WEST VIRGINIA PUBLIC EMPLOYEES GRIEVANCE BOARD

CRYSTAL SPURLOCK,

Grievant,

v. **Docket No. 2019-1863-CONS**

DEPARTMENT OF HEALTH AND HUMAN RESOURCES/ WILLIAM R. SHARPE, JR. HOSPITAL,

Respondent.

DECISION

Grievant, Crystal Spurlock, was employed at Sharpe Hospital by Respondent, the Department of Health and Human Resources. On May 10, 2019, Grievant was suspended pending investigation of allegations that she ordered mechanical restraints on a patient and falsely charted behaviors she had not actually witnessed. On May 13, 2019, Grievant filed a grievance under docket number 2019-1613-DHHR alleging, "Indefinite suspension without good cause." As relief, Grievant requested, "To be made whole in every way including back pay with interest and benefits restored." On June 25, 2019, Grievant filed a second grievance under docket number 2019-1802-DHHR alleging, "Respondent refused to conduct predetermination." As relief, Grievant requested "to be made whole in every way including back pay with interest and benefits restored and removal of all discipline."

These grievances were filed directly to level three pursuant to W. VA. CODE § 6C-2-4(a)(4). On July 17, 2019, the grievances were consolidated under the current action. On August 2, 2019, Grievant was dismissed for the same allegations that led to her suspension. The parties agree that the only matter now being grieved is the dismissal.

A level three hearing was held before the undersigned over the course of three days: September 23, 2020; April 20, 2021; and May 19, 2022.[1] Grievant was represented by Gregory Schillace, Esq. Respondent was represented during the first two days of hearing by Brandolyn Felton-Ernest, Assistant Attorney General, and thereafter by Steve Compton, Deputy Attorney General.

On the third day of hearing, attorney Schillace indicated that there existed possible exculpatory evidence that had not been provided by Respondent or even made a part of any investigative report. This evidence allegedly included contemporaneous restraint reports and investigative interview notes. The parties agreed that these would be provided to Grievant after the final day of hearing. Grievant raised the possibility of submitting these into the record after reviewing them. The parties agreed to a July 1, 2022, deadline to submit Proposed Findings of Fact and Conclusion of Law (PFFCL). The undersigned informed Grievant that any move for submission of the new exhibits must be by this deadline. Grievant received the new exhibits from Respondent on May 22, 2019,[2] but did not move for their submission by the July 1st deadline.

Respondent submitted its PFFCL on July 1st. On July 6, 2022, Grievant submitted her PFFCL and two new exhibits which she claims are exculpatory. Grievant contends these new exhibits show that she did not order the restraints. Grievant requests these exhibits be entered into the record and an adverse inference made due to spoilation of evidence.[3]

---

[1]The gap between hearings resulted from scheduling issues between the parties.
[2]As stated in Grievant's PFFCL.
[3]The Grievance Board has held that an adverse inference is appropriate where, upon weighing four factors, the administrative law judge concludes that spoliation has occurred. The administrative law judge must consider and weigh the following factors: (1) the party's

On July 8, 2022, Respondent filed *Respondent's Objection to Grievant's Motion to Supplement Record and Motion to Strike Grievant's Findings of Fact and Conclusion of Law as Untimely*. The undersigned sustained Respondent's objection to the new exhibits, as Grievant did not submit these exhibits by the July 1st deadline. Thus, Grievant's spoilation argument is premature. Regardless, Grievant failed to effectively allege spoilation because she did not argue the documents were missing or destroyed. As for Respondent's motion to strike Grievant's late submission of PFFCL, the undersigned denied this request but offset any unfair advantage by allowing Respondent to file supplemental PFFCL. Respondent timely filed supplemental PFFCL on July 26, 2022,[4] whereupon this matter matured for decision.

Synopsis

Grievant was dismissed from her employment as an RN at Sharpe Hospital by Respondent, the Department of Health and Human Resources. Respondent alleged that Grievant improperly ordered mechanical restraints on a patient, but it failed to have any eyewitness testify. Respondent instead chose to rely on inaudible video evidence and hearsay that garnered little weight. It thus failed to prove that Grievant ordered the restraints. Respondent also claimed that Grievant "falsely charted behaviors [she] had

---

degree of control, ownership, possession or authority over the undisclosed evidence; (2) the amount of prejudice suffered by the grievant as a result of the missing or destroyed evidence and whether such prejudice was substantial; (3) the reasonableness of anticipating that the evidence would be needed for the grievance; and (4) if the party controlled, owned, possessed or had authority over the evidence, the party's degree of fault in failing to produce the evidence. The party requesting the adverse inference based upon spoliation of evidence has the burden of proof on each element of the four-factor test. See Syl. Pt. 2, *Tracy v. Cottrell*, 206 W. Va. 363, 524 S.E.2d 879 (1999); *Hannah v. Heeter*, 213 W. Va. 704, 584 S.E.2d 560 (2003).

[4]The original July 21st deadline for supplemental PFFCL was extended to July 29th for good cause in conjunction with Respondent's timely request.

not actually witnessed." Respondent did not prove that this or Grievant's failure to initially differentiate hearsay from firsthand information was false charting. Respondent thus failed to prove good cause for dismissal. This grievance is therefore GRANTED.

The following Findings of Fact are based upon a complete and thorough review of the record created in this grievance.

Findings of Fact

1. Grievant, Crystal Spurlock, was employed at Sharpe Hospital (Sharpe) by Respondent, the Department of Health and Human Resources (DHHR), as a registered nurse (RN) at the time of her dismissal.

2. Sharpe is a State-owned psychiatric hospital operated by DHHR. Sharpe houses patients suffering from mental illness, some of whom are forensic patients charged with or convicted of violent crimes.

3. Grievant was the RN in charge on Unit G1 the evening of May 5, 2019.

4. Patient JY[5] was a forensic patient on Unit G1 that same evening. As a forensic patient, Patient JY was either charged with or convicted of a violent crime and was deemed unpredictable and aggressive.

5. If a patient is deemed an imminent danger to himself or others, the patient can be placed in mechanical restraints when less restrictive measures are ineffective.

6. At 19:04 on the evening of May 5, 2019, Patient JY triggered a CO2 alarm through aggressively and repeatedly tapping it. Staff attempted to calm Patient JY by talking to him, but he would not be calmed and continued tapping. Patient JY was therefore administered anti-psychotic medication and sent to his room.

[5]Initials are used to protect a patient's identity.

7. In his room, Patient JY used his shoe to knock the head off the sprinkler system, causing Unit G1 to flood.

8. All patients on Unit G1 were eventually transferred to Unit N2, an empty unit on a different floor, while Patient JY remained on Unit G1.

9. A support team (comprised of HSW[6] Joshua Hitt, HSW Alan Stevens, LPN[7] Brandon Smith, HSW James Karp, and HSW Randy Riggins) was called on to manage Patient JY.

10. Patient JY willingly received medication to calm him, asked permission to lay down in a quiet room, and was taken to a seclusion room on Unit G1.

11. After calmly laying down in the seclusion room, Patient JY suddenly jumped up and again knocked a sprinkler head off with his shoe.

12. In conjunction with the Guidelines for Restraints and Seclusion (Policy 45.106), restraints must be applied in accordance with a physician's order, unless it is an emergency. An RN may initiate an emergency application of restraints prior to obtaining an order from a physician if no physician is "immediately available." The use of restraints must be documented in the patient's treatment or care plan. (Respondent's Exhibit 9)

13. Mechanical restraints must only be applied under the constant supervision of an RN, a doctor, or a physician's assistant. (Respondent's Exhibit 9)

14. Brittany Cross is employed at Sharpe as a physician's assistant (PA). She was on call the evening of May 5, 2019, and was considered the attending physician at

[6]Health Service Worker.
[7]Licensed Practical Nurse.

the time of the incident. Thus, she would have been the one with authority to approve mechanical restraints that evening.

15. Grievant was authorized to initiate restraints on an emergency basis if PA Cross was not immediately available. This would have required her to obtain an order from PA Cross and to document the restraints in Patient JY's treatment plan.

16. PA Cross was called and arrived on Unit G1 that evening to assist with Patient JY. She was therefore immediately available. This obviated any perceived need for Grievant to order restraints on an emergency basis.

17. Once on Unit G1, PA Cross conversed with Grievant about Patient JY and the possibility of placing him in mechanical restraints.

18. Since all patients had been evacuated from Unit G1 due to the flooding, it was determined that Patient JY also needed to be evacuated. After conversing with PA Cross, Grievant directed the support team to bring Patient JY and the bag containing mechanical restraints to Unit N2, as Unit N2 was unoccupied and not equipped with necessary supplies for standard operation.

19. Thus, it was appropriate for Grievant to direct the support team to bring mechanicals restraints to Unit N2 to be available if needed. (PA Cross' testimony)

20. There is no direct evidence that Grievant took the next step of ordering the support team to apply restraints to Patient JY, and none of the apparent eyewitnesses were called to testify.

21. The support team took Patient JY to Unit N2, unaccompanied by Grievant. Once there, Patient JY again willingly complied and calmly laid down.

22. Nevertheless, between 22:02 and 22:04,[8] the support team put Patient JY in mechanical restraints even though no RN, PA, or physician was present to supervise the restraints as required by policy. (Respondent's Exhibits 3, 4, 8, & 11)

23. Some of the support team members felt that JY posed a danger even when externally calm, due to his unpredictability and aggressiveness. (Respondent's Exhibits 3 & 8)

24. Grievant was not present on Unit N2 when the restraints were applied to Patient JY but remained on Unit G1 to secure patient medicines and charts.

25. RN Christina O'Baker was the charge nurse on Unit N2 and the only person on the unit when mechanical restraints were applied that had the authority to issue an emergency order and supervise restraints. However, RN O'Baker was not in the seclusion room with Patient JY when restraints were initiated and there is no evidence that she ordered the restraints.

26. Between 22:10 and 22:14, PA Cross arrived on Unit N2, assessed Patient JY, and directed the support team to keep Patient JY in mechanical restraints. (Respondent's Exhibits 3, 4, 8, & 11 and PA Cross' testimony)

27. At 22:45, PA Cross entered a required progress note in Patient JY's medical record to justify the restraints. It states in part:

> [Patient JY] was refusing verbal redirection following pulling 2 sprinklers and flooding the unit. He was threatening to continue this behavior once relocated due to the flood. … He continued to yell and argue. He yelled at this provider with clenched fists and was attempting to sit up in the bed while restrained. … [Patient JY] was **still** yelling at this provider

[8]The times given by eyewitnesses differ from time stamps on the video evidence. Even though one lags the other by a few minutes, there is no indication as to which is more accurate.

> when seen at 2210 and threatening to continue pulling down sprinklers and destroy state property. Restraint needs to be continued. … Restraint or seclusion episode and treatment plan reviewed with the available treatment team and no further modification is indicated at this time. [emphasis added]

(Respondent's Exhibit 11)

28. However, the evidence shows that Patient JY was calm and compliant when PA Cross ordered that he be kept in restraints. (Respondent's Exhibits 3, 4, 8, & 11)

29. Grievant first went to Unit N2 to assess Patient JY between 22:40 and 22:45, well after PA Cross had assessed Patient JY. After determining that Patient JY was not a danger to himself or others, Grievant directed that the restraints be removed. (Respondent's Exhibits 3, 4, 8, & 11 and Grievant's testimony)

30. On May 6, 2019, at 00:54, Grievant completed a progress note to Patient JY's medical record, stating in part:

> Patient [JY] continues to threaten to destroy State property[.] He is posturing as though to strike [PA Cross]. … Time RN Assessed Patient: 2202 …Patient was released at 2240 after agreeing to safety to self and others. Patient agreed to not damage property[.] He appears to be calm and is no longer verbalizing threats or posturing aggressively[.]

(Respondent's Exhibit 10)

31. On May 6, 2019, at 02:12, Grievant added to the progress note, stating:

> Patient had knocked off two fire sprinklers on Unit G1 and flooded the unit. When the unit was moved downstairs to Unit N2 [Patient JY] threatened [PA Cross] that he was going to break a sprinkler on the unit also. He then got very close to [PA Cross] and was standing in a threatening posture with his hands clenched into fists. Patient stated to [PA Cross] that he was going to continue to destroy sprinklers and was going to hurt people. [PA Cross] ordered mechanical restraints at that time. Patient was placed in mechanical 4-point restraints. Vital signs were measured, circulation check was done, hydration and nutrition were offered and refused, elimination was

> offered and the patient reported a need for urination. A receptacle was brought to the patient and after attempting to urinate he reported that he could not. Range of motion was assessed. Criteria for release was stated to the patient. He was straining at the restraints and had an aggressive affect.

(Respondent's Exhibit 10)

32. On May 6, 2019, Grievant submitted the following written statement to Adult Protective Services (APS):

> Pt. [JY] stood on his bed and used his shoe to knock that fire sprinkler off the ceiling in his room. He was taken to the day area. Pt. requested to go and lie on the bed in the quiet room. He had accepted a PRN medication. Earlier in the shift pt. had been walking and hitting the CO alarm on the wall setting off the alarm. He had agreed to go to his room, saying he was going to break something else. Pt.was on CCO with order for attendant to sit outside pt's room when pt was in his room. When pt was in quiet room, CCO was outside the room watching him. Pt. lay quietly for a moment, then jumped up and hit the fire sprinkler on the ceiling with his shoe. That sprinkler also began flooding the Unit. B. Cross was present on the Unit as I called her again. She ordered additional medication for the patient. Pt was sitting in the day room, the floors of the Unit were flooding and a call came to move the patients to another unit. Pt walked to the other unit with Support Team personnel. When he arrived he was given the quiet room to sleep in. Again the door was open with the attendant outside the door. [Patient JY] threatened that he was going to break a sprinkler on that unit also. [Patient JY] approached the PA-C[ross] and was standing in a threatening posture with his fists clenched. Pt stated the PA-C[ross] that he was going to continue to destroy sprinklers and hurt people. PA C[ross] asked for mechanical restraints at that time. [Patient JY] was placed in 4-pt mechanical restraints at 2202. PA-C[ross] returned to the room where patient was fighting against restraints. Pt was informed of criteria for release. Vital signs were measured, circulation was checked and found WNL, hydration and nutrition were refused, elimination was offered[.] [P]t asked urinate and receptacle was brough, he then stated he was unable to urinate. Range of motion was assessed. Criteria for release was again stated to the patient. He continued to strain against restraints, he had an aggressive affect. When patient stated he was calm and

> would not hurt others or property[,] [h]e was released from restraints at 2240. Pt was calm and rested in the bed continuing CCO.

(Respondent's Exhibit 2 & 3)

33. After receiving a complaint that the restraints may have been unnecessary and improper, Respondent summarily suspended Grievant pending investigation since she was the charge nurse on Unit G1 that evening. No other employee was suspended pending investigation.

34. Investigations were conducted by Legal Aid of West Virginia (LAWV) and APS.

35. The APS investigation was led by Sharpe employees Randall McDaniels[9] (an Infection Control Coordinator) and Shawna Huddle[10] (a Survey Coordinator).

36. The LAWV investigation was led by LAWV employee Sharoon Reed (a Behavioral Health Advocate).

37. Even though investigators recorded their interviews and took notes,[11] they did not submit these at the hearing or as part of their reports. (Ms. Reed & Ms. Huddle's testimony)

38. After talking to witnesses and viewing video evidence, APS and LAWV investigators concluded that Grievant was the one who ordered that Patient JY be placed in mechanical restraints.

---

[9]Mr. McDaniels' level three testimony was stricken from the record on agreement of the parties because the witness was unavailable for cross examination.
[10]Ms. Huddle has since been promoted to Interim Chief Nursing Officer.
[11]Some of these notes were provided to Grievant after the hearing and were part of the late submission excluded by the undersigned.

39. Investigators concluded that Patient JY was calm and that he should not have been initially placed in restraints or kept in restraints by PA Cross. (Respondent's Exhibits 3 & 8)

40. While the LAWV report concluded that Grievant filed a false report because her APS statement read as if she witnessed the events reported when she was not present, most of Grievant's written APS statement does not specify that it is either personal knowledge or hearsay.

41. Further, Grievant informed investigators early in the investigation that her charting was based on information provided to her. (Respondent's Exhibit 8)

42. The evidence shows that in documenting Patient JY's behavior Grievant was simply repeating information provided to her.

43. Video evidence does not have audio and simply shows the following:

> Grievant and the support team are on Unit G1. Grievant gets the canvas bag containing mechanical restraints, points to the support team, makes a circular gesture in the air, points for the team to leave the unit, and grabs her wrist. The support team then takes Patient JY to Unit N2 and places him in restraints even though he is calm. Grievant does not accompany them to Unit N2. A few minutes later, PA Cross enters the seclusion room where Patient JY is under restraints and exits without having the restraints removed. Grievant first arrives on Unit N2 over a half hour later. Grievant talks with Patient JY and Patient JY is released from restraints shortly thereafter.

(Respondent's Exhibit 4)

44. Investigators concluded that in grabbing her wrist Grievant revealed she was at that moment ordering the support team to place Patient JY in restraints. Investigators reached this conclusion in conjunction with interviewing RN O'Baker, PA Cross, Grievant, and five support team members.

45. Support team members with whom the APS and LAWV investigators met were the only apparent eyewitnesses to any inaudible directive Grievant may have given while grabbing her wrist on the video. Yet, Respondent did not call any support team member or other apparent eyewitness to testify to this apparent directive from Grievant.

46. Grievant testified that the video shows her on Unit G1 telling the support team to take the restraints and Patient JY to Unit N2. Grievant testified that she sent the support team to Unit N2 with the restraints because all patients were being evacuated and Unit N2 was unoccupied and without any supplies or equipment.

47. LPN Smith was the only eyewitness who apparently told Ms. Reed and Ms. Huddle that Grievant directed the restraints. Yet, he also apparently told them Grievant was following directives from PA Cross, that he did not hear PA Cross, and that Patient JY "continued to posture aggressive behavior" on Unit N2. The other team members who were apparently present provided a different story. None of the five apparent eyewitnesses on the support team testified or were subpoenaed by Respondent.

48. The investigative reports state that LPN Smith said Grievant told the support team to put Patient JY in restraints. The investigative reports state that the other support team members said they did not hear this, did not recall this, or were told that PA Cross gave the order. (Respondent's Exhibits 3 & 8)

49. Ms. Huddle and Mr. McDaniels interviewed Grievant on or before May 17, 2019, and summarized this interview in the APS report, in part, as follows:

> [Grievant] denies giving instructions to put [Patient JY] into mechanical restraints. [Grievant] states that she was not aware that [Patient JY] was in mechanical restraints until she arrived on N2 and was informed by Brittany Cross, PAC, that patient [JY] was in restraints. .. [Grievant] states in her interview that she was told, however "She wrote it like she was

> there" that [Patient JY] was posturing and fighting against the restraints with clenched fists at the time that he was being assessed by Brittany Cross.

(Respondent's Exhibit 8)

50. Ms. Huddle and Mr. McDaniels interviewed PA Cross on or before May 17, 2019, and summarized this interview in the APS report, in part, as follows:

> After [Patient JY] broke the second sprinkler head [PA Cross] said that she and [Grievant] had a conversation **that if [Patient JY] continued to act out or break any more sprinkler heads that he would need to be restrained**, however she denies giving any order to put [Patient JY] into restraints. … [PA Cross] states that upon being informed by staff she went into the seclusion room to assess the patient, she states that upon seeing her [Patient JY] became agitated, was making threats to knock off sprinkler heads, [Patient JY's] fists were clenched, and he was attempting to sit up in the bed. [emphasis added]

(Respondent's Exhibit 8)

51. Ms. Huddle and Mr. McDaniels interviewed LPN Smith on or before May 17, 2019, and summarized this interview in the APS report, in part, as follows:

> [LPN Smith] states that he was told by [Grievant], along with the rest of the support team to take Brandon[12] to N-2 and place him in mechanical restraints. Brandon also states that he has been on support team calls in the past for [Patient JY], and that [Patient JY] is very unpredictable and very aggressive.

52. Ms. Huddle and Mr. McDaniels interviewed HSW Stevens[13] on or before May 17, 2019, and summarized this interview in the APS report, in part, as follows:

> [HSW Stevens] states that he does not recall who gave [the] direction to take [Patient JY] to the seclusion room and put him into restraints. … [He] states that when [PA Cross] came

[12]Brandon is LPN Smith's first name, but Ms. Huddle testified this should have read "Patient JY."

[13]The report misspells "Stevens" as "Stephens."

> to assess [Patient JY], he was not aggressive, and denied doing anything .... When asked if there was any RN present at the time that restraints were applied [he] stated that there was not.

53. Ms. Huddle and Mr. McDaniels interviewed HSW James Karp on or before May 17, 2019, and summarized this interview in the APS report, in part, as follows:

> [HSW Karp said] [t]he support team was instructed that [Patient JY] was to be taken to N-2 and placed into restraints, however he could not recall who had given the order.

54. Ms. Huddle and Mr. McDaniels interviewed HSW Randy Riggins on or before May 17, 2019, and summarized this interview in the APS report, in part, as follows:

> [HSW Riggins] states that the support team was given direction to take [Patient JY] to unit N-2 and put him in restraints, Randy also states that he doesn't recall the patient acting out at any time, however he was on guard because he had responded to support team calls for [Patient JY], and that [Patient JY] is very unpredictable and very aggressive.

55. Ms. Reed interviewed Grievant on May 9 & 14, 2019, and summarized this in the LAWV report, in part, as follows:

> [Grievant] said she was told JY yelled at Ms. Cross which prompted Ms. Cross to order the restraint. [Grievant] said she was on G1 when JY activated the sprinklers. [Grievant] said she was not on the unit when JY was moved to N2 and restrained. [Grievant] said when she arrived on N2 she was not aware JY had been restrained. [Grievant] stated to the investigator, 'I was told that Brittany Cross ordered the restraints. …' … [in regard to her gestures on the video] [Grievant] said her circular motion indicated, "All of you guys are going to have to go." [Grievant] said when she grabbed her wrist, it indicated, "And I need you (a staff member to take the restraints with you." When [Grievant] saw the restraint on the video she stated, "I don't get it. There's no reason for that Bob. I didn't give the order. I don't know why that's happening. Brittany [Cross] told me she told 'em to, but I never saw her order."

(Respondent's Exhibit 3)

56. Ms. Reed interviewed PA Cross on May 10 & 14, 2019, and summarized this in the LAWV report, in part, as follows:

> **[PA Cross] talked to [Grievant] and Ms. Chidester about a plan to manage the situation. Ms. Cross said she checked JY's chart to determine if he was IDD, just in case he needed to be mechanically restrained. Meanwhile [Grievant] called G2 to request the use of their seclusion room for JY in case it was needed.** Ms. Cross reported she advised Dr. Justice by telephone of the situation. … Ms. Cross … later returned to N2 to check on JY when she was informed he was restrained. … Ms. Cross said she went to see JY and he was 'still upset." Ms. Cross said JY cursed at her and said he would continue to destroy property if released. Ms. Cross said she decided to allow JY to remain in mechanical retraints. … **Ms. Cross acknowledged she, [Grievant], and Ms. Chidester, discussed a plan to place JY in another room in the event he needed restrained.** Ms. Cross denied she ever told [Grievant] JY needed to be restrained. The investigator asked Ms. Cross if she considered writing an order for the mechanical restraint of JY before he was restrained. Ms. Cross replied, "I would've put in an order if I felt he [sic] that he needed to be restrained, but the times I had seen him, he did not indicate that he needed to be restrained." [emphasis added]

(Respondent's Exhibit 3)

57. Ms. Reed interviewed HSW Hitt on May 12, 2019, and summarized this interview in the LAWV report, in part, as follows:

> Mr. Hitt said he observed JY getting in Ms. Cross's face and "that's when Ms. Cross told [Grievant] to put JY in restraints."

(Respondent's Exhibit 3)

58. However, Ms. Reed's interview summary also implies that HSW Hitt contradicted his statement of direct observation, in then stating:

> Mr. Hitt said he did not actually hear Ms. Cross tell Ms. Spurlock to put JY in restraints. … Mr. Hitt said from what he heard second-hand, Ms. Cross made the order to restrain JY,

> but did not actually hear her make the order, but he did hear [Grievant] tell him they were looking for a room to restrain JY.

59. Ms. Reed interviewed LPN Smith on May 12, 2019, and summarized this interview in the LAWV report, in part, as follows:

> Mr. Smith said while on G1 [Grievant] told the support team, including Josh Hitt and Chris Cleary, that Brittany Cross had given an order to put JY in restraints on N2. **Mr. Smith said they arrived on N2 and JY continued to posture aggressive behavior with his shoulders "hunched up" and "fists clenched."** Mr. Smith said JY did not want to follow directions. The investigator mentioned the video showed JY as totally calm. Mr. Smith commented, "It may have looked like that, but he (JY) was very unpredictable. The investigator asked Mr. Smith if it crossed his mind not to restrain JY. **Mr. Smith stated, "I was under the impression we had an order."** [emphasis added]

(Respondent's Exhibit 3)

60. Ms. Reed interviewed HSW Stevens on May 12, 2019, and summarized this interview in the LAWV report, in part, as follows:

> Mr. Stevens said JY was not restrained until he went to N2. Mr. Steven reported he did not hear anyone instruct the team to restrain JY when they arrived on N2. … Mr. Stevens said JY went to the restroom and when he exited, he was told he would be placed in restraints. …
>
> Mr. Stevens recalled Ms. Cross came in to assess JY's health and to ask him why he "did what he did." Mr. Stevens said while JY was restrained, he did not hear JY threaten Ms. Cross. Mr. Steven did not know why Ms. Cross did not release JY. Mr. Stevens commented JY should have never been put in restraints while he was calm.

(Respondent's Exhibit 3)

61. Ms. Reed interviewed RN O'Baker on May 12, 2019, and summarized this interview in the LAWV report, in part, as follows:

> Ms. O'Baker said a plan was discussed to take JY to G2 in case he needed to be restrained. … Ms. O'Baker reported she

> did not hear anyone give an order to restrain JY, but a plan was discussed in case JY needed to be restrained.

(Respondent's Exhibit 3)

62. Grievant did not retroactively request approval for any emergency use of restraints.

63. Neither investigation appeared to explore the possibility that the support team acted on its own or simply misunderstood Grievant's directive to bring the restraints with them to Unit N2.

64. Grievant was dismissed by letter dated August 2, 2019. It states in part:

> Your dismissal is the result of the following: An APS Investigation substantiated patient abuse by the improper use of mechanical restraints and false charting.
>
> This is a violation of the following:
>
> CMS Tag A-0154 §482.13(e) Standard: Restraint or seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.
>
> Title 64 Series 59-10.1. Seclusion and Restraints: General. Clients have the right to freedom from seclusion or mechanical or chemical restraints. **Seclusion and restraint shall only be used where there is imminent danger** that the client will injure himself or herself or others and when all other less restrictive measures have been exhausted.
>
> Hospital policy 45.106 Guidelines for Seclusion and Restraint: Restraints are considered an emergency measure and may only be used as a last resort to control a patient's behavior and **patient should be removed from mechanical restraints as soon as possible** and Seclusion or Restraint may be used after all less restrictive interventions have been

attempted or determined ineffective and should not be used for the convenience of the staff. …

DHHR Policy 2108, Employee Conduct, which provides: "Employees are expected to: comply with all relevant Federal, State and local laws; comply with all applicable State and Federal Regulations governing their field of employment; **be accurate when completing Agency records**; avoid physical abuse, harassment or intimidation of residents/patients/clients or fellow employees."

So that you may understand the specific reason for your dismissal I recount the following:

On May 5, 2019, you were suspended pending an investigation into allegations of physical abuse, relating to a patient who was placed in mechanical restraints. **Video of the incident revealed that you made hand gestures indicating that the support team should remove the patient from the unit and put him in mechanical restraints**. You denied giving any such directive. Although it previously had been reported that the patient had forcefully removed 2 sprinkler heads, at the time this directive was given, the patient was calm and cooperative; he followed the support team willingly.

You filed a report of the incident in which you stated that the patient was combative, and upon check, was assuming a threatening posture, clenching fists and making threats. You admitted in the interview conducted by the APS team that you did not personally witness the incident; **you falsely charted behaviors you had not actually witnessed**. This action was an improper use of mechanical restraints. [emphasis added]

(Respondent's Exhibit 13)

65. Further, W. VA. CODE ST. R. § 64-59-10.5 (1995) states, in part:

Examination by Physician. No client may be placed in seclusion until he or she is examined by the attending physician …. In the event that an attending physician is **not immediately available**, the registered nurse in charge shall discuss the situation with the interdisciplinary team members and obtain a telephone order from the physician if the physician concurs that seclusion is required. [emphasis added]

(Respondent's Exhibit 5)

66. Respondent did not discipline PA Cross even though an investigative report deemed her directive to continue the restraints to be improper and even though PA Cross did not order the restraints to be removed after seeing that Patient JY was calm.

67. Respondent did not discipline any member of the support team, even though the support team applied restraints without the required personal supervision of an RN, a PA, or a physician.

68. Grievant has intermittently been employed elsewhere since her dismissal.

Discussion

The burden of proof in disciplinary matters rests with the employer to prove by a preponderance of the evidence that the disciplinary action taken was justified. W. VA. CODE ST. R. § 156-1-3 (2018). "The preponderance standard generally requires proof that a reasonable person would accept as sufficient that a contested fact is more likely true than not." *Leichliter v. W. Va. Dep't of Health & Human Res*., Docket No. 92-HHR-486 (May 17, 1993). Where the evidence equally supports both sides, the employer has not met its burden. *Id*.

Permanent state employees who are in the classified service can only be dismissed "for good cause, which means misconduct of a substantial nature directly affecting the rights and interest of the public, rather than upon trivial or inconsequential matters, or mere technical violations of statute or official duty without wrongful intention." Syl. Pt. 1, *Oakes v. W. Va. Dep't of Finance and Admin*., 164 W. Va. 384, 264 S.E.2d 151 (1980); *Guine v. Civil Serv. Comm'n*, 149 W. Va. 461, 141 S.E.2d 364 (1965); *Sloan v. Dep't of Health & Human Res*., 215 W. Va. 657, 600 S.E.2d 554 (2004) (*per curiam*). *See*

also W. VA. CODE ST. R. § 143-1-12.2.a. (2016). "'Good cause' for dismissal will be found when an employee's conduct shows a gross disregard for professional responsibilities or the public safety." *Drown v. W. Va. Civil Serv. Comm'n*, 180 W. Va. 143, 145, 375 S.E.2d 775, 777 (1988) (*per curiam*).

Respondent dismissed Grievant for improperly ordering the support team to mechanically restrain Patient JY and then falsely charting patient behavior she did not witness.[14] Respondent relies on inaudible video evidence showing Grievant retrieve the restraints bag, point to staff, and grab her wrist. Respondent asserts that in grabbing her wrist Grievant revealed she was ordering the support team to restrain Patient JY. Respondent also submitted hearsay evidence purporting that one eyewitness confirmed that Grievant ordered restraints but gave no reason for failing to call the eyewitnesses to testify. Grievant denies that she ordered the restraints but contends she simply told the support team to take Patient JY and the restraint bag to Unit N2 since Unit G1 was flooding and Unit N2 was empty without supplies. Grievant asserts that while grabbing her wrist, she was telling the support team to bring the restraints with them to Unit N2.

The parties seem to agree that patients can only be restrained when posing an immediate danger to themselves or others; that when Patient JY was restrained he was calm and not a danger; that only a physician or a PA can order restraints, except that an RN can do so in an emergency when a physician or PA is not immediately available; that an RN, a PA, or a physician must be present when restraints are applied; that no RN, PA,

[14]The dismissal letter relies on inaudible video of the incident, stating, "Video of the incident revealed that you made hand gestures indicating that the support team should remove the patient from the unit and put him in mechanical restraints." Regarding the allegation of false charting, the dismissal letter goes on to specify, "you falsely charted behaviors you had not actually witnessed." (Respondent's Exhibit 13)

or physician was present when Patient JY was restrained; that PA Cross was considered the on-call physician with authority to order or approve restraints; that, as an RN, Grievant could only order restraints in an emergency situation if a PA or physician was not "immediately available" but that she would have ultimately needed post emergency use approval; that, shortly before Patient JY was restrained on Unit N2, Grievant and PA Cross engaged in a discussion on Unit G1 about the possible need to restrain Patient JY "if [Patient JY] continued to act out or break any more sprinkler heads;"[15] that Grievant remained on Unit G1 while the support team brought Patient JY to Unit N2 and mechanically restrained him; that PA Cross was at Sharpe when Patient JY was initially restrained; that PA Cross went to Unit N2 and assessed Patient JY while he was under restraints and before Grievant first arrived on the unit; that PA Cross thereafter directed the support team to keep Patient JY in restraints; that PA Cross then left to prepare a progress note stating that Patient JY was "still" yelling at her when she assessed Patient JY while he was under restraints; and that Grievant thereafter arrived on Unit N2, assessed Patient JY, and ordered that the restraints be removed.

Thus, the primary issue in dispute is whether Grievant ordered the support team to restrain Patient JY. The burden is on Respondent to present evidence sufficient to prove that it is more likely than not that Grievant issued this order. Respondent attempts to meet its burden primarily through inaudible video evidence showing Grievant grab her wrist. Respondent asserts that in grabbing her wrist Grievant reveals that her inaudible words were in fact a directive to restrain Patient JY. Respondent in essence asks the undersigned to guess at the words spoken by Grievant by deciphering her body language.

[15]As related by PA Cross to APS investigators.

The undersigned cannot conclude it is more likely than not that the words Grievant spoke while grabbing her wrist were a directive to place Patient JY in restraints or that such a directive originated with Grievant. It is bewildering that none of the eyewitnesses seen in the video when Grievant grabbed her wrist were called to testify.

APS and LAWV investigators, Ms. Huddle and Ms. Reed, interviewed five support team members who were present when Grievant grabbed her wrist. These investigators provided secondhand testimony that one support team member said Grievant directed the support team to restrain Patient JY. This testimony is hearsay.[16] "Hearsay evidence is generally admissible in grievance proceedings. The issue is one of weight rather than admissibility. This reflects a legislative recognition that the parties in grievance proceedings, particularly grievants and their representatives, are generally not lawyers and are not familiar with the technical rules of evidence or with formal legal proceedings." G*unnells v. Logan County Bd. of Educ*., Docket No. 97-23-055 (Dec. 9, 1997). The Grievance Board has applied the following factors in assessing hearsay testimony: 1) the availability of persons with first-hand knowledge to testify at the hearings; 2) whether the declarants' out of court statements were in writing, signed, or in affidavit form; 3) the agency's explanation for failing to obtain signed or sworn statements; 4) whether the declarants were disinterested witnesses to the events, and whether the statements were routinely made; 5) the consistency of the declarants' accounts with other information, other witnesses, other statements, and the statement itself; 6) whether collaboration for these statements can be found in agency records; 7) the absence of contradictory

[16]"Hearsay includes any statement made outside the present proceeding which is offered as evidence of the truth of matters asserted therein." BLACK'S LAW DICTIONARY 722 (6th ed. 1990).

evidence; and 8) the credibility of the declarants when they made their statements. *Id*.; *Sinsel v. Harrison County Bd. of Educ*., Docket No. 96-17-219 (Dec. 31, 1996); *Seddon v. W. Va. Dep't of Health/Kanawha-Charleston Health Dep't*, Docket No. 90-H-115 (June 8, 1990).

LPN Smith was the only support team member to apparently tell investigators that Grievant directed the restraints. Yet, Respondent did not provide a reason for not having LPN Smith testify. As for signed statements, the only one that was entered into the record did not belong to LPN Smith but to HSW Stevens. The contents thereof are illegible and do not corroborate the allegation that Grievant ordered restraints. Significantly, even though APS and LAWV investigators recorded their interviews with each of the five support team members, none of these recordings were produced at the hearing.

Respondent implies that the video of the incident corroborates LPN Smith's statement that Grievant directed the application of restraints on Patient JY. However, as previously discussed, the video is inaudible and its probative value dubious, particularly because Respondent attributes import primarily to Grievant's hand gestures and asks the undersigned to guess at their meaning. Respondent does so despite video evidence showing several employees who may have heard Grievant's voice and been better qualified to attribute meaning to her gestures. The only eyewitnesses that investigators talked to were five support team members. No one other than LPN Smith recalled who directed the restraints, and no one heard anyone order them.

This failure to call an eyewitness may have been calculated, as team member statements are inconsistent and do not uniformly confirm that Grievant directed, let alone originated, an order to restraint Patient JY. Even LPN Smith, in confirming that Grievant

directed that Patient JY be restrained, told APS investigators that Grievant informed them that PA Cross issued the order. LPN Smith created further uncertainty as to who originated the order by telling the LAWV investigator, "I was under the impression we had an order," implying he was not present when the order was originally given. HSW Hitt only further confounded the issue in telling the LAWV investigator that "he observed JY getting in Ms. Cross's face and 'that's when Ms. Cross told [Grievant] to put JY in restraints.'" HSW Hitt contradicted this implied statement of observation in then apparently saying he never heard PA Cross or Grievant order the restraints.

LPN Smith's credibility, as represented in the investigative reports, is questionable. Juxtaposed against Respondent's assessment that Patient JY was calm on Unit N2, LPN Smith was not credible in apparently telling the LAWV investigator that Patient JY "continued to posture aggressive behavior" when he arrived on Unit N2. Interestingly, the LAWV investigator called LPN Smith out on this, telling LPN Smith that it was inconsistent with Patient JY's calm demeanor as seen on the video. LPN Smith then backtracked in responding, "It may have looked like that, but he (JY) was very unpredictable." Thus, the undersigned cannot determine that the only declarant relied on by Respondent was credible or whether investigators mistakenly documented verbal statements by the other support team members in writing that some "did not recall" who gave the directive, as opposed to "did not hear" the directive being given. Further, the APS and LAWV reports are sometimes at odds. For instance, the APS report documents that HSW Stevens said he "[did] not recall who gave [the] direction." However, the LAWV report documents that Stevens said he "did not hear anyone instruct the team to restrain JY" but "surmised" there was an order.

Even if investigators and the firsthand witnesses they interviewed are credible, it is apparent that some essentials were lost in translation. Hearsay is inherently less trustworthy than firsthand testimony and deprives the party it is being used against of the opportunity to cross examine the declarant. While hearsay is typically restricted in court proceedings, it is permitted in administrative proceedings before the Grievance Board upon a weight assessment. This assessment determines an attribution of weight to hearsay based on factors touching on the availability of firsthand evidence and the reliability of the hearsay evidence. Respondent did not show that firsthand witnesses were not readily available to testify and did not ensure the reliability of the hearsay evidence through signed statements. In this case, doing so was necessary due to the contradictory evidence provided and the credibility issues surrounding the declarant statements Respondent relied on in making allegations against Grievant.

Further, neither the APS nor the LAWV investigation appeared to explore the possibility that the support team acted on its own or simply misconstrued Grievant's directive to bring the restraints to Unit N2 as permission to apply restraints to Patient JY. Grievant could not explore this possibility or the conflicting statements made by support team members and the one declarant Respondent relied on because Respondent did not have any of them testify. After considering the hearsay factors, the undersigned can attribute little weight to the hearsay evidence provided by APS and LAWV investigators. Respondent failed to prove by a preponderance of the evidence that Grievant directed the restraints.

This renders any of Grievant's arguments and Respondent's counter arguments irrelevant. Nevertheless, they will be summarily addressed. Grievant denies she directed

the restraints and places culpability on PA Cross. Respondent counters by asserting that PA Cross is more credible than Grievant in her denial, reframing the issue as a binary choice between Grievant and PA Cross. Yet, PA Cross never asserted she heard Grievant order the restraints. As Respondent failed to prove that Grievant ordered the restraints, a comparison of each's credibility in the denial of culpability would transfer the burden of proof to Grievant.

Even so, a credibility analysis[17] of PA Cross reveals bias and motive to lie. PA Cross was considered the on-call physician with authority to order or approve restraints the evening of May 5, 2019. PA Cross admitted to investigators that, prior to the application of the restraints, she had a conversation with Grievant that if Patient JY broke any more sprinkler heads he would need to be restrained. PA Cross was the one who would have properly ordered the restraints since her immediate availability at the facility deprived Grievant of any emergency authority.

[17]In situations where "the existence or nonexistence of certain material facts hinges on witness credibility, detailed findings of fact and explicit credibility determinations are required." *Jones v. W. Va. Dep't of Health & Human Res*., Docket No. 96-HHR-371 (Oct. 30, 1996); *Young v. Div. of Natural Res*., Docket No. 2009-0540-DOC (Nov. 13, 2009); *See also Clarke v. W. Va. Bd. of Regents*, 166 W. Va. 702, 279 S.E.2d 169 (1981). In assessing the credibility of witnesses, some factors to be considered ... are the witness's: 1) demeanor; 2) opportunity or capacity to perceive and communicate; 3) reputation for honesty; 4) attitude toward the action; and 5) admission of untruthfulness. HAROLD J. ASHER & WILLIAM C. JACKSON, REPRESENTING THE AGENCY BEFORE THE UNITED STATES MERIT SYSTEMS Protection Board 152-153 (1984). Additionally, the ALJ should consider: 1) the presence or absence of bias, interest, or motive; 2) the consistency of prior statements; 3) the existence or nonexistence of any fact testified to by the witness; and 4) the plausibility of the witness's information. *Id*., *Burchell v. Bd. of Trustees, Marshall Univ*., Docket No. 97-BOT-011 (Aug. 29, 1997). Not every factor is necessarily relevant to every credibility determination. In this situation, the relevant factors include demeanor, motive, opportunity to perceive, attitude toward the action, the consistency of prior statements, and plausibility.

Video shows Patient JY was calm and did not pose a danger when PA Cross continued the restraints. Yet, PA Cross entered progress notes to justify her directing that Patient JY be kept in restraints. PA Cross entered these notes right after Grievant ordered the release of Patient JY from restraints. Thus, it appears that PA Cross had motive to cover her own mistakes. Curiously, PA Cross does not make any mention in her progress notes that protocol may have been violated when Patient JY was initially placed in restraints. Rather, PA Cross' progress notes state that Patient JY was "still" yelling at her when she saw him at 22:10. This implies that Patient JY had yelled at PA Cross earlier that evening, meaning PA Cross would have already seen Patient JY and had opportunity and motive to order the initial restraints. Because PA Cross was in the facility and immediately available when the initial decision to apply restraints to Patient JY was made, it would have been impermissible under the emergency use of restraints policy for Grievant to order restraints on her own. PA Cross made a special trip to the facility after being summoned to respond to the situation. Thus, she was at the facility to direct the handling of Patient JY. If restraints were initially applied without her approval, one would expect PA Cross to be alarmed by and document the policy violation of not being included this decision; that is, if she had in fact not been a part of the decision. These factors shed further doubt on Grievant's alleged role in the apparent order to restrain Patient JY, further rendering Grievant's credibility irrelevant.

The other allegation used to justify dismissal is that Grievant falsely charted Patient JY's behavior. The dismissal letter specifically states: "[Grievant] did not personally witness the incident; [Grievant] falsely charted behaviors [she] had not actually witnessed. This action was an improper use of mechanical restraints." The only apparent reference

to false charting in any submitted policy is DHHR Policy 2108, which states in relevant part, "Employees are expected to: … be accurate when completing Agency records." Respondent failed to present any authority defining false charting and failed to show that charting must only include firsthand information. The fact that PA Cross was not investigated or disciplined after entering notes that included hearsay casts doubt on an interpretation of false charting which limits appropriate charting content to firsthand information. Ironically, Grievant was simply complying with her duty to document restraints. It is foreseeable that she would have been disciplined had she not documented what she had only heard about regarding Patient JY's restraints.

At level three, Respondent attempted to modify this allegation by claiming that Grievant's notes read as if they were firsthand information, implying that employees are allowed to chart hearsay if they identify it as hearsay. Yet, while Grievant's notes generally fail to identify hearsay or firsthand information, they clearly appear to be based on information Grievant received from other employees. Respondent did not show that this was improper or that Grievant had any intent to deceive. Grievant's lack of intent to deceive was apparent when Grievant readily informed investigators early in the investigation that much of her charting and reporting was based on hearsay. Thus, Respondent failed to prove by a preponderance of evidence its allegations against Grievant or good cause for dismissal.

The following Conclusions of Law support the decision reached.

Conclusions of Law

1. The burden of proof in disciplinary matters rests with the employer to prove by a preponderance of the evidence that the disciplinary action taken was

justified. W. VA. CODE ST. R. § 156-1-3 (2018). "The preponderance standard generally requires proof that a reasonable person would accept as sufficient that a contested fact is more likely true than not." *Leichliter v. W. Va. Dep't of Health & Human Res.*, Docket No. 92-HHR-486 (May 17, 1993). Where the evidence equally supports both sides, the employer has not met its burden. *Id*.

2. Permanent state employees who are in the classified service can only be dismissed "for good cause, which means misconduct of a substantial nature directly affecting the rights and interest of the public, rather than upon trivial or inconsequential matters, or mere technical violations of statute or official duty without wrongful intention." Syl. Pt. 1, *Oakes v. W. Va. Dep't of Finance and Admin.*, 164 W. Va. 384, 264 S.E.2d 151 (1980); *Guine v. Civil Serv. Comm'n*, 149 W. Va. 461, 141 S.E.2d 364 (1965); *Sloan v. Dep't of Health & Human Res.*, 215 W. Va. 657, 600 S.E.2d 554 (2004) (*per curiam*). *See also* W. VA. CODE ST. R. § 143-1-12.2.a. (2016). "'Good cause' for dismissal will be found when an employee's conduct shows a gross disregard for professional responsibilities or the public safety." *Drown v. W. Va. Civil Serv. Comm'n*, 180 W. Va. 143, 145, 375 S.E.2d 775, 777 (1988) (*per curiam*).

3. "Hearsay evidence is generally admissible in grievance proceedings. The issue is one of weight rather than admissibility. This reflects a legislative recognition that the parties in grievance proceedings, particularly grievants and their representatives, are generally not lawyers and are not familiar with the technical rules of evidence or with formal legal proceedings." *Gunnells v. Logan County Bd. of Educ.*, Docket No. 97-23-055 (Dec. 9, 1997). The Grievance Board has applied the following factors in assessing hearsay testimony: 1) the availability of persons with first-hand

knowledge to testify at the hearings; 2) whether the declarants' out of court statements were in writing, signed, or in affidavit form; 3) the agency's explanation for failing to obtain signed or sworn statements; 4) whether the declarants were disinterested witnesses to the events, and whether the statements were routinely made; 5) the consistency of the declarants' accounts with other information, other witnesses, other statements, and the statement itself; 6) whether collaboration for these statements can be found in agency records; 7) the absence of contradictory evidence; and 8) the credibility of the declarants when they made their statements. *Id*.; *Sinsel v. Harrison County Bd. of Educ*., Docket No. 96-17-219 (Dec. 31, 1996); *Seddon v. W. Va. Dep't of Health/Kanawha-Charleston Health Dep't*, Docket No. 90-H-115 (June 8, 1990).

4. Respondent did not prove by a preponderance of the evidence that Grievant directed restraints on Patient JY or that she falsely charted Patient JY's behavior, and thus failed to prove good cause for dismissal.

Accordingly, the grievance is GRANTED. Respondent is ORDERED to reinstate Grievant and to provide her back pay from the date of her dismissal to the date she is reinstated, minus all wages she earned in the interim, plus interest at the statutory rate; to restore all benefits, including seniority; and to remove all references to the dismissal from Grievant's personnel records maintained by Respondent.

Any party may appeal this Decision to the Intermediate Court of Appeals.[18] Any such appeal must be filed within thirty (30) days of receipt of this Decision. W.

[18]On April 8, 2021, Senate Bill 275 was enacted, creating the Intermediate Court of Appeals. The act conferred jurisdiction to the Intermediate Court of Appeals over "[f]inal judgments, orders, or decisions of an agency or an administrative law judge entered after

VA. CODE § 6C-2-5. Neither the West Virginia Public Employees Grievance Board nor any of its Administrative Law Judges is a party to such appeal and should not be named as a party to the appeal. However, the appealing party is required to serve a copy of the appeal petition upon the Grievance Board by registered or certified mail. W. VA. CODE § 29A-5-4(b).

DATE: September 8, 2022

_____
Joshua S. Fraenkel
Administrative Law Judge

June 30, 2022, heretofore appealable to the Circuit Court of Kanawha County pursuant to §29A-5-4 or any other provision of this code[.]" W. VA. CODE § 51-11-4(b)(4). The West Virginia Public Employees Grievance Procedure provides that an appeal of a Grievance Board decision be made to the Circuit Court of Kanawha County. W. VA. CODE § 6C-2-5. Although Senate Bill 275 did not specifically amend W. VA. CODE § 6C-2-5, it appears an appeal of a decision of the Public Employees Grievance Board now lies with the Intermediate Court of Appeals.