United States of America
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
1120 20th Street, N.W., Ninth Floor
Washington, DC 20036-3419

SECRETARY OF LABOR,	:	
	:	
Complainant,	:	
	:	
v.	:	OSHRC DOCKET NO. 97-0588
	:	
VICTORY MEMORIAL HOSPITAL & SKILLED NURSING CENTER,	:	
	:	
Respondent.	:	

APPEARANCES:

Nancee Adams-Taylor, Esquire	Martin Gringer, Esquire
New York, New York	Garden City, New York
For the Complainant.	For the Respondent.

Before: Chief Judge Irving Sommer

DECISION AND ORDER

This proceeding is before the Occupational Safety and Health Review Commission ("the Commission") pursuant to section 10 of the Occupational Safety and Health Act of 1970, 29 U.S.C. § 651 *et seq*. ("the Act"). The Occupational Safety and Health Administration ("OSHA") conducted an inspection of Respondent ("Victory" or "the Hospital") from January 28-30, 1997; as a result, Victory was issued a serious and an "other" citation. Victory contested the citations, and a hearing was held on January 7, 1998. Both Victory and the Secretary have submitted post-hearing briefs.

Background

Kay Gee, the OSHA industrial hygienist ("IH") who conducted the inspection, went to the facility on January 28, 1997, pursuant to a complaint about the Central Sterile Supply ("CSS") area, where the Hospital's instruments are sterilized and packaged; the process involves placing canisters of ethylene oxide ("EtO"), a sterilizing agent, into the EtO sterilizing equipment, and, outside the room where the equipment is kept, an EtO monitor which sounds in the event of a leak is mounted

on the wall.[1] IH Gee met with Richard Holley, Victory's associate administrator, and Nicholas Polymenakos, the director of the Biomedical Engineering Department ("Biomedical"), and then conducted a walk-around of CSS with Holley, Polymenakos and Janeth Minto, the CSS supervisor; the IH also interviewed employees and took photos. OSHA received another complaint about the facility on the morning of January 29, 1997, a claim that the EtO monitor was not working, and IH Gee went back to the facility on the morning of January 30, 1997, and continued her inspection. The IH held a closing conference at the Hospital on April 10, 1997, after which the subject citations were issued; items 1, 2a and 2b of serious citation 1 allege violations of 29 C.F.R. §§ 1910.165(d)(1), 1910.1047(h)(1)(i) and (h)(1)(iii), respectively, and items 1, 2 and 3 of "other" citation 2 allege violations of 29 C.F.R. §§ 1904.8, 1910.1020(e)(2)(ii)(B) and 1910.1047(d)(7)(i), respectively.[2]

Citation 1 - Item 1

This item alleges a violation of 29 C.F.R. 1910.165(d)(1), which states as follows:

> The employer shall assure that all employee alarm systems are maintained in operating condition except when undergoing repairs or maintenance.

IH Gee testified that when she saw the EtO monitor on January 30 its flow meter was at zero, indicating that it was not taking in air and was therefore not working. IH Gee asked Nicholas Polymenakos about the monitor, who initially said it was working; however, they went to his office, and as she was reviewing the manual for the monitor Polymenakos told her it was not working and that they were in the process of getting a "loaner." The IH noted that C-10, the manual for the monitor, required the flow meter to be checked daily per employee shift to assure proper operation, and that Polymenakos told her he did not check the flow meter daily but did calibrate it monthly; she further noted that the condition was a serious violation because an EtO release could have occurred and resulted in employee exposure to EtO, which can cause cancer.[3] (Tr. 14-31; 78-81; 91-93).

Nicholas Polymenakos testified that he was with the IH when she saw the monitor on January 30, and that when he looked at the flow meter it was "sputtering very wildly and then it just died."

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[1]Leaks are detected by means of tubing going from the monitor into the sterilizer room.

[2]Item 3 of citation 1, which alleged a violation of 29 C.F.R. 1910.1047(j)(3)(iii)(C), was withdrawn in the Secretary's complaint.

[3]Other effects of EtO exposure are set out in 29 C.F.R. § 1910.1047, OSHA's EtO standard.

He further testified that he and the IH both realized at that time that the flow meter was not working, that he told her that it seemed the pump had died, and that shortly thereafter he arranged to have a replacement monitor sent in. Polymenakos said that he and the IH went to his office so that she could review the manual, and he denied telling her that the monitor was working when it was not; he also denied telling her that he looked at the flow meter only once a month, and said that he viewed it almost every day when he was in CSS to pick up or check on equipment. Polymenakos noted that he had no knowledge the monitor was not working before the IH saw it on January 30, that the flow meter pump had been replaced just over six months before, and that no one had reported that the monitor was not working on January 28 or 29; he also noted that the replacement monitor arrived the next day, that a secondary hand-held monitor was in use in any case, and that the EtO sterilizing equipment had safeties on it which shut it down if a malfunction occurred. (Tr. 133-42).

As a preliminary matter, Victory contends that the "sole basis" of the alleged violation is the "inconspicuous clause" on page 4-5 of C-10, which, as noted above, requires that the flow meter be checked daily per employee shift to assure proper operation; in addition, Victory points out that it was in compliance with 29 C.F.R. 1910.165(d)(2), which requires that employee alarm systems be tested every two months. However, it is clear from the record that this citation item was also based on the fact that the monitor was not working when the IH saw it on January 30. Moreover, I would not characterize the clause on page 4-5 of C-10 as "inconspicuous," as it is preceded by the caption "Other Sampling Considerations" and by the word "Note," both of which are in large bold type. Finally, that the Hospital complied with another standard relating to alarm systems does not preclude its being found in violation of the cited standard, Victory's contention notwithstanding.

Victory next contends that the Secretary failed to prove either that it did not conduct daily checks or that it did not maintain the monitor in operating condition, pointing to the testimony of Polymenakos and to that of Yelena Rud, a technician in the CSS area. Rud testified that her practice was to look at the flow meter every time she went in the sterilizer room to make sure it was working, and that the "first rule" in CSS was to report anything unusual; she further testified that she knew she was at work on January 29, 1997, based on R-4, the schedule for that day, and that if she had seen anything unusual she would have reported it to Janeth Minto, her supervisor. (Tr. 145-49). Regardless, despite the testimony of Rud and Polymenakos, I am not persuaded that daily checks

were made of the monitor. First, there is nothing in the record alluding to daily flow meter checks besides Rud's testimony, which, standing alone, does not persuade me that this was an established work procedure in the CSS area. Second, Polymenakos' testimony that he viewed the flow meter "almost every day" was contrary to the testimony of IH Gee, which is credited for the reasons set out below. Third, it is my conclusion that the monitor was not working on either January 29, 1997, the day OSHA received the second complaint, or on January 30, 1997, and that Victory did not maintain the monitor in operating condition as required by the standard.[4]

IH Gee testified that she did not recall if the monitor was functioning on January 28, the first day of her inspection, as she observed it only cursorily. (Tr. 64-67). She returned to the facility on January 30 due to an employee complaint on the morning of January 29 that the monitor was not working; in addition, as set out *supra*, she testified the flow meter was not functioning when she saw it on January 30 and that while Polymenakos initially told her it was working he then admitted it was not. (Tr. 17-21; 70-71; 79-83; 91-93). Victory asserts the IH's testimony was evasive, contradictory and not credible. I disagree. I found IH Gee's testimony to be clear, concise and consistent, and I observed her demeanor and found her statements credible and convincing; accordingly, I conclude that IH Gee's was the more reliable account of the events on January 30 and her testimony is credited over that of Polymenakos. Victory also suggests that the employee who made the complaint on January 29 sabotaged the monitor on the morning of January 30 because he knew when the IH would be there. Again, I disagree. IH Gee testified that she did not speak to the employee when he called OSHA, and there is no evidence that her supervisor, who did speak to the employee, advised that individual when the IH would be returning to the facility; IH Gee also testified that no one ever raised with her the idea that the monitor had been sabotaged, and, in any case, her testimony about what Polymenakos told her on January 30 has already been credited.[5] (Tr. 70-71; 80-85; 163).

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[4]The Secretary's motion to amend the citation and complaint to reflect both of these dates, rather than just January 30, 1997, was granted.

[5]In rejecting Victory's assertions, I have considered the evidence indicating alcohol and other substances could set off or otherwise affect the monitor and the IH's testimony that none of the other employees reported the monitor was not working. (Tr. 70-71; 80-83; 128-129; 140-43; 173-74; 180).

Victory's final contention is that it should not be held liable for the cited condition because it contracted with a professional management company to oversee Biomedical, which encompassed CSS. The record shows that in January 1996 Victory contracted with Professional Services ("PS") to direct and manage Biomedical, and that PS contracted with Professional Contract Services ("PCS") to provide certain employees to perform these functions, including Nicholas Polymenakos and Robert Marsh, the director and manager, respectively, of Biomedical; Marsh was responsible for the servicing and maintenance of the equipment in Biomedical, and for contracting with outside companies to perform air contaminant testing, and one of Polymenakos' responsibilities was the monthly calibration of the flow meter on the EtO monitor. The record also shows that the purpose of the contract with PS was to improve the service in Biomedical, that PCS was responsible for complying with OSHA and other safety regulations and for selecting its employees who worked in Biomedical, and that while the Hospital could recommend dismissal only PCS could carry out the actual dismissal of a PCS employee. (Tr.; 113-21; 134-36; 143-45; 150-51; R-2-3).

Victory notes that an employer that did not create or control a violation can avoid liability by proving it took whatever steps were reasonable in the circumstances to protect its employees from the cited hazard. Victory asserts that its contract with PS absolved it of liability with respect to the alleged violation, citing to *Anning-Johnson Co.*, 4 BNA OSHC 1193 (Nos. 3694 & 4409, 1976), and *Grossman Steel & Aluminum Corp.*, 4 BNA OSHC 1185 (No. 12775, 1976), the first Commission decisions recognizing the multi-employer work site defense. However, it is the employer's burden to prove this defense, and these cases require each employer to have primary responsibility for the safety of its own employees and to make reasonable efforts to detect and correct or have corrected conditions to which its workers have access. *Anning-Johnson* at 1198-99; *Grossman Steel* at 1189. Further, "an employer is responsible for ... violations ... where it could be reasonably expected to prevent or detect and abate the violations due to its supervisory authority and control over the worksite." *IBP, Inc.*, 17 BNA OSHC 2073, 2074 (No. 93-3059, 1997) (citation omitted).

Applying these principles to this case, Victory has not established its asserted defense. First, it is clear Victory employees were exposed to the cited hazard; Robert Marsh supervised only one individual in the CSS area, who, like himself, was a PCS employee, while Janeth Minto, a Hospital employee, supervised the various CSS technicians, all of whom worked for Victory. (Tr. 104-07;

115-16; 131-32; 145; 149; 171-72). Second, it is also clear Victory was responsible for maintaining the monitor prior to its contract with PS, and that despite that contract Victory had supervisory authority and control over its own facility, including CSS. However, in view of my findings above, the Hospital did not have a work rule requiring daily checks of the flow meter to assure proper operation, as provided for in the monitor's manual, and the contract with PS did not remedy the situation; Polymenakos' checks occurred monthly, and there was nothing in the record to indicate Marsh performed daily checks. Further, the flow meter's condition was easily observable, as the monitor was in plain view on the wall outside the sterilization room. (Tr. 12; 21; 81; 146; 149; C-5).

Based on the record, Victory was in violation of the cited standard. Victory urges this citation item should be characterized as *de minimis* because a hand-held monitor was used as a backup and because the sterilization equipment had safeties on it which shut it down if a malfunction occurred. The record shows that a hand-held monitor was in fact used as a backup when the sterilization equipment was in use, and that the equipment doors would lock in the event of a malfunction; regardless, the record also shows that the backup monitor was not used when employees carried canisters of EtO to and from the sterilization equipment, that the backup monitor did not meet OSHA's EtO detection level requirements, and that, according to page 6-20 of R-10, the sterilization equipment troubleshooting manual, operators and others in the area were required to leave when the equipment display panels indicated a possible gas leak. (Tr. 85-89; 98-99; 129-33; 141; 161; 176). I conclude, therefore, that this item was properly characterized as a serious violation.

IH Gee testified the initial penalty of $5,000.00 for this item was based on the high gravity of the condition and the five to six employees who were exposed to it on a daily basis. She further testified that no reductions were given for size, history or good faith as the Hospital had over 200 employees, had had a previous serious violation within the past three years, and had deficiencies in its safety programs; IH Gee also said the initial penalty of $5,000.00 was increased to $7,000.00 in her supervisor's discretion. (Tr. 28-34). In her brief, the Secretary states she was in error as to history and that a 10 percent reduction is due. Further, the Secretary provided no specific reason for the $7,000.00 penalty, and I have noted the evidence as to Victory's financial difficulties and its prompt abatement of the cited items in this case. (Tr. 94; 111-15). In view of the record, I find that a penalty of $4,500.00, which is based on the initial penalty and a 10 percent reduction, is appropriate.

Citation 1 - Items 2a and 2b

These items allege violations of 29 C.F.R. §§ 1910.1047(h)(1)(i) and 1910.1047(h)(1)(iii), which are part of OSHA's EtO standard and provide, respectively, as follows:

> A written plan for emergency situations shall be developed for each workplace where there is a possibility of an emergency. Appropriate portions of the plan shall be implemented in the event of an emergency.
>
> The plan shall include the elements prescribed in 29 C.F.R. 1910.38, "Employee emergency plans and fire prevention plans."

IH Gee testified that she requested a plan for emergency situations involving EtO and was given C-12 and C-13; when she asked Richard Holley which plan was in effect he gave her no definite answer but did say that the Hospital no longer used the EtO cylinders referred to in C-13, upon which she concluded that C-12 was the facility's plan. IH Gee further testified that C-12 did not meet the cited standards; it did not have emergency escape procedures or procedures for the employees who might have to remain to perform critical facility operations to follow, it did not list rescue and medical duties for employees who would perform them or identify by name and job title the persons to contact for further information, and the emergency number shown on C-12, which she called, was not a good number for emergency response. The IH said that the failure to have an adequate plan was a serious hazard due to the potential for employee exposure to EtO.[6] (Tr. 35-46).

Victory contends it substantially complied with the cited standards, based on the testimony of the IH that the two most important elements were evacuation and containment and the testimony of Janeth Minto indicating that employees had yearly training in what to do if the alarm went off; employees were to leave the sterilization area, close the door, and call the operator, who would "take care of everything." (Tr. 99-101; 172-73). However, it is clear from the standards set out above that a written plan with the elements the IH noted was required and that C-12 does not contain those elements.[7] It is also clear that in an August 1996 incident in which there was a suspected EtO leak, employees did not follow the procedures indicated in Minto's testimony and C-12 and C-13, dated

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[6]The Secretary's motion to amend item 2a, which initially alleged that employees entered the sterilization area without checking EtO levels, was granted to allege a deficient written plan.

[7]The elements noted by the IH are set out in 29 C.F.R. 1910.38.

August 1995 and February 1996, respectively. The record shows that the Hospital summoned the fire department on August 7, 1996, due to a suspected EtO release; the fire department evacuated and secured the sterilization area and called the HAZMAT unit, which, upon its arrival, entered and tested the area and found that no gas leak had actually occurred. (R-1). However, there is no evidence that Victory evacuated and secured the area before the fire department arrived. In fact, Janeth Minto testified that she entered the sterilization area and removed a canister of EtO from the equipment, and Robert Marsh testified that he held his breath and entered the area to try to contain the leak. (Tr. 125-28; 178-82). These actions are prohibited by C-12 and C-13 and are also contrary to what Minto herself described. In view of the record, Victory was in violation of the cited standards. Items 2a and 2b are therefore affirmed as serious violations, and a total penalty of $4,500.00 for these two items, based on the proposed penalty of $5,000.00 and a 10 percent reduction for history, is assessed.

Citation 2 - Item 1

This item alleges a violation of 29 C.F.R. 1904.8, which states as follows:

> Within 8 hours after the ... in-patient hospitalization of three or more employees as a result of a work-related incident, the employer ... shall orally report the ... hospitalization by telephone or in person to [OSHA].

The basis of this item was Victory's failure to report the employee hospitalizations resulting from the August 7, 1996 incident noted above. The record shows that Robert Marsh and four CSS employees went to the Hospital's emergency room after the incident; one employee was released the same day, Marsh and another employee were released on August 8, and the other two were released on August 9. The record also shows that Marsh and the others went to the emergency room because they were experiencing what they at the time believed were reactions to EtO exposure. (Tr. 46-49; 73-78; 104-09; 125-28; 165-66; C-9; R-1). Victory contends the hospitalizations were not the result of a work-related incident as there was no EtO release, pointing to R-1, the fire department's report of the event. R-1 does, in fact, state that the HAZMAT unit's testing revealed a zero concentration of gas and that the employees apparently suffered a psychosomatic experience. Regardless, it is clear that the Hospital summoned the fire department due to a suspected EtO release, and R-1 notes that the fire department was met upon arrival by the Hospital's administrator Krishin Bhatia, who advised that the gas which had leaked was EtO. It is my conclusion that the hospitalizations were the result of a work-related incident, and this item is affirmed as an "other" violation. However, the proposed

penalty of $5,000.00 for this item is excessive, in my opinion. A penalty of $2,250.00 is assessed, based on applying a 10 percent reduction for history to an initial amount of $2,500.00.

Citation 2 - Item 2

This item alleges a violation of 29 C.F.R. 1910.1020(e)(2)(ii)(B), which provides as follows:

> Each employer shall, upon request, assure the access of each designated representative to the employee medical records of any employee who has given the designated representative specific written consent.

The basis of this item was Victory's failure to provide Peter LaBua, one of the technicians in CSS who was hospitalized after the August 7, 1996 incident, with his hospitalization records. Dr. Robert Vaccarino, LaBua's physician, testified that he spoke to Victory's Personnel Department about LaBua's records on October 7, 1996, and was advised to send them a letter requesting the records and a release form. Dr. Vaccarino further testified that on January 7, 1997, his office faxed C-14, his letter setting out LaBua's symptoms and dates of hospitalization, to Victory's Personnel Department, along with a records release authorization signed by LaBua indicating that the records should be sent to Dr. Vaccarino's office. (Tr. 49-54; 152-60). Dr. Vaccarino said he never got a response to C-14 but did not know if the Hospital had actually received it; however, IH Gee testified that during her inspection she spoke with Christine Sileo, Victory's personnel director, who told her that C-14 had been received and was forwarded to the Records Department. (Tr. 156-58; 161-62). On April 23, 1997, LaBua completed R-7, one of Victory's authorization forms, and on April 28, 1997, Victory sent LaBua copies of his hospitalization records, along with R-8, a cover letter.

Victory's first contention, that C-14 was not received, is rejected in light of the foregoing. Victory also contends, however, that it was not in violation of the standard because C-14 was not a proper request. I disagree. First, I see nothing wrong with the release form that was attached to C-14, which is substantially the same as the sample form set out in Appendix A to the standard. Second, Richard Holley himself conceded that the Hospital, upon receiving an improper request, has a duty to call the physician's office. (Tr. 169-70). Third, Holley's testimony as to why C-14 was not a proper request, *i.e.*, that Victory's own release form must be used and the form must be signed in the presence of Records Department personnel, does not persuade me the standard was not violated. (Tr. 167-71). This item is therefore affirmed as an "other" violation, and a penalty of $900.00 is assessed, based on the proposed penalty of $1,000.00 and a 10 percent reduction for history.

Citation 2 - Item 3

This item alleges a violation of 29 C.F.R. 1910.1047(d)(7)(i), which states as follows:

> The employer shall, within 15 working days after the receipt of the results of any monitoring performed under this standard, notify the affected employee of these results in writing either individually or by posting of results in an appropriate location that is accessible to affected employees.

The record shows that Victory had EtO testing done in the CSS area by an outside contractor in September of 1996[8] and that although CSS employees were told when they asked about it that the results were negative for EtO, the Hospital neither posted the results nor informed employees in writing of the results; the record also shows that the only testing results which were posted on the bulletin board in the CSS area, which were still there when IH Gee visited the facility, were from the HAZMAT unit's testing from the August 7, 1996 incident. (Tr. 56-60; 101-02; 106-07; 118-23; 128; 131;173; 179-80). Victory contends that this item should be classified as *de minimis* because all of the testing results were negative for EtO and employees were so advised. However, the language of the standard is mandatory and specifically requires that employees be notified in writing of testing results. Further, the record establishes that employees were notified of the results only when they asked, and not, as Victory suggests, as a matter of course. This item is affirmed as an "other" violation. No penalty was proposed for this item, and none is assessed.

Conclusions of Law

1. Respondent, Victory Memorial Hospital & Skilled Nursing Center, is engaged in a business affecting commerce and has employees within the meaning of section 3(5) of the Act. The Commission has jurisdiction of the parties and of the subject matter of the proceeding.

2. Respondent was in serious violation of 29 C.F.R. §§ 1910.165(d)(1), 1910.1047(h)(1)(i) and 1910.10047(h)(1)(iii).

3. Respondent was in "other" violation of 29 C.F.R. §§ 1904.8, 1910.1020(e)(2)(ii)(B) and 1910.1047(d)(7)(i).

4. Respondent was not in violation of 29 C.F.R. § 1910.1047(j)(3)(iii)(C).

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[8]The Secretary's motion to amend the citation and complaint to reflect the year 1996, rather than 1997, was granted.

Order

On the basis of the foregoing Findings of Fact and Conclusions of Law, it is ordered that:

1. Items 1 and 2 of citation 1 are affirmed as serious violations, and a penalty of $4,500.00 is assessed for each of these items.

2. Item 3 of citation 1 is vacated.

3. Items 1, 2 and 3 of citation 2 are affirmed as "other" violations. Penalties of $2,250.00 and $900.00 are assessed for items 1 and 2, respectively, and no penalty is assessed for item 3.

Irving Sommer
Chief Judge

Date: