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KARL MARSH

v.

DOCKET NO. 92-HHR-027

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES/
WESTON HOSPITAL**

DECISION

Grievant, Karl Marsh, filed a grievance at level four on January 29, 1992, in which he alleged that he had been "unjustly dismissed" from his duties as a security guard at Weston State Hospital. An evidentiary hearing was conducted on March 17, 1992, and the submission of proposed findings of fact and conclusions of law with responses thereto by April 15, 1992, completed the record for decision.

Hospital Administrator Rein Valdov notified Grievant of his dismissal by letter dated January 23, 1992. That letter further advised Grievant of the reasons for the disciplinary action, stating in part:

The charge for your dismissal is physical abuse of a patient. The specific reason for that charge is:

Liz Marteny, Patient Advocate, conducted an investigation regarding allegations of abuse by Patient #12902. Evidence from that investigation

held by the Patient Advocate supports the charge that in the Hospital Auditorium on January 6, 1992, you grabbed both arms of Patient #12902 with your arms and pulled them behind her back and held them in that position. In addition, while taking this patient back to Ward B, you pushed her face into the corner of the elevator and held her in that position while on the elevator. When the patient was returned to Ward B, you took her straight to the seclusion room. Testimony taken during the investigation indicates that Patient #12902 is a person who is easily calmed, and that it would have helped in this situation to talk with her. Testimony further indicates that you did not try to talk to the patient or try to calm her at all before, during, or after the incident. Your action was a violation of this patient's right to be free from unreasonable physical restraint and constituted abuse.

DHHR Policy 8000 defines physical abuse as the use of physical force, body posture/gesture or body movement that inflicts or threatens to inflict pain or harm a person. Physical abuse includes, but is not limited to:

unnecessary use of physical restraint

use of unnecessary force in holding/restraining a client (see facility procedure on Client Management)

improper use or application of physical or mechanical restraints

use of seclusion without proper orders or cause (See Policy 3325, Emergency Control Measures and Facility Client Management Procedures)

slapping, kicking, hitting, pushing, shoving, choking, hair pulling, biting, etc.

inappropriate horseplay

intentional inflicting of pain

punitive measures of any kind; this includes corporal punishment, withholding of meals for punitive reasons, inappropriate removal from treatment programs, restricting of communications,

withdrawal of privileges (see also Patient Rights Policy 3050 and 8000.02)

All Security Guards employed at Weston Hospital have been trained in non-violent crisis intervention. These interventions are considered a safe, non-harmful behavior management system designed to help Health Service Workers, professional staff and others during interventions with patients and provide for the best possible care and welfare of assaultive, disruptive or out-of-control persons even during the most violent moment. One of the primary objectives of that training is the use of techniques which are effective in approaching and reducing the tension rather than escalating the tension of an agitated person. All the holds presented in this training are to assist in maintaining dignity of the patient and eliminating potential for pain or harm. You were re-certified in this crisis training on November 14, 1991.

The security staff at Weston Hospital provide leadership in dealing with crisis situations. The Security staff set the example of how to effectively de-escalate a crisis situation. When Security staff abuse that leadership role, it adversely affects patients both directly and indirectly by the example set for other employees. This abusive intervention cannot be tolerated.

You are reminded that on December 2, 1991, I signed an agreement between you and Weston Hospital (Docket #91-HHR-393) as a result of a similar incident which occurred on August 6, 1992 and which resulted in your receiving a five-day suspension.

You are also reminded of another similar incident occurring on May 13, 1985, which resulted in your receiving a nine-month suspension.

Inasmuch as this is not the first or second occurrence of your excessive use of physical force constituting patient abuse, I am terminating your services as a Security Guard at Weston Hospital.

At the level four hearing Respondent offered the testimony of four employees who witnessed the Grievant's action during the incident which led to his dismissal. Drema Wine, a Health Service Worker, stated that she was in

the auditorium on January 6, 1992, at which time a social event was being held for the patients. Patient #12902, a female, was involved in a controversy with two male patients and at a point of disagreement threw a half-full soft drink can into the air. Ms. Wine recalled that she was in control of the situation but that Grievant quickly appeared, took hold of the patient and removed her from the area. Ms. Wine stated that Grievant blocked her view to some extent when he was in front of her but that she did not hear Grievant speak to the patient, whom he had taken by the arms, pulling them behind her back.

Ms. Wine apparently had not requested Grievant's assistance since she stated that she was having no difficulty in managing the patient, who could be talked to, and who was acting out verbally but was not fighting. Having been trained in the National Crisis Prevention Institute's (CPI) nonviolent crisis intervention program, Ms. Wine observed that Grievant should have been assisted by his partner to avoid potential harm to both the patient and the employees and that the hold used by Grievant to remove the patient was not that which the Hospital employees were trained to use.

At the time of the incident Tuesday Jefferies was employed by Respondent as a 90-day temporary employee and was classified as a security guard. On January 6, Ms. Jefferies was assigned to work with Grievant and was in the auditorium when he removed the patient. Ms. Jefferies

stated that Grievant indicated he did not want her assistance and proceeded to grasp the patient by her arms which he pulled behind her back. She observed that the patient struggled at first but then said she was fine and that Grievant could let go; however, Grievant ignored both the patient and a Health Service Worker who advised him that he could release the patient. Grievant then directed the patient to the elevator where he put her head in the corner. Ms. Jefferies continued to accompany Grievant who, she recollected, retained his grip on the patient while in the elevator and as they proceeded down the ward to the seclusion room, where he finally released her. Ms. Jefferies recalled hearing the patient complain about being restrained and, based upon her observation, opined that Grievant had hurt the patient.

Lucille Ullman was the Night Nurse Administrator on duty the evening of January 6. Ms. Ullman stated that she was called to Ward B where she found two nurses attending the patient who was angry and complaining about Grievant's treatment. When red marks were noticed on the patient's upper arms and back Ms. Ullman spoke with Grievant and asked him to show her how he had held the patient. Ms. Ullman demonstrated what she said Grievant had indicated to her, that he had held the patient's arms doubled behind her back.

Wavah Fultineer, a Health Service Worker assigned to Ward B, was on duty when Grievant returned the patient, who she recalled was crying and complaining about her arms and

back hurting.¹ Ms. Fultineer also stated that it was not necessary to restrain the patient who was immediately released from the seclusion room.

Elizabeth Marteny, who was at that time employed as an external advocate, investigated the patient's complaint filed against Grievant. Ms. Marteny stated that when she began her review she found that the patient had been discharged the day following the incident but that she was able to interview Ms. Wine, Ms. Jefferies, Ms. Fultineer, Ms. Ullman, and Grievant, who did not refer her to any additional witnesses.

Ms. Marteny stated that she asked Grievant to demonstrate for her how he handled the patient during the alleged incident and observed that in his reenactment Grievant held the patient above the elbows, pulling her arms back. This lead her to surmise that the patient's claim that Grievant had placed a knee in her back was probably inaccurate and that it was more likely his knuckles that she had felt. Grievant indicated to Ms. Marteny that he had acted in an emergency situation and did not have time to wait for help; however, after completing her investigation the advocate was not so convinced and determined that Grievant was guilty of abuse.

¹There is some possibility that the patient's crying could be attributed to her encounter with the male patient.

After reviewing Ms. Marteny's report with other staff members Mr. Valdov ascertained that Grievant had engaged in the abuse of a patient. Although Respondent utilizes a progressive discipline policy, Mr. Valdov determined that incidents of patient abuse were exempt from progressive discipline. Nevertheless, Mr. Valdov noted that Grievant had a record of prior incidents of this nature in 1985 and in September 1991. Because Grievant failed to act appropriately even after he had received additional training and counseling subsequent to the 1991 incident, Mr. Valdov concluded that he had no choice other than to terminate Grievant's employment.

Grievant offered the testimony of five co-workers to support his assertions that not all of the staff members present at the incident were interviewed by the advocate and that the CPI training was not effective in all situations. Ann Jamison, Licensed Practical Nurse, observed the patient throw the soda can and a Health Service Worker attempt to restrain the girl, whom she described as agitated, cursing, and attempting to free herself. Ms. Jamison noted that Grievant took the patient by her upper arms and directed her out the door. She did not hear Grievant ask for assistance and observed that Ms. Jefferies did not offer to help.

Ms. Jamison stated that she was aware that the procedures which employees were to use when physically controlling patients required the participation of two individuals but opined that it is impossible to utilize certain holds

when the patient is combative.² Ms. Jamison concluded that she did not perceive Grievant's actions in dealing with the patient to be harsh or rough.

Tim Ash, Health Service Trainee, stated that he saw Grievant place his hands on the patient's elbows and lead her out the door. Mr. Ash also opined that the nonviolent crisis intervention training was often not appropriate for real-life situations. Both Mr. Ash and Ms. Jamison indicated that their view was somewhat obstructed throughout the incident.

Linda Mick, Health Service Worker, also observed Grievant hold the patient by her elbows and lead her out of the room. Ms. Mick agreed that two people should have restrained the patient, but stated that she found the specific holds were hard to remember when faced with a crisis situation. John Slaughter and John Snyder, Security Guards, both testified that the CPI training was not effective with combative patients and was difficult to use, even with the elderly.³

Respondent asserts that the evidence supports a finding that Grievant was guilty of patient abuse, an act which warrants termination under West Virginia Department of

²Of course the testimony of all the witnesses establishes that the patient Grievant removed on the night in question was not combative.

³Grievant chose to not testify on his own behalf.

Health and Human Resources' (DHHR) discipline policy. Grievant argues that Respondent failed to prove that the termination of his employment was warranted; rather, he contends, the discipline was imposed in an arbitrary and capricious manner because Respondent had (1) failed to properly train security guards in handling combative patients, (2) used security guards in only such situations, (3) disciplined only one guard, (4) failed to conduct a proper investigation of the incident, (5) failed to retrain Grievant in dealing with combative patients, and (6) failed to prove Grievant was abusive to the patient. Grievant asserts that his actions were proper because efforts to "talk down" the patient had been unsuccessful and because he had used the least restrictive means necessary to de-escalate the situation.

The testimony of those Health Service Workers most familiar with the patient in question establishes that she could be controlled through talking and reasoning. None of the witnesses indicated that she had become involved in any direct physical altercation with the Health Service Worker who was supervising her that evening. Further, Grievant did not attempt to simply verbally calm or control the patient but forcefully removed her from the room and placed her in seclusion.

Although the view of all the witnesses was somewhat impaired their collective testimony supports a conclusion that, under the circumstances, Grievant exercised an

unnecessary use of physical restraint and seclusion, actions defined by DHHR Policy 8000 as physical abuse of a patient. Grievant also failed to properly perform his duties by utilizing the methods of control required by Respondent. While certain situations may arise where specific holds are ineffective or inappropriate, Grievant had recently been retrained and knew, or should have known, to first try and control the situation by talking to the patient and to seek assistance from his partner if physical intervention was necessary.

The progressive discipline program utilized by Respondent generally provides for varying levels of discipline for first through fourth offenses. This purpose of the program is to assist the employee in correcting unacceptable behavior and usually permits the opportunity for improvement; however, the guidelines are flexible and may be adjusted to the unique circumstances of specific situations. For example, a first infraction of a minor offense may warrant only a verbal reprimand, while the first incident of gross misconduct might warrant dismissal. The policy provides that the first infraction for patient abuse warrants a suspension pending further investigation. "If the charges are substantiated, appropriate disciplinary steps...may be levied."

The present matter constituted Grievant's third offense involving patient abuse. Grievant was first charged with abuse in May 1985 and, as a result, was terminated effective

June 15 of that year. Upon appeal, the Civil Service Commission found that Grievant was

capable of performing his job adequately with perhaps some additional training in the management of aggressive patients. Accordingly, Karl Marsh will have one last chance. We find there is sufficient cause to discipline Karl Marsh but believe dismissal is not warranted under the circumstances.

The Commission subsequently rescinded the dismissal and imposed a nine-month suspension.

Grievant was again charged with the physical abuse of a patient following an incident on August 6, 1991. As a result of that charge Grievant was initially suspended for thirty days; however, after Grievant filed a grievance, a settlement was negotiated whereby Respondent reduced the period of suspension to five days and agreed to provide Grievant with additional training in the management of aggressive and non-aggressive patients. Grievant was provided recertification training and counseling in September 1991, only three months prior to the third incident of patient abuse.

The undersigned finds that Respondent has proven by a preponderance of the evidence that on January 6, 1992, Grievant engaged in patient abuse through the unnecessary use of physical restraint, the use of unnecessary force in restraining a patient, and the use of seclusion without proper orders or cause. Patient abuse constitutes good cause for dismissal. Williams v. W.Va. Dept. of Human Services, Docket No. 90-DHS-130 (Sept. 30, 1990).

Therefore, Respondent's decision to terminate Grievant's employment must be upheld.

In addition to the foregoing narration it is appropriate to make the following specific findings of fact and conclusions of law.

Findings of Fact

1. Grievant has been employed by Respondent as a Security Guard at Weston State Hospital since 1981.

2. Grievant was terminated from his employment by Respondent on January 23, 1992, based upon a charge that he physically abused a patient.

3. Grievant had twice been previously suspended for charges of physical abuse. The first incident resulted in a nine-month suspension while the second incident resulted in a five-day suspension and the provision of additional training and counseling for Grievant.

4. Approximately three months after Grievant received the additional training and counseling, the third incident of patient abuse by Grievant was reported.

5. Grievant did not deny that he engaged in the actions set forth by Respondent but merely asserts that the training he received was ineffective.

Conclusions of Law

1. Pursuant to W.Va. Code §29-6A-6 the burden of proof in disciplinary matters rests upon the employer. The standard of proof is by a preponderance of the evidence. Ford v. W.Va. Dept. of Health/Welch Emergency Hospital, Docket No. 91-H-096 (Jan. 17, 1992); Dilley v. W.Va. Dept. of Health/Pinecrest Hospital, Docket No. 90-H-520 (July 18, 1991).

2. Respondent has proven by a preponderance of the evidence that Grievant engaged in the abuse of a patient, misconduct which establishes good cause for dismissal.

Accordingly, the grievance is DENIED.

Any party or the West Virginia Division of Personnel may appeal this decision to the "circuit court of the county in which the grievance occurred," and such appeal must be filed within thirty (30) days of receipt of this decision. W.Va. Code §29-6A-7. 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. Any appealing party must advise this office of the intent to appeal and provide the civil action number so that the record can be prepared and transmitted to the appropriate court.

DATED

July 23, 1992

Sue Keller

SUE KELLER
SENIOR ADMINISTRATIVE
LAW JUDGE