Issue: Group III Written Notice with termination (failure to prevent patient abuse); Hearing Date: November 14, 2001; Decision Date: November 16, 2001; Agency: Department of Mental Health, Mental Retardation and Substance Abuse Services; AHO: David J. Latham, Esquire; Case Number: 5321

COMMONWEALTH of VIRGINIA

Department of Employment Dispute Resolution

DIVISION OF HEARINGS

DECISION OF HEARING OFFICER

In re:

Case No: 5321

Hearing Date: November 14, 2001
Decision Issued: November 16, 2001

APPEARANCES

Grievant
Three witnesses for Grievant
Representative for Agency
Legal Representative for Agency
Three witnesses for Agency

ISSUES

Did the grievant's actions on April 15, 2001 warrant disciplinary action under the Commonwealth of Virginia Standards of Conduct? If so, what was the appropriate level of disciplinary action for the conduct at issue?

FINDINGS OF FACT

The grievant filed a timely appeal from a Group III Written Notice issued on August 27, 2001 because he had failed to prevent abuse of a patient. The grievant was discharged from employment as part of the disciplinary action. Following failure to resolve the grievance at the third resolution step, the agency head qualified the grievance for a hearing.

The Department of Mental Health, Mental Retardation and Substance Abuse Services (MHMRSAS) (Hereinafter referred to as "agency") has employed the grievant for 13 years. He is a direct service associate (DSA) and normally works from 7:00 a.m. to 3:30 p.m. He did not have any active disciplinary action at the time this incident occurred. The patients at this facility are mentally retarded, physically handicapped, mentally ill or some combination of these conditions.

Section 201-1 of MHMRSAS Departmental Instruction 201 on Reporting and Investigation Abuse and Neglect of Clients states, in pertinent part: "The Department has zero tolerance for acts of abuse or neglect." Section 201-3 defines client neglect:

> Neglect means failure by an individual, program or facility responsible for providing services to provide 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.[1]

The facility at which grievant was employed has promulgated its own policy statement on Abuse of Patients; the definition of neglect contained therein is essentially the same as that contained in Departmental Instruction 201.[2]

Grievant has received annual training on patient rights on November 10, 1992, August 10, 1993, August 9, 1994, November 2, 1994, August 13 & 14, 1996, September 2, 1997, October 8, 1998, February 2, 2000, March 2, 2001, and Mandt System® training[3] on May 14, 1993, October 25, 1993, January 24, 1996, July 16, 1998, May 11, 1999, June 22, 2000.[4]

On April 15, 2001, grievant and two coworkers (all DSAs) were assigned to work with 16 clients in the admission ward. Five clients were specifically

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[1] Exhibit 4. Departmental Instruction 201(RTS)00, Reporting and Investigating Abuse and Neglect of Clients, revised April 17, 2000.

[2] Exhibit 2. General Administrative *Policy Statement Number 050-57*, October 1, 2000.

[3] The main goal of The Mandt System® is to teach one how to effectively manage a potentially negative or even dangerous situation by calming one's own emotional response and managing one's own behavior so you can interact with other people positively. See page 7, The Mandt System® *Student Manual*, revised May 31, 1998.

[4] Exhibit 6. Grievant's Individual Training Record.

assigned to grievant even though all three staff members have overall responsibility for the entire group of clients. One of the clients assigned to grievant – client K – has dementia, and will not voluntarily bathe, even after defecating on himself. He was also an especially intrusive client and frequently annoyed both staff and other clients by coming close and attempting to converse with them. Because of his offensive odor, others did not want to be near him. Staff members are not permitted to force a client to bathe unless a physician has written an order.

The clients had returned from dinner at about 5:30 p.m. and several were in the dayroom while some were in their own rooms. Between 5:45 and 6:00 p.m., client K was in the dayroom annoying the clients and staff. Another client – client B – was a self-appointed leader of the other clients in this ward. He frequently tried to assist the staff in their responsibilities. Client B came into the dayroom and noticed client K annoying staff. He told the staff that he would pick up client K and carry him back to his room.[5] One of the DSAs said, "And we wouldn't see anything." Client B picked up client K and carried him down the hall toward the bedrooms; the DSAs present in the dayroom observed this but did not intervene.

Within a few minutes, those in the dayroom heard sounds of a small scuffle. Client B returned to the dayroom stating that client K had attempted to hit him. Client K then entered the dayroom and appeared to have a red mark near his right eye. Client K continued to annoy staff and be restless. The licensed practical nurse (LPN) assigned to the ward was called and gave him Ativan at about 6:05 p.m. After the medication became effective, client K fell asleep in a chair in the dayroom.

Client K did not testify at the hearing; during the investigation of this event, his recollection of the event was confused. Client B signed a typewritten statement during the investigation acknowledging that he had picked up client K and thrown him in his bed. The other male DSA on duty did not remember this event.[6] The female DSA did not recall any interaction between the two clients. She had observed a red mark near client K's eye but believes that it occurred prior to the 3:00-11:00 p.m. shift. The registered nurse (RN) on duty for this ward did not see, and was not aware of, any problem between clients K and B. She did not see any marks on client K.

The agency's case is based, in large part, on the hearsay testimony of a client – client M - who was at the facility for only six days (April 11-16, 2001). He did not testify at the hearing. The agency's investigator considered client M to be

[5] Client K is a small, slight person. Client B is a tall, large person who could easily pick up and carry client K.

[6] After this DSA was accused of neglect in this case, he stopped coming to work and would not answer his home telephone. When it became apparent that he had abandoned his job, the agency discharged him.

credible, accurate and detailed. He voluntarily admitted himself to the facility for depression. On his first day of admission, another client punched him in the face. On April 16th client M decided to leave the facility, after witnessing client B hit client K in the cafeteria. He reported these incidents to his counselor at the local Community Services Board. That counselor called the agency, which then initiated an investigation into the April 16th incident. During the investigator's interview with client M, he mentioned the April 15th incident and the investigator initiated a separate investigation track that culminated in the grievant's discharge.

APPLICABLE LAW AND OPINION

The General Assembly enacted the Virginia Personnel Act, Va. Code § 2.1-110 et seq., establishing the procedures and policies applicable to employment within the Commonwealth. This comprehensive legislation includes procedures for hiring, promoting, compensating, discharging and training state employees. It also provides for a grievance procedure. The Act balances the need for orderly administration of state employment and personnel practices with the preservation of the employee's ability to protect his rights and to pursue legitimate grievances. These dual goals reflect a valid governmental interest in and responsibility to its employees and workplace. Murray v. Stokes, 237 Va. 653, 656 (1989).

Code § 2.1-116.05(A) sets forth the Commonwealth's grievance procedure and provides, in pertinent part:

> It shall be the policy of the Commonwealth, as an employer, to encourage the resolution of employee problems and complaints . . . To the extent that such concerns cannot be resolved informally, the grievance procedure shall afford an immediate and fair method for the resolution of employment disputes which may arise between state agencies and those employees who have access to the procedure under § 2.1-116.09.

In disciplinary actions, the agency must show by a preponderance of evidence that the disciplinary action was warranted and appropriate under the circumstances.[7]

To establish procedures on Standards of Conduct and Performance for employees of the Commonwealth of Virginia and pursuant to §§ 2.1-114.5 of the Code of Virginia, the Department of Personnel and Training[8] promulgated Standards of Conduct Policy No. 1.60 effective September 16, 1993. The Standards of Conduct provide a set of rules governing the professional and personal conduct and acceptable standards for work performance of employees.

[7] § 5.8 Department of Employment Dispute Resolution *Grievance Procedure Manual*
[8] Now known as the Department of Human Resource Management (DHRM).

The Standards serve to establish a fair and objective process for correcting or treating unacceptable conduct or work performance, to distinguish between less serious and more serious actions of misconduct and to provide appropriate corrective action. Section V.B.3 of the Commonwealth of Virginia's *Department of Personnel and Training Manual* Standards of Conduct Policy No. 1.60 provides that Group III offenses include acts and behavior of such a serious nature that a first occurrence normally should warrant removal from employment. The agency's policy on patient abuse provides that neglect will be cause for the issuance of a Group III Written Notice.[9]

The preponderance of evidence establishes that at about 5:45 p.m., client B picked up client K, carried him from the dayroom, took him to his bedroom where a scuffle ensued and B hit K causing a red mark near his right eye. Clients are not permitted to physically manhandle each other. The definition of neglect is sufficiently broad to include a situation where a staff member knowingly permits one client to manhandle another and fails to intervene. There were no witnesses to what occurred in the bedroom. However, client M saw client B physically pick up client K, and tell staff he would take him to his room. Thus, the investigator correctly concluded that client B manhandled client K.

However, the issue in this case is whether the grievant witnessed this incident. Grievant testified that he did not witness the incident because he had taken trays back to the cafeteria and was not in the dayroom. The agency has not presented any witnesses to contradict this statement. Of the four other staff assigned to this ward, neither the RN nor the LPN were in the dayroom and were totally unaware that any incident had occurred. The other male DSA denied any knowledge of the incident and the female DSA was not in the dayroom. The sole witness placing grievant in the dayroom is client M. According to his hearsay testimony, grievant and two other male staff were present when client B picked up client K.

The agency determined that grievant was present based on the fact that client M identified grievant from a photo line-up. Client M selected the two male DSAs assigned to his ward for the evening shift. However, the fact that grievant was on duty in the ward for eight hours does not prove that he was in the dayroom when the incident occurred. Grievant initialed the patient monitor sheet at 5:45 p.m. but the initials at 6:00 p.m. and 6:15 p.m. are those of the female DSA. Thus, this document does not prove whether grievant was present in the area after 5:45 p.m. Therefore, it is concluded that the photo identification is not persuasive evidence of grievant's presence at the moment when client B picked up client K and carried him down the hall.

It is likely that the other male DSA did witness the incident. While his abandonment of employment is not conclusive proof of his culpability, it suggests that, more likely than not, he did acquiesce in client B's actions. However, the

[9] Exhibit 2. *Ibid*. Item 10.

grievant's sworn denial of knowledge must be given more evidentiary weight than the hearsay statement of a client who was not available for cross-examination. Accordingly, the agency has not borne the burden of proof to demonstrate, by a preponderance of evidence, that grievant knowingly neglected a client.

DECISION

The disciplinary action of the agency is reversed.

The Group III Written Notice issued to the grievant on August 27, 2001, and his discharge effective August 27, 2001 are REVERSED. The grievant is reinstated to his position with full back pay, benefits and seniority.

APPEAL RIGHTS

As Sections 7.1 through 7.3 of the Grievance Procedure Manual set forth in more detail, this hearing decision is subject to administrative and judicial review. Once the administrative review phase has concluded, the hearing decision becomes final and is subject to judicial review.

Administrative Review – This decision is subject to three types of administrative review, depending upon the nature of the alleged defect of the decision:

1. **A request to reconsider a decision or reopen a hearing** is made to the hearing officer. This request must state the basis for such request; generally, newly discovered evidence or evidence of incorrect legal conclusions is the basis for such a request.
2. **A challenge that the hearing decision is inconsistent with state or agency policy** is made to the Director of the Department of Human Resources Management. This request must cite to a particular mandate in state or agency policy. The Director's authority is limited to ordering the hearing officer to revise the decision to conform it to written policy.
3. **A challenge that the hearing decision does not comply with grievance procedure** is made to the Director of EDR. This request must state the specific requirement of the grievance procedure with which the decision is not in compliance. The Director's authority is limited to ordering the hearing officer to revise the decision so that it complies with the grievance procedure.

A party may make more than one type of request for review. All requests for review must be made in writing, and received by the administrative reviewer, within **10 calendar** days of the **date of the original hearing decision.** (Note: the 10-day period, in which the appeal must occur, begins with the date of **issuance** of the decision, **not receipt** of the decision. However, the date the decision is rendered does not count as one of the 10 days; the day following the

issuance of the decision is the first of the 10 days). A copy of each appeal must be provided to the other party.

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

1. The 10 calendar day period for filing requests for administrative review has expired and neither party has filed such a request; or,
2. All timely requests for administrative review have been decided and, if ordered by EDR or HRM, the hearing officer has issued a revised decision.

Judicial Review of Final Hearing Decision

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

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David J. Latham, Esq.
Hearing Officer