UNITED STATES OF AMERICA
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION

THOMAS E. PEREZ, Secretary of Labor, United States Department of Labor, Complainant, v. UNIFIRST CORPORATION, Respondent.	OSHRC DOCKET No. 13-1703

DECISION AND ORDER

COUNSEL: M. PATRICIA SMITH, Solicitor of Labor, STANLEY E. KEEN, Regional Solicitor, THERESA BALL, Associate Regional Solicitor, DONNA E. SONNER, Esq., for Complainant

BRADFORD J. SMITH, Esq., Goodwin Procter, LLP, for Respondent.

JUDGE: GATTO, J.

I. INTRODUCTION

The above-styled action came before the Court on a complaint filed by Thomas E. Perez, Secretary of Labor, United States Department of Labor (the "Secretary"), pursuant to section 10(c) of the Occupational Safety and Health Act of 1970 ("the Act")[1] and Commission Rule 34(a),[2] alleging in Citation 1, Item 1 of the Citation and Notification of Penalty (the "Citation") that UniFirst Corporation ("UniFirst") committed a serious violation of section 5(a) of the Act[3] and the Bloodborne Pathogens standard[4] by requiring employees to unnecessarily handle, or handle with excessive agitation, contaminated laundry. The Secretary proposed a penalty of

[1] 29 U.S.C. § 659(c).

[2] 29 C.F.R. § 2200.34(a).

[3] 29 U.S.C. § 654(a).

[4] 29 C.F.R. § 1910.1030(d)(4)(iv)(A).

$3,000.00 for the alleged violation. UniFirst timely contested the Citation and argues the bloodborne pathogen standard does not apply to the cited conditions. It also contends, should the Court find the bloodborne pathogen standard does apply, that it complied with the terms of the standard. A bench trial was held on February 5, 2014, in Birmingham, Alabama.[5] Both parties filed post-trial briefs.[6] The Court has jurisdiction over the subject matter and the parties pursuant to section 10(c) of the Act. For the reasons indicated *infra*, the Secretary's citation and proposed penalty are **VACATED**.

II. BACKGROUND

UniFirst owns a uniform supply facility located at 907 Third Avenue North in Birmingham, Alabama, where it also operates an industrial laundry.[7] (Tr. 132.) The Birmingham facility employs twelve route sales representatives, who provide delivery and pickup services for customers on a weekly basis. UniFirst assigns to each route sales representative a designated route with regular customers. (Tr. 133.) Typically, a route sales representative will deliver clean uniforms and pick up soiled uniforms once a week at a scheduled time. (Tr. 134.) The route sales representative then delivers the soiled uniforms to UniFirst's facility, where they are

[5] The case was designated for Simplified Proceedings on November 15, 2013, in accordance with Subpart M of the Commission's Rules. *See* 29 C.F.R. §§ 2200.200--.211. On December 3, 2013, the parties announced a settlement. At the parties' request, the Court issued an order on December 5, 2013, removing the case from the trial calendar. The Court directed the parties to file their settlement agreement no later than January 6, 2014. On January 9, 2014, the Secretary's counsel notified the Court that the parties were unable to agree on the language of the settlement agreement. The Court then set this case for trial on February 5, 2014, in Birmingham, Alabama. Although each party entered an appearance for new counsel on January 29, 2014, the trial proceeded as scheduled.

[6] Commission Rule 209(f) generally requires that decisions be issued within 45 days of the trial (or in his case, by March 24, 2014). However, at the close of the trial, the parties requested the opportunity to file post-trial briefs. When asked if they could submit the briefs within two weeks of receipt of the transcript, counsel for both parties expressed their preference for a period of 30 days to submit the briefs. The Court granted this request. (Tr. 173-174.) The transcript was received on February 21, 2014, and the parties timely submitted their briefs on Monday, March 24, 2014, the day this Decision and Order ordinarily would have been due. In accordance with Commission Rule 209(f), the Chief Judge approved the Court's request for additional time in which to issue this Decision and Order. *See* 29 C.F.R. §§ 2200.209(f).

[7] UniFirst also leases items such as industrial mats, mops, and shop towels, which are picked up, cleaned, and delivered to the route customer. (Tr. 133-134.)

laundered. The route sales representative delivers the clean uniforms to the customer the following week and picks up the next batch of soiled uniforms. (Tr. 133.)

In February of 2013, UniFirst entered into a contract with a new customer, The Surgery Center, located in Oxford, Alabama. (Tr. 28.) Medical personnel at The Surgery Center perform same-day elective procedures, such as tonsil removals and ear intubations. (Tr. 168, 172.) The Surgery Center has approximately twenty employees, to whom it provides scrubs (a set of scrubs consists of a top and a pair of pants). (Tr. 36.) All personnel at The Surgery Center, including administrative employees, wear scrubs at work. The employees who do not participate in operating room procedures wear or take their scrubs home to launder them. (Tr. 125, 169.)

Personnel who perform or assist with medical procedures in the operating rooms wear surgical gowns over their scrubs. (Tr. 40.) Afterwards, the employees dispose of their surgical gowns in an area separate from the employees' locker rooms (UniFirst does not handle or come into contact with the soiled surgical gowns). (Tr. 169.) These employees are required to change out of their scrubs and deposit them in lockers labeled "Dirty Bin" in the men's and women's locker rooms. The Dirty Bin lockers are equipped with hinged doors at the top through which the employees drop the soiled clothing. (Ex. C-2; Tr. 36.)

The Surgery Center was dissatisfied with its previous uniform supply service because The Surgery Center was incurring costs due to missing scrubs. UniFirst offered the option of leasing scrubs with barcodes sewn into the garments (in the back of the collar for tops and in the waist band for pants), which can be scanned by the route sales representative each week before the laundry is removed from the premises. Brian Ada is UniFirst's general manager for the Birmingham facility. He explained that UniFirst's scanning capability was an incentive for The Surgery Center to contract with it:

> The Surgery Center was having problems with theft. People—garments disappearing, and they wanted some sort of accountability as to where—as to control their costs and accountability for the laundry that they did business with before.
>
> It was kind of one of those deals where the laundry was saying, "We didn't lose it," The Surgery Center was saying, "We didn't lose it." We offered a process to get—for accountability. So, yes, they chose us as their vendor because we were able to scan.

(Tr. 138.)

UniFirst assigned route sales representative Eric Foshee to service The Surgery Center's account. Foshee subsequently resigned from UniFirst over The Surgery Center account. Foshee had worked for UniFirst for approximately 7½ years at the time of this assignment. (Tr. 78.) Foshee first added The Surgery Center to his route in May of 2013. To service this account, Foshee would first place the clean sets of scrubs in designated lockers in the locker rooms. He would then put on his personal protective equipment ("PPE"), including safety glasses and two pairs of nitrile gloves, and open the Dirty Bin lockers. Foshee would remove each garment individually and use a handheld scanner to scan the barcode and then place the scanned garment in a biohazard bag. When he had scanned and bagged all of the scrubs, he would load the bags in his truck and drive to UniFirst's facility to deliver the soiled scrubs to the laundry. (Tr. 161.) Foshee scanned approximately 200 individual garments each week for The Surgery Center account (Tr. 46.) The entire servicing process took approximately 45 minutes to complete at The Surgery Center's facility. (Tr. 161.)

Foshee complained repeatedly to the staff of The Surgery Center and to UniFirst's management about the scanning requirement for The Surgery Center account. Leslie LaPlante is an administrator for The Surgery Center, where she had worked for 15 months at the time of trial. (Tr. 167.) She said of Foshee:

> Frequently, when he was there, he would make comments to that regard, that he needed to get home to his family that our facility took longer than what he was used to, and he commented on the poor quality of the scanners that he had been given by the company. He commented on the poor quality of the scrubs that his company issued, and he commented—he often seemed disgruntled.

(Tr. 170.)

UniFirst general manager Ada explained that UniFirst's pay structure was the source of Foshee's disgruntlement with The Surgery Center account:

> I mean, he had told everybody in the facility, in my facility, and I was hearing it from multiple people coming to me, that he did not want to scan this account. Not because of safety reasons but because it was taking time away from his family.
>
> And based on the way we compensate our employees, an employee works on commission. So if he goes in there and makes this account, does it in 30 minutes, it's a $200.00 a week account. Then, he makes 7 percent commission, he makes $14.00 in 30 minutes. If it takes him an hour to do it, then certainly his income is less. So he thought because it took extra time to scan, he was making less money.
>
> What he didn't take into consideration, he has accounts that run a couple of thousand dollars a week that take him an hour to run and he may make $140.00 an hour. And I never could get him to understand that, you know, you've got these great accounts and the bad ones, you put them all together and you come out with a pretty good paycheck every week[.]

(Tr. 140.)

Two months after UniFirst began servicing The Surgery Center's account, the Department of Labor's Occupational Safety and Health Administration ("OSHA") Birmingham Area Office received a complaint regarding the working conditions for UniFirst's route sales representatives at The Surgery Center worksite. (Ex. C-1; Tr. 19.) Alpha Davis, a Compliance Safety and Health Officer in that office was assigned to investigate the complaint. (Tr. 19.) On July 22, 2013, Officer Davis went to The Surgery Center's facility and met with The Surgery Center representatives (no one from UniFirst was present at the site at that time). Officer Davis interviewed The Surgery Center employees, conducted a walkaround inspection of the men's and

women's locker rooms, and took photographs of the Dirty Bin in the women's locker room. (Ex. C-2; Tr. 21-22.) Officer Davis did not observe the scanning process. (Tr. 37.) She stated she may have seen "one or two" garments in the bins. (Tr. 64.) The next day, Officer Davis went to UniFirst's Birmingham facility and opened an inspection with UniFirst. (Tr. 23.) Subsequently, upon Officer Davis's recommendation, the Secretary issued the instant Citation to UniFirst.[8] (Tr. 24.)

III. THE CITATION

Item 1: Alleged Serious Violation of Section 1910.1030(d)(4)(iv)(A)

Item 1 of the Citation alleges:

> 29 CFR 1910.1030(d)(4)(iv)(A)[9]: Contaminated laundry was unnecessarily handled or was handled with excessive agitation:
>
> On or about 07/23/13—1440 Highway Drive, Oxford, AL, employees hand sorted laundry from a bin prior to placing items in biohazard bags.

IV. ELEMENTS OF THE SECRETARY'S BURDEN OF PROOF

The Secretary has the burden of establishing the employer violated the cited standard. To prove a violation of an OSHA standard, the Secretary must show by a preponderance of the evidence that: (A) the cited standard applies; (B) the employer failed to comply with the terms of the cited standard; (C) employees had access to the violative condition; and (D) the cited employer either knew or could have known with the exercise of reasonable diligence of the violative condition. *JPC Group, Inc.*, 22 BNA OSHC 1859, 1861 (No. 05-1907, 2009). UniFirst contends the Secretary failed to establish the first three elements of his burden of proof. The

[8] The Secretary did not issue a citation to The Surgery Center. (Tr. 39.)

[9] Section 1910.1030(d)(4)(iv)(A) provides in pertinent part:
Contaminated laundry shall be handled as little as possible with a minimum of agitation. *(1)* Contaminated laundry shall be bagged or containerized at the location where it was used and shall not be sorted or rinsed in the location of use.

company does not contest the Secretary's proof of the element of knowledge. Therefore, only the first three factors will be addressed *infra*.

(A) Applicability of the Cited Standard

Section 1910.1030, the bloodborne pathogen standard, is found in Subpart Z (Toxic and Hazardous Substances) of the general industry standards. Section 1910.1030(a) (Scope and Application) provides: "This section applies to all occupational exposure to blood . . . as defined by paragraph (b) of this section."[10]

(1) Contaminated Laundry

The cited subsection, 1910.1030(d)(4)(iv)(A), addresses "contaminated laundry." Subsection 1910.1030(b) defines contaminated laundry as "laundry which *has been soiled* with blood . . . or may contain sharps." (Emphasis added.) In contrast, the definition of "contaminated" found in section 1910.1030(b) requires "the presence *or the reasonably anticipated presence* of blood . . . on an item or surface." (Emphasis added.) Therefore, blood must be physically present to constitute "contaminated laundry"—the "reasonably anticipated presence" of blood—is insufficient to establish that laundry is contaminated laundry within the meaning of the standard. Therefore, the Court concludes that in order to establish that section 1910.1030(d)(4)(iv)(A) applies to UniFirst's working conditions at The Surgery Center, the Secretary must establish that the scrubs Foshee was required to scan and bag had *actually* been soiled with blood or may have contained sharps.

[10] Although the bloodborne pathogen standard regulates occupational exposure to blood "or other potentially infectious material," at trial, the focus of the Secretary's case was the scrubs' exposure to blood that resulted from medical procedures performed in The Surgery Center's operating rooms. The issue of "other potentially infectious material" was not addressed at trial and therefore, will not be addressed in this decision and order. However, any findings made herein related to exposure to "blood", or lack thereof, would apply equally to "other potentially infectious material" since the evidence proffered was indistinguishable.

At trial, the Secretary presented no evidence establishing that the scrubs were actually soiled with blood or may have contained sharps. Foshee testified that he had never found sharps in the scrubs. (Tr. 86.) In his post-trial brief, the Secretary does not address the issue of whether the scrubs were contaminated laundry within the meaning of the standard. Instead, the Secretary assumes, without proof, that the scrubs were contaminated laundry. Officer Davis testified she concluded UniFirst's scanning procedure at The Surgery Center facility was a violation of section 1910.1030(d)(4)(iv)(A) because the route sales representative was handling garments "that were presumed to be contaminated." (Tr. 25.)

However, as indicated *supra*, the cited subsection of the bloodborne pathogen standard does not presume contact with blood—it is the Secretary's burden to establish that blood is *actually* present in the laundry. Officer Davis did not attempt to establish the presence of blood on the scrubs:

> Q. Was there blood on the scrubs?
>
> Officer Davis: I didn't pick the scrubs up, sir.
>
> Q. Did you see any blood apparent on the scrubs?
>
> Officer Davis: I didn't make a visual assessment of the scrubs for blood.
>
> Q. So you didn't even look?
>
> Officer Davis: No, I didn't.

(Tr. 64.)

Cedric Thomas is a district service manager for UniFirst. (Tr. 152.) He substituted as the route sales representative for The Surgery Center account twice in July of 2013. (Tr. 153.) He testified he "never saw any stains on the garments." (Tr. 162.) The Surgery Center administrator LaPlante testified that The Surgery Center personnel who are present during medical procedures

"wear protective equipment over their scrubs," including a surgical gown "that goes down past their knees." (Tr. 168.) The soiled surgical gowns are disposed of in an area separate from the locker rooms. LaPlante stated she had never seen blood or bodily fluid stains on soiled scrubs. (Tr. 169.)

The only witness who testified he observed stains on the scrubs was Foshee. He stated that "there were stains on garments and nobody could give me an explanation of what they were." (Tr. 79.) Foshee testified that every week he would go to The Surgery Center's contact person for the UniFirst account (the "key individual" or KI): "And I would bring these garments to her attention. You know, ask her, 'What is this? Can you explain what this is?' you know, and she—she would—I—and so whatever was going on was bleeding through whatever PPE that they had on, was coming through onto their clothes." (Tr. 86.) Foshee claimed that The Surgery Center personnel told him that the stains he brought to their attention were iodine stains:

> Q. You don't know if those stains you saw may have been iodine, for example, that is swabbed?
>
> Foshee: Sir, I don't know what they could have been.
>
> Q. And you said that, I think, earlier that you showed it to a Surgery Center representative and asked them. Did they tell you what it was?
>
> Foshee: She said that it was iodine, but she didn't, like, physically get it under the microscope and say, "It's iodine."
>
> Q. Okay. But she told you that it was iodine?
>
> Foshee: I mean, that's the typical response. Everything was iodine. Everything was okay.
>
> Q. That was her typical response?
>
> Foshee: Yeah, every—iodine. If I brought something to her attention, it was iodine. It was always iodine.
>
> . . .
>
> Q. So the stains you observed were—what color were they?

Foshee: Yellowish in color.

(Tr. 127-128.)

There is only one mention in the record of blood actually coming into contact with a garment. Foshee stated, "I had a nurse come in there and say, 'This one—this garment has some blood splatter on it,' and she just threw it in the pile of dirties." (Tr. 86.) The Court finds this single instance is insufficient to establish UniFirst's servicing of The Surgery Center account is covered by the bloodborne pathogen standard.

(2) Occupational Exposure

As indicated *supra*, Section 1910.1030(a) provides that the bloodborne pathogen standard applies "to all occupational exposure to blood or other potentially infectious materials as defined by paragraph (b) of this section." Section 1910.1030(b) defines "occupational exposure" as "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." In order to determine the meaning of a standard, "the Commission and the courts consider the language of the standard, the legislative history, and, if the drafter's intent remains unclear, the reasonableness of the [Secretary's] interpretation." *Shaw Global Energy Services, Inc.*, 23 BNA OSHC 2105, 2107 (OSHRC Docket No. 09-0555, 2012) (citing *Oberdorfer Industries, Inc.*, 20 BNA OSHC 1321, 1328-29 (Nos. 97-0469, 97-0470, 2003) (consolidated). The 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)).

The preamble to the bloodborne pathogen standard emphasizes 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 routine duties, such as autopsies, surgeries, phlebotomies, and surgical dressing changes:

> 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.

56 Fed. Reg. 64004, 64101 (December 6, 1991).

In the examples given, blood or other potentially infectious materials are reasonably anticipated to come into contact with "gloves or other protective clothing" during procedures where blood is actually present. In these examples, 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.

The atypical nature of the blood-spattered garment at issue is reflected by the nurse's comment to Foshee that "this garment has some blood spatter on it." (Tr. 86.) The presence of blood on the garment was unusual enough to elicit a comment from the nurse, who cautioned Foshee about it. The Secretary adduced no evidence establishing that "blood or other potentially infectious materials are an integral part of the activity" that Foshee performed weekly at The Surgery Center.

The Court concludes that the Secretary failed to establish that UniFirst's servicing of The Surgery Center account resulted in "occupational exposure" to its route sales representative. Contact with blood or other infectious materials was not reasonably anticipated during the route sales representative's routine performance of his work duties. The Secretary also failed to establish the soiled scrubs the route sales representative scanned and bagged at The Surgery Center constituted "contaminated laundry" within the meaning of the bloodborne pathogen standard. The Secretary adduced no evidence establishing the scrubs were actually soiled with blood. The single incident reported by Foshee of blood on a garment is an aberration that is insufficient to bring UniFirst's work at The Surgery Center facility within the purview of section 1910.1030(d)(4)(iv)(A). Therefore, the Court concludes that the cited standard does not apply to the cited conditions.

(B) Compliance with the Terms of the Standard

Assuming, *arguendo*, that the cited standard does apply, the Court nonetheless concludes that the Secretary did not establish that UniFirst failed to comply with the terms of the standard. Indeed, the Secretary had difficulty identifying the terms of the standard. The Secretary's characterization of the violative activity for which he cited UniFirst presented something of a moving target at trial. The alleged violation description of the Citation states that UniFirst was in violation of section 1910.1030(d)(4)(iv)(A) because Foshee "hand sorted laundry from a bin prior to placing items in biohazard bags." When initially asked to specify the alleged violative activity, Officer Davis stated, "The violation was that the employee was hand-sorting textiles and linens that were presumed to be contaminated, prior to placing them in a biohazard bag." (Tr. 25.) Officer Davis stated Foshee could come into contact with blood on the scrubs or could be stuck by a sharp "by picking [the scrubs] up out of the bin and hand-scanning them." (Tr. 27.)

Officer Davis equates "scanning" with "sorting." When asked to clarify her definition of "sorting," Officer Davis replied:

> [S]orting in this case, to me, was to manually --to manually sort, to identify that you had a -- had a scrub and you were sorting it to make sure that you -- let's see -- that you cataloged it, so you know, you removed that particular scrub and put it in a bag. So "sort" in that case was what I was thinking it was.
> . . .
> I think just picking them up out of a bin like that—male, female, and scanning—that was part of what I considered to be scanning.

(Tr. 42-43.)

Officer Davis then stated that if Foshee had removed the scrubs from the locker and placed them directly into the biohazard bag without scanning them, she "probably would not have characterized that as sorting," even if he had removed the garments one by one and placed them in the biohazard bag. (Tr. 43.) Officer Davis went on to state, however, that she would still consider the removal of the scrubs from the Dirty Bins to the biohazard bag to be a violation of section 1910.1030(d)(4)(iv)(A). (Tr. 44.) Thus, according to Officer Davis, even if the alleged "sorting" was removed from the process, a violation still existed. When asked on what basis she formed this opinion, Officer Davis replied, "Based on the fact that I believed that there was a better way to do the job. I think that the fact—now, this is my understanding, that prior to [the introduction of UniFirst's scanning procedure], that there had just been a big bag in there." (Tr. 45.)

As her testimony proceeded, Officer Davis's characterization of the violative activity evolved to a point where the "hand sorting" identified in the Citation was no longer an aspect of the violation. Officer Davis was asked if Foshee would be in violation of the cited standard if he reached into the Dirty Bin and picked up all of the scrubs at once and deposited them into the

biohazard bag. She responded, "I would determine that's probably not the best practice" and that [p]robably, yes," that would be a violation. (Tr. 47-48.)

It became clear at trial that Officer Davis considered *any* handling of the scrubs by Foshee to be a violation of section 1910.1030(d)(4)(iv)(A):

> Q. Okay. So, and just so we're clear: The scanning was not the problem; it was the fact that he picked them up, whether one by one or by group or for several groups. It was the fact that he touched them was the source of the violations; is that correct?
>
> Officer Davis: I believe scanning played a part in it because you are handling -- you're handling each garment. Yes, I believe that's a contributing factor. But the fact that he was manually handling those, yes, that's a part of the violation.
>
> Q. All right. The manual handling of them. To remove them from the locker and place them into the biohazard bag?
>
> Officer Davis: Yes.
>
> . . .
>
> The Court: Before you move on, so as to be clear, then, as I understand it, you're indicating that any handling, whether in a lump fashion or individually, would be a violation; is that right?
>
> Officer Davis: Yes, Your Honor.
>
> The Court: Just because it might not be best practices?
>
> Officer Davis: That would not be the best practice. In my determination, that there would be -- there are feasible means for them to do the job another way.
>
> The Court: As I understand it, though, that regulation does not prohibit all handling. It says that handling shall be as little as possible, with a minimum of agitation. Do you believe the scenario that you've described fits into that definition?
>
> Officer Davis: The hand-sorting?
>
> The Court: Yes.
>
> Officer Davis: Yes, sir.
>
> . . .
>
> The Court: Or not hand-sorting? You said that they're picked up in bulk and placed into the bag.

> Officer Davis: My concern with that is that anything could be in that bulk when you pick it up. It -- I believe that the hand-sorting was a greater issue, but picking them up –
>
> The Court: Take it one step further, then. What would be the best practice if they're not permitted to pick them up in bulk?
>
> Officer Davis: The best practice would have been the hazard -- some type of container that you would just -- already in there that you would close and take out. That the bag would already be there, and you would just take it with you.

(Tr. 48-50.) Despite these assertions, UniFirst was not cited with a Universal Precautions standard violation. Significantly Officer Davis categorized the severity justification in her report as "low," and indicated that "blood was unlikely." (*Id*. at 6.)

Under the Secretary's interpretation of section 1910.1030(d)(4)(iv)(A), as explained by Officer Davis, any handling of contaminated laundry is a violation of the standard. This interpretation runs counter to the express terms of the standard, which only requires that contaminated laundry be "handled as little as possible with a minimum of agitation." 29 C.F.R. § 1910.1030(d)(4)(iv)(A). The employer is obligated to minimize the handling of contaminated laundry, not eliminate it altogether.

The word "sorted" is also not defined in the standard. The Court does not agree with Officer Davis's characterization of "sorting." The preamble to the standard noted that information provided by laundry workers demonstrated that exposure to blood and other potentially infectious materials did occur during processing of contaminated laundry, because as one worker testified, "[y]ou have to sort the linen. You put bath blankets in one place and you put sheets in another, you put towels in another. You sort it. . . ." *See* 56 Fed. Reg. 64149-50 (1991); *see also* Resp't's Ex. 1, p. 246.[11]

[11] *See also* https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_id=811&p_table=PREAMBLES.

Consistent with the preamble's characterization of "sorting," the Merriam-Webster dictionary also defines the verb "sort" as "the act of separating things and putting them in a particular order," to "arrange according to characteristics," or "to put in a certain place or rank according to kind, class, or nature."[12] Applying these definitions within the context expressed in the preamble, the Court concludes that the scrubs were not "sorted" within the meaning of the cited regulation or as defined by Officer Davis.

Further, the bloodborne pathogen standard is a performance standard. 56 Fed. Reg. at 64088. Unlike a specification standard, which details precise requirements an employer must meet, a performance standard indicates the degree of safety and health protection required, but leaves the method of achieving the protection to the employer. Compliance with a performance standard is determined by whether the employer acted as a reasonably prudent employer would:

> [T]he employer is required to assess only those hazards that a "reasonably prudent employer" would recognize. See *W.G. Fairfield Co*., 19 BNA OSHC 1233, 1235, 2000 CCH OSHD ¶ 32,216, p. 48,864 (No. 09-0344, 2000), aff'd, 285 F.3d 499 (6th Cir. 2002); see also *Thomas Indus. Coatings, Inc*., 21 BNA OSHC 2283, 2287, 2004-09 CCH OSHD ¶ 32,937, p. 53,736 (No. 97-1073, 2007) ("[P]erformance standards ... are interpreted in light of what is reasonable."). A reasonably prudent employer is a reasonable person familiar with the situation, including any facts unique to the particular industry. *W.G. Fairfield Co.,* 19 BNA OSHC at 1235, 2000 CCH OSHD at pp. 48,864-65; *Farrens Tree Surgeons, Inc*., 15 BNA OSHC 1793, 1794, 1991-93 CCH OSHD ¶ 29,770, p. 40,489 (No. 90-998, 1992); *see also Brennan v. Smoke-Craft, Inc.,* 530 F.2d 843, 845 (9th Cir. 1976). Under Commission precedent, industry practice is relevant to this analysis, but it is not dispositive. *W.G. Fairfield,* 19 BNA OSHC at 1235-36, 2000 CCH OSHD at p. 48,865; *Farrens Tree Surgeons*, 15 BNA OSHC at 1794, 1991-93 CCH OSHD at p. 40,489; *see also Smoke-Craft,* 530 F.2d at 845 (noting that in absence of any industry custom the need to protect against an alleged hazard "may often be made by reference to" what a reasonably prudent employer "familiar with the industry would find necessary to protect against this hazard").

Associated Underwater Services, 24 BNA OSHC 1248, 1250 (No. 07-1851, 2012).

[12] *See* http://www.merriam-webster.com/dictionary/sort.

Here, the Secretary has offered no evidence demonstrating that UniFirst's procedure for handling the soiled scrubs at The Surgery Center's facility deviated from what a reasonably prudent employer would do under the same conditions. UniFirst trained its employees in bloodborne pathogen safety and provided them with PPE. (Tr. 135-136.) Foshee was required to handle each garment at The Surgery Center facility once for a few seconds.

UniFirst district service manager Thomas, who substituted as a route sales representative on The Surgery Center account twice, demonstrated at trial the procedure for scanning and bagging the garments, which was not disputed. Thomas donned PPE equipment; including safety glasses, a barrier coat, and two pairs of nitrile gloves (it is UniFirst's policy to require its employees to double-glove). Thomas held a scanner in his right and reached to a pile of scrubs with his left. Thomas grasped the edge of a garment with the fingers of his left hand and scanned the barcode of each garment with his right hand. He then dropped each garment into the biohazard bag, which was supported on a scissors rack. (Tr. 157-162.) Thomas stated that if the barcode is not immediately visible, "you can jiggle sometime, and sometimes you have to set the scanner down and you just have to find the barcode." (Tr. 163.) During the demonstration, the only contact Thomas made with the garments was with the double-gloved fingers of his left hand.

The Court concludes that UniFirst acted as a reasonably prudent employer when processing the laundry at The Surgery Center facility. UniFirst's process for scanning and bagging the laundry ensured that the laundry was handled as little as possible, with a minimum of agitation. Therefore, the Court concludes that UniFirst complied with the terms of section 1910.1030(d)(4)(iv)(A).

(C) Employee Access to the Hazard

Finally, the Court also concludes that Foshee did not have access to the hazard of contact with blood or sharps. As indicated *supra*, he testified that he had never found sharps in the scrubs. The Secretary presented no evidence beyond the single instance that the scrubs were routinely contaminated with blood. Even if such evidence were adduced, the record establishes the use of PPE required by UniFirst eliminated Foshee's exposure to blood. As noted *supra*, Foshee wore double nitrile gloves, a barrier coat, and safety glasses when scanning the scrubs, and offered him a safety hat. Thus, the Secretary has not established employee access to the hazard of bloodborne pathogens.

Therefore, the Court concludes that the Secretary has failed to establish that the cited standard applies to UniFirst's scanning and bagging procedure at The Surgery Center facility. The Secretary also failed to establish UniFirst was in noncompliance with the terms of the cited standard or that its route sales representative had access to the cited hazard. Thus, the Court concludes a violation of section 1910.1030(d)(4)(iv)(A) was not established. Accordingly,

V. 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.

VI. ORDER

IT IS HEREBY ORDERED THAT Item 1 of the Citation and Notification of Penalty, alleging a serious violation of section 1910.1030(d)(4)(iv)(A), is VACATED and no penalty is assessed.

SO ORDERED THIS 10th day of April, 2014.

/s/
JOHN B. GATTO, JUDGE
U.S. Occupational Safety and
Health Review Commission