United States of America
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
1924 Building - Room 2R90, 100 Alabama Street, SW
Atlanta, Georgia 30303-3104

Secretary of Labor, Complainant, v. Fresenius USA Manufacturing, Inc., d/b/a TruBlu Logistics, Respondent.	OSHRC Docket No. **10-0652**

Appearances:

Schean G. Belton, Esq., Office of the Solicitor, U. S. Department of Labor, Nashville, Tennessee
For Complainant

Jefferson Starling, III, Esq., Balch & Bingham, LLP, Birmingham, Alabama
For Respondent

Before: Administrative Law Judge Ken S. Welsch

DECISION AND ORDER

Fresenius USA Manufacturing, Inc. d/b/a TruBlu Logistics (Fresenius), is a subsidiary of Fresenius Medical Care, which manufactures medical devices and operates kidney dialysis clinics throughout the United States. On January 25, 2010, the Occupational Safety and Health Administration (OSHA) inspected the Fresenius distribution warehouse in Birmingham, Alabama. OSHA had received a complaint about an employee who was shocked on January 13, 2010, while changing the battery for a forklift in the battery charging area. After OSHA's inspection, Fresenius received serious and other-than-serious citations on March 12, 2010. Fresenius timely contested the citations.

The hearing, designated for Simplified Proceedings pursuant to 29 C.F.R. § 2200.200 *et. Seq.*, was held on July 22, 2010 in Birmingham, Alabama. The parties stipulated jurisdiction and coverage (Tr. 5). The parties also announced partial settlement regarding all items alleged in the serious and

other than serious citations except the alleged serious violations of 29 C.F.R. § 1910.151(a) (Item 1) for the lack of available medical personnel for advice and consultation, and 29 C.F.R. § 1910.305(g)(2)(iii) (Item 4) for failing to provide an adequate strain relief on flexible cables at the connector plug (Tr. 6-8). The parties' Stipulation of Partial Settlement Agreement dated August 23, 2010, is approved and incorporated into this decision.

Fresenius denies the alleged violations of § 1910.151(a) and § 1910.305(g)(2)(iii). Fresenius claims the cited standards do not apply and, if found applicable, the terms of the standards were not violated.

As discussed, serious citation, Items 1 and 4 are vacated and no penalties are assessed.

Background

Until February 2010, Fresenius operated a distribution warehouse in Birmingham, Alabama.[1] The warehouse included administrative offices, a loading dock, break room, and battery charging area. The warehouse operated with day and night shifts. The night shift began at 3:00 p.m. and was staffed with approximately eight employees. Battery operated forklifts were used by employees in the warehouse. Each forklift had its own numbered battery station to charge separate batteries for the day and night shifts. The distribution warehouse manager was Michael Spivey (Exh. C-3; Tr. 40, 51-52).

On January 13, 2010, a night shift order selector arrived at the warehouse at approximately 2:45 p.m. He drove his forklift to the #4 battery charging station to replace the battery already in the forklift with the fully charged battery for night shift operation. Each 36-Volt battery had two, approximate 3-foot long cables. The red and black sheathing on the cables protected copper wires which were anchored at terminal screws inside a grey, 3-inch wide, plastic connector plug. Similarly, the battery charger had approximate 5-foot long red and black cables which anchored at terminal screws inside another plastic connector plug. When charging the battery, the two connector plugs were joined. The charger automatically shuts off when the battery was fully charged and when the battery was disconnected from the charger. When placing the battery in the forklift, the connector plug was joined to a similar connector plug on the forklift. Employees were instructed to hold the

[1]In February 2010, Fresenius opened a new warehouse in Alabaster, Alabama (Tr. 122).

two connector plugs and not the cables when connecting or disconnecting the battery from the battery charger and forklift (Exh. R-4; Tr. 30, 34, 53, 131, 134-135, 140-141).

When the order selector disconnected the night battery from the charger, he testified that the sheathing covering the two cables near the connector plug was back from the connector plug, exposing bare copper wires (Tr. 22). When he pulled the two connector plugs apart, he heard a "Pow, Pow" and "everything went out for a few seconds" (Tr. 14, 38). He experienced ringing in his ears and tingling in his left arm. Another employee helped him take off his shirt because he also felt heat in his arm. The employee walked the order selector to the break room. When Spivey and the night supervisor came to inquire about the accident, the order selector testified that he was asked if he was all right to continue work or did he want to be taken to the hospital. He said that he asked twice to be taken to the hospital. He did not arrive at the hospital for approximately 45 minutes after the accident (Tr. 12, 15-17, 56).

Spivey testified that when he was informed of the accident, he went to the battery charging area and saw the battery sitting on the rack below the charger. He said the battery cables were laying across the battery and a black mark, approximately 4 inches long, was on the side of the battery. He described the black mark as it "looked like soot from arcing," (Tr. 125). When Spivey went to the break room, he testified the order selector was standing and he asked him "did it hit you" and "where." The order selector said "yes," "on my hands." Spivey testified there were no marks on the selector's hands and his eyes were clear. When asked if he needed to go to the hospital, Spivey testified that the order selector said "No, I think I'm OK, I think I'll be all right" (Tr. 126). Spivey told the selector to sit down and rest. Spivey testified the order selector spoke in a normal tone and manner and his breathing was normal. He did not observe sweating or any symptoms of injury indicating electric shock. Spivey noted the selector's hands were shaking, a little. He believed the shaking was from "scare" of the accident. Spivey did not believe the selector was electrocuted. Spivey testified the order selector never asked to see a doctor. He directed the night supervisor to watch the order selector and let him know if he wanted to go to the doctor. Spivey returned to his office. About 10 minutes later, he was advised the order selector wanted to go to the hospital. He directed the night supervisor to drive him (Tr. 127-128, 130).

The order selector estimated he was in the break room for approximately 30 minutes and it took another 10-15 minutes to be driven to the hospital (Tr. 17, 18). The order selector was admitted to the hospital where he spent 4 days. He testified that he was diagnosed with nerve and tissue damage in his left arm and hand (Tr. 48, 58). At the hearing, the order selector testified that he was not working and was receiving "workers' compensation" (Tr. 13).

After receiving a complaint regarding the accident, OSHA inspected the Fresenius warehouse on January 25, 2010. Compliance safety and health officer (CSHO) Jennifer McWilliams who had recently been hired by OSHA, participated in the inspection along with two supervisors (Tr. 66, 69). The OSHA inspectors interviewed employees and inspected the battery charging station (Tr. 70, 73).

On March 12, 2010, Fresenius was issued the serious citation which included alleged violations of § 1910.151(a) (item 1) and § 1910.305(g)(2)(iii) (item 4).

Discussion

The Secretary has the burden of proving a violation of the cited standards.

> In order to establish a violation of an occupational safety or health standard, the Secretary has the burden of proving: (a) the applicability of the cited standard, (b) the employer's noncompliance with the standard's terms, (c) employee access to the violative conditions, and (d) the employer's actual or constructive knowledge of the violation (*i.e.*, the employer either knew or, with the exercise of reasonable diligence could have known, of the violative conditions). *Atlantic Battery Co.*, 16 BNA OSHC 2131, 2138 (No. 90-1747, 1994).

Fresenius disputes the application of § 1910.151(a) (Item 1) and § 1910.305(g)(2)(iii) (Item 4) and that it violated the standards.[2] Fresenius withdrew its unpreventable employee misconduct defense to item 4 (Tr. 155-156).

[2]Issues not briefed are deemed waived. See *Georgia-Pacific Corp.*, 15 BNA OSHC 1127, 1130 (No. 89-2713, 1991).

Alleged Violations

Alleged Violation of § 1910.151(a) (Item 1)

The citation alleges that "on or about January 25, 2010 - the employer did not provide medical personnel to evaluate an employee that was injured at the battery charging station."[3] Section 1910.151(a) provides, under the heading "Medical services and first aid," that:

> The employer shall ensure the ready availability of medical personnel for advice and consultation on matters of plant health.

According to OSHA, the basis for the alleged violation was Fresenius' failure to contact medical personnel for 45 minutes after the order selector's accident (Tr. 76, 90). McWilliams described the purpose of § 1910.151(a) as to ensure that medical advice and consultation is available in the critical minutes between an injury and the receipt of treatment by a physician or hospital. For support, OSHA relies on an OSHA Interpretation letter dated January 16, 2007 (Exh. C-4). The Secretary argues that Fresenius should have consulted with medical personnel earlier than 45 minutes after the accident.

By its wording, § 1910.151(a) requires an employer to ensure that medical personnel are readily available to provide "advice and consultation on plant health matters." "Ready availability" is not defined and is stated in general terms. OSHA's Interpretation letter provides no assistance because it applies to subsections (b) and (c) within § 1910.151.[4]

As a broadly worded standard, § 1910.151(a) is interpreted in the light of the conduct to which it is being applied and by external objective criteria, including the knowledge and perceptions of a reasonable person. Such criteria give meaning to the standard in the particular situation. *American Bridge Company*, 17 BNA OSHC 1169, 1172 (No 92-0959, 1995). There is no OSHA

---

[3] Although the citation refers to "January 25, 2010," the parties agree the alleged violation was the result of the order selector's accident which occurred on January 13, 2010.

[4] Section 1910.151(b) and (c) provide:

> (b) In the absence of an infirmary, clinic, or hospital in near proximity to the workplace which is used for the treatment of all injured employees, a person or persons shall be adequately trained to render first aid. Adequate first aid supplies shall be readily available.
>
> (c) 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.

interpretative letter or other authority stating that § 1910.151(a) requires an employer to take an employee to a medical facility or contact a health care provider for consultation within a set amount of time after an accident.

The § 1910.151(a) standard applied to Fresenius' warehouse in Birmingham, Alabama. It required Fresenius to have medical personnel available to contact for advice and consultation regarding warehouse health matters. The warehouse did not have a nurse or other medical personnel on staff. Fresenius maintained a list of emergency telephone numbers for medical assistance including 911, the fire department, poison control, an ambulance service, and a nearby health care facility. Fresenius trained personnel to contact emergency by dialing 911 in the event that medical advice was needed for health matters (Tr. 25, 79-80, 137). A first aid kit was also onsite (Tr. 138). There were first aid posters including one which described the signs and symptoms of electrical shock (Tr. 156)

Under the circumstances in this case, a violation of § 1910.151(a) is not established. The Secretary failed to show that the approximate 45-minutes to obtain medical assistance was unreasonable given the order selector's lack of visible injury, distress, and unconsciousness. The selector's breathing and speech were normal (Tr. 128). He was not sweating (Tr. 126). He was able to understand, communicate and physically move without noticeable bruises or burns. He said his finger tips "were kind of bluish" which he compared to a "quick injury like if you hit the ground" (Tr. 42-43). Although he complained immediately after the accident of feeling a tingling and heat in his left arm, there is no showing such problems continued when he was assisted to the break room.

There is no showing medical personnel needed to be consulted prior to the order selector's request to see a doctor. Fresenius had medical personnel available through telephone contact for consultation and advice, if it was deemed necessary. Such telephone contacts comply with the standard (Tr. 93-94).

Also, as noted by McWilliams, the standard does not require an employer to immediately contact medical personnel or seek medical treatment for every accident, injury or other health matter (Tr. 92-93). She acknowledged an employer does not have to contact medical personnel every time an accident occurs, particularly if the employee does not think it is necessary (Tr. 98). An employer does not have to call 911 for every minor injury.

The standard requires medical personnel to be readily available for advice and consultation, if necessary. There is nothing in § 1910.151(a) that addresses when an employer must contact medical personnel for advice and consultation. If the Secretary wanted to require an employer to contact health care personnel within a set time frame after every accident, injury or illness, she would have drafted the standard to state such a requirement. She did not.

Section 1910.151(a) allows an employer to make a reasoned decision based upon the circumstances. Spivey, not observing any signs and symptoms of electrocution, decided that medical consultation was not required for the order selector (Tr. 168). The 45-minutes in getting order selector to the hospital does not establish that medical personnel were not readily available to provide advice and consultation. The delay was not the result of the lack of readily available medical personnel.

Even if the order selector's testimony is given weight that he twice asked to be taken to the hospital, the record fails to establish medical personnel were not available for advice or consultation. Because of the accident, the selector's recollection of events especially time could have been affected. Nothing in the order selector's condition immediately after the accident was shown to require a more immediate medical contact. His speech and breathing were normal. There were no visible signs of burn or injury. He was not sweating or showing signs of distress. The standard does not require medical personnel to be present at the workplace. It only requires such medical personnel be available through contact for advice and consultation.

The 15-minutes driving time or approximate 10 miles to the hospital may be a violation of § 1910.151(b), which was not cited. That standard requires medical facilities in "near proximity." However, even if cited, the record shows that an urgent care clinic was within 1.1 miles (3 minutes) of the warehouse (Exh. R-3). Such availability meets the Secretary Interpretation letter of "near proximity" (Exh. C-4).

Alleged Violation of § 1910.305(g)(2)(iii) (Item 4)

The citation alleges that "on or about January 25, 2010 - in the south corner of the warehouse, battery charging station #4 and the green and/or yellow batteries had exposed wires on the connector plugs." Section 1910.305(g)(2)(iii) provides:

> Flexible cords shall be connected to devices and fittings so that strain relief is provided which will prevent pull from being directly transmitted to joints or terminal screws.

The order selector testified that prior to receiving the electric shock, he observed the sheathing on the red and black battery cables were pulled away from the connector plug, exposing the bare copper wires (Tr. 14, 22, 31). After he was admitted to the hospital, the order selector asked another employee to take photographs of the connector plug. The selector gave the photographs to OSHA (Exhs, C-1, C-2; Tr. 24).

When asked to identify the photographs at hearing, the order selector was unable to testify whether the connector plug in the photographs was the connector at the #4 battery station that he was unplugging at the time of the accident (Tr. 23, 49). There is no showing when the photographs were taken and the employee who took the photographs did not testify (Tr. 102). Also, the battery connector plug shown in the photographs appears to have been taken out of service (Exh. R-1; Tr. 28, 65).

Spivey testified he did not observe exposed copper wires on the battery cables at station #4 when he inspected the battery used by order selector immediately after the accident (Tr. 131). Spivey observed the cables laying across the battery and a black mark on the side. The black mark appeared to Spivey as a sign of arcing and not electrocution (Tr. 125). He observed a cable with a "nick" in the sheathing laying across the metal casing of the battery. The battery was taken out of service because of Spivey's concern that there may have been a cut in the sheathing. The battery cables were replaced by Fresenius' contractor who maintain the batteries (Exh. C-5; Tr. 143). Fresenius used another contractor to conduct periodic inspections of the battery station (Exhs. R-5, R-6).

Section 1910.305(g)(2), requiring a strain relief, applies. The red and black cables are flexible cords. Under §1910.305(g)(1)(i)(F), flexible cables are used for "connections of stationary equipment to facilitate their frequent interchange." Such was the battery charger where batteries were regularly connected and disconnected. The purpose of a strain relief is to eliminate stress from being placed directly on the terminal screws inside the connector plug if the employee pulled on the cables instead of the plastic connector. There is no evidence that employees pulled on the cables instead of the connector plugs.

The record fails to establish the lack of a strain relief, as alleged. McWilliams testified the connector plug had a strain relief, but she believed it was worn (Tr. 110-111). She considered the connector housing was the strain relief (Tr. 111). By the time of the OSHA inspection, the cables had been replaced and McWilliams did not open the connector plug to observe the condition of the strain relief.

Spivey's testimony is credited. When he went to the battery charger area immediately after the accident, he did not observe any exposed wires on the battery cables. He saw a cut in the sheathing and evidence of arcing. The order selector, on the other hand, was unable to identify the connector plug in the photographs as the battery cables involved in the accident. He did not take the photographs. He could not testify regarding when the photographs were taken and whether the exposed wiring was new or how it became exposed (Tr. 21, 27, 31). His ability to recall the exposed wires may have been affected by the trauma of the accident.

McWilliams did not observe the #4 battery or any defects in any of the batteries during the OSHA inspection on January 25, 2010 (Tr. 100-101). She did not see any exposed wires on the battery cables. She had "no idea if this [photograph] was the battery/connector that was involved in the accident" (Tr. 103). Also, she conceded that if the battery cables shown in the photographs were not in service and no evidence that anyone had used them, there was no violation (Tr. 113).

McWilliams testified she had no idea how the wires became exposed (Tr. 106). If the exposed wires existed, such condition could have been caused by something other than the lack of a strain relief. Neither McWilliams nor the order selector could testify whether the battery cables in the photographs were the cables that may have caused the incident on January 13, 2010 (Tr. 21, 29-30, 102-103).

Also, the connector plug, depicted in the photographs, shows a tag identifying it as a battery that was "not in service" at the time the photograph was taken (Exh. C-2; Tr. 29, 141-142). There is no evidence that the connector plug on which OSHA relies was in use in January 2010.

A violation § 1910.305(g)(2)(iii) is not established.

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.

ORDER

Based upon the foregoing decision, it is ORDERED:

1. Serious violation of § 1910.151(a) (item 1) is vacated and no penalty is assessed.

2. Serious violation of § 1910.151(c) (item 2) is affirmed pursuant to the parties' partial settlement agreement and a penalty of $2,500.00 is assessed.

3. Serious violation of § 1910.178(p)(1) (item 3a) is withdrawn pursuant to the parties' partial settlement agreement and no penalty is assessed.

4. Serious violations of § 1910.178(l)(1)(i) (item 3b), § 1910.178(l)(3)(i)(K) (item 3c) and § 1910.178(l)(6) (item 3d) are affirmed pursuant to the parties' partial settlement agreement and a grouped penalty of $2,500.00 is assessed.

5. Serious violation of § 1910.305(g)(2)(iii) (item 4) is vacated and no penalty is assessed.

6. Other-than-Serious violations of § 1904.7(b)(3) (item 1a) and § 1904.29(b)(1) (item 1b) are withdrawn pursuant to the parties' partial settlement agreement and no penalty is assessed.

7. Other-than-Serious violation of § 1904.32(a)(1) (item 1c) is affirmed pursuant to the parties' partial settlement agreement and a penalty of $1,000.00 is assessed.

8. Other-than-Serious violation of § 1910.157(c)(1) (item 2) is withdrawn pursuant to the parties' partial settlement agreement and no penalty is assessed.

\s\ Ken S. Welsch
KEN S. WELSCH
Judge

Date: September 3, 2010