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ADMINISTRATIVE REVIEW

In the matter of the Department of Behavioral Health and Developmental Services
Ruling Number 2019-4924
June 7, 2019

The Department of Behavioral Health and Developmental Services (the "agency") has requested that the Office of Employment Dispute Resolution ("EDR") at the Virginia Department of Human Resource Management ("DHRM")[1] administratively review the hearing officer's decision in Case Number 11319. For the reasons set forth below, EDR will not disturb the hearing decision.

FACTS

The relevant facts in Case Number 11319, as found by the hearing officer, are as follows:[2]

> 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.
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> 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.
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> 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

[1] The Office of Equal Employment and Dispute Resolution has separated into two office areas: the Office of Employment Dispute Resolution and the Office of Equity, Diversity, and Inclusion. While full updates have not yet been made to the *Grievance Procedure Manual* to reflect this change, this Office will be referred to as "EDR" in this ruling. EDR's role with regard to the grievance procedure remains the same.

[2] Decision of Hearing Officer, Case No. 11319 ("Hearing Decision"), Apr. 17, 2019, at 2-4.

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.

On January 16, 2019, the grievant was issued a Group III Written Notice with removal for client neglect.[3] The grievant timely grieved the disciplinary action and a hearing was held on March 28, 2019.[4] In a decision dated April 17, 2019, the hearing officer concluded that the agency had not presented sufficient evidence to demonstrate that the grievant's actions constituted neglect of the Patient or otherwise supported the issuance of discipline.[5] As a result, the hearing officer rescinded the disciplinary action, ordered the grievant reinstated to his former position or an equivalent position at the Facility, and directed the agency to provide him with back pay, less any interim earnings.[6] The agency now appeals the hearing decision to EDR.

DISCUSSION

By statute, EDR has been given the power to establish the grievance procedure, promulgate rules for conducting grievance hearings, and "[r]ender final decisions . . . on all matters related to . . . procedural compliance with the grievance procedure . . . ."[7] If the hearing officer's exercise of authority is not in compliance with the grievance procedure, EDR does not award a decision in favor of either party; the sole remedy is that the hearing officer correct the noncompliance.[8] The Director of DHRM also has the sole authority to make a final determination on whether the hearing decision comports with policy.[9] The DHRM Director has directed that EDR conduct this administrative review for appropriate application of policy.

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[3] *Id.* at 1.
[4] *See id.*
[5] *Id.* at 4-7.
[6] *Id.* at 7.
[7] Va. Code §§ 2.2-1202.1(2), (3), (5).
[8] *See Grievance Procedure Manual* § 6.4(3).
[9] Va. Code §§ 2.2-1201(13), 2.2-3006(A); *see* Murray v. Stokes, 237 Va. 653, 378 S.E.2d 834 (1989).

Inconsistency with Agency Policy

In its request for administrative review, the agency asserts that the hearing officer's decision is inconsistent with agency policy. The agency appears to take the position that its "interpretations of its own policies . . . [are] entitled to deference," and thus the hearing officer should have upheld the disciplinary action because the agency determined that the grievant's actions constituted neglect of the Patient. EDR has reviewed the agency's submission and is unable to find any argument, not otherwise addressed herein, that raises any way in which agency policy was not properly applied by the hearing officer. Accordingly, there is no basis to conclude that the hearing decision is inconsistent with policy.

Hearing Officer's Consideration of Evidence

In the remainder of its request for administrative review, the agency essentially argues that the hearing officer's findings of fact, based on the weight and credibility he accorded to the testimony presented at the hearing, are not supported by the evidence. Hearing officers are authorized to make "findings of fact as to the material issues in the case"[10] and to determine the grievance based "on the material issues and the grounds in the record for those findings."[11] Further, in cases involving discipline, the hearing officer reviews the facts *de novo* to determine whether the cited actions constituted misconduct and whether there were mitigating circumstances to justify a reduction or removal of the disciplinary action, or aggravating circumstances to justify the disciplinary action.[12] Thus, in disciplinary actions the hearing officer has the authority to determine whether the agency has established by a preponderance of the evidence that the action taken was both warranted and appropriate under all the facts and circumstances.[13] Where the evidence conflicts or is subject to varying interpretations, hearing officers have the sole authority to weigh that evidence, determine the witnesses' credibility, and make findings of fact. As long as the hearing officer's findings are based upon evidence in the record and the material issues of the case, EDR cannot substitute its judgment for that of the hearing officer with respect to those findings.

In the decision, the hearing officer assessed the evidence and concluded that the "Grievant did not fail to provide care or services to the Patient for his health, safety, and welfare," and that he was "at all times focused on providing assistance to the Patient to help the Patient move to the Second Building."[14] The hearing officer also clearly determined that events occurring before the grievant's arrival at the Vestibule area were critical to determining the appropriateness of his response. For example, the DSA and the Security Officer dragged the patient from the Lobby into the Vestibule and left him in that area before the Security Officer called the grievant for assistance.[15] When the grievant arrived, the Patient initially refused to move out of the Vestibule.[16] The hearing officer determined that, according to agency policy, the grievant "was not authorized to assess the Patient's medical condition" to determine whether the

[10] Va. Code § 2.2-3005.1(C).
[11] *Grievance Procedure Manual* § 5.9.
[12] *Rules for Conducting Grievance Hearings* § VI(B).
[13] *Grievance Procedure Manual* § 5.8.
[14] Hearing Decision at 4.
[15] *Id.* at 3.
[16] *Id.*

Patient could be moved,[17] that the "Patient did not need to be moved due to his safety or for emergency medical care" against his will,[18] and that "[t]he Patient was not in jeopardy of injury by remaining in the Vestibule."[19] Based on all of these findings, the hearing officer found that the grievant's actions and explanation for his decisions were "consistent with the appropriate care to render to the Patient."[20]

The determination as to whether a Written Notice was issued at the appropriate level (or whether the behavior constituted misconduct at all) is a mixed question of fact and policy, and the agency's arguments challenge the hearing officer's application of agency policies to the facts of this case, as well as the hearing officer's factual findings on certain issues. Significantly, the agency does not appear to challenge the hearing officer's factual conclusions about what occurred during the incident; rather, the agency contends that the grievant did not ensure the Patient was properly monitored while he was in the Vestibule, and that the hearing officer should have upheld the Written Notice based on the grievant's failure to monitor the Patient. The agency specifically asserts that the video recording of the incident shows that the grievant "had his back towards the Patient" for a period of time while he was in the Lobby, and that the Patient "was left alone . . . with two locked doors and a lobby" between him and the grievant. The agency further argues that the "presence of windows" through which the grievant and the Security Officer could watch the Patient did not allow them to "adequately provide for the safety and welfare of the Patient" in this case.

In this case, the hearing officer clearly considered the evidence presented by the agency to support its charge of client neglect, finding that it was insufficient to support the Written Notice. In cases involving discipline, the burden is on the agency to show that the grievant engaged in the behavior charged on the Written Notice, that the behavior constituted misconduct, and that the discipline was consistent with law and policy.[21] While the agency conducted an investigation and determined that the grievant's actions constituted neglect,[22] the evidence presented by the parties at the hearing did not support the agency's argument that the disciplinary action was warranted and appropriate under the circumstances. For example, there is no evidence in the record to support the agency's assertion on administrative review that the presence of windows would not allow the grievant to adequately monitor the Patient. No witness testified about this issue in particular and, indeed, the testimony of the agency's witnesses at the hearing was that the grievant should have lifted the Patient immediately and moved him to the Lobby because it was not safe for him to remain in the Vestibule.[23] As discussed above, the hearing officer found that these arguments were not persuasive, and the agency does not challenge the hearing officer's findings relating to the grievant's decision not to lift the Patient and move him into the Lobby.

The hearing officer further discussed the evidence relating to the grievant's monitoring of the Patient as follows:

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[17] *Id.* at 5.
[18] *Id.* at 6.
[19] *Id.*
[20] *Id.* at 5.
[21] *Rules for Conducting Grievance Hearings* § VI(B)(1).
[22] Agency Ex. C.
[23] Hearing Recording at 30:30-31:03, 43:32-43:51 (testimony of Investigator), 1:11:47-1:13:08 (testimony of Director).

> 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.[24]

Although the video recording of the incident shows that the grievant and the Security Officer stood in the Lobby for approximately one minute and were not both directly facing the Patient in the Vestibule during this time, they were also located within several feet of the door to the Vestibule throughout this period.[25] At the hearing, the grievant testified that either he or the Security Officer could see the Patient at all times while the Patient was in the Vestibule.[26] While the agency disagrees with the hearing officer's findings regarding the grievant's monitoring of the Patient, no record evidence conclusively demonstrates that the grievant and/or the Security Officer were not monitoring the Patient or unable to intervene while they stood in the Lobby such that the hearing officer's findings were arbitrary or not supported by the record. In addition, EDR has not identified testimony from the agency's witnesses that would establish whether it would have been acceptable for the grievant to monitor the Patient from the Lobby in this manner. Under these circumstances, EDR cannot conclude that the hearing officer abused his discretion or otherwise erred in finding that the evidence in the record showed the grievant properly monitored the Patient throughout the incident.

In addition, the agency asserts that grievant's actions were inconsistent with Facility Policy 450-035, *Emergency Use of Seclusion or Restraint*, because the locked Vestibule doors prevented the Patient from leaving the Vestibule. To the extent the agency contends that any alleged violation of Policy 450-035 supported the issuance of the Group III Written Notice, such an assertion is directly contradicted by the testimony of the Facility Director, who stated that the alleged seclusion of the Patient was not neglect in and of itself.[27] More importantly, however, EDR has reviewed Policy 450-035 and finds that it was not directly applicable to the circumstances presented in this case. Although the policy does not specifically discuss whether the room in which a Patient is placed must be "intended to be used for seclusions"[28] for the policy to apply, it does describe specific procedures to be followed before a patient is placed in seclusion. In particular, it appears that a Registered Nurse or Licensed Independent Practitioner at the Facility must first authorize the use of seclusion, and then assign direct care staff to monitor a patient who is placed in seclusion.[29] In this case, there is no evidence that direct care staff at the Facility assessed the Patient or ordered the Patient placed in seclusion. Moreover, the grievant was not assigned to monitor the Patient and worked in a security position, not a direct care position; Policy 450-035 contemplates that employees who would be assigned to monitor a patient in seclusion should be direct care staff.[30] While Policy 450-034 may not have been directly applicable to the incident that occurred here, the fact that the Patient was located in the

[24] Hearing Decision at 6.
[25] *See id.* at 3-4; Agency Ex. D.
[26] Hearing Recording at 2:13:23-2:13:59, 2:17:28-2:18:40, 2:23:08-2:23:13 (testimony of grievant).
[27] *Id.* at 1:22:23-1:23:07 (testimony of Director).
[28] Hearing Decision at 6.
[29] Agency Ex. E at 3-5.
[30] *Id*. at 2, 5-6.

Vestibule between two locked doors was certainly a relevant factor for the hearing officer to consider in determining whether the grievant's actions were properly considered neglect, as he did here.[31]

The outcome of a case such as this one will necessarily depend on the hearing officer's assessment of the evidence presented by the parties, including the credibility of the witnesses who testified at the hearing and the corresponding weight given to their testimony. Indeed, conclusions as to the credibility of witnesses and the weight of their respective testimony on issues of disputed facts are precisely the kinds of determinations reserved solely to the hearing officer, who may observe the demeanor of the witnesses, take into account motive and potential bias, and consider potentially corroborating or contradictory evidence. Weighing the evidence and rendering factual findings is squarely within the hearing officer's authority, and EDR has repeatedly held that it will not substitute its judgment for that of the hearing officer where the facts are in dispute and the record contains evidence that supports the version of facts adopted by the hearing officer, as is the case here.[32]

In summary, EDR has thoroughly reviewed the hearing record and cannot find record evidence that would suggest the hearing officer abused his discretion in making the factual conclusion that the agency had not carried its burden of demonstrating that the grievant's actions constituted neglect of the Patient, or that he otherwise engaged in misconduct warranting the issuance of disciplinary action. Where the evidence conflicts or is subject to varying interpretations, hearing officers have the sole authority to weigh that evidence, determine the witnesses' credibility, and make findings of fact. Because the hearing officer's findings in this case are based upon evidence in the record and the material issues of the case, EDR cannot substitute its judgment for that of the hearing officer with respect to those findings. Accordingly, EDR declines to disturb the decision.

CONCLUSION AND APPEAL RIGHTS

For the reasons set forth above, EDR declines to disturb the hearing officer's decision. Pursuant to Section 7.2(d) of the *Grievance Procedure Manual*, a hearing decision becomes a final hearing decision once all timely requests for administrative review have been decided.[33] Within 30 calendar days of a final hearing decision, either party may appeal the final decision to the circuit court in the jurisdiction in which the grievance arose.[34] Any such appeal must be based on the assertion that the final hearing decision is contradictory to law.[35]

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[31] Hearing Decision at 6.
[32] *See, e.g.*, EDR Ruling No. 2014-3884.
[33] *Grievance Procedure Manual* § 7.2(d).
[34] Va. Code § 2.2-3006(B); *Grievance Procedure Manual* § 7.3(a).
[35] *Id.*; *see also* Va. Dep't of State Police v. Barton, 39 Va. App. 439, 445, 573 S.E.2d 319, 322 (2002).