BEFORE THE
STATE OF CALIFORNIA
OCCUPATIONAL SAFETY AND HEALTH
APPEALS BOARD

In the Matter of the Appeal of:	Inspection No. **1483438**
SUTTER BAY HOSPITALS **1501 TROUSDALE DR.** **BURLINGAME, CA 94010** **Employer**	**DECISION**

Statement of the Case

Sutter Bay Hospitals, doing business as Mills-Peninsula Medical Center (Employer or Sutter), is a health care provider. On July 15, 2020, the Division of Occupational Safety and Health (the Division), through Associate Safety Engineer Geraldine Tolentino (Tolentino), commenced an inspection of Employer's facility located at 1501 Trousdale Drive in Burlingame, California, after a report of an illness on June 23, 2020.

On December 23, 2020, the Division cited Employer for three alleged safety violations: failure to immediately report a serious illness suffered by an employee who was hospitalized with COVID-19[1]; failure to investigate exposure incidents in order to notify employees who had significant exposures to COVID-19 cases; and failure to provide training regarding a new procedure for donning and doffing gowns when treating COVID-19 patients.

Employer filed timely appeals of the citations, contesting the existence of the violations, the classification of the citations, and the reasonableness of the proposed penalties for each citation. Employer asserted that the abatement requirements were unreasonable for Citation 2. Additionally, Employer asserted various affirmative defenses to each citation.[2] The parties submitted verification of abatement for Citation 2, and no argument was offered regarding the reasonableness of abatement requirements.

This matter was heard by Kerry Lewis, Administrative Law Judge (ALJ) for the California Occupational Safety and Health Appeals Board on March 7 and 8, 2023, August 8 through 10, 2023, December 13 through 15, 2023, and February 6, 2024. ALJ Lewis conducted

[1] When COVID-19 is used herein, it is in reference to the disease caused by the SARS-CoV-2 virus, also commonly known as Coronavirus 2019.

[2] Except where discussed in this Decision, Employer did not present evidence in support of its affirmative defenses, and said defenses are therefore deemed waived. (*RNR Construction, Inc.,* Cal/OSHA App. 1092600, Denial of Petition for Reconsideration (May 26, 2017).)

the hearing from Sacramento County, California, with the parties and witnesses appearing remotely via the Zoom video platform. Attorney Lisa Prince of The Prince Firm represented Employer. Deborah Bialosky, Staff Counsel, represented the Division. Carol Igoe and Imhotep Royster, attorneys for the California Nurses Association, represented the union on behalf of third party affected registered nurses employed by Employer. The matter was submitted on June 30, 2024.

Issues

1. Did Employer fail to report to the Division a serious illness occurring at the job site?

2. Did Employer fail to sufficiently investigate a COVID-19 exposure and notify employees who had a significant exposure?

3. Did Employer provide its employees with training related to the donning and doffing of gowns when a new reuse procedure was introduced?

4. Did the Division establish a rebuttable presumption that Citation 2 was properly classified as Serious?

5. Did Employer rebut the presumption that the violation in Citation 2 was Serious by demonstrating that it did not know and could not, with the exercise of reasonable diligence, have known of the existence of the violation?

6. Is the proposed penalty for Citation 2 reasonable?

Findings of Fact

1. Vorng Thep (Thep), a registered nurse working in Employer's emergency department, was hospitalized from April 7 to 9, 2020, for treatment of COVID-19.

2. Thep left his shift at Sutter early on March 30, 2020, because he was feeling ill.

3. In 2020, Thep worked at least four days per month as a per diem nurse at Sutter.

4. Thep worked eight-hour shifts on March 22, 23, 24, and 27, prior to experiencing COVID-19 symptoms on March 30, 2020.

5. On April 2, 2020, Thep informed his supervisor at Sutter that he had tested positive for COVID-19.

6. In addition to his per diem work at Sutter, Thep worked full time at Kaiser Hospital in Redwood City (Kaiser).

7. Sutter did not report Thep's COVID-19 hospitalization to the Division.

8. Employer was unaware that Thep had been hospitalized for treatment of COVID-19 until Tolentino brought it to management's attention after she commenced her inspection in July 2020.

9. Kathy Sforzo, Employer's Director of Safety, was aware of the requirement to timely report serious injuries and illnesses to the Division and had reported another employee's COVID-19 hospitalization in June 2020.

10. Employer was aware that employees had been exposed to COVID-19, a reportable aerosol transmissible disease, through contact with Thep.

11. Employer conducted an exposure analysis for the March 30, 2020, shift that Thep worked when he exhibited symptoms of COVID-19.

12. No exposure analysis was conducted for the 14-day period before March 30, 2020.

13. The contagious period between infection and exhibiting symptoms of COVID-19 can be between two and 14 days.

14. Employer's exposure analysis form for March 30, 2020, did not indicate who made determinations regarding the risk levels or post-exposure follow up of exposed employees.

15. On Friday, March 27, 2020, Employer prepared for the possibility that its supply of disposable gowns might be depleted over the weekend before more gowns were delivered the following week. The preparation for the shortage involved a procedure for using alternative gowns with one gown per nurse per patient, so the gowns would be reused and left in the patient's room between uses.

16. Employer created detailed instructions and provided support over the weekend to ensure that the nurses on the various shifts understood the gown reuse procedure.

17. The supply of disposable gowns was not depleted over the weekend and the supply was replenished before there was a need to implement the reuse procedure.

18. Contracting COVID-19 may result in hospitalization for pulmonary failure, acute respiratory distress syndrome, pneumonia, strokes from blood clots, multisystem failure including kidney failure, and may result in death.

19. If an employee is not notified of an exposure incident, he may not seek medical treatment and may spread the disease to others more readily than if he is aware that he may have contracted the disease.

20. Employer abated the violation alleged in Citation 2 on January 20, 2021.[3]

Analysis

1. Did Employer fail to report to the Division a serious illness occurring at the job site?

California Code of Regulations, title 8, section 342, subdivision (a),[4] under "Reporting Work-Connected Fatalities and Serious Injuries," provides:

> Every employer shall report immediately to the Division of Occupational Safety and Health any serious injury or illness, or death, of an employee occurring in a place of employment or in connection with any employment. The report shall be made by the telephone or through a specified online mechanism established by the Division for this purpose. Until the division has made such a mechanism available, the report may be made by telephone or email.
>
> Immediately means as soon as practically possible but not longer than 8 hours after the employer knows or with diligent inquiry would have known of the death or serious injury or illness. If the employer can demonstrate that exigent circumstances exist, the time frame for the report may be made no longer than 24 hours after the incident.
>
> Serious injury or illness is defined in section 330(h), Title 8, California Administrative Code.
>
> In Citation 1, Item 1, the Division alleges:
>
> The Employer failed to immediately report to the Division of Occupational Safety and Health the serious illness suffered by an employee who was hospitalized with COVID-19 for about two days starting on or about April 7, 2020.

[3] Finding of Fact No. 20 was a stipulation of the parties.
[4] Unless otherwise specified, all references are to sections of California Code of Regulations, title 8.

The Division has the burden of proving a violation, including the applicability of the safety order, by a preponderance of the evidence. (*Coast Waste Management, Inc*., Cal/OSHA App. 11-2385, Decision After Reconsideration (Oct. 7, 2016.) "Preponderance of the evidence" is usually defined in terms of probability of truth, or of evidence that when weighed with that opposed to it, has more convincing force and greater probability of truth with consideration of both direct and circumstantial evidence and all reasonable inferences to be drawn from both kinds of evidence. (*Lone Pine Nurseries*, Cal/OSHA App. 00-2817, Decision After Reconsideration (Oct. 30, 2001), citing *Leslie G. v. Perry & Associates* (1996) 43 Cal.App.4th 472, 483.)

a. Serious injury or illness

Section 330, subdivision (h), provides:

> "Serious injury or illness" means any injury or illness occurring in a place of employment or in connection with any employment that requires inpatient hospitalization for other than medical observation or diagnostic testing, or in which an employee suffers an amputation, the loss of an eye, or any serious degree of permanent disfigurement, but does not include any injury or illness or death caused by an accident on a public street or highway, unless the accident occurred in a construction zone.

Thep, a registered nurse working in Employer's emergency department, was hospitalized from April 7 to 9, 2020, for treatment of COVID-19. There was no dispute about this fact. Thus, there was an illness that required inpatient hospitalization for other than medical observation or diagnostic testing.

b. Occurring in a place of employment or in connection with any employment

Employer argued that Thep's illness did not occur at his place of employment with Sutter. The Appeals Board has stated that section 342, subdivision (a), "requires reporting of employee injuries, illnesses and deaths which occur on an employer's premises, even if they are not work related." (*Honeybaked Hams*, Cal/OSHA App. 13-0941, Denial of Petition for Reconsideration (Jun. 25, 2014) [employee suffered fatal heart attack on his lunch break while relaxing outdoors on the employer's premises].) "Requiring reports of illnesses, injuries and deaths occurring at work, or that have a tangible connection to work, even if not ostensibly work related, provides the Division with the opportunity to acquire data that may allow it to recognize patterns indicating workplace hazards, which employers might not have sufficient expertise or

experience to recognize on their own." (*Western Digital Corporation*, Cal/OSHA App. 1200858, Decision After Reconsideration and Order of Remand (May 16, 2019).)

Thep testified that he left his shift at Sutter early on March 30, 2020, because he felt that he was sick. Thep recalled that he was experiencing fatigue and muscle aches from the start of his shift that day. Thep testified strongly and with credible detail about how he was concerned about the illness infecting others. Thep explained that, in order to protect his coworkers, he wore an N95 respirator during his entire shift and kept his distance from his coworkers. Both of these specific efforts taken by Thep, and explained without hesitation or vagueness during his testimony, give indicia of reliability in the recollection as to why he left his shift early that day. (Hearing Transcript (Hrg. Tr.), Mar. 7, 2023, pp. 246, 254-255.)

Employer's time records for Thep reflect that he worked 3.5 hours on March 30, 2020, instead of his full eight-hour schedule. (Exh. 31.) Although Employer's witnesses and time records reflect that Thep was released from his shift early because the workload was light and he was not needed, his testimony was more persuasive regarding why he left early, and the shortened shift coincided directly with the onset of his illness.

The fact that Thep was experiencing symptoms of COVID-19 while he was working at Sutter on March 30, 2020, makes his illness "occurring in a place of employment or in connection with any employment[.]" (§ 330, subd. (h).)

c. Employer shall report to the Division immediately

Section 342, subdivision (a), establishes the timing required for reporting a serious injury or illness:

> "Immediately" means as soon as practically possible but not longer than 8 hours after the employer knows or with diligent inquiry would have known of the death or serious injury or illness.

There was no dispute that Thep's COVID-19 illness and hospitalization was not reported to the Division. The Division learned that Thep had been hospitalized because the issue arose while Tolentino was conducting a concurrent inspection of the Kaiser facility where Thep also worked.

Having established that there was a serious illness that was required to be reported immediately in accordance with section 342, subdivision (a), the Division has the burden to establish that the employer knew "or with diligent inquiry would have known" of the serious illness.

(1) Actual knowledge of hospitalization

The inspection opened by Tolentino on July 15, 2020, followed Employer's timely report of a serious illness when one of its employees, Marie Catherine Ireneo (Ireneo), was hospitalized for COVID-19 in June 2020. Employer asserts that it had no knowledge that Thep had been hospitalized until Tolentino informed Kathy Sforzo (Sforzo), Employer's Director of Safety, several months into the Sutter inspection. During the entirety of Tolentino's communications with Sutter management, the various individuals told her that they were not aware that Thep had been hospitalized.

Sforzo testified that she had no knowledge of Thep's hospitalization until Tolentino mentioned it as a "casual statement" while they were standing in a hallway discussing the Sutter inspection. (Hrg. Tr., Dec. 14, 2023, pp. 37-38.) Sforzo restated her lack of knowledge in an email exchange with Tolentino on October 30, 2020, when Tolentino requested Thep's contact information. (Exh. BBB.)

Elizabeth Asifo, Employer's Director of Quality and Patient Safety, testified that Sutter's records indicated that Thep had called in to report that he had tested positive for COVID-19, but that there was no record of him reporting that he had been hospitalized.[5] (Hrg. Tr., Feb. 6, 2024, pp. 130-133, Exh. FFF.) Additionally, Sandra Piedra (Piedra), In-Patient Nursing Director, testified that she did not know that Thep had been hospitalized prior to Tolentino's inspection after the Ireneo hospitalization. (Hrg. Tr., Mar. 7, 2023, pp. 104-105.)

Thep provided some testimony on the issue of reporting his hospitalization to Sutter management, but the overall quality of the information he provided is not credited. He was uncertain and his memory was faded. In addition to the fact that the situation occurred three years prior to his testimony, Thep was working at both Sutter and Kaiser, and his memory of reporting his illness versus reporting his hospitalization to one or the other, or both, came across as unreliable. Much of Thep's testimony on this issue on March 7, 2023, was "refreshed" by reference to Tolentino's notes of her interview with him in 2020. (Hrg. Tr., Mar. 7, 2023, pp. 238-243.) Those notes, as discussed below, do not establish that Thep had reported his hospitalization to Sutter. Overall, Thep's testimony was not sufficiently persuasive to overcome the strong and unwavering testimony from Employer's numerous witnesses saying that they had not been informed that Thep was hospitalized.

[5] Elizabeth Asifo testified using the surname "Johns" on March 8, 2023, and is referred to during various witnesses' testimony under the name Johns as well. She testified using the surname "Asifo" on Feb. 6, 2024.

When asked the basis for her determination that Employer had knowledge that Thep had been hospitalized, Tolentino testified that she relied on her interview with Thep for determining Employer knowledge: "Through the employee interview with Vorng Thep, he stated he reported to management that he was going into the hospital." (Tolentino, Hrg. Tr., Aug. 10, 2023, p. 82.)

However, on cross-examination, Tolentino acknowledged that her interview notes did not actually contain anything about Thep informing his Sutter supervisors that he had been hospitalized.

> Q. […] And again, Mr. Thep called [Sutter] Mills-Peninsula and Kaiser letting them know that he had COVID; right?
> A. Yes.
> Q. Okay. And there's not anything in this document [Exhibit 13] regarding a conversation with Mills-Peninsula regarding his hospitalization?
> A. You're correct.

(Hrg. Tr., Aug. 10, 2023, p. 153.)

Tolentino's notes give no indication of what questions she was asking that elicited a response regarding "Supervisor—Sandra or Angie." The notes say:

> Mills Peninsula:
> Surgical mask
> On day feeling sick, I wore an N95
> N95 not a problem
> Supervisor—Sandra and Angie (not sure which one)
> Need to establish that Management knew VT was in hospital.

(Exh. 13, p. 2.)

The rest of Tolentino's notes refer to Thep's report to Kaiser and Sutter that he had tested positive for COVID-19 and say nothing about Sutter and hospitalization. Tolentino's notation that the Division needed to establish knowledge of the hospitalization raises a reasonable question of whether any of the information she had in her notes did, in fact, relate to Sutter's knowledge. The highlighting of the issue in the notes calls into question the credibility of Tolentino's direct examination testimony that Thep told her he had informed Sutter management. The notes are lacking in substance and do not establish the critical issue to establish the violation. In sum, Tolentino's testimony regarding this information in her notes is not credited, as the notes do not indicate what questions she asked Thep, despite Tolentino's apparent acknowledgement of the importance of the issue of knowledge.

Sforzo testified that she is responsible for reporting serious injuries or illnesses to the Division and described Sutter's procedures for doing so. (Hrg. Tr., Dec. 14, 2023, p. 38.) Indeed, the Division's inspection was initiated as a result of Employer's report of Ireneo's hospitalization in June 2020. The fact that Employer would report Ireneo's hospitalization to the Division points to Employer's propensity toward compliance with the requirements of section 342, subdivision (a).

The preponderance of the evidence does not support a finding that Employer had actual knowledge that Thep had been hospitalized. Section 342, subdivision (a), includes a constructive knowledge component that must be analyzed as well.

(2) Diligent inquiry

In *Benicia Foundry & Iron Works, Inc.*, Cal/OSHA App. 00-2976, Decision After Reconsideration (Apr. 24, 2003), the Appeals Board offered the following discussion regarding determining whether the employer had constructive knowledge of an employee's serious injury:

> We find that in addressing the constructive knowledge requirement in section 342(a), the circumstances must be examined in order to determine whether Employer would have known in the exercise of reasonable diligence the nature of the injury as being serious. Facts which are relevant include, but are not limited to, the type and location of the injury or illness suffered by the employee, Employer's knowledge of the cause of the injury or illness, Employer's observations of the employee following the injury or illness, steps taken to obtain or provide medical treatment, Employer's efforts to determine the nature of the hospitalization (e.g. for observation, tests, treatment, duration, etc.) and the timeline and events following Employer learning of the injury or illness. Thus, the facts in a particular case must be examined to determine if an employer knew or with diligent inquiry would have known of the nature of the serious injury that requires the hospitalization described in section 330(h).

There are several circumstances surrounding Thep's employment and illness that must be examined to determine the level of inquiry Sutter was required to undertake after Thep reported that he had tested positive for COVID-19. First, Thep worked an irregular schedule and was not a full-time employee. At the time of Thep's illness, CDC guidelines for when employees were exposed to COVID-19 was that the exposed employee was to stay away from work for 14 days to monitor symptoms. These are the guidelines on which Employer relied for its own exposure analysis. Here, Employer had been informed that Thep had actually tested positive for COVID-19. Thus, it would be a reasonable expectation by Employer that Thep would not come in to

work for at least 14 days and that absence alone would not necessarily raise concern that anything more had happened to Thep in the interim.

This incident occurred during the very early days of the COVID-19 pandemic, when a lot of people were falling ill. The range of outcomes from infection with the disease varied from people testing positive with no symptoms at all, to people who had flu-like symptoms that recovered after a brief period of respite, to people who were hospitalized for treatment, to the people who passed away from severe illness. The varying degrees of illness experienced by people in the early days of the COVID-19 pandemic make it unreasonable to require every employer to regularly contact every employee that called out sick while they were on leave. Unlike other circumstances requiring diligent inquiry, this situation did not call for further inquiry, given that it was an illness that thousands of people were experiencing at the time without hospitalization, and Employer had no independent reason to believe that Thep's illness would result in hospitalization.

Employer did not have actual or constructive knowledge of Thep's hospitalization until Tolentino brought it to Sforzo's attention in October 2020. By that time, reporting of the illness was rendered moot and an investigation was already in progress. Accordingly, Citation 1, Item 1, is vacated.

2. Did Employer fail to sufficiently investigate a COVID-19 exposure and notify employees who had a significant exposure?

Section 5199, subdivision (h)(6)(C), provides:

(h) Medical Services.

[…]

(6) Exposure Incidents.

[…]

(C) Each employer who becomes aware that his or her employees may have been exposed to an RATD case or suspected case, or to an exposure incident involving an ATP-L shall do all of the following:

1. Within a timeframe that is reasonable for the specific disease, as described in subsection (h)(6)(B), but in no case later than 72 hours following, as applicable, the employer's report to the local health officer or the receipt of

notification from another employer or the local health officer, conduct an analysis of the exposure scenario to determine which employees had significant exposures. This analysis shall be conducted by an individual knowledgeable in the mechanisms of exposure to ATPs or ATPs-L, and shall record the names and any other employee identifier used in the workplace of persons who were included in the analysis. The analysis shall also record the basis for any determination that an employee need not be included in post-exposure follow-up because the employee did not have a significant exposure or because a PLHCP [Physician or other Licensed Health Care Professional] determined that the employee is immune to the infection in accordance with applicable public health guidelines. The exposure analysis shall be made available to the local health officer upon request. The name of the person making the determination, and the identity of any PLHCP or local health officer consulted in making the determination shall be recorded.

2. Within a timeframe that is reasonable for the specific disease, as described in subsection (h)(6)(B), but in no case later than 96 hours of becoming aware of the potential exposure, notify employees who had significant exposures of the date, time, and nature of the exposure.

3. As soon as feasible, provide post-exposure medical evaluation to all employees who had a significant exposure. The evaluation shall be conducted by a PLHCP knowledgeable about the specific disease, including appropriate vaccination, prophylaxis and treatment. For M. tuberculosis, and for other pathogens where recommended by applicable public health guidelines, this shall include testing of the isolate from the source individual or material for drug susceptibility, unless the PLHCP determines that it is not feasible.

4. Obtain from the PLHCP a recommendation regarding precautionary removal in accordance with subsection (h)(8), and a written opinion in accordance with subsection (h)(9).

5. Determine, to the extent that the information is available in the employer's records, whether employees of any other employers may have been exposed to the case or material. The employer shall notify these other employers within a

> time frame that is reasonable for the specific disease, as described in subsection (h)(6)(B), but in no case later than 72 hours of becoming aware of the exposure incident of the nature, date, and time of the exposure, and shall provide the contact information for the diagnosing PLHCP. The notifying employer shall not provide the identity of the source patient to other employers.

In Citation 2, the Division alleges:

Prior to and during the course of inspection, the employer failed to investigate and provide notifications after an exposure incident that occurred in the Emergency Department on or about April 7, 2020, in the following instances:

Instance 1) Employer failed to conduct an exposure analysis to determine whether any employees had significant exposures to a fellow employee who was a confirmed case of COVID-19. [5199(h)(6)(C)1]

Instance 2) The employer did not notify employees who had a significant exposure to a fellow employee who was a confirmed COVID-19 case within 96 hours of becoming aware of the potential exposure. [5199(h)(6)(C)2]

Instance 3) The employer did not provide post-exposure medical evaluation to all employees who had a significant exposure to a fellow employee who was a confirmed case of COVID-19, as soon as feasible. [5199(h)(6)(C)3]

Instance 4) The employer did not obtain from the PLHCP a recommendation regarding precautionary removal of employees who had a significant exposure to a fellow employee who was a confirmed case of COVID-19 in accordance with subsection (h)(8), and a written opinion in accordance with subsection (h)(9). [5199(h)(6)(C)4]

Instance 5) The employer did not notify the other employer [Kaiser Redwood City Medical Center] of an employee's significant exposure to COVID-19, no later than 72 hours of becoming aware of the exposure incident. [5199(h)(6)(C)5]

a. Applicability of section 5199, subdivision (h)(6)(C)

The five elements set forth in subdivision (h)(6)(C) are required for:

> Each employer who becomes aware that his or her employees may have been exposed to an RATD case or suspected case, or to an exposure incident involving an ATP-L[.][6]

(§ 5199, subd. (h)(6)(C).)

(1) Reportable Aerosol Transmissible Disease

A "reportable aerosol transmissible disease," or RATD, is defined as "A disease or condition which a health care provider is required to report to the local health officer, in accordance with Title 17 CCR, Division 1, Chapter 4, and which meets the definition of an aerosol transmissible disease (ATD)." (§ 5199, subd. (b).)

California Code of Regulations, title 17, section 2500, as amended on March 9, 2020, provides, in relevant part:[7]

> (j) Health care providers shall submit reports for the following diseases or conditions.
>
> […]
>
> Coronavirus disease 2019 (COVID-19)

The second component of the RATD definition is that the disease or condition "meets the definition of an aerosol transmissible disease." An aerosol transmissible disease, or ATD, is a "disease or pathogen for which droplet or airborne precautions are required, as listed in Appendix A." (§ 5199, subd. (b).) Appendix A to section 5199 lists diseases or pathogens that require droplet or airborne precautions. Although COVID-19 is not listed specifically in Appendix A, it is included in the list by virtue of any of the following categories:

> Novel or unknown pathogens
> Any other disease for which public health guidelines recommend airborne infection isolation

[6] The second prong refers to exposure to a pathogen in a laboratory setting and is, therefore, inapplicable here.

[7] The assigned ALJ took official notice of California Code of Regulations, title 17, section 2500.

> Any other disease for which public health guidelines recommend droplet precautions

A "novel or unknown pathogen" is defined, in relevant part, as:

> A pathogen capable of causing serious human disease meeting the following criteria:
>
> (1) There is credible evidence that the pathogen is transmissible to humans by aerosols; and
>
> (2) The disease agent is:
>
> (a) A newly recognized pathogen […]

(§ 5199, subd. (b).)

The Division's expert, Deborah Gold (Gold), testified that SARS-CoV-2 is the pathogen that causes COVID-19. (Hrg. Tr., Aug. 8, 2023, p. 78.) Gold further testified that the pathogen is transmissible to humans by aerosols and that it was a newly recognized pathogen in early 2020. (*Id.* at pp. 81-83.) Accordingly, SARS-CoV-2 meets the definition of a "novel or unknown pathogen" and Appendix A characterizes novel or unknown pathogens as ATDs.[8]

Additionally, public health guidelines from the United States Center for Disease Control and Prevention (CDC) and California Department of Public Health (CDPH) indisputably designated COVID-19 as an ATD, with recommendations for either droplet or airborne precautions at all times. (Ex. HHH, p. 3.)

Accordingly, COVID-19 was a reportable ATD.

(2) Employer who becomes aware that employees were exposed to RATD

After being informed that Thep had tested positive for COVID-19 and had been working several shifts in the weeks prior to his diagnosis, Employer was aware that there was the potential for other employees to have been exposed to Thep and COVID-19. Employer did not dispute that Thep had reported his diagnosis on April 2, 2020.

[8] For purposes of Citation 2 and the alleged exposure analysis violation, the threshold issue is whether the potential exposure was a reportable ATD, not whether COVID-19 requires droplet or airborne precautions, which are listed separately in Appendix A.

Accordingly, section 5199, subdivision (h)(6)(C), required that Employer perform an exposure analysis related to Thep's illness.

b. Instance 1

In Instance 1, the Division alleges that Employer failed to conduct an exposure analysis after Thep reported that he had tested positive for COVID-19. During the course of the testimony, Tolentino admitted that she had never asked Employer for its exposure analysis during her inspection and document request. Tolentino testified that the issuance of Citation 2 was based on the Division's presumption that there had been no analysis conducted because no exposure analysis report had been produced.

During the discovery process in the appeal of the citations in this matter, Employer produced its exposure analysis report, which was introduced during the hearing as Exhibit 27. Employer argues that Exhibit 27 demonstrates that it was in compliance with the first requirement in section 5199, subdivision (h)(6)(C). That is, there was a report prepared after an exposure analysis was conducted.

There are two problems with Employer's argument, which will be discussed separately below: (1) The completed report relating to Thep's shift on March 30, 2020, was lacking and not in compliance with the requirements of the first element of subdivision (h)(6)(C); and (2) Employer did not complete an exposure analysis for any of the other dates that Thep worked during the 14-day potentially infectious period prior to his COVID-19 diagnosis.

(1) <u>March 30, 2020, report was deficient</u>

The first element of section 5199, subdivision (h)(6)(C), contains numerous components of the exposure analysis that must be present. Specifically, the requirements are that the analysis must:

1. Be conducted by an individual knowledgeable in the mechanisms of exposure to ATPs; and
2. Record the names and any other employee identifier used in the workplace of persons who were included in the analysis; and
3. Record the basis for any determination that an employee need not be included in post-exposure follow-up; and
3. Be made available to the local health officer upon request; and
4. Include the name of the person making the determination that an employee need not be included in post-exposure follow-up; and

5. Include the identity of any PLHCP or local health officer consulted in making the determination that an employee need not be included in post-exposure follow-up.

(§ 5199, subd (h)(6)(C)1.)

The fact that there was a form filled out does not satisfy an employer's obligations under the safety order. Employer's exposure analysis form was lacking in numerous areas. For example, Employer was required to "record the basis for any determination that an employee need not be included in post-exposure follow-up because the employee did not have a significant exposure." Employer now asserts that the employees listed on the exposure analysis form did not have a significant exposure, so there was no requirement that Employer take any further action regarding post-exposure follow-up. However, the exposure analysis form does not provide information explaining *why* Employer found that those employees did not have significant exposure. Indeed, the report lists Kamal Shyam (Shyam) and Gerardo Ramirez (Ramirez) as having "medium" exposure. Yet there is nothing in Employer's exposure analysis report that provides the basis for a determination that any employees did not need a post-exposure follow-up.[9]

Additionally, the first element in section 5199, subdivision (h)(6)(C), provides that "[t]he name of the person making the determination, and the identity of any PLHCP or local health officer consulted in making the determination shall be recorded." Employer's exposure analysis report, identified as Exhibit 27, provides no identification of the person who determined the risk level for any of the employees, and makes no reference to a PLHCP whatsoever. Of particular note is that none of the witnesses who testified about the exposure analysis form knew who had actually completed the various sections of the report. In fact, numerous employees had access to the form and multiple people were apparently assigned to the exposure analysis investigation, but there was no indication of what section was filled out by whom. (Hrg. Tr., Mar. 7, 2023, pp. 129, 190-195.) For example, the section entitled "IP [Infection Prevention] Notes" records notes from two phone calls with Thep, but there is nothing that identifies who wrote the notes. Piedra, Thep's direct supervisor, testified that the only part of the form that she completed was the list of employees that worked with Thep on March 30, 2020. She did not know who else filled out the form and she did not make any determinations of levels of exposure or talk to any employees who may have been exposed. (Hrg. Tr., Mar. 7, 2023, pp. 126-130.) The exposure analysis form provides no "name of the person making the determination [regarding whether there were any significant exposures]." (§ 5199, subd. (h)(6)(C)1.)

[9] The two exposed employees testified that did not recall anyone contacting them, and, significantly, Employer did not argue that anyone had followed up with the employees. (Shyam: Hrg. Tr., Mar. 7, 2023, pp. 69-76; Ramirez: Hrg. Tr., Mar. 7, 2023, pp. 22-26.)

Employer's own Aerosol Transmissible Disease Exposure Control Plan, admitted as Exhibit 14, provides, in relevant part:

> If the exposed person(s) is deemed immune to infection or experienced insignificant exposure and therefore will not be given post-exposure follow-up unless requested, this documentation shall be made with the inclusion of the person making such determination and/or the identity of any physician or other licensed health care professional or local health officer consulted in making such a determination.

(Ex. 14, pp. 33-34.)

In sum, the exposure analysis report is not compliant with the first of the five elements of section 5199, subdivision (h)(6)(C). Exhibit 27 does not provide a basis for a determination that anyone potentially exposed did not require follow-up, and it does not identify the name of the person who made that determination.

(2) No exposure analysis was conducted for shifts worked in 14 days before symptoms

As set forth above, from very early in the pandemic, including prior to the Thep exposure incident, the CDC, and the CDPH, and Employer's own internal documents disseminated to its staff were referencing an infectious period for COVID-19 of up to 14 days prior to symptoms being experienced. (Ex. 22, 38, 42, 52, XX, and HHH.) The CDPH's COVID-19 Mitigation Playbook states that the infectious incubation period was "estimated to be 2-14 days." (Exh. HHH, p. 3.) Additionally, the Division's expert, Janet Prudhomme, M.D., testified that the period of time between exposure and exhibiting symptoms of COVID-19 can be between 2 and 14 days. (Hrg. Tr., Aug. 9, 2023, pp. 115-116.)

Time records reflect that Thep worked eight-hour shifts on March 22, 23, 24, and 27, prior to experiencing COVID-19 symptoms on March 30, 2020. (Exh. 31.) Employer did not perform an exposure analysis for any of those prior shifts despite knowledge that the infectious period could be up to 14 days before Thep was exhibiting symptoms.

Accordingly, even if the flawed exposure analysis performed for the March 30, 2020, exposure incident had been sufficient to meet the requirements of section 5199, subdivision (h)(6)(C)1, the fact that no exposure analysis was conducted for the rest of the shifts would result in a finding of a violation. As such, the Division met its burden of proof with regard to Instance 1.

The Appeals Board has held that a citation may be upheld on the basis of a single instance. (*Chevron U.S.A. Inc*., Cal/OSHA App. 13-0655, Decision After Reconsideration (Oct 20, 2015).) However, each instance will be discussed separately below.

Instance 2

The second element of section 5199, subdivision (h)(6)(C), requires that an employer notify any employees who had a significant exposure. There was a great deal of testimony and argument related to whether Shyam and Ramirez experienced a "significant exposure" and should have been notified of the exposure. Ultimately, as set forth above, the two identified employees were not notified of their exposure to COVID-19 through contact with Thep on March 30, 2020. Further, there was no exposure analysis completed for the shifts worked before March 30, 2020, so there was no identification of exposed employees who needed to be notified during those shifts. As such, whether Shyam and Ramirez had "medium risk" or "low risk" is not the only relevant issue. The other employees, who very likely would have had a higher risk level because Thep testified that he did not wear an N95 respirator all the time, were not even identified and, therefore, could not have been notified.

The Division met its burden of proof to establish by a preponderance of the evidence that employees with significant exposure were not notified based on Employer's failure to conduct an exposure analysis for the days prior to March 30, 2020. Therefore, Instance 2 is affirmed.

Instance 3

The third element of section 5199, subdivision (h)(6)(C), requires that an employer "provide post-exposure medical evaluation to all employees who had a significant exposure."

The analysis and arguments for Instance 3 are the same as those set forth above in Instance 2. Section 5199, subdivision (h)(6)(C)3, requires a post-exposure medical evaluation. There was no evidence that such an evaluation was offered or performed to Shyam or Ramirez. Additionally, no exposure analysis was conducted at all for the shifts Thep worked in the 14 days prior to March 30, 2020. Employer's argument that there was no significant exposure to Shyam and Ramirez is unpersuasive because Sutter did not even conduct an analysis to determine whether a post-exposure evaluation was needed for exposures during the period prior to March 30, 2020.

Accordingly, the Division met its burden of proof to establish by a preponderance of the evidence that Employer did not provide a post-exposure medical evaluation to employees who were determined to have a significant exposure. Instance 3 is affirmed.

Instance 4

The fourth element of section 5199, subdivision (h)(6)(C), requires that, following the post-exposure evaluation required by the third element, above, an employer shall "obtain from the PLHCP a recommendation regarding precautionary removal in accordance with subsection (h)(8), and a written opinion in accordance with subsection (h)(9)."

The analysis and arguments for Instance 4 are the same as those set forth above in Instance 3. Section 5199, subdivision (h)(6)(C)3, requires a post-exposure medical evaluation if there was a significant exposure. Section 5199, subdivision (h)(6)(C)4, then requires that the physician or other licensed health care provider issue a written opinion. There was no evidence that the post-exposure evaluation was offered or performed, and, thus, no written opinion was provided for Shyam or Ramirez. Additionally, Employer did not do an analysis for the days Thep worked prior to March 30, 2020. Employer's argument that there was no significant exposure is unpersuasive.

The Division met its burden of proof by a preponderance of the evidence to establish that Employer's post-exposure analysis did not result in a recommendation regarding removal from the workplace and a written opinion thereon. Accordingly, Instance 4 is affirmed.

Instance 5

The fifth element of section 5199, subdivision (h)(6)(C), provides, in relevant part:

> Determine […] whether employees of any other employers may have been exposed to the case or material. The employer shall notify these other employers within a time frame that is reasonable for the specific disease, as described in subsection (h)(6)(B), but in no case later than 72 hours of becoming aware of the exposure incident of the nature, date, and time of the exposure, and shall provide the contact information for the diagnosing PLHCP. The notifying employer shall not provide the identity of the source patient to other employers.

The AVD for Instance 5 refers to Sutter providing notification to Thep's "other employer," which was Kaiser. In this instance, the Division has misapplied the safety order to the facts of this exposure. The entirety of section 5199, subdivision (h)(6)(C), relates to employees exposed to Thep. Thep is "the case" to whom other employees were exposed. The exposure analysis and all other requirements of subdivision (h)(6)(C) are aimed at taking care of people exposed to Thep, and those people are the "employees … exposed to the case… ." (§ 5199, subd. (h)(6)(C)5.) Thus, the notification to "other employers" pertains to other employers of Shyam

and Ramirez, as well as the unknown but inferred exposure to other employees, not employers of Thep.

Additionally, the rest of section 5199, subdivision (h)(6)(C)5, does not make sense if it is applicable to the source, or infected, employee. The "exposure incident" relates to Thep's exposure to Shyam and Ramirez, so providing the "nature, date, and time of the exposure" is not relevant to Thep's work at Kaiser. The contact information for the diagnosing PLHCP relates to the PLHCP that [should have] examined the exposed employees, not Thep. Finally, not providing the identity of the "source patient" to the other employer would make the report impossible with regard to Thep and Kaiser.

The plain meaning of section 5199, subdivision (h)(6)(C)5, makes it apparent, as it relates to COVID-19, that reporting to "other employers" relates to the employees who have been exposed to the COVID-19 positive case, not the case himself. There was no evidence that Shyam, Ramirez, or any other unknown but potentially exposed employees, had any employers other than Sutter. While the facts reasonably lead to an inference that there were other employees that were exposed to Thep during all of his shifts in the infectious period, there can be no reasonable inference that other employees had other employers for purposes of enforcing this provision of the safety order.

As such, the Division did not meet its burden of proof with regard to Instance 5.

Because Items 1 through 4 were established as violations, Citation 2 is affirmed.

3. Did Employer provide its employees with training related to the donning and doffing of gowns when a new reuse procedure was introduced?

Section 5199, subdivision (i), provides, in relevant part:

> (i) Training
>
> (1) Employers shall ensure that all employees with occupational exposure participate in a training program.
> (2) Employers shall provide training as follows:
> […]
> (D)When changes, such as introduction of new engineering or work practice controls, modification of tasks or procedures or institution of new tasks or procedures, affect the employee's occupational exposure or control measures. The additional training may be limited to addressing the new exposures or control measures.
> […]

(4) The training program shall contain at a minimum the following elements:
[…]
(G) An explanation of the basis for selection of personal protective equipment, its uses and limitations, and the types, proper use, location, removal, handling, cleaning, decontamination and disposal of the items of personal protective equipment employees will use.

In Citation 3, the Division asserted a violation of subdivision (i)(4)(G) and alleges:

Prior to and during the course of the inspection, including but not limited to the month of June 2020, the employer failed to provide effective training to employees on the explanation of the basis of personal protective equipment, its uses and limitations and the types, proper use, location, removal, and handling of gowns for use while caring for COVID-19 positive patients, in that the nurses on 3 West night shift engaged in the practice of donning, doffing, and storing their gowns inside of the COVID-19 positive patient rooms throughout their shift.

a. Employees with occupational exposure must participate in a training program

Employer's registered nurses had extensive training regarding donning and doffing of gowns. During the hearing, there were training records produced for various nurses which established that Employer's training program provided regular training that included donning and doffing gowns. (Exh. F, G, CC, and TTT.) Multiple witnesses also testified that the nurses undergo an annual competency testing and training that covers donning and doffing of gowns.

However, the focus of the alleged violation for Citation 3 was a change of the usual donning and doffing procedure that Employer contemplated implementing for a few days in late-March, early-April 2020 when it appeared that there would be a critical shortage of disposable gowns for a period of time.

b. Modification of procedures affects employee's occupational exposure or control measures

Two of Employer's management employees, Aileen Guina (Guina) and Cassandra Pingol (Pingol), testified that, on Friday, March 27, 2020, it was discovered that Employer was running low on its disposable gown supply and there was the possibility that the supply would not be replenished until early the following week. To ensure that the nurses had gowns to use through the weekend, Guina and Pingol prepared a protocol in the event that the disposable gown supply was depleted. The procedure involved the use of alternative gowns that the nurses would reuse

by doffing them carefully, hanging them in the COVID-19 patient's room, and then carefully donning the same gown again when they returned to the room.

It was this reuse procedure that the Division identified as a modification of procedures that affected the nurses' exposure to COVID-19 contaminants. The Division asserted that Employer did not properly train the night shift nurses in the "COVID unit," which was also identified as "3 West," how to safely don and doff the gowns for this reuse policy.

Guina and Pingol testified confidently, credibly, and unwaveringly about the dissemination of information and oversight the Infection Prevention (IP) staff provided to the nurses over the weekend after the potential supply issue was identified. There was a pictogram prepared that was posted and shared to the nurses which provided the step-by-step procedures to doff and don the alternative gowns if the supply of disposable gowns ran out. Guina testified that she and her IP team were either present or on call 24 hours per day over that weekend if anyone had questions about the procedure. The information was provided to all three shifts, day, evening, and night, with the pictogram laminated and placed on a central information board, a copy provided to the charge nurse on each shift, and the IP staff were available for each shift over the weekend.

Guina and Pingol testified that the disposable gown supply did not run out over the weekend. Pingol testified that she spoke to a night shift nurse early Monday morning and asked if the nurse had needed to reuse gowns. The nurse replied that they had not needed to reuse gowns over the weekend. (Hrg. Tr., Dec. 13, 2023, pp. 119-120.) Guina checked the supply of disposable gowns on Monday and found that they had not run out over the weekend. Guina testified that the disposable gown supply was then replenished that Monday, March 30, 2020. (Hrg. Tr., Dec. 13, 2023, p. 221.)

Ultimately, the credible testimony of Guina and Pingol supports a finding that the reuse policy was never implemented. Employer developed the procedure and disseminated information to the nurses in the event that the disposable gown supply ran out before it could be replenished, but the gown supply was sufficient to meet the nurses' needs over the weekend of March 28 and 29, 2020. (See testimony of Guina, Hrg. Tr., Dec. 13, 2023, pp. 112-143 and 219-221; Pingol Hrg. Tr., Dec. 14, 2023, pp. 109-120.)

The Division based its citation and assertions on the statements of nurses during Tolentino's investigation. Those hearsay statements are inconsistent with the testimony of Guina and Pingol. Additionally, the hearsay statements do not supplement or explain other non-hearsay evidence that is being relied upon for a finding of fact. The only thing those hearsay statements do is contradict the persuasive testimony from Pingol and Guina.

There was some testimony by two nurses, Richelle Mas (Mas) and Elisa Ofria (Ofria), regarding reuse of gowns. Mas testified that she did not have any direct experience with the proposed reuse policy when she worked on the COVID-19 Unit. (Hrg. Tr., Mar. 8, 2023, p. 65.) Ofria's testimony was uncertain and unclear, with estimates that a reuse policy lasted "weeks" in March and April, but she was vague in her recollections and did not come across as being certain of her answers. (Hrg. Tr., Mar. 8, 2023, pp. 11-13.) Mas and Ofria's testimony did not sufficiently refute the extensive testimony of Guina and Pingol that there was no gown shortage and the gown reuse policy was not implemented. (Guina, Hrg. Tr., Dec. 13, 2023, pp. 112-143 and 219-221; Pingol Hrg. Tr., Dec. 13, 2023, pp. 109-120.)

c. Training program related to modified gown procedure

Although it is found that the gown reuse policy was ultimately not implemented due to no shortage of disposable gowns, even if it had been, the inquiry would not end with implementation alone. There would still need to be an evaluation of whether the training provided was sufficient. Training must "be of sufficient quality to make employees 'proficient or qualified' on the subject of the training." (*Siskiyou Forest Products*, Cal/OSHA App. 01-1418, Decision After Reconsideration (Mar. 17, 2003.)

It is found that the nurses had extensive training regarding personal protective equipment in general, which was directly applicable to the reuse procedure. The information provided to the nurses regarding the reuse of the alternative gowns was sufficient to explain the steps to safely doff and don the gowns, including multiple points during the process when the nurses were instructed to engage in the handwashing and sanitizing procedures that are a regular facet of their training and daily routines. (Gold, Hrg. Tr., Aug. 8, 2023, p. 210; Guina, Hrg. Tr., Dec. 13, 2023, pp. 127-132; Jeffrey Silvers, M.D., Hrg. Tr., Feb. 6, 2024, p. 100.) The nurses were required to read through the pictogram and sign acknowledging that they had read it, had the opportunity to discuss the procedure with a member of the IP team and their charge nurse, and had the pictogram on display at the nurse's station in the unit. In addition to their general knowledge and training as registered nurses, this information was sufficient to make them proficient to perform the reuse procedure if it had been needed.

The Division made some representations that there was a reuse procedure implemented in June of 2020, but the basis for those representations was hearsay. There was no non-hearsay testimony that supported this assertion and the credible testimony of the witnesses during the hearing was that there were no further supply shortages and no contemplation of implementing the reuse policy after early April 2020. (Hrg. Tr., Dec. 13, 2023, p. 145, 153-155.)

The reuse procedure was not ultimately implemented because the supply of disposable gowns never ran out, so the issue of training on the task is moot. Nonetheless, the Division did

not establish that the training provided was insufficient to make the nurses proficient in the task. Accordingly, Citation 3 is vacated.

4. Did the Division establish a rebuttable presumption that Citation 2 was properly classified as Serious?

Labor Code section 6432, subdivision (a), provides, in relevant part:

> (a) There shall be a rebuttable presumption that a "serious violation" exists in a place of employment if the division demonstrates that there is a realistic possibility that death or serious physical harm could result from the actual hazard created by the violation. The demonstration of a violation by the division is not sufficient by itself to establish that the violation is serious. The actual hazard may consist of, among other things:
> […]
>
> (2) The existence in the place of employment of one or more unsafe or unhealthful practices that have been adopted or are in use.

The Appeals Board has defined the term "realistic possibility" to mean a prediction that is within the bounds of human reason, not pure speculation. (*A. Teichert & Son, Inc. dba Teichert Aggregates*, Cal/OSHA App. 11-1895, Decision After Reconsideration (Aug. 21, 2015), citing *Janco Corporation*, Cal/OSHA App. 99-565, Decision After Reconsideration (Sep. 27, 2001).) "Serious physical harm" is defined as an injury or illness occurring in the place of employment that results in, among other possible factors, "inpatient hospitalization for purposes other than medical observation." (Lab. Code § 6432, subd. (e).)

The Division's expert witness, Dr. Janet Prudhomme, testified that the hazard created by the violation in Citation 2 was the potential that exposed employees could suffer more serious symptoms of COVID-19 if their exposure risk is not analyzed, they are not notified of the exposure, and they do not receive a medical evaluation as set forth in section 5199, subdivision (h)(6)(C). Dr. Prudhomme testified that making exposed employees aware of the exposure gives them the opportunity to get a medical evaluation sooner, obtain treatment if needed, and take other precautions to potentially minimize the effects of the illness. The exposed employee may also expose others unknowingly if they are not notified of the exposure incident, spreading the virus to others who may have medical vulnerabilities.

Dr. Prudhomme testified that serious physical harm or death may occur as a result of contracting COVID-19. Dr. Prudhomme testified that COVID-19 can result in hospitalization for treatment of pulmonary failure, acute respiratory distress syndrome, pneumonia, strokes from

blood clots, multisystem failure including kidney failure, and may result in death. She testified that millions of people have died from COVID-19. (Hrg. Tr., Aug. 9, 2023, pp. 104, 162-165.)

Accordingly, the Division met its burden to establish a rebuttable presumption that the violation cited in Citation 2 was properly classified as Serious.

5. Did Employer rebut the presumption that the violation in Citation 2 was Serious by demonstrating that it did not know and could not, with the exercise of reasonable diligence, have known of the existence of the violation?

Labor Code section 6432, subdivision (c), provides that an employer may rebut the presumption that a Serious violation exists by demonstrating that the employer did not know and could not, with the exercise of reasonable diligence, have known of the presence of the violation. In order to satisfactorily rebut the presumption, the employer must demonstrate both:

(1) The employer took all the steps a reasonable and responsible employer in like circumstances should be expected to take, before the violation occurred, to anticipate and prevent the violation, taking into consideration the severity of the harm that could be expected to occur and the likelihood of that harm occurring in connection with the work activity during which the violation occurred. Factors relevant to this determination include, but are not limited to, those listed in subdivision (b) [; and]

(2) The employer took effective action to eliminate employee exposure to the hazard created by the violation as soon as the violation was discovered.

As set forth in Labor Code section 6432, subdivision (b), the burden is on the employer to rebut the presumption that the citation was properly classified as Serious. The violation in Citation 2 was the failure to perform the various aspects of the exposure analysis discussed in detail above. There was no real argument set forth by Employer that it did not know or could not have known about the inadequacy of its exposure analysis. In addition to the flaws in the exposure analysis form itself, Employer did not even perform an exposure analysis for four other shifts in the 14-day period prior to March 30, 2020.

There is no reasonable finding that Employer "took all the steps a reasonable and responsible employer in like circumstances should be expected to take[.]" (Lab. Code § 6432, subd (c)(1).)

Accordingly, Citation 2 was properly classified as Serious.

6. Is the proposed penalty for Citation 2 reasonable?

Penalties calculated in accordance with the penalty-setting regulations set forth in sections 333 through 336 are presumptively reasonable and will not be reduced absent evidence that the amount of the proposed civil penalty was miscalculated, the regulations were improperly applied, or that the totality of the circumstances warrant a reduction. (*Stockton Tri Industries, Inc*., Cal/OSHA App. 02-4946, Decision After Reconsideration (Mar. 27, 2006).)

The Appeals Board has held that "while there is a presumption of reasonableness to the penalties proposed by the Division in accordance with the Director's regulations, the presumption does not immunize the Division's proposal from effective review by the Board... ." (*DPS Plastering, Inc*., Cal/OSHA App. 00-3865, Decision After Reconsideration (Nov. 17, 2003).) Nor does the presumptive reasonableness of the penalty calculated in accordance with the penalty-setting regulations relieve the Division of its duty to offer evidence in support of its determination of the penalty since the Appeals Board has historically required proof that a proposed penalty is, in fact, calculated in accordance with the penalty-setting regulations. (*Plantel Nurseries*, Cal/OSHA App. 01-2346, Decision After Reconsideration (Jan. 8, 2004); *RII Plastering, Inc*, Cal/OSHA App. 00-4250, Decision After Reconsideration (Oct. 21, 2003).)

The Appeals Board has held that when the Division does not provide evidence to support its proposed penalty, it is appropriate that an employer be given the maximum credits and adjustments provided under the penalty-setting regulations such that the minimum penalty provided under the regulations for the violation is assessed. (*RII Plastering, Inc*, *supra*, Cal/OSHA App. 00-4250.)

The violation set forth in Citation 2 was the failure to sufficiently evaluate a COVID-19 exposure. Tolentino testified regarding the basis for the penalty for Citation 2. The factors used to calculate the penalty must be evaluated to determine whether the proposed penalty was reasonable.

a. Severity

The Base Penalty for a Serious violation is $18,000. (§ 336, subd. (c).) The citation was properly classified as Serious. As such, the Base Penalty of $18,000 is appropriate.

b. Extent

Tolentino testified that she rated Extent as Medium based on the number of employees that were exposed to the violation. Employer's exposure analysis identified 20 employees who had contact with Thep on March 30, 2020, and were part of the exposure analysis.[10] As such, a Medium rating for Extent is appropriate and no adjustment is made to the Base Penalty. (§ 335, subd. (a)(2); § 336, subd. (c).)

c. Likelihood

Section 335, subdivision (a)(3), defines the adjustment for Likelihood:

> Likelihood is the probability that injury, illness or disease will occur as a result of the violation. Thus, Likelihood is based on (i) the number of employees exposed to the hazard created by the violation, and (ii) the extent to which the violation has in the past resulted in injury, illness or disease to the employees of the firm and/or industry in general, as shown by experience, available statistics or records. Depending on the above two criteria, Likelihood is rated as:
>
> LOW, MODERATE OR HIGH

When questioned about the basis for the Medium Likelihood rating, Tolentino's testimony was vague, and she ultimately stated that she was unable to determine the extent to which the violation has resulted in illness in the past, so she "didn't put it as high. I didn't put it as low, so I put it as medium." (Hrg. Tr., Aug. 10, 2023, pp. 110-111.)

None of the testimony provided by Tolentino regarding Likelihood is sufficient to support a Medium rating. Accordingly, Employer is afforded maximum credit for Likelihood for Citation 2. (*RII Plastering, Inc*, *supra*, Cal/OSHA App. 00-4250.) As such, the Low Likelihood results in a 25 percent reduction of the Base Penalty. (§ 336, subd. (c)(1).) The resulting Gravity-based Penalty is $13,500 ($18,000, less $4,500).

After determining the Gravity-based Penalty, the regulations require that the Division evaluate the application of adjustment factors to determine whether the penalty may be reduced based on the various factors of Good Faith, Size, and History. (§ 336, subd. (b)-(d).)

[10] Based on the findings herein, it is possible that the Extent could have been High because there were more employees exposed to Thep within the 14 days prior to March 30, 2020. However, there was no evidence about the possible number of employees and the evidence established *at least* 20 employees, so the Medium rating will not be increased.

d. Good Faith

Section 335, subdivision (c), provides:

> (c) The Good Faith of the Employer--is based upon the quality and extent of the safety program the employer has in effect and operating. It includes the employer's awareness of CAL/OSHA, and any indications of the employer's desire to comply with the Act, by specific displays of accomplishments. Depending on such safety programs and the efforts of the employer to comply with the Act, Good Faith is rated as:
>
> GOOD-- Effective safety program.
>
> FAIR-- Average safety program.
>
> POOR-- No effective safety program.

Tolentino testified that she gave Employer a 15 percent adjustment factor, or Fair rating, for Good Faith because, "The employer provided some of the documentation that I needed; was helpful in providing me contact information for employees to be interviewed." (Hrg. Tr., Aug. 10, 2023, p. 113.)

The testimony does not support the application of a Fair rating for Good Faith. The Division did not provide any further support for its application of the Fair rating for Good Faith. Accordingly, the "Good" rating for Good Faith is hereby applied, which results in a reduction of 30 percent of the Gravity-based Penalty. (§ 336, subd. (d)(2).)

e. Size

Section 336, subdivision (b), provides that employers may be entitled to a reduction in the penalty based on the number of individuals employed at the time of the inspection. Employers with more than 100 employees are not entitled to an adjustment for Size. (§ 336, subd. (d)(1).) Tolentino testified that she did not apply an adjustment for Size due to the large number of individuals employed by Employer at the time of the inspection. (§ 336, subd. (d)(1).) This assertion was not disputed by Employer and is found to be appropriate.

f. History

The History adjustment factor is based on the number of violations an employer has had in the three years prior to the issuance of the citation. Employer was given the highest adjustment

factor of 10 percent for History, so there is no greater adjustment that would be afforded based on evidence during the hearing and it is found to be appropriate.

The Gravity-Based Penalty of $13,500 is reduced by 40 percent after applying Adjustment Factors of 30 percent for Good Faith and 10 percent for History. After the application of the adjustment factors, the Adjusted Penalty is $8,100. (§ 336, subd. (d).)

g. Abatement Credit

Section 336, subdivision (e)(2), permits a credit of 50 percent of the Adjusted Penalty if an employer did one of the following:

(A) Abated the Serious violation at the time of the initial or a subsequent visit during an inspection and prior to the issuance of a citation.
(B) Submitted a statement signed under penalty of perjury, together with supporting evidence when necessary to prove abatement, that the employer has abated the Serious violation within the period fixed for abatement in the citation. The signed statement and supporting evidence must be received within 10 working days after the end of the period fixed in the citation for abatement.

The citation indicates that abatement must be corrected by January 8, 2021. (Exh. 1.) Pursuant to stipulation by the parties, the Division accepted Employer's proof of abatement on January 20, 2021. Because the proof of abatement was received by the Division within 10 working days after the end of the period fixed in the citation, Employer is entitled to a credit of 50 percent of the Adjusted Penalty. (§ 336, subd. (e)(2).)

Accordingly, the appropriate penalty for Citation 2 is $4,050.

Conclusions

The evidence did not establish that Employer violated section 342, subdivision (a), because it was not proven that Employer was aware that its employee had been hospitalized with a serious illness. Accordingly, Citation 1 is dismissed.

The Division established that Employer did not conduct a sufficient exposure analysis after a COVID-19 exposure incident. Citation 2 is affirmed and the penalty, as modified herein, is reasonable.

The Division did not establish that Employer failed to provide effective training to employees on a modified procedure involving reuse of disposable gowns. Accordingly, Citation 3 is dismissed.

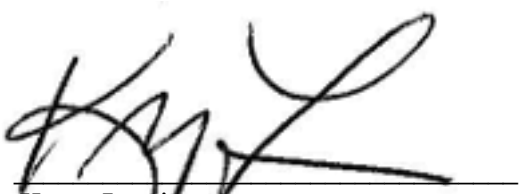
Order

It is hereby ordered that Citation 1 is dismissed and the penalty is vacated.

It is hereby ordered that Citation 2 is affirmed and the modified penalty of $4,050 is sustained.

It is hereby ordered that Citation 3 is dismissed and the penalty is vacated

It is further ordered that the penalty indicated above and set forth in the attached Summary Table be assessed.



Dated: 07/23/2024

Kerry Lewis
Presiding Administrative Law Judge

The attached decision was issued on the date indicated therein. If you are dissatisfied with the decision, you have thirty days from the date of service of the decision in which to petition for reconsideration. Your petition for reconsideration must fully comply with the requirements of Labor Code sections 6616, 6617, 6618 and 6619, and with California Code of Regulations, title 8, section 390.1. **For further information, call: (916) 274-5751.**