DECISION OF HEARING OFFICER

In the matter of
Case Number: 11977
Hearing Date: June 27 and 28, 2023
Closing Arguments Submitted on July 5, 2023
Decision Issued: August 1, 2023

SUMMARY OF DECISION

The Agency had found Grievant violated Departmental Instruction (DI) 201 regarding reporting and investigating abuse and neglect to clients. Then, the Agency issued Grievant a Group III Written Notice with removal. The Hearing Officer found the Agency failed to meet its burden. Accordingly, the Hearing Officer rescinded the Group III Written Notice with termination.

HISTORY

On April 18, 2023, Agency issued Grievant a Group III Written Notice with removal. This notice asserted that Grievant violated DI 201. Grievant timely filed a grievance. The Office of Employment Dispute Resolution (EDR) assigned this Hearing Officer to the matter effective May 18, 2023.

The Hearing Officer held a telephonic prehearing conference on May 26, 2023.[1] Based on discussions during the prehearing conference (PHC), the Hearing Officer determined that the first available date for the hearing was June 27, 2023. Accordingly, she set the hearing for that date. Among other matters discussed during the PHC was the date for the parties to exchange their exhibits and witness lists and also provide them to the Hearing Officer. Accordingly, it was determined during the PHC that the exchange would take place by 5:00 p.m. on June 21, 2023. On May 26, 2023, the Hearing Officer issued a scheduling order addressing those matters discussed and ruled on during the telephone conference, to include the exchange deadline, the requests for the production of documents and witness orders. Grievant requested the issuance of witness orders. The Agency objected to several. After considering arguments from the parties for or against issuing witnesses order to which Agency objected, Hearing Officer issued those deemed appropriate. Hearing Officer received a motion to quash the witness order for a social worker with the local department of social services. Upon considering arguments for and against granting the motion to quash, the Hearing Officer granted the motion. The orders issued by Hearing Officer are incorporated here by reference.[2]

Hearing Officer commenced the hearing on June 27, 2023. Four hours had been set aside for the hearing. It was determined that more time was needed to complete the hearing and to give the parties a fair opportunity to present their respective cases. Accordingly, the hearing was continued the hearing until the next day, June 28, 2023, from 8:30 a.m. to 10:30 a.m. The hearing concluded at approximately 10:00 a.m. on July 28, 2023.

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[1] The parties agreed to this scheduling.
[2] *See* Scheduling Order.

On the date of the hearing and prior to commencing it, the parties were given an opportunity to present matters of concern to the Hearing Office. The Agency objected to Grievant's Exhibit L through L.3.[3] Hearing Officer admitted Agency Exhibits 1, 2, 3, 4, and 6. Hearing Officer admitted Grievant's Exhibits B.1; D; F; G; I and I.1-I.6; and J.

At the hearing both parties were given the opportunity to make opening statements and call witnesses. Each party was provided the opportunity to cross examine any witnesses presented by the opposing party. The parties agreed to submit written closing arguments by the due date, July 5, 2023.

During the proceeding, the Agency was represented by its advocate. Grievant was represented by her advocate.

APPEARANCES

Advocate for Agency
Agency's Representative
Witnesses for the Agency (4 witnesses)
Advocate for Grievant
Grievant
Witnesses for Grievant (9 including Grievant)

ISSUE

Was the written notice with removal warranted and appropriate under the circumstances?

BURDEN OF PROOF

The burden of proof is on the Agency to show by a preponderance of the evidence that its disciplinary actions against Grievant were warranted and appropriate under the circumstances. Grievance Procedure Manual ("GPM") § 5.8(2). 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

1. Grievant was employed by Agency as a Public Safety Officer (PSO) in 2021. She was one of several PSOs in the Agency's Department of Public Safety. The agency terminated her employment on April 18, 2023, due to an incident which occurred on March 9, 2023. This incident is discussed in other facts below. (Grievant's Testimony; A Exh. 1).

2. By virtue of her employment title and Agency's policy applicable to Agency's Department of Public Safety, Hearing Officer finds Grievant was responsible along with her co-workers in the same department with providing a safe environment at Agency.

[3] Grievant withdrew Exhibit L through L.3 during the course of the hearing.

March 9, 2023 Incident

3. On March 9, 2023, at about 2:55 p.m., a public safety officer transported Patient to PT Office to receive physical therapy. Patient became hyperverbal with the therapist and the Agency called a Code White for PT Office.[4] PSOs then arrived at PT Office to escort Patient back to Unit. Per policy, forensic patients must be handcuffed when in transport. Normally, a patient is handcuffed in the back. This practice is used to better secure the patient being transported and to maintain safety. Notwithstanding, Grievant handcuffed Patient (a forensic patient) in the front due to his having injured his shoulder. Patient began yelling at Grievant and made threats to another officer. Patient's transport was by van from PT Office to Unit. (A Exh. 4; Grievant's Testimony).

4. Several PSOs were present and a part of the group of PSOs escorting Patient back to Unit They included Grievant. Grievant had placed her hand on Patient's arm to help support him as he walked. In addition, PSO 1 was a part of the escort group, as well as PSOs 3, 5, 6 and a DSA 2). (A Exh 4).

5. Grievant's placement of her hand on Patient's arm to support him as he walked was a proper procedure. (A Exh. 4 at 18).

6. As Patient was entering Unit, he was being guided in the unit by Grievant. Patient turned around and pulled away from Grievant. Patient was very upset and visibly angry. He told the officers that he was going to fuck them up. In addition, Patient told Grievant to "get the fuck off me." Grievant attempted to gain control of Patient by verbally redirecting Patient. Grievant stated to Patient she would be taking off the handcuffs once they "were over there" (indicating an area in Unit). Grievant attempted to grab Patient's arm or clothing to gain control of Patient. Patient snatched away again calling Grievant a "bitch." Patient put his hands on Grievant. Grievant reached out to keep a distance between herself and Patient. Patient yelled and threatened officers. Patient faces Grievant in an aggressive manner. Patient spits at Grievant. Patient then kicked Grievant in the low abdomen-groin area. At some point another Code White was called because of Patient's behavior. Grievant grabs Patient's left collar shoulder area to gain control of him and to prevent Patient from striking her again. Those PSOs present then tried to gain control of Patient. PSO 6 was about one foot behind Grievant once they were in Unit. Because of danger Patient posed, PSO 6 instructed the public safety officers to take Patient to the floor. It took several PSOs to take Patient down to the floor, including Grievant. As Patient is being taken to the floor, Patient grabs Grievant's arm and presses his fingernails in Grievant's arm causing scratches to her arm. Patient also caused Grievant's shirt sleeve to tear by failing to release Grievant's arm even though Grievant instructed him to do so. Patient does not comply with the directive. Once down on the floor Patient tried to bit and kick. Patient's handcuffs were eventually removed and Patient was placed in the Emergency Restraining Chair (ERC). (PSO 6's Testimony; A Exh. 6; Grievant's Testimony; A Exh 4; G Exhs. I, I.1 through 1.6).

[4] A Code White is called by the Agency, not by PSOs. A Code White means there is a psychiatric emergency. Some examples of situations causing Agency to announce a Code White are a patient being hyperverbal, a patient being threatening to staff, etc. On March 9, 2023, ESH called two "code whites" on Patient, one while he was in PT Office threatening to staff. Another was called in Unit due to Patient being hyperverbal, aggressive, and threatening to staff. (Testimony of Grievant; A Exh. 4)

7. RN and Nurse Practitioners assessed Patient on March 9, 2023, immediately after the incident and found no visible physical injuries. (Testimonies of RN and Nurse Practitioner; A Exh. 4 at 21, 24-25).

8. The evidence is insufficient to demonstrate that Grievant hit Patient with her right fist or attempted to hit Patient. (A Exh. 6; Testimonies of PSOs 1, 3, 5, 6, DSA 2 and 3, RN, Grievant, and Nurse Practitioner; G Exh. 1 through I. 6).

9. CEO and Investigator were not eye witnesses to the March 9, 2023 incident.

Offense Report Regarding the Incident with Witness Statements written on March 9, 2023

10. Immediately following the incident witness statements were taken regarding what had occurred. PSO 1, PSO 5, PSO 3, DSA 2, and Grievant provided statements of what they observed during the incident. In addition, an Offense Report was made. (G Exh. I, I.1 through I.6).

11. **PSO 1's March 9, 2023 Statement:** PSO 1, an eye witness to the incident, wrote a statement regarding the incident. The time noted on his written statement is 3:33 p.m. on March 9, 2023. In this statement, PSO 1 reports that when Grievant placed handcuffs on Patient, he began yelling at Grievant. In addition, Patient threatened another officer saying "you will get yours." Further, once Patient was being escorted back on Unit, he continued yelling at Grievant saying "get the fuck off of me." According to PSO 1's statement, Patient then attempted to break free of Grievant's hold on his arm. PSO 1 stated that he grabbed Patient's right arm to gain control of him. At this point, PSO 1 states that he **saw** Patient kick Grievant in the mid-section. PSO 1 then states that Patient was taken down to the floor. Patient was then uncuffed, placed in ERC, and transported to his room. (G Exh. I.1).

12. Hearing Officer finds that this statement by PSO 1 does not mention that PSO 1 observed Grievant punch or strike Patient. *(Id.)*.

13. **PSO 5's March 9, 2023 Statement:** In addition, PSO 5 provided a written statement at 3:14 p.m., on March 9, 2023. He wrote the following:

> When transporting [Patient] back to unit he became very aggressive with officers while being escorted in. [Patient] put his hands on [Grievant] then kicked her and ripped her shirt and scratches her arm up. [Patient] was put in ERC chair.

(G Exh. I.2).

14. Hearing Officer finds that this eyewitness' statement does not indicate PSO 5 observed Grievant punch Patient or even raise her hand to do so. (*Id.*).

15. **PSO 3's March 9, 2023 Statement:** PSO 3 was also an eye witness to the incident. She

provided a written statement on March 9, 2023. The noted time of the statement is 7:30 p.m. PSO 3 noted that once the officers and Patient entered the unit, Patient "started jerking away" from Grievant. Further, PSO 1 tried to gain control by grabbing Patient's arm so Grievant could remove the handcuffs. PSO 3 wrote that at that point, Patient looked at Grievant and kicked her. Then all officers placed Patient on the ground so that the handcuffs could be removed. Patient then placed in ERC. (G Exh. I.3).

16. Hearing Officer finds no mention of Grievant punching Patient in PSO 3's statement.

17. DSA 2 was also an eye witness and provided a written statement of her observation of the incident. Her March 9, 2023 statement notes it was written around 7:00 p.m. According to DSA 2's statement, Patient was very upset and visibly angry. Patient was walking ahead of the officers yelling and threatening them. Patient turned around and postered the officers and threatened to harm them. Patient pushed the closest officer to him. This officer reached out to keep him away. Patient continued to go after the officers. The Officer protected the unit and peers. (G Exh. I.5).

18. Hearing Officer finds that this eyewitness statement does not indicate the witness observed Grievant punch Patient. While DSA 2 referenced an officer reaching out to keep Patient away, the statement does not indicate there was a strike to Patient or an attempt to do so.

19. Grievant also provided a statement on March 9, 2023, of the incident. The time noted on her statement is 8:46 p.m.

20. Grievant wrote that she handcuffed Patient in preparation for escorting him back to Unit. As she was attempting to escort him by the arm to the van so he could be transported back to Unit, he attempted to jerk away from her and stated "you don't have to touch me." Patient was driven in the van back to Unit. Those riding with the patient were Grievant, other staff, and PSO 6.

21. As the PSOs and staff entered the unit and Grievant is specifically escorting Grievant, Patient jerked away from her causing Grievant to lose her hold on Patient. Patient then yelled "Get the fuck off me bitch." Patient then faced Grievant in an aggressive manner. Then Patient kicked Grievant in the right lower abdomen. Grievant then grabbed Patient's left collar shoulder area in order to gain control of him and prevent Patient from striking her again. PSO 1 grabbed Patient's right arm. Patient yelled, she hit me first. Other PSOs used TOVA and placed Patient on the ground. Patient grabbed Grievant's arm digging his fingernails in it. Patient also ripped Grievant's shirt sleeve. Only then was Grievant able to free her arm from Patient.

22. An assault and battery charge was obtained against Patient and served on him on March 9, 2023.

(G Exh. I.4).

23. Grievant's March 9, 2023 statement does not note she struck or tried to strike Patient.

24. The March 9, 2023 Incident Report also contains photographs of Grievant's arm showing bruises, scratches, and a torn sleeve. (G Exh. I.6).

25. Hearing Officer finds the photographs are consistent with Grievant's report of injuries in her written statement.

Investigation

26. Investigator received notification of anonymous complaints about Grievant using excessive use of force sometime around March 29, 2023. Investigator proceeded to conduct a probe of the incident. (A Exh. 4).

27. During the investigation, Investigator viewed the video of the incident. After watching the video, Investigator determined individuals he believed had knowledge of the incident. He then interviewed those individuals and obtained witness statements from them. (Investigator's Testimony; A Exh. 4).

28. **PSO 6's April 3, 2023 Statement:** Particularly, on April 3, 2023, Investigator interviewed PSOs 6 and obtained a witness statement on the same date from him. (A Exh. 4 at 19).

29. PSO 6 noted in his statement that he was personally involved in attempting to control Patient. More particularly, in his statement, PSO 6 noted that as Grievant was guiding Patient into the Unit, Patient snatched away from Grievant. Further, at the time Grievant was verbally redirecting Patient and as Grievant attempted to gain control, Patient snatched away again calling Grievant a "bitch." Patient spit and kicked Grievant. PSOs tried to gain control, including Grievant. PSO 6 then instructed the officers to take Patient to ground for safety reasons. While on the ground with handcuffs still on, Patient tried to bite and kick. ERC was brought and Patient placed in it. PSO 6 noted he was an eyewitness and did not see Grievant use excessive force. (A Exh. 4 at 16-17).

30. **PSO 3's April 3, 2023 Statement:** In addition, Investigator interviewed PSO 3 on April 3, 2023, and obtained a witness statement from PSO 3 on the same date. (A Exh. 4 at 19).

31. PSO 3 noted in her statement that she was present during the March 9, 2023 incident, that Agency policy was followed in containing Grievant. Specifically, Grievant had one hand on Patient's arm to escort him. Per PSO's statement, Patient turns around as he is being escorted in and states "Get the fuck off me." Patient then jerks away from Grievant and turns facing Grievant in an aggressive posture. PSO3 also notes that Patient kicks Grievant. Further, as Patient is being taken to the ground by the officers, including Grievant, Patient grabs Grievant's arm. PSO 3's statement notes that Grievant at that point is attempting to redirect Patient to release her arm so the handcuffs could be removed. At some point, Grievant's shirt sleeve is ripped. Patient is non-complaint. Even after being placed in ERC Patient continues to threaten staff. PSO 3 notes that at no point did Grievant hit Patient. (A Exh. 4 at 18-19).

32. The Hearing Officer finds PSO 3's March 9, 2023 and April 3, 2023 statements are corroborating.

33. **RN's April 4, 2023 Statement:** Investigator also interviewed RN on April 4, 2023, and obtained a statement from RN on the same date. RN noted in her statement that Patient told her that "they assaulted me." Further, RN noted in her statement that upon examining Patient after his placement in the ERC she did not observe any redness, bruising, bleeding and that she had witnessed Patient being physically aggressive with security staff during escort. (A Exh. 4 at 20-22).

34. **DSA 3's April 5, 2023 Statement:** On April 5, 2023, Investigator interviewed DSA 3 and obtained a written statement from DSA 3 on the same date. In her statement, DSA 3 reported that while being assigned to watch Patient one-on-one, DSA 3 observed once Patient was on the unit, Patient pulled away from Grievant as Grievant tried to gain control of Patient. Further, Patient stated to RN that he had been assaulted by public safety. DSA 3 stated that staff saw no signs of his being assaulted such as marks or bruises on his face. DSA 3's statement notes that her view of the incident as it unfolded was partially blocked by other staff being around Patient. (A Exh 4 at 224-25).

35. **DSA 2's April 5, 2023 Statement:** On April 5, 2023, Investigator also interviewed DSA 2 and obtained a written statement from this worker. In DSA's statement she notes in pertinent that as Patient entered the unit, Patient was very upset, yelling, and "cussing" at the officers. He told the officers that he was going to "fuck them up." She further notes that the Patient was getting aggressive and a registered nurse directed DSA to get the ERC. Further the statement notes the officers were trying to get the handcuffs off Patient. PSOs were trying to keep the unit and Patient safe according to her statement. Patient was placed in the ERC by PSOs and nursing staff. (A Exh. 4 at 27-28).

36. The Hearing Officer finds DSA 2's March 9, 2023 and April 3, 2023 statements are corroborating.

37. **PSO 5's April 4, 2023 Statement:** On April 4, 2023, Investigator interviewed PSO 5 and obtained a written statement from this officer. PSO 5 stated he was present during the incident and did not see Grievant hi[t] Patient. He reported Patient was verbally out of control. Patient head moved, but PSO 5 stated that he was not sure if this was from a push or pull. PSO 5 stated after Patient was placed on the ground, he calmed down and was placed in the ERC. (A Exh. 4 at 26).

38. The Hearing Officer finds PSO 5's March 9, 2023 and April 3, 2023 statements are corroborating.

39. **PSO 1's April 4, 2023 Statement:** On April 4, 2023, Investigator interviewed PSO 1 and obtained a written statement from this officer on the same date. According to PSO 1's statement, he was one of the security officers escorting Patient on March 9, 2023, as the officers were returning Patient to unit. PSO 1 noted that as Grievant was escorting Patient on the unit, Patient stated "get your hands off me" and snatched away from Grievant. PSO 1 then states that Grievant grabbed Patient by the shoulders driving Patient backwards. Then Grievant instructed Patient to stop moving. Patient then backed away and said do not touch him. Patient again attempted to break away from Grievant. According to PSO 1's statement, a struggle ensued with PSO 1

attempting to gain control of Patient by grabbing his right arm and Grievant attempting to grab the patient's left arm. Then PSO states that "[d]uring the struggle, Grievant struggled, stepped back, and struck Patient with her right fist in the jaw." (A Exh. 4 at 22-23).

40. The Hearing Officer finds inconsistencies in PSO 1's statements written March 9, 2023, and April 4, 2023. First, PSO 1's first statement mentions that PSO 1 saw Grievant being kicked by Patient. The second statement does not mention this observation. Also, in PSO's March 9, 2023 statement PSO 1 makes no mention of Grievant striking Patient. In the second statement, PSO 1 contends that Grievant struggled in trying to get control of Patient, stepped back, and struck Patient with her right fist in the jaw.

41. **Grievant's April 6, 2023 Statement:** On April 6, 2023, Investigator interviewed Grievant and obtained a written statement of same day at 3:30 p.m.

Grievant stated that she was escorting Patient to Unit at about 3:14 p.m. on March 9, 2023. She had handcuffed Patient in the front as opposed to the back because Patient had a left shoulder injury. Patient snatched away from Grievant and said " you don't have to keep touching me." Grievant stated that proper procedure when one snatches away is to grab the arm, wrist, or clothing to regain control. Grievant stated that she gave a verbal command for Patient to stop and informed Patient that he would be uncuffed once they "walked over there."

Further, Grievant stated that Patient proceeded to walk backwards making demeaning comments. Grievant was trying to grab his arm or shirt. As Grievant gains control of Patient's arm, Patient pushes off of Grievant and backs up. PSO 1 grabs Patient's right arm. Grievant grabs Patient's right hand attempting to gain control. Also, PSO 1 attempted redirection by verbal control.

At this point, Patient lifts his left leg and kicks Grievant in the lower abdomen/hip area. Grievant then closed the distance between herself and Patient to close the gap so she would not get another full kick from the patient. Then with her right hand, Grievant grabbed Patient's collar. Patient moved his head back and yelled "that bitch just fucking hit me."

Grievant stated she never hit Patient; he turned his head on his own. After Grievant grabbed Patient's collar, Patient dug his fingernails in both of his hands in her left arm. Grievant attempted to verbally redirect Patient to let go of her arm. Grievant tried pulling away. PSO 6 gave verbal directions for Patient to let go. Patient was then taken to the ground. Grievant went down on the floor as well because Patient had Grievant left arm pulled into his body. Patient eventually released Grievant after seeing the charge nurse could see him. Patient was secured and then uncuffed. Patient was placed in the ERC. (A Exh. 4 at 29-32).

42. The Hearing Officer finds Grievant's March 9, 2023 and April 6, 2023 statements are corroborating.

43. The Agency's Neglect/Abuse Investigation Training Manual notes in pertinent part that "injuries are an important piece of physical evidence" and they should be seen and photographed (when possible). In addition, the manual indicates that "if there is an alleged perpetrator, the

perpetrator should be checked for injuries also." (G Exh. J at 58).

44. During his investigation, Investigator did not review the safety or offense report(s) completed on the same date that the incident occurred. Nor did he review the accompanying written statements provided on March 9, 2023, by eye witnesses: PSO 1, PSO 3, PSO 5, Grievant, and DSA 2. Moreover, Investigator did not review the photographs taken on March 9, 2023. (Investigator's Testimony). These photographs show scratches on Grievant's arm and her arm's sleeve torn. (G Exh. I. 6).

45. In conducting other investigations, Investigator has reviewed the related safety or offense reports. Per Investigator's testimony, in his view, he did not need to review the safety reports because he saw the video and the video showed Grievant punching Patient. (Investigator's Testimony).

46. Hearing Officer finds Investigator failed to review an important piece of the evidence, physical evidence and witness statements taken on the day of the incident.

47. Investigator did not interview Patient because Patient refused to be interviewed. (Investigator's Testimony).

48. Investigator was not familiar with the camera system used to video the incident. Investigator was not familiar with the distortions that different camera angles may cause. Investigator did not consider camera distortions. However, Investigator opined that there was no distorted view from the camera used to record the incident. Investigator perceived that he saw Grievant hit Patient with a closed fist on the video. (Investigator's Testimony).

49. At the conclusion of the investigation, Investigator determined the allegation of excessive use of force was shown by a preponderance of the evidence. Investigator based his decision on a view of the non-audible video of the incident, interviews he conducted, and written statements of those he interviewed in April 2023. Investigator was convinced excessive force took place due to what he perceived from the video and PSO 1's written statement dated April 4, 2023.

50. Regarding the video at about the 24 -26 seconds, by Investigator's testimony, he perceived that the video showed Patient kicking Grievant and Grievant responding by punching Patient in the face with a closed right fist.

Regarding PSO 1's April 4, 2023 statement, by Investigator's testimony, he deemed PSO 1's statement credible because PSO 1 was present during the incident and Investigator concluded PSO 1 was remorseful for not reporting the alleged excessive use of force.

(Investigator's Testimony).

51. On April 10, 2023, Investigator concluded his investigation. Investigator submitted his investigative report to CEO. In the summary of this report, Investigator recommended finding by a preponderance of the evidence that Grievant had used excessive force. (A Exh. 4 at 15; Investigator's Testimony).

52. Investigator found Grievant was cooperative with the investigation, but Investigator deemed her statement inconsistent with what he observed in the video. (Investigator's Testimony).

53. Investigator did not notify the state police of his belief that Grievant committed an assault and battery on Patient. Per Investigator's testimony, it was his job to investigate the incident, not report it to law enforcement. (Investigator's Testimony).

54. As referenced here, Investigator recommended CEO find Grievant used excessive force. (Investigator's Testimony; A Exh. 4).

55. Agency CEO has been the agency's CEO for nine (9) months. As CEO he makes disciplinary decisions. (CEO's Testimony).

56. On or about April 18, 2023, CEO made the decision to terminate Grievant for using excessive force on Patient. CEO deems the discipline appropriate because Agency determined Grievant had violated Department Instruction 201 (DI 201). (CEO's Testimony; Exh. 1).

57. In making the decision to issue a Group III with removal, CEO considered three things.

- For one, he watched the video several times. From his observation of the video, he concluded Grievant used excessive force. Particularly, CEO concluded the video appears to show Grievant's arm in the air with a closed fist and Patient dodging or moving his head due to force of contact.

- In addition to viewing the video, CEO considered witness statements obtained during the investigation. He concluded the April 4, 2023, statement of PSO 1 was credible, particularly where PSO 1 wrote that Grievant struck Patient with her right fist in the jaw. CEO found PSO 1's statement credible because PSO 1 acknowledged to CEO that PSO 1 should have reported the incident and CEO found that PSO 1 was remorseful for having not done so.

- Further, CEO considered written statement of RN in which RN wrote Patient stated "they assaulted me."

(CEO's Testimony).

58. CEO reviewed statements of others obtained during the investigation. Even though multiple statements were from eye witnesses and noted that (i) Grievant did not use excessive force and/or (ii) Grievant did not strike Patient, CEO found those statements incredible. CEO's reasoning was that in his 9-month experience as the agency's head, employees observing use of force fail to report it at least 75% of the time. (CEO's Testimony).

59. Grievant had been trained regarding using therapeutic options. By CEO's testimony, in the situation on March 9, 2023, "there were physical interventions that Grievant could have employed involving managing Patient's limbs and ...; however, those interventions would not

have involved grabbing and holding onto Patient's clothing, striking or hitting Patient, or shoving/pushing Patient. " In CEO's opinion Grievant employed unapproved methods to gain control of Patient, especially considering Patient was handcuffed.

Per CEO's Testimony, even if Grievant did not strike Patient, any effort to swing at Patient in the manner he observed on the video places Patient in the way of harm or places Patient in fear of harm. Thus, CEO concluded there was abuse under DI 201.

(CEO's Testimony).

60. CEO concluded that by a preponderance of the evidence, Grievant struck Patient, committing an assault and battery against Patient. In drawing this conclusion, CEO did not rely on the anonymous emails sent on or about March 15 and 29, 2023. (CEO's Testimony).

61. CEO did not report Grievant's action to VSP because CEO understood that VSP did not desire Agency to report suspected criminal activity that does not rise to the level of a suspected felony. (CEO's Testimony).

62. At the time CEO made his decision to terminate Grievant, CEO was unaware of PSO 1's statement written on March 9, 2023, which makes no mention of Grievant striking Patient. (Testimony of CEO; G Exh. I.1).

63. Accordingly, Hearing Officer finds that in making his decision to discipline Grievant, CEO did not consider PSO 1's March 9, 2023 statement.

May 13, 2023 Conversation

64. By the testimony of PSO 2, on May 13, 2023, around 10:00 p.m., PSO 2 was having a conversation with PSO 3. PSO 1 then walked in and at some point interjected himself in the conversation. When PSO 1 did so, PSO 1 stated that he did not see Patient kick Grievant. Neither did he see Grievant strike Patient. (PSO 2's Testimony).

65. PSO 3 testified that when PSO 1 interjected himself in the May 13, 2023 conversation, she recalls PSO 1 stating that he (PSO 1) did not see why he was written up for something he did not see and that his focus was on restraining Patient's arm. Per PSO 3's testimony, PSO 1 stated that he did not see Patient kick Grievant. Further, during PSO 3's testimony, she testified that she was present during the incident and did not observe Grievant strike Patient. (PSO 3's Testimony).

66. The Hearing Officer had an opportunity to observe PSO 2 and PSO 3 as they testified and found their testimony corroborating, persuasive, and credible.

Hearing Testimony and Credibility findings

67. Hearing Officer finds PSO 1's testimony and April 4, 2023 statement indicating that Grievant struck Patient unconvincing.

PSO 1 provided inconsistent statements. In his March 9, 2023 statement, he does not mention Grievant struck Patient. PSO 1 provided this statement about 15 minutes after the incident. Almost a month later, PSO 1 provided another written statement, dated April 4, 2023. In this second statement, PSO 1 writes that Grievant struck Patient with her right fist in the jaw. Another inconsistency noted is during PSO 1's testimony PSO 1 testified that he did not see a kick. Someone told him about it. Yet, as mentioned here in his initial statement written on March 9, 2023, PSO 1 writes that he saw a kick from Patient. In addition to his varied written and testimonial accounts of the incident, PSO 1 injected himself in a conversation between two officers on May 13, 2023, indicating that he did not see Patient kick Grievant. Nor did he observe Grievant strike Patient. (PSO 1's Testimony; G Exh. I.1; A Exh. 4 at 22-24; Testimonies of PSOs 2 and 3).

Due to PSO 1's variation on what unfolded during the incident and his testimony that he was not fully observant, HO finds PSO 1 is not a reliable witness.

68. PSOs 6, 5, and 3 helped to escort Patient to Unit and witnessed the incident. None reported in written statements or testimony that Grievant struck Patient. Hearing Officer finds that they are credible witnesses. (G Exhs I, I.2, I.3; Testimonies of PSO 3, 5, and 6; A Exh. 4.

69. Specifically, per PSO 6's testimony, he was directly behind Grievant and only about a foot away when the incident unfolded in Unit. Per his testimony, Patient pulled away from Grievant and told Grievant to "get her fucking hands off him." Patient jerked away from Grievant, turned around, and kicked Grievant in the groin. Grievant tried to pull Patient in closer and tried to grab his shoulder. By PSO 6's testimony, Grievant did not strike Patient. (PSO 6's Testimony).

70. PSO 6's written statement provided to Investigator and his testimony are consistent. (A Exh. 4 and PSO 6's Testimony). Hearing Officer observed his demeanor during the hearing. Hearing Officer finds this witness' testimony convincing and gives great weight to it.

71. Also, by PSO 5's testimony, he was on duty on March 9, 2023, and was several feet from Grievant and Patient during the incident. He observed Patient displaying aggressiveness once the PSOs entered Unit. He saw Patient scratching Grievant and ripping Grievant's shirt sleeve. He did not observe Grievant punching Patient.

PSO 5's written statements provided on March 9, 2023, at 3:14 p.m., his statement to Investigator on April 4, 2023, and his testimony are consistent. PSO 5's first statement was written immediately after the incident. Further, he was only several feet away from Patient and Grievant during the incident.

Hearing Officer observed PSO 5's demeanor during the hearing. Hearing Officer finds this witness' testimony credible.

72. In addition, per PSO 3's testimony, PSO 3 witnessed the incident. She saw Patient kick Grievant. She did not observe Grievant strike the patient. (G Exh. I and I.2; Testimony of PSO 3).

73. HO found her testimony consistent with her statements written on March 9, 2023, and April

3, 2023. Also, Hearing Officer had an opportunity to observe the demeanor of the witness and finds PSO 3 a credible witness.

74. Further, by RN's and Nurse Practitioner's testimonies, Patient was assessed immediately after being placed in ERC on March 9, 2023. No physical signs of an assault were observed. Per Nurse Practitioner's testimony, having no physical signs such as lacerations, redness, etcetera was inconsistent with Patient reporting being assaulted. (A Exh. 4 at 21 and; Testimonies of RN and Nurse Practitioner).

75. Hearing Officer had an opportunity to observe the demeanor of these witnesses and consider any written statements RN and Nurse Practitioner may have provided. The Hearing Officer finds these witnesses credible.

76. DSA 2 also witnessed the incident. She estimated being about 20 to 30 feet away. Written statement and testimony are consistent. Both indicate DSA observed Patient was upset as he came on Unit. He cursed at officers and stated he was going to "fuck her/them up." She observed him attacking or being aggressive toward the officers. By DSA 2's testimony, she did not observe Grievant strike Patient. (A Exh. 4 at 27-28; DSA's Testimony).

77. Hearing Officer had an opportunity to observe this witness' demeanor and consider the consistency of her written and oral statements. Hearing Officer finds this witness credible.

78. In Grievant's testimony, she admits providing Patient with a supportive escort to keep him from tripping or falling. Grievant also notes she provided verbal commands instructing patient to calm down and she will be taking off the handcuffs soon. As Patient was backing away from Grievant, Grievant tried to grab Patient to prevent him from getting to other patients in Unit and hurting them. Grievant denies striking Patient or attempting to do so. Hearing Officer observed the demeanor of Grievant, considered the Grievant's testimony and written statements. Hearing Officer has determined those statements and Grievant's testimony are consistent. Hearing Officer finds Grievant is a credible witness.

Video

79. During the hearing, the video of the incident was shown several times. In addition, in her deliberation of this matter, Hearing Officer has viewed the video multiple times. The Hearing Officer finds the video shows the following:

- Public Safety Officers and DSA escorted Patient into Unit;
- PSO 1 entered the unit first. Followed by Patient and then Grievant;
- As Patient enters the unit, he turns around and confronts Grievant;
- Now that Patient is facing Grievant, she appears to make attempts to put distance between Patient and Grievant, presumably for safety reasons;
- shortly thereafter, Patient still facing Grievant, raises his leg and kicks Grievant;
- Grievant appears to immediately raise her right arm and seconds later her right hand is on Patient's shoulder.
- Hearing Officer is unable to decipher if Grievant struck Patient with her hand or fist or if

Grievant was aiming to strike Patient in the face. Neither could Hearing Officer decipher if Grievant raised her arm as a reflex in the heat of the moment;

- Patient is taken down to the floor by several officers including Grievant a few seconds later and an ERC is brought to the area to place Patient in.

80 The video is non-audible. Images on the video are not of the best quality. The video alone is insufficient to show Grievant struck Patient or tried to do so. (Hearing Officer's observations; Chief's Testimony; A Exh. 6).

Policies

I. Departmental Instruction 201 (DI 201)

81. In pertinent part Departmental Instruction 201, section 201-3 defines abuse as follow:
...[A]ny act or failure to act by an employee or other person responsible for the care of an individual in a facility operated by the department 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 disability, or substance abuse.

(A Exh. 3 at 1).

82. Moreover, DI 201-7 provides in pertinent part the following:

The facility director shall immediately contact local law enforcement of the State Police Bureau of Criminal Investigations, or both, in all cases of suspected criminal activity. If a law enforcement agency determines that a criminal investigation is warranted, any department investigation of the allegation may be suspended if requested by law enforcement agency investigator.

(A Exh. 3 at 7; G Exh. B.1 at 7).

83. DI 201 at 201-3 continues by providing examples of abuse. One, among others provided, is use of excessive force. In the example provided, DI 201-3 mentions use of excessive force when placing a patient in physical or mechanical restraints. *(Id.).*

84. Hearing Officer finds using excessive force on a patient constitutes abuse.

II. Policy 450-047 – Management of Aggressive and abnormal Behavior (Critical Policy)

85. Agency Policy 450-047 provides in pertinent part the following procedure for all staff to follow:

When aggressive behavior is observed and there is a probability that it will

> escalate to assaultive behavior, immediately initiate non-physical interventions and request assistance from other direct care staff as needed. If physical intervention is required immediately to ensure the safety of the patient or others, approved techniques are to be utilized as much as possible. However, if there are no approved techniques to deal with the current situation, staff is allowed to utilize non-approved techniques to ensure the safety of the patient or others. A code White (Psychiatric Emergency) may be called if needed.

(G Exh. F at 3; A Exh. 4 at 70).

86. Hearing Officer finds that where appropriate, Agency policy provides for utilization of non-approved intervention techniques to ensure the safety of the patient and others. *(Id.).*

III. Agency's Use of Force Policy

87. Policy SOP 021-DD is a policy in effect at Agency which is applicable to Agency's public safety officers. (Testimony of Chief).

88. In pertinent part SOP 021-DD provides the following:

> **Therapeutic Options of Virginia (TOVA)**
>
> **Public Safety Officers at [Agency] are dually trained in TOVA and the law Enforcement Continuum.** [Agency] **Public Safety Officers utilize techniques as required for physical and non-physical apprehension and redirection. TOVA utilization of intervention techniques apply to the broad terms and requirements of patient redirection administered by DBHDS policies and procedures. The [Agency] Public Safety Officer fully indentifies (sic), assesses, and if possible incorporates TOVA applications at the first and second levels of application in the law enforcement force continuum model. When TOVA applications are no longer effective in a patient care situation, higher levels of force are implemented to restore order.** Higher levels of force applied to "elevated or violent patients" are strictly based on the force continuum for "ALL" Sworn Virginia Law Enforcement officers, and mandated by the Department of Criminal Justice Services of Virginia.

(G Exh. D at 6; SOP 021-DD Procedures §C TOVA(emphasis added)).

89. The Continuum of Force Chart in SOP 021-DD demonstrates the following:

- if the officer perceives the subject/patient's activity is only verbally resisting, the officer should/may respond at levels 1 and 2; that is with verbal commands, or touching the subject/patient;
- if the officer perceives the subject/patient is passively resisting, the officer should/may respond at level 3; that is, pain compliance, take downs, chemical agent;
- if the officer perceives the subject/patient is resisting physically, the officer may respond at level 4; that is, with an impact weapon, CEW or Canine;
- if the officer perceives the subject/patient is demonstrating assaultive behavior, the officer may respond at a level 5; that is, with incapacitating strikes or holds.

(*Id.* at 3; SOP 021-DD, Policy §F Continuum Chart).

90. Striking, holding, punching the body of a subject/patient constitute an incapacitating response by the officer. (Chief's Testimony; SOP 021-DD Policy §F)).

Other Facts

91. CEO has been employed by Agency for about nine months. CEO is only minimally aware of Agency's **Public Safety Policies on Use of Force**. (CEO's Testimony).

92. Under DI 201, CEO determines if abuse has occurred.

93. CEO's opines that if there is tension between Policy DI 201 and the Public Safety Polices on Use of Force, DI 201 controls. (CEO's Testimony).

94. Agency produced no policy stating that DI 201 controls Public Safety Polices on Use of Force. Hearing Officer finds that the evidence insufficient to show one policy controls the other.

95. Agency has a training academy for conservators of the peace officers. The curriculum is written by Agency employees and certified instructors. The manual is approved by Agency. Grievant is a conservator of the peace. (Chief's Testimony).

97. Grievant went through therapeutic options training at Agency about two weeks before the March 9, 2023 incident. The instructor taught that shirt grabbing is a permissible technique to use to gain control of a patient. (Grievant's Testimony).

96. CEO **not currently a therapeutic options** instructor. CEO has been an instructor in the past teaching methods to manage aggressive individuals. (CEO's Testimony).

97. CEO's work experience includes 10 years total working on the floor of a maximum-security prison and mental health facility responding to aggressive behavior of individuals. (CEO's Testimony).

98. In addition to disciplining Grievant for using excessive force, CEO took disciplinary action against those he observed in the video and in his opinion who saw the March 9, 2023 incident and failed to report the incident. Similarly, employees who CEO determined heard

Patient's complaint of assault and failed to report it were disciplined. (CEO's Testimony).

99. Patients at agency are not treated by public safety officers like subjects that police officers would encounter outside the agency or on the streets. PSOs are trained in this area and if possible are first to try to respond to an aggressive or combative patient by using TOVA. PSOs are trained to not use wrist locks at ESH unless the situation the PSO encounters is seriously out of control. (Chief's Testimony).

100. In addition to having therapeutic options training, Grievant has had TOVA training.

101. In January 2023, Grievant had Special Conservator of the Peace Training at Agency. In that training, Grievant was taught she could employ the Use of Force continuum and law enforcement use of force policies.

102. Techniques Grievant employed or attempted during the incident included TOVA, redirection, verbalization, grabbing Patient's arm; pulling Patient in to block his power, and blocking a hold. (Grievant's Testimony; A Exh. 4; G Exh I – I.5.).

103. Methods used were approved by Agency.

104. Patient was handcuffed. But a handcuffed patient can pose a danger to officers and others. Even a person handcuffed from behind (which is considered securing the subject/or patient even more) can pose a danger. (Testimony of Chief).

105. Use of force was necessary due to the combativeness of Patient.

106. A forensic patient is a label given to a patient by ESH. Patient was deemed a forensic patient. ESH policy is that when a forensic patient is being taken to appointments or transported from one building to the next, that patient is required to be handcuffed. (Testimony of Grievant).

107. Chief has been employed by the agency for about 20 years. Currently, he serves as the Public Safety Manager of the Security Department. He has served in this role for about two years. Prior to becoming the department's head, Chief served as a police officer with the agency when the agency employed police officers. Before being promoted as Chief and after the title police officer was changed, Chief was employed as a PSO. (Chief's Testimony).

108. Chief is familiar with the policies governing public safety officers. (Chief's Testimony).

109. When a patient is assaultive, the level of enforcement is a 5 on the continuum chart. The chart demonstrates an officer's response is incapacitating, striking, or holding. Kicks, punches, or strikes are incapacitating holds. (Chief's Testimony).

110. By Chief's testimony, based on his training as a PSO and law enforcement officer certain kicks, punches, or slaps to the body of a patient by an officer are incapacitating strikes. Chief taught this standard as a law enforcement officer and at ESH. (Chief's Testimony).

111. Hearing Officer concludes Agency policy does permit PSO to respond with force such as

kicks, punches, strikes if the officer's perspective is patient/subject is reacting at a level 5.

112. Grievant worked as a law enforcement officer (PSO) from 2002 until 2012. She had law enforcement defensive tactic instruction from 2002 to 2006. From 2013 to 2016 she was employed as a PSO with the Agency. She worked as a security officer or PSO from 2017 to 2018. She worked for Agency a second time from 2018-2021. (Grievant's Testimony).

In 2021, Grievant received TOVA training by Agency. In February 2023, Grievant taught therapeutic options. Grievant is familiar with the public safety policies that govern use of force by PSOs/law enforcement officers. PSOs employed by Agency are annually trained on the standards regarding Use of Force for Agency PSOs (Grievant's Testimony).

113. Investigator is a certified investigator with Agency. He was trained as an investigator by Agency and has been employed as an investigator for 15 years. (Investigator's Testimony).

114. Cameras have limited ability to show what has occurred. (CEO's Testimony).

116. The local department of social services (DSS) conducted an independent investigation regarding whether Grievant had abused Patient. DSS's investigation decided that the allegation abuse by Grievant was unfounded. (Testimonies of CEO and Grievant).

117. Hearing Officer finds the evidence is insufficient to determine the standard used by DSS to determine abuse.

118. Chief viewed the video. He could not decipher Grievant striking or punching Patient from the video. Chief concluded Grievant used excessive force based on PSO 1's April 4, 2023 written statement and based on a non-identified employee stating Patient used excessive force. (Chief's Testimony).

119. Hearing Officer gives little weight to Chief's testimony that PSO 1's April 4, 2023 statement and the anonymous report of excessive force showed excessive force. For one, Hearing Officer has found PSO 1 gave inconsistent statements/testimony. Further, the anonymous reporter of excessive force was not examined by anyone.

120. D1 201-7 does not explicitly state that an individual making an abuse complaint can remain anonymous. (D1 201).

121. Under Policy 1.60, Standards of Conduct, a Group III offense is defined an offense that is so severe in nature that a first occurrence warrants termination usually. Group III offenses include, but are not limited to, those that endanger others in the workplace. (A Exh. 2 at 8 and 22).

DETERMINATIONS AND OPINION

The General Assembly enacted the *Virginia Personnel Act, VA. Code* §2.2-2900 et seq., establishing the procedures and policies applicable to employment within the Commonwealth.

This comprehensive legislation includes procedures for hiring, promoting, compensating, discharging and training state employees. It also provides for a grievance procedure. The Act balances the need for orderly administration of state employment and personnel practices with the preservation of the employee's ability to protect his/her rights and to pursue legitimate grievances. These dual goals reflect a valid governmental interest in, and responsibility to, its employees and workplace. *Murray v. Stokes,* 237 VA. 653, 656 (1989).

Va. Code § 2.2-3000 (A) sets forth the Commonwealth's grievance procedure and provides, in pertinent part:

> It shall be the policy of the Commonwealth, as an employer, to encourage the resolution of employee problems and complaints… To the extent that such concerns cannot be resolved informally, the grievance procedure shall afford an immediate and fair method for resolution of employment disputes which may arise between state agencies and those employees who have access to the procedure under § 2.2-3001.

In disciplinary actions, the agency must show by a preponderance of evidence that the disciplinary action was warranted and appropriate under the circumstances.[5]

To establish procedures on Standards of Conduct and Performances for employees of the Commonwealth of Virginia and pursuant to § 2.2-1201 of the *Code of Virginia*, the Department of Human Resource Management promulgated Standards of Conduct Policy No. 1.60 (Policy 1.60). The Standards of Conduct provide a set of rules governing the professional and personal conduct and acceptable standards for work performance of employees. The Standards serve to establish a fair and objective process for correcting or treating unacceptable conduct or work performance, to distinguish between less serious and more serious actions of misconduct and to provide appropriate corrective action.

Under the Standards of Conduct, Group I offenses are categorized as those that are less severe in nature, but warrant formal discipline; Group II offenses are more than minor in nature or repeat offenses. Further, Group III offenses are the most severe and normally a first occurrence warrants termination unless there are sufficient circumstances to mitigate the discipline. *See* Standards of Conduct Policy 1.60.

On April 18, 2023, management issued Grievant a Group III Written Notices with removal for the reasons stated in the above section. The Hearing Officer examines the evidence to determine if the Agency has met its burden.

I. Analysis of Issue(s) before the Hearing Officer

Issue: Whether the discipline was warranted and appropriate under the circumstances?

The Agency contends Grievant violated DI 201 by using excessive force on Patient during

[5] Grievance Procedural Manual §5.8

the incident. The incident is detailed in "Findings of Facts" (FF) 3 through 7 and incorporated by reference here.

Pertinent provisions of DI 201 are set forth in the findings of facts and are incorporated here also.

Evidence fails to show Grievant violated DI 201. For one, the Agency heavily relies on a particular segment of the video at markers numbered "24 through 26." Hearing Officer has viewed the video at least 10 times, including during the hearing and in her deliberation. In doing so, Hearing Officer has paused and studied the video on those segments the agency claims demonstrates that Grievant struck Patient. Hearing Officer does not find video shows Grievant struck Patient or was intending to do so. Further, the image quality of the video is poor. In addition, the Hearing Officer notes the video is without sound. Accordingly, no audio exists to corroborate Agency's claim of use of excessive force.

Furthermore, the evidence shows that video cameras have limitations in accurately portraying a scene and that camera angles used in videoing can distort views.

What is more, all the eyewitnesses to the incident except PSO 1 could not identify Grievant as striking Patient. For example, written statements and testimonies from PSO 5, PSO 6, PSO 3, and DSA 2 indicate that they did not see Grievant strike Patient. In addition written statements and/or testimonies from the RN and Nurse Practitioner note that upon their immediate assessment of Patient after the incident, they observed no physical signs of Patient being assaulted. That is, redness or lacerations were not identified. Nurse Practitioner also testified that having no such physical signs was inconsistent with being struck. The Hearing Officer observed the demeanor of the witnesses, considered their written statements, and found the witnesses, except PSO 1, credible.

Furthermore, Agency relies on PSO 1's written statement provided on April 4, 2023, as well as a statement Patient made to RN. Patient's statement was "they assaulted me."

Regarding PSO 1's statement. The Hearing Officer finds PSO 1 provided inconsistent statements. In his March 9, 2023 statement, he does not mention Grievant struck Patient. He does note that he saw Grievant being kicked by Patient. PSO 1 provided this statement about 15 minutes after the incident. This was presumably a time when the incident was fresh in his mind. Almost a month later, PSO 1 provided another written statement, dated April 4, 2023. In this second statement, PSO 1 writes that Grievant struck Patient with her right fist in the jaw. Another inconsistency noted is during PSO 1's testimony, PSO 1 testified that he was focused on grabbing Patient's arm and that he did not see a kick. Someone told him about it. Yet, as mentioned here in his initial statement written on March 9, 2023, PSO 1 writes that he saw a kick from Patient. In addition to his varied written and testimonial accounts of the incident, the evidence shows that PSO 1 injected himself in a conversation between two officers on May 13, 2023, indicating that he did not see Patient kick Grievant. Nor did he observe Grievant strike Patient.

Hearing Officer observed PSO 1's demeanor during the hearing, considered the inconsistencies in his statements and testimony. The Hearing Officer does not find PSO 1 a

reliable witness and gives little weight to his April 4, 2023 statement and testimony.

Next, Hearing Officer turns to Patient's reported statement, "they assaulted me." Hearing Officer notes the patient declined to be interviewed. Hearing Officer finds there is insufficient evidence to corroborate this statement. The statement is not convincing.

Hearing Officer is cognizant that CEO, Chief, and Investigator believed Grievant used excessive force. CEO and Investigator based their opinion on the video, Patient's statement mentioned above, and PSO 1's April 4, 2023 written statement. For reasons already noted, Hearing Officer finds CEO and Investigator's identical conclusion is erroneous. Equally as important, the evidence shows that neither CEO nor Investigator reviewed or considered the offense report, eye witness statements, and photographs of Grievant's injuries that were complied on the day of the incident.

While Chief did not find the video showed Grievant struck Patient, he placed faith in PSO 1's April 4, 2023 statement and the statement of another unidentified employee. Again, the Hearing Officer finds PSO 1's testimony and April 4, 2023 statement unreliable. Concerning the unidentified employee's statement, that individual did not present himself to be examined or cross examined. Hearing Officer gives little weight to the anonymous complainant or unidentified employee's statement.

Hearing Officer now turns to Agency's claim that any pushing, shoving, or grabbing Patient was an inappropriate use of force.

Agency has in effect policy SOP 021-DD. This policy is set forth in FF ## 87 through 90. This policy approves the use of force by PSOs where appropriate.

The Continuum of Force Chart set forth in SOP 021-DD notes that if an officer perceives the patient is demonstrating assaultive behavior, the officer may respond at a level 5. The policy indicates that a level 5 response involves incapacitating strikes or holds. According to Chief who has 20 years of experience at Agency in law enforcement or as a PSO, striking, holding, and or punching the body of a patient constitute an incapacitating response by the officer.

The Evidence in the case at bar shows the patient was combative and aggressive. He cursed at the officers. He threatened them. He jerked away from Grievant. He spat at Grievant. He kicked Grievant. During his actions Grievant spoke to him. Instructed him on what to do. He was non-complainant. He broke away from Grievant. Grievant attempted to gain control by grabbing him or his clothing. Hearing Officer finds Grievant did not violate Agency's policy regarding the use of force or use inappropriate techniques.

Hearing Officer notes that CEO testified that the applicable policy in determining if Grievant violated the code of conduct is DI 201. Further, CEO noted that the where there is tension between DI 201 and SOP 021-DD, DI 201 controls. CEO offered nothing in support of this assertion. In addition, HO finds that such an interpretation is not reasonable since Agency has established both policies and they both are and were effective on March 9, 2023. Under the policy if patient is aggressive and combative, appropriate use of force can be employed. The continuum

of force governs. In this case as noted above, Patient's actions constituted assaultive behavior. Under the continuum of force chart, the PSO may respond with incapacitating strikes or holds. Grievant did so. Chief, again with 20 years of law enforcement and public safety officer experience with Agency, agreed in his testimony that such response may be used when patient is assaultive. Chief was very familiar with the use of force policy. CEO did not believe Grievant could employ level five use of force. Of note, CEO was only minimally familiar with the use of force policy. At the time of the hearing CEO had only been an employee of the agency for about nine months. Additionally, CEO acknowledged that he is not currently a therapeutic options instructor. The Hearing Officer does not find persuasive CEO's contention that pushing, shoving, or grabbing Patient was inappropriate. Hearing Officer finds, CEO not have the information before him to make an informed decision on the use of force.

Hearing Officer finds the agency has not met its burden. Grievant did not engage in the alleged misconduct.

B. Did the Agency's Discipline violate law or policy?

Agency's actions of disciplining Grievant for use of excessive force was erroneous.

Accordingly, for the reasons noted above, the Hearing Officer finds that the Grievant did not engage in misconduct and therefore the Agency's discipline was not consistent with policy or law.

DECISION

The Agency is ordered to take the following action:

1. rescind the Group III Written Notice;

2. pay full back pay for the period Grievant has been separated from her job (back pay is to be offset by interim earnings);

3. appropriately restore other benefits and seniority;

4. reinstate Grievant to her former position or, if occupied, to an equivalent position.

APPEAL RIGHTS

You may file an **administrative review** request within **15 calendar days** from the date the decision was issued, if any of the following apply:

1. If you believe the hearing decision is inconsistent with state policy or agency policy, you may request the Director of the Department of Human Resource Management to review the decision. You must state the specific policy and explain why you believe the decision is inconsistent with that policy. Please address your request to:

Director
Departmental of Human Resource Management
101 N. 14th St., 12th Floor
Richmond, VA 23219

or, send by fax to (804) 371 – 7401, or e-mail.

2. If you believe that the hearing decision does not comply with the grievance procedure or if you have new evidence that could not have been discovered before the hearing, you may request that EDR review the decision. You must state the specific portion of the grievance procedure with which you believe the decision does not comply. Please address your request to:

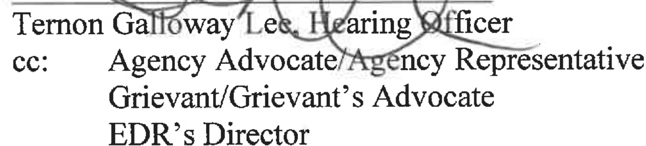
Office of Employment Dispute Resolution
Department of Human Resource Management
101 N. 14th St., 12th Floor
Richmond, VA 23219

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

You may request more than one type of review. Your request must be in writing and must be **received** by the reviewer within 15 calendar days of the date the decision was issued. You must provide a copy of all of your appeals to the other party, EDR, 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.

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 arose within **30 days** of the date when the decision becomes final.[6]

Entered this 1st day of August, 2023.



Ternon Galloway Lee, Hearing Officer

cc: Agency Advocate/Agency Representative
Grievant/Grievant's Advocate
EDR's Director

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