

**State of California**

Division of Occupational Safety and Health  
Cal/OSHA District Office (0950615; 4016)  
1221 Farmers Lane, Suite 300  
Santa Rosa, CA 95405

**Inspection Number:** 300752722

**Inspection Dates:** 12/13/2010 -

**Issuance Date:** 06/01/2011

**CSHO ID:** N7538

**Optional Inspection Nbr:** 16-11



**Citation and Notification of Penalty**

**Company Name:** CA Dept of Mental Health Napa State Hospital

**Inspection Site:** 2100 Napa-Vallejo Hwy, Napa, CA 94558

**Citation 1 Item 1 Type of Violation: General**

T8 CCR 3203(a)(2) Effective July 1, 1991, every employer shall establish, implement and maintain an effective Injury and Illness Prevention Program (Program). The Program shall be in writing and, shall, at a minimum: Include a system for ensuring that employees comply with safe and healthy work practices. Substantial compliance with this provision includes recognition of employees who follow safe and healthful work practices, training and retraining programs, disciplinary actions, or any other such means that ensures employee compliance with safe and healthful work practices.

On or before 12/11/10, the employer's Injury and Illness Prevention Program was not effectively implemented in that employer did not ensure that employees who escort individuals comply with safety procedures and policies. On 12/11/10, an employee escorting an individual was seriously injured.

|   |           |
|---|-----------|
| Date By Which Violation Must be Abated: | Abated    |
| Proposed Penalty:                       | \$ 675.00 |

See pages 1 through 4 of this Citation and Notification of Penalty for information on employer and employee rights and responsibilities.

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**Company Name:** CA Dept of Mental Health Napa State Hospital  
**Inspection Site:** 2100 Napa-Vallejo Hwy, Napa, CA 94558

**Citation 2 Item 1** Type of Violation: **Serious**

T8 CCR 3203(a)(6) Effective July 1, 1991, every employer shall establish, implement and maintain an effective Injury and Illness Prevention Program (Program). The Program shall be in writing and, shall, at a minimum include methods and/or procedures for correcting unsafe or unhealthy conditions, work practices and work procedures in a timely manner based on the severity of the hazard.

On or about 12/11/10, Employer's Program was not effective with respect to correction of unsafe work practices in a timely manner, in that the hazard of impulsive and violent attack on employees by individuals was not corrected in a timely manner.

Employer was aware that individuals with a history of escalating impulsive violent behavior toward staff could result in serious injury. The employer allowed an employee to take such an individual out of the ward on a walk without implementing new written safe escort procedures on 12/11/10. The individual assaulted and seriously injured the employee.

|   |            |
|---|------------|
| Date By Which Violation Must be Abated: | Abated     |
| Proposed Penalty:                       | \$ 8100.00 |

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**Citation and Notification of Penalty**

**Company Name:** CA Dept of Mental Health Napa State Hospital

**Inspection Site:** 2100 Napa-Vallejo Hwy, Napa, CA 94558

**Citation 3 Item 1** Type of Violation: **Serious**

T8 CCR 3220(c)(1) The employer shall establish an employee alarm system which complies with Article 165.

On or about 12/11/10, the employer had not established an employee alarm system which complied with Article 165, Section 6184 as follows:

a. The screamers issued to employees on the grounds did not give adequate warning because there was no way to tell from which direction the emergency alarm was coming.

b. The screamers issued to employees were not able to be perceived by emergency responders.  
[Ref 6184(b)(3)]

c. The screamers issued to employees on the grounds could not provide warning for necessary emergency response because they could not be activated in all emergencies.  
[Ref 6184(b)(2)]

As a result, an employee was assaulted and seriously injured by an individual because the employee was not able to summon emergency aid.

|   |            |
|---|------------|
| Date By Which Violation Must be Abated: | 06/11/2011 |
| Proposed Penalty:                       | \$ 8100.00 |



Compliance Officer/District Manager

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State of California  
Division of Occupational Safety and Health



**Investigation Summary**

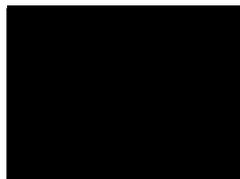
Thu May 26, 2011 12:34pm

| Reporting ID  | Investigation Summary Number | OSHA-36 Number | OSHA-36 Establishment Name                   |
|---------------|------------------------------|----------------|--|
| 0950615       | 201023124                    | 102647724      | CA Dept of Mental Health Napa State Hospital |
| Event Date    | 12/11/10                     | Event Time     | 08:30 am                                     |
| Type of Event | Assault by inmate            |                |  |

|  |   |
|--|---|
| Inspection Number/<br>Establishment Name | 300752722<br>CA Dept of Mental Health Napa State Hospital |
| Injured/Deceased Name                    | George Anderson   |
| Sex:                                     | M. Male   |
| Age:                                     | 59  |
| Injury:                                  | B. Hospitalized   |
| Nature:                                  | 06 Concussion   |
| Part of Body:                            | 13 Head   |
| Source of Injury:                        | 34 Person   |
| Event Type:                              | 01 Struck by  |
| Environmental Factor:                    | 18 Other  |
| Human Factor:                            | 14 Other  |
| Task:                                    | A Regularly Assigned                                      |
| Substance Code:                          |   |
| Occupational Code                        | 105 - THERAPISTS, N.E.C.                                  |

**Abstract:**

On 12/12/10 at approximately 6:33 pm the Santa Rosa District Office was informed of an attack by an individual at a state mental hospital in Napa on an employee which resulted in a serious injury. The employee was assaulted by the inmate while he was escorting him off the ward on 12/11/10 at approximately 10:00 am. The employee was found wandering the grounds by co-workers and was taken to Queen of the Valley Hospital in Napa, and later transferred to Santa Rosa Memorial Hospital, Santa Rosa, where he was treated. The employee received severe head injuries. The district office initiated an inspection on 12/13/10.



NARRATIVE SUMMARY

|   |                                |
|---|--------------------------------|
| Establishment Name: CA Dept of<br>Mental Health/Napa State Hospital | Inspection No.300752722        |
| Management Official: Cathie<br>Reichstein                           | Title: Health & Safety Officer |

Information on Injured

Covered by Worker's Compensation Yes

| Victim name, address, phone number | Occupation               |
|------------------------------------|--------------------------|
| George Anderson/EE1                |                          |
| [REDACTED]                         | Rehabilitation Therapist |
| [REDACTED]                         |                          |
| [REDACTED]                         |                          |

Witness Names(s) and Title

(\* Check box preceding name if confidentiality is given.)

| * | Name/title                   | Address | Phone | Signed Statement?<br>Y/N |
|---|------------------------------|---------|-------|--------------------------|
|   | [REDACTED]<br>[REDACTED]/EE2 |         |       | N                        |
|   | [REDACTED]/EE3               |         |       | N                        |

Summary:

On December 12, 2010 at approximately 6:33 pm, the Santa Rosa district office was notified of a worksite injury which occurred at Napa State Hospital, in Napa, California. Employee George Anderson, 59 years old, EE1, was found wandering dazed and bloodied by staff at the hospital. An individual was arrested and charged in the attack. The district office initiated an investigation on December 13, 2010.

EE1 had worked as a Rehabilitation Therapist at Napa State Hospital for approximately 14 years. On 12/11/10 he was walking with the individual to calm him down when he was attacked by him. EE1's skull was fractured in at least four places. EE1 has no memory of the incident. He currently suffers from post-traumatic stress disorder and has memory problems. He cannot drive.

Narrative:

The mission of Napa State Hospital is "to provide hope to adults with a serious mental illness and support each individual to achieve personal recovery."

Napa State Hospital (NSH) is a state facility which houses a population of over one thousand three hundred individuals, approximately 90% of which are forensic. The individuals are referred through local governments or the court system, using the following criteria for either male or female admissions to NSH:

a. Penal Code (PC):

PC 1026-not guilty by reason of insanity,  
PC 1370-incompetent to stand trial,  
PC 1372-prior PC 1370,  
PC 2964-mentally disordered parolee from California Department of Corrections (CDCR) on community outpatient treatment under CONREP,  
PC 2972-mentally disordered offender, ex-parolee from CDCR, committed to Department of Mental Health on a civil commitment for one year,  
PC 2974-parolee from CDCR Outpatient Parole admitted under LPS provisions.

b. Welfare & Institutions Code:

WIC 702.3-minor, not guilty by reason of insanity,  
WIC 1756-CDCR-DJJ (Department of Juvenile Justice) commitment,  
WIC 6316-mentally disordered sex offender.

c. Penal Code 1610-a mechanism for hospitalizing an individual previously living in the community under the supervision of CONREP.

The individual resided on Program 5, which includes Units Q5 & 6. The individual was on the ward on 12/11/10 during a time of high activity-the ward was being cleaned, there was an upcoming Christmas present exchange which caused him to become apprehensive and agitated. Observing this, EE1 around 8:15 am decided to take the individual out of the ward and walk with him to ease his agitation and prevent him from acting out his aggression, which he done in the past. They proceeded down Cedar Drive along the outer perimeter of the STA. There are police kiosks located at intervals but none was staffed at the time. EE1 was carrying a screamer but was unable to activate it when the individual unexpectedly and suddenly attacked EE1 and knocked him unconscious. EE1 was later found by staff when the individual returned to another unit unescorted.

Regulatory Action:

Employer was issued two serious citations:

3203(a)(6)-failure to correct the unsafe work practice of employees escorting individuals with poor violent impulse control without proper protective methods.

3220(c)(1)-failure to have an emergency alarm system which provided proper, effective and timely warning to police and emergency responders when an employee was experiencing an assault by an individual.

Employer was issued one general citation:

3203(a)(2)-failure to require that employees follow safe work practices.

|                   | Signature  | Date    |
|-------------------|------------|---------|
| Prepared by:      | [Redacted] | 5/26/11 |
| Reviewed by:      | [Redacted] | 5/26/11 |
| Regional Manager: |            |         |
| Deputy Chief:     |            |         |