COMMONWEALTH OF VIRGINIA

Department Of Human Resource Management

Office of Employment Dispute Resolution

DECISION OF HEARING OFFICER

In re:

Case number: 12170

Hearing Date: November 12, 2024
Decision Issued: December 18, 2024

PROCEDURAL HISTORY

On August 30, 2024, Grievant was issued a Group III Written Notice of disciplinary action with termination. In the written notice, the Agency described the nature of the offense as:

> Violation of D.I. 201: Reporting and Investigating Abuse and Neglect of Clients: [Case No. ### #### ####]. A preponderance of the evidence exists to corroborate a substantiated finding of patient neglect when you failed to intervene appropriately during a physical altercation between two patients.[1]

On September 4, 2024, Grievant timely filed a grievance to challenge the Agency's action. The matter advanced to hearing. On September 16, 2024, the Office of Employment Dispute Resolution assigned this matter to the Hearing Officer. On November 12, 2024, a hearing was held at the Facility.

APPEARANCES

Grievant
Agency Advocate
Agency Party Designee
Witnesses

[1] Agency Ex. at 3.

ISSUES

1. Whether Grievant engaged in the behavior described in the Group III Written Notice of disciplinary action?

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:

Prior to her dismissal, Grievant was a Direct Service Associate III at a Department of Behavioral Health and Developmental Services Facility.[2] Grievant had worked at the Facility for more than two years.[3] A prior evaluation of Grievant's work indicated that Grievant's work had been satisfactory to the Agency.[4]

The Employee Work Profile for Grievant's position included among Grievant's Core Responsibilities that she maintain a safe and therapeutic environment, including that she "[i]mmediately intervene in dangerous situations" and "[a]pply physical restraints to prevent a patient who presents an[] imminent danger to self/others from causing harm."[5] Measures of this core responsibility included that Grievant:

- Utilizes therapeutic communication and role-modeling.

. . .

[2] Agency Ex. at 24-38. Based on the testimony during the hearing, Grievant's position also is referred to as a Psychiatric Technician III. (Hearing Recording at 2:03:00-2:03:52).
[3] Hearing Recording at 2:11:39-2:12:33.
[4] Agency Ex. at 34-38.
[5] Agency Ex. at 27.

- Immediately resolves safety issues such as spills, objects impeding traffic flow, removal of unsafe items.
- Ensures all patients are present prior to movement within the facility.
- Uses TOVA techniques when intervening in dangerous patient behaviors and follows all expectations. In the case of environmental dangers, remains with the dangerous situation keeping patients away from the area until help arrives.

  . . .
- Identifies, intervenes in and reports early cues to agitation using a graded approach of least restrictive interventions.[6]

Grievant had been trained on Therapeutic Options (previously Therapeutic Options of Virginia (TOVA)) and Therapeutic Communications.[7] This training teaches Facility staff approved methods for managing aggressive behaviors. Therapeutic Options Instructor testified that the Therapeutic Options training teaches staff to physically intervene to control patients in emergency situations, specifically when there is risk that the patient will harm themselves, harm others, or destroy state property.[8]

On June 29, 2024, Grievant was on duty in a Day Room on a Unit of the Facility.

Video footage showed that at approximately 19:35:42, Patient 1 entered the Day Room. At approximately 19:35:45, Patient 1 appeared to see Patient 2 sitting in an alcove on the telephone. Patient 1 walked toward Patient 2. At approximately 19:35:48, Patient 1 can be seen to begin to repeatedly hit Patient 2. Grievant is across the room from Patient 1 and Patient 2. At approximately 19:35:50, Grievant and Witness 2 can be seen to begin to walk across the room toward Patient 1 and Patient 2. Tech-4 also is in the room and appears to begin to move toward Patient 1 and Patient 2. Based on testimony during the hearing, Grievant called out for someone to call for a response or a “10-33.” Witness 3 can be seen to grab what appears to be a phone or radio to call for a “10-33.” In this case, the call for a “10-33” was a call for assistance over the radio to alert staff to respond to the Day Room to assist. Witness 2 and Grievant are the first staff members to arrive to the alcove where Patient 1 is continuing to assault Patient 2. Witness 2 approaches from the back, right side of Patient 1 and Grievant approaches from the back, left side of Patient 1. As Witness 2 approaches Patient 1, she can be seen to immediately attempt to grab Patient 1’s right arm. While Witness 2 attempts to grab Patient 1’s right arm, Grievant also has stepped to within reach of Patient 1, but Grievant does not appear to try to physically intervene. Tech-4 also can be seen to approach the alcove. Grievant steps slightly to the left and away from Patient 1 and Patient 2. Witness 2 continues to try to grab Patient 1’s right arm and Patient 1 swats her hand away. Witness 1 has entered the Day Room from the nurses’ station and Witness 1 and Witness 3 also now approach the alcove area. Witness 1 attempts to grab Patient 1’s right arm and Tech-4 also now appears to attempt to grab Patient 1’s left arm. A security staff person enters the Day Room and runs across the room to the alcove. By approximately 19:36:11, the security staff person and Witness 1 appear to have stopped Patient 1 from hitting Patient 2 and

[6] Agency Ex. at 27.
[7] Agency Ex. at 20-23, Hearing Recording at 59:00-1:01:12.
[8] Hearing Recording at 28:15-29:54, 33:21-34:06, 34:35-37:48, 41:11-42:0042:18-46:05, 46:05-47:35.

are beginning to pull Patient 1 away from Patient 2 and toward the door. Patient 1 then leaves the Day Room. Patient 2 has stood up from where he had been sitting in the alcove and steps away from the alcove. The entire incident lasted approximately 23 seconds.[9]

Following the incident, the Facility Investigator investigated the incident to determine whether the staff involved had neglected Patient 2 by failing to intervene to stop the assault by Patient 1. The Facility Investigator made a finding of "unsubstantiated for neglect."[10] The Facility Investigator explained that his finding of "unsubstantiated for neglect" was as to the group of staff involved in the incident as a whole and was not a finding with respect to any individual staff member involved. Facility Investigator testified that he recommended a finding of unsubstantiated for neglect for the group as a whole because four of the six staff available to respond attempted to physically intervene to stop Patient 1's assault of Patient 2.[11] The Facility Director reviewed the report and determined that a finding of neglect was substantiated for individual staff members, including Grievant.[12]

CONCLUSIONS OF POLICY

The Agency has a responsibility to the public to provide its clients with a safe and secure environment. It has no tolerance for acts of abuse or neglect and these acts are punished severely. The Agency has adopted Departmental Instruction ("DI") 201, Reporting and Investigating Abuse and Neglect of Individuals Receiving Services in Department Facilities,[13] to establish policies, procedures, and responsibilities for reporting, responding to, and investigating allegations of abuse and neglect at Agency facilities. The Facility has adopted Policy RTS-15c, Patient Abuse, Reporting and Investigation of Allegations[14] which defines patient abuse and neglect according to DI 201 and establishes the requirement for reporting and investigating alleged patient abuse and/or neglect that may have occurred at the Facility.

Pursuant to the Facility's policy RTS-15c, "neglect" is defined as:

> Failure by a person, program or facility operated 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 an individual receiving care or treatment for mental illness, developmental disability or substance abuse.[15]

Policy RTS-15c makes clear that "[t]hose not complying with [DI-201] and this policy may be terminated from employment."[16]

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[9] See Video footage 26 Unit Dayroom and footage 25 Unit Dayroom at 19:35:42-19:36:11.
[10] Agency Ex. at 6-17.
[11] Hearing Recording at 15:04-20:20.
[12] Hearing Recording at 1:11:45-1:14:21 and Agency Ex. at 8.
[13] Agency Ex. at 55-67.
[14] Agency Ex. at 47-54.
[15] Agency Ex. at 48.
[16] Agency Ex. at 48.

Whether Grievant engaged in the behavior and whether the behavior constituted misconduct

On June 29, 2024, Patient 1 was hitting Patient 2 and engaging in behavior that could cause harm to Patient 2. Grievant was one of the first two Facility staff members to reach the area of the Day Room where Patient 1 was assaulting Patient 2. Grievant directed Witness 3 to call for help and instructed Patient 1 to "stop," but Grievant did not physically intervene when she first reached the patients or at any point during Patient 1's on-going assault of Patient 2.

The Agency argued that Grievant's failure to physically intervene to assist Patient 2 was within the Facility's definition of "neglect" because Grievant was responsible for providing services to Patient 2 and she failed to provide services necessary for his health, safety, or welfare. Grievant argued that she did not neglect Patient 2 because she took actions to help Patient 2 to the best of her ability when she directed Witness 3 to call for assistance and when she repeatedly tried to verbally redirect Patient 1 by instructing him to stop.[17]

The Employee Work Profile for Grievant's position made clear that she was required to "immediately intervene in dangerous situations" and "apply physical restraints to prevent a patient who presents an imminent danger to self/others from causing harm" as part of her responsibility to "maintain a safe and therapeutic environment."[18] Therapeutic Options Instructor, Chief Nurse, and Facility Director credibly testified that Facility staff, including Grievant, were required, and trained, to physically intervene to stop patients from engaging in behavior that could cause harm to the patient or others.[19] These Agency witnesses also testified that because Patient 1's behavior was physically aggressive and verbal interventions were not working, then physical intervention was required. Their testimony was supported by the testimony of Witness 2 and Witness 1, who both testified regarding their responses to the incident, their efforts to physically intervene, and their understanding of their responsibility to Patient 2.[20]

Although Grievant believed that her response to Patient 1's assault of Patient 2 was sufficient, the Agency has met its burden of proving that Grievant's job responsibilities included a duty of care to Patient 2 that required her to do more. The Agency has met its burden of proving that Grievant engaged in misconduct when she failed to physically intervene to assist Patient 2.

Whether the Agency's discipline was consistent with law and policy

Unacceptable behavior is divided into three types of offenses, according to their severity. Group I offenses "include acts of minor misconduct that require formal

[17] Hearing Recording at 2:03:52-2:06:03.
[18] Agency Ex. at 27.
[19] Hearing Recording at 28:15-29:54, 33:21-34:06, 34:35-37:48, 41:11-42:0042:18-46:05, 46:05-47:35, 49:03-59:00, 1:22:40-1:23:55, 1:11:28-1:15:30.
[20] Hearing Recording at 1:39:48-1:46:00, and 1:29:55-1:32:11.

disciplinary action."[21] Group II offenses "include acts of misconduct of a more serious and/or repeat nature that require formal disciplinary action." Group III offenses "include acts of misconduct of such a severe nature that a first occurrence normally should warrant termination."

Group III offenses include serious violations of policy, including safety or health infractions that may endanger someone, as well as significant neglect of duty. In this case Grievant owed a duty of care to Patient 2. Grievant's failure to act in this case was a serious neglect of her duty of care to Patient 2 and a serious violation of policy that might have allowed Patient 2 to suffer physical or psychological harm. The Agency's issuance of a Group III Written Notice with termination was consistent with law and policy.

Mitigation

Grievant argued that the discipline was too harsh and that the Agency failed to appropriately consider mitigating factors, including her efforts during the incident to assist Patient 2 by directing Witness 3 to call for assistance and by attempting to verbally redirect Patient 1. Grievant asserted that that the incident happened very quickly and with security personnel arriving on the scene quickly to assist. Grievant also argued that the Agency had made Grievant wary of Patient 1 by advising staff that he was "dangerous" and by providing specific training to staff to avoid manipulation by Patient 1.

The Standards of Conduct provide that an Agency may reduce the level of a disciplinary action if there are mitigating circumstances, such as conditions that compel a reduction to promote the interests of consistency, equity and objectivity, or based on an employee's otherwise satisfactory work performance.

In this case, the Agency argued that it considered mitigating factors, including Grievant's prior work performance and that she tried to verbally intervene during the incident, but the Agency determined that the discipline was warranted.

That the Agency could have further mitigated the discipline based on the facts of this case, but determined that it was inappropriate to do so, is not a reason for the Hearing Officer to conclude that the Agency's action exceeds the limits of reasonableness.

Grievant also argued that the Agency was inappropriately treating her differently from other similarly situated employees, including Witness 3 and Tech-4. Grievant's inaction was distinguishable from other staff members, including Tech-4 and Witness 3 because Grievant was among the first staff to arrive to the alcove area and Grievant did not attempt to physically intervene when she was first within reach of Patient 1 or at any time after that as she watched other staff try to intervene and Patient 1's assault on Patient 2 continue. Grievant also was the first to arrive on the left side of Patient 1 and as she watched Witness 2 and then Witness 1 attempt to grab Patient 1 from his right side, she never attempted to assist by attempting to physically intervene from Patient 1's left side.

[21] The Department of Human Resources Management ("DHRM") has issued DHRM Policy 1.60 setting forth Standards of Conduct for State employees.

Virginia Code § 2.2-3005.1 authorizes hearing officers to order appropriate remedies including "mitigation or reduction of the agency disciplinary action." Mitigation must be "in accordance with rules established by the Department of Human Resource Management…."[22] Under the Rules for Conducting Grievance Hearings, "[a] hearing officer must give deference to the agency's consideration and assessment of any mitigating and aggravating circumstances. Thus, a hearing officer may mitigate the agency's discipline only if, under the record evidence, the agency's discipline exceeds the limits of reasonableness. If the hearing officer mitigates the agency's discipline, the hearing officer shall state in the hearing decision the basis for mitigation." A non-exclusive list of examples includes whether (1) the employee received adequate notice of the existence of the rule that the employee is accused of violating, (2) the agency has consistently applied disciplinary action among similarly situated employees, and (3) the disciplinary action was free of improper motive. In light of this standard, the Hearing Officer finds no mitigating circumstances exist to reduce the disciplinary action.

The outcome of this case is unfortunate. Based on the testimony at the hearing, Grievant was a good and dedicated employee who worked well with patients and other staff. A Hearing Officer is not a super-personnel officer, however, and must give the appropriate level of deference to actions by Agency management that are found to be consistent with law and policy. In this case, the Agency has demonstrated that its actions were consistent with law and policy.

DECISION

For the reasons stated herein, the Agency's issuance to Grievant of Group III Written Notice with termination is **upheld**.

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.

[22] Va. Code § 2.2-3005.

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.[23]

Angela Jenkins

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Angela Jenkins, Esq.
Hearing Officer

[23] 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.