United States of America
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
1120 20th Street, N.W., Ninth Floor
Washington, DC 20036-3457

SECRETARY OF LABOR, Complainant, v. UHS OF WESTWOOD PEMBROKE, INC., UHS OF DELAWARE, INC., Respondent.	OSHRC Docket No. 17-0737

ON BRIEFS:

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For the Complainant

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For the Respondent, UHS of Westwood Pembroke, Inc.

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For the Respondent, UHS of Delaware, Inc.

DECISION

Before: ATTWOOD, Chairman and LAIHOW, Commissioner.

BY THE COMMISSION:

UHS of Westwood Pembroke, Inc. (UHS-WP) owns and operates Pembroke Hospital, a psychiatric hospital located in Pembroke, Massachusetts. UHS of Delaware, Inc. (UHS-DE) serves as the management company for UHS-WP pursuant to a management agreement between the two entities. Following an employee complaint of workplace violence due to patient aggression at Pembroke Hospital, OSHA inspected the hospital on October 11, 2016, and subsequently issued a single citation to UHS-WP and UHS-DE alleging a repeat violation of the

Occupational Safety and Health Act's general duty clause, 29 U.S.C. § 654(a)(1), for exposing hospital employees to physical assaults by patients.[1]

Administrative Law Judge Keith E. Bell affirmed the citation as to UHS-WP only, rejecting the Secretary's claim that the two companies should be treated as a single employer, and recharacterized the general duty clause violation from repeat to serious. Both the Secretary and UHS-WP petitioned for review of the judge's decision. For the following reasons, we find UHS-WP and UHS-DE operated as a single employer and affirm the citation as repeat.[2]

BACKGROUND

Pembroke Hospital (Pembroke) is a 120-bed inpatient psychiatric hospital owned by UHS-WP, which operates three facilities as a single entity under one license: Pembroke, Westwood Lodge, and the Lowell Treatment Center. UHS-WP is in turn ultimately owned by Universal Health Services (UHS). The other cited entity, UHS-DE, which is also owned by UHS, provides Pembroke with management services and budget oversight. Pembroke's Chief Executive Officer (CEO) and Chief Financial Officer (CFO) are both employed and supervised by UHS-DE. Pembroke's Director of Nursing and its Risk Manager also report to UHS-DE employees, including Pembroke's CEO. And UHS-DE's Loss Control Manager handles Pembroke's budget for workers' compensation claims and visits the hospital monthly to participate in aggression reduction team meetings, which are attended by the hospital's CEO.

Pembroke is divided into six patient care units—four for adults, one for adolescents, and one for geriatric patients—that each care for approximately 15-25 patients. Registered nurses and Mental Health Associates (MHAs) provide direct patient care over three shifts and anywhere from one to approximately five MHAs are assigned to each unit.[3] MHAs are responsible for providing around the clock care to patients, which includes completing wellness and vital checks for each patient every 15 minutes (even when they are sleeping), assisting with personal hygiene and

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[1] The general duty clause provides that "[e]ach employer . . . shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees." 29 U.S.C. § 654(a)(1).

[2] Throughout our decision, each company is referenced by name when relevant to the discussion and referenced as Respondent when being addressed as a single employer.

[3] The number of MHAs increases or decreases in correlation with the number of patients on each unit. For instance, the record reflects that the number of patients on each unit could vary from five to twenty-seven, with the corresponding number of MHAs ranging from one to about five.

housekeeping activities, leading group activities, performing admissions duties for new patients, and escorting patients outside their units for meetings, fresh air breaks, and meals.

At least one MHA is expected to always remain on the unit, although MHAs are also expected to respond to calls for assistance on other units when incidents relating to patient aggression occur. In addition, MHAs are responsible for monitoring and detecting when verbal de-escalation or other calming techniques are needed to address patient aggression, and to implement those techniques as necessary. Each patient has a personal de-escalation plan that lists their proven or preferred calming measures.

DISCUSSION

To prove a violation of the general duty clause, the Secretary must establish that: (1) a condition or activity in the workplace presented a hazard; (2) the employer or its industry recognized the hazard; (3) the hazard was causing or likely to cause death or serious physical harm; and (4) a feasible and effective means existed to eliminate or materially reduce the hazard. *Arcadian Corp.*, 20 BNA OSHC 2001, 2007 (No. 93-0628, 2004). The Secretary must also show that the employer knew or, with the exercise of reasonable diligence, could have known of the hazardous condition. *Tampa Shipyards, Inc.*, 15 BNA OSHC 1533, 1537 (No. 86-0469, 1992).

On review, UHS-WP argues that in affirming the violation, the judge erred in finding the Secretary established a feasible and effective means of abatement. The Secretary argues the judge erred in finding that UHS-WP and UHS-DE should not be treated as a single employer and that the violation should not be characterized as repeat. [4] We turn first to the single-employer issue, then to whether a feasible and effective means of abatement has been proven, and last to the violation's characterization.

I. Single Employer

The three factors relevant to determining whether separate entities operate as a single employer for purposes of liability under the Act are whether the entities (1) share "a common worksite," (2) "are interrelated and integrated with respect to operations and safety and health matters," and (3) "share a common president, management, supervision, or ownership." *S. Scrap Materials Co.*, 23 BNA OSHC 1596, 1627 (No. 94-3393, 2011). The Secretary bears the burden

[4] Separate review briefs were filed by UHS-WP and UHS-DE. The briefs filed by UHS-WP address the abatement issue and repeat characterization issue. The briefs filed by UHS-DE are limited to the single-employer issue.

of establishing the existence of a single-employer relationship.[5] *Loretto-Oswego*, 23 BNA OSHC 1356, 1358 n.4 (No. 02-1164, 2011) (consolidated), *aff'd*, 692 F.3d 65 (2d Cir. 2012). The judge found that none of these factors supported finding a single-employer relationship between UHS-WP and UHS-DE.

On review, the parties rely heavily on *Loretto-Oswego* to support their arguments with respect to each factor. 23 BNA OSHC at 1359-61, 692 F.3d at 77-78. In that case, both the Commission and the Second Circuit concluded that the cited nursing home did not operate as a single employer with its management company primarily because the two entities were not interrelated and integrated as to safety matters. 23 BNA OSHC at 1359-60; 692 F.3d at 77. The Secretary argues that *Loretto-Oswego* is distinguishable from this case because "the record [here] shows that UHS-Pembroke and UHS-DE handled policy and other safety matters at Pembroke Hospital as one company." In response, UHS-DE argues that this case is closely analogous to *Loretto-Oswego* because all three factors weigh against finding a single-employer relationship and therefore the Commission should affirm the judge's decision dismissing the company from the case. For the reasons set forth below, we agree with the Secretary and find the record establishes that the two cited entities operated as a single employer for purposes of the alleged violation.

Common worksite

There is no dispute that the two cited entities have employees working at the same worksite—Pembroke. Indeed, Pembroke's CEO is a UHS-DE employee who works onsite full-time at Pembroke supervising the hospital's employees and overseeing its day-to-day operations. Likewise, a UHS-DE Loss Control Manager is regularly present at the hospital addressing various safety matters including the cited workplace violence hazard. The judge nevertheless found that UHS-WP and UHS-DE do not share a common worksite because neither of these UHS-DE

[5] After the close of briefing on review, the Secretary filed a letter "direct[ing] the Commission's attention to relevant [single-employer] findings in a recent decision by Administrative Law Judge Dennis L. Phillips in *Secretary of Labor v. UHS of Delaware, Inc., and Premier Behavioral Health Solutions of Florida d/b/a Suncoast Behavioral Health Center*, OSHRC Docket No. 18-0731." In that decision, which was issued on April 9, 2021, and is currently pending on review before the Commission, the judge found that UHS-DE and the cited mental health facility operated as a single employer for purposes of liability under the Act as it pertained to the general duty clause violation alleging workplace violence at issue. We do not rely on this unreviewed decision in addressing the inquiry before us here and in any event, the judge's findings are limited to the record in that case. *See Leone Constr. Co.*, 3 BNA OSHC 1979, 1981 (No. 4090, 1976) ("[A] Judge's opinion . . . lacking full Commission review does not constitute precedent binding upon us.").

employees were exposed to the cited workplace violence hazard. He also relied on the fact that the two entities have separate business addresses—UHS-DE operates out of Pennsylvania while UHS-WP operates its facilities (including Pembroke) out of Massachusetts.

We agree with the Secretary's contention on review that the judge erred in making these findings. Under Commission and relevant circuit court precedent, mutual employee access to a hazard is not a precondition to establishing the common worksite factor. In *A.C. Castle v. Acosta*, 882 F.3d 34, 42 (1st Cir. 2018), the First Circuit rejected the notion that a common business address or headquarters is necessary to find a single-employer relationship or "that workers from each entity must be at the site at the time the violation occurred, or directly exposed to the risk."[6] 882 F.3d at 42. In addition, as the Secretary points out, and we address below, the facts here are distinguishable from those in *Loretto-Oswego*, where the management company had "no physical presence" at the inspected nursing home, was rarely onsite, and was not involved in its day-to-day operations. *Loretto-Oswego*, 23 BNA OSHC at 1361.

As noted above and discussed in detail below regarding the next single-employer factor, UHS-DE has two employees, Pembroke's CEO and UHS-DE's Loss Control Manager, working onsite at Pembroke who are integrally involved in the hospital's day-to-day operations, including hiring, firing, and managing hospital staff, as well as overseeing patient treatment and care and addressing the cited workplace violence hazard. *C.T. Taylor*, 20 BNA OSHC 1083, 1085 (finding single-employer relationship where one entity's employee directed and supervised the work performed by the other entity's employees). And although the two entities have different principal addresses and perform their primary work at different locations, the central inquiry is whether they share a common worksite. *A.C. Castle*, 882 F.3d at 42 (noting that a while a shared headquarters or business address "generally satisfies the common worksite factor" it is not "necessary" to do so and requiring such would rewrite the test to mean "common business address"). There can be no dispute here that UHS-DE employees work alongside UHS-WP employees on a consistent basis

[6] The First Circuit is a relevant circuit here, as UHS-WP and Pembroke are located in Massachusetts. *See* 29 U.S.C. § 660(a) ("Any person adversely affected or aggrieved by an order of the Commission . . . may obtain . . . review . . . in any United States court of appeals for the circuit in which the violation is alleged to have occurred or where the employer has its principal office, or in the Court of Appeals for the District of Columbia Circuit . . . ."); s*ee Kerns Bros. Tree Serv.*, 18 BNA OSHC 2064, 2067 (No. 96-1719, 2000) (Commission generally applies law of the circuit where it is probable a case will be appealed). The Third Circuit is also relevant because UHS-DE is based in Pennsylvania.

at Pembroke. For all these reasons, we find the common worksite factor supports finding a single-employer relationship.

Interrelation and integration

We also find that the two cited entities are interrelated and integrated regarding operations, including safety and health matters. According to the judge, UHS-WP and UHS-DE are distinct businesses, as UHS-WP provides direct patient care at its facilities, while UHS-DE is a management and consulting business. The judge also found that Pembroke primarily develops and sets its own budgets. As to safety matters, the judge merely stated that "[t]here is no evidence that [UHS-WP] lacked sufficient capital or other resources to address worker health and safety."

Turning first to operations, we find that the record establishes not only UHS-DE's direct involvement in supervising Pembroke staff and in providing patient care, but also its control of and influence over the hospital's budget and finances, as well as the clinical and operational aspects of running the hospital, such as regulatory compliance, licensing, quality of clinical care, and clinical programming. The Secretary points to two key undisputed facts demonstrating that UHS-DE manages daily operations at Pembroke: (1) Pembroke's CEO, a UHS-DE employee, is responsible for hiring, disciplining, and firing hospital staff, and (2) Pembroke's Director of Nursing and its Risk Manager both report to UHS-DE management. Indeed, at the hearing, Dr. Thomas Hickey, Pembroke's CEO at the time of OSHA's inspection,[7] confirmed the extent of his duties at the hospital, and his testimony in this regard stands unrebutted:

> I was responsible for hiring staff, disciplinary actions, firing, maintaining our budget, overviewing the quality of the program, addressing regulatory issues, making sure we were meeting joint commission and [state] standards, working with staff to develop excellent treatment planning and programming for our patients, program development, growing our program, making sure our patient beds were filled, all of the-- both clinical and operational aspects of running the hospital.

Dr. Hickey also testified, when asked by the judge about the scope of UHS-DE's management at the hospital, that:

> It involves a number of broad areas. One is regulatory compliance, licensing, it involves quality of clinical care, developing clinical programming, marketing, budget, hiring and firing of staff. I was responsible for hiring medical staff, operating the pharmacy, the whole caboodle of what's involved in running a free-

[7] Dr. Hickey served as Pembroke's CEO until January 31, 2017, approximately three months before OSHA issued the citation.

> standing psychiatric facility and out-patient programs as well. Developing new programs, expanding, market share, etc.

Contrary to UHS-DE's assertion that clinical and administrative functions at Pembroke are kept separate, Dr. Hickey testified that even though his "responsibility was not to make the clinical decisions," he nonetheless was responsible for "mak[ing] sure the [clinical] process happened the way it should." In fact, the two Pembroke managers who work on clinical matters—the Director of Nursing and the Risk Manager—both report to Pembroke's CEO (a UHS-DE employee), as well as other UHS-DE management. For instance, Pembroke's Risk Manager, who is tasked with reviewing incidents of patient aggression and coordinating an initiative at the hospital to reduce such aggression, regularly works with a Corporate Clinical Director employed by UHS-DE. And although Pembroke's Medical Director manages patient care and has authority over clinical and staffing decisions, Dr. Hickey had hiring and firing authority over all employees at Pembroke, which would include the Medical Director. Indeed, Dr. Hickey testified that while admitting a patient is a clinical decision made by the Medical Director, he participated as CEO in all decisions regarding admissions capacity. UHS-DE is also involved in establishing hospital policy through Pembroke's Board of Advisors, which includes both Pembroke managers (the Risk Manager and Director of Nursing) and UHS-DE corporate employees (Pembroke's CEO and CFO and UHS-DE Group Director) and is led by UHS-DE's Regional Vice President. Further, UHS-DE drafts the hospital's Strategic Plan, which is submitted to the Department of Mental Health. The plan describes UHS-DE's implementation of patient care improvements, such as staff training and retention.

Finally, as the Secretary asserts, the management agreement between the two entities reflects UHS-DE's authority over the hospital's budget and finances. Contrary to the judge's conclusion and UHS-DE's related arguments, the evidence shows that it is UHS-DE, through its employees who serve as Pembroke's CEO and CFO, that develops the hospital's budget, which is then reviewed and approved by higher-level UHS-DE employees. This is consistent with the management agreement, which confirms that UHS-DE is responsible for central financial systems at Pembroke, including: "(a) the billing system; (b) the collection system; (c) the disbursement system; (d) the payroll system; (e) the insurance claim system; (f) the management information system; and (g) the patient safety improvement system." For all these reasons, we find the Secretary has shown that the cited entities have integrated and interrelated operations.

We also find that the same integration exists regarding safety and health matters. Again, the record shows that UHS-DE directs safety and health matters through its onsite CEO, who participates in Pembroke's committees and meetings related to patient aggression and workplace violence. Pembroke also reports workplace violence incidents to UHS-DE, and UHS-DE provides detailed comparisons between a benchmark created by UHS-DE and various metrics at Pembroke relating to patient aggression, such as the rate of restraints and injury. Additionally, UHS-DE identifies opportunities to address workplace violence at Pembroke and makes recommendations in that regard to the hospital.

Moreover, UHS-DE's Loss Control Manager, Gina Gilmore, visits Pembroke monthly and attends "aggression reduction" meetings where she presents analyses of patient aggression data and directly interacts with hospital employees regarding worker safety. Following these meetings, she prepares a "loss control summary" in which she compares injuries at Pembroke to targets set by UHS-DE and discusses whether Pembroke will receive a prevention credit to its workers' compensation budget if employee injuries fall below the UHS-DE target. In the loss control summary, Gilmore also analyzes data on patient aggression, identifies times when patient aggression is most likely to occur, and specifies corrective action to address such aggression. When injuries to staff occur due to patient aggression, she performs root cause analyses, which involve interviewing hospital staff, and presents Pembroke's CEO and other hospital managers, including the Risk Manager and Clinical Director, with the results of these analyses. Gilmore also advises Pembroke on safety training for employees and identifying and mitigating issues related to patient aggression.

Thus, this case is not like *Loretto-Oswego* where the corporate management entity was only infrequently and indirectly involved in employee safety and health, and nursing home personnel retained primary responsibility for safety matters. 23 BNA OSHC at 1360. Rather, as the Secretary asserts, it is clear that UHS-DE and UHS-WP "handled safety matters [at Pembroke] as one company." *Compare C.T. Taylor*, 20 BNA OSHC at 1083 (single-employer relationship established where entity assumed responsibility for employee safety on the job by directly intervening in safety matters); *with FreightCar Am. Inc.*, No. 19-0970, 2021 WL 2311871, at *6-7 (OSHRC March 3, 2021) (single-employer relationship not established where record was unclear if parent was involved in safety at subsidiary's worksite).

Common president, management, supervision, or ownership

The judge found that this last factor weighed against a single-employer relationship because UHS-DE has its own management structure with a separate CEO, CFO, and management group. In addition, the judge found that Pembroke's CEO has no managerial duties for UHS-DE and that UHS-DE does not provide daily oversight at the hospital. The Secretary maintains that this finding was erroneous, citing the parties' stipulation that UHS is the ultimate corporate owner of both UHS-WP and UHS-DE. Again, the Secretary points to the direct line of management between Pembroke and UHS-DE that runs through the hospital's CEO, who supervises Pembroke's employees and is in turn supervised by UHS-DE employees. UHS-DE asserts the two companies' corporate parent—UHS—operates only as a holding company such that there is no shared ownership or management. According to UHS-DE, its role at the hospital is limited to administrative and financial functions while Pembroke controls clinical functions. UHS-DE also echoes the judge's finding in arguing that, unlike the entities in *Loretto-Oswego*, UHS-WP and UHS-DE have their own management structures and employees.[8]

For all the reasons already discussed above, we agree with the Secretary that the cited entities are linked through Pembroke's CEO and CFO who are UHS-DE employees supervised by higher-level UHS-DE managers. Dr. Hickey testified that as Pembroke CEO, he reported to the Regional Vice President and Regional Group Director of UHS-DE. Pembroke's CFO, in turn, reports to the CEO as her immediate supervisor, and UHS-DE's Regional CFO and Regional Vice President both have oversight over the CFO's work. Evidence of shared management is also found in Pembroke's Board of Advisors—as noted, the Board is comprised of both Pembroke and UHS-DE employees (including the hospital's CEO and CFO) and approves policy changes at the hospital. And as the parties stipulated, UHS-WP and UHS-DE share the same ultimate corporate parent. *Cf. S. Scrap Materials Co.*, 23 BNA OSHC at 1627 (common management factor not met where entities were owned by same parent company and shared a company president but record lacked evidence that "supervision or management at the two subsidiary companies' scrap yards was shared"); *Loretto-Oswego*, 23 BNA OSHC at 1359 ("At the time of the violations, LMC and

[8] UHS-DE also relies on the judge's findings that Pembroke's CEO and CFO—both UHS-DE employees—have no managerial duties for UHS-DE and there are no shared management employees between UHS-DE and Pembroke because UHS-DE's corporate structure does not include either hospital official. But this merely shows that Pembroke's management did not control UHS-DE, not the converse.

the three affiliates shared the same president, chief executive officer, and chief financial officer. This outward appearance of a common identity gives way, however, . . . because the record shows that on a day-to-day basis, administrative personnel at Loretto-Oswego operated independently of LMC."). Finally, as we have already found, the evidence shows that UHS-DE is integrally involved in the day-to-day management of Pembroke, including the hospital's core function of patient care and related safety matters. *See C.T. Taylor*, 20 BNA OSHC at 1083 (finding single-employer relationship where direct management and safety involvement was present between the two entities.) In short, the key roles that UHS-DE employees play in managing operations, including safety, at Pembroke Hospital also establish their shared management.

We therefore reverse the judge and find that all three factors support finding a single-employer relationship existed between UHS-DE and UHS-WP at the time of the alleged violation.

II. Abatement

In the citation, the Secretary lists several proposed measures to abate the cited workplace violence hazard and these measures address various aspects of hospital operations relating to patient care, such as admissions, security, and therapeutics.[9] Prior to the judge's decision in this

[9] The proposed abatement measures are:

> a. Establish a team of nurses and mental health associates (MHAs) that focuses primarily on the performance of the tasks associated with the admission and assessment of new patients. This team should not be staffed by employees who are assigned to care for already-admitted patients.
>
> b. Dedicate a physical area, apart from all other units of the hospital, to the admission and assessment of new patients. Do not allow new patients into other units until the tasks associated with admission, including clinical assessments and the provision of medical orders, are complete.
>
> c. Cease efforts to interfere with the issuance of medical orders that specify required staffing arrangements. Ensure that staffing is sufficient to allow the issuance and implementation of medical orders that specify staffing arrangements.
>
> d. Provide personal panic alarms for all employees who may work in close proximity to patients, including but not limited to nurses, MHAs, housekeeping staff, and case workers. Provide training on this equipment and ensure that the equipment is maintained in working order at all times.
>
> e. Provide security staff and/or crisis intervention specialists on all three shifts to assist in preventing and responding to violent events.

case, but after the parties submitted their post-hearing briefs to the judge, the Commission issued its decision in another case involving a general duty clause violation, *A.H. Sturgill Roofing, Inc*., No. 13-0224, 2019 WL 1099857 (OSHRC Feb. 28, 2019), and held that because the citation's list of abatement measures were proposed as alternatives, the Secretary could only prevail in that case if he proved that none of them were implemented by the cited employer. *Id.* at 9. In other words, the Commission held that implementing any one of the proposed alternatives would constitute abatement of the alleged violation. *Id.*

The judge did not address *Sturgill* in his abatement analysis as he relied on other Commission precedent to conclude that the Secretary had proposed the citation's listed measures as a process and correctly acknowledged that a process-based approach to abatement is permitted where the hazard alleged under the general duty clause cannot be abated with a single action.[10] *Pepperidge Farm, Inc.*, 17 BNA OSHC 1993 (No. 89-265, 1997) (finding that "the appropriate response to the hazard [alleged under the general duty clause] . . . was a process that included actions selected from a menu of alternatives"); *Integra Health Mgmt., Inc.*, No. 13-1124, 2019 WL 1142920, at *12-13 (OSHRC March 4, 2019) (considering numerous proposed abatement measures as means of materially reducing workplace violence hazard alleged under general duty clause); *see also BHC Nw. Psychiatric Hosp., LLC, v. Sec'y of Labor*, 951 F.3d 558, 564 (D.C. Cir. 2020) (Secretary proposed "menu" of abatement options to materially reduce workplace violence hazard alleged under general duty clause).

On review, Respondent invokes *Sturgill* and now claims that the Secretary proposed the abatement measures as alternatives, and because the record contains substantial evidence that it has adequately implemented at least some of the measures at Pembroke, the Secretary cannot prove the abatement element of the alleged violation. The Secretary responds that the proposed

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> f. Maintain staffing that is adequate to safely address changes in patient acuity and new patient admissions. For example, do not decrease staffing levels mid-shift regardless of the timing of patient discharges.
>
> g. Maintain adequate staffing to support therapeutic activity groups and recreation periods, thereby engaging patients in activities that reduce patient agitation and incidents of workplace violence. Maintain equipment that is sufficient for the implementation of each patient's individual crisis prevention plan.

[10] We note that the judge cited to *Sturgill* in his analysis of Respondent's due process claims, which he rejected. Those claims are not at issue on review.

abatement measures "would each cumulatively reduce the hazard" such that every measure identified in the citation should be implemented. According to the Secretary, "each proposed abatement method would help avoid different and separate acts of patient-on-staff violence."

We agree with the judge that the Secretary proposed, and the parties tried, the measures listed in the citation as a process-based approach to abate the cited hazard. Indeed, the Secretary explained in his post-hearing brief that while "each of his proposed abatement measures would have independently provided a material reduction in the hazard of workplace violence[,]" it may also be necessary for UHS to "implement[] . . . multiple abatement measures" to satisfy its "duty to remove all preventable instances of the hazard." Before the judge, Respondent demonstrated the same understanding, referring in its joint post-hearing brief to the proposed measures as "abatement steps" and accusing the Secretary of trying to impose "various abatement methods" through a general duty clause citation to effectively create a workplace violence standard. This supports the Secretary's position on review that the parties understood the measures were proposed as a process, not as alternatives. *See Nat'l Realty v. OSHRC*, 489 F.2d 1257, 1266-67 (D.C. Cir. 1973) ("All preventable forms and instances of hazardous conduct must [] be entirely excluded from the workplace."). *Cf. Sturgill*, 2019 WL 1099857, at *9 n.17 (noting Secretary's acknowledgement during oral argument that abatement measures were proposed as alternatives). The Secretary's approach in this regard aligns with the nature of workplace violence, which as alleged here arises in different contexts and conditions at Pembroke, necessitating different abatement measures. *Cf. Sturgill*, 2019 WL 1099857, at *9 (finding abatement measures to be alternatives where "any one of them would constitute abatement of the alleged violation"); *SeaWorld*, 748 F.3d 1202 (D.C Cir. 2014) (finding two abatement measures proposed as alternatives because if one were implemented, the second would offer no further protection). Indeed, the citation identifies measures that range from preventative to mitigative.

For all these reasons, we reject Respondent's argument and find that to establish the abatement element here, the Secretary need only prove that at least one of the measures he proposed was not implemented and that the same measure is both effective and feasible in addressing the alleged hazard. *Sturgill*, 2019 WL 1099857, at *9 (noting where each measure is proposed as a "component of a single means of abatement," the Secretary "need only show a failure to implement one of them"); *Arcadian Corp.*, 20 BNA OSHC 2001, 2011 (No. 93-0628, 2004) (citing *Beverly Enters. Inc.*, 19 BNA OSHC 1161, 1190 (No. 91-3144, 2000) (consolidated) (to

establish the feasibility of a proposed abatement measure, the Secretary must "demonstrate both that the measure[] [is] capable of being put into effect and that [it] would be effective in materially reducing the incidence of the hazard") (citations omitted). And given that Respondent has taken measures to address the cited hazard, the Secretary must also show that those measures were inadequate. *U.S. Postal Serv.*, 21 BNA OSHC 1767, 1773-74 (No. 04-0316, 2006); *Cerro Metal Prods. Div., Marmon Grp., Inc.*, 12 BNA OSHC 1821, 1822 (No. 78-5159, 1986)).

As discussed below, we agree with the judge that the Secretary established Respondent's failure to adequately implement two feasible and effective means of abatement proposed here: the provision of personal panic alarms for staff to summon assistance and the provision of adequate equipment to support de-escalation efforts for patients in crisis.[11]

Equipment for summoning assistance

The Secretary proposes that Respondent "[p]rovide personal panic alarms for all employees who may work in close proximity to patients" and "[p]rovide training on this equipment and ensure that the equipment is maintained in working order at all times." There is no dispute that Pembroke's employees are not provided with any type of panic alarms. Before the judge and also on review, Respondent maintains that employees were nonetheless able to adequately summon assistance when faced with patient aggression because the hospital provided them with walkie-talkies and access to an intercom system in every common area. The judge disagreed, finding that (1) walkie-talkies were not consistently available to allow every staff member to carry one; (2) if an employee did not have one, there was only access to one phone (connected to the intercom system) in the middle of each unit; (3) the walkie-talkies were not reliable due to technical issues, such as faulty batteries; and (4) requiring staff to call out for help or make such requests through walkie-talkies or the intercom system meant they could be heard by the agitated patient, which could escalate the situation further.

[11] The judge also found that the Secretary established that Pembroke was inadequately staffed in several respects, including regarding its admissions procedures and found that the Secretary had established feasible and effective abatement measures to remedy those deficiencies. Because we conclude that the Secretary has proven two of his proposed abatement measures, we need not reach these other proposed abatement measures. *Sturgill*, 2019 WL 1099857, at *9; *see S. Scrap Materials Co.*, 23 BNA OSHC at 1599 n.1 ("Although the parties briefed Citation 2, Item 40, as requested, we decline to review the judge's disposition of this item.") (citations omitted).

We agree with the judge that Pembroke's reliance on walkie-talkies and the intercom system was inadequate. The evidence shows that the hospital supplied three to four walkie-talkies per unit at the time of the OSHA inspection but not every employee always carried one during their shift. Employees who did carry a walkie-talkie would at times forget to return the device at the end of their shift and leave work with one in their possession, making the device unavailable for others to use. Even when available, testimony from former Pembroke MHA Andrew Santos, former Pembroke Registered Nurse Janine Senatore, and Pembroke's Director of Nursing shows that the walkie-talkies were not reliably functional because the batteries would die over time or would not hold a charge; these employees also testified that static or chatter due to the device's shared communication channels made it difficult to decipher a call for help.

As for the intercom system, the judge found, and the record shows, it was neither practical nor widely used—to access the one phone connected to the system located in the middle of each unit, an employee had to walk away from a potentially unstable situation to call for help rather than remain with the patient in crisis, as Pembroke encouraged. And as we find below, requiring employees to audibly call for assistance creates the potential to further escalate an agitated patient's distress. In sum, we find that the Secretary established Pembroke's program was inadequate to address the cited hazard because it failed to provide employees with the means to reliably, timely, and discreetly summon help when confronted with a threat of workplace violence.

The Secretary also has proven that the use of personal panic alarms is an effective and feasible means of addressing the cited hazard.[12] The Secretary's expert witness, Dr. Robert Welch,[13] testified that access to personal panic alarms correlated with significantly lower rates of employee assault by hospital patients. Specifically, Dr. Welch stated that employees can wear personal panic alarms inconspicuously and silently call for help, making the devices more efficient in reducing the likelihood of staff becoming victims of patient violence. He explained that personal panic alarms allow employees to immediately seek help without audibly calling for help over a walkie-talkie or with a loud voice, as that can agitate a distressed patient and escalate the

[12] Respondent does not dispute the feasibility of providing personal panic alarms to employees.

[13] Dr. Welch, a board-certified physician in psychiatry and neurology, holds degrees from Harvard College and Columbia University, and has served as a professor of psychiatry at Harvard Medical School; he also has had overall clinical responsibility and served as chief of psychiatry at mental health hospitals, and is a member of numerous professional organizations for psychiatry.

situation.[14] Dr. Welch's opinion was corroborated by former Pembroke Registered Nurse Senatore, who testified that she had effectively used personal panic alarms at other behavioral health hospitals: "They're just a very immediate system for alerting that you need help . . . and people come right away. There's very little lag time."

On review, Respondent disputes the relevance of Dr. Welch's testimony, arguing that one study he relied on to support his opinions involved emergency rooms, not psychiatric hospitals. But in both situations medical personnel are caring for potentially violent patients in a hospital setting. Put simply, it is apparent from the record that in the face of patient aggression and the potential for imminent violence, verbally asking or yelling for help in the presence of the distressed individual is not equivalent to silently and discreetly summoning help via a personal panic alarm.

For all these reasons, we find the Secretary has established that Respondent failed to maintain adequate equipment for Pembroke employees to summon assistance when faced with patient aggression and that providing personal panic alarms is both feasible and effective.

Equipment for de-escalation

The Secretary also proposes that Respondent "[m]aintain equipment that is sufficient for the implementation of each patient's individual crisis prevention plan."[15] The judge agreed, finding that Pembroke lacked the necessary equipment to implement these plans, also known as "de-escalation" plans, specifically regarding the availability of music-playing devices. On review, Respondent does not dispute that Pembroke lacked enough devices to make them immediately available to every patient who wanted or needed one but argues that the hospital had numerous alternative techniques to keep patients calm, and the Secretary has not shown that these other measures were ineffective. The Secretary maintains that Pembroke's patients specifically

[14] We note that on review, Respondent does not rely on its expert witness, Monica Cooke, with respect to the efficacy of personal panic alarms, or otherwise dispute the judge's decision to afford less weight to Cooke's expert testimony. According to the judge, "[w]hile satisfying the minimum requirements for admissibility," Cooke failed to identify the source material for her opinions and her testimony was largely based on her experience rather than peer-reviewed studies or time spent reviewing Pembroke's records. Indeed, on this particular issue, the judge found that it is unclear if Cooke had reviewed any studies or peer-reviewed literature in reaching her conclusion.

[15] Given how this case was argued and tried by the parties, the Secretary need only show that at least one of the citation's proposed abatement measures was feasible and effective to establish this element of his case. This does not, however, preclude our consideration of more than one abatement measure, and we find that it is appropriate to do so here.

identified music as a means of de-escalation in their plans, but it was not consistently available to them due to the limited supply of devices. The Secretary also argues that regardless of whether other measures might calm patients, the record clearly shows that providing sufficient equipment would reduce the cited workplace violence hazard.

We agree with the judge that Pembroke lacked sufficient equipment to adequately implement its patient de-escalation plans. Approximately nine out of ten patients identified listening to music as a "helping" strategy in their respective plans, yet at the time of the inspection, Pembroke supplied at most four music-playing devices to each unit. This was plainly inadequate, as the record shows that one of the adult units had sixteen patients, but only three music-playing devices, and that patient conflicts regarding access to the limited number of music-playing devices occurred regularly. And while Pembroke permitted units to borrow devices from each other when needed, availability was neither assured nor immediate. In short, regardless of whether other calming techniques listed in the patient plans were effective, it is nearly impossible to reconcile Pembroke's decision to provide so few devices to each unit with the fact that approximately 90% of its patients requested music as their preferred coping strategy. For all these reasons, we find the Secretary has established that implementation of Pembroke's patient de-escalation plans was deficient.[16]

Turning to the effectiveness and feasibility of providing additional listening devices, Respondent argues that the Secretary has not shown, through Dr. Welch or otherwise, that providing more equipment would materially reduce the cited hazard. We disagree. According to Dr. Welch, the use of music as a de-escalation measure can result in a significant reduction in the potential for a violent incident:

> [I]t's largely what the patients [here] . . . identify as their technique, their preferred technique for calming down and de-escalating when they are upset. So you've got patients tell[ing] staff this is what works to help me stay calm and not being able to provide that creates a higher risk situation.

[16] On review, Respondent claims that "the decision regarding the appropriate therapeutic means for managing patient agitation is a clinical one properly made by a patient's treating doctors and clinical staff and should not be second guessed or regulated by the Secretary with a one-size-fits-all approach." While a clinical judgment may be present in determining how best to de-escalate a situation involving an agitated patient, the fact remains that the vast majority of Pembroke patients identified music as their preferred calming strategy, yet the hospital lacked sufficient music equipment to meet that demand.

He also gave an example of how being able to provide a patient with a listening device can assist the staff with de-escalating a situation:

> [Y]ou can say, John you seem upset, would [you] like to listen to music and then maybe we can talk about what's getting you upset later. You put the headphones on, they walk up and down the hall, you've de-escalated the situation right there.

And Dr. Welch testified that in his experience, hospitals can readily obtain wireless headphones at minimal expense.[17]

Three employee witnesses confirmed that listening to music helps calm agitated patients. Former MHA Sherwin testified that as a verbal de-escalation instructor, she has observed how patient aggression, agitation, and pacing can be lessened by listening to music:

> So oftentimes you'll see [patients] continue to keep pacing for a couple more minutes, kind of still agitated, and then slowly within 15 to 20 minutes you can see them start to calm down and deescalate and then be able to have a conversation with staff about what is occurring.

Former Pembroke nurse Libby offered similar testimony, explaining the positive effect music has on patients in crisis:

> It is a great help. And I realized it even more once I became board certified how much of a role music can be in deescalating a situation. Especially with patients that have a schizophrenic diagnosis. They are hearing voices; it is very helpful.

And former MHA Santos testified that music was "[s]oothing, calming" and confirmed that he had seen listening to music work to calm "patients who were acting aggressive and threatening." Thus, we find that Dr. Welch's expert testimony, corroborated by these former Pembroke employees, shows that providing sufficient music equipment would materially reduce the risk of patient assaults by de-escalating situations in which patients may become violent.

Based on the foregoing, we conclude that the Secretary has established that Respondent failed to maintain adequate equipment for Pembroke employees to summon assistance and implement patient de-escalation plans, and that the proposed abatement measures in this regard are both feasible and effective. Accordingly, we find that the Secretary has established the

[17] After the inspection, Pembroke switched to providing wireless headphones and supplied as many as ten pairs per unit. *See Pitt-Des Moines, Inc.*, 16 BNA OSHC 1429 (No. 90-1349, 1993) (employer's post-inspection implementation of abatement measure admissible to establish feasibility).

abatement element of the general duty clause violation. As none of the other prima facie elements of the violation are in dispute on review, we affirm the citation.

III. Characterization

The Secretary argues that the judge erred in recharacterizing the general duty clause violation from repeat to serious. *See* 29 U.S.C. § 666(a) (setting increased penalties for employer that "repeatedly violates" the Act's requirements). Under Commission precedent, a violation is properly characterized as repeat, "if, at the time of the alleged . . . violation, there was a Commission final order against the same employer for a substantially similar violation." *Potlatch Corp.*, 7 BNA OSHC 1061, 1063 (No. 16183, 1979); *Lake Erie Constr. Co.*, 21 BNA OSHC 1285, 1289 (No. 02-0520, 2005). The Commission has long held that "similarity of abatement is not the criterion for finding a repeat violation; it is whether the two violations resulted in substantially similar hazards." *Lake Erie Constr. Co.*, 21 BNA OSHC at 1289 (citing *Stone Container Corp.*, 14 BNA OSHC 1757 (No. 88-310, 1990)). To determine whether the hazards are substantially similar, the Commission looks to the circumstances surrounding the violation. *See, e.g., Active Oil Serv., Inc.*, 21 BNA OSHC 1184, 1189 (No. 00-0553, 2005) (finding general duty clause citation violations substantially similar where both involved employee exposure to hazard of asphyxiation in entering fuel tanks to clean).

In citing the violation here as repeat, the Secretary relies on a 2015 general duty clause citation issued to UHS-WP for exposing employees at its Lowell Treatment Center, an inpatient psychiatric care facility also located in Massachusetts, "to acts of workplace violence including, but not limited to: verbal threats of assault, physical assaults, choking, punches, kicks, human bites, scratches and/or pulling of hair by patients." Specifically, the 2015 citation alleged that:

> From January 1, 2011 through December 31, 2014 there have been at least 16 documented cases identified in the OSHA 300 log of employees assaulted on the job by patients resulting in approximately 255 restricted duty days and 730 days away from work. Additionally there have been at least 38 documented non-recordable cases resulting in a dislocated shoulder, concussion, sprains, strains, contusions, swollen body parts, headaches, human bites, punched in the face, kicked, hit, choked, hair pulled, scratched, bitten, grabbed and thrown by patients. During 2014 there were at least five instances of workplace violence, including an incident on November 30, 2014, when a nurse was punched in the face and knocked out unconscious by a patient, resulting in soft tissue damage to the face and jaw, contusions, swelling, and headaches.

The citation was resolved by a settlement agreement and became a final order in April 2016.

In the present citation, the Secretary alleges that Pembroke employees were exposed to assaults by patients in that:

> Employees including Nurses, Mental Health Associates (MHAs), and Crisis Intervention Specialists (CISs) at UHS of Westwood Pembroke, Inc. (Pembroke Hospital) have suffered serious workplace violence related injuries such as concussion, fracture, strains, contusions, and burns (from hot coffee thrown at face) while performing their job duties, such as attempting to prevent injuries to staff and patients, and during restraint holds.

In rejecting the citation's repeat characterization, the judge concluded that the Secretary failed to proffer sufficient information to determine if the workplace violence hazards at issue in the two cases were substantially similar. He acknowledged that the hazards "share some commonality" but found that "the limited information in the record reveals only that the cited workplaces had significant differences related to the hazard" in that some of the abatement measures proposed in the two citations are different.

On review, Respondent adopts the judge's rationale in claiming that the Secretary failed to establish the two violations are substantially similar and relies on the same underlying fallacy—that substantial similarity hinges on abatement.[18] But the Secretary need only show that employees were exposed to a substantially similar hazard and here, both violations involve employees exposed to an almost identical hazard—the hazard of physical assault by patients at a psychiatric care facility. *Lake Erie Constr. Co.*, 21 BNA OSHC at 1289 (holding that "similarity of abatement is *not* the criterion for finding a repeat violation") (citation omitted) (emphasis added). The burden therefore shifts to Respondent to rebut the Secretary's prima facie showing of similarity, and it has not done so here given that its arguments focus almost exclusively on abatement.[19] *See Manganas*

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[18] Respondent specifically relies on the Commission's decision in *Angelica Textile Serv.*, 27 BNA OSHC 1246, 1254-59 (No. 08-1774, 2018), *vacated as moot*, 803 F. Appx. 542 (2d Cir. 2020, unpublished), *dismissed case on remand*, 2020 WL 4475583 (OSHRC July 27, 2020), a case identified in the Commission's briefing notice, to argue that the prior citation "did not place [Respondent] on notice of what additional measures were required to prevent subsequent violations," and the present citation should not be characterized as repeat because it does not indicate a failure to learn from the prior citation. The Second Circuit, however, has since vacated the Commission's *Angelica* decision, rendering any arguments that rely on the rationale of that case unsupported. 803 F. Appx. 542. Accordingly, we do not consider those arguments here.

[19] Although the similarity of abatement measures is not relevant to the inquiry here, we note that at least one of the measures proposed in the prior citation is essentially the same as one proposed in the present citation—maintaining sufficient equipment to summon assistance.

Painting Co. v. Sec'y of Labor, 273 F.3d 1131, 1135 (D.C. Cir. 2001) (once Secretary has made prima facie showing of substantial similarity, "burden then shifts to the employer to demonstrate that the violations took place under disparate conditions and hazards associated with the separate violations") (*citing Potlatch*, 7 BNA OSHC at 1061).

For all these reasons, we affirm the citation as repeat and assess the proposed penalty of $25,350.[20]

SO ORDERED.

/s/
Cynthia L. Attwood
Chairman

/s/
Amanda Wood Laihow
Commissioner

Dated: March 3, 2022

[20] Respondent has not disputed the $25,350 proposed penalty throughout these proceedings. *See KS Energy Servs., Inc.*, 22 BNA OSHC 1261, 1268 n.11 (No. 06-1416, 2008) (assessing proposed penalty where undisputed).

United States of America
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION
1120 20th Street, N.W., Ninth Floor
Washington, DC 20036-3457

SECRETARY OF LABOR, Complainant, v. UHS OF WESTWOOD PEMBROKE, INC., UHS OF DELAWARE, INC., Respondents.	OSHRC DOCKET NO. 17-0737

Appearances:

Kate O'Scannlain, Solicitor of Labor
Maria S. Fisher, Regional Solicitor
Robin Ackermann, Senior Trial Attorney
Ralph Minichiello, Senior Trial Attorney
U.S. Department of Labor, Office of the Solicitor, Boston, MA
For the Complainant

Melanie L. Paul
Raymond Perez, II
Jackson Lewis P.C., Atlanta, GA
For Respondents

Before: Keith E. Bell, Administrative Law Judge

DECISION AND ORDER

Following its receipt of a complaint about workplace violence, OSHA commenced an inspection of UHS of Westwood Pembroke, Inc.'s ("Pembroke's") facility located at 199 Oak Street in Pembroke, MA ("Pembroke Hospital"). As a result of this inspection, Pembroke received a Citation and Notification of Penalty ("Citation") alleging it violated the Occupational Safety and Health Act of 1970, 29 U.S.C. §§ 651-678 (the "Act"). The Citation alleges a violation of 29 U.S.C. § 654(a)(1), the provision commonly referred to as the general duty clause, for exposing

employees to the hazard of workplace violence in the form of patient on staff aggression.

Pembroke timely contested the Citation bringing the matter before the Commission.[1] The Secretary of Labor ("Secretary") filed his initial Complaint on April 27, 2017. He moved to amend his Complaint to add UHS of Delaware, Inc. ("UHS DE") as a Respondent and to change the classification of the Citation from "serious" to "repeat." This request was granted in an October 30, 2017 Order, after which Pembroke and UHS DE together became the Respondents for this matter.

Subsequently, the Secretary moved again to amend abatement in the Citation and Complaint. This request was uncontested and was approved in a December 13, 2017 Order. A hearing was held on July 17-20, 2018 and July 24-25, 2018.

For the reasons discussed, the Citation is affirmed as serious and a $12,675 penalty is assessed.

I. Jurisdiction

Pembroke filed a timely Notice of Contest bringing this matter before the Commission.[2] (Stip. 4-6.) Pembroke and its corporate parent, UHS DE, are both employers affecting commerce within the meaning of 29 U.S.C. § 659(c) and both are employers under the Act.[3] (Stip. 1, 10-13.)

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[1] The Joint Exhibit of the parties' Stipulations indicates that: "Respondent timely filed its Notice of Contest on May 17, 2018." (Ex. J-1, Sec'y Br. at 1; Tr. 194.) The undersigned accepts the acknowledgment that the Notice of Contest was timely, but rejects the date listed in the Stipulation. The record reflects that the Secretary issued the Citation on April 7, 2017, and Pembroke filed a Notice of Contest on April 12, 2017. Pembroke then filed an Answer to the Secretary's Complaint on May 17, 2017. (Resp't Br. at 5.) The record does not reflect a document filed on May 17, 2018.

[2] Stipulation 4 is: "The Occupational Safety and Health Review Commission has jurisdiction in this proceeding pursuant to § 10(c) of the [Act]." Stipulation 5 is: "The Citation and Notification of Penalty underlying this proceeding was issued on April 7, 2017."

[3] Stipulation 1 states: "Respondents are employers engaged in a business affecting commerce within the meaning of Section 3(5) of the Occupational Safety and Health Act of 1970, 29 U.S.C. § 6252(5)."

Based upon the record, including the parties' admission to jurisdiction, the undersigned concludes the Commission has jurisdiction over the parties and the subject matter of this case. (Stip. 1, 4-6.)

II. Background

A. Corporate Structure

Pembroke operated three facilities at the time of the inspection: Pembroke Hospital, Westwood Lodge, and Lowell Treatment Center. (Tr. 697; Ex. R-38 at 2.) While each facility was located at a separate address, collectively the sites shared a license and were a single legal business entity. (Tr. 723-24.) Pembroke is a wholly-owned subsidiary of UHS DE. (Stip. 12.) UHS DE, in turn, is a wholly-owned subsidiary of Universal Health Services, Inc. ("UHS"). (Stip. 13.) Thus, UHS owns UHS DE and indirectly owns Pembroke. (Stip. 13; Tr. 752-53.)

UHS DE is described as a "management company" for Pembroke. (Tr. 740; Ex. C-27.) At the time of the inspection, Pembroke's CEO and CFO were both employees of UHS DE.[4] (Stip. 10-11; Tr. 598, 693, 757.) UHS DE employees provided oversight for the work of Pembroke's CEO and CFO. (Tr. 599, 696, 757-58, 1325, 1327-28.) In addition, Gina Gilmore, a Loss Control Manager at UHS DE, handled Pembroke's budget for workers' compensation claims and visited the facility every month. (Tr. 549-551.) During these visits, she would meet with Pembroke's CEO and attend the facility's Aggression Reduction Team meetings. (Tr. 553-54.) The Director of Nursing, Claire Kent, and the Risk Manager, Stacey Coke Burns, were Pembroke employees but also reported to individuals employed by UHS DE. (Tr. 369-70, 457, 497-98, 502.)

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[4] As explained by Stipulation 10, "Raymond Robinson, Gary Gilberti, Diane Airosus, and Gina Gilmore were employed by UHS of Delaware, Inc. during the time of the inspection." Thomas Hickey was the chief executive officer ("CEO") from the start of the inspection until January 21, 2017. (Tr. 692-93; Stip. 11 ("Thomas Hickey was employed by UHS Delaware, Inc. during a portion of the time of the inspection.")

B. Respondents' Request for Judicial Notice

In its brief, Respondents assert that the Secretary has pursued general duty clause violations at "several other [UHS] managed hospitals." (Resp't Br. at 3.) Respondents fail to discuss whether these other citations were issued to UHS DE or entities affiliated with Pembroke. However, in a footnote elsewhere in the brief, Respondents ask the undersigned to take judicial notice of "other Citations that have been issue to behavioral hospitals." (Resp't Br. at 33.) It requests judicial notice of three specific cases:

> *Secretary of Labor v. BHC Northwest Psychiatric Hospital, LLC d/b/a Brooke Glen Behavioral Hospital*, (OSHRC Docket 17-0063), *Secretary of Labor v. UHS of Westwood Pembroke, Inc., d/b/a Lowell Treatment Center* (OSHRC Docket 17-1302 and 17-1304) and *UHS of Delaware, Inc. ("UHS DE") and Premier Behavioral Health Solutions of Florida, Inc., d/b/a Suncoast Behavioral Health Center* (OSHRC Docket 18-0657).

(Resp't Br. at 33.) The first matter listed concerns BHC Northwest Psychiatric Hospital ("BHC"). Respondents do not explain how or if that entity is affiliated with them. *Id.* The undersigned is aware that a matter involving BHC has become a final order of the Commission. However, BHC is appealing the matter and the matter is currently pending before the D.C. Circuit. *BHC Nw. Psychiatric Hosp*. *LLC d/b/a Brooke Glen Behavioral Hosp.*, 27 BNA OSHC 1862 (No. 17-0063, 2019) (ALJ), *argued*, 19-1087 (D.C. Cir. Jan. 9, 2020).

Federal Rule of Evidence 201(b) permits judicial notice of a "fact" that is not subject to reasonable dispute because it: (1) is generally known within the court's territorial jurisdiction; or (2) can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned. Even though Respondents do not discuss their affiliation with BHC, the undersigned can and has reviewed the ALJ's decision, *BHC Nw. Psychiatric Hosp. LLC d/b/a Brooke Glen Behavioral Hosp.*, 27 BNA OSHC 1862 (No. 17-0063, 2019) (ALJ). However, taking judicial notice of a non-binding decision that is still on appeal is not appropriate.

As for the other two matters highlighted by Respondents, both are active disputes without final determinations. As such, there are no established facts for which judicial notice is appropriate. At the hearing, Respondents did not attempt to offer any evidence regarding the relevance of these matters or how Premier Behavioral Health Solutions of Florida, Inc. is affiliated with them. As a result, the Secretary was deprived of an opportunity to respond to these claims. Further, Respondents assert that UHS DE had only a minimal role at Pembroke Hospital and asks for the entity to be dismissed from this pending matter. (Resp't Br. at 40.) Asking the undersigned to now undertake a search of other citations issued to behavioral health centers is not the purpose of judicial notice and the late request is denied.

The undersigned notes that the Secretary offered evidence of another citation issued against Pembroke, the same employer cited in the present matter. That citation, which became a final order on May 27, 2016, is a part of the record before me and has been considered in reaching this decision. (Exs. C-14 thru C-17.)

C. Nature of the Workplace

Pembroke Hospital is an inpatient psychiatric hospital with six patient care units, serving up to 120 patients at a time.[5] (Stip. 2-3; Tr. 290, 373; Ex. R-38 at 1, 8.) Four units focus on adults, one is for adolescents, and the sixth is for geriatric patients. (Tr. 373.) Nurses and Mental Health Associates ("MHAs") work directly with patients in the units. (Tr. 669, 821-824.) Units always have a registered nurse. (Tr. 380.)

The MHAs at Pembroke Hospital have many responsibilities, including providing security and fulfilling housekeeping responsibilities. (Tr. 50-52, 96.) The nurse on the unit could not see

[5] Stipulation 2 states: "Pembroke Hospital is an inpatient psychiatric hospital." Stipulation 3 states: "Pembroke Hospital has six patient care units with a total of 120 beds."

patients from his or her workstation. (Tr. 58.) So, the MHAs functioned as the "eyes and ears of the nursing staff" and were responsible for monitoring patient behavior, including for signs of aggression or agitation. (Tr. 50.) MHAs searched patient belongings to identify prohibited items that could hurt patients or staff. (Tr. 79, 81, 86.) MHAs conducted these searches alone in small rooms on the unit. (Tr. 79, 81.) MHAs had to make sure certain doors remained locked. They would open and close bathrooms when requested by patients, which might occur fifty times a shift. (Tr. 55, 827.) MHAs also accompanied patients off units for certain meetings, fresh air breaks, and meals.[6] (Tr. 55-56.) If a patient was unable to leave the unit for meals, an MHA would leave the unit instead and get the patient's meal. (Tr. 52.) MHAs also left the units for laundry and other housekeeping tasks. (Tr. 50-54, 96.) Consequently, while more than one MHA was assigned to each unit, the staff was often divided between those on the unit and those off the unit. (Tr. 822, 863.)

D. Prior OSHA Inspections of Pembroke

About a year before the inspection leading to the Citation before the undersigned, OSHA inspected Pembroke Hospital. (Ex. R-38.) That inspection led to the issuance of a letter on October 2, 2015, which indicates that MHAs were exposed to workplace violence hazards but that "it is not considered appropriate *at this time* to invoke the Section 5(a)(1), the general duty clause of the [Act]."[7] (Ex. R-37 at 2 (emphasis added).) The letter does not state that OSHA considered workplace violence hazards to be outside of the scope of the general duty clause. (Resp't Br. at

[6] Mealtimes themselves were a "very high time for assault" at Pembroke. (Tr. 960; Exs. C-55 at 2, C-58 at 2.)

[7] Respondents neglect to note the critical phrase "at this time" when discussing this document. (Resp't Br. at 21.)

21.) Rather, OSHA exercised its discretion to issue a letter at the end of the investigation.[8] The letter goes on to outline several methods of feasible abatement for workplace violence hazards Pembroke could adopt, but does not demand any specific action.[9] (Ex. R-37.)

After the letter was issued, OSHA commenced an inspection of Pembroke's facility in Lowell, MA (the Lowell Treatment Center). After the inspection, the Secretary issued Pembroke a citation for a violation of the general duty clause because it exposed employees to workplace violence in the form of, among other things, patients assaulting staff through punches, kicks, bites, scratches, and hair pulling. (Exs. C-14, C-15 at 2, R-38 at 2.) While Pembroke initially contested the citation, it subsequently agreed to accept it as issued and agreed to take several abatement actions to address the workplace violence hazards at the Lowell Treatment Center. (Ex. C-15.)

E. Current Inspection

In October 2016, OSHA received another complaint about worker safety at Pembroke Hospital. (Tr. 277; Ex. C-8.) The complaint cites a worker injury following an instance of patient aggression. (Ex. C-8.) This complaint led OSHA to commence another inspection of Pembroke Hospital. (Tr. 277.) OSHA Compliance Safety and Health Officer Salvatore Insogna ("CO") led the investigation. *Id.* He first visited the site on October 11, 2016. (Tr. 342.) In addition to the initial complaint triggering the investigation, OSHA received a second complaint on March 27, 2017. (Ex. C-11.) Like the prior complaint, the second one cites employee injuries from

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[8] There is no evidence that the conditions, particularly those related to the cited hazard, were the same during the two inspections. For example, the number of staff injuries increased in the year after this letter was sent. (Exs. C-60; C-68, C-69; R-38 at 3.)

[9] After the 2015 inspection, but before the one which led to the present matter, OSHA conducted another inspection of Pembroke Hospital. That investigation commenced after OSHA received two employee complaints alleging several hazards related to workplace violence. (Ex. R-38 at 1-2.) Pembroke Hospital participated in the investigation, including by answering questions and providing responses to various document requests. *Id.* at 3-5. Ultimately, OSHA closed this inspection on August 4, 2016, without issuing any citations. *Id.* at 5.

workplace violence in the form of assaults by patients against staff. *Id.* The CO's investigation included a review of documents related to employee injuries and illnesses, and interviews with ten or more non-management employees. (Tr. 290-92, 297; Ex. C-68.) When the investigation concluded, the Secretary issued the Citation that is the subject of this litigation.

III. Legal Standard

A. Due Process Claims

Respondents claim that the Citation's issuance violated due process. (Resp't Br. at 19.) The Commission ensures that OSHA provides due process by upholding violations of the general duty clause only where the employer or its industry recognized the hazard before the citation was issued. The inquiry is whether the employer or its industry could reasonably foresee an accident capable of causing death or serious injury. *Armstrong Cork Co*., 8 BNA OSHC 1070, 1074 (No. 76-2777, 1980), *aff'd*, 636 F.2d 1207 (3d Cir. 1980) (unpublished). Knowledge of the hazard provides adequate notice to satisfy the requirement of due process. *See e.g., Cape & Vineyard Div. of New Bedford Gas & Edison Light v. OSHRC,* 512 F.2d 1148 (1st Cir. 1975) (finding that actual knowledge of the hazard provides fair notice); *Bethlehem Steel Corp. v. OSHRC*, 607 F.2d 871, 875 (3d Cir. 1979) (finding that fair notice is addressed by the requirement that the hazard is recognized); *Babcock & Wilcox Co. v. OSHRC*, 622 F.2d 1160, 1164 (3d Cir. 1980) (concluding that either the employer or its industry must be aware of the hazard).

Respondents raise no challenges to how the Secretary defined the hazard here or Pembroke's recognition of both the hazard and its presence at Pembroke Hospital. Indeed, they stipulated that the "hazard of workplace violence, specifically defined in this case as violence and/or assault by patients against staff, was recognized by [Pembroke]." (Stip. 8.) And they

stipulated that the "hazard of workplace violence, specifically defined in this case as violence and/or assault by patients against staff is recognized in the industry." (Stip. 9.)

Even if Pembroke had not stipulated to the definition and recognition of the hazard, the record still provides ample support for such findings. Patient attacks on employees routinely occurred at Pembroke Hospital. (Exs. C-8, C-11, C-68.) One employee indicated he was hit or kicked approximately fifty different times by various patients in his four years working for Pembroke. (Tr. 56-57.) *See Gen. Dynamics Land Sys. Div., Inc*., 15 BNA OSHC 1275, 1285 (No. 83-1293, 1991) (accidents put the employer on notice of the hazard), *aff'd*, 985 F.2d 560 (6th Cir. 1993) (unpublished). Pembroke was aware of these events through accident reports employees could choose to complete after incidents and through the direct knowledge of supervisors, some of whom were exposed to the hazard themselves. (Tr. 794, 802; Exs. C-55, C-56.)

Moreover, Pembroke had specific and direct knowledge of the Secretary's view that the general duty clause applied to the hazard of workplace violence. On May 19, 2015, Pembroke was cited for violating the general duty clause because its employees "were exposed to acts of workplace violence." (Ex. C-14.) This citation was issued in 2015 and became a final order on May 27, 2016, months before the commencement of the inspection and issuance of the present citation. (Exs. C-15 thru C-17.) So, Pembroke accepted responsibility for a violation of the general duty clause based upon the presence of the hazard of workplace violence before the investigation leading to the instant Citation commenced.[10] This establishes direct notice of the applicability of the general duty clause to workplace violence hazards at Pembroke's facilities. *See Corbesco Inc.*

[10] This citation related to the Lowell Treatment Center. After this Pembroke's acceptance of this citation, another inspection of Pembroke Hospital concluded without the issuance of any citations. (Ex. R-38 at 5.) However, OSHA never indicated there were no hazards at Pembroke Hospital or that Pembroke did not have a duty to provide its employees with a workplace "free from recognized hazards that are causing or are likely to cause death or serious physical harm." 29 U.S.C. § 654(a)(1).

v. Sec'y of Labor, 926 F.2d 422, 428 (5th Cir. 1991) (holding notice is provided through Commission decisions); *Armstrong*, 8 BNA OSHC at 1073 (finding that the employer itself recognized the hazard because it took an abatement action).

Besides Pembroke's direct knowledge, the Secretary provided other evidence that the industry was on notice of the hazard. First, there is no dispute that experts familiar with the industry would take the hazard of workplace violence into account in prescribing a safety program for a behavioral health hospital. *See Nat'l Realty & Constr. Co. v. OSHRC,* 489 F.2d 1257, 1266 (D.C. Cir. 1973). Experts for both parties recognized that any risk assessment of a facility like Pembroke Hospital would include assessing workplace violence and the hazard would be relevant to any safety program. (Tr. 903, 915-17, 1455.) Second, OSHA published guidance documents to inform the industry of the hazard and ways to address it. In 2015, it published Preventing Workplace Violence: A Road Map for Healthcare Facilities ("Road Map"). (Ex. C-102.) The Road Map describes the problem of workplace violence in healthcare facilities and provides information on how to identify hazards and respond to risks identified. *Id.* The Road Map is related to an earlier OSHA publication, Guidelines for Prevention of Violence in Healthcare ("Workplace Violence Guidelines"). (Exs. C-97, C-102 at 4.) Neither the Workplace Violence Guidelines nor the Road Map constitute specific standards. At the same time, the documents do not suggest that there is some type of immunity from citation for failing to free a workplace of recognized hazards, as the general duty clause requires. *Id.* These OSHA publications bolster the uncontested point that Pembroke and its industry are aware of the hazard.

Perhaps in recognition of its actual awareness of both the hazard and its presence at Pembroke Hospital, Respondents suggest another due process test. (Resp't Br. at 20.) They argue the Citation failed to set forth the "specific actions" to be taken so that Respondents can avoid

future citations. *Id.* Respondents argue they must have notice of the Secretary's views regarding appropriate abatement before a citation can be issued. *Id*. at 20-21, 23.

Respondents attempt to conflate the due process fair notice requirement, which is driven by Constitutional constraints, with the abatement requirement, which is a statutory interpretation created by binding precedent. The Constitution precludes depriving "any person of life, liberty, or property, without due process of law." U.S. Const. amend V. The Commission sets forth requirements to ensure that proceedings before the Commission provide due process. For example, the citation must sufficiently define the hazard and the abatement so that the employer can reasonably defend itself. The Secretary must make the employer aware of what he alleges are feasible means of abatement prior to the hearing, but the Commission has not required such information before the issuance of a citation. *See Erickson Air-Crane Inc.,* No. 07-0645, 2012 WL 762001 (O.S.H.R.C, Mar. 2, 2012). In *Erickson*, the Secretary proposed various abatement methods but the ALJ concluded that none of the proposed methods were feasible. *Id.* at *2-3. Nonetheless, the ALJ went on to determine that the hazard could be feasibly abated through some other action. *Id.* The parties had neither tried nor consented to try whether that action was feasible. *Id.* The Commission considered this a due process violation because the pleadings did not put the employer on notice that the alternative abatement method was at issue. *Id.* Notice must be given before the record closes as to what is being considered feasible means of abatement. *Id.* The Commission did not hold that the employer must know before the citation's issuance what

constitutes feasible means of abatement.[11] *Id.*

Respondents cite cases where the parties disputed the presence of a hazard, the employer's recognition of it, or are otherwise not relevant to the due process issues before me. (Resp't Br. at 20-21.) Respondents rely on *Asamera Oil (U.S.)*, 9 BNA OSHC 1426 (No. 1426, 1980) (consolidated), a non-binding ALJ opinion addressing a specific standard, not the general duty clause, and a non-binding Ninth Circuit decision, *Donovan v. Royal Logging Co*, 645 F.2d 822 (9th Cir. 1981).[12] *See Asamera,* 9 BNA OSHC at 1427 (affirming the ALJ's decision but according it only "the precedential value of an unreviewed judge's decision"); *Integra Health Mgmt., Inc.*, 27 BNA OSHC 1838, n.15 (No. 13-1124, 2019) (noting that *Royal Logging* is "not relevant precedent" for cases, like the present matter, that cannot be appealed to the Ninth Circuit). Respondents' reliance on *Davey Tree Expert Co*., 11 BNA OSHC 1898 (No. 77-2350, 1984) is also misplaced. (Resp't Br. at 24.) Unlike that case, in this matter, Respondents explicitly chose not to contest the Secretary's definition of the hazard or Pembroke's recognition of it.[13] (Stips. 7-9.) Here, Pembroke recognized the hazard of patient on staff violence and knew this hazard was present in its facility. (Stips. 8-9.)

The recognition requirement relates to "knowledge of the hazard, not recognition of the

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[11] *A.H. Sturgill Roofing, Inc*., 27 BNA OSHC 1809 (No. 13-0224, 2019) is also instructive. There, the citation was somewhat ambiguous about the scope of the proposed abatement. 27 BNA OSHC 1818-19. However, before the record closed, the Secretary subsequently clarified it. *Id.* The Commission did not require the Secretary to show that the employer understood the proposed methods of abatement before the citation was issued. *Id.* The Commission was satisfied that during the hearing the Secretary made clear that the measures in the citation were alternative means of abatement. *Id.*

[12] This case can be appealed to the First and D.C. Circuits. *See* 29 U.S.C. § 660(a) ("Any person adversely affected or aggrieved by an order of the Commission ... may obtain ... review ... in any United States court of appeals for the circuit in which the violation is alleged to have occurred or where the employer has its principal office, or in the Court of Appeals for the District of Columbia Circuit ...."); *Kerns Bros. Tree Serv*., 18 BNA OSHC 2064, 2067 (No. 96-1719, 2000) (Commission generally applies law of circuit where it is probable case will be appealed).

[13] Respondents also quote the discussion in *Missouri Basin Well Service*, 26 BNA OSHC 2314 (No. 13-1817, 2018) about how the hazard must be defined and attempt to apply the statements more broadly. (Resp't Br. at 20, 28.) In this matter, there is no dispute as to how the hazard is defined or Pembroke's recognition of it.

means of abatement." *Kansas City Power & Light Co*., 10 BNA OSHC 1417, 1422 (No. 76-5255, 1982), citing *Gen. Dynamics Corp., Quincy Shipbuilding Div. v. OSHRC*, 599 F.2d 453 (1st Cir. 1979). *See also Brock v. L.R. Willson & Sons, Inc.,* 773 F.2d 1377 (D.C. Cir. 1985) (noting in the context of a violation of a specific standard that "The constitution does not require that employers be actually aware that the regulation is applicable to their conduct"). Fair notice challenges to a general duty clause citation fail when the abatement measures are available to and readily knowable by the industry. *Integra,* 27 BNA OSHC 1851 at n.15. Like the abatement measures in *Integra*, the abatement measures proposed for Pembroke track the Workplace Violence Guidelines and Road Map as well as those specified in a letter issued to Pembroke after a previous inspection. *Id.* The Secretary set forth specific abatement measures and Respondents were informed of them in advance of the hearing. The Secretary's Amended Complaint sets forth his proposed abatement and there is no allegation that Respondents were not aware of his proposal well before the hearing. The feasibility of the specific measures discussed herein was tried with the full consent of the parties. (Jt. Pre-Hr'g Stmt. at 16.) *See Beverly Enters.,* 19 BNA OSHC 1161, 1168-69 (No. 91-144, 2000) (consolidated) (excusing a lack of precision in the complaint because, "at the time of the hearing" the Secretary sufficiently specified the alleged hazard).

Respondents then take another tack and argue that because they were not cited after prior inspections, they lacked fair notice they would be cited in the future. (Resp't Br. at 21-22.) Respondents make this argument without citation to precedent. *Id.* An employer cannot deny the existence of a hazard or its knowledge of it "by relying on the Secretary's earlier failure to cite the condition." *Seibel Modern Mfg. & Welding Corp*., 15 BNA OSHC 1218, 1244 (No. 88-821, 1991). Employers must comply with the Act regardless of whether they have been previously informed that a violation exists. *Id.*

Respondents claim that the Citation, including the Secretary's proposed abatement, violates the Constitution is rejected.[14]

B. Test to Establish a General Duty Clause Violation

The general duty clause requires every employer to provide its employees with a workplace "free from recognized hazards that are causing or are likely to cause death or serious physical harm."[15] 29 U.S.C. § 654(a)(1). As interpreted by the Commission, to establish a violation of this clause, the Secretary must show: (1) there was an activity or condition in the employer's workplace that constituted a hazard to employees; (2) either the cited employer or its industry recognized that the condition or activity was hazardous; (3) the hazard was causing or was likely to cause death or serious physical harm; and (4) there were feasible means to eliminate the hazard or materially reduce it. *Waldon Health Care Ctr*., 16 BNA OSHC 1052, 1058 (No. 89-3097, 1993). The evidence must also show the employer knew, or with the exercise of reasonable diligence, could have known of the hazardous condition. *Otis Elevator Co.*, 21 BNA OSHC 2204, 2207 (No. 03-1344, 2007).

Despite agreeing that *Waldon* sets forth the test for finding a violation of the general duty clause, Respondents, citing *National Realty*, argue that the Secretary must meet various other

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[14] Separate from these Constitutional considerations is the requirement for the Secretary to establish feasible means of abatement. The requirement is not set forth in the text of the general duty clause itself. 29 U.S.C. § 654(a)(1). *See e.g., SeaWorld of Fla. v. Perez,* 748 F.3d 1202, 1207 (D.C. Cir. 2014); *A.C. Castle Constr. Co., Inc. v. Acosta*, 882 F.3d 34, 44 (1st Cir. 2018) (limiting the scope of the fair notice requirement); Mark A. Rothstein, *Occupational Safety and Health Law* §§ 6:1, 6:9 (2019 ed.). It arose as a means to interpret the Act so as to avoid the application of strict liability. *See* 29 U.S.C. § 651(b) (requiring employers "to assure so far as possible … safe and healthful working conditions"). Respondents other contentions that the Secretary failed to meet the abatement prong of the test for establishing a violation of the genera duty clause as developed by the Commission and relevant Circuits are discussed below.

[15] The parties stipulated that this is an applicable principle of law. (Am. Pre-Hr'g Stmt. at 16; Resp't Br. at 6.)

requirements.[16] (Am. Pre-Hr'g Stmt. at 16; Resp't Br. at 6, 28-30.) In *National Realty,* the D.C. Circuit distinguishes between an unrecognized hazard and one, like the situation at hand, that is recognized. 489 F.2d at 1266. Hazard recognition does not automatically trigger liability. *Id.* The Secretary still must demonstrate "at the hearing" what the employer should have done. *Id.* at 1266-68. When discussing whether feasible abatement can be found after the hearing, as opposed to beforehand, the D.C. Circuit notes the concept of preventability. *Id.* If the conduct resulting in the hazard is something "conscientious experts, familiar with the industry" would take it into account when "prescribing a safety program," then the Secretary can establish a violation. *Id.* at 1266. In the present matter, the testifying experts agree that workplace violence is something facilities like Pembroke Hospital must consider when prescribing a safety program. While the hazard is not entirely preventable, there are steps employers can take to reduce the likelihood of such incidents and the severity of the ones which occur. *See Integra*, 27 BNA OSHC 1841 at n.3 (discussing *National Reality* in the context of a general duty clause violation based on workplace violence hazards); *Armstrong*, 8 BNA OSHC at 1074 (noting that the inquiry into foreseeability is limited to whether the hazard will result in serious injuries or death).

1. **Presence of a Hazard**

While *National Realty* analyzes what it means for a workplace to be free of a recognized hazard, *Waldon* and more recent cases apply a four-part test to assess general duty clause violations. Under this framework, the first element the Secretary must prove is that "a condition or activity in the workplace presented a hazard." 16 BNA OSHC at 1058. The parties stipulated: Employees at the worksite were exposed to the hazard of workplace violence, specifically defined

[16] *National Realty* predates *Waldon* and the development of the Commission's four-part test for sustaining violations of the general duty clause. *See Integra*, 27 BNA OSHC 1841 at n.3.

in this case as violence and/or assault by patients against staff, during the six months prior to the issuance of the citation (October 11, 2016 to April 7, 2017). (Stip. 7; Tr. 203, 923.) At the hearing, Respondents' counsel also made plain that they conceded the presence of a hazard to which employees were exposed. (Tr. 194-95.) The Secretary established that employees at Pembroke Hospital were exposed to the hazard of violence and/or assault by patients against staff.

2. Recognition and Knowledge of the Hazard

The second element looks at whether the employer or its industry recognized the condition as a hazard. Again, there is no dispute that Pembroke and the behavioral health industry both recognized the hazard of workplace violence in the context of patient on staff violence.[17] (Stips. 8-9; Resp't Br. at 1.) As for knowledge of the hazard, establishing this does not require a showing that the employer was actually aware that it was in violation of the Act. *See e.g., Peterson Bros. Steel Erection Co.*, 16 BNA OSHC 1196, 1199 (No. 90-2304, 1993), *aff'd*, 26 F.3d 573 (5th Cir. 1994). Knowledge is established if the record shows the employer knew or should have known of the conditions constituting a violation. *Peacock Eng'g Inc.*, 26 BNA OSHC 1588, 1592 (No. 11-2780, 2017).

Here, Pembroke had actual knowledge of the hazard's on-going presence at its workplace. It also knew its employees were exposed to both actual and potential incidents of workplace violence. Pembroke knew patients had the potential to become aggressive towards staff. (Resp't Br. at 1.) It trained employees about the fact that patients may be assaultive or even homicidal. (Exs. C-30, R-32.) And it knew that injuries from violence had occurred. Written employee accident reports detailing injuries from violence were provided to management. (Ex. C-3.)

[17] In addition to the stipulation, Respondents' counsel also acknowledged at the hearing that both Pembroke Hospital and the industry as a whole recognized the hazard. (Tr. 924.)

Employee injuries were discussed by management at daily meetings. (Tr. 1441-42.) An MHA explained that she repeatedly communicated safety concerns to multiple supervisors, including discussing a violent incident directly with the Director of Nursing, Claire Kent.[18] (Tr. 853.) Loss control reports provided to Pembroke's CEO routinely documented many employee injuries and noted the link between the injuries and patient aggression. (Exs. C-55 thru C-60.) Supervisors were also made aware of occurrences of the hazard through verbal reports and by witnessing assaultive behavior directly. (Tr. 559, 564, 1263, 1268, 1302-3; Exs. C-3, C-55 thru C-60, R-38, R-39, R-40.)

The Secretary established recognition and knowledge of the hazard of workplace violence present at Pembroke Hospital.

3. Serious Physical Harm

The third element of the test is also met: the cited hazard was causing or was likely to cause death or serious physical harm. A hazard is likely to cause death or serious physical harm if the likely consequence of employee exposure to the hazard would be serious physical harm. *Morrison-Knudsen Co./Yonkers Contracting Co.,* 16 BNA OSHC 1105, 1122 (No. 88-572, 1993). The Secretary offered expert testimony on this point.[19] (Tr. 919; Exs. C-66, C-99.) Dr. Robert Welch opined that at the time of the inspection the hazard of workplace violence was causing serious injury at Pembroke Hospital. (Tr. 923-24, 926.) Before reaching his conclusion, Dr. Welch

[18] This MHA (KS) was employed by Pembroke for over two years. (Tr. 792.) She left her position approximately two weeks before the hearing to work in another type of psychiatric care facility. (Tr. 792-93.) Her demeanor lent her testimony credibility. Her testimony about safety concerns related to the hazard of workplace violence at Pembroke was supported by the documentary evidence.

[19] Respondents' expert, Monica Cooke, was offered only as an expert who evaluated the suggested feasible abatement methods offered by the Secretary. (Tr. 1463.) She was not offered (or accepted) as an expert who assessed whether the hazard was causing serious physical harm.

reviewed the employee accident reports and records of OSHA recordable injuries for the two years before the Citation. (Tr. 926.) He identified thirty-two injuries attributable to patient violence over that time. *Id.* The incidents included episodes of staff being bit, concussed, head butted, spit at, and suffering hand injuries. *Id.*

Other record evidence supports Dr. Welch's conclusions. Pembroke provided training to new employees about risk management. (Tr. 519; Exs. C-3, C-30.) The training explains that Pembroke's patients may have the potential for assaultive or even homicidal behavior.[20] (Ex. C-30 at 19, 22.) Pembroke employees reported suffering physical harm as a result of patient on staff violence. (Exs. C-3, C-56, C-57, C-58; Tr. 648, 794, 810-11.) The CO reviewed Pembroke Hospital's records of OSHA recordable injuries and found that a "very substantial majority were workplace violence related." (Tr. 292.) Injuries to employees constitute at least prima facie evidence that the hazard was likely to cause death or serious injury. *See e.g., Usery v. Marquette Cement Mfg. Co*., 568 F.2d 902, 910 (2d Cir. 1977).

Pembroke's records detail five different employee injuries from violence in one month alone of the inspection period.[21] (Exs. C-3, C-56.) KS worked as an MHA on the adolescent unit on both the day and evening shifts. (Tr. 793-94.) She described multiple assaults over the nearly two-year period when she worked for Pembroke Hospital. (Tr. 792-94.) During the inspection period, on November 12, 2016, KS was injured by a patient. (Exs. C-3, C-74; Tr. 794, 803, 857.) The incident occurred on the adolescent unit on a Saturday during the evening shift. (Tr. 794, 853.) KS and another staff member tried to calm an agitated patient verbally, consistent with their

[20] Respondents risk management training does not appear to label any particular behavior as "workplace violence," but discusses "issues inherent" in the patient population and indicates that patients are to be monitored for increases in "assaultive/homicidal potential …." (Ex. C-30 at 8-9.)

[21] Five employee injury reports all dated in November 2016 refer to injuries from patient aggression. (Exs. C-3, C-60 at 2-3.) In each of these circumstances, the employee required medical attention. (Tr. 563; Ex. C-60 at 3.)

training.[22] (Tr. 795-96.) Their efforts were not successful, and the patient began throwing shampoo bottles and other objects. (Tr. 796.) The patient then proceeded to physically assault KS. *Id.* KS attempted to restrain the patient, but before she could, the patient was able to grab KS's hair. *Id.* The patient pulled with such force as to lift KS's head and remove chunks of hair. (Tr. 796, 1266.) Another employee, JQ, was also punched in the head as he tried to assist with the restraint. (Tr. 1264-65.)

Following the attack, the patient was put on 1:1 observation. (Tr. 801.) 1:1 observation is a staffing arrangement to assign a staff member to stay with a single patient. (Tr. 77-78.) This is typically done as a result of violent or self-injurious behavior and must be approved by a doctor. *Id.* However, not long after this arrangement was put into place, the order for 1:1 observation was removed. KS was concerned by this, particularly because of the severity of the incident and the fact that it was not the first time the patient exhibited violent behavior.[23] (Tr. 797-98.) She informed the nursing supervisor, Kristin Devane, of her concerns. (Tr. 814-15; Ex. C-3.) The supervisor did not dispute the concern for violent behavior but indicated there was not enough staff at the time to have the patient on 1:1 observation. (Tr. 815.)

KS completed her shift and returned to work the next day, which was a Sunday. (Tr. 803-4.) Near the end of her shift, a physical conflict developed between two groups of patients. The same patient involved with the attack against KS on the prior day acted as the "ringleader" for one of the factions. (Tr. 804.) When the staff attempted to intervene to protect the patients, the patients began to assault staff. (Tr. 804-5.) Patients kicked staff in their heads, their backs, and their legs.

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[22] AS, a former MHA at Pembroke, explained that employees were trained to verbally de-escalate patients by using conversation to engage a patient and then attempt to calm them down. (Tr. 89.)

[23] For example, about one week before her assault, KS reported to her supervisor that the same patient tried to hit her. (Tr. 798.) The patient was not placed on 1:1 observation after that incident. (Tr. 799.)

Staff members were punched, scratched, and bitten during the incident. (Tr. 805.) The incident lasted for about two hours before it was appropriately contained. (Tr. 807.)

Besides the assaults on November 12 and 13, 2016, KS described another incident which occurred on November 3, 2016. The incident involved a dispute over a music player. Many patients rely on music as a method to calm themselves. Two patients began fighting over an MP3 music player. (Tr. 809.) KS attempted to intervene to restrain the primary aggressor. *Id.* KS sustained a tear to the triangular fibrocartilage complex in her wrist. (Tr. 809, 811.) The injury required emergency treatment and eventual surgery. (Tr. 809-11.) KS still has ongoing numbness in two fingers. (Tr. 811.) Two additional employees assisted with the restraint and were also injured. (Tr. 810.) One of these employees was kicked with enough strength to knock her into the opposite wall. *Id.* The assault caused her to suffer cranial nerve damage. (Tr. 810-811.)

KS's experiences at Pembroke Hospital were not unique. Other employees also described injuries from workplace violence. AS, an MHA, indicated he was hit or kicked approximately 50 times during his four-year employment with Pembroke.[24] (Tr. 47, 56-57.) He described one instance that occurred during the inspection period. He was about to commence the required search of a newly arrived patient's belongings. (Tr. 86.) The patient became angry and pushed AS into a wall. *Id.* Another nurse recalled multiple assaults, including an incident where a patient nearly tore an employee's ear off.[25] (Tr. 217-18; Ex. C-60.)

The assaults against staff resulted in multiple employee injuries. (Tr. 805; Exs. C-3, C-68,

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[24] AS was employed by Pembroke during the inspection and left after the Citation was issued. (Tr. 47.)

[25] In addition, a former nurse at the facility, TL, indicated that in her three years at the facility serious staff injuries from assaults regularly occurred. (Tr. 651-52.) She left before the latest investigation commenced. However, her testimony is relevant to whether the recognized hazard was capable of causing serious physical harm. Although TL was terminated, her testimony had multiple indices of credibility. She explained that she had wanted to leave the position but remained on for financial and family reasons. She was forthright in her testimony, directly answering questions without a suggestion of malice or ill will toward her former employer.

C-69.) Employee injuries included concussions, bruises, scratches, and bites. (Tr. 364, 446, 448, 466-67, 805; Exs. C-3, C-60, C-68, C-69.) Some of the injuries required employees to seek care in an emergency room and some staff injuries persisted for a long time. (Tr. 805, 810-11; Exs. C-3, C-60, C-68, C-69.) While some injuries are documented in accident reports, the decision to complete an accident report was left to the employees themselves. (Tr. 1273-74.) Further, besides incidents requiring medical attention, there were many more incidents of aggression against employees.[26] (Tr. 563; Exs. C-57, C-58, C-60 at 3, C-61 at 1.) Respondents do not dispute these accounts of routine assault and injury. The Secretary established that the recognized hazard was causing serious physical harm at Pembroke.

4. Pembroke's Abatement Measures Were Inadequate

As to the fourth element, abatement, the parties agree that under *Waldon* the Secretary must show there are feasible means to eliminate or materially reduce the hazard. (Resp't Br. at 6.) However, they disagree as to what constitutes such a showing and whether the Secretary satisfied the requirements in this case.

Although the parties cobble together snippets of various cases in an attempt to create abatement tests suited to their respective positions, the Commission's decision in *Integra* sets forth a straightforward three prong test to determine whether the Secretary established that there are feasible means to materially reduce a hazard. 27 BNA OSHC at 1849-50. In *Integra*, which also involved a violation of the general duty clause due to the hazard of workplace violence, the Commission explains that the threshold question is whether the abatement actions the employer

[26] In October and November 2016, there were seven incidents of aggression for which medical attention was sought and an additional six incidents of aggression, such as hits or kicks, for which the affected employees declined to seek medical attention. (Tr. 563; Ex. C-60.) Overall, UHS DE tracked 151 incidents of aggressive behavior for the fourth quarter of 2016. (Ex. C-61.)

took are inadequate. *Id.* at n.14, quoting *U.S. Postal Serv.*, 21 BNA OSHC 1767, 1774 (No. 04-0316, 2006). If the Secretary shows that the employer's abatement is inadequate, then he must propose abatement measures which can be put into effect, i.e., show that the measures are "feasible." *Id.* at 1849-50. If the measures are feasible, then the Secretary must show the measures will materially reduce the incidence of the hazard, i.e., the Secretary must show the identified measures will be effective. *Id.*

Turning first to the abatement measures in place at the time of the inspection, Pembroke's approach to minimizing the hazard centers around training, policies, and procedures. (Resp't Br. at 24-27.) Pembroke describes its abatement methods for the hazard to include: (1) staffing, (2) written policies, (3) management commitment, (4) employee participation, (5) worksite analysis and hazard identification, (6) hazard prevention and control, (7) training, (8) program evaluation, (9) medical orders, and (10) procedures and equipment for responding to staff calls for assistance. (Resp't Br. at 2, 24-27.) Collectively, these things constitute Pembroke's Workplace Violence Prevention Program, which Respondents' argue appropriately protected staff from patient aggression. (Resp't Br. at 27.) Respondents concede that their abatement efforts did not eliminate the hazard of workplace violence. *Id.* Still, they argue the measures adequately addressed the hazard and the Secretary failed to establish otherwise. (Resp't Br. at 23.)

The Secretary finds fault with Pembroke's existing measures because of the number of workplace violence incidents that continued to occur at the facility. (Sec'y Br. at 52.) While Pembroke cites various policies as part of its Workplace Violence Prevention Program, most are brief, generic, and focus on patient care rather than protecting staff. For example, the one-page Management of Assaultive Behavior policy refers to patient arguments with other patients and visitors, but not arguments with staff. (Ex. R-10.) It calls for patients to be "monitored" for violent

behavior and changes related to "assaultive potential" are to be reported to the supervising nurse. *Id.* It does not reference to precautions staff should take. *Id.* Similarly, the one-page Patient Observation Rounds checklist has a space for nurses to check a box indicating the patient has the potential for "assaultive or destructive behavior," but does not specifically refer to staff safety risks or how to address them.[27] (Ex. R-17.)

Further, some of the measures called for by the policies were not consistently or thoroughly implemented. There was significant disconnect between the stated policies and what occurred in practice. For example, Pembroke's Seclusion and/or Restraint Use policy does not require debriefings if a workplace violence incident did not result in a patient being restrained or secluded.[28] (Ex. R-12 at 2.) Also, the assessments Pembroke did conduct after workplace violence incidents were often incomplete. (Ex. C-74.) Staffing levels were not considered relevant to the assessment of injuries. (Tr. 513-14.) Even if an employee cited insufficient staffing as a cause of an injury, such information was not included in the analysis. (Tr. 559.) Additionally, although called for by the policies, patient treatment plans were not always updated after a patient had been restrained or secluded. (Ex. R-13.) The December 2016 Massachusetts Department of Mental Health ("DMH") survey, which overlapped the OSHA inspection period, made recommendations to address shortfalls with Pembroke's debriefing practices, such as failing to adequately note triggers for violent behavior.[29] *Id.* at 10-11. So, while Pembroke indicated that it conducted root cause analyses of injuries, its program was incomplete. (Tr. 852, 854-58; Exs. C-26 at 12, R-12,

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[27] The form specifies that only nurses should complete this section of the form; not the MHAs who typically perform the Observation Rounds. (Ex. R-17.)

[28] Although Pembroke cites this document as its policy on debriefings, it indicates that Pembroke "*shall develop procedures* to ensure debriefing activities occur." (Ex. R-12 at 2 (emphasis added).)

[29] After the December 2016 regulatory visit, Pembroke indicated to the DMH that it corrected, or planned to correct, these deficiencies. (Exs. C-26, R-13.)

R-13.) *See Chevron Oil Co*., 11 BNA OSHC 1329, 1333 (No. 10799, 1983) (finding employer's abatement approach inadequate in part because of the lack of accurate measuring and monitoring of data collected through inspections).

Dr. Welch testified in support of the Secretary's view that Respondents failed to adequately abate the hazard. Dr. Welch practiced medicine as an attending psychiatrist at multiple facilities during his career and his work experience includes training staff about the management of violence in psychiatric care facilities and handling behavioral emergencies. (Ex. C-66; Tr. 915.) Also, he previously served on the Workplace Violence Committee for a healthcare system. (Ex. C-66.) Before offering his opinion at the hearing, Dr. Welch reviewed and analyzed: employee statements, an employee survey focusing on safety, notes from employee interviews, OSHA 300 logs, UHS DE loss control reports, staffing grids and 1:1 staffing information, employee accident reports, photographs of the physical layout of space at Pembroke Hospital, and DMH inspection reports and corrective action plans for the facility. (Tr. 919-20, 922-23, 1143-44.) Dr. Welch also reviewed approximately 60 articles from medical, nursing, and hospital security literature. (Tr. 921-922.) Finally, he surveyed other psychiatric facilities in the same geographic area as Pembroke Hospital to assist with the evaluation of the Secretary's proposed methods of abatement. (Tr. 920-21.)

The abatement measures in place at Pembroke Hospital were inadequate because the Secretary showed: (1) the hazard remains at Pembroke Hospital; (2) staffing was inadequate; (3) employees lacked sufficient means to summon assistance; and (4) Pembroke failed to properly implement patient de-escalation plans.

a) Hazard Remains at Pembroke Hospital

Despite clinical attempts to address patient aggression, the hazard of workplace violence

remained prevalent at Pembroke Hospital during the inspection period. All the non-management employees described multiple incidents of workplace violence and Respondents' records detail additional injuries. Dr. Welch identified "many, many reports" of Pembroke employees documenting their injuries resulting from workplace violence. (Tr. 927.) OSHA 300 and 300A forms for 2016 identified 23 recordable injuries. (Tr. 290-92, Ex. C-68.) From this self-reported information, the CO compared rates of injury at Pembroke Hospital with national averages for psychiatric hospitals.[30] (Tr. 293.) In comparing injury rates, the CO only considered injuries that resulted in lost work time, restricted duties or job transfers. (Tr. 291, 293-94.) Pembroke Hospital's injury rate was approximately two and a half times the national average for psychiatric facilities. (Tr. 293-94, 355, 927.)

Respondents point out that the existence of injuries does not establish that its abatement efforts were inadequate. (Resp't Br. at 27.) While accurate, the presence of a higher than average injury rate is relevant to assessing the sufficiency of Pembroke's program. *SeaWorld,* 748 F.3d at 1215 (existing safety procedures held inadequate where evidence showed employer's training and protocols did not prevent continued injuries). Injuries and incidents are not dispositive, but they do lend support to the Secretary's claim that the abatement methods, as implemented, were inadequate.

b) Staffing was Inadequate

One of Pembroke's abatement methods was staffing. Both experts agreed that staffing is a way to reduce the hazard of workplace violence in a behavioral health setting. (Tr. 937-40, 942-952, 959-60, 966, 980-81, 1510.) Dr. Welch explained that higher staffing levels mitigate violence

[30] Because it is based on days away, restricted duties and transfers, the rate of injury is often referred to as the DART rate. (Sec'y Br. at 7.)

and provide a safer working environment. (Tr. 946-47, 952.) He discussed peer reviewed studies that supported his view that adequate staffing reduced the hazard.[31] (Tr. 950-52, 962, 989; Exs. C-94, C-96, C-98, C-100, C-101.) Understaffing is linked to more assaults while higher staff to patient ratio resulted in fewer patients escalating to a point where they became violent and fewer patient emergencies. (Exs. C-96, C-97, C-98, C-100, C-101; Tr. 980-81.) Pembroke employees working at the site during the inspection period confirmed that, in their experience, insufficient staffing harmed worker safety. (Tr. 90, 329-31, 325-26, 666, 793.)

Dr. Welch concluded Pembroke's staffing was inadequate to manage the risk of workplace violence at Pembroke. (Tr. 939, 1067.) Most shifts at Pembroke had less staff per patient than the national averages for similar facilities. (Tr. 939, 1046-47.) Pembroke does not dispute this, but argues it follows the minimum staffing requirements set by the DMH for patient care. (Resp't Br. at 13, 26.) The DMH requirements vary with the number of patients (i.e. the census) at the facility. (Ex. C-20.) Pembroke uses a document referred to as the "grid" to determine when the census reaches a point that additional hours are needed under the DMH requirements.[32] (Ex. C-20; Tr. 371-72, 387-88, 930-33, 1316.) At a minimum, there is one nurse and one MHA for each unit. (Ex. C-20; Tr. 380.) As the census increases, additional staffing hours may be added. (Tr. 371-72, 387-88; Ex. C-20.) Each additional patient does not automatically trigger an increase in staffing. (Ex. C-20.) The grid is focused on minimum staffing levels per patient for their medical

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[31] Dr. Welch relied on several studies, including, Paul Morrison & Michael Lehane, *Staffing Levels and Seclusion Use*, 22 J. of Advanced Nursing 1193-1202 (1995) (hereafter, Lehane Study). The Lehane Study found "a highly significant difference between the levels of staffing" and the number of violent incidents requiring patient seclusion. *Id.* at 1193. Similarly, Vanya Hamrin, *et al*., *A Review of Ecological Factors Affecting Inpatient Psychiatric Unit Violence: Implications for Relational and Unit Cultural Improvements*, Issues in Mental Health Nursing, 30:214-226 (2009), also found that violence is prevented by having adequate staff to patient ratios. (Ex. C-101 at 9.)

[32] Because admissions and discharges alter the number of patients, the census is based on the average number of patients on the unit as counted at least once during a shift.

care. (Tr. 931.) In setting the minimum staffing levels, the DMH does not focus on staff safety or workplace violence. (Tr. 931-33.)

Besides the individuals "on the grid," other personnel can assist with workplace violence incidents. (Tr. 475-76.) During the day shift on weekdays, additional support staff and medical personnel are available to prevent and respond to workplace violence situations. (Tr. 475, 819, 1299.) However, not all personnel can respond to a code or request for assistance. (Tr. 1299.) At least one person must stay on each unit at all times. (Tr. 375-77, 871; Ex. R-17.) The employee assigned to conduct patient checks is limited to that task only. *Id.* Further, the number of additional potential responders is not the same on all three shifts. On the evening shift, there is a single "crisis intervention specialist" who can assist units as needed. (Tr. 871, 1233.) The Director of Nursing explained that "a lot of crises" happen on the evening shift. (Tr. 1437.) The crisis intervention specialist is not involved in direct care and tries to be "proactive" to identify problems before they become "huge issues." (Tr. 473.)

On the night shift, each staff member was responsible for the greatest number of patients. (Tr. 388; Exs. C-20, C-78.) There is no crisis intervention specialist and fewer other employees as well. (Tr. 374; Ex. C-78.) For example, by the grid, there only needs to be one nurse per adult unit unless the census for that unit exceeds twenty-three patients.[33] (Ex. C-20.) And, even when the census reaches a point that more staffing hours are required, the grid typically only requires four more hours of care, i.e., an additional employee for only half of the eight-hour shift. *Id.* After the four hours of care are provided, the employee could be sent home, even if additional admissions

[33] The adolescent unit also only has one nurse on the night shift, but its census is capped at eighteen patients. On the night shift, Pembroke added one "float" position on for the entire hospital. (Tr. 375, 730.) The DMH concluded that this was insufficient. (Ex. C-47 at 6-7.) During its four-day survey in the spring of 2016 (before the OSHA inspection commenced, the DMH noted one unit operating with 22 patients but only two employees (one nurse and one MHA). *Id.* While there was a float, that employee was also needed in another unit. *Id.*

are anticipated. (Tr. 107-8, 1316.)

As with the night shift, on weekends there were fewer employees at the hospital who could respond in the event of a workplace violence incident. There was only one doctor for all 90 patients on weekends. (Tr. 961-62.) There were fewer social workers and case managers as well. (Tr. 960-62.) Patients often were not seen by a psychiatrist, social worker, or case manager until Monday if they were admitted on the weekend. *Id.* In fact, 40% of assaults took place on weekends when there was significantly less staff on site.[34] (Tr. 960.)

The Secretary contends that Respondents failed to have sufficient staff to abate the hazard of workplace violence.[35] The evidence reveals that staffing was the overwhelming safety issue for employees and Dr. Welch agreed with employee concerns. (Tr. 306.) According to Dr. Welch, the baseline level of staffing at Pembroke Hospital was both inadequate and significantly below other hospitals he surveyed or worked in. (Tr. 939, 1067-68.) The staff to patient ratios were inadequate to successfully manage the hazard. (Tr. 1067.) Dr. Welch cited multiple occasions during the inspection period when Pembroke fell below its own minimum staffing requirements and employees reported injuries. (Tr. 942.) Studies have found that there is a higher rate of violence and aggression from patients when each staff member is responsible for a higher number of patients. (Tr. 943, 946-47; Ex. C-101.) As discussed in more detail below, the Secretary showed that Respondents' approach to staffing resulted in an insufficient number of people to

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[34] Ms. Gilmore's letters regarding her loss control visits to Pembroke Hospital also note increased episodes of aggression on weekends. (Ex. C-59.)

[35] The Secretary does not specifically allege that staffing was inadequate from a medical perspective. However, he does argue that the "unmet needs" of patients increases the likelihood of a workplace violence incident. (Sec'y Br. 37-38.) As discussed above, patients were dependent upon staff for meals, bathroom access, medication and other needs. If there was inadequate staff to respond to such needs, certain patients can become aggressive and angry. (Tr. 946-47; Ex. C-101 at 7-9.) "A recurring theme in the research was that unmet needs trigger aggression or violence." (Ex. C-101 at 9.) Pembroke's training materials on de-escalation also acknowledged this can occur. (Ex. R-32.)

accommodate medical orders for 1:1 supervision, to safely address changes in patient acuity, and to handle new patient admissions. (Sec'y Br. at 51, 54, 61.) Pembroke also failed to maintain adequate staffing levels for appropriate de-escalation and for therapeutic activities.

(1) Inadequate Staffing for 1:1 Medical Orders

Pembroke argues that one of its methods for addressing the hazard was to allow staff to seek a higher level of observation for certain patients. (Resp't Br. at 14, 27.) MHAs and nurses could request a doctor to order an MHA to be assigned directly to a particular patient. Doctors could order an MHA to stay within arm's reach of a single patient. (Tr. 78, 683; Ex. R-11 at 2.) This level of observation is referred to as a 1:1, meaning one employee for one patient. The arrangement permits focused de-escalation and prompt notification of co-workers if a patient starts to become violent. (Tr. 1040-41, 1045, 1125.) While assaultive behavior could support a 1:1 assignment, employee safety was not a specific reason for a patient to be placed on 1:1 observation.[36] (Tr. 1191; Ex. R-11 at 2.) Typically, such arrangements were called for because the patient was injuring themselves. (Tr. 479-80, 1191; Ex. R-11.)

The Secretary agrees with the importance of 1:1 assignments as a method for both reducing workplace violence incidents and reducing the likelihood such incidents cause serious injuries. (Tr. 1045-46.) He does not call for more 1:1 assignments or cite issues with Pembroke's policies addressing 1:1s. Rather, the Secretary's concern lies with how Pembroke addressed, or failed to address, the need for staff to allow the implementation of orders for 1:1s. In particular, there was not always enough staff to fill a recommendation for 1:1 staffing. (Tr. 233-36, 453-55, 657, 666, 814-15; Ex. C-78.) Nor did placing a patient on 1:1 supervision typically result in additional staff

[36] Pembroke's policy permitted "special precautions" for "Assaultive/Destructive Behavior" as well "other reasons deemed appropriate by the physician or nursing staff." (R-11 at 2.)

being assigned to the unit. (Tr. 332, 383, 453, 945-46; Ex. C-38.) Often an MHA was re-assigned from helping a group of patients on the unit to instead focus on a single patient. (Tr. 383, 388-89, 946.) This was particularly the case if more than one patient required 1:1 staffing. (Tr. 332, 383.) Ms. Kent acknowledged it was not a policy to bring an additional staff member in to cover the first 1:1 ordered on a unit. *Id.* Typically, it would be covered on the next shift, regardless of when the doctor first ordered it. *Id.* If there was a need to place a second patient on 1:1 observation due to violent behavior, Pembroke generally *did not* add additional staff. (Tr. 332, 383, 388-89; Ex. C-47.) Staff reported "tension" between management's desire to remove a patient from 1:1 observation to improve the staff to patient ratio and the belief of front-line workers that doing so was premature and could result in assaultive behavior. (Tr. 235-36, 664, 657-58.)

Even with a history of violence, 1:1 observation was not assigned until after a patient was violent towards others or engaged in serious self-injurious behavior at Pembroke Hospital. The potential for violence to employees did not result in additional staff. (Tr. 77-78, 799.) The patient had to demonstrate violence or self-injurious behavior to a sufficient degree before a doctor would order 1:1 observation. (Tr. 77-78.) If a patient previously assaulted medical professionals or others before arriving at Pembroke, that was not sufficient. *Id.* They had to exhibit violent behavior at Pembroke. *Id.*

For example, during the inspection period, a patient attempted to punch an MHA in the face. (Tr. 798.) The incident was reported to supervisors. *Id.* A week later, the same patient succeeded in assaulting the MHA. (Tr. 798-99.) Even at that point, the patient was only briefly placed on 1:1 observation for part of a shift. (Tr. 800-1.) According to the MHA, the 1:1 observation was discontinued not because anyone thought the patient no longer needed it, but

because there was no female MHA available to fill the role.[37] (Tr. 801-2.) The same patient was then involved in another violent attack against staff the following day. (Tr. 804-5.)

Pembroke understood the need for additional staff to implement1:1 assignments. In 2016, before the latest OSHA inspection commenced, the DMH identified several deficiencies in Pembroke's approach to staffing. (Ex. C-47.) The DMH found that Pembroke lacked enough staff to allow for emergency coverage.[38] *Id.* In response to the DMH's investigation, in December 2016, Pembroke submitted a Plan of Correction to the DMH that called for 1:1 assignments to be handled by additional staff, rather than by reassigning workers from providing care for all patients to caring for a single patient. (Tr. 396, 703-4; Exs. C-26, C-38, C-47.) In practice, Pembroke admits that it failed to adhere to its Plan of Correction. (Tr. 332, 736; Ex. C-38.) On multiple shifts during the inspection period, placing a second patient on 1:1 observation did not increase the number of staff members on the unit, despite Pembroke's commitment in the Plan of Correction.[39] (Exs. C-26, C-38.)

The Secretary argues that Respondents tried to conceal the number of patients on 1:1 observation to make their staff to patient ratio appear better than it was in reality.[40] (Sec'y Br. at 31.) Melissa Heron prepared staffing records for production to OSHA. (Tr. 417-19.) The staffing records initially contained the number of patients, the total number of staff, and how many employees were assigned a single patient (i.e., how many were assigned to 1:1 observations). (Tr.

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[37] Per Pembroke's "Special Precautions Guidelines" there was a preference for the assigned staff member to be of the same gender, but it was not required other than during certain time, such as for personal hygiene and toileting. (Ex. R-11.)

[38] While DMH findings relate to patient care, not employee safety, they still had the impact of notifying Respondents that its staffing levels were low.

[39] The Secretary does not allege that Pembroke's approach to 1:1 staffing would still be deficient if it had followed what was called for by the December 2016 Plan of Correction consistently during the inspection period.

[40] The undersigned notes that the DMH review of Pembroke over three days in December 2016 found that documentation about what level of precaution patients were on was not consistent. (Ex. R-13.)

419, 423-24, 887-89; Ex. C-78.) Before turning over the documents, Pembroke removed the information related to 1:1 assignments. (Tr. 417-19, 889.) By removing this information, it could appear that there was adequate staff for all patients and that the units were less acute. (Tr. 887-88, 1054-55.) This perception was corrected when before the hearing, Pembroke provided the removed information to OSHA. (Tr. 417-19, 421-22, 883-84, 887-88; Ex. C-78.) Considering the record as a whole, the Secretary did not establish the editing warranted adverse inferences.[41]

Dr. Welch concluded that Pembroke's approach to staffing was inadequate and left too few employees responsible for too many patients and tasks. The approach of not consistently adding staff when there was a doctor ordered 1:1 observation reduced the effectiveness of Pembroke's Special Precaution Guidelines, and left staff more vulnerable to the hazard.

(2) Inadequate Staffing for Acuity

Pembroke argues that it altered staffing based on a unit's acuity to address the hazard. In the context of a behavioral health hospital, the "acuity" of a unit refers to the level of activity and risk. (Tr. 1001-2.) Factors influencing the level of acuity include how many patients, staff, and visitors are present, and the condition of the patients. (Tr. 1002-3.) The higher the level of acuity within a unit, the more staff that are needed. (Tr. 576.)

In practice, employees explained that increasing staff for acuity did not consistently

[41] The Secretary also cites Pembroke's coaching of employees only to answer the questions investigators asked and to not offer information. (Tr. 113, 119, 125; Ex. C-1.) After management provided information about how it expected employees to act during investigations in writing, employees were specifically directed to destroy the instructions. (Tr. 125.) Respondents argue that the instructions were perfectly appropriate. The written instructions do not direct employees to lie or provide misinformation. (Ex. C-1.) AS acknowledged that he did not fear reprisal after speaking with OSHA. (Tr. 184.) Although the Secretary's curiosity about why Pembroke would direct employees to destroy instructions about regulatory investigations is understandable, he did not establish that the coaching practices warrant adverse inferences.

occur.[42] (Tr. 132, 307; Ex. C-22.) Dr. Welch evaluated staffing at the facility and agreed with the employees' view that Pembroke did not sufficiently staff for acuity during the inspection period.[43] (Tr. 1053-54, 1056, 1058.) Pembroke's claims about increasing staff for acuity were not supported by its records. (Tr. 1055-56.) Although Pembroke took steps to ensure that the minimum level of staffing called for by the grid was met before employees could leave, this requirement did not extend to situations where a unit's level of acuity required a higher ratio of staff per patient. (Tr. 454.) Pembroke's goal was to ensure that the base level of staffing for patient care was met, not to have enough staff for purposes of abating the hazard of workplace violence.

Even by the grid, the facility was understaffed for parts of shifts on at least three dates during the inspection period. (Tr. 942; 1443-44.) Injuries from workplace violence incidents were documented on understaffed shifts. (Tr. 942, 960; Ex. C-78.) In one instance, on November 14, 2016, one adult unit was operating for the evening shift with only one nurse and one MHA. There had been a series of assaults in the same unit during prior shifts. Just at the start of the night shift, a patient bit an employee during a restraint. As was always the case on the night shift, there was no crisis intervention specialist who could move onto the unit if the violent behavior continued and only one float employee for all the units.

Inadequate staffing harmed preventative actions and responses to violence. Both experts agreed that when staff is available to attend to patients' initial signs of agitation, verbal intervention alone can be effective at preventing physical violence. (Tr. 947, 1512.) The experts also agreed

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[42] In 2016, UHS DE conducted a staff survey of "safety culture." Several of the comments cite a need to staff appropriately for acuity. (Ex. C-22.) Although admissible, less weight is given to these survey results than the testimony of the current and former employees at the hearing. There is no information about the credibility of the persons providing the information in the survey and it is not clear what time period the survey responses relate to. *Id.*

[43] The undersigned notes that in contrast to the scope of Dr. Welch's review of staffing at Pembroke, Ms. Cooke only reviewed two days of staffing records in depth.

that having numerous potential responders in the event of behavioral health emergencies aids safety. (Tr. 947-48, 1512.) It facilitates addressing the individual whose behavior started the situation and limits the ability of other patients to take advantage of an employee's isolation or distraction during a workplace violence incident. *Id.* Dr. Welch explained that "at least five people" are required for each behavioral health emergency.[44] (Tr. 947-48, 1000.) He cited an employee accident report involving a patient who weighed 388 pounds. (Tr. 948.) A situation involving such a large patient could require as many as eight employees to ensure safety for all. *Id.* At times during the inspection period, there were only twelve MHAs for the whole facility. (Ex. C-78.)

KS, a former MHA at Pembroke, explained that she did not feel safe working at Pembroke because routinely there was not enough staff to address the unpredictability of patient behavior. (Tr. 793.) She described one situation during the inspection period that spiraled into a melee. (Tr. 794.) Even after calls for all available staff to respond, there was still not enough support. (Tr. 806, 1482-83.) The situation progressed to a point where some patients started to restrain other patients for the safety of everyone in the unit. (Tr. 794, 807, 856, 948.) KS noted that the situation would have been worse had it not occurred near the end of one shift and the start of the next. (Tr. 806.) Because of this coincidence, some people who had arrived early for their shift could assist with bringing the situation under control. *Id.* Had the incident occurred mid-shift such resources would not have been available. *Id.*

[44] Pembroke's policy Code Greens also contemplates the involvement of multiple employees. (Ex. R-9 at 3.)

(3) Inadequate Staffing for Admissions

In addition to prior violent incidents, new admissions also impact the acuity of the units.[45] (Tr. 1057-58; Exs. C-55, C-101 at 9.) When a patient arrived at Pembroke, a nurse would briefly take vital signs just inside the door to the unit. (Tr. 75.) An MHA would then bring the patient to "a very small room" on the unit.[46] *Id.* The MHA would continue the admissions process alone in the room with the patient. (Tr. 75, 81.) There were no cameras in the room and only a very small, high window.[47] (Tr. 88, 512.) The MHA's assessment included searching the patient and their belongings for contraband, i.e. items that could harm staff or patients. (Tr. 81, 837, 1181-82; Exs. R-1, R-8.) AS explained that he did not feel safe to be alone with patients at this point in the admissions process. (Tr. 81-82.) First, the patient's condition was not yet well understood. *Id.* Second, the patient and MHA are in the room alone before the contraband search is completed.[48] *Id.* Pembroke's Contraband and Restricted Articles policy notes numerous types of objects that could pose a danger to staff. (Ex. R-1.) AS explained that some patients became aggressive during the searches.[49] (Tr. 81-82.) In addition to contraband a patient may come in with, the room used for the searches also had multiple objects that could be used as projectiles. *Id.* The location and size of the room made it difficult to call for help even with a radio. (Tr. 82.) Thus, admissions

[45] A UHS DE conducted regular "loss control" visits of Pembroke Hospital and prepared summary letters after the visits. (Ex. C-55.) The December 12, 2016 letter notes an increase of "aggression episodes on weekends due to large number of admissions …." *Id.* at 2.

[46] AS indicated that the room was eight feet by eight feet in one of the units. (Tr. 82.) Some of the other units might have had slightly bigger rooms. *Id.*

[47] The window is described as about the size of "loaf of French bread." (Tr. 88.) There were no security cameras on the units, but a few offices have cameras. (Tr. 512.)

[48] Searches were also required after patients returned to the units from appointments off-site. (Ex. R-8.)

[49] Per Pembroke's policy, patients could decline the searches. (Ex. R-8.) According to the policy, the patient was to "remain in open areas unit assessed" if they declined. *Id.* The policy does not call for them to be secluded from staff. *Id.*

were one of the "scarier" parts of the job. *Id.*

After the MHA completed his or her assessment, the new patient moved to the common room where the existing patients were until it was possible to meet with a physician.[50] (Tr. 91-92, 861-62.) The wait to meet with a physician could take several hours, particularly on weekends, when only one doctor attended the hospital. (Tr. 861-62.) New patients would often become agitated or aggressive after being moved into the common room, particularly if in need of medication,.[51] (Tr. 79.)

Admissions impacted acuity in multiple respects. First, arriving patients were typically distressed and at their sickest. (Tr. 1057.) As they were not fully assessed yet, the practice of having the new patient enter the common room directly increased risk and acuity. (Tr. 1014.) Second, Pembroke did not set separate limits for the number of violent patients being admitted. (Tr. 77.) Often there were multiple admissions of patients with a history of violent behavior during a single shift. *Id.* Third, the admission process itself was very time consuming and could occupy both a nurse and an MHA for long periods. (Tr. 1058.) Admitting a patient typically required twenty to thirty minutes of time from an MHA and as much as 90 minutes for the nursing tasks. (Tr. 653-54, 837-38, 1006-7.) In general, according to the Director of Nursing, there were 6.9 admissions per day. (Tr. 1346.) But admissions, both in terms of their number and their timing, varied significantly. (Tr. 863, 1008, 1382, 1436, 1516). Pembroke's Director of Admissions explained that "every day is very different." (Tr. 1382.) Sometimes there would be as many as

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[50] It can take up to twenty-four hours before a physician completes his or her complete assessment of the patient. (Tr. 1291; Ex. R-7.) Typically, at Pembroke, a doctor sees a patient within two hours to assess their competency and conduct a brief assessment. *Id.* Patients are also seen by a social worker within three days (72 hours). (Tr. 1423; Ex. R-7.)

[51] Ms. Gilmore, the UHS DE Loss Control Manager, also noted that the lack of clinical case management for patients admitted over the weekends can increase these patients becoming upset. (Ex. C-58 at 2.)

seven admissions to a single unit during a shift. (Tr. 863.) Dr. Welch pointed to another shift during the inspection period with fourteen admissions. (Tr. 1014.) While admitting a patient, the staff member could not focus on de-escalating potentially violent patients and timely intervening to address assaultive behavior towards staff. Fourth, admissions could result in staffing levels that fell below the minimum "floor" required by the grid. (Tr. 455.) Pembroke Hospital had no staff dedicated to handling the admissions tasks. Moreover, it did not consistently staff in anticipation of admissions. (Tr. 242-43, 381-82, 455, 878-79; Ex. C-78.) Rather, the shift would often continue with the same number of employees working despite the number of admissions. (Tr. 878-79.) Additional staff would only be added for the next shift. *Id.* Fifth, when there was a high influx of patients, admission tasks had to be performed hastily and sometimes potential weapons were overlooked. (Tr. 837.) This could increase the risk of injury from workplace violence. For these reasons, Dr. Welch concluded that Respondents failed to assign enough staff for admissions and that this increased both the likelihood and potential severity of workplace violence. (Tr. 962, 1056-58.) Admissions increased the number of patients for each staff member and created additional work to assess the newly admitted patients. (Tr. 838-39, 1057-58; Ex. C-55.)

Respondents note that discharges reduce the number of patients. Discharges only occurred on the day shift when there already was additional staff who could respond to workplace violence events. In contrast, admissions occurred throughout the twenty-fours and were not evenly distributed. (Tr. 1382, 1014.) Admissions also did not automatically result in increased staff until the next shift, while discharges could result in staff being sent home mid-shift. (Tr. 107-8, 1316.) Staff reductions occurred even when new patients were anticipated but had not yet arrived. (Tr. 107-8, 838-39.) Discharges also impacted the acuity of units. The patients likely to be discharged are, by definition, the healthiest and most stable. (Tr. 1056-57.) The most stable patients were

then replaced with the newly admitted, sicker patients. (Tr. 1005, 1056-57.) The patients arriving for admission are "acutely decompensated." (Tr. 1012.) They may not yet be medicated, and Dr. Welch described it as a "very high-risk time." *Id.*

The Secretary established that Pembroke's approach to admissions was inadequate.

(4) Inadequate Staff to Verbally De-escalate Patients

Pembroke argues that its use of verbal de-escalation, which included a written policy and training, was adequate. Pembroke's Management of Aggression policy was a one-page document described by the risk manager as a review for staff about how to manage assaultive behavior. (Tr. 1186-87; Ex. R-10.) But the document does not provide guidance on how to accomplish this. (Ex. R-10.) Instead, it notes that patients will be assessed for assault risk and monitored for behavior. *Id.* Changes in behavior or events related to the potential for assaultive behavior are to be reported to the charge nurse, and such reports may alter treatment. *Id*. Staff did receive other training, including being taught a technique called Handle with Care, which the Risk Manager indicated was a method to safely intervene with patients at risk of harming themselves or others.[52] (Tr. 747, 1188, 1419-20; Ex. R-32.)

In addition to the Handle with Care training, Respondents allege that Pembroke also presents a "Workplace Violence Prevention PowerPoint" to employees and indicates that Exhibit R-32 is this presentation. (Resp't Br. at 7.) At the hearing, Mr. Quinn described Exhibit R-32, not as a Workplace Violence Prevention PowerPoint, but as the "Handle With Care with the Verbal De-escalation PowerPoint." (Tr. 1235.) He did not refer to it as workplace violence training and

[52] Pembroke's "Seclusion and/or Restraint Use" policy indicates that staff was also to be trained annually in "Handle with Care" and "Trauma Informed Care." (Ex. R-12 at 1.) Ms. Kent cited trauma informed care as being part of the initial training, but it's unclear if that was also part of the annual re-training. (Tr. 1420-21.)

his description matches what is listed on the first page of the document.[53] *Id.* Ms. Burns, Pembroke's risk manager, was not asked whether Exhibit 32 constituted Pembroke's workplace violence training. (Tr. 497.) She testified that, in general, employees were trained about workplace violence, but she did not provide such information to staff. (Tr. 1219-20.) When shown Exhibit C-31, a different collection of PowerPoint slides that uses the phrase "workplace violence," she could not confirm whether it was used at Pembroke to train employees. *Id.* So, the record does not show that employees were trained on, given, or reviewed Exhibit C-31.[54]

Dr. Welch acknowledged that almost all behavioral health hospitals use verbal de-escalation and that it is an appropriate, albeit incomplete, intervention for certain patients. (Tr. 1010.) He did not raise specific issues with Pembroke's training but explained that Pembroke's approach to handling workplace violence hazards requires enough staff so employees can promptly identify who is escalating and intervene quickly.[55] *Id.* Pembroke failed to consistently have enough staff to implement the techniques called for by its Handle With Care Program. *Id.*

So, as implemented, Pembroke's approach to verbal de-escalation was not sufficiently effective at abating the hazard. (Tr. 1010.) Training could not make up for the lack of adequate

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[53] Exhibit R-32 does not include the term "workplace violence" but does refer to violence and "dangerous behaviors." (Ex. R-32.) It states that one of the goals of the training is to "Reduce staff and patient injuries." *Id.*

[54] Respondents did not introduce Exhibit C-31 (a PowerPoint presentation discussing workplace violence) or raise it with any witness. The Secretary's counsel showed Ms. Burns Exhibit C-31 on cross examination. (Tr. 1219-20.) Ms. Burns did not use the materials herself and was unsure if the other employees who conducted training used them. *Id.*

[55] Dr. Welch also noted that verbal de-escalation can be ineffective. (Tr. 1010-1011.) For example, if the patient is already violent or if their untreated psychosis precludes rational conversation, verbal de-escalation is ineffective. *Id.* Ms. Gilmore, the Loss Control Manager for UHS DE, noted in both her October 25, 2016, and December 12, 2016 letters that while non-clinical staff can recognize escalating situations and had training on verbal de-escalation, at the time of her visit certain employees "DO NOT know how to defend themselves if attacked." (Ex. C-55 at 2 (capitalization in original); Ex. C-59 at 2 (same capitalization).)

staff to handle psychiatric emergencies.[56] (Ex. C-96 at 15.)

(5) Inadequate Staff for Therapeutic Activities

Dr. Welch explained that therapeutic group activities are effective at reducing incidents of workplace violence. (Tr. 949, 968-69; Ex. C-101.) Regularly scheduled and predictable activities promote engagement and decrease levels of acuity on the units. (Tr. 820-21, 949-50, 1061-62.) Pembroke recognized the importance of regularly scheduled therapeutic groups.[57] (Exs. C-55, C-57, C-59, R-32.) Its de-escalation training called for increasing structure as a means to control crises. (Ex. R-32 at 13.) The Handle With Care training cites schedules and programs as helpful in avoiding power struggles that can lead to violence. (Ex. R-32 at 22.) Before regulatory visits, Pembroke instructed employees to check to make sure details about groups were written, that groups occurred, and that schedule changes were noted.[58] (Ex. C-1 at 1-2, 4-5, 7-8.) Pembroke also agreed with the DMH's audit findings that the posted information about groups failed to adequately describe what groups were actually going to occur. (Exs. C-26, R-13, R-29.)

Despite this recognition of the importance of making sure groups occurred, groups were regularly canceled due to insufficient staff. (Tr. 221.) KS indicated that at least three times a week a group would be canceled. (Tr. 819.) This most frequently occurred on the evening shift, which had fewer available employees. *Id.* Still, even on the day shift, groups were routinely canceled.

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[56] The Handle with Care program also called for structure and having employees be able to provide calming modalities. (Ex. R-32.) As discussed below in addition to a lack of adequate staffing, Pembroke also fell short in implementing these aspects of the program. *Id.*

[57] Ms. Gilmore assessed whether groups were occurring and how they were functioning as part of her routine reviews of Pembroke Hospital. (Tr. 549; Exs. C-55, C-57, C-59.) Her reports discuss how groups can help patients and how not having groups as scheduled can trigger aggression. (Ex. C-59 at 2; C-57 at 2.)

[58] One witness said that she was not aware of any policies related to when groups would be canceled. (Tr. 228.) The risk manager indicated that Pembroke had an "activities therapy policy," as well as policies related "running groups" and the "staff to patient ratio" for groups. (Tr. 535.) Pembroke did not introduce any of these policies into the record.

(Tr. 50, 137.) Groups were canceled because staff was too busy with admissions or because of the need to respond to emergencies. (Tr. 138, 221, 677-78, 820.) There was not enough staff to consistently run the groups and handle the other tasks. *Id.* Groups were an "afterthought," rather than an effective means of abatement. (Tr. 677-78; Exs. C-26 at 3, R-13, R-28, R-29.)

c) Inadequate Means to Summon Assistance

Pembroke argues that staff could adequately summon additional assistance when needed to prevent or end patient on staff violence. Pembroke's units often only had three employees. (Tr. 380, 1047; Ex. C-20.) There is no debate that this was insufficient to address all workplace incidents. Staff could verbally announce a "Code Green" to seek assistance in the event of violence or if they anticipated the need for additional support. (Tr. 57; Ex. R-9.) Typically, at least one or two times a day, staff would seek assistance through the Code Green process. (Tr. 827.)

Code Greens could also be called over two-way radios (i.e., walkie talkies) if available or by using a phone that could connect to an overhead public address system.[59] (Tr. 57, 59-60.) Employees were instructed to stay with the patient even when summoning assistance. (Ex. R-9.) However, if the employee did not have a radio, they would need to access the one phone located in the middle of the unit.[60] (Tr. 59.) There was no phone in the area used for admissions. *Id.* The number of two-way radios on each unit varied but there were never more than four.[61] (Tr. 60-61,

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[59] Per Pembroke's Code Green policy, psychiatric emergencies also "should be announced using walkie talkies and the overhead paging system." (Ex. R-9.) Employees described using either a walkie or the phone system. (Tr. 57, 59-60.) Some incidents would require multiple calls for assistance.

[60] It is unclear if patients also used these phones. (Ex. R-28.) An audit by the DMH from May 2016 specifically called for more phones in at least two units. *Id.*

[61] More recently, Pembroke increased the number of radios to six per unit and implemented steps to make sure each unit had a sufficient number of working radios. (Tr. 456.) The Secretary does not argue that this revised approach was still deficient. However, the suitability of Pembroke's abatement program is assessed as of the time in the Citation.

456-57.) Staff who could not access the phone or a radio could verbally request that someone else commence the Code Green process. (Tr. 59.) There was no equipment or procedures to silently alert others of the need for assistance.

Employees discussed various issues with the radios. First, there were not enough to permit every staff member to carry one while working on the units. (Tr. 60-61, 231; Ex. C-78 at 3.) Second, the radios had reliability issues. (Tr. 60.) Problems included static, faulty batteries, and radio airwaves shared with maintenance workers. (Tr. 60, 815.) During fresh air breaks for patients, a single MHA is responsible for seven patients. (Tr. 56.) At such times, staff must rely on the radio to summon additional assistance. *Id.* A nurse described multiple occasions when she attempted to use the radio to call for a Code Green and just heard static or was not able to reach enough employees. (Tr. 221.) Sometimes staff would have to make multiple calls for help with both the radios and through the one phone on the unit in order to get enough people to respond to the situation. (Tr. 806-7.) One nurse described a situation during the inspection period that continued to escalate as attempts to get assistance were repeatedly made. (Tr. 806, 1482-83.) In short, there was both difficulty in communicating the need for help and then a lack of people who could respond. (Tr. 221, 815.)

Dr. Welch concluded that Pembroke lacked an adequate system for employees to summon assistance. (Tr. 1000.) In addition to the problems with the radios and the limited number of phones, there was also no way to silently seek assistance. Staff communications over the radios, verbal calls for assistance, and use of the unit phone could be audible to potential assailants. In contrast, panic alarms allow for discreet requests, which may help to avoid escalating a patient further. (Tr. 1049.) The Secretary established that Pembroke's approach was inadequate.

d) Failure to Properly Implement De-Escalation Plans

To help manage patient aggression and thereby reduce incidents of workplace violence, Pembroke sought information from patients about activities or interventions that successfully calmed them in the past. (Tr. 512, 1255, 1293; Exs. R-12, R-18, R-32 at 9.) This information was then used to develop crisis intervention plans for staff to follow in order to limit patient aggression. (Tr. 512-13.) Staff could augment the information from the patient based on what they observed during treatment. *Id.*

The Secretary does not dispute that Pembroke sought information for de-escalation plans and communicated the findings to staff. His contention is that the facility lacked sufficient equipment to implement one aspect of the plans. Staff were instructed as part of their verbal de-escalation training to employ the calming techniques patients identified. (Ex. R-32.) "Listening to music" is the first option listed in the "helping or comforting strategies" section of the form used for the de-escalation plans and many of the plans called for its use. (Tr. 830, 1434; Ex. R-18.) Dr. Welch and employees reported that music was effective for de-escalating aggressive patients. (Tr. 73-74, 666, 830-31, 962-63, 1064, 1245, 1293, 1306.) However, employees discussed situations where they were unable to allow patients to listen to music because there were too few devices. (Tr. 74, 667.) The insufficient number of music playing devices also led to conflicts among patients.[62] (Tr. 74-75, 809-10.) The failure to have the equipment necessary to implement the plans rendered the policy ineffective at abating the hazard. *See Chevron*, 11 BNA OSHC at 1332-33 (finding inspection program to be an inadequate method of abatement because of how it was implemented).

[62] About six months before the hearing, Pembroke had implemented a new approach that improved patient access to music for de-escalation. (Tr. 1255-56.) The Secretary's arguments are limited to the conditions observed at the time of the inspection.

e) Pembroke's Abatement was Inadequate

Pembroke's approach to staffing, summoning assistance, and implementing de-escalation plans was inadequate. While Pembroke's training program was not shown to be deficient, staff training alone is insufficient to abate the hazard.[63] Dr. Welch, supported by research, concluded that to address the hazard, workplace violence programs must include adequate staffing and the use of engineering controls such as maintaining systems to quickly summon assistance. (Tr. 986, 1000.) Despite the abatement measures implemented by Pembroke, the facility continued to experience higher than average injuries. Pembroke failed to appropriately implement the safety measures it had identified to address the hazard. *See SeaWorld,* 748 F.3d at 1206, 1215 (finding existing procedures inadequate). The Secretary established that Pembroke's program was inadequate. *Cf. U.S. Postal,* 21 BNA OSHC at 1773-74.

The general duty clause requires employers to "take all feasible steps" to protect against recognized hazards and implement every abatement measure "whenever it is recognized by safety experts as feasible, even though it is not of general usage in the industry." *Gen. Dynamics*, 599 F.2d at 464. As discussed below, the Secretary identified currently available engineering and administrative controls that can be feasibly taken and will materially reduce the hazard. *See Pelron Corp.,* 12 BNA OSHC 1833, 1836 (No. 82-388, 1986) (finding that the Secretary may establish that an employer's existing safety procedures were inadequate by demonstrating that there were "specific additional measures" required to abate the hazard).

5. Feasible Means to Abate the Hazard Exist

Despite acknowledging it recognized the hazard and arguing it has taken multiple effective

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[63] Dr. Welch cited a study that pointedly notes the lack of research supporting the effectiveness of training alone in reducing workplace violence. (Ex. C-96 at 15.)

steps to abate it, Pembroke claims the hazard is too unpredictable to be abated. (Resp't Br. at 28-29.) However, its own expert flatly refuted this contention. She explained "there are certainly methods" to reduce the risk of workplace violence. (Tr. 1508.) Dr. Welch concurred with her that there are feasible means to reduce incidents of workplace violence.[64] (Tr. 934-35.) Unpredictable events do not remove an employer's obligation to adhere to the general duty clause and address recognized hazards with feasible means of abatement. *SeaWorld,* 748 F.3d at 1207, 1215; *Armstrong*, 8 BNA OSHC at 1074 (finding the employer's contention that it should not be found in violation of the general duty clause when it could not foresee the sequence of events that led to injury to be without merit).

Respondents also criticize the nature of the Secretary's multi-prong abatement. Yet, when a workplace contains a recognized hazard that is likely to cause death or serious harm, the employer must take "all feasible steps to eliminate or materially reduce the hazard." *Armstrong,* 8 BNA OSHC at 1074, citing *Gen. Dynamics*, 599 F.2d at 464. Feasible abatement may take the form of a process rather than a single one-time action. In *Pepperidge Farm*, *Inc.,* 17 BNA OSHC 1993 (No. 89-265, 1997), the hazard could not be abated with a single action, so it was permissible for OSHA to require the employer to engage in a process approach to abatement to determine what action or combination of actions would materially reduce the hazard. 17 BNA OSHC at 2033. *See also Pegasus Tower*, 21 BNA OSHC 1190, 1191 (No. 01-0547, 2005) (finding that following a detailed compliance directive was a feasible means of abatement). Similarly, in *Integra Health*,

[64] Dr. Welch acknowledged the role of patient behavior but argued that individual patient factors should not be over-emphasized at the expense of other factors, particularly environmental or administrative factors well within the facility's control. (Tr. 973, 1010-11.) Peer reviewed literature supports his opinion. (Exs. C-95 at 2-3, C-96 at 16.)

several actions were found to be feasible methods for reducing workplace violence hazard.[65] 27 BNA OSHC at 1849-51. The Secretary does not have to prescribe an action or series of actions that address all situations where the hazard arises. Abatement may still be feasible even if it cannot be used in all situations. *See Wheeling-Pittsburgh Steel Corp.,* 10 BNA OSHC 1242, 1245 (No. 76-4807, 1981) (consolidated).

While not a process *per se*, the Secretary has set forth multiple abatement methods here.[66] He argues that each method is feasible and will materially reduce the hazard. (Sec'y Br. at n.7.) The Secretary argues that all these actions should be taken. *Id.* But, if the undersigned concludes that one or more of the methods are not feasible, the Secretary argues that each remaining method is feasible and would materially reduce the hazard. *Id.*

Several of the proposed abatement actions relate to maintaining appropriate staffing at the facility:

1. Cease efforts to interfere with the issuance of medical orders that specify required staffing arrangements.

2. Ensure that staffing is sufficient to allow the issuance and implementation of medical orders that specify staffing arrangements.

3. Maintain staffing that is adequate to safely address changes in patient acuity and new patient admissions. For example, do not decrease staffing levels mid-shift regardless of the timing of patient discharges.

4. Maintain adequate staffing to support therapeutic activity groups and recreation periods, thereby engaging patients in activities that reduce patient agitation and incidents of workplace violence.

5. Provide security staff and/or crisis intervention specialists on all three shifts to

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[65] The abatement methods proposed for the workplace violence hazard in *Integra* included: creating a written workplace violence prevention program, creating a system for reporting and tracking safety concerns, providing employees with a reliable way to summon assistance when needed, and increasing the number of staff for certain types of assignments. 27 BNA OSHC 1849-50.

[66] The Secretary divides his proposed abatement into seven paragraphs, labeled (a) through (g). (Sec'y Br. at 4.) Some of the paragraphs require more than one action. *Id.*

assist in preventing and responding to violent events.

(Sec'y Br. at 4.) Three actions focus on how and where new patients are admitted.

1. Establish a team of nurses and mental health associates (MHAs) that focuses primarily on the performance of the tasks associated with the admission and assessment of new patients. This team should not be staffed by employees who are assigned to care for already-admitted patients.

2. Dedicate a physical area, apart from all other units of the hospital, to the admission and assessment of new patients.

3. Do not allow new patients into other units until the tasks associated with admission, including clinical assessments and the provision of medical orders, are complete.

Id. The final abatement measures relate to the provision of equipment to summon assistance and implement patient crisis prevention plans:

1. Provide personal panic alarms for all employees who may work in close proximity to patients, including but not limited to nurses, MHAs, housekeeping staff, and case workers. Provide training on this equipment and ensure that the equipment is maintained in working order at all times.

2. Maintain equipment that is sufficient for the implementation of each patient's individual crisis prevention plan.

(Sec'y Br. at 4.)

Pembroke does not allege that any of these steps are technologically or economically infeasible. Notably, Respondents argue that Pembroke already complies with some of the abatement methods. Nor does Pembroke allege it lacked the authority or control to implement the proposed abatement measures. Instead, Respondents argue that the Secretary failed to provide enough detail about what constituted adequate abatement and therefore it was deprived of the fair notice of the abatement required. (Resp't Br. at 21.) In their view, besides showing fair notice of the hazard, the Secretary should also have to prove the employer knew how to materially abate the hazard before the citation was issued. (Resp't Br. at 21-23.)

Discussions of "fair notice" in Commission cases involving alleged violations of the

general duty clause typically center on the employer's notice of an obligation to address a hazard in the workplace, not on whether the employer had notice about how to abate or materially reduce a hazard. *See e.g., Otis,* 21 BNA OSHC at 2206 (discussing fair notice in the context of how the Secretary defined the hazard); *Beverly,* 19 BNA OSHC at 1163 (noting that although the complaint may not have been precise, "at the time of the hearing" the Secretary sufficiently specified the alleged hazard). Having found above that the Secretary provided sufficient notice of the hazard to satisfy the Constitution's due process clause, it is time to assess Respondents' demand that the Act requires the Secretary to show that employers had fair notice of the required abatement.

The requirement to show feasible means of abatement relates to the Commission's test for ensuring that the Act does not impose strict liability. The Commission has not articulated the abatement test in the manner Respondents seek. Under the Commission's test, the abatement prong requires the Secretary to establish the existence of feasible means to eliminate or materially reduce the hazard. *See e.g., Integra*, 27 BNA OSHC at 1849 (addressing a violation of the general duty clause for a workplace violence hazard); *Waldon*, 16 BNA OSHC at 1062 (affirming a violation of the general duty clause for a viral exposure risk at a healthcare facility). Showing feasibility requires the Secretary to put forth abatement methods that are capable of materially reducing the hazard while also being technologically and economically possible. 27 BNA OSHC at 1849-51. The Secretary does not have to show that the abatement methods would eliminate the hazard. *Arcadian Corp*., 20 BNA OSHC 2001, 2011-13 (No. 93-0628, 2004) (finding two of the Secretary's proposed methods of abatement feasible). Nor is he tasked with showing that the absence of the abatement method was the sole cause of harm. *Id*. His obligation is to show that the proposed abatement is capable of being put into place and effective. *Acme Energy Servs*., 23 BNA OSHC 2121, 2127-29 (No. 10-0108, 2012) (finding the abatement prong met because

prescribed action would materially reduce the harm, even though it would not eliminate the hazard), *aff'd*, 542 F.App'x 356 (5th Cir. 2013) (unpublished).

Respondents point to no precedent imposing an obligation on the Secretary to establish an employer's knowledge of the proposed abatement methods prior to a citation being issued. In *Chevron Oil*, the Commission concluded that the Secretary had to show that feasible means to eliminate the hazard exist. 11 BNA OSHC at 1330. It was not the Secretary's burden to show that the employer or its industry recognized the necessity for proposed safety equipment. *Id.* at 1330-31. Instead, the Act requires the Secretary to establish recognition of the hazard and that it can be materially reduced feasibly. *Id. See also Kansas Cit*y, 10 BNA OSHC at 1422 ("the recognition element of an employer's duty under the general duty clause refers to knowledge of the hazard, not recognition of the means of abatement); *Integra*, 27 BNA OSHC at 1849, 1851.

In the present matter, the employer had notice of effective methods of abatement before the Secretary issued the citation. The methodologies proposed here, while tailored for the issues identified at Pembroke Hospital during the inspection, align with the OSHA Road Map and Workplace Violence Guidelines. (Exs. C-97, C-102.) The Road Map specifically discusses administrative controls to address the hazard, including, assessing patients for violence during admission, ensuring adequate staffing on all units and shifts, and having policies and procedures that minimize stress for patients. (Ex. C-102 at 18-19.) It also discusses engineering controls such as panic buttons. *Id.*

Besides these publications, a letter sent to Pembroke prior to commencement of the investigation that lead to the instant Citation outlines similar approaches to abatement as those the Secretary now seeks. (Ex. R-37.) The letter explains that MHAs are exposed to workplace violence hazards at Pembroke Hospital. *Id.* But, as noted above, the letter states that OSHA

elected not to cite the hazard.[67] Still, the letter encourages Pembroke to act and advises that feasible and acceptable means to reduce the hazards of workplace violence at Pembroke Hospital include: (1) modifying admissions process, (2) improving responses to crises, (3) making adjustments to staffing, and (4) providing staff with personal panic alarms:

> Carefully review admissions to ensure your staff are equipped to handle acute patients who have a history of violent behavior. If an admitted patient has a known history of violent behavior from previous institutions, increase staffing levels for the unit and inform all workers of the potential of violent behavior.
>
> Conduct a workplace analysis … to find existing or potential hazards for assaults and workplace violence. This process should involve record analysis, tracking of injuries, and monitoring trends based on location, shift changes, and staffing levels.
>
> Workplace analysis should include review of personnel ability to respond to unit crisis on all shifts. Review the staffing on all shifts to ensure that it reflects the daily acuity of the patient as well [as] patient census and to ensure workers are able to work without putting themselves at risk for a violent assault.
>
> Change the present grid to increase staffing levels on the acute units and other units where attacks are occurring. Ensure that extra staff is in place when a patient's condition requires a one to one watch and when there has been a history of attacks in a unit. An increase in staff levels has the potential to decrease injuries in the workplace. … .
>
> … A silent button that is carried by staff would provide an additional and immediate way to alert staff, in the event of an escalating situation with a patient and may reduce response times. Ensure that if purchased, all employees are trained and that the panic buttons are maintained and tested according to manufacturer instructions. …

Id. The letter goes on to point Pembroke to the OSHA Workplace Violence Guidelines and indicates the facility can request a free on-site consultation to identify other feasible measures of abatement. *Id.* The letter does not provide an obligation independent of the Act to take the specific steps identified therein. *Id.* Pembroke was free to adopt different feasible abatement measures to

[67] In the year prior to this letter, Pembroke had thirteen injuries related to aggressive behavior. (Ex. R-37.) After its issuance, the number of injuries at Pembroke increased. (Tr. 292, 926; Exs. C-60, C-68, C-69.)

address recognized hazards in its workplace. *See Pepperidge Farm,* 17 BNA OSHC at 2032 (employers are free to develop solutions different than what the Secretary proposes to render their workplace "free" of recognized hazards); *Brown & Root, Inc., Power Plant Div.*, 8 BNA OSHC 2140, 2144 (No. 76-1296, 1980); *Chevron*, 11 BNA OSHC at 1334, n.16 (emphasizing that the employer could institute "other equally effective methods as long as its alternative methods achieve at least as great a reduction of the hazard").

Although the letter did not obligate Pembroke to approach the hazard the way the Secretary suggests, it also did not provide immunity from complying with the Act. When employers know existing safety standards do not adequately address hazards, they must take all feasible steps necessary to protect employees. *Int'l Union, United Auto., Aerospace & Agric. Implement Workers of Am., et al. v. Brock*, 815 F.2d 1570, 1577 (D.C. Cir. 1987). "The question is whether a precaution is recognized by safety experts as feasible, and not whether the precaution's use has become customary." *Beverly*, 19 BNA OSHC at 1191.

Pembroke did not adopt the suggested measures outlined in the letter. The number of employee injuries from the hazard increased from 2015 to 2017. (Exs. C-68, C-69.) Dr. Welch identified thirty-two employee accident reports attributable to patient on staff violence in the Pembroke records he reviewed. (Tr. 926.) The Secretary showed that Pembroke's alternative approach to abating the hazard was inadequate. So, rather than a lack of fair notice, this case represents a situation of notice of both the presence of a hazard (something Respondents do not dispute) as well as notice of feasible abatement measures.

The OSHA publications and letter to Pembroke alone do not satisfy the Secretary's burden on the abatement prong. The Secretary must show that his proposed abatement will materially reduce the hazard. To meet that obligation, the Secretary largely relies on the expert testimony of

Dr. Welch. Before offering his opinion, Dr. Welch conducted an extensive review of Pembroke documents and relevant peer reviewed literature. (Tr. 919-23, 1143-44.) He also surveyed how other similar facilities abated the hazard. *Id.* Based on his experience and research, he concluded that each abatement measure outlined in the amended citation was a feasible means by which an employer could materially reduce the hazard of workplace violence. (Tr. 923-24.) *See Arcadian*, 20 BNA OSHC at 2011 ("Feasible means of abatement are established if conscientious experts, familiar with the industry would prescribe those means and methods to eliminate or materially reduce the recognized hazard").

Respondents also offered expert testimony on the issue of abatement from Ms. Cooke. Her testimony was largely based on her experience rather than peer reviewed studies or time spent reviewing Pembroke Hospital. (Tr. 1458.) Throughout much of her testimony, Ms. Cooke failed to identify the source material for her expressed beliefs. (Tr. 1458-59.) When asked, Ms. Cooke did not identify any specific literature she reviewed before evaluating this matter. She said that she "might've (sic)" re-looked at the Workplace Violence Guidelines or the Joint Commission's Sentinel Event Alert on Preventing Violence in the Health Care Setting ("Sentinel Alert"). (Tr. 1458; Exs. C-97, C-98.) However, these publications were not identified as documents she reviewed in her opinion letter. (Tr. 1459.) Similarly, Ms. Cooke indicated that she "attempted" to look up "some of the research" relied on by Dr. Welch, but does not indicate which studies, if any, she reviewed either before issuing her opinion letter or before testifying at the hearing. (Tr. 1458.) Ms. Cooke was not sure how much time she spent on her review but "would venture to guess" it was 25-30 hours.[68] (Tr. 1461.)

[68] "About six hours" of her time was spent at Pembroke Hospital itself. (Tr. 1474.)

Ms. Cooke was offered for only limited purposes. (Tr. 1463.) She offered no opinion on whether Pembroke could have materially reduced the hazard of workplace violence. (Tr. 1461.) She was accepted as an expert who evaluated "the suggested feasible abatement methods offered by the Secretary in this case." *Id.* In contrast, Dr. Welch was asked to assess, among other things: (1) the risk of workplace violence at Pembroke, (2) the recognition of the risk of workplace violence; (3) what measures would create a material reduction in that risk; and (4) were those methods identified feasible for Pembroke to implement. (Tr. 902.) While satisfying the minimum requirements for admissibility, Ms. Cooke's testimony is given less weight than that of Dr. Welch. His opinions more fully addressed the contentions at hand and were backed by specifically identified peer reviewed literature.

a) Staffing

As discussed in the evaluation of the existing methods of abatement in place, staffing at Pembroke was deficient. Dr. Welch, supported by peer reviewed studies, testified that increasing staffing could materially reduce the risk from the hazard and that doing so was feasible. (Tr. 903, 937-38, 985; Exs. C-97, C-98, C-101.) Ms. Cooke agreed that examining staffing was relevant to the cited hazard. (Tr. 1498-99.) She acknowledged that one of the ways to reduce the risk associated with workplace violence is to both review and have "good staffing." (Tr. 1510.) She has advised hospitals that adequate staffing is important to prevent workplace violence. (Tr. 1529.) The Director of Nursing, Ms. Kent, also recognized the role extra staff can play in diffusing aggressive events. She explained that the facility experienced more crises on the evening shift and that adding an additional person was helpful to both prevent and address crises. (Tr. 1437.) The Secretary established a link between shifts with inadequate staffing and increases in the hazard. (Exs. C-3, C-78.)

The Secretary showed that it was feasible to increase staffing at Pembroke Hospital. Levels of staffing at Pembroke Hospital were objectively lower than at similar facilities in the region and nationally. (Tr. 104-5, 937-38.) For example, depending on the shift, Pembroke Hospital had approximately 15-30% fewer nurses than a similar psychiatric facility in the same state.[69] (Tr. 937.) AS, who worked both at Pembroke Hospital and another similar facility with the same sized units, explained that there was less direct care staff at Pembroke. (Tr. 105.) The other facility had more nurses per shift and no less than three MHAs per unit. *Id.* In comparison, Pembroke's units typically operated with fewer nurses and MHAs. (Tr. 105-6.) The competitor facilities in the region surveyed by Dr. Welch maintain higher levels of staffing and Respondents failed to counter his research that implementing the abatement called for by the Secretary was feasible.[70] *See Trinity Indus.,* 15 BNA OSHC 1481, 1485 (No. 88-2691, 1992) (finding in connection with a violation of a specific standard that the implementation of a safety measure at other facilities shows the action was feasible).

The Secretary proposes five methods to address the staffing deficiency. (Sec'y Br. at 4.) The proposed abatement implicitly acknowledges that there was more than one way to increase staffing at the facility. Respondents twist this flexibility to argue that the Secretary failed to establish the specific steps it must take to sufficiently reduce the hazard. In fact, the Secretary showed that Respondents failed to maintain a sufficient level of staffing: (1) to allow for increased observation of particular patients; (2) for the acuity of particular units; (3) for anticipated admissions; (4) to respond to crises, particularly on the evening and overnight shift; and (4) to

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[69] Pembroke also had more patients per doctor than other facilities surveyed by Dr. Welch. (Tr. 938.)

[70] Respondents do not contend that the facility failed to make a profit. Respondents did not introduce any information regarding the facility's finances such as budget documents. There is no evidence the facility could not afford any of the Secretary's proposed abatement measures. *See Capeway Roofing Sys., Inc.,* 20 BNA OSHC 1331, 1342-43 (No. 00-1968, 2003) (party would have produced evidence if it had been favorable).

engage patients in therapeutic group activities. The Secretary established that bringing the facility into alignment with the baseline staffing at other similar facilities was feasible and would reduce the hazard by addressing these deficiencies.

(1) Staffing for Medical Orders

The Secretary argues that Pembroke interfered with the issuance of medical orders for staffing and failed to ensure there was enough staff to implement such medical orders:

> Cease efforts to interfere with the issuance of medical orders that specify required staffing arrangements. Ensure that staffing is sufficient to allow the issuance and implementation of medical orders that specify staffing arrangements.

As noted above, when a patient is at high risk for assaultive behavior, a doctor can issue a medical order for direct observation by assigning an MHA to stay at all times within arm's reach of a patient.[71] (Tr. 378-79, 1190-91.) Pembroke considered such orders to be a "last resort" to handling patients and were used only temporarily. (Tr. 1191, 1300.) Orders for 1:1 observation are reviewed by the management team. (Tr. 1191.) The focus of these reviews is to assess whether the patient continues to need the higher level of observation.[72] *Id.*

Dr. Welch expressed his view that administrators were pressuring staff to remove patients from 1:1 observation. (Tr. 1037-38.) He explained that interference, by management, with the medical determination of whether such 1:1 observation is inappropriate and increases the risk of workplace violence. (Tr. 1038.) His opinion was based on employee statements as well as

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[71] Sometimes 1:1 observation would be limited to only those times that the patient was awake. (Tr. 379.) Patient behavior is unpredictable, and patients wake at unexpected times. In such instances, there would be an immediate need for an employee to observe the patient directly. (Tr. 379-80.) Ms. Devane indicted that in such situations the supervisor would have the float take over that patient. (Tr. 380.) However, only one person worked as a float on the overnight shift.

[72] A smaller group also assesses the need for such observation at other times, so that orders for 1:1s are reviewed approximately every eight hours. (Tr. 1191.)

testimony about management's involvement in the decisions about orders for 1:1s. (Tr. 919-24.) He was surprised that the medical decision to implement a 1:1 required notification of the CEO and opined that this practice alone could pressure employees to refrain from seeking a 1:1 even though safety concerns warranted such an arrangement. (Tr. 1004, 1006, 1038.)

An MHA explained her view that 1:1 observation was not consistently put in place when called for on the grounds of employee safety. She testified that after a patient attacked her, the patient was only briefly placed on 1:1 observation for part of the shift.[73] (Tr. 799-801.) Staff also described pressure to have just enough staff to meet the minimum requirements. (Tr. 1044.) On some shifts, there were just three employees for a unit. (Tr. 380.) If one of the MHAs was assigned to observe a single patient, the other two employees had to handle the remaining patients and tasks. *Id.* If a second patient required a 1:1, that could not always be accommodated until the next shift. *Id.* The CEO described receiving "heat" about his decisions around the number of staff per patient but asserted that his determinations about staffing were not over-ridden. (Tr. 732-33.) Still, Pembroke's approach of having the least number of employees working as possible made fulfilling staffing requests difficult, particularly during the overnight shift. (Tr. 801, 1044.) Notably, Pembroke was not able to consistently implement the Plan of Correction it submitted to the DMH which called for 1:1 assignments to be handled by adding staff. (Tr. 396, 703-4; Exs. C-38, C-47.)

Compared to other facilities, staff to patient ratios were consistently lower at Pembroke Hospital than at other stand-alone psychiatric hospitals. (Tr. 1046-47.) On average, Pembroke Hospital had less nursing staff per occupied bed as compared to national averages.[74] (Tr. 1046-

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[73] Ms. Devane explained that 1:1 observation could be intrusive for patients. (Tr. 1191.) The Secretary does not dispute this. His contention is limited to situations when 1:1 observation is clinically warranted for assaultive behavior that creates a risk of violence directed at employees.

[74] Pembroke Hospital operated shifts with 15 to 20 percent fewer nurses than other similar psychiatric facilities in the same state. (Tr. 1047.)

47.) Dr. Welch opined that it would be feasible for Pembroke to maintain a higher level of baseline staff to bring it in line with other similar facilities. *Id.* Such staffing would permit 1:1s to be put in place more quickly rather than waiting for the next shift to begin. (Tr. 1044-47.) While Ms. Cooke indicated staffing was adequate, she did not dispute or counter the evidence relied on by Dr. Welch in reaching his conclusion that increasing the level of staff would reduce the hazard.

As for the other part of this proposed abatement, the interference with medical orders concerning staffing arrangements, the record reveals that Pembroke was already abiding by this. Rather than interference with the issuance of orders for 1:1s, the issue was Pembroke's ability to staff the assignments. The Secretary established that having a greater staff to patient ratio would permit the prompt, appropriate use of 1:1 observation to materially reduce the hazard.

(2) Staffing for Acuity and New Admissions

The Secretary argues that to materially reduce the hazard, Respondents need to maintain adequate staffing to address changes in patient acuity and new patient admissions:

> Maintain staffing that is adequate to safely address changes in patient acuity and new patient admissions. For example, do not decrease staffing levels mid-shift regardless of the timing of patient discharges.

(Sec'y Br. at 4.) Dr. Welch, supported by peer reviewed literature, explained the need for appropriate staffing, particularly to handle admissions, which are a "high risk time for acuity." (Tr. 1058.) Increased admissions are associated with workplace violence incidents. (Ex. C-101.)

Respondents agree with the need to staff for acuity and admissions. Still, as discussed, Pembroke largely only met the minimum number of staffing hours per patient. There's no debate that this minimum number was not the appropriate average ratio of staff per patient for all circumstances. In other words, the DMH's view is that it is never appropriate to have less than the ratio of staff per patient called for by the grid. However, no one contends that the level of staffing

called for by the grid is always adequate to address the hazard of patient on staff violence. There is no dispute that to keep workers safe, each unit will routinely require higher staff to patient ratios to address acuity.

While the staffing records showed 1:1 assignments, there was little evidence of increased staffing to address overall acuity. Increasing the number of patients on 1:1 observation caused the remaining employees to be responsible for a higher number of patients. (Tr. 1045.) For example, on some shifts, there were just three employees for a unit. (Tr. 380.) If one of the MHAs was assigned to observe a single patient, the other two employees had to handle the remaining patients and tasks. *Id.* Ordering 1:1 observation helped to minimize risks associated with a single patient in acute distress, but it left fewer employees to monitor the rest of the patients for agitation or other signs of potential violence. (Tr. 871, 1010-11.) Each employee was responsible for more patients, making it more difficult to work on de-escalation.[75] *Id.*

Maintaining adequate staff for admissions was also a feasible abatement method which the Secretary showed would reduce the hazard. Respondents' expert, Ms. Cooke, acknowledged that new patients "really need a lot of attention and a lot of care." (Tr. 1467-68.) She described admissions as "very difficult" and "critical junctures." *Id.* In her view, they present "an opportunity for danger." (Tr. 1468.) Patients may be harmful to others during the transition into the facility. *Id.* Adequate staffing was necessary to address the potential of violence from the

[75] Dr. Welch explained that verbal de-escalation requires several people. (Tr. 966, 1010.) It requires enough staff who can both quickly identify who is escalating and then change tasks so there can be a quick intervention. *Id.* Even then, patients may not have sufficient connection with reality for verbal intervention to work. (Tr. 1010-11.) So, a program needs additional forms of abatement to be effective. (Tr. 1011.) Similarly, Mr. Quinn, the crisis intervention specialist, indicated that he can spend considerable amounts of time trying to talk to a patient to find reasonable alternatives to their violent behavior. (Tr. 1250.) However, there are six patient units and typically only one crisis intervention specialist on one shift for all the units. (Tr. 1250-53.) KS, an MHA, explained that often there were multiple agitated patients and frequently there were not enough people to de-escalate two or three agitated patients. (Tr. 871-72.)

arriving patient. Admissions also triggered the need for adequate staff to work with the already admitted patients to minimize risks and respond quickly if assaultive behavior occurred. (Tr. 947, 963, 966, 1010, 1057-58.)

Dr. Welch opined that there were simply not enough employees to prevent workplace violence incidents and minimize the consequences of such occurrences. (Tr. 963, 1031, 1047-48.) Pembroke argues it staffed for acuity and admissions but did not offer documentary evidence showing a pattern of higher staffing levels to accommodate acuity or anticipated admissions. In contrast to the management witnesses, direct care employees testified that Pembroke did not consistently staff for admissions or acuity. (Tr. 132, 839, 863, 871-72, 879.) The number of admissions varied greatly. On at least one shift during the inspection period 14 patients were admitted. (Tr. 1008.) KS recalled having seven patients admitted to one unit during a shift. (Tr. 863.) Another MHA explained that admissions took a patient to staff ratio that was "already stretched too thin" to an even lower level. (Tr. 84.)

Records reveal consistently low staffing levels, and even some occasions where the level of staff did not meet the DMH minimum requirements. (Exs. C-29, C-47, C-78.) The testimony from direct care providers about the failure to staff appropriately for admissions and acuity is credited over the management witnesses on this issue. Management employees could have offered documentary evidence to support their claims, if it was available, but chose not to do so. *See Capeway,* 20 BNA OSHC at 1342-43. Dr. Welch explained that Pembroke could feasibly maintain sufficient staffing to accommodate changes in patient acuity and new patient admissions. He noted that another similar facility maintains a much higher patient to staff ratio for newly admitted patients. (Tr. 1117-18.) The higher ratio allows more staff to safely respond to assaultive behavior as opposed to Pembroke's approach of having a single employee in an isolated room handle

searches and other tasks with the new patients. (Tr. 947, 1031, 1118.) The Secretary showed it is feasible for Pembroke to maintain staffing that is adequate to safely address changes in patient acuity and new patient admissions.

As for the second part of this abatement method, ending the practice of sending employees home mid-shift, employees explained that when the ratio of patients to staff exceeded the minimum requirement set out in the grid, an employee would be sent home before the end of his or her shift. (Tr. 109, 329, 838-39.) AS and KS both described instances where staff was sent home, and then a new admission would leave the unit short staffed for the remainder of the shift. (Tr. 109, 838-39.) According to AS, the other psychiatric facility he was familiar with did not adjust staffing downward partway through shifts.[76] (Tr. 109.) Pembroke acknowledges that this occurred and recognizes that the facility "may or may not" be able to add staff after the start of a shift if admissions increase the census to the point that additional staff is needed either by terms of the grid or because of acuity. (Tr. 382.) Dr. Welch viewed the practice of mid-shift reductions as unsafe, particularly given the low baseline level of staffing at Pembroke. (Tr. 1060-61.) The practice made it more likely that Pembroke would be left unable to respond appropriately to prevent or mitigate violent situations if admissions or the overall level of acuity changed. *Id.* Pembroke had no separate staff focused on admissions, so being understaffed when a new patient arrived, made it particularly difficult for staff to handle potentially violent patients who may be in acute distress.[77] (Tr. 1059-61.) The Secretary established that ending the practice of sending

[76] The other facility was a state-run hospital. (Tr. 103.) It has fewer units, but the unit size is the same as at Pembroke Hospital. (Tr. 103-4.)

[77] Dr. Welch also explained that when staff was tied up with admissions tasks, other patients have "unmet needs." (Tr. 1030-31.) The frustration associated with unmet needs is a well-documented pre-cursor to violent acts by patients. (Tr. 946-47, 962, 1033; Ex. C-101.) KS explained that this occurred at Pembroke Hospital. (Tr. 871-72.) There were times when the number of agitated patients exceeded the number of caregivers resulting in staff being unable to timely address patient agitation. *Id.*

employees home mid-shift was one way to increase the number of workers available to address changes in unit acuity and handle new admissions.[78]

(3) Provide security staff and/or crisis intervention specialists

The Secretary proposes security staff "and/or" crisis intervention specialists on all three shifts. (Sec'y Br. at 4.) Dr. Welch, supported by peer reviewed literature, opined that the presence of security personnel reduces the rate of assaults. (Tr. 980; Ex. C-96.) Similarly, having inadequate security is a risk factor for workplace violence. (Tr. 985, 995; Ex. C-97, C-99.)

Pembroke did not have "security" personnel. (Tr. 96.) Instead, all individuals with direct patient care responsibilities were trained in a de-escalation technique, called Handle with Care. (Tr. 1189; Exs. R-10, R-32.) Only on the evening shift did Pembroke employ a "crisis intervention specialist." (Tr. 1233.) The crisis intervention specialist is not assigned to any particular unit and does not have direct patient care tasks. (Tr. 964, 1437.) The employee rounds through the units to identify problems and address them before they escalate. *Id.* The individual is also responsible for making sure doors are appropriately locked. (Tr. 964.)

In proposing security or crisis intervention specialists for all shifts, the Secretary does not insist that Pembroke specifically designate employees as "security"—the proposal permits use of crisis intervention specialists instead. (Sec'y Br. at 4.) The abatement method calls for there to be employees without specific direct care tasks focused on safety who could immediately respond to actual or threatened incidents of violence. The Secretary argues that having such people available is feasible and would materially reduce the hazard.

Dr. Welch conceded that the crisis intervention specialist on the evening shift was effective.

[78] Ending the practice of having employees leave mid-shift was not the only way to maintain sufficient staffing to manage increases in acuity and/or admissions.

(Tr. 1009, 1051.) However, it was only one employee on one shift. The one employee was responsible for six units, including making sure multiple doors were locked and secured. (Tr. 1009.) Dr. Welch opined that there should have been enough people available on all three shifts to ensure safety and to prevent and minimize the hazard. (Tr. 1010, 1051-52.) He explained how abating the hazard required regular rounds focused on security. (Tr. 995.) And, he emphasized the importance of having staff dedicated to responding to immediate crises. (Tr. 1052, 1087.)

At Pembroke Hospital, MHAs and nurses had numerous patient care tasks, such as dispensing medications, running groups, housekeeping, and coordinating care. (Tr. 1087.) Many tasks could not be instantly stopped to permit the person to respond to a call for assistance. *Id.* In addition, MHAs were responsible for routinely taking patients off units for fresh air breaks and meals in the cafeteria. (Tr. 55-56, 863.) When conducting such tasks, MHAs could not leave patients alone to respond to requests for assistance. (Tr. 863, 949.)

Dr. Welch also explained that some staff did not feel physically capable of managing very large, violent patients --- particularly on their own. (Tr. 1087.) In his view, Pembroke needed employees physically capable of assisting with restraining large patients and who were focused on safety as opposed to other tasks. (Tr. 1087, 1093-94.) The single person in the role of crisis intervention specialist on one shift was not adequate for the degree of patient aggression and the number of workplace violence incidents. (Tr. 1051.) Dr. Welch opined that other behavioral health facilities were able to have staff dedicated primarily to safety and opined that Pembroke could feasibly do the same. (Tr. 1053.)

While Ms. Cooke had concerns with maintaining a security staff, she acknowledged the value of having additional staff available to respond to crises and manage situations. (Tr. 1492, 1495-96.) She noted that managing patient behavior is particularly difficult on the evening shift.

(Tr. 1496.) However, in her view, having only one person on the evening shift as a crisis intervention specialist was not problematic. As for the lack of someone in such a role on the night and day shift, Ms. Cooke cited the float position at night and the availability of other staff during the day. (Tr. 1478.) However, the float could be assigned patient care tasks, including a 1:1 assignment that would prevent him/her from being available to respond to a crisis. (Tr. 374-75, 379, 1437, 1478.)

Importantly, Ms. Cooke did not dispute Dr. Welch's opinion that having staff focused on security was feasible. She did not specifically review the studies relied on by Dr. Welch in reaching his conclusions. (Tr. 1518.) Also, she admitted awareness of other facilities that had building security. (Tr. 1493-94.) In particular, she acknowledged being familiar with facilities that have security respond to a code, such as to "be manpower" and "help restrain" patients or de-escalate situations.[79] (Tr. 1492-93.) Ms. Cooke did not address the two concerns with Pembroke's approach cited by Dr. Welch: (1) the lack of anyone assigned only to safety on the day and night shifts; and (2) the lack of physical capabilities of some of the individuals tasked with controlling violent patients. Additionally, her testimony failed to rebut the Secretary's evidence of feasibility and effectiveness. Altogether, Ms. Cooke's testimony did not rebut the Secretary's evidence that having security staff "and/or" crisis intervention specialists on all three shifts was feasible and would materially reduce the hazard.

(4) Staffing for Therapeutic Activity Groups and Recreation Periods

The Secretary proposes that Pembroke maintain sufficient staffing for "therapeutic activity

[79] Pembroke's Code Green policy directed employees to contact 911 for "psychiatric emergencies or as deemed appropriate." (Ex. R-9 at 3-4.) Ms. Cooke argued that uniformed personnel could increase a patient's agitation but did not discuss Pembroke's policy of contacting outside emergency responders for psychiatric emergencies. (Tr. 1495.)

groups and recreation periods." (Sec'y Br. at 4.) Dr. Welch, supported by peer reviewed literature, explained that canceling therapeutic activities can increase the level of acuity for the unit. (Tr. 969-70; Ex. C-101.) Boredom and insufficient activities are also precipitants for violence. (Tr. 967-68, Ex. C-101.) Structured organized activities, along with the reliability and predictability of their occurrence promotes positive engagement and reduces acuity. (Tr. 820-21, 949-50, 1062.) Conversely, unmet needs can trigger violence. (Tr. 946-47, 949-50, 960, 1030; Ex. C-101 at 9.) If an MHA can engage some patients in an activity, this frees staff to better intervene with sicker patients. (Tr. 970.) Dr. Welch, informed by the employee statements, noted that the lack of activities was particularly detrimental for the adolescent units. *Id.* Teenagers "tend to be very stimulus prone" and failing to engage them consistently can lead to adverse consequences such as agitation. (Tr. 965, 970-71.) Engaging patients in therapeutic group activities and recreation reduces patient agitation and incidents of workplace violence, making it an effective method to materially reduce the hazard.[80] (Tr. 967-68, Ex. C-101.)

As discussed, therapeutic groups were routinely canceled due to inadequate staffing. (Tr. 819-20.) Dr. Welch explained that increased staffing would allow therapeutic group activities to occur consistently as scheduled. (Tr. 1062-63.) He noted that another similar facility has a dedicated staff for conducting therapeutic group activities. (Tr. 1063.) Because the employees running the groups have no direct care responsibilities, the need to handle admissions or emergencies did not result in therapeutic activities being canceled. *Id.* Ms. Cooke recognized that group activities were regularly canceled but alleged that the number of cancellations was not "an

[80] The proposed abatement calls for both group activities and recreation periods. (Sec'y Br. at 4.) MHAs took patients off the units for fresh air breaks. (Tr. 55-56.) The Secretary failed to show that the few times during the inspection period when these breaks did not occur materially contributed to the hazard. Pembroke appeared to have sufficiently implemented the need for fresh air breaks.

overabundance." (Tr. 1503.) She did not refute Dr. Welch's view that therapeutic groups materially reduce the hazard. Nor did she address whether Pembroke could maintain a higher staff to patient ratio to ensure groups more consistently occurred as scheduled. The Secretary established that it was feasible to maintain a higher level of staffing which would reduce the frequency with which groups were canceled. The Secretary also established that maintaining therapeutic group activities would materially reduce the hazard.

b) Change how admissions occur

The next proposed abatement method is to have an admissions area separate from the on-going care units for admissions and requiring that new patients remain in the separate area until all clinical assessments are complete. Specifically, the Secretary proposes that Pembroke:

1. Establish a team of nurses and mental health associates (MHAs) that focuses primarily on the performance of the tasks associated with the admission and assessment of new patients. This team should not be staffed by employees who are assigned to care for already-admitted patients.

2. Dedicate a physical area, apart from all other units of the hospital, to the admission and assessment of new patients.

3. Do not allow new patients into other units until the tasks associated with admission, including clinical assessments and the provision of medical orders, are complete.

(Sec'y Br. at 4.) The first method calls for an admissions team focused solely on the tasks associated with admitting new patients. The Secretary showed there was an overall need for additional staff at the facility to reduce the cited hazard. (Tr. 1058.) Carefully screening newly admitted patients was critical to addressing the hazard. The initial assessments looked at the patients' history of violent behavior and sought information on how patients could be de-escalated. (Exs. R-1, R-9.) As part of this assessment, MHAs searched patient belongings to identify materials that could harm staff. *Id.* Most of the admissions process took place in a small room

with the MHA alone with the patient even before the belongings search was completed. (Tr. 81.) The room had no phone to commence a Code Green and even with a radio it was difficult to call for help from the room. (Tr. 82.)

The record reveals that admissions tasks are time consuming and that there is an increased risk for an employee to experience violence during this time. (Tr. 1006-7, 1011-13.) The overall level of staffing was often too low to handle the acuity of existing patients and more than a few admissions. Admissions took time away from existing patients and sometimes introduced an acute patient into the unit population before he/she had adequate medication. (Tr. 1030-31.)

In those instances where there was enough staff to adequately handle the admissions tasks and care for existing patients, the Secretary did not adequately explain how precluding employees who handle admissions from other care responsibilities would materially reduce the hazard. In other words, the Secretary showed that Pembroke failed to maintain adequate staffing levels but he did not show how implementing the additional abatement method of precluding admissions staff from having other care responsibilities would materially reduce the hazard if staffing was already adequate to handle admissions. Unlike other facilities, Pembroke Hospital does not accept "walk-ins," i.e. patients that have not yet been assessed by someone outside of the facility. (Ex. R-9.) The information obtained during these pre-admissions calls is often incomplete. Still, the facility had some information about the patients and sometimes the patients were stabilized before their arrival at Pembroke.[81] (Tr. 1468-69; Ex. R-9.) Dr. Welch indicated that admissions could

[81] When Ms. Cooke was discussing admissions, she was not always clear about whether she was describing the situation at Pembroke or her experience at other facilities. (Tr. 1469.) For example, she indicated that at "most" in-patient facilities she was aware of, or worked act, they would not accept "highly psychiatrically unstable" patients. (Tr. 1468.) She did not clarify whether that was true of Pembroke. (Tr. 1468-69.) Further, when describing the threats associated with newly admitted patients, she said that "we mitigate the risk." (Tr. 1468.) When asked by counsel whether she meant "Pembroke" when she used the term "we," Ms. Cooke explained that she meant Pembroke or was using the term "we" in the sense of the "behavioral health world." (Tr. 1469.)

take as many as twenty-two hours of nursing time per day. (Tr. 1008.) On average, however, much less time was necessary for admissions at Pembroke. To reach twenty-two hours of nursing time, there would have to be fifteen admissions, and each would have to take ninety minutes. (Tr. 1008.) While some admissions took the full ninety minutes and sometimes there were many admissions, the record indicates that in 2016, on average, Pembroke had approximately seven admissions per day. (Tr. 1436.)

Regarding the admission and assessment of new patients in a dedicated physical area, Dr. Welch opined that a separate admissions unit would materially reduce the risk of workplace violence. (Tr. 1028-30.) In his view, the existing spaces on the units used for some of the admissions tasks were unsafe because they were isolated and small. (Tr. 1031.) Further, patients went directly from the small rooms into the common area with existing patients. (Tr. 1033.) The newly admitted patients find themselves in uncertain situations, may be frustrated, and could lack proper medication. (Tr. 1032-34.) Dr. Welch explained that Pembroke's approach creates a "destabilizing situation." (Tr. 1034.) AS and KS also asserted that a separate unit would be helpful to abate the hazard. (Tr. 83-84, 861-65.) AS explained that while a separate unit would not change patient behavior it would eliminate "a big risk factor" in terms of the new patient interacting with existing patients. (Tr. 164.) Similarly, Ms. Wollner, the Director of Admissions, acknowledged that a separate admissions unit would reduce the burden on the units. (Tr. 1386-87.)

In terms of technical feasibility, the facility had space apart from the units that could be used for admissions. (Tr. 93, 1034.) Other similar facilities also had dedicated admissions areas. (Tr. 104-5.) Dr. Welch discussed other similar facilities at which the assessment, evaluation, and medication of new patients occur in dedicated areas apart from where existing patients are located. (Tr. 936, 1027, 1031-32, 1034, 1101.) The Secretary presented evidence that it was

technologically feasible to dedicate a physical area apart from the other units to handle assessments before patients are moved into the treatment units.

However, the Secretary falls short on persuading how moving admissions from the units to this separate area would materially reduce the hazard if Pembroke was adequately staffed to handle such admissions and addressed the difficulties with summoning assistance. Again, the Secretary showed that Pembroke failed to consistently staff in anticipation of admissions and addressing this deficiency would materially reduce the hazard. Rather than being a separate abatement method, the proposal to have a separate admissions area appears to be one approach to handling the inadequate staffing and insufficient means to summon assistance. In other words, if Pembroke had enough employees on the units and employees could quickly summon assistance, then a separate admissions unit might not be necessary to further reduce the hazard. *See Cerro Metal Prods. Div.* 12 BNA OSHC 1821, 1822-23 (No. 78-5159, 1986) (noting that the abatement actions must be "necessary and valuable").

As for Pembroke's practice of allowing new patients into the units before all assessments and the provision of medical orders are complete, the evidence reveals that this increased acuity and created workplace violence risks. The evidence of record also reveals that increasing staff to appropriately address acuity and 1:1 assignments would materially reduce the risk. The Secretary established that waiting to integrate new patients into the units was one way to handle the acuity new admissions bring. However, if the facility had adequate staff and means to summon assistance it is not clear that segregating the patients would further reduce the hazard. *See Cerro,* 12 BNA OSHC at 1822-23.

The Secretary proved that establishing a team of nurses and MHAs focused primarily on the performance of the tasks associated with the admission and assessment of new patients, was

feasible and would materially reduce the hazard. He failed to show that if the other identified abatement was in place, (1) that the employees on this team could not have any other responsibilities; (2) that admissions had to occur in an area apart from all other units of Pembroke Hospital, or (3) that patients had to remain segregated until all of the tasks associated with admission were complete.

c) Equipment

Finally, the Secretary calls for two types of equipment: personal panic alarms and equipment to implement patient crisis prevention plans. (Sec'y Br. at 4.)

(1) Personal Panic Alarms

The Secretary proposes that Pembroke provide "personal panic alarms for all employees who may work in close proximity to patients, including but not limited to nurses, MHAs, housekeeping staff, and case workers." *Id.* Pembroke's approach to summoning help in the event of a workplace violence incident was ineffective. JS, a nurse, discussed her experience with personal panic alarms at two other behavioral health hospitals. (Tr. 241.) She found them to be an effective way to seek immediate assistance. (Tr. 241-42.) Dr. Welch explained that personal panic alarms are more effective at summoning assistance than Pembroke's current approach, and that providing them would reduce the likelihood of staff members becoming victims of workplace violence. (Tr. 937, 974-75.) Unlike radios and the overhead paging system, panic alarms allow for discreet requests during emergencies. (Tr. 1049.) Dr. Welch relied on studies which found that access to panic alarms correlated with significantly lower rates of assault against staff in a healthcare setting. (Tr. 972-74, 995, Ex. C-95 at 3-10, C-96.) Workers without access to such equipment were victims of workplace violence more often. (Ex. C-95 at 10.) Regarding feasibility, other similar facilities provide personal panic alarms and literature discusses their

successful use in healthcare settings.[82] (Tr. 974, 1049; Ex. C-95.)

Ms. Cooke argued that there was no evidence to support the efficacy of panic alarms in reducing risk. (Tr. 1481.) It is unclear if she reviewed the studies Dr. Welch cited in reaching his conclusion that panic alarms are effective at materially reducing the hazard. (Tr. 1458.) She only indicated that she "might've (sic)" re-looked at the Sentinel Alert. *Id.* The Sentinel Alert describes physical and verbal violence against health care workers. (Ex. C-99 at 1-2.) It cites, among other things, lack of access to emergency communication such as a "call bell" as a contributing factor to violence against healthcare workers.[83] (Ex. C-99 at 3, 6.) Ms. Cooke acknowledged there were times when panic alarms may be easier, but said they were not "standard." (Tr. 1485-86, 1521.)

The general duty clause requires employers to "take all feasible steps" to protect against recognized hazards. *Gen. Dynamics*, 599 F.2d at 464. Employers must implement abatement measures safety experts agree are feasible even if they are "not of general usage in the industry." 599 F.2d at 464. *See also Beverly*, 19 BNA OSHC at 1191 (finding abatement measures may be required even if the practice is not yet customary in the industry). Ms. Cooke did not testify that panic alarms were technologically or economically infeasible and agreed they may be an easier way to obtain assistance with a violent patient. (Tr. 1483.) No witness testified they were too expensive or would not work at Pembroke for technological reasons. Ms. Cooke's testimony does not refute the evidence establishing that personal panic alarms would materially reduce the hazard and constitute a feasible means of abatement.

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[82] One peer reviewed study Dr. Welch relied on, Simha F. Landau, *Personnel Exposure to Violence in Hospital Emergency Wards: A Routine Activity Approach*, 34 Aggressive Behavior 88, 91 (2008), described access to an "emergency button" as a "widely used" and "important physical protective device." (Ex. C-95.)

[83] The Sentinel Alert was issued after the inspection occurred and was not considered as evidence of Respondents' knowledge of the hazard. (Ex. C-99.) However, it was reviewed by Dr. Welch and possibly by Ms. Cooke to assess the feasibility of the proposed abatement.

The Secretary's burden is to establish that the abatement in place, a limited number of unreliable radios, was ineffective and that this issue could be addressed feasibly. *Integra*, 27 BNA OSHC at 1849; *Armstrong,* 8 BNA OSHC at 1073-74 (upholding a violation of the general duty clause when the employer failed to maintain an abatement measure it implemented). Dr. Welch's opinion that personal panic alarms are feasible and effective at reducing the likelihood a worker would be injured by the hazard was well supported by the testimony of other witnesses and numerous studies. (Tr. 241, 309-10; Exs. C-95, C-96, C-99.) The Secretary established that personal panic alarms are a feasible and effective means to abate the hazard by making it easier for additional people to respond to violent incidents or threats of violence.

(2) Equipment for Crisis Intervention Plans

The final abatement method proposed calls for Pembroke to "maintain equipment that is sufficient for the implementation of each patient's crisis prevention plan." (Sec'y Br. at 4.) Pembroke asks patients to complete forms about what helps to calm them down and what helps them to cope with situations. (Tr. 512, 1423, 1432, 1439; Ex. R-18.) Some patients decline to complete it. (Tr. 512, 1432.) However, staff can add information to the plans even if a patient does not provide any. (Tr. 512-13, 1249, 1431-32.) The plans assist staff with knowing how to deescalate a patient who becomes aggressive. (Tr. 512-13, 1432.) Most of the plans call for the use of music to de-escalate patients. (Tr. 73, 830, 1434.)

Dr. Welch opined that having music playing equipment would significantly reduce the risk of workplace violence and indicated that the equipment necessary for patients to have access to music could be affordably obtained. (Tr. 1064.) He explained that patients most often cite music as a calming technique, and he had seen it work effectively. (Tr. 962.) Dr. Welch asserted that providing access to calming modalities would decrease the hazard. (Tr. 1064-65.) In his

experience, the headsets for playing music could be affordably maintained to allow them to be given out by request, rather than having waiting lists as was the case at Pembroke during the inspection period. (Tr. 963.) Employees agreed that providing music worked effectively at Pembroke to soothe and calm aggressive patients. (Tr. 73-74, 666, 831.) A nurse considered it a great help in handling patients who were distressed or agitated. (Tr. 666.) Ms. Cooke did not dispute the evidence regarding the usefulness of crisis prevention plans or providing music when patients indicate it has helped calm them in the past. Rather, her testimony revealed that she was unaware of any studies that proposed a specific number of devices based on the patient count. (Tr. 1505-6.) The Secretary established that being able to implement patient crisis prevention plans by providing music to calm distressed patients would materially reduce the hazard.

As for technical feasibility of implementing the abatement, by the time of the hearing, Pembroke had improved the ability of caregivers to routinely provide music consistent with de-escalation plans. Fed. R. Evid. 407 (evidence of subsequent remedial measures may be admitted to show "the feasibility of precautionary measures"); *SeaWorld*, 748 F.3d at 1215. Accordingly, there is no dispute that providing music as part of implementing patient crisis prevention plans was technologically and economically feasible.[84]

IV. Relationship of UHS DE and Pembroke

The Secretary contends that despite being separate corporate entities, UHS DE and Pembroke should be treated as a single employer of the workers exposed to the hazard. Related employers are treated as a single entity when "they share a common worksite, have interrelated

[84] To the extent that the proposed abatement could be interpreted as requiring other types of equipment, the Secretary failed to sufficiently identify such equipment or establish how it would materially abate the hazard.

and integrated operations, and share a common president, management, supervision, or ownership."[85] *Loretto-Oswego Residential Health Care Facility*, 23 BNA OSHC 1356, 1359 (No. 02-1174, 2011) *aff'd*, 692 F.3d 65 (2d Cir. 2012); *C.T. Taylor Co*., 20 BNA OSHC 1083, 1086 (No. 94-3241, 2003) (consolidated); *Trinity Indus., Inc*., 9 BNA OSHC 1515, 1518 (No. 77-3909, 1981). The Secretary fails to satisfy these criteria.

Pembroke and UHS DE have different worksites: UHS DE operates out of Pennsylvania, while Pembroke operates in Massachusetts. (Tr. 724.) As the First Circuit explained in *A.C. Castle*, the common worksite element requires consideration of the location of where the employees work and are exposed to the hazard. 882 F.3d at 42. The Secretary does not allege that any UHS DE employees were exposed to the cited hazard. Nor does he allege that employees were exposed to the hazard of workplace violence at locations other than Pembroke Hospital. The record is clear that UHS DE and Pembroke have different business addresses and there is no allegation of workplace hazards at both locations.

With regard to operations, Gary Gilberti, the Senior Vice President in the Behavioral Health Division for UHS DE, testified that UHS DE and Pembroke were related, but distinct businesses. (Tr. 724.) Pembroke provides direct patient care, while UHS DE is a management and consulting business. *Id.* Pembroke primarily develops and sets its own budgets.[86] (Tr. 643-44, 1326.) *See Loretto-Oswego*, 23 BNA OSHC at 1359 (finding healthcare facility and management company were not a single employer). There is no evidence that Pembroke lacked sufficient capital or other resources to address worker health and safety.

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[85] The parties agree that this is the appropriate test to assess whether two legal entities functioned as a single employer. (Am. Pre-Hr'g Stmt. at 16; Resp't Br. at 6.)

[86] Respondents assert that Pembroke set its own budget. (Resp't Br. at 42.) However, Ms. Gilmore, a UHS DE employee testified that she handled the workers' compensation budget for Pembroke Hospital. (Tr. 550; Stip. 10.)

As for personnel, Pembroke Hospital's CEO (Dr. Hickey) was employed by UHS DE. (Tr. 695; Stips. 10-11.) Other UHS DE employees routinely visited the Pembroke Hospital but did not provide daily oversight of Pembroke Hospital. (Tr. 533-34.) UHS DE had its own management structure with a separate CEO, chief financial officer, and management group. (Tr. 741.) Dr. Hickey had no managerial duties for UHS DE. (Tr. 741.) *Cf. C.T. Taylor*, 20 BNA OSHC at 1085 (finding two entities to be a single employer when both companies were owned and controlled by the same person and operated from the same office). The Secretary failed to establish that UHS DE and Pembroke operate as a single entity. Accordingly, the finding of a violation and assessment of a penalty are against UHS of Westwood Pembroke only. The Secretary's allegation against UHS DE is DISMISSED.

V. Repeat Characterization

Respondents argue that if UHS DE and Pembroke are not a single employer, then the citation cannot be characterized as repeat. (Resp't Br. at 42.) This misconstrues the record evidence of Respondents' own corporate structure. The Secretary does not rely on a citation issued to UHS DE to support the repeat characterization. Instead, he relies on one issued to Pembroke itself. (Exs. C-14 thru C-17.)

A violation is repeated if the same employer was previously cited for a substantially similar violation. *Potlach Corp.,* 7 BNA OSHC 1061, 1063 (No. 16183, 1979); *Lake Erie Constr. Co.*, 21 BNA OSHC 1285, 1289 (No. 02-0520, 2005) (similarity of hazards is a "principle factor" in assessing the appropriateness of a repeat characterization). A violation of the general duty clause may be "found to be repeated on the basis of either a prior section 5(a)(1) or section 5(a)(2) violation." 7 BNA OSHC at 1064. When relying on previous general duty citation, the Secretary must show substantial similarity based on the circumstances surrounding the hazard. *GEM Indus.,*

Inc., 17 BNA OSHC 1861, 1865-66 (No. 93-1122, 1996) (declining to rely on a previous 5(a)(1) citation to support characterizing a subsequent violation of a specific standard as repeat) *aff'd*, 149 F.3d 1183 (6th Cir. 1998).

The Secretary argues that the hazard cited in 2016 at Pembroke's Lowell Treatment Center and the one cited in 2017 at Pembroke Hospital are substantially similar. (Sec'y Br. at 74.) But, the Secretary failed to offer enough information about the circumstances surrounding the cited hazard at Lowell Treatment Center. The limited information in the record reveals only that the cited workplaces had significant differences related to the hazard. For example, while the Secretary proposed some similar abatement measures, others were notably different. (Ex. G-14.) The undersigned finds that while the hazards appear to share some commonality the record does not establish that the two violations are sufficiently similar to support a repeat characterization. *GEM*, 17 BNA OSHC at 1866 (declining to conclude that two violations were substantially similar even though both involved fall hazards).

The Secretary has met his burden to establish, by a preponderance of the evidence, that UHS of Westwood Pembroke violated 29 U.S.C. § 654(a)(1) of the Act and such violation was "serious" rather than "repeat".

VI. Penalty

"Section 17(j) of the Act, 29 U.S.C. § 666(j), requires that when assessing penalties, the Commission must give due consideration to four criteria: the size of the employer's business, the gravity of the violation, the employer's good faith, and any prior history of violations." *Hern Iron Works, Inc.*, 16 BNA OSHC 1619, 1624 (No. 88-1962, 1994). When determining gravity, the Commission considers the number of exposed employees, the duration of their exposure, whether precautions could have been taken against injury, and the likelihood of injury. *Capform, Inc.*, 19

BNA OSHC 1374, 1378 (No. 99-0322, 2001), *aff'd*, 34 F.App'x 85 (5th Cir. 2000 (unpublished). Gravity is typically the most important factor for determining the penalty. *Id.*

When initially issued, the Citation included a proposed penalty of $12,675. In the Amended Complaint, the Secretary increased the proposed penalty to $25,350. This amount could only be imposed if the violation was characterized as repeat rather than serious. Under the Act, as amended by the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015, Public Law 114-74, sec. 701, the maximum penalty for a violation cited in 2017 and characterized as "serious" was $12,675.00.

Having considered the four factors, the undersigned finds that a penalty of $12,675 is appropriate. The hazard caused serious injury and was capable of causing death. Many employees were exposed to the hazard, with several suffering serious injuries. (Ex. C-60.) There is no evidence that Pembroke is a small employer. While it took some steps to mitigate the hazard, it failed to implement feasible abatement measures even after they were identified. In terms of history, it was previously cited for a violation related to workplace violence. (Ex. G-14.) Although the prior citation is not enough to support a repeat characterization, it is relevant to the evaluation of Pembroke's history.

As to good faith, as noted above, employees felt pressure to be less than forthcoming with investigators. (Ex. C-1; Tr. 883-84, 886-89.) Also, it is worth noting that MHAs were provided with a "cheat sheet" on how to communicate with regulators and then told to destroy it after reviewing it. (Tr. 125-26.) However, there is no evidence of actual obstruction. The MHA AS explained that they were to be direct and honest with surveyors, including OSHA. (Tr. 181-82.) Further, Respondents had a safety program and, as noted, had taken steps to minimize the hazard.

On this record, neither an increase nor a decrease for good faith is warranted.[87]

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The foregoing constitutes the findings of fact and conclusions of law in accordance with Rule 52(a) of the Federal Rules of Civil Procedure.

ORDER

Based upon the foregoing findings of fact and conclusions of law, it is ORDERED that:

Citation 1, Item 1 for a violation of section 5(a)(1) of the Act is AFFIRMED as SERIOUS, and a penalty of $12,675 is ASSESSED against UHS of Westwood Pembroke.

SO ORDERED.

/s/
Keith E. Bell
Administrative Law Judge, OSHRC

Dated: February 19, 2020
Washington, D.C.

[87] Respondents limit their argument on the penalty amount to asserting that if the violation is affirmed it should not be characterized as repeat. (Resp't Br. at 43.)