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.

BHC NORTHWEST PSYCHIATRIC HOSPITAL LLC d/b/a BROOKE GLEN BEHAVIORAL HOSPITAL,

Respondent.

PASNAP,

Authorized Representative,

TEAMSTERS LOCAL 107,

Authorized Representative.

OSHRC DOCKET NO. 17-0063

Appearances:

Kate O'Scannilain, Solicitor of Labor
Oscar L. Hampton III, Regional Solicitor
Michael P. Doyle, Regional Counsel for OSHA
Judson H. Dean, Senior Trial Attorney
U.S. Department of Labor, Office of the Solicitor, Philadelphia, PA
For the Complainant

Carla J. Gunnin
Raymond Perez
Jackson Lewis P.C., Atlanta, GA
For Respondent

Before: Covette Rooney, Chief Administrative Law Judge

DECISION AND ORDER

Following a complaint, the Occupational Safety and Health Administration (OSHA) commenced an investigation of Brooke Glen Behavioral Hospital (BGH) facility in Fort

Washington, Pennsylvania. After the completion of the investigation, BGH received a Citation alleging it violated the Occupational Safety and Health Act of 1970, 29 U.S.C. §§ 651-678 (the Act). (Ans. at ¶ 1.) Specifically, the Citation alleges BGH violated 29 U.S.C. § 654(a)(1), the provision commonly referred to as the general duty clause, for exposing employees to the hazard of workplace violence in the form of patient on staff aggression. BGH timely contested the Citation and a hearing was held on February 21-23, and May 2-4, 2018. (Ans. at ¶ 2; Stip. 8, 9.)

For the reasons discussed, the Citation is affirmed and the proposed penalty of $12,471 is assessed.

JURISDICTION

Respondent filed a timely notice of contest and admitted that it is an employer under the Act. (Ans. at ¶¶ 3-4.) Respondent is an employer affecting commerce within the meaning of 29 U.S.C. § 659(c). (Stip. 5-11; Ans. at ¶¶ 2-4.) Based upon the record, including the Respondent's admission to jurisdiction, the undersigned concludes that the Commission has jurisdiction over the parties and the subject matter of this case. *Id.*

PROCEDURAL BACKGROUND

After BGH filed its Notice of Contest, two organizations moved for party status as authorized bargaining agents for affected employees, Teamsters Local 107 (Teamsters) and the Pennsylvania Association of Staff Nurses & Allied Professionals (PASNAP). *See* Commission Rule 20(a), 29 C.F.R. § 2200.20(a) (permitting authorized representatives of affected employees to elect party status if the Act confers a right to participate). There were no objections to the requests, and the undersigned granted the motions for party status.[1]

[1] Matthew Thom attended the hearing as an observer. (Tr. 9.) No one filed an appearance on behalf of PASNAP or Teamsters.

On February 16, 2018, the Secretary and Respondent submitted a partial settlement agreement. No one, including the two organizations granted party status, Teamsters and PASNAP, objected to the reasonableness of any abatement time set out in the settlement. 29 U.S.C. § 659(c) (permitting employees or representatives of employees to object to the abatement date set out in the citation as unreasonable). The undersigned approved the partial settlement agreement in an Order dated March 28, 2018. On the same day, Respondent's contest of Citation 1, Items 1b, Item 2, Item 3, Item 4a, Item 4b, Item 4c, and Item 4d, from Inspection No. 1161234, was severed from Docket No.17-0063 and assigned a new docket number, No. 18-0292. Thus, those Items are no longer part of the instant matter.

Before the hearing on the only Citation Item still at issue (Item 1a), the parties entered into seventeen stipulations. (Tr. 10-13; Jt. Ex. 1.) After the hearing, on August 31, 2018, the parties stipulated that if the Court affirms a general duty clause violation, the proposed penalty of $12,471 is appropriate pursuant to the factors set forth at 29 U.S.C. § 666(j).

Both parties submitted post-hearing briefs. In its brief, Respondent requests that the undersigned take judicial notice of aspects of pending litigation and "review the Citation" issued in connection with it. (Resp't Br. at 22.) The request fails to meet the requirements of Federal Rule of Evidence 201(b), which 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. Respondent does not seek the establishment of a fact; it wants the undersigned to assess ongoing litigation not before her. Respondent's judicial notice request does not meet the criteria of Rule 201(b) and is therefore denied.

BACKGROUND

BGH employs approximately two hundred employees at its 146-bed inpatient psychiatric

hospital in Fort Washington, Pennsylvania. (Stip. 1-3; Post Hr'g Stip. at 2.) It has eight separate units that can accommodate a range of patient impairments, such as depression and schizophrenia. (Stip. 3-4; Tr. 39, 45-46.) The extended acute care (EAC) and close observation units have the patients with the most needs. (Stip. 4.) Most patients at BGH pose a risk of harm to themselves or others. (Tr. 710-11.) Staff with direct patient involvement includes registered nurses (RNs), mental health technicians (MHTs), psychiatrists, psychologists, and social workers. (Tr. 43, 624, 713.)

On July 11, 2016, OSHA received an anonymous complaint alleging that the number of workplace violence incidents were increasing, partially because of understaffing. (Tr. 164-65; Ex. C-34.) OSHA commenced an investigation, with its Compliance Safety and Health Officer (CO) visiting the site four different times. (Tr. 165.) Based on the evidence gathered during the investigation, the CO concluded that there were at least fifty-one workplace violence incidents involving patients and staff in one year. (Tr. 184-85.) This included: seventeen incidents of employees being punched, kicked, or slapped; sixteen incidents of bites or scratches; four incidents of employees being hit with an object; four incidents of spitting, hair-pulling, or grabbing; and ten other physical injuries, including impacts to backs, hands, and knees. (Tr. 185; Ex. C-54.)

At the close of the investigation, a Citation alleging a violation of the general duty clause was issued. Specifically, the Citation asserts that:

> On or about July 11, 2016, nurses and mental health technicians who provide inpatient care, especially in the close observation and adolescent units, during the course of de-escalating aggressive patients or while trying to prevent patients from injuring themselves are exposed to serious physical injuries such as from bites, bruises, or strains and sprains.

DISCUSSION

I. Legal Standard

The general duty clause requires every employer to "furnish to each of his employees

employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm."[2] 29 U.S.C. § 654(a)(1). To establish a general duty clause violation, 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.[3] *Waldon Health Care Ctr*., 16 BNA OSHC 1052, 1058 (No. 89-3097, 1993).

Respondent stipulated to the first two elements of the test. (Tr. 11-12, 121-22.) First, it admitted that employees at its worksite "were exposed to the hazard of workplace violence." (Stip. 12; Tr. 122.) In this case, the hazard of workplace violence is defined as "patient to staff aggression during the six-month period prior to the issuance of the citation."[4] (Stip. 12-13.) Second, BGH stipulated that both it and the relevant industry recognized the hazard of patient to staff aggression.[5] (Stip. 13-14.)

The parties dispute the test's remaining two elements: (1) was the hazard likely to cause

[2] The parties stipulated that this is what the general duty clause requires of employers. (Stip. 15; Tr. 12.)

[3] The parties stipulated that this is the test to establish liability for a violation of the general duty clause. (Stip. 16; Tr. 12-13.)

[4] This six-month period commenced on July 11, 2016, and concluded on January 11, 2017. (Stip. 12; Tr. 11-12.)

[5] Specifically, BGH stipulated that:

> (13) The hazard of workplace violence specifically defined in this case to be patient-to-staff aggression was recognized by Respondent.
> (14) The hazard of workplace violence specifically defined in this case to be patient-to-staff aggression is recognized in the industry.

(Tr. 12.)

death or serious physical harm, and (2) are there feasible means of abatement that Respondent could have implemented to materially reduce the hazard of workplace violence. (Stip. 16 (citing *Waldon*, 16 BNA OSHC at 1058).) For the reasons set forth below, the undersigned finds that the hazard is likely to cause death or serious physical harm and there are feasible means of abatement.

II. Hazard of Workplace Violence is Likely to Cause Death or Serious Physical Harm

Generally, workplace violence refers to violent acts that happen in the workplace, including assaults and threats of assault. (Tr. 403.) Workplace violence can occur in several different ways. (Tr. 403-4.) For example, employees can face threats from co-workers, or, as was the situation at BGH, from patients. (Tr. 403-4, 1327; Exs. R-12, R-27, R-48, C-4.) *See W. World, Inc.*, 24 BNA OSHC 2116, 2125-26 (No. 07-0144, 2014) (ALJ) (affirming a violation of the general duty clause when employer's firearm policies and procedures were inadequate), *aff'd*, 604 F. App'x. 188 (3d Cir. 2015) (unpublished); *Megawest Fin., Inc.*, No. 93-2879, 1995 WL 383233, at *6 (O.S.H.C.A.L.J., May 8, 1995) (finding that the Secretary could assert that workplace violence constitutes a general duty clause violation).

There is no specific OSHA standard addressing the hazard of workplace violence. This does not mean that employers have no obligation to address the hazard. Rather, if an employer or its industry recognize that workplace violence is an actual or potential hazard that can cause death or serious physical harm, the Act's general duty clause requires such employers to act to eliminate or materially reduce this hazard. 29 U.S.C. § 654(a)(1). *See e.g.*, *Con Agra, Inc.*, 11 BNA OSHC 1141, 1144-45 (No. 79-1146, 1983) (finding a violation of the general duty clause even though no employee had been injured by the identified hazard); *Babcock & Wilcox, Co. v. OSHRC*, 622 F.2d 1160, 1165 (3d Cir. 1980) ("The issue is not whether an accident was likely to happen but rather whether, assuming one had occurred, it was likely that employees would have suffered serious

physical harm.").

Both BGH and its industry recognize the hazard of workplace violence in the form of patient on staff aggression. (Tr. 397-98, 1327; Stip. 13-14; Exs. C-4 at 5-8, 31, C-47, R-46, R-48.) BGH employees work directly with patients who may act unpredictably and violently because of mental health issues. (Tr. 95, 295, 453.) As for the industry, the Secretary's expert, Dr. Lipscomb, explained, that "workplace violence is one of the most dangerous occupational hazards" for workers in the behavioral health setting face. (Ex. C-4 at 3-4.) She cites a 2015 study of 614 psychiatric care units that identified nearly 15,000 assaults by patients over a four-year period. (Tr. 475-77; Ex. C-47.) Nearly 75% of these assaults involved an incident where only the employee was injured. (Ex. C-47.)

As there is agreement that this is a hazard, we turn to whether the results of accidents related to the hazard are likely to cause death or serious harm. *See Waldon*, 16 BNA OSHC at 1060 (focus is not on the likelihood of injury, but whether, if an accident occurs, are the results likely to cause death or serious harm.) Every non-management employee who testified described receiving workplace injuries from patient attacks. In 2016, there were fifty-one employee injuries from patient on staff violence at BGH. (Tr. 185, 417, 1173; Exs. C-12, C-54, R-48.) The injuries included employees being punched, kicked, slapped, bitten, scratched, hit with objects, spit at, grabbed, knocked down, and having hair pulled. (Tr. 185, 420, 1011.) One employee testified that in his three years at the facility patients punched him at least eight times, including once in the face. (Tr. 52, 60; Exs. C-55, 56.) This was not the only instance of workplace violence he experienced. He also received scratches that drew blood two or three times, was bitten, spit on "countless" times, and knocked down. (Tr. 52, 1011.) Another employee was attacked and beaten by a patient. (Tr. 137.) The patient lunged at her, hitting her repeatedly in the back of her head,

neck, and shoulders, and pulled her hair. *Id.* A third employee had a telephone thrown at her head while she was writing notes at a desk. (Tr. 233.) A fourth employee sprained her knee after being thrown against the wall and a door during an incident involving two different patients. (Tr. 369.) She missed a few days of work and had to use crutches and an immobilizer brace for a few weeks. (Tr. 370.) A fifth employee described to the CO a patient hitting her and biting her neck. (Tr. 196-97.) A sixth employee described being attacked or assaulted "countless times," three of which sent him to the hospital and one of which left him with a permanent scar from a bite. (Tr. 586-87.) BGH employees provided numerous examples of experiencing serious physical harm from patient on staff violence. (Tr. 420.)

Besides the testimony from employees, the CO explained that she identified twelve employee injuries related to patient violence that resulted in eight lost workdays and 121 restricted time or job transfer days in 2016. (Exs. C-4 at 4, C-12, R-48; Tr. 175, 184, 206.) While this was a notable increase from the prior three years, BGH had OSHA recordable injuries related to workplace violence every year from 2013 thru the time referenced in the Citation. (Ex. C-4 at 4; Tr. 204.)

In short, the working conditions at BGH presented a serious risk of workplace violence and the staff was at risk of experiencing assaults with the potential for severe injuries. (Ex. C-4 at 31.) Injuries to employees constitute at least prima facie evidence that the hazard was likely to cause death or serious injury. *See e.g., Usery v. Marquette Cement Mfg. Co.*, 568 F.2d 902, 910 (2d Cir. 1977). BGH offers no rebuttal to the Secretary's position that the general duty clause covers head injuries and those serious enough to necessitate trips to the hospital. The Secretary established the presence of a hazard which BGH and its industry recognized, and this hazard is likely to cause death or serious physical harm.

III. Abatement

Having found that BGH recognized that the hazard of patient on staff aggression was present at its facility and that this hazard could lead to death or serious injury, we turn to whether the Secretary satisfied the test's abatement prong. *See Waldon*, 16 BNA OSHC at 1062.

A. Expert Testimony

Both sides offered expert testimony on the sufficiency of BGH's abatement efforts as of when the Citation was issued, and the abatement methods proposed in the Citation. Monica Cooke testified for the Respondent. The undersigned accepted her as an expert on risk reduction of workplace violence and healthcare, including reducing patient to staff aggression in a behavioral health hospital setting. (Tr. 1259.) Dr. Lipscomb testified on the Secretary's behalf. She was accepted, without objection, as an expert in workplace violence prevention in the healthcare setting, including the behavioral healthcare setting. (Tr. 416, 418-19.)

Dr. Lipscomb has a bachelor's degree in nursing, a master of science degree in public health nursing and occupational health nursing, and a PhD in epidemiology with a focus on occupational and environmental health. (Tr. 398-99; Ex. C-5.) In her long career, she provided extensive consulting services to various governmental agencies on workplace violence in the healthcare setting. (Tr. 401-2, 405-6.) This work included testifying before state legislatures about workplace violence prevention. (Tr. 413-14.) She also conducted extensive field research work on violence in healthcare facilities. (Tr. 400, 402, 410.) As part of this work, she visited numerous behavioral healthcare facilities in different states to evaluate the effectiveness of abatement measures to minimize workplace violence. (Tr. 405-8.) This and other research resulted in the publication of approximately twenty-five papers on workplace violence in peer-reviewed journals. (Tr. 410-11; Exs. C-4 at 32, 49, C-5 at 3-10, C-46, C-49.) Most of this work and the related

publications center on the same type of workplace violence at issue here: patients acting aggressively against healthcare workers. (Tr. 404.)

Respondent's expert, Ms. Cooke, has a bachelor's degree in nursing and a master's degree in healthcare administration. (Tr. 1237.) She has conducted risk assessments that include an examination of the risk of patient aggression against staff at several behavioral health facilities. (Tr. 1237-38.) Ms. Cooke has not conducted any field research related to workplace violence prevention. (Tr. 1256-57.) In terms of publications, while she co-authored a chapter in a book about behavioral health risk and published newsletters for various organizations, she has not published any peer-reviewed papers or book chapters on workplace violence prevention. (Tr. 1244-45, 1257.)

Dr. Lipscomb and Ms. Cooke both satisfy the threshold requirements to allow them to offer expert opinions. But their testimonies are not entitled to equal weight. The Secretary raised the scope of Ms. Cooke's review and questioned whether its limited parameters precluded her testimony from being sufficiently helpful. (Sec'y Br. at 43-47; Tr. 1245.) These challenges were not enough to exclude the testimony. Still, they are relevant when determining what weight to give her testimony and expert report. *See U.S. Steel v. OSHRC*, 537 F.2d 780, 783 (3d Cir. 1976) (explaining that expert testimony need not be accepted even if uncontradicted); *Conn. Nat. Gas Corp*., 6 BNA OSHC 1796, 1800 (No. 13964, 1978) (noting that it is up to the trier of fact to determine what weight, if any, to give expert testimony).

Ms. Cooke spent a few hours at BGH on one day. (Tr. 1251-52, 1331; Ex. R-57 at 2.) She was not hired to conduct the kind of comprehensive workplace violence assessment that she typically conducts for clients. (Tr. 1251-52, 1331.) She acknowledged that she did not have enough information from an assessment standpoint to opine on whether there were any additional

prevention strategies that BGH could have implemented to reduce workplace violence injuries. (Tr. 1248-50, 1330.) She assessed whether BGH's approach was consistent with the behavioral health industry as a whole. (Ex. R-57.) She did not determine what else BGH could have done to address workplace violence—her review was limited to assessing what they were actually doing. (Tr. 1252, 1330.) Her report evaluated the feasibility of only one of the Secretary's proposed abatement measures, the use of a buddy system. (Tr. 1328; Ex. R-57.) She offered no opinion on whether any of the other abatement measures discussed during the hearing were economically or technologically feasible. (Tr. 1327-28.)

Several pieces of information Ms. Cooke cites in her report as support for her opinion are not adequately borne out by the evidence. First, in terms of BGH's policies, Ms. Cooke indicated that the employee handbook and workplace violence policy show that the facility had "zero-tolerance" for acts or threats of violence. (Ex. R-57 at 2, 5.) However, BGH's management explained that the policy Ms. Cooke cites is not focused on patient on staff violence. (Tr. 1099.) The zero-tolerance policy did not appear to apply to violent acts committed by patients.[6] (Tr. 139-40.) Second, her report states that BGH required staff to report acts of violence. (Ex. R-57 at 2, 5.) But employees were not required to fill out employee accident reports (EARs) and verbal threats and abuse did not have to be documented. (Tr. 659, 907.) Ms. Cooke also refers to forms that employees did not use to support her opinions on the adequacy of BGH's approach. (Tr. 656, 1033, 1058-60; Ex. R-57 at 3, 11.)

Third, in terms of workplace practices, Ms. Cooke's report concludes that incidents of aggression or violence are "routinely debriefed by the staff and events are communicated to care

[6] The record does not include evidence that BGH had any type of workplace violence incidents other than patient on staff violence.

providers." (Ex. R-57 at 2, 6.) However, as discussed below, BGH's debriefing practices were not consistent. (Tr. 579-80.) Fourth, the report refers to monthly "EOC rounds" being conducted by "Facilities and the Risk Manager" and said that reports from these rounds were provided to the Safety Committee. (Ex. R-57 at 4.) No witness defined what EOC meant or described these EOC rounds—it is not referred to in Respondent's Brief, and there is no evidence of any monthly reports from such rounds being given to the Safety Committee, or it reviewing information from an EOC round. Fifth, the report states that camera surveillance footage of workplace violence incidents is utilized for training purposes. *Id.* at 4-5. However, the person that leads the reviews said that he was not instructed to do a camera review of every incident of workplace violence he knew about. (Tr. 1006, 1067-68.) For the reviews he did conduct, he placed the forms from the camera review in a file and did not complete them at all if an employee did not want to do the voluntary camera review.[7] (Tr. 1044, 1047.) Sixth, the report refers to "available walkie talkies" to mitigate the risk of violence. (Ex. R-57 at 6.) But, after multiple employees testified about the inadequacy of the walkie talkies, Ms. Cooke did not indicate she still believed that they were reliable. (Tr. 1340; Ex. R-57 at 6.)

Dr. Lipscomb's report and testimony focused on the adequacy of BGH's approach and whether there were any additional feasible steps it could take to materially reduce the hazard of patient on staff violence. (Ex. C-4.) In contrast, Ms. Cooke's expert opinion focused on whether what BGH was doing was consistent with the industry. (Tr. 1329; Ex. R-57.) But that is not the test. The Commission has long held that the general duty clause may require more than what is customary. *S. Ry. Co.*, 3 BNA OSHC 1657, 1658 (No. 5960, 1975) (concluding that abatement

[7] He indicated that in "most cases" he would "try to set up a camera review if necessary … ." (Tr. 1006.)

under the general duty clause "may require that work practices and safety precautions be upgraded to a feasible level which is above that considered customary or 'reasonable' by an industry"); *Cont'l Oil Co*., 6 BNA OSHC 1814, 1816 (No. 1829, 1978), *aff'd*, 630 F.2d 446 (6th Cir. 1980). The general duty clause requires employers to take all feasible steps to protect against recognized hazards. *Gen. Dynamics Corp., Quincy Shipbuilding Div*., 599 F.2d 453, 464 (1st Cir. 1979). Employers must implement abatement measures whenever they are "recognized by safety experts as feasible, even though it is not of general usage in the industry." 599 F.2d at 464. "The question is whether a precaution is recognized by safety experts as feasible, not whether the precaution's use has become customary." *Nat'l Realty & Constr. Co. v. OSHRC*, 489 F.2d 1257, 1265-66 n.37 (D.C. Cir. 1973). *See also Wheeling-Pittsburgh Steel Corp.*, 10 BNA OSHC 1242, 1245 (No. 76-4807, 1981) (consolidated) (concluding that the general duty clause "may require that feasible protective measures be taken even though such measures are not considered customary in a particular industry"), *aff'd*, 688 F.2d 828 (3d Cir. 1982) (table).

So, the issue is whether the employer sufficiently abated a recognized hazard that exposes employees to serious injuries as opposed to whether an employer's actions are consistent with other behavioral health hospitals. Dr. Lipscomb's testimony credibly and directly addressed the sufficiency of BGH's abatement methods and the feasibility of additional abatement measures. Her testimony was largely unrebutted either by fact witnesses or Ms. Cooke. Thus, Dr. Lipscomb's testimony is credited to support the findings that BGH failed to adequately abate the hazard and that there were feasible methods of abatement BGH could adopt to materially reduce the hazard. *See i4i Ltd. P'ship v. Microsoft Corp.*, 598 F.3d 831, 852 (Fed. Cir. 2010) (noting that a judge can give little weight to expert testimony although found reliable enough to pass the threshold of Fed. R. of Evid. 702), *aff'd*, 564 U.S. 91 (2011).

B. Sufficiency of BGH's Approach

For general duty clause violations, when an employer has undertaken measures to address the cited hazard the Secretary must show that such measures were inadequate. *Mo. Basin Well Serv., Inc.*, 26 BNA OSHC 2314, 2319 (No. 13-1817, 2018). BGH's workplace violence prevention program primarily consisted of: (a) its clinical care of patients, (b) written policies related to violence among co-workers, management of aggression, and responding to codes, (c) accident reporting procedures, (d) management committees that reviewed patient aggression, and (e) training.[8] (Resp't Br. 5-11.)

The Secretary asserts that these prevention efforts were inadequate. Certainly, BGH's approach did not eliminate the hazard: fifty-one incidents of patient on employee violence occurred in 2016 alone. (Tr. 185, 1173; Ex. C-54.) The Secretary argues that BGH failed to fully implement and enforce its existing program. *See SeaWorld of Fla., LLC v. Perez*, 748 F.3d 1202, 1206, 1215 (D.C. Cir. 2014) (finding existing safety procedures inadequate).

1. Clinical Care Policies

BGH contends that it took reasonable steps to abate the hazard of patient on staff violence through its clinical treatment of patients. (Tr. 738-39.) The treatment program includes: (a) gathering information about a patient as part of the admissions process to develop a Crisis Plan, and (b) assessing and then clinically treating patients. (Tr. 318-20, 329, 741-43; Ex. R-7.)

a. Crisis Plans

According to the Chief Nursing Officer (CNO), during the admission process, patients are

[8] BGH did not organize its policies relevant to the hazard of workplace violence in a single document or binder. (Tr. 33, 1084; Ex. C-4 at 10.) The Workplace Violence and Code 100 policies were available on BGH's internal homepage (Intranet), but witnesses did not specifically indicate whether the Management of Aggression policy was available there. (Tr. 1098-99, 1103.)

given a form called a Crisis Plan that asks about what helps them when they feel anxious or agitated. (Tr. 291, 928-29; Ex. R-7.) Patients complete the form by themselves unless they need assistance from the staff in which case someone will assist them. (Tr. 291.) None of the witnesses addressed whether a plan was still developed even if a patient was unable to, or refused to, provide information about what had calmed them in the past. Whatever utility these forms may have had to address the hazard is undermined by the evidence that they were frequently left blank. (Tr. 93.) Because of how the forms were used, the undersigned finds that the Crisis Plans were not an effective abatement method for the cited hazard.

b. Assessment and Progress Notes

To determine whether the facility has the capacity to treat a person, an employee first completes a form used for triage purposes called the "pink sheet."[9] (Tr. 320-21, 722; Ex. R-1.) The one-page form includes space for the person completing it to check off whether there was or was not a risk of "homicidal ideation" or "assaultive behavior." (Ex. R-1.) The record does indicate the background or training of the people who fill out the pink sheets.[10] (Tr. 318, 620.)

Ms. Cooke appeared to suggest that if the pink sheet identified the patient as having potential aggression issues, that patient would be "flagged" by forwarding the pink sheet to the unit where they were going to be treated.[11] (Tr. 1303.) But, the "pink sheets" were not used to differentiate patients considered to present a greater risk of engaging in violent behavior. The form

[9] The form is labeled "Inquiry Call/Client Information" but was typically printed on pink paper leading to it being called the "pink sheet." (Tr. 318, 766; Ex. R-1.)

[10] The CNO said a "specialist" completed the forms. (Tr. 318.)

[11] At first, Ms. Cooke indicated that she did not know if just the information was conveyed or if the pink sheet itself was sent to the unit. (Tr. 1278.) The House Supervisor said that "admissions" completes the form and that it "stays with the patient's paperwork." (Tr. 620-21.)

was filled out for anyone referred to the facility—all such patients had the same type of pink sheet in their files.[12] (Tr. 620; Ex. R-1.)

BGH's House Supervisor said that a physician looked at the pink sheets, but all staff members had "access" to the risk assessment information it might contain. (Tr. 621.) There is no indication that warnings or other information was specifically conveyed to the front-line workers to advise them about particular risks related to workplace violence. No one testified that MHTs were trained or instructed to review the pink sheets before working in a unit.[13]

Besides the pink sheet, within eight hours of being admitted, an RN completes an assessment of the patient. (Tr. 329.) The CNO explained that this assessment is "mostly" about what is going on with the patient medically, but it includes a question about "homicidal assault risk." (Tr. 331.) A psychiatrist and a social worker also complete patient evaluations after admissions. (Tr. 625.) This information becomes part of the patient's chart and staff members have access to it. (Tr. 93, 624.) The assessments inform clinical care, but, as with the pink sheet, there does not appear to be a process to specifically flag the charts or make staff specifically aware of which patients are at higher risk for contributing to the hazard of patient on staff violence.

After the initial care assessments, employees were to document information about significant patient behaviors, including physical aggression.[14] (Tr. 267-68, 931-32.) Employees can write a "BIRP note," which is a note describing the behavior, the intervention, the response,

[12] If a patient came directly to the facility on their own (i.e., they were a "walk-in"), the "pink sheet" was not used. (Tr. 322-23; Ex. R-2.) Instead, a "clinician" completed a more detailed form titled "Intake Assessment" to see if BGH could offer appropriate care. *Id.*

[13] The House Supervisor indicated that the supervising "charge" nurse is given a "report" about new patients before they arrive in the unit. (Tr. 622.) It is not clear if this "report" differs from the "pink sheet."

[14] Verbally aggressive behavior also "could be" recorded. (Tr. 268, 631.)

and the plan. (Tr. 272-73, 339, 633; Ex. R-8.) BIRP notes were supposed to make the staff aware of what is going on with each patient.[15] (Tr. 339.)

Employees also completed progress notes. (Tr. 272.) If a patient assaulted a staff member, that would be in the progress note, but it does not appear that preventing the hazard of patient on staff violence was the focus of the progress notes. Rather, the House Supervisor explained that the progress notes were about what was important to the patients, their treatment, and when they could be discharged. (Tr. 631.) They were also used to obtain reimbursement from insurance. *Id.* Essentially, the BIRP notes and progress notes were a review of the patient's treatment, what their needs were, and whether those needs have been met. *Id.* They were not about how to prevent or mitigate the hazard.

The degree to which anyone reviewed assessments, BIRP notes, or other progress notes for purposes of assessing whether anything needed to be done relative to staff safety is unclear. BGH submitted blank versions of the forms used for admissions, assessments, BIRP notes, and the night shift reports.[16] (Exs. R-1, R-3, R-5, R-8, R-9, R-11; Tr. 1372.) It did not explain the plan to mitigate the hazard of workplace violence for any patients that had been involved in violent attacks

[15] For events occurring overnight, employees may have used a different form, referred to as a night shift note. (Tr. 632; Ex. R-9.) The House Supervisor indicated that the night shift note would be for the physicians to know "anything over and above, a routine, took-my-my-meds-and-went-to-sleep-night," including if a verbal or physical assault took place during the night. (Tr. 632.) She did not say whether other workers, such as MHTs or RNs, were informed about workplace violence risks that have been raised in the night shift note, or if it was only for physicians. The night shift notes appear to be focused on informing patient care rather than contributing to the abatement of the cited hazard.

[16] Respondent's brief also refers to Exhibit R-4, but that exhibit was withdrawn. (Resp't Br. at 7; Tr. 1372.)

against staff or were considered likely to engage in aggressive behavior.[17] An MHT explained that no one in management ever spoke with him about any of the BIRP notes he submitted. (Tr. 116.) He explained that the type of information that was to be captured in the BIRP note frequently was not conveyed to the MHTs. (Tr. 110.) Sometimes the person in charge of the transition would "blow through" the information, covering all thirty patients very briefly.[18] *Id.*

While the results of the assessments inform patient care, there is no evidence that direct care workers were specifically informed if an assessment or progress note identified a risk of patient on staff violence or described actual violent incidents.[19] Employees had access to the information but were not required to review it. The record does not show that patient files were flagged to alert employees of specific workplace violence risks. There is no evidence that information about workplace violence contained in the progress notes was brought to the attention of the Safety Committee or anyone working in human resources. While some types of incidents were documented elsewhere, for those documented only in the progress notes it did not appear that they were tracked or analyzed so as to reduce or mitigate the hazard.

BGH argued that its admissions and initial care assessment processes were part of its workplace violence prevention program. Ann Hunter, the Director of Risk Management and

[17] Respondent made no requests to file any documents under seal. (Tr. 955.) While the Chief Medical Officer (CMO) discussed the forms used at BGH he did not testify that the documents were effective in reducing the hazard of workplace violence. (Tr. 765-68, 775.)

[18] This MHT worked at BGH for three years. (Tr. 36.) He left in February 2017, after the Citation's issuance. (Tr. 36-37.) He indicated that he left his position because the workplace was "unsafe" and "not professional." (Tr. 37.)

[19] Although the House Supervisor broadly indicated that "everyone" reviewed the progress notes, there did not appear to be a requirement for any particular person to necessarily do so. (Tr. 631.) For example, the CNO indicated that when she was the manager of one of the units, she would review the progress notes if she needed more information than what was provided during the shift change. (Tr. 277-78.)

Performance Improvement (Director of Risk Management) and chair of the Safety Committee, discussed the company's abatement efforts. She did not review admissions documents for patients who acted violently towards employees. (Tr. 1198.) And she was not aware of anyone else reviewing whether the admissions and assessments reports were successfully identifying violent patients. *Id.* The record lacks sufficient information about how any of the documents either prevented or minimized injuries from patient on staff violence. (Tr. 1197-98.) Thus, the record does not establish that the assessments and progress notes adequately abated the cited hazard. (Tr. 764-67, 775.)

c. Clinical Management of Patients

According to BGH's Chief medical officer (CMO), staff regularly review the clinical care provided to patients. If patients exhibit persistent aggressive behaviors, the treatment team meets to determine if additional clinical treatments, such as medication adjustments are needed. (Tr. 748-49.) Aggressive patients can also be transferred to different units or have their level of observation increased, such as by assigning an MHT to continually monitor the patient (called a one-to-one). (Tr. 750-51.) The CMO did not indicate if these meetings also address employee risks or the need for specific precautions directed at protecting employees.

The Secretary does not allege that Respondent failed to follow clinical care guidelines or that inappropriate clinical care contributed to the hazard. Nor does he allege altering the clinical care of patients would materially reduce the hazard. Rather, the Secretary's argument is that despite BGH's efforts at clinically treating patients, the hazard of patient on staff violence remains. (Tr. 37, 175, 184-85, 417-18.) Clinical management of patients has not eliminated or materially reduced the number of incidents. (Tr. 417.) Thus, in the Secretary's view, it is not some failure to clinically treat patients that is at issue, but BGH's failure to adopt feasible abatement methods

to protect employees that violates the general duty clause. (Sec'y Br. at 51, 54.) The undersigned agrees. Even accepting that all clinical care was the best possible, Dr. Lipscomb explained there were several non-clinical abatement measures that could materially reduce the hazard if implemented by BGH. (Tr. 474; Exs. C-4, C-46.) *See Brock v. Gen. Dynamics Land Sys. Div., et al.*, 815 F.2d 1570, 1576-77 (D.C. Cir. 1987) (adherence to other safety standards did not absolve the employer from obligations under the general duty clause).

2. Written Policies on Workplace Violence

BGH appears to acknowledge that clinical care guidelines alone were not enough to protect its employees. It points out that it also had written procedures related to workplace violence. (Resp't Br. at 14.) Both parties agree that written procedures can be part of an effective abatement program for workplace violence. Dr. Lipscomb explained that a written, comprehensive, up to date workplace violence prevention program is a well-established method to address the hazard. (Tr. 458, 460; Ex. C-4 at 10.) She noted that the OSHA Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers (OSHA Guidelines), called for comprehensive written programs, both when they were initially published in 1996 and in the 2015 revision. (Tr. 458-59; Ex. C-4.) Ms. Cooke concurred that it is important to review policies annually and make sure everyone knows what the practices are. (Tr. 1322, 1324.) She agreed it is important for staff to be able to speak to what the policy is and that this allows them to appropriately approach the issue of workplace violence. (Tr. 1324.) In her view, policies can help staff learn and identify whether there is anything more that can be done to abate the hazard. (Tr. 1323.)

While the parties agree on the need for written policies, they disagree on the content and implementation of BGH's policies. Dr. Lipscomb argued that BGH lacked a comprehensive and

coordinated approach to workplace violence prevention. BGH had three written policies as part of its workplace violence program: (1) a policy titled Workplace Violence; (2) a policy titled Management of Aggression; and (3) a policy about calling codes to obtain additional assistance with a patient (called the Code 100 Policy). It argued that that these policies, along with its written training materials and its Employee Accident Reporting Procedure, were adequate to abate the hazard.[20] (Resp't Br. At 14, 17.)

a. Workplace Violence

BGH's written "Workplace Violence" policy focuses on employee-against-employee violence. (Ex. R-12.) It discusses how supervisors should handle violence among co-workers but does not inform non-supervisors how to handle workplace violence. *Id.* Nor does it discuss the company's policy about violent acts committed by patients. (Tr. 434; Ex. R-12.) The fact that the policy was not designed to address patient aggression was confirmed by Ms. Hunter, who oversaw regulatory compliance at BGH. (Tr. 1096, 1099-1100.)

Not only was the scope insufficient, but it also failed to provide supervisors with accurate information. It directs employees to contact the "Security department" in various scenarios and also discusses the role of "Security" in investigating and addressing threats or acts of violence. (Ex. R-12 at 2-3.) However, the facility did not employ any security personnel. (Tr. 166, 204, 355.)

Besides the lack of focus on patient on staff violence, the Secretary also argues that the policy was not effective at abating the hazard because it was not sufficiently communicated or updated. (Sec'y Br. at 28.) Dr. Lipscomb explained that it was customary to review and update

[20] Training and the Employee Accident Reporting Procedure are discussed separately in other sections below

policies in healthcare facilities on an annual basis. (Tr. 431-32.) Respondent argued that it reviewed the policy annually, but it did not provide the date of the last review and the policy itself indicates it had not been updated since 2011. (Tr. 433; Ex. R-12.) More importantly, it does not appear that the policy was well communicated to employees. The Director of Risk Management was not aware of how or even if the Workplace Violence policy was made available to employees. (Tr. 1205.) Ian Hunter, who conducts new employee training, neither used it nor provided it to employees. (Tr. 920-21, 967-70.)

b. Management of Aggression

BGH also had a Management of Aggression policy addressing how staff should approach a patient who may become aggressive. (Ex. R-14; Tr. 1101, 1207.) The policy refers to preventative techniques as well as response procedures for when those techniques fail. (Ex. R-14.) It includes instructions for debriefing, or discussing, and documenting incidents after they occur. *Id.* at 5. As with the Workplace Violence policy, the Management of Aggression policy was not well communicated or implemented. Although the policy was developed in 2003, thirteen years later, at the time of the inspection, the Director of Nursing was not even aware that the facility had a written Management of Aggression policy. (Tr. 347, 1208.) Dr. Lipscomb was "shocked" that the policy had not been updated at all since its implementation fifteen years ago. (Tr. 432, 1208.)

Turning to implementation, the policy calls for a post-incident debriefing of the people involved in aggressive incidents.[21] (Ex. R-14 at 5.) However, the Secretary showed that, in practice, debriefings did not consistently occur. (Tr. 453, 579.) One MHT explained that he was

[21] According to Mr. Hunter, the Management of Aggression policy mirrors the CPI training employees receive. (Tr. 1101; Ex. R-30.) That training is discussed below.

not always debriefed, even when the incident of patient on staff violence was reported or involved a restraint. (Tr. 54-55, 97.) Another employee told the CO that she was never debriefed after an incident required a visit to the emergency room and days off work. (Tr. 197.) And Joel Somers, the MHT Manager, said he never used the debriefing section of the camera review form. (Tr. 1058-60.)

Even when debriefings occurred, their scope was often so limited that Dr. Lipscomb questioned whether they were effective at abating the hazard. (Tr. 453-55.) Employees were not consistently asked what was done correctly or what changes could be made to improve safety. (Ex. C-4 at 11, 26; Tr. 255.) Nor was much attention given to using the information learned. Mr. Somers had been the MHT Manager for ten years and also had the title of "Safety Champion." (Tr. 53, 579-80, 987-89.) As part of his position, he conducted many debriefings and he reviewed video camera footage of incidents of patient against staff violence with employees if they wanted to do so.[22] (Tr. 1006.) He explained that employees "don't necessarily want to see themselves get assaulted" and so reviewing incidents is voluntary. (Tr. 1008.) When he conducted reviews with an injured employee, he collected information on a two-sided form. But he only used one side of the form, the section that focused on the camera review. (Tr. 1047.) He did not address the other questions on the form and he did not share the forms with anyone else to obtain the information sought by these questions. (Tr. 1048, 1059-60.) In his view, the focus of the camera review is whether there was a good response to the incident and the forms document the conclusions the employees themselves reach after reviewing the incident of workplace violence. (Tr. 1044, 1047.) So, in the camera review section of the form, if an employee came in to review the footage, he

[22] Video cameras record events in most, but not all, patient areas of the facility. (Tr. 52, 113, 803, 1007.)

documented whether the employees involved in the incident thought it was handled appropriately and adequately. (Tr. 1043-44, 1047.) The forms include space for suggestions for what could be done in the future to prevent such incidents. (Tr. 1047.) If an employee did not want to review the camera footage, Mr. Somers generally would still look at the video but would not complete the camera review form or any other documentation relating to how the incident could have been handled better or how to prevent the hazard of patient on staff violence. (Tr. 1046-47.) Any information Mr. Somers did collect was filed in his office filing cabinet.[23] (Tr. 1048.) The forms were not reviewed by anyone in human resources or the Safety Committee. They were not reviewed to identify trends or to examine effective or ineffective approaches to workplace violence.[24] Nor were the forms shared with those providing care to the patient involved in the workplace violence incident.

BGH argues that it captured incident information two other ways: (1) through forms filed out after patient restraints; and (2) through a computer reporting system called "MIDAS."[25] (Tr. 255, 655, 1219-20.) First, with respect to the post-restraint forms, Dr. Lipscomb noted that by failing to debrief after incidents that did not involve restraints, BGH missed many opportunities to

[23] Besides the form, Mr. Somers indicated that sometimes he puts notes in a file and sometimes in a book. (Tr. 1041.) There did not seem to be a system in place for whether he used one or the other. (Tr. 1060.) Regardless of how he took notes, they focused on which cameras were used, not what occurred or what changes should be made to protect employees from the hazard. (Tr. 1042, 1057.)

[24] Mr. Somers indicated that he spoke with Ms. Cella, from "loss control" on an approximately weekly basis. (Tr. 988.) BGH did not offer any evidence as to what her role, if anything, was in abating the cited hazard. *See Capeway Roofing Sys., Inc.*, 20 BNA OSHC 1331, 1342-43 (No. 00-1986, 2003) (drawing an inference when two supervisors failed to testify).

[25] Managers also create a short "24-hour report" that has various checkoff boxes to note "issues throughout the hospital," including codes and restraints. (Tr. 634; Ex. R-11.) However, this report is "not for the staff on the units," is not disseminated to front-line workers, and is not tracked or reviewed by the Safety Committee. (Tr. 635.)

learn from the high number of occurrences of patient on staff violence that did not end in a restraint. (Tr. 453.) Further, although technically a requirement, the post-restraint debriefing forms were not consistently filled out. (Tr. 97-98, 453.) One of the charge nurses explained that when people from other units respond to codes, they are not always included in the debriefing. (Tr. 254-55.) She also indicated that the paperwork required that you ask the patient specific questions after a restraint, but there were no specific questions directed toward the staff. (Tr. 255.) Further, if an employee experienced workplace violence but a patient was not restrained during the incident then the debriefing form would not be completed.[26]

Second, as for the MIDAS computer program, the CNO described it as BGH's "vehicle for collecting data around events." (Tr. 674, 1089, 1219-20; Ex. R-58.) She considered it their way of collecting information to allow the company to "pursue quality improvement." (Tr. 1220.) She did not explain what she meant by "quality improvement" and did not clarify whether this information was used to abate the hazard of patient on staff violence or if it served other purposes. *Id.* Ms. Cooke believed that staff were encouraged to go in and report incidents in the program. (Tr. 1316.) She emphasized the need to track and trend the data from the system as an abatement method. (Tr. 1316-17.)

However, BGH did not provide any aggregate information such as the number of entries about patients who committed violence against staff members and which techniques were effective at preventing injuries from violent behavior.[27] Further, the evidence shows that all direct care employees did not use the MIDAS system. Despite working for BGH for several years, one MHT never used the system, even though he had repeatedly experienced violent actions committed by

[26] BGH had a separate Employee Accident Reporting procedure. As discussed more fully below, this too was inadequate.

[27] Ms. Cooke did not review any completed MIDAS entries as part of her assessment. (Tr. 1350.)

patients. (Tr. 109.) Mr. Somers, who trained and supervised all the MHTs, was not aware of any MHTs using or inputting information into the MIDAS system and he explained that it was not required. (Tr. 1022-23.) BGH did not indicate that the information collected through MIDAS was passed on to front-line workers to minimize the hazard.

Moreover, it is not clear how the information collected effectively contributed to abating patient on staff violence. The MIDAS system has a checkbox for staff to specify if the incident related to a physical confrontation. (Ex. R-58 at 3.) The employee entering the information can then indicate if a patient attacked or injured a staff member and describe the event. *Id.* at 4-6. If they take this step, the system permits them to enter information focused on the patient, such as mental state and any injuries the patient incurred. (Tr. 1113-14; Ex. R-58 at 4-6.) It does not have a field that seeks information about the staff member's injury. *Id.* There are fields to input the opinion of patient and his or her family members, but not similar fields for staff.[28] *Id.* There are no fields directing RNs or MHTs to indicate what could have been done better, how to minimize staff injuries, or how to prevent a future incident of patient on staff violence.[29] *Id.*

Accordingly, the undersigned finds the Management of Aggression policy, including its debriefing requirement, was not effectively communicated or implemented as it relates to the cited hazard of patient on staff violence. The Secretary showed that the Management of Aggression policy, neither on its own nor when considered in conjunction with BGH's other actions, was not adequate to abate the hazard. *See SeaWorld*, 748 F.3d at 1215 (finding existing safety procedures inadequate). *Cf. U.S. Postal Serv.*, 21 BNA OSHC 1767, 1774 (No. 04-0316, 2006) (finding that

[28] Ms. Hunter indicated that BGH wanted to inform the patient's family and see if they were angry, upset, or okay with a restraint. (Tr. 1116.) There did not appear to be a desire to gather similar information from the staff's perspective. (Tr. 1116; Ex. R-58.)

[29] There is a field labeled "physician response," but BGH did not provide a screenshot or otherwise explain of the type of information the physician could record in the field. (Ex. R-58 at 6.)

the Secretary failed to show Respondent's abatement was inadequate).

c. Code 100

BGH calls its policy for addressing psychiatric emergencies, "Code 100." (Ex. R-15.) According to the written policy, the charge nurse or his/her delegate can decide that a patient's physically assaultive behavior cannot be controlled by other means and can seek assistance from other employees. *Id.* Per the written policy, to receive assistance to handle the patient's behavior, an employee dials 100, asks the operator to page Code 100, and gives the location of where the assistance is needed. *Id.* The Code 100 policy was developed in 2003 and had not been updated or revised since. (Tr. 1208; Ex. R-15.)

It appears that employees followed a different process than what the written policy describes. (Tr. 1081-82.) First, the code cannot be commenced from any phone in the facility; the phones designated for patient use cannot be used for this. (Tr. 246.) Second, it appears that employees dialed 233, not 100. (Tr. 48, 1027.) Third, dialing 233 did not connect employees to an operator but rather permitted the phone to become like an intercom which would transmit the message through overhead speakers. (Tr. 1027.) Fourth, employees were told they could use walkie talkies to call for assistance, but neither the Code 100 policy nor any other written policy specifically address their use to commence a code. (Tr. 48; Ex. R-15.)

More important than these discrepancies is the difficulty employees had commencing the procedures. Dr. Lipscomb described BGH's approach as "haphazard" and "archaic." (Tr. 441-42.) The units had a limited number of phones, which made it more difficult for the employees to summon help. (Tr. 75.) In the EAC unit, which had patients with high needs, there was only one accessible phone, located at the nurses' station. (Tr. 11, 48-49; Stip. 4.) Other units had two phones. (Tr. 48.) There were no phones in the patient rooms, hallways, or the day rooms where

patients spent a lot of time. (Tr. 235, 372-73, 442.) Nor were there phones in the "quiet room" where agitated patients could go, or, sometimes were sent. (Tr. 50-51.) Acts of patient on staff violence frequently occurred in these areas. (Tr. 75-76, 78, 80, 235-36.) For example, an MHT explained that he would be in the quiet room and say "call code" repeatedly because a patient was behaving aggressively. (Tr. 75-76.) "A lot of times" the RN by the phone could not hear him. (Tr. 76.) This resulted in him being injured. (Tr. 76-77.) Dr. Lipscomb concluded that the phones were not in effective locations to facilitate the Code 100 process. (Tr. 442-43.)

Even if the room had a phone, it could still be difficult to commence a Code 100. (Tr. 133, 442-43, 578.) The social worker described how she, like other social workers at BGH, had to meet with patients alone in the social work offices. (Tr. 133.) She explained that when she met with patients in the office, she frequently was using the phone to try to arrange for care services outside of BGH. *Id.* If a patient suddenly became aggressive there were no panic buttons, cell phones or other alternative methods to summon help if the phone was in use.[30] (Tr. 132-34, 446.)

This was not a theoretical risk. The social worker explained that on December 9, 2016, a patient attacked her. (Tr. 134; Ex. C-54 at 50.) The patient was in the process of being discharged from the facility. As part of that process, the social worker had to be sure that the patient and the individual who was expected to oversee his care after he left the facility understood the situation. *Id.* The patient previously made threats and was aggressive toward other staff members. (Tr. 152.) The social worker requested the presence of an additional staff member at the meeting to prevent or address any harmful behaviors. (Tr. 134-36.) Although this request was initially agreed to, right before the meeting the social worker was told no one was available to be at the meeting with her and the patient. (Tr. 136.) The meeting still occurred. (Tr. 137.) At one point, the patient

[30] Employees are not permitted to carry cell phones when meeting with patients. (Tr. 133.)

lunged at the social worker and hit her in the head, neck, and shoulders multiple times and pulled her hair. (Tr. 137; Ex. C-54.) Someone else commenced a code and the patient was then escorted back to his unit. (Tr. 138.) After the attack, the social worker was treated at an urgent care facility for her injuries and advised to look for symptoms related to concussions. (Tr. 137; Ex. C-54.)

In another instance, the phone itself was weaponized by a patient so it could not be used to commence a Code 100. (Tr. 233.) An RN was at the desk writing notes when an upset patient threw the phone at her, hitting her in the head.[31] *Id.*

BGH argues that the difficulties with using the phone system were not significant because employees could use a walkie talkie to commence a code. (Resp't Br. at 6.) If an employee tried to use a walkie talkie to commence a code, it was not announced through the overhead speakers, like it was when the phone system was used. (Tr. 1027.) Rather, it went only to the other walkie talkies. *Id.* Then someone else could use a phone to commence the Code 100 procedure. (Tr. 48.)

This approach was problematic for several reasons. First, not every employee carried a walkie talkie. (Tr. 352.) MHTs carried them when assigned to work as a "one-to-one" with a particular patient with very high needs. (Tr. 49.) When working as a one-to-one, the MHT was not to leave the patient for "whatever reason" and had to remain within arm's reach of that one particular patient at all times.[32] *Id.* Thus, while these individuals might hear calls for assistance, they were not available to respond to it. The only other time an employee had to have a walkie talkie was when he or she was escorting patients off a unit. (Tr. 353.) In such situations, the employee could not easily respond to codes, as they were already with a patient or patients and

[31] Another employee told the CO about an incident when after being slapped by a patient, he could not access the phone because it was behind the desk on the nurses' station. (Tr. 578.)

[32] Employees were also instructed not to leave patients when they were "escalating." (Ex. R-14 at 3.)

were not on any unit. (Tr. 442-43.) Second, the units often did not have enough walkie talkies. (Tr. 75, 197-98, 234, 374.) This was a routine occurrence. (Tr. 197-98, 558.) Third, even if there were enough devices, frequently they were not charged, unable to hold a charge, or not working for some other reason. (Tr. 51, 234, 579, 594.) According to one RN, she would go to use a walkie talkie only to find it uncharged or inoperable. (Tr. 234.) The units did not have extra batteries to use with the devices if they were not charged. (Tr. 246.)

The problems with the walkie talkies led to situations where codes announced over them were not heard by all employees; only those close enough to a working device. (Tr. 251, 374, 594.) Employees available to respond to a situation sometimes did not hear, and therefore did not respond to, the calls for assistance. *Id.* One employee indicated that, in her view, calling a Code 100 on a walkie talkie could be "pointless because you're speaking to no one." (Tr. 374.) Similarly, another RN described situations where no response to a code was heard and employees were forced to wait and worry if anyone would be coming to assist them. (Tr. 595-96.) Likewise, an MHT explained that there were times when he needed to call a code because of patient violence but was unable to do so because a walkie talkie was not working. (Tr. 75.) Thus, at the time of the Citation the walkie talkies "were not reliable" as a way to initiate or ensure a response to a psychiatric emergency.[33] (Tr. 251, 558.)

In addition to the difficulty with commencing the Code 100 procedure, there also seemed to be some confusion about when it was appropriate to initiate the process. An MHT described an RN refusing his request to commence a code even when a patient was running in the hallway and slamming into walls and doors. (Tr. 79.) Under the written policy, only the RN in charge or her

[33] As discussed below, inadequate staffing may have been exacerbated the technical problems with commencing codes. (Tr. 81, 201.)

delegate could make the decision to use the emergency code, not social workers or MHTs.[34] (Ex. R-15 at 1.) Further, even among management, there seemed to be some disagreement as to the appropriate procedures. Mr. Somers, the MHT Manager, indicated that using the overhead system to commence a Code 100 was discouraged. (Tr. 1027, 1079-80.) Instead, employees could commence a "silent code." *Id.* As he described the practice, an employee could call another unit or the operator who would then "call different units to get help." *Id.* But, he did know not which units the operator would call or how the operator or employees determined which units to call. (Tr. 1080-82.) The Director of Risk Management indicated that it was not her understanding that MHTs and RNs are discouraged from calling overhead codes. (Tr. 1199.) The CNO seemed to be aware of the informal silent code practice but indicated that there was no training regarding "silent codes." (Tr. 1200.) Nor was there evidence of this practice being accurately described in writing.[35] (Tr. 1082-84, 1199-1200.)

Mr. Somers also referred to a "code card system" which he said employees had the option of using to better manage codes. (Tr. 1029-30, 1126.) This process apparently involved handing out cards when employees responded so that individuals would know what role they were being assigned and what actions to take. (Tr. 1029-30.) Mr. Somers said that the cards "should be in the nurses' stations." (Tr. 1030.) However, the record does not support a finding that these code cards were used in a manner relevant to abating the hazard of patient on staff violence. As with some of BGH's other policies and procedures, there seemed to be a disconnect between the programs management said were in place and what occurred on the units. Employees did not

[34] Like the Code 100 policy, the Management of Aggression policy also indicated that employees can notify the charge nurse of the situation and then the charge nurse will decide if a Code 100 will be implemented. (Ex. R-14 at 2.)

[35] The Code 100 policy indicates that a silent code may be called during the 11-7 shift without describing how this is done. (Ex. R-15 at 1.)

discuss using the cards and the record does not include what information was on the cards. Nor is there anything in the written Code 100 policy or any other written policy about how they are to be used. (Ex. R-15.) Mr. Hunter, who was in charge of training about codes, did not discuss training employees about these cards or refer to their use at the facility. (Tr. 921.) Similarly, Ms. Cooke did not mention or discuss code cards in her report or during her testimony. (Ex. R-57.)

The Secretary showed that BGH's Code 100 policy was not an adequate abatement method for the hazard of patient on staff violence. Respondent was not ignorant of the fact that its phone system did not adequately cover all areas of the facility and that additional methods of summoning help were routinely needed. To address this, it required some employees to carry walkie talkies, such as when they accompanied a patient off the unit and when assigned as a one-to-one. (Tr. 443.) However, the devices consistently did not work. This was not a random, occasional failure but a chronic issue that continued unabated even though management was made aware of the issue. (Tr. 197-200.) *See Con Agra,* 11 BNA OSHC at 1145 (employer's abatement failed to free its workplace of the hazard because the abatement method was not reliable).

d. Written Policies Did Not Adequately Abate the Hazard

BGH also presented evidence of forms employees did not use or had not seen before. For instance, Ms. Hunter referred to a peer review form and explained how, in her view, it is used. (Ex. R-59; Tr. 1117.) However, no completed forms for any incident were provided, including for any incident where an employee was injured as a result of patient on staff violence. Further, Mr. Somers, the MHT Manager, was unfamiliar with the form. (Tr. 1033.) Thus, the undersigned relies more on the credible testimony from the MHT about how the forms were used and how information was conveyed as opposed to the blank forms in concluding that BGH failed to adequately abate the cited hazard.

BGH argues it had written policies and its management was committed to addressing the hazard. (Resp't Br. at 14.) It asserts that employees had a voice regarding patient safety, but the this stated willingness to listen did not translate to effective abatement of the hazard during the time alleged in the Citation. While BGH took some action, the Secretary showed BGH's written policies were not adequate at abating the hazard of patient on staff on violence. He identified significant shortcomings in both the scope and implementation of the policies. In Dr. Lipscomb's view, the deficiencies essentially left BGH without a workplace violence prevention program. (Tr. 538.) Therefore, Respondent's claims that its policies were adequate to address the hazard of patient on staff violence are rejected. *See St. Joe Minerals Corp. v. OSHRC*, 647 F.2d 840, 844 (8th Cir. 1981) (finding that although employer took some action to abate the hazard and acted in good faith, it failed to free its workplace of the hazard and thereby violated the general duty clause).

3. Employee Accident Reporting

BGH argues that its written workplace violence policies were augmented by its Employee Accident Reporting Procedure, which permits employees to report accidents and injuries in writing to their supervisor by completing an Employee Accident Report (EAR).[36] (Tr. 677, 1182.) The EARs are discussed by supervisors during "flash" meetings which occur every Monday thru Friday. (Tr. 681, 917.) At the flash meeting, the nurse manager typically gives any completed EARs to the HR Director. (Tr. 681.) Although EARs were the mechanism for BGH to track employee injuries, Ms. Hunter did not review them at any point. (Tr. 1182-83.) Instead, another employee logged the incidents and forwarded copies of the reports to the MHT Manager (Mr.

[36] At the time of the hearing, EARs were no longer being filed out and a new procedure was in place. (Tr. 1068.)

Somers) and Ms. Cella.[37] (Tr. 677-78, 1054; Ex. R-48.)

Two human resources managers acknowledged that it was important to track incidents of workplace violence to make changes or adjustments to how the hazard is handled.[38] (Tr. 679, 889-90.) Dr. Lipscomb agreed, explaining that employers need to look at incidents and find out as much as possible about the surrounding circumstances. (Tr. 450.) She noted the significance of looking at all workplace violence incidents to see if there is "commonality" that can be addressed, such as the units where they are occurring or the time of day. (Tr. 451-52.) But the incident log maintained by a human resource manager did not include any details about the incident's cause or how to prevent future occurrences.[39] (Tr. 678; Ex. R-48.) Despite her role in maintaining the log, she had no formal training in detecting trends and could not think of a specific trend she ever identified. (Tr. 695.)

The Secretary criticizes the limitations on the type of incidents employees were to report, how the reporting was done, and how BGH used the EARs that were completed. (Sec'y Br. at 25, 64-65.) In terms of scope, if the incident involved spitting or verbal assaults, employees generally would not complete an EAR; there were no forms for reporting incidents of workplace violence that did not result in an injury requiring first aid. (Tr. 206-7, 580, 699, 889-90, 906-7, 1172-73; Ex. R-46.) They could, but were not required to, complete EARs if physically injured in an

[37] Ms. Cella did not testify, and it is not clear if she worked for BGH or another company. (Tr. 1084.)

[38] These witnesses, Jillian Collom and Laura Nolet, said they were human resources managers. (Tr. 676, 859.)

[39] Ms. Morley tracked whether the medical treatment was required, the date, time and location of the injury, the employee's job title, their date of hire, and whether the injury was patient-related or due to a restraint. (Tr. 678; Ex. R-48.) The log also had a "comments" field, but it was blank for every entry in 2016. (Ex. R-48.)

incident of patient on staff violence.[40] (Tr. 657, 659, 906.) No one was disciplined for not completing an EAR. (Tr. 698-99.) As noted above, incidents of patient on staff violence were to be noted in the progress report or night shift reports but this was not done consistently. Further, if this information was only in a progress note or night shift report, it would not be tracked by the human resource manager like the incidents for which EARs were completed. (Tr. 699-700.) So, BGH did not have a system of ensuring that all incidents of patient on staff violence were documented or recorded. (Tr. 699, 906.)

In terms of the EARs' content, BGH produced a written document titled "Guidelines for Accident Report Completion and Questions for Investigation" (Guidelines for Accident Reports). But employees, even those involved in multiple incidents of patient on staff violence, had not seen the document before. (Tr. 86, 597.) And, the Director of Risk Management acknowledged the document was not used. (Tr. 1215.) Dr. Lipscomb noted that the EAR form did not solicit adequate information from the injured employee about what could have been done differently, such as how to prevent or minimize the injury that occurred or to prevent re-occurrences.[41] (Tr. 453-54, 465-66.)

Even when concerns were raised, employees described a culture dismissive towards employee safety concerns and injuries. An MHT described how none of the EARs he completed after three different incidents were effectively used to abate the hazard of patient on staff violence.

[40] In the event of patient restraint, and other some other circumstances, BGH required written documentation. But, employee injuries were not required to be put in writing. (Tr. 658-59.) Despite her responsibilities related to injury reporting and tracking, the human resources manager had difficulty explaining BGH's reporting policy. (Tr. 887-96, 901-7.) For example, she was unsure what counsel meant when he asked if reporting was "required" and appeared to be evasive. (Tr. 902.) Based on her demeanor and the record as a whole, the undersigned finds that written reporting for all workplace violence incidents was not required.

[41] The EARs do not include the names, or any other identifying information, of patients involved in incidents that led to an employee injury. (Tr. 212, 699; Ex. C-54.)

During one of the documented events, an MHT observed a patient wandering around a unit after patients were to be in their rooms. (Tr. 59; Ex. C-55.) Another employee started teasing the patient and engaging in horseplay with him. (Tr. 59-60.) This activity caused the patient to become agitated. *Id.* The patient tried to strike the employee who was teasing him but missed and hit another MHT in the face instead. (Tr. 60; Ex. C-55.) The next day, the injured MHT spoke to his supervisor, to express his concerns about returning so quickly to the same unit where he was attacked. (Tr. 61-62.) The supervisor dismissed his concerns and diminished his injury. (Tr. 61-62, 1017.) Later, when the supervisor reviewed the video of the incident with both of the MHTs involved, there was no discussion of how the employee's actions could have contributed to the incident or how avoiding such activity could be helpful in the future.[42] (Tr. 99, 112, 1017.)

The two other incidents described by the MHT also indicate a failure to use the EARs to minimize the hazard of patient on staff violence. In the one instance, a patient was slamming his body against doors and walls. (Tr. 78-79.) The MHT asked several times for a Code 100 to be called. (Tr. 79-80.) The RN declined, indicating that she could handle the situation. (Tr. 79.) Her efforts at calming or redirecting the patient were unsuccessful. The patient continued to keep hitting his body and was bleeding from his head. (Tr. 79-80.) An MHT tried running alongside the patient to de-escalate him and prevent the patient from further injuring himself since the RN refused to call a code. *Id.* At one point the patient turned and slammed his head into the MHT's head, knocking him into a door and causing him to fall over. (Tr. 80-81.) After that, a Code 100 was called but the response was so slow that injured MHT had to continue to assist with the patient

[42] BGH does not offer any evidence that the MHT who provoked the patient was disciplined or spoken to by any other supervisor. (Tr. 1017.) It did not provide any information about whether staff was alerted about how the behavior might have upset the patient or if the patient's care plan was altered as a result of the incident.

despite his own injury. (Tr. 81-82.) Subsequently, during the camera review of the incident, the injured MHT was told that he should have allowed the patient to continue to bang into the walls even though the RN refused his request to call the code and given the delayed response when it was eventually called.[43] (Tr. 85.) No one asked the MHT for input about what could have been done differently or how to address the patient better to prevent the hazard of patient on staff violence in the future. *Id.*

The third incident showed a similar disconnect between the EAR and the hazard of patient on staff violence. A patient punctured an MHT's skin by biting him during a restraint. (Tr. 87-89.) According to the injured MHT, the other employees participating in the restraint were not fully trained and did not have the correct equipment. *Id.* Even though the employee knew that the improper restraint led to his injury, no one from management discussed the incident with him or asked about how to prevent another employee from being injured the same way.[44] (Tr. 89.)

Further, the record does not include evidence of adequate information gathering about incidents of patient on staff violence through other means. (Tr. 453-54.) The charge nurse explained that she did not have access to EARs and noted that they were not on the unit, so she could not assist employees with completing them. (Tr. 257.) Mr. Somers explained that he took the EARs that were forwarded to him and would attempt to contact the injured employee. (Tr. 1046.) If the employee wanted to review available camera footage of the incident, he would do that with him or her and then simply filed the EAR along with a partially completed camera review

[43] BGH's Management of Aggression policy advises a similar response to patient behavior as what the MHT did. (Ex. R-14 at 4.) The policy suggests telling a patient: "It is okay to pace the hall and I will walk with you." *Id*.

[44] Another employee told the CO that after she was bitten on the neck and had to go to the emergency room, no one ever asked for input about the incident or asked what could have been done differently. (Tr. 196-97; Ex. C-40.)

form in his office.[45] (Tr. 1046-48.) He did not usually take notes on the videos, other than which camera was being used and the date. (Tr. 1042, 1057.) If the employee declined to view the video or did not respond to the request, Mr. Somers would review the footage and then just file the EAR in his office. (Tr. 1047-48.) The documents remained there until they were shipped off site for storage.[46] (Tr. 1048.)

Mr. Somers indicated that the EARs usually described the incident, but the copies of EARs produced included few details. (Exs. C-54, C-55, C-56.) The forms did not ask any questions about what actions should be taken in the future to minimize subsequent injuries (either from the same patient or in general). *Id.* Nor did Mr. Sommer's discuss whether he evaluated what actions could have been done differently or if any additional precautions were necessary for purposes of employee safety. He seemed to do little with the information other than note the number of incidents and specify the camera that provided the footage. The EARs were not brought to Safety Committee meetings and the Director of Risk Management did not see them. (Tr. 1183-85.)

Dr. Lipscomb noted the lack of follow up on staff suggestions and indicated that employees did not feel safe about speaking up. (Tr. 454.) Having reviewed multiple behavioral health clinical settings, she viewed BGH's culture as interfering with the ability to undertake sufficient post-incident debriefing to address the hazard of workplace violence. (Tr. 454-55, 579-80.) In addition to the deficiencies in the scope of the reports, BGH also failed to respond to the information it did

[45] As discussed above, Mr. Somers did not address all of the questions on the form. (Tr. 1048, 1059-60.)

[46] For a two-month period in 2016, a human resources manager handled the follow up on the EARs instead of Mr. Somers. (Tr. 684.) She indicated that she would contact the injured employee to discuss what happened and if it could have been done differently. (Tr. 684-85.) If the employee did not return her call, she did not indicate any other actions taken to gather this information, such as reviewing the footage herself or interviewing employees who were not injured but witnessed the event.

gather. The EARs did not include any names or information identifying the patient responsible for the injury. (Tr. 466.) Dr. Lipscomb argued that this made it more difficult to use the EAR to change patient care plans. *Id.* It also made it less likely that trends or commonality could be identified or addressed. (Tr. 459-60.) While BGH claimed that it used the EARs to follow up on incidents and make changes to reduce the hazard of patient on staff violence, it did not refute the employees' testimony about multiple incidents for which the follow up was lacking. Despite BGH's claims that it tracked employee injuries and debriefed employees, BGH did not provide examples of actions taken as a result of any EAR related to patient on staff violence. Similarly, Ms. Cooke could not recall any "actual steps" BGH took before OSHA commenced its investigation to attempt to reduce the frequency of patient on employee violence. (Tr. 1339.)

As implemented, BGH's policies and procedures regarding the reporting of employee injuries resulting from violent attacks by patients were not adequate to abate the hazard. The forms did not solicit information about what could have been done differently or how to minimize risks in the future. Even the information that was provided appeared to have had little impact. Regardless of whether employees thought a response to an incident was good or bad, there is not much evidence of the information being used in a way to minimize the hazard. Accordingly, BGH's Employee Accident Reporting procedure did not effectively abate the hazard of patient on staff violence.[47]

[47] Although not discussed in Respondent's Brief, some witnesses referred to an annual staff survey. (Tr. 877, 1105.) The record does not include any of the actual survey questions or responses. (Tr. 526.) *See Capeway*, 20 BNA OSHC at 1342-43 (party would have produced evidence if it had been favorable). Ms. Cooke said that the survey did not include any questions about workplace violence; nor did it include the phrase "patient violence." (Tr. 1217.) The record does not support a finding that the annual survey contributed to the abatement of the cited hazard.

4. Management Committees

BGH's Quality Council and Safety Committee both reviewed incidents of workplace violence. (Tr. 201, 680, 1143; Ex. R-55.) The Quality Council is BGH's performance improvement committee. (Tr. 1106-7, 1143.) It is unclear how frequently the Quality Council met, and it did not discuss patient aggression "to the same depth" as the Safety Committee. (Tr. 1143.) The Safety Committee meets monthly and reviews things such as trends and specific data related to tracking patient aggression. (Tr. 354, 1108, 1122.) Ms. Hunter co-chaired the Safety Committee, along with overseeing the "patient safety program" and "regulatory compliance." (Tr. 1096, 1177.) However, when the CO asked her about the Safety Committee's meetings, she only indicated that the committee "had meetings." (Tr. 202.) She did not know how frequently it met and BGH did not provide the dates of any committee meetings.[48] *Id.*

Dr. Lipscomb viewed a safety committee with input from front-line workers as a "critically important" abatement measure. (Tr. 435.) Such safety committees are the "primary forum" for behavioral health hospitals to bring together everyone's expertise to look at a workplace hazard and develop strategies specific to the facility to reduce the hazard of workplace violence. *Id.* She emphasized the importance of having front-line staff engagement about abating the hazard of patient on staff violence. (Tr. 435-38.) Direct care staff "are the most knowledgeable about what

[48] BGH also argued that the flash meetings were about safety. (Resp't Br. at 14.) When asked about the safety meetings she attends, the CNO only cited the Safety Committee meetings. (Tr. 265.) She was then asked specifically about the flash meetings and did not refer to safety when asked to describe the purpose of those meetings. *Id.* After further prompting, she indicated that employee injuries would be brought up at those meetings. *Id.* Similarly, when the CMO was asked on direct about the flash meetings, he described them as focused on clinical issues. (Tr. 758.) And then, when counsel asked if an incident such as staff member being injured by a patient would be discussed, he agreed that was the case. *Id.* Codes might be discussed, depending on the situation. (Tr. 758-59.) The record suggests that while injuries were noted during the flash meetings, employee safety was not the focus of those meetings.

goes on over the course of their shift," and they have the most expertise "at managing the direct care of patients." (Tr. 426.)

Ms. Hunter did not disagree. She recognized that front-line MHTs and RNs often have the most detailed information about what happened leading up to and during an incident of patient on staff violence. (Tr. 1185-87.) And, she agreed that front-line workers could have the most valuable information in terms of preventing similar incidents in the future. *Id.* Ms. Cooke concurred that including front-line workers was a "good practice" that could be helpful.[49] (Tr. 1335.)

But, when the Citation was issued, the Quality Council and Safety Committee both consisted only of management employees. (Tr. 241.) Front-line workers actively sought participation on the Safety Committee. RNs asked for a presence on the committee and also requested that the facility would hold a safety meeting within twenty-four hours of an incident of patient on staff violence. *Id.* Both requests were rejected by BGH management. *Id.* At the hearing, an RN expressed the belief that BGH's management was not "interested in what the front-line staff thinks." *Id.* Dr. Lipscomb could not understand why a company would deny the request of a front-line employee at a behavioral health hospital to be on a safety committee. (Tr. 436.)

Neither the Safety Committee nor Quality Council obtained much input from front-line employees through other means. Ms. Hunter suggested that the Safety Committee reviewed information from the MIDAS database. (Tr. 1220-21.) But, MHTs did not input information to that database, so any records pulled from it would not reflect their direct input.[50] (Tr. 1022-23.) BGH provided screenshots of the type of information that could be inputted into the MIDAS

[49] Ms. Cooke went on to indicate that there were "other channels" for staff to report concerns. (Tr. 1335-36.) The undersigned credits the testimony of Dr. Lipscomb and the employees about the insufficiency of these channels over Ms. Cooke's assessment.

[50] The majority of the time, nurse managers enter information to the MIDAS database. (Tr. 1023, 1116.)

database, but did not offer completed records or aggregate information. (Ex. R-58.) It did not provide any specific information about how the database was used to abate the hazard. The record contains no information about a situation where information in the MIDAS database was used to evaluate a potential risk of workplace violence or how the information in the database led to the prevention of workplace violence. The MIDAS database may well play a role in clinical outcomes, but it was not established that it effectively abated the hazard of patient on staff violence.

Further, although BGH sometimes gathered information directly from MHTs about workplace violence incidents through the camera review forms, neither the Safety Committee nor the Quality Council looked at them.[51] Neither committee reviewed the actual EARs employees had the option to complete after incidents.[52] (Tr. 466, 1182-83; Ex. R-55.) The reports were never brought to meetings and the chair did not review them outside of the meetings.[53] (Tr. 695, 1183.) This approach led Dr. Lipscomb to question whether the Safety Committee was functioning in a way that could address staff safety. (Tr. 466.)

Ms. Hunter indicated that aggregate data about employee injuries and workplace violence incidents were discussed during committee meetings. (Tr. 109-98.) But no committee agendas,

[51] Mr. Somers helped employee fill these forms out. (Tr. 1044.) But he did not bring the forms to Safety Committee meetings or pass them on to other committee members. (Tr. 1044-45, 1215.)

[52] A human resources manager gave copies of the EARs to Mr. Sommers and Ms. Cella. Ms. Cella did not testify and no else explained what she did with the information gathered. (Tr. 684, 693-94.) A log of the EARs was brought to the Safety Committee meetings, but it did not contain any information about how to prevent the hazard of patient on staff violence. (Tr. 695; Ex. R-48.) Further, although the human resources manager said she looked for trends, she had no experience in workplace violence prevention, no formal training in detecting trends, and could not think of any specific trend she identified. (Tr. 695, 697.)

[53] At the hearing, Respondent's counsel asked the CO whether she was "aware that Brooke Glen reviews the EARS" during the Safety Committee meetings. (Tr. 848.) Ms. Hunter, who chaired the Safety Committee, and Mr. Somers, who was a member, both acknowledged that the EARs themselves were not brought to the committee meetings. (Tr. 695, 1183.)

minutes, or other summaries of the committee's work were provided.[54] (Tr. 202-3, 438, 1220-21.) Members of the Safety Committee and Quality Council did receive monthly and annual reports with various statistics on metrics that could have some bearing on workplace violence.[55] (Tr. 1123, 1140-43; Ex. R-55.) These reports focus on the number of restraints, patient hold rates, and the seclusion of patients. (Tr. 1140-43; Ex. R-55.) They do not include the number of OSHA recordable injuries, the number of employee injuries, the number of EARs, or the number of incidents of patient on staff violence. (Ex. R-55.) Nor do the reports include information on patient on staff violence that did not result in injuries, such as information from the debriefings that were supposed to occur. *Id.* They contain no discussion or analysis of patient on staff violence, like what worked and what did not.[56] *Id.* Dr. Lipscomb explained how the data included in the monthly report was not a sufficient proxy for information directly related to the hazard of patient on staff violence. (Tr. 453; Ex. R-55.) For example, while restraint rates may bear on the risk of workplace violence, many staff injuries result from situations unrelated to a restraint. *Id.*

BGH also alleges that employees could raise safety concerns during town hall meetings

[54] Ms. Hunter indicated that minutes were kept and that she reviewed them in connection with this litigation but did not turn them over to the CO or during the litigation discovery process. (Tr. 202-3, 1220-21.) She claimed, without explanation by her or counsel, that the minutes had "patient safety work product." (Tr. 1221.) BGH did not move to file any documents under seal or in a redacted format. The undersigned notes that, according to BGH, the EARs for workplace violence incidents do not contain patient information. (Tr. 699.) Since the committees did not even review the EARs, it is difficult to accept Ms. Hunter's rationale for not providing dates or agendas from any of the meetings that she indicated addressed workplace violence. When one party has evidence but does not present it, the court may conclude that the evidence, if it had been presented, would not have helped that party's case. *Capeway*, 20 BNA OSHC at 1342-43.

[55] At the hearing, Ms. Hunter discussed Exhibit R-54, a report provided to the Quality Council and Safety Committee, in detail. (Tr. 1121, 1123-35.) However, after an objection from the Secretary Exhibit R-54 was not offered for admission. (Tr. 1136-1140.)

[56] The report only includes charts with the rates of certain occurrences, such as the number of restraints and the number of times contraband is found. (Tr. 1141-42; Ex. R-55.)

and through suggestion boxes.[57] (Tr. 878.) As with the committee meetings, BGH provided no agendas, minutes, summaries of what occurred or other supportive information showing how the hazard of patient on staff violence was addressed at a town hall meeting. It did not sufficiently describe efforts to facilitate attendance. It did not give the date of when any town hall meetings occurred, and witnesses gave differing accounts of their frequency.[58] BGH did not identify any action it took to address a hazard as a result of a concern raised at such a meeting. (Tr. 226, 596, 1339.)

In terms of the suggestion boxes, a human resources manager went through the written suggestions placed in the boxes on a monthly basis. (Tr. 878, 880.) She said that there were "maybe hundreds" of suggestions but had difficulty indicating what any of the suggestions related to. (Tr. 880-82.) The record lacks evidence about the content of any of the suggestions and there are no examples of any safety suggestion or concern BGH acted upon. (Tr. 271, 690, 880, 882.) So, the record does not support BGH's assertion the suggestion boxes had a material impact on abating the hazard.

Dr. Lipscomb opined that BGH had a "culture of … being dismissive about what workers are suggesting and their experience." (Tr. 454-55.) An example of this is shown by the MHT's testimony that "widespread" complaints about staffing not being adequate for safety were made

[57] As noted above, BGH also had flash meetings but these did not involve direct care workers, only "upper management." (Tr. 355, 746, 758.) The CMO did not know if minutes of these meetings were taken and none were introduced into the record. (Tr. 781-82.)

[58] A human resources manager indicated that there was "no set schedule" for the town hall meetings but said they "typically" occurred about once a quarter. (Tr. 878.) She could not recall the dates of any town hall meetings that occurred in 2016 before the Citation was issued and was not certain that there were any. (Tr. 879.) There was also some confusion about the time of day any of the town hall meetings occurred. A human resources manager said that town halls were typically duplicated so each shift could attend, but Mr. Somers indicated that the town hall meetings were held only offered once, at 3:00 p.m. (Tr. 877, 1020.)

but it did not matter to management. (Tr. 372.) Likewise, complaints about the ineffectiveness of walkie talkies went largely unaddressed during the time referenced in the Citation. (Tr. 374.)

BGH does not suggest that including front-line staff is not feasible or helpful. Its expert agreed that having non-management employees participate in safety committees could be helpful in reducing the hazard and was an industry best practice. (Tr. 1335-36.) And, after the Citation, BGH changed the committee structure. (Tr. 374-75.) An MHT explained that she was able to attend some meetings about safety starting in 2017 and that this allowed her to participate in discussions about improving the methods for summoning help. (Tr. 374, 382-83.)

BGH's Safety Committee and Quality Council's actions were not adequate to materially reduce the hazard of patient on staff violence because: (1) when the Citation was issued, the committees lacked sufficient input from front-line workers; (2) the committees failed to gather and review sufficient information related to the hazard; and (3) the lack of supporting evidence addressing what was discussed and the actions related to workplace violence that were taken as result of the meetings.

5. Training

BGH alleges its training program effectively addressed the hazard of patient on staff violence by teaching new employees about patient behaviors and how to respond to them and through describing the daily routine, including how to conduct patient rounds, complete paperwork, and perform restrictive interventions. (Tr. 920-21; Resp't Br. at 15.) BGH trains employees about the Code 100 process and how to handle situations in which they feel physically threatened. (Tr. 921-25; Exs. R-30, R-31, R-32.)

Besides the training, RNs and MHTs also take "annual competencies."[59] (Tr. 1229.) Ms. Hunter indicated a PowerPoint presentation (Exhibit R-27) on workplace violence was presented to RNs and MHTs. (Tr. 1229-30.)

Dr. Lipscomb was aware of Exhibit R-27. While she did not criticize the information in it, she explained that training involves more than just handing people a PowerPoint presentation. (Tr. 545.) And yet, there is little evidence about how the slides were used prior to the issuance of the Citation. Ms. Cooke's expert report does not discuss the PowerPoint. (Ex. R-57 at 2.) Although Ms. Hunter said it was part of annual training for RNs and MHTs, neither she nor any of the other witnesses said that they trained employees on the slides or indicated who provided such training. (Tr. 860-61, 970, 1230.) BGH did not explain when the annual training started or even if it occurred in 2016, or at any other time before the Citation was issued. In fact, BGH did not provide any of the dates of training and the document itself is not dated. (Ex. R-27.) No one detailed how the document was used. No one said they received a copy of it. No one described how or if it was made available to employees.[60]

Mr. Hunter, who conducts training for new employees and went through it himself, explained that he did not use Exhibit R-27 or the term "workplace violence" in the training he gave

[59] The charge nurse indicated that employees are supposed to be annually trained on patient de-escalation practices through a program called CPI. (Tr. 244.) However, in the period referenced in the Citation, the training was abbreviated for at least one employee because of short staffing. (Tr. 245.)

[60] Respondent's counsel repeatedly asked the CO about whether she was aware that employees were trained on the specifics in the PowerPoint and whether she could recall various details of it. The Secretary's counsel objected to the suggestion that the CO had firsthand knowledge of any training at BGH. (Tr. 828, 830, 832, 834-50.) While the CO recognized Exhibit R-27, she did not recall anything in it and did not know if employees were trained "specifically" on it. (Tr. 827-832, 840.)

other employees.[61] (Tr. 920-21, 967-70.) Nor did the training documents he utilized discuss "workplace violence." (Tr. 968-69; Ex. R-43.) When asked if in his eight years at BGH he received any training that used the term workplace violence, he initially indicated that he had "seen a PowerPoint" but could not recall when or in what context that occurred. (Tr. 970-71.) It was not something he covered in orientations or that was addressed in his own orientation. (Tr. 969-70.) Even though BGH says it was part of annual training, Mr. Hunter had trouble recalling if he had seen something on workplace violence in the last year. (Tr. 972.) Upon subsequent questioning, he believed he saw a PowerPoint on the topic in the fall of 2017, after the Citation was issued. (Tr. 973.) Based on his tone and overall demeanor, the undersigned finds that Mr. Hunter did not establish that he was trained on the PowerPoint slides that comprise Exhibit 27 prior to the issuance of the Citation or that all employees received such training before OSHA commenced its investigation. Much like BGH's Guidelines for Accident Reports, Exhibit 27 appears to be a document that the Director of Risk Management found, as opposed to supportive evidence of effective training on workplace violence.

Dr. Lipscomb explained the importance of training as a way to abate the cited hazard. (Tr. 460.) The MHT provided a practical example of how training shortfalls can contribute to injuries. He was bitten during a restraint because the other MHTs that responded to code did not have sufficient training and made an error. (Tr. 87-88.) The error permitted the patient to bite the MHT, taking "a nice chunk out" of his gloved hand. (Tr. 89.) The Secretary established that neither BGH's training program nor the other abatement measures it had in place adequately abated the hazard of patient on staff violence. *See SeaWorld,* 748 F.3d at 1215.

[61] Ms. Nolet, a human resources manager, indicated that Exhibit R-27 was also used for new hire training and for other staff on an annual basis but did not say who did this training as it was not Mr. Hunter. (Tr. 860, 969.)

C. Feasible Abatement Measures That Would Materially Reduce the Hazard Exist

Having shown that BGH's workplace violence program failed to adequately address the hazard, we turn to whether the Secretary showed there were feasible steps BGH could have taken to materially reduce the hazard. BGH insists there are no such measures. (Resp't Br. at 17.) In her expert report, Ms. Cooke discusses the abatement methods set out in the Citation. (Ex. R-57 at 5-12.) She largely concludes that the proposed abatement measures were already in place or were unnecessary. *Id.* However, the record lacks support for all of the factual statements underpinning her opinion.[62] Further, she did not offer an opinion that any of the proposed methods of abatement discussed at the hearing were technologically infeasible or would not materially reduce the hazard.[63] (Ex. R-57 at 5-12; Tr. 1328.)

In contrast, Dr. Lipscomb argued that there were a number of feasible abatement measures that BGH "could and should have been doing to materially reduce the hazard." (Tr. 421.) The Secretary argues that feasible methods of abatement include: (a) performing a comprehensive evaluation of workplace violence at the facility and developing appropriate policies based upon the evaluation; (b) ensuring that units have appropriate levels of staff given the acuity of the workplace violence hazard; (c) improving procedures for summoning assistance when patients become agitated or violent; (d) improving how incidents of workplace violence are documented and how employees are debriefed after such incidents; (e) having a safety committee obtain input

[62] The undersigned notes that if the record showed that BGH had the program it described to Ms. Cooke, it would have been more difficult for the Secretary to meet his burden of showing that its abatement was inadequate.

[63] As noted above Ms. Cooke argued that a buddy system was not fiscally feasible. (Tr. 1328; Ex. R-57 at 11.) But, BGH indicated that it trained new employees about and encouraged the use of a buddy system as a way to address violence at the facility. (Tr. 927.)

about the hazard from front-line staff; and (f) training.[64] (Sec'y Br. at 54-68.) The Secretary concedes that taking these steps would not free the workplace from the hazard. *Id.* at 68-69. Still, it argues that implementing these measures will materially reduce the hazard by addressing the deficiencies in BGH's existing program. *See Babcock*, 622 F.2d at 1165 (affirming finding of liability when the company failed to take feasible precautions to reduce the risk of injury).

1. Comprehensive Hazard Evaluation

The Citation indicates that it would be feasible for BGH to evaluate and modify its policies related to workplace violence. Specifically, BGH could evaluate and then modify its Management of Aggression policy and Workplace Violence policy to include:

> a. i. Clear written description of how to report incidents of workplace violence, including intimidation and verbal abuse. Provide guidelines on when to call police.
> ii. A clear written statement that employees will not experience retaliation for reporting incidents of threats or violence or for calling police.
> iii. Information on how and where employees affected by [workplace violence] can seek emotional support and mental health care including after hours.

[64] The Secretary did not specifically address the abatement measures set out in sub-sections (b)(iv) and (b)(v) of the Citation. One of these measures called for BGH to evaluate "the need and appropriateness of devices affected employees can use to protect themselves during a crisis such as but not limited to blocking pads." Dr. Lipscomb did not address this method. Ms. Cooke's report argued that BGH already had undertaken such an evaluation. (Ex. R-57 at 9-10.) The undersigned finds that the Secretary failed to establish that the further evaluation called for by (b)(iv) would materially reduce the hazard. The other measure (described in (b)(v)) called for BGH to ensure affected employees utilize a buddy system while providing services to patients with a history of violence. The Secretary raised issues with employees being left alone but did not specifically discuss a buddy system. (Sec'y Br. at 9, 35-36, 57, 62.) BGH trained new employees about and encouraged the use of a buddy system. (Tr. 927.) While the Secretary showed that BGH lacked sufficient controls to ensure that staffing levels addressed acute workplace violence risks, the Secretary did not show that BGH needed to take additional steps beyond its existing buddy system.

BGH also could perform "a workplace hazard assessment of the units."[65] After an updated workplace violence prevention program is in place, abatement could include engaging employees in an annual review of the program to update it with "steps taken in response to any workplace violence incidents."[66]

In her report, Ms. Cooke indicates that BGH already implemented these abatement measures. (Ex. R-57 at 5-6, 9, 12.) But the record compels a different conclusion. First, in discussing possible abatement method (a)(i), the report incorrectly indicates that staff leaders "insist" on employees completing an EARs "even if there is no injury and treatment is not required." *Id.* at 5. EARs are only encouraged. (Tr. 580, 657, 889.) In addition, the report indicates that: "Staff are expected to document in the Observation Round sheets if patients display acts of aggression including verbal threats." (Ex. R-57 at 5.) No completed Observation Round sheets were offered for admission and no witness described what information had been included on such sheets for specific incidents of patient on staff violence. (Tr. 286-90, 629-30.) The form itself allows someone to check a box if the patient has already been placed on precautions for

[65] The Citation sets forth this abatement method in section (b)(iii) in the Citation:

> Develop workplace violence controls, including implementation of the following engineering and administrative controls and methods used to prevent potential workplace violence incidents. These controls and methods should include the following: … (iii) Perform a workplace hazard assessment of the units, especially Close Observations and C1 to ensure nurses stations are secure. Evaluate the configuration of the nurses station desk, including the height and depth, to prevent patients from jumping over the desk and assaulting staff members. Ensure all items that could be used as weapons are secured or removed from the nurses station desk and other areas accessible to patients.

[66] This abatement method is set forth as (e) in the Citation and states:

> Annually review the workplace violence prevention program, including updating the program as necessary. Such review and updates should set forth any mitigating steps taken in response to any workplace violence incidents. Solicit and include employee input in the review.

"aggression" or "homicide," but is not an assessment to determine if such precautions are needed. (Ex. R-6.) Rather, there are 12 activities or behaviors staff can check off as having observed. *Id*. The activities include yelling, pacing, and disruptiveness, as well as benign behaviors such as sitting. *Id.* There is not a category of "aggression" or "verbal threats." *Id.* Nor does the form include the word "violence" or specifically refer to behaviors that might injure staff. *Id.*

Second, in discussing possible abatement method (a)(ii), Ms. Cooke appeared to believe that staff at BGH were comfortable discussing safety concerns with their supervisor and that employees felt supervisors address their concerns. (Ex. R-57 at 5.) At the hearing and in their conversations with the CO, the employees described markedly different experiences that were not consistent with Ms. Cooke's conclusion. (Tr. 37, 60-61, 454-55; Exs. C-40, C-42.) For example, an RN told the CO how no action is taken even when a patient is a known "biter." (Ex. C-40 at 2.) Another employee explained that supervisors did not respond to issues with the walkie talkies. (Exs. C-42 at 2.)

Third, as for proposed abatement method (a)(iii), Ms. Cooke's report states: "There are times when a staff person may need to move to work on another unit temporarily due to not feeling safe with a particular patient." (Ex. R-57 at 6.) No witness described a set practice for this and BGH did not identify any written policy consistent with it. Further, the social worker said that when she returned to work after a violent attack she was still assigned to work alone directly with her attacker. (Tr. 138.) Dr. Lipscomb explained that in her opinion "the last thing you want to do post incident is to send someone who has been traumatized by an interaction with a patient back to the same unit to work with those patients." (Tr. 452.) Even after the attack, it took another threat from the same patient before the social worker consistently had help in meetings with him.

(Tr. 138-40.) She was never removed from the case or the unit.[67] (Tr. 139-40.)

Ms. Cooke's report goes on to indicate that employees have access to referral services, but the social worker described the difficulty she had accessing these services. (Tr. 141-43; Ex. R-57 at 6.) Dr. Lipscomb explained the need for mental and emotional care after workplace violence incidents. (Tr. 452-53.) Ms. Cooke's report also states that: "Supervisors will perform debriefing with staff to learn why the injury occurred and what could have been done differently to prevent it." (Ex. R. 57 at 6.) As discussed above, everyone involved in an incident of workplace violence was not consistently debriefed. (Tr. 97, 255,453-54, 579-80; Exs. C-4 at 25-26; R-58.)

Fourth, with respect to workplace hazard assessment called for in section (b)(iii) of the Citation, Ms. Cooke had not performed such an assessment. (Tr. 1330-31.) However, she agreed that this type of assessment is advisable for facilities. (Tr. 1338.) Dr. Lipscomb concurred, arguing that it was an important engineering control for the cited hazard. (Tr. 439-40, 448-50.) In addition to being advisable, both experts viewed such an assessment as technologically and economically feasible. (Tr. 421-24, 1328.)

Fifth, as for the annual review of the workplace violence program described in section (e) of the Citation, Ms. Cooke's report says that BGH "reviews and updates policies/protocols related to [workplace violence] routinely as opposed to just on an annual basis." (Ex. R-57 at 12; Tr. 1322.) At the hearing, she explained that because the "hazard of aggression is constant," employers should "certainly" look at their policies annually to make sure they are up to date. (Tr. 1322.) However, the policies that made up BGH's program at the time of the Citation had not been updated in several years and BGH did not provide any of the dates of its reviews. (Exs. R-

[67] An MHT also described being assigned to work on the same unit a day after he was attacked there. (Tr. 61-62.)

12, R-14, R-15.) Key policies did not accurately describe current procedures. For instance, the Code 100 policy had not been revised in 13 years and did not set forth the procedures staff actually follow. (Ex. R-15; Tr. 48, 246, 1027). And, the Workplace Violence policy, which was last revised in 2011, states that employees should call "Security" but BGH had no such department. (Ex. R-12 at 3; Tr. 166, 204.) Dr. Lipscomb testified that policies are very common in healthcare and that they should be reviewed and updated annually, at a minimum. (Tr. 431-32.) She described being "quite shocked" at the length of time that had passed without some of the policies being updated. (Tr. 431-33.) So, the record does not support a finding that the written policies which made up BGH's workplace violence program were regularly reviewed and revised. (Tr. 432, 460.)

The Secretary established that at the time of the Citation's issuance BGH had not appropriately evaluated the hazard or implemented a comprehensive workplace violence program to address it.[68] As such, he proposes that BGH look at its existing program and identify what is not working and evaluate whether there is anything on the available "menu" of abatement options that will materially reduce the hazard. *See Pepperidge Farm Inc.*, 17 BNA OSHC 1993, 2033-344 (No. 89-0265, 1997) (finding that a feasible method of abatement can include a process approach to identify suitable measures).

Dr. Lipscomb explained the importance of a facility examining its own experience with the hazard of patient on staff violence to understand the nature of the problem and whether the actions being taken are sufficiently responsive. (Tr. 460, 462.) In her opinion, this administrative control was feasible and effective at reducing the hazard. (Tr. 423.)

[68] At the time of the hearing, BGH was in the process of developing a single written document that would encompass its workplace violence prevention program. (Tr. 1084.)

Research supports Dr. Lipscomb's opinion that the evaluation process minimizes the hazard of workplace violence.[69] (Tr. 460-62, 469, 565; Exs. C-45, C-46, C-48.) One study involved six mental health care facilities. (Tr. 473; Ex. C-46.) Three "intervention facilities" undertook an evaluation process and then implemented a comprehensive workplace violence programs based on the OSHA workplace violence guidelines. (Tr. 473.) The programs were "built on genuine employee engagement and … based on a hard look at the data." (Tr. 474.) The study concluded that the evaluation-based approach was feasible and had a positive impact on reducing workplace violence. (Tr. 473-74.)

A second study showed, after a randomized, clinically-controlled test, that this type of process-based approach reduced workplace violence in healthcare facilities. (Tr. 460-61, 469; Ex. C-45.) Forty healthcare facilities at high risk were monitored for a two-year period. (Ex. C-45.) Half the units were "intervention units" that engaged in a process to identify weak areas and effective abatement. (Tr. 461, 492.) The facilities in the intervention group "looked at the incidents that were occurring in their units" and working as a team management and direct care workers selected abatement measures relevant to the facility's particular issues. (Tr. 474, 485; Ex. C-45, C-48.) They tracked incidents and evaluated the impact of the interventions, beyond what the facilities had been doing to clinically care for their patients. (Tr. 474, 485-87; Ex. C-45.)

[69] Five research papers on workplace violence in the healthcare setting were admitted into the record: (1) Judith E. Arnetz, Lydia Hamblin et al., *Preventing Patient to Worker Violence in Hospitals: Outcome of a Randomized Controlled Intervention*, 59 Am. C. of Occupational and Envtl. Med. 18 (2017); (2) Jane Lipscomb, et al. *Violence Prevention in the Mental Health Setting, The New York State Experience*, 38 Canadian J. of Nursing Res. 97 (2006); (3) Vincent S. Staggs, *Trends, Victims and Injurious Patient Assaults on Adult, Geriatric, and Child/Adolescent Psychiatric Units in US Hospitals*, 2007-2013, 38 Res. in Nursing & Health, 116 (2015); (4) Lydia E. Hamblin, Judith E. Arnetz, *et al.*, *Worksite Walkthrough Intervention*, 59 Am. C. of Occupational and Envtl. Med. 875 (2017); (5) Kathleen M. McPaul, Jane Lipscomb, *et al.*, *Environmental Evaluation for Workplace Violence in Healthcare and Social Services*, 39 J. of Safety Res. 237 (2008). (Exs. C-45, C-46, C-47, C-48, C-49.)

While the intervention units still saw incidents of workplace violence, they had a 60% reduction in staff assaults relative to the control units. (Tr. 461, 469, 487-88; Ex. C-45 at 6, 9; Sec'y Reply Br. at 1-2.) Dr. Lipscomb explained that because of the control units, the study demonstrates that the approach had a statistically significant impact on workplace violence. (Tr. 469-70, 487-88.) While the study was published in January 2017, the interventions tracked the OSHA Guidelines on workplace violence which had been available for many years. (Ex. C-45 at 8.)

BGH argues that a "one size[d] fits all approach will not work" to materially reduce the hazard. (Resp't Br. at 22.) Despite this recognition, it suggests it cannot evaluate what interventions would be successful. And yet, its own expert acknowledged that conducting a comprehensive risk assessment of a facility is considered a best practice. (Tr. 1338.) *See Arcadian Corp.*, 20 BNA OSHC 2007, 2011 (No. 93-0628, 2004) ("Feasible means of abatement are established if 'conscientious experts, familiar with the industry' would prescribe those means and methods to eliminate or materially reduce the recognized hazard"). The Secretary may require an employer to engage in an abatement process, the goal of which is to determine what action or combination of actions will eliminate or materially reduce the hazard. *Pepperidge Farm,* 17 BNA OSHC at 2033-344. The nature of Respondent's workplace does not remove the employer's obligation under the general duty clause to protect its employees from a recognized hazard. *SeaWorld,* 748 F.3d at 1240. The undersigned finds that at the time in the Citation, this abatement method was not already in place but was something BGH could feasibly and economically adopt.

2. Appropriate Staffing for the Hazard

BGH challenges the Secretary's assertion that it failed to staff appropriately for the hazard. It followed a minimum ratio of patients per staff member and had mechanisms for physicians to assign an MHT to work directly with a single patient if a physician determined the patient was at

high risk for harming themselves or others. (Tr. 299, 347; Exs. R-10, R-44, R-45.) RNs, nurse managers, physicians, and MHTs can request additional staffing if they believe it is needed due to feeling unsafe.[70] (Tr. 296-97; Ex. R-46.)

The Secretary contends that, in practice, BGH's approach to staffing failed to sufficiently take the hazard of patient on staff violence into account. (Sec'y Br. at 35-36.) While nothing barred requests, the criteria for adding staffing focused on patient needs. (Tr. 242, 280, 302, 314-15, 348-49, 559.) Direct care staff often complained to supervisors about sufficient staffing for employee safety. (Tr. 351-52, 372, 1069; Ex. C-4 at 14-17.) The CNO admitted to denying staffing requests but believed she never denied a request for acuity staffing when she thought it would be unsafe to do so. (Tr. 302-3, 345, 351.) She did not have the final say on assigning one-to-one staff to patients and did not indicate whether a request for a one-to-one was ever denied by a physician when she had recommended it.[71] (Tr. 345-46, 352.) The Secretary offered evidence that requests for additional support in dealing with violent patients were denied and that insufficient staffing led to slower responses when a Code 100 was called.[72] (Tr. 82, 86, 202; Exs. C-4 at 15-17, C-42 at 3.) *Cf. Brennan v. OSHRC (Hanovia Lamp Div. of Canred Precision Indus.)*, 502 F.2d 946, 952 (3d Cir. 1974) (remanding decision vacating a citation alleging a violation of

[70] The CNO did not address how requests from social workers for additional staffing were handled. (Tr. 296-97.) The social worker said that requests were made through the nurse manager and unit nurse. (Tr. 153.)

[71] At one point, the CNO indicated that she had "been given the reign" to make staffing decisions. (Tr. 349.) But one-to-one assignments required a physician to agree with her assessment. (Tr. 51, 301, 523, 750.) Similarly, RNs could request that a patient be transferred to a unit with a higher staff to patient ratio, but a physician would have to agree to the request. (Tr. 751.)

[72] One employee described how her annual refresher training in 2016 had to be substantially curtailed because of staff shortages. (Tr. 245.) Dr. Lipscomb believed that this showed a failure to staff for acuity. (Tr. 429.) Other employees expressed their belief that additional staffing could have prevented workplace violence incidents. (Tr. 143, 590.)

the general duty clause to address whether employer exposed employee to serious hazard by permitting him to work alone).

The Citation indicates that a feasible abatement measure for the hazard of patient on staff violence would be to:

> Determine the appropriate number of staff needed in each unit based on acuity of the workplace violence hazard to ensure a safe workplace for employees. Ensure the staffing levels are met daily and on each shift.

The Secretary makes no arguments that staffing was inadequate for purposes of patient care. His argument is that BGH failed to have sufficient procedures and practices in place to increase when needed for employee safety. For example, when a social worker had a well-founded concern about taking a patient off the close observations unit to make a required planning phone call, her request for an additional staff member to attend the meeting was denied.[73] (Tr. 135-37, 143.) No one disagreed with her assessment of the need, but she still had to have the meeting alone because there was no staff available. (Tr. 136-37, 143.) This occurred despite the social worker making the request for support days in advance and giving repeated reminders of the need. (Tr. 135-36, 143, 153-54.)

Several other employees also complained about insufficient staffing and explained how it contributed to the hazard of patient on staff violence at BGH. Their testimony undermines BGH's claims that it sufficiently increased staff when needed to address patient aggression against staff. An MHT described multiple requests for additional staffing being denied, even after he described to supervisors getting hurt by patients due to insufficient staffing.[74] (Tr. 62-63, 65.) After one of his injuries, he vomited but had to continue his shift because there would have been only one other

[73] The close observation unit is one of the units with "high acuity patients." (Stip. 4.)

[74] The CNO was aware that this MHT requested more staffing and said: "we try to get staff in there if we can." (Tr. 314.) She did not explain what prevented them from honoring the request.

person on the floor working if he left. (Tr. 82.) He could not even take time to fill out the EAR during his shift because it would have left insufficient coverage on the unit. *Id.* And he was aware of incidents involving other people who were left alone with patients and were attacked. (Tr. 65-66, 574.)

A charge nurse shared the MHT's concerns about insufficient staffing for purposes of patient on staff violence. (Tr. 232, 242.) She complained frequently to the unit manager about staffing. (Tr. 242.) Sometimes the unit manager would advocate for additional staffing when patient needs were acute, but she could "only do so much." *Id.* Another RN explained how that on some nights several units would only have one RN and one MHT, making it very difficult to have enough people respond to emergencies. (Tr. 590.)

Dr. Lipscomb opined that appropriate staffing could prevent injuries and materially reduce the hazard. (Tr. 422, 429, 431; Ex. C-4 at 14-17.) She explained that both the actual experience of BGH's employees as well as the research supported this. (Tr. 425.) For instance, the social worker believed her attack could have been prevented if her request for additional staffing had been honored. (Tr. 426-29.) Likewise, an RN explained that more staffing would ease the potential for violence directed towards staff. (Tr. 590, 593.) Depending on the number of patients, a unit may only have two staff members. (Tr. 590.) When one employee is on break or if they are needed to respond to another unit, the remaining employee is then left alone. *Id.* He explained that having two or three "float techs," who are employees not assigned to any particular unit but go where help is needed, as opposed to the single one in place before the Citation was issued, would permit more flexibility so staff members would not be left alone when incidents take an MHT or RN off the unit. (Tr. 574, 591-92.) The MHT Manager also acknowledged that to protect employees from being injured, it is crucial to have a sufficient number of employees respond to

codes. He explained that there is "safety in numbers" and additional staff "brings other potential resources" to a psychiatric emergency. (Tr. 1018, 1069-70.)

In terms of the research, Dr. Lipscomb stated that it is widely recognized that working alone with a patient is a risk factor for workplace violence. (Tr. 427; Ex. C-4 at 14-16.) She noted that although more than one person was on staff in each unit, more than one person was not always present as MHTs went on breaks and escorted patients off the unit. *Id. Cf. Hanovia Lamp*, 502 F.2d at 952 (citing expert's testimony that a laboratory technician should not have been left alone during a procedure). BGH does not argue that it cannot change its staffing procedures to align with the proposed abatement set forth in the Citation (or another method that will accomplish the same result). *See Pepperidge Farm*, 17 BNA OSHC at 2032. Shortly before the Citation was issued, it added a Milieu Coordinator and after the OSHA inspection concluded, it filled the position of Security Mental Health Technician (Security MHT). (Tr. 240, 353-56, 361, 1071, 1340.) The Security MHT does not have ongoing direct patient care responsibilities. He can respond to codes anywhere in the facility as needed and addresses safety concerns, such as the availability of working walkie talkies. (Tr. 355, 360, 1070-71, 1075.)

Ms. Cooke's report does not explicitly disagree with Dr. Lipscomb's belief that BGH failed to sufficiently staff for the hazard of patient on staff violence. Her opinion is that staffing is sufficient for patient management.[75] (Ex. R-57 at 8.) She cites the Security MHT as support for her conclusion that staffing was adequate. *Id.* However, this position was not in place until after

[75] Her report states that BGH had "determined the appropriate number of staff to safely manage patients" but does not expressly state that BGH had the appropriate number of staff for employees to be safe. (Ex. R-57 at 8.)

the OSHA's inspection.[76] (Tr. 240, 1071.) Ms. Cooke's report also argues that staff are moved from a unit if they do not feel safe or if a patient is "targeting" them. (Ex. R-57 at 8.) This conflicts with the social worker's credible testimony that she had to continue to work directly with the patient who attacked her and continued to make verbal threats after her beating.[77] (Tr. 138-40.)

BGH also argues that the Secretary failed to identify a specific staff to patient ratio and that an employer could not know when it reached a correct staffing level. (Tr. 29.) However, as BGH itself elucidated, staffing strictly to a set ratio was not feasible as the level of observation needed shifted depending on the nature of the patient population. (Resp't Br. at 28.) It argues that it must approach staffing the same way the Secretary seeks, i.e., increasing when necessary to address the hazard of patient on staff violence. An employer is not at risk for an OSHA citation if it fails to follow an arbitrary staffing ratio. *See Pepperidge Farm*, 17 BNA OSHC at 2032 (the employer may use any method that renders its workplace free of the hazard and is not limited to the methods the Secretary suggests). As discussed above, the Secretary cannot sustain a violation for the hazard of patient on staff violence unless multiple hurdles are cleared. He must show the hazard is likely to cause serious injury or death, that employees are exposed to patient on staff violence, that the employer's program to address the hazard is inadequate, and that adopting further abatement measures would not just reduce the hazard but also be feasible and make a material difference. *Waldon*, 16 BNA OSHC at 1058-59. (Stip. 16.)

Besides being feasible, Dr. Lipscomb also explained how having sufficient staffing for the

[76] The exact date this position was added is unclear. The CNO thought it was added in July 2017 and Mr. Somers also thought the change occurred after the end of the OSHA inspection. (Tr. 355-56, 1071.)

[77] An MHT also described being immediately assigned back to the unit where he was attacked. (Tr. 61-62.) The CMO indicated that if patient "repeatedly" targets staff, the employee would have to be moved. (Tr. 737.)

hazard reduces the hazard of patient on staff violence. (Tr. 425-26, 1356, 1360-61, 1364-67.) Dr. Lipscomb discussed a facility she researched that has a "milieu safety officer." (Tr. 1356.) This abatement measure was implemented "very successfully" and reduced patient on staff injuries. (Tr. 1361.) By the time of the hearing, BGH had both a Security MHT and a Milieu Coordinator, each of whom had responsibilities focused on safety. (Tr. 354-55, 361-62, 1071, 1075, 1085-86, 1209-10, 1340.) Ms. Cooke did not offer any rebuttal testimony against the Secretary's evidence that adding these positions was feasible and would materially contribute to the abatement of the hazard. (Tr. 1341-42.) Indeed, she cites the Security MHT as evidence of an adequate staffing procedure in her expert report. (Ex. R-57 at 8.) The Secretary provided sufficient evidence to show that a feasible method of abatement would be for BGH to determine the appropriate number of staff each unit requires based on acuity of the workplace violence hazard.

3. Summoning Help

Multiple employees discussed difficulties in summoning help during the time referenced in the Citation. Dr. Lipscomb explained that a reliable and effective method of summoning assistance is a preventative measure. (Tr. 423, 440, 575-76.) The House Supervisor concurred. (Tr. 616, 653-54.) And Ms. Cooke acknowledged that summoning help could prevent injuries from patient aggression. (Tr. 1342.)

The Secretary does not prescribe a set system BGH should implement. Instead, he indicates that BGH must provide an effective system and have procedures to ensure its continued suitability. In section (b)(ii) of the Citation, the Secretary indicates that a feasible method of abatement includes BGH acting to:

> Provide all affected employees with reliable and readily available means of communication that are effective throughout the facility. Develop a policy to maintain the effectiveness of the communication devices such as walkie talkies. Inform all employees of this policy and train them on the use of the equipment. Enforce the policy as necessary.

The MHT Manager explained that the walkie talkies are used to call codes and they are crucial in attempting to minimize patient violence. (Tr. 1085-86.) Yet, four different employees testified that at the time referenced in the Citation, the walkie talkies were ineffective at summoning assistance. (Tr. 51, 234, 251, 374.) As one RN explained, they did not hold a charge and sometimes did not work leading to a system that was "haphazard" at best.[78] (Tr. 594-95.) The CNO acknowledged that there were complaints about the walkie talkies not working. (Tr. 362.)

While employees could also use certain phones, or shout for assistance, these methods had significant drawbacks. Sometimes emergencies arose in areas where there were no phones, or the phone was already in use. (Tr. 132-33, 235-36, 442-43.) Other times, shouting for assistance was not effective because there was not always another employee who could hear you. (Tr. 77, 250.) *See Con Agra,* 11 BNA OSHC at 1145 (finding employer inadequately addressed the hazard because its abatement method was unreliable).

Dr. Lipscomb testified that having a reliable method of summoning assistance when there is a potential for assault would reduce the likelihood of injury. (Tr. 423, 440-41, 575-76; Ex. C-4 at 18-20.) Ms. Cooke quibbled about whether summoning help prevented the hazard or just the injuries related to it. (Tr. 1341-42.) The Secretary does not argue that BGH's methods for summoning help were inadequate for patient medical care: his focus is on patient aggression

[78] In addition, during her investigation, other employees told the CO about difficulties they had using the walkie talkies to summon help. (Tr. 197-200, 573; Exs. C-40 at 4, C-42 at 2.)

against staff that can lead to an employee's serious injury or death.[79] (Sec'y Br. at 32, 48-49.) And, on that issue, Ms. Cooke agreed that summoning help "absolutely reduces injuries." (Tr. 1342.) Consistent with that is Dr. Lipscomb's opinion that staff should summon help whenever they are unable to manage a patient. (Tr. 441.) She explained that by summoning help when there is a risk as opposed to after an attack, injuries are prevented. *Id.* Mr. Somers agreed that the reason to call codes is to minimize patient violence, whether it is to the patients themselves or employees. (Tr. 1086.)

The Secretary indicates that BGH can satisfy the Citation's call for "reliable and readily available means of communication that are effective throughout the facility" by: (1) ensuring the walkie talkies are kept in working order and available in sufficient quantiles; and (2) adding personal alarms and panic buttons. (Sec'y Br. at 37-38.) The Secretary leaves open the possibility that BGH could implement a different system that meets the same criteria. *See Pepperidge Farm*, 17 BNA OSHC at 2032 (employer may use any method that abates the hazard).

With respect to the first aspect of ensuring a reliable system for summoning assistance, addressing the issues with the walkie talkies, near the end of the OSHA investigation, in December 2016, BGH created the position of Milieu Coordinator.[80] (Tr. 353-54.) The Milieu Coordinator makes sure the walkie talkies are charged, in working order and that each unit has enough devices. (Tr. 361-62, 383, 1085-86, 1209-10.) Mr. Somers and Ms. Hunter acknowledged that these tasks are key to minimizing the hazard because the devices are used to call codes. (Tr. 1086, 1210.) Ms. Cooke asserted that, in her view, the Milieu Coordinator addressed the known issues with the

[79] The Secretary does not contend that patient aggression which lacks the potential to seriously injure an employee violates the general duty clause.

[80] Mr. Somers thought that the position may have been created later than December 2016. (Tr. 1085.)

walkie talkies that were present in 2016. (Tr. 1340-41.) BGH does not argue that it could not have tasked someone with overseeing the walkie talkies before the inspection commenced.

As for adding personal alarms and panic buttons, Dr. Lipscomb explained that these had been successfully used in other mental health facilities for many years. (Tr. 443-46.) Indeed, BGH already had panic buttons in place at the front desk and in the admissions area to summon help in the event of outside intruders. (Tr. 236-37, 444-45.) Dr. Lipscomb explained that personal alarms and panic buttons reduce the likelihood that patient aggression will result in injury. (Tr. 441.) For example, when the social worker was attacked, the severity of the assault could have been reduced because with a personal alarm or panic button because "timing is of the utmost importance" in those situations. (Tr. 446-47.) The charge nurse also explained how it could assist employees in violent situations. (Tr. 238.)

In her expert report, Ms. Cooke states that there are adequate emergency alert systems in place at BGH. (Ex. R-57 at 8.) Her report indicates that staff can easily call for help if assistance and does not note any of the difficulties with the reliability or availability of the walkie talkies.[81] *Id.* at 9. However, employees testified about multiple difficulties they consistently encountered when trying to summon assistance during the period referenced in the Citation. Ms. Cooke also seems to imply that there were more panic buttons at the facility. Her report states that there are panic buttons in "Interview Rooms" and, at the hearing, she referred to "panic alarm**s**" in the admissions area and "panic button**s**" in the assessment department. (Ex. R-57 at 9; Tr. 354, 1296, 1308.) But, other evidence indicates that there are only two panic buttons at the facility: one in the admissions area and one at the front desk in the reception area. (Tr. 354, 373.) There are no

[81] The report's description of the Code 100 procedure also differs from what was set forth in the written policy. (Exs. R-15, R-57 at 8.)

panic buttons in any rooms on the units where most of the employee injuries occurred. (Tr. 133, 235-37, 354, 373; Ex. C-4 at 29, C-54, R-48.)

Ms. Cooke also appeared to believe that employees could verbally request help and that this was effective. (Ex. R-57 at 9; Tr. 1308.) However, employees described difficulty with yelling for help. (Tr. 77, 249.) To this point, Dr. Lipscomb explained that yelling is not a reliable means of summoning support in a behavioral health hospital and it was not recommended. (Tr. 527-28, 556.) As she articulated, "the last thing you'd want to be doing is screaming" in a unit. (Tr. 529.) In the case of the social worker who could not commence a code during her attack despite being near a phone, Dr. Lipscomb explained how the lack of a reliable and effective method could have delayed assistance to her. (Tr. 446-47.) The Secretary showed it was feasible for BGH to address the issues employees had summoning help in 2016 and that doing so would materially reduce the hazard.

4. Documenting Incidents and De-Briefing

As discussed above, BGH's post-incident documentation and review procedures were inconsistent and ineffective. After camera footage of an incident of workplace violence was reviewed, the MHT Manager partially filled out a form and filed it in his office. (Tr. 1044.) The head of the Safety Committee was not even aware that these forms existed, and BGH did not produce any completed or blank copies of it. (Tr. 1215.) Considering the record as a whole and his demeanor at the hearing, the undersigned does not credit the MHT Manager's testimony that the camera review forms provide a teaching opportunity for the whole facility. (Tr. 1052-53.) Despite his designated role as Safety Champion he did not seem to grasp the importance of workplace violence prevention or the role camera reviews could play in abating the hazard. (Tr. 453-55, 487, 987-88, 1006.) He said that it was important that camera reviews happen as quickly

as possible after an incident but could not approximate how often the reviews occur within three days of an incident. (Tr. 1036.) He could not clearly explain what information the camera review form was supposed to include or if more incidents occur more frequently on any particular shift. (Tr. 1059-60, 1076-77.) His testimony was not reflective of someone well informed about the hazard and how to abate it.

BGH could not identify any changes it made as a result of its incident review procedures. (Tr. 596, 1339.) Nor could it describe any trends it identified because of its incident tracking procedures. (Tr. 695.) Employees were not required to report all workplace violence incidents in writing. (Tr. 658.) For example, if an employee was slapped, but did not receive a physical injury, an EAR would generally not be completed. (Tr. 889, 906.) Further, while BGH had guidelines to assist employees with completing the accident reports, even employees who had been involved in workplace violence incidents were not familiar with these guidelines and it did not appear they were used by employees. (Tr. 242-43, 597.)

BGH accepts that post-incident debriefing is feasible and important to address the hazard. (Tr. 964, 1026.) Ms. Cooke acknowledged that one of the purposes of tracking and trending is to see where improvements can be made. (Tr. 1339.) Doing so allows employers to learn where policies and practices can be revised to address the hazard. *Id.* The CNO described debriefings as an opportunity to discuss how things could have been prevented and what could be done in the future. (Tr. 337.) Although documenting incidents and conducting debriefings may be BGH's policy, employees explained that the type of debriefing the CNO described did not consistently occur before the issuance of the Citation. (Tr. 53-54, 97, 254-55, 577, 579.) If an employee experienced an act of violence there was no debriefing unless the incident also involved a patient being restrained or being put into seclusion. (Tr. 337.) Further, while BGH produced a document

it initially alleged was used for debriefings, at the hearing multiple employees indicated that they never saw it before. (Tr. 1214.) And, Ms. Hunter admitted that is was not in fact used. (Tr. 1215.)

Dr. Lipscomb explained that after an incident of workplace violence, it is important to review the incident and find out as much as possible about the circumstances surrounding it. (Tr. 450-51.) She noted that by reviewing all incidents, employers can identify if there are common elements, which can then be addressed. (Tr. 452.) She argued that it would be feasible for BGH to assign a staff person to ensure that all workplace violence incidents were debriefed and that these debriefings include staff input as to what could have been done differently and what is needed to prevent future incidents. (Tr. 453-54, 465-66.)

To address these deficiencies, the Citation, in section (c), indicates that one feasible method of abatement would be the "[d]evelopment of a recordkeeping system designed to report any violent incident." The system should:

> (i) Require and ensure that affected employees report all acts of violence to a supervisor or manager, regardless of severity. Investigate all violent incidents as soon as possible.
> (ii) Review and analyze all crisis interventions with staff involved to determine root cause, what actions worked correctly and any necessary improvements.
> (iii) Make any necessary changes to the patients Criss Plan quickly.
> (iv) Implement appropriate recommendations resulting from workplace violence incident investigations.

The Secretary showed that it would be feasible and effective for BGH to modify and enforce its workplace violence prevention program to ensure that staff are debriefed after incidents and that the information learned is utilized. BGH already documented and debriefed incidents involving patient restraints.[82] (Tr. 99, 336-37, 613, 1026.) But, BGH's program as implemented did not capture all incidents of workplace violence, was often incomplete, and the information

[82] As noted above, the after a restraint, there were specific questions staff asked patients, but there were not specific questions the staff were asked. (Tr. 255.)

from the camera reviews was not effectively utilized. (Tr. 53, 97, 254, 453-54, 579, 655.)

BGH's approach is analogous to the one discussed in *Con Agra.* In that case, the employer's abatement was not sufficiently comprehensive. 11 BNA OSHC at 1142, 1145. Employees tested boxcars for air contaminants under certain circumstances. *Id.* The Secretary showed that the employer's selective approach was ineffective at addressing the hazard because it was not consistent and did not cover air contaminants that lacked an odor. *Id.* The Commission found that testing all boxcars before employees entered was a feasible method of abatement as it was extending an existing practice. *Id.* at 1144-45. Here, the Secretary is proposing that BGH fully implement its existing program and extend it to cover all incidents of workplace violence, as opposed to focusing on those that occur during restraints. *See SeaWorld,* 748 F.3d at 1215. The Secretary showed that this approach is feasible and would materially reduce the hazard.

5. Involvement of Front-Line Workers in Reviewing Policies

The Citation, in section (b)(i), informs BGH that a feasible method of abatement would be to develop a safety committee which involves employees who are exposed to the hazard of workplace violence. This committee should:

> a. Review workplace violence incidents during the meetings to ensure effective and timely follow-up.
> b. Develop a system for affected employees to report violence [related] safety concerns and suggestions anonymously.
> c. Develop a system to provide communication and feedback to employees about their workplace violence safety concerns and suggestions.
> d. Develop a system of flagging patients with a history of violence … .

Dr. Lipscomb opined that requesting the expertise from direct care staff could materially reduce the hazard of patient on staff violence. (Tr. 435-36, 459.) It allows organizations to take advantage of all the expertise to address the hazard of patient on staff violence. (Tr. 437-38.) Her opinion is supported by published research and the OSHA Guidelines. (Tr. 437, 487-88; Ex. C-

49 at 12.) BGH agreed, indicating that front-line employees have the most critical information about how to abate the hazard. (Tr. 1185-86.)

Ms. Cooke appeared to believe that BGH already had this abatement method in place. (Ex. R-57 at 7-8.) However, as discussed above, her assessment was partially based on information not supported by the record. First, with respect to the Safety Committee, the depth of its review is not clear. Employees described incidents that were never followed up or only done so months after they occurred. (Tr. 82, 454, 579-80.) As for feasibility, Dr. Lipscomb expressed that it is unusual not to have direct care staff involved in a safety committee and she has seen it in most other similar facilities. (Tr. 435-36.) She could not think of any reason why it would not be feasible at BGH. (Tr. 435.) Indeed, after the Citation, BGH added a front-line employee to a safety committee. (Tr. 374-75, 382-83.) In this role, the employee indicated that she was able to raise issues with Ms. Hunter and have them resolved. (Tr. 383-84.) For example, the committee worked to address issues with the walkie talkies. *Id.*

BGH also had a structure for town hall meetings. Although these did not regularly occur in 2016, the record suggests that they may have occurred more regularly in 2017, after the issuance of the Citation. (Tr. 878.) BGH does not deny that it can hold these meetings in manner that can provide communication and gather feedback about workplace violence.

In terms of employee suggestions, while there were some mechanisms for anonymous reporting, the Secretary showed there was little follow up during the time referenced in the Citation. Employees indicated that in 2016 concerns about the walkie talkies went unaddressed. (Tr. 579.) And despite receiving "hundreds" of suggestions through the anonymous suggestion box, BGH did not identify any safety concern or suggestion it followed up on. (Tr. 271, 690, 880, 882.) BGH does not deny that its Safety Committee could ensure that employees can effectively

report workplace violence safety concerns and suggestions anonymously.

Turning to the proposal in section (b)(i)(d) for BGH to flag patients with a history of violence, Ms. Cooke believed that the "pink sheets" were used for this purpose. (Ex. R-57 at 8.) But, as noted above, patients determined to be more likely to engage in patient on staff violence were not specifically flagged. (Tr. 620; Ex. C-40 at 2.) Similarly, the Crisis Plans, which were supposed to provide guidance about and methods to avoid or minimize the risks from aggressive incidents, were frequently incomplete or blank. (Tr. 93-94.) Thus, BGH had forms to identify or "flag" patients at risk, but the record does not reflect that these were used effectively to address the hazard. The MHT explained that every six or seven months someone would "crack down" and the Crisis Plans would be filled out, but these occurrences were short-lived and soon the forms would start being blank again. (Tr. 93.) His testimony supports the conclusion that BGH could ensure that the information on the pink sheets was being conveyed to direct care employees and that the Crisis Plans would be filled out for all patients.

As with some of the other proposed means of abatement, BGH had the structure in place for the workplace violence controls section (b)(i) of the Citation calls for but was not properly implementing them at the time of the investigation. The Secretary showed that involving direct care workers in reviewing policies was a feasible method of abatement BGH could adopt that would materially reduce the hazard.

6. Training

Section (d) of the Citation calls for an:

> Evaluation of training needs and implementation of appropriate workplace violence training. … The training should include the employer's workplace violence prevention program, crisis prevention, de-escalation techniques, the employer's policies and requirements for recording and documenting a patients aggressive behavior, and how and when to complete an Employee Accident Report.

BGH had a training program, but the Secretary identified significant gaps, particularly with respect to training on the hazard at issue here, patient on staff violence. BGH produced a PowerPoint presentation at the hearing that addressed the hazard of patient on staff violence. (Ex. R-27.) However, the record does not reflect that this was in use at the time referenced in the Citation, at least not for all employees. (Tr. 970, 1230.) Dr. Lipscomb explained that sufficient training should include an orientation to BGH's workplace violence prevention policy that includes risk factors for violence, procedures for preventing workplace violence, and the staff's role in the process of risk analysis, hazard control, and evaluation. (Tr. 545; Ex. C-4 at 30-31.)

BGH does not dispute that training can materially reduce the hazard or that correcting the deficiencies the Secretary identified would be feasible. It already had Guidelines for Accident Reports, but employees were not familiar with the procedures and had not seen the document at any point. (Tr. 86, 596.) Ms. Hunter acknowledged that the guidelines were not used but did not suggest that doing so would be infeasible or not contribute to reducing the hazard. (Tr. 1215.) BGH also had training materials on workplace violence (Exhibit 27) but had not appropriately trained all employees at the time of the Citation. The Secretary showed that it was feasible for BGH to evaluate and implement workplace violence training and that this would materially reduce the hazard.

7. Adverse inference

The Secretary also asks that the undersigned draw an adverse inference regarding the blank clinical treatment forms and the lack of documents related to the work of the Safety Committee. (Sec'y Br. at 51-54.) The undersigned finds that the record speaks for itself.

In terms of the forms, the Secretary showed that they were sometimes incomplete or not used at all. As used, the forms did not contribute to the abatement of the hazard of patient on staff

violence. In terms of the lack of minutes, agendas, or other documents related to the Safety Committee, BGH's inability to identify any changes made, undermines its claims that the Safety Committee addressed injuries, obtained input from front-line employees, and acted on it. The lack of documentation also undercuts BGH's claims that there were no additional steps it could take to materially reduce the hazard.

8. Feasible Abatement Identified

There is no evidence BGH was incapable of adopting any of the abatement measures identified by the Secretary during the hearing. *See 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). In some instances, this was because Respondent had implemented the abatement called for by the time of the hearing. For the others, Dr. Lipscomb testified how similar abatement efforts were used effectively at other behavioral health facilities. Such evidence shows the efficacy and feasibility of the Secretary's proposed approach. *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); *Wheeling,* 10 BNA OSHC at 1246 n.5 (finding abatement method feasible when it had previously been used at the facility). *Cf. Mo. Basin,* 26 BNA OSHC at 2321, n.13 (noting that when the Commission considers the efficacy of an abatement method, it looks to industry standards and expert testimony). By showing that BGH failed to implement feasible means to materially reduce a hazard the Secretary met his burden. *See Arcadian,* 20 BNA OSHC at 2011 (finding that the Secretary's burden is limited to showing how that the abatement method would materially reduce the hazard, not that it would eliminate the hazard); *Morrison-Knudson Co./Yonkers Contracting Co., A Joint Venture,* 16 BNA OSHC 1105, 1122 (No. 88-572, 1993) (same).

IV. Fair Notice

Respondent claims because there was not a single one-time solution to the hazard of patient on staff violence, employers would be subject to an ever-moving target. (Resp't Br. at 12.) As BGH and its industry learn more about how their employees are threatened in the workplace, they do have an ongoing obligation to act if there are feasible means to eliminate or minimize hazards that pose a threat of serious physical harm or death. *See Nat'l Realty*, 489 F.2d at 1266-67; *Hanovia Lamp,* 502 F.2d at 951; *Con Agra,* 11 BNA OSHC at 1145. "All preventable forms and instances of hazardous conduct must, however, be entirely excluded from the workplace." *Nat'l Realty*, 489 F.2d at 1266-67. *See also Gen. Dynamics*, 815 F.2d at 1577 (finding that when employers know that existing safety standards do not adequately address hazards, they must take whatever steps are necessary to protect employees).

Facial challenges to the general duty clause have been repeatedly rejected. *SeaWorld*, 748 F.3d at 121; *Ensign-Bickford Co. v. OSHRC*, 717 F.2d 1419, 1421 (D.C. Cir. 1983) (rejecting a constitutional challenge to general duty clause). In terms of as-applied challenges, such as Respondent's, courts have explained that possible fair notice problems are addressed when the clause is applied in a situation where "a reasonably prudent employer in the industry would have known that the proposed method of abatement was required." *Donovan v. Royal Logging Co.*, 645 F.2d 822, 831 (9th Cir. 1981) (finding fair notice). Far from being strict liability, the requirements of general duty clause apply only to hazards that are recognized and for which abatement is feasible. *Hanovia Lamp*, 502 F.2d at 951. The Secretary must show more than just an injury from the hazard. *Nat'l Realty,* 489 F.2d at 1267. He also must show that there are feasible means of prevention. *Id.* at 1266-67. An injury causing activity "is not preventable if it is so idiosyncratic and implausible in motive or means that conscientious experts, familiar with the industry would not take it into account in prescribing a safety program." *Id.* at 1266.

Here, unlike many cases where fair notice is contested, there is no debate BGH knew what the hazard was and that its employees were exposed to it. (Stip. 13.) *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); *Babcock*, 622 F.2d at 1164 (either employer or its industry must be aware of the hazard). Nor is there any dispute that experts familiar with the industry would take the hazard into account in 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. (Tr. 460-61, 1331.) Patient attacks on employees were not idiosyncratic events at BGH. They routinely occurred. (Tr. 185.) *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). BGH was aware of these events through the EARs completed by employees and through the direct knowledge of supervisors. (Exs. C-54, C-55, C-56, R-46.)

So too is the behavioral health industry aware of the hazard of patient on staff violence. (Stip. 14.) OSHA, academia, and industry groups published guidelines and ways to evaluate the need for and information about how to implement effective abatement measures. (Exs. C-4, C-45, C-46, C-47, C-48, C-49.) BGH took some steps to develop abatement measures. But then it failed to implement many of the measures it identified as ways to protect employees and minimize serious injuries from workplace violence. *See St. Joe*, 647 F.2d at 844 (employer violated the general duty clause because its abatement was not sufficiently protective). Other than clinically caring for patients, it failed to implement the policies it had on paper or use the information it collected from incidents of patient on staff violence to reduce the hazard. BGH knew there are practices and procedures within its control that would decrease the likelihood of patient violence

and minimize injuries from such incidents, and yet it failed to implement them fully and appropriately. *See SeaWorld*, 748 F3d at 1216 (finding that employer could have anticipated that abatement measures it applied after other incidents would be required); *Babcock*, 622 F.2d at 1165 (affirming finding of liability when the company failed to take feasible precautions to reduce the risk of injury).

In *Con Agra*, the Commission upheld a violation of the general duty clause even though there had not been any injuries and even though the proposed abatement method was not required by any specific standard. 11 BNA OSHC at 1145. In that matter, the employer was in compliance with a standard for air contaminants. *Id.* Still, the risk of potential chemical exposure remained at the workplace. *Id*. Because the employer knew of the hazard and failed to implement feasible methods of abatement, it violated the general duty clause. *Id*.

The Secretary met his burden of showing that, at the time of the violation, Respondent's existing measures for addressing patient on staff violence were insufficient and Respondent had not taken feasible measures capable of materially reducing the hazard. He did not also have to have to show that the hazard can be eliminated or that the abatement methods will reduce the hazard by a specific quantifiable measurement. *See Morrison,* 16 BNA OSHC at 1122-23 (Secretary not required to offer quantifiable measurement of how much the lead exposure hazard would be reduced by implementing abatement measure of wearing protective clothing); *Acme,* 542 F. App'x at 366-67 (Secretary not required to offer quantifiable measurement as to the extent of hazard reduction resulting from "commonsense" abatement measure of prohibiting employees from certain areas); *Wheeling,* 10 BNA OSHC at 1245 (abatement still feasible even though it could not be used in all situations). Respondent's challenge to the application of the general duty clause to the hazard it recognized is rejected.

V. Penalty

The parties reached several stipulations about the Secretary's proposed penalty of $12,471:

1. In issuing the serious general duty clause violation in Inspection No. 1161234, OSHA assigned a gravity of "High," which resulted in an automatic penalty calculation of $12,471.
2. At the time of the alleged violation, Respondent employed approximately 200 employees at Brooke Glen Behavioral Hospital.
3. Prior to Inspection No. 1161234, OSHA had not issued any citations to Respondent BHC Northwest Psychiatric Hospital LLC.
4. OSHA did not make any adjustments for employer size, good faith, or history.
5. OSHA's proposed penalty was therefore $12,471.00.
6. The parties stipulate that if the general duty clause violation is affirmed by the Court, the proposed penalty of $12,471.00 is appropriate pursuant to the factors set forth at 29 U.S.C. § 666(j).

Consistent with these stipulations, the undersigned agrees that $12,471 is the appropriate penalty in light of the factors set forth at 29 U.S.C. § 666(j). The Secretary does not allege that the violation was willful or repeat. Nor does the record support such a characterization. The Citation was issued on January 11, 2017. At that time, the statutory maximum penalty for a serious violation of the OSH Act was $12,471. 81 Fed. Reg. 43430 (July 1, 2016.) The violation is serious because, as discussed above, the cited hazard is capable of causing serious injury or death. There is no evidence that a penalty reduction is warranted. Thus, a penalty of $12,471 is appropriate.

ORDER

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

Citation 1, Item 1a for a serious violation of section 5(a)(1) of the Act is AFFIRMED, and a penalty of $12,471 is ASSESSED.

SO ORDERED.

/s/Covette Rooney
COVETTE ROONEY
Chief Judge, OSHRC

Dated: January 22, 2019
Washington, D.C.