COMMONWEALTH OF VIRGINIA

Department Of Human Resource Management

Office of Employment Dispute Resolution

DECISION OF HEARING OFFICER

In re:

Case number: 12194

Hearing Date: January 23, 2025
Decision Issued: March 6, 2025

PROCEDURAL HISTORY

On October 2, 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:

> As a result of an investigation in accordance with DBHDS Department Instruction 201, Reporting and Investigating Abuse and Neglect of Clients, it has been determined that your actions on September 7, 2024 have been substantiated as Patient Neglect, defined as "The failure by an individual, program, or facility responsible for providing services to provide nourishment treatment, care, goods or services necessary to the health, safety, or welfare of a person receiving care or treatment in the facility." The investigation determined that you failed to physically intervene, as trained in Therapeutic Options training, to prevent two patients from becoming physically aggressive towards each other. This resulted in patient injuries. It was also determined that you failed to physically intervene after one patient began assaulting the other patient. Direct Care Staff have an obligation to provide for the safety of all patients.
>
> These actions also are in violation of DHRM Policy 1.60 Standards of conduct and constitute unsatisfactory performance and failure to follow policy and instructions, and [Facility] Policy 050-057 Reporting and Investigating Abuse and Neglect of Patients.[1]

[1] Agency Ex. at 85-87.

On October 7, 2024, Grievant timely filed a grievance to challenge the Agency's action. The matter advanced to hearing. On November 12, 2024, the Office of Employment Dispute Resolution assigned this matter to a hearing officer. A pre-hearing conference was held by that hearing officer with the parties and the hearing date was scheduled. On December 17, 2024, the Office of Employment Dispute Resolution reassigned the case to this Hearing Officer. On January 23, 2025, a hearing was held at the Facility. During the hearing, the Grievant objected to the admission of two of the Agency's exhibits. The Grievant objected to the admission of the Agency's exhibits at 143-151 which was an unsigned copy of an Employee Work Profile for the Grievant's position on the grounds that as an unsigned exhibit it was not relevant because the Grievant argued that she had not previously been provided with the Employee Work Profile. The Grievant also objected to the admission of a late exhibit by the Agency identified as Agency Exhibit page 99 which was a missing page of a previously submitted Agency policy that the Agency's Advocate asserted had been inadvertently left out of the Agency's submission of exhibits. The Hearing Officer noted the Grievant's objections but admitted all of the Agency's exhibits.[2] The Agency objected on the grounds of relevance to the Grievant's exhibit marked as Tab 4 which was information provided by a county social services investigator. The Hearing Officer noted the Agency's objection but admitted all of the Grievant's exhibits into the record.[3]

APPEARANCES

Grievant
Grievant's Advocate
Agency Advocate
Agency Party Designee
Witnesses

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?

[2]See Hearing Recording at 18:40-21:00, 3:56:37-3:58:21.
[3]See Hearing Recording at 5:11:59-5:16:40, 6:20:21-6:21:51.

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 at a Department of Behavioral Health and Developmental Services Facility. No evidence of active prior disciplinary action was introduced during the hearing.

Grievant had been trained on Therapeutic Options (previously Therapeutic Options of Virginia (TOVA)).[4] This training teaches Facility staff approved methods for managing aggressive behaviors. The same Therapeutic Options training is provided to all Facility staff who work with patients.[5]

The Facility had a Unit with Patient rooms connected to a Day Area. The Agency had a camera in the Day Area to record patients and staff. The video of the Day Area did not include sound.[6]

On September 7, 2024 during the events involved in this case, Grievant was on duty on the Unit in Continuous Supportive Observation (1:1) of Patient B, which meant that she was required to have constant visual contact with Patient B but could be no further than 20 feet away from Patient B.[7] Grievant also was required to carry a tablet computer with her while she was on continuous supportive observation of Patient B so that she could record her required checks and observations of Patient B.[8]

Based on the evidence presented, in the moments leading up to the events captured by the video, Patient B had been pacing in the Day Area and had walked close enough to Patient A that he was described as having "brushed" or "bumped" Patient A.[9]

At approximately 18:57:00, video footage from the Day Area showed a view of the Day Area that included at least five tables with chairs.[10] On the opposite side of the room

[4] Agency Ex. at 141, Hearing Recording at 2:32:34-2:34:37.
[5] Hearing Recording at 3:10:51-3:11:11, 3:25:22-3:25:53, 4:56:20-4;57:00.
[6] See Agency Ex. 2, Video footage.
[7] Hearing Recording at Hearing Recording at 2:22:28-2:24:02, 6:15:40-6:18:25 and Agency Ex. at 153-161.
[8] Hearing Recording at Hearing Recording at 2:22:28-2:24:02, 6:15:40-6:18:25 and Agency Ex. at 153-161.
[9] Agency Ex. at 12-34.
[10] See Agency Ex. at 2, video footage.

(from the camera), was what appeared to be a short hallway that was described during the hearing as leading to a laundry room.[11] Patient A was standing on the far side of the Day Area just inside the hallway. Patient A was facing the Day Room Area. Two Facility staff (DSA-1 and DSA-2) were seated in chairs positioned along each wall of the hallway so that they were facing the Day Area and were seated on each side of Patient A. Another staff member, DSA-3, was leaning on a wall of the Day Area just to the left of the small hallway and just to the left of where DSA-2 was seated. There were nurses' stations flanking each side of the Day Area. The nurses' stations had windows that appeared to allow for observation of the Day Area from inside the nurses' station.

At approximately 18:57:23, Patient B entered the portion of the Day Area in view of the camera and appeared to walk the length of the room (as captured on video) toward Patient A on the far side of the room. At approximately 18:57:26, as Patient B continued to walk toward Patient A, Grievant entered the Day Area within view of the camera and could be seen walking as she followed Patient B. Grievant was carrying a tablet computer and wearing a mask that covered her nose and mouth.

In addition to Patient A and Patient B, there were approximately 5-6 other patients in the Day Area during the incident.

Grievant testified that prior to the moments captured by the video footage, she had been trying to redirect Patient B to walk in another direction, away from Patient A, but Patient B had been ignoring her.[12]

By approximately 18:57:32, Patient B was standing in front of and facing Patient A. Patient B's back was toward the camera. Patient A was facing Patient B and the Day Area (and the camera). Grievant had followed Patient B and stood behind and to the right of Patient B to continue her observation of Patient B. Based on their movements and gestures, Patient A and Patient B appeared to speak to each other. The discussion between Patient A and Patient B appeared at times to be animated as Patient A moved his hands and made gestures while speaking to Patient B. Based on the evidence provided, during this time Patient A was telling Patient B that Patient A suffered from Post Traumatic Stress Disorder. Patient A also was asking Patient B to stop walking in such close proximity to Patient A because it was causing Patient A stress and anxiety. Patient B responded to Patient A that he was not amenable to avoid walking in the area where Patient A was standing and that he could walk where he wanted.[13] While Patient A and Patient B were speaking to each other, Grievant crossed the room, so that she was standing to the left of Patient B and in closer proximity to DSA-3. Grievant testified that as the Patients spoke to each other she attempted to verbally redirect Patient B by telling him to avoid the area where Patient A was standing and to just turn around.[14]

At approximately 18:58:13, Patient A moved closer to Patient B by taking approximately four steps toward him and Patient B took one step back and away from Patient A. At approximately 18:58:17, Patient A and Patient B moved into what appeared

[11] See Agency Ex. 2, Video footage.
[12] Hearing Recording at 5:55:51-5:57:00.
[13] See Agency Ex. at 12-34.
[14] Agency Ex. at 26-29 and see Hearing Recording at 5:55:51-5:59:42.

to be “a fighting posture” toward each other. Both Patient A and Patient B were mirroring each other’s movements, each staying in front of and facing the other. They had their arms raised as though to strike or defend against a punch. As Patient A and Patient B moved into a fighting posture, Grievant took a step back from the Patients. Grievant asserted that she attempted to verbally redirect the Patients by repeatedly telling each of them to “Stop!” and “Please don’t do this!”[15] At approximately 18:58:20, Patient A and Patient B continued to move around maintaining a fighting posture toward each other. As Patient A and Patient B moved toward the left side of the room, DSA-1 stayed closer to the right side of the room and Grievant, DSA-2, and DSA-3 stepped out of the way of Patient A and Patient B and moved toward the right side of the room. Another staff member who had entered the Day Area, DSA-4, also moved further away from the Patients and closer to the center of the room. At approximately 18:58:25, Grievant could be seen raising her right arm in what appeared to be an attempt to get the attention of staff inside the nurses’ station. Inside the nurses’ station, Nurse-1 stood up, grabbed what appeared to be a radio, and then exited the nurses’ station to move closer to the incident in the Day Area. Based on her written statement, Nurse-1 called for assistance from the Crisis Prevention Response Team before exiting the nurses’ station.[16]

At approximately 18:58:27, Patient A stood up straighter and lowered his arms. Patient B, however, appeared to maintain his fighting posture. As Patient A walked forward toward the hallway and toward the laundry room and away from the Day Area, Patient B maintained his fighting posture continuing to face Patient A and moving backward toward the hallway as Patient A moved forward toward him and the hallway. As they moved, they appeared to argue with each other including Patient A gesturing toward Patient B. As Patient A and Patient B started moving down the hallway, Grievant appeared to follow them.

At 18:58:37, Patient B turned so that his back was to the left wall of the hallway with Patient A in close proximity and facing him. Patient A and Patient B continued to engage in close proximity to each other and Patient A repeatedly pointed toward the Day Area as he spoke to Patient B. Although neither Patient A nor Patient B were in a fighting posture at this point, they appeared to be arguing in very close proximity to each other.[17]

At approximately 18:58:45, Patient A punched Patient B on the left-side of Patient B’s head/face area. Patient A then appeared to grab at Patient B and, although it is difficult to determine their specific movements, Patient A and Patient B continued to physically struggle and fight each other. DSA-2 was the staff person in closest proximity to Patient A at this time. DSA-2 appeared to step away from Patient A and Patient B. Grievant appeared to be the staff person in closest proximity to Patient B at this time and she backed away from the two Patients. At 18:58:49, the two Patients fell to the floor as they continued to fight. As the Facility staff, including Grievant, appeared to move out of the way of Patient A and Patient B, other patients in the Day Area moved closer to the fighting Patients. At 18:58:52, two other patients appeared to be standing closer to where Patient A and Patient B were fighting than any of the Facility staff. Four other patients in the Day

[15] Agency Ex. at 27.
[16] Agency Ex. at 13 and 23.
[17] See also Agency Ex. at 16 and 34.

Area appeared to be moving to get in closer proximity to the fighting Patients. At 18:58:54, DSA-2 had moved so that she was in front of and pointing to the nurses' station. At approximately 18:58:56, Grievant blew her whistle to signal that assistance was needed. At this point, Grievant was standing to the left of and appeared to be behind a patient who had moved closer to the fighting Patients. Based on the evidence, DSA-2 called out for someone to call the "Code White" and DSA-3 ran into the nurses' station and called a "Code White" (a psychiatric emergency) so that other staff would come to assist.[18]

Grievant and DSA-2 then both appeared to move closer to the Patients who were still fighting on the floor and appeared to stand over them. Based on their movements and the evidence presented, it appeared as though at this point both Grievant and DSA-2 were repeatedly shouting at the fighting Patients to "stop." The video also showed that other patients also continued to stand over the fighting patients.

At 18:59:07, another patient, Patient C, stepped between Grievant and DSA-2 to get closer to Patient A and Patient B. Based on the testimony of Grievant, Patient C moved closer to assist with breaking up the fight which, according to Grievant, patients sometimes did when there was an all-female staff on the Unit.[19] Grievant did not take measures to prevent Patient C from intervening in the fight. As Patient C reached down to try to separate Patient A and Patient B, another patient appeared to reach down toward Patient A and Patient B, it is unclear whether he too was attempting to separate the fighting Patients.

By 18:59:10, a member of the Facility's Crisis Prevention Response Team entered the area. She immediately proceeded to where the Patients were still fighting on the floor. Two other Crisis Prevention Response Team staff entered the area and also immediately proceeded toward Patient A and Patient B to attempt to separate the fighting Patients. As the Crisis Prevention Team members started to separate the Patients, Grievant could be seen to reach down toward where Patient A and Patient B were on the floor.

By 18:59:38, Patient A and Patient B appeared to have been separated. Officer-1 documented observing that Patient A was bleeding from scratches on the right side of his neck.[20]

On September 10, 2024, Patient B reported the incident and alleged that "staff sitting in the area allowed a peer to attack him." Patient B alleged that the peer "walked towards him making loud verbal threats and as the peer walked towards him the CNAs and DSAs moved out of the peer's way to enable the peer to attack him."[21]

The Facility Investigator was assigned to investigate the incident to determine whether the staff involved had neglected Patient B. The Facility Investigator issued a report of his investigation which included a recommended finding of "unsubstantiated for peer-to-peer neglect."[22] The Facility Investigator concluded that:

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[18] Agency Ex. at 12-34.
[19] Hearing Recording at 6:11:42-6:12:11.
[20] Grievant Ex. Tab 7.
[21] Agency Ex. at 35, 36. Agency Ex. at 36 appeared to be a duplicate of Agency Ex. at 35.
[22] Agency Ex. at 5-66 and see 69-70.

> there is not a preponderance of evidence to say Neglect occurred against [Patient B] by [Facility] Nursing staff. [Patient B] was noted by staff as walking back in fourth from the unit entrance door to the Laundry room. [Patient A] was standing near the entrance to the Laundry room talking to staff. [Patient B] was noted by Nursing staff as walking past [Patient A] on 2 occasions and brushing ([Patient A]) on his last pass. [Patient A] asked [Patient B] to walk in another direction twice due to ([Patient B]) triggering ([Patient A]) anxiety walking around ([Patient A]). [Patient B] was also redirected verbally by staff to please walk in another direction. [Patient B] was noted as saying "I can walk wherever I want." [Patient B] began arguing with [Patient A] and eventually got into a fighting posture. [Patient A] also got into a fighting posture. Both patients were noted as being in their fighting posture for a few seconds. [Patient A] and [Patient B] both got out of their fighting stance and began arguing verbally by the Laundry room. [Patient A] hit [Patient B] in the face and both Patients hit the floor entangled with each other. Staff on the unit blew their whistles, verbally asked both Patients to stop and called for a code white to be called. Nursing staff called the code as CPRT staff immediately came to separate both Patients. [Patient A] was taken to the Quiet room and [Patient B] was seen on camera walking towards the Quiet room but was redirected to the Common area. Nursing staff interviewed stated at the time of this incident there was not a male on the unit. [DSA-3] could not be interviewed for this investigation and subsequently resigned from [the Facility]. This investigator recommends that this investigation be Unsubstantiated for Neglect.[23]

Agency policy sets forth the procedures for investigating potential abuse or neglect of patients and provides the Facility Director with making the final determination as to whether a finding of neglect has been substantiated.[24] In this case, the Facility Director reviewed the Investigator's report and the video of the incident and determined that a finding of neglect was substantiated for individual staff members,[25] including Grievant, because he found that the staff:

> failed to intervene physically as they were trained in Therapeutic Options. While the staff report they provided verbal redirection to the two patients, they did not intervene physically when the patients engaged in a "fighting posture." After the physical assault began, the [identified staff] also failed to promptly intervene physically to stop the assault. The failure to intervene physically as trained and expected in the circumstance to provide for the safety of a patient constitutes neglect.[26]

The timing of the incident and investigation was such that Facility Director retired shortly after his review of the investigation into this matter. Therefore, Interim Facility Director also reviewed the Facility Investigator's Report and the video of the incident and

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[23] Agency Ex. at 17.
[24] Hearing Recording at 10:33-12:38, 21:35-22:56 and see Agency Ex. at 99.
[25] Agency Ex. at 69-70, 80.
[26] Agency Ex. at 80 and Hearing Recording at 9:51-12:38.

noted her concurrence with Facility Director's determination and the personnel actions taken as a result of that determination.[27]

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 such 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,[28] 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 050-057, Reporting and Investigating Abuse and Neglect of Patients[29] which defines patient abuse and neglect 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 050-057, "neglect" is defined as:

> The failure by an individual, program, or facility responsible for providing services to provide nourishment, treatment, care, goods or services necessary to the health, safety, or welfare of a person receiving care or treatment in the facility.[30]

The Facility also has adopted Policy #450-047, Management of Aggressive and Abnormal Behavior (Critical Policy),[31] which sets forth procedures for responding to aggressive and assaultive behavior. The policy defines "aggressive behavior" as "violent or harmful physical or verbal behavior directed toward self, others, or property with intensity ranging from mild to severe." "Assaultive behavior" is "violent physical behavior intended to inflict harm to other people." Policy #450-047 sets forth the following procedure for all staff to respond to aggressive behavior:

> When aggressive behavior is observed and there is a probability that it will escalate to assaultive behavior, immediately initiate non-physical interventions, and request assistance from other direct care staff as needed. If physical intervention is required immediately to ensure the safety of the patient or others, approved techniques are to be utilized. A Code White (Psychiatric Emergency) may be called if needed.
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> 1. If assaultive behavior occurs, immediately initiate interventions consistent with approved behavior intervention/management techniques to separate the involved persons and ensure the safety of all patients and staff.

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[27] Agency Ex. at 70.
[28] Agency Ex. at 90-101.
[29] Agency Ex. at 102-107.
[30] Agency Ex. at 103.
[31] Agency Ex. at 127-130.

2. Redirect others from the area and report to [Nurse Manager] or designee immediately.[32]

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

Patient A and Patient B were patients within Grievant's care and to whom Grievant owed a duty of care, including a duty to take measures to keep them safe from their own aggressive and assaultive behavior. Based on the Agency's definition of neglect, Grievant engaged in misconduct when she failed to take the measures she reasonably was expected to take to intervene when Patient A and Patient B engaged in aggressive behavior.

The Facility has made clear the expectation that all staff are required to "immediately initiate non-physical interventions" when "aggressive behavior is observed and there is a probability that it will escalate to assaultive behavior." There did not appear to be a dispute that at the point when the Patients moved into a fighting posture, there was a probability that the Patients' aggressive behavior would escalate to assaultive behavior.

Although Grievant engaged in non-physical interventions, Grievant and the Agency disagreed as to whether her interventions were sufficient to ensure the safety of the Patients.

Based on the definitions of "aggressive behavior" and "assaultive behavior" it was clear that Patient A's behavior escalated to "assaultive behavior" when he hit Patient B. Prior to the point when Patient A hit Patient B, however, the Patients' behavior appeared to fall within the Agency's definition of "aggressive behavior" and there was no evidence presented to suggest otherwise.

The Agency appeared to argue that because of the nature of the escalation of the Patients' aggressive behavior to the point where the Patients were in a fighting posture, Grievant should have taken additional steps, including physical interventions, to separate the Patients consistent with Policy #450-047.

The Agency witnesses testified that as Patient A and Patient B were arguing about Patient B walking by Patient A, Grievant should have been doing more to de-escalate the situation.

Based on the Agency witnesses' testimony, once the Patients moved into a fighting posture, Grievant should have taken immediate actions to blow her whistle for additional help and to de-escalate and separate the Patients.

Facility Director and TO Coordinator both testified that when Patient A and Patient B's dispute rose to the level where they each moved into a "fighting posture," Grievant and the other staff present were required to physically intervene to separate the Patients

[32] Agency Ex. at 128.

in order to ensure the safety of the Patients rather than moving out of the way of the Patients as Grievant and the other DSAs did.[33] Interim Facility Director and Chief Nurse Executive were less clear in their testimony as to when Grievant should have physically intervened prior to the moment when Patient A hit Patient B. Interim Facility Director and Chief Nurse Executive both testified, however, that throughout the incident Grievant was expected to do more to de-escalate the situation to ensure the safety of the Patients. Interim Facility Director testified that consistent with her training Grievant should have blown her whistle to get help when Patient B was walking toward Patient A because, according to Interim Facility Director, that was a potential cue of the potential for more aggressive behavior by Patient B toward Patient A. Interim Facility Director also testified that when the Patients first moved into a fighting posture Grievant, consistent with her training, should have immediately blown her whistle. Interim Facility Director also appeared to suggest that rather than move away from the Patients, Grievant and the other DSAs should physically have gotten between the Patients to re-direct and de-escalate the situation.[34]

When Patient A hit Patient B, it was clear that the aggressive behavior had become assaultive, and the Agency argued that Grievant should have physically intervened to separate the Patients. Grievant had approximately four seconds to act from the time that Patient A hit Patient B until the two Patients fell to the floor. That may have been time for Grievant to blow a whistle or perhaps to start trying to position herself to engage in further intervention, but it was not clear that Grievant had sufficient time to put down the Agency-issued tablet computer and physically intervene before the Patients fell to the floor. Further, the Agency did not provide any evidence of its instructions to employees equipped with a tablet computer regarding its expectations for how an employee was to responsibly manage the Facility tablet computer while responding to aggressive behavior. Chief Executive Nurse testified that there was no written policy or guidance telling staff that they could not put the tablet down to physically intervene, but she also did not provide any information as to what, if any, instructions staff were provided when they were charged with managing Facility property, patient data, and ensuring patient safety.[35]

Once the Patients were on the floor fighting, Grievant's decision to not intervene physically appeared to be consistent with the evidence presented during the hearing that Facility staff have been trained to only utilize "approved" methods when engaging physically with patients and that staff have not been trained in "approved" methods to separate two patients while those patients are fighting on the floor.[36]

Agency witnesses testified that at the point that the Patients were on the floor fighting, consistent with Policy #450-047, Grievant and the other staff involved should have prevented other patients from intervening or otherwise becoming involved in the fight.

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[33] Hearing Recording at 9:51-12:38, 27:25-28:48, 2:41:12-2:47:06, 3:00:12-3:04:37 and see Agency Ex. 80.
[34] Hearing Recording at 45:19-1:04:44, 1:07:50-1:15:21, 1:17:14-1:25:43, 1:28:04-1:34:22.
[35] Hearing Recording at 3:41:45-3:43:46, 3:43:46-3:44:28, but see Hearing Recording at 4:41:25-4:42:57, 4:46:47-4:47:08, 5:02:13-5:03:33, 5:09:10-5:10:42, 5:25:33-5:27:58, 6:06:48-6:08:58.
[36] See Hearing Recording at 31:13-33:02, 2:52:10, 2:58:36-2:59:17, 4:51:40-4:52:00, 5:09:10-5:10:42 and Agency Ex. 127-130.

According to Grievant, she had not been trained to know that when Patient B was walking toward Patient A that was an early cue to aggressive behavior by Patient B. And Grievant did not perceive their interaction initially as an argument or an emergency, but a dialogue. Grievant testified that she had been trying to verbally re-direct Patient B before he approached Patient A, but that he ignored her. According to Grievant, she continued her efforts to verbally re-direct Patient B when he and Patient A were discussing Patient A's concerns with where Patient B walked. Grievant testified that she attempted to verbally re-direct both Patients when they moved into a fighting posture. Grievant argued that her decision to verbally re-direct the Patients to "Stop!" and "Please Don't Do This!" was consistent with Agency training that staff should first attempt non-physical intervention with aggressive behavior and the admonition that TO Coordinator provided to staff during the Therapeutic Options training when he told them to "know your limits" and "stay safe." Grievant testified that while the Patients were in a fighting posture, she also blew her whistle and tried to get the attention of the nurse in the nurses' station. Grievant testified that she previously had been instructed to not put the tablet computer down because the tablet could be used as a weapon, broken, or reveal sensitive data. According to Grievant she had never been trained as to how to physically intervene while managing a tablet.[37] Finally Grievant argued that she was hesitant to physically intervene with the Patients because they were both physically larger and stronger than her. Grievant also asserted that she was afraid of Patient B because he had made threats to Grievant, and she was aware of him violently attacking other staff.[38]

Based on the evidence, it was not clear to this Hearing Officer that Grievant's failure to physically intervene during the incident constituted neglect. The Agency has proved, however, that Grievant's failure to immediately blow the whistle when Patient A took steps toward Patient B and the Patients first moved into their fighting postures was misconduct that constituted "neglect" as defined by the Agency because of the duty Grievant owed to the Patients to provide services necessary for their safety.

Patient B and Patient A were patients within Grievant's care and to whom Grievant owed a duty of care, including keeping them safe from their own aggressive and assaultive behavior.[39] The preponderance of the evidence showed that the Patients' behavior had been escalating for some period of time even before the events captured by the video. The statements witnesses made to the Facility Investigator showed that at least during some of that time, Patient B had been walking near and "brushing" or "bumping" Patient A before Patient B again walked toward Patient A at the beginning of the incident captured on the video.[40] To the extent Grievant had attempted to verbally re-direct Patient B prior to, or as he approached Patient A, when those efforts failed and the Patients' behavior escalated from "discussing" where Patient B could walk to Patient A taking steps toward Patient B and the two Patients moving into their fighting postures, the preponderance of the evidence showed that the Agency had a reasonable expectation that Grievant's efforts also would have escalated, including blowing her whistle immediately in order to get additional help to de-escalate the situation, separate the

[37] Hearing Recording at 6:06:48-6:08:58 and see Hearing Recording at 4:41:25-4:42:57, 4:46:47-4:47:08, 5:02:13-5:03:33, 5:09:10-5:10:42, 5:25:33-5:27:58.
[38] Hearing Recording at 5:55:51-5:59:42, 6:02:00-6:03:24, 6:06:48-6:08:58, 6:15:40-6:17:38.
[39] Hearing Recording at 2:22:28-2:24:02, 6:15:40-6:18:25, Agency Ex. at 153-161.
[40] Agency Ex. at 12-34.

Patients, and prevent the Patients from hurting themselves and each other.[41] Based on Grievant's testimony, she was concerned about Patient B potentially engaging in violent behavior toward her. While Grievant's concerns about Patient B might explain why she would not immediately attempt to physically intervene with Patient B, they do not explain, or excuse, her failure to take immediate action to protect Patient A from Patient B by immediately blowing her whistle to signal that additional help was needed to separate the Patients. Particularly if, as she testified, she had concerns about the potential for violence by Patient B. As the Patients' posturing continued, Grievant waved her arm to get the attention of Nurse-1 in the nurses' station and it appeared that Nurse-1 responded at that time. There was varying evidence as to when Grievant first blew her whistle, however, based on this Hearing Officer's review of the video and Grievant's written statement to the Facility Investigator, Grievant appeared to first blow her whistle after Patient A hit Patient B.[42] Even assuming, however, that Grievant first blew her whistle at the same time that she waved her arm to get the attention of Nurse-1, the Agency had a reasonable expectation that Grievant would have blown her whistle sooner and immediately when the Patients' behavior escalated to Patient A taking steps toward Patient B and the Patients then moving into their fighting postures. Once the Patients were on the floor fighting, Grievant was required to take steps to prevent other patients from becoming involved in the fight. Although based on Grievant's statement to the Facility Investigator she stayed near Patient B as a way to try to keep other patients from engaging in the fight, there was no evidence to suggest that she attempted to re-direct or stop Patient C from intervening in the fight.[43] Even if Patient C was motivated to help improve the situation, as Grievant appeared to suggest, Agency policy and Grievant's duty of care to the patients required her to try to stop Patient C from becoming involved in the altercation between Patient A and Patient B.

The preponderance of evidence showed that Grievant engaged in misconduct when she failed to meet the Agency's reasonable expectations that, when Patient A stepped toward Patient B and the Patients moved into their fighting postures, she would have taken immediate measures to get additional help to de-escalate and separate the patients by blowing a whistle in addition to yelling at the Patients to "stop" and "don't do this." Additionally, the evidence showed that Grievant was required to take additional steps to keep the other patients, including Patient C, from intervening in the fight between Patient A and Patient B. The Agency has met its burden of proving that Grievant's misconduct was neglect as defined by the Agency.

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 disciplinary action."[44] Group II offenses "include acts of misconduct of a more serious and/or repeat nature that require formal disciplinary action." Group III offenses "include

[41]Hearing Recording at 9:51-12:38, 27:25-28:48, 2:41:12-2:47:06, 3:00:12-3:04:37, 45:19-1:25:43, 1:28:04-1:35:24, 3:49:22-3:51:36, see also 2:22:28-2:24:02, 2:26:40-2:28:09.
[42] Agency Ex. 2, video footage and Agency Ex. 26-29.
[43] See Hearing Recording at 6:11:42-6:12:11.
[44] See DHRM Policy 1.60, Standards of Conduct.

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. The Agency's issuance of a Group III Written Notice with termination was consistent with law and policy.

Mitigation

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…."[45] 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.

DECISION

For the reasons stated herein, the Agency's issuance to Grievant of a 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.

[45] Va. Code § 2.2-3005.

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.[46]

Angela Jenkins

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Angela Jenkins, Esq.
Hearing Officer

[46] 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.

COMMONWEALTH OF VIRGINIA

Department Of Human Resource Management

Office of Employment Dispute Resolution

DECISION OF HEARING OFFICER

In re:

Case number: 12194-R

Reconsideration Decision Issued: April 22, 2025

PROCEDURAL HISTORY

On October 2, 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:

> As a result of an investigation in accordance with DBHDS Department Instruction 201, Reporting and Investigating Abuse and Neglect of Clients, it has been determined that your actions on September 7, 2024 have been substantiated as Patient Neglect, defined as "The failure by an individual, program, or facility responsible for providing services to provide nourishment treatment, care, goods or services necessary to the health, safety, or welfare of a person receiving care or treatment in the facility." The investigation determined that you failed to physically intervene, as trained in Therapeutic Options training, to prevent two patients from becoming physically aggressive towards each other. This resulted in patient injuries. It was also determined that you failed to physically intervene after one patient began assaulting the other patient. Direct Care Staff have an obligation to provide for the safety of all patients.
>
> These actions also are in violation of DHRM Policy 1.60 Standards of conduct and constitute unsatisfactory performance and failure to follow policy and instructions, and [Facility] Policy 050-057 Reporting and Investigating Abuse and Neglect of Patients.[1]

[1] Agency Ex. at 85-87.

On October 7, 2024, Grievant timely filed a grievance to challenge the Agency's action. The matter advanced to hearing. On November 12, 2024, the Office of Employment Dispute Resolution assigned this matter to a hearing officer. A pre-hearing conference was held by that hearing officer with the parties and the hearing date was scheduled. On December 17, 2024, the Office of Employment Dispute Resolution reassigned the case to this Hearing Officer. On January 23, 2025, a hearing was held at the Facility. The Hearing Officer issued a decision in this case on March 6, 2025.[2]

Grievant timely requested an administrative review of the Hearing Officer's decision.

On April 4, 2025, the Office of Employment Dispute Resolution (EDR) issued Administrative Review Ruling 2025-5851 (the EDR Ruling), remanding the case to the Hearing Officer for further consideration as follows:

> The hearing officer essentially found that the grievant should have taken more non-physical steps to intervene in the conflict between the two patients by blowing her whistle or making further verbal statements. The hearing officer also appears to find that the grievant failed to take additional steps to prevent other patients from intervening in the situation. However, it is not clear based on EDR's review of the Written Notice issued to the grievant that such misconduct is properly encapsulated by the charges described therein. Both the former Facility Director's findings as to why neglect had allegedly occurred and the description of those findings in the Written Notice find the grievant at fault for failing to physically intervene in the altercation. The hearing officer did not appear to sustain that aspect of the disciplinary action. However, the hearing officer's finding in this regard requires further clarification in that she determined it was "not clear" whether the grievant's failure to physically intervene was neglect. While we would interpret the hearing officer's statements to suggest that a preponderance of the evidence did not support a finding that the grievant engaged in neglect by failing to physically intervene, we would also acknowledge that such a definitive determination was not made in the decision.
>
> Thus, on remand, the hearing officer must clarify her findings as to whether the record evidence supports a finding of neglect for the grievant's failure to physically intervene. If the hearing officer finds that the agency has not carried its burden of proof in this regard, then the hearing officer must determine whether the Written Notice charges any other misconduct beyond the failure to physically intervene, such as the failure to intervene in a non-physical way or the failure to further prevent other patients from intervening. Based on EDR's review, it is not clear that the Written Notice extends to any misconduct other than the grievant's failure to physically intervene in the altercation itself. If the hearing officer so finds, then the only

[2] Decision of Hearing Officer, Case No. 12194 ("Hearing Decision"), Mar. 6, 2025.

reasonable result is for the Written Notice and the grievant's termination to be rescinded in full.[3]

RECONSIDERATION DESCISION

The Findings of Fact set forth in the original Hearing Decision for Case No. 12194 are incorporated by reference. Upon reconsideration, the Hearing Officer provides the following clarifications:

The Written Notice that the Agency issued to Grievant charged Grievant with patient neglect based on the results of an investigation that determined that Grievant "failed to physically intervene, as trained in Therapeutic Options training, to prevent two patients from becoming physically aggressive towards each other" and that Grievant "failed to physically intervene after one patient began assaulting the other patient."[4] Although the Written Notice alleged that "these actions" violated various Agency policies, Grievant's failure to "physically intervene" was the only "action" or behavior that the Written Notice identified as the misconduct of patient neglect for which Grievant was disciplined. The Written Notice did not identify any other behavior by Grievant as misconduct.

Additionally, and to clarify, the preponderance of the evidence in this case did not support a finding that Grievant's failure to physically intervene constituted the misconduct of patient neglect.

The evidence showed that Facility Policy #450-047, Management of Aggressive and Abnormal Behavior (Critical Policy), left to staff discretion to determine when *physical* intervention was *required* when patients' behavior was aggressive but not yet assaultive.[5] A decision to physically intervene with a patient is a serious undertaking because of the potential risk of injury or harm to the patient and staff, therefore the Agency requires that staff physically intervene only when necessary and only by approved methods. Although there was testimony during the hearing that Grievant was trained in approved methods for managing aggressive behavior, there was limited information provided during the hearing as to how Facility staff were trained to exercise the discretion afforded by the language in the Policy #450-047, including how they were to determine when aggressive behavior that was not yet assaultive had risen to a level that *required* physical intervention. In addition to the discretion afforded by the Facility's policy, as noted in the original Hearing Decision, in this case, Grievant was equipped with a tablet computer, however, the Agency did not provide any evidence of its instructions to staff as to how to responsibly manage that Facility property, including patient data, while also ensuring

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[3] See Office of Employment Dispute Resolution, Administrative Review Ruling 2025-5851 (Apr. 4, 2025) at 7-8. (footnotes omitted).
[4] Agency Ex. at 85-87.
[5] As noted in the original Hearing Decision, based on the definitions of "aggressive behavior" and "assaultive behavior" it was clear that Patient A's behavior escalated to "assaultive behavior" when he hit Patient B. Prior to the point when Patient A hit Patient B, however, based on the evidence presented the Patients' behavior appeared to fall within the Agency's definition of "aggressive behavior." See Hearing Decision at 9.

patient safety and responding to aggressive behavior.[6] Reflective of the discretion allowed by the Facility's policy for staff to determine when physical intervention was required, this Hearing Officer found the testimony of the Agency's witnesses to be inconsistent and unclear as to how or when Grievant was *required* to intervene *physically* as both Patients moved around the room prior to the moment when Patient A's behavior became assaultive (i.e., when he hit Patient B). Although Facility Director and TO Coordinator both testified that when Patient A and Patient B's dispute rose to the level where they each moved into a "fighting posture," physical intervention was required, this Hearing Officer found the testimony of Interim Facility Director and Chief Nurse Executive to be less clear as to when physical intervention was *required* prior to the moment when Patient A hit Patient B. All of the Agency's witnesses described additional *non-physical* measures that Grievant should have utilized throughout the period of the Patients' aggressive behavior.[7] To clarify and upon reconsideration, based on the Facility's policy that appeared to require non-physical intervention, but allowed discretion to determine when *physical* intervention was necessary, an absence of any instruction to staff as to how to manage the Facility's tablet computer if they observed aggressive behavior, and the inconsistent testimony of the Agency's witnesses as to when the Patients' aggressive behavior *required* physical intervention prior to the moment when Patient A's behavior became assaultive, the preponderance of the evidence did not support a finding that Grievant engaged in misconduct when she failed to intervene physically during the Patients' aggressive behavior.

As further clarification, the preponderance of the evidence also did not support a finding that Grievant engaged in misconduct when she failed to intervene physically after the Patients' behavior became assaultive. When Patient A hit Patient B, it was clear that their aggressive behavior had become assaultive, and the Agency argued that Grievant should have physically intervened to separate the Patients. Grievant had approximately four seconds to act from the time that Patient A hit Patient B until the two Patients fell to the floor. That may have been time for Grievant to blow a whistle or perhaps to start trying to position herself to engage in further intervention, but the evidence did not show that Grievant had sufficient time to put down the Agency-issued tablet computer and physically intervene before the Patients fell to the floor. Once the Patients were on the floor fighting, Grievant's decision to not intervene physically appeared to be consistent with the evidence presented during the hearing that Facility staff have been trained to only utilize approved methods when engaging physically with patients and that staff have not been trained in approved methods to separate two patients while those patients are fighting on the floor.[8]

The Agency has not met its burden of proving by a preponderance of the evidence that Grievant's failure to physically intervene during the incident constituted misconduct.

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[6] Hearing Recording at 3:41:45-3:43:46, 3:43:46-3:44:28, but see Hearing Recording at 4:41:25-4:42:57, 4:46:47-4:47:08, 5:02:13-5:03:33, 5:09:10-5:10:42, 5:25:33-5:27:58, 6:06:48-6:08:58.
[7] Hearing Recording at 9:51-12:38, 27:25-28:48, 2:41:12-2:47:06, 3:00:12-3:04:37, 45:19-1:04:44, 1:07:50-1:15:21, 1:17:14-1:25:43, 1:28:04-1:34:22 and see Agency Ex. 80.
[8] See Hearing Decision at 10.

Because the Group III Written Notice that was issued to Grievant did not identify any other behavior by Grievant as misconduct, the Agency's discipline cannot be upheld and must be rescinded.

RECONSIDERATION ORDER

For the reasons stated herein, the Agency's issuance to Grievant of a Group III Written Notice of disciplinary action with termination is **rescinded**. The Agency is ordered to **reinstate** Grievant to Grievant's same position prior to removal, or if that position is filled, to an equivalent position. The Agency is directed to provide **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 reconsidered decision was issued on any new matter addressed in the reconsideration decision. 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 and, if ordered by DHRM, the hearing officer has issued a revised decision.

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.[9]

Angela Jenkins

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Angela Jenkins, Esq.
Hearing Officer

[9] 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.