VIRGINIA: DEPARTMENT OF HUMAN RESOURCE MANAGEMEMT

OFFICE OF EMPLOYMENT DISPUTE RESOLUTION

DECISION OF HEARING OFFICER

In the matter of Grievant v. Eastern State Hospital

Case Number: 11980

Hearing Date: July 12, 2023
Decision Issued: August 1, 2023

PROCEDURAL HISTORY

On April 7, 2023, Grievant was issued a Group III written notice of disciplinary action with removal for a substantial violation of Departmental Instruction 201.

On May 3, 2023, the Grievant timely filed a grievance to challenge EHS's action and he requested a hearing.

On May 3, 2023 the Office of Dispute Resolution received the Grievant's due process request. On May 17, 2023, the Office of Employment Dispute Resolution assigned the appeal to the Hearing Officer.

On July 12, 2023, a hearing occurred in a conference room at the Hospital.

APPEARANCES

Grievant
Hospital Representative
Agency Advocate
Hospital Witnesses: Hospital Director and Investigator
Grievant's Witness: Hospital RN

EXHIBITS

For the Agency:

Exhibit 1: Hospital Exhibit Book (AE-1).

Exhibit 2: Hospital Investigative Report (AE-2).

Exhibit 3: Hospital Policy (AE-3).

Exhibit 4: DHRM Standards of Conduct (AE-4).

Exhibit 5: Hospital Videos, Clip 1, appended (AE-5, Clip 1) and Hospital Video, Clip 2, appended (AE-5, Clip 2).

For the Grievant:

The Hearing officer rejected the Grievant's proffer of local newspaper articles relating to the Hospital but the Grievant did not submit them to the Hearing Officer.

ISSUES

1. Did Grievant engage in the behavior described in the Written Notice?
   No. The evidence was not preponderant to substantiate the written notice.

2. Did the behavior constitute misconduct?
   Yes.

3. Did the Hospital's discipline comply with the law and policy?
   No, because the evidence presented at the hearing did not substantiate termination by a preponderance of the evidence.

4. Were there mitigating circumstances justifying a reduction or removal of the disciplinary action?
   Yes. The Grievant had not received TOVA restraint training before being placed on a psychiatric floor with forensic patients who are extremely dangerous. Also, the Hospital Videos did not conclusively show the Grievant lifting Patient A's legs or feet over his head. But the Hospital Videos did show that the Grievant made contact with Patient A's calf or calves which is an inappropriate restraint method.

5. Did the Hearing Officer consider mitigating circumstances?
   Yes. The Hearing Officer exercises her authority to reduce the abuse charge, from termination Grade III to a Grade II offense and the Grievant will be suspended for 15 days, without pay, for the exercise of an inappropriate restraint method (making contact with Patient A's calf or calves). The Grievant received some restraint training when he was hired three years ago. The Grievant testified he asked, and never received, TOVA restraint training though he requested that his supervisor provide him with the updated restraint training. The Hospital Director admitted that the Hospital was short-handed and many DSA's, including the Grievant, were never properly trained in the TOVA restraint method for handling out-of-control patients.

BURDEN OF PROOF

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

FINDINGS OF FACT

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 forensic hospital ("Hospital") which is a psychiatric hospital that houses criminally aggressive patients in the hospital wards together with patients who have psychiatric diagnoses. The Grievant was employed by the hospital for 31/2 years. But the Grievant testified that his COVID illness prevented him from working at the Hospital for about one year.

The Grievant was given a Group III written notice and terminated on April 7, 2023 for alleged abuse of an aggressive patient who, moments earlier, had punched the Grievant in the face.

WRITTEN NOTICE OF OFFENSE

On April 7, 2023 the Hospital Director presented the following termination notice to the Grievant:

"An allegation was reported that [the Grievant] was involved in a patient altercation on March 18, 2023 which resulted in physical patient abuse. The subsequent [Hospital authorized investigation], through testimonial evidence and video surveillance, substantiated this allegation. [The Grievant] intervened during an altercation between two patients, one of whom had allegedly previously struck the [Grievant] in the face. While intervening, the [Grievant] grabbed one of the patients by his ankles, lifting the patient up off the floor to shoulder height, causing the patient to fall from the floor. This is not an approved method of attempting to restrain a patient or lower a patient to the floor, and is neither safe nor appropriate nor is it reflective of any training he has received through Hospital staff development and training. [The Grievant's] actions were not consistent with approved behavior intervention/management techniques to separate patients, while ensuring the safety of the patients involved. His actions were a direct violation of Departmental Instruction 201, Reporting and Investigating Abuse and Neglect of Patients, which in part defines abuse as "… any 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." In accordance with DHRM Policy, 1.60, Standards of Conduct, this violation warrants a Group III Written Notice with Termination. AE-1, at 2.

GRIEVANT'S RESPONSE

In the Investigative Report, the Grievant stated to the Hospital's Investigator and to the City Department of Social Services (DSS) worker on March 24, 2023:

On Saturday, around 8:15 PM the Grievant was giving Patient B and Patient C water from the kitchen. The Grievant stated that Patient B and Patient C were at the entrance of the door receiving water. The Grievant stated Patient B was to the left of him and Patient C was to his right. The Grievant stated that Patient A came up from behind and punched him in the face, closed fist, unprovoked. The Grievant stated that Patient A and himself had no prior interactions. The Grievant stated Patient A came in between the two patients and attacked him. The Grievant stated Patient A was placed on the ground by Patient B and himself. The Grievant stated CPRT was called, and he reported the information to the evening supervisor. AE-2, at 9.

During his testimony, the Grievant stated that he attempted to grab Patient A's leg because, "[Patient A is] so much taller than I am."[1] Both the Hospital Advocate and the Grievant stipulated that Patient A is over 6.'0" tall and the Grievant's height is 5'5".

Also, the Grievant testified at the Grievant's hearing on July 12, 2023 that he never received the Therapeutic Options of Virginia ("TOVA") [2] training which, arguably, would have provided him with the required de-escalation skills to properly restrain a recalcitrant patient. The Grievant stated that he received his initial pre-hire training but was not re-trained in TOVA de-escalation methods when he returned from his one year absence from the Hospital for COVID illness. The Grievant testified that he requested, more than once, that his superiors re-train him per TOVA standards. At the hearing, the Hospital did not present evidence to dispute the Grievant's above assertions that [the Grievant] was never retrained or received TOVA training after he returned from his one year COVID absence. At the hearing, the Hospital did not demonstrate that the Grievant attained the restraint level training necessary for the Grievant to control a forensic patient and did not contradict his lack of TOVA training.

The participants stipulated that the Hospital is a forensic hospital.[3] Because the Hospital is forensic, the Hospital is charged with managing criminally aggressive patients, who await psychiatric "restoration to competency" [4] certification. Forensic patients are sent to the Hospital by Virginia state courts, criminal division, because certain patients have been adjudicated incompetent in a state court. The term, restoration to competency, applies to the treatment that criminally aggressive patients must receive at the Hospital. Ultimately, the forensic patients must answer pending criminal charges in a Virginia state court. Patient A was a patient who awaited restoration to competency certification when this incident happened. He had a violent history. The Hospital Director testified that dangerous forensic patients are kept together with patients who have psychiatric disorders but do not have pending criminal charges against them on the Hospital's Unit 5-C.

The Grievant testified also in his defense that his Co-Worker DSA was not in his vicinity when the incident occurred and was unable to assist him to quickly de-escalate the incident. One of the Hospital

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[1] Grievant's hearing testimony.

[2] The Hospital's TOVA training policy states as follows: "All direct care, clinical staff will receive specialized training and be verified competent in approved behavioral interaction and management techniques in accordance with [Hospital] Policy 080-013 'Behavior Interaction and Management Training.' (AE-3, p.71).

[3] The Hospital is the largest state forensic hospital in Virginia. Hospital Director's testimony.

[4] The parties stipulated that Patient A was being held at the Hospital for restoration to competency to answer for criminal charges.

Videos, Clip 1, appended, clearly shows that the Grievant's Co-Worker DSA [5] was performing a nightly check or "Q"[6] on another patient's bath room. Given the volatility of these patients, the Hospital Director testified that this nightly DSA inspection function requires two DSA's to perform together.

Thus, the Hearing Officer's review of the Hospital Video, Clip 1, appended, and the Hospital Video, Clip 2, appended, does not show that the Grievant encountered an emergency situation in the presence of his Co-Worker DSA whom the Grievant alleged to be five months pregnant. Grievant's hearing assertion, that he wanted to protect his pregnant co-worker from harm which prompted the Grievant to "[attempt] to grab [Patient A's] leg," [7] is without merit.

HOSPITAL DIRECTOR'S TESTIMONY

The Hospital Director testified remotely at the hearing. [8] The Hospital Director stated that he reviewed the Investigative Report and opined that the assault charge against the Grievant was substantiated. The Hospital Director testified that the Grievant "placed a choke hold" [9] on [Patient A] and that instead of stabilizing [Patient A], the Grievant then picked up [Patient A] by the knees and caused [Patient A] to fall to the ground. The Hospital Director testified that this method of restraint substantiates the physical abuse charge against the Grievant. The Hospital Director testified that the restraint the Grievant used was inconsistent with [DSA] training or with appropriate TOVA restraint and that the Grievant caused harm to [Patient A] and placed those around him in danger.

On cross-examination, the Hospital Director testified that hospital staff are "all"[10] trained to handle incidents such as this one "given the population we are charged with"[11] in response to the Grievant's question to the Hospital Director about how much restraint training the Grievant had received. The Hospital Director admitted that he knew that the Grievant had not been TOVA "recertified" [12] when the Grievant was assigned to the Hospital's, Unit 5-C, the state's largest forensic unit, because he encountered a "staffing shortage." [13]

The Hospital Director testified that on March 18, 2023, four Hospital staff members were assigned to the Hospital's, Unit, 5-C, which was an appropriate number to oversee about 25 patients. The Grievant asked the Hospital Director why, in the Hospital's video of this incident, it appeared that only 3 staff members were visibly on the floor. The Hospital Director testified that one of the Hospital's assigned employees, or a DSA, must have been temporarily off the floor. The Hospital Director admitted, however, that it was only by August 2022 that the Hospital was able to meet minimum Virginia state staffing requirements. But the Hearing Officer reviewed extensively the incident on the Hospital Videos, Clip1 and Clip 2. In the Investigative Report, Hospital workers made statements indicating their presence on the Hospital's Unit 5-C during the incident. The Hearing Officer does not deem that the number of

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[5] Hospital Video, Clip 1, appended. This DSA is also identified later as Witness A whom the Grievant alleged to be five months pregnant. (AE-5, Clip 1; AE-5, Clip 2).
[6] A "Q" is a bathroom inspection.
[7] Grievant's hearing testimony.
[8] During the beginning of his video testimony, Internet issues developed and the Hospital Director provided his remaining testimony by telephone to which the Agency Advocate and the Grievant assented on the record. Earlier during the hearing, the Hearing Officer denied the Grievant's request for a hearing continuance because of the Internet issue.
[9] Hospital Director's testimony.
[10] *Id.*.
[11] *Id.*
[12] *Id.*
[13] *Id.*

Hospital workers present on Unit 5-C was deficient, as the Grievant alleged. The two Hospital videos, showing the incident in question, prove that there were at least four workers, including the Grievant, on the Hospital's Unit 5-C that evening.

Regarding the specific incident involving the Grievant on the evening of March 18, 2023, the Hospital Director admitted that he was unable to "view" [14] the Grievant's patient "assault" [15] for which the Grievant was terminated. The Hearing Officer is at a loss to understand how the Hospital Director concluded that the Grievant held Patient A in a choke hold and pulled [Patient A] up to his knees if he admitted his view of the incident was blocked. Instead, the Hospital Director testified that the abuse charge was substantiated because he reviewed the Investigative Report. In the Investigative Report, however, none of the Hospital patients or staff say, unequivocally, that the Grievant placed the Patient A in a choke hold. Only one witness, Witness A, [16] stated in the Investigative Report that the Grievant "picked [Patient A] up by his knees" [17] yet Witness A was not present when the incident occurred and she based her statement on her viewing of the Hospital Video and not on her firsthand knowledge. Witness A was conducting bathroom inspections and arrived after she heard commotion. Also, of the two witnesses who stated they saw the Grievant mishandle Patient A, (Witness A and Patient B) each witness qualified his or her statement, and reversed his or her statement, by saying, in essence, "I didn't see the Grievant do anything inappropriately to [Patient A].

Thus, the Hearing Officer extensively reviewed the Hospital Video, Clip 2, appended, to independently reach factual conclusions underlying the incident. The Hearing Officer is mindful that the Grievant's livelihood, and his reputation as a twenty-year health care worker, are at stake. Therefore, it was essential that the fact-finder painstakingly examine the evidence presented to separate speculation from fact.

HOSPITAL INCIDENT VIDEOS

The Hospital presented two videos of the incident, one, Hospital Video, Clip 1, appended, specifically shows the positions of the Grievant's co-workers that lead up to the incident. In Hospital Video, Clip 2, appended, the video shows the Grievant's actions, and the patient actions, that lead to the abuse charge against him. [18] When the Hearing Officer reviewed the Hospital Video, Clip 2, appended, she found the following: AE-5, Clip 1; AE-5, Clip 2.

.02 – Patient A is a tall man who appears to be over 6'0" tall which the parties had stipulated. Patient A is wearing a black shirt over a white shirt, black pants, black shoes and he has a noticeable bald spot. Also visible is Patient B who is a tall man wearing a blue shirt, blue jeans and black and white sneakers. Patient B holds a small white object in his right hand. The Grievant is not visible. Patient C is not visible. Patient A stands behind them about four feet.

.16 – Patient A moves quickly forward to the left of Patient B. Patient A now stands in the middle to the right of Patient B. The Grievant is not yet visible. Patient C is only slightly visible.

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[14] *Id.*
[15] *Id.*
[16] Witness A is referred to earlier as the Grievant's Co-Worker DSA on March 18, 2023.
[17] Witness A made this statement after she viewed the Hospital Video. But also in her Investigative statement, she later changed her assessment and concluded her statement by saying, "[I] don't remember [the Grievant] physically intervening." (AE-2, p.5-6).
[18] The two Hospital videos are referred to in the decision as Hospital Video, Clip 1, appended and Hospital Video, Clip 2, appended. The two videos were converted from the Hospital's DVD tape showing the events occurring on the Hospital's, Unit 5-C on March 18, 2023. (AE-5, Clip 1; AE-5, Clip 2).

.17 – Patient A steps in front of Patient B. Patient B places Patient A in a choke hold.

.18 – Patient B moves to the left, still holding Patient A in a choke hold. Patient C becomes visible. He is a very large man wearing a black short-sleeved shirt with dark cargo shorts, white socks and flip flops. Patient C begins to move backward behind the Grievant who is now visible. Grievant is wearing his blue scrubs with a long sleeved white undershirt. The parties stipulated at the hearing that the Grievant is 5'5" in height.

.19 – The Grievant reaches toward Patient A who is still held in a choke hold by Patient B. Grievant makes contact with Patient A's right arm.

.20 – Patient B still holds Patient A in a choke hold. View of Grievant is blocked by Patient C.

.21 – The Grievant holds both wrists of Patient A. Patient B holds Patient A in a choke hold.

.22 – The Grievant's right arm reaches downward. Patient A and B are blocked from view by Patient C.

.23 – Patient C entirely blocks the view of Patient A and Patient B. The Grievant is only partially visible. It appears that a struggle occurred but the actors are not visible. The Grievant appears to hold Patient A's calf or calves which are not being held over Patient A's head.

.24 – The participants in the struggle are no longer visible because Patient C blocks the view.

.25 – The Grievant's hands are not visible. Patient A and Patient B are not visible because Patient C blocks the view. Another patient, wearing red pants, black shirt and white sneakers, now stands to the left of Patient C. He also blocks the view.

.26-.29- The Grievant is now visible from the back and stands directly in front of Patient C who continues to block the view. Patient A and Patient B are not visible.

.33- Patient C stands directly behind the Grievant is standing and who appears to be about one yard from Patient B who holds Patient A on the ground. Though most of Patient A's body is curled on the floor, Patient A's face is visible and is held in Patient B's arm.

.34 –.39 - Patient B is now somewhat visible. Patient B holds Patient A on the ground in front of him. The Grievant appears to now be about 10' away from Patient A and Patient B. The Grievant moves to the left and walks toward a co-worker DSA, who is dressed in blue scrubs. This is Witness A, the Grievant's co-worker DSA for the evening. The Grievant has moved to the left of the counter. Patient C is blocking the view. Witness A walks over and bends down toward Patient A and Patient B.

1.03 – Grievant appears to be discussing the event with Witness A. Meanwhile, a group of patients converge and completely obliterate the view.

1.14 - Witness A helps Patient A to his feet and leads him to his feet. The Grievant has moved about 6' away from the incident scene.

1.18 – Patient A is lead away by Witness A and is seated at a small round table. Witness appears to check Patient A for injuries.

INVESTIGATIVE REPORT

The Hospital employs an experienced Investigator who testified at the hearing. [19] The Investigator took the following statements from witnesses[20] who were present on March 18, 2023 at the Hospital, Unit 5-C at about 8:45 PM or who rendered a professional opinion after viewing the Hospital's incident video. When the Investigator interviewed the witnesses, she was accompanied by a City DSS worker. The witnesses and patients stated to the Investigator as follows:

Witness A: [21] Witness A could not see the Grievant at first but then she saw the Grievant come over to Patient A and ask him why he had hit him. Witness A did not remember [the Grievant] physically intervening but according to the video it appears as if the Grievant picked up Patient A's feet before Patient A went to the floor…. Witness A did not see inappropriate interactions between Patient A and the Grievant. AE-2, p. 6.

Witness B:[22] Witness B testified at the hearing. She was on Unit 5-C when the incident occurred. She believes that all DSA's are trained but did not recall how many staff occupied the Hospital's Unit 5-C when the incident occurred. She testified that it is sometimes difficult to restrain unruly patients and that her unit does have volatile moments but is generally a safe place. She testified that Patient A has been known to have incidents of aggression. She testified that she did see blood on Patient A's finger at the time of the incident. AE-2, p.7.

In the Investigative Report, Witness B had also stated that she heard a commotion in the milieu and when she looked up, she saw Patient B holding Patient A and the Grievant standing over them both. Witness B stated a Code White [23] was called. Witness B stated she went over and was told by Patient B that Patient A had attacked the Grievant. Witness B stated she helped Patient A to his feet and encouraged the Grievant to leave the scene. Witness B stated that Patient A was still visibly agitated with his fists balled and had an angry affect on his face. Witness B stated she walked Patient A to the medication window and cleaned his finger due to blood. Patient A was then placed in open seclusion for the remainder of the night. AE-2, p. 7.

Witness C:[24] Witness C stated that she was cleaning up after snack time in the kitchen . The Grievant came into the kitchen and got two cups of water. About 5-10 minutes later, she heard commotion. When she opened the [kitchen] door, she saw the Grievant yell out, "He punched me, he fucking punched me." Witness C said she looked down and saw ice all over the ground. Witness C stated she looked down and saw Patient A on the ground restrained by another patient… Witness C stated that [Hospital] staff noticed that one side of the Grievant's face was more swollen than the other side of his face. AE-2, p. 8.

Witness D: [25] The witness stated to the Investigator that she was obtaining a medication for a patient in the medication room when she heard commotion to her right. She looked across the dayroom

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[19] The Investigator worked at another large, local hospital for about two years prior to employment at the Hospital.
[20] The Hearing Officer divided the Investigative Report statements into witness and patient statements. Witnesses are defined as the Hospital's staff. Patients are those who receive treatment at the Hospital, Unit 5-C.
[21] Witness A was the Grievant's co-worker at the Hospital, Unit 5-C and was present on the incident date. Witness A did not testify at the hearing but her statement was included in the Investigative Report. (AE-2, p. 5).
[22] Witness B is an RN who works at the Hospital, Unit 5-C and was present during the incident. Witness C testified at the hearing and her statement is included in the Investigative Report. (AE-2, p. 7).
[23] Code White is a Hospital emergency signal call for assistance on the floor.
[24] Witness C is the Grievant's co-worker who worked at the Hospital, Unit 5-C on the incident date. Witness C did not testify at the hearing but her statement was included in the Investigative Report. (AE-2, p. 8).
[25] Witness D, an LPN, was the Grievant's co-worker who worked at the Hospital, 5-C when the incident occurred. She did not testify but her statement was included in the Investigative Report. (AE-2, p. 10).

and saw Patient B sitting on the floor with Patient A sitting between [Patient B's] legs in front of him. Witness D stated that Patient B had his arms around Patient A and heard Patient B say, "Why would you do that?" Witness D stated that then both Patient A and Patient B stood up. AE-2, p. 10.

Witness E:[26] The witness viewed the video footage of the incident then provided his statement to the Investigator. He opined that the Grievant's failure to properly employ a TOVA restraint was not appropriate in this incident. He related that he has been a TOVA methodology supervisor for 15 years. It was his opinion that the TOVA method the Grievant failed to employ was not safe or appropriate. Witness E did not testify at the hearing and was not present during the incident. AE-2, p. 10.

Patient A: Patient A stated that he did not have anything to say [about the incident] and he did not want to talk about it. Patient A refused to answer if a staff member did anything to him. Patient A was asked about his injury and he stated he was alright. AE-2, p.7.

Patient B: Patient B stated that Patient C and I were standing in line to get water. Patient B stated Patient A socked the Grievant in the face. Patient B stated his first reaction was to prevent further damage. Patient B stated he put Patient A in a choke hold and took him to the ground. Patient B stated a lady came out of the back and said get off him. Patient B says the Grievant may have punched Patient A or grabbed his face but Patient B does not know. Patient B stated he did not see the Grievant make contact, that it happened so fast. ... Patient B stated he didn't recall who separated him from Patient A, Patient B was choking Patient A because he was mad at Patient A. AE-2, p. 6.

Patient C: Patient C stated Patient A was violent and his roommate Patient B was trying to protect him and the staff members who got hit. Patient C stated Patient B put Patient A in a choke hold and they fell by the wall… Patient C said the Grievant was serving snacks and joking, talking about pizza and stuff. Patient C said the Grievant was stunned. AE-2, p. 7.

Patient D: Patient D stated that the Grievant was handing out snacks and giving Patient B ice water. Patient D stated that Patient A punched the Grievant in the face for no reason. Patient D stated that Patient B put his arm around Patient A's neck to defend the Grievant. Patient D stated that Patient B let go when staff told him to. Patent D stated that [Patient A and Patient B] fell to the ground and Patient A tripped and fell to the ground. Patient D stated he did not see the Grievant punch Patient A and that Patient A punched the Grievant. Patient D stated he did not see physical contact from the Grievant to Patient A. Patient D stated the grievant put his hands up to protect his face from Patient A. AE-2, p. 10.

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. [27] 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. (AE-4, p.1-20).

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,

[26] Witness E, the TOVA supervisor, assessed the incident after viewing the Hospital Video of the incident. (AE-2, p. 10).

[27] *See generally DHRM Department of Human Resource Management, Policy 1.60 Standards of Conduct.* (AE-4, p. 1-20).

Standards of Conduct, Policy No. 1.60 (the "SOC"). The SOC provide 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." [28] The SOC's stated 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." [29] 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 did not reasonably assess 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." [30] 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 not 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 but without the more serious intent element which would be to show the Grievant intended to harm Patient A by retaliating against him for hitting him in the face.

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 asserts he is entitled to mitigation. The Grievant proffers his twenty years of service as a health care worker and the fact that he was never retrained in TOVA methods to properly manage and de-escalate the dangerous situation confronting him on March 18, 2023. The Hearing Officer concurs with the Grievant's assertion that he was unprepared in TOVA to handle this emergency initiated by Patient A's sudden punch to his face. The offense charged against the Grievant, originally classified as Group III offense, for physical abuse is hereby reduced to a Group II offense for improperly restraining a patient and failing to comply with written policy or Hospital procedures. The Grievant is to be suspended, without pay, for 15 days. The Grievant will be required to receive satisfactory TOVA [31] certification at Level 3, before he is placed back on the Hospital's Unit 5-C.

DISCUSSION

The termination of this employee for the Hospital 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:

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[28] *Id.* at 2.
[29] *Id.,* at 2.
[30] *Id.,* at 8-9.
[31] Hospital staff TOVA certification at Level 3 is described at AE-3, p. 40.

"… 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 Grievant's statement that he made attempted to grab Patient A's leg, because Patient A was so much taller than he was, is believable and does not reflect an intent to harm Patient A. The Hearing Officer believes also that the Grievant was stunned after Patient A punched him in the face. The Grievant's statements do not conflict with his actions during this incident reflected in the Hospital Video, Clip 2, appended.

The Hearing Officer also considered the Grievant's isolation as a factor in this incident. Though there were enough trained staff on the Hospital's Unit 5-C on March 18, 2023, it is evident that the Grivant's co-worker DSA, Witness A, was not in the vicinity of the Grievant when the incident occurred. It does appear that the Grievant was somewhat stranded at an extremely "volatile moment" [32] on the Hospital's Unit 5-C.

Further, the evidence presented at the hearing did not substantiate the charge that the Grievant placed Patient A in a choke hold, that the Grievant lifted Patient A to his knees or that the Grievant caused Patient A to fall to the ground as he was charged. The Grievant's alternate description of his actions, that he attempted to assist Patient A to the ground, which is also an impermissible restraint method, is credible

The Hospital Director's allegation that the Grievant's intent was to cause physical or psychological harm to Patient A is not convincing. The Hospital Video, Clip 2, appended, together with the witnesses' statements, generally support the Grievant in this incident. The abuse charge has not been substantiated because the Hospital's evidence was not preponderant to support termination. But the evidence does show that the Grievant used an improper restraint method in that he grabbed Patient A's calf or calves , a Level II offense.

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 entitled to the existence of a mitigating circumstance on March 18, 2023 to reduce the Hospital's termination. The Grievant's employment and placement on the Hospital's, Unit 5-C, without proper TOVA training, is a significant factor and a mitigating circumstance. Without appropriate TOVA training, at Level 3,[33] the

[32] In Witness B's testimony, she referred to having experienced "volatile moments" on the Hospital's Unit 5-C.
[33] TOVA training and mandated certification, and yearly recertification, is required to be completed by all Hospital employees before Hospital employees are permitted to be placed in charge of forensic patients. (AE-3, pgs. 38-40).

Grievant's assertion, that he was not appropriately prepared to restrain a dangerous patient, to protect himself or to de-escalate an emergency, is persuasive. AE-3, pgs. 38-73.

DECISION

The Agency has not 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 DOES NOT UPHOLD the written notice in its entirety. The Hearing Officer reduces the Group III termination to a Group II for the Grievant's failure to follow written policy or Hospital procedures. But the Grievant's removal is too harsh a penalty and not warranted by the evidentiary record. Grievant must receive Level 3 TOVA certification before being placed back on the Hospital's Unit 5-C. The Grievant is suspended without pay for 15 days then he will be placed back on the job at the same paygrade .

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: August 1, 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 1st day of August, 2023.

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

Sarah. S. Freeman, Esq., VSB# 21354
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VIRGINIA: OFFICE OF EMPLOYMENT DISPUTE RESOLUTION

HEARING OFFICER REMAND DECISION

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

Case Number: 11980

I. PROCEDURAL HISTORY

A. Decision Dates:

Hearing Date: July 12, 2023.

Decision Issued: August 1, 2023.

EDR Remanded: September 1, 2023.

Hearing Officer Remand Decision: September 19, 2023.

B. Disciplinary Actions:

On April 7, 2023, the Grievant was issued a Group III written notice of disciplinary action with removal for a substantial violation of Departmental Instruction 201.

On May 3, 2023, the Grievant timely filed a grievance to challenge the agency's termination action and requested a termination hearing to challenge the agency's action in the Office of Employment Dispute Resolution ("EDR").

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

On July 12, 2023, a termination hearing occurred in a conference room at the Agency.

On August 2, 2023, the agency appealed the decision to EDR.

On September 1, 2023, EDR requested that the termination hearing Written Decision be remanded to the hearing officer and gave leave to the hearing officer to reopen and amend, if necessary, the earlier decision after reviewing the agency's witnesses' testimony, the grievant's witness and the grievant's testimony. The hearing officer has now made a careful review of the entire recordation of the termination hearing taken on July 12, 2023 and agrees to make appropriate changes to the prior decision dated August 1, 2023. In the prior decision, the hearing officer did not support termination, reduced the grievant's penalty to a Group 11 offense, suspended him for 15 days, awarded back pay, and provided terms for the grievant's return to his DSA job based upon the existence of mitigating circumstances.

After careful, extensive review of the evidence and hearing recordation Tapes Nos. 1-7, the hearing officer vacates the prior grievance hearing Written Decision, dated August 1, 2023, and supports

the grievant's termination. Further, as a result of the hearing officer's reexamination and review of all termination hearing witnesses' testimony, the hearing officer does not find that mitigating circumstances were warranted in the matter. The hearing officer requests that EDR accept the following Remand Decision in which the hearing evidence is substantiated and fully supported by a preponderance of the evidence. Lastly, the hearing officer sincerely apologizes to all for her misunderstanding regarding her manual notation of the termination hearing evidence, contained in her written notes, taken on July 12, 2023 and herein makes appropriate findings based on reexamination and reconsideration of the termination hearing record taken on the above date.

II. APPEARANCES

Grievant
Hospital Representative
Agency Counsel
Hospital Witnesses: Hospital Director and Investigator
Grievant's Witness: Hospital RN

III. EXHIBITS

Agency Exhibits "AE," Tabs 1-5 were admitted into evidence.

Agency Exhibit 1: Agency's Written Notice to Grievant; Grievant's Department of Resource Management ("DRHM") Written Notice of Appeal, AE1.

Agency Exhibit 2: DRHM Abuse Policy, No. 1.60. AE2, pgs. 1-20; DRHM Attachment A: Policy 1.60 Standards of Conduct, *"Examples of Offenses Grouped By Level*," AE2, pgs. 1-7.

Agency Exhibit 3: Agency Policy, Departmental Instruction No. 201 (RTS)03, AE3, pgs. 1-12.

Agency Exhibit 4: Agency Investigative Report, AE4; DBHDS Departmental Instruction (DI) 104 (TX) "*Behavioral Interaction and Management Techniques Training*" AE4, D1-7; Critical Policy 450-035 "*Emergency Use of Seclusion or Restraint*" AE4, D1-8; Witness and Patient Statements, signed and dated by the Agency Investigator, AE4, C-1.

Agency Exhibit 5: Agency Videos, Clip 1, appended AE5, Clip 1; and Agency Video, Clip 2, appended

AE5, Clip 2.

For the Grievant:

The hearing officer rejected the grievant's proffer of local newspaper articles relating to the agency but the grievant never submitted them to the hearing officer.

The grievant also attempted to show a diagram he created of Unit 5-C's floorplan but agency counsel objected to its consideration at the hearing. The diagram was never exchanged with counsel prior to the termination hearing. The hearing officer rejected the drawing on that ground. The grievant did not share the drawing with any hearing participants or with the hearing officer.

IV. ISSUES

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

2. Did the behavior constitute misconduct?
   Yes.

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

4. Were there mitigating circumstances justifying a reduction or removal of the disciplinary action?
   No. The grievant had received Therapeutic Options of Virginia ("TOVA") restraint training [1] long before being placed with agency patients on the agency's Unit 5-C. Also, the agency video, Clip 2, appended, showed the grievant lifting the patient's legs and feet over his head per the testimony of the agency Director and Investigator. The Grievant grabbed the patient's legs and feet which is an inappropriate TOVA restraint method. A DSA who was on Unit 5-C when the commotion began tried, unsuccessfully, to pull the grievant away from the patient before agency assistance arrived.

5. Did the hearing officer consider mitigating circumstances?
   Yes. The grievant's assertion that he was not properly recertified in TOVA techniques after he returned from his COVID illness had no relevance to this incident. The grievant received thorough TOVA restraint training when he was hired. The fact that the grievant had not been recertified was solely the grievant's responsibility and no fault of the agency Director or of the grievant's immediate supervisor. Further, the agency Director never testified that the agency was short-staffed on the incident date though the grievant often arbitrarily indicated that the agency had a staff shortage. Somehow, the proffered the notion that the incident occurred as a result of the agency's staff shortage because, as he incorrectly asserted, the staff to patient ratio was inadequate. The agency Director denied this statement was accurate on the date the incident occurred or on any other date. Agency witnesses, the Director and the Investigator, both repeatedly denied this allegation. Thus, this factor was irrelevant, not critical, to this termination. Finally, the agency Investigator and the Director both testified competently that all agency staff, including contract employees, all DSA's, including the grievant, and any individuals who work with the agency's patients, are properly trained in TOVA restraint methods for handling out-of-control patients during on-boarding which is the agency's pre-hiring protocol.

[1] TOVA restraint training is a specific methodology developed in Virginia for properly restraining patients who reside in state healthcare facilities in the Commonwealth of Virginia. Thus, the agency is required to use safe TOVA restraint techniques, which are taught to all employees, and are mandated for all state healthcare workers to use when combative situations develop with patients inside state healthcare facilities. *See also* AE4, D1-7.

V. BURDEN OF PROOF

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

VI. FINDINGS

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

The agency is a state operated psychiatric hospital that also contains forensic patients. Prior to the termination incident, the grievant was employed by the hospital for 3 1/2 years. The Grievant testified, however, that his COVID illness prevented him from working at the agency for about one year. When the grievant later returned to the agency, he asserted he went back to work though he was not TOVA recertified at Level III.

An incident occurred on March 18, 2023 involving the grievant who was given a Group III written notice. He was terminated for his participation in the incident on April 7, 2023 for alleged abuse of a patient ("patient A") who had arbitrarily, within moments before the incident, punched the Grievant in the face.

VII. WRITTEN NOTICE OF OFFENSE

On April 7, 2023 the Hospital Director presented the following termination notice to the Grievant:

"An allegation was reported that [the grievant] was involved in a patient altercation on March 18, 2023 which resulted in physical patient abuse. The subsequent [agency authorized investigation], through testimonial evidence and video surveillance, substantiated this allegation. [The grievant] intervened during an altercation between two patients, one of whom had allegedly previously struck the [grievant] in the face. While intervening, the [grievant] grabbed one of the patients by his ankles, lifting the patient up off the floor to shoulder height, causing the patient to fall to the floor. This is not an approved method of attempting to restrain a patient or lower a patient to the floor, and is neither safe nor appropriate nor is it reflective of any training he has received through [agency] staff development and training. [The grievant's] actions were not consistent with approved behavior intervention/management techniques to separate patients, while ensuring the safety of the patients involved. His actions were a direct violation of Departmental Instruction 201, *Reporting and Investigating Abuse and Neglect of Patients*, which in part defines abuse as "… any 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." In accordance with DHRM Policy, 1.60, Standards of Conduct, this violation warrants a Group III Written Notice with Termination. AE2, Tab 2.

In the Investigative Report, the Grievant stated to the agency's Investigator and to the City Department of Social Services (DSS) worker on March 24, 2023:

On Saturday, around 8:15 PM, the grievant stated that he was giving water to patient B and patient C from the kitchen. The grievant stated that patient B and patient C were at the entrance of the door receiving water. The grievant stated patient B was to the left of him and patient C was to his right. The grievant stated that patient A[2] came up from behind and punched him in the face, closed fist, unprovoked. The grievant stated that patient A and himself had no prior interactions. The grievant stated patient A came in between the two patients and attacked him. The grievant stated that patient A was placed on the ground by patient B and himself. The grievant stated that CPRT was called, and he reported the information to the evening supervisor. AE4.

During his testimony, the grievant stated that after he was struck, he twice told patient A to calm down, But patient A was "still kicking." [3] The grievant then admitted that he "grabbed" [4] patient A's legs and pulled patient A "to the floor." [5] Though both agency counsel and the grievant agreed to stipulate that patient A is "tall" [6] and the grievant's height is only 5'5, this factor did not prevent the grievant from admitting that he was able to grab patient A's legs and pull patient A to the floor. Agency emplyees are not permitted to grab patients legs and pull them to the floor. The grievant's action in this incident constituted abuse and was a violation of the agency's abuse policy per the Code of Virginia, Departmental Instruction No. 201.[7]

In his defense, the grievant testified at his grievance hearing on July 12, 2023 that he never received the TOVA [8] retraining which he asserted inferentially would have provided him with the required de-escalation skills to properly restrain a recalcitrant patient. But he admitted upon cross-examination that he received his initial TOVA training when he began his DSA job, but that he was not re-trained in TOVA de-escalation methods when he returned from his one year absence from the agency for COVID illness. The grievant testified that he requested, more than once, that his supervisor schedule his recertification training. He testified that his immediate supervisor told him the agency was short-staffed and that he would have to schedule his own recertification training. He testified also that he asked the agency Director about recertification and he indicated that he would take care of it but that he "never did."[9] At the hearing, however, the grievant did not request the immediate supervisor to testify and he asked no questions, on this topic, of the agency Director.

At the hearing, the agency demonstrated through the agency director and through the agency Investigator, that the Grievant attained the restraint level training necessary for the Grievant to control a

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[2] For identification purposes, and in the interest of preserving the patients' privacy, the hearing officer refers herein to the patients involved in the incident as patient A, patient B and patient C.
[3] Grievant's hearing testimony on Tape No. 6, @ 11:22 min.
[4] Id.
[5] Id.
[6] Id.
[7] *See also* AE3, pg. 1. Departmental Instruction 201 (RTS) 03, "*Reporting and Investigating Abuse and Neglect of Individuals Receiving Services in Department Facilities"* stating 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 regulation, and takes any action necessary to prevent future occurrences of abuse or neglect."
[8] The agency's TOVA training policy states as follows: "All direct care, clinical staff will receive specialized training and be verified competent in approved behavioral interaction and management techniques in accordance with [Agency] Policy 080-013 "*Behavior Interaction and Management Training*." (AE3, p.71).
[9] Grievant's hearingTestimony, Tape No. 6 @ 16.25 min.

forensic patient. Again , it was ultimately the grievant's primary responsibility to seek TOVA retraining if he knew he needed it. In the hearing officer's reconsideration of the termination hearing evidence, the grievant's defense to this termination action is not supported by the grievant's assertion that he had not obtained TOVA recertification. He knew TOVA methodology when he began the job and it was his choice, not the agency Director or his supervisor's duty, to obtain recertification in TOVA de-escalation and restraint techniques. And the fact that the grievant was not recertified to TOVA at Level III was not the proximate cause of this incident. The grievant's disregard of TOVA methods, that he clearly knew from TOVA training and experience, caused the incident resulting in abuse to patient A.

Regarding the grievant's characterization of patient A as an aggressive individual who initiated an unprovoked attack on the grievant, agency counsel and the grievant stipulated that the agency functions as a forensic hospital.[10] Because the agency is forensic, the agency is charged with managing challenging patients, who await psychiatric "restoration to competency" [11] certification. Forensic patients are sent to the agency by Virginia state courts, criminal division, because certain patients have been adjudicated incompetent in a state court. The term, restoration to competency, applies to the treatment that forensic patients must receive at the agency. Ultimately, the forensic patients must answer pending criminal charges in a Virginia state court. Until they are restored to competency and depart from the agency, these patients must be handled appropriately by all agency employees during their stay.

Patient A was a patient who awaited restoration to competency certification when this incident happened. Indeed, patient A has a prior history of aggressive behavior. But patient A was entitled to be treated with dignity and respect at the agency. Patient A did not deserve to be catapulted from the floor by his lower extremities, summarily dropped to the floor and, in essence, assaulted arbitrarily by the grievant. At the termination hearing, the grievant admitted that he took a "shortcut," in grabbing patient A's legs and feet and abruptly lowering him abruptly to the floor, to get the patient under control. [12] But he testified that the termination penalty for his bad judgment, is too harsh and that mitigating circumstances should prevail over his poor choice in taking a shortcut to restrain patient A.

The hearing officer disagrees with the grievant's thoughts regarding mitigation of the incident. In sum, after reexamining the entire recorded termination hearing, the hearing officer agrees that mitigating circumstances are not warranted. All agency employees are well-trained in TOVA techniques and they know how to deescalate and properly restrain aggressive patients without assaulting them. The agency does not permit employee restraint shortcuts, in dealing with aggressive patients, which are never permissible by the agency.

Further, the grievant testified that the other DSA, who was also working on Unit 5-C, was not in his vicinity when the incident first occurred and was unable to assist him to quickly de-escalate the incident. One of the agency Videos, Clip 1, appended, clearly shows that the other DSA [13] was performing a nightly check or "queu" [14] on another patient's bath room. The agency Director testified that

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[11] The parties stipulated that patient A was at the agency for restoration to competency treatment to answer for pending state charges.

[12] Grievant's hearing testimony, Tape No. 7, @ 14:32 min.

[13] *See also* Agency Video, Clip 1, appended. The Grievant alleged that the other DSA on the floor was six months pregnant, the inference being that he was motivated to protect her safety. No agency witness confirmed this fact. (AE5, Clip 1; AE5, Clip 2).

[14] A "queu" is a bathroom inspection. Ideally, per the Director, a queue requires that two DSA's complete the job. On the evening in question, however, the other DSA is shown on the Agency Video, Clip 1, appended, and does appear to be alone. The grievant asserted during his testimony that two DSA's were required to be together at all times. Neither the Director or the Investigator confirmed the requirement.

this nightly DSA inspection requires that two DSA's perform the task together. But the hearing officer did not hear the agency Director state that two DSA's must accompany each other at all times. Also, the hearing officer did not hear from any agency witnesses, the Investigator or by the Director, that the other DSA on 5-C that night was six months pregnant. And in the hearing officer's opinion, the fact did not matter at all in this incident.

But he Grievant introduced incessant questioning of the agency witnesses on this matter. Constantly, he asked the Director and the Investigator if they knew about the other DSA's pregnancy. But Agency employees never confirmed the other DSA's pregnancy. It is significant to note that the grievant's obligation was to safely restrain patient A not to ensure that the other DSA was safe. Patient A's safety only was paramount. Patient A could have been severely injured in this incident though it does not appear that he was. The other DSA who worked on Unit 5-C that evening did not testify at the hearing, however, she credibly provided her written statement to the agency Investigator. The other DSA stated that she heard a large commotion and ran to its source when she heard it. When she arrived, she saw the grievant attacking patient A. She attempted to pull the grievant away from the fray. Ultimately, a nurse on the floor called a Code White (emergency) and agency assistance responded.

Thus, the Hearing Officer's review of the Agency Video, Clip 1, appended, and Agency Video, Clip 2, appended, shows that the Grievant encountered an emergency situation in proximity to the other DSA, whom the Grievant alleged to be six months pregnant, but was not substantiated by the evidence. Thus, the grievant's hearing assertion, that he wanted to protect the other DSA from harm, which prompted the grievant to "to grab [Patient A's] leg," [15] is without merit and may be disregarded as irrelevant to the incident.

In response to the grievant's assertions, the agency Director testified remotely at the hearing. [16] The Director testified credibly and convincingly at the termination hearing. He testified competently that he reviewed the Investigative Report and opined that the assault charge against the grievant was substantiated. The Director testified also that the grievant saw patient A being placed into a choke hold by patient B and that instead of stabilizing patient s A and B, the Grievant then picked up patient A by the knees and caused patient A, who could have been seriously injured, to fall to the ground. The Director testified that this method of restraint substantiates the physical abuse charge against the Grievant resulting in a Group III termination. The agency Director testified that the restraint the Grievant used was inconsistent with any employee restraint training or with safe and appropriate TOVA restraint techniques. Also, he added, that the grievant's actions may have caused serious harm to patient and that the grievant's actions placed all individuals, patients, employees and any others around the fray, in serious danger.

On cross-examination, in response to the Grievant's question to the Director about how much restraint training the grievant had received. The Director never testified that he knew that the Grievant had not been TOVA recertified when the grievant was assigned to the agency's Unit 5-C. Also, the agency Director **never** stated during his testimony that the agency had encountered a "staffing shortage" [17] though the grievant often attempted to assert the agency's staffing shortage issues. Ultimately, the grievant was unable to prove that a staffing shortage existed on the incident's date. The agency Director, and the agency Investigator credibly and repeatedly denied the grievant's assertion that a staffing shortage existed at the agency on March 18, 2023. The hearing officer rules that an agency wide staffing shortage was not proven and was irrelevant to the grievant's termination charge.

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[15] Grievant's hearing testimony, Tape No. 6 @ 22:30 min.; Tape No 6, @11:22 min.

[16] During the beginning of his video testimony, Internet issues developed and the Director provided his remaining testimony by telephone to which agency counsel and the grievant assented on the record. Earlier during the hearing, the hearing officer denied the grievant's request for a hearing continuance because of the Internet issue.

[17] Director's hearing testimony, Tape No. 3 @ 4.50 min.

Further, the agency Director testified that on March 18, 2023, four agency staff members were assigned to the agency's unit, 5-C, which was an appropriate number to oversee about 25 patients. On cross-examination, the grievant asked the agency Director why, in the hospital's video of this incident, it appeared that only 3 staff members were visibly on the floor. The Director testified that one of the agency's assigned employees must have been temporarily off the floor. The hearing officer does not deem that the number of agency employees present that evening on Unit 5-C was deficient, as the grievant laboriously alleged during his testimony and cross-examination of the Director. The two agency videos, showing the incident in question, prove that there were at least four workers, including the grievant, on the agency's Unit 5-C that evening.

Regarding the specific incident involving the grievant on the evening of March 18, 2023, the agency Director testified that the abuse charge was substantiated because he reviewed the Investigative Report and saw the agency videos. In the Investigative Report, one witness [18] stated in the Investigative Report that the Grievant "picked [patient A] up by his knees". [19] Though the witness was not present initially when the incident occurred, in her written statement she asserted that she attempted to pull the grievant away from patient A. She later viewed the agency video and confirmed what she saw on it. Though this witness did not testify, her credible written statement regarding the incident is contained in the agency's Investigative Report. This witness was a DSA who was conducting bathroom inspections that evening. She arrived quickly as the incident unfolded after she heard commotion on the floor.

The hearing officer extensively reviewed the agency Video, Clip 2, appended, to independently reach factual conclusions underlying the incident. The Hearing Officer is mindful that the Grievant's livelihood, and his reputation as a twenty-year health care worker, are at stake. Therefore, it was essential for the fact-finder to re-examine the hearing recordation to correctly understand the facts underlying this incident. But the hearing officer's record reexamination fully supports the termination for abuse, a Group III offense.

VIII. AGENCY INCIDENT VIDEOS

The agency presented two videos of the incident: Agency Video, Clip 1, appended, specifically shows the agency environment and the whereabouts of the other DSA and the grievant leading up to the incident. In Agency Video, Clip 2, appended, the video shows the grievant's actions more clearly but the actual incident is somewhat obliterated by spectators. Thus, the hearing officer reconsidered the incident videos in conjunction with the extensive Investigative Report, its accompanying witness statements, and the first-hand accounts describing the grievant's actions leading to the abuse charge against him. [20] When the hearing officer reconsidered the totality of the evidence, instead of focusing on the viewing inadequacies apparent in Agency Video, Clip 2, appended, the hearing officer reconsidered her perspective on this entire matter. In so doing, the hearing officer found that the facts supported the agency Director, and the agency Investigator's version of the events. AE5, Clip 1 appended; AE5, Clip 2, appended.

In sum, the hearing officer found that the Agency video, Clip 2, appended, showed patient B placed patient A in a choke hold.[21] Instead of properly intervening to deescalate and apply TOVA

[18] The other DSA who worked on Unit 5-C on March 18, 2023.
[19] The other DSA made this statement after she viewed Agency Video, Clip 2, appended.
[20] The two agency videos are referred to in the decision as Agency Video, Clip 1, appended and Agency Video, Clip 2, appended. The two videos were converted from the agency's DVD tape showing the events occurring on the Agency's Unit 5-C on March 18, 2023. AE5, Clip 1, appended; AE5, Clip 2, appended.
[21] Agency Video, Clip 2, appended @ .17 min.

restraint methods to safely separate patient A from the chokehold, the grievant held patient A's wrists while patient A remained caught in the chokehold. [22] A struggle occurred between patient A, patient B. and the grievant. The grievant responded by grabbing patient A's leg or legs. Patient A's legs appeared to rise upward. [23] Though the hearing officer could not see patient A being dropped to the floor, the agency Investigative Report, and the Investigator's testimony, confirmed that patient A was dropped to the floor after the grievant grabbed his legs, first by his ankles then by his legs. This activity by the grievant constitutes abuse. The agency does not tolerate patient abuse.

The grievant's response to the above actions was that, "I was just trying to break up a fight… I had a job to do… My actions were not improper…. I was just doing my job." [24] The hearing officer opines that breaking up fights between patients likely happens often at the agency which is why a DSA is specifically trained to deescalate, not escalate, and to apply TOVA restraint techniques which are safe. If patient A had continued to be placed in a chokehold, he could have suffocated. And when patient A was dropped to the floor, he could have broken his hip or leg. Clearly, the grievant did not safely intervene as the Director testified.

IX. **INVESTIGATIVE REPORT**

The Hospital employs an experienced Investigator who testified at the hearing. [25] She has been employed by the agency for 3 years and 7 months. The Investigator took the following statements from witnesses who were present on March 18, 2023 at the agency, Unit 5-C at about 8:45 PM or who rendered a professional opinion after viewing the agency's incident videos. When the Investigator interviewed the witnesses, she was accompanied by a City DSS worker. The Investigative Report is regularly made and entitled to great weight in this matter.[26] The Investigator credibly deemed the abuse accusation to have been substantiated by her viewing of the two incident videos and by certain witness statements, supporting her findings, that the abuse incident occurred as the grievant's termination charging documents stated.

The Investigator primarily supported her findings by three pivotal statements made in her Investigative Report. First, the other DSA who worked the floor that night with the grievant and witnessed (on the agency video) that the grievant's method for lowering the patient to the floor was not in any way associated with TOVA methods. The RN, who also testified on behalf of the grievant, reiterated that at the agency we do not grab a patient's feet and bring them to the floor. The RN also deemed that an assault had occurred when she came upon the three men outside of the kitchen. Finally, the 15 year agency TOVA instructor did not testify at the termination hearing. But the TOVA Instructor related in his statement to the Investigator after he watched the two agency videos and confirmed that the grievant had not utilized TOVA restraint methods in this incident.

Regarding the grievant's defenses to the above, the grievant had called the above RN to testify at the termination hearing. She stated that it is sometimes difficult to restrain unruly patients and that the agency's Unit 5-C does have its volatile moments but is generally safe. The RN testified also that patient A has been known to have incidents of aggression. She also testified that she did see blood on patient A's finger at the time of the incident. AE4, p.7.

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[22] *Id*. @ .20.
[23] *Id*. @ .23.
[24] Grievant's hearing testimony, Tape No. 6, @ 18:45 min.
[25] The Investigator testified that she had worked at another large, local hospital for about two years prior to her agency employment.
[26] *See also* AE4.

In the Investigative Report, the other DSA stated that she did not see the grievant physically intervene but that when she viewed the agency video, it seemed to her that the grievant picked up patient's A's feet before dropping him to the floor. She stated, "The part where [the grievant] picked up [patient A's] feet is not a TOVA method used to lower a patient to the floor. Typically, she stated, a Code White is called for a peer to peer altercation on a case by case basis."[27]

In the Investigative Report, the RN who was working on the agency's unit 5-C that night, had stated that she heard a commotion in the milieu and when she looked up, she saw patient B holding patient A and the Grievant standing over them both. The RN stated to the investigator that a Code White was then called. The RN stated that she went over and was told by patient B that patient A had attacked the Grievant. The RN stated that she helped patient A to his feet and encouraged the grievant to leave the scene. The RN stated that patient A was still visibly agitated with his fists balled and had an angry [effect] on his face. The RN stated that she walked patient A to the medication window and cleaned his finger due to blood. Patient A was then placed in open seclusion for the remainder of the night. AE4, p. 7.

The agency TOVA instructor, who did not testify but who was clearly qualified to render his opinion about the incident video footage also provided his statement to the Investigator. He opined that the grievant's failure to properly employ a TOVA restraint was not appropriate in this incident. He related that he has been a TOVA methodology supervisor for 15 years. It was his opinion that the TOVA method the grievant employed was not safe or appropriate. AE4, p. 10.

X. 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 provide 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).[29]

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." [30] The SOC's stated 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.

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[27] Investigative Report, witness handwritten statement, AE4, pg. 2.
[28] *See also generally DHRM Department of Human Resource Management, Policy 1.60 Standards of Conduct.* AE2, p. 1-20.
[29] *Id*.
[30] *Id.* at 2.

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." [31] 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." [32] 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 with serious intent element to harm patient A.

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 asserts he is entitled to mitigation. The Grievant proffers his twenty years of service as a health care worker and the fact that he was never retrained in TOVA methods to properly manage and de-escalate the dangerous situation confronting him on March 18, 2023. The Hearing Officer concurs with the agency's assertion that the grievant was sufficiently knowledgeable in TOVA methodology to handle this emergency initiated by patient A's sudden punch to his face. The patient, not a female employee, the grievant, or any others present, supersede the grievant's nebulous assertions that he wanted to break up a fight, clear the area, make the area safe or that he attempted to control the patient in his own misguided way. The patient's safety only, aggressive or not, must be the grievant's primary concern. Other matters are simply irrelevant in this matter and by the grievant's own admission, he grabbed patient A's legs and brought him to the ground. Thus, the agency evidence substantiates the physical abuse charge. The offense charged against the grievant, originally classified as Group III offense, for physical abuse is hereby **upheld** for the grievant's improper restraint of a patient and failing to comply with agency written policy or DRHM procedures. The grievant is to be terminated and the written remand decision is complete.

XI. **DISCUSSION**

The termination of this employee for the termination 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: AE3, 1-12.

"… 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."

[31] *Id.,* at 2.
[32] *Id.,* at 8-9.

Clearly, the grievant did not employ TOVA restraint techniques, call a Code White for assistance or deescalate the situation, and had to be coaxed by other employees to remove himself bodily from patient A. In consideration of all the credible agency evidence that was presented by the Director, the Investigator and even the grievant's witness, the grievant's actions appeared to be reactionary and resulted in physical abuse. The grievant's actions departed dramatically from the agency's acceptable restraint methods for which he must be held accountable. All of these actions described hereinabove were intentional, reckless and wholly inappropriate in violation of Departmental Instruction No 201 and resulted in patient physical abuse under the agency's policy.

XII. 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 does not find that the grievant was entitled to the existence of a mitigating circumstance on March 18, 2023.

XIII. DECISION

The Agency 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.

XIV. 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 remand 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 -

Entered: September 19, 2023

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

CERTIFICATE

I certify that I have emailed/mailed the above Remand Decision to all parties on this 19th day of September, 2023.

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

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