VIRGINIA: DEPARTMENT OF HUMAN RESOURCE MANAGEMEMT

OFFICE OF EMPLOYMENT DISPUTE RESOLUTION

HEARING OFFICER DECISION

Grievant v. Department of Behavioral Health and Developmental Services (the "Agency")

Case Number: 11991

Hearing Date: August 22, 2023
Decision Issued: September 6, 2023

PROCEDURAL HISTORY

On May 25, 2023, Grievant was issued a Group III written notice of disciplinary action with removal for a substantial violation of Departmental Instruction Number 201.

On June 21, 2023, the Grievant timely filed a grievance to challenge the Agency's action and he requested a hearing in the Office of Employment Dispute Resolution ("EDR").

On July 17, 2023, EDR assigned the appeal to the Hearing Officer.

On August 22, 2023, a hearing occurred in a conference room at the Agency.

APPEARANCES

Grievant
Agency Counsel
Agency Witnesses: CPRT Supervisor, Director, Investigator, DSA III
Grievant's Witnesses: DSA III , and a CPRT member

EXHIBITS

Agency Exhibit Book containing AE1-6, pgs. 1-165 was admitted into evidence without objection by the Grievant.

Agency Exhibit 1: Written Notice to Grievant (AE1, pgs. 1-3).

Agency Exhibit 2: DHRM, Policy 1.60, Employee Standards of Conduct (AE2, pgs. 4-30).

Agency Exhibit 3: *Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by(the Agency)* , 12 VAC 35-115-115-10 *et seq*.; VAC Section 37.2-400 *et seq*. (AE3, pgs. 31-32); Departmental Instruction 201 (RTS) 03, *Reporting and Investigating Abuse and Neglect of Individuals Receiving Services in Department Facilities* (AE3, pgs. 33-44).

Agency Exhibit 4: Agency Director's Issue Statement for Investigator (AE4, p. 45); Investigator's Summary (AE4, pgs. 46-97); Critical Policy 450-035, *Emergency Use of Seclusion or Restraint* AE4, pgs. 99-124; Investigator's Report containing handwritten witness statements, AE4, pgs. 125 -153.

Agency Exhibit 5: Grievant's Response Training Team History and TOVA Certifications (AE5, pgs. 154-165).

Agency Exhibit 6: agency video # 1 - Patient enters his room escorted by staff.

2 – Grievant and CPRTs arriving on the scene.

2A – Patient in seclusion room.

3 – Cook enters common area with CPRTs.

For the Grievant:

The Grievant did not offer any exhibits.

ISSUES

1. Did the Grievant engage in the behavior described in the Written Notice?
   Yes. The evidence was preponderant to substantiate the written notice.

2. Did the behavior constitute misconduct?
   Yes.

3. Did the Agency's discipline comply with the law and policy?
   Yes, because the evidence presented at the hearing substantiated termination by a preponderance of the evidence.

4. Were there mitigating circumstances justifying a reduction or removal of the disciplinary action?
   No.

5. Did the Hearing Officer consider mitigating circumstances?
   Yes. There were no mitigating circumstances to consider.

BURDEN OF PROOF

The Agency bears the burden of proof to show by a preponderance of the evidence that its disciplinary action against the Grievant was warranted and appropriate under the circumstances. *See*

Grievance Procedure Manual ("GPM") Sec. 5.8. A preponderance of the evidence shows that what is sought to be proved is more probable than not.

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

The Agency is a state operated psychiatric facility. Patients on this Unit often use colorful expletives, refuse medication or threaten those who care for them. It is a difficult job for which most staff members must become immune [1] to salty language and contentious behavior. The CPRT Supervisor, who is also the agency's TOVA Instructor, testified competently and convincingly at the hearing. The CPRT Supervisor monitors employees and teaches them to treat each patient with dignity as if each patient suffers from a prior trauma.[2] In order to instruct the employees' interactions with patients, the CPRT Supervisor teaches employees how to best intervene in each situation to avoid injury to the patient, to other patients, and to other agency employees. [3]

The Agency's policy toward abuse and neglect is clearly stated in Departmental Instruction 201(RTS) 03 is set forth as follows:

"*The [agency] strives to provide a safe and secure environment to individuals admitted to a facility for treatment or services. There is no tolerance for abuse and neglect. The [agency] investigates and acts upon every allegation of abuse or neglect. Whenever an allegation of abuse or neglect is made, the [agency] takes immediate steps to protect the safety and welfare of individuals who are the victims of the alleged abuse or neglect, conducts a thorough investigation pursuant to central office procedures and all applicable laws and regulations, and takes any action necessary to prevent future occurrences of abuse and neglect."* [4]

On April 23, 2023, the Grievant was reported to have physically restrained a Patient without justification and given a Group III written notice and terminated on May 25, 2023 for alleged abuse in two incidents in which he unsafely restrained an aggressive patient and later lunged at him while he was restrained. The patient had secreted a food tray and food items in his room which he refused to surrender to staff when asked to do so. He became aggressive with staff and the floor RN, in her sole discretion, decided to give the patient an IM which would eventually calm him down enough to be placed into the seclusion room.

Grievant, was a CPRT. CPRTs are contacted by agency nursing staff for assistance when a patient is non-compliant with the agency nursing staff on the floor. The CPRT's must decide how to safely restrain a patient who becomes aggressive when called by the agency nursing staff to control a patient. Often, the issue is quite challenging as it was in these two incidents. But a CPRT may never react to an aggressive patient's protests.

For these reasons, the grievant was charged with two violations, improperly restraining the patient to enter the restraint chair and for lunging at the patient after he was safely into the restraint chair.

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[1] Grievant's witness, CPRT's testimony, at tape recording # 5 @ 16.00 min.
[2] AE3, pgs. 31-32.
[3] AE3, pgs. 31-32.
[4] AE3, p.33.

On May 25, 2023, 2023 the agency's Director presented the following termination notice to the grievant:

"On April 23, 2023, the grievant was reported to have physically restrained a patient without justification. A subsequent investigation of his actions, including witness testimonials and video surveillance, resulted in a substantiated violation of DBHDS DI #201, reporting and investigating abuse and neglect of clients and [Agency] Policy # 050-057 Reporting and Investigation Abuse and Neglect of Clients, which in part defines patient abuse as *"... Use of physical or mechanical restraint on a person that is not in compliance with federal and state laws, regulations, and policies, professional accepted standards but practice or the persons, individual's service plan.*" After the patient was safely restrained in the emergency chair, the grievant lunged toward the patient, and was restrained by his co-workers to prevent further physical contact with the patient. The actions placed the patient, his co-workers, and himself in significant risk of physical harm. His actions are considered a failure to follow the aforementioned policies, as well as unsatisfactory performance of job duties. In accordance with DHRM policy number 1.60, Standards of Conduct, a determination of patient abuse/neglect warrants a Group III Written Notice and termination from employment. AE1, p. 1. DRHM Policy 1.60.

DRHM policy number 1.60, Standards of Conduct states as follows: [5]

"*This policy sets forth the Commonwealth's Standards of Conduct and the disciplinary process that agencies must utilize to address unacceptable behavior, conduct, and related employment problems in the workplace or outside the workplace when the conduct impacts an employee's ability to do their job and/or influences the agency's overall effectiveness."*

DRHM Policy 1.60, Standards of Conduct states its intent as follows: [6]

"*The intent of this policy and its procedures is to help employees become fully contributing members of the organization. The policy enables agencies to administer corrective action or discipline to include performance or conduct or terminate employees whose conduct and/or performance does not improve."*

GRIEVANT'S RESPONSE

On May 8, 2023, the grievant stated to the investigator and to the city social worker:

The grievant stated that CPRT staff responded to unit 5-A after getting a call regarding the patient having food in his room. As the grievant stated, CPRT staff were told by the RN that the patient would be getting an IM [7] and has refused to take it. The patient was to be placed into the restraint chair. The grievant stated that he approached the patient's room and informed the patient that the RN was getting an IM. The grievant stated that the patient stated "I am not taking a shot." The grievant stated that he asked the patient two more times to take the shot. The grievant stated that the patient refused both requests and walked to the common area. The grievant stated that the RN said "If he's not going to take the shot then he's going into the chair." The grievant stated that CPRT staff attempted to verbally redirect the patient to his living area. The grievant stated that once the patient saw the restraint chair he walked back to his living area and stated "Y'all not putting me in the chair." The grievant stated that the patient turned his attention to another CPRT telling her, "Bitch you put me in the chair." The grievant stated that he grabbed the patient from the front. The grievant stated that proper procedure is to hold the patient from

[5] AE2, p.4.
[6] Id, p.5.
[7] Medication to calm the patient.

the side. The grievant stated that as he was trying to secure the patient he leaned back and hit the table behind him. The grievant stated that the patient was able to get one arm around the grievant and stated "I am going to put you in the chair." The grievant stated that he rotated his body and staff helped to release the patient's grip on the grievant. The grievant stated that he was able to turn his body and position the patient in the restraint chair. The grievant stated that the patient was strapped into the restraint chair. The grievant stated that as the patient was being taken to the seclusion room he threatened to spit on the grievant. The grievant stated that he reacted as a CPRT staff member pulled him away. [8]

Also, the grievant stated on his DRHM Grievance Form A, filed on June 21, 2023, as follows: [9]

"I have been with the agency for almost two years. I have had one allegation of abuse and neglect before, but I was retrained and remained out of trouble. I have worked on many units, patients, and staff alike[.] I have been investigated on a few times [.] I took the course of action needed to be a better employee but terminated because [the Director] said that it looked like from where he sat I grabbed the patient before everyone else was ready to engage even though it was fully explained in my interview as to why I restrained the patient. If you want to make something up about me trying to stop the patient from spitting while in the [restraint chair] I can see why and understand even though I never once tried to hurt the patient or slam the patient. I did not say or do anything demoralizing and so by definition I did not violate DI 201-3. Furthermore, I have always done my job to the best of my ability. Some staff have discriminated against me because of my size to do my job. Which I have been doing for almost two years even with criticism. The fact is that you can ask anyone about me past or present. They can speak about my character and go to the units; or the PODS ask the staff that have dealt with me what is their impression of how I work? I was essentially terminated on May 25, 2023 and never shown any proof of wrong doing."

The grievant requests relief by reinstatement, and all alleged allegations removed with back pay retroactively and to be made whole.

AGENCY WITNESS TESTIMONY

The Director testified credibly and convincingly at the hearing. The Director thoroughly explained why these two incidents warranted the grievant's termination. He stated that what challenged his consideration of mitigating circumstances was that the grievant was involved in two separate incidents with this patient. Both incidents the Director considered were aggravated. The Director testified that there was no mitigation ground for him to consider within this factual scenario. The first incident involved what he referenced as "a significant struggle" and "rushed" [10] the patient when the grievant ineffectively "forced" [11] the patient into the restraint chair. And the second incident occurred when the grievant lunged at the patient as the patient was seated and strapped into the restraint chair. The Director's additional concern with these two incidents also was that the grievant knew that the RN had just administered an IM injection. An IM inevitably works to calm agitated patients. The grievant knew that the patient had just received an IM when he forced the patient into the restraint chair and when he lunged at the patient. The Director testified that the grievant never gave the IM a chance to work on the patient to calm him. Also, the Director cited the fourth bullet under Departmental Instruction 201 (RTS) 03 as his procedural guideline at the core of all abuse and neglect incidents he must determine.[12] The Director stated that under

[8] AE4, pgs. 50-51.
[9] *See also* Grievant's DRHM Grievance Form A, "Issues" portion of the form.
[10] Agency witness, Director's testimony, at tape recording # 4 @ 5.05 min.
[11] Id. at 5.05 min.
[12] *Regulations To Assure the Rights of Individuals Receiving Services From Providers Licensed, Funded, or Operated by the [Agency]*, 12 VAC 35-115-10 *et seq*.

these circumstances, and per agency procedural guidelines, the two incidents were aggravated. The Director testified that because of these two aggravated incidents consisting of the initial hold (assault) and the lunge toward the patient, there were no mitigating circumstances for him to consider in the grievant's case and that the charges warranted a Group III termination notice.

The CPRT Supervisor also testified credibly and convincingly at the hearing. His experience at the agency is extensive. He has been a TOVA instructor for 15 years at the agency, worked as a behavior specialist for the agency for 15 years and functioned as a public safety officer at the agency as well. He described his treatment principle as one of "Trauma Informed Care Model" [13] in which he considers all agency patients as if the patient has been the subject of a heinous act from which the patient suffers from PTSD.

The CPRT Supervisor agreed with the grievant that his work history until these incidents was good. He noted that the grievant received extensive, recent retraining in which the grievant made a high score, 90.9, after a two day 16 hour course.[14] The grievant was recertified in TOVA restraint methodology on April 7, 2023. The other related trainings the grievant received at the agency are extensive. [15]

The CPRT Supervisor testified that when he looked at the agency's video #3 showing the first incident, he recalled that the patient was originally in his bedroom then he walked out into the living area.[16] When the CPRT Supervisor examined the video footage he noted that the patient had his body turned to the side. The CPRT Supervisor stated that the patient had his body turned to the side when the RN ordered the patient into the restraint chair. The CPRT Supervisor advised that the side body stance would have been a perfect opportunity for the grievant and a second CPRT to do a side body hold and ease the patient into the chair. He emphasized the need for de-escalation in this instance because the agency's goal is to find the least restrictive way to restrain a patient, without injury to the patient, to other patients or to staff.

The CRPT Supervisor referred to the agency's "abuse" [17] policy the grievant, in his opinion, had violated which the CPRT Supervisor noted in his testimony as follows:

"Abuse – This means any act or failure to act by and employee or other person responsible for the care of an individual in a facility operated by the agency that was 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." [18]

The CPRT Supervisor carefully pointed out in the agency video that the grievant utilized a full body hold on the patient to get him seated in the restraint chair. The full body hold violated the agency's abuse standard because it resulted in the grievant grabbing the patient and forcing him into the restraint chair . The CPRT Supervisor testified also that the grievant could have been assisted by any of the six other CPRT's in attendance to ease the patient into a sitting position into the restraint chair. The CPRT

[13] Agency Witness, CPRT Supervisor's testimony, at tape recording # 2, @ 18.13 min.
[14] AE5, p. 155. Agency hybrid course showing the grievant completed the agency's restraint course in "*Emergency Use of Seclusion and Restraint*" on January 6, 2023 and completed TOVA recertification most recently on April 7, 2023.
[15] AE5, p. 154-165.
[16] Agency video # 3 at 20.52 min.
[17] AE3, p. 33.
[18] Id.

Supervisor noted that the grievant knowingly assaulted and used excessive force to make the patient comply with the RN's order instead of relying on agency guidance on restraint.

An agency DSA III testified at the hearing. She stated that she was on the floor when the CPRT members arrived. The DSA III stated that when she first the grievant with the patient, the patient had his hands around the grievant's midsection. She then saw the grievant holding his hands in the air, above his body, when she heard the patient say to the grievant, "You're going into the restraint chair before me." The DSA III also saw the grievant lunge at the patient and another CPRT pull the grievant off of the patient who was then seated in the restraint chair. [19]

The agency investigator testified credibly and convincingly regarding the two incidents. He had spoken personally to each witness to these two incidents and took down their statements which are carefully documented in his investigative report. The agency investigator stated that the incidents began when the patient began to take his lunch tray to his room along with his utensils. After agency staff confronted the patient, he refused twice to relinquish the items, the patient verbally and aggressively refused to return the items to agency staff. The RN ordered that the patient receive a medication , or IM, to call him down. But the RN stated that she preferred to give the patient the medication after he was strapped into a restraint chair. CPRT staff were called in and the team decided to get a safety plan together. But for some reason, the patient focused on challenging the grievant and asked him, "Why don't you put me in the chair?" The agency investigator stated in his report that [the agency video # 3] shows that the patient had walked away when the grievant grabbed him from behind. [20] The agency investigator stated that the grievant acted alone to originate the physical restraint but after the grievant physically engaged the patient, other CPRT staff helped to restrain a physically aggressive patient. At this point, the patient held onto the grievant's chest and midsection as the CPRT staff eventually got the patient into the restraint chair and properly strapped him in. The patient was eventually given the IM by nursing staff. The patient was then taken via the restraint chair to the seclusion room by various staff, the RN and the grievant. Again the patient verbally challenged the grievant and was hyper verbal. The patient had threatened to spit on staff when the grievant lunged at the patient. [21]

The agency investigator substantiated the abuse charge by explaining how the grievant deviated from the agency abuse standard. He stated that the grievant's lunge toward the patient, strapped into the restraint chair, though the incident is not fully shown in the agency's video #3, constitutes abuse. Numerous agency and grievant witnesses testified that they saw the grievant lunge toward the patient as the patient was about to enter the seclusion room. Also in the agency's video # 3, the agency investigator showed that the patient had walked away but was "tackled" [22] first by the grievant. The agency investigator referred to these two incidents as abuse because the grievant initially grabbed the patient, assaulting him, and subsequently lunged at the patient.[23] As the agency investigator testified, both incidents reflected the grievant's intent. The agency investigator concluded in his report, that the evidence substantiates the agency charges of physical abuse because the grievant used unnecessary restraint against the patient.[24]

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[19] AE4, p. 138.
[20] Agency witness, Investigator's testimony, at tape recording # 3, @ 10.50 min.
[21] Id., p. 61.
[22] Id., p. 147. See also agency video # 3 @ 20.53 min.
[23] Agency witness, Investigator's testimony, at tape recording # 3, @ 7.44 min.
[24] AE4, p. 61.

GRIEVANT'S WITNESSES

The grievant's first witness was a fellow CPRT staff member who has worked for the agency for three years and as a CPRT for two years. As soon as the CPRT entered the room where the patient was with the grievant, the CPRT testified that he was struck immediately by the patient's aggressive verbal attack, lasting about 20-30 minutes, on the grievant. The CPRT witness confirmed that the patient called the grievant demeaning names and used insulting language to him. On cross exam by agency counsel, however, the CPRT witness stated that the CPRT staff is quite indifferent to this sort of insulting language from which most CPRT staff become "immune." [25] The CPRT staff member who testified also admitted on cross-exam that he pulled the grievant off of the patient who was strapped to the restraint chair testifying he grabbed the grievant because he didn't know what the Grievant would do: [26]
The CPRT confirmed how the fracas evolved and testified as follows:

"Yes, [the patient] objected to getting that shot. That was the reason for the whole thing. The patient said, "I'm not taking it. And [the patient] wouldn't take it orally." [27]

The grievant's second witness was an agency DSA III who confirmed that the patient was aggressively verbally attacking the grievant and calling him names. She confirmed that the patient became even more agitated when the RN ordered the patient into the restraint chair. The DSA III witness confirmed that the grievant did attempt to put the patient into the restraint chair.

The grievant testified regarding his own admission that he would do things differently if given the chance. Though he stated that watching the two incidents on the videos was difficult for him, he seemed genuinely ashamed of his actions that day. But curiously, the grievant stated that he believes that he safely got the patient into the restraint chair on April 23, 2023.

CONCLUSIONS OF LAW AND POLICY

The Commonwealth of Virginia establishes procedures and policies that apply to state employment matters in the hiring, promoting, compensating, discharging, and disciplining of state employees in Virginia. [28] The *Grievance Procedure Manual,* Sec. 5.8 requires a state agency to show by preponderance of evidence that the disciplinary action is warranted and appropriate under the circumstances.

The procedural standards for disciplinary actions in employment are set forth in the *Code of Virginia,* Sec. 2.2-1201, as established and set forth by the Department of Resource Management, Standards of Conduct, Policy No. 1.60 (the "SOC"). The SOC provides criteria by which state agencies may consider employee misconduct ranging in seriousness from least severe (a Group I offense) to most serious and warranting the employee's removal (a Group III offense).

The purpose of the SOC's underlying policy is for state agencies to apply "a progressive course of discipline that fairly and consistently addresses employee behavior, conduct, or performance that is incompatible with the state's SOC for employees and /or related Agency policies." [29] The SOC's stated

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[25] Grievant's witness, CPRT's testimony, at tape recording #5 @ 16.00 min.
[26] Grievant's witness, CPRT's testimony, at tape recording # 5 @ 16.42 min.; and at 16.44 min.
[27] Id. at tape recording # 5 @ 4.0 min.; @ 4.10 min.; @ 5.25 min.
[28] *See generally DHRM Department of Human Resource Management, Policy 1.60 Standards of Conduct.* (AE2, pgs. 4-30.
[29] *Id.* at p. 5.

objective is grounded in due process which requires the hearing officer to consider a vast range of disciplinary alternatives applicable to the employee's misconduct charged by the Agency. If the offense fits the discipline, the hearing officer is not at liberty to dismiss the seriousness of the charge(s) and to insert his or her own subjective thoughts and apply the sensibilities of a human resource officer.

Regarding the SOC's applicability to state employees, as stated therein, the SOC's legislative intent is "help employees to become fully contributing members of the organization." [30] But when employees do deviate from the Agency's standards, and employees commit misconduct, the SOC describes penalties for the employee's converse behavior and provide the hearing officer available options for the hearing officer to consider in assessing the employee's misconduct charges.

In the instant case, the agency reasonably assessed the grievant's offense as a Group III offense because the SOC describes Group III Level Offenses as "Offenses in this category include acts of misconduct of such severe nature that a first occurrence normally should warrant termination." [31] The SOC further identifies Group III offenses and gives examples of such employee misconduct characterized as the most severe: to endanger others in the workplace, to commit illegal or unethical conduct, to neglect one's duty, to disrupt the workplace, or to commit other acts that constitute serious violations of policies, procedures or laws. In this case, the evidence was preponderant to support the charge that the grievant's intent can be characterized as the most severe misconduct. More appropriately, the grievant is at fault for failing to properly restrain the patient and for lunging at a defenseless patient who was strapped into a restraint chair.

The SOC further clarifies the hearing officer's consideration of mitigating circumstances in that one Group III offense, if it is proven, should result in termination unless there are mitigating circumstances. The grievant asserted to the Director that he is entitled to he is entitled to mitigation because the patient threatened to spit on him. The Hearing Officer agrees with the Director that the grievant's defense is without merit. Threatening to spit on an agency employee never entitles a CPRT, or any agency employee, to retaliate against a patient. The grievant was honest in his assertion to the Director that the patient's spitting threat caused him to lose his head. But the grievant knows that a CPRT is never entitled to lose his wits when interacting with patients. As his CPRT witness stated, a CPRT must stay immune to such behavior. The grievant must face the consequence of his retaliatory behavior which, regrettably, is termination.

DISCUSSION

The termination of this employee for the Director's charge of physical abuse carries with it, to prove the termination charge, the duty to prove that the grievant's intent directly violated Department Instruction 201, Reporting and Investigating Abuse and Neglect as follows:

"… *any act of 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, that caused or might have caused physical or psychological harm injury or death to an individual receiving care or treatment*." The agency's evidence at the hearing was convincing. The grievant's actions on April 23, 2023 were intentional.

The Director's allegation that the Grievant's intent was to cause physical or psychological harm to patient is convincing. The agency videos, Clips 1 and 3, support the abuse charges which were fully substantiated. The evidence showed that the grievant used an improper restraint method in that he grabbed

[30] *Id.*, at p. 5.
[31] *Id.*, at p. 11.

the patient and forced him into the restraint chair then he later lunged at the patient who was then strapped into the restraint chair, Level III termination offences. The CPRT who testified for the grievant admitted that he restrained the grievant after he lunged at the patient.

MITIGATION

Under the *Rules For Conducting Grievance Hearings,* [a] hearing officer must give deference to the agency's consideration and assessment of any mitigating and aggravating circumstances. Thus, a hearing officer may mitigate the agency's discipline only if, under the record evidence, the agency's discipline exceeds the limits of reasonableness. If the hearing officer mitigates the agency's discipline, the hearing officer shall state in the hearing decision the basis for mitigation. A non-exclusive list of examples includes whether (1) the employee received adequate of the existence of the rule the employee is accused of violating, (2) the agency has consistently applied disciplinary action among similarly situated employees, and (3) the disciplinary action was free of improper motive.

In light of the mitigation standard, the Hearing Officer finds that the grievant was not entitled to the existence of a mitigating circumstance on April 23, 2023 to reduce the Hospital's termination.

DECISION

The Agency has met its evidentiary burden of proving upon a preponderance of the evidence that the Grievant violated Agency policies including Policy No 1.60 and that the violations rose to the level of the Group III offense charged in the Written Notice. The Hearing Officer UPHOLDS the written notice in its entirety.

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 have new evidence that could not have been discovered before the hearing, or if you believe the decision contains an incorrect legal conclusion, you may request the hearing officer either to reopen the hearing or to reconsider the decision.

2. If you believe the hearing decision is inconsistent with state policy or agency policy, you may request the Director of 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 of Human Resource Management, 101 North 14th Street, 12th Floor, 22219 or send by fax to (804) 371-7401, or email.

3. 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 the Office of Employment Dispute Resolution to 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, Office of Employment Dispute Resolution, Department of Human resource Management, 101 North 14th Street, 12th Floor, Richmond, VA 23219 or send by email to EDR@dhrm.va.gov , or by fax to (804) 786-1606.

4. 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 when the decision was issued. You

must give a copy of all your appeals to the other party and to EDR. The hearing officer's decision becomes final when the 15 calendar days has expired, or when the administrative review has been decided.

5. You may file a request for judicial review if you believe the decision is contrary 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.

   [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].

- Signature Page to Follow -

Enter: September 6, 2023

Sarah Smith Freeman, Hearing Officer
Sarah Smith Freeman, Hearing Officer

CERTIFICATE

I certify that I have emailed/mailed the above Written Decision to all parties on this 6th day of September, 2023.

Sarah Smith Freeman, Hearing Officer
Sarah Smith Freeman, Hearing Officer

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