COMMONWEALTH of VIRGINIA

Department of Human Resource Management

OFFICE OF EMPLOYMENT DISPUTE RESOLUTION

DECISION OF HEARING OFFICER

In re:

Case Number: 12065

Hearing Date: February 22, 2024
Decision Issued: March 5, 2024

PROCEDURAL HISTORY

On December 26, 2023, Grievant was issued a Group III Written Notice of disciplinary action with removal for client neglect. The Written Notice referred to a case number to describe the nature of the offense.

On December 26, 2023, Grievant timely filed a grievance to challenge the Agency's action. The matter advanced to hearing. On January 22, 2024, the Office of Employment Dispute Resolution assigned this appeal to the Hearing Officer. On February 22, 2024, a hearing was held by remote conference.

APPEARANCES

Grievant
Agency Party Designee
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. 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 Safety Management Tech at one of its facilities. She had been employed by the Agency for approximately two years. No evidence of prior active disciplinary action was introduced during the hearing.

Grievant reported to work on October 30, 2023. She was assigned to a different Unit than the one where she usually worked. She received a report on the patients in the Unit before she began working with them. Grievant was warned of the Patient's dangerous behavior and her catatonic diagnosis that she sometimes would not respond when being addressed. Grievant was responsible for observing the Patient.

The Building had a Unit with Patient rooms connected to a Dayroom. The Agency had cameras in the Dayroom to record patients and staff. The quality of the video did not always reveal the details of staff and patient behavior. In many respects, the video was "foggy" and only showed a general outline of people and gave some indication when they moved their arms.

One of the walls in the Dayroom had a grate/grill to allow air to pass through the building's HVAC system. A chair was located to the left side of the grate.

While working in the Dayroom, Grievant was expected to observe patients but remain at a reasonable distance from the patients. Grievant and two other staff would sit at a table located near the center of the room to monitor patients.

A video recording of the incident on October 30, 2023 showed the Patient initially standing facing a wall with her left and right hand pressed against the wall and her face close to the wall. The top of the grate was below the Patient's waist. The chair was positioned to the Patient's left side.

At 9:45:09 a.m., Employee O and Grievant were seated in the Dayroom at the staff table. The Patient was in the Dayroom and standing against the wall across from both technicians. They could see the Patient's back.

Grievant left the Dayroom at 9:47:54 a.m. and returned at 9:48:39 a.m.

The Patient staired at the wall. The Patient began to slap her thigh, hips, and buttocks with the palm of her hand. These slaps were not harming the Patient or placing her in immediate danger. Grievant noticed the Patient's behavior. At 9:48:52 a.m., Grievant walked to the Patient and began talking to the Patient. Grievant tried to redirect the Patient to the Patient's room. The Patient disregarded Grievant's comments and continued to stare at the wall. Grievant returned to the staff table at 9:49:27 a.m.

The Patient continued to hit her herself with her left hand.

At 10:05:18 a.m., the Patient bent to her left while facing the wall. She moved her left arm and hand in a hitting motion. It is unclear what she was hitting, but it is possible she was hitting the grate with her left hand. While the Patient was bent to her left, her right hand remained pressed against the wall. She did not move her right arm and hand to hit anything. She did not hit the grate with her right hand.

At 10:06:44 a.m., Grievant left the table and the Dayroom to take an approved break. She was no longer in a position to observe the Patient. The Patient continued hitting with her left arm and hand.

At 10:11:07 a.m., RN T came out of the treatment room and into the Dayroom. She heard a banging sound in the Dayroom and saw the Patient next to the wall hitting her hand against the HVAC grate. At 10:12:22 a.m., RN T went to the Patient and stopped the Patient and redirected the Patient to the Patient's room.

RN T confronted Employee O and Employee B about not stopping the Patient from hitting the HVAC grate. Grievant was not in the Dayroom at that time.

RN T wrote a patient note indicating she saw blood on the vent from wounds to knuckles on both hands. RN T administered medical treatment to the Patient's hand. RN T noticed the Patient's right hand was swollen two times normal size with extensive

bruising from just above the Patient's wrist down through the fingers and was already a dark bluish purple.

The Agency's primary care staff concluded that the Patient should be referred to the local Hospital Emergency Department for "imaging of her right hand and to collect labs."[1] PNP B indicated that two staff escorted the Patient to the Emergency Department and used forensic transportation restrains but without restrain on the right wrist due to acute injury.

Staff who escorted the Patient to the Emergency Department reported to the PNP B that, "the patient was combative and they were unable to collect blood work, x-ray the left hand, or collect vital signs."[2]

The Patient was diagnosed with a "boxers fracture" of her right hand.

When the Patient returned from the Hospital, she had a soft wrap and mesh sling on her right hand and arm.

The Written Notice was issued by the Assistant Chief Nurse Executive who did not testify. The Manager testified regarding the Agency's decision to discipline Grievant.

The Agency's Investigator focused on the question of, "did the unit technicians not intervene/stop [the Patient] from banging her right hand on the HVAC grill in the unit dayroom resulting in an injury to her right hand."[3]

The Agency's Investigator summarized the investigation's evidence as:

> On 10/20/23 on or about 1000-1100 hrs, [the Patient] was in [the Unit] dayroom and leaning against the wall. [The Patient] was banging her hands against the wall/hip and eventually started banging her right hand against the HVAC grate. Several technicians were seated in the dayroom and were within plain sight of [the Patient] and what she was doing with her hands. [RN T] walked into the dayroom and saw [the Patient] banging her right hand against the HVAC grate and saw blood on the HVAC grate. [RN T] immediately redirected [the Patient] and administered medical treatment. [RN T] is seen on video confronting the technicians seated at the staff table.[4]

The video showed that the Patient's right hand was pressed against the wall during the time the Patient was bent to her left side and hitting her left hand against something.

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[1] Agency Exhibit p. 29.

[2] Agency Exhibit p. 21.

[3] Page 4 of Investigator's Summary.

[4] Page 5 of Investigator's Summary.

In particular, at 10:05 a.m., the video showed the Patient with her right hand pressed against the wall with the hand at approximately the Patient's shoulder level. When the Patient bent to her left, her right hand remained pressed flat against the wall. The Patient's right hand remained pressed against the wall through the time period when Grievant left the room at 10:06:44 a.m. In other words, the Investigator's conclusion that the Patient started banging her right hand against the HVAC grate is not supported by the evidence.

The Agency took disciplinary action against other employees in the Dayroom who failed to intervene when the Patient was hitting the grate. The Agency chose to mitigate their disciplinary action to allow them to remain employed by the Agency. The Agency did not mitigate Grievant's disciplinary action because the Agency was aware of another instance when the Agency believed Grievant failed to intervene to prevent an injury to a patient. The Agency had not yet taken disciplinary action for that incident.

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 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.

The Agency alleges the time frame during which Grievant was neglectful was from 10:05:18 a.m. to 10:06:44 a.m. when Grievant left the room. The Manager testified, "I mean in my opinion the neglect starts at 10:05" and "so it was basically one minute and 20 seconds."

The Agency asserts:

(1) Grievant was in a position to observe the Patient,
(2) Grievant was obligated to observe the Patient and stop the Patient from engaging in behavior that caused injury,
(3) the Patient bent to her left as she faced the wall,
(4) the Patient hit her right hand against the HVAC grate,
(5) the Patient's hand bled on the HVAC grate,
(6) the Patient's right hand was injured when the Patient hit the grate, and
(7) Grievant failed to stop the Patient from hitting the grate which meant Grievant was responsible for the injury to the Patient's right hand.

The Agency has not met its burden of proof to show that Grievant engaged in client neglect because the Agency did not show Grievant was present when the Patient injured

her right hand. At some point in time, possibly on October 30, 2023, the Patient suffered a "boxers fracture" on her right hand. That point in time, however, was not between 10:05:18 a.m. and 10:06:44 a.m. when the Agency alleged Grievant failed to monitor the Patient. The Patient could have injured her right hand before 9:45:09 a.m. when the video started.

The Agency's evidence was inconsistent regarding whether the Patient's left or right hand was fractured while Grievant was observing the Patient. Prior to the hearing, the Agency asserted the Patient's right hand was fractured. The Agency's Investigative Report stated the Patient, "started banging her right hand against the HVAC grate."

During the hearing, the Agency's Manager showed the video of the incident and asserted that the fracture was to the Patient's left hand and resulted from the Patient hitting the HVAC grate with her left hand. The medical evidence did not show that the Patient suffered a fracture to her left hand. The medical evidence showed that the Patient suffered a fracture of her right hand.

The Hearing Officer viewed the video of the incident and concludes it is most likely that the Patient did not suffer a fracture to her right hand from 10:05:18 a.m. to 10:06:44 a.m. because the Patient's right hand was pressed against the wall. In other words, Grievant's failure to intervene from 10:05:18 a.m. to 10:06:44 a.m. did not result in the fracture to the Patient's right hand.

The Hearing Officer finds that the Patient suffered a fracture of her right hand and that the fracture did not occur when Grievant was responsible for watching the Patient from 10:05:18 a.m. to 10:06:44 a.m. as alleged by the Agency.

The evidence is unclear about the amount of blood observed on the grate. The video of the incident does not show any blood on the grate. It is unclear whether the blood was from the Patient's left or right knuckles. RN T did not testify but wrote a note that, "RN sees blood on the vent from wounds to knuckles on both hands."[5] If the blood resulted from wounds on the Patient's right hand, Grievant was not present when the blood was placed on the grate.

Although it is not necessary for the Agency to show actual injury to support a finding of client neglect, the Agency's decision to issue disciplinary action in this case rested primarily on the fact that the Patient suffered a fracture to her right hand. The Manager testified, "I was more concerned about the injury that resulted in the blood on the grate in her hand and the fracture." The Manager testified, "[f]or this particular case, I considered it for hitting the grate and receiving the boxer's fracture." When asked if the key to neglect was a fracture, the Manager testified, "in this particular case – yes."

If the Patient had not suffered a fracture, the Hearing Officer believes the Agency would not have taken disciplinary action against Grievant. For example, the Patient hit

[5] Page 16 of Investigator's Summary.

her hip and side numerous times from 9:45:09 a.m. to 10:05:18 a.m. yet the Agency did not consider Grievant to have neglected the Patient during that time frame.

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, or if the position is filled, to an equivalent position. 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]

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

[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