JEFF WATSON,

Grievant,

v. DOCKET NO. 01-HHR-508

DEPARTMENT OF HEALTH AND HUMAN RESOURCES/

MILDRED MITCHELL-BATEMAN HOSPITAL,

Respondent.

D E C I S I O N

This grievance was filed directly at Level IV by Grievant, Jeff Watson, pursuant to W. Va. Code § 29-6A-4(e), on September 10, 2001, after he was dismissed from his employment with Respondent Department of Health and Human Resources ("HHR") at the Mildred Mitchell-Bateman Hospital. The statement of grievance reads:

> I was charged with patient abuse (which did not happen) and then inappropriately dismissed from my job. I was fired August 31.

As relief Grievant seeks to have the patient abuse charge removed from his record, reinstated to his position, and back pay. (See footnote 1)

Discussion

The burden of proof in disciplinary matters rests with the employer, and the employer must meet that burden by proving the charges against an employee by a preponderance of the evidence. W. Va. Code § 29-6A-6; Ramey v. W. Va. Dep't of Health, Docket No. H-88-005 (Dec. 6, 1988). "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 and Human Resources, Docket No. 92-HHR-486 (May 17, 1993). Where the evidence equally supports both sides, the employer has not met its burden. Id.

The employer must also demonstrate that misconduct which forms the basis for the dismissal of a tenured state employee is of a "substantial nature directly affecting rights and interests of the public." House v. Civil Serv. Comm'n, 181 W. Va. 49, 380 S.E.2d 226 (1989). "The judicial standard in West Virginia requires that 'dismissal of a civil service employee be for good cause, which means misconduct of a substantial nature directly affecting rights and interests of the public, rather than upon trivial or inconsequential matters, or mere technical violations of statute or official duty without wrongful intention.' Syl. Pt. 2, Buskirk v. Civil Service Comm'n, [175 W. Va. 279, __,] 332 S.E.2d 579, 581 (W. Va. 1985); Oakes v. W. Va. Dept. of Finance and Admin., [164 W. Va. 384,] 264 S.E.2d 151 (W. Va. 1980); Guine v. Civil Service Comm'n, [149 W. Va. 461,]141 S.E.2d 364 (W. Va. 1965)." Scragg v. Bd. of Directors W. Va. State College, Docket No. 93-BOD-436 (Dec. 30, 1994).

Grievant was told he was suspended on August 28, 2001. A decision was then made to dismiss Grievant. The dismissal letter, dated August 28, 2001, and signed by Jo Pierce, Chief Executive Officer at Mildred Mitchell-Bateman Hospital, states the reasons for the dismissal as follows:

> In accordance with Section 12.02 of the Administrative Rule of the West Virginia Division of Personnel, Title 64, *The Behavioral Health Patients Rights Rule,* Department of Health and Human Resources Policy Memorandum 2104, *Progressive Discipline* and 2108, *Employee Conduct*, and Mildred Mitchell-Bateman Hospital Policy HHC15, *Progressive Disciplinary Action*, you are hereby dismissed from your duties as a Health Service Worker.
>
> The charge for your dismissal is physical patient abuse, and non-adherence to policy and procedures. The specific reasons for this charge is that onAugust 7, 2001, while you were assigned as Health Service Worker on Unit 4, you assisted in escorting Patient #09031 to the rear of the Clinical Building waiting transport to his home. When the patient refused to put out a cigarette, the other Health Service Worker tried to flip it out of his hand, the patient retaliated and you stepped in, began arguing with the patient, and pushed him backwards out of the exit door with both hands on his chest. The patient complained that you choked him and a coworker observed red marks around the patient's neck.
>
> At the conclusion of an investigation, the evidence discloses that you were abusive in this incident in the following ways:
>
> 1. you did physically grab this patient around the neck until his throat turned red;

2. you did restrict his communication by hanging up the phone and not allowing him to complete a phone call;

3. you did use an improper restraint technique, i.e. you did not use the Non-Violent Physical Crisis Intervention training taught to you by Staff Development.

This is the third substantiated incident of patient neglect and/or abuse. You met with Kieth Anne Worden, Director of Human Resources, Harriet Fitzgerald, Representative from Employee Relations[,] and Carol Wellman, Administrator, to discuss this issue on August 28, 2001, to explain the type of action under consideration and to give you an opportunity to explain why you believe this action is unwarranted. At that time you explained that you thought “this is just a political thing” and that you did nothing wrong. After reevaluation of this event and consideration of the other two incidents of patient neglect and patient abuse by you within the last six months, it is decided that the safety of the patients could not be assured with your continued employment.

As you must be aware, Bateman Hospital has been under extreme scrutiny from federal and state survey teams because of patient care issues, specifically patient safety. In fact, Bateman Hospital patients have been found in the survey of August 18-30, 2001, [sic] remain in immediate jeopardy. We obviously must move aggressively to enforce patient care requirements related to patient safety. As a result, we believe that we cannot allow you to continue to be employed by the Department of Health and Human Resources at Bateman Hospital.

On March 29, 2001, you received a verbal reprimand for patient neglect, and on July 18, 2001, you received a one-day suspension for verbal patient abuse. We are very concerned about your ability to ensure the safety of the patients of this hospital.

All of the aforementioned, when viewed both singularly and collectively, demonstrate unacceptable conduct warranting disciplinary action. The cumulative effect of your unprofessional conduct is one of inability or unwillingness to effectively perform the functions of your position.

Bateman Hospital is mandated to protect and care for a segment of the mentally challenged population of the State of West Virginia. Individuals who are placed in residence at the Hospital and entrusted to our care are often emotionally, mentally, and physically vulnerable. As a Health Service Assistant within the Hospital, your responsibility is to train, mold and protect these individuals. Considering that your duties and responsibilities involve direct care of the patients, you are a role model. Your conduct has been such that it has caused me to lose faith in your ability to carry

> out your duties in an effective and responsible manner.
>
> I believe the State of West Virginia has reason to expect its employees to observe a standard of conduct which will not reflect discredit on their abilities or integrity, or create suspicions with reference to their capacity to discharge their duties and responsibilities. I believe the nature of your misconduct is sufficient to cause me to conclude that you have not met a reasonable standard of conduct as an employee of the West Virginia Department of Health and Human Resources, Bateman Hospital, as set forth in Policy Memorandum 2108 Employee Conduct, thus warranting your dismissal. For these reasons, I believe it is in the best interests of this hospital and the patients we serve that I take this personnel action.
>
> Since we consider this action as gross misconduct, the required notice period is waived, and your dismissal is effective immediately. You are restricted from all areas of the hospital except the Human Resources Office or my office by appointment.

The letter does not indicate how Respondent arrived at the conclusion that “at the conclusion of the investigation, the evidence disclose[d] that [Grievant] . . . did physically grab this patient around the neck until his throat turned red.” The only investigation noted during the Level IV hearing was conducted by the patient advocate, an Adult Protective Services representative, and an RN at the hospital. The report prepared at the conclusion of this investigation does not make any finding that Grievant grabbed the patient by the neck.

Grievant was given this letter on August 31, 2001. It should be noted at this point that Grievant also grieved the one day suspension for verbal abuse of a patient mentioned in the dismissal letter. The Level III grievance evaluator found that the charge was not proven by Respondent, and Respondent did not appeal that decision.

During the Level IV hearing Respondent focused on the allegation made by the patient that Grievant had choked him, noting, quite correctly, that choking a patient wasgrounds for dismissal. Grievant denies he choked the patient in question, who will be referred to as M.B., or that he did anything improper. Although Grievant was never alone with the patient during the time the alleged choking occurred, and was always in a public area during this time, no one testified he or she saw Grievant choke the patient. The choking allegation is based solely upon the statements of M.B. made immediately after he had tried to hit another employee in the head with a telephone receiver. Grievant had blocked this blow, and had backed M.B. out the door. The patient was not called to

testify, because Respondent could not find him.

Mildred Mitchell-Bateman Hospital houses patients who are mentally ill, and who can become verbally and physically aggressive. Staff are trained in Nonviolent Crisis Intervention ("NVCI"). NVCI teaches staff to first talk to the patient to try to de-escalate the situation. It also teaches acceptable ways to restrain a patient who physically assaults them or someone else, which are supposed to be effective in any situation. These restraint techniques require two people. One of the NVCI tactics taught to staff is to put their hand up in front of them if a patient invades their personal space.

M.B. is a 6' 2", approximately 260 pound male, with size 38D breast implants, which set unusually high on his chest. M.B. had been physically aggressive toward staff during his stay at the hospital. John Herrera, a guard at the hospital, testified he was called to assist with M.B. one evening when he was demanding his medications be given by injection. While Mr. Herrera was observing the situation, M.B. picked up a chair and started to throw it at a staff member. Mr. Herrera stated he smacked the chair out of M.B.'s hand and got him on the floor. He stated it took five male staff members 45 minutes to restrain M.B.

On August 6, 2001, M.B. had a violent episode involving staff. On either August 6 or 7, he had verbally assaulted an employee. He was discharged from the hospital on August 7, 2001. Barbara Anderson, a 5' 2" Health Service Worker, was assigned to help M.B. pack his things, and ride with him to his home. (See footnote 2) Ms. Anderson testified that as she would fold M.B.'s clothes he would rip them out of her hands and throw them at her or across the room. M.B. was verbally abusive toward Ms. Anderson the entire time she was helping him pack, and this continued even after he was finally in the vehicle to take him home. He called Ms. Anderson a damn bitch, whore, and slut, swore at her continually, and told her he was going to get back at her, and he was going kill her. Several people checked in on Ms. Anderson while she was helping M.B. pack. Todd Jenkins, an LPN, asked Grievant to assist Ms. Anderson, and he went to M.B.'s room and sat and watched the situation. Grievant is about the same height and weight as M.B., or perhaps somewhat larger.

Ms. Anderson and Grievant escorted M.B. down to the first floor. Grievant testified that he, Ms. Anderson, and M.B. went out to the vehicle to load M.B.'s belongings. M.B. was smoking a cigarette. Grievant testified that M.B. refused to get into the vehicle. Grievant testified M.B. then began demanding his medicine. Grievant stated he went inside, and called Mr. Jenkins and explained that M.B. did not want to leave, and he was demanding his medication. Mr. Jenkins then went to the

doctor who had ordered M.B.'s discharge, who told him he was not going to give M.B. the medication he had brought with him when he was admitted. Grievant testified he told M.B. the doctor would not give him the medicine, and M.B. said he was not leaving without it. Grievant testified he called again to get direction on what to do, and the doctor said to tell M.B. that if he would not leave, the police would be called. Grievant testified he told M.B. the doctor had given him two choices, either get in the vehicle and leave, or they would call the police and he would be taken to jail. Grievant testified that M.B. still demanded his medicine. Grievant went inside and picked up the telephone again, giving the impression that he was going to callthe police. M.B. could see Grievant, and started toward the car. Grievant hung up the phone and went further inside the building, but watched M.B. through a small window in the door.

Grievant testified that as soon as M.B. thought Grievant was out of sight, he came inside and picked up the telephone receiver and started dialing numbers. Ms. Anderson also came inside. Grievant testified he came back into the hallway where the phone was, and asked M.B. to give him the phone. He testified that Ms. Anderson was asking M.B. to give her the cigarette. Grievant stated M.B. was swearing at them, and Grievant reached over and pushed the button down to disconnect the call. Grievant testified he was planning to get the telephone from M.B. at that point so he could call for assistance so they could avoid a conflict. Grievant did not feel it was safe for him to leave at that point. He stated he asked M.B. for the phone, and he would not give it to him. Grievant stated M.B. held the receiver up with his right hand, and was bringing it down to strike Ms. Anderson. Grievant testified he used his left arm to try to get him to stop, as they are taught in their NVCI training, and M.B. continued forward into his hand. Grievant believed his hand could have brushed M.B.'s neck, noting there was not much room between M.B.'s breast implants and his neck. Grievant stated he did not choke M.B. Grievant admitted he then backed M.B. out the door, keeping his hand on his chest. He denied he had pushed M.B. Grievant testified that M.B. continued to swear at him, and told him he was going to have some bikers get him. Other witnesses also heard this threat.

Ms. Anderson's recollection of the incident was consistent with Grievant's in most respects. She stated they were in a hallway when M.B. tried to hit her in the head with a telephone receiver. She stated she ducked, and Grievant blocked the telephone receiver to prevent M.B. from hitting her. She stated M.B. then tried to hit her with his other hand, and Grievant blocked this attempted blow as well. She stated Grievant pushed the patient back with his hand. She felt M.B. would have hurt her

badly if Grievant had not intervened. She testified that M.B. still had the cigarette in his hand, and was swinging his fists at both she and Grievant, and she attempted to knock the cigarette out of his hand as she felt it was a weapon. She did not believe the hallway was large enough to apply NVCI techniques, and noted M.B. was not going to stand still for them to get into position to restrain him. Ms. Anderson testified M.B. went out the door backward.

Ms. Anderson acknowledged that M.B. stated Grievant had choked him, as did Grievant. Ms. Anderson testified she knew Grievant did not put his hands on M.B.'s neck. She stated she was there, and was the closest observer. She was verbally reprimanded for trying to get the cigarette out of M.B.'s hand.

Ms. Anderson stated M.B. continued to be verbally abusive and make threats during the car ride to his home, and did not respond to her verbal attempts to calm him.

Rhonda Nolan, the Housekeeping supervisor at the hospital, testified that she heard loud voices in the hallway, and she peeked through the small window in the door leading to the hallway. She stated Grievant had the telephone receiver in his hand, although she did not know whether Grievant was on the telephone. M.B. was facing her, and Ms. Anderson was standing in front of M.B. with her back to Ms. Nolan. She could not see M.B.'s hands. She saw Grievant drop the telephone receiver, place his hands on M.B.'s chest and push him away from Ms. Anderson, and then go out the door, with M.B. going out backward and Grievant's hands still on M.B.'s chest. She stated it “all happened so fast.”

Ms. Nolan immediately went outside also, and M.B. was sitting on the stoop. She stated M.B. asked her if she could get Larry in Admissions, and was talking about some medications he was missing, and he said he wanted his medication. She stated M.B. then said to Grievant, “you choked me,” to which Grievant responded that he did not choke him. She stated M.B. said, “yes, you did. Look at my neck,” and he pulled down his shirt andshowed his neck, which was light pink. She could not testify as to whether he had been choked from the mark, noting the color could have been from his sweater.

Ms. Nolan testified she went to Grievant the next day and told him she saw what he did, and he had better watch where he put his hands when he put his hands on a patient, because he did not know who was there to see him. She told Grievant she was not going to tell anyone. She stated Grievant responded that he put his hands on the patient's chest; as far as he knew he did not choke

him, but it could have been in the scuffle or taking him out the door that his hands might have slipped. She acknowledged Grievant told her that if she thought she saw him do something improper, she should report it, because she was a mandatory reporter. She stated she did not see Grievant do anything wrong, although she was not sure whether his actions were wrong.

Larry Lanham, an Office Assistant II in the Admissions Office, testified he was called outside to try to calm M.B. He stated M.B. was irate, and he stated Grievant had choked him. Mr. Lanham did not see Grievant choke M.B., nor did he see any marks on M.B.'s neck. Mr. Lanham testified he had no reason not to believe M.B., and he had known M.B. for four or five years and he had always been truthful with him.

Linda Butcher, an LPN at the hospital, testified she had not observed the incident in the hallway, but had observed events which occurred outside from where she was smoking. She testified that the driver, and the other staff member who was to ride along to take M.B. home, were outside. It will be noted that neither the driver nor this other staff member was called as a witness. Ms. Butcher testified she did not see Grievant choke M.B. When she was interviewed during the investigation into the allegation she stated Grievant "threw down the phone, he got [M.B.] like this, ____ (See footnote 3) come around, set [him] down like that and was like that. But I'm behind ____ I thought ____." She was then askedduring the interview, "[y]ou thought [Grievant] had [M.B.] up around the neck", and she responded, "[y]eah. So at that point I go up to confront Barbara because I was so upset about the medicine . . .." She testified at the Level IV hearing that M.B. sat down, giving no indication that Grievant had assisted M.B. in attaining a sitting position, although she later testified Grievant had put the phone down and gone over and put his hands on M.B. and sat him down. She further stated Grievant was standing behind M.B. with his hands on his shoulders close to his neck. She stated Grievant did not have M.B. around the neck, and if she had thought he was hurting M.B., she would have confronted Grievant. During the investigation she also stated, "when Jeff went after [M.B.], just put [him] down, but it was....I don't know, from her to...." She was then asked if she felt anyone was in danger, and she responded yes, M.B. She explained at the Level IV hearing that Grievant had not "gone after" M.B., but rather, had gone over to him and moved him away from Ms. Anderson and sat him down. She further explained she was afraid M.B. was going to get hurt because the situation was close to being out of control, and she felt it was leading to a "Code 3." This would mean staff would have to restrain M.B., which could have led to M.B. getting hurt. A Code 3 is called when it is a crisis

situation, and things are out of control.

Ms. Butcher testified she heard M.B. state that Grievant had choked him. She testified Grievant seemed angry and upset. She stated the scene was mass confusion, and she did not know what to believe, although M.B. had never lied to her. She stated she saw marks on M.B.'s neck, although in her statement taken during the investigation she had said Mr. Lanham had told her there were marks on M.B.'s neck, but she “wasn't paying attention to that.” At the Level IV hearing she was not able to read the statement she had given during the investigation due to her poor eyesight. She then stated she did not get close enough to M.B. to check to see if he had bruises, but she could see a reddened area. She also heard M.B. threaten to have a biker friend get Grievant. Ms. Butcher's testimony and her statement given during the investigation are inconsistent. While the statement given during the investigation has the advantage of being taken closer in time to the events, it was not given under oath, it was not signed by Ms. Butcher, Ms. Butcher could not read the statement during the hearing to attest to its authenticity, the record does not reflect who transcribed the statement, and it is not certified as accurate. It further contains gaps, not only from where the transcriptionist apparently could not understand what was being said, but also from where Ms. Butcher did not finish her thought or did not make clear what she meant. The investigators at times did not follow up to clarify what Ms. Butcher meant, and when they did, Ms. Butcher sometimes still did not offer a clear explanation. As Grievant pointed out, Ms. Butcher was upset that M.B. was not allowed to have his medicine, and she focused on this during the interview. She acknowledged that the scene was “mass confusion,” and it is clear she did not have a good understanding of the situation. The undersigned does not find Ms. Butcher's portrayal of events, either in her statement taken during the investigation, or in her testimony given at the Level IV hearing, to be reliable. The undersigned concludes, however, that Ms. Butcher did not see Grievant choke M.B. Had Grievant put his hands around M.B.'s neck at this time, other staff members would have also had a clear view of this. This is apparently the same conclusion reached by the investigators, as the report states, “[a]nother staff observed Jeff placing both of his hands on the patient[']s shoulders to sit the patient down.” There is no mention in the report that anyone saw Grievant put his hands on the patient's neck. (See footnote 4)

Patient advocate Nancy Fry was notified that there was an allegation of patient abuse. Ms. Fry, Joeleen Franklin, a representative from Adult Protective Services, and Barbara Bias, RN at the hospital, conducted an investigation and prepared a written report. None of these investigators was

called as a witness. The written report, dated August 23, 2001, states the complaint as Grievant grabbed M.B. by the throat “in front of the clinical building inside the smoke building.” The report found there was patient physical abuse when Ms. Anderson flipped a cigarette out of the patient's hand in his personal space, when Grievant restricted the patient's communication, and “use of non therapeutic physical intervention as defined by NVCI.” The report does not discuss whether the allegation that Grievant choked M.B. was substantiated. The report notes as a system issue whether there was appropriate discharge planning.

Ms. Fry and Ms. Bias interviewed M.B. over the telephone. A transcript of the interview was placed into evidence as Respondent's Exhibit 3. M.B. was not under oath, the statement was not signed by M.B., and the transcript is not certified. As with Ms. Butcher's statement, it contains many gaps where the transcriptionist apparently could not make out what M.B. had said. M.B. stated, “[t]he guy grabbed me by the throat, outside. . . . He grabbed me by the throat and lift[ed] me off the ground and set me ___ picnic table outside. . . . He grabbed me right by the throat....knocked the phone out of my hand and grabbed me by the throat and lifted me off the ground.” M.B. again stated this occurred outside.

This statement is hearsay.

> Under W. Va. Code § 18-29-6, the formal rules of evidence are not applicable in grievance proceedings, except for the rules of privilege recognized by law. 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. Seddon v. W. Va. Dept. of Health, Docket No. 90-H-115 (June 8, 1990). Nonetheless, an administrative law judge must determine what weight, if any, is to be accorded hearsay evidence in a disciplinary proceeding. See Miller v. W. Va. Dept. of Health and Human Res., Docket No. 96-HHR-501 (Sept. 30, 1997); Harry v. Marion County Bd. of Educ., Docket Nos. 95-24-575 & 96-24-111 (Sept. 23, 1996); Seddon, supra.

> There are several factors to consider in determining the weight to be allocated to hearsay evidence, including: the availability of persons with first-hand knowledge to testify at the hearing; whether the declarant's out-of-court statements were in writing, were signed, or were in affidavit form; the employer's explanation for failing to obtain signed or sworn statements; whether the declarants were disinterested witnesses to the events and whether the statements were routinely made; the consistency of the declarants' accounts with other information in the case, their internal consistency, and their consistency with each other; whether corroboration for the statements can otherwise be found in the employer's records; the absence of contradictory evidence; and the credibility of the declarants when they made the statements attributed to them. See Borninkhof v. Dept. of Justice, 5 M.S.P.B. 150 (1981).

Gunnells v. Logan County Bd. of Educ., Docket No. 97-23-055 (Dec. 9, 1997).

Ms. Anderson testified that when M.B. returned to the hospital after this incident, he had repeatedly boasted that he had gotten one fired, and that “gray haired bitch is the next one,” referring to Ms. Anderson. Mr. Jenkins testified M.B. had bragged to him that he had gotten Grievant fired, and that “long gray haired bitch” was next.

M.B.'s statement will be given no weight. M.B. obviously was not a disinterested party, his statement is not corroborated by anyone, although if Grievant had grabbed him by the throat and lifted him off the ground outside several people would have seen this, his statement was not signed or given under oath, and it is not believable that Grievant could have grabbed this large man by the throat and lifted him off the ground.

Several witnesses testified that Grievant would not abuse a patient, and that his presence at the hospital made it a safer place for everyone, rather than a dangerous place for patients. Ms. Anderson stated the patients love Grievant and feel safe with him, and they ask for him all the time. She stated Grievant was gentle and loving with the patients. Sal Barbosa, the charge nurse on Ward 4, likewise testified that the patients trusted Grievant, would talk to him if they needed someone to talk to, and they have been asking for him. He opined that the patients and staff were safer with Grievant at the hospital. Cindy Seagraves, the Nurse Manager on Unit 2, testified Grievant's presence diffused a lot of situations, and the hospital was safer with Grievant there because of his size. She had in the past been the week-end Nursing Supervisor, and had supervised Grievant'swork. She had never seen him act improperly toward a patient. Mr. Jenkins referred to Grievant as a “gentle giant.” He stated Grievant had excellent rapport and patience with the patients, he was a comfort to everyone when he was employed at the hospital, and everyone was safer with Grievant there.

Respondent failed to prove Grievant choked M.B. There was no evidence whatsoever that Grievant put his hands around M.B.'s neck. No one saw this, no one heard M.B. gasping for breath or coughing, and no one saw any marks on M.B.'s neck which they could state were attributable to choking.

As to the other charges, while Grievant admitted he prevented M.B. from using the telephone, no one testified that this was improper under the circumstances or that any policy prevented it. In this instance, M.B. had already been discharged and he was supposed to be getting into the vehicle, not using the telephone. He did not ask anyone if he could use the telephone, and there is no indication

that he had any need to use it. The undersigned cannot find that Grievant did anything wrong when he hung up the telephone so M.B. could not use it.

The dismissal letter further states Grievant used an improper restraint technique. It does not make clear what particular action by Grievant was improper, other than the alleged choking. It refers earlier to Grievant “push[ing]” M.B. “backwards out of the exit door with both hands on his chest.” No one testified Grievant “pushed” M.B. out the door. Grievant did put both hands on M.B.'s chest and backed him out the door; however, no one testified that this was an improper action under the circumstances, nor did Respondent argue that Grievant was punished for this.

Patty Queen, Coordinator of Nursing Education, instructs the staff in NVCI. She testified that NVCI is a team approach. It takes the efforts of two people to properly use NVCI, with one person one each side of the patient to restrain him. She testified it was proper procedure to put one's hand out to tell a patient to stop, but it was not properprocedure to leave the hand out so that the patient ran into it. In this instance, assuming Grievant's efforts to prevent M.B. from hurting Ms. Anderson and to get the situation under control by using his hand to stop M.B. was not appropriate, NVCI could not have been used, because Ms. Anderson was ducking to avoid being hit with the telephone, and was not up helping Grievant restrain M.B. as is necessary to apply NVCI. Respondent has not proven Grievant's efforts to protect Ms. Anderson from serious bodily harm were improper.

It will be noted at this point that several witnesses testified they did not believe NVCI would work in all situations; and, indeed, it had not been effective with this patient during an earlier episode when it took five people to restrain him. Mr. Jenkins characterized it as “an absurd tool in an assaultive situation with a large male.” He testified he had been involved in hundreds of Code 3 situations. Mr. Herrera described an incident where a patient was involved in a fight. Mr. Herrera was called, and when he arrived, the patient was sitting in the floor. Mr. Herrera and another male security officer, who was approximately 260 pounds, got on either side of the patient and put one hand on each shoulder. He stated the patient was able to stand up with no problem, even though they were trying to restrain him. During another incident with this patient, Mr. Herrera had gone down 37 steps, and 13 staff members were injured during this time period. Mr. Herrera also stated he believed that for NVCI to be effective, the two staff members attempting to use the technique needed to practice the technique together routinely in order to develop teamwork, so that when a sudden emergency situation arose, they could work together more effectively. He testified he had been involved in 171

Code 3's at the hospital since January 2000, and he had not seen NVCI effectively used in any of these Code 3's.

The following Findings of Fact are made based upon the record developed at Level IV.

Findings of Fact

1. Grievant was employed at Mildred Mitchell-Bateman Hospital as a Health Service Worker for nearly three years when he was dismissed on August 31, 2001. Theprimary reason for Grievant's dismissal was the charge he had “physically grab[bed] this patient around the neck until his throat turned red.” He was also charged with restricting the patient's “communication by hanging up the phone and not allowing him to complete a phone call,” and using “an improper restraint technique, i.e. you did not use the Non- Violent Physical Crisis Intervention training taught to you by Staff Development.”

2. Mildred Mitchell-Bateman Hospital houses and treats patients who are mentally ill.

3. On August 7, 2001, Grievant was assisting Barbara Anderson, a Health Service Worker, with a patient, M.B., who was being discharged. The patient was swearing continuously at Ms. Anderson and Grievant, and when they got him to the vehicle which was to be used to transport him home, he refused to get into the vehicle and demanded the medication he had brought with him to the hospital.

4. Grievant checked on M.B.'s medication, and was told the doctor would not release it. He was also told to tell M.B. if he would not leave, the police would be called. Grievant relayed this information to M.B. M.B. still refused to get into the vehicle.

5. Grievant went inside and acted as though he was going to use the telephone to call the police. M.B. started toward the vehicle and Grievant put the telephone down and walked further inside. M.B. then went inside and started to use the telephone. Ms. Anderson followed him inside. Grievant came back to the hallway where the telephone was and disconnected M.B.'s telephone call. M.B. started to hit Ms. Anderson in the head with the telephone receiver. Grievant blocked M.B.'s efforts with his arm, and put his hand out toward M.B.'s chest to stop his advance. Grievant's hand met M.B. in the chest and neck area. Ms. Anderson did not attempt to assist Grievant to restrain M.B., as she was ducking to avoid being hit with the telephone receiver. Grievant put his hands on M.B.'s chest and backed him out the door.

6. Grievant did not choke M.B. 7. Mildred Mitchell-Bateman Hospital trains its employees

in NVCI. NVCI teaches staff to first talk to the patient to try to de-escalate the situation. It also teaches acceptable ways to restrain a patient who physically assaults them or someone else, which are supposed to be effective in any situation.

8. It is a proper NVCI technique to use one's arm to block a patient's attempt to strike someone. It is also a proper NVCI technique to put one's hand out when a patient is invading one's personal space. It is not a proper technique to leave the hand out if the patient continues to advance. The proper technique is to move away from the patient.

9. It takes at least two people to properly restrain a patient using NVCI. Grievant could not use a proper NVCI technique on M.B. without Ms. Anderson's assistance. In past situations with M.B., it had taken at least five people to restrain him.

10. Grievant was dismissed from his employment with HHR in 1999, based upon a charge of abuse, which was found to be false. Grievant was reinstated.

11. Grievant received a verbal reprimand on March 29, 2001, for patient neglect, when a patient was left outside alone.

12. Grievant was suspended for one day on July 18, 2001, based upon a charge of verbal abuse of a patient. Grievant filed a grievance challenging the suspension, and prevailed at Level III of the grievance procedure on September 14, 2001. The suspension was reversed, and was ordered removed from his records. This suspension was considered by Respondent in the decision to fire Grievant.

13. Grievant's most recent performance appraisals, including one for the five months ending February 28, 2001, praise his rapport with the patients and staff. His performance appraisal for the four month period ending June 1, 2000, notes “[y]ou provide a sense of security to the staff as well as the patients by talking and interacting and accepting them.” His performance appraisal for what appears to be the period from October 1, 1999, through August 31, 2000, comments “[y]ou are open and honest with thepatients, co-workers and nurse manager. Your facts are usually in order when you bring issues to me and that is a big help in sorting out deatails [sic].” It later states, “I have witnessed you and your interactions with the clients. You show concern and interest in them and it shows in their interactions with you that they know you care.” Grievant's overall rating on his performance appraisals was in the “meets expectations” range, and he received a merit increase in October 2000.

The following Conclusions of Law support the Decision reached.

Conclusions of Law

1. Pursuant to W. Va. Code § 29-6A-6, the burden of proof in disciplinary matters rests with the employer, and the employer must meet that burden by proving the charges against an employee by a preponderance of the evidence. Ramey v. W. Va. Dep't of Health, Docket No. H-88-005 (Dec. 6, 1988).

2. Grievant's dismissal was based upon the charge that he had choked a patient. Respondent failed to prove Grievant choked a patient. Respondent also failed to prove Grievant acted improperly in hanging up the telephone while the patient was using it, or that he had otherwise failed to use a proper NVCI restraint technique.

Accordingly, this grievance is **GRANTED**. Respondent is **ORDERED** to reinstate Grievant to his position as a Health Service Worker at Mildred Mitchell-Bateman Hospital, to assure that all record of the allegations of patient abuse and his dismissal are removed from all files, to pay Grievant back pay, plus interest, from August 31, 2001, and to restore all benefits, including annual and sick leave, retirement, and medical insurance, if any, to that date, as though Grievant had not been dismissed from his employment.

Any party or the Division of Personnel may appeal this Decision to the circuit court of the county in which the grievance arose, or the Circuit Court of Kanawha County. Any such appeal must be filed within thirty (30) days of receipt of this Decision. W. Va. Code § 29-6A-7 (1998). Neither the West Virginia Education and State Employees Grievance Board nor any of its Administrative Law Judges is a party to such appeal and should not be so named. However, the appealing party is required by W. Va. Code § 29A-5-4(b) to serve a copy of the appeal petition upon the Grievance Board. The appealing party must also provide the Grievance Board with the civil action number so that the record can be prepared and transmitted to the circuit court.

BRENDA L. GOULD

Administrative Law Judge

Dated: December 28, 2001

Footnote: 1

Two days of hearing were held at Level IV, on October 29 and November 20, 2001. Grievant represented himself, and Respondent was represented by Jon R. Blevins, Esquire. This matter became mature for decision upon receipt of the last of the parties' written arguments on November 29, 2001.

Footnote: 2

Ms. Anderson believed M.B. was 365 pounds, perceiving him to be about 100 pounds heavier than other witnesses perceived him to be.

Footnote: 3

The transcripts of the interviews contain many blank spaces, and were not certified by a court reporter.

Footnote: 4

The investigators had the advantage of interviewing the driver and the staff member who was present to assist in the transportation of M.B., while the undersigned did not.