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Union Dedicates Contract to Deceased Lab Worker UC Refuses to Publish Dedication

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March 3, 2012 (LOS ANGELES, CA) – UPTe-CWA Local 9119, representing over 12,000 professional, research and technical employees in the University of California system, announced the distribution of its new contract, which includes stronger health and safety language dedicated to the memory of staff researcher Sherharbano “Sheri” Sangji. Sangji, then 23, who died in 2009 as a result of injuries suffered in a lab fire at UCLA. The union printed the dedication on stickers to place in the contracts after UC refused to allow its inclusion in the official text.

According to former UPTe-CWA chief bargainer, Kevin Rooney, the dedication was discussed intensively during contract negotiations right up to the point of reaching a tentative agreement. “They refused to budge on this,” he said and speculated that UC’s adamancy was due to a fear of admitting liability.

Since the incident UCLA has attempted to downplay its responsibility for Sangji’s death, inaccurately describing her as an “experienced” chemist and the fire as an “unfathomable” tragedy. Sangji was, however, one of the least experienced members of her lab. Patrick Harran, her lab head, UCLA, and the UC Regents face criminal charges for her death and will be arraigned in Los Angeles on March 7th.

A recent graduate of Pomona College, Sangji took a job in Harran’s lab at UCLA in October 2008 to save money for law school. Hired primarily to set up equipment, she was instructed by Harran to perform a dangerous experiment using a chemical that catches fire on contact with air. As she was transferring the chemical from one closed container to another using a syringe, the barrel separated from the housing. The chemical spilled, burst into flames and ignited her clothing, melting her synthetic sweatshirt and nitrile gloves and fusing them onto her skin. After receiving emergency care at UCLA, she was transferred to a burn center where she died on January 16, 2009.

The fire and Sangji’s injuries were caused and compounded by several factors— inadequate training and supervision, lack of personal protective equipment, and an unsafe work place.

Sangji was performing the experiment alone during the campus holiday shutdown on December 29, 2008. She had done it once before during her first week on the job. Now she was asked to increase the volume and instructed to use a method that ran counter to the manufacturer’s instructions. Additionally, Harran had not discussed the dangers of the procedure with her nor provided guidance for scaling up the experiment.

Sangji had not been issued a lab coat—no coats or gloves in use in the lab at that time were fire resistant—and Harran did not enforce the use of personal protective equipment. The hood she was working under was crowded with extraneous chemicals, some flammable, which may have accelerated the flames. Also, the lab worker who came to her assistance, untrained to handle emergency situations, first tried to smother the fire with his lab coat, which also caught fire, and then poured cups of water over her burning body instead of placing her under a nearby shower.

A UCLA Environmental, Health and Safety inspector had cited Harran's lab for multiple safety violations weeks before the incident, but Harran failed to remedy any of them. A subsequent Cal/OSHA investigation turned up a similar incident a year earlier in the same department. UCLA did not report it and made no attempt to correct deficiencies in its health and safety policies.

In the 95-page report supporting the criminal charges the Cal/OSHA Bureau of Investigation blamed the fatality on a lack of safety training and enforcement of safety measures. It concluded that enforcement of safety regulations in UCLA's labs was so lax as to constitute a "breakdown of overall laboratory safety practices at UCLA."

To read the Cal/OSHA Bureau of Investigation report, go to:

<http://www.defendingscience.org/upload/Calif-BOI-report-Sheri-Sangji.pdf>

To read the criminal complaint, go to:

http://cen.acs.org/content/dam/cen/static/pdfs/Article_Assets/90/09001-notw1-uclacharges.pdf

For a copy of the dedication, contact Judith Sweeney (see above).

Statement of Kevin Rooney regarding bargaining the dedication with UCLA:

The short answer is that they didn't want to admit to any liability. Lots of discussion happened on this subject and I was still pushing them right up to the minute we TA'd the rest of the contract. This was an important issue for me and the team was totally supportive. They refused to budge on this. I even tried to get them to agree to put it on the title page, after failing to get it placed with the Health & Safety article.

Cal/OSHA Bureau of Investigation report conclusions on (see pages 90-93):

UCLA's lax enforcement of health and safety standards:

Based upon the investigation, it is apparent that the laboratory safety policies and practices utilized by UCLA prior to Victim Sangji's death, were so defective as to render the University's required Chemical Hygiene Plan and Injury and Illness Prevention Program essentially non-existent. The lack of adequate lab safety training and documentation, lack of effective hazard communication practices, and repeated failure to correct persistent and repeated safety violations within University labs, were all causal deficiencies that led to a systemic breakdown of overall laboratory safety practices at UCLA.

UCLA's knowledge of prior incidents and failure to act:

While the University EH&S Department was made aware, through its numerous inspections, of continuous and pervasive safety violations within the laboratories, particularly with respect to the failure of personnel to utilize adequate personal protective equipment, the University failed to take the required efforts to correct recurring hazards to employees. In fact, even after the occurrence of two incidents that resulted in significant burn injuries to employees as a result of failing to wear required personal protective equipment, the EH&S Department failed to take any affirmative steps to abate a rather clear and appreciable danger.

The testimony obtained in this case clearly establishes that University accepted the fact that many Principal Investigators consistently failed to enforce the use of personal protective equipment within their labs as "part of the culture". In fact, as the University's former Manager of Chemical Safety, William Peck, candidly admitted, **"...It was kind of common knowledge that laboratory people don't use the proper PPE when they are in the lab... it was hard to convince the professors that they needed to...and if the professors didn't enforce it, nobody did. Because...EH&S didn't enforce things like that."** Not only did the University permit Principal Investigators to violate safety regulations without consequence, the University also failed to exercise any reasonable diligence to verify whether an incoming Principal Investigator had the requisite ability to comply with University policy and other mandated safety regulations, prior permitting the PI to undertake research and supervise personnel.

Sheri Sangji's training and the method she was instructed to use in carrying out her experiment:

Despite Dr. Harran's assertions to the contrary, it is clear that Victim Sangji was not properly trained, if at all, in the procedures necessary for the safe handling and transfer of t-Butyllithium. While Dr. Harran initially represented to both the University EH&S Department and to the Division that Victim Sangji had been trained by senior personnel in accordance with the Aldrich Bulletin and that Victim Sangji had training and experience as an undergraduate relative to the use of t-Butyllithium, subsequent investigation revealed that these assertions were at best misleading.

Victim Sangji's undergraduate advisor, as well as her previous employer, both confirmed that the Victim did not have any previous experience using pyrophoric reagents. Further, a review of Victim Sangji's research at UCLA indicated that she had completed the reaction on only one occasion prior to the fatal incident.

The subsequent interview of Dr. Paul Hurley, confirmed that he [Hurley] did not follow the Aldridge bulletin as a normal practice, nor was he familiar with the procedures outlined by Aldrich. In fact, upon specific inquiry into Dr. Hurley's actual practices in the lab, it was revealed that many of the procedures that he employed when making transfers of t-Butyllithium were actually contrary to both the procedures outlined by Aldrich and by generally accepted laboratory standards.

...

Dr. Harran's additional contention that Victim Sangji was otherwise adequately trained to handle t-Butyllithium, since she allegedly demonstrated some familiarity with general syringe transfer techniques when handling non-hazardous reagents during her first day in the lab, is nothing short of incredulous. Many of the techniques utilized by Victim Sangji on the date of the fatal incident, were, in fact, contrary to the procedures specified by Aldrich. While the techniques may have, in many respects, been generally acceptable when handling non-hazardous reagents, these same practices were directly attributable to the cause of the fatal incident in this case. As previously stated, the handling and transfer of t-Butyllithium requires the use of specialized transfer methods by "experienced laboratory personnel under carefully controlled conditions and with suitable protective measures in place" [Aldrich AL-164]. Dr. Harran's position in this regard, simply runs counter to the numerous manufacturer warnings relative to the use of t-Butyllithium and is contrary to generally recognized practices for making transfers of the reagent.

Sangji's experience in performing the experiment that cost her life:

Victim Sangji's undergraduate advisor, as well as her previous employer, both confirmed that the Victim did not have any previous experience using pyrophoric reagents. Further, a review of Victim Sangji's research at UCLA indicated that she had completed the reaction on only one occasion prior to the fatal incident.

Harran's failure to inform Sangji of the hazards of working with a pyrophoric chemical:

Further, Dr. Harran confirmed that he did not discuss the hazards of t-Butyllithium with Victim Sangji, nor did he inquire whether Victim Sangji was familiar with the reagent, prior to directing her to use it. Dr. Harran also admitted that he never attempted to determine whether Victim Sangji had actually been trained by his senior researcher, Dr. Paul Hurley, despite the fact that Dr. Harran was well aware of Victim Sangji's research activity as it related to the use of t-Butyllithium; a reagent he acknowledged was extremely hazardous.

Failure to follow manufacturer's guidelines and standard operating procedures:

Dr. Harran's failure to utilize required standard operating procedures relative to the use and handling of t-Butyllithium, was also a causal element in this case. As Dr. Harran admitted during his BOI interview, the Aldrich Bulletin was used as a "general" reference only. Any alleged employee training was based primarily upon the experience of senior personnel. As Dr. Harran

confirmed, “...in my field we pass down knowledge open, ah, one generation to another and this is lore. It’s something that you do almost on a daily basis...the procedures are very general.” Indeed, as evidenced by Dr. Paul Hurley’s interview, so-called “training” based upon a researcher’s experience can lead to the use of improper methodologies.

Harran’s failure to provide and enforce the use of personal protective equipment in his lab:

More significantly however, was Dr. Harran’s failure to both provide appropriate personal protective equipment to Victim Sangji and to ensure that PPE was utilized by his laboratory personnel. While Dr. Harran maintained that he “encouraged” the use of lab coats in the laboratory facilities under his control, testimony obtained from researchers employed by Dr. Harran indicated that, with few exceptions, personnel did not routinely wear lab coats while working in the lab. It was also confirmed that Victim Sangji did not routinely wear a lab coat while in the lab. The lab personnel also indicated that while Dr. Harran was aware that lab coats were not being utilized by employees, he [Harran] did not enforce their use. Further, no evidence exists that Victim Sangji had ever been issued a lab coat during her employment at UCLA.

Even assuming, arguendo, that Victim Sangji was issued a cotton lab coat, the level of protection that would have been afforded by the coat was wholly insufficient for Victim Sangji’s activities on the date of the fatal incident. Without question, the use of t-Butyllithium carries with it an inherent and extreme potential for serious burn injuries in the event of an incidental exposure to the reagent. Given the reagent’s well known characteristics, fire resistant clothing is the minimally required clothing when handling a highly reactive pyrophoric such as t-Butyllithium, particularly in light of the scale of transfer attempted by Victim Sangji on the date of the fatal incident. As Aldrich’s Mark Poyten confirmed, “**the bare minimum is a fire protective coat...**” This same requirement is echoed by another leading manufacturer of t-Butyllithium, FMC Lithium, “**...all protective clothing should be flame retardant and easy to remove in the event of a spill...**”²⁰ General Industry Safety Order 3383(b) mandates that clothing appropriate for the work being done shall be worn.

UCLA and Harran’s failure to provide a safe working environment:

UCLA through its failure to maintain an effective Chemical Hygiene Plan and Injury and Illness Prevention Plan, through repeated inability of the Office of Environmental Health & Safety to assure enforcement chemical safety requirements, and through the actions of Dr. Harran, wholly neglected its legal obligations to provide a safe working environment for lab personnel. Dr. Harran simply disregarded the open and obvious dangers presented in this case and permitted Victim Sangji to work in a manner that knowingly caused her to be exposed to a serious and foreseeable risk of serious injury or death. If Dr. Harran had utilized a standard operating procedure as required and would have properly trained Victim Sangji, and assured that clothing appropriate for the work was worn to protect her from inadvertent exposure to t-Butyllithium, Victim Sangji’s death would have been prevented.

See FMC Lithium, Butyllithium Safe Handling Guide p. 62 (March 2005), available at