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State of Vermont
Agency of Human Services, Department of Children and Families
Department of Buildings and General Services
Attention: Kenneth Schatz, Commissioner, Department of Children and Families
Michael Obuchowski, Commissioner, Department of Buildings and General Services

Dear Commissioners Schatz and Obuchowski:

VOSHA conducted an inspection into the fatality of Department of Children and Families (DCF) Social Worker Lara Sobel on August 7, 2015. VOSHA determined that workplace violence is recognized nationally and by the State as a serious safety and health hazard for social workers. The purpose of this letter is to bring your attention to this hazard and to encourage you to address it in State worksites and facilities.

Our inspection found that: the State DCF had a workplace violence policy; the policy was not fully developed and implemented; and, did not contain comprehensive measures to protect workers from assaults at the workplace. It cannot be said that a more comprehensive, fully developed and implemented policy would have prevented the fatality. VOSHA does not consider it appropriate at this time to invoke the General Duty Clause, 21 VSA §223(a) of the Vermont Occupational Safety and Health Act. No citation(s) will be issued as a result of this investigation. In the interest of workplace safety and health, however, VOSHA recommends that the State voluntarily take the necessary steps to eliminate or materially reduce your employees' exposure to the risk factors stated above.

The investigation revealed that the Employer's documented program titled "Department for Children and Families – Risk and Security Notification Protocols" did not meet the minimum guidelines as defined in OSHA CPL 02-01-052 ("Enforcement Procedures for investigating or Inspecting Workplace violence Incidents"). Employers whose activities fall within the scope of this enforcement procedure must have a minimally effective program to successfully mitigate exposure of employees to the threat of workplace violence.

OSHA CPL 02-01-052 instructs an employer covered by the scope of this directive to *"Develop a written, comprehensive workplace violence prevention program, which should include:"*

- *A policy statement regarding potential violence in the workplace and assignment of oversight and prevention responsibilities.*
- *A workplace violence hazard assessment and security analysis, including a list of the risk factors identified in the assessment and how the employer will address the specific hazards identified.*
- *Development of workplace violence controls, including implementation of engineering and administrative controls and methods used to prevent potential workplace violence incidents.*
- *A recordkeeping system designed to report any violent incidents. Additionally, the employer shall address each specific hazard identified in the workplace evaluation. The reports must be in writing and maintained for review after each incident and at least annually to analyze incident trends.*
- *Development of a workplace violence training program that includes a written outline or lesson plan.*
- *Annual review of the workplace violence prevention program, which should be updated as necessary. Such review and updates shall set forth any mitigating steps taken in response to any workplace violence incidents.*
- *Development of procedures and responsibilities to be taken in the event of a violent incident in the workplace.*
- *Development of a response team responsible for immediate care of victims, reestablishment of work areas and processes and providing debriefing sessions with victims and coworkers. Employee assistance programs, human resource professionals and local mental health and emergency service personnel should be contacted for input in developing these strategies.*

An investigation of the employer's written policies and procedures as well as interviews and interrogatories related to the fatality on August 7, 2015, reveals the following deficiencies in the employer's procedures:

- **Overall Statement:** While the employer's opening statement in the policy did assign responsibilities for response to incidents, it did not assign responsibility for oversight of the program to ensure effective communication, evaluation and training of employees is done on a timely basis. In addition, the employer's responses and public comments from senior management officials indicated that the senior level managers may not have had the level of knowledge of the employer's program that would be necessary for effectiveness. It is very

important for the overall statement to express clear commitment from management to the prevention of violence in the workplace.

- **Hazard Assessment:** There was no comprehensive hazard analysis of the threat of workplace violence in the workplace. Such an analysis must include each field office with consideration of the uniqueness of the facilities, availability and expected use of outside resources such as local/state police and the Department of Buildings and General Services (BGS). It should include an analysis of major tasks performed by staff in which the exposure of violence could be reasonably expected. These tasks could include field operations, such as home visits. In addition, there was no evidence that investigations of events or the outcomes were used in consideration of whether or not procedures and controls were as effective as possible to prevent future events.

- **Hazard Controls:** While there was evidence of recent de-escalation training given to DCF social workers, there was no evidence that comprehensive controls addressing threats was implemented at each worksite. The controls must follow a process of consideration of engineering controls (locks, barriers, lighting, accessibility controls, etc.) and administrative controls (de-escalation techniques, communications, staffing patterns for particular known behaviors/clients, building evacuations or shelter in place strategies, etc.). These controls must be specific to the individual workplace and the major tasks in which there is reasonable exposure to the threat of violence. These controls must be in documented form.

- **Recordkeeping:** The investigation revealed a number of incidents in which employees were exposed to threats of violence prior to the August 7, 2015 event. Injuries were reported on the employer's OSHA 300 log, so the employer met the minimum standard of recording an injury, but there was no evidence that the incidents were investigated to evaluate whether specific tasks or procedures should be changed to protect workers while they perform social work duties. There was no evidence that the investigations and the determined outcomes were in writing, or maintained for review by employees both after the event and at least annually. There was no evidence that these events and the associated findings were shared with employees in any meaningful way.

- **Training:** While there was evidence of recent raining, and of newly revised mandatory training, the earlier training was not effective:
    - The training lacked a general overview of the Workplace Violence Program in effect;

- The training was not specific to threats expected for each facility and/or task, or the controls/procedures to be utilized for those threats;
- The training was not conducted comprehensively (there is no evidence that all employees took, or were required to take, the training); and,
- The training was limited in scope. Among the items not included in the training module evaluated were specific procedures and controls (as mentioned previously), specific responsibilities (including upper level management), a statement of commitment of employee involvement, instructions of reporting violent events, services available to employees in the event of a violent act, specific statement encouraging reporting and assuring non-retaliation for reporters of violent events.

- **Annual Review:** There was no evidence that the procedure submitted had been reviewed annually. Such a review must include all aspects of the program, including any events/injuries/fatalities reported. Such a review must include a review of procedures/controls and the effectiveness of those procedures. These annual reviews must include the Department of Buildings and General Services (BGS) to determine the effectiveness of BGS protocols and procedures in handling violent events reported to them by AHS employees. Most importantly, such a review must be conducted with direct involvement of affected employees.

- **Procedures and Responsibilities:** While the employers procedures did address responsibilities and procedures in the event of violent incident, there were deficiencies, including:
  - The procedures had not been updated to include changes in facilities, responsible staff, technology (or its limitations), unique characteristics of the various locations, and tasks throughout the state;
  - The procedures did not specify responsibilities in addressing and following up with BGS Security (who was identified on security form FS-110) to ensure appropriate security measures are enacted per the incident;
  - The procedures did not specify responsibility for follow up with employees who had experienced a violent event, including appropriate care; and,
  - The procedures did not specify responsibilities for debriefing and evaluation of the event immediately following the event and at least annually thereafter. This includes communicating findings with employees

- **Development of a Response Team:** It could not be determined if such a team exists. The team(s) would be available as "rapid response" to an incident. The team would be specially trained in the recognition and appropriate response in the

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areas outlined above. The team is extremely important in assisting and ensuring victims are provided with the best care and intervention following an incident, as well as the continuance of the employer's ability to serve clients in a most timely manner. The team can and should be made up of both management and line employee participation. The team should be included in any post incident evaluation of an event.

For your use, we have provided information on recognizing and prevention of violence in the workplace. This information as well as information contained at the OSHA web site at https://www.osha.gov/SLTC/workplaceviolence/index.html as well as the NIOSH website at http://www.cdc.gov/niosh/topics/violence/ will be very helpful to you as you go forward in addressing this issue. Of particular interest is a document titled Workplace Violence, Issues in Response, which was authored by the US Department of Justice, Federal Bureau of Investigations (included in your information packet) which is very authoritative on the subject of workplace violence and solutions.

Under OSHA's current inspection procedures, VOSHA may return to your work site in approximately one year to further examine the conditions noted above.

If you have any questions, please feel free to call Dan Whipple at 802-828-5084.

Sincerely,

Daniel A. Whipple, OHST
VOSHA Manager

Attachments included in CD:

- Workplace Violence Sample Program
- Various training videos
- CPL 02-01-052
- OSHA Fact Sheets on Workplace Violence
- Workplace Violence Issues and Response
- Training Power Point Presentations
- OSHA Guidelines for the Prevention of Workplace Violence for Health Care and Social Service Workers