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 DELAWARE, INC. and PREMIER BEHAVIORAL HEALTH SOLUTIONS OF FLORIDA, INC. d/b/a SUNCOAST BEHAVIORAL HEALTH CENTER, Respondents.	OSHRC DOCKET NO. 18-0731

Appearances:

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Before: Dennis L. Phillips, Administrative Law Judge

DECISION AND ORDER

After receiving a complaint about workplace violence at an inpatient psychiatric hospital in Bradenton, Florida, the Occupational Safety and Health Administration ("OSHA") sought additional

information from Suncoast Behavioral Health Center ("Suncoast").[1] (Ex. 4; Tr. 99-100, 315, 346, 353, 517-20.) In its October 25, 2017 ("NOI"), OSHA advised Suncoast about alleged employee exposure to the hazard of workplace violence and its possible failure to ensure the adequate protection of employees in possible violation of the Occupational Safety and Health Act of 1970, 29 U.S.C. §§ 651-678 (the "OSH Act"). *Id.*

Adam Curl, Suncoast's Director of Risk Management and Director of Performance Improvement, responded to the NOI via email on November 1, 2017, the deadline indicated in the NOI.[2] (Tr. 2539, 2606-07; Exs. 4-6.) OSHA evaluated the response and determined that Compliance Officer ("CO") Lizbeth Trouche[3] should conduct an on-site inspection to gather additional information. (Tr. 91, 102-4; Exs. 5-6.) The CO visited the facility, located at 4480 51st Street West in Bradenton, Florida, several times between November 2017 and April 2018.[4] (Tr. 91, 104, 128-29; Ex. 9; Stip. 2.)

At the close of OSHA's investigation, on April 24, 2018, a Citation was issued to Suncoast and UHS of Delaware Inc. ("UHS-DE") (collectively with Suncoast, "Respondents"). (Ex. 1.) The Citation alleges a repeat violation of 29 U.S.C. § 654(a)(1), the provision commonly referred to as the general duty clause, for failing to furnish a place of employment free from the recognized hazard of workplace violence. *Id.*

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[1] OSHA addressed its inquiry to Suncoast Behavioral Health Center. (Ex. 5.) Subsequently, the Secretary learned that the owner of the facility is Premier Behavioral Health Solutions of Florida, Inc. ("Premier"), which is doing business as Suncoast Behavioral Health Center.

[2] Mr. Curl has a Bachelor's degree in organizational management from Tusculum College. Before starting at Suncoast on December 29, 2016, he worked as a MHT for about two years, a shift supervisor for nine months and director of risk management and performance improvement at a hospital in Illinois and at the Palm Shores Behavioral Health Center in Bradenton, Florida, both UHS-DE facilities. (Tr. 2607-13, 2825-27.)

[3] CO Trouche has a Bachelor of Science degree in natural science, with a concentration in biology. She also has a Master of Science degree with a concentration in industrial hygiene. She has worked at OSHA since August 2008. She has performed more than 350 OSHA inspections. In about 2013, she performed her first OSHA workplace violence investigation. (Tr. 95-96.)

[4] In their post trial brief, Respondents number the stipulations differently than what is set forth in the Am. Joint Pre-Hearing Statement. (Resp't Br. 9-11.) As the parties acknowledged at trial that the stipulations were as set forth in the Joint Pre-Hr'g Statement, that is the numbering adopted in this opinion. (Tr. 59-60.) Stipulation 2 is: "Premier Behavioral Health Solutions of Florida, Inc. dba Suncoast Behavioral Health Center ("Suncoast") is an inpatient psychiatric hospital operating at 4480 51st St. W, Bradenton, Florida 34210."

Respondents timely contested the Citation bringing the matter before the Occupational Safety and Health Review Commission ("Commission").[5] (Stip. 6.) The Secretary timely filed his initial Complaint and then filed an Amended Complaint on March 21, 2019. A twelve-day trial was held. It commenced on April 23, 2019 and continued through May 2, 2019. There was an approximately three-month continuance, with the trial resuming on August 20, 2019, and concluding on August 23, 2019. The trial transcript is 3,617 pages long. Both parties submitted post trial briefs and reply briefs.[6]

In addition to Respondents' challenge to the Citation, the Secretary's March 29, 2019 Motion for Sanctions for Respondents' Destruction of Relevant Video Surveillance Evidence ("Sanctions Motion"), renewed by the Secretary in his post trial brief, is also pending before the Court. (Sec'y Br. 197-201.) In its Order Denying without Prejudice Complainant's Motion for Sanctions dated April 18, 2019 ("Sanctions Order"), the Court granted in part and denied without prejudice in part the Sanctions Motion.

For the reasons discussed, the Sanctions Motion is now GRANTED to the extent indicated herein. Further, the Citation is AFFIRMED as a serious violation, and a $12,934 penalty is assessed.

I. Jurisdiction

Respondents filed a timely Notice of Contest bringing this matter before the Commission. (Stip. 6.) Suncoast and UHS-DE are both employers affecting interstate commerce within the meaning of 29 U.S.C. § 659(c).[7] (Stip. 1.) Both are employers under the Act. *Id.* Based upon the record, including the parties' admission to jurisdiction, the Court concludes the Commission has jurisdiction over the parties and the subject matter of this case.[8] (Stips. 1, 4.)

[5] Stipulation 6 is: "Respondents timely filed their Notice of Contest on April 30, 2018."
[6] One post trial brief exceeded 200 pages.
[7] 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."
[8] Stipulation 4 provides: "The Occupational Safety and Health Review Commission has jurisdiction in this proceeding pursuant to § 10(c) of the Occupational Safety and Health Act … ."

II. Preliminary Matters

A. Corporate Structure

Suncoast is a wholly-owned subsidiary of Premier.[9] (Stips. 2, 10.) Premier, in turn, is wholly owned by Universal Health Services, Inc. ("UHS"), a publicly traded company. (Stip. 10; Meloni Dep. 17, 22, 24-25; Ex. 2.) UHS is a holding company without any employees. UHS-DE Vice President and Chief Compliance Officer Mia Meloni testified at her March 26, 2019 deposition that "[i]t does not have health care operations of its own." (Ex. 92 at 10; Meloni Dep. 20-21, Ex. 41.) UHS is one of the nation's largest hospital management companies. It has more than 350 acute care hospitals, behavioral health facilities, and ambulatory centers across the United States. (Ex. 9.) It operates through its wholly-owned management company, UHS-DE, and other subsidiaries.[10] (Stip. 9; Ex. 9 at 309; Ex. 92 at 19; Meloni Dep. 19-20, 25; Ex. 41.) UHS-DE performs management services for Suncoast and many other subsidiaries UHS wholly owns.[11] (Stip. 13; Tr. 128, 1691-92; Ex. 9 at 309; Meloni Dep. 25.) Revenue from UHS subsidiaries is reported to the SEC on a consolidated basis. (Meloni Dep. 24.)

Suncoast and UHS-DE began operating an in-patient facility for psychiatric care in Bradenton, Florida, late in September 2014.[12] (Tr. 91, 329; Ex. 9 at 323.) The facility consists of a one-level building with three separate units. Two of the units, Ocean Point and Cora Key, have adult patients,[13] and the third unit, Turtle Cove, cares for children (ages 5-17). (Tr. 92-93, 193, 1345-46, 2303-4; Ex. 9 at 310, 323.) The facility is licensed for sixty beds but, during the inspection, had an average number of thirty-

[9] Stipulation 10 is: "Suncoast is a wholly owned subsidiary of Premier Behavioral Solutions, Inc., which is a wholly owned subsidiary of Psychiatric Solutions, Inc., which is a wholly owned subsidiary of UHS."
[10] Stipulation 9 is: "UHS-DE is a wholly owned subsidiary of Universal Health Services, Inc. ["UHS"]."
[11] Stipulation 13 is: "UHS-DE performed management services for Suncoast and for Lowell [UHS of Westwood Pembroke, Inc. dba Lowell Treatment Center, herein "Lowell"] pursuant to a management agreement." (Tr. 217-18; Stip. 12). UHS-DE has the same management agreement with all of the UHS affiliated health care operation entities it works with. (Meloni Dep. 22-28, 33-34; Ex. 6.) Some subsidiaries are directly owned by UHS while there are additional corporate layers for others. (Meloni Dep. 26-28, Ex. 39.) There are no partial owners of UHS-DE or Suncoast or its parent companies. (Stips. 9-10.)
[12] Prior to Respondents commencing operations at the site, the facility was operated as Manatee Palms Youth Services. (Ex. 9 at 323.)
[13] Coral Key has more acutely psychotic patients and Ocean Point has older patients who have sensitivity disorders, suffer from anxiety and depression, or drug or alcohol abuse. Ocean Point does not generally care for acute patients. (Tr. 92-93, 697-98, 1258.)

five to thirty-seven patients in its daily census.[14] But, employees described caring for up to 20 patients at a time in a single unit that had a maximum capacity of twenty. (Stip. 3; Tr. 92, 192-93, 219, 1078, 1444, 1497, 2304-05; Ex. 9 at 323, Ex. 81.) Suncoast admits between 200 and 250 patients each month. (Tr. 2234.) Chief Executive Officer ("CEO") Brandy Hamilton testified that the average length of stay is about five days.[15] (Tr. 2310, 2324, 3547).

The CEO, along with other administrators, conducts routine audits and "rounds" to ensure that Suncoast followed safety policy. (Tr. 1613, 3113; Ex. 251 at 3942.) These audits include observing employee behavior in the units and reviewing documentation. (Tr. 1613-14; Ex. 251 at 3942.) Employees raised safety issues, including those related to the hazard of workplace violence with the CEO. (Tr. 1382-83.) In addition, after the Citation's issuance, the CEO worked to improve safety issues such as how law enforcement brings patients to the facility. (Ex. 35.)

Additional UHS-DE employees participate in risk management and oversight activities. (Tr. 370, 1612; Ex. 251; Meloni Dep. 42.) At least four UHS-DE employees have significant oversight responsibilities for Suncoast and do periodic site visits to ensure compliance with UHS-DE policies and requirements. (Tr. 128-29, 370, 1417, 2294; Hamilton Dep. 20-21, 25-27; Haider Dep. 12, 23-24; Curl Dep. 22-23, 27; Meloni Dep. 42-43.) UHS-DE employees participate in the monthly UHS Patient Safety Council ("UHS-PSC") meetings and are part of the Environment of Care ("EOC") committee, both of

[14] Stipulation 3 is: "Suncoast has three patient care units with a total of 60 beds."

[15] CEO Hamilton earned a bachelor's degree in psychology from Eastern Kentucky University in 2002 and a master's degree in health care administration from the University of Central Florida in 2014. She started working as a MHT at Ridge Behavioral Health Center, a 110-bed hospital located in Kentucky, in about 2001 and continued through about 2004. She later worked there as an Intake Specialist, evening shift supervisor, and business development representative. (Tr. 2277-78, 2282, 2284.) She then relocated to Florida and worked in an intake position at a residential facility, before returning to Kentucky and again working as a business development representative. She then worked as Director of Business Development at Central Florida Behavioral Hospital for five years. (Tr. 2285-88.) In January 2015, she became a Chief Operating Officer ("COO") in Training at Suncoast at a time when Kerry Knott was CEO there. (Tr. 2288-89.) She also became a UHS-DE employee at that time. In March 2015, she became Suncoast CEO. As CEO, she manages the department directors and oversees Suncoast from a financial standpoint and its day-to-day operations. She reports to a regional vice-president of UHS-DE. (Tr. 2290-95, 2568-69.) All of the facilities where she worked were owned by UHS. (Tr. 2277-93, 2267-68.)

which have safety responsibilities.[16] (Tr. 1612, 2150-51, 2337, 2527-28, 2530-31, 2671-72; Exs. 35, 243 at 4303, 251 at 3936-37, 3999-4000, 4023, 262.) The UHS-DE Corporate Clinical Director visits the site for a few days at least annually to assess the facility and provide a report on operations. (Tr. 1417-18; Curl Dep. 22-23; Meloni Dep. 42-43, 94.) Mr. Curl and others are required to explain to the UHS-DE Clinical Director how they will address her report. *Id.*

Other UHS-DE managed facilities were previously cited for workplace violence hazards.[17] (Stips. 12-13; Tr. 217, 372.) Lowell was cited for a violation of section 5(a)(1) of the OSH Act. (Stip. 12.) That citation was affirmed as a final order on May 27, 2016, before OSHA commenced its investigation of Respondents. (Tr. 217-18; Ex. 1.)

B. Motion for Sanctions

During discovery, the Secretary filed a Motion to Compel seeking all videos relevant to a particular document request, which was granted on December 4, 2018. (First Produc. Order 4, 10, 11.) When Respondents indicated they could not comply with the Production Order because the videos were not available, the Secretary moved for sanctions alleging that Respondents destroyed relevant video surveillance evidence. (Sanctions Mot. 1-2.) In ruling on the Sanctions Motion, the Court found that the

[16] The CEO attended most of the UHS-PSC meetings from 2016 through the end of OSHA's investigation. (Ex. 251 at 3936-37, 3999-4000, 4023.) Another UHS-DE employee started attending these meetings in 2017. *Id.* at 3675. At least two UHS-DE employees were standing members of this committee. *Id.* at 3995, 3707. No direct care staff members attend the UHS-PCS meetings or serve on the committee. (Tr. 2584-85.)

[17] Stipulation 12 is:

> UHS of Westwood Pembroke, Inc. dba Lowell Treatment Center ("Lowell") was previously cited for a violation of Section 5(a)(1) of the OSH Act under OSHA Inspection Number 1009746 and that citation was affirmed as a final order on May 27, 2016, with respect to a workplace located at 391 Varnum Avenue, Lowell, Massachusetts 01584.

Multiple UHS-DE employees worked at Lowell, but none also worked at Suncoast. (Stips. 15-16, 19-20.) Stipulation 15 is: "Lowell's CEO Dania O'Conner, CFO Diane Airosus, and COO Patrick McCabe were employed by UHS-DE, when Lowell was in existence. None of these managers worked at the Suncoast facility." And Stipulation 16 is: "At the time of OSHA's inspection of Lowell, UHS-DE employee Eric Lewis was Lowell's Loss Control Manager. At the time of Lowell's closing, UHS-DE employee Gina Gilmore was Lowell's Loss Control Manager." After working at Lowell, Eric Lewis became a Regional Control Manager for UHS-DE: "At the time of the Lowell Facility's closing, Eric Lewis was Regional Control Manager and Gina Gilmore reported to him. Eric Lewis reported to UHS-DE employee Valerie Cupo at the time of the Lowell closing." (Stip. 19.) "Neither Eric Lewis nor Gina Gilmore have worked as Loss Control Mangers at the Suncoast facility." (Stip. 20.)

Secretary established Respondents had an obligation to preserve certain evidence and that such evidence was relevant to and would support the Secretary's claims. (Sanctions Order 12-13.) In other words, Respondents should have preserved videos related to workplace violence incidents, and the failure to do so was prejudicial to the Secretary. *Id.*

However, because the record at that time was insufficiently developed on Respondents' state of mind, the Court withheld its ruling on the type of sanctions, if any, to be imposed for Respondents' destruction of evidence. *Id.* Instead, the Court permitted the parties to elicit further evidence regarding whether Respondents intended to deprive the Secretary of the evidence at trial. *Id.* After the parties adduced further evidence during the trial, the Secretary renewed his Sanctions Motion, arguing the record establishes that sanctions are appropriate for Respondents' destruction of evidence. (Sec'y Br. 197-201.)

1. **Background of Discovery Dispute**

The Facts and Discussion from the Sanctions Order are incorporated. CO Troche first inspected Suncoast in response to a complaint of workplace violence on about October 8, 2015. As part of that inspection, she met with Suncoast's Director of Performance Improvement Cheryl Pearson, Director of Plant Operations Joseph Altuchoff, and CEO Brandy Hamilton. She also interviewed a number of employees, including MHTs[18] and management employees. Although no subpoenas were issued, she received a copy of the "Handle With Care" program, its Workplace Violence Prevention Program ("WVPP"), and other documents. CO Trouche recalled speaking with Ms. Pearson about a video and what a video would show of an incident. She said she thought that she was aware that Suncoast had

[18] The Job Description for this position states, "MHTs have the primary responsibility for ensuring the patient's safety on the unit." (Ex. 93.) It further states that the minimum education qualification for an MHT is "High school graduate or equivalent." *Id.* No license or certification is required. *Id.* The Job Description also states that an MHT "[m]ust be able to participate in and complete Handle With Care Training on an annual basis." (Tr. 1513-14; Ex. 93 at 629.) MHT AB testified that she understood that a high school graduate was qualified to be a Suncoast MHT. She said she was paid "like $14 something" per hour, including a night differential. (Tr. 869-70.) RN VG testified that Suncoast "hired people off the street, basically." (Tr. 902.) MHT VN said she was paid $10 to work as an on-call MHT in the Fall, 2018. (Tr. 1000-01; Sec. Br. 87.)

security footage. A handwritten note by CO Trouche made during her 2015 inspection states Ms. Pearson told her that, "One of the incidents; video review/accident did not appeared (sic) to be as serious'…" She testified that she did not ask Suncoast to personally see any video footage during her 2015/2016 inspection because "[i]t was not something that I considered doing during that inspection." (Tr. 455.) CO Trouche testified that she could not recall whether she asked Suncoast to preserve any video footage of workplace violence incidents during her 2015 inspection. (Tr. 96, 316-26, 332-346, 2542-43; Exs. 3, 268.)

On February 3, 2016, OSHA's Tampa, Florida office's Area Director ("AD"), Leslie L. Grove III, issued a 5(a)(1) Hazard Alert Letter to Suncoast as a result of CO Troche's initial inspection that notified it "that employees were exposed to hazardous conditions associated with workplace violence" finding "**four employees over the past year were injured and experienced serious fractures caused by interactions with patients admitted to the hospital.**"[19] (Ex. 3 (emphasis in original)). Although the Hazard Alert Letter stated "[n]o citation(s) will be issued at this time for the presence of this workplace violence hazard," AD Grove recommended ways to eliminate or reduce the hazard, including: (1) creating a stand-alone WVPP, (2) direct care staff in all aspects of its WVPP, including having a safety committee, (3) communicating the behavioral history of patients to staff and training staff on the flagging system, (4) enclosing nursing stations, (5) implementing a communication system to request assistance in case of a workplace violence incident, including use of panic buttons, hand-held alarms and radios, and (6)

[19] In his Reply Brief, the Secretary asserts that the purpose of a Hazard Alert letter is "to warn employers about the dangers of specific industry hazards and provide information on how to protect workers exposed to those safety and health hazards" and "to assist employers in meeting their responsibilities regarding hazards in the industry." *Marion Landmark, Inc*., No. 79-936, 1980 WL 10108, at *4 (O.S.H.R.C.A.L.J., Mar. 3, 1980). OSHA's Hazard Alert Letter asserted that employees were exposed to the hazard of workplace violence at Suncoast and encouraged the implementation of abatement measures. The Court agrees with Complainant that the Hazard Alert Letter provided Respondents with heightened notice of the workplace violence hazard and identified measures that could abate the hazard. (Ex. 3; Sec. Reply Br. 15-16.)

establishing debriefings of employees who were victims and/or witnesses of any assaults on staff.[20] (Tr. 97-98, 340-43, 455; Exs. 3, 20.)

CEO Hamilton did not initially believe a response to OSHA's February 3, 2016 Hazard Alert Letter was required. (Tr. 2540, 2759-60.) However, Mr. Curl emailed a written response to the Hazard Alert Letter on December 27, 2017 to CO Trouche with a copy to CEO Hamilton.[21] (Tr. 2540-41, 2759-60, 2871; Ex. 20 at 183-193, Ex. 239.) CEO Hamilton testified that Respondents were doing "most everything" in the Hazard Alert Letter and that they provided OSHA with the policies that showed the processes in place to meet the recommendations included within OSHA's letter. (Tr. 2544-58.)

2. Incidents of Workplace Violence Occurring from February 3, 2016 through October 25, 2017

Mr. Curl testified that he received about 8 reports of patient on staff workplace violence per month at Suncoast. (Tr. 2831.) Examples occurring after OSHA's February 3, 2016 Hazard Alert Letter include an incident on about March 20, 2016, where a patient aggressively approached MHT RF. MHT RF sustained injuries, including scrapes on his left arm, a cut on his right arm, and red marks on his lower jaw. (Tr. 1495-97; Ex. 7 at 416.) On April 29, 2016, a patient, who was throwing furniture and punching walls, injured MHT JF's left wrist when she restrained the patient on the floor. (Ex. 36.) On May 18, 2016, a patient injured MHT JJ's and MHT JF's backs when they were preventing one patient from injuring another patient. (Ex. 37.) At 2:40 p.m. on June 6, 2016, a patient "violently attacked" two staff members while being processed at the intake department. (Ex. 38.) While sitting at a desk at the intake nurses' station, a patient came up from behind and punched Registered Nurse ("RN") SM in the back

[20] None of these recommended ways to eliminate or materially reduce employees' exposure from workplace violence were fully, adequately, and effectively implemented prior to the Citation's issuance on April 24, 2018. These six ways were essentially identified as feasible and acceptable means of abatement in the Secretary's Amended Complaint. (Exs. 2-3; Sec. Br. 13-15.)

[21] Mr. Curl testified that he prepared the December 2017 response to OSHA's February 3, 2016 Hazard Alert Letter "in response to Ms. Trouche's document request that came through in December of 2017." (Tr. 2759-60; Ex. 20 at 186-93.)

right side of her head, causing a strain there, and at her right shoulder and lower back.[22] *Id.* At the same date, time, and place, Intake Specialist JM was struck 4-5 times with a closed fist on the left side of his head. He sustained two small abrasions on top of his left cheek. (Tr. 3244-45; Ex. 38.) At 2:30 a.m. on July 12, 2016, a patient attempted to 'elope' through a door. When unsuccessful, he threatened other patients with physical aggression. He then "physically aggressed on staff attempting to hit, kick and scratch."[23] (Tr. 2873-75; Ex. 39 at 462-68, 501-04, 529.) At noon on July 12, 2016, MHT TJ strained his back and chest on his left side when placing a patient in a settled position.[24] (Tr. 2872-75; Ex. 39 at 4110.) At about 2:50 p.m. on August 17, 2016, a patient in the day area punched MHT AR in the lower left ribs and spit in his face twice. He sustained a contusion at his lower left ribs. (Tr. 2472-73; Exs. 40 at 419, 92 at 30.) On September 8, 2016, a patient trying to touch another staff member struck MHT MM #1 in the head, cutting his lip, and gouging his eye. (Ex. 7 at 420-21.) On September 22, 2016, an "out of control"[25] patient assaulted MHT MM #1 with his fist and fingers in the hallway of the Coral Key unit. MHT MM #1 sustained "cuts around both eyes, bruises and knots on right side of head." He missed three days of work. (Tr. 2876-77; Ex. 7 at 400, Ex. 42.) On September 23, 2016, a patient punched MHT AK in the left eye in the hallway of the Coral Key unit. His eye was swollen as a result and he missed three days of work. (Tr. 2876-77; Ex. 7 at 400, Ex. 43.) On September 27, 2016, an "out of control" patient

[22] At that time, the intake nurses' station was not enclosed with a plexiglass barrier. (Tr. 3246.)
[23] The Court is unaware of there being an Employee Accident Report ("EAR") in evidence for this incident. (Tr. 2875.)
[24] There is no Risk Management Worksheet or Restraint/Seclusion Order/Record ("RSO") for this incident in evidence. (Tr. 2875-76.) Respondents did not always complete RSOs or accurately document a debriefing when a patient was placed into a restraint or seclusion. (Sec. Br. 48-55, 58-61.)
[25] Mr. Curl testified that a patient coded as "out of control" on the Risk Management Worksheet is supposed to indicate that the patient was not involved in an incident that involves acts of aggression. (Tr. 2855, 2881-87; Sec. Br. 63-64.) He said he would consider this incident to be patient aggression even though the Risk Management Worksheet indicated an "out of control" patient. (Tr. 2876-77.) Mr. Curl also said that the Q-15 checklist inaccurately indicated that the patient was cooperative at the time of the incident when he was not. (Tr. 2878-79; Ex. 42 at 749.) Dr. Forman opined that Suncoast's Q-15 checklist "was not really being a serious document" because incorrect codes were used, and the checklists were not validated. Consequently, he said "[t]hese are nonsensical documents." (Tr. 3400-02, 3511, 3522-23; Ex. 42 at 749; Sec. Br. 70-72.)

kicked and bit MHT NA on the back of his right arm during a restraint at the Coral Key unit.[26] (Tr. 2878-79; Ex. 44.) On October 21, 2016, a patient hit RN MH in the face causing a fat lip while passing out medications at the Nurses' station. (Tr. 2188; Ex. 45, Ex. 92 at 31.) Respondents also reported that on November 4, 2016 a patient in the intake area injured RN SM.[27] (Exs. 46, 92 at 32.)

On about November 8, 2016, Psychiatric RN VG, age 72, was slapped in the face by a patient, not assigned to her, while she held an injection in each hand. Her supervisor witnessed the slapping. RN VG testified that "[s]he [the patient] aggressed on staff. … She sent one of my techs to the ER all the time. She hit him in the head. She hit them in the face. She slapped people all the time."[28] (Tr. 881.) RN VG was referring to an assault by this same patient on MHT DR that occurred on November 9, 2016. According to RN VG, the patient hit MHT DR "in the temple so hard that it broke his glasses. I know he ended up in the ER because of a head injury." (Tr. 882.) She said MHT DR "got hit several times by her [the patient] in the head, injured wrist due to physical hold of violent patient." (Tr. 881-82, 913-14, 928-30, 2475-76; Ex. 47.) Dr. Lipscomb testified that this aggressive patient's chart should have been flagged, and the patient should have been "on Q5s or one-on-ones, or something" as abatement measures to prevent the assault upon MHT DR. (Tr. 1894-95.)

Later that month, on November 22, 2016, at about 5:15 p.m., the same patient that slapped RN VG on November 8, 2016 was lying face down in her bed being restrained by two MHTs and a social worker, in the presence of RN supervisor Zarak Haider, to receive two injections from RN VG.[29] After receiving the injections, the patient intentionally kicked RN VG so hard in the right side of her chest that she "flew five feet in the air," striking the corner of the wall that was "five to six feet away from the bed." (Tr.

[26] Mr. Curl said that the Q-15 checklist inaccurately indicated that the patient was resting at the time of the incident when he was not. (Tr. 2877-78; Ex. 44 at 886.)
[27] There is no EAR providing details of this incident in the record. (Sec. Br. 56.)
[28] RN VG testified that Suncoast did nothing to deal with the patient's assaults on staff. She said, "Nobody did a thing. Nobody said anything. She [the patient] wasn't reprimanded, and it was let go." (Tr. 935-36.)
[29] The patient was "a good-sized woman" and weighed between 150 to 160 pounds. (Tr. 889.)

890.) She could not breathe, stand, or sit in a wheelchair. The social worker who had let go of the patient's legs said, "My bad Ginny. I'm sorry" to RN VG while she laid on the floor.[30] (Tr. 902.) After "quite a while" and not "done immediately," Mr. Haider called 911, and an ambulance took RN VG to the hospital. (Tr. 907.) The patient's kick caused three breaks in RN VG's right hip and four broken ribs. She was hospitalized, had surgery, and was sedated for eight days before being transferred to a rehabilitation facility. She was returned to "light duty" on February 14, 2017. She missed 91 days of work and was on transferred or restricted work for 21 days. (Tr. 884-907, 933-46; Ex. 7 at 400, Ex. 49.) No one in management discussed the incident with RN VG in any meaningful way.[31] (Tr. 894-95, 909-11.)

The EAR dated November 22, 2016 signed by RN supervisor Haider stated that RN VG "was walking backwards after giving injection" and the patient " 'barely' " kicked staff."[32] (Ex. 49.) To the EAR's question, "Object or Substance that injured employee," Mr. Haider answered, "Employee [RN VG] appeared to have lost balance." (Tr. 884-907; Ex. 49 at 1.) The Risk Management Worksheet stated:

> Nurse started walking backwards after giving injection and patient kicked her foot out in a reflex motion, "barely" touching nurse with her toes, who then lost her balance and fell into the wall. … The nurse was unsteady on her feet as she was walking backwards and the patient accidentally knocked her off balance. Staff members are not to walk backwards and should walk with steady gait.

[30] RN VG testified that the patient's leg should have not been loose such that she could kick. (Tr. 901-02, 914-15.)
[31] When she returned to work, RN VG told the Director of Nursing ("DON") and Human Resources that she wanted to see the video tapes of the incident. She was told that there were no cameras in patient rooms, and no one offered to show her any video tape of the hallway with her lying on the floor. (Tr. 909-10, 2225.)
[32] Mr. Curl testified that the purpose of the EAR is to report staff member injury. He said the Risk Management Worksheet in MIDAS "focused on the patient and the treatment of the patient", although it "could contain the staff member's injury." (Tr. 2699, 2839, 2848.) Mr. Curl further testified that before April 8, 2018 the Sedgwick Clinical Consultation Report initiated through a hotline replaced the hand-written EAR to make a record of an incident that caused an injury to a staff member. (Tr. 2723; Ex. 69.)

(Ex. 49 at 2.) The Court finds both the EAR and the Risk Management Worksheet's description of the November 22, 2016 incident to be false and misleading.[33] (Tr. 1929; Ex. 49 at 2; Sec. Br. 58-59.)

On December 1, 2016, a patient trying to get keys attacked MHT NP in the hallway. The patient "dug her nails into [the MHT's] arm" cutting MHT NP's right arm. (Tr. 2902-03; Ex. 50.) At 8:15 p.m. on February 2, 2107, an "out of control," belligerent patient threatened and slapped at a staff member at the Coral Key unit.[34] (Tr. 2833-34; Ex. 51 at 1143-49.) At 11:00 a.m., on February 3, 2017, MHT AR strained his shoulder when an "out of control" patient hit him in his right shoulder while he and a nurse administered medicine.[35] (Tr. 2616-19, 2683-89, 2833-34; Ex. 51 at 4102, 1206.)

On February 27, 2017, MHT JJ strained his right knee when restraining an aggressive patient who began to break a chair. He was on job transfer or restriction for 17 days. (Ex. 7 at 373, 380.) On March 9, 2017, a patient hit, kicked, and spit on staff, including into Therapist PY's right eye, in the Turtle Cove unit. (Tr. 2904-06; Ex. 54.) On March 30, 2017, MHT MM #1 was scratched and bruised, with his left elbow swollen, when he stopped a patient from trying to escape with his badge. (Ex. 55.)

On May 23, 2017, a patient pushed MHT BA in the chest with both hands and hit RN RO,[36] a 65-year old, in the neck, head, and chest several times.[37] The patient also head-butted RN RO in the right

[33] RN VG testified that the EAR's description of the incident is inaccurate and was written to "CYA". (Tr. 897-99; Ex. 49 at 1.) Having observed her courtroom demeanor during about one hour and forty minutes of testimony, the Court finds RN VG's courtroom testimony of the November 22, 2016 incident to be entirely credible. (Tr. 871-957.) The Court further finds that the EAR's description of the incident to be cleverly written by RN Supervisor Haider, but false and misleading. Likewise, the OSHA Form 301 Injury and Illness Incident Report dated November 23, 2016 completed by Director of Human Resources, Dina Balsamo, states: "After administering prolixin the RN was walking backwards and the client made slight contact with a kicking motion the RN lost her balance and fell backwards against the wall" was inaccurate. (Ex. 7 at 413.) And similarly, Respondents' Supplemental Response to Request for Production No. 9(sic) at Exhibit A concerning the November 22, 2016 assault is inaccurate. (Ex. 92 at 33.)

[34] Mr. Curl testified that he did not consider this to be a patient on staff workplace violence incident because the patient did not reportedly actually hit the staff member. (Tr. 2844-47.)

[35] No Risk Management Worksheet for this incident is in evidence. (Tr. 2843.)

[36] RN RO was board certified in psychiatric nursing and worked as a nurse for about 25 years, including 23 years in psychiatric and substance abuse working at Sarasota Memorial Hospital, Manatee Memorial Hospital and Coastal Behavioral. (Tr. 465.) He was never injured anywhere on the job except at Suncoast where he was seriously injured twice in May and August 2017. (Tr. 467, 527.)

[37] MHT BA quit working at Suncoast immediately after the incident. (Tr. 478.)

temple and eye. RN RO's neck and right eye became swollen. RN RO was transported by stretcher to Blake Hospital where he was found to have a concussion. RN RO testified that his "neck swelled up like the size of a grapefruit right in that area, and I had deep muscular damage, and it took actually about three months for it to completely heal…." (Tr. 472-89; Ex. 4 at 301-303, Ex. 56.) RN RO testified that the Risk Management Worksheet inaccurately stated the incident's location and that a code was called when it had not been.[38] (Tr. 472, 481; Ex. 56 at 1464.) Police took the patient who assaulted RN RO and MHT BA to jail "for battery/assault on staff." (Tr. 641, 673-74, 1264, 1320; Ex. 56 at 1491.)

On May 25, 2017, while administering medications, a patient used both hands to pull RN ET's right arm and injured her shoulder. X-Rays showed her shoulder to be strained, and she was placed on light duty while she completed about two to three months of physical therapy. (Tr. 1348-1356; Ex. 57.) She missed 3 days of work and was on transferred or restricted work for 72 days. (Ex. 7 at 373.) The incident occurred at the nurses' station and cameras should have been able to record the incident. RN ET was not shown any video of the incident. (Tr. 1362.)

On May 30, 2017, Therapist PY suffered a torn rotator cuff and strained right lower back due to a workplace violence incident at the nurses' station. He missed 18 days of work and was on restricted or transferred work for 162 days. (Ex. 7 at 373, 386, Exs. 58, 92 at 36.)

On July 26, 2017, a patient attacked staff at the day area of Turtle Cove. Using her fingernails, a patient scratched both forearms of MHT NA, causing a small cut. (Tr. 2906-08; Ex. 59.)

On August 9, 2017, Supervisor "SL" telephoned RN RO and told him that a patient in the Coral Key and Turtle Cove combined unit was "threatening them" and would he "come over to protect the nurses."[39] (Tr. 489-92.) While at the combined unit's nurses' station, RN RO saw a 16-year-old male

[38] RN RO testified extensively and consistently had a credible demeanor. His testimony was well corroborated, and his description of the events is credited over the Risk Management Worksheet.
[39] There was one combined nurses' station for the Coral Key and Turtle Cove units. (Tr. 558.)

patient weighing about 286 pounds starting to slam his fist on a door about 170 feet away at the end of the hallway. RN RO repeatedly told Supervisor SL "to call 911 now, and she refused." She repeatedly told RN RO she was "not allowed to call 911." The patient then headed toward the nurses' station and SL finally called 911 and RN RO told her to say they needed emergency help now. The patient "started slamming on the door right by our nurses station." The patient then "walked back about 20 feet from the nursing station and ran full blast and dove on top of the exposed nursing station." RN RO grabbed the patient and tried to put him in a hold. The patient "pounded" RN RO and, with a pen in one hand and scissors[40] in his other hand that the patient grabbed from within the nurses' station, the patient hit RN RO several times, knocking him unconscious for a moment.[41] RN DL testified the patient had "pinned [RN RO] on the floor with scissors on his throat." When RN RO regained consciousness, he was "bleeding profusely" and laying on top of the patient. He said,

> I couldn't see because I was blinking trying to see, but I had so much blood coming down in my eyes, I couldn't even see. I was choking on blood too because I was stabbed through the mouth there on top of my head and behind the left ear. Plus my face was all beaten up and I was all bruised up from other blows ….

RN RO testified that it "took about ten minutes for 911 to arrive." (Tr. 502.) In shock, he was taken to the hospital by ambulance on a stretcher. (Tr. 503-05; Ex. 27.) His injuries included "a severe concussion," "neck injuries," an arm injury, multiple bruises throughout the body, "terrible tinnitus," and headaches. (Tr. 170, 502; Ex. 4.) He received "facial stitches to lower lip and upper right forehead." (Ex. 60.) RN RO also lost consciousness multiple times. (Tr. 170; Ex. 4.) He missed 27 days of work and

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[40] CEO Hamilton admitted that "the scissors were on top of the nurses' station" and she could not "recall why they had scissors out in the first place." (Tr. 2362.) She said, "patients should never have scissors." (Tr. 2372.)

[41] RN RO testified:

Q. Were your coworkers able to help you in this restraint?

A. They did not respond. They did not react. I guess they stood and watched me get pounded some. And then, finally, one of them – I think it was ["JSS"] reacted by hustling and grabbing one of his arms. Several never reacted at all. One of the nurses pinned their self against the wall and it looked like she was crying because she was so scared. She didn't react. Another stayed on the 911 call and didn't help at all. So –

(Tr. 500, 509, 512.) RN VL testified that she "removed myself and went into the office." She said she did not attempt to restrain the patient. (Tr. 778.)

was on restricted or transferred work for 127 days. (Ex. 4 at 305, Ex. 7 at 373.) This incident is referred to herein as the "RN RO Attack". (Tr. 100, 464-65, 489-507, 563, 1045, 1064; Exs. 4, 28, 60.) MHT BG testified that during the melee, the patient also stabbed Supervisor SL in the leg with a pen and she was also bleeding. (Tr. 644, 677, 1064.)

Suncoast's video camera system recorded the August 9, 2017 RN RO Attack. (Tr. 1806-7, 2557-58; Ex. 28.) Suncoast has over 80 video cameras that continuously film the activity occurring in most of the facility's common areas as well as the seclusion area.[42] (Tr. 755, 949-50, 2302, 2730, 2917-19, 3044-45, 3224.) All video is stored on a hard drive. (Tr. 2938.) Mr. Curl was tasked with reviewing the video of the RN RO Attack, and other incidents. (Tr. 2682, 2701, 2704, 2942-43, 2999.) Mr. Curl reviewed videos to "get additional information" that may cause him to change information previously reported in MIDAS, the facility's incident reporting system.[43] He said that the information contained in videos "might be more factual." When investigating an incident, Mr. Curl said he "would watch camera, if the camera was available. So I could watch camera before I look at medical record, or vice versa, or I could watch camera, read medical record, watch camera, read medical record again, really just until I feel satisfied with my investigation." (Tr. 2682-83, 2700-01.) Mr. Curl said that he likes to show the video of an incident during debriefings and ask viewers what could have been done better. (Tr. 2765-66.)

Mr. Curl said he "pulled [the] camera, [and] "reviewed [the] camera" of the RN RO Attack on the day it occurred. (Tr. 2703-05.) As part of his investigation, Mr. Curl learned from the Risk Management Worksheet that the patient "had been agitated all day, and that he had self-harmed earlier in the shift."[44]

[42] Dr. Hemsath testified that "[s]eclusion means we're going to stick somebody in … a special room and seclude them from everybody else with typically a locked door where they can't get out of the room." (Tr. 2063-64.) There was a camera located in the corner of the ceiling in the intake area. (Tr. 132-33; Ex. 8 at 523 [top photo at "A"].) There are no cameras in patient bedrooms or bathrooms. (Tr. 950, 2543, 2917.)

[43] UHS-DE facilitates Suncoast's access to MIDAS. (Meloni Dep. 59-60.)

[44] Mr. Curl testified that the Patient Observation/Rounds Form [Q-15 Check] for August 8, 2017 "is probably not accurate" since it does not accurately reflect the patient's agitated behavior earlier that day. (Tr. 2853; Ex. 60 at 1758.)

Mr. Curl said he "really wanted to know why we didn't intervene earlier with this client because the client had exhibited behaviors that are, you now, troublesome, and they needed to be dealt with earlier, as in self-harming." He concluded that the evening shift staff members left the patient "in an acute state. And they [Staff] should have stayed to help stabilize the milieu before they left. And that right there is one thing that could have prevented this incident from happening because they would have had additional staff members present, as many as they needed really. Any they could have done anything that they needed to." (Tr. 2713-14.)

Local law enforcement also investigated the RN RO Attack and requested the video as part of its review. (Tr. 2934.) Suncoast consulted legal counsel about the request. (Tr. 2558, 2934-37.) Though he could not recall when he copied the video footage onto a DVD or turned the DVD containing the video footage over to local law enforcement, there is no dispute that Mr. Curl preserved the available video of the RN RO Attack. Mr. Curl said that he did not keep a copy of the DVD he gave the sheriff's department. (Tr. 2934, 2999-3002; Ex. 28.)

On September 13, 2017, Night Supervisor RN CC was hit and swung at twice in the hallway by a verbally aggressive, very intoxicated patient reinjuring a lower back injury when she twisted her body trying to avoid the second hit. Her back "really started to hurt" near the end of her shift. As a result, she was put on light duty for about 28 days. The Risk Management Worksheet for the incident states that "DRM [Director of Risk Management] reviewed incident on camera." (Tr. 1427-31, 1461-63, 1470-71, 1827; Ex. 7 at 373, Ex. 61). On September 26, 2017, MHT AS suffered a strained right shoulder injury breaking up a fight involving three patients in the Day Area. (Ex. 7 at 392, Ex. 62.)

At least three more workplace violence incidents occurred in October 2017. (Tr. 2880, 3042; Exs. 63-64, 78.) On October 2, 2017, MHT MM #1 was injured by a patient who was hitting staff and grabbing their clothes in the Day Area. The Risk Management Worksheet stated: "Staff members

intervened preventing patient access to the RN station. DRM reviewed incident on camera." (Ex. 63.) The patient injured MHT MM #1's left thigh and right arm. *Id*. At 9:00 p.m. on October 3, 2017, MHT RS was punched in the mouth and eye when he attempted to break up a fight between two patients at "Nursing." (Tr. 2880-81; Ex. 64.) At the same date and time, MHT MG was kicked and placed in a chokehold at the Coral Key social quiet room while trying to break up the fight. (Tr. 2880-81; Ex. 64.) All three incidents occurred in areas surveilled by video. (Ex. 63-64.) Unlike the RN RO Attack, local law enforcement did not seek video of these incidents.[45]

3. OSHA'S Investigation

Later that same month, on October 25, 2017, OSHA notified Suncoast by letter and telephone that it had received notice of alleged workplace hazards at its facility.[46] (Tr. 101-02, 347-51; Exs. 5, 9.) Specifically, OSHA informed Suncoast about an allegation that employees were exposed to workplace violence and that the employer failed to ensure that employees had adequate protection from patients in possible violation of section 5(a)(1) of the OSH Act. (Tr. 102, 348, 2757; Ex. 5.) OSHA requested an immediate investigation into the alleged hazard and a response by November 1, 2017.[47] (Ex. 5.) As part of this response, OSHA asked to be provided with any helpful "photographs." (Tr. 351; Ex. 5 at 290.) Respondents acknowledge that OSHA's NOI "open[ed] the second [OSHA] investigation of Suncoast." (Resp't Br. 51.) The NOI did not specifically request the production of any video surveillance footage. (Tr. 352.) Nonetheless, the Court finds that Respondents were on notice of their duty to preserve the video footage following their receipt of OSHA's NOI. They were obligated at that time to preserve all available photographs, including videos, relating to incidents of workplace violence that occurred at

[45] There is no evidence that Florida law enforcement officials were informed of the October 2017 incidents.
[46] OSHA received the non-formal complaint that initiated the investigation against Respondents at 4:30 p.m. on October 19, 2017. (Tr. 100; Exs. 4, 9.) The NOI is addressed to the attention of DON Sweeney. (Tr. 953, 1507; Ex. 5.) It is not clear if she was employed by UHS-DE or Suncoast. CEO Hamilton was responsible for hiring the DON. (Tr. 2397.) The DON at the time of trial, Rachell Phillips, was a UHS-DE employee. (Phillips Dep. 14.)
[47] The NOI states that in the absence of a response, "an OSHA inspection will be conducted." (Ex. 5 at 1.)

Suncoast. *See Magdaluyo v. MGM Grand Hotel, LLC,* No. 2:14-cv-01806-RFB-GWF, 2016 WL 614397, at *4 (D. Nev. Feb. 16, 2016) ("Although Plaintiff did not specifically request that surveillance video of the incident be preserved, Defendant reasonably had a duty to investigate Plaintiff's allegation and to preserve any available video as part of that investigation."), *aff'd,* 757 F. App'x 599 (9th Cir. 2019); *Cretacci v. Hare*, No. 4:19-CV-55-SKL, 2021 WL 201778, at *2 (E.D. Tenn. Jan. 20, 2021) ("Court further finds that a duty to preserve the video did arise once officials received the letter from Plaintiff's counsel indicating he was investigating potential causes of action arising from the alleged assault.").

On November 1, 2017, Suncoast responded to OSHA's inquiry by email to Assistant Area Director ("AAD") Maveline Perez, with a copy addressed to "groves.leslie@dol.gov." (Tr. 102, 2757; Ex. 6.) The response consisted of a written discussion, including confirmation that the facility had posted a notice of alleged hazards. (Ex. 6.) The response cites the video camera system as part of the facility's abatement. *Id.* at 264-65. It explains how video is randomly reviewed, as well as after certain types of events, stating, in part, "Video Surveillance: Video surveillance cameras monitor the facility at all times.… [Mr. Curl] reviews all incidents of restraint[48] and seclusion on camera to identify opportunities for improvement and will either meet with the staff involved to provide education and direction, share the findings with the supervisor for follow up education or/and communicate findings to the safety committee." *Id*. at 264. It further stated, **Employee Injury Response** [emphasis in original]: If a staff member is involved in an accident that results in a recordable work-related injury, an accident analysis is performed, the Risk Manager reviews the videotape, and all is reported to corporate risk as well as hospital committee." *Id*. at 264-65. The response neither addressed any review of videotape of any particular incidents of workplace violence by patients on staff nor included any photographs, videos, or

[48] Dr. Hemsath testified that a "restraint" means "we'll hold a patient for a couple of minutes, … to either redirect them from a situation … or give them medication." (Tr. 2063-66.)

other documentation related thereto. *Id.* Nor did Respondents take any steps to preserve any video related to worker health and safety hazards in general or workplace violence specifically available when it received the NOI. AAD Perez did not consider Mr. Curl's response to be adequate and the matter was assigned to CO Trouche for investigation. (Tr. 102-03; Ex. 9.)

On about November 8, 2017, CO Trouche began an on-site inspection of the Suncoast facility. (Tr. 91, 99-101, 104, 346, 353; Exs. 4, 9.) She conducted an opening conference with CEO Hamilton and Risk Manager Curl. At that time, Respondents did not allow the CO to walk through the facility. (Tr. 129; Ex. 9.) In her first document request, CO Trouche requested to be provided with OSHA 300 logs (Log of Work-Related Injuries and Illnesses) for 2015 through 2017, OSHA 300A summaries (Summary of Work-Related Injuries and Illnesses) for 2014 through 2016, OSHA 301 reports (Injury and Illness Incident Report), EARs pertaining to workplace violence, any workplace violence risk assessment, any documents pertaining to workplace violence policy, programs, training, and educational material, and any plans for emergency action, infectious controls, disease, ergonomics, and slips, trips, and falls. (Tr. 104-06, 112, 353-55.) She was given OSHA 300 logs, OSHA 300A summaries, OSHA 301 reports, and EARs on November 8, 2017. She gave Respondents seven days to collect other documents. (Tr. 106-07, 110, 355; Ex. 7.)

CO Trouche returned to Suncoast on November 30, 2017 to conduct additional interviews, walk through the facility, and gather additional information. She took photographs during her walk around. (Tr. 129-30, 432; Ex. 8.) During this visit, she requested copies of any recordings of incidents and had the opportunity to view video of the RN RO Attack from a DVD Mr. Curl had made.[49] She "asked to

[49] CO Trouche testified:

> Q. Ms. Trouche you mentioned that during your visit on the 30th you also asked for video surveillance footage.
> A. Yes. I request a copy of video recording of any incidents that they have records of. Unfortunately, the response was that I will need a – more of a legal request. And for preserving the amicability of the

view this footage because it is useful to see the actual acts of violence to understand what employees are doing in the moment to address the hazard, and to assess whether Suncoast's employees are prepared to respond to such hazards." She testified that the video "will provide a more live image to the testimony that I already have received and the review of the records that I was provided." (Tr. 127-29, 433, 449-50; Ex. 267 at 2, ¶¶ 3-5.) CO Trouche testified that she "felt that it was sufficient" to observe the video since it showed what she already knew about the August 9, 2017 incident. (Tr. 129, 433-35, 3002-04; Exs. 28, 267 at 2, ¶ 6; Hamilton Dep. 59, ¶ F.) She was not shown video of the three October 2017 incidents or of other incidents of patient on staff violence that occurred in November 2017.[50] (Tr. 129, 434; Exs. 65-66, 92 at 37-38.) CO Trouche also testified that she did not recall being told that the videos she requested were destroyed, although she had an understanding that after about 30 days the videotape system recorded over them. She acknowledged that she did not ask any questions or develop any information about Respondents' video retention policy during her investigation. But she said she knew that the videotape system "even though it's on a loop, allows Suncoast to record from that video feed and preserve videos that pertain to workplace violence," evidenced by the fact that on November 30, 2017 Respondents showed her a video of the August 9, 2017 RN RO Attack. (Tr. 172, 436-40.)

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inspection, I request to see to – if there was an opportunity to me to observe the videos and not getting a copy at the moment, and I was given that opportunity, at least for one video.
Q. Which video were you allowed to watch?
A. The August 9 incident.
(Tr. 146, 171; Ex. 28.)

[50] The record indicates there were at least two instances of patient on staff violence which occurred less than thirty days before the CO's second November 30, 2017 site visit. (Exs. 65-66.) On November 2, 2017, MHT VC suffered a strained left shoulder as a result of a patient attack. She was placed on restricted or transferred work for 69 days. (Ex. 7 at 373, Ex. 65.) Another attack occurred on November 11, 2017, when a "very violent" patient acting "like a raging bull" bit MHT CCM's index and small fingers and hit her in the face several times. (Tr. 1174.) The patient bit the nail off of MHT CCM's small finger and ripped open her index finger. (Tr. 1166-68, 1173-74, 1179-81, 1191, 1220-22; Ex. 66.) Both of these incidents occurred in patients' bedrooms where there were no cameras. (Tr. 950, 2543, 2917.) The Court credits MHT CCM's direct testimony over the Risk Management Worksheet's incident description. The Risk Management Worksheet for the November 11, 2017 incident inaccurately states that the attack occurred in the hallway, when it actually occurred in the patient's bedroom's bathroom. The Court also finds that the patient intentionally bit MHT CCM's fingers in the bathroom and did not do so "impulsively" while walking in the hallway as the worksheet inaccurately states. (Tr. 1166-68, 1180-81, 1929; Ex. 66 at 2042.)

Respondents' witnesses' recollections differ somewhat as to why the CO could view the video footage of the RN RO Attack during her November 30, 2017 visit. Mr. Curl claimed he only made a copy of the footage at the local sheriffs' department's request and had just not yet turned it over at the time of the CO's second visit in November. (Tr. 3000, 3003.) He indicated it was just a happenstance of "good timing." (Tr. 3003-04.) However, he also stated that the sheriffs' department had "immediately" requested the footage pursuant to a subpoena.[51] (Tr. 2934, 2999-3000.) Mr. Curl was unsure why he had not yet turned it over months later when he showed it to the CO. (Tr. 2934, 3000.) Although he consulted UHS-DE employees and counsel about the request, Mr. Curl denied that anyone at UHS-DE decided to retain the video. (Tr. 2558, 2934, 2950, 3000.) He said the video system erased its recording by September 8, 2017. (Tr. 3002.)

In contrast, CEO Hamilton testified a copy was retained because an employee injured in the RN RO Attack filed a workers' compensation claim.[52] (Tr. 2558, 2595-96.) RN RO confirmed that he sought workers' compensation for the injuries he sustained during the RN RO Attack. (Tr. 894.) CEO Hamilton's view is also consistent with the video retention policy, which required videos related to litigation to be kept. (Tr. 2934; Opp'n to Sanctions Mot. 4; Mot. to Compel Ex. G.)

After viewing the RN RO Attack video,[53] the CO requested a copy of what she had been shown. (Tr. 129, 146, 433, 449, 458.) CEO Hamilton told the CO a written request would be necessary before

[51] Mr. Curl said that a law enforcement subpoena would have had to be received at Suncoast by September 8, 2017 so that the video footage was not automatically overwritten. (Tr. 3000.)

[52] At one point, CEO Hamilton indicated that the video may have been available at the time of the CO's visit because the visit was within thirty days of the incident. (Tr. 2595.) However, there is no dispute that the CO's visit occurred on November 30, 2017, nearly four months after the RN RO Attack.

[53] Suncoast's Surveillance Video Camera policy states, in part:

> K. In the course of an investigation, police and/or state licensing departments may request the video footage. If the video footage exists within that 30 day timeframe, it is acceptable to show the video to the investigating agency or officer.

(Hamilton Dep. Ex. 14 at 60, ¶ K.)

OSHA could receive a copy of any video.[54] (Tr. 146, 433, 458, 2559.) OSHA did not immediately make a formal written request. Instead, its investigation continued over several months. During this time, there were additional workplace violence incidents. Respondents did not retain any videos related to these incidents, including the one on February 19, 2018 discussed further below where a patient injured MHT GS's left foot and ankle at intake. (Tr. 1095-1103; Ex. 67.)

On December 19, 2017, CO Trouche requested a written response as to what efforts Respondents had implemented after receiving OSHA's February 3, 2016 Hazard Alert Letter.[55] She also requested an explanation of procedures and evidence of debriefings that occurred after incidents and materials related to intake procedures and communication in between staff shifts.[56] CO Trouche said she did not receive any documentary evidence in response to her December 19, 2017 request. (Tr. 175; Ex. 20.)

In January 2018, CO Trouche returned to Suncoast to conduct further interviews. She made another document request in early January 2018, but did not include another request for video. (Tr. 436-37.)

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[54] Respondents deny the CO asked for a copy of the video. (Tr. 2558; Resp't Br. 50.) In his April 12, 2019 Declaration, which was submitted shortly before trial commenced, Mr. Curl declared that he "offered her [CO Troche] a copy of the [RO Attack] video but she declined the offer." (Sanctions Order 12.) At trial, he made no such assertion. CEO Hamilton refuted this claim about offering a copy. She indicated that she told the CO to request a copy in writing. (Tr. 2559; Sec. Br. 14, ¶ 23.) No such response to the CO was necessary unless the CO had made a verbal request for the video. Accordingly, CEO Hamilton's testimony that CO Troche said nothing to her before Suncoast's receipt of the OSHA Subpoena in April 2018 to make her [CEO Hamilton] think that Suncoast needed to retain video is rejected. (Tr. 2560.) A direction to make a written request would most logically follow a verbal request for an item, which is how the CO recalled the conversation. (Tr. 129, 146, 433, 447-49, 458.) Mr. Curl's email sent to the CO after the visit at which she viewed the video also supports the CO's account. (Ex. 20.) In that email, he indicates that before he can provide the specific details she requested about "incident investigations" he must get approval from the "Corporate Legal Team." *Id.* Thus, the CO's testimony that she verbally requested a copy of the RN RO Attack video on November 30, 2017 is credited. (Tr. 129, 146, 171, 447-49.) The Court finds that Respondents were alternatively obligated to preserve all available videos relating to incidents of workplace violence that occurred at Suncoast on or after November 1, 2017, thirty days back from the CO's November 30, 2017 request to view the video. (Hamilton Dep. Ex. 14 at 60, ¶ K.)

[55] On December 27, 2017, Mr. Curl responded by email sending CO Trouche a written response to the 2016 Hazard Alert letter. (Tr. 174-76, 2758-59, 2900; Exs. 20, 239.) He also told CO Trouche to have her let him know if there was a specific incident that she was looking for so that he could communicate with his team. *Id*. She did not identify any specific incident to Mr. Curl since she "was looking into all of them." (Tr. 176-77.)

[56] Respondents told CO Trouche that they would need to seek corporate legal advice as to their producing incident investigations and actions taken material because OSHA's request sought material that was "Patient Safety Work Product protected." (Tr. 175-76, 401-02; Ex. 20.)

As OSHA's investigation continued, additional workplace violence incidents occurred. On February 19, 2018, MHT GS prevented a "belligerent" patient who did not want to be held at Suncoast from forcefully entering the intake nurses' station. The patient wedged his foot and arm in a partially opened door. RN CMC testified that she saw the patient on the floor in the hall lying on top of the MHT who had a one arm hold on the patient. Two other staff members helped restrain the patient by holding his legs while the patient was on the floor. MHT GS's left foot and ankle were injured in the melee. He could not walk on his foot and it was very painful. The Risk Management Worksheet recharacterized the physical scuffle by stating, "when the staff member went to back up the patient accidentally stepped on the staff's shoe causing them both to fall to the ground resulting in the staff member injuring his ankle."[57] (Tr. 1095-1103, 1133; Ex. 67 at 208-09, 2159, 2161.) RN CMC testified that the same patient later threw a telephone within the intake nurse's station at her. (Tr. 1136, 1146.)

On April 18, 2018 OSHA AD Grove issued an OSHA Subpoena Duces Tecum addressed to "UHS of Delaware, Inc. and Premier Behavioral Health Solutions of Florida, Inc., dba Suncoast Behavioral Health Center" ("OSHA Subpoena") for the maintenance and production of video recordings. (Tr. 435-36, 439; Exs. 79, 267 at 2, ¶ 7.) Specifically, the OSHA Subpoena sought the production of "copies of any and all video of acts of violence by patients against employees during the period January 1, 2017 to the present [April 18, 2018], including but not limited to the November 2, 2017 incident at Coral Key Unit, in which a patient snatched the hair and pulled the neck of a mental health technician that resulted in

[57] RN CMC also testified that her supervisor, Mr. Haider, helped her write the RSO for the incident. (Ex. 67 at 2206, 2208, 2210, 2212.) The version of the RSO that she originally prepared was "never received." Instead, her supervisor told her "to reinforce that he [the patient] was calm and cooperative." She did not agree with her own handwritten entry on the RSO that said the event was "Handled appropriately." Instead, she wanted to write that the patient should have been processed as a direct admission and not processed at the intake nurses' station. She also discussed with Mr. Haider her view that a MHT should also have been assigned to the intake station. This recommended increased staffing was not included in the RSO. She also said that on February 25, 2018 she backdated the order six days to "2-19-18." (Tr. 1140-45; Ex. 67 at 2206, 2208, 2210, 2212.)

the employee having a strained shoulder."[58] (Tr. 171-72, 437, 2266, 2559; Exs. 79, 267 at 2, ¶ 7.)

As a result of the OSHA Subpoena, and after consultation with UHS-DE employees and counsel, Mr. Curl took steps to preserve six videos from April 8 through April 11, 2018, related to workplace violence incidents.[59] (Tr. 172, 2559-60, 2950.) Respondents did not provide these videos to OSHA in response to the OSHA Subpoena.[60] Further, Respondents took no action to prevent the destruction of video related to any incidents that occurred after receiving the OSHA Subpoena, including after litigation in this matter formally commenced.[61] (Tr. 2938-39, 2942.) CO Trouche testified that Respondents failed to respond to the OSHA Subpoena. (Tr. 172; Ex. 267 at 2, ¶ 7.)

4. OSHA'S Citation and Resulting Litigation

Approximately one week after issuing the OSHA Subpoena, on April 24, 2018, OSHA cited Respondents for exposing employees to acts of workplace violence in violation of section 5(a)(1) of the OSH Act.[62] (Ex. 1 at 6; Stip. 5.) The Citation explains that the incidents of workplace violence include, but are not limited to, physical assaults by patients against employees "in the form of punches, kicks, bites, scratches, pulling and the use of objects as weapons … ."[63] (Ex. 1 at 6.) Respondents timely filed a Notice of Contest to the Citation on April 30, 2018, bringing the matter before the Commission. (Stip. 6.)

The Secretary filed and served his Complaint, which largely mirrored the allegations set out in the Citation, on May 21, 2018. On June 2, 2018, Respondents filed their Answer to the Secretary's Complaint. The Answer includes several affirmative defenses. These stated defenses make clear

[58] The OSHA Subpoena required Respondents to produce books, papers, diaries, logbooks, documents, and videos that were responsive to the subpoena at OSHA's Tampa, Florida office by 4:00 p.m., April 26, 2018. (Ex. 79.)
[59] CEO Hamilton testified that Suncoast only had a "handful or so" of videos at that time because the video system only had video available for 15 to 30 days before videos were rewritten over. (Tr. 2560.)
[60] Eventually, these six videos were turned over to Secretary's counsel after the issuance of the December 14, 2018 Order Granting Complaint's Motion to Compel Production of Documents and are not included in the sanctions part of this Order. (Exs. 29-33.)
[61] Incidents of workplace violence that occurred on May 28, June 2, June 23, and July 12, 2018, may have been captured on video that was not preserved. (Tr. 849, 1453, 2691, 2887, 2917; Exs. 72-73, 75-76, 78; Sanctions Order 3-4.)
[62] Stipulation 5 is: "OSHA issued the Citation and Notification of Penalty underlying this proceeding on April 24, 2018."
[63] On March 15, 2019, the Court granted the Secretary's unopposed motion to modify the proposed abatement set out in the Citation. The modification did not alter the allegation related to the violation itself. (Am. Compl. at 3.)

Respondents' view that their response to workplace violence incidents was adequate.

On August 9, 2018, the Secretary served his First Request for the Production of Documents (First Produc. Request), seeking video of incidents related to the cited hazard from February 3, 2016, through the date of the request (August 9, 2018). Respondents initially provided no videos in its October 11, 2018 response to the Secretary's First Produc. Request. (Ex. 92 at 8.) In particular, they did not produce: (1) video of the RN RO Attack, (2) video of incidents in their possession when they received the October 25, 2017 NOI, (3) video of incidents in their possession when they received the OSHA Subpoena, including the six videos of the incidents that occurred between April 9 and April 11, 2018, or (4) any video of incidents that occurred after they filed their April 30, 2018 Notice of Contest. *Id.* Instead, Respondents indicated that they only keep videos for thirty days and represented that they had nothing responsive to the request. (Ex. 92 at 8, Hamilton Dep. Ex. 14.) The response does not indicate why there was no video of the July 12, 2018 incident, which was less than thirty days before the First Produc. Request or explain whether it could obtain the video of the RN RO Attack from Manatee County. *Id.* Nor does it discuss any attempts to search to confirm whether any relevant video remained preserved on its hard drive despite the passage of time. *Id.*

Videos of incidents of workplace violence are relevant and discoverable. Mr. Curl told OSHA in writing that the facility's video surveillance system was part of its program for preventing workplace violence. (Tr. 2943; Ex. 6 at 5.) Suncoast's Medical Director, Dr. Randolph Hemsath, testified that Suncoast had "videos of stuff that happens in real time. And there are people that review those videos and look and see what's going on and whether or not events were handled appropriately. So we have a process for going through that." (Tr. 2073-75.) Likewise, in their post trial brief, Respondents argue that the videos in existence support their claims of adequate abatement. (Resp't Br. 48-50.) *See Apple Inc. v. Samsung Elecs. Co., Ltd.*, 888 F. Supp. 2d 976, 993 (N.D. Ca. 2012) (inferring that the destroyed

evidence went to the case's merits).

As a result of the lack of production from either the OSHA Subpoena or the Secretary's First Produc. Request, the Secretary filed a Motion to Compel Production of Videos on November 13, 2018. After review, on December 4, 2018, the Court ordered Respondents to produce all videos from February 3, 2016, through April 24, 2018. (First Produc. Order 9-11.) A few days later, on December 14, 2018, the Court clarified the ruling and ordered Respondents to produce all videos from February 3, 2016 through the date of the First Produc. Request, August 9, 2018. (Second Produc. Order 11-12.) On about the same day, Respondents produced six videos related to incidents between April 8, 2018 and April 11, 2018. Five of these six videos were introduced into evidence. (Exs. 29-33, 92 at 24-25.) Respondents did not produce the video of the RN RO Attack at that time, saying a copy of the video was at the State Attorney's office in Manatee County. (Exs. 28, 92 at 25.) Respondent stated that "all other video" was "lost after fifteen to thirty days" because it was "written over," including any video relating to workplace violence incidents that occurred on September 26, 2017, October 2, 2017, October 3, 2017 (MHTs RS and MG), February 19, 2018, March 18, 2018, and possibly April 8, and April 9, 2018 (RN ED).[64] (Ex. 92 at 24-25, 57-59; Resp't Br. 50.) Respondents failed to institute a hold on their practice of allowing videos showing incidents of workplace violence to be overwritten after receipt of the NOI, OSHA's Subpoena on April 19, 2018, the April 24, 2018 Citation, or the Secretary's May 21, 2018 complaint. (Tr. 2938-42.)

After this limited production of six videos, on December 27, 2018, the Secretary moved for an Order to Show Cause Why Sanctions Should Not Issue ("Show Cause Motion"), based on Respondents' apparent spoliation of evidence. On January 16, 2019, Respondents indicated in writing that there were

[64] These workplace violence incidents all occurred either thirty days before OSHA's October 25, 2017 NOI or after the NOI through April 24, 2018 and occurred in areas where cameras existed and should have been retained by Suncoast and not allowed to be written over. Since one of the six produced videos related to workplace violence incidents occurring from April 8 through April 11, 2018 is not in the record it is possible that Respondents produced a video relating to either the April 8, 2018 incident or the April 9, 2018 incident involving RN ED. (Exs. 62, 64, 67-69, 92 at Ex. A.)

no other videos responsive to the December 14, 2018 Order.[65]

On February 13, 2019, the Secretary deposed Mr. Curl and learned additional information about the video system and the preservation of videos after incidents. After Mr. Curl's deposition, Respondents obtained video of the RN RO Attack from local law enforcement, who had preserved it after Respondents provided it to them when requested for their law enforcement investigation. Respondents made the video available to the Secretary on March 15, 2019.[66] (Tr. 2596, 2990.)

After discovery for this matter closed, on March 29, 2019, the Secretary filed his Sanctions Motion, which sets out seven incidents of workplace violence occurring between October 2, 2017 and July 12, 2018, for which videos from the facility's surveillance system were destroyed and sought appropriate sanctions for the destruction of this evidence. (Sanctions Mot. 11-12.)

As noted, on April 18, 2019, the Court found that the Respondents had an obligation to preserve video evidence of the: (1) May 28, 2018 incident of patient aggression against MHT DY; (2) June 2, 2018 incident of patient aggression against staff members; (3) June 23, 2018 incident of patient aggression against Intake Specialist CS; and (4) July 12, 2018 incident of patient aggression against MHT SJ. (Sanctions Order 5, 9.) The Sanctions Order also found that such evidence was relevant to and would support the Secretary's case.[67] *Id.* at 12-13. These four incidents all occurred after Respondents

[65] On the same day, the Court issued an Order Granting in Part and Denying in Part as Moot the Show Cause Motion, primarily because of the supplemental information Respondents provided and because of an upcoming evidentiary hearing scheduled to occur on January 24, 2019 which would permit the parties to be heard on the issues relating to the Show Cause Motion. On January 22, 2019, the Court cancelled the evidentiary hearing at the same time it granted the Secretary's [Unopposed] Motion for Three Week Extension to Discovery Deadlines.

[66] Any delay in Respondents not providing the video of the RO Attack is not included within the scope of sanctions. *See Marquette Transp. Co. Gulf Island LLC v. Chembulk Wesport M/V*, No. 13-6216, 2016 WL 930946, at *3 (E.D. La. Mar. 11, 2016) (finding that Fed. R. Civ. Proc. 37(e) does not permit sanctions if the lost ESI can be provided through additional discovery). *Cf. Bruno v. Bozzuto's, Inc.*, 127 F. Supp. 3d 275, 282 (M.D. Pa. 2015) (citing cases and noting that in assessing prejudice the test "is not whether a party *ever* had access to information, but whether the party's experts were provided adequate and meaningful access to the information.").

[67] In his December 2, 2019 renewed Motion for Sanctions, the Secretary identified these same four incidents that occurred in areas covered by surveillance cameras where employee injuries were documented i.e., May 28, 2018 (MHT DY), June 2, 2018 (RN CS), June 23, 2018 (Intake Specialist CS), and July 12, 2018 (MHT JS). (Ex. 78 at 3; Sec. Br. 199.)

commenced litigation and are relevant to the issue of the sufficiency of any abatement measures related to workplace violence, and/or whether the Secretary's proposed abatement measures would have prevented or lessened the severity of the injuries to employees. *Id.* at 8. Despite concluding that Respondents should have preserved the evidence and that the destruction prejudiced the Secretary, the Sanctions Order found that there was insufficient evidence, at the time, to conclude Respondents' state of mind warranted the harshest sanctions. *Id.* at 13. The Sanctions Motion was denied without prejudice, permitting the Secretary to elicit further testimony at trial on the issue of whether Respondents acted with an intent to deprive. *Id.*

On December 2, 2019, the Secretary renewed his Sanctions Motion, seeking an "adverse inference" that destroyed video footage of four incidents of workplace violence "would have shown that Respondents' response to the hazard was insufficient and/or that the abatement measures described by the Secretary would have prevented or lessened the severity of the injuries to that employee." (Sec'y Br. 197-201.) He also requested "any other relief" the Court finds appropriate, "up to an including dismissal of Respondents' contest of the Citation and Notification of Penalty."[68] *Id.* at 200-1. Respondents argue that they did not intentionally destroy video footage in bad faith and that there should be no sanctions for the destroyed video. (Resp't Br. 50-54.)

5. Rules 26 and 37 – Discovery of Electronically Stored Information

a) Video of Patient on Staff Attacks Should Have Been Preserved

"Parties may obtain discovery regarding any nonprivileged matter that is relevant to any party's claim or defense …. Information within this scope of discovery need not be admissible in evidence to be discoverable."[69] Fed. R. Civ. Proc. 26(b)(1); 29 C.F.R. § 2200.52(b) (Commission rule permitting

[68] Initially, the Secretary also sought an order precluding Respondents from eliciting testimony related to the destroyed video in support of their claims or defenses. (Sec'y Mot. 21.) That relief was not provided. (Sanctions Order 13.)

[69] Procedure before the Commission is in accordance with the Federal Rules of Civil Procedure in the absence of a specific provision in the Commission's own Rules of Procedure. 29 C.F.R. § 2200.2(b). *See also Williams Enters., Inc.*, 4 BNA OSHC 1663, 1665 n.2 (No. 4533, 1976).

discovering of relevant nonprivileged information). When a party does not preserve relevant, discoverable electronically stored information ("ESI"), before imposing sanctions, courts consider whether: (1) the ESI "should have been preserved in the anticipation or conduct of the litigation," (2) the ESI was "lost because a party failed to take reasonable steps to preserve it," and (3) the ESI "cannot be restored or replaced through additional discovery." Fed. R. Civ. Proc. 37(e).

Rule 37(e) does not place the burden of proving or disproving prejudice on any particular party. Fed. R. Civ. P. 37(e)(1) advisory committee's note to 2015 amendment. However, where the content of the lost information may be fairly evident, the information may appear to be unimportant, or the abundance of preserved information is sufficient, it may be reasonable to require the party seeking curative measures to prove it has suffered prejudice as a result. *Id*. In the circumstances of this matter, it is appropriate to place the burden of proving prejudice on the Secretary. *See Eli Lilly & Co. v. Air Exp. Intern. USA, Inc.,* 615 F.3d 1305, 1318 (11th Cir. 2010) (finding, in case not involving ESI, "a party moving for sanctions must establish, among other things, that the destroyed evidence was relevant to a claim or defense such that the destruction of that evidence resulted in prejudice").

Prior Orders make it plain that the destroyed video evidence was relevant, discoverable, and Respondents should have preserved it. (First Produc. Order 5-9; Sanctions Order 12-13.) Nonetheless, Respondents renew their argument that they had "no legal duty to preserve the video footage." (Resp't Reply Br. 14.) Not surprisingly, they cite no relevant precedent for this proposition.

The duty to preserve evidence arises "not only during litigation but extends to that period before the litigation when a party reasonably should know that the evidence may be relevant to anticipated litigation." *Silvestri v. Gen. Motors Corp.,* 271 F.3d 583, 591 (4th Cir. 2001) (citing *Kronisch v. United States,* 150 F.3d 112, 126 (2nd Cir. 1998); *Jones v. Hawley*, 255 F.R.D. 51, 52-53 (D.D.C. 2009) ("[i]t is settled beyond all question that at common law the destruction, alteration, or failure to preserve evidence

in pending or reasonably foreseeable litigation warrants the finder of fact inferring that the destroyed evidence would have been favorable to the opposing party"); *Oil Equip. Co., Inc. v. Modern Welding Co., Inc.,* 661 F. App'x. 646, 652 (11th Cir. 2016) (obligation to preserve attaches when ligation was pending or reasonably foreseeable) (unpublished); Fed. R. Civ. Proc. 37(e). Once a party reasonably anticipates litigation, it must suspend its routine destruction policy and act to preserve relevant ESI.[70] *See Ala. Aircraft Indus, Inc. v. Boeing Co.,* 319 F.R.D. 730, 741 (N.D. Ala. 2017) (duty to preserve commences before litigation is pending and deliberate deletion of ESI warranted sanctions under Fed. R. Civ. Proc. 37(e)), *mot. to certify appeal denied*, No. 2:11-CV-03577-RDP, 2017 WL 4572484 (N.D. Ala. Apr. 3, 2017); *Stevens & Sons, Inc. v. JELD-WEN, Inc.,* 327 F.R.D. 96, 108 (E.D. Va. 2018) (finding that reasonableness requires a party to "suspend its routine document retention/destruction policy and put in place a 'litigation hold' to ensure the preservation of relevant documents"); *First Fin. Sec. Inc. v. Freedom Equity Grp*., LLC, No. 15-CV-1893-HRL, 2016 WL 5870218, at *3-4 (N.D. Ca. 2016) (declining to infer that the deletion of text messages after litigation commenced was simply "routine").

Respondents' suggestion that this matter's commencement before the Commission suspended their obligation to preserve relevant ESI is baseless. *See Graff v. Baja Marine Corp*., 310 F. App'x. 298, 301 (11th Cir. 2009) (unpublished) ("Spoliation is the destruction or significant alteration of evidence, or the failure to preserve property for another's use as evidence in pending or reasonably foreseeable litigation"). This claim is at odds with other claims and defenses Respondents themselves raise as well as Commission precedent. Evidence of post-citation actions, particularly those related to a hazard's abatement, are relevant and admissible. *See, e.g., SeaWorld of Fla., LLC v. Perez,* 748 F.3d 1202, 1215 (D.C. Cir. 2014) (finding that evidence of post-citation actions supports finding that the proposed means of abatement were

[70] Once the duty is triggered, the party should "identify, locate, and maintain information that is relevant to specific, predictable, and identifiable litigation" and "notify the opposing party of evidence in the hands of third parties." *Victor Stanley, Inc. v. Creative Pipe, Inc.,* 269 F.R.D. 497, 522-23 (D. Md. 2010).

feasible); *CSA Equip. Co. LLC*, No. 12-1287, 2019 WL 1375918, at *6, 8 (O.S.H.R.C., Mar. 19, 2019) (reviewing post-accident procedures when assessing the feasibility of abatement); *FMC Corp*., 12 BNA OSHC 2008, 2012 n.5 (No. 83-488, 1986) (consolidated) ("Under ... Fed. R. of Evid. 407, evidence of post-accident measures [is] admissible to establish feasibility."). Once Respondents reasonably anticipated litigation, i.e., by October 25, 2017, they had an obligation to preserve relevant evidence in their possession or under their control, and this obligation lasted at least until the Secretary served his First Produc. Request. Rather than suspending Respondents' obligation to preserve evidence, the Notice of Contest and the filing of the Secretary's complaint removed any credible claim that Respondents might have had that video evidence of workplace violence (the cited hazard) would not be relevant to these proceedings.[71] *See Storey v. Effingham Cty.,* CV415-140, 2017 WL 2623775, *4 (S.D. Ga. Jun. 16, 2017) (preservation duty includes what is reasonably likely to be requested during discovery and/or is the subject of a pending discovery request). The Secretary is not alleging that Respondents should have preserved all evidence related to workplace violence incidents.[72] Respondents should have "reasonably anticipated" litigation upon receipt of the NOI. And they should have preserved evidence from that point through, at least, the First Produc. Request. (Sanctions Order 12-13.)

[71] The NOI and OSHA's Subpoena distinguishes this matter from ones where video is overwritten before a party has reason to know of its relevance to litigation. *See ML Healthcare Servs., LLC v. Publix Super Mkts., Inc.,* 881 F.3d 1293, 1309 (11th Cir. 2018) (partial deletion of video did not necessitate sanctions when most relevant portion was saved even before notice of litigation was provided). Law enforcement's request for video of the RN RO Attack and Respondents own past use of video also supports finding that Respondents knew that such evidence was helpful in assessing workplace violence incidents.

[72] The Second Produc. Order also found that the amount of requested video was appropriately proportional to the needs of the case. (Second. Produc. Order 8-9.) In its Sanctions Motion, the Secretary sought sanctions for video that was destroyed between October 2, 2017 through March 29, 2019; specifically video for workplace violence incidents occurring in surveilled areas, including on October 2, 2017, October 3, 2017, February 19, 2018, May 28, 2018, June 2, 2018, June 23, 2018, and July 12, 2018. (Sanctions Mot. 1, 11-12.) The Sanctions Order stated its willingness to revisit the:

> statement made in its December 4, 2018 Order Granting Motion to Compel that it agreed with the Secretary that Respondents received sufficient notice from OSHA by letter and telephone on October 25, 2017 to preserve any existing video relating to any incidents of workplace violence occurring before April 19, 2018. [citation omitted] However, by any measure, Respondents received such notice upon receipt of the OSHA's Subpoena on about April 19, 2018.

(Sanctions Order, at 12.) Having heard more evidence on Respondents' obligation to preserve videos at trial, the Court finds that their obligation to preserve available videos arose when they received notice of OSHA's investigation.

Respondents' view that the Secretary needed to enforce OSHA's Subpoena in federal district court does not undermine this basic principle. (Resp't Reply Br. 15-16.) At best, Respondents' arguments relate to whether the materials had to be turned over immediately upon the issuance of the OSHA Subpoena, not whether the evidence could be destroyed. A subpoena is not even necessary to trigger the responsibility to preserve relevant evidence. Fed. R. Civ. Proc. 37(e) (establishing that the "anticipation or conduct of litigation" triggers the responsibility to preserve evidence).

Respondents' argument that the Hazard Alert Letter OSHA issued to Suncoast after it first inspected the facility in 2016 did not provide notice of the need to preserve videos is equally unpersuasive. (Resp't Br. 51.) The February 3, 2016 Hazard Alert Letter did not put Respondents on notice of the present litigation.[73] (Ex. 3.) OSHA's NOI triggered Respondents' obligation to preserve videos.

The assessment of the appropriateness of sanctions is based on Respondents' conduct after it reasonably anticipated, or should have reasonably anticipated, the present litigation; in this case by October 25, 2017. Respondents' argument that they did not need to retain any videos because the NOI referred to photographs but not videos, also does not persuade. (Resp't Br. 51-52.) In this decision, the Court has found that Respondents had a duty to preserve any video relating to workplace violence incidents that it had in their possession on October 25, 2017,[74] including that of incidents on February 19, 2018, March 18, 2018, and possibly April 8, and April 9, 2018 (RN ED); as well as any video of incidents relating to abatement that occurred on May 28, 2018 (MHT DY), June 2, 2018 (RN CS), June 23, 2018

[73] Respondents also indicate that OSHA did not request copies of video during its 2015 inspection. At that time, Suncoast had been operating for less than a year. (Tr. 330.) It is unclear whether there were videos of workplace violence incidents available during the time of the 2015 OSHA inspection. The CO remembered discussing what the cameras will capture of an incident but could not recall whether she viewed any videos of incidents. (Tr. 332, 334.) Nor did she recall reviewing EARs discussing incidents of patient aggression during her 2015 visit. (Tr. 331.)

[74] These may also include videos of incidents of workplace violence that occurred on September 26, 2017 involving MHT AS, October 2, 2017 involving MHT MM#1, and October 3, 2017 involving MHTs RS and MG that may have still been available as of October 25, 2017. (Exs. 7 at 392, 397, 63-64.)

(Intake Specialist CS), and July 12, 2018 (MHT JS).[75] (Exs. 78 at 3; Ex. 92 at 24-25, 57-59; Sec'y Br. 199; Resp't Br. 50.)

OSHA's Subpoena also separately and explicitly put Respondents on notice of the need to retain video of workplace violence and that litigation was likely. Thus, Respondents' position that it had no duty to preserve the April 8 through April 11, 2018 videos is rejected, and the prior Court ruling that these videos needed to be preserved, as they were, stands.

b) Failure to Take Reasonable Steps to Prevent the Destruction of ESI

Having found no reason to set aside the ruling in the Sanctions Order that the identified videos were relevant, discoverable, and should have been preserved, the next issue is whether Respondents took reasonable steps to prevent the destruction of videos that ought to have been preserved. Fed. R. Civ. P. 37(e); *Paisley Park Enters., Inc. v. Boxill*, 330 F.R.D. 226, 233 (D. Minn. 2019) (finding that party failed to take reasonable steps to preserve text messages).

As discussed, Mr. Curl only preserved a few videos of incidents that occurred about one week before the OSHA Subpoena was served. (Tr. 2938-39, 2942.) CEO Hamilton and counsel were consulted about the OSHA Subpoena. (Tr. 2559, 2941-42.) And yet, there is no evidence that the NOI, CO's visits, OSHA Subpoena, Citation, or Notice of Contest triggered any type of litigation hold for relevant discoverable evidence related to the cited hazard. (Tr. 2938-39, 2942.) While not in and of itself determinative, the absence of a litigation hold is relevant to assessing whether there was spoliation. *See, e.g., Chin v. Port Auth. of N.Y. & N.J.*, 685 F.3d 135, 162 (2d Cir. 2012).

Respondents had a process in place to view videos of incidents where patients or staff were injured. (Tr. 2926-27, 3223-24; Resp't Br. 50.) The video retention policy called for the preservation of videos related to physical altercations and liability claims: "Video footage … should be maintained and

[75] Having heard more evidence on Respondents' obligation to preserve videos at trial, the Court has determined that the obligation arose as early as October 25, 2017 upon receipt of OSHA's NOI and telephone call. Respondent should also have stopped deleting any videos that it possessed on that date.

copied … (i) If such footage is related to Probable Claim Report (PCR) matter and/or for liability claims as warranted; … (iv) For any allegations of rape, assault or other physical altercations involving patients or residents … ."[76] (Tr. 2924-26, 2937-38; Hamilton Dep. Ex. 14 at 59; Sec. Br. 23, ¶ 43.) Respondents did not always adhere to this policy, particularly when videos related to assaults by patients against staff in which the patient suffered no injury. (Tr. 2938.) They took no steps to preserve most of the videos of staff assaults that occurred during OSHA's investigation[77] and preserved none of the video of incidents that occurred after litigation commenced.[78] (Tr. 2938-39, 2942.) Even the video of the RN RO Attack was not intentionally preserved by Respondents.[79] Instead, an employee gave a copy of the video to local law enforcement and that entity preserved it. (Tr. 2595-96, 2934, 3002.)

The deletion of the videos was not accidental or the result of circumstances beyond Respondents' control. Respondents have the capability to preserve video. (Tr. 2926-27.) They can, and do record, from their video feed, incidents pertaining to workplace violence and preserve such evidence. (Tr. 439.) UHS-DE and Suncoast have an incident evaluation process and routinely preserve videos related to

[76] Mr. Curl testified that CEO Hamilton and his corporate risk manager "dictate[d]" to him whether to complete a PCR. (Tr. 2924-26.) He said Ms. Pearson was the corporate risk manager for UHS-DE in April 2018. (Tr. 2926.) He further said PCRs are more related to injuries to patients or claims filed by patients or their families. Mr. Curl said that PCRs are filed "based off of severity of the incident." He said he never recalled doing a PCR regarding a staff injury from a patient assault. He "was told by CEO Hamilton and/or Ms. Pearson not to create a PCR for" the RN RO Attack." Because he was instructed not to create a PCR. he did not send a copy of the video of the RN RO Attack to UHS's legal or claims departments. (Tr. 2933-34.) He said that the RN RO Attack was "not necessarily" a high severity incident, especially from the patient's perspective. (Tr. 2930-34, 2989-90.) But he agreed that the RN RO Attack was an assault involving a patient. (Tr. 2936-37.)

[77] For example, Respondents did not preserve any video of the February 19, 2018 incident where MHT GS's left foot and ankle were injured by an agitated patient. The Risk Management Worksheet recasts an incident of workplace violence into a patient accidentally stepping on an MHT's shoe causing an injury to the MHT's ankle. Similarly, a backdated RSO that was written with the help of a supervisor claiming the patient was "calm & cooperative", when he was not, and asserting that the event was "Handled appropriately" when the RN involved asserted that it was not. (Tr. 1096-1106; Ex. 67 at 2159, 2210.) Video of the incident would have shed light on whether the incident was an incident of workplace violence or an accidental stepping on toes. Instead of preserving the video, Respondents allowed any video of the incident to be written over and destroyed; doing so while OSHA's investigation was ongoing.

[78] As noted, Respondents only preserved video of the April 8 through 11, 2018 incidents. There were at least four other incidents involving employee injuries linked to patient aggression from May through July 2018 that were relevant to abatement. (Ex. 78 at 3.)

[79] CEO Hamilton testified that video was not preserved after a matter was "settled," so once RN RO's Worker's Compensation case was resolved, Respondents "no longer needed a copy of the video," even though law enforcement had previously requested a copy of the video. (Tr. 2596.)

violence between patients and staff. (Tr. 2924, 2926-27; Mot. to Compel at Ex. G.) For example, if UHS-DE believes that an incident may lead to legal action brought by a patient or his or her representative, then Mr. Curl preserves any relevant video. (Tr. 2926-27; Mot. to Compel at Ex. G.)

Respondents claim that the video system automatically overwrites any video in thirty or fewer days unless someone actively intervenes. (Tr. 172, 436, 2927, 3000, 3002.) Although CEO Hamilton suggested that the system could overwrite video in as few as fifteen days, Respondents' Response to the First Produc. Request and the written video retention policy, Compliance 9.1 Facility Surveillance Video Camera Recording [Revised 10-4-2017], indicate that the system typically preserved videos for thirty days.[80] (Tr. 2927, 3000; Ex. 92, Hamilton Dep. Ex. 14 at ¶¶ A, F; Mot. to Compel at Ex. G.) Respondents' procedures for camera footage specifies that "within" thirty days of an incident involving a physical altercation with a patient or a liability claim, video of the incident should be forwarded from Suncoast to UHS-DE.[81] (Mot. to Compel, Ex. G.)

Respondents do not allege that at any point after receiving the: (1) OSHA's NOI, (2) CO's November 30, 2017 request for video, (3) April 24, 2018 Citation, (4) May 21, 2018 Complaint, or (5) August 9, 2018 First Produc. Request, they took or attempted to take any steps to preserve video surveillance. They make no claim that they looked for video but found it destroyed in less than thirty days. Their claim is limited to contending that after receiving the OSHA Subpoena on April 19, 2018, employees looked for video of workplace incidents that occurred in the four weeks before the receipt of the OSHA Subpoena, and then later, after Mr. Curl's deposition, he sought a copy of the video of the RN

[80] UHS-DE's former Chief Compliance Officer Jim Caponi drafted the form template used for Suncoast's Surveillance Video Camera Recording policy. (Meloni Dep. 113; Ex. 8.)

[81] The policy directs video to be sent to UHS at Director of Claims, UHS Insurance Department, 367 Gulph Road, King of Prussia, PA 19406, which is the location of corporate office for UHS-DE. (Ex. 9 at 309-10; Hamilton Dep. Ex. 14, at 60, ¶ G; Resp't Br. 74; Resp't Reply Br. 8.)

RO Attack from law enforcement.[82] Respondents do not claim that they made any attempt to preserve any video responsive to the OSHA Subpoena for workplace violence events that occurred after January 1, 2017 (beginning date of scope of OSHA Subpoena) through March 19, 2018, or that they attempted to preserve any video relevant to abatement after the April 24, 2018 Citation through August 9, 2018. (Exs. 79, 92.) Other than the April 2018 videos, there is no evidence that Respondents took any steps to preserve any subsequent videos related to workplace violence incidents or instructed anyone to do so. (Tr. 2942.) Nor do they claim that they were unaware of the incidents and the availability of video of them.

Mr. Curl was fully capable of preserving videos of workplace violence incidents and did so when UHS-DE requested. (Tr. 2927.) He acknowledged conferring with Respondents' counsel and UHS-DE's corporate counsel about OSHA's Subpoena.[83] (Tr. 2942, 2949-50.) Consistent with Respondents' programs and policies, Mr. Curl continued to review video after workplace violence incidents. (Tr. 2924-27, 2942-43; Ex. 6 at 264.) And yet, despite the NOI, OSHA Subpoena, and on-going litigation, Respondents continued their routine practice of having surveillance video overwritten.[84] (Tr. 2942.)

UHS-DE is a large, sophisticated entity that manages healthcare facilities throughout the country. (Tr. 2331; Ex. 9; Stips. 12-14; King Dep. 14-17, Meloni Dep. 58-61, Phillips Dep. 24.) Mr. Curl was supported by and able to consult with UHS-DE employees regarding incidents, including a risk manager and counsel. (Tr. 128-29, 2925-26, 2939-42; Curl Dep. 25, 28-29; Meloni Dep. 41-42; Stip. 14.) Also, Mr. Curl confirmed that he consulted UHS-DE employees and counsel after receiving the OSHA

[82] Respondents never turned over anything in response to the OSHA Subpoena. Rather, they produced copies of a total of seven videos only after the Court granted the Secretary's Motion to Compel.
[83] Mr. Curl did not recall whether he had any conversation with Ms. Pearson about any obligation to retain video depicting incidents of workplace violence after the Citation's issuance. (Tr. 2948-49.)
[84] Mr. Curl and CEO Hamilton were both aware that video would be overwritten if no one acted to preserve it. Mr. Curl testified that the video system was set up to automatically overwrite unpreserved videos in thirty days. (Tr. 2927; Hamilton Dep. Ex. 14.) *Cf. Boone v. Everett,* 751 F. App'x. 400 (4th Cir. 2019) (judge refusing sanctions when party did not know the video would be erased and though it had been preserved) (unpublished).

Subpoena. (Tr. 2925-26, 2940, 2942.) He knew how to and could preserve video. (Tr. 2925-26, 2939-40.) He and CEO Hamilton (a UHS-DE employee) were aware of and participated in OSHA's investigation from its inception. (Tr. 128-29; Ex. 20.)

Respondents, relying on precedent dealing with non-electronic evidence, point to the lack of affirmative action to destroy the evidence.[85] (Resp't Br. 53; Resp't Reply Br. 13-17.) However, although this matter does not involve tossing something into the trash, there still was an affirmative act. Respondents let the videos get overwritten rather than saving them data on another disk. *See In re Krause,* 367 B.R. 740, 766 (Bankr. D. Kan. 2007) (sanctioning debtor who continued routine deletion of emails and failed to deactivate "wiping" software which routinely removed information), *aff'd*, 637 F.3d 1160 (10th Cir. 2011); *Philips Elecs. N. Am. Corp. v. BC Tech*., 773 F. Supp.2d 1149, 1197 (D. Utah 2011) (sanctioning defendant who had a duty to preserve ESI by preventing it from getting lost, inadvertently overwritten, or wiped out). There is no allegation that the loss of relevant ESI resulted from anything outside of Respondents' control.[86]

Thus, Respondents claim that it followed a "routine standard policy for the retention of security video footage" is rejected. (Resp't Br. 50.) Unlike ESI lost due to a routine, good-faith operation of an information system, Respondents were already under a legal duty to preserve information when they allowed the videos' destruction. *See Domanus v. Lewicki*, 284 F.R.D. 379, 389 (N.D. Ill. 2012), *objections sustained*, No. 08-C-4922, 2012 WL 3307364 (N.D. Ill. Aug. 13, 2012) (concluding destruction was bad faith). Likewise, their contention that the obligation to preserve relevant, discoverable ESI evidence ended with the Citation's issuance is also rejected. As Respondents took no

[85] Respondents cite no precedent regarding sanctions for the destruction of ESI issued after the 2015 Amendments to Rule 37(e). (Resp't Br. 53; Resp't Reply Br. 13-16.)

[86] Mr. Curl testified that removing the videos from the system to prevent their destruction was somewhat cumbersome. (Tr. 3001.) He also indicated that in the time period between the RN RO Attack and the CO's visit in November 2017, he was very busy dealing with the aftermath of a hurricane and other regulatory matters. (Tr. 2979, 2999, 3004.)

steps to preserve video related to the cited hazard, there is no basis for finding that "reasonable steps to preserve" occurred.[87]

c) Fed. R. Civ. P. 37(e) Provides Relief for Destroyed ESI

Federal Rule of Civil Procedure 37(e) makes plain that when a party fails to take reasonable steps to preserve ESI a court may take action to cure the prejudice (if any) that results. A court may remedy the prejudice caused by a failure to act; no affirmative act of destruction is required:

> (e) Failure to Preserve Electronically Stored Information. If electronically stored information that should have been preserved in the anticipation or conduct of litigation is lost because a party failed to take reasonable steps to preserve it, and it cannot be restored or replaced through additional discovery, the court:
>
> (1) upon finding prejudice to another party from loss of the information, may order measures no greater than necessary to cure the prejudice; or
>
> (2) only upon finding that the party acted with the intent to deprive another party of the information's use in the litigation may: (A) presume that the lost information was unfavorable to the party; (B) instruct the jury that it may or must presume the information was unfavorable to the party; or (C) dismiss the action or enter a default judgment.

Fed. R. Civ. P. 37(e). *See ML Healthcare,* 881 F.3d at 1309 (explaining that Fed. R. Civ. Proc. 37(e) was amended "to address the spoliation of electronically stored information like the video at issue here"); *Sosa v. Carnival Corp*., No.18-20957, 2018 WL 6335178, at *8-10 (S.D. Fla. Dec. 4, 2018) (discussing cases and concluding that video from a closed-circuit system was ESI and Fed. R. Civ. Proc. 37(e) governed sanctions for its spoliation), *reconsideration denied*, No.18-20957, 2019 WL 330865 (S.D. Fla. Jan. 25, 2019).

Rule 37(e)(1) allows for curative measures when lost ESI causes prejudice to another party. In contrast, Rule 37(e)(2) provides for more severe sanctions when the loss of ESI occurred with "intent to deprive another party of the information's use in litigation." Fed. R. Civ. P. 37(e). *See also* advisory

[87] Fed. R. Civ. P. 37(e) is limited to providing relief for ESI that was destroyed and cannot be restored. Other than the video of the RN RO Attack and the six videos from April 8 through 11, 2018, Respondents did not discuss any attempt to restore videos overwritten during OSHA's investigation or after they received OSHA's Subpoena. There is no basis for finding that the destroyed evidence can be restored.

committee's notes to 2015 amendment ("The better rule for the negligent or grossly negligent loss of [ESI] is to preserve a broad range of measures to cure prejudice caused by its loss, but to limit the most severe measures to instances of intentional loss or destruction.").

d) Curative Measures under Fed. R. Civ. Proc. 37(e)(1)

Litigation was reasonably anticipated in this matter as early as October 25, 2017. (Stip. 5; Sanctions Order 12.) *See Zubake v. UBS Warburg LLC,* 220 F.R.D. 212, 216 (S.D.N.Y. 2003) (duty to preserve evidence arose "at the latest" when an employee filed a charge with a governmental agency); *Reed v. Royal Caribbean Cruises, Ltd*., No. 19-24668-CIV-Lenard/O'Sullivan, 2020 WL 5878814 (S.D. Fla. Oct. 2, 2020) (finding that defendant had an obligation to preserve video available at the time its employee completed an incident report); *Peskoff v. Faber*, 251 F.R.D. 59, 62 (D.D.C. 2008) (threat of litigation should have prompted defendant to "deactivate network maintenance tools that automatically delete electronically stored information").

Briefly, the duty to preserve is broader than the duty to produce in discovery. *Food Lion, Inc. v. United Food and Commercial Workers Int'l Union*, 103 F.3d 1007, 1012 (D.C. Cir.1997); *Point Blank Solutions, Inc. v. Toyobo Am. Inc.*, No. 09-61166-CIV, 2011 WL 1456029, *12 (S.D. Fla. Apr. 5, 2011) (noting that relevance for purposes of discovery "is an extremely broad topic"). For example, a party may have a duty to preserve information that turns out to be protected by privilege or is not admissible. In *Bistrian v. Levi*, 448 F. Supp. 3d 454 (E.D. Pa. 2020), the government had a video recording system which, like Suncoast's, overwrote videos every three to four weeks. *Id.* at 469. The court found that the government "reasonably should have anticipated the litigation" soon after one inmate attacked another and taken steps to preserve relevant video. *Id.* It did not matter that the plaintiff failed to file his claim within the time before the video was overwritten. *Id*.

The Sanctions Order explains that, at a minimum, Respondents should have preserved video related to the four incidents of workplace violence that occurred on May 28, June 2, June 23, and July 12,

2018, all of which occurred after the filing of the Notices of Contest and the Complaint.[88] (Sanctions Order 5, 12.) As explained in the Sanctions Order, Respondents failed to take reasonable steps to preserve these four videos, and again as to the videos of incidents in their possession as of October 25, 2017 or that occurred during OSHA's investigation. The information that could have obtained from the destroyed evidence could not be replaced through other discovery. *See Jenkins v. Woody,* No. 3:15-cv-355, 2017 WL 362475, at *16-17 (E.D. Va. Jan. 21, 2017) (imposing sanctions where video was deleted and the ESI could not be restored or replaced). This lost ESI prejudiced the Secretary. (Sanctions Order 12-13.) So, Rule 37(e)(1)'s threshold requirements are met. The Secretary is entitled, at least, to the relief necessary to cure the prejudice resulting from Respondents' actions.

"An evaluation of prejudice from the loss of information necessarily includes an evaluation of the information's importance in the litigation." Fed. R. Civ. P. 37(e)(1) advisory committee's notes to 2015 amendment. The rule leaves judges with discretion to determine how best to assess prejudice and what curative measures are necessary. *Id*. *See also Barbera v. Pearson Educ., Inc*., 906 F.3d 621, 628 (7th Cir. 2018) (upholding magistrate judge's sanction for destroyed email chain). The Court is tasked with determining the weight to give to the parties' evidence and to evaluate its credibility. *See DVComm, LLC v. Hotwire Comm., LLC, et al*., Civ. A. No. 14-5543, 2016 WL 6246824, at *1 (E.D. Pa. Feb. 3, 2016) (imposing sanctions after evaluating the credibility of alleged spoliators).

The destroyed videos relate to multiple issues, particularly: (1) the existence of a hazard in the workplace; (2) employee exposure to that hazard; (3) whether the hazard was capable of causing serious injury or death; (4) Respondents' knowledge of the hazard; (5) abatement of the hazard, and (6) the

[88] At trial, MHT VN also described being attacked in the hallway on August 10, 2018. This incident occurred after the Secretary served his First Produc. Request. MHT VN indicated that she asked Mr. Curl for an opportunity to view video of the attack. (Tr. 973-75, 985.) In response, Mr. Curl said the recording was "too dark." (Tr. 975-76.) Respondents never produced a copy of this video. This Court previously concluded that Respondents must produce surveillance videos between April 24, 2018 through August 9, 2018. (Second Produc. Order 12.) The Secretary does not argue that the failure to preserve video related to the August 10th incident should be considered as grounds for sanctions. (Sec'y Br. 199.)

gravity element of the penalty calculation.

Respondents mitigated some of the prejudice resulting from the spoliation by stipulating, prior to trial, to these first two issues: the existence of hazard and employee exposure to it.[89] (Stip. 7-8.) As to the seriousness of the hazard, the RN RO Attack video and the litany of workplace violence incidents described above establishes that the hazard was both capable of causing, and caused, serious injury that could have resulted in death.[90] (Tr. 3193; Exs. 28-29, 32-33, 36-40, 42-52, 54-61, 63-71.) Similarly, on the issue of knowledge, the preserved videos and other evidence remove any doubt as to Respondents' knowledge of the existence of the hazard.[91] *Id*. So, the availability of other evidence somewhat mitigates the prejudice on this issue as well.

This leaves the issues of abatement, and if a violation is established, its gravity. Looking first at abatement, the parties did not reach any stipulations directly regarding abatement. Respondents argue that there was no prejudice because they maintained written records related to several workplace violence incidents, and witnesses were available to provide some information about incidents for which it failed to preserve the videos. (Resp't Br. 50, 52-53.)

The written records and availability of certain witnesses are not an adequate remedy for the ESI's destruction in this matter. *See Woodward v. Wal-Mart Stores E., LP,* 801 F. Supp. 2d 1363, 1373 (M.D. Ga. 2011) (finding that employee testimony about an event "hardly works" to address the loss of video);

[89] Stipulation 7 is: "Employees at the worksite were exposed to the hazard of workplace violence, specifically defined in this case as violence and/or assault by patients against staff, during the six months prior to the issuance of the citation (October 24, 2017 to April 24, 2018)." Stipulation 8 is: "The hazard of workplace violence, specifically defined in this case as violence and/or assault by patients against staff, was recognized by Respondents Suncoast and UHS of Delaware, Inc." Besides these stipulations, the record also includes substantial other evidence establishing that the hazard existed, and employees were routinely exposed to it.

[90] RN Cooke also testified that she did not consider broken bones, being punched in the neck, stabbed with a pen or scissors, or bites on arms leaving permanent markings to be minor injuries. (Tr. 3193.) The Court rejects Respondents' contention that "the [August 9, 2017] video does not contain any relevant or useful information beyond other documents that recorded the incident and other information obtained from witnesses." (Resp't Br. 51-52.)

[91] Because Respondents were unable to provide the video of the RN RO Attack for nearly a year after OSHA subpoenaed it, the Secretary had to incur time and expense in seeking a Motion to Compel and pursuing other evidence.

Storey, 2017 WL 2623775, at *5 (discussing the "unique and irreplaceable nature" of video evidence); *Moody v. CSX Transp., Inc.,* 271 F. Supp. 3d 410, 429-30 (W.D.N.Y. 2017). In *CSX,* the railroad failed to preserve ESI from the train's event recorder. 271 F. Supp. 3d at 429-30. The ESI would have conclusively established whether a bell rang before the train began to move. *Id.* The court found that the plaintiff was prejudiced by the destruction even though there was other evidence as to whether there was a sound was emitted, and the event recorder might not have supported the plaintiff's claim. *Id*. Prejudice under Rule 37(e) may be found when the destruction causes a party to "piece together information from other sources." *In re: Ethicon, Inc*., No. 2:12-cv-00497, 2016 WL 5869448, at *4 (S.D.W. Va. Oct. 6, 2016); *Abdulahi v. Wal-Mart Stores E., L.P.,* 76 F. Supp. 3d 1393, 1396-97 (N.D. Ga. 2014) (other evidence consisting of emails and testimony did not remove prejudice caused by the employer's destruction of video footage).

The other evidence's inadequacy as a replacement for the destroyed videos is made apparent by examining the video from the few incidents for which it was available. For the RN RO Attack, the EAR's mild language bears little resemblance to the severity of the incident seen in the video. (Tr. 152-166; Exs. 4, 28.) Among other things, Respondents' claim about the swiftness with which endangered employees are assisted rings hollow as one watches the employee sustain blow after blow. It took five staff members, including four women, to eventually physically restrain the attacker. (Tr. 380-82; Ex. 28.)

The record establishes other instances where the information in the written records conflicted with images in the few preserved videos. At about noon on April 8, 2018, a patient was banging a telephone on his head and the wall before physically assaulting RN CG by "biting and hitting" in the hallway. (Tr. 2910-11; Ex. 69.) The Risk Management Worksheet describes some agitation and then indicates that the patient "was able to calm and continue programming." (Ex. 69 at 2329.) A four-minute video showing RN CG and another nurse bringing the patient down the hallway starting at 1206:50 [12:06 p.m.] was

played at the trial.[92] The video does not support the characterization in the Risk Management Worksheet. It shows staff struggling to contain the patient, a stark contrast from the benign written description. (Tr. 2912-17; Exs. 29, 69; Sec. Br. 61-62.) For these events, the videos offered definitive proof of the incident's nature, the significance of the harm suffered, and the adequacy of Respondents' abatement. The documents suggest that the abatement was adequate. In contrast, the videos support the Secretary's claim of inadequacy. Quoting the Supreme Court, the First Produc. Order explains that "illustrations are an extremely important form of expression for which there is no genuine substitute."[93] (First Produc. Order 8-9, quoting *Regan v. Time, Inc*., 468 U.S. 641, 678 (1984).)

The destroyed ESI would have been favorable to the Secretary's claims that Respondents' abatement was inadequate and that certain of the proposed abatement measures could have reduced the hazard. *See Storey*, 2017 WL 2623775, at *5 (issuing sanctions for spoliation of videos, including precluding evidence or argument that the contents of the videos corroborated the defendants' version of events); *Jenkins*, 2017 WL 362475, at *18 (ordering similar sanctions for an automatically overwritten video); *Coward v. Forestar Realty, Inc*., No. 4:15-CV-0245-HLM, 2017 WL 8948347, at *9 (N.D. Ga. Nov. 30, 2017) (allowing arguments to the jury concerning the effect of the loss of the videos).

Finally, the Court concludes that the destroyed videos would have provided support for the Secretary's claims about the appropriateness of the gravity-based penalty he proposes. The CO explained that she viewed this violation as being of "high. Greater" severity and gravity. (Tr. 220.) To address the prejudice caused by the destruction, the Secretary is entitled to a finding that the destroyed evidence

[92] Mr. Curl said that there was no recorded video showing the patient biting RN CG because a camera did not cover that area. (Tr. 2917-19.)

[93] The video of the RN RO Attack provides strong evidence of one element of the Secretary's burden, the capability of the hazard to cause serious physical harm or death. The other evidence of the event, while helpful, is not nearly as conclusive as the video. Mr. Curl argued that videos "don't tell the entire picture." (Tr. 2064-65; Ex. 4.) The inaccuracies in the written records undermine his credibility that videos would not be helpful in understanding the hazard. Respondents' own investigations and audits relied on video evidence to check the accuracy of written documents and assess the degree to which policies were being adhered to by employees. (Ex. 251.)

would have supported OSHA's conclusions about the appropriate penalty amount.[94]

e) Further Relief under Fed. R. Civ. 37(e)(2) is Available

Beyond addressing prejudice caused by the destruction of evidence, courts may also impose sanctions if a party acted with the intent to deprive the opposing party of the information's use in the litigation. Fed. R. Civ. Proc. 37(e)(2). The Secretary requested definitive rulings that the destroyed videos would have shown that Respondents' response to the cited hazard was insufficient and that the abatement measures the Secretary proposes would have prevented or lessened the severity of the injuries to employees. (Sanctions Mot. 4; Sec'y Br. 199-200.) The Secretary also requested dismissal of Respondents' contest of the Citation as a sanction. *Id.* The Sanctions Order left unresolved whether Respondents had the requisite state of mind required to take actions beyond those necessary to cure the prejudice caused by the lost ESI. (Sanctions Order 11-12.)

The Secretary asks for an inference that Respondents acted with the intent to deprive because Respondents failed to prevent the destruction of relevant, discoverable ESI after litigation was not only anticipated but had commenced. (Sec'y Br. 199.) The Secretary argues that Respondents engaged in a pattern of discovery abuses by refusing to comply with the OSHA Subpoena and then denying that they had any videos before finally turning certain ones over after being ordered to do so by the Court. *See Marrocco v. Gen. Motors, Corp., et al.*, 966 F.2d 220, 224 (7th Cir. 1992) (in a non-ESI matter, giving particular weight to the fact that the offending party waited months before it attempted to investigate the lost evidence, and delayed even longer before informing their opponents that key evidence was missing); *Ala. Aircraft,* 319 F.R.D. at 741 (finding sufficient circumstantial evidence to conclude party acted with an intent to destroy ESI). Respondents offer no explanation for why they departed from their own written

[94] In concluding that the loss of ESI prejudiced the Secretary, the Court is not finding that the Secretary was unable to sustain his burden on any necessary element of his case due to the destruction. Rather, Respondents' failure to preserve the videos deprived the Secretary of extremely helpful evidence and forced him to piece together other evidence. *See Ethicon*, 2016 WL 5869448, at *4; *Abdulahi*, 76 F. Supp.3d at 1396-97 (prejudice remained despite availability of non-ESI evidence).

video retention policy. *See Brown v. Chertoff,* 563 F. Supp. 2d 1372, 1381 (S.D. Ga. 2008) (awarding sanction for spoliation when Government was culpable for violating its own policies and for failing to take notice that litigation was likely). Nor do Respondents explain *any* steps they took to preserve videos of the hazard taken after receiving the NOI or after litigation commenced through August 9, 2018. *See Ottoson v. SMBC Leasing & Fin., Inc.*, 268 F. Supp. 3d 570, 582 (S.D.N.Y. 2017) (finding sanctions appropriate when it could be inferred that party either took no steps to preserve emails or simply failed to produce them); *Ala. Aircraft,* 319 F.R.D. at 739-42 (finding duty to preserve triggered before a letter attempting to terminate a contract was sent and even though party with the control of the ESI may not have anticipated the exact nature of the future litigation).

Respondents provide no reasonable explanation for destroying videos. Their only explanation is that Mr. Curl had not previously been involved in litigation related to the OSH Act and that they lacked sufficient notice of the need to preserve the videos. (Resp't Br. 50-54.) Their claims do not hold up to even modest scrutiny. Although they claim that this case was Mr. Curl's first time he "ever had to deal with such a situation," the record establishes otherwise. *Id.* at 51. He explained that one of his responsibilities "is to respond to regulatory or any type of litigation." (Curl Dep. 18.) His primary duties include investigating adverse incidents at the facility, including injuries. (Tr. 2612-13, 2923-34; Curl Dep. 18, Ex. 58.) He routinely reviewed surveillance video of patients assaulting staff. *Id.* After such reviews, he would discuss incidents with UHS-DE employees and together they would assess whether to preserve videos. (Tr. 2924-26.) He recognized the need to preserve video if there was potential for litigation.[95] (Tr. 2924, 2927.) In addition, probable legal claims were an agenda item for the monthly UHS-PSC meetings Mr. Curl attended.[96] (Ex. 251.) Even if the Court rejected Mr. Curl's own testimony

[95] Respondents video retention policy also called for the preservation of video relevant to litigation. (Mot. to Compel at Ex. G.)

[96] Mr. Curl attended all of the UHS-PSC meetings from January 2017 through the end of the OSHA investigation. (Ex. 251 at 3594-3805.)

about his experience with preserving videos, any lack of sophistication on his part was addressed by his access to, and actual conferral with others, including an experienced UHS-DE risk manager and counsel.[97] (Tr. 2925-26, 2941-42, 2948-50; Meloni Dep. 42.)

Suncoast and UHS-DE employees were aware of the utility of reviewing videos to assess safety hazards. Indeed, they claimed it was part of their WVPP. CEO Hamilton, a UHS-DE employee, explained how senior staff, including herself, would conduct weekly "rounds" of the units by reviewing video from the recording system to look for safety concerns. (Tr. 2362-67.)

As for Respondents "notice" of the need to preserve relevant evidence, any credible claim of confusion about the relevancy of the videos to this matter ended with the receipt of OSHA's October 25, 2017 NOI and the OSHA Subpoena, which explicitly called for the production of relevant videos of workplace video. (Ex. 79.) As the Sanctions Order sets forth, "by any measure," as of the date of the OSHA Subpoena, Respondents should not have permitted the destruction of relevant evidence. (Sanctions Order 12.) The Citation itself re-iterated that workplace violence was at the heart of this matter.[98] (Ex. 1.) Respondents conduct never changed—they permitted the destruction of videos after OSHA's 2017 investigation started and continued this practice, with the limited exception of preserving 6 videos between April 8 through April 11, 2018, even after filing a Notice of Contest, being served with the Complaint, filing their Answer, and receiving a discovery request.

Respondents' discussion of other litigation concerning violations of the general duty clause where video surveillance was not offered for inclusion into the record is unpersuasive. (Resp't Br. 53-54.) In one breath, Respondents argue that Suncoast had nothing to do with other facilities managed by UHS-DE,

[97] The UHS-DE Risk Manager Cheryl Pearson who Mr. Curl consulted with was familiar with Suncoast as she previously was the Director of Risk Management for the facility. (Tr. 2539, 2926; Curl Dep. 25-26.) She routinely attended meetings at the facility and the 2016 Hazard Alert Letter was sent to her. (Tr. 341; Exs. 3, 251 at 3936, 3963, 3972, 3983; Curl Dep. 27.)
[98] As discussed, the 2016 Hazard Alert Letter did not establish an open-ended responsibility to preserve all video of workplace violence. (Ex. 3.) These sanctions are based on Respondents conduct after it reasonably anticipated, or should have anticipated, the present litigation, i.e., by October 25, 2017.

but on the other hand claim that litigation involving those facilities should determine what evidence is relevant in this matter. *Id*. at 53-54, 73-76. The Court rejects this argument. Here, the Secretary established that Respondents were on notice of the need to preserve the videos and showed how Respondents' inaccurate paper records made the videos' destruction particularly detrimental. That the Secretary may not have relied on video evidence in some other trial does not justify Respondents' failure to preserve relevant ESI in this matter after receipt of the written notice of OSHA's investigation on October 25, 2017 and the OSHA Subpoena.[99]

Intent is rarely proved by direct evidence. *See e.g., Paisley Park*, 330 F.R.D. at 236-37 (evaluating defendants' conduct throughout the litigation before deciding to issue sanctions); *BankDirect Capital Fin., LLC v. Capital Premium Fin., Inc.*, No. 15 C 10340, 2018 WL 1616725, at *2 (N.D. Ill. Apr. 4, 2018) ("[A] combination of events, each of which seems mundane when viewed in isolation, may present a very different picture when considered together."); *CSX*, 271 F. Supp. at 431–32 (finding intent based on defendants' actions in the litigation that allowed evidence to be overwritten and destroyed); *Ottoson*, 268 F. Supp. 3d at 581–82 (considering plaintiff's conduct throughout the litigation and during discovery disputes); *Ala. Aircraft*, 319 F.R.D. at 746–47 (imposing sanctions pursuant to Fed. R. Civ. Proc. 37(e)(2) where "unexplained, blatantly irresponsible behavior" led to the destruction of ESI).[100] There is sufficient circumstantial evidence here to infer an intent to deprive the Secretary of the best evidence of the hazard and how Respondents' abatement program addressed the hazard. Respondents knew OSHA was investigating the hazard of workplace violence, they knew they had video evidence of

[99] Neither Suncoast nor UHS-DE were party to one of the litigations Respondents argues justified their failure to preserve evidence. (Resp't Br. 54 *discussing BHC Nw. Psychiatric Hosp. LLC d/b/a Brooke Glen Behavioral Hosp.*, No. 17-0063, 2019 WL 989734 (O.S.H.R.C.A.L.J., Jan. 22, 2019), *aff'd in part*, 951 F.3d 558 (D.C. Cir. 2020).) If actions in other litigation were relevant to the spoliation in this matter, it would be appropriate for the Court consider the many cases where video surveillance was preserved and used at trial.

[100] Dr. Lipscomb testified that her assessment of Suncoast "is that there is a blatant indifference to staff safety and from patient assaults on staff here." (Tr. 1745.)

the hazard, they knew the Secretary sought this ESI, and they knew that they were contesting the allegations in the Citation. They offer no sound explanation for why companies with access to counsel and risk managers failed to preserve relevant information after receipt of written notice of an OSHA investigation, as well as after an OSHA Subpoena, and the commencement of litigation.

Although Respondents had the requisite state of mind to permit the imposition of any of the remedies available under Fed. R. Civ. P. 37(e)(2), the harshest of sanctions this rule permits are not appropriate here. The "remedy should fit the wrong." Advisory committee's notes to 2015 amendment. Here, the most biting sanctions are unnecessary. The Secretary is not entitled to a dismissal of Respondents' contest of the Citation based on the spoliation. Instead, the Court will: (1) reject Respondents' argument that the destroyed video would have been favorable to their defenses; (2) find that the destroyed videos would have supported the Secretary's claims regarding the insufficiency of Respondents' existing abatement; (3) find that the destroyed videos would have supported the Secretary's claims regarding the effectiveness of certain of his proposed abatement; and (4) find that the destroyed videos support the Secretary's conclusion regarding the gravity of the violation. *See Envision Waste Servs., LLC*, No. 12-1600, 2018 WL 1735661, at *10 (O.S.H.R.C., Apr. 4, 2018) (concluding that the failure to produce authentic documents corroborated evidence of employer's non-compliance).

Further, the Court will consider awarding the costs of the Secretary pursuing his Sanctions Motion. *See* Fed. R. Civ. Proc. 16(f)(2); Fed. R. Civ. Proc. 37; *NL Indus., Inc*., 11 BNA OSHC 2156, 2168 (No. 78-5204, 1984). If the Secretary wishes to pursue reimbursement for the costs incurred in connection with his Sanctions Motions, he shall file with the Court and present an accounting of those costs to Respondents within four days of the issuance of this decision. He may include any relevant authority supporting the awarding of costs. Respondents, if they wish, may, within four days of receiving the accounting, file with the Court any objections to the Secretary's accounting or the authority relied on

for awarding such costs.

6. UHS-DE Responsibility

Respondents also contend that UHS-DE should not be held responsible for destroying any evidence because Suncoast, not it, owned the video system. (Resp't Reply Br. 13.) UHS-DE and Suncoast work together to discuss workplace violence incidents. (Tr. 2924-27, 2950; Balsamo Dep. 14-15.) Together they reached decisions regarding the preservation of videos taken on Suncoast's premises. (Tr. 2924, 2931.) Mr. Curl reported incidents to two UHS-DE employees, CEO Hamilton and Ms. Pearson. (Tr. 2924, 2934, 2948; Curl Dep. 40.) These employees would then evaluate incidents with him. (Tr. 2925-26, 2931, 2950; Curl Dep. 40; Meloni Dep. 41-42.)

Employees sent incident reports related to employee injuries, including those sustained due to patient violence, to an email address ending with "@UHSinc.com." (Ex. 25; Tr. 1417; Meloni Dep. 69-72.) Although Mr. Curl, a Suncoast employee, could preserve video, he did so only when directed by a UHS-DE employee in its insurance department, when requested by law enforcement in a subpoena, or when requested by a subpoena received from a court or other agency, after conferral with UHS-DE.[101] (Tr. 2926-28; Exs. 79, 92 at 2; Curl Dep. 29, 40; Meloni Dep. 42.) UHS-DE's insurance department would make the "final determination" about preserving video. (Tr. 2926-27.) If UHS-DE determined that a video would be retained, Suncoast was to send the video to UHS-DE's insurance department.[102] (Tr. 2924-27; Hamilton Dep. 67.) Mr. Curl said he believed that he produced videos from the week of April 8, 2018 in response to OSHA's Subpoena issued on April 18, 2018. (Tr. 2927-30; Ex. 79.) Although receipt of the OSHA Subpoena may account for the preservation of the six videos of workplace violence

[101] Even when the video was immediately requested by law enforcement, Mr. Curl still conferred with UHS-DE employees about whether to create a PCR and preserve video of an incident. (Tr. 2927-34.) He said he procured a copy of the video of the RN RO Attack for the sheriff's department; but did not keep a copy or send a copy to UHS-DE for retention. (Tr. 2934.) He said he later obtained a copy of the RN RO Attack video from the sheriff's department and Respondents produced it. (Tr. 2990.)

[102] Mr. Curl testified that Suncoast's written surveillance video recording policy "says that if I don't follow that policy as it's written, that I can be subject to corrective action or termination." (Tr. 2934-35.)

incidents occurring between April 8 through April 11, 2018,[103] Respondents did not produce these six videos to the Secretary until December 14, 2018, after the Court issued an Order directing them to do so.

Suncoast alone did not decide to allow the system to overwrite the recordings. As Mr. Curl succinctly put it, "I'm not making those calls on my own." (Tr. 2936, 2948.) It was at UHS-DE employees' direction that he either preserved or permitted the destruction of video surveillance of workplace violence events. (Tr. 2926-27.)

Respondents point to no evidence suggesting that UHS-DE independently could not control whether videos were preserved or destroyed. *See Brewer v. Quaker State Oil Refining Corp.*, 72 F.3d 326, 334 (3d Cir. 1995) (stating that the evidence must "be within the party's control"); *Watson v. Edelen*, 76 F. Supp. 3d 1332, 1343 (N.D. Fla. 2015) (finding, in a matter decided before the 2015 amendments to Rule 37(e), "it is essential that the evidence in question be within the party's control, that is, the party actually destroyed or was privy to the destruction of the evidence."). EARs and Sedgwick reports were sent to UHS-DE, and at least one of its on-site employees was routinely involved in reviewing workplace violence incidents, including the assessment of whether to preserve video of such incidents. (Tr. 2934.)

The NOI giving notice of the start of OSHA's investigation was addressed to "Suncoast Behavioral Health Center Attn: Janet Sweeny." (Ex. 5.) While the record does not conclusively establish that DON Sweeny was a UHS-DE employee, there is no confusion about whether a UHS-DE employee participated in the meetings with CO Trouche, including when she requested video evidence. (Tr. 129.) In addition, the OSHA Subpoena addressed both UHS-DE and Suncoast. (Tr. 172; Ex. 79.) UHS-DE's employee, CEO Hamilton, accepted service of the OSHA Subpoena. (Tr. 2929; Ex. 79.) The OSHA Subpoena was discussed with UHS-DE employees and counsel for that entity. (Tr. 2950.) Likewise, both entities were cited for the violation at issue. (Ex. 79.) And, both entities commenced this litigation by

[103] Mr. Curl testified that he was told "to preserve videos for the [OSHA] subpoena timeframe." (Tr. 2940.)

filing Notices of Contest. (Stip. 6.) UHS-DE's own employees were aware of incidents of workplace violence, whether there was video of such incidents, and could control whether the video was preserved or overwritten. Its own employees routinely reviewed video to assess the safety of the units. (Tr. 2363-65.) Respondents share culpability in the destruction of relevant ESI that should have been preserved in anticipation of litigation.

III. DISCUSSION

A. Expert Testimony

During the trial, both sides offered expert testimony. Janet Lipscomb, RN Ph.D., and Howard Forman, MD, testified on behalf of the Secretary. (Sec. Br. 123-28, 134-36.) Monica Cooke, RN, testified for the Respondents. A written report by each expert was admitted into the record. (Exs. 81, 83, 264.) Although each person satisfied the threshold requirements to be qualified to offer expert testimony, their respective opinions are not entitled to equal weight. RN Cooke was found qualified as an expert regarding: (1) the feasibility of the recommended abatement measures, (2) Respondents' use of many of the recommended feasible abatement measures, and (3) industry standard practices in behavioral health hospitals. (Tr. 3060-65; Am. Joint Pre-Hr'g Statement at 15.)

RN Cooke does not have a doctorate, and she had not published any peer-reviewed papers or book chapters on workplace violence.[104] (Tr. 3026; Ex. 263.) Although she stated that OSHA had contacted her at some point about workplace violence, she could not provide the name of who contacted her or the

[104] RN Cooke graduated from the Washington Hospital Center School of Nursing in 1977. She received a Bachelor of Science degree in Nursing from Bowie State University in 1984. She earned a Master of Arts degree in Administration/Health Care from the University of Maryland in 1986. Since 2006, she has served as CEO of Quality Plus Solutions where she does risk management and quality support for organizations with behavioral health populations and workplace violence issues. Before that, she was the Nursing Division Chief at the Regional Institute for Children and Adolescents at Rockville, Maryland from 1980 through 1987. She was Department Director/Inpatient Psychiatry at Prince George's Hospital Center in Cheverly, Maryland from 1987 through 1990. She was the DON and Residential Services at the Regional Institute for Children and Adolescents in Cheltenham, Maryland from 1991 to 1994. She served as the Assistant DON at the Regional Institute for Children and Adolescent at Rockville, Maryland from 1994 to 1999. She served as the Director of Quality Improvement/Risk Management/Compliance at the Washington Hospital Center in Washington, D.C. from 1999 to 2001. She later served as the Director of Performance Improvement/Risk Management/Staff Development at the Riverside Hospital in Washington, D.C. from 2001 to 2006. (Tr. 3007-23; Ex. 263.)

location of where the person worked.[105] (Tr. 3027.) Her report mentions one piece of literature, but she does not provide the author or publication date.[106] (Tr. 3029; Ex. 264.) Her testimony and expert report are deficient in many respects because she fails to provide context as to the timing of when abatement measures were in actual effect. Abatement measures introduced after OSHA issued its Citation on April 24, 2018 show the feasibility of abatement measures. They do not excuse Respondents' responsibility for failing to furnish a place of employment free from recognized hazards likely to cause serious harm where employees are exposed to acts of workplace violence caused by patients prior to April 24, 2018. In short, RN Cooke's review of Respondents' program was limited. (Tr. 3035; Ex. 264.) She visited Suncoast once during the day shift, spoke with select direct care workers, and reviewed certain documents.[107] She testified that she looked at whether Suncoast was implementing the abatement OSHA recommended. (Tr. 3036-37, 3066; Ex. 264.) She did not review all the patient records that are exhibits in this matter. *Id.* She did not interview anyone working in the high-risk intake department. (Tr. 3053-54.) Her meetings with direct care employees were brief. She asked about patient aggression but did not ask if the employees witnessed co-workers being injured by patients. (Tr. 3040.) She assumed debriefings occurred, even when written records indicated that a key employee was not part of a debriefing, and despite Respondents' acknowledgment that debriefings did not happen after all types of workplace violence incidents. (Tr. 1101, 2555, 3041-42, 3212-13.) She did not ask the staff whether they believed there was a need for security at the facility. (Tr. 3053.)

When questioned about why she did not ask employees about key matters, she explained there was

[105] RN Cooke indicated she thought it was "federal" OSHA. (Tr. 3027.)
[106] At trial, she clarified that she was not "quoting" this reference. (Tr. 3030-31.) She explained that other than the mention to the document, her report does not cite to or reference published literature. (Tr. 3031.)
[107] On January 22, 2019, RN Cooke met separately with three MHTs, JE, DY and LC, and two nurses, DL and DM, she randomly selected from the day shift. These meetings were scheduled for 15 minutes each. (Tr. 3039-40, 3043-44, 3101-04; Ex. 264 at 3.) Her expert report incorrectly states the number of MHTs she met with as four. (Tr. 3040; Ex. 264 at 3.) At least one of the RN/MHTs she met with, and possibly others, were new and did not work at the facility at all during OSHA's investigation. (Tr. 3102.)

"no way [she] could get into all that information and detail" in the short amount of time Respondents gave her to talk with her interviewees. (Tr. 3043-44, 3049-50.) Similarly, although she indicated that she reviewed various documents that are part of Respondents' alleged abatement program, she did not check records for accuracy or consistency. (Tr. 3042-47, 3051, 3053, 3055.) For example, she claimed that workplace violence events were communicated in Situation, Background, Assessment, Recommendation ("SBAR") reports but did not review any such reports. (Tr. 1613, 3049, 3153-54; Ex. 224.) Nor are any completed SBAR reports part of the trial record. (Tr. 3049.)

RN Cooke did not conduct the depth of review she typically does when retained as a consultant assessing workplace violence programs at behavioral health facilities. (Tr. 3044.) She did not perform a risk assessment or prepare a report with findings and recommendations for abating the hazard. (Tr. 3037.) In her own opinion, a risk assessment would have required, among other things, additional time and validating the information leadership told her. (Tr. 3038-39.) She was not asked by Respondents to "identify risks" at the facility. (Tr. 3037-38.) Nor did she assess whether Respondents were doing everything possible to reduce workplace violence. *Id.* She did not provide any opinions on whether there were feasible means of abatement that Respondent could have implemented. And she was "not in a position to evaluate" whether there was anything Respondents could be doing to reduce instances of workplace violence. (Tr. 3038; Sec. Br. 128-34.)

Two other experts testified on behalf of the Secretary, Dr. Forman and Dr. Lipscomb. The Court found Dr. Lipscomb qualified and accepted her without objection as an expert in: (1) workplace violence prevention for health and human service workers in the healthcare setting, including the behavioral healthcare setting, (2) adequacy and deficiencies of WVPPs, (3) incidents of workplace violence, and (4)

review of proposed abatement measures.[108] (Tr. 1633-34; Ex. 80.) Her work, which began over thirty years ago, focuses on patient attacks on healthcare workers. (Tr. 1526, 1536-38; Ex. 80.) She worked for OSHA as a consultant on compliance assistance to identify practices to prevent workplace violence in healthcare facilities. (Tr. 1541-42.) This project included visiting approximately 30 healthcare facilities to examine what they were doing to prevent employees from being injured by patient violence. (Tr. 1542-43; Ex. 80.) Other projects she led include designing training programs on workplace violence for healthcare workers. (Tr. 1540.) She has many publications, including twenty-five peer-reviewed publications about workplace violence. (Tr. 1546; Ex. 80.) She frequently lectures about workplace violence in healthcare. (Tr. 1545, 1547-49.) She has been trained in research methodologies and taught epidemiology for several years. (Tr. 1766.) Dr. Lipscomb has long studied the cited hazard and how to implement effective abatement methods. (Ex. 80.)

At trial, Dr. Lipscomb offered her opinions on a variety of subjects, including abatement measures Respondents could have implemented to materially reduce the hazard of workplace violence. She testified:

> Q. Briefly, can you just tell us quickly what opinions you have reached about this matter?
>
> A. I reached the opinion that employees at Suncoast Behavioral Health were exposed to the hazard of workplace violence, that it is – they are at risk of incurring serious harm, injury from workplace violence, that workplace violence is well-recognized as a hazard in healthcare, especially in behavioral health, that the employer recognized workplace violence as a hazard, and there are feasible abatement measures, specifically the ones that were included in the OSHA citation and in my report, that would materially reduce the hazard.

[108] Dr. Lipscomb graduated from Boston College in 1976 with a Bachelor of Science degree in Nursing. Shen then worked as a staff nurse at Boston University Medical Center for three years. In about 1979, she received her Master of Science Degree in Occupational Health Nursing from Boston University/Harvard School of Public Health. She then worked for three years at the National Institute for Occupational Safety and Health ("NIOSH") in a unit doing hazard evaluations in various industries. In 1989, she received her Ph.D. in epidemiology, Occupational Health from the University of California Berkeley School of Public Health. She then spent five years as Assistant Professor and Director of the University of California San Francisco's Occupational Health Nursing program. She then served three years as a Senior Scientist at NIOSH's headquarters in Washington, D.C. From 1997 through to 2017, she taught and performed research as a Professor at the University of Maryland. Since then, she has worked as an expert consultant on workplace violence. (Tr. 1527-36; Ex. 80.)

(Tr. 1525-26, 1658. 1676-78; Ex. 81; Sec. Br. 128, 142-75.)

She based her review on the OSHA investigative file, Respondents' responses to the Secretary's Discovery Requests, deposition transcripts, witness testimony at trial, scientific literature on workplace violence prevention, and her experiences at conferences. She scanned in about 15,000 pages of documents that were produced. (Tr. 1629-30, 1636, 1650, 1801; Exs. 81, 84-85.) She concluded that the abatement measures set out in the Amended Complaint were available and could be implemented feasibly by Respondents and would materially reduce the hazard of workplace violence. (Tr. 1658-59, 1664, 1676-78; Exs. 3, 81; Sec. Br. 128, 142-75.)

Dr. Forman testified as a rebuttal witness for the Secretary, and his testimony and expert report were admitted into the trial record.[109] He currently works as a psychiatrist and teacher in a forensic behavioral health facility. He is the Director of the Addiction Consultation Service, where he treats about 2,000 psychiatrically ill patients annually. (Tr. 3269-80; Exs. 82-83.) He has published a book, book chapters, peer-reviewed articles, and non-peer-reviewed articles. (Exs. 82, 83 at 1-5.) He has given presentations at numerous meetings, including on risk assessments. (Ex. 83 at 2.) He assessed Respondents' management of patient violence and the effectiveness of the Secretary's proposed abatement measures. *Id.* at 6. In preparing his opinion, he reviewed: OSHA's investigative file, documents produced by Respondents, Dr. Hemsath's deposition transcript, CEO Hamilton's deposition transcript, and the trial testimony. (Tr. 3267; Ex. 83 at 6.) He attended the trial and listened to the witnesses. (Tr. 3267.) The Court found Dr. Forman to be qualified as an expert to: (1) testify regarding the causes and prevention of patient-on-staff violence in a psychiatric hospital setting, (2) render opinions regarding

[109] Dr. Forman received a Bachelor of Arts degree, *cum laude*, in chemistry and environmental science from Columbia University in 2001. He received a Medical Doctor degree from Albert Einstein College of Medicine in 2008. He completed Post Graduate training at Beth Israel Medical Center as an Intern in Psychiatry in 2009. He served as Resident and Chief Resident at Montefiore Medical Center from 2009 through 2012. He was a fellow in Forensic Psychiatry at the Albert Einstein College of Medicine from 2012 through 2013. He has a New York State Medical License and became board certified in Psychiatry in 2012, Forensic Psychiatry in 2013 and addiction medicine. (Tr. 3268-81, 3493-94; Ex. 82.)

feasible means of abatement on the issue of workplace violence, and (3) testify whether Respondents' workplace violence policies and procedures were adequate to address patient-to-staff aggression, including what clinical treatment is appropriate to address aggression and whether Suncoast provided such appropriate clinical treatment. (Tr. 3266, 3347-48; Ex. 83).

Like Dr. Lipscomb, he concluded that Respondents' approach to managing patient aggression was inadequate and that the abatement measures proposed by the Secretary would "lead to a far safer work environment for the staff." (Ex. 83 at 6, 11; Sec. Br. 159-60, 164-65, 169.)

While RN Cooke's testimony and report met the minimum admissibility requirements, it is not entitled to the same weight as the testimony and reports of Drs. Lipscomb and Forman. Her opinions were not well supported by research. Her speculation about Respondents' implementation of policies and procedures was not borne out by employee testimony or other record documents.

In contrast, Dr. Lipscomb's own research and the research she relied on to help form her opinions has been subject to the rigorous peer-review process. (Tr. 1546-47, 1754-56, 1765; Exs. 84-85.) Dr. Forman advised about how the Secretary's proposed abatement is in place at other facilities and how Respondents' approach fell appallingly short. (Ex. 83.) RN Cooke did not examine whether the proposed measures were feasible or if there any steps Respondents could take to materially reduce the hazard, a critical issue before this Court.[110] *See BHC*, 951 F.3d at 564 (discussing the relative weight given to two experts assessing workplace violence at psychiatric facilities and upholding the ALJ's decision not to afford both opinions equal weight).

B. Legal Standard

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." 29 U.S.C.

[110] In *BHC Nw. Psychiatric Hosp., LLC v. Sec'y of Labor,* 951 F.3d 558 (D.C. Cir. 2020), the court upheld a general duty clause violation issued to a facility that was owned by UHS and managed by UHS-DE. 951 F.3d at 561. Both RN Cooke and Dr. Lipscomb offered expert testimony in that case. *Id.*

§ 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).

C. Presence of a Hazard to Which Employees Were Exposed

Under *Waldon's* four-part 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 to the presence of the hazard of workplace violence and that employees were exposed to it. (Stip. 7.)

As noted, this stipulation addresses some of the prejudice caused by the unavailability of the videos of certain workplace violence incidents. Further, even without stipulation, the record contains ample evidence of the hazard of workplace violence and employee exposure to it. (Tr. 111-12, 193, 195-96; Exs. 9, 28-29, 32-33, 36-40, 42-52, 54-61, 63-71.) The CO reviewed annual records of injuries for the two years before the Citation's issuance.[111] In 2017, Respondents documented on its OSHA-300 form eleven different employees injured in workplace violence incidents. (Ex. 9 at 317-18.) Further, Mr. Curl

[111] The CO's review included the OSHA-300 forms for 2014, 2015, 2016 and 2017. (Tr. 107, 110, 594; Exs. 1, 7, 9.) Respondents also offered materials from the monthly UHS-PSC meetings from January 2016-August 2018. (Ex. 251.) For several months, these minutes note the number of patient attacks on staff. *Id.* at 3943-45, 3980, 4033. However, once Mr. Curl started attending the meetings as the risk manager, the total number of attacks stopped being listed as separate items. Although the minutes stop listing the total, the materials presented at the meetings continue to refer to incidents of patients attacking staff. *Id.* at 3602, 3612, 3641.

was aware of approximately eight to ten workplace violence incidents per month.[112] (Tr. 2831.) Employees themselves also described at trial multiple assaults they experienced during OSHA's investigation. MHT CCM described being pinned against a sink by a patient on November 11, 2017. (Tr. 1164.) The patient hit her, bit her, and shoved her fingers in the MHT's mouth. *Id.* The attack continued for a couple of minutes. (Tr. 1167.) During the incident, the patient "ripped open" the employee's index finger and bit off one of her fingernails. (Tr. 1168.) MHT MM #2 discussed two separate injuries resulting from patient violence she experienced in April 2018. (Tr. 220, 232-35; Exs. 70-71.) On April 9, 2018, she was kicked and bitten by a patient.[113] (Ex. 70.) A few days later, a patient elbowed her in the throat, and she received multiple scratches. (Ex. 71.) This injury left MHT MM #2 with difficulty swallowing.[114] *Id.* at 236. MHT VN testified that patient attacks on staff at Suncoast "happened so often." (Tr. 985.)

In addition to actual injuries, employees also described workplace violence events that could have injured them. For example, Intake RN CMC said patients attempted to slap, spit at, and kick her weekly, and threatened her too many times to count.[115] (Tr. 1088-89, 1093, 1127, 1130.) MHT SS testified that he had been "Spit at plenty of times." (Tr. 2177.) Dr. Hemsath acknowledged that doctors at Suncoast were also exposed to the hazard of physical aggression from patients. (Tr. 2027, 2490). Dr. Lipscomb

[112] If a workplace violence incident involved a patient, Mr. Curl would generally be informed through an electronic incident report generated through the company's MIDAS reporting system. (Tr. 2827-28.) On a monthly basis, about eight to ten of these reports concerned workplace violence, but not all involved employee injuries. (Tr. 2831.) Records in evidence indicate that over 10 incidents of patient aggression on staff occurred during the OSHA 2017/2018 inspection. (Exs. 65-71, 78, 251 at 3848, 3906.)

[113] The UHS-DE Risk Management Worksheet indicates that the patient punched, kicked, hit, and bit staff. (Ex. 70 at 2407.) This worksheet also indicates that one staff member was hit in the eye and that staff required first aide. *Id.* at 2415. The records related to the incident also describes patient kicking, hitting, and biting staff. *Id.* at 2469, 2473.

[114] The UHS-DE Risk Management Worksheet indicates that the patient was striking at staff before the employee was elbowed in the throat. (Ex. 71 at 2506.) The records describe the patient attempting to strike the staff before the employee was injured. *Id.* at 2513.

[115] After reporting these instances to her supervisor, Mr. Haider, he told her: "Just kind of that's what it was like to work in mental health. That was just kind of what you tolerated, what happened, the way that things went. It was just kind of that way. That's what you put up with." (Tr. 1089, 1093-95.)

agreed, providing her expert opinion that the hazard of workplace violence was present at the facility, and employees were exposed to it. (Ex. 81 at 5; Tr. 1526, 1761.)

Respondents do not allege that UHS-DE employees were not exposed to the hazard. The CEO and the COO in training, both of whom worked for UHS-DE, were in the units regularly.[116] (Stip. 11; Tr. 2574.) Other UHS-DE employees routinely visited the facility. (Tr. 1417-18; Exs. 250-51.) The Secretary established the hazard was present, and employees were exposed to the hazard of violence and/or assault by patients against staff.

D. Recognition and Knowledge of the Hazard

The Waldon test's second element examines whether the employer or its industry recognized the condition as a hazard. Again, there is no dispute that Respondents recognized the hazard of workplace violence in the context of patient on staff violence: "The hazard of workplace violence, specifically defined in this case as violence and/or assault by patients against staff, was recognized by Respondents Suncoast and UHS of Delaware, Inc." (Tr. 194; Stip. 8; Ex. 11 at 666.) The record also establishes that the behavioral health industry recognized the hazard.[117] (Tr. 93, 1654-55; Ex. 81.) Dr. Lipscomb explained that the hazard of workplace violence has "long been recognized in the health care industry." (Tr. 1654; Ex. 81 at 6-10.)

Besides hazard recognition, the Secretary must also show the employer's knowledge of the hazardous condition. *Burford's Tree,* 22 BNA OSHC 1948, 1950 (No. 07-1899, 2010), *aff'd*, 413 F. App'x 222 (11th Cir. 2011) (unpublished). Establishing knowledge does not require showing that the employer was actually aware it was violating the Act. *See e.g., Peterson Bros. Steel Erection Co.*, 16

[116] Stipulation 11 states: "Suncoast's Chief Executive Officer ("CEO") Brandy Hamilton, Chief Financial Officer ("CFO") Linda Weymouth, and COO in Training Amrita Nambiar were employed by UHS-DE during the time of the inspection." (Ex. 9.) Ms. Nambiar was no longer employed by UHS-DE at the time of trial. (Tr. 2574.) DON Phillips was also employed by UHS-DE and was the DON at the time of the OSHA inspection. (Phillips Dep. 14.)

[117] Respondents also acknowledge that other UHS-DE managed hospitals have "dealt with workplace violence issues with patients" and that the Secretary has pursued citations alleging violations of the general duty clause against these hospitals. (Resp't Br. 6.)

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).

As explained, Respondents permitted the destruction of evidence related to their knowledge and recognition of the hazard. If necessary, to cure the prejudice caused by the destruction, the Secretary would be entitled to a finding that this element was met. Such a finding is unnecessary as the record includes extensive evidence of Respondents' recognition of the hazard and its presence at the worksite.

Respondents knew employees were exposed to both actual and potential incidents of workplace violence. Management employees experienced workplace violence directly.[118] (Tr. 644; Exs. 7 at 373; 70 at 225.) Employees also reported actual occurrences of workplace violence as well as some threats of workplace violence to their supervisors. (Tr. 646, 649, 653; Exs. 24-26, 36-78.) Patients routinely injured staff before and during OSHA's investigation. (Exs. 28, 36-40, 42-52, 54-61, 63-71.) Injuries to employees from workplace violence included stab wounds, facial bruises (black eyes), sore and bruised backs, sore muscles, bites, permanent scars, cuts requiring stitches, concussions, and a fractured hip.[119] (Tr. 100, 170, 233-34, 890, 963, 974, 985, 1049, 1168, 1191, 1222, 1472; Exs. 28, 36-40, 42-52, 54-61, 63-71.) The facility's video surveillance system, which Respondents indicate is "monitored by the Clinician and Senior management staff," recorded many of these incidents. (Tr. 391-92, Ex. 6 at 264.) In addition, many staff injuries were documented in written EARs shared with management or through

[118] As described elsewhere, many of the EARs omitted details or mischaracterized events. Witnesses described more extensive injuries with longer consequences than what is set out in the EARs. (Tr. 481, 485.) In addition, for the incidents where video was available, the videos depict violent scenes showing the hazard in the workplace. (Exs. 28-33.) The EARs do not provide an equivalent depiction of the seriousness of the events.

[119] The record in this case shows that more than forty instances of workplace violence occurred after OSHA issued its February 3, 2016 Hazard Alert Letter through April 24, 2018, when the Citation was issued. (Exs. 78, 92 at 27-43.) Many other incidents of physical assaults by patients on staff were also not reported or went unrecognized. (Tr. 704-05, 845-46, 931, 1041-42, 1128-29, 2010-11; Sec. Br. 43-45.)

patient-specific incident reports.[120] (Exs. 9, 36-77.) Both Suncoast and UHS-DE employees reviewed EARs and other incident reports. (Tr. 2576-77, 2934; Balsamo Dep. 14-15, 17-18.) Incidents of physical confrontation and staff injuries were discussed at the monthly UHS-PSC meetings, which Suncoast and UHS-DE employees attended. (Ex. 251 at 3602, 3935, 3937, 3943, 3962-63, 3980, 3995-97, 4033, 4035-37, 4039, 4050, 4052-55, 4065-67, 4082, 4084-85.) The EOC committee, which, like the UHS-PSC, had members that included both UHS-DE and Suncoast employees, discussed employee injuries from patient aggression and making both Suncoast and UHS-DE aware of the hazard.[121] (Tr. 2337; Exs. 35, 262.)

Written training materials and policies also acknowledge the hazard of patient on staff violence. (Tr. 195; Exs. 9-11, 13 at 748, 19.) The Workplace Violence policy indicates it provides guidelines for supervisors regarding their role and responsibility for identifying, reporting, and prohibiting threats or acts of violence. (Tr. 111-12; Ex. 10 at 1.) It tasks supervisors with the responsibility of observing and reporting individuals who pose a potential threat.[122] *Id.* Suncoast, using materials prepared by UHS-DE, trained employees about workplace violence. (Ex. 11; Stips. 14, 21.) The materials explain that patients cause most of the aggressive or violent events. (Ex. 9 at 324; Ex. 11 at 666.) UHS-DE understood the hazard, was aware of its presence at the worksite, and provided training materials about the hazard. (Stips. 14-15, 21; King Dep. 13, 15.) The facility also had a Behavioral Management policy. (Ex. 9.) This policy explains that "All employees working in the facility are potentially at risk for assault." *Id.* at 324.

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[120] Patient injuries were generally tracked through a system called MIDAS while employee injuries were supposed to be documented in EARs. (Tr. 2848-49.) Mr. Curl indicated that he receives about forty incident reports through the MIDAS system per month and that approximately 20-25% of the involve workplace violence. (Tr. 2831.)

[121] As noted above, multiple UHS-DE employees worked at the Lowell, which was previously cited for workplace violence hazards. The parties stipulated: "While acting Loss Control Manager during their respective time periods, both Eric Lewis and Gina Gilmore handled Lowell's worker's compensation claims and talked with staff who had worker's compensation injuries. While acting as Loss Control Manager during their respective time periods, Eric Lewis and Gina Gillmore tracked expected and actual workers' compensation expenses." (Stips. 17, 18.)

[122] Although Respondents failed to implement this policy appropriately, its existence bears on the employer's knowledge of the hazard.

Further, on February 3, 2016, not long after the facility opened, OSHA specifically wrote to Suncoast about the hazard of workplace violence at the facility. (Ex. 3.) OSHA addressed the letter to Ms. Pearson, who at the time was Suncoast's Director of Performance. *Id.* Ms. Pearson subsequently changed positions from Suncoast to the UHS-DE risk management department. (Tr. 316, 2594.) The change in position did not erase her knowledge of the hazard.[123] *See MJP Constr. Co.*, 19 BNA OSHC 1638, 1648 (No. 98-0502, 2001) (supervisor chargeable with knowledge of the requirement "based on their prior work experience, wherever that experience originates"), *aff'd*, 56 F. App'x 1 (D.C. Cir. 2003) (unpublished). The Secretary showed Respondents' recognition and knowledge of the hazard's presence at the worksite.[124]

E. Serious Physical Harm

The Secretary also met the *Walden* test's third element: 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). As discussed, Respondents' destruction of ESI showing injuries suffered by employees could have entitled the Secretary to a finding that the hazard was capable of causing serious injury or death. However, as Respondents eventually produced the videos of the RN RO Attack and some other incidents, such a finding as a matter of law is not necessary. The evidence in the record leaves no question that the hazard was capable of causing serious physical or death. On the first day of trial, the Secretary played the video of the RN RO Attack in its entirety. CO Trouche narrated while the video of the RN RO attack was played. (Tr. 146-67; Ex. 28.) She said it was helpful to view the video as "it provided more of a visual of what I had been reading in the OSHA 301, the employee accident report, and my interviews. And also, you know, it

[123] The Lowell facility's CEO, CFO, COO, and loss control manager were also all employed by UHS-DE. (Stips. 15, 16.)
[124] In addition, as discussed above, the Court finds that Respondents destroyed evidence that would support the conclusion that they had actual knowledge of the hazard.

helped to have a visual of what Mr. Curl and CEO Hamilton had spoken to me during the initial portion of the investigation." (Tr. 170-71.) The RN RO Attack video shows the Turtle Cove and Coral Key units combined nurses' station from a stationary perspective, looking toward the nurses' station in the direction toward the Turtle Cove unit. (Ex. 28.) It shows the open areas above both counters (Ex. 8 at 524, 527, Ex. 28) and the Dutch door (Ex. 8 at 524 at "C," Ex. 28). The RN RO Attack video shows the action occurring between about 0023:53 [military time] [12:23 a.m.] through about 0032:59 [12:32 a.m.], August 9, 2017.[125] (Tr. 146-167; Exs. 3, 8 at 524 [bottom], 28.) The RN RO Attack video shows the 16-year-old patient[126] gaining access to the nurses' station at about 0024:28 [12:24 a.m.] by diving over the opening above the counter separating the nurses' station from the Turtle Cove unit and physically attacking RN RO within the nurses' station.[127] (Tr. 156; Exs. 8, at 524 [bottom] at "B," at 525, 527 [top photo at "A" and bottom photo], Ex. 28.) A struggle ensues as RN RO and primarily two other staff members try to physically restrain the youth patient behind the counter inside of the nurses' station.[128] The video shows the youth patient stabbing RN RO using either scissors or a pen from the counter of the nurses' station. (Tr. 159-67; Ex. 28.) At 0026:46 [12:26 a.m.], the video shows an RN going into the "med room" to get a chemical restraint to be administered to the youth patient by a needle to sedate him. (Tr. 160-66; Ex. 28.) At about 0026:55 [12:26 a.m.], the video shows a MHT using her cell phone to call local law enforcement. The chemical restraint medication was given to the youth patient while he was on the ground behind the counter by about 0030:40 [12:30 a.m.]. The video shows three uniformed police officers arriving at the nurses' station at 0031:10 [12:31 a.m.] and thereafter subduing the patient. (Tr.

[125] The Court finds that the Secretary's counsel mistakenly referred to the timer on the RN RO Attack video that showed 0023.53 [12:23 a.m.] as referring to "11:53 p.m., August 9, 2017" in her question at trial transcript page 152. The RN RO Attack occurred during the very early morning hours of August 9, 2017. (Tr. 508-09; Exs. 4, 28, 60.)
[126] RNs and MHTs described the youth patient to CO Trouche as having an appearance of a football player. He was an extremely strong male patient, very big, and tall. (Tr. 157.)
[127] The EAR, dated August 9, 2017, signed by Supervisor Lovett and RN RO describes the assault, "260 lb male adolescent psych pt. dove over counter attacking staff -/c scissors in one hand, pen in other." (Ex. 4 at 297.)
[128] MHT BG testified that after jumping over the nurses' station that patient was "grabbing things, pulling phones out, knocking computers over, knocking files over." (Tr. 642-43.)

162-66; Ex. 28.) The RN RO Attack video ends at 0032:59 [12:32 a.m.], August 9, 2017. (Tr. 166-67; Ex. 28.) The law enforcement officers took the youth patient into custody. (Tr. 165-66; Ex. 28.) The Incident/Investigation Report stated: "At the request of Suncoast staff," the officers removed the patient from Suncoast and "transported [him] to Centerstone due to lack of man power to deal with [him]." (Tr. 2516, 2705; Exs. 4 at 300, 60 at 1675; Sec. Br. 13-14.)

Many employees described the serious injuries they received while working at the facility.[129] Employee injuries 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); *Pepperidge Farm, Inc.*, 17 BNA OSHC 1993, 2003 (No. 89-0265, 1997) (considering injuries to employees when assessing whether the hazard was recognized and capable of causing serious physical harm). RN RO worked at the facility as a RN from its opening in 2014 and left four years later. (Tr. 464-65.) He was violently attacked in separate incidents occurring on May 23, 2017 and in the RN RO Attack. (Tr. 167, 467, 1260-61; Exs. 4, 27-28, 56, 60.) In one of the attacks, a patient punched him in the neck and face, then headbutted him in the right temple.[130] (Tr. 1270; Ex. 56.) He described the incident as "a long, grueling, bleeding, wrestling match on the floor." (Tr. 501.) He was "really dazed" and "out of it" when the police arrived, and there was finally enough help to restrain the patient. (Tr. 1261, 1265.) RN RO was evacuated to the hospital, where he was diagnosed with a concussion and neck injuries. (Tr. 478, 481, 1260-61, 1264-65; Ex. 56.) His injuries took months to heal. (Tr. 478-79, 514-15.)

That attack was not RN RO's only experience with workplace violence at Suncoast that caused him serious physical harm. Two months later, as discussed above, another patient leaped over the nurses'

[129] Dr. Forman described the injuries suffered by employees as "tremendous injuries." (Tr. 3491-92.)
[130] Just prior to this attack, the same patient threatened to "snap" the neck of another RN. (Tr. 1268.) The patient was large (approximately 6'4") and had a history of aggression. (Tr. 1263, 1271; Ex. 56.) The RN believed the patient could break her neck as he threatened. (Tr. 1271.) RN RO was initially working on a different unit and was called to assist with addressing this threatening patient. (Tr. 471-72.)

station and stabbed him in the neck and face with a pair of scissors. (Tr. 499-500; Ex. 28.) He was wounded and suffered another concussion. (Tr. 511-12.) He required stitches and suffered multiple bruises "through the body." (Tr. 170; Exs. 4, 60.) Besides stabbing RN RO, the patient also stabbed a supervisor in the leg during this incident. (Tr. 644.)

A second RN described similar experiences with workplace violence at Suncoast, including being attacked by a patient twice in a single month. (Tr. 878.) During the second incident that occurred on November 22, 2016, RN VG was kicked with sufficient force that she fell over backwards. (Tr. 878, 893-94.) The incident left her with a broken hip and multiple broken ribs. (Tr. 889-91.) As discussed, RN VG was hospitalized, had surgery, and was sedated for eight days before being transferred to a rehabilitation facility. She returned to "light duty" on February 14, 2017 after missing 91 days of work. She was on transferred or restricted work for 21 days. (Tr. 884-907, 933-46; Ex. 7 at 400, Ex. 49.)

On March 18, 2018, an aggressive, combative, and defiant patient tried to instigate fights with other patients while pacing up and down the hallway. Staff escorted the patient to her room, where she spit on staff and kicked RN NH in the middle of her back while she was "attempting to secure the patient's legs in the restraint." RN NH suffered "Back swelling, bruise or pain from direct blow to the back." (Tr. 2210-13, 2226-36; Ex. 68.)

Risk Management Worksheets and RSOs describe multiple injuries related to the cited hazard that occurred on the same date. At 1:45 p.m., April 9, 2018, a patient bit RN ED's lower right forearm in the Turtle Cove unit. The bite wound was "2cm long and broke skin." At 2:33 p.m., April 9, 2018, an irritated and physically aggressive patient attacked staff and hit a staff member in the eye. (Ex. 70 at 2415-22, 2467-69.) At 6:00 p.m., on April 9, 2018, a patient kicked staff member LB in her left knee at the Turtle Cove unit. At the same date, time, and location, a patient bit MHT MG's left hand. (Tr. 2725; Ex. 70.) Later, at 8:55 p.m., a patient kicked, hit, and bit staff in his room and continued to try to do so

after being placed in a seclusion room. (Tr. 2724-25; Ex. 70 at 2407-14, 2470-73, 2500-01.)

MHT MM #2 described at trial three other separate attacks that occurred on April 9 and April 11, 2018, shortly before the Citation's issuance. (Tr. 232.) A patient's violent actions led to MHT MM #2's serious injuries. (Tr. 232-41; Exs. 32-33, 70-71.) As discussed in Section III.C, on April 9, 2018, at about 6:15 p.m., MHT MM #2 was kicked in the right shin and bitten on the right forearm. (Tr. 233-36; Ex. 70 at 231.) Later that evening, the same patient kicked supervisor LB in her left knee and slapped her on the arm. (Tr. 238-39; Ex. 70 at 223). On April 11, 2018, at 6:58 p.m., a 13-year-old female patient elbowed MHT MM #2 in the throat and scratched her right forearm.[131] (Tr. 2725; Exs. 32, 71.) At trial, MHT MM #2 narrated two videos taken from two cameras on April 11, 2018. The videos show a patient elbowing MHT MM #2's throat and scratching her right forearm at 6:58 p.m. and minutes later at about 7:10 p.m. kicking while three staff members held the patient down. (Tr. 250-58; Exs. 32-33.)

More witnesses described punches, kicks, bites, shoves, and violent threats.[132] (Tr. 233-34, 625-27, 632-33, 702-4, 848-49, 1047-48, 2145-48.) Some of these attacks left employees with bruises, concussions, and in need of hospital care. (Tr. 1047-48.) Respondents' records also refer to injuries to vulnerable areas of the body, such as the eyes. (Exs. 9, 35, 54, 70.) *See Vanco Constr. Co*., 11 BNA OSHC 1058, 1059-61 (No. 97-4945, 1982) (discussing the significant vulnerability of eyes). The CO explained how many of the injuries employees suffered because of workplace violence required days off, restricted work, or job transfers. (Tr. 180-84, 187-88; Ex. 7.) In other words, the injuries were severe enough that the employees were unable to fulfill their typical duties. (Tr. 180-84, 187-88; Ex. 7.)

[131] Dr. Lipscomb testified that although three staff members responded to the incident, no code was called. She also said that Respondents should have used some special strategies to make sure the "patient did not assault staff." (Tr. 1903-06.)
[132] MHT SS testified that on October 31, 2015 he was bitten on his rib cage by a threatening agitated 17-year old patient. He initially said during direct examination that he watched a video of the assault as part of a debriefing. Later, during cross examination, he said he did not watch any video of the incident. (Tr. 2148-49, 2171-74; Ex. 7 at 444.) The Court is unaware of any such video being in the record. MHT SS also said that he had been "[s]pit at, plenty of times", but did not report these incidents. (Tr. 2176-77, 2216-17.)

In addition to this evidence about the serious physical harm the hazard caused and was capable of causing, the Secretary also offered expert testimony supporting his claim. (Tr. 1526, 1657-58; Ex. 81.) Dr. Lipscomb noted that concussions, broken bones, a dislocated shoulder, torn knee muscles, a broken pelvis, and other injuries were serious physical harm. (Tr. 1657-58.) She concluded that the cited hazard was causing serious physical harm.[133] (Ex. 81 at 1; Exs. 36-78.) In her report, RN Cooke characterized workplace violence events at Suncoast as resulting in "minor" injuries. (Ex. 254 at 3.) At trial, however, she clarified that many of the injuries suffered were not minor. (Tr. 3193.) She agreed that broken bones, punches to the neck, stabbings with pen or scissors, and bites that leave permanent marks were not minor injuries. *Id.* The Secretary showed that the hazard caused and was capable of causing serious physical harm.

F. Abatement

Having shown that the worksite had a recognized hazard capable of causing serious physical harm to employees, the Secretary must then establish that the employer failed to render its workplace free of the hazard. There is no dispute that the hazard remained in the workplace throughout OSHA's investigation and beyond. However, the requirement to have a workplace free of recognized hazards is limited to preventable hazards. *Nat'l Realty & Constr. Co., Inc. v. OSHRC*, 489 F.2d 1257, 1265-66 (D.C. Cir. 1973). When an employer has already undertaken methods to address a hazard, the Secretary must show that those methods were inadequate. *U.S. Postal Serv., Nat'l Ass'n of Letter Carriers*, 21 BNA OSHC 1767, 1773 (2006).

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[133] Dr. Lipscomb testified:

> Q. Okay. Have you reached a conclusion about whether at the time of the OSHA inspection in this case that the hazard of workplace violence was causing or likely to cause serious physical harm?
> A. Yes, I have formed an opinion that that is the case. And I must say, after sitting through – what is this day five of testimony and hearing from 13 employees or former employees about the seriousness of their injuries, I am just shocked that this continues to go on. … There was a broken nose cited, a broken jaw. I'm working my way down the body parts. Dislocated shoulder, torn meniscus, broken pelvis. I think there is no question that the violent acts that continue to occur at Suncoast cause very serious harm.

(Tr. 1657-58.)

Respondents argue that it took several actions to address the hazard and that their measures were adequate to address it. (Resp't Br. 43.) Respondents had a WVPP, which included written policies and training. (Exs. 10-11; Resp't Br. 44-48, 60-63.) According to Respondents, its WVPP was not a standalone policy "but encompassed a number of different policies and procedures." (Tr. 3108-21; Resp't Br. 44-45; Ex. 264 at 4-5.)

The Secretary counters that Respondents' abatement was inadequate both as conceived and as implemented. *See Integra Health Mgmt., Inc*., 27 BNA OSHC 1838, 1849 n.14 (No. 13-1124, 2019) (indicating that the threshold question is whether the employer's abatement was inadequate). As addressed below, the Secretary showed the significant gap between how Respondents said they mitigated the hazard and what occurred at the facility. Respondents relied heavily on the testimony of two senior employees, CEO Hamilton and Risk Manager Curl. Frequently, documents or employees' experiences at the facility did not support Respondents' claims. *See Kaspar Wire Works, Inc.*, 18 BNA OSHC 2178, 2182, n.12 (No. 90-2775, 2000) (finding that while witness claimed her recordkeeping practices remained unchanged the claim was belied by data), *aff'd*, 268 F.3d 1123 (D.C. Cir. 2001); *BHC*, 951 F.3d at 565 (discussing the disconnect between stated policies and actual practices before upholding a citation for violating the general duty clause). Overall, the Court found the front-line workers' testimony more credible than that of CEO Hamilton or Mr. Curl. Both CEO Hamilton and Mr. Curl gave evasive or incomplete responses, and this, coupled with their demeanor during their testimony, undercut their credibility. In addition to evidence about the inadequacy of Respondents' abatement put forth at trial, as a sanction, the Secretary is entitled to a finding that the destroyed videos would have supported his claims about the abatement's inadequacy.[134]

[134] The Court finds that the Secretary was able to meet his burden of showing Respondents failed to adequately abate the hazard but that this was made more difficult because of Respondents' destruction of evidence.

1. High Number of Injuries

The number of injuries at the worksite far exceeds the industry average for other similar facilities. (Exs. 7, 36-40, 42-52, 54-61, 63-71, 78.) The CO reviewed records of injuries from workplace violence incidents. (Tr. 180-84, 187-88; Ex. 7.) Suncoast had more injuries from workplace violence alone than other similar facilities had for all causes of injuries.[135] (Tr. 187; Exs. 7, 9, 35-40, 42-52, 54-61, 63-71, 78.) Further, the data Respondents provided to the CO to make this calculation undercounted the total number of injuries. According to the OSHA-300A and EARs, there were ten injuries from patient aggression in all of 2017.[136] (Ex. 9 at 318.) For the first six months of the following year, 2018, minutes from the EOC committee indicate fifteen injuries from patient aggression. (Ex. 35.) Further, multiple employees discussed how only significant injuries were recorded. Being hit, slapped, or having something thrown at you were considered "small incidents," which routinely went undocumented. (Tr. 846, 1041.)

Higher than average injury rate is a relevant measure of the sufficiency of Respondents' 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 support the Secretary's claim that the abatement methods as implemented were inadequate.

2. Inadequate Policies & Procedures

Respondents, in their brief, allege that their abatement included: (a) written policies; (b) management commitment to those policies and employee participation in patient care; (c) worksite analysis, hazard identification, prevention, and control; (d) post-incident debriefings; (e) program evaluation; (f) training; (g) staffing, and (h) relationship with local law enforcement. (Resp't Br. 45-48.)

[135] RN ET testified that there were more injuries at Suncoast than the other behavioral health facility she had worked at. (Tr. 1380, 1392.)

[136] The Secretary does not allege any record-keeping violations.

No single document described these things as comprising the WVPP. Nor did any witness list the elements of this program in a single explanation of the facility's response to the hazard.

Instead, after being led by counsel, Respondents cited bits of various documents and policies in an attempt to claim that the cobbled-together collection was a comprehensive and effective approach to abating the cited hazard. The record reveals the Respondents' WVPP to be an after-the-fact scattershot attempt to claim they had adequate policies and procedures for a known serious hazard. The program was not implemented as written, not backed by a commitment to the policies or employee participation in addressing the hazard, and not guided by sufficient analysis. (Ex. 81 at 18.) The clinical policies and procedures Respondents claim show adequate abatement focus on individual patient aggression without sufficiently addressing employee injuries, risk factors, and post-incident corrective measures. *Id.* At bottom, Respondents did not have the workplace violence prevention program they claimed they did. *See BHC*, 951 F.3d at 567 (emphasizing policy implementation when assessing whether a facility effectively abated the hazard of patient on staff violence). Instead, the incomplete implementation and insufficient staffing rendered the WVPP ineffective and led to additional actual and potential injuries. (Tr. 1945-46; Ex. 81 at 18.)

a) Workplace Violence Policy & Workplace Violence Training PowerPoint

The written program directly concerning workplace violence included a short generic Workplace Violence policy and a collection of PowerPoint slides from a training program titled "Preventing Workplace Violence" ("UHS PowerPoint").[137] (Exs. 10-11; Stip. 14; Ex. 92 at 17, Response to

[137] Stipulation 14 states:

> UHS-DE provides the facilities it manages, including Suncoast and Lowell, with certain policies, procedures, and forms, in either final and/or template form, available on an internal website to all subsidiaries. The facilities have the option of accepting these templates or conforming them to fit their particular worksite. Some of these form documents include: Employee Accident Forms, Workplace Violence Policy Manual, Preventing Workplace Violence PowerPoint and the Employee handbook.

Stipulation 21 is: "Valerie Cupo, a UHS-DE employee, developed the UHS-DE Workplace Violence PowerPoint Presentation."

Interrogatory (Resp. to Int.) No. 5.)

The Workplace Violence policy's stated purpose is to guide "supervisors." (Ex. 10 at 654.) In the event of an act of violence, the policy directs employees to "call the Security department and/or 911." *Id.* at 656. The document does account for the fact that there was no such security department at Suncoast to call. (Tr. 1807.) Further, employees received conflicting information about whether utilizing 911 was appropriate and repeatedly delayed doing so. (Tr. 423, 891, 900, 907.) The RN RO Attack illustrates this confusion. In the midst of trying to protect himself and his co-workers from a violent patient, RN RO asked his supervisor to call 911 early on in the incident. She initially refused to do so. As the situation developed, she eventually called 911. The delay wasted critical time. (Tr. 100, 424, 464-65, 478-79, 489-507, 512, 563, 641-43, 1045, 1064; Exs. 4, 28, 60.)

RN VG described a separate incident where a different RN supervisor, Mr. Haider,[138] neglected to timely contact 911 following a serious workplace violence incident. (Tr. 891, 900, 907.) RN VG described how, after being badly injured by a patient, Mr. Haider and others were just "standing over me" in the hallway. (Tr. 891, 900.) She continued, "Nobody was helping me. I knew I was hurt badly." *Id.* She indicated remaining on the floor for "a good 30 to 40 minutes." After "quite a while" and not "done immediately," Mr. Haider eventually called 911. (Tr. 907.) It then took ten minutes before law enforcement arrived. *Id. Cf. Dukane Precast, Inc. v. Perez*, 785 F.3d 252 (7th Cir. 2015) (citing the failure to timely call 911 to assist an injured employee as support for willful characterization).

The Workplace Violence policy also called for reporting acts of violence engaged in by employees or non-employees "to the proper authorities and prosecuted to the fullest extent of the law." (Ex. 10 at 654, 657.) Respondents did not adhere to this policy.[139] Critically, the Workplace Violence policy fails

[138] RN VG testified that Mr. Haider "was in training" at the time. (Tr. 934.)
[139] RN RO himself reported one of the attacks to the police. (Tr. 519-20, 2934.) There are no other incidences in the record where Suncoast reported other attacks to the proper law enforcement authorities and called for their prosecution to the fullest extent of the law.

to directly address patient-on-staff violence, which is by far the most prevalent type of workplace violence at Suncoast. (Ex. 10; Tr. 111-12, 193-94, 1668, 1817.)

Respondents argue that the UHS PowerPoint supplemented the Workplace Violence policy. (Resp't Br. 3-4.) The UHS PowerPoint cites violence by patients as a form of workplace violence and refers to elements of the facility's Workplace Violence policy. It states, "**Most aggressive or violent events are caused by patients**." (emphasis in original) (Ex. 11 at 660, 666.) Like the Workplace Violence policy, the UHS PowerPoint states that the facility has "zero tolerance for violence of any kind" and applied to both employees and patients. (Exs. 10, 11 at 662-63, 672.) Employees explained that these claims of a "zero tolerance" policy were "a joke because patients are … acting out in a violent way towards staff. … it's tolerated." (Tr. 1668.) Respondents do not have an effective zero-tolerance policy for patient on staff violence. (Tr. 197, 624-25.)

The UHS PowerPoint also proclaims that a "key" component of the facility's Workplace Violence policy is reporting threats of violence and investigating and addressing threats of violence. (Ex. 11 at 662.) It says supervisors are to report "individuals whose behaviors may pose a potential threat" and relay "reports of fear from employees." *Id.* at 664. Despite this clear language, the obligation to report threats was neither sufficiently conveyed to employees nor practiced. (Tr. 1708-09, 1716-17.) As an illustration, Respondents identified another training document as part of their WVPP, the UHS Behavioral Health Risk Management All Staff Orientation for Remote Data Entry (RDE) Facilities (Risk Management All Staff Orientation) PowerPoint. The document lists out fourteen situations when employees should complete an incident report, but none refer to threats of violence.[140] (Ex. 243 at 4283.) As one employee explained about threats, "if I was supposed to document it, I wasn't made aware." (Tr. 2218.) Threats of

[140] Mr. Curl appeared to recognize the generic content of the UHS Risk Management PowerPoint, stating that it was not "tailored" to the Suncoast staff. (Tr. 2786.) By the time of trial, he no longer used it. (Tr. 2787.)

violence by patients against employees occurred "all the time," both verbally and in writing. (Tr. 704-5, 833, 1674-75, 2176-77, 2216-18.) Employees testified about being threatened more times than they could count. (Tr. 1093-94.) When MHT BG reported receiving two separate threatening notes from a patient in June 2017 during the same shift written in blood, her nursing supervisor, "VL," was dismissive and told her to "hang it on the wall next to their artwork."[141] (Tr. 627-33; Ex. 26.) BG explained that she stopped reporting threats because the DON would blame the employee or suggest she was not right for the job.[142] (Tr. 634-36, 967, 1815.) Another employee confirmed that MHT BG had been threatened "multiple times on the unit." (Tr. 715.) After another employee reported threats in writing to the CEO, no one ever came to discuss the incident with her. (Tr. 758.) Some threats included a male patient touching a female MHT working alone on the Ocean Unit, including a patient grabbing an employee's thigh and making a sexually suggestive comment.[143] She thought the patient was going to rape her. (Tr. 637-38, 653-54, 846-47; Ex. 25 at 1095.) Another employee explained that even though Respondents did not direct her to report threats, recognizing the importance, she would note threats in a patient's paper medical chart if she had time. (Tr. 1094-95, 1815.) However, the Risk Manager neither tracked nor assessed threats documented in medical charts. Other employees did not even note threats or threatening behavior in the medical charts. (Tr. 882, 931, 1815, 2217-18.)

Threats of violence routinely went unreported. (Tr. 1674-75, 1815; Ex. 9.) The UHS PowerPoint recognized that reporting threats is a "key component" of the prevention program, but Respondents did not treat it as such. (Ex. 11 at 662.) The document proclaims: "all reports of violence will be treated

[141] The first note said, "I will kill you." The second note said, "I'm the devil I kill people that get in my way. if [sic] I don't get to see there (sic) Blood on the floor I cut for fun to see my own." (Tr. 631-34; Ex. 26.)
[142] Janet Sweeney was the DON in July 2017, and she was succeeded by Sherry Swanson. (Tr. 294-95, 522). Ms. Phillips was the DON when deposed on February 14, 2019, less than a year after being hired. (Phillips Dep. 14, 22.) Ms. Phillips and the regional clinical nurse who supervises her are both UHS-DE employees. *Id*. at 22.
[143] Interestingly, the UHS Behavioral Health Risk Management All Staff Orientation PowerPoint directs employees to complete an incident report for "Sexually provocative language/discussion between any patients." (Ex. 243 at 4283.) While the list of when to complete an incident report does not claim to be all inclusive, it does not specifically call out threats, actual violence or sexually provocative language directed toward staff. *Id.*

seriously" and "will be investigated promptly and fully."[144] (Ex. 230 at 665.) The record bore neither statement out. Respondents dismissed reports of threatening behavior. (Tr. 227, 632-33, 2010-11.) Further, as evaluated in the section on incident investigation below, Respondents reviewed many violent events only briefly, and frequently the reviews did not include the injured employee.

By neglecting to discuss the type of workplace violence that occurred multiple times per month, the Workplace Violence policy was insufficient. While UHS PowerPoint supplemented this policy, significant employee confusion remained. Dr. Lipscomb particularly faulted how the written information was communicated to employees and Respondents' failure to follow the policies. (Tr. 1731-33, 1740-42.) It did not appear as though employees were aware there was a WVPP. (Tr. 1668.) When the CO showed the written materials to employees, "they barely recognized those documents, and they were not familiar with the content."[145] (Tr. 199.) This lack of clarity on the WVPP led to, among other things, a practice of not reporting threatening behavior and a belief that employees should view enduring patient aggression as part of the job. The Secretary showed that the Workplace Violence policy and the UHS PowerPoint were not effective at abating the hazard.

b) Other Written Policies

In addition to the Workplace Violence policy and UHS PowerPoint, Respondents offered several generic policies, each of which they allege is part of their abatement.[146] (Exs. 200-211, 238, 244-45; Stip. 14.) None of the referenced policies use the term "workplace violence."[147] Some of the documents

[144] Respondents' 2017 Employee Handbook included similar language. (Ex. 21 at 29.)
[145] RN Cooke claimed that that employees were tested after the workplace violence training. (Tr. 3158.) Although employees were tested after Handle With Care training, no other witness discussed testing after the UHS PowerPoint. (Tr. 2132.) Nor do Respondents claim that such testing occurred.
[146] The parties stipulated to aspects of the generic policies UHS-DE provides its subsidiaries. (Stip. 14.) The policies include: Behavioral Management Program, Level of Observation/Patient Safety Rounds, Assessment/Admissions Procedure for Acute Services, Safety Management Plan, Intake Safety Policy and Procedures, Electronic Search of Patients, Shift to Shift Safety Rounds, and Hand-off Communication. (Exs. 200, 208, 210, 212, 224, 238; Stip. 14.)
[147] The Hand-off Communication policy, indicates that it is "To ensure the safety *of patients.*" (Ex. 211 at 42 (emphasis added).) The Use of Restraint/Seclusion policy uses the term "violent", and the intake forms seek a history of violence. (Exs. 209, 212.) Still, the Use of Restraint/Seclusion policy does not directly address patient on staff violence or workplace

included stated purposes that neither refer to employee safety nor workplace violence.[148] (Ex. 206, 211, 244.) The documents are brief, with most including less than three pages of bulleted content. (Exs. 202-4, 207-8, 210-11.) They are directed at the clinical management of patients, not employee health and safety.[149] (Exs. 81 at 14; Tr. 205-7, 210-19, 223-24, 405.) The policies only tangentially touch on the risks to employees and how to mitigate them. (Ex. 81 at 14-18; Ex. 83 at 10-11.)

Collectively the documents do not set out a comprehensive, coordinated, or site-specific approach to patient on staff violence. *Id.* They concern "how to deal with the different behavioral issues of the patients," not worker safety. (Tr. 403-5.) Further, when shown the documents that allegedly made up the WVPP, employees did not recognize them or "were not even aware that those documents existed." (Tr. 404-5, 1688.)

c) Management Commitment & Employee Participation

The Secretary argues that management was not committed to implementing their WVPP and failed to engage employees on mitigating the hazard. Dr. Lipscomb described management commitment as a "foundational element" for an effective WVPP. (Tr. 1666.) Respondents did not adequately solicit

violence in general. *Id.* Dr. Forman opined that Respondents did not follow the policy of having a psychiatrist authenticate a RSO and document a clinical assessment within 24 hours. (Tr. 3377-78, 3497-98; Ex. 209 at 33, ¶ 5.1.4.) He described an incident where RN HV initiated a medication restraint order at 2:15 a.m., July 12, 2106 following a patient's assault on MHT TJ where the psychiatrist did not authenticate the order until 2:40 p.m., July 13, 2016. (Tr. 3372-73; Ex. 39.) He described another incident where RN KN initiated a medication restraint order at 12:37 p.m., August 17, 2106 following a patient's assault on MHT AR where the doctor did not authenticate the order until 11:45 p.m., August 19, 2016. (Tr. 3373-74; Ex. 40.) He described another incident where RN RB initiated a RSO at 4:25 p.m., November 7, 2106 following a patient's assault on MHT DR where the doctor did not authenticate the order until December 17, 2016, more than a month later. (Tr. 3374-75; Ex. 40.) He described another incident where RN BO initiated a RSO at 1:35 p.m., July 26, 2107 following a patient's assault on MHT NA where the doctor did not authenticate the order until 1:20 p.m., July 28, 2017. (Tr. 3375-76; Ex. 59.) Dr. Forman testified, "I can't overstate enough how much their actual practice differs from the stated policies based on the documents that were given." (Tr. 3370-71; Ex. 83 at 8-9, Ex. 209.) He said that Suncoast does not "execute according to the policies." (Tr. 3521-24.) He also opined that a doctor should see a patient within thirty minutes of a RSO. (Tr. 3498-99.) Dr. Hemsath testified that a doctor has to be notified by staff within thirty minutes of a restraint situation. (Tr. 3577.)

[148] Neither the Nursing Assessment/Reassessment policy nor the Pre-employment Assessment policy refers to violence, safety, or homicide risk. (Ex. 207, 244.) The Secretary is not alleging that any of Respondents policies are deficient in terms of caring for patients. His arguments contend that these policies, individually or collectively, are not effective at addressing the hazard of patient on staff violence. He is not claiming that these policies do not serve other purposes. He attacks only the overall sufficiency of Respondents existing abatement of the cited hazard.

[149] Respondents offered only blank copies of various forms it uses for patient treatment. (Ex. 213-17.) These documents include no direction as to how the information they purport to collect can or should be used to mitigate the hazard.

information from direct care staff about the hazard or act on the information received. (Tr. 1665-66.) Employees described times when they reached out to the CEO, the DON, or the Director of Risk Management with concerns about how Respondents addressed the hazard. (Tr. 649, 765-69, 1666; Exs. 24-25.) The requests to better address the hazard were, at best, ignored, and regardless of the response given to the concerns, the Respondents did not implement any meaningful changes to mitigate the hazard better. (Tr. 273, 299-300, 522, 569-70, 880, 1947, 1665-69.)

Whenever one RN raised staffing concerns with the DON or the CEO, she was either told that staffing was adequate or that they were hiring more.[150] (Tr. 1382-83.) The promises about more staffing went unfilled. RN ET testified that the staffing situation only worsened. *Id.* RN BF said Suncoast actually "cut staffing" by combining units putting depressed, anxious patients in with psychotic patients so that Suncoast could cut both a nurse and MHT position.[151] (Tr. 1283-84.) MHTs asked for more staff during bi-monthly MHT meetings with management following the RN RO Attack, but "nothing ever changed;" except extra staff was added for shifts that worked when the Joint Commission was visiting Suncoast. (Tr. 268, 273-74, 293-95, 299.) MHT MM #2 testified that she left Suncoast partly because she "didn't feel there was enough staff and it made me feel unsafe."[152] (Tr. 299-300.) MHT VN testified that "there's too much safety issues that there's not enough staff." (Tr. 998.) RN BF said she was concerned about both safety and staffing at Suncoast, and that they were "absolutely" related. (Tr. 1284.)

[150] CEO Hamilton testified that she never received complaints about staffing. (Tr. 2536.) She later acknowledged that MHTs had brought up concerns with how the patient to staff ratio was calculated. She said MHTs "wish[ed] that the nurses weren't counted in the grid", but she did not know why. (Tr. 2588.)

[151] Dr. Hemsath testified that he thought, based upon an unidentified evidence base, "that the more staff you have involved with patients in the milieu, just more activity and more stimulation, that that tends to escalate violence rather than deescalate violence." (Tr. 3598-99.)

[152] Handle With Care MHT Instructor SS testified that he felt safe when he worked at Suncoast. (Tr. 2150.) When he worked at Suncoast from about April 2015 through September 2018, he weighed about 280 to 295 pounds, stood six feet tall, and was in is early twenties. He was in the running for a state wrestling championship while in high school. (Tr. 2165; Ex. 7 at 445.) As of the date of his testimony, SS continues to be paid by UHS-DE as a master instructor who continues to provide training at Suncoast. He also continues to attend master instructor training provided by UHS-DE "[i]n our Brentwood corporate office" in Tennessee. (Tr. 2168-69.) His wife works at Suncoast's intake department. He said although she has been spat at, she did not report such incidents. She has also been threatened by patients. (Tr. 2174-76.)

Night Supervisor RN CC[153] testified:

> Q. Why is there so much turnover, do you think?
>
> A. A lot of people feel the place is unsafe. They have worked psych before, and they just are appalled by our numbers and how we don't act until somebody has been hurt. And just really the numbers, that there is 1 tech per 20 on each unit at night.[154] And they just get scared. Something happens, and they just don't want to be in that environment. (emphasis added)

(Tr. 1497.) When asked during cross examination immediately following whether she felt safe at Suncoast, Night Supervisor RN CC stated, "There are nights I feel very unsafe there." (emphasis added) (Tr. 1498.)

In late 2018, RN VL wrote the CEO repeatedly about being threatened while alone in the intake area where new patients typically first enter the facility.[155] (Tr. 753-62, 2589-90; Ex. 24.) A patient dropped off by the police threatened to kill a "human being" and was making a fist at her. (Tr. 764-65, 2589; Ex. 24.) She had no "back up" and could not get assistance from the staff on the units even after multiple requests. (Tr. 756, 2589, Ex. 24.) The CEO only responded by saying she should make the supervisor "aware" and never followed up in person. (Tr. 765; Ex. 24.) RN VL also attempted to follow up with Mr. Curl, but no changes were made. (Tr. 765.) RN RO also suggested improving the limited staffing to management multiple times until he was "severely scolded" by the DON for raising the issue. (Tr. 522.)

Similarly, on March 12, 2017, MHT BG wrote to Mr. Curl explaining how she did not feel safe at work because, among other reasons, she had been alone for at least part of every shift since she started.[156]

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[153] RN CC worked as an RN at Suncoast since about November 2015. RN CC was Suncoast's night RN supervisor at the time of her testimony and had served in that position for two years. (Tr. 1455.)
[154] Supervisor RN CC said earlier that a ratio of one MHT for twenty patients on any one unit is ridiculous. (Tr. 1444.)
[155] RN VL's concerns at this time show the ineffectiveness of Respondents' abatement measures after the Citation's issuance.
[156] MHT BG testified:
Q. Okay. Why did you send it?
A. Because I was really concerned and worried about my safety and the safety of my coworkers.
(Tr. 649.)

(Tr. 649-50, 678; Ex. 25.) This practice contradicted her training, during which she was told she would never be alone on a unit.[157] (Tr. 637, 649-50; Ex. 25.) She described an incident when, while she was alone on the unit, a male patient grabbed her thigh, and she feared sexual violence. (Tr. 652-53; Ex. 25.) She indicated that staffing was insufficient at night and requested a different work shift with a higher staff to patient ratio. *Id.* She stated that the staffing issue "needs to be resolved because it's unacceptable to feel like our safety is not a priority. I know this issue probably comes down to money but it's unethical to have your staff at risk." (Ex. 25 at 1094.)

Rather than address any of her concerns, in a response dated March 13, 2017, Mr. Curl told her that sharing "grievances with peers and co-workers accomplish[es] nothing other than spreading insecurities and frustration." (Tr. 678-79; Ex. 25 at 1093.) Neither he nor any other supervisor addressed the concerns she raised in writing. (Tr. 655.) Instead, Mr. Curl informed her that she could either continue working the same shift with the same limited staffing or notify the company she was quitting. (Tr. 653, 686; Ex. 25.) When DON Sweeney discussed MHT BG's March 13, 2017 email to Mr. Curl with RN BF about insufficient staffing and workplace violence, the DON was also unresponsive, wondering "where do these girls get off" and stating that "they need to know their place." DON Sweeney told RN BF that the patients "aren't serious about hurting you. They're not going to hurt anyone." (Tr. 1279; Ex. 25.) Rather than take her safety concerns seriously, CEO Hamilton counseled MHT BG to find other work, telling her, "You don't have to be here if you don't want to be here."[158] (Tr. 646, 686, 1278-79; Ex. 25.)

Respondents argue that employees could attend UHS-PSC and EOC committee meetings. (Tr. 2573, 2761.) They claim that employees did not attend such meetings because they did not want to do so.

[157] MHT BG testified that she "was alone on the unit every single night until I brought it up to Janet [the DON]." (Tr. 637.)
[158] Dr. Lipscomb described reports of verbal threats "fell on deaf ears" so employees stopped reporting them. (Tr. 1668-69, 1815-16, 1947-48.)

However, eight different employees testified they were unaware these committees existed and were not invited to attend.[159] (Tr. 274-75, 764, 866, 915, 996, 1057, 1147, 1185-86.) The UHS Risk Management All Staff Orientation discusses the UHS-PSC. (Ex. 243 at 4302-5.) It does not discuss its meetings being open, or that staff can attend. *Id.* Nor was the information from these meetings shared. Indeed, members of the UHS-PSC "must sign a confidentiality agreement." *Id.* at 4305.

Mr. Curl attempted to dispute this well-corroborated testimony about employees being unaware of their ability to purportedly attend the UHS-PSC and EOC meetings, arguing that the CEO sent memos to encourage employees to attend the UHS-PSC meetings. (Tr. 2761.) His testimony is rejected as the CEO herself explicitly acknowledged there were no memos or written invitations. (Tr. 2572-73.) She also testified that no direct care employees generally attend either the UHS-PSC or monthly performance improvement meetings.[160] (Tr. 2531, 2571-72.)

Mr. Smith, a former MHT and trainer at Suncoast, indicated he created a staff resolutions committee with about four staff members, but it met only three times over four years with either DON Sweeney or Charlotte Klear as host.[161] (Tr. 1504, 2094, 2198-2200, 2206-07.) He also claimed that minutes were created for these meetings, but Respondents did not produce any in response to the Secretary's relevant discovery requests. (Tr. 2205-6; Ex. 92.) There is no documentary evidence that this committee engaged employees about how to address workplace violence.[162]

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[159] Mr. Smith indicated that he attended more than two UHS-PSC. (Tr. 2200.) However, attendance records from the meetings only list him as a guest at two meetings, one in January and one in February 2017. (Tr. 2200-2201, 2005; Ex. 251 at 3594, 3605.) The attendance records are credited over his initial recollection. (Ex. 251.) Non-management employees did not appear to attend any of the meetings cited by Respondents as part of their abatement for the cited hazard during the time of the OSHA investigation. *Id.*

[160] At trial, CEO Hamilton indicated that direct care employees are invited to the EOC committee meetings. (Tr. 2571.) This contradicted her earlier deposition testimony and the testimony of multiple direct care employees. (Tr. 274-75, 866, 915, 966, 1057, 1147, 1185-86, 2573.) Her testimony at trial on this point is rejected as not credible.

[161] Ms. Klear was a "nurse educator." (Tr. 1258-59, 1356.)

[162] A RN indicated that after the close of OSHA's investigation she attended a meeting advertised as being about employee retention. (Tr. 1147-48.) She thought insufficient staffing, particularly support for the intake department, would be addressed. *Id.* However, the meeting did not address staffing or the cited hazard. *Id.*

Multiple people described management's lack of commitment to addressing the hazard or engaging direct care workers to reduce it. (Tr. 227-28, 513-14, 649, 764-65, 863-66, 1279, 1348-52, 1382-83.) Workers told the CO that sometimes they were not asked how they were doing after experiencing workplace violence. (Tr. 217.) Employees sought assistance from management on addressing the hazard both verbally and in writing. (Tr. 514; Exs. 24-25.) Their safety requests were dismissed or ignored. (Tr. 522, 996-97, 1665-69.) Occasionally employee concerns about the hazard were at least acknowledged, but Respondents took no meaningful actions.[163] (Tr. 569-70, 1382-83.) RN RO described how people were "constantly" quitting "because of the excessive danger of working" at Suncoast. (Tr. 513-14.) He noted multiple occasions where two MHTs had to handle safety for all three different facility wings due to short staffing. (Tr. 514.) He suggested ways to address the chronic shortage but, as he explained, "So no one cared. No one did anything to try to improve the situation. I had begged several administrators to hire … some large … techs to keep us safe, because everybody around me is quitting. My other supervisor, he quit and left. He said it was too dangerous to work there. And no one seemed to care about the risk involved."[164] (Tr. 513-14, 556.)

Dr. Lipscomb found that despite Respondents' claims that they sought employee input on addressing the hazard, "there was no strategy" for engagement. (Tr. 1670, 1947.) Even if employees were aware of the meetings, employees "didn't see any point" in attending because their prior efforts to engage with management on the hazard had not been successful.[165] *Id.* "The various committee

[163] Respondents indicate that there are "town hall" meetings at Suncoast. The frequency of such meetings and whether they relate to the hazard was not clearly established. (Tr. 1182, 1947.) CEO Hamilton testified that Town Hall meetings were held two to four times a year. (Tr. 2535.) The DON indicated that neither she nor other "leaders" attend the meetings. (Tr. 1621.) There is no evidence that such meetings were effective at abating the hazard.

[164] Sometime after August 9, 2017, RN RO said he was told by different staff members that Suncoast hired about 15 large, powerful MHTs to assist in safety. (Tr. 515-16). He said he was not completely satisfied with Suncoast's response because there were still several times when only three MHTs worked at night when they had four places to cover. (Tr. 516.)

[165] MHT BG indicated that after raising multiple safety concerns, management informed her about the existence of various committees. (Ex. 25.) However, as her request to be moved from the night shift was denied, she could not attend meetings during the day. (Tr. 654.) No arrangements were made for her to share feedback with the committees whose meetings she could not attend.

structures do not assure direct worker participation." (Tr. 1669-72; Ex. 81 at 18; Sec. Br. 93-97.) The failure to engage employees rendered Respondents' abatement ineffective because employee participation is an "essential" element to an effective WVPP. (Tr. 1670-72.) Reducing patient on staff assaults requires direct care staff involvement because they are the ones constantly with the patients. (Tr. 1670-71.)

d) Worksite analysis, hazard identification, prevention, & control

Respondents allege that throughout a patient's stay, "there is attention paid to analyzing and identifying risk factors." (Resp't Br. 46.) They indicate the use of multiple methods to address patient aggression, starting with the intake procedures, continuing with developing and updating treatment plans, and the routine observation of patient behavior. *Id.*

The Secretary showed severe flaws in the intake procedures and the efficacy of the observation rounds as conducted. In addition, although nurses' workstations were the location of many staff injuries, Respondents failed to make safety changes facility-wide to mitigate the hazard.

(1) Intake

Respondents allege that the intake assessment procedures were designed to identify patients more likely to engage in aggression. *Id.* They claim these procedures analyze and identify "risk factors related to individual patients" and that they use the procedures to develop patient treatment plans. *Id.* Where Respondents' approach significantly falters is in conveying information about aggression to employees. For instance, there are no medical files available in the intake department and no system to promptly see a patient's history of violence. (Tr. 720, 1112-13; Sec. Br. 65.) Employees could only access insurance information, date of birth, and the number of prior admissions. (Tr. 1112-14, 1600, 2357.) When asked how a person working in intake would know if an incoming patient had a violent history, the intake RN bluntly explained, "You don't." (Tr. 720.) Although information about past episodes of aggression might be available in paper files located elsewhere in the facility or off-site, frequently, only one person was

working in the intake department, and the individual could not leave the area to go to the medical records storage area.[166] (Tr. 1108-10, 1113, 1660-61, 2061.)

In intake, one employee was typically alone with patients for extended periods, with no way of knowing whether the individual was "one of the most assaultive patients" in the facility's history. (Tr. 719, 754, 1107, 1115-16; Ex. 24.) For example, it was not until she was relieved for a bathroom break that an employee learned that one of the patients she had been handling was previously extremely assaultive. (Tr. 1116-17.) During the RN's initial assessment, the patient did not explain her violent history. *Id.* The RN had no way of knowing this history until the supervisor happened to recognize the patient's name.[167] (Tr. 1117-18.)

After intake, staff brought patients into the units. When a patient's violent history was not identified in intake, direct care employees would not have this information, even if the patient had previously assaulted staff. (Tr. 229-30, 722, 1360.) This was not a theoretical risk. Two MHTs were injured by patients who had previously assaulted other employees. (Tr. 234-35, 971-72; Ex. 70.) A patient threatened the MHT early in the shift and then later injured her. (Tr. 971-72.) The MHT explained that if she had been promptly informed of the patient's violent history, which included breaking a caregiver's jaw, she would have insisted on additional precautions after the first time the patient threatened her. (Tr. 972.)

Rather than going through intake, some patients were direct admissions, meaning that the facility had already agreed to accept them into the hospital upon arrival. (Tr. 229-30, 722, 1360.) Staff brought such patients directly to the units. (Tr. 722, 1360.) Employees working in the units would have no

[166] Even when there was more than one person in intake, there were often too many patients to permit going to get the records, let alone flip through them to see about past involvement in workplace violence. (Tr. 1112-3, 1118.) Only about one year's medical records were kept on. (Tr. 2961.) Mr. Curl indicated that over 50% of the records that were presented at trial were stored off-site. (Tr. 2960.)

[167] This RN's experience also highlights the deficiency with relying on the intake assessment form for abating the hazard.

information on the history of violence until after assessments were completed. (Tr. 231-32, 722-23, 829, 1360; Sec. Br. 66.) The patient could be in the unit for many hours before medical staff completed the assessments. (Tr. 829-30, 1112; Ex. 83 at 7-8.)

For example, it may take up to twenty-four hours before a patient is assessed by a psychiatrist, and other parts of the initial assessment can take up to 72 hours after admission. (Tr. 2319, 2743; Ex. 212.) The direct care staff is left to manage emergencies without the guidance of the more highly trained medical professionals. (Ex. 83 at 8.) Dr. Forman found this "particularly troubling" because intake and the initial part of hospitalization is when patient behavior is the most "unpredictable." *Id.* In his view, the likelihood of a patient harming a staff member is highest during intake, and the first day at the facility. *Id.* at 6, 8. The delays in these assessments rendered them less effective at abating the hazard than Respondents claim. *Id.*

Respondents' Workplace Violence policy and the UHS PowerPoint recognized the role of patient history in preventing workplace violence incidents. (Ex. 10 at 655; Ex. 230.) The Workplace Violence policy cites a "history of violent, intimidating or destructive behavior" as a characteristic that might be "indicative of posing a potential threat." (Ex. 10 at 654-55.) The UHS PowerPoint explained that employees should know a "patient's potential for violence and how to manage aggressive behaviors." (Ex. 230 at 670.) Despite this recognition, information about patients' past aggression, even if it occurred at Suncoast, was not consistently conveyed to employees directly caring for the patients. Employees in the intake department or coming from other units to assist would not see the precaution forms before having to interact with violent patients. (Tr. 522, 2945-46.) The Secretary showed that Respondents' intake procedures, as implemented, did not adequately abate the hazard. (Tr. 1696-99; Ex. 83 at 7-8.)

(2) Patient Observation Rounds

Respondents indicate that their observation program of patients on the units is part of the WVPP. (Tr. 386, 2871; Exs. 5-6, 221, 233; Hamilton Dep. 60-61.) Under the program, patients can be assigned

different observation levels. (Tr. 115, 2062-63; Ex. 6 at 264, 14, 208, 221.) The program calls for an employee to check patient behavior at least every fifteen minutes. (Tr. 2063, 2871-72; Exs. 6 at 264, 221.) This is referred to as "Q15 checks." (Tr. 2062-63, 2871-72; Ex. 6 at 264.) Some patients are observed every five minutes, "Q5 checks," if their condition warrants it. (Tr. 2063; Ex. 6 at 264.) Staff conducting the Q15 or Q5 checks follow a checklist that sets out particular "risk factors" to look for when observing the patients. (Tr. 529, 548, 2062; Ex. 221.) However, the checklist does not specify whether the patient has aggressed against staff during his or her current or previous hospitalizations. (Exs. 14, 56 at 1493, 1507-8.)

In addition to this deficiency, the Secretary also showed that aggressive or violent behavior often was not documented on the Q5 or Q15 checklists. The Secretary identified numerous instances related to the cited hazard where patient behavior recorded on the checklist was inconsistent with the discussion in the Risk Management Worksheet or EAR for the same time.[168] (Tr. 911-14, 1100, 2841-42, 2852-53, 2872-83, 2887-89, 2898-2899; Exs. 36-77.) For instance, at practically the same time as an employee needed to restrain a patient for violent behavior, the Q15 checklist describes the patient as "cooperative." (Tr. 2841-42, 2853, 2872-73; Ex. 39.)

Respondents audit the Q5 and Q15 checklists. During OSHA's investigation, their audit records indicate that staff were not sufficiently observing sleeping patients. (Ex. 251 at 3719, 3758, 3779, 3806.) The audits also looked at whether the checklists appropriately noted patient precautions and whether the unit nurse signed the checklists. *Id.* The audits did not focus on overall accuracy or completeness. (Tr. 2006; Ex. 251.) The review focused on the creation of records, not their accuracy. (Tr. 2958-59, 3401.) Still, even with this limited review, Respondents found that only half of the checklists reviewed as part of the February 2018 audit (during OSHA's investigation) identified the correct precautions, and only 38%

[168] Respondents produced Patient Observation Round forms for the patients involved in instances of workplace violence.

were signed as their policy required.[169] (Ex. 251 at 3791.)

Two of the checklists Respondents produced occurred after the issuance of the OSHA Subpoena for videos. (Tr. 2887-89; 2898-2899; Exs. 72-73.) As addressed in the Sanctions Motion discussion, had Respondents preserved video of these incidents, such evidence could have answered which document was correct, the checklist or the EAR. Considering the video destruction, Mr. Curl's twisted hypotheses about how the checklists and the EARs could both be accurate is rejected. The Court credits the evidence that observation rounds, as conducted, did not sufficiently abate the hazard.

Dr. Forman also explained that Respondents near sole reliance on observation checks rather than the use of 1:1 assignments substantially reduced the effectiveness of patient observation as an abatement method. (Tr. 3391-95.) Respondents' "Level of Observation/Patient Safety Rounds" policy set out three observation levels, fifteen-minute checks (Q15), five-minute checks (Q5), and 1:1 continuous observation. (Ex. 208; Tr. 2711.) Typically, when patients are identified as being particularly aggressive, a behavioral health facility will assign a single individual to remain within arm's reach of that one patient so that they can monitor the patient closely and quickly intervene in the event of an escalation. (Tr. 1002, 1250, 1599, 2062; Ex. 83 at 10, Ex. 208.) Respondents rarely used such 1:1 assignments to manage patients.[170] (Tr. 983, 1250, 3391-92; Ex. 83 at 10-11.) MHT VN indicated that "maybe once" she had such an assignment in her years at Suncoast. (Tr. 983.) In her recollection, even the patient identified as the most assaultive in the facility's history was not assigned a 1:1. *Id.* According to Dr. Forman, this was yet another example of where "on paper" the policy was appropriate, but not as implemented. (Ex. 83 at 10.) He could find no clear examples of it being used. *Id.* In Dr. Forman's view, given the acuity of the

[169] Dr. Forman also questioned the accuracy of the Q15 records. (Ex. 83 at 10.) For instance, one Risk Management Worksheet indicates that a patient was "agitated all day," exhibiting both verbal and physical aggression, before assaulting two staff members in the evening. *Id.* However, the Q15 checklists from the same day indicate the patient was "asleep" or "cooperative." *Id.*

[170] Although Respondents cited their Level of Observation/Patient Safety Rounds as part of their WVPP, their brief does not discuss the use of 1:1 observation.

patient population and frequency of violent incidents, 1:1 assignments should be used much more frequently for the patient observation program to be an effective abatement. *Id.* Dr. Forman opined that more 1:1 assignments for high-risk patients "would materially reduce violence." (Tr. 3402-04; Ex. 83 at 10-11.)

Dr. Forman concluded that while the record suggests patient checks were documented, this had little utility for abating the hazard because of how the policy was implemented. (Tr. 3395-96, 3399-3401.) He cited an MHT being punched despite the check form repeatedly indicating the calmest rating. (Tr. 3399-3401.) In Dr. Forman's view, the form was false for that patient. (Tr. 3401.) Even when accurate, because Respondents relied solely on employees from the different units to respond to emergencies, an employee would often have to address an emergency without reviewing the Patient Observation information. (Tr. 529.)

RN Cooke also questioned the utility of Respondents' patient observation rounds as abatement, albeit for different reasons than Dr. Forman. In her view, the purpose of the checks was to know that the patient was on the unit. (Tr. 3078.) She considered the round's purpose to be "not even so much what they're doing" but understanding that "we haven't lost them." *Id.* In her view, given the number of patients a single staff person is checking on, "there's not a whole lot they can do, except make sure the patient is where they need to be." (Tr. 3079.) There is no time "for a lot of interaction." *Id.*

The Secretary showed that, as implemented, the Patient Observation Rounds were not effective at abating the hazard.

(3) RN Reports/SBAR

Respondents also suggest that the inability to access medical records and the deficiencies in the patient observation rounds checklists did not matter because staff communicated verbally with each other

as they ended one shift and started another.[171] (Tr. 1481, 1491.) The Secretary does not dispute that employees communicated during shift changes. (Sec'y Br. 162.) His contention is that this communication was inadequate because it only included patients on a single unit when direct care employees were tasked with responding to calls for assistance anywhere at the facility. (Sec'y Br. 162; Tr. 997-98.) They lacked critical information on patients in other units despite being tasked with providing security or other support when workplace violence incidents occurred. (Tr. 244, 474, 485, 493, 507, 566, 643, 831, 852, 882-83, 2225-26; Ex. 14 at 20.)

There was no flagging system to readily identify patients with a history of violence or those who presented a greater likelihood for violence. (Tr. 209-10, 244, 529, 643, 832.) Staff was often not informed that a patient had injured employees in the past, even if the prior incident had occurred at Suncoast itself. (Tr. 234, 474, 643, 832, 882-83, 971-72.) While violent histories might be in a patient's medical file, employees explained that they had no time to review all patient files, which could be hundreds of pages for a single patient.[172] (Tr. 244, 474, 493, 529, 831-32, 852, 2226.) Staff was responsible for all the patients in their unit as well as assisting other units when staff went on breaks or in the event of a violent incident.[173] (Tr. 566, 860, 882-83, 885, 1567, 1689, 2307.) Even if the staff occasionally had time to obtain and review the file, it would not necessarily contain information about past incidents of violence. (Tr. 474, 644.)

[171] If the checklists and medical history are not part of Respondents' abatement, then the Secretary would not need to show that they were ineffective.

[172] For example, the patient that attacked RN RO on May 23, 2017 was readmitted to Suncoast in 2018. CEO Hamilton testified that there was nothing in Suncoast's computer that would alert staff that a prior patient who had been removed from Suncoast by law enforcement and jailed based upon an assault upon a staff member had been later re-admitted. But she said it would be in the patient's medical record. She did not say that the information would be flagged in the record. (Tr. 2356-57; Ex. 56.)

[173] There were around 10-20 patients per unit. (Tr. 92, 193, 144, 1486, 2307, 3601, 3078; Ex. 22.) RN DL indicated that when she worked there were rarely less than ten patients. (Tr. 1078.) In her experience it was "at least 12" and sometimes up to 20. *Id.* RN VG explained how she prepared an injection for a patient. (Tr. 882-90.) She was injured during its administration. *Id.* She had not seen anything written down in a medical chart or SBAR report because the patient was not assigned to her. *Id.*

CEO Hamilton testified that RNs used a "SBAR form" to inform the oncoming shift of a patient's precaution level and status.[174] (Tr. 2381.) However, completed forms were not provided in discovery to OSHA or offered at trial for inclusion into the record. It is also not clear when the SBAR forms started to be used.[175] The Court finds that SBAR Forms were not in use at Suncoast on or before March 31, 2017. (Tr. 876, 926-27; Ex. 224.) Further, as one of the MHTs explained, RNs would exchange information outside of the unit. (Tr. 245-46, 364, 545.) MHTs, and other direct care staff, did not receive the same information as the nurses because they did not have the time at shift change to receive the information. *Id.* Information about whether a patient needed a higher level of precaution was not consistently conveyed accurately to the MHTs. (Tr. 288-91.) When shown the SBAR form, an MHT did not know what SBAR stood for and said that they were not trained on using or reviewing it. (Tr. 284-85; Ex. 224.) While this particular MHT, MM #2, "would try" to access this information, doing so was "not required," and she would review the information only if she had a "chance."[176] (Tr. 245.) The SBAR forms were not particularly useful as a quick way to determine a patient's status. (Tr. 1410, 1416.) This seriously undercuts CEO Hamilton's claim that such forms were a significant part of Respondents' WVPP.

Dr. Lipscomb also concluded that Respondents' claims that a patient's risk for violence was conveyed to direct staff were unsupported. Employees reported that they did not know anything about a patients' history of violence before being assigned to care for him or her. (Tr. 1700-1.) She explained that orally conveying the information was not enough; it needed to be written down so it would not

[174] RN RO also testified that SBARs helped oncoming RNs be better prepared to provide care to patients that resided in the nurse's assigned unit only. (Tr. 545-46, 566-67; Ex. 224.) RN RO further said that he did not see any SBAR or have any sort of patient handoff communication for the two patients who were not residing in his assigned unit that injured him on May 23 and August 9, 2017. (Tr. 567.)

[175] RN VG testified that SBAR's were "never used" while she was employed at Suncoast. She essentially ceased working as an RN on duty at Suncoast after March 2017. (Tr. 876, 926-27; Ex. 224.)

[176] MHT MM #2 testified that "pretty often" she did not have the time to review reports and charts. (Tr. 296.) She did so "[m]aybe once a week." *Id.* However, she said she did get a copy of SBAR reports maybe four out of five times a week because she asked for them. (Tr. 298.) MHT MM #2 testified that near July 2018 she and another MHT created an unofficial MHT SBAR that only MHT MM #2 filled out to provide information for the rest of the staff. (Tr. 298, 301.)

"somehow slip through the cracks."[177] (Tr. 1701.) When such information was conveyed in writing, employees who were not part of the oral briefing or who missed it would still be informed of the greater potential for violence. *Id.*

This failure to consistently and accurately convey violent histories reduced the effectiveness of Respondents' abatement efforts. Dr. Lipscomb explained that "one of the most well-recognized risk factors for violence is a history of violence." (Tr. 1699.) Respondents' failure to communicate this information to the frontline workers directly involved in patient care significantly undermined the abatement's utility. Dr. Forman agreed, explaining that Respondents' approach was insufficient to protect staff members from violent patients. (Ex. 83 at 10.)

(4) Leadership & Other Rounds

"Leadership" or Administrator on Call ("AOC") rounds were conducted on each of the three shifts, for a total of three rounds per week. (Tr. 1456-57, 1614, 2363.) They involved checking to ensure the patient observation checklists and assignment sheets were filed out and looking for issues. (Tr. 1989-90.) The night shift AOC rounds were "usually" done by video as opposed to in-person walkthroughs. (Tr. 2363.) Respondents assert that this was effective despite also arguing that several areas of the facility could not be seen on the videos and arguing that videos of incidents were not helpful. CEO Hamilton also claimed that staff conduct patient safety rounds on the units every day. (Tr. 2360-61.) No documentation regarding findings from these rounds was provided and no one tasked with conducting these rounds testified about them.

Respondents' post trial brief also refers to "EOC rounds" as part of their abatement. (Resp't Br. 20.) At trial, CEO Hamilton could not recall whether the frequency of these rounds was monthly or quarterly. (Tr. 2363.) Only one page of the meeting minutes from a single post-Citation meeting of the

[177] As discussed, this was not a theoretical risk. Multiple employees described situations where they were not informed about patient histories before being tasked with patient care in actual or potentially violent situations. (Tr. 1699.)

EOC committee is included in the record. (Ex. 35.) This document discusses the implementation of Supervisor Senior Leadership Observation rounds. *Id.* There are no documents in the record related to findings from these rounds during or before OSHA's investigation. The record does not establish that the leadership and any other rounds, as conducted, sufficiently abated the hazard.

(5) Code Gray Procedures

Respondents' program directed employees to call a "code gray" when a patient was escalating and appeared at risk of injuring themselves or property. (Tr. 1977-79, 2402; Ex. 251 at 3780-81, 3787.) In actuality, the code gray procedures were rarely used or practiced.[178] A code was not called on May 23, 2017 in an incident that occurred around 3:00 a.m. to 4:00 a.m. where RN RO's supervisor, RN Lovett, telephoned him and asked to help medicate a patient that was yelling and acting out of control in his room.[179] RN RO was not told anything about the patient's medications. He "was just told to help try to get him to take some medicine that [RN RO] knew wouldn't work." RN RO told RN Lovett that the patient was "a very violent and dangerous guy" and "there's a good chance someone's going to be injured…." RN RO entered the patient's room along with four or five other staff members.[180] The patient immediately went "into a rage, yelling and cussing and threatening." RN BF testified that the patient threatened her by saying "You know I could snap your neck right now, and I wouldn't even care because I know there's not a person in there." (Tr. 1260.) RN RO moved over towards RN BF to protect her, and then the patient slammed RN RO on the head with his fist three times. Unable to medicate the patient, Supervisory RN Lovett told the staff to exit the room. The patient "came running out of the room

[178] MHT BG testified that a code gray was "Never" called while she was working at Suncoast. (Tr. 642.) RN Cooke's testimony that she hasn't "heard any evidence that there's -- that the [Code Gray] responses haven't been effective" ignores the testimony of RN RO, RN BF, MHT BG, and MHT AB, and is rejected. (Tr. 492, 641-42, 851-52, 1313-14; Ex. 264 at 7, ¶ L.)

[179] RN RO testified that the patient was "well known to Suncoast as an extremely dangerous and violent offender. He was a large, muscular man, about 240 pounds, 6'4" or so, vicious, a very vicious dangerous man who had injured, seriously injured, our staff in his prior admissions. He had broken jaws, broken tables apart, threatened to stab the doctor and staff." (Tr. 473, 482, 1259; Ex. 56 at 4276.)

[180] One of these, MHT BG, testified that she did not feel comfortable restraining the patient because "I physically wouldn't be able to do it." (Tr. 639-40.)

at a full speed run" and "stated wailing on [RN RO], and he head butted [RN RO] and gave [RN RO] a concussion with his fist." (Tr. 476.) RN RO said, "And one fist landed in my neck and my neck, the base of my neck area there, swelled up really huge and was very painful for about six weeks." (Tr. 267, 471-80, 484-86, 530, 638-41, 851, 1044, 1259-62, 1268-71, 1309-13; Exs. 56, 81 at 22-24.) The patient on staff brutality continued in the hallway where the patient "locked his teeth into [RN RO's] right forearm. So I'm bleeding all over the floor, …." RN RO testified that the patient "was kicking and growling and slamming us with his head, so it was a violent wrestling going on for about 10 minutes, until the police came and handcuffed him and took him out." RN RO said several staff members, including MHT BA, quit after this incident "saying it was far too dangerous a place to work." (Tr. 476-82, 1260, 1268-70; Ex. 56 at 4277-78.) RN DL testified that the same patient that attacked RN RO on May 23, 2017 later told her that "he was going to kill me and do bad things to me." (Tr. 1043-44.)

A code gray was also not called during the RN RO Attack.[181] (Tr. 492, 641.) MHT AB testified she could not recall ever hearing the code called. MHT AB said, "We've never called a code." (Tr. 851-52.) Even the employees who recalled a code gray acknowledged they were very infrequent and never used at night. (Tr. 472, 1313-14, 2006-7.)

There were no requirements to use the code gray procedures. (Tr. 2565.) There was "no set time" to call a code. *Id.* The lack of clear procedures inhibited the abatement's effectiveness. (Ex. 81 at 23.) The Risk Management Worksheets document the need for procedures and response protocols, but these were not sufficiently developed.[182] *Id.* Likewise, the UHS-PSC appeared to recognize the need for

[181] While a code gray should have been called under the procedures, doing so would not have been effective during the RN RO Attack because there was "no one" to respond. (Tr. 641, 1313-14.)

[182] RN RO testified that he never had a walkie-talkie at Suncoast. (Tr. 472, 492.) MHT BG said she was given a walkie-talkie by another MHT only one time in April 2017 during her 9-month tenure at Suncoast. (Tr. 626.) RN VG said she never had a walkie-talkie. (Tr. 908.) RN BF said she never had a walkie-talkie prior to the summer, 2018. Before that she said there were radios, but they were in disrepair. (Tr. 1275, 1333-34.) Sometime after about August 2018, Suncoast established a walkie-talkie system where staff needed to sign walkie-talkies in and out. (Tr. 999.) RN DL testified that she got an

practicing "code gray" procedures, but plans were not implemented during OSHA's nearly six-month investigation. (Ex. 251 at 3818, 3883.)

Respondents claim that on each shift, a code team was responsible for responding if a code for patient aggression was called.[183] (Ex. 6 at 263.) Some employees, including MHT MM #2, were unaware of these code teams.[184] (Tr. 272, 982, 994.) When asked about a reference to a code team on the daily patient assignment sheet on which she was listed, MHT VN testified that she had "no idea" what a code team was. (Tr. 994; Ex. 34 at 4897.) Although the program calls for designated people with assigned roles to respond, in actuality, everyone was needed to respond. (Tr. 567, 982-83.) There were no employees, such as staff with specialized security training, focused on responding to incidents. (Tr. 641, 757, 851, 875, 982, 1314; Ex. 2 at 4, ¶¶ 3-4, Ex. 24.) The employee testimony is credited over the documentary evidence about code teams.

The Secretary showed Respondents' code grey procedures were not fully implemented as conceived and did not effectively abate the hazard. (Ex. 81 at 22-24; Sec. Br. 81-83.)

(6) Workstations

Dr. Lipscomb found that the "nurses' station between [two of the units], as it's configured, poses a

assigned walkie-talkie in January 2019. She said before that, there were two walkie-talkies available for use at the nurses' station but there was no policy to use them. She said staff did not have walkie-talkies in May 2017. (Tr. 1044, 1072.) Intake RN CMC said she received a walkie-talkie in the Fall, 2018 after an elopement had occurred. (Tr. 1087-88.) RN CR testified that as of April 30, 2019 every employee gets a radio when they first come on the unit in the morning. (Tr. 1993-94.) She also said she thought that radios were always at Suncoast, but later testified that she "cannot honestly tell you when the radios were put on the assignment sheet." RN CR said, "I don't know that." (Tr. 1998-99.) At trial, Mr. Curl testified that the most common way staff members call a code is on their walkie-talkie. (Tr. 2755.) The Court finds that functional walkie-talkies were generally not available and assigned to RNs and MHTs before April 24, 2018. (Tr. 2980-81; Ex. 251 at 3900; Sec. Br. 79-80; Sec. Reply Br. 6.)

[183] In its initial written response to OSHA, Suncoast explained that "staff are assigned to respond to emergency codes." (Ex. 6 at 263.)

[184] CO Trouche was not made aware of any MHTs being assigned to code teams during her interviews. (Tr. 362.) She said that "there was no team to respond to incidents." Instead, whoever is available, and not on one-on-one or on other assigned duties, would respond and assist the coworkers in the event of a violent incident. (Tr. 379-80.) MHT VN testified:
Q. Do you know what a code team is?
A. A response team, but we don't have a team for that. There's no teamwork about it.
Q. Well who is expected to respond to the code if called?
A. Everybody.
(Tr. 982.)

risk to staff and patients, and that it needs to be reconfigured." (Tr. 1939.) As explained in more detail in the next section, whatever worksite analysis Respondents did, they failed to recognize how the configuration contributed to the risk to employee safety. The Secretary showed that Respondents' worksite analysis was ineffective at abating the hazard.

e) Inadequately protected employee workstations

Respondents Behavioral Management Program identified several "high risk areas" at the facility such as the "direct care areas" and "most particularly the acute care units." (Ex. 19 at 731.) Staff repeatedly raised concerns about the lack of a protective barrier to management, expressing how additional protection could prevent injuries. RN RO told managers, including CEO Hamilton, before the RN RO Attack that a barrier should be installed at the nurses' station for safety. Nothing was done. (Tr. 521-22, 1283, 1356, 1358.)

Despite recognition of these being high risk areas, only the nurses' workstation in the intake area had a full protective barrier.[185] (Ex. 8 at 522; Hamilton Dep. 102-3.) The nurses' stations in the units had a lower barrier of about 43 inches high, with the upper portion completely open.[186] (Tr. 144-45, 2816; Ex. 8 at 523-29.) When employees are seated behind the lower barrier, their heads and the upper part of their torsos are above the barrier. *Id.* To access the space behind the counter, one can either reach and/or jump over the nurses' station counter or opened the "Dutch"-style door and counter or enter through the two-part "Dutch"-style door. (Tr. 134, 140-44, 521, 1186, 3123; Ex. 8 at 523 (Ocean Point unit), at 524 at bottom photo at "C" [Dutch door], nurses' station with access to Turtle Cove at "B" and Coral Key at "D"), 525.) The top half of the door is usually left open. *Id.* Patients can either go over the lower half or reach in and open the Dutch-style door. (Tr. 135-39, 140-41, 499, 521, 642-43, 674, 904, 1186, 1354-55;

[185] Intake personnel, RNs and MHTs told CO Trouche that the intake workstation was enclosed after a patient injured two employees in 2016 and a computer was damaged. (Tr. 131-32, 1283; Ex. 8 at 522.)
[186] The photographs show it to be slightly above waist high. (Ex. 8 at 528.) Employees could not close off the area above the barrier. (Tr. 142.)

Ex. 8 at 523-26, Ex. 9 at 324, Ex. 28.) The four photographs taken by CO Trouche on November 30, 2017 at Exhibit 8, at 525 and 527 (both photos where clipboard is shown), show the nurses' station where the youth patient dove through the opening over the counter from the direction of the Turtle Cove unit into the nurses' station during the RN RO Attack. (Tr. 133-35, 139-43; Ex. 8 at 525 [top photo] [bottom photo at "A," 527 at top photo at "A," bottom photo.) CO Trouche testified that an enclosed nurses' station could have prevented the youth patient from gaining access to RN RO.[187] (Tr. 169, 199-201.) RN ET testified that she thought "some sort of barrier" at the nurses' station may have prevented the patient from pulling her right arm and injuring her shoulder on May 25, 2017. RN ET said she recommended to CEO Hamilton that a barrier be installed but was told by her once that "it was illegal to have a barrier like that."[188] (Tr. 1356-57.) RN Cooke testified that staff members located behind a plexiglass enclosed nursing station would not get injured. (Tr. 3242-43.)

On a weekly basis, patients attempted to enter the nurses' station. (Tr. 1276.) Several of these entries resulted in employee injuries. (Tr. 201, 723, 767, 904, 980, 1364; Ex. 28.) About January 2016, RN ET saw an angry patient leap over the Ocean Point nurses' station, causing her to leave and call for help. (Tr. 1404-05.) In addition to the RN RO Attack previously described, RN VG testified that in 2016 a patient jumped over the nurses' station counter to get to her.[189] (Tr. 520, 904.) MHT VN testified that she saw patients jump over the nurses' station "[m]aybe once every two, three months." RN BF said she saw patients jumping over, or attempting to jump over, the counters at the nurses' station "very frequently," "say once a week." (Tr. 1276.) MHT CCM testified she twice saw patients jump over into

[187] Suncoast Supervisory RN CC agreed that a barrier at the nurses' station would have protected RN RO from attack on August 9, 2017. (Tr. 1443.)
[188] The validity of any such claim is undermined by the fact that the nurses' station in the intake department was enclosed. At trial, Respondents did not assert that it was illegal to have an enclosed barrier at the nurses' station.
[189] RN VG testified that a 250-pound male patient refused his medication and jumped over the nurses' station counter sometime between June and November 2016. She said her supervisor, Mr. Haider, was unbeknownst to her nearby. He picked the patient up and threw him back over to the other side of the counter. (Tr. 903-05.) MHT VN testified that [in November 2017] a guy jumped over the nurses' station counter and punched [RN CC] in the face causing her to go to the hospital for x-rays because RN CC thought her face was broken. (Tr. 981-82.)

the nurses' station. (Tr. 1186.) A RN described workers as being "very concerned about how easily kids could get over the countertop" and enter the workstation. (Tr. 767.)

The insufficient barrier also left employees at risk of being hit by projectiles. Patients threw stuff at the staff sitting behind the nurses' station like hot coffee, water, ice, cups, and towels.[190] (Tr. 520, 716, 1276-77, 2007-08.) RN RO testified that there were "several incidents of patients leaning over the nurses' stations and yelling and throwing things to hit us inside the nurses station…. one night, we were slammed with ice, a big handful of ice thrown into our faces by a patient."[191] (Tr. 520.)

Objects like scissors and staplers were left out on the workstation and were accessible to patients on every shift.[192] (Tr. 143, 499-500, 655, 723, 904, 980-81, 1065, 1187, 1275-76, 1278, 1363; Ex. 9 at 324.) While Respondents implemented a rule after the RN RO Attack that potentially dangerous office supplies should be kept in a locked box when not in use, this was not always adhered to, and frequently the supplies were left out.[193] (Tr. 143, 202, 264, 378, 507, 642, 655, 1045, 1187, 1199-1200, 1276, 1335,

[190] RN BF testified that in about March 2018, a patient hurled hot coffee onto RN TW's face reddening her face. (Tr. 1277-78.) She also discussed an incident where a patient threw a chair at a wall. (Tr. 1280.) Although the chair was heavy, the patient was still able to lift and throw it at a wall breaking plexiglass covering a bulletin board into shards near an employee while she was trying to administer medication to another patient. (Tr. 1280, 1336-37.) There was no MHT available to respond to the violent patient. (Tr. 1281.)

[191] For the purpose of showing only that whatever abatement measures Respondents implemented either before or after the issuance of the citation on April 24, 2018 were ineffective, RN DL testified that about [November 2018]/February 2019, a "young guy just jumped right over the nurses station in that open area and punched her [RN CC] right in the face and knocked her into the chart rack." RN CC suffered "a concussion and a black eye." RN DL said the young guy jumped over the same open counter at the nurses' station in the same way a patient had during the RN RO Attack. (Tr. 1047-48, 1067-68, 1933, 1945-46.) RN CC testified that in November 2018 the patient initially jumped over the opened Dutch half-door into the nurses' station, struck her, and then "jumped back over the nurses' station." (Tr. 1439-1441, 1471-72, 1610.)

[192] RN VL testified that scissors and staplers within reach of patients were out on the desk at the combined Turtle Cove/Coral Key Nurses station "[e]very day." (Tr. 723.) MHT VN testified that there was a "drawer full of long screwdrivers," as well as staplers and hole punches at the nursing station. (Tr. 980-81.) MHT CCM testified that she once observed a patient reach over the counter and go into a drawer. (Tr. 1187.)

[193] The testimony of multiple employees who indicated that scissors and other office supplies were routinely left out, either because they were in use or because a person got distracted and failed to put them away after use is credited over DON Phillips's testimony. (Tr. 143, 202, 264, 378, 507, 642, 655, 1045, 1187, 1199-1200, 1275-76, 1335, 1615.) She claimed that the AOC conducted rounds at least weekly to, among other things, make sure there is nothing laying around. (Tr. 1614-16.) She claimed she never saw any sharps, including scissors laying out at the nurses' station. (Tr. 1615.) Considering that RNs spend most of their time at the nursing stations and the MHTs work in the units, they are in better position to understand how the supplies are used and what practices are in place. (Tr. 1824-25.) The demeanor of the employee witnesses was more credible than DON Phillips who had difficulty recalling the frequency of the AOC rounds and did not work at the facility during the time referenced in the Citation. (Tr. 1555, 1626.)

2018.)

Dr. Lipscomb explained that because scissors needed to be used at times, a patient could still access them even if they were locked up promptly after use.[194] (Tr. 1823-25.) As described above, in August 2017, RN RO was violently attacked with a pair of scissors after a patient leapt over the counter and into nurses' station. (Tr. 159, 499-500, 507, 642, 1064-66; Ex. 28.) A few months before the RN RO Attack, on May 25, 2017, another patient reached over the desk at the same nurses' station and twisted RN ET's arm, injuring her shoulder.[195] (Tr. 201, 1354-55; Ex. 57.) Dr. Lipscomb explained that the current configuration is "obviously not good for staff," creates an "extremely risky place," at which staff can suffer disabling injuries. (Tr. 1682-83.) Citing several incidents, she considered it a matter of "common sense" that the current configuration needed to be modified to reduce patient access to the area. (Tr. 1679.)

Dr. Forman concurred, indicating that the workstation's configuration created a risk that patients can enter the nurses' station and pick up items and use them "to stab, to cut, to bludgeon nurses or nurses' aides." (Tr. 3413.) Respondents allowed patients to obtain "the very items" that are properly considered contraband under Respondents' policies. (Tr. 385, 3414; Ex. 200.) If a patient had a hole puncher or stapler in their possession, employees were to remove it, and the patient would not have access to it for the duration of their stay. (Tr. 3414-15; Exs. 200, 204.) And yet, the low barriers permitted access to these same items that could be used to injure employees. (Tr. 1251, 1278-79, 3413-15; Ex. 9 at 324, Ex. 28.) The Secretary showed that the nurses' workstations, except in the intake area, were not effective at abating the hazard.

[194] RN DL testified that scissors, as of the trial, are now locked up at the nurses' station. (Tr. 1049.)
[195] Respondents produced a "Risk Management Worksheet" for this attack. These worksheets were electronic incidents reports the nursing staff completed after an "adverse incident." (Tr. 2827-28.) At trial, the RN who had been attacked explained the document was inaccurate. (Tr. 1354-55, 1929.) She had not been shown the document after the incident itself. *Id.* She had a credible demeanor, and her testimony of the events is credited over the exhibits.

RN Cooke claimed that she looked to the Behavioral Health Design Guide by James Hunt and David Sine ("Design Guide") to support her conclusion that further assessment or modification of the workstations was not necessary. (Tr. 3033.) RN Cooke did not reach an opinion on whether a re-design would materially reduce the hazard. In any event, the Design Guide she cites does not support Respondents' position. Rather than applying the Design Guide, RN Cooke tried to extrapolate from the recommendations and apply them to different types of care units. (Tr. 3095-96; Ex. 258.) The Design Guide indicates explicitly it does not address concerns for adolescent patients and geriatric patients.[196] (Tr. 3199-3200.) Yet, employees treated both types of patients at Suncoast. (Tr. 2966, 3200.) Employees explained that adolescents were both more likely to try and more likely to be successful at entering the nurses' station by getting over the divider. (Tr. 642, 723, 1276.) RN Cooke was aware that adolescent patients frequently attempt to jump into the nurses' station. (Tr. 3199-3200.) Even for the non-geriatric/non-adolescent patients, the Design Guide recognizes that permitting individuals to have the ability to reach or jump over counters is a safety concern. (Tr. 3201; Ex. 258.)

In addition to the nurses' stations, the Secretary also cites inadequate protection for the kitchen staff. Respondents argue that the configuration was adequate and that not all patients were permitted in the kitchen area. VN, who worked both as a kitchen aide and MHT, refuted management's claims about patient access to the kitchen area. She indicated that she was attacked by a patient who was supposed to be "on precautions." (Tr. 1010-13.) The patient had hit, bit, and threatened staff, yet whatever the "precautions" were, they did not prevent the patient from gaining access to the kitchen and its staff. (Tr. 1011.)

VN's experience highlights the flaw with Respondents' reliance on rules rather than engineering

[196] RN Cooke acknowledged the design guide's lack of applicability here when she testified:
Q. Okay. And so this design guide was not created with those types of patients in mind, was it?
A. Well, according to the authors no.
(Tr. 3200, 3233.)

controls to address workplace violence. (Tr. 1663-65, 1676; Ex. 81 at 20.) The Secretary showed that the nurses' station's configuration and access to the kitchen area were not sufficiently effective at abating the hazard. Respondents need to reconfigure the nurses' station to include design features that prevent patients from jumping over, reaching into, or otherwise entering the nurses' station. The Court finds that this is a feasible abatement measure that would materially reduce the hazard of workplace violence and prevent incidents of future serious and/or disabling staff injuries. (Tr. 1861-62; Ex. 2 at 4, ¶ 2.)

f) Post-Incident Investigation and Debriefing

Respondents identified the post-restraint debriefings as part of their existing abatement. (Tr. 2900-1, Ex. 20.) The Secretary argues that Respondents' incident investigation and debriefing procedures were not sufficiently comprehensive and poorly implemented, rendering the program ineffective at abating the hazard. (Sec'y Br. 170.)

Respondents allege that after "any incident of workplace violence, the team would meet to discuss what happened and what can be done to prevent it in the future."[197] (Ex. 230 at 672; Resp't Br. 45.) The employee experience differed vastly from this statement and the assertions in the UHS PowerPoint. (Tr. 198-99, 216-17, 489, 910, 1101, 1828.) Several employees testified that no one spoke to them after a workplace violence incident. (Tr. 248-49, 483, 486, 507, 512, 654, 763, 880, 856-57, 894, 909-10, 973-74, 988, 1101, 1106.) Respondents' records support the employees' testimony about the failure to conduct debriefings after workplace violence incidents consistently. For example, reports related to the May 23, 2017 and the RN RO Attack do not indicate RN RO was involved in any debriefing, and he did not recollect being involved with one either. (Tr. 483, 488-89, 507-08, 512; Ex. 56 at 1492, ¶ 6.) Similarly, there was no debriefing after a patient pulled RN ET's right arm injuring her shoulder. (Tr. 1352.) Respondents did not provide any written evidence of root cause analyses or "lessons learned"

[197] Respondents' brief refers to the proposed facts they identified as 92-94. This cross reference relates to patient treatment plans, not post-incident debriefings or incident investigation. (Resp't Br. 25-26, 45.)

regarding workplace violence incidents. (Tr. 216-17.)

The Secretary established multiple deficiencies with this abatement method and showed that the flaws rendered it ineffective at abating the hazard. First, when debriefings were required, they focused on the patient's well-being and psychological comfort, not the trauma or injury experienced by staff. (Tr. 2903-4, Exs. 20, 50, 81, 83.) The forms used do not solicit information about staff injuries.[198] (Tr. 2904; Exs. 50, 243.) Second, debriefings did not always occur as management employees indicated.[199] The Secretary identified multiple incidents where an EAR or Risk Management Worksheet refers to a patient restraint and there is no completed debriefing form. (Tr. 398, 641-45; Exs. 40, 42, 49, 51, 54, 58, 63, 68.)

Third, debriefings often did not include critical individuals. Less than half of the forms produced indicate that the injured employee participated in the debriefing.[200] (Tr. 512, 702-3, 895; Exs. 37, 40, 43-44, 53, 56 at 1492, 61, 64, 67- 68, 71, 73.) Nor did Respondents expect a psychiatrist to attend the debriefing meeting. (Ex. 83 at 9.) Dr. Forman explained how this left a critical member of the team out of the immediate discussion after an incident.[201] (Tr. 3379-81; Ex. 83 at 9.)

Fourth, the debriefing forms were frequently incomplete and/or inaccurate. Even when debriefing forms listed their names, employees explained this was false or misleading. They had not been part of any meaningful debriefing or discussion after the workplace violence incident.[202] (Tr. 248, 481, 507, 512,

[198] The UHS Risk Management PowerPoint directs employees about how to report incidents. (Ex. 234.) As mentioned above, the document does not specifically refer to threats or violence against staff. In assessing the severity of incidents, the focus is primarily on whether an injury or outcome "alters a patient or visitor's function." *Id.* at 4297.
[199] To show that any abatement measures instituted either before or after the Citation's issuance were not effectively implemented, RN DL testified that no one talked to her about the assault on RN CC that occurred about [November 2018]/February 2019. (Tr. 1048-49.)
[200] Dr. Lipscomb recommended that debriefings "be done with the people that were involved in the incident." (Tr. 1830.)
[201] The facility had a policy requiring communication between psychiatrists and staff at the start and end of each period of coverage. (Ex. 83 at 9.) Considering that Respondents did not require a psychiatrist to always be on site and permitted a great deal of remote work, Dr. Forman questioned how much of this communication took place as required. *Id.* at 6-9. Dr. Foreman also testified that "on weekends there is actually not a psychiatrist present" because the fourth-year resident physician who generally handled weekends was not eligible for certification by the American Board of Psychiatry and Neurology. (Tr. 3388-90, 3510, 3609-10.)
[202] RN CMC was not shown any video of the February 19, 2018 incident and Respondents did not preserve any video of the incident. (Tr. 1101.)

857, 1101, 1106, 1131-32, 1142-43, 1265-66, 1742, 1929.) RN BF testified that the response "Nothing" written after the question "What could have been handled differently to prevent this event?" ignores the fact that "more staffing or security" could have prevented the incident. She said she would not write down more staff or security needed on the Patient/Staff Debriefing paragraph 6 of the RSO pertaining to the May 23, 2017 battery on RN RO and MHT BA because Suncoast was "not going to do it anyway." (Tr. 1269-70; Ex. 56 at 1492.) Several employees who were injured or witnessed events purported to be captured by Respondents' reporting mechanisms testified that there were errors in the descriptions of events, including the description of the response to a violent incident. (Tr. 237, 249, 481, 484-85, 507, 511-13, 896, 908-9, 1100-1106, 1288-89, 1354-55, 1437-38; Ex. 67 at 2159, 2210.) Related reports described debriefings and follow-up instructions that did not occur. (Tr. 237, 249, 513, 1438; Ex. 56 at 1492, Exs. 70-71.) Employees often were not shown the reports about incidents that involved them. (Tr. 236, 247, 895, 908.) RN VG indicated that the report about her attack downplayed the patient's conduct because the manager was attempting to cover up the true situation.[203] (Tr. 908-9; Ex. 49.) Similarly, for the few incidents for which Respondents preserved video footage, the incident reports discount the seriousness of the violence and the adequacy of the response. (Tr. 2913-17; Exs. 28-29, 69.)

Respondents' incident investigations and debriefings were also hampered by their scope. *See SeaWorld,* 748 F.3d at 1215 (fact that employer implemented safety measures only for one set of workers supported finding general duty clause liability because the employer did not implement those measures throughout its facility). Written debriefings were not required for all workplace violence incidents.[204] (Tr. 2837-38, 2555.) Regardless of the impact on staff, debriefings were not documented if the incident

[203] During the attack, RN VG suffered a broken hip and four broken ribs. (Tr. 894.) She did not have difficulty recalling the incident and strongly disputed the written account. As discussed, RN VG's testimony is credited over Exhibit 49.
[204] When an incident resulted in a restraint, employees were to complete an RSO. (Tr. 2707.) The RSO form included a section entitled "Patient/Staff Debriefing." (Tr. 2707-11, 2837-38.) If there was no restraint, the RSO was not completed. (Tr. 2555.)

did not result in a patient being restrained or secluded. (Tr. 2555.) *See BHC*, 951 F.3d at 562 (assessing the relative adequacy of two workplace violence programs where one facility discussed every incident of patient on staff violence and one that did not).

Further, although the UHS PowerPoint explains that "threats" are a form of violence, Respondents did not actually require employees to report threats. (Tr. 2217-2218.) Employees were told to only "report life threatening situations." (Tr. 704-5, 818-19, 833, 1717, 2176.) Such instructions leave out a whole range of serious physical harm. A RN was called a vile racial slur, and it was considered "part of the job." (Tr. 2010-11.)

RN VL described being threatened with violence more than ten times. (Tr. 704-5, 818, 833.) She was not told to complete incident reports for any of the threats. *Id.* A third nurse, RN CMC, was threatened "too many to count." (Tr. 1093.) The threats included patients graphically saying they would kick her, hit her, or "be waiting for her when she left the facility." *Id.* Such incidents "happened a lot," and it was "tolerated" as just "the way things were." (Tr. 1094.) Similarly, Respondents' "master" trainer for the Handle With Care program, SS, indicated that although he was told by patients, "I'm going to hurt your family, I'm going to … beat you up, tear you up," he never reported or documented these or any other threats. (Tr. 2168, 2176.)

Even without clear instruction or standardized reporting mechanisms for threats of workplace violence, some employees still reported threatening behavior to management. (Exs. 24, 26.) Rather than acting on the information to limit the potential for workplace violence, employee reports were ignored or dismissed outright. (Tr. 632-33, 1665-69; Ex. 24.) One MHT was verbally assaulted with inappropriate sexual threats. (Tr. 227.) She reported the incident to the unit nurse, but neither the nursing supervisor nor any other manager discussed the incident with her. *Id.* Even a threat written in blood was summarily dismissed without any assessment of the need for preventative action. (Tr. 627, 632-33; Ex. 26.) Threats

of violence against particular staff members did not result in changed assignments. (Tr. 969-70, 976.)

By failing to track verbal assaults and behavior that stopped short of physical violence, Respondents missed opportunities to prevent workplace injuries. (Tr. 1663.) Appropriate risk assessment requires consideration of threats and harassment. (Tr. 1663, 1669, 1709.) Respondents' practice of ignoring employee reports of threats made it less likely employees would report troubling behavior in the future and showed management's lack of commitment to addressing the problem. (Tr. 1669-71, 1674-75.) Dr. Forman explained that "just the impression that violence and threats will be taken seriously can prevent further violence." (Ex. 83 at 11.) The failure to have a process for investigating or debriefing incidents where a patient threatened an employee limited the effectiveness of Respondents' debriefing program.

Besides the failure to sufficiently include threatening behavior, Respondents' tracking and trending of data was flawed in other ways. Respondents risk management focused on patient, not staff injuries. Sometime after about March 2017, supervisory nurses used an electronic system to track "adverse incidents" called MIDAS.[205] (Tr. 1076, 1436, 1464-65, 1486-87, 1798, 2827-28; Ex. 61 at 1762-1767.) An incident report or "Risk Management Worksheet" was "generated for the patient" and "patient specific." (Tr. 2832, 2839, 2848.) If an employee is injured during an "adverse incident," the report may or may not mention the staff member. (Tr. 2839.) But no "incident report is generated for the staff member."[206] (Tr. 2699, 2839.) The system requests information about the significance level for injury to the patient without soliciting information about any injuries to employees. (Tr. 2699, 2848.)

[205] RN VG testified that she did not know what the MIDAS system was. (Tr. 931-32.) RN VL testified that she never completed a MIDAS incident report. (Tr. 1075-76.) RN CMC said she did not "even know what an incident report looks like at Suncoast." (Tr. 1139, 1150-56.)

[206] Such information is supposed to be captured in EARs. (Tr. 2699, 2839.) However, the MIDAS system, not the EARs, was used for risk management analysis by both the UHS-PSC and performance improvement committee. (Tr. 2849.) The failure to include staff data undermines the effectiveness of any tracking or trending done by the committees for purposes of abating the hazard.

Incidents would be recorded as "patient aggression without injury" as long as the patient was not injured. (Tr. 2856.) In other words, incidents were tracked as "without injury" even if an employee was severely injured. (Tr. 2856, 2860-61, Exs. 250-251.) The Risk Management Worksheet for the RN RO Attack illustrates this flaw. It characterizes the incident as being of low significance and records it as a "no injury" event, without mention of RN RO's extensive, serious injuries.[207] (Tr. 2847-48, 2860-61; Ex. 60.)

Respondents' expert, RN Cooke, acknowledged that debriefings can be a helpful strategy to mitigate the cited hazard. (Tr. 3168.) She did not dispute the employee testimony about a lack of debriefings. (Tr. 3166-67, 3169.) Although she acknowledged at trial on direct examination that "there possibly could be times when it [debriefing] hasn't happened," she asserted in her expert report without a firm basis of support that "debriefing is conducted and documented on all events of violence immediately after the event by the staff involved and supervisor."[208] (Tr. 3165-66, 3192; Ex. 264 at 10, ¶ A.) Without support, she cites possible reasons for the debriefings not to occur. (Tr. 3167.) She offers theoretical reasons for why debriefings did not happen, but there is no support in the record for her speculations. The Court finds that Respondents did not immediately conduct debriefings with the employees who were involved in the events for all workplace violence incidents during the period preceding the issuance of the Citation. (Tr. 1101, 2555, 3041-42, 3165-66, 3213-14.)

Dr. Lipscomb concluded there was a lack of meaningful debriefing and risk mitigation following incidents of patient-on-staff violence. (Ex. 81 at 21.) Debriefing is "essential" for implementing hazard controls to prevent future workplace violence incidents. *Id.* at 36. The Secretary showed that this aspect

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[207] As noted, the incident report for another incident involving RN RO was also inaccurate. (Tr. 484-85; Ex. 56.) Similarly, other witnesses discussed never seeing the Risk Management Worksheet for instances that injured them and when they viewed the documents at trial found them to be inaccurate. (Tr. 1100-02, 1354-55, 1929.)

[208] RN Cooke testified:

Q. So with respect to debriefing though, you didn't find it problematic that a number of the witnesses who witnessed a patient injuring an employee were missing from the debriefings or the fact that the injured employee was missing from the debriefings? That's not something you notated or realized?

A. No, I did not make a judgment about that.

(Tr. 3192.)

of Respondents' WVPP was not sufficiently effective at abating the hazard.

g) Program Evaluation

The flaws cited above in the discussions about incident investigation and debriefing also undermined the effectiveness of any program evaluation Respondents conducted. Respondents argue it tracked workplace violence incidents through EARs. EARs were not specific to injuries from workplace violence. (Ex. 7.) The forms do not seek any root cause analysis or critical assessment of why an employee was injured or how the injury could be prevented. (Exs. 36-42, 44-45, 48-50, 52-77.) EARs were not provided to co-workers or included with patient charts. The Director of Risk Management was not sure if his department even kept copies of EARs. (Tr. 2848.)

The Secretary also identified multiple errors in the descriptions of patient behavior in the record. These rendered Respondents purported tracking and trending of data about the hazard ineffective. Many reports were not coded to show that the incident involved a patient physically attacking a staff member.[209] (Tr. 2860-61; Exs. 39, 42, 61, 63-64, 67, 69-71.) The codes, rather than the descriptions of events, were what Respondents used to develop their tracking and trending data. (Tr. 2845-46; Ex. 250.) Respondents' approach focused on injuries to patients, not staff safety: "the incident reports here are patient-centered." (Tr. 2699, 2839, 2854-56, 2860.) The data used by the committees looking at the cited hazard also appeared to have mathematical errors. (Tr. 2856-58.) Mr. Curl could not explain whether these were errors in the formulas used on the spreadsheets or errors in the underlying data: "So the formula could be correct, or it could be wrong." (Tr. 2856-63; Exs. 250-51.)

Respondents argue their monthly UHS-PSC meetings were also part of their ongoing workplace violence program evaluation. In 2016, CEO Hamilton attended most of these meetings, and staff injuries were routinely listed as agenda items for the meetings. (Ex. 251 at 3935-4085.) At that time, the number

[209] If a patient was "out of control" but had not "physically aggressed on somebody" the incident was supposed to be recorded as "patient out of control." (Tr. 2886.) In contrast, incidents when a patient made physical contact with someone were to be recorded as "patient aggression." *Id.*

of staff attacks was tracked and included in the meeting records. *Id.* at 4033, 4050, 4065-67. However, in January 2017, staff injuries stopped being a listed agenda item for UHS-PSC meetings.[210] *Id.* at 3595, 3669, 3680. The records note the number of patient injuries, patient aggression, and "out of control" patient behavior. *Id.* But the impact of these incidents on employees, such as the number of staff injuries or the total number of patient attacks on staff are no longer set out. (Tr. 2634, 2639, 2845-46; Ex. 251.) After May 2017, including for the six months preceding the Citation, the UHS-PSC records omit any reference to patient attacks on staff, even in the month following the RN RO Attack. *Id.* at 3644-3811. While at some point before OSHA started its investigation, the UHS-PSC may have been an effective part of Respondents' abatement program, during the time referenced in the Citation, the committee appeared to focus only on patient, not employee, safety. *Id.*

Although Respondents talked about tracking and trending, Dr. Lipscomb found that, in practice, there was little analysis of the hazard. (Tr. 1674.) Respondents collected data but failed to use it. *Id.* And they did not encourage workers to report all injuries and threats. *Id.* Workers would say they had not been injured, but then reveal they were repeatedly slapped and kicked. (Tr. 1088, 1674-75.) Even when it occurred, the discussion of employee injuries during committee meetings was "very cursory." (Ex. 81 at 18.) Numbers of injuries were noted but there is no record of notable discussion regarding engineering or administrative controls to prevent similar future incidents. *Id.* The Secretary showed that, as implemented, Respondents' approach was deeply flawed and failed to abate the hazard effectively.

h) Training

Respondents had two training programs directly related to workplace violence: (1) the UHS PowerPoint, and (2) the annual Handle with Care and Verbal De-escalation ("Handle With Care")

[210] For April and March 2017, there is some information on patient attacks on staff but there is no evidence of the committee tracking or trending information related to staff safety. (Ex. 251.) The limited data presented in March 2017 conflicts; in one place it indicates 4 attacks on staff occurred and elsewhere it indicates there were two. *Id.* at 3692. The following month there appeared to be nine attacks on staff, but this was not separately tabulated. *Id.* at 3641-43.

training. (Tr. 112-13, 118, 226, 701; Exs. 6, 11, 15-16, 18, 235-37, 238, 243, 245.) The Secretary identified significant issues, which undermined the effectiveness of Respondents' training program at abating the hazard. *See BHC*, 951 F.3d at 562 (emphasizing the importance of effectively using training materials). Dr. Forman opined that Respondents are insufficiently training their "staff to address workplace violence regardless of … what the policy is written, in terms of the way that it's executed, that it's insufficient." (Tr. 3520-21.)

Looking first at the UHS PowerPoint, the Secretary faults the glaring disconnect between the actions the training calls for and what occurred in practice. For instance, as discussed, while the slides call for reporting threats and indicate the facility has a "zero tolerance for violence of any kind," this was not true. (Tr. 894, 1668; Ex. 230.)

Besides the UHS PowerPoint, most employees also received Handle With Care training upon hiring, and then there was an annual re-certification. (Tr. 2102, 2104; Exs. 15-16, 234-35, 245.) The program purports to teach self-protection techniques and approved methods of restraining a patient. (Tr. 2102.) The focus of the training is to teach employees how to protect patients when intervening. (Tr. 2130.)

The Secretary cites the program's limitations and lack of support for employees charged with implementing the called for techniques. The UHS PowerPoint was only presented during orientation and not reviewed with employees again. (Tr. 112, 3246; Exs. 11, 17.) The Handle With Care training was repeated. (Ex. 245.) However, employees explained how in "slow-motion" the techniques could be done, but this was not practical for their actual experiences at the facility. (Tr. 524-25, 1061, 1123, 1146-47, 1376, 2001.) Real patient interactions occurred quickly and with unpredictable patient behavior. (Tr. 905, 1061, 1147, 1190-91, 1299.) In contrast, co-workers acting as patients went slowly; they did not act as typical patients. (Tr. 1147, 1190-91.) Participants acting as patients in the practice scenarios were

instructed not to replicate real patient behavior. *Id.* One employee could do the techniques with the assistance of knee pads during the training, but that accommodation was not available in real-time when responding to patient aggression.[211] (Tr. 2016, 2021-22, 2117.) During the training, employees were paired with people of "similar stature." (Tr. 1329.) Employees did not practice with an individual significantly larger than themselves, as was the situation they often faced when working in the units. (Tr. 262, 473, 490, 497, 507, 523-24, 569, 1043, 1329.)

Another employee, who was sufficiently proficient with the program was trained on how to lead the training for new hires, explained that the techniques were not consistently effective in practice. (Tr. 262-63.) She described a situation where an approximately 300-pound patient pulled a refrigerator off the wall. (Tr. 262.) She did not believe she could have restrained such a patient because he "could have potentially flipped [her] over." (Tr. 262-63.) A different employee, RN LC, described a similar situation when in about April 2018 she was working alone at the intake department when a large angry man pushed her to get through a door.[212] (Tr. 703; Sec. Br. 91.) She did not believe that she could have used her training to restrain him because of his size and mental state. (Tr. 703-4.) Respondents did not take the age, size, or ability to perform the techniques without accommodation into account when they determined an employee was able to respond and address violent incidents. (Tr. 1565.)

Other employees described how the restraint techniques taught could not be used in the circumstances they faced at the facility. (Tr. 167, 704, 708, 904-5, 1056, 1123, 1146-47, 1299.) As RN DL explained, the techniques could address minor hair pulling or wrist grabbing but were "not practical for most of the people that [she] work[s] with." (Tr. 1056.) Employees could only practice the

[211] Her need for knee pads was not noted on sheets indicating she completed the training. (Tr. 2016, 2021-22.)
[212] Dr. Lipscomb testified that working alone was the top of the list of risky situations. She said, "And to think that it goes on for hours a day at Suncoast in the admissions unit and other places at night is just to me unconscionable. And again, I think Suncoast is really lucky that they haven't had any fatalities." (Tr. 1713, 1741.)

techniques with mentally sound co-workers, not the "psychotic" patient population.[213] (Tr. 1056, 1123, 1146, 1259.) Instead of feeling trained to sufficiently handle situations, employees were left to "call for help and hope you don't get killed in the meantime." (Tr. 904.) RN RO and RN VG described how supervisors also failed to take prompt appropriate action during workplace violence incidents. RN VG thought that perhaps her supervisor, Mr. Haider, was "in shock" because he took no prompt action upon her injury. (Tr. 899-900.)

Even with the benefits of a slower-paced scenario and the safety of knowing that the participants were co-workers, not patients, many still could not perform the techniques.[214] (Tr. 203, 266, 645, 708, 1372-73, 1447-50, 2000-01, 2120, 2124, 2189; Exs. 15, 23.) One employee explained that "there were people who weren't physically fit enough to participate an awful lot" with implementing the techniques. (Tr. 496-97, 525.) A significant number of direct care employees were unable to demonstrate and perform all of the positions called for by the training program.[215] (Ex. 23.) In such situations, the person leading the Handle With Care training still signed off that the employees completed the training, even though they could not complete the positions and generally only observed others performing them.[216] (Tr. 708-11, 767-68, 1193-94, 1272-74, 1373-74, 1446-49, 1509-13, 1999-2001, 2119-20, 2124, 2189; Ex. 23

[213] RN BF testified that verbal de-escalation did not work well with psychotic patients because "you couldn't really rationalize with them. You can't speak to them and even get to like a more de-escalated place because they're not in their right mind. I mean, they may be threatening you or whatever. They're not going to listen. So, you're not going to be able to verbally de-escalate them, all the time anyway." (Tr. 1259.)

[214] MHT BG testified that "I wasn't able to do most of the things they wanted us to do. Like, I couldn't perform it on another employee, so I knew I wouldn't be able to do it on a patient." (Tr. 645.)

[215] During *voir dire* questioning by the Secretary's counsel, RN Cooke testified:

Q. And you stated that if an employee could not complete all the movements, then they could not work with patients, correct?
A. Yes, that's what I said, but I think, to clarify that, it's that they can't physically maneuver patients, basically.

(Tr. 3051.) Later, during direct examination she said she was not concerned that some staff members could not perform certain positions during Handle With Care training because they were primarily nurses who are "often not the ones that are hands on." (Tr. 3164-65.) She provided no statistical analysis to support her assertion. The trial record has many incidents where RNs were the victims of workplace violence caused by patients. (Exs. 38, 45, 49, 52, 56-57, 60-61, 68-70.)

[216] Handle With Care Instructor Smith testified,

Q. … So, folks that, at least, as long as they observe the positions being done, they can be considered trained, correct?
A. Yes.

(Tr. 2189.)

at 4406, 4414-15, 4424, 4431, 4449, 4458, 4467, 4483, 4488, 4503, 4506, 4521, 4527-28, 4532, 4540-41, 4545, 4630-32, 4642, 4675, 4678, 4681, 4686, 4692, 4695, 4706, 4712, 4719, 4725, 4729, 4735, 4744, 4752, 4796, 4806; Sec. Br. 37-42.) RN VL testified that there was "no possibility" that she could do the things covered in the Handle With Care training.[217] (Tr. 767-68.) She said she "could never perform most of these restraints." (Tr. 774.) She said that before starting to work at Suncoast she "had a back injury" and "a heart problem." (Tr. 776.) She explained, "I can't … exercise. I can't do a lot of activity … I can't get down on the floor. I can't grab somebody and hold them." *Id.* She could not perform the restraint techniques "[j]ust by virtue of size and strength."[218] After the training sessions, the training leaders determined that several employees could only "assist" with implementing the necessary techniques. (Tr. 775-76, 825-26, 828, 2182-95; Ex. 23 at 4406, 4414-15, 4424, 4449, 4503, 4527, 4545, 4630, 4678, 4719, 4735, 4744; Ex. 248 at 4796.) Yet, there were no procedures to ensure that there would be enough people capable of performing the techniques on each shift. Respondents only required attendance, not success at completing the required tasks of the Handle With Care program.

At the OSHA inspection's start, the annual re-training on Handle With Care techniques was four hours.[219] (Tr. 523, 1502, 2178, 3220; Ex. 17.) Employees testified that this was insufficient and called for more frequent training. (Tr. 903.) One employee explained it was difficult to remember "every move you're supposed to make when your hair is getting pulled [or] when you're getting choked." (Tr. 979-80, 996.)

During the time of OSHA's investigation, outside of the annual training, employees did not

[217] RN VL's Handle With Care Program Component Checklist for November 2, 2017 indicated that she was "due to active injury, unable to perform restrain techniques", including: (1) Primary Restraint Technique (PRTs), (2) PRT in Settle, (3) Two Person Floor Transition Stop Position, (4) Two Person Floor transition, (5) Supine Floor Containment, (6) Modified PRT for Very Small Children (DEMO) and (7) Pregnant Female – Settle vs. Supine (DEMO). (Ex. 23 at 4796.)

[218] RN VL testified that she has held a patient's arms or legs so that a patient could not kick anyone when assisting other staff restraining, or administering medication to, an unruly patient. (Tr. 778-81.)

[219] MHT MM #2 testified that in August 2017 Handle with Care and Verbal De-escalation training was conducted on the same day. By July 2018, these training programs were conducted on separate days, eight hours of training on each day. (Tr. 284, 3220.)

regularly participate in drills to practice the skills taught. (Tr. 205-06, 901, 996, 2198; Ex. 81 at 22.) Respondents themselves appeared to recognize the need for drills and additional safety meetings. (Tr. 2766; Ex. 251 at 2780-81, 3811, 3883.) But, Mr. Smith, the Handle With Care trainer, indicated that there was only one drill involving three people in the more than three years he worked at Suncoast. (Tr. 2196-98.) He could not recall the year the drill occurred. (Tr. 2197.) Although he claimed the drill was documented, no such documentation was produced in discovery or offered at trial. (Tr. 2197; Ex. 92; Sec'y Br. 42 n.6.)

Despite directly interacting with patients, kitchen staff and medical doctors do not receive Handle With Care training. (Tr. 977-78, 1503, 2490.) The medical director, Dr. Hemsath, indicated that the medical training doctors receive was sufficient because they were not involved in the restraints. (Tr. 2491, 3582.) He said, "it's supposed to be people who are trained that do hands on." (Tr. 2491-92.) He would not ask someone not sufficiently trained to restrain any patient.[220] *Id.* Respondents' policies were contradictory on this point. (Ex. 83 at 9.) The job description for a psychiatrist at Suncoast states, "some physical confrontation and/or restraint may be necessary when dealing with residents." *Id.* Mr. Curl also indicated he was "sure" psychiatrists had responded to code grays. (Tr. 2996.) Dr. Forman explained that psychiatrists should be trained in restraint and self-defense techniques. (Tr. 3438-40; Ex. 83 at 9.)

Even if Respondents' rationale for not training doctors, there is no similar justification for limiting the kitchen staff's training to the UHS PowerPoint. (Tr. 1503.) Kitchen staff interacted with patients in the dining room at every meal, and patients had access to the kitchen. (Tr. 977-78.) A cook indicated that the kitchen was rarely locked, despite the presence of items considered contraband if found elsewhere in the facility. (Tr. 384-85, 977-78, 3112; Ex. 200.) She described patients throwing utensils and trays. (Tr.

[220] Dr. Hemsath testified that it was his personal opinion that it would be inappropriate to train doctors in hands on training. (Tr. 3582-87.)

977, 1010.) Respondents argued that not all patients were permitted in the dining area adjacent to the kitchen. However, even patients "on precautions" sometimes still were mistakenly given access to the dining room. (Tr. 1011-12.)

Respondents also allege that it trains staff on "milieu[221] management." (Resp't Br. 17.) In discussing this training, Respondents rely on Exhibits 240 and 242. *Id.* Neither of these documents was accepted for admission to the record, and so they were not considered. (Tr. 41, 52-53, 300, 2387-91, 3249.) At trial, CEO Hamilton had difficulty recalling details but expressed the belief that new employee orientation included training on milieu management. (Tr. 2392.) However, neither she nor the other employees who testified discussed what information was provided or how it abated the hazard.[222] (Tr. 668, 784, 1299.) The record does not establish that the milieu management training contributed to the hazard's abatement.

Respondents also offered a list of other trainings various employees may be required to take. (Ex. 224.) Only the titles of these sessions were provided. *Id.* None of the titles refer to workplace violence, and nearly all appear to focus on patient care. *Id.* Whatever content these trainings included, how they might have mitigated the hazard, or their effectiveness at doing so was not established. The Secretary established that Respondents' training program did not adequately abate the hazard.

i) Staffing - Insufficient staff to respond to workplace violence incidents

The Secretary argues that there was not enough staff to respond to workplace violence incidents adequately. (Sec'y Br. 152-54.) As explained in the training discussion, dozens of employees, although

[221] CEO Hamilton described "milieu" as following the schedule of patient activities and groups for the day, keeping them safe, and taking care of things relating to patient's daily living. (Tr. 2280-81.)

[222] The record includes a handout CEO Hamilton described as being related to the training, but the document does not discuss when the training occurred. (Ex. 231.) Mr. Curl indicated that in May 2017, a UHS-DE employee provided milieu management training after some events that had occurred in the prior month. (Tr. 2985.) He said that Suncoast has had such trainings "a couple of times," but did not indicate that they occur on any set schedule. (Tr. 2988.) The Court notes that in his initial response to OSHA, Mr. Curl did not mention such training as part of the WVPP. (Ex. 6.) Further, the Staff Development policy refers to "on-going" education on Handle With Care, but not milieu management. (Ex. 245 at 4163, 4165.)

trained, could not properly be considered available to respond to violent incidents because they were not physically capable of performing the restraints and self-defense techniques taught. (Tr. 1271, 1447-50, 3221; Ex. 23.) Other times there was just not enough staff. Dr. Lipscomb argued that there were many instances where the absence of staff resulted in employees getting injured. (Tr. 1686-87.)

Respondents did not adhere to the requirement in their abatement plan to ensure there was at least two physically qualified staff for each unit on every shift. (Tr. 1555-56; Ex. 19.) Multiple times employees had to restrain patients alone or there were not enough employees physically capable of implementing the restraint techniques working on a shift. (Tr. 569-70, 904-5, 1029, 1271, 1565.) If during the Handle With Care training an employee could not demonstrate the required techniques, the employee leading the session would note it on a training checklist. (Ex. 23.) Nothing was done with this information. Notes on the training checklist such as "unable to perform restraint" or "assist only" were not communicated to those in charge of staffing.[223] (Tr. 711, 1450-51, 1565, 1511-12, 1568-69.) The trainers identified limitations on the ability to perform the techniques, but no one considered this when determining who should work which shift or what their duties would be. (Tr. 711, 1273-74, 1375, 1450-51, 1556-57, 2001, 2124.) The RN supervisor, who was designated "assist only" was paired with another "assist only" employee on a shift where she was injured. (Tr. 1450-51.) Supervisors "had no idea" of who had not been unable to demonstrate the Handle With Care techniques. *Id.* The HR Director did not consider or communicate limitations identified by the trainers to any other manager. (Tr. 1508-13, 1568-69; Ex. 23.) Even the DON was not aware that her own checklist indicated that she could "assist only." (Tr. 1567-68, Ex. 23 at 4498.) It only mattered that the employee attended the class, not whether they

[223] The Director of Human Resources testified:
Q. So these notes that the trainer is making, those don't make any difference at all.
A. They would if the trainer physically came to me and said that they are unable to perform these duties for – to pass this training. But I've never had that happen from a trainer.
(Tr. 1512.) Likewise, DON Phillips testified that she never reviewed the Handle With Care competency checklists. (Tr. 1557, 1568-69.)

could perform the techniques. (Tr. 1273-74, 1556-57.)

RN Cooke argued that deficiencies in employees' ability to perform the techniques were not important because four or five people responded to violent incidents. (Tr. 3164-65.) Her opinion is rejected as insufficiently supported. Employees explained that sometimes they were working alone or that there were only two employees assigned to a unit at night, and during the time of OSHA's investigation, only one person in the intake department. (Tr. 626, 637, 678-9, 703, 751, 763, 1055, 1103, 1167, 1692, 2283; Ex. 24.) At night, it was a "skeleton crew." (Tr. 1045, 1332, 1444.) There were often not four or five people who could respond to a violent incident; sometimes, not even a single person responded to a call for help. (Tr. 751, 761, 764, 1045, 1108-10, 1167, 1404, 1697, 1741; Ex. 9 at 325.) At least one employee needed to remain in each unit at all times. (Tr. 205, 1236-37, 1697.) Sometimes, calling a code was pointless because there was "no one else to respond." (Tr. 1314, 1324, 1333.) Further, Respondents took no steps to ensure that at least one person could complete the techniques in each unit. RN Cooke assumes that would be the case without support. (Tr. 2194-95, 3164.)

The facility had such low staffing levels that it lacked additional people on-site to assist with aggression in multiple units. Dr. Lipscomb testified that "the absence of staff resulted in employees getting injured." (Tr. 1686.) Respondents' Behavioral Management Program mandates that "an adequate number of physically qualified staff shall be available on each unit for each shift in accordance with the written acuity system." (Tr. 121-22; Ex. 19 at 731.) Despite this provision, the facility had no such written acuity system. (Tr. 1563-64, 2579-80; Exs. 19, 22.) There was no particular staffing ratio based on the level of aggressiveness of the patient population.[224] (Tr. 268, 1563-64, 2580-82; Exs. 19, 22.) Given that, it is unsurprising that greater acuity did not automatically result in additional staffing. (Tr.

[224] In its July 20, 2018 Final Accreditation Report, the Joint Commission observed that Suncoast "had not completed an analysis of staffing related to identified high risk events (fall, seclusion/restraint, patient aggression, self harm)." (Tr. 2810-11, 2869-70; Ex. 256 at 4260.)

122, 268, 1077-78, 1597, 2309, 2582.) Staff increases had to be requested by a supervisor and approved by the CEO (or AOC in her absence). (Tr. 2309-10, 2581.) The CEO is not a medical doctor. (Tr. 2277.) CEO Hamilton claimed she never turned down a request for more staff due to acuity,[225] i.e., the degree of needs of the patient population.[226] (Tr. 2310.) She testified that when asked, usually by RN nurse supervisors, to keep an extra staff member on duty beyond the staff allowed per the staffing grid for acuity in 2017 and 2018, she agreed but did not provide any specifics of doing so.[227] (Tr. 2309-10; Ex. 22.) Nor did she explain how often staffing was increased for acuity. Disputing her vague assertions, employees indicated that the patient count determined staffing levels, not the acuity of those patients.[228] (Tr. 122, 268, 1077-78, 1444.)

DON Phillips, who began working at Suncoast after the Citation's issuance, indicated she would consider requests for additional staff to address patient aggression. (Tr. 1597.) However, she did not proactively consider the number of admitted patients with histories of violence against staff or how many were identified as "high risk" for aggression in their intake or nursing assessments. (Tr. 1594, 1597, 2581-82.) She did not know how many patients were identified on the high-risk alert forms as aggressive on a day-to-day basis. (Tr. 1564.) Her understanding was that the high-risk alert forms were used for the precautions taken, not for staffing levels. (Tr. 1593-94.) She did not review the information on the high-risk notification forms routinely, and thus it was not used to inform her daily staffing decisions. (Tr. 1594.) In practice, the assignment of "high risk," was a distinction without meaning. According to CEO

[225] CEO Hamilton described "acuity" as being "where a specific patient's behavior may be a little more difficult to work with than another patient's behavior." (Tr. 2308-09.)
[226] DON Phillips did not indicate whether she turned down staffing requests. Nor did CEO Hamilton indicate whether other administrators turned down staffing requests. On cross examination, the CEO appeared to modulate her blanket statement, indicated that she did not turn requests "to keep additional staffing," as opposed to denying requests for increasing staffing. (Tr. 2588.)
[227] The staffing grid at Exhibit 22 was not in effect in 2015 through 2018. (Tr. 2307, 2580; Ex. 22.) The staffing grid that was in effect in that time frame allowed more patients with fewer staff members. (Tr. 2580-81.)
[228] One employee indicated that staffing would occasionally increase when the facility was being reviewed by an outside accreditation agency. (Tr. 268.) However, when the review process ended or was delayed, the additional staff was sent home. (Tr. 268-69.)

Hamilton, "every patient gets a high risk alert." (Tr. 1594, 2582.) Neither the patient files nor the high-risk alert notifications resulted in increased staff levels. (Tr. 1597, 2582.)

The record shows that staffing requests related to employee safety did go unheeded. Routinely, there were not enough people to handle violent incidents appropriately.[229] (Tr. 769, 1947-48.) Mr. Curl found during his investigation of the RN RO Attack that the presence of additional staff members is "one thing that could have prevented this incident from happening." (Tr. 2713-14.) Dr. Lipscomb opined that Respondents do not prioritize employee safety. (Tr. 1947.)

MHT CCM explained, "nine times out of ten," the unit lacked sufficient staffing to handle violent patients. (Tr. 1198.) Phone calls requesting assistance went unanswered "probably every day." (Tr. 756, 1109, 1114.) In an anxious series of texts, one employee explained how frightened she was working alone in intake on a particular shift with a very aggressive patient. (Ex. 24.) CEO Hamilton wrote back to MHT CC but took no responsive action, either at the time or subsequently. (Tr. 2589-90; Ex. 24.) Multiple employees testified that their requests for additional staffing to handle aggression were belittled, ignored, or dismissed. (Tr. 299, 522, 1078, 1198, 1665-69; Exs. 24-25.) Employees who brought up staffing issues or enclosing the nurses' station to management were "severely scolded" and told to "hush up." (Tr. 522.) Dr. Lipscomb testified that it was "unconscionable" for front-line MHTs and RNs recommending improvements to be told that "maybe behavioral health isn't for you if you can't accept this high risk of being assaulted and potentially having a disabling injury on the job." (Tr. 1666-67, 1672-74.) The Court credits the employee testimony about denials for staff increases and enclosing the nurses'

[229] When writing the RSO regarding the February 19, 2018 incident where MHT GS was injured, RN CMC testified:

> Q. Would you have felt comfortable writing that you needed an MHT at intake there?
> A. I put on there that – I mean, yeah, there needed to be a tech there. I said that from the beginning, that there should never, ever, ever, under any circumstances, whether it be a tech or anything else, that there should never be – you should never be alone in the intake department. Patients come in. They're unstable. I mean, you don't know what's going to happen from moment to moment.

(Tr. 1144.)

RN CMC's recommendation that a MHT be assigned to the intake department was not included in the RSO at the prompting of Mr. Haider, who essentially told her what to write in the order. (Tr. 1105, 1144-46.)

station.

Respondents also point to the creation of a "float" MHT position on the night shift after the RN RO Attack. (Resp't Br. 47; Tr. 361, 2396.) This float was to assist when other staff went on breaks, handle transferring patients from intake to the units, and assist with patient inventory and documentation. (Tr. 1339, 1378, 2143.)

The Secretary does not dispute that a float MHT could be part of an effective abatement program for the cited hazard. The issue concerns how the person functioned at Suncoast. The float only worked the nightshift.[230] (Tr. 2396.) Frequently, either the float position went unstaffed, or the person assigned to the role was needed to be directly involved with caring for already admitted patients and could not respond to workplace violence incidents.[231] (Tr. 1378-81, 1281-82, 1378-82, 1689.) If a patient in intake needed to go to the bathroom, the float tech would have to accompany them as it was in a separate area. (Tr. 761, 1113, 1282.) This left only one worker in the intake area with the other patients. (Tr. 1281-82, 1381.) One to three times a week, the float tech would fill in as a unit MHT, and no one would work as a float tech. (Tr. 1282, 1382.) CO Trouche testified that the float tech position Respondents created after the RN RO Attack "went away after a while. But, during that time that the floater was there, it was not really there." (Tr. 419, 717-20; Sec. Br. 87-88.) The ineffectiveness of how any such float MHT was utilized is demonstrated by the many incidents of patient on staff workplace violence that continued beyond the putative establishment of the position. (Ex. 78, at 1-2 [e.g., incident Nos. 35-49].)

Unlike the units, where multiple staff worked, often only one person was in the intake

[230] It is not clear whether the MHT float position was created before or after OSHA commenced its investigation. Respondents indicate it occurred in the "fall of 2017." (Resp't Br. 15; Tr. 2396.) RN DL testified that Respondents hired a "float tech" to be a fourth MHT from 7:00 p.m. to 7:00 a.m. in about April 2018. But, about half the time, the float tech was not actually a fourth MHT. Instead, the float tech filled in for an absent MHT. There were "not enough techs at night." (Tr. 1050-55.) MHT SS testified that he was designated to serve as the initial MHT floater for one month possibly in early summer 2018, which would have been after the Citation's issuance. He did not know why a new float position was created. (Tr. 2141-42, 2195-96.)

[231] Employees explained that if a person was assigned to patient checks or to directly observe a particular patient, they could not stop that task to assist a co-worker, even during an incident of violence. (Tr. 1363.)

department.[232] (Tr. 702, 707, 1282.) The intake department is where the facility receives patients who are in a psychiatric emergency. (Tr. 2442-43.) Dr. Lipscomb explained that the intake department was a "high risk area." (Tr. 1696-97.) Patients often arrive unmedicated, intoxicated, and/or in a state of psychiatric crisis. (Tr. 229, 704, 762, 1110, 2441-43.) Dr. Forman said intake is often the most volatile time of a patient's hospitalization. (Ex. 83 at 7.) Workers from intake described patients as aggressive and violent, and Dr. Hemsath agreed that patients can be volatile upon arrival. (Tr. 761-62, 1110-11, 2440-41.) Intake staff "take the brunt of most patients' emotions and behaviors," including being spit at and receiving severe threats. (Tr. 2175-76; Ex. 9.)

Daily law enforcement escorted individuals in handcuffs to the facility. (Tr. 650, 707, 863, 1110, 1114.) Intake staff would ask patients about criminal history, but they did not look up criminal records, and patients would not consistently share information about their histories. (Tr. 720, 822, 1113-18, 1301.) Particularly during the intake process, staff know little about the patient's condition or propensity for violence. (Tr. 720, 1112-4, 1301, 1360, 2356-57.) This is still the case for patients that were previously violent against staff at Suncoast. For instance, the patient involved in the RN RO Attack returned to the facility about a year after that incident. There was nothing about his previous violent attack on staff or his subsequent arrest in the computer system to alert the staff member upon his arrival. (Tr. 2356-57.) Likewise, another employee working in intake did not know that a patient she was assessing alone had assaulted a co-worker leaving that person with a broken hip during a prior admission. (Tr. 1114-18.)

While the employee working in intake could call for assistance, routinely there would be no response even after repeated requests. (Tr. 1103, 1109-10, 1697.) Sometimes the phone would be

[232] After the Citation's issuance, an intake MHT position was added in about November or December 2018 from 5:00 p.m. to 1:00 a.m. (Tr. 718-19.) That person quickly left the position, and the role went unfilled until February or March 2019. (Tr. 718-19, 862, 1050, 1090.) Even when there was an intake MHT, that person did not work on weekends or all the way through the night shift. (Tr. 719, 1054-55, 1103.) Dr. Forman opined that the additional intake MHT position should be there 24 hours a day, seven days a week. (Tr. 3244-24.)

answered, only for the employee to be told no one could come help deal with the threatening behavior. (Tr. 763-64.) When RN CMC was working alone in intake, law enforcement officers arrived with an irate patient. (Tr. 1108-09.) The patient was psychotic and threatening. (Tr. 1109.) She called each of the three units twice, letting the phone ring numerous times during each call, and there was still no response to any of her calls. (Tr. 1109-10.) RN VL also explained how sometimes two or three police officers would bring someone to the facility, unable to control them. (Tr. 768.) She alone was then expected to take over. *Id.* Dr. Lipscomb bluntly described the situation as a "fatal injury waiting to happen." (Tr. 1697.)

Dr. Forman also criticized the limited intake staffing and the absence of a psychiatrist during the intake process. (Tr. 3353-57; Ex. 83 at 6-7.) He was particularly troubled by the presence of a single employee during the night shift. He explained that night is a perilous time for intake because drug and alcohol use increases, which, in turn, increases the likelihood of violent behavior. (Tr. 3422-23.) Dr. Forman described an example where the patient who attacked RN RO at about 3:30 a.m., May 23, 2017, arrived at Suncoast at about 4:45 p.m., the day before. Dr. Forman said the patient was not seen by a psychiatrist at Suncoast. (Tr. 3353-66; Ex. 56.)

Dr. Forman also noted the amount of time that could pass between arrival at the facility and when a psychiatrist would assess the individual. (Ex. 83 at 6-8.) Patients could be moved from intake to the units, waiting up to 24 hours or more before being evaluated by a psychiatrist, noting "24 hours is too long." (Tr. 3357-3369, 3495-96; Ex. 83 at 7.) Dr. Forman refuted Respondents' position that their approach to staffing adequately abated the hazard.[233] *Id.*

[233] The Secretary does not assert that Respondents' medical care was deficient. Rather, his position is that because patients were not yet fully assessed, there was a greater risk to staff safety. Dr. Forman referred to Exhibit 96 to rebut Suncoast's assertion that patients were seen by a psychiatrist within 24 hours of admission. On August 1, 2017, a patient was admitted to Suncoast at 3:15 p.m. Dr. Forman testified that the patient was not seen by a psychiatrist until 7:00 p.m., August 2, 2017. (Tr. 3366-3369; Ex. 83 at 7-8, Ex. 96.)

The Secretary showed that Respondents' approach to staffing did not sufficiently abate the hazard. (Sec. Br. 83-86.)

j) Relationship with Local Law Enforcement

Most patients enter Suncoast involuntarily pursuant to a state law called the Baker Act, which permits involuntary confinement of patients with mental health diagnoses or disorders for psychiatric assessment.[234] (Tr. 93, 2030-32, 2038, 2097, 2283, 2324.) Two local law enforcement agencies, the Manatee County Sheriff's Department and the Bradenton Police Department, bring patients for assessment nearly every day.[235] (Tr. 650, 707, 1110, 2329.) Respondents indicate that these agencies obtain necessary background information on patients brought to the facility and assisted with bringing in such patients. (Resp't Br. 48.)

Employees described a very different situation. (Tr. 704.) As a preliminary matter, to be admitted to the facility under the Baker Act, the person must be a "danger to self or others," including those who are suicidal or "overly aggressive." (Tr. 2037-38, 2097, 2325-26.) Patients with only dementia, substance abuse problems, and developmental or intellectual problems, without a dual diagnosis of a mental health disorder, do not meet this criterion. (Tr. 2037-38.) Patients arrive at Suncoast: (1) from other medical facilities typically using medical transportation through the Baker Act process, (2) when police bring them after initiating the Baker Act directly or as a result of an outpatient Baker Act referral by a doctor, family member, or case manager, and (3) as a walk-in seeking assistance for a mental health problem.[236] Consistently, most patients present a "danger," either to themselves, employees, or other

[234] CEO Hamilton testified that about 65% of patients come into Suncoast under the Baker Act. (Tr. 2324.) According to her, about 5% of the patients voluntarily walk into Suncoast, not from a hospital, saying I want to be a patient. (Tr. 2324.) She estimated that about 60 to 70% of patients who also voluntarily come to Suncoast, but not as surprised walk-ins, do so from a hospital. (Tr. 2326-27.)

[235] CEO Hamilton testified that since 2015 Suncoast has joined with multiple local hospitals and agencies to provide Crisis Intervention Training on how to deal with mental health patients to these two departments once or twice a year. (Tr. 2329-32.) She said Respondents' contact at the Manatee County Sheriff's office is Lieutenant J. Perez. (Tr. 2335.)

[236] Dr. Hemsath testified that "everybody who's brought through the door [at Suncoast] is going to get assessed [by Suncoast staff]." (Tr. 2083.) Walk-in patients are "fairly rare." (Tr. 2038-40.)

individuals.[237] (Tr. 2037-42, 2076-79.) Because of their mental status, law enforcement officers typically bring the patient in handcuffs. (Tr. 649-50, 707, 1110, 1911, 3277.) When law enforcement arrives with a potential patient, as noted, often only one person was working in the intake department.[238] (Tr. 707, Ex. 25.) Generally, law enforcement enters the facility with the patient, but they leave the patient at the intake door. (Tr. 1127.) Law enforcement did not, as Respondents suggest, consistently stay with violent patients until they calmed down. (Tr. 650-51, 704, 797-98, 863, 1911-12.) Further, while some patients appeared calm when law enforcement was present, that quickly changed as soon as the officers left, and the employee was alone with the new patient. (Tr. 720-21, 1110-11.)

While Respondents claimed that law enforcement would stay with patients until they calmed down and would also assist with bringing certain patients directly to the units, there was no evidence of a shared understanding on the part of the law enforcement officers during OSHA's investigation. (Tr. 650, 709, 1110-11, 1911-12.) There was no written agreement with local law enforcement agencies. (Tr. 1911-12, 2346; Sec. Br. 97-100.) Although Lieutenant Perez of the Manatee County Sheriff's Department was a part of the UHS-PSC, he rarely attended the meetings. (Tr. 2342, Ex. 251; Sec. Br. 99-100.) CEO Hamilton acknowledged that the UHS-PSC did not discuss an arrangement whereby law enforcement would stay with patients until they calmed down or whereby officers would assist with bringing patients directly to the units until after the Citation's issuance. (Tr. 2343.)

CO Trouche testified that she learned during her investigation that "there was not a clear understanding, especially with the RN supervisor, if they were allowed to contact local law enforcement." She said, "[t]here was a few minutes there that were wasted according to the statements because she was

[237] Dr. Hemsath, testified that "the majority of [Suncoast's] patients are suicidal and have depression issues. A minority of patients have issues with mania and psychosis." (Tr. 2053, 2311.)

[238] RN VL explained that she was by herself when law enforcement came in with patients to the intake area. (Tr. 707.) MHT BG also described RNs being alone at intake when law enforcement left patients in the intake area. (Ex. 25.) The Court notes that on certain days, there would be two people in intake for part of one of the three shifts. (Tr. 862-63.) Still, much of the time, there was only one person working in the intake area.

not even aware that that was a possibility or something that she was allowed to do." (Tr. 167-68, 423-24.)

The Secretary showed deficiencies in how staff and law enforcement worked together and refuted Respondents' claims. Respondents' working relationship with law enforcement was not effectively abating the hazard at the time of the OSHA inspection,

3. Respondents' WVPP Was Inadequate

In discussing the WVPP, Respondents rely heavily on the testimony of two managers, CEO Hamilton and Mr. Curl, the Director of Risk Management.[239] The CEO frequently could not recall details about how the hazard was addressed, and Mr. Curl was often evasive.[240] (Tr. 2588, 2590, 2595, 2642, 2830, 2858, 2866, 2933.)

In contrast, direct care employees explained how the policies and training materials were not adequately followed, communicated, or implemented. The record reflects no clear motivation for bias or incentives for these employees to misrepresent their experiences. One already retired and several now worked at other facilities.[241] (Tr. 224, 463, 623, 697-98, 959, 1087, 1159.) These employees made eye contact, and their testimony did not appear to be motivated by animus. Frequently, their testimony was well corroborated by documents and other evidence. Some worked in other similar types of facilities, both before and after their time working for Respondents, and were in a better position to evaluate

[239] While the current DON, Ms. Phillips, testified, the person who served in this role during the investigation, Ms. Sweeney, was not called to testify. Ms. Phillips started working at the facility in May 2018 after the Citation's issuance. (Tr. 1555, 1560.) She candidly acknowledged that she did not know what staffing was like in 2017. She also did not know anything about Respondents conducting any committee meetings prior to her arrival. (Tr. 1597, 1626.) Nor did she know the process for investigating workplace violence incidents during the time referenced in the Citation. (Tr. 1598, 1626.)

[240] For example, on direct, Mr. Curl described a trend line on a graph as representing "the average for the UHS corporation as a whole." (Tr. 2655.) When asked about the same page of the same document on cross-examination, he claimed he did not know if the trend line was from UHS. (Tr. 2860.) Similarly, on direct, he stated for Exhibit 251, "all the data and trends that are provided, the source of that data is Midas," a computer reporting system the facility used. (Tr. 2673-74, 2677, 2679; Ex. 251.) But on cross, he would not agree that the source for the data for the same exhibit was MIDAS. (Tr. 2673, 2866; Ex. 251.)

[241] RN CMC testified that there was over a 70% turnover rate for employee retention. (Tr. 1147.) RN BF testified that the turnover rate for MHTs was 75 % annually. She said "Techs come and go there very rapidly. That's a problem." (Tr. 1339.) RN ET also said staff "turnover is pretty high" at Suncoast, 70 % in 2018. (Tr. 1379, 1409.) Night Supervisor RN CC also testified that there was much staff turnover at Suncoast. (Tr. 1497.) CEO Hamilton concurred with their assessments. (Tr. 2399.)

Respondents' approach to workplace violence. (Tr. 698, 871-75, 1255.) For example, RN RO explained he was never injured at any other facility despite working in psychiatry and substance abuse nursing for over twenty years. (Tr. 465, 467, 527.) Consistent with their testimony, Dr. Lipscomb explained that "procedures for calling a code, when to summon support, who is to show up, who is to take the lead" were not "clearly delineated" for the facility. (Tr. 1677.)

Respondents produced a flurry of paper alleging their WVPP reflected a robust program. But most of the documentation related to patient care, not worker safety. (Tr. 403-4.) Respondents attempted to point to "bits all over the place." *Id.* They lacked a "cohesive or comprehensive" WVPP. (Tr. 404, 1664-67, 1942-43; Ex. 81.) When asked if Respondents had a written, comprehensive WVPP, Dr. Lipscomb responded with "a definite 'no'." (Tr. 1942-43.) The documents that Respondents allege comprised their program "do not sufficiently address the employee injury, risk factors and corrective measures to be taken post incident." (Ex. 81 at 18.)

Respondents also argue that it is reviewed by a state agency focused on "healthcare administration," called the Florida Agency for Healthcare Administration and an independent accreditor, referred to as the "Joint Commission."[242] (Resp't Br. 26-28.) Neither entity focuses on employee health or safety, and Respondents do not allege that either entity has jurisdiction over employee health and safety as OSHA does.[243] (Tr. 578-84, 601-04; Stips. 1, 4; Resp't Br. 26-28.) There is no evidence that either

[242] The Joint Commission accredits 21,000 healthcare organizations, including hospitals, laboratories, ambulatory health home care, long-term care and behavioral healthcare. (Tr. 578-80, 728.) The Joint Commission is a voluntary body that certifies hospitals every three years enabling hospitals to bill Medicare for services. (Tr. 1838-39, 2029-30.) Dr. Lipscomb testified that the Joint Commission does not say a lot with respect to employee safety explaining that the "Joint Commission is the organization that focuses on patient care, and OSHA and NIOSH are concerned with worker health and safety." (Tr. 1937.)

[243] Not knowing OSHA handles workplace safety, RN VL, who has more than forty years of nursing experience, testified that in about early January 2019, she submitted, for the first time, a written complaint to the Joint Commission stating, "I had been employed with this facility [Suncoast] for 3 years, and observed multiple serious staff of patient injuries, due to inadequate or unsafe staffing for the acuity on the units." (Ex. 24.) She said she did so "[b]ecause there were multiple nights, whether you were in intake, or in the nursing units, that we didn't have enough staff or things were unsafe, or people were getting hurt, or we weren't following policies." (Tr. 759-60; Ex. 24 at 1084.)

entity evaluated or concluded that Respondents' WVPP was adequate to abate the hazard or assessed what actions could be taken to materially reduce the hazard to employees.

In sum, Respondents' workplace violence prevention abatement efforts were inadequate. Preventing staff injuries was not a priority. (Tr. 1338, 2130.) While Respondents had written policies and conducted training, they failed to implement this program appropriately. *See SeaWorld*, 748 F.3d at 1206, 1215 (finding existing safety procedures inadequate); *BHC*, 951 F.3d at 565 (finding that incomplete and inconsistently implemented safety protocols were inadequate to address the hazard of patient on staff violence). This failure rendered their abatement seriously flawed and ineffective. (Exs. 81, 83.) Respondents' abatement was inadequate as implemented, and the Secretary met his burden on this element.[244]

G. Feasibility of Proposed Abatement

Having found that Respondents' approach to addressing the hazard was inadequate, the Court next examines whether the Secretary identified feasible means to reduce the hazard materially. *See Integra*, 27 BNA OSHC at 1849-50. "The Secretary must 'demonstrate both that the measures are capable of being put into effect and that they would be effective in materially reducing the incidence of the hazard.' " *Mo. Basin Well Serv., Inc*., 26 BNA OSHC 2314, 2319 (No. 13-1817, 2018) (citation omitted). To meet his burden, the Secretary must show the proposed actions have to be "recognized by safety experts as feasible." *See Beverly Enters.,* 19 BNA OSHC 1161, 1191 (No. 91-3144, 2000) (consolidated). However, the Secretary does not have to show that "the precaution's use has become customary." *Id.* The Secretary need only show that the abatement method would materially reduce the hazard, not that it would eliminate the hazard. *Arcadian Corp.*, 20 BNA OSHC 2001, 2011 (No. 93-0628, 1004) (citing *Morrison-Knudsen*, 16 BNA OSHC at 1122).

[244] Moreover, the Court finds that the destroyed evidence would have further bolstered the findings regarding the inadequacy of Respondents' existing abatement efforts.

The Secretary identified eight actions to abate the hazard. Briefly, the proposed abatement requires: (1) developing a comprehensive written WVPP; (2) redesigning of nurses' workstations to prevent patients from entering; (3) designating specific staff to monitor patients for potential aggression and respond to violent events in the units; (4) designating a particular staff member with specialized security training to be available at intake on all shifts; (5) revising intake procedures; (6) revising procedures for when law enforcement brings potential patients; (7) training about workplace violence prevention and response for all workers; and (8) investigating each act of workplace violence. (Ex. 2.)

Respondents do not contest the technical feasibility of any of these steps. Indeed, many of the steps are things that Respondent either implemented after the Citation or said they had in place but did not.[245] For the few actions that do not fall into one of those two categories, Respondents claim the actions are unnecessary. Respondents also contend that establishing feasibility requires the Secretary to show the employer knew or should have known about each specific abatement step in advance.[246] (Resp't Br. 6-9.)

In contrast, the Secretary, supported by expert testimony, peer-reviewed literature, and other evidence, showed that each aspect of the proposed abatement was technically feasible and that the proposed actions would materially reduce the hazard. *See SeaWorld*, 748 F.3d at 1215 (concluding that "abatement is feasible when it is economically and technically capable of being done"); *Acme Energy Servs. v. OSHRC*, 542 F. App'x. 356, 367 (5th Cir. 2013) (Secretary only needs to show the abatement is feasible or capable of being done). Dr. Forman found that if Respondents implemented the Secretary's abatement measures, they "will lead to a far safer work environment for the staff." (Ex. 83 at 11.) Similarly, Dr. Lipscomb concluded that the abatement measures "would materially reduce the hazard of

[245] Mr. Curl testified that at some point following the RN RO Attack various changes were made, including: (1) providing education to each shift that they needed to stay for their entire shift, (2) educating nurses on securing scissors and other contraband at the nurses' station, (3) educating staff members to keep patients away from the nurses' station counter, (4) adding a float MHT on the night shift, (5) recruiting about four new male MHTs for the night shift, and (6) updating leadership observation rounds. (Tr. 2715-22.)

[246] Respondents notice of the prohibited condition is addressed elsewhere in this Decision.

workplace violence and prevent incidents of future serious and/or disabling staff injuries." (Tr. 1676-78; Ex. 81 at 40.) She explained how research supported the proposed additional abatement measures. (Tr. 1769.) The Secretary showed that each abatement measure was knowable, and in most instances, actually known by Respondents before the Citation's issuance. (Exs. 85, 89.) Each was technically feasible, and nearly all would materially reduce the cited hazard. By showing that Respondents failed to implement feasible means to materially reduce the cited hazard the Secretary met his burden.[247] *See Arcadian*, 20 BNA OSHC at 2011 (finding that the Secretary's burden is limited to showing how the abatement method would materially reduce the hazard, not that it would eliminate the hazard); *Morrison-Knudson*, 16 BNA OSHC at 1122.

1. **WVPP (Proposed Abatement Method 1)**

The first aspect of the Secretary's proposed abatement is to revise and expand Respondents' existing WVPP. Specifically, the Secretary proposes that Respondents:

> [(a)] Develop, integrate, and implement workplace violence policies and programs, including but not limited to, the workplace violence policy manual and the workplace violence prevention PowerPoint presentation, into one written comprehensive Workplace Violence Prevention Program (WVPP). This WVPP must include a worksite-specific hazard analysis that addresses patient-on-employee violence and describes hazard prevention and control measures. The WVPP must also provide for the participation of direct care staff such as Mental Health Technicians and Registered Nurses, e.g., through the committees that discuss workplace violence incidents, including, but not limited to, the Environment of Care Committee. [(b)] Provide copies of the WVPP and make it readily available to all staff. [(c)] Annually review the WVPP and update as necessary. Provide bi-annual training on the WVPP to all staff.

(Tr. 197-98; Ex. 2 at 3.)

There is no evidence that any of these elements are not technically feasible or would increase the hazard. Dr. Lipscomb explained that the proposed abatement is consistent with existing guidelines and codified into law in a number of states. (Ex. 81 at 18.) These revisions to Respondents' WVPP would

[247] As a sanction for the destruction of evidence, the Secretary is also entitled to a finding that the destroyed evidence would have supported his claims about the effectiveness of the Secretary's proposed abatement.

materially reduce the hazard of workplace violence and reduce the number and severity of future incidents of staff injuries. *Id.* She opined that a 10% reduction in the number of workplace violence incidences "would be a material reduction." (Tr. 1925.)

Looking first at the development, integration, and implementation of workplace violence policies and programs, Respondents had elements of an effective WVPP. But both the actual policies and the implementation of them fell short. *Id.* The CO explained Respondents had "bits and pieces" of a WVPP "all over the place." (Tr. 403-04.) What Respondents had "did not represent a cohesive or comprehensive standalone program." *Id.* Dr. Lipscomb said the same thing. (Tr. 1665-67.) The Secretary showed that key aspects of Respondents' abatement were not well developed, such as the limited attention to patient on staff violence. Dr. Lipscomb testified that "the greatest risk to staff at Suncoast is type 2 patient-on-staff violence. If you're going to have a workplace violence policy, how can you not address the most important source of it?"[248] (Tr. 1668.) Other components were not effectively implemented, such as consistently reporting and addressing threats of violence.[249] Nor was it clear how the program in place at the time of the Citation included: (1) a worksite-specific hazard analysis that addresses patient-on-employee violence and describes hazard prevention and control measures; (2) the participation of direct care staff; and (3) regular review and updating, as necessary.[250] (Tr. 198-99, 1947-48, 1668-76; Ex. 81.)

Dr. Lipscomb, supported by peer-reviewed literature, explained how Respondents could feasibly implement a comprehensive WVPP as described in this abatement method. (Tr. 1675-76; Ex. 81 at 13-

[248] RN Cooke admitted at trial that her assertion in her expert report that Suncoast's Workplace Violence Policy "outlines the types of aggression and that most aggression is caused by patients" was incorrect. The policy did not do so. (Tr. 3222-23; Ex. 264 at 4, ¶ 1Ca.)
[249] Dr. Lipscomb testified that Respondents were "not encouraging workers to report minor injuries or threats." (Tr. 1674-75.)
[250] CO Trouche testified that employees she interviewed were not familiar with the content of the Human Resource Policy Manual, titled Workplace Violence (Ex. 10) and "PREVENTING WORKPLACE VIOLENCE" guidelines (Ex. 11). (Tr. 199, 404-05.)

18.) Neither RN Cooke nor any other witness refuted Dr. Lipscomb's views about this abatement method's feasibility and effectiveness.

The Secretary indicates that this abatement step requires an annual review of the WVPP and bi-annual staff training. Respondents argue that the frequency of their program review and training is sufficient.

The Secretary showed that Respondents did not regularly review and update their WVPP. *See BHC*, 951 F.2d at 562 (discussing the importance of review and updating workplace violence policies). The Commission has held that an abatement method calling for action to be taken as needed was not sufficiently specific. *Mid-South Waffles, Inc*., No 13-1022, 2019 WL 990226, *6 (O.S.H.R.C. Feb. 15, 2019). The Secretary needed to identify the specific additional steps necessary. Here, the Secretary specifies how often Respondents need to review the WVPP and the frequency of training on it. He identified the "specific additional steps" that Respondents must take to rectify their existing approach to the hazard, as required by *Mid-South*. *Id.* That is, modifying the frequency with which they review the WVPP (annually rather than periodically) and altering the training frequency from upon hiring and then "as needed" to twice a year.

The proposed abatement addresses other deficiencies in Respondents' training program. The Secretary established the need for workplace violence training and showed that the current training program was defective. Respondents' training left staff confused about how to respond to incidents appropriately. The training program did not cover all workers who routinely directly encountered patients. In discussing a violent incident in which she was injured, RN VG explained that the social worker involved "[o]bviously" needed more training on how to properly restrain a patient. (Tr. 914-15, 917.) Nor was the training consistently communicated or reinforced. MHT VN testified that she "asked multiple times for more [Handle With Care] training" and also said to CEO Hamilton in a town hall

meeting that "[W]e need more Handle With Care training." (Tr. 978-79, 998.) At best, employees recalled seeing information on workplace violence during their new employee orientation. (Tr. 701.) However, witnesses could not recall key aspects of their training. Employees did not believe that the WVPP called for certain actions when they were never done in practice. Illustrations of this include the staff's confusion about whether they could call 911 for assistance when dealing with patient aggression and whether to report threats.[251] The Secretary, supported by experts, showed how addressing the WVPP's deficiencies and aligning the stated procedures with what employees actually did would materially reduce the hazard.

The only aspect of this proposed abatement not sufficiently supported by the record is the need to provide copies of the WVPP to all staff if the document is accessible and Respondents adequately train employees in the manner called for by this abatement action. Dr. Lipscomb plainly acknowledged a WVPP has to be in writing to be well thought out and communicated. (Tr. 1665.) But the overwhelming value of the program is in its implementation, not "the paper it's written on." *Id.* The Secretary did not show that physical copies of the WVPP instead of employees having access to the written program would materially reduce the hazard.

Accordingly, the Secretary established that a feasible and effective method of abatement includes acting to:

> [d]evelop, integrate, and implement workplace violence policies and programs, including but not limited to, the workplace violence policy manual and the workplace violence prevention PowerPoint presentation, into one written comprehensive Workplace Violence Prevention Program (WVPP).[252] This WVPP must include a worksite-specific hazard analysis that addresses patient-on-employee violence and describes hazard prevention and control measures. The WVPP must also provide for the participation of direct care staff such as Mental Health Technicians and Registered Nurses, e.g., through the committees

[251] Respondents did not have any written policy or procedure addressing how and when staff were to assess police intervention. (Tr. 2587-88.)

[252] Instead of one written comprehensive WVPP, CO Trouche testified that Respondents had three separate documents. (Tr. 197-98; Exs. 10-11, 19.)

> that discuss workplace violence incidents, including, but not limited to, the Environment of Care Committee.

Respondents must make the WVPP accessible to all staff, "annually review the WVPP and update as necessary" and "provide bi-annual training on the WVPP to all staff." (Tr. 197-98, 1669-71; Ex. 2 at 3.)

2. Nurses' Workstations (Proposed Abatement Method 2)

The second element of the Secretary's proposed abatement is to re-configure the nurses' workstations:

> Reconfigure the nurses' workstations to include design features that prevent patients from jumping over, reaching into, or otherwise entering into the workstations. Ensure items in the workstations, such as but not limited to scissors, hole punchers, staplers, telephones, cords, pens, computers, computer peripherals, and other items are not accessible by the patients, so they cannot be used as weapons. All scissors at the facility should be replaced with childproof scissors.

At the height of four feet, even some adolescent patients can reach over the top of the nurses' workstations. (Ex. 8, Ex. 81 at 20.) The low height permits patient access to items they can weaponize. (Ex. 81 at 20; Ex. 9 at 324.) Patients also could leap the barrier and come into direct contact with the staff. (Tr. 132, 426; Ex. 81 at 20.) The CO and employees discussed incidents where a better barrier would have prevented injuries. Dr. Lipscomb testified that a reconfigured nurses' station would have prevented RN RO's injuries suffered during the RN RO Attack. (Tr. 200-01, 412, 426, 1443, 1685.) In April 2017, DL, a RN with more than 40 years-experience, told CEO Hamilton about the need to enclose the nursing station because there were "incidents of people trying to get over the counter." RN DL said CEO Hamilton told her that it was Suncoast policy not to enclose the nursing station. RN DL also told Mr. Curl after the RN RO Attack that she wanted a barrier at the nurses' station. His response was the same.[253] (Tr. 1045-49.) CO Trouche testified that the main reason for the barrier was to provide employees a secure place where they can go and protect themselves from out-of-control patients. (Tr.

[253] Despite this claim of policy, the nurses' station in the intake department was enclosed. (Tr. 1283; Hamilton Dep. 102-03.)

415.) She said that employers were required to evaluate their workplaces and implement the hierarchy of controls, from eliminating the hazard to using personal protective equipment. (Tr. 416-17.)

As with element one, there is no evidence that this abatement method is not technically or economically feasible. RN Cooke did not reach a conclusion about the technical feasibility or whether a re-designed workstation would materially reduce the hazard.[254] Prior to the latest OSHA inspection, a patient hopped over the desk in the intake area and threw computers and phones. (Tr. 131-32, 706.) Two employees were injured in the incident and a computer was damaged. After this event, CEO Hamilton recommended that a barrier be installed. (Tr. 1283; Hamilton Dep. 102-03.) The workstation in the intake department was enclosed, and employees felt this improved safety. (Tr. 132, 706, 756.) However, the same action was not taken at the nurses' stations in the other units.[255] (Tr. 132, 706; Hamilton Dep. 103.) Any contention that the nurses' stations could not be modified to be more protective is undermined by the evidence showing that Respondents enclosed the nursing station in the intake area without adverse consequences. (Exs. 8 at 522, 9 at 325, 81 at 20-21.) *See BHC,* 951 F.3d at 565 (finding that the application of the general duty clause "turned in significant part on the employer's failure to extend throughout its workplace the very safety measures it had already applied, albeit inconsistently"); *Con Agra, Inc., McMillan Co. Div.,* 11 BNA OSHC 1141, 1145 (No. 79–1146, 1983) (finding abatement method feasible when it required the employer to extend existing practices more broadly); *SeaWorld,* 748 F.3d at 1215 (finding abatement feasible when it was in practice in part of the facility); *Wheeling-*

[254] The Design Guide referred to by RN Cooke in reaching her conclusion that the existing workstations were adequate, indicates that facilities "have found ways to design nurses' stations that protect against" patients reaching or jumping over. (Tr. 3202; Ex. 258 at 4981.) RN Cooke acknowledged that the Design Guide stated that the goal of having the least acceptable barrier between staff and patients "is sometimes felt to be in conflict with safety concerns as patients may be able to reach or jump over counters." (Tr. 3201; Ex. 258 at 4981.) This Design Guide also came out after the issuance of the Citation and was not relied on by Respondents in any way in their electing not to enclose the nurses' station.

[255] CEO Hamilton and Mr. Curl testified that the combined nurses' station was kept open and not enclosed so Coral Key staff could hear what is going on in Turtle Cove. (Tr. 2564-65, 2817-18.) RN BF said she talked with DON Sweeney about wanting to enclose the nursing station. RN BF also testified that at a nursing meeting the nursing staff said, "We should have enclosures, too." But RN BF said nothing ever came of these suggestions. (Tr. 1283.)

Pittsburgh Steel Corp., 10 BNA OSHC 1242, 1246 n.5 (No. 76-4807, 1981) (consolidated) (finding abatement method feasible when it had previously been used at the facility), *aff'd*, 688 F.2d 828 (3d Cir. 1982) (table).

Despite partially implementing this method, Respondents argue that they cannot increase the barrier height at the other workstations because doing so could adversely affect patient care. (Resp't Br. 47.) They claim they already examined "restructuring" the nurses' stations. (Tr. 2528-29; Resp't Br. 47.) However, CEO Hamilton admitted that this was inquiry was only to evaluate enlarging the workstations. (Tr. 2591-92.) The consultation was about making the workstations less "crowded," not about safety or workplace violence. (Tr. 2591-93.) Respondents never asked an architect or safety consultant to evaluate a higher barrier's feasibility or otherwise limiting patients' ability to enter workstations. (Tr. 2591-93, 3702-03.) Instead of considering changes to the workstation's configuration after multiple serious injuries at that location, the CEO instead chose to conclude it was unnecessary.[256] (Tr. 2593-94.) RN Cooke testified that she never saw any documentation analyzing whether to reconfigure the nurses' station. (Tr. 3203-04.)

Employees, Dr. Lipscomb, and Dr. Forman refuted Respondents' claims that patient care precluded a better-protected nurses' workstation. (Tr. 528, 830-31, 874-75, 954, 1046-47, 1345, 1369-70, 1443-44, 3411-16; Ex. 81.) The two experts identified how more protective workstations would prevent

[256] In *HRI Hosp. Inc.,* No. 17-0303, 2019 WL 989735 (O.S.H.R.C.A.L.J., Jan. 22, 2019), the Secretary sought only an evaluation of the nurses' workstation. The employer had already evaluated a different design, leading the ALJ to conclude that the Secretary failed to establish the utility of an additional evaluation at that facility. 2019 WL 989735, at *29. The record includes no evidence about the HRI facility. The decision itself reveals several factual distinctions, which support finding that the Secretary established that this proposed abatement method would materially reduce the hazard. First, there is no indication of patients' routinely gaining access to the workstation and injuring staff at HRI, as was established in this matter. (Tr. 132, 140-41.) Second, there is no indication that patients were involuntary brought to HRI for treatment, as is the case at Suncoast. (Tr. 93, 2097, 2030, 2324, 2283.) Third, neither the *HRI* decision, nor the record before this Court indicates what height the workstations at HRI were. Fourth, Suncoast was able to successfully enclose one of its workstations, a situation not addressed by the *HRI* decision. As Dr. Lipscomb explained, the fact that HRI may not have barriers at some of its workstations does not impact her assessment that the nurses' station at the Suncoast facility needed to be reconfigured. (Tr. 1939.)

injuries. (Tr. 1678-79, 3411-16; Exs. 81, 89.) Dr. Lipscomb opined that the current design permitted repeated staff injuries and placed patients at risk when they attempted to enter the area by going over the barrier. (Tr. 1678-79.) She was not aware of any randomized clinical trials indicating an enclosed nursing station would impact the therapeutic environment. (Tr. 1682-84.) In contrast, published literature supported her view that better-protected workstations reduced the hazard. (Ex. 81 at 20.) Further, installing a plexiglass barrier at one of the workstations did not impact patient care.[257] (Tr. 527-28, 1046-47; Ex. 81 at 19-20.) The employee working there could still sufficiently hear what was occurring in the intake area. *Id.*

Dr. Forman explained how revising the workstation configuration would reduce the hazard of workplace violence. (Tr. 3413.) Having approximately five-foot-high barriers prevent patients from jumping over but still permits sufficient interaction between patients and staff. (Tr. 3411-12, 3416.) Features that prevent patient access to the nurses' station mitigate the risk of a patient entering the area and picking up items "to stab, to cut, to bludgeon nurses." (Tr. 3413.)

Respondents indicated they require nurses to keep patients a safe distance from the nurses' station. As Dr. Lipscomb points out, this is difficult to do when they are engaged in other tasks. (Ex. 81 at 20.) Photographs from the CO's November 30, 2017 visit to Suncoast show employees working directly next to the barrier. (Tr. 129; Ex. 8 at 525-27.) In addition, the existence of the work rule undercuts Respondents' argument that further enclosing the space would hinder communication between patients and staff. (Ex. 81 at 20.) The Secretary seeks an engineering control to provide sufficient distance rather than Respondents' existing work rule, which relies on staff direction and compliance from psychiatric patients. Both approaches have the goal of keeping patients away from office supplies and physically

[257] Dr. Lipscomb testified that it was feasible for Respondents to enclose the nurses' station and have an opening for communicating with patients. (Tr. 1683-84.)

harming staff at the nurses' station. But the Secretary established how his proposal is more effective while still being feasible.[258] (Ex. 81 at 20; Tr. 201-2, 378, 412, 415, 1199, 1276, 1683-84, 1888.)

The experience of several employees was consistent with the testimony of Drs. Forman and Lipscomb. *See Pepperidge Farm*, 17 BNA OSHC at 2034 (viewing "successful use of a similar approach elsewhere" and expert testimony as elements of an effective abatement method). *Cf. Mo. Basin*, 26 BNA OSHC at 2321, n.13 (noting that when the Commission considers an abatement method's efficiency, it looks to industry standards and expert testimony). The employees discussed how the workstations at other facilities offered greater protection without compromising patient care. (Tr. 682-83, 700.) Employees also described how a different configuration could have prevented injuries.[259] (Tr. 1356.)

Turning to the accessibility of office supplies, Respondents showed that they had a rule precluding patient access to various office supplies by the time of the trial. [260] However, employees sometimes needed to use these items during the workday. (Tr. 202, 655, 1335, 3414.) The low barrier contributed to patients' access to these items, and a work rule was less effective than a design change. (Ex. 81 at 20.) The CO explained that a better barrier would "engineer out" the hazard rather than relying on a rule that

[258] For example, Respondents' policies direct staff to find a safe place if violence occurred. (Tr. 200.) When working behind the enclosure the employee is already in such a location reducing the likelihood a violent patient will be able to reach them. (Tr. 199-01; Ex. 89.)

[259] RN VG, a psychiatric RN and charge nurse with over forty years-experience, testified there were protective barriers between staff and patients around all the nursing stations at the twelve psychiatric facilities where she worked. Most of those facilities also had patients who were involuntarily committed. (Tr. 873-77.) RN RO testified that all of the nurse's stations in the other hospitals where he worked for twenty or so years were enclosed with plexiglass with openings for communicating and passing medications. (Tr. 527-28.) MHT BG also testified that the psychiatric hospital with patients similar to Suncoast where she worked at after leaving Suncoast had nurses' stations of a design different than at Suncoast with glass, doors, and separation that provided more protection. (Tr. 656-57, 679-82.) RN VL also testified that the entire nursing station was enclosed at the hospital facility where she worked in Naples, Florida after leaving Suncoast. (Tr. 698-700.) Intake RN CMC testified that there was a security officer and a glass barrier with a hole for speaking at the nurses' station at the outpatient psychiatric center where she worked before working at Suncoast. (Tr. 1086-87.) MHT CCM testified that a glass enclosed nursing station at a prior inpatient psychiatric facility where she worked kept her "from getting spit or reached out and yanked on, things of that sort." (Tr. 1161-62.) RN ET also said that the behavioral health center at Bradenton, Florida where she worked prior to Suncoast had plexiglass barriers at their nurses' stations. (Tr. 1342-45.)

[260] DON Phillips, who began working at Suncoast after the Citation's issuance, indicated that on her rounds of the units she did not see sharp objects left out. (Tr. 1614.) The CO spoke to another individual who was serving as the DON during OSHA's investigation. (Tr. 177.) However, that person, Ms. Sweeney, did not testify at trial.

permits the hazard to remain. (Tr. 200, 378)

Dr. Forman detailed how facilities he was familiar with had higher barriers and designated work areas behind doors where office supplies were kept. (Tr. 3414-15.) Such an approach effectively prevents patient access to these items that indisputably could seriously injure staff. *Id.* He noted that if a patient had the same types of things present in the workstation, they would be considered "contraband" under Respondents' policy, which required removing such things from patients. (Tr. 384-85, 3414; Exs. 200, 204.) However, Respondents permitted access to these same items by leaving the nurses' station exposed. (Tr. 3414-15.)

The third part of this abatement method calls for replacing all scissors at the facility with childproof ones. (Tr. 201-02; Ex. 2 at 4.) CO Trouche testified non-childproof scissors should not be used at the nurses' stations where there is no adequate barrier so that they could not be used as weapons.[261] (Tr. 201-02.) Respondents do not allege that they could not replace the existing scissors. The Secretary has shown that the third part of his abatement method will reduce the hazard by eliminating a potentially deadly weapon.

3. **Designated Staff for Aggression and to Respond to Violence (Proposed Abatement Methods 3 & 4)**

The third element of the Secretary's proposed abatement method is to designate staff with security training to prevent and respond to aggression and violence:

> Designate specific staff with specialized training in security to monitor patients for potential aggression on all shifts and to assist in preventing and responding to violent events occurring in the units. Designated staff must have the physical capability to effectively respond to aggressive patients. The staff designated to monitor and respond to patient aggression should not be given other assignments such as patient rounds, which would prevent the designated person from immediately responding to an alarm or other notification of a violent incident. Conduct periodic drills for psychiatric crisis/patient aggression (currently known as "Code Grey") to allow all designated staff to practice and evaluate their skills in real-life settings.

[261] Dr. Lipscomb did not specifically address the use of only childproof scissors in her report or at trial.

This element and element four address the need for staff designated to monitor patients for potential aggression and an additional staff member to help prevent and respond to violent events. Abatement method three refers to having designated staff for preventing and responding to violence, and the fourth abatement step refers to the need for staff in the intake unit. Specifically, the fourth abatement method calls for:

> An additional designated staff member with specialized training in security should be available at intake on all shifts. This staff member should have the physical capability to respond to aggressive patients. This staff person should not be given other assignments such as patient rounds, which would prevent the person from immediately responding to an alarm or other notification of a violent incident.

Respondents do not employ individuals solely responsible for security, at intake or otherwise. (Tr. 203-07, 875, 915, 1934-35.) Instead, they rely on direct care staff to perform this function, even though the WVPP directed employees to contact "Security" in the event of a violent incident. (Ex. 9 at 325; Ex. 10 at 656.) Management indicated that employees could also contact local law enforcement for assistance with violent individuals. However, this was not well communicated, with employees believing they were not supposed to contact local law enforcement or waiting long periods before doing so.[262] (Tr. 348, 423-24, 477, 512, 891, 900; Ex. 56.)

Respondents attempt to argue that security would negatively impact patient care. However, their own response plan relies on having local law enforcement respond to incidents.[263] (Tr. 673, 712, 798, 1241, 2347; Ex. 56 at 1464, 1490-92.) Police were called when there was insufficient staff to respond to violent incidents. (Tr. 166, 207, 712, 1241, 2347, 2849; Ex. 28.) The Workplace Violence policy directed employees to "call the Security department," which did not exist at Suncoast, or "911." (Ex. 10

[262] CO Trouche testified that "there was no understanding if they [staff] were even allowed to contact law enforcement for assistance." (Tr. 211-12.)

[263] Respondents also argued that their doctors should not be involved in restraints because it would be inappropriate for the doctor/patient relationship. (Resp't Br. 71.) This concern did not extend to other types of direct care providers conducting restraints.

at 656.) Waiting for the officers to arrive can prolong the time employees are in dangerous situations and subject them to continued assault until the officers arrive and can successfully intervene. (Tr. 424, 477, 481, 501, 907; Ex. 28.) Further, employees only called law enforcement after a patient began acting violently. (Tr. 712.) In contrast, the proposed abatement would have on-going designated staff with specific training in security and security responsibilities on all shifts to assist with prevention, not just after an attack has commenced.[264] (Tr. 1281-82, 1871, 1877-78; Ex. 2 at 4, ¶¶ 3-4, 81 at 28, 89 at 20.) It is a preventive measure rather than a reactionary one.[265] (Tr. 1321-22.)

Respondents partially implemented these abatement methods by adding a "float" MHT and partially increasing intake staffing. In about March 2019, approximately one month or so before the start of the trial, an MHT was assigned to work in intake along with a nurse at certain times.[266] (Tr. 861-62, 1050.) This position is supposed to be filled five days a week, from 5:00 p.m. to 2:00 a.m. (Tr. 862-63, 1050, 1103.) After 2:00 a.m. until 5:00 p.m. the following evening on weekdays, and throughout weekends, only one employee is assigned to intake. (Tr. 862-63, 1050, 1054-55, 1103.) Even when there are two employees in intake, frequently one of them had to assist in the units, leaving the other employee alone. (Tr. 702, 862, 1103.) Similarly, while the float MHT could function in the way called for by the proposed abatement, that is not how Respondents used the position. (Sec. Br. 90-93.)

Respondents do not contest the feasibility of these abatement steps, and their partial implementation of this abatement supports the Secretary's feasibility argument. Similarly, their existing Behavioral Management Program called for an "adequate number of physically qualified staff" to be

[264] Dr. Lipscomb testified that she recommended Respondents hire one additional MHT/Security/Milieu officer for each of three shifts at the intake department and one additional MHT/Security/Milieu officer for each of three shifts to cover all three other units. (Tr. 1877-78; Ex. 2 at 4, ¶¶ 3-4.)

[265] Dr. Lipscomb testified that the incident where a patient threw a telephone within the intake nurses' station at RN CMC on February 19, 2018 would not have happened had designated staff with specific training in security and security responsibilities been there. (Tr. 1136, 1146, 1698.)

[266] Suncoast also briefly had a person in this role for about two weeks around November or December 2018. (Tr. 718-19, 1090.)

available for each unit. (Tr. 122; Ex. 19 at 731.) The number of staff was supposed to increase with patient acuity under this policy. *Id.*

In practice, Respondents relied on a specific patient-to-staff ratio. They did not sufficiently consider acuity or whether there was enough "physically qualified staff," as called for by their Behavioral Management Program.[267] (Tr. 122, 268, 1002, 1077-78, 1444; Ex. 19 at 731.) The "specific additional steps" the Secretary proposes, as required by *Mid-South*, is the expansion of the hours the MHT is available in the intake department and adding an employee to work with all the units for the specific purpose of preventing aggression and responding to patient on staff violence.

Dr. Lipscomb opined that having an employee with security training and the physical ability to handle aggressive patients to help prevent and respond to violent events would materially reduce the hazard. (Tr. 1692-96; Ex. 81 at 25-26, 28.) She cited a case study where officers were trained to respond to psychiatric emergencies and assume a supportive role to staff to support. *Id.* Dr. Lipscomb testified that trained security personnel were not accessible to workers in a timely manner. Respondents definitely did not have adequate staffing available at all times to protect or aid workers against assaults or other violence. (Tr. 1943-44.) As discussed, the Secretary showed how Respondents' approach of simply providing training without regard to whether the employee was physically capable of performing the techniques was ineffective. There needs to be someone who can stop what they are doing and respond to aggression. (Ex. 81 at 26-28.) Staff who are assigned to care for a patient on a 1:1 basis or are responsible for continual patient checks cannot respond to actual or potential aggression. *Id.* at 22.

Several direct care employees also spoke of the need for employees focused on security and their

[267] RN RO testified that four, preferably six, staff members were needed to safely take down a powerful male patient. (Tr. 523-24.) MHT BG testified, "I don't even think it's about male or female. I was just hoping for someone more fit for the position." She acknowledged that gender did not matter; it was about physical ability. (Tr. 652.) MHT VN said there were benefits of having both male and female MHTs to handle a patient looking for a confrontation. (Tr. 1026.) The proposed abatement calls for designated staff to be physically capable to effectively respond to aggressive patients regardless of gender or size. (Tr. 1687.)

experience with such staff at other facilities.[268] (Tr. 203-04, 527, 680, 699, 866, 873-75, 915, 1002, 1255-56, 1321, 1343.) RN Cooke herself worked at four different behavioral health facilities, each with designated security staff. (Tr. 3177-79.) Employees stated that they felt safer at facilities with dedicated staff for assisting with violence. (Tr. 527, 698-99, 1002, 1257, 1344.) They experienced and witnessed fewer workplace violence incidents at facilities with designated personnel for responding to workplace violence incidents. (Tr. 527, 682-83, 1002, 1257, 1344.) Dr. Lipscomb cited her experience with another behavioral health facility where the employer added an employee tasked with preventing and responding to escalating behavior. (Tr. 1688, 1719-20; Ex. 81 at 25.) This position was very effective at addressing the hazard and reduced injuries at the facility. (Tr. 1688.)

The Secretary established that the intake area was hazardous and particularly at risk for workplace violence.[269] (Tr. 1696-97, 1920-23; Exs. 52, 81, 83.) Dr. Lipscomb explained how having a security person or additional MHT assigned to intake on all shifts to respond to emergencies would have "probably prevented" or "materially reduced" the severity of injuries suffered by intake workers. (Tr. 1886-87, 1928-29; Ex. 52.) Similarly, the CO explained how time was wasted in both evaluating whether to call for law enforcement and then waiting for them to arrive. (Tr. 424.) Employees also explained the link between adequate staffing and safety: "if you have enough staff to control a patient, then you're not going to get hurt …. However, if you don't, then someone is going to get hurt …. Even with Handle With Care … someone is going to get hurt." (Tr. 203, 1285, 1321-22.) The Secretary showed that a person

[268] RN VG testified that about nine of the twelve psychiatric facilities where she worked had security, separately trained, on staff who responded to patients acting violently. In contrast, "Suncoast did not have security." (Tr. 873-75.) RN ET also said that the behavioral health center at Bradenton, Florida where she previously worked had security officers. (Tr. 1343-44.) CO Trouche testified that employees told her that employees designated to assist in workplace violence incidents were not available to do so because they were performing other staff duties. (Tr. 203-05.)

[269] As an example, on February 15, 2017, RN WS was slammed against a wall, punched, and had her hair pulled by a patient at intake when she tried to stop the patient who had been dropped off by law enforcement from attacking another patient. She suffered lower back pain and was away from work for 42 days as a result of the assault. Dr. Lipscomb testified that the presence of a Security/MHT at intake and an agreement with Law Enforcement not to simply drop off patients would have "probably prevented, this incident." (Tr. 1927-29, 2476-77; Ex. 7 at 375, Ex. 52.)

needed to be immediately available to respond to potential aggression on all shifts and help prevent and respond to violent events in the intake area or the other units.

Abatement method three also calls for periodic drills for staff to practice responding to psychiatric emergencies. (Tr. 206, 214; Ex. 2 at 4.) Employees explained how drills would reduce the hazard. (Tr. 646, 902, 1195, 1376.) Dr. Lipscomb provided expert testimony that periodic drills, as this abatement step proposes, were feasible and would materially reduce the hazard by allowing the response team time to practice and evaluate their skills in real-time situations. (Tr. 1732-33; Ex. 81 at 22, 26.) She refuted RN Cooke's opinion that drills were unnecessary because the job provided sufficient "real life scenarios." (Tr. 1733.) Dr. Lipscomb identified this flawed logic. By practicing the techniques mostly in "real life," employees were repeatedly injured. *Id.* "If staff were sufficiently trained, and there were sufficient numbers to implement the training successfully, they wouldn't have all these staff injured in the process of restraining patients." *Id.* Mr. Curl also explained that drills were subsequently implemented after the Citation's issuance and that they were "another good time for staff member to just ask their Handle With Care trainers for help." (Tr. 2766.)

The Secretary established that abatement methods three and four are feasible and effective at abating the cited hazard. *See Pepperidge Farm*, 17 BNA OSHC at 2034 (viewing "successful use of a similar approach elsewhere" and expert testimony as elements of an effective abatement method).

4. **Revise Intake Procedures (Proposed Abatement Method 5)**

The Secretary's next abatement step calls for the revision of intake procedures to flag patients with a history of violence and ensure the information is communicated:

> Revise intake procedures to ensure specific information about an incoming patient's history of violence, including, but not limited to, history of violent acts against staff members at this facility and others, is transmitted to all care providers on all shifts, prior to the patient's admission to the unit. Ensure that a "flag" specifying the history of violence (including if a patient had previously assaulted staff and the most recent assault) is available to all staff that may interact with the patient. Assure that mental health technicians ("MHTs") have dedicated time to review all intake information on a patient before working with them.

The Secretary established that these actions are technically feasible. Respondents already had procedures for obtaining a patient's history of violence and to flag some patient risks, such as seizures or falling. (Tr. 208-9.) They just did not appropriately flag risks to employees. (Tr. 208-10, 832, 1264, 1698-1703.)

RN Cooke discussed "electronic" flags as beneficial. (Tr. 3152.) She appeared either not to realize or to have forgotten that Suncoast does not have electronic medical files and that such information was contained in less accessible paper files. (Tr. 264, 2061, 2356-57.) Her testimony undermines Respondents' claim that they could not "flag" a patient. (Resp't Br. 27.) Respondents point to no regulation, law, or guidance that precludes the type of abatement proposed here. Indeed, both experts appear to agree to it being beneficial. Neither RN Cooke nor anyone else testified about or pointed to any evidence that this abatement method could not legally be implemented. *Id.*

Respondents sought and recorded information about a patient's history of violence.[270] (Tr. 385, 720, 1593.) Typically, an employee recorded the available information in a paper file. (Tr. 1114, 1302-03, 1660, 2061.) These files were difficult for staff to access during their shifts or when a person showed up in the intake department. (Tr. 722-23, 832, 1112-13, 1660-61, 2061.) For example, an individual who was previously so violent toward staff that she was considered the facility's "most assaultive patient" was discharged and later re-admitted. (Tr. 1114-16.) The intake nurse handling the re-admission had no way of knowing this before interacting alone with the patient.[271] (Tr. 1114.) In contrast, Dr. Forman explained that the computer system at the facility where he works shows the patient's history of violence

[270] Dr. Forman explained there are ways to predict violence. (Tr. 3252-53.) A history of violence increases the likelihood the patient will engage in violence again. *Id.*

[271] Typically, there was only one individual working in the intake department. (Tr. 678-79, 703, 719, 761-62, 1095-98, 1112-3, 1144-46.) The nurse could not leave the area and go to the paper file room to look up a patient's prior history contained in the paper file record room. (Tr. 1113, 1303, 2078.) The intake nurse had access to a computer, but there was no medical or psychiatric information (such as whether a person injured staff before) accessible. (Tr. 1113-14; 2356-57.) Only demographic information such as insurance plans and addresses were available. (Tr. 1114.) Accessing the paper medical records where information about past attacks on staff generally would be recorded was a cumbersome process making it difficult and sometimes impossible for those with direct care responsibilities to access. (Tr. 832, 1113, 1219, 1660-61, 2373.)

at intake. (Tr. 3431-32.)

Further, the information was not well communicated with the units and across the facility. (Tr. 832, 1702.) For instance, the intake nurse might learn that a person was intoxicated and could subsequently experience detoxing complications. (Tr. 1702-3.) This information was not consistently communicated with the MHTs in the units. (Tr. 209-10, 1702-03.) Information for already admitted patients would be in the patient's paper file, but employees often did not have time to review the paper records. There were no electronic records or flags on paper records to quickly identify those who had been assessed as having a high assaultive risk.[272] (Tr. 208-09, 831-32, 2061.) MHTs were not directed to review the high-risk assessment sheets. (Tr. 287.) And when called to assist or cover from another unit, staff were not given the high-risk notification forms before interacting with patients. (Tr. 209-210, 287, 493.) The issue with the Respondents' approach is that sometimes information was not verbally communicated. As one RN explained, past dangerous behavior toward staff was conveyed via "word of mouth." (Tr. 1263-64.) "There's nothing that flags a chart or anything like that." (Tr. 1264.) Without flagging, staff lacked the necessary information to plan patient interactions to mitigate the hazard, such as asking for more assistance. (Tr. 209-10; Ex. 81 at 29-30.) CO Trouche testified that Respondents did not have a flagging system that flagged patients who exhibited assaultive or combative behavior. (Tr. 209-10; Ex. 89 at 28-29.)

Dr. Hemsath explained, "unfortunately we have paper records," and some individual patient records fill multiple binders. (Tr. 2061, 2373.) The medical records department was "large" and only

[272] Even if a staff member knew that they were incapable of performing all of the protective techniques taught in Handle With Care (which as discussed was not always the case), they often did not know about a patient's past aggression against staff or their increased likelihood of aggression. (Tr. 722-23, 1194.) Had they been able to identify patients at a greater risk for aggression they could seek out a colleague able to perform the self-protective techniques if needed or alert the supervisor of the need for more staff. (Tr. 270-71.) Respondents' argument that they would increase staff when needed is undercut by the fact that the direct care employees lacked sufficient information to know when to seek additional support before a patient aggressed.

kept about one year of medical records on-site. (Tr. 2961.) Unlike the Respondents' approach, this abatement method does not require employees to wade through voluminous files. Flagging files and communicating the risk to all employees is a feasible and effective means of contributing to the hazard's material reduction.[273] (Tr. 421-22, 1659-60; Ex. 89 at 28-29.) Dr. Lipscomb, supported by peer-reviewed literature, indicated that a medical chart flagging system that alerts staff right away that a patient has assaulted staff in the past substantially reduced workplace violence. (Tr. 1659-61.) Dr. Forman agreed that "flagging generally would make things better." (Tr. 3431-32.)

Information about actual or potential acts of violence was not shared across units. (Tr. 209, 493, 1264.) So, when covering another unit or assisting with a disturbed patient when the assigned unit staff was insufficient, employees lacked prompt access to critical information to reduce their risk of assault or injury.[274] (Tr. 567, 832.) Dr. Lipscomb pinpointed how revising intake procedures and adding flags was superior to Respondents' approach of permitting access to paper medical records but not making such access routine or easy. (Tr. 1660-61, 1698-1703, 2061; Ex. 89 at 28-29.) Respondents already used flags for other types of issues such as different colored bracelets and having patients at risk for falls wear bells. (Tr. 209; Ex. 251 at 3724, 3764, 3789.) The proposed abatement calls for similar measures to alert staff quickly to patients presenting high risks of violence. *See HRI*, 2019 WL 989735, at *18 (discussing facility's use of multiple measures, including different colored paperwork, notes, a whiteboard, and open meetings to alert staff to patients at higher risk for acting aggressively).

Published literature supported Dr. Lipscomb's opinion. (Tr. 1661.) Dr. Forman also provided

[273] The RN working in the unit would share information with the RN assigned to the next shift using the facility's SBAR form. (Tr. 285, 386, 812-13, 1073-74, 1480-81, 3558-61; Ex. 224.) Some RNs only included a few details preventing the SBAR form from being consistently helpful. (Tr. 1410, 1412.) Further, MHTs were not trained on the SBAR form and it was not reviewed routinely with the MHTs working in the unit. (Tr. 285-86, 296-97.) Nor was it shared with those working in other units who were needed to assist with incidents or routine coverage for breaks. (Tr. 387, 529, 566-67.)

[274] CO Trouche testified that, as an example, RN RO was assigned to the Ocean Point unit on August 8/9, 2017 but was subsequently called over to the Turtle Cove unit, where he had no knowledge of the behavioral conditions of the patients there. (Tr. 209-11.)

support that this method was both feasible and effective at addressing the hazard. (Tr. 3356.) He explained that on-site employees frequently contacted off-site doctors for medical orders for new patients or to revise orders for existing patients. (Tr. 3380-81; Ex. 83.) Neither the intake nurse nor the remote physician had ready access to the larger paper files or a readily identifiable "flag" about assaultive risk. (Tr. 832, 3356.) In his view, such historical information on assaultive risk would inform opinions on how patient care should be managed to mitigate the risk to themselves and others. (Tr. 3356.) The Secretary met his burden for this abatement method.

5. Alter How Law Enforcement Brings Patients to the Facility (Proposed Abatement Method 6)

The Secretary's sixth proposed abatement measure relates to improving the arrangements with local law enforcement. It calls for a law enforcement liaison position to develop agreements with law enforcement and for Respondents to consider written agreements governing arrangements with the authorities who bring patients to the facility:

> Create a law enforcement liaison position to develop relationships and agreements with law enforcement entities who most often bring patients to the worksite. Consider establishing a written agreement with the law enforcement entities that describes how officers will assist with aggressive patients brought into the facility, e.g., officers will keep patient handcuffed until the patient is completely calm and if the patient is not calm, the law enforcement entity will keep the patient cuffed and escort the patient with facility staff to an appropriate location within facility where the patient will remain cuffed until calm or the facility staff can administer medication to calm the patient.

Dr. Lipscomb discussed the importance of behavioral health facilities, "having a close working relationship with law enforcement." (Tr. 1703-11; Ex. 89 at 19.) She explained that a formalized process for bringing in involuntary patients would reduce the volatility of such situations, thereby reducing the risk for employees. (Tr. 1703-04.) In her view, it was something that any "high-risk workplace should be doing and should have been doing a long time ago." (Tr. 1704.)

As discussed, during the time alleged in the Citation, law enforcement frequently brought in a patient in handcuffs, removed the handcuffs, and then left, regardless of the patient's state of agitation.

(Tr. 704, 707, 650-51, 863.) Staff explained how patients would often become more aggressive after law enforcement left because the officers helped to calm patients. (Tr. 212-13, 798.) Having law enforcement assistance with intake resulted in patients being calmer and better able to communicate.[275] (Tr. 212-13.) The improved communication allowed the employee to obtain more accurate information that could then be shared with the other direct care providers.[276] *Id.* Dr. Forman agreed that having law enforcement present during the assessment facilitated the safety of the employees. (Ex. 83 at 7.)

Nothing in RN Cooke's testimony or report counters the testimony of the Secretary's witnesses. In fact, post-Citation actions show the feasibility of the abatement method. After the Citation's issuance, CEO Hamilton acted as a liaison between Suncoast and law enforcement.[277] Specifically, on November 15, 2018, Respondents and the Manatee County Sheriff's Department "solidified" an arrangement to consistently address how law enforcement brings patients to the facility.[278] (Tr. 2338-39.) Under the oral understanding, law enforcement will keep patients in handcuffs until they are completely calm. If necessary, to calm the patient, law enforcement will remain with the patient until the facility can administer medication to calm the patient medically. (Tr. 1705-06, 2329, 2338-39; Ex. 35.) Since reaching this understanding, law enforcement has adhered to the arrangement. (Tr. 2338-39, 2346.)

Thus, after the Citation's issuance, Respondents adopted this abatement method by entering into a more formalized, albeit oral, arrangement after considering the feasibility of a written agreement. *Id.* As they have been able to meet this abatement's requirements, so there is no concern that Respondents cannot feasibly implement this abatement method. *See BHC*, 951 F.3d at 556 (rejecting employer's feasibility

[275] At various points, Respondents had more frequent discussions with local law enforcement. For example, Lieutenant J. Perez attended UHS-PSC meetings in 2016 and 2017 but did not attend any of the monthly meetings during the time of the OSHA investigation. (Ex. 251 at 3663, 3936, 4057.)
[276] CO Trouche said liaising with law enforcement would reduce law enforcement's response time to incidents. (Tr. 211-12.)
[277] Notes from the November 15, 2018 EOC meeting indicate that CEO Hamilton "reached out to Manatee County Sheriff and Bradenton Police to develop a safety plan for aggressive/psychotic baker acts." (Tr. 2338-39; Ex. 35.) Dr. Lipscomb testified that "it's insufficient to just have notation of it [any agreement] in meeting minutes." (Tr. 1710.)
[278] In April 2019 CEO Hamilton was told for the first time that local law enforcement was unwilling to enter into signed written agreements. (Tr. 2346, 2586.)

arguments when it had "embraced" the measures "at least on paper"). The Secretary met his burden concerning this aspect of the Secretary's proposed abatement.

6. Training & Identifying Who Is Available to Assist (Proposed Abatement Method 7)

The Secretary showed deficiencies in the scope and frequency of employee training. The specific additional steps the Secretary proposes to address the issues are:

> Ensure all staff members, including, but not limited to, physicians and meal staff, who may come into contact with patients in the course of their work are trained in all elements of a comprehensive WVPP, including opportunities for them to be involved in evaluating and improving the program. Training should specifically include: (1) When and how to call for assistance, including how to use emergency communication systems such as walkie-talkies, the overhead pager, and/or panic buttons; (2) Uniform and effective methods for responding to a Code Grey or other type of workplace violence incident; (3) Hands-on exercises, practice drills, and assault scenario drills to improve staff skills and confidence in responding to Codes; and (4) How to contribute to a post-incident debriefing and/or root cause analysis. The hands-on exercises, practice drills and assault scenario drills should occur at least bi-annually. A staff member is not considered available to assist with incidents of workplace violence if they are not able to complete the training and/or they are not comfortable implementing the appropriate actions while working with aggressive patients.[279]

The Secretary argues that these steps are technically feasible and will address the deficiencies in the training program. (Tr. 203-04, 213-14; Ex. 81 at 20.) Respondents do not rebut the Secretary's evidence of feasibility. Indeed, they cite having trained employees as part of their abatement program. (Ex. 6.) They added unit meetings partway through OSHA's investigation and planned drills after the Citation's issuance. (Ex. 251 at 3780-81, 3811, 3818, 3883.) Mr. Curl also modified the workplace violence training to use something "more tailored" by the time of the trial and made other improvements while the proceedings were pending. (Tr. 2787, 2969.) Rather than dispute that this method can be implemented, Respondents contend these actions will not materially reduce the hazard.

Respondents provided training during orientation and then repeated some aspects on an annual

[279] CO Trouche testified that some MHTs told her that "they don't feel comfortable in applying what they have been told in the Handle with Care training, as they were not – they didn't feel capable to apply the techniques, …." (Tr. 167-68.)

basis.[280] At the time of OSHA's inspection, nurses and MHTs received 7-8 hours of training on violence prevention as part of the New Employee Orientation.[281] This training covered about 4 hours of Verbal De-escalation and about 4 hours of Handle With Care. (Tr. 2178, 2381-82; Exs. 6, 81 at 32, Ex. 236.) Handle With Care MHT Instructor Smith testified that anyone who was not certified as trained in both programs could not work in direct contact with patients.[282] (Tr. 2131-32.) The UHS PowerPoint was also part of orientation. (Tr. 3246.) Employees described not feeling capable of applying the techniques taught, and those conducting the trainings frequently concluded that the employees could not do so. (Tr. 203, 903; Ex. 23.) Dr. Lipscomb testified that "being trained once a year and maybe not doing the techniques just isn't sufficient in my experience." (Tr. 1738.) She said that Respondents' front-line workers need "a lot of tools" to do their job because "[t]hey're doing very dangerous work." (Tr. 1739.) The Secretary showed that this frequency was insufficient, explaining that training should occur bi-annually.[283] (Tr. 205-06, 213-14, 903, 1712, 1738-39.)

The Secretary also showed that the scope of the training was insufficient. Dr. Lipscomb found that many staff lacked a clear understanding of what constitutes workplace violence and what a reportable incident of workplace violence is. (Tr. 1715; Ex. 81 at 32-33.) Staff did not know to report a threat, a kick, or a shove. (Tr. 704-05, 818, 931, 1041-42, 1094, 1128-29, 1715, 2011, 2177, 2217-18.) Similarly,

[280] Mr. Curl suggested that re-training occurred after certain incidents. (Tr. 2104-06.) Several employees refuted this, denying they ever received retraining or further education. (Tr. 512-13, 1355, 1438.) Mr. Curl's claims were not sufficiently corroborated, and the record does not show that drills or spot training he referred to regularly occurred during the time referenced in the Citation. (Tr. 2198.) The employees' testimony is credited over Mr. Curl's and post incident documents that were not drafted by, and in some cases were not even seen by, the employees.

[281] RN Cooke's expert report stated that the Handle With Care training was "an eight-hour course". (Ex. 264 at 9, ¶ H.) The Handle With Care training was only a four-hour course when the Citation was issued. (Tr. 2178, 3220; Ex. 81 at 32, Ex. 236 at 652.)

[282] Handle With Care MHT Instructor Smith testified no Suncoast employee has been denied the opportunity to work with patients because all employees have completed the Handle With Care training, except in one instance when a new hire removed herself from the course and quit her job at Suncoast because she did not feel comfortable placing patients in a protective hold. (Tr. 2132-33, 2159-60, 2181.)

[283] As noted above, under Commission precedent, abatement calling for an action on an "as needed" basis was not sufficiently specific and vacated the citation. *Mid-South,* 2019 WL 990226, at *6.

there was significant confusion about how to summon assistance to handle actual or potential workplace violence.[284] RN Cooke was under the mistaken impression that RN and MHTs "always had walkie-talkies" at Suncoast to call for help.[285] She testified:

> They've [walkie-talkies] always been at the facility. Staff have chosen not to use them, some staff choose to use them. Maybe that's indictive of how safe they feel. If they have walkie-talkies and they don't need – feel like they need them, maybe they feel safe. I don't know.

(Tr. 3160-61.) In this regard, the Court finds RN Cooke to be misinformed. The Court also finds RN Cooke's assertion that the staff's lack of use of walkie-talkies prior to the Citation's issuance is indicative that staff may have felt safe to be a great leap without any basis of fact and is rejected. Similarly, RN Cooke incorrectly asserts in her expert report that "Panic buttons are installed at each unit nursing station and in the group rooms. They are functioning and accessible and immediately summon assistance." (Ex. 264.) The Court found there were no panic buttons at Suncoast, including at the nurses' station and in patient rooms. (Tr. 265, 999, 1057, 1166, 1362; Ex. 264 at 7, ¶ N.)

Witnesses expressed uncertainty about what a code team was, when to call a code, and when (if ever) to call law enforcement. (Tr. 272, 383-84, 498, 891, 900, 907, 994, 1739, 2565.) Even supervisors hesitated to call law enforcement or waited until senior officials directed them to do so. (Tr. 498, 900, 712.)

The Secretary also showed the need for drills. (Tr. 902, 1739.) Respondents' post trial brief claimed that such drills occurred regularly.[286] (Resp't Br. 17.) Witness after witness disputed this. (Tr. 205-06, 902, 2196.) The testimony of the direct care employees, which is consistent with the discussion

[284] The proposed abatement called for training to specifically include when and how to call for assistance, including how to use emergency communication systems such as walkie-talkies, the overhead pager, and/or panic buttons to the extent they exist at Suncoast. (Tr. 1730-31; Ex. 3 at 5.) The Court finds that there were no panic buttons at Suncoast. (Tr. 214, 265, 999, 1057, 1166, 1362.)

[285] The Court has found that functional walkie-talkies were generally not available and assigned to nurses and MHTs before April 24, 2018. (Tr. 2980-81; Ex. 251 at 3900.)

[286] Perhaps, Respondents Brief was referring to post-Citation actions. As noted, after the Citation's issuance, meeting minutes discuss plans to hold drills. (Ex. 251.)

of drills being arranged post Citation, is credited over Respondents' assertions. (Ex. 251.) Dr. Lipscomb corroborated the employee testimony that training sessions do not mimic "real life." (Tr. 1299, 1731.) She explained that drills give employees a better opportunity to implement actual restraint techniques. *Id.* In her view, the number of injuries employees experienced showed the need for drills. (Tr. 1733-34.) The CO concurred, explaining how drills improve response time and ensure employees are better able to apply the techniques Respondents claim they taught them to handle violent patients safely. (Tr. 206.)

The second part of this abatement method addresses the failure to have a sufficient number of workers who were both trained and fully capable of implementing the techniques be available to respond to workplace violence incidents. Respondents considered an employee trained to handle violent patients if the employee attended the Handle With Care training session. It did not matter if they could not complete the techniques. When supervisors assigned staff to a shift, the scheduler did not consider whether enough of the selected workers were fully capable of implementing the techniques taught during the training session. (Tr. 1450-51, 1509, 1512, 1717-18.) The abatement method does not call for firing or refusing to hire individuals physically unable to complete the techniques. (Tr. 1717-18.) Rather, it requires the availability of enough individuals who can perform the techniques. (Tr. 1718.) In her expert report, Dr. Lipscomb opined that "additional opportunities to practice techniques taught in HWC [Handle With Care] System, in real life situations and, or drills, along with rigorous evaluation of physical intervention technique and opportunities for remediation, will materially reduce the risk of future staff injury." (Tr. 1732-33; Ex. 81 at 35.) The Court agrees.

The Secretary identified the specific additional steps Respondents needed to have in place as of the time of the Citation's issuance regarding training and ensuring the availability of enough people on each shift capable of performing the techniques called for by the training program. *See BHC*, 951 F.3d at 561-63 (accepting the ALJ's finding that the Secretary's proposal for enhanced targeted employee

training about handling patient on staff violence was part of an effective abatement program). The Secretary's proposed actions will address the deficiencies and contribute to a material reduction in the hazard. (Tr. 1717.)

7. Incident Investigation & Debriefing (Proposed Abatement Method 8)

The next aspect of the abatement the Secretary calls for is to augment Respondents' incident investigation and debriefing procedures.

> Conduct an investigation and debriefing after each act of workplace violence with the attacked and/or injured employee and other involved employees, including root cause or similar analysis, lessons learned, and corrective actions to prevent reoccurrence. Provide the attacked and/or injured employee and other involved employees with an opportunity to provide feedback about specific measures that could prevent such future incidents. Review and evaluate each workplace violence related incident, both on a case-by-case basis and to monitor for trends in areas with high rates of incidents such as the acute units.

Once again, Respondents are unable to rebut the Secretary's evidence of technical feasibility. Indeed, their own procedures already called for accident investigation and debriefing in certain situations. (Tr. 2555; Exs. 10-11, 251.) The abatement calls for them to be implemented rather than to just exist on paper.[287] *BHC,* 951 F.3d at 565 (discussing the ALJs finding that the employer failed to implement the "policies it had on paper to prevent [workplace] violence.").

Respondents had no single location for documenting or reporting instances of patient violence against staff members. Instead, they had a hodgepodge of different forms stored in different locations. (Tr. 2696-99, 2848.) Debriefing forms after patient restraints were kept in the patient's paper medical file. (Tr. 2707, 2838-39.) Employee injuries were reported to Human Resources via an EAR. (Tr. 2723-24, 2838.) They did not include a section where anyone involved could write what could have been done to prevent an injury. (Tr. 1267; Ex. 56.) Some incidents were documented in Risk Management Worksheets. (e.g., Ex. 51 at 1143-49.) However, Mr. Curl acknowledged he would not typically use the

[287] CO Trouche testified that employees told her that there was no debriefing process after an incident. (Tr. 217.)

Risk Management Worksheets. (Tr. 2617.)

As discussed, frequently debriefings either did not occur or occurred without input from injured employees. When the CO asked employees if they had been part of any debriefing after workplace violence incidents that focused on improving safety, the majority indicated they had not.[288] (Tr. 198-99, 217, 398, 1735; Ex. 81 at 36-37.) Dr. Lipscomb testified that the general sense that she got from the testimony of staff victims of workplace violence "was most individuals said, no-one asked me, you know, what had happened, what went wrong, what could have been done better, and how am I doing."[289] (Tr. 1735.) She also questioned the validity of many of the debriefing records stating, "I really question the validity of a lot of those forms that were completed because many of the workers that were then read the comments on the incident of workplace violence didn't agree with the way it was described. And so I'm not even sure they were valid." (Tr. 1742.)

Dr. Lipscomb provided expert testimony supporting that this abatement method was feasible and would materially reduce the hazard. (Tr. 1675, 1741-43; Exs. 81 at 39, 89 at 22-24.) She also identified how pre-Citation meeting minutes often did not address patient on staff injuries. Those participating in the safety meetings lacked information needed to lead to "strategies for prevention." *Id.* The proposed abatement calls for Respondents to fully implement their existing program and extend it to cover all workplace violence incidents, as opposed to focusing only on those incidents where a patient is injured, restrained, or secluded. *See Con Agra*, 11 BNA OSHC at 1145; *SeaWorld,* 748 F.3d at 1215.

Respondents' own experience shows the effectiveness of this abatement method. Post-Citation meeting minutes from the EOC committee discuss improvements to Respondents' incident investigation and debriefing procedures. (Ex. 35.) Their actions included reviewing each incident with the staff

[288] RN Cooke acknowledged that although some documentation said education happened, she did not ask staff members if any of the alleged education actually occurred. (Tr. 3215-16.)
[289] CO Trouche similarly said employees told her that they sometimes felt that they were not even asked how they were doing after an incident. (Tr. 217, 237, 241, 246-50.)

member involved. After noticing a trend from these staff interviews, Respondents undertook changes related to restricting patients to the units. *Id.* In addition, they implemented audits of Q15 check forms and took action to make sure staff were aware of the precautions assigned to patients.[290] *Id.*

The Secretary showed that this abatement method is both feasible and effective.

H. General Duty Clause Not Unconstitutionally Vague as Applied

Respondents knew that workplace violence was a hazard in their facility.[291] (Ex. 3.) They knew employees were both exposed to, and injured by, workplace violence.[292] They had workplace violence policies and procedures, and OSHA directed them to specific resources to improve their program over a year before the RN RO Attack led to the second OSHA inspection. *Id.* Undeterred, Respondents still argue that the Secretary acted unconstitutionally in issuing the Citation. They allege that applying the reasonably-prudent-employer and material-reduction standards is unenforceable as unconstitutionally vague in this case. (Resp't Br. 29-33.)

These claims do not withstand scrutiny. As the D.C. Circuit explained, neither a context-sensitive reasonableness standard, nor an unquantified precautionary threshold is necessarily vague. *BHC*, 951 F.3d at 566 (evaluating the employer's claim that a general duty clause violation at a psychiatric health facility was unconstitutional). "Even if the scope of a general standard 'may not be clear in every application,' where its 'terms are clear in their application to' the conduct at issue, the 'vagueness challenge must fail.' " *Id.* quoting *Holder v. Humanitarian Law Project*, 561 U.S. 1, 21 (2010).

In *BHC*, the employer made arguments very similar to the ones Respondents now raise. 951 F.3d at 566. D.C. Circuit's reasoning is applicable and compelling. Here, like in *BHC*, the Secretary identified specific measures, including an overarching WVPP, needed to meet the general duty clause's

[290] Meeting minutes from November 2018, indicate that Supervisor Senior Leadership Observation rounds were added to audit the Q15s. (Ex. 35.)
[291] UHS-DE was also familiar with the presence of the hazard in other behavioral health facilities. (Ex. 9.) *See also BHC*, 951 F.3d at 561, and discussion in Section III.C above.
[292] *See* discussion in Section III.D, Recognition and Knowledge of the Hazard above.

requirements and protect staff from patient violence at a behavioral health facility. *Id*. The proposed "measures accord with well-known industry best practices and peer-reviewed research." *Id*. Further, "the need for full and consistent implementation of such measures is or should be evident to reasonably prudent managers of any major psychiatric inpatient hospital." *Id*.

Similar to *SeaWorld* and *BHC*, the application of the general duty clause "here turns in significant part on the employer's failure to extend throughout its workplace the very safety measures it had already applied, albeit inconsistently." *Id*. Just as Chief Judge Rooney was troubled by the disconnect between BHC's written policies and its actual practices, this Court also finds that Respondents did not implement the abatement they claimed. *Id*. Like in *BHC*, Respondents here "can hardly object that it was blindsided by the utility of measures it had already embraced, at least on paper." *Id*.

In this matter, unlike many cases where fair notice is contested, there is no debate Respondents knew what the hazard was and that their employees were exposed to it. (Stips. 7-8, 12.) *See 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). Patient attacks on employees were not idiosyncratic events. They routinely occurred. *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). Respondents were aware of these events through the EARs and the direct knowledge of supervisors. Nor is there any dispute that experts familiar with the industry would take the hazard into account when prescribing a safety program. *See Nat'l Realty*, 489 F.2d at 1266. Both experts recognized that any risk assessment of the facility would include assessing workplace violence.

In addition to knowledge of the hazard, the abatement measures were available to and readily knowable by Respondents. Indeed, much of the Secretary's proposed abatement calls for the actual implementation of the policies and procedures Respondents themselves identified as methods to protect

employees and minimize serious injuries from workplace violence. *See St. Joe's Minerals Corp. v. OSHRC*, 647 F.2d 840, 844 (8th Cir. 1981) (employer violated the general duty clause because its abatement was not sufficiently protective). All of the Secretary's proposed feasible abatement measures came from OSHA Publication 3148, Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers ("OSHA Guidelines") and the Workplace Violence Compliance Directive. (Tr. 98, 196, 374-75; Ex. 2 at 3-5, Ex. 89.) Both documents were issued before OSHA commenced its investigation. *Id.* Respondents knew of the OSHA Guidelines and the guidelines' relevance to their facility. (Exs. 3, 11.) OSHA, after identifying the presence of the hazard of workplace violence at the Suncoast facility, explicitly directed Suncoast to the OSHA Guidelines so that it could obtain "feasible methods to protect employees."[293] (Ex. 3.) The UHS PowerPoint refers expressly to the same OSHA Guidelines. (Tr. 196; Ex. 11 at 16, Ex. 89.) Respondents knew of the practices and procedures within their control that would decrease the likelihood of patient on staff violence and minimize the severity of such incidents. (Exs. 3, 10-11, 21, 89.) Yet, they failed to implement these actions fully and appropriately. *See SeaWorld*, 748 F.3d at 1216 (finding that employer could have anticipated that abatement measures it applied after incidents would be required); *Babcock & Wilcox Co. v. OSHRC*, 622 F.2d 1160, 1165 (3d Cir. 1980) (affirming finding of liability when the company failed to take feasible precautions to reduce the risk of injury).

The Secretary showed that, at the time alleged in the Citation, Respondents' existing measures for addressing patient on staff violence were insufficient, and Respondents failed to implement feasible measures capable of materially reducing the hazard. *See CF&T Available Concrete Pumping, Inc.,* 15 BNA OSHC 2195, n.9 (No. 90-239, 1993) (noting that the "mere existence of a safety program on paper

[293] Dr. Lipscomb indicated that the recommendations in the OSHA Guidelines were "in very plain language," such that they could be implemented by facilities even without having her level of expertise when developing a WVPP. (Tr. 1768-69.) She said, "the OSHA [G]uidelines provide a great roadmap for any behavioral health hospital to materially reduce the risk of patient-on-staff assaults." (Tr. 1743; Ex. 89.)

does not establish that the program was effectively implemented on the worksite"); *Pepperidge Farm*, 17 BNA OSHC at 2007-8 (employer failed to implement abatement it identified).

Neither the need for an implemented program nor the contents of an appropriate program were unknowable to Respondents. In *Integra,* the Commission rejected the employer's constitutional vagueness challenge because the proposed abatement measures were "available to, and readily knowable by the industry." 27 BNA OSHC at n.15. In that case, akin to the matter at hand, the abatement derived from OSHA's Workplace Violence Compliance Directive. *Id.*

Moreover, in 2016, OSHA specifically identified employee exposure to workplace violence at this worksite and explained the steps necessary to determine effective abatement. (Ex. 3.) Respondents attempt to turn this written warning on its head, claiming that rather than providing clear notice of the presence of a hazard that it somehow provides immunity from citing the hazard in the future. (Resp't Br. 36.) The purpose of an OSHA Hazard Alerts is "to assist employers in meeting their responsibilities and regarding hazards in the industry." *Marion*, 1980 WL 10108, at *4. The Hazard Alert Letter explained that the hazard of workplace violence was present and that they needed to evaluate and implement effective abatement measures. 17 BNA OSHC at 2003-4, 2007-8 (memos from insurer put the employer on notice of lifting hazards and provided abatement methods). Like *Pepperidge Farm*, the Hazard Alert Letter did not just tell Respondents that "a problem existed," it also told Respondents how to mitigate the hazard. *Id.* at 2007. Respondents' claims that the letter excuses their failure to assess their WVPP and take action to mitigate the hazard are rejected. *Id*. at 2008 (finding a willful violation of the general duty clause when employer was made aware of a hazard but failed to implement any abatement measures over the subsequent year); *Martin v. OSHRC*, 941 F.2d 1051, 1058 (10th Cir. 1991) (finding that CO's discussion of program requirements with company provided actual notice and this was "fatal" to employer's due process claim).

Respondents also assert that disparate outcomes in cases involving other alleged general duty clause violations require vacating the Citation. (Resp't Br. 36-40.) They argue this despite offering no evidence of the similarity of the situations at trial. Instead, they allege in their brief that HRI Hospital, Inc. ("HRI") and BHC Northwest Psychiatric Hospital, LLC ("BHC") are "two behavioral hospitals which have separate consultation agreements with UHS-DE."[294] *Id*. at 7. The citations issued to HRI and BHC were not offered or introduced to the record. Nor did Respondents seek to admit any evidence or elicit any testimony about those facilities, such as their relationship to them, the similarities or differences among the facilities, the presence of the hazard of workplace violence at them, or any abatement in place at those facilities to address workplace violence. Without citation to the record or the cases themselves, Respondents assert that HRI and BHC had "very similar procedures and policies addressing patient to staff aggression." *Id*. at 8.

Respondents made no attempt to offer evidence of the supposed "facts" for which they now seek judicial notice. (Resp't Br. at 40.) The Secretary "strongly" objected to the Court considering information outside of published decisions and the facts within the record. (Sec'y Reply Br. 10, n.2.) The Court agrees that Secretary had no opportunity to address Respondents' characterization of the supposed facts regarding the hazard present at HRI and BHC and how those entities did, or did not, address it. While Courts regularly consider case law to address the legal effect (if any) of such decisions, this does not extend to factual findings in unrelated proceedings. Fed. R. Evid. 201.

Moreover, the ALJ who reviewed the citations issued to BHC and HRI found substantial differences between the facilities, the nature of the hazard at those facilities, and what actions the entities took to address workplace violence.[295] *Compare BHC Nw. Psychiatric Hosp. LLC*, No. 17-0063, 2019

[294] Respondents cite no record evidence for support of this statement.
[295] The evidence offered also differed in the two trials.

WL 989734, at *8-40 (O.S.H.R.C.A.L.J., Jan. 22, 2019) (finding existing abatement was inadequate and that the Secretary's proposed abatement would materially reduce the cited hazard) *with HRI*, 2019 WL 989735, at *29-30 (finding the employer had already taken many of the abatement measures identified and that the Secretary failed to establish that the remaining ones would materially reduce the hazard). As the D.C. Circuit found, rather than these two hospitals having similar approaches to the known hazard of patient aggression towards staff, BHC's incomplete and inconsistently implemented safety protocols "were inadequate to materially reduce the hazard." 951 F.3d at 566. BHC, like Respondents, allowed "whole categories of incidents to go unreported and failed to review and learn from incidents that had occurred." *Id.* at 567. BHC, unlike HRI, also "failed to involve its employees in formulating policies to combat patient-on-staff violence and was unable to show the effectiveness of its training."[296] *Id.*

I. Characterization

The Secretary argues this violation is repeat. (Sec'y Br. 175, 196.) A repeat characterization requires two findings. First, the past and present violations must be substantially similar. *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). Second, both violations must have been issued to the same employer. *Id*.

Looking first at the "principle factor" of similarity, the Secretary relies on a prior section 5(a)(1) violation issued to Lowell, a UHS affiliated entity. (Tr. 10, 217-19, 371, 1691-92.) That citation, which resulted from OSHA Inspection No. 1009736, became a final order on May 27, 2016. (Tr. 10, 217; Stip. 12; Ex. 1.) When relying on a previous general duty citation to support characterizing a subsequent citation as repeat, the Secretary must show substantial similarity based on the circumstances surrounding

[296] The D.C. Circuit also noted that BHC, unlike HRI, "failed to ensure staff would have means at hand throughout the facility to summon help." 951 F.3d at 567. In the present matter, while noting some difficulties with the means for seeking help, a key issue the Secretary establishes is that there was not enough staff to respond to requests for help. (Tr. 1314, 1324.) In other words, employees could call for help, but that did not matter if there was no one available to respond to the call. (Tr. 756, 1109, 1114.)

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); *Potlach*, 7 BNA OSHC at 1064 (concluding that 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").

Neither party moved the citation issued to Lowell into the record.[297] The CO acknowledged that her analysis did not include looking closely at the citation issued to Lowell. (Tr. 372.) She did not look at the differences between the abatement proposed for this matter as compared to the abatement called for in Lowell's citation.[298] *Id.* No witness discussed what conditions were like at the Lowell facility. No one who worked there testified. CEO Hamilton, while acknowledging that she worked for the same entity that managed Lowell, indicated she never worked with or spoke to anyone at Lowell and did not know anything about the facility. (Tr. 3394.)

The Secretary failed to offer enough information about the circumstances surrounding the cited hazard at Lowell to conclude that hazard was substantially similar to the situation at Suncoast. While the hazards appear to share some commonality, the record does not establish that the two violations are

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[297] In their post trial brief, Respondents ask the Court to take judicial notice of and "review" the citation at issue in "Secretary of Labor v. UHS of Westwood Pembroke, Inc., d/b/a Lowell Treatment Center (OSHRC Docket 17-1302 and 17-1304." (Resp't Br. 40 n.8.) The Secretary objected to the Court taking judicial notice of documents not in the record and/or of information not within published decisions. (Sec'y Reply Br. 10 n.2.) There is no published decision related to OSHRC Docket Nos. 17-1302 and 17-1304. As noted, the parties stipulated that Lowell was cited "for a violation of Section 5(a)(1)" and that this has become a final order. (Stip. 12.) 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. A request to "review" a citation in an unrelated proceeding is not equivalent to a request to acknowledge a "fact." Respondents' request for judicial notice is denied.

[298] CO Trouche testified:

> Q. Okay. And so you did review the [Lowell] citation, and so you saw that … the abatement items and the citation … were different than the items that you cited in this case?
> A. I didn't do that kind of evaluation.
> Q. Okay. So you didn't look that closely towards their [Lowell] citation and what they were issued or what the abatements were?
> A. No.

(Tr. 372.)

sufficiently akin to support a repeat characterization. *See GEM*, 17 BNA OSHC at 1866 (declining to conclude that two violations were substantially similar even though both involved fall hazards). The record lacks details about the similarity of the facilities and the nature of the hazard at them.[299] The Secretary did not detail the abatement efforts necessary for Lowell to come into compliance or what it was doing to prevent the hazard.[300] (Resp't Reply Br. 11-12.)

J. UHS-DE & Suncoast Acted as Single Employer for Purposes of OSH Act Liability

UHS-DE also argues it should be dismissed from the Citation. (Resp't Br. 6, 73.) The Secretary showed that UHS-DE's own employees were exposed to the hazard, UHS-DE recognized the hazard, knew of its presence at the Suncoast location, had a significant role in both the development and implementation of the abatement in place at the time of the Citation's issuance, and that its employees will need to implement many aspects of the abatement.

First, in terms of exposure, while UHS-DE employees were in much less frequent contact with patients than other workers, they still were regularly present in the units. (Tr. 1417-18, 2362-64, 2383-84; Exs. 92, 251.) Second, UHS-DE stipulated that it recognized the hazard. (Stip. 8.) Third, workplace violence is recognized as a hazard by the relevant industry. (Tr. 93.) In addition, UHS-DE had actual knowledge of the hazard's presence and that it was causing serious physical harm. Its own employees reviewed video of workplace incidents and reviewed EARs routinely. (Tr. 2365-72; Ex. 222.) Fourth, as to the abatement's sufficiency, Suncoast relied on policies and training materials about the cited hazard UHS-DE developed. (Stips. 14, 21.) UHS-DE's employee, CEO Hamilton, aided by other UHS-DE

[299] The Lowell facility closed sometime after the citation issued to it became a final order of the Commission. (Stip. 16.) The Court agrees with Respondents that the Secretary failed to carry hiss burden to establish that UHS-DE, Suncoast and Lowell all together and collectively operated as a single employer to the extent necessary to justify the classification of the Citation against UHS-DE and Suncoast as Repeat based upon the citation issued to Lowell that became a final order of the Commission on May 27, 2016. (Resp't Reply Br. 7-10; Stip. 12.)

[300] Respondents note that although UHS-DE managed Lowell, neither UHS-DE nor Suncoast was cited as a result of OSHA Inspection No. 1009736. (Stips. 12-13; Resp't Br. 2; Tr. 217-18, 371-72, 2293-94.) *See Loretto-Oswego Residential Health Care Facility,* 23 BNA OSHC 1356, 1359-60 (No. 02-1174, 2011) (consolidated) (concluding that three affiliated companies operated independently and declining to characterize violation as repeat), *aff'd*, 692 F.3d 65 (2d Cir. 2012).

employees, oversaw many aspects of the facility's WVPP. Under the current leadership structure, the CEO and other UHS-DE employees would need to approve and cooperate to implement any abatement. In short, the Secretary satisfied each element of the *Walden* test.

The Secretary sets out another theory for citing UHS-DE, arguing UHS-DE and Suncoast acted as a "single employer" for purposes of the OSH Act. (Sec'y Br. 176, *discussing C.T. Taylor Co., Inc.*, 20 BNA OSHC 1083, 1086-88 (No. 94-3241, 2003).) Under Commission precedent, in certain circumstances, the purposes of the OSH Act, including effective enforcement, "are well served" by holding two separate legal entities equally responsible for a cited violation. 20 BNA OSHC at 1086. In *C.T. Taylor*, the Commission concluded that if "two entities were treated as separate employers," then one of the employers "would avoid a degree of responsibility and penalties for the willful conduct of its handpicked foreman." *Id.* at 1087.

Borrowing from other areas of the law, the Commission developed a test to determine whether two entities should be considered a single employer for purposes of the OSH Act. The test examines whether the entities: (1) have interrelated and integrated safety and health operations; (2) share a common president, management, supervision, and ownership; and (3) share a common worksite.[301] *Id.* at 1086-87; *Altor, Inc*., 23 BNA OSHC 1458, 1463 (No. 99-0958, 2011), *aff'd,* 498 F. App'x 145 (3d Cir. 2012) (unpublished). *Cf. StormForce of Jacksonville, LLC,* No. 19-0593, at 6-7 (OSHRC 2021) (discussing the importance of control in the multi-employer context). Shared control over safety concerns is a persuasive factor in establishing interrelatedness for purposing of imposing liability on more than one employer at worksite. 20 BNA OSHC at 1087 (finding that two entities handled safety matters as one company); *Solis v. Loretto-Oswego Residential Health Care Facility*, 692 F.3d 65, 76 (2d Cir. 2012) (noting that the "Commission's single employer inquiry turns on whether the entities in question "handled safety matters

[301] The Secretary does not allege that any entity abused the corporate form.

as one company").

1. UHS-DE & Suncoast Have Interrelated & Integrated Safety and Health Operations

UHS-DE and Suncoast have interrelated and integrated safety and health operations, particularly concerning the cited hazard. All UHS-DE managed facilities follow the UHS-DE code of conduct. (King Dep. 15-21, 36-37; Meloni Dep. 95, 132-33.) UHS-DE trained its selected CEO for the Suncoast facility and every other one of its employees on the UHS-DE code of conduct. (King Dep. 15-21, 36-38, 41-48; Meloni Dep. 132-33.) UHS-DE provides management training for front-line supervisors at Suncoast. (King Dep. 37, 41-48.) It provided both training and education materials to Suncoast, including training and materials addressing the cited hazard. (Tr. 119, 370, 835, 2168-69, 2579; Curl Dep. 23-24; King Dep. 13-15, 22, 36-38, 41-48.) UHS-DE ensures that the facilities it manages, including Suncoast, comply with all applicable laws and regulations, including the OSH Act. (Meloni Dep. 76-77; Ex. 6 at 104, ¶ 3B(6).) Suncoast's CEO, a UHS-DE employee, had multiple responsibilities related to preventing workplace violence, including overseeing the WVPP and training. (Hamilton Dep. 27.) Employees brought concerns related to the hazard to a UHS-DE's employee. (Tr. 514; Exs. 24-25.)

UHS-DE was directly involved in reviewing reported employee injuries. In late 2017, UHS-DE decided to contract with a third party, Sedgewick, to assist with preparing EARs and OSHA reporting forms.[302] (Tr. 971-73, 2971; Ex. 71; Balsamo Dep. 17; Meloni Dep. 46.) Even after this change, Suncoast's Director of Human Resources continued to communicate with UHS-DE whenever an employee reported an injury. (Balsamo Dep. 14, 17.) The UHS-DE Regional Loss Control Manager Scott Lind investigated the incidents reported in the EARs and Sedgwick Clinical Consultation Reports. (Tr. 2576-77; Balsamo Dep. 14-15, 17.) Respondents reported that several incidents were assessed using the Risk Management Worksheet provided by UHS-DE. (Tr. 1354.) In addition, Suncoast could be

[302] A Sedgwick Clinical Consultation Report in the record is dated November 2, 2017. (Ex. 65.)

required to send videos of certain incidents to UHS-DE's insurance department. (Tr. 2926-27; Hamilton Dep. 67; Hamilton Dep. Ex. 14, 59, ¶ G.)

Nearly all of the abatement Respondents claim to have had in place for the cited hazard was developed by UHS-DE, and its employee, CEO Hamilton, was ultimately responsible for implementing it. (Hamilton Dep. 27, 50-51.) Suncoast relied on UHS-DE training and educational materials about risk management in general and workplace violence specifically. (Tr. 370, 378, 2785-86; Exs. 11, 243; King Dep. 18, 25, 31-32, 34-38, Exs. 12-13, 30.) UHS-DE employees provided surveys of and training to Suncoast employees. (Tr. 119, 2168-69, 2579; Curl Dep. 23-24.) The UHS PowerPoint, which Respondents' claim was a key component of their WVPP, is a collection of PowerPoint slides with the UHS logo on every slide. (Ex. 11.) None of the slides refer to Suncoast or Premier Behavioral Health. *Id.* UHS-DE decided that patient observation rounds are the way Suncoast would monitor its patients. (Hamilton Dep. 61.) Suncoast had to follow UHS-DE's policy regarding solo restraints of patients. (Tr. 777.) UHS-DE also developed the verbal de-escalation program used at the facility. (Tr. 2102-03, 2129.) For restraint and seclusion training, UHS-DE required Suncoast to use either Handle With Care or a Crisis Prevention Institute training program. (Tr. 2100, 2578-79, 3239.) UHS-DE contracted with the vendor for the use of the Handle With Care training program at Suncoast. *Id.*

Suncoast used many other UHS-DE policies related to workplace safety, including the EAR Forms, Preventing Workplace Violence PowerPoint, Employee Handbook, Milieu Management, Trauma Informed Care PowerPoint, Patient Observation Rounds PowerPoint, Verbal De-Escalation Training, the Risk Management All Staff Orientation, and the Risk Management Worksheet. (Tr. 114, 116, 120, 127, 483, 1179, 1354, 1435, 2103-4, 2575-76, 2785-86; Exs. 11-14, 18, 56, 92, 95, 220, 231-32, 243; Hamilton Dep. 51-52, 54, 61, Exs. 6, 10; Balsamo Dep. 25; King Dep. 11, 13, 18-19, 25, 30-31; Meloni dep. 124-25; Ex. 10.) Suncoast's Risk Manager used data provided by UHS-DE to assess the facility's

performance. (Tr. 2655-56, 2659, 2859-61, 2867-68; Ex. 250.) UHS-DE set the safety benchmarks Mr. Curl used to assess risk. (Tr. 2676-77, 2679, 2867; Ex. 250.)

Respondents claim that Suncoast had the "option" to edit certain policies, but the documentation and testimony show that it did not make substantive edits to these documents. (Tr. 2575-76; Exs. 10, 12-13, 21, 95; King Dep. 12; Balsamo Dep. 25-26.) Further, the person who could choose to make the edits was typically another UHS-DE employee. (Tr. 2570; Hamilton Dep. 50.) For example, CEO Hamilton signed the form letter at the start of the employee handbook without making any edits. And Suncoast's governing board, which included multiple UHS-DE employees, approved the facility's policies and procedures. (Tr. 2569-70.)

UHS-DE employees were involved in the key committees Respondents cite as having responsibility related to employee safety. At the monthly UHS-PSC meetings, UHS-DE provided training materials and various updates on safety issues. (Ex. 251 at 3754.) The UHS-PSC meetings also reviewed instances of patient aggression resulting in injuries.[303] (Tr. 2570.) The records provided cover from the February 24, 2016 meeting through the July 17, 2018 meeting. (Ex. 251.) In addition to the UHS-PSC, the CEO also sits on these committees: EOC, Compliance, Leadership, Medical Executive, Performance Improvement, Patient Safety, Pharmacy and Therapeutics, and Infection Control. (Tr. 2521-22; Curl Dep. 19-20; Hamilton Dep. 103; Meloni Dep. 96.)

2. **Management & Ownership**

UHS-DE provides management services for Suncoast and other UHS affiliated entities, pursuant to similar management agreements UHS-DE's legal department creates. (Tr. 128, 218, 367, 1691-92; Meloni Dep. 25, 33-34, 36-44, 60; Hamilton Dep. Ex. 5; Ex. 92 at 19, Resp. to Int. Nos. 12-13.) There is no evidence that Suncoast or any other UHS affiliate could select a management company other than

[303] During OSHA's investigation, the CEO attended three of the six UHS-PSC meetings and the COO, who was also a UHS-DE employee, attended four. (Ex. 251 at 3717-3811.)

UHS-DE. *See Altor,* 23 BNA OSHC at 1464 (evaluating inter-reliance of two businesses and citing the fact that both entities always did business together). UHS-DE administers Suncoast's benefits, internet, and email access, contracting, purchasing, and liability. (Tr. 1417, 2576-78; Ex. 25; Balsamo Dep. 22; Meloni Dep. 39-40, 55-57, 68-69, 76-77, 82-83; Curl Dep. 40.) It provides information and legal services to Suncoast. (Tr. 2950; King Dep. 13, 15; Balsamo Dep. 15; Meloni Dep. 33, 39-42; Curl Dep. 40.) The UHS-DE legal department reviews contracts before Suncoast enters into them. (Meloni Dep. 55-56.)

UHS-DE pays the physicians who work at Suncoast under contract. (Meloni Dep. 61-63, 85.) UHS-DE employees prepare Suncoast's annual budget, then the UHS-DE Regional Vice President and the UHS-DE operations management approve it. (Tr. 2293, 2577; Meloni Dep. 47-48.) UHS-DE must approve all capital improvements over $500. (Tr. 2577-78; Hamilton Dep. 93-94.) For projects over $5,000, UHS-DE, not Suncoast, makes the purchases from vendors directly. (Tr. 2577-78.)

"Upper management" of Suncoast are direct employees of UHS-DE. (Tr. 128-29; Meloni Dep. 39; Phillips Dep. 14.) UHS-DE is responsible for "the retention or hiring of the C-suite leadership in a given facility," including at Suncoast. (Tr. 128, 2293, 2297, 2568-69; Ex. 92 at 1-2; Stip. 11; Meloni Dep. 39, Ex. 6, 35-36; King Dep. 20-22, 24.) UHS-DE is involved in the interview process for the CEO, CFO, and COO for Suncoast. (King Dep. 21.) It hired the CEO to manage Suncoast. CEO Hamilton and Suncoast's CFO and COO are paid directly by UHS-DE. (Tr. 2569; King Dep. 21-24, Ex. 5; Meloni Dep. 61-62; Ex. 92 at 1.) At least three high-ranking officials, including the CEO and CFO, at Suncoast were direct employees of UHS-DE. (Tr. 128, 179, 370, 2293-97, 2568-69; Ex. 9.) Debra K. Osteen was employed by UHS-DE as the President of the Behavioral Health Division when OSHA inspected the Suncoast worksite. (Meloni Dep. 29-30, Ex. 35.) At the same time, she also served as Suncoast's President and Director. (Meloni Dep. Ex. 35; Ex. 92 at 47.) The CFO handles Suncoast's financial matters and has an office at Suncoast. (Tr. 2297; Ex. 92; Hamilton Dep. 50.) He sits on the performance

improvement and financial committees for Suncoast. (Curl Dep. 20.) The CEO, her supervisor, another UHS-DE employee, and the CFO all sit on Suncoast's governing board. (Tr. 2293-94, 2526, 2568-70; Curl Dep. 19; Hamilton Dep. 20.) This governing board approves Suncoast's policies and procedures. (Tr. 2570.) CEO Hamilton consulted with her clinical resource, Gail Leonard, another UHS-DE employee, when CEO Hamilton considered enlarging the nurses' station in either 2017 or 2018. (Tr. 2592-93; Sec. Br. 100-23.)

The CEO is responsible for hiring the various directors at the facility, including the Medical Director, the DON, and the Director of Risk Management.[304] (Tr. 2397.) She is also involved in the process of hiring nurses and MHTs. (Tr. 2397-98.) The CEO is responsible for supervising all of the managers at the facility, including the Directors of Risk Management, Human Resources, Intake, Nursing, and Plant Operations, as well as the Medical Director.[305] (Hamilton Dep. 24, 50, 95-96; Curl Dep. 17; King Dep. 40; Balsamo Dep. 11; Meloni Dep. 80; Phillips Dep. 14; Hemsath Dep. 17; Haider Dep. 12.) Increases in staffing had to be approved by her. (Tr. 2309-10.) She manages "the regulatory requirements" and oversees the facility "from a financial standpoint." (Tr. 2293.) She, along with her subordinate, investigated compliance issues. (Balsamo Dep. 20.)

The CEO provides a monthly report to her supervisor, another UHS-DE employee. (Tr. 2294; Hamilton Dep. 20-21, 25-27.) At times, these reports include incidents involving patient aggression that led to staff injuries. (Hamilton Dep. 25-27.)

3. **Common Worksite**

UHS-DE and Suncoast share a common worksite. Suncoast's corporate filings list the address of its corporate offices as 367 S. Gulph Road, King of Prussia, PA. (Meloni Dep. Ex. 35; Ex. 9 at 309.) UHS-DE's filings provide the same address for its corporate office. *Id.* Job listings were posted on both

[304] The DON who testified at trial was a UHS-DE employee. (Phillips Dep. 14, 22.)
[305] Dina Balsamo has been Suncoast's Director of Human Resources since it opened. Carol King was UHS-DE corporate director of human resources on March 26, 2019, when she was deposed in this case. (Tr. 1501; King Dep. 6.)

UHS-DE and Suncoast's websites. (Balsamo Dep. 49.) Some employees applied for their jobs at the Suncoast location through UHS's main website. (Tr. 224-25, 371; Hamilton Dep. 39-40; Balsamo Dep. 18-19.) All employees at UHS-DE managed facilities have an email address ending with "@uhsinc.com." (Tr. 1417; Meloni Dep. 72; Curl Dep. 29.)

Respondents do not dispute that the same location in King of Prussia serves as the corporate office for both Suncoast and UHS-DE. They only argue that OSHA sent the Citation to the worksite, not the corporate office. (Resp't Br. 74.) While relevant, the location of where OSHA sent the Citation is not determinative of whether the entities shared a common worksite. The Citation was sent to the inspection site, where both UHS-DE and Suncoast employees worked. (Stip. 11; Tr. 1417; Ex. 92; Hamilton Dep. 50.)

In addition to the shared King of Prussia address, both Suncoast and UHS-DE employees worked together at the inspection site. A UHS-DE employee oversaw operations and is present at Suncoast daily. (Tr. 1810; Hamilton Dep. 50.) Much like the situation in *C.T. Taylor*, UHS-DE's "handpicked" supervisor oversaw the work of the Suncoast employees involved with implementing the WVPP. 20 BNA OSHC at 1087.

UHS-DE and Suncoast acted as a "single employer" for purposes of the OSH Act liability. Thus, either as a result of its direct employment of exposed workers, or as acting as a single employer with Suncoast, UHS-DE was appropriately cited, and its request to be dismissed from the Citation is denied.

IV. Penalty

"Regarding penalty, 'the judge is empowered to affirm, modify, or vacate any or all of these items, giving due consideration in his penalty assessment to 'the size of the business of the employer . . ., the gravity of the violation, the good faith of the employer, and the history of previous violations.' " *Atlas Roofing Co. v. OSHRC*, 430 U.S. 442, 446 (1977) (quoting 29 U.S.C. § 666[j]). These factors are not necessarily accorded equal weight. *J.A. Jones Constr.*, 15 BNA OSHC 2201, 2216 (No. 87-2059, 1993)

(citation omitted). "The gravity of the violation is the 'principal factor in a penalty determination and is based on the number of employees exposed, duration of exposure, likelihood of injury, and precautions taken against injury.' " *Jim Boyd Constr., Inc.*, 26 BNA OSHC 1109, 1114 (No. 11-2559, 2016) (quotation omitted).

When initially issued, the Citation included a proposed penalty of $71,137. (Tr. 218; Ex. 1 at 67.) This amount could only be imposed if the violation is characterized as repeat rather than serious. Under the OSH 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 2018 and characterized as "serious" was $12,934. While Respondents challenged the violation's characterization, they did not raise arguments about the penalty factors. As addressed above in the discussion regarding the Secretary's Motion for Sanctions, the Court finds that the destroyed evidence would have supported the Secretary's conclusions regarding the violation's gravity. The violation's gravity was high, both in terms of the potential for serious physical harm or death and the number of employees exposed. (Tr. 220.) The hazard caused grave injuries and was capable of causing death.[306] (Tr. 1667.)

None of the other penalty factors warrant a reduction in the penalty amount. Approximately 80-100 employees worked at the facility, with most facing at least potential exposure to the cited hazard. (Tr. 219-21, 1501; Hamilton Dep. 24.) Most were exposed to the hazard on a frequent basis. (Tr. 220.) As for good faith, Respondents' destruction of evidence undermines arguments regarding cooperation with the OSHA investigation. The CO also concluded that no penalty adjustment for good faith was warranted. (Tr. 221.)

Turning to the history factor, the CO argued that the penalty should be increased by 10% for

[306] See also Section III. E., *Serious Physical Harm*. CO Trouche testified that the nature of injuries, included "broken hips, dislocation, contusions, stabbings." (Tr. 220.) Moreover, even if the record lacked sufficient evidence of the gravity of the violation, the Court would still find the violation to be of sufficient gravity to warrant the assessed penalty as a sanction for Respondents' destruction of ESI.

history. *Id.* OSHA previously inspected Suncoast in 2015, but that investigation did not result in the issuance of a Citation.[307] (Ex. 3.) Still, this inspection alerted both Suncoast and UHS-DE to the existence of the cited hazard at the facility.[308] Suncoast had no prior citation history for the five-year period that preceded the issuance of the citation at issue. (Tr. 353.) Neither an increase nor a decrease for history is appropriate on this record.

Considering the four factors, with particular weight on the violation's gravity and limited good faith, the Court finds $12,934 to be an appropriate penalty amount.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The preceding 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 OSH Act is AFFIRMED as SERIOUS, and a penalty of $12,934 is ASSESSED.

SO ORDERED.

/s/_____
The Honorable Dennis L. Phillips
U.S. OSHRC Judge

Dated April 20, 2021

[307] Suncoast opened in September 2014. Before the OSHA inspection in 2015, Suncoast did not have any prior OSHA inspection history. (Tr. 314-15, 330.)

[308] UHS-DE employees worked at Suncoast during OSHA's first inspection of the site in 2015/2016. In addition, Suncoast's risk manager moved from Suncoast to UHS-DE after OSHA issued its 2016 Hazard Alert Letter. There is no evidence of UHS-DE being previously inspected or cited for violations of the OSH Act.