

1944

LABOR AND INDUSTRIAL RELATIONS APPEALS BOARD  
STATE OF HAWAII

In the Matter of	)	CASE NO. OSAB 88-6
	)	(OSHCO ID C0308)
DIRECTOR, DEPARTMENT OF LABOR	)	
AND INDUSTRIAL RELATIONS,	)	
	)	
Complainant,	)	
	)	
vs.	)	
	)	
MAUI INTER-CONTINENTAL	)	
WAILEA HOTEL,	)	
	)	
Respondent.	)	

---

FILED  
MAY 9 1988  
91 MAY -9 P2:34

DECISION AND ORDER

This occupational safety and health case is before the Board on appeal by Respondent, MAUI INTER-CONTINENTAL WAILEA HOTEL, from a citation and notification of penalty issued by the Director of Labor and Industrial Relations ("Director") on March 1, 1988.

On March 18, 1988, Respondent filed a timely notice of contest of the citation and proposed penalty.

The parties agreed to waive a hearing before the Board and to submit the appeal on the record. The file was stipulated into evidence.

The issues before the Board are:

- (1) Whether Respondent breached its general duty to provide a safe workplace, pursuant to §12-60-2(a)(3) of the



Hawaii Occupational Safety and Health Standards, and §396-6(a), H.R.S.; and

(2) If so, whether Respondent committed a serious violation, pursuant to §396-10(k), H.R.S.; and

(3) If so, whether Respondent's penalty was properly calculated, pursuant to §396-10(b), H.R.S.

#### FINDINGS OF FACT

1. In 1976, Respondent installed an 884 cubic inch Waukesha generator in the machine room. It served as the emergency generator. An exhaust pipe led from the generator out of the machine room, and vented into the loading ramp area. The machine room, the compactor room, and various offices are located within the loading ramp area.

2. The loading ramp area is fifty feet across and is located on the fifth level of Respondent's hotel. The loading ramp area is enclosed by a ceiling, by walls on three sides, and by a partially blocked fourth side. The loading ramp area is not adequately ventilated.

3. The compactor room is an enclosed area seventeen feet wide by thirty-eight feet long, and has two entrances, a door at one end and a roll up door, ten feet wide, at the other end. At the top of the roll up door is an opening twelve feet wide by eight inches high. When the roll up door and the back door are closed, the air circulator in the compactor room draws air in through the opening at the top of the roll up door.

4. The generator exhaust pipe was located twelve feet above the floor and discharged gases containing high concentrations of carbon monoxide into the loading ramp area, toward the roll up door of the compactor room, thirty-eight inches away. Exhaust gases entered the compactor room through the eight inch by twelve foot opening above the roll up door. This contributed to the buildup of carbon monoxide in the compactor room, and in the loading ramp area near the compactor room. This created a hazardous condition for the employees working in or near the compactor room and the loading ramp area.

5. Respondent's engineering department was responsible for operating, maintaining, and testing the generator. The engineering department kept a copy of the generator service manual in the office, where everyone in the department had access to it.

6. Tony Harris, the acting chief engineer, testified at his deposition that he had access to the generator service manual, but did not read the safety precaution section prior to January 22, 1988.

7. Edward Simanek, a journeyman in the engineering department in charge of operating and testing the generator, stated at his deposition that he understood the dangers of carbon monoxide. He had access to the generator service manual, but did not read it prior to January 22, 1988.

8. The hazards of carbon monoxide in an enclosed area were also known to Tony Harris, and to Vincent Mozina, Respondent's project coordinator.

9. Mr. Harris, Mr. Mozina, and Mr. Simanek testified that reading the safety precautions in the generator service manual prior to January 22, 1988, would have been prudent.

10. The generator service manual, at the page entitled "Safety Precautions", which follows the cover and title pages, states:

The exhaust products of an internal combustion engine are toxic and may cause injury to health or death if inhaled. All engine installations, especially those within a closed shelter or building, should be equipped and maintained with an exhaust discharge pipe so that exhaust gases are delivered into the open air.

11. Most of the hotels inspected by the Division of Occupational Safety and Health ("DOSH") on Maui had their generators housed in separate buildings away from the main hotel buildings, with the exhaust pipes discharging into the open air.

12. Prior to January 1988, Respondent's generator was tested each month for thirty minutes. Beginning on January 22, 1988, the generator was to be tested each week for thirty minutes.

13. Mary Holtquist was an employee in Respondent's purchasing office, which was located in the loading ramp area,

a few feet from the compactor room and the generator exhaust pipe. On a number of occasions in 1987, she experienced headaches or lightheadedness within a half hour of the generator's operation. There was a strong odor in the office at the time.

14. Mary Holtquist complained to her manager, Ginny Rech, three to four times prior to January 1988, about the smell and the headaches when the generator was tested. Ms. Holtquist also told Tony Harris that she believed the generator's operation caused her headaches.

15. Respondent's employees had unrestricted access to the compactor room and the loading ramp area, even during the operation of the generator. The employees were issued no safety warnings prior to the testing of the generator. The employees were exposed to the hazard of carbon monoxide in an enclosed area.

16. On January 22, 1988, the generator was test-run from 1:30 p.m. to 1:35 p.m. About that time, Constancio Alviedo, an employee of Respondent, entered the compactor room to deposit trash. The roll-up door of the compactor room was closed.

17. At 2:05 p.m. on January 22, 1988, Mr. Alviedo was found lying face down next to the trash container in the compactor room. While Mr. Alviedo was being provided with emergency assistance, several of the emergency personnel

experienced dizziness and/or nausea. Mr. Alviedo was pronounced dead at 3:00 p.m. on January 22, 1988, and the compactor room was sealed.

18. Mr. Alviedo's death was caused by asphyxia due to carbon monoxide toxicity. His hemoglobin contained 38% carboxyhemoglobin. Carboxyhemoglobin levels above 25% are considered life-threatening.

19. On January 26, 1988, the generator was test run, and after two minutes, the carbon monoxide reading in the compactor room was over 900 parts per million (ppm). After five minutes of generator operation, the carbon monoxide reading was over 1500 ppm. Carbon monoxide levels in the loading ramp area, between the compactor room and the machine room, ranged from 200 to 450 ppm, up to several thousand ppm. The test run was stopped after twenty minutes because it was too dangerous to continue.

20. Feasible alternatives were available to Respondent to reduce materially the likelihood of the hazard created by the improperly vented generator exhaust pipe. Respondent could have rerouted the exhaust pipe to the outside area, extended the pipe through the ceiling to the open air above the hotel, or extended the pipe across the ceiling to the area outside the decorative hollow tile. Respondent could also have avoided the hazardous condition by building a shelter for the generator

outside the main hotel building, or by moving the generator to the other side of the hotel.

21. Respondent was assessed a proposed penalty of \$480.00 for a serious violation.

#### CONCLUSIONS OF LAW

1. We conclude that Respondent breached its general duty to provide a safe workplace, pursuant to §12-60-2(a)(3) of the Hawaii Occupational Safety and Health Standards, and §396-6(a), H.R.S.

Section 12-60-2(a)(3), HOSHS, provides in relevant part:

§12-60-2 Employer responsibilities. (a)  
General duty of employers.

\*\*\*

(3) Every employer shall provide safe work places and practices by elimination or reduction of existing or potential hazards. Elimination of existing or potential hazards by design, process substitution, or other appropriate methods is preferred because it eliminates the need for further employee protection. When elimination is not feasible, reduction of existing or potential hazards to acceptable levels, using methods such as engineering or administrative controls, isolation, or guarding, shall be promptly used. When these methods are inadequate to reach acceptable levels, personal protective equipment shall be provided and used.

Section 396-6(a), H.R.S. provides:

§396-6 Employer responsibility: safe place of employment; safety devices and

safeguards. (a) Every employer shall furnish to each of the employer's employees employment and a place of employment which are safe as well as free from recognized hazards. No employer shall require or direct or permit or suffer any employee to go or be in any employment or place of employment which is not free from recognized hazards that are causing or likely to cause death or serious physical harm to employees or which does not comply with occupational safety and health standards, rules, regulations, citations, or orders made pursuant to this chapter except for the specific purpose of abating said hazard.

We find, on the record before us, that Respondent failed to render its workplace free of the hazard of the unsafe venting of the emergency generator exhaust pipe, which contributed to the buildup of carbon monoxide in the compactor room, and in the loading ramp area.

We also find that Respondent recognized, or with the exercise of reasonable deligence, could have recognized, and had knowledge of, the hazard of the unsafe venting of the emergency generator exhaust pipe. The generator exhaust pipe discharged into the loading ramp area, which was not adequately ventilated. Mary Holtquist complained to her manager and to the acting chief engineer of headaches or lightheadedness shortly after a number of generator tests. No safety warnings were issued prior to the testing of the generator. Moreover, the acting chief engineer, and the journeyman in charge of operating and testing the generator had access to the generator

service manual, but did not read the safety precaution section prior to January 22, 1988. Both men, along with the project coordinator, testified that they knew of the hazards of carbon monoxide in an enclosed area.

We further find that Respondent's employees were exposed to the hazards of carbon monoxide in an enclosed area, due to the unsafe venting of the emergency generator exhaust pipe. The employees had unrestricted access to the compactor room and the loading ramp area, even during the operation of the generator. Carbon monoxide readings taken in the compactor room during a test run of the generator on January 26, 1988, showed levels far in excess of those permitted under Chapter 202 of the Hawaii Occupational Safety and Health Standards. We also find that there were feasible alternatives available to Respondent to reduce materially the likelihood of the hazard created by the improperly vented generator exhaust pipe.

2. We conclude that Respondent's breach of its general duty to provide a safe work place was a serious violation, pursuant to §396-10(k), H.R.S. That section provides:

Section 396-10 Violations and penalties.

\*\*\*

(k) For the purposes of this section, a serious violation shall be deemed to exist in a place of employment if there is a

substantial probability that death or serious physical harm could result from a condition which exists, or from one or more practices, means, methods, operations, or processes which have been adopted or are in use, in such place of employment unless the employer did not, and could not with the exercise of reasonable diligence, know of the presence of the violation.

\*\*\*

We find that, consistent with our findings above, Employer knew or with the exercise of reasonable diligence, could have known of the unsafe venting of the emergency generator exhaust pipe. We further find that a serious violation existed in Respondent's workplace due to the serious physical harm, in this case death, that resulted from the unsafe venting of the emergency generator exhaust pipe.

3. We further conclude that Respondent's penalty of \$480.00 was properly calculated, pursuant to Section 396-10(b), H.R.S., which provides:

Section 396-10 Violations and penalties.

\*\*\*

(b) Any employer who has received an order or citation for a serious violation of any standard, rule, or regulation promulgated pursuant to this chapter, shall be assessed a civil penalty of not more than \$1,000 for each such violation.

\*\*\*

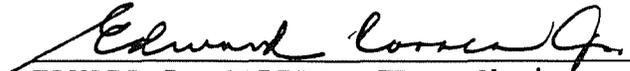
On review of the record before us, including the worksheet completed by the compliance officer, we find that the

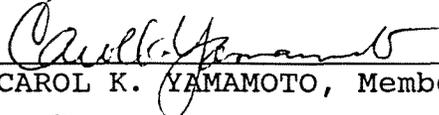
penalty of \$480.00 was properly calculated, pursuant to §396-10(b), H.R.S.

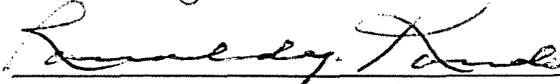
ORDER

The citation and notification of penalty issued by the Director on March 1, 1988, is hereby affirmed. Respondent shall pay the penalty amount of \$480.00, and correct the hazard of the unsafe venting of the emergency generator exhaust pipe.

Dated: Honolulu, Hawaii, MAY - 9 1991.

  
EDWARD L. CORREA, JR., Chairman

  
CAROL K. YAMAMOTO, Member

  
RONALD Y. KONDO, Member

I do hereby certify that the foregoing  
is a full, true and correct copy of

