979). The

[1]The Act places primary responsibility on employers to achieve compliance with its standards and to ensure a safe workplace. *See* S. Rep. No. 91-1282, *reprinted in* 1970 U.S.C.A. 5177, 5186. It is well settled that an employer may not shift responsibility or contract away its legal duties or its ultimate responsibility under the Act by requiring another to perform them. *Baker Tank Co.*, 17 BNA OSHC 1177, 1180 (No. 90-1786, 1995); *Central of Georgia R.R. Co. v. OSHRC*, 576 F.2d 620, 625 (5th Cir. 1978).

Second Circuit[2] has held that, to make out a prima facie violation of a performance standard, the Secretary also has the burden of proving feasibility and utility of abatement measures.[3]

The cited standard requires that the employer utilize engineering controls and work practices to minimize employee exposure.[4] The standard does not specify the manner in which this is to be accomplished. The preamble to the standard states that "[w]hile work practice controls also act on the source of the hazard, the protection they provide is based upon the behavior of the employer and employee behavior rather than installation of a physical device such as a protective shield." The preamble further states that engineering controls and work practices "frequently work in tandem because it is often necessary to employ work practice controls to assure effective operation of engineering controls."[5] 56 Fed Reg. 64175 (1991). It is thus clear from the preamble that the drafters of the standard provided for the exercise of judgment on the part of the employer.

IH Strelec testified that he recommended this citation item due to his belief that the hospital's practice was to use passing pans in lieu of hand-to-hand transfers between the surgeon and the surgical technician (hereafter, "scrub tech") and the practice was not being enforced. (Tr. 130-32, 143, 227-30, 272-74). He further testified that he talked to several circulating nurses[6] who told him

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[2]The Second Circuit is the Court of Appeals to which an appeal of this matter would be filed.

[3]The Secretary must specify the particular steps an employer should have taken to avoid being cited and to show the feasibility and likely utility of those measures. *General Elec. Co. v. OSHRC*, 540 F.2d 67, 69-70 (2d Cir. 1976) [the court noted that, in regard to a case under 29 C.F.R. 133(a)(1), the applicable rule as to technological and economic feasibility for section 5(a)(1) cases was set out in *National Realty & Constr. Co. v. OSHRC*, 489 F.2d 1257, 1266-1268 (D.C. Cir. 1973)].

[4]Work practice controls are controls that reduce the likelihood of exposure by altering the manner in which a task is performed. *See* 29 C.F.R..1910.1030(b).

[5]The Commission has held that a final rule's preamble is the most authoritative statement of the Secretary's intent. *American Sterlizer Co.,* 15 BNA OSHC 1476 (No. 86-1179, 1992).

[6]A circulating nurse is a registered nurse whose job in the operating room is to ensure that the procedure goes smoothly. These nurses check the patient's chart prior to coming into the room, get the patient in position on the surgical table, do the surgical counts, oversee instrument needs, help the scrub tech in setting up instruments, and assist the anesthesiologist and the doctor in any way necessary (*i.e.*, leaving the room to get extra supplies or needed equipment). The circulating nurses do not scrub since they do not enter the sterile field in which the doctors and scrub techs work. If the nurse has to provide the doctor additional equipment it is given to the scrub tech. (Tr. 12-13, 147-48, 176, 355-56).

that doctors generally did not use passing pans and that they had seen surgeons as recently as the day of the inspection performing hand-to-hand transfers.[7] (Tr. 132-36). The IH also spoke with Pat Durr, the infection control coordinator, who told him that passing pan use had been developed due to three operating room needle stick injuries in 2001; she also told him that the use of passing pans had been in contention for a while and had really never been enforced. (Tr. 136-37; Exhs. C- 1A and 1B).

It is clear from the record that IH Strelec's interviews of the circulating nurses formed the basis of his decision to recommend the subject citation item.[8] Further, I have no reason to believe that the employee statements he testified about were anything other than what he expressed at the hearing. However, I find that what the nurses told him does not demonstrate a violation of the cited standard because the IH was unaware of Lourdes' complete work practice with respect to the handling of sharp instruments. Specifically, while he was given Exhibit C-3, Lourdes' exposure control plan, during the inspection, he was not given Exhibit R-43, Lourdes' neutral zone policy. Exhibits C-3 and R-43 were adopted at the same time, and while both set out the neutral zone procedure, R-43 contains an exception allowing hand-to-hand transfers of sharps under certain circumstances. (Tr. 317-19). The exception is not set out in C-3, and the IH was never told about the exception. (Tr.140).

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[7]Specifically, Lou Ann Taylor told him that physicians generally did not use passing pans. She said that in the month before the inspection she had seen Dr. Dreyfuss and Dr. Patel do surgery without using a passing pan; instead, the doctors performed hand-to-hand transfers of contaminated instruments. Jennifer Setlak told the IH that, on the day of the inspection, Dr. Mata had made a hand-to-hand transfer of contaminated sharps during surgery. She also told the IH that she had reported other such incidents to management. Heidi Collins told the IH that, on the day before his arrival, Dr. Walker had performed an operation without using a passing pan. Ms. Collins and Ms. Setlak both told the IH that they had worked with Dr. Dreyfuss in the past and that he had not used a passing pan. Janet Signorile stated to the IH that, about a month before the inspection, Dr. Mata had not used a passing pan during surgery and had made a hand-to-hand transfer of contaminated sharps. (Tr. 132-36).

[8]The circulating nurses who the IH interviewed were called as witnesses for the Secretary. The testimony of Jennifer Setlak, a former Lourdes nurse, agreed with the IH's recollection of her interview. However, the nurses who still worked for Lourdes, *e.g.*, Heidi Collins, Robin Fedourich, Lou Ann Taylor and Janet Signorile, could not recall their conversations with the IH, and, at the hearing, they denied that they had said what he testified they had told him. Further, they could not recall what observations they may have made in the operating room on or about November 2002. Based upon my observations of their demeanor, as well as their evasive testimony and their inability to recall, I conclude that their testimony reflected a bias towards their employer. I find, therefore, that the testimony of the nurses who were still employed by Lourdes was not credible. (Tr. 38-42, 48-52, 68, 73-75, 83-88, 95-96, 107-08, 114, 118).

The record shows that Lourdes' work practices addressing the reduction of the incidence of percutaneous injuries and blood exposures by utilizing a "neutral zone" are set out in Exhibits C-3 and R-43.[9] In C-3, the exposure control plan, the neutral zone procedure is set out in detail under the section entitled "Sharps."[10] In R-43, a one-page document entitled "General Principles of the Neutral Zone (NZ)," the neutral zone procedure is essentially the same, although it is somewhat less detailed, as the one in C-3; however, as noted above, a significant difference between the two procedures is the exception set out in R-43, which is not in C-3. The exception states as follows:

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[9]A neutral zone is an area where the surgeon and the scrub tech agree to place sharp instruments; the purpose of the neutral zone is so that, when one of them lays down a sharp object, the other person will not be in the way.

[10]Exhibit C- 3, Lourdes' exposure control plan, was originated in October 2000, reviewed in November 2001, and revised in October 2002. It states that "[s]tandardized workplace practices will be used to protect employees from exposure to bloodborne and body fluid pathogens." It also addresses the issues of using protective wear, such as eye wear, gloves and gowns, and utilizing a neutral zone when handling sharps. With respect to handling sharps, C-3 provides in pertinent part as follows:

III. Sharps
B. Hands-free technique will be used for passing instruments that are potentially a sharp hazard. This includes scalpels, needles including suture needles, skin hooks, metacarpal retractors, sharp rakes, etc. The sharp instrument will be placed in a square basin lined with a towel or washcloth. The basin will be kept in the sterile field in an area designated as the neutral zone. The following guidelines will assist in safe use of the neutral zone:

1. Before the first incision or injection is made, the Neutral Zone (NZ) is SELECTED AND DESIGNATED by the surgeon in consultation with the person passing the instruments to determine the optimal placement for the NZ for a given procedure. The NZ is dedicated to sharps ONLY. All other instruments are passed hand-to-hand.
2. Only ONE sharp is to occupy the NZ at any given time.
3. The scrub person ANNOUNCES THE SHARP by name when placing it in the NZ ("suture", "scalpel"). Or, alternatively, instead of saying the sharp by name, they can say "Safe zone."
4. The scrub person DOES NOT HOLD the NZ device, but leaves it in the intended location on the field to keep fingers out of harm's way.
5. The scrub person ORIENTS THE SHARP in the NZ so the surgeon may pick it up with the dominate hand without the need to turn or reposition it.
6. The scrub person ensures suture needles are MOUNTED AND POSITIONED OPTIMALLY to avoid the need for the surgeon to reposition them in the needleholder.
7. The surgeon and the scrub person COMMUNICATE FREELY. The NZ may be moved at different times during the procedure at will and by agreement to accommodate the surgeon's needs.

> Hand-to-hand transfer of sharps remains an appropriate option at the surgeon's discretion in situations when he or she cannot avert eyes from the field or cannot reach the NZ because of positioning or other factors.

The record establishes that Exhibits C-3 and R-43 are both posted in all of the scrub rooms at Lourdes Hospital. The record further establishes that both documents were implemented together in December of 2000 or January 2001. (Tr. 317-20).

As the foregoing indicates, the NZ procedure is a hands-free technique wherein all sharp items are placed in a container or in a designated "safe zone." Various devices are employed in this regard, such as mats, trays, basins, and all or part of an instrument stand or a designated area on the field. (Tr. 43-44, 54-59, 64-66,178-85, 322-25, 358-59, 386-87; Exhs. R-47A-G). Lourdes' procedure was adapted from a book by Dr. Mark S. Davis entitled *Advanced Precautions for Today's O.R.*, wherein Dr. Davis sets out seven guidelines for application of the neutral zone.[11] These guidelines emphasize the importance of team interaction and good verbal communication between the surgeon and the scrub personnel. They also emphasize that the surgeon designates the NZ prior to the first incision or injection and that the NZ may be moved at different times during a given procedure to accommodate the surgeon's needs; further, an instrument is placed in the NZ so that the surgeon can pick it up without turning or repositioning it. (Tr. 177-80, 323-25, 355-57, 385-87, 388-89).

In addition to the above, the record shows that the surgeon, who is always in charge, makes the determination as to when hand-to-hand passing will be done. The record also shows that in November of 2002, the use of the neutral zone was standard practice in the operating rooms at Lourdes Hospital; however, when doctors performed surgery with the assistance of a microscope, they performed hand-to-hand transfers. (Tr. 77, 95-96, 107, 118, 170-71, 177, 186, 209, 213, 337, 352, 388, 391). Two of the surgeons who perform surgery at Lourdes, that is, Dr. Mark Walker and Dr. David Dreyfuss, testified that because the field of vision is so small when using magnifying instruments, it is difficult for a surgeon to avert his eyes from the operating field. (Tr. 342, 353-54, 361-64). Finally, the record shows that Lourdes employees are trained during their first two weeks

[11]Dr. Mark S. Davis is an experienced surgeon who devotes much time to promoting safety in operating rooms and hospitals. (Tr. 318-19, 329; Exh. R-27). His book, entitled *Advanced Precautions for Today's O.R.*., was published in 1999 by Sweinbinder Publications LLC, in Atlanta, Georgia. Exhibit R-43, noted above, is an excerpt from Dr. Davis' book.

on the job about the NZ policy and techniques for hand-to-hand passing in those situations where the exception applies. (Tr. 320-21, 329-30, 333; Exhs. R-17, 27and 28). In such circumstances, employees have been trained in how to angle the instrument into the surgeon's waiting hand. (Tr. 109, 129, 186-89, 193, 202-04, 372-73).

In view of the evidence of record, I find that the Secretary has failed to sustain her burden of proof with respect to the alleged violation. There is no evidence that the neutral zone policy detailed in Exhibits C-3 and R-43 was not being followed, and I find that the policy and its exception meet the mandate set out in the cited performance standard. The Secretary's attempt to demonstrate that Lourdes' conduct fell short of the standard was based on statements from witnesses, that is, the circulating nurses, which I have found unreliable, as noted *supra*, and, as a result, the information the IH obtained was simply inaccurate; in this regard, I note that IH Strelec admittedly did not interview any doctors or surgical technicians.[12] (Tr. 237, 279, 292). Furthermore, the Secretary's attempt to show, during her cross-examination of certain witnesses, that it was feasible to use larger passing pans during surgery involving magnifying instruments, was sheer speculation unsupported by any objective evidence and was thus insufficient to establish a prima facie case. (Tr. 207, 345, 376). Finally, the Secretary's attempt to establish a strict specification standard by imposing the use of passing pans is inconsistent with the intent of a performance standard, which, as set out above, allows the employer, within the standard's guidelines, to identify hazards peculiar to it own workplace and determine the steps necessary to abate them. The Secretary has not met her burden of proving the alleged violation, and this citation item is accordingly vacated.[13]

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[12]I also note that the injury logs the IH relied upon to support his conclusions do not reveal any injuries that resulted from hand-to-hand transfers. (Tr. 137, 265-66; Exh. C-1B).

[13]In vacating this citation item, I am aware of footnote 3 of the Secretary's brief, wherein the Secretary's counsel notes that he was not allowed to offer rebuttal testimony from his expert witness to rebut Lourdes' affirmative defense of infeasibility. Specifically, the Secretary's counsel attempted to rebut Lourdes' evidence through the proposed expert testimony of Dr. Don Wright, the Director of Occupational Medicine at OSHA. However, counsel was unable to lay a proper foundation for Dr. Wright to express an opinion on the feasibility of passing pans, and I found, based upon Dr. Wright's knowledge, skill, experience, training and education, that counsel did not establish a sufficient basis for the court to find him qualified as an expert rebuttal witness.

Serious Citation 1, Item 2

This item alleges a violation of 29 C.F.R. 1910.1030(d)(3)(ii), which provides as follows:

> The employer shall ensure that the employee uses appropriate personal protective equipment unless the employer shows that the employee temporarily and briefly declined to use personal protective equipment when, under rare and extraordinary circumstances, it was the employee's professional judgment that in the specific instance its use would have prevented the delivery of health care or public safety services or would have posed an increased hazard to the safety of the worker or co-worker. When the employee makes this judgement, the circumstances shall be investigated and documented in order to determine whether changes can be instituted to prevent such occurrences in the future.

The Secretary alleges that on or about November 26, 2002, in the Lourdes operating rooms, the employer did not ensure the use of goggles or face shields for circulating nurses working in the operating rooms.

The basis of the foregoing personal protective equipment provision is the existence of occupational exposure, which, by definition, is "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.[14] *See* § 1910.1030(b). The record shows that Exhibit C-3, Lourdes' exposure control plan, addresses wearing protective eye wear, gloves and gowns. It requires scrub personnel to wear protective eye wear during all surgical procedures and circulating staff to wear protective eye wear when there is a potential for exposure to droplets of blood or other body fluids. This policy was communicated to new staff during orientations and was posted in the scrub room of every operating room. (Tr. 33-35, 325-29, 338). Lourdes ensured enforcement of the policy with random monthly observations. (Tr. 345-46).

IH Strelec testified that, based on his interviews of the circulating nurses, he determined that they were not wearing protective eye wear during surgical procedures; he also determined that, because they were located around the surgical table and could be anywhere, *i.e.*, near the surgeons or scrub techs, they could be exposed to airborne droplets of blood. (Tr. 147-54).

[14]The equipment used is to be chosen to protect against contact with blood or other potentially infectious materials based on the type of exposure and quantity of substances which can be reasonably anticipated to be encountered while performing a task or procedure. *See* 56 Fed Reg. 64004 (1991).

Despite the foregoing, I find that there is no evidence in the record that clearly establishes an incident in which a circulating nurse was not wearing eye protection and it was required. For example, while the IH said that two nurses told him that some operations like those involving hips can be "pretty bloody" and can "splatter blood in the air," he apparently did not ask whether they had been in an operating room during such a procedure and not wearing eye protection when it was required.[15] (Tr. 149-50). The IH also said that another nurse told him that circulating nurses can be exposed to blood, but, when asked if she had stated how they can be exposed, the IH said that "she wasn't specific."[16] (Tr. 150-51). One nurse did testify that she had been involved in surgical procedures during November 2002 in which she had had to change her clothing because blood had splashed on it; however, she also testified that she wore eye protection when there was a potential for exposure, and it was not clear from her testimony whether she had been wearing eye protection during the surgical procedures in which she had had to change her clothing.[17] (Tr. 28-30, 34-35). A blanket assertion that circulating nurses were not wearing protective eye wear is not enough to met the Secretary's burden of proof. This citation item is accordingly is vacated.

"Other" Citation 2, Item 1

This item alleges a violation of 29 C.F.R. 1910.147(c)(4)(ii), which states that:

> The [energy control] procedures shall clearly and specifically outline the scope, purpose, authorization, rules, and techniques to be utilized for the control of hazardous energy, and the means to enforce compliance including, but not limited to, the following....
> **(B)** Specific procedural steps for shutting down, isolating, blocking and securing machines or equipment to control hazardous energy;

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[15]That circulating nurses may not often be exposed to splatters of blood or other fluids in the operating room is supported by the evidence set out in footnote 6, *supra*, indicating that the circulating nurses do not enter the sterile field in which the surgeons and the scrub techs work.

[16]The non-specific nature of the information the IH obtained from the nurses is also demonstrated by his testimony on cross-examination. (Tr. 251-57).

[17]This particular nurse no longer worked for Lourdes at the time of the hearing. Although there were other circulating nurses who testified who still worked for Lourdes at the time of the hearing, their clear bias in favor of their employer was evident in their demeanor. Because of this, and also because of their inability to recall the contents of their interviews with the IH, I find their testimony in this regard not credible. (Tr. 52, 74-75, 89-92, 94-95, 114).

> **(C)** Specific procedural steps for the placement, removal and transfer of lockout devices or tagout devices and the responsibility for them....

The Secretary alleges that on or about January 30, 2003, Lourdes' energy control procedures for equipment such as, but not limited to, air compressors, chillers, circulating pumps, boilers and ovens, did not include the following procedural information: 1) specific steps for shutting down, isolating, blocking and securing equipment; and 2) the specific steps for the placement, removal and transfer for lockout devices.

IH Strelec testified that he recommended this item because Exhibit C-2, the LOTO program he saw for the boilers, air compressors, chillers and circulating pumps at the hospital, contained neither information on shutting down, isolating, blocking and securing equipment nor information on removal, placement and transfer for LOTO devices. When he asked for the energy control procedures, he was told that that information was on the last page of the program; when he asked for more specific information, Mr. D'Antuono told him there was none. (Tr. 155-57). IH Strelec also testified that he was familiar with the exception in 1910.147(c)(4)(ii) and that he was not aware of any exceptions applying to Lourdes' equipment; he noted that in his experience, equipment such as the kind Lourdes had has multiple energy sources. (Tr. 268-71).

Mr. D'Antuono acknowledged at the hearing that the document he provided was the hospital's general LOTO policy and that the hospital did not have any written procedures for specific pieces of equipment; he noted, however, that the hospital had the owner's manuals for specific pieces of equipment that contained shutdown procedures for those pieces of equipment. (Tr. 100-03).

I find the cited standard applies because air compressors, chillers, circulating pumps, boilers and ovens are all machines or equipment that require servicing and maintenance, and the unexpected energization or startup of the machines or equipment, or release of stored energy, could cause injury to employees. I also find the terms of the standard were violated, for the following reasons.

The energy control procedures required under section 1910.147(c)(4) are to be developed and utilized by employers for the control of potentially hazardous energy when employees are engaged in servicing and maintenance activities. The purpose of an energy control procedure is to ensure that, before any employee performs any servicing or maintenance on a machine or equipment where the unexpected energizing, start up or release of stored energy could occur and cause injury, the machine

or equipment is isolated from the energy source and rendered inoperative. *See* § 1910.147(c). The procedure must be written in sufficient detail and provide enough direction to enable employees to follow the procedure and determine how to safely perform servicing or maintenance work.

Exhibit C-2, the LOTO program given to the IH in this case, contains a generalized outline that has little or no utility for employees who must follow the procedure. Employers have some leeway to develop a plan tailored to their workplace, so long as the minimum contents are included. I find that Lourdes' written program does not contain the required information because it is too general and thus would not serve to guide an employee through the LOTO process with respect to specific machinery or equipment. In this regard, I note that Mr. D'Antuono himself admitted that Lourdes' LOTO program was general. *Drexel Chem. Co.*, 17 BNA OSHC 1908 (No. 94-1460, 1997). I also note that while Lourdes apparently had equipment manuals with shutdown procedures, they were not incorporated into C-2; further, they were not shown to the IH or offered in evidence. (Tr. 103). The Secretary has shown noncompliance with the standard's terms, and she has also shown employee exposure and employer knowledge. This citation item is therefore affirmed.[18]

As to the classification of this item, an "other" violation is one that has a direct and immediate relationship between the violative condition and occupational safety; however, unlike a serious violation, the probability of death or serious physical injury does not exist. I find that this item is properly classified as "other." This citation item is accordingly affirmed as an other-than-serious violation. No penalty was proposed for this item, and none is assessed.

[18]Section1910.147(c)(4)(i) identifies eight conditions that must exist in order to excuse the employer's obligation to maintain a written procedure for a specific machine or piece of equipment. Employers need not document LOTO procedures for individual machines as long as they meet all the qualifications to be exempt from the standard's requirements. The exception is intended to apply to situations in which the procedure for deenergiztion, servicing and reenergization can be carried out without detailed interactions of energy sources, machines, and employees. The Commission has held, however, that the party who claims the benefit of an exception has the burden of proving its claim. *Kaspar Electroplating Corp.*, 16 BNA OSHC 1517, 1522 (No. 90-2866, 1993). In this case, Lourdes presented no evidence to show that it met the conditions to qualify for the exception.

"Other" Citation 2, Item 2

This item alleges a violation of 29 C.F.R. 1910.147(c)(6)(i), which states that:

> The employer shall conduct a periodic inspection of the energy control procedure at least annually to ensure that the procedure and the requirements of this standard are being followed.

The Secretary alleges that on or about January 30, 2003, Lourdes did not perform annual inspections of LOTO procedures for equipment such as, but not limited to, air compressors, chillers, circulating pumps, boilers and ovens.

IH Strelec testified that when he asked if the energy control procedures were inspected annually, Mr. D'Antuono's response was that he did not do an annual inspection of the energy control procedures; Mr. D'Antuono also did not say that he reviewed or discussed the policy with his employees every year. (Tr. 157). When asked at the hearing whether Lourdes did annual inspections of LOTO policies, Mr. D'Antuono testified as follows:

> We did annual reviews of our policies. In the policy there's a test here for staff, which was conducted annually for competencies. Lourdes' actual review policy is three years for all their policies to review them. This one was reviewed with the staff annually. The actual policy was not updated annually. (Tr. 101).

Mr. D'Antuono further testified that Exhibit C-2, Lourdes' LOTO program, was effective in April 1999 and was reviewed in January 2002. (Tr. 102).

I find that the cited standard applies because air compressors, chillers, circulating pumps, boilers and ovens are all machines or equipment that require servicing and maintenance, and the unexpected energization or startup of the machines or equipment, or release of stored energy, could cause injury to employees.[19] I also find, based on the above, that Lourdes did not comply with the standard. The record shows there had been a three-year lapse between the time the program was implemented and the time it was reviewed, there was no evidence of any other review in the record, and the safety director admitted Lourdes' LOTO procedures were not annually inspected. Finally, I

[19]The periodic inspection required by the standard is intended to assure the employer's energy control procedures continue to be implemented properly and that employees involved are familiar with their responsibilities under those procedures. These inspections are intended to provide for immediate feedback and action by the employer to correct any inadequacies observed. *See* 54 Fed Reg. 36644, 36673 (1989).

find that employees were exposed to the cited condition and that Lourdes had knowledge of the condition. The Secretary has proved the alleged violation and this item is therefore affirmed.

As to the classification of this item, an "other" violation is one that has a direct and immediate relationship between the violative condition and occupational safety; however, unlike a serious violation, the probability of death or serious physical injury does not exist. I find that this item is properly classified as "other." This citation item is accordingly affirmed as an other-than-serious violation. No penalty was proposed for this item, and none is assessed.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

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

ORDER

Based upon the foregoing, it is hereby ORDERED that:

1. Citation 1, Item 1, alleging a serious violation of 29 C.F.R. 1910.1030(d)(2)(i), is VACATED.

2. Citation 1, Item 2, alleging a serious violation of 29 C.F.R. 1910.1030(d)(3)(ii), is VACATED.

3. Citation 2, Item 1, alleging an "other" violation of 29 C.F.R. 1910.147(c)(4)(ii), is AFFIRMED, and no penalty is assessed.

4. Citation 2, Item 2, alleging an "other" violation of 29 C.F.R. 1910.147(c)(6)(i), is AFFIRMED, and no penalty is assessed.

/s/

Covette Rooney
Judge, OSHRC

Dated: February 23, 2004
Washington, D.C.