Issue: Group III Written Notice with Termination (client neglect); Hearing Date: 03/28/19; Decision Issued: 04/17/19; Agency: DBHDS; AHO: Carl Wilson Schmidt, Esq.; Case No. 11319; Outcome: Full Relief; **Administrative Review Ruling Request received 05/02/19; EDR Ruling No. 2019-4924 issued 06/07/19; Outcome: AHO's decision affirmed; Attorney's Fee Addendum issued 06/27/19 awarding $2,934.40.**

COMMONWEALTH of VIRGINIA

Department of Human Resource Management

OFFICE OF EMPLOYMENT DISPUTE RESOLUTION

DECISION OF HEARING OFFICER

In re:

Case Number: 11319

Hearing Date: March 28, 2019
Decision Issued: April 17, 2019

PROCEDURAL HISTORY

On January 16, 2019, Grievant was issued a Group III Written Notice of disciplinary action with removal for neglect.

On January 31, 2019, Grievant timely filed a grievance to challenge the Agency's action. The matter advanced to hearing. On February 11, 2019, the Office of Employment Dispute Resolution assigned this appeal to the Hearing Officer. On March 28, 2019, a hearing was held at the Agency's office.

APPEARANCES

Grievant
Grievant's Counsel
Agency's Representative
Witnesses

ISSUES

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

2. Whether the behavior constituted misconduct?

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

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

BURDEN OF PROOF

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

FINDINGS OF FACT

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

The Department of Behavioral Health and Developmental Services employed Grievant as a Security Officer III at one of its facilities. He had been employed by the Agency for approximately nine years. No evidence of prior active disciplinary action was introduced during the hearing.

The 40 year old Patient was subject to a temporary detention order requiring his placement at the Facility. He was blind and suicidal. The Patient did not understand why he was at the Facility.

The Patient was brought into the Building through the Vestibule and into the Lobby. The Vestibule had a standing metal detector with a durable-styled carpeted floor. The Vestibule had one door that opened to the outside and one door that opened into the Lobby. Both doors automatically locked when they closed and could not be opened without swiping a fab against the lock. The temperature in the Vestibule was a few degrees colder than the temperature in the Lobby, but was not freezing or intolerable. The Lobby had a chair and a couch. On the side opposite the Vestibule door was a door opening into an administrative office.

The door between the Vestibule and the Lobby had a nearly full length window. Three windows were placed vertically to the left of the Vestibule door. The administrative office had a window allowing someone inside the administrative office to see into the Lobby and through the Vestibule door into the Vestibule. The door from the Lobby into the administrative office had a window in the top half of the door. At the opposite end of the door to the Lobby, the administrative office had a door opening into a hallway.

Once the Patient was in the Lobby as part of the admission process, he was to be taken out of the Building and driven to a Second Building where he would reside. The Security Officer and DSA spoke with the Patient in the Lobby. They tried to persuade him to stand up and walk with them outside to a vehicle. The Security Officer picked up the Patient's cane and offered it to the Patient. The Patient did not take the cane and the Security Officer placed it in one of his shoes. At 9:28 p.m., the DSA picked up the shoes and cane and took them through the Vestibule and outside. The Security Officer remained with the Patient. The DSA returned to the Lobby.

At 9:29 p.m., the DSA grabbed the Patient under his right arm and the Security Officer grabbed the Patient under his left arm. They lifted him out of the chair and he folded his legs to avoid standing up. The two women were not able to hold him up so the Patient fell to his knees on the floor. They dragged him several feet through the doorway and into the Vestibule. They placed him on his side. The Security Officer went out the door to the outside and the DSA walked through the door into the Lobby. The DSA left the Lobby at 9:30 p.m.

At 9:31 p.m., the Security Officer entered the Lobby and used her radio. The Security Officer informed Grievant that she needed assistance with a patient who was refusing transport to the Second Building. At 9:36 p.m., Grievant entered the Vestibule and noticed the Patient laying on the floor. The Security Officer was also in the Vestibule. Grievant asked the Security Officer why the Patient was laying on the floor and was advised the Patient refused to move. Grievant introduced himself to the Patient and asked the Patient if he was hurt or injured. The Patient said "no." Grievant advised the Patient that the Security Officer could assist him in getting off of the floor. The Patient refused to move. Grievant then went into the Lobby. The Security Officer followed him. Grievant unlocked the door into the administrative office. He listened to the Security Officer express her displeasure with the behavior of the DSA who the Security Officer felt abandoned her and failed to perform several job duties. At 9:37 p.m., Grievant entered the administrative office and the Security Officer followed him. Grievant called the Administrative Duty Officer (AOD) using the office telephone for assistance because Grievant believed the Patient could not be transported to the Second Building without a DSA present and the DSA had left the area. The AOD said she would "get another person down there" to help. At 9:38 p.m., Grievant exited the administrative offices and walked through the Lobby and opened the door to enter the Vestibule. Grievant spoke with the Patient who was now seated on the Vestibule floor with his back against a wall. At 9:42 p.m., the Security Officer exited the administrative offices and walked to the Vestibule door to speak with Grievant as he continued to hold

the Vestibule door open to speak with the Patient. At 9:42 p.m., Grievant walked to the administrative office's door and entered the administrative offices while the Security Officer continued speaking with the Patient. At 9:43 p.m., the Security Officer exited the Vestibule to the outside. Grievant was not present when the Security Officer exited the Vestibule. Approximately 41 seconds later, the Security Officer returned to the Vestibule. It is likely she returned with the Patient's cane and shoes. At 9:45 p.m., the Security Officer opened the door from the Vestibule to the Lobby and escorted the Patient from the Vestibule into the Lobby. At 9:46 p.m., the Patient sat in the chair in the Lobby with the help of the Security Officer. The Patient was wearing his shoes and holding his cane. At 9:46 p.m., a male DSA employee entered the Lobby to join the Security Officer. At 9:47 p.m., Grievant exited the administrative office's door to enter the Lobby. At 9:48 p.m., the Security Officer, a male employee, and Grievant escorted the Patient from the Lobby through the Vestibule to the outside of the Building.

CONCLUSIONS OF POLICY

The Agency alleged that Grievant engaged in client neglect, violated Policy 450-067 governing Safe Patient Handling, Lifting and Moving, Policy 450-035 Emergency Use of Seclusion or Restraints and Human Rights Regulations 12 VAC 35-115-50 Dignity. The Agency has not presented sufficient evidence to support its disciplinary action. The disciplinary action must be reversed with Grievant reinstated.

Departmental Instruction ("DI") 201 defines Neglect as:

> The failure by an individual, program, or facility operated, licensed, or funded by the department responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of a person receiving care or treatment for mental illness, mental retardation, or substance abuse.

Grievant did not fail to provide care or services to the Patient for his health, safety, and welfare. Grievant was at all times focused on providing assistance to the Patient to help the Patient move to the Second Building.

Grievant was not responsible for the actions of the Security Officer or the DSA. The Agency alleged that the Security Officer and DSA were neglectful regarding their treatment of the Patient. Grievant was not responsible for how the Patient was moved from the chair in the Lobby to the Vestibule floor.

The Agency argued that Grievant should have provided the Patient with his cane and shoes. The evidence showed that Grievant told the Patient he did not know where the items were but would try to get them for the Patient.

The Agency argued that Grievant should have provided the Patient with a blanket because the Vestibule was cold. The temperature in the Vestibule was lower than in

the Lobby, but there is no reason to believe that the temperature was so low as to adversely affect the Patient's health. Providing the Patient with a blanket would be a matter of convenience, not a matter of medical treatment. Grievant would have had to leave the area to obtain a blanket.

The Agency argued Grievant should have picked up the Patient from the floor and placed him in a wheelchair. Grievant was not present when the Patient was placed on the Vestibule floor. Grievant did not know why the Patient was on the Vestibule floor or if the Patient had been injured being placed on the floor. Grievant was not a medical professional. He was not authorized to assess the Patient's medical condition and determine that the Patient could be moved safely from the floor to a wheelchair. It appears from the video that the Patient did not wish to be moved. He refused numerous requests from staff to move to other locations. If Grievant had simply picked up the Patient and placed him in a wheelchair, Grievant may have been acting contrary to the Patient's wishes. On January 9, 2019, Grievant explained his actions:

> The Patient stated that he was not going to get up until the nurse returned his cane and shoes for his feet. We did not attempt to put our hands on the patient and put him in a chair because he was not being combative. Also, upon my arrival I did not know the circumstances as to how this patient got on the floor. I did not want to move or touch him due to the fact that I am not direct care staff and I do not have medical training other than basic CPR. By moving him I could have caused bodily harm to this patient. We did not have a physician's order to put out hands directly on the patient as well.

Grievant's explanation is consistent with the appropriate care to render to the Patient.

The Agency argued that Grievant should have taken charge of the situation and added more staff. The evidence showed that Grievant and the Security Officer were the only security staff available that night and that Grievant entered the administrative offices to call the AOD to obtain more staff. Grievant's actions were appropriate.

The Agency asserted that Grievant could have called a Code over the radio which would have resulted in all male staff responding to the area. The evidence showed that such codes typically were called when patients were combative and posed a danger to others. The Patient did not pose a danger to anyone and he repeatedly expressed his desire to remain on the floor of the Vestibule. Grievant did not err by failing to call a code for assistance.

Policy 450-067 governs Safe Patient Handling, Lifting and Moving. This policy states the Agency is committed to, "minimizing the need for staff to physically lift patients." Item 9 of the Procedures requires:

> If a patient falls or is found on the floor, NEVER lift or move the patient until a Licensed Independent Practitioner (physician or nurse practitioner)

> or RN has assessed the patient, unless he/she must be moved immediately for the patient's physical safety or to initiate emergency medical care.

The Agency alleged Grievant failed to remove promptly the Patient from the Vestibule floor. The Agency alleged Grievant should have put the Patient into a wheelchair.

Grievant complied with Policy 450-067. The Patient did not need to be moved due to his safety or for emergency medical care. The Patient was not in jeopardy of injury by remaining in the Vestibule. Only Grievant, the DSA, and the Security Officer entered the Vestibule while the Patient was inside. If Grievant had moved the Patient against the Patient's will as the Agency claimed was Grievant's obligation, Grievant would have acted contrary to Policy 450-067.

Policy 450-035 governs Emergency Use of Seclusion or Restraint. Seclusion is defined as, "The involuntary placement of a patient alone in an area secured by a door that is locked …." Under this policy, "Patients in restraints/seclusion will never be left unmonitored in any room."

Although the Patient was in a room secured by two doors that were locked, the room was not intended to be used for seclusions; it was intended to be used for passage from outside the Building to inside the Lobby.

There was no evidence presented showing the Patient was aware he was in between two secured doors and that he wanted to exit either of those doors. The Patient did not attempt to get up or to leave the Vestibule. Indeed, it appears the Patient only wanted to leave the Vestibule after being persuaded to do so by Grievant.

Grievant did not place the Patient in seclusion. Once the Patient was in seclusion, Grievant attempted to remove the Patient from seclusion by persuading the Patient that he should get from the floor and move to another location. Grievant was not authorized to place his hands on the Patient and involuntarily move the Patient against the Patient's will. There is no reason to believe Grievant left the Patient unmonitored at any time. When Grievant was inside the administrative offices, his actions were not visible to the camera in the Lobby. There was a window allowing viewing from the administrative office to the Vestibule and there was a window in the door to the administrative offices. Grievant claimed either he or the Security Officer were watching the Patient while they were in the administrative offices. There is no evidence to contradict this assertion.

Grievant did not act contrary to Policy 450-035.

12 VAC 35-115-50 governs Dignity. Section A provides:

> Each individual has a right to exercise his legal, civil, and human rights, including constitutional rights, statutory rights, and the rights contained in this chapter, except as specifically limited in this chapter or otherwise by law. Each individual has a right to have services that he receives respond to his needs and preferences and be person-centered. Each individual also has the right to be protected, respected, and supported in exercising these rights. Providers shall not partially or totally take away or limit these rights solely because an individual has a mental health or substance use disorder or an intellectual disability and is receiving services for these conditions or has any physical or sensory condition that may pose a barrier to communication or mobility.

The Patient's preference was to remain on the floor in the Vestibule. If Grievant had forcefully removed the Patient from the floor, Grievant would have acted contrary to this regulation by ignoring the Patient's preference. Grievant did not deny dignity to the Patient.

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

DECISION

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

APPEAL RIGHTS

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

Please address your request to:

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

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

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

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

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

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

/s/ Carl Wilson Schmidt

Carl Wilson Schmidt, Esq.
Hearing Officer

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

COMMONWEALTH of VIRGINIA

Department of Human Resource Management

OFFICE OF EMPLOYMENT DISPUTE RESOLUTION

ADDENDUM TO DECISION OF HEARING OFFICER

In re:

Case No: 11319-A

Addendum Issued: June 27, 2019

DISCUSSION

The grievance statute provides that for those issues qualified for a hearing, the Hearing Officer may order relief including reasonable attorneys' fees in grievances challenging discharge if the Hearing Officer finds that the employee "substantially prevailed" on the merits of the grievance, unless special circumstances would make an award unjust.[1] For an employee to "substantially prevail" in a discharge grievance, the Hearing Officer's decision must contain an order that the agency reinstate the employee to his or her former (or an objectively similar) position.[2]

To determine whether attorney's fees are reasonable, the Hearing Officer considers the time and effort expended by the attorney, the nature of the services rendered, the complexity of the services, the value of the services to the client, the results obtained, whether the fees incurred were consistent with those generally charged for similar services, and whether the services were necessary and appropriate.

Grievant's attorney devoted 22.40 hours to representing Grievant. EDR allows attorney's fees at the rate of $131 per hour unless the attorney is in the Northern Virginia area. Thus, Grievant is awarded attorney's fees of $2,934.40.

The petition also included paralegal fees. The statute provides for the award of attorneys' fees, not paralegal fees. Accordingly, the Hearing Officer has no authority to award paralegal fees.

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[1] Va. Code § 2.2-3005.1(A).

[2] § 7.2(e) Department of Human Resource Management, *Grievance Procedure Manual*, effective August July 1, 2017. § VI(E) EEDR *Rules for Conducting Grievance Hearings*, effective July 1, 2017.

AWARD

Grievant is awarded attorney's fees in the amount of $2,934.40. The request for paralegal fees is denied.

APPEAL RIGHTS

If neither party petitions the EDR Director for a ruling on the propriety of the fees addendum within 10 calendar days of its issuance, the hearing decision and its fees addendum may be appealed to the Circuit Court as a final hearing decision. Once the EDR Director issues a ruling on the propriety of the fees addendum, and if ordered by DHRM, the hearing officer has issued a revised fees addendum, the original hearing decision becomes "final" as described in §VII(B) of the *Rules* and may be appealed to the Circuit Court in accordance with §VII(C) of the *Rules* and §7.3(a) of the *Grievance Procedure Manual*. The fees addendum shall be considered part of the final decision. Final hearing decisions are not enforceable until the conclusion of any judicial appeals.

/s/ Carl Wilson Schmidt

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Carl Wilson Schmidt, Esq.
Hearing Officer