Team Wilson: how a single workplace violence incident changed healthcare security

Robert Rusting

A potential breakthrough in the need for hospital management to recognize the consequences of violence to nurses and other staff members and to take action to upgrade security result from CEO reactions to a horrendous incident in a Massachusetts hospital. The involvement of a nurses’ organization in providing hospital management with the means to deal with the growing violence against staff is also detailed.

On June 14, 2017, Elise Wilson, a 65-year-old registered nurse at Harrington Hospital, Southbridge, MA, became a statistic. She became one of an estimated 15,000 healthcare employees a year in the US who are reported victimized by workplace violence. A veteran emergency room nurse who had worked at the hospital for 35 years, she was suddenly stabbed eleven times by a patient she was triaging.

But unlike most of the workplace violence incidents in the statistical database which produce no changes in the workplace, this incident has had some positive results, not only at her hospital, but statewide.

For one thing, media coverage of the savage attack revived interest in a bill that had been around the Massachusetts Senate (Senate Bill 1374) for years, an act requiring health care employers to de-
velop and implement programs to prevent workplace violence. Now known as “Elise’s Law,” the bill appeared to be on a fast track to passage last year. It was not passed, but according to one of its major backers, the Massachusetts Nurses Association (MNA), it stands a good chance of passing this year.

AN UNEXPECTED CEO REACTION

The major result of the savage attack, however, came from the management of the Harrington Healthcare System. Ed Moore, President and CEO of the system, announced implementation of a three-point plan to minimize workplace violence through enhanced physical security, emergency preparedness and staff education/awareness. Physical security included the installation of walk-through metal detectors at the entrances to the emergency departments at the system’s Southbridge and Webster campuses, making Harrington hospital the first to install metal detectors in the state. Furthermore, he announced “we will be working closely with the Massachusetts Health & Hospital Associa-

ciation (MHA) to share what we have learned from this experience with other member hospitals and to take a leadership role in advancing best practices in workplace safety.”

INTERVIEW WITH A SURVIVOR

After spending eight hours in surgery and weeks in intensive care, Elise Wilson described her experience in a press interview at her home. Most of the stab wounds were on the inside of her left arm. Two nerves in Mrs. Wilson’s left arm were severed, as was her brachial artery. She said her surgeon took a vein from her leg to conduct a bypass of the artery. She added she lacked sensation in her left hand and can’t lift anything with it. She said she can move her fingers somewhat, but cannot use them. More surgery is scheduled.

After screaming for help, she said, and banging the clogs on her feet to make as much noise as possible, she remembered a security officer entering the triage room. She said she’s fortunate Southbridge paramedics came equipped with a special tourniquet system and a “quick clot” to
best deal with her severe injuries. She was then flown to the UMass Memorial Medical Center - University Campus in Worcester for extensive treatment.

Regarding her attacker, Mrs. Wilson said he was not confrontational when he entered the room, nor did he show signs of being upset. She said she took his vital signs and went to her computer to type his information. But at that point, she said she noticed he was anxious and his eyes were scattered. But that didn’t necessarily raise a red flag, either, she said. “We deal with a lot of anxious and edgy people in the emergency room.” She noticed the chair in which he was seated was empty, and as she turned to see where he was standing, he punched her in the head and exposed the knife.

A 24-year-old man, Conor O’Regan, who fled, was tracked to his home by police and arrested. In a court appearance, he said he was unhappy with his treatment at a previous visit to the hospital for a wrist injury and was seeking revenge. He said his victim was picked at random and that he was aiming at her face, but her arm blocked it.

**TEAM ELISE**

During her treatment and recovery, Mrs. Wilson sparked a movement on social media called “Team Elise” and “Harrington Strong.” Hospital workers and public safety officials posed for photos and wrote supportive messages to her. In her interview Mrs. Wilson noted that injured or killed officers and firefighters often draw massive outpourings, but it doesn’t happen in nursing. She said she’s pleased to have been included in a widely viewed YouTube clip by ZDoggMD, a doctor who makes videos illustrating the demands some patients place on ER workers, including violent encounters. The video asserts that hospital workers will be, “silent no more.”

**SENATE BILL 1374**

Along with her husband and family with the MNA, Mrs. Wilson has been promoting the newly named Elise’s Law which had been in the works for nine years. Senate bill 1374 is “an act requiring health care employers to develop and implement programs to prevent workplace violence.” It was passed favorably by the Joint Committee of Public Safety and
Homeland Security on July 19, 2017, and appeared to be on a fast track to passage, but was not, in 2017. The bill would subject health care employers in the state with five or more employees to:

- Perform an annual risk assessment.
- Develop and implement a plan to minimize the danger of violence based on findings.
- Designate a senior manager responsible for program implementation.

The bill has specific reporting requirements, and violators face fines of up to $2,000.

Violence in the bill is defined as “harassment, intimidation, or other threatening disruptive behavior that occurs at the work site ranging from threats and verbal abuse to physical assaults and homicide.”

**HARRINGTON STRONG**

CEO Moore’s reaction was not in keeping with that of other CEO’s when faced with a horrific incident involving violence against an employee. According to a national investigation by WGN, Chicago, such violence against nurses and other employees has not been routinely tracked or reported, and these included incidents that rivaled Elise Wilson’s—a beating in which a nurse’s ear was ripped off; a hostage situation involving a prisoner patient who raped, tortured, and beat a nurse; a pregnant nurse who was kicked in the stomach, etc. The standard reply reported to media usually consists of the following:

“1. We take workplace violence very seriously.
2. We have programs and protocols in place that deal with it...but we will review these programs and protocols to see if we can make improvements.”

After a while, the media departs and, except for the nurses’ associations, the pressure is off the hospitals to do more to prevent workplace violence unless they are among those investigated by OSHA or its state agencies.

**CEO Moore: A Different Approach**

Not so, the Harrington HealthCare System. The system, with 1500 employees, serves more than 25 communities across south central Massachusetts and northeastern Connecticut. It includes: the 114-bed acute-care Harring-
ton Hospital in Southbridge, an outpatient multi-service facility in Webster, MA, and three major medical office buildings. In a statement issued after Elise Wilson was attacked, CEO Ed Moore said:

"According to the Bureau of Labor Statistics, the incidence of serious workplace violence is four times more likely in healthcare. That national statistic hit home on June 14 with the tragic attack of long-time Harrington Hospital emergency department nurse, Elise Wilson, on our facility’s Southbridge campus. The attack drew national attention to the issue of healthcare workplace violence and left our organization searching for answers to important questions: Could this attack have been prevented? Was our response to the situation adequate? What can we do to prevent similar tragedies in the future?

"In the aftermath of that attack, we’ve been working to answer those questions and to create a safer environment for our employees, patients and visitors alike. Indeed, in the weeks and months leading up to the incident, Harrington had already organized a workplace safety committee and initiated efforts to make the healthcare system and its many accessible spaces safer, a task made more urgent by the June attack.

"Healthcare professionals work with an especially fragile and sometimes unpredictable population, which makes them soft targets for aggressive patients. In an effort to anticipate and minimize that risk, Harrington’s workplace safety committee conducted professional security assessments of all public spaces across the entire campus and is now implementing a three-point plan to minimize workplace violence."

A Three Point Plan
The plan was outlined as follows:

Physical Security
- The installation of walkthrough metal detectors at the entrances to the emergency departments at the Southbridge and Webster campuses.
- Patients being evaluated or treated in the emergency department were now limited to one visitor and re-entry is discouraged. (Exceptions may be made at the discretion of the charge nurse).
Cameras, panic buttons and alarms have been added in many locations.

Some areas were restricted to card access and the Southbridge vestibule area has been re-constructed to better accommodate public safety and registration personnel.

**Emergency Preparedness**
- A new reverse 911 system, similar to what many communities now use to inform their residents, to keep all staff informed of emergencies.
- Adoption of new emergency codes that describe situations in plain language so staff, patients and visitors will immediately know the nature of impending danger.
- New communication protocols and incident command training/drills.

**Staff Education/Awareness**
- Training in managing aggressive behaviors, unit-specific violence avoidance training, collaboration with local law enforcement and continued policy review and development learned.

**Additions and Revisions**
In an updated report in September, the healthcare system reported some revisions and additions.

Patients will now be limited to two visitors, with Public Safety managing visitor flow. Re-entry and visitor swapping will be permitted and managed by Public Safety at reasonable intervals, and Public Safety will also collaborate with the charge nurse in situations where visitation should be limited.

Efforts have included the addition of more Public Safety staff, more security cameras, further securing access to facilities, and panic button installation across all locations. Many of Harrington's employees, including Public Safety staff, will be undergoing advanced training in de-escalation and defensive tactics with programs such as MOAB (Management of Aggressive Behavior). The Public Safety officers, many of whom have law enforcement backgrounds as Auxiliary members to local Police Departments, will now carry batons, pepper spray (foam-based) and handcuffs.
“There are very strict guidelines and circumstances under which these tools would be used, and that is being communicated during the training being taken by our Public Safety Department,” Vice-President Harry Lemieux said. “We recognize our initial policy caused some frustration for our patients and their families. Our priority continues to be creating the safest environment possible for anyone who visits our hospital or any of our medical office buildings. We have been working hard to revise our policy to create safe but more flexible visitation and we think this adjustment accomplishes that need.”

A Role Model For Other Hospitals?

According to local media, Harrington has become somewhat of a role model for other statewide healthcare organizations, which are recognizing the need to do more to protect patients and employees. Harrington, besides being the first in Massachusetts to place metal detectors at its Emergency Room entrances, has implemented other policies ahead of a national standard for preventing workplace violence.

VP Lemieux and Carlton Rondneau, Manager of Public Safety, have appeared at meetings of Massachusetts hospitals, including the December 1 seminar program of the Boston Chapter of IAHSS, describing Harrington’s response to the Elise Wilson incident and its long-term goals.

TWO MORE METAL DETECTOR INSTALLATIONS

Both Moore and UMass Memorial Medical Center CEO Patrick Muldoon visited Wilson in the intensive care unit soon after her attack, according to media reports. Muldoon said Wilson’s husband urged him to boost safety efforts as the chief executive of the region’s largest hospital. A formal safety review followed, he added. One result is the decision to install metal detectors at the hospital’s two Worcester campuses.

Given the climate around safety in hospitals, Muldoon said other measures were added this year, before Wilson was stabbed. For example, a group of about two dozen managers meets daily to discuss safety issues. Muldoon said stories of assault, unfortunately, are frequent.
PROS AND CONS OF METAL DETECTORS

Up until the time Elise Wilson was stabbed, none of Massachusetts' 63 acute care hospitals had installed walk-through metal detectors. In the months following two had installed four of them. In the latest statistics, 7.5% of hospitals nationally reported using them (with 33% employing hand detectors). Undoubtedly the CEO's of the Harrington and UMass systems were aware of the limitations ascribed to walk-through systems. The topic had been widely discussed in local, security, and healthcare media two-and-a-half years earlier when a surgeon was shot and killed by the son of one or his patients at Brigham and Woman's Hospital in Boston.

A Shooting in Boston

Security directors of many of the city’s world-class hospitals were interviewed on why they rejected installing metal detectors. The reasons given stressed that metal detectors would not have prevented this shooting and do not always prevent acts of violence from occurring, slow visitors down, are very costly and require additional staffing, and create an atmosphere that the hospital is unsafe. Their comments also reflected those of a study of hospital shootings four years earlier by four emergency medicine physicians at Johns Hopkins University following the shooting of a doctor there.

A Shooting in Baltimore

That study of 154 hospital-based shootings in an 11-year period which resulted in 235 dead or injured, found that such shootings are difficult to prevent because most involved a “determined shooter.” The Hopkins research team concluded that specialized training for law enforcement and security personnel, such as proper securing of firearms, may prove a more effective deterrent to future incidents than investment in expensive or intrusive technologies, such as magnetometers. Such technologies, they said, may create a false sense of security, primarily because potential weapons get into hospitals by a variety of channels, and because more than 40 percent of all the shootings studied occurred on hospital property outside of buildings.
500 Weapons a Month

In an article in the *Journal of Healthcare Protection Management*, "Metal detectors: security vs. customer service," 2010; 26(1):74-80, Mustapha B. Rhimi, CHPA, then Security Program Manager, Hospital Shared Services (HSS), Denver, CO, anticipated the debate on their effectiveness. Currently Security Manager of NCH Healthcare System, Naples, FL, Rhimi concluded that “it is clear that the use of metal detection is limited especially in a hospital environment when medical needs override security, but it is also clear that the deterrent effect is impactful. There were many times when visitors were observed turning around and going back to their vehicles to rid themselves of weapons they were carrying. There is also no denying the effectiveness of metal detection at alerting security to weapons carried by patients and visitors and minimizing the possibility of weapons being used against staff.”

Citing his experience in a hospital ED, he said, “this became very clear to me after installing metal detectors in the ER following a violent and traumatic incident that led to a death. Since the installation of metal detection the number of weapons seized in the ER environment has been staggering. We collect over 500 weapons capable of inflicting irreparable damage and fatal injuries every month. These weapons range from firearms, swords, knives, pepper spray to razors and other tools that can do serious harm if that is their intended use.”

ADDING SECURITY TO NURSES’ GOALS

Whether metal detectors are installed, or not, incidents of workplace violence like the Elise Wilson at Harrington Hospital or the physician shooting at Brigham and Woman’s Hospital (BWH), have mobilized state and national nurses organizations to include more and improved security as essential goals in their contract negotiations with hospitals.

Following the BWH shooting, the hospital and the Massachusetts Nurses Association (MNA), representing its 3,300 nurses, reached a three-year agreement that MNA officials said protects safe patient care and enhances
hospital security. “We are especially proud to have significantly improved security at the hospital for everyone,” said Trish Powers, RN OR staff nurse and chair of the MNA BWH bargaining unit. “Security was our top priority entering negotiations.”

According to an association press release, Brigham nurses were forced to bring improved security to the bargaining table following the tragic shooting death of the Brigham doctor. Nurses were also being assaulted at high rates throughout the hospital, it said. “Unfortunately, the hospital was not working with the nurses to consider and implement their security proposals, so we turned to contract negotiations and received assistance from the federal Occupational Health and Safety Administration (OSHA). OSHA sent two hazard letters to the hospital about security concerns and nurses delivered their message about hospital safety to the press and to lawmakers on Beacon Hill. The hospital ultimately agreed to a lengthy list of security improvements proposed by Brigham nurses, and has said it spent more than $2 million making the hospital more secure.”

The agreement, according to MNA, included security items and improvements already made and pledged by the hospital:

- Improved access control at the BWH main campus and the Shapiro building
- Signs at all hospital entrances notify entrants that weapons are prohibited and video surveillance is in effect
- New weapons and ankle bracelet policies
- Additional panic alarms installed, with training for staff and regular testing
- Staff training to include online, live discussion and/or mock drills in areas such as personal safety, self-defense, security awareness, active shooter, threat assessment, de-escalation, SAFE response, Code Gray and/or crisis protocols
- Nurses affected by workplace violence will be contacted by supervisors as soon as reasonably possible and the hospital will assist nurses who have experienced a security incident in receiving reasonable medical attention and/or psychological care
- On request, the hospital will be available to meet with MNA
representatives to discuss safety and security concerns, subject to patient privacy requirements.

**CODE GRAY**

Code Gray is a healthcare workplace violence prevention policy and plan which has been developed by the MNA for hospitals, according to Christine Pontus, Associate Director Health & Safety, a registered nurse credentialed in Occupational Health. It is distributed to nurses and other healthcare professionals at various hospital facilities throughout the state and nationally. It includes a comprehensive and detailed action plan for managers and employees for de-escalating and preventing violence, along with forms for security assessment, surveys, documentation, and reports. Also included is A Policy for Prevention of Workplace Violence which is reprinted with permission on the following pages.

(IAHSS members can obtain a pdf copy of the complete Code Gray manual be e-mailing me at robertrusting@gmail.com)
A Policy for Prevention of Workplace Violence

[Organization name] is committed to providing the work force, visitors, patients and others with a safe environment in which to work, secure and free from all forms of violence. Behavior that could affect the safety or well-being of anyone or behavior that may affect the safety of [organization name’s] property and operations is prohibited and will be prosecuted to the fullest extent of the law. This policy is in effect whether the behavior occurs on or off institutional premises (including grounds and parking lots) at company sponsored events and where company business or business related activities are being conducted.

Conduct prohibited under this policy includes but is not limited to:

• Threatening or bullying communication
• Verbal, written, electronic or threatening physical gestures
• Physical injury or potential physical harm to another person
• Aggressive, intimidating or hostile behavior that creates a reasonable fear of injury to a worker or subjects a worker to emotional distress
• Unlawful possession of a weapon with intent to harm people or property (such as firearm, explosive, knife, or chemical spray) on institutional premises or while conducting hospital business is prohibited

Purpose
The purpose of this policy is to clearly state [organization name’s] position to achieve a safe workplace. This is accomplished by assessment, prevention, a quick and total response, debriefing, reporting, monitoring and a continuous process to improve safety within this organization. This policy provides guidance for violence committed by a doctor against a nurse, patient against a nurse, a family member, visitor or vendor against a nurse, management against a nurse, a nurse against a nurse and a nurse against a patient. Also included is the clarification and communication of behavioral expectations, accountability, and compliance with state laws regarding workplace violence.
Procedure

Administrative Controls/IT/Engineering: Hospital administrators are responsible for promoting a safe and nonviolent workplace providing support and resources with a strong understanding of high risk areas and problem situations.

Specific administrative controls are outlined in the Violence Prevention Plan.

Human Resources (HR): is responsible to provide guidance to the intent of the policy which includes the violence prevention plan, and for making all who enter the institution’s property across all professional boundaries aware of the policy. HR will provide a copy of the violence prevention plan and policy to any of its employees, labor organizations, and vendors upon their request.

The HR Department is also responsible for the creation of the Code Gray Committee. This committee will oversee the creation and development of the policy. This group will be responsible for making adjustments in the policy as needed, and review the Code Gray occurrences. This committee will meet once a month. The committee should include, but is not limited to senior management, security personnel, IT Department, nursing management, chief medical officers, bedside nurses, bedside doctors, and a union representative (if applicable in the institution).

HR recruitment must maintain procedures to identify possible abusers which include CORI checks, reference checks, and inquiries into professional registers. HR is responsible for exit interviews and to track and identify reasons for nurses leaving by unit or identified hospital areas. HR is responsible to make all who enter the property aware of the no retaliation policy. See no retaliation policy or employee handbook. If no retaliation policy exists, check with the compliance officer as a no retaliation clause is part of the Massachusetts law.

Risk Manager/Quality Manager/Patient Safety Officer: One or all is responsible for directing the committee that will perform annual risk assessments of all factors that may put any of the employees at risk of workplace assaults and homicide with members consisting of the crisis intervention team (Code Gray Team), and representatives of unit man-
agers, security, human resources, employees at large and any labor organization representing the employees. The risk manager will be a resource for and/or participant in the crisis intervention team. This team is responsible for mandatory debriefing after the Code Gray response with all those who participated with preventing or dealing with the violent incident. Risk management will offer council for the documentation of the incident in the medical record and request an organizational incident report be submitted.

The risk assessment of the environment and environmental audit assessing the safe working environment in public settings will be provided by the safety committee. This assessment focuses on guarding or maintaining property or possessions, working in high-crime areas, working late night or early morning hours, working alone or in small numbers, uncontrolled public access to the workplace, working in public areas where people are in crisis, working in areas where a patient or residents may exhibit violent behavior, working in areas with known security problems. Risk Manager/Quality Manager/Patient Safety Officer will update the violence prevention plan as needed in reference to any rules that the Commissioner of Labor adds to the law.

Security is responsible for the safety of all personnel who are on the property and/or enter the facilities. All security personnel will be the first responders and take the lead in a Code Gray. Security will be trained in hospital operations, identification of predicting factors for violence and aggression and the prevention and management of violent disturbances. Security will be trained and responsible for de-escalation, violence prevention and the code of conduct. Security will establish a liaison with law enforcement representative who can help identify prevention of Work Place Violence and establish a working relationship providing police with a tour and understanding of property and security measures. Security will assess any new building or renovation for possible engineering controls to prevent workplace violence that could be implemented prior to any approval or start dates of building or renovations. Security will work closely with facilities in maintaining security systems throughout the facility.
Management is responsible for being proactive in the implementation and in compliance with the policy. This violence prevention plan ensures all workers are safe in the workplace and those employees, visitors or vendors that violate the violence policy are held accountable. Management will ensure compliance to the policy, plan and Code Gray Resource Book by education and orientation upon hire and annually. Management will oversee the entire environment and culture of violence prevention and set up systems that will support a positive culture. Management will ensure proper reporting of violence claims and the support of employees through system improvements and accountability. Appointment to a management role requires participation in workplace violence education directed toward advanced strategies to reduce workplace violence for the entire organization.

Employees will adhere to the policy, plan and Code Gray guidelines and the code of conduct (see employee handbook). All members of the work force are required to report any incidents of violence or potential violence witnessed or committed against them, to supervisory staff immediately. The work force, upon hiring and annually thereafter, will be educated to the prevention of violence by:

- Policy and procedures
- Violence prevention plan
- High risk area for violence
- Assessment of the environment, patient and workplace setting
- De-escalation of violence
- Code Gray
- Debriefing
- Staffing
- Documentation, reporting
- Referral
- Education
- Monitoring
- Quality improvement process

Reporting

Violence in the work place plan will include at a minimum a list of
those factors and circumstances that may pose a danger to employees, a description of the methods that the health care employer will use to alleviate hazards associated with each factor, including, but not limited to: a) employee training and b) any appropriate changes in job design, staffing, security, equipment or facilities; and will also include a description of the reporting and monitoring system. The plan will be reviewed annually and updated as needed with special attention to additions of rules to the law by the commissioner of Labor. Once the plan is updated the plan should be submitted to the Safety Committee for final approval. (See Violence Prevention Plan).

Incident activation team (Code Gray Team) Members of this team consist of nurses, nurse managers, security, security supervisor, medical attending or house officer, crisis intervention and/or psychology staff and/or social service. Each member of the Code Gray Team will need to have in-depth and on-going education in the area of abuse and interventions. The Risk Manager/Quality Manager /Patient Safety Officer and members of the Code Gray Team will work closely with all other entities within the hospital to respond to: Code Gray detailed below.

Steps Taken in Code Gray
- High potential for violence to occur
- Violent act occurs
- Employee calls a Code Gray by either calling hospital operator or hits panic button
- Hospital operator calls a Code Gray over intercom and states the location of the Code Gray
- Security officers respond to Code Gray location within 2 minutes with equipment
- Employee who activated Code Gray gives detailed report to security officers
- Security decides which pathway to follow based on the persons involved in the Code Gray (see attached algorithms for list of pathway)
- Incident Activation or Code Gray Team arrives and treats situation based on persons involved (see algorithms)
• Code Gray ends
• Employee who activated Code Gray fills out on-line documentation and prints out copy of report
• Debriefing occurs
• Members of Code Gray Committee, VP of institution, HR, Management, and persons involved in Code Gray receive an email of the Code Gray documentation
• Employee Assistance Program and Human resources contact persons involved in Code Gray within 24 hours for affirming report and provide assistance as needed.
• Code Gray Committee meets within one week of Code and reviews case and determines if more follow-up or support is needed
• Code Gray committee determines if policy met the needs of the situation or revising of the policy is needed
• Process when Code Gray is called: (See Violence Prevention Plan)

Reporting

Reporting a potential or actual violent act, will occur following the completion of the Code Gray during the debriefing. A list of all employees that responded to the Code Gray and circumstances that lead up to the potential or violent act will be documented.

The IT Department along with the Code Gray Committee will create a Code Gray on-line documentation sheet. This along with all incident reports, will be filed on-line and have the capability to be printed so the persons involved will be able to proofread and maintain a copy of their incident report.

Members of Code Gray Committee, VP of the institution, HR, Management, and persons involved in Code Gray receive an email of the Code Gray documentation. The Employee Assistance Program and a Human Resource representative contacts each person involved in the Code Gray within 24 hours to affirm the final report and provide assistance as needed. The Code Gray Committee will meet within one week to review the case and determines if more follow-up or support is
needed. The Code Gray Committee determines if policy met the needs of the situation or revising of the policy is needed.

The Violence Prevention Policy Reporting Requirements are modeled from Massachusetts State law which requires inclusion at a minimum:

1. A list of those factors and circumstances that may pose a danger to employees
2. A description of the methods that the health care employer will use to alleviate hazards associated with each factor, including, but not limited to, a) employee training and b) any appropriate changes in job design, staffing, security, equipment or facilities
3. A description of the reporting and monitoring system

The plan will be reviewed every three years and updated as needed with special attention to additions of rules to the law by the Commissioner of Labor. Once the plan is updated the plan should be submitted to the Safety Committee for final approval (see Violence Prevention Plan).

Reference Material


Policy name and #

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