Issue: Group III Written Notice with termination (client abuse); Hearing Date: 11/29/04; Decision Issued: 12/03/04; Agency: DMHMRSAS; AHO: Carl Wilson Schmidt, Esq.; Case No. 7899

COMMONWEALTH of VIRGINIA

Department of Employment Dispute Resolution

DIVISION OF HEARINGS

DECISION OF HEARING OFFICER

In re:

Case Number: 7899

Hearing Date: November 29, 2004
Decision Issued: December 3, 2004

PROCEDURAL HISTORY

On June 30, 2004, Grievant was issued a Group III Written Notice of disciplinary action with removal for:

> *Violation of D.I. 201, Reporting and Investigating Abuse and Neglect of Clients as defined in Section 201-3 for a substantiated allegation of abuse: After a team of Security and Nursing personnel had successfully placed a client in the seclusion room on Ward 1, [Grievant] lunged back into the seclusion room, grabbed the client, forcing the client backward, landing on the floor against the far wall. The client's shoulder and back hit the wall and floor. The client was diagnosed with a fractured right clavicle. The actions taken by [Grievant] are not approved or authorized by the Facility or the DHMRSAS.*

On July 12, 2004, Grievant timely filed a grievance to challenge the Agency's action. The outcome of the Third Resolution Step was not satisfactory to the Grievant and he requested a hearing. On October 20, 2004, the Department of Employment Dispute Resolution assigned this appeal to the Hearing Officer. On November 29, 2004, a hearing was held at the Agency's regional office.

APPEARANCES

Grievant
Grievant's Counsel
Agency Party Designee
Agency Advocate
Witnesses

ISSUE

Whether Grievant should receive a Group III Written Notice of disciplinary action with removal for client abuse.

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. 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 Mental Health Mental Retardation and Substance Abuse Services employed Grievant as a Safety and Security Technician at one of its facilities. He worked for the Agency for over a year until his removal effective July 1, 2004. The purpose of Grievant's position is to "maintain security, custody and control over a patient population ranging in ages from 18-64 at the Forensic Unit. Responsible to maintain controlled access both inside and outside the Forensic Unit." In October 2003, Grievant's work performance was evaluated and he received an overall rating of "Contributor." Grievant's Supervisor commented:

> [Grievant] is a new employee that requested to become a member of the Special Management Team. Since joining the team he has been able to deal with verbally abusive and [physically] aggressive patients. He responds to crisis situations in a professional manner and intervenes as trained.[1]

[1] Agency Exhibit 8.

Grievant stands 6'5" tall and weights 290lbs. No evidence of prior disciplinary action against Grievant was introduced at the hearing.

Grievant received training regarding application of the Mandt System and TOVA. The main goal of the Mandt System is to teach an individual how to effectively manage a potentially negative or dangerous situation by calming the individual's own emotional response and managing the individual's own behavior so the individual can interact with other people positively. (Mandt System Student Manual, page 7.) TOVA is designed to help an individual understand, predict, and prevent aggressive behavior in clients. (TOVA Manual, page 1.)

Under the Mandt System, an employee may restrain a client using a body hug. In order to apply this procedure, an employee is supposed to approach the client from the client's side, place his chest against one side of the client's body and wrap his arms around the other side of the client's body. The objective is for the employee to stop the client from moving his arms and stop his body movement. A body hug may also be used with the employee facing the client when approaching the client from the side is not possible. According to the Agency's expert on the Mandt System, when an employee uses a body hug on a client, there is about an 80 percent chance that the employee and the client will fall on the ground.

When an emergency is called, the Special Management Team (SMT) responds immediately. Grievant is a part of the SMT. He and his team members wear helmets and protective clothing including protective vests.

The Agency uses camera to observe many areas of the Facility including inside the seclusion room and the hallway outside the seclusion room. The cameras take still photographs every one to two seconds. Because of the quickness of a number of events occurring, the cameras do not present a complete picture of what happened. The cameras did not record sound.

The Client resides at the Facility involuntarily because he was adjudicated not guilty of a crime by reason of insanity. He is sometimes delusional. He stands approximately 5'8" and weights approximately 180lbs.

When staff have concerns about an a client's behavior, the client is placed in a seclusion room. If the client is held in a "time out", then the door to the seclusion room remains open while the client remains in the room to "cool off." If the client is not held in a "time out", then the door to the seclusion room is closed and the client is observed through a small window in the door. A nurse is responsible for deciding whether or not the client will be placed in "time out."

On May 29, 2004, the Client was in the dining hall when he and another client began fighting. The Registered Nurse told the Client to stop fighting but he continued. She became so concerned that the two clients would hurt themselves as they fought, that she called a 10-33 meaning she announced an emergency. Grievant and at least

three other SMTs responded to the emergency. After the fight was stopped, Grievant and another employee held the Client by the Client's arms. Grievant held the Client's left arm. They escorted the Client from the dining room through the dayroom and to the hallway containing a seclusion room. Grievant and another employee briefly held the Client against the wall in the hallway outside the seclusion room as the Client struggled. Grievant and a second SMT took the Client into the seclusion room, a small empty room. Grievant and the SMT took the Client to the back of the room as two other SMTs and other staff entered the room. At 5:24:17, Grievant and the second SMT holding the Client released the Client. The Client assumed a fighting posture and swung at Grievant. Grievant backed away from the Client and continued to walk backwards out the door while continuing to watch the Client. The second SMT holding the Client also backed out of the seclusion room. A third and fourth SMT and another employee also began to back out of the room. The fourth SMT turned his back to the Client as he exited the door.

As the last part of the fourth SMT's body was about to pass through the doorway into the hall, the Client raised his hands and began a rush towards the door. At 5:24:31, the Client pushed through the door with both of his arms such that all of his arms up to his shoulders are outside of the seclusion room. He was pushing the fourth SMT as he exited the room and pushing the other employees huddled in the hall around the doorway. The Client's body was at a 45 degree angle leaning into the push. His body and head remained in the room.[2]

As the Client pushed towards the door, the Nurse was standing on Grievant's left looking into the seclusion room to observe the Client. Grievant was also closely watching the Client. The Nurse had stated she wanted the Client held in "time out" such that the door to the room would remain open and the Client would be observed while he "cooled down." Once the Nurse observed the Client rushing the door, she announced that the Client needed to be placed in restraints. Grievant began moving into the seclusion room. He reached down to place a body hug on the Client and moved quickly forward towards the Client. The Client saw Grievant coming towards him and attempted to escape by moving backwards away from Grievant. Grievant attempted to catch the Client and quickly placed the Client in a body hug. With the force of the motion, Grievant landed on top of the Client at 5:24:33. The other SMTs entered the room and also held the Client down. Approximately a minute later at 5:25:31, the Nurse brought in the restraints and the Client was then placed in restraints.

The Agency's doctor issued and Evaluation and Order authorizing the Agency to place the Client in a 4-point ambulatory restraint because the Client was a risk of injuring himself or others and he had caused minor injury to himself or others. The medical order was to last for four hours.[3]

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[2] It is possible that more than the Client's arms to his shoulders were outside of the room. Because the camera takes still photographs every one or two seconds and the Client was moving so quickly, it is possible that more of the Client's body passed into the hallway than was shown by the camera.

[3] Agency Exhibit 3.

After the Client was placed in restraints, the Agency regularly checked his condition. At some point, the Client complained of pain and was examined and diagnosed as having a broken clavicle. A later more accurate radiological evaluation determined that the Client's clavicle was not broken. There is no credible evidence to suggest Grievant caused any significant injury to the Client.

CONCLUSIONS OF POLICY

The Agency has a duty to the public to provide its clients with a safe and secure environment. It has zero tolerance for acts of abuse or neglect and these acts are punished severely. Departmental Instruction ("DI") 201 defines[4] client abuse as:

> Abuse means any act or failure to act by an employee or other person responsible for the care of an individual 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 a person receiving care or treatment for mental illness, mental retardation or substance abuse. Examples of abuse include, but are not limited to, acts such as:
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> - Rape, sexual assault, or other criminal sexual behavior
> - Assault or battery
> - Use of language that demeans, threatens, intimidates or humiliates the person;
> - Misuse or misappropriation of the person's assets, goods or property
> - Use of excessive force when placing a person in physical or mechanical restraint
> - Use of physical or mechanical restraints on a person that is not in compliance with federal and state laws, regulations, and policies, professionally accepted standards of practice or the person's individual services plan; and
> - Use of more restrictive or intensive services or denial of services to punish the person or that is not consistent with his individualized services plan.

For the Agency to meet its burden of proof in this case, it must show that (1) Grievant engaged in an act that he performed knowingly, recklessly, or intentionally and (2) Grievant's act caused or might have caused physical or psychological harm to the Client. It is not necessary for the Agency to show that Grievant intended to abuse a client – the Agency must only show that Grievant intended to take the action that caused the abuse. It is also not necessary for the Agency to prove a client has been

[4] See, *Va. Code § 37.1-1 and 12 VAC 35-115-30.*

injured by the employee's intentional act. All the Agency must show is that the Grievant might have caused physical or psychological harm to the client.

When an employee acts within the scope of his duties and in accordance with Agency policy and training, he may not be considered as having engaged in client abuse. In this case, Grievant's position enabled him to make physical contact with the Client in order respond to the Client's aggressive behavior. Grievant's contact had to be in accordance with Mandt System and Therapeutic Options of Virginia (TOVA) training.

At the moment Grievant began moving into the room, Grievant had no reason to believe the Client would stop his attempt to push outside the door and leave the room.[5] Grievant's perception is confirmed by the Nurse's action of immediately changing from a "time out" to placing the Client in restraints once the Nurse realized the Client was attempting to leave the room. Based on these two factors, it was appropriate for Grievant to move towards Grievant into the room and attempt to place him in a body hug. Restraints were brought and the Client was quickly restrained.

The Agency argues Grievant could have simply closed the door to the room. This argument is based on the assumption that Grievant knew in advance that the Client would stop pushing forward. At the time Grievant reacted, he did not know that the Client would stop pushing forward. It may be the case that the Client stopped pushing forward only because Grievant and the other SMTs moved back towards the room. The door could not have been closed while the Client was in the doorway. Once the Nurse called for restraints it was appropriate for Grievant to place the Client in a position were he could be restrained.

The Agency contends Grievant should not have lunged at the Client. Grievant did not lunge at the Client. He stepped quickly towards the Client and attempted to use a body hug as required under the Mandt system. The Client attempted to get away from Grievant and began moving backwards. Grievant is 6'5" tall and had to bend down to grab the Client around the Client's shoulder and arms in order to lock his arms. With the events of Grievant quickly moving forward, the Client moving backwards, and Grievant having to bend down, it may have appeared that Grievant lunged. His actions, however, were appropriate under the circumstances.

The Agency contends the RN's testimony is not credible because she testified that the Client came out of the room which in fact only the part of his body that came out is his arms ending at his shoulders. His head and face remain inside the room. When events occur quickly minor inaccuracies in perception are not unexpected and do not destroy the credibility of a witness. The RN was outside in the hallway looking into the room. As the SMT staff exited the room, they filled the hall. The hallway camera provides an angle of view that more closely shows what the RN was observing. When the Client charged the door and attempted to move into the hall, he pushed several

[5] If the Client had gotten out of the room, he would have had a greater opportunity to run down the hall making it more difficult to restrain him.

SMT staff standing close together. The RN is standing right next to them and as the Client moved forward the staff move backwards. It is not likely she could distinguish every individual in the group including the Client and determine the precise location and movement of each person. Her conclusion that the Client came out of the room is not unreasonable given that she is standing immediately next to a number of large men wearing helmets and security vests. Her testimony actually confirms her conclusion that she believed restraints were necessary and ordered that the Client be placed in restraints.

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 reinstated Grievant to his former position, or if occupied, to an objectively similar position. He is to be awarded full **back pay** from which any interim earning must be deducted. He is to be restored to full benefits and seniority. Grievant is further entitled to recover a reasonable **attorney's fee**, which cost shall be borne by the agency.[6] Grievant's attorney is advised of her obligation to timely submit a fee petition to the Hearing Officer.[7]

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 the Department of Human Resource Management to review the decision. You must state the specific policy and explain why you believe the decision is inconsistent with that policy. Please address your request to:

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

[6] Va. Code § 2.2-3005.1.A & B.

[7] Section VI.D, *Rules for Conducting Grievance Hearings*, effective August 30, 2004. Counsel for the grievant shall ensure that the hearing officer *receives*, within 15 calendar days of the issuance of the hearing decision, counsel's petition for reasonable attorneys' fees.

3. If you believe that the hearing decision does not comply with the grievance procedure, you may request the Director of EDR 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:

    Director
    Department of Employment Dispute Resolution
    830 East Main St. STE 400
    Richmond, VA 23219

You may request more than one type of review. Your request must be in writing and must be **received** by the reviewer within 15 calendar days of the date the decision was issued. You must give a copy of your appeal to the other party. The hearing officer's **decision becomes final** when the 15-calendar day period has expired, or when administrative requests for review have been decided.

You may request a judicial review if you believe the decision is contradictory to law. You must file a notice of appeal with the clerk of the circuit court in the jurisdiction in which the grievance arose within **30 days** of the date when the decision becomes final.[8]

[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].

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Carl Wilson Schmidt, Esq.
Hearing Officer

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