

STATE OF VERMONT

HUMAN SERVICES BOARD

In re) Fair Hearing No. 18,423
)
Appeal of)

INTRODUCTION

The petitioner appeals a decision by the Department of Aging and Disabilities (DAD) finding that he abused a mentally ill adult and proposing that his name be placed in the registry.

FINDINGS OF FACT

1. The petitioner is a "Psychiatric Technician II" at the Vermont State Hospital (VSH). He is currently on leave due to an injury associated with the event at issue. The petitioner's duties at the state hospital involved caring for mentally ill adults and included protecting them from harming themselves or others.

2. On September 20, 2002, at a time when he had been working at VSH for a year and a half, the petitioner was supervising several patients who were on a smoking porch. He was standing in the doorway of the porch and two other staff members were on the porch with the patients.

3. One of the patients, a severely manic man of large stature (6'2", 185 pounds) who had been at the hospital for about five weeks, Dave, began to harass another patient. Although Dave had no history of aggression at the hospital he was described as strong and energetic by all of the witnesses. He was instructed by a female staff member, A.B., to stop bothering the other patient. When he persisted, he was asked to leave the porch by B.W., a male member of the ward staff. He was also asked to leave by the petitioner. At that point, Dave got up quickly, causing some alarm to the staff. The petitioner and B.W. approached him and told him they were going to escort him back to his room. He flicked a lighted cigarette at the petitioner's feet. Each of them took an arm, B.W. on the right and the petitioner on the left, and attempted to escort Dave out of the smoking porch and to his room.

4. As they were moving through the doorway, Dave began to flail wildly. He butted B.W., who was on his right, with his head, hitting B.W. hard in the nose and knocking off his glasses and injuring his face (B.W. had just had eye surgery). By this time, they had been joined by a newly hired psychiatric technician, W.B., who had been passing in the hall. He grabbed Dave by the legs to keep him from kicking

the others. B.W. was having difficulty holding on to Dave's right arm due to his own injury and said to the petitioner that they had to "take him to the floor" in order to control him. They had called for extra help and a five-point restraint bed but it was slow in coming. They were also assisted by A.B., the female staff member who had been on the porch who also held Dave's legs. Throughout this time, Dave continued to flail, to swear and to scream in German at the staff members.

5. At this point, the petitioner says he put his right hand on Dave's upper back while holding his left wrist with his left hand and pushed him downward. He says that his hand may have slipped to Dave's neck in the struggle but he did not intend to push him by the neck nor did he shove him violently. When Dave went to the ground, the others fell with him. The petitioner says then that he put his right hand against the back of the petitioner's head and kept his cheek against the ground to keep him from turning his head because he felt Dave was trying to bite him. Someone else came to put a towel over Dave's head because according to the petitioner Dave was trying to spit at the staff. He continued to struggle until six persons restrained him by placing him on the five point bed. Dave calmed down later and was returned to his room.

6. Dave was not injured in the incident. The petitioner received a serious shoulder injury for which he is still being treated and for which he faces an operation in the near future. B.W. was also seriously injured. The petitioner reported to work briefly the morning after this event but has not been able to return since due to his injury. He continues to be an employee at VSH.

7. VSH did not report this incident immediately to DAD as it is required to do under the hospital licensing regulations. However, the matter did eventually come to DAD's attention and an investigation was conducted. After speaking with all of the witnesses, the alleged victim and the petitioner, the DAD investigator concluded that abuse had occurred because the petitioner had violated regulations in place for handling aggressive patients, known as "NAPPI" rules.

8. "NAPPI" (Non-abusive psychological & physical intervention) guidelines contain a number of holds or procedures to be followed to prevent a patient from injuring himself or others. Among the general principles of this methodology are to "always use the least restrictive/least forceful physical intervention possible" and to eschew take-downs.

9. The petitioner has been trained in this methodology twice, first when he worked at the Department of Corrections and second when he started at VSH. The training lasts for about a week. All of those involved in the incident on September 20 have had "NAPPI" training.

10. In spite of their immersion in the NAPPI training, virtually every witness, A.B., W.B. and later D.B., a more experienced technician testified that take-downs are part of the routine practice at the state hospital when aggressive patients cannot be restrained through NAPPI procedures. They all described NAPPI as an ideal procedure which cannot be carried out in the most difficult cases due to a shortage of staff members. Take-downs are a last but not uncommon approach to dealing with situations in which there is a danger to the staff or patients that must be minimized. However, although take downs are tolerated at VSH, there has been no training or guidelines in how to accomplish a take-down safely.

11. A.B., the female staff member who had been a "Psychiatric Technician I" for two and a half years and was present right after but not during the take-down said she observed the petitioner's hand on Dave's neck when he was on the ground. She offered the opinion that the take-down, which

she did not see, was, in hindsight, probably an excessive act due to the hand on the neck. She noted, however, that judgments have to be made quickly in dangerous conditions and it was clear that this was one because Dave was out of control, a staff member who was holding him was hurt, and there were no other staff members available to help in subduing him. She also said that she saw the petitioner's hand against Dave's cheek when he was on the ground which she felt was an appropriate action if Dave had been trying to bite him. She did not observe biting activity herself.

12. B.W., the other injured staff member was not called to testify but PATH agreed that its reports show that he called for the take-down after he was injured and did not feel that the petitioner used excessive or unwarranted force in performing this action.

13. W.B., the staff member who held Dave's legs during the take-down, had been at the state hospital as a "Psychiatric Technician I" for about five weeks at the time of the incident. He heard the attempts to verbally defuse the situation on the porch when he was walking down the hall and asked if he could help. When he came on the scene he saw the petitioner and B.W. "appropriately" restraining Dave by holding both of his arms. He originally testified that it was

the petitioner's idea to take Dave to the ground after he head-butted B.W. but later testified that it could have been B.W. himself who gave the order because he was losing his hold on Dave. He remembers that the petitioner pushed him to the floor by his neck although it did not strike him as unnecessarily rough at the time. He held Dave's legs while the restraint bed was brought. He recalls also that the petitioner was holding Dave's cheek against the floor. Dave was screaming "stop choking me" but W.B. said that the petitioner clearly was not choking Dave. He does not recall that Dave was biting but does recall that he was spitting. In retrospect, after more experience at the hospital, W.B. felt that the force might have been excessive because the petitioner had pushed him down by the neck, a maneuver he has never seen since although he has seen many other take-downs. He agreed, though, that the matter escalated quickly, that at least one person had already been injured and that Dave was out of control.

14. D.B., a "Psychiatric Technician II" at VSH who was not involved in the incident testified that the petitioner later bragged to him while they were working together that he had taken Dave down by the throat. The petitioner denies that he ever made such a statement.

15. Based on the above testimony, it is found that the petitioner's assertion that he did not intend to push Dave down by the neck or to treat him with unwarranted force is credible. The petitioner's testimony and that of other witnesses to the event were largely consistent. The evidence clearly shows that there was an emergency situation in which a very strong and out of control person had already seriously injured one technician, that the petitioner was responding as best he could to protect everyone, including the patient, and that he was forced to take action in the absence of either adequate staff or adequate training by the hospital in how to subdue a person in this situation. The allegation that he subsequently bragged about this take-down to a co-worker on a future shift is found to lack credibility since the petitioner did not continue to work at VSH after the incident due to his own injuries and since reporting to a more senior staff member that he "grabbed Dave by the throat" would be a statement seriously against his interests and in no way matched any description offered by any witness of what occurred on that day.

ORDER

The decision of the Department substantiating the abuse is reversed.

REASONS

The Commissioner of the Department of Aging and Disabilities is required by statute to investigate reports regarding the abuse of disabled adults and to keep those reports that are substantiated in a registry under the name of the person who committed the abuse. 33 V.S.A. § 6906, 6911(b). Persons who are found to have committed abuse may apply to the Human Services Board pursuant to 33 V.S.A. § 6906(d) for relief on the grounds that the report in question is "unsubstantiated."

The statute defines "disabled adult" as a person eighteen years of age or older, who has a diagnosed physical or mental impairment." 33 V.S.A. § 6902(5). Abused is defined, in pertinent part, as follows:

(1) "Abuse" means:

(A) Any treatment of an elderly or disabled adult, which places life, health or welfare in jeopardy or which, is likely to result in impairment of health;

(B) Any conduct committed with an intent or reckless disregard that such conduct is likely to cause unnecessary harm, unnecessary pain, or

unnecessary suffering to an elderly or disabled adult;

. . .

33 V.S.A. § 6902

DAD may substantiate a report of abuse if, after investigation, it determines that the "report is based upon accurate and reliable information that would lead a reasonable person to believe that the . . . disabled adult has been abused . . . 33 V.S.A. § 12. DAD has argued that the petitioner's conduct meets the above definition because it was outside of the boundaries of the NAPPI guidelines used at the state hospital. Taking the patient down, was in DAD's view, sufficient to find that the patient was abused, regardless of the manner in which he was taken down.¹

DAD's position is not sustainable because the statute above does not say that a violation of the NAPPI guidelines per se constitutes abuse. The statute requires that the individual conduct of the alleged perpetrator must be evaluated to see if it is reasonable to conclude that abuse

¹ DAD was asked at hearing whether it intended to make abuse findings against all of the witnesses who had admitted under oath that they regularly take-down patients. DAD's response was just as the police do not have to arrest all speeders it does not have to make findings against all persons who violate NAPPI. DAD made no attempt to distinguish this case from any others described at hearing calling into serious question whether it really feels that all vulnerable adults need to be protected from these procedures.

has occurred as it is described in the abuse statute. DAD did not make such an evaluation in this case.

The facts here show that the petitioner did take an action that could have resulted in injury to the mentally disabled patient. However, his motivation in taking that action was clearly to prevent more serious injury to the patient and to other staff members. It is possible that the petitioner could have taken some other action which might have been less risky to the patient but, as every witness pointed out, there is not a lot of time to reflect on what to do in this kind of emergency situation. The other witnesses did not accuse the petitioner of acting in bad faith or recklessly in handling a difficult situation. It appears from the unanimous testimony of all the VSH employees that the petitioner had been put in the unenviable position of creating an appropriate immediate response to a dangerous situation because VSH staffing numbers and NAPPI guidelines do not adequately address the situations in which staff members often find themselves.

It would be unfair in this case to find that the petitioner abused the patient because someone after the fact could imagine some better method of dealing with the problem. Ironically, the patient was not injured at all during this

allegedly abusive incident but both of those charged with his care were seriously injured by the patient. If the proof is in the pudding, it must be said that the petitioner did protect the patient, even at the cost of serious injury to himself and his colleague. If the petitioner did place his hand on the patient's neck in the course of the take-down it was accidental and the result of the patient's flailing, not a deliberate or reckless attempt to cause unnecessary harm. A reasonable person could not believe that the patient had been abused in this case and thus DAD's decision to substantiate the report should be reversed.

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