COMMONWEALTH of VIRGINIA

Department of Human Resource Management

OFFICE OF EMPLOYMENT DISPUTE RESOLUTION

DECISION OF HEARING OFFICER

In re:

Case Number: 11843

Hearing Date: September 2, 2022
Decision Issued: September 21, 2022

PROCEDURAL HISTORY

On May 17, 2022, Grievant was issued a Group III Written Notice of disciplinary action with removal for client abuse.

On May 27, 2022, Grievant timely filed a grievance to challenge the Agency's action. The matter advanced to hearing. On June 14, 2022, the Office of Employment Dispute Resolution assigned this appeal to the Hearing Officer. On September 2, 2022, a hearing was held by remote conference.

APPEARANCES

Grievant
Grievant's Counsel
Agency's Representative
Witnesses

ISSUES

1. Whether Grievant engaged in the behavior described in the Written Notice?

2. Whether the behavior constituted misconduct?

3. Whether the Agency's discipline was consistent with law (e.g., free of unlawful discrimination) and policy (e.g., properly characterized as a Group I, II, or III offense)?

4. Whether there were mitigating circumstances justifying a reduction or removal of the disciplinary action, and if so, whether aggravating circumstances existed that would overcome the mitigating circumstances?

BURDEN OF PROOF

The burden of proof is on the Agency to show by a preponderance of the evidence that its disciplinary action against the Grievant was warranted and appropriate under the circumstances. The employee has the burden of raising and establishing any affirmative defenses to discipline and any evidence of mitigating circumstances related to discipline. Grievance Procedure Manual ("GPM") § 5.8. A preponderance of the evidence is evidence which shows that what is sought to be proved is more probable than not. GPM § 9.

FINDINGS OF FACT

After reviewing the evidence presented and observing the demeanor of each witness, the Hearing Officer makes the following findings of fact:

The Department of Behavioral Health and Developmental Services employed Grievant as a Security Officer III at one of its facilities.[1] He began working for the Agency in January 2019. Grievant had prior active disciplinary action. On January 22, 2022, Grievant received a Group II Written Notice for failure to follow policy.

Grievant received training regarding Therapeutic Options of Virginia (TOVA).[2] TOVA sets forth the holds employees are encouraged to use when physically controlling patients.

On May 4, 2022, the Patient was agitated while in his room. A physician ordered that the Patient receive Haldol by pill or injection to treat his behavior. The Patient did not want to consume a pill so staff determined he should receive an injection. The Registered Nurse entered the Patient's room to give him an injection. The Patient did not want to receive an injection. He exited his room and went into the hallway.

[1] Grievant worked in a department that was responsible for "providing for the safety and security of patients, visitors, and staff." See, Agency Exhibit N.

[2] "Therapeutic Options of Virginia is a comprehensive, humane, and effective approach to preventing and managing behavioral emergencies, but no course can guarantee that it covers all situations and circumstances." Agency Exhibit H.

Ms. Q called for a Show of Support[3] because the Patient was yelling, agitated, and threatening. This meant the Patient was a possible threat to himself or others.[4] There was to be a "show of force" such that many staff would gather and approach the Patient "for the purpose of support for de-escalation."[5] Once numerous staff arrived at the Patient's location, the Patient continued to defy staff instructions to allow them to inject him. There were approximately six women employees in the hallway along with Grievant and Mr. M. Another male employee was present but did not participate.

The Registered Nurse determined the Patient would be given the injection against his will. She instructed Grievant to use force on the Patient by holding the Patient. Grievant approached the Patient and positioned himself on the Patient's left side. Mr. M approached the Patient and positioned himself on the Patient's right side. They placed the Patient in a side body hold in accordance with TOVA.

To perform the side body hold, Grievant pressed the front of his body against the left side of the Patient's body. Grievant's chest was against the Patient's left shoulder. Grievant had his left arm wrapped across the Patient's front and his right arm was behind the Patient. Grievant firmly and tightly held the Patient to prevent the Patient from moving. The Patient's back was against a wall which prevented the Patient from escaping to his rear.

The Registered Nurse attempted to inject a needle into the Patient's upper left shoulder. She was unable to do so because the Patient struggled trying to break free of Grievant's and Mr. M's hold. The Patient turned his head to his left and yelled at Grievant. The Patient attempted to duck down and bump Grievant. Grievant moved his left leg to wrap it around the Patient's left leg. Grievant squeezed the Patient in order to hold the Patient still. The Registered Nurse could not make the injection into the Patient's left shoulder, so she stepped back and then stepped towards the Patient's right leg. With the assistance of another nurse, the Registered Nurse injected the medication into the Patient's right hip.

The Patient was informed he was going to be released. Upon hearing this, the Patient "fixated" on Grievant.

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[3] The evidence is unclear regarding whether a Code White, show of support, or show of force was announced to staff. The Agency's policies discuss these concepts differently. For example, if there is a show of support it means Grievant's Department, Public Safety, is not involved. If Public Safety staff become involved it is a Code White. These differences are not significant. Regardless of the terminology uses, an emergency was announced and numerous staff including Grievant responded. See, Agency Exhibit I.

[4] Throughout the incident, the Patient was threatening to harm staff including Grievant and Mr. M.

[5] Agency Exhibit H. A show of force was called even though "it is not used for a patient who is actively aggressive."

Immediately after the injection, the Patient attempted to break free from Grievant's hold. The Patient raised his left arm and twisted his body. The Patient attempted to walk forward while turning to attempt to hit Grievant's head. Grievant moved forward with the Patient. Grievant had to move forward with the Patient in order to retain control of the Patient. Grievant told Mr. M to release the Patient. Mr. M began to release his hold on the Patient as the Patient began moving forward. Mr. M did not release his hold completely until the Patient had moved away from Mr. M. As Mr. M was releasing the Patient, Mr. M continued to watch the employees and the Patient "to be sure [the Patient] did not swing at them." As Grievant and the Patient moved forward, Grievant released his grip of the Patient, put his hands on the Patient's back and extended his arms to push the Patient away from the group. The Patient continued moving forward because he was walking forward and also because of Grievant's push. The Patient did not fall. Once the Patient was away from the group of employees, Grievant took two steps backwards while watching the Patient's movement. The Patient turned and began approaching Grievant while speaking angrily to Grievant. The Patient said, "Don't you ever put your hands on me again!" and "F—k you, come at me." Grievant waited to determine if the Patient would calm down. As the Patient continued to display agitation and anger, Grievant and Mr. M began moving slowly towards the Patient. The Patient began moving backwards while speaking to the employees. Once the Patient stopped gesturing, the Nursing Supervisor spoke to Grievant and told him to move away. Grievant took approximately four steps backwards while watching the Patient.

Throughout the incident, Grievant did not speak to the Patient or otherwise verbally confront the Patient. Grievant maintained a steady demeanor.

CONCLUSIONS OF POLICY

The Agency has a duty to the public to provide its clients with a safe and secure environment. It has zero tolerance for acts of abuse or neglect and these acts are punished severely.

The definition of client abuse appears in statute, regulation, and policy. Va. Code 37.2-100 provides:

> "Abuse" means any act or failure to act by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the Department, excluding those operated by the Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to an individual receiving care or treatment for mental illness, developmental disabilities, or substance abuse. Examples of abuse include acts such as:
> 1. Rape, sexual assault, or other criminal sexual behavior;
> 2. Assault or battery;

3. Use of language that demeans, threatens, intimidates, or humiliates the individual;
4. Misuse or misappropriation of the individual's assets, goods, or property;
5. Use of excessive force when placing an individual in physical or mechanical restraint;
6. Use of physical or mechanical restraints on an individual that is not in compliance with federal and state laws, regulations, and policies, professionally accepted standards of practice, or his individualized services plan; and
7. Use of more restrictive or intensive services or denial of services to punish an individual or that is not consistent with his individualized services plan.

12 VAC 35-115-30 provides:

"Abuse" means any act or failure to act by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to a person receiving care or treatment for mental illness, intellectual disability, or substance abuse. Examples of abuse include acts such as:
1. Rape, sexual assault, or other criminal sexual behavior;
2. Assault or battery;
3. Use of language that demeans, threatens, intimidates, or humiliates the person;
4. Misuse or misappropriation of the person's assets, goods, or property;
5. Use of excessive force when placing a person in physical or mechanical restraint;
6. Use of physical or mechanical restraints on a person that is not in compliance with federal and state laws, regulations, and policies; professionally accepted standards of practice; or the person's individualized services plan; and
7. Use of more restrictive or intensive services or denial of services to punish the person or that is not consistent with his individualized services plan. See § 37.2-100 of the Code of Virginia.

Departmental Instruction (“DI”) 201 defines client abuse as:

This means any act or failure to act by an employee or other person responsible for the care of an individual in a Department facility that was performed or was failed to be performed knowingly, recklessly or intentionally, and that caused or might have caused physical or psychological harm, injury or death to a person receiving care or treatment

for mental illness, mental retardation or substance abuse. Examples of abuse include, but are not limited to, acts such as:

- Rape, sexual assault, or other criminal sexual behavior
- Assault or battery
- Use of language that demeans, threatens, intimidates or humiliates the person;
- Misuse or misappropriation of the person's assets, goods or property
- Use of excessive force when placing a person in physical or mechanical restraint
- Use of physical or mechanical restraints on a person that is not in compliance with federal and state laws, regulations, and policies, professionally accepted standards of practice or the person's individual services plan; and
- Use of more restrictive or intensive services or denial of services to punish the person or that is not consistent with his individualized services plan.

For the Agency to meet its burden of proof in this case, it must show that (1) Grievant engaged in an act that he performed knowingly, recklessly, or intentionally and (2) Grievant's act caused or might have caused physical or psychological harm to the Client.

This case involves interpreting and applying two separate policies – DHRM Policy 1.60 and DBHDS DI 201. The issuance of a written notice pursuant to DHRM Policy 1.60 only becomes relevant if Grievant has engaged in client abuse.

The Agency's policy reflects the application of State law. The Hearing Officer must apply DI-201 as if he were applying State law.

The Agency has not established that Grievant engaged in client abuse under State law and, thus, under the Agency's policy for several reasons.

First, the Agency had several types of employees providing care to the Patient. Nursing staff were responsible for providing medical care to the Patient. Nursing staff were responsible for using force only as a minor and secondary part of their duties. Grievant was not responsible for providing medical treatment to the Patient. Grievant's responsibilities included the application of physical force on patients. He worked in the Public Safety / Safety and Security department and his responsibilities extended to protecting patients, other employees, and himself. Grievant was not simply authorized to use force, he was expected to use force when necessary. Grievant's push was intended to further his security duties.

Second, the amount of force Grievant used to hold (physically restrain) the Patient was significant and constant. Grievant immobilized the Patient so the Patient could

receive medication. The amount of force Grievant used to push the Patient away was not significant. Grievant's push was not material when viewed in the context of all of the force used on the Patient.

Third, because the Patient was moving forward, Grievant's push appears more forceful than it actually was. If Grievant's push had been forceful, the Patient would likely have fallen.

Fourth, Grievant's intent was not to harm, punish, or fight the Patient. Grievant's intent and objective was to put distance between a patient who was swinging his arms and fists wildly and the other staff Grievant was obligated to protect.

Grievant's use of force was not client abuse. Because Grievant did not engage in client abuse, the Group III Written Notice must be reversed.

The Agency argued that Grievant had been taught to step back from the Patient instead of pushing the Patient. If Grievant had stepped back from the Patient, the Patient would have remained within easy striking distance of at least three staff. By pushing the Patient away from the group, Grievant reduced to one the number of staff available to be hit by the Patient if the Patient continued fighting. Neither Grievant nor anyone else could have predicted when the Patient would stop fighting.

The Agency argued that the Patient responded to Grievant's push by turning and walking towards Grievant as if to fight. It is unknown what part of the incident motivated the Patient's action.[6] Was it because of Grievant's push or because Grievant had used his entire body weight to restrain the Patient and frustrate the Patient who was unable to move while being injected with medication against his will? It is unknown how the Patient would have acted had Grievant simply moved back from the Patient to release the Patient. The Patient may have continued swinging his arms and fighting staff, thus, injuring the co-workers Grievant was obligated to protect, but would no longer have been in a position to protect because he had withdrawn.

The Agency argued Grievant engaged in client abuse because he used "excessive force when placing a person in physical or mechanical restraint." The evidence showed that Grievant's force was not excessive and Grievant was not placing the Patient in physical restraint, Grievant was releasing the Patient from a physical restraint.

The Agency argued Grievant engaged in client abuse because he committed "[a]ssault or battery." Grievant used his body to fully restrain the Patient's movement. If a full restraint is not assault or battery, it is difficult for the Hearing Officer to conclude that a minor push was assault or battery. Whether Grievant's behavior was assault or battery does not hinge on whether Grievant's action was taught in TOVA training.

[6] The Patient told Grievant, "don't you ever put your hands on me again." No one testified that the Patient expressed anger with Grievant specifically for the push. It appears the Patient was angry because he had been physically restrained and injected with medication against his will.

The Written Notice refers to Grievant's "posturing" and suggested that doing so was improper. The evidence showed that the Agency only considered Grievant's push of the Patient to be client abuse. Nevertheless, Grievant's posturing was appropriate because he needed to remain in a position to protect other staff in case the Patient began fighting other staff. Indeed, one of Grievant's responsibilities was to use force to protect staff when necessary. Expecting Grievant to back away from the Patient when the Patient was expressing an aggressive demeanor was inconsistent with his work responsibilities.

The Virginia General Assembly enacted *Va. Code § 2.2-3005.1(A)* providing, "In grievances challenging discharge, if the hearing officer finds that the employee has substantially prevailed on the merits of the grievance, the employee shall be entitled to recover reasonable attorneys' fees, unless special circumstances would make an award unjust." Grievant has substantially prevailed on the merits of the grievance because he is to be reinstated. There are no special circumstances making an award of attorney's fees unjust. Accordingly, Grievant's attorney is advised to submit an attorneys' fee petition to the Hearing Officer within 15 days of this Decision. The petition should be in accordance with the EDR Director's *Rules for Conducting Grievance Hearings*.

DECISION

For the reasons stated herein, the Agency's issuance to the Grievant of a Group III Written Notice of disciplinary action with removal is **rescinded**. The Agency is ordered to **reinstate** Grievant to Grievant's same position at the same facility prior to removal, or if the position is filled, to an equivalent position. The Agency is directed to provide the Grievant with **back pay** less any interim earnings that the employee received during the period of removal. The Agency is directed to provide **back benefits** including health insurance and credit for leave and seniority that the employee did not otherwise accrue.

APPEAL RIGHTS

You may request an administrative review by EDR within **15 calendar** days from the date the decision was issued. Your request must be in writing and must be **received** by EDR within 15 calendar days of the date the decision was issued.

Please address your request to:

Office of Employment Dispute Resolution
Department of Human Resource Management
101 North 14th St., 12th Floor
Richmond, VA 23219

or, send by e-mail to EDR@dhrm.virginia.gov, or by fax to (804) 786-1606.

You must also provide a copy of your appeal to the other party and the hearing officer. The hearing officer's **decision becomes final** when the 15-calendar day period has expired, or when requests for administrative review have been decided.

A challenge that the hearing decision is inconsistent with state or agency policy must refer to a particular mandate in state or agency policy with which the hearing decision is not in compliance. A challenge that the hearing decision is not in compliance with the grievance procedure, or a request to present newly discovered evidence, must refer to a specific requirement of the grievance procedure with which the hearing decision is not in compliance.

You may request a judicial review if you believe the decision is contradictory to law. You must file a notice of appeal with the clerk of the circuit court in the jurisdiction in which the grievance arose within **30 days** of the date when the decision becomes final.[1]

[See Sections 7.1 through 7.3 of the Grievance Procedure Manual for a more detailed explanation, or call EDR's toll-free Advice Line at 888-232-3842 to learn more about appeal rights from an EDR Consultant].

/s/ Carl Wilson Schmidt

Carl Wilson Schmidt, Esq.
Hearing Officer

[1] Agencies must request and receive prior approval from EDR before filing a notice of appeal.

COMMONWEALTH of VIRGINIA

Office of Employment Dispute Resolution

DIVISION OF HEARINGS

DECISION OF HEARING OFFICER

In re:

Case No: 11843-R

Reconsideration Decision Issued: April 28, 2023

RECONSIDERATION DECISION

On November 18, 20922, OEDR issued Ruling 2023-5468 remanding the matter to the Hearing Officer. Grievant requested a hearing to present additional evidence. On February 27, 2023, a second evidentiary hearing was held by remote conference.

The Ruling states:

> On remand, the hearing officer must additionally address points raised by the agency but that do not appear in the decision. First, record evidence appears to reflect the agency's contention that the grievant's act of pushing the patient was inconsistent with the TOVA training he had received. The agency appears to equate an action that violates TOVA with abuse. The hearing decision does not appear to address this key point: to what extent an action inconsistent with TOVA training is equivalent to abuse. The hearing decision is also lacking findings as to whether the grievant's conduct was a technique disallowed under or violative of TOVA. Accordingly, these issues must be addressed on remand.
>
> Second, the agency's evidence appears to make the point that any push, however forceful, is not appropriate and that there is no authority that allows an agency employee like the grievant to push a patient in any circumstance. This evidence has not been directly addressed in the hearing decision. The hearing officer does appear to have partially considered this issue when addressing the agency's evidence about teaching employees to step back from a patient when they are being released from a hold. However, the

hearing officer essentially appears to have found that the grievant's push was appropriate as an attempt to put distance between the patient and other staff to prevent harm. EDR is unable to identify evidence in the record to support this finding as a matter of agency policy, or at least the basis for the hearing officer's determination is not articulated in the decision. The agency's evidence appears to suggest that no push is permitted. EDR cannot determine what policy or other basis the hearing officer is relying upon to find that there was a justified basis to push the patient. Accordingly, the hearing officer must address these issues on remand.

Third, the agency alleges that the grievant's push was "assault or battery" under the examples of abuse listed in DI 201. The hearing officer determined that the grievant's push was not "assault or battery" because the push was "minor." EDR is unable to determine what definition of "assault or battery" is being applied in this context, or what definition the agency utilizes under its policy. On remand, the hearing officer must clarify his findings to explain the basis for his determination. If the hearing officer wishes to take additional evidence or argument from the parties as to this definition, the hearing officer has discretion to do so. Further, while the level of significance of the push may certainly be relevant to the question of whether the conduct amounts to "assault or battery," more critically as stated above, the hearing officer must clearly address the grievant's conduct under the definition of abuse, including the elements of intent and potential to cause harm. The hearing officer must identify the record evidence, or lack thereof, for his findings on remand.

REMAND FINDINGS OF FACT

The Department of Behavioral Health and Developmental Services employed Grievant as a Security Officer III at one of its facilities.[1] He began working for the Agency in January 2019. Grievant had prior active disciplinary action. On January 22, 2022, Grievant received a Group II Written Notice for failure to follow policy.

Grievant received training regarding Therapeutic Options of Virginia (TOVA).[2] TOVA sets forth the holds employees are encouraged to use when physically controlling patients. TOVA does not teach employees to push patients as a form of restraint. A reason not to push patients is that doing so could cause patients to fall and be injured. TOVA discourages but also does not prohibit employees from pushing patients. For example, employees are authorized by the Agency to use reasonable force to protect

[1] Grievant worked in a department that was responsible for "providing for the safety and security of patients, visitors, and staff." See, Agency Exhibit N.

[2] "Therapeutic Options of Virginia is a comprehensive, humane, and effective approach to preventing and managing behavioral emergencies, but no course can guarantee that it covers all situations and circumstances." Agency Exhibit H.

themselves and others.[3] Pushing a patient with minimal force to protect other employs is not a technique disallowed by TOVA.

On May 4, 2022, the Patient was agitated while in his room. A physician ordered that the Patient receive Haldol by pill or injection to treat his behavior. The Patient did not want to consume a pill so staff determined he should receive an injection. The Registered Nurse entered the Patient's room to give him an injection. The Patient did not want to receive an injection. He exited his room and went into the hallway.

Ms. Q called for a Show of Support[4] because the Patient was yelling, agitated, and threatening. This meant the Patient was a possible threat to himself or others.[5] There was to be a "show of force" such that many staff would gather and approach the Patient "for the purpose of support for de-escalation."[6] Once numerous staff arrived at the Patient's location, the Patient continued to defy staff instructions to allow them to inject him. There were approximately six women employees in the hallway along with Grievant and Mr. M. Another male employee was present but did not participate.

The Registered Nurse determined the Patient would be given the injection against his will. She instructed Grievant to use force on the Patient by holding the Patient. Grievant approached the Patient and positioned himself on the Patient's left side. Mr. M approached the Patient and positioned himself on the Patient's right side. They placed the Patient in a side body hold in accordance with TOVA.

To perform the side body hold, Grievant pressed the front of his body against the left side of the Patient's body. Grievant's chest was against the Patient's left shoulder. Grievant had his left arm wrapped across the Patient's front and his right arm was behind the Patient. Grievant firmly and tightly held the Patient to prevent the Patient from moving. The Patient's back was against a wall which prevented the Patient from escaping to his rear.

The Registered Nurse attempted to inject a needle into the Patient's upper left shoulder. She was unable to do so because the Patient struggled trying to break free of Grievant's and Mr. M's hold. The Patient turned his head to his left and yelled at Grievant.

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[3] For example, the Facility Director testified he believed Mr. 2 was authorized to shove Patient 2 to avoid being head-butted by Patient 2.

[4] The evidence is unclear regarding whether a Code White, show of support, or show of force was announced to staff. The Agency's policies discuss these concepts differently. For example, if there is a show of support it means Grievant's Department, Public Safety, is not involved. If Public Safety staff become involved it is a Code White. These differences are not significant. Regardless of the terminology uses, an emergency was announced and numerous staff including Grievant responded. See, Agency Exhibit I.

[5] Throughout the incident, the Patient was threatening to harm staff including Grievant and Mr. M.

[6] Agency Exhibit H. A show of force was called even though "it is not used for a patient who is actively aggressive."

The Patient attempted to duck down and bump Grievant. Grievant moved his left leg to wrap it around the Patient's left leg. Grievant squeezed the Patient in order to hold the Patient still. The Registered Nurse could not make the injection into the Patient's left shoulder, so she stepped back and then stepped towards the Patient's right leg. With the assistance of another nurse, the Registered Nurse injected the medication into the Patient's right hip.

The Patient was informed he was going to be released. Upon hearing this, the Patient "fixated" on Grievant.

Immediately after the injection, the Patient attempted to break free from Grievant's hold. The Patient raised his left arm and twisted his body. The Patient attempted to walk forward while swinging his arms and turning to attempt to hit Grievant's head. Grievant moved forward with the Patient. Grievant had to move forward with the Patient in order to retain control of the Patient. Grievant told Mr. M to release the Patient. Mr. M began to release his hold on the Patient as the Patient began moving forward. Mr. M did not release his hold completely until the Patient had moved away from Mr. M. As Mr. M was releasing the Patient, Mr. M continued to watch the employees and the Patient "to be sure [the Patient] did not swing at them." As Grievant and the Patient moved forward, Grievant released his grip of the Patient, put his hands on the Patient's back and extended his arms to push the Patient away from the group. The Patient had been spitting and fighting and Grievant did not want the Patient to harm staff. Grievant wanted to move the Patient away from staff as best he could. As Grievant testified, his intent was to protect staff and himself from the Patient.

The Patient continued moving forward because he was walking forward and also because of Grievant's push. The Patient did not fall. Once the Patient was away from the group of employees, Grievant took two steps backwards while watching the Patient's movement. The Patient turned and began approaching Grievant while speaking angrily to Grievant. The Patient said, "Don't you ever put your hands on me again!"[7] and "F—k you, come at me." Grievant waited to determine if the Patient would calm down. As the Patient continued to display agitation and anger, Grievant and Mr. M began moving slowly towards the Patient. The Patient began moving backwards while speaking to the employees. Once the Patient stopped gesturing, the Nursing Supervisor spoke to Grievant and told him to move away. Grievant took approximately four steps backwards while watching the Patient.

Throughout the incident, Grievant did not speak to the Patient or otherwise verbally confront the Patient. Grievant maintained a steady demeanor.

Mr. 2 worked as a security officer at the same Facility where Grievant worked.

[7] It is important to emphasize that the Patient did not say "don't you ever push me again." The Patient said put your hands on me which was something Grievant did when he first engaged the Patient. Someone watching the video may suspect that the Patient's reaction was a result of Grievant's push but the Patient's words suggest that the Patient's reaction was because of the entire restraint, not just one part of it.

On August 14, 2022, Mr. 2 escorted Patient 2 down a hallway at the Facility. Mr. 2 was several inches taller than Patient 2. As Mr. 2 walked, he had his arms crossed in front with his hands tucked under his arms. In other words, Mr. 2's hands were not visible to Patient 2. Patient 2 turned around and began walking up the hallway. Mr. 2 followed Patient 2. Patient 2 stopped walking and turned around to face Mr. 2. Patient 2 told Mr. 2 to stop following him. They stood several feet apart and talked. Patient 2 extended his arm and pointed his finger at Mr. 2 as they continued to talk. Mr. 2 shook his head "no" in disagreement with what Patient 2 was saying.[8]

Patient 2 began telling Mr. 2 that Patient 2 was going to kill Mr. 2. Patient 2 used racial slurs towards Mr. 2, according to the Investigation report.

Patient 2 took a few small steps towards Mr. 2 to enter Mr. 2's "personal space." Mr. 2 did not back up when Patient 2 entered Mr. 2's personal space even though Mr. 2 had a lot of room to back up.

While holding his hands to his sides, Patient 2 steadily moved his head directly in front of Mr. 2 and then used his nose and top part of his face to touch Mr. 2. Patient 2 touched Mr. 2's upper chest just below his neck. Mr. 2 told the Investigator, he thought Patient 2 was going to head-butt him.

Mr. 2 could have stepped back from the Patient 2. Instead, Mr. 2 raised both of his arms and shoved Patient 2 in Patient 2's chest. Mr. 2 shoved with sufficient force to move his body back one and a half steps and move Patient 2's body back three or four steps. Because of Mr. 2's shove, Patient 2 fell backwards and landed on the hard hallway floor. Instead of standing still or backing up, Mr. 2 began stepping towards Patient 2 as if to continue the fight.

Patient 2 jumped up from the floor and assumed a fighting stance with his fists raised. He began moving towards Mr. 2 while prepared to punch Mr. 2. Instead of backing up, Mr. 2 assumed a fighting stance with open hands.

Patient 2 took a swing at Mr. 2. Mr. 2 was able to grab Patient 2's left wrist and right hand and began pushing Patient 2 backwards.[9] Mr. 2 was able to turn Patient 2 around and wrap his arms around Patient 2. Patient 2 stopped fighting.

Other staff observed the conflict and a code white was called. One security officer heard Mr. 2 say he "would not be f—king punched by anyone."[10]

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[8] Grievant called Mr. 2 as a witness but the Agency did not produce Mr. 2 as a witness even though he remained an Agency employee.

[9] The Agency did not consider this push to be client abuse.

[10] Patient 2's words suggest that after he was shoved to the ground he got up to fight because Mr. 2 shoved him. Patient 2 perceived Mr. 2's shove as if it were the same as being punched.

The Agency reviewed the video footage of Mr. 2's interaction with Patient 2. The Investigator wrote, "It is the conclusion of this investigation that [Mr. 2] did use excessive force in moving [Patient 2] away from him and that TOVA techniques were not applied in this situation."

On August 22, 2022, the Facility Director indicated that he "Agreed with investigator" and concluded that Mr. 2's "Corrective Action(s)" should "[Mr. 2] should repeat the 2-day TOVA course."

REMAND CONCLUSIONS OF POLICY

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The definition of client abuse appears in statute, regulation, and policy. Va. Code 37.2-100 provides:

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12 VAC 35-115-30 provides:

"Abuse" means any act or failure to act by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to a person receiving care or treatment for mental illness, intellectual disability, or substance abuse. Examples of abuse include acts such as:
1. Rape, sexual assault, or other criminal sexual behavior;
2. Assault or battery;
3. Use of language that demeans, threatens, intimidates, or humiliates the person;
4. Misuse or misappropriation of the person's assets, goods, or property;
5. Use of excessive force when placing a person in physical or mechanical restraint;
6. Use of physical or mechanical restraints on a person that is not in compliance with federal and state laws, regulations, and policies; professionally accepted standards of practice; or the person's individualized services plan; and
7. Use of more restrictive or intensive services or denial of services to punish the person or that is not consistent with his individualized services plan. See § 37.2-100 of the Code of Virginia.

Departmental Instruction (“DI”) 201 defines client abuse as:

This means any act or failure to act by an employee or other person responsible for the care of an individual in a Department facility that was performed or was failed to be performed knowingly, recklessly or intentionally, and that caused or might have caused physical or psychological harm, injury or death to a person receiving care or treatment for mental illness, mental retardation or substance abuse. Examples of abuse include, but are not limited to, acts such as:

- Rape, sexual assault, or other criminal sexual behavior
- Assault or battery
- Use of language that demeans, threatens, intimidates or humiliates the person;
- Misuse or misappropriation of the person’s assets, goods or property
- Use of excessive force when placing a person in physical or mechanical restraint
- Use of physical or mechanical restraints on a person that is not in compliance with federal and state laws, regulations, and policies, professionally accepted standards of practice or the person’s individual services plan; and

- Use of more restrictive or intensive services or denial of services to punish the person or that is not consistent with his individualized services plan.

For the Agency to meet its burden of proof in this case, it must show that (1) Grievant engaged in an act that he performed knowingly, recklessly, or intentionally and (2) Grievant's act caused or might have caused physical or psychological harm to the Client.

This case involves interpreting and applying two separate policies – DHRM Policy 1.60 and DBHDS DI 201. The issuance of a written notice pursuant to DHRM Policy 1.60 only becomes relevant if Grievant has engaged in client abuse.

The Agency's policy reflects the application of State law. The Hearing Officer must apply DI-201 as if he were applying State law.

The Agency has not established that Grievant engaged in client abuse under State law and, thus, under the Agency's policy for several reasons.[11]

First, the Agency had several types of employees providing care to the Patient. Nursing staff were responsible for providing medical care to the Patient. Nursing staff were responsible for using force only as a minor and secondary part of their duties. Grievant was not responsible for providing medical treatment to the Patient. Grievant's responsibilities included the application of physical force on patients. He worked in the Public Safety / Safety and Security department and his responsibilities extended to protecting patients, other employees, and himself. Grievant was not simply authorized to use force, he was expected to use force when necessary. Grievant's push was intended to further his security duties.

Second, the amount of force Grievant used to hold (physically restrain) the Patient was significant and constant. Grievant immobilized the Patient so the Patient could receive medication. The amount of force Grievant used to push the Patient away was not significant. Grievant's push was not material when viewed in the context of all of the force used on the Patient. Grievant had to use both arms, one leg, and his entire weight and strength to restrain the Patient while the Patient was receiving the shot. He only used the strength of his arms to push the Patient away from himself and other staff.

Third, because the Patient was moving forward, Grievant's push appears more forceful than actually it was. If Grievant's push had been forceful, the Patient would likely have fallen.

[11] The Hearing Officer can assume for the sake of argument that Grievant engaged in client abuse and the outcome of this case does not change. The Agency concluded that both Grievant and Mr. 2 engaged in client abuse yet only Grievant received disciplinary action. The Agency improperly applied DI-201 to discipline Grievant without taking disciplinary action against Mr. 2. The Agency should have treated Grievant and Mr. 2 the same.

Fourth, Grievant's intent was not to harm, punish, or fight the Patient. Grievant's intent and objective was to put distance between staff Grievant was obligated to protect and a patient who was spitting and swinging his arms and fists wildly. Grievant's objective was to protect other staff and, thus, his actions were not contrary to TOVA and not subject to disciplinary action.

Grievant's use of force was not client abuse. Because Grievant did not engage in client abuse, the Group III Written Notice must be reversed.

The Agency argued that Grievant had been taught to step back from the Patient instead of pushing the Patient. If Grievant had stepped back from the Patient, the Patient would have remained within easy striking distance of at least three staff. By pushing the Patient away from the group, Grievant reduced to one the number of staff available to be hit by the Patient if the Patient continued fighting. Neither Grievant nor anyone else could have predicted when the Patient would stop fighting.

The Agency argued that the Patient responded to Grievant's push by turning and walking towards Grievant as if to fight. It is unknown what part of the incident motivated the Patient's action.[12] Was it because of Grievant's push or because Grievant had used his entire body weight to restrain the Patient and frustrate the Patient who was unable to move while being injected with medication against his will? It is unknown how the Patient would have acted had Grievant simply moved back from the Patient to release the Patient. The Patient may have continued swinging his arms and fighting staff, thus, injuring the co-workers Grievant was obligated to protect, but Grievant would no longer have been positioned to protect them because he had withdrawn.

The Agency argued Grievant engaged in client abuse because he used "excessive force when placing a person in physical or mechanical restraint." The evidence showed that Grievant's force was not excessive and Grievant was not placing the Patient in physical restraint, Grievant was releasing the Patient from a physical restraint.

The Agency argued Grievant engaged in client abuse because he committed "[a]ssault or battery." The Agency did not provide a definition of assault and battery under DI-201.[13] Grievant used his body to fully restrain the Patient's movement. If Grievant had

[12] The Patient told Grievant, "don't you ever put your hands on me again." No one testified that the Patient expressed anger with Grievant specifically for the push. It appears the Patient was angry because he had been physically restrained and injected with medication against his will.

[13] Virginia law provides:

> To sustain a conviction for battery, the Commonwealth must prove a "wil[l]ful or unlawful touching" of another. Wood v. Commonwealth, 149 Va. 401, 404, 140 S.E. 114, 115 (1927). It is not necessary that the touching "result in injury to the [victim's] corporeal person. It is sufficient if it does injury to the [victim's] mind or feelings." Id. at 405, 140 S.E. at 115.
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> [A] common law assault, whether a crime or tort, occurs when an assailant engages in an overt act intended to inflict bodily harm and has the present ability to inflict such harm *or* engages in an overt act intended to place the victim in fear or apprehension of

approached an individual who was not a patient at the Facility and controlled that person's movement, Grievant would have engaged in an assault and battery under Virginia law.[14] Because the Patient was at the Facility when Grievant fully restrained the Patient, the Agency did not consider that to be an assault and battery. If the Agency did not believe Grievant assaulted the Patient when Grievant restrained him, it is difficult for the Hearing Officer to conclude that Grievant's push of the Patient was an assault and battery. Grievant's push of the Patient was insignificant when compared to the force Grievant used to restrain the Patient. Grievant's push of the Patient cannot be assault and battery if Grievant's full restraint of the Patient is not an assault and battery. Whether Grievant's behavior was assault or battery does not hinge on whether Grievant's action was taught in TOVA training.

The Written Notice refers to Grievant's "posturing" and suggested that doing so was improper. The evidence showed that the Agency only considered Grievant's push of the Patient to be client abuse. Nevertheless, Grievant's posturing was appropriate because he needed to remain in a position to protect other staff in case the Patient began fighting other staff. Indeed, one of Grievant's responsibilities was to use force to protect staff when necessary. Expecting Grievant to back away from the Patient when the Patient was expressing an aggressive demeanor was inconsistent with his work responsibilities.

The Agency's interpretation of DI-201 must be viewed in light of how differently it treated Grievant and Mr. 2. The Agency's interpretation and application of DI-201 was arbitrary and capricious. The Agency unfairly and inconsistently applied DI-201 to Grievant. The Agency is required to apply discipline consistently among employees engaging in similar behavior.

Mr. 2's behavior was worse than Grievant's behavior yet the Agency took no disciplinary action against Mr. 2. Mr. 2's behavior was worse for several reasons. First, Mr. 2's shove was more forceful than Grievant's push. Mr. 2 shoved Patient 2 so hard that Patient 2's body moved several feet and caused him to become unbalanced and fall backwards onto the hard floor. In other words, Mr. 2 shoved Patient 2 to the ground, while Grievant simply pushed the Patient away. Second, following the shove, Mr. 2 began to advance towards Patient 2 as if to continue the fight. Grievant remained stationary without any material advance. Only after it appeared the Patient remained out of control did Grievant and the other security officer begin to move towards the Patient. Third, Grievant's duty to protect staff extended to himself and many other staff. Mr. 2's duty to protect staff was limited to protecting himself. In other words, Grievant's decision-making framework was more complex than Mr. 2's decision-making framework.

Although once the threshold of abuse is met, whose behavior was worse is not significant in itself. The fact that Mr. 2's behavior was worse than Grievant's behavior,

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bodily harm and creates such reasonable fear or apprehension in the victim. Carter v. Commonwealth, 269 Va. 44, 47 (2005).

[14] The same reasoning applies to the nurse who injected the Patient with a drug against his will.

however, highlights the unreasonableness of the Agency's different treatment of the two employees.

Grievant and Mr. 2 were similarly situated employees. They were both safety officers trained to apply TOVA principles. Mr. 2 and Grievant worked at the same Facility under the same Facility executives. Grievant's incident was on May 4, 2022 and Mr. 2's incident was on August 14, 2022. Both incidents were investigated and an Investigator concluded both engaged in client abuse. If the Agency declined to discipline Mr. 2 because Mr. 2 shoved Patient 2 to protect himself, the Agency should have declined to discipline Grievant who pushed the Patient to protect himself and other staff.

The Agency argued it was appropriate to treat Mr. 2 differently from Grievant because Patient 2 had spit on Mr. 2 two days earlier, threatened him one day earlier and was about to head-butt Mr. 2.[15] This argument is not persuasive. The Patient also made repeated threats to harm Grievant. Grievant did not react to those threats. The Agency argued that Grievant should not have pushed the Patient but instead backed up or remained in his position as the Patient was being released. The same argument can be applied to Mr. 2. If Mr. 2 believed he was going to be head-butted by Patient 2, Mr. 2 could have moved backwards. If Grievant had moved in a straight line backwards, he would have hit the wall after a few paces. By contrast, if Mr. 2 moved in a straight line backwards, he would have had nothing blocking his backward movement. Mr. 2 was standing in the middle of the hallway.

The Agency argued that pushing is never allowed under TOVA and that because Grievant pushed the Patient, Grievant engaged in client abuse under DI-201 and should receive disciplinary action. The evidence on remand showed that the Agency tolerated Mr. 2 shoving Patient 2 and did not believe disciplinary action was warranted. Thus, the Hearing Officer concludes that pushing a patient does not in itself show that an employee should be disciplined for client abuse.

The Agency asserted it had zero tolerance for client abuse. The Agency's failure to take disciplinary action against Mr. 2 shows it will excuse client abuse under certain circumstances. The Investigator concluded Mr. 2 engaged in client abuse. The Facility Director wrote that he agreed with the Investigator's finding but then declined to take any disciplinary action.

The Hearing Officer has thoroughly reviewed all evidence in this matter and weighed it appropriately. There is no basis for disciplinary action in this matter. The Hearing Officer will not change his position in this case. The Group III Written Notice must be reversed and Grievant must be reinstated to his former position and restored his benefits as originally ordered.

[15] This reasoning would also support the conclusion that Mr. 2 had a motive to harm Patient 2.

Grievant is entitled to attorney's fees at the rate of $131 per hour. This rate is set by OEDR and the Hearing Officer cannot alter that rate. Grievant may request additional attorney's fees relating to the remand decision.

REMAND DECISION

For the reasons stated herein, the Agency's issuance to the Grievant of a Group III Written Notice of disciplinary action with removal is **rescinded**. The Agency is ordered to **reinstate** Grievant to Grievant's same position at the same facility prior to removal, or if the position is filled, to an equivalent position. The Agency is directed to provide the Grievant with **back pay** less any interim earnings that the employee received during the period of removal. The Agency is directed to provide **back benefits** including health insurance and credit for leave and seniority that the employee did not otherwise accrue.

APPEAL RIGHTS

A hearing officer's original decision becomes a **final hearing decision**, with no further possibility of an administrative review, when:

1. The 15 calendar day period for filing requests for administrative review has expired and neither party has filed such a request; or,
2. All timely requests for administrative review have been decided and, if ordered by DHRM, the hearing officer has issued a revised decision.

Judicial Review of Final Hearing Decision

Within thirty days of a final decision, a party may appeal on the grounds that the determination is contradictory to law by filing a notice of appeal with the clerk of the circuit court in the jurisdiction in which the grievance arose. The agency shall request and receive prior approval of the Director before filing a notice of appeal.

/s/ Carl Wilson Schmidt

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Carl Wilson Schmidt, Esq.
Hearing Officer