

**THIS CASE IS NOT A FINAL ORDER OF THE REVIEW COMMISSION AS IT IS
PENDING COMMISSION REVIEW**

Some personal identifiers have been redacted for privacy purposes



United States of America
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
721 19th Street, Room 407
Denver, Colorado 80202-2517

SECRETARY OF LABOR,

Complainant,

v.

CHARLES W. MASON, DDS,
& ASSOCIATES, PLLC,

Respondent.

OSHRC Docket No. 10-2313

APPEARANCES:

Gregory W. Tronson, Esquire, U.S. Department of Labor
Office of the Solicitor, Denver, Colorado
For the Complainant.

Donald R. Murray, Esquire
Hash, O'Brien, Biby & Murray, PLLP, Kalispell, Montana
For the Respondent.

BEFORE:

John H. Schumacher
Administrative Law Judge

DECISION AND ORDER

This proceeding is before the Occupational Safety and Health Review Commission ("the Commission") under section 10(c) 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") inspected the office of Charles W. Mason, DDS, & Associates ("Respondent"), on July 14, 2010 and August 5, 2010. The office was located

in Kalispell, Montana, and the inspection resulted in Respondent being issued a Citation and Notification of Penalty (“Citation”). The Citation alleged serious violations of the hazard communication standard and the bloodborne pathogens standard.¹ Respondent contested the Citation, and the hearing in this matter took place in Kalispell, Montana, on November 8, 9 and 10, 2011. Both parties have filed post-hearing briefs.

The OSHA Inspection²

OSHA Compliance Officer (“CO”) Jeffery Hanson went to Respondent’s office on July 14, 2010, due to a complaint OSHA had received. Another CO, Chris Dickey, accompanied CO Hanson. Upon arriving, the two COs met with Charles Mason, DDS, the individual who owned and operated The Brace Place, an orthodontic practice in Kalispell, Montana. The COs held an opening conference with Dr. Mason, explained why they were there, and gave him a copy of the complaint OSHA had received. Referring to the items in the complaint, the COs discussed the hazard communication (“HazCom”) standard and asked to see the material safety data sheets (“MSDSs”) that Dr. Mason had. He showed them the binder where he kept the MSDSs, but they were in no particular order and there was no list so that employees could readily find an MSDS for a particular chemical. The COs advised Dr. Mason that he should make a list and index it with the MSDSs for easy access and use. (Tr. 43-50; GX-1).

The COs next asked Dr. Mason if he had an exposure control plan as required by the bloodborne pathogens (“BBP”) standard. He showed them his plan, which the COs found satisfactory. The COs then asked about sharps containers, and Dr. Mason took them to his clinical area and showed them what he had.³ The COs told Dr. Mason they wanted to interview the employees who worked in the clinical area, and he made those employees available. The employees the COs interviewed were Beverly Palmer (the clinical staff supervisor and the X-ray specialist), and [redacted] (both clinical assistants).⁴ Upon interviewing these employees, the COs learned they used products called Maxicide and Solutek. Maxicide was used to sterilize instruments, and Solutek

¹ As issued, the Citation had seven items, three of which had sub-items. Prior to the hearing, the Secretary withdrew Item 6 of Citation. That item alleged a violation of 29 C.F.R. § 1910.1030(d)(4)(ii).

² The following is based upon the testimony of OSHA Compliance Officer Jeffery Hanson.

³ One item in the complaint alleged a lack of ventilation in an area where casts and molds were made. The COs terminated this complaint item after observing the area and concluding there was no hazard. (Tr. 51).

⁴ The initials of these two employees are being used to protect their privacy.

was used to develop X-rays. Both of these products were used on a daily basis, and both contained hazardous chemicals. When the COs asked Dr. Mason who did training in the use of chemicals, he told them Ms. Palmer was in charge of that training. However, Ms. Palmer stated that she did not train on the chemicals; in fact, all the employees said there was no training in the chemicals they used. (Tr. 50-72, 234; GX-3, GX-4).

During the employee interviews, the COs learned that the clinical staff was exposed to patient blood and saliva. When the clinical assistants worked in patients' mouths, they performed duties such as banding and debanding, and inserting, adjusting or removing orthodontic wires; in doing so, an assistant would use her fingers to protect the gum or cheek of a patient to keep a wire or instrument from poking or sticking the patient. While the assistants wore gloves for this work, they could be poked or stuck by a wire or instrument, which could puncture their skin. The assistants also wore masks with face shields; however, until shortly before the inspection, they had worn only masks, and there had been times when an assistant's eye had been splattered with patient saliva. The assistants said that there had been some training before the OSHA inspection that had addressed exposure to BBPs such as HIV and HBV, but they did not feel that they had the necessary training to protect themselves.⁵ For example, if an assistant's finger was punctured by a wire, she was told to put alcohol on it; the assistants were not trained in receiving post-exposure evaluation and follow-up. (Tr. 76, 81- 94).

The COs also learned that the office's handling of contaminated waste did not comply with the standard. A plastic trash can with a plastic bag inside it was located under the counter in the clinical area. The plastic trash can had a biohazard label on it. Employees would put contaminated waste, such as used orthodontic wires and cotton balls or gauze containing blood and/or saliva, in the can through a hole in the counter. At the end of the day, an employee would remove the plastic bag from the trash can and put it in one of the large city-owned trash containers located outside; if a used wire had poked a hole in the plastic bag, an employee could have been exposed to a skin puncture. There were also two small plastic jars with screw-on lids for disposing of waste. The jars were on top of the counter in the clinical area. The jars had biohazard labels and indicated that

⁵ The COs asked for training documents on July 14, 2010, but Dr. Mason provided no such documentation that day. (Tr. 74, 84, 191-92).

they were for used wires and other regulated waste. However, the lids were not always kept on the jars, and the top of the counter was a high-traffic area; if a jar had been knocked over, the wires and other waste would have fallen onto the counter and/or the floor. In addition, employees were allowed to put the used wires and other regulated waste into the jars or into the plastic trash can under the counter. (Tr. 95-114, 124-26).

Another practice the COs learned about was that some orthodontic wires that had been used in patients' mouths were put into small ziplock bags; the bags were then put in the patients' charts and kept for later use. The wires were not sterilized before being put in the bags. When an assistant needed the wires later for the same patient, she would reach into the chart to retrieve the bag and then reach into the bag to take the wires out. This activity could have resulted in the assistant being stuck or poked by a wire, which presented the risk of exposure to a BBP. (Tr. 115-23).

CO Hanson returned to Dr. Mason's office by himself on August 5, 2010, in order to speak further to Ms. Palmer and Dr. Mason. He was able to speak only to Dr. Mason, because Ms. Palmer was busy with patients. Dr. Mason told the CO he had training documents but could not give them to him then. After that visit, Dr. Mason mailed training documents and MSDSs to the CO. Also after that visit, the CO had follow-up phone conversations with employees. (Tr. 51-53, 56, 73-77, 84, 191-92; GX-5).

Credibility of Witnesses

A number of witnesses testified in this matter. In addition to CO Hanson, the witnesses included Dr. Mason, Ms. Palmer, [redacted]. Cristina Fetveit, another clinical assistant in Dr. Mason's office, also testified.⁶ The Secretary presented Kimberly Laudenslager, who testified as an expert in infection control in dental settings. And Respondent presented Dr. Gregory Schade and Dr. Robert Windauer, two orthodontists who had each practiced for many years before retiring in 2003.

As to CO Hanson, Respondent contends his testimony should be given little weight, asserting that he had had little experience, that this was his first inspection of a dental office, and that he had some significant misunderstandings of the requirements of

⁶ Another employee who testified was Cynthia Featherly, the treatment coordinator in Dr. Mason's office; she has worked for Dr. Mason for 11 years. Her testimony was very brief and also cumulative in light of other evidence in the record. (Tr. 519-22). Further, to the extent her testimony conflicted with that of other witnesses I found credible, I found it unpersuasive, particularly in view of her 11 years with Dr. Mason.

the cited standards. R. Brief, p. 5. The CO did testify that his position with OSHA was his first job after college, that he had been with OSHA for less than a year at the time of the subject inspection, and that this was his first dental office inspection. (Tr. 142-44). I find, however, that the CO's education and experience adequately prepared him for the inspection. CO Hanson is an industrial hygienist with a B.S. degree in environmental health. He had been with OSHA for ten months at the time of the inspection. He was trained at the OSHA Institute, and he had had six months of on-the-job training before he began conducting inspections on his own.⁷ During his training, he participated in two inspections involving the BBP standard. And after he began doing his own inspections, one of those involved a nursing home and focused on the BBP standard. During the inspection in this case, he obtained documents from OSHA's web site and documents from entities like CDC and NIOSH to support his interpretation of the cited standards. (Tr. 43-44, 57, 62-63, 67-69, 112-13, 116-18, 142-44; GX-4, GX-9, GX-15, GX-16).

I also observed CO Hanson's demeanor on the witness stand, including his body language and his facial expressions.⁸ I found his testimony to be candid, convincing and forthright. Further, the determinations he made as to the cited standards were based on the statements of Dr. Mason and the clinical employees he interviewed, and, as noted above, documents he obtained from OSHA and other entities, such as CDC and NIOSH. For these reasons, and those above, I found the CO's testimony credible.

With respect to Dr. Mason, the record shows that he has had an orthodontic practice in Kalispell for nearly 30 years. Dr. Mason earned his D.D.S. degree from Emory University and his orthodontic certification from the University of Pennsylvania. He is a member of the American Dental Association and the American Association of Orthodontics, and he is a diplomat of the American Board of Orthodontics. (Tr. 570-73). While I found some of Dr. Mason's testimony to be straightforward, other testimony he gave appeared to lack candor. This was especially notable when it conflicted with witness testimony that I found credible. CO Hanson, for example, testified that when Dr. Mason presented his MSDS binder the MSDSs were in no particular order and there was no list to enable an employee to easily find the MSDS for a particular chemical; he thus

⁷ At the time of the hearing, CO Hanson had been with OSHA for over two years and had conducted over 100 inspections. (Tr. 43).

⁸ This statement applies to all of the witnesses who appeared and testified in this matter.

advised Dr. Mason to make a list and index it with the MSDSs. (Tr. 50). Dr. Mason testified at the hearing that if the CO had asked to see a list of chemicals, he would have shown it to him. (Tr. 579). CO Hanson also testified that Dr. Mason told him that anyone who does clinical orthodontic work is subject to being stuck by a wire. (Tr. 109). Dr. Mason testified at the hearing that a percutaneous wire stick from a wire affixed in a patient's mouth was "fairly rare" and had happened to him perhaps five times; he also testified that being stuck by a loose wire was not a risk. (Tr. 649-50). On this basis, and because his testimony also conflicted with that of other witnesses, as set out *infra*, I found Dr. Mason to be a less than reliable witness in this matter.

[redacted] was a clinical assistant in Dr. Mason's office from May 2003 to September 2010; she was a patient scheduler in his office from June 2002 to May 2003. (Tr. 353-58, 393). [redacted] had no concerns about her job until late May 2010, when the office staff was told in a meeting that an HIV-positive patient was seeking treatment. The staff was concerned, as there had been no training in BBPs, taking care of HIV patients, and the proper personal protective equipment ("PPE") to use. Dr. Mason decided to not treat the patient, but the staff still had concerns. [redacted] went on the internet and found information about OSHA's BBP and HazCom regulations. She went to Dr. Mason with her concerns and told him she felt that the office might be in violation of the regulations. He was dismissive and said the office was OSHA compliant. She went back to him several more times, with the same result. In late June of 2010, she gave him a packet of about 75 pages of the information she had found. In the packet, she included a letter from [redacted], who had had experience with OSHA compliance in his job; in the letter, [redacted] offered to help bring the office into OSHA compliance.⁹ Dr. Mason's response was dismissive, and [redacted] discussed the matter further with [redacted]. [redacted] then phoned Dr. Mason to express his concerns about the office and to again offer his assistance. [redacted] (Tr. 358-59, 362-65, 368-73, 382-84, 395-98).

At this point, some changes were made in the office. Dr. Mason began to have training sessions with the clinical staff that covered BBPs like HIV and hepatitis and PPE

⁹ [redacted] knew about the situation as she had talked to him about it and he was concerned for her safety; she also said that he had no financial motivation in making his offer. (Tr. 369, 372).

like gloves. He also brought two plastic jars and a plastic trash can into the office and told the staff they were for disposing of used wires and cotton balls or gauze that had blood or saliva on them. The jars and can had biohazard labels and writing on them indicating they were for regulated waste. [redacted] felt that these measures and the training sessions were inadequate. She also felt that the office environment, which had been very positive before, had changed, [redacted] discussed the situation with [redacted], and [redacted] decided to call OSHA. [redacted] made the call, and, shortly after, the inspection took place. After the OSHA inspection, the clinical staff had some training about the chemicals they used, like the X-ray and the sterilizing chemicals. On July 22, 2010, the employees were asked to sign a document entitled “Regulatory Compliance Training.” [redacted] refused to sign because the sessions had not covered everything set out in the document; also, the staff had not had annual training sessions, as the document implied. Dr. Mason was angry when [redacted] would not sign the document. [redacted] (Tr. 361, 371-82, 387-89, 396-97).

Respondent urges that [redacted] testimony was not credible, [redacted]. It also urges that [redacted] contacted OSHA not out of concern about safety but to retaliate against Dr. Mason for refusing the offer of assistance [redacted]. R. Brief, pp. 2-4, 19. I note first that Respondent’s suggestion that [redacted] sought to be paid for his help has no credible support in the record. R. Brief, p. 3, 19. [redacted] testified, as set out above, that [redacted] had no financial motive in offering his help.¹⁰ (Tr. 372). Second, [redacted]. I observed her demeanor as she testified, and I found her to be sincere and believable. (Tr. 400-02). I thus reject Respondent’s argument that her testimony was not trustworthy. Third, I have noted Dr. Mason’s testimony that [redacted]. (Tr. 444, 665). [redacted] worked for Dr. Mason for more than eight years [redacted]. Further, Dr. Mason described [redacted] as a “wonderful” employee, and Ms. Palmer testified that [redacted] was a good worker, that she followed instructions and wore her PPE, and that she trained other employees. (Tr. 447, 665). And Dr. Windauer, one of the retired orthodontists Respondent presented, testified that he had spoken to Dr. Mason’s staff and

¹⁰ [redacted], and contacted OSHA because Dr. Mason had refused [redacted] help, this does not alter the fact that OSHA found a number of violations upon inspecting the worksite. Respondent also asserts that [redacted] “threatened” Dr. Mason with an OSHA inspection during their phone conversation. R. Brief, p. 3. Again, even if this is true, it does not change what OSHA discovered during its inspection.

that those he talked to indicated that [redacted] was “exceptionally good” and had trained them very well. (Tr. 542). For all of these reasons, I found the testimony of [redacted] credible.

[redacted] was a clinical assistant in Dr. Mason’s office from October 2008 until late 2010; since January 2011, she has been a clinical assistant in another orthodontics office. (Tr. 297-99). The testimony of [redacted] was very similar to that of [redacted] in terms of the work the clinical assistants did in Dr. Mason’s office, [redacted]. Her testimony about the HIV patient was also similar to that of [redacted], and she confirmed that [redacted] had obtained information from the internet about BBP exposure.¹¹ [redacted] testimony was very much like that of [redacted] as to the PPE worn in the office. The testimony of [redacted] was also alike as to the training given in the office and the disposal of waste and when the new trash can and jars began to be used. Like [redacted] refused to sign the training sheet indicating the office was compliant with OSHA, as she was not sure that it was; the sheet also indicated that there were annual training sessions, which was not true, and Dr. Mason was angry when she would not sign the sheet. (Tr. 301-26, 333, 340-51). In her testimony about [redacted] Ms. Palmer stated that [redacted] was [redacted]. (Tr. 418, 423, 438). This testimony was unpersuasive, however, and I found [redacted] testimony credible.

Ms. Palmer has worked in Dr. Mason’s office for 31 years. She is the clinical director, and she works as a clinical assistant and supervises the other clinical assistants; she is also a registered X-ray technician. (Tr. 409-12). Like Dr. Mason, I found some of Ms. Palmer’s testimony believable, but other testimony she gave seemed less than trustworthy. This was especially true when her testimony was contrary to that of other witnesses I found credible. CO Hanson testified, for example, that Ms. Palmer told him that getting “stuck” was just part of the job. (Tr. 88). Ms. Palmer testified, however, that she had had wire sticks that had broken the skin not over ten times in 30 years. (Tr. 430). The CO also testified that Dr. Mason told him Ms. Palmer was in charge of training employees in the chemicals used in the office; when he spoke to Ms. Palmer, she said she did not train on the chemicals. (Tr. 72). Ms. Palmer agreed she said she did no training,

¹¹ [redacted] said that after she herself insisted a container be obtained for used wires, Dr. Mason brought in a jar; after this point, she began to feel she was being harassed by Dr. Mason and other staff. (Tr. 318-19).

but she stated that she had misunderstood; she thought the COs had asked if she did all of the clinical assistant training. (Tr. 436-37). Finally, the CO testified Ms. Palmer and the other employees told him that either the trash can or the jars could be used for disposing of used wires and contaminated waste. (Tr. 97-98). Ms. Palmer testified employees were instructed to put contaminated wires into the sharps containers when those began to be used; she also testified this was not optional but that some wires might have been put in the trash can by accident. (Tr. 437-38). Based on these examples, and on others set out *infra*, I found Ms. Palmer to be a less than reliable witness.¹²

Christina Fetveit has been a clinical assistant in Dr. Mason's office since June 2010; before then, she was Dr. Mason's scheduling coordinator. (Tr. 483-84). Ms. Fetveit testified about how she was trained for her job, which included training in BBPs and MSDSs; she also described the safety measures in place in the office, like the PPE she used, the containers used for regulated waste, and the annual refresher training that was provided. (Tr. 485-501). The record shows, however, that Ms. Fetveit did not actually start treating patients until August or September of 2010; the new scheduling coordinator had to have surgery shortly after she began her job, and Ms. Fetveit had to continue in her old position until the new employee returned. (Tr. 505-06). By the time Ms. Fetveit began her clinical assistant duties, changes had occurred in the office, as set out above. Ms. Fetveit's testimony was thus not based on the conditions in the office during the relevant period. Further, to the extent her testimony was in conflict with that of other witnesses I found credible, it was not reliable. For example, Ms. Fetveit testified she had never been stuck by a wire such that she bled. (Tr. 490). [redacted], on the other hand, both indicated that percutaneous wire sticks were fairly common. (Tr. 321, 340-41, 382-84, 397-99). Also, Ms. Fetveit had worked for Dr. Mason for more than four years by the time of the hearing, and it is reasonable to conclude that her testimony about the office was an effort to help her employer in this matter. (Tr. 484). For all of these reasons, I found Ms. Fetveit's testimony to be less than trustworthy.¹³

¹² In view of her many years in Dr. Mason's office, it is reasonable to conclude that Ms. Palmer was attempting to assist her employer in this matter.

¹³ Similar to Ms. Palmer, Ms. Fetveit described [redacted]. She also testified that she did not think that anyone in the office had ostracized or "turned on" [redacted] due to the OSHA inspection. (Tr. 502-05). This testimony is not credited.

Kimberly Laudenslager is a dental hygienist with a B.A. degree in sociology and medicine and a Master's degree in public administration. Besides working as a dental hygienist, she was a clinical professor for 32 years at the University of Colorado School of Dentistry, where she taught dental hygiene and infection control to both dental hygiene and dentistry students. In 1995, she was appointed to Colorado's state board of dental examiners, where she examined candidates for licensure, and in 2005, the Central Regional Dental Testing Services hired her as their dental hygiene examinations director. In 1989, she began holding seminars in infection control and OSHA compliance, and, since the early nineties, she has given these through Laudenslager Seminars; most are group seminars held in Colorado and other states, but some are private seminars given in dental offices.¹⁴ Ms. Laudenslager has testified as an expert in infection control in Colorado state board proceedings that have addressed complaints against dentists. (Tr. 236-47; GX-25). In view of her education, experience and background, I accepted Ms. Laudenslager as an expert in infection control in dental settings. (Tr. 248-49). I found her to be an extremely knowledgeable and credible witness in this matter.

Dr. Schade and Dr. Windauer are retired orthodontists; they both practiced for about 30 years before retiring in 2003, and they both are acquaintances of Dr. Mason.¹⁵ Both testified about their professional education, training and experience, the professional organizations they belonged to, and their familiarity with infection control in dental and orthodontic offices. They further testified that they had visited Dr. Mason's office both before and after the OSHA inspection; they visited the office together in July of 2011, at which time they observed the office and spoke to Dr. Mason and his staff to address the issues that OSHA had determined were violations.¹⁶ (Tr. 458-66, 522-28). Dr. Schade and Dr. Windauer testified that they were very impressed with Dr. Mason's office both before and after the OSHA inspection; they also indicated their belief that the office was in compliance with OSHA requirements. (Tr. 464-82, 528-37, 540-45, 550, 555-57). Dr. Schade stated, however, that he "really didn't get into" whether the staff was doing things

¹⁴ Ms. Laudenslager has also been hired by dentists to help them get into compliance after being cited by OSHA. (Tr. 247).

¹⁵ Dr. Schade's practice was in Boise, Idaho; he has known Dr. Mason since 2003 and considers him a friend. (Tr. 459, 462). Dr. Windauer's practice was in Kalispell, Montana; he has known Dr. Mason professionally since the early eighties. (Tr. 524-28).

¹⁶ Dr. Schade first visited Dr. Mason's office in 2009. (Tr. 464). Dr. Windauer visited the office once before the inspection and three times after; one of these was his visit with Dr. Schade. (Tr. 525, 528).

differently than it had been a year before. (Tr. 468). And while Dr. Windauer indicated his impression that the practices in place in July 2011 had been in place “all along,” he agreed that his observations of Dr. Mason’s office were after the inspection. (Tr. 540, 557-58). It is clear, therefore, that what Drs. Schade and Windauer learned about Dr. Mason’s office in July 2011 has little relevance to the conditions that were cited at the time of the OSHA inspection. Further, while the two doctors gave their opinions about various aspects of infection control in dental settings, they were not offered as experts in that regard. Their testimony about infection control will thus be given less weight than that of Ms. Laudenslager, the Secretary’s expert witness.

The Secretary’s Burden of Proof

To prove a violation of an OSHA standard, the Secretary must prove by a preponderance of the evidence that: (1) the cited standard applies; (2) its terms were not met; (3) employees had access to the violative condition; and (4) the employer either knew, or could have known with the exercise of reasonable diligence, of the violative condition. *Atlantic Battery Co.*, 16 BNA OSHC 2131, 2138 (No. 90-1747, 1994).

Citation 1, Item 1

Item 1 alleges a violation of 29 C.F.R. 1910.1200(h)(1), which provides that:

Employers shall provide employees with effective information and training on hazardous chemicals in their work area at the time of their initial assignment, and whenever a new physical or health hazard the employees have not previously been trained about is introduced into their work area....Chemical-specific information must always be available through labels and materials safety data sheets.

The Citation alleges that employees were exposed to hazardous chemicals such as glutaraldehyde and hydroquinone and that they had not had adequate and/or effective training as to the safe handling and use of such chemicals. CO Hanson testified that he learned through employee interviews with Ms. Palmer, [redacted] that they used products called Maxicide and Solutek. Both of these products were used daily, and both contained hazardous chemicals. When the CO asked Dr. Mason who did training in the use of chemicals, he said that Ms. Palmer was in charge of that training. However, Ms. Palmer stated that she did not train on the chemicals; further, all of the employees interviewed said there was no training in the chemicals used. (Tr. 55-72).

CO Hanson also testified that when the inspection began, Dr. Mason was asked for training documents. No such documents were provided. On the CO's second visit, Dr. Mason said he had training documents but could not give them to him then. After the inspection, Dr. Mason mailed training documents to the CO. *See* CX-5. Based on what he learned during his inspection and his review of CX-5, CO Hanson concluded that no HazCom training had occurred until after the OSHA inspection. (Tr. 73-77).

Dr. Mason offered testimony indicating that Ms. Palmer had always trained employees in the chemicals used in his office. He also indicated that at present, he does "classroom sessions" on the HazCom standard while Ms. Palmer does the "practical training." He said he had held HazCom training before the OSHA inspection, although not every year, and he had not always kept records. He also said that the employees know the location of the written HazCom program and the MSDSs. (Tr. 578-83).

Despite Dr. Mason's testimony, I find that no HazCom training took place until after the OSHA inspection. Dr. Mason agreed he had sent CO Hanson an e-mail on July 16, 2010. (Tr. 681-84; RX Vol. II, p. 20). In that e-mail, Dr. Mason stated that he "did indeed start the [HazCom] training sessions on 07/15/2010" and would conclude them the following week; he also stated that he had organized and indexed the MSDS binder. Further, the testimony of [redacted] shows they had had no training in the chemicals they used and did not know about MSDSs until after [redacted] obtained information from the internet and provided it to Dr. Mason in June 2010.¹⁷ (Tr. 333, 363-68).

I further find that the chemicals at issue, *i.e.*, glutaraldehyde and hydroquinone, were hazardous and that employees were required to be trained in them. The CO testified about Maxicide, which the employees used daily to sterilize instruments; he noted the hazards of glutaraldehyde, which Maxicide contains. (Tr. 56-63, 70). The MSDS for Maxicide shows that it is 2.5 percent glutaraldehyde and that contact with Maxicide can cause skin irritation and eye damage; it can also cause mild irritation if inhaled, and it is toxic if ingested. If contact with skin occurs, washing with soap and water should take

¹⁷ [redacted] indicated that the morning training sessions on chemicals first took place in June 2010. (Tr. 368). CX-5, the training documents from Dr. Mason, shows that five training sessions took place prior to the inspection. These were on June 25, 29 and 30 and on July 1 and 14; CX-5 does not state what the sessions covered, however. The CO testified that on July 14, 2010, employees told him the training they had had up to then had addressed BBP's but not chemicals. (Tr. 71-72, 76). In view of the CO's records of his inspection, his testimony that no HazCom training occurred until after the inspection is credited.

place. If contact with eyes occurs, eyes should be flushed with water for 15 minutes, and, if irritation persists, medical attention should be sought. Recommended control measures are protective gloves and safety glasses. (GX-3; RX Vol. I, p. 98).

The CO also testified about Solutek, which employees used to develop X-rays; he discussed the hazards of hydroquinone, which Solutek contains. (Tr. 63-71). The MSDS for Solutek shows it is less than 10 percent hydroquinone and that contact with Solutek can cause eye and skin irritation; inhalation with mist or dried residue can cause respiratory tract irritation, and ingestion can cause gastrointestinal irritation, nausea and headache. If contact with skin occurs, skin should be flushed with a copious amount of water; if contact with eyes occurs, eyes should be flushed immediately with water for at least 15 minutes, and a physician should be called. Recommended control measures are protective gloves and chemical splash goggles. (GX-3; RX Vol. I, p. 107).

[redacted] testified about using Solutek for developing X-rays. When they did this work, they had to lower a tray that held the X-ray film into a tub of Solutek by hand and also remove it by hand; sometimes the film would slip out of the tray, and then they would have to reach into the Solutek solution to retrieve the film. They were not told to wear any PPE for this process and were discouraged from wearing gloves as Dr. Mason believed that doing so would cause spots on the films.¹⁸ [redacted] further testified that in the first meeting about the chemicals they used, and despite the MSDS for the X-ray developer [redacted] had given to Dr. Mason, he and Ms. Palmer told them it was not necessary to wear gloves for developing X-rays. Also during this meeting, Dr. Mason told them that a sink in the clinical area that patients used to brush their teeth was the eyewash station, as the faucet could be turned up to rinse the eyes; [redacted] had never been told this before. (Tr. 322-23, 329-34, 339-40, 365-68, 385-86).

Based on the foregoing, I conclude that the Secretary has shown that the cited standard applies, that its terms were not met, and that employees were exposed to the cited condition. I also conclude the employer had knowledge of the violative condition.

¹⁸ Dr. Mason and Ms. Palmer both testified that employees were not discouraged from using gloves for this process. (Tr. 422-23, 584-87). Their testimony is not credited, in view of the testimony of [redacted] As to eye protection, [redacted] indicated she wore no PPE while developing X-rays. (Tr. 367). [redacted] indicated she wore glasses or face shields at times, but this testimony was in the context of working with patients. (Tr. 306-08, 343-44). The CO's notes indicate that employees wore face shields while working with chemicals. See CX-21, ¶ 28. I conclude that one or more employees told him they used face shields.

As the Secretary notes, Dr. Mason was aware of the violative condition as he had a written HazCom program and MSDSs in his office, which he showed to CO Hanson on the first day of the inspection. (Tr. 50). As she also notes, in June 2010, [redacted] gave Dr. Mason MSDSs she had obtained from the internet for chemicals being used in the office. (Tr. 363-69). S. Brief, pp. 13-14. The Secretary has established knowledge.

Respondent disputes the serious classification of this item. R. Brief, pp. 16-17. I find, however, that the violation was properly characterized as serious. The record shows the clinical assistants used Maxicide and Solutek on a daily basis. (Tr. 63, 67, 308-09, 329-33, 365-68). The MSDSs for these chemicals, noted above, describe their hazards and the PPE to use, *i.e.*, protective gloves and eye protection. [redacted] were not told about the hazards of the chemicals, and they were not instructed to wear PPE when using them; in fact, as [redacted] and CO Hanson testified, employees were discouraged from wearing gloves when developing X-rays. (Tr. 66-67, 332-33, 365-68). Employees were thus exposed to the risk of skin irritation and eye damage.¹⁹

The CO further testified about why the chemicals were hazardous. Employees used Maxicide continuously every day to sterilize instruments, and OSHA and CDC documents state that glutaraldehyde is a mutagen and a sensitizer, in that each subsequent exposure can cause a more intense response; it can also cause lung damage. Employees also used Solutek daily. They mixed the X-ray chemicals each morning for use that day, and they put their hands in the chemicals when they developed the X-rays. OSHA and CDC documents state that hydroquinone is a mutagen and a suspected teratogen; it can also affect the central nervous system. (Tr. 57-71, 331-32; CX-4).

As the Secretary notes, a serious violation exists where there is “a substantial probability that death or serious physical harm could result” from the condition. *See* section 17(k) of the Act. As she also notes, it is the likelihood of serious physical harm or death arising from an accident rather than the likelihood of the accident occurring which is considered in determining whether a violation is serious. *Dravo Corp.*, 7 BNA OSHC 2095, 2101 (No. 16317, 1980). S. Brief, p. 14. Based on the record, Item 1 is affirmed as a serious violation.

¹⁹ [redacted] said she often got rashes and dry skin under her ring from using the X-ray chemicals. (Tr. 367).

The Secretary has proposed a penalty of \$1,500.00 for Item 1. The Commission, in assessing penalties, is required to give due consideration to the gravity of the violation and to the size, history and good faith of the employer. *See* section 17(j) of the Act. The CO testified that this violation had high severity, as employees were exposed to chronic irreversible or life-threatening injury or illness; he also testified that the violation had greater probability, due to the frequency and duration of exposure. The employer was given a 60 percent reduction for its small size and a 10 percent reduction because it had no prior OSHA history. The employer received no reduction for good faith, however, due to severity of the violation and the fact that the Citation was “serious.” (Tr. 78-80). I find that the proposed penalty is appropriate. That penalty is assessed.

Citation 1, Items 2(a) and 2(b)

These items allege violations of 29 C.F.R. 1910.1030(g)(2)(ii)(A) and 29 C.F.R. 1910.1030(f)(3). The cited standards state, respectively, that:

Training [in occupational exposure to blood and other potentially infectious materials] shall be provided as follows: (A) At the time of initial assignment to tasks where occupational exposure may take place....

Following a report of an exposure incident, the employer shall make immediately available to the exposed employee a confidential medical evaluation and follow-up....

The Citation alleges that the cited standards were violated as employees were exposed to blood and other potentially infectious materials, putting them at risk of infection from BBPs like HIV and HBV, and were provided with neither the required training nor the confidential medical evaluation and follow-up after an exposure incident.

As the Secretary notes, the BBP standard requires an employer to provide training to employees with occupational exposure; “occupational exposure” means “reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials (“OPIM”) that may result from the performance of an employee’s duties.” OPIM includes “saliva in dental procedures.” “Parenteral” means “piercing mucous membranes or the skin barrier through such events as needlesticks, human bites, cuts, and abrasions.” As she also notes, an “exposure incident” means “a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or [OPIM] that results from the performance of an employee’s duties.” *See* 29

C.F.R. 1910.1030(b). After a report of an exposure incident, the employer is required to make available a confidential medical evaluation and follow-up. S. Brief, p. 16.

The clinical staff's patient care at The Brace Place included inserting and removing bands, brackets, ties and orthodontic wires in patients' mouths. (Tr. 301-04, 358). These employees also used and cleaned by hand orthodontic instruments that had been in patients' mouths. (Tr. 59, 302-04, 309, 358). Further, they handled and disposed of waste resulting from patient care, including orthodontic wires that had been in the patients' mouths. (Tr. 89-109, 124-29, 310-15, 360-61, 389-90). When performing these duties, the clinical staff was exposed to patient blood and saliva. (Tr. 82, 85-86, 303-04, 358-59, 430-31, 649). Specific exposure incidents the clinical employees had included having saliva splatter in their eyes and having their skin punctured by orthodontic wires and instruments that had been in patients' mouths or while working in patients' mouths. (Tr. 86-87, 91-92, 304-06, 321, 345, 382-84, 430, 649).²⁰

Dr. Mason offered testimony indicating that his training of new clinical assistants included BBPs, universal precautions and barrier protection; he also indicated that he told his new assistants to report exposure incidents and that his office had a post-exposure protocol and follow-up. (Tr. 607-25). The reliable evidence of record, however, shows that there was no training in occupational exposure to BBPs at The Brace Place until after [redacted] provided the information she had obtained on the internet to Dr. Mason.²¹ The training sessions in regard to BBPs took place on June 25, 29 and 30, and on July 1 and 14, 2010. (Tr. 71-77, 82-84, 321-22-324, 327, 333, 363-64, 368, 371-77, 640-42; CX-5). The reliable evidence of record also shows that when a clinical assistant would tell Dr. Mason or Ms. Palmer that she had been stuck by an orthodontic wire or an instrument, they would instruct the employee to clean the wound with alcohol and to "express" the

²⁰ The record shows that the clinical assistants used gloves when they worked in patients' mouths but that a wire or instrument could poke through or rip the gloves. (Tr. 85, 125, 306, 321, 345, 382-84, 431). It also shows that while the clinical assistants could wear cotton masks if they chose to, the mask/face shield combination [redacted] requested was not used at The Brace Place until shortly before the OSHA inspection. (Tr. 85, 306-07, 611-12). Finally, the record shows that Dr. Mason's office offered the HBV vaccine to employees and had them sign a form if they chose not to have it. (Tr. 179-80, 338-39, 418, 508, 609).

²¹ Dr. Mason himself testified that he was not aware that the exposed ends of orthodontic wires were considered "sharps" under the BBP standard until [redacted] provided him with a copy of the OSHA opinion letter in that regard and other information. (Tr. 363-64, 640-41; GX-9).

wound to get it to bleed as much as possible; when such an incident occurred, no medical evaluation or follow-up by a medical doctor was offered. (Tr. 92-93, 321, 384).

Based on the above, the Secretary has shown the standards apply, that their terms were not met, and that employees were exposed to the violations. She has also shown knowledge. Dr. Mason had a written exposure control plan at the time of the inspection but had not implemented it. (Tr. 50). He had constructive knowledge of the violation, as [redacted] found information about OSHA's BBP standard and the fact that orthodontic wires are considered sharps by performing some simple internet research. (Tr. 363-64, 373-77, 640-42). The Secretary's expert, Ms. Laudenslager, testified that knowledge of sharps in dental offices and the use of universal precautions, like sharps containers, has been the standard of practice since at least 1991. (Tr. 255-56). S. Brief, p. 18. Items 2(a) and (b) are affirmed. They are properly classified as serious violations, in view of CO Hanson's testimony that HIV and HBV are incurable, life-threatening diseases. (Tr. 87).

The Secretary has proposed a single penalty of \$1,500.00 for Items 2(a) and (b). The CO testified that the severity of these items was high, in view of employee exposure to chronic irreversible and/or life-threatening diseases; the probability was greater, due to the frequency of exposure to blood and OPIM and the actual exposure incidents that employees had had. (Tr. 88). The same reductions that were applied in Item 1 were also applied to Items 2(a) and (b), with no credit given for good faith.²² *Id.* I find that the proposed penalty is appropriate. A penalty of \$1,500.00 is therefore assessed.

Citation 1, Items 3(a) and 3(b)

These items allege violations of 29 C.F.R. 1910.1030(d)(4)(iii)(A)(1) and 29 C.F.R. 1910.1030(d)(2)(viii). The cited standards provide, respectively, that:

Contaminated sharps shall be discarded immediately or as soon as feasible in containers that are: (i) Closable; (ii) Puncture resistant; (iii) Leakproof on sides and bottom; and (iv) Labeled or color-coded in accordance with paragraph (g)(1)(i) of this standard.

Immediately or as soon as possible after use, contaminated reusable sharps shall be placed in appropriate containers until properly reprocessed. These

²² These reductions apply equally to all of the penalties assessed in this case.

containers shall be: (A) Puncture resistant; (B) Labeled or color-coded in accordance with this standard; (C) Leakproof on the sides and bottom; and (D) In accordance with the requirements set forth in paragraph (d)(4)(ii)(E) for reusable sharps.

The Citation alleges contaminated sharps and contaminated reusable sharps were not put in appropriate containers, as required. As the Secretary points out, “contaminated sharps” means “any contaminated object that can penetrate the skin, including ... exposed ends of dental wires.” “Contaminated” means “the presence or the reasonably anticipated presence of blood or [OPIM] on an item or surface.” OPIM includes “saliva in dental procedures. *See* 29 C.F.R. 1910.1030(b). S. Brief, p. 20.

The record shows the duties of the clinical staff included handling and disposing of waste resulting from patient care; this waste included orthodontic wires that had been in patients’ mouths. Employees were instructed to dispose of this waste in the trash, which was a cardboard box with a plastic liner in it that was located in the clinical area underneath a round opening in the counter. At the end of each day, an employee would take the plastic liner out of the box and take it outside and put it into a city garbage can. At times, the employee would have to reach into the plastic bag to retrieve an orthodontic instrument that had been thrown away by mistake; she would also compact the trash in the liner by hand, and, if the can outside was full, she would have to compact the plastic liner so that it would fit in the can. Near the end of June 2010, after [redacted] had given Dr. Mason the information she had found on the internet, Dr. Mason replaced the cardboard box with a kitchen-type plastic garbage can; this can also utilized plastic liners, and it had a biohazard label on it. In addition, he brought into the office two small plastic jars with screw-on lids for disposing of contaminated waste. The jars had biohazard labels and writing on them indicating they were for orthodontic wires and OPIM. The jars were kept on the counter in the clinical area. Dr. Mason told the employees the jars were for those who did not feel comfortable putting the used wires in the trash can; employees could still throw the wires into the trash can, however.²³ (Tr. 95-114, 124-29, 309-15, 318-20, 360-61, 373-78, 389-90, 642; GX-10).

²³ Dr. Mason and Ms. Palmer disputed that employees were told they could continue to throw the wires and other contaminated waste into the trash can. (Tr. 437-38, 642-45). Their testimony is not credited, in light of the contrary testimony of [redacted] and CO Hanson. (Tr. 97-101, 318-19, 374, 378).

As the Secretary asserts, the changes Dr. Mason made did not meet the cited standard. An employee could have been stuck by a wire and exposed to blood or OPIM upon compacting the trash in the liner or upon compacting the liner so that it would fit in the city garbage can outside. (Tr. 110-14, 124-29). Expert Kim Laudenslager testified the plastic liners were not compliant as they were not puncture resistant. (Tr. 262-63). Further, the jars Dr. Mason provided were not sufficient to reduce the likelihood of exposure to blood or OPIM. Ms. Laudenslager testified the jars were “homemade” and had not been tested for puncture resistance to meet ANSI requirements. She said to be truly closable, a container would need to have guards or flaps to keep the contents from spilling out if knocked over. She also said that there are sharps containers basically designed for “ortho” practice that have wider flaps so the wires will go in easily. (Tr. 253-54). The subject jars had wide open tops, and they were kept on the counter, which was a high-traffic area. It was difficult to take off the lids to put the wires in the jars, so the employees left the jars open on the counter, where they could have been knocked over. (Tr. 99, 114, 319-20, 376; GX-10). Even Dr. Windauer agreed that the jars being left open increased the risk of exposure. (Tr. 560). S. Brief, pp. 20-22.

The record further shows that the clinical staff was instructed to put certain orthodontic wires that had been used in patients’ mouths into the patients’ charts; at a later time, when Dr. Mason decided to reuse them, a clinical assistant would reach into the chart and retrieve the wires.²⁴ In late June 2010, Dr. Mason and Ms. Palmer told the staff to put the wires in Ziploc bags before storing them in the charts; after CO Hanson’s first visit, employees were told to clean the wires with alcohol before putting them in the bags. When the wires were needed later, a clinical assistant would reach into the chart to retrieve the bag and then remove the wires from the bag. (Tr. 115-23, 335-36, 386-87, 652-54). The CO testified that these activities could have caused an assistant to be stuck or poked by a wire, which presented the risk of exposure to a BBP. (Tr. 115-21).

Dr. Mason testified at the hearing, and Respondent urges in its brief, that cleaning the wires with alcohol disinfected them; thus, the wires were no longer contaminated and presented no risk of exposure to BBPs. (Tr. 652-56; R. Brief, pp. 31-32). However, Ms. Laudenslager testified that this practice would not meet the standard’s requirements, as

²⁴ The nickel titanium wires were the wires that were stored and reused. (Tr. 440, 653).

proper reprocessing involves cold chemical immersion for ten hours, after which the wires could be stored in hard plastic containers. (Tr. 269-70). S. Brief, pp. 22-23.

In view of the foregoing, I find that the Secretary has met her burden of showing that the cited standards applied, that their terms were not met, and that employees were exposed to the violative conditions. I further find that the record shows Dr. Mason had knowledge of the cited conditions. He had a written exposure control plan but had failed to implement it. (Tr. 50). Dr. Mason also had constructive knowledge of the conditions. [redacted] found information about the BBP standard and the fact that OSHA had determined orthodontic wires to be sharps by performing some simple internet research. (Tr. 363-64, 373-77, 642). In addition, Ms. Laudenslager testified that knowledge of sharps in dental offices and the use of universal precautions, such as sharps containers, has been the standard of practice in the dental industry since at least 1991. (Tr. 256). The violations are affirmed as serious, as HIV and HBV are incurable, life-threatening diseases.

The total proposed penalty for Items 3(a) and 3(b) is \$1,500.00. CO Hanson determined the severity of these items to be high, in light of employee exposure to HIV and HBV, and the probability to be greater, due to the frequency and duration of exposure to blood and OPIM; the proposed penalty included reductions for size and history. (Tr. 113-14). I find the proposed penalty appropriate. That penalty is assessed.

Citation 1, Item 4

Item 4 alleges a violation of 29 C.F.R. 1910.1030(d)(4)(ii)(E), which states:

Reusable sharps that are contaminated with blood or other potentially infectious materials shall not be stored or processed in a manner that requires employees to reach by hand into the containers where these sharps have been placed.

The Citation alleges that employees were exposed to blood and OPIM when they reached into patient charts and Ziploc bags to retrieve the reusable wires, which could have been contaminated with BBPs such as HIV and HBV. As the Secretary notes, this item is based on the same factors set out in Item 3, *supra*, but focuses on retrieval of the wires from the patients' charts and the Ziploc bags. S. Brief, p. 24. The CO testified as to his belief that reaching into a chart and then into a Ziploc bag to retrieve the wires resulted in even greater exposure to being stuck and exposed to a BBP than placing the

wires in a chart and/or a bag in the first place. (Tr. 121-23). I find that the discussion set out above in Item 3 establishes all of the elements of the Secretary's case as to this item. I further find that the proposed penalty of \$1,500.00, which is based on the same factors noted in Item 3, is appropriate. *Id.* A penalty of \$1,500.00 is assessed for Item 4.

Citation 1, Items 5(a) and 5(b)

These items allege violations of 29 C.F.R. 1910.1030(d)(4)(iii)(A)(4) and 29 C.F.R. 1910.1030(d)(4)(iii)(C), which provide, respectively, as follows:

Reusable containers shall not be opened, emptied, or cleaned manually or in any other manner which would expose employees to the risk of percutaneous injury.

Disposal of all regulated waste shall be in accordance with applicable regulations of the United States, States and Territories, and political subdivisions of States and Territories.

Item 5(a) alleges that when employees opened and emptied the contents of the plastic trash can into the outside trash can they were exposed to blood and OPIM which could have been contaminated with BBPs like HIV and HBV. Item 5(b) alleges that the manner in which employees disposed of regulated waste in the outside trash can was not in accordance with the Montana Code for the disposal of such waste.

CO Hanson testified that Item 5(a) was based on the same factors set out in Item 3, *supra*, addressing how employees emptied the contents of the cardboard box and then the plastic trash can once it was provided. The evidence of record, as detailed on pages 18 and 19 above, shows that the way in which the trash was emptied and disposed of exposed the employees to wires that had been in patients' mouths and could have been contaminated with BBPs. The CO said that other regulated waste, such as cotton balls, gauze or gloves that had been used in patient care and contained blood or saliva, also ended up in the plastic trash can. (Tr. 98, 123-29). I find that the discussion set out in Item 3 demonstrates all of the elements of the Secretary's case as to Item 5(a).

The CO further testified that Item 5(b) was also based on the above factors but focused on the fact that the waste disposal practices of The Brace Place violated the Montana Code for the storage, transportation, treatment and disposal of infectious waste. (Tr. 127-29). Part of the Montana Code was received in evidence as GX-20. The BBP

standard's definition of "regulated waste" includes contaminated sharps, which, in turn, includes exposed ends of dental wires. *See* 29 C.F.R. 1910.1030(b).

As the Secretary notes, the "Montana Code" set out in the citation is Montana's Infectious Waste Management Act, Montana Statute 75-10-1001 *et seq.* That Act states that "Infectious waste must be separated from ordinary waste at the point of origin and stored until the waste is rendered noninfectious in separate, distinct containers with biohazard warning labels." It also states that "Sharps must be contained for storage, transportation, treatment, and subsequent disposal in leakproof, rigid, puncture-resistant containers that must be taped closed or capped securely to prevent loss of contents." MT Stat. 75-10-1005(1) and (1)(a).²⁵ "Infectious waste" means "waste capable of producing infectious disease" and includes "sharps that have been used in patient care." "Sharps" are any discarded health care article that may cause punctures or cuts, including but not limited to broken glass that may be contaminated with blood, needles, and scalpel blades. MT Stat. 75-10-1003(4)(d) and (7). The Act further states: "Treatment and disposal of infectious waste must be accomplished through the following methods: (i) incineration with complete combustion that reduces infectious waste to carbonized or mineralized ash; (ii) steam sterilization that renders infectious waste noninfectious; or (iii) sterilization by standard chemical techniques or by any scientifically proven techniques approved by state and federal authorities." MT Stat. 75-10-1005(4)(a)(i)-(iii). S. Brief, pp. 25-26.

In defense of this item, Respondent urges that the Montana Act is based on EPA regulations, which do not consider orthodontic wires to be "sharps." It also urges that the Montana Act has terminology and definitions different from those in the BBP standard; for example, the Montana Act uses the term "infectious waste," rather than the "regulated waste" set out in the BBP standard. In sum, Respondent asserts that the Montana Act and the BBP standard are two very different laws with different purposes and that without assessing the facts under the specific provisions of the Montana Act, which OSHA did not do, there was no violation of the cited standard. R. Brief, pp. 33-37.

²⁵ GX-20 contains section 75-10-1005 of the Montana Act. GX-20 does not contain section 75-10-1003 of that Act, and some of that section's provisions, which the Secretary has cited to in her brief, are set out *infra*. S. Brief, pp. 25-26. Respondent has also cited to provisions in that section. R. Brief, p. 35. That section is available at: <http://data.opi.mt.gov/bills/mca/75/10/75-10-1003.htm>.

In support of its position, Respondent relies on an American Dental Association (“ADA”) document entitled “Infectious Waste Disposal in the Dental Office.” The document is in a “Question and Answer” format, and it does in fact reference the EPA in some of its answers; for example, as Respondent has indicated, it notes that “[t]he EPA has stated that orthodontic wires are not sharps.” R. Ex. Vol. II, p. 163. Respondent’s reliance on this document, however, is completely misplaced. First, the document is not a law or statute; as it states on its cover, it is “A resource for ADA-member dentists.” Second, the document is dated August 1989 and predates the BBP standard by more than two years. It thus has no relevance in this matter. Finally, as Ms. Laudenslager testified, OSHA regulates waste disposal in dental offices, while states regulate trash and its disposal outside of such offices. She also testified that the Colorado law in this regard is almost identical to the Montana law.²⁶ According to Ms. Laudenslager, soft waste goes into a corrugated box or other appropriate container, and a sharps container, when full, goes into the same box; thereafter, a company in the business of handling such waste picks up the box and disposes of the waste pursuant to state regulations. (Tr. 263-64). In view of the record, Respondent’s position as to Item 5(b) is rejected, and the Secretary has met her burden of proving all elements of the alleged violation.²⁷

Based on the foregoing, Items 5(a) and 5(b) are affirmed. They are affirmed as serious violations for the same reasons set out in Item 3, *supra*. (Tr. 125-30). The total proposed penalty of \$1,500.00 for Items 5(a) and 5(b) is appropriate, in light of the CO’s testimony in that regard. (Tr. 126-31). A penalty of \$1,500.00 is assessed for Item 5.

Citation 1, Item 7

Item 7 alleges a violation of 29 C.F.R. 1910.151(c), which states as follows:

Where the eyes or body of any person may be exposed to injurious corrosive materials, suitable facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use.

The Citation alleges that employees were exposed to hazards associated with eye injuries due to handling and using hazardous chemicals and not having an adequate quick drench or eyewash station. CO Hanson testified that on July 14, 2010, as he and the other

²⁶ Most of Ms. Laudenslager’s education and experience has been in the State of Colorado. See GX-25.

²⁷ Knowledge is established by the statement of Ms. Laudenslager set out on page 20, *supra*.

CO were getting ready to leave from the parking lot, an employee came up to them and mentioned her concerns about Dr. Mason's eyewash station. The COs acknowledged her concerns but did not go back to the office; the only faucet they had seen in the clinical area was a "long, gooseneck faucet" that was not a suitable eyewash station. A day or two later, Dr. Mason sent CO Hanson an e-mail stating the COs had not asked him about the eyewash station and explaining what he had. The CO testified that the faucet he had seen did not meet the requirements for an eyewash station; it had a single spout rather than a spout for each eye, an employee would have to turn the faucet up to rinse the eyes, and it did not have a cap on it to protect it from contaminants. (Tr. 131-35).

The record shows that the COs did not discuss the faucet they saw in the clinical area with Dr. Mason on July 14, 2010. (Tr. 221-24, 606). And, as indicated above, Dr. Mason's e-mail of July 16, 2010, states:

You didn't ask me about the eye-wash stations (we have two vertical rise faucet stations in the clinical area where we could accommodate two employees at the same time for 15 minutes each)....

See RX Vol. II, p. 20. The record also shows that CO Hanson did not discuss this matter with Dr. Mason when he returned to The Brace Place on August 5, 2010; he also did not look at what he had seen before. (Tr. 230-31, 607). Further, he did not photograph the faucet that he and the other CO had seen. The eyewash station was not on the complaint that initiated the OSHA inspection, and CO Hanson admitted it was not one of the things he had looked at on the first day of the inspection and that it was only addressed after the employee approached the COs in the parking lot. (Tr. 221-22; GX-1).

At the hearing, Respondent asserted that what CO Hanson saw was not the eyewash station; rather, there were two different faucets that were the eyewash stations. (Tr. 223-26). Respondent repeats this assertion in its brief. R. Brief, p. 8. I disagree with this assertion. The CO did refer initially to a single faucet he had seen; he later testified there might have been two but he could not recall. (Tr. 131-32, 221). He also testified he had recently seen a photograph from Dr. Mason that showed the use of an eyewash station, but he stated that he did not recognize that sink. (Tr. 135). I conclude, however, that the CO's testimony merely shows he did not really focus on the eyewash station the one time he saw it as it was not one of the complaint items. I also conclude

that the CO's testimony was based primarily on Dr. Mason's e-mail and on what the employees told him in the telephone interviews after his visits to The Brace Place. (Tr. 222-23). In that regard, [redacted] testified that in a meeting after OSHA's first visit, Dr. Mason told them the two sinks in the clinical area where patients brushed their teeth were also eyewash stations; when the faucets were turned up, they served as drinking fountains and eyewash stations. (Tr. 333-34, 385-86). Dr. Mason's own testimony indicates that these two faucets were the eyewash stations. (Tr. 603-06).

The CO's testimony set out above gives the reasons for his determination that the faucets were not suitable eyewash facilities. (Tr. 132-33). His testimony was based on ANSI and OSHA documents that set out eyewash station requirements. (Tr. 133-35). As Respondent notes, however, the cited standard is not premised on a facility meeting ANSI or other requirements; rather, the facility must be "suitable." R. Brief, pp. 9-11. As Respondent further notes, the Commission has held that whether facilities for flushing or drenching the eyes are suitable depends on the particular circumstances of the case. *E.I. du Pont de Nemours & Co.*, 10 BNA OSHC 1320, 1325 (No. 76-2400, 1982). *See also Atlantic Battery Co.*, 16 BNA OSHC 2131, 2168 (No. 90-1747, 1994). Here, I find that the Secretary has not proved that Respondent's eyewash facilities were not suitable.

Dr. Mason testified that he assessed his eyewash facilities by going through the latest ANSI standard, and he described how his facilities met those requirements, in his view. After rotating the faucet up, the lever that turned the water on did not have to be held open for the water to continue to flow; also, the water was temperate and flowed at high volume but low velocity. The faucets did not have caps on them but the sinks and faucets were cleaned regularly, and the faucets were centrally located in the clinical area and could be reached in a few seconds. The height of the faucets was appropriate, and while each had only one spout, putting the bridge of one's nose on the spout divided it into two such that water flushed across both eyes. Dr. Mason stated that in all the years he had had the facilities, no one had ever had to use them as an eyewash. (Tr. 603-06).

In addition to the above, Dr. Windauer had seen a picture showing the operation of Dr. Mason's eyewash. He testified that he preferred that one over the two-jet eyewash he had had in his office, as it would provide a gentler flushing of the eyes. He indicated that no one in his office had ever needed to use his eyewash. (Tr. 555-56). Dr. Schade

testified that the eyewash station he had had was very similar to Dr. Mason's and that he had never had to use it as an eye flush for an employee or a patient. (Tr. 481-82). Also, the CO testified that no one he talked to in Dr. Mason's office had reported an incident from chemical use that would have required an eyewash station. (Tr. 226-27).

For all of the foregoing reasons, I find that the record does not establish that the eyewash facilities in Dr. Mason's office were not suitable for the particular circumstances in his office. In so finding, I have noted the testimony of [redacted] that they were not told until after OSHA's first visit that the sinks and faucets were eyewash facilities. Their testimony shows, however, that they were clearly aware of the facilities and knew the faucets rotated up. (Tr. 333-34, 385-86). Further, the record shows that no one in the office had ever needed to use the faucets as an eyewash, and the testimony of Drs. Schade and Windauer supports a conclusion that while eyewashes are required in orthodontic offices they are not commonly used. (Tr. 226-27, 556-57, 603-04). This item is vacated.

Findings of Fact and Conclusions of Law

The foregoing decision constitutes the findings of fact and conclusions of law in accordance with Federal Rule of Civil Procedure 52(a). All proposed findings of fact and conclusions of law inconsistent with this decision are denied. Further, any arguments not addressed above have been considered and rejected.

ORDER

In accordance with the foregoing findings of fact and conclusions of law, it is ORDERED that:

1. Item 1 of Serious Citation 1, alleging a violation of 29 C.F.R. 1910.1200(h)(1), is AFFIRMED, and a penalty of \$1,500.00 is assessed.
2. Items 2(a) and 2(b) of Serious Citation 1, alleging violations of 29 C.F.R. 1910.1030(g)(2)(ii)(A) and 29 C.F.R. 1910.1030(f)(3), respectively, are AFFIRMED, and a penalty of \$1,500.00 is assessed.
3. Items 3(a) and 3(b) of Serious Citation 1, alleging violations of 29 C.F.R. 1910.1030(d)(4)(iii)(A)(1) and 29 C.F.R. 1910.1030(d)(2)(viii), respectively, are AFFIRMED, and a penalty of \$1,500.00 is assessed.
4. Item 4 of Serious Citation 1, alleging a violation of 29 C.F.R. 1910.1030(d)(4)(ii)(E), is AFFIRMED, and a penalty of \$1,500.00 is assessed.

5. Items 5(a) and 5(b) of Serious Citation 1, alleging violations of 29 C.F.R. 1910.1030(d)(4)(iii)(A)(4) and 29 C.F.R. 1910.1030(d)(4)(iii)(C), respectively, are AFFIRMED, and a penalty of \$1,500.00 is assessed.

6. Item 7 of Serious Citation 1, alleging a violation of 29 C.F.R. 1910.151(c), is VACATED.

/s/
John H. Schumacher
Judge, OSHRC

Dated: September 5, 2012
Denver, Colorado