Issue: Group III Written Notice with Suspension (client abuse – excessive force); Hearing Date: 09/16/16; Decision Issued: 10/06/16; Agency: DBHDS; AHO: Carl Wilson Schmidt, Esq.; Case No. 10849; Outcome: Full Relief.

COMMONWEALTH of VIRGINIA

Department of Human Resource Management

OFFICE OF EMPLOYMENT DISPUTE RESOLUTION

DECISION OF HEARING OFFICER

In re:

Case Number: 10849

Hearing Date: September 16, 2016
Decision Issued: October 6, 2016

PROCEDURAL HISTORY

On May 16, 2016, Grievant was issued a Group III Written Notice of disciplinary action with a five work day suspension for client abuse – excessive force.

On June 3, 2016, 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 July 26, 2016, the Office of Employment Dispute Resolution assigned this appeal to the Hearing Officer. On September 16, 2016, a hearing was held at the Agency's office.

APPEARANCES

Grievant
Agency 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. 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 employs Grievant as a Treatment Associate at one of its Facilities. No evidence of prior active disciplinary action was introduced during the hearing.

Grievant received training regarding Therapeutic Options of Virginia (TOVA) which informed him of proper methods to restrain residents.

The Resident at the Facility was easily angered and often became physically violent to staff or engaged in self-injurious behavior such as repeatedly punching walls with his hands. He would sometimes hit his head against the wall. One witness described the Resident as "volatile". Once he displayed one act of physical aggression, it was very likely that he would display additional acts unless staff intervened. Part of the Resident's behavioral plan was for him to be escorted to the "calm down room" when he became upset or aggressive. The Psychology Associate Senior testified the Resident had walked out of group therapy sessions and as he walked to another location, he tried to hurt himself by punching walls or kicking doors. She testified that the Resident's behavioral plan specified that if he showed signs of escalation such as kicking or throwing things, he was to be considered for immediate placement in the Facility's behavioral unit.

The Agency presented a video recording of the incident with two camera angles. The videos did not show a continuous frame sequence. In other words, very short gaps appeared between separate frames showing motion by employees and residents in the

videos. The videos showed actions at a distance and the picture quality was worse than what one would see watching standard definition television. The videos did not contain audio.

On March 29, 2016, Grievant was working in the dayroom with several residents and employees. The Resident was seated in a chair watching television in the day room. Grievant was standing ahead of him but to his left side. Another Security Officer was standing ahead of the Resident and to his left as well but standing closer to the Resident than Grievant.

The Resident had been arguing with another resident. They were cursing and calling each other names. The Resident threatened the other resident to "punch his f—king ass in the face." Staff working in the dayroom concluded that the two residents should be separated and be escorted to another area to calm down. The Resident was told he had to leave the dayroom. The Resident wanted the movie he and several other residents were watching on the television to be paused. He was told the movie would not be paused and he could watch it later. This angered the Resident. He expressed anger towards Grievant. He stood up. As he stood up, he jerked his arms downwards and then upwards. He clinched his fists. He stepped forward away from his chair but also to his right and away from Grievant. The Resident threatened to punch Grievant in the face. The Resident turned his head to his left to look at Grievant, cocked his arm, and punched towards Grievant's direction but not coming close to Grievant. The Resident threatened, "I'll punch your ass in the f—king face you fucking ni—er." Grievant did not move from where he was standing. Grievant told the Resident to calm down. The Resident continued to express his anger verbally towards Grievant. The Resident continued to walk away from Grievant but looked at Grievant. He turned his head clockwise to look in the direction he was walking and with his back to Grievant.

A plastic chair was positioned in front of him. He could have easily avoided the chair but instead used his left leg and foot to kick the side of the chair and send it flying until it landed several feet away. After kicking the chair, he took four steps forward which were away from Grievant. Grievant was speaking to the Resident as the Resident walked away. Grievant was trying to calm down the Resident.

Grievant was approximately ten to fifteen feet away from the Resident. Grievant observed the Resident kick the chair and believed the Resident was likely to continue with additional physical outbursts. Grievant took a few steps towards the Resident as he talked to the Resident. The Resident turned to his left to see Grievant approaching. As the Resident was yelling to Grievant, he turned to face Grievant as they stood approximately eight feet apart. The Resident began walking towards Grievant as Grievant moved towards the Resident. The Resident cocked his right arm and swung it forward as if to hit Grievant but his hand was not in a fist and he was too far away to hit Grievant. He then moved forward as Grievant continued to move towards the Resident. The Resident put his left foot forward and his right foot back to turn his body towards Grievant in a fighting position. He cocked his elbows back with his fists at his chest level and was prone to punch Grievant who was close enough to be hit. The Resident

lowered his fists without punching as Grievant moved quickly towards the Resident. The Resident began moving backwards as Grievant approached the Resident's left side with the objective of wrapping his arms around the Resident's chest. Grievant decided to implement a side-body restraint, an approved TOVA technique. Grievant moved his head to the left of the Resident's right shoulder and wrapped his arms around the Resident's upper body. Grievant wrapped his arms around the Resident's body in a manner to immobilize the Resident's left arm but allowing the Resident's right arm to remain free. Grievant was unable to wrap his arms around the Resident's right arm because the Resident had pulled his right side and arm away from Grievant. The Resident continued to have his right hand in a fist and they both moved backwards.

The Resident twisted himself to his left so he could use his right hand to punch Grievant. The back of Grievant's head became accessible to the Resident's blows from the Resident's right hand as the Resident continued to move backwards to pull away from Grievant's grasp.

Even though it was obvious that Grievant was attempting to restrain the Resident, the Security Officer offered no assistance other than using his radio to call for assistance.

Grievant and the Resident struggled and move towards a closed door with a glass window against a wall. The Resident had one leg between Grievant's legs attempting to pull away from Grievant and towards the glass window. The Resident repositioned his legs so that he had a leg behind him as he pushed forward against Grievant. The Resident's legs gave way and the Resident re-positioned himself with his back towards the glass. Grievant's momentum resulting from the Resident's push back caused the Resident's back to push against the glass window with sufficient force to break the window. The two men struggle for balance while they were against the window. The Resident positioned himself to face Grievant and Grievant's head was exposed to the Resident. The Resident punched Grievant in the head as they continued to struggle. Grievant moved forward on the balls of his feet as he attempted to regain balance while the Resident struggled back and forth. Grievant's upper body twisted to his right and his right leg bent. The two men fell to the ground with Grievant landing on his right shoulder and the Resident landing partly on Grievant's right shoulder and partly on the floor. The Resident continued to roll from his left to his right while Grievant held him. Grievant landed with his face downward grasping the Resident's left side as the Resident looked upward. Grievant reached his left hand over top of the Resident's chest to hold the Resident's right arm downward. Other staff arrived and surrounded the two men. One employee held the Resident's right arm down. The Resident stopped resisting.

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[1] client abuse as:

> This means any act or failure to act by an employee or other person responsible for the care of an individual in a Department facility 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:
>
> - 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 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.

The Agency has not presented sufficient evidence to support the issuance of disciplinary action in this case. The unique characteristics of the Resident's pattern of behavior and deficiencies in the Agency's video recording render the Agency unable to meet its burden of proof.

[1] See, Va. Code § 37.2-100 and 12 VAC 35-115-30.

The Agency's policies permit an employee to use a side-body restraint in the case of an emergency situation "in which the safety of residents and/or staff are threatened …."[2] The restraint must be consistent with TOVA training.

The Agency argued that Grievant should not have advanced towards the Resident because the Resident was walking away from Grievant. According to the Agency, employees are taught that if a resident is focusing on the employee, the employee should remove him or herself from the conflict.

The evidence showed that Grievant did not advance towards the Resident until after the Resident kicked the chair. Grievant explained that he began advancing towards the Resident because he knew that once the Resident displayed one act of physical aggression, he would continue hitting and kicking other things or other people. Grievant presented credible witness testimony that the Resident was unique in that once he displayed one physical outburst, he typically followed with additional violent physical actions. Grievant interpreted the Resident's kicking the chair to mean the Resident would continue his physical aggression including possibly punching a wall. Grievant decided to intervene for the Resident's safety with the hope he could prevent the second or more acts of physical aggression by the Resident.

The Agency argued that Grievant failed to properly secure the Resident's right arm. It is clear that Grievant attempted to fully restrain the Resident, but that he was unable to wrap his arms around the Resident's right arm because the Resident pulled his right arm backwards and moved away from Grievant. Grievant's failure to fully execute the side-body restraint is not client abuse.

The Agency argued that Grievant used excessive force as evidenced by the broken window. The video of the incident did not show the window breaking. It did not show whether Grievant or the Resident or both were at fault for breaking the window.

The Agency alleged that while Grievant and the Resident were against the window, Grievant positioned his hip and twisted his body in a manner to force the Resident to the ground where Grievant then landed on the Resident's left shoulder. The Agency's evidence of this is a video which depicts this shows only the back of Grievant's body from his feet to a few inches above his waist. The video only shows the Resident's legs and body to the extent not blocked by Grievant's body. Whether Grievant tossed or forced the Resident to the ground cannot be determined by only looking at the bottom half of their bodies. It may have been the case that the Resident jerked himself away from the window and Grievant fell backwards taking the Resident down with him. The video is also misleading because it does not show a continuous frame sequence. The images "jump" or "burst" slightly so that a more deliberate movement appears when a less deliberate movement may have actually occurred. The Agency may be correct that Grievant improperly took the Resident to the ground, but it is equally likely that they fell as a result of the struggle and Grievant's loss of footing and

[2] Agency Exhibit 7.

balance. The Agency has not met its burden of proof to show that Grievant engaged in client abuse when he and the Resident fell to the ground.

Another factor affecting the outcome of this case is that the other Security Officer did not provide Grievant with any assistance once it was obvious Grievant had begun to restrain the Resident. If the Security Officer had grabbed the Resident's right arm so that the Resident could no longer punch the back of Grievant's head, Grievant and the Security Officer may have been able to stabilize the Resident without damage to the window or falling to the ground.

DECISION

For the reasons stated herein, the Agency's issuance to the Grievant of a Group III Written Notice of disciplinary action with a 5 day suspension is **rescinded**. The Agency is directed to provide the Grievant with **back pay** less any interim earnings that the employee received during the period of removal and credit for leave and seniority that the employee did not otherwise accrue.

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 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

   or, send by fax to (804) 371-7401, or e-mail.

2. 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 that EDR 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
   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 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 provide a copy of all of your appeals to the other party, EDR, 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.

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.[3]

[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

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